Regular Meeting of the

Santa Clara County Health Authority
Governing Board

Thursday, December 12, 2019, 12:00 PM - 2:30 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference
Business
4000 Moorpark Avenue, #200
San Jose, CA 95112

AGENDA

1.	**Roll Call**	Mr. Brownstein	12:00	5 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Governing Board reserves the right to limit the duration of the public comment period to 30 minutes. **Announcement Prior to Recessing into Closed Session** Announcement that the Governing Board will recess into closed session to discuss Item No. 3 below.	Mr. Brownstein	12:05	5 min
3.	**Adjourn to Closed Session**		12:10	

a. **Existing Litigation** Government Code Section 54956.9(d)(1)):
It is the intention of the Governing Board to meet in Closed Session to confer with Legal Counsel regarding consolidated Cases before the Board Administration of the California Public Employees' Retirement System:

i. In the Matter of the Appeal Regarding Membership Exclusion of Foundation Employees by Santa Clara County Health Authority (Respondent) and Craig W. Walsh (Respondent) Case Number: CalPERS Case No. 2017-1114; OAH No. 2018051223.

ii. In the Matter of Appeal Regarding Membership Exclusion of Foundation Employees by Santa Clara County Health Authority (Respondent) and Melodie U. Gellman (Respondent) Case Number: CalPERS Case No. 2017-1115; OAH Case No. 2018051029.

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

4.	**Report from Closed Session**	Mr. Brownstein	12:35	5 min
5.	**Annual CEO Evaluation Process** Consider potential annual salary adjustment and incentive bonus for the Chief Executive Officer. **Possible Action:** Approve an annual salary increase and incentive bonus for the CEO	Mr. Brownstein	12:40	5 min
6.	**Approve Consent Calendar and Changes to the Agenda** Items removed from the Consent Calendar will be considered as regular agenda items. **Possible Action:** Approve Consent Calendar	Mr. Brownstein	12:45	5 min

a. Approve minutes of the September 26, 2019 **Regular Board** Meeting

b. Accept minutes of the October 24, 2019, 2019 **Executive/Finance Committee** Meeting
- Ratify acceptance of the FY2018-2019 Independent Auditor's Report
- Ratify approval of the August 2019 Financial Statements

c. Accept minutes of the November 14, 2019 **Executive/Finance Committee** Meeting
- Ratify approval of the September 2019 Financial Statements
- Ratify acceptance of the of the Network Detection and Prevention Update

d. Accept minutes of the November 14, 2019 **Compliance Committee** Meeting
- Ratify acceptance of the Compliance Program Update
- Ratify acceptance of the Compliance Activity Report
- Ratify acceptance of the Compliance Dashboard and Work Plans
- Ratify acceptance of the Oversight Committee Report
- Ratify acceptance of the Fraud, Waste and Abuse Report

e. Accept minutes of the November 19, 2019 **Quality Improvement Committee** Meeting
- Ratify acceptance of the Accessibility of Provider Network Assessment MY2019
- Ratify acceptance of the Member Services Email Response Evaluation
- Ratify acceptance of Committee Reports:
  - Credentialing Committee – September 26, 2019
  - Pharmacy & Therapeutics Committee – June 20, 2019
  - Utilization Management Committee – July 17, 2019

f. Accept minutes of the December 4, 2019 **Quality Improvement Committee** Meeting
- Ratify acceptance of the Network Adequacy Assessment
- Ratify acceptance of the Quality & Accuracy Assessment of Personalized Information of Health Plans Services
- Ratify acceptance of the Quality & Accuracy Assessment of Pharmacy Benefit Information
- Ratify acceptance of the Continuity & Coordination of Medical Care
- Ratify acceptance of the Member Experience Analysis

- Committee Reports
  - Credentialing Committee
  - Pharmacy & Therapeutics

g. Accept minutes of the November 13, 2019 **Provider Advisory Council** Meeting
h. Accept minutes of the December 10, 2019 **Consumer Advisory Committee** Meeting
i. Approve **Publicly Available Salary Schedule**
j. Adopt resolution approving the revised **Conflict of Interest Code**
k. Approve the Annual Report to the **County Board of Supervisors**

7.	**Compliance Report** Review and discuss quarterly compliance activities and notifications. **Possible Action:** Accept Compliance Report	Ms. Larmer	12:50	10 min
8.	**October 2019 Financial Statements** Review recent organizational finance performance. **Possible Action:** Approve the October 2019 Financial Statements	Mr. Cameron	1:00	10 min
9.	**Fund Retiree Healthcare Liability** Review CalPERS 6/30/2019 retiree health care liability. **Possible Action:** Approve Resolution for final payment of outstanding retiree health care liability	Mr. Cameron	1:10	5 min
10.	**Community Resource Center Lease** Discuss the lease of 408 N. Capitol Avenue, San Jose, CA and the proposed demolition and build out. **Possible Action:** Authorize CEO to execute contracts as necessary for demolition and build out at 408 N. Capitol Avenue, San Jose, CA, not to exceed approved capital budget amount of $1.25 million	Mr. Cameron Ms. Tomcala	1:15	10 min
11.	**Naming the Community Resource Center** Discuss naming the Community Resource Center. **Possible Action:** Adopt a resolution naming the CRC.	Ms. Tomcala	1:25	5 min
12.	**Community Health Investment Program** Discuss establishment of a Community Health Investment Program that includes an Innovation Fund and a Special Project Fund for CBOs. **Possible Action:** Approve establishment and funding of an Innovation Fund (Policy GO.03) **Possible Action:** Approve revisions and funding for Policy GO.02 (Special Project Fund for CBOs)	Ms. Tomcala Mr. Cameron	1:30	40 min
13.	**Government Relations Update** Discussion of CalAIM and other local, state and federal legislative and policy issues impacting the Plan and its members.	Mr. Haskell	2:10	10 min
14.	**CEO Update** Discuss status of current topics and initiatives. **Possible Action:** Accept CEO Update	Ms. Tomcala	2:20	10 min
15.	**Adjournment**	Mr. Brownstein	2:30	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Governing Board on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Rita Zambrano 48 hours prior to the meeting at 408-874-1896.
- To obtain a copy of any supporting document that is available, contact Rita Zambrano at 408-874-1896. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com.

Regular Meeting of the

Santa Clara County Health Authority Governing Board

Thursday, September 26, 2019, 12:00 PM - 2:30 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Draft

Members Present
Bob Brownstein
Alma Burrell
Darrell Evora
Kathleen King
Liz Kniss
Ria Paul, M.D.
Sherri Sager
Linda Williams

Members Absent
Dolores Alvarado
Sue Murphy
Evangeline Sangalang
Jolene Smith

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance & Regulatory Affairs Officer
Chris Turner, chief Operating Officer
Laurie Nakahira, D.O., Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Laura Watkins, VP Marketing & Enrollment
Sharon Valdez, VP Human Resources
Neal Jarecki, Controller
Tyler Haskell, Director of Government Affairs
Janet Gambatese, Director, Provider Network Management
Jordan Yamashita, Director, Compliance
Johanna Liu, Director, Quality & Process Improvement
Jayne Giangreco, Manager, Administrative Services
Rita Zambrano, Executive Assistant

Others Present
Daphne Annett, Burke, Williams & Sorenson, LLP *(via telephone)*
Christine Rutherford-Stuart, County of Santa Clara
Phillip Vu, Community Health Partnership
Tiffany Washington, Anthem

1. Roll Call

Bob Brownstein, Chair, called the meeting to order at 12:10 pm. Roll call was taken and a quorum was established. Mr. Brownstein welcomed Alma Burrell and Sherri Sager as new members of the Santa Clara County Health Authority Governing Board.

2. Public Comment

There were no public comments.

3. **Adjourn to Closed Session**

   a. **Existing Litigation**
   The Governing Board met in Closed Session to confer with Legal Counsel regarding consolidated Cases (i) CalPERS Case No. 2017-1114; OAH No. 2018051223 and (ii) CalPERS Case No. 2017-1115; OAH Case No. 2018051029.

Alma Burrell arrived at 12:19 pm.
Sherri Sager arrived at 12:21 pm
Liz Kniss arrived at 12:23 pm.

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

Kathleen King arrived at 12:44 pm.

   c. **Real Property Negotiations**
   The Governing Board met in Closed Session to confer with its Real Property Negotiators concerning the price and terms of payment related to the possible lease of real property located at 408 N. Capital Avenue, San Jose, CA.

4. **Report from Closed Session**

   Mr. Brownstein reported the Governing Board met in Closed Session to discuss existing litigation, contract rates and real property negotiations.

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

   Mr. Brownstein presented the Consent Calendar and indicated all items would be approved in one motion.

   a. Approve minutes of the June 27, 2019 **Regular Board** Meeting
   b. Approve minutes of the May 21, 2019 **Special Board** Meeting
   c. Accept minutes of the July 25, 2019 **Executive/Finance Committee** Meeting
   - Ratify authority of staff to negotiate and execute a lease for the real property 408 N. Capitol Avenue within budget parameters.
   - Ratify approval of the May 2019 Financial Statements
   - Ratify approval of the Investment Diversification proposal

   d. Accept minutes of the August 22, 2019 **Executive/Finance Committee** Meeting
   - Ratify approval of the Preliminary June 2019 Financial Statements
   - Ratify acceptance of the Network Detection & Prevention Update

   e. Accept minutes of the August 22, 2019 **Compliance Committee** Meeting
   - Ratify acceptance of the Compliance Activity Report
   - Ratify acceptance of the Compliance Dashboard and Work Plans
   - Ratify acceptance of the Oversight Committee Report
   - Ratify acceptance of the Fraud, Waste and Abuse Report

   f. Accept minutes of the August 14, 2019 **Quality Improvement Committee** Meeting
   - Ratify approval of the CMC Availability of Practitioners Evaluation
   - Ratify approval of the Population Health Management Impact 2018 Report
   - Ratify approval of the Updates to Policy QI.13 Comprehensive Case Management
   - Ratify acceptance of Committee Reports:
     - Credentialing Committee – June 5, 2019
     - Pharmacy & Therapeutics Committee – March 21, 2019
     - Utilization Management Committee – April 17, 2019

   g. Accept minutes of the August 7, 2019 **Provider Advisory Council** Meeting
   h. Accept minutes of the September 10, 2019 **Consumer Advisory Committee** Meeting
   i. Accept 2018 **Employee Satisfaction Survey Report**
   j. Approve **Publicly Available Salary Schedule**

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

6. **Compliance Report**

Robin Larmer, Chief Compliance and Regulatory Affairs Officer, provided a status update on the CMS Program Audit. Ms. Larmer noted a draft report was received from the Independent Validation Auditors. After review by the Plan and minor editing, the Final Report will be submitted to CMS. CMS will review the Report and make a determination regarding closure of the Audit.

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

7. **July 2019 Financial Statements**

Dave Cameron, Chief Financial Officer, presented the July 2019 financial statements, which reflected a current month net surplus of $692 thousand ($262 thousand unfavorable to budget). Enrollment decreased by 1,050 members from the prior month to 248,155 members. Medi-Cal enrollment has generally declined since October 2016 while CMC membership has grown due to continued outreach efforts. Revenue reflected a favorable current month variance of $82 thousand (0.1%) largely due to higher member months versus budget. Medical expense reflected an unfavorable current month variance of $444 thousand (0.5%) due to slightly higher capitation member months and higher fee-for-service expenses. Administrative expense reflected an unfavorable current month variance of $85 thousand (1.7%) due largely to the timing of personnel hiring and certain non-personnel expenses. The balance sheet reflected a Current Ratio of 1.2:1, versus the minimum required by DMHC of 1.0:1. Year-to-date capital investments of $229 thousand were made.

It was moved, seconded, and the July 2019 Financial Statements were **unanimously approved.**

8. **Preliminary Fiscal Year 2018-2019 Year in Review**

Christine Tomcala, Chief Executive Officer, presented the preliminary year-end status of the Fiscal Year 2018-2019 Plan Objectives. A summary of performance on the six Plan Objectives was provided.

It was moved, seconded, and unanimously approved to accept the FY'19 Plan Objectives Performance Report.

9. **Fiscal Year 2018-2019 Team Incentive Compensation**

Ms. Tomcala reminded the Board of the Fiscal Year 2018-2019 Team Incentive Compensation program, which is designed to recognize employees for achieving critical Plan Objectives, including Compliance Metrics and answering member calls within ≤ 30 seconds, as well as CMC NCQA Accreditation and Medi-Cal HEDIS improvement, noting that staff has earned a 1.2% bonus. The Executive Team recommends that the Board consider increasing the Incentive Compensation payment for non-Executive staff to 2% in recognition of the significant efforts expended and progress achieved.

It was moved, seconded, and unanimously approved to accept the recommended 2018-2019 Team Incentive Compensation Payout at 2% for non-Executive staff, and 1.2% for Executive staff (excluding the CEO).

10. **Fiscal Year 2019-2020 Plan Objectives**

Ms. Tomcala presented the proposed Fiscal Year 2019-2020 Plan Objectives, which have an overarching focus on quality improvement and operational excellence. Management proposed specific objectives in six areas. Benchmark quality performance, and compliance and delegation oversight, are critical priorities, with additional objectives in IT infrastructure, membership growth and retention, collaboration with Safety Net community partners, and achieving budgeted financial performance.

It was moved, seconded, and the Fiscal Year 2019-2020 Plan Objectives were **unanimously approved** with the following amendments: 1. Quality objectives should include "expand Member Health Education programs," 2. Adjust the average speed of answer from 120 to 100 seconds, and 3. The

objective related to fostering member growth should reference maintaining membership in proportion to Medi-Cal managed care enrollment in Santa Clara County.

11. Fiscal Year 2019-2020 Team Incentive Compensation

Ms. Tomcala presented the proposed Fiscal Year 2019-2020 Team Incentive Compensation program, which is designed to recognize employees for achieving critical Plan Objectives. Following discussion, the Board and Management agreed to schedule follow-up discussions regarding strategies to attain established goals related to member calls and HEDIS measures.

It was moved, seconded, and the FY'20 Team Incentive Compensation Program was **unanimously approved.**

12. Annual CEO Evaluation Process

Mr. Brownstein indicated it is time for the annual CEO review, and recommended appointment of a subcommittee to lead the annual evaluation process.

It was moved, seconded, and unanimously approved to appoint Bob Brownstein, Dolores Alvarado, Linda Williams and Kathleen King to a temporary ad hoc subcommittee to conduct the annual evaluation of the CEO.

13. Election of Vice-Chairperson

Mr. Brownstein nominated Dolores Alvarado for the office of Vice-Chairperson, which position shall also serve as Chair of the Executive/Finance Committee.

It was moved, seconded, and unanimously approved to appointment Dolores Alvarado as Vice Chairperson as well as Chair of the Executive/Finance Committee.

14. Appointment of Executive/Finance Committee Member

Mr. Brownstein proposed appointing Susan Murphy to the Executive/Finance Committee.

It was moved, seconded, and unanimously approved to appoint Susan Murphy to the Executive/Finance Committee.

15. 2020 Board Meeting Calendar

The proposed 2020 SCCHA Governing Board, Executive/Finance and Compliance Committee meeting calendar was presented for consideration.

It was moved, seconded, and the 2020 SCCHA Governing Board, Executive/Finance and Compliance Committee meeting calendar was **unanimously approved.**

16. Government Relations Update

Tyler Haskell, Director, Government Relations, gave a verbal report on current policy and legislative issues. He noted the state legislature wrapped up the 2019 regular session on September 13, 2019. Governor Newsom has until October 13 to act on nine bills relevant to the Plan that have an implementation date of January 1, 2020. The State will unveil the new Medicaid 1115 Waiver on October 29, and it roughly equates to $200 billion annually in Santa County alone. Mr. Haskell noted that DHCS has a new acting Director, Richard Figueroa.

He further reported that the new Public Charge rule goes into effect on October 15, 2019. People 21 and over who have full Medi-Cal coverage could be impacted, and he expects the rule to dampen demand for the expanded Medi-Cal coverage now available to undocumented individuals.

The Federal Government is approaching budget deadlines. The House-passed Continuing Resolution provides funding through November 21, 2019, and includes:

- Community Health Centers Fund

- DSH cut delay
- Fair and Accurate Medicaid Pricing Act (closing a loophole allowing authorized generic prices to be used to calculate average manufacturer's price, and lowering state rebates). The Act is expected to save the federal government $3 billion over the next decade.

Supervisor Wasserman visited the Plan and discussed County issues and healthcare.

17. CEO Update

Ms. Tomcala reported on the Healthy Kids transition to Medi-Cal by October 1, 2019, noting that most of the CCHIP kids have been transitioned except for two siblings who will be offered applications for Valley Kids. The transition will be completed by the end of CY 2019.

Ms. Tomcala also shared a one-page “At a Glance” information sheet about SCFHP.

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

18. Adjournment

The meeting was adjourned at 2:30 pm.

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Robin Larmer, Secretary

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, October 24, 2019, 11:30 AM - 1:30 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Draft

Members Present
Bob Brownstein, Chair
Dolores Alvarado
Linda Williams

Members Absent
Liz Kniss
Sue Murphy

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance and Regulatory Affairs Officer
Laurie Nakahira, D.O., Chief Medical Officer
Laura Watkins, Vice President, Marketing and Enrollment
Neal Jarecki, Controller
Jayne Giangreco, Manager, Administrative Services
Rita Zambrano, Executive Assistant

Others Present
Chris Pritchard, Moss Adams LLP
Rianne Suicco, Moss Adams LLP

1. **Roll Call**

   Bob Brownstein, Chair, called the meeting to order at 11:40 am. Roll call was taken and a quorum was not established.

2. **Public Comment**

   There were no public comments.

Dolores Alvarado arrived at 11:44 am and a quorum was established.

3. **Fiscal Year 2018-19 Independent Auditor's Report**

   Dave Cameron, Chief Financial Officer, introduced Chris Pritchard, Partner, and Rianne Suicco, Senior Manager, from the Plan's independent accounting firm, Moss Adams LLP. Mr. Pritchard presented the Plan's audited financial statements and Board communication letter for the fiscal year ended June 30, 2019. He indicated the financial statements received an unmodified audit opinion (meaning that the Plan has presented fairly its financial position, results of operations, and changes in cash flows and that the financial statements are in conformity with generally accepted accounting principles). Ms. Suicco reviewed a summary of the Plan's financial statement detail and advised that: (1) management's accounting estimates were reasonable, (2) there were no disagreements with management, and (3) no audit adjustments to the financial statements were necessary.

It was moved, seconded, and the FY2018-2019 Independent Auditor's Report was **unanimously approved.**

4. Adjourn to Closed Session

a. Real Property Negotiations
The Executive/Finance Committee met in Closed Session to confer with its Real Property Negotiators concerning the price and payment terms related to the possible lease of real property located at 408 N. Capitol Avenue, San Jose, CA.

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

5. Report from Closed Session

Mr. Brownstein reported that the Executive/Finance Committee met in Closed Session to discuss Real Property Negotiations and Contract Rates.

6. Meeting Minutes

The minutes of the August 22, 2019 Executive/Finance Committee were reviewed.

It was moved, seconded, and the August 22, 2019 Executive/Finance Committee Minutes were **unanimously approved.**

7. Compliance Update

Robin Larmer, Chief Compliance and Regulatory Affairs Officer, discussed audit activity and corrective action plan progress. Ms. Larmer reported that the Plan received the final report from DMHC's full scope audit report and that there were a total of four findings for all lines of business. She reported that in the last full scope audit, there were 18 findings for Medi-Cal and 14 for Cal MediConnect, and noted the Plan's significant improvement in performance.

Ms. Larmer further noted that the Plan passed the Medicare Data Validation Audit.

The Plan received the CMS Validation Audit final report, which reflected the material remediation of 26 of the 31 Conditions identified in the Program Audit. Because 3 of the 5 Conditions found to not be fully remediated had potential to impact more than 50 members, CMS requested further remediation and another Validation Audit.

While the non-closure of the Audit is disappointing in light of the significant effort and perseverance of the staff, the tremendous improvement across several operational areas is nonetheless remarkable and offers reason for optimism about future Audit performance.

As a matter of policy, the Plan will be referred to enforcement due to its failure to fully correct all 31 Conditions. It is possible that CMS will impose an additional financial penalty, but seems unlikely.

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

8. August 2019 Financial Statements

Mr. Cameron presented the August 2019 financial statements, which reflected a current month net surplus of $1.4 million ($441 thousand favorable to budget) and a fiscal year-to-date net surplus of $2.1 million ($178 thousand favorable to budget). Enrollment decreased by 1,123 members from the prior month to 247,032 members (877 favorable to budget). Medi-Cal enrollment has generally declined since October 2016 while CMC membership has grown due to continued outreach efforts. Revenue reflected a favorable current month variance of $1.6 million (1.8%) largely due to higher member months and slightly higher capitation rates versus budget. Medical expense reflected an unfavorable current month variance of $1.5 million (1.8%) due to higher capitation member months and certain higher fee-for-service expenses versus budget. Administrative expense reflected a favorable current month variance of $246 thousand (4.9%) due largely to the timing of personnel hiring and of certain non-personnel expenses. The balance sheet reflected a Current Ratio of 1.20:1, versus the minimum required by DMHC of 1.0:1. Year-to-date capital investments of $266 thousand were made.

It was moved, seconded, and the August 2019 Financial Statements were **unanimously approved.**

9. CEO Update

Christine Tomcala, Chief Executive Officer, noted that with Dolores Alvarado's appointment as Vice-Chair, she will chair future meetings of the Executive/Finance Committee.

Ms. Tomcala discussed the State's focus on quality and the impact for health plans. She also invited Ms. Alvarado to comment on the status of the 340-B Drug Pricing Program. Ms. Alvarado noted that the community clinics will be significantly affected by 340-B going to the State as part of the pharmacy carve-out.

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

10. Adjournment

The meeting was adjourned at 1:06 pm.

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Robin Larmer, Secretary

Communication with
Those Charged with Governance

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

June 30, 2019

Communication with Those Charged with Governance

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

We have audited the combined financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan), and Santa Clara Community Health Authority (collectively the "Health Authority"), as of and for the year ended June 30, 2019, and have issued our report thereon dated _____, 2019. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated June 3, 2019, our responsibility, as described by professional standards, is to form and express an opinion about whether the combined financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Our audit of the combined financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts and to design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Authority's internal control over financial reporting. Accordingly, we considered the Health Authority's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

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

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to management, who has been charged by the Governing Board to oversee the audit, during our pre-audit planning meeting on June 12, 2019.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Health Authority are described in Note 1 to the combined financial statements. No new accounting policies were adopted and there were no changes in the application of existing policies during 2019. We noted no transactions entered into by the Health Authority during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the combined financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

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

- Management recorded an estimated capitation receivable. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon a historical experience methodology. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

- Management recorded an estimated liability for incurred but unpaid claims expense. The estimated liability for unpaid claims is based on management's estimate of historical claims experience and known activity subsequent to year-end. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

- Management's estimate of the net pension asset is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

- Management's estimate of net other post-employment benefit ("OPEB") liability is actuarially determined using assumptions on the long-term rate of return on OPEB plan assets, the discount rate used to determine the present value of benefit obligations, and changes in healthcare costs. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

- Management recorded an estimated liability for the medical loss ratio requirement for Medi-Cal Expansion. The estimated liability is based on management's estimate of revenues and allowable medical expenses related to Medi-Cal Expansion. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

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

- The useful lives of capital assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

Financial Statement Disclosures

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

Significant Difficulties Encountered in Performing the Audit

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

Corrected and Uncorrected Misstatements

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

Disagreements with Management

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

Management Representations

We have requested certain representations from management that are included in the management representation letter dated _____, 2019.

Management Consultation with Other Independent Accountants

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

Independence

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

Other Significant Audit Findings or Issues

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

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

San Francisco, California,
_____, 2019

Report of Independent Auditors and
Combined Financial Statements

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

June 30, 2019 and 2018

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Management's Discussion and Analysis

Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority
Management's Discussion and Analysis
June 30, 2019, 2018, and 2017

INTRODUCTION:

In accordance with the Governmental Accounting Standards Board Codification Section 2200, Comprehensive Annual Financial Report, the management of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority, (the "JPA") (collectively, the "Health Authority") has prepared this discussion and analysis to provide readers and interested parties with an overview of the organizations' financial activities for the fiscal years ended June 30, 2019, 2018, and 2017. This discussion should be reviewed in conjunction with the Health Authority's combined financial statements and accompanying notes to enhance the reader's understanding of the Health Authority's financial performance.

ORGANIZATION:

Santa Clara County Health Authority is a licensed health maintenance organization that operates in Santa Clara County (the "County"). The County's Board of Supervisors established Santa Clara County Health Authority in August 1995 in accordance with the State of California Welfare and Institutions Code (the "Code") Section 14087.38. During 1996, the Health Authority obtained licensure under the Knox-Keene Health Care Services Plan Act of 1975 and commenced operations.

The JPA is a licensed health maintenance organization that operates in the County. The County's Board of Supervisors established the JPA in October 2005 in accordance with the Code Section 14087.54. During 2006, the JPA obtained licensure under the Knox-Keene Health Care Services Plan Act of 1975 and commenced operations. The Health Authority has advised the California Department of Managed HealthCare ("DMHC") of its intent to surrender the JPA's license as of December 31, 2019.

OVERVIEW OF FINANCIAL STATEMENTS:

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

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

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

FINANCIAL HIGHLIGHTS:

- Total enrollment decreased 4.0% to 249,206 members at June 30, 2019, from 259,475 members at June 30, 2018. Total enrollment decreased 6.0% to 259,475 members at June 30, 2018, from 276,028 members at June 30, 2017.

- Net position increased by $24,108,887 to $202,124,752 for the fiscal year ended June 30, 2019, from $178,015,865 for the fiscal year ended June 30, 2018, due to operating income of $18,297,260 and nonoperating income of $5,811,627. Net position increased by $19,635,304 to $178,015,865 for the fiscal year ended June 30, 2018, from $158,380,561 for the fiscal year ended June 30, 2017, due to operating income of $15,867,109 and nonoperating income of $3,768,195.

- Total assets and deferred outflows of resources increased to $1,009,258,566 as of June 30, 2019, from $763,293,226 as of June 30, 2018. Total assets and deferred outflows of resources decreased to $763,293,226 as of June 30, 2018, from $866,340,704 as of June 30, 2017.

- Total liabilities and deferred inflows of resources increased to $897,133,814 at June 30, 2019, from $585,277,361 at June 30, 2018. Total liabilities and deferred inflows of resources decreased to $585,277,361 at June 30, 2018, from $707,960,143 at June 30, 2017.

- The current ratio (current assets divided by current liabilities) of 1.19 as of June 30, 2019, reflected a decrease from 1.26 at June 30, 2018. The current ratio (current assets divided by current liabilities) of 1.26 as of June 30, 2018, reflected an increase from 1.22 at June 30, 2017.

CONDENSED COMBINED STATEMENTS OF NET POSITION:

	June 30			2019 to 2018 Change		2018 to 2017 Change	
	2019	2018	2017	Amount	% Change	Amount	% Change
Assets:							
Current assets	$ 1,060,344,723	$ 724,183,257	$ 846,240,713	$ 336,161,466	46.4%	$ (122,057,456)	-14.4%
Capital assets	27,392,240	24,269,369	10,507,128	3,122,871	12.9%	13,762,241	131.0%
Other assets	2,283,994	305,350	305,350	1,978,644	648.0%	-	0.0%
Total assets	1,090,020,957	748,757,976	857,053,191	341,262,981	45.6%	(108,295,215)	-12.6%
Deferred outflows of resources	9,237,609	14,535,250	9,287,513	(5,297,641)	-36.4%	5,247,737	56.5%
Total assets and deferred outflows of resources	$ 1,099,258,566	$ 763,293,226	$ 866,340,704	$ 335,965,340	44.0%	$ (103,047,478)	-11.9%
Liabilities:							
Current liabilities	$ 891,448,830	$ 574,535,150	$ 695,799,085	$ 316,913,680	55.2%	$ (121,263,935)	-17.4%
Noncurrent liabilities	2,539,090	6,533,514	11,675,729	(3,994,424)	-61.1%	(5,142,215)	-44.0%
Total liabilities	893,987,920	581,068,664	707,474,814	312,919,256	53.9%	(126,406,150)	-17.9%
Deferred inflow of resources	3,145,894	4,208,697	485,329	(1,062,803)	-25.3%	3,723,368	767.2%
Net position:							
Net investment in capital assets	27,392,240	24,269,369	10,507,128	3,122,871	12.9%	13,762,241	131.0%
Restricted	305,350	305,350	305,350	-	0.0%	-	0.0%
Unrestricted:							
Designated by Board of Governors	2,200,000	-	-	2,200,000	100.0%	-	0.0%
Unrestricted	172,227,162	153,441,146	147,568,083	18,786,016	12.2%	5,873,063	4.0%
Total net position	202,124,752	178,015,865	158,380,561	24,108,887	13.5%	19,635,304	12.4%
Total liabilities, deferred inflows of resources, and net position	$ 1,099,258,566	$ 763,293,226	$ 866,340,704	$ 335,965,340	44.0%	$ (103,047,478)	-11.9%

Assets and Deferred Outflows of Resources

For the fiscal year ended June 30, 2019, assets increased $341,262,981 or 45.6% due primarily to the accrual of receivables for fiscal year 2018 hospital directed payments, which were received after the end of the fiscal year. During the same period, deferred outflows of resources decreased $5,297,641 or 36.4% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2018, assets decreased $108,295,215 or 12.6% due primarily to repayment to the Department of Health Care Services ("DHCS") of prior years' Med-Cal Expansion ("MCE") rate overpayments. During the same period, deferred outflows of resources increased $5,247,737 or 56.5% due to the timing of amounts attributable to employee retirement plans.

Liabilities and Deferred Inflows of Resources

For the fiscal year ended June 30, 2019, liabilities increased $312,919,256 or 53.9% due primarily to the accrual of payables for fiscal year 2018 hospital directed payments. During the same period, deferred inflows of resources decreased $1,062,803 or 25.3% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2018, liabilities decreased $126,406,150 or 17.9% due primarily to repayment to DHCS of prior years' MCE rate overpayments. During the same period, deferred inflows of resources increased $3,723,368 or 767.2% due to the timing of amounts attributable to employee retirement plans.

Tangible Net Equity

The Health Authority is required to maintain a minimum level of tangible net equity ("TNE") per its contract with DHCS. TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets, if any. The Health Authority's TNE was $202,124,752, $178,015,865, and $158,380,561 at June 30, 2019, 2018, and 2017, respectively. The Health Authority exceeded the minimum required TNE levels at all times during the three fiscal years.

CONDENSED COMBINED RESULTS OF OPERATIONS:

	Fiscal Year			2019 to 2018 Change		2018 to 2017 Change	
	2019	2018	2017	Amount	% Change	Amount	% Change
Year end membership:							
Medi-Cal	237,698	248,776	265,753	(11,078)	-4.5%	(16,977)	-6.4%
Medicare	8,022	7,503	7,543	519	6.9%	(40)	-0.5%
Healthy Kids	3,486	3,196	2,732	290	9.1%	464	17.0%
Total year end membership	249,206	259,475	276,028	(10,269)	-4.0%	(16,553)	-6.0%
Annual member months:							
Medi-Cal	2,904,840	3,090,265	3,568,375	(185,425)	-6.0%	(478,110)	-13.4%
Medicare	92,838	96,513	92,374	(3,675)	-3.8%	4,139	4.5%
Healthy Kids	40,083	33,830	35,667	6,253	18.5%	(1,837)	-5.2%
Total annual member months	3,037,761	3,220,608	3,696,416	(182,847)	-5.7%	(475,808)	-12.9%
Operating revenues:							
Capitation and premium revenue	$ 1,161,897,093	$ 1,329,112,179	$ 1,373,491,475	$ (167,215,086)	-12.6%	$ (44,379,296)	-3.2%
Total operating revenues	1,161,897,093	1,329,112,179	1,373,491,475	(167,215,086)	-12.6%	(44,379,296)	-3.2%
Operating expenses:							
Medical expenses	979,948,153	1,162,181,837	1,167,862,922	(182,233,684)	-15.7%	(5,681,085)	-0.5%
General and administrative expenses	54,419,879	45,893,851	45,357,972	8,526,028	18.6%	535,879	1.2%
Depreciation	3,816,251	3,548,003	1,985,807	268,248	7.6%	1,562,196	78.7%
Premium tax	105,415,550	101,621,379	101,463,280	3,794,171	3.7%	158,099	0.2%
Total operating expenses	1,143,599,833	1,313,245,070	1,316,669,981	(169,645,237)	-12.9%	(3,424,911)	-0.3%
Operating income	18,297,260	15,867,109	56,821,494	2,430,151	15.3%	(40,954,385)	-72.1%
Nonoperating revenues:							
Interest income	5,811,627	3,768,195	1,265,612	2,043,432	54.2%	2,502,583	197.7%
Changes in net position	24,108,887	19,635,304	58,087,106	4,473,583	22.8%	(38,451,802)	-66.2%
Net position, beginning of year	178,015,865	158,380,561	100,293,455	19,635,304	12.4%	58,087,106	57.9%
Net position, end of year	$ 202,124,752	$ 178,015,865	$ 158,380,561	$ 24,108,887	13.5%	$ 19,635,304	12.4%

Membership and Enrollment

During the fiscal year ended June 30, 2019, the Health Authority experienced a decrease in enrollment of 4.0% predominately in the Medi-Cal program.

During the fiscal year ended June 30, 2018, the Health Authority experienced a decrease in enrollment of 6.0% predominately in the Medi-Cal program.

Operating Revenue

During the fiscal year ended June 30, 2019, operating revenues decreased by $167,215,086 or 12.6% to $1,161,897,093 versus the prior year operating revenue of $1,329,112,179. Much of the decrease was attributable to the phase-out of In-Home Supportive Services ("IHSS") from the Coordinated Care Initiative ("CCI"), which entail the Medi-Cal Dual Managed Long-Term Services & Supports ("MLTSS") and the Cal MediConnect ("CMC") programs, effective January 1, 2018.

During the fiscal year ended June 30, 2018, operating revenues decreased by $44,379,296 or 3.2% to $1,329,112,179 versus the prior year operating revenue of $1,373,491,475. Much of the decrease was attributable to the phase-out of IHSS from the CCI, which entail the MLTSS and the CMC program, effective January 1, 2018.

Medical Expenses

During the fiscal year ended June 30, 2019, medical expenses decreased by $182,233,684 or 15.7% to $979,948,153 versus the prior year of $1,162,181,837. Much of the decrease was attributable to the phase-out of IHSS from the CCI, which entail the MLTSS and the CMC program, effective January 1, 2018.

During the fiscal year ended June 30, 2018, medical expenses decreased by $5,681,085 or 0.5% to $1,162,181,837 versus the prior year of $1,167,862,922. Much of the decrease was attributable to the phase-out of IHSS from the CCI, which entail the MLTSS and the CMC program, effective January 1, 2018.

The Health Authority's medical loss ratio ("MLR"), or medical expenses as a percentage of capitation and premium revenue (less contra-revenue premium tax), was 92.8%, 94.7%, and 91.8% for the fiscal years ended June 30, 2019, 2018, and 2017, respectively.

Premium Deficiency Reserve

During the fiscal year ended June 30, 2019, management maintained its estimated premium deficiency reserve ("PDR") on the CMC contract at $8,294,025 for fiscal year 2020 due to continuing uncertainties about final rate recasts for multiple fiscal years, shared risk corridor payments, and hierarchical condition category ("HCC") risk adjustments, for which management cannot fully quantify the likelihood of these impacts.

During the fiscal year ended June 30, 2018, management maintained its estimated PDR on the CMC contract at $8,294,025 for fiscal year 2019 due to continuing uncertainties about final rate recasts for multiple fiscal years, shared risk corridor payments and HCC risk adjustments, for which management cannot fully quantify the likelihood of these impacts.

General and Administrative Expenses

During the fiscal year ended June 30, 2019, administrative expenses increased by $8,526,028 or 18.6% to $54,419,879 versus the prior year expense of $45,893,851 due to increased staffing, contracted services, and printing and postage expenses.

During the fiscal year ended June 30, 2018, administrative expenses increased by $535,879 or 1.2% to $45,893,851 versus the prior year expense of $45,357,972 due to general cost increases.

The Health Authority's administrative loss ratio ("ALR"), or general and administrative (including depreciation and amortization expense) as a percentage of capitation and premium revenue (including contra-revenue premium tax), was 5.5%, 4.0%, and 3.7% for the fiscal years ended June 30, 2019, 2018, and 2017, respectively.

CONDENSED COMBINED CASH FLOW INFORMATION:

The table below summarizes the major sources and uses of cash and cash equivalents for the fiscal years ended June 30, 2019, 2018, and 2017:

	As of June 30			2019 to 2018 Change		2018 to 2017 Change	
	2019	2018	2017	Amount	% Change	Amount	% Change
Cash flows from operating activities	$ 75,870,490	$ (130,630,635)	$ 224,795,253	$ 206,501,125	-158.1%	$ (355,425,888)	-158.1%
Cash flows from capital and financing activities	(6,415,822)	(13,590,598)	(7,533,687)	7,174,776	-52.8%	(6,056,911)	80.4%
Cash flows from investing activities	5,811,627	3,768,195	1,265,612	2,043,432	54.2%	2,502,583	197.7%
Net change in cash and cash equivalents	75,266,295	(140,453,038)	218,527,178	215,719,333	-153.6%	(358,980,216)	-164.3%
Cash and cash equivalents, beginning of year	223,850,859	364,303,897	145,776,719	(140,453,038)	-38.6%	218,527,178	149.9%
Cash and cash equivalents, end of year	$ 299,117,154	$ 223,850,859	$ 364,303,897	$ 75,266,295	33.6%	$ (140,453,038)	-38.6%

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

CONDENSED CAPITAL ASSET INFORMATION:

The table below summarizes the major changes in capital assets for the fiscal years ended June 30, 2019, 2018, and 2017. Capital assets largely included furniture and fixtures, computer hardware and software, and leasehold improvements:

	Fiscal Year Ended June 30,			2019 to 2018 Change		2018 to 2017 Change	
	2019	2018	2017	Amount	% Change	Amount	% Change
Beginning balance, net	$ 24,269,369	$ 10,507,128	$ 4,941,914	$ 13,762,241	131.0%	$ 5,565,214	112.6%
Additions	6,941,405	17,365,176	7,795,195	(10,423,771)	-60.0%	9,569,981	122.8%
Reductions/adjustments	(2,283)	(54,932)	(244,174)	52,649	-95.8%	189,242	-77.5%
Depreciation expense	(3,816,251)	(3,548,003)	(1,985,807)	(268,248)	7.6%	(1,562,196)	78.7%
Ending balance, net	$ 27,392,240	$ 24,269,369	$ 10,507,128	$ 3,122,871	12.9%	$ 13,762,241	131.0%

KEY FACTORS INFLUENCING THE FISCAL YEAR 2019-2020 BUDGET:

In June 2019, the Health Authority's Governing Board formally approved operating and capital budgets for the fiscal year ending June 30, 2020. The operating budget anticipates a 4.5% reduction in enrollment, an overall increase in Medi-Cal capitation rates received from DHCS, and modest growth in expenses. The 2020 capital budget includes approximately $4.8 million for capital investments in information systems and facilities.

REQUESTS FOR INFORMATION

This financial report is designed to provide a general overview of the Health Authority's finances for interested parties. Questions concerning any of the information provided in this report or requests for additional information should be addressed to Santa Clara Family Health Plan, Attn: Controller, 6201 San Ignacio Avenue, San Jose, California 95119 or call (408) 376-2000.

Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying combined financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority (collectively, the "Health Authority"), a discrete component unit of the County of Santa Clara, California, which comprise the combined statements of net position as of June 30, 2019 and 2018, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined net position of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority as of June 30, 2019 and 2018, and the results in their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 7, supplementary schedule of proportionate share of the net pension asset/liability, supplementary schedule of pension contributions, supplementary schedules of changes in net other post-employment benefit liability, and supplementary schedule of other post-employment benefit contributions on pages 37 through 40 are not a required part of the combined financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the combined financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of the Health Authority's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the combined financial statements, and other knowledge we obtained during our audits of the combined financial statements. We do not express an opinion or provide an assurance on the supplementary information because limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

San Francisco, California
_____, 2019

Combined Financial Statements

Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority
Combined Statements of Net Position
June 30, 2019 and 2018

	2019	2018
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets		
Cash and cash equivalents	$ 299,117,154	$ 223,850,859
Premiums receivable	751,066,126	493,307,426
Prepaids and other assets	10,161,443	7,024,972
Total current assets	1,060,344,723	724,183,257
Capital assets, net		
Nondepreciable	4,136,236	10,057,379
Depreciable, net of accumulated depreciation and amortization	23,256,004	14,211,990
Total capital assets, net	27,392,240	24,269,369
Assets restricted as to use	305,350	305,350
Net pension asset	1,978,644	-
Total assets	1,090,020,957	748,757,976
Deferred outflows of resources	9,237,609	14,535,250
Total deferred outflows of resources	9,237,609	14,535,250
Total assets and deferred outflows of resources	$ 1,099,258,566	$ 763,293,226
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
Current liabilities		
Accounts payable and accrued liabilities	$ 9,371,499	$ 19,836,108
Amounts due to the State of California	53,143,088	24,429,978
In-home supportive services payable	416,092,526	413,549,551
Due to providers	316,682,675	15,954,984
Medical incurred but not reported claims and medical claims payable	82,355,017	78,089,647
Provider incentives and other medical liabilities	5,510,000	14,380,857
Premium deficiency reserves	8,294,025	8,294,025
Total current liabilities	891,448,830	574,535,150
Noncurrent liabilities		
Net pension liability	-	1,824,796
Other post-employment benefits liability	2,539,090	4,708,718
Total liabilities	893,987,920	581,068,664
Deferred inflows of resources	3,145,894	4,208,697
Total deferred inflows of resources	3,145,894	4,208,697
Net position		
Net investment in capital assets	27,392,240	24,269,369
Restricted	305,350	305,350
Unrestricted:		
Designated by Governing Board	2,200,000	-
Unrestricted	172,227,162	153,441,146
Total net position	202,124,752	178,015,865
Total liabilities, deferred inflows of resources, and net position	$ 1,099,258,566	$ 763,293,226

See accompanying notes to combined financial statements.

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

Combined Statements of Revenues, Expenses, and Changes in Net Position

For the Years Ended June 30, 2019 and 2018

	2019	2018
Operating revenues		
Capitation and premium revenue	$ 1,161,897,093	$ 1,329,112,179
Total operating revenues	1,161,897,093	1,329,112,179
Operating expenses		
Medical expenses	979,948,153	1,162,181,837
Premium tax	105,415,550	101,621,379
General and administrative expenses	54,419,879	45,893,851
Depreciation and amortization	3,816,251	3,548,003
Total operating expenses	1,143,599,833	1,313,245,070
Operating income	18,297,260	15,867,109
Nonoperating revenues		
Interest and other income	5,811,627	3,768,195
Change in net position	24,108,887	19,635,304
Net position, beginning of year	178,015,865	158,380,561
Net position, end of year	$ 202,124,752	$ 178,015,865

Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority
Combined Statements of Cash Flows
For the Years Ended June 30, 2019 and 2018

	2019	2018
Cash flows from operating activities		
Capitation and premiums received	$ 904,138,393	$ 1,310,670,950
Medical expenses paid	(749,114,557)	(1,368,780,535)
Marketing, general, and administrative expenses paid	(79,153,346)	(72,521,050)
Net cash provided by (used in) operating activities	75,870,490	(130,630,635)
Cash flows from capital and financing activities		
Purchases of capital assets	(6,415,822)	(13,590,598)
Net cash used in capital and financing activities	(6,415,822)	(13,590,598)
Cash flows from investing activities		
Interest collection on investments	5,811,627	3,768,195
Net cash provided by investing activities	5,811,627	3,768,195
Net change in cash and cash equivalents	75,266,295	(140,453,038)
Cash and cash equivalents, beginning of year	223,850,859	364,303,897
Cash and cash equivalents, end of year	$ 299,117,154	$ 223,850,859
Reconciliation of operating income to net cash provided by (used in) operating activities		
Operating income	$ 18,297,260	$ 15,867,109
Adjustments to reconcile operating income to net cash provided by (used in) operating activities		
Depreciation and amortization	3,816,251	3,548,003
Changes in operating assets and liabilities		
Premiums receivable	(257,758,700)	(18,441,229)
Net pension asset	(1,978,644)	-
Prepaids and other assets	(3,136,471)	45,647
Accounts payable and accrued liabilities	(10,987,909)	(20,501,900)
Amounts due to the State of California	28,713,110	(217,094,347)
In-home supportive services payable	2,542,975	113,329,285
Due to providers	300,727,691	(2,764,473)
Net pension liability	1,431,379	(4,167,907)
Net other post-employment benefits liability	(1,190,965)	(2,498,677)
Medical incurred but not reported claims and medical claims payable	4,265,370	1,552,216
Provider incentives and other medical liabilities	(8,870,857)	495,638
Net cash provided by (used in) operating activities	$ 75,870,490	$ (130,630,635)
Supplemental cash flow disclosure		
Cash paid during the year for premium tax	$ 105,415,548	$ 140,124,201
Supplemental disclosure of noncash item		
Payables for capital asset purchases	$ 525,583	$ 3,774,578

See accompanying notes to combined financial statements.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

History and organization – The accompanying combined financial statements include the Santa Clara County Health Authority and the Santa Clara Community Health Authority Joint Powers Authority ("JPA") (collectively, the "Health Authority"). The combined financial statements are included in the County of Santa Clara's basic financial statements as a discretely presented component unit.

The Santa Clara County Health Authority (dba Santa Clara Family Health Plan ("SCFHP")) was established on August 1, 1995, by the Santa Clara County Board of Supervisors pursuant to Section 14087.38 of the State of California Welfare and Institutions Code (the "Code"). SCFHP was created for the purpose of developing the Local Initiative Plan (the "Plan") for the expansion of Medi-Cal Managed Care, as presently regulated by the California Department of Managed Health Care ("DMHC"). The Medi-Cal Managed Care Program offers no-cost health coverage to children, birth through age 18, pregnant women, and other low-income adults in Santa Clara County (the "County"). During 1996, SCFHP obtained licensure under the Knox-Keene Health Care Service Plan Act of 1975 and commenced operations.

The JPA is a licensed health maintenance organization that operates in the County. The County's Board of Supervisors established the JPA in October 2005 in accordance with the Code Section 14087.54. The JPA received its Knox-Keene license on May 11, 2006, and commenced operations on June 1, 2006. The Health Authority has advised the DMHC of its intent to surrender the JPA's license as of December 31, 2019.

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

The Health Authority contracts with the Centers for Medicare & Medicaid Services ("CMS") and the DHCS, effective January 1, 2015, to participate in Cal MediConnect ("CMC"), a demonstration project to integrate care for dual-eligible beneficiaries. Cal MediConnect is part of California's larger demonstration plan known as the Coordinated Care Initiative ("CCI"), which transforms the delivery of health care for seniors and people with disabilities. It integrates dual eligibles' care across all their entitlement benefits from Medicare, Medi-Cal, and other supportive services.

The Health Authority operates a Healthy Kids program to provide medical coverage to children of parents not otherwise eligible for the Medi-Cal program. This program has been assigned to the JPA. Healthy Kids members will transition to other programs, largely Medi-Cal, by December 31, 2019, or sooner.

On March 1, 2016, SB X2-2 established a Managed Care Organization ("MCO") provider tax for July 1, 2016, through June 30, 2019, and administered by DHCS. The tax is assessed on by DHCS on licensed health plans contracted to provide Medi-Cal services. The legislation established taxing tiers and per-enrollee amounts for the fiscal years ended June 30, 2017, 2018, and 2019. The Health Authority paid $105,415,548 and $140,124,201 in MCO premium taxes during fiscal years 2019 and 2018, respectively. At June 30, 2019 and 2018, the Health Authority had payables due in the amount of $26,353,889 and $0, respectively, included in Amounts due to the State of California.

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

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

Basis of combination – The accompanying financial statements include the Santa Clara County Health Authority and the Santa Clara Community Health Authority, as both entities are under common management and control.

Use of estimates – The preparation of the combined financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Medical incurred but not reported claims and medical claims payable, premiums receivable, net pension asset/liability, other post-employment benefits liability, premium deficiency reserves, and useful lives of capital assets represent significant estimates. Actual results could differ from those estimates.

Cash and cash equivalents – The Health Authority considers all highly liquid instruments with a maturity of three months or less at the time of purchase to be cash equivalents. Cash and cash equivalents are carried at cost, which approximates fair value. At June 30, 2019 and 2018, the Health Authority's cash deposits had carrying amounts of $299,117,154 and $223,850,859, respectively. The Health Authority's bank balances at June 30, 2019 and 2018, including interests in an investment pool, were $306,584,080 and $245,879,254, respectively. Of the bank and investment pool balances at June 30, 2019 and 2018, $305,834,080 and $245,129,254, respectively, were not covered by federal depository insurance.

Amounts invested in the County Treasurer's investment pool (the "Investment Pool") are considered as cash and cash equivalents, as funds can be withdrawn by the Health Authority on demand. The County's Investment Oversight Committee Board has oversight responsibility for the Investment Pool. The Investment Pool is not U.S. Securities and Exchange Commission registered, and based on the California statutes and the County's investment policy, primarily invests in obligations of U.S. Treasury, certain federal agencies, bankers' acceptances, commercial papers, certificates of deposit, repurchase agreements, and California State Treasurer's Local Agency Investment Fund. The amounts invested in the Investment Pool are considered investments in an external investment pool and earn interest based on the blended rate of return earned by the entire portfolio in the pool. Fair value is the amount at which a financial instrument could be exchanged in a current transaction between willing parties, other than in forced liquidation. The fair value of the Investment Pool is generally based on published market prices and quotations from major investment firms. As the Health Authority does not own identifiable investment securities of the pool but participates as a shareholder of the pool, these cash and cash equivalents are not individually identifiable and were not required to be categorized under GASB Codification Section C20, *Cash Deposits with Financial Institutions*, Section 150, *Investments* and Section 155, *Investments – Reverse Repurchase Agreements*. The fair value of the Health Authority's share in the pool approximated the fair value of the position in the pool at June 30, 2019 and 2018.

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

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

Assets restricted as to use – The Health Authority is required by DMHC to restrict cash having a fair value of at least $300,000 for payment of member claims in the event of insolvency. The amount recorded was $305,350 at June 30, 2019 and 2018, respectively.

Amounts due to the State of California – When the Health Authority is made aware of changes to DHCS rate structure, such as rate changes, risk corridors or program reconciliations, that significantly impact the financial outlook, an accrual for the estimated change is recorded.

In-Home Supportive Services ("IHSS") payable – DHCS paid IHSS payments directly to the Santa Clara County's Department of Social Services. As part of CCI, the Health Authority assumed full risk for IHSS provider payments. These amounts are included in both premium revenue and medical expenses and equivalent amounts are recorded as premiums receivable and IHSS payable, respectively, in the Health Authority's combined financials statements. Additionally, the Health Authority paid the MCO tax on the IHSS revenue and recorded it as premium tax. Effective January 1, 2018, IHSS was phased-out of CCI.

Due to providers – Due to providers consists predominately of payables related to managed care hospital directed payments, Proposition 56 funds, and Ground Emergency Medical Transportation funds.

Effective July 1, 2017, DHCS implement three Medi-Cal managed care hospital directed payments: (1) Private Hospital Directed Payment ("PHDP"), 2) Designated Public Hospital Enhanced Payment Program ("EPP"), and (3) Designated Public Hospital Quality Incentive Pool ("QIP").

- For PHDP, the Department has directed Managed Care Plans ("MCP") to reimburse private hospitals as defined in WIC 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient care.

- For EPP, which consists of fee-for-service and capitated pools, the Department has directed MCPs to reimburse California's designated public hospitals ("DPH") for contracted services based on actual utilization of contracted services.

- For QIP, the Department has directed MCPs to make additional payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization.

Proposition 56 is a supplemental payment for certain professional medical services to Medi-Cal beneficiaries funded by the Tobacco Tax (California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) as defined by DHCS in APL 19-006.

Ground Emergency Medical Transportation ("GEMT") is a supplemental payment that provides additional funding to eligible providers of GEMT services to Medi-Cal beneficiaries as defined by DHCS in APL 19-007.

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

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

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

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

Other post-employment benefit liability – The Health Authority recognizes a net other post-employment benefit ("OPEB") liability, which represents the excess of the total OPEB liability over the fiduciary net position of the Health Authority's OPEB plan, which is administered by CalPERS. The net OPEB liability is measured as of the Health Authority's prior fiscal year-end. Changes in the net OPEB liability are recorded in the period incurred as OPEB expense and as deferred inflows of resources or deferred outflows of resources depending on the nature of the change. The changes in net OPEB liability that are recorded as deferred inflows of resources or deferred outflows of resources are recognized in OPEB expense systematically over time.

For purposes of measuring the net OPEB liability, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position, and additions to and deductions from the fiduciary net position have been determined on the same basis as they are reported by the CalPERS Financial Office. For this purpose, benefit payments (including refunds of employee contributions) are recognized when currently due and payable in accordance with the benefit terms. Investments are reported at fair value, except for money market investments and participating interest-earning investment contracts that have a maturity at the time of purchase of one year or less, which are reported at cost.

Net position – Net position is classified as net investment in capital assets, restricted net position, board-designated funds, or unrestricted net position. Net investment in capital assets represents capital assets, net of accumulated depreciation and amortization. Restricted net position is noncapital net position that must be used for a particular purpose, as specified by the state regulatory agency, grantors, or contributors external to the Health Authority. In December 2018, the Health Authority's Governing Board designated $2,200,000 for board-designated investments, the specific composition and recipients of which will be determined at a later date. Unrestricted net position consists of net position that does not meet the definition of restricted or net investment in capital assets.

Premium revenue – The Health Authority has agreements with the Medi-Cal Program in the state to provide certain health care products and services to enrolled Medi-Cal beneficiaries. Eligibility of beneficiaries is determined by Santa Clara County Social Services Agency and validated by the State of California. The State of California provides the Health Authority the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month. The Health Authority receives monthly premium payments from DHCS based on the number of enrolled Medi-Cal beneficiaries, regardless of services actually performed. Premiums are due from DHCS monthly and are recognized as revenue during the period in which the Health Authority is obligated to provide services to members. A portion of revenues received from DHCS is subject to possible retroactive adjustments. Provisions have been made for estimated retroactive adjustments. For the years ended June 30, 2019 and 2018, premium revenues recorded from DHCS under the Medi-Cal Program totaled $998,083,852 and $1,177,273,921, respectively.

The Health Authority entered into a three-way contract with CMS and the DHCS effective January 1, 2015, to participate in the CMC program. For the years ended June 30, 2019 and 2018, premium revenues totaled $30,482,500 and $36,143,056, and $129,063,173 and $112,123,902 for the Medi-Cal and Medicare components of the CMC program, respectively. According to Chapter 33, Statutes of 2013 (SB 78, Committee on Budget and Fiscal Review), premium tax is imposed on only the revenues received by MCOs through their Medi-Cal and Healthy Kids managed care plans; consequently, Medicare revenues are not subject to premium tax.

The Health Authority has an agreement with the County of Santa Clara to provide health care services to enrolled Healthy Kids beneficiaries. The Health Authority issues monthly invoices to the funding organization for its respective portion of premium costs for all Healthy Kids enrollees. Premiums are due monthly and are recognized as revenue in the period the Health Authority is obligated to provide medical services. A nominal monthly premium is invoiced directly to the family of the Healthy Kids enrolled child and recognized as revenue in the service month. Annual premium revenue for the Healthy Kids Program totaled $4,267,568 and $3,571,300 for the years ended June 2019 and 2018, respectively, and were funded by County of Santa Clara. Healthy Kids members will transition to other programs, largely Medi-Cal, by December 31, 2019, or sooner.

Premium deficiency reserves – The Health Authority performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. The Health Authority entered into a three-way contract with CMS and the DHCS effective January 1, 2015, to participate in a demonstration project to integrate care for dual-eligible beneficiaries. The Contract shall be renewed in one-year terms through December 31, 2022. The Health Authority has the option to cancel this agreement prior to the end of each term. Management has estimated that it may incur losses on the contract. Accordingly, a premium deficiency reserve in the amount of $8,294,025 has been recorded at June 30, 2019 and 2018. The Health Authority may receive future revenue adjustments in the form of shared risk corridor payments and CMS hierarchical condition category risk adjustment true-ups; however, these adjustments cannot currently be estimated. Management has determined that no other premium deficiency reserves are needed at June 30, 2019 and 2018.

Concentration of credit risk – A majority of the Health Authority's revenues are derived from contracts with DHCS and CMS. Loss of the contracts due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of the Health Authority. As of June 30, 2019, the Health Authority had premiums receivable of $734,627,346, $7,941,454, $7,812,105, and $685,221 due from Medi-Cal Program, CMC program, Medicare, and Healthy Kids Program, respectively. As of June 30, 2018, the Health Authority had premiums receivable of $483,612,087, $3,425,599, $5,579,432, and $690,308 due from Medi-Cal Program, CMC program, Medicare and Healthy Kids Program, respectively.

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

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

Income taxes – The Health Authority is a public entity and falls under the purview of Internal Revenue Code, Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to federal income or state franchise taxes.

New accounting pronouncements – In January 2017, the GASB issued GASB Statement No. 84*, Fiduciary Activities* ("GASB 84"), which is effective for financial statements for period beginning after December 15, 2018. GASB 84 establishes criteria for identifying fiduciary activities of all state and local governments. The focus of the criteria generally is on whether a government is controlling the assets of the fiduciary activity and the beneficiaries with whom a fiduciary relationship exists. Separate criteria are included to identify fiduciary component units and post-employment benefit arrangements that are fiduciary activities. The Health Authority is reviewing the impact of the adoption of GASB 84 for the fiscal year ending 2020.

In June 2017, the GASB issued GASB Statement No. 87, *Leases* ("GASB 87"), which is effective for financial statements for periods beginning after December 15, 2019. GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. The Health Authority is reviewing the impact of the adoption of GASB 87 for the fiscal year ending 2021.

Reclassifications – Certain amounts in the 2018 combined financial statements have been reclassified to conform to the 2019 presentation. These reclassifications have no effect on the 2018 operating income or net position.

NOTE 2 – CAPITAL ASSETS

Capital asset activity for the fiscal years ended June 30, 2019 and 2018, are as follows:

	2019				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	3,507,578	$ -	$ -	$ -	$ 3,507,578
Furniture and equipment	10,839,469	1,146,309	(2,285)	-	11,983,493
Leasehold improvements	759,482	-	(759,482)	-	-
Building and building improvements	6,235,856	1,165,733	-	9,865,980	17,267,569
Software	10,657,629	97,000	-	587,526	11,342,155
Vehicles	29,248	-	-	-	29,248
Software work in progress	347,526	301,887	-	(587,526)	61,887
Building improvements work in progress	6,202,275	4,230,476	-	(9,865,980)	566,771
Total capital assets	38,579,063	6,941,405	(761,767)	-	44,758,701
Less accumulated depreciation and amortization for:					
Furniture and equipment	9,397,651	841,746	(592,059)	-	9,647,338
Leasehold improvements	746,602	12,879	(167,425)	-	592,056
Building and building improvements	159,894	595,109	-	-	755,003
Software	4,003,516	2,361,642	-	-	6,365,158
Vehicles	2,031	4,875	-	-	6,906
Total accumulated depreciation and amortization	14,309,694	3,816,251	(759,484)	-	17,366,461
Capital assets, net	$ 24,269,369	$ 3,125,154	$ (2,283)	$ -	$ 27,392,240

	2018				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ -	$ 3,507,578	$ -	$ -	$ 3,507,578
Furniture and equipment	10,290,008	754,131	(204,670)	-	10,839,469
Leasehold improvements	759,482	-	-	-	759,482
Building and building improvements	-	6,235,856	-	-	6,235,856
Software	3,816,470	438,300	-	6,402,859	10,657,629
Vehicles	-	29,248	-	-	29,248
Software work in progress	6,402,859	347,526	-	(6,402,859)	347,526
Building improvements work in progress	-	6,052,537	149,738	-	6,202,275
Total capital assets	21,268,819	17,365,176	(54,932)	-	38,579,063
Less accumulated depreciation and amortization for:					
Furniture and equipment	8,261,463	1,136,188	-	-	9,397,651
Leasehold improvements	592,058	154,544	-	-	746,602
Building and building improvements	-	159,894	-	-	159,894
Software	1,908,170	2,095,346	-	-	4,003,516
Vehicles	-	2,031	-	-	2,031
Total accumulated depreciation and amortization	10,761,691	3,548,003	-	-	14,309,694
Capital assets, net	$ 10,507,128	$ 13,817,173	$ (54,932)	$ -	$ 24,269,369

Depreciation and amortization expense totaled $3,816,251 and $3,548,003, at June 30, 2019 and 2018, respectively.

NOTE 3 – MEDICAL INCURRED BUT NOT REPORTED CLAIMS AND MEDICAL CLAIMS PAYABLE

The Health Authority estimates medical incurred but not reported ("IBNR") claims and medical claims payable based on historical claims payment and other relevant information. Estimates are monitored and reviewed and, as settlements are made or estimates are adjusted, differences are reflected in current operations. Such estimates are subject to impact of changes in the regulatory environment. Activity for medical IBNR and medical claims payable for the years ended June 30, 2019 and 2018, is summarized as follows:

	2019	2018
Beginning balance	$ 78,089,647	$ 76,537,431
Incurred related to:		
Current year	584,499,785	547,935,606
Prior year	(12,368,761)	(9,848,544)
Total incurred	572,131,024	538,087,062
Paid related to:		
Current year	503,819,454	471,250,062
Prior year	64,046,200	65,284,784
Total paid	567,865,654	536,534,846
Ending balance	$ 82,355,017	$ 78,089,647

As presented in the table above, $572,131,024 and $538,087,062 in medical claims were incurred at June 30, 2019 and 2018, respectively, which are reflected in medical services in the combined statements of revenues, expenses, and changes in net position.

As a result of changes between actual payments for medical services and estimated amounts in previous years, claims expenses decreased in 2019 and 2018 by $14,043,447 and $11,252,647, respectively.

NOTE 4 – DESIGNATED NET POSITION

Designated funds remain under the control of the Governing Board, which may, at its discretion, later use the funds for other purposes. For the fiscal years ended June 30, 2019 and 2018, board-designated funds of $2,200,000 and $0, respectively, were made.

NOTE 5 – OPERATING LEASE OBLIGATIONS

The Health Authority leased facilities under an operating lease that expired in August 2018. The Health Authority also has various equipment operating leases expiring in various years through September 2023.

