Ventura County MediCal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)

Regular Meeting
Monday, May 23, 2016, 3:00 p.m.
County of Ventura Government Center – Hall of Administration
Lower Plaza Assembly Room, 800 South Victoria Avenue, Ventura, CA 93009

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Ventura County Medi-Cal Managed Care Commission (VCMMCC) doing business as Gold Coast Health Plan (GCHP) on the agenda. Persons wishing to address VCMMCC should complete and submit a Speaker Card.

Persons wishing to address VCMMCC are limited to three (3) minutes. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission.

SPECIAL PRESENTATIONS

1. **Sponsorship Award to National Health Foundation**

2. **Sponsorship Award to Ventura County Area Agency on Aging**

FORMAL ACTION ITEMS

3. Pharmacy Benefits Manager Request for Proposals

Staff: Scott Campbell, General Counsel

RECOMMENDATION

Reject all proposals from the Request for Proposals (RFP) that staff initiated on November 6, 2015; and provide direction to staff to either: (i) open a revised RFP to all proposers, or (ii) limit a revised RFP to the three finalists identified in the initial RFP process.

4. March 2016 Fiscal Year to Date Financials

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION

Accept and file March 2016 Fiscal Year to Date Financials.

5. Fiscal Year 2016/2017 Budget

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION

Approve Fiscal Year 2016/2017 Budget.

6. Internal Audit Report, Revenue

Presenter: Martin Haisma, Certified Information System Analyst, Certified Internal Auditor, Project Management Professional, Etonien Consulting

RECOMMENDATION

Approve the Internal Audit Report.

7. Reinsurance for High Cost Claims Policy Renewal

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION

Approve and authorize binding reinsurance for high cost claims policy renewal with StarLink per the quote estimate.

8. Ventura County Behavioral Health Overdose Rescue Project Sponsorship Application Request (ARCH)

Staff: Ralph Oyaga, Executive Director for Government, Regulatory and External Relations

RECOMMENDATION

Approve the Ventura County Behavioral Health Overdose Rescue Project sponsorship application request for fifty-one thousand three hundred ($51,300) dollars for 1,000 naloxone overdose rescue kits.

REPORTS

9. Chief Executive Officer (CEO) Update

RECOMMENDATION

Accept the CEO Report as presented.

10. Chief Operations Officer (COO) Update

RECOMMENDATION

Accept the COO Report as presented.

11. Health Services Update

RECOMMENDATION

Accept the Health Services Report as presented.

12. Health Education Update

RECOMMENDATION

Accept the Health Education Report as presented.

CLOSED SESSION

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

14. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Scott Campbell, General Counsel
Unrepresented employee: Chief Executive Officer

15. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Diversity Officer

16. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: Two Cases

17. CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION
Paragraph (1) of subdivision (d) of Section 54956.9
Clinicas Del Camino Real Inc. v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan, Ventura County Superior Court Case No. 56-2014-00456149-CU-BC-VTA

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on June 27, 2016, in the County of Ventura Government Center, Hall of Administration – Lower Assembly Room, 800 South Victoria Avenue, Ventura, CA 93009.

Administrative Reports relating to this agenda are available at 711 East Daily Drive, Suite #106, Camarillo, California, during normal business hours and on http://goldcoasthealthplan.org. 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.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5509. Notification for accommodation must be made by the Thursday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

This agenda was posted on Thursday, May 19, 2016, at 4:30 p.m. at the Gold Coast Health Plan Notice Board and on its website.

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: May 23, 2016

SUBJECT: Rejection of All Proposals for Pharmacy Benefits Manager and Direction for Revised Request for Proposals

SUMMARY:

At the Commission's meeting on April 26 in Closed Session after consultation with General Counsel, the Commission directed staff to prepare an agenda item to consider rejection of all proposals related to the Request for Proposals (RFP) for the Pharmacy Benefits Manager (PBM) Contract. Upon rejecting all proposals, the Commission should provide direction to staff regarding the terms of a revised RFP for these services. The Commission may elect to open the new RFP to all applicants, or it may direct staff to request new proposals only from the three finalists of the previous RFP.

BACKGROUND:

Gold Coast Health Plan (GCHP or the Plan) contracts with a Pharmacy Benefits Manager (PBM) in order to provide pharmacy benefit services to its members. The contract with the current PBM, Script Care LTD. (SCL), terminates on September 30, 2016. GCHP began the current process on November 6, 2015 to select a PBM for the next contract term.

GCHP received responses from ten PBMs. The PBMs were assessed for their ability to meet the RFP requirements, meet minimum qualifications, the quality of their responses, and the ability to accept GCHP contract terms and pricing. Plan staff reviewed the RFPs and then selected and interviewed three finalists. At the Commission's February 22 meeting, staff presented the results of the RFP to the Commission, identifying the three finalists selected by staff. The three finalists were SCL, Magellan, and Optum Rx. The Commission originally asked SCL and Magellan to participate in interviews with the Commission but after additional consultation with General Counsel, the Commission determined that due to potential conflict of interest issues and a desire to become more involved in the selection process and have certain subject areas specifically addressed in the RFP, staff should present an agenda item for the Commission's consideration concerning the rejection of all bids.

If the Commission takes action rejecting all bids, then it will need to provide direction to staff for the procurement of a new PBM contract. The method for the procurement is subject to the Commission's discretion. There are two options for the Commission to consider. First, given that

the prior RFP process resulted in identification of three finalists prior to the interviews, the Commission may choose a more limited procedure and request that each of the three finalists submit new proposals for the Commission's review. Second, the Commission could direct staff to re-advertise the revised RFP publicly and accept proposals from all interested companies.

If the Commission rejects all bids, staff will provide notice to all of the bidders. Staff has been working on a revised RFP that will take into account the Commission's direction. Alternatively, the Commission could proceed with the interviews of Magellan and SCL under the prior RFP. Correspondence from Magellan and SCL concerning this agenda matter is attached.

As the Commission may recall, at the April 25, 2016 meeting, the Commission authorized staff to enter into an agreement with SCL extending their contract up to 9 additional months to allow any new RFP process to be completed.

RECOMMENDATIONS:

1. Reject all proposals from the RFP that Plan staff initiated on November 6, 2015; and

2. Provide direction to staff to either: (i) open a revised RFP to all proposers, or (ii) limit a revised RFP to the three finalists identified in the initial RFP process.

FISCAL IMPACT:

There is no direct fiscal impact for rejecting all bids. An RFP process that is open to all companies will likely have more of an impact on staff time than a limited RFP process due to the need to review and consider more proposals. The impact on the final PBM contract amount is unknown.

ATTACHMENTS:

Correspondence from Magellan and SCL.

Magellan Rx MANAGEMENT

March 21, 2016

Ventura County Medi-Cal Managed Care Commission
C/O Mr. Scott Campbell
Best Best & Krieger
300 South Grand Avenue
25th Floor
Los Angeles, CA 90071

Dear Commission Members:

I am the Chief Executive Officer of the Magellan Rx Management division of Magellan Health, Inc. ("Magellan"). We were very pleased to learn that the Gold Coast Health Plan ("GCHP") evaluation committee recommended award of the Pharmacy Benefits Manager contract ("Contract") to us, after ranking us the top scorer on 14 of 18 evaluation factors, as well as finding that we offered the most competitive price.

Magellan understands your need to verify that GCHP is awarding to the appropriate provider, and your concerns in ensuring a smooth transition of services. Therefore, I am writing to both express my commitment to a successful transition of your program and address certain matters that were raised on February 22, 2016 when the Ventura County Medi-Cal Managed Care Commission ("Commission") was considering the recommended award to Magellan. I hope this letter provides you with greater insight into Magellan's capabilities and the soundness of the evaluation committee's recommendation.

For the past 30 years, Magellan has served Medicaid programs, assisting agencies in caring for their members as a pharmacy benefits manager ("PBM"). We specialize in helping to develop and implement pharmacy benefit programs that mitigate disruption, are in compliance with state and federal regulations and in alignment with the quadruple aim of lowering costs, improving outcomes, providing a superior member experience, and providing an improved and positive clinician experience.

Throughout our history, Magellan has successfully transitioned numerous contracts for other public entities, and we have developed best practices to do so while ensuring minimal impact. Magellan will provide an experienced team of transition professionals that have worked together for several years to ensure a successful implementation for GCHP. The account management team also will be involved from implementation through ongoing operations, providing continuity and a single point of contact. Any transition can involve some disruption – as several pharmacy

representatives acknowledged during the February 22 meeting that they experienced with Script Care – but we deliver a structured, proven implementation process for our health plan clients that mitigates the risk through careful planning. Importantly, the transition of services to Magellan will result in years of expanded, modernized services for GCHP and the population that you care for.

In response to concerns raised at the February 22 meeting about available pharmacies, we have confirmed that, of the 231 pharmacies identified on the current network list, Magellan holds contracts with 209 of them. GCHP staff confirmed that nine of the ten pharmacies whose representatives appeared at the February 22 meeting are in Magellan's network. Moreover, Magellan includes 39 **additional** pharmacies in Ventura County that are not in the Script Care network and that will be available to GCHP's members, for a total today of 248. In addition, Magellan will extend contracts to the remaining independent pharmacies that are not part of Magellan's network.[1] Thus, Magellan will not only minimize any disruption during transition, but we will expand access and provide more options for filling prescriptions.

We understand that some confusion over 340B adjudication may have been raised during the February 22 meeting. The Request for Proposals requires that the proposers "be able to adjudicate 340B drug pricing for the Plan from contracted pharmacies associated with eligible FQHCs." Magellan is absolutely able to adjudicate 340B drug pricing, and currently does so for numerous clients. Dealing with 340B contracts is a standard part of the PBM implementation process. Contrary to claims at the February 22 meeting of a $24 million loss to GCHP, Magellan will accept the currently-negotiated rates, so that GCHP will continue to receive the financial benefits negotiated on its behalf. Similarly, the 340B system partners (covered entities) will not lose the benefits or efforts they have invested, but will simply transfer their agreements to Magellan or more effectively, to GCHP for Magellan to administer – ensuring continuity for GCHP moving forward.

Magellan also will expand tools available to GCHP, and offer solutions that Script Care does not. Magellan's collaborative and integrated approach and advanced, easy-to-use tools are a critical reason that Magellan scored the highest on so many of the RFP's evaluation factors. For example, Magellan offers a robust "automated prior authorization" process that incorporates medical claim data into our claims system to improve access to care and reduce provider burden. Our innovative information technology systems and extensive clinical knowledge will help GCHP to identify opportunities to improve health outcomes and move GCHP to a next generation PBM program. These and other sophisticated tools allow us to deliver the greatest value to GCHP. Finally, specialty pharmacy is a leading driver of costs in any program, and Magellan has unique

[1] Nine of the 22 remaining pharmacies are Kaiser Permanente pharmacies. In our experience, Kaiser contracts with a PBM only after the PBM vendor has been selected.

Magellan Rx MANAGEMENT

capabilities and solutions that will advance GCHP's management of these expensive, life-saving pharmaceuticals.

In short, Magellan provides excellent customer service to our clients and to all providers that touch the pharmacy program. We work within the communities we serve to build productive and collaborative relationships with our clients and the providers that care for your members. Provider engagement is a critical element to success, and we recognize and plan for it. Magellan has extensive expertise in working collaboratively with our clients to provide guidance in the complex realm of health care, caring for special populations, and providing quality care to those who receive their health care through Medicaid.

Thank you for the opportunity to introduce Magellan to you. We agree that implementing the services as of October 1, 2016 is important, and we stand by our commitment to ensure a smooth transition by that date. We look forward to addressing any further questions that the Commission may have in connection with the transition of its pharmacy benefits manager.

Sincerely,

Mostafa M. Kamal
Chief Executive Officer
Magellan Rx Management, LLC

Magellan Rx MANAGEMENT

April 21, 2016

Ventura County Med-Cal Managed Care Commission
C/O Mr. Scott Campbell
Best Best & Krieger
300 South Grand Avenue
25th Floor
Los Angeles, CA 90071

Dear Commission Members:

Magellan Rx Management LLC ("Magellan") looks forward to attending the April 25 Ventura County Medi-Cal Managed Care Commission ("Commission") meeting and plans to participate during the public comments component. We are committed to continuing to work with the Commission and Gold Coast Health Plan ("GCHP") to move forward and will make ourselves available as may be requested.

We hope that the Commission found our March 21 letter helpful and informative. We are writing this letter in anticipation of the April 25 meeting and in support of the Gold Coast Executive Review Committee's ("ERC") recommendation of Magellan as GCHP's pharmacy benefit manager ("PBM").

The ERC's recommendation is based on written proposals and oral presentations. Magellan scored first in 14 of 18 categories. We fully support the ERC's recommendation.

Magellan has operated in the Medicaid pharmacy benefit management environment for well over 30 years. We are well versed in what it takes to implement and operate a PBM in the public sector, with extensive experience collaborating with Medicaid plans and partnering with their providers to provide exceptional care to members. Magellan has never failed to implement on time. Our implementation approach focuses on minimizing member disruption. We assure the Commission that Magellan has resources and people available to achieve a successful implementation, and that we still can achieve that implementation, as scheduled, on or before October 1, 2016.

Our systems, processes, and programs will help GCHP to create a next generation pharmacy benefit program to meet the challenges ahead. As GCHP continues to grow and experience new challenges to providing care and containing costs, Magellan is the best partner to help you meet those challenges head on with sophisticated, proven, advanced, and scalable technology, robust reporting and analytic capabilities, high-touch member care, and innovative clinical programs that span the gap between pharmacy and medical care. With these proven strengths, Magellan will help GCHP advance its pharmacy benefit program, meet its potential to provide the very best care for its members, and achieve its goal of having a 'Member-first' focus through a holistic approach to managing pharmacy benefits.

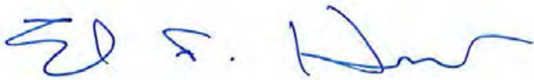
We have the confidence of managed Medicaid plans and 26 Medicaid fee-for-service agencies to which we provide an array of complex pharmacy benefit management services. We are providing herein a few recent

references in order to provide the Commission with further insight into our customer service, client satisfaction, and high service ethic. Should the Commission approve the ERC recommendation, we believe that GCHP will, like other Magellan customers, find Magellan to be an excellent partner.

Finally, we note that the Request for Proposals did not include a specific date on which proposals would expire, but it did indicate that GCHP intended to award the contract in January 2016. Further, the award initially was agendized for February 2016. As a result, GCHP may be unclear whether the proposals remain available for award. Magellan hereby confirms that our proposal remains available for award, and will continue to remain available for a reasonable time to permit GCHP to review and approve the ERC recommendation for award.

We look forward to working closely with GCHP and the Commission to assure that your members receive the highest level of clinical expertise and are able to have increased outcomes, pharmacy access and convenience.

Sincerely,



Earl F. Hurst
SVP, General Manager of Managed Care Market
Magellan Rx Management, LLC

HEALTH PLAN

April 15, 2016

Earl Hurst
General Manager & SVP, Managed Care
15950 N. 76th St., Ste 200
Scottsdale, Arizona 85260

Dear Earl,

Please find this note as a Letter of Reference from McLaren Health Plan for Magellan Rx (MRx) and its predecessor 4D Pharmacy Management.

Magellan Rx has been a long standing partner of McLaren Health Plan since 1998. Over the years McLaren Health Plan has grown from a newly formed Managed Medicaid HMO to an integrated health plan covering almost 250,000 members. We have grown our lines of business to include fully insured benefit plans offered both on and off the Marketplace Exchange for individuals, small and large employer groups, Medicare Advantage, Managed Medicaid and self-funded employers.

All of our lines of business have been supported by MRx which is one reason we have been so successful in our growth and financial performance over the last 17 years. We have a very close working relationship with the entire PBM team at MRx and have found them to be highly skilled individuals with extensive years of experience in the Managed Care pharmacy business. McLaren Health Plan has maintained this partnership with MRx because of their leadership and ability and willingness to provide us with the highest level and both quality of service, exceeding our expectations and contractual obligations.

As a business woman I have assessed the capabilities of the PBM competitors to ensure we were still receiving the best value from MRx. As a testament to MRx, they have always excelled over their competitors in cost, quality and service which has forged an even stronger business partnership between MRx and McLaren Health Plan.

In closing, I want to emphasize our relationship with MRx is one of a partnership, not "vendor". We both strive to help the other be successful, which is not often found in today's business world. MRx is a partner I value and am happy to be a reference for.

Sincerely,

Kathy Kendall
President & CEO

810.733.9700 . G-3245 Beecher Road.Flint.MI.49532

Midwest
Health Plan

April 14, 2016

To whom it may concern,

Please find this note as a Letter of Reference for Magellan Rx and its predecessor company 4D Pharmacy.

HAP Midwest Health Plan has used the Pharmacy Benefit Management services of Magellan Rx since January 1, 2013.

Magellan Rx has been a strong partner to HAP Midwest. They took on our account on short notice (Oct, 2012) and was able to go live without any major issues with multiple plan set-ups on 1/1/13. This included lines of business that included County Health Plans (4 with approximately 25,000 lives), Medicaid (approx. 70,000 lives), Children's Special Health Care (approx. 2,000 lives), MiChild (approx. 1,000 lives), and a Medicare Dual Eligible Special Needs plan (approx. 600 lives).

During our contract period they have delivered exceptional quality and service to the plan. They have represented the PBM activities at State and CMS audits, Pharmacy and Therapeutics Committee, quality and HPMS reporting, and representation at State and CMS workgroup meetings. Our account management team and their office-based supports have been complimented many times by State and CMS agencies and reviewers for the completeness and accuracy of their work product. Their team is proactive and always aware of reporting requirements. Their communications are timely and valuable, and they have been great partners in sharing best practices that have improved our operations, quality, and financial performance.

It is also important to note that Magellan Rx partners with strong organizations to provide a full menu of services that we require. Their relationships with Medicare Formulary and Medication Therapy Management sub-vendors have provided for a seamless, high-quality delivery of these services.

Our contract management team is made up of highly skilled and conscientious individuals who take pride in delivering a high-quality product. They represent a wide scope of subject matter experts who have many years of experience in Managed Care and pharmacy practice. They interact well with our staff and maintain relationships with regulators and accrediting agencies so that they have the most accurate and up to date information.

Magellan Rx has always gone above and beyond our contractual obligations to support our needs. They deliver a high-value product that our organization could not support internally. I would personally recommend their services to other organizations.

My role with the organization was as the Director of Pharmacy from 10/1/2011 through 6/1/2015. Since 6/1/2015 my role has expanded into a higher level of leadership with direct responsibility of the pharmacy product.

Please feel free to contact me if you should require any additional information.

Best regards,

Brian J. Peltz, MS, RPh, FACHE, FAHM
Vice President – Clinical Services
HAP Midwest Health Plan
21700 Northwestern Highway (T03G19)
Southfield, MI 48075
P: (248)663-3799
E: bpeltz@midwesthealthplan.com

Spring 2016

To Potential Clients of Magellan Rx:

The selection of the optimum Pharmacy Benefit Manager (PBM) is an important component in the management of a health plan, employer group or payer's pharmacy benefit program. A PBM must be a partner not just a vendor compliant with contractual requirements. As Upper Peninsula Health Plan's (UPHP's) Pharmacy Benefit Manager, Magellan Rx is just that, a true partner.

On a day to day basis they provide account management that is responsive and flexible providing timely, assistance. We have real time access to account management on a day to day basis as well as for scheduled meetings. The support we receive for reporting, compliance and fraud, waste and abuse activities is consistent and timely. They have complied and been transparent with audits that are performed and assisted UPHP in providing documentation, trending and analysis for initiatives.

UPHP has Medicare and Medicaid product lines and we can count on Magellan Rx to be both proactive and strategic in managing these benefits and keeping current with industry changes. There can be challenges to managing State and Federal programs when changes (often involving programming) are made with little turn-around time. We have been able to count on Magellan Rx to provide the support we have needed. When developing our Medicaid/Medicare Demonstration plan they provided assistance in the development of the program prior to member enrollment, even coming on site to assist UPHP with the Readiness Review process.

As the healthcare landscape has changed, we have been able to count on Magellan Rx to work with us to develop services to meet changing requirements even if they are outside of current contract. Magellan Rx employs staff with varied backgrounds and expertise. This depth of experience has proven time and time again to be valuable to UPHP.

Magellan Rx has supported our plan design and helped us to manage pharmacy trend. We have been able to manage our formulary with the utilization management tools provided. Formulary tools, point of sale messaging systems and clinical programs are all supported by the PBM. They have provided us the tools that assist us in maintaining a clinically sound, evidenced based pharmacy benefit program that has helped UPHP to manage trend.

228 West Washington Street • Marquette, MI 49855 • 906-225-7500 • 888-904-7526 • (Fax) 906-225-7690 • www.uphp.com

There are challenges in navigating the health care industry and managing a pharmacy benefit. I feel partnering with Magellan Rx has allowed us to focus on serving our members and our providers in a sound partnership relationship.

Please feel free to contact me with any questions or to verify any statements.

Sheryl D. Waudby, MS, RPh
Pharmacy Director
906-225-7876

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May 4, 2016

VIA U.S. MAIL and EMAIL - Scott.Campbell@bbklaw.com

Ventura County Medi-Cal Managed Care Commission
c/o Mr. Scott Campbell
Best Best & Krieger
300 South Grand Avenue
25th Floor
Los Angeles, CA 90071

Re: RFP - GCHP110215
Our File No. 4678-001

Dear Commission Members:

I am writing on behalf of my client, Magellan Rx Management LLC ("Magellan"), to address the Commission's intention to hold a special meeting for the purpose of "formally rejecting all current bids received [in] the pharmacy benefit manager (PBM) Request for Proposals (RFP) process." Such a pre-ordained action would be highly inappropriate. Instead, the Commission should award the contract to Magellan – the high scorer on this RFP in nearly all categories – or should obtain additional information within the context of the current RFP. Under no circumstance should the RFP be re-bid.

