Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, October 22, 2020, 11:30 PM – 1:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference
(669) 900-6833
Meeting ID: 930 4397 2435
Passcode: ExFin0ct
https://zoom.us/j/93043972435

AGENDA

1.	**Roll Call**	Ms. Alvarado	11:30	5 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Governing Board reserves the right to limit the duration of the public comment period to 30 minutes.	Ms. Alvarado	11:35	5 min
3.	**Fiscal Year 2019-2020 External Independent Auditor's Report** Discuss draft FY2019-2020 External Independent Auditor's Report including Board Communication Letter and Audited Financial Statements. **Possible Action:** Approve FY2019-2020 External Independent Auditor's report	Moss Adams	11:40	30 min
4.	**Meeting Minutes** Review meeting minutes of the Augut 27, 2020 Executive/Finance Committee. **Possible Action:** Approve August 27, 2020 Executive/Finance Committee Minutes	Ms. Alvarado	12:10	5 min
5.	**CEO Update** Discuss status of current topics and initiatives.	Ms. Tomcala	12:15	10 min
6.	**Government Relations Update** Discuss local, state, and federal legislative and policy issues impacting the Plan and its members.	Mr. Haskell	12:25	10 min
7.	**Compliance Report** Review and discuss compliance activities and notifications.	Mr. Haskell	12:35	10 min
8.	**August 2020 Financial Statements** Review August 2020 Financial Statements. **Possible Action:** Approve the August 2020 Financial Statements	Mr. Jarecki	12:45	15 min

9.	**Quality Update** Discuss CY'19 Medi-Cal HEDIS Plan Comparison Rates	Dr. Nakahira	1:00	10 min
10.	**Outreach & Retention Update for Medi-Cal** Review accomplishments and key strategies for outreach and member retention	Ms. Byom	1:10	20 min
11.	**Adjournment**		1:30	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Governing Board on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Rita Zambrano 48 hours prior to the meeting at (408) 874-1842.
- To obtain a copy of any supporting document that is available, contact Rita Zambrano at (408) 874-1842. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com.

Report of Independent Auditors and Financial Statements

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

June 30, 2020 and 2019

Table of Contents

Management's Discussion and Analysis

INTRODUCTION:

In accordance with the Governmental Accounting Standards Board Codification Section 2200, Comprehensive Annual Financial Report, the management of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) ("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, 2020, 2019, and 2018. 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.

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

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 1.9% to 253,875 members at June 30, 2020, from 249,206 members at June 30, 2019. Total enrollment decreased 4.0% to 249,206 members at June 30, 2019, from 259,475 members at June 30, 2018.

- Net position increased by $6,515,031 to $208,640,786 for the fiscal year ended June 30, 2020, from $202,125,755 for the fiscal year ended June 30, 2019, due to operating income of $38,958 and nonoperating income of $6,476,073. Net position increased by $24,109,890 to $202,125,755 for the fiscal year ended June 30, 2019, from $178,015,865 for the fiscal year ended June 30, 2018, due to operating income of $18,298,263 and nonoperating income of $5,811,627.

- Total assets and deferred outflows of resources increased to $1,189,881,233 as of June 30, 2020, from $1,009,258,566 as of June 30, 2019. Total assets and deferred outflows of resources increased to $1,009,258,566 as of June 30, 2019, from $763,293,226 as of June 30, 2018.

- Total liabilities and deferred inflows of resources increased to $981,240,447 at June 30, 2020, from $897,132,811 at June 30, 2019. Total liabilities and deferred inflows of resources increased to $897,132,811 at June 30, 2019, from $585,277,361 at June 30, 2018.

- The current ratio (current assets divided by current liabilities) of 1.18 as of June 30, 2020, reflected a decrease from 1.19 at June 30, 2019. The current ratio (current assets divided by current liabilities) of 1.19 as of June 30, 2019, reflected a decrease from 1.26 at June 30, 2018.

CONDENSED STATEMENTS OF NET POSITION:

	June 30			2020 to 2019 Change		2019 to 2018 Change	
	2020	2019	2018	Amount	% Change	Amount	% Change
Assets:							
Current assets	$ 1,152,476,888	$ 1,060,344,723	$ 724,183,257	$ 92,132,165	8.7%	$ 336,161,466	46.4%
Capital assets	26,649,088	27,392,240	24,269,369	(743,152)	-2.7%	3,122,871	12.9%
Other assets	2,352,997	2,283,994	305,350	69,003	3.0%	1,978,644	648.0%
Total assets	1,181,478,973	1,090,020,957	748,757,976	91,458,016	8.4%	341,262,981	45.6%
Deferred outflows of resources	8,402,260	9,237,609	14,535,250	(835,349)	-9.0%	(5,297,641)	-36.4%
Total assets and deferred outflows of resources	$ 1,189,881,233	$ 1,099,258,566	$ 763,293,226	$ 90,622,667	8.2%	$ 335,965,340	44.0%
Liabilities:							
Current liabilities	$ 977,464,723	$ 891,447,827	$ 574,535,150	$ 86,016,896	9.6%	$ 316,912,677	55.2%
Noncurrent liabilities	-	2,539,090	6,533,514	(2,539,090)	-100.0%	(3,994,424)	-61.1%
Total liabilities	977,464,723	893,986,917	581,068,664	83,477,806	9.3%	312,918,253	53.9%
Deferred inflow of resources	3,775,724	3,145,894	4,208,697	629,830	20.0%	(1,062,803)	-25.3%
Net position:							
Net investment in capital assets	26,649,088	27,392,240	24,269,369	(743,152)	-2.7%	3,122,871	12.9%
Restricted	305,350	305,350	305,350	-	0.0%	-	0.0%
Unrestricted:							
Designated by Governing Board	17,339,275	2,200,000	-	15,139,275	100.0%	2,200,000	100.0%
Unrestricted	164,347,073	172,228,165	153,441,146	(7,881,092)	-4.6%	18,787,019	12.2%
Total net position	208,640,786	202,125,755	178,015,865	6,515,031	3.2%	24,109,890	13.5%
Total liabilities, deferred inflows of resources, and net position	$ 1,189,881,233	$ 1,099,258,566	$ 763,293,226	$ 90,622,667	8.2%	$ 335,965,340	44.0%

Assets and Deferred Outflows of Resources

For the fiscal year ended June 30, 2020, assets increased $91,458,016 or 8.4% due primarily to increases in receivables from the California Department of Health Care Services (“DHCS”). During the same period, deferred outflows of resources decreased $835,349 or -9.0% due to the timing of amounts attributable to employee retirement plans.

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

Liabilities and Deferred Inflows of Resources

For the fiscal year ended June 30, 2020, liabilities increased $83,477,806 or 9.3% due primarily to increases in timing of payables to DHCS and certain providers. During the same period, deferred inflows of resources increased $629,830 or 20.0% due to due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2019, liabilities increased $312,918,253 or 53.9% due primarily to the accrual of payables for fiscal year 2018 hospital directed payments. During the same period, deferred inflows of resources decreased $1,062,803 or -25.3% due to the timing of amounts attributable to employee retirement plans.

Tangible Net Equity

The Health Authority is required to maintain a minimum level of tangible net equity ("TNE") per its contract with DHCS. TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets, if any. The Health Authority's TNE was $208,640,786, $202,125,755, and $178,015,865 at June 30, 2020, 2019, and 2018, respectively. The Health Authority exceeded the minimum required TNE levels at all times during the three fiscal years.

CONDENSED RESULTS OF OPERATIONS:

	Fiscal Year			2020 to 2019 Change		2019 to 2018 Change	
	2020	2019	2018	Amount	% Change	Amount	% Change
Year end membership:							
Medi-Cal	244,888	237,698	248,776	7,190	3.0%	(11,078)	-4.5%
Cal Medi-Connect	8,987	8,022	7,503	965	12.0%	519	6.9%
Healthy Kids	-	3,486	3,196	(3,486)	-100.0%	290	9.1%
Total year end membership	253,875	249,206	259,475	4,669	1.9%	(10,269)	-4.0%
Annual member months:							
Medi-Cal	2,829,690	2,904,840	3,090,265	(75,150)	-2.6%	(185,425)	-6.0%
Cal Medi-Connect	101,391	92,838	96,513	8,553	9.2%	(3,675)	-3.8%
Healthy Kids	10,528	40,083	33,830	(29,555)	-73.7%	6,253	18.5%
Total annual member months	2,941,609	3,037,761	3,220,608	(96,152)	-3.2%	(182,847)	-5.7%
Operating revenues:							
Capitation and premium revenue	$ 1,147,826,608	$ 1,161,897,093	$ 1,329,112,179	$ (14,070,485)	-1.2%	$ (167,215,086)	-12.6%
Total operating revenues	1,147,826,608	1,161,897,093	1,329,112,179	(14,070,485)	-1.2%	(167,215,086)	-12.6%
Operating expenses:							
Medical expenses	1,036,714,518	979,947,150	1,162,181,837	56,767,368	5.8%	(182,234,687)	-15.7%
General and administrative expenses	57,442,133	54,419,879	45,893,851	3,022,254	5.6%	8,526,028	18.6%
Depreciation and amortization	3,370,268	3,816,251	3,548,003	(445,983)	-11.7%	268,248	7.6%
Premium tax	50,260,731	105,415,550	101,621,379	(55,154,819)	-52.3%	3,794,171	3.7%
Total operating expenses	1,147,787,650	1,143,598,830	1,313,245,070	4,188,820	0.4%	(169,646,240)	-12.9%
Operating income	38,958	18,298,263	15,867,109	(18,259,305)	-99.8%	2,431,154	15.3%
Nonoperating revenues:							
Interest and other income	6,476,073	5,811,627	3,768,195	664,446	11.4%	2,043,432	54.2%
Changes in net position	6,515,031	24,109,890	19,635,304	(17,594,859)	-73.0%	4,474,586	22.8%
Net position, beginning of year	202,125,755	178,015,865	158,380,561	24,109,890	13.5%	19,635,304	12.4%
Net position, end of year	$ 208,640,786	$ 202,125,755	$ 178,015,865	$ 6,515,031	3.2%	$ 24,109,890	13.5%

Membership and Enrollment

During the fiscal year ended June 30, 2020, the Health Authority experienced an increase in enrollment of 1.9% predominately Due to the County's suspension of Medi-Cal disenrollments during the COVID-19 public health emergency.

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

Operating Revenue

During the fiscal year ended June 30, 2020, operating revenues decreased by $14,070,485 or -1.2% to $1,147,826,608 versus the prior year operating revenue of $1,161,897,093. Much of the decrease was attributable to changes in enrollment and capitation rates.

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

Medical Expenses

During the fiscal year ended June 30, 2020, medical expenses increased by $56,767,368 or 5.9% to $1,036,714,518 versus the prior year of $979,947,150. Much of the increase was attributable to certain increases in capitation and fee-for-service expenses.

During the fiscal year ended June 30, 2019, medical expenses decreased by $182,234,687 or -15.7% to $979,947,150 versus the prior year of $1,162,181,837. Much of the decrease was attributable to the phase-out of IHSS from the CCI, which entail the MLTSS and the CMC program, effective January 1, 2018.

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 94.5%, 92.8%, and 94.7% for the fiscal years ended June 30, 2020, 2019, and 2018, respectively.

Premium Deficiency Reserve

During the fiscal year ended June 30, 2020, management maintained its estimated premium deficiency reserve ("PDR") on the CMC contract at $8,294,025 for fiscal year 2021 due to continuing uncertainties about final rate recasts for multiple fiscal years, shared risk corridor payments and hierarchical condition category ("HCC") risk adjustments, for which management cannot fully quantify the likelihood of these impacts.

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

General and Administrative Expenses

During the fiscal year ended June 30, 2020, general and administrative expenses increased by $3,022,254 or 5.3% to $57,442,133 versus the prior year expense of $54,419,879 due to increased staffing and increases in other expenses.

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

The Health Authority's administrative loss ratio ("ALR"), or general and administrative (including depreciation and amortization expense) as a percentage of capitation and premium revenue (including contra-revenue premium tax), was 5.5%, 5.5%, and 4.0% for the fiscal years ended June 30, 2020, 2019, and 2018, 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, 2020, 2019, and 2018:

	Fiscal Year			2020 to 2019 Change		2019 to 2018 Change	
	2020	2019	2018	Amount	% Change	Amount	% Change
Cash flows from operating activities	$ 30,887,730	$ 75,870,490	$ (130,630,635)	$ (44,982,760)	-59.3%	$ 206,501,125	-158.1%
Cash flows from capital and financing activities	(2,826,838)	(6,415,822)	(13,590,598)	3,588,984	-55.9%	7,174,776	-52.8%
Cash flows from investing activities	(193,407,282)	5,811,627	3,768,195	(199,218,909)	-3427.9%	2,043,432	54.2%
Net change in cash and cash equivalents	(165,346,390)	75,266,295	(140,453,038)	(240,612,685)	-319.7%	215,719,333	-153.6%
Cash and cash equivalents, beginning of year	299,117,154	223,850,859	364,303,897	75,266,295	33.6%	(140,453,038)	-38.6%
Cash and cash equivalents, end of year	$ 133,770,764	$ 299,117,154	$ 223,850,859	$ (165,346,390)	-55.3%	$ 75,266,295	33.6%

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

CONDENSED CAPITAL ASSET INFORMATION:

The table below summarizes the major changes in capital assets for the fiscal years ended June 30, 2020, 2019, and 2018. Capital assets largely included furniture and fixtures, computer hardware and software, and leasehold improvements:

	Fiscal Year Ended June 30,			2020 to 2019 Change		2019 to 2018 Change	
	2020	2019	2018	Amount	% Change	Amount	% Change
Beginning balance, net	$ 27,392,240	$ 24,269,369	$ 10,507,128	$ 3,122,871	12.9%	$ 13,762,241	131.0%
Additions	2,826,838	6,941,405	17,365,176	(4,114,567)	-59.3%	(10,423,771)	-60.0%
Reductions/adjustments	(199,722)	(2,283)	(54,932)	(197,439)	8648.2%	52,649	-95.8%
Depreciation and amortization expense	(3,370,268)	(3,816,251)	(3,548,003)	445,983	-11.7%	(268,248)	7.6%
Ending balance, net	$ 26,649,088	$ 27,392,240	$ 24,269,369	$ (743,152)	-2.7%	$ 3,122,871	12.9%

KEY FACTORS INFLUENCING THE FISCAL YEAR 2020-2021 BUDGET:

In June 2020, the Health Authority's Governing Board formally approved operating and capital budgets for the fiscal year ending June 30, 2021. The fiscal year 2021 operating budget anticipates enrollment growth of 5.5%, carve-out of pharmacy from Medi-Cal, modest changes in Medi-Cal capitation rates, and modest growth in operating expenses. The 2020 capital budget includes approximately $6.9 million for investments in facilities and information systems.

REQUESTS FOR INFORMATION

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

Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) ("Health Authority"), which comprise the statements of net position as of June 30, 2020 and 2019, 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.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the net position of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) as of June 30, 2020 and 2019, and the results in its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 7, supplementary schedule of proportionate share of the net pension asset/liability, supplementary schedule of pension contributions, supplementary schedules of changes in net other post-employment benefit liability, and supplementary schedule of other post-employment benefit contributions on pages 39 through 42 are not a required part of the financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of the Health Authority's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the financial statements, and other knowledge we obtained during our audits of the financial statements. We do not express an opinion or provide an assurance on the supplementary information because limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

San Francisco, California
_____, 2020

Financial Statements

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Net Position
June 30, 2020 and 2019

	2020	2019
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets		
Cash and cash equivalents	$ 133,770,764	$ 299,117,154
Investments	199,883,355	-
Premiums receivable	811,006,716	751,066,126
Prepaids and other assets	7,816,053	10,161,443
Total current assets	1,152,476,888	1,060,344,723
Capital assets, net		
Nondepreciable	4,074,349	4,136,236
Depreciable, net of accumulated depreciation and amortization	22,574,739	23,256,004
Total capital assets, net	26,649,088	27,392,240
Assets restricted as to use	305,350	305,350
Net pension asset	1,017,002	1,978,644
Other post-employment benefits asset	1,030,645	-
Total assets	1,181,478,973	1,090,020,957
Deferred outflows of resources	8,402,260	9,237,609
Total deferred outflows of resources	8,402,260	9,237,609
Total assets and deferred outflows of resources	$ 1,189,881,233	$ 1,099,258,566
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
Current liabilities		
Accounts payable and accrued liabilities	$ 13,010,770	$ 9,371,499
Amounts due to the State of California	104,429,798	53,143,088
In-home supportive services payable	419,268,582	416,092,526
Due to providers	345,356,397	316,691,672
Medical incurred but not reported claims and medical claims payable	84,105,151	82,355,017
Provider incentives and other medical liabilities	3,000,000	5,500,000
Premium deficiency reserves	8,294,025	8,294,025
Total current liabilities	977,464,723	891,447,827
Noncurrent liabilities		
Other post-employment benefits liability	-	2,539,090
Total liabilities	977,464,723	893,986,917
Deferred inflows of resources	3,775,724	3,145,894
Total deferred inflows of resources	3,775,724	3,145,894
Net position		
Net investment in capital assets	26,649,088	27,392,240
Restricted	305,350	305,350
Unrestricted:		
Designated by Governing Board	17,339,275	2,200,000
Unrestricted	164,347,073	172,228,165
Total net position	208,640,786	202,125,755
Total liabilities, deferred inflows of resources, and net position	$ 1,189,881,233	$ 1,099,258,566

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, 2020 and 2019

	2020	2019
Operating revenues		
Capitation and premium revenue	$ 1,147,826,608	$ 1,161,897,093
Total operating revenues	1,147,826,608	1,161,897,093
Operating expenses		
Medical expenses	1,036,714,518	979,947,150
Premium tax	50,260,731	105,415,550
General and administrative expenses	57,442,133	54,419,879
Depreciation and amortization	3,370,268	3,816,251
Total operating expenses	1,147,787,650	1,143,598,830
Operating income	38,958	18,298,263
Nonoperating revenues		
Interest and other income	6,476,073	5,811,627
Change in net position	6,515,031	24,109,890
Net position, beginning of year	202,125,755	178,015,865
Net position, end of year	$ 208,640,786	$ 202,125,755

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Cash Flows
For the Years Ended June 30, 2020 and 2019

	2020	2019
Cash flows from operating activities		
Capitation and premiums received	$ 1,087,886,018	$ 904,138,393
Medical expenses paid	(1,004,597,624)	(757,985,414)
Marketing, general, and administrative expenses paid	(52,400,664)	(70,282,489)
Net cash provided by operating activities	30,887,730	75,870,490
Cash flows from capital and financing activities		
Purchases of capital assets	(2,826,838)	(6,415,822)
Net cash used in capital and financing activities	(2,826,838)	(6,415,822)
Cash flows from investing activities		
Purchase of investments	(311,638,909)	-
Sale of investments	111,755,554	-
Interest collection on investments	6,476,073	5,811,627
Net cash (used in) provided by investing activities	(193,407,282)	5,811,627
Net change in cash and cash equivalents	(165,346,390)	75,266,295
Cash and cash equivalents, beginning of year	299,117,154	223,850,859
Cash and cash equivalents, end of year	$ 133,770,764	$ 299,117,154
Reconciliation of operating income to net cash provided by operating activities		
Operating income	$ 38,958	$ 18,298,263
Adjustments to reconcile operating income to net cash provided by operating activities		
Depreciation and amortization	3,370,268	3,816,251
Changes in operating assets and liabilities		
Premiums receivable	(59,940,590)	(257,758,700)
Prepaids and other assets	2,345,390	(3,136,471)
Net pension asset	961,642	(3,803,440)
Other post-employment benefits asset/liability	(3,569,735)	(2,169,628)
Deferred outflows of resources	835,349	5,297,641
Accounts payable and accrued liabilities	3,838,993	(10,987,909)
Amounts due to the State of California	51,286,710	28,713,110
In-home supportive services payable	3,176,056	2,542,975
Due to providers	28,664,725	300,736,688
Medical incurred but not reported claims and medical claims payable	1,750,134	4,265,370
Provider incentives and other medical liabilities	(2,500,000)	(8,880,857)
Deferred intlows of resources	629,830	(1,062,803)
Net cash provided by operating activities	$ 30,887,730	$ 75,870,490
Supplemental cash flow disclosure		
Cash paid during the year for premium tax	$ 26,353,887	$ 105,415,548
Supplemental disclosure of noncash item		
Payables for capital asset purchases	$ 257,855	$ 525,583

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 adults in Santa Clara County (the "County"). During 1996, SCFHP obtained licensure under the Knox-Keene Health Care Service Plan Act of 1975 and commenced operations. The financial statements are included in the County of Santa Clara's basic financial statements as a discretely presented component unit.