Future minimum lease payments as of June 30, 2019, consist of the following:

Years Ending June 30,	
2020	$ 118,404
2021	118,404
2022	50,257
2023	50,257
2024	12,564
Total minimum lease payments	$ 349,886

Rent expense, included in general and administrative expenses in the combined statements of revenues, expenses, and changes in net position, for the years ended June 30, 2019 and 2018, was $171,779 and $1,407,585, respectively.

NOTE 6 – EMPLOYEE BENEFIT PLANS

Internal Revenue Code 401(a) Plan – The Health Authority has a defined contribution plan under Section 401(a) of the Internal Revenue Code. For employees hired prior to January 1, 2013, participants must contribute 6% of their gross compensation and the Health Authority must contribute 3% of the participant's gross compensation. For employees hired on or after January 1, 2013, participants must contribute 6.25% of their gross compensation within a specific range and the Health Authority must contribute 6.533% of the participant's gross compensation with the same specific range. For senior staff employees, the Health Authority contributes greater than 3% of gross compensation and senior staff employees contribute less than 6% of their gross compensation. Contributions by the Health Authority totaled $716,716 and $535,167 for the years ended June 30, 2019 and 2018, respectively.

The 401(a) plan is administered through a third-party administrator and is available to all employee groups. The Heath Authority does not perform the investment function and has no fiduciary accountability for the plan. Thus, plan assets and any related liability to plan participants have been excluded from the Health Authority's combined financial statements.

Internal Revenue Code 457 Plan – The Health Authority has a deferred compensation plan under Section 457 of the Internal Revenue Code. Participants may contribute up to the maximum allowed under Section 457. The Health Authority makes matching contributions only to 457 plan participants who are not participating in the 401(a) plan. For those employees, the Health Authority matches 50% of employee contributions, up to a maximum of 3% of compensation. Matching contributions are made to the 401(a) plan.

The 457 plan is administered through a third-party administrator and is available to all employee groups. The Heath Authority does not perform the investment function and has no fiduciary accountability for the plan. Thus, plan assets and any related liability to plan participants have been excluded from the Health Authority's combined financial statements.

California Public Employees' Retirement System

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

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

Funding policy – The contribution requirements of the plan members and the Health Authority are established and may be amended by CalPERS. With the election to participate in CalPERS, participation in Social Security is discontinued, and contributions to CalPERS are in lieu of contributions to Social Security. The Health Authority is required to contribute an actuarially determined rate. The employer contribution rate was 8.00% of annual covered payroll for both the years ended June 30, 2019 and 2018. All eligible participating employees are required to contribute 7.00% of their monthly salaries to CalPERS. The Health Authority deducts the contributions from employees' wages and remits to CalPERS on their behalf and for their account. Contributions to the pension plans from the Health Authority were $1,669,920 and $4,426,715 for the years ended June 30, 2019 and 2018, respectively.

Pension liabilities, pension expense, and deferred outflows of resources and deferred inflows of resources related to pension – The net pension liability at June 30, 2019, is measured as of June 30, 2018, using an annual actuarial valuation as of June 30, 2017, rolled forward to June 30, 2018, using standard update procedures. The total pension liabilities in the June 30, 2017 actuarial valuation was based on the following actuarial methods and assumptions:

Actuarial cost method:	Entry Age Normal in accordance with the requirements of GASB Statement No. 68
Actuarial assumptions:	
Discount rate	7.15%
Inflation	2.50%
Salary increases	Varies by Entry Age and Service
Mortality rate table	Derived using CalPERS' Membership Data for all Funds
Postretirement benefit increase:	Contract COLA up to 2.00% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.50% thereafter

The net pension liability at June 30, 2018, is measured as of June 30, 2017, using an annual actuarial valuation as of June 30, 2016, rolled forward to June 30, 2017, using standard update procedures. The total pension liabilities in the June 30, 2016 actuarial valuation was based on the following actuarial methods and assumptions:

Actuarial cost method:	Entry Age Normal in accordance with the requirements of GASB Statement No. 68
Actuarial assumptions:	
Discount rate	7.15%
Inflation	2.75%
Salary increases	Varies by Entry Age and Service
Mortality rate table	Derived using CalPERS' Membership Data for all Funds
Postretirement benefit increase:	Contract COLA up to 2.75% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.75% thereafter

All other actuarial assumptions used in the June 30, 2017 and 2016 valuation were based on the results of an actuarial experience study for the fiscal years 1997 to 2011, including updates to salary increase, mortality, and retirement rates. The experience study report can be obtained at the CalPERS' website under Forms and Publications.

Change of assumptions – The inflation rate decreased from 2.75% to 2.5% for the June 30, 2018 measurement date. The discount rate decreased from 7.65% to 7.15% for the June 30, 2017 measurement date.

Discount rate – The discount rate used to measure the total pension liability at June 30, 2019 and 2018, measurement date was 7.15%. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. The test revealed the assets would not run out. Therefore, the current 7.15% discount rate is appropriate and the use of the municipal bond rate calculation is not deemed necessary. The long-term expected discount rate of 7.15% is applied to all plans in the Public Employees Retirement Fund. The cash flows used in the testing were developed assuming that both members and employers will make their required contributions on time and as scheduled in all future years. The stress test results are presented in a detailed report called "GASB Crossover Testing Report" that can be obtained from the CalPERS website.

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

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

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

Asset Class	Current Target Allocation	Real Return Years 1-10 [(a)]	Real Return Years 11+ [(b)]
Global equity	50.0%	4.80%	5.98%
Fixed Income	28.0%	1.00%	2.62%
Inflation assets	0.0%	0.77%	1.81%
Private equity	8.0%	6.30%	7.23%
Real estate	13.0%	3.75%	4.93%
Liquidity	1.0%	0.00%	-0.92%

[(a)] An expected inflation rate of 2.00% was used for this period.
[(b)] An expected inflation rate of 2.92% was used for this period.

Sensitivity of the employer's proportionate share of the net pension asset/liability to changes in the discount rate – The following presents the Health Authority's net pension asset/liability as of June 30, 2019 and 2018, as well as what the net pension asset/liability would be if it were calculated using a discount rate that is 1% point lower or 1% point higher than the current rate:

	June 30, 2019		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Health Authority's net pension (asset) liability	$ 3,796,634	$ (1,978,644)	$ (6,746,042)

	June 30, 2018		
	1% Decrease (6.65%)	Current Discount Rate (7.65%)	1% Increase (8.65%)
Health Authority's net pension liability (asset)	$ 7,138,936	$ 1,824,796	$ (2,576,471)

The Health Authority's proportion for the miscellaneous plan was -0.0205% and 0.0184% at June 30, 2019 and 2018, respectively.

For the years ended June 30, 2019 and 2018, the Health Authority recognized pension expense of $1,122,685 and $1,546,128, respectively. Pension expense represents the change in the net pension asset/liability during the measurement period, adjusted for actual contributions and the deferred recognition of changes in investment gain/loss, actuarial gain/loss, actuarial assumptions or method, and plan benefits.

As of June 30, 2019, the Health Authority had $6,533,870 of deferred outflows of resources and $2,994,548 of deferred inflows of resources related to pensions from the following sources:

	2019	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 29,685	$ (2,671,652)
Difference in experience	25,833	(75,914)
Differences between employer's actual contributions and its proportionate share of total employer contributions	4,753,151	(11,637)
Net differences between projected and actual earnings on pension plan investments	-	(9,782)
Changes in assumptions	55,281	(225,563)
Pension contributions made subsequent to measurement date	1,669,920	-
	$ 6,533,870	$ (2,994,548)

As of June 30, 2018, the Health Authority had $10,830,147 of deferred outflows of resources and $4,034,620 of deferred inflows of resources related to pensions from the following sources:

	2018	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 138,370	$ (3,697,278)
Difference in experience	12,993	(186,153)
Differences between employer's actual contributions and its proportionate share of total employer contributions	4,275,305	(28,260)
Net differences between projected and actual earnings on pension plan investments	364,604	-
Changes in assumptions	1,612,160	(122,929)
Pension contributions made subsequent to measurement date	4,426,715	-
	$ 10,830,147	$ (4,034,620)

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

Deferred outflows of resources of $1,669,920 and $4,426,715 resulting from contributions subsequent to the measurement date will be recognized as a reduction of the net pension asset/liability in the years ending June 30, 2019 and 2018, respectively.

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

Year Ended June 30,	
2020	$ 640,121
2021	$ 663,003
2022	$ 548,482
2023	$ 17,796

NOTE 7 – POST-EMPLOYMENT HEALTH BENEFITS

Plan description – The Health Authority participates in the California Employers' Retiree Benefit Trust (“CERBT”), a single employer agent plan as administered by CalPERS to prefund its post-employment healthcare benefits. The Health Authority's OPEB plan provides healthcare benefits to eligible employees and certain dependents. Retired employees who retire directly from the health plan are eligible to receive contributions from the Health Authority toward their monthly Public Employees’ Medical and Hospital Care Act (health plans offered by CalPERS) if they meet certain age and service eligibility requirements as outlined in the plan document and as approved by the Health Authority’s Governing Board.

Employees hired prior to May 1, 2018, who attain age 50, with a minimum of 5 years of CalPERS service, and are employed by the Health Authority at the time of retirement, are eligible for coverage. Employees hired on or after May 1, 2018, who attain age 50, with a minimum of 12 continuous years at the Health Authority, and are employed by the Health Authority at the time of retirement, are eligible for coverage.

Copies of CERBT's annual financial report may be obtained from the executive office at 400 Q Street, Sacramento, California 95811. A separate report for the Health Authority's participation in the CERBT trust is not available.

Funding policy – For employees hired prior to May 1, 2018, the Health Authority pays for 90% of the cost of retiree medical plan premiums, including the cost for spouse and dependent coverage. Retirees are required to pay the other 10% of the cost of coverage. The Health Authority's contribution is capped at 90% of the monthly premium cost of the second most expensive HMO plan available from CalPERS (basic and supplemental rates for non-Medicare and Medicare retirees, respectively) for retirees who elect PERS Care or out-of-state coverage. Upon the death of the retiree, the Health Authority will continue contributions described above for the surviving spouse or until surviving minor dependents reach age 26.

For retirees hired on or after May 1, 2018, the Health Authority pays for 90% of the cost of retiree-only medical plan premiums. Retirees are required to pay the other 10% of the cost of coverage. The Health Authority's contribution is capped at 90% of the employee-only premium cost of the second most expensive HMO plan available from CalPERS (basic and supplemental rates for non-Medicare and retirees, respectively) for retirees who elect PERS Care or out-of-state coverage.

Employees covered – At June 30, 2019 and 2018, the following employees were covered by the plan:

	2019	2018
Active	232	216
Retirees	55	55
Total participants	287	271

Contributions – The Health Authority must contribute the minimum required amount of $5,000 or the actuarially determined contribution, whichever is lower. The contribution requirements of the Health Authority are established and may be amended by the CERBT.

Net OPEB liability – The Health Authority's net OPEB liability at June 30, 2019 and 2018, was measured as of June 30, 2018 and 2017, respectively, and the total OPEB liability used to calculate the net OPEB liability was determined by an actuarial valuation as of June 30, 2018 and 2017, respectively.

The total OPEB liability in the June 30, 2018, actuarial valuation was determined using the following actuarial assumptions:

Actuarial cost method:	Individual Entry Age Normal Level Percent of Pay
Actuarial assumptions:	
Discount rate	6.75%
Inflation	2.75%
Investment rate of return	6.75%
Healthcare cost trend rates:	7.50% for 2019 – Non-Medicare, decreasing to 4.00% in 2076, 6.5% for 2019 – Medicare, decreasing to 4% in 2076

Mortality rates are based on statistics taken from the CalPERS 1997-2015 Experience Study Report. Mortality projected fully generational with Scale MP-17.

The total OPEB liability in the June 30, 2017, actuarial valuation was determined using the following actuarial assumptions:

Actuarial cost method:	Individual Entry Age Normal Level Percent of Pay
Actuarial assumptions:	
Discount rate	6.75%
Inflation	2.75%
Investment rate of return	6.75%
Healthcare cost trend rates:	7.50% for 2019, decreasing to 4.00% for year 2017 for ages pre-65 and 6.5% for 2019, decreasing to 4.00% in 2075 for ages post-65

Mortality rates are based on statistics taken from the CalPERS Experience Study Report adopted in 2014. The rates include a projection to 2028 using Scale BB to account for anticipated future mortality improvement.

Discount rate – The discount rate used to measure the total OPEB liability was 6.75% at both June 30, 2018 and 2017 measurement dates. The projection of cash flows used to determine the discount rate assumed that Health Authority contributions will be made at rates equal to the actuarially determined contribution rates. Based on those assumptions, the OPEB plan's fiduciary net position was projected to be available to make all projected OPEB payments for current active and inactive employees. Therefore, the long-term expected rate of return on OPEB plan investments was applied to all periods of projected benefit payments to determine the total OPEB liability.

The Health Authority's retiree health plan assets are invested in the California Employers' Retirement Benefit Trust Fund Strategy 1 ("Strategy"). The table below reflects the Strategy's asset allocation.

Asset Class	Expected Real Rate of Return	Asset Allocation
Global equity	4.82%	57.00%
Fixed Income	1.47%	27.00%
Treasury inflation-protected securities	1.29%	5.00%
Commodities	0.84%	3.00%
Real estate investment trusts	3.76%	8.00%
Assumed long-term rate of inflation		2.75%
Expected long-term net rate of return		6.75%

Changes in the net OPEB liability – The changes in the net OPEB liability for the years ended June 30, 2019 and 2018, were as follows:

	June 30, 2019		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability
Balance at June 30, 2018	$ 11,046,155	$ 6,337,437	$ 4,708,718
Changes during the year:			
Service cost	1,119,648	-	1,119,648
Interest on the total OPEB liability	805,036	-	805,036
Contributions from employer	-	3,588,109	(3,588,109)
Net investment income	-	518,470	(518,470)
Benefit payments	(478,669)	(478,669)	-
Administrative expense	-	(12,267)	12,267
Net change in total OPEB liability	1,446,015	3,615,643	(2,169,628)
Balance at June 30, 2019	$ 12,492,170	$ 9,953,080	$ 2,539,090

	June 30, 2018		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability
Balance at June 30, 2017	$ 10,006,805	$ 5,188,446	$ 4,818,359
Changes during the year:			
Service cost	756,248	-	756,248
Interest on the total OPEB liability	708,213	-	708,213
Actual vs. expected experience	(14,700)	-	(14,700)
Assumption changes	131,618	-	131,618
Contributions from employer	-	1,142,027	(1,142,027)
Net investment income	-	551,777	(551,777)
Benefit payments	(542,029)	(542,029)	-
Administrative expense	-	(2,784)	2,784
Net change in total OPEB liability	1,039,350	1,148,991	(109,641)
Balance at June 30, 2018	$ 11,046,155	$ 6,337,437	$ 4,708,718

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability of the Health Authority as of June 30, 2019 and 2018, as well as what the Health Authority's net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current discount rate:

	June 30, 2019		
	1% Decrease (5.75%)	Current Discount Rate (6.75%)	1% Increase (7.75%)
Health Authority's net OPEB liability	$ 4,299,307	$ 2,539,090	$ 1,090,984

	June 30, 2018		
	1% Decrease (5.75%)	Current Discount Rate (6.75%)	1% Increase (7.75%)
Health Authority's net OPEB liability	$ 6,249,142	$ 4,708,718	$ 3,440,656

Sensitivity of the net OPEB liability to changes in the healthcare cost trend rates – The following presents the net OPEB liability of the Health Authority, as well as what the Health Authority's net OPEB liability would be if it were calculated using healthcare cost trend rates that is 1 percentage point lower or 1 percentage point higher than the current healthcare cost trend rates:

	June 30, 2019		
	1% Decrease in Healthcare Costs Trend Rate	Current Healthcare Costs Trend Rate	1% Increase in Healthcare Costs Trend Rate
Health Authority's net OPEB liability	$ 832,325	$ 2,539,090	$ 4,574,514

	June 30, 2018		
	1% Decrease in Healthcare Costs Trend Rate	Current Healthcare Costs Trend Rate	1% Increase in Healthcare Costs Trend Rate
Health Authority's net OPEB liability	$ 3,318,333	$ 4,708,718	$ 6,353,250

OPEB expense and deferred outflows of resources and deferred inflows of resources related to OPEB – For the year ended June 2019, the Health Authority recognized OPEB expense of $1,410,374. At June 30, 2019, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2019	
	Deferred outflows of resources	Deferred inflows of resources
Difference in experience	$ -	$ (11,434)
Net differences between projected and actual earnings on pension plan investments	-	(139,912)
Changes in assumptions	102,370	-
OPEB contributions made subsequent to measurement date	2,601,369	-
	$ 2,703,739	$ (151,346)

As of June 2018, the Health Authority recognized OPEB expense of $1,089,469. At June 30, 2018, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2018	
	Deferred outflows of resources	Deferred inflows of resources
Difference in experience	$ -	$ (13,067)
Net differences between projected and actual earnings on pension plan investments	-	(161,010)
Changes in assumptions	116,994	-
OPEB contributions made subsequent to measurement date	3,588,109	-
	$ 3,705,103	$ (174,077)

The Health Authority reported $2,601,369 and $3,588,109 as deferred outflows of resources related to contributions made subsequent to the measurement date for the years ended June 30, 2019 and 2018. This amount will be recognized as a reduction of net OPEB liability in the years ended June 30, 2020 and 2019, respectively.

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

Year Ended June 30,	
2020	$ (32,050)
2021	$ (32,050)
2022	$ (32,052)
2023	$ 8,204
2024	$ 12,991
Thereafter	$ 25,981

Payable to the OPEB plan – At June 30, 2019 and 2018, the Health Authority had no outstanding amount of contributions to the OPEB plan required for the years ended June 30, 2019 and 2018.

NOTE 8 – MEDICAL STOP LOSS INSURANCE

The Health Authority has entered into certain stop-loss agreements with third parties in order to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse the Health Authority certain proportions of the cost of each member's annual hospital services excluding those that are capitated, in excess of specified deductibles, up to a maximum of $1,500,000 per member per contract year. Insurance premiums are recorded as medical expenses and recoveries are recorded as a reduction of these expenses. Premiums exceed stop-loss recoveries by $2,479,214 in 2019. Stop-loss recoveries exceeded premiums by $819,793 in 2018.

NOTE 9 – TANGIBLE NET EQUITY

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975, the Health Authority is required to maintain a minimum level of tangible net equity. The required tangible net equity level was $30,888,357 and $36,037,000 at June 30, 2019 and 2018, respectively. The Health Authority's tangible net equity was $202,124,752 and $178,015,865 at June 30, 2019 and 2018, respectively.

NOTE 10 – RISK MANAGEMENT

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

NOTE 11 – COMMITMENTS AND CONTINGENCIES

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

NOTE 12 – HEALTH CARE REFORM

The Patient Protection and Affordable Care Act (“PPACA”) allowed for the expansion of Medi-Cal members in the State of California. Any further changes in federal or state funding could have an impact on the Health Authority. The future of the PPACA and the impact of future changes in Medicaid to the Health Authority is uncertain at this time.

Supplementary Information

Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority
Schedule of Proportionate Share of the Net Pension Asset/Liability

	2019	2018	2017	2016	2015
Measurement period	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Proportion of the net pension (asset) liability	-0.02053%	0.01840%	0.07925%	0.07311%	0.07849%
Proportionate share of the net pension (asset) liability	$ (1,978,644)	$ 1,824,796	$ 6,857,370	$ 5,018,386	$ 4,883,971
Covered-employee payroll*	$ 19,966,458	$ 16,512,291	$ 11,010,647	$ 7,427,745	$ 9,121,825
Proportionate share of the net pension liability as a percentage of covered-employee payroll	-9.91%	11.05%	62.28%	67.56%	53.54%
Proportionate share of plan's fiduciary net position as a percentage of the plan's total pension liability	75.26%	73.31%	74.06%	78.40%	80.43%

*For the year ending on the measurement date

Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority
Schedule of Pension Contributions

	2019	2018	2017	2016	2015
Measurement period	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Actuarially determined contribution	$ 1,669,920	$ 1,198,065	$ 1,287,320	$ 910,906	$ 886,335
Contributions in relation to the actuarially determined contribution	1,669,920	4,426,715	7,188,179	910,906	886,335
Contribution excess	$ -	$ (3,228,650)	$ (5,900,859)	$ -	$ -
Covered-employee payroll*	$ 23,706,126	$ 19,966,458	$ 16,512,291	$ 11,010,647	$ 7,427,745
Contributions as a percentage of covered-employee payroll	7.04%	22.17%	43.53%	8.27%	11.93%

*For the fiscal year ending on the date shown

Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority
Schedule of Changes in Net Other Post-Employment Benefit Liability

	2019	2018	2017
Measurement period	2017-2018	2016-2017	2015-2016
Total OPEB liability			
Service cost	$ 1,119,648	$ 756,248	$ 736,008
Interest on the total OPEB liability	805,036	708,213	648,807
Actual vs. expected experience	-	(14,700)	-
Assumption changes	-	131,618	-
Benefit payments	(478,669)	(542,029)	(499,704)
Net change in total OPEB liability	1,446,015	1,039,350	885,111
Total OPEB liability, beginning of year	11,046,155	10,006,805	9,121,694
Total OPEB liability, end of year	$ 12,492,170	$ 11,046,155	$ 10,006,805
Plan fiduciary net position			
Contributions from employer	$ 3,588,109	$ 1,142,027	$ 954,155
Net investment income	518,470	551,777	283,871
Benefit payments	(478,669)	(542,029)	(499,704)
Administrative expense	(12,267)	(2,784)	(2,239)
Net change in plan fiduciary net position	3,615,643	1,148,991	736,083
Plan fiduciary net position, beginning of year	6,337,437	5,188,446	4,452,363
Plan fiduciary net position, end of year	$ 9,953,080	$ 6,337,437	$ 5,188,446
Health Authority's net OPEB liability	$ 2,539,090	$ 4,708,718	$ 4,818,359
Plan fiduciary net position as a percentage of the total OPEB liability	79.67%	57.37%	51.85%
Covered-employee payroll*	$ 20,046,373	$ 17,216,515	$ 17,195,643
Health Authority's net OPEB liability as a percentage of covered-employee payroll	12.67%	27.35%	28.02%

*For the year ending on the measurement date

Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority
Schedule of Other Post-Employment Benefit Contributions

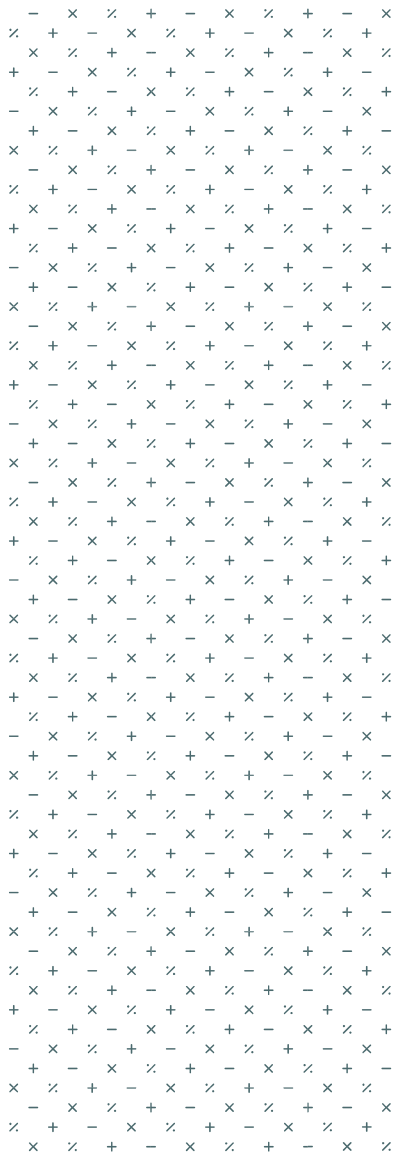
	2019	2018	2017
Measurement period	2017-2018	2016-2017	2015-2016
Actuarially determined contribution	$ 1,269,369	$ 1,427,237	$ 1,217,313
Contributions in relation to the actuarially determined contribution	2,601,369	3,588,109	1,217,313
Contribution excess	$ (1,332,000)	$ (2,160,872)	$ -
Covered-employee payroll*	$ 24,360,228	$ 20,046,373	$ 17,195,643
Contributions as a percentage of covered-employee payroll	10.68%	17.90%	7.08%

*For the fiscal year ending on the date shown

MOSSADAMS

2019 Audit Results:

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



Report of Independent Auditors

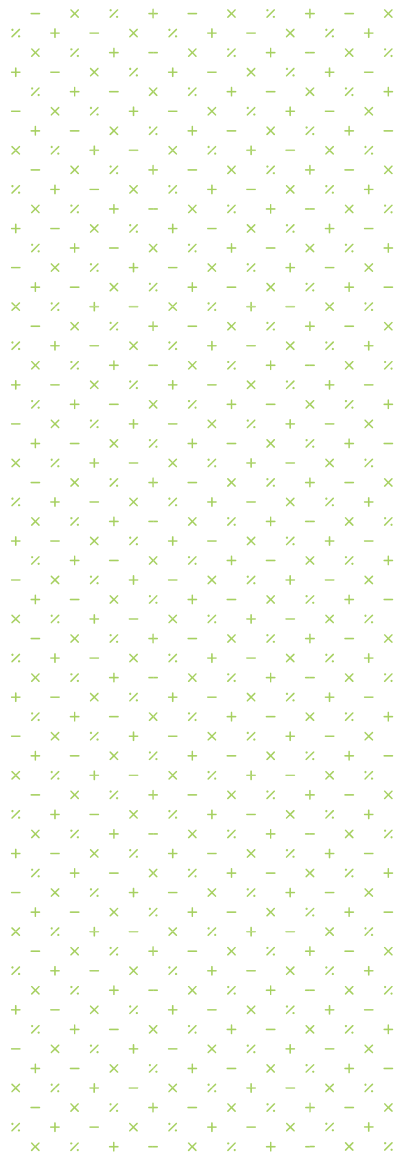
Unmodified Opinion

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

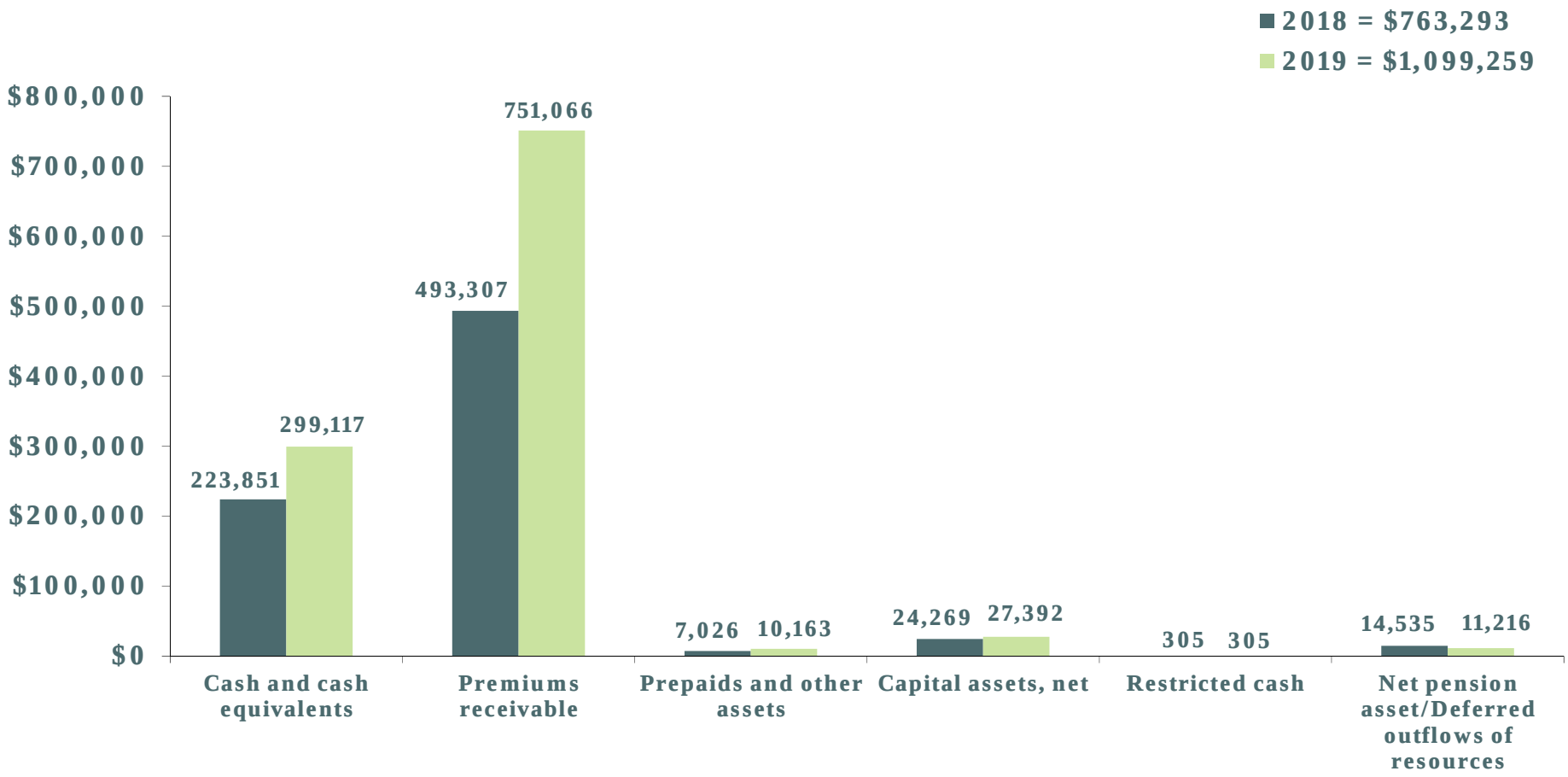
MOSSADAMS

Combined Statements of Net Position

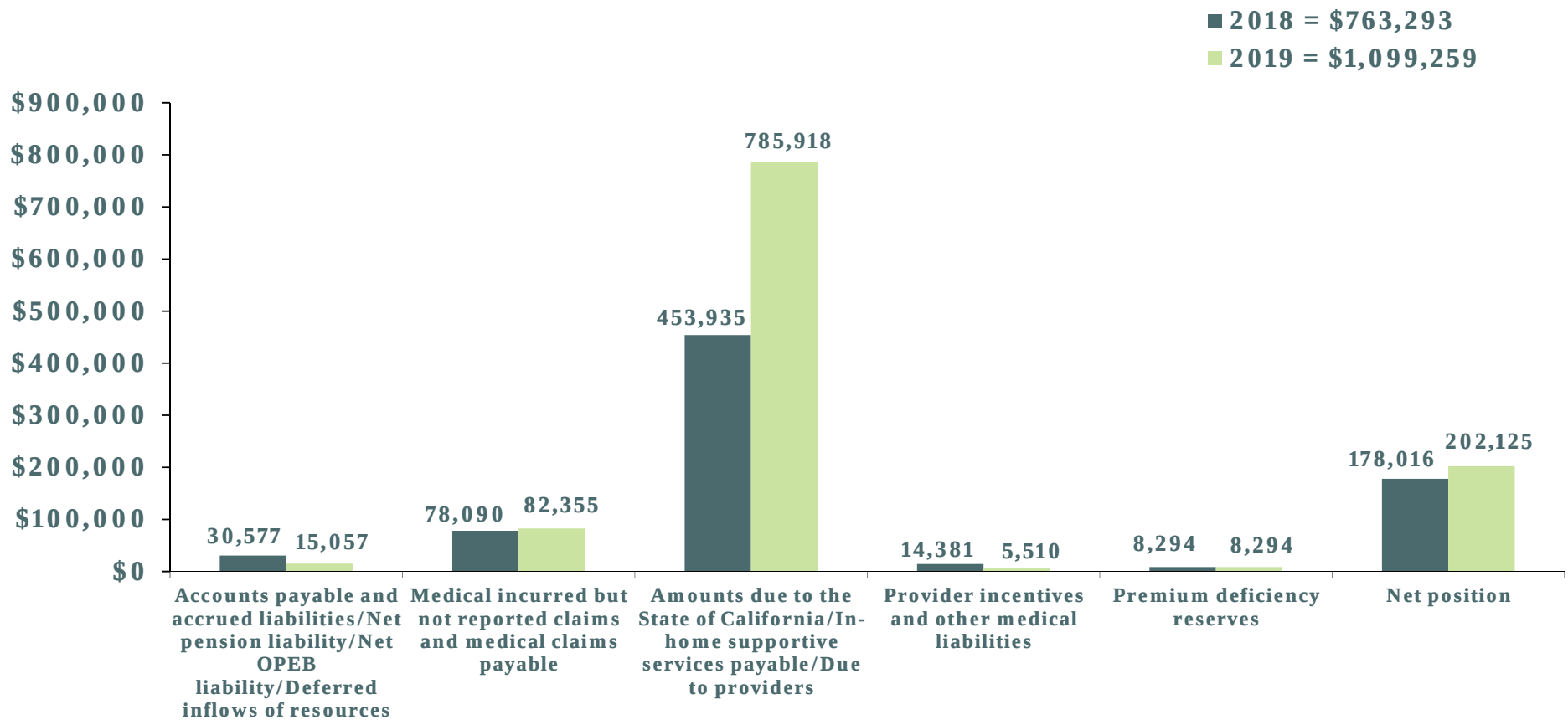
Better Together: Moss Adams & Santa Clara Family Health Plan



Asset Composition (in Thousands)



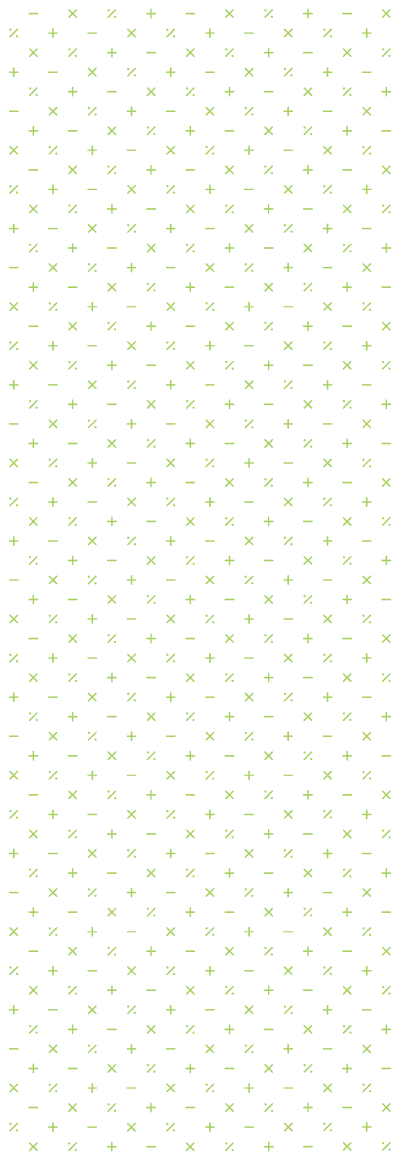
Liabilities and Net Position Balance (in Thousands)



MOSSADAMS

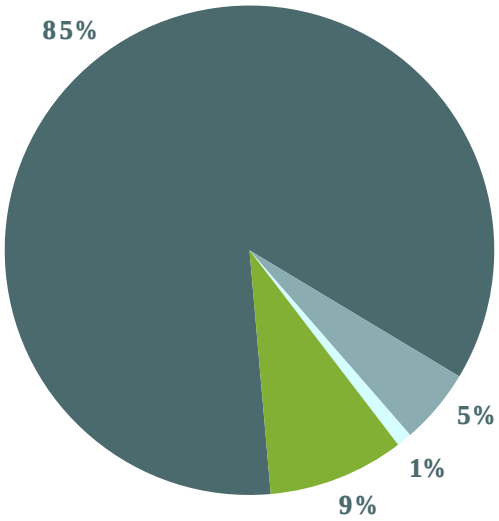
Operations

Better Together: Moss Adams & Santa Clara Family Health Plan

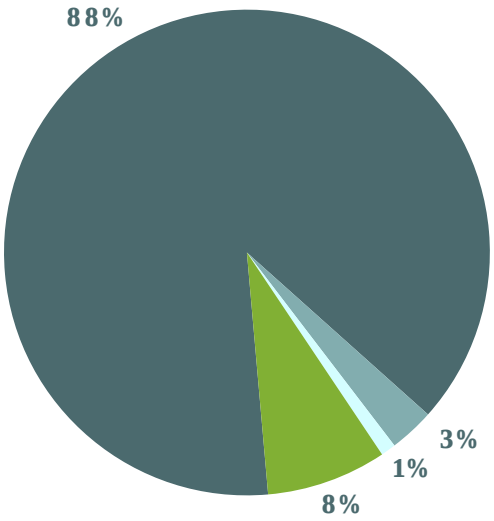


Operating Expenses (in Thousands)

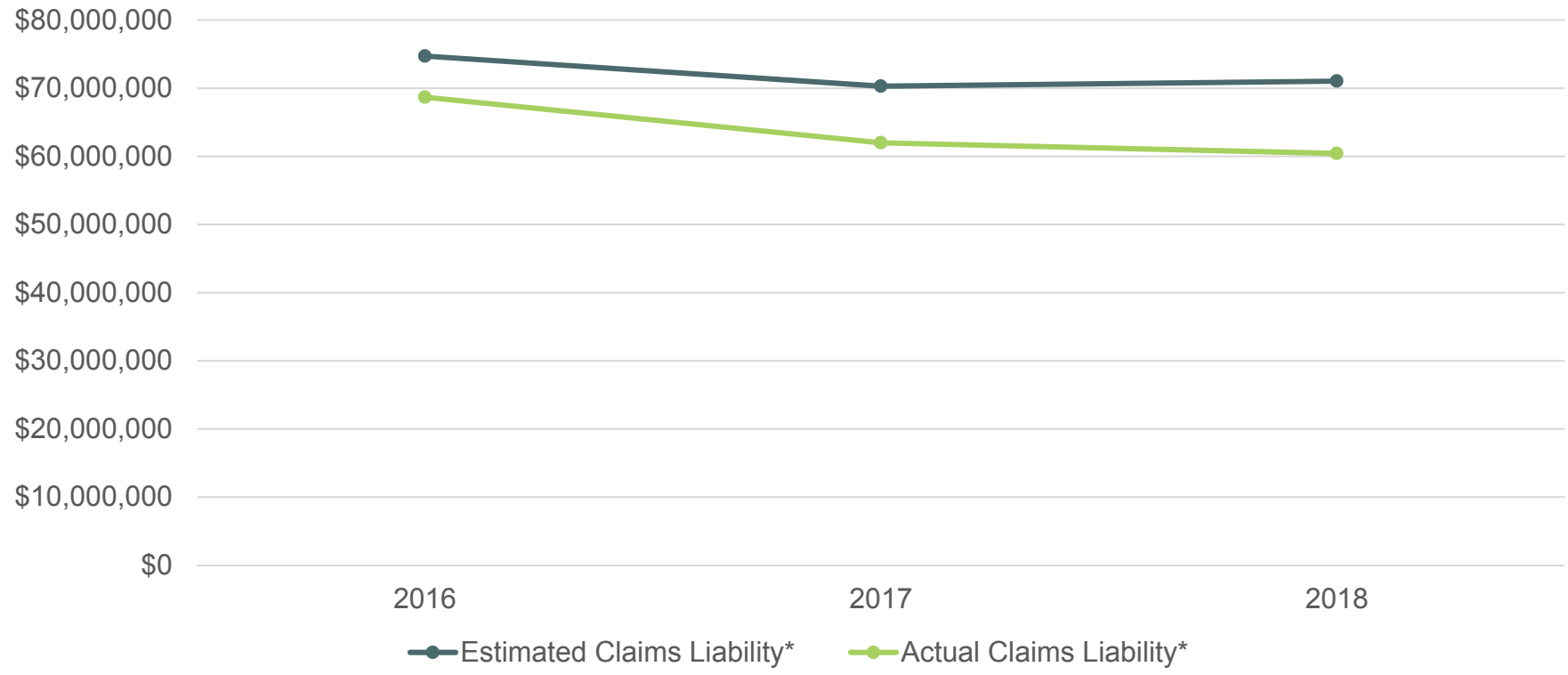
June 30, 2019
$1,143,600



June 30, 2018
$1,313,245



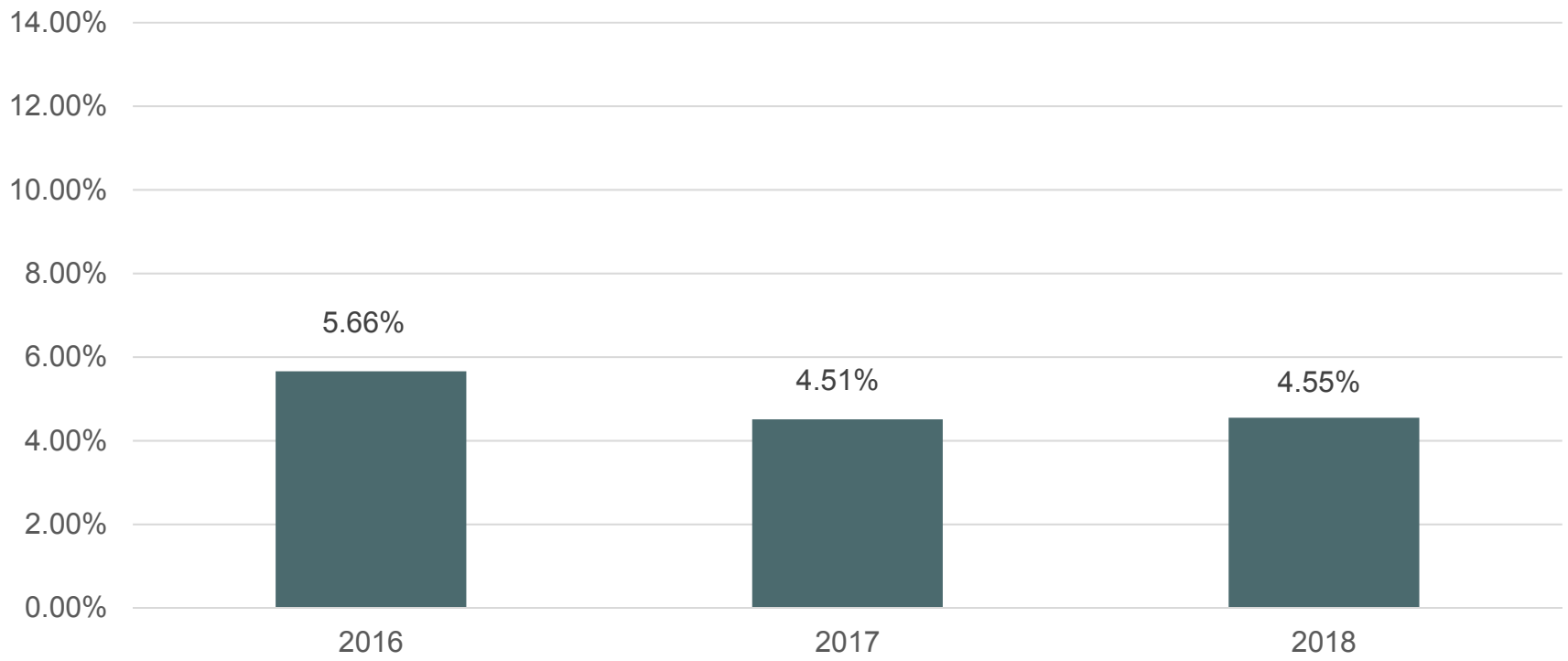
Historic Estimated Claims Liability and Historic Actual Claims Liability



* Estimated claims liability and actual claims liability excludes pharmacy claims.

Source: SCFHP's internal reports

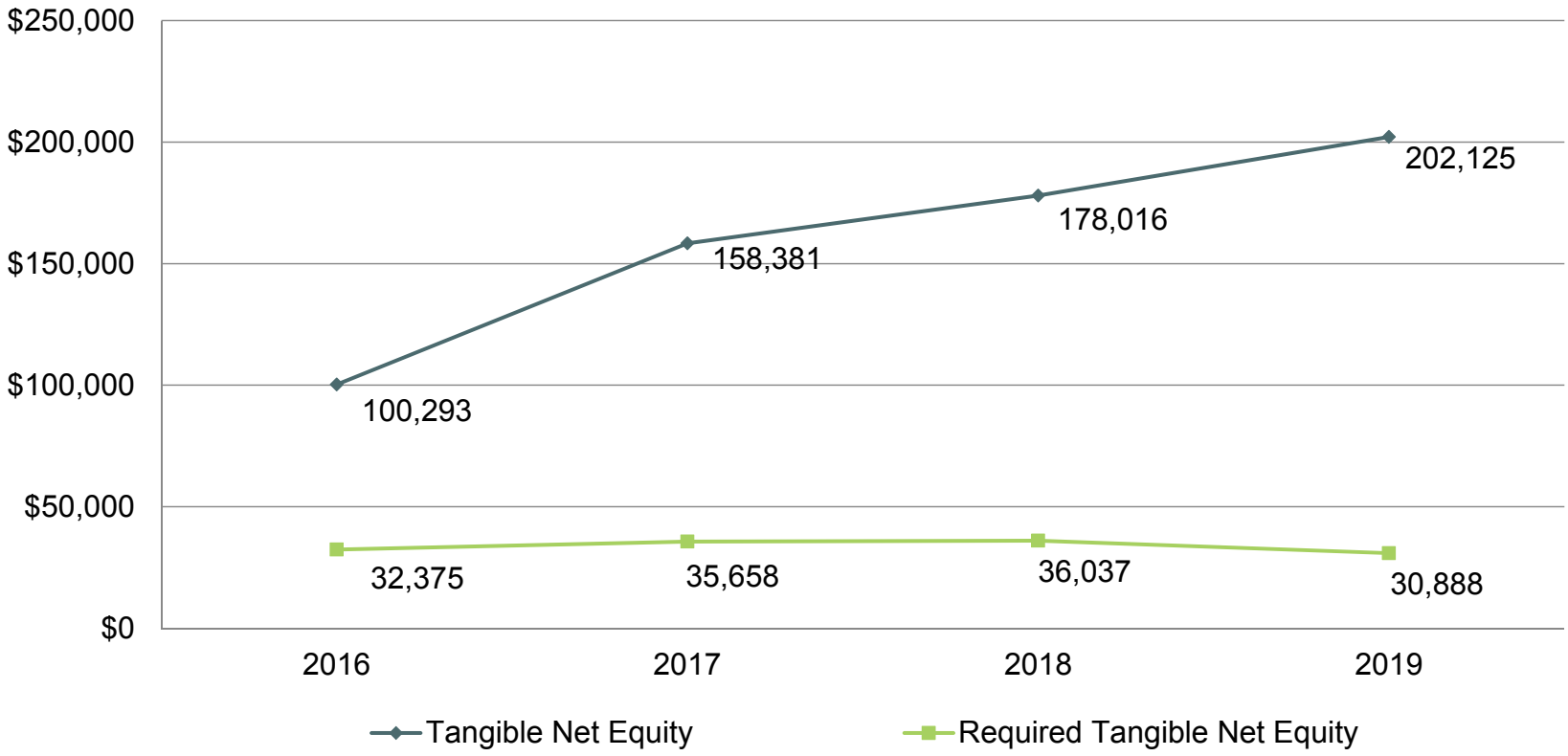
Historic Actual Claims Liability* as a % of Capitation and Premium Revenues



* Actual claims liability excludes pharmacy claims

Source: SCFHP's internal reports

Tangible Net Equity (in Thousands)



Source: Annual Department of Managed Health Care Filing

Important Board Communications

- AU-C Section 260 – *The Auditor's Communication with Those Charged with Governance*
- Significant accounting policies
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of instances of fraud or noncompliance with laws and regulations

Questions?

Santa Clara Family Health Plan™

Unaudited Financial Statements
For The Month Ended August 31, 2019

Agenda

Santa Clara Family Health Plan

Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$91 M		$181 M	
Medical Expense (MLR)	$85 M	93.6%	$170 M	93.8%
Administrative Expense (% Rev)	$4.8 M	5.2%	$9.9 M	5.5%
Other Income/Expense	$354,779		$783,371	
Net Surplus (Loss)	**$1,435,550**		**$2,127,526**	
Cash on Hand			$291 M	
Receivables			$752 M	
Total Current Assets			$1,056 M	
Current Liabilities			$878 M	
Current Ratio			1.20	
Tangible Net Equity			$204 M	
% of DMHC Requirements			**676.4%**	

Financial Highlights

Net Surplus (Los)	Month: Surplus of $1.4M is $441K or 44.3% favorable to budget of $995K. YTD: Surplus of $2.1M is $178K or 9.2% favorable to budget of $1.9M.
Enrollment	Month: Membership was 247,032 (877 or 0.4% favorable budget of 246,155). YTD: Membership was 495,187 (1,917 or 0.4% favorable budget of 493,270).
Revenue	Month: $91.2M ($1.6M or 1.8% favorable to budget of $89.6M). YTD: $180.9M ($1.7M or 0.9% favorable to budget of $179.3M).
Medical Expenses	Month: $85.3M ($1.5M or 1.8% unfavorable to budget of $83.8M). YTD: $169.7M ($2.0M or 1.2% unfavorable to budget of $167.7M).
Administrative Expenses	Month: $4.8M ($246K or 4.9% favorable to budget of $5.0M). YTD: $9.9M ($161K or 1.6% favorable to budget of $10.1M).
Tangible Net Equity	TNE was $204.3M (676.4% of minimum DMHC requirement of $30.2M).
Capital Expenditures	YTD Capital Investments of $266K vs. $4.8M annual budget, primarily IT hardware.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment has decreased since June 30, 2019 by 2,173 or -0.9%, slightly better than budgeted expectation.
- As detailed on page 7, much of the Medi-Cal enrollment decline has been in the Medi-Cal Non-Dual Child, Adult Expansion and Adult categories of aid. Medi-Cal Dual enrollment has been stable overall while CMC enrollment continues to grow in line with budget due to outreach efforts.
- Membership Trends:
  - Medi-Cal membership has decreased since the beginning of the fiscal year by 1.0%.
  - CMC membership increased since the beginning of the fiscal year by 1.4%.
  - Healthy Kids membership increased since the beginning of the fiscal year by 0.7%.

Santa Clara Family Health Plan Enrollment Summary

	For the Month of August 2019				For Two Months Ending August 31, 2019					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY19 vs. FY20
Medi-Cal	235,389	234,711	678	0.3%	471,967	470,425	1,542	0.3%	493,709	(4.4%)
Cal Medi-Connect	8,134	8,096	38	0.5%	16,210	16,149	61	0.4%	15,063	7.6%
Healthy Kids	3,509	3,348	161	4.8%	7,010	6,696	314	4.7%	6,465	8.4%
Total	**247,032**	**246,155**	**877**	**0.4%**	**495,187**	**493,270**	**1,917**	**0.4%**	**515,237**	**(3.9%)**

Santa Clara Family Health Plan Enrollment By Network
August 2019

Network	Medi-Cal		CMC		Healthy Kids		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	30,364	13%	8,134	100%	359	10%	38,857	16%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	117,073	50%	-	0%	1,551	44%	118,624	48%
Palo Alto Medical Foundation	6,750	3%	-	0%	86	2%	6,836	3%
Physicians Medical Group	41,271	18%	-	0%	1,245	35%	42,516	17%
Premier Care	14,516	6%	-	0%	268	8%	14,784	6%
Kaiser	25,415	11%	-	0%	-	0%	25,415	10%
Total	**235,389**	**100%**	**8,134**	**100%**	**3,509**	**100%**	**247,032**	**100%**
Enrollment at June 30, 2019	237,697		8,022		3,486		249,205	
Net Δ from Beginning of FY20	-1.0%		1.4%		0.7%		-0.9%	

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

Enrollment By Aid Category

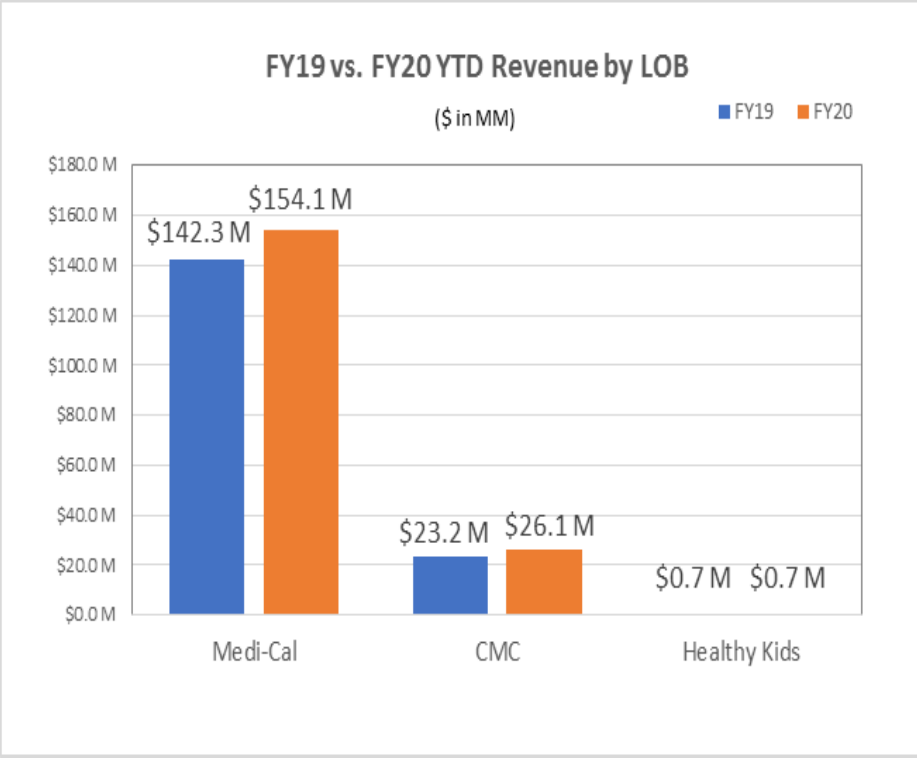
SCFHP TRENDED ENROLLMENT BY COA YTD AUG-19

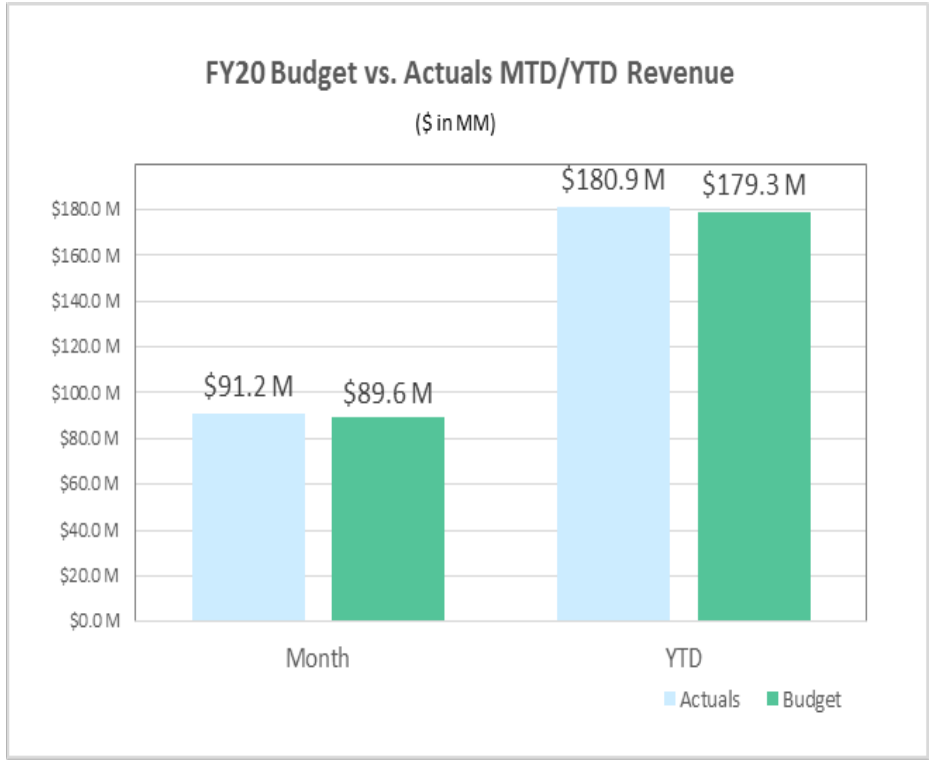
		2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08
NON DUAL	Adult (over 19)	27,001	26,652	26,568	26,354	26,213	26,175	25,954	25,846	25,779	25,563	25,198	25,204	24,989	24,888
	Child (under 19)	99,369	98,316	98,255	97,518	96,830	96,331	95,155	95,177	95,229	94,956	94,255	94,026	93,536	92,668
	Aged - Medi-Cal Only	10,909	10,815	10,887	10,869	10,887	10,923	10,901	10,963	10,934	10,949	10,871	10,995	10,948	10,958
	Disabled - Medi-Cal Only	10,742	10,679	10,635	10,611	10,624	10,631	10,629	10,579	10,595	10,678	10,780	10,819	10,774	10,833
	Adult Expansion	74,261	73,971	73,959	73,601	73,398	73,186	72,075	72,223	72,143	72,114	71,364	71,465	71,082	70,635
	BCCTP	13	14	13	12	11	11	9	9	8	10	11	11	10	10
	Long Term Care	382	384	387	379	377	372	371	376	375	375	370	372	372	364
	Total Non-Duals	**222,676**	**220,831**	**220,703**	**219,343**	**218,340**	**217,629**	**215,093**	**215,173**	**215,063**	**214,644**	**212,848**	**212,891**	**211,711**	**210,356**
DUAL	Adult (21 Over)	387	385	382	385	390	379	373	376	367	368	354	352	351	345
	SPD (21 Over)	22,919	22,928	22,984	22,963	22,897	22,893	22,765	22,728	22,725	22,941	23,009	22,988	23,087	23,230
	Adult Expansion	455	485	521	533	538	586	556	529	479	304	252	253	209	226
	BCCTP	2	2	2	1	1	1	2	1	1	0	0	0	0	0
	Long Term Care	1,316	1,323	1,292	1,268	1,233	1,208	1,209	1,203	1,201	1,187	1,192	1,213	1,220	1,232
	Total Duals	**25,079**	**25,123**	**25,181**	**25,150**	**25,059**	**25,067**	**24,905**	**24,837**	**24,773**	**24,800**	**24,807**	**24,806**	**24,867**	**25,033**
	Total Medi-Cal	**247,755**	**245,954**	**245,884**	**244,493**	**243,399**	**242,696**	**239,998**	**240,010**	**239,836**	**239,444**	**237,655**	**237,697**	**236,578**	**235,389**
	Healthy Kids	**3,278**	**3,187**	**3,163**	**3,217**	**3,460**	**3,345**	**3,252**	**3,375**	**3,348**	**3,465**	**3,507**	**3,486**	**3,501**	**3,509**
CMC	CMC Non-Long Term Care	7,302	7,318	7,386	7,383	7,407	7,484	7,540	7,616	7,680	7,661	7,706	7,815	7,869	7,921
	CMC - Long Term Care	221	222	214	218	218	211	210	198	204	208	209	207	207	213
	Total CMC	**7,523**	**7,540**	**7,600**	**7,601**	**7,625**	**7,695**	**7,750**	**7,814**	**7,884**	**7,869**	**7,915**	**8,022**	**8,076**	**8,134**
	Total Enrollment	**258,556**	**256,681**	**256,647**	**255,311**	**254,484**	**253,736**	**251,000**	**251,199**	**251,068**	**250,778**	**249,077**	**249,205**	**248,155**	**247,032**

Revenue

Current month revenue of $91.2M is $1.6M or 1.8% favorable to budget of $89.6M. This month's variances were due to several factors including Medi-Cal revenue, which is $1.9M favorable due to:

- Higher FY20 rates in the Non-Dual Adult Expansion, Adult, and Long Term Care (LTC) categories of aid ($545K)
- Higher member months than budget ($600K)
- BHT revenue is $500K favorable to budget due to higher utilization.

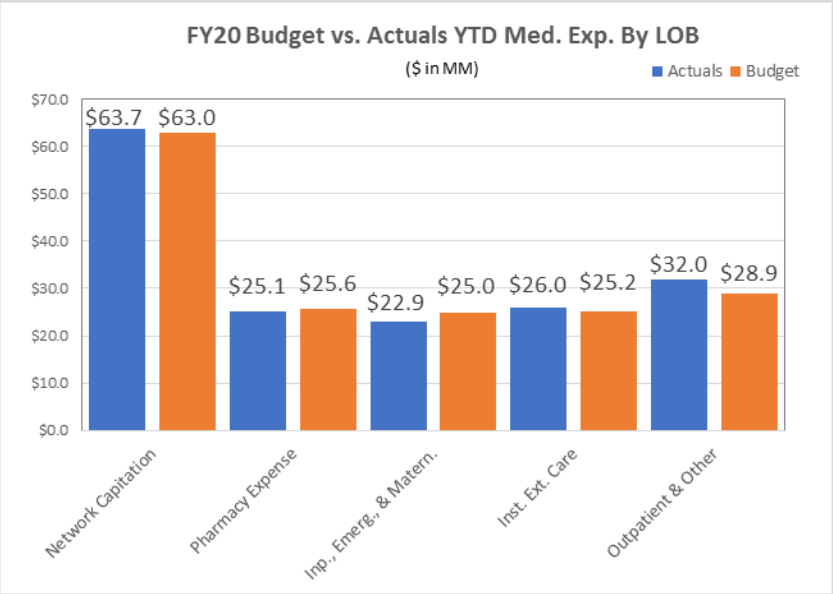


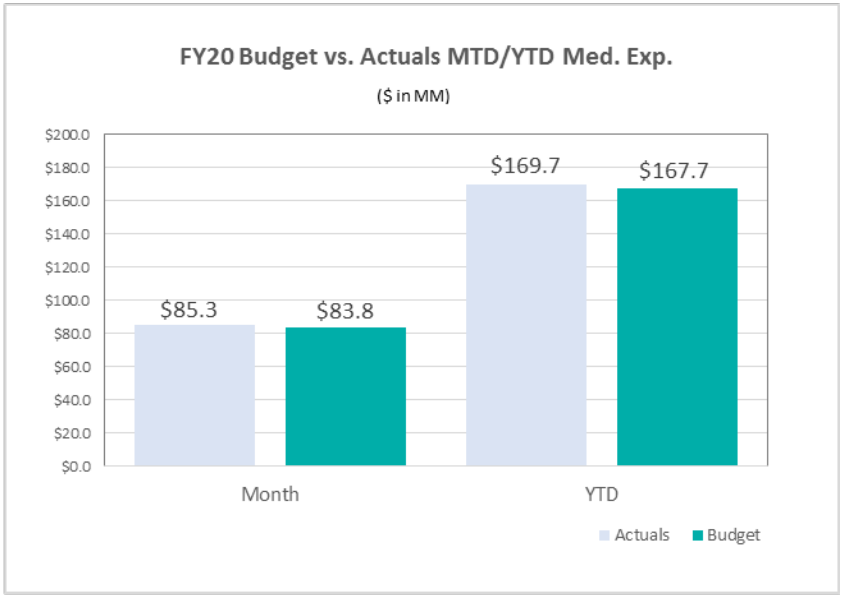


Medical Expense

Current month medical expense of $85.3M is $1.5M or 1.8% unfavorable to budget of $83.8M. The current month variances were due to a variety of factors, including:

- Capitation expense is $456K unfavorable due to higher member months than budgeted.
- Medi-Cal LTC, Outpatient Professional and Specialty expenses in excess of budget yielded an unfavorable variance of $1.0M due to higher average rates versus budget.