I. The Commission Should Award the Contract to Magellan.

The Commission should award the contract to Magellan for several reasons.

First, the award of the contract to Magellan is both warranted and more than defensible. The current record is very strong, given that Magellan scored first in 14 of 18 evaluation categories. The Gold Coast Health Plan ("GCHP") evaluators had substantial discretion in scoring the proposals to reach that result, and getting a court to overturn a selection on scores which so overwhelmingly favor Magellan would be all but impossible. Conversely, rejection of proposals and re-bidding gives an appearance of favoring the incumbent contractor/competitor by providing it with yet another opportunity to secure the contract after having been scored well below Magellan.

Second, the decision to re-bid was based on an alleged conflict of interest, but no conflict precluded Dale Villani from participating in the interviews. We understand that the value of his Magellan stock is well below $4,000, and that any financial interest is "remote" and/or "minimal." As such, he is not "interested in the contract" under

Government Code section 1091.5(a)(1). Accordingly, no conflict prevents award of the contract to Magellan.

Magellan appreciates that the Commission is being careful about its award of the PBM contract. However, the Commission could fairly and efficiently address any concern regarding a possible conflict by returning to the original scores, prior to the interviews, and awarding the contract based on those scores. The RFP did not require interviews and, in any event, a decision based on the original scores (prior to Mr. Villani's involvement), would negate any possibility of anyone validly raising a conflict concern.

Finally, it is highly unlikely that another round of bidding will result in a challenge-free award. More likely, any eventual award will be protested, and may be challenged in court. An award on the current record provides the soundest basis on which to defend the Commission's actions. In addition, if the Commission proceeds with award now, transition may be accomplished in the scheduled timeframe and without need to exercise the extensions of ScriptCare's contract, which were beyond the scope (duration) of services that ScriptCare bid. Such a transition also would expedite the substantial benefits that Magellan offers to the Ventura County public, and avoid the significant time and expense associated with yet another bid process.

II. The Commission Should Obtain Any Additional Information Within The Context of the Current RFP.

If the Commission has any concerns about a current award of the contract to Magellan, it should obtain additional information within the context of the current RFP. The Commission's comments in its press release suggest some concern regarding Magellan's ability to administer 340B contracts and to contract with local pharmacies currently contracted with ScriptCare. Both issues are addressed in the RFP. *See* RFP ¶A(1.4) (requiring proposers be "able to adjudicate 340B drug pricing for the Plan") and ¶A(2.1) and (2.15) (listing "provider network management" and 340B as "key elements to the success of the project"). GCHP experienced and expert staff tasked with evaluating these "key elements" have reviewed the proposals and concluded that Magellan is fully capable of performing in these areas, without need for further information. However, if the Commission continues to have concerns, the law and the RFP allow for Magellan to address any such concerns without requiring rejection of all proposals.

A. The Commission should reject speculation regarding Magellan's abilities.

The Commission's concern appears based on unfounded and misleading public comments about Magellan's abilities, including self-serving statements from ScriptCare. No one has produced any actual evidence – as opposed to careless speculation and

innuendo – suggesting that Magellan is unable to perform in these areas. Further, Magellan has addressed the issues in its prior letters.

For example, as Magellan has explained, all proposers submitted their current network lists, and Magellan not only holds contracts with nearly all of the pharmacies contracted with ScriptCare, but includes an additional 39 pharmacies in Ventura County that are not in ScriptCare's network. Magellan will extend contracts to pharmacies that are contracted by ScriptCare, but not in Magellan's network. No basis exists to disregard or invalidate the GCHP staff determination that Magellan's network is adequate.

B. The Commission may conduct a responsibility hearing.

Moreover, the 340B and network issues raise matters of responsibility, *i.e.,* Magellan's ability to perform. If the Commission has any such concern, then the law provides for a responsibility hearing at which the Commission notifies Magellan of any evidence against it and permits Magellan to respond. Such a hearing is a far more appropriate avenue than a rejection of all proposals.

First, it provides Magellan with due process, as opposed to relying on one-sided and unfounded complaints and unsupported allegations raised in public hearings. Second, it is the process established by law to allow the Commission to verify Magellan's capabilities. Third, it avoids starting the entire process over, causing the Commission and everyone involved unnecessary delay and additional expense. In short, a responsibility hearing – if necessary – will allow the process to move forward while reassuring the Commission that Magellan is fully capable of performing its commitments.

C. The Commission may conduct new interviews.

Alternatively, if the Commission wants to be "more active in the selection process," it can bring both finalists in for interviews prior to award based on the proposals on the current RFP. Of course, the Commission is required to select the contract recipient based on the criteria in the RFP, which have been carefully defined and applied by its GCHP experts. Further, the issues on which the Commission has expressed concern are raised in the RFP, so would be appropriate topics during any interview.

In sum, the Commission's expressed concerns can be addressed within the structure of the current RFP. The Commission should proceed based on the current proposals. There is no justification for a re-bid.

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III. Rejection of All Proposals Would Reflect Improper Favoritism.

The Commission's proposed rejection of all proposals is inappropriate, both because it is unfair to Magellan and, as discussed above, because less drastic and more appropriate alternatives exist. Rejecting all proposals without a valid reason, as is the case here, also unfairly favors the losing bidders like ScriptCare. Information regarding Magellan's pricing and proposal strengths has been publicly disclosed, giving unsuccessful proposers a "third bite" at the apple and an unfair advantage of knowing where to strengthen their proposal to attempt to improve their scores. Under the circumstances, a rejection at this stage gives at least the appearance of favoritism for the incumbent, ScriptCare.

In this regard, the Commission's premature statements regarding the action that **will be taken** and the reasons for that action – rather than stating that the issue will be considered at a public hearing – give further appearance of impropriety. The issuance of a press release stating the bases for the Commission's forthcoming action, prior to a public hearing, only increases that appearance. Magellan was surprised by the announcement, as it suggests that the decision already has been made (likely in closed session) without the opportunity for public discussion and input, and that the Commission only intends to rubber stamp a prior decision made without proper notice.

The proposed rejection (if carried out) gives the appearance that the Commission is simply attempting to achieve a pre-determined result of award to the incumbent. The competitive bidding process is designed to avoid even an appearance of such favoritism.

IV. Recusals Are Required On Any Decision to Reject All Proposals.

If the Commission disregards this request and votes to reject all proposals, Commissioners Alatorre and Pawar should recuse themselves. Both are employed by Clinicas, including Commissioner Alatorre as "Chief Business Development Officer." At the February 22 meeting, the Clinicas Chief Financial Officer expressed her concern that Clinicas' "very good rate" would disappear under an award to Magellan, strongly indicating that Clinicas has determined that award to ScriptCare is in its financial interest. Thus, Commissioners Alatorre's and Pawar's employer appears to believe that it is harmed by an award to any entity other than ScriptCare, raising a question as to their neutrality.

If the Commission is acting "in an abundance of caution" regarding the involvement of Mr. Villani, it also should act "in an abundance of caution" with respect to Commissioners Alatorre and Pawar. They should recuse themselves from any decision regarding the award of the PBM contract, particularly the decision whether to reject and

re-bid, thus giving a favored bidder another chance at success. The appearance of impropriety and favoritism would only be strengthened by their continued participation.

My client and I intend to be present to address these issues at the anticipated special meeting. Given the importance of these concerns, and the fact that my client's prior communications addressing some of these very concerns have not been acknowledged, we request that the Commission waive its standard 3-minute limitation on comments. We are confident that the appropriate action is award to Magellan, and Magellan is prepared to pursue such an award vigorously through all available fora.

Very truly yours,

DIEPENBROCK ELKIN GLEASON LLP

Jennifer L. Dauer

JLD/sa

cc: Mostafa M. Kamal, Chief Executive Officer
Earl F. Hurst, SVP, General Manager of Managed Care Market
Ronald Foll, Esquire

{00508829; 1}

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May 18, 2016

VIA E-MAIL AND U.S. MAIL

Ventura County Medi-Cal Managed Care Commission
c/o Mr. Scott Campbell
Best Best & Krieger
300 South Grand Ave., 25th Floor
Los Angeles, CA 90071

Re: Benefit Management Services RFP - GCHP110215

Dear Honorable Commissioners:

This firm represents Script Care Ltd. ("Script Care"), one of the proposers in the above-referenced RFP. We write today to address the accusations made by Magellan Rx Management LLC ("Magellan"), in its letter to the Commission dated May 4, 2016.

As you know, after discussing this RFP at the Commission's meeting on April 25, 2016, the Commission directed staff to prepare an agenda item for the upcoming meeting on May 23, 2016, that would formally reject all proposals and re-compete this contract. As detailed in Gold Coast Health Plan's ("GCHP") press release, this decision was based on concerns surrounding Mr. Villani's participation in the procurement, the Commission's desire to be more active in the selection process, and a need to obtain greater detail on each proposers' plan to work with local pharmacies.

Magellan responded to this action by accusing the Commission of creating an "appearance of impropriety." Nothing could be further from the truth. This decision was made, in part, to ***avoid*** an appearance of impropriety, not to create one.

We would like to make clear at the outset that Script Care has the highest degree of respect and admiration for GCHP's tremendous staff. California conflict of interest laws, however, are designed to not only discourage actual impropriety, but even the appearance of impropriety. *City of Imperial Beach v. Bailey* (1980) 103 Cal.App.3d 191, 197. Moreover, courts have traditionally construed such laws liberally to remove the appearance of inappropriate influence in the conduct of the public's business and, when faced with close calls, have ruled consistently on the side of a violation. *See, e.g., Thomson v. Call* (1985) 38 Cal.3d 633, 652 (requiring strict enforcement with conflict of interest statutes); *Milbrae Assn. for Residential Survival v. City of Milbrae* (1968) 262 Cal.App.2d 226, 237.

Given this history of liberal application and the draconian penalties that could result should a reviewing court find an actionable conflict of interest – *see, e.g.,* Government Code §§

1092 (voiding of contract), 1097 (imprisonment and disqualification from public office) – the Commission is acting well within its discretion. Indeed, the Commission's direction is consistent with the GCHP Code of Conduct which requires commissioners to avoid even the "appearance of impropriety," and with the Commission's bylaws which require the Commission to "avoid any real or potential conflict of interest." Art. VII, section (i).

Magellan attempts to discount these risks by arguing that Mr. Villani's Magellan stock holdings are "below $4,000" and thus not sufficient to create a conflict under Government Code section 1090. Yet regardless, this argument does not address the separate conflict rules under the Political Reform Act of 1974, which prohibit public officials from participating in government decisions that impact a business entity in which they own an investment worth $2,000 or more. *See* Government Code § 87103(a). Put simply, Magellan's arguments are specious and meant only to protect their own financial interests, not the public interest.

Magellan's contention that it has been deprived of legal due process is likewise frivolous. It is axiomatic that public agencies such as the Commission have broad discretion to reject bids. *See e.g.,* Public Contract Code §§ 20150.9, 20166. Courts have consistently refused to interfere with this discretion, "however arbitrary or capricious." *Universal By-Products, Inc. v. City of Modesto* (1974) 43 Cal.App.3d 145, 152. "To countenance a judicial review of the reasons behind a rejection of bids in order to ascertain whether the entity acted in 'good faith' would thwart the right to reject all bids and would subject public agencies to endless lawsuits by bidders contending that their bids had not been given proper consideration." *Id.* at 153.

In other words, Magellan, like any other proposer, has no legal right to a public contract. *See Kajima/Ray Wilson v. LACMTA* (1999) 23 Cal.4th 305, 315. Rather, as the California Supreme Court has explained, competitive bidding laws must be construed and administered with "sole reference to the public interest, and not the interest of private bidders." *Domar Electric, Inc. v. City of Los Angeles* (1994) 9 Cal.4th 161, 173.

Here, the Commission determined that the staff recommendation was not in the public interest. That determination was based on three grounds; namely, the risks associated with the potential conflict of interest, the Commission's desire to be more active in the selection process, and a need to obtain greater detail on each proposers' plan to work with local pharmacies. A reviewing court will not interfere with the Commission's discretionary determination. *See Michael Leslie Productions, Inc. v. City of Los Angeles* (2012) 207 Cal.App.4th 1011, 1026 (local government's determination of what is in the public's interest is a "classic discretionary function").

Magellan's argument also ignores one of the central roles of the Commission. The Commission is not a "rubber stamp" body; rather, as the awarding agency, the Commission must independently analyze the staff recommendation to determine if it promotes the public interest and GCHP's members. The Commission did just that at its February 22nd and April 25th meetings, and now has several options before it.

The Commission can reject all proposals and re-compete the contract as suggested at its April 25th meeting. Alternatively, as discussed at the February 22nd meeting, the Commission can undertake an independent analysis after listening to finalist presentations by Script Care and Magellan and obtaining additional information about their 340B programs and pharmacy networks. For the record, if the Commission wants to choose the latter approach in order to save the time and costs associated with a new procurement, Script Care is amenable to that approach.

In sum, contrary to Magellan's accusations, the Commission has not deprived Magellan of due process or created an appearance of impropriety. The Commission has acted in the public interest and insulated GCHP from needless risk. Script Care thus urges the Commission to ignore Magellan's baseless threats and looks forward to competing in a finalist presentation under the current RFP or a new procurement.

If you should have any questions concerning the foregoing, please do not hesitate to contact me.

Sincerely,

Andrew T. Kugler

cc: Frank T. Messina, General Counsel, Script Care, Ltd.

SCRIPT CARE, LTD.
6380 Folsom Drive
Beaumont, Texas 77706

Ventura County Medi-Cal Managed Care Commission
c/o Mr. Scott Campbell
Best, Best, & Krieger
300 South Grand Avenue
25th Floor
Los Angeles, CA 90071

May 18, 2016

RE: Gold Coast Health Plan ("GCHP") PBM RFP.

Dear Commission Members:

I am Vice-President of Managed Care for Script Care, Ltd ("Script Care"). I want to thank the Commission for its service and in taking an active role in the RFP process. I have had the privilege of previously speaking to you in public comments this year but want to reiterate that Script Care is vested in the Ventura County community as a whole and ultimately wants to ensure GCHP's membership, pharmacy providers, and health system partners are all provided with best in class services. Script Care's intent is not one of "self-serving statements" or "careless speculation" as described by Magellan Rx Management's ("Magellan") attorneys, but instead is simply one of awareness. This letter is aimed at expounding upon the awareness of our Ventura County collaborative synergistic partnerships and several significant areas (e.g., pharmacy network and 340B Drug Pricing Program) that should be considered in a potential change of PBMs.

(1) GCHP Managed Medi-Cal Pharmacy Network:

As you and/or your predecessors will recall, prior to the GCHP plan going-live, there was a loud and collective voice of the local Ventura County pharmacies heard over the course of several Commission meetings. The pharmacy speakers vehemently addressed rates, contracts, and access concerns. At that time, the pharmacies had only filled for the state fee-for-service Medi-Cal plan and refused to move to a Managed Medi-Cal plan with a commercial reimbursement contract. Therefore, Script Care dove into an intense negotiation process with the local pharmacies. Months were spent in grassroots efforts to address the pharmacies' concerns and to develop a Managed Medi-Cal specific limited network and specific network contract with an aggressive reimbursement structure. When Script Care refers to being the only provider in Ventura County which holds contracts with these pharmacies, it is specifically referring to Managed Medi-Cal specific contracts for which GCHP accesses. Script Care does not contest that Magellan may have some general network contracts (*e.g.,* commercial) with providers within the network; instead, Script Care has concerns that Magellan does not have Managed Medi-Cal specific contracts with many of the network pharmacies for GCHP based on multiple verifications from network pharmacies confirming this concern.

SCRIPT CARE, LTD.
6380 Folsom Drive
Beaumont, Texas 77706

It also warrants mentioning that a reference was made to suggest that Magellan would expand the GCHP network to include pharmacies which are not contracted by Script Care. This goes against the concept and limiting of the Ventura County Managed Medi-Cal current network; however, I do want to clarify that SCL holds contracts with all pharmacies currently open in Ventura County. Network expansion is available with SCL but this may come at the cost of valuable pharmacies dropping from the network due to losing volume to the expansion thus causing possible disruption. To date, pharmacy network access has never been an issue for GCHP; in fact, GCHP staff has promoted the success of their limited network via public webinars.

(2) 340B Drug Pricing Program:

The other impactful consideration is that of 340B: how it works, who benefits, what is compliant, and who is responsible. This is an area that deserves great scrutiny and in-depth explanations to the Commission. The RFP contained surface-level questions regarding 340B that failed to reveal some of the more pertinent compliance and operational 340B concerns. For instance, the RFP simply states that all bidders "be able to adjudicate 340B drug pricing for the Plan from contracted pharmacies associated with eligible FQHCs." *RFP - GCHP110215, Section A, Subsection 1.4.* This is a relatively simple request and virtually all PBMs are capable of adjudicating 340B drug prices when the pharmacy, an in-house pharmacy, submits the 340B drug cost in the pharmacy claim transmission. This is not the case in a 340B contract pharmacy[1] arrangement with multiple 340B Covered Entities in the same geographical region with patient and physician crossover.[2] Under this arrangement, the 340B contract pharmacy does not have knowledge of which claims are 340B, nor do they have access to the pricing structure which would be required for transmitting the 340B drug cost to the PBM. Script Care operating in the dual role of GCHP's PBM and 340B administrator circumvents these 340B operational and compliance concerns.[3] Additionally, contrary to GCHP's staff's statement at the February 22, 2016 Commission meeting, a real-time 340B verification process will not be possible if there was a change in PBMs under the current arrangement.

At the April 25, 2016 Commission meeting, GCHP staff presented the option to the Commission that a working retrospective model could be implemented to continue to allow GCHP to reap the benefits of the Covered Entity's 340B programs. This suggestion is counter-intuitive to the 340B program intention and regulatory directives as a whole. The two main directives from which 340B Covered Entities must protect themselves under the 340B program are diversion and duplicate discounting. In this instance, the duplicate discounting is most relevant. Section 340B(a)(5)(A) of the Public Health Service Act prohibits duplicate discounts; that is, manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. The 340B Covered

[1] 340B Covered Entities participating in the 340B Program may contract with pharmacies to dispense drugs purchased through the program on their behalf. Such pharmacies are referred to as 340B contract pharmacies.
[2] Ventura County is unique in that it holds one of the more complex 340B scenarios, which includes three different 340B Covered Entities with multiple cross-over physicians and Carve-in Medi-Cal.
[3] In fact, the GCHP Pharmacy Director at the Commission's April meeting acknowledged the benefits of the PBM and 340B administrator being one in the same by describing the process as "nice, clean, and neat."

Entity is responsible for preventing duplicate discounts and is required to have a mechanism in place to prevent this type of discount. Furthermore, effective 2017 COHS plans will become a responsible party for 340B claim identification to the State. In a retrospective model, there are significant complications and compliance issues with attempts at retrospective coding and these models have had significant complications in the California Managed Medi-Cal market. Ultimately, this has placed many MCO plans and 340B Covered Entities in jeopardy. Script Care acting in the dual role of PBM and 340B administrator places the stakeholders in the optimal position to ensure 340B compliance.

At the February 22, 2016 Commission meeting, GCHP staff intimated that if GCHP were to change to a different PBM, it would not change who the 340B Covered Entities chose as their administrator; however, a letter from Magellan dated March 21, states otherwise: "…the 340B system partners (covered entities) . . . will simply transfer their arrangements to Magellan or more effectively, to GCHP for Magellan to administer…." Perhaps this is a miscommunication but it does imply the 340B Covered Entity would be required to make significant changes to their agreements in place at this time.

In an effort to provide pertinent information but also to be brief, I've addressed some areas of concern to the Commission. Script Care respectfully accepts the Commission's direction on how best to acquire this information, whether it is through additional presentations from the top bidders, through a clarification request via the RFP instrument, or through a third RFP. Script Care is ready and willing to do what is best for GCHP, its membership, and its partners.

Once again, I thank the Commission for its consideration, devotion, and time in reviewing the information presented.

Sincerely,

Amy Cansler

Amy Cansler
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Ventura County Medi-Cal Managed Care Commission
c/o Mr. Scott Campbell
Best, Best, & Krieger
300 South Grand Avenue
25th Floor
Los Angeles, CA 90071

May 18, 2016

RE: Gold Coast Health Plan ("GCHP") PBM RFP.

Dear Commissioners:

I am the President of Script Care, Ltd. ("Script Care") and SCL 340B Care, LLC ("SCL 340B Care"). I am writing to express Script Care's current and continued dedication to GCHP and its members.

Script Care has served GCHP since before the name GCHP was bestowed on the Plan. We are proud to have helped bring the Managed Medi-Cal vision of Ventura County to fruition and a partner in ensuring its continued growth and success. Throughout the past 6 years, many things have changed (*e.g.,* multiple executive employee changes, State reviews, etc.), but one thing that has remained the same is Script Care's devoted, diligent, and innovative services to GCHP. As a couple speakers stated at the February Commission meeting, the one thing that has always worked from the start of the GCHP program is the Script Care pharmacy benefit plan. Our GCHP dedicated account team is still the same team that started with the plan in 2010 only now it has grown to a team of 21 dedicated members and numerous support staff (predominately located in Ventura County). Our goal is stability for the Plan and more importantly GCHP's members.

Script Care has helped strategically build and cultivate a unified pharmacy healthcare system in Ventura County that brings together multiple health agencies and health plans. These community programs not only provide significant savings to GCHP, but also provide savings and access to the many Ventura County non-insured and homeless patients, to commercial health plan patients based in the County, and to the governmental health plans in the County. Ventura County has become a model for other counties in the state who provide similar health services and want to build a strategic and synergy based pharmacy healthcare system. Script Care is currently working with two other California counties in developing similar county-centric programs. In fact, Script Care and SCL 340B Care were invited to present the county-centric program model to the "*California Primary Care Association - Chief Financial Officers Conference*" during the week of May 16, 2016.