The Santa Clara Community Health Authority Joint Powers Authority ("JPA") is a licensed health maintenance organization that operates in the County. The County's Board of Supervisors established the JPA in October 2005 in accordance with the Code Section 14087.54. The JPA received its Knox-Keene license on May 11, 2006, and commenced operations on June 1, 2006. The Health Authority has advised the DMHC of its intent to surrender the JPA's license as of December 31, 2019 and the JPA ceased to exist on 12/31/19.

The following table presents certain combined financial statement captions as previously reported which combines the JPA with the Health Authority, and compares them to the current presentation which does not combine the JPA with the Health Authority as of and for the years ended June 30:

	2020		
	Health Authority with JPA	Health Authority without JPA	Difference
Total operating revenues	$ 1,149,827,409	$ 1,147,826,608	$ 2,000,801
Total operating expenses	$ 1,146,694,775	$ 1,147,787,650	$ (1,092,875)
Change in net position	$ 9,608,707	$ 6,515,031	$ 3,093,676

	2019		
	Health Authority with JPA	Health Authority without JPA	Difference
Total operating revenues	$ 1,161,897,093	$ 1,161,897,093	$ -
Total operating expenses	$ 1,143,598,830	$ 1,143,598,830	$ -
Change in net position	$ 24,109,890	$ 24,109,890	$ -

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

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

The Health Authority operates a Healthy Kids program to provide medical coverage to children of parents not otherwise eligible for the Medi-Cal program. All Health Kids members transitioned to Medi-Cal by December 31, 2019.

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 $0 and $105,415,548 in MCO premium taxes during fiscal years 2020 and 2019, respectively. At June 30, 2020 and 2019, the Health Authority had payables due in the amount of $48,615,420 and $26,353,889, respectively, included in Amounts due to the State of California.

Basis of accounting – The Health Authority is a governmental health insuring organization and, accordingly, follows principles, as prescribed by the Governmental Accounting Standards Board ("GASB"), the provisions of the American Institute of Certified Public Accountants Audit and Accounting Guide ("AICPA"), *Health Care Organizations*, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines. The Health Authority utilizes the proprietary fund method of accounting under which the 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 claims and medical claims payable, premiums receivable, fair market value of investments, net pension asset/liability, other post-employment benefits asset/liability, premium deficiency reserves, and useful lives of capital assets represent significant estimates. Actual results could differ from those estimates.

Cash and cash equivalents – The Health Authority considers all highly liquid instruments with a maturity of three months or less at the time of purchase to be cash equivalents. Cash and cash equivalents are carried at cost, which approximates fair value. At June 30, 2020 and 2019, the Health Authority's cash deposits and investment pool had carrying amounts of $133,770,764 and $299,117,154, respectively. The Health Authority's bank and investment pool balances at June 30, 2020 and 2019, including interests in an investment pool, were $344,500,631 and $306,584,080, respectively. Of the bank and investment pool balances at June 30, 2020 and 2019, $343,653,375 and $305,834,080, 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, 2020 and 2019.

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 $305,350 at June 30, 2020 and 2019.

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

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

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

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

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

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 benefit asset/liability – The Health Authority recognizes a net other post-employment benefit (“OPEB”) asset/liability, 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/liability is measured as of the Health Authority's prior fiscal year-end. Changes in the net OPEB asset/liability are recorded in the period incurred as OPEB expense and as deferred inflows of resources or deferred outflows of resources depending on the nature of the change. The changes in net OPEB asset/liability that are recorded as deferred inflows of resources or deferred outflows of resources are recognized in OPEB expense systematically over time.

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

Net position – Net position is classified as net investment in capital assets, restricted net position, 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, 2020, $17,339,275 was unexpended. In December 2018, the Health Authority's Governing Board designated $2,200,000 for board-designated investments, the specific composition and recipients of which will be determined at a later date.

Capitation and premium revenue – The Health Authority has agreements with the Medi-Cal Program in the state to provide certain health care products and services to enrolled Medi-Cal beneficiaries. Eligibility of beneficiaries is determined by Santa Clara County Social Services Agency and validated by the State of California. The State of California provides the Health Authority the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month. The Health Authority receives monthly premium payments from DHCS based on the number of enrolled Medi-Cal beneficiaries, regardless of services actually performed. Premiums are due from DHCS monthly and are recognized as revenue during the period in which the Health Authority is obligated to provide services to members. A portion of revenues received from DHCS is subject to possible retroactive adjustments. Provisions have been made for estimated retroactive adjustments. For the years ended June 30, 2020 and 2019, premium revenues recorded from DHCS under the Medi-Cal Program totaled $972,210,890 and $998,083,852, 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, 2020 and 2019, premium revenues totaled $34,839,647 and $30,482,500, and $141,653,083 and $129,063,173 for the Medi-Cal and Medicare components of the CMC program, respectively. According to Chapter 33, Statutes of 2013 (SB 78, Committee on Budget and Fiscal Review), premium tax is imposed on only the revenues received by MCOs through their Medi-Cal and Healthy Kids managed care plans; consequently, Medicare revenues are not subject to premium tax.

The Health Authority has an agreement with the County of Santa Clara to provide health care services to enrolled Healthy Kids beneficiaries. The Health Authority issues monthly invoices to the funding organization for its respective portion of premium costs for all Healthy Kids enrollees. Premiums are due monthly and are recognized as revenue in the period the Health Authority is obligated to provide medical services. A nominal monthly premium is invoiced directly to the family of the Healthy Kids enrolled child and recognized as revenue in the service month. Annual premium revenue for the Healthy Kids Program totaled $1,123,789 and $4,267,568 for the years ended June 30, 2020 and 2019, respectively, and were funded by County of Santa Clara. All Health Kids members transitioned to Medi-Cal by December 31, 2019.

Premium deficiency reserves – The Health Authority performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. The Health Authority entered into a three-way contract with CMS and the DHCS effective January 1, 2015, to participate in a demonstration project to integrate care for dual-eligible beneficiaries. The Contract shall be renewed in one-year terms through December 31, 2022. The Health Authority has the option to cancel this agreement prior to the end of each term. Management has estimated that it may incur losses on the contract. Accordingly, a premium deficiency reserve in the amount of $8,294,025 has been recorded at June 30, 2020 and 2019. 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, 2020 and 2019.

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, 2020, the Health Authority had premiums receivable of $787,273,372, $7,405,424, $17,972,777, and $454 due from Medi-Cal Program, CMC program, Medicare, and Healthy Kids Program, respectively. As of June 30, 2019, the Health Authority had premiums receivable of $734,627,346, $7,941,454, $7,812,105, and $685,221 due from Medi-Cal Program, CMC program, Medicare, and Healthy Kids Program, respectively.

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

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

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

New accounting pronouncements – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities* (“GASB 84”). GASB 84 provides improved guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. The statement also provides for recognition of a liability to the beneficiaries in a fiduciary fund when an event has occurred that compels the government to disburse fiduciary resources. 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 84 to reporting periods beginning after December 15, 2019. The Health Authority is reviewing the impact of the adoption of GASB 84 for the fiscal year ending 2021.

In June 2017, the GASB issued GASB 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 is reviewing the impact of the adoption of GASB 87 for the fiscal year ending 2022.

Reclassifications – Certain amounts in the 2019 financial statements have been reclassified to conform to the 2020 presentation. These reclassifications have no effect on the 2019 operating income or net position.

NOTE 2 – INVESTMENTS

At June 30, 2020, the Health Authority's investments consisted of money market funds, commercial paper, U.S. government agency bonds, corporate bonds, municipal bonds, asset back securities, commercial paper, and U.S. treasury securities.

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, 2020, 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, 2020:

Description	Fair value	AAA	AA	AA+	AA-	A	A+	A-1+	A-2
Investments in:									
U.S. government agency bonds	$ 101,825,363	$ 2,026,549	$ -	$ -	$ -	$ -	$ -	$ 99,798,814	$ -
Corporate bonds	34,790,027	2,047,076	-	-	2,015,254	7,982,729	22,744,968	-	-
Municipal bonds	9,018,771	-	2,560,532	1,681,741	-	-	761,476	4,015,022	-
Asset-backed securities	1,203,170	1,203,170	-	-	-	-	-	-	-
Commerical paper	10,995,235	-	-	-	-	-	-	10,995,235	-
U.S. treasury securities	42,050,789	18,358,657	-	-	-	-	-	23,692,132	-
Total investments	$ 199,883,355	$ 23,635,452	$ 2,560,532	$ 1,681,741	$ 2,015,254	$ 7,982,729	$ 23,506,444	$ 138,501,203	$ -

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 Alliance's investments as a percentage of its portfolio at June 30, 2020 were as follows:

Investment	Issuer	Percentage of portfolio
U.S. government agency bonds	Various	50.0 %
Corporate bonds	Various	17.0
Municipal bonds	Various	5.00
Asset-backed securities	Various	1.0
Commerical paper	Various	6.0
U.S. treasury securities	Various	21.0
		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, 2020:

Description	Level 1	Level 2	Level 3	2020
Investments in:				
U.S. government agency bonds	$ -	$ 101,825,363	$ -	$ 101,825,363
Corporate bonds	-	34,790,027	-	34,790,027
Municipal bonds		9,018,771		9,018,771
Asset-backed securities	-	1,203,170	-	1,203,170
Total investments subject to fair value hierarchy	$ -	$ 146,837,331	$ -	$ 146,837,331
Investments and restricted cash not subject to fair value hierarchy				
Commerical paper				10,995,235
U.S. treasury securities				42,050,789
Certificate of deposits				305,350
Total investments and restricted cash				$ 200,188,705

NOTE 4 – CAPITAL ASSETS

Capital asset activity for the fiscal years ended June 30, 2020 and 2019, are as follows:

	2020				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ 3,507,578	$ -	$ -	$ -	$ 3,507,578
Furniture and equipment	11,983,493	849,663	(6,290)	(184,611)	12,642,255
Building and building improvements	17,267,569	1,568,598	(12,565)	184,611	19,008,213
Software	11,342,155	408,577	(150,207)	31,227	11,631,752
Vehicles	29,248	-	-	-	29,248
Software work in progress	61,887	-	(30,660)	(31,227)	-
Building improvements work in progress	566,771	-	-	-	566,771
Total capital assets	44,758,701	2,826,838	(199,722)	-	47,385,817
Less accumulated depreciation and amortization for:					
Furniture and equipment	9,647,338	621,469	592,056	-	10,860,863
Leasehold improvements	592,056	-	(592,056)	-	-
Building and building improvements	755,003	802,915	-	-	1,557,918
Software	6,365,158	1,941,009	-	-	8,306,167
Vehicles	6,906	4,875	-	-	11,781
Total accumulated depreciation and amortization	17,366,461	3,370,268	-	-	20,736,729
Capital assets, net	$ 27,392,240	$ (543,430)	$ (199,722)	$ -	$ 26,649,088

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

Depreciation and amortization expense totaled $3,370,268 and $3,816,251 at June 30, 2020 and 2019, respectively.

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

The Health Authority estimates medical incurred but not reported ("IBNR") claims and medical claims payable based on historical claims payment and other relevant information. Estimates are monitored and reviewed and, as settlements are made or estimates are adjusted, differences are reflected in current operations. Such estimates are subject to impact of changes in the regulatory environment. Activity for medical IBNR and medical claims payable for the years ended June 30, 2020 and 2019, is summarized as follows:

	2020	2019
Beginning balance	$ 82,355,017	$ 78,089,647
Incurred related to:		
Current year	609,184,841	584,499,785
Prior year	(12,867,896)	(12,368,761)
Total incurred	596,316,945	572,131,024
Paid related to:		
Current year	529,237,516	503,819,454
Prior year	65,329,295	64,046,200
Total paid	594,566,811	567,865,654
Ending balance	$ 84,105,151	$ 82,355,017

As presented in the table above, $596,316,945 and $572,131,024 in medical claims were incurred at June 30, 2020 and 2019, respectively, which are reflected in medical services in the statements of revenues, expenses, and changes in net position.

Claims payable liability increased by $8,963,079 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, 2020 and 2019, board-designated funds of $17,339,275 and $2,200,000, respectively, were made.

NOTE 7 – OPERATING LEASE OBLIGATIONS

The Health Authority leases the Blanca Alvarado Community Resource Center (scheduled to open in October 2020) and various equipment leases expiring in various years.

Future minimum lease payments as of June 30, 2020, consist of the following:

Years Ending June 30,	
2021	$ 242,209
2022	189,886
2023	189,886
2024	189,886
2025	189,886
Thereafter	31,648
Total minimum lease payments	$ 1,033,401

Rent expense, included in general and administrative expenses in the statements of revenues, expenses, and changes in net position, for the years ended June 30, 2020 and 2019, was $23,923 and $171,779, respectively.

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. For employees hired prior to January 1, 2013, participants must contribute 6% of their gross compensation and the Health Authority must contribute 3% of the participant's gross compensation. For employees hired on or after January 1, 2013, participants must contribute 6.25% of their gross compensation within a specific range and the Health Authority must contribute 6.533% of the participant's gross compensation with the same specific range. For senior staff employees, the Health Authority contributes greater than 3% of gross compensation and senior staff employees contribute less than 6% of their gross compensation. Contributions by the Health Authority totaled $656,347 and $716,716 for the years ended June 30, 2020 and 2019, 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 was 8.00% of annual covered payroll for both the years ended June 30, 2020 and 2019. All eligible participating employees are required to contribute 7.00% of their monthly salaries to CalPERS. The Health Authority deducts the contributions from employees' wages and remits to CalPERS on their behalf and for their account. Contributions to the pension plans from the Health Authority were $2,058,408 and $1,669,920 for the years ended June 30, 2020 and 2019, respectively.

Pension asset/liability, pension expense, and deferred outflows of resources and deferred inflows of resources related to pension – The net pension asset at June 30, 2020, is measured as of June 30, 2019, using an annual actuarial valuation as of June 30, 2018, rolled forward to June 30, 2019, using standard update procedures. The total pension asset in the June 30, 2018 actuarial valuation was based on the following actuarial methods and assumptions:

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

The net pension asset at June 30, 2019, is measured as of June 30, 2018, using an annual actuarial valuation as of June 30, 2017, rolled forward to June 30, 2018, using standard update procedures. The total pension asset in the June 30, 2017 actuarial valuation was based on the following actuarial methods and assumptions:

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

All other actuarial assumptions used in the June 30, 2018 and 2017 valuation were based on the results of an actuarial experience study for the fiscal years 1997 to 2011, including updates to salary increase, mortality, and retirement rates. The experience study report can be obtained at the CalPERS' website under Forms and Publications.

Change of assumptions – The inflation rate remained unchanged at 2.50% for the June 30, 2019 measurement date. The discount rate decreased from 2.75% to 2.50% for the June 30, 2018 measurement date.

Discount rate – The discount rate used to measure the total pension asset at June 30, 2020 and 2019, measurement date was 7.15%. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. The test revealed the assets would not run out. Therefore, the current 7.15% discount rate is appropriate and the use of the municipal bond rate calculation is not deemed necessary. The long-term expected discount rate of 7.15% is applied to all plans in the Public Employees Retirement Fund. The cash flows used in the testing were developed assuming that both members and employers will make their required contributions on time and as scheduled in all future years. The stress test results are presented in a detailed report called "GASB Crossover Testing Report" that can be obtained from the CalPERS website.

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

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

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

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

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

Sensitivity of the employer's proportionate share of the net pension asset/liability to changes in the discount rate – The following presents the Health Authority's net pension asset/liability as of June 30, 2020 and 2019, 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, 2020		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Health Authority's net pension (asset) liability	$ 5,574,335	$ (1,017,002)	$ (6,457,686)

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

The Health Authority's proportion for the miscellaneous plan was -0.00992% and -0.02053% at June 30, 2020 and 2019, respectively.

For the years ended June 30, 2020 and 2019, the Health Authority recognized pension expense of $2,924,828 and $1,122,685, respectively. Pension expense represents the change in the net pension asset/liability during the measurement period, adjusted for actual contributions and the deferred recognition of changes in investment gain/loss, actuarial gain/loss, actuarial assumptions or method, and plan benefits.

As of June 30, 2020, the Health Authority had $5,296,371 of deferred outflows of resources and $1,661,827 of deferred inflows of resources related to pensions from the following sources:

	2020	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 686,603	$ (1,245,899)
Difference in experience	5,473	(70,635)
Differences between employer's actual contributions and its proportionate share of total employer contributions	2,510,916	(296,798)
Net differences between projected and actual earnings on pension plan investments	17,780	-
Changes in assumptions	17,191	(48,495)
Pension contributions made subsequent to measurement date	2,058,408	-
	$ 5,296,371	$ (1,661,827)

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

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

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 $2,058,408 and $1,669,920 resulting from contributions subsequent to the measurement date will be recognized as a reduction of the net pension asset/liability in the years ending June 30, 2020 and 2019, 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,	
2021	$ 839,934
2022	$ 636,843
2023	$ 102,952
2024	$ (3,593)

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, 2020 and 2019, the following employees were covered by the plan:

	2020	2019
Active	238	232
Retirees	54	55
Total participants	292	287

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/liability – The Health Authority's net OPEB asset/liability at June 30, 2020 and 2019, was measured as of June 30, 2019 and 2018, respectively, and the total OPEB asset/liability used to calculate the net OPEB asset/liability was determined by an actuarial valuation as of June 30, 2019 and 2018, respectively.