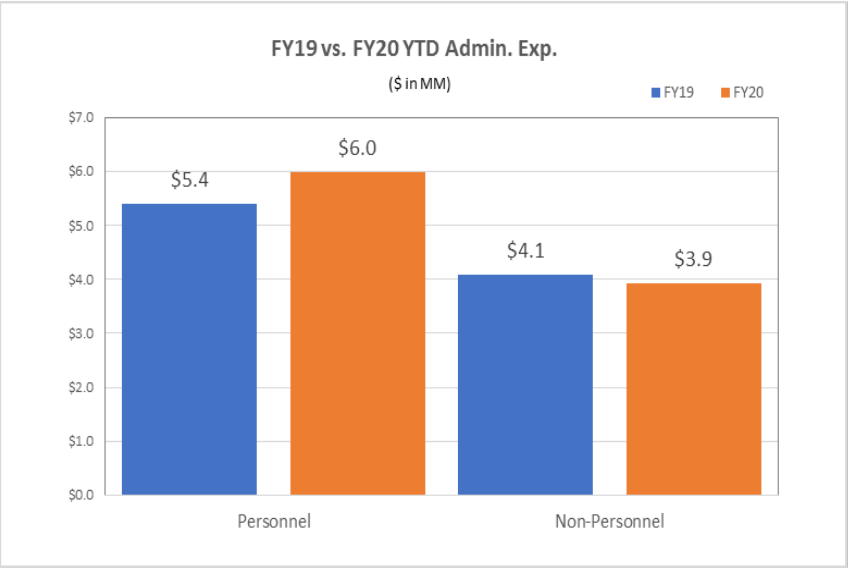
	FY20 Budget vs. Actuals YTD Med. Exp. By LOB			
	Actuals	Budget	Variance	
Network Capitation	$63.7	$63.0	($0.7)	-1.1%
Pharmacy	$25.1	$25.6	$0.5	2.0%
Inp., Emerg., & Matern.	$22.9	$25.0	$2.1	8.6%
Inst. Ext. Care	$26.0	$25.2	($0.8)	-3.1%
Outpatient & Other	$32.0	$28.9	($3.1)	-10.9%
Total Medical Expense	**$169.7**	**$167.7**	**($2.0)**	**-1.2%**

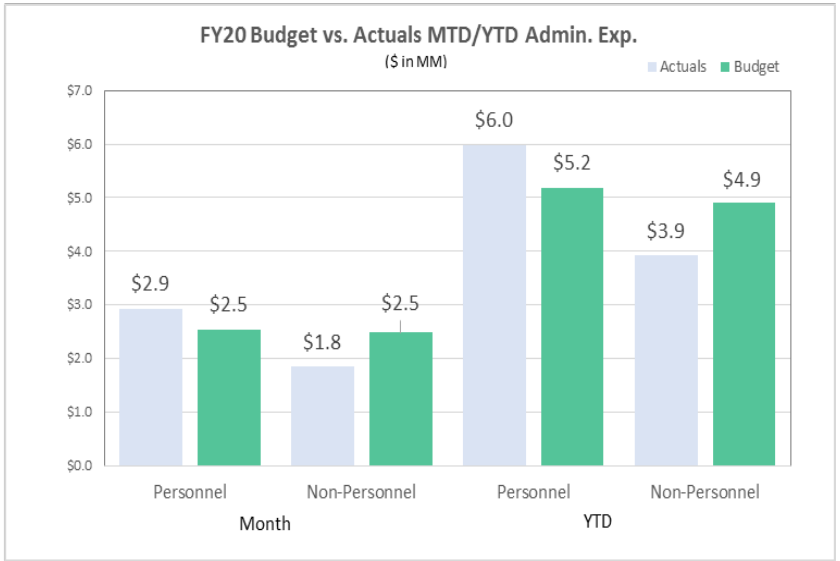
	FY20 Budget vs. Actuals MTD/YTD Med. Exp.			
	Actuals	Budget	Variance	
Month	$85.3	$83.8	($1.5)	-1.8%
YTD	$169.7	$167.7	($2.0)	-1.2%

Administrative Expense

Current month admin expense of $4.8M is $246K or 4.9% favorable to budget of $5.0M. The current month variances were primarily due to the following:

- Personnel expenses were $392K or 15.5% unfavorable to budget due to accelerated hiring.
- Non-Personnel expenses were overall $639K or 25.7% favorable to budget due to the timing of consulting, advertising and postage expenses and reduced QI spending versus budget.





	FY19 vs. FY20 YTD Admin. Exp.			
	FY19	FY20	Variance	
Personnel	$5.4	$6.0	$0.6	9.8%
Non-Personnel	$4.1	$3.9	($0.2)	-4.1%
Total Administrative Expense	**$9.5**	**$9.9**	**$0.4**	**4.3%**

		FY20 Budget vs. Actuals MTD/YTD Admin. Exp.			
		Actuals	Budget	Variance	
Month	Personnel	$2.9	$2.5	-$0.4	-15.5%
	Non-Personnel	$1.8	$2.5	$0.6	25.7%
	MTD Total	**$4.8**	**$5.0**	**$0.2**	**4.9%**
YTD	Personnel	$6.0	$5.2	-$0.8	-15.6%
	Non-Personnel	$3.9	$4.9	$1.0	19.8%
	YTD Total	**$9.9**	**$10.1**	**$0.2**	**1.6%**

Balance Sheet

- Current assets totaled $1,055M compared to current liabilities of $878.5M, yielding a current ratio (Current Assets/Current Liabilities) of 1.20:1 vs. the DMHC minimum requirement of 1.0:1.
- Cash balance decreased by $8.1M compared to the cash balance as of year-end June 30, 2019 due to timing of payments.
- Current Cash & Equivalent components and yields were as follows:
  - Investment yield exceeds budget.

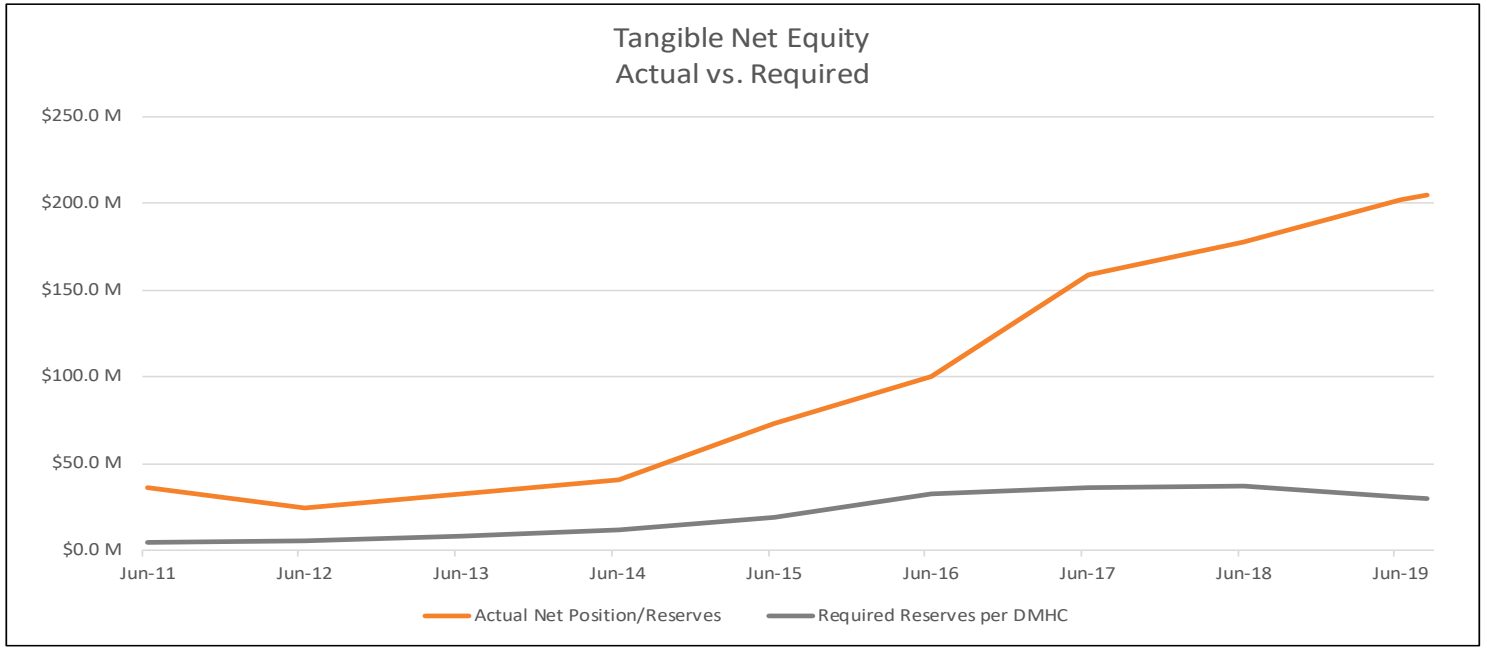
Description	Month-End Balance	Current Yield %	Interest Earned	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$79,235,260	1.95%	$100,000	$200,000
Cash & Equivalents				
Bank of the West Money Market	$76,614	1.12%	$4,655	$14,195
Wells Fargo Bank Accounts	$211,707,610	1.99%	$362,122	$789,201
	$211,784,225		$366,777	$803,396
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.42%	$0	$13
Petty Cash	$500	0.00%	$0	$0
Total Cash & Equivalents	**$291,325,334**		**$466,777**	**$1,003,408**

Tangible Net Equity

- TNE was $204.3M or 676.4% of the most recent quarterly DMHC minimum requirement of $30.2M.
- TNE trends are presented below:

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of August 31, 2019

	Jun-11	Jun-12	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Aug-19
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	$202.1 M	$204.3 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	$30.9 M	$30.2 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	$61.8 M	$60.4 M
Actual as % Required	722.5%	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	676.4%



Reserves Analysis

SCFHP RESERVES ANALYSIS August 2019	
Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	204,253,278
Current Required TNE	30,198,072
Excess TNE	**174,055,207**
Required TNE %	676.4%
SCFHP Target TNE Range:	
350% of Required TNE (Low)	105,693,251
500% of Required TNE (High)	150,990,359
TNE Above/(Below) SCFHP Low Target	**98,560,027**
TNE Above/(Below) High Target	**53,262,919**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	291,325,334
Less Pass-Through Liabilities	
Other Pass-Through Liabilities	(17,664,845)
Total Pass-Through Liabilities	**(17,664,845)**
Net Cash Available to SCFHP	273,660,489
SCFHP Target Liability	
45 Days of Total Operating Expense	(133,202,869)
60 Days of Total Operating Expense	(177,603,825)
Liquidity Above/(Below) SCFHP Low Target	**140,457,620**
Liquidity Above/(Below) High Target	**96,056,664**

Note 1: In December 2018, the Governing Board established a Board Discretionary Fund of $2.2M. The specific projects/recipients have yet to be determined.

Note 2: Other Pass-Through Liabilities include Prop 56 and other provider payables.

Note 3: SCFHP Target Liability policy is based on monthly budget.

Capital Expenditures

Expenditure	YTD Actual	Annual Budget
Hardware	$177,369	$620,000
Software	$38,112	$1,029,000
Building Improvements	$50,213	$3,149,500
TOTAL	**$265,693**	**$4,798,500**

Santa Clara Family Health Plan™

Financial Statements

Income Statement

Santa Clara Family Health Plan

Santa Clara County Health Authority
INCOME STATEMENT
For Two Months Ending August 31, 2019

	Aug-2019 Actuals	% of Rev	Aug-2019 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD Aug-2019 Actuals	% of Rev	YTD Aug-2019 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 77,777,458	85.3%	$ 75,375,188	84.2%	$ 2,402,271	3.2%	$ 154,099,617	85.2%	$ 150,970,755	84.2%	$ 3,128,862	2.1%
CMC MEDI-CAL	2,654,223	2.9%	2,822,687	3.2%	(168,464)	-6.0%	5,290,822	2.9%	5,630,381	3.1%	(339,559)	-6.0%
CMC MEDICARE	10,360,913	11.4%	11,006,998	12.3%	(646,084)	-5.9%	20,812,080	11.5%	21,955,534	12.2%	(1,143,454)	-5.2%
TOTAL CMC	13,015,136	14.3%	13,829,684	15.4%	(814,548)	-5.9%	26,102,902	14.4%	27,585,916	15.4%	(1,483,014)	-5.4%
HEALTHY KIDS	367,416	0.4%	347,857	0.4%	19,559	5.6%	739,571	0.4%	695,714	0.4%	43,856	6.3%
TOTAL REVENUE	**$ 91,160,011**	**100.0%**	**$ 89,552,729**	**100.0%**	**$ 1,607,282**	**1.8%**	**$ 180,942,090**	**100.0%**	**$ 179,252,385**	**100.0%**	**$ 1,689,705**	**0.9%**
MEDICAL EXPENSES												
MEDI-CAL	$ 71,640,650	78.6%	$ 70,450,111	78.7%	$ (1,190,538)	-1.7%	$ 143,713,389	79.4%	$ 141,131,113	78.7%	$ (2,582,277)	-1.8%
CMC MEDI-CAL	2,682,303	2.9%	2,976,765	3.3%	294,462	9.9%	5,230,127	2.9%	5,938,013	3.3%	707,886	11.9%
CMC MEDICARE	10,644,097	11.7%	9,974,884	11.1%	(669,213)	-6.7%	20,160,144	11.1%	19,892,717	11.1%	(267,427)	-1.3%
TOTAL CMC	13,326,400	14.6%	12,951,649	14.5%	(374,750)	-2.9%	25,390,271	14.0%	25,830,729	14.4%	440,459	1.7%
HEALTHY KIDS	332,691	0.4%	374,468	0.4%	41,778	11.2%	574,578	0.3%	748,937	0.4%	174,359	23.3%
TOTAL MEDICAL EXPENSES	**$ 85,299,740**	**93.6%**	**$ 83,776,229**	**93.5%**	**$ (1,523,511)**	**-1.8%**	**$ 169,678,238**	**93.8%**	**$ 167,710,779**	**93.6%**	**$ (1,967,459)**	**-1.2%**
MEDICAL OPERATING MARGIN	**$ 5,860,271**	**6.4%**	**$ 5,776,500**	**6.5%**	**$ 83,771**	**1.5%**	**$ 11,263,852**	**6.2%**	**$ 11,541,606**	**6.4%**	**$ (277,754)**	**-2.4%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 2,930,498	3.2%	$ 2,538,128	2.8%	$ (392,370)	-15.5%	$ 5,987,080	3.3%	$ 5,177,154	2.9%	$ (809,926)	-15.6%
RENTS AND UTILITIES	27,337	0.0%	11,917	0.0%	(15,420)	-129.4%	42,059	0.0%	39,134	0.0%	(2,925)	-7.5%
PRINTING AND ADVERTISING	41,580	0.0%	78,613	0.1%	37,033	47.1%	68,449	0.0%	127,226	0.1%	58,777	46.2%
INFORMATION SYSTEMS	216,630	0.2%	302,410	0.3%	85,780	28.4%	562,754	0.3%	649,820	0.4%	87,067	13.4%
PROF FEES/CONSULTING/TEMP STAFFING	896,398	1.0%	1,322,763	1.5%	426,365	32.2%	1,916,968	1.1%	2,519,821	1.4%	602,853	23.9%
DEPRECIATION/INSURANCE/EQUIPMENT	297,940	0.3%	380,979	0.4%	83,039	21.8%	681,769	0.4%	771,878	0.4%	90,109	11.7%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	93,798	0.1%	77,741	0.1%	(16,057)	-20.7%	153,681	0.1%	155,882	0.1%	2,201	1.4%
MEETINGS/TRAVEL/DUES	95,697	0.1%	112,882	0.1%	17,186	15.2%	173,324	0.1%	240,724	0.1%	67,400	28.0%
OTHER	179,621	0.2%	200,250	0.2%	20,629	10.3%	333,614	0.2%	399,250	0.2%	65,636	16.4%
TOTAL ADMINISTRATIVE EXPENSES	**$ 4,779,500**	**5.2%**	**$ 5,025,683**	**5.6%**	**$ 246,183**	**4.9%**	**$ 9,919,697**	**5.5%**	**$ 10,080,889**	**5.6%**	**$ 161,192**	**1.6%**
OPERATING SURPLUS (LOSS)	**$ 1,080,771**	**1.2%**	**$ 750,817**	**0.8%**	**$ 329,954**	**43.9%**	**$ 1,344,154**	**0.7%**	**$ 1,460,717**	**0.8%**	**$ (116,563)**	**-8.0%**
ALLOWANCE FOR UNCOLLECTED PREMIUM	-377	0.0%	0	0.0%	377	0.0%	473	0.0%	0	0.0%	(473)	0.0%
GASB 75 - POST EMPLOYMENT BENEFITS EXPENSE	59,780	0.1%	60,000	0.1%	220	0.4%	119,559	0.1%	120,000	0.1%	441	0.4%
GASB 68 - UNFUNDED PENSION LIABILITY	75,000	0.1%	75,000	0.1%	0	0.0%	150,000	0.1%	150,000	0.1%	0	0.0%
NON-OPERATING EXPENSES	**$ 134,403**	**0.1%**	**$ 135,000**	**0.2%**	**$ 597**	**0.4%**	**$ 270,032**	**0.1%**	**$ 270,000**	**0.2%**	**$ (32)**	**0.0%**
INTEREST & OTHER INCOME	489,182	0.5%	379,225	0.4%	109,957	29.0%	1,053,404	0.6%	758,450	0.4%	294,953	38.9%
NET NON-OPERATING ACTIVITIES	**$ 354,779**	**0.4%**	**$ 244,225**	**0.3%**	**$ 110,554**	**45.3%**	**$ 783,371**	**0.4%**	**$ 488,450**	**0.3%**	**$ 294,921**	**60.4%**
NET SURPLUS (LOSS)	**$ 1,435,550**	**1.6%**	**$ 995,042**	**1.1%**	**$ 440,508**	**44.3%**	**$ 2,127,526**	**1.2%**	**$ 1,949,167**	**1.1%**	**$ 178,359**	**9.2%**

Balance Sheet

Santa Clara Family Health Plan

SANTA CLARA COUNTY HEALTH AUTHORITY
For Two Months Ending August 31, 2019

	Aug-2019	Jul-2019	Jun-2019	Aug-2018
Assets				
Current Assets				
Cash and Marketable Securities	291,325,334	288,050,069	299,422,504	235,488,838
Receivables	752,169,795	744,725,861	751,127,472	497,747,681
Prepaid Expenses and Other Current Assets	12,070,465	11,465,989	12,078,741	7,792,801
Total Current Assets	**1,055,565,595**	**1,044,241,919**	**1,062,628,717**	**741,029,320**
Long Term Assets				
Property and Equipment	45,024,463	44,987,513	44,758,770	42,306,060
Accumulated Depreciation	(18,023,037)	(17,697,374)	(17,366,530)	(14,888,918)
Total Long Term Assets	27,001,425	27,290,140	27,392,239	27,417,142
Total Assets	**1,082,567,020**	**1,071,532,059**	**1,090,020,956**	**768,446,462**
Deferred Outflow of Resources	**9,237,609**	**9,237,609**	**9,237,609**	**14,535,240**
Total Assets & Deferred Outflows	**1,091,804,629**	**1,080,769,668**	**1,099,258,565**	**782,981,702**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	6,415,364	6,980,419	6,205,578	5,065,862
Employee Benefits	1,690,637	1,808,174	1,821,153	1,527,690
Retirement Obligation per GASB 75	4,062,845	4,003,066	3,943,286	5,002,354
Advance Premium - Healthy Kids	95,965	98,208	91,917	80,809
Deferred Revenue - Medicare	9,997,983	-	0	19,419,939
Whole Person Care / Prop 56	17,664,845	19,703,965	17,810,066	6,746,391
IGT, HQAF, Other Provider Payables	305,128,711	303,266,025	298,881,608	12,243,870
MCO Tax Payable - State Board of Equalization	-	0	26,353,889	18,113,329
Due to DHCS	28,372,563	27,506,572	26,789,200	28,918,777
Liability for In Home Support Services (IHSS)	416,092,527	416,092,527	416,092,526	413,549,551
Current Premium Deficiency Reserve (PDR) - AOC Data	8,294,025	8,294,025	8,294,025	8,294,025
Current Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	86,591,338	87,129,411	87,855,016	80,296,993
Total Current Liabilities	**878,487,303**	**868,962,891**	**888,218,764**	**593,340,090**
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	150,000	75,000.00	0	1,974,796
Total Non-Current Liabilities	**6,069,500**	**5,994,500**	**5,919,500**	**7,894,296**
Total Liabilities	**884,556,803**	**874,957,391**	**894,138,264**	**601,234,386**
Deferred Inflow of Resources	**2,994,548**	**2,994,548**	**2,994,548**	**4,034,640**
Net Assets				
Invested in Capital Assets	27,001,425	27,290,140	27,392,239	27,417,142
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Board Designated Reserve	2,200,000	2,200,000	2,200,000	0
Unrestricted Net Equity	172,618,977	172,330,263	148,118,274	150,293,371
Current YTD Income (Loss)	2,127,526	691,976	24,109,890	(303,187)
Total Net Assets / Reserves	**204,253,278**	**202,817,728**	**202,125,753**	**177,712,676**
Total Liabilities, Deferred Inflows and Net Assets	**1,091,804,629**	**1,080,769,668**	**1,099,258,565**	**782,981,702**

Cash Flow – YTD

	Aug-2019	Year-to-date
Cash Flows from Operating Activities		
Premiums Received	84,582,068	155,129,241
Medical Expenses Paid	(83,975,128)	(164,694,814)
Adminstrative Expenses Paid	2,137,037	601,636
Net Cash from Operating Activities	**2,743,977**	**(8,963,936)**
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	(36,949)	(265,693)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	489,182	1,053,404
Net Increase/(Decrease) in Cash & Cash Equivalents	**3,196,209**	**(8,176,226)**
Cash & Cash Equivalents (Beginning)	288,050,069	299,422,504
Cash & Cash Equivalents (Ending)	**291,246,278**	**291,246,278**
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Income/(Loss)	946,368	1,074,122
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	246,608	577,451
Changes in Operating Assets/Liabilities		
Premiums Receivable	(7,443,934)	(1,042,323)
Other Receivable	-	-
Due from Santa Clara Family Health Foundation	-	-
Prepaids & Other Assets	(604,476)	8,276
Deferred Outflow of Resources	-	-
Accounts Payable & Accrued Liabilities	7,333,808	10,055,639
State Payable	865,992	(24,770,525)
IGT, HQAF & Other Provider Payables	1,862,686	6,247,103
Net Pension Liability	75,000	150,000
Medical Cost Reserves & PDR	(538,073)	(1,263,678)
IHSS Payable	-	(1)
Deferred Inflow of Resources	-	-
Total Adjustments	**1,797,609**	**(10,038,058)**
Net Cash from Operating Activities	**2,743,977**	**(8,963,936)**

Statement of Operations by Line of Business - YTD

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Two Months Ending August 31, 2019

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)						
REVENUE	$154,099,617	$5,290,822	$20,812,080	$26,102,902	$739,571	**$180,942,090**
MEDICAL EXPENSE (MLR)	$143,713,389	$5,230,127	$20,160,144	$25,390,271	$574,578	**$169,678,238**
GROSS MARGIN	$10,386,228	$60,695	$651,936	$712,631	$164,993	**$11,263,852**
ADMINISTRATIVE EXPENSE (% of Revenue Allocation)	$8,448,126	$290,056	$1,140,970	$1,431,026	$40,545	**$9,919,697**
OPERATING INCOME/(LOSS) (% of Revenue Allocation)	$1,938,102	($229,361)	($489,034)	($718,395)	$124,448	**$1,344,154**
OTHER INCOME/(EXPENSE) (% of Revenue Allocation)	$667,159	$22,906	$90,104	$113,010	$3,202	**$783,371**
NET INCOME/(LOSS)	$2,605,261	($206,455)	($398,930)	($605,385)	$127,650	**$2,127,526**
PMPM (ALLOCATED BASIS)						
REVENUE	$326.51	$326.39	$1,283.90	$1,610.30	$105.50	**$365.40**
MEDICAL EXPENSES	$304.50	$322.65	$1,243.69	$1,566.33	$81.97	**$342.65**
GROSS MARGIN	$22.01	$3.74	$40.22	$43.96	$23.54	**$22.75**
ADMINISTRATIVE EXPENSES	$17.90	$17.89	$70.39	$88.28	$5.78	**$20.03**
OPERATING INCOME/(LOSS)	$4.11	($14.15)	($30.17)	($44.32)	$17.75	**$2.71**
OTHER INCOME/(EXPENSE)	$1.41	$1.41	$5.56	$6.97	$0.46	**$1.58**
NET INCOME/(LOSS)	$5.52	($12.74)	($24.61)	($37.35)	$18.21	**$4.30**
ALLOCATION BASIS:						
MEMBER MONTHS - YTD	471,967	16,210	16,210	16,210	7,010	495,187
REVENUE BY LOB	85.2%	2.9%	11.5%	14.4%	0.4%	100.0%

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, November 14, 2019, 11:30 AM - 1:30 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

Members Present
Dolores Alvarado, Chair
Liz Kniss
Linda Williams

Members Absent
Bob Brownstein
Sue Murphy

Staff Present
Christine Tomcala, Chief Executive officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance and Regulatory Affairs Officers
Laurie Nakahira, D.O., Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Laura Watkins, Vice President, Marketing and Enrollment
Neal Jarecki, Controller
Tyler Haskell, Director, Government Relations
Jayne Giangreco, Manager, Administrative Services
Rita Zambrano, Executive Assistant

1. **Roll Call**

   Dolores Alvarado, Chair, called the meeting to order at 11:35 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. **Real Property Negotiations**
   The Executive/Finance Committee met in Closed Session to confer with its Real Property Negotiators concerning the price and terms of payment related to the possible lease of real property located at 408 N. Capitol Avenue, San Jose, CA.

4. **Report from Closed Session**

   Ms. Alvarado reported that the Executive/Finance Committee met in Closed Session to discuss Real Property Negotiations.

5. Network Detection and Prevention Update

Jonathan Tamayo, Chief Information Officer, reported on firewall intrusion, detection, and prevention efforts.

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

Liz Kniss arrived at 11:58 am and a quorum was established.

6. Compliance Update

Robin Larmer, Chief Compliance and Regulatory Affairs Officer, discussed audit activity and corrective action plan progress. The Independent Validation Audit (IVA) to assess the Plan's correction of the Conditions cited in the CMS Program Audit Final Report is complete. Based on the results of the validation audit, CMS determined that 26 of the 31 Conditions identified in the Program Audit Final report had been fully remediated, and 5 Conditions had not been fully remediated. There was also one new Condition identified. CMS acknowledged the substantial progress made by the Plan throughout the remediation period. However, because some of the 5 non-remediated Conditions impacted more than a few members, CMS was unwilling to close the Program Audit, and directed the Plan to: (1) submit corrective action plans; (2) complete remediation; and (3) undergo a second validation audit of those 5 initial Conditions and the new Condition.

ATTAC Consulting Group (ACG) will conduct the second validation audit. ACG is developing a proposed audit work plan and timeline that will be submitted to CMS for approval. If the work plan is approved, we anticipate that the auditor's report will be submitted to CMS in June 2020.

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

7. Meeting Minutes

The minutes of the October 24, 2019 Executive/Finance Committee were reviewed.

It was moved, seconded, and the October 24, 2019 Executive/Finance Committee Minutes were **unanimously approved.**

8. September 2019 Financial Statements

Dave Cameron, Chief Financial Officer, presented the September 2019 financial statements, which reflected a current month net surplus of $497 thousand ($66 thousand favorable to budget) and a fiscal year to date net surplus of $2.6 million ($223 thousand favorable to budget). Enrollment decreased by 824 members from the prior month to 246,184 members (877 favorable to budget). Medi-Cal enrollment has generally declined since October 2016 while CMC enrollment has grown due to continued outreach efforts. Revenue reflected a favorable current month variance of $2.1 million (2.3%) largely due to higher member months and slightly higher capitation rates versus budget. Medical expense reflected an unfavorable current month variance of $2.8 million (3.3%) due to higher capitation member months and rates coupled with certain higher fee-for-service expenses versus budget. Administrative expense reflected a favorable current month variance of $557 thousand (10.3%) due largely to the timing of personnel hiring and of certain non-personnel expenses. The balance sheet reflected a Current Ratio of 1.28:1, versus the minimum required by DMHC of 1.0:1. Tangible Net Equity of $204.3 million represented approximately two months of the Plan's total monthly expenses. Year-to-date capital investments of $499 thousand were made, comprised largely of building improvements.

It was moved, seconded, and the September 2019 Financial Statements **were unanimously approved.**

9. Government Relations Update

Tyler Haskell, Director, Government Relations, discussed local, state, and federal legislative and policy issues impacting the Plan and its members. Mr. Haskell noted that DHCS is proposing significant changes to Medi-Cal over the next few years, with changes roughly falling into eight categories:

1. Population Health Management plan (2021)

2. Enhanced Case Management/ILOS (in lieu of services) benefits (2021)
3. Ending CMC while requiring dual enrollment (2022-23)
4. Mandatory MMC enrollments for almost all (2021)
5. Annual open enrollment (2021)
6. NCQA accreditation for plans and delegates (2025)
7. Regional Rates
8. Changes to county-based Serious Mental Illness (SMI) system (payment reform, revising medical necessity criteria)

There are unanswered questions that will be addressed through the workgroup process. SCFHP is represented in 2 out of 5 state workgroups, LHPC is on all of them. Other questions will be answered through finalized proposals, legislation, and behind the scenes conversations.

Mr. Haskell noted that DHCS is freeing up some Proposition 56 funding for behavioral health integration projects under six categories:

1. Basic behavioral health integration
2. Maternal access to mental health and substance use disorder screening and treatment
3. Medication management for beneficiaries with co-occurring chronic medical and behavioral diagnoses
4. Diabetes screening and treatment for people with serious mental illness
5. Improving follow-up after hospitalization for mental illness
6. Improving follow-up after an emergency department visit for behavioral health diagnosis

Interested providers may apply to MCPs by January 21, and will require letters of support from the County if they address severe mental illness or substance use disorder. MCPs will issue decisions by March 18 and programs start April 1. Each project contains a target population, practice redesign components, performance measures.

Mr. Haskell also gave an overview of proposed prescription drug legislation and noted the unlikelihood of a House vote until December, where leaders are waiting for a Congressional Budget Office analysis, because now the bill is tied to some expanded Medicare benefits (vision, hearing, and dental). The Senate will likely wait to see if the House passes its bill, which the Senate would substitute with its own bipartisan/moderate bill. The biggest question now is, can Ms. Pelosi get enough votes; many House Democrats want to move the bill to the left and go into conference with the strongest possible position. White House has recently publicly opposed House bill, and praised the Senate bill.

The Health Extenders Act of 2019 deadline is November 21, 2019 and another short-term extension is likely at hand. The question is whether it will it be a one or three-month extension. Medicaid and Medicare are largely unaffected by this process, but it provides funding for Federally Qualified Health Centers (FQHC) and Medicaid DSH funding.

On December 14, 2018 a federal district court in Texas struck down the Affordable Care Act (ACA) in its entirety, finding that the 2017 Tax Cuts and Jobs Act (TCJA), which zeroed out the tax penalties associated with the ACA's individual mandate, renders the mandate unconstitutional. The judge further concluded that since the individual mandate is "essential" to the ACA, it could not be severed from the rest of the ACA, and the entire ACA was therefore unconstitutional. If the 5th Circuit appeals court upholds the lower court decision, it will be appealed to the Supreme Court.

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

10. Strategic Investment Funding

Christine Tomcala, Chief Executive Officer, reported on Strategic Investment Funding, noting the Plan anticipates having sufficient reserves to direct some funding into projects in the community and she outlined a proposed Community Health Investment Program. Ms. Tomcala referred to the Board Discretionary Fund Policy and solicited discussion and input from the Board regarding potential revisions to the Policy.

11. CEO Update

Ms. Tomcala noted that effective November 18, 2019 Valley Health Plan (VHP) has a new CEO, Laura Rosas. Ms. Tomcala further noted that Dolly Goel, M.D., is leaving VHP for a position at Valley Medical Center.

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

12. Adjournment

The meeting was adjourned at 1:28 pm.

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Robin Larmer, Secretary

Santa Clara Family Health Plan™

Unaudited Financial Statements
For Three Months Ended September 30, 2019

Agenda

Santa Clara Family Health Plan

Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$91 M		$272 M	
Medical Expense (MLR)	$86 M	94.7%	$256 M	94.1%
Administrative Expense (% Rev)	$4.9 M	5.3%	$14.6 M	5.4%
Other Income/Expense	$475K		$1.3 M	
Net Surplus (Loss)	**$497K**		**$2.6 M**	
Cash on Hand			$293 M	
Receivables			$512 M	
Total Current Assets			$817 M	
Current Liabilities			$639 M	
Current Ratio			1.28	
Tangible Net Equity			$205 M	
% of DMHC Requirements			**675.7%**	

Financial Highlights

Santa Clara Family Health Plan

Net Surplus (Loss)	Month: Surplus of $497K is $66K or 15.3% favorable to budget of $431K. YTD: Surplus of $2.6M is $223K or 9.4% favorable to budget of $2.4M.
Enrollment	Month: Membership was 246,184 (982 or 0.4% favorable budget of 245,202). YTD: Membership was 741,371 (2,899 or 0.4% favorable budget of 738,472).
Revenue	Month: $91.3M ($2.1M or 2.3% favorable to budget of $89.2M). YTD: $272.2M ($4.1M or 1.5% favorable to budget of $268.1M).
Medical Expenses	Month: $86.4M ($2.8M or 3.3% unfavorable to budget of $83.6M). YTD: $256.2M ($4.9M or 2.0% unfavorable to budget of $251.3M).
Administrative Expenses	Month: $4.9M ($557K or 10.3% favorable to budget of $5.4M). YTD: $14.6M ($487K or 3.2% favorable to budget of $15.1M).
Tangible Net Equity	TNE was $204.7M (675.7% of minimum DMHC requirement of $30.3M).
Capital Expenditures	YTD Capital Investments of $499K vs. $4.8M annual budget, primarily building improvements.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment of 246,184 members exceeds budget by 982 or 0.4%. Total enrollment has decreased since June 30, 2019 by 3,021 or 1.2%, slightly better than budgeted expectation.
- As detailed on page 7, much of the Medi-Cal enrollment decline has been in the Medi-Cal Non-Dual Child, Adult Expansion and Adult categories of aid. Medi-Cal Dual enrollment has been stable overall while CMC enrollment continues to grow in line with budget due to outreach efforts.
- Membership Trends:
  - Medi-Cal membership has decreased since the beginning of the fiscal year by 3,219 or 1.4%. CMC membership increased since the beginning of the fiscal year by 172 or 2.1%. Healthy Kids membership increased since the beginning of the fiscal year by 26 or 0.7%.

	For the Month of September 2019				For Three Months Ending September 30, 2019					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY19 vs. FY20
Medi-Cal	234,478	233,715	763	0.3%	706,445	704,140	2,305	0.3%	739,593	(4.5%)
Cal Medi-Connect	8,194	8,139	55	0.7%	24,404	24,288	116	0.5%	22,663	7.7%
Healthy Kids	3,512	3,348	164	4.9%	10,522	10,044	478	4.8%	9,628	9.3%
Total	**246,184**	**245,202**	**982**	**0.4%**	**741,371**	**738,472**	**2,899**	**0.4%**	**771,884**	**(4.0%)**

Santa Clara Family Health Plan Enrollment By Network
September 2019

Network	Medi-Cal		CMC		Healthy Kids		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	30,526	13%	8,194	100%	366	10%	39,086	16%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	116,407	50%	-	0%	1,552	44%	117,959	48%
Palo Alto Medical Foundation	6,704	3%	-	0%	85	2%	6,789	3%
Physicians Medical Group	41,061	18%	-	0%	1,232	35%	42,293	17%
Premier Care	14,448	6%	-	0%	277	8%	14,725	6%
Kaiser	25,332	11%	-	0%	-	0%	25,332	10%
Total	**234,478**	**100%**	**8,194**	**100%**	**3,512**	**100%**	**246,184**	**100%**
Enrollment at June 30, 2019	237,697		8,022		3,486		249,205	
Net Δ from Beginning of FY20	(1.4%)		2.1%		0.7%		(1.2%)	

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

Enrollment By Aid Category

Santa Clara Family Health Plan

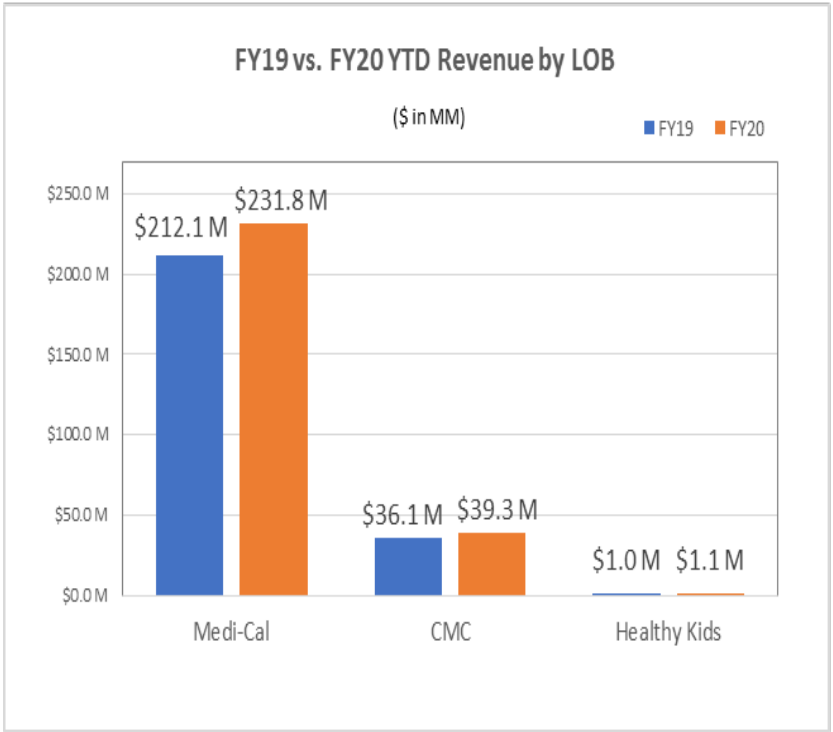
SCFHP TRENDED ENROLLMENT BY COA YTD SEP-19

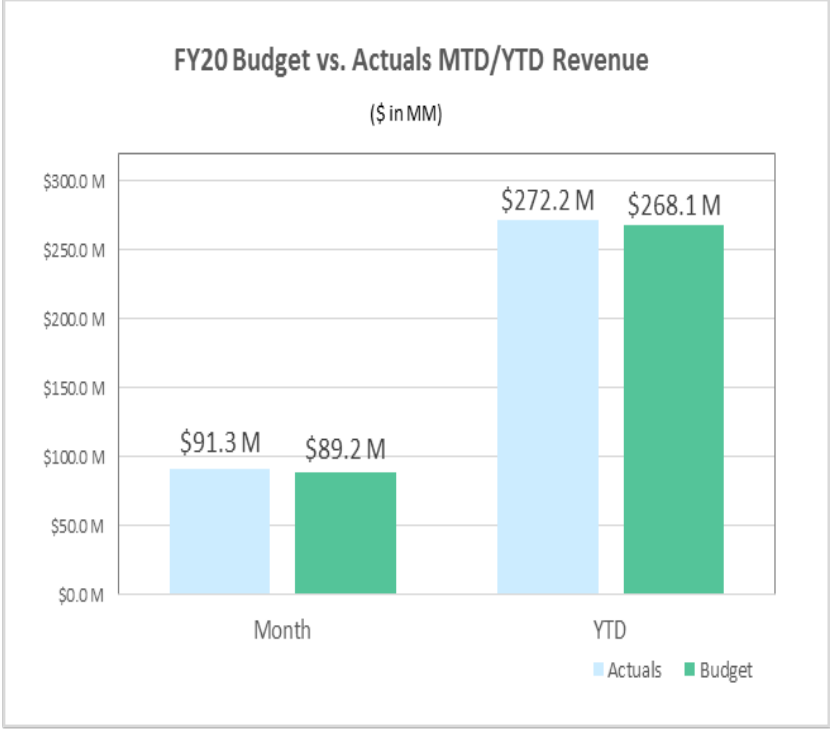
		2018-09	2018-10	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	FYE var	%
NON DUAL	Adult (over 19)	26,568	26,354	26,213	26,175	25,954	25,846	25,779	25,563	25,198	25,204	24,989	24,888	24,689	(515)	(2.0%)
	Child (under 19)	98,255	97,518	96,830	96,331	95,155	95,177	95,229	94,956	94,255	94,026	93,536	92,668	92,092	(1,934)	(2.1%)
	Aged - Medi-Cal Only	10,887	10,869	10,887	10,923	10,901	10,963	10,934	10,949	10,871	10,995	10,948	10,958	10,855	(140)	(1.3%)
	Disabled - Medi-Cal Only	10,635	10,611	10,624	10,631	10,629	10,579	10,595	10,678	10,780	10,819	10,774	10,833	10,814	(5)	(0.0%)
	Adult Expansion	73,959	73,601	73,398	73,186	72,075	72,223	72,143	72,114	71,364	71,465	71,082	70,635	70,418	(1,047)	(1.5%)
	BCCTP	13	12	11	11	9	9	8	10	11	11	10	10	10	(1)	(9.1%)
	Long Term Care	387	379	377	372	371	376	375	375	370	372	372	364	366	(6)	(1.6%)
	Total Non-Duals	**220,703**	**219,343**	**218,340**	**217,629**	**215,093**	**215,173**	**215,063**	**214,644**	**212,848**	**212,891**	**211,711**	**210,356**	**209,244**	(3,647)	(1.7%)
DUAL	Adult (21 Over)	382	385	390	379	373	376	367	368	354	352	351	345	351	(1)	(0.3%)
	SPD (21 Over)	22,984	22,963	22,897	22,893	22,765	22,728	22,725	22,941	23,009	22,988	23,087	23,230	23,445	457	2.0%
	Adult Expansion	521	533	538	586	556	529	479	304	252	253	209	226	201	(52)	(20.6%)
	BCCTP	2	1	1	1	2	1	1	0	0	0	0	0	0	0	0.0%
	Long Term Care	1,292	1,268	1,233	1,208	1,209	1,203	1,201	1,187	1,192	1,213	1,220	1,232	1,237	24	2.0%
	Total Duals	**25,181**	**25,150**	**25,059**	**25,067**	**24,905**	**24,837**	**24,773**	**24,800**	**24,807**	**24,806**	**24,867**	**25,033**	**25,234**	428	1.7%
	Total Medi-Cal	**245,884**	**244,493**	**243,399**	**242,696**	**239,998**	**240,010**	**239,836**	**239,444**	**237,655**	**237,697**	**236,578**	**235,389**	**234,478**	(3,219)	(1.4%)
	Healthy Kids	**3,163**	**3,217**	**3,460**	**3,345**	**3,252**	**3,375**	**3,348**	**3,465**	**3,507**	**3,486**	**3,501**	**3,509**	**3,512**	26	0.7%
CMC	CMC Non-Long Term Care	7,386	7,383	7,407	7,484	7,540	7,616	7,680	7,661	7,706	7,815	7,869	7,921	7,982	167	2.1%
	CMC - Long Term Care	214	218	218	211	210	198	204	208	209	207	207	213	212	5	2.4%
	Total CMC	**7,600**	**7,601**	**7,625**	**7,695**	**7,750**	**7,814**	**7,884**	**7,869**	**7,915**	**8,022**	**8,076**	**8,134**	**8,194**	172	2.1%
	Total Enrollment	**256,647**	**255,311**	**254,484**	**253,736**	**251,000**	**251,199**	**251,068**	**250,778**	**249,077**	**249,205**	**248,155**	**247,032**	**246,184**	(3,021)	(1.2%)

Revenue

Current month revenue of $91.3M is $2.1M or 2.3% favorable to budget of $89.2M. The current month variance was due to largely to Medi-Cal revenue, which is $2.6M favorable due to:

- Higher retro member months than budget ($1.2M).
- Higher FY20 rates in the Non-Dual Adult Expansion, Adult, and Long Term Care (LTC) categories of aid ($645K).
- Supplemental Kick revenue is $625K favorable to budget due to higher utilization.

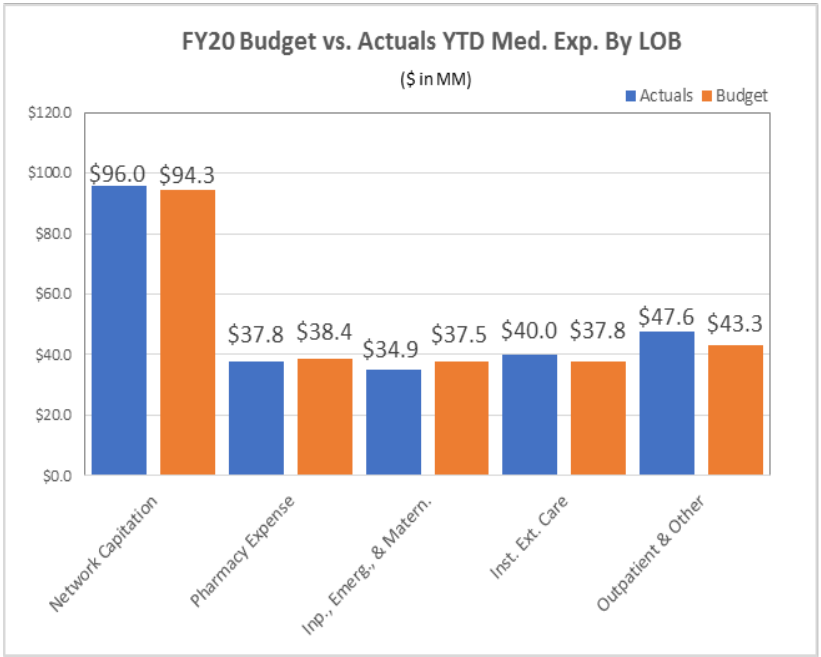


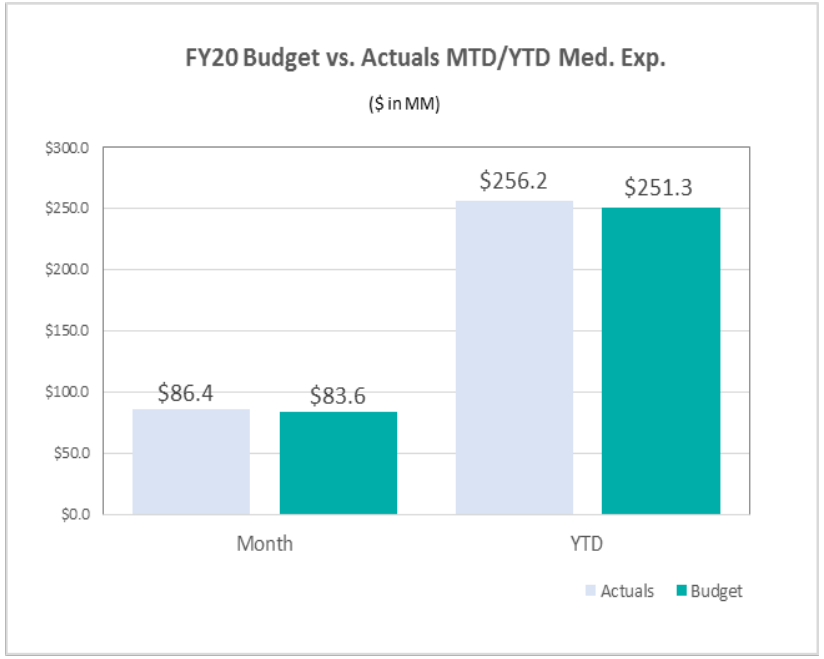


Medical Expense

Current month medical expense of $86.4M is $2.8M or 3.3% unfavorable to budget of $83.6M. The current month variance was due largely to:

- Medi-Cal LTC, Outpatient Professional and Specialty expenses in excess of budget yielded an unfavorable variance of $2.1M due to higher average member months versus budget.
- Capitation expense is $955K unfavorable due to higher member months and rates than budgeted.

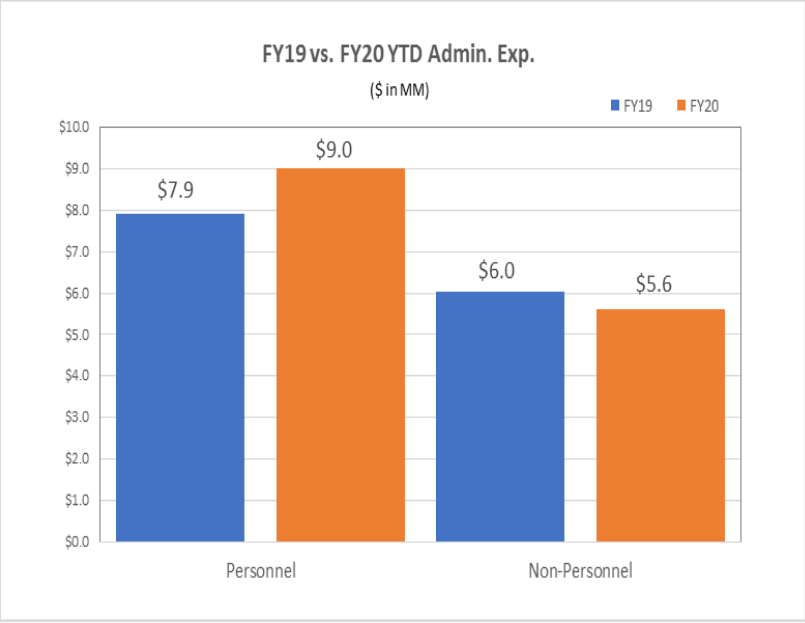


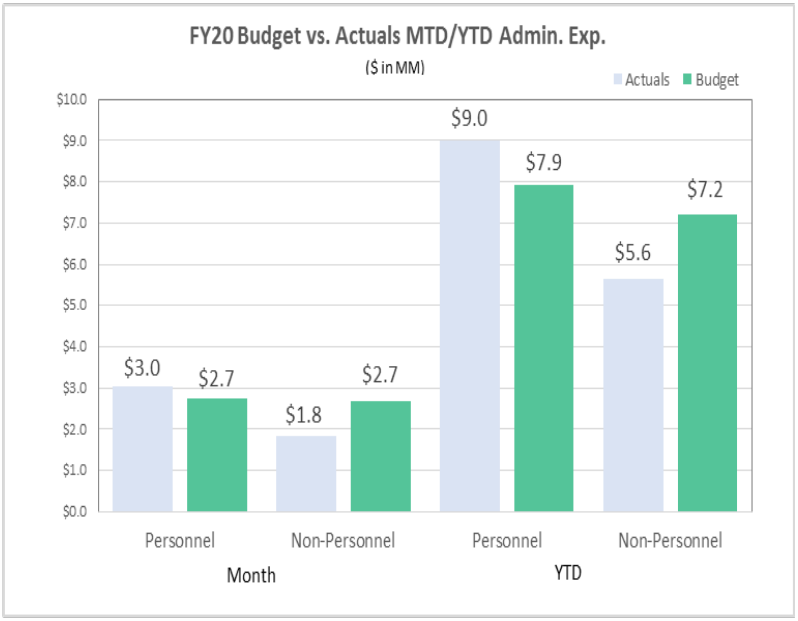


Administrative Expense

Current month admin expense of $4.9M is $557K or 10.3% favorable to budget of $5.4M. The current month variances were primarily due to the following:

- Non-Personnel expenses were overall $884K or 31.2% favorable to budget due to the timing of consulting, advertising and postage expenses and reduced QI spending versus budget.
- Personnel expenses were $277K or 10.1% unfavorable to budget due to accelerated hiring.





Balance Sheet

- Current assets totaled $817.2M compared to current liabilities of $639.4M, yielding a current ratio (Current Assets/Current Liabilities) of 1.28:1 vs. the DMHC minimum requirement of 1.0:1.
- Cash balance decreased by $6.6M compared to the cash balance as of year-end June 30, 2019 due to timing of payments.
- Current Cash & Equivalent components and yields were as follows:
  - Overall cash and investment yield exceeds budget (2.4% actual vs. 1.4% budgeted).

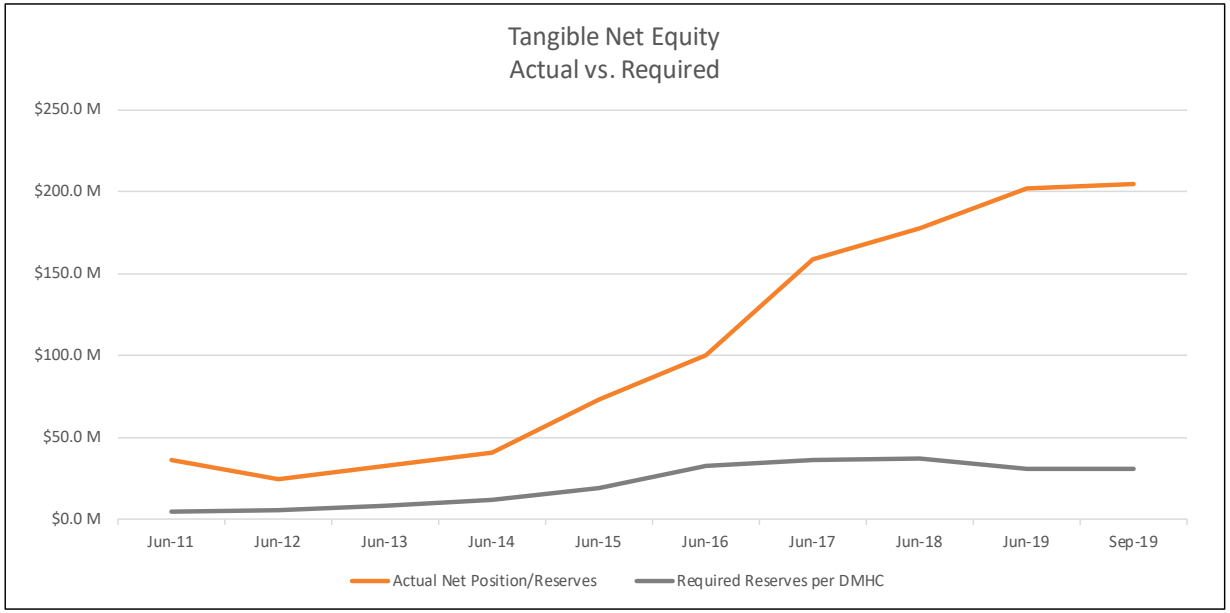
Description	Month-End Balance	Current Yield %	Interest Earned	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$79,390,883	2.23%	$100,000	$300,000
Wells Fargo Investments	$190,599,560	2.06%	$166,992	$166,992
	$269,990,443		$266,992	$466,992
Cash & Equivalents				
Bank of the West Money Market	$129,139	1.13%	$32,509	$46,705
Wells Fargo Bank Accounts	$22,376,739	1.81%	$276,130	$1,065,330
	$22,505,878		$308,639	$1,112,035
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.42%	$377	$389
Petty Cash	$500	0.00%	$0	$0
Total Cash & Equivalents	**$292,802,171**		**$576,008**	**$1,579,416**

Tangible Net Equity

- TNE was $204.7M or 675.7% of the most recent quarterly DMHC minimum requirement of $30.3M.
- TNE trends are presented below:

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of September 30, 2019

	Jun-11	Jun-12	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Sep-19
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	$202.1 M	$204.7 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	$30.9 M	$30.3 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	$61.8 M	$60.6 M
Actual as % Required	722.5%	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	675.7%



Reserves Analysis

Santa Clara Family Health Plan

SCFHP RESERVES ANALYSIS SEPTEMBER 2019	
Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	204,722,378
Current Required TNE	30,295,758
Excess TNE	**174,426,620**
Required TNE %	675.7%
SCFHP Target TNE Range:	
350% of Required TNE (Low)	106,035,152
500% of Required TNE (High)	151,478,789
TNE Above/(Below) SCFHP Low Target	**98,687,225**
TNE Above/(Below) High Target	**53,243,589**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	292,802,171
Less Pass-Through Liabilities	
Net Payable to State of CA	(31,057,710)
Other Pass-Through Liabilities	(19,531,214)
Total Pass-Through Liabilities	**(50,588,924)**
Net Cash Available to SCFHP	242,213,247
SCFHP Target Liquidity	
45 Days of Total Operating Expense	(133,551,708)
60 Days of Total Operating Expense	(178,068,944)
Liquidity Above/(Below) SCFHP Low Target	**108,661,538**
Liquidity Above/(Below) High Target	**64,144,302**

Note 1: In December 2018, the Governing Board established a Board Discretionary Fund of $2.2M. The specific projects/recipients have yet to be determined.

Note 2: Other Pass-Through Liabilities include Prop 56 and other provider payables.

Note 3: SCFHP Target Liquidity is based on total monthly budgeted expenses.

