Gold Coast Health Plan℠
A Public Entity

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan Commission Meeting

2240 E. Gonzales, Suite 200, Oxnard, CA 93036
Monday, June 24, 2013
3:00 p.m.

AGENDA

CALL TO ORDER / ROLL CALL

PUBLIC COMMENT

1. **APPROVE MINUTES**
   a. Regular Meeting of May 20, 2013

2. **CONSENT ITEMS**
   a. Ratification of Reinsurance Vendor Contract

3. **APPROVAL ITEMS**
   a. Approval of DHCS Contract Amendments 6 & 7
   b. Approval of FY 2013-14 Budget

4. **ACCEPT AND FILE ITEMS**
   a. CEO Update
   b. April Financials
   c. Quarterly QI Report

Meeting Agenda available at http://www.goldcoasthealthplan.org

ADMINISTRATIVE REPORTS RELATING TO THIS AGENDA AND MATERIALS RELATED TO AN AGENDA ITEM SUBMITTED TO THE COMMISSION AFTER DISTRIBUTION OF THE AGENDA PACKET ARE AVAILABLE FOR PUBLIC REVIEW DURING NORMAL BUSINESS HOURS AT THE OFFICE OF THE CLERK OF THE BOARD, 1701 LOMBARD STREET, SUITE 100, OXNARD, CA.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT 805/889-6900. REASONABLE ADVANCE NOTIFICATION OF THE NEED FOR ACCOMMODATION PRIOR TO THE MEETING (48 HOURS ADVANCE NOTICE IS PREFERABLE) WILL ENABLE US TO MAKE REASONABLE ARRANGEMENTS TO ENSURE ACCESSIBILITY TO THIS MEETING

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba
Gold Coast Health Plan June 24, 2013 Commission Meeting Agenda *(continued)*
PLACE: 2240 E. Gonzalez, Room 200, Oxnard, CA
TIME: 3:00 p.m.

5. INFORMATIONAL ITEMS

a. Tatum Work Update
b. State Budget Update
c. Healthy Families Transition / Outreach Update

CLOSED SESSIONS

Closed Session Conference with Legal Counsel – Existing Litigation pursuant to Government Code Section 54956.9 Lucas v. Regional Government Services et al, VCSC Case No. 56-2013-00432444-CU-CE-VTA

Closed Session Conference with Legal Counsel – Anticipated Litigation significant exposure to litigation pursuant to Government Code section 54956.9(d). (Two cases – Claim of Lisa Johnson & Claim of William Padilla, Jr.)

Announcement from Closed Session, if any.

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on July 22, 2013 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

Meeting Agenda available at http://www.goldcoasthealthplan.org

ADMINISTRATIVE REPORTS RELATING TO THIS AGENDA AND MATERIALS RELATED TO AN AGENDA ITEM SUBMITTED TO THE COMMISSION AFTER DISTRIBUTION OF THE AGENDA PACKET ARE AVAILABLE FOR PUBLIC REVIEW DURING NORMAL BUSINESS HOURS AT THE OFFICE OF THE CLERK OF THE BOARD, 1701 LOMBARD STREET, SUITE 100, OXNARD, CA.

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Commission Meeting Minutes

May 20, 2013

(Not official until approved)

CALL TO ORDER

Chair Gonzalez called the meeting to order at 3:00 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
May Lee Berry, Medi-Cal Beneficiary Advocate
Anil Chawla, MD, Clinicas del Camino Real, Inc.
Lanyard Dial, MD, Ventura County Medical Association
John Fankhauser, MD, Ventura County Medical Center Executive Committee (arrived 3:02 p.m.)
Peter Foy, Ventura County Board of Supervisors
David Glyer, Private Hospitals / Healthcare System
Robert Gonzalez, MD, Ventura County Health Care Agency
Robert S. Juarez, Clinicas del Camino Real, Inc. (arrived 3:05 p.m.)
Catherine Rodriguez, Ventura County Medical Health System

EXCUSED / ABSENT COMMISSION MEMBERS
Laurie Eberst, Private Hospitals / Healthcare System

STAFF IN ATTENDANCE
Michael Engelhard, CEO
Nancy Kierstyn Schreiner, Legal Counsel
Michelle Raleigh, CFO
Traci R. McGinley, Clerk of the Board
Charlie Cho, MD, Chief Medical Officer
Melissa Scrymgeour, IT Director
Nancy Wharfield, MD, Medical Director Health Services
Brandy Armenta, Compliance Officer
Sherry Bennett, Provider Network Manager
Cassie Undlin, Interim COO

The Pledge of Allegiance was recited.

Language Interpreting and Translating services provided by GCHP from Lourdes González Campbell of Lourdes González Campbell and Associates.

Commissioner Fankhauser arrived.

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of April 22, 2013

Commissioner Foy moved to approve the Regular Meeting Minutes of April 22, 2013. Commissioner Berry seconded. The motion carried. **Approved 9-0.**

Commissioner Juarez arrived.

2. STUDY SESSION

a. FY 2013-14 Budget

CFO Raleigh reviewed the budget and highlighted the following: 1) significant planned growth due to the Healthy Families Programs (HFP) and Medi-Cal expansion as part of the Affordable Care Act (ACA); 2) GCHP will have more capitated services; 3) GCHP assumes (for budgeting purposes) that there will be no change between this and next year's capitation rates from DHCS; and, 4) estimated costs regarding the Medical Management Systems (MMS) and transition of the nurses from Xerox to GCHP employees have been reflected.

CFO Raleigh noted that the budget reflects assumptions that could change due to the fact that the State budget has not yet been finalized. Also, costs associated with the MMS may need to be updated when the selection has been finalized. There may also be impacts on the budget due to the ACA (physician rate increases), program changes the State has implemented, the Diagnostic Related Groups (DRG) for instance, as well as other pending items such as the IGT.

CFO Raleigh explained that the Per-Member Per-Month (PMPM) Administrative Expenses show a decrease as the Plan is leveraging its cost structure to efficiently handle membership growth. Required TNE is still projected at $16 million as of 06/30/14.

Discussion was held as to how the membership figures were determined. CFO Raleigh explained that it comprised of the number of current ACE members and looking at what other health plans are estimating. CEO Engelhard noted that based on a published report, GCHP believes there are about 30,000 individuals in Ventura County that will sign up for Medi-Cal after implementation of the ACA.

CFO Raleigh added that when the costs were projected, GCHP looked at historical data trends, proposed operational changes and contracted payment rates.
Commissioner Dial questioned the 2013-14 inpatient services capitated costs. CFO Raleigh responded that long-term care services were included in that figure.

In response to questions from Commissioner Dial, clarification was made that in the Clinicas' current capitated contract hospital fees are not included, only professional fees are currently capitated. CFO Raleigh confirmed that currently there is a Specialty contract with Clinicas and GCHP is working on a fully delegated contract with AHP.

CFO Raleigh explained that the required TNE will be slightly lower as GCHP is moving some fee-for-service (FFS) payments to capitated arrangements. CFO Raleigh stressed that by the end of the next fiscal year, GCHP is expected to exceed its TNE requirements. Discussion was also held regarding required levels of TNE due to the increase in membership.

CFO Raleigh continued, noting that several items have not been reflected in the budget. GCHP is expecting to receive $535,000 related to the FY 2011-12 IGT transaction. The Plan will be able to recognize $1.9 million of the $2.9 million set aside for AB 97 payment reductions (The Plan is still in discussion with auditors and the State regarding this matter). Lastly, GCHP has not reflected any additional IGTs.

Discussion was held regarding the Corrective Action Plan (CAP) and the level of services provided by the monitors, Berkeley Research Group (BRG).

Commissioner Rodriguez noted that benchmarks are needed to compare GCHP to other COHS; particularly CenCal. She requested detailed information on the impact of the additional staff, Healthy Families be separated in order to be tracked and the rate for salary trend.

Commissioner Araujo asked for a breakdown of inpatient and hospital days expenses in order to provide better oversight in those areas.

3. APPROVAL ITEMS

a. Kaiser Contract for Healthy Families Transition

CEO Engelhard reviewed his report with the Commission and noted that the item was tabled at the previous Commission Meeting. He highlighted key aspects of the three-way agreement between Kaiser and managed care health plans. The shift of Healthy Families Program (HFP) members currently with Kaiser being able to stay with Kaiser (this would allow current HFP to stay with their Kaiser doctor). When a new member becomes eligible for Medi-Cal and they have had some preexisting relationship with Kaiser during the previous twelve months they would have the option of selecting Kaiser. DHCS established this contracting arrangement between Kaiser and the Medi-Cal managed care plans to ensure that there is continuity of care for new Medi-Cal members.

Commissioner Juarez asked if this would be a Plan-to-Plan contract. CEO Engelhard responded that it would be fully delegated.

Commissioner Juarez questioned why GCHP was bringing this item to the Commission for approval when the CAP did not allow GCHP to proceed forward on Plan-to-Plan implementation until this restriction was lifted. CEO Engelhard explained that the Plan has not performed any implementation work with Kaiser to date. The Healthy Families transition is a state-mandated policy and implementing the agreements was consistent with that policy. The State must give GCHP permission to proceed with other Plan-to-Plan contracts. CEO Engelhard added further clarification that Kaiser would be a Medi-Cal subcontractor for the limited population outlined in the Board request and that Kaiser would not be eligible for auto-assignment of membership.

Chair Gonzalez stated that GCHP is waiting for the approved template from the State so GCHP can do Plan-to-Plan contracting. GCHP is not executing the contract until the State approves the template. CEO Engelhard confirmed that once GCHP has an approved template it could move forward with both Kaiser and AHP.

Discussion was held regarding the timeline for approval of the contract and the required notices to "members" of HFP. CEO Engelhard explained that the State handles the noticing as HFP are State members.

Commissioner Juarez clarified that this would be fully delegated, yet AHP has a contract with GCHP but cannot go forward until the State does their work. Commissioner Juarez added that the AHP contract is proprietary. CEO Engelhard explained that whatever template the State approves will be GCHP's standard template for Plan-to-Plan contracts. CEO Engelhard and Legal Counsel Kierstyn Schreiner both confirmed the templates are not proprietary.

CFO Raleigh noted that GCHP assumes a start date of August 1st for Kaiser and end of September for AHP because it is a new health plan and GCHP has not worked out the readiness details, etc.

Commissioner Foy expressed concern that this line of discussion was a conflict of interest. Legal Counsel Kierstyn Schreiner explained that this was considered general conversation concerning why when the CAP was in existence GCHP could approve a Plan-to-Plan contract with Kaiser and not others. Further, the Welfare and Institution Code exempts conflict under certain circumstances, allowing COHS to have more leeway than other government entities.

Chair Gonzalez reminded the Commission that the issue is the HFP currently with Kaiser which represents 20% of the HFP population statewide. This is about enabling children in the HFP to continue seeing their existing doctors once they transition into the Medi-Cal program, so issues of Kaiser and continuity of care is what should be discussed and addressed.

Commissioner Juarez expressed concern that conflict of interest was only discussed with regard to him yet every member of the Commission, with the exception of the Medi-Cal Beneficiary Advocate seat, has a conflict.

Commissioner Dial moved to authorize and direct the Chief Executive Officer (CEO) to execute 1) a three-way agreement with the DHCS and Kaiser related to the transition of Healthy Families Program (HFP) children and Medi-Cal beneficiaries who are former Kaiser members or family-linked within the previous twelve months and 2) an agreement with Kaiser related to transitioning certain defined categories of members to Kaiser as described in the two-way agreement. Commissioner Foy seconded. The motion carried. **Approved 8-2**, with Commissioners Juarez and Chawla voting no.

4. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Engelhard reviewed his report and emphasized that the Line of Credit (LOC) was approved by the County of Ventura Board of Supervisors, has been signed and GCHP has drawn down the $5 million. The Medical Management System (MMS) is still being analyzed and functions being reviewed. GCHP has hired the COO; she has experience in COHS, Medi-Cal and the State. CEO Engelhard highlighted several items in the State budget. The State is attempting to make the MCO tax permanent, the plans would like some of the money to come back to fund Medi-Cal.

b. CMO Update

CMO Cho reviewed his report with the Commission and highlighted that the Medical Advisory Committee (MAC) reviewed how telemedicine works and what it can do for GCHP.

CMO Cho noted that the MAC also reviewed whether GCHP should consider including OB / GYN specialists as PCPs and allow patient assignment on the capitated network. After reviewing the GCHP “PCP Scope of Services” they concluded that Obstetricians and Gynecologists would not qualify to be PCPs in the GCHP system. However, if an OB / GYN has had extra training to become a PCP, then such specialist may individually apply for consideration to be a PCP with a caveat that such physician shall not be included in auto-assignment.

CMO Cho reviewed the pharmacy costs and noted that the Plan is developing guidelines on the proper use of the drugs.

CMO Cho reported that GCHP HEDIS data was submitted to the vendor and overall GCHP HEDIS, for a new plan, is doing well.

c. March Financials

CFO Raleigh reported that the Plan is performing slightly below budget, with an actual net loss of $1.2 million compared to a projected net loss of approximately $1.0 million. This is after four months of positive net income. The primary reason for the loss is higher health care costs, mostly due to allergies and the flu season. These results contributed to the Plan’s Tangible Net Equity (TNE) deficit for the month.

Commissioner Chawla moved to approve the Accept and File Items as presented. Commissioner Rodriguez seconded. The motion carried. **Approved 10-0.**

5. INFORMATIONAL ITEMS

a. Tatum Work Update
b. State and Federal Budget and Health Care Reform Update
c. Utilization Management / Care Management Update

The Commission was reminded that the information was provided in the packet for their review.

LEGAL COUNSEL - Oral Report

Legal Counsel Kierstyn Schreiner reported that the Closed Session Items that have been included on the Agenda were not included in this meeting due to the lack of action.

CLOSED SESSION

Legal Counsel Kierstyn Schreiner reported that the Closed Session Item was not needed and could be removed from the Agenda.

COMMENTS FROM COMMISSIONERS

Commissioner Berry questioned whether there was a media budget for the Resource Fairs, to which CEO Engelhard responded yes.

ADJOURNMENT

Meeting adjourned at 4:44 p.m.

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AGENDA ITEM 2a

To: Gold Coast Health Plan Commissioners

From: Michelle Raleigh, Chief Financial Officer

Date: June 24, 2013

Re: Ratification of Reinsurance Contract

SUMMARY:
Gold Coast Health Plan's (GCHP) contract with OneBeacon for reinsurance coverage expires on June 30, 2013. The Plan's insurance broker, Beecher Carlson, has prepared a proposal of reinsurance options for coverage during FY 2013-14. GCHP staff presented the analysis and recommendation to the Executive / Finance Committee on June 6th. The Executive / Finance Committee authorized the Plan to continue reinsurance coverage through OneBeacon and to raise the deductible level to $500,000. The Plan is requesting ratification from the Commission.

BACKGROUND / DISCUSSION:
GCHP is currently utilizing OneBeacon to provide reinsurance coverage for claims[1] exceeding $350,000 per member per year. OneBeacon also provided this type of reinsurance coverage during FY 2011-12. Note that once the claim reaches these levels, OneBeacon reimburses GCHP approximately 90% of the payment in excess of the deductible.

OneBeacon's annual contract expires on 06/30/13. Therefore, GCHP staff requested that Beecher Carlson (insurance broker), review experience and obtain bids from reinsurance vendors, both of which are summarized below.

- GCHP's experience – the Plan has paid significantly less in premium compared to the payments received back from the reinsurer, as shown in the table below:

Fiscal Year	Premium	Paid Claims	Loss Ratio (Paid Claims / Premium)
FY 2011-12	$1,108,795	$2,631,671	237%
FY 2012-13	$2,708,634	$4,306,134[2]	159%

[1] Coverage is provided for hospital inpatient services, hospital outpatient services, sub-acute care, pharmaceuticals (other than retail pharmacy), durable medical equipment, ambulance and a limited amount of physician services (that are part of a transplant case rate).
[2] This is an estimate based on $2,583,680 paid claims through 05/21/13 at a 60% completion factor supplied by Beecher Carlson.

- Proposals - Beecher Carlson has prepared a summary of reinsurance options for coverage during FY 2013-14 (see attachment) with key premium information summarized below:

Traditional Medi-Cal Population				
Reinsurance Vendor	**Reinsurance Premium Rate (PMPM) at various deductible levels:**			
	$350k (current level)	***$400k***	***$450k***	***$500k***
OneBeacon	$4.54	$3.84	$3.16	$2.55
OnPoint/XL	$5.14	N/A	$3.36	$2.76
ION Re	$6.35	$5.54	$4.43	$3.55

Targeted Low Income Children Population (e.g., Healthy Families Program Transition)				
Reinsurance Vendor	**Reinsurance Premium Rate (PMPM) at various deductible levels:**			
	$350k	***$400k***	***$450k***	***$500k***
OneBeacon	$2.73	$2.31	$1.90	$1.53

After analyzing the Plan's claim history and premium amounts at the above deductible levels, staff is recommending moving to a $500,000 deductible level with OneBeacon. For the following reasons:

- The Plan is increasing staff, improving case and utilization management, and is engaged in provider re-contracting efforts; all designed to lower future claims costs.
- OneBeacon has been a reliable business partner providing good customer service.

FISCAL IMPACT:
Reinsurance premiums will increase from $2.7 million in FY 2012-13 to $3.0 million in FY 2013-14 for the traditional Medi-Cal population, due to the high claims experience at the Plan.

Because GCHP is increasing the deductible limit from $350,000 to $500,000, premiums will be approximately $2.3 million lower than it otherwise would have been due to the change in the deductible for the traditional Medi-Cal population. At the same time, claims that GCHP will self-insure will increase by approximately $1.9 million, resulting in an expected positive impact of $0.4 million.

The premium for the Targeted Low-Income Child (TLIC) population is expected to be approximately $0.3 million. The TLIC population is new for FY 2013-14.

RECOMMENDATION:
Staff requests that the Commission ratifies the Executive / Finance Committee's recommendation of selecting OneBeacon to provide reinsurance coverage at the $500,000 deductible level for FY 2013-14.

CONCURRENCE:
Executive / Finance Committee (06/06/2013)

Attachments:
Beecher Carlson Proposal

Gold Coast Health Plan

PROPOSAL

HMO SPECIFIC EXCESS OF LOSS REINSURANCE

6 Hutton Centre Drive, Suite 1280
Santa Ana, CA 92707
(714) 481-7106 Phone * (714) 444-4155 Fax

May 30, 2013

Gold Coast Health Plan

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Gold Coast Health Plan

Market Summary

Managing General Underwriter / Carrier	Best's Rating	Quoted	Did Not Quote	Comments
OneBeacon Insurance Company	**A**	✓		**Incumbent**
OnPoint* / XL Reinsurance America	**A+**	✓		
Ironshore	**A-**	✓		
IOA Re	**A**	✓		
Midwest Risk / U.S. Fire	**A**		✓	**Claims Experience**
BEL / American Fidelity Assurance	**A+**		✓	**Underwriting Criteria**
Munich Re	**A+**		✓	**Could Not Meet Deadline**

***Compensation Disclosure Statement for BCIS Placements into OnPoint Programs:**

The total cost of this insurance program includes a fee to Beecher Carlson Insurance Services, LLC, a California limited liability company ("BCIS") as set forth in the quote. OnPoint Underwriting, Inc., a Delaware corporation ("OnPoint") is the program administrator for some or all of this insurance program. OnPoint receives compensation from the insurance companies that participate in this insurance program for providing services to those insurance companies, including underwriting, policy issuance and other services. OnPoint and BCIS are each wholly owned subsidiaries of Beecher Carlson Holdings, Inc. For more information, please refer to the Beecher Carlson Holdings, Inc. fee policy available at www.beechercarlson.com.

Covered Persons Classifications
Medi-Cal

Gold Coast Health Plan

Premium Comparison Summary

Deductible	*Medi-Cal*	
	Rate PMPM	***Estimated Annual Premium***
$350,000 (expiring)		
OneBeacon	$4.54	$5,306,243
OnPoint / XL (ASD Model)	$5.14	$6,007,509
IOA Re*	$6.35	$7,421,728
Expiring 2012 Rates	**$2.33**	$2,723,248
$400,000		
OneBeacon	$3.84	$4,488,100
IOA Re*	$5.54	$6,475,019
$450,000		
OneBeacon	$3.16	$3,693,332
OnPoint / XL	$3.36	$3,927,087
IOA Re*	$4.43	$5,177,678
$500,000		
OneBeacon	$2.55	$2,980,379
OnPoint / XL	$2.76	$3,225,822
IOA Re	$3.55	$4,149,155
$700,000		
IOA Re	$1.09	$1,273,966
Ironshore	$2.48	$2,898,564
$750,000		
IOA Re	$0.76	$888,270
Ironshore	$1.78	$2,080,421
$800,000		
Ironshore	$1.20	$1,402,531
$850,000		
Ironshore	$0.99	$1,157,088

Estimated Membership

Total: 97,398 *Rate Indication Only (non-bindable)

Gold Coast Health Plan

Premium Comparison Summary

Deductible	*TLIC (Healthy Families)*	
	Rate PMPM	***Estimated Annual Premium***
$350,000		
OneBeacon	$2.88	$518,400
$400,000		
OneBeacon	$2.44	$439,200
$450,000		
OneBeacon	$2.01	$361,800
$500,000		
OneBeacon	$1.62	$291,600

Estimated Membership
Total: 15,000

Gold Coast Health Plan

Estimated Annual Premium Summary - ***ASD (Aggregating Specific Deductible)***

Deductibles	Medi-Cal (Pay Rate)		Medi-Cal (Held Rate)		Total (Pay + Held Rate)	Total
	Rate (PMPM)	Estimated Pay Premium	Rate (PMPM)	Estimated Held Pool		
Deductible $350,000						
OnPoint / XL	$1.81	$2,115,485	$3.33	$3,892,024	$5.14	$6,007,509
Expiring 2012 Rates	**$2.33**	**$2,723,248**	**$0.00**	**$0**	**$2.33**	**$2,723,248**

For the agreement period, payable claims are aggregated and deducted from the Held Rate Pool. Once exhausted, the Underwriter is responsible for all subsequent payable Claims.

Estimated Membership (Current)

Medi-Cal (All) 97,398

Gold Coast Health Plan

Coverage Comparison

Coverage	Current	OneBeacon	OnPoint/XL
Maximum Payable Per Covered Member	$2MM	✓	✓
Claims Basis	12/18/21	✓	12/18/18
Coinsurance	90% / 50% for Non-Approved	✓	90%
Hospital Inpatient Services	Contracted Amount; if no contracted amount than the Medi-Cal Allowable	Amount Paid or Contracted Amount	Amount Paid
Hospital Outpatient Services	Contracted Amount; if no contracted amount than the Medi-Cal Allowable	Amount Paid or Contracted Amount	Amount Paid
Sub Acute Care (ECF, SNF, Home Health, Rehab and Long Term Acute Care)	Contracted Amount; if no contracted amount than the Medi-Cal Allowable	Amount Paid or Contracted Amount	Amount Paid
Pharmaceuticals (not including Retail Rx)	Contracted Amount; if no contracted amount than the Medi-Cal Allowable	Amount Paid or Contracted Amount	Amount Paid
Durable Medical Equipment	Contracted Amount; if no contracted amount than the Medi-Cal Allowable	Amount Paid or Contracted Amount	Amount Paid
Ambulance	Contracted Amount; if no contracted amount than the Medi-Cal Allowable	Amount Paid or Contracted Amount	Amount Paid
Physician Services	Included only when part of a Transplant Case Rate	Also includes Diagnostic Lab Services POS 81	Also includes Diagnostic Lab Services POS 81
Off Label Drugs	Excluded	New Language Proposed	Included
31 Day Carryforward Included	Included	✓	At Renewal
Insolvency & Conversion	Not Covered	✓	✓
Experience Refund	30% of 60%	15% of 60% (no deficit carryforward)	N/A

Summary only, please refer to actual carrier Quotations for coverage detail.