Script Care stands ready and willing to implement the Commission's instructions and will support the Commission's decision either way (*e.g.,* third RFP or finalist presentation under the second

RFP). Script Care's competitor has chosen another approach wherein they have threatened the Commission with legal action if the Commission does not follow its demand.[1] Script Care has a great deal of respect and admiration for the GCHP staff and Commission. At the Commission's February meeting, Script Care was simply there to ensure all relevant information was taken into account during the RFP process. This included vetting GCHP's staff's scoring methodology and any potential conflicts of interest in the RFP process. While Script Care favors the finalist presentation approach, as opposed to a third RFP, Script Care will support the Commission's decision regardless. The finalist presentation approach will enable the Commission to be fully involved in the decision-making process, expedite the RFP award, and save GCHP time and money. In that vein, Script Care is willing to offer a waiver of any protest and/or legal action in regards to the second RFP subject to Magellan Rx Management ("Magellan") making the same waiver and removing its baseless legal threats to the Commission. This would allow the Commission to make its decision free from the threat of any purported legal action from either one of the parties. As a true partner to GCHP, Script Care is not interested in further legal impediments to the Commission's decision; instead, we want to assist the Commission in facilitating an expedited determination that will allow GCHP to get back to its primary focus—high quality health care services to its members.

Script Care remains fully engaged in the well being and future of GCHP, the County healthcare partners, County pharmacies, and the GCHP members.

Sincerely,

*Kevin Brown*__________________

Kevin J. Brown
President
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[1] *Letter from Diepenbrock, Elkin, Gleason, LLP to Ventura County Medi-Cal Managed Care Commission, Dated May 4, 2016* (stating the following in the letter "it is highly unlikely that another round of bidding will result in a challenge-free award. More likely, any eventual award will be protested, and may be challenged in court . . . . We are confident that the appropriate action is award to Magellan, and Magellan is prepared to pursue such an award vigorously through all available fora.")

AGENDA ITEM NO. 4

TO: Gold Coast Health Plan Commission

FROM: Patricia Mowlavi, CFO

DATE: May 23, 2016

SUBJECT: March 2016 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached fiscal year to date (FYTD) March 2016 financial statements (unaudited) of Gold Coast Health Plan (Plan) for review by the Executive/Finance Committee. The Plan requests that the Executive/Finance Committee recommend approval of these financials to the Commission.

BACKGROUND / DISCUSSION:

The staff has prepared the FYTD March 2016 financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Financial Highlights

Overall Performance – For the nine months ended March 31, 2016, the Plan's gain in unrestricted net assets was approximately $33.2 million on aggregate revenues of $497.8 million. This represents a $21.2 million favorable variance to budget which was largely due to the continued growth in membership in the Adult Expansion (AE) category of aid. Also contributing to the variance was lower than anticipated health care and administrative costs.

Tangible Net Equity – The Plan's operating performance has increased the Tangible Net Equity (TNE) amount to approximately $133.1 million, which is $42.8 million better than budget. The sharp rise in TNE is mostly attributable to an increase in capitated arrangements which are excluded from the required TNE calculation. The $7.2 million County of Ventura lines of credit that was previously included in the TNE calculation was repay with associated accrued interest in full in March 2016.

Membership – March membership of 205,206 exceeded budget by 5,717 members. The increase in membership was primarily in the Adult Expansion (AE) and Adult / Family categories, which has accounted for more than 92% of the total enrollment growth for FYTD.

Revenue – FYTD, net revenue was $497.8 million or $21.2 million favorable to budget. The positive variance was primarily due to increase in membership with higher capitation rates (Adult Expansion).

For the year, revenue includes a $17.3 million reserve for rate reductions associated with AE. This reserve represents an expected refund, to Department of Health Care Services (DHCS), for rate overpayments (DHCS was paying at July 1, 2014 rates rather than the July 1, 2015 published rates) and the anticipated refund of revenue to achieve a medical loss ratio (MLR) of 85%, for this aid category. (The MLR is calculated by dividing health care costs by revenue.). The combined total due back to the DHCS, for both rate overpayment and 85% MLR portion, is $223.9 million. Beginning in January, the DHCS has started to recoup the AE rate overpayment through monthly reductions of its payment to the Plan. For the three months ended March 31, 2016, a total of $51.8 million has been was deducted, including $17.3 million in March.

Health Care Costs – FYTD health care costs were $436.9 million or $1.8 million above budget. For the year, the MLR was 87.8% versus budget of 91.3%.

Some health care cost items of note include:

- Capitation – FYTD, capitation was $74.9 million or $21.6 million unfavorable to budget. The unfavorable variance was driven by the Enhanced Adult Expansion Capitation program, which was revised effective July 2015, as well as higher than budgeted capitated membership growth.
- Fee for Service – FYTD, total claims expense was $350.1 million compared to a budget of $363.4 million. While there was some movement of services between categories, the overall variance was driven by lower than expected Inpatient and Specialty Physician costs.
- Pharmacy – FYTD, overall Pharmacy expense was $72.3 million or $3.1 million unfavorable to budget. This variance was offset by specialty drug reimbursement which appears in revenue.

Administrative Expenses – FYTD, administrative costs were $27.8 million or $3.4 million lower than budget. Savings were realized due to delays in new hires and related costs associated with personnel. These savings were somewhat offset by higher expenses in outside services, which are primarily driven by membership.

The administrative cost ratio (ACR) for FYTD was 5.6% versus 6.5% for budget. (The ACR is calculated by dividing administrative expenses by total revenue.)

Cash and Medi-Cal Receivable – At March 31, 2016, the Plan had $416.6 million in cash and short term investments and $64.3 million in Medi-Cal Receivable for an aggregate amount of $480.9 million. The cash amount also included pass-through payments for AB 85 of $1.9 million and Managed Care Organizations (MCO) tax of $4.7 million. Excluding the impact of these amounts, the combined cash and short term investment amount would be $410.1 million. Note that a significant portion of the cash will be used for repayments

of amounts owed to the State of California ($229.3 million) with and approximately half the amount owed expected to be paid within the next 12 months.

Investment Portfolio – As of March 31, 2016, the value of the investments were as follows:

- Short-term Investments $233.5 million: Cal Trust $80.3 million; Ventura County Investment Pool $85.1 million; LAIF CA State $63.1 million; Bonds $5.0 million.
- Long-term Investments (Bonds) $19.4 million.

RECOMMENDATION:

Staff requests that the Executive / Finance Committee recommend approval of the March 2016 financial package to the Commission.

ATTACHMENT:

March 2016 Financial Package

Gold Coast Health Plan[SM]
A Public Entity

FINANCIAL PACKAGE
For the month ended March 31, 2016

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- Financial Overview
- Financial Performance Dashboard

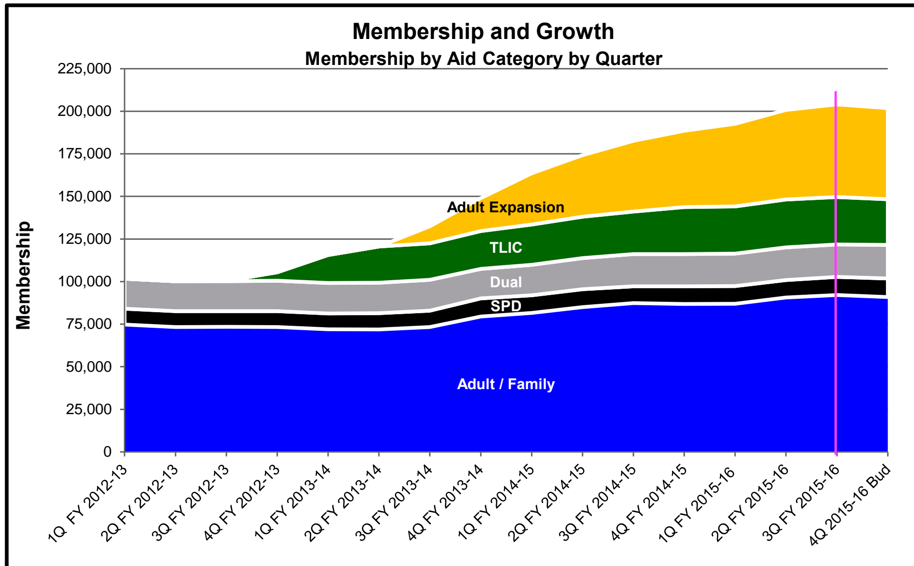
APPENDIX

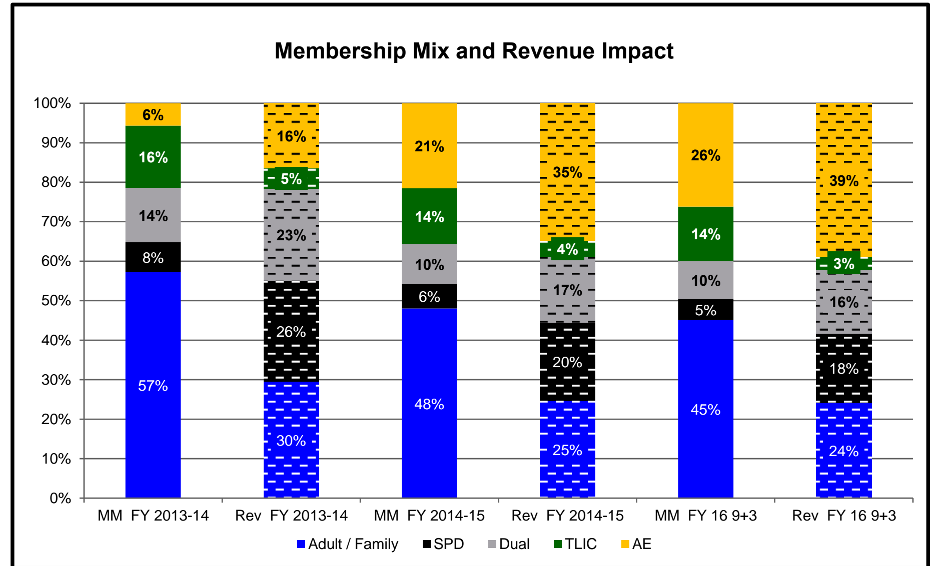
- Statement of Financial Positions
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Financial Positions
- YTD Cash Flow
- Monthly Cash Flow
- Cash Trend Combined
- Membership
- Total Expense Composition
- Paid Claims and IBNP Composition
- Pharmacy Cost & Utilization Trends

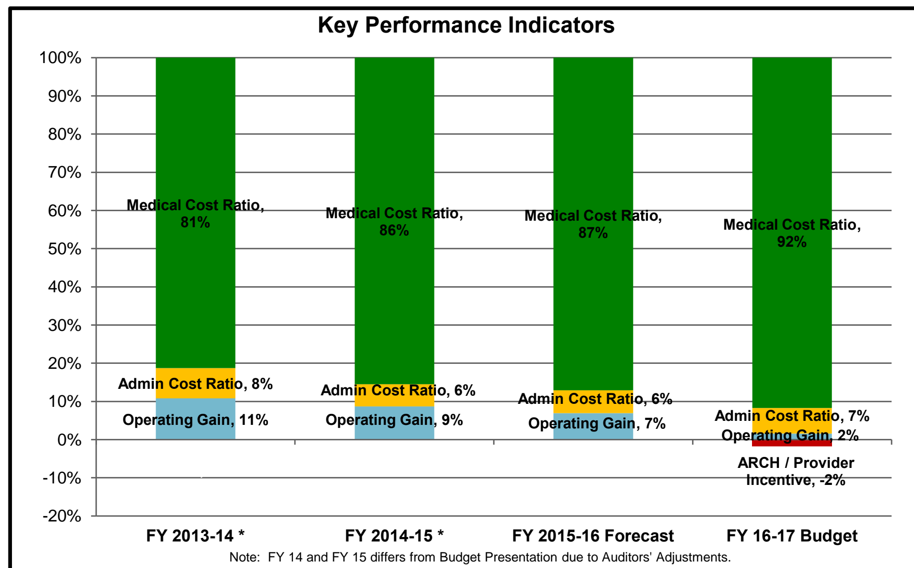
Description	AUDITED FY 2011-12	AUDITED FY 2012-13	AUDITED FY 2013-14	AUDITED FY 2014-15	FY 2015-16 JUL - SEP 15	OCT - DEC 15	JAN - MAR 16	MAR 16 FYTD	Budget Comparison Budget FYTD	Variance Fav / (Unfav)	Variance Fav / (Unfav)%
Member Months	**1,258,189**	**1,223,895**	**1,553,660**	**2,130,979**	**578,056**	**602,390**	**612,132**	**1,792,578**	**1,754,549**	38,029	2.2 %
Revenue	**304,635,932**	**315,119,611**	**402,701,476**	**595,607,370**	**162,960,677**	**159,744,239**	**175,131,344**	**497,836,260**	**476,616,269**	21,219,991	4.5 %
pmpm	*242.12*	*257.47*	*259.20*	*279.50*	*281.91*	*265.18*	*286.10*	*277.72*	*271.65*	6.07	2.2 %
Health Care Costs	**287,353,672**	**280,382,704**	**327,305,832**	**509,183,268**	**137,845,237**	**142,711,885**	**156,369,522**	**436,926,643**	**435,098,436**	(1,828,207)	(0.4)%
pmpm	*228.39*	*229.09*	*210.67*	*238.94*	*238.46*	*236.91*	*255.45*	*243.74*	*247.98*	4.24	1.7 %
% of Revenue	94.3%	89.0%	81.3%	85.5%	84.6%	89.3%	89.3%	87.8%	91.3%	3.5 %	3.9 %
Admin Exp	**18,891,320**	**24,013,927**	**31,751,533**	**34,814,049**	**8,827,059**	**9,035,546**	**9,891,069**	**27,753,673**	**31,170,367**	3,416,694	11.0 %
pmpm	*15.01*	*19.62*	*20.44*	*16.34*	*15.27*	*15.00*	*16.16*	*15.48*	*17.77*	2.28	12.9 %
% of Revenue	6.2%	7.6%	7.9%	5.8%	5.4%	5.7%	5.6%	5.6%	6.5%	1.0 %	14.8 %
Total Increase / (Decrease) in Unrestricted Net Assets	**(1,609,063)**	**10,722,980**	**43,644,110**	**51,610,053**	**16,288,381**	**7,996,808**	**8,870,753**	**33,155,943**	**10,347,466**	22,808,477	220.4 %
pmpm	*(1.28)*	*8.76*	*28.09*	*24.22*	*28.18*	*13.28*	*14.49*	*18.50*	*5.90*	12.60	213.6 %
% of Revenue	-0.5%	3.4%	10.8%	8.7%	10.0%	5.0%	5.1%	6.7%	2.2%	4.5%	206.8 %
YTD											
100% TNE	16,769,368	16,138,440	17,867,986	22,556,530	21,819,072	22,591,994	24,405,592	24,405,592	26,407,185	(2,001,592)	(7.6)%
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%		
Minimum Required TNE	6,036,972	10,974,139	17,867,986	22,556,530	21,819,072	22,591,994	24,405,592	24,405,592	26,407,185	(2,001,592)	(7.6)%
GCHP TNE	**(6,031,881)**	**11,891,099**	**55,535,211**	**107,145,264**	**123,433,646**	**131,430,454**	**133,101,207**	**133,101,207**	**90,327,243**	**42,773,964**	**47.4 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**37,667,225**	**84,588,734**	**101,614,573**	**108,838,460**	**108,695,615**	**108,695,615**	**63,920,058**	**44,775,556**	**70.0 %**
% of Required TNE level			**311%**	**475%**	**566%**	**582%**	**545%**	**545%**	**342%**		
% of Required TNE level (excluding $7.2 million LOC)			**271%**	**443%**	**533%**	**550%**	**545%**	**545%**	**315%**		

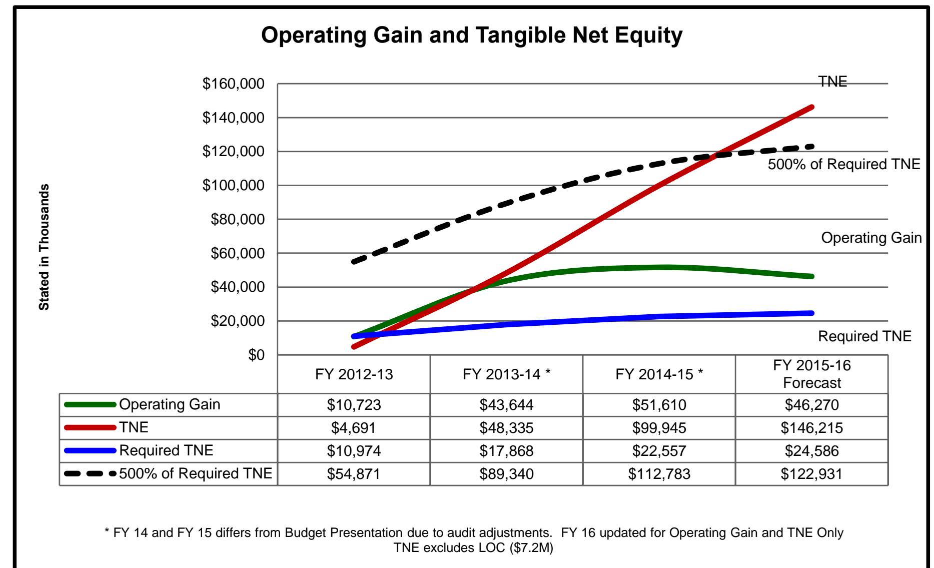
Note: TNE amount includes $7.2 million related to the Lines of Credit (LOC) from Ventura County.

FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING MARCH 31, 2016









	FY 2012-13	FY 2013-14 *	FY 2014-15 *	FY 2015-16 Forecast
Operating Gain	$10,723	$43,644	$51,610	$46,270
TNE	$4,691	$48,335	$99,945	$146,215
Required TNE	$10,974	$17,868	$22,557	$24,586
500% of Required TNE	$54,871	$89,340	$112,783	$122,931

* FY 14 and FY 15 differs from Budget Presentation due to audit adjustments. FY 16 updated for Operating Gain and TNE Only
TNE excludes LOC ($7.2M)

Note: 9+3 indicates 9 months of actual results followed by 3 months of forecasts

For the month ended March 31, 2016

APPENDIX

- Statement of Financial Positions
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Financial Positions
- YTD Cash Flow
- Monthly Cash Flow
- Cash Trend Combined
- Membership
- Total Expense Composition
- Paid Claims and IBNP Composition
- Pharmacy Cost & Utilization Trends

STATEMENT OF FINANCIAL POSITION

	03/31/16	02/29/16	01/31/16	Audited FY 2014 - 15
ASSETS				
Current Assets:				
Total Cash and Cash Equivalents	**$ 183,075,433**	**$ 204,233,778**	**$ 206,754,441**	**$ 57,218,141**
Total Short-Term Investments	**233,529,909**	**225,463,017**	**220,436,007**	**165,090,357**
Medi-Cal Receivable	64,292,235	64,081,474	63,104,725	129,782,958
Interest Receivable	461,810	382,485	425,810	208,010
Provider Receivable	305,404	428,925	440,971	579,482
Other Receivables	171,958	171,958	175,122	979,647
Total Accounts Receivable	**65,231,408**	**65,064,842**	**64,146,628**	**131,550,096**
Total Prepaid Accounts	1,152,318	1,301,437	1,193,317	766,831
Total Other Current Assets	133,545	133,545	133,545	81,702
Total Current Assets	**483,122,613**	**496,196,618**	**492,663,938**	**354,707,127**
Total Fixed Assets	**1,329,168**	**1,241,489**	**1,190,313**	**1,084,113**
Total Long-Term Investments	**19,418,836**	**19,439,894**	**19,460,935**	**24,647,362**
Total Assets	**$ 503,870,618**	**$ 516,878,001**	**$ 513,315,185**	**$ 380,438,602**
LIABILITIES & NET ASSETS				
Current Liabilities:				
Incurred But Not Reported	$ 61,218,949	$ 57,889,688	$ 60,457,328	$ 52,372,146
Claims Payable	10,265,571	15,089,156	10,270,198	13,747,426
Capitation Payable	40,034,217	36,329,863	31,907,261	34,466,106
Physician ACA 1202 Payable	9,600,012	9,600,012	9,600,012	10,965,642
AB 85 Payable	1,858,433	1,850,953	1,818,410	3,818,147
Accounts Payable	511,934	543,183	590,696	3,449,087
Accrued ACS	1,636,075	1,631,285	3,245,276	1,480,556
Accrued Expenses	107,437,725	111,793,052	121,461,780	6,249,194
Accrued Premium Tax	4,656,097	3,891,138	3,854,191	3,641,573
Accrued Interest Payable	0	99,494	95,906	70,711
Current Portion of Deferred Revenue	115,000	153,333	191,667	460,000
Accrued Payroll Expense	1,005,125	763,573	720,057	1,152,720
Total Current Liabilities	**238,339,138**	**239,634,731**	**244,212,780**	**131,873,310**
Long-Term Liabilities:				
DHCS - Reserve for Capitation Recoup	131,694,946	135,494,946	133,384,946	140,970,602
Other Long-term Liability-Deferred Rent	735,327	709,422	683,517	449,427
Notes Payable	0	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	**132,430,273**	**143,404,368**	**141,268,463**	**148,620,029**
Total Liabilities	**370,769,411**	**383,039,099**	**385,481,243**	**280,493,338**
Net Assets:				
Beginning Net Assets	99,945,264	99,945,264	99,945,264	48,335,211
Total Increase / (Decrease in Unrestricted Net A	33,155,943	33,893,639	27,888,678	51,610,053
Total Net Assets	**133,101,207**	**133,838,903**	**127,833,942**	**99,945,264**
Total Liabilities & Net Assets	**$ 503,870,618**	**$ 516,878,001**	**$ 513,315,185**	**$ 380,438,602**