Capital Expenditures

Santa Clara Family Health Plan

Expenditure	YTD Actual	Annual Budget
Hardware	$115,776	$620,000
Software	$40,846	$1,029,000
Building Improvements	$342,402	$3,149,500
TOTAL	**$499,023**	**$4,798,500**

Santa Clara Family Health Plan™

Financial Statements

Income Statement

Santa Clara Family Health Plan

Santa Clara County Health Authority
INCOME STATEMENT
For Three Months Ending September 30, 2019

	Sep-2019 Actuals	% of Rev	Sep-2019 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD Sep-2019 Actuals	% of Rev	YTD Sep-2019 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 77,745,224	85.2%	$ 75,160,024	84.2%	$ 2,585,200	3.4%	$ 231,844,842	85.2%	$ 226,130,779	84.3%	$ 5,714,062	2.5%
CMC MEDI-CAL	2,667,391	2.9%	2,837,679	3.2%	(170,287)	-6.0%	7,958,213	2.9%	8,468,060	3.2%	(509,847)	-6.0%
CMC MEDICARE	10,489,623	11.5%	10,875,332	12.2%	(385,709)	-3.5%	31,301,703	11.5%	32,453,626	12.1%	(1,151,922)	-3.5%
TOTAL CMC	13,157,015	14.4%	13,713,010	15.4%	(555,996)	-4.1%	39,259,916	14.4%	40,921,685	15.3%	(1,661,769)	-4.1%
HEALTHY KIDS	383,765	0.4%	347,857	0.4%	35,907	10.3%	1,123,335	0.4%	1,043,572	0.4%	79,764	7.6%
TOTAL REVENUE	**$ 91,286,003**	**100.0%**	**$ 89,220,892**	**100.0%**	**$ 2,065,112**	**2.3%**	**$ 272,228,093**	**100.0%**	**$ 268,096,036**	**100.0%**	**$ 4,132,057**	**1.5%**
MEDICAL EXPENSES												
MEDI-CAL	$ 73,503,171	80.5%	$ 70,221,136	78.7%	$ (3,282,035)	-4.7%	$ 217,299,753	79.8%	$ 211,352,249	78.8%	$ (5,947,504)	-2.8%
CMC MEDI-CAL	2,724,945	3.0%	2,992,284	3.4%	267,339	8.9%	7,955,072	2.9%	8,930,296	3.3%	975,224	10.9%
CMC MEDICARE	9,906,032	10.9%	10,029,304	11.2%	123,273	1.2%	30,150,474	11.1%	29,922,021	11.2%	(228,452)	-0.8%
TOTAL CMC	12,630,977	13.8%	13,021,588	14.6%	390,611	3.0%	38,105,545	14.0%	38,852,318	14.5%	746,772	1.9%
HEALTHY KIDS	269,500	0.3%	374,468	0.4%	104,969	28.0%	844,373	0.3%	1,123,405	0.4%	279,032	24.8%
TOTAL MEDICAL EXPENSES	**$ 86,403,647**	**94.7%**	**$ 83,617,193**	**93.7%**	**$ (2,786,455)**	**-3.3%**	**$ 256,249,672**	**94.1%**	**$ 251,327,972**	**93.7%**	**$ (4,921,700)**	**-2.0%**
MEDICAL OPERATING MARGIN	**$ 4,882,356**	**5.3%**	**$ 5,603,699**	**6.3%**	**$ (721,343)**	**-12.9%**	**$ 15,978,421**	**5.9%**	**$ 16,768,064**	**6.3%**	**$ (789,643)**	**-4.7%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 3,023,718	3.3%	$ 2,746,696	3.1%	$ (277,022)	-10.1%	$ 9,010,798	3.3%	$ 7,923,850	3.0%	$ (1,086,948)	-13.7%
RENTS AND UTILITIES	20,692	0.0%	11,917	0.0%	(8,775)	-73.6%	62,751	0.0%	51,051	0.0%	(11,700)	-22.9%
PRINTING AND ADVERTISING	3,108	0.0%	73,113	0.1%	70,005	95.7%	71,557	0.0%	200,339	0.1%	128,782	64.3%
INFORMATION SYSTEMS	294,127	0.3%	302,410	0.3%	8,283	2.7%	856,881	0.3%	952,230	0.4%	95,349	10.0%
PROF FEES/CONSULTING/TEMP STAFFING	849,660	0.9%	1,471,619	1.6%	621,959	42.3%	2,626,472	1.0%	3,620,003	1.4%	993,531	27.4%
DEPRECIATION/INSURANCE/EQUIPMENT	327,803	0.4%	384,211	0.4%	56,408	14.7%	1,009,573	0.4%	1,156,090	0.4%	146,517	12.7%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	66,640	0.1%	77,741	0.1%	11,101	14.3%	220,321	0.1%	233,623	0.1%	13,302	5.7%
MEETINGS/TRAVEL/DUES	106,246	0.1%	150,572	0.2%	44,326	29.4%	279,570	0.1%	391,296	0.1%	111,726	28.6%
OTHER	168,579	0.2%	199,000	0.2%	30,421	15.3%	502,192	0.2%	598,250	0.2%	96,058	16.1%
TOTAL ADMINISTRATIVE EXPENSES	**$ 4,860,574**	**5.3%**	**$ 5,417,280**	**6.1%**	**$ 556,706**	**10.3%**	**$ 14,640,115**	**5.4%**	**$ 15,126,731**	**5.6%**	**$ 486,616**	**3.2%**
OPERATING SURPLUS (LOSS)	**$ 21,782**	**0.0%**	**$ 186,420**	**0.2%**	**$ (164,637)**	**-88.3%**	**$ 1,338,306**	**0.5%**	**$ 1,641,333**	**0.6%**	**$ (303,027)**	**-18.5%**
ALLOWANCE FOR UNCOLLECTED PREMIUM	2995	0.0%	0	0.0%	(2,995)	0.0%	3468	0.0%	0	0.0%	(3,468)	0.0%
GASB 75 - POST EMPLOYMENT BENEFITS EXPENSE	59,780	0.1%	60,000	0.1%	220	0.4%	179,339	0.1%	180,000	0.1%	661	0.4%
GASB 68 - UNFUNDED PENSION LIABILITY	75,000	0.1%	75,000	0.1%	0	0.0%	225,000	0.1%	225,000	0.1%	0	0.0%
NON-OPERATING EXPENSES	**$ 137,775**	**0.2%**	**$ 135,000**	**0.2%**	**$ (2,775)**	**-2.1%**	**$ 407,807**	**0.1%**	**$ 405,000**	**0.2%**	**$ (2,807)**	**-0.7%**
INTEREST & OTHER INCOME	612,723	0.7%	379,225	0.4%	233,498	61.6%	1,666,126	0.6%	1,137,675	0.4%	528,451	46.5%
NET NON-OPERATING ACTIVITIES	**$ 474,948**	**0.5%**	**$ 244,225**	**0.3%**	**$ 230,723**	**94.5%**	**$ 1,258,319**	**0.5%**	**$ 732,675**	**0.3%**	**$ 525,644**	**71.7%**
NET SURPLUS (LOSS)	**$ 496,730**	**0.5%**	**$ 430,645**	**0.5%**	**$ 66,086**	**15.3%**	**$ 2,596,625**	**1.0%**	**$ 2,374,008**	**0.9%**	**$ 222,617**	**9.4%**

Balance Sheet

SANTA CLARA COUNTY HEALTH AUTHORITY
For Three Months Ending September 30, 2019

Santa Clara Family Health Plan

	Sep-2019	Aug-2019	Jul-2019	Sep-2018
Assets				
Current Assets				
Cash and Marketable Securities	292,802,171	291,325,334	288,050,069	233,279,977
Receivables	512,462,788	752,169,795	744,725,861	501,964,866
Prepaid Expenses and Other Current Assets	11,888,886	12,070,465	11,465,989	7,176,276
Total Current Assets	**817,153,845**	**1,055,565,595**	**1,044,241,919**	**742,421,119**
Long Term Assets				
Property and Equipment	45,257,793	45,024,463	44,987,513	42,357,057
Accumulated Depreciation	(18,348,130)	(18,023,037)	(17,697,374)	(15,212,360)
Total Long Term Assets	26,909,663	27,001,425	27,290,140	27,144,697
Total Assets	**844,063,508**	**1,082,567,020**	**1,071,532,059**	**769,565,816**
Deferred Outflow of Resources	**9,237,609**	**9,237,609**	**9,237,609**	**14,535,240**
Total Assets & Deferred Outflows	**853,301,117**	**1,091,804,629**	**1,080,769,668**	**784,101,056**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	7,598,240	6,442,995	7,003,498	5,194,835
Employee Benefits	1,740,524	1,690,637	1,808,174	1,584,705
Retirement Obligation per GASB 75	4,122,625	4,062,845	4,003,066	5,062,134
Advance Premium - Healthy Kids	85,058	95,965	98,208	87,424
Deferred Revenue - Medicare	-	9,997,983	-	-
Whole Person Care / Prop 56	19,531,214	17,664,845	19,703,965	7,324,264
IGT, HQAF, Other Provider Payables	35,620,914	305,128,711	303,266,025	11,186,459
MCO Tax Payable - State Board of Equalization	31,057,710	-	-	27,231,162
Due to DHCS	28,665,798	28,372,563	27,506,572	30,997,454
Liability for In Home Support Services (IHSS)	416,092,527	416,092,527	416,092,527	413,549,551
Current Premium Deficiency Reserve (PDR) - AOC Data	8,294,025	8,294,025	8,294,025	8,294,025
Current Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	92,558,575	86,591,338	87,129,411	89,491,101
Total Current Liabilities	**639,447,709**	**878,514,934**	**868,985,970**	**594,083,614**
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	216,983	150,000.00	75,000	2,049,796
Total Non-Current Liabilities	**6,136,483**	**6,069,500**	**5,994,500**	**7,969,296**
Total Liabilities	**645,584,191**	**884,584,434**	**874,980,470**	**602,052,910**
Deferred Inflow of Resources	**2,994,548**	**2,994,548**	**2,994,548**	**4,034,640**
Net Assets				
Invested in Capital Assets	26,909,663	27,001,425	27,290,140	27,144,697
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Board Designated Fund	2,200,000	2,200,000	2,200,000	0
Unrestricted Net Equity	172,710,740	172,618,977	172,330,263	150,565,816
Current YTD Income (Loss)	2,596,625	2,099,895	668,897	(2,357)
Total Net Assets / Reserves	**204,722,378**	**204,225,647**	**202,794,649**	**178,013,506**
Total Liabilities, Deferred Inflows and Net Assets	**853,301,117**	**1,091,804,629**	**1,080,769,668**	**784,101,056**

Cash Flow – YTD

	Sep-2019	Year-to-date
Cash Flows from Operating Activities		
Premiums Received	$362,343,955	$517,473,196
Medical Expenses Paid	(349,944,207)	(514,806,808)
Adminstrative Expenses Paid	(11,302,303)	(10,453,824)
Net Cash from Operating Activities	**$1,097,444**	**($7,787,436)**
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	(233,330)	(499,023)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	612,723	1,666,126
Net Increase/(Decrease) in Cash & Cash Equivalents	**1,476,837**	**(6,620,333)**
Cash & Cash Equivalents (Beginning)	291,325,334	299,422,504
Cash & Cash Equivalents (Ending)	**$292,802,171**	**$292,802,171**
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Income/(Loss)	(115,992)	930,499
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	291,076	868,527
Changes in Operating Assets/Liabilities		
Premiums Receivable	239,707,007	238,664,684
Other Receivable	-	-
Due from Santa Clara Family Health Foundation	-	-
Prepaids & Other Assets	181,579	189,855
Deferred Outflow of Resources	-	-
Accounts Payable & Accrued Liabilities	(6,843,592)	3,318,734
State Payable	31,350,944	6,580,419
IGT, HQAF & Other Provider Payables	(269,507,797)	(263,260,694)
Net Pension Liability	66,983	216,983
Medical Cost Reserves & PDR	5,967,237	4,703,559
IHSS Payable	-	(1)
Deferred Inflow of Resources	-	-
Total Adjustments	**1,213,437**	**(8,717,935)**
Net Cash from Operating Activities	**$1,097,444**	**($7,787,436)**

Statement of Operations by Line of Business - YTD

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Three Months Ending September 30, 2019

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)						
REVENUE	$231,844,842	$7,958,213	$31,301,703	$39,259,916	$1,123,335	**$272,228,093**
MEDICAL EXPENSE (MLR)	$217,299,753	$7,955,072	$30,150,474	$38,105,545	$844,373	**$256,249,672**
GROSS MARGIN	$14,545,088	$3,141	$1,151,230	$1,154,371	$278,962	**$15,978,421**
ADMINISTRATIVE EXPENSE (% of Revenue Allocation)	$12,468,350	$427,984	$1,683,370	$2,111,353	$60,412	**$14,640,115**
OPERATING INCOME/(LOSS) (% of Revenue Allocation)	$2,076,738	($424,842)	($532,140)	($956,983)	$218,550	**$1,338,306**
OTHER INCOME/(EXPENSE) (% of Revenue Allocation)	$1,071,656	$36,785	$144,686	$181,471	$5,192	**$1,258,319**
NET INCOME/(LOSS)	$3,148,394	($388,057)	($387,454)	($775,512)	$223,743	**$2,596,625**
PMPM (ALLOCATED BASIS)						
REVENUE	$328.19	$326.10	$1,282.65	$1,608.75	$106.76	**$367.20**
MEDICAL EXPENSES	$307.60	$325.97	$1,235.47	$1,561.45	$80.25	**$345.64**
GROSS MARGIN	$20.59	$0.13	$47.17	$47.30	$26.51	**$21.55**
ADMINISTRATIVE EXPENSES	$17.65	$17.54	$68.98	$86.52	$5.74	**$19.75**
OPERATING INCOME/(LOSS)	$2.94	($17.41)	($21.81)	($39.21)	$20.77	**$1.81**
OTHER INCOME/(EXPENSE)	$1.52	$1.51	$5.93	$7.44	$0.49	**$1.70**
NET INCOME/(LOSS)	$4.46	($15.90)	($15.88)	($31.78)	$21.26	**$3.50**
ALLOCATION BASIS:						
MEMBER MONTHS - YTD	706,445	24,404	24,404	24,404	10,522	741,371
REVENUE BY LOB	85.2%	2.9%	11.5%	14.4%	0.4%	100.0%

Santa Clara Family Health Plan™

Network Detection and Prevention Report

November 2019

Executive Finance Committee Meeting

Firewall Background

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

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

The attempts have been categorized in three severity levels:

Critical/High

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

Medium

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

Low/Informational

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

11/8/2019

Attack Statistics Combined

July/August/September/October

	Number of Different Types of Attacks				Total Number of Attempts				Percent of Attempts			
Severity Level	Jul	Aug	Sep	Oct	Jul	Aug	Sep	Oct	Jul	Aug	Sep	Oct
Critical	8	12	8	9	61	55	83	107	0.12	0.12	0.15	0.21
High	4	7	6	7	40	81	112	62	0.08	0.18	0.20	0.12
Medium	11	24	17	24	7215	5204	12140	11616	14.70	11.33	21.82	23.12
Low	7	3	4	4	2920	1068	93	188	5.95	2.32	0.17	0.37
Informational	16	14	16	18	38829	39531	43197	38275	79.15	86.05	77.66	76.17

During the month of October SCFHP had a higher number of events in the Critical Severity Level compared to the previous 3 months and a lower amount of High events compared to September and August. SCFHP also had a high number in the Medium Severity Level events compared to July and August. The Low Severity events were a lot lower compared to July and August but twice as much compared to September. SCFHP analyzed the trend that was developing and this is common with other PAN Firewall customers our size. The increase in the Critical count was due to increased code-execution and botnet attacks.

Code-Execution = attempts to install or run an unknown application
Botnet Attack = denial of service attack (flooding network to be saturated)

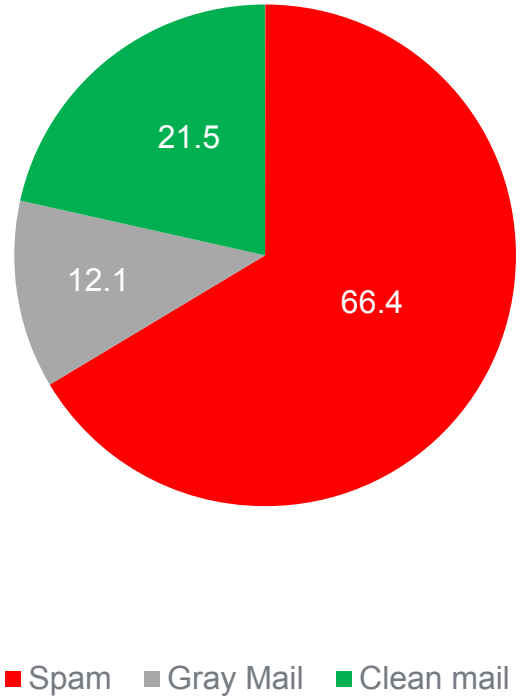
11/8/2019

Email Security – Monthly Statistics

Santa Clara Family Health Plan

Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by Reputation Filtering	45.0%	124.9k
Stopped as Invalid Recipients	0.0%	35
Spam Detected	21.3%	59.3k
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	2
Messages with Malicious URLs	0.1%	297
Stopped by Content Filter	0.1%	358
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**66.4%**	**184.6k**
Marketing Messages	9.1%	25.4k
Social Networking Messages	0.2%	496
Bulk Messages	2.8%	7,762
Total Graymails:	**12.1%**	**33.6k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	21.5%	59.6k
Total Attempted Messages:		**277.9k**



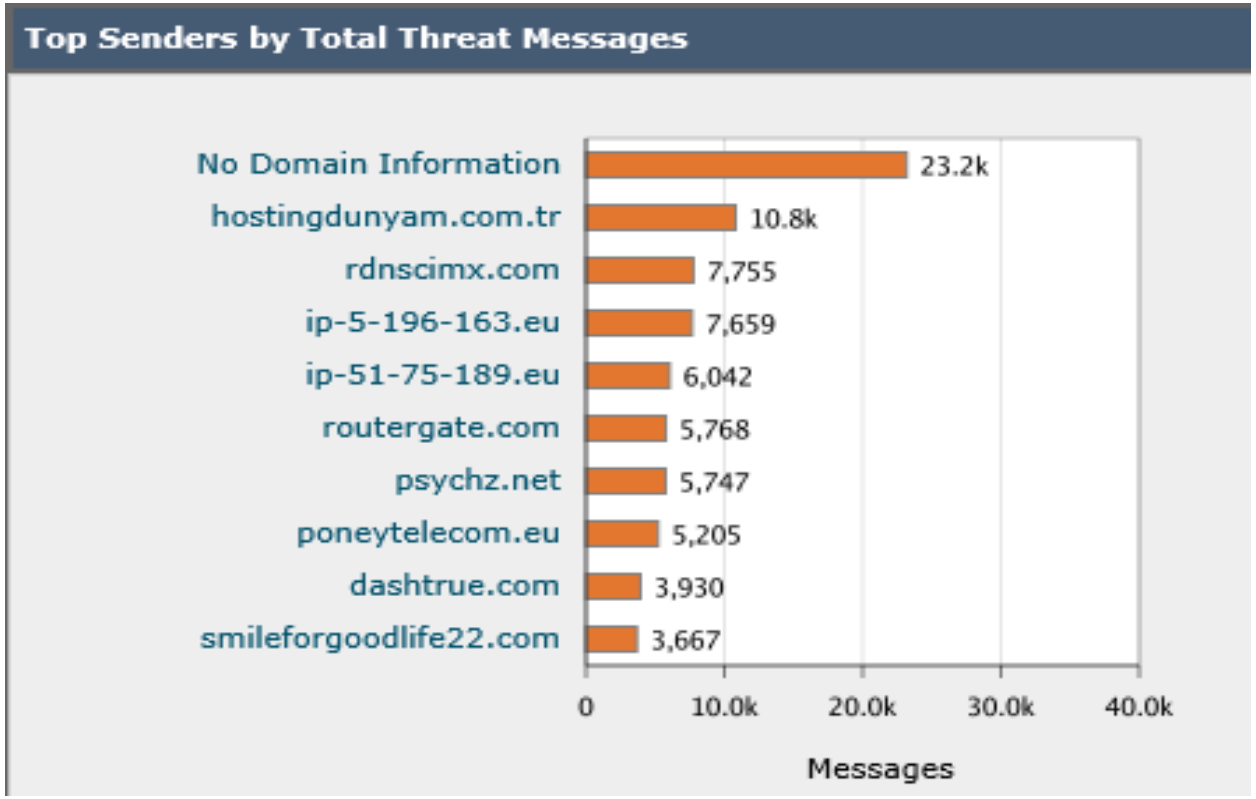
October

During the month.

- 66.4% were blocked as threat messages.
- 12.1% were Graymails *(Graymail is solicited bulk email messages that don't fit the definition of email spam).*
- 21.5% were clean messages that were delivered.

11/8/2019

Email Security – Monthly Threat Statistics



October

hostingdunyam.com.tr
- web and domain hosting from Turkey

rdnscimx.com
- Domain hosting from Turkey

ip-5-196-163.eu
- web and domain hosting from France

ip-51-75-189.eu
- web and domain hosting from France

routergate.com
- web and domain hosting from Turkey

psychz.net
- web and domain hosting

poneytelecom.eu
- web and domain hosting from Europe

dashtrue.com
- web and domain hosting from Germany

smileforgoodlife22.com
- web and domain hosting from Helsinki

These top 10 domains were blocked by File Reputation and Analysis from our Cisco Email Security Appliance.
The "**No Domain Information**" category is for IP addresses with no reverse DNS information.

11/8/2019

Email Background

For email protection, SCFHP utilizes software that intercepts every incoming email and scans for suspicious content, attachments, or URLs (Uniform Resource Locator or address to the World Wide Web). The software has anti-malware and phishing-detection technology that is constantly being updated to detect the latest threats. It is configured to detect phishing attempts as well as SPF (Sender Policy Framework) anti-spoofing. SPF is a simple technology that detects spoofing by providing a mechanism to validate the incoming mail against the sender's domain name. The software can check those records to make sure mail is coming from legitimate email addresses.

SCFHP Phishing Attacks August 2019

Santa Clara Family Health Plan

	INCIDENT 65 – 8/16/2019	INCIDENT 66 – 8/22/2019	INCIDENT 67 – 8/26/2019
TYPE OF ATTACK	Phishing	Phishing	Phishing
SUMMARY	2 employees	44 employees	8 employees
TYPE OF CONTENT and PURPOSE	PDF Attachment – Attempt to steal your credentials.	Display Name spoofing - Impersonate a user into a scheme to infiltrate your systems and data.	Display Name Spoofing – Impersonate a user into a scheme to infiltrate your systems and data.
RESPONSE	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.
	Step 2. • Block source email address on email gateway Suzanne.Clark@sjeccd.edu • Subject: REVIEW • Legitimate user email address was compromised.	**Step 2.** • Block source email address on email gateway flatlinepiper@gmail.com • Sent from: Christine M. Tomcala • Subject: REQUEST • No unique keywords to filter • No IP address to block • Implement new rule to filter sender name	**Step 2.** • Block source email address on email gateway myexecutive@mywireless-email.net • Sent from: Christine M. Tomcala • Subject: Santa Clara Family Health Plan • No unique keywords to filter • No IP address to block • Implement new rule to filter sender name
	Step 3. Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.
	Step 4. Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.

SCFHP Phishing Attacks September 2019

Santa Clara Family Health Plan

	INCIDENT 68 – 9/9/2019	INCIDENT 69 – 9/12/2019	INCIDENT 70 – 9/19/2019	INCIDENT 71 – 9/30-2019
TYPE OF ATTACK	Phishing	Phishing	Phishing	Phishing
SUMMARY	59 employees	5 employee	1 employee	2 employees
TYPE OF CONTENT and PURPOSE				Display Name Spoofing - Impersonate a user into a scheme to infiltrate your systems and data.
RESPONSE	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.
	Step 2. Block source email address on email gateway. NoReply@echohealthinc.com • Subject: Welcome to Change Healthcare Settlement Interface • No unique word to filter expression • No IP address provided to block.	**Step 2.** Block Source email address on email gateway. Scfhp@ses.igauzio.com • Subject: Missed Call • No unique words to Filter Expression • No unique IP address to block	**Step 2.** Block Source email address on email gateway. thakur1234soniya@gmail.com • Subject: (empty subject) • No unique word to filter expression • No IP address provided to block.	**Step 2.** Block Source email address on email gateway. myworkemail@naver.com • Sent from: Dang Huynh • Subject: CHANGE • No unique word to filter expression • No IP address provided to block.
	Step 3. Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.
	Step 4. Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.

SCFHP Phishing Attacks October 2019

Santa Clara Family Health Plan

	INCIDENT 72 – 10/03/2019	INCIDENT 73 – 10/03/2019	INCIDEN 74 – 10/09/2019	INCIDENT 74 – 10/18/2019	INCIDENT 75 – 10/24/2019
TYPE OF ATTACK	Phishing	Phishing	Phishing	Phishing	Phishing
SUMMARY	1 employee	1 employee	1 employee	1 employee	1 employee
TYPE OF CONTENT and PURPOSE	Suspicious voice message attachment.	Suspicious voice message attachment	Suspicious URL link	Suspicious URL link	Suspicious URL link
RESPONSE	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.
	Step 2. Block source email address on email gateway. bofkN@sakai-y.co.jp • Subject: IMPORTANT: Voice Message Attached • No unique word to filter expression • Blocked source IP address (202.218.230.130).	**Step 2.** Block source email address on email gateway. yHyit@watanabenoji.com • Subject: Audlo Message Attached • No unique word to filter expression • Blocked source IP address (211.1.227.18).	**Step 1.** Analyze email and take appropriate action. RPeznv@narutoscissors.co.jp • Subject: Syncing Error Failure Notification • No unique word to filter expression • Blocked source IP address (210.189.85.2)	**Step 1.** Analyze email and take appropriate action. xc158743@gmail.com • Subject: Russians accused of extremism • No unique word to filter expression • No IP address provided to block.	**Step 1.** Analyze email and take appropriate action. dfkoger@iu.edu • Subject: Error Notification • No unique word to filter expression • No IP address provided to block.
	Step 3. Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.
	Step 4. Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.

During this month, there were only 5 suspected phishing emails discovered and added to our blacklist. All others were unsolicited and marketing messages.

11/8/2019

Santa Clara Family Health Plan

Questions

11/8/2019

Santa Clara Family Health Plan

Regular Meeting of the Santa Clara County Health Authority Compliance Committee

Thursday, November 14, 2019
1:30 PM – 3:30 PM
6201 San Ignacio Ave.
San Jose, CA 95119

Minutes

Members Present
Linda Williams, Board Member
Christine M. Tomcala, Chief Executive Officer
Robin Larmer, Chief Compliance and Regulatory Affairs Officer
Neal Jarecki, Controller, Finance
Chris Turner, Chief Operating Officer
Laura Watkins, VP Marketing and Enrollment
Jonathan Tamayo, Chief Information Officer
Jordan Yamashita, Director, Compliance

Staff Present
Mai Phuong Nguyen, Oversight Manager
Leanne Kelly, Delegation Oversight Analyst

1. **Roll Call**

   Ms. Larmer called the meeting to order at 1:45pm. Roll call was taken and a quorum established.

2. **Public Comment**

   There were no public comments.

3. **Approve Minutes of the May 23, Regular Compliance Committee Meeting**

   Minutes of the August 22, 2019 regular Compliance Committee meeting were approved as presented.

4. **Compliance Program**

   Ms. Larmer presented the proposed Compliance Program for 2020 with red-line changes from the 2018-2019 version of the Compliance Program. Ms. Larmer explained that the changes are mostly grammatical and not material. There were updates made to information regarding the Compliance Hotline.

   A **motion** was made to approve the 2020 Compliance Program; the motion was **seconded and unanimously approved.**

5. **CMS Program Audit**

Ms. Larmer provided an update on the Independent Validation Audit (IVA) to validate the Plan's correction of the Conditions cited in the Centers for Medicare and Medicaid (CMS) Program Audit report. Ms. Larmer stated that CMS declined to close the audit based on the IVA Report, which indicated that 5 of the 31 Conditions were not fully remediated, because 3 of the 5 non-remediated Conditions impacted more than 50 members. Corrective Action Plans (CAPs) have been submitted for the 5 conditions. CMS has accepted the CAPs, and indicated that the Plan will have to have a second IVA to validate full remediation. The Plan will submit a draft IVA Work Plan for CMS' review and approval next week, and anticipates submission of the IVA Report to CMS in June 2020. There is some potential for an additional fine based on the failure to fully remediate all 31 Conditions.

6. **Compliance Activity and Audit Report**

   a. The Plan received DMHC's Report from the 2019 full-scope Audit. The Report noted only 4 deficiencies, and shows a marked improvement over the Plan's performance in the last full-scope Audit, which cited 32 deficiencies.
   b. Ms. Kelly and Ms. Nguyen reviewed the status of the current delegation audits.
   c. Corrective Action Plans (CAPs): Ms. Nguyen reported that there are 4 active CAPs issued to the delegates: Language Line, VHP, PMG and CHME.

A **motion** was made to accept the Compliance Activity and Audit Report; the motion was **seconded and unanimously approved.**

7. **CMC Contract Management Team HRA PIP**

CMS notified the Plan that CA's performance on HRA completion and related tasks is materially below the national average. As a result, most CA MMP's, including the Plan, have been directed to submit Performance Improvement Plans (PIPs). Through its PIP, the Plan must demonstrate how it will improve performance in the next 6 months.

8. **Review CMC and Medi-Cal Compliance Dashboard and Work Plans**

Ms. Nguyen stated that operational measures will be removed from the Dashboard and new compliance measures will be added due to findings from recent regulatory audits. Customer Services CAPs were closed as they provided evidence of training on the new work flow for handling off cases to G&A. CM and IT continues to work on the extraction of the data for the reporting of SPD HRA completion. G&A has 2 CAPs, both are related to the acknowledgement within 5 days. Due to the system (QNXT) upgrade in July, UM only reported partial data. UM's complete data will be available by the end of October.

A **motion** was made to approve the Compliance Dashboard; the motion was **seconded and unanimously approved.**

9. **Oversight Committee Report**

Ms. Yamashita explained that regulators have been focusing heavily on delegation oversight. The Oversight Committee has been re-instated and reports up to the Governing Board through the Compliance Committee. Meetings are on a monthly basis and provide an opportunity for the Plan to present issues staff has identified with delegates. The Committee also discusses internal

oversight, including internal audits and monitoring and resulting CAPs. The Committee is used as a functioning work group to look at and collaboratively resolve issues. The meeting minutes for the 9.19.19 meeting were reviewed.

A **motion** was made to approve the Oversight Committee Report; the motion was **seconded and unanimously approved.**

10. Fraud, Waste and Abuse Report

The Fraud, Waste, and Abuse (FWA) Vendor, T&M Protection Resources, continues to data mine to look for possible fraud cases. CMS announced a new 5 pillar program on FWA prevention. The program focuses on paying the right amount and shifting from a "pay and chase" model to a more proactive focus on fraud prevention. Audits will need to demonstrate strong prevention methods which leverage technology.

Ms. Yamashita reported that upon reviewing records obtained during a Physical Therapy practice investigation, the Plan discovered that that the practice provided electronic records created after the notice of audit was sent, not contemporaneous with provision of services. The claims value of the services at issue is roughly $6000. Ms. Williams noted that, in general, if a medical service is not properly recorded, it is to be considered not done. Ms. Turner and Ms. Larmer discussed adding language to provider training about fraudulent charting.

The group addressed the recoupment period for instances of suspected, but not definitively established, fraud (CA law allows for an extension of the one-year period for recoupment of payments to providers where fraud was a factor in the overpayment). Ms. Yamashita noted that in general, most CA Health Plans attempt to recoup outside the one-year limitations period only where the DOJ has definitively concluded fraud has occurred. The Plan will adopt a similar policy.

A **motion** was made to approve the Fraud, Waste, and Abuse Report; the motion was **seconded and unanimously approved.**

11. Adjournment

The meeting was adjourned at 2:49pm.

SANTA CLARA COUNTY HEALTH AUTHORITY
d/b/a
SANTA CLARA FAMILY HEALTH PLAN

Compliance Program
2018 - 2019 20

Governing Board approval date: September 27, 2018

Compliance Program Overview

Santa Clara County Health Authority d/b/a Santa Clara Family Health Plan ("SCFHP" or "Plan") has developed this Compliance Program to provide guidance and ensure its activities as a Medi-Cal and a Cal MediConnect Plan are conducted in an ethical and legal manner, in accordance with the 3-way Contract between the United States Department of Health ~~Care~~ and Human Services~~,~~ Center for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and Plan, the Plan's Medi-Cal contract with ~~The California Department of Health Care Services (~~DHCS~~),~~ ~~with~~ the Plan's Standards of Conduct and policies and procedures, and with applicable State and Federal law and regulations. The Compliance Program includes seven core elements with a particular focus in each of the following areas: oversight of first tier, downstream and related entities (FDRs), compliance program effectiveness measures, and fraud, waste and abuse (FWA) prevention, detection and correction principles. These elements serve as the directional basis and source of guidance for development of operational and oversight policies and procedures for all Plan lines of business. This Compliance Program also articulates the framework and guiding principles for how the Plan will effectively ensure its compliance with applicable program requirements. The Compliance Program reflects the Plan's commitment to compliance with all applicable program requirements, including all applicable Federal and State standards. It is updated annually, and as appropriate from time-to time, and such updates are reviewed, approved and adopted by the Plan's Compliance Committee and Governing Board ("Board").

The Compliance Program described herein governs the activities of the Plan's employees (including temporary staff), contractors and volunteers, as well as Board and Committee members, collectively referred to as "Personnel:"

The Compliance Program also applies to any subcontractors, vendors, agents or entities otherwise defined as FDRs under the Centers for Medicare & Medicaid Services (CMS) regulations and guidance, to whom Plan has delegated administrative or health care service functions relating to the Plan's 3-Way contract, and their employees (including temporary staff) and contractors who provide health and/or administrative services in connection with Plan's Cal Medi-Connect plan or that relate to Plan's Medicare functions.

The information contained in this Compliance Program is effective as of the date of approval by the Board.

Element I: Written Policies and Procedures and Standards of Conduct

SCFHP's Standards of Conduct is a policy and reference guide that describes the Plan's Standards of Conduct and Code of Ethics, including by way of practical application of the organization's core values and cultural attributes. This document sets forth the expectation of employees to report instances of potential non-compliance and Fraud Waste and Abuse ("FWA"). The Standards of Conduct, together with Plan's policies and procedures, are accessible to all employees within a shared location and demonstrate the Plan's commitment to comply with all applicable Federal and State laws and regulations. It is the Plan Leadership's expectation that all Personnel and FDRs shall adhere to the Plan's Standards of Conduct and policies and procedures, as well as applicable law, in the course of performing their duties on behalf of the Plan and its enrolled beneficiaries. This expectation is promoted through communications and training, and enforced through disciplinary, contractual and other standards.

The Standards of Conduct emphasize the need to maintain a high ethical standard for individual and organizational behavior and legal business practices. In addition, the Standards of Conduct and our policies and procedures provide practical guidance for Personnel and FDRs for effectuating compliance with law and promoting ethical and business practices in their daily roles. In doing so, the Standards of Conduct and our policies and procedures support the Plan's FWA prevention, detection and correction efforts, including but not limited to through emphasis on compliance with:

- Federal and state False Claims Acts;
- Federal and state Anti-Kickback Statutes;
- Health Insurance Portability and Accountability Act of 1996, as amended;
- Prohibition on inducements to beneficiaries; and
- Plan Conflict of Interest rules.

The Standards of Conduct, as well as SCFHP's policies and procedures, also describes the process that any and all Personnel and FDRs (and their employees) are expected to use to report possible compliance and FWA issues to management, or anonymously using the Plan's free hotline, and includes a statement of non-intimidation and non-retaliation for good faith participation in the Compliance Program. Disciplinary actions, such as suspension or termination of employment, termination of contractual relationship or removal from office or Board membership may be taken for failure to comply with the Standards of Conduct. Reported issues are investigated and resolved in accordance with Plan's established policies and procedures.

FDRs to whom Plan has delegated administrative or health care service functions relating to the Plan's Three-way contract may either adopt the Plan's policies and procedures (as relevant to delegated functions) and Standards of Conduct (as provided upon contracting and annually thereafter) or implement their own policies, procedures, and/or standards of conduct consistent with Plan's and in full compliance with DHCS, DMHC and CMS requirements. FDRs shall distribute such Standards of Conduct and/or policies and procedures to their employees upon hire, appointment or contracting, at any time material revisions are made, and annually thereafter. The FDR's compliance program, policies, procedures and standards of conduct are subject to review upon audit by the Plan.

The Standards of Conduct is presented to Personnel at the time of hire, appointment or contracting and any time material revisions are made. All Personnel must attest that they have read and agree to comply with the Standards of Conduct and guidelines. Such attestations are kept with the employee or other individual's record. Attestations of FDRs and their employees concerning receipt of the relevant materials are maintained by the FDRs and can be audited by the Plan at any time.

In addition to the Standards of Conduct, Plan has issued and implemented policies and procedures that are detailed and specific, and describe the operation of the Compliance Program. Compliance policies and procedures are reviewed and updated as necessary, but no less than annually, to incorporate any relevant changes in applicable laws, regulations and other program requirements. Proposed revisions are developed under the direction of the Chief Compliance Officer, referred to the Compliance Committee for review and approval, and reported to the Board.

Element II: Compliance Officer, Compliance Committee and High Level Oversight

The success of the Compliance Program is the responsibility of many individuals within the Plan. The Chief Compliance Officer, Senior Management, the Compliance Committee and the Board all play an important role in the implementation and success of the Compliance Program. As used in this Compliance Program, the phrase "Senior Management" refers to the Chief Executive Officer, the Chief Operating Officer, the Chief Financial Officer, the Chief Medical Officer, the Chief Information Officer, the Vice President of Human Resources, the Vice President of Marketing and Enrollment, and such other executive level staff as may join the organization.

The sections below serve to describe the responsibilities of the Chief Compliance Officer, Compliance Committee, the Board and Senior Management.

A. The **Chief Compliance Officer** (CCO) serves as the Compliance Officer (as the term is used within Chapters 9 and 21 of the Prescription Drug Benefit Manual and Medicare Managed Care Manual, respectively) and is an employee of, and reports directly to, the Plan's CEO and Board. The CCO has detailed involvement in, and familiarity with, the Plan's operational and compliance activities (but shall be independent from, and not have direct responsibility over, program operations). The CCO directs the Plan's day-to-day operations and execution of the Compliance Program. The CCO is also a member of Senior Management and has direct access to the Plan's Chief Executive Officer (CEO) and the Board, and is provided with sufficient resources and authority to effectively carry out his or her duties.

The CCO shall have the authority to:

- Provide periodic written and/or in-person reports (as appropriate) directly to the Governing Board;
- Interview or delegate the responsibility to interview Plan employees and other relevant individuals;
- Review and retain company contracts and other documents pertinent to the Medi-Cal and Cal MediConnect programs;
- Review or delegate the responsibility to review the submission of data to CMS and DHCS to ensure that it is accurate and in compliance with their respective reporting requirements;
- Independently seek advice from legal counsel;
- Report misconduct and potential FWA to CMS, its designee and/or law enforcement;
- Conduct and direct audits and investigations of any first tier entities, downstream entities, or related entities;
- Conduct and/or direct audits of any area or function involved with Medi-Cal or Cal MediConnect plans (excluding those conducted under the purview of SCFHP's Executive/Finance Committee, such as external financial audits);
- Recommend policy, procedure and process changes;
- Enforce compliance program requirements at all levels of the Plan organization.

The duties for which the CCO is responsible include, but are not limited to:

- Communicating regularly with and reporting to the Board, Senior Management and the Compliance Committee on the status of the Compliance Program, including issues identified, investigated and resolved;
- Developing, implementing, managing, and monitoring the effectiveness of the Compliance Program and ensuring that the Board and Senior Management are aware of performance metrics and potential issues and their potential solutions;
- Identification and resolution of potential or actual instances of noncompliance or FWA;
- Creating, coordinating, and/or participating in educational training programs to ensure Personnel and FDRs are knowledgeable of Plan's Compliance Program, Standards of Conduct, operational and compliance policies and procedures, and applicable statutory, regulatory, and other program requirements;
- Monitoring Federal and State legal and regulatory developments (including but not limited to, Fraud Alerts and Advisory Opinions issued by the U.S. Department of Health and Human Services' Office of Inspector General (OIG) and Health Plan Management Systems (HPMS) memos and updating the Compliance Program as appropriate);
- Developing, maintaining and promoting use of retribution-free methods and programs for reporting in good faith suspected Medicare program non-compliance, misconduct or potential FWA by Personnel, FDRs or others;
- Working with Human Resources to ensure that the Plan conducts appropriate background checks, including routine screening, against all required exclusion lists;
- Developing risk analyses that are used to focus Compliance Program efforts in a manner designed to promote overall effectiveness;
- Developing and monitoring the implementation of, and adherence to, compliance policies and procedures through the creation and implementation of a compliance work plan (Work Plan) that defines internal monitoring, audit requirements, schedule and methodology;
- Maintaining documentation and tracking of each report of potential non-compliance and FWA received through any of the reporting methodologies or as self-identified through monitoring, auditing or other means;
- Conducting self-evaluations of the Compliance Program to assess overall effectiveness and identify areas for improvement;
- Conducting (or evaluating information obtained from) exit interviews; and,
- Responding to reports of potential instances of FWA, including through coordination of internal investigations and the development of appropriate corrective or disciplinary actions, or referral to law enforcement, as necessary.

B. The **Compliance Committee** assists the Plan's Board in the oversight of the Compliance Program and is accountable to provide support and guidance necessary to the CCO in overseeing the outcomes and performance of activities initiated under the Compliance Program. The Compliance Committee, through the CCO, shall periodically report directly to the Board on the activities and status of the Compliance Program, including issues identified, investigated, and resolved by the Compliance

Program.

The Compliance Committee shall include individuals with a variety of backgrounds to ensure CCO's functional representation. Such members shall have both decision-making authority and understanding of vulnerabilities within their areas of expertise. Members shall include representatives from areas including, but ~~may~~ not ~~be~~ necessarily limited to, finance, health plan operations (including enrollment, appeals and grievances, and customer service), medical management, pharmacy services, quality improvement, marketing and sales, information technology and legal counsel. The Compliance Committee is a Brown Act Committee. ~~will be appointed by the Board and t~~The CCO will act as the Compliance Committee chairperson.

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

The Committee has been delegated by the Board to uphold certain responsibilities, including but not limited to:

- Meeting on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program;
- Development, implementation and annual review and approval of compliance policies and procedures;
- Reviewing and approving relevant compliance documents, including but not limited to:
    - CCO's performance goals;
    - Compliance and FWA training;
    - Compliance risk assessment;
    - Compliance and FWA monitoring and auditing Work Plan and audit results; and
    - Corrective action plans resulting from audits or other means of identification (and monitoring of their effectiveness);
- Developing strategies to promote compliance and the detection of any potential compliance violations, especially as they relate to core beneficiary protection issues such as, but not limited to, appeals and grievances, enrollment, transition, coverage determinations and exceptions;
- Reviewing effectiveness of the system of internal controls, such as dashboards, scorecards, self-assessment tools, etc. designed to reveal compliance issues or FWA issues, and metrics concerning operational compliance with key Medicare regulatory requirements, such as, but not limited to, those governing enrollment, appeals and grievances, and prescription drug benefit administration; and
- Ensuring that SCFHP has an easy to use system for employees and FDRs to ask compliance questions and report potential instances of noncompliance and potential FWA confidentially or anonymously (if desired) without fear of retaliation

The Compliance Committee will collect and review measurable evidence (using tools such as dashboards reports, scorecards and key performance indicators) concerning Compliance Program performance as a concrete means of measuring/demonstrating the extent to which the Compliance

Program is detecting and correcting noncompliance and FWA on a timely basis, and providing insights into any potential needed process improvements. The CCO will provide the Compliance Committee with data showing the status of organizational compliance through:

- Use of monitoring tools to track and review open/closed corrective action plans, FDR compliance, Notices of Non-Compliance, Warning Letters, CMS sanctions, marketing material approval rates, training completion/pass rates, results of CMS readiness checklist review, past performance review metrics, etc.;
- Implementation of new or updated Medicare program requirements (*e.g.*, tracking HPMS memo from receipt to implementation) including monitoring or auditing and quality control measures to confirm appropriate and timely implementation;
- Increase or decrease in number and/or severity of complaints from employees, FDRs, providers, or beneficiaries through customer service calls or the Complaint Tracking Module (CTM), including those relating to alleged marketing misrepresentations, etc.;
- Timely response to reported instances of potential noncompliance and FWA (including issues raised by CMS), and effective resolution (*i.e.*, non-recurring issues);
- Application of consistent, timely and appropriate disciplinary action; and
- Detection of noncompliance and FWA issues through monitoring and auditing:
    - Whether root cause was determined and corrective action appropriately and timely implemented and tested for effectiveness;
    - Detection of FWA trends and schemes via, for instance, daily claims reviews, outlier reports, pharmacy audits, etc.; and
    - Actions taken in response to non-compliance or FWA reports submitted by FDRs.

C. The governing body providing appropriate oversight of the Compliance Program is SCFHP's Board. The Board reviews and approves the Compliance Program and subsequent updates as revisions are made. As mentioned previously, the Board has delegated certain responsibilities to the Compliance Committee, but the Board as a whole remains accountable for Compliance Program oversight.

In addition to the above, the duties for which the Board is responsible include, but are not limited to, active oversight of the effectiveness of the Compliance Program and compliance results as follows:

- Understanding the Compliance Program structure, content and operation (including through appropriate training that educates Board Members regarding the Compliance Program operations, compliance risks and strategies and methods of gauging Compliance Program effectiveness);
- Evaluation of SCFHP's Senior Management team's commitment to ethics and the Compliance Program;
- Reviewing, understanding and questioning information provided within reports presented to them, including by the CCO, at least quarterly, on the activities of the Compliance Program. Such activities include, but are not limited to, actively considering:
    - Compliance Program outcomes (such as results of internal and external audits);

  - The effectiveness of corrective action plans implemented in response to identified issues;
  - Governmental compliance enforcement activity, such as Notices of Non-Compliance, Warning Letters, Corrective Action Plan requests, contract actions and/or other sanctions;
  - Reports of potential noncompliance and/or FWA issues identified, investigated, and resolved;
  - Identified risks and mitigation performed; and
  - The results of performance and effectiveness assessments (including self-assessments) of the Compliance Program;
- Conducting follow-up on issues and taking appropriate action when necessary; and
- Approval of Standards of Conduct and Compliance Program (and modifications thereto).

The Board shall document in meeting minutes and related records its active engagement in the oversight of the Compliance Program and include documentation of the Board's discussion, follow-up on issues and actions taken in response and to ensure an effective Compliance Program.

D. Senior Management

The CCO shall provide SCFHP's CEO with periodic reports of risk areas facing the organization, the strategies being implemented to address them, and the results of those strategies. The CCO shall notify the CEO and the Senior Management team, as appropriate, of all governmental compliance enforcement activity, including the issuance of Notices of Non-compliance, Warning Letters, Corrective Action Plan requests, and contract actions and/or other sanctions, and seek consultation and assistance regarding how best to respond to and address the same.

Element III: Effective Training and Education

A. General Compliance Training

SCFHP provides a comprehensive education and training program to ensure communication and understanding of the Compliance Program and SCFHP's Standards of Conduct and Compliance policies and procedures. The education, training and communication program is designed to ensure that all Personnel (including without limitation the CEO, Senior Management and Board members), and any other applicable individual acting on behalf of SCFHP in connection with its Medicare program(s), such as FDRs and their employees, are fully capable of carrying out their duties in compliance with the Compliance Program, Standards of Conduct and relevant policies and procedures. The education program includes general Compliance Program awareness training, and specific training and education tailored to individuals' roles and responsibilities, delivered by the Compliance Department or operational business units. For example, employees whose job primarily focuses on enrollment or claims would receive additional training in these areas.

Compliance Program education and training occurs within ninety (90) days of hire (or appointment to Board), and, at a minimum, annually thereafter. The education and training may be provided through a variety of teaching methods, including classroom study, computer-based training, and distance learning. Additional tools may be used to communicate the Compliance Program process, such as use of posters, written Compliance Program updates, internet and intranet resources, and topical newsletters and other publications. SCFHP shall document and/or maintain records of Personnel who complete the required Compliance Program education and training in a format that is easily accessible. SCFHP shall implement controls to ensure that all Personnel are trained, as required. SCFHP shall review and update the general Compliance Program training, as necessary, whenever there are material changes in statute, regulation or Medicare Part C or Part D program guidance, and at least annually.

B. FWA Training

SCFHP provides Personnel with standard FWA training within ninety (90) days of initial hiring (or appointment to the Board), and annually thereafter. SCFHP may require that particular individuals participate in specialized or refresher training on issues posing FWA or other risks relevant to the individual's particular job function. Training may be required, as appropriate, when ~~MMP~~ the Plan's program requirements change, when an individual is found to be non-compliant or needs additional training, or when training is appropriate to address an identified organizational deficiency or with respect to an area where FWA was identified in the past or presents heightened risk.

C. First Tier, Downstream and Related Entity Training

SCFHP requires FDRs, to whom SCFHP has delegated administrative or health care service functions relating to SCFHP's ~~MMP~~ regulatory contract(s), to conduct training that meets CMS training requirements and is consistent with SCFHP's training materials. SCFHP shall accept the

certificate of completion of the CMS Standardized General Compliance Program Training and Education Module as satisfaction of the training requirement.

Any FDR that has met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier is deemed to have met, and fully satisfied, SCFHP's training and educational requirements related to FWA. In such context, no additional documentation beyond the documentation necessary for proper credentialing is required to establish that an employee or FDR or employee of an FDR has met SCFHP's FWA training requirements. In the case of chains, such as chain pharmacies, each individual location must be enrolled into Medicare Part A or B to be deemed. Such deemed individuals must, however, participate in the CMS general Medicare compliance training. FDRs that do not qualify for deeming status must take both the General Compliance and the FWA training programs offered by CMS.

Element IV: Effective Lines of Communication

SCFHP has established numerous mechanisms to ensure effective lines of communication exist between the CCO, members of the Compliance Committee, Personnel (including the Board) and SCFHP's FDRs (and their employees).

For instances, in order to facilitate communication among all Personnel, FDRs and the CCO, SCFHP offers a phone hotline, available 24 hours a day, 7 days a week, which can be used anonymously if preferred, through which an individual may seek guidance or disclose information about potential compliance or FWA issues. Through Compliance Program activities, Personnel and FDRs are encouraged to ask compliance and FWA related questions through various means, such as direct contact with the CCO, in order to assist such individuals in evaluating and dealing with suspected, detected or reported compliance or FWA issues. If requested and as appropriate, the CCO shall treat such communications confidentially. The CCO also communicates with Personnel, FDRs and enrollees concerning compliance and FWA issues through various educational mechanisms, as discussed more fully below.

A. Procedures for Reporting Noncompliant or Unethical Behavior

All Personnel and FDRs are required to report compliance concerns and suspected or actual violations related to SCFHP's ~~MMP~~ programs to SCFHP. The reporting process set forth in this Compliance Program, as well as CCO name and contact information, is communicated to Personnel and FDRs and their employees through various means, including general Compliance Program training. An individual may confidentially report compliance and FWA concerns in multiple ways, at their option, including: 1) directly to his/her supervisor or manager (as applicable), 2) to SCFHP's CCO, or 3) anonymously using SCFHP's toll-free phone hotline reporting tool (available 24/7). SCFHP's non-intimidation and non-retaliation policy provides the individual who makes a report, complaint, or inquiry in good faith with protection from retaliatory action, including with respect to reporting of False Claims Act complaints and/or reporting to appropriate officials. SCFHP has a no tolerance policy for intimidation of, or retaliation taken against, individuals making such good faith reports, complaints or inquiries and shall take disciplinary action against individuals who are determined to have intimidated or retaliated against such individuals.

SCFHP recognizes that enrollees, contracted providers and FDRs are important sources for identifying potential non-compliance and/or FWA. SCFHP widely publicizes the methods by which individuals and entities outside the SCFHP organization can report possible instances of fraud, waste, abuse or non-compliance to the organization and can ask questions, including through the hotline (which is accessible to all).

Hotline information is provided to enrollees through ~~the~~ an ~~quarterly~~ annual FWA feature in the enrollee newsletter. ~~and to FDRs and other means. As part of this communication process,~~ In addition, FDRs receive quarterly informational bulletins containing, as a standing item, hotline

availability and reasons for use (including for compliance questions). The CCO's contact information is also always contained within these materials. SCFHP customer service representatives, who ~~intake~~ receive calls from both enrollees and FDRs~~, including providers,~~ have also been trained to recognize potential instances of non-compliance or FWA, and to properly memorialize and direct issues within the Plans Sponsor organization for appropriate follow-up by the CCO or others.

B. Education

The CCO engages in active communication with Personnel, FDRs and enrollees concerning a wide range of compliance issues, including the standards for compliance with laws, regulation and guidance; changes in legal authorities and/or compliance policies and procedures; and guidance on how to identify and report FWA issues. Such communication is accomplished through various educational means, including through newsletters and posters, SCFHP Websites, formal training, and individual and group meetings.

C. Follow-Up and Tracking

Once received, issues of potential non-compliance or FWA will be documented and forwarded to the CCO and/or his or her designee for investigation/resolution and reporting to the Compliance Committee and the applicable State and/or Federal agency, or law enforcement, as required.

D. Integrated Communications

To enhance SCFHP's day-to-day communication, understanding and focus on its actual compliance, and to ensure that potential compliance and FWA issues are examined early and corrective actions are implemented timely, each department maintains a set of compliance "dashboard" metrics that are routinely shared with the CCO. These dashboard results are i) reported to department staff to increase their attention to compliance, and ii) reported to the CCO for monitoring and auditing activities (such as trend analysis and identification of anomalies), and to provide status of any corrective actions undertaken and implemented (including barriers to implementation). Reports on these and other compliance activities will be routinely reviewed by Senior Management and reported to the Compliance Committee and the Board at each meeting, as appropriate.

Element V: Well-Publicized Disciplinary Standards

Compliance training, in its various forms (*e.g.* mandatory formal training, newsletters, websites and posters), demonstrates practical application of the Standards of Conduct. These training programs provide instruction regarding various regulations and laws pertinent to our business, as well as "Questions and Answers" that describe the expectation that SCFHP has of Personnel when confronted with certain situations, including appropriate reporting and the duty to assist in issues resolution. These programs set forth the expectation by SCFHP of Personnel and FDRs and their employees to report illegal or unethical behavior and potential compliance and/or FWA issues, as well as to assist in their resolution. They also encourage Personnel to contact the CCO or others if they have questions concerning potential compliance or FWA issues.

In various communications, SCFHP explains the ramifications faced by SCFHP for non-compliance with regulations and laws affecting its business, as well as disciplinary action to be taken against individual(s) or entities who have either committed a crime and/or participated in or knew about potential non-compliance, unethical behavior and/or FWA, but failed to report it to SCFHP. *Disciplinary action will be assessed based on the infraction and could range from retraining of the individual/entity, up to termination of employment/Board membership/contract.*

Enforcement of the standards will be timely, consistent and effective when non-compliance or unethical behavior (such as fraud) is determined. As set forth in Element IV, Part A, employees have an affirmative obligation to identify non-compliance and unethical behaviors, and failure to meet this obligation will result in appropriate action according to the disciplinary standards. Records of enforcement of standards will be maintained for ten years for all disciplinary actions based on compliance violations or FWA (or the failure to report the same), and such records will capture the date the violation was reported, a description of the violation, the date(s) of investigation, a summary of findings, the disciplinary action taken and the date it was taken. SCFHP may, from time-to time, review such records to ensure that discipline is appropriate to the seriousness of the offense, fairly and consistently applied, and imposed within a reasonable time frame after the infraction and/or discovery of such.

Finally, compliance is a measurement on SCFHP's annual employee performance evaluation to reinforce the importance that compliance plays in each individual's role within the organization. Issues of non-compliance will be considered by SCFHP in connection with whether to renew or continue any particular arrangement with an FDR.

Element VI: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks and FWA

SCFHP will establish and implement an effective system for identification of non-compliance or unethical behavior (such as activities involving fraud and abuse) and evaluation of the Compliance Program through risk analysis, engagement in monitoring and auditing activities and review of reported issues (including any issues identified by CMS). The system will include, among other things, routine and targeted internal monitoring and auditing of operational areas and auditing and monitoring of FDRs. SCFHP may from time-to-time engage external auditors to assist with focused review of particular areas where it deems such appropriate (*e.g.*, because of expertise required or resource limitations).

Multiple methods will be employed to facilitate monitoring and auditing of operational areas in a focused and efficient manner, including without limitation conducting risk assessments, developing annual Work Plans, engaging in on-site audits or desk reviews, conducting monitoring, including through periodic reports, and analyzing and responding to such monitoring and auditing results.

A. Risk Assessment

SCFHP will regularly conduct a risk assessment of all business operational areas, and those of FDRs to whom SCFHP has delegated functions under its ~~MMP~~ regulatory contract(s). Each operational area (including those delegated to FDRs) will be assessed for the types and levels of risks the area presents to the ~~MMP~~ Medi-Cal and CMC programs, to SCFHP and to its Medicare-Medi-Cal beneficiaries, paying close attention to those areas CMS considers high risk, such as but not limited to:

- enrollment and disenrollment non-compliance;
- appeals and grievances;
- benefit and formulary administration;
- credentialing;
- quality assessment;
- organization determinations;
- coverage determinations;
- transition and protected class policy;
- utilization management;
- accuracy of claims processing;
- previously identified areas of vulnerability for potentially fraudulent claims;
- outbound enrollment verification calls;
- marketing and enrollment violations, agent/broker misrepresentation, and selective marketing; and
- FDR oversight and monitoring.

In addition, SCFHP's risk assessment(s) will take into account information received from the OIG's annual work plan and Medicare Managed Care Manual and Medicare Prescription Drug

Benefit Manual chapter guidance updates, as well as other CMS program instructions, Fraud Alerts, CMS audits and other CMS indicators regarding plan performance (such as Warning Letter, Deficiency Notices, audit results, etc.). The risk assessment will expressly take into account CMS guidance provided concerning its prior year audits findings and any recent interim sanction or civil monetary penalties assessed by the agency, as well as DHCS Policy, All Plan and Dual Plan Letters, and DHCS and DMHC audit findings. The CCO will rank those risks identified during this process in order to identify those areas presenting the greatest potential risk to SCFHP. Risks identified through CMS audits and oversight, as well as SCFHP's own monitoring, auditing and investigations, will be considered priority items in the overall risk analysis. The CCO will develop the proposed annual Work Plan in consultation with the Compliance Committee and/or departmental staff~~s~~ as appropriate, taking into account the results of the risk assessment.

B. Annual Monitoring and Auditing Work Plan

An annual Work Plan, based on the results of the risk assessment, will be developed and brought to the Compliance Committee for review, input and approval. The Work Plan will include the audits to be performed (both of SCFHP and FDRs), the audit schedule, methodology to be used, if it is to be performed desktop and/or onsite, and the responsible party for performing the audit, as well as specify routine monitoring to be conducted. Such monitoring and auditing activities are designed to test controls and prevent, detect and correct compliance issues and FWA through verification of compliance standards and adherence to State and Federal laws, contractual requirements, Medicare regulatory requirements, Part C and Part D program instruction, SCFHP Compliance Program policy and procedures, and Standards of Conduct. During the course of the year, the CCO may propose modifications to the Work Plan to the Compliance Committee, as developments warrant (such as changes in law or identified compliance or FWA issues).

C. Audits

The Compliance Department, which is independent from the Plan's daily operations, will perform, or will arrange for independent, external parties to perform, audits of SCFHP's internal operations and FDRs. The CCO shall coordinate with auditors regarding audit design and related considerations, and receive regular reports from the auditors regarding audit status and results. Auditors will be directed to use a standard audit report format addressing audit objectives, scope and methodology, findings (including regarding condition, cause and effect), and recommendations. They will use care in selecting sample and sample size, based on whether a targeted or statistically valid sample is intended. Auditors shall be knowledgeable about CMS and DHCS operational requirements for the operational areas (whether internal or of FDRs) under review. Operations staff may assist auditors, as long as such assistance does not interfere with the auditors' independent review. Such assistance can take the form of gathering data for samples or providing other basic information to auditors. Auditors shall have access to relevant Personnel, records and areas of operation under review, including the operational departments at SCFHP, as well as FDR employees and operations. All Personnel and FDRs have a duty to cooperate with monitoring and auditing efforts directed by the CCO.

D. Monitoring

Routine operational metrics relative to regulatory standards and compliance measures will be maintained by the business units and the results reported to the CCO. Monitoring will also be conducted in each instance to determine whether corrective action plans are effective in addressing the compliance issue identified.

E. Analyzing and Responding to Monitoring and Auditing Results

Results of audits and monitoring, and any required root cause analyses and corrective action plans will be reported by the CCO (or his or her designee) to the Compliance Committee and, as appropriate, Senior Management (including the CEO) and/or the Board. Audit findings will also serve to identify Personnel, business units and/or FDRs requiring additional training (general or focused); the need for clarification or amendment of policies and/or procedures; the need for correction of system logic; and/or other necessary actions. The CCO shall be responsible for overseeing follow-up reviews of areas found to be non-compliant, as necessary, to determine if implemented corrective action has fully addressed the underlying problem identified. If applicable and appropriate, the CCO will consider whether to voluntarily self-report audit findings of non-compliance and/or potential fraud or misconduct related to the ~~MMP~~ Plan's programs to CMS or its designee, such as the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), DHCS or DMHC.

F. Excluded Parties

SCFHP, in an effort to prevent FWA, shall screen Personnel against United States Department of Health & Human Services' (DHHS) OIG List of Excluded Individuals and Entities and the General Services Administration's (GSA) Excluded Parties Lists System, prior to hiring or contracting and monthly thereafter, to ensure that such individual or entity does not appear on such list(s) (*i.e.*, is not an excluded individual or entity). SCFHP also requires its FDRs to have a similar policy and audits accordingly to ensure compliance with such requirements.

G. Compliance Program Effectiveness

SCFHP is committed to a process of continual process improvement with respect to its Compliance Program. As such, SCFHP will conduct an annual audit of the effectiveness of the Compliance Program. After completion of a baseline compliance program effectiveness audit, such audit will be conducted by external auditors (or Personnel not part of the Compliance department). To assist in determining effectiveness, the Compliance Committee will annually evaluate whether activities under the Work Plan were completed in a timely and appropriate manner, actual performance of the CCO against performance goals (if relevant), CMS compliance assessments *(e.g.,* Warning Letters, Notices of Non-compliance, CAP requests, audits, sanctions), results of CMS readiness checklist assessment, and past performance review measurements as they relate to compliance. Results of this audit will be shared with the Compliance Committee, Senior Management and the Board. Either the CCO, Compliance Committee and/or the Board may recommend modifications, such as enhancing or increasing internal monitoring frequency in

areas that have previous low threshold results or areas that have become the subject of increased scrutiny (through regulation, audit or guidance), by state and/or federal regulatory agencies, including but not limited to CMS or the OIG.

Element VII: Procedures and System for Prompt Response to Compliance and FWA Issues

SCFHP has established and will maintain a process for assuring prompt response to reports or other identification of potential non-compliance and/or FWA, including timely investigation of potential problems, implementation of corrective actions to address past issues and mitigate future occurrences; appropriate self-reporting of fraud and misconduct, and processes to ensure appropriate action is taken with regard to identified overpayments.

A. Investigations of Compliance and FWA Issues

SCFHP will establish and implement procedures and a system for promptly responding to potential compliance and FWA issues as they are raised. Compliance or FWA problems identified in the course of self-evaluations, reports or complaints to the SCFHP, audits and/or other means and verified through investigation will be corrected promptly and thoroughly to address the issue, reduce the potential for recurrence, and promote ongoing compliance with CMS requirements. If a potentially serious violation is identified, SCFHP will consult with its designated FWA/SIU vendor for assistance to determine the type and extent of the potential violation and liability. SCFHP may invoke attorney-client privilege at any time during the investigation as determined by legal counsel. External legal, auditing, and other expert resources may be engaged to provide additional services. SCFHP will immediately cease, or instruct its FDR to immediately cease, questionable practices upon knowledge or clear indication of a violation. In addition:

- SCFHP will conduct a timely, reasonable inquiry into any evidence of misconduct related to a payment or delivery of items or services under the contract with CMS and/or DHCS (with such inquiry initiated within 2 weeks after the date the potential non-compliance or FWA incident is identified);
- SCFHP will conduct appropriate corrective actions (for example, repayment of overpayments and/or disciplinary actions against responsible individuals) in response to the potential violations referenced above; and,
- SCFHP will have procedures to consider whether to voluntarily self-report fraud or misconduct related to the ~~MMP~~ Plan's programs to CMS or its designee (such as NBI MEDIC), DHCS and DMHC in appropriate situations, consistent with ~~CMS~~ guidelines and time frames.

SCFHP and its Pharmacy Benefit Manager (PBM) shall monitor Fraud Alerts and will review its contractual agreements (or direct the PBM to review contractual agreements) with the identified parties, as appropriate, to determine whether any additional action should be taken. SCFHP and/or its PBM will review past paid claims from the identified entities to determine if there are any claims that it may have paid that were not payable (*e.g.*, related to an Excluded Individual) and should be removed for prior sets of prescription drug event drug submissions.

Responses to detected offenses will vary according to the offense and circumstance; however the response will always be in accordance with requirements of regulation and law. The CCO shall

maintain a record of reported issues, including documentation of the status, investigation, finding and resolution of each issue. This information shall be reported to the Compliance Committee regularly.

Any determination that potential FWA related to the ~~MMP~~ Plan's programs has occurred will be referred to the appropriate regulatory agency, as appropriate, for further investigation after the determination that a violation may have occurred. SCFHP will, as appropriate, provide information timely in response to follow-up requests for information.

B. Corrective Action Plans (CAPs)

Corrective action plans will be implemented whenever it is determined by the CCO and the Compliance Committee that any Personnel, FDRs or their employees have engaged in an activity that violated SCFHP policies and procedures, federal or state laws or regulations or CMS contractual or other requirements. These corrective action plans will be in writing and developed based on a root cause analysis conducted in response to any wrongful activity discovered by way of investigation resulting from any report, complaint, and/or internal or external audit or monitoring efforts, or as identified by CMS. Through the root cause analysis, SCFHP will undertake to determine what caused or allowed the non-compliance or FWA to occur so that an appropriate and effective remedy can be developed.

The goal of any CAP implemented is to remedy underlying issues and prevent future recurrence. Each CAP will be tailored to the particular misconduct identified and include specific time frames for completion. SCFHP will immediately cease any non-compliant practice upon knowledge or clear indication of a violation. When developing a corrective action plan to address non-compliance by an FDR, the elements of the corrective action plan, and the ramifications for non-compliance, will be included in a written CAP provided to the FDR. Corrective actions may include, for instance, disciplinary action against any Personnel; prompt identification and refund of any overpayment to the government or any enrollee; and/or suspension or termination of any FDR contract (or delegated functions thereunder).

CAPs will be monitored to ensure the required remediation has been carried out, and is sustained over time. All corrective action plans recommended, in progress, and implemented, along with results of ongoing monitoring will be documented and reported at least quarterly to the Compliance Committee and to the Board.

C. Government Investigations

SCFHP's policy is to be forthright and cooperative when dealing with government investigations, inquiries, or requests for information. Any Personnel or FDR made aware of a government investigation, inquiry or request for information is required to notify the CCO and/or Compliance Department immediately to ensure prompt response to the request(s).