**OneBeacon: 50% for Non-Approved Transplant Provider*

Gold Coast Health Plan

Disclaimer

"This insurance document is furnished to you as a matter of information for your convenience. It only summarizes the listed proposed policy(ies) and is not intended to reflect all the terms and conditions or exclusions of such proposed policy(ies). Moreover, the information contained in this document reflects proposed coverage as of the effective date(s) of the proposed policy(ies) and does not include subsequent changes. This document is not an insurance policy and does not amend, alter or extend the coverage afforded by the listed proposed policy(ies). The insurance afforded by the listed proposed policy(ies) is subject to all terms, exclusions and conditions of such policy(ies)."

AGENDA ITEM 3a

To: Gold Coast Health Plan Commissioners

From: Michelle Raleigh, Chief Financial Officer

Date: June 24, 2013

Re: State of California Contract Amendments 6 & 7

SUMMARY:
State of California (State) Department of Health Care Services (DHCS) has presented Gold Coast Health Plan (GCHP) with contract amendments 6 and 7 which reflect changes to State capitation payments. GCHP staff is requesting approval by the Commission for the GCHP Chief Executive Officer (CEO) to execute these contract amendments.

BACKGROUND / DISCUSSION:
The DHCS establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments.

Amendment 6 reflects the following changes to GCHP paid capitation rates:

Fiscal Year	Change
FY 2011-12	No change from Amendment 5 where rates were increased to reflect SB335 (Hospital Quality Assurance Fee).
FY 2012-13 & FY 2013-14	Rates were increased by approximately 3.1% (from FY 2011-12 rates) to be used as a placeholder until rates are finalized by the State. Additional amounts for the Hospital Quality Assurance Fee were also provided for FY 2012-13 rates. Note these rates have not been reduced for any AB 97 provider reductions, and have not been reduced for the State's policy change (effective 07/01/12) regarding retroactive enrollment of members.

Amendment 7 reflects the following changes to GCHP paid capitation rates:

Fiscal Year	Change
FY 2011-12	Rates were increased from Amendment 6 to reflect increases in payment for the Inter-governmental Transfer (IGT)
FY 2012-13 & FY 2013-14	No change from Amendment 6

FISCAL IMPACT:
Impact on financial statements will be:

- FY 2011-12 – these rates reflect the impact of the previously approved IGT. As part of the IGT, GCHP will retain approximately $535,000 which will be recorded as additional revenue in the May, 2013 financial statements.
- FY 2012-13 – after reserving for the AB 97 reserves[1], and the State's policy change regarding retroactive enrollment, GCHP annual revenue will increase by approximately $2.6 million.

RECOMMENDATION:
Staff requests that the Commission allow the GCHP CEO to execute the DHCS contract amendments.

CONCURRENCE:
N/A

Attachments:
None

[1] Note – GCHP will continue to reserve for potential AB 97 cuts over FY 2013-14 until additional information is available regarding the State budget and related court actions.

AGENDA ITEM 3b

To: Gold Coast Health Plan Commissioners

From: Michelle Raleigh, Chief Financial Officer

Date: June 24, 2013

Re: Fiscal Year 2013–14 Budget

SUMMARY:
Gold Coast Health Plan (GCHP or Plan) staff has finalized the operating and capital budgets for FY 2013-14. The budget has been updated from the May 20, 2013 Commission meeting and reviewed during the June 6, 2013 Executive / Finance Committee meeting. The Executive / Finance Committee has recommended the FY 2013-14 budget for approval and GCHP staff is requesting approval of this budget by the Commission. The final budget is summarized in this memo and the attached presentation.

BACKGROUND / DISCUSSION:
The FY 2013-14 GCHP budget includes projections for membership, revenue, health care costs, and administrative expenses. Staff followed a robust process of:

- Estimating membership growth and changes as GCHP gains new members primarily through the transition of Healthy Families program and Medi-Cal expansion under the Affordable Care Act (ACA),
- Calculating revenue based on updated capitation rates provided by the State Department of Health Care Services (DHCS),
- Projecting health care costs as the Plan continues to implement and operationalize many cost savings/avoidance initiatives and replaces certain fee-for-service reimbursement with capitated arrangements, and
- Collecting and reviewing administrative expenditure information from each department.

An initial draft of the FY 2013-14 budget was provided to the Commission on May 20th. Staff made modifications after this meeting based on new information provided by the State and the Plan's further refinement of assumptions. GCHP staff provided a revised budget at the June 6th Executive / Finance Committee meeting. The Executive / Finance Committee recommended the budget be approved by the Commission. Since that meeting, final changes were made based on further review and decisions made during the June 6th meeting and reflected in the budget attached.

Please note that revenue and expenses in the budget are presented and projected on the "accrual basis" of accounting in accordance with Generally Accepted Accounting Principles.

Staff has summarized final budget information below and details can be found in the attached presentation.

- **Membership -** Covered Lives are projected to average 123,547 members monthly for FY 2013-14. The budget reflects new populations joining the Plan:
  - Targeted Low Income Children (TLIC) from the Healthy Families Program (HFP) (approximately 17,000 members transition on August 1, 2013) and
  - Medi-Cal Expansion under the ACA (estimating 6,800 initial enrollment on January 1, 2014 and growing to 11,600 by June 30, 2014).

- **Revenue**

  - **Capitation Rates** - State capitation is budgeted using the draft FY 2012-13 rates, which were the most recent rates available from the State (per Amendments 6 & 7). FY 2013-14 revenue is budgeted at $347.8 million and a weighted average capitation rate of $234.18 per member per month (PMPM).

  - **Reserve for Retro Rate Adjustment** - In March 2011, the Legislature adopted and the Governor signed into law Assembly Bill 97 (AB 97) which called for a 10% payment reduction for certain providers. At the date of this budget, the courts upheld the provider payment reductions and it is expected that the Plan's rates will be reduced due to these provider reductions at a later date when FY 2013-14 rates are finalized. The budget includes the reversal of FY 2011-12 and FY 2012-13 reserves. However, the Plan will continue to reserve for the rate reductions in FY 2013-14. Total reserves are budgeted to be $1.6 million at 06/30/14.

  - **Adjustment for State Policy Change** – On July 1, 2012, the State modified the policy regarding GCHP's responsibility for covering members who are deemed retroactively eligible. This policy change results in a decrease of costs associated with retroactive claims payments. The State has provided draft adjustments for this policy change but not yet reflected the adjustment in the draft rates, so the Plan reduced rates (by an estimated amount of $4.1 million) to reflect expected net payments.

- **Health Care Expenses -** The FY 2013-14 medical and pharmacy expense budget was developed using actual cost over the Plan's operating history and then trended forward.

This projection included adjustments for the estimated membership, impact of ongoing and new initiatives, and new provider contracting arrangements.

Total health care costs are estimated to be $305.5 million for FY 2013-14 and reflect the impact of GCHP's initiatives focused on managing care, recouping overpayments, enhancing cost avoidance efforts, and re-contracting for a total of $13.8 million.

- **Administrative Expenses -** The administrative budget starts with the base of actual expenditures incurred for the current fiscal year, with additions and deletions as appropriate. This includes a review of continued appropriateness of all previous and current expense items and discussions with each department to reflect the resources that are necessary to carry out their responsibilities for the upcoming budget year.

  To summarize, the administrative expenses budget is $25.5 million, which is 5.7% greater than projected FY 2012-13 administrative expenses. However, on a PMPM basis, the estimated administrative cost declined by 13.5% and has declined from $19.90 PMPM to $17.22 PMPM. Moreover, the administrative expense as a percent of revenue also declines from 7.8% to 7.3%, further indicating a more efficient use of administrative spending. Additional costs were driven primarily by increases in:
  - Staffing levels as the Plan shifts away from utilizing consultants and as the Plan incurs significant membership growth in the upcoming fiscal year, and
  - Capital expenditures as the Plan implements a new Medical Management System.

- **Lines of Credit –** The Plan drew down on two lines of credit provided by Ventura County during FY 2012-13 for a total of $7.2 million. These lines of credit are assumed to continue through FY 2013-14 and will be repaid after approval by DHCS.

- **Net Income –** The results of the above membership, revenue, and cost assumptions drive the FY 2013-14 net income of $16.7 million.

- **Tangible Net Equity (TNE) –** The combination of $16.7 million budgeted net income plus the $7.2 million in subordinated lines of credit will allow the Plan to end FY 2013-14 with TNE of $23.9 million. This exceeds the TNE requirement of $15.8 million by 151%.

- **Cash –** FY 2013-14 budget reflects the Plan's continued commitment to closely monitor cash flow. In addition, several of the initiatives incorporated in the budget are designed to increase Medi-Cal revenue and reduce health care costs. Payment terms to vendors, where allowed, will continue to be 30 days. These processes will result in a 70% increase in cash on hand (from $27.6 million to $47.0 million) to cover operations from 33 days to 51 days at 06/30/14.

FISCAL IMPACT:
FY 2013-14 budget is expected to produce the following results on an average monthly basis:

Average Monthly Membership:	123,547
Total Revenue (PMPM)[1]:	$234.56
Health Care Costs (PMPM):	$206.05
Administrative Costs (PMPM):	$17.22
Net Income (PMPM):	$11.29
TNE at 06/30/14:	$23.9 million

RECOMMENDATION:
Staff requests that the Commission adopt the budget as submitted. The Executive / Finance Committee recommended (during the June 6th meeting) that the Commission approve the budget.

CONCURRENCE:
Executive / Finance Committee (06/06/13)

Attachments:
FY 2013-14 Final GCHP Budget Presentation

[1] Includes premium income, interest income and other revenue.

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Fiscal Year 2013-14 Budget

Commission Meeting
June 24, 2013
Michelle Raleigh, CFO

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Table of Contents

Introduction

Gold Coast Health Plan's (GCHP) FY2013-14 (7/1/13-6/30/14) budget is summarized in this document and reflects the following major assumptions:

- Membership growth due to the transition of Healthy Families and the expansion of the Medi-Cal program under the Affordable Care Act (ACA)
- Provider contracting changes result in more services paid for and members covered under capitated arrangements
- Health care costs reflect the impact of GCHP's initiatives underway
- Revenue reflects new draft rates received by the State for FY2012-13 and FY2013-14
- New Medical Management System (MMS) implementation targeted for 1st half of FY 2013-14 which includes transitioning case management nurses to GCHP employees

Pending items potentially impacting FY2013-14 Budget:

- State's FY2013-14 final budget
- FY2012-13 & 2013-14 final State capitation rates
- Requirements for ACA implementation costs (e.g., physician rate increase), State program changes (e.g., Diagnostic Related Groups (DRG) requirement), and other pending items (e.g., provider capitation rate development)

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Updates

Changes Since the May 20, 2013 Commission Meeting

- FY2012-13 results now reflect April 2013 actual results (vs. estimates), which include release of FY2011-12 Assembly Bill (AB) 97 reserve
- FY2012-13 & FY2013-14 revenue has been updated to reflect new draft capitation rates received from State
- FY2011-12 IGT income of approximately $535K has been reflected in revenue
- Certain administrative estimates (i.e. legal, State monitor, and actuarial expenses) have been refined
- Medi-Cal expansion population estimated enrollment, revenue, and costs have been updated based on State budget information
- MMS Vendor selection was finalized
- Reinsurance vendor & coverage was finalized
- Revised financial forecast initiatives to reflect updated financial impacts and timing

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Highlights

- Enrollment growth is driving increase in revenue and health care costs
- Health care costs reflect the impact of the financial forecast initiatives
- Administrative expenses (on a PMPM basis) are decreasing

	FY 2011-12	Projected FY 2012-13 *	Budget FY 2013-14
	($ amounts are stated in thousands)		
Average Monthly Enrollment	104,849	101,068	123,547
Premium Revenue	$ 304,636	$ 309,077	$ 347,755
Health Care Costs	$ 287,354	$ 278,936	$ 305,485
Administrative Expense	$ 18,891	$ 24,139	$ 25,526
Net Income	**$ (1,609)**	**$ 6,002**	**$ 16,744**
MLR	94.3%	90.2%	87.8%
ALR	6.2%	7.8%	7.3%
Administrative Expense - PMPM	$ 15.01	$ 19.90	$ 17.22
TNE	**$ (6,032)**	**$ 7,170**	**$ 23,914**

** Reflects actual experience through 4/30/13 and estimates from 5/1/13 to 6/30/13*

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Membership

- Covered lives are projected to average 123,547 resulting in 1,482,568 member months for FY2013-14
- Responsibility regarding retroactive membership has been clarified by the State, resulting in updated projections
- Other items impacting Membership
  - Continued phase-in of Targeted Low Income Children (TLIC) membership, with full transition of the approximate 17,000 members remaining in the HFP as of 8/1/2013
  - Phase-in of Medi-Cal Expansion (MCE) members, starting with approximately 6,800 on 1/1/14 and reaching approximately 11,600 by 6/30/14

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Membership

Aid Category – Members (See Note 1)	FY 2011-12	Projected FY 2012-13	Budget FY 2013-14
	(Stated in Averaged Member Months)		
Adult/Family	77,533	73,199	74,079
SPD	9,538	9,277	9,413
Dual	17,779	17,578	17,769
Sub-total (Note 2)	104,849	100,053	101,260
Annual Percentage Growth		*-4.6%*	*1.2%*
TLIC (Healthy Families)	-	1,015	17,676
Medi-Cal Expansion (Note 3)	-	-	4,611
Averaged Members	**104,849**	**101,068**	**123,547**
Annual Percentage Growth		*-3.6%*	*22.2%*

Note 1 - Member categories have been grouped to include as follows: Seniors and persons with disabilities (SPD) includes Aged-Medi-Cal, Disabled-Medi-Cal, Long-term Care-Medi-Cal, and Breast and Cervical Cancer Treatment Plan (BCCTP). Dual (includes Aged-Dual, Disabled-Dual, and Long-term Care-Dual)

Note 2 -Decrease from FY 2011-12 to FY 2012-13 due to change in retroactive eligibility

Note 3 - Medi-Cal expansion starts on 1/1/14 with approximately 6,800 members and reaching approximately 11,600 members by 6/30/14

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Revenue

- Draft FY2012-13 State capitation rates have been updated based on information sent by State:
  - New capitation rates from State reflects increases in revenue of approximately $2.6 million for FY 2012-13 and FY 2013-14
  - FY2013-14 State capitation rates are assumed to be equal to FY2012-13 State capitation rates
  - Estimated Assembly Bill #97 (AB97) provider reductions have been reserved for FY 2013-14
  - Estimated MCO Tax and Hospital Quality Assurance Fee were treated as a pass-throughs
  - Estimated retroactive eligibility enrollment policy change has reduced rates for both years

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Revenue

Total Revenues in PMPM (See Note)	FY 2011-12	Projected FY 2012-13	Budget FY 2013-14
Adult/Family	$ 132.37	$ 130.52	$ 130.10
SPD	$ 846.76	$ 900.54	$ 914.87
Dual	$ 436.92	$ 444.83	$ 440.19
Averaged PMPM for Existing Categories	*$ 249.00*	*$ 257.13*	*$ 257.46*
TLIC (Healthy Families)	$ -	$ 77.90	$ 77.90
Medi-Cal Expansion	$ -	$ -	$ 349.99
Averaged PMPM - Aggregate	*$ 249.00*	*$ 255.33*	*$ 234.18*

Total Revenues in $ (stated in thousands)	FY 2011-12	Projected FY 2012-13	Budget FY 2013-14
	$ 304,636	$ 309,077	$ 347,755

Note: Member categories have been grouped to include as follows: SPD (includes: Aged-Medi-Cal, Disabled-Medi-Cal, Long-term Care-Medi-Cal, and BCCTP). Dual (includes Aged-Dual, Disabled-Dual, and Long-term Care-Dual)

Health Care Costs

- Medical and pharmacy expenses were derived from actual costs over the Plan's history (7/1/11-4/30/13) and projected forward, reflecting impact of:
  - Provider contracting assumed changes
    - Clinicas "Specialty" contract is replaced with Americas Health Plan (AHP) "plan-to-plan" contract (approximately 14,000 members)
    - "Plan-to-plan" contract with Kaiser to cover their current Healthy Families members (approximately 2,900 members)
  - GCHP financial forecast initiatives
    - Overall impact is approximately $13.8 million in health care cost reductions

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Health Care Costs

- Health care cost reflects the shift from fee-for-service to capitation
- Total health care costs are decreasing (on a PMPM basis) due to financial forecast initiatives and transition of TLIC (Healthy Families Transition) members

	FY 2011-12	Projected FY 2012-13	Budget FY 2013-14
	(in thousands)		
Capitation *	$ 7,535	$ 10,623	$ 46,085
Claims:			
Inpatient	$ 140,403	$ 132,795	$ 122,899
Outpatient	$ 45,802	$ 41,269	$ 39,900
Professional	$ 29,560	$ 27,577	$ 27,262
Pharmacy	$ 36,022	$ 40,927	$ 38,901
Other * *	$ 22,268	$ 18,308	$ 21,958
Care Management	$ 5,763	$ 7,437	$ 8,482
	279,819	268,313	259,400
Total	**$ 287,354**	**$ 278,936**	**$ 305,485**

Total Health Care Costs in PMPM	**FY 2011-12**	**Projected FY 2012-13**	**Budget FY 2013-14**
	$ 228.39	$ 229.99	$ 206.05

* Includes PCP, Specialty, Plan-to-Plan, Non-emergency transportation, and Vision Service Plan

** Other claims include all other fee for service expenses, reinsurance and transportation expenses

Administrative Expenses

- In addition to increases due to staffing Plan (more details on next slide), other items impacting administrative expenses include:
  - Implementation of new Medical Management System
  - Additional community outreach activities including community events, translation services, cultural and linguistics, and health educational materials
  - Increase in FY2012-13 staffing resulted in increase in square footage (average rent per square foot dropped by 9%)
  - Increases in resources needed due to additional oversight and compliance requirements

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Staffing

- GCHP shifts from utilizing consultants to hiring full-time employees
  - FY2012-13 FTEs: 84 (year-end target), including Chief Operating Officer
  - FY2013-14 FTEs: 123 (84 previous + 19 new hires + 20 nurses)

    Additional positions will enhance the Plan's analytical and compliance-related capabilities as well as to meet the demands of health care reform and enrollment growth.
    - Health services staffing* - 20 ACS nurses converted to GCHP, plus additional medical management (3) and health services (6)
    - Other Plan staffing – including staff additions in finance (3), information technology (2), administrative support (2), quality improvement (1), government relations (1), and compliance (1)

  - Health plan benchmarks range 1.3-2.0 staff per 1,000 members (GCHP will be at 1.8**)
  - Salaries consistent with pay grades/ranges approved by the Commission on 8/27/2012

* Categorized financially as part of medical costs, not administrative costs.

** Includes outsourced ACS staff for comparability.

Vendor Contracts

Additional Vendors (contracts expected to be over $100K annually):

[ACS shown on Administrative Expenses detail page]

Vendor	Services Provided	Projected FY 2012-13	Budget FY 2013-14
Pharmacy Benefit Manager	Pharmacy management	$ 3,147,000	$ 2,839,000
Insurance Vendors	Business insurance (not including reinsurance*)	$ 109,000	$ 164,000
Lease Expense	Office space and maintenance	$ 250,000	$ 320,000
IT Consultant	IT support	$ 183,000	$ 180,000
Communications Consultant	Communication and website contents	$ 118,000	$ 110,000
HEDIS Consultant	HEDIS Data and Consulting	$ 114,000	$ 125,000

* Note reinsurance premium reflected in health care costs, not administrative costs.

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Consulting Contracts

Major consulting contracts (contracts over $100K annually):

Consultant	Duties	Projected FY 2012-13	Budget FY 2013-14
State Monitor	Performs on-going state monitoring duties	$ 1,500,000	$ 996,000
Actuarial Consultants	Performs assistance related to claims reserving, state rate development data requests, provider capitation and risk analysis	$ 217,000	$ 100,000
Financial Auditor	Performs financial audit required by the state and answers ongoing questions related to financial statement development	$ 150,000	$ 150,000
Legal Services	Performs support for Commission and Committee meetings, employees issues, and review of contracts (for both vendor and provider) ▪ Employee issues and benefits (10%) ▪ Vendor and provider contracts (60%) ▪ Commission and committee services (15%) ▪ Litigation/complaints (15%)	$ 390,000	$ 365,000

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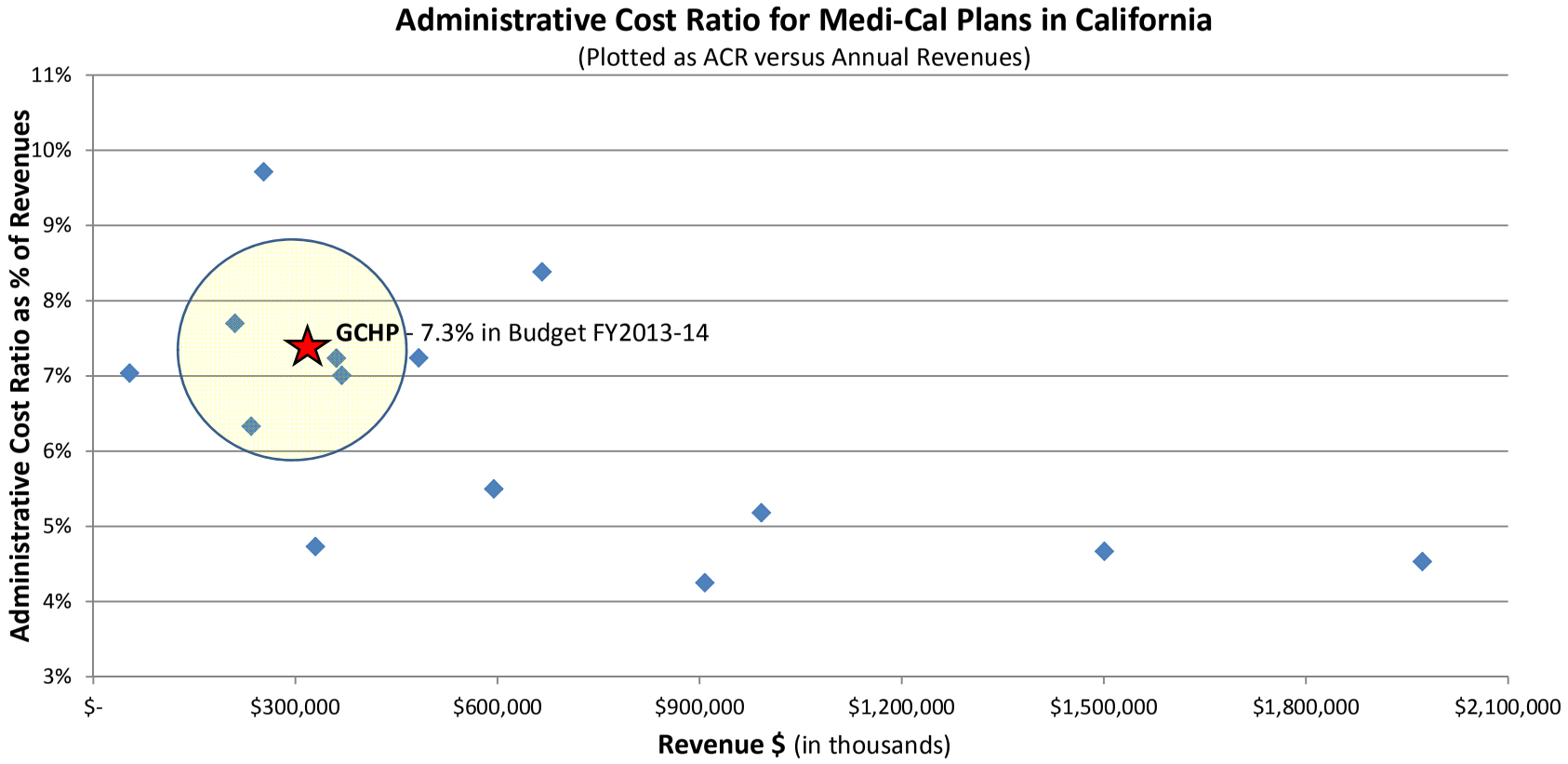
Administrative Expenses

- Increased enrollment allows Plan to access reduced pricing tier for ACS
- Reflects a shift from consultants to employees
- Lower PMPM expenses leverages infrastructure while growing membership