FINANCIAL INDICATORS				
Current Ratio	2.03 : 1	2.07 : 1	2.02 : 1	2.69 : 1
Days Cash on Hand	196	257	244	67
Days Cash + State Capitation Rec	226	295	279	107
Days Cash + State Capitation Rec (less Tax Li	224	293	277	106

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR NINE MONTHS ENDING MARCH 31, 2015

	March 2016 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	1,792,578	1,754,549	38,029
Revenue			
Premium	$ 535,603,820	$ 524,794,077	$ 10,809,743
Reserve for Rate Reduction	(17,325,000)	(29,000,954)	11,675,954
MCO Premium Tax	(21,089,402)	(19,521,854)	(1,567,548)
Total Net Premium	**497,189,418**	**476,271,269**	**20,918,149**
Other Revenue:			
Miscellaneous Income	646,841	345,000	301,841
Total Other Revenue	646,841	**345,000**	301,841
Total Revenue	**497,836,260**	**476,616,269**	**21,219,991**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	74,899,733	53,335,684	(21,564,049)
FFS Claims Expenses:			
Inpatient	80,615,870	89,569,827	8,953,957
LTC / SNF	79,435,976	81,879,461	2,443,485
Outpatient	33,626,475	28,885,653	(4,740,822)
Laboratory and Radiology	2,873,133	2,035,992	(837,141)
Emergency Room	14,019,772	11,762,715	(2,257,057)
Physician Specialty	33,294,546	37,931,586	4,637,040
Primary Care Physician	10,924,540	11,943,092	1,018,552
Home & Community Based Services	10,928,213	11,209,672	281,459
Applied Behavior Analysis Services	649,198	1,146,813	497,615
Mental Health Services	3,339,253	4,039,723	700,470
Pharmacy	72,280,147	69,210,292	(3,069,855)
Provider Reserve	0	5,189,904	5,189,904
Other Medical Professional	1,661,325	1,879,760	218,435
Other Medical Care	1,032	0	(1,032)
Other Fee For Service	5,310,951	5,439,467	128,516
Transportation	1,101,365	1,298,322	196,957
Total Claims	350,057,982	363,422,279	13,364,297
Medical & Care Management Expense	11,838,441	15,828,574	3,990,133
Reinsurance	1,766,454	2,511,899	745,445
Claims Recoveries	(1,635,968)	0	1,635,968
Sub-total	11,968,928	18,340,473	6,371,546
Total Cost of Health Care	**436,926,643**	**435,098,436**	**(1,828,207)**
Contribution Margin	**60,909,616**	**41,517,833**	**19,391,784**
General & Administrative Expenses:			
Salaries and Wages	6,783,918	7,824,082	1,040,164
Payroll Taxes and Benefits	1,819,473	2,354,298	534,825
Travel and Training	185,460	468,786	283,326
Outside Service - ACS	14,337,607	13,566,642	(770,965)
Outside Services - Other	1,337,685	1,625,199	287,514
Accounting & Actuarial Services	193,613	222,000	28,388
Legal	741,077	787,500	46,423
Insurance	293,464	244,512	(48,952)
Lease Expense - Office	683,173	782,460	99,287
Consulting Services	645,812	1,197,189	551,377
Advertising and Promotion	57,572	63,273	5,701
General Office	1,286,787	2,126,692	839,905
Depreciation & Amortization	187,135	324,303	137,168
Printing	53,137	148,930	95,793
Shipping & Postage	72,490	123,111	50,621
Interest	310,444	194,309	(116,135)
Total G & A Expenses	**28,988,847**	**32,053,286**	**3,064,439**
Total Operating Gain / (Loss)	**$ 31,920,769**	**$ 9,464,547**	**$ 22,456,222**
Non Operating			
Revenues - Interest	1,269,049	900,000	369,049
Expenses - Interest	33,876	17,081	(16,795)
Total Non-Operating	1,235,174	882,919	352,255
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 33,155,943**	**$ 10,347,466**	**$ 22,808,477**
Net Assets, Beginning of Year	99,945,264		
Net Assets, End of Year	133,101,207		

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2015-16 Monthly Trend			Current Month		
	DEC 15	JAN 16	FEB 16	MARCH 2016		Variance
				Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	203,857	202,945	203,981	205,206	199,489	5,717
Revenue:						
Premium	$ 60,609,835	$ 60,525,329	$ 60,531,080	$ 61,560,475	$ 57,904,040	$ 3,656,435
Reserve for Rate Reduction	(4,300,000)	(2,100,000)	(2,110,000)	3,800,000	(1,612,648)	5,412,648
MCO Premium Tax	(2,386,513)	(2,383,185)	(2,383,411)	(2,423,944)	(2,216,474)	(207,470)
Total Net Premium	**53,923,322**	**56,042,144**	**56,037,668**	**62,936,531**	**54,074,918**	**8,861,613**
Other Revenue:						
Miscellaneous Income	38,333	38,333	38,333	38,333	38,334	1
Total Other Revenue	38,333	38,333	38,333	38,333	38,334	1
Total Revenue	**53,961,656**	**56,080,478**	**56,076,002**	**62,974,864**	**54,113,252**	**8,861,613**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	8,416,645	8,597,538	9,085,138	8,798,713	5,600,283	(3,198,430)
FFS Claims Expenses:						
Inpatient	6,939,460	9,397,915	7,392,640	12,503,077	10,381,180	(2,121,897)
LTC / SNF	9,457,002	9,940,604	7,895,479	10,257,828	9,248,405	(1,009,423)
Outpatient	4,874,113	3,126,572	3,379,287	4,852,606	3,326,331	(1,526,275)
Laboratory and Radiology	253,526	544,597	278,498	197,693	235,636	37,943
Emergency Room	1,384,893	1,534,104	1,672,260	2,487,940	1,350,736	(1,137,204)
Physician Specialty	3,527,663	3,148,079	4,054,445	5,109,877	4,384,301	(725,576)
Primary Care Physician	1,051,572	1,165,162	1,110,036	2,054,272	1,365,028	(689,244)
Home & Community Based Services	1,351,551	1,468,164	1,158,925	1,323,347	1,266,333	(57,014)
Applied Behavior Analysis Services	56,046	82,896	58,589	200,187	163,460	(36,727)
Mental Health Services	296,508	318,802	298,271	434,177	463,412	29,235
Pharmacy	8,641,594	8,140,173	8,431,109	9,377,773	7,970,888	(1,406,885)
Provider Reserve	0	0	0	0	593,488	593,488
Other Medical Professional	116,294	259,041	165,970	292,238	216,739	(75,499)
Other Medical Care	0	0	293	0	0	0
Other Fee For Service	786,864	549,506	599,049	655,014	620,805	(34,209)
Transportation	106,588	97,684	114,225	152,782	149,591	(3,191)
Total Claims	38,843,673	39,773,299	36,609,076	49,898,811	41,736,333	(8,162,478)
Medical & Care Management Expense	1,410,289	1,325,198	1,185,612	1,344,784	1,826,570	481,786
Reinsurance	287,084	133,103	291,461	291,220	292,562	1,342
Claims Recoveries	316,981	(611,548)	(274,027)	(78,857)	0	78,857
Sub-total	2,014,354	846,753	1,203,046	1,557,148	2,119,132	561,985
Total Cost of Health Care	**49,274,672**	**49,217,590**	**46,897,260**	**60,254,672**	**49,455,748**	**(10,798,924)**
Contribution Margin	**4,686,984**	**6,862,888**	**9,178,742**	**2,720,192**	**4,657,504**	**(1,937,312)**
General & Administrative Expenses:						
Salaries and Wages	787,225	794,596	740,575	866,810	898,453	31,643
Payroll Taxes and Benefits	174,678	239,223	217,016	221,933	279,882	57,949
Travel and Training	12,853	19,361	40,568	35,035	46,079	11,044
Outside Service - ACS	1,628,393	1,614,744	1,613,004	1,637,111	1,541,448	(95,663)
Outside Services - Other	125,073	140,276	183,036	173,053	200,963	27,910
Accounting & Actuarial Services	78,148	1,680	6,895	18,300	0	(18,300)
Legal	98,593	155,481	130,846	183,477	87,500	(95,977)
Insurance	25,161	32,588	32,588	32,588	27,168	(5,420)
Lease Expense - Office	66,034	66,034	110,467	110,467	86,940	(23,527)
Consulting Services	81,081	152,043	82,510	38,009	175,643	137,634
Advertising and Promotion	0	2,721	3,803	2,849	20,640	17,791
General Office	183,685	105,893	131,842	160,291	243,603	83,312
Depreciation & Amortization	20,768	21,247	21,153	21,153	45,074	23,921
Printing	700	9,836	376	19,515	23,445	3,930
Shipping & Postage	81	29,771	108	3,610	17,244	13,634
Interest	49,638	25,541	9,282	98,188	22,045	(76,143)
Total G & A Expenses	**3,332,111**	**3,411,034**	**3,324,069**	**3,622,389**	**3,716,127**	**93,738**
Total Operating Gain / (Loss)	**1,354,873**	**3,451,854**	**5,854,672**	**(902,197)**	**941,377**	**(1,843,574)**
Non Operating:						
Revenues - Interest	154,302	152,995	153,877	169,594	100,000	69,594
Expenses - Interest	4,436	1,361	3,588	5,092	37	(5,055)
Total Non-Operating	**149,867**	**151,634**	**150,288**	**164,501**	**99,963**	**64,538**
Total Increase / (Decrease) in Unrestricted Net Assets	**1,504,740**	**3,603,488**	**6,004,961**	**(737,696)**	**1,041,340**	**(1,779,036)**
Full Time Employees				**181**	**204**	**23**

PMPM - STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	DEC 15	JAN 16	FEB 16	MARCH 2016 Actual	MARCH 2016 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	203,857	202,945	203,981	205,206	199,489	5,717
Revenue:						
Premium	297.32	298.24	296.75	299.99	290.26	9.73
Reserve for Rate Reduction	(21.09)	(10.35)	(10.34)	18.52	(8.08)	26.60
MCO Premium Tax	(11.71)	(11.74)	(11.68)	(11.81)	(11.11)	(0.70)
Total Net Premium	**264.52**	**276.14**	**274.72**	**306.70**	**271.07**	**35.63**
Other Revenue:						
Interest Income	0.00	0.00	0.00	0.00	0.00	0.00
Miscellaneous Income	0.19	0.19	0.19	0.19	0.19	(0.01)
Total Other Revenue	0.19	0.19	0.19	0.19	0.19	(0.01)
Total Revenue	**264.70**	**276.33**	**274.91**	**306.89**	**271.26**	**35.63**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	41.29	42.36	44.54	42.88	28.07	(14.80)
FFS Claims Expenses:						
Inpatient	34.04	46.31	36.24	60.93	52.04	(8.89)
LTC / SNF	46.39	48.98	38.71	49.99	46.36	(3.63)
Outpatient	23.91	15.41	16.57	23.65	16.67	(6.97)
Laboratory and Radiology	1.24	2.68	1.37	0.96	1.18	0.22
Emergency Room	6.79	7.56	8.20	12.12	6.77	(5.35)
Physician Specialty	17.30	15.51	19.88	24.90	21.98	(2.92)
Primary Care Physician	5.16	5.74	5.44	10.01	6.84	(3.17)
Home & Community Based Services	6.63	7.23	5.68	6.45	6.35	(0.10)
Applied Behavior Analysis Services	0.27	0.41	0.29	0.98	0.82	(0.16)
Mental Health Services	1.45	1.57	1.46	2.12	2.32	0.21
Pharmacy	42.39	40.11	41.33	45.70	39.96	(5.74)
Provider Reserve	0.00	0.00	0.00	0.00	2.98	2.98
Other Medical Professional	0.57	1.28	0.81	1.42	1.09	(0.34)
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	3.86	2.71	2.94	3.19	3.11	(0.08)
Transportation	0.52	0.48	0.56	0.74	0.75	0.01
Total Claims	190.54	195.98	179.47	243.16	209.22	(33.95)
Medical & Care Management Expense	6.92	6.53	5.81	6.55	9.16	2.60
Reinsurance	1.41	0.66	1.43	1.42	1.47	0.05
Claims Recoveries	1.55	(3.01)	(1.34)	(0.38)	0.00	0.38
Sub-total	9.88	4.17	5.90	7.59	10.62	3.03
Total Cost of Health Care	241.71	242.52	229.91	293.63	**247.91**	**(45.72)**
Contribution Margin	**22.99**	**33.82**	**45.00**	**13.26**	**23.35**	**(10.09)**
General & Administrative Expenses:						
Salaries and Wages	3.86	3.92	3.63	4.22	4.50	0.28
Payroll Taxes and Benefits	0.86	1.18	1.06	1.08	1.40	0.32
Travel and Training	0.06	0.10	0.20	0.17	0.23	0.06
Outside Service - ACS	7.99	7.96	7.91	7.98	7.73	(0.25)
Outside Services - Other	0.61	0.69	0.90	0.84	1.01	0.16
Accounting & Actuarial Services	0.38	0.01	0.03	0.09	0.00	(0.09)
Legal	0.48	0.77	0.64	0.89	0.44	(0.46)
Insurance	0.12	0.16	0.16	0.16	0.14	(0.02)
Lease Expense - Office	0.32	0.33	0.54	0.54	0.44	(0.10)
Consulting Services	0.40	0.75	0.40	0.19	0.88	0.70
Advertising and Promotion	0.00	0.01	0.02	0.01	0.10	0.09
General Office	0.90	0.52	0.65	0.78	1.22	0.44
Depreciation & Amortization	0.10	0.10	0.10	0.10	0.23	0.12
Printing	0.00	0.05	0.00	0.10	0.12	0.02
Shipping & Postage	0.00	0.15	0.00	0.02	0.09	0.07
Interest	0.24	0.13	0.05	0.48	0.11	(0.37)
Other/ Miscellaneous Expenses	0.00	0.00	0.00	0.00	0.00	0.00
Total G & A Expenses	16.35	16.81	16.30	17.65	18.63	0.98
Total Operating Gain / (Loss)	6.65	17.01	28.70	(4.40)	4.72	(9.12)
Non Operating:						
Revenues - Interest	0.76	0.75	0.75	0.83	0.50	0.33
Expenses - Interest	0.02	0.01	0.02	0.02	0.00	(0.02)
Total Non-Operating	0.74	0.75	0.74	0.80	0.50	0.30
Total Increase / (Decrease) in Unrestricted Net Assets	7.38	17.76	29.44	(3.59)	5.22	(8.81)

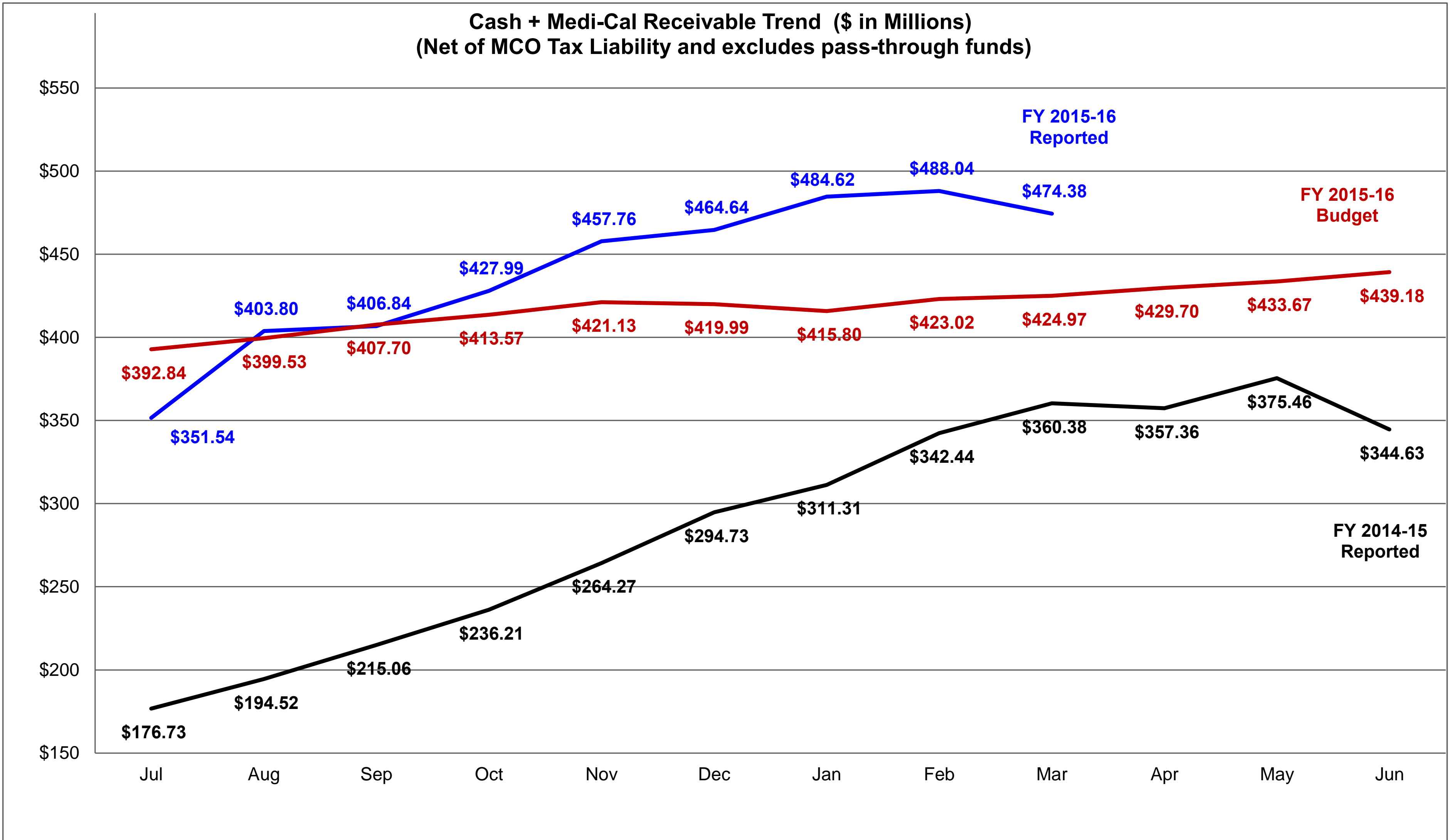
STATEMENT OF CASH FLOWS - FYTD

	MAR 16
Cash Flow From Operating Activities	
Collected Premium	$ 666,487,940
Miscellaneous Income	1,058,023
State Pass Through Funds	60,073,251
Paid Claims	
Medical & Hospital Expenses	(283,819,970)
Pharmacy	(75,100,651)
Capitation	(72,538,134)
Reinsurance of Claims	(2,546,582)
State Pass Through Funds Distributed	(33,500,498)
Paid Administration	(37,215,813)
MCO Taxes Received / (Paid)	(26,280,659)
Net Cash Provided / (Used) by Operating Activities	**196,616,907**
Cash Flow From Investing / Financing Activities	
Net Acquisition / Proceeds from Investments	(63,211,027)
Net Discount / Premium Amortization of Investments	211,027
Net Acquisition of Property / Equipment	(559,617)
Net Cash Provided / (Used) by Investing / Financing	**(63,559,616)**
Net Cash Flow	**$ 133,057,291**
Cash and Cash Equivalents (Beg. of Period)	57,218,141
Cash and Cash Equivalents (End of Period)	183,075,433
	$ 125,857,291
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income / (Loss)	33,155,943
Depreciation & Amortization	314,561
Net Discount / Premium Amortization of Investments	(211,027)
Decrease / (Increase) in Receivables	66,318,689
Decrease / (Increase) in Prepaids & Other Current Assets	(437,331)
(Decrease) / Increase in Payables	94,863,246
(Decrease) / Increase in Other Liabilities	(9,334,756)
Change in MCO Tax Liability	1,014,524
Changes in Claims and Capitation Payable	2,086,255
Changes in IBNR	8,846,803
	196,616,907
Net Cash Flow from Operating Activities	**$ 196,616,907**