Appendix A
Fraud, Waste and Abuse (FWA)
(Measures for Prevention, Detection and Correction)

SCFHP employs multiple measures to prevent, detect and correct potential instances of FWA. Many of these measures are outlined in the Compliance Program, including, for instance:

- Communicating standards of individual and organizational ethical and legal business practices in the, ~~*Reference Guide,*~~ including compliance with Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse;
- Educating Personnel and FDRs about FWA issues through appropriate training and the sharing of ~~newsletters and other~~ educational materials;
- Communicating to all (including FDRs and enrollees) the availability of an anonymous compliance hotline for potential FWA issue reporting and asking fraud related questions;
- Engaging in monitoring and auditing of Part C and Part D operations, based on risk analyses conducted that expressly consider FWA concerns;
- Engaging in timely and vigorous investigation of suspected FWA, in whatever manner reported to SCFHP;
- Responding to identified FWA, including as appropriate, by reporting to the MEDIC and/or returning identified overpayments and making adjustments to prescription drug event or other claims payment data.

SCFHP actively engages FDRs to assist in its FWA prevention, detection and correction efforts. Thus, for instance, FDRs perform compliance and FWA related activities on SCFHP's behalf, such as monitoring, auditing and training. SCFHP performs oversight of the FWA and compliance related activities of each FDR and has processes in place to revoke delegated functions in accordance with 42 C.F.R. § 42.422.504(i)(5) and42 C.F.R. § 423.505(i)(4) and its contractual rights if such functions are not being performed satisfactorily.

If identified instances of FWA are discovered, SCFHP, directly or through its FWA/SIU vendor, engages in vigorous investigation and will, as it determines appropriate, report to CMS, the MEDIC or other appropriate regulatory or law enforcement entities.

The purpose of this Appendix is to provide additional information concerning specific measures SCFHP will use to prevent, detect and correct FWA.

Targeted Efforts

A. Credentialing

SCFHP's credentialing program for contracted providers and pharmacies is comprehensive and includes elements that have both a direct and indirect effect on the quality, delivery, and outcome of health care provided to SCFHP's members. SCFHP's credentialing program is based on National Committee for Quality Assurance (NCQA) standards and in accordance with CMS requirements.

SCFHP has contracted with a PBM to provide pharmacy benefits to its members enrolled in the ~~MMP~~Plan. By contract, the PBM employs a similar, vigorous credentialing program for each

pharmacy in SCFHP's network, with each pharmacy needing to partake in the credentialing and re-credentialing process, performed at a minimum every three years, for participation, or continued participation, within the SCFHP's network.

B. Claims Adjudication

~~MMP~~ The Plan's claims are processed on a system using adjudication rules which employ FWA edits. Thus, for instance, such adjudication rules are designed to eliminate duplicate payments for services and make payment (or denial) of claims based on SCFHP eligibility rules, contracted provider pricing, referrals and authorizations and Correct Coding Initiative (CCI) edits. In addition, Local Coverage Determinations (LCDs) and national coverage determinations (NCDs) are also reviewed to ensure payment consistent with Medicare guidelines. Claims processes also ensure claims submitted, intentionally or unintentionally, by providers who have opted out of Medicare are not paid. Finally, certain check run controls are also in place to prevent inappropriate payments under Medicare or Medi-Cal.

Similarly, Part D has point of sale system edits that ensure appropriate authorizations are in place before dispensing and that prevent SCFHP from paying for prescriptions written by excluded prescribers.

C. Auditing and Data Analytics

SCFHP engages in auditing -- directly or through contracted entities -- pursuant to the terms of the annual compliance Work Plan. As part of its standing audit practice, SCFHP, by engagement of an external consultant and use of internal coding staff, performs Part C retrospective coding reviews annually. The reviewers substantiate the documentation of the Hierarchical Condition Categories (HCCs) supporting the Risk Adjustment Factors (RAF) scores submitted to CMS for member premium payment. SCFHP submits "additions" *and* "deletions" as appropriate dependent upon its ability to substantiate the HCCs within the audited documentation. In addition to ensuring accurate payment is received by the SCFHP ("adds"), and paid by CMS ("deletes"), these reviews can reveal potential fraudulent provider documentation practices and allow SCFHP to take corrective actions, as appropriate. It also allows SCFHP to identify providers who may need additional training regarding the appropriate provision of encounter data.

Where claims administration is delegated to an FDR, SCFHP audits the FDR annually for proof of data integrity, timeliness of claims payment, proper payment consistent with contractual and other requirements, and proper payment amounts.

Similarly, SCFHP has engaged its PBM to engage in analysis of pharmacy, prescribing provider, and beneficiary data to detect potentially defective claims. Such data analysis is a tool for identifying coverage and payment errors, and other indicators of potential FWA and non-compliance. To gather and analyze data to protect against FWA, on behalf of the SCFHP, the PBM, among other audits, performs retrospective (post-pay) audits. Standardized algorithms are applied to root out overpayments or erroneous payments to pharmacies. Through use of sophisticated modeling

techniques, auditors can identify patterns in the data that may indicate potential FWA that may not be readily apparent. Such data mining activities will focus on areas of concern identified by CMS in guidance and entities identified by the MEDIC, as well as known areas of potentially aberrant behavior or high incidence of fraud based on industry experience. SCFHP's PBM employs staff pharmacists, physicians and others (as appropriate) to engage in follow-up research and investigation of suspect claims.

Pharmacies within the SCFHP's network are also subject to desk top and/or onsite audit. Pharmacies can be chosen for a variety of reasons, such as aberrant claims patterns revealed through the modeling techniques noted above. Claim sample selection will focus on identifying claims and/or claims patterns that potentially deviate from the norm. SCFHP can designate particular pharmacies for in-depth audits, upon request.

If FWA is found through any of the auditing methodologies applied by the PBM, the SCFHP will receive a FWA alert and take appropriate follow-up action in a prompt manner.

In addition to PBM audits, SCFHP receives various reports daily, weekly and monthly from the PBM. The reports are reviewed promptly and on a routine basis by the SCFHP's Pharmacy Department. Review of these reports can reveal potential fraudulent activity requiring investigation and action. Examples of reports received and reviewed regularly include (but are not limited to): summaries of controlled substances claims per member; top 3% prescribers; prescriber dispensing patterns; and FWA reports, which include results of all claims adjusted or reversed during the quarter due to audit results.

Compliance Activity Report
November 14, 2019

2018 CMS Program Audit Update

The Independent Validation Audit (IVA) to assess the Plan's correction of the Conditions cited in the CMS Program Audit Final Report is complete. Based on the results of the validation audit, CMS determined that 26 of the 31 Conditions identified in the Program Audit Final report had been fully remediated, and 5 Conditions had not been fully remediated. There was also one new Condition identified. CMS acknowledged the substantial progress made by the Plan throughout the remediation period. However, because some of the 5 non-remediated Conditions impacted more than a few members, CMS was unwilling to close the Program Audit, and directed the Plan to: (1) submit corrective action plans; (2) complete remediation of the Conditions; and (3) undergo a second validation audit of those 5 initial Conditions and the new Condition.

ATTAC Consulting Group (ACG) will conduct the second validation audit. ACG is developing a proposed audit work plan and timeline that will be submitted to CMS for approval. We anticipate that the auditor's report will be submitted to CMS in May 2019.

Cal MediConnect

- The Plan received a passing score on the 2019 Medicare Data Validation Audit (MDV).
- The CMC Contract Management Team (CMT) has directed several California Plans, including SCFHP, to submit a Performance Improvement Plan (PIP) demonstrating how the Plan will improve performance related to HRAs. Apparently, California plans perform at a materially lower level than plans in other parts of the country, and the CMT is both perplexed and concerned about the discrepancy. SCFHP's PIP must address how we will bolster timely completion rates for ICPs, and is due on November 22, 2019.
- CY19 reporting elements have met the 2019 reporting deadlines. The Plan had identified that an incorrect data set was used in conjunction with incorrect revenue codes when generating Q4 2018 data for the CORE 9.1 report. The Plan informed NORC of this finding and requested a resubmission of that data, which was granted.
- Performance Measure Validation (PMV/HSAG) Audit: The Plan completed this annual Audit on September 24, 2019. The Audit reviewed measures Core 2.1 and Core 3.2. The PMV/HSAG Audit team noted areas on noncompliance but has not issued its Final Report.

Medi-Cal

DHCS implemented its plan to move County Children's Health Initiative Program (CCHIP) into Medi-Cal as of October 1, 2019, which effectively ended the Plan's Healthy Kids program. The change required the Plan to submit material modification filings with DMHC for termination of the program, and to surrender the related Knox-Keene license.

The Governor's 2019-2020 Budget includes restoration of some of the optional benefits that include: audiology, podiatric services, speech therapy, incontinence creams and washes, and optician and optical lab services. The benefits will be effective January 1, 2020. This will also carry over into Cal MediConnect. The DHCS is working with Plans on a Medi-Cal EOC errata to be sent out to the members.

CalAIM

DHCS has unveiled a multi-year plan to transform Medi-Cal through federal waiver updates and other mechanisms. The plan, known as CalAIM, requires Medi-Cal managed care plans to structure their Medi-Cal services around a population health management plan, institutes a new "enhanced care management" benefit for the highest risk members, ends the Cal MediConnect program at the end of 2022, requires managed care enrollment for most populations, institutes regional managed care rates, and makes significant changes to the county-based behavioral health systems. DHCS has set up five work groups to gather stakeholder input and surface significant issues. SCFHP was selected to serve on two of the work groups and will participate on the others indirectly through our statewide association, LHPC. Additionally, Santa Clara County has kicked off a series of similar stakeholder meetings through its Health Care Reform Stakeholder Working Group, led by Working Partnerships USA.

2019 DMHC and DHCS Audit(s)

The 2019 Full-Scope Medical Survey with DMHC and DHCS remains ongoing. The Plan has received its final DHCS Audit Report and the request for corrective action plans (CAPs) in July, with a total of 19 findings (12 for Medi-Cal and 6 for Cal MediConnect). The DHCS Audit Report was reviewed and CAP responses were submitted on August 12th. In October, the Plan received the DMHC Preliminary Report with a total of 4 findings for the Medi-Cal and Healthy Kids Medical Survey. Within 45 days of receipt of the report, the Plan will need to file a corrective action report that describes the actions the Plan has or will be taken to correct the deficiencies. The 4 deficiencies included: oversight of delegates' UM denial letter requirements, provide evidence that care is deemed authorized if the Plan does not approve/disapprove a request for post-stabilization medical care within 30 minutes of the request, Plan did not apply correct legal standard (for HK) when evaluation for medical necessity of emergency services, and the Plan did not have updated block transfer policy and procedure.

2019 Annual Network Certification

The Plan must submit to DHCS a complete and accurate Network Certification Report annually that reflects the entire network of providers, hospitals and pharmacies. DHCS is required to review and certify the Plan's network to CMS. In addition to submitting the Network Certification, the Plan submits the network information in the monthly 274 electronic data file to DHCS. The agency then samples the network to validate and compare it with other MCP networks.

For the 2019 Network Certification, DHCS imposed a CAP and monetary sanction as it found the Plan had no access to providers/specialists in a specific zip code that is "inhabitable", as indicated by the U.S. Census Bureau, but has no Plan membership. The Plan submitted its CAP response to DHCS on August 12, 2019. DHCS has completed the assessment of the Plan's CAP response and has approved/closed the Network Certification deficiencies as of September 20, 2019.

DMHC Complaints

The Plan received a total of 23 member complaints between end of August and November 2019. Four cases were forwarded to IMR.

Operational Compliance Report (Dashboard) – Corrective Actions

- Customer Service: Two remaining Medi-Cal CAPs reported in Q2 2019 have been closed.
- Case Management: For Medi-Cal, 2 CAPs for SPD HRA completion remain open due to inconsistent performance. The business unit and IT continue to work on data extraction for operational tracking.
- Grievance and Appeals: G&A current has two CAPs: CMC's Standard Grievances that Received Acknowledgement Letters within 5 days (94.0% in August and 95.5% in September) and Medi-Cal's Standard Appeals Whose Acknowledgement Letters Sent within 5 Calendar Days (97.8% in August and 97.5% in September). The missed goals were due to human error and a higher caseload. The G&A team went through timeliness training to understand received and due dates. The importance of acknowledgement letter timeliness

was reiterated. Of note, the October percentage for both measures reached at least 98.0% (measure substantially but not fully met; CAP/adverse action unlikely or not anticipated).

Utilization Management: Due to a system upgrade in July, the August and September data were identified to be inaccurate. Hence, Compliance is postponing issuing CAPs until the business unit and IT complete their data verification.

Joint Operations Committee (JOC) Meetings

The following JOCs have been held since the last Compliance Committee Meeting:

- September: PCNC, PMGSJ
- October: New Directions, MedImpact, CBHSD, HealthLogix, T&M, Shield, Language Line, VSP, Signify Health, Yellow Cab
- November: Green Cab, Kens Transportation, PCNC

HIPAA Disclosures

There were 4 incidents between September and November 2019. Two incidents involved and were reported to DHCS by Kaiser. In the first, a Kaiser employee released another person's PHI to a member. In the second, 36 totes containing prescription orders went missing from a courier's truck. Two SCFHP members' orders were among those missing. The other two incidents involved Plan staff and were reported by the Plan. A staff member sent a non-secure email containing PHI to a vendor. Additionally, it was discovered that a former employee emailed (non-securely) PHI to their personal email account.

FWA Activities

T&M (the Plan's FWA/SIU vendor) currently has 31 open cases for which it has identified anomalies through its datamining activities. T&M is currently reviewing the medical records for most of those cases, and has requested medical records for the others.

In its November 2019 Report, T&M advised that CMS released a five-pillar program integrity strategy to help modernize and protect Medicare for future generations. The pillars are:

- Stop Bad Actors. Work in collaboration with law enforcement to quickly identify, investigate and take action against those who commit healthcare fraud.
- Prevent Fraud. Shift from the "pay and chase" model to increased efforts to prevent FWA on the front end.
- Mitigate Emerging Programmatic Risks. Continue the use of prior authorization and value-based models in Medicare Advantage.
- Reduce Provider Burden. Streamline administrative work to help prevent fraud by eliminating clerical errors.
- Leverage New Technology. Leverage healthcare sector innovation to modernize and automate its program integrity tools.

Santa Clara Family Health Plan™

Santa Clara Family Health Plan – Operational Compliance Report – Calendar Year 2019

Cal MediConnect CY 2019	Goal	Q1 2019	Q2 2019	Q3 2019
ENROLLMENT				
Enrollment Materials				
% of New member packets mailed within 10 days of effective date	100%	Not Met	Met	Met
% of New Member ID cards mailed within 10 days of effective date	100%	Not Met	Met	Met
Out of Area Members				
% Compliance with OOA Member Process	100%	Met	Met	Met
CUSTOMER SERVICE				
Call Stats				
Member Queue				
Member Average Speed of Answer in Seconds	≤ 30 seconds	Not Met	Not Met	
Member Average Hold Time in Seconds	≤120 Seconds	Met	Met	Met
Member Abandonment Rate	≤5%	Met	Met	Met
Member Service Level	80% in ≤30 Seconds	Not Met	Met	Met
HEALTH SERVICES (UTILIZATION MANAGEMENT)				
Pre-Service Organization Determinations				
Standard Part C				
% of Timely Decisions made within 14 days	100%	Met	Met	Met
Expedited Part C				
% of Timely Decisions made within 72 Hours	100%	Met	Met	Not Met
Urgent Concurrent Organization Determinations				
% of Timely Decisions made within 24 hours	100%			Not Met
Post Service Organization Determinations				
% of Timely Decisions made within 30 days	100%	Met	Met	Met
HEALTH SERVICES (CASE MANAGEMENT)				
HRAs and ICPs				
% of HRAs completed in 45 days for High Risk Members	100%	Met	Met	
% of HRAs completed in 90 days for Low Risk Members	100%	Met	Met	
% of ICPs completed within 30 days for High Risk Members	100%	Met	Met	
% of ICPs completed within 30 working days for Low Risk Members	100%	Not Met	Met	
General HRA % Completion	100%			Met
General ICP % Completion	100%			Not Met

Medi-Cal CY 2019	Goal	Q1 2019	Q2 2019	Q3 2019
ENROLLMENT				
Enrollment Materials				
% of New member packets mailed within 7 days of effective Ddte	100%	Met	Met	Met
% of New Member ID cards mailed within 7 days of effective date	100%	Met	Met	Met
CUSTOMER SERVICE				
Call Stats				
Member Queue				
Member Average Speed of Answer in Seconds	≤ 30 seconds	Not Met	Not Met	
Member Average Hold Time in Seconds	≤120 Seconds	Not Met	Met	
Member Abandonment Rate	≤5%	Not Met	Met	
Member Service Level	80% in ≤30 Seconds	Not Met	Not Met	
Member Average Speed of Answer in Seconds	≤600 Seconds			Met
% of Reports Submitted Timely	100%			Met
HEALTH SERVICES (UTILIZATION MANAGEMENT)				
Medical Authorizations				
Routine Authorizations				
% of Timely Decisions made within 5 Business Days of request	95%	Met	Met	Met
Expedited Authorizations				
% of Timely Decisions made within 72 Hours of request	95%	Met	Met	Met
Urgent Concurrent Review				
% of Timely Decisions made within 24 Hours of request	95%			Met
Retrospective Review				
% of Retrospective Reviews completed within 30 Calendar Days of request	95%	Met	Met	Met
HEALTH SERVICES (CASE MANAGEMENT)				
Initial Health Assessment				
% of High Risk SPD Members who completed HRA in 45 days	100%	Not Met	Not Met	Not Met
% of HRAs completed in 90 days for Low Risk SPD Members	100%	Not Met	Not Met	Not Met
% of HRAs completed in 45 days for High Risk MLTSS Members	100%	Report Pending	Not Met	
% of HRAs completed in 90 days for Low Risk MLTSS Members	100%	Report Pending	Not Met	
% Overall compliance for High Risk SPD ICP requirements	100%			Not Met

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

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Santa Clara Family Health Plan – Operational Compliance Report – Calendar Year 2019

Cal MediConnect CY 2019	Goal	Q1 2019	Q2 2019	Q3 2019
CLAIMS				
Non-Contracted Providers				
% of Clean Claims to Non-Contracted Providers processed within 30 days	90%	Met	Met	Met
Contracted Providers				
% of Claims to Contracted Providers processed within 45 days	90%	Met	Met	Met
% of Claims to Contracted Providers processed within 90 days	99%	Met	Met	Met
% of Claims to Contracted Providers processed beyond 90 days	≤1%	Met	Met	
PHARMACY - PART D				
Standard Part D Authorization Requests				
% of Standard Prior Authorizations completed within 72 Hours	100%	Met	Met	Met
Expedited Part D Authorization Requests				
% of Expedited Prior Authorizations completed within 24 Hours	100%	Met	Met	Met
Other Pharmacy Requirements (SCFHP)				
Formulary posted on website by 1st of the month	100%	Met	Met	
Step Therapy posted on website by 1st of the month	100%	Met	Met	
PA criteria posted on website by 1st of the month	100%	Met	Met	
% MTM/CMR Completion Rate	22%	Met	Met	
Other Pharmacy Requirements (MedImpact)				
Provider/Pharmacy Average Hold Time in Seconds	100%			Met
Provider/Pharmacy Service Level	100%			Met
Disconnect Rate	100%			Met
Disconnect Rate from CMS Quarterly Report (part D)	22%			Met

Medi-Cal CY 2019	Goal	Q1 2019	Q2 2019	Q3 2019
CLAIMS				
All Claims				
% Claims Processed within 45 business days / 62 calendar days	95%			Met
% Claims Processed within 90 calendar days	99%			Met
% Misdirected Claims forwarded within 10 business days	95%			Met
Clean Claims				
% Practitioner/CBAS/SNF Claims Processed within 30 calendar days	90%			Met
% of Claims Processed to Non Practitioners, SNF CBAS Providers within 45 wrk days	99%			Met
Non-Contracted Providers				
% of Clean Claims to Non-Contracted Providers processed within 30 days	90%	Met	Met	
Contracted Providers				
% of Claims to Contracted Providers processed within 45 working days	95%	Met	Met	
Provider Claim Dispute Requests				
% of Provider Disputes Acknowledged within 15 business days	95%			Met
% of Contracted Provider Disputes Processed within 45 days	95%	Met	Met	Met
Overturned Cases with Check Provided Within 5 Business Days				
% Overturned Cases with Check Provided Within 5 Business Days	95%			Met
PHARMACY				
Standard Authorization Request				
% of Standard Prior Authorizations completed within 24-hours July 1 2017	95%	Met	Met	Met
Expedited Authorization Request				
% of Standard Prior Authorizations completed within 24-hours July 1 2017	95%	Met	Met	Met
HEALTH SERVICES (QUALITY)				
Facility Site Reviews				
% of FSRs completed timely	100%		Met	Met

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

Santa Clara Family Health Plan™

Santa Clara Family Health Plan – Operational Compliance Report – Calendar Year 2019

Cal MediConnect CY 2019	Goal	Q1 2019	Q2 2019	Q3 2019
GRIEVANCE & APPEALS				
Grievances, Part C				
Standard Grievances Part C				
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in < 5 calendar days	100%	Not Met	Not Met	Not Met
% of Standard Grievances resolved within 30/44 days	100%	Met	Met	Met
Expedited Grievances Part C				
% of Expedited Grievances resolved within 24 hours	100%	Met	Met	Met
Grievances, Part D				
Standard Grievance Part D				
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in < 5 calendar days	100%	Met	Met	Met
% of Standard Grievances resolved within 30/44 days	100%	Met	Met	Met
Expedited Grievance Part D				
% of Expedited Grievances resolved within 24 hours	100%	Met	Met	Met
Reconsiderations, Part C				
Standard Pre-Service Part C				
% of Standard Pre-Service Reconsiderations that received Acknowledgement Letters within 5 days	100%	Not Met	Met	Met
% of Standard Pre-Service Reconsiderations resolved within 30/44 days	100%	Met	Met	Met
Standard Post-Service Part C				
% of Standard Post-Service Reconsiderations resolved within 60 days	100%	Met	Met	Met
Expedited Pre-Service Part C				
% of Expedited Pre-Service Reconsiderations resolved with oral notification to member within 72 Hours	100%	Met	Met	
% of Expedited Pre-Service Reconsiderations resolved with written notification to member within 72 Hours	100%	Met	Met	
% of Expedited Redeterminations grouped on Resolution Letter Date and resolved within 72 hours	100%			Met
% Expedited Pre-Service Reconsiderations (upheld & untimely) submitted to IRE within 24-hours of decision	100%	Met	Met	Met
Redeterminations, Part D				
Standard Part D				
% of Standard Redeterminations resolved within 7 calendar days	100%	Met	Met	Met
Expedited Part D				
% of Expedited Redeterminations resolved with oral notification to member within 72 Hours	100%	Met	Met	
% of Expedited Redeterminations resolved with written notification to member within 72 hours	100%	Met	Met	
% of Expedited Redeterminations grouped on Resolution Letter Date and resolved within 72 hours with Resolution Letter and Oral Notification	100%			Met
% of Untimely Expedited Redeterminations Submitted to IRE within 24 Hours of decision	100%		Met	Met
Complaint Tracking Module (CTM) Complaints				
% Resolved Timely	100%	Met	Met	Met

Medi-Cal CY 2019	Goal	Q1 2019	Q2 2019	Q3 2019
GRIEVANCE & APPEALS				
Grievances				
Standard Grievances				
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in < 5 calendar days	100%		Not Met	Met
% of Grievances resolved within 30 days	100%	Met	Not Met	Met
Expedited Grievances				
% of Expedited Grievances grouped on Resolution Letter Date and resolved within 72 hours	100%	Met	Met	Met
% of Expedited Grievances that received Oral Notification within 72 hours	100%	Met	Met	
% of Expedited Grievances that received Resolution Letter within 72 hours	100%	Met	Met	
Appeals				
Standard Appeals				
% of Acknowledgement Letters sent within 5 calendar days	100%	Not Met	Not Met	Not Met
% of Standard Appeals resolved within 30/44 calendar days	100%	Met	Met	Met
Expedited Appeals				
% of Expedited Appeals grouped on Resolution Letter Date and resolved within 72 hours	100%	Not Met	Met	Met

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

Santa Clara Family Health Plan™

Santa Clara Family Health Plan – Operational Compliance Report – Calendar Year 2019

Cal MediConnect CY 2019	Goal	Q1 2019	Q2 2019	Q3 2019
PROVIDER RELATIONS				
Provider Directories updated monthly by the first day of the month	100%	Met	Met	Met
Annual Health Service Delivery Tables Submission	100%	Met	Met	Met
Monthly Excluded Provider Screening Completed (Independent Providers)	100%	Met	Met	Met
MARKETING				
% of Marketing Materials Submitted for Approval	100%	Met	Met	Met
% of Materials Posted to the Website	100%			Met
Web review completed	100%			Met
Annual member materials distributed on schedule	100%			Met
Annual MCMG training completed	100%			Met
FINANCE				
% of Encounters successfully submitted to CMS	95%	Met	Met	Met
% of Encounters submitted to CMS within 180 days of date of Service	80%	Met	Met	Met
% of RAPS records successfully submitted to CMS (not duplicate)	95%	Met	Met	Met

Medi-Cal CY 2019	Goal	Q1 2019	Q2 2019	Q3 2019
PROVIDER NETWORK MANAGEMENT				
% of New Independent Providers Rec'd Orientation within 10 days	100%	Met	Met	Met
Monthly Excluded Provider Screening Completed	100%	Met	Met	Met
Timely Access Surveys (due in June)	100%	Met	Met	Met
Annual Network Certification	100%	Met	Met	Met
INFORMATION TECHNOLOGY				
% Encounter Files Successfully Submitted to DHCS by end of month	100%	Met	Met	Met
% Monthly Eligibility Files successfully submitted to Delegates Timely	100%	Met	Met	Met
% 274 File submitted to DHCS by the 10th of Each Month	100%	Met	Met	Met

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

Santa Clara Family Health Plan™

Santa Clara Family Health Plan – Operational Compliance Report – Calendar Year 2019

Company Wide Compliance CY 2019				
	Goal	Q1 2019	Q2 2019	Q3 2019
COMPLIANCE TRAINING				
% New Employee Training Completed Timely	100% completed within 3 business days	Met	Not Met	Met
% Annual Employee Training Completed	100% completed by year end	Met	Met	Met
BOARD OF DIRECTORS TRAINING				
% Annual Board Training Completed Timely	100% completed by year end	Annual Measure	Met	Met
HUMAN RESOURCE				
Excluded Individual Screening Completed Monthly	100%	Met	Met	Met
INTERNAL AUDITS				
% of Internal Audits Completed	100% completed by year end	Met	Met	Met
DELEGATION OVERSIGHT				
% of Scheduled Audits Completed	100%	Met	Met	Met
REPORTING				
% of CMC Routine Reports Submitted Timely	100%	Met	Met	Met
% of Medi-Cal Routine Reports Submitted Timely	100%	Met	Not Met	Met
FILINGS				
% of Key Personnel Filings Timely	100%	Met	Met	Met

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, November 19, 2019, 6:00 PM - 8:00 PM
Santa Clara Family Health Plan, Redwood
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Ria Paul, MD, Chair
Jimmy Lin, MD
Jennifer Foreman, MD
Christine Tomcala, Chief Executive Officer
Ali Alkoraishi, MD

Members Absent
Jeffrey Arnold, MD
Nayyara Dawood, MD
Laurie Nakahira, D.O., Chief Medical Officer

Staff Present
Chris Turner, Chief Operating Officer
Johanna Liu, PharmD, Director, Quality & Process Improvement
Robin Larmer, Chief Compliance and Regulatory Affairs Officer
Tanya Nguyen, Director, Customer Service
Victor Hernandez, Program Manager, Grievance and Appeals Quality Assurance
Jamie Enke, Manager, Process Improvement

Others Present
Carmen Switzer, Manager, Provider Network Access *(via telephone)*

1. **Introduction**

   Ria Paul, Chair, called the meeting to order at 6:09pm. Roll call was taken and a quorum was established.

2. **Meeting Minutes**

   Minutes of the August 14, 2019 Quality Improvement Committee (QIC) meeting were reviewed.

   > **It was moved, seconded, and** the minutes of the August 14, 2019 Quality Improvement Committee meeting were **unanimously approved**.

3. **Public Comment**

   There were no public comments.

4. **CEO Update**

   Christine Tomcala, Chief Executive Officer, announced gift bags were assembled for all committee members as a thank you for their help, time, and work invested throughout the year.

Ms. Tomcala announced membership is currently at 240,641, which is a slight decrease as anticipated. The Cal MediConnect (CMC) population stands at 8,289 and continues to increase through the hard work of SCFHP's Outreach team. As discussed in the last meeting, Healthy Kids is down to two members. The County expanded the income range on their analysis program, which offers the two children on Healthy Kids an opportunity to apply for Valley Kids. Once this transition takes place, Healthy Kids will come to an end by the end of this year.

Ms. Tomcala announced there is a new set of proposals called CalAIMS, California Advancing and Innovating Medi-Cal. CalAIMS was recently released on October 28, 2019. These proposals will use Medi-Cal as a tool for the Governor to address some of the challenges including, homelessness, insufficient access to behavioral health care, and children with complex medical needs. There are three stated goals for CalAIMS. One is to identify and manage member risks and needs to whole person care as well as address the social determinants of health. The second goal is to decrease complexity of Medi-Cal's system by increasing flexibility and consistency within the system. The third goal is to improve quality outcomes and drug delivery system transformation through value based initiatives, modernization systems, and technical forum. Shall the CalAIMS proposal remain, SCFHP's health population will ultimately be impacted, resulting in the required replacement of the CMC program with the Dual Special Needs Program (DSNP).

Ms. Tomcala added, by year 2025, SCFHP will need to have NCQA accreditation, as well as a delegate format. Also, there are a couple of Prop 56 pediatric initiatives in progress.

This concludes Ms. Tomcala's update.

5. Follow-Up / Old Business

There were no follow-up items.

6. Action Items

a. Accessibility of Provider Network Assessment MY2019

Carmen Switzer, Manager of Provider Network Access, reviewed the results of the annual Accessibility of Provider Network survey for CMC. The purpose of this survey is to ensure SCFHP's contracted providers are in compliance with timely access standards. The surveys conducted every year include: Provider Appointment and Availability Survey, After-Hours Survey, CAHPS, and Member Grievance. Ms. Switzer noted that this report does not include VHP or Kaiser as they conduct their own surveys. The providers from the groups included in this survey are Palo Alto Medical Foundation (PAMF), Premier Care (PC), and Physician's Medical Group (PMG).

Ms. Tomcala asked if Ms. Switzer would be able to share the results from VHP's survey as VHP has a large portion of SCFHP's membership. Ms. Switzer agreed to share both VHP's and Kaiser's survey results once they release them, typically in the spring. Chris Turner, Chief Operating Officer, asked if the survey results for VHP and Kaiser for 2018 can be shared at next QIC meeting. Ms. Switzer agreed.

Ms. Switzer explained the methodology used in the Provider Appointment and Availability Survey follows the DMHC's methodology to administer the provider appointment availability survey (PAAS). The following provider types were included in the survey:

- Primary Care Providers (PCP)
- High Volume Specialists
- High Impact Specialists
- Behavioral Health Providers

For the After-Hours Survey, SCFHP issued provider contact lists to the survey vendor and the following provider types are included in the survey:

- PCP
- Behavioral Health (BH)

Ms. Switzer reported there were 361 providers that were surveyed for urgent care appointments within 48 hours. The PCP's rate of performance fell short of goal by 22 percentage points at 68%, however, performance improved by 1 percentage point from 2018. The raw data report showed that the highest rate of response for non-urgent care appointments was from PAMF at 53%, and the rate of compliance was at 43%. The other group's performance rates were at 95% or higher. PAMF increased participation in 2019 at 29% and the other group's participation rates were nearly the same from 2018.

There were 361 providers that were surveyed for non-urgent care appointments within 10 days. The PCP's rate of performance fell short of goal by 6 percentage points at 84%, and there was a decrease in performance by 7 percentage points from 2018. The raw data report showed that the highest rate of response for non-urgent care appointments was from PAMF at 58%, and rate of compliance was at 76%. The other group's rate of compliance was at 95% or higher and PMG increased performance from 90% to 100% in 2019. PAMF's participation increased in 2019 at 27% and the other groups participation rates were nearly the same from 2018.

Ms. Switzer reported there were 504 PCP providers that were surveyed for compliance in providing 911 information in an after-hours answering machine message. The PCP rate of compliance is at 82%; a decrease in performance by 10 percentage points from 2018. The raw data showed 1 PAMF phone number which represents 46 PCP providers was non-compliant, therefore, SCFHP conducted a resurvey and confirmed this phone number did not have the 911 message. PAMF was contacted and they agreed to update the message on this phone line. Following the updated PAMF message, the overall rate of compliance for PCP providers is at 93%; 3 percentage points above goal.

Continuing the after-hours survey, 504 PCP providers were surveyed for their timeliness compliance in returning calls within 30 minutes or less of receiving a voice message. The PCP rate of compliance is at 54%; an increase in performance by 2 percentage points from 2018. PAMF showed the highest non-compliant rate at 69%, followed by PMG at 20%.

There were 328 Behavioral Health providers surveyed for their compliance in providing 911 information in an after-hours answering machine. The BH provider rate of compliance is at 80%; an increase in performance by 9 percentage points from 2018. PAMF had a total of 33 providers and/or groups on the contact list, of which 85% were compliant. Non-compliance providers and/or groups in 2019 were issued a Corrective Action Plan (CAP) and provider outreach will be conducted by the Provider Network Management (PNM) department.

Of those 328 Behavioral Health providers, the rate of compliance for timeliness compliance in returning calls within 30 minutes or less of receiving a voice message, is at 40%; a decrease in performance by 7 percentage points from 2018. PAMF showed the highest non-compliant rate at 69%, followed by PMG at 20%.

Ms. Switzer reported the results for urgent care appointments within 96 hours with a Specialist were not sufficient enough to draw a meaningful conclusion. The raw data showed that direct providers and PAMF Cardiology had the lowest performance rates for urgent appointments. The other provider group's performance rates were at 88% or higher. The response rates for non-urgent/routine care appointments within 15 days with a Specialists were not sufficient enough to draw conclusions. The raw data showed that direct providers and PAMF Cardiology providers had the lowest performance outcomes for non-urgent appointments. The other provider group's compliance rates were at 88% or higher.

There were 83 Psychiatry providers that were surveyed, 12 of which responded and answered all questions in 2019.In both 2018 and 2019, no providers answered the “non-life threatening emergency within 6 hours.” Overall results were not sufficient to draw meaningful conclusions.

Ms. Tomcala asked if SCFHP is looking for Autism providers that fall under Behavioral Health Treatment (BHT). Ms. Switzer was asked by Ms. Turner if she could follow-up on this.

Ms. Switzer reported Psychology providers had a low response rate in 2019, with a compliance rate of 50% or lower. The same of which applies to Non-Physician Mental Health providers. However, there were 5 providers who participated in 2018 with similar results. The respondents (5) in 2018 met the “follow up routine care within 30 days” measure at 100%.

Ms. Switzer reported Marriage/Family Therapists were identified as a high volume provider in 2019. This provider type also had a low response rate in 2019, and in 2018 there was only 1 respondent. Therefore, meaningful conclusions could not be drawn.

Ms. Switzer summarized the CAHPS survey results. The data collection showed there were several letters mailed out, with the option of completing the survey in a language other than English. The results reflect that although the goal was not met for any measures, member satisfaction improved in 4 out of 7 measures from 2018. The measure most improved was “getting care needed right away” with an increase of 7.78 percentage points from 2018.

Ms. Switzer reviewed the ratings of the health plan. On a 0 to 10 scale, about 9 in 10 gave SCFHP a rating of 7, 8, 9, or 10, which is not significantly different from two years ago. About 6 in 10 gave SCFHP a rating of 9 or 10.

Ms. Switzer reviewed the assessment on Member Access Grievances. The Access Complaint Record June 2018-June 2019 reflects 38% of member complaints were associated with appointments, which appeared to be readily resolved by SCFHP’s Customer Service department. Most other complaints were relevant to communication issues where members and provider offices were unaware of authorization and referral requirements and/or timelines.

Ms. Switzer reviewed barriers and opportunities of improvement. The barriers include:

- Timely access to urgent and non-urgent appointments
- In office wait times
- Timely Access – Behavioral Health non-life threatening emergency within 6 hours, after-hour messaging that advises patients of 911 information as well as an on-call provider that will call back within 30 minutes

  The opportunities include:
  - o Improve access to urgent, non-urgent care appointments
  - o Improve office wait times
  - o Increase the number of BH providers within SCFHP’s network
  - o Educate PCP and BH providers on after-hours messaging

  The interventions include:
  - o Require access training from providers who show continued non-compliance through resurveys
  - o Distribute SCFHP’s Timely Access Matrix to network providers via fax blast
  - o Explore contracting opportunities to expand BH network
  - o Distribute SCFHP’s Timely Access Matric to network providers
  - o Provider outreach

It was moved, seconded, and the Accessibility of Provider Network Assessment MY2019 was **unanimously approved**.

b. Member Services E-mail Response Evaluation

Tanya Nguyen, Director of Customer Service, explained SCFHP has a responsibility to provide accurate, quality information on health plan services to members through the website, over the telephone, and through e-mail. SCFHP ensures that members can contact the organization through e-mail for any reason and receive a response within one business day. Personal information on health plan services may change periodically throughout the year, therefore, SCFHP has an obligation to be sure the information submitted to members via e-mail is accurate, current, and timely. This is accomplished by measuring and evaluating the quality and accuracy of the information. Deficiencies will be documented and addressed as process improvement.

Ms. Nguyen explained the process in which the Customer Service department responds and tracks e-mail responses. SCFHP then audits the information on e-mail turnaround time and the quality of the e-mail response on a quarterly basis. The data is then rolled up into an annual rate for comparison year over year.

Ms. Nguyen reviewed the results on timeliness and quality of e-mail responses. There were a total of 18 e-mails received from Q3-2018 through Q2-2019. SCFHP received a score of 100% on all four measures, which include:

- Responses sent to Member within one business day
- The response comprehensively addresses the member's request
- No spelling errors identified
- Customer Service contact information provided

It was moved, seconded, and the Member Services E-mail Responses Evaluation was **unanimously approved**.

7. Discussion Items

a. Appeals and Grievances

Victor Hernandez, Grievance and Appeals Quality Assurance Program Manager, reported the total number of cases received in 2019 were 469, 281 of which were for Medi-Cal and Healthy Kids, and 188 of which were from CMC. In 2018, the total number of cases received were 311. Since 2018, there has been an increase in membership, which can lead to an increase in the amount of cases received.

Mr. Hernandez identified the top three Medi-Cal grievance categories as Quality of Service, Quality of Care, and Access. The top 3 Medi-Cal grievance subcategories are Quality of Service – Transportation, Quality of Care – Inappropriate Provider Care, and Access – Timely Access to Specialist.

Mr. Hernandez reviewed the Medi-Cal Pharmacy appeals by determination. The determinations include, Overturn, Partially Favorable, Uphold, and Dismissed. For the pharmacy Overturn and Partially Favorable, the main determination is medical necessity met. For pharmacy Uphold, the main determination is no evidence to overturn.

Mr. Hernandez reported an increase in cases for CMC from 2018 to 2019. The top three CMC grievance categories are Quality of Service, Quality of Care, and Access. The subcategories are Quality of Service – Balance Billing, Quality of Service – Transportation Services, Quality of Service – CHME Delivery Date.

b. Initial Health Assessments (IHA)

Johanna Liu, PharmD, Director of Quality and Process Improvement, reviewed the requirements for the Initial Health Assessment (IHA) to be completed. The IHA requires completion within the first 120 days of plan enrollment. There are five elements required for completion credit:

- Comprehensive history

- Administration of preventive services (screenings, immunizations, etc.)
- Comprehensive physical and mental status exam
- Diagnosis and plan of care
- Staying Healthy Assessment (SHA) Questionnaire

New criteria has been added for 2019 review which include, outreach attempts by providers for members who haven't scheduled the IHA or have cancelled the appointment. Documentation is required within the medical record as well as two attempts via telephone and mail.

Dr. Liu reported a 90% IHA records retrieval rate in Q1 and a rate of 62% for Q2. The IHA audit compliance results reflect a total of 26% being fully compliant in Q1 and 12% in Q2. SHA is the element with greatest opportunity for improvement. Other areas of improvement include, improving provider education regarding required documentation, outreach, and ongoing support based on provider feedback. Helping keep members informed of when the IHA is due, adding IHA reminders to the Member Portal, and timely member education regarding need for IHA and portal use, are additional areas for improvement.

8. Committee Reports

a. Credentialing Committee

Dr. Liu asked if the committee would accept the written report rather than a verbal report as Dr. Nakahira was unable to attend. The committee reviewed the Credentialing Committee report for September 26, 2019.

It was moved, seconded, and the September 26, 2019 Credentialing Committee Report was **unanimously approved**.

b. Pharmacy and Therapeutics Committee

Minutes of the June 20, 2019 Pharmacy and Therapeutics Committee (P&T) meeting were reviewed by Jimmy Lin, MD.

It was moved, seconded, and the June 20, 2019 Pharmacy and Therapeutics Committee meeting minutes were **unanimously approved**.

c. Utilization Management Committee

Minutes of the July 17, 2019 Utilization Management Committee (UMC) meeting were reviewed by Dr. Lin.

It was moved, seconded, and the July 21, 2019 Utilization Management Committee meeting minutes were **unanimously approved**.

d. Compliance Report

Robin Larmer, Chief Compliance and Regulatory Affairs Officer, reported SCFHP engaged an audit firm (ATTAC Consulting Group) to conduct an Independent Validation Audit (IVA) to validate the Plan's correction of the conditions cited in the CMS Program Audit Final Report. The Compliance Program Effectiveness (CPE) portion of the IVA is complete. The Plan submitted its final universes for the remaining audit areas on August 16, 2019, Universe integrity testing will be conducted on August 21 and 23, and fieldwork will begin on August 26, 2019 and continue through September10, 2019.

Ms. Larmer reported the 2019 Medicare Data Validation Audit (MDV) is complete. In all but one area the Plan received passing scores. In addition, the 2020 Plan Benefit Package (PBP) was submitted prior to the June 3 deadline and subsequently revised to address DHCS and CMS questions. The Plan has been preparing for the annual Performance Measure Validation Audit which has been scheduled for September 24, 2019.

DHCS is moving forward with the Plan to move County Children's Health Initiative Program (CCHIP) into Medi-Cal, effective October 1, 2019. This means the Plan's Healthy Kids program effectively ends.

Ms. Larmer reported the 2019 Full-Scope Medical Survey with DMHC and DHCS remains ongoing. The Plan has received its final DHCS Audit Report and the request for corrective action plans (CAPs) in July, with a total of 19 findings. The DHCS Audit Report was reviewed and CAP responses were submitted on August 12th. The Plan has not yet received the DMHC Final Report.

Additionally, the Plan must annually submit to DHCS a complete and accurate Network Certification Report that reflects the entire network of providers, hospitals, and pharmacies. DHCS is required to review and certify the Plan's network to CMS. In addition to submitting the Network Certification, the Plan submits the network information in the monthly 274 electronic data file to DHCS. The agency then samples the network to validate and compare it with other MCP networks.

Ms. Larmer reported a total of 41 member complaints between June and August 2019. Four cases were forwarded to IMR. The Compliance team is looking into the reason(s) for the significant increase in complaints over the last two quarters.

e. Quality Dashboard

Dr. Liu reviewed what a Facility Site Review (FSR) is. A FSR is a 3 part evaluation of all PCPs and high volume specialists to audit provider offices for patient safety. Dr. Liu reported 100% of FSR's passed with 80% or higher in Q2 2019.

An IHA is a comprehensive assessment completed during a new Medi-Cal member's initial visit with their PCP within 120 days of joining the plan. Dr. Liu reported a completion rate of 43.3% in June, 46.8% in July, and 47.4% in August 2019. The Quality Improvement department is currently developing a work plan to improve the IHA completion rate.

Dr. Liu reported a 100% of June's Potential Quality of Care Issues (PQI) cases were closed on time. 88% of PQIs due in Q3 were closed on time.

Dr. Liu announced Health Homes Program (HHP) launched July 1, 2019 with six Community Based Care Management Entities (CB-CME). HHP is designed to coordinate care for Medi-Cal beneficiaries with chronic conditions and/or substance use disorders. 130 members have verbally consented into Health Homes as of September 27, 2019.

Dr. Liu reported a total number of 159 PQIs received in Q2 investigated by the Quality Team. Network 20 (VHP) has the highest number of cases (38) of level 1 issues.

Dr. Liu shared SCFHP is partnered with two different health centers, Indian Health Center and Gardner Health Center, to facilitate Cervical Cancer Screening (CCS) Clinic Days. Members are scheduled for a pap smear and those who complete the test are given a $30 gift card at the end of their appointment. Dr. Liu reported an average of 58% completion rate for Clinic Days as of September 26, 2019.

9. Adjournment

The next QIC meeting will be on December 4, 2019. The meeting was adjourned at 7:51pm.

_____ _____

Ria Paul, MD, Chair of Quality Improvement Committee Date

Santa Clara Family Health Plan™

Accessibility of Provider Network – MY2019
Cal MediConnect

Prepared by: Carmen Switzer, Provider Network Access Manager

For review and approval by the Quality Improvement Committee

November 19, 2019

Introduction

In order to ensure that SCFHP's contracted providers are in compliance with timely access standards, the Plan monitors and reports through administering surveys.

- The following survey assessments are included in this report:
  - ❑ Provider Appointment Availability Survey
  - ❑ After Hours Survey
  - ❑ CAHPS
  - ❑ Member Grievance

* SCFHP has a Plan-to-Plan arrangement for delivery of care with Valley Health Plan (VHP) and Kaiser and they conduct their own surveys; thus, this report does not include VHP or Kaiser survey results. The providers and groups included in this survey are Direct (individually contracted providers), Palo Alto Medical Foundation (PAMF), Physician Medical Group (PMG) and Premier Care (PC).

Provider Appointment and Availability Survey

Santa Clara Family Health Plan

Methodology

- SCFHP follows the DMHC's methodology to administer the provider appointment and availability survey (PAAS).
- SCFHP issued provider contact lists to the survey vendor and the following provider types were included in the survey:

  - ❑ Primary Care Providers
  - ❑ High Volume Specialists
  - ❑ High Impact Specialists
  - ❑ Behavioral Health Providers

- Survey dates:

  - ❑ Wave I - May 30, 2019 - June 24, 2019
  - ❑ Wave II - July 17, 2019 – August 9, 2019.

- The survey was initiated by fax and email with a telephone follow-up.

After Hours Survey

Methodology

- SCFHP issued provider contact lists to the survey vendor and the following provider types are included in the survey:
  - ❑ PCP (N=469)
  - ❑ BH (N=299)
- Survey dates:
  - ❑ July 1, 2019 – July 31, 2019
  - ❑ Pacific Standard Time (6:00 pm - 8:00 am on weekdays, and all day on weekends)
- The survey was initiated by telephone.

Measures

Santa Clara Family Health Plan

Table I: Appointments and After-Hours

Provider Type	Urgent Appointment	Non-Urgent/ Routine Appointment	Non-Life Threatening Appointment	Follow-up Care	After-Hours Care
Family Practice	48 hours	10-days	NA	NA	24-hours / 7-days a week
General Medicine	48 hours	10-days	NA	NA	24-hours / 7-days a week
Internal Medicine	48 hours	10-days	NA	NA	24-hours / 7-days a week
Oncology (HIS)	96 hours	15-days	NA	NA	NA
Gynecology (HVS)	96 hours	15-days	NA	NA	NA
Cardiology (HVS)	96 hours	15-days	NA	NA	NA
Ophthalmology (HVS)	96 hours	15-days	NA	NA	NA
BH - Prescribers	48 hours	10-days	6-hours	30-days	NA
BH – Non-Prescribers	48 hours	10-days	6-hours	30-days	NA

The table includes appointment and after-hours measures for Primary Care, High Volume Specialists (HVS), High Impact Specialists (HIS) and Behavioral Health (BH) Prescribers and Non-Prescribers.

Results

The percentage of PCP respondents at 55% provided a statistically valid sample from which conclusions could be drawn. PCP respondents increased by 20% in 2019.

Table II: Primary Care Provider (PCP)

A. Standard: Urgent Care Appointment within 48-hours

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=361)	199	90%	No	68%	+1

- PCP's rate of performance fell short of goal by 22 percentage points at 68%; however, performance improved by 1 percentage point from 2018.
- The raw data report showed that the highest rate of response for non-urgent care appointments was from Palo Alto Medical Foundation (PAMF) at 53%, and the rate of compliance was at 43%.
- The other groups performance rates were at 95% or higher.
- PAMF increased participation in 2019 at 29% and the other group's participation rates were nearly the same from 2018.

Results

B. Standard: Non-Urgent/Routine Appointment within 10-days

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=361)	218	90%	No	84%	-7

- PCP's rate of performance fell short of goal by 6 percentage points at 84%, and there was a decrease in performance by 7 percentage points from 2018.
- The raw data report showed that the highest rate of response for non-urgent care appointments was from Palo Alto Medical Foundation (PAMF) at 58%, and rate of compliance was at 76%.
- The other group's rate of compliance was at 95% or higher and PMG increased performance from 90% to 100% in 2019.
- PAMF's participation increased in 2019 at 27% and the other groups participation rates were nearly the same from 2018.

Results

C. After-Hours – PCP Access Compliance: 911 Information

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=504)	453	90%	No	82%	-10

- PCP rate of compliance is at 82%; a decrease in performance by 10 percentage points from 2018.
- The raw data showed one PAMF phone number which represents 46 PCP providers was non-complaint therefore SCFHP conducted a resurvey and it was confirmed that this phone number did not have the 911 message.
- PAMF was contacted and they agreed to update the message on this phone line.
- It is worth noting that following the updated PAMF message, the overall rate of compliance for PCP providers is at 93%; 3 percentage points above goal.

Results

D. After-Hours – PCP Timeliness Compliance: 30-minutes or less

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=504)	453	90%	No	54%	+2

- PCP rate of compliance is at 54%; an increase in performance by 2 percentage points from 2018.
- PAMF showed the highest non-compliant rate at 69%, followed by PMG at 20%.
- Provider education should be a focus point to ensure provider after-hours messaging states that a return call will be made to the patient within 30-minutes.

Results

E. After-Hours – Behavioral Health Access Compliance: 911 Information

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
BH (N=328)	299	90%	No	80%	+9

- BH rate of compliance is at 80%; an increase in performance by 9 percentage points from 2018.
- Following survey results from 2018, provider outreach was conducted which may have contributed to performance improvements in 2019.
- There were a total of 263 Direct providers and/or groups on the contact list of which 80% were compliant.
- PAMF had a total of 33 providers and/or groups on the contact list of which 85% were compliant.
- Non-compliant providers/groups in 2019 were issued a CAP and provider outreach will be conducted by the PNM department.

Results

F. After-Hours – Behavioral Health (BH) Timeliness Compliance: 30-minutes or less

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
BH (N=328)	299	90%	No	40%	-7

- BH rate of compliance is at 40%; a decrease in performance by 7 percentage points from 2018.
- PAMF showed the highest non-compliant rate at 69%, followed by PMG at 20%.
- Provider education should be a focus point to ensure provider after-hours messaging states that a return call will be made to the patient within 30-minutes.

Results

Although SCFHP made efforts to increase the number of respondents in 2019 by improving provider demographic data and enhancing provider communications, the rate of response did not increase from 2018.

Table III: Specialists – High Volume and High Impact

A. Standard: Urgent Care Appointment within 96-hours

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Cardiology (N=134)	33	90%	No	68%	-3
Gynecology (N=187)	44	90%	No	47%	-34
Ophthalmology (N=89)	22	90%	No	62%	-38
*Oncology (N=74)	20	90%	No	58%	+2

- Response rates were not sufficient enough to draw meaningful conclusions.
- The raw data showed that Direct and PAMF Cardiology had the lowest performance rates for urgent appointments:
  - ❑ Direct at 35%
  - ❑ PAMF at 50%
- The other provider groups (PMG and PC) performance rates were at 88% or higher.
- Performance outcomes on the other specialty types had similar results.

Results

B. Standard: Non-Urgent/Routine Care Appointment within 15-days

Provider Group	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Cardiology (N=134)	33	90%	No	81%	+11
Gynecology (N=187)	27	90%	No	57%	-33
Ophthalmology (N=89)	14	90%	No	87%	-9
Oncology (N=74)	12	90%	No	84%	+34

- Response rates were not sufficient enough to draw meaningful conclusions.
- The raw data showed that Direct and PAMF Cardiology had the lowest performance outcomes for non-urgent appointments as follows:
  - ❑ Direct at 59%
  - ❑ PAMF at 75%
- The other provider groups compliance rates were at 88% or higher.

*It is worth noting that the CAHPS survey showed an increase in satisfaction from 2018 to "received appointment to see a specialist as soon as needed (Q29)" by 3.32 percentage points.

Results

Although the number of respondents increased from 2018 across all behavioral health provider types, the lack of responses were not sufficient enough to draw meaningful conclusions.

Table V: Behavioral Health

A. Psychiatry (N=83) – Prescribers (High Volume Provider)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	12	90%	No	58%	NA
Urgent Care within 48-hours	12	90%	No	25%	NA
Non-Life Threatening Emergency within 6-hours	12	90%	NA	0%	NA
Follow-up Routine Care within 30-days	12	90%	No	58%	NA

- Psychiatry was identified as a high volume provider type in 2019.
- There were 12 providers that answered all questions in 2019 and 4 in 2018. In both years, no providers answered the “non-life threatening emergency within 6-hours”.
- Overall results in 2019 and 2018 are not sufficient enough to draw meaningful conclusions.

Results

Santa Clara Family Health Plan

B. Psychology (N=32) - Non-Prescribers

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	5	90%	No	20%	NA
Urgent Care within 48-hours	4	90%	No	25%	NA
Non-Life Threatening Emergency within 6-hours	3	90%	No	0%	NA
Follow-up Routine Care within 30-days	2	90%	No	50%	NA

- Psychology had a low response rate in 2019 where meaningful conclusions could not be drawn.
- In 2018 there were no responses by this provider type.

Results

Santa Clara Family Health Plan

C. Non-Physician Mental Health (N=63) – Non-Prescribers

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	6	90%	No	80%	NA
Urgent Care within 48-hours	6	90%	No	60%	NA
Non-Life Threatening Emergency within 6-hours	5	90%	No	0%	NA
Follow-up Routine Care within 30-days	4	90%	No	67%	NA

- Non-Physician Mental Health providers had a low response rate in 2019 and in 2018 where meaningful conclusions could not be drawn.

- There were 5 providers who participated in 2018 with similar results. However, the respondents (5) in 2018 met the “follow up routine care within 30-days” measure at 100%.

Results

Santa Clara Family Health Plan

D. Marriage/Family Therapy (N=34) - Non-Prescribers (High Volume Provider)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	8	90%	No	75%	NA
Urgent Care within 48-hours	8	90%	No	63%	NA
Non-Life Threatening Emergency within 6-hours	5	90%	No	20%	NA
Follow-up Routine Care within 30-days	3	90%	No	67%	NA

- Marriage/Family Therapy was identified as a high volume provider type in 2019.
- This provider type also had a low response rate in 2019, and in 2018 there was only 1 respondent. Therefore meaningful conclusions could not be drawn.

* SCFHP members have access to behavioral health services through the County Behavioral Health Services Department (CBHSD).

Conclusion:

Timely Appointment Access:

- Although the Provider Appointment Availability Survey (PAAS) showed some improvements from 2018, the results continue to show that –
  - ❑ Providers may not have an adequate understanding of regulatory requirements for timely access to care.
  - ❑ Longer wait times for urgent and non-urgent/routine care could be due to inefficient scheduling procedures.
- It is also worth noting that several provider groups may have other providers in the office who are available within the required timeframe to serve patients; therefore, the survey's focus on the availability of a specific provider may not reflect the way patients experience care and it may not provide a comprehensive picture of the access SCFHP offers.

Member Experience Survey (CAHPS)

Santa Clara Family Health Plan

Methodology

- SCFHP uses a vendor to annually administer the CAHPS survey. The survey results are then officially published by CMS. At the time of this analysis, the final CMS CAHPS report was unavailable. Additionally, many of the questions of interest have historically been "NA" on the final CMS report. Therefore, for purposes of this report SCFHP has used DSS' unofficial CAHPS report for SCFHP, which provides the plan's rates in comparison to DSS' entire book of business.
- Data Collection:

Survey Protocol	Date
Pre-notification letter mailed	3/7/2019
First questionnaire mailed	3/13/2019
Second questionnaire mailed	4/3/2019
Initiate follow-up calls to non-responders	4/24/2019
Last day to accept completed surveys	5/31/2019
Data submission to CMS	6/20/2019

Item	Volume
Total mailed	1600
Ineligibles	65
Total completed surveys	461
Mail completes	348
Phone completes	113
Adjusted response rate	30.03%

*Respondents were given the option of completing the survey in a language other than English. In place of the English survey, a foreign language survey was mailed to 401 members who were identified by the plan as speaking Chinese, Spanish, or Vietnamese.

Results

Santa Clara Family Health Plan

Table I: Access

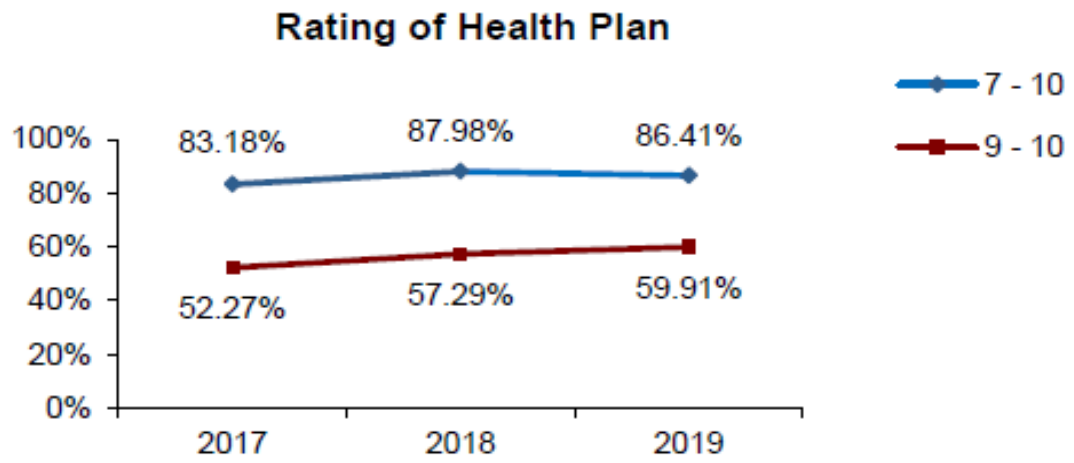
Composite Rating & Questions	# Surveyed	# of Respondents	Goal	Goal Met	Always and Usually (2019)	Always and Usually (2018)	PY Change
Rating of Health Plan (Q38)	434	375	90%	No	86.41%	87.98%	-1.5
Getting tests results when needed (Q21)	309	258	90%	No	83.50%	78.93%	+4.57
Getting appointments with specialists (Q29)	246	185	90%	No	75.20%	71.88%	+3.32
Getting needed care, tests or treatment (Q10)	445	355	90%	No	79.78%	78.93%	+1
Getting care needed right away (Q4)	161	132	90%	No	81.99%	74.21%	+7.78
Getting appointments (Q6)	348	266	90%	No	76.44%	77.96%	-1.52
Getting seen within 15min of your appointment (Q8)	332	180	90%	No	54.22%	60.63%	-6.41

- Although the goal was not met for any measures, member satisfaction improved in 4 out of 7 measures from 2018.
- The measure most improved was “getting care needed right away” (Q4) with an increase of 7.78 percentage points from 2018.
- It appears that Provider offices are not communicating in office wait times with members at check in or contacting them ahead of time to allow members to come in at a later time.

Results

Santa Clara Family Health Plan

Table II: Rating of Health Plan - SCFHP



↑ ↓ Indicates a significantly higher or lower 2019 plan result than the 2018 plan result.

‡ ‡ Indicates a significantly higher or lower 2019 plan result than the 2017 plan result.

- On a 0 to 10 scale about 9 in 10 (84.41%) gave SCFHP a rating of 7, 8, 9 or 10 which is not significantly different from two years ago.
- About six in 10 (59.91%) gave SCFHP a rating of 9 or 10, which is not significantly different from last year and not significantly different from two years ago.

Conclusion:

Santa Clara Family Health Plan

CAHPS:

- SCFHP is pleased to acknowledge that 4 out of 7 measures showed a marked improvement from 2018.
- SCFHP recognizes that “getting care needed right away” has a relatively high impact on members and is pleased that satisfaction ratings showed an improvement of 7.78 percentage points from 2018.
- Overall “access” results showed the Plan’s performance improved by 7.02 percentage points.

Member Access Grievances

Santa Clara Family Health Plan

Table I: Access Complaint Record June 2018 – June 2019

Provider Type	Appts	In Office	Phone Pick Up	Phone-Medical	Phone Non-Medical	After Hours	Provider Not Accepting New PT's	Authorizations	Referrals	Interpreter Services	Other	Total #
PCP	9	1	4				2	2	2		2	22
Allergist									1			1
Neurology							1					1
*PSYCH	1											1
*PT	4										1	5
LCSW					1							1
DME				1							2	3
NEMT	1											1
SCFHP								2		1		3
Pharmacy											1	1
*HH											1	1
Total	**15**	**1**	**4**	**1**	**1**	**0**	**3**	**4**	**3**	**1**	**7**	**40**

***HH**-Home Health - ***PT**-Physical Therapy - ***PSYCH**: Psychiatry

- Thirty eight percent (38%) of member complaints were associated with appointments, which appeared to be readily resolved by SCFHP's customer service department.
- Most other complaints were relevant to communication issues where members and provider offices were unaware of authorization and referral requirements and/or timelines.

Conclusion:

Member Access Grievances

- The overall findings on member complaints showed 2 primary categories:
  - ❑ Appointment Timeliness
  - ❑ Communications

- SCFHP has identified that most member complaints were related to:
  - ❑ a lack of PCP extended office hours,
  - ❑ hours of operation not suiting the patient, and
  - ❑ members desired PCP is not in network

- SCFHP will continue to address member complaints expeditiously and will re-direct members to network and/or out-of-network providers to ensure timely access to care is met.