	Projected FY 2012-13	Budget FY 2013-14	Increase (Decrease)	% Change
	(PMPM)			
ACS Management Fees	$ 9.44	$ 7.68	$ (1.76)	-18.6%
Personel expenses	$ 4.26	$ 5.57	$ 1.31	30.7%
Legal and professional services	$ 5.13	$ 1.87	$ (3.26)	-63.6%
Infrastructure expenses	$ 1.03	$ 1.97	$ 0.95	92.5%
Community and provider outreach	$ 0.04	$ 0.12	$ 0.08	173.2%
Total	**$ 19.90**	**$ 17.22**	**$ (2.69)**	**-13.5%**
Total Admin Expenses in $ (thousands)	**$ 24,139**	**$ 25,526**	**$ 1,387**	**5.7%**

Administrative Expenses

GCHP administrative cost ratio is in line with other plans consistent with GCHP size



Capital Budget

Capital expenditures for FY 2013-14 budget is primarily for acquisition and implementation of the Medical Management System (MMS) with other small amounts for equipment used to support member/staff expansion:

- Capital assets, including office furniture and fixtures, computer equipment, software and leasehold improvements, whose acquisition costs exceed $1,500 are accounted for in the capital budget. Purchases less than $1,500 are included in the administration budget.
- Capital asset acquisitions for FY 2013-14 budget is approximately to be $1.6 million of which $1.4 million pertains to the MMS System and its implementation. The new MMS is needed to coordinate authorization of medical services for our member population.
- The capital budget assumes our current locations are adequate to absorb staff expansion
- No provisions have been made in the capital budget for any needed DRG software and related implementation costs

Tangible Net Equity

- As of 6/30/14,
  - the Plan is projected to be at a TNE of $23.9 million, which exceeds the TNE requirement of $15.8 million (151% of requirement)
  - the TNE requirement is fully phased-in (at 100%) versus 68% of the requirement at 6/30/13
  - the required TNE is lower due to the shift to capitation being a larger portion of health care costs
  - the TNE includes $7.2 million related to two lines of credit with the County of Ventura

	FY 2011-12	Projected FY 2012-13	Budget FY 2013-14
	($ amounts stated in thousands)		
100% TNE	$ 16,769	$ 16,153	$ 15,836
% TNE Required	36%	68%	100%
Required TNE	$ 6,037	$ 10,984	$ 15,836
GCHP TNE	***$ (6,032)***	***$ 7,170***	***$ 23,914***
TNE Excess / (Deficiency)	$ (12,069)	$ (3,814)	$ 8,077
GCHP TNE as a % of Required TNE	-99.9%	65.3%	151.0%

- Any potential impact related to FY 2012-13 IGT is not reflected in the budget

Tangible Net Equity Roll-forward Schedule

- Plan is projected to exceed FY2012-13 Net Income budget of $4.1 million partially due to:
  - Updated revenue based on new draft State capitation rates ($2.6 million)
  - Release of FY2011-12 AB97 reserves ($1.9 million)
  - Reflection of FY2011-12 IGT revenue ($536k)
  - Improved operations and ongoing initiative efforts ($1.6 million+)
  - Lines of Credit ($7.2 million) provided by the County of Ventura

	Amounts (in thousands)	
Tangible Net Equity - 6/30/12		**$ (6,032)**
Projected Net Income for FY 2012-13		
YTD Net Income through 4/30/13	$ 1,104	
Projected Net Income for May and June 2013	4,897	6,002
Subordinated Debt		7,200
Projected Tangible Net Equity - 6/30/13		**7,170**
Budget Net Income for FY 2013-14		16,744
Budget Tangible Net Equity - 6/30/14		**$ 23,914**

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Cash & Liquidity

- Cash & Medi-Cal Receivable balance increasing next year as full impact of initiatives are realized
- Ongoing cash management processes will be in effect

	Actual 6/30/12	Projected 6/30/13	Budget 6/30/14
	(in thousands)		
Cash	$ 25,554	$ 27,596	$ 46,998
Medi-Cal Receivable	28,535	26,249	31,265
	$ 54,089	$ 53,845	$ 78,263
Financial Indicators:			
Current Ratio	0.92:1	1.15:1	1.39:1
Days Cash on Hand	30	33	51
Days Cash + State Capitation Receivable	64	64	85

Appendix A - Balance Sheet

	Actual 6/30/12	Projected 6/30/13	Budget 6/30/14
	(in thousands)		
Assets			
Cash	$ 25,554	$ 27,596	$ 46,998
Receivables	35,074	27,743	31,687
Prepaid expenses	2,334	1,204	948
Total current assets	62,963	56,544	79,633
Deposits	375	131	132
Computers (Net of Accum Deprec)	176	208	1,629
Total Assets	$ 63,514	$ 56,882	$ 81,393

Appendix A - Balance Sheet – cont.

	Actual 6/30/12	Projected 6/30/13	Budget 6/30/14
	(in thousands)		
Liabilities and Fund Balance			
Medical claims payable	$ 63,602	$ 40,750	$ 48,067
Other payables	2,759	637	1,836
Accrued expenses	803	7,060	6,634
Current Portion of Deferred Revenue	460	460	385
Accrued Payroll Expense	-	337	558
Current Portion of L/T Debt	500	83	-
Total current liabilities	68,124	49,328	57,480
Deferred Revenue - Long Term Portion	1,380	385	-
L/T Debt	42	-	-
Subordinated Loan	-	7,200	7,200
Total noncurrent liabilities	1,422	7,585	7,200
Total Liabilities	69,546	56,913	64,680
Fund Balance	(6,032)	(30)	16,714
Total Liabilities & Fund Balance	$ 63,514	$ 56,882	$ 81,393

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Appendix B – Income Statement

	Actual 6/30/12	Projected 6/30/13	Budget 6/30/14
	(in thousands)		
Member Months	1,258	1,213	1,483
Revenues	$ 304,636	$ 309,077	$ 347,755
Health Care Costs:			
Capitation	7,535	10,623	46,085
Claims:			
Inpatient	140,403	132,795	122,899
Outpatient	45,802	41,269	39,900
Professional	29,560	27,577	27,262
Pharmacy	36,022	40,927	38,901
Other	23,456	21,200	19,619
Reinsurance	(1,188)	(2,892)	2,338
Care management	5,763	7,437	8,482
	279,819	268,313	259,400
Total Health Care Costs	287,354	278,936	305,485
Administrative Expenses	18,891	24,139	25,526
Net Income	$ (1,609)	$ 6,002	$ 16,744

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Appendix C - Cash Flow

	Actual 6/30/12	Projected 6/30/13	Budget 6/30/14
	(in thousands)		
Cash Flow from Operating Activities			
Collected Premium	$ 284,748	$ 310,257	$ 342,171
Interest Income	190	115	108
Paid Claims	(223,143)	(294,351)	(290,654)
Admin Expenses	(23,029)	(29,163)	(31,574)
Provider Receivable	(6,540)	5,045	1,072
MCO Tax Expense	(6,759)	3,511	(4)
Net cash provided (used) by Operations	25,467	(4,586)	21,119
Cash Flow from Investing/Financing			
Net Prop & Equip	(116)	(75)	(1,634)
Proceeds from Subordinated Debt	-	7,200	-
Debt Payments	(458)	(497)	(83)
Net Cash Provided (Used) by Inv/Fin	(574)	6,628	(1,717)
Net Cash Flow	24,893	2,042	19,402
Cash & Equiv at Beg of Period	661	25,554	27,596
Cash & Equiv at End of Period	$ 25,554	$ 27,596	$ 46,998

Appendix D - Revenue Cross-walk FY2012-13 to FY2013-14

- Revenue from new populations accounted for approximately $36 million or 12% in additional revenues for FY 2013-14
- Budget holds rates constant across both years
- Financial forecast included assumptions in revenue growth for conversion of members in LTC facilities

	Amount (in thousands)
FY2012-13 Projected Revenue	**$ 309,077**
Volume	
TLIC (Healthy Families Kids)	$ 16,523
Medi-Cal Expansion	$ 19,366
Financial forecast Initiatives	$ 1,573
Membership Mix	$ 1,216
FY2013-14 Budget Revenues	**$ 347,755**

Appendix E - Health Care Costs Cross-walk FY2012-13 to FY2013-14

- Health care cost grow by approximately $33 million due to growth in membership
- Financial Forecast Initiatives reflect full impact in FY2013-14
- Additional initiatives not yet estimated present opportunities for further reductions (e.g., new pharmacy price list for a majority of generics)

	Member Months	PMPM	Amount (in thousands)
FY2012-13 Projected Health Care Costs			**$ 278,936**
Volume			
TLIC (Healthy Families Kids)	212,110	$ 69.31	$ 14,701
Medi-Cal Expansion	55,333	$ 325.49	$ 18,010
Financial forecast Initiatives			$ (13,834)
Other			$ 7,671
FY2013-14 Budget Health Care Costs			**$ 305,485**

Appendix F - Provider Capitation

- Health care cost reflects the shift from fee-for-service to capitation
- In addition to new capitated arrangements in FY2012-13 (i.e., Specialty, NEMT, Vision), the Plan is expect to assume full-risk contracts with Kaiser and AHP in FY2013-14
- Capitation rates are being developed by actuarial consultants

	FY 2011-12	Projected FY 2012-13	Budget FY 2013-14
		(in thousands)	
Plan-to-Plan and Cap Rate Re-Basing	$ 7,534	$ 8,714	$ 37,803
Non-Emergency Transportation	$ -	$ 1,121	$ 4,863
Vision	$ -	$ 788	$ 3,419
Total	**$ 7,534**	**$ 10,623**	**$ 46,085**

AGENDA ITEM 4a

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, CEO

Date: June 24, 2013

Re: CEO Update

GOVERNMENT RELATIONS UPDATE

State Budget Update
State Legislators met the state constitutional deadline and passed a state budget on June 15th. The $96.3 billion state budget requires counties to return approximately $300 million of their state reimbursements for providing health care to the uninsured. The Brown Administration expects local costs to drop dramatically when the federal Affordable Care Act (ACA) is fully implemented and counties will save an equal amount of money after many of the uninsured are moved into the state Medi-Cal Program.

The California State Association of Counties (CSAC) estimates that between 3 to 4 million people will remain uninsured even after the ACA is fully implemented. A study from the Robert Wood Johnson Foundation estimates that nearly half of California's seven million uninsured residents will remain uninsured post ACA implementation due to a variety of factors including undocumented status or being homeless.

Medi-Cal Budget Update
The approved state budget includes $77 million to restore dental benefits for approximately three million Medi-Cal beneficiaries. Dental benefits were eliminated from Medi-Cal coverage in 2009.

MCO Tax
Legislators passed the MCO tax with a three-year sunset date of December 31, 2016. As passed, funds from the MCO Tax will be deposited in the Children's Health and Human Services Special Fund solely for the purpose of funding managed care rates for health care services for children, seniors and persons with disabilities, and dual eligibles in the Medi-Cal Program.

Health Care Reform Legislation
The Legislators approved SBX 1 and AB X1, both bills implement key provisions of the federal Affordable Care Act (ACA) into state law. Specifically, these measures prohibit insurers from denying coverage to persons with existing medical conditions and streamline

the eligibility and asset test criteria under Medi-Cal. Legislators are still debating SB X1 3, which would enact the Medicaid Bridge Plan. The Medicaid Bridge Plan would allow individuals with incomes below 200 percent of federal poverty level who are no longer eligible for Medi-Cal to remain in a Medi-Cal plan pending their transition into the health benefits exchange.

Health Care Reform Outreach

The GCHP Outreach and Communications Team, which includes the Health Education Department, is charged with carrying out the GCHP Outreach and Communications Plan to stakeholders, local government and county residents utilizing the following strategies, goals, and objectives:

1) Identify and establish strong working relationships with key stakeholder groups and individuals in Ventura County. Emphasis will be focused on regular communication and outreach to the provider and consumer communities served by GCHP in Ventura County.

2) Increase GCHP member and public awareness of the changes coming to the Medi-Cal Program and managed care system in 2013 and 2014. *These include the transition of the Healthy Families Program to Medi-Cal managed care, Medicaid expansion under the Affordable Care Act (ACA),* and future integration of the dual eligible population into Medi-Cal managed care.

3) Focus on wellness, prevention, and early intervention through health education.

Additionally, DHCS is developing notices to those eligible for Medi-Cal under Health Care Reform and the ACA. These notices will be distributed through and co-branded with county low-income health programs (LIHP). Additional notices will also be sent through the LIHPs for the Exchange-eligible and Medicaid-eligible populations.

DHCS, in partnership with the University of California Los Angeles (UCLA) and the University of California Berkeley (UCB), will convene a meeting of the Low Income Program (LIHP) Transition Planning Stakeholder Workgroup on June 28, 2013, from 1:00pm-4:00pm. The Workgroup will have about 30 members, including GCHP staff, consumer advocates, LIHP programs and other county representatives, health plans, Covered California, and DHCS staff. The meeting will focus on strategies and processes to facilitate continuity of care for the LIHP population when they transition to Medi-Cal and Covered California. After a draft of the Continuity of Care plan is complete, DHCS will solicit additional stakeholder feedback to help finalize the LIHP Continuity of Care plan. Members of the public will be able to review the plan and comment by email.

Health Care Reform / Affordable Care Act (ACA) Implementation

DHCS is collaborating with Covered California, formerly known as the health benefits exchange, to implement a new and streamlined eligibility and enrollment system. This system is called the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). Some components of the CALHEERS system will not be ready to launch until January 2014. Covered California will conduct aggressive statewide marketing and outreach to specific tax credit populations and use a phone-based enrollment system to reach those immediately eligible for participating in the health benefits exchange.

Medicaid Expansion

As outlined by DHCS, there are approximately 600,000 individuals currently enrolled in low income health programs, or LIHPs, state-wide. These individuals will be eligible for either Medi-Cal or subsidies for health care coverage through Covered California. DHCS officials indicated that under federal Medicaid expansion California will offer the same medical benefits to the newly eligible as those offered to current Medi-Cal beneficiaries.

Discussions are on-going whether mid-level mental health services should be carved-in or carved-out of Medi-Cal managed care plan benefits. The Senate Budget Subcommittee added $50 million for providing services to autistic children. DHCS and advocates alike have expressed concern as to the adequacy of this funding to meet the need. Beginning in 2014 DHCS is expecting the federal government to cover 100% of the cost of these services.

ACA PCP Rate Increase

DHCS now has a self-attestation form available on-line. Plans are being encouraged to conduct outreach to preferred providers. DHCS notified the Plans that rate packages are under review by CMS. It now appears that funding for this program through the managed care plans may not occur until late summer or early fall according to DHCS.

Hospital Quality Assurance Fee (SB 335)

As expected, the Plan received FY 2011-12 hospital quality assurance fee (HQAF) payments from the State in early June. However, the Plan is waiting for another payment that will include the MCO tax related to the HQAF payment. Once the payment and documentation is provided, the Plan will distribute the HQAF payment to hospitals according to a schedule provided by the California Hospital Association. The Plan expects to distribute funds by June 30th.

Medical Audits

Starting in 2014, the DHCS Medi-Cal Managed Care Division will conduct medical audits of plans on annual basis instead of once every three years. These audits will be conducted jointly between DHCS and DMHC.

May 29th All-Plan / DHCS Meeting

GCHP's CEO, CFO and Director of Government Relations attended the All-Plan Meeting with the California Department of Health Care Services (DHCS) on May 29th in Sacramento. Key topics discussed included:

- Health Care Reform / Affordable Care Act (ACA) Implementation
- Medicaid Expansion
- ACA PCP Rate Increase
- Medical Audits

COMPLIANCE

Compliance has engaged a third party, Provencio Advisory Services to assist in the development / improvement of required delegation oversight functions the Plan is bound to. Provencio has concluded the first phase that included interviews with our delegated partners as well as core document review.

Compliance staff participated in the DEA / LA Care Anti-Fraud Work Group held on June 11, 2013. In addition compliance staff continues to attend meetings held by the Department of Justice on a quarterly basis. The meetings include other Health Plans and increase awareness of fraud activities / trends occurring in the industry. HIPAA and Fraud Waste and Abuse training has been ongoing for all employees and is regularly scheduled for all new associates to ensure compliance.

Compliance continues to build out compliance software which has been and will be a valuable tool for the organization. In addition compliance continues to work with DHCS on all regulatory submissions and requirements to ensure compliance.

MEDICAL MANAGEMENT SYSTEM (MMS) SELECTION

GCHP presented the final recommendation for a replacement Medical Management System (MMS) at the June 6, 2013 Executive / Finance Committee. After a 5-month RFI / RFP selection process, the GCHP MMS selection committee - comprised of the GCHP Medical Director, Director of Health Services, Director of Information Technology (IT), a Medical Management system consultant, and clinical subject matter experts - narrowed the selection to two vendors: MedHOK Healthcare Solutions, LLC and Essette, Inc. The Executive / Finance Committee unanimously approved the recommendation of MedHOK as the MMS vendor of choice and to allow CEO Engelhard to enter into an agreement to implement the MedHOK system, pending final contract negotiations. Those negotiations are currently in progress with a target of June 30, 2013 for final contract execution. The project implementation kickoff is scheduled for July 8, 2013, pending contract completion.

AGENDA ITEM 4b

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: June 24, 2013

Re: April, 2013 Financials

SUMMARY:
Staff is presenting the attached April, 2013 financial statements of Gold Coast Health Plan (Plan) for review by the Commission. Staff reviewed the financial package in detail with the on June 6th. At that meeting, the Executive / Finance Committee recommend approval of April, 2013 financials to the Plan's Commission.

BACKGROUND / DISCUSSION:
The Plan has prepared the April, 2013 financial package, including balance sheets, income statements and statements of cash flows reflecting monthly and year-to-date information.

FISCAL IMPACT:
When compared to budget on a year-to-date basis, overall the Plan is performing ahead of budget, with an actual net income of $1.1 million compared to a projected net income of approximately $0.5 million. This month's net income of $2.3 million includes the effect of reversing $1.9 million in AB 97 (10 percent provider rate reductions for certain services / providers) reserves held for FY 2011-12. The AB 97 reserves were released for this time period based on the clarifications provided in the May revision to the FY 2013-14 State budget and review by the Plan's auditors. Operating income, net of the AB 97 adjustment, was approximately $364,000.

The month's positive results contributed to an improvement in the Plan's Tangible Net Equity (TNE), which is currently at a negative $2.7 million. Year to date, the Plan is behind its budgeted TNE by $3.9 million. The budgeted TNE included the assumption that an additional $6 million line of credit (LOC) to be drawn in March, 2013. Excluding the assumed $6 million LOC, the Plan's TNE is $2.1 million ahead of budget. It should be noted that the Plan reached an agreement with the County of Ventura for a $5.0 million LOC, which was executed in April and drawn upon in May. The impact of this LOC will be reflected in the May financial statements.

Highlights of **this month's** financials include:

Membership - The Plan had 3,694 more members than budgeted for the month with larger than expected enrollment in the Adult / Family, Dual, and TLIC categories.

Revenue - Enrollment mix, with lower revenue members than budgeted, led to a lower than anticipated average revenue per member per month (PMPM). Lower than expected CBAS revenue also contributed to the shortfall, resulting in overall net premium (capitation) revenue of $8.22 PMPM below budget.

Health Care Costs -The primary item that contributed to the differences between the actual ($229.98 PMPM) and budgeted costs ($231.85 PMPM) were net reinsurance and claims recoveries which are higher than in the budget.

Administrative Expenses - Overall operational costs were higher than anticipated by $2.82 PMPM. Expenses were impacted by the following items:

- Non-budgeted charges related to the HEDIS audit.
- Higher than projected consulting fees from extended engagement of monitor and IT consulting.
- Higher than expected general office expenses including non-capitalized computer equipment, furniture / office installation / configuration charges, employee recruitment / conversion fees and telephone services.
- The increase was partially offset by delays in hiring, lower ACS management fees, and lower printing expenses.

Cash + Medi-Cal Receivable -the Plan continues to monitor its cash balance and is continuing with cash management programs that began in February. The cash and Medi-Cal Premium Receivable balances of $45.2 million are lower than the budget of $52 million due to the timing difference of the LOC. After adjusting for the $6 million LOC assumed in the budget, the cash and Medi-Cal receivable budget would have been $46 million.

Note:

- The higher use of cash this month is the result of an additional claims and pharmacy payment made (i.e., 5 payments were made vs. 4 in a typical month).
- The cash balance includes the $2.2 million proceeds from a line of credit with the County of Ventura; an additional $5 million was received during the month of May.

Please note the balance sheet reclassification made in the April financials is a realignment of the net Receivable and Payable from / to the State. The MCO Tax and the AB 97 reserves which was previously included as part of the receivable from the State is now separately stated.

RECOMMENDATION:
Staff proposes that the Plan's Commission approve the April, 2013 financial package.

CONCURRENCE:
Executive / Finance Committee (06/06/13)

Attachments:
April, 2013 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
FOR THE MONTH ENDED APRIL 30, 2013

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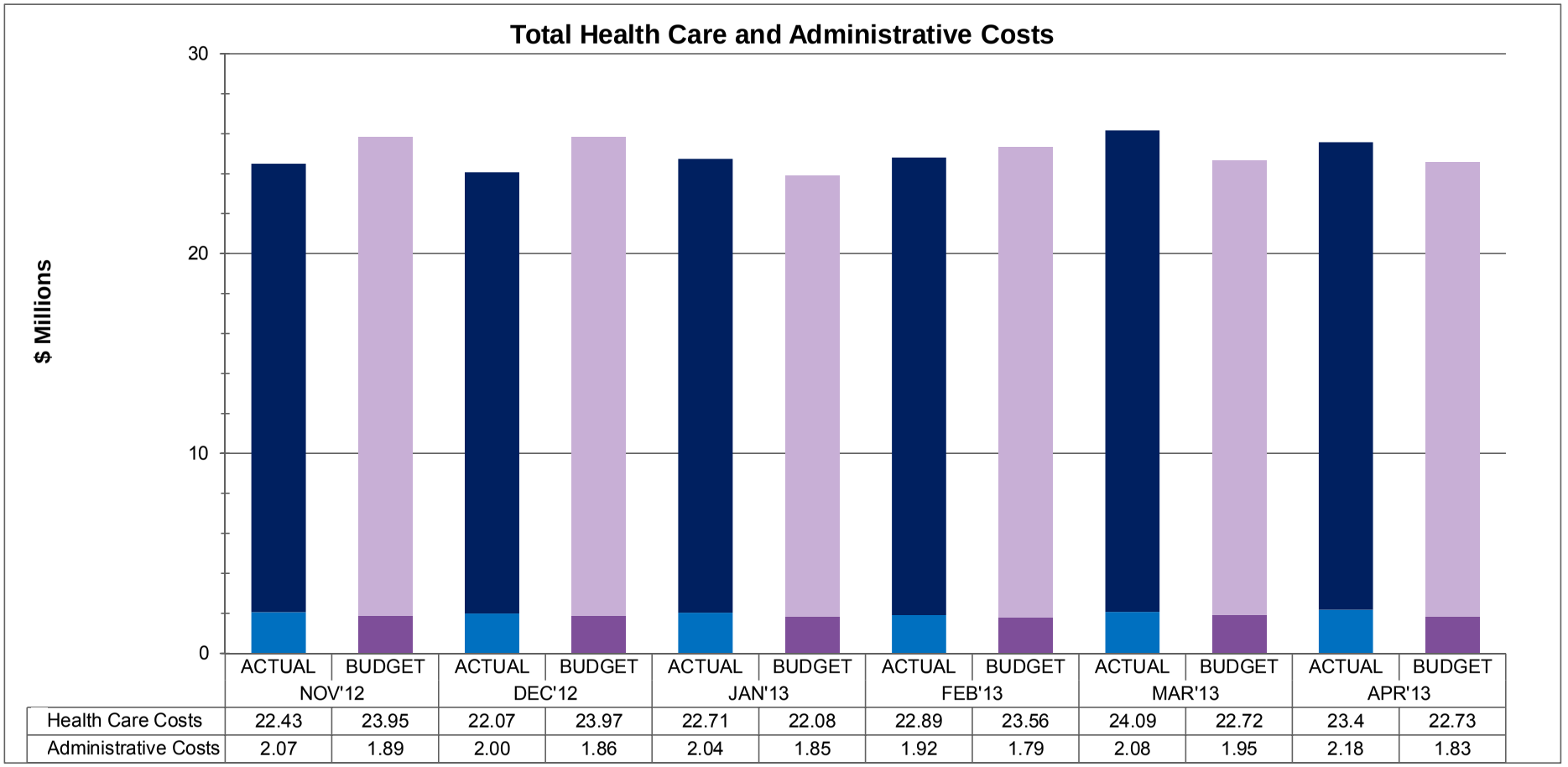
FINANCIAL OVERVIEW