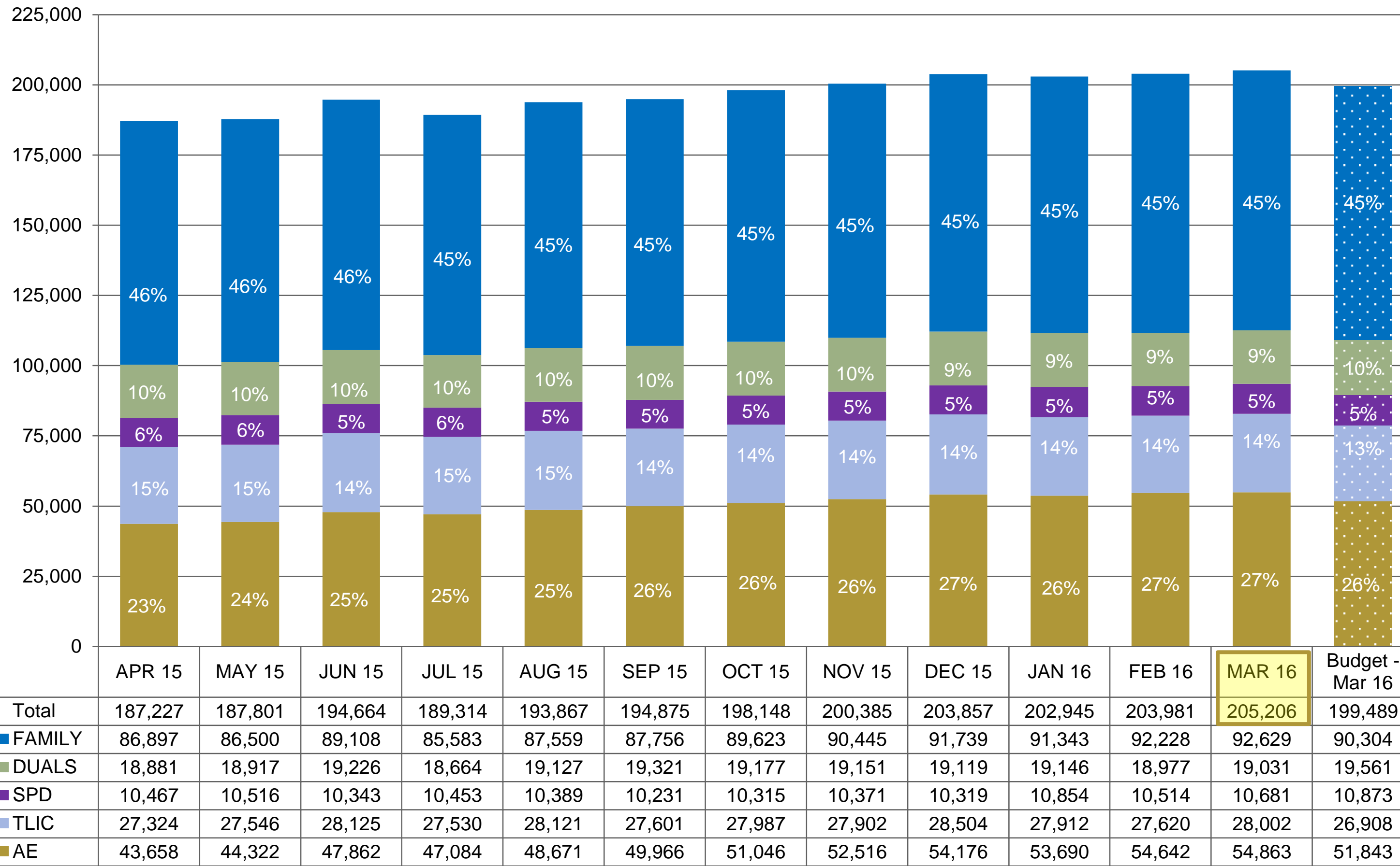
STATEMENT OF CASH FLOWS - MONTHLY

	MAR 16	FEB 16	JAN 16
Cash Flow From Operating Activities			
Collected Premium	$ 52,127,297	$ 50,212,450	$ 67,256,791
Miscellaneous Income	123,759	147,908	105,604
State Pass Through Funds	7,185,818	1,893,015	1,910,810
Paid Claims			
Medical & Hospital Expenses	(42,463,530)	(25,925,285)	(29,020,122)
Pharmacy	(9,348,750)	(8,598,863)	(8,859,251)
Capitation	(5,094,359)	(4,356,051)	(4,431,554)
Reinsurance of Claims	(291,220)	(291,461)	(292,101)
State Pass Through Funds Distributed	(1,850,953)	(1,818,410)	(1,835,505)
Paid Administration	(4,171,763)	(5,966,237)	(2,888,898)
MCO Tax Received / (Paid)	(2,051,653)	(2,731,240)	(2,738,879)
Net Cash Provided / (Used) by Operating Activities	**(5,835,354)**	**2,565,825**	**19,206,896**
Cash Flow From Investing / Financing Activities			
Net Acquisition / Proceeds from Investments	(8,045,835)	(5,005,969)	(47,392)
Net Discount / Premium Amortization of Investments	45,835	5,969	47,392
Repayment of Line of Credit	(7,200,000)	-	-
Net Acquisition of Property / Equipment	(122,990)	(86,488)	(289,909)
Net Cash Provided / (Used) by Investing / Financing	**(15,322,990)**	**(5,086,488)**	**(289,909)**
Net Cash Flow	**$ (21,158,345)**	**$ (2,520,663)**	**$ 18,916,988**
Cash and Cash Equivalents (Beg. of Period)	204,233,778	206,754,441	187,837,453
Cash and Cash Equivalents (End of Period)	183,075,433	204,233,778	206,754,441
	$ (21,158,345)	**$ (2,520,663)**	**$ 18,916,988**
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	(737,696)	6,004,961	3,603,488
Net Discount / Premium Amortization of Investments	(45,835)	(5,969)	(47,392)
Depreciation & Amortization	35,311	35,311	35,406
Decrease / (Increase) in Receivables	(166,566)	(918,214)	(1,141,868)
Decrease / (Increase) in Prepaids & Other Current As:	149,119	(108,120)	344,727
(Decrease) / Increase in Payables	(4,232,248)	(11,250,584)	7,534,264
(Decrease) / Increase in Other Liabilities	(3,812,429)	2,097,571	2,095,108
Change in MCO Tax Liability	764,959	36,947	32,248
Changes in Claims and Capitation Payable	(1,119,231)	9,241,560	5,071,570
Changes in IBNR	3,329,261	(2,567,640)	1,679,343
	(5,835,354)	2,565,825	19,206,896
Net Cash Flow from Operating Activities	**(5,835,354)**	**2,565,825**	**19,206,896**

GOLD COAST HEALTH PLAN
MARCH 2016



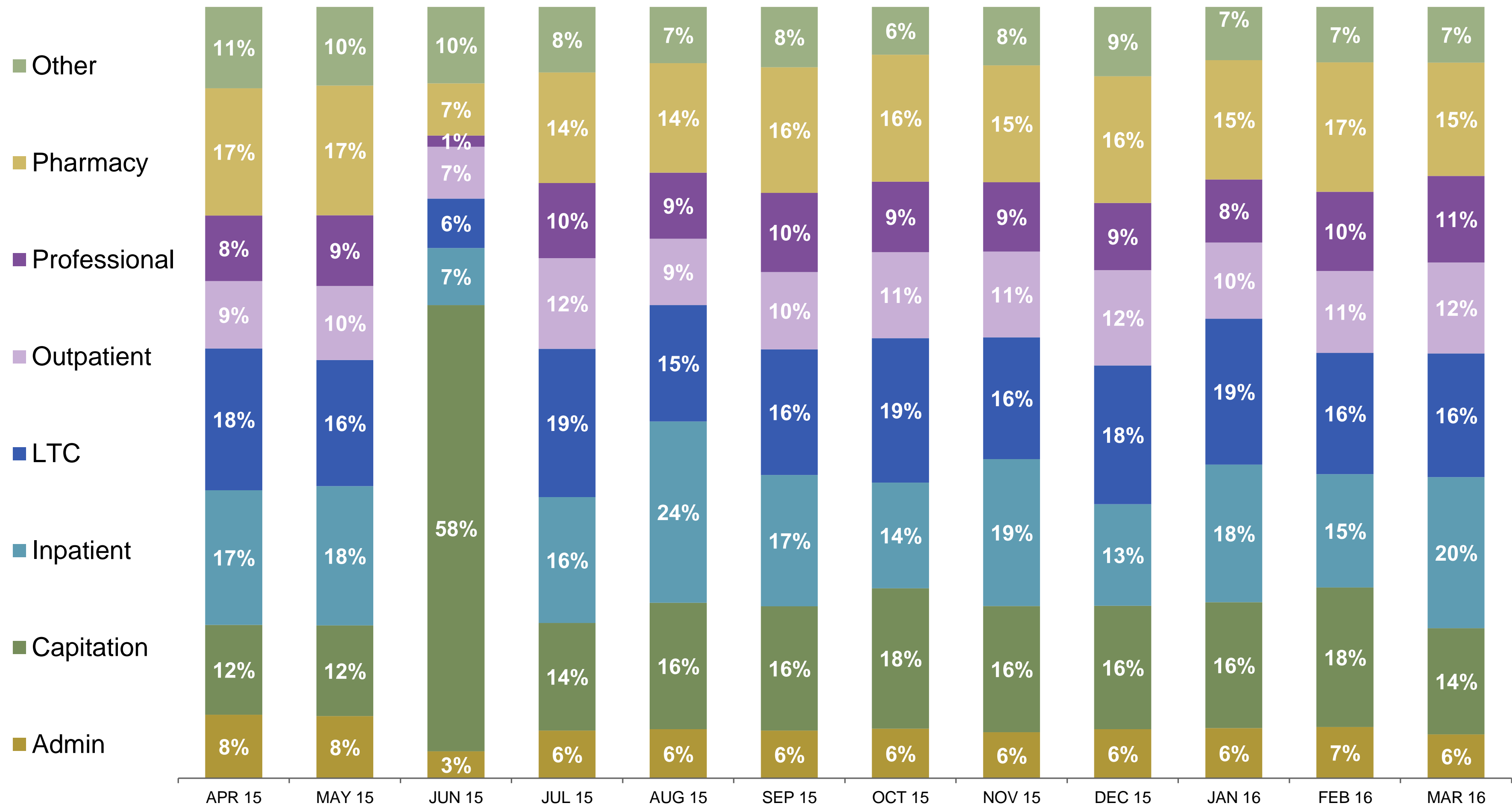
GOLD COAST HEALTH PLAN



	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16	Budget - Mar 16
Total	187,227	187,801	194,664	189,314	193,867	194,875	198,148	200,385	203,857	202,945	203,981	205,206	199,489
FAMILY	86,897	86,500	89,108	85,583	87,559	87,756	89,623	90,445	91,739	91,343	92,228	92,629	90,304
DUALS	18,881	18,917	19,226	18,664	19,127	19,321	19,177	19,151	19,119	19,146	18,977	19,031	19,561
SPD	10,467	10,516	10,343	10,453	10,389	10,231	10,315	10,371	10,319	10,854	10,514	10,681	10,873
TLIC	27,324	27,546	28,125	27,530	28,121	27,601	27,987	27,902	28,504	27,912	27,620	28,002	26,908
AE	43,658	44,322	47,862	47,084	48,671	49,966	51,046	52,516	54,176	53,690	54,642	54,863	51,843

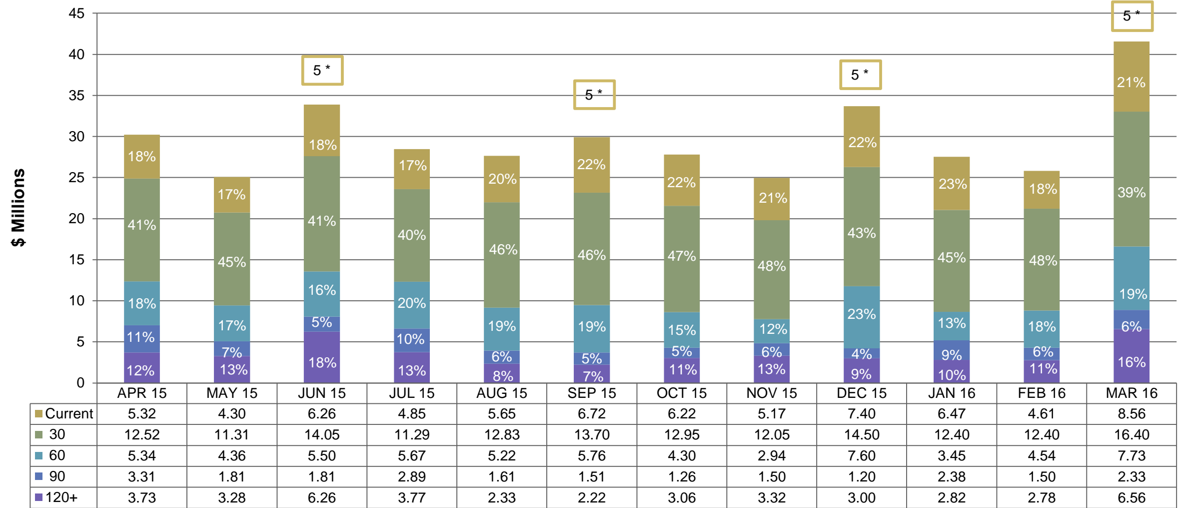
SPD = Seniors and Persons with Disabilities TLIC = Targeted Low Income Children AE = Adult Expansion

GOLD COAST HEALTH PLAN



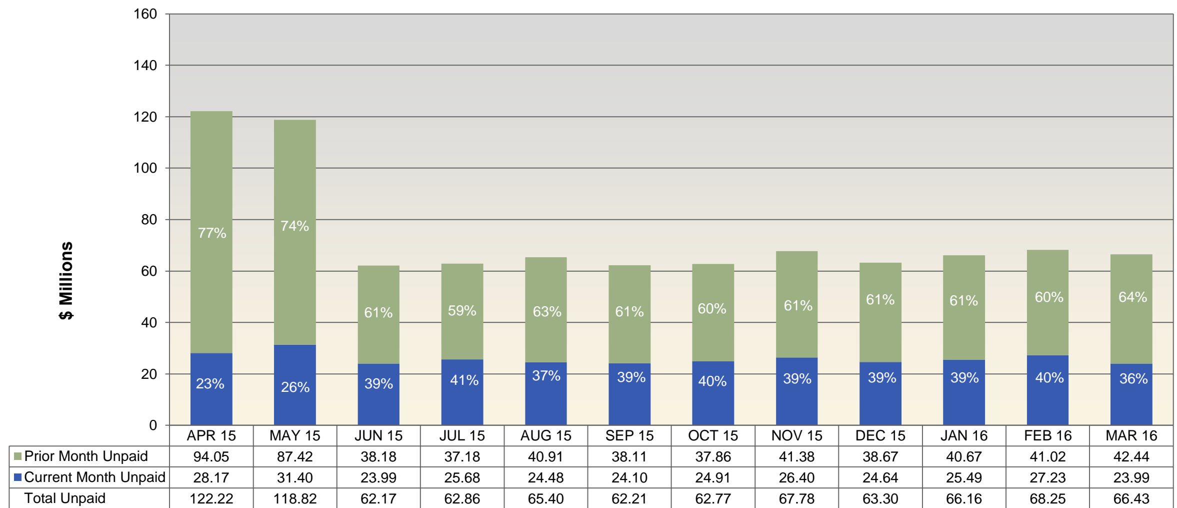
Note: June 15 reflects the Enhanced Adult Capitation program and reclassification of fee -for-service expense to capitation expense.

GOLD COAST HEALTH PLAN
MARCH 2016



	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16
Current	5.32	4.30	6.26	4.85	5.65	6.72	6.22	5.17	7.40	6.47	4.61	8.56
30	12.52	11.31	14.05	11.29	12.83	13.70	12.95	12.05	14.50	12.40	12.40	16.40
60	5.34	4.36	5.50	5.67	5.22	5.76	4.30	2.94	7.60	3.45	4.54	7.73
90	3.31	1.81	1.81	2.89	1.61	1.51	1.26	1.50	1.20	2.38	1.50	2.33
120+	3.73	3.28	6.26	3.77	2.33	2.22	3.06	3.32	3.00	2.82	2.78	6.56

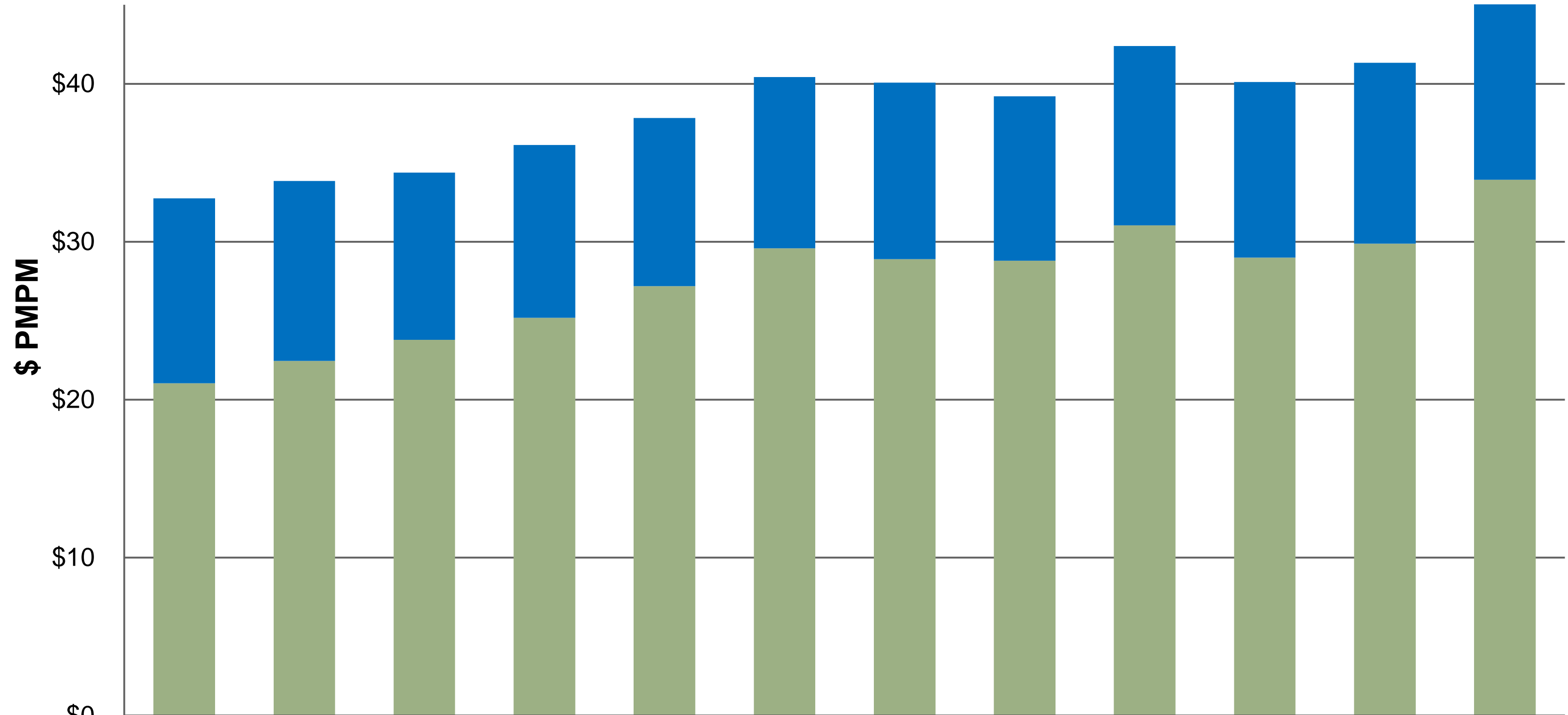
Note: Paid Claims Composition - reflects adjusted medical claims payment lag schedule.
Months Indicated with 5* represent months for which there were 5 claim payments. For all other months, 4 claim payments were made.



	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16
Prior Month Unpaid	94.05	87.42	38.18	37.18	40.91	38.11	37.86	41.38	38.67	40.67	41.02	42.44
Current Month Unpaid	28.17	31.40	23.99	25.68	24.48	24.10	24.91	26.40	24.64	25.49	27.23	23.99
Total Unpaid	122.22	118.82	62.17	62.86	65.40	62.21	62.77	67.78	63.30	66.16	68.25	66.43

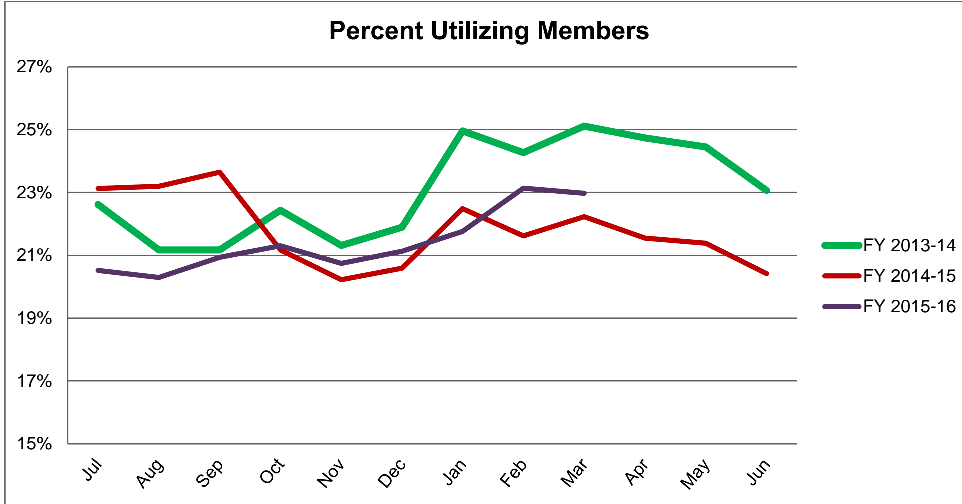
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.
June 2015 - reflects the Enhanced Adult Capitation program and reclassification of fee -for-service expense to capitation expense.

