Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, October 27, 2022, 10:30 AM – 12:30 PM

Santa Clara Family Health Plan

6201 San Ignacio Ave, San Jose, CA 95119

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

AGENDA

1.	**Roll Call**	Ms. Murphy	10:30	5 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Executive/Finance Committee reserves the right to limit the duration of the public comment period to 30 minutes.	Ms. Murphy	10:35	5 min
3.	**Fiscal Year 2021-2022 Independent Auditor's Report** Discuss draft FY2021-2022 Independent Auditor's Report including Board Communication Letter and Audited Financial Statements **Possible Action:** Approve FY2021-2022 Independent Auditor's Report	Moss Adams	10:45	20 min
4.	**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 **a.** Approve August 25, 2022 **Executive/Finance Committee** minutes **b.** Approve June 2022 **Quarterly Investment Performance and Compliance Report** **c.** Approve **continued use of teleconferencing** without providing public access to each teleconference location pursuant to Government Code Section 54953	Ms. Murphy	10:40	5 min
5.	**August 2022 Financial Statements** Review August 2022 Financial Statements. **Possible Action:** Approve the August 2022 Financial Statements	Mr. Jarecki	11:05	10 min
6.	**Innovation Fund Expenditure Request** Consider funding request from **Unity Care** for the Seasons of Wellness Pilot Project. **Possible Action:** Approve expenditure from the Board Designated Innovation Fund for the Unity Care Seasons of Wellness Pilot Project	Ms. Tomcala	11:15	10 min

7.	**Government Relations Update** Discuss local, state, and federal legislative and policy issues impacting the Plan and its members.	Mr. Haskell	11:25	10 min
8.	**CEO Update** Discuss status of current topics and initiatives.	Ms. Tomcala	11:35	10 min
	Announcement Prior to Recessing into Closed Session Announcement that the Executive/Finance Committee will recess into Closed Session to discuss Item No. 9 below.			
9.	**Adjourn to Closed Session**		11:45	
	a. Pending Litigation (Government Code Section 54956.9(d)(1)): It is the intention of the Executive/Finance Committee to meet in Closed Session to confer with Legal Counsel regarding Kindred Hospital – San Francisco Bay Area v. Santa Clara Family Health Plan; Superior Court of the State of California for the County of Alameda Case No.:RG20076644			
	b. Contract Rates (Welfare and Institutions Code Section 14087.38(n)): It is the intention of the Executive/Finance Committee to meet in Closed Session to discuss Plan partner rates.			
10.	**Report from Closed Session**	Ms. Murphy	12:25	5 min
11.	**Adjournment**		12:30	

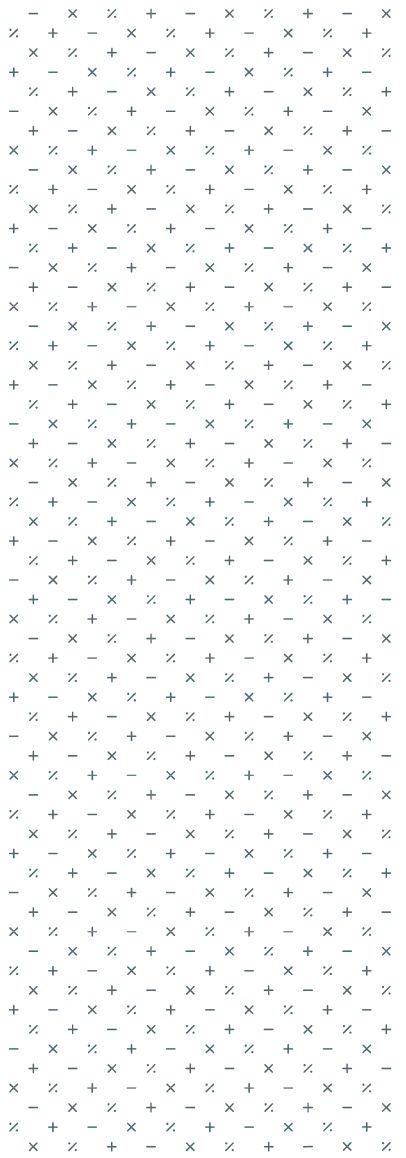
Notice to the Public—Meeting Procedures

- Persons wishing to address the Executive/Finance Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Ashley Kerner 48 hours prior to the meeting at (408) 874-1896.
- To obtain a copy of any supporting document that is available, contact Ashley Kerner 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.

MOSSADAMS

2022 Audit Results:

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



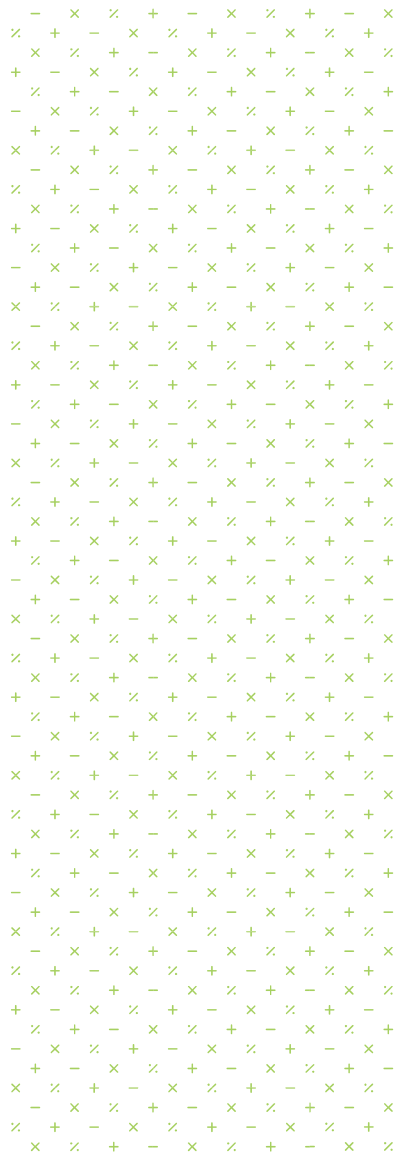
Report of Independent Auditors

Unmodified Opinion

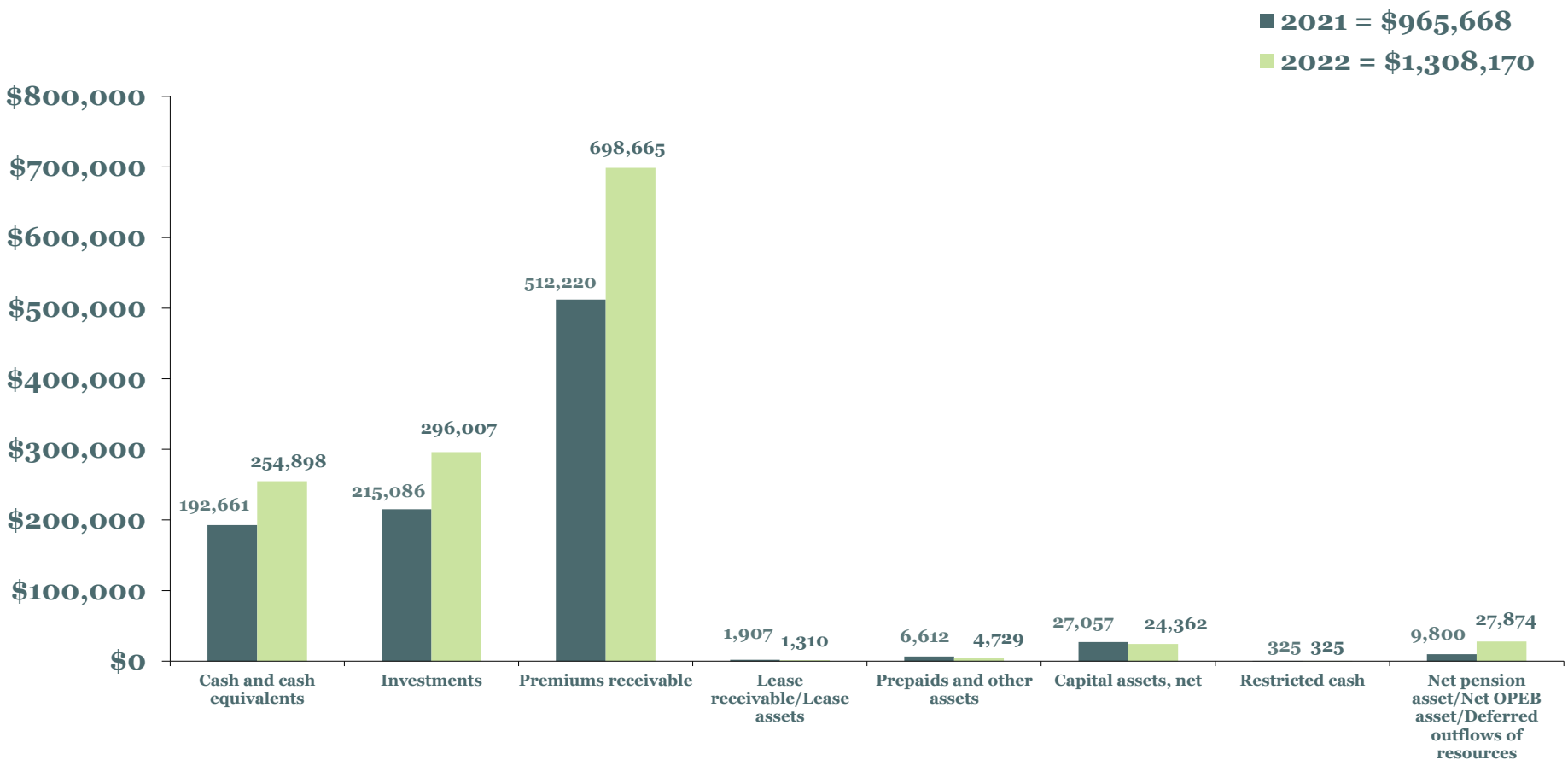
Financial statements are fairly presented in accordance with generally accepted accounting principles.

MOSSADAMS

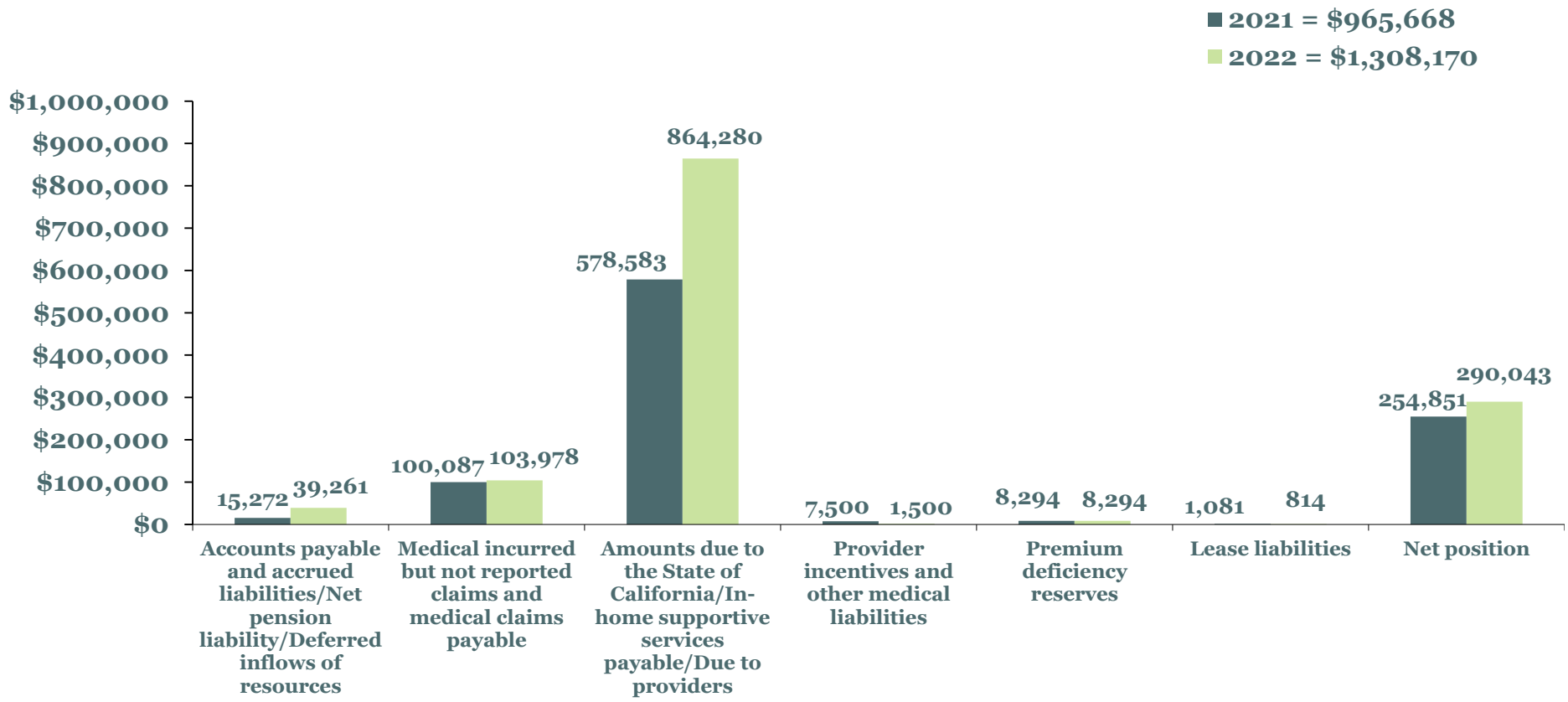
Statements of Net Position



Asset Composition (in Thousands)

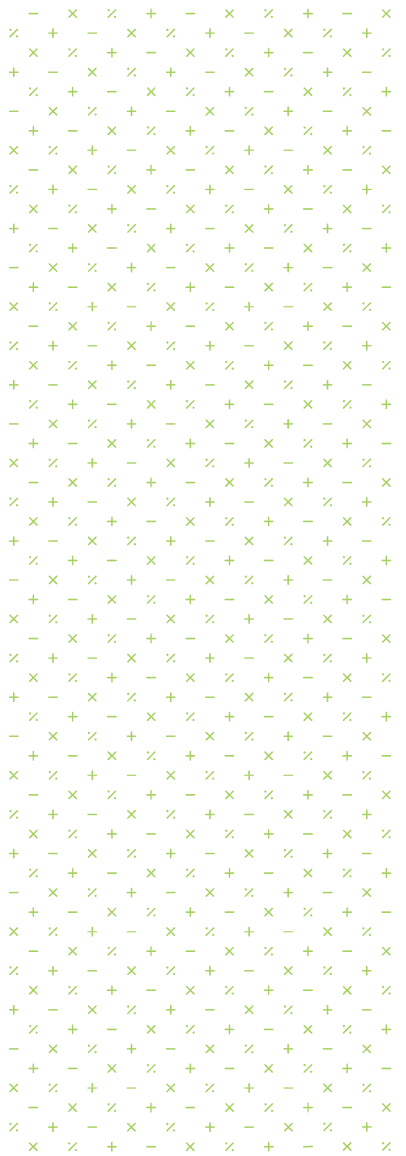


Liabilities and Net Position Balance (in Thousands)



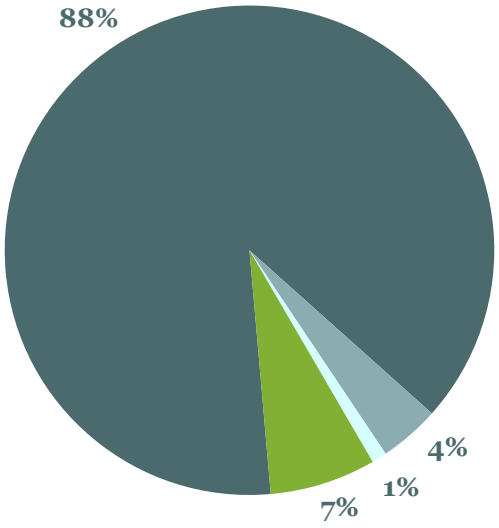
MOSSADAMS

Operations



Operating Expenses (in Thousands)

June 30, 2022
$1,800,267



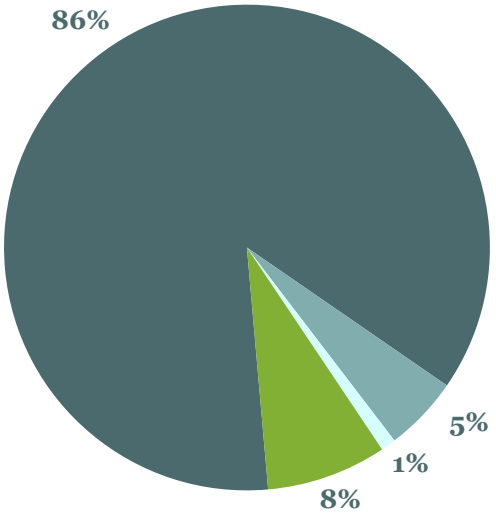
Medical expenses

Marketing, general, and administrative expenses

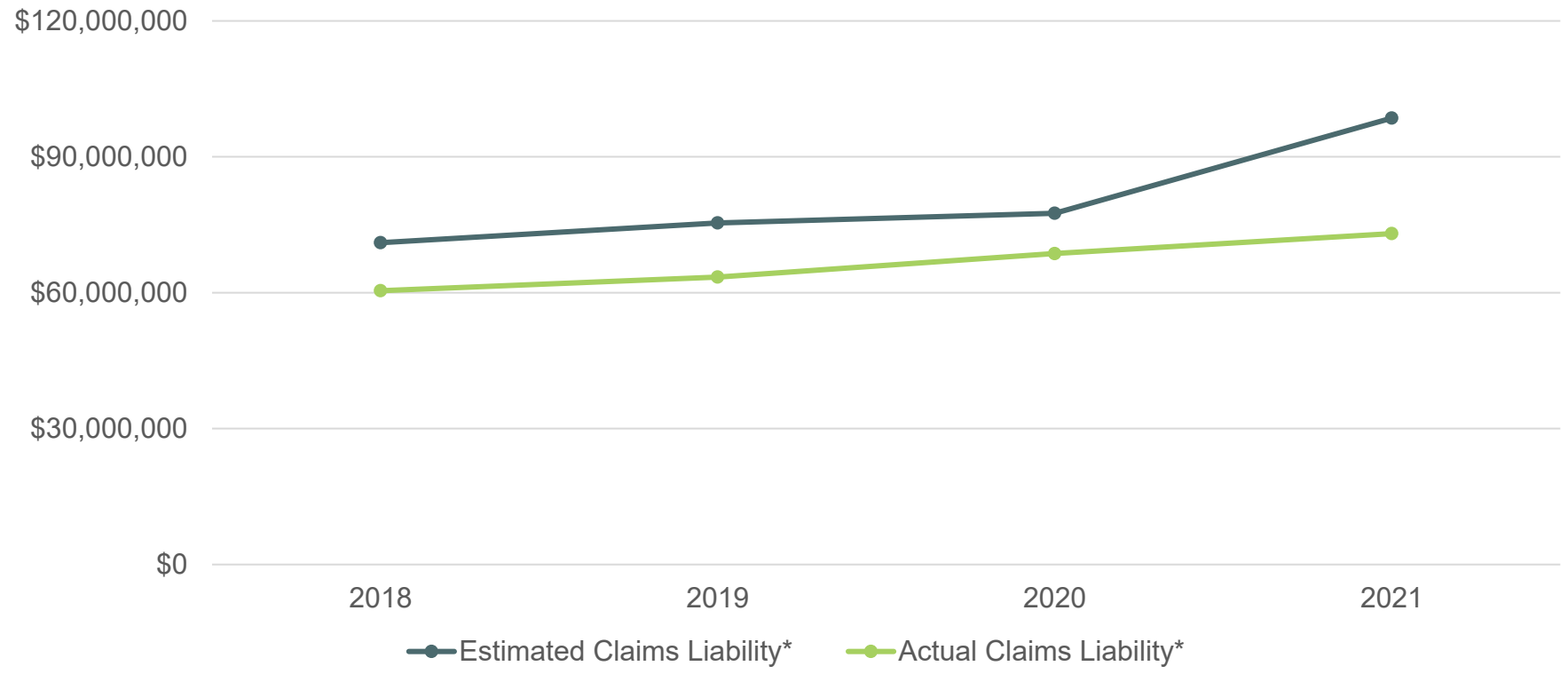
Depreciation

Premium tax

June 30, 2021
$1,337,018



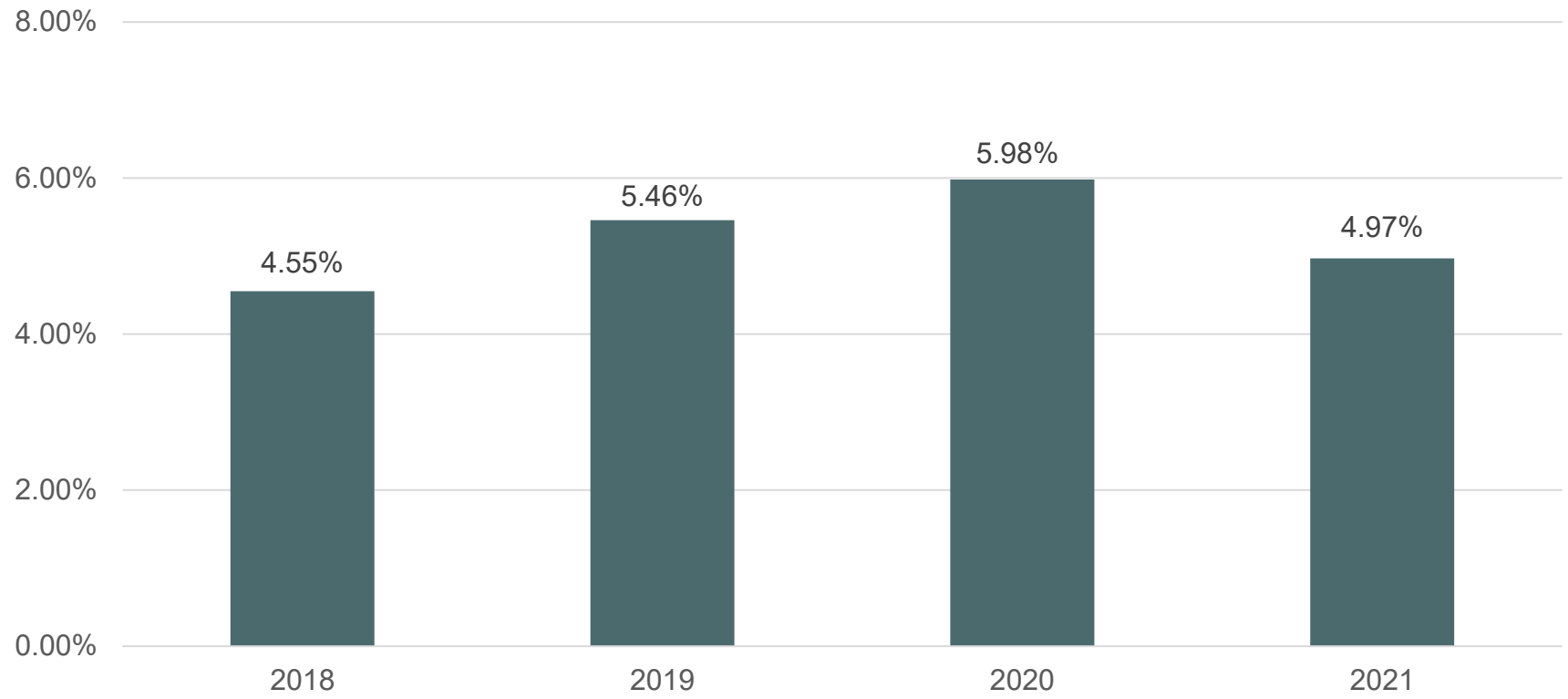
Historic Estimated Claims Liability and Historic Actual Claims Liability



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

Source: SCFHP's internal reports

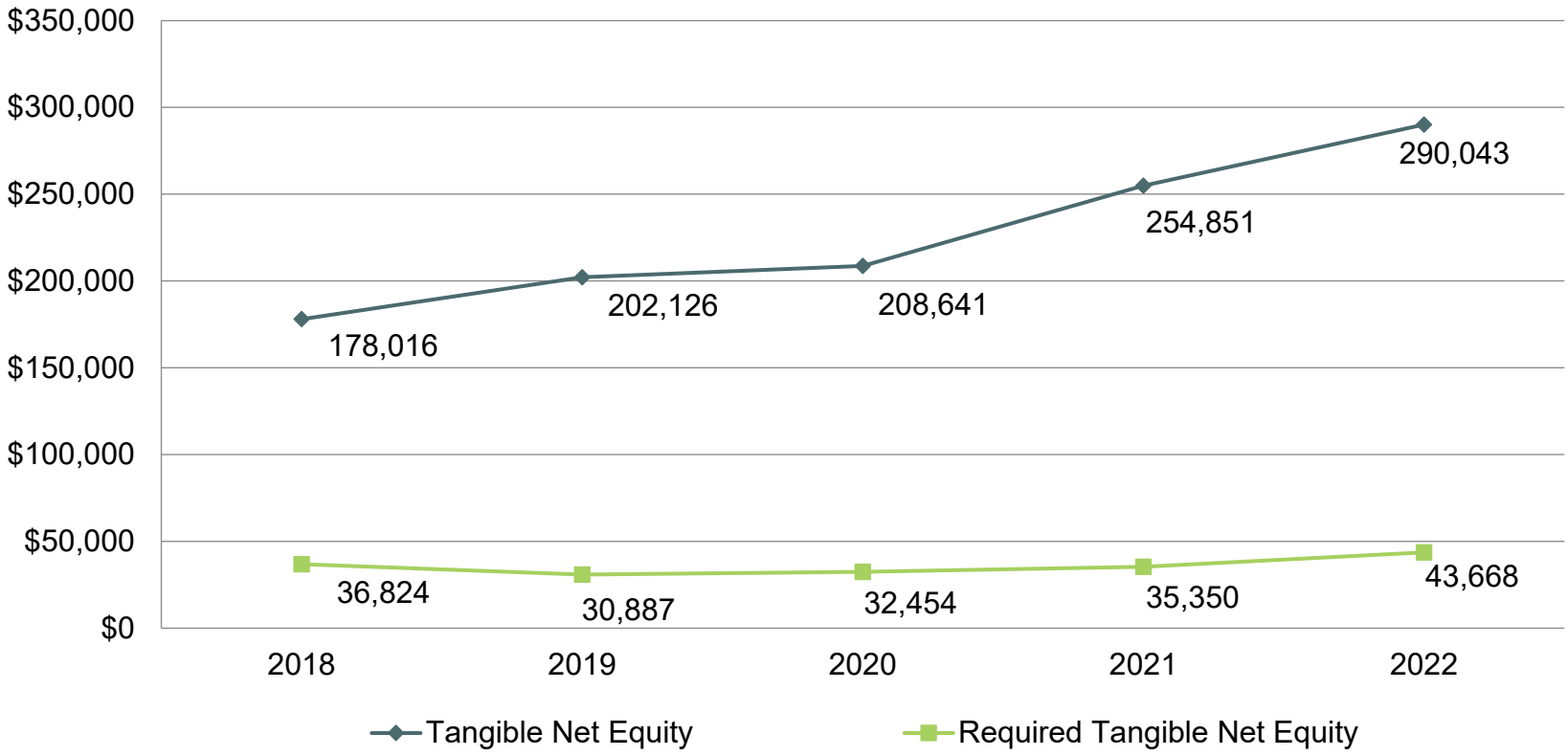
Historic Actual Claims Liability* as a % of Capitation and Premium Revenues



* 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
- Proposed audit adjustment
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of material instances of fraud or noncompliance with laws and regulations

Questions?

Report of Independent Auditors and Financial Statements

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

June 30, 2022 and 2021

MOSSADAMS

Table of Contents

Management's Discussion and Analysis

INTRODUCTION:

In accordance with the Governmental Accounting Standards Board Codification Section 2200, *Annual Comprehensive Financial Report*, the management of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) ("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, 2022, 2021, and 2020. This discussion should be reviewed in conjunction with the Health Authority's 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.

OVERVIEW OF FINANCIAL STATEMENTS:

The Health Authority's annual 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 Statements of Net Position present the Health Authority's assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position.
- The 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 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 increased by 8.4% to 306,351 members at June 30, 2022, from 282,670 members at June 30, 2021. Total enrollment increased by 11.3% to 282,670 members at June 30, 2021, from 253,875 members at June 30, 2020.

- Net position increased by $35,192,319 to $290,042,921 for the fiscal year ended June 30, 2022, from $254,850,602 for the fiscal year ended June 30, 2021, due to operating income of $33,061,836 and nonoperating income of $2,130,483. Net position increased by $46,209,816 to $254,850,602 for the fiscal year ended June 30, 2021, from $208,640,786 for the fiscal year ended June 30, 2020, due to operating income of $43,357,542 and nonoperating income of $2,852,274.

- Total assets and deferred outflows of resources increased to $1,308,170,177 as of June 30, 2022, from $965,668,156 as of June 30, 2021. Total assets and deferred outflows of resources decreased to $965,668,156 as of June 30, 2021, from $1,189,881,233 as of June 30, 2020.

- Total liabilities and deferred inflows of resources increased to $1,018,127,256 at June 30, 2022, from $710,817,554 at June 30, 2021. Total liabilities and deferred inflows of resources decreased to $710,817,554 at June 30, 2021, from $981,240,447 at June 30, 2020.

- The current ratio (current assets divided by current liabilities) of 1.24 as of June 30, 2022, reflected a decrease from 1.31 as of June 30, 2021. The current ratio (current assets divided by current liabilities) of 1.31 as of June 30, 2021, reflected an increase from 1.18 as of June 30, 2020.