Description	Audited FY 2011-12	FY 2012-13 Actual					Budget YTD	Variance Fav/(Unfav)	Variance Fav/(Unfav) %
		July - Sep	Oct - Dec	Jan - Mar	Apr	YTD			
Member Months	1,258,189	305,220	300,604	301,560	104,683	1,012,067	999,600	12,467	1.2 %
Revenue	**304,635,932**	73,225,136	76,563,668	76,414,965	**27,863,013**	**254,066,782**	**253,705,699**	361,083	0.1 %
pmpm	*242.12*	*239.91*	*254.70*	*253.40*	*266.17*	*251.04*	*253.81*	(2.77)	(1.1)%
Health Care Costs	**287,353,672**	71,648,550	68,967,923	69,698,937	**23,399,396**	**233,714,806**	**235,125,096**	1,410,290	0.6 %
pmpm	*228.39*	*234.74*	*229.43*	*231.13*	*223.53*	*230.93*	*235.22*	4.29	1.8 %
% of Revenue	94.3%	97.8%	90.1%	91.2%	84.0%	92.0%	92.7%		
Admin Exp	**18,891,320**	4,976,867	6,036,079	6,049,617	**2,185,050**	**19,247,613**	**18,105,537**	(1,142,076)	(6.3)%
pmpm	*15.01*	*16.31*	*20.08*	*20.06*	*20.87*	*19.02*	*18.11*	(0.91)	(5.0)%
% of Revenue	6.2%	6.8%	7.9%	7.9%	7.8%	7.6%	7.1%		
Net Income	**(1,609,063)**	(3,400,282)	1,559,667	666,411	**2,278,567**	**1,104,363**	**475,066**	629,297	(132.5)%
pmpm	*(1.28)*	*(11.14)*	*5.19*	*2.21*	*21.77*	*1.09*	*0.48*	0.62	(129.6)%
% of Revenue	-0.5%	-4.6%	2.0%	0.9%	8.2%	0.4%	0.2%		
100% TNE	16,769,368	16,693,841	16,308,936	16,264,038	16,241,914	16,241,914	16,413,394	(171,480)	(1.0)%
% TNE Required	36%	36%	52%	52%	52%	52%	52%		
Required TNE	6,036,972	6,009,783	8,480,647	8,457,300	8,445,795	8,445,795	8,534,965	(89,170)	(1.0)%
GCHP TNE	**(6,031,881)**	**(9,432,163)**	**(5,672,496)**	**(5,006,086)**	**(2,727,518)**	**(2,727,518)**	**1,150,126**	(3,877,644)	337.1 %
TNE Excess / (Deficiency)	**(12,068,853)**	**(15,441,946)**	**(14,153,143)**	**(13,463,385)**	**(11,173,313)**	**(11,173,313)**	**(7,384,839)**	(3,788,474)	(51.3)%

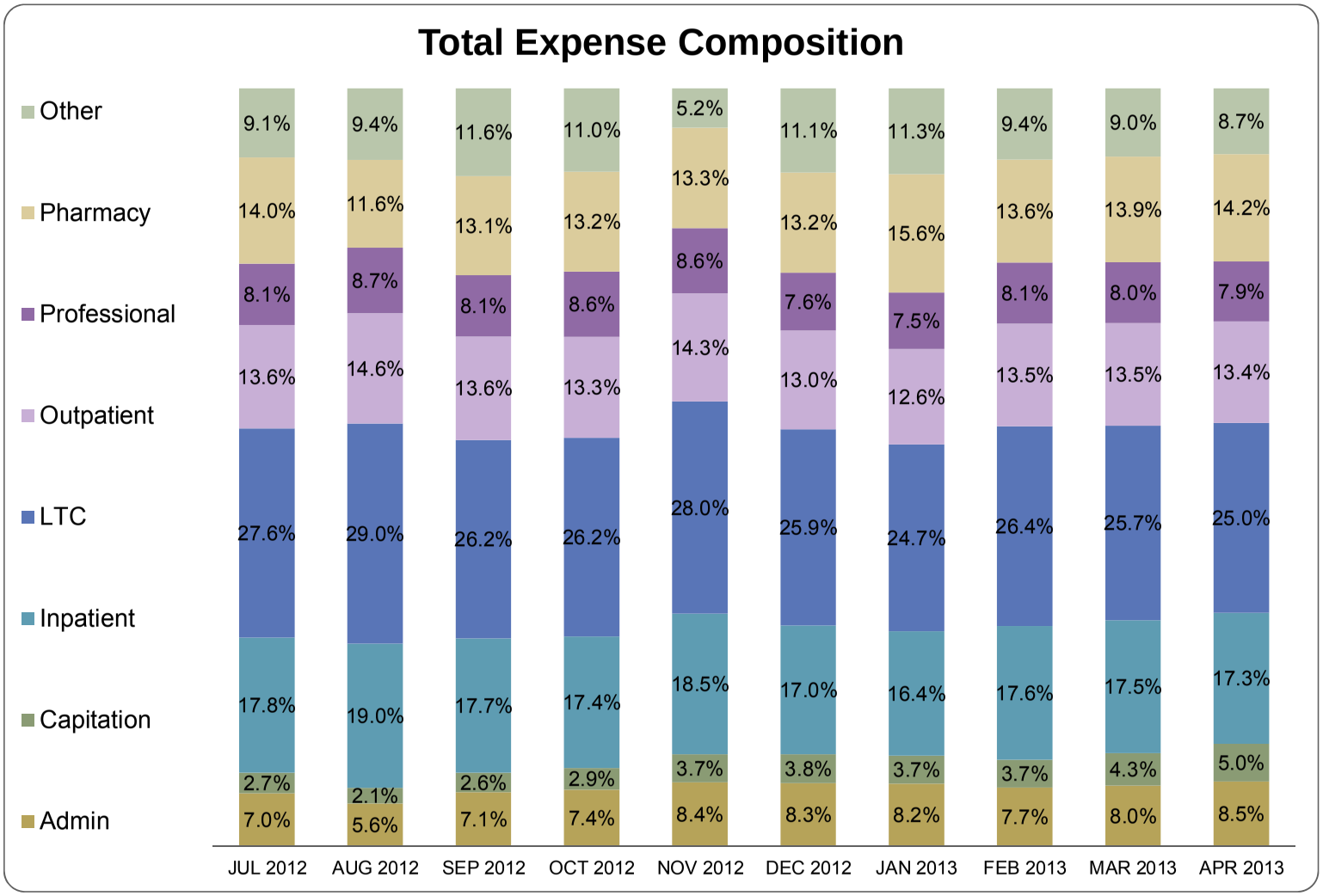
Note:

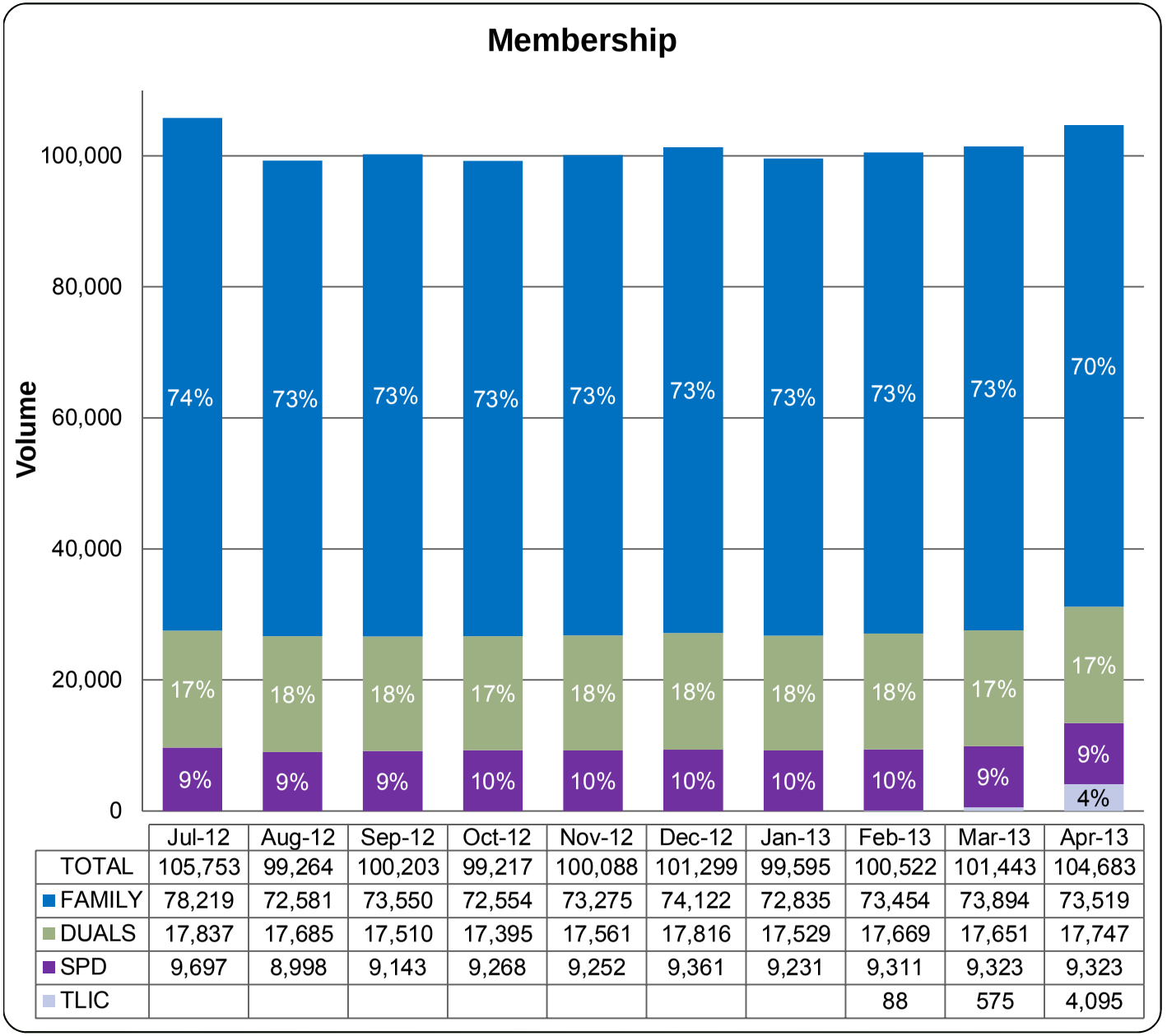
Jul-Sep- Health Care Costs include $7M IBNR addition.

Budgeted TNE assumed additional $6M subordinated debt in March '13



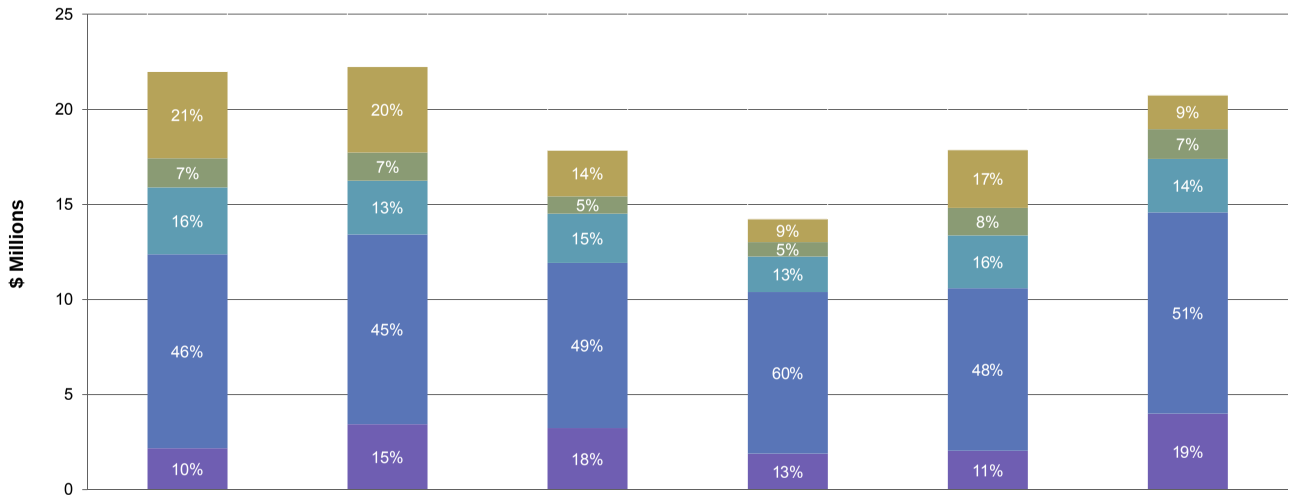
	ACTUAL NOV'12	BUDGET NOV'12	ACTUAL DEC'12	BUDGET DEC'12	ACTUAL JAN'13	BUDGET JAN'13	ACTUAL FEB'13	BUDGET FEB'13	ACTUAL MAR'13	BUDGET MAR'13	ACTUAL APR'13	BUDGET APR'13
Health Care Costs	22.43	23.95	22.07	23.97	22.71	22.08	22.89	23.56	24.09	22.72	23.4	22.73
Administrative Costs	2.07	1.89	2.00	1.86	2.04	1.85	1.92	1.79	2.08	1.95	2.18	1.83


Total Expense Composition
Other
Pharmacy
Professional
Outpatient
LTC
Inpatient
Capitation
Admin
9.1%
14.0%
8.1%
13.6%
27.6%
17.8%
2.7%
7.0%
9.4%
11.6%
8.7%
14.6%
29.0%
19.0%
2.1%
5.6%
11.6%
13.1%
8.1%
13.6%
26.2%
17.7%
2.6%
7.1%
11.0%
13.2%
8.6%
13.3%
26.2%
17.4%
2.9%
7.4%
5.2%
13.3%
8.6%
14.3%
28.0%
18.5%
3.7%
8.4%
11.1%
13.2%
7.6%
13.0%
25.9%
17.0%
3.8%
8.3%
11.3%
15.6%
7.5%
12.6%
24.7%
16.4%
3.7%
8.2%
9.4%
13.6%
8.1%
13.5%
26.4%
17.6%
3.7%
7.7%
9.0%
13.9%
8.0%
13.5%
25.7%
17.5%
4.3%
8.0%
8.7%
14.2%
7.9%
13.4%
25.0%
17.3%
5.0%
8.5%
JUL 2012
AUG 2012
SEP 2012
OCT 2012
NOV 2012
DEC 2012
JAN 2013
FEB 2013
MAR 2013
APR 2013



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13
TOTAL	105,753	99,264	100,203	99,217	100,088	101,299	99,595	100,522	101,443	104,683
FAMILY	78,219	72,581	73,550	72,554	73,275	74,122	72,835	73,454	73,894	73,519
DUALS	17,837	17,685	17,510	17,395	17,561	17,816	17,529	17,669	17,651	17,747
SPD	9,697	8,998	9,143	9,268	9,252	9,361	9,231	9,311	9,323	9,323
TLIC								88	575	4,095

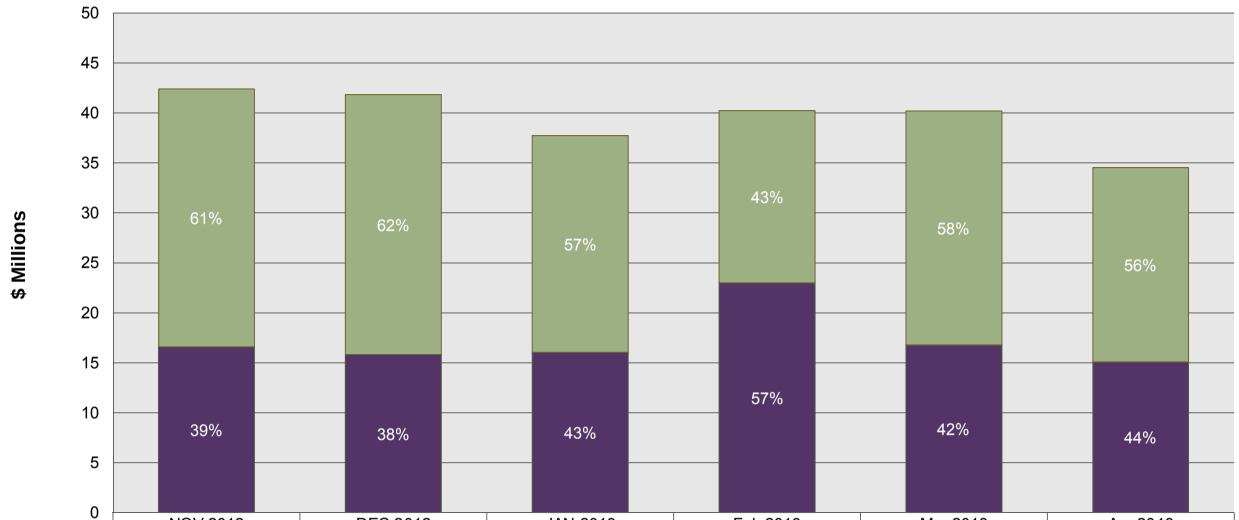
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13
Total	22.0	22.3	17.9	14.2	17.9	20.8
120+	4.6	4.5	2.4	1.2	3.1	1.8
90	1.5	1.5	0.9	0.8	1.4	1.6
60	3.5	2.8	2.6	1.9	2.8	2.8
30	10.2	10.0	8.7	8.5	8.6	10.6
Current	2.2	3.4	3.2	1.9	2.0	4.0

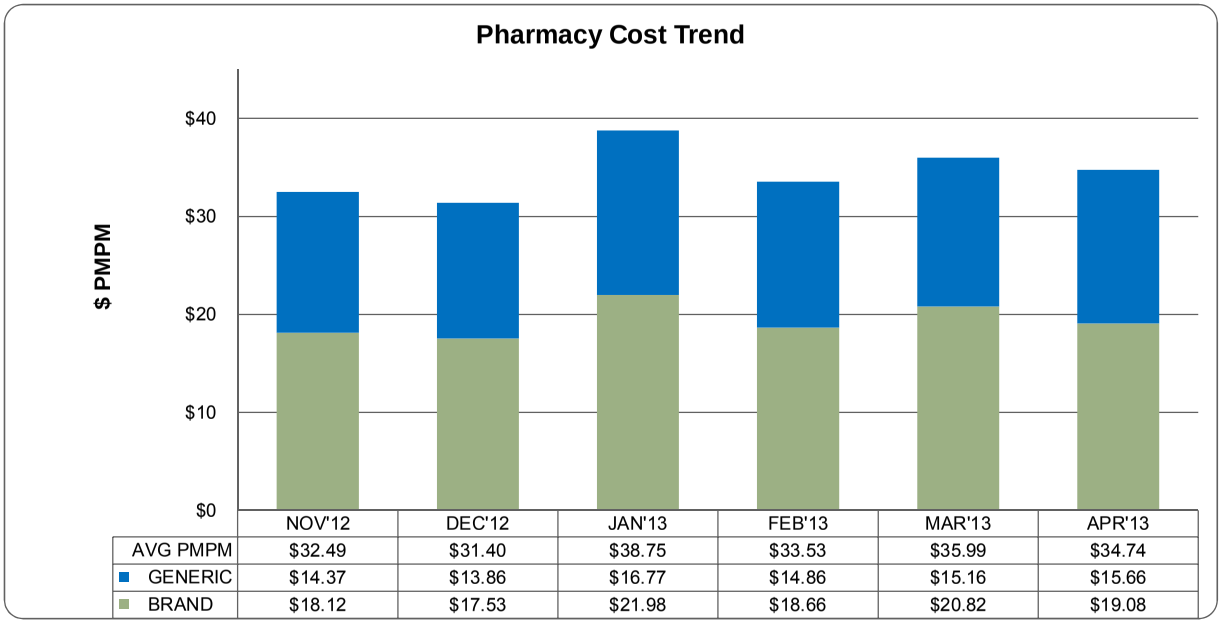
Note: **Paid Claims Composition**- reflects adjusted medical claims payment lag schedule.

IBNP Composition (excluding Pharmacy and Capitation Payments)

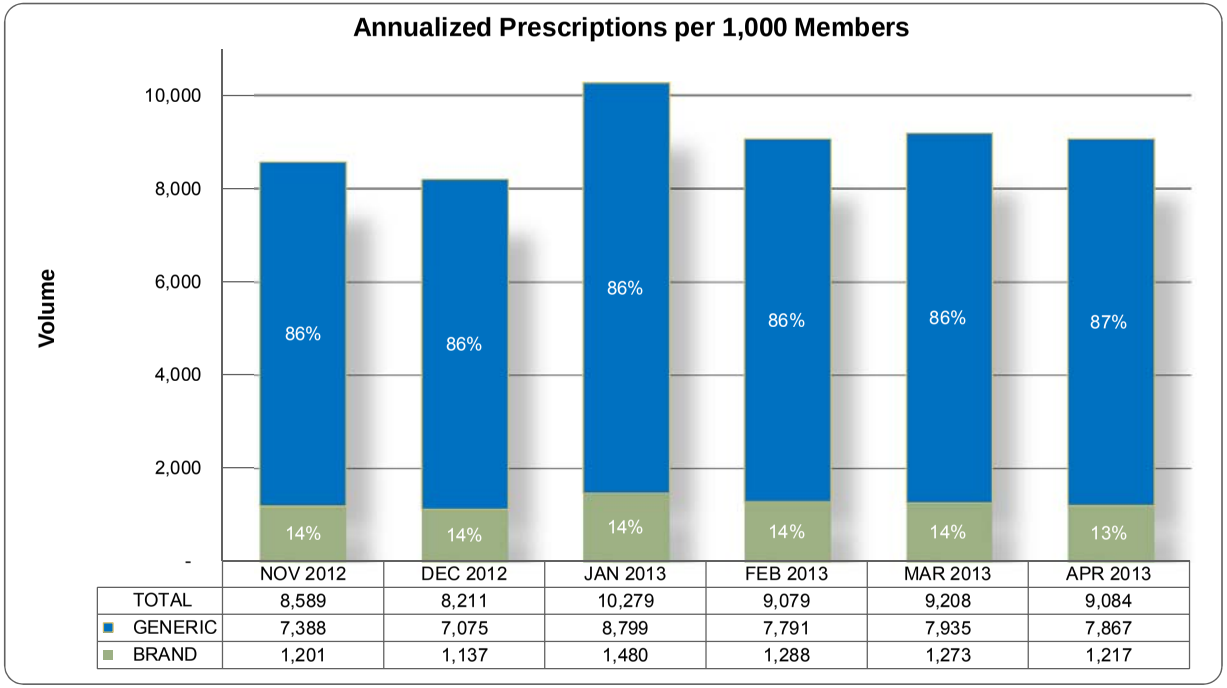


	NOV 2012	DEC 2012	JAN 2013	Feb 2013	Mar 2013	Apr 2013
Total Unpaid	42.41	41.81	37.73	40.23	40.18	34.53
Prior Month Unpaid	25.80	25.98	21.66	17.22	23.39	19.45
Current Month Unpaid	16.61	15.83	16.07	23.01	16.79	15.08

Note: IBNP Composition- reflects updated medical cost reserve calculation plus total system claims payable.