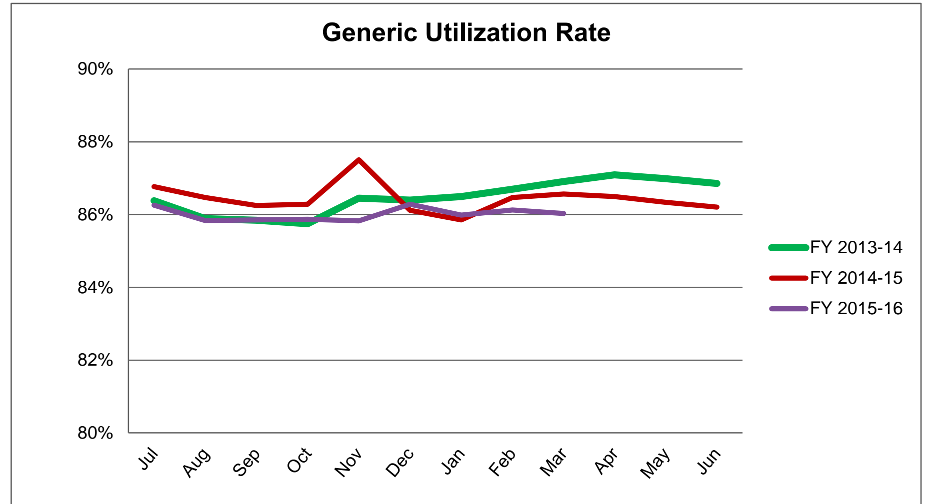
GOLD COAST HEALTH PLAN



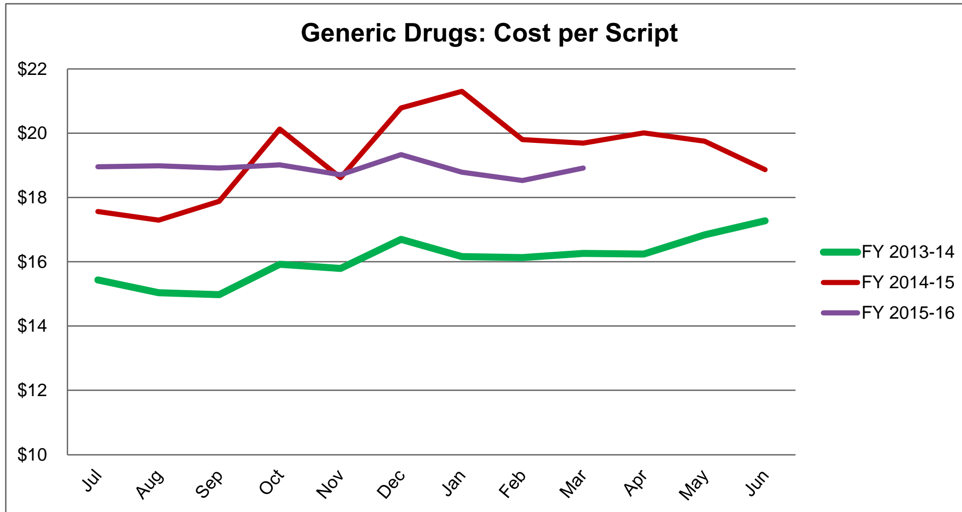
	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16
AVG PMPM	$32.74	$33.84	$34.38	$36.13	$37.84	$40.43	$40.07	$39.21	$42.39	$40.11	$41.33	$46.03
GENERIC	$11.71	$11.39	$10.60	$10.94	$10.66	$10.86	$11.17	$10.42	$11.35	$11.11	$11.45	$12.11
BRAND	$21.03	$22.45	$23.78	$25.19	$27.18	$29.58	$28.90	$28.79	$31.04	$29.00	$29.88	$33.92

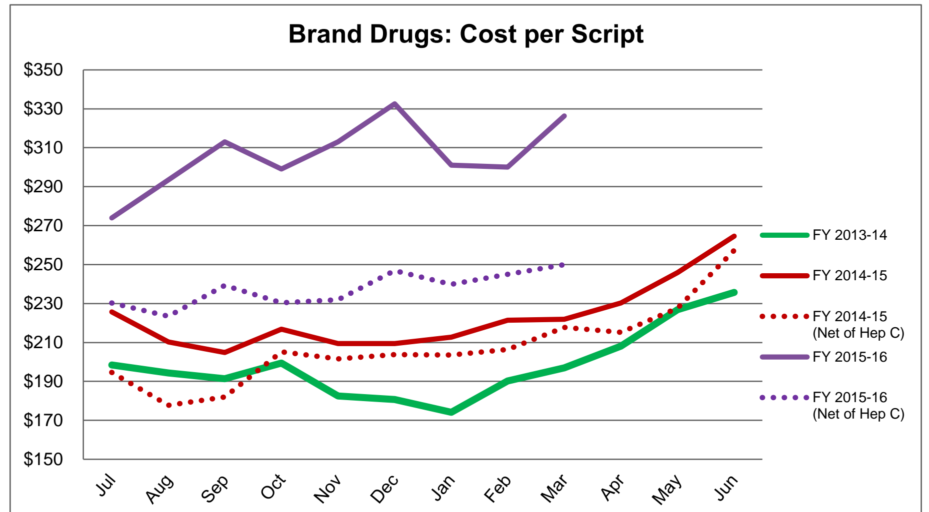
GOLD COAST HEALTH PLAN
PHARMACY ANALYSIS





Effective Oct 14, Dual members were responsible for prescription copays, lowering the percentage of utilizing members.





AGENDA ITEM NO. 5

TO: Gold Coast Health Plan Commission

FROM: Patricia Mowlavi, CFO

DATE: May 23, 2016

SUBJECT: Fiscal Year 2016-2017 Proposed Operating Budget

SUMMARY/DISCUSSION:

Gold Coast Health Plan (GCHP or Plan) is emerging from a period of significant growth which was fueled by the transition of Targeted Low Income Children (TLIC) into Medi-Cal Managed Care and the Affordable Care Act's Medi-Cal Adult Expansion (AE) program. SB75 - Full Scope Medi-Cal Coverage for All Children is expected to add 2,900 members during the current fiscal year. Membership growth is expected to level off in fiscal year 2016-17 with projected annual growth of 2.9% and a similar slow growth trajectory expected for the foreseeable future.

As the Plan stabilizes and matures, additional investments are being made to improve members' health through ongoing support of contracted hospitals, providers and the safety net. The shift toward increased collaboration with plan provider partners, outcome-based payment and new benefit design is driving innovation in how GCHP pays for health care and how health care will be delivered. These investments and GCHP's commitment to collaboration are demonstrated by the increase in medical benefits, as a percent of revenue to 93.5%, which includes the Alternative Resources for Community Health (ARCH) program.

Fiscal year 2016-17 revenue is projected to approach $688 million. The greater revenue is solely due to increased membership. Overall, revenue rates are declining as a result of the reduction in the Adult Expansion rates, effective July 1, 2016. Despite the revenue rate reductions, administrative expenses are projected to remain flat at 6.7% of revenue.

FISCAL IMPACT:

The proposed budget reflects an operating gain of $12 million or 1.7% of revenue before strategic projects and ARCH funding. These investments in infrastructure, community health and provider incentives will result in a $3 million decrease in net position which will begin to draw down the Plan's excess tangible net equity (TNE). GCHP has targeted TNE to be between 400% and 500% of the State minimum requirements. TNE is expected

to be drawn down from a projected high of 595% of minimum state requirements at the end of fiscal year 2016 to 498% by the end of fiscal year 2017, which is just under the upper bound target range.

The Ventura County economy is expected to advance unevenly over the next two years, according to the Los Angeles County Economic Development Corporation and Kyser Center for Economic Research. This, coupled with a potential change in the political environment as a result of this fall's election, suggests that maintaining a TNE near the upper bound target of 500% of the State required minimum is prudent at this time.

RECOMMENDATION:

Staff is recommending the Commission approve the proposed Fiscal Year 2016-2017 Operating Budget.

ATTACHMENT:

Fiscal Year 2016-17 Operating and Capital Budget

Fiscal Year 2016-17 Operating and Capital Budget

Integrity

Accountability

Collaboration

Trust

Respect

Commission Meeting
Patricia Mowlavi, CFO
May 23, 2016

711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

Key Budget Assumptions

- Annual membership growth of 6,083 or 2.9% to reach 214,728 members, by June 2017.
- Revenue includes a 13.9% reduction for Adult Expansion rates. Total revenue rates declining by 4.8%.
- Alternative Resources for Community Health (ARCH) program funded at $12.1 million or 1.8% of revenue.
- Administrative expenses are budgeted to remain flat at 6.7% of revenue.
- TNE is projected to be 498% of the state required minimum.

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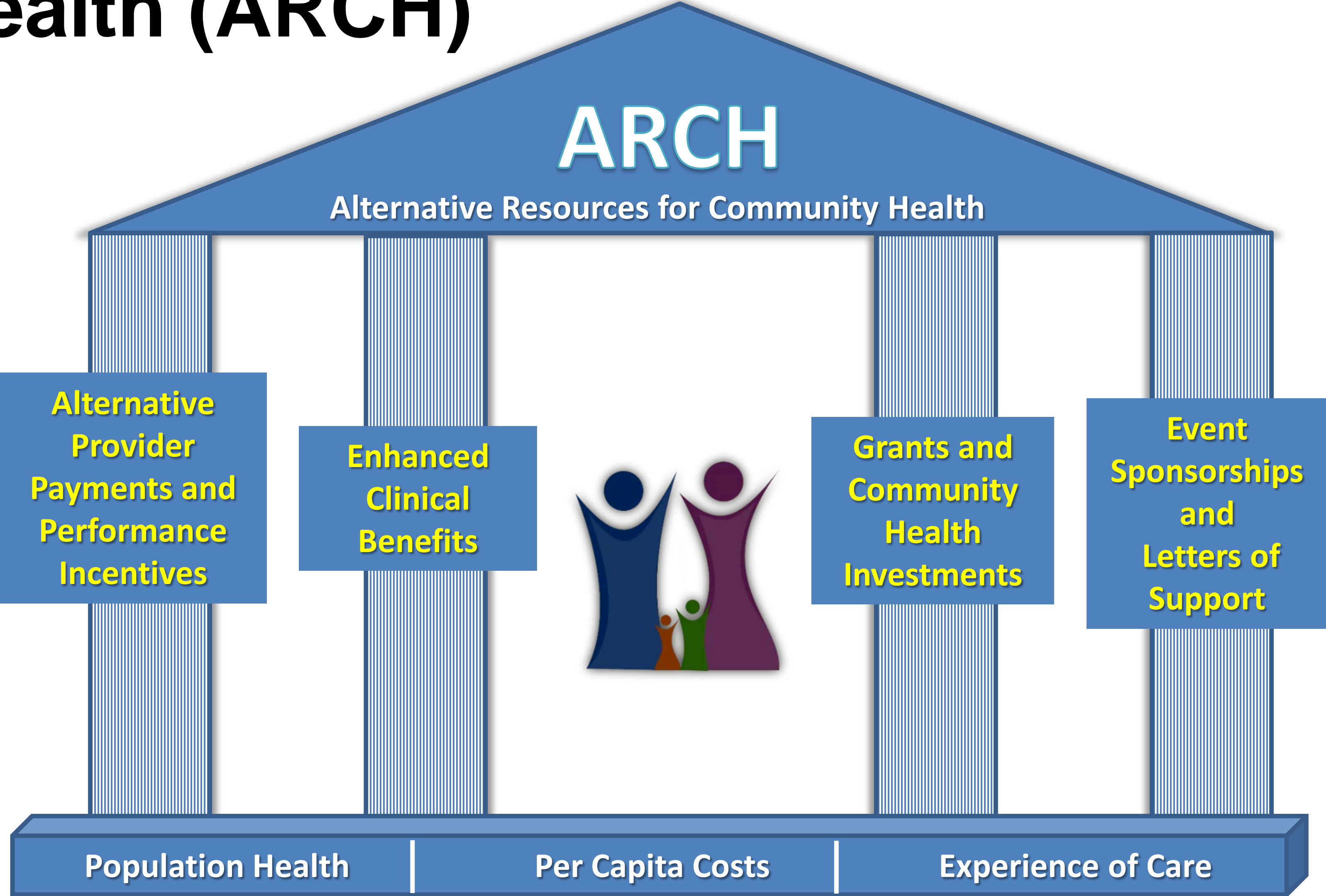
Alternative Resources for Community Health (ARCH)



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Value Based Contracting

TRIPLE AIM OF HEALTH CARE

POPULATION HEALTH

PROGRAM:
Patient Navigator Program

GOAL:
Care Coordination of Chronic Disease and High Risk Members

OUTCOME:
Reduction in ER utilization and lower cost of care

EXPERIENCE OF CARE

PROGRAM:
VCOE Audiology Services

GOAL:
Create needed audiology access for children

OUTCOME:
Enhanced member access

PER CAPITA COST

PROGRAM:
Pulmonary Rehab- V.C. Dept of Health

GOAL:
Benefit Enhancement & Care Coordination

OUTCOME:
Reduce overall cost in care of members with pulmonary disease

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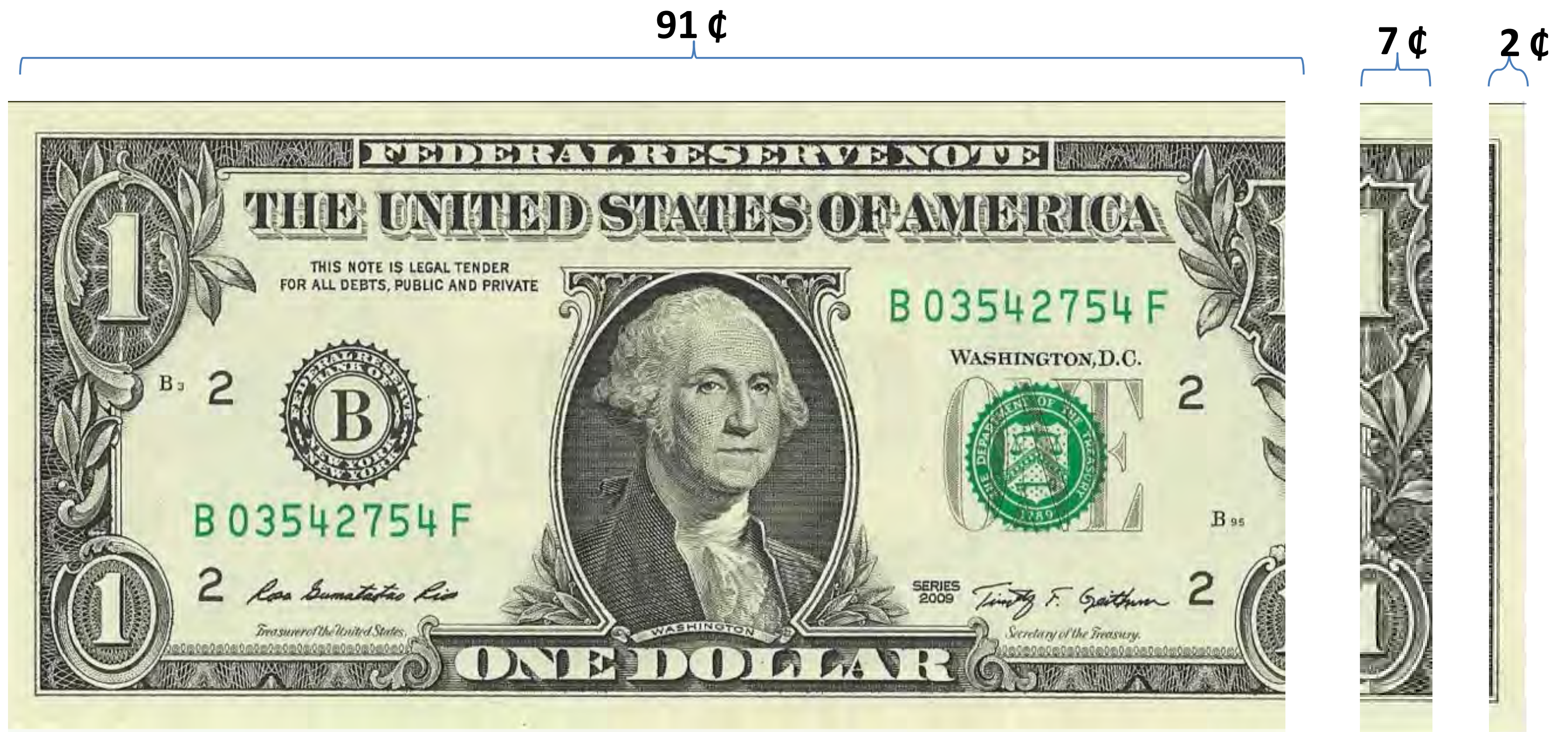
Costs

For every dollar in revenue received from the State:

- 91 cents goes to cost of health care benefits (MCR).
- 7 cents goes to administrative costs (ACR).
- 2 cents normally goes toward reserves, but this year will be used in Alternative Resources for Community Health program (ARCH).



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Highlights

	FY 2014-15	Projected FY 2015-16 *	Budget FY 2016-17
	(Amounts are stated in thousands, except Enrollment and %)		
FYE Membership	190,701	208,645	214,728
Average Monthly Enrollment	177,582	201,391	212,070
Premium Revenue	$ 595,117	$ 664,169	$ 687,544
Other Revenue	490	762	-
Total Revenue	**595,607**	**664,931**	**687,544**
Health Care Costs	510,905	580,435	630,443
Administrative Expense	33,649	39,969	46,289
Operating Gain	**51,054**	**44,527**	**10,812**
Non-Operating Income (Expense)	556	1,743	1,068
Operating Gain	51,610	46,270	11,880
Strategic Projects			(2,820)
ARCH / Provider Incentives			(12,174)
Increase in Net Position	**$ 51,610**	**$ 46,270**	**$ (3,113)**
Medical Cost Ratio (MCR)	85.8%	87.3%	91.7%
Administrative Cost Ratio (ACR)	5.6%	6.0%	6.7%
Administrative Expense - PMPM	$ 15.79	$ 16.54	$ 18.19
TNE**	**$ 107,145**	**$ 146,215**	**$ 143,102**

** Reflects actual experience through 3/31/16 and estimates from 4/1/16 to 6/30/16*

*** TNE includes $7.2M in lines of credit for FY 2014-15. Line of Credit paid in FY 2015-16*

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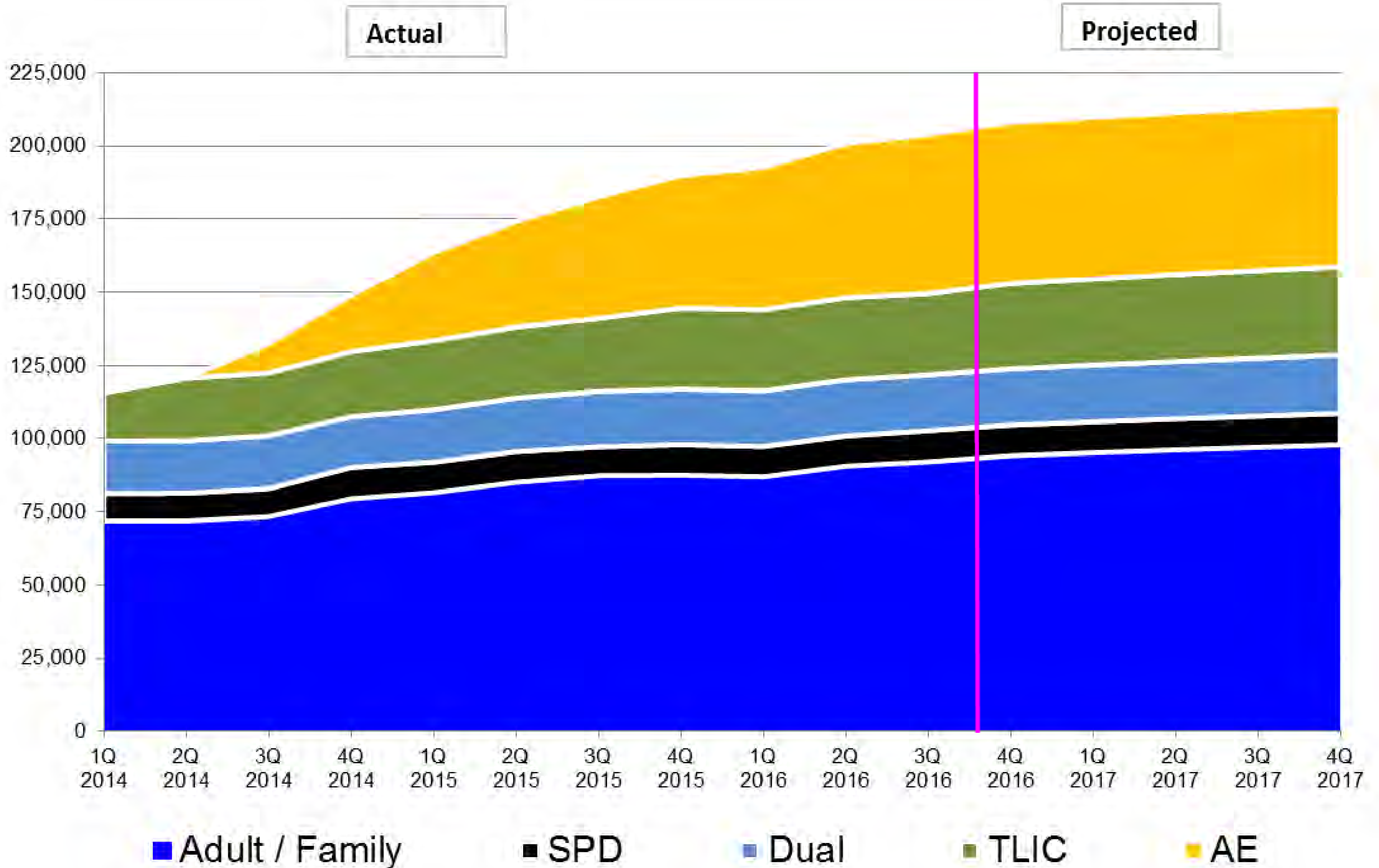
Members by Aid Category