Opportunities:

Barrier	Opportunity	Intervention	Selected for 2019	Date Initiated
Timely access to urgent and non-urgent appointments	• Improve access to urgent, non-urgent care appointments	• Require access training from providers who show continued non-compliance through resurveys	Yes	10/2019
In office wait times	• Improve in office wait times	• Distribute SCFHP's Timely Access Matrix to network providers via fax blast	Yes	12/2019
Timely Access—Behavioral Health non-life threatening emergency within 6-hours	• Increase the number of BH providers within SCFHP's network • Educate BH providers on timely access standards	• Explore contracting opportunities to expand BH network • Require access training from providers who show continued non-compliance through resurveys	Yes Yes	Ongoing 10/2019
After Hours messaging that advises patients -- 1. In an emergency to hang up and dial 911 or go to the nearest emergency room. 2. On-call provide will call back within 30-minutes	• Educate PCP and BH providers on after-hours messaging	• Distribute SCFHP's Timely Access Matrix to network providers via fax blast • Provider Outreach	Yes Yes	12/2019 10/2019

SCFHP Personalized Information on Health Plan Services:

2019 E-mail Response Evaluation

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee (QIC) on
October 9, 2019

I. Overview

Providing accurate and timely personalized information of member health plan services is central to the promotion of member engagement and self-management. SCFHP has a responsibility to provide accurate, quality information on health plan services to members through the website, over the telephone, and through e-mail.

In an effort to make this information readily available, SCFHP ensures that members can contact the organization through e-mail for any reason and receive responses within one-business day.

Personal information on health plan services may change periodically throughout the year; therefore, SCFHP has an obligation to be sure the information submitted via e-mail to members is accurate, current and timely. This is accomplished by measuring and evaluating the quality and accuracy of the information. SCFHP audits e-mail response annually to identify any opportunities to improve interactions with the members.

II. Methodology: E-mail

The Call Center collects all member e-mails through Microsoft Outlook and documents the contact in the QNXT Call Tracking system. Data included in this analysis was captured from July 1, 2018 through June 30, 2019.

A dedicated staff in Customer Service checks the e-mail inbox intermittently throughout each business day. The staff will respond to the member's inquiry with a thorough answer to the member's question within one-business day.

Once a complete reply is sent to the member, the request is documented in the QNXT call tracking system using appropriate contact codes. The call note includes the question and inquiry received from the member and the response provided.

SCFHP audits the information on e-mail turnaround time and the quality of the email response on a quarterly basis to be able to identify opportunities to improve based on data collected and analyzed. This data is then rolled up into an annual rate for comparison year over year.

Measure 1: Email Turnaround-Time

- **Numerator:** Number of emails received from Q3-2018 through Q2-2019
- **Denominator:** Number of emails received from Q3-2018 through Q2-2019
- **Goal**: 100% of emails are collected, reviewed Q3-2018 through Q2-2019 that were responded to within one business day.

Measure 2: Response Comprehensiveness

- **Numerator:** Number of emails received from Q3-2018 through Q2-2019
- **Denominator:** Number of emails received from Q3-2018 through Q2-2019
- **Goal**: 100% of emails comprehensively address the member's request

Measure 3: Spelling Errors

- **Numerator**: Number of emails received from Q3-2018 through Q2-2019
- **Denominator**: Number of emails received from Q3-2018 through Q2-2019
- **Goal**: 100% of emails were responded to with zero spelling errors

Measure 4: Customer Service Contact Information Provided

- **Numerator**: Number of emails received from Q3-2018 through Q2-2019
- **Denominator**: Number of emails received from Q3-2018 through Q2-2019
- **Goal**: 100% of email responses contained Customer Service contact information

III. Analysis

a. Results

Table 1: Timeliness and Quality of E-mail Responses

Measure	Goal	Q3-2018.	Q4-2018	Q1-2019	Q2-2019	Goal Met Y/N
M1: Responses sent to Member within one-business day	100%	100%	100%	100%	100%	Y
Information is legible, complete and allows the member to understand:						
M2: The response comprehensively addresses the member request	100%	100%	100%	100%	100%	y
Other items that may also reflect the quality of the e-mail response:						
M3: No spelling errors identified	100%	100%	100%	NA	100%	y
M4: Customer Service contact information provided	100%	100%	100%	100%	100%	y

b. Quantitative Analysis

Eighteen (18) emails were received from Q3-2018 thru Q2-2019. All eighteen e-mail contacts met the turn-around time quality and accuracy standards.

Although the number of e-mail contacts had increased compared to one (1) e-mail received in the previous year, the volume of e-mail inquiries for the Cal MediConnect line of business is still quite low. The low number of e-mail contacts lead to an assumption that our members prefer to communicate verbally via the telephone. This is most likely due to several factors that affect the specific population we serve. These factors can prevent members from accessing electronic devices required to submit emails. Factors include: language barriers, multiple chronic medical conditions, education levels, and economic background.

c. Qualitative Analysis

2019 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2019	Date Initiated
NA	NA		NA	

IV. Reporting

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Monitoring or Meeting Period:

Credentialing Committee 09/26/2019

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	24	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	10	
Number practitioners recredentialed within 36-month timeline	10	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 08/31/2019	275	

(For Quality of Care ONLY)	Stanford	LPCH	VHP	PAMF	PMG	PCNC
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1504	1449	745	795	407	138

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Actions Taken

1. All current network practitioners were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. - # currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

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

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

MINUTES – *Open Session*

Regular Meeting of the

Santa Clara County Health Authority

Pharmacy & Therapeutics Committee

Thursday, June 20, 2019, 6:00 PM - 8:00 PM
Santa Clara Family Health Plan, Redwood
6201 San Ignacio Ave, San Jose, CA 95119

Voting Committee Members	Specialty	Present (Y or N)
Jimmy Lin, MD, Chairperson	Internal Medicine	Y
Hoa Bui, BS, RPh	Community Pharmacy (Walgreens)	N
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	Y
Peter Nguyen, MD	Family Practice	N
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, PharmD	Health System Pharmacy (SCVMC)	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Dolly Goel, MD	VHP Chief Medical Officer	N
Xuan Cung, PharmD	VHP Pharmacy Supervisor	Y
Laurie Nakahira, DO	SCFHP Chief Medical Officer	Y
Dang Huynh, PharmD	SCFHP Pharmacy Director	Y

Non-Voting Committee Members	Specialty	Present (Y or N)
Tami Otomo, PharmD	SCFHP Clinical Pharmacist	Y
Michelle Huynh	SCFHP Pharmacy Coordinator	Y
Duyen Nguyen, PharmD	SCFHP Clinical Pharmacist	Y
Amy McCarty, PharmD	MedImpact	Y
Darryl Breakbill	SCFHP Appeals & Grievance Director	Y
Nancy Aguirre	SCFHP Administrative Assistant	Y
Kelsey Kaku, PharmD	VMC Pharmacy Resident (PGY-2)	Y

1. **Introduction**
   Jimmy Lin, Chair, called the meeting to order at 6:08 pm. Roll call was taken. Missing one committee member to reach a quorum. Meeting commenced while pending the arrival of Dr. Alkoraishi.

2. **Public Comment**
   There were no public comments.

3. **Meeting Minutes**
The review of the March 21st, 2019 Pharmacy and Therapeutics Committee meeting minutes were tabled. Pending the arrival of Dr. Alkoraishi.

4. **Standing Agenda Items**

a. **CMO Health Plan Updates**
Dr. Nakahira announced Dang Huynh as the new Santa Clara Family Health Plan (SCFHP) Pharmacy Director.

Dr. Nakahira noted SCFHP was in the middle of the DHCS & DMHC audit during the last Pharmacy and Therapeutics Committee meeting in March, 2019. Since then, SCFHP has received a draft audit report from DHCS and the Plan is currently responding to their findings. DMHC has yet to submit a report. Anticipating a report to be submitted by early July, 2019.

b. **SCFHP/DHCS Global DUR**
Dr. Otomo presented the updates on the Plan's global drug utilization review (DUR) programs:

i. Anticholinergic Initiative:
This is a retrospective DUR program specifically looking at Medi-Cal members ages 65 and older with use of second-generation antipsychotic and anticholinergic medication.

Data revealed a total of two (2) members met the criteria. The data showed that each member had one provider for both the anticholinergic medication and the antipsychotic medication. Since there were only two impacted providers, it was the committee's opinion during the last P&T Committee meeting to conduct a direct telephonic outreach to each provider rather than a mailing.

The two impacted providers were cautioned of the potential risks of concomitant of these drug classes. Both providers were aware of these risks and attested that the members are stable on therapy.

In conclusion, in SCFHP's Medi-Cal population of members 65 years and older, benztropine or trihexyphenidyl and a second-generation antipsychotic, does not appear to be commonly co-prescribed, which is good.

Dr. Ali Alkoraishi arrived at 6:21pm. A quorum was establish at this time. Review of the Pharmacy & Therapeutics Committee meeting minutes of the March 21st, 2019 meeting commenced.

Dr. Lin motioned to accept the meeting minutes as presented. It was motioned by Dr. Nakahira and seconded by Dr. Alkoraishi. The motion carried.

c. **Appeals & Grievance**
Mr. Breakbill presented the following Appeals & Grievance reports:

i. 2018 4th Quarter Report:
Pharmacy appeals were 50% overturned and 37% were upheld, with 6% partially favorable. Partly favorable is when a prescriber will ask for beyond what is recommended.

ii. 2019 1st Quarter Report:
Format was changed to reflect total amount rather than percentage. Data reveals 19 of the pharmacy appeals for Medi-Cal were overturned, 50 of them were upheld, and 1 was partially favorable. For Cal Medi-Connect, 16 were overturned and 18 were upheld.

d. **Emergency Supply Report**

Dr. Nguyen presented the Emergency Supply Report. Dr. Nguyen explained the goal of the report is to evaluate access to medications prescribed after emergency room (ER) visits and to determine (if) any barriers to care exists.

i. 2018 2nd Quarter Report:
Evaluated patients diagnosed with urinary tract infections (UTI) and if they were prescribed medications within 72 hours of their ER visit.

There were no issues for approved or denied claims. Denied claims were a result of patient's primary insurance being outside of the Health Plan. For members who did not have a claim (18 members), data revealed most of these patients had a prescription filled several days before, or more than 4 days after their ER visit.

ii. 2018 3rd Quarter Report:
There were no issues identified for approved or denied claims. For members who did not have claim, data revealed the same results for 2018's 2nd quarter report.

Adjourned to Closed Session
Pursuant to *Welfare and Institutions Code Section 14087.36 (w)*

5. **Closed Meeting Minutes**
Previous quarter's closed meeting minutes approved.

6. **Metrics & Financial Updates**
Dr. Nakahira presented the membership reports. Dr. Otomo presented the pharmacy dashboard. Dr. McCarty presented the Drug Use Evaluation (DUE). Dr. McCarty presented the drug utilization & spend.

7. **Discussion and Recommendations for Changes to SCFHP Cal MediConnect (CMC) Formulary & Coverage Determination Criteria**
Dr. McCarty presented MedImpact minutes and Part D actions. Both were approved.

8. **Discussion and Recommendations for Changes to SCFHP Medi-Cal & Health Kids Formulary & Prior Authorization (PA) Criteria**
Dr. Otomo presented formulary modifications and were approved. Dr. McCarty presented CDL updates from February-May 2019 and were approved. Dr. Nguyen presented the PA criteria changes and were approved. Annual PA criteria were reviewed by committee and approved.

9. **New Drugs and Class Reviews**
Dr. McCarty presented new drugs and class reviews. Recommendations were approved.

Reconvene to Open Session
Committee reconvened to open session at 7:40pm

10. **Discussion Items**
New and Generic Pipeline
Dr. McCarty presented the new and generic pipeline.
In May, 2019, AVXS-101 came to market with Zolgensma, a gene therapy for Spinal Muscular Atrophy. Cost is high but results are promising. Study included 15 children. 13 out of 15 children responded significantly.

Oral semaglutide (diabetes)-C will come to market in September 2019. First oral treatment in its class. Other treatments are injectable. Anticipating a big impact in utilization when oral semaglutide comes to market.

11. Adjournment

Next meeting is Thursday, September 19th, 2019.

The meeting was adjourned at 7:48pm.

Jimmy Lin, MD
Chair of Pharmacy & Therapeutics Committee

9/19/19
Date

Regular Meeting of the

Santa Clara County Health Authority

Utilization Management Committee

Wednesday, July 17, 2019, 6:30 PM - 8:00 PM
Santa Clara Family Health Plan, Redwood
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Jimmy Lin, MD, Chairperson, Internal Medicine
Indira Vemuri, Pediatric Specialist
Dung Van Cai, MD, OB/GYN Specialist
Ali Alkoraishi, MD, Adult & Child Psychiatry
Habib Tobbagi, Psychiatry Specialist MD
Laurie Nakahira, DO, SCFHP Chief Medical Officer

Members Absent
Ngon Hoang Dinh, DO, Head & Neck Surgery
Dung Van Cai, MD, OB/GYN Specialist
Jeff Robertson, MD, SCFHP Medical Director

Staff Present
Christine Tomcala, Chief Executive Officer
Lily Boris, MD, Medical Director
Lori Andersen, Director of Long Term Services & Support
Sandra Carlson, Director of Medical Management
Natalie McKelvey, Manager of Behavioral Health
Luis Perez, Utilization Management Supervisor
Nancy Aguirre, Administrative Assistant
Amy O'Brien, Administrative Assistant

1. **Introduction**

   Jimmy Lin, Chair, called the meeting to order at 6:30 pm. Roll call was taken and a quorum was established.

2. **Meeting Minutes**

   The April 17th, 2019 Utilization Management Committee (UMC) meeting minutes were reviewed.

   It was **moved by Dr. Alkoraishi** and **seconded by Dr. Vemuri**, **and** the minutes of the April 17, 2019 Utilization Management Committee meeting were **unanimously approved.**

3. **Public Comment**

   There were no public comments.

4. CEO Update

Ms. Tomcala presented the following updates:
Santa Clara Family Health Plan (SCFHP) recently ended the fiscal year. SCFHP is now on to the new fiscal year with the primary focus being quality, followed by compliance.

SCFHP is developing a satellite office. The satellite office would be used as a community service center, offering various classes and resources for members. Location is pending.

Ms. Tomcala reported one of the State's new requirements is that the minimum quality performance level of health plans will be the HEDIS 50th percentile, retroactive to January 2019. The State will also implement immediate sanctions prior to corrective action plans.

5. CMO Health Plan Updates

Dr. Nakahira presented the following Health Plan updates:
The CMS Independent Validation Audit has begun as of May 1st, 2019 and will end on July 31st, 2019.

DHCS Exit Conference took place on June 13th, 2019. SCFHP received a draft audit report and the Plan is currently responding to their findings.

SCFHP is working closely with the Quality department to improve gaps in care for HEDIS measures.

6. Old Business/Follow Up Items

Presented by Dr. Boris.
There was one (1) staff member with an Inter Rater Reliability (IRR) follow up.

Ms. McKelvey presented Behavioral Health Treatment (BHT) and Mild to Moderate (MTM) Services as well as their utilization, excluding Kaiser and VHP.

BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. Treatment can be Applied Behavioral Analysis (ABA) or Social Skills in either individual or group settings.

Ms. McKelvey reported a total of 586 children with autism receiving BHT services, and 7 children with other primary diagnoses receiving BHT services for the 2018 calendar year.

Managed Care Plans (MCP) must inform members that EPSDT services are available for members under 21 years of age. Provide access to comprehensive screening and prevention services, at designated intervals or at other intervals indicated as medically necessary, including but not limited to:

- A health and developmental history
- A comprehensive unclothed physical examination
- Appropriate immunizations
- Lab tests and lead toxicity screening
- Screening services to identify developmental issues as early as possible

MCPs must also provide access to medically necessary diagnostic and treatment services, including but not limited to, BHT services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist.

Ms. McKelvey explained for Mild to Moderate (MTM) services, MCPs are responsible for outpatient mental health services for MTM conditions such as psychiatry and talk therapy.

7. Action Items

There were no action items to present.

8. Reports (MediCal/SPD, Healthy Kids)

a. Membership Reports

Dr. Nakahira presented the membership reports.

From July 2018 to July 2019, Cal MediConnect (CMC) membership increased by over 500 members. As a result, SCFHP met its' organizational goals. For MediCal, there is a slow decline. Healthy Kids has remained close to the same as last month. Overall membership has slightly decreased due to the reduced MediCal membership.

b. UM Reports 2019

Ms. Carlson presented the Utilization Management (UM) Reports for January through May 2019.

For UM expedited authorizations for Med-Cal, 100% of timely decisions were made within 72 hours of request. For Cal MediConnect, SCFHP was between 98-100% compliant. For UM standard authorizations for both MediCal (5 business days) and Cal MediConnect (14 business days), SCFHP was 97.8-100% compliant.

Ms. Carlson will bring UM provider phone call metrics to present to next UMC meeting in October.

Dr. Vemuri shared her experience in language barriers with patients as well as barriers in certifying office staff as bilingual. Dr. Boris will reach out to help access SCFHP's language line services as it is a provided interpretation service for members. Dr. Nakahira offered help from Ms. Shah, SCFHP Health Educator, to reach out to Dr. Vemuri for assistance with this barrier.

Dr. Boris presented the Standard Utilization Metrics Powerpoint. The goal is to compare SCFHP utilization levels against relevant industry benchmarks and monitor utilization trends among SCFHP membership over time. In addition, SCFHP is to analyze key drivers and potential barriers, prioritize opportunities for improvement, and develop interventions that promote high-quality and cost-effective use of medical services.

The metrics report reflects four (4) full quarters through May 30th, 2019. The MediCal inpatient utilization (IPU) for non-seniors or persons with disabilities (SPD) has been relatively stable. Average length of stay (ALOS) has maintained less than four (4).

For MediCal for SPD, the ALOS is 4.7 days. For CMC, the population is about eight (8) thousand, the average LOS is significantly longer at 5-6 days. SCFHP ranks less than 10% in The National Medicaid NCQA benchmark.

For the non-SPD population, readmission rates have been about 10-12%. For SPD population, rates are higher, reflecting 23%. The CMC population has been stable with less readmissions, reflecting 10-14%.

Comparatively to NCQA Medicare Benchmark for readmission rates, SCFHP ranked greater than 90th percentile for CMC members ages 18-64. For CMC members ages 64+, SCFHP ranked greater than the 50th percentile. The CMC members ages 18-64 are receiving Medicare based on a disability. The CMC members ages 64+ include MediCal, which adds social economic factors.

Dr. Boris noted the requests for bariatric surgery has increased, in both men and women, ages 20-64. This reflects general obesity within the population.

Ms. Tomcala asked for post-surgery outcomes and data, to reflect the success of the surgery. Dr. Boris will present a comprehensive study for bariatric surgery to one of the next two (2) UMC meetings. Dr. Boris will ask SCFHP's Health Education department for materials on bariatric surgery and bring a guideline of bariatric to the UMC meeting in October, 2019.

c. HS.04.01 Reporting Quality Monitoring of Plan Authorizations, Denials etc. (Q2 19)
Presented by Ms. Carlson.
SCFHP completed the 2nd quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations.

30 unique denial letters were randomly selected. 16 out of 30 were for MediCal and the remaining 14 were for CMC. 100%, or 13/13, of the expedited authorizations met regulatory turnaround time of 72 calendar hours. 100%, or 17/17, of the standard authorizations met regulatory turnaround time. 100% were provided member and provider notification. 100% of the letters were readable and rationale for denial provided. 100% of the letters included IMR information, interpreter rights and instructions on how to contact CMO or Medical Director for Peer to Peer review.

Ms. Carlson shared SCFHP will continue the quarterly quality assurance report monitoring process and manage reviews to meet turn-around time requirements.

d. Referral Tracking Quarterly Report (Q2 19)
Presented by Ms. Carlson.
This report gives a breakdown of CBAS, and monitors how many services were approved and how many were rendered. The data shows approximately 68%, which has been our highest, and has remained stable since.

9. Behavioral Health UM Reports

a. Criteria for ABA Services
Presented by Ms. McKelvey.
For MediCal Q2 2019, there have been 191 members receiving BHT, 1 receiving SCFHP Case Management, and 7 receiving MTM referrals. For MediCal year to date, there have been 418 members receiving BHT, 4 receiving SCFHP Case Management, and 17 MTM referrals.

The county has not provided data for number of members in Q2 2019 receiving mental health benefits.

b. Criteria for other BHT Services
Presented by Ms. McKelvey
For Cal MediConnect in Q2 2019, there have been 43 members receiving BHT, 11 opt outs of SCFHP Case Management, and 1 MTM referrals. For Cal MediConnect year to date, there have been 79 members receiving BHT, 19 opt outs of SCFHP Case Management, and 3 MTM referrals.

The county has not provided data for number of members in Q2 2019 receiving County Mental Health.

10. Adjournment

Next meeting is Wednesday, October 16th, 2019 at 6:30pm.

The meeting was adjourned at 7:46pm

Jimmy Lin, MD
Chair of Utilization Management Committee

10/16/19
Date

Santa Clara Family Health Plan™

Assessment of Network Adequacy 2019

Cal Medi-Connect

Prepared by: Carmen Switzer, Provider Network Access Manager

For review and approval by the Quality Improvement Committee

December 4, 2019

Introduction

Santa Clara Family Health Plan ("SCFHP" or "Plan") monitors the adequacy of its network on access, availability and member experience and annually reviews and analyzes data to identify opportunities for improvement.

Opportunities to improve network adequacy are identified and prioritized based on an evaluation of member experience, availability and accessibility of providers and services, and out of network requests for services.

This report includes a summary of findings from the NET 1 (provider availability) and NET 2 (provider accessibility) reports and includes new information relevant to NET 3 (i.e., out of network requests/approvals). Combined reporting elements helps the Plan determine if there are network gaps that need to be addressed.

Availability Assessment (NET 1)

Table I: Time and Distance Standards **Member Count = 7822**

Provider Type	Members with Access	Members without Access	% with no Access	Standard	Goal	Met/Not Met
Primary Care Providers						
General Practice	**5,416**	**2,406**	**31%**	5 miles and 10 min	90%	Not Met

- The NET 1 report (availability of network providers) showed that the standards for geographic time or distance were not met for General Practice in multiple cities in the southeast area of Santa Clara County.
- The NET 1 report also showed that SCFHP's PCP's combined network meets provider to member ratios at 1:16.
- SCFHP has a combined network of PCP providers (Family Practice, General Practice and Internal Medicine) available in the southeast area of Santa Clara County where members who reside in this area are assigned to a PCP without incident.

Accessibility Assessment (NET 2)

The accessibility of network providers were assessed in the NET 2 report. The network accessibility tables in the next few slides show the provider types that did not meet the Plan's performance goal of 90% on appointment and after-hours access.

Primary Care Provider – Appointment Availability

Table I: Standard - Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Family Medicine (N=156)	95	90%	No	58%	-11
General Practice (N=12)	6	90%	No	83%	+1
Internal Medicine (N=193)	98	90%	No	63%	No Change

- As noted in the NET 2 report, PCP's combined performance is at 68%; 22 percentage points below goal.

Accessibility Assessment (NET 2)

<u>Primary Care Provider</u> – Appointment Availability

Table II: Standard - Non-Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Family Medicine (N=156)	104	90%	No	88%	-4
General Practice (N=12)	6	90%	No	83%	+1
Internal Medicine (N=193)	108	90%	No	81%	-11

- As noted in the NET 2 report, PCP's combined performance is at 84%; 6 percentage points below goal.

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

After-Hours

Table III: Standard - Access Compliance: 911 Messaging

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=504)	453	90%	No	82%	-10
BH (N=328)	299	90%	No	80%	+9

- As noted in the NET 2 report, SCFHP worked with PAMF to address a main phone line that affected 46 PCP's compliance rate on access compliance.
- Following the updated PAMF message, the overall rate of compliance for PCP providers is at 93%; 3 percentage points above goal.
- BH providers showed a marked improvement in 2019.

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

After-Hours

Table IV: Standard - Timeliness Compliance: 30-minutes or less

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=504)	453	90%	No	54%	+2
BH (N=328)	299	90%	No	40%	-7

- As noted in the NET 2 report, the assessment concluded that PCP's and BH providers are unfamiliar with the after-hours timeliness standard.
- Provider education on after-hours timeliness will be a focus point in 2019/2020.

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

High Volume and High Impact Specialists – Appointment Availability

Table V: Standard - Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Cardiology (N=134)	33	90%	No	68%	-3
Gynecology (N=187)	44	90%	No	47%	-34
Ophthalmology (N=89)	22	90%	No	62%	-38
*Oncology (N=74)	20	90%	No	58%	+2

Table VI: Standard - Non-Urgent Care

Provider Group	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Cardiology (N=134)	33	90%	No	81%	+11
Gynecology (N=187)	27	90%	No	57%	-33
Ophthalmology (N=89)	14	90%	No	87%	-9
*Oncology (N=74)	12	90%	No	84%	+34

*Oncology is a high impact specialist (HIS) – all other provider types are high volume specialists (HVS)

- As noted in the NET 2 report, although SCFHP made efforts to increase the number of respondents in 2019 by improving provider demographic data and enhancing provider communications, the rate of response did not increase from 2018.
- Response rates were not sufficient enough to draw meaningful conclusions.

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

High Volume Behavioral Health – Appointment Availability

Table VII: Psychiatry-High Volume / Prescribers (N=83)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	12	90%	No	58%	NA
Urgent Care within 48-hours	12	90%	No	25%	NA
Non-Life Threatening Emergency within 6-hours	12	90%	NA	0%	NA
Follow-up Routine Care within 30-days	12	90%	No	58%	NA

Table VIII: Psychology / Non-Prescribers (N=32)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	5	90%	No	20%	NA
Urgent Care within 48-hours	4	90%	No	25%	NA
Non-Life Threatening Emergency within 6-hours	3	90%	No	0%	NA
Follow-up Routine Care within 30-days	2	90%	No	50%	NA

Accessibility Assessment (NET 2)

Table IX: Non-Physician Mental Health / Non-Prescribers (N=63)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	5	90%	No	80%	NA
Urgent Care within 48-hours	5	90%	No	60%	NA
Non-Life Threatening Emergency within 6-hours	4	90%	No	0%	NA
Follow-up Routine Care within 30-days	3	90%	No	67%	NA

Table X: Marriage/Family Therapy – Non-Prescriber (High Volume Provider) – (N=20)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	8	90%	No	75%	NA
Urgent Care within 48-hours	8	90%	No	63%	NA
Non-Life Threatening Emergency within 6-hours	5	90%	No	20%	NA
Follow-up Routine Care within 30-days	3	90%	No	67%	NA

- As noted in the NET 2 report, although SCFHP made efforts to increase the number of respondents in 2019 by improving provider demographic data and enhancing provider communications, response rates did not increase from 2018.
- Response rates were not sufficient enough to draw meaningful conclusions.

Member Satisfaction with Behavioral Health

Santa Clara Family Health Plan

Member Satisfaction Survey

Table I: Survey Sample Size

Category	Count
# to Survey	279
# of Respondents	37
# of Non-respondents	242
% Completed	13%

Table II: Behavioral Health Survey Results – "Access"

Measures	# Responded	# Always/Usually	Rate of Compliance	Goal	Goal Met	PY Change
How often did you get an appointment as soon as you wanted? (Q7)	37	32	86%	90%	No	+2
How often did you see someone as soon as you wanted when you needed help right away? (Q8)	37	26	70%	90%	No	-4

- Members undergoing active BH treatment are difficult to contact due to frequent changes in contact information and where they access BH services. This may explain why the response rate was only at 13%.
- The assessment showed that members were satisfied overall with access to behavioral health providers.

Grievance and Appeals

Santa Clara Family Health Plan

Grievances

Member Count = 7822

Grievance Category	Total Grievances	Per 1,000 members	Goal per 1,000 members	Goal Met	Total Grievances	Per 1,000 members	Goal per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Access	38	4.85	5.0	Yes	2	.3	5.0	Yes
Billing and Financial (related to network adequacy)	0	0	5.0	Yes	0	0	5.0	Yes
Total	38	4.85	5.0	Yes	2	.3	5.0	Yes

- Compared to 2018, access grievances per 1,000 members increased from 2.4 to 4.85 regarding non-behavioral health providers and increased from none to .3 for behavioral health providers.
- There are no billing/financial grievances to report for 2019 and there were none reported in 2018.
- With the exception of Psychiatry, there were no other member grievances relevant to non-behavioral health or behavioral health providers that did not meet specific access standards or that were classified as HVS or HIS.
- As reported in NET 2 (accessibility of provider network), the Psychiatry (1) complaint was due to member/provider scheduling conflicts. It was noted that customer service worked with the members LCSW to find a provider that meets the members scheduling needs. The member was readily established with a new Psychiatrist.

Grievance and Appeals

Santa Clara Family Health Plan

Appeals

Member Count = 7822

Appeals Category	Total Appeals	Per 1,000 members	Goal per 1,000 members	Goal Met	Total Appeals	Per 1,000 members	Goal per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Access	9	1.2	5.0	Yes	0	0	5.0	Yes
Billing and Financial (related to network adequacy)	0	0	5.0	Yes	0	0	5.0	Yes
Total	9	1.2	5.0	Yes	0	0	5.0	Yes

- Compared to 2018, access appeals per 1,000 members increased from .67 to 1.2 regarding non-behavioral health providers and there is no change relevant to behavioral health providers.

- There are no billing/financial appeals to report for 2019 and none were reported in 2018.

- All 9 appeals were pre-service appeals and the following are 2 examples:

  - ❑ Ophthalmology (N=1) – Member requested an OON provider to perform cataract surgery and the Plan redirected the member to an in-network provider.

  - ❑ Pulmonary (N=1) -- Member requested an OON provider, and the Plan determined that there were in-network providers available to serve the member

Out of Network Requests

SCFHP reviews out of network utilization activity on an annual basis to assess Cal-MediConnect members use of out of network providers and other services.

Out of Network Encounters **Member Count = 7822**

Category	Total	Per 1,000 members	Threshold per 1,000 members	Goal Met	Total	Per 1,000 members	Threshold per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Prior Authorizations (PA)	412	53	25	No	9	1	2	Yes
PA's Approved	334	43	25	No	9	1	2	Yes
PA's Denied	78	10	5	No	0	0	2	NA

- Non-behavioral health provider requests were approved at 81%.
- The behavioral health provider requests were approved at 100%.
- Eighty nine (89%) of the OON denials (78) were denied due to medical necessity and 11% were denied due to services were availability in network.

Out of Network Requests

Santa Clara Family Health Plan

Non-Behavioral Health Providers

Provider Type	Assessment Reason(s)	# of OON Approvals	Approval: COC	Approval: Retro-Authorization	Timely Access Issue	Provider is now PAR/or in Process	Other
General Practice	TD/Access	0	NA	NA	NA	NA	NA
Cardiology	HVS/Access	3	3	NA	NA	NA	NA
Ophthalmology	HVS/Access	1	1	NA	NA	NA	NA
Gynecology	HVS/Access	0	NA	NA	NA	NA	NA
Oncology	HIS/Access	2	2	NA	NA	NA	NA
Physical Therapy	GA	9	6	1	NA	NA	2
ASC	10+	30	12	10	NA	NA	8
Home Health	10+	136	NA	136	NA	NA	NA
Acute Hospital	10+	54	NA	NA	NA	NA	54
Total	**NA**	**235**	**24**	**147**	**NA**	**NA**	**64**

- **Home Health (HH):**
  - Sequoia HH was responsible for 60% of the OON requests, South Springs HH was responsible for 36% and 4% (3 facilities) were responsible for out of service area encounters.
  - The OON requests were retro actively submitted to the Plan, which were approved to ensure continuity of care.
- **Acute Hospital:**
  - The OON inpatient approvals were admissions from out of state (19%), out of service area (80%) and 1% were in service area emergency room admissions that are subject to EMTALA provisions.
- **Ambulatory Surgical Center (ASC):**
  - The OON approvals (N=30), involved 4 ASC's -- Peninsula Eye Surgery Center and Tri-County Vascular Care are responsible for 47% of ASC OON approvals.

Out of Network Requests

Santa Clara Family Health Plan

Behavioral Health Providers

Provider Type	Assessment Reason	# of Approvals	Approval: COC	Approval: Retro-Authorization	Timely Access Issue	Provider is now PAR/or in Process	Other
Marriage/Family Therapists	HVS/Access	9	1	NA	NA	8	NA
Psychiatry (HVS)	HVS/Access	3	2	NA	NA	1	NA
Psychology	Access	12	2	2	NA	8	NA
Total	**NA**	**24**	**5**	**2**	**NA**	**17**	**NA**

- **Marriage/Family Therapy:**
  - Six (6) OON approvals were for Discovery Counseling who has since entered a contract with SCFHP.
  - Two (2) OON approvals were for Gardner Family Care who has since entered a contract with SCFHP.
  - One (1) was due to COC.

- **Psychiatry:**
  - One (1) OON approval was for AACI Behavioral Health who has since entered a contract with SCFHP.
  - The other two (2) requests were relevant to continuity of care (COC).

- **Psychology:**
  - Eight (8) OON approvals were for Memory Check Psychological who has since entered a contract with SCFHP.
  - The other four were due to COC (2) and retro active requests (2).

Conclusion

Overall the NET 1-3 analyses demonstrated that –

- SCFHP standards for provider availability are realistic for the communities and delivery system within Santa Clara County.
- With the exception of General Practice, Santa Clara Family Health Plan was able to demonstrate its ability to meet performance goals relevant to provider to member ratios and geographic distances across all in network primary care providers, high volume and high impact specialists (including behavioral health).
- Although there were low response rates relevant to the appointment and availability survey, SCFHP concludes that there are several network providers (medical and behavioral health) who are unaware of appointment access standards.
- A high percentage of providers are unaware of the after-hours messaging requirement – *return call within 30-minutes or less.*
- Overall findings on member complaints indicated two primary categories – timeliness and communication and the reports showed that member complaints were managed effectively and timely by SCFHP.
- The majority of out of network requests and approvals were relevant to continuity of care, retro-active requests and out of area hospital admissions.

OPPORTUNITIES:

Barrier	Opportunity	Intervention	Selected for 2019	Date Initiated
Timely access— Urgent appointments within 48-hours, 96-hours Providers are unaware of appointment access standards	• Improve access to urgent care appointments • Educate providers on access standards	• Following CAP, resurvey non-complaint providers • Require providers who show continued non-compliance through resurveys to complete SCFHP"s access training and submit an attestation. • Submit SCFHP's access matrix via fax blast to network providers.	Yes Yes Yes	In Process In Process 12/2019
Appointment Access—Behavioral Health non-life threatening emergency within 6-hours BH providers are unaware of appointment access standards - Non-life threatening emergency within 60 Shortage of BH providers	• Increase the number of BH providers within SCFHP's network • Educate BH providers on timely access standards • BH network development	• Following CAP, resurvey non-complaint providers. • Require providers who show continued non-compliance through resurveys to complete SCFHP's access training and submit an attestation. • Submit SCFHP's access matrix via fax blast to network providers. • Continue to seek contracting opportunities with behavioral health providers.	Yes Yes Yes Yes	Ongoing In Process 12/2019 Ongoing
PCP's and Behavioral Health Providers After-Hours Access (return call within 30min or less) – Providers are unaware of --- 1. After-hours messaging requirements 2. Calls are required to be returned within 30-minutes.	• Improve after- hours access • Educate providers on after-hours access	• Following CAP, conduct provider outreach (Training) • Submit SCFHP's access matrix via fax blast to network providers.	Yes Yes	In Process 12/2019
In-office wait times exceed 15 minutes	• Educate providers on in-office wait times	• Submit SCFHP's access matrix via fax blast to network providers.	Yes	12/2019

Santa Clara Family Health Plan
Personalized Information on Health Plan Services:
Website and Telephone Functionality - 2019 Accuracy and Quality Analysis

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee
December 4, 2019

I. Overview

In order to best serve our members, it is important for members to have the ability to easily obtain personalized health plan information.

Santa Clara Family Health Plan (SCFHP) has the responsibility to provide access to accurate, quality personalized health information via the SCFHP website and the telephone. This includes the ability to request or reorder an SCFHP member ID card, to change primary care practitioners (PCPs), and to determine how and when to obtain referrals and/or authorizations for specific services.

SCFHP members have no financial responsibility beyond a copay for pharmacy benefits. There is no copay for medical services.

SCFHP ensures the availability of this information by:

1) Telephone – SCFHP Customer Service Representatives (CSRs) are trained to handle PCP changes, member ID card requests, and the determination of services requiring a referral or authorization and to address inquiries. CSRs are able to educate members on how to obtain specific services and/or an authorization; if there is a copay and the amount of the copay for pharmacy benefits and to offer assistance including the ability to initiate an Organization Determination on behalf of a member.
2) SCFHP Website – Members may submit requests for SCFHP member ID cards and to change PCPs via the SCFHP Website. The website includes a list of services requiring an authorization and instructions for obtaining an authorization.

SCFHP conducts monthly quality monitoring to assure the quality of the information provided to members. In addition, SCFHP also conducts an annual evaluation through the selection of certain call categories to identify opportunities to improve the quality and accuracy of the information provided by CSRs to members.

II. Methodology

A. Via Telephone

Annually, SCFHP audits Customer Service telephone calls to and from members. The auditor (Customer Service Quality Manager) randomly selects 20 member contacts based on select call categories of member requested information on determining how and when to obtain referrals and authorizations for specific services or for information on costs for pharmacy services. The auditor assesses the call to determine whether the member was able to obtain answers to their inquiries. To determine the quality and accuracy of member inquiries, the auditor reviews the CSR's call documentation for completeness. The audit is performed on an annual basis by collecting and assessing data on the completion of an evaluation form (see Appendix A for Audit Sheet). Data included in this analysis was captured from July 1, 2018 through June 30, 2019.

SCFHP members do not have any financial responsibility for covered services as long as members follow the plan's rules such as receiving services within the SCFHP network or contracted providers.

B. Via Web

Customer Service receives confirmation through Microsoft Outlook when a member completes a request to reorder an ID card or change a PCP. A dedicated staff person in the Customer Service department checks the e-mail inbox intermittently throughout each business day to assure a timely response to the member. The staff responds to the members request and documents the request in the QNXT call tracking system using appropriate contact codes.

SCFHP audits requests received via the Health Plan website for turnaround times to identify opportunities for improvement. The audit will be performed on an annual basis by collecting data on the quality and accuracy of PCP change and ID card requests received. The auditor uses the test account to check the accuracy and quality of how and when to obtain referrals and authorization for specific services.

Goals:

Accuracy: 100%

Quality: 100%

Table 1: Website- Accuracy of information provided for referral and authorization

Evaluation Criteria	Total Sample	Accuracy Goal Met	% Goal Accuracy Goal Met
information is accurately showing if a referral and/or authorization is required for specific service			
1.The information on how and when to obtain a referral and authorization for medical services is populated correctly	5	5	100%
2. Information accurately reflect what services SCFHP would pay for and if there is any limits on the services	5	5	100%
3. Information accurately reflect what services are excluded or not covered by SCFHP	5	5	100%

Table 2: Website- Quality of information for referral and authorization

Evaluation Criteria	Total Sample	Quality Goal Met	% goal Quality Goal Met
Information is legible, complete and allows the member to understand			
1. The link for the member handbook moves to the correct page	5	5	100%
2. Detailed instructions are provided on what chapter/section of the member handbook to refer to on how and when to obtain referrals and authorizations for specific services	5	5	100%

Table 3: Website- Accuracy & Quality of information provided to PCP change and ID card Requests

Evaluation Criteria	Total Sample	Accuracy Goal Met	% goal Accuracy Goal Met	Quality Goal Met	% goal Quality Goal Met
1. The member's request and response were documented with accuracy	10	10	100%	10	100%
2. The request was executed in the database system (PCP updated, ID card ordered)	10	10	100%	10	100%
3. The appropriate contact code was selected	10	10	100%	10	100%
4. The acknowledgement/confirmation sent to member within one-business day	10	10	100%	9	90%

III. Data

Table 1: Telephone interactions: Accuracy of information provided is assessed for the following.

Evaluation Criteria	Total Sample	Accuracy Goal Met			% Accuracy Goal Met
Job Knowledge		Yes	No	N/A	
1. Was the inquiry initiated by the member or member's representative?	20	20	0	0	100%
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization?	20	20	0	0	100%
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination.	20	20	0	0	100%
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member?	20	20	0	0	100%
Call Documentation		Yes	No	N/A	
1. Did the agent document call in the data base system and select appropriate contact code(s)?	20	20	0	0	100%
2. Did the CSR summarize accurately the service request or interaction in the data base system?	20	20	0	0	100%

Table 2: Telephone interactions: Quality of information is assessed for the following during accuracy review.

Evaluation Criteria	Total Sample	Quality Goal Met			% Quality Goal Met
Job Knowledge		**Yes**	**No**	**N/A**	
1. Was the inquiry initiated by the member or member's representative?	20	20	0	0	100%
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization?	20	20	0	0	100%
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination.	20	20	0	0	100%
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member?	20	20	0	0	100%
Call Documentation		**Yes**	**No**	**N/A**	
1. Did the agent document call in the data base system and select appropriate contact code(s)?	20	20	0	0	100%
2. Did the agent summarize accurately and clearly the service request or interaction in the data base system?	20	20	0	0	100%

III. Accuracy and Quality Analysis

A. Accuracy: Accuracy measures met the target goal of 100% for Job Knowledge evaluation criteria 1, 2 and 4 as well as Call Documentation criteria 1 and 2.

Website: All of the website measures met the accuracy goal at 100%.

B. Quality: Quality measures met the goal at 100% of the target goal of 100% for the Telephone and met at 90% for the Website since there was delay in responding to one of the PCP change requests.

Deficiency	Accuracy or Quality	Plan for Correction	Target Date of Completion	Re-audit Completed? Y/N	Re-audit Completion Date
Delay in responding to PCP change request	Quality	Develop a daily monitor process to ensure all of the requests are processed timely	December 2019		

APPENDIX A

Audit Sheet

Reviewed by: **Date Reviewed:** **QNXT call number:**

Call recording number:

Accuracy and Quality of Personalized Information on Health Plan Services over the telephone

Measure: Determine how and when to obtain referrals and authorizations for specific services, as applicable.	**Call # Date**		**Accuracy Goal Met**	**Quality Goal Met**
Job Knowledge	**Y/N**	**N/A**	**Y/N**	**Y/N**
1. Was the inquiry initiated by the member or member's representative? Accuracy: The CSR confirmed who the caller was in relationship to the member. Quality: The CSR verified personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization? Accuracy: The CSR confirms whether or not the requested service requires an authorization. Quality: The CSR clearly explains whether or not the member needs prior authorization and/or verifies the status of the authorization if there is one on the member's file before obtaining the requested service.				
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination. Accuracy: The CSR accurately explains how the member can obtain an authorization or referral. Quality: The CSR explains thoroughly how the member can obtain and offer to initiate an organization determination.				
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member? Accuracy: The CSR accurately provides list of network provider to the member Quality: The CSRs provides list of network provider and offer to schedule an appointment with network providers				

Measure: Determine how and when to obtain referrals and authorizations for specific services, as applicable.	Call # Date		Accuracy Goal Met	Quality Goal Met
Call Documentation	**Y/N**	**N/A**	**Y/N**	**Y/N**
1. Did the agent document call in the data base system and select appropriate contact code(s)? Accuracy: The agent used the correct contact code for the interaction. Quality: The agent did not use incorrect contact codes that do not pertain to the interaction.				
2. Did the agent summarize accurately and clearly the service request or interaction in the data base system? Accuracy: The agent clearly documents all aspects of the interaction with the member. Quality: The agent's documentation is easy to understand by the auditor without the need for the auditor to listen to the call.				

Accuracy and Quality of Personalized Information on Health Plan Services via the Health Plan Website

Evaluation Criteria	Total Sample	Accuracy Goal Met	% goal Accuracy Goal Met	Quality Goal Met	% goal Quality Goal Met
1: The member's request and response were documented with accuracy					
2. The request was executed in the database system (PCP updated, ID card ordered)					
3. The appropriate contact code was selected					
4. The acknowledgement/confirmation sent to member within one-business day					

Santa Clara Family Health Plan

Regular Meeting of the Santa Clara County Health Authority Compliance Committee

Thursday, November 14, 2019
1:30 PM – 3:30 PM
6201 San Ignacio Ave.
San Jose, CA 95119

Minutes

Members Present
Linda Williams, Board Member
Christine M. Tomcala, Chief Executive Officer
Robin Larmer, Chief Compliance and Regulatory Affairs Officer
Neal Jarecki, Controller, Finance
Chris Turner, Chief Operating Officer
Laura Watkins, VP Marketing and Enrollment
Jonathan Tamayo, Chief Information Officer
Jordan Yamashita, Director, Compliance

Staff Present
Mai Phuong Nguyen, Oversight Manager
Leanne Kelly, Delegation Oversight Analyst

1. **Roll Call**

   Ms. Larmer called the meeting to order at 1:45pm. Roll call was taken and a quorum established.

2. **Public Comment**

   There were no public comments.

3. **Approve Minutes of the May 23, Regular Compliance Committee Meeting**

   Minutes of the August 22, 2019 regular Compliance Committee meeting were approved as presented.

4. **Compliance Program**

   Ms. Larmer presented the proposed Compliance Program for 2020 with red-line changes from the 2018-2019 version of the Compliance Program. Ms. Larmer explained that the changes are mostly grammatical and not material. There were updates made to information regarding the Compliance Hotline.

A **motion** was made to approve the 2020 Compliance Program; the motion was **seconded and unanimously approved.**

5. **CMS Program Audit**

Ms. Larmer provided an update on the Independent Validation Audit (IVA) to validate the Plan's correction of the Conditions cited in the Centers for Medicare and Medicaid (CMS) Program Audit report. Ms. Larmer stated that CMS declined to close the audit based on the IVA Report, which indicated that 5 of the 31 Conditions were not fully remediated, because 3 of the 5 non-remediated Conditions impacted more than 50 members. Corrective Action Plans (CAPs) have been submitted for the 5 conditions. CMS has accepted the CAPs, and indicated that the Plan will have to have a second IVA to validate full remediation. The Plan will submit a draft IVA Work Plan for CMS' review and approval next week, and anticipates submission of the IVA Report to CMS in June 2020. There is some potential for an additional fine based on the failure to fully remediate all 31 Conditions.

6. **Compliance Activity and Audit Report**

   a. The Plan received DMHC's Report from the 2019 full-scope Audit. The Report noted only 4 deficiencies, and shows a marked improvement over the Plan's performance in the last full-scope Audit, which cited 32 deficiencies.
   b. Ms. Kelly and Ms. Nguyen reviewed the status of the current delegation audits.
   c. Corrective Action Plans (CAPs): Ms. Nguyen reported that there are 4 active CAPs issued to the delegates: Language Line, VHP, PMG and CHME.

A **motion** was made to accept the Compliance Activity and Audit Report; the motion was **seconded and unanimously approved.**

7. **CMC Contract Management Team HRA PIP**

CMS notified the Plan that CA's performance on HRA completion and related tasks is materially below the national average. As a result, most CA MMP's, including the Plan, have been directed to submit Performance Improvement Plans (PIPs). Through its PIP, the Plan must demonstrate how it will improve performance in the next 6 months.

8. **Review CMC and Medi-Cal Compliance Dashboard and Work Plans**

Ms. Nguyen stated that operational measures will be removed from the Dashboard and new compliance measures will be added due to findings from recent regulatory audits. Customer Services CAPs were closed as they provided evidence of training on the new work flow for handling off cases to G&A. CM and IT continues to work on the extraction of the data for the reporting of SPD HRA completion. G&A has 2 CAPs, both are related to the acknowledgement within 5 days. Due to the system (QNXT) upgrade in July, UM only reported partial data. UM's complete data will be available by the end of October.

A **motion** was made to approve the Compliance Dashboard; the motion was **seconded and unanimously approved.**

9. **Oversight Committee Report**

Ms. Yamashita explained that regulators have been focusing heavily on delegation oversight. The Oversight Committee has been re-instated and reports up to the Governing Board through the Compliance Committee. Meetings are on a monthly basis and provide an opportunity for the Plan to present issues staff has identified with delegates. The Committee also discusses internal oversight, including internal audits and monitoring and resulting CAPs. The Committee is used as a functioning work group to look at and collaboratively resolve issues. The meeting minutes for the 9.19.19 meeting were reviewed.

A **motion** was made to approve the Oversight Committee Report; the motion was **seconded and unanimously approved.**

10. **Fraud, Waste and Abuse Report**

The Fraud, Waste, and Abuse (FWA) Vendor, T&M Protection Resources, continues to data mine to look for possible fraud cases. CMS announced a new 5 pillar program on FWA prevention. The program focuses on paying the right amount and shifting from a "pay and chase" model to a more proactive focus on fraud prevention. Audits will need to demonstrate strong prevention methods which leverage technology.

Ms. Yamashita reported that upon reviewing records obtained during a Physical Therapy practice investigation, the Plan discovered that that the practice provided electronic records created after the notice of audit was sent, not contemporaneous with provision of services. The claims value of the services at issue is roughly $6000. Ms. Williams noted that, in general, if a medical service is not properly recorded, it is to be considered not done. Ms. Turner and Ms. Larmer discussed adding language to provider training about fraudulent charting.

The group addressed the recoupment period for instances of suspected, but not definitively established, fraud (CA law allows for an extension of the one-year period for recoupment of payments to providers where fraud was a factor in the overpayment). Ms. Yamashita noted that in general, most CA Health Plans attempt to recoup outside the one-year limitations period only where the DOJ has definitively concluded fraud has occurred. The Plan will adopt a similar policy.

A **motion** was made to approve the Fraud, Waste, and Abuse Report; the motion was **seconded and unanimously approved.**

11. **Adjournment**

The meeting was adjourned at 2:49pm.

Santa Clara Family Health Plan™

Continuity and Coordination of Medical Care: 2019 Analysis

Quality Improvement Committee: December 4, 2019

Author: Lori Andersen, Director, Long Term Services and Supports (LTSS)

Overview

Santa Clara Family Health Plan (SCFHP) monitors activities directed at improving continuity and coordination of medical care and takes action, as necessary, to improve the outcomes of the monitored activities. Annually, SCFHP reviews data associated with member movement between practitioners and member movement between settings. Through analysis, SCFHP identified four opportunities for improvement. During 2019 the following opportunities were monitored for aspects of continuity and coordination of medical care:

- Measure 1: Medication Reconciliation Post Discharge (MRP)– HEDIS
- Measure 2: Comprehensive Diabetes Care (CDC) Eye Exam Rate - HEDIS
- Measure 3: PCP Follow up After 30 days of Discharge
- Measure 4: Plan All-Cause Readmissions (PCR) – HEDIS

	Name of Measure	Movement Across Settings?	Movement Across Practitioners?
Measure 1	Medication Reconciliation Post Discharge	[X]	
Measure 2	Comprehensive Diabetes Care (CDC) Eye Exam Rate		[X]
Measure 3	PCP Follow up After 30 days of Discharge	[X]	
Measure 4	Plan All-Cause Readmissions (PCR)	[X]	

SCFHP sets performance goals for each measure, and through the analysis process, identifies opportunities to improve the coordination and continuity of medical care between practitioners and settings. The quantitative analysis process includes a review of results and trends over time and compares those results against an established performance goal. The qualitative analysis process utilizes the trend data to identify potential root cause and barriers applicable against achieving the performance goal. The process incorporates opportunities and interventions to remediate negative impact that is a direct effect of the root cause. Calendar year 2018 was the first year that SCFHP collected data for the purpose of the continuity and coordination of medical care NCQA analysis. With this report, two years of data have been collected and presented for each measure. Going forward, SCFHP will track and trend each measure over a three-year period.

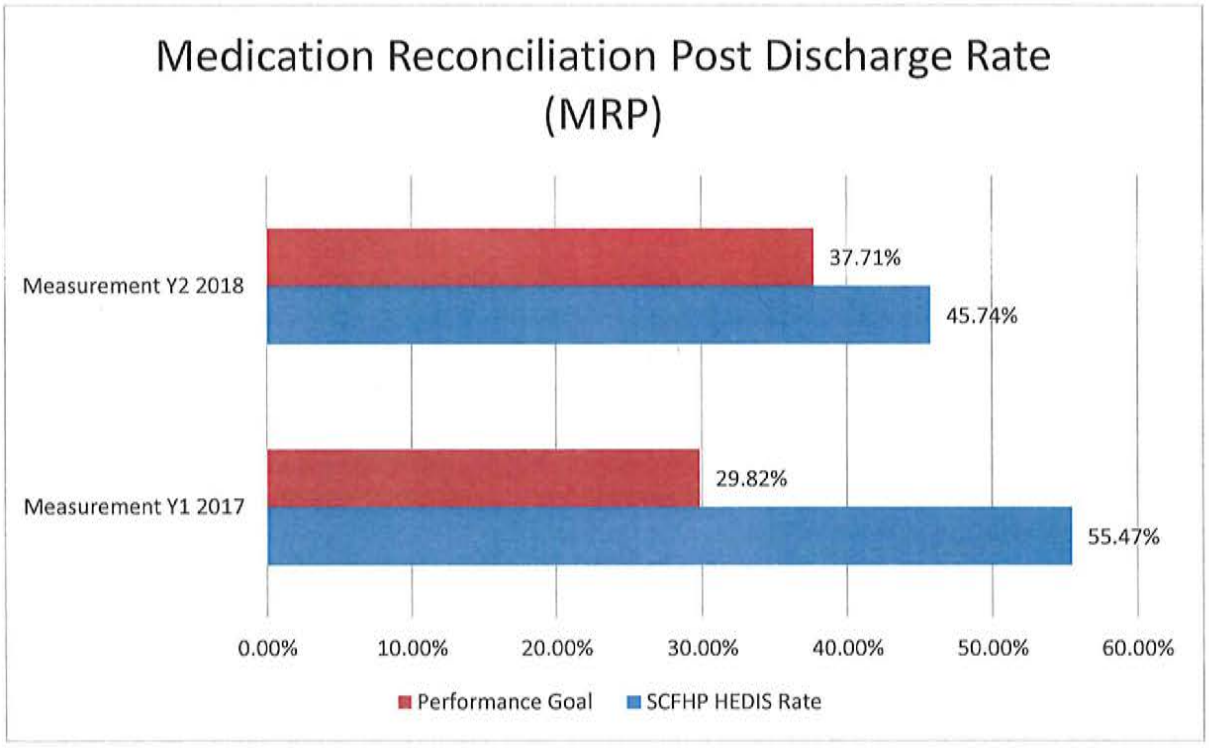
I. Measure 1: Medication Reconciliation Post-Discharge

a. Methodology

SCFHP monitors Medication Reconciliation Post-discharge annually as part of HEDIS reporting. For members 18 years of age and older, this measure identifies the percentage of discharges within the measurement/calendar year for whom medications were reconciled from the date of discharge through 30 days post-discharge (31 total days). The HEDIS technical specifications are included in Appendix A for further detail regarding methodology. The performance goal for measurement year 1 was 29.82% and for measurement year 2 was 37.71%. The rate provided is measured from 1/1/2018 – 12/31/2018 and reported for year 2019. SCFHP monitors this rate annually and sets performance goals based on previous year performance

II. Analysis

a. Result



Measure 1: Medication Reconciliation Post Discharge Rate (MRP)	Numerator	Denominator	Rate	Performance Goal	Goal Met?
Measurement Y1 2017	288	411	55.47%	29.82%	Y
Measurement Y2 2018	188	411	45.74%	37.71%	Y

b. Quantitative analysis

In measurement year 1 (2017), SCFHP was able to exceed the annual performance goal of 29.82% of members for whom medications were reconciled within 30 days of discharge totaling a performance rate of 55.47%. In measurement year 2 (2018), SCFHP again exceeded the annual performance goal for the year of 37.71% of members for whom medications were reconciled within 30 days of discharge totaling a performance rate of 45.74% thus showing an overall slight decline from the previous year.

c. Qualitative analysis

The best available source to measure Medication Reconciliation (MRP) is our HEDIS data. The current MRP rate of 55.5% is both an administrative and hybrid HEDIS rate. The admin rate for the 2018 HEDIS was 3.02%. However, once the hybrid chart review was completed, we see a marked increase up to the 55.74%. This in fact demonstrates that the physicians are actually documenting medication reconciliation in their notes, but apparently not always billing for the care provided. As such we lack admin/claims data. This is good news because it demonstrates that the providers are actually providing the care as part of the discharge plan. With the interventions proposed, we hope to increase the administrative rate from 3.02% by 5% points, which would move us to 8.02%.

2019 Barrier and Analysis Table

Barrier	Opportunity	Intervention	Selected for	Date Initiated
SCFHP lacks complete medication reconciliation data because while providers do provide the service, they don't always document it consistently and/or bill for it	Understand which providers are successfully completing medication reconciliation and submitting claims for the encounter.	Provider education on procedure codes to be used for medication reconciliation billing and the need for chart notes specifying medication reconciliation	Y	11/19
	Provide education on Medication reconciliation to practitioners through a provider memo campaign	Develop a provider communication with the assistance of Provider Network Management and plan to send this communication out to our network of practitioners.	Y	12/15/19

III. Measure 2: Comprehensive Diabetes Care (CDC) Eye Exam Rate - HEDIS

a. Methodology

SCFHP monitors the Comprehensive Diabetes Care (CDC) Eye Exam HEDIS rate to assess the movement of diabetic patients between practitioners. This rate measures the percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. The HEDIS technical specifications are included in Appendix B for further detail regarding methodology. The rate provided is measured from 01/01/2018 – 12/31/2018 and reported for year 2019. SCFHP monitors this rate annually and sets performance goals based on previous year performance. In MY3 2018, the target goal was to maintain or exceed the goal from MY2 2017. We met the goal for this measure in CY 2018 however the plan decided to have on-going monitoring for an additional year to ensure we continued to meet the targeted performance.

IV. Analysis

a. Results

Measure 1: CDC Eye Exam Rate	Numerator	Denominator	Rate	Performance Goal	Goal Met?
Measurement Y1 2016	257	411	62.53%	47.41%	Y
Measurement Y2 2017	297	411	72.26%	62.53%	Y
Measurement Y3 2018	320	411	77.86%	65.56%	Y

b. Quantitative analysis

In 2018, SCFHP aimed to increase or maintain the previous year performance rate of 72.26% of members with Type I or Type II having completed an eye exam. SCFHP managed to exceed this goal and reached a rate of 77.86%; an increase of approximately 5.5 percentage points over the previous measurement year. SCFHP continues to help our members improve in this measure by scheduling and completing an annual eye exam. The performance goals were met and therefore further qualitative analysis or opportunity for improvement is not required at this time. As the data show, SCFHP has consistently hit the target goal for three years consecutively. SCFHP will select a new measure in calendar year 2020 focusing on member movement between practitioners.

V. Measure 3 PCP Follow up after 30 days of Discharge Rate

a. Methodology

On a quarterly basis, SCFHP monitors CMC members that have an acute inpatient hospital discharge and a follow-up visit within 30 days of discharge. A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Monitoring this measure is a requirement of all Medicare-Medicaid Plans (MMPs) under the "Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements". This state-specific measure, among others, supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®1 and HOS. Detailed methodology can be found in the following reporting requirements, (: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CAReportingRequirements2019.pdf SCFHP reports this data to CMS and the State of California quarterly for evaluation. A performance goal for this measure is not prescribed by any regulatory agency. Given that the 2017 results of 90% were not feasible, SCFHP's UM Management Leadership discussed and determined that an annual stretch goal of 85% follow-up rate was more realistic and attainable.

Measure 3 – Ambulatory Care Follow Up Visit 30 Days After Hospital Discharge

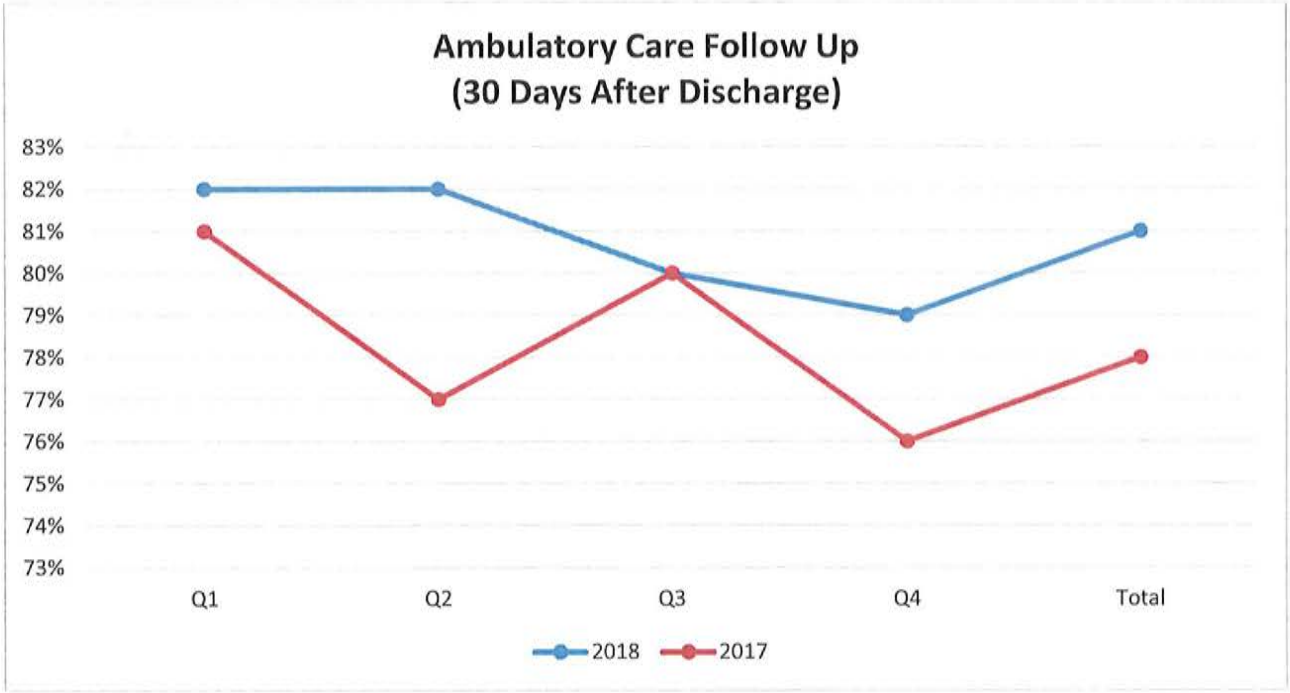
a. **Numerator definition**: Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the inpatient hospital stay.
b. **Denominator definition:** Total number of acute inpatient hospital discharges during the reporting period.
c. **Goal for comparison**: 85% of members with an acute inpatient hospital discharge within the reporting period have an ambulatory care follow-up visit within 30 days of discharge.

VI. **Analysis**

a. **Results**

Measure 3: Ambulatory Care Follow Up 30 Days After Discharge (Year 1 – 2017)		**Q1**	**Q2**	**Q3**	**Q4**	**2017 Total**
Numerator	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital.	280	254	217	239	990
Denominator	Total number of hospital discharges.	345	331	271	315	1,262
	Rate:	**81%**	**77%**	**80%**	**76%**	**78%**

Measure 3: Ambulatory Care Follow Up 30 Days After Discharge (Year 2 – 2018)		**Q1**	**Q2**	**Q3**	**Q4**	**2018 Total**
Numerator	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital.	283	249	253	233	1018
Denominator	Total number of hospital discharges.	346	302	315	296	1259
	Rate:	**82%**	**82%**	**80%**	**79%**	**81%**



b. Quantitative analysis

The performance goal set for Measurement Year 2 (2018) of 85% was not met cumulatively for 2018, nor was it met at any point in Q1-Q4. Q1 and Q2 achieved the highest rates of 30 day follow-up visits with 82%. Rates dipped back down in Q3 and Q4 by 2-3 percentage points. The 2018 cumulative rate of 81% shows improvement from 2017 and that SCFHP is 4 percentage points away from meeting the goal of 85%. This gap indicates opportunities for continued improvement in the existing process of encouraging members to schedule and keep appointments with their physicians after discharge from an acute inpatient hospital stay.

c. Qualitative analysis

Planned UM process improvements included the development and implementation of PCP admission notification letters at the time these admissions were received and entered into QNXT for Inpatient Concurrent review purposes.
A barrier analysis was completed to identify opportunities and interventions to improve the rate of members receiving 30-day follow up. The analysis was completed by an Internal Cross-Functional Work Group, comprised of representatives from UM, Case Management, Quality and IT. Efforts to notify PCPs of admissions were not successful in part due to inconsistent census information provided by hospitals. Improvements in the rate are expected with changes made to the TOC process and a more consistent process for informing PCPs of member discharges.

Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2020?	Date Initiated
PCPs are not always aware that their patients have been admitted or subsequently discharged to home	Improve acute and skilled discharge notification to member's assigned PCP's	As part of the transition of care (TOC) call follow-up, the case manager will send a notification letter to PCP with discharge information in an SBAR format	Y	January 2020

VII. Measure 4: Plan All-Cause Readmissions (PCR) HEDIS Rate

a. Methodology

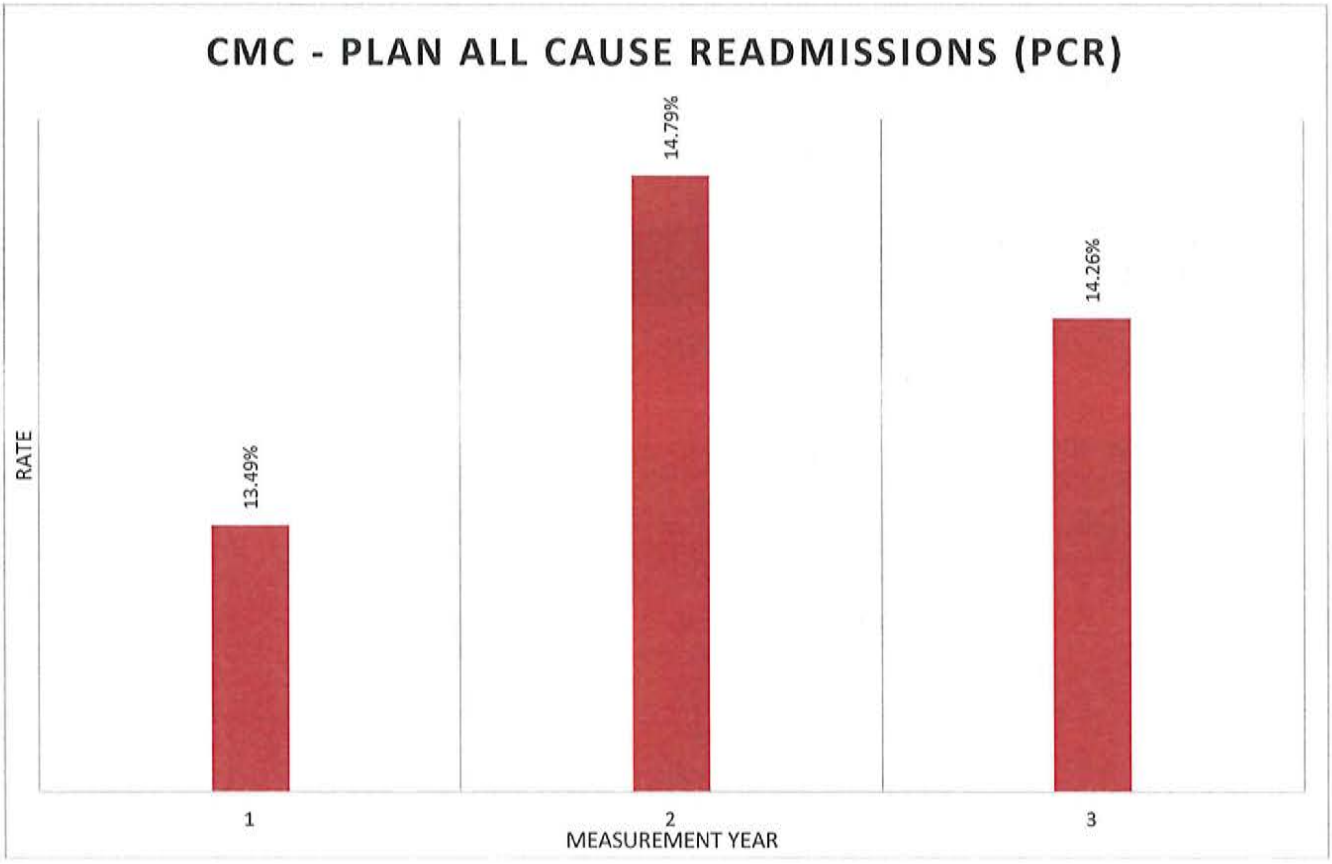
SCFHP monitors all-cause acute readmissions annually as part of HEDIS reporting and as part of the Quality Withhold data set. For Quality Withhold, Medicare and Medicaid withhold a percentage of capitation rates to incent MMPs to provide high quality care and conduct quality improvement. For members 18 years of age and older, this measure identifies the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. One of two different performance goals are determined by CMS benchmarks. CMS benchmarks are established using national data such that all MMPs across demonstrations are held to a consistent level of performance. The CMS benchmark for PCR is 14.66% and SCFHP has adopted this performance goal for the purposes of this analysis. Data for this measure is reported in the following categories:

- **Denominator**: Count of Index Hospital Stays (IHS)
  - *An IHS is defined as an acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year.*
- **Numerator**: Count of 30-Day Readmissions
  - *Defined as an acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.*
- **Expected Readmissions Rate**
  - **Performance Goal:** 14.66% (CMS Benchmark for 2019)

VIII. **Analysis**

a. Results

Measure 2: PCR Rate	Numerator	Denominator	Rate	Performance Goal	Goal Met?
Measurement Y1 2016	151	1,119	13.49%	11%	N
Measurement Y2 2017	183	1,246	14.79%	11%	N
Measurement Y3 2018	185	1,297	14.26%	14.66%	Yes



b. Quantitative analysis

SCFHP missed the performance goal of 11% by 2.5 percentage points in 2016, and 3.8 percentage points in 2017. In 2018, SCFHP met and improved on the goal of 14.66% indicating a decreasing trend overall. While an improvement from 2017, opportunities remain to improve internal and external processes to prevent unplanned acute readmissions within 30 days of discharge and continue to maintain below the CMS Benchmark of 14.66%.

c. Qualitative analysis

A barrier analysis was completed to identify opportunities and interventions to decrease the rate of members readmitted within 30 days of discharge. The analysis was completed at the Internal Cross-Functional Work Group comprised of representatives from UM, Case Management (CM), QI and IT. The group agreed that readmissions are most likely to occur because of a lack of timely follow up care and noncompliance with/and or not receiving discharge instructions. This can be impacted by regular transition of care (TOC) calls, but the current SCFHP TOC program has been limited in scope due to staff turnover and capacity. Currently we receive near real-time census data on admissions from only a few hospitals and the UM staff forwards this information to the case management team to complete, document and follow up on TOC outreach calls. The group discussed expanding this by finding ways to collect real time notifications of discharges and expand the scope of outbound calls to members discharged from other hospitals. The group also identified opportunities for continued coordination between the internal UM and CM departments that includes weekly concurrent review meetings and timely hand-off for TOC calls.

2019 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2020?	Date Initiated
Inconsistent and changing TOC roles for UM and CM staff combined with limited staff resources to conduct TOC calls	Improve TOC call implementation and consistent follow up by increasing case management staff resources for timely completion of all TOC calls with prioritization for identifying the patient population with the highest needs.	Re-assign member cases in CM by care teams with responsibility for TOC calls.	Y	April 2020

SCFHP currently lacks a centralized real time notification system from hospitals that allows follow up after discharges.	Real-time census data from additional hospitals with admission and discharge information will increase TOC calls and reduce preventable readmissions	Work with IT to build user-defined fields to provide real-time updates for 3 County hospitals allowing for this type of reporting to UM	Y	January, 2020

Committee Review

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

APPENDIX

Appendix A

Medication Reconciliation Post-Discharge (MRP)

SUMMARY OF CHANGES TO HEDIS 2020

- Modified value sets to make them compatible with digital measure formatting.
- Added instructions for identifying acute inpatient events that occur between the admission and discharge dates of a nonacute inpatient stay.
- Clarified the fifth bullet in the hybrid specification.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

Description

The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

Definition

Medication reconciliation	A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.*

Product line	Medicare.
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	Date of discharge through 30 days after discharge (31 total days).
Allowable gap	None.
Anchor date	None.
Benefit	Medical.
Event/diagnosis	An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Readmission or direct transfer If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 total days), count only the last discharge. To identify readmissions and direct transfers during the 31-day period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay (the admission date must occur during the 31-day period).
3. Identify the discharge date for the stay (the discharge date is the event date).

Exclude both the initial and the readmission/direct transfer discharges if the last discharge occurs after December 1 of the measurement year.

If the admission date and the discharge date for an acute inpatient stay occur between the admission and discharge dates for a nonacute inpatient stay, include only the nonacute inpatient discharge.

Note: *If a member remains in an acute or nonacute care setting through December 1 of the measurement year, a discharge is not included in the measure for this member, but the organization must have a method for identifying the member's status for the remainder of the measurement year, and may not assume the member remained admitted based only on the absence of a discharge before December 1. If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.*

Administrative Specification

Denominator The eligible population.

Numerator Medication reconciliation (Medication Reconciliation Encounter Value Set; Medication Reconciliation Intervention Value Set) conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days).

Hybrid Specification

Denominator A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

The denominator is based on episodes, not on members. Members may appear more than once in the sample.

Numerator Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days).

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

Only documentation in the outpatient medical record meets the intent of the measure, but an outpatient visit is not required.

Note

- *The denominator is based on the discharge date found in administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.*
- *This measure assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table MRP-3: Data Elements for Medication Reconciliation Post-Discharge

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		✓
Administrative rate on MRSS		✓
Number of medical records excluded because of valid data errors		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS. HEDIS measures may not be adjusted for any NCQA program.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Medication Reconciliation Post-Discharge

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	Age determination dates may be changed (e.g., select, "age as of June 30"). Changing denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events that contain (or map to) codes in the value sets may be used to identify the eligible population for each rate. The Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members with documentation of medication reconciliation after each discharge).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Medication Reconciliation	Yes, with limits	Value sets and logic may not be changed. May require medication reconciliation within an alternate time frame.

Appendix B

Comprehensive Diabetes Care (CDC)

SUMMARY OF CHANGES TO HEDIS 2020

- Modified value sets to make them compatible with digital measure formatting.
- Removed "with or without a telehealth modifier" language; refer to *General Guideline 43*.
- Updated value sets to identify acute and nonacute inpatient events for the event/diagnosis.
- Updated value sets used to identify advanced illness.
- Updated value sets to identify IVD acute inpatient events.
- Updated value sets to identify thoracic aortic aneurysm inpatient events.
- Clarified the telehealth requirements.
- Removed the telehealth exclusion from ESRD.
- Reformatted the denominator of the Hybrid Specification.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population*.
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).

**Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.*

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.*

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Stratification

For only Medicare, for only the Eye Exam (retinal) indicator, report the following SES stratifications and total:

- Non-LIS/DE, Nondisability.
- LIS/DE.
- Disability.
- LIS/DE and Disability.
- Other.
- Unknown.
- Total Medicare.

Note: *The stratifications are mutually exclusive, and the sum of all six stratifications is the Total population. The stratifications are reported in a separate table.*

Ages 18–75 years as of December 31 of the measurement year.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), online assessments (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.

Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Only one of the two visits may be an outpatient telehealth visit, a telephone visit or an online assessment. Identify outpatient telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit.

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlinitide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empaglifozin-linagliptin	• Empagliflozin-metformin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide	• Albiglutide • Liraglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Exclusions

Exclude members who meet any of the following criteria:

Note: *Supplemental and medical record data may not be used for these exclusions.*

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
       3. Identify the discharge date for the stay.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
     - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set). To identify an acute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
       3. Identify the discharge date for the stay.
     - A dispensed dementia medication (Dementia Medications List).

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine

Administrative Specification

Denominator

The eligible population.

Note: *The eligible population for the HbA1c Control <7% for a Selected Population indicator is reported after required exclusions are applied.*

Required exclusions for HbA1c Control <7% for a Selected Population indicator

Exclude members who meet any of the following criteria:

- 65 years of age and older as of December 31 of the measurement year.
- *CABG.* Members who had CABG (CABG Value Set) in any setting during the measurement year or the year prior to the measurement year.
- *PCI.* Members who had PCI (PCI Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- *IVD.* Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
  - At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set).
  - A telephone visit (Telephone Visits Value Set) with an IVD diagnosis (IVD Value Set).
  - An online assessment (Online Assessments Value Set) with an IVD diagnosis (IVD Value Set).
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
  - At least one acute inpatient discharge with an IVD diagnosis (IVD Value Set) on the discharge claim. To identify an acute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    3. Identify the discharge date for the stay.

  Only one of the two visits may be an outpatient telehealth visit, a telephone visit or an online assessment. Identify outpatient telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit.

- *Thoracic aortic aneurysm.* Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
  - At least one outpatient visit (Outpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set).
  - At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set) ***without*** (Telehealth Modifier Value Set; Telehealth POS Value Set).
  - At least one acute inpatient discharge with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set). To identify an acute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    3. Identify the discharge date for the stay.
- Any of the following, in any setting, any time during the member's history through December 31 of the measurement year.
  - *Chronic heart failure.* A diagnosis of chronic heart failure (Chronic Heart Failure Value Set).
  - *Prior MI.* A diagnosis of MI (MI Value Set).
  - *ESRD.* ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set).
  - *Chronic kidney disease (stage 4).* Stage 4 chronic kidney disease (CKD Stage 4 Value Set).
  - *Dementia.* A diagnosis of dementia (Dementia Value Set; Frontotemporal Dementia Value Set).
  - *Blindness.* A diagnosis of blindness (Blindness Value Set).
  - *Amputation (lower extremity).* Lower extremity amputation (Lower Extremity Amputation Value Set).

Numerators

HbA1c Testing An HbA1c test (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) performed during the measurement year.

HbA1c Poor Control >9% Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).*

HbA1c Control <8%

Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant*
HbA1c Level Greater Than 9.0 Value Set	Not compliant

HbA1c Control <7% for a Selected Population

Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥7.0% or is missing a result, or if an HbA1c test was not performed during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

* The CPT Category II code (3045F) in this value set indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization must use other sources (laboratory data, hybrid reporting method) to identify the actual value and determine if the HbA1c result was <8%. Because providers assign the Category II code after reviewing test results, the date of service for the Category II code may not match the date of service for the HbA1c test found in other sources; if dates differ, use the date of service when the test was performed. The date of service for the Category II code and the test result must follow the requirements outlined in *General Guideline 33: Measures That Require Results From the Most Recent Test or Measurement* (i.e., the dates of service for the code and the test result must be no more than seven days apart).

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Not compliant

Note: *This indicator uses the eligible population with additional eligible population criteria (e.g., removing members with required exclusions).*

Eye Exam Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
- Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the measurement year.
- Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year.
- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) ***and*** right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service.

- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more apart.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) with service dates 14 days or more apart.

Medical Attention for Nephropathy

A nephropathy screening or monitoring test ***or*** evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening or monitoring test (Urine Protein Tests Value Set).
- Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).
- Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).
- Evidence of ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set).
- Evidence of nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set).
- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- At least one ACE inhibitor or ARB dispensing event (ACE Inhibitor and ARB Medications List).

Note: *A process flow diagram is included at the end of this specification to help implement this measure.*

ACE Inhibitor and ARB Medications

Description	Prescription				
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril	• Enalapril • Fosinopril	• Lisinopril • Moexipril	• Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan	• Eprosartan • Irbesartan	• Losartan • Olmesartan	• Telmisartan • Valsartan	
Antihypertensive combinations	• Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan • Amlodipine-valsartan	• Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan	• Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Sacubitril-valsartan • Trandolapril-verapamil		

BP Control <140/90 mm Hg

Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during an outpatient visit (Outpatient Value Set) or a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year.

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than or Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80–89 Value Set	Diastolic compliant
Diastolic Greater Than or Equal To 90 Value Set	Diastolic not compliant

Exclusions *(optional)*

Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the *HbA1c Control (<7.0%) for a Selected Population* denominator.

If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Hybrid Specification

Denominator—Organizations Not Reporting HbA1c Control <7%

Organizations should use a sample size of 411 if they do not report the *HbA1c Control <7% for a Selected Population* indicator. The *HbA1c Control <7% for a Selected Population* indicator is not collected or reported for the Medicare product line.

For Medicare reporting, the denominator for the Total Medicare SES stratification is the entire systematic sample. Do not pull samples for each stratification. The individual stratifications for the denominators and all numerators must sum to the total.

Denominator—Organizations Reporting HbA1c Control <7%

Organizations reporting the *HbA1c Control <7% for a Selected Population* indicator should use a sample size of 548 for each indicator. This sample size is based on the goal of achieving a denominator of at least 411 for the *HbA1c <7% for a Selected Population* indicator after required exclusions.

Organizations should use their prior experience with the number of required exclusions to determine the appropriate oversample percentage. Members who meet the required exclusion criteria for the *HbA1c Control <7% for a Selected Population* indicator are excluded from the *HbA1c Control <7% for a Selected Population* denominator. Report this indicator as 548 minus the required exclusions.

If the denominator drops below 411, use members from the oversample to bring the denominator back up to 411. Members added from the oversample must be added to the denominators for every measure indicator. This will result in some indicators having a denominator larger than 548. If the oversample was underestimated and all oversample members have been exhausted without satisfying the denominator of 411 for the *HbA1c Control <7% for a Selected Population* indicator, per the *Guidelines for Calculations and Sampling*, the organization must contact NCQA to determine next steps.

Note: *The eligible population for the HbA1c Control <7% for a Selected Population indicator is reported after required exclusions are applied.*

Denominator—Sample Size Reduction

The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate among all the reported CDC indicators. The lowest rate for all reported indicators must be used when reducing the sample size.

If the organization chooses to reduce the sample size and report the *HbA1c Control <7% for a Selected Population* indicator, the sample size for this indicator must still be the appropriate sample size as specified in Table 2: Sample Sizes When Data Are Available on the Product Line Being Measured (in the *Guidelines for Calculations and Sampling*) after the required exclusions are removed.

Required exclusions for HbA1c Control <7% for a Selected Population

Administrative

Refer to *Administrative Specification* to identify required exclusions from administrative data.

Medical record

Exclude members who meet any of the following criteria:

- 65 years of age and older as of December 31 of the measurement year.
- *CABG.* Dated documentation of CABG in the measurement year or the year before the measurement year.
- *PCI.* Dated documentation of PCI in the measurement year or the year before the measurement year.
- *IVD.* Documentation of an IVD diagnosis. Look as far back as possible in the member's history through December 31 of the measurement year. Appropriate diagnoses include:
  - IVD.
  - Ischemic heart disease.
  - Angina.
  - Coronary atherosclerosis.
  - Coronary artery occlusion.
  - Cardiovascular disease.
  - Occlusion or stenosis of precerebral arteries (including basilar, carotid and vertebral arteries).
  - Atherosclerosis of renal artery.
  - Atherosclerosis of native arteries of the extremities.
  - Chronic total occlusion of artery of the extremities.
  - Arterial embolism and thrombosis.
  - Atheroembolism.
- *Thoracoabdominal or thoracic aortic aneurysm.* Documentation of thoracoabdominal aneurysm or thoracic aortic aneurysm. Look as far back as possible in the member's history through December 31 of the measurement year.
- *CHF.* Documentation of CHF or cardiomyopathy diagnosis. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Prior MI. Documentation of prior MI.* Look as far back as possible in the member's history through December 31 of the measurement year.
- *ESRD. Documentation of stage 5 chronic kidney disease, ESRD or dialysis.* Look as far back as possible in the member's history through December 31 of the measurement year.
- *Chronic kidney disease (stage 4).* Documentation of stage 4 chronic kidney disease. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Dementia.* Documentation of dementia. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Blindness.* Documentation of blindness in one or both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Amputation (lower extremity).* Documentation of lower extremity amputation. Look as far back as possible in the member's history through December 31 of the measurement year.

Note: *For Hybrid reporting, search the medical record for required exclusions and apply them before determining if the member has a numerator hit. Organizations are not required to search for required exclusions if a member has an administrative hit for the indicator, but must exclude these members if they are discovered during medical record review.*

Numerators

HbA1c Testing An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Count notation of the following in the medical record:

- A1c.
- HbA1c
- HgbA1c.
- Hemoglobin A1c.
- Glycohemoglobin A1c.
- Glycohemoglobin.
- Glycated hemoglobin.
- Glycosylated hemoglobin.

HbA1c Poor Control >9% The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through laboratory data or medical record review.

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).*

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

HbA1c Control <8% The *most recent* HbA1c level (performed during the measurement year) is <8.0% as identified by laboratory data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

HbA1c Control <7% for a Selected Population

The *most recent* HbA1c level (performed during the measurement year) is <7.0% as identified by laboratory data or medical record review.

Note: *This indicator uses the eligible population with additional eligible population criteria (i.e., removing members with comorbid conditions).*

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥7.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Eye Exam

Screening or monitoring for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).

- Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

Medical Attention for Nephropathy

A nephropathy screening or monitoring test during the measurement year ***or*** evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

Note: *A process flow diagram is included at the end of this specification to help implement this measure.*

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

Any of the following during the measurement year meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy.

- A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria:
  - 24-hour urine for albumin or protein.
  - Timed urine for albumin or protein.
  - Spot urine (e.g., urine dipstick or test strip) for albumin or protein.
  - Urine for albumin/creatinine ratio.
  - 24-hour urine for total protein.
  - Random urine for protein/creatinine ratio.
- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of medical attention for any of the following (no restriction on provider type):
  - Diabetic nephropathy.
  - ESRD.
  - Chronic renal failure (CRF).
  - Chronic kidney disease (CKD).
  - Renal insufficiency.
  - Proteinuria.
  - Albuminuria.
  - Renal dysfunction.
  - Acute renal failure (ARF).
  - Dialysis, hemodialysis or peritoneal dialysis.
- Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include evidence that the member received ACE inhibitor/ ARB therapy during the measurement year. Any of the following meet criteria:
  - Documentation that a prescription for an ACE inhibitor/ARB was written during the measurement year.

– Documentation that a prescription for an ACE inhibitor/ARB was filled during the measurement year.
– Documentation that the member took an ACE inhibitor/ARB during the measurement year.

BP Control <140/90 mm Hg

The *most recent* BP level (taken during the measurement year) is <140/90 mm Hg, as documented through administrative data or medical record review.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

The organization should use the medical record from which it abstracts data for the other CDC indicators. If the organization does not abstract for other indicators, it should use the medical record of the provider that manages the member's diabetes. If that medical record does not contain a BP, the organization may use the medical record of another PCP or specialist from whom the member receives care.

Identify the most recent BP reading noted during the measurement year. Do not include BP readings that meet the following criteria:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
- Reported by or taken by the member.

BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be included. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored and transmitted to the provider, and interpreted by the provider.

Note: *Member-reported results to the provider from a remote monitoring device are not acceptable.*

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The member is not numerator compliant if the BP does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (i.e., the systolic or diastolic level is missing).

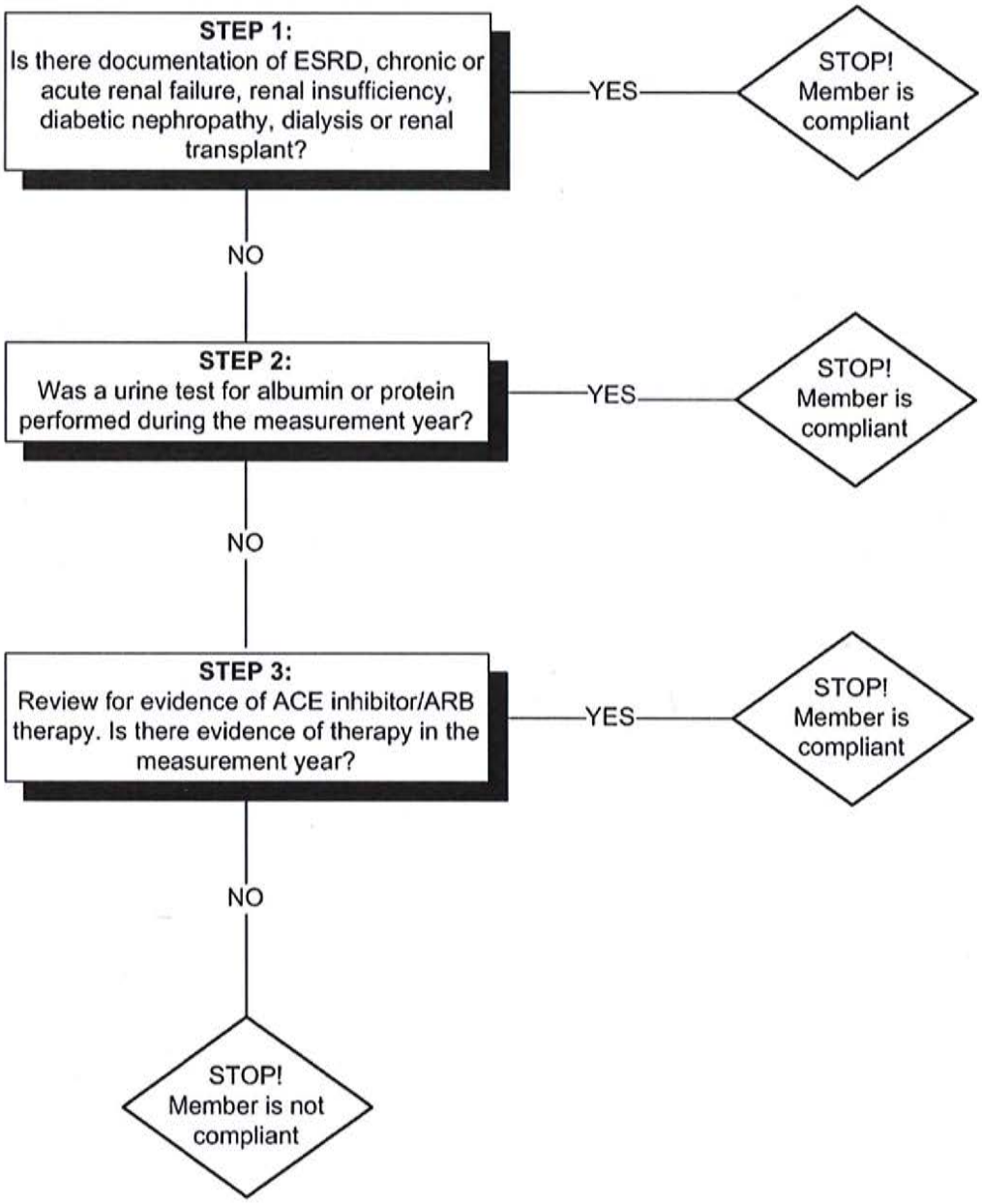
Exclusions *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Note

- *Organizations may select a data collection method (Administrative vs. Hybrid) at the indicator level, but the method used for HbA1c testing and control rates must be consistent.*
- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*
- *To facilitate HEDIS reporting the denominator for all rates (with the exception of the HbA1c Control (<7.0%) for a Selected Population must be the same. While an eye exam is not possible, services measured in the other indicators are important for members with bilateral eye enucleation. For these reasons bilateral eye enucleation is considered a numerator hit (rather than an optional exclusion).*
- *Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting the Eye Exam indicator; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of the Eye Exam indicator is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.*
- *If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.*
- *If an organization chooses to apply the optional exclusions, members must be numerator negative for at least one indicator, with the exception of HbA1c Poor Control (>9%). Remove members from the eligible population who are numerator negative for any indicator (other than for HbA1c Poor Control [>9%]) and substitute members from the oversample. Do not exclude members who are numerator compliant for all indicators except HbA1c Poor Control (>9%), because a lower rate indicates better performance for this indicator.*
- *When excluding BP readings from the BP Control <140/90 mm Hg indicator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. For example (this list is just for reference, and is not exhaustive):*
  - *A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication is taken to prep the colon).*
  - *Dialysis, infusions and chemotherapy (including oral chemotherapy) are all therapeutic procedures that require a medication regimen.*
  - *A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol).*
  - *A patient forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.*
- *BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure are eligible for use. For example, the following procedures are considered common low-intensity or preventive procedures (this list is just for reference, and is not exhaustive):*
  - *Vaccinations.*
  - *Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone, lidocaine).*
  - *TB test.*
  - *IUD insertion.*
  - *Eye exam with dilating agents.*
  - *Wart or mole removal.*

Monitoring for Nephropathy



Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CDC-1/2/3: Data Elements for Comprehensive Diabetes Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	*Each of the 7 rates*	*Each of the 7 rates*
Eligible population with required exclusions applied	*Each of the 7 rates*	*Each of the 7 rates*
Number of numerator events by administrative data in eligible population (before optional exclusions)		*Each of the 7 rates*
Current year's administrative rate (before optional exclusions)		*Each of the 7 rates*
Minimum required sample size (MRSS)		*Each of the 7 rates*
Oversampling rate		*Each of the 7 rates*
Number of oversample records		*Each of the 7 rates*
Number of numerator events by administrative data in MRSS		*Each of the 7 rates*
Administrative rate on MRSS		*Each of the 7 rates*
Number of medical records excluded because of valid data errors		*Each of the 7 rates*
Number of optional administrative data records excluded		*Each of the 7 rates*
Number of optional medical records excluded		*Each of the 7 rates*
Number of employee/dependent medical records excluded		*Each of the 7 rates*
Number of HbA1c <7 required medical records excluded		*HbA1c <7 Rate*
Number of HbA1c <7 required administrative data records excluded		*HbA1c <7 Rate*
Records added from the oversample list		*Each of the 7 rates*
Denominator		*Each of the 7 rates*
Numerator events by administrative data	*Each of the 7 rates*	*Each of the 7 rates*
Numerator events by medical records		*Each of the 7 rates*
Numerator events by supplemental data	*Each of the 7 rates*	*Each of the 7 rates*
Reported rate	*Each of the 7 rates*	*Each of the 7 rates*

Table CDC-3-B: Data Elements for Comprehensive Diabetes Care: Eye Exam (Medicare SES Stratifications only. Report the Total Medicare population in Table CDC-1/2/3)

	Administrative	Hybrid
Eligible population	*Each of the 6 stratifications*	*Each of the 6 stratifications*
Denominator		*Each of the 6 stratifications*
Numerator events by administrative data	*Each of the 6 stratifications*	*Each of the 6 stratifications*
Numerator events by medical records		*Each of the 6 stratifications*
Numerator events by supplemental data	*Each of the 6 stratifications*	*Each of the 6 stratifications*
Reported rate	*Each of the 6 stratifications*	*Each of the 6 stratifications*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS. HEDIS measures may not be adjusted for any NCQA program.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Comprehensive Diabetes Care

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). Changing denominator age range is allowed within specified age range (ages 18–75 years). The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied; value sets and logic may not be changed.
Required Exclusions	No	The age exclusion for the HbA1c <7.0% indicator must be applied.
Exclusions: I-SNP, LTI, Frailty or Advanced Illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.

Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
• Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • HbA1c control (<7.0%) for a selected population • Eye exam (retinal) performed • Medical attention for nephropathy • BP control (<140/90 mm HG)	No	Medication lists, value sets and logic may not be changed.

Appendix C

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO HEDIS 2020

- Added definitions of "outlier," "nonoutlier" and "plan population."
- Added observation stays to inpatient admissions.
- Revised direct transfers to include observation discharges.
- Moved instructions for direct transfer to *Guideline 6* in the *Guidelines for Risk Adjusted Utilization Measures*.
- Added steps to remove hospitalizations for outlier members and report a count of outlier members.
- Removed the high-frequency hospitalization stratification for Medicaid.
- Added a step in the Risk Adjustment Weighting section for observation stay IHS.
- Removed the base weight variable from the Risk Adjustment Weighting.
- Removed Sample Table: PCR—Risk Adjustment Weighting in Risk Adjustment Weighting.
- Added a *Note* to step 4 in the numerator.
- Revised the data element tables to combine the 18–64 and 65+ populations.
- Added instructions and data element tables to report plan population and outlier rate.
- Removed the "Total 18-64 Medicare" and "Total 65+ Medicare" rows from Table PCR-B-3 and removed associated footnotes.
- Added instructions and data element tables to report the rate among index stays discharged or transferred to skilled nursing care.

Description

For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of Observed 30-Day Readmissions (numerator).
3. Count of Expected 30-Day Readmissions.

Note: *For commercial and Medicaid, report only members 18–64 years of age.*

Definitions

IHS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.

Index Readmission Stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 3 (required exclusions) of the *numerator*.
Plan population	Members who meet all of the following criteria: • 18 and older as of January 1 of the measurement year. • Continuously enrolled for at least 395 days, with no more than one gap in enrollment of up to 45 days during the 395-day period, between January 1 of the year prior to the measurement year and December 1 of the measurement year. Assign members to the product and product line at the start of this defined continuous enrollment period.
Outlier	Medicaid and Medicare members in the eligible population with four or more index hospital stays between January 1 and December 1 of the measurement year. Commercial members in the eligible population with three or more index hospital stays between January 1 and December 1 of the measurement year. Assign members who transition between product lines during the measurement year to the product they were enrolled in on January 1 of the measurement year.
Nonoutlier	Members in the plan population who are not considered outliers.
Classification period	365 days prior to and including an Index Discharge Date.

Risk Adjustment Tables

Table	Table Description
HCC-Surg	Surgery codes for Risk Adjustment Determination
PCR-DischCC	Discharge Clinical Condition category codes for Risk Adjustment Determination
CC-Comorbid	Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2
HCC–Rank	HCC rankings for Risk Adjustment Determination step 3
HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5
PCR-MA-DischCC-Weight-Under65	MA and SNP primary discharge weights for Risk Adjustment Weighting step 3 for ages under 65
PCR-MA-DischCC-Weight-65plus	MA and SNP primary discharge weights for Risk Adjustment Weighting step 3 for ages 65 and older

Table	Table Description
PCR-MA-SDischCC-Weight-Under65	MA and SNP primary discharge weights for Risk Adjustment Weighting step 3 for index stays discharged to skilled nursing among ages under 65
PCR-MA-SDischCC-Weight-65plus	MA and SNP primary discharge weights for Risk Adjustment Weighting step 3 for index stays discharged to skilled nursing among ages 65 and older
PCR-Comm-DischCC-Weight	Commercial primary discharge weights for Risk Adjustment Weighting step 3
PCR-MD-DischCC-Weight	Medicaid primary discharge weights for Risk Adjustment Weighting step 3
PCR-MA-ComorbHCC-Weight-Under65	MA and SNP comorbidity weights for Risk Adjustment Weighting step 4 for ages under 65
PCR-MA-ComorbHCC-Weight-65plus	MA and SNP comorbidity weights for Risk Adjustment Weighting step 4 for ages 65 and older
PCR-MA-SComorbHCC-WeightUnder65	MA and SNP comorbidity weights for Risk Adjustment Weighting step 4 for index stays discharged to skilled nursing among ages under 65
PCR-MA-SComorbHCC-Weight-65plus	MA and SNP comorbidity weights for Risk Adjustment Weighting step 4 for index stays discharged to skilled nursing among ages 65 and older
PCR-Comm-ComorbHCC-Weight	Commercial comorbidity weights for Risk Adjustment Weighting step 4
PCR-MD-ComorbHCC-Weight	Medicaid comorbidity weights for Risk Adjustment Weighting step 4
PCR-MA-OtherWeights-Under65	MA and SNP observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5 for ages under 65
PCR-MA-OtherWeights-65plus	MA and SNP observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5 for ages 65 and older
PCR-MA-SOtherWeights-Under65	MA and SNP observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5 for index stays discharged to skilled nursing among ages under 65
PCR-MA-SOtherWeights-65plus	MA and SNP observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5 for index stays discharged to skilled nursing among ages 65 and older
PCR-Comm-OtherWeights	Commercial observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5
PCR-MD-OtherWeights	Medicaid observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5

Note: *The risk adjustment tables will be released on November 1, 2019, and posted to www.ncqa.org.*

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Refer to General Guideline 10: Reporting for small denominator limits.

Product line Stratification

Commercial, Medicare, Medicaid (report each product line separately).

For only Medicare IHS', report the following SES stratifications and total:

- Non-LIS/DE, Nondisability.
- LIS/DE.
- Disability.
- LIS/DE and Disability.
- Other.
- Unknown.
- Total Medicare.

Note: *The stratifications are mutually exclusive, and the sum of all six stratifications is the Total population.*

Ages

For commercial, ages 18–64 as of the Index Discharge Date.

For Medicare, ages 18 and older as of the Index Discharge Date.

For Medicaid, ages 18–64 as of the Index Discharge Date.

Continuous enrollment

365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.

Allowable gap

No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.

Anchor date

Index Discharge Date.

Benefit

Medical.

Event/diagnosis

An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year.

The denominator for this measure is based on discharges, not members. Include all acute inpatient or observation stay discharges for nonoutlier members who had one or more discharges on or between January 1 and December 1 of the measurement year.

Follow the steps below to identify acute inpatient and observation stays.

Administrative Specification

Denominator The eligible population.

Step 1 Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient and observation stay discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays.

The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the *Guidelines for Risk Adjusted Utilization Measures.*

Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4 Exclude hospital stays for the following reasons:

- The member died during the stay.
- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

Step 5 Calculate continuous enrollment.

Step 6 Remove hospital stays for outlier members and report these members as outliers in Table PCR-1/2/3.

Note: *Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier members.*

Step 7 Assign each remaining acute inpatient or observation stay to an age and stratification category using the reporting instructions below.

Risk Adjustment Determination

For each IHS among nonoutlier members, use the following steps to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age and gender.

Observation Stay Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.

Surgeries Determine if the member underwent surgery during the stay. Download the list of codes from the NCQA website (Table HCC-Surg) and use it to identify surgeries. Consider an IHS to include a surgery if at least one procedure code in Table HCC-Surg is present from any provider between the admission and discharge dates.

Discharge Condition Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its primary discharge diagnosis, using Table PCR-DischCC. For direct transfers, use the primary discharge diagnosis from the last discharge. Exclude diagnoses that cannot be mapped to Table PCR-DischCC.

Comorbidities Refer to the *Utilization Risk Adjustment Determination* in the *Guidelines for Risk Adjusted Utilization Measures.*

Risk Adjustment Weighting

For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, comorbidity, age and gender.

Note: *The final weights table will be released on November 1, 2019, and posted to www.ncqa.org.*

Step 1 For each IHS discharge that is an observation stay, link the observation stay IHS weight.

- *For Medicare product lines ages 18–64:*
  - Use Table PCR-MA-OtherWeights-Under65.
  - Use Table PCR-MA-SOtherWeights-Under65.
- *For Medicare product lines ages 65 and older:*
  - Use Table PCR-MA-OtherWeights-65plus.
  - Use Table PCR-MA-SOtherWeights-65plus.
- *For commercial product lines:* Use Table PCR-Comm-OtherWeights.
- *For Medicaid product lines:* Use Table PCR-MD-OtherWeights.

Step 2 For each IHS with a surgery, link the surgery weight.

- *For Medicare product lines ages 18–64:*
  - Use Table PCR-MA-OtherWeights-Under65.
  - Use Table PCR-MA-SOtherWeights-Under65.
- *For Medicare product lines ages 65 and older:*
  - Use Table PCR-MA-OtherWeights-65plus.
  - Use Table PCR-MA-SOtherWeights-65plus.
- *For commercial product lines:* Use Table PCR-Comm-OtherWeights.
- *For Medicaid product lines:* Use Table PCR-MD-OtherWeights.

Step 3 For each IHS with a discharge CC Category, link the primary discharge weights.

- *For Medicare product lines ages 18–64:*
  - Use Table PCR-MA-DischCC-Weight-Under65.
  - Use Table PCR-MA-SDischCC-Weight-Under65.
- *For Medicare product lines ages 65 and older:*
  - Use Table PCR-MA-DischCC-Weight-65plus.
  - Use Table PCR-MA-SDischCC-Weight-65plus.
- *For commercial product lines:* Use Table PCR-Comm-DischCC-Weight.
- *For Medicaid product lines:* Use Table PCR-MD-DischCC-Weight.

Step 4 For each IHS with a comorbidity HCC Category, link the weights.

- *For Medicare product lines ages 18–64:*
  - Use Table PCR-MA-ComorbHCC-Weight-Under65.
  - Use Table PCR-MA-SComorbHCC-Weight-Under65.
- *For Medicare product lines ages 65 and older:*
  - Use Table PCR-MA-ComorbHCC-Weight-65plus.
  - Use Table PCR-MA-SComorbHCC-Weight-65plus.
- *For commercial product lines:* Use Table PCR-Comm-ComorbHCC-Weight.
- *For Medicaid product lines:* Use Table PCR-MD-ComorbHCC-Weight.

Step 5 Link the age and gender weights for each IHS.

- *For Medicare product lines ages 18–64:*
  - Use Table PCR-MA-OtherWeights-Under65.
  - Use Table PCR-MA-SOtherWeights-Under65.
- *For Medicare product lines ages 65 and older:*
  - Use Table PCR-MA-OtherWeights-65plus.
  - Use Table PCR-MA-SOtherWeights-65plus.
- *For commercial product lines:*
  - Use Table PCR-Comm-OtherWeights.
- *For Medicaid product lines:*
  - Use Table PCR-MD-OtherWeights.

Step 6 Sum all weights associated with the IHS (i.e., observation stay, presence of surgery, primary discharge diagnosis, comorbidities, age and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS:

$$\text{Estimated Readmission Risk} = \frac{e^{(\Sigma \text{ WeightsForIHS})}}{1+e^{(\Sigma \text{ WeightsForIHS})}}$$

OR

Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)]

Note: *"Exp" refers to the exponential or antilog function.*

Step 7 Calculate the Count of Expected Readmissions for each age and stratification category. The Count of Expected Readmissions is the sum of the Estimated Readmission Risk calculated in step 6 for each IHS in each age and stratification category.

$$Count\ of\ Expected\ Readmissions = \sum (\text{Estimated Readmission Risk})$$

Step 8 Use the formula below and the Estimated Readmission Risk calculated in step 6 to calculate the variance for each IHS.

Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk)

Example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476.

Note: *This variance is calculated at the IHS level. Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables.*

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient and observation admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the *Guidelines for Risk Adjusted Utilization Measures.*.

Step 3 Exclude acute hospitalizations with any of the following criteria on the discharge claim:

- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
- Planned admissions using any of the following:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set).
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
  - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
  - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Note: *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

Step 4 For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

Note: *Count each acute hospitalization only once toward the numerator, for the last denominator event.*

If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:

- *Acute Inpatient Stay 1: May 1–10.*
- *Acute Inpatient Stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy).*
- *Acute Inpatient Stay 3: May 30–June 5.*

All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of Stay 1 and Stay 2. Count Stay 3 as a numerator event only towards the last denominator event (Stay 2, May 15–25).

Reporting: Number of Members in Plan Population

Step 1 Determine the member's age as of January 1 of the measurement year.

Step 2 Report the count of members in the plan population for each age group and the overall total. Enter these values in reporting Tables PCR-1/2/3.

Reporting: Number of Outliers

Step 1 Determine the member's age as of January 1 of the measurement year.

Step 2 Report the count of outlier members for each age group and the overall total. Enter these values in reporting Tables PCR-1/2/3.

Calculated: Outlier Rate

The number of outlier members divided by the number of members in the plan population, displayed as a permillage (multiplied by 1,000), for each age group and the overall totals calculated by IDSS.

Reporting: Denominator

Count the number of IHS among nonoutlier members for each age group and enter these values into the reporting table under Count of Index Stays.

Reporting: SES Stratification (Medicare only)

Step 1 Determine the member's SES stratifications as of the end of the continuous enrollment period for each Medicare discharge:

- *Non-LIS/DE, Nondisability:* Member is eligible for Medicare due to age only (i.e., does not receive LIS, is not DE for Medicaid, does not have disability status).
- *LIS/DE:* Member is eligible for Medicare due to age and receives LIS (includes members eligible for Medicare due to DE), does not have disability status.
- *Disability*: Member is eligible for Medicare due to disability status only.
- *LIS/DE and Disability:* Member is eligible for Medicare, receives LIS and has disability status.

- *Other:* Member has ESRD-only status or is assigned "9—none of the above."
- *Unknown:* Member's SES is unknown.
- *Total Medicare:* Total of all categories.

Step 2 Report Medicare discharges based on the SES stratification assigned for each Medicare index stay in Table PCR-B-3.

Reporting: Skilled Nursing Care Stratification (Medicare only)

Step 1 For Medicare nonoutlier members, determine if the IHS was discharged or transferred to skilled nursing care (Skilled Nursing Stay Value Set).

An index stay is discharged or transferred to skilled nursing care when the discharge date from the acute inpatient or observation stay precedes the admission date for skilled nursing care by one calendar day or less. For example:

- An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 1, is an IHS discharged or transferred to skilled nursing care.
- An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 2, is an IHS discharged or transferred to skilled nursing care.
- An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 3, is not an IHS discharged or transferred to skilled nursing care.

Step 2 Report Medicare discharges for each IHS discharged or transferred to skilled nursing care to an age group in Table PCR-C-3.

Reporting: Numerator

Count the number of observed IHS among nonoutlier members with a readmission within 30 days of discharge for each age group and enter these values into the reporting tables under Count of Observed 30-Day Readmissions.

Calculated: Observed Readmission Rate

The Count of Observed 30-Day Readmissions divided by the Count of Index Stays calculated by IDSS.

Reporting: Count of Expected 30-Day Readmissions

Step 1 Calculate the Count of Expected Readmissions among nonoutlier members for each age group and overall total.

Step 2 Round to four decimal places using the .5 rule and enter the Count of Expected Readmissions into the reporting tables.

Calculated: Expected Readmission Rate

The Count of Expected 30-Day Readmissions divided by the Count of Index Stays calculated by IDSS.

Reporting: Variance

Step 1 Calculate the total (sum) variance for each SES stratification (Medicare only), skilled nursing stratification (Medicare only) and age group.

Step 2 Round to four decimal places using the .5 rule and enter the variance into the reporting tables.

Calculated: O/E Ratio

The Count of Observed 30-Day Readmissions divided by the Count of Expected 30-Day Readmissions calculated by IDSS.

Note

- *Supplemental data may not be used for this measure.*

Table PCR-1/2/3: Plan Population and Outlier Rate (Medicaid, Commercial and Medicare, 18+)

Age	Members in Plan Population	Outlier Members	Outlier Rate
18-44			
45-54			
55-64			
65-74			
75-84			
85+			
18-64 Total			
65+ Total			

Table PCR-A-1/2/3: Plan All-Cause Readmissions Rates Among Nonoutlier Members by Age (Medicaid, Commercial and Medicare, 18+)

Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate	Count of Expected 30-Day Readmissions	Expected Readmission Rate	Variance	O/E Ratio
18-44							
45-54							
55-64							
65-74							
75-84							
85+							
18-64 Total							
65+ Total							

Table PCR-B-3: Plan All-Cause Readmissions Rates Among Nonoutlier Members by SES Stratification (Medicare, 18+)

SES Stratification	Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate	Count of Expected 30-Day Readmissions	Expected Readmission Rate	Variance	O/E Ratio
Non-LIS/ DE, Non-disability	18-64							
	65+							
LIS/DE	18-64							
	65+							
Disability	18-64							
	65+							
LIS/DE and Disability	18-64							
	65+							
Other	18-64							
	65+							
Unknown	18-64							
	65+							

Table PCR-C-3: Plan All-Cause Readmissions Rates Among Nonoutlier Members Discharged or Transferred to Skilled Nursing Care by Age (Medicare, 18+)

Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate	Count of Expected 30-Day Readmissions	Expected Readmission Rate	Variance	O/E Ratio
18-44							
45-54							
55-64							
65-74							
75-84							
85+							
18-64 Total							
65+ Total							

Santa Clara Family Health Plan
Member Experience, Including Behavioral Health: 2018 Analysis

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For review by the Quality Improvement Committee, December 4, 2019

I. Overview

Santa Clara Family Health Plan (SCFHP) uses feedback from members and employs mechanisms to assess and improve the member experience, including behavioral health. Since member complaints and appeals may impact overall member satisfaction, SCFHP tracks and trends compliant and appeal activity to identify barriers to care and identify potential interventions.

The behavioral health member satisfaction survey is another means to monitor the member experience. The member experience assessment is used to identify areas of improvement and help meet the specific needs of SCFHP members. SCFHP reviews data associated with complaints and appeals and the Behavioral Health Member Satisfaction Survey on an annual basis. The quantitative analysis process includes a review of results and compares those results against any established performance goals. In future measurement years, the quantitative analysis will also track trends year over year. The qualitative analysis process utilizes the trend data to identify potential root cause and barriers applicable to improving performance and quality. The process incorporates opportunities and/or interventions to address the root cause. In CY2018, the following measures were monitored for aspects shaping the Member Experience by conducting at a minimum, a quantitative analysis of all of the results and a qualitative analysis of non-behavioral health results:

1. Member complaint and appeals categories:
    a. Non-Behavioral Health
    b. Behavioral Health
2. Member Satisfaction Survey
    a. Behavioral Health

1. Member Complaints and Appeals

SCFHP collects data on five major categories of member grievances and appeals.

Methodology: SCFHP's Grievance and Appeals (G&A) Department uses the QNXT information system and the Grievance and Appeals database to document, collect, store and calculate grievance and appeals data which includes behavioral health-related issues. The data included in this analysis was captured in calendar year 2018 (January 1-December 31). The G&A Department utilizes an internal code set to categorize grievances and appeals. These codes are cross-walked to five categories required by NCQA. The data is then collected for the entire SCFHP Cal MediConnect population and is aggregated into the following categories:

- Quality of Care
- Access
- Attitude/Service

- Billing/Financial
- Quality of Practitioner office site

Standards and Thresholds:

SCFHP's goals are to:

- Maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each quarter, and
- Maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each category

  If a grievance and/or appeal exceeds this threshold, a root cause analysis will be conducted to identify the root cause and develop initiatives to address underlying issues. Internal and external stakeholders will be included as needed to assist in the root-cause analysis as well as remediation of the issues.

Member Complaints/Grievances and Appeal Categories

Table 1. CMS Member Complaints/Grievances Categories

Complaint / Grievance Category	1Q-2018	2Q-2018	3Q-2018	4Q-2018	(Jan. 1-Dec. 31, 2018)	Grievances / per 1,000 members 18.31 = 2018 average 9.649 = 2017 average
Quality of Care	**4** *0.53*	**19** *2.53*	**25** *3.33*	**29** *3.86*	**77**	**10.246**
Access	**5** *0.67*	**5** *0.67*	**15** *2.00*	**19** *2.53*	**44**	**5.855**
Attitude/Service	**48** *6.39*	**81** *10.78*	**79** *10.51*	**72** *9.58*	**280**	**37.259**
Billing/Financial	**75** *9.98*	**83** *11.04*	**58** *7.72*	**71** *9.45*	**287**	**38.190**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0.000**
Total	**132**	**188**	**177**	**191**	**688**	**91.550**

Quantitative Analysis: Member Complaints/Grievances

SCFHP tracks and trends all member complaints/grievances for each of the five categories listed above. In addition to the quarterly analysis, an annual analysis is completed. The collection methodology includes all complaints from the Cal MediConnect membership. The data as shown in Table 1 represents all member complaints/grievances and is not a sample.

In 2018, the complaints/grievances analysis showed that two categories consistently did not meet the threshold throughout the year: Attitude/Service and Billing/Financial. Attitude and Service increased by 69% with a result of 48 in the first quarter and a result of 81 in the second quarter. The third and fourth quarter remained closer to the second quarter's numbers, with a result of 79 and 72 respectively. Billing/Financial was consistently high throughout the year. However, Billing/Financial decreased by 43% from a result of 83 in the second quarter and a result of 58 in the third quarter. This is also the highest result and the lowest result in 2018 for Billing/Financial respectively.

In addition, Attitude/Service had a result of 37 grievances per 1,000 members and Billing/Financial had a result of 38 grievances per 1000 members for all of 2018. Out of the remaining three categories, Quality of Care and Access were also above the threshold when looking at all of 2018. Quality of Care had a result of 10 grievances per 1,000 members and Access had a result of 6 grievances per 1000 members. On a quarterly basis, they were below their threshold. Quality of Care also had the largest overall increase, nearly quintupling over the course of the year with a result of 4 in the first quarter to a result of 29 in the fourth quarter. The last category, Quality of Practitioner Office Site, met the goal and remained flat throughout the year.

Table 2. CMS Member Appeal Categories

Appeals Category	1Q-2018	2Q-2018	3Q-2018	4Q-2018	(Jan. 1-Dec. 31, 2018) Total Appeals	Appeals / per 1,000 members
Quality of Care	**0**	**0**	**0**	**0**	**0**	**0.000**
Access	**0**	**0**	**0**	**0**	**0**	**0.000**
Attitude/Service	**0**	**0**	**0**	**0**	**0**	**0.000**
Billing/Financial	**121** *16.10*	**112** *14.90*	**72** *9.58*	**60** *7.98*	**365**	**48.570**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0.000**
Total	**121**	**112**	**72**	**60**	**365**	**48.570**

Quantitative Analysis: Member Appeals

SCFHP tracks and trends all member appeals for each of the five categories listed above. In addition to the quarterly analysis, an annual analysis is completed. The collection methodology includes all appeals inclusive of pre-service authorization and post-service claims appeals filed by a member or member representative. The data as shown in Table 2 is representative of all member appeals and is not a sample.

In 2018, the appeals analysis showed a significant decrease in the second half of the year in the following category: Billing/Financial. The Billing and Financial category halved their appeals over the course of the year with a result of 121 in the first quarter and a result of 60 in the fourth quarter. However, the results indicate 49 appeals per 1000 members which does not meet the goal. The remaining four categories, Quality of Care, Access, Attitude/Service and Quality of Practitioner Site had results of zero appeals and, therefore, met the goal.

Qualitative Analysis: Root Causes- Member Complaints/Grievances and Appeals (Tables 1 & 2)

In analyzing the Attitude/Service grievances, the following root causes were determined for the high amount of grievances:

- Out of the 280 Attitude/Service grievances, 81 of them were a result of a durable medical equipment (DME) vendor. This would be 40% of all Attitude/Service grievances in 2018. The DME vendor was a preferred vendor for DME services in 2018. Around the end of 2018, SCFHP as a whole noticed that this DME vendor contributed a large amount of grievances and had other compliance concerns related to timeliness of authorizations and delivery of supplies. Starting in Q2 2019, SCFHP began to transition to another DME vendor as a preferred vendor. The contract for the original DME vendor is set to expire January 1, 2020.
- Out of the 280 Attitude/Service grievances, 74 of them were a result of transportation services. This would be 36% of all Attitude/Service grievances in 2018. One vendor had more grievances than other transportation vendors, with a total of 46 out of 74 transportation grievances involving them. This vendor also received more members as other transportation vendors merged under them. This merge happened in the third quarter of 2018. This led to an increase in grievances for this vendor. The vendor's program manager met with the G&A Director and agreed to increase the amount of management positions that can address grievances. This should lead to quicker solutions and responses.

In analyzing the Billing/Financial complaints/grievances the following root cause was determined to be responsible for the Q3 2018 increase:

- Out of the 287 Billing/Financial grievances, 113 of them are a result of a specific hospital. The billing staff at this hospital has claimed to not understand the Cal MediConnect (CMC) product and how it pays for the member's bills. The billing staff believed they could bill the members directly for the amount that Medi-Cal did not pay. The G&A Department has since worked with this hospital's billing staff to understand CMC and how it handles payment. More importantly, the hospital in question is now aware that they are not permitted to bill or balance bill members according to state and federal laws.

In analyzing the Billing/Financial appeals the following root causes were determined to be responsible for the increase:

- Post-service (claims payment) appeals were a significant portion of the Billing/Financial appeals category. This is a result of non-contracted providers failing to recognize the prior authorization rules for services rendered to SCFHP members. Specifically, all services requested intended to be rendered by a non-contracted provider require review and authorization by SCFHP's Utilization Management (UM) Department. Rather than the services being requested on a pre-service basis, providers rendered the services and then requested payment through the claims process. The claims were denied which led to appeals being filed.

There has one specific provider that submitted a major amount of appeals. Fortunately, that provider is now contracted. SCFHP will work with the provider to identify any remaining claims denied prior to their contracted status and work to close any older matters out.

Time Frame: January 1, 2018 - December 31, 2018						
Behavioral Health Complaint / Grievance/Appeal Category	**1Q-2018**	**2Q-2018**	**3Q-2018**	**4Q-2018**	**Total Grievances**	**BH Grievances/per 1,000 members** *(2017 AVG = 7,482)*
Quality of Care	0	0	0	0	0	0
Access	0	0	0	0	0	0
Attitude/Service	*0*	0	0	0	0	0
Billing/Financial	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	
Total	**0**	**0**	**0**	**0**	**0**	

Qualitative Analysis: Root Causes- Member Complaints/Grievances and Appeals

No data is available. There were no members receiving behavioral services that filed appeals or grievances within CY 2018.

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Monitoring or Meeting Period:

Credentialing Committee 10/30/20/19

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	29	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	2	
Number practitioners recredentialed within 36-month timeline	2	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 08/31/2019	288	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**VHP**	**PAMF**	**PMG**	**PCNC**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1577	1496	748	802	412	139

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Actions Taken

1. All current network practitioners were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. - # currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

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

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

MINUTES –Open Session Draft

Regular Meeting of the

Santa Clara County Health Authority
Pharmacy and Therapeutics (P&T) Committee

Thursday, September 19, 2019, 6:00-8:00 PM
Santa Clara Family Health Plan, Redwood Conference Room
6201 San Ignacio Ave, San Jose, CA 95119

Voting Committee Members	Specialty	Present (Y or N)
Jimmy Lin, MD, Chairperson	Internal Medicine	Y
Hao Bui, BS, RPh	Community Pharmacy (Walgreens)	Y
Minh Thai, MD	Family Practice	N
Peter Nguyen, MD	Family Practice	Y
Amara Balakrishnan, MD	Pediatrics	N
Narinder Singh, PharmD	Health System Pharmacy (SCVMC)	Y
Jesse Parashar-Rokicki, MD	Family Practice	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Dolly Goel, MD	VHP Chief Medical Officer	N
Xuan Cung, PharmD	VHP Pharmacy Supervisor	Y
Laurie Nakahira, DO	SCFHP Chief Medical Officer	Y
Dang Huynh, PharmD	SCFHP Pharmacy Director	Y

Non-Voting Committee Members	Specialty	Present (Y or N)
Darryl Breakbill	SCFHP Appeals & Grievance Director	Y
Tami Otomo, PharmD	SCFHP Clinical Pharmacist	Y
Michelle Huynh	SCFHP Pharmacy Coordinator	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Janet Gambatese	SCFHP Provider Network Management Director	Y

Public	Title/Association	Present (Y or N)
Gio Ottobre	Immunology Account Representative, Merck	Y

1. **Roll Call / Establish Quorum**
   Dr. Lin called the meeting to order at 6:11 PM. Roll call was taken. Quorum was established.

2. **Public Comment**
   There were no comments from the public.

3. **Open Meeting Minutes**
   The committee reviewed the Pharmacy & Therapeutics Committee meeting minutes from June 20, 2019. Dr. Lin motioned to accept the meeting minutes as presented. It was motioned by Dr. Nguyen and seconded by Dr. Alkoraishi. The motion carried.

4. **Standing Agenda Items**
   a. **CMO Health Plan Updates**
      Dr. Nakahira stated that SCFHP recently completed the Centers for Medicare & Medicaid Services (CMS) validation audit and is awaiting results. SCFHP's Healthy Kids line of business will be ending on October 1, 2019. All current Healthy Kids members, except two members, will be transitioned into the Medi-Cal line of business. The two members not getting transitioned are siblings and are not eligible to be Medi-Cal members. SCFHP is currently working with the two members to determine if they would be eligible to be enrolled into the Valley Kids system.

   b. **Plan/Global Medi-Cal Drug Use Review: Concomitant Anticholinergic and Antipsychotic Use**
      Dr. Otomo shared a summary of a recent educational article posted by the Department of Health Care Services (DHCS) Drug Use Review (DUR) Board regarding the risks of concomitant anticholinergic and antipsychotic use. Dr. Otomo stated that SCFHP completed a retrospective study earlier this year which revealed that there were only two Medi-Cal members on both a second generation antipsychotic and either trihexyphenidyl or benztropine for six months or longer. The doctors of these two members were aware of the risks of concomitant therapy with these drugs.

   c. **Appeals & Grievance 2Q2019 Report**
      Mr. Breakbill presented the 2019 2nd Quarter Appeals and Grievance reports:
      i. For Medi-Cal, there were a steady number of appeals and number of appeals upheld. The majority of appeals were upheld due to lack of medical necessity.
      ii. For Cal MediConnect, the volume of appeals and the uphold rate were lower than Medi-Cal. The higher volume of Medi-Cal appeals may be partially attributed to second prior authorization request submissions that are forwarded to Appeals & Grievances if received within 60 days of a denied prior authorization for the same medication from the same provider. Some of the commonly appealed medications in Cal MediConnect include: sildenafil, diclofenac 1% gel, Lyrica, and hydrocodone-acetaminophen.

   d. P&T Committee Charter
      Dr. Huynh presented the revised P&T Committee Charter, which is reviewed annually. The main revision was the addition of the statement that SCFHP's Chief Medical officer and Director of Pharmacy shall be automatically designated as voting P&T Committee members. Additional revisions were limited to formatting.

      Dr. Nguyen motioned to accept the charter as presented, and it was seconded by Dr. Bui. The motion carried.