	NOV'12	DEC'12	JAN'13	FEB'13	MAR'13	APR'13
AVG PMPM	$32.49	$31.40	$38.75	$33.53	$35.99	$34.74
GENERIC	$14.37	$13.86	$16.77	$14.86	$15.16	$15.66
BRAND	$18.12	$17.53	$21.98	$18.66	$20.82	$19.08

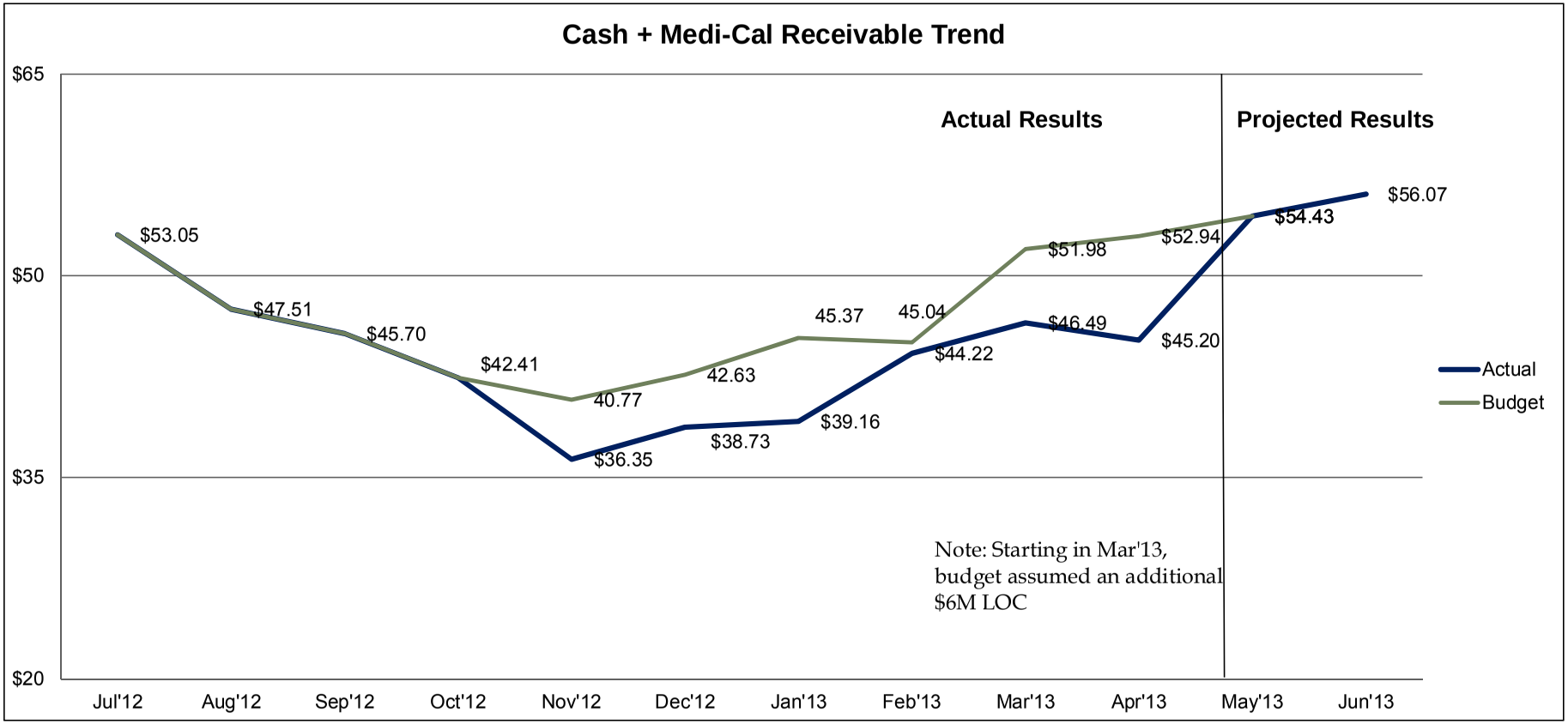


	NOV 2012	DEC 2012	JAN 2013	FEB 2013	MAR 2013	APR 2013
TOTAL	8,589	8,211	10,279	9,079	9,208	9,084
GENERIC	7,388	7,075	8,799	7,791	7,935	7,867
BRAND	1,201	1,137	1,480	1,288	1,273	1,217

Comparative Balance Sheet

	4/30/13	3/31/13	Audited FY 2011 - 2012	Notes
ASSETS				
Current Assets				
Total Cash and Cash Equivalents	**$ 16,850,331**	**$ 46,487,904**	**$ 25,554,098**	April Capitation Payment was received in May
Medi-Cal Receivable	28,350,590		28,534,938	Realignment - accounting for MCO tax portion of premium
Provider Receivable	1,844,652	2,257,588	6,539,541	Continued collection of outstanding provider recoveries & write-off of old receivables
Other Receivables	198,108	187,399	2,148,270	
Total Accounts Receivable	**30,393,350**	**2,444,986**	**37,222,748**	
Total Prepaid Accounts	1,207,130	1,204,535	185,797	
Total Other Current Assets	13,125	13,125	375,000	
Total Current Assets	**$ 48,463,936**	**$ 50,150,550**	**$ 63,337,644**	
Total Fixed Assets	**212,928**	**211,398**	**176,028**	
Total Assets	**$ 48,676,864**	**$ 50,361,948**	**$ 63,513,672**	
LIABILITIES & FUND BALANCE				
Current Liabilities				
Incurred But Not Reported	$ 28,646,992	$ 34,794,210	$ 52,610,895	5 provider payments occurred in April, which resulted in less required reserves.
Claims Payable	9,793,036	9,310,045	10,357,609	
Capitation Payable	965,477	948,127	633,276	
Accrued Premium Reduction	1,180,078	4,340,655	1,914,157	Realignment of MCO tax and AB97 Reserves associated with State premium. Also, $1.9M of FY 2011-12 AB97 reserves were reversed.
Accounts Payable	2,379,416	1,979,831	886,715	Ongoing cash management impact
Accrued ACS	1,207,996	1,170,323	200,000	
Accrued Expenses	266,800	403,998	-	
Accrued Premium Tax	5,252,718	604,580	602,900	Realignment of MCO tax reclassifed as separate liability
Accrued Interest Payable	4,600	3,459	-	
Current Portion of Deferred Revenue	460,000	460,000	460,000	
Accrued Payroll Expense	83,935	151,139	-	
Current Portion Of Long Term Debt	166,667	166,667	500,000	Original $1 million pre-implemention cost
Total Current Liabilities	**$ 50,407,715**	**$ 54,333,034**	**$ 68,165,553**	
Long-Term Liabilities				
Other Long-term Liability	-	-	-	
Deferred Revenue - Long Term Portion	996,667	1,035,000	1,380,000	Original $2.3M Implementation Payment
Notes Payable	2,200,000	2,200,000	-	Subordinated Line of Credit of $2.2M
Total Long-Term Liabilities	**3,196,667**	**3,235,000**	**1,380,000**	
Total Liabilities	**$ 53,604,382**	**$ 57,568,034**	**$ 69,545,553**	
Beginning Fund Balance	(6,031,881)	(6,031,881)	(4,422,819)	
Net Income Current Year	1,104,363	(1,174,204)	(1,609,062)	
Total Fund Balance	**(4,927,518)**	**(7,206,085)**	**(6,031,881)**	
Total Liabilities & Fund Balance	**$ 48,676,864**	**$ 50,361,948**	**$ 63,513,672**	

FINANCIAL INDICATORS			
Current Ratio	96.1%	92.3%	92.9%
Days Cash on Hand	20	22	30
Days Cash + State Capitation Receivable	53	50	64


Cash + Medi-Cal Receivable Trend
$65
$50
$35
$20
Actual Results
Projected Results
$53.05
$47.51
$45.70
$42.41
$36.35
$38.73
$39.16
$44.22
$46.49
$45.20
$54.43
$56.07
40.77
42.63
45.37
45.04
$51.98
$52.94
Note: Starting in Mar'13, budget assumed an additional $6M LOC
Actual
Budget
Jul'12
Aug'12
Sep'12
Oct'12
Nov'12
Dec'12
Jan'13
Feb'13
Mar'13
Apr'13
May'13
Jun'13

Statement of Cash Flows

	APR'13	MAR'13
Cash Flow From Operating Activities		
Collected Premium	$ 1,607,736	$ 51,621,583
Miscellaneous Income	7,579	6,873
Paid Claims		
Medical & Hospital Expenses	(20,985,456)	(16,458,829)
Pharmacy	(5,757,094)	(3,640,696)
Capitation	(948,127)	(1,086,244)
Reinsurance of Claims	(229,552)	(227,620)
Reinsurance Recoveries		
Payment of Withhold / Risk Sharing Incentive		
Paid Administration	(2,673,630)	(3,466,971)
Repay Initial Net Liabilities		
MCO Tax Paid	(653,664)	-
Net Cash Provided/ (Used) by Operating Activities	**(29,632,207)**	**26,748,095**
Cash Flow From Investing/Financing Activities		
Proceeds from Line of Credit	-	-
Repayments on Line of Credit	-	-
Net Acquisition of Property/Equipment	(5,366)	(58,389)
Net Cash Provided/(Used) by Investing/Financing	**(5,366)**	**(58,389)**
Net Cash Flow	**$(29,637,573)**	**$ 26,689,706**
Cash and Cash Equivalents (Beg. of Period)	46,487,904	19,798,198
Cash and Cash Equivalents (End of Period)	16,850,331	46,487,904
	$(29,637,573)	**$ 26,689,706**
Adjustment to Reconcile Net Income to Net Cash Flow		
Net (Loss) Income	2,278,567	(481,295)
Depreciation & Amortization	3,836	3,554
Decrease/(Increase) in Receivables	(27,948,363)	26,191,472
Decrease/(Increase) in Prepaids & Other Current Assets	(2,596)	149,097
(Decrease)/Increase in Payables	(2,926,579)	499,494
(Decrease)/Increase in Other Liabilities	(38,333)	(80,000)
Change in MCO Tax Liability	4,648,137	182
Changes in Claims and Capitation Payable	500,342	(1,985,163)
Changes in IBNR	(6,147,218)	2,450,753
	(29,632,207)	26,748,095
Net Cash Flow from Operating Activities	**$(29,632,207)**	**$ 26,748,095**

Gold Coast Health Plan℠
A Public Entity

APPENDIX

Income Statement Comparison

	Actual Monthly Trend		Apr-13			Explanation
			Month-To-Date		Variance	
	Feb 13	Mar 13	Actual	Budget	Fav/(Unfav)	
Membership (excludes retro members)	97,691	98,520	101,741	98,047	3,694	Larger enrollment in Adult/Family, Duals, & TLIC categories
Revenue:						
Premium	$ 25,469,855	$ 25,821,551	$ 26,032,054	$ 26,128,637	$ (96,584)	
Reserve for Rate Reduction	(90,347)	(167,680)	1,785,047	(127,094)	1,912,141	Reversal of FY 2011-12 AB97 reserves
MCO Premium Tax	(3)	(182)	-	(784)	784	
Total Net Premium	**25,379,504**	**25,653,689**	**27,817,101**	**26,000,759**	**1,816,342**	
Other Revenue:						
Interest Income	6,478	6,873	7,579	15,677	(8,098)	
Miscellaneous Income	38,333	38,333	38,333	38,333	-	
Total Other Revenue	44,811	45,206	45,912	**54,010**	(8,098)	
Total Revenue	**25,424,315**	**25,698,895**	**27,863,013**	**26,054,770**	**1,808,244**	
Medical Expenses:						
Capitation (PCP, Specialty, NEMT & Vision)	911,344	1,123,027	1,274,651	946,624	(328,027)	Vision capitation added in April
Incurred Claims:						
Inpatient	4,376,271	4,594,575	4,422,556	3,731,291	(691,265)	
LTC/SNF	6,546,009	6,718,243	6,404,450	6,669,482	265,032	
Outpatient	2,629,778	2,776,364	2,682,417	2,916,497	234,080	
Laboratory and Radiology	221,259	232,801	225,582	226,639	1,057	
Emergency Room Facility Services	509,253	537,953	521,965	367,099	(154,866)	
Physician Specialty Services	2,000,658	2,102,513	2,026,032	1,777,442	(248,590)	
Pharmacy	3,370,333	3,650,281	3,626,289	3,153,795	(472,494)	
Other Medical Professional	280,898	225,650	216,345	244,594	28,249	
Other Medical Care Expenses	-	647	-		-	
Other Fee For Service Expense	1,512,773	1,574,293	1,489,453	1,506,335	16,882	
Transportation	187,014	102,868	73,499	250,769	177,270	Run-out of NEMT FFS expenses plus ER Transportation
Total Claims	21,634,246	22,516,189	21,688,588	20,843,943	(844,645)	
Medical & Care Management Expense	613,599	631,474	894,013	708,694	(185,319)	Prior period ACS billing omissions are reflected in the current month's charges due to new nurses
Reinsurance	(374,504)	227,620	26,355	233,709	207,354	Reflects reinsurance premiums less recoveries
Claims Recoveries	109,876	(407,819)	(484,211)	-	484,211	Additional provider recoveries not allocated to specific categories of service
Sub-total	348,972	451,275	436,157	942,403	506,246	
Total Cost of Health Care	**22,894,562**	**24,090,491**	**23,399,396**	**22,732,970**	**(666,426)**	
Contribution Margin	**2,529,753**	**1,608,404**	**4,463,617**	**3,321,800**	**1,141,818**	
General & Administrative Expenses:						
Salaries and Wages	374,176	457,668	464,103	489,411	25,308	Delays in hiring
Payroll Taxes and Benefits	81,676	91,493	113,969	103,302	(10,667)	
Total Travel and Training	5,050	4,398	5,140	5,896	756	
Outside Service - ACS	891,100	904,052	892,178	942,453	50,275	
Outside Services - Other	30,339	24,294	99,755	69,494	(30,261)	Current month's actual includes $80K expenditure for records abstracted during HEDIS audit
Accounting & Actuarial Services	21,061	18,828	33,046	30,400	(2,646)	
Legal Expense	31,577	24,015	37,957	16,850	(21,107)	
Insurance	9,245	9,245	9,245	10,792	1,547	
Lease Expense - Office	25,980	25,980	26,080	27,630	1,550	
Consulting Services Expense	336,440	401,116	286,436	9,150	(277,286)	Continued monitor consulting and positions filled by consultants
Translation Services	1,182	2,515	1,125	20,773	19,648	
Advertising and Promotion Expense	-	-	-	0	-	
	103,468	86,891	171,615	50,211	(121,404)	Consultant to employee conversion fees ($55K), furniture installation ($32K), telephone reconfigurations and no-capital equipment for new hires
General Office Expenses						
Depreciation & Amortization Expense	3,554	3,554	3,836	6,631	2,795	
Printing Expense	1,645	1,722	5,445	34,761	29,316	
Shipping & Postage Expense	349	5,507	10,933	1,689	(9,244)	
Interest Exp	1,511	28,423	24,186	9,299	(14,887)	Interest expense resulting from the adjusting of old claims
Total G & A Expenses	**1,918,352**	**2,089,699**	**2,185,050**	**1,828,742**	**(356,308)**	
Net Income / (Loss)	**$ 611,401**	**$ (481,295)**	**$ 2,278,567**	**$ 1,493,058**	**$ 785,510**	

PMPM Income Statement Comparison

	Feb'13	Mar'13	Mar'13 Month-To-Date Actual	Mar'13 Month-To-Date Budget	Variance Fav/(Unfav)
Members (Member/Months)	97,691	98,520	101,741	98,047	3,694
Revenue:					
Premium	260.72	262.09	255.87	266.49	(10.63)
Reserve for Rate Reduction	(0.92)	(1.70)	17.55	(1.30)	18.84
MCO Premium Tax	(0.00)	(0.00)	-	(0.01)	0.01
Total Net Premium	**259.79**	**260.39**	**273.41**	**265.19**	**8.22**
Other Revenue:					
Interest Income	0.07	0.07	0.07	0.16	(0.09)
Miscellaneous Income	0.39	0.39	0.38	0.39	(0.01)
Total Other Revenue	**0.46**	**0.46**	**0.45**	**0.53**	**(0.08)**
Total Revenue	**260.25**	**260.85**	**273.86**	**265.74**	**8.12**
Medical Expenses:					
Capitation	9.33	11.40	12.53	9.65	2.87
Incurred Claims:					
Inpatient	44.80	46.64	43.47	38.06	(5.41)
LTC/SNF	67.01	68.19	62.95	68.02	5.07
Outpatient	26.92	28.18	26.37	29.75	3.38
Laboratory and Radiology	2.26	2.36	2.22	2.31	0.09
Emergency Room Facility Services	5.21	5.46	5.13	3.74	(1.39)
Physician Specialty Services	20.48	21.34	19.91	18.13	(1.79)
Pharmacy	34.50	37.05	35.64	32.17	(3.48)
Other Medical Professional	2.88	2.29	2.13	2.49	0.37
Other Medical Care Expenses	-	0.01	-	-	-
Other Fee For Service Expense	15.49	15.98	14.64	15.36	0.72
Transportation FFS	1.91	1.04	0.72	2.56	1.84
Total Claims	221.46	228.54	213.17	212.59	(0.58)
Medical & Care Management	6.28	6.41	8.79	7.23	(1.56)
Reinsurance	(3.83)	2.31	0.26	2.38	2.12
Claims Recoveries	1.12	(4.14)	(4.76)	-	4.76
Sub-total	3.57	4.58	4.29	9.31	5.02
Total Cost of Health Care	234.36	244.52	229.99	231.86	1.87
Contribution Margin	25.90	16.33	43.87	**33.88**	**9.99**
Administrative Expenses					
Salaries and Wages	3.83	4.65	4.56	4.99	0.43
Payroll Taxes and Benefits	0.84	0.93	1.12	1.05	(0.07)
Total Travel and Training	0.05	0.04	0.05	0.06	0.01
Outside Service - ACS	9.12	9.18	8.77	9.61	0.84
Outside Services - Other	0.31	0.25	0.98	0.71	(0.27)
Accounting & Actuarial Services	0.22	0.19	0.32	0.31	(0.01)
Legal Expense	0.32	0.24	0.37	0.17	(0.20)
Insurance	0.09	0.09	0.09	0.11	0.02
Lease Expense -Office	0.27	0.26	0.26	0.28	0.03
Consulting Services Expense	3.44	4.07	2.82	0.09	(2.72)
Translation Services	0.01	0.03	0.01	0.21	0.20
Advertising and Promotion Expense	-	-	-	-	-
General Office Expenses	1.06	0.88	1.69	0.51	(1.17)
Depreciation & Amortization Expense	0.04	0.04	0.04	0.07	0.03
Printing Expense	0.02	0.02	0.05	0.35	0.30
Shipping & Postage Expense	0.00	0.06	0.11	0.02	(0.09)
Interest Exp	0.02	0.29	0.24	0.09	(0.14)
Total Administrative Expenses	**19.64**	**21.21**	**21.48**	**18.65**	**(2.82)**
Net Income / (Loss)	**6.26**	**(4.89)**	**22.40**	**15.23**	**7.17**

For The Ten Months Ended April 30, 2013

	Apr'13 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership (excludes retro members)	975,802	967,582	8,220
Revenue:			
Premium	$ 252,852,838	$ 254,347,708	$ (1,494,870)
Reserve for Rate Reduction	734,078	(1,168,911)	1,902,989
MCO Premium Tax	(1,680)	(6,207)	4,527
Total Net Premium	**253,585,236**	**253,172,590**	**412,646**
Other Revenue:			
Interest Income	98,213	149,776	(51,563)
Miscellaneous Income	383,333	383,333	(0)
Total Other Revenue	481,546	**533,109**	(51,563)
Total Revenue	**254,066,782**	**253,705,699**	**361,083**
Medical Expenses:			
Capitation	8,678,283	8,299,138	(379,145)
Incurred Claims:			
Inpatient	44,652,829	43,753,704	(899,125)
LTC/SNF	67,047,017	68,975,165	1,928,148
Outpatient	26,868,696	28,556,654	1,687,958
Laboratory and Radiology	2,256,369	2,314,879	58,510
Emergency Room Facility Services	5,206,707	5,026,052	(180,655)
Physician Specialty Services	20,582,887	19,750,293	(832,594)
Pharmacy	34,206,774	32,113,954	(2,092,820)
Other Medical Professional	2,715,582	2,671,500	(44,082)
Other Medical Care Expenses	4,958		(4,958)
Other Fee For Service Expense	15,414,224	15,647,546	233,322
Transportation	2,493,080	2,868,303	375,223
Total Claims	221,449,123	221,678,050	228,927
Medical & Care Management Expense	6,102,178	5,984,462	(117,716)
Reinsurance	156,344	(836,554)	(992,898)
Claims Recoveries	(2,671,123)	-	2,671,123
Sub-total	3,587,400	5,147,908	1,560,508
Total Cost of Health Care	**233,714,806**	**235,125,096**	**1,410,290**
Contribution Margin	**20,351,976**	**18,580,603**	**1,771,373**
General & Administrative Expenses:			
Salaries and Wages	3,725,486	3,729,555	4,069
Payroll Taxes and Benefits	946,249	901,048	(45,201)
Total Travel and Training	51,208	54,928	3,720
Outside Service - ACS	9,094,154	9,166,682	72,528
Outside Service - RGS	23,674	23,674	0
Outside Services - Other	479,887	456,890	(22,997)
Accounting & Actuarial Services	293,352	178,627	(114,725)
Legal Expense	323,093	251,386	(71,707)
Insurance	86,477	93,158	6,681
Lease Expense - Office	179,775	186,676	6,901
Consulting Services Expense	2,598,230	1,935,286	(662,944)
Translation Services	14,578	49,341	34,763
Advertising and Promotion Expense	9,491	11,650	2,159
General Office Expenses	841,856	579,562	(262,294)
Depreciation & Amortization Expense	35,735	43,261	7,526
Printing Expense	55,714	97,185	41,471
Shipping & Postage Expense	55,973	35,928	(20,045)
Interest Exp	432,681	310,700	(121,981)
Total G & A Expenses	**19,247,613**	**18,105,537**	**(1,142,076)**
Net Income / (Loss)	**$ 1,104,363**	**$ 475,066**	**$ 629,297**

Statement of Cash Flows

	APR '13 YTD
Cash Flow From Operating Activities	
Collected Premium	$ 258,338,987
Miscellaneous Income	98,213
Paid Claims	
Medical & Hospital Expenses	(200,558,737)
Pharmacy	(36,666,790)
Capitation	(8,036,907)
Reinsurance of Claims	(2,528,442)
Reinsurance Recoveries	-
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(20,823,793)
Repay Initial Net Liabilities	-
MCO Taxes Expense	(653,664)
Net Cash Provided/(Used) by Operating Activities	**(10,831,133)**
Cash Flow From Investing/Financing Activities	
Proceeds from Line of Credit	2,200,000
Repayments on Line of Credit	-
Net Acquisition of Property/Equipment	(72,634)
Net Cash Provided/(Used) by Investing/Financing	**2,127,366**
Net Cash Flow	**$ (8,703,767)**
Cash and Cash Equivalents (Beg. of Period)	25,554,098
Cash and Cash Equivalents (End of Period)	16,850,331
	$ (8,703,767)
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	1,104,363
Depreciation & Amortization	35,735
Decrease/(Increase) in Receivables	6,829,399
Decrease/(Increase) in Prepaids & Other Current Assets	(659,458)
(Decrease)/Increase in Payables	2,121,953
(Decrease)/Increase in Other Liabilities	(716,668)
Change in MCO Tax Liability	4,649,817
Changes in Claims and Capitation Payable	(232,372)
Changes in IBNR	(23,963,903)
	(10,831,133)
Net Cash Flow from Operating Activities	**$ (10,831,133)**

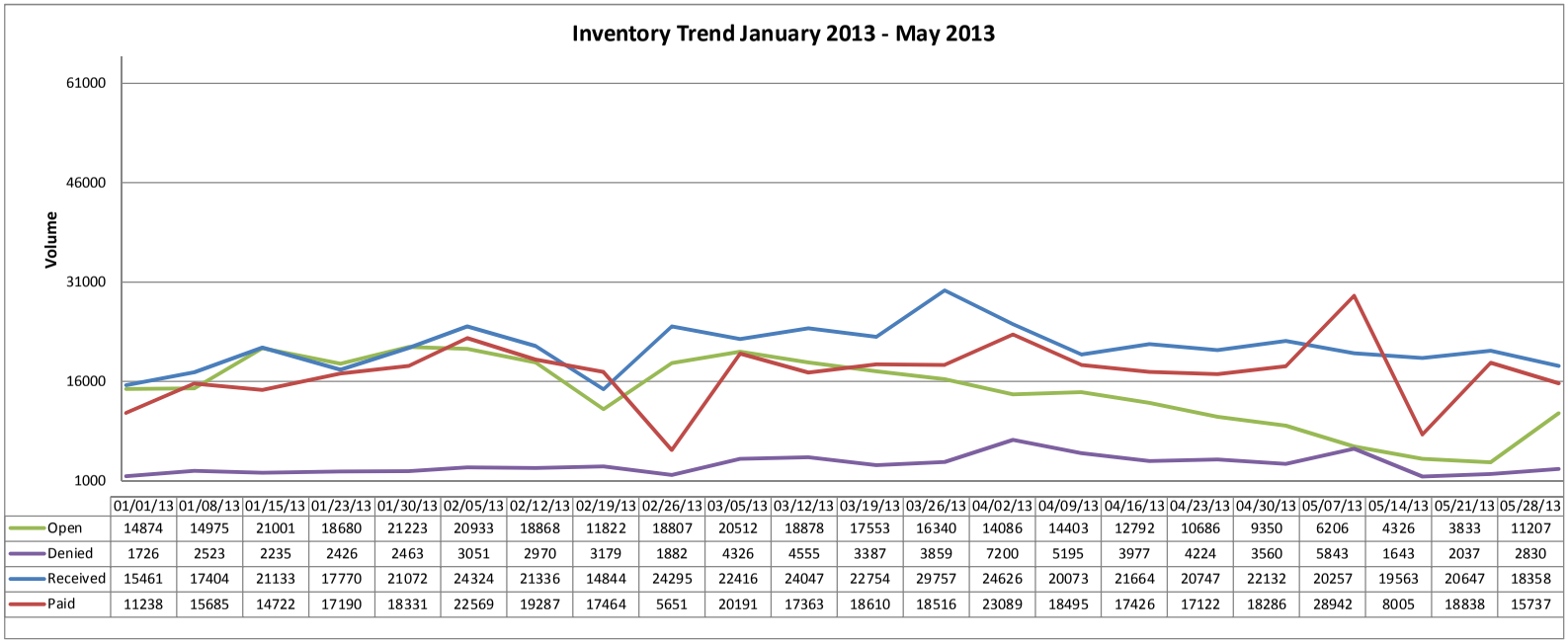
Gold Coast Health Plan - Inventory Trend Comparison

From 01/01/13 thru 05/28/13

Week	Open	Denied	Received	Paid	
01/01/13	14874	1726	15461	11238	
01/08/13	14975	2523	17404	15685	
01/15/13	21001	2235	21133	14722	
01/23/13	18680	2426	17770	17190	*inventory day late due to delayed payment run
01/30/13	21223	2463	21072	18331	*inventory day late due to delayed payment run
02/05/13	20933	3051	24324	22569	
02/12/13	18868	2970	21336	19287	
02/19/13	11822	3179	14844	17464	
02/26/13	18807	1882	24295	5651	*Check run time moved from 5:30pm to 12:00pm. Claims processed after 12pm will reflect on next report.
03/05/13	20512	4326	22416	20191	
03/12/13	18878	4555	24047	17363	
03/19/13	17553	3387	22754	18610	
03/26/13	16340	3859	29757	18516	
04/02/13	14086	7200	24626	23089	
04/09/13	14403	5195	20073	18495	
04/16/13	12792	3977	21664	17426	
04/23/13	10686	4224	20747	17122	
04/30/13	9350	3560	22132	18286	
05/07/13	6206	5843	20257	28942	
05/14/13	4326	1643	19563	8005	
05/21/13	3833	2037	20647	18838	
05/28/13	11207	2830	18358	15737	

Month*	Open	Denied	Received	Paid	# GCHP business days	Average Received in Month	Average Paid in Month
January	90753	11373	92840	77166	21	4,421	3,675
February	70430	11082	84799	64971	18	4,711	3,610
March	73283	16127	98974	74680	21	4,713	3,556
April	61317	24156	109242	94418	22	4,966	4,292
May	25572	12353	78825	71522	23	3,427	3,110

* Counts of claims may actually span an earlier or later month than shown and are summarized according to weekly check run.