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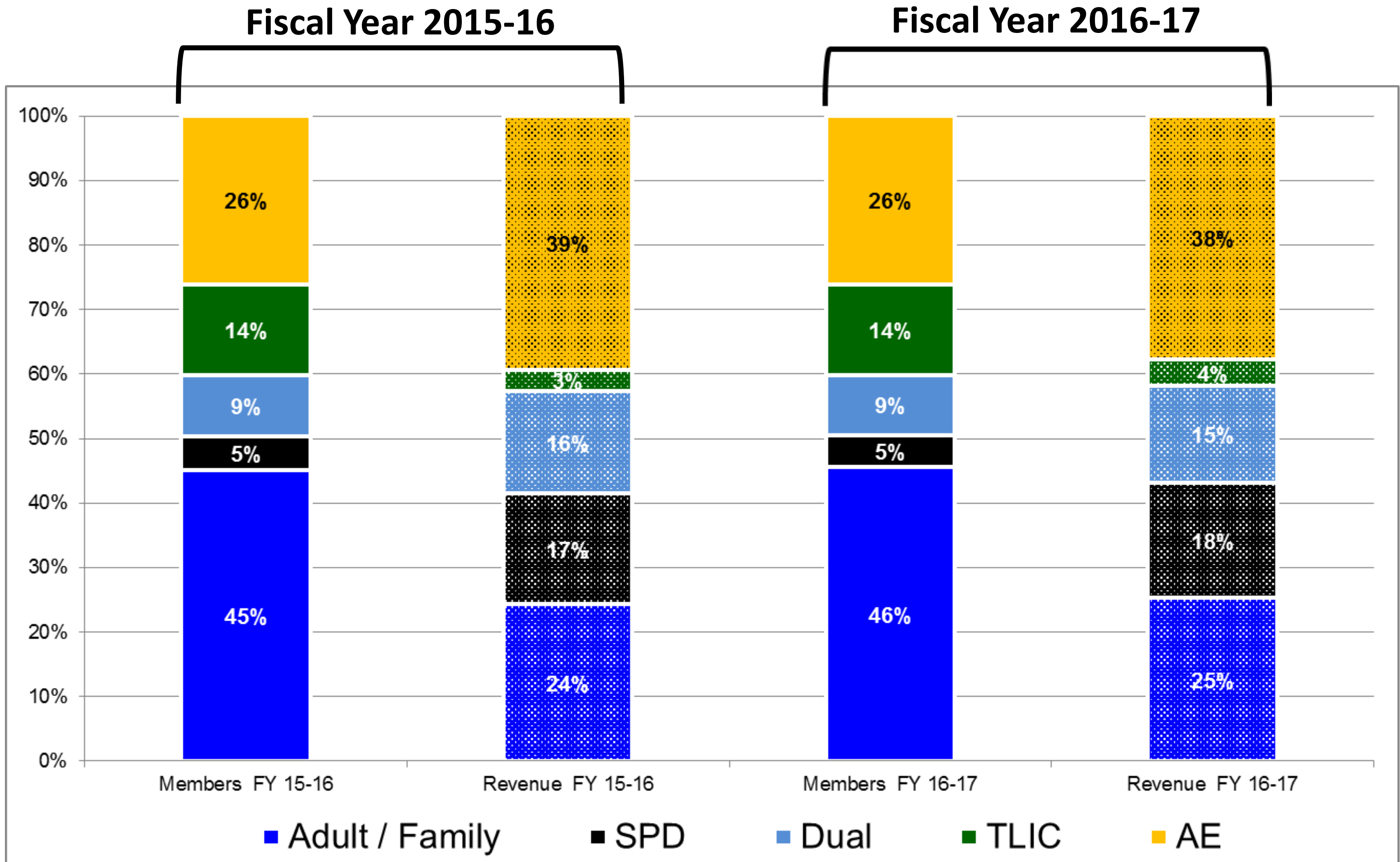
Membership Mix and Revenue Impact



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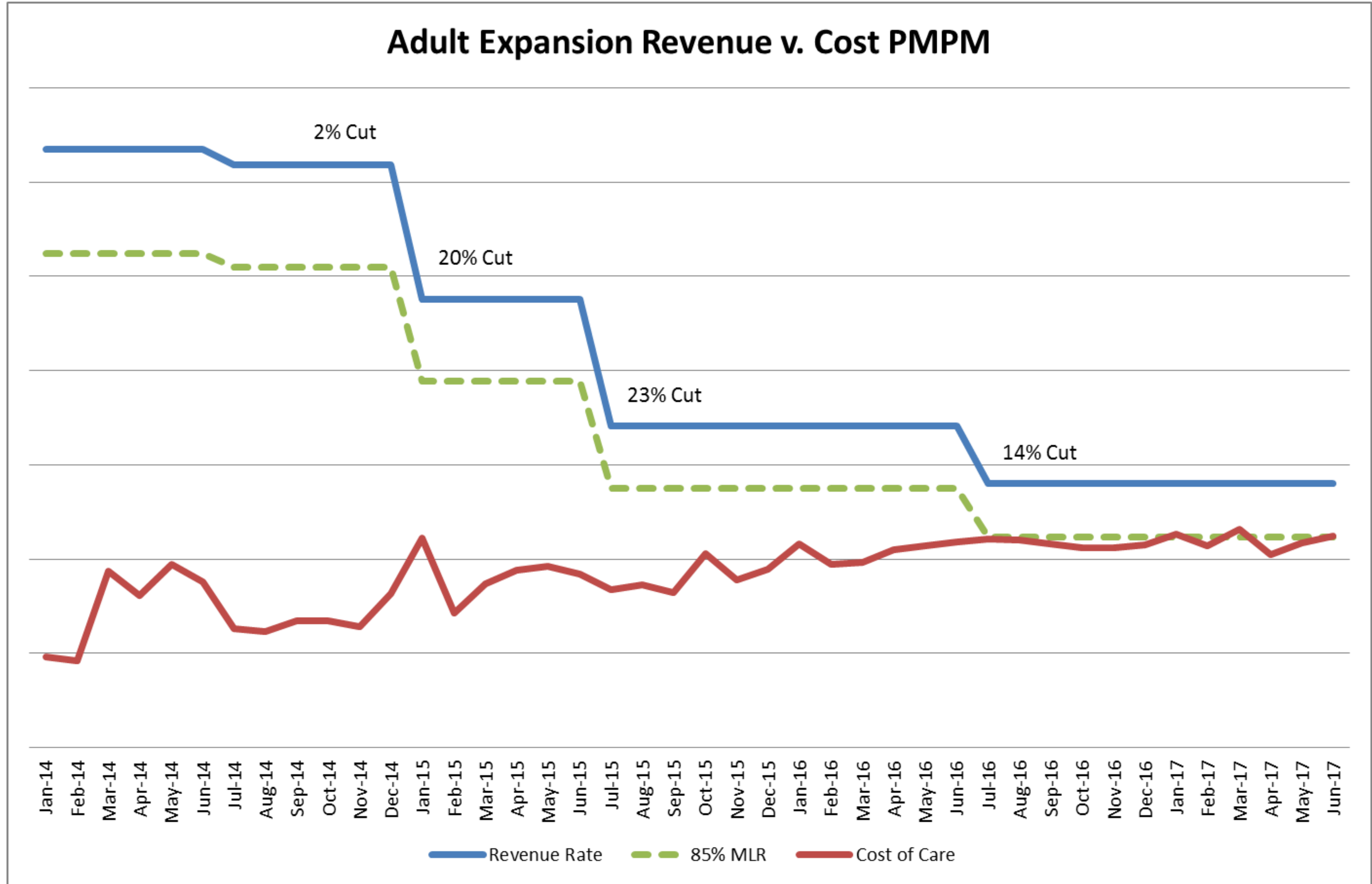
Adult Expansion Convergence



Cost of care – actual through 3/31/16. Budget year 16-17 contains random error term within ± 1 standard deviation.

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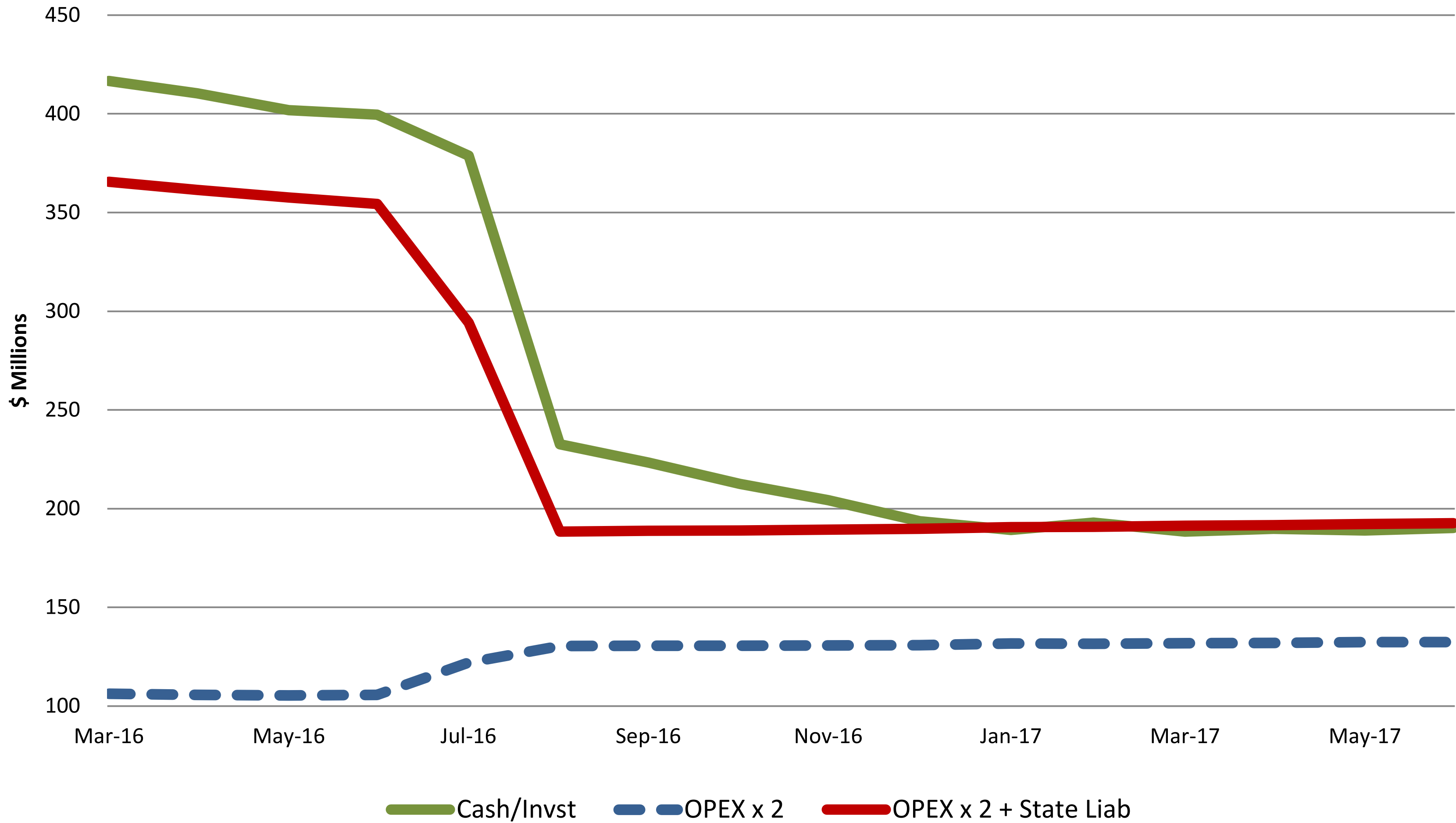
Cash



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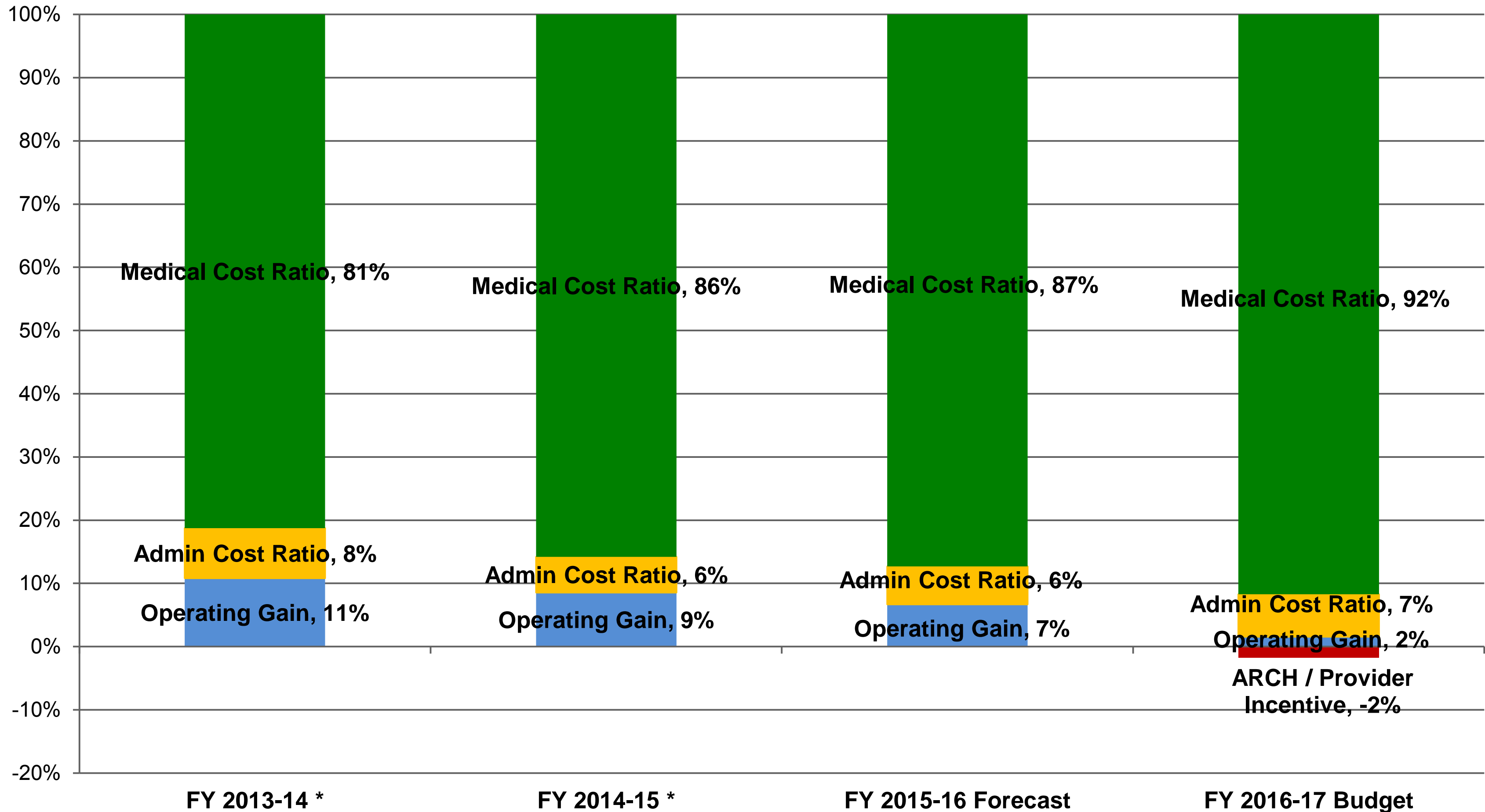
Key Performance Indicators



Note: FY 14 and FY 15 differs from Budget Presentation due to Auditors' Adjustments.

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Health Care Costs

	FY 2014-15	Projected FY 2015-16	Budget FY 2016-17
		(in thousands)	
Capitation *	$ 95,270	$ 104,477	$ 60,551
Claims:			
Inpatient	184,239	214,717	242,850
Outpatient	53,977	64,020	74,063
Professional/Other	94,107	85,645	115,620
Pharmacy	69,090	94,149	117,848
Care Management	14,222	17,428	19,511
	415,635	475,958	569,891
Total	**$ 510,905**	**$ 580,435**	**$ 630,443**

Total Health Care Costs PMPM	FY 2014-15	Projected FY 2015-16	Budget FY 2016-17
	$ 239.75	$ 240.18	$ 247.73

* Includes PCP, Specialty, Non-emergency transportation, and Vision

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Administrative Expense Crosswalk

($ in thousands)	Amount	% of Revenue	PMPM
FY 2015-16 Administrative Expense Budget	$ 43,120	6.7%	$ 18.27
FY 2016-17 Administrative Expense Budget	46,289	6.7%	$ 18.19
Increase (decrease) Year over Year	$ 3,169	0.0%	$ (0.08)
Additional Required Administrative Expenses			
CDO Expenses	$ 405		
770 Paseo Camarillo	630		
Additional Legal Expenses	510		
Additional ACS Expenses	1,043		
Personnel Expenses	581		
	$ 3,169		
Additional Adminstrative Expenses From Strategic Projects			
Consulting Expenses	$ 2,461	0.36%	$ 0.97
Additional Software Expenses	358	0.05%	$ 0.14
	$ 2,819	0.41%	$ 1.11

Note: Salaries are consistent with the updated compensation plan rate ranges (see Appendix page 19).

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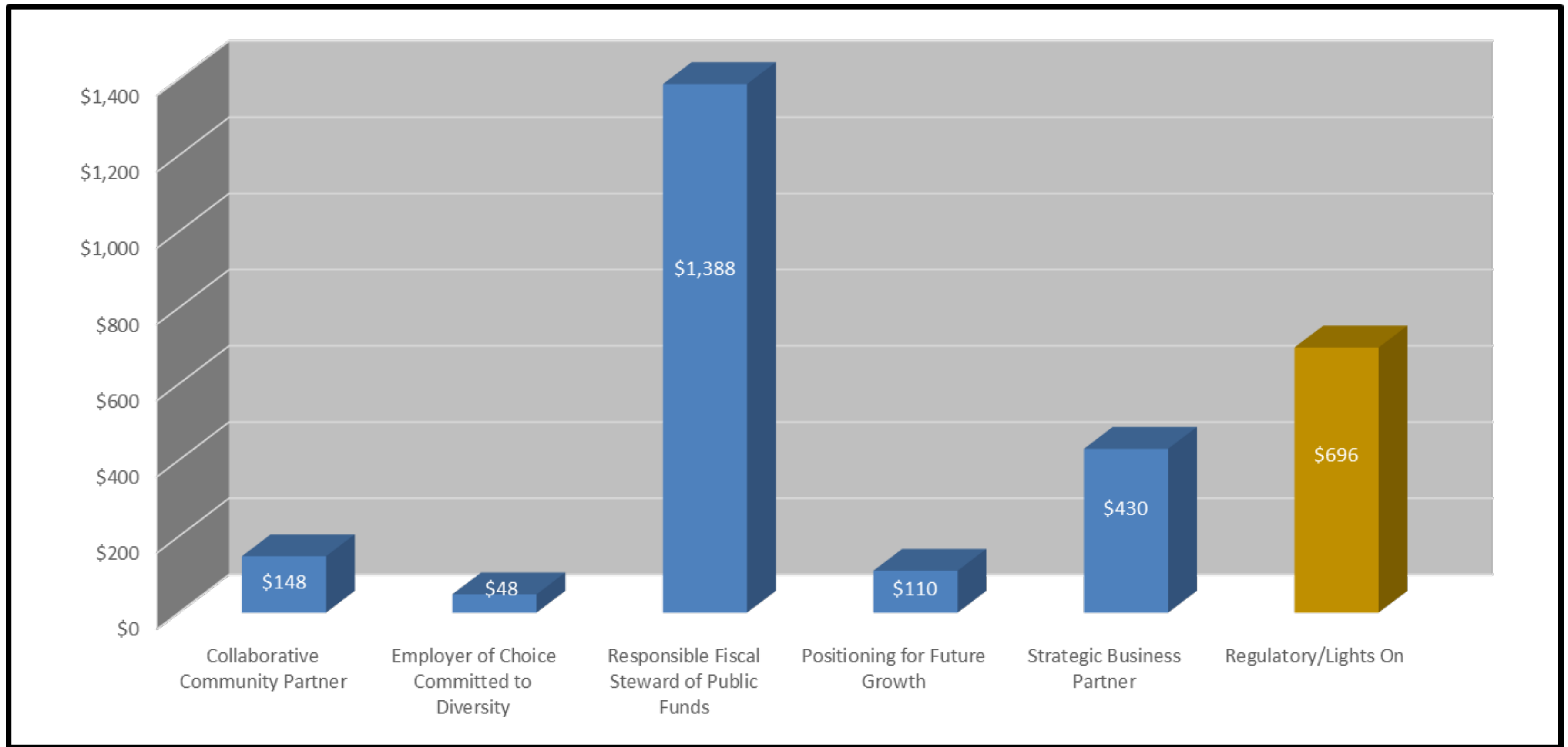
Projects by Strategic Objective



*Healthcare Leader project investments reflected in MLR

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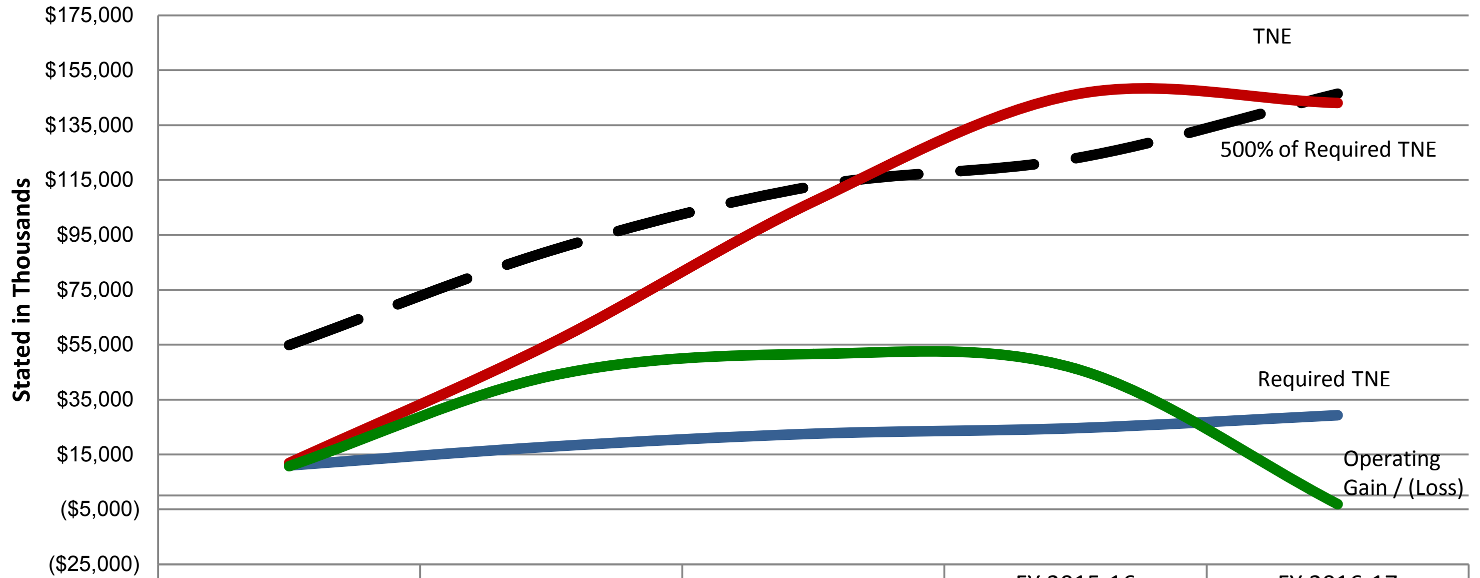
Key Indicators