CONDENSED STATEMENTS OF NET POSITION:

	June 30			2022 to 2021 Change		2021 to 2020 Change	
	2022	2021 (As Restated)	2020	Amount	% Change	Amount	% Change
Assets:							
Current assets	$ 1,254,649,142	$ 926,897,526	$ 1,152,476,888	$ 327,751,616	35.4%	$ (225,579,362)	-19.6%
Capital assets	24,361,878	27,056,663	26,649,088	(2,694,785)	-10.0%	407,575	1.5%
Other assets	15,980,478	4,300,610	2,352,997	11,679,868	271.6%	1,947,613	82.8%
Total assets	1,294,991,498	958,254,799	1,181,478,973	336,736,699	35.1%	(223,224,174)	-18.9%
Deferred outflows of resources	13,178,679	7,413,357	8,402,260	5,765,322	77.8%	(988,903)	-11.8%
Total assets and deferred outflows of resources	$ 1,308,170,177	$ 965,668,156	$ 1,189,881,233	$ 342,502,021	35.5%	$ (224,213,077)	-18.8%
Liabilities:							
Current liabilities	$ 1,010,459,937	$ 706,660,855	$ 977,464,723	$ 303,799,082	43.0%	$ (270,803,868)	-27.7%
Noncurrent liabilities	521,308	1,013,567	-	(492,259)	100.0%	1,013,567	100.0%
Total liabilities	1,010,981,245	707,674,422	977,464,723	303,306,823	42.9%	(269,790,301)	-27.6%
Deferred inflow of resources	7,146,011	3,143,132	3,775,724	4,002,879	127.4%	(632,592)	-16.8%
Net position:							
Net investment in capital assets	24,361,878	27,056,663	26,649,088	(2,694,785)	-10.0%	407,575	1.5%
Restricted	325,000	325,000	305,350	-	0.0%	19,650	6.4%
Unrestricted:							
Designated by Governing Board	15,587,414	17,067,275	17,339,275	(1,479,861)	-8.7%	(272,000)	100.0%
Unrestricted	249,768,629	210,401,664	164,347,073	39,366,965	18.7%	46,054,591	28.0%
Total net position	290,042,921	254,850,602	208,640,786	35,192,319	13.8%	46,209,816	22.1%
Total liabilities, deferred inflows of resources, and net position	$ 1,308,170,177	$ 965,668,156	$ 1,189,881,233	$ 342,502,021	35.5%	$ (224,213,077)	-18.8%

Assets and Deferred Outflows of Resources

For the fiscal year ended June 30, 2022, assets increased by $336,736,699 or 35.1% due primarily to increased premiums receivable attributable to the timing of anticipated hospital directed payments (as noted in the footnotes to the financial statements), coupled with increased cash and investment balances. During the same period, deferred outflows of resources increased by $5,765,322 or 77.8% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2021, assets decreased by $223,224,174 or -18.9% due primarily to decreases in hospital pass-through receivables. During the same period, deferred outflows of resources decreased by $988,903 or -11.8% due to the timing of amounts attributable to employee retirement plans.

Liabilities and Deferred Inflows of Resources

For the fiscal year ended June 30, 2022, liabilities increased by $303,306,823 or 42.9% due primarily to increased liabilities for hospital directed payments (as noted in the footnotes to the financial statements). During the same period, deferred inflows of resources increased by $4,002,879 or 127.4% due to the timing of amounts attributable to employee retirement plans and recording deferred inflow of resources related to the adoption of Government Accounting Standards Board Statement No. 87 – *Leases* (“GASB 87”).

For the fiscal year ended June 30, 2021, liabilities decreased by $269,790,301 or -27.6% due primarily to decreases in hospital pass-through payables. During the same period, deferred inflows of resources decreased by $632,592 or -16.8% due to the timing of amounts attributable to employee retirement plans and recording deferred inflow of resources related to the adoption of GASB 87.

Tangible Net Equity

The Health Authority is required to maintain a minimum level of tangible net equity ("TNE") per its contract with the California Department of Health Care Services ("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 $290,042,921, $254,850,602, and $208,640,786 at June 30, 2022, 2021, and 2020, respectively. The Health Authority exceeded the minimum required TNE levels at all times during the three fiscal years.

CONDENSED RESULTS OF OPERATIONS:

	Fiscal Year			2022 to 2021 Change		2021 to 2020 Change	
	2022	2021 (As Restated)	2020	Amount	% Change	Amount	% Change
Year end membership:							
Medi-Cal	296,019	272,590	244,888	23,429	8.6%	27,702	11.3%
Cal Medi-Connect	10,332	10,080	8,987	252	2.5%	1,093	12.2%
Total year end membership	306,351	282,670	253,875	23,681	8.4%	28,795	11.3%
Annual member months:							
Medi-Cal	3,390,356	3,137,271	2,829,690	253,085	8.1%	307,581	10.9%
Cal Medi-Connect	123,700	116,365	101,391	7,335	6.3%	14,974	14.8%
Healthy Kids	-	-	10,528	-	0.0%	(10,528)	-100.0%
Total annual member months	3,514,056	3,253,636	2,941,609	260,420	8.0%	312,027	10.6%
Operating revenues:							
Capitation and premium revenue	$ 1,833,328,501	$ 1,380,375,797	$ 1,147,826,608	$ 452,952,704	32.8%	$ 232,549,189	20.3%
Total operating revenues	1,833,328,501	1,380,375,797	1,147,826,608	452,952,704	32.8%	232,549,189	20.3%
Operating expenses:							
Medical expenses	1,597,879,729	1,162,912,637	1,036,714,518	434,967,092	37.4%	126,198,119	12.2%
General and administrative expenses	69,145,367	60,783,541	57,442,133	8,361,826	13.8%	3,341,408	5.8%
Depreciation and amortization	4,406,582	3,937,385	3,370,268	469,197	11.9%	567,117	16.8%
Premium tax	128,834,987	109,384,692	50,260,731	19,450,295	17.8%	59,123,961	117.6%
Total operating expenses	1,800,266,665	1,337,018,255	1,147,787,650	463,248,410	34.6%	189,230,605	16.5%
Operating income	33,061,836	43,357,542	38,958	(10,295,706)	-23.7%	43,318,584	111193.0%
Nonoperating revenues:							
Interest and other income	2,130,483	2,852,274	6,476,073	(721,791)	-25.3%	(3,623,799)	-56.0%
Changes in net position	35,192,319	46,209,816	6,515,031	(11,017,497)	-23.8%	39,694,785	609.3%
Net position, beginning of year	254,850,602	208,640,786	202,125,755	46,209,816	22.1%	6,515,031	3.2%
Net position, end of year	$ 290,042,921	$ 254,850,602	$ 208,640,786	$ 35,192,319	13.8%	$ 46,209,816	22.1%

The Healthy Kids program ended December 31, 2019, The Cal Medi-Connect program is scheduled to end December 31, 2022 and will be replaced with Dual Connect, a dual-eligible special needs plan ("D-SNP").

Membership and Enrollment

During the fiscal year ended June 30, 2022, the Health Authority experienced an increase in enrollment of 8.4% predominately due to the County's suspension of Medi-Cal disenrollment during the continued COVID-19 public health emergency.

During the fiscal year ended June 30, 2021, the Health Authority experienced an increase in enrollment of 11.3% predominately due to the County's suspension of Medi-Cal disenrollment during the COVID-19 public health emergency.

Operating Revenue

During the fiscal year ended June 30, 2022, operating revenues increased by $452,952,704 or 32.8% to $1,833,328,501 versus the prior year operating revenue of $1,380,375,797. Much of the increase was attributable to a new DHCS requirement to record hospital directed payments on the statement of net position, coupled with increased enrollment.

During the fiscal year ended June 30, 2021, operating revenues increased by $232,549,189 or 20.3% to $1,380,375,797 versus the prior year operating revenue of $1,147,826,608. Much of the increase was attributable to changes in enrollment and capitation rates.

Medical Expenses

During the fiscal year ended June 30, 2022, medical expenses increased by $434,967,092 or 37.4% to $1,597,879,729 versus the prior year of $1,162,912,637. Much of the increase was attributable to a new DHCS requirement to record hospital directed payments on the statement of net position, coupled with increased enrollment.

During the fiscal year ended June 30, 2021, medical expenses increased by $126,198,119 or 12.2% to $1,162,912,637 versus the prior year of $1,036,714,518. Much of the increase was attributable to increases in certain capitation and fee-for-service expenses.

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 93.7%, 91.5%, and 94.5% for the fiscal years ended June 30, 2022, 2021, and 2020, respectively.

Premium Deficiency Reserve

During the fiscal year ended June 30, 2022, management maintained its estimated premium deficiency reserve ("PDR") on the CMC contract at $8,294,025 for fiscal year 2023 due to continued uncertainties and past reconciliations.

During the fiscal year ended June 30, 2021, management maintained its estimated premium deficiency reserve ("PDR") on the CMC contract at $8,294,025 for fiscal year 2022 due to continued uncertainties and past reconciliations.

General and Administrative Expenses

During the fiscal year ended June 30, 2022, general and administrative expenses increased by $8,361,826 or 13.8% to $69,145,367 versus the prior year expense of $60,783,541 due to increased headcount required by expanding scope of responsibilities under the various California Advancing and Innovative Medi-Cal CalAIM programs.

During the fiscal year ended June 30, 2021, general and administrative expenses increased by $3,341,408 or 5.8% to $60,783,541 versus the prior year expense of $57,442,133 due to increased employee headcount and associated benefit costs.

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 4.3%, 5.1%, and 5.5% for the fiscal years ended June 30, 2022, 2021, and 2020, respectively.

CONDENSED CASH-FLOW INFORMATION:

The table below summarizes the major sources and uses of cash and cash equivalents for the fiscal years ended June 30, 2022, 2021, and 2020:

	Fiscal Year			2022 to 2021 Change		2021 to 2020 Change	
	2022	2021	2020	Amount	% Change	Amount	% Change
		(As Restated)					
Cash flows from operating activities	$ 141,997,704	$ 75,657,913	$ 30,675,986	$ 66,339,791	87.7%	$ 44,981,927	146.6%
Cash flows from capital and financing activities	(1,846,248)	(4,197,579)	(2,826,838)	2,351,331	-56.0%	(1,370,741)	48.5%
Cash flows from investing activities	(77,915,004)	(12,569,800)	(193,195,538)	(65,345,204)	519.9%	180,625,738	-93.5%
Net change in cash and cash equivalents	62,236,452	58,890,534	(165,346,390)	3,345,918	5.7%	224,236,924	-135.6%
Cash and cash equivalents, beginning of year	192,661,298	133,770,764	299,117,154	58,890,534	44.0%	(165,346,390)	-55.3%
Cash and cash equivalents, end of year	$ 254,897,750	$ 192,661,298	$ 133,770,764	$ 62,236,452	32.3%	$ 58,890,534	44.0%

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 and City National Bank Managed Investment Account, both of 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, 2022, 2021, and 2020. Capital assets largely included furniture and fixtures, computer hardware and software, and leasehold improvements:

	Fiscal Year Ended June 30,			2022 to 2021 Change		2021 to 2020 Change	
	2022	2021	2020	Amount	% Change	Amount	% Change
		(As Restated)					
Beginning balance, net	$ 27,056,663	$ 26,649,088	$ 27,392,240	$ 407,575	1.5%	$ (743,152)	-2.7%
Additions	2,182,144	4,583,540	2,826,838	(2,401,396)	-52.4%	1,756,702	62.1%
Reductions/adjustments	(749,294)	(446,556)	(199,722)	(302,738)	67.8%	(246,834)	123.6%
Depreciation and amortization expense	(4,127,635)	(3,729,409)	(3,370,268)	(398,226)	10.7%	(359,141)	10.7%
Ending balance, net	$ 24,361,878	$ 27,056,663	$ 26,649,088	$ (2,694,785)	-10.0%	$ 407,575	1.5%

GENERAL ECONOMIC FACTORS:

While the COVID-19 pandemic seems to be winding down, the public health emergency ("PHE") continues to remain in effect. The resulting pause in redeterminations has continue to increase the Plan's enrollment and will continue to do so until the PHE has concluded. The Plan's membership will likely decrease significantly over the subsequent twelve months as the County processes Medi-Cal renewal applications. The Plan's costs may move with potential changes in member acuity and utilization patterns. Changes in the general economic and employment conditions may also impact the Plan. For example, the broader economy faces additional challenges such as increasing inflation, supply chain concerns and changes to monetary policy, which may add cost pressures to the healthcare delivery system. SCFHP will continue to carefully navigate the vast landscape of unknowns to ensure it remains in a stable financial position.

FISCAL YEAR BUDGETS:

Fiscal Year 2022 Key Budget Impacts:

- COVID-19 Impact – The declaration of a Public Health Emergency by the State of California paused the normal Medi-Cal disenrollment process. The Plan saw a significant increase in enrollment for the fiscal years ended June 30, 2021 and June 30, 2020. Following the conclusion of the public health emergency, the Plan anticipates that Medi-Cal disenrollment process resumes.

- California Advancing and Innovative Medi-Cal ("CalAIM") – The State of California launched a multi-year initiative entitled California Advancing and Innovative Medi-Cal to improve health outcomes for the Medi-Cal population by implementing a multi-year program of broad reforms to the delivery systems, programs, and payment reforms. The initial components of CalAIM launched January 1, 2022. CalAIM is expected to provide new funding to the Plan and increased expenses, the magnitude of which are unknown at this time.

Fiscal Year 2023 Budget Summary:

In June 2022, the Health Authority's Governing Board formally approved operating and capital budgets for the fiscal year ending June 30, 2023. The fiscal year 2023 operating budget anticipates an enrollment decline of 2.1% due to the resumption of Medi-Cal eligibility redeterminations following the end of the public health emergency, transition of the Cal Medi-Connect program to the Dual Connect D-SNP program, introduction of additional CalAIM programs, modest changes in capitation rates, and modest growth in operating expenses.

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, Attention: Controller, 6201 San Ignacio Avenue, San Jose, California 95119 or call (408) 376-2000.

Report of Independent Auditors

The Governing Board
Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan), which comprise the statements of net position as of June 30, 2022 and 2021, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) as of June 30, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Santa Clara County Health Authority (dba Santa Clara Family Health Plan)'s ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 Santa Clara County Health Authority (dba Santa Clara Family Health Plan)'s internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Santa Clara County Health Authority (dba Santa Clara Family Health Plan)'s ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Emphasis of Matter – New Accounting Standard

As discussed in Note 1 to the combined financial statements, San Francisco Health Authority and San Francisco Community Health Authority adopted Government Accounting Standards Board No. 87, Leases, as of July 1, 2020. Our opinion is not modified with respect to this matter.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the 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 asset/liability, and supplementary schedule of other post-employment benefit contributions on pages 41 through 44 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

[Signature]

San Francisco, California
October ___, 2022

Financial Statements

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Net Position
June 30, 2022 and 2021

	2022	2021 (As Restated)
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets		
Cash and cash equivalents	$ 254,897,750	$ 192,661,298
Investments	296,007,423	215,085,767
Premiums receivable	698,665,326	512,219,526
Lease receivable, current portion	349,459	318,790
Prepaids and other assets	4,729,184	6,612,145
Total current assets	1,254,649,142	926,897,526
Lease receivable, net of current portion	233,139	582,597
Capital assets, net		
Nondepreciable	3,509,128	3,509,128
Depreciable, net of accumulated depreciation and amortization	20,852,750	23,547,535
Total capital assets, net	24,361,878	27,056,663
Assets restricted as to use	325,000	325,000
Net pension asset	8,138,023	-
Other post-employment benefits asset	6,557,302	2,387,052
Lease assets, net of accumulated amortization	727,014	1,005,961
Total assets	1,294,991,498	958,254,799
Deferred outflows of resources	13,178,679	7,413,357
Total deferred outflows of resources	13,178,679	7,413,357
Total assets and deferred outflows of resources	$ 1,308,170,177	$ 965,668,156
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
Current liabilities		
Accounts payable and accrued liabilities	$ 32,114,924	$ 11,930,005
Amounts due to the State of California	132,578,880	90,485,269
In-home supportive services payable	419,990,933	419,990,933
Due to providers	311,710,640	68,106,473
Medical incurred but not reported claims and medical claims payable	103,977,932	100,087,324
Provider incentives and other medical liabilities	1,499,998	7,500,000
Premium deficiency reserves	8,294,025	8,294,025
Lease liabilities, current portion	292,605	266,826
Total current liabilities	1,010,459,937	706,660,855
Noncurrent liabilities		
Net pension liability	-	199,654
Lease liabilities, net of current portion	521,308	813,913
Total liabilities	1,010,981,245	707,674,422
Deferred inflows of resources	7,146,011	3,143,132
Total deferred inflows of resources	7,146,011	3,143,132
Net position		
Net investment in capital assets	24,361,878	27,056,663
Restricted	325,000	325,000
Unrestricted:		
Designated by Governing Board	15,587,414	17,067,275
Unrestricted	249,768,629	210,401,664
Total net position	290,042,921	254,850,602
Total liabilities, deferred inflows of resources, and net position	$ 1,308,170,177	$ 965,668,156

See accompanying notes to financial statements.

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Revenues, Expenses, and Changes in Net Position
For the Years Ended June 30, 2022 and 2021

	2022	2021 (As Restated)
Operating revenues		
Capitation and premium revenue	$ 1,833,328,501	$ 1,380,375,797
Total operating revenues	1,833,328,501	1,380,375,797
Operating expenses		
Medical expenses	1,597,879,729	1,162,912,637
Premium tax	128,834,987	109,384,692
General and administrative expenses	69,145,367	60,783,541
Depreciation and amortization	4,406,582	3,937,385
Total operating expenses	1,800,266,665	1,337,018,255
Operating income	33,061,836	43,357,542
Nonoperating revenues		
Interest and other income	2,130,483	2,852,274
Change in net position	35,192,319	46,209,816
Net position, beginning of year	254,850,602	208,640,786
Net position, end of year	$ 290,042,921	$ 254,850,602

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Cash Flows
For the Years Ended June 30, 2022 and 2021

	2022	2021 (As Restated)
Cash flows from operating activities		
Capitation and premiums received	$ 1,646,882,701	$ 1,679,162,987
Medical expenses paid	(1,443,126,332)	(1,542,306,908)
Marketing, general, and administrative expenses paid	(61,758,665)	(61,198,166)
Net cash provided by operating activities	141,997,704	75,657,913
Cash flows from capital and financing activities		
Purchases of capital assets	(1,898,211)	(4,350,663)
Principal payments on lease liabilities	(266,826)	(133,198)
Proceeds from lease receivable	318,789	286,282
Net cash used in capital and financing activities	(1,846,248)	(4,197,579)
Cash flows from investing activities		
Purchase of investments	(1,801,354,060)	(693,316,965)
Sale of investments	1,721,308,573	677,894,891
Interest collection on investments	2,130,483	2,852,274
Net cash used in investing activities	(77,915,004)	(12,569,800)
Net change in cash and cash equivalents	62,236,452	58,890,534
Cash and cash equivalents, beginning of year	192,661,298	133,770,764
Cash and cash equivalents, end of year	$ 254,897,750	$ 192,661,298
Reconciliation of operating income to net cash provided by operating activities		
Operating income	$ 33,061,836	$ 43,357,542
Adjustments to reconcile operating income to net cash provided by operating activities		
Depreciation and amortization	4,406,582	3,937,385
Net unrealized (gain) loss on investments	(876,169)	219,662
Changes in operating assets and liabilities:		
Premiums receivable	(186,445,800)	298,787,190
Prepaids and other assets	1,882,961	1,184,258
Net pension asset/liability	(8,337,677)	1,216,656
Other post-employment benefits asset	(4,170,250)	(1,356,407)
Deferred outflows of resources	(5,765,322)	988,903
Accounts payable and accrued liabilities	20,650,280	(867,086)
Amounts due to the State of California	42,093,611	(13,944,529)
In-home supportive services payable	-	722,351
Due to providers	243,604,167	(277,249,924)
Medical incurred but not reported claims and medical claims payable	3,890,608	15,982,173
Provider incentives and other medical liabilities	(6,000,002)	4,500,000
Deferred inflows of resources	4,002,879	(1,820,261)
Net cash provided by operating activities	$ 141,997,704	$ 75,657,913
Supplemental cash-flow disclosure		
Cash paid during the year for premium tax	$ 118,500,088	$ 82,038,521
Supplemental disclosure of noncash item		
Payables for capital asset purchases	$ 283,933	$ 232,877

See accompanying notes to financial statements.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

History and organization – The Santa Clara County Health Authority (dba Santa Clara Family Health Plan ("Health Authority") 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 populations in Santa Clara County (the "County").

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 Cal Medi-Connect program is scheduled to end December 31, 2022 and will be replaced with Dual Connect, a dual-eligible special needs plan ("D-SNP").

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. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified MCO tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services on April 3, 2020. The effective date range for this approval is January 1, 2020 through December 31, 2022. The Health Authority paid $118,500,088 and $82,038,521 in MCO premium taxes during fiscal years 2022 and 2021, respectively. At June 30, 2022 and 2021, the Health Authority had payables due in the amount of $35,019,123 and $31,975,622, respectively, included in amounts due to the State of California.

Beginning January 1, 2022, CDHCS began implementing California Advancing and Innovating Medi-Cal ("CalAIM") to modernize the state of California's Medi-Cal Program. CalAIM will require managed care plans to implement a whole-system, person-centered strategy that focuses on wellness and prevention, including assessments of each enrollee's health risks and health-related social needs, and provide care management and care transitions across delivery systems and settings. CalAIM is expected to provide additional new funding to the Health Authority and increase expenses, the total magnitude of which are unknown at this time.

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 financial statements are prepared on the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when incurred.

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

Use of estimates – The preparation of the 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 financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Medical incurred but not reported ("IBNR") claims and medical claims payable, premiums receivable, fair market value of investments, net pension asset/liability, other post-employment benefits asset, 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, 2022 and 2021, the Health Authority's cash deposits and investment pool had carrying amounts of $254,897,750 and $192,661,298, respectively. The Health Authority's bank and investment pool balances at June 30, 2022 and 2021, including interests in an investment pool, were $260,066,086 and $223,433,288, respectively. Of the bank and investment pool balances at June 30, 2022 and 2021, $259,267,576 and $222,563,094, respectively, were not covered by federal depository insurance.

Amounts invested in the County Treasurer's investment pool (the "Investment Pool") are considered 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, 2022 and 2021.

Investments – The Health Authority adopted GASB Statement No. 72, *Fair Value Measurement and Application* ("GASB 72"), effective July 1, 2019. GASB 72 requires the Health Authority to use valuation techniques which are appropriate under the circumstances and are consistent with the market approach, the cost approach, or the income approach. GASB 72 establishes a hierarchy of inputs used to measure fair value consisting of three levels. Level 1 inputs are quoted prices in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. Level 3 inputs are unobservable inputs.

Capital assets – Purchased capital assets are stated at cost. Depreciation and amortization 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 $325,000 at June 30, 2022 and 2021.

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 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 ("GEMT") funds.

Effective July 1, 2017, DHCS implemented 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.

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 incentive 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 is 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 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 benefits asset – The Health Authority recognizes a net other post-employment benefits ("OPEB") asset, which represents the difference 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 asset is measured as of the Health Authority's prior fiscal year-end. Changes in the net OPEB asset 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 asset 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 asset, 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.

Lease assets and lease liabilities – The Health Authority has recorded lease assets and lease liabilities as a result of implementing GASB 87, *Leases* ("GASB 87"). The lease assets are initially measured at an amount equal to the initial measurement of the related lease liability plus any lease payments made prior to the lease term, less lease incentives, and plus ancillary charges necessary to place the lease into service. The lease assets are amortized on a straight-line basis over the life of the related lease.

The Health Authority recognizes lease contracts or equivalents that have a term exceeding one year that meet the definition of an other than short-term lease. The Health Authority uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the Health Authority's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments are expensed when incurred.

Lease receivable and deferred inflow of resources - Pursuant to GASB 87, the Health Authority, as a lessor, recognized a lease receivable and a deferred inflow of resources in the statements of net position. A lease receivable represents the present value of future lease payments expected to be received by the Health Authority during the lease term. A deferred inflow of resources is recognized corresponding to the lease receivable amount and is defined as an acquisition of net position by the Health Authority that is applicable to future reporting periods. Amortization of the deferred inflow of resources is based on the straight-line method over the terms of the leases.

The Health Authority recognizes lease contracts or equivalents that have a term exceeding one year that meet the definition of an other than short-term lease. The Health Authority uses the same interest rate it charges to lessee as the discount rate or that is implicit in the contract to the lessee. Short-term lease receipts and variable lease receipts not included in the measurement of the lease receivable are recognized as income when earned.

Net position – Net position is classified as net investment in capital assets, restricted net position, and unrestricted net position, which includes board designated funds. 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. Unrestricted net position consists of net position that does not meet the definition of restricted or net investment in capital assets and board designated funds. In December 2019, the Health Authority's Governing Board designated $16,000,000 for an Innovation fund and increased its previous designation for a Community-Based Organization fund to $4,000,000. As of June 30, 2022 and 2021, $15,587,414 and $17,067,275 was unexpended, respectively.

Capitation and premium revenue – The Health Authority has agreements with the Medi-Cal Program in the State of California 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, 2022 and 2021, premium revenues recorded from DHCS under the Medi-Cal program totaled $1,605,283,554 and $1,169,271,641, 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, 2022 and 2021, premium revenues totaled $42,996,569 and $45,682,524, and $185,048,378 and $165,421,632 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.

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, 2023. 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, 2022 and 2021. 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, 2022 and 2021. The Cal Medi-Connect program is scheduled to end December 31, 2022 and will be replaced with D-SNP.

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, 2022, the Health Authority had premiums receivable of $654,743,403, $10,468,902, and $33,453,021 due from Medi-Cal program, CMC program, and Medicare, respectively. As of June 30, 2021, the Health Authority had premiums receivable of $490,415,912, $9,002,439, and $12,801,175 due from Medi-Cal program, CMC program, and Medicare, 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 June 2017, the GASB issued Statement No. 87, *Leases* ("GASB 87"). 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. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 87 to fiscal years beginning after June 15, 2021. The Health Authority adopted GASB 87 as of July 1, 2020. The Health Authority calculated and recognized lease assets of $1,005,961, lease liabilities of $1,080,739, lease receivables of $901,387, and deferred inflows of resources of $866,537 as of June 30, 2021. There was no material impact to beginning net position from the adoption of GASB 87.

NOTE 2 – INVESTMENTS

At June 30, 2022 and 2021, the Health Authority's investments consisted of commercial paper, U.S. government agency bonds, corporate bonds, foreign bonds, municipal bonds, commercial paper, U.S. treasury securities and money market funds.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. The Health Authority manages risk of market value fluctuations due to overall changes in the general level of interest rates by complying with California Government Code Section 53600.5. As of June 30, 2022 and 2021, the Health Authority's investments all have maturities of less than one year.