	01/01/13	01/08/13	01/15/13	01/23/13	01/30/13	02/05/13	02/12/13	02/19/13	02/26/13	03/05/13	03/12/13	03/19/13	03/26/13	04/02/13	04/09/13	04/16/13	04/23/13	04/30/13	05/07/13	05/14/13	05/21/13	05/28/13
Open	14874	14975	21001	18680	21223	20933	18868	11822	18807	20512	18878	17553	16340	14086	14403	12792	10686	9350	6206	4326	3833	11207
Denied	1726	2523	2235	2426	2463	3051	2970	3179	1882	4326	4555	3387	3859	7200	5195	3977	4224	3560	5843	1643	2037	2830
Received	15461	17404	21133	17770	21072	24324	21336	14844	24295	22416	24047	22754	29757	24626	20073	21664	20747	22132	20257	19563	20647	18358
Paid	11238	15685	14722	17190	18331	22569	19287	17464	5651	20191	17363	18610	18516	23089	18495	17426	17122	18286	28942	8005	18838	15737

Gold Coast Health Plan℠
A Public Entity

June 2013
Quality Improvement Quarterly Report

Charles Cho, MD
Chief Medical Officer

www.goldcoasthealthplan.org

GOLD COAST HEALTH PLAN 2013 QUALITY IMPROVEMENT PROGRAM

III. VENTURA COUNTY MEDI-CAL

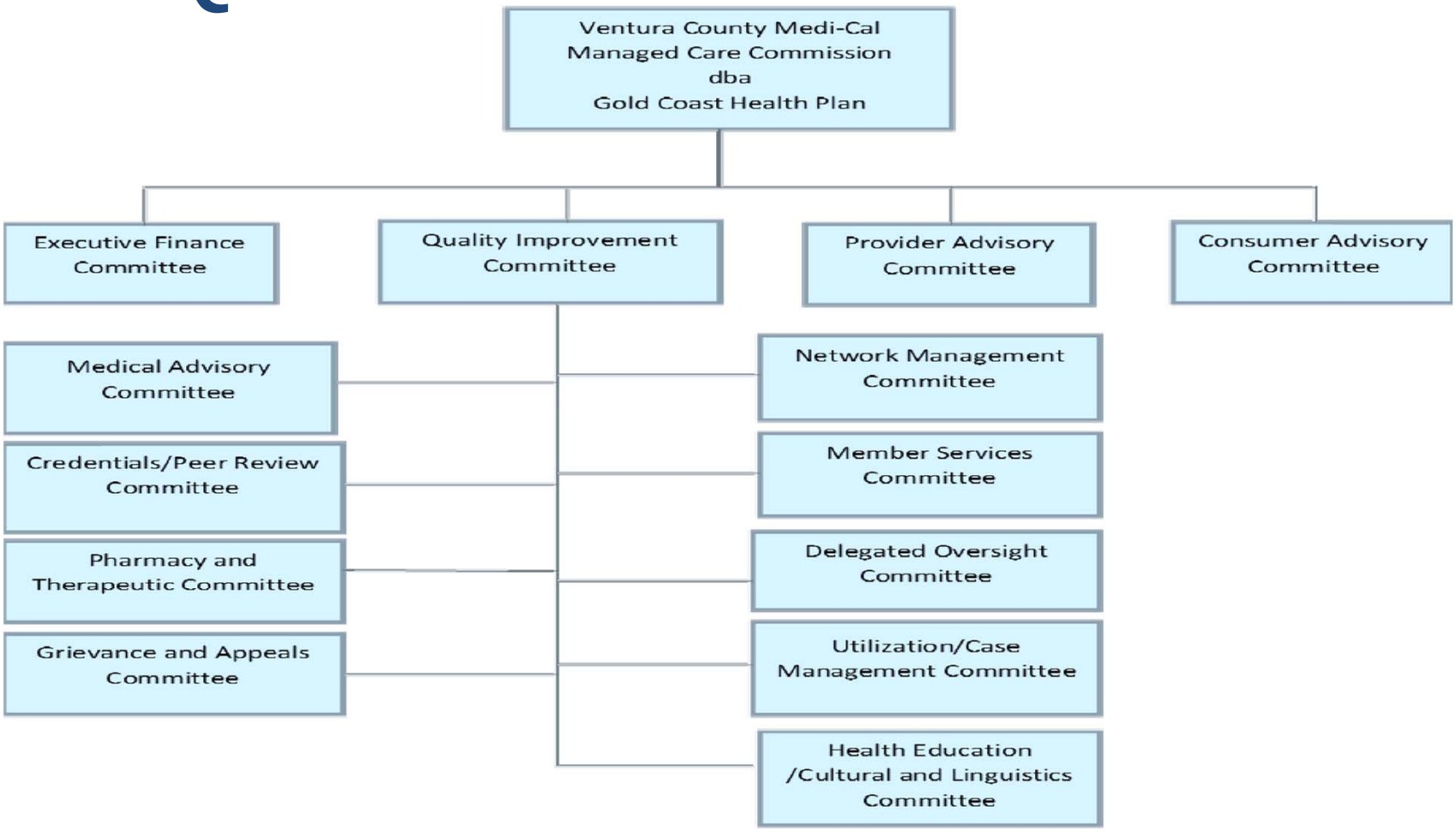
MANAGED CARE COMMISSION will receive quarterly updates to the QI Work Plan <u>for review and comment.</u>

Mission of GCHP Quality Improvement (QI) Program

- To improve the health and well-being of the people of Ventura County by providing access to high quality medical services.

- To achieve that goal, the QI Program will strive to continuously improve the care and quality of service for its members in partnership with its contracted quality provider network.

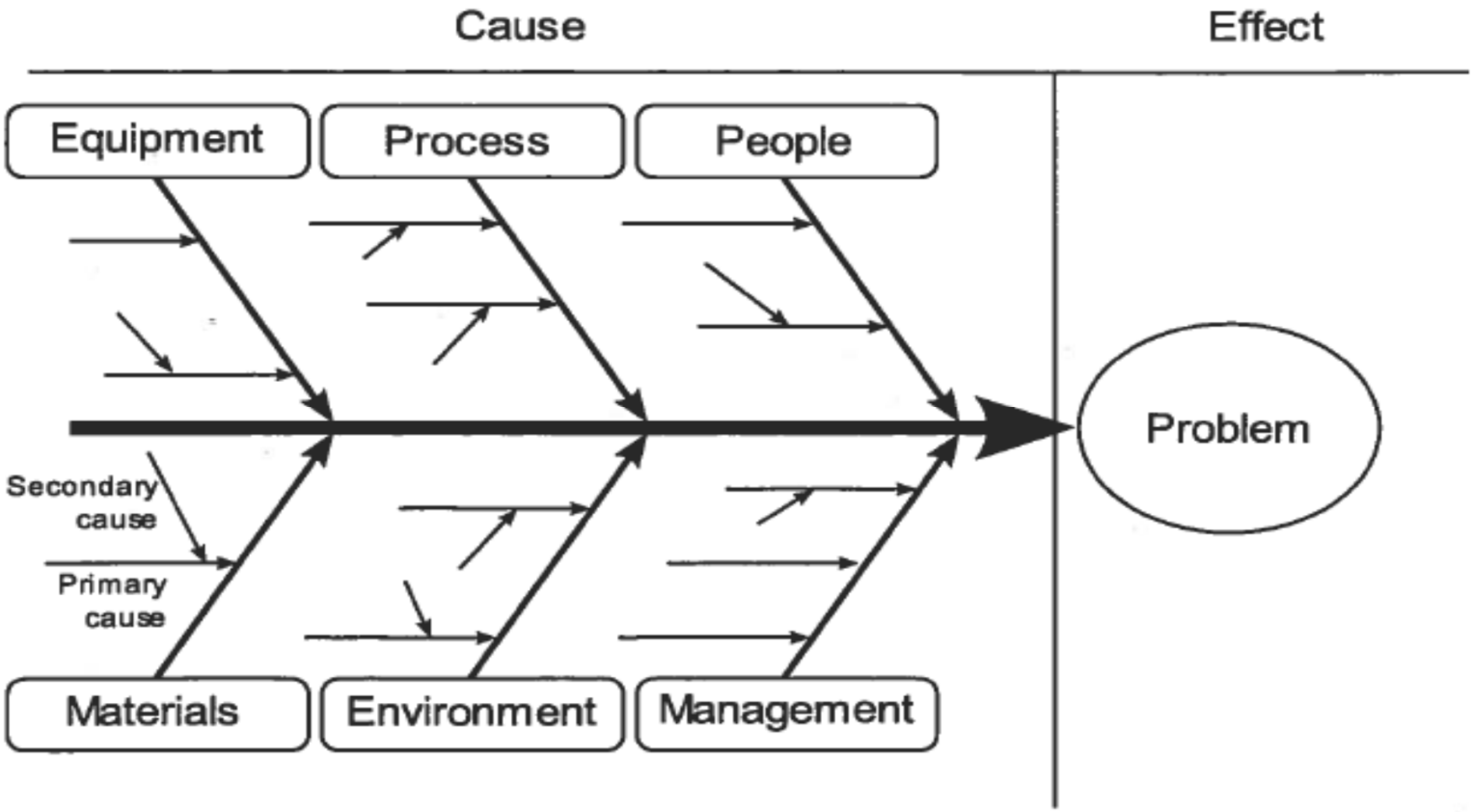
QI Plan Committees



Quality Improvement Committee Chairperson: Charles Cho, MD

- Health Care Effectiveness Data Information Set (HEDIS) submitted by 6/17/13
- DHCS Facility Site Review audit completed.
- Approved the “Fishbone Diagram” as the model for barrier analysis as requested by Department of Health Services (DHCS).

Model For Barrier Analysis
"Fishbone Diagram"



Pharmacy & Therapeutics (P&T) Committee Chairperson: Charles Cho, MD

- Last meeting on 5/16/13. Attendance: 12 out of 14 members
- Formulary reviewed every quarter, adding, deleting & modifying
- Generic use is very high at 86% indicating proper utilization management of drugs. However,
- PMPM cost is increasing due to:
  - Increase use of very expensive brand name specialty drugs such as Neulasta, Revlimid, Gleevec, Copaxone
  - Increase in high risk illnesses
- Top 2 therapeutic disease categories for expenses have always been asthma and diabetes, such as Advair and Lantus that are expensive brand name drugs but are very effective treating diseases. There are no cheaper alternatives that are as effective.

GCHP - Top 12 Drugs By Rx's
5/1/2013 - 5/31/2013

May-13		
Drug	**# Scripts**	**Amnt Paid**
HYDROCO/APAP	3143	$46,966.37
METFORMIN	1847	$9,748.74
AMOXICILLIN	1832	$11,059.12
OMEPRAZOLE	1674	$51,689.60
VENTOLIN HFA	1634	$65,825.58
IBUPROFEN	1578	$5,449.11
LEVOTHYROXIN	1452	$9,058.10
LISINOPRIL	1354	$4,663.19
LORATADINE	1300	$9,758.94
IBUPROFEN	1081	$7,624.29
GABAPENTIN	1043	$22,287.52
AMLODIPINE	1020	$4,604.02

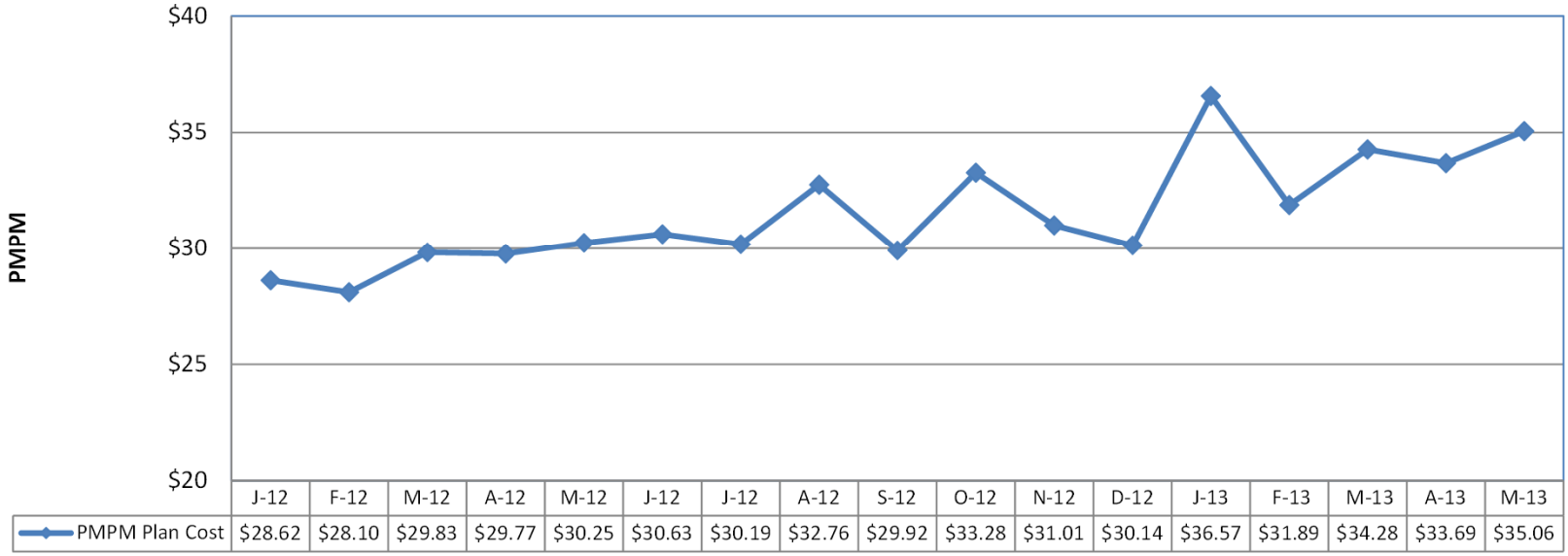
GCHP - Top 12 Drugs By Dollar
5/1/2013 - 5/31/2013

May-13		
Drug	**# Scripts**	**Amount Paid**
ADVAIR DISKU	422	$89,469.55
LANTUS	574	$85,152.34
NEULASTA	21	$84,470.40
VENTOLIN HFA	1,634	$65,825.58
OMEPRAZOLE	1674	$51,689.60
COPAXONE	10	$47,753.53
HYDROCO/APAP	3143	$46,966.37
DIVALPROEX	462	$45,140.89
ENOXAPARIN	43	$44,795.10
PANTOPRAZOLE	628	$44,528.36
HUMIRA PEN	16	$43,072.78
VENLAFAXINE	353	$43,004.10

GCHP - Top 12 Therapeutic Classes
5/1/2013 - 5/31/2013

May-13		
Therapeutic Class	**Claim Count**	**Amount Paid**
Antiasthmatic	3892	$345,211.06
Antidiabetic	4452	$315,440.27
Anticonvulsant	4352	$245,923.38
Antidepressants	5262	$195,634.95
Analgesics-Narcotic	5138	$188,324.49
Stimulants/Anti-Obesity Anorexiants	1232	$186,767.01
Antineoplastics	306	$182,541.75
Analgesics-Anti-Inflammatory	3725	$160,160.98
Misc. Cardiovascular	41	$149,530.88
Ulcer Drugs	3198	$134,571.45
Hematopoitic Agents	1895	$125,181.22
Assorted Classes	184	$112,594.89

Per Member Per Month Cost



	J-12	F-12	M-12	A-12	M-12	J-12	J-12	A-12	S-12	O-12	N-12	D-12	J-13	F-13	M-13	A-13	M-13
PMPM Plan Cost	$28.62	$28.10	$29.83	$29.77	$30.25	$30.63	$30.19	$32.76	$29.92	$33.28	$31.01	$30.14	$36.57	$31.89	$34.28	$33.69	$35.06

GOOD NEWS!

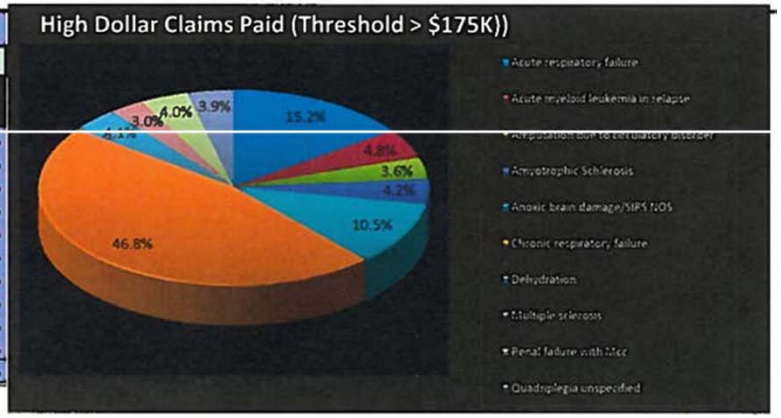
- The PBM just adjusted the Maximum Allowable Cost (MAC), which is expected to reduce drug expenses substantially

High Dollar Claims Paid

Actual Claims Paid Out (Per Member)

Threshold (> $175,000)

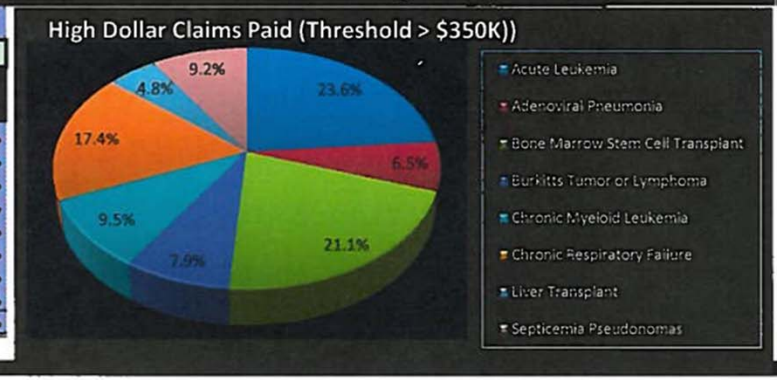
Primary Diagnosis Description	Members	Acute	LTC	Ancillaries	Other/Prof Fees	Total	% of Total
Acute respiratory failure	4	870,207			49,938	920,145	15.2%
		283,369			8,284	291,653	4.8%
		121,278			52,854	218,124	3.6%
		252,467				252,467	4.2%
		618,259			15,339	633,598	10.5%
		2,763,294			64,574	2,827,868	46.8%
		230,000			19,811	249,811	4.1%
					2,698	179,160	3.0%
	1	120,241		44,547	74,115	238,903	4.0%
Quadriplegia unspecified	1	206,685			29,680	236,365	3.9%
Total Amount Paid Out	**24**	**$5,465,800**	**$0**	**$265,001**	**$317,293**	**$6,048,094**	**100%**
type of service % total paid out claims		*90%*	*0%*	*4%*	*5%*	*100%*	



Actual Claims Paid Out (Per Member)

Threshold (> $350,000)

Primary Diagnosis Description	Members	Acute	LTC	Ancillaries	Other/Prof Fees	Total	% of Total
Acute Leukemia	3	1,952,321			35,363	1,987,684	23.6%
		545,803			2,563	548,366	6.5%
		1,592,898			181,662	1,774,560	21.1%
		645,661			18,823	664,484	7.9%
		765,102			33,705	798,807	9.5%
	4	1,303,435			156,921	1,460,356	17.4%
	1	396,974			6,984	403,958	4.8%
	1	765,417			7,091	772,508	9.2%
	15	**$7,967,611**	**$0**	**$0**	**$443,113**	**$8,410,724**	**100%**
type of service % total paid out claims		*95%*	*0%*	*0%*	*5%*	*100%*	



Credentials and Peer Review Committee
Chairperson: Charles Cho, MD

- Last meeting on 3/21/13. 6 out of 9 members attending
- Twelve applicants reviewed and approved at March 21, 2013 meeting.
- Decision made to limit out-of-county applicants to “needed” specialties only.

Medical Advisory Committee (MAC) Chairperson: Charles Cho, MD

- Last meeting on 4/18/13; Attendance 12/16 members
- Telemedicine approved “in concept” and a draft of P & P approved
- OB/GYN as PCP’s discussed
- Behavioral health referral process and resources discussed
- ER utilization and ER Navigation project announced, and this will be monitored

Health Education/Cultural Linguistics (HE/CL) Committee Chairperson: Lupe Gonzalez, PhD

- Follow-up with Commissioner Eberst regarding her recommendation on a translation service vendor
- HE Manager to spear head the ER Navigation project for the Health Services

Utilization Management (UM) and Case Management (CM) Committee Chairperson: Nancy Wharfield, MD

- Contact and work with Director of Case Management at St. John's Hospital per Commissioner Eberst's recommendation.
- Meet with Dr. Araujo to develop a process for home health visits for high risk patients after hospital discharge.