	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16 Forecast	FY 2016-17 Budget
500% of Required TNE	54,871	89,340	112,783	122,931	146,453
Required TNE	10,974	17,868	22,557	24,586	29,291
GCHP TNE *	11,891	55,535	107,145	146,215	143,102
Operating Gain	10,723	43,644	51,610	46,270	(3,113)
% of Required TNE	108%	311%	475%	595%	489%

* GCHP TNE includes $7.2M in lines of credit for FY 2012-13 through FY2014-15. Lines of Credit paid in FY 2015-16

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Appendix

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Income Statement

	FY 2014-15	Projected FY 2015-16	Budget FY 2016-17
		(in thousands)	
Member Months	**2,131**	**2,417**	**2,545**
Revenues	**$ 595,607**	**$ 664,931**	**$ 687,544**
Health Care Costs:			
Capitation	95,270	104,477	60,551
Claims:			
Inpatient	184,239	214,717	242,850
Outpatient	53,977	64,020	74,063
Professional / Other	94,107	85,645	115,620
Pharmacy	69,090	94,149	117,848
Care Management	14,222	17,428	19,511
	415,635	475,958	569,891
Total Health Care Costs	**510,905**	**580,435**	**630,443**
Administrative Expenses	33,649	39,969	46,289
Operating Gain	**51,054**	**44,527**	**10,812**
Non-operating Revenue (Expense)	556	1,743	1,068
Net Gain / (Loss)	51,610	46,270	11,880
Strategic Projects	-	-	(2,820)
ARCH / Provider Incentives	-	-	(12,174)
Increase (Decrease) in Net Position	**$ 51,610**	**$ 46,270**	**$ (3,113)**

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Balance Sheet

	Actual 6/30/15	Projected 6/30/16	Budget 6/30/17
		(in thousands)	
Assets			
Cash and marketable securities	$ 222,308	$ 399,595	$ 190,147
Other current assets	157,046	85,795	90,286
	379,354	485,391	280,433
Capital assets (net of accum depr)	1,084	2,296	2,082
Total Assets	$ 380,439	$ 487,687	$ 282,515
Liabilities and Net Position			
Medical claims payable	$ 100,586	$ 106,604	$ 98,161
Other accrued liabilities	172,708	234,868	41,252
	273,293	341,472	139,413
Subordinated loan	7,200	-	-
Total Liabilities	280,493	341,472	139,413
Net Position	99,945	146,215	143,102
Total Liabilities and Net Position	$ 380,439	$ 487,687	$ 282,515

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May 12, 2016

Gold Coast Health Plan
Attn: Patricia Mowlavi, CFO
711 E. Daily Dr.
Camarillo, CA 93010

Dear Ms. Mowlavi:

From June 1, 2015 through September 30, 2015 HewlettGreene Consulting, Inc., researched and prepared an updated compensation plan for the Gold Coast Health Plan. Utilizing the Radford Survey, Economic Research Institute (ERI) and IBM Kenexa CompAnalyst to align ranges and compare job descriptions in like industries. At the conclusion of the project, HGC presented the Executives with a presentation outlining the recommended changes to the ranges (an increase of .89%) as well as realignment of positions within Job Families and like ranges.

The presentation was approved internally and results were presented to the Commission on November 23, 2015 with the Commission approving changes and agreeing upon an effective date of January 1, 2016.

In keeping with the results of the project, several positions were moved up one level and employees whose salary fell below the entry level of their adjusted positions were adjusted to meet the minimum level of their new range. Additionally, once the .89% overall adjustment had been made to the ranges, any employees not within the minimum of their ranges were also adjusted to fall within the current level of their ranges.

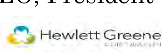
Finally, six positions, affecting seven employees were revised to comply with their current value, based upon the scope, bandwidth and levels of responsibilities. These individuals have been grandfathered to remain in their prior levels and will remain at the previous level to accommodate salary levels. New hires, after the date of January 1, 2016 will be placed at the newer lower range upon hire.

2016	2012	2014	Job Title	Minimum	Target	Midpoint	Maximum
Positions which dropped one or more levels from 2012 to 2016				25th%	50th%	75th%	90th%
10	11		Specialist, Compliance Delegation Oversight	$57,757	$62,671	$67,403	$72,261
14	18		RN - Quality Improvements	$70,610	$78,033	$85,456	$100,302
15	20		Manager, Quality Improvement Projects	73,487	81,461	89,435	105,832
22	23	23	Manager, Care Management/Care Coordination in	104,324	118,853	128,168	146,795
22	23	23	Manager, IT Business Solutions	104,324	118,853	128,168	146,795
22	23		Manager, IT Infrastructure	104,324	118,853	128,168	146,795
23		25	Director - Health Education Disease Management	110,200	119,000	134,900	149,300

Very truly yours,

Vicki Hewlett

CEO, President



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AGENDA ITEM NO. 6

TO: Gold Coast Health Plan Committee

FROM: Martin Haisma, Certified Information System Analyst, Certified Internal Auditor, Project Management Professional, Etonien Consulting

DATE: May 23, 2016

SUBJECT: Internal Audit Report, Revenue

SUMMARY:

Staff is presenting the Revenue Internal Audit Report for the Audit Committee to accept and file.

BACKGROUND / DISCUSSION:

The Internal Auditor was tasked with following the Internal Audit Plan. The first area for review is revenue policy and procedures. There were no significant findings as a result of the audit and all risks are mitigated.

FISCAL IMPACT:

The review of the audit report and results of the audit will not result in any immediate fiscal impact.

RECOMMENDATION:

Staff recommends approval of the audit report.

ATTACHMENT:

Revenue Internal Audit Report

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AUDIT REPORT

REVENUE RECOGNITION

REVIEW COVERING THE

PERIODS JULY 1, 2015 THROUGH FEBRUARY 29, 2016

Recipients:

1. Patricia Mowlavi
2. Lyndon Turner

Prepared by:

1. Martin Haisma
2. Will Oliver

Date: 5/05/2016

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1.0 EXECUTIVE SUMMARY

1.1 CONTEXT

The Gold Coast Health Plan (“GCHP” or “Plans”) Accounting and Finance departments are responsible for the recognition of revenue on a monthly basis. This includes the processing of all invoice remittances from the Department of Health Care Services and the recording of cash earned from various investments of GCHP. Responsibilities also include tracking payments received to be deposited into the Plan’s account and maintaining the liability account for the unearned revenue reserve in the accounting system of record.

1.2 SUMMARY OF FINDINGS

1) Invoice remittance received by Finance was not signed as certified by the Department of Health Care Services.
2) Policy was not followed in regards to payments received being tracked and deposited into the Plans account.
3) Electronic signature or written initials of the reviewer were not evidenced in some of the documentation.

1.3 MANAGEMENT RESPONSE

Management agrees with the findings and recommendations. Management has also taken steps to address each of the findings as noted in each section in this report.

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2.0 INTRODUCTION AND BACKGROUND

2.1 OBJECTIVES

The objective of this review is to:

1) Ensure that internal controls over Revenue Recognition are adequately designed and operating effectively.
2) Document the process for the recognition and recording of revenue.
3) Identify deficiencies and provide recommendations that require improvement in the revenue recognition related processes.

2.2 SCOPE

The scope of this review includes an assessment of Revenue Recognition related processes, internal controls and transactions for the period 7/1/15 thru 2/29/16 ("audit period").

2.3 METHODOLOGY

Specifically, this review included:

1) The adequate acceptance and approvals for contract amendments that occurred during the period of scope.
2) Ensuring the accuracy of premium revenue in calculation of current and retro members to the appropriate program capitation rates.
3) Accurate recording of revenue related transactions including investment income.
4) Ensuring proper procedures, including proper review and approvals, as it relates to journal entries and reconciliations.
5) Ensuring proper procedures relating to the tracking of received payments to be deposited into the Plans account.
6) Monthly "Orange Blank" financial reports are adequately prepared and reviewed prior to submitting documents to the Department of Health Care Services.
7) Ensuring the monthly Financial Reporting Package is being reviewed and approved by the Commission.

The review was conducted in accordance with generally accepted auditing standards.

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3.0 FINDINGS AND RECOMMENDATIONS

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3.1 INVOICE REMITTANCE RECEIVED BY FINANCE WAS NOT SIGNED AS CERTIFIED BY THE DEPARTMENT OF HEALTH CARE SERVICES.

Risk - Premium rates per program category are not properly calculated which could materially affect revenue.

The certification of an invoice remittance that is evidenced by an authorized signature from the Department Of Health Care Services was missing. This discrepancy was noted in one invoice.

MANAGEMENT RESPONSE

There was a lot of turnover in the roles and responsibilities at the Department of Health Care Services in which an invoice may have been missed in signature certification.

The Department of Health Care Services has a Rates Unit and Payments Unit that enters the capitation rates in their system and creates a check payment to the Plans, respectfully. Signature certification is completed once a check is created by the Payments Unit. The Payments Unit has nothing to do with the rates.

Another critical factor is the subsequent receipt, which is the exact amount that is received from the Department of Health Care Services. GCHP is paid for the invoices from the previous month otherwise; there is no information on how to obtain the number for the revenue amount. In conclusion, Management does not believe it is considered defalcation.

RECOMMENDATION

The Department of Health Care Services is the only major source of revenue for the Plans. With one source of revenue being a significant factor, it is recommended to check for certification to meet a certain comfort level of the revenue number being correct in the remittances. This attribute also checks for due diligence and making sure accountability is upheld. This discrepancy occurred once during the period of scope and is considered an isolated incident.

3.2 POLICY WAS NOT FOLLOWED IN REGARDS TO PAYMENTS RECEIVED BEING TRACKED AND DEPOSITED INTO THE PLANS ACCOUNT.

Risk – No proper custody of the funds and payment is not delivered and deposited in the Plans account in a timely manner.

A new policy was put into place with the Department of Health Care Services paying GCHP by courier service to deposit the check into the Plans account to improve the custodian process, which began Nov. 1, 2015.

The payment was delivered to the Plans from the Department of Health Care Services by mail. The check was manually delivered to the bank for deposit with evidence of a deposit slip. This occurred multiple times before and after the new policy went into effect.

MANAGEMENT RESPONSE

If payment is delivered directly to the Plans in the future, it is suggested that a substitute courier should be hired to complete the delivery and deposit the check into the Plans account as a mitigating control.

RECOMMENDATION

The mitigating control is an acceptable solution to this key control process and no additional recommendations are required at this time.

3.3 ELECTRONIC SIGNATURE OR WRITTEN INITIALS OF THE REVIEWER WERE NOT EVIDENCED IN SOME OF THE DOCUMENTATION.

Risk - Accounting errors could go undetected and account balances may be incorrectly stated.

There was no evidence of reviewer's electronic signature. Reviewer initials and last name was typed on one of the Accounts Receivable (“A/R”) reconciliations, which is not considered an acceptable level for evidence of review.

It was also noted that preparer and reviewer initials was typed into the “Orange Blank” financial monthly review sheets which is not considered an acceptable level for evidence of review.

MANAGEMENT RESPONSE

The reconciliation was reviewed by the previous Senior Accounting Manager, which was the control stakeholder at the time. The subsequent A/R reconciliations all have electronic signatures from both preparer and reviewer.

The “Orange Blank” financial review sheet was originally designed to be used as a checklist. It was agreed to by Management to take the necessary steps and revise the “Orange Blank” financial review sheet to be used as both a checklist and become an official review sheet adding in electronic signatures for the preparer and the reviewer.

RECOMMENDATION

This is an acceptable improvement to this process key control. No additional recommendations are required at this time.

4.0 CONCLUSION

Based on the work performed, except for the items noted above, it is concluded that internal controls over Revenue Recognition were adequately designed and operating effectively for the scope and period under review.

5.0 OPEN ITEMS UNDER REVIEW

We are still in the process of reviewing the IBNR financial model that is included to the Minimum Medical Loss Ratio calculation in determining the unearned premium to be reserved in the Long Term Liability Account.

6.0 APPENDICES

Details of the items noted in this report are available to the report recipients upon request.

AGENDA ITEM NO. 7

TO: Gold Coast Health Plan Commission

FROM: Patricia Mowlavi, CFO

DATE: May 23, 2016

SUBJECT: Reinsurance Renewal

SUMMARY:

The annual reinsurance policy is up for renewal. The current policy with StarLine expires on June 30, 2016.

BACKGROUND/DISCUSSION:

Gold Coast Health Plan's insurance broker, Beecher Carlson, went to bid for the reinsurance policy. Quotes were received from five carriers for aggregating specific deductible (ASD) reinsurance policies. The broker recommends remaining with StarLine which provided the best rate with a potential for refund, based on past experience.

FISCAL IMPACT:

The StarLine ASD renewal quote was the lowest received at $3,057,377 in estimated premium cost and includes a rate reduction from the current policy with potential premium savings of $453,830.

RECOMMENDATION:

Staff is recommending the Commission approve and authorize binding reinsurance with StarLink per the quoted estimate.

ATTACHMENT:

Premium Comparison Summary

Managing General Underwriter / Carrier	Best's Rating / Size	Quoted	Did Not Quote	Comments
StarLine / United States Fire Insurance	A / XIII	✓		Incumbent
Munich Re	A+/ XV	✓		
Odyssey Re	A / XV	✓		
Ironshore	A / XIV	✓		
OnPoint / Everest Re	A+ / XV	✓		

Premium Comparison Summary – ASD (Aggregating Specific Deductible)

Deductibles	Pay Rate		Held Rate		Total Rate (Pay + Held)	Total (Max Cost)
	Rate (PMPM)	Estimated Pay Premium	Rate (PMPM)	Estimated Held Fund		
Deductible $650,000 (Current)						
StarLine - Renewal	**$1.28**	**$3,057,377**	**$0.91**	**$2,173,604**	**$2.19**	**$5,230,981**
Expiring 2015 Rates	**$1.47**	**$3,511,207**	**$0.96**	**$2,293,033**	**$2.43**	**$5,804,240**

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 (April)

Total 199,048

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AGENDA ITEM NO. 8

TO: Gold Coast Health Plan Commission

FROM: Ralph Oyaga, Executive Director
Governmental, Regulatory and External Relations

DATE: May 23, 2016

SUBJECT: Ventura County Behavioral Health Overdose Rescue Project

SUMMARY:

Staff is seeking Commission approval to fund the cost of 1,000 naloxone kits in support of the Ventura County Behavioral Health Overdose Rescue Project (the "Project") through Gold Coast Health Plan's Alternative Resources for Community Health Program. The Project goal for 2017 is to reduce the number of fatal prescription drug abuse and opioid related overdoses in Ventura County by 50 percent.

BACKGROUND:

More Americans die every day from drug overdoses than from motor vehicle crashes and the majority of those deaths involve legal prescription drugs. In late 2014, Ventura County Behavioral Health launched the Overdose Prevention Project to address the local epidemic prescription drug abuse and opioid-related deaths. Naloxone is a very safe and highly effective drug used to reverse potentially fatal opioid overdoses. Data collected after the first year of the Project was favorable with documentation of lives saved.

The Project is currently at ten sites across Ventura County, including Ventura County Alcohol and Drug Program sites, Western Pacific Medical and Syringe Replacement Program locations. The Project provides information to reduce the likelihood of overdose among high-risk persons and overdose recognition and response education for families to help prevent overdose deaths. Project staff receives training on naloxone kit distribution procedures and data collection. Every naloxone kit recipient is trained on the risk of opioid overdose and proper naloxone administration procedures. Data collection and tracking tools have been designed and implemented to ensure all aspects of the program implementation and outcomes are monitored by the Project staff.

711 East Daily Drive, Suite 106, Camarillo, CA 93010-6082 | Member Services: 888-301-1228 | Administration: 805-437-5500 | Fax: 805-437-5132

DISCUSSION:

As a key strategy in efforts to drive down overdose fatalities in Ventura County, the Ventura County Behavioral Health Overdose Rescue Project would like funding for 1,000 naloxone kits to expand the distribution of naloxone to target the 'at risk' population, provide increased access and reduce the access hurdles by offering a nasal spray. This Project is in line with GCHP's strategic objective to promote community health and positive health outcomes.

Following is a breakdown of the items in each kit and the respective cost:

A. Naloxone

Item	Total Kits	# per kit	Total Naloxone Needed	Unit Cost	Total Cost
Naloxone Vials	700	2	1,400	$ 15.00	$ 21,000
Naloxone Syringes	700	2	1,400	$ 2.00	$ 2,800
Naloxone Nasal Spray (NARCAN)	300	1	300	$ 75.00	$ 22,500
Total					**$ 46,300**

B. Kit Supplies - Printed Materials

Item	Total Kits	Unit Cost	Total Cost
Kit Bag / Printed Materials	**1,000**	**$ 5.00**	**$ 5,000**

Total Expenses **$ 51,300**

FISCAL IMPACT:

$51,300 fiscal impact to be funded through the Alternative Resources for Community Health (ARCH) program.

RECOMMENDATION:

GCHP recommends the Commission approve an award of $51,300 to VCBH to cover the cost of 1,000 naloxone overdose rescue kits in support of the Ventura County Behavioral Health Overdose Rescue Project through Gold Coast Health Plan's Alternative Resources for Community Health Program.

AGENDA ITEM NO. 9

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, Chief Executive Officer (CEO)

DATE: May 23, 2016

SUBJECT: Chief Executive Officer Update

NEW CEO EXECUTIVE ASSISTANT – LUPE HARRION:

Lupe Harrion accepted the position as executive assistant to CEO Villani effective immediately. She previously was the executive assistant to Chief Medical Officer Reeves.

50TH ANNIVERSARY OF MEDI-CAL:

In 1966, Medi-Cal was created to provide health coverage to low-income families, children, pregnant women, and the disabled. For many years, it was considered a "welfare program."
Now, 50 years later, Medi-Cal is the state's largest health insurer and provides coverage to 1 in 3 Californians. Largely due to the expanded eligibility requirements under the Affordable Care Act, more than 13 million people—including single adults, families, seniors, and children—are covered by Medi-Cal.

Medi-Cal is a safety net for those whose circumstances may prevent them from affording health insurance or medical care. With the same benefits as most other health insurance plans at no cost or low cost, Medi-Cal covers a broad spectrum of medical needs, including preventive care, pregnancy, alcohol and drug abuse, mental health and long-term care.

Marlen Torres Manager, Government and External Relations will represent Gold Coast Health Plan at the DHCS celebration ceremony in Sacramento on Tuesday, May 24th, from 4:00 p.m. – 6:00 p.m. There will be events throughout the year commemorating the anniversary.

GOVERNOR RELEASES MAY REVISE: REVENUES ARE DOWN:

Governor Brown released the May Revision to his January budget proposal. The revised budget's estimated revenue is down by $1.9 billion.

With respect to health care programs the passage of the Managed Care Organization (MCO) tax solidifies funding for Medi-Cal over the next three years. The tax has yet to be approved by the federal government.

Significant health related adjustments in the May Revisions include:

- $2.2 billion in federal funds for the new Medi-Cal 2020 waiver.
- $188.2 million General Fund, an increase of $45.4 million, to provide full-scope benefits to 185,000 undocumented children.
- An increase of $5 million General Fund and 38 positions to implement the federal Medicaid regulations.
- $180.2 million General Fund, an increase of $86.4 million, to provide federally required Behavioral Health Treatment services.

The budget must be passed by the Legislature by June 15th.

GOLD COASE HEALTH PLAN (GCHP) 2016/17 BUDGET, PRIORITIES, AND OPPORTUNITIES

As the Plan matures, moving into our sixth year since our launch in 2011, it is clear to me that what got us here is not necessarily what we need for the next five years to continue to evolve the organization. Our tools and technology, reliance on outsourced vendors, skill sets and capacity of our employees must also keep pace and position us for new opportunities that align with our strategic plan.

Membership growth is incremental and remains somewhat flat around our projected figure of 208k members by years end. With the State reducing our rates for the Adult Expansion population by 13.9% our overall rate reduction is 4.8%. This means the Plan must budget and grow thoughtfully to be able to meet our future needs and live within our means. We will spend close to 91 cents of every dollar received on health care related services. This leaves 7 cents of every dollar for administrative expenses and 2 cents for community and provider investment opportunities through our Alternative Reimbursement for Community Health (ARCH) program.

The challenge facing the Plan is finding operational efficiencies within the administrative budget to run the day to day operations and to invest in our future capabilities. I have been discussing with potential industry consultants opportunities to help us analyze our current staffing, technology and vendor footprint and to assist us in finding the optimal alignment of our limited resources. This work will begin in the next 30 days as we finalize the vendor and scope of work.

As a not-for-profit Medi-Cal Health Plan we are committed to investing every available dollar in the health and wellness of Ventura County. Our initial investments through the ARCH program are being celebrated today with Commission approved awards to the Ventura County Recuperative Care Program and the Ventura County Area Agency on Aging Senior Nutrition Program. The Commission also approved investments in health care services not reimbursed by Medi-Cal (pulmonary rehab and expanded podiatry services). We are finalizing our

investment in enhanced provider reimbursement models utilizing incentives such as pay for performance and value based care which provide additional dollars to providers who demonstrate improved clinical outcomes and better access to care for their patients. We think this investment of 2 cents of our revenue dollar as part of the 2016/17 budget is the right strategy for Ventura County