The total OPEB asset in the June 30, 2019, actuarial valuation was determined using the following actuarial assumptions:

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

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

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

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

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

Discount rate – The discount rate used to measure the total OPEB asset/liability was 6.75% at both June 30, 2019 and 2018, measurement dates. The projection of cash flows used to determine the discount rate assumed that Health Authority contributions will be made at rates equal to the actuarially determined contribution rates. Based on those assumptions, the OPEB plan's fiduciary net position was projected to be available to make all projected OPEB payments for current active and inactive employees. Therefore, the long-term expected rate of return on OPEB plan investments was applied to all periods of projected benefit payments to determine the total OPEB asset/liability.

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

Asset Class	Asset Allocation	Expected Real Rate of Return
Global equity	59.00%	4.82%
Fixed Income	25.00%	1.47%
Treasury inflation-protected securities	5.00%	1.29%
Commodities	3.00%	0.84%
Real estate investment trusts	8.00%	3.76%
Assumed long-term rate of inflation		2.75%
Expected long-term net rate of return		6.75%

Changes in the net OPEB asset/liability – The changes in the net OPEB asset/liability for the years ended June 30, 2020 and 2019, were as follows:

	June 30, 2020		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability (Asset)
Balance at June 30, 2019	$ 12,492,170	$ 9,953,080	$ 2,539,090
Changes during the year:			
Service cost	1,089,286	-	1,089,286
Interest on the total OPEB liability	901,963	-	901,963
Actual vs. expected experience	(2,076,281)	-	(2,076,281)
Assumption changes	(90,590)	-	(90,590)
Contributions from employer	-	2,601,369	(2,601,369)
Net investment income	-	795,021	(795,021)
Benefit payments	(438,081)	(438,081)	-
Administrative expense	-	(2,277)	2,277
Net change	(613,703)	2,956,032	(3,569,735)
Balance at June 30, 2020	$ 11,878,467	$ 12,909,112	$ (1,030,645)

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

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability of the Health Authority as of June 30, 2020 and 2019, as well as what the Health Authority's net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current discount rate:

	June 30, 2020		
	1% Decrease (5.75%)	Current Discount Rate (6.75%)	1% Increase (7.75%)
Health Authority's net OPEB (asset) liability	$ 676,268	$ (1,030,645)	$ (2,428,373)

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

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

	June 30, 2020		
	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	$ (2,684,513)	$ (1,030,645)	$ 1,053,799

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

OPEB expense and deferred outflows of resources and deferred inflows of resources related to OPEB – For the year ended June 2020, the Health Authority recognized OPEB expense of $1,008,809. At June 30, 2020, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2020	
	Deferred outflows of resources	Deferred inflows of resources
Difference in experience	$ -	$ (1,876,357)
Net differences between projected and actual earnings on pension plan investments	-	(156,101)
Changes in assumptions	87,746	(81,439)
OPEB contributions made subsequent to measurement date	3,018,143	-
	$ 3,105,889	$ (2,113,897)

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

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

The Health Authority reported $3,018,143 and $2,601,369 as deferred outflows of resources related to contributions made subsequent to the measurement date for the years ended June 30, 2020 and 2019. This amount will be recognized as a reduction of net OPEB asset/liability in the years ended June 30, 2021 and 2020, 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,	
2021	$ (266,234)
2022	$ (266,236)
2023	$ (225,980)
2024	$ (221,191)
2025	$ (205,885)
Thereafter	$ (840,625)

Payable to the OPEB plan – At June 30, 2020 and 2019, the Health Authority had no outstanding amount of contributions to the OPEB plan required for the years ended June 30, 2020 and 2019.

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 $248,999 and $2,479,214 in 2020 and 2019, 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 $32,471,000 and $30,887,000 at June 30, 2020 and 2019, respectively. The Health Authority's tangible net equity was $208,640,786 and $202,125,755 at June 30, 2020 and 2019, respectively.

NOTE 10 – RISK MANAGEMENT

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

NOTE 11 – COMMITMENTS AND CONTINGENCIES

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

NOTE 12 – HEALTH CARE REFORM

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

Supplementary Information

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

	2020	2019	2018	2017	2016	2015
Measurement period	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Proportion of the net pension (asset) liability	-0.00992%	-0.02053%	0.01840%	0.07925%	0.07311%	0.07849%
Proportionate share of the net pension (asset) liability	$ (1,017,002)	$ (1,978,644)	$ 1,824,796	$ 6,857,370	$ 5,018,386	$ 4,883,971
Covered-employee payroll*	$ 23,706,126	$ 19,966,458	$ 16,512,291	$ 11,010,647	$ 7,427,745	$ 9,121,825
Proportionate share of the net pension (asset) liability as a percentage of covered-employee payroll	-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	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

	2020	2019	2018	2017	2016	2015
Measurement period	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Actuarially determined contribution	$ 2,058,408	$ 1,669,920	$ 1,198,065	$ 1,287,320	$ 910,906	$ 886,335
Contributions in relation to the actuarially determined contribution	2,058,408	1,669,920	4,426,715	7,188,179	910,906	886,335
Contribution excess	$ -	$ -	$ (3,228,650)	$ (5,900,859)	$ -	$ -
Covered-employee payroll*	$ 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	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

	2020	2019	2018	2017
Measurement period	2018-2019	2017-2018	2016-2017	2015-2016
Total OPEB liability				
Service cost	$ 1,089,286	$ 1,119,648	$ 756,248	$ 736,008
Interest on the total OPEB liability	901,963	805,036	708,213	648,807
Actual vs. expected experience	(2,076,281)	-	(14,700)	-
Assumption changes	(90,590)	-	131,618	-
Benefit payments	(438,081)	(478,669)	(542,029)	(499,704)
Net change in total OPEB liability	(613,703)	1,446,015	1,039,350	885,111
Total OPEB liability, beginning of year	12,492,170	11,046,155	10,006,805	9,121,694
Total OPEB liability, end of year	$ 11,878,467	$ 12,492,170	$ 11,046,155	$ 10,006,805
Plan fiduciary net position				
Contributions from employer	$ 2,601,369	$ 3,588,109	$ 1,142,027	$ 954,155
Net investment income	795,021	518,470	551,777	283,871
Benefit payments	(438,081)	(478,669)	(542,029)	(499,704)
Administrative expense	(2,277)	(12,267)	(2,784)	(2,239)
Net change in plan fiduciary net position	2,956,032	3,615,643	1,148,991	736,083
Plan fiduciary net position, beginning of year	9,953,080	6,337,437	5,188,446	4,452,363
Plan fiduciary net position, end of year	$ 12,909,112	$ 9,953,080	$ 6,337,437	$ 5,188,446
Health Authority's net OPEB (asset) liability	$ (1,030,645)	$ 2,539,090	$ 4,708,718	$ 4,818,359
Plan fiduciary net position as a percentage of the total OPEB liability	108.68%	79.67%	57.37%	51.85%
Covered-employee payroll*	$ 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	-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

	2020	2019	2018	2017
Measurement period	2018-2019	2017-2018	2016-2017	2015-2016
Actuarially determined contribution	$ 1,062,967	$ 1,269,369	$ 1,427,237	$ 1,217,313
Contributions in relation to the actuarially determined contribution	3,018,143	2,601,369	3,588,109	1,217,313
Contribution excess	$ (1,955,176)	$ (1,332,000)	$ (2,160,872)	$ -
Covered-employee payroll*	$ 26,732,488	$ 24,360,228	$ 20,046,373	$ 17,195,643
Contributions as a percentage of covered-employee payroll	11.29%	10.68%	17.90%	7.08%

*For the fiscal year ending on the date shown

Communication with
Those Charged with Governance

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

June 30, 2020

Communication with Those Charged with Governance

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) ("Health Authority"), as of and for the year ended June 30, 2020, and have issued our report thereon dated _____, 2020. 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 5, 2020, our responsibility, as described by professional standards, is to form and express an opinion about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Our audit of the financial statements does not relieve you or management of your responsibilities.

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

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

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to management, who has been charged by the Governing Board to oversee the audit, during our pre-audit planning meeting on April 28, 2020.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Health Authority are described in Note 1 to the financial statements. No new accounting policies were adopted and there were no changes in the application of existing policies during 2020. 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 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 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'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") liability is actuarially determined using assumptions on the long-term rate of return on OPEB plan assets, the discount rate used to determine the present value of benefit obligations, and changes in healthcare costs. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

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

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

Financial Statement Disclosures

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

Significant Difficulties Encountered in Performing the Audit

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

Corrected and Uncorrected Misstatements

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

Disagreements with Management

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

Management Representations

We have requested certain representations from management that are included in the management representation letter dated _____, 2020.

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.

Independence

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

Other Significant Audit Findings or Issues

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

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

San Francisco, California
_____, 2020

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, August 27, 2020, 11:30 PM – 1:30 PM
Santa Clara Family Health Plan - Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

Minutes

Members Present
Dolores Alvarado, Chair
Bob Brownstein
Dave Cameron

Members Absent
Sue Murphy
Liz Kniss

Staff Present
Christine Tomcala, Chief Executive Officer
Neal Jarecki, Chief Financial Officer
Laurie Nakahira, D.O., Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Chris Turner, Chief Operating Officer
Ngoc Bui-Tong, VP, Strategies & Analytics
Teresa Chapman, VP, Human Resources
Laura Watkins, VP, Marketing & Enrollment
Barbara Granieri, Controller
Tyler Haskell, Director, Government Relations and Interim Compliance Officer
Johanna Liu, Director, Quality & Process Improvement
Jayne Giangreco, Manager, Administrative Services
Rita Zambrano, Executive Assistant

Others Present
Carlyn Obringer, Government & Community Engagement Manager at Blue Shield of California

1. **Roll Call**

   Dolores Alvarado, Chair, called the meeting to order at 11:32 am. Roll call was taken and a quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Adjourn to Closed Session**
   a. **Contract Rates**
      The Executive/Finance Committee met in Closed Session to discuss plan partner rates.

4. **Report from Closed Session**

   Ms. Alvarado reported the Executive/Finance Committee met in Closed Session to discuss plan partner rates.

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

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

   a. Approve minutes of the **July 23, 2020 Executive/Finance Committee** meeting
   b. Approve the **Quarterly Investment Compliance Report**
   c. Accept the **Network Detection and Prevention Update**

d. Approve the **Fiscal Year 2020-2021 Plan Objectives**

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

Motion: Mr. Brownstein
Second: Mr. Cameron
Ayes: Ms. Alvarado, Mr. Brownstein, Mr. Cameron
Absent: Ms. Murphy, Ms. Smith

6. CEO Update

Ms. Tomcala reported that Jordan Yamashita, Compliance Officer, has left the Plan and Tyler Haskell, Director, Government Relations, has agreed to serve as Interim Compliance Officer until the position is filled.

Ms. Tomcala provided an overview of COVID-19 data, noting DHCS' request in March 2020, and the Plan's subsequent request to provider partners and the County. She noted the data received has improved, and work continues with provider partners in an effort to have complete and consistent data.

Ms. Tomcala shared a status update on the Community Resource Center (CRC), noting occupancy is projected for mid-October.

7. Partnering on Race & Health Disparities Initiative

Tyler Haskell, Director, Government Relations, discussed a recent Board of Supervisors' referral, which directed the County Health System to create a plan addressing disparities in health care outcomes that exist among different racial groups in the County. Since the referral named SCFHP as a potential collaborator, Mr. Haskell used the public comment period at a recent Board of Supervisors (BOS) meeting to communicate some of the Plan's actions in this area to the BOS. He mentioned our use of data analysis to find disparities, our work with certain community leaders, our work with the County's Black Infant Health program, our plans to join a Stanford collaborative seeking to reduce disparities in COVID testing, and our plans to improve diabetes screening for our Latino population.

Discussion ensued regarding opportunities for transformational change.

8. Government Relations Update

Mr. Haskell presented an update on federal and state legislative and administrative developments. Mr. Haskell discussed eight bills and their respective impacts on Medi-Cal, should they become law. He announced that the Department of Health Care Services will no longer be pursuing a Long-Term Care At Home benefit. He also discussed a new statewide COVID testing program announced by the Governor, which aims to provide shorter results turnaround times and increase the overall volume of tests at a relatively low unit cost. Mr. Haskell gave an update about the next possible federal legislative COVID response, which has been on hold due to lack of consensus in the Senate Majority. Relatedly, the County is awaiting federal and state action before taking its own final actions on the County budget. However, recently, it officially passed a County budget for the 2020-2021 fiscal year and took some steps to reduce its budget deficit by deleting vacant positions.

9. Compliance Update

Mr. Haskell, Interim Compliance Officer, presented an update on recent and ongoing compliance audits. The Plan is in the final stages of the CMS Program Audit revalidation, during which we will validate our compliance in two remaining areas: Case Management and Grievances and Appeals. The data revalidation audit of the Case Management conditions will take place on Monday, August 31, while the field work for the Grievances and Appeals conditions will begin in September. Mr. Haskell announced that the Plan recently received the final annual DHCS audit report, which showed a total of six findings, which is down from 14 in last year's audit.

10. June 2020 Financial Statements

Neal Jarecki, Chief Financial Officer, presented the pre-audit June 2020 financial statements, which reflected a current month net surplus of $5 million ($4.5 million favorable to budget) and a fiscal year-to-date net surplus of $7.1 million ($627 thousand unfavorable to budget).

Enrollment increased by 4,382 members from the prior month to 253,875 members (17,030 favorable to the FY20 budget of 236,845). The Plan has seen recent growth due to (1) DHCS' direction to Counties to suspend Medi-Cal disenrollment's during COVID (which has increased enrollment by approximately 4,000 members per month beginning in March), (2) a small increase in Medi-Cal enrollment due to COVID but not associated with suspended disenrollment's, and (3) new undocumented Medi-Cal Adult members (beginning in February). CMC enrollment has increased due to continued outreach efforts.

Revenue reflected a favorable current month variance of $610 thousand (0.7%) due largely to a combination of higher enrollment, FY20 capitation rates in excess of budget, higher supplemental Medi-Cal revenues, increased Prop 56 revenue (offset by higher Prop 56 medical expense), and revisions to Medicare estimates, reduced by the retroactive 1.5% retroactive Medi-Cal rate decrease for FY20.

Medical expense reflected a favorable current month variance of $7.0 million (8.5%) due to a combination of higher enrollment, certain higher fee-for-service expenses versus budget, changes to estimates, and increased Prop 56 expense (offsetting higher Prop 56 revenue).

Administrative expense reflected a favorable current month variance of $160 thousand (2.9%) due largely to certain non-personnel expenses lower than budgeted.

The balance sheet reflected a current ratio of 1.25:1, versus the minimum required by DMHC of 1.0:1. Tangible Net Equity was $209.2 million, which represented approximately two months of the Plan's total monthly expenses. Within TNE, Unrestricted Net Assets represented $165.1 million. Year-to-date capital investments of $2.5 million were comprised largely of building improvements and I.T. hardware & software.

Mr. Jarecki noted that the year-end financial audit is currently ongoing. The Plan's auditors, Moss Adams LLP, will present the final financial results at the October 2020 Executive/Finance meeting.

It was moved, seconded, and the June 2020 Financial Statements were **unanimously approved.**

Motion: Mr. Brownstein
Second: Mr. Cameron
Ayes: Ms. Alvarado, Mr. Brownstein, Dave Cameron
Absent: Ms. Kniss, Ms. Murphy

Ms. Alvarado noted she will leave the meeting early and requested that agenda items 13 & 14 be brought forward for review.

11. COVID-19 Funding Request

Ms. Tomcala reviewed and discussed the East Side Access: Community Wireless Project funding request, noting the project will build a Wi-Fi infrastructure to provide free broadband access to East Side families and community members who otherwise are challenged to schedule medical appointments and engage in telehealth services, as well as complete job applications on-line, among other basic needs. The request is for $150,000 ($50,000/year for three years) starting in September 2020 through September 2022.

It was moved, seconded, and the East Side Access: Community Wireless Project funding request was **unanimously approved.**

Motion: Mr. Brownstein
Second: Ms. Alvarado
Ayes: Ms. Alvarado, Mr. Brownstein, Mr. Cameron
Absent: Ms. Kniss, Ms. Murphy

12. Ballot Measure Support Proposal

Bob Brownstein, Board Member, presented a proposal to support Proposition 16, which would repeal Proposition 209 and remove the ban on affirmative action from the California Constitution. This ban currently prohibits state government institutions from considering race, sex, or ethnicity, specifically in the areas of public employment, public contracting, and public education.

The California Legislature passed legislation in 2020, resulting in Proposition 16, the Repeal Proposition 209

Affirmative Action Amendment, which is on the November 3, 2020 ballot. The federal law would become the controlling authority on affirmative action in California. Federal courts ruled racial quotas and point systems in higher education admissions are unconstitutional and have upheld narrowly tailored programs designed to serve a compelling state interest (such as educational diversity).

It was moved, seconded, and unanimously approved to adopt a resolution to endorse Proposition 16, the Repeal Proposition 209 Affirmative Action Amendment, on the November ballot, and to direct staff to inform the Proposition 16 campaign of SCFHP's endorsement.

Motion: Mr. Brownstein
Second: Ms. Alvarado
Ayes: Ms. Alvarado, Mr. Brownstein, Mr. Cameron
Absent: Ms. Kniss, Ms. Murphy

Dolores Alvarado left the meeting at 1:17 pm.

Mr. Brownstein resumed the meeting and noted that the remaining topics would be a discussion only, due to lack of a quorum.

13. Fiscal Year 2019-2020 Team Incentive Compensation

Ms. Tomcala highlighted Plan performance on the FY'19-'20 Team Incentive Compensation measures. The team met the target of no more than four measures below the 50th percentile in Medi-Cal HEDIS, exceeded the target for CMC HEDIS with a composite average of 71.72%, exceeded the Medi-Cal member call performance target with an average speed of answer of 62 seconds, and achieved the minimum payout tier on Compliance with 93.8% of dashboard metrics in compliance during the fiscal year.

Ms. Tomcala noted the payout is contingent on a net operating surplus on the audited financial statements for the fiscal year, which is anticipated. She acknowledged upcoming financial challenges as a result of COVID-19 budget impacts, and also discussed reasons for recommending Board approval of a payout, due to the commitment to staff and hard work undertaken to achieve the performance metrics. Dave Cameron, Board Member, noted based on everything that had to be done, and given the circumstances, this is an outstanding achievement. Mr. Brownstein concurred and pointed out these were genuinely challenging targets, staff worked hard to reach them, and to the extent the Plan has the resources, staff should receive the incentive compensation. Ms. Tomcala thanked them for their input.

14. Fiscal Year 2020-2021 Team Incentive Compensation

Ms. Tomcala put forward a FY'20-'21 Team Incentive Compensation proposal for consideration. She spoke to the three proposed measures, and discussed scaling back the payout opportunity to 3% given the financial impact of the pandemic. The potential payout would exclude the executive team.

Mr. Brownstein indicated the proposal was appropriate, and suggested if the Plan is financially challenged at the end of next fiscal year, consideration could be given to carrying over the payout to the next fiscal year. Mr. Cameron expressed support for the recommendation, recognizing the need to motivate staff to meet all these objectives as the bar is raised on Plan performance expectations. Ms. Tomcala thanked the committee members for their feedback.

15. Adjournment

The meeting was adjourned at 1:29 pm.

_____
Susan G. Murphy, Secretary

SCFHP's COVID-19 Responses – October 13, 2020

Group	Focus Area	Activities and Metrics
Members	Statistics	Data as of 10/13; includes data from Kaiser and VMC, but not VHP (for non-VMC users) • 2,343 members positive • Cumulatively 897 members hospitalized • 63 deceased (34 SNF and 29 non-SNF), representing 17% of County-reported total (total membership equals about 12% of the County population)
	Call Center	• Call volume down 6.4% week of 10/5 vs prior year average • Average wait time of 21 seconds for CMC and 129 seconds for Medi-Cal
	Nurse Advice Line	• 333 Nurse Advice Line calls regarding coronavirus as of 10/13 • 924 members created and activated MDLIVE accounts as of 9/30 • 775 members have completed an MDLIVE visit with a provider as of 9/30
	Grievance and Appeals	• 54 COVID-19 related grievances (Rx access due to provider office closed; transportation safety concerns, employment concerns) as of 10/13.
	Outreach to Vulnerable Populations	• Mailed flyer telling members we are here for them, to visit our website for information on resources and support, reiterate CDC's guidelines to stay safe, to call the nurse advice line for health questions, and call Customer Service for all other help. • Robo-calls to high risk members telling them they may be more vulnerable to COVID-19, reiterate CDC's guidelines to stay safe, call doctor for health questions or call nurse advice line, visit our website for more information on resources and support, and call Customer Service for questions. • Outbound calls: o To pregnant & post-partum population, asking how they are doing and if they need any help. o To members age 65+ with multiple chronic conditions, asking how they are doing and if they need any help. o To newly enrolled members:

Group	Focus Area	Activities and Metrics
		▪ Case Management (CM) outreached and informed 1,719 members about COVID resources o To annual re-assessed members: ▪ CM outreached and informed 2,920 members about COVID resources o To members recently discharged after COVID hospitalizations: ▪ CM outreached 16 members of our Transitions of Care program who were recently discharged after COVID hospitalizations o To Behavioral Health/SMI members: ▪ Behavioral Health outreached 207 members
	Pharmacy	• Refills available via mail-order for 90 day fills; pharmacy overrides to allow early refills • Formulary expanded to include disinfectant and gloves
	Transportation	• Lifted requirement to provide Customer Service notice 3-5 business days before medical appointment to arrange transportation (NMT and NEMT). Reinstated in early July for non-COVID-related appointments. • Amended agreements with two vendors to make special accommodations and cleaning relating to transporting suspected or confirmed COVID members
	Communications to Members	• Developed new webpage; published 31 member news updates • April newsletter includes infographics on do's and don'ts of coronavirus and five steps to clean hands • July newsletter includes telehealth and our commitment to member's health and safety (including a reminder to follow CDC guidelines to prevent the spread of coronavirus) • Facebook posts in April through October to include more information on coronavirus precautions and getting preventive care • Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Cal MediConnect was discontinued for 2020. Surveys were mailed out but no additional phone outreach will be conducted by the vendor.
	Eligibility Redetermination	• State and counties have paused redeterminations from mid-March through October for beneficiaries with a change in status (affects approximately 3-5k SCFHP members each month who otherwise would have lost their eligibility), so these members will not lose eligibility • SCFHP enrollment will be temporarily elevated April – October, and will fall as the pause is lifted

<table>
<tr><th>Group</th><th>Focus Area</th><th>Activities and Metrics</th></tr>
<tr><td rowspan="4">Providers</td><td>Prior Authorizations</td><td>• Suspended SCFHP requirement for all prior authorizations for network providers to decrease burden on providers; resumed authorizations on 5/1
• Delegates are following their own prior authorization guidelines</td></tr>
<tr><td>Telehealth</td><td>• Regulations during state of emergency allow provider reimbursement, with specific coding and documentation requirements
• Added capability for Nurse Advice Line to offer members telephonic physician consultation
• Communication sent to BHT providers with guidelines</td></tr>
<tr><td>CBAS centers</td><td>• All five contracted CBAS centers submitted operations plans to the State outlining Temporary Alternative Services (TAS) they have been providing.
• All of the CBAS centers has had their operational plans approved by CDA. Internal monitoring of these TAS indicate successful implementation of the plans.</td></tr>
<tr><td>Skilled Nursing Facilities</td><td>• SCFHP has requested that hospitals divert non-LTC and non-COVID-positive members away from facilities with three or more COVID positives.
<table>
<tr><th>LTC</th><th># Positive</th><th>Expired</th><th>Total Beds</th><th>STAR Rating</th></tr>
<tr><td>Almaden Health…</td><td>2</td><td>1</td><td>77</td><td>5</td></tr>
<tr><td>Mission De La Casa</td><td>2</td><td>0</td><td>163</td><td>4</td></tr>
<tr><td>The Villas</td><td>1</td><td>1</td><td>85</td><td>3</td></tr>
<tr><td>Gilroy HRC</td><td>33</td><td>8</td><td>134</td><td>4</td></tr>
<tr><td>San Tomas Convalescent</td><td>5</td><td>1</td><td>130</td><td>4</td></tr>
<tr><td>Dycora</td><td>1</td><td>0</td><td>116</td><td>5</td></tr>
<tr><td>A Grace Subacute & Skilled</td><td>1</td><td>0</td><td>166</td><td>3</td></tr>
<tr><td>Woodlands HCC</td><td>1</td><td>5</td><td>65</td><td>4</td></tr>
</table>
• # Positive = Current (w/14 days). Expired = Cumulative & relating or subsequent COVID-positive reporting.</td></tr>
</table>

Group	Focus Area	Activities and Metrics
		• SCFHP identified and reached out to three of the contracted SNFs hard-hit by COVID patients asking what staff support would be helpful. In response, a meal was delivered for all staff at two SNFs. • Public Health Dept disallowed SNFs from unilaterally refusing patients who test positive for COVID-19 • Produced "Healthcare Heroes" flyers for contracted SNFs to thank them for caring for our members
	Clinics/Providers	• By measure of outreach completed to community clinics, direct contracts, and IPA practice locations (last updated 10/13): o PCPs: ▪ 133 locations are open to in-person visits, member walk-ins included. ▪ 26 are open to in-person visits, appointments only. ▪ 4 locations are telehealth only. ▪ 1 location anticipates opening within a month. o Specialists: ▪ 162 are open to in-person visits, member walk-ins included. ▪ 20 are open to in-person visits, appointments only. ▪ 0 locations are telehealth only. ▪ 0 locations anticipate any future change in their operations. • HEDIS Medical Record Review outreach has stopped for the Cal MediConnect line of business. The vendor will no longer call/fax/email/visit providers to obtain medical records. For Medi-Cal line of business, vendor is only reviewing records they can access electronically.
Staff	Working from home	• 97% of staff working remotely (10 regularly on site) • Planning has begun for certain staff to return to the office following shelter-in-place • Implemented relaxed telecommuting agreement • Staff onsite only for work that cannot be performed remotely • PTO/leave emergency policies implemented consistent with federal legislation
Community	Communications	• Informed CBOs and general community of SCFHP operational status via email and social media posts: still working and providing services for members and providers, most staff remote, lobby closed to visitors, how to contact us • Published a press release to announce telehealth integration with nurse advice line

Group	Focus Area	Activities and Metrics
	Partnerships with CBOs	• SCFHP staff donated $10,250 in cash to Second Harvest of Silicon Valley • Supported meal distribution programs by providing SCFHP's reusable bags to Veggielution, Santa Clara County's Senior Nutrition Program and Gilroy Compassion Center, Youth Alliance, and West Valley Community Services. • Provided financial support for Community Heath Partnership Diaper Drive, FIRST 5 certified infant formula distribution, and meal distribution to providers working in hospital settings • Provided individual hand sanitizers to Community Clinics for distribution to patients and to the Gilroy Compassion Center for distribution to the homeless population in South County • Donated reusable bags and toothbrushes to Next Door Solutions' pantry for individuals experiencing domestic violence during pandemic • Participated in County assessment of food access needs for seniors to inform use of federal dollars • Continued documentation and sharing of community resources available to support members during COVID • Promoted and provided free member access to YMCA Healthy Living Day Camp

Santa Clara Family Health Plan
Blanca Alvarado Community Resource Center

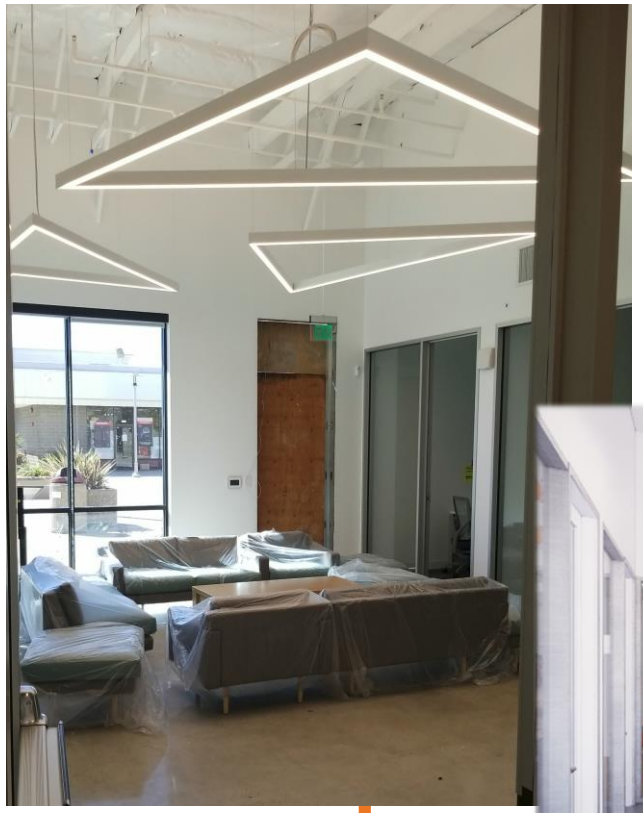
Update

- Construction nearly complete. Electrical, plumbing, and mechanical inspections passed. Final inspection to be completed by October 22nd. Occupancy projected for October 26th.
- CRC Manager candidate identified. Other staffing considerations under discussion.
- Program planning under way, with adjustments for COVID-19. Input from consumer survey is being reviewed.

Santa Clara Family Health Plan | Blanca Alvarado Community Resource Center

October 16, 2020

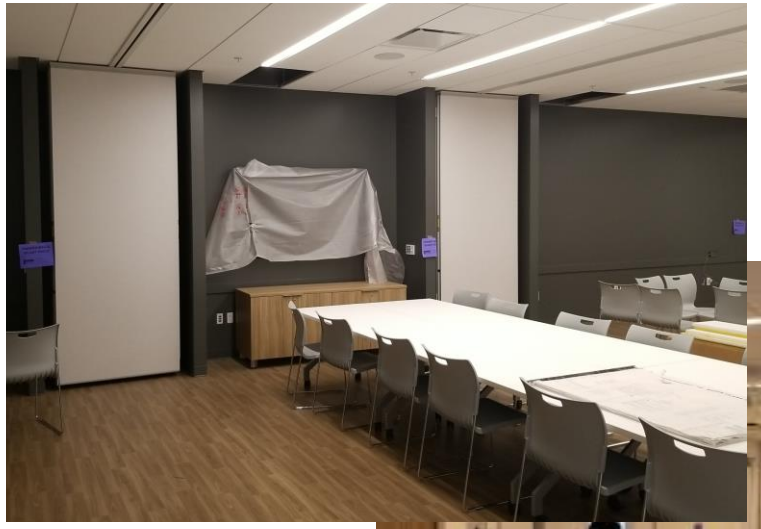
Santa Clara Family Health Plan
Blanca Alvarado Community Resource Center



Santa Clara Family Health Plan
Blanca Alvarado Community Resource Center

Visitor room

Kids' room

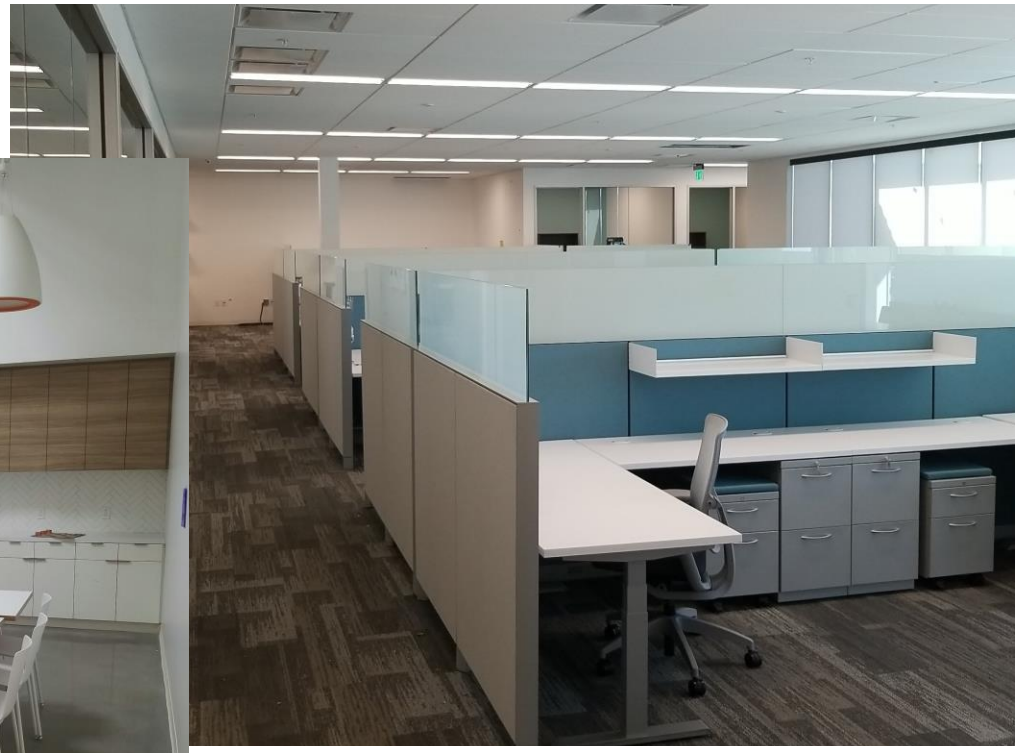


Event room

Santa Clara Family Health Plan
Blanca Alvarado Community Resource Center

Private office

Break room



SCFHP cubicles

Compliance Report

October 22, 2020

AUDIT UPDATE

- **Centers for Medicare & Medicaid Services (CMS) Program Audit**

  The Plan has wrapped up activities related to our CMS Program Audit Revalidation (Revalidation Audit). For the revalidation of the Care Coordination and Quality Improvement Program Effectiveness (CCQIPE) conditions, the Plan worked to sustain full compliance and completed the audit "clean period" at the end of July. Audit field work for the CCQIPE conditions took place in August, and were conducted by ATTAC, the firm conducting audit activities on behalf of CMS.

  The second component of the Revalidation Audit was related to the Coverage Determinations, Appeals and Grievances (CDAG) portion. The clean period for the CDAG re-test closed at the end of August, and related audit fieldwork took place in early September with ATTAC.

  SCFHP received the final Revalidation Audit report from ATTAC in September, which included no findings. SCFHP submitted the report to CMS, and subsequently received from CMS a letter which, recognizing that we had sufficiently corrected all 31 of the Program Audit findings, officially closed the audit.

- **Department of Health Care Services (DHCS) Medi-Cal Managed Care Audit**

  DHCS issued its final report for our 2020 annual Medi-Cal audit, which includes a total of six findings, which is a 57% reduction from the 14 findings in the 2019 audit. SCFHP submitted Corrective Action Plans addressing the six deficiencies to DHCS in September.

- **Compliance Program Effectiveness (CPE) Audit**

  In accordance with CMS requirements, the Plan will be undergoing its annual Compliance Program Effectiveness Audit (CPE) in the Fall. Given that in recent years, the Plan has been examined for some of the CPE requirements as part of its CMS Program Audit, our recent CPE audits have been correspondingly limited in scope. This year's CPE audit will include the full scope of CPE audit requirements.

- **Department of Managed Health Care (DMHC) Medi-Cal Managed Care Audit**

  The DMHC has indicated that the Plan is scheduled for a follow-up audit in March 2021.

Santa Clara Family Health Plan™

Unaudited Financial Statements
For Two Months Ended August 31, 2020

Agenda

Santa Clara Family Health Plan

Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$99 M		$197 M	
Medical Expense (MLR)	$94 M	94.5%	$184 M	93.0%
Administrative Expense (% Rev)	$5.0 M	5.1%	$10.9 M	5.5%
Other Income/Expense	$208K		$384K	
Net Surplus (Loss)	**$599K**		**$3.3 M**	
Cash and Investments			$316 M	
Receivables			$824 M	
Total Current Assets			$1,151 M	
Current Liabilities			$971 M	
Current Ratio			1.18	
Tangible Net Equity			$213 M	
% of DMHC Requirement			**645.0%**	

Financial Highlights

Santa Clara Family Health Plan

Net Surplus (Loss)	Month: Surplus of $599K is $338K or 36.1% unfavorable to budget of $937K. YTD: Surplus of $3.3M is $1.8M or 119.4% favorable to budget of $1.5M.
Enrollment	Month: Membership was 260,270 (7,504 or 2.8% unfavorable budget of 267,774). YTD: Membership was 517,306 (11,979 or 2.3% unfavorable budget of 529,285).
Revenue	Month: $99.1M ($626K or 0.6% unfavorable to budget of $99.8M). YTD: $197.5M ($562K or 0.3% unfavorable to budget of $198.0M).
Medical Expenses	Month: $93.7M ($57K or 0.1% favorable to budget of $93.8M). YTD: $183.6M ($2.5M or 1.4% favorable to budget of $186.1M).
Administrative Expenses	Month: $5.0M ($270K or 5.1% favorable to budget of $5.3M). YTD: $10.9M ($33K or 0.3% unfavorable to budget of $10.9M).
Tangible Net Equity	TNE was $213.2M (represents approximately two months of total expenses).
Capital Expenditures	YTD Capital Investments of $1.7M vs. $6.9M annual budget, primarily Community Resource Center.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment of 260,270 members is lower than budget by 7,504 or 2.8%. Since June 30, 2020, total enrollment has increased by 6,395 members or 2.5%.
- Medi-Cal enrollment has been increasing since January, reflecting newly-eligible and COVID enrollment (beginning in March annual redeterminations of eligibility was suspended).
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 2.7%, Dual enrollment has increased 1.0%, and CMC enrollment has grown 3.1%.

	For the Month August 2020				For Two Months Ending August 31, 2020					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY20 vs. FY21
Medi-Cal	251,004	258,760	(7,756)	-3.0%	499,011	511,297	(12,286)	-2.4%	2,840,218	(82.4%)
Cal Medi-Connect	9,266	9,014	252	2.8%	18,295	17,988	307	1.7%	101,391	(82.0%)
Total	**260,270**	**267,774**	**(7,504)**	**-2.8%**	**517,306**	**529,285**	**(11,979)**	**-2.3%**	**2,941,609**	**(82.4%)**

Santa Clara Family Health Plan Enrollment By Network
August 2020

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	31,797	13%	9,266	100%	41,063	16%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	125,894	50%	-	0%	125,894	48%
Palo Alto Medical Foundation	6,759	3%	-	0%	6,759	3%
Physicians Medical Group	43,436	17%	-	0%	43,436	17%
Premier Care	15,274	6%	-	0%	15,274	6%
Kaiser	27,844	11%	-	0%	27,844	11%
Total	**251,004**	**100%**	**9,266**	**100%**	**260,270**	**100%**
Enrollment at June 30, 2020	244,888		8,987		253,875	
Net Δ from Beginning of FY21	2.5%		3.1%		2.5%	

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

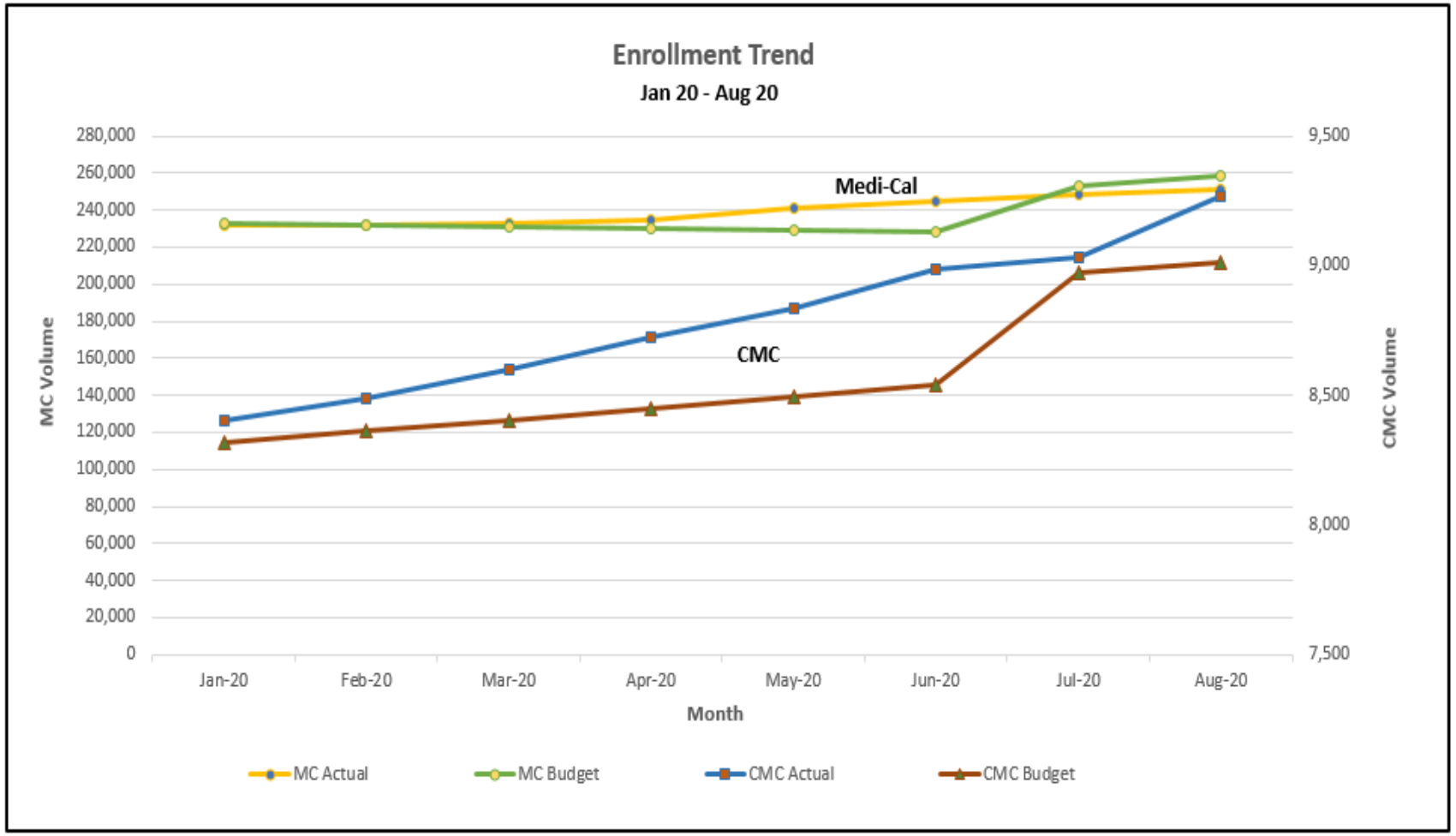
Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD AUGUST-2020

		2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	FYTD var	%
NON DUAL	Adult (over 19)	24,888	24,689	24,492	24,207	23,999	23,620	23,604	23,873	24,051	25,253	26,299	27,066	27,877	1,578	6.0%
	Child (under 19)	92,668	92,092	95,000	93,829	93,477	92,339	92,248	92,843	93,374	95,145	96,173	96,605	97,359	1,186	1.2%
	Aged - Medi-Cal Only	10,958	10,855	10,850	10,897	10,903	10,904	10,831	10,753	10,801	11,044	11,207	11,227	11,178	(29)	(0.3%)
	Disabled - Medi-Cal Only	10,833	10,814	10,836	10,865	10,839	10,845	10,854	10,882	10,851	10,902	10,922	10,944	10,910	(12)	(0.1%)
	Adult Expansion	70,635	70,418	70,285	69,889	69,069	68,130	68,372	69,272	70,458	72,546	74,553	76,262	77,701	3,148	4.2%
	BCCTP	10	10	10	12	11	11	11	11	11	11	11	11	11	0	0.0%
	Long Term Care	364	366	372	371	373	379	373	367	380	398	405	402	406	1	0.2%
	Total Non-Duals	**210,356**	**209,244**	**211,845**	**210,070**	**208,671**	**206,228**	**206,293**	**208,001**	**209,926**	**215,299**	**219,570**	**222,517**	**225,442**	**5,872**	**2.7%**
DUAL	Adult (21 Over)	345	351	341	350	341	330	328	320	311	320	321	327	320	(1)	(0.3%)
	SPD (21 Over)	23,230	23,445	23,531	23,577	23,498	23,472	23,540	23,541	23,443	23,595	23,508	23,641	23,686	178	0.8%
	Adult Expansion	226	201	122	82	177	139	130	136	134	190	241	261	289	48	19.9%
	BCCTP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
	Long Term Care	1,232	1,237	1,256	1,271	1,308	1,266	1,257	1,231	1,235	1,252	1,248	1,261	1,267	19	1.5%
	Total Duals	**25,033**	**25,234**	**25,250**	**25,280**	**25,324**	**25,207**	**25,255**	**25,228**	**25,123**	**25,357**	**25,318**	**25,490**	**25,562**	**244**	**1.0%**
	Total Medi-Cal	**235,389**	**234,478**	**237,095**	**235,350**	**233,995**	**231,435**	**231,548**	**233,229**	**235,049**	**240,656**	**244,888**	**248,007**	**251,004**	**6,116**	**2.5%**
	Healthy Kids	**3,509**	**3,512**	**2**	**2**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**
CMC	CMC Non-Long Term Care	7,921	7,982	8,016	8,069	8,206	8,177	8,261	8,388	8,511	8,625	8,775	8,814	9,055	280	3.2%
	CMC - Long Term Care	213	212	217	220	222	224	225	213	214	212	212	215	211	(1)	(0.5%)
	Total CMC	**8,134**	**8,194**	**8,233**	**8,289**	**8,428**	**8,401**	**8,486**	**8,601**	**8,725**	**8,837**	**8,987**	**9,029**	**9,266**	**279**	**3.1%**
	Total Enrollment	**247,032**	**246,184**	**245,330**	**243,641**	**242,425**	**239,836**	**240,034**	**241,830**	**243,774**	**249,493**	**253,875**	**257,036**	**260,270**	**6,395**	**2.5%**

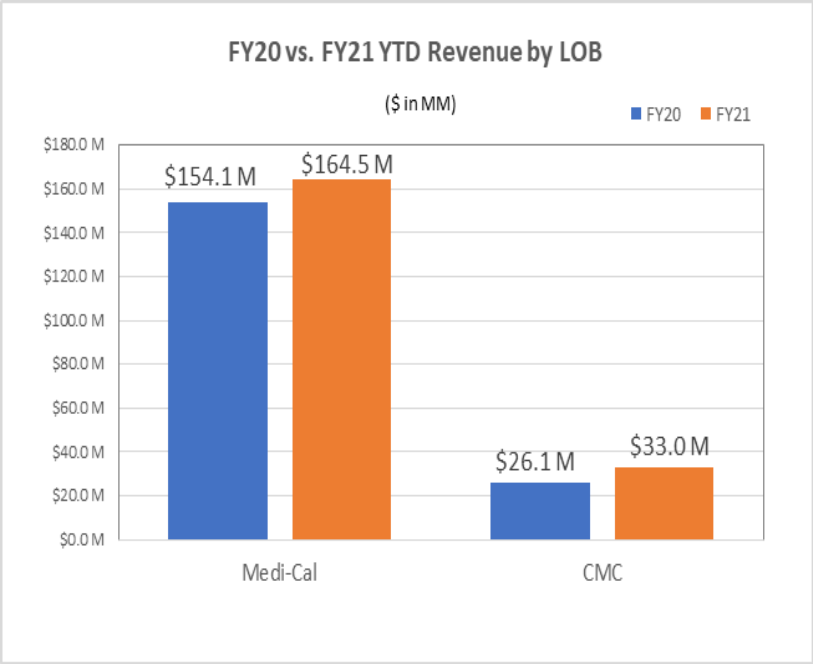
Enrollment Trend

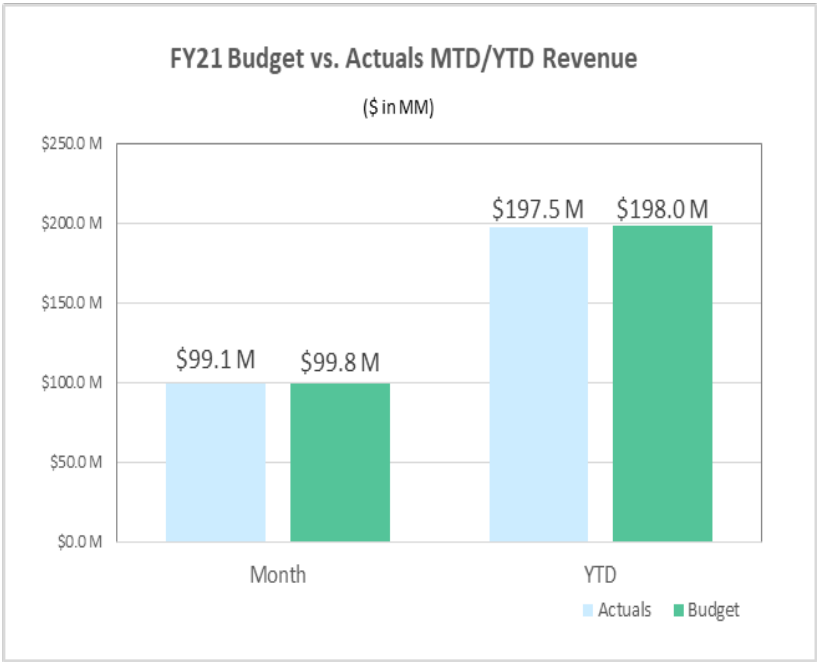


Revenue

Current month revenue of $99.1M is $626K or 0.6% unfavorable to budget of $99.8M. The current month variance was primarily due to the following:

- MediCal revenue is $1.36M unfavorable to budget due to lower enrollment offset with higher Optional Expansion and Adult rates than expected.
- Supplement revenue is $639K favorable to budget due to increase in BHT utilization.
- CMC MediCal revenue is $264K favorable to budget due to higher rate and enrollment than expected.

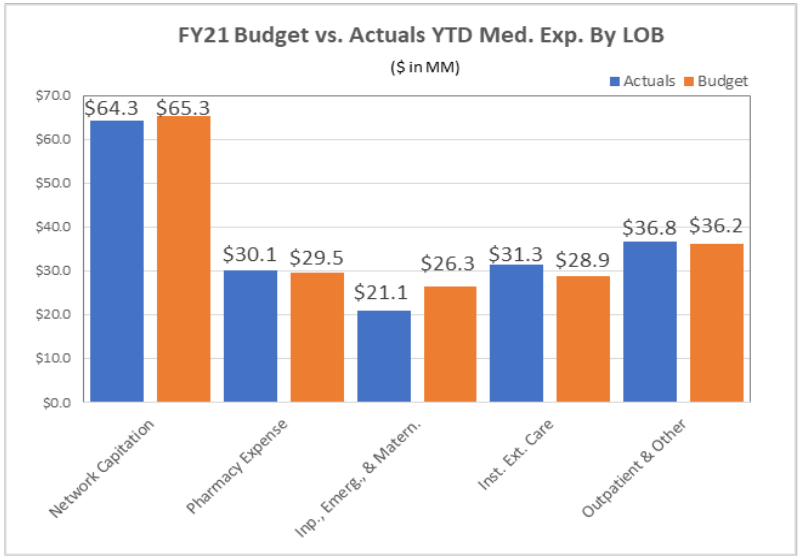


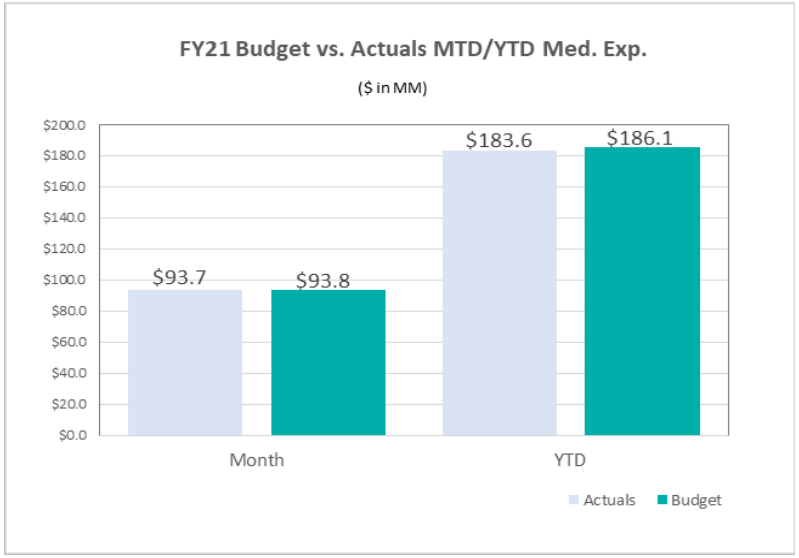


Medical Expense

Current month medical expense of $93.7M is $57K or 0.1% favorable to budget of $93.8M. The current month variance was due largely to:

- Favorable capitation expense variance of $750K due to lower enrollment than budget (2.3%).
- Fee-For-Service expense is $327K favorable variance due to several categories of service for which net actual expense is lower than budget.
- Increased utilization in supplemental services of $563K (primarily BHT services) is unfavorable to budget (with offsetting increase to revenue).
- Pharmacy expense is $491K unfavorable variance due to increase in prescriptions resulting from DHCS allowing refill and prior authorization overrides due to COVID-19.

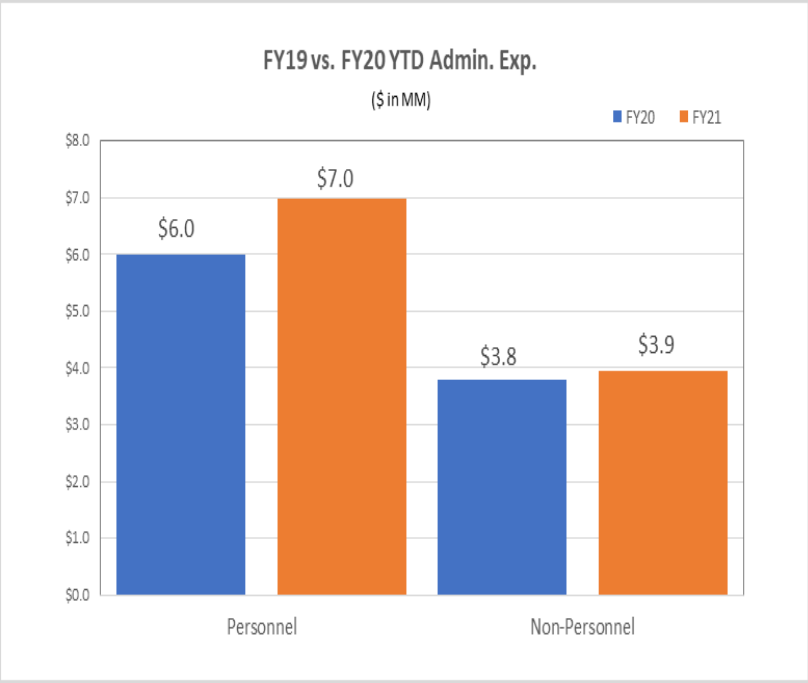


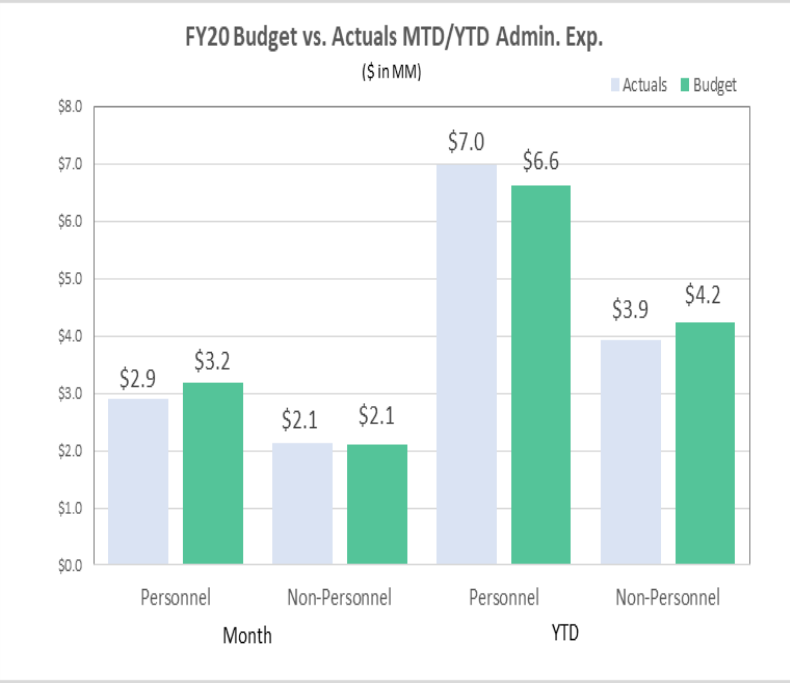


Administrative Expense

Current month admin expense of $5.0M is $270K or 5.1% favorable to budget of $5.3M. The current month variances were primarily due to the following:

- Personnel expenses were $285K or 8.9% favorable to budget due to a one-time reclassification of an annual CalPERS payment, slightly higher average salaries, partially offset by a lower head count.
- Non-Personnel expenses were $15K or 0.7% unfavorable to budget due to timing of budget spending in contract, consulting and professional services.





Balance Sheet

- Current assets totaled $1.2B compared to current liabilities of $971.5M, yielding a current ratio (Current Assets/Current Liabilities) of 1.18:1 vs. the DMHC minimum requirement of 1.0:1.
- Cash balance decreased by $17.7M compared to the cash balance as of year-end June 30, 2020 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	$105,978,654	1.54%	$100,000	$200,000
Wells Fargo Investments	$180,537,741	0.43%	$19,058	$94,445
	$286,516,395		$119,058	$294,445
Cash & Equivalents				
Bank of the West Money Market	$133,628	0.13%	$1,826	$3,393
Wells Fargo Bank Accounts	$29,340,697	0.01%	$540	$1,923
	$29,474,325		$2,366	$5,315
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.42%	$107	$107
Petty Cash	$500	0.00%	$0	$0
Month-End Balance	**$316,296,570**		**$121,531**	**$299,868**

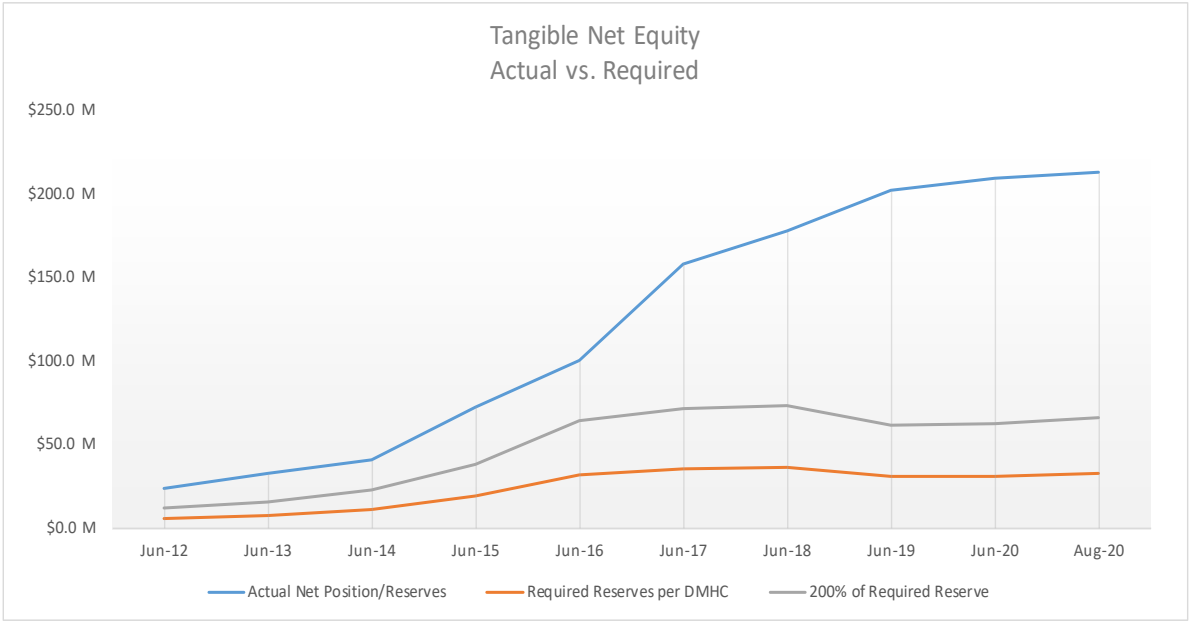
- County of Santa Clara Comingled Pool funds have longer-term investments which are currently yielding a higher rate than WFB investments.
- Overall cash and investment yield is lower than budget (0.76% actual vs. 1.4% budgeted).

Tangible Net Equity

- TNE was $213.2M - representing approximately two months of the Plan's total expenses.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of August 31, 2020

	Jun-12	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20	Aug-20
Actual Net Position/Reserves	$24.2 M	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$202.1 M	$209.2 M	$213.2 M
Required Reserves per DMHC	$5.9 M	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$30.9 M	$31.3 M	$33.1 M
200% of Required Reserve	$11.8 M	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$61.8 M	$62.6 M	$66.1 M
Actual as % Required	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	668.7%	645.0%



Reserves Analysis

Santa Clara Family Health Plan

SCFHP RESERVES ANALYSIS AUGUST 2020

Financial Reserve Target #1: Tangible Net Equity	Approved	Expended	Balance
Unrestricted Net Assets			**$167,766,243** *
Board Designated Funds (Note 1):			
Special Project Funding for CBOs	$4,000,000	$540,727	$3,459,274
Innovation & COVID-19 Fund	$16,000,000	$2,119,999	$13,880,001
Subtotal	$20,000,000	$2,660,726	$17,339,275
Net Book Value of Fixed Assets			$27,803,501
Restricted Under Knox-Keene Agreement			$305,350
Total Tangible Net Equity (TNE)			$213,214,369
Current Required TNE			$33,058,534
TNE %			645.0%
SCFHP Target TNE Range:			
350% of Required TNE (Low)			$115,704,868
500% of Required TNE (High)			$165,292,668
Total TNE Above/(Below) SCFHP Low Target			**$97,509,501**
Total TNE Above/(Below) High Target			**$47,921,701**
Financial Reserve Target #2: Liquidity			
Cash & Investments			$316,296,570
Less Pass-Through Liabilities			
MCO Tax Payable to State of CA			(66,846,203)
Whole Person Care / Prop 56			(37,973,007)
Other Pass-Through Liabilities (Note 2)			(42,443,146)
Total Pass-Through Liabilities			**(147,262,356)**
Net Cash Available to SCFHP			169,034,214
SCFHP Target Liquidity (Note 3)			
45 Days of Total Operating Expense			(148,603,473)
60 Days of Total Operating Expense			(198,137,964)
Liquidity Above/(Below) SCFHP Low Target			**20,430,741**
Liquidity Above/(Below) High Target			**-$29,103,750**

- **Unrestricted Net Assets represents less than two months of total expenses.**
- **Cash balance is unusually low due to the CYTD 20 MCO tax not received until Sept-20.**

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 Fund.

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

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

Capital Expenditures

- Majority of the capital variances are Community Resource Center, hardware, software, and building improvements due to timing of certain projects.

Expenditure	YTD Actual	Annual Budget
Community Resource Center	$1,666,073	$3,507,100
Hardware	$16,546	$1,282,500
Software	$0	$1,194,374
Building Improvements	$9,760	$866,500
Furniture & Equipment	$0	$28,000
TOTAL	**$1,692,379**	**$6,878,474**

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, 2020

	Aug-2020 Actuals	% of Rev	Aug-2020 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD Aug-2020 Actuals	% of Rev	YTD Aug-2020 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 83,207,151	83.9%	$ 83,927,526	84.1%	$ (720,375)	-0.9%	$ 164,489,236	83.3%	$ 166,459,550	84.0%	$ (1,970,315)	-1.2%
CMC MEDI-CAL	3,173,635	3.2%	2,909,735	2.9%	263,901	9.1%	6,044,604	3.1%	5,806,624	2.9%	237,979	4.1%
CMC MEDICARE	12,751,166	12.9%	12,920,397	13.0%	(169,231)	-1.3%	26,953,762	13.6%	25,783,460	13.0%	1,170,302	4.5%
TOTAL CMC	15,924,802	16.1%	15,830,132	15.9%	94,670	0.6%	32,998,365	16.7%	31,590,084	16.0%	1,408,281	4.5%
HEALTHY KIDS	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
TOTAL REVENUE	**$ 99,131,953**	**100.0%**	**$ 99,757,658**	**100.0%**	**$ (625,706)**	**-0.6%**	**$ 197,487,601**	**100.0%**	**$ 198,049,634**	**100.0%**	**$ (562,034)**	**-0.3%**
MEDICAL EXPENSES												
MEDI-CAL	$ 78,378,238	79.1%	$ 78,755,863	78.9%	$ 377,625	0.5%	$ 154,267,705	78.1%	$ 156,181,295	78.9%	$ 1,913,590	1.2%
CMC MEDI-CAL	2,335,081	2.4%	2,981,527	3.0%	646,446	21.7%	5,946,343	3.0%	5,950,161	3.0%	3,818	0.1%
CMC MEDICARE	12,993,898	13.1%	12,032,346	12.1%	(961,552)	-8.0%	23,396,635	11.8%	24,010,164	12.1%	613,530	2.6%
TOTAL CMC	15,328,979	15.5%	15,013,874	15.1%	(315,106)	-2.1%	29,342,978	14.9%	29,960,326	15.1%	617,348	2.1%
HEALTHY KIDS	5,384	0.0%	0	0.0%	(5,384)	0.0%	6,424	0.0%	0	0.0%	(6,424)	0.0%
TOTAL MEDICAL EXPENSES	**$ 93,712,601**	**94.5%**	**$ 93,769,736**	**94.0%**	**$ 57,135**	**0.1%**	**$ 183,617,107**	**93.0%**	**$ 186,141,621**	**94.0%**	**$ 2,524,514**	**1.4%**
MEDICAL OPERATING MARGIN	**$ 5,419,352**	**5.5%**	**$ 5,987,922**	**6.0%**	**$ (568,570)**	**-9.5%**	**$ 13,870,494**	**7.0%**	**$ 11,908,013**	**6.0%**	**$ 1,962,480**	**16.5%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 2,904,698	2.9%	$ 3,189,495	3.2%	$ 284,797	8.9%	$ 6,976,442	3.5%	$ 6,634,505	3.3%	$ (341,936)	-5.2%
RENTS AND UTILITIES	24,496	0.0%	22,109	0.0%	(2,387)	-10.8%	58,537	0.0%	44,218	0.0%	(14,318)	-32.4%
PRINTING AND ADVERTISING	31,579	0.0%	67,042	0.1%	35,462	52.9%	56,504	0.0%	134,083	0.1%	77,579	57.9%
INFORMATION SYSTEMS	176,481	0.2%	316,405	0.3%	139,925	44.2%	491,130	0.2%	632,810	0.3%	141,681	22.4%
PROF FEES/CONSULTING/TEMP STAFFING	1,118,245	1.1%	990,225	1.0%	(128,020)	-12.9%	1,890,707	1.0%	1,999,881	1.0%	109,174	5.5%
DEPRECIATION/INSURANCE/EQUIPMENT	332,491	0.3%	325,730	0.3%	(6,761)	-2.1%	648,954	0.3%	641,757	0.3%	(7,197)	-1.1%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	74,816	0.1%	56,173	0.1%	(18,642)	-33.2%	127,921	0.1%	111,866	0.1%	(16,054)	-14.4%
MEETINGS/TRAVEL/DUES	115,674	0.1%	102,274	0.1%	(13,400)	-13.1%	171,265	0.1%	222,263	0.1%	50,998	22.9%
OTHER	250,671	0.3%	229,792	0.2%	(20,879)	-9.1%	491,826	0.2%	459,209	0.2%	(32,617)	-7.1%
TOTAL ADMINISTRATIVE EXPENSES	**$ 5,029,151**	**5.1%**	**$ 5,299,246**	**5.3%**	**$ 270,095**	**5.1%**	**$ 10,913,285**	**5.5%**	**$ 10,880,593**	**5.5%**	**$ (32,692)**	**-0.3%**
OPERATING SURPLUS (LOSS)	**$ 390,201**	**0.4%**	**$ 688,676**	**0.7%**	**$ (298,475)**	**-43.3%**	**$ 2,957,209**	**1.5%**	**$ 1,027,421**	**0.5%**	**$ 1,929,789**	**187.8%**
GASB 75 - POST EMPLOYMENT BENEFITS EXPENSE	$ (75,602)	-0.1%	$ 60,000	0.1%	$ 135,602	226.0%	$ 168,134	0.1%	$ 120,000	0.1%	$ (48,134)	-40.1%
GASB 68 - UNFUNDED PENSION LIABILITY	403,405	0.4%	75,000	0.1%	(328,405)	-437.9%	487,472	0.2%	150,000	0.1%	(337,472)	-225.0%
NON-OPERATING EXPENSES	**$ 327,803**	**0.3%**	**$ 135,000**	**0.1%**	**$ (192,803)**	**-142.8%**	**$ 655,606**	**0.3%**	**$ 270,000**	**0.1%**	**$ (385,606)**	**-142.8%**
INTEREST & INVESTMENT INCOME	$ 121,424	0.1%	$ 350,000	0.4%	$ (228,576)	-65.3%	$ 299,761	0.2%	$ 700,000	0.4%	$ (400,239)	-57.2%
OTHER INCOME	414,831	0.4%	32,896	0.0%	381,936	1161.1%	739,853	0.4%	65,791	0.0%	674,062	1024.5%
NON-OPERATING INCOME	**$ 536,255**	**0.5%**	**$ 382,896**	**0.4%**	**$ 153,359**	**40.1%**	**$ 1,039,613**	**0.5%**	**$ 765,791**	**0.4%**	**$ 273,822**	**35.8%**
NET NON-OPERATING ACTIVITIES	**$ 208,452**	**0.2%**	**$ 247,896**	**0.2%**	**$ (39,444)**	**-15.9%**	**$ 384,007**	**0.2%**	**$ 495,791**	**0.3%**	**$ (111,784)**	**-22.5%**
NET SURPLUS (LOSS)	**$ 598,653**	**0.6%**	**$ 936,572**	**0.9%**	**$ (337,919)**	**-36.1%**	**$ 3,341,216**	**1.7%**	**$ 1,523,212**	**0.8%**	**$ 1,818,005**	**119.4%**

Balance Sheet

Santa Clara Family Health Plan

SANTA CLARA COUNTY HEALTH AUTHORITY
As of August 31, 2020

	Aug-2020	Jul-2020	Jun-2020	Aug-2019
Assets				
Current Assets				
Cash and Investments	316,296,570	345,046,103	333,959,470	291,325,334
Receivables	823,990,945	823,652,403	812,652,027	752,169,795
Prepaid Expenses and Other Current Assets	10,324,440	10,905,149	9,863,699	11,991,409
Total Current Assets	**1,150,611,955**	**1,179,603,655**	**1,156,475,195**	**1,055,486,539**
Long Term Assets				
Property and Equipment	49,078,265	47,539,137	47,385,886	45,024,463
Accumulated Depreciation	(21,274,764)	(20,999,421)	(20,736,798)	(17,943,981)
Total Long Term Assets	27,803,501	26,539,716	26,649,087	27,080,481
Total Assets	**1,178,415,456**	**1,206,143,371**	**1,183,124,283**	**1,082,567,020**
Deferred Outflow of Resources	**8,402,260**	**8,402,260**	**8,402,260**	**9,237,609**
Total Assets & Deferred Outflows	**1,186,817,716**	**1,214,545,631**	**1,191,526,543**	**1,091,804,629**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	7,871,178	9,718,507	10,460,763	6,442,995
Employee Benefits	2,324,666	2,302,119	2,174,389	1,690,637
Retirement Obligation per GASB 75	2,282,031	2,197,964	2,113,897	4,062,845
Advance Premium - Healthy Kids	0	0	0	95,965
Deferred Revenue - Medicare	0	12,385,712	191,510	9,997,983
Whole Person Care / Prop 56	37,973,007	34,951,070	34,643,968	17,664,845
Pass-Throughs Payable	26,877	26,877	801,274	279,440,736
Due to Santa Clara County Valley Health Plan and Kaiser	10,742,452	36,882,621	34,945,075	25,687,975
MCO Tax Payable - State Board of Equalization	66,846,203	57,730,811	48,615,420	0
Due to DHCS	42,416,269	53,508,650	49,644,515	28,372,563
Liability for In Home Support Services (IHSS)	419,268,582	419,268,582	419,268,582	416,092,527
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
Medical Cost Reserves	98,089,487	87,446,092	94,318,096	86,591,338
Total Current Liabilities	**971,454,048**	**1,000,024,352**	**979,991,563**	**884,434,434**
Non-Current Liabilities				
Net Pension Liability GASB 68	487,472	243,735.68	(0)	150,000
Total Non-Current Liabilities	**487,472**	**243,735.68**	**(0)**	**150,000**
Total Liabilities	**971,941,520**	**1,000,268,088**	**979,991,563**	**884,584,434**
Deferred Inflow of Resources	**1,661,827**	**1,661,827**	**1,661,827**	**2,994,548**
Net Assets				
Board Designated Fund: Special Project Funding for CBOs	3,459,274	3,459,274	3,459,274	2,200,000
Board Designated Fund: Innovation & COVID-19 Fund	13,880,001	13,880,001	13,880,001	0
Invested in Capital Assets (NBV)	27,803,501	26,539,716	26,649,087	27,080,481
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	164,425,027	165,688,813	157,832,041	172,539,922
Current YTD Income (Loss)	3,341,216	2,742,563	7,747,400	2,099,895
Total Net Assets / Reserves	**213,214,369**	**212,615,716**	**209,873,153**	**204,225,648**
Total Liabilities, Deferred Inflows and Net Assets	**1,186,817,716**	**1,214,545,631**	**1,191,526,543**	**1,091,804,629**

Cash Flow Statement

Santa Clara Family Health Plan

	Aug-2020
Cash Flows from Operating Activities	
Premiums Received	$96,816,421
Medical Expenses Paid	(109,209,375)
Adminstrative Expenses Paid	(15,353,704)
Net Cash from Operating Activities	**($27,746,659)**
Cash Flows from Capital and Related Financing Activities	
Purchase of Capital Assets	(1,539,128)
Cash Flows from Investing Activities	
Interest Income and Other Income (Net)	536,255
Net Increase/(Decrease) in Cash & Cash Equivalents	**(28,749,533)**
Cash & Investments (Beginning)	345,046,103
Cash & Investments (Ending)	**$316,296,570**
Reconciliation of Operating Income to Net Cash from Operating Activities	
Operating Income/(Loss)	$62,398
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities	
Depreciation	275,343
Changes in Operating Assets/Liabilities	
Premiums Receivable	(338,542)
Prepaids & Other Assets	580,710
Accounts Payable & Accrued Liabilities	(11,096,539)
State Payable	(1,976,990)
IGT, HQAF & Other Provider Payables	(26,140,169)
Net Pension Liability	243,736
Medical Cost Reserves & PDR	10,643,395
Total Adjustments	**(27,809,057)**
Net Cash from Operating Activities	**($27,746,659)**

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, 2020

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$164,489,236	$6,044,604	$26,953,762	$32,998,365	**$197,487,601**
MEDICAL EXPENSE	$154,267,705	$5,946,343	$23,396,635	$29,342,978	**$183,617,107**
(MLR)	93.8%	98.4%	86.8%	88.9%	93.0%
GROSS MARGIN	$10,221,530	$98,261	$3,557,127	$3,655,387	**$13,870,494**
ADMINISTRATIVE EXPENSE	$9,089,775	$334,028	$1,489,481	$1,823,510	**$10,913,285**
(% of Revenue Allocation)					
OPERATING INCOME/(LOSS)	$1,131,756	($235,768)	$2,067,646	$1,831,878	**$2,957,209**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$319,843	$11,754	$52,411	$64,164	**$384,007**
(% of Revenue Allocation)					
NET INCOME/(LOSS)	$1,451,599	($224,014)	$2,120,056	$1,896,042	**$3,341,216**
PMPM (ALLOCATED BASIS)					
REVENUE	$329.63	$330.40	$1,473.29	$1,803.68	**$381.76**
MEDICAL EXPENSES	$309.15	$325.03	$1,278.85	$1,603.88	**$354.95**
GROSS MARGIN	$20.48	$5.37	$194.43	$199.80	**$26.81**
ADMINISTRATIVE EXPENSES	$18.22	$18.26	$81.41	$99.67	**$21.10**
OPERATING INCOME/(LOSS)	$2.27	($12.89)	$113.02	$100.13	**$5.72**
OTHER INCOME/(EXPENSE)	$0.64	$0.64	$2.86	$3.51	**$0.74**
NET INCOME/(LOSS)	$2.91	($12.24)	$115.88	$103.64	**$6.46**
ALLOCATION BASIS:					
MEMBER MONTHS - YTD	499,011	18,295	18,295	18,295	517,306
REVENUE BY LOB	83.3%	3.1%	13.6%	16.7%	100.0%

Santa Clara Family Health Plan™

Appendices

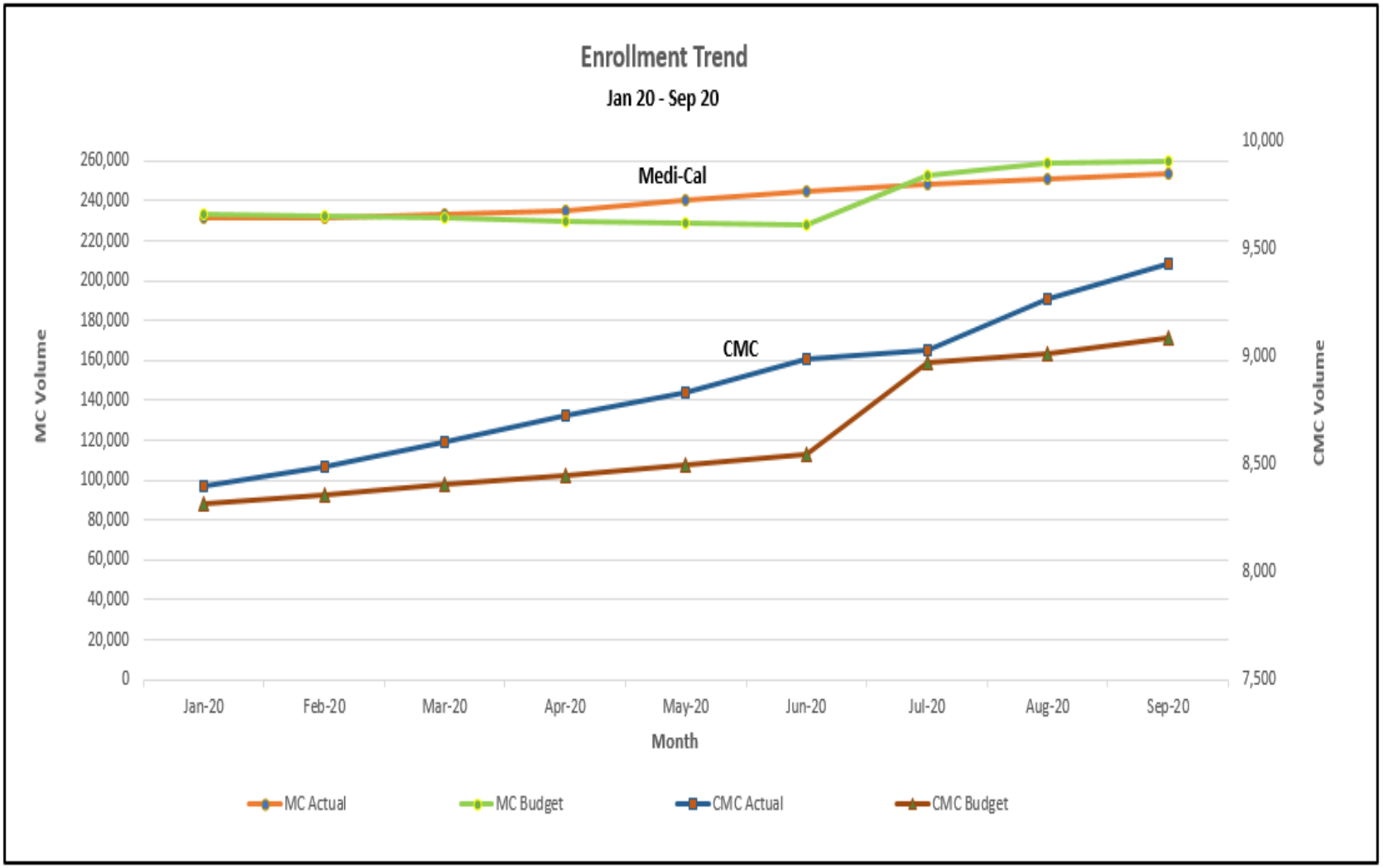
Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD SEP-2020

		2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	FYTD var	%
NON DUAL	Adult (over 19)	24,989	24,888	24,689	24,492	24,207	23,999	23,620	23,604	23,873	24,051	25,253	26,299	27,066	27,877	28,269	392	1.5%
	Child (under 19)	93,536	92,668	92,092	95,000	93,829	93,477	92,339	92,248	92,843	93,374	95,145	96,173	96,605	97,359	97,629	270	0.3%
	Aged - Medi-Cal Only	10,948	10,958	10,855	10,850	10,897	10,903	10,904	10,831	10,753	10,801	11,044	11,207	11,227	11,178	11,229	51	0.5%
	Disabled - Medi-Cal Only	10,774	10,833	10,814	10,836	10,865	10,839	10,845	10,854	10,882	10,851	10,902	10,922	10,944	10,910	10,839	(71)	(0.7%)
	Adult Expansion	71,082	70,635	70,418	70,285	69,889	69,069	68,130	68,372	69,272	70,458	72,546	74,553	76,262	77,701	79,263	1,562	2.1%
	BCCTP	10	10	10	10	12	11	11	11	11	11	11	11	11	11	11	0	0.0%
	Long Term Care	372	364	366	372	371	373	379	373	367	380	398	405	402	406	407	1	0.2%
	Total Non-Duals	**211,711**	**210,356**	**209,244**	**211,845**	**210,070**	**208,671**	**206,228**	**206,293**	**208,001**	**209,926**	**215,299**	**219,570**	**222,517**	**225,442**	**227,647**	**2,205**	**1.0%**
DUAL	Adult (21 Over)	351	345	351	341	350	341	330	328	320	311	320	321	327	320	337	17	5.3%
	SPD (21 Over)	23,087	23,230	23,445	23,531	23,577	23,498	23,472	23,540	23,541	23,443	23,595	23,508	23,641	23,686	23,654	(32)	(0.1%)
	Adult Expansion	209	226	201	122	82	177	139	130	136	134	190	241	261	289	358	69	28.6%
	BCCTP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
	Long Term Care	1,220	1,232	1,237	1,256	1,271	1,308	1,266	1,257	1,231	1,235	1,252	1,248	1,261	1,267	1,256	(11)	(0.9%)
	Total Duals	**24,867**	**25,033**	**25,234**	**25,250**	**25,280**	**25,324**	**25,207**	**25,255**	**25,228**	**25,123**	**25,357**	**25,318**	**25,490**	**25,562**	**25,605**	**43**	**0.2%**
	Total Medi-Cal	**236,578**	**235,389**	**234,478**	**237,095**	**235,350**	**233,995**	**231,435**	**231,548**	**233,229**	**235,049**	**240,656**	**244,888**	**248,007**	**251,004**	**253,252**	**2,248**	**0.9%**
	Healthy Kids	**3,501**	**3,509**	**3,512**	**2**	**2**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**
CMC	CMC Non-Long Term Care	7,869	7,921	7,982	8,016	8,069	8,206	8,177	8,261	8,388	8,511	8,625	8,775	8,814	9,055	9,215	160	1.8%
	CMC - Long Term Care	207	213	212	217	220	222	224	225	213	214	212	212	215	211	213	2	0.9%
	Total CMC	**8,076**	**8,134**	**8,194**	**8,233**	**8,289**	**8,428**	**8,401**	**8,486**	**8,601**	**8,725**	**8,837**	**8,987**	**9,029**	**9,266**	**9,428**	**162**	**1.8%**
	Total Enrollment	**248,155**	**247,032**	**246,184**	**245,330**	**243,641**	**242,425**	**239,836**	**240,034**	**241,830**	**243,774**	**249,493**	**253,875**	**257,036**	**260,270**	**262,680**	**2,410**	**0.9%**

Enrollment Trend



September 2020 Enrollment Comparison

Santa Clara Family Health Plan

SEPT 20 PROJECTED AND FORECAST COMPARISON

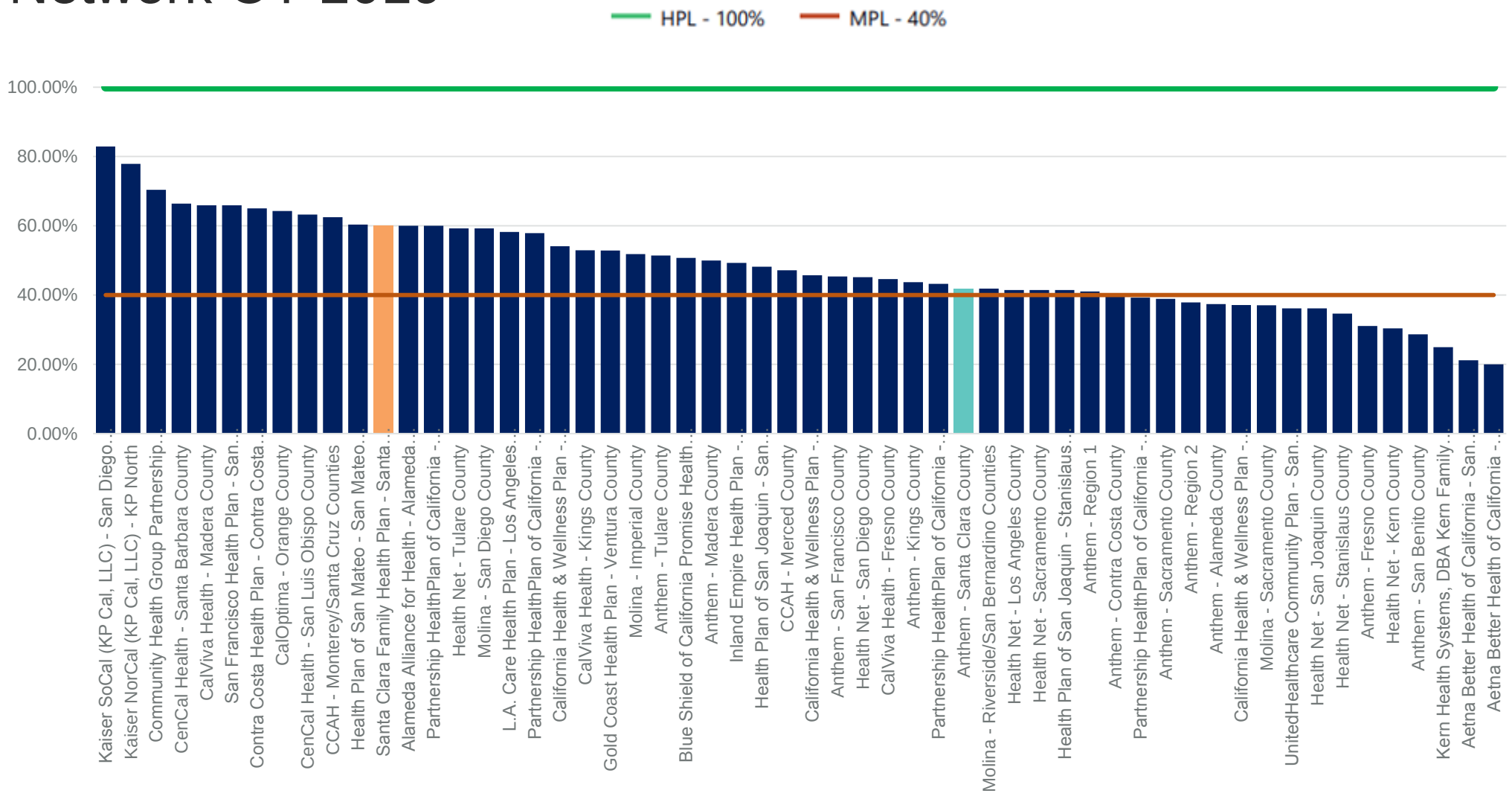
NON DUALS	Sep-20 Actual	APPROVED Sep-20 Budget	Actual vs. Budget Incr / (Decr)	Actual vs. Budget %	Sep-20 Actual	Sep-20 Forecast	Variance Incr / (Decr)	Variance %	Forecast vs. Budget Incr / (Decr)	Forecast vs. Budget %
Adult Expansion	79,263	79,669	(406)	-0.5%	79,263	79,101	162	0.2%	(568)	-0.7%
Adult/Family (under 19)	97,629	104,487	(6,858)	-6.6%	97,629	98,099	(470)	-0.5%	(6,388)	-6.1%
Adult/Family (over 19)	28,269	27,733	536	1.9%	28,269	28,688	(419)	-1.5%	955	3.4%
SPD	22,068	22,039	29	0.1%	22,068	22,136	(68)	-0.3%	97	0.4%
BCCTP	11	11	-	0.0%	11	11	-	0.0%	-	0.0%
Long Term Care	407	398	9	2.3%	407	406	1	0.2%	8	2.0%
Non-Dual Subtotal	**227,647**	**234,337**	**(6,690)**	**-2.9%**	**227,647**	**228,441**	**(794)**	**-0.3%**	**(5,896)**	**-2.5%**
DUALS										
Adult Expansion	358	190	168	88.4%	358	317	41	12.9%	127	66.8%
Adult/Family (21 over)	337	320	17	5.3%	337	320	17	5.3%	-	0.0%
SPD	23,654	23,612	42	0.2%	23,654	23,726	(72)	-0.3%	114	0.5%
BCCTP	-	-	-	0.0%	-	-	-	0.0%	-	0.0%
Long Term Care	1,256	1,435	(179)	-12.5%	1,256	1,267	(11)	-0.9%	(168)	-11.7%
Dual Subtotal	**25,605**	**25,557**	**48**	**0.2%**	**25,605**	**25,630**	**(25)**	**-0.1%**	**73**	**0.3%**
Total Medi-Cal	**253,252**	**259,894**	**(6,642)**	**-2.6%**	**253,252**	**254,071**	**(819)**	**-0.3%**	**(5,823)**	**-2.2%**
Cal MediConnect	**9,428**	**9,084**	**344**	**3.8%**	**9,428**	**9,339**	**89**	**1.0%**	**255**	**2.8%**
TOTAL ENROLLMENT	**262,680**	**268,978**	**(6,298)**	**-2.3%**	**262,680**	**263,410**	**(730)**	**-0.3%**	**(5,568)**	**-2.1%**

	Sep-20	Variance from Actual	
Actual	262,680		
Budget	268,978	(6,298)	-2.40%
Forecast	263,410	(730)	-0.28%

Santa Clara Family Health Plan™

Medi-Cal Managed Care Plan Performance Review
CY 2019

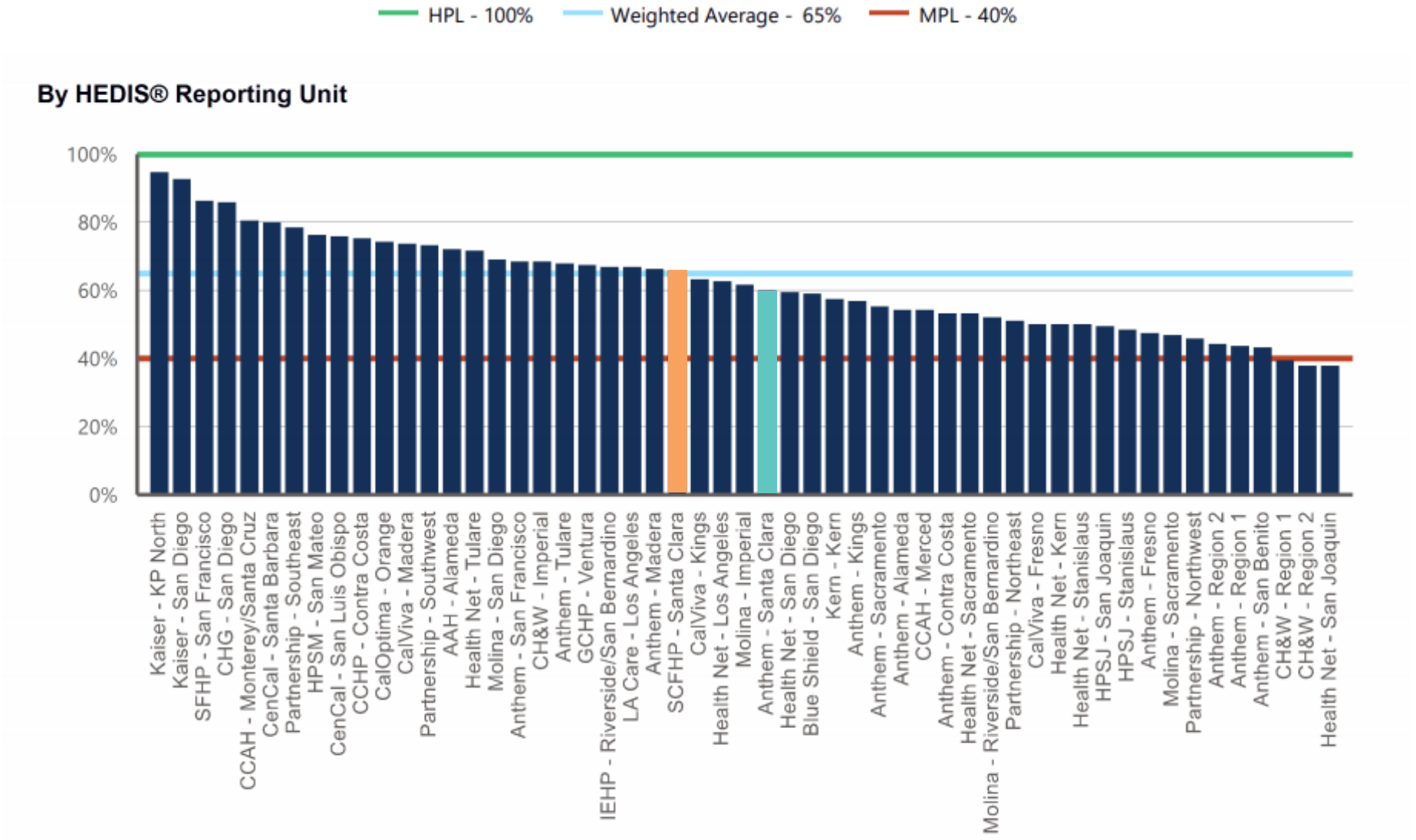
Estimated Aggregated Quality Factor Score (AQFS) by Network CY 2019



SCFHP – Rank 12
Anthem – Rank 35
Total # of MCPs = 56

**Performance might be affected as some plans reported the rates as is during COVID.*

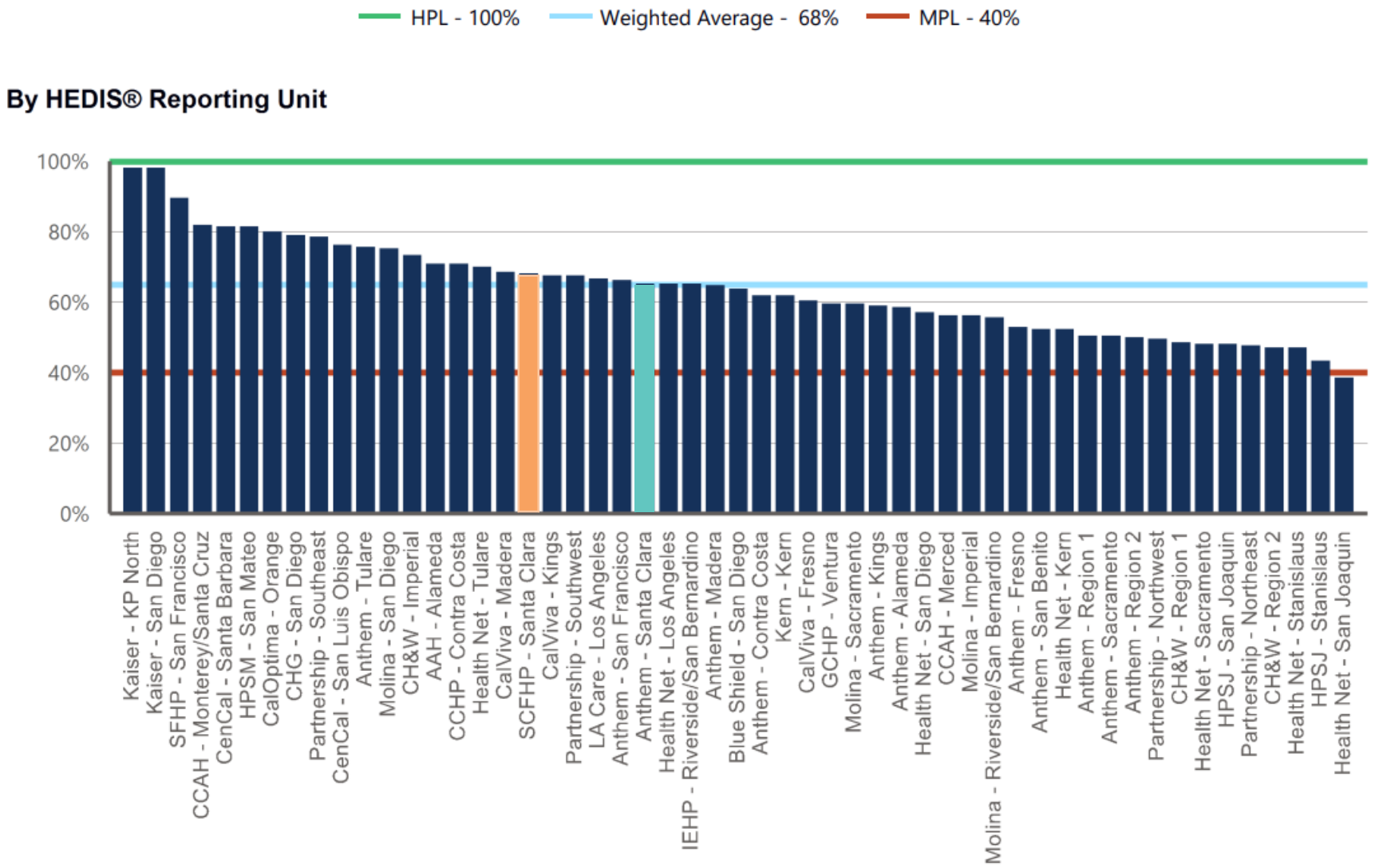
Aggregated Quality Factor Score (AQFS) by Network CY 2018



SCFHP – Rank 24
Anthem – Rank 28
Total # of MCPs = 53

Aggregated Quality Factor Score (AQFS) by Network CY 2017

SCFHP – Rank 18
Anthem – Rank 23
Total # of MCPs = 53



Measure Rankings

SCFHP generally performed in the top 50% of all MCPs (56 total plans)*

Measure	Rank	Percentile
Childhood Immunizations – Combo 10	1	95th
Antidepressant Med Mgmt – Cont	3	90th
Well Child Visits in First 15 Months	3	90th
Breast Cancer Screening	5	75th
Antidepressant Med Mgmt – Acute	6	75th
All Cause Readmit -Expected Readmission	7	95th
Post Partum Care	10	95th
Diabetes Care – HbA1c>9	11	75th
Children and Adolescents Access to Primary Care -7-11 Years[1]	*13*	*25th*
Immunizations for Adolescents – Combo 2	14	75th
Children and Adolescents Access to Primary Care – 12-19 Years[1]	*15*	*25th*
Children and Adolescents Access to Primary Care -25 Months – 6 Years[1]	*15*	*50th*
Follow Up Care for Children on ADHD Medication – Cont	16	10th
All Cause Readmit – Observed Readmission	16	95th

Measure*	Rank	Percentile
Prenatal Care	17	95th
Children and Adolescent BMI Percentile Documentation	17	75th
Well Child Visits 3-6 Years[2]	*18*	*50th*
All Cause Readmit –Observed to Expected Ratio	19	10th
Children and Adolescents Access to Primary Care – 12-24 Months[1]	*21*	*25th*
Adolescent Well Child[2]	*23*	*25th*
Follow Up Care for Children on ADHD Medication – Init	24	25th
Asthma Medication Ratio	27	25th
Adult BMI Assessment[1]	*27*	*50th*
Cervical Cancer Screening	29	50th
Controlling Blood Pressure	33	50th
Chlamydia Screening in Women	36	50th
Diabetes Care – HbA1c Testing	38	25th
Ambulatory Care – ED Visits[3]	51	< 10th

**Performance might be affected as some plans reported the rates as is during COVID.*

Held to MPL

1. Measure has been retired
2. AWC and W34 will be combined into a new measure, WCV
3. Ambulatory Care—Emergency Department Visits summarizes utilization of ambulatory care for ED visits. This measure is reported in number of visits per 1,000 member months in the IDSS file. Higher or lower rates do not necessarily indicate better or worse performance.

Auto-Assignment

Year 16 (2021) with 20% cap

HEDIS Measures	Anthem Blue Cross	Santa Clara Family Health Plan	Statistically Superior?	Anthem Blue Cross	Santa Clara Family Health Plan	Audit Means, Percentiles, & Ratios	Improvement Score for > 90th Nat P: Anthem Blue Cross	Improvement Score for > 90th Nat P: Santa Clara Family Health Plan	Improvement Score: Anthem Blue Cross	Improvement Score: Santa Clara Family Health Plan	Aggregate Score: Anthem Blue Cross	Aggregate Score: Santa Clara Family Health Plan	Current Year: z	Current Year: Two Tailed	Current Year: Difference Between Rates	Annual Improvement: Anthem Blue Cross: z	Annual Improvement: Anthem Blue Cross: Two Tailed	Annual Improvement: Santa Clara Family Health Plan: z	Annual Improvement: Santa Clara Family Health Plan: Two Tailed
Well Child Visits: 3rd - 6th Years of Life	76.22%	77.13%	No	1	1	83.85%	0	0	0	0	1	1	-0.3085	0.7577	0.9%	0	1.0000	0.32868	0.7424
	411	411																	
Timeliness of Prenatal Care	86.13%	93.19%	Santa Clara Family Health Pl	0	2	90.98%	0	0	0	1	0	3	-3.2017	0.0014	7.1%	-0.0965	0.9231	3.04514	0.0023
	360	411																	
Comprehensive Diabetes Care - HbA1c Testing	83.21%	86.13%	No	1	1	92.82%	0	0	0	0	1	1	-1.1628	0.2449	2.9%	0	1.0000	-1.6101	0.1074
	411	411																	
Controlling High Blood Pressure	56.20%	62.04%	No	1	1	92.94%	0	0	0	0	1	1	-1.7059	0.0880	5.8%	0	1.0000	1.49418	0.1351
	411	411																	
Cervical Cancer Screening	54.26%	61.07%	Santa Clara Family Health Pl	0	2	72.02%	0	0	0	0	0	2	-1.9805	0.0476	6.8%	1.04842	0.2944	0	1.0000
	411	411																	
Safety Net Provider Support Measures							ptest												
% of inpatient hospitalizations which occurred at Disproportionate Share Hospitals (DSH)*	23.91%	39.01%	Santa Clara Family Health Pl	0	1.5		0.00%	0.00%	0	0	0	1.5	-25.656	0.0000	15.1%	0	1.0000	0	1.0000
All Discharges	7,880	20,594																	
% of members enrolled with a PCP at a safety net provider site**	53.30%	55.45%	No	0	0		0.00%	0.00%	0	0	0	0	-9.8402	0.0000	2.2%	0	1.0000	0	1.0000
Total Assigned to a PCP	66,293	242,396																	
		Total Points		**3.0**	**8.5**				**0.0**	**1.0**	**3.0**	**9.5**							

Score Summary	Anthem Blue Cross	Santa Clara Family Health Plan	
Current Year Score	3.0	8.5	
Improvement Score	0.0	1.0	
Aggregate Score (or zero)	3.0	9.5	12.5
Percentage Allocation	**24%**	**76%**	
Baseline Allocation	36%	64%	
Difference	-12%	12%	
Add-on Allowed to Baseline	-12%	12%	
New Base Allocation	**24.00%**	**76.00%**	

*For the most recent year for which data are available, % of inpatient hospitalizations which occurred at Disproportionate Share Hospitals (DSH) for HMO-specific enrollees residing within the county

**% of members assigned to PCPs at rural health clinics, FQHCs, Indian or Tribal clinics, non-profit licensed community or free care clinics, and clinics associated with publicly owned DSH facilities for HMO-specific enrollees residing within the county

Note: 50/50 allocation is the functional equivalent of a 1:1 allocation

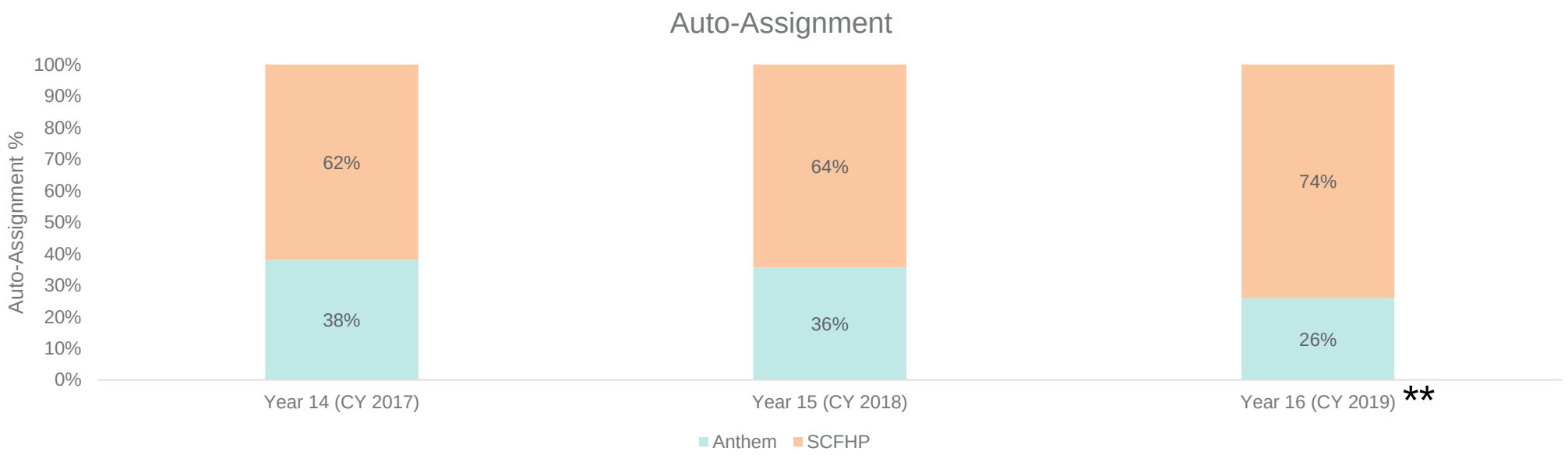
Encounter Data Adjustments	Anthem Blue Cross	Santa Clara Family Health Plan
Encounter Data Grade Low-Performing = 0 High-Performing = 1	1	1
Encounter Data Default %	**3.00%**	**3.00%**
Adjusted Original Algorithm %	**23.00%**	**71.00%**
Final Adjusted Rate	**26.00%**	**74.00%**

* Highlighted cells assume no change from previous year

**Performance might be affected as some plans reported the rates as is during COVID.*

Auto-Assignment

SCFHP's auto-assignment percentage would be potentially increasing.



**Performance might be affected as some plans reported the rates as is during COVID.*
*** Due to COVID, for Year 16, the rates are frozen from Year 15. Displayed rates are an estimate.*

Santa Clara Family Health Plan™

Questions?

Santa Clara Family Health Plan™

Outreach & Retention Update for Medi-Cal

Chelsea Byom, Director, Marketing & Communications

Medi-Cal Marketing Requirements

Prohibited Activities

- Marketing on state or county premises or at a provider's site
- Door-to-door marketing activity
- "Cold-calling" by phone, text, email or in person
- Unsolicited marketing
- Deception, misrepresentation, discrimination, etc.

Acceptable Activities

- Mail or public posting of approved marketing materials
- Media advertising
- Sponsorship or participation in organized community or neighborhood events
- In-home presentations, by request
- Discussion and distribution of approved plan information by health care providers

Organizational Objectives

Fiscal Year 2020-2021

- Increase Medi-Cal market share to 80%
- Open Community Resource Center; partner with CBOs on health education & fitness programming
- Implement YMCA membership benefit for Medi-Cal and CMC members

Outreach & Retention Plan Goals

1

Create and strengthen partnerships with Community Based Organizations (CBOs), government agencies, and providers

2

Improve recognition of and engagement with SCFHP by members and prospective members

3

Improve member retention through enhanced onboarding and service delivery

Outreach & Retention Plan

Completed July 2019 – September 2020

Goal	Tactic
1	Implemented Salesforce in July 2019 to track contacts and outreach activities
2, 3	Launched redesigned SCFHP website in December 2019 to improve accessibility
1, 2	Revised event strategy due to COVID19 to support virtual events and distributed over 15,500 bags, hand sanitizers, toothbrushes, etc. directly to CBO partners since March 2020
3	Selected new fulfillment vendor for member materials, Arvato, in April 2020
1, 2	Launched branded Aunt Bertha community resource website in May 2020
2	Contracted with advertising agency, Dobies Health Marketing, in July 2020
1, 2	Partnered with SSA Dept. of Employment and Benefits Services to certify SCFHP outreach and enrollment staff as County of Santa Clara Authorized Application Assistors for CalWORKs, CalFresh, Medi-Cal, & General Assistance in August 2020
2	Completed internal and external brand awareness surveys in September 2020

Outreach & Retention Plan

Ongoing

Goal	Tactic
3	Complete monthly mailings to approximately 4,000 members with Medi-Cal eligibility on hold due to incomplete redetermination
1, 2, 3	Maintain multi-channel communications strategy, including: • Facebook & LinkedIn • Quarterly community e-newsletter (launched July 2019) • Quarterly member newsletter • Monthly provider e-newsletter (increased from bimonthly in April 2020) • On-hold messaging (launched September 2020)
1	Co-chair the Client Engagement, Outreach and Communication Sub-Group of the Santa Clara County Bridge to Recovery Program Safety Net Task Force (created in April 2020)
1	Enhance and maintain Salesforce to track contacts, outreach activities, events and sponsorships

Outreach & Retention Plan

Planned for FY 2020-2021

Goal	Tactic
2, 3	Launch brand awareness advertising campaign by December 2020 and preventive care advertising campaign by March 2021 (contingent on DHCS approval)
3	Complete implementation of new fulfillment vendor and revised new member welcome packets and personalized provider directories by February 2021 to reflect enhancements to PCP assignment process (contingent on DHCS approval)
1, 2, 3	Open SCFHP Blanca Alvarado Community Resource Center (CRC) by November 2020 and publicly promote CRC by March 2021
1	Publish annual community report in early 2021

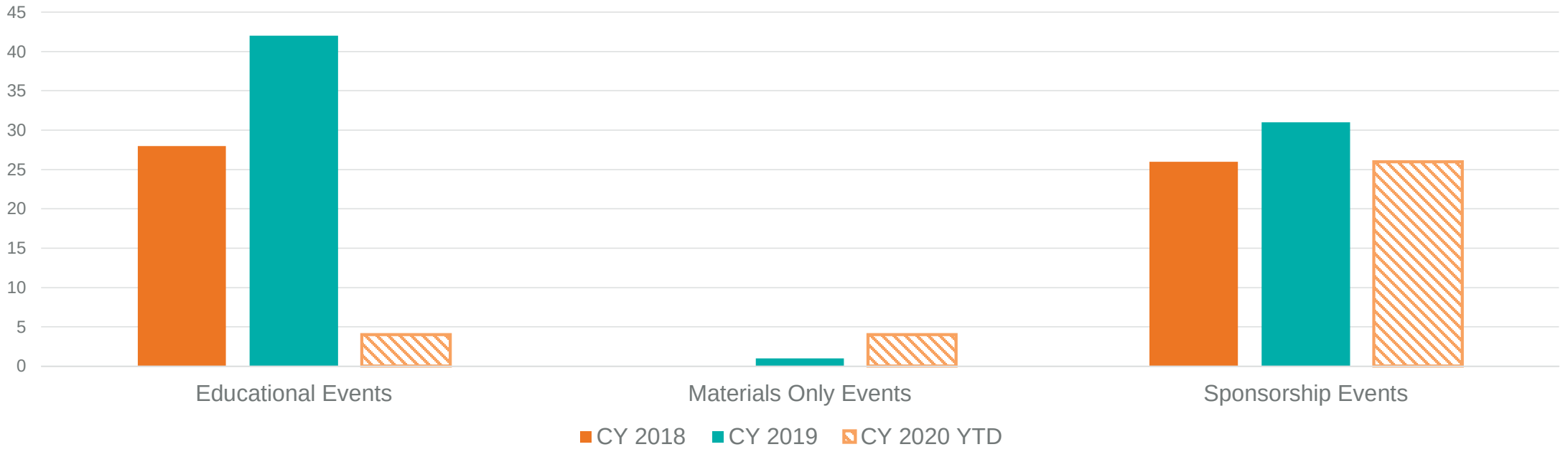
Outreach & Retention Plan

Planned for FY 2020-2021

Goal	Tactic
3	Launch new member orientations in person or via alternate modalities by March 2021
3	Implement redetermination mailing campaign in partnership with SCC Social Services
2, 3	Develop and implement process to capture member opt-in for communications to ensure compliance with Telecommunications Consumer Protection Act (TCPA)
2	Develop and distribute Medi-Cal education/enrollment flyer in partnership with CBOs and government agencies

Outreach Activities

CY 2018, CY 2019, and CY 2020 YTD Accomplishments



Outreach Activities

CY 2018, CY 2019, and CY 2020 YTD Accomplishments

SCFHP facilitates and/or participates in a number of meetings, including:

- Stakeholder/Collaborative meetings
- Introduction meetings
- Strategy meetings
- Networking at community events