Grievances & Appeals (G&A) Committee
Chairperson: Nancy Wharfield, MD

- 1st Qtr 2013 – 26 Grievances/4 Appeals
- Most frequent Grievance type – Quality of Care (6)
- 75% of Appeals “in-favor” of member (3)

Member Services Committee Chairperson: Luis Aguilar

- New balance billing process flow for call Center implemented late March 2013.
- 1295 Medicare Part A applications sent out/ 810 returned and submitted to SSA for potential eligibility.

Network Management Committee Chairperson: Sherri Bennett

- Confirm contracted 24-hour pharmacy
  - The CVS Pharmacy located at 5900 Telegraph in Ventura is the only contracted 24 hour pharmacy.
  - Looking into uses of emergency rooms as back-up 24 hour pharmacy.
  - Working with PBM GCHP is looking into feasibility of adding at least another 24 hour standby pharmacy in another part of the County
- There are 559 existing physician providers in the GCHP network as of 1st Qtr 2013.

Delegation Oversight Committee Chairperson: Robert Franco

- Working on delegation oversight for plan-to-plan activities
- QIC requested a report regarding call stats and utilization of the transportation vendor.

Gold Coast Health Plan℠
A Public Entity

Any Comments and Questions?

Ventura County Medi-Cal Managed
Care Commission (VCMMCC) dba
Gold Coast Health Plan

Quality Improvement Committee Meeting

Thursday, February 7, 2013

Call to Order

Dr. Charles Cho – Chief Medical Officer called the meeting to order at 3:04pm, in Suite 280, Ventura County Public Health Building located in 2240 E. Gonzales Road, Suite 280, Oxnard, CA 93036.

Members in Attendance

Dr. Charles Cho – Chief Medical Officer, Laurie Eberst – Commissioner, John Fankhauser, MD – Commissioner, Nancy Wharfield, MD, - Medical Director Health Services, Julie Booth – Director Quality Improvement, Susan Tweedy – Senior QI Project Manager, Doris De La Huerta – FSR Nurse, Helen Chtourou – HEDIS Project Manager, Robert Franco – Delegation Oversight Project Manager, Andre Galvan – Manager Member Services, Lupe Gonzalez – Manager of Health Education & Disease Management & Cultural Linguistics, Guillermo Gonzalez – Director Government Affairs, Jennifer Palm – Director Health Services, Sherri Bennett – Provider Network Manager

Other Staff in Attendance

Cassie Undlin, Interim Chief Operating Officer

Absent/Excused

Michael Engelhard, Chief Executive Officer

Approval of QIC meeting minutes

Approval of the Minutes of December 14, 2012. No revisions or additions. A motion by Lupe Gonzales to approve the minutes and seconded by John Fankhauser, MD. Everyone was in favor of adopting the minutes.

CMO REPORT

Dr. Cho presented the Annual CMO QI Report for 2012 to the Committee members. The intent is to re-emphasize the importance of Quality Improvement (QI) and to garner support from the Committee as a cooperative and collaborative process for all areas and each department. QI is not only a must but it is mandated by the State and it is a good thing to do for managed care. The best quality medicine is the most cost effective. The Mission Statement which was approved by DHCS states “to improve the health and well-being of the people of Ventura County by providing access to high quality medical services.” The QI program continuously strives to improve the care and provide services “in partnership with its contracted quality provider network.” We need to keep emphasizing this and this will then result in high quality care and saving money.

Who are the quality providers? Good diagnosticians make correct diagnoses and practice quality medicine producing the best outcome. They avoid unnecessary tests and procedures; know when to refer and when not to refer patients for consultations. Good quality care is having good quality doctors.

The health plan has the responsibility to provide proper tools for these quality doctors. The policies and procedures need to be user friendly. With so many HMO’s coming in with their policies and procedures the provider offices are getting bogged down. When GCHP first started, we needed to make it easy for the doctors by making the “Direct Referral Policy” without requiring prior authorization, trusting that they know when to refer. In many other HMO situations they require prior authorizations resulting in delay of medical care. GCHP has received very good feedback from providers because of this policy. We have

not lost anything and satisfied physicians take care of their patients with more enthusiasm, which is good for patient care.

The QI program was almost delayed a year because of other priorities to get the Plan going live. Further delay had occurred with difficulty in recruiting a suitable QI Director. When Julie Booth, Director was hired in late April 2012 it was almost a year later than was originally had planned. Julie quickly assembled a credible staff and met all State reporting deadlines.

In reviewing the GCHP QI Functional Chart there are three functional columns that are directly related to regulatory requirements. The three are DHCS QIP, HEDIS and All Plan Letter requirements. The other two areas are Pharmacy Oversight with a $40 million dollar plus budget and that is a big task. Finally there are nine sub-committees under QI. The QI process is a collaborative effort and Dr. Cho encouraged the Committee members to submit ideas to QI. Again QI is a collaborative effort with all of the subcommittees working closely together with the QI Department.

Three of the committees are chaired by Dr. Cho and he gave an overview of these committees. Dr. Cho emphasized that membership of the committees are pulled from the best of the providers in the Community. There is overlap of providers in the Committees because of their expertise and are the best ones for the Committees and they are able to serve on both.

Pharmacy and Therapeutics (P&T):
The most important function of the P&T is the review of the formularies. The formulary was designed to be user friendly and that can best serve the needs of the members. The goal is to have a formulary where there are choices for the doctors to choose from and choose the right drug that is cost effective. Designed for the doctor to think about the medicine for a certain disease and the doctor can go to that category for that therapeutic brand of medicine. He will see the drug that he was thinking of prescribing but he will also see four or five other drugs. He can compare. Without this type of system the provider would have prescribed what he was thinking of at the beginning. When he sees this he can see the differences, the dosages and the pricing. By providing this kind of formulary we are providing the doctor a selection. He doesn't have to choose one; he can consult the formulary and choose the one that is the best medicine for that condition and most cost effective. It has been working.

The generic percentage use was in the low 80s when the plan first started. That number has moved up to about 85% which is among the best in the industry.

ScriptCare has been very good from the very start of the Plan by providing the Plan valuable reports. We can see the top 15 – 25 drugs. If the medicine is good for that patient's care, whether it is expensive or not, the provider should use it. GCHP should not necessarily restrict expensive medicine. In looking at the top 15, a couple of times expensive medicines were prescribed but they are not any better than the less expensive. P&T committee then would eliminate the higher cost drug without any problem because the less expensive medicine is just as good. An example of eliminating a drug is Proair. Ventolin and ProAir are the same drug. ProAir was eliminated because it has ethanol in it which may cause an allergy and is four times more expensive. This was taken to the Committee and removed. P&T also adds medications, if appropriate, when a request is made by a provider. The request is reviewed and added if meritorious.

The formulary and the newsletter are both important factors in educating the doctors. The Pharmacy newsletter is also sent out to all providers which is informative and educational. This quarter the newsletter covered drug adherence problems, 50% of patient problems related to patients not sticking to the medicine regimen. Case Management and Health Education are making additional efforts to address medication adherence

Credentials Committee
There are eight physicians on the Credentials Committee. Three are CMO's of the biggest hospitals. Two doctors are Medical Directors CMO's of the largest clinics in the county; one is the leading physician from Clinicas, and the other one is the Medical Director of SeaView IPA. The Committee also has one

leading doctor from Oxnard. These doctors have been involved in Credentialing before and it made it easier for the Plan and they have been doing a very good job operationally.

Medical Advisory Committee (MAC)
The progress of MAC has been a little hampered for a while because of lack of data. But, data is coming now. Most are teachers and top in their specialty in the community. Their function is to analyze reports, advise, recommend and make policies.

In addition to the three Committees, there are two committees under Dr. Wharfield, Utilization Management Committee and Grievance and Appeals Committee. We are starting to see preliminary reports of hospital stays and length of stay. These reports become very important to the UM Committee and to MAC for developing new policies. Beginning October 1, 2012 nearly 1,000 Adult Day Health Care Center members were successfully transitioned into CBAS.

GCHP plans on adding a number of staff in Utilization Management. Investing in the proper personnel is necessary, and a good case manager will easily pay off 5 to 10 times of the investment, as an example. The remaining subcommittee, Membership Committee, has the Call Center data which is of great interest to the Commission. A question at the last Commission meeting was the number of dropped calls for providers. The number still is not that high.

Network Management is managed by Sherri Bennett. Robert Franco has Delegation Oversight and the three delegated groups all passed their credentialing audits. Health Education is responsible for educating the members in doing so can change behaviors to healthier ones. Lupe Gonzalez presented to the Commission the GNA survey results and it showed what the members were interested in as health topics. They are: healthy eating, cholesterol or heart health, healthy teeth, diabetes and exercise. Using this Survey as a guide, the last member newsletter sent in January contains a topic on cholesterol. Also, the survey showed that 80% wanted information obtained through mail. Language preference was 52% for English and 42% for Spanish. Lupe is always out in the community and recently met with City of Ventura Housing authority and now has a nice room to provide education classes, to educate on benefits, PCP selection, etc.

QI SUBCOMMITTEE REPORTS

Credentialing/Peer Review Committee
The Committee met in November and the minutes were presented at the December 14, 2012 QI Committee meeting.

Pharmacy & Therapeutics Committee
Financials were already presented in the 2012 QI annual review. The next meeting is in two weeks and the pharmacist is bringing eight pages of drugs that need discussion for either deletion or requiring prior authorization. Any drugs added to the formulary are formally reviewed by the P&T Committee. A lot of work is going on with P&T. January financial reported increase in pmpm to 36.00 largely attributable to flu epidemic. Use of Tamiflu and Zithromax contributed to nearly $100,000. Also, one case of Hemophiliac drug use was $145,000.

Medical Advisory Committee
The MAC meeting was held January 17, 2013. Issues under discussion are: 1- ER usage was discussed in the MAC. There are some high utilizers. A decision MAC made was in regards to the Zostavax vaccine. The Zostavax for herpes roster shingles vaccine is very expensive. The current recommendation is for people 60 and older to be offered this vaccine. A similar vaccine pneumovax is also recommended but it is inexpensive. Zostavax is only about 60% effective with some complications and there are contraindications. The Committee decided to keep the Zostavax vaccine on the prior authorization list. 2- The Diabetic population is relatively low in our Plan and right now only 4% of the diabetic population is receiving medication. This is less than half of what we expected. The reason for the low number may be related to the fact that 60% of our population is under the age of 21. We are continuing to monitor the number. 3- SeaView IPA is doing a tremendous job of discharge planning, resulting in saving a lot of

money. A discussion ensued and Dr. Cho noted that according to Dr. Proffet, the Medical Director of SeaView IPA, they have reduced the ER visits by 46% through this discharge planning process and a similar percentage decrease in readmissions. Dr. Cho has placed a call to Dr. Proffet and asked him to verify the numbers. Dr. Fankhauser inquired as to whether SeaView IPA was going to give GCHP their plan for reducing ER visits. Dr. Wharfield will follow up. 4- Julie Booth submitted the Readmission Data for the Statewide Quality Improvement Project (QIP) for SPD's and Non-SPD's. The readmissions rate was 15%. The data still requires validations. 5- Telemedicine was also discussed. This would apply to patients who need a referral to a specialist. There would be a video or telephone conference for consultation. We would like to get into telemedicine. VCMC is doing it and how can we as a plan accommodate it. The equipment is being taken care of through grants for VCMC. UCLA is connecting with VCMC.

Member Services Committee
Andre Galvan reviewed the minutes from the Member Services Committee meeting held on January 17, 2013. A highlighted issue was balance billing. This was the number one identified issue from the call center and member walk-ins. Dr. Fankhauser wanted to know what happened in July enrollment since the graph showed a large dip. Andre explained that is when the State stopped retro-disenrollment. New Call Center Statistics were discussed and it was mentioned that Dr. Araujo Commissioner, noted at the Board meeting that almost 50% of the calls were by providers calling. Dr. Araujo was concerned about the abandonment rate. Andre explained the average standard is 5%. GCHP rate is still below the average. Call Center is tracking the Spanish abandonment rate and the numbers are coming down due to staffing and looking when most of the calls are coming in and having the appropriate Spanish speaking staff. Dr. Cho asked if they know why there was a blip in July. Andre explained that it was due to staffing issues. Cassie commented that the call center didn't have dedicated Spanish speaking staff.
Dr. Fankhauser commented how terrific it was to see the calls going down for the Spanish speaking members and terrific work on the call centers part.

Graphs presented and discussed included:
1. Per non-enrollment
2. Enrollment stratified by SPD and Non-SPD
3. Enrollment stratified by family and duals

Andre Galvan presented the Member Services Committee 2013 initiatives and the analysis. The first initiative is to analyze provider call volume at 50% of the total calls. The second initiative is to analyze balance billing issues for members. We will start doing a deep dive analysis on how to resolve these issues but first need to look at the reasons why they are occurring. Dr. Fankhauser commented that providers have a hard time accessing the website because providers don't have their tax ID number. The providers at VCMC bill under the Counties tax ID number and they don't have that number when they access the website, either the Provider web portal or the call center. Cassie Undlin remarked that she appreciated the comment by Dr. Fankhauser and will look into that. Andre stated they don't know the real reasons at this time for the high volume of calls but we will find out and we expect to decrease provider calls and increase provider satisfaction. The second initiative is the balance billing issue. We will work together with provider relations and claims to identify possible solutions. They are not mapped out yet.

Grievance and Appeals Committee
Dr. Wharfield discussed grievance and appeals and the overarching idea is that this is a new culture in the County to have Managed Care and that people normally don't know they have a PCP. They don't realize that they have a grievance and appeals process. The number of grievances is very low. Included in the packet are the minutes from the last meeting.

<u>Appeals</u>
The number of appeals for 2012 was 22. The compliance for responding to appeals is 30 days and turnaround time (TAT) was pretty good, and if you miss 2 it would bring the percentage number to 91%, but the absolute number was only 2. Would like to maintain that number and improve on it. Through Member Services we have a much enhanced process for tracking the appeals. Think that it is going to be better.

Grievances

For grievances there were 68. We are looking at the data that is available and doing a comparison, the grievance rate was 6.8 grievances/10,000 members. The benchmark example from MRMIB, shows a report of 900,000 members showing rates of 57/10,000 members. Our numbers are very low, so the question is whether everyone's care is perfect out there or the other possibility is that members don't understand the process. What we would like to do is enhance the capture of what these issues are. We need education for all the departments to encourage people how to file a formal grievance if you are identifying a member complaint. Dr. Wharfield shared that she had picked one up today just doing regular work. She was trying to deal with an issue and invited the member to file a grievance so it could be logged and tracked. Cassie mentioned they need to reinforce with ACS to do this as well.
Dr. Wharfield stated that one of the departments they want to work with is the Call Center. Dr. Cho commented that when the Plan first began it was thought there were a lot of grievances because members were used to the fee for service system and didn't like managed care. Jenny commented that at the beginning members were assigned to the wrong PCP and getting flooded with calls. There were system issues and some pharmacy related issues as well. Dr. Fankhauser asked if there is a phone number on their card as to who to call for grievances or a customer service phone number. Cassie said yes there is a phone number and the Plan is also working on the website to make sure the information is available and clear. The other thing tracked is the turnaround time. There are three types of letters that go out: acknowledgement, resolution and extension letters. Each of the letters has a different time frame that needs to be met and we are 91% compliant with the 5 day turnaround time for the acknowledgement letters. The resolution letters we are at 69%. That will be a focus and there is a tracking system in place. However, just knowing the numbers does not tell the entire story but compliance is on the upswing. Lupe mentioned that the phone number is also listed in the member handbook for filing a grievance along with the process, both locally and for the State. Dr. Wharfield stated people call with concerns or complaints and we are trying to educate our departments to recognize and mention that if it actually sounds like a grievance, we would invite the member to file it as a grievance. We cannot file it as a grievance unless the member requests it.

Network Management Committee

Sherri Bennett discussed that she had recently acquired the role as Network Manager and has responsibility for Contracting, Provider Relations and Credentialing. She is looking at a different structure to be a more provider friendly group. Started to staff up and recently added two external provider relations representatives, one internal provider relations representative to handle phone calls. The external representatives will have time to be in the provider offices and educating the providers on what types of programs the Plan has to offer and ask them to offer those things to the members. We want to have something to offer instead of just always fixing things. Two contract coordinators have been hired. One will oversee the credentialing area and comes from Children's LA. This person is very knowledgeable and knows a lot about contracting with providers and hospitals and knows the credentialing requirements. We also promoted an associate from Health Services who will oversee the provider database and the provider directory functions. This person came from WellPoint and has the background and experience in Managed Care around data. In the coming meetings the initiatives we are working on are cleaning up our data bases and creating a strategic plan for the department with the whole team taking part. It has been a fun exercise and the department can see where they are going and the accomplishments. Sherri wants to become more available to the providers as a department.

The next thing will be a provider network audit. In the past month had to do State provider updates. We did get a one week extension due on February 8, 2013. We found that there are issues in the way that data is being stored. The Access data base has issues and moving forward on how to store the data and looking at Cactus or a different data base that has more restrictions on it and less vulnerable to changes. Need to control the data going in and track changes. Access database has limitations of tracking changes. We are working hard to validate the provider rosters coming in. Want to get monthly updates, quarterly was not sufficient. We found that providers moved around or no longer here. Want to make sure the data base is accurate and up to date. Cleaning up and how we clean it up will be based on the vehicle we want to use. We will be going through our database, provider by provider and when it is cleaned up we hope to put it into better database.

Another initiative is for provider reps to do site visits. We are copying what some of the other COHS are doing. Sherri was able to contact and meet some of the staff at the other COHS who shared how they track their provider visits. Criteria for provider visits would be based, for example, if a provider has 1,000 plus members the offices would get 4 visits a year. Trying to quantify it but also based on the provider's needs. Dr. Fankhauser inquired as to what the visit would look like, would they schedule a time with the provider or just drop by. Sherri said it depends on the provider office but the Plan has to have something to offer. One of the things as far as information would be to report something good that is happening at Gold Coast. The current Provider Bulletin email blast doesn't get into the hands of the people who do the work and want to make sure the Providers know what is really going on at GCHP and that they are up to date. We need to include, policies and procedures and validating information, appointment availability, routine vs. sick and what time allotments do they need. Also documenting every piece of correspondence being loaded into the KWIK system, educational materials, verification of hours, etc., shows way we have good quality standards.

The last initiative to discuss is provider satisfaction surveys that they are developing and that will go out to providers. This will go out to PCP's and Specialists. We are determining whether to do the data entry and analysis internally or externally. The external vendors are expensive. Cen Cal shared their survey tool and we may utilize that and do it ourselves. There is an access to care survey. There were will be a couple of types of access surveys. One will be after hours to see what their phone system says, making sure the standard is met and the second is blind calls during the day. May hire an outside vendor or hire a couple of temps to do it, to check available appointment times, special needs, etc. The department is making strides. Dr. Cho wanted to know if for the survey are there any State requirements. Sherri mentioned that there are annual requirements. Have not done one yet and the goal is to do it the second quarter of this year. Determine what needs to happen and can start moving forward. Dr. Cho asked if there are two surveys. How satisfied are the providers with us and the other one is about how available is their access. Dr. Fankhauser commented great work.

Delegation Oversight
Robert Franco presented Delegation Oversight. We are continuing oversight of the delegated credentialing entities. We are moving to monthly updates beginning Jan 2013 for the delegate's entire network. These updates will capture additions, updates and terminations. DO is working closely with Provider Relations to ensure the updates are incorporated into our database and will translate into our network and directory.

DO is also working with Ventura Transit System (VTS) which is the new Non-Emergency Transportation provider. We have conducted a readiness assessment and identified some minor issues that the vendor is addressing. There will be monthly monitoring for the first year to ensure compliance to the contractual agreements.

The Clinicas Specialty Contract is also in the process of scheduling an onsite visit to ensure all the contractually required reporting is being captured and DO is also working with ACS to acquire the reported encounter data from Clinicas.

Finally, the Plan to Plan is coming up and GCHP is working with an outside vendor to create a readiness tool and conduct the initial readiness reviews. In addition to the readiness tool, the vendor is creating an ongoing monitoring tool that will be utilized for the annual plan to plan audits.

428 physicians were credentialed by our three delegated organizations. Moving towards monthly updates and on the 15th of each month will receive those updates. On the DO graph it also indicates the type of specialty for each provider who was added or termed.

DO is now expanding from just credentialing with our goal to create a dashboard and identify milestones. It is an evolving process. Discussion ensued and Dr. Cho requested further details on ICE. Robert explained that ICE is a collaboration of health plans and they have developed a template for delegation

oversight and we use their tool. The tool is used for annual delegation oversight. We go onsite for each of the facilities.

Health Education/Cultural Linguistics Committee
The first year HE/CL focused on the structure. We are developing a health education department and unit as well as providers and members having access to culturally and linguistically appropriate materials. Dr. Cho covered some of the topics that were surveyed last year and that will continue to occur in the member newsletter. Lupe Gonzalez showed a sample of the newsletter sent out a couple of weeks ago. The newsletter went out to 45,000 households to unique household members. It is a way to disseminate health education materials. This year we are following the National Public Health Calendar and health promotion. This newsletter issue focused on cholesterol. Having fun and controlling blood pressure, four ways of how to measure blood pressure, diabetes and colon cancer screening and knowing the risks and signs of a heart attack. She differentiated between genders because there are different signs for men and women. She shared a little on women's health that focused on pap smears and the importance of getting the test. The newsletter is bi-lingual and goes out on a tri-annual basis. The next issue is currently in the planning stage. We are looking at a variety of issues based on the population. We want to make it diverse and we're also looking at Seniors and Children to make the newsletter friendly and specific to our members. One of the things that will be incorporated is a calendar of diabetes education, zumba classes, health activities and dental services that are offered through community resources. Members will be able to tear it out and have a resource available in both English and Spanish. It is a self-management, self-referral process that they can call directly. If they are interested in a diabetes class they can call St. John's, making it as easy as possible for members to self-refer.

In the packet there are two work plans because the two areas of Health Education and Cultural Linguistics are unique and different, yet they do overlap. Health Education does cross over to member services and provider relations as well as the general community. In regards to the health topics we will continue to focus on provider relations by providing PCP's the contact information for our Cultural Linguistic services. We are using "train the trainer" model to train the provider relations staff to show the materials for telephonic interpreters, ASL interpreters and Mixteco interpreters. So when provider relations go out they will have a packet of Cultural Linguistic materials available to give to the provider. Free of charge, so that our members who have diversity have access to those services. Each of the providers are given an ID badge along with provider access code that they can apply to their badge and questions that they need to ask directly. We recently gave VCMC over 200 cultural/linguistics materials for their center. We are currently working with CBAS centers, working with CMH and all the other providers. We are also, working on a spreadsheet to tally the number of contacts that we have and materials that were provided. This year we are looking at tracking all our telephonic interpreters and total number of interpreters used internally and by the providers. We are looking at the number of minutes used as well as cost and focusing on providing education on cultural sensitivity training which is one of our mandates. We are looking at bringing in individuals to meet with our staff as well as our providers. Training is scheduled for March. Pacific Interpreters educate the importance of having a culturally linguistically sensitive staff and offer workshops on how to access an interpreter and sensitivity training for seniors. Last year the sensitivity training was put on the website so providers could access it. This year we will need to track it because it is a mandate and our providers are utilizing the website for training purposes and hands on training for seniors and individuals with disabilities. We are partnering with community based agencies to help us.

Another initiative are the women's health issues, breast feeding issues, pre-natal care and working closely with the Women, Infants and Children (WIC) program to ensure that new moms have resources and information on breast feeding and lactation promotion. There is a big demand for general health information classes in the community. We will continue to work with local partners such as St. John's, the County, City of Ventura and other agencies as well. The second work plan is one of the health education initiatives promoted by Dr. Wharfield, Jenny Palm and Dr. Cho and was identified by the auditors as an area for cost reduction. The high use of ER utilization by our members and the other three are objectives that we hope to move forward. We are in the beginning stages of developing a task force to come up with strategies for reducing ER visits. We have contacted other health plans to see what they have done, One thing that has worked for them is they utilize the health navigator model by using professionals to work

with the members directly at the different ER facilities. We are looking at developing strategies of working with our members directly and putting together policies when they are discharged from an ER. We want to connect them with their PCP for follow up visits, instead of going back to the ER by increasing their knowledge of the Medical Home and appropriate ER use. This will be presented to finance committee and senior management for staffing as well. A prototype of a smoking brochure was shared which is a resource guide that focuses on the State's help line, support groups and community resources. It is in the process of being reviewed and going through the Communication department for outline. We are collecting feedback and will be sent to Dr. Fankhauser for his comments. We will be developing future brochures on different topics.