Adjourn to Closed Session
Pursuant to Welfare and Institutions Code Section 14087.36 (w)

5. **Closed Meeting Minutes**
   Review SCFHP 2Q2019 P&T Closed Minutes
   Possible Action: Approve SCFHP P&T Closed Minutes

6. **Metrics & Financial Updates**
   a. Membership Report
   b. Pharmacy Dashboard
   c. Drug Use Evaluation
   d. Drug Utilization & Spend

7. **Discussion and Recommendations for Changes to SCFHP's Cal MediConnect Formulary & Coverage Determination Criteria**
   a. MedImpact 2Q2019 P&T Minutes
   b. MedImpact 3Q2019 P&T Ad Hoc Minutes
   c. MedImpact 3Q2019 P&T Part D Actions
   Possible Action: Approve MedImpact Minutes & Actions

8. **Discussion and Recommendations for Changes to SCFHP's Medi-Cal & Healthy Kids Formulary & Prior Authorization Criteria**
   a. Old Business/Follow-Up
      i. Ciprodex Indication
      ii. Mycobutin TB Treatment Duration
   b. Formulary Modifications
      Possible Action: Approve recommendations
   c. Fee-for-Service Contract Drug List Comparability
      Possible Action: Approve recommendations
   d. Prior Authorization Criteria
      i. New or Revised Criteria:
         1. Brand Name
         2. Enbrel (etanercept)
         3. Humira (adalimumab)
         4. Insulin Pens
         5. Januvia (sitagliptin)
         6. Off-label
         7. Oncology
         8. Opioid Safety Edits
         9. Quantity Limit
         10. Taltz (ixekizumab)
         11. Trintellix (vortioxetine)
         12. Xelpros (latanoprost)
         13. Zyvox (linezolid)
      ii. Annual Review:
         1. Compound Medications
         2. Duragesic (fentanyl patch)
         3. Emend (aprepitant)

4. Myrbetriq (mirabegron)
5. Nicotrol (nicotine)
6. Opioids – Reauthorization
7. Penlac (ciclopirox solution)
8. Retacrit (epoetin alfa-epbx)

Possible Action: Approve criteria

9. New Drugs and Class Reviews

a. Sleep Pharmacology
   i. Sunosi (solriamfetol)
   ii. Wakix (pitolisant)

b. Rheumatoid Arthritis
   i. Rinvoq (upadacitinib)

c. Oncology Update
   i. Xpovio (selinexor)
   ii. Piqray (alpelisib)
   iii. Polivy (polatuzumab vedotin-piiq)
   iv. Turalio (pexidartinib)

d. Community-Acquired Bacterial Pneumonia: Xenleta (lefamulin)
e. Irritable Bowel Syndrome with Constipation **informational only*
   i. Tenapanor
   ii. Tegaserod
f. Vyleesi (bremelanotide)
g. Lumateperone
h. Semaglutide (oral)
i. New Derivatives/Formulations/Combinations
j. Biosimilar Update
k. New and Expanded Indications

Possible Action: Approve recommendations

Reconvene to Open Session

Committee reconvened to open session at 7:50 PM.

10. Discussion Items

a. **New and Generic Pipeline**

Dr. McCarty presented the new and generic pipeline. Oral semaglutide is awaiting approval, and it is expected to be a "blockbuster drug" coming out in October 2019. AR101, a drug for peanut allergy, may also be a "blockbuster drug" potentially in the first quarter of next year. Generic Lyrica was released in July and is much more cost-effective than the brand product.

11. Adjournment

Next meeting is Thursday, December 12, 2019.

The meeting was adjourned at 7:54 PM.

Santa Clara County Health Authority
Updates to Pay Schedule
December 12, 2019

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Grievance and Appeals Clinical Specialist	Annually	$ 89,986	$114,732	$139,478
Grievance and Appeals Data Analyst	Annually	$ 79,813	$ 99,676	$119,720
IT Project Coordinator	Annually	$ 69,403	$ 86,754	$104,104
Production Services Coordinator	Annually	$ 40,213	$ 49,261	$ 58,308
Production Services Lead	Annually	$ 44,234	$ 54,187	$ 64,139

Adjust Pay Schedule in its entirety as recommended by C-Biz Talent & Compensation Solutions by an adjustment factor of 2.15% retroactive to July 1, 2019 to ensure salary range minimums and maximums remain competitive to the market.

Santa Clara County Health Authority
Job Titles Removed from Pay Schedule
December 12, 2019

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Support Services Coordinator	Annually	$39,366	$ 48,224	$ 57,081
Support Services Lead	Annually	$43,303	$ 53,046	$ 62,789

Santa Clara County Health Authority

(dba Santa Clara Family Health Plan)

Conflict of Interest Code

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

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

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

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

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

NOW, THEREFORE BE IT RESOLVED THAT, the terms of 2 California Code of Regulations Section 18730 (available at http://www.fppc.ca.gov/content/dam/fppc/NS-Documents/LegalDiv/Regulations/Index/Chapter7/Article2/18730.pdf) and any amendments to it duly adopted by the FPPC are hereby incorporated by reference and this regulation and the Appendices, attached hereto and incorporated herein, designating officials and employees, and establishing disclosure categories, shall constitute the Conflict of Interest Code of the Health Authority.

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IT IS **FURTHER RESOLVED THAT,** designated employees shall file their statements of economic Interests with the Health Authority's filing official. If a statement is received in signed paper format, the Health Authority's filing official shall make and retain a copy and fo1ward the original of this statement to the filing officer, the County of Santa Clara Clerk of the Board of Supervisors. If a statement is electronically filed using the County of Santa Clara's Form 700 e-fling system, both the Health Authority's filing official and the County of Santa Clara Clerk of the Board of Supervisors will receive access to the e-filed statement simultaneously. The Health authority shall make a copy of the statements available for public inspection and reproduction in accordance with Government Code section 81008.

PASSED AND ADOPTED by the Santa Clara County Health Authority of the County of Santa Clara, State of California on December 12, 2019 by the following vote:

AYES:

NOES:

ABSENT:

Signed: _____
Robert Brownstein, Chair

Attest: _____
Robin Larmer, Secretary

Attachments to this Resolution:

Appendix A - Positions Required to File
Appendix B – Disclosure Categories

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

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

Required to File Form 700:

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

*Newly Created Positions

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

statement of the extent of disclosure requirements. The Health Authority's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code. (Gov. Code Section 81008.)

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

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

Appendix 8 - Amended
Santa Clara County Health Authority
Conflict of Interest Code
DISCLOSURE CATEGORIES

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

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

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

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

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

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

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

Santa Clara County Health Authority
Summary of Amendments to Conflict of Interest Code
January 2020

Position Additions

- Director of Quality and Process Improvement
- Director of Pharmacy

Position Deletion

- Director of Quality and Pharmacy

Santa Clara Family Health Plan

TO: Santa Clara County Board of Supervisors

FROM: Santa Clara County Health Authority Governing Board
Santa Clara Community Health Authority Governing Board

DATE: December 2019

Annual Report

Santa Clara County Health Authority and Santa Clara Community Health Authority, collectively doing business as Santa Clara Family Health Plan (SCFHP), serve more than 240,000 low-income residents of Santa Clara County through the Medi-Cal, Healthy Kids, and Cal MediConnect programs. Medi-Cal enrollment continues to reflect declining state and national trends. SCFHP experienced a 4% decrease in enrollment during the fiscal year, while maintaining a consistent 78% Medi-Cal market share. Attached is a summary of SCFHP 2018-2019 Financial Highlights.

During fiscal year 2018-2019, SCFHP continued to bolster its compliance program to meet the expectations of state and federal regulators. SCFHP also focused on improving quality performance, achieving 3-year accreditation by the National Committee for Quality Assurance for our Cal MediConnect program. To increase member engagement, we launched a Wellness Rewards Program, Community Outreach Program, and online member portal. And, as the attachment shows, SCFHP maintained an administrative loss ratio below 6% and remains in strong financial condition.

This year's state budget enabled the migration of all but two of our 3,500 Healthy Kids members to full Medi-Cal coverage in October. The two ineligible members have been offered assistance with applying for coverage through Valley Kids, and the Healthy Kids line of business will close at the end of December.

Given our exclusive focus on providing access to timely, high quality care to the safety net population in our community, we work closely with Valley Health Plan, Valley Medical Center, and Santa Clara Valley Health and Hospital System (SCVHHS). SCFHP continued to collaborate with the County on the Whole Person Care initiative, and achieved 40 long term care community transitions during the past fiscal year.

We are excited to share that we have recently leased a space near the intersection of North Capitol Ave and McKee Road in San Jose, where we look forward to opening a Community Resource Center in 2020. This site will improve and increase member engagement by making our services more physically accessible to our members.

As you know, the State has proposed sweeping changes to the Medi-Cal program. Planning for these changes is already well underway and we suspect will require a significant investment in human and other resources during and beyond fiscal year 2019-2020. We look forward to discussing how these proposals will affect County residents. At the same time, SCFHP will continue to focus on our strategic goals of meeting newly increased state quality requirements and implementing an enhanced delegation oversight program.

Santa Clara Family Health Plan™

Financial Highlights Fiscal Year 2018-2019

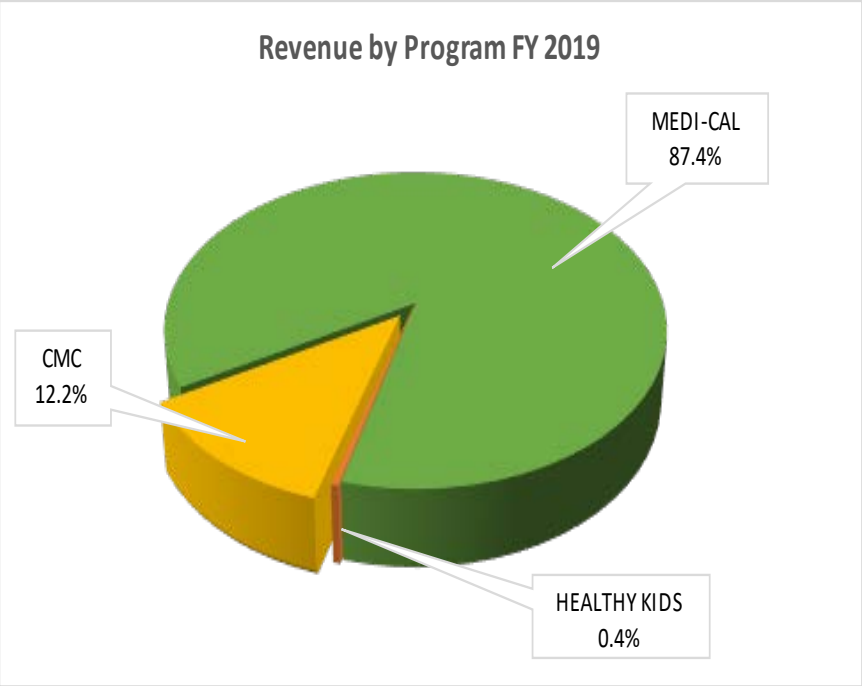
Santa Clara Family Health Plan

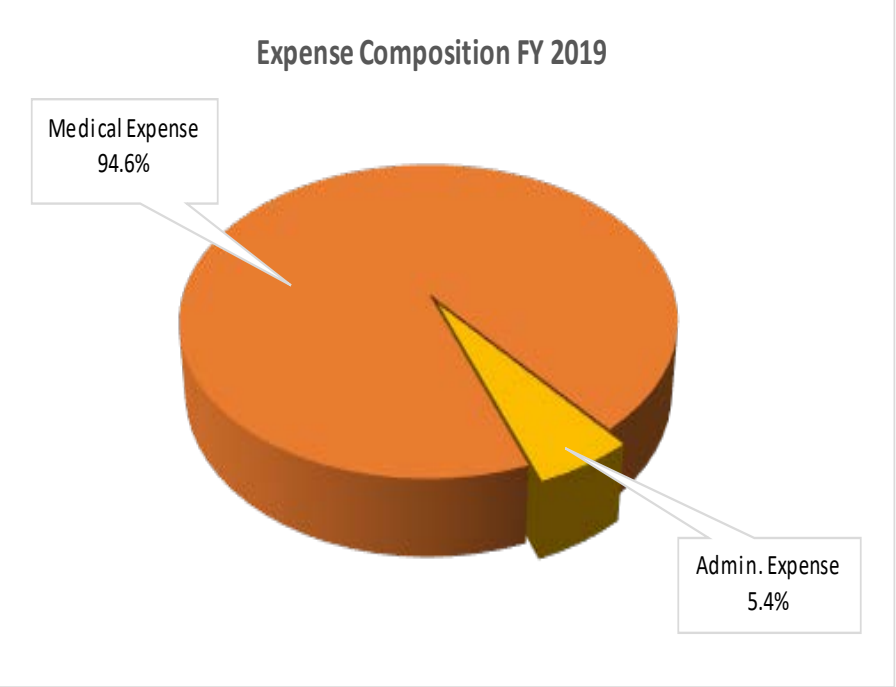
SCFHP Financial Highlights for Fiscal Year 2018-19

- Total enrollment decreased 4.0% to 249,205 members at June 30, 2019 from 259,475 members at June 30, 2018.
- Net position increased by $24,109,890 to $202,125,753 for the fiscal year ended June 30, 2019 from $178,015,863 for the fiscal year ended June 30, 2018 due to operating income of $20,157,578 and non-operating income of $3,952,312.
- Total assets and deferred outflows of resources increased to $1,099,258,565 as of June 30, 2019 from $763,293,226 as of June 30, 2018.
- Total liabilities and deferred inflows of resources increased to $897,132,812 at June 30, 2019 from $585,277,361 at June 30, 2018.
- The current ratio (current assets divided by current liabilities) of 1.20 as of June 30, 2019 reflected a decrease from 1.26 at June 30, 2018.

SCFHP Financial Highlights for Fiscal Year 2018-2019

- Fiscal Year 2018-2019 Revenue and Expense Composition:





- For FY18-19, of every dollar of expense, SCFHP distributes approximately 95% to providers and retains 5% for administrative expenses.

Santa Clara Family Health Plan™

Unaudited Financial Statements
For Four Months Ended October 31, 2019

Agenda

Santa Clara Family Health Plan

Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$92 M		$364 M	
Medical Expense (MLR)	$87 M	94.6%	$343 M	94.3%
Administrative Expense (% Rev)	$5.1 M	5.5%	$19.7 M	5.4%
Other Income/Expense	$426K		$1.7 M	
Net Surplus (Loss)	**$262K**		**$2.9 M**	
Cash on Hand			$301 M	
Receivables			$528 M	
Total Current Assets			$841 M	
Current Liabilities			$663 M	
Current Ratio			1.27	
Tangible Net Equity			$205 M	
% of DMHC Requirements			**671.5%**	

Financial Highlights

Net Surplus (Loss)	▶ Month: Surplus of $262K is $264K or 50.1% unfavorable to budget of $526K. ▶ YTD: Surplus of $2.9M is $41K or 1.4% unfavorable to budget of $2.9M.
Enrollment	▶ Month: Membership was 245,330 (1,077 or 0.4% favorable budget of 244,253). ▶ YTD: Membership was 986,701 (3,976 or 0.4% favorable budget of 982,725).
Revenue	▶ Month: $91.7M ($2.6M or 2.9% favorable to budget of $89.1M). ▶ YTD: $363.9M ($6.7M or 1.9% favorable to budget of $357.2M).
Medical Expenses	▶ Month: $86.8M ($3.4M or 4.0% unfavorable to budget of $83.4M). ▶ YTD: $343.0M ($8.3M or 2.5% unfavorable to budget of $334.7M).
Administrative Expenses	▶ Month: $5.1M ($341K or 6.3% favorable to budget of $5.4M). ▶ YTD: $19.7M ($827K or 4.0% favorable to budget of $20.5M).
Tangible Net Equity	▶ TNE was $205.0M (671.5% of minimum DMHC requirement of $30.5M).
Capital Expenditures	▶ YTD Capital Investments of $890K vs. $4.8M annual budget, primarily building improvements and hardware.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment of 245,330 members exceeds budget by 1,077 or 0.4%. Total enrollment has decreased since June 30, 2019 by 3,875 or 1.6%, slightly better than budgeted expectation.
- As detailed on page 7, excluding 3,289 HK members merged into Child category, much of the Medi-Cal enrollment decline has been in the Non-Dual Child, Adult Expansion and Adult categories of aid. Medi-Cal Dual enrollment has been stable overall while CMC enrollment continues to grow in line with budget due to outreach efforts.
- Membership Trends:
  - With the transfer of the Healthy Kids program on Oct 1st, Medi-Cal membership has decreased since the beginning of the fiscal year by 602 or 0.3%. CMC membership increased since the beginning of the fiscal year by 211 or 2.6%.

	For the Month October 2019				For Four Months Ending October 31, 2019					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY19 vs. FY20
Medi-Cal	237,095	236,070	1,025	0.4%	943,540	940,210	3,330	0.4%	984,086	(4.1%)
Cal Medi-Connect	8,233	8,183	50	0.6%	32,637	32,471	166	0.5%	30,264	7.8%
Healthy Kids	2	0	2	0.0%	10,524	10,044	480	4.8%	12,845	(18.1%)
Total	**245,330**	**244,253**	**1,077**	**0.4%**	**986,701**	**982,725**	**3,976**	**0.4%**	**1,027,195**	**(3.9%)**

Santa Clara Family Health Plan Enrollment By Network
October 2019

Network	Medi-Cal		CMC		Healthy Kids		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	30,951	13%	8,233	100%	2	100%	39,186	16%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	117,335	49%	-	0%	-	0%	117,335	48%
Palo Alto Medical Foundation	6,784	3%	-	0%	-	0%	6,784	3%
Physicians Medical Group	42,021	18%	-	0%	-	0%	42,021	17%
Premier Care	14,660	6%	-	0%	-	0%	14,660	6%
Kaiser	25,344	11%	-	0%	-	0%	25,344	10%
Total	**237,095**	**100%**	**8,233**	**100%**	**2**	**100%**	**245,330**	**100%**
Enrollment at June 30, 2019	237,697		8,022		3,486		249,205	
Net Δ from Beginning of FY20	(0.3%)		2.6%		(99.9%)		(1.6%)	

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

Enrollment By Aid Category

Santa Clara Family Health Plan

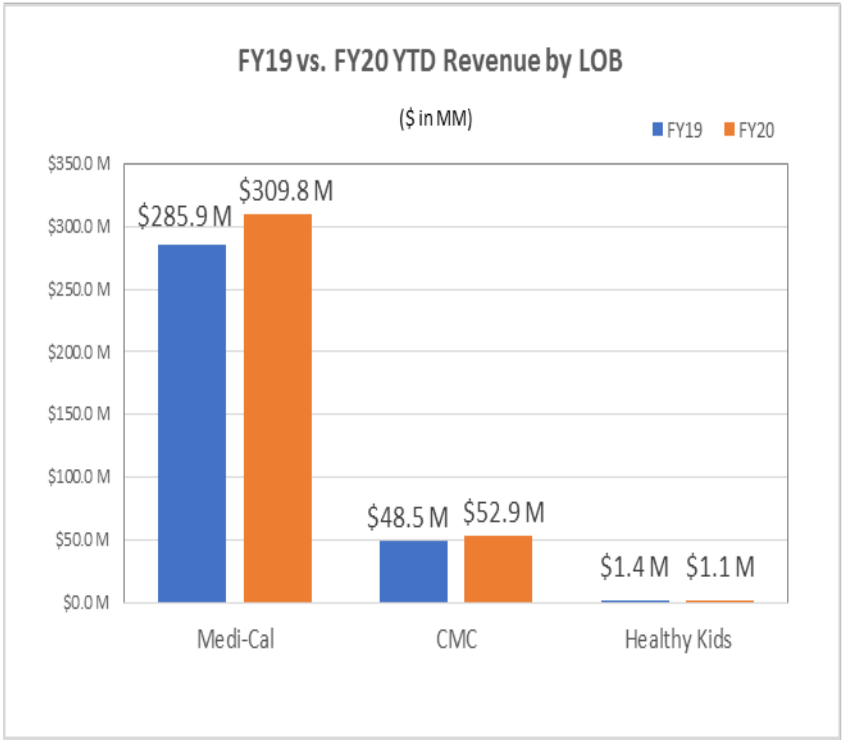
SCFHP TRENDED ENROLLMENT BY COA YTD OCT-19

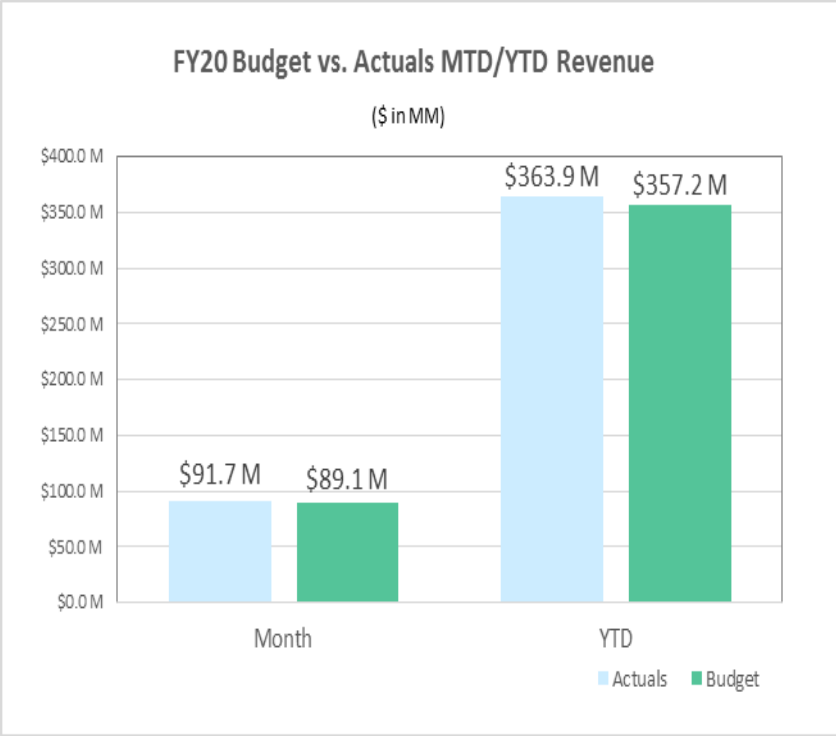
		2018-10	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	FYE var	%
NON DUAL	Adult (over 19)	26,354	26,213	26,175	25,954	25,846	25,779	25,563	25,198	25,204	24,989	24,888	24,689	24,492	(712)	(2.8%)
	Child (under 19)	97,518	96,830	96,330	95,155	95,177	95,229	94,956	94,255	94,026	93,536	92,668	92,092	95,000	974	1.0%
	Aged - Medi-Cal Only	10,869	10,887	10,923	10,901	10,963	10,934	10,949	10,871	10,995	10,948	10,958	10,855	10,850	(145)	(1.3%)
	Disabled - Medi-Cal Only	10,611	10,624	10,631	10,629	10,579	10,595	10,678	10,780	10,819	10,774	10,833	10,814	10,836	18	0.2%
	Adult Expansion	73,601	73,398	73,186	72,075	72,223	72,143	72,114	71,364	71,465	71,082	70,635	70,418	70,285	(1,180)	(1.7%)
	BCCTP	12	11	11	9	9	8	10	11	11	10	10	10	10	(1)	(9.1%)
	Long Term Care	379	377	372	371	376	375	375	370	372	372	364	366	372	0	0.0%
	Total Non-Duals	**219,343**	**218,340**	**217,628**	**215,093**	**215,173**	**215,063**	**214,644**	**212,848**	**212,891**	**211,711**	**210,356**	**209,244**	**211,845**	**(1,046)**	**(0.5%)**
DUAL	Adult (21 Over)	385	390	379	373	376	367	368	354	352	351	345	351	341	(11)	(3.1%)
	SPD (21 Over)	22,963	22,897	22,893	22,765	22,728	22,725	22,941	23,009	22,988	23,087	23,230	23,445	23,531	543	2.4%
	Adult Expansion	533	538	586	556	529	479	304	252	253	209	226	201	122	(131)	(51.8%)
	BCCTP	1	1	1	2	1	1	0	0	0	0	0	0		0	0.0%
	Long Term Care	1,268	1,233	1,208	1,209	1,203	1,201	1,187	1,192	1,213	1,220	1,232	1,237	1,256	43	3.5%
	Total Duals	**25,150**	**25,059**	**25,067**	**24,905**	**24,837**	**24,773**	**24,800**	**24,807**	**24,806**	**24,867**	**25,033**	**25,234**	**25,250**	**444**	**1.8%**
	Total Medi-Cal	**244,493**	**243,399**	**242,695**	**239,998**	**240,010**	**239,836**	**239,444**	**237,655**	**237,697**	**236,578**	**235,389**	**234,478**	**237,095**	**(602)**	**(0.3%)**
	Healthy Kids	**3,217**	**3,460**	**3,345**	**3,252**	**3,375**	**3,348**	**3,465**	**3,507**	**3,486**	**3,501**	**3,509**	**3,512**	**2**	**(3,484)**	**(99.9%)**
CMC	CMC Non-Long Term Care	7,383	7,407	7,484	7,540	7,616	7,680	7,661	7,706	7,815	7,869	7,921	7,982	8,016	201	2.6%
	CMC - Long Term Care	218	218	211	210	198	204	208	209	207	207	213	212	217	10	4.8%
	Total CMC	**7,601**	**7,625**	**7,695**	**7,750**	**7,814**	**7,884**	**7,869**	**7,915**	**8,022**	**8,076**	**8,134**	**8,194**	**8,233**	**211**	**2.6%**
	Total Enrollment	**255,311**	**254,484**	**253,735**	**251,000**	**251,199**	**251,068**	**250,778**	**249,077**	**249,205**	**248,155**	**247,032**	**246,184**	**245,330**	**(3,875)**	**(1.6%)**

Revenue

Current month revenue of $91.7M is $2.6M or 2.9% favorable to budget of $89.1M. The current month variance was due to largely to Medi-Cal revenue, which is $2.6M favorable due to:

- Supplemental Kick revenue is $1.2M favorable to budget due to higher utilization.
- Higher retro member months than budget ($705K).
- Higher FY20 rates in the Non-Dual Adult Expansion, Long Term Care (LTC) and Adult categories of aid ($695K).

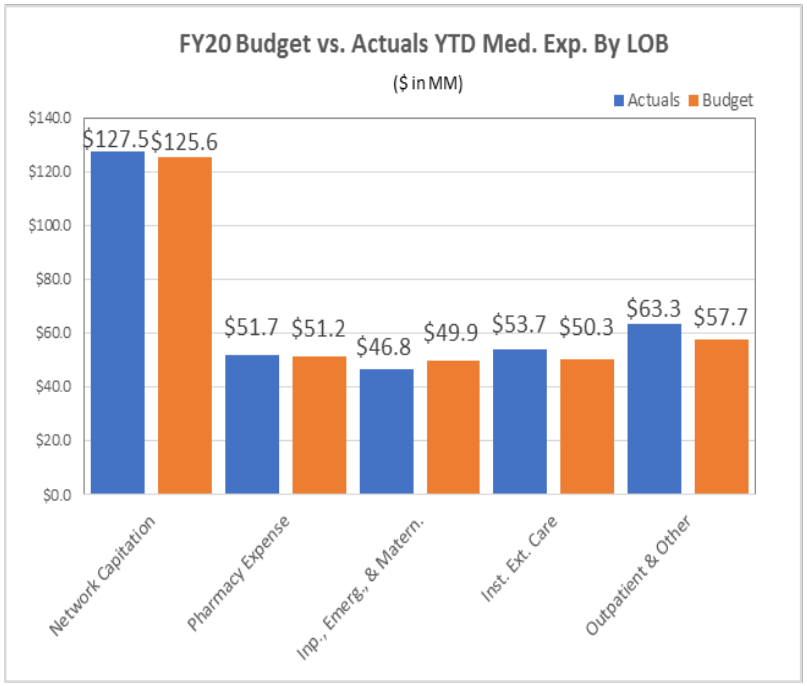


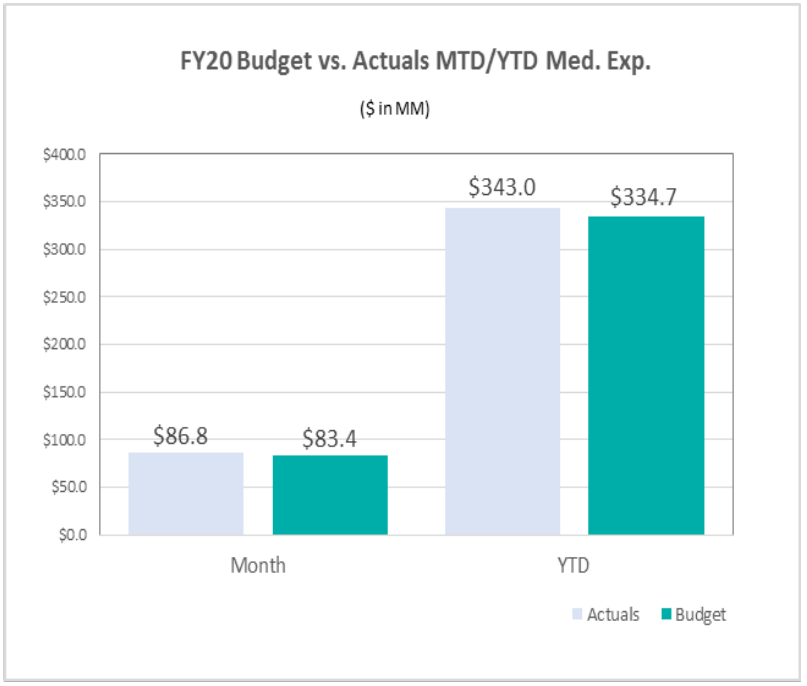


Medical Expense

Current month medical expense of $86.8M is $3.4M or 4.0% unfavorable to budget of $83.4M. The current month variance was due largely to:

- Medi-Cal LTC, Outpatient Facility and Other MLTSS expenses in excess of budget yielded an unfavorable variance of $2.0M due to higher average cost versus budget.
- Pharmacy expense is $1.1M unfavorable due to higher average drug cost and utilization.
- Capitation expense is $314K unfavorable due to higher member months and rates than budgeted.

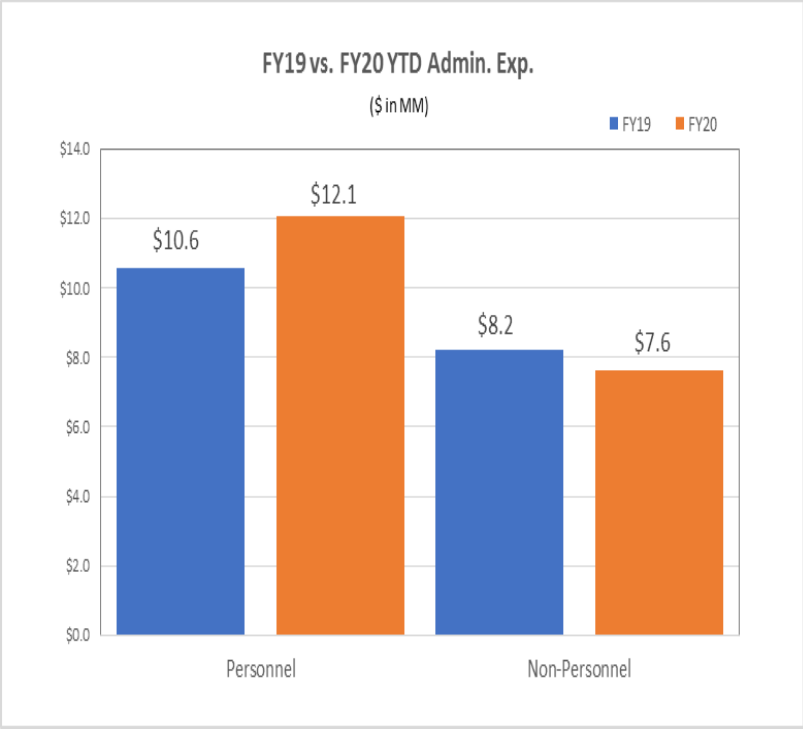


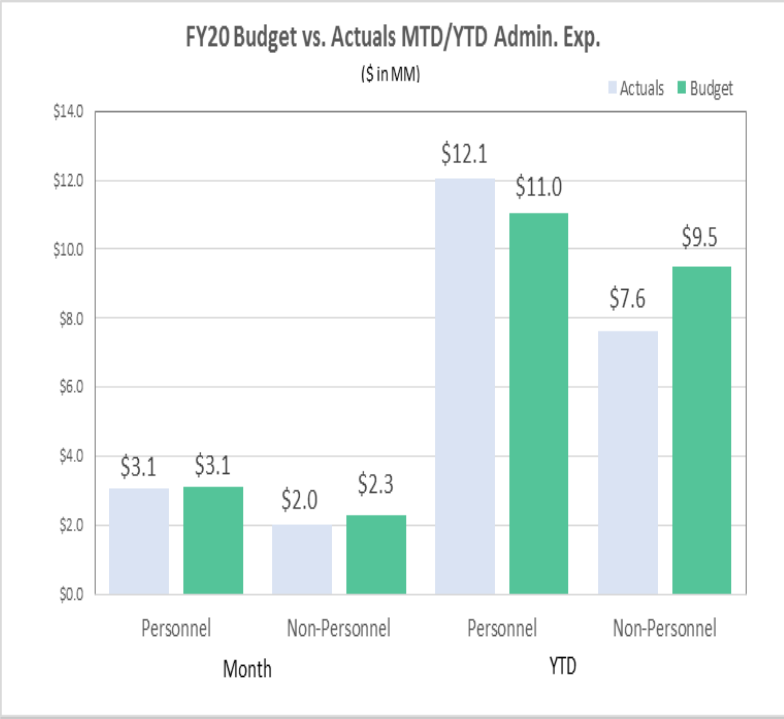


Administrative Expense

Current month admin expense of $5.1M is $341K or 6.3% favorable to budget of $5.4M. The current month variances were primarily due to the following:

- Non-Personnel expenses were overall $295K or 12.8% favorable to budget due to the timing of consulting, advertising and postage expenses and reduced QI spending versus budget.
- Personnel expenses were $46K or 1.5% favorable to budget due to expected vacancy.





Balance Sheet

- Current assets totaled $840.7M compared to current liabilities of $662.8M, yielding a current ratio (Current Assets/Current Liabilities) of 1.27:1 vs. the DMHC minimum requirement of 1.0:1.
- Cash balance increased by $1.2M compared to the cash balance as of year-end June 30, 2019 due to timing of payments.
- Current Cash & Equivalent components and yields were as follows:
  - Overall cash and investment yield exceeds budget (2.3% actual vs. 1.4% budgeted).

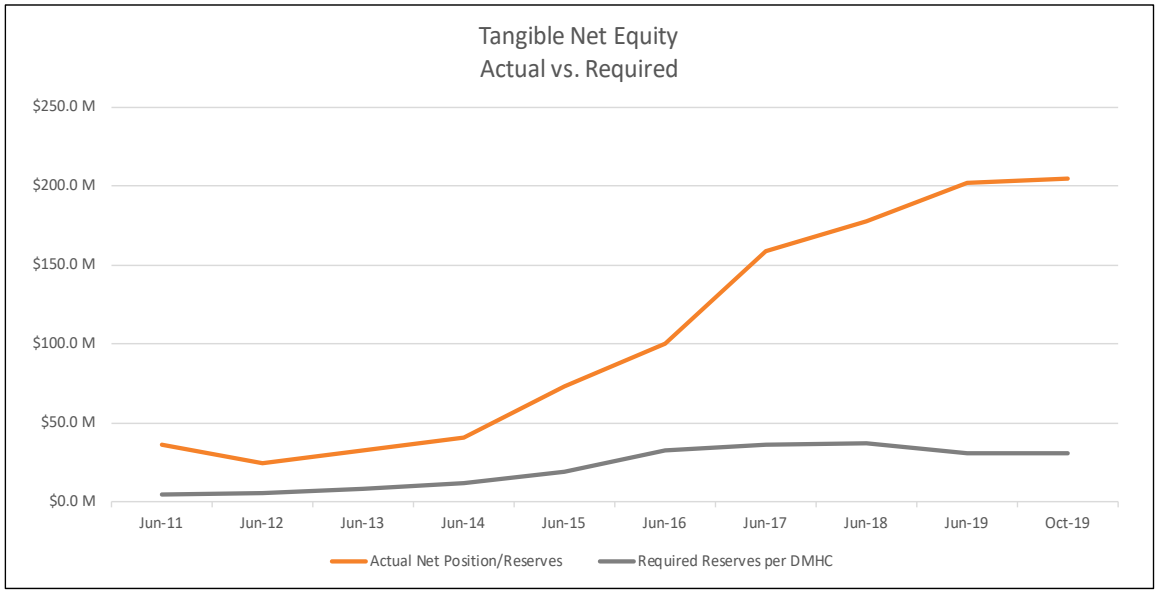
Description	Month-End Balance	Current Yield %	Interest Earned	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$79,390,883	2.13%	$100,000	$400,000
Wells Fargo Investments	$183,635,207	2.07%	$407,404	$574,397
	$263,026,090		$507,404	$974,397
Cash & Equivalents				
Bank of the West Money Market	$695,528	0.91%	$8,086	$54,791
Wells Fargo Bank Accounts	$36,625,647	1.67%	$55,663	$1,120,993
	$37,321,175		$63,749	$1,175,784
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.42%	-$42	$348
Petty Cash	$500	0.00%	$0	$0
Total Cash & Equivalents	**$300,653,115**		**$571,111**	**$2,150,528**

Tangible Net Equity

- TNE was $205.0M or 671.5% of the most recent quarterly DMHC minimum requirement of $30.5M.
- TNE trends are presented below:

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of October 31, 2019

	Jun-11	Jun-12	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Oct-19
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	$202.1 M	$205.0 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	$30.9 M	$30.5 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	$61.8 M	$61.1 M
Actual as % Required	722.5%	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	671.5%



Reserves Analysis

Santa Clara Family Health Plan

SCFHP RESERVES ANALYSIS OCTOBER 2019

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	204,984,695
Current Required TNE	30,527,856
Excess TNE	**174,456,839**
Required TNE %	671.5%
SCFHP Target TNE Range:	
350% of Required TNE (Low)	106,847,497
500% of Required TNE (High)	152,639,281
TNE Above/(Below) SCFHP Low Target	**98,137,198**
TNE Above/(Below) High Target	**52,345,414**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	300,653,115
Less Pass-Through Liabilities	
Net Payable to State of CA	(41,410,280)
Other Pass-Through Liabilities	(21,339,570)
Total Pass-Through Liabilities	**(62,749,850)**
Net Cash Available to SCFHP	237,903,265
SCFHP Target Liquidity	
45 Days of Total Operating Expense	(133,196,124)
60 Days of Total Operating Expense	(177,594,831)
Liquidity Above/(Below) SCFHP Low Target	**104,707,142**
Liquidity Above/(Below) High Target	**60,308,434**

Note 1: In December 2018, the Governing Board established a Board Discretionary Fund of $2.2M. The specific projects/recipients have yet to be determined.

Note 2: Other Pass-Through Liabilities include Prop 56 and other provider payables.

Note 3: SCFHP Target Liquidity is based on total monthly budgeted expenses.

Capital Expenditures

Santa Clara Family Health Plan

Expenditure	YTD Actual	Annual Budget
Hardware	$334,747	$620,000
Software	$54,318	$1,029,000
Building Improvements	$500,649	$3,149,500
TOTAL	**$889,713**	**$4,798,500**

Santa Clara Family Health Plan™

Financial Statements

Income Statement

Santa Clara Family Health Plan

Santa Clara County Health Authority
INCOME STATEMENT
For Four Months Ending October 31, 2019

	Oct-2019 Actuals	% of Rev	Oct-2019 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD Oct-2019 Actuals	% of Rev	YTD Oct-2019 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 78,000,230	85.1%	$ 75,291,999	84.5%	$ 2,708,232	3.6%	$ 309,845,072	85.1%	$ 301,422,778	84.4%	$ 8,422,294	2.8%
CMC MEDI-CAL	2,699,135	2.9%	2,853,019	3.2%	(153,884)	-5.4%	10,657,349	2.9%	11,321,079	3.2%	(663,731)	-5.9%
CMC MEDICARE	10,956,748	12.0%	10,934,125	12.3%	22,624	0.2%	42,258,452	11.6%	43,387,750	12.1%	(1,129,299)	-2.6%
TOTAL CMC	13,655,884	14.9%	13,787,144	15.5%	(131,260)	-1.0%	52,915,800	14.5%	54,708,829	15.3%	(1,793,029)	-3.3%
HEALTHY KIDS	151	0.0%	0	0.0%	151	0.0%	1,123,487	0.3%	1,043,572	0.3%	79,915	7.7%
TOTAL REVENUE	**$ 91,656,266**	**100.0%**	**$ 89,079,143**	**100.0%**	**$ 2,577,123**	**2.9%**	**$ 363,884,359**	**100.0%**	**$ 357,175,179**	**100.0%**	**$ 6,709,180**	**1.9%**
MEDICAL EXPENSES												
MEDI-CAL	$ 73,754,842	80.5%	$ 70,294,823	78.9%	$ (3,460,019)	-4.9%	$ 291,054,596	80.0%	$ 281,647,072	78.9%	$ (9,407,524)	-3.3%
CMC MEDI-CAL	2,579,722	2.8%	3,008,163	3.4%	428,440	14.2%	10,534,794	2.9%	11,938,459	3.3%	1,403,665	11.8%
CMC MEDICARE	10,440,748	11.4%	10,084,619	11.3%	(356,129)	-3.5%	40,591,221	11.2%	40,006,640	11.2%	(584,582)	-1.5%
TOTAL CMC	13,020,470	14.2%	13,092,782	14.7%	72,311	0.6%	51,126,016	14.1%	51,945,099	14.5%	819,083	1.6%
HEALTHY KIDS	(24,633)	0.0%	0	0.0%	24,633	0.0%	819,740	0.2%	1,123,405	0.3%	303,665	27.0%
TOTAL MEDICAL EXPENSES	**$ 86,750,680**	**94.6%**	**$ 83,387,605**	**93.6%**	**$ (3,363,075)**	**-4.0%**	**$ 343,000,352**	**94.3%**	**$ 334,715,576**	**93.7%**	**$ (8,284,775)**	**-2.5%**
MEDICAL OPERATING MARGIN	**$ 4,905,586**	**5.4%**	**$ 5,691,538**	**6.4%**	**$ (785,952)**	**-13.8%**	**$ 20,884,007**	**5.7%**	**$ 22,459,602**	**6.3%**	**$ (1,575,595)**	**-7.0%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 3,055,093	3.3%	$ 3,101,076	3.5%	$ 45,982	1.5%	$ 12,065,891	3.3%	$ 11,024,925	3.1%	$ (1,040,965)	-9.4%
RENTS AND UTILITIES	7,225	0.0%	22,217	0.0%	14,992	67.5%	69,976	0.0%	73,268	0.0%	3,292	4.5%
PRINTING AND ADVERTISING	22,910	0.0%	72,613	0.1%	49,703	68.4%	94,468	0.0%	272,952	0.1%	178,484	65.4%
INFORMATION SYSTEMS	165,279	0.2%	302,410	0.3%	137,131	45.3%	1,022,160	0.3%	1,254,640	0.4%	232,480	18.5%
PROF FEES/CONSULTING/TEMP STAFFING	1,128,187	1.2%	1,108,951	1.2%	(19,236)	-1.7%	3,754,658	1.0%	4,728,950	1.3%	974,292	20.6%
DEPRECIATION/INSURANCE/EQUIPMENT	355,524	0.4%	398,898	0.4%	43,374	10.9%	1,365,417	0.4%	1,554,988	0.4%	189,571	12.2%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	76,119	0.1%	77,741	0.1%	1,622	2.1%	296,440	0.1%	311,364	0.1%	14,924	4.8%
MEETINGS/TRAVEL/DUES	94,487	0.1%	125,405	0.1%	30,918	24.7%	374,057	0.1%	516,702	0.1%	142,644	27.6%
OTHER	164,048	0.2%	200,500	0.2%	36,452	18.2%	666,240	0.2%	798,750	0.2%	132,510	16.6%
TOTAL ADMINISTRATIVE EXPENSES	**$ 5,068,871**	**5.5%**	**$ 5,409,811**	**6.1%**	**$ 340,940**	**6.3%**	**$ 19,709,306**	**5.4%**	**$ 20,536,539**	**5.7%**	**$ 827,232**	**4.0%**
OPERATING SURPLUS (LOSS)	**$ (163,285)**	**-0.2%**	**$ 281,727**	**0.3%**	**$ (445,012)**	**-158.0%**	**$ 1,174,700**	**0.3%**	**$ 1,923,064**	**0.5%**	**$ (748,363)**	**-38.9%**
ALLOWANCE FOR UNCOLLECTED PREMIUM	38799	0.0%	0	0.0%	(38,799)	0.0%	42267	0.0%	0	0.0%	(42,267)	0.0%
GASB 75 - POST EMPLOYMENT BENEFITS EXPENSE	59,780	0.1%	60,000	0.1%	220	0.4%	239,119	0.1%	240,000	0.1%	881	0.4%
GASB 68 - UNFUNDED PENSION LIABILITY	75,000	0.1%	75,000	0.1%	0	0.0%	300,000	0.1%	300,000	0.1%	0	0.0%
NON-OPERATING EXPENSES	**$ 173,579**	**0.2%**	**$ 135,000**	**0.2%**	**$ (38,579)**	**-28.6%**	**$ 581,386**	**0.2%**	**$ 540,000**	**0.2%**	**$ (41,386)**	**-7.7%**
INTEREST & OTHER INCOME	599,181	0.7%	379,225	0.4%	219,956	58.0%	2,265,627	0.6%	1,516,900	0.4%	748,727	49.4%
NET NON-OPERATING ACTIVITIES	**$ 425,603**	**0.5%**	**$ 244,225**	**0.3%**	**$ 181,377**	**74.3%**	**$ 1,684,242**	**0.5%**	**$ 976,900**	**0.3%**	**$ 707,341**	**72.4%**
NET SURPLUS (LOSS)	**$ 262,317**	**0.3%**	**$ 525,952**	**0.6%**	**$ (263,635)**	**-50.1%**	**$ 2,858,942**	**0.8%**	**$ 2,899,964**	**0.8%**	**$ (41,022)**	**-1.4%**

Balance Sheet

Santa Clara Family Health Plan

SANTA CLARA COUNTY HEALTH AUTHORITY
For Four Months Ending October 31, 2019

	Oct-2019	Sep-2019	Aug-2019	Oct-2018
Assets				
Current Assets				
Cash and Marketable Securities	300,653,115	292,802,171	291,325,334	210,241,106
Receivables	528,367,815	512,462,788	752,169,795	507,221,512
Prepaid Expenses and Other Current Assets	11,641,445	11,776,133	11,991,409	8,811,521
Total Current Assets	**840,662,376**	**817,041,092**	**1,055,486,539**	**726,274,139**
Long Term Assets				
Property and Equipment	45,648,483	45,257,793	45,024,463	42,947,276
Accumulated Depreciation	(18,544,570)	(18,235,377)	(17,943,981)	(15,535,422)
Total Long Term Assets	27,103,913	27,022,416	27,080,481	27,411,854
Total Assets	**867,766,289**	**844,063,508**	**1,082,567,020**	**753,685,993**
Deferred Outflow of Resources	**9,237,609**	**9,237,609**	**9,237,609**	**14,535,240**
Total Assets & Deferred Outflows	**877,003,898**	**853,301,117**	**1,091,804,629**	**768,221,233**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	10,008,958	7,598,240	6,442,995	5,327,678
Employee Benefits	1,781,081	1,740,524	1,690,637	1,599,736
Retirement Obligation per GASB 75	4,182,405	4,122,625	4,062,845	5,121,914
Advance Premium - Healthy Kids	-	85,058	95,965	80,686
Deferred Revenue - Medicare	-	-	9,997,983	-
Whole Person Care / Prop 56	21,339,570	19,531,214	17,664,845	7,896,914
IGT, HQAF, Other Provider Payables	38,212,182	35,620,914	305,128,711	9,213,280
MCO Tax Payable - State Board of Equalization	41,410,280	31,057,710	-	8,784,631
Due to DHCS	29,964,404	28,665,798	28,372,563	28,225,971
Liability for In Home Support Services (IHSS)	416,092,527	416,092,527	416,092,527	413,549,551
Current Premium Deficiency Reserve (PDR) - AOC Data	8,294,025	8,294,025	8,294,025	8,294,025
Current Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	97,451,250	92,558,575	86,591,338	95,703,419
Total Current Liabilities	**662,817,181**	**639,447,709**	**878,514,934**	**577,878,305**
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	287,974	216,982.78	150,000	2,124,796
Total Non-Current Liabilities	**6,207,474**	**6,136,483**	**6,069,500**	**8,044,296**
Total Liabilities	**669,024,655**	**645,584,191**	**884,584,434**	**585,922,601**
Deferred Inflow of Resources	**2,994,548**	**2,994,548**	**2,994,548**	**4,034,640**
Net Assets				
Invested in Capital Assets	27,103,913	27,022,416	27,080,481	27,411,854
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Board Designated Fund	2,200,000	2,200,000	2,200,000	0
Unrestricted Net Equity	172,516,490	172,597,987	172,539,921	150,298,659
Current YTD Income (Loss)	2,858,942	2,596,625	2,099,895	248,129
Total Net Assets / Reserves	**204,984,695**	**204,722,378**	**204,225,647**	**178,263,992**
Total Liabilities, Deferred Inflows and Net Assets	**877,003,898**	**853,301,117**	**1,091,804,629**	**768,221,233**

Cash Flow Statement

Santa Clara Family Health Plan

	Oct-2019	Year-to-date
Cash Flows from Operating Activities		
Premiums Received	$87,402,414	$604,875,611
Medical Expenses Paid	(79,266,736)	(594,073,544)
Adminstrative Expenses Paid	(493,225)	(10,947,369)
Net Cash from Operating Activities	**$7,642,453**	**($145,302)**
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	(390,690)	(889,713)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	599,181	2,265,627
Net Increase/(Decrease) in Cash & Cash Equivalents	**7,850,944**	**1,230,611**
Cash & Cash Equivalents (Beginning)	292,802,171	299,422,504
Cash & Cash Equivalents (Ending)	**$300,653,115**	**$300,653,115**
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Income/(Loss)	(336,864)	593,315
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	309,193	1,178,039
Changes in Operating Assets/Liabilities		
Premiums Receivable	(15,905,027)	222,759,657
Other Receivable	-	-
Due from Santa Clara Family Health Foundation	-	-
Prepaids & Other Assets	134,688	437,296
Deferred Outflow of Resources	-	-
Accounts Payable & Accrued Liabilities	4,234,353	7,440,013
State Payable	11,651,176	18,231,595
IGT, HQAF & Other Provider Payables	2,591,268	(260,669,426)
Net Pension Liability	70,991	287,974
Medical Cost Reserves & PDR	4,892,675	9,596,234
IHSS Payable	-	-
Deferred Inflow of Resources	-	-
Total Adjustments	**7,979,317**	**(738,617)**
Net Cash from Operating Activities	**$7,642,453**	**($145,302)**

Statement of Operations by Line of Business - YTD

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Four Months Ending October 31, 2019

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)						
REVENUE	$309,845,072	$10,657,349	$42,258,452	$52,915,800	$1,123,487	**$363,884,359**
MEDICAL EXPENSE (MLR)	$291,054,596	$10,534,794	$40,591,221	$51,126,016	$819,740	**$343,000,352**
GROSS MARGIN	$18,790,476	$122,554	$1,667,230	$1,789,784	$303,746	**$20,884,007**
ADMINISTRATIVE EXPENSE (% of Revenue Allocation)	$16,782,341	$577,241	$2,288,872	$2,866,113	$60,852	**$19,709,306**
OPERATING INCOME/(LOSS) (% of Revenue Allocation)	$2,008,135	($454,687)	($621,642)	($1,076,329)	$242,894	**$1,174,700**
OTHER INCOME/(EXPENSE) (% of Revenue Allocation)	$1,434,120	$49,328	$195,594	$244,921	$5,200	**$1,684,242**
NET INCOME/(LOSS)	$3,442,255	($405,359)	($426,048)	($831,407)	$248,094	**$2,858,942**
PMPM (ALLOCATED BASIS)						
REVENUE	$328.39	$326.54	$1,294.80	$1,621.34	$106.75	**$368.79**
MEDICAL EXPENSES	$308.47	$322.79	$1,243.72	$1,566.50	$77.89	**$347.62**
GROSS MARGIN	$19.91	$3.76	$51.08	$54.84	$28.86	**$21.17**
ADMINISTRATIVE EXPENSES	$17.79	$17.69	$70.13	$87.82	$5.78	**$19.97**
OPERATING INCOME/(LOSS)	$2.13	($13.93)	($19.05)	($32.98)	$23.08	**$1.19**
OTHER INCOME/(EXPENSE)	$1.52	$1.51	$5.99	$7.50	$0.49	**$1.71**
NET INCOME/(LOSS)	$3.65	($12.42)	($13.05)	($25.47)	$23.57	**$2.90**
ALLOCATION BASIS:						
MEMBER MONTHS - YTD	943,540	32,637	32,637	32,637	10,524	986,701
REVENUE BY LOB	85.1%	2.9%	11.6%	14.5%	0.3%	100.0%

RESOLUTION TO FUND CALPERS
OTHER POST-EMPLOYMENT BENEFITS LIABILITY

WHEREAS, the Santa Clara County Health Authority dba Santa Clara Family Health Plan (the Plan) participates in the California Public Employees' Retirement System's (CalPERS) California Employers' Retiree Benefit Trust (CERBT) program. The Plan makes regular contributions to the CalPERS CERBT program, which will provide other post-employment benefits (OPEB) as medical benefits to retired employees.

WHEREAS, on an annual basis, the Plan's actuaries calculate the actuarial unfunded OPEB liability. The Plan seeks to make annual contributions of the unfunded OPEB liability to reduce its overall OPEB expense and to work toward full funding of its OPEB liability.

NOW, THEREFORE, BE IT RESOLVED:

I. On an annual basis the Plan's executive management will obtain the actuarial unfunded employer OPEB liability per the annual OPEB valuation reports and will present their recommendation of funding such annual amounts to the Plan's Governing Board.

II. Based on the most recent OPEB valuation, dated June 30, 2018, the Plan will make an employer contribution of $1,252,850 including interest, payable by December 31, 2019. This is the third of three annual contributions approved by the Governing Board in December 2017.

III. Once the annual employer contribution is approved by the Governing Board, the Plan's CFO will remit funds to the CalPERS CERBT program in a timely manner.

PASSED AND ADOPTED by the Governing Board of the Santa Clara County Health Authority.

_____
this 12th day of December, 2019.

BY:

_____
Robert Brownstein, Board Chair,
Santa Clara County Health Authority

Santa Clara Family Health Plan™

CalAIM Overview

Governing Board Meeting

December 12, 2019

What is CalAIM?

California Advancing and Innovating Medi-Cal

- Set of proposals using Medi-Cal as a tool to address many of Governor's top challenges:
  - Homelessness
  - Insufficient access to behavioral health care
  - Children with complex medical needs
  - Clinical needs of justice-involved populations
  - Aging population

CalAIM: Three Primary Goals

1. Identify and manage member risk and need through whole person care approaches and addressing the social determinants of health

2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility

3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform

What does it propose?

Eight Core Initiatives

- Annual open enrollment
- NCQA accreditation for plans and delegates
- Population health management plan
- Enhanced Care Management & In Lieu of Services
- Ending Cal MediConnect and requiring DSNPs
- Mandatory managed care populations
- Regional rates
- Behavioral health

CalAIM Timeline

2020
- Regional rate-setting and shared savings/risk methodologies
- Submit transition plan for WPC/HH

2021
- Implement population health management plan
- Implement ECM/ILOS benefit
- SPD/LTC blended rate
- Regional rates in targeted areas
- Enrollment of mandatory managed care populations
- Revise medical necessity criteria for behavioral health

2022
- Cal MediConnect ends December 31

2023
- Statewide implementation of regional rates
- Mandatory duals enrollment
- D-SNP coverage begins for duals

2024
- Implement prospective shared savings/risk methodology

2025
- NCQA accreditation for plans and delegates

2026
- Full implementation of integrated, managed long-term services and supports program

Medi-Cal Membership Change FY17/18 to FY19/20

Membership	FY18	FY19	FY20*
Adult Expansion	937,378	876,060	849,324
Adult/Family (under 19)	1,240,847	1,168,853	1,115,100
Adult/Family (over 19)	343,489	319,797	303,828
Percent Change	**FY19 v FY18**	**FY20* v FY19**	**FY20* v FY18**
Adult Expansion	-7%	-3%	-9%
Adult/Family (under 19)	-6%	-5%	-10%
Adult/Family (over 19)	-7%	-5%	-12%
FY20* Jul-Sep annualized			

Healthy Kids Transitions and Closure

CCHIP Members

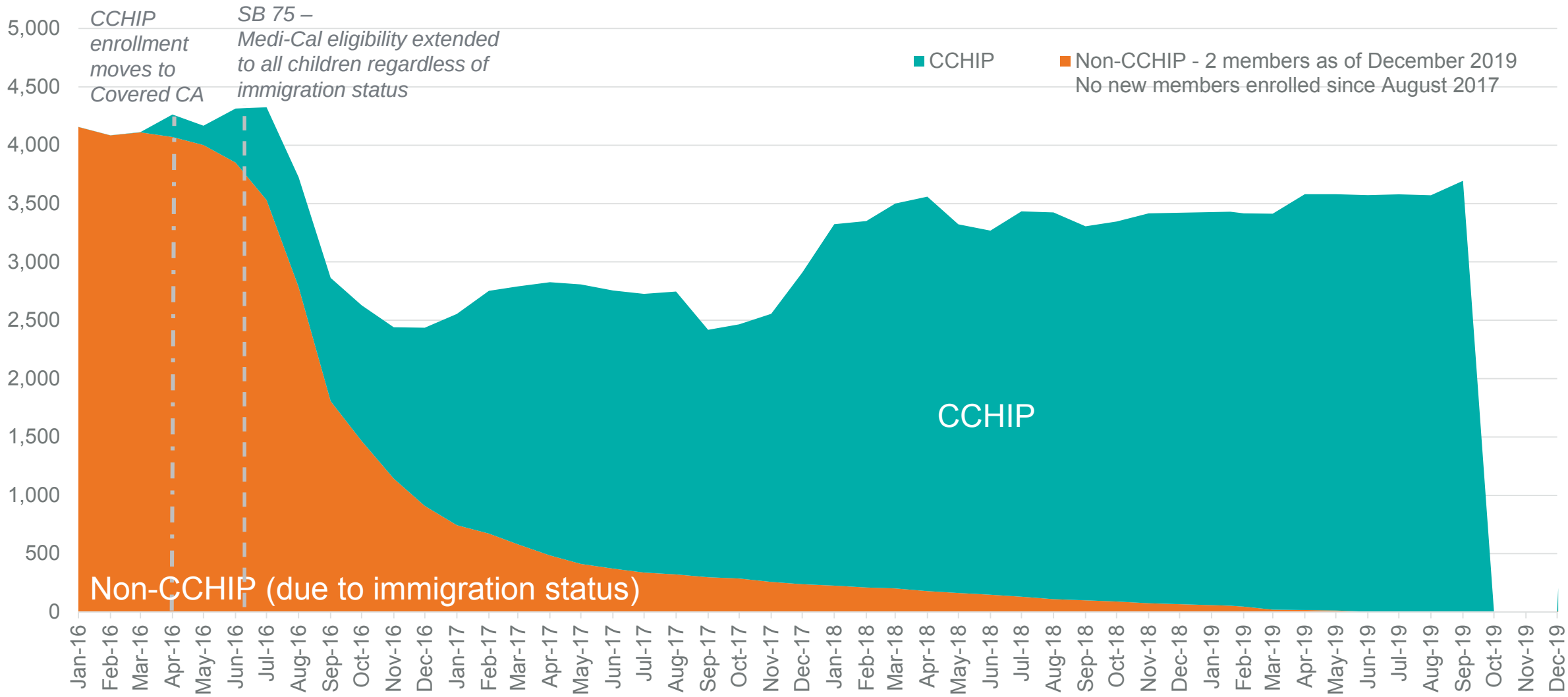
- Transitioned to Medi-Cal October 1, 2019
  - 3,556 HK CCHIP members eligible with SCFHP as of 9/30/2019
  - Of those, 3,468 remained eligible with SCFHP as of 10/31/2019
  - Disenrollment is consistent with historical monthly churn
- No significant issues; eligibility issues in transition month were resolved in favor of the beneficiary retaining eligibility

Non-CCHIP Members

- 2 members as of December 2019
- Member notices mailed (90 day and 30 day)
- Phone outreach conducted to connect family with Patient Access for assistance with applying for coverage through Valley Kids

Santa Clara Family Health Plan

Healthy Kids Enrollment



Medi-Cal Young Adult Expansion

Through SB 104, beginning January 1, 2020, all low-income young adults, ages 19 through 25, can enroll in Medi-Cal, regardless of immigration status.

- Transition population
  - Young adults enrolled in Emergency Medi-Cal prior to SB 104 implementation
  - 3,080 in Santa Clara County as of November 2019, per DHCS
  - Will be automatically moved to full scope fee-for-service Medi-Cal
  - Will receive multiple notices and Health Care Options choice packet
    - Sent by DHCS, counties, HCO
    - First notice sent in November
- New enrollee population
  - Beneficiaries follow existing processes for eligibility and enrollment
  - No advance noticing as population is unknown to DHCS and counties

Medi-Cal Young Adult Expansion

Santa Clara County Workgroup

- Medi-Cal Expansion 2020 Task Force
  - Outreach Subcommittee established
  - Draft flyer developed (attached)
- Legal landscape
  - From statewide convening of immigration advocates and state officials, attended by staff from Amigos de Guadalupe
    - Overall consensus was that majority of expansion population will not be affected by the Public Charge rule
    - Remains difficult to identify under what circumstances a Medi-Cal recipient would be flagged
    - State-funded Medi-Cal is not considered a benefit in the new public charge test and should not be reported on the I-944 form (for LPR/green card applicants)
- Given the uncertainty around Public Charge, Outreach Subcommittee does not want to issue blanket reassurances that the expansion population will be safe from the Public Charge rule, but agreed that because this change is coming, the community needs to be informed

5 THINGS YOU NEED TO KNOW ABOUT

Medi-Cal Expansion for Undocumented Young Adults

Medi-Cal has expanded to include undocumented young adults up to the age of 26.

1. Beginning January 1, 2020, all low-income young adults, ages 19 through 25, can enroll in Medi-Cal, regardless of immigration status.

2. You can enroll in emergency Medi-Cal NOW and automatically receive full-scope coverage when the program starts in January. You can get more information and confidential help applying at a clinic or with a community organization. To find a clinic, go to: http://localclinic.net

3. If you already have "emergency" Medi-Cal, you will be automatically enrolled in full-scope services on January 1, 2020.

4. Full-scope Medi-Cal means you can access health services for FREE or at low cost, including preventive services – like annual check-ups, dental care, and medication.

5. If you have questions about your immigration status and accessing healthcare, please contact an immigration advocate. These groups offer free, confidential immigration help in your area: OneCalifornia – http://bit.ly/immigrationhelp

health happens aquí

#HealthAndJustice4All