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a nationally recognized statistical rating organization. The following are the credit ratings for each investment type at June 30, 2022:

Description	Fair value	Not rated	AAA	AA+	AA	AA-	A+	A	A-
Investments in:									
U.S. government agency bonds	$ 1,988,320	$ 1,988,320	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	53,440,085	-	1,010,623	-	-	4,000,163	6,816,745	4,375,795	37,236,759
Foreign bonds	22,983,662	-	-	-	-	14,935,397	-	-	8,048,265
Municipal bonds	24,295,915		11,783,975	1,830,183	1,850,023	999,568	7,832,166		
Commercial paper	108,906,959	108,906,959							
U.S. Treasury securities	49,987,500	49,987,500	-	-	-	-	-	-	-
Money market funds	34,404,982	-	34,404,982	-	-	-	-	-	-
Total investments	$ 296,007,423	$ 160,882,779	$ 47,199,580	$ 1,830,183	$ 1,850,023	$ 19,935,128	$ 14,648,911	$ 4,375,795	$ 45,285,024

The following are the credit ratings for each investment type at June 30, 2021:

Description	Fair value	AAA	AA+	AA	AA-	A+	A	A-	A-1+	A-1
Investments in:										
U.S. government agency bonds	$ 91,032,849	$ 25,549,604	$ -	$ 5,074,397	$ -	$ -	$ -	$ -	$ 60,408,848	$ -
Corporate bonds	62,445,780	-	3,019,216	-	9,520,715	16,644,503	20,140,173	13,121,173	-	-
Municipal bonds	13,108,692	1,925,611	499,868	6,596,581	4,086,632	-	-	-	-	-
Commercial paper	40,257,340	-	-	-	-	-	-	-	24,658,032	15,599,308
U.S. Treasury securities	8,241,106	2,541,134	-	-	-	-	-	-	5,699,972	-
Total investments	$ 215,085,767	$ 30,016,349	$ 3,519,084	$ 11,670,978	$ 13,607,347	$ 16,644,503	$ 20,140,173	$ 13,121,173	$ 90,766,852	$ 15,599,308

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer. The Health Authority's investments as a percentage of its portfolio at June 30, 2022 were as follows:

Investment	Issuer	Percentage of portfolio
U.S. government agency bonds	Various	1.0 %
Corporate bonds	Various	18.0
Foreign bonds	Various	8.0
Municipal bonds	Various	8.0
Commercial paper	Various	36.0
U.S. Treasury securities	Various	17.0
Money market funds	Various	12.0
		100.00 %

The Health Authority's investments as a percentage of its portfolio at June 30, 2021 were as follows:

Investment	Issuer	Percentage of portfolio
U.S. government agency bonds	Various	42.0 %
Corporate bonds	Various	29.0
Municipal bonds	Various	6.0
Commercial paper	Various	19.0
U.S. Treasury securities	Various	4.0
		100.00 %

NOTE 3 – FAIR VALUE

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The following table present fair value measurements of assets recognized in the accompanying financial statements measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at June 30:

Description	Level 1	Level 2	Level 3	2022
Investments in:				
U.S. government agency bonds	$ -	$ 1,988,320	$ -	$ 1,988,320
Corporate bonds	-	53,440,085	-	53,440,085
Foreign bonds	-	22,983,662	-	22,983,662
Municipal bonds	-	24,295,915	-	24,295,915
Total investments subject to fair value hierarchy	$ -	$ 102,707,982	$ -	102,707,982
Investments and restricted cash not subject to fair value hierarchy				
Commercial paper				108,906,959
U.S. Treasury securities				49,987,500
Money market funds				34,404,982
Certificates of deposits				325,000
Total investments and restricted cash				$ 296,332,423

Description	Level 1	Level 2	Level 3	2021
Investments in:				
U.S. government agency bonds	$ -	$ 91,032,849	$ -	$ 91,032,849
Corporate bonds	-	62,445,780	-	62,445,780
Municipal bonds	-	13,108,692	-	13,108,692
Total investments subject to fair value hierarchy	$ -	$ 166,587,321	$ -	166,587,321
Investments and restricted cash not subject to fair value hierarchy				
Commercial paper				40,257,340
U.S. Treasury securities				8,241,106
Certificates of deposits				325,000
Total investments and restricted cash				$ 215,410,767

NOTE 4 – CAPITAL ASSETS

Capital asset activity for the fiscal years ended June 30, 2022 and 2021, are as follows:

	2022				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ 3,509,128	$ -	$ -	$ -	$ 3,509,128
Furniture and equipment	13,236,492	930,513	(351,341)	-	13,815,664
Building and building improvements	22,913,963	307,959	(108,547)	-	23,113,375
Software	11,833,970	943,672	(289,406)	-	12,488,236
Vehicles	29,248	-	-	-	29,248
Total capital assets	51,522,801	2,182,144	(749,294)	-	52,955,651
Less accumulated depreciation and amortization for:					
Furniture and equipment	11,474,319	794,725	(13,373)	-	12,255,671
Building and building improvements	2,885,035	1,613,970	(16)	-	4,498,989
Software	10,090,129	1,736,079	(8,624)	-	11,817,584
Vehicles	16,655	4,874	-	-	21,529
Total accumulated depreciation and amortization	24,466,138	4,149,648	(22,013)	-	28,593,773
Capital assets, net	$ 27,056,663	$ (1,967,504)	$ (727,281)	$ -	$ 24,361,878

	2021				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ 3,507,578	$ 1,550	$ -	$ -	$ 3,509,128
Furniture and equipment	12,642,255	594,237	-	-	13,236,492
Building and building improvements	19,008,213	3,767,238	(214,889)	353,401	22,913,963
Software	11,631,752	220,515	(18,297)	-	11,833,970
Vehicles	29,248	-	-	-	29,248
Building improvements work in progress	566,771	-	(213,370)	(353,401)	-
Total capital assets	47,385,817	4,583,540	(446,556)	-	51,522,801
Less accumulated depreciation and amortization for:					
Furniture and equipment	10,860,863	613,456	-	-	11,474,319
Building and building improvements	1,557,918	1,327,117	-	-	2,885,035
Software	8,306,167	1,783,962	-	-	10,090,129
Vehicles	11,781	4,874	-	-	16,655
Total accumulated depreciation and amortization	20,736,729	3,729,409	-	-	24,466,138
Capital assets, net	$ 26,649,088	$ 854,131	$ (446,556)	$ -	$ 27,056,663

Depreciation and amortization expense totaled $4,406,582 and $3,937,385 at June 30, 2022 and 2021, respectively.

NOTE 5 – MEDICAL INCURRED BUT NOT REPORTED CLAIMS AND MEDICAL CLAIMS PAYABLE

The Health Authority estimates 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, 2022 and 2021 is summarized as follows:

	2022	2021
Beginning balance	$ 100,087,324	$ 84,105,151
Incurred related to:		
Current year	661,732,668	677,315,048
Prior year	(28,652,411)	(13,082,432)
Total incurred	633,080,257	664,232,616
Paid related to:		
Current year	555,604,717	578,912,062
Prior year	73,584,932	69,338,381
Total paid	629,189,649	648,250,443
Ending balance	$ 103,977,932	$ 100,087,324

As presented in the table above, $633,080,257 and $664,232,616 in medical claims were incurred for the years ended June 30, 2022 and 2021, respectively, which are reflected in medical services in the statements of revenues, expenses, and changes in net position.

IBNR liability increased by $3,890,608 in comparison to the previous year as a result of changes between actual payments for medical services and estimated amounts in previous years. Management believes the increase in estimated prior year's claims experience is largely a result of higher-than-anticipated adverse health care claims experience.

NOTE 6 – 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, 2022 and 2021, board-designated funds of $15,587,414 and $17,067,275, respectively, were made.

NOTE 7 – LEASES

The Health Authority is a lessee for noncancellable lease of office space and equipment with lease terms through 2026. There are no residual value guarantees included in the measurement of the Health Authority's lease liability nor recognized as an expense for the years ended June 30, 2022 and 2021. The Health Authority does not have any commitments that were incurred at the commencement of the leases. The Health Authority is not subject to variable payments. No termination penalties were incurred for the years ended June 30, 2022 and 2021.

The Health Authority has the following lease right of use activities as of June 30:

	2022			
	Beginning Balance	Increase	Decrease	Ending Balance
Lease assets				
Office space	$ 876,823	$ -	$ -	$ 876,823
Equipment	337,114	-	-	337,114
Total lease assets	1,213,937	-	-	1,213,937
Less accumulated amoritzation				
Office space	172,490	172,490	-	344,980
Equipment	35,486	106,457	-	141,943
Total accumulated amoritzation	207,976	278,947	-	486,923
Net lease assets	$ 1,005,961	$ (278,947)	$ -	$ 727,014

	2021			
	Beginning Balance	Increase	Decrease	Ending Balance
Lease assets				
Office space	$ 876,823	$ -	$ -	$ 876,823
Equipment	-	337,114	-	337,114
Total lease assets	876,823	337,114	-	1,213,937
Less accumulated amoritzation				
Office space	-	172,490	-	172,490
Equipment	-	35,486	-	35,486
Total accumulated amoritzation	-	207,976	-	207,976
Net lease assets	$ 876,823	$ 129,138	$ -	$ 1,005,961

For the year ended June 30, 2022 and 2021, the Health Authority recognized $278,947 and $207,976, respectively, in amortization expense.

The future principal and interest lease payments as of June 30, 2022, were as follows:

Year Ending June 30,	Principal	Interest	Total
2023	$ 292,605	$ 34,106	$ 326,711
2024	297,288	18,899	316,187
2025	205,938	6,546	212,484
2026	18,082	75	18,157
	$ 813,913	$ 59,626	$ 873,539

The Health Authority evaluated the lease assets for impairment and determined there was no impairment for the years ended June 30, 2022 and 2021.

The Health Authority is a lessor for noncancellable lease of office space with lease terms through fiscal year 2026. For the year ending June 30, 2022, the Health Authority recognized $329,632 in lease revenue released from deferred inflows of resources related to the office space lease. The Health Authority recognized interest revenue of $36,616 for the year ended June 30, 2022. No variable payments charged to the lessees. No inflows of resources were recognized in the year related to termination penalties or residual value guarantees during the year.

NOTE 8 – 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. Non-senior staff employees may make an irrevocable election by their first day of employment to contribute 6% of their gross compensation and the Health Authority must contribute 3% of the participant's gross compensation. 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 $907,115 and $854,462 for the years ended June 30, 2022 and 2021, 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 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 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 for Classic members was 10.32% and 10.34% of annual covered payroll for the years ended June 30, 2022 and 2021. The employer contribution rate for PEPRA members was 7.47% and 7.59% for the years ended June 30, 2022 and 2021. All eligible participating Classic employees are required to contribute 7.00% of their monthly salaries to CalPERS for years ended June 30,2022 and 2021. All eligible participating PEPRA employees are required to contribute 6.75% for years ended June 30, 2022 and 2021. 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 $2,519,660 and $2,361,122 for the years ended June 30, 2022 and 2021, respectively.

Pension liability/asset, pension expense, and deferred outflows of resources and deferred inflows of resources related to pension – The net pension liability at June 30, 2022, is measured as of June 30, 2021, using an annual actuarial valuation as of June 30, 2020, rolled forward to June 30, 2021, using standard update procedures. The total pension liability in the June 30, 2020 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 2.50% until Purchasing Power Protection Allowance Floor on Purchasing Power applies

The net pension asset at June 30, 2021, is measured as of June 30, 2020, using an annual actuarial valuation as of June 30, 2019, rolled forward to June 30, 2020, using standard update procedures. The total pension asset in the June 30, 2019 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 2.50% until Purchasing Power Protection Allowance Floor on Purchasing Power applies

All other actuarial assumptions used in the June 30, 2020 and 2019 valuations were based on the results of an actuarial experience study for the fiscal years 1997 to 2015, 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 remained unchanged at 2.50% for the June 30, 2021 and 2020, measurement dates.

Discount rate – The discount rate used to measure the total pension asset at June 30, 2022 and 2021, 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)]
Public 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, 2022 and 2021, 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, 2022		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Health Authority's net pension liability (asset)	$ (116,848)	$ (8,138,023)	$ (14,769,014)

	June 30, 2021		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Health Authority's net pension (asset) liability	$ 7,419,584	$ 199,654	$ (5,765,948)

The Health Authority's proportion for the miscellaneous plan was -0.15047% and 0.00183% at June 30, 2022 and 2021, respectively.

For the years ended June 30, 2022 and 2021, the Health Authority recognized pension income of $13,019,517 and pension expense of $3,551,927, respectively. Pension income/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, 2022, the Health Authority had $12,516,133 of deferred outflows of resources and $1,417,320 of deferred inflows of resources related to pensions from the following sources:

	2022	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 2,660,042	$ -
Difference in experience	-	(912,592)
Differences between employer's actual contributions and its proportionate share of total employer contributions	-	(504,728)
Net differences between projected and actual earnings on pension plan investments	7,104,064	-
Changes in assumptions	-	-
Pension contributions made subsequent to measurement date	2,752,027	-
	$ 12,516,133	$ (1,417,320)

As of June 30, 2021, the Health Authority had $4,204,264 of deferred outflows of resources and $539,318 of deferred inflows of resources related to pensions from the following sources:

	2021	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 1,248,667	$ (84,236)
Difference in experience	10,290	-
Differences between employer's actual contributions and its proportionate share of total employer contributions	573,703	(453,658)
Net differences between projected and actual earnings on pension plan investments	5,931	-
Changes in assumptions	-	(1,424)
Pension contributions made subsequent to measurement date	2,365,673	-
	$ 4,204,264	$ (539,318)

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

Deferred outflows of resources of $2,752,027 and $2,365,673 resulting from contributions subsequent to the measurement date will be recognized as an increase/reduction of the net pension asset/liability in the years ending June 30, 2023 and 2022, 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,	
2023	$ 2,213,608
2024	$ 2,162,273
2025	$ 2,007,707
2026	$ 1,963,198

NOTE 9 – 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, 2022 and 2021, the following employees were covered by the plan:

	2022	2021
Active	331	238
Retirees	65	54
Total participants	396	292

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 asset – The Health Authority's net OPEB asset at June 30, 2022 and 2021, was measured as of June 30, 2021 and 2020, respectively, and the total OPEB asset used to calculate the net OPEB asset was determined by an actuarial valuation as of June 30, 2021 and 2020, respectively.

The total OPEB asset in the June 30, 2022, actuarial valuation was determined using the following actuarial assumptions:

Actuarial cost method:	Individual Entry Age Normal Level Percent of Pay
Actuarial assumptions:	
Discount rate	6.25%
Inflation	2.50%
Investment rate of return	6.75%
Healthcare cost trend rates:	6.76 % for 2022 – Non-Medicare, decreasing to 4.00% in 2076, 5.90% for 2023 – Medicare, decreasing to 4.00% in 2076

Mortality rates are based on statistics taken from the CalPERS 2000-2019 Experience Study Report. Mortality projected fully generational with Scale MP-2021.

The total OPEB liability in the June 30, 2021, 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:	7.00% for 2022 – Non-Medicare, decreasing to 4.00% in 2076, 6.10% for 2022 – Medicare, decreasing to 4.00% in 2076

Mortality rates are based on statistics taken from the CalPERS 1997-2015 Experience Study Report. Mortality projected fully generational with Scale MP-2019.

Discount rate – The discount rate used to measure the total OPEB asset was 6.25% and 6.75% at June 30, 2021 and 2020 measurement dates, respectively. 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 asset.

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	Asset Allocation	Expected Real Rate of Return
Global equity	59.00%	4.56%
Fixed income	25.00%	0.78%
Treasury inflation-protected securities	5.00%	-0.08%
Commodities	3.00%	1.22%
Real estate investment trusts	8.00%	4.06%
Assumed long-term rate of inflation		2.50%
Expected long-term net rate of return		6.25%

Changes in the net OPEB asset – The changes in the net OPEB asset for the years ended June 30, 2022 and 2021, were as follows:

	June 30, 2022		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB (Asset)
Balance at June 30, 2021	$ 13,485,032	$ 15,872,084	$ (2,387,052)
Changes during the year:			
Service cost	1,231,856	-	1,231,856
Interest on the total OPEB asset	977,230	-	977,230
Actual vs. expected experience	(1,267,092)	-	(1,267,092)
Assumption changes	(167,716)	-	(167,716)
Contributions from employer	-	588,065	(588,065)
Net investment income	-	4,362,468	(4,362,468)
Benefit payments	(478,810)	(478,810)	-
Administrative expense	-	(6,005)	6,005
Net change	295,468	4,465,718	(4,170,250)
Balance at June 30, 2022	$ 13,780,500	$ 20,337,802	$ (6,557,302)

	June 30, 2021		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB (Asset)
Balance at June 30, 2020	$ 11,878,467	$ 12,909,112	$ (1,030,645)
Changes during the year:			
Service cost	1,222,378	-	1,222,378
Interest on the total OPEB asset	867,980	-	867,980
Actual vs. expected experience	-	-	-
Assumption changes	-	-	-
Contributions from employer	-	3,018,143	(3,018,143)
Net investment income	-	435,252	(435,252)
Benefit payments	(483,793)	(483,793)	-
Administrative expense	-	(6,630)	6,630
Net change	1,606,565	2,962,972	(1,356,407)
Balance at June 30, 2021	$ 13,485,032	$ 15,872,084	$ (2,387,052)

Sensitivity of the net OPEB asset to changes in the discount rate – The following presents the net OPEB asset of the Health Authority as of June 30, 2022 and 2021, as well as what the Health Authority's net OPEB asset would be if it were calculated using a discount rate that is one percentage point lower or one percentage point higher than the current discount rate:

	June 30, 2022		
	1% Decrease (5.25%)	Current Discount Rate (6.25%)	1% Increase (7.25%)
Health Authority's net OPEB (asset)	$ (4,641,149)	$ (6,557,302)	$ (8,138,562)

	June 30, 2021		
	1% Decrease (5.75%)	Current Discount Rate (6.75%)	1% Increase (7.75%)
Health Authority's net OPEB (asset)	$ (438,734)	$ (2,387,052)	$ (3,981,312)

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

	June 30, 2022		
	1% Decrease in Healthcare Costs Trend Rate	Current Healthcare Costs Trend Rate	1% Increase in Healthcare Costs Trend Rate
Health Authority's net OPEB (asset)	$ (8,451,652)	$ (6,557,302)	$ (4,179,007)

	June 30, 2021		
	1% Decrease in Healthcare Costs Trend Rate	Current Healthcare Costs Trend Rate	1% Increase in Healthcare Costs Trend Rate
Health Authority's net OPEB (asset) liability	$ (4,396,093)	$ (2,387,052)	$ 161,692

OPEB expense and deferred outflows of resources and deferred inflows of resources related to OPEB – For the years ended June 2022, the Health Authority recognized OPEB expense of $178,226. At June 30, 2022, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2022	
	Deferred outflows of resources	Deferred inflows of resources
Difference in experience	$ -	$ (2,598,897)
Net differences between projected and actual earnings on pension plan investments	-	(2,378,173)
Changes in assumptions	58,498	(214,726)
OPEB contributions made subsequent to measurement date	604,048	-
	$ 662,546	$ (5,191,796)

For the year ended June 2021, the Health Authority recognized OPEB expense of $1,008,472. At June 30, 2021, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2021	
	Deferred outflows of resources	Deferred inflows of resources
Difference in experience	$ -	$ (1,664,999)
Net differences between projected and actual earnings on pension plan investments	291,278	-
Changes in assumptions	73,122	(72,288)
OPEB contributions made subsequent to measurement date	2,844,693	-
	$ 3,209,093	$ (1,737,287)

The Health Authority reported $604,048 and $2,844,693 as deferred outflows of resources related to contributions made subsequent to the measurement date for the years ended June 30, 2022 and 2021, respectively. This amount will be recognized as an increase of net OPEB asset in the years ended June 30, 2023 and 2022, 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,	
2023	$ (925,446)
2024	$ (920,657)
2025	$ (905,353)
2026	$ (1,002,110)
2027	$ (356,839)
Thereafter	$ (1,022,893)

Payable to the OPEB plan – At June 30, 2022 and 2021, the Health Authority had no outstanding amount of contributions to the OPEB plan required for the years ended June 30, 2022 and 2021.

NOTE 10 – 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 exceeded stop-loss recoveries by $896,925 and $861,145 in 2022 and 2021, respectively.

NOTE 11 – 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 $43,667,905 and $35,350,150 at June 30, 2022 and 2021, respectively. The Health Authority's tangible net equity was $290,042,921 and $254,850,602 at June 30, 2022 and 2021, respectively.

NOTE 12 – 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 13 – COMMITMENTS AND CONTINGENCIES

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

NOTE 14 – HEALTH CARE REFORM

There are various proposals at the federal and state levels that could, among other things, significantly change member eligibility, payment rates or benefits. The ultimate outcome of these proposals, including the potential effects of or changes to health care reform that will be enacted cannot presently be determined.

Supplementary Information

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

	2022	2021	2020	2019	2018	2017	2016	2015
Measurement period	2020-2021	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Proportion of the net pension liability (asset)	-0.15047%	0.00183%	-0.00992%	-0.02053%	0.01840%	0.07925%	0.07311%	0.07849%
Proportionate share of the net pension liability (asset)	$ (8,138,023)	$ 199,654	$ (1,017,002)	$ (1,978,644)	$ 1,824,796	$ 6,857,370	$ 5,018,386	$ 4,883,971
Covered-employee payroll*	$ 29,826,808	$ 26,732,488	$ 23,706,126	$ 19,966,458	$ 16,512,291	$ 11,010,647	$ 7,427,745	$ 9,121,825
Proportionate share of the net pension liability (asset) as a percentage of covered-employee payroll	-27.28%	0.75%	-4.29%	-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 (asset)	88.29%	75.10%	75.26%	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)
Schedule of Pension Contributions

	2022	2021	2020	2019	2018	2017	2016	2015
Measurement period	2020-2021	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Actuarially determined contribution	$ 2,752,027	$ 2,365,673	$ 2,058,408	$ 1,669,920	$ 1,198,065	$ 1,287,320	$ 910,906	$ 886,335
Contributions in relation to the actuarially determined contribution	2,752,027	2,365,673	2,058,408	1,669,920	4,426,715	7,188,179	910,906	886,335
Contribution excess	$ -	$ -	$ -	$ -	$ (3,228,650)	$ (5,900,859)	$ -	$ -
Covered-employee payroll*	$ 32,455,141	$ 29,826,808	$ 26,732,488	$ 23,706,126	$ 19,966,458	$ 16,512,291	$ 11,010,647	$ 7,427,745
Contributions as a percentage of covered-employee payroll	8.48%	7.93%	7.70%	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)
Schedule of Changes in Net Other Post-Employment Benefit Asset/Liability

	2022	2021	2020	2019	2018	2017
Measurement period	2020-2021	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016
Total OPEB liability						
Service cost	$ 1,231,856	$ 1,222,378	$ 1,089,286	$ 1,119,648	$ 756,248	$ 736,008
Interest on the total OPEB liability	977,230	867,980	901,963	805,036	708,213	648,807
Actual vs. expected experience	(1,267,092)	-	(2,076,281)	-	(14,700)	-
Assumption changes	(167,716)	-	(90,590)	-	131,618	-
Benefit payments	(478,810)	(483,793)	(438,081)	(478,669)	(542,029)	(499,704)
Net change in total OPEB liability	295,468	1,606,565	(613,703)	1,446,015	1,039,350	885,111
Total OPEB liability, beginning of year	13,485,032	11,878,467	12,492,170	11,046,155	10,006,805	9,121,694
Total OPEB liability, end of year	$ 13,780,500	$ 13,485,032	$ 11,878,467	$ 12,492,170	$ 11,046,155	$ 10,006,805
Plan fiduciary net position						
Contributions from employer	$ 588,065	$ 3,018,143	$ 2,601,369	$ 3,588,109	$ 1,142,027	$ 954,155
Net investment income	4,362,468	435,252	795,021	518,470	551,777	283,871
Benefit payments	(478,810)	(483,793)	(438,081)	(478,669)	(542,029)	(499,704)
Administrative expense	(6,005)	(6,630)	(2,277)	(12,267)	(2,784)	(2,239)
Net change in plan fiduciary net position	4,465,718	2,962,972	2,956,032	3,615,643	1,148,991	736,083
Plan fiduciary net position, beginning of year	15,872,084	12,909,112	9,953,080	6,337,437	5,188,446	4,452,363
Plan fiduciary net position, end of year	$ 20,337,802	$ 15,872,084	$ 12,909,112	$ 9,953,080	$ 6,337,437	$ 5,188,446
Health Authority's net OPEB (asset) liability	$ (6,557,302)	$ (2,387,052)	$ (1,030,645)	$ 2,539,090	$ 4,708,718	$ 4,818,359
Plan fiduciary net position as a percentage of the total OPEB liability	147.58%	117.70%	108.68%	79.67%	57.37%	51.85%
Covered-employee payroll*	$ 28,680,020	$ 26,732,488	$ 24,360,228	$ 20,046,373	$ 17,216,515	$ 17,195,643
Health Authority's net OPEB (asset) liability as a percentage of covered-employee payroll	-22.86%	-8.93%	-4.23%	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)
Schedule of Other Post-Employment Benefit Contributions

	2022	2021	2020	2019	2018	2017
Measurement period	2020-2021	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016
Actuarially determined contribution	$ 639,939	$ 624,728	$ 1,062,967	$ 1,269,369	$ 1,427,237	$ 1,217,313
Contributions in relation to the actuarially determined contribution	604,048	2,844,693	3,018,143	2,601,369	3,588,109	1,217,313
Contribution excess	$ 35,891	$ (2,219,965)	$ (1,955,176)	$ (1,332,000)	$ (2,160,872)	$ -
Covered-employee payroll*	$ 34,511,813	$ 28,680,020	$ 26,732,488	$ 24,360,228	$ 20,046,373	$ 17,195,643
Contributions as a percentage of covered-employee payroll	1.75%	9.92%	11.29%	10.68%	17.90%	7.08%

*For the fiscal year ending on the date shown

Communications with the Governing Board

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

June 30, 2022

Communications with the Governing Board

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

We have audited the financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) (the Health Authority), as of and for the year ended June 30, 2022, and have issued our report thereon dated October ___, 2022. 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 May 4, 2022, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

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 Santa Clara County Health Authority (dba Santa Clara Family Health Plan)'s internal control over financial reporting. Accordingly, we considered Santa Clara County Health Authority (dba Santa Clara Family Health Plan)'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 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.

The supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated May 4, 2022, and our planning meeting with management on May 16, 2022.

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 Santa Clara County Health Authority (dba Santa Clara Family Health Plan) are described in Note 1 to the financial statements. During the year ended June 30, 2022, the Health Authority adopted Governmental Accounting Standards Board Statement No. 87, *Leases*, under the retrospective approach. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2022. 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 financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the 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 financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

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

- Management recorded an estimated capitation receivable. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon 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 financial statements taken as a whole.

- Management's estimate of the fair values of investments in the absence of readily determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.

- 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 financial statements taken as a whole.

- Management's estimate of net other post-employment benefit (OPEB) asset 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 financial statements taken as a whole.

- 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 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 financial statements taken as a whole.

- Management's estimates of the discount rate, useful lives, lease terms related to the Health Authority's lease receivable, deferred inflows of resources related to leases, lease assets, and lease liabilities. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the Health Authority's financial statements taken as a whole.

Financial Statement Disclosures

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

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of the Health Authority's financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the Health Authority's financial statements.

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 financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS. There were no circumstances that affected the form and content of the auditor's report.

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.

Corrected Misstatements: None of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements as a whole.

Uncorrected Misstatements: The below summarizes uncorrected misstatements of the financial statements related to the effects of investment returns due to market volatility to the estimated net pension asset/liabilities and other post-employment benefits asset/liabilities.

- To decrease accounts payable and accrued liabilities by $13,895,325 and decrease general and administrative expenses by $13,895,325.

Management has determined that their effects are immaterial, both individually and in the aggregate, to the financial statements as a whole. Uncorrected misstatements, or matters underlying those uncorrected misstatements, as of and for the year ended June 30, 2022 could potentially cause future-period financial statements to be materially misstated, even though we have concluded that the uncorrected misstatements are immaterial to the financial statements under audit.

Management Representations

We have requested certain representations from management that are included in the dmanagement representation letter dated October ___, 2022.

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 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.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

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 its management, and is not intended to be, and should not be, used by anyone other than these specified parties.

[Signature]

San Francisco, California
October ___, 2022

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, August 25, 2022, 10:30 AM – 12:30 PM
Santa Clara Family Health Plan – Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Michele Lew, Chair
Alma Burrell
Dave Cameron
Sarita Kohli

Members Absent
Sue Murphy

Staff Present
Christine Tomcala, Chief Executive Officer
Neal Jarecki, Chief Executive Finance Officer
Laurie Nakahira, D.O., Chief Medical Officer
Chris Turner, Chief Operating Officer
Ngoc Bui-Tong, VP, Strategies & Analytics
Chelsea Byom, VP, Marketing, Communications & Outreach
Tyler Haskell, Interim Compliance Officer
Barbara Granieri, Controller
Khanh Pham, Director, Financial Reporting & Budgeting
Arlene Bell, Director Claims
Ashley Kerner, Manager, Administrative Services
Kris Cameron, Strategic Planning Project Manager
Lloyd Alaban, Copy Writer and Content Strategist
Nancy Aguirre, Administrative Assistant

Others Present
Kate Margolis, PhD, University of California San Francisco

1. Roll Call

Michele Lew, Chair, called the meeting to order at 10:34 AM. Roll call was taken and a quorum was established.

2. Public Comments

There were no public comments.

3. Approve Consent Calendar and Changes to the Agenda

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

a. Approve July 28, 2022 **Executive/Finance Committee** minutes
b. Accept **Network Detection and Prevention Update**
c. Approve **Governance Policy** GO.01 v2 Organizational Policies
d. Approve **Claims Policies**
- CL.02 v4 Misdirected Claims
- CL.04 v3 Skilled Nursing Facility
- CL.07 v6 Emergency Room Services
- CL.10 v4 Provider Dispute Resolution
- CL.28 v2 Other Health Coverage Cost Avoidance and Post Payment Recovery

e. Approve **County of Santa Clara Reentry Resource Center sponsorship**

f. Approve **continued use of teleconferencing** without providing public access to each teleconference location pursuant to Government Code Section 54953 questions.

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

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

4. **June 2022 Financial Statements**

Neal Jarecki, Chief Financial Officer, presented the unaudited financial statements for June 2022, which reflected a current month net surplus of $4.3 million ($4.3 million favorable to budget) and a year-to-date net surplus of $30.3 million ($21.7 million favorable to budget) for the fiscal year.

Enrollment increased by 5,120 members from the prior month to 306,382 members (3,745 members or 1.2% higher than budget, predominately due to the newly-eligible Medi-Cal undocumented Adult population, which was not budgeted. YTD member months of 3.5 million trailed budget by 81,555 member months or 2.3% due largely to fewer newly-eligible members having Other Health Coverage (OHC) than budgeted. Membership continues to grow due to the extended duration of the COVID public health emergency during which disenrollments have been suspended.

Revenue reflected a net unfavorable current month variance of $4.6 million (3.9%) due to several factors. Unfavorable variances resulted from: (1) the inclusion of Medi-Cal pharmacy throughout FY22 in the budget (pharmacy was carved-out of managed care effective January 1, 2022, which significantly reduced revenue (with a corresponding reduction to medical expense), (2) additional CMC medical loss ratio accruals payable to DHCS, and (4) retroactive DHCS recoupments for fiscal years 2011-2020. Positive variances resulted from: (1) higher current month enrollment, (2) favorable calendar year 2022 Medi-Cal non-dual & CCI rates versus budget, and (3) increased Medi-Cal supplemental revenue, (4) prior year Prop 56 reconciliation and (5) prior and current year CMC quality withhold reconciliations.

Medical Expense reflected a net favorable current month variance of $9.1 million (8.2%) largely due to the favorable offsets of key revenue items above (pharmacy carve-out and reduced OHC enrollment). Certain fee-for-service expense categories reflected unfavorable variances due to increased unit costs and higher supplemental services expenses than budgeted. Capitation expense was unfavorable to budget due to higher CY22 capitated rates true-up coupled with higher capitated enrollment vs. budget.

Administrative Expense was $302 thousand (4.3%) unfavorable to budget for the month largely due to the net effect of (1) lower headcount than budgeted and (2) an unfavorable variance in non-personnel expense due to the timing of certain expenses vs. budget.

The **Balance Sheet** reflected a Current Ratio, a key measure of liquidity, of 1.30:1 versus the DMHC minimum current ratio requirement of 1.00:1.

Tangible Net Equity of $285.1 million, which represented approximately three months of the Plan's total expenses, included unrestricted net assets of $245.1 million.

Capital Investments of $1.2 million have been made year-to-date, predominately computer software licenses, versus the annual capital budget of $3.25 million, with certain, largely Medicare-related, projects deferred into the fiscal year 2022-2023.

It was moved, seconded, and the unaudited June 2022 Financial Statements were **unanimously approved.**

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

5. Innovation Fund Expenditure Adjustment Request

Ngoc Bui-Tong, VP, Strategies & Analytics, presented a modification request from FIRST 5 Santa Clara County for the Integrated Behavioral Health Pilot Project. Modifications to the original funding request of $500,000 include extending the project timeline, reducing the number cohorts, and adding potential activities to the scope of services. Ms. Bui-Tong introduced Kate Margolis of the University of California San Francisco, who was available for questions.

A discussion regarding the requested adjustments to the use and terms of funding ensued and Ms. Lew offered a conceptual motion.

It was moved, seconded, and unanimously approved to delay the second payment to FIRST 5 from the Board Designated Innovation Fund until further progress is made, and to extend the contract period for the Integrated Behavioral Health Pilot Project to achieve the initial cohort number.

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

Ms Kohli left the meeting at 11:08 a.m.

6. Government Relations Update

Tyler Haskell, Interim Compliance Officer, presented federal issues of note, including the Centers for Medicare and Medicaid Services (CMS) extension of the COVID-19 public health emergency.

Mr. Haskell discussed the impact of the recently-enacted Inflation Reduction Act, which gives Medicare the authority to negotiate prescription drug prices affecting costs for payers and consumers in the Part D Program. Mr. Haskell shared the new caps on out-of-pocket spending for insulin and other Part D drugs, and an extension of the enhanced subsidies for individual and family plans on the insurance exchanges.

Mr. Haskell presented state issues impacting the Plan. Mr. Haskell informed the members that the announcement on Medi-Cal reprocurement would come in later in the day. Mr. Haskell described the Medi-Cal Office of Health Care Affordability that has been created to collect data on total health care expenditures, analyze the health care market for cost trends and drivers of spending, create a state strategy for controlling the cost of health care, improve affordability for consumers and purchasers, and enforce annual state health care cost targets.

Mr. Haskell reported on three California Senate Bills. Mr. Haskell shared that Senate Bill 250, which would have required the waiving of prior authorization requirements for certain providers, will not move forward. Mr. Haskell then discussed Senate Bill 987, which would require health plans to connect qualifying Medi-Cal members with facilities specially designated to treat complex cancers. Mr. Haskell shared Senate Bill 858, which would give the Department of Managed Health Care (DMHC) increased authority to implement larger penalties for health plan noncompliance.

7. CEO Update

Christine Tomcala, Chief Executive Officer, reported that the Plan welcomed 6,455 newly eligible undocumented residents aged fifty and over who became eligible for full-scope medical and were “lifted and shifted” from emergency Medi-Cal during May through July. She indicated that the Plan partnerd with VMC to ensure continuity for care of members, resulting in 85% of individuals being assigned to a VHP primary care physician.

8. Adjourn to Closed Session

a. Contract Rates

The Executive/Finance Committee met in Closed Session to discuss Plan partner rates.

9. Report from Closed Session

Ms. Lew reported that the Executive/Finance Committee met in Closed Session to discuss contract rates.

10. Adjournment

The meeting was adjourned at 11:38 AM.

_____

Sarita Kohli, Secretary

Santa Clara Family Health Plan
Quarterly Investment Performance & Compliance Report
For The Quarter Ended June 30, 2022

1. OVERVIEW

The California Government Code (the Code), Section 53646, which governs Santa Clara Family Health Plan's investment policy, states that the Chief Financial Officer may render a quarterly report on the status of investment portfolio and cash to the Governing Board.

This quarterly report, for the date indicated above, includes the following:

1. Analysis of recent changes to the Plan's investment landscape.
2. Statement of compliance with the investment policy.
3. Summary of investments & cash held at quarter-end.
4. Statement of SCFHP's ability to meet its expenditure requirements for the next six months.
5. Statement of diversification compliance with SCFHP investment policy.
6. Details of investment diversification.
7. Analysis of, and commentary on, investment yield.
8. Reports & other reference materials

2. INVESTMENT LANDSCAPE UPDATES

Change in Investment Advisor: This report was prepared by CFO Neal Jarecki. The Plan has contracted with a new investment oversight advisor, Meketa Investment Group, for future investment reporting, beginning with the quarter ending September 30, 2022.

Transition from Wells Fargo: At the end 2021, the Plan commenced movement of bank-held investments from Wells Fargo Bank to City National Bank, as approved by the Exec/Finance Committee in August 2021. The transition to City National Bank has been completed and final checks are clearing from Wells Fargo prior to account closure.

Interest Rate Increases: To combat inflation, the Federal Reserve has implemented a series of interest rate hikes in 2022 as per the chart below, which has caused bond yields to increase.

FOMC Meeting Date	Rate Change (bps)
Sept 21, 2022	+75
July 27, 2022	+75
June 16, 2022	+75
May 5, 2022	+50
March 17, 2022	+25

Santa Clara Family Health Plan™

Santa Clara Family Health Plan
Quarterly Investment Performance & Compliance Report
For The Quarter Ended June 30, 2022

3. COMPLIANCE WITH THE INVESTMENT POLICY

The Plan's Investments and Cash & Equivalent accounts include the following:

1. Investments
    a. County of Santa Clara Comingled Investment Pool (County Investment Pool)
    b. City National Bank (CNB Investments)

2. Cash & Equivalents
    a. City National Bank
    b. Wells Fargo Bank
    c. Chase Bank

Following review of the quarterly investment reports of the above-listed accounts, all investments made were compliant with Santa Clara Family Health Plan's Investment Policy (as adopted at the Executive/Finance Committee meeting of April 28, 2022 and attached to this report) and with the California Government Code.

4. SUMMARY OF INVESTMENTS & CASH BALANCES

The quarter-end value of the Investments and Cash & Equivalents accounts were as follows:

CHART #1: PORTFOLIO SUMMARY	
Investments:	
County Comingled Investment Pool	$183,653,817
City National Bank Investments	$296,007,423
	$479,661,240
Cash & Equivalents:	
City National Bank	$66,495,396
Wells Fargo Bank	$4,699,527
Chase Bank	$48,510
	$71,243,433
Quarter-End Balance of Investments and Cash & Equivalents	**$550,904,673**

- Petty Cash of $500 and Restricted Cash of $325,000 pledged to the Department of Managed Health Care (DMHC) are excluded from the amounts above.

Santa Clara Family Health Plan™

Santa Clara Family Health Plan
Quarterly Investment Performance & Compliance Report
For The Quarter Ended June 30, 2022

5. SIX MONTH CASH SUFFICIENCY

The Plan has sufficient cash on-hand, plus projected revenues, to meet its operating expenditure requirements for at least the next six months.

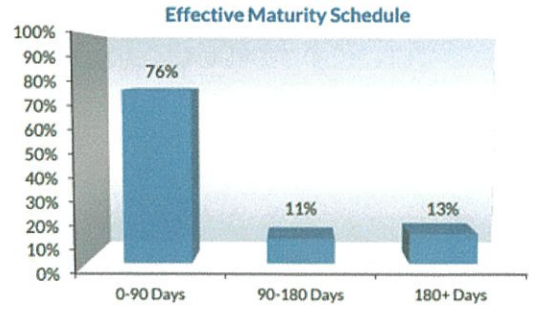
6. DIVERSIFICATION COMPLIANCE

Prior published Quarterly Investment Reports for the Santa Clara County Commingled Investment Pool indicate compliance with the County Treasurer's Investment Policy and Diversification parameters, attached for reference. The Plan's investment policy specifies no maximum percentage or investment in the Commingled Investment Pool.

City National Bank provided a report of compliance with the Plan's investment policy, attached to this report.

CHART #2: DIVERSIFICATION SUMMARY

Investment Type	Maximum Maturity	Maxium % of Portfolio	Quality Requirements	Quarter-End Balance	Compliant?
County Comingled Investment Pool	N/A	None	None	$183,653,817	Yes
City National Bank Investments:	410 days	See below & attached	See below & attached	$296,007,423	Yes



MARKET VALUE	
Market Value	$295,139,192.55
Accrued Income	$868,251.10
Total	$296,007,443.65

COMPLIANCE	
Acceptable Investments	☑
Credit Quality	☑
Diversification	☑
Marketability/Liquidity	☑
Maturity/Portfolio Duration	☑

FIXED INCOME PORTFOLIO CHARACTERISTICS	
Estimated Annual Income:	$3,696,426.65
Yield to Maturity:	1.82%
Estimated Acquisition Yield:	1.23%
Average Quality:	AA
Effective Duration:	0.19
Average Days to Maturity:	69
Percent of Floaters:	0%

Preliminary Total Return Performance

As of 6/30/2022	Since Inception 11/10/2021
Account Gross	0.01%
Account Net	-0.01%
Barclays 1-3 Month T-Bill Index	0.16%

Santa Clara Family Health Plan

Santa Clara Family Health Plan
Quarterly Investment Performance & Compliance Report
For The Quarter Ended June 30, 2022

7. INVESTMENT PERFORMANCE

CHART #3: INVESTMENT PERFORMANCE

Santa Clara County Comingled Investment Trust

Annualized Yield = 1.25%

Weighted Average Life = 2.02 years (738 days)

City National Bank Investments

Annualized Yield = 0.10%

Benchmark: 3-Month T-Bill Rate: 0.16%

Average Duration: 99 days

The average investment yield of 1.09% for June was lower than budget of 1.4%. Actual yield has been increasing as a result of 2022 Federal Reserve actions to increase interest rates in combatting inflation.

8. REFERENCE/ATTACHMENTS

a. 2022 SCFHP Investment Policy
b. County Investment Report excerpt
   The full quarterly County Investment report is available at the following link: https://controller.sccgov.org/sites/g/files/exjcpb511/files/report/Quarterly-Investment-Report-20220331_0.pdf)
c. City National Bank Investment Compliance Report

(A)

Santa Clara Family Health Plan™

POLICY

Policy Title:	Investment Policy	Policy No.:	FA.07
Replaces Policy Title (if applicable):	NA	Replaces Policy No. (if applicable):	NA
Issuing Department:	Finance	Procedure Review Frequency:	Annual
Lines of Business (check all that apply):	☐ Medi-Cal	☐ CMC	

I. PURPOSE

This Investment Policy sets for the investment guidelines and structure for the investment of short- term operating funds not required for the immediate cash needs of the Plan on and after April 22, 2021 of the Santa Clara Family Health Plan ("SCFHP" or the "Plan") which was established by the Santa Clara County Board of Supervisors under Ordinance 300.576 and licensed by the State of California under the Knox-Keene Act of 1975 in 1996.

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

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

II. OBJECTIVES

i. **Safety**: the primary objective of this Policy is the preservation of principal; avoiding capital losses by minimizing credit risk and interest rate or market risk.
ii. **Liquidity:** maintain sufficient liquidity to meet the operating requirements for six months.
iii. **Yield:** achieve a market-average rate of return (yield) through budgetary and economic cycles, considering SCFHP's regulatory constraints and cash flow characteristics. Investments will be limited to low risk securities in anticipation of earning a fair return relative to the risk being assumed.
iv. **Diversification:** provide diversification of the portfolio securities to avoid incurring unreasonable market and credit risks.

(A)

Santa Clara Family Health Plan™

POLICY

III. INVESTMENT STRATEGY

The Plan will adhere to the investment goal of holding investments to maturity. From time to time, the portfolio may go out of alignment. The Chief Financial Officer may choose to rebalance the portfolio at any time to bring it back into compliance if the portfolio will not suffer any losses for selling the investment prior to maturity.

IV. ETHICS AND CONFLICTS OF INTEREST

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

V. DELEGATION OF AUTHORITY

A. Governing Board

The Governing Board (the "Board") is responsible for the management and oversight of SCFHP's investment program.

B. Executive/Finance Committee

The Executive/Finance Committee ("Committee") is responsible for providing advice and recommendations on the SCFHP Investment Policies, Procedures and Practices.

C. Chief Financial Officer

The Chief Financial Officer is responsible for day-to-day managing and reporting of SCFHP's Investment Program. The Chief Financial Officer is also responsible for the oversight of investment contractual obligations between SCFHP and the County, Depository Institution and/or Investment Manager that has been granted authority over any SCFHP funds.

D. County of Santa Clara Commingled Investment Pool

The Board has directed that available excess funds not required for immediate operational cash flow purposes be deposited with the County Treasurer into the County of Santa Clara Commingled Investment Pool which will be invested by the County Treasurer in accordance with the policies contained in the County of Santa Clara Treasury Investment Policy, now in effect, and which may be revised from time to time. As per the deposit requirements for county health plans under California Health and Safety Code Section 1346 and 1376.1, depositing SCFHP's excess funds with the County of Santa Clara is permitted if:

Santa Clara Family Health Plan™

POLICY

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

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

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

E. Depository (Financial) Institutions

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

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

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

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

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

(5) Funds not required to compensate for transaction costs shall be invested in and earn a market rate of return in the depository institution's highest rated money market mutual fund as permitted by the California Government Code, Section 53600 et seq.

F. Portfolio Investment Manager

The Governing Board may grant authority to a qualified investment manager to direct investments of excess funds in accordance with the AIP and be subject to periodic review for compliance to the AIP. The qualified investment manager must meet all requirements established by federal and California law. Any Board-approved changes in Authorized Investments and the AIP shall be communicated to the investment manager upon approval.

Santa Clara Family Health Plan™

POLICY

G. Exceptions to this Policy

The Governing Board may grant express written authority to make a one-time investment not permitted by this Policy however, the investment must be permitted by the California Government Code. The Board may also make amendments to the AIP at any quarterly meeting as needed.

VI. AUTHORIZED INVESTMENTS

A. Authorized Investment Types: SCFHP shall invest only in instruments as permitted by the California Government Code Section 53601, subject to the limitations of this AIP.

1. Permitted investments in the investment manager portfolio shall be considered short-term operating funds and are subject to a maximum stated term of two years.

2. The Governing Board may designate a reserve fund for excess funds not required for operational cash flow for which permitted investments are subject to a maximum term of five years pursuant to the Code.

Authorized Investments

Investment Type	Maximum Maturity (Code Allowance in Parenthesis if Different)	Maximum Specified % of Portfolio (Code Allowance in Parenthesis if Different)	Minimum Quality Requirements (Code Allowance in Parenthesis if Different)
U.S. Treasury Obligations	2 years (5 years)	None	None. May invest in securities that could result in zero or negative interest accrual if held to maturity, in the event of a period of negative market interest rates.
U.S. Agency Obligations	2 years (5 years)	None	None
State Obligations: CA and Others	2 years (5 years)	None	None for CA; AA or better for other States (None for all States)
CA Local Agency Obligations	2 years (5 years)	None	AA rated (None)
Commercial Paper: Non-Pooled Funds (minimum $100,000,000 of investments)[5]	270 days or less	40% of Plan's investible funds	Highest letter and number rating by an NRSRO[1]
Negotiable Certificates of Deposit	2 years (5 years)	30%	None
Placement Service Certificates of Deposit	2 years (5 years)	$250,000 per deposit per institution (50%)	FDIC insured at all times (None)

Santa Clara Family Health Plan™

POLICY

Repurchase Agreements	1 year	None	U.S. Treasury and Agency Obligations (None)
Medium-term Notes	2 years (5 years or less)	30%, with not more than 10 % in any one institution (30%)	"A" rating category or better
Mutual Funds and Money Market Mutual Funds	N/A	20%, with no more than 10% invested in any one mutual fund; limitation does not apply to money market mutual funds	Multiple[2]
Collateralized Bank Deposits	2 years (5 years)	None	If investments require collateral, collateral must be placed in institution not affiliated with the issuer of the obligation.
Mortgage Pass-through and Asset Backed Securities	2 years (5 years or less)	20%	"AA" rating category or its equivalent or better[4]
County Pooled Investment Funds-Santa Clara County Pool	N/A	None	"A" or better (None)
Joint Powers Authority Pool (CAMP, CalTrust)	N/A	None	Multiple[3]
Local Agency Investment Fund (LAIF)	N/A	None	None
Supranational Obligations	2 years (5 years or less)	30%	"AA" rating or better
Public Bank Obligations	2 years (5 years)	None	Section 57600 (b) [6]

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

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

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

[4]Any investments in asset-backed securities (mortgage pass-through securities, collateralized mortgage obligations, mortgage-backed or other pay-through bonds, equipment lease-backed certificates, consumer receivable pass-through certificates, or consumer receivable-backed bonds) are required to have a maximum remaining maturity of five years or less. While the Legislature removed

Santa Clara Family Health Plan™

POLICY

the requirement that the securities' issuer be rated "A" or its equivalent or better for the issuer's debts in accordance with a nationally recognized statistical rating organization (NRSRO), the Plan retains this requirement.

[5] In 2021, Section 53601 (h) amended to allow local agencies that have one hundred million dollars or more of investment assets under management to invest no more than 40% of their moneys in eligible commercial paper. Further amendment to Section 53601 limits local agencies to invest no more than 10% of their total investment assets in commercial paper and medium- term notes of any single issuer. Commercial Paper: Pooled Funds are not allowed in the Investment Manager Portfolio.

[6] Public Bank means a corporation organized under the Nonprofit Mutual benefit corporation Law for the purpose of engaging in the commercial banking business or industrial banking business that is wholly owned by a local agency, local agencies or a joint powers authority that is composed only of local agencies. A local agency may invest in commercial paper, debt securities, or other obligations of a public bank.

Santa Clara Family Health Plan™

POLICY

B. Prohibited Investment Types: California Government Code Section 53601.6 prohibits local agencies from investing in inverse floaters, range notes, or mortgage-derived, interest-only strips, and any security which could result in zero interest accrual if held to maturity. In addition, the Plan does not authorize investment in the following:

i. Bankers' Acceptances
ii. Commercial Paper: Pooled Funds (pertains only to Investment Manager Portfolio)
iii. Non-negotiable Certificates of Deposit
iv. Reverse Repurchase Agreements and Securities Lending Agreements
v. Voluntary Investment Program Fund

VII. REPORTING REQUIREMENTS

The following documents and reports will be periodically provided to support the investment procedures, oversight and reporting requirements:

A. County of Santa Clara Investment Pool Disclosure and Agreement for Voluntary Deposits

B. County of Santa Clara Treasury Investment Policy

C. County of Santa Clara Treasury Quarterly Report

D. SAP Balance and Interest Earnings Report of SCFHP Invested Funds

E. Depository Institution – daily transaction and monthly activity report

F. Investment Manager Portfolio - month-end and quarter-end portfolio performance summary, income, ending balance sheet, trading activity, transaction detail and portfolio diversification report. The listing must include issuer names, dates of maturity, par amounts, dollar amount, market values as of month-end and comparable published index as to diversification and duration that most closely tracks the performance of the portfolio.

G. Investment Oversight Quarterly Report – provides independent review of all invested funds for tracking of AIP, diversification requirements and performance review. Minimum reporting requirements includes a listing of the types of investment, issuer names, dates of maturity, par amounts, dollar amount, market values, descriptions of the programs under the management of contracted parties, a statement of compliance with the investment policy, and a statement of the ability to meet cash flow needs for six months. Any irregularities shall be noted and included in the report.

(A)

Santa Clara Family Health Plan™

POLICY

VIII. REVIEW OF INVESTMENT POLICY

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

Any modifications to this Investment Policy, including withdrawal from the County of Santa Clara Commingled Investment Pool, will be made in accordance with California Government Code Sections 27130 et seq., Sections 53635 and/or 53601 et seq., Section 1346 of the Knox Keene Act of 1975 as well as the prudent investment standard.

IX. Approval/Revision History

First Level Approval	Second Level Approval
Barbara Granieri, Controller Date	Neal Jarecki Chief Financial Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Exec/Finance	Approved 04/26/18	Approved 06/28/18
V1	Original (no changes)	Exec/Finance	Approved 05/01/19	Approved 06/27/19
V2	Revised	Exec/Finance	Approved 04/23/20	Approved 06/25/20
V3	Revised	Exec/Finance	04/22/21	Approved 06/24/2021
V4	Revised	Exec/Finance	04/28/22	

Quarterly Investment Report

June 30, 2022

Santa Clara County Commingled Pool and Segregated Investments

June 30, 2022

Fund	Cost Value**	Market Value	Variance	% Variance
Commingled Investment Pool	$11,103,252,552	$10,827,797,373	-$275,455,179	-2.48%
Worker's Compensation	$30,172,452	$29,168,997	-$1,003,455	-3.33%
Park Charter Fund	$4,432,079	$4,302,413	-$129,666	-2.93%
San Jose-Evergreen	$21,296,027	$21,249,103	-$46,925	-0.22%
Medical Malpractice Insurance Fund (1)	$9,837,267	$9,468,296	-$368,970	-3.75%
Total	**$11,168,990,377**	**$10,891,986,181**	**-$277,004,196**	**-2.48%**

(1) Managed by Chandler Asset Management, Inc.

Summary of Yields* for Select Santa Clara County Investment Funds

Fund	2022			2021
	Apr 30	May 31	Jun 30	Jun 30
Commingled Investment Pool	0.86%	1.09%	1.25%	0.76%
Worker's Compensation	1.22%	1.54%	1.61%	1.41%
Weighted Yield	**0.86%**	**1.09%**	**1.25%**	**0.76%**

*Yield to maturity (YTM) is the rate of return paid on a bond, note, or other fixed income security if the investor buys and holds it to its maturity date and if the coupon interest paid over the life of the bond is reinvested at the same rate as the coupon rate. The calculation for YTM is based on the coupon rate, length of time to maturity, and market price at time of purchase.

Yield is a snapshot measure of the yield of the portfolio on the day it was measured based on the current portfolio holdings on that day. This is not a measure of total return, and is not intended to be, since it does not factor in unrealized capital gains and losses and reinvestment rates are dependent upon interest rate changes

**Cost Value is the amortized book value of the securities as of the date of this report.

Santa Clara County Commingled Pool and Segregated Investments

Economic Update and Portfolio Strategy

June 30, 2022

The U.S. domestic economy is already slowing and has clearly lost momentum in response to the Federal Reserve Bank's repeated interest rate increases and the challenges presented by rising inflation. Gross domestic product contracted at a 0.9 percent annualized pace in the second quarter, a consecutive quarterly decline after 1.6 percent negative growth in the first three months of the year. Nevertheless, economists are not viewing the current circumstance as broad-based weakness in the economy or as a recession. The economy continues to be bolstered by strong labor markets with an unemployment rate of 3.6 percent, a 50-year low. The U.S. added 2.7 million jobs the first half of 2022, a pace of about 450,000 jobs a month which is much stronger than the average prior to the Covid-19 pandemic. Payroll growth has been slowing but continues to be positive. Adjusted for inflation, personal consumption has continued to expand this year, rising in five of the past six months. Consumer spending accounts for around 70 percent of the US economy, so it remains a key driver for growth.

Federal Reserve Bank (Fed) policy makers have been forcefully raising interest rates to slow inflation and have signaled that their top priority is to reduce high inflation. Policy makers who have a dual mandate from Congress for maximum employment and to maintain price stability (low inflation) have been a target of criticism for misjudging inflation and being slow to respond. The Fed is seeking to cool off economic demand in response to surging prices that have persisted longer than expected. The consumer price index rose 9.1 percent in June from a year earlier in a broad-based advance, and which was the largest gain since 1981. The Fed has hiked its benchmark rate four times since March 2022 at which time, rates were near zero. Most recently, the central bank lifted its rate to a range between 2.25 and 2.50 percent on July 27th. Economists expect the Fed will accelerate the reduction of its balance sheet, which began this June with the runoff of maturing securities. Overall reductions should amount to $1.1 trillion a year. This means the bank's balance sheet should shrink to $8.4 trillion by year end, and contract to $6.5 trillion in December 2024.

It is too soon to fully gauge the impact of the Fed's efforts so far. Certain inflation sources including the war in Ukraine and China's Covid Zero program lie outside the influence of monetary policy. The effects of higher rates are particularly evident in the housing market where sales have slowed as higher borrowing costs continue to reduce affordability. The average rate on a 30-year mortgage is nearly double what it was a year prior. Sales of previously owned homes fell in June to a two-year low. The Fed's impact also appears to be filtering more broadly through the economy. A steep decline in residential investment, a reduction in business spending and a slower rate of inventory replacement all contributed to GDP shrinking at a 0.9 percent annual rate from April through June 2022.

Most recently, US manufacturing activity continued to grow at a slower rate in June. Manufacturing has struggled this year amid supply chain difficulties, fewer orders as consumer spending slowed and a stronger US dollar which made exports more expensive. Companies have cited the damaging impact of inflation on costs which was now increasingly affecting revenues as rising prices destroyed demand for some goods and to a lesser extent services.

The central bank's interest-rate increases have not made a dent on wages. This has heightened concerns that prices will remain persistently high. The Labor Department's employment cost index (ECI), a broad gauge of wages and benefits, increased 1.3 percent in the second quarter from the prior three months. Compared with a year earlier, the labor costs measure rose 5.1 percent, an increase not seen in 20 years. Employers, with a near-record number of open positions, used higher pay and other perks to attract and retain workers. ECI is the preferred gauge of labor costs for Federal Reserve policy makers. The measure is not distorted by employment shifts among occupations or industries.

Santa Clara County Commingled Pool and Segregated Investments

Economic Update and Portfolio Strategy

June 30, 2022

Consumer spending has largely remained resilient despite inflation, mostly from energy prices as well as broader-based increases, diminishing spending power. Even though wages have been rising fast, they are still not keeping up with inflation. Inflation-adjusted spending barely rose in June after falling in the prior month according to Commerce Department data. Consumers are drawing down savings, switching brands, forgoing discretionary purchases to cope with higher prices. The saving rate declined to 5.1%, the lowest since 2009.

Because of discouraging inflation and growth news, some economists expect policy makers will not have to tighten monetary policy much further, thereby pausing early and then lowering interest rates quickly. Others see the Fed raising rates to a range of 4.0 to 4.25 percent by the first quarter of 2023. This compares with 2.25 to 2.50 percent today. Even though, recent results from the purchasing manager's index and housing data imply that demand is starting to wane, the June CPI figures suggest that such developments have had little impact on prices thus far, both in terms of the general level and the broadening of price pressures. Consequently, continued tightening is required. Those who expect more aggressive tightening also expect policy makers will maintain their resolve to push inflation completely back down to 2 percent, the preferred pace of inflation cited by policy makers.

The yields of U.S. government securities along with those of all domestic bonds have risen in anticipation of tighter monetary policy and consequently have suffered substantial price declines. Bond prices and yield are inversely related and hence, move in opposite directions. Although the Fed has increased, so far, its policy rate, fed funds four times, the two-year Treasury yield has increased by 222 basis points from .734 percent on December 31, 2021, to 2.957 percent on June 30th, 2022. Likewise, ten-year Treasury yields rose almost as much over the same period to 3.016 percent from 1.51 percent, a 151-basis point surge.

The portfolio strategy continues to focus on the:
(1) acquisition of high-quality issuers;
(2) identifying and selecting bonds with attractive valuations;
(3) appropriately sizing the liquidity portion of the portfolio to ensure adequate cash for near term obligations; and
(4) ensuring that monies targeted for longer term investments are deployed in vehicles with favorable risk-adjusted yields.

Santa Clara County Commingled Pool and Segregated Investments

Portfolio Liquidity Adequacy, Review, and Monitoring

June 30, 2022

Yield and Weighted Average Maturity

The yield of the Commingled Pool is 1.25 and the weighted average life is 738 days.

Liquidity Adequacy

The County Treasurer believes the Commingled Pool contains sufficient cash flow from liquid and maturing securities, bank deposits and incoming cash to meet the next six months of expected expenditures.

Review and Monitoring

FHN Financial Main Street Advisors, the County's investment advisor, currently monitors the Treasury Department's investment activities.

Additional Information

Securities are purchased with the expectation that they will be held to maturity, so unrealized gains or losses are not reflected in the yield calculations.

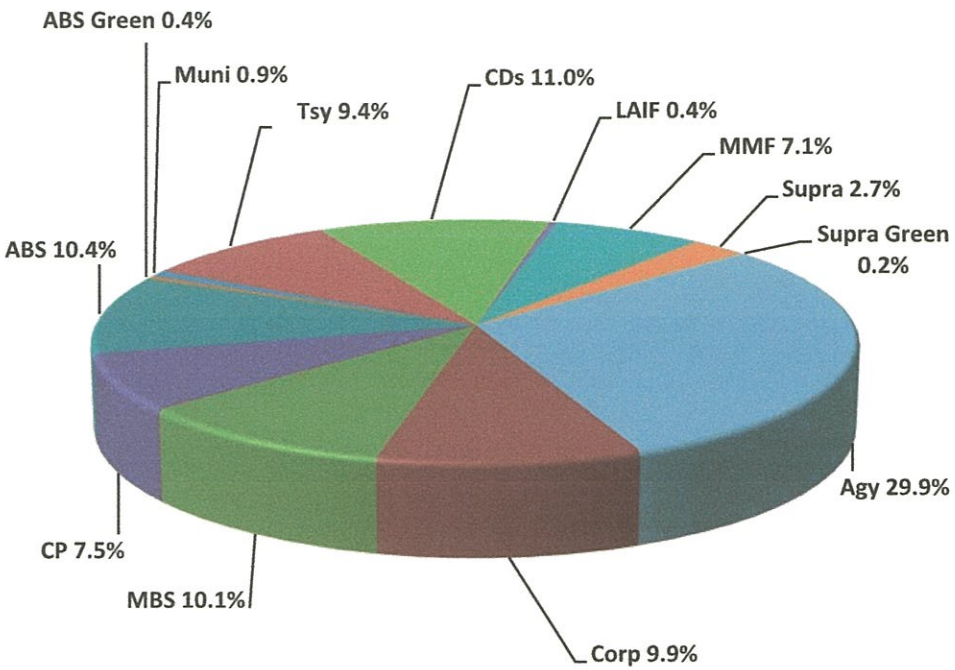
The market values of securities were taken from pricing services provided by the Bank of New York Mellon, Bloomberg Analytics, dealer quotes, and an independent pricing service.

Santa Clara County Commingled Pool

Allocation by Security Types

June 30, 2022

Sector	6/30/2022	3/31/2022	% Chng
Federal Agencies	29.89%	29.73%	0.17%
Corporate Bonds	9.91%	9.50%	0.41%
Mortgage Backed Securities	10.15%	7.19%	2.96%
Commercial Paper	7.53%	7.48%	0.05%
ABS	10.41%	8.89%	1.52%
ABS Green Bonds	0.44%	0.47%	-0.02%
Municipal Securities	0.86%	0.97%	-0.11%
U.S. Treasuries	9.37%	9.17%	0.20%
Negotiable CDs	11.03%	15.59%	-4.56%
LAIF	0.39%	0.41%	-0.02%
Money Market Funds	7.11%	7.55%	-0.44%
Supranationals	2.67%	2.82%	-0.15%
Supranationals Green Bonds	0.22%	0.23%	-0.01%
Total	100.00%	100.00%	



Sector	6/30/2022	3/31/2022
Federal Agencies	3,319,066,939	3,127,034,107
Corporate Bonds	1,100,816,465	999,803,424
Mortgage Backed Securities	1,126,469,304	755,887,855
Commercial Paper	836,595,674	787,284,454
ABS	1,155,725,801	935,073,222
ABS Green Bonds	48,993,778	48,993,778
Municipal Securities	95,925,213	102,196,141
U.S. Treasuries	1,040,331,758	964,281,931
Negotiable CDs	1,224,900,420	1,639,901,049
LAIF	43,246,452	43,212,399
Money Market Funds	789,873,918	794,323,347
Supranational	296,801,892	296,816,390
Supranationals Green Bonds	24,504,939	24,464,690
Total	11,103,252,552	10,519,272,787

Amounts are based on book value

Santa Clara County Commingled Pool
Compliance with Investment Policy
June 30, 2022

Item/Sector	Parameters	In Compliance
Maturity	Weighted Average Maturity (WAM) must be less than 36 months	Yes
Interest Periods	Securities must pay interest within one year of the initial investment and at least semiannually in subsequent years	Yes
Investment Swaps	Similar maturity swaps, so as not to affect cash flow needs, should have minimum 5 basis point gain	Yes
Issuer Limits	No more than 5% of the portfolio shall be invested in aggregate of any single institution of the following types: Bankers Acceptances, CP, Negotiable CDs, and Corporate Notes	Yes
U.S. Treasuries	No sector limit, no issuer limit, max maturity 5 years	Yes
U.S. Federal Agencies	No sector limit, no issuer limit, max maturity 5 years	Yes
LAIF	No sector limit, no issuer limit, CA State's deposit limit $65 million	Yes
Repurchase Agreements	No sector limit, no Issuer limit, max maturity 92 days, treasury and agency collateral at 102% of investment, if maturity exceeds 15 days, must be collateralized by securities with 5 years or less maturities	Yes
Commercial Paper	Sector limit 40%, issuer limit 5%, max maturity 270 days, rated by at least two: A-1 (S&P), P-1 (Moody's), F-1 (Fitch), issued by domestic corporation w/ at least $500 mil of assets, and long term debt rated by at least two: AA- (S&P/Fitch)/Aa3 (Moody's)	Yes
Corporate Bonds	Sector limit 30%, issuer limit 5%, max maturity 5 years, rated by at least two: AA- (S&P/Fitch)/Aa3 (Moody's), issued by domestic corps/depositories	Yes
Money Market Funds	Sector limit 20%, issuer limit 10%, rated by at least two: AAA-m (S&P/Fitch)/Aaa-mf (Moody's), MMF has at least $500 mil managed	Yes
Negotiable Certificates of Deposit	Sector limit 30%, issuer limit 5%, max maturity 5 years, if under 1 year rated by at least two: A-1 (S&P), P-1 (Moody's), F-1 (Fitch), if greater than 1 year rated by at least two: AA- (S&P/Fitch)/Aa3 (Moody's)	Yes
Municipal Securities	Sector limit 10%, no issuer limit, State of CA, local CA agencies, and other municipal securities of the other 49 states, if long-term rated, then by at least two: A- (S&P/Fitch)/A3 (Moody's), if short-term rated, then by at least two: SP-1 (S&P), MIG-1 (Moody's), F-1 (Fitch), revenue based bonds payable solely out of the States' or local agencies' revenues	Yes
Mortgage-Backed Securities	Sector limit 20% in aggregate with ABS, no issuer limit, max maturity 5 years, collateralized by pools of conforming residential mortgage loans insured by FHLMC/FNMA and residential mortgages guaranteed by FHA (GNMA)	No
Asset-Backed Securities	Sector limit 20% in aggregate with ABS, no issuer limit, max maturity 5 years, collateralized by pools of loans such as installment/receivables, security must be rated by at least two: AA- (S&P/Fitch), Aa3 (Moody's), issuer rated by at least two: A- (S&P/Fitch), A3 (Moody's)	No
Supranational Debt Obligations	Sector limit 10%, max maturity 5 years, issued or unconditionally gauranteed by the IBRD, rated by at least two: AAA (S&P/Fitch), Aaa (Moody's)	Yes
Bankers' Acceptances	Sector limit 40%, issuer limit 5%, max maturity 180 days, rated by at least two: A-1 (S&P), P-1 (Moody's), F-1 (Fitch), issued by commercial banks , collateral must exceed market value of security by 2%	Yes, None in Portfolio
Securities Lending	Sector limit 20%, max maturity 92 days for loans and reinvestment, loan counterparty must be a primary dealer, loaned securities must be owned for at least 30 days	Yes, None in Portfolio

CITY NATIONAL ROCHDALE

AN RBC/CITY NATIONAL COMPANY

June 2022

Portfolio Review

Prepared for: Santa Clara Family Health Plan

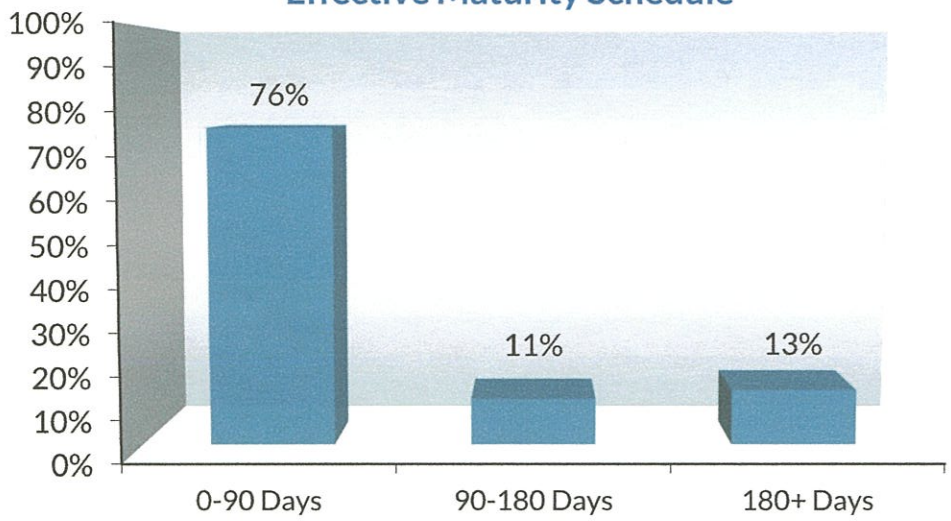
Presented by:

Michael Taila

Managing Director, Co-Director Fixed Income

Portfolio Review Snapshot as of 6/30/2022

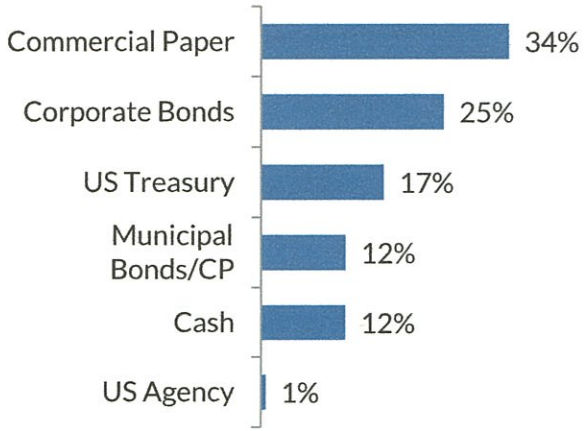
Effective Maturity Schedule



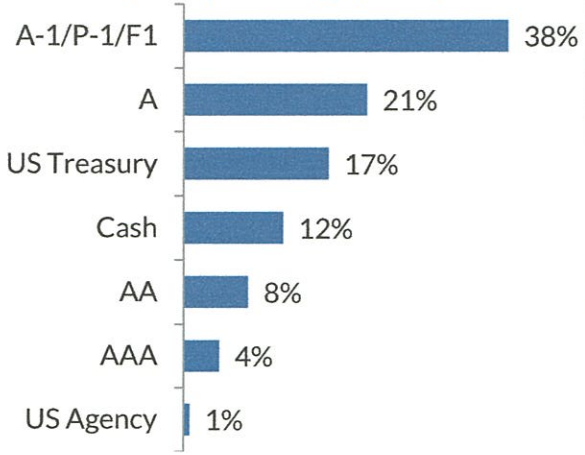
MARKET VALUE	
Market Value	$295,139,192.55
Accrued Income	$868,251.10
Total	$296,007,443.65

COMPLIANCE	
Acceptable Investments	☑
Credit Quality	☑
Diversification	☑
Marketability/Liquidity	☑
Maturity/Portfolio Duration	☑

Sector Allocation



Quality Ratings (S&P)



FIXED INCOME PORTFOLIO CHARACTERISTICS	
Estimated Annual Income:	$3,696,426.65
Yield to Maturity:	1.82%
Estimated Acquisition Yield:	1.23%
Average Quality:	AA
Effective Duration:	0.19
Average Days to Maturity:	69
Percent of Floaters:	0%

Preliminary Total Return Performance

As of 6/30/2022	Since Inception 11/10/2021
Account Gross	0.01%
Account Net	-0.01%
Barclays 1-3 Month T-Bill Index	0.16%

Investment Statement as of 6/30/2022

ACCOUNT SUMMARY

The Market Value Reconciliation outlines how the value of your account has changed during this statement period and since the beginning of the year. Income accrued, but not yet received by your account has been estimated.

The Income Summary highlights, by major category, the income added to your account during the statement period and since the beginning of the year.

Market Value Reconciliation

		06/01/22 - 06/30/22 ($)		CALENDAR YEAR TO DATE ($)
Beginning Market Value		$269,934,012.58		$224,289,512.40
Additions	+	125,046,053.91	+	971,227,515.89
Withdrawals	–	100,000,000.00	–	900,000,000.00
Fees	–	10,151.39	–	45,832.26
Income	+	425,612.00	+	656,825.03
Security Transfers	+	0.00	+	0.00
Other Activity	+	0.00	+	0.00
Asset Price Appreciation/Depreciation	–	256,334.55	–	988,828.51
Ending Market Value on 06/30/22	=	295,139,192.55	=	295,139,192.55
Estimated Accrued Income	+	868,251.10		
Market Value + Estimated Accrued Income	=	$296,007,443.65		

Income Summary

Income		
Dividends	$5,654.39	$11,191.26
Interest	419,957.61	645,633.77
Rental Income	0.00	0.00
Other Income	0.00	0.00
Total Income	$425,612.00	$656,825.03

Gain/Loss Summary

Income		
Short Term Gain (Loss)	$0.00	-$152,401.53
Long Term Gain (Loss)	0.00	0.00

Portfolio Holdings as of 6/30/2022 – By Maturity

Par ($000)	CUSIP	Description	Moody Short	S&P Short	Fitch Short	Moody Long	S&P Long	Fitch Long	Coupon	Maturity	Days	Market Price	Market Value + Accrued	YTW	Acq Yield	Eff Dur	Total Gain or Loss
34,309	0000CNAM8	Cash & Equivalent				U.S.	U.S.	U.S.	0.840	06/30/2022	0	100.00	34,309,979.16	0.84	0.840	0.00	0.00
25,000	912796R68	United States Treas Bills Dt 010622-070722 Dt 010				U.S.	U.S.	U.S.		07/07/2022	7	99.99	24,996,925.00	0.64	0.918	0.02	1,325.59
25,000	912796K57	United States Treas Bills Dt 071521-071422 Dt 071				U.S.	U.S.	U.S.		07/14/2022	14	99.96	24,990,775.00	0.96	0.900	0.04	-597.84
8,000	09659CGF9	Bnp Paribas Sa 0% Cp 15/07/2022	P-1	A-1						07/15/2022	15	99.93	7,994,672.00	1.62	1.048	0.04	-1,884.00
11,850	11070KGJ0	British Columbia Prov Cda 0% Cp 18/07/2022	P-1	A-1+						07/18/2022	18	99.92	11,840,638.50	1.60	1.066	0.05	-3,135.24
10,050	87019SGK4	Swedbank Foreningssparbkn Ab 0% Cp 19/07/2022	P-1	A-1+	F1+					07/19/2022	19	99.92	10,041,718.80	1.58	1.027	0.05	-2,911.31
10,725	07274MH16	Bayerische Landesbank N Y 0% Cp 01/08/2022	P-1	NR			USAGY	USAGY		08/01/2022	32	99.85	10,708,483.50	1.76	1.394	0.09	-3,425.08
7,700	13068XAA7	California St Pub Wks Brd Leas Ref Bds 2022 a Ref Bd - Var Cap Projs			NR	Aa3	A+	AA-	5.000	08/01/2022	32	100.27	7,831,096.78	1.80	1.344	0.09	-3,080.00
600	223047AA9	Covina Calif Pension Oblig Taxable Bds 2021 Taxabl					AA		0.299	08/01/2022	32	99.87	599,986.52	1.76	0.299	0.09	-756.00
855	419792F68	Hawaii St GO Ref Taxable Bds 2021 G GO Ref			NR	Aa2	AA+	AA	0.247	08/01/2022	32	99.88	854,856.62	1.63	0.247	0.09	-1,017.45
800	612574EP4	Monterey Peninsula Calif Cmnty Election 2020 Taxable GO a Electi					AA		0.182	08/01/2022	32	99.87	799,578.62	1.67	0.182	0.09	-1,024.00
8,000	697379XV2	Palo Alto Calif Uni Sch Dist Election 2018 GO Bds 2022 Electi				Aaa	AAA		5.000	08/01/2022	32	100.26	8,107,066.67	1.99	1.271	0.09	-5,040.00
475	796720NX4	San Bernardino Calif Cmnty Col Taxable GO Ref Bds 2021 Taxabl				Aa1			0.225	08/01/2022	32	99.87	474,839.09	1.70	0.225	0.09	-603.25
1,000	9523474S8	West Contra Costa Calif Uni SC Taxable GO Ref Bds 2021 B Taxabl			NR		AA-	AAA	0.206	08/01/2022	32	99.87	999,562.61	1.71	0.206	0.09	-1,290.00
10,725	80285QH29	Santander Uk Plc 0% Cp 02/08/2022	P-1	A-1	F1					08/02/2022	33	99.84	10,707,646.95	1.79	1.455	0.09	-3,263.07
7,250	19424JHC3	Collaterized Coml Paper V Llc 0% Cp 12/08/2022	P-1	A-1						08/12/2022	43	99.77	7,233,107.50	1.98	2.034	0.12	438.56
5,900	22533UHG1	Credit Agricole Corp 0% Cp 16/08/2022	P-1	A-1	F1					08/16/2022	47	99.77	5,886,188.10	1.82	1.933	0.13	837.14
10,000	63873KHG5	Natixis Disc Coml Paper 0% Cp 16/08/2022	P-1	A-1	F1					08/16/2022	47	99.74	9,974,200.00	2.01	1.344	0.13	-8,523.60
3,800	87019SHG2	Swedbank Foreningssparbkn Ab 0% Cp 16/08/2022	P-1	A-1+	F1+					08/16/2022	47	99.77	3,791,286.60	1.79	1.912	0.13	619.33

Portfolio Holdings as of 6/30/2022 – By Maturity

Par ($000)	CUSIP	Description	Moody Short	S&P Short	Fitch Short	Moody Long	S&P Long	Fitch Long	Coupon	Maturity	Days	Market Price	Market Value + Accrued	YTW	Acq Yield	Eff Dur	Total Gain or Loss
2,000	06406RAK3	Bank New York Mellon Corp Fr 1.95%082322 Fr 1.9			NR	A1	A	AA-	1.950	08/23/2022	54	99.94	2,012,628.33	2.32	0.132	0.15	-6,478.00
8,000	13078FCM6	California St Univ Taxable Iam Coml Paper Coml P	P-1	A-1					1.400	09/01/2022	63	99.97	8,005,991.11	1.59	1.400	0.17	-2,720.00
1,345	14913Q3A5	Caterpillar Finl Svcs Mtns Be Fr 1.9%090622 Fr 1.9			NR	A2	A	A	1.900	09/06/2022	68	99.98	1,352,765.58	2.02	-0.319	0.18	-5,806.36
3,000	89236TEC5	Toyota Mtr Cr Corp Fr 2.15%090822 Fr 2.1			NR	A1	A+	A+	2.150	09/08/2022	70	99.96	3,018,908.67	2.34	-0.286	0.19	-14,979.00
8,000	5006E1JC9	KDBNY CP 09/12/22	P-1	A-1+						09/12/2022	74	99.57	7,965,448.00	2.14	1.286	0.20	-13,748.38
6,800	14912EJF5	Caterpillar Finl Svcs Corp 0% Cp 15/09/2022	P-1	A-1						09/15/2022	77	99.59	6,772,174.40	1.95	1.070	0.21	-12,510.80
2,450	63743HEQ1	National Rural Utils Coop Fin Fr 2.3%091522 Fr 2.3			NR	A2	A-	A	2.300	09/15/2022	77	99.91	2,464,303.92	2.70	0.175	0.21	-8,633.55
8,000	22533UJL8	Credit Agricole Corp 0% Cp 20/09/2022	P-1	A-1	F1					09/20/2022	82	99.52	7,961,584.00	2.15	1.296	0.23	-15,191.13
2,000	46625HJE1	Jpmorgan Chase & CO Sr Nt 3.25%22 Sr Nt			NR	A2	A-	AA-	3.250	09/23/2022	85	100.15	2,020,599.89	2.55	0.172	0.23	-11,094.00
780	69371RQ33	Paccar Financial Corp Fr 2%092622 Fr 2%0				A1	A+		2.000	09/26/2022	88	99.83	782,757.47	2.70	0.152	0.24	-4,756.44
2,000	313313J58	Federal Farm Cr Bks Matures 10/06/22 Mature				USAGY	USAGY	USAGY		10/06/2022	98	99.42	1,988,320.82	2.19	0.171	0.27	-10,761.35
3,000	91324PDD1	Unitedhealth Group Inc Sr Nt 2.375%22 Sr Nt			NR	A3	A+	A	2.375	10/15/2022	107	99.99	3,014,678.75	2.38	0.227	0.29	-18,936.00
8,000	86562MAU4	Sumitomo Mitsui Fin Grp Inc 2.778%22 2.778%				A1	A-		2.778	10/18/2022	110	100.04	8,047,784.00	2.62	0.898	0.30	-41,552.00
3,605	68607DPP4	Oregon St Dept Transn Hwy User Senior Lien Ref Bds 2012 a Senior			NR	Aa1	AAA	AA+	5.000	11/15/2022	138	101.33	3,675,297.50	1.44	1.611	0.38	2,379.30
11,600	010392EB0	Alabama Pwr CO Sr Glbl -S Nt 22 Sr Glb			NR	A1	A-	A+	5.875	12/01/2022	154	101.06	11,778,183.41	3.29	1.885	0.42	-68,892.40
4,000	166764AB6	Chevron Corporation Sr Nt 2.355%22 Sr Nt				Aa2	AA-		2.355	12/05/2022	158	99.91	4,002,993.67	2.56	0.640	0.43	-15,912.00
8,000	06051GEU9	Bk of America Corp Fr 3.3%011123 Fr 3.3			NR	A2	A-	AA-	3.300	01/11/2023	195	100.17	8,137,197.33	2.98	0.963	0.52	-85,428.00
6,830	85771PAG7	Equinor Asa Sr Nt 2.45%23 Sr Nt				Aa2	AA-		2.450	01/17/2023	201	99.91	6,899,536.61	2.62	1.832	0.54	-29,068.48
12,700	69349LAK4	Pnc Bk N a Pittsburgh PA Disc Fr 2.95%013023 Fr 2.9			NR	A3	A-	A	2.950	01/30/2023	214	99.83	12,834,006.17	3.25	3.052	0.58	-14,465.30
8,000	961214DZ3	Westpac Bkg Corp Sr Glbl Nt 23 Sr Glb			NR	Aa3	AA-	A+	3.650	05/15/2023	319	100.08	8,042,556.00	3.56	1.864	0.86	-117,248.00
3,000	769110CW5	Riverside Cnty Calif Tax Rev Antic Nt 2022 Tax Re		SP-1+	F1+			NR	5.000	06/30/2023	365	102.90	3,087,120.00	2.03	2.150	0.99	3,660.00
295,149									**1.341**	**09/07/2022**	**69**	**100.01**	**296,007,443.65**	**1.82**	**1.228**	**0.19**	**-525,472.11**

MEMORANDUM

Date: October 19, 2022

From: Tyler Haskell, Interim Compliance Officer

To: SCFHP Executive/Finance Committee

Re. AB 361 compliance

Background

Because the Governor's executive order suspending certain Brown Act requirements expired at the end of September 2021, the Legislature passed, and the Governor signed, AB 361. AB 361 amended Government Code §54953 to permit teleconferencing by local agencies during a declared state of emergency without providing public access to each individual teleconference location. In order to do so, a local agency must make the following findings by majority vote every 30 days:

- The local agency has reconsidered the circumstances of the state of emergency.
- Any of the following circumstances exist:
    - The state of emergency continues to directly impact the ability of the members to meet safely in person.
    - State or local officials continue to impose or recommend measures to promote social distancing.

The Governing Board met and made the above findings in September, and the Executive/Finance Committee needs to do so again in order for the Governing Board and committees to continue meeting remotely during the ongoing declared state of emergency.

Recommended Action

Make the following findings and approve continued use of teleconferencing without providing public access to each teleconference location:

- Santa Clara Family Health Plan has reconsidered the circumstances of the state of emergency.
- Any of the following circumstances exist:
    - The state of emergency continues to directly impact the ability of the members to meet safely in person.
    - State or local officials continue to impose or recommend measures to promote social distancing.

Santa Clara Family Health Plan™

Unaudited Financial Statements

For Two Months Ended August 31, 2022

Agenda

Santa Clara Family Health Plan

Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$113.4 M		$227.7 M	
Medical Expense (MLR)	$103.8 M	91.5%	$208.4 M	91.5%
Administrative Expense (% Rev)	$5.7 M	5.1%	$11.8 M	5.2%
Non-Operating Income	$624K		$1.2 M	
Net Surplus (Net Loss)	**$4.5 M**		**$8.8 M**	
Cash and Investments			$523 M	
Receivables			$711 M	
Total Current Assets			$1.26 B	
Current Liabilities			$980 M	
Current Ratio			1.28	
Tangible Net Equity			$313 M	
% of DMHC Requirement			**910.4%**	

Financial Highlights

Santa Clara Family Health Plan

Net Surplus (Net Loss)	Month: Surplus of $4.5M is $4.1M or 914.5% favorable to budget of $444K surplus. YTD: Surplus of $8.8M is $7.5M or 606.2% favorable to budget of $1.2M surplus.
Enrollment	Month: Membership was 315,281 (7,683 or 2.5% higher than budget of 307,598). YTD: Member Months YTD was 629,010 (15,737 or 2.6% higher than budget of 613,273).
Revenue	Month: $113.4M ($826K or 0.7% favorable to budget of $112.6M). YTD: $227.7M ($3.1M or 1.4% favorable to budget of $224.7M).
Medical Expenses	Month: $103.8M ($1.2M or 1.1% favorable to budget of $105.0M). YTD: $208.4M ($1.0M or 0.5% favorable to budget of $209.4M).
Administrative Expenses	Month: $5.7M ($1.6M or 21.5% favorable to budget of $7.3M). YTD: $11.8M ($2.5M or 17.6% favorable to budget of $14.3M).
Non-Operating Income	Month: $624K ($470K or 306.8% favorable to budget of $153K). YTD: $1.2M ($931K or 303.5% favorable to budget of $307K).
Tangible Net Equity	TNE was $312.7M (represents approximately three months of total expenses).
Capital Expenditures	YTD Capital Investments of $148K vs. $6.2M annual budget, primarily computer software.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment of 315,281 members is 7,683 or 2.5% higher than budget. Since the beginning of the fiscal year, total enrollment has increased by 8,899 members or 2.9%, which largely represents newly-eligible Medi-Cal undocumented adults.
- Medi-Cal & CMC enrollment have been increasing since March 2020 largely due to COVID. Beginning in March 2020, annual eligibility redeterminations were suspended and, as a result, enrollment continues to increase.
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 3.2%, Medi-Cal Dual enrollment has increased 0.9%, and CMC enrollment has grown 0.8%.

	For the Month August 2022				For Two Months Ending August 31, 2022					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY23 vs. FY22
Medi-Cal	304,867	297,214	7,653	2.6%	608,242	592,505	15,737	2.7%	549,257	10.7%
Cal Medi-Connect	10,414	10,384	30	0.3%	20,768	20,768	0	0.0%	20,393	1.8%
Total	**315,281**	**307,598**	**7,683**	**2.5%**	**629,010**	**613,273**	**15,737**	**2.6%**	**569,650**	**10.4%**

Santa Clara Family Health Plan Enrollment By Network
August 2022

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	38,730	13%	10,414	100%	49,144	16%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	156,471	51%	-	0%	156,471	50%
North East Medical Services	3,426	1%	-	0%	3,426	1%
Palo Alto Medical Foundation	7,452	2%	-	0%	7,452	2%
Physicians Medical Group	45,850	15%	-	0%	45,850	15%
Premier Care	16,489	5%	-	0%	16,489	5%
Kaiser	36,449	12%	-	0%	36,449	12%
Total	**304,867**	**100%**	**10,414**	**100%**	**315,281**	**100%**
Enrollment at June 30, 2022	296,050		10,332		306,382	
Net Δ from Beginning of FY22	3.0%		0.8%		2.9%	

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

Enrollment By Aid Category

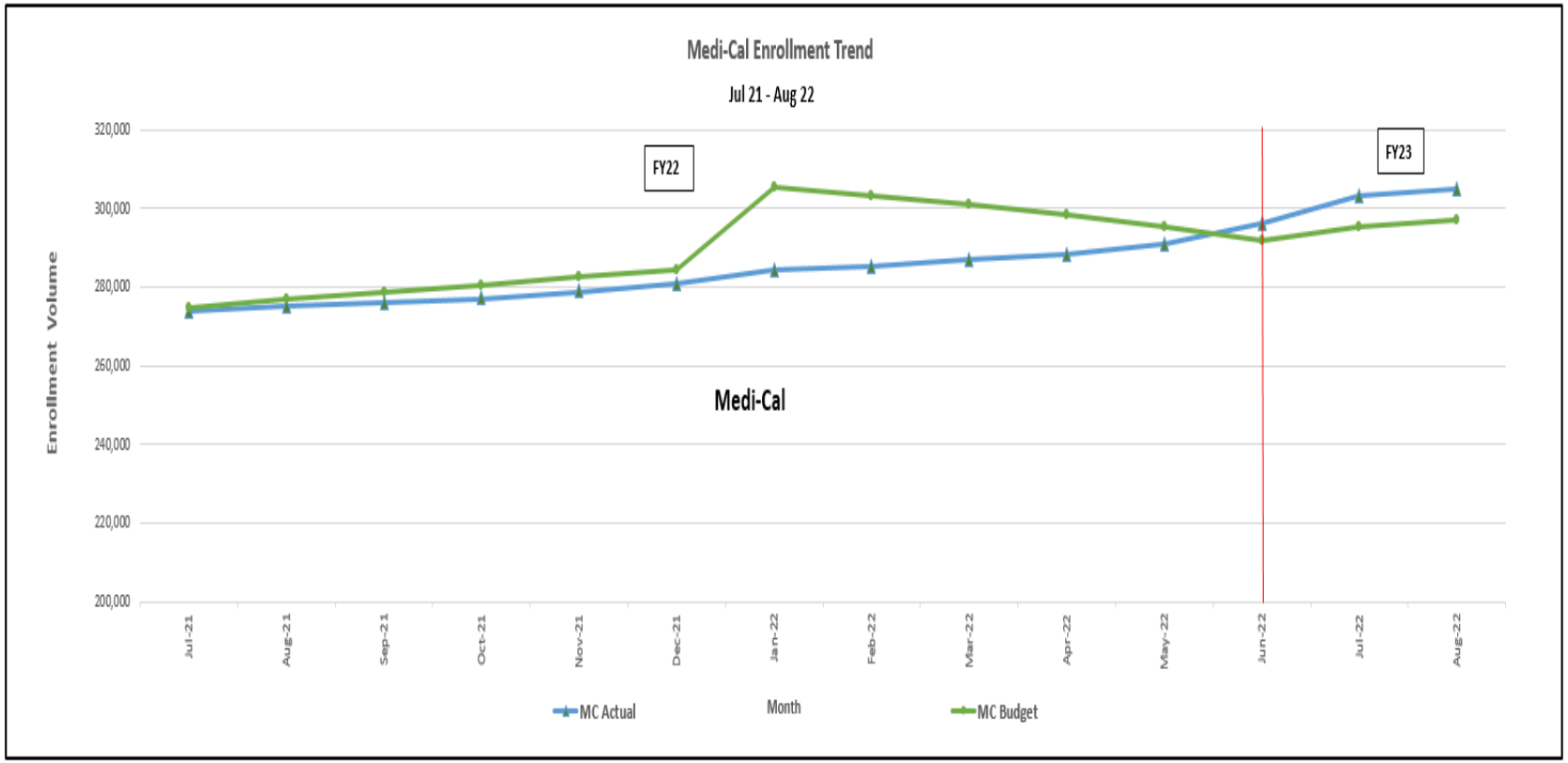
Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD AUGUST - 2022

		2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	FYTD var	%
NON DUAL	Adult (over 19)	33,281	33,546	33,809	34,245	34,653	35,652	35,761	36,104	36,529	37,033	37,861	39,310	39,644	1,783	4.7%
	Child (under 19)	101,085	101,093	101,125	101,411	101,722	102,516	102,519	102,740	103,211	103,765	103,621	103,866	103,987	366	0.4%
	SPD	22,276	22,331	22,381	22,463	22,537	22,740	22,731	22,749	22,751	22,836	24,200	25,130	25,189	989	4.1%
	Adult Expansion	91,392	91,960	92,393	93,186	94,092	95,819	96,366	97,386	98,130	99,249	102,198	106,715	107,599	5,401	5.3%
	Long Term Care	408	401	391	385	392	391	403	395	393	397	398	412	432	34	8.5%
	Total Non-Duals	**248,442**	**249,331**	**250,099**	**251,690**	**253,396**	**257,118**	**257,780**	**259,374**	**261,014**	**263,280**	**268,278**	**275,433**	**276,851**	**8,573**	**3.2%**
DUAL	Adult (over 21)	376	375	396	398	408	410	403	407	412	431	423	424	422	-1	(0.2%)
	SPD	24,159	24,206	24,244	24,307	24,320	24,330	24,350	24,378	24,282	24,352	24,384	24,491	24,518	134	0.5%
	Long Term Care	1,115	1,092	1,083	1,106	1,111	1,085	1,107	1,102	1,111	1,126	1,148	1,159	1,153	5	0.4%
	SPD OE	1,135	1,223	1,308	1,372	1,431	1,496	1,531	1,612	1,666	1,739	1,817	1,868	1,923	106	5.8%
	Total Duals	**26,785**	**26,896**	**27,031**	**27,183**	**27,270**	**27,321**	**27,391**	**27,499**	**27,471**	**27,648**	**27,772**	**27,942**	**28,016**	**244**	**0.9%**
	Total Medi-Cal	**275,227**	**276,227**	**277,130**	**278,873**	**280,666**	**284,439**	**285,171**	**286,873**	**288,485**	**290,928**	**296,050**	**303,375**	**304,867**	**8,817**	**3.0%**
CMC	CMC Non-Long Term Care	10,037	10,122	10,160	10,211	10,221	10,017	10,038	10,084	10,127	10,128	10,127	10,146	10,200	73	0.7%
	CMC - Long Term Care	208	203	208	204	210	202	213	215	206	206	205	208	214	9	4.4%
	Total CMC	**10,245**	**10,325**	**10,368**	**10,415**	**10,431**	**10,219**	**10,251**	**10,299**	**10,333**	**10,334**	**10,332**	**10,354**	**10,414**	**82**	**0.8%**
	Total Enrollment	**285,472**	**286,552**	**287,498**	**289,288**	**291,097**	**294,658**	**295,422**	**297,172**	**298,818**	**301,262**	**306,382**	**313,729**	**315,281**	**8,899**	**2.9%**

- From July to August 2022, total enrollment increased by 1,552 members largely due to newly-eligible Medi-Cal undocumented adults and continued suspended disenrollments due to COVID.

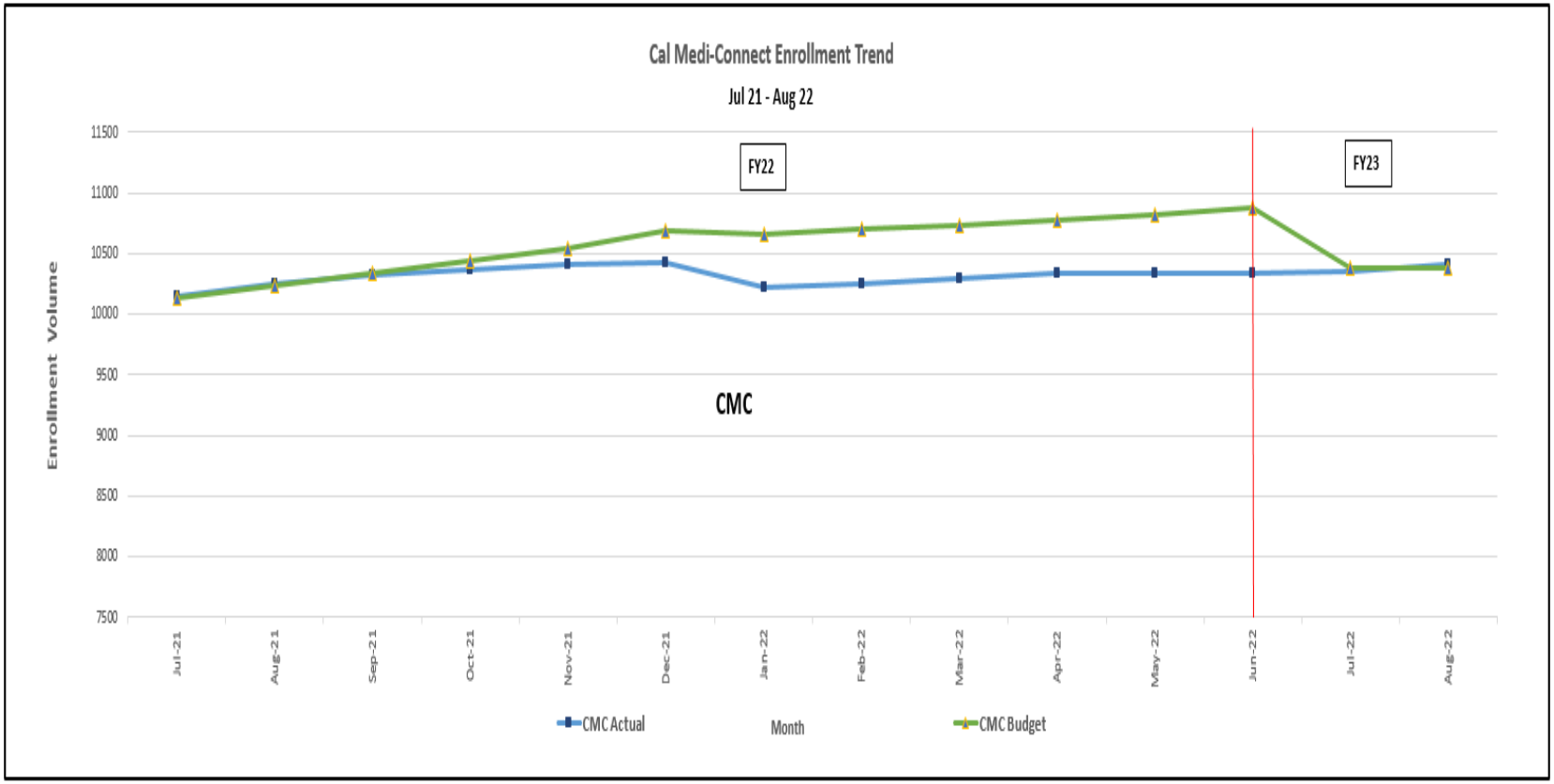
Medi-Cal Enrollment Trend



- Actual enrollment, represented by the blue line, showed a continued COVID enrollment growth through FY22 primarily due to public health emergency (PHE). Newly undocumented members started July 22.

- Budgeted enrollment, represented by the green line, was presumed to decrease in late FY22 but continues to increase due to sustained public health emergency. The FY22 budget included a higher projection of new mandatory Medi-Cal population having Other Health Coverage (OHC) starting Jan 2022. The FY23 budget assumed (1) the PHE continued through October & (2) lower estimated Undocumented Adult enrollment.

Cal Medi-Connect Enrollment Trend

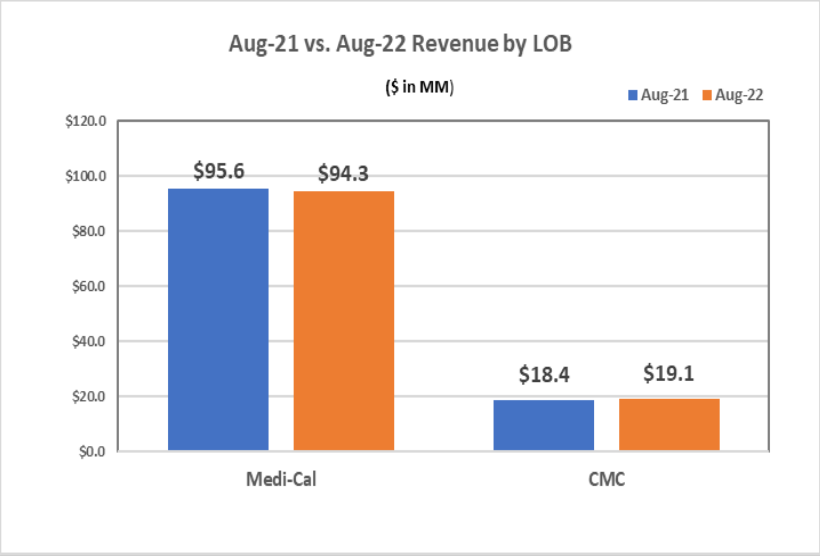


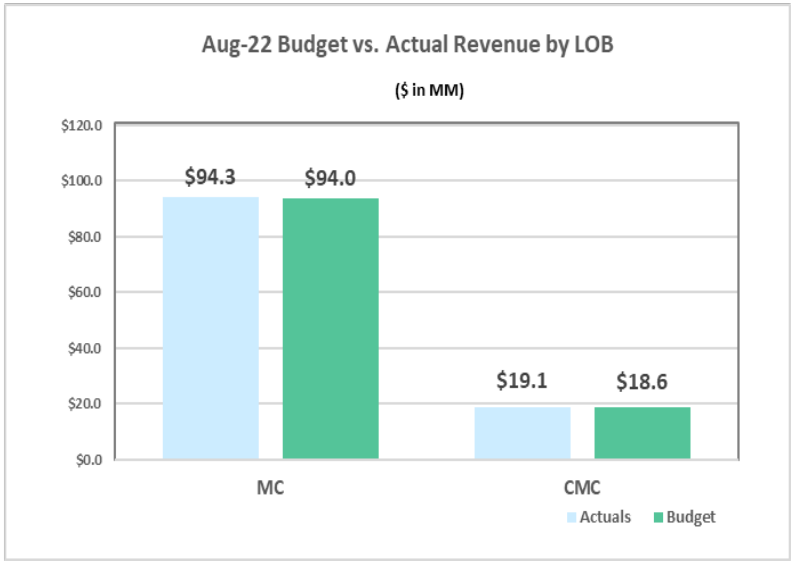
- Actual enrollment, represented by the blue line, showed a continued COVID enrollment growth through FY22 primarily due to public health emergency (PHE).
- Budgeted enrollment, represented by the green line, was presumed to plateau in late FY22 but continues to increase due to the sustained public health emergency. Beginning Jan 23, projections for D-SNP program replace projections for CMC.

Current Month Revenue

Current month revenue of $113.4M was $826K or 0.7% favorable to budget of $112.6M. The current month variance was primarily due to the following:

- Medi-Cal revenue was $377K or 0.4% favorable to budget due primarily to (1) higher enrollment ($2.9M favorable) due to newly undocumented Adults and extended PHE, (2) supplemental revenue ($1.1M favorable) due to increased BHT utilization and higher maternity deliveries, (3) COVID incentive program ($485K favorable), offset by (4) unfunded DHCS incentive programs (HH, ECM and SBH) ($3.5M unfavorable), and (5) the Prop 56 Value Based Payment program was discontinued on June 30 ($608K unfavorable). Unfavorable revenue variances and favorable medical expense variances pertaining to Prop 56 & incentive payments offset.
- CMC revenue was $449K or 2.4% favorable to budget due to (1) higher Part C rate, (2) favorable mix corridor estimate and (3) higher enrollment versus budget.

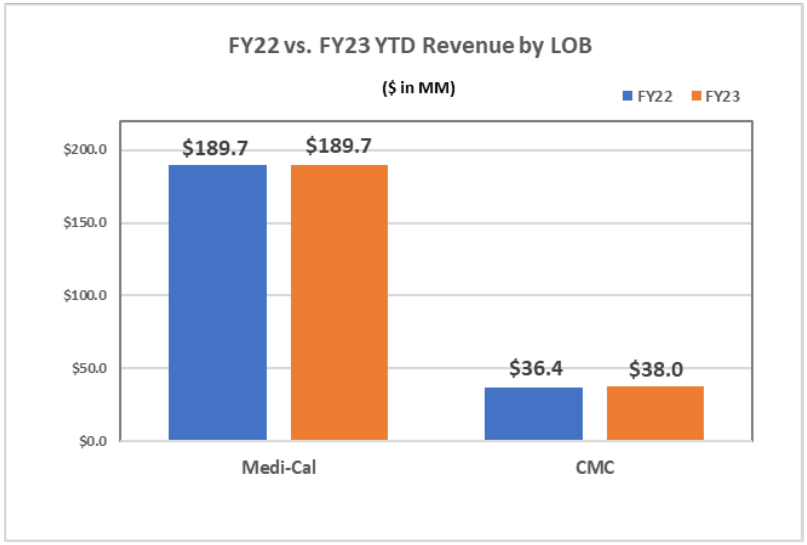


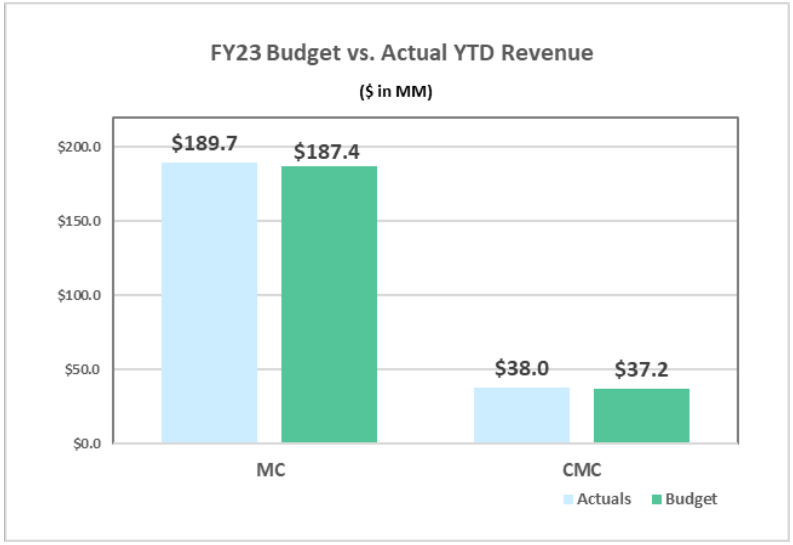


YTD Revenue

YTD revenue of $227.7M was $3.1M or 1.4% favorable to budget of $224.7M. The YTD variance was primarily due to the following:

- Medi-Cal revenue was $2.2M or 1.2% favorable to budget due primarily to (1) higher enrollment ($6.4M favorable) due to newly undocumented Adults and extended PHE, (2) supplemental revenue ($2.5M favorable) due to increased BHT utilization and higher maternity deliveries, (3) COVID incentive program ($1.4M favorable), offset by (4) unfunded DHCS incentive programs (HH, ECM and SBH) ($6.9M unfavorable), and (5) the Prop 56 Value Based Payment program was discontinued on June 30 ($1.2M unfavorable). The unfavorable revenue variances and favorable medical expense variances pertaining to incentive payments offset, due to timing of receipt.
- CMC revenue was $816K or 2.2% favorable to budget due to (1) higher Part C rate, (2) favorable mix corridor estimate and (3) higher enrollment versus budget.

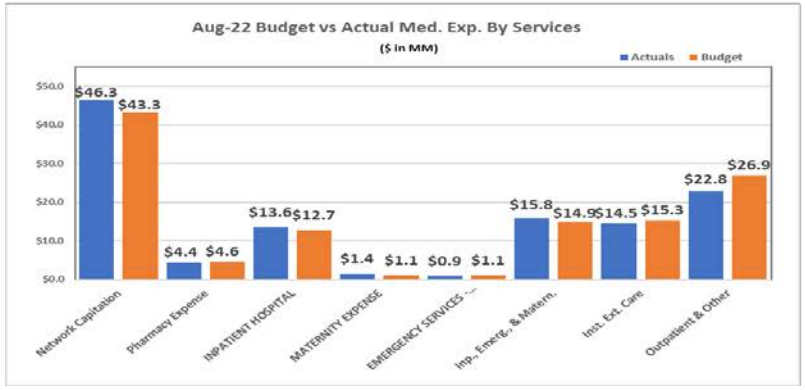


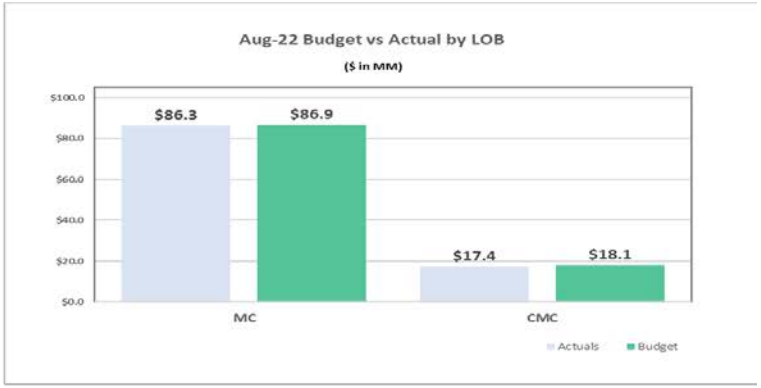


Current Month Medical Expense

Current month medical expense of $103.8M was $1.2M or 1.1% favorable to budget of $105.0M.
The current month variance was due largely to:

- Capitation expense was $1.7M or 3.9% unfavorable to budget due to (1) higher capitated enrollment than expected ($1.3M unfavorable volume variance) and (2) higher blended CY22 rate which is based on actual member mix ($441K unfavorable rate variance).
- Fee-For-Service expense was $1.1M or 2.3% unfavorable to budget due to (1) increased unit cost versus budget for Inpatient, Outpatient, LTC, and Primary Care Physician services ($1.8M unfavorable) and (2) increased supplemental Behavioral Health Therapy utilization and maternity deliveries ($759K unfavorable) (offset with favorable revenue variance); offset by (3) lower utilization in Emergency Room, Other Medical, MLTSS, ECM, and Community Support services ($1.4M favorable).
- Reinsurance & Other expenses were $3.9M or 57.5% favorable to budget due to unspent (1) Housing & Homelessness Incentive Program ($1.8M favorable), (2) ECM Provider Incentive Program ($957K favorable), (3) Prop 56 Value Based Payment program was discontinued on June 30 ($718K favorable), (4) School of Behavioral Health Incentive Program ($375K favorable), (5) Board Designated Fund ($187K); offset by (6) lower claim recoveries ($137K unfavorable). The unfavorable revenue variances and favorable medical expense variances pertaining to incentive payments offset.

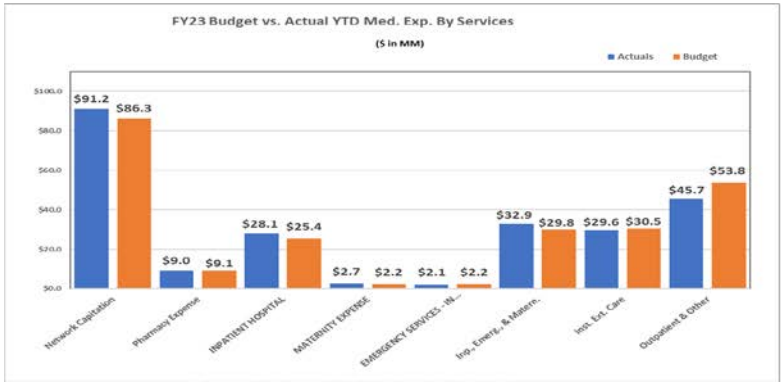


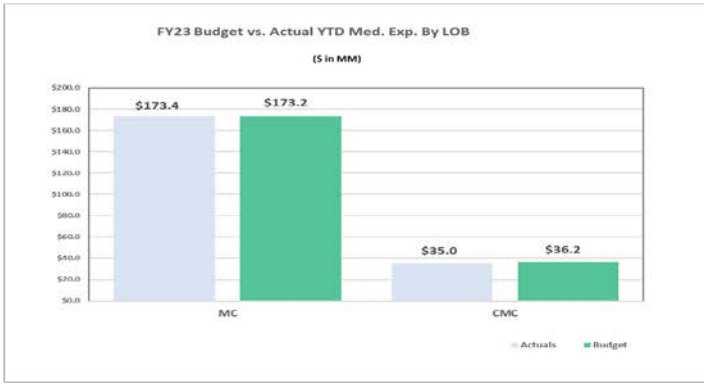


YTD Medical Expense

YTD medical expense of $208.4M was $4.1M or 26.9% favorable to budget of $209.4M. The YTD variance was due largely to:

- Capitation expense was $2.4M or 2.7% unfavorable to budget due to (1) higher capitated enrollment than expected ($2.1M unfavorable volume variance) and (2) higher blended CY22 rate which is based on actual member mix ($336K unfavorable rate variance).
- Fee-For-Service expense was $4.3M or 4.3% unfavorable to budget due to (1) increased unit cost versus budget for Inpatient Hospital, LTC, PCP, Physician Specialty, and Transportation services ($3.8M unfavorable), (2) increased supplemental Behavioral Health Therapy utilization and maternity deliveries ($2.4M unfavorable) (offset with favorable revenue variance), and offset by (3) lower utilization in Outpatient Facility, Emergency Room, Behavioral Health Therapy, ECM and Community Support services ($1.9M favorable).
- Reinsurance & Other expenses were $7.6M or 55.9% favorable to budget due to unspent (1) Housing & Homelessness Incentive Program ($3.7M favorable), (2) ECM Provider Incentive Program ($1.9M favorable), (3) Prop 56 Value Based Payment program was discontinued on June 30 ($1.2M favorable), (4) School of Behavioral Incentive Program ($750K favorable), (5) Board Designated Fund ($318K); offset by (6) lower claim recoveries ($184K unfavorable). The unfavorable revenue variances and favorable medical expense variances pertaining to incentive payments offset, due to timing of receipt.

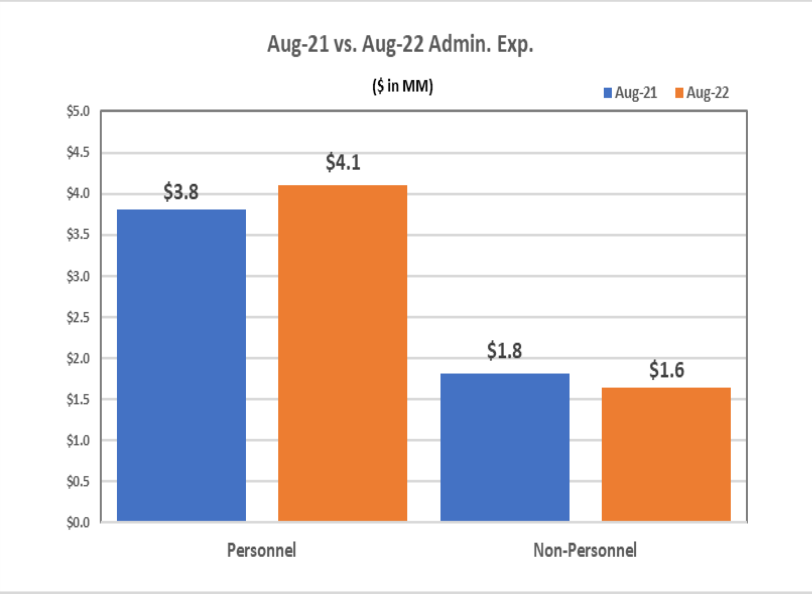


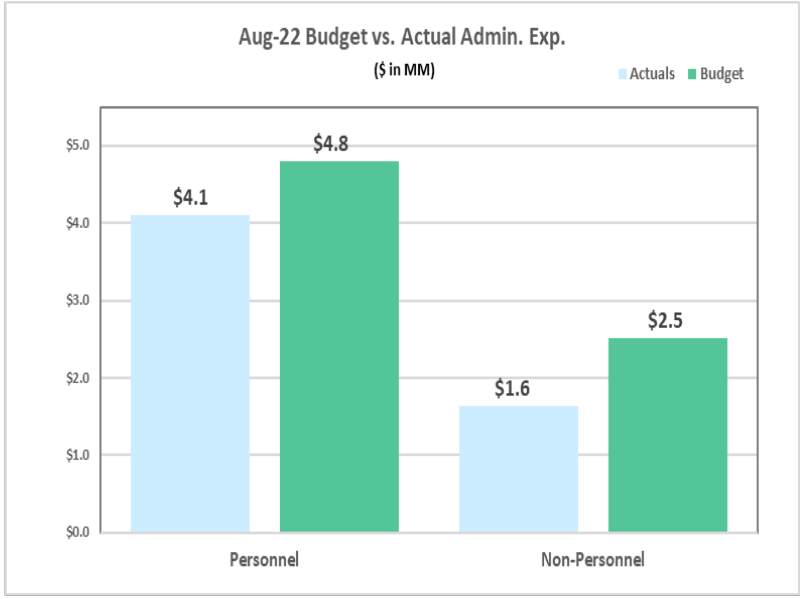


Current Month Administrative Expense

Current month expense of $5.7M was $1.6M or 21.5% favorable to budget of $7.3M. The current month variances were primarily due to the following:

- Personnel expenses were $700K or 14.6% favorable to budget due to lower headcount than budget which included payroll tax and benefit savings.
- Non-Personnel expenses were $867K or 34.6% favorable to budget due to the timing of spending in certain expense categories (consulting, contract services, software licenses, translation, marketing and other expenses) which are expected to be incurred later in the fiscal year.

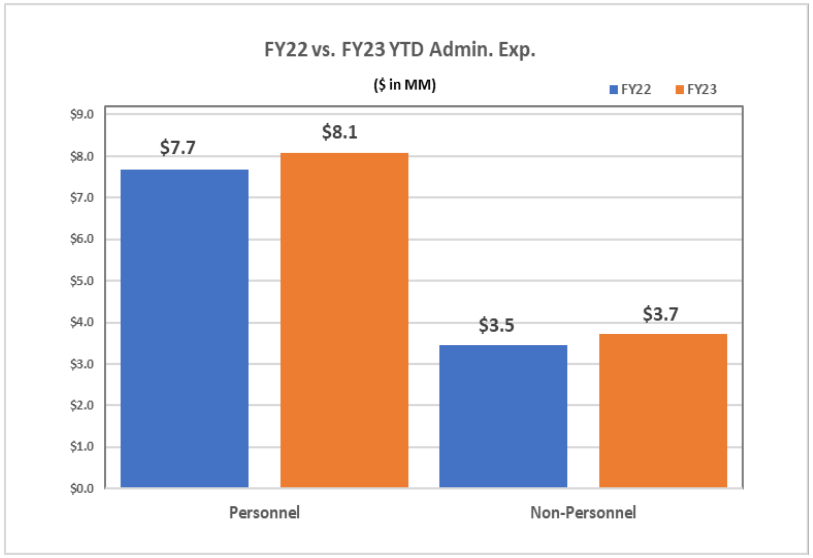


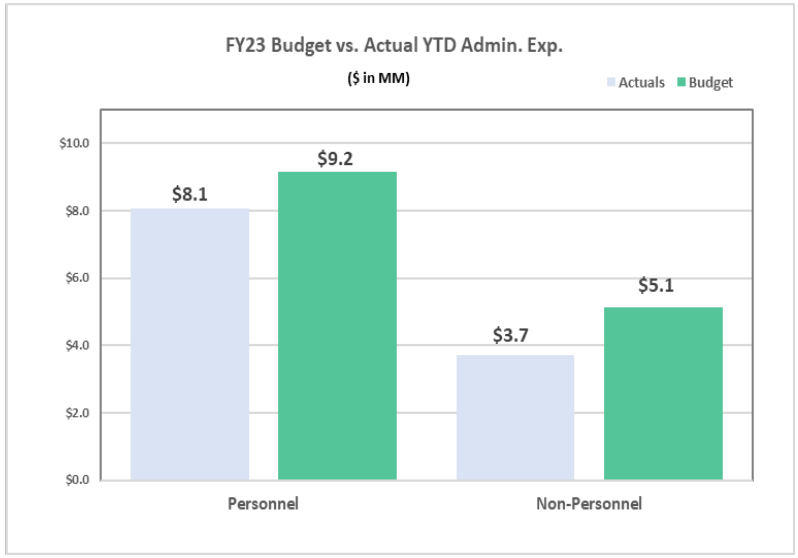


YTD Administrative Expense

YTD administrative expense of $11.8M was $2.5M or 17.6% favorable to budget of $14.3M. The YTD variance was primarily due to the following:

- Personnel expenses were $1.1M or 11.9% favorable to budget due to lower headcount than budget which included lower payroll tax and benefits.
- Non-Personnel expenses were $1.4M or 27.6% favorable to budget due to the timing of budget spending in certain expenses (consulting, contract services, translation, printing & advertising, information systems, and other fees).





Balance Sheet

- Current assets totaled $1.26B compared to current liabilities of $980.2M, yielding a current ratio (Current Assets/Current Liabilities) of 1.28:1 vs. the DMHC minimum requirement of 1.0:1.
- On a YTD basis, the overall cash balance decreased by $28.6M compared to the cash balance as of year-end June 30, 2022 due to the timing of inflows and outflows.
- Current Cash & Equivalents components and yields were as follows:

Description	Cash & Investments	Current Yield %	Interest Income	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$184,114,157	1.25%	$100,000	$200,000
Wells Fargo Investments	($20)	0.00%	$0	$0
City National Bank Investments	$268,715,839	2.01%	$484,569	$955,697
	$452,829,976		$584,569	$1,155,697
Cash & Equivalents				
City National Bank Accounts	$64,748,683	0.01%	$508	$1,044
Wells Fargo Bank Accounts	$4,686,458	2.02%	$7,880	$13,474
Chase HMS Lockbox	$40,189	0.00%	$0	$0
	$69,475,330		$8,387	$14,517
Assets Pledged to DMHC				
Restricted Cash	$325,000	0.01%	$3	$5
Petty Cash	$500	0.00%	$0	$0
Month-End Balance	**$522,630,806**		**$592,959**	**$1,170,219**

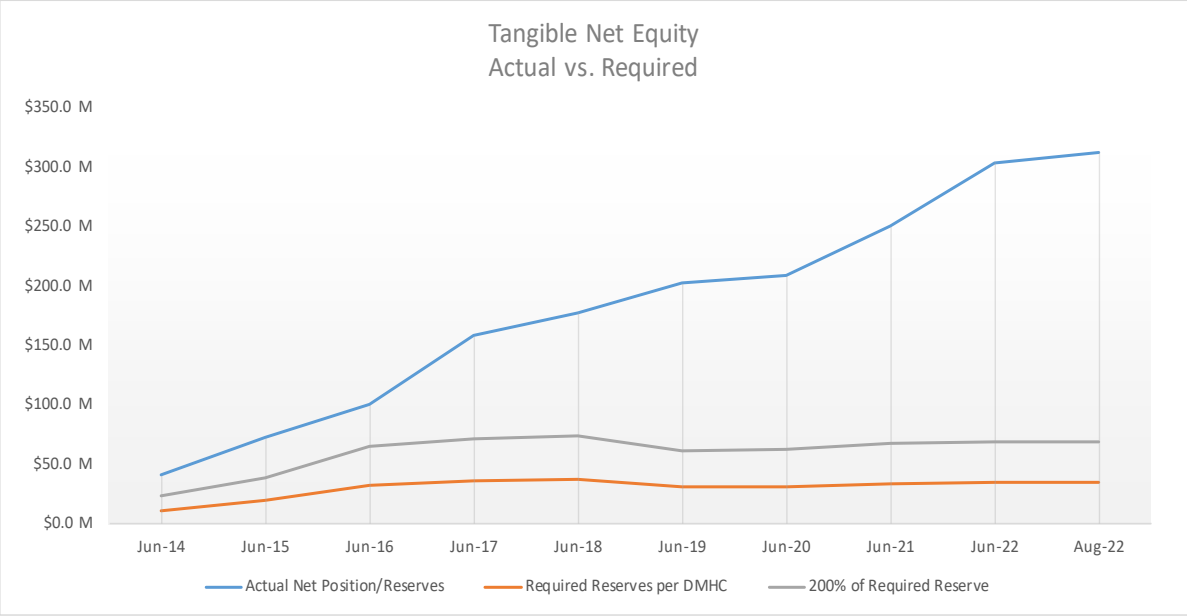
- Cash balances include balances payable to the State of CA for certain items.
- County of Santa Clara Comingled Pool funds have longer-term investments with a higher yield.
- Overall cash and investment yield is significantly higher than budget (1.49% actual vs. 0.3% budgeted).

Tangible Net Equity

- TNE was $312.7M - representing approximately three months of the Plan's total expenses.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of August 31, 2022

	FYE Jun-14	FYE Jun-15	FYE Jun-16	FYE Jun-17	FYE Jun-18	FYE Jun-19	FYE Jun-20	FYE Jun-21	FYE Jun-22	Aug-22
Actual Net Position/Reserves	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$202.1 M	$208.6 M	$250.4 M	$303.9 M	$312.7 M
Required Reserves per DMHC	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$30.9 M	$31.3 M	$33.9 M	$34.7 M	$34.3 M
200% of Required Reserve	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$61.8 M	$62.5 M	$67.8 M	$69.5 M	$68.7 M
Actual as % Required	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	667.2%	739.1%	875.0%	910.4%



Reserves Analysis

SCFHP RESERVES ANALYSIS AUGUST 2022

Financial Reserve Target #1: Tangible Net Equity

	Board Funds Committed	Approved Projects	Funds Expended	Balance	
Unrestricted Net Assets				**$272,283,303**	*
Board Designated Funds (Note 1):					
Special Project Funding for CBOs	$4,000,000	$774,995	$494,995	$3,505,005	
Innovation & COVID-19 Fund	$16,000,000	$8,444,043	$4,100,091	$11,899,910	
Subtotal	$20,000,000	$9,219,038	$4,595,085	$15,404,915	
Net Book Value of Fixed Assets				$24,705,007	
Restricted Under Knox-Keene Agreement				$325,000	
Total Tangible Net Equity (TNE)				$312,718,225	
Current Required TNE				$34,349,530	
TNE %				910.4%	
SCFHP Target TNE Range:					
350% of Required TNE (Low)				$120,223,354	
500% of Required TNE (High)				$171,747,648	
Total TNE Above/(Below) SCFHP Low Target				**$192,494,872**	
Total TNE Above/(Below) High Target				**$140,970,577**	

Financial Reserve Target #2: Liquidity

Cash & Investments	$522,630,806
Less Pass-Through Liabilities:	
Hospital Directed Payments	(139,718,455)
MCO Tax Payable to State of CA	(34,190,773)
Prop 56 / Whole Person Care	(1,666,180)
Other Pass-Through Liabilities (Note 2)	(124,996,494)
Total Pass-Through Liabilities	**(300,571,903)**
Net Cash Available to SCFHP	222,058,903
SCFHP Target Liquidity (Note 3)	
45 Days of Total Operating Expense	(168,418,159)
60 Days of Total Operating Expense	(224,557,545)
Liquidity Above/(Below) SCFHP Low Target	**53,640,745**
Liquidity Above/(Below) High Target	**(2,498,642)**

- **Unrestricted Net Assets represents approximately two months of total expenses.**

Note 1: In December 2018, the Governing Board established a Board Discretionary Fund for Special Projects of $2.2M. In December 2019, the Governing Board also approved additional $1.8M for Special Project fund ($4M total) and $16M for Innovation & COVID-19 Fund.

Note 2: Other Pass-Through Liabilities include HQAF, Rate Range IGT, and DHCS overpayments.

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

Capital Expenditures

- YTD Capital investments of $148K, largely computer software, were comprised of the following:

Expenditure	YTD Actual	Annual Budget
Community Resource Center	$0	$94,400
Hardware	$25,743	$2,205,000
Software	$119,764	$3,806,437
Building Improvements	$0	$30,650
Furniture & Equipment	$2,402	$36,000
TOTAL	**$147,909**	**$6,172,487**

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, 2022

	Aug-2022 Actuals	% of Rev	Aug-2022 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD Aug-2022 Actuals	% of Rev	YTD Aug-2022 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 94,333,799	83.2%	$ 93,956,824	83.5%	$ 376,976	0.4%	$ 189,670,006	83.3%	$ 187,435,512	83.4%	$ 2,234,494	1.2%
CMC MEDI-CAL	4,015,161	3.5%	3,771,482	3.4%	243,679	6.5%	7,880,512	3.5%	7,542,964	3.4%	337,548	4.5%
CMC MEDICARE	15,047,050	13.3%	14,841,540	13.2%	205,510	1.4%	30,161,113	13.2%	29,683,079	13.2%	478,034	1.6%
TOTAL CMC	19,062,211	16.8%	18,613,022	16.5%	449,189	2.4%	38,041,625	16.7%	37,226,043	16.6%	815,582	2.2%
TOTAL REVENUE	**$ 113,396,010**	**100.0%**	**$ 112,569,845**	**100.0%**	**$ 826,165**	**0.7%**	**$ 227,711,631**	**100.0%**	**$ 224,661,555**	**100.0%**	**$ 3,050,075**	**1.4%**
MEDICAL EXPENSES												
MEDI-CAL	$ 86,333,184	76.1%	$ 86,869,741	77.2%	$ 536,557	0.6%	$ 173,353,984	76.1%	$ 173,224,438	77.1%	$ (129,546)	(0.1%)
CMC MEDI-CAL	2,848,527	2.5%	3,649,800	3.2%	801,273	22.0%	6,016,503	2.6%	7,293,974	3.2%	1,277,471	17.5%
CMC MEDICARE	14,592,085	12.9%	14,454,255	12.8%	(137,829)	(1.0%)	29,010,861	12.7%	28,906,018	12.9%	(104,843)	(0.4%)
TOTAL CMC	17,440,611	15.4%	18,104,055	16.1%	663,444	3.7%	35,027,364	15.4%	36,199,992	16.1%	1,172,628	3.2%
TOTAL MEDICAL EXPENSES	**$ 103,773,796**	**91.5%**	**$ 104,973,796**	**93.3%**	**$ 1,200,001**	**1.1%**	**$ 208,381,349**	**91.5%**	**$ 209,424,431**	**93.2%**	**$ 1,043,082**	**0.5%**
GROSS MARGIN	**$ 9,622,215**	**8.5%**	**$ 7,596,049**	**6.7%**	**$ 2,026,166**	**26.7%**	**$ 19,330,282**	**8.5%**	**$ 15,237,125**	**6.8%**	**$ 4,093,157**	**26.9%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 4,098,373	3.6%	$ 4,797,935	4.3%	$ 699,562	14.6%	$ 8,064,569	3.5%	$ 9,156,983	4.1%	$ 1,092,414	11.9%
RENTS AND UTILITIES	12,816	0.0%	39,803	0.0%	26,987	67.8%	67,345	0.0%	79,607	0.0%	12,262	15.4%
PRINTING AND ADVERTISING	(156,042)	-0.1%	88,975	0.1%	245,017	275.4%	(96,913)	0.0%	177,950	0.1%	274,863	154.5%
INFORMATION SYSTEMS	370,702	0.3%	430,730	0.4%	60,028	13.9%	723,999	0.3%	892,159	0.4%	168,160	18.8%
PROF FEES/CONSULTING/TEMP STAFFING	705,377	0.6%	1,165,380	1.0%	460,003	39.5%	1,661,241	0.7%	2,368,063	1.1%	706,822	29.8%
DEPRECIATION/INSURANCE/EQUIPMENT	342,984	0.3%	446,318	0.4%	103,334	23.2%	654,079	0.3%	895,834	0.4%	241,755	27.0%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	57,034	0.1%	64,761	0.1%	7,727	11.9%	113,677	0.0%	129,922	0.1%	16,245	12.5%
MEETINGS/TRAVEL/DUES	109,111	0.1%	131,241	0.1%	22,130	16.9%	221,829	0.1%	320,254	0.1%	98,425	30.7%
OTHER	197,634	0.2%	139,833	0.1%	(57,800)	(41.3%)	377,590	0.2%	279,667	0.1%	(97,923)	(35.0%)
TOTAL ADMINISTRATIVE EXPENSES	**$ 5,737,988**	**5.1%**	**$ 7,304,976**	**6.5%**	**$ 1,566,988**	**21.5%**	**$ 11,787,415**	**5.2%**	**$ 14,300,438**	**6.4%**	**$ 2,513,023**	**17.6%**
OPERATING SURPLUS/(LOSS)	**$ 3,884,227**	**3.4%**	**$ 291,073**	**0.3%**	**$ 3,593,154**	**1,234.5%**	**$ 7,542,867**	**3.3%**	**$ 936,687**	**0.4%**	**$ 6,606,180**	**705.3%**
INTEREST & INVESTMENT INCOME	$ 592,959	0.5%	$ 118,000	0.1%	$ 474,959	402.5%	$ 1,170,219	0.5%	$ 236,000	0.1%	$ 934,219	395.9%
OTHER INCOME	30,625	0.0%	35,284	0.0%	(4,659)	(13.2%)	66,912	0.0%	70,568	0.0%	(3,656)	(5.2%)
NON-OPERATING INCOME	**$ 623,584**	**0.5%**	**$ 153,284**	**0.1%**	**$ 470,300**	**306.8%**	**$ 1,237,131**	**0.5%**	**$ 306,568**	**0.1%**	**$ 930,563**	**303.5%**
NET SURPLUS (LOSS)	**$ 4,507,811**	**4.0%**	**$ 444,357**	**0.4%**	**$ 4,063,454**	**914.5%**	**$ 8,779,998**	**3.9%**	**$ 1,243,255**	**0.6%**	**$ 7,536,743**	**606.2%**

Balance Sheet

Santa Clara Family Health Plan

SANTA CLARA COUNTY HEALTH AUTHORITY
As of August 31, 2022

	Aug-2022	Jul-2022	Jun-2022	Aug-2021
Assets				
Current Assets				
Cash and Investments	$ 522,630,806	$ 496,391,466	$ 551,230,175	$ 410,684,675
Receivables	710,827,555	705,480,592	698,665,336	544,807,886
Prepaid Expenses and Other Current Assets	22,991,872	22,817,506	20,007,106	9,900,313
Total Current Assets	**$ 1,256,450,233**	**$ 1,224,689,564**	**$ 1,269,902,617**	**$ 965,392,874**
Long Term Assets				
Property and Equipment	$ 54,317,567	$ 54,277,864	$ 54,169,659	$ 52,015,817
Accumulated Depreciation	(29,612,560)	(29,317,642)	(29,080,766)	(25,157,882)
Total Long Term Assets	24,705,007	24,960,221	25,088,893	26,857,935
Total Assets	**$ 1,281,155,240**	**$ 1,249,649,785**	**$ 1,294,991,510**	**$ 992,250,809**
Deferred Outflow of Resources	**$ 13,178,679**	**$ 13,178,679**	**$ 13,178,679**	**$ 7,413,357**
Total Assets & Deferred Outflows	**$ 1,294,333,920**	**$ 1,262,828,465**	**$ 1,308,170,190**	**$ 999,664,166**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	$ 15,493,238	$ 15,810,610	$ 13,616,818	$ 5,588,358
Deferred Rent	808,879	856,917	857,699	47,735
Employee Benefits	4,922,981	4,771,651	4,559,004	3,210,465
Retirement Obligation per GASB 75	5,191,796	5,191,796	5,191,796	1,897,787
Whole Person Care	1,666,180	1,675,180	1,681,180	1,843,180
Prop 56 Pass-Throughs	54,076,711	51,437,856	48,842,763	48,257,091
HQAF Payable to Hospitals	27,009	4,715	4,715	103,357
Hospital Directed Payment Payable	139,691,447	139,694,171	139,694,171	23,516,453
Pass-Throughs Payable	33,100,689	28,838,527	24,557,190	182
Due to Santa Clara County Valley Health Plan and Kaiser	49,356,406	42,192,114	80,511,985	20,402,761
MCO Tax Payable - State Board of Equalization	34,190,773	23,046,639	42,311,132	24,885,874
Due to DHCS	91,895,805	90,960,487	90,267,754	60,193,218
Liability for In Home Support Services (IHSS)	419,990,933	419,990,933	419,990,933	419,990,933
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
DHCS Incentive Programs	14,273,060	16,589,389	16,418,646	0
Medical Cost Reserves	106,736,487	103,308,827	105,477,937	115,818,873
Total Current Liabilities	**$ 980,198,374**	**$ 953,200,731**	**$ 1,002,814,642**	**$ 734,050,292**
Non-Current Liabilities				
Net Pension Liability GASB 68	(0)	(0)	(0)	(10,335)
Total Non-Current Liabilities	**$ (0)**	**$ (0)**	**$ (0)**	**$ (10,335)**
Total Liabilities	**$ 980,198,374**	**$ 953,200,730**	**$ 1,002,814,642**	**$ 734,039,957**
Deferred Inflow of Resources	**$ 1,417,320**	**$ 1,417,320**	**$ 1,417,320**	**$ 539,318**
Net Assets				
Board Designated Fund: Special Project Funding for CBOs	$ 3,505,005	$ 3,505,005	$ 3,505,005	$ 3,337,274
Board Designated Fund: Innovation & COVID-19 Fund	11,899,910	11,957,410	12,082,410	13,682,004
Invested in Capital Assets (NBV)	24,705,007	24,960,221	25,088,893	26,857,935
Restricted under Knox-Keene agreement	325,000	325,000	325,000	325,000
Unrestricted Net Equity	263,503,305	263,190,591	213,849,293	210,648,389
Current YTD Income (Loss)	8,779,998	4,272,187	49,087,627	10,234,291
Total Net Assets / Reserves	**$ 312,718,225**	**$ 308,210,415**	**$ 303,938,228**	**$ 265,084,892**
Total Liabilities, Deferred Inflows and Net Assets	**$ 1,294,333,920**	**$ 1,262,828,465**	**$ 1,308,170,190**	**$ 999,664,166**

Cash Flow Statement

Santa Clara Family Health Plan

	Aug-2022	Year-to-date
Cash Flows from Operating Activities		
Premiums Received	$ 120,128,500	$ 209,057,104
Medical Expenses Paid	(93,181,844)	(238,278,378)
Adminstrative Expenses Paid	(1,291,196)	(467,318)
Net Cash from Operating Activities	**$ 25,655,460**	**$ (29,688,592)**
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	$ (39,704)	$ (147,909)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	623,584	1,237,131
Net Increase/(Decrease) in Cash & Cash Equivalents	**$ 26,239,340**	**$ (28,599,370)**
Cash & Investments (Beginning)	496,391,466	551,230,175
Cash & Investments (Ending)	**$ 522,630,806**	**$ 522,630,806**
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Surplus/(Loss)	$ 3,884,227	$ 7,542,867
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	294,918	531,794
Changes in Operating Assets/Liabilities		
Premiums Receivable	(5,346,963)	(12,162,219)
Prepaids & Other Assets	(174,366)	(2,984,766)
Accounts Payable & Accrued Liabilities	4,326,240	13,773,070
State Payable	12,079,452	(6,492,308)
IGT, HQAF & Other Provider Payables	7,164,292	(31,155,579)
Medical Cost Reserves & PDR	3,427,660	1,258,550
Total Adjustments	**$ 21,771,233**	**$ (37,231,458)**
Net Cash from Operating Activities	**$ 25,655,460**	**$ (29,688,592)**

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, 2022

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$189,670,006	$7,880,512	$30,161,113	$38,041,625	**$227,711,631**
MEDICAL EXPENSE	$173,353,984	$6,016,503	$29,010,861	$35,027,364	**$208,381,349**
(MLR)	91.4%	76.3%	96.2%	92.1%	91.5%
GROSS MARGIN	$16,316,021	$1,864,009	$1,150,252	$3,014,261	**$19,330,282**
ADMINISTRATIVE EXPENSE	$9,818,204	$407,932	$1,561,280	$1,969,212	**$11,787,415**
(% of Revenue Allocation)					
OPERATING SURPLUS/(LOSS)	$6,497,818	$1,456,077	($411,028)	$1,045,049	**$7,542,867**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$1,030,455	$42,814	$163,862	$206,676	**$1,237,131**
(% of Revenue Allocation)					
NET SURPLUS/(LOSS)	$7,528,273	$1,498,891	($247,166)	$1,251,725	**$8,779,998**
PMPM (ALLOCATED BASIS)					
REVENUE	$311.83	$379.45	$1,452.29	$1,831.74	**$362.02**
MEDICAL EXPENSES	$285.01	$289.70	$1,396.90	$1,686.60	**$331.28**
GROSS MARGIN	$26.82	$89.75	$55.39	$145.14	**$30.73**
ADMINISTRATIVE EXPENSES	$16.14	$19.64	$75.18	$94.82	**$18.74**
OPERATING INCOME/(LOSS)	$10.68	$70.11	($19.79)	$50.32	**$11.99**
OTHER INCOME/(EXPENSE)	$1.69	$2.06	$7.89	$9.95	**$1.97**
NET INCOME/(LOSS)	$12.38	$72.17	($11.90)	$60.27	**$13.96**
ALLOCATION BASIS:					
MEMBER MONTHS - YTD	608,242	20,768	20,768	20,768	629,010
REVENUE BY LOB	83.3%	3.5%	13.2%	16.7%	100.0%

Santa Clara Family Health Plan™

Appendices

Statement of Operations by Line of Business – Current Month

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For the Month August 2022

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$94,333,799	$4,015,161	$15,047,050	$19,062,211	**$113,396,010**
MEDICAL EXPENSE	$86,333,184	$2,848,527	$14,592,085	$17,440,611	**$103,773,796**
(MLR)	91.5%	70.9%	97.0%	91.5%	91.5%
GROSS MARGIN	$8,000,615	$1,166,634	$454,966	$1,621,600	**$9,622,215**
ADMINISTRATIVE EXPENSE	$4,773,415	$203,172	$761,401	$964,573	**$5,737,988**
(% of Revenue Allocation)					
OPERATING SURPLUS/(LOSS)	$3,227,200	$963,462	($306,435)	$657,027	**$3,884,227**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$518,758	$22,080	$82,746	$104,826	**$623,584**
(% of Revenue Allocation)					
NET SURPLUS/(LOSS)	$3,745,958	$985,542	($223,689)	$761,853	**$4,507,811**
PMPM (ALLOCATED BASIS)					
REVENUE	$309.43	$385.55	$1,444.89	$1,830.44	**$359.67**
MEDICAL EXPENSES	$283.18	$273.53	$1,401.20	$1,674.73	**$329.15**
GROSS MARGIN	$26.24	$112.03	$43.69	$155.71	**$30.52**
ADMINISTRATIVE EXPENSES	$15.66	$19.51	$73.11	$92.62	**$18.20**
OPERATING INCOME/(LOSS)	$10.59	$92.52	($29.43)	$63.09	**$12.32**
OTHER INCOME/(EXPENSE)	$1.70	$2.12	$7.95	$10.07	**$1.98**
NET INCOME/(LOSS)	$12.29	$94.64	($21.48)	$73.16	**$14.30**
ALLOCATION BASIS:					
MEMBER MONTHS	304,867	10,414	10,414	10,414	315,281
REVENUE BY LOB	83.2%	3.5%	13.3%	16.8%	100.0%

Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD SEPTEMBER - 2022

		2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	FYTD var	%
NON DUAL	Adult (over 19)	33,546	33,809	34,245	34,653	35,652	35,761	36,104	36,529	37,033	37,861	39,310	39,644	40,012	702	1.8%
	Child (under 19)	101,093	101,125	101,411	101,722	102,516	102,519	102,740	103,211	103,765	103,621	103,866	103,987	104,097	231	0.2%
	SPD	22,331	22,381	22,463	22,537	22,740	22,731	22,749	22,751	22,836	24,200	25,130	25,189	25,311	181	0.7%
	Adult Expansion	91,960	92,393	93,186	94,092	95,819	96,366	97,386	98,130	99,249	102,198	106,715	107,599	108,216	1,501	1.4%
	Long Term Care	401	391	385	392	391	403	395	393	397	398	412	432	434	22	5.3%
	Total Non-Duals	**249,331**	**250,099**	**251,690**	**253,396**	**257,118**	**257,780**	**259,374**	**261,014**	**263,280**	**268,278**	**275,433**	**276,851**	**278,070**	**2,637**	**1.0%**
															0	
DUAL	Adult (over 21)	375	396	398	408	410	403	407	412	431	423	424	422	421	-3	(0.7%)
	SPD	24,206	24,244	24,307	24,320	24,330	24,350	24,378	24,282	24,352	24,384	24,491	24,518	24,579	88	0.4%
	Long Term Care	1,092	1,083	1,106	1,111	1,085	1,107	1,102	1,111	1,126	1,148	1,159	1,153	1,151	-8	(0.7%)
	SPD OE	1,223	1,308	1,372	1,431	1,496	1,531	1,612	1,666	1,739	1,817	1,868	1,923	1,994	126	6.7%
	Total Duals	**26,896**	**27,031**	**27,183**	**27,270**	**27,321**	**27,391**	**27,499**	**27,471**	**27,648**	**27,772**	**27,942**	**28,016**	**28,145**	**203**	**0.7%**
															0	
	Total Medi-Cal	**276,227**	**277,130**	**278,873**	**280,666**	**284,439**	**285,171**	**286,873**	**288,485**	**290,928**	**296,050**	**303,375**	**304,867**	**306,215**	**2,840**	**0.9%**
															0	
CMC	CMC Non-Long Term Care	10,122	10,160	10,211	10,221	10,017	10,038	10,084	10,127	10,128	10,127	10,146	10,200	10,278	132	1.3%
	CMC - Long Term Care	203	208	204	210	202	213	215	206	206	205	208	214	202	-6	(2.9%)
	Total CMC	**10,325**	**10,368**	**10,415**	**10,431**	**10,219**	**10,251**	**10,299**	**10,333**	**10,334**	**10,332**	**10,354**	**10,414**	**10,480**	**126**	**1.2%**
															0	
	Total Enrollment	**286,552**	**287,498**	**289,288**	**291,097**	**294,658**	**295,422**	**297,172**	**298,818**	**301,262**	**306,382**	**313,729**	**315,281**	**316,695**	**2,966**	**0.9%**

Santa Clara County Health Authority

Board Designated Innovation Fund Request Summary

Organization Name:	Unity Care
Project Name:	Seasons of Wellness Pilot Project
Contact Name and Title:	Tatiana Colon Rivera, Director of Strategic Partnerships tcolon@unitycare.org 408.917.9822 ext. 4140
Requested Amount:	$200,000
Time Period for Project Expenditures:	11/1/2022 – 10/31/2023
Proposal Submitted to:	Executive Finance Committee, 10/27/2022
Date Proposal Submitted to SCFHP for Review:	08/08/2022

Summary of Proposal:

Seasons of Wellness is a health and wellness pilot project that provides treatment and prevention strategies to help transitional foster youth cope with complex trauma and manage stressors. With the help of a behavioral health clinician, youth will participate in structured and flexible activities that put youth in the driver's seat to seek out opportunities for self-reflection, empowerment, and personal growth. Modalities will include Individual Therapy, Caring Connections, and Self- Care Strategies. The program will target 30 young adults ages 18-24, specifically those who are Black and current or former foster youth who struggle with complex barriers to wellness and independence.

Summary of Projected Outcome/Impact:

- To decrease negative outcomes associated with complex trauma and high stress situations by teaching practical coping skills that youth in or exiting from foster care can adapt in everyday life.
    - Within 12 months, provide individualized twice monthly therapy to 30 youth.
    - Within 12 months connect all 30 youth to at least 1 caring and supporting individual to support their wellness journey.
    - Within 12 months provide at least 12 activities that can support self-care for youth.
- To increase positive coping strategies for youth who have experienced foster care.

- By the end of services, 75% of young people in the program will report greater confidence in their ability to cope with stressful situations.
- 75% of participants will report increased knowledge of positive coping strategies within 6 months of participation.
- By the end of services, 75% of young people in the program will have developed a plan of self-care designed to manage their stress.

Summary of Additional Funding and Funding Requests:

Unity Care has not sought other funders for this pilot; however, as part of this program Unity Care will research and work with SCFHP on becoming a provider for Medi-Cal services provided.

Evaluation Relative to SCFHP Innovation Funding Criteria

Criteria	Met/Not Met
1. Indicate if funding is being sought from other potential sources.	X
2. Demonstrate alignment with SCFHP Strategic Plan.	✓
3. Demonstrate the project addresses SDOH.	✓
4. Demonstrate the project addresses health equity.	✓
5. Demonstrate the project reduce health disparities for SCFHP members.	✓
6. Indicate if the project promotes quality of care and cost efficiency.	X
7. Indicate if the project addresses issues that affect SCFHP regulatory compliance or accreditation.	X
8. Demonstrate focus on identified gaps in serving our members, potential members, and providers to better meet health needs, consistent with SCFHP's mission.	–
9. Demonstrate that project will enable SCFHP to address evolving state and federal health care policy and regulatory expectations.	–
10. Demonstrate ability to work in collaboration with community, as appropriate for the initiative.	✓
11. Indicate that this is a strategic investment which may span years.	–

✓ Criteria met

– Criteria partially met

X Criteria not met, or not applicable

SCFHP Board Funding Request

Organization Information

Organization Name or Fiscal Agent, if applicable: Unity Care Group
Tax ID: 77-0323115
Organization Type: 501c3
Address: 1400 Parkmoor Ave. San Jose CA 95126
Phone: (408) 971-9822
Web Address: www.unitycare.org

Executive Director/Chief Executive Officer Contact Information:

Sheila Mitchell
Chief Executive Officer
Address: 1400 Parkmoor Ave. San Jose CA 95126
Phone: (408) 971-9822 ext 403
Email: smitchell@unitycare.org

Request Primary Contact
Tatiana Colón Rivera, MPA
Director of Strategic Partnerships
Address: 1400 Parkmoor Ave. San Jose CA 95126
Phone: (408) 971-9822 ext 4140
Email: tcolon@unitycare.org

Funding Request Information

Project Title: Seasons of Wellness
Project Summary (one paragraph description):
Request Amount: $200,000
Total Project Budget: $200,000
Project Start Date: November 1, 2022 Project End Date October 31, 2023

- **Has the project sought other funders? Names, amounts. If so, what was the outcome?**
  Unity Care has not yet sought out other sources of funding for this project. We were looking to the SCFHP as our first investor in this pilot project and are hoping to leverage the partnership along with the data produced by the project to gain additional partners to implement the program widely.
- **If not, please describe plans to seek other or additional funding:**
  Our hope is to use the funds provided by SCFHP to leverage the partnership and resources to build additional partners to support this work. We will identify foundations that support mental health programming to expand the program in other regions and provide ongoing support to the San Jose

program. Additionally, we will seek to secure mental health contracts with various counties to continue funding the individual and group therapy components of the model.

- **If this project will require ongoing funding, what will be the source of that funding? Has this funding been secured?**
  Unity Care is working to add foundations as patrons of this project and also to secure mental health contracts with various counties to continue funding the individual and group therapy components of the model. While we have not yet secured these funding sources, we are hopeful that with an investment from the SCFHP, Unity Care will be in a position to build the necessary body of work and supporting data to prove proof of concept and gain additional support across various foundations and public partners in multiple counties.

Project Impact Areas

- **Project Alignment with SCFHP Strategic Plan:**
- **Which SDOH is being addressed? Please see the below SDOH and provide information on how this project will address one or more of the SDOHs.**

Unity Care's **Seasons of Wellness Pilot Project** addresses the impacts of childhood exposure to trauma on health and well being including access to the social determinants of health listed below. Stress is being felt universally across the world today. These are trying times for everyone, even those who have not been exposed to significant amounts of childhood trauma. Unity Care has seen the impacts of this universal stress on the youth it serves, including how they lack the skills to cope with the most basic of stressors and how that in turn impacts their ability to remain successfully housed, retain employment, succeed in school, access health care and maintain positive healthy relationships. Every day, in spite of our staff's heroic efforts, it is clear that *our* youth experiencing foster care care and *all* youth experiencing foster care need more. The Seasons of Wellness pilot project aims to decrease negative outcomes associated with complex trauma and high stress situations by teaching practical coping skills that can be adapted in everyday life to youth in or exiting from foster care.

- **Economic Stability** (such as employment, income, expenses, debt, medical bills, etc.): Youth with complex trauma histories have a difficult time securing and maintaining employment, which leads to economic instability. Challenges often arise when youth meet demands and expectations in the workplace that they feel incapable of meeting. This can lead to frustrating encounters that result in a loss of employment. Seasons of Wellness will address economic stability by teaching youth coping strategies and self care that allows them to develop healthy lifestyles, manage the stressors of employment, and limit escalations that lead to loss of employment.
- **Education Access and Quality** (such as literacy, language, vocational training, higher education): Similarly, youth with complex trauma histories have a difficult time focusing and often develop learning disabilities that can lead to challenges in accessing and securing educational opportunities. Seasons of Wellness will provide youth with access to a support system, individual therapy, and self care strategies that will help them learn to self-advocate and take on goals and challenges at a pace that is reasonable to them. This will help mitigate any stressors arising from demands and expectations in education that they feel incapable of meeting. In turn, we hope that educational goals will begin to feel attainable for the youth we serve.
- **Health Care Access and Quality** (such as health coverage, provider linguistic and cultural competency, quality of care): Seasons of Wellness is a mental health program tailored to the specific unmet needs of transitional aged youth of color in or exiting from foster care. The program will help close a current gap in care that is not being addressed by any other entity and as such, will address health care access and quality.

- **Neighborhood and Built Environment** (such as housing, transportation, safety, food insecurity): Youth that are in or exiting from foster care depend on housing services made available by community providers such as Unity Care. Their ability to remain successfully housed is directly linked to their ability to follow each provider's rules and program structure. This structure (however loose or strict) can prove to be a difficult challenge for many youth with complex trauma, as their emotions and reactions to stressors often interfere with their ability to keep the environment safe for themselves and others. This often leads to their exit from a program and potential homlessness. Seasons of Wellness aims to increase healthy coping strategies to mitigate negative responses to stressors that may place a youth's housing at risk.
- **Social and Community Context** (such as social integration, social supports, community engagement, discrimination): One of the three strategies used by Seasons of Wellness is connecting youth to supportive individuals that will become part of their support system during stressful times. These social supports help with healthy decision making in multiple areas and model what healthy relationships look like.

- **Does this project address health equity?**
  Seasons of Wellness addresses health equity by meeting a gap in care for transitional aged youth of color in or exiting from foster care that is not being addressed by any other entity at present time. While youth in foster care have access to traditional mental health services, these often do not consider and/or are not tailored to their unique situations The services proposed herein, not only provide basic standards of therapeutic interventions, but also addresses the need for additional skill building that young people can use and benefit from long term. The program addresses health equity by meeting youth "where they are at" and providing tailored programming that ensures their comfort and success of the care. The program will use client-centered strategies and not expect youth to adhere to more traditional structures for mental health care that they are unfamiliar with and therefore would have a hard time navigating.

- **Will this project reduce health disparities for SCFHP members?**
  Yes, Unity Care clients are members of the SCFHP.

- **Does this project promote quality of care and cost efficiency? If so, how?**
  Yes, the project promotes quality care by providing tailored client-centered care designed for our target population. The project also promotes cost efficiency as it provides a more comprehensive three pronged wellness strategy for the cost of a single traditional therapeutic intervention. Further, increasing positive coping strategies for youth who are at risk of depression, PTSD, and other health complications could potentially reduce the amount of future hospitalizations, emergency visits, and psychiatric holds by reducing the factors that lead to complications ending in hospital visits.

- **Does this project address issues that affect SCFHP regulatory compliance or accreditation? If so, how?**
  No.

Project Narrative

Project Summary

Seasons of Wellness is a health and wellness pilot project that provides treatment and prevention strategies to help young adults cope with complex trauma and manage stressors. This will be accomplished by promoting the healing process through helping participants build an understanding of the effects of trauma and toxic stress on their own health and providing coping strategies to manage stress.

Project Need

The American Academy of Pediatrics (AAP) classified children in foster care as a population of children with special health care needs. This is due to the well documented and extensive trauma these children have before, and continue to experience, upon entering foster care. For example, as many as 80% of children and adolescents enter foster care with a significant mental health need. Early childhood trauma/toxic stress has been correlated with poor emotional regulation, aggression, hyperactivity, impulsivity, attention and attachment problems and the inability to associate thought and mood. Left untreated and without the proper tools to self-mitigate the impacts of trauma and stress, children grow into adulthood to experience high rates of mental health problems including Post Traumatic Stress Disorder (PTSD), unemployment, homelessness, and low educational attainment.

Black youth are disproportionately represented in foster care as compared to the total child population. While Black youth make up 14% of the total child population, in foster care they account for 23% of youth. The impact of foster care on Black and other youth of color is compounded by the chronic stress brought on by discrimination, neighborhood stress, family stress, and environmental stress to name a few. The National Institute of Health has established that chronic stress can increase the risk for numerous health problems such as heart disease, obesity, diabetes, depression, cognitive impairment, and others.

National statistics are mirrored in Santa Clara County. A Santa Clara County Social Services Agency Transitional Aged Youth (TAY) Report for Fiscal Year 2020-21 noted that there were approximately 375 TAY between the ages of 16-21 with open child welfare cases in the county. Females ages 16-21 represent 54.67% of the TAY population, slightly higher than their male counterparts at 45.33%. Their report highlights that African Ancestry and Latino youth are disproportionately represented in the TAY population ages 16-21, with Latinos representing 65.78%, followed by African Ancestry at 10.70%. 100% are MediCal eligible.

The data above illustrates that Black and Latino youth in or exiting from foster care are exposed to an enormous amount of challenges that create chronic stress impacting their overall health and well being. This leads to countless physical and mental health problems AND adversely impacts their access to the social determinants of health such as housing, employment, education, and health care. When these variables are operationalized, they can be reduced to many incidences in which individuals did not have the proper coping skills and support to recognize and manage situations and/or opportunities they were presented with. **For example:** Shelly, an 18 year old female with stable housing placed it at risk because of a fight that escalated quickly. When Shelly lost her keys and one of her roommates laughed at her because of it, she dealt with the stressors by yelling at her roommates and threatening to kill one of them with a knife. Verbal and physical threats are not tolerated in Shelley's housing unit, therefore she was discharged from the program and became homeless. In this example, a simple unfortunate event leads to extreme circumstances and crisis because Shelly lacks the coping skills to deal with everyday life challenges, making any potential circumstance a crisis event, if not provided the proper support.

The Seasons of Wellness pilot project aims to decrease negative outcomes associated with complex trauma and high stress situations by teaching practical coping skills that can be adapted in everyday life to youth in or exiting from foster care.

Population Served

Unity Care will target young adults ages 16-21, especially those who are Black and current or former foster youth who struggle with complex barriers to wellness and independence. This population is in desperate need of trusted and flexible support that can help them overcome histories that may include severe trauma, family chaos, housing instability, mental health and substance use issues, disengagement in school, and systems involvement (juvenile justice, mental health, family and child services). As of March 2020, we can also add the impacts of COVID-19 to the stressors and challenges that continue to layer on foster youth, especially Black foster youth. The COVID-19 pandemic represents a difficult time that exacerbated conditions typical for foster youth such as PTSD, substance abuse, and depression, retraumatizing them with additional feelings of loneliness, hopelessness, and helplessness. Through Seasons of Wellness, Unity Care will serve 30 youth ages 16-21 in foster care living in Santa Clara County Unity Care properties through Individual Therapy, Caring Connections, and Self- Care Strategies.

Program Structure and Design

Seasons of Wellness will work to mitigate the previously described stressors and address wellness and well being by allowing youth to design and implement their own wellness journeys. The project will accomplish this via structured and flexible activities that put youth in the driver's seat to seek out opportunities for self reflection, empowerment, and personal growth. With the help of a clinician, youth will participate in new experiences to which they would not otherwise have access. Seasons of Wellness is intended as a preventative care program designed to promote, encourage, and teach self-care strategies for coping with stress and trauma. The goal is to prevent crisis situations and chronic stress associated with poor emotional regulation, aggression, hyperactivity, impulsivity, attention and attachment problems, and the inability to associate thought and mood.

Throughout the course of the year, the program will use a three pronged approach to address wellness barriers: 1) Promote Caring Connections; 2) Encourage Facing Your Feelings; and 3) Engage in Self-Care. The cumulative impact of these strategies will lead to self acceptance, empowerment, and emotional wellness. Activities are free of charge and offered at times convenient for the population of focus so that they can participate outside of school and work time.

1. **Promote Caring Connections**: This component will connect youth to supportive adults that can

provide support during difficult times, teaching youth how to identify positive influences in their lives and how to build trust through healthy boundaries.

2. **Encourage Facing Your Feelings:** Through individualized therapy, youth will learn to face their feelings and cope with past traumas. Through talk therapy, they learn strategies to manage stress and their feelings. Individual therapy sessions will be provided by a clinician once per week and/or as needed. Therapy sessions usually last one hour and address a variety of emotional/mental, physical and social wellness challenges that threaten participant self-actualization. Clinicians provide sessions wherever the youth feel most comfortable, which may include their homes, our program office, the park, and even while going for a walk.

   Once enrolled in the program, youth will attend therapy sessions a minimum of twice per month or as needed based on their treatment plan. A youth in the program for an entire year will participate in at least 24 therapy sessions.

3. **Engage in Self- Care**: Youth are led through a wellness journey where they are presented with self-care options through a variety of activities designed to teach them how to design a self-care routine that is right for them. Activities range from spending time in nature, to eating healthy and nutrition, cooking classes, exercise and yoga classes, art and music therapy, chats about the impact of meditation, relaxation, and the importance of a good night's sleep. Youth in the program are treated as one cohort. As part of the cohort, they select what activities they would like to participate in as a group from a menu of activities selected by staff and youth. Youth are encouraged to pick one wellness goal on which they wish to focus, and as a team (youth and staff), work to meet their goals across settings and activities, and monthly workshops. For example, youth may want to work on body and mind activities one month and they may propose having a yoga class. Staff would arrange for this activity to take place. Youth Self Care activities will be led by paid or volunteer contractors and, as relevant, staff.

Goals and Objectives

Goal 1	To decrease negative outcomes associated with complex trauma and high stress situations by teaching practical coping skills that youth in or exiting from foster care can adapt in everyday life.
Objectives	**1a:** Within 12 months, provide individualized therapy to 30 youth. **1b**: Within 12 months connect all 30 youth to at least 1 caring and supporting individual to support their wellness journey. **1c**: Within 12 months provide at least 12 activities that can support self-care for youth.
Goal 2	To increase positive coping strategies for youth who have experienced foster care.
Objectives	**2a:** By the end of services, 75% of young people in the program will report greater confidence in their ability to cope with stressful situations. **2b:** 75% of participants will report increased knowledge of positive coping strategies within 6 months of participation **2c:** By the end of services, 75% of young people in the program will have developed a plan of self-care designed to manage their stress.

Outcomes and Reporting

Performance Measures: As part of the initial project workplan, Unity Care will include a data collection and evaluation plan which identifies the data to be collected, who will collect it, and where it is stored. We anticipate this will look like the following:

Performance Measures		Target Goal	How to Calculate	Unity Care Method of Data Collection
How Much Did We Do?	Performance Measure 1. Number of youth served. 2. Number of classes/activities provided	20 individual therapy 75 youth via classes 12 classes per year	1. Unduplicated and duplicated count of youth served. 2. Classes scheduled	Data entry into AWARDS Activities Calendar
How Well Was it Done?	Performance Measure Percent of participants who meet at least bi-weekly with their clinician 5 Pillars of Success targets (Housing, Education,Employment, Wellness, and Unconditional Care)	75%	# of youth who met with their clinician at least biweekly in the reporting period # of active participants in the reporting period # of youth achieving targets	Clinicians and Case Managers enter data into AWARDS, Impact and Outcomes Analyst runs related reports

Is Anyone Better Off?	Performance Measure 1. Percent of participants meeting at least 1 therapeutic goal created at program entry. 2. Reduction in serious incident reports 3. Decrease in the number of exits related to crisis situations. 4. # of youth reporting feeling better-prepared to manage stress.	75% 25% 25% 75%	1. # of participants who met at least 1 therapeutic goal created at program entry that ended during the reporting period 2. # of youth involved in crisis incidents as compared to previous years without the intervention. 3. Reason for exit data 4. Self report data from a survey.	Clinicians, Case Managers enter data into AWARDS, Impact and Outcomes Analyst runs related reports Survey Monkey created, administered by clinician; data analyzed by IOA

Outcomes and Reporting Overview

Unity Care's data evaluation team comprises a wide range of individuals at all levels of the agency, including the Director of Strategic Partnerships (DSP), the Impact and Outcomes Analyst (IOA), the Evaluation and Learning Staff Committee (consisting of Case Managers, Resident Advisors, and Management Representatives), and the Evaluation and Learning Board of Directors Committee (comprised of Board Members, community members, and agency directors) to oversee agency-wide learning and represent evaluation and learning interests at the Board level. Committees meet monthly to discuss data learning, challenges, and data implementation strategies. Led by the DSP, the IOA and evaluation and learning committees, Unity Care conducts regular and ongoing tracking, data analysis, reporting and evaluation of the effectiveness of program services and a quantifiable analysis of successful outcomes for youth involved.

The agency utilizes AWARDS (an electronic health record system) to collect data, track service activity efforts, and monitor participant outcomes and Microsoft Power BI to generate visual data insights that can be easily understood by all stakeholders (e.g. staff, clients, board members, funders). With the support of the IOA, Program Managers ensure tracking and reporting compliance by generating reports in AWARDS to verify that the Unity Care team is completing the required contacts and assessments. The documentation in AWARDS includes recorded efforts and other documentation necessary to monitor and evaluate the quality, quantity, timeliness of service activities, and ultimately impact. Power BI data insights are updated weekly and staff at all levels are given access to their personal data insights to evaluate their own performance.

All direct service program staff (Clinicians, Case Managers, Coordinators) will document and track participant engagement, successes and steps taken toward goal achievement in the form of case notes. Case notes must be entered into the agency's AWARDS within 48 hours of contact. AWARDS is used to aggregate all client and services information from intake to discharge, including participant demographic, intake and assessment information, clinical documentation, case plans, tracking of programmatic outputs and client outcomes, tracking of services provided and billing information.

How Unity Care will collect data and measure outcomes: At the start of the contract, the Clinical Supervisor will meet with the DSP and the IOAt to establish a data and learning plan identifying the outcome data to be collected, means of collection, and relevant staff roles and responsibilities. This plan is then operationalized on AWARDS, ensuring the program module is set up and that the appropriate data collecting systems are in place. Program staff (Clinician and Coordinator) are then trained to collect data for the program. Outcomes and measures for all Unity Care Programs include the Five Pillars of Success assessments which measure impact of each of the pillars on each individual youth and then the collective program as a whole. The plan will be implemented at the start of service provision and will include:

Quantitative data: Data documenting the number of persons served, types of services provided, number of sessions provided, and number of events will be tracked by entering the information into AWARDS and comparing reports run in AWARDS against targets. Unity Care will additionally track information based on our Five Pillars of Success model. These elements will be tracked monthly and at program exit.

Qualitative data: Effectiveness data will be tracked in AWARDS, with reports generated to define progress toward goals, as follows:

- *Individual Therapy:* All individual therapy meetings will be accounted for in AWARDS. Clinicians are required to document all contact attempts regardless of method and all actual contacts in AWARDS. Reports can be generated detailing the number of appointments, length of time and other data that may be useful to the county.
- *Case notes*: Direct service program staff will document and track a participant's engagement, successes and steps taken toward goal achievement in the form of case notes. Case notes must be entered into AWARDS within 48 hours of contact and include all contact attempts regardless of whether or not actual contact is made.
- *Measuring participant progress:* Client data will be gathered at admission, regularly throughout their stay, at exit, and at follow-up Each participant's baseline is determined through the use of the Child Adolescent Needs and Strengths Assessment (CANS)/ Adult Needs and Strengths Assessment (ANSA) and the Ansell Casey Life Skills assessments to identify youth skill sets when the client enters the program as well as through discussions with the client, which is part of the information-gathering process during intake. Progress is measured at least monthly in the required domains so that any issues or needs may be addressed immediately and youth continue to make progress in housing status and other self-sufficiency indicators. Unity Care will measure the same domains at program completion to assess whether or not the participant has made progress in each domain.

In addition, Unity Care conducts an annual client survey, Unity Listens, through which clients are asked t what programs and services had the most and least impact. Clients also have opportunities to provide feedback on how to make programs better and can identify service gaps that often lead to the development of new services for the youth.

One Year Project Budget

SCFHP Request Budget Table and Narrative:

Item	Description	Percent of Request	Cost
1.0 FTE Clinician + Benefits at 25%	Clinician will provide individual therapy to all youth in the program. Cost associated with this line item includes salary and benefits calculated at 25%. 1.0 FTE assumes at least 24 clients hours per week.	47%	$93,750
0.20 FTE Clinical Program Manager + Benefits at 25%	Clinician is supervised by the Clinical Program Manager who spends 20% of his time on this task.	11%	$22,500
0.5 FTE Activities Coordinator + Benefits at 25%	A 0.5 FTE activities coordinator will also support the project and help coordinate all wellness and self care activities. This person is responsible for the project management and implementation of all activities including the recruitment of instructors for self care activities.	19%	$37,500
Self Care Activities Fund (instructors, spaces, equipment etc)	Fund supports the full cost of self care activities including equipment, rental space, contracted instructors, class fees etc.	10%	$20,163
Total operating Costs			$173,913
Indirect Costs at 15% of total program	Indirect costs are all the costs associated with the ongoing support of every Unity Care program and the administration of the organization. These costs include finance, administration, facilities, IT, Evaluation and Learning etc.	13%	$26,087
Total Project Request for One Year			$200,000

Project Sustainability

To have the desired impact, the necessary resources must be in place to ensure the Seasons of Wellness program enjoys long term success beyond the life of the pilot project. To that end, during the pilot phase of the program, Unity Care intends to work with SCFHP to identify how this project can be successful under the MediCal provider model, as well as look into other existing services we currently provide that have the potential to be billable services as a provider.

SCFHP Supplemental Questions

1. **Do you have local SCC data on foster care youth including ethnicity that illustrates what the specific need is here in SCC?**
    - Yes, see needs

2. **How many youth will be served this year-long pilot?**
    - 30

3. **How frequently do the youth meet with staff/clinician? How many therapy sessions per youth on average?**
    - Once enrolled in the program, youth will attend therapy sessions a minimum of twice per month or as needed based on their treatment plan.

4. **How long will each youth be enrolled in the program?**
    - Youth can be enrolled in the program while they continue to have clinical treatment goals and while still living in Unity Care housing. It is possible for youth to have met their treatment goals and still choose to participate in group self care activities as maintenance. The ultimate goal is for clients to graduate out of treatment because they no longer need it.

5. **Will youth be discharged/graduated from the program and how will that be measured and decided?**
    - Youth can be discharged/ graduated from the program upon meeting t all of their treatment goals. Progress will be measure by youths ability to meet their co-created treatment goals

6. **What is the criteria that each youth need to meet to qualify for enrollment into this program? (Assuming that this 1 FTE will not be able to assist every foster youth in SCC but will get a better understanding once they provide general foster youth data in SCC vs how many individuals this pilot program is intending to serve).**
    - In an effort to determine the impact of the three-pronged approach strategy on a reduction in crisis episodes, youth enrolled in the program will be recruited from Unity Care's existing pool of clients living in our Transitional Housing Units. This will allow us to monitor incident reports, exit reports, and crisis incidents to note the expected reduction of these as a result of the program's interventions. There are an estimated 375 youth in foster care living in Santa Clara County. Unity Care aims to serve 30.

7. **How will these services be provided? Is it via 1:1 or group sessions or a combination of both? Where will these services be provided and how will this impact the population served?**
    - Individualized therapy will occur on a 1:1 basis with the clinician and the client. Services happen in the community and where clients feel most comfortable. This means they can be at a clients home, in the park, while out for a walk, wherever youth feel most comfortable.
    - Self Care activities will be organized as a group activity (with some exceptions) and provided according to the activity selected. For example, if yoga is selected, the activity might be provided at a local park or at the Sobrato Center for Non-profits depending on the weather. Some activities might be individual. For example if one youth seems particularly interested in an activity that the group cannot agree on, we can decide to pay the class fee for the youth to attend that class in the community.
    - All services are meant to be very accessible for youth. We will also have options for joining activities and therapy virtually if that is more convenient for the client. Our goal is attendance, so staff will always choose the method, space, and location that will yield the highest level of engagement from our youth people.

8. **How will progress be tracked?**
    - See the outcome and reporting overview in the narrative.

9. **Can you share an example of a case study?**
    - We don't know of any other program that has been designed with this specific program model that we can share. However, there is plenty of evidence and many studies have been conducted demonstrating the impacts of trauma on youth and the benefits of self care, therapeutic interventions, and connecting to a caring support system as key components necessary in coping with stressors and trauma. The National Child Traumatic Stress Network (NCTSN), the Centers for Disease Control, National Institute of Health (NIH) and the American Psychological Association have all published numerous studies and data on the subject that can validate the combination of activities in our program model.

10. **How will progress be tracked for each youth?**
    - See the outcome and reporting overview in the narrative.

11. **How are outcomes established and measured?**
    - See the outcome and reporting overview in the narrative.

12. **How is preventing crisis situations and chronic stress measures? Is there an assessment use for pre and post enrollment in the pilot?**
    - Unity Care will compare incident reports and exit data from previous years to incidents within the pilot's reporting period. CANS/ANSA data is also collected at program entrance and exit and the pre and post scores are compared. See the performance measures and measuring participant progress under the outcome and reporting section of the narrative.

13. **What type of talk therapy modalities will be utilized?**

    Evidence-based practices to be incorporated include:

- Dialectical Behavior Therapy (DBT): This is a type of cognitive behavioral therapy that teaches individuals to live in the moment, develop healthy ways to cope with stress, regulate their emotions, and improve their relationships with others. DBT can help people who have difficulty with emotional regulation or are exhibiting self-destructive behaviors. Cognitive Behavioral Therapy tries to identify and change negative thinking patterns and pushes for positive behavioral changes. DBT provides people with new skills to manage painful emotions and decrease conflict in relationships. Psychology Today describes the four key areas DBT focuses on as: 1) *Mindfulness*: focuses on improving an individual's ability to accept and be present in the current moment. 2) *Distress tolerance* is geared toward increasing a person's tolerance of negative emotion, rather than trying to escape from it. 3) *Emotion regulation* covers strategies to manage and change intense emotions that are causing problems in a person's life. 4) *Interpersonal effectiveness*: consists of techniques that allow a person to communicate with others in a way that is assertive, maintains self-respect, and strengthens relationships. While DBT is a tool to be used in therapeutic environments, DBT techniques are becoming widely used with direct service staff to prepare them in their ability to support wellness and treatment goals led by clinicians.

- Motivational Interviewing (MI)**:** This goal-oriented, client-centered counseling style elicits behavioral change by helping youth and families explore and resolve their ambivalence toward changing their problematic behavior. The approach upholds four principles— expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (youth's beliefs can successfully make a change). MI can be used by clinicians and direct service staff to gain essential information about the youth and their family and to begin to involve the youth and their Child Family Team (CFT) in determining the course of treatment and the measures of treatment success. MI techniques keep the youth actively engaged in their own recovery and build and maintain a sense of

empowerment on the part of the youth since the youth's belief in his or her ability to recover is an important element in effecting recovery.

- Social-Emotional Learning: The Collaborative for Academic, Social, and Emotional Learning (CASEL) defines social-emotional learning (SEL) as "the process through which children and adults understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions." CASEL outlines five core competencies central to SEL:
    - Self-awareness: "Do I have insight into my strengths, limitations, and needs?"
    - Self-management: "Can I manage my emotions and physical behaviors in ways that align with expectations in a range of circumstances?"
    - Social awareness: "Can I empathize with those who are different from me?" "Can I accurately detect the rules of social engagement relevant to my current context?"
    - Relationship skills: "Can I cultivate and deal with the challenges inherent in maintaining relationships with diverse individuals and groups?"
    - Responsible decision-making: "Can I deliberate and settle upon a course of action with adequate attention to various considerations and possible outcomes?"

14. If physical, mental, and social needs are identified what are the next steps in addressing those needs? Will the therapist connect clients with their PCPs/specialist providers to address these needs or provide additional resources?

- Every client at Unity Care is assigned their own Case Manager that works to connect them with additional necessary services. Part of each youth's case management plan at Unity Care includes targets in the Five Pillars of Success (Housing, Education, Employment, Wellness, and Caring Connections) that would address physical and social needs. If new needs are identified during the course of services, the youth's Case Manager and Clinician would work together to identify appropriate services and referrals. When youth enter into services with Unity Care, one of our first goals is to establish their connection to a health plan and primary care physician and ensure ongoing follow up occurs as needed.

15. If the youth speaks about self-harm will Unity Care connect the youth to appropriate services and notify the appropriate parties?

- All staff at Unity Care are trained in emergency protocols and there is a procedure in place should a youth exhibit the intent to harm themselves or others that includes collaborating with the youths support team, a clinical assessment, therapeutic interventions, and potentially a referral for a psychiatric hold.

16. When considering the "engage in self-care" prong who will provide the activities designed to teach the clients self-care: time in nature, yoga, cooking classes, exercise classes, art and music therapy?

- Youth Self-Care activities will be led by paid or volunteer contractors and as relevant, staff. For example a time in nature activity can be led by a staff person with a passion for nature. A yoga or Zumba class would need a trained yoga or Zumba instructor; in these cases we would identify and contract an instructor and pay a per class/person fee. Should we find these services in-kind in the community we would leverage these as well.

17. What is the case load for the 1.0 FTE clinician? Ratio of clinician to youth during active participation/enrollment in the program?

- The caseload of a clinician at Unity Care is 1-25. This is the same ratio we will uphold for the program.

18. What are some of the indirect costs?

- See budget narrative.

19. **How will this program compliment and coordinate the current system of care for those in the foster care system and transitioning out of the foster care system?**
    - This pilot program presents a new strategy for supporting youth that have experienced foster care**.** This pilot project is meant to be additive and would complement other available services that, while necessary, do not always provide the level of intensity needed to support youth through and out of the debilitating impacts of the trauma they have experienced in their lives. This project would be a pilot at our agency in that it would only be available in San Jose and would allow Unity Care to try a new model of care to be added to our menu of services. Since COVID-19 pandemic began, we have seen a rise in serious incidents with the youth Unity Care serves. It has become increasingly clear that additional measures need to be implemented to support the level of care necessary for youth to move from surviving to thriving.

20. **What quantitative and qualitative analysis will be provided to SCFHP at the end of the pilot program?**
    - See the outcome and reporting overview in the narrative.

Santa Clara Family Health Plan™

Government Relations Update

October 27, 2022

Federal Issues

CMS

- Public Health Emergency extended to January 11, 2023

Congress - Lame Duck Forecast

- Improving Seniors' Timely Access to Care Act
- Advancing Telehealth Beyond COVID-19 Act
- Mental health legislation
- Statutory PAYGO sequester
- Unresolved: MA, gold carding

State Issues

Administration

- COVID State of Emergency lifted Feb 28, 2023
- CalAIM updates

Legislation

- SB 1473 – COVID testing coverage
- SB 987 – complex cancer cases
- SB 858 – health plan penalties
- SB 966 – FQHC PHE flexibilities
- AB 2697 – CHW services