Utilization Management Committee

Dr. Wharfield summarized the Utilization Management report. This is where the expenses are for the health plan. She discussed hospital days, average length of stay, ER utilization and readmission days. There will be a lag when all the claims data is in for current months. An NIH data report for 2011 the mean ALOS for all hospitals was 4.6. We are not at that number but we are not so far off for a new organization. Our largest utilizer VCMC has a self-published rate of 4.9 ALOS. When we look at our claims data it is 4.07. There are two issues. Is VCMC doing better than they think they are or is there validation through the claims data? There are a lot of numbers that feed into the ALOS and need to be analyzed before reporting final numbers. This is something to be aware of when our data is validated. Regarding hospital days, the focus is on continued stay review process and improving that. We are working hard with the CSO nurses to make sure they understand how to apply the Milliman Guidelines that we use to review the patient. We are focusing both on their review of the cases and on hiring a discharge planner which will be a huge asset in anticipating the discharge needs at the beginning of the hospital stay. The other initiative will be to improve communication. There is a lot of going back and forth. We need to closely monitor the level of service. Is the patient in the DOU because the need or because there isn't a bed available. Are they really intermediate level of care? We have formally committed to reducing the bed days by half a day this year and we will do trending month to month. Dr. Fankhauser noted that based on 2012 data looks like first half of the year was worse than the second half of the year. Dr. Wharfield said the last drop in the year is not a real data because not all data is available yet. ER concerns are that we have people who use the ER multiple times and don't use their PCP. We think that patient education is going to be an important thrust and in addition we will try and contact those members directly for education. The little sample we have done, if you call someone about something in the past they can't recall. We want to partner with the ER's to get more real-time data. We want to talk to those members right when they come out of the ER. That's when we are going to get the most impact, getting them the follow up appointment they need; the medicines they need, essentially doing ER discharge planning. Dr. Fankhauser inquired how you would capture that information. Dr. Wharfield said there are some models in other cities where you get real time ER data. We are probably not going to get the day they are in the ER but we may be able to get it right after. The ER's know their census and they know who they saw but we need to enhance our partnership so we can get the information. Just as in good discharge planning like the SeaView model it requires immediate attention at the time of discharge and/or at the time of ER discharge. Long term there may be a role for a nurse advice line where we are continuing to discuss this. Will our members utilize it? If they are not understanding the concept of a medical home and having a PCP would they engage in a nurse advice line? On readmission rates, there are no great bench marks.

All 30 day readmission rates is a new initiative. Looking at data from 2011 that All Cause readmission rates are 18%. We may not be doing so bad. We have to compare ourselves to the other COHS. The data will be available in June and have real benchmarks. How will we approach, who will we select? We can't look at every single discharge. Selection criteria that we will be using are you somebody who is readmitted a lot (3 or more readmissions); are you socially isolated; NICU discharges; and anybody with multiple discharge needs including poly pharmacy. The discharge planner we are hiring is going to be key on targeting this. We have concurrent stay review nurses and a new urgent discharge line for the DME to get the work done. The big thing that SeaView is doing is "eyes on the ground" approach. Many organizations approach this process by making phone calls to members, it is probably a poor substitute for going into a home and seeing what is really occurring. What SeaView does is they have Nurse Practitioners who in a way have a private practice and they go out and assess if they see someone who

has CHF they can order LASIK, will do the medication, facilitate the follow up appointment. GCHP is not a care giver and we cannot hire nurse practitioners to go out and provide medical care. GCHP can approach that kind of activity through home health care. We will pick up the home health care at the time of discharge and then we will determine through them what we think the visit should be. Should the member be seen for example: 3 times a week for the next 3 weeks, then once a month or quarterly, whatever it needs to be. Dr. Wharfield did go out and look and see if there were organizations we can hire and do that kind of work and there are not any. Home Health agency is going to be a first step for us and how to create that service level. The readmissions rates we found were 17% to 18%. Dr. Cho commented as far as bench marks go, comparing to our peers in California is more appropriate than comparing with National rates. For an example, Cen Cal has 27 years of data that are very reliable and reproducible. Our demographics are similar and Dr. Cho will ask them for their bench marks. The hospital days are more important than LOS (which dropped down from 3.80 to 3.25), and Dr. Cho noted that their hospital days went down from 380 days to 325 within the last 3 years. Cen Cal's readmission rates went down because of special programs. Better to use their bench marks than National Rates.
Dr. Fankhauser commented that Inpatient utilization by top billing providers, St. John's Pleasant Valley Hospital has an unusual long rate. Is it because they have a rehab and everyone agreed that was the reason because they have a sub-acute. Dr. Wharfield noted this data pull is new for us and trying to not include LTC data required some additional refinements. Dr. Fankhauser noted that if you compare the local hospitals and VCMC who has a disproportionate number of oncology patients; the numbers could be skewed. Dr. Cho commented that you don't want a low number and find that it isn't achievable.

APPROVAL ITEMS

Quality Improvement Plan
Dr. Cho said it had been looked at the last meeting. The requirement is that it does need to be reviewed the first quarter of the year. The only correction Dr. Cho had was to include Dr. Wharfield on the Medical Advisor Committee. With that correction a motion to adopt was taken from Sherri Bennett and Dr. Fankhauser seconded it. All voted in favor. The QI Plan can now go to the Commission for approval.

DISCUSSION ITEMS

Readmission Quality Improvement Project (QIP)
Julie Booth, Director, Quality Improvement provided an update on the Statewide QIP – to decrease hospital readmissions. The specifications are different then some readmission numbers already presented, such as exclusion of OB/GYN cases; requiring continuous enrollment of 120 days; and exclusion of all patents under the age of 21. The QI Department confirmed that each readmitted patient was an actual readmission for the Readmission QIP by doing a line by line analysis. The Readmission rate was 14% versus 18% for All Plan. Dr. Cho commented that the number is expected to be higher if it included the high risk patients. The State says that when they run SPD's the readmissions rate is 20%. In any case, the objective of the QIP is to lower the readmission rate. We stratify between SPD and non-SPDA. The barrier analysis using a fishbone diagram was designed based on the QI Committee (QIC) input. QIC made a decision to focus on patient discharge and to provide education and follow up after discharge. The State mandated form for Interventions includes hiring additional staff which was the idea at the time but in further discussion with Dr. Wharfield and Dr. Cho, the Home Health option may be a better solution. Our task will be to track the data from the follow-up after discharge patients to see what works and what does not and to determine impact on our readmission rate.

Facility Site Review
The Physical Accessibility Review Survey (PARS) demonstrated that only 6% have exam table that automatically changes height for the patient. Statewide most provider offices with the exception of VCMC have not been passing that one question. It has to be a certain kind of exam table. VCMC is up to date on all the requirements. The PARS evaluate the offices if they are limited or have basic access for the handicap. Dr. Wharfield commented that "basic" means they don't have a ramp, parking accessibility, etc. The PARS for High volume specialists went into effect in November 2012. Most access was fine. Braille or signage varied for each facility.

HEDIS Status
Julie Booth gave an overview of the Medical Advisory Committed (MAC) presentation. The minimum performance level (MPL) ratio must be achieved or we will need to do a corrective action plan. The High Performance Level (HPL) would be a wonderful level to reach. Some of the measures are administrative and calculated off of claims data. If it is a hybrid measure, it is calculated on both claims and chart review. We will have an opportunity to look at the chart. Dr. Fankhauser commented that the health plan could actually prompt the patient on cervical cancer screening, adolescent well care visits, etc. The COHS comparison was shown and it shows the rates for all the COHS for 2012. These will be the bench marks when we do have results. Dr. Fankhauser noted we need to figure out what Cen Cal and Central Alliance are doing. There have a lot of HPL's. We have visited Central Alliance and have been on calls with the COHS on what they are doing to get their numbers up but a lot of it has to do with claims coding and has with the provider practice. Dr. Wharfield noted that most of these are positive measures. On the avoidance of antibiotic treatment in adults with acute bronchitis, how is that counted? Is it counted by the diagnosis and noted there was no antibiotic therapy? How is it calculated? Julie commented that is it strictly based on claims data and a look at the diagnosis without an antibiotic. No chart review is performed. We would actually be looking for an antibiotic and count those who don't have one. Julie said she will look into it and get back to Dr. Wharfield. Julie noted that diabetes poor control is also an inverse measure and is more of a black and white method. Dr. Wharfield noted that it is a funny measure if you are tracking URI's and looking at ICD-9. Julie said we would need to look at the HEDIS specifications. One of our measures was presented and GCHP is at 93% for kids who have access to care for the 12 to 24 month age range. This is based on test data only. The providers are going to get an email shortly about HEDIS, giving them information on what to expect. It is also in the provider bulletin and discussed at meetings.

Operations Update
Cassie Undlin noted that she is reporting in her role as COO on quality initiatives in the operations area. She also proposed the establishment of a Quality Operations Committee that would report to the QI Committee. Cassie reported on the Auto Adjudication Project which is in collaboration with Xerox as a Six Sigma project. One of the issues on the State Corrective Action Plan (CAP) was that the auto adjudication rate is extremely low. The concern is having too many manual processes increasing the error rate. The Plan was mandated by the State to increase the auto adjudication rate 60% by the end of December. We assessed the process to improve, prioritize and work on issues that would give the greatest return. Although the Plan did not make 60% in December, significant headway was made. We have seen an increase in auto adjudication of 23% and at the end of the year at 35%. A big improvement will be the implementation of a claims editing system.

We do have an issue with Long Term Care (LTC), the system is designed for hospital claims. For billing, LTC counts the date of admission and not the date of discharge. Hospitals are reverse, not counting the admit date but counting the date of discharge. This created problems in manual data entry of trying to simulate an Electronic Data Interchange (EDI) claim coming in. We found that there were processes that needed to be remapped so they would look just like an EDI claim.

Another issue is Coordination of Benefits (COB). We have to make sure to coordinate the EOB and the tools with the State because the COB facilitates this. We fully anticipate that one of our over payment issues is around not getting the EOB's from the providers. Dr. Cho asked, "Will auto adjudication increase provider satisfaction?" There is still a lot of work to do, but yes, because there will be fewer errors.

<u>Inventory</u>
Inventory processes are a QI process which needs to reduce the number of pends and look at turnaround time for claims payment. We are looking at the excess of State requirements on TAT. We are required by the State to meet 15,000 claims inventory at a certain point in time. It was met at one point and now it is fluctuating. The State wants to make sure we can keep on track and keep inventory at a low number. It will rise at some point. Currently at 98% of 30 days and our requirement is 90%.

<u>Quality Operations Committee</u>

This is a formal committee that pulls all the operational committees together to discuss what they are doing, but the other committees would still be their own committees. We are trying to make it more of an operational focus on process improvement.

There were no further comments.

ADJOURNMENT

Dr. Cho adjourned the meeting at 4:59pm. Next QI meeting will be scheduled on May 2, 2013.

Submitted by Julie Booth

Approved by: _____ Date: _____
Charles Cho, M, D., Chair

Tatum

Gold Coast Health Plan℠

A Public Entity

May 20, 2013

Tatum Team

Cassie Undlin

Debbie Rieger

Tatum Status Wrap-up

Tatum concentrated on five primary areas for their engagement:

- *Project Management* – providing oversight on key initiatives.
- *Staff Evaluation and Development* – improving departmental cohesiveness through development of policies and procedures, making staffing recommendations and restructuring where needed.
- *Operational Optimization* – assessing the "as is" state of current operations, and recommending and/or developing tools to further enhance operations.
- *System Optimization and Configuration* – working with internal and external resources to enhance and further automate key processes.
- *Transitioning* – transferring work to GCHP staff with appropriate amount of training and documentation

Transition Plan:

Transition Item:	GCHP Resource:	Completion Date:
Project Management		
• Specialty contract	Ruth Watson, COO/Sherri Bennett, Network Management	June 30
• Plan to Plan toolkit	Ruth Watson, COO/Sherri Bennett, Network Management	June 30
• Enrollment issues	Ruth Watson, COO/Luis Aguilar, Member Services	June 30
• Long term care	Ruth Watson, COO	June 30
• Recoveries Management	Ruth Watson, COO, Percy Mayfield, Claims Manager	June 30
Staff Evaluation/Development		
• IT Director	Melissa Scrymgeour, IT Director	Complete
• Network Management	Ruth Watson, COO	June 30
• Member Services	Ruth Watson, COO	June 30
• Claims	Ruth Watson, COO	June 30
• Interdepartmental communications	Ruth Watson, COO	June 30
• Vendor Management	Ruth Watson, COO	June 30

Transition Plan:

Transition Item:	GCHP Resource:	Completion Date:
Operational Optimization		
• Claims Processing	Ruth Watson, COO/ Percy Mayfield ,Claims Manager	June 30
• Network Management Reorganization	Sherri Bennett, Network Management	Complete
• Member Services Reorganization	Luis Aguilar, Member Services	Complete
• Vendor Management	Ruth Watson, COO/Andre Galvan, Vendor Manager	June 30
• Financial Recovery Project	Ruth Watson, COO/Percy Mayfield, Claims Manager	June 30
System Optimization/Configuration		
• ICES	Percy Mayfield, Claims Manager/Jenny Palm, Health Services Director	June 30
• Milliman Configuration	Melissa Scrymgeour, IT Director	Complete
• System Config IKA setup	Ruth Watson, COO	June 30
• IKA Updates 5.1, 5.3	Melissa Scrymgeour, It Director	Complete
• Work Flow Management	Andre Galvan, Vendor Manager	June 1

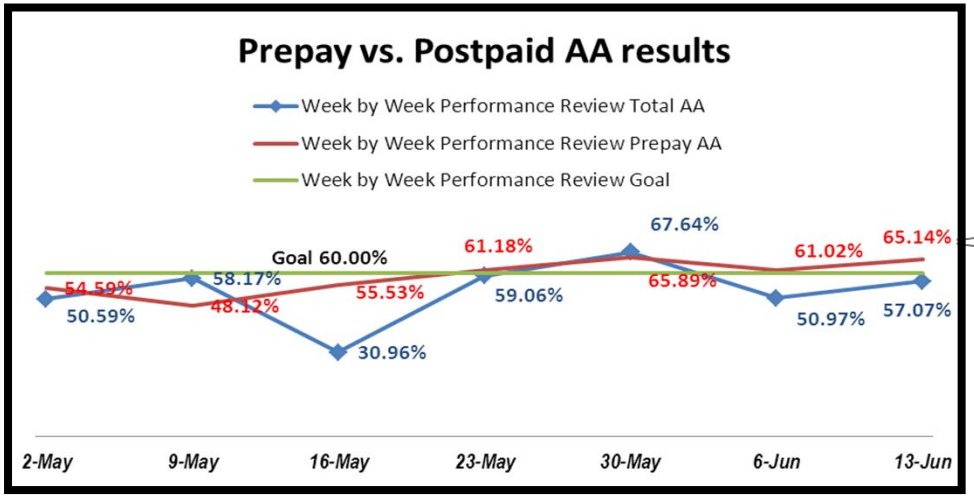
Objectives/Accomplishments:

Transition Item:	Target Completion:	Completion Date:
Project Management		
• Specialty contract	May 30	Operational
• Plan to Plan toolkit	June 30	
• Enrollment issues; • Part A • LTC • Admin	 April 30 April 30 June 30	 Operational Operational 80% Operational
• Long term care	June 1	90% Operational
Staff Evaluation/Development		
• Provider Relations	June 30	
• Member Services	June 30	
• Claims	June 30	
• Interdepartmental communications	June 30	
• Vendor Management	June 30	

Objectives/Accomplishments:

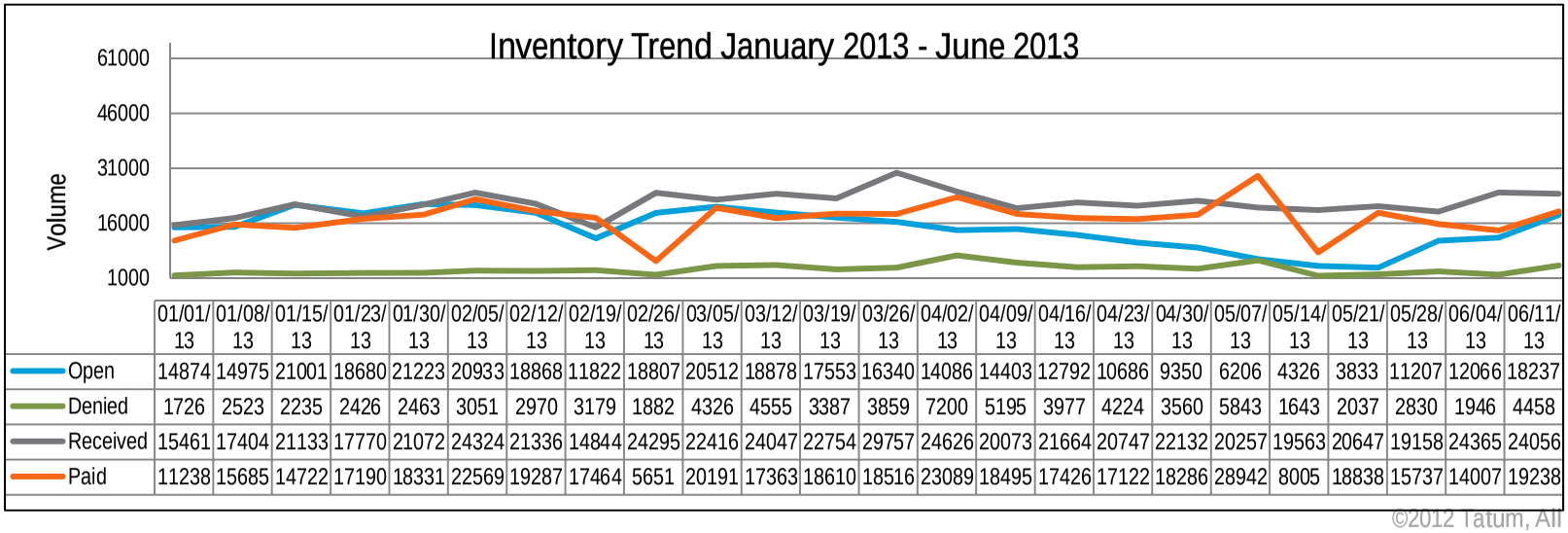
Transition Item:	Target Completion:	Completion Date:
Operational Optimization		
• Claims Processing	June 30	Ongoing
• **Enrollment**	May 30	May 30
• Provider Contracting	March 31	Complete
• Vendor Management	Ruth Watson, COO	Ongoing
• Financial Recovery Project	June 30	Ongoing
System Optimization/Configuration		
• ICES	June 30	Complete
• System Config IKA setup	March 30	April 30
• Work Flow Management	June 1	Complete

Operational Optimization – Claims Stats:



Auto Adjudicate Target:
51% by April 11, 2013
60% by June 30, 2013

Inventory Analysis



	01/01/13	01/08/13	01/15/13	01/23/13	01/30/13	02/05/13	02/12/13	02/19/13	02/26/13	03/05/13	03/12/13	03/19/13	03/26/13	04/02/13	04/09/13	04/16/13	04/23/13	04/30/13	05/07/13	05/14/13	05/21/13	05/28/13	06/04/13	06/11/13
Open	14874	14975	21001	18680	21223	20933	18868	11822	18807	20512	18878	17553	16340	14086	14403	12792	10686	9350	6206	4326	3833	11207	12066	18237
Denied	1726	2523	2235	2426	2463	3051	2970	3179	1882	4326	4555	3387	3859	7200	5195	3977	4224	3560	5843	1643	2037	2830	1946	4458
Received	15461	17404	21133	17770	21072	24324	21336	14844	24295	22416	24047	22754	29757	24626	20073	21664	20747	22132	20257	19563	20647	19158	24365	24056
Paid	11238	15685	14722	17190	18331	22569	19287	17464	5651	20191	17363	18610	18516	23089	18495	17426	17122	18286	28942	8005	18838	15737	14007	19238

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Gold Coast Healthy Plan Budget Update

By Don Gilbert and Trent Smith

June 17, 2013

It was a battle between a tight fisted Governor and legislative leadership with a thirst to spend new-found riches after years of budget slashing. If one had to determine a winner in the State Budget showdown, the scorecard would show Governor Brown as the clear winner.

The final budget deal does include some victories for the Assembly Speaker and Senate Pro Tem. For example, the Speaker received $305 million in annual funding for a new middle-class college scholarship program. The Senate Pro Tem pushed hard and won approval for restoring adult dental benefits to Medi-Cal and improved spending in basic mental health services. The Legislature also pushed through a compromise on the Governor's new K-12 education funding plan. However, in the end the Governor got most of what he wanted in the State Budget.

Chief among the Governor's wins was the adoption of lower revenue projections for the current and future budget years. The non-partisan independent Legislative Analyst Office (LAO) projected $3.2 billion more in future revenues compared to the Governor's projections. The Legislature wanted to use the LAO's revenue projections, allowing them to dedicate more money towards new proposals or restoring state programs drastically cut in recent budgets. Instead, the final budget uses the Governor's more conservative projections. Obviously, if the LAO is correct and state revenues grow beyond the Governor's expectations, the state could have an even greater budget surplus next year.

Most experts believe the Governor had most of the leverage in the budget negotiations because legislators lose their pay for everyday the budget is late beyond the June 15 deadline. As a result, the Legislature had to surrender on most of their budget priorities if they hoped to get a deal done by the deadline and continue to get paid.

The final State Budget produces mixed results for the Medi-Cal program. On the positive side, the final plan does not include the efficiency reductions that the Governor proposed for managed care plans.

In addition, the budget includes a state-based approach to implementing Medicaid expansion under the federal Affordable Care Act, as opposed to the county-based approach put forth by Governor in January.

As previously mentioned, the budget includes a partial restoration of adult dental benefits and basic mental health programs within Medi-Cal. The budget also includes

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some funding for newly qualified immigrant parents and a minor increase in funding for enteral nutrition benefits

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Unfortunately, the final budget did not include a repeal of AB 97 ten percent rate cuts to Medi-Cal providers for which many Legislators had pushed. Even a narrow proposal to eliminate the ten percent cuts to Distinct Part Nursing rates was abandoned at the last minute. A proposal to include funding to treat autism was also shelved.

The reauthorization of a 2.35 percent gross premium tax on Medi-Cal managed care plans (MCO tax) in 2012-13 and 3.94 percent state sales tax in future years was passed after a fierce debate. Health plans wanted greater assurances that the new revenue generated from these new taxes would be used to enhance Medi-Cal rates. In addition, they wanted an expiration date on the taxes. In the end, the taxes passed with a three year sunset date. Health plans will have to wait and see if the assurance from the Administration that the Medi-Cal rates will increase with revenue from the new taxes will be realized.

Gold Coast Health Plan℠
A Public Entity

Healthy Families Program Transition to Medi-Cal

Commission Meeting

June 24,2013

www.goldcoasthealthplan.org

Communication & Outreach

- Radio
- Resource Fairs
  - Cinco de Mayo
  - Oxnard College Health Fair
- Provider Town Hall Meetings
- Plan Partners-transition strategy sessions
- Outreach materials
  - Newsletters, FAQ's, Benefit Comparison

Enrollment

- June 1-Pre-transition:
  - 5000 Targeted Low Income Children (TLIC) enrolled
- August 1- Expected Transition:
  - Ventura County Health Care Plan (VCHCP)- ~10,000 members
  - Anthem: ~5000 members
  - Kaiser: ~3500 members

Call Center Preparation

- Add staffing to manage increase in call volume
  - Both pre and post transition
- Staff development
  - Developing scripts
  - Educating call center staff
  - Developing escalation policies

Continuity of Care

- Gap in Mental and Behavioral Health
- Formulary differences
  - Mandatory Generics
- Provider contracting
  - Scope will not be known until transition
- Assignment of member to GCHP contracted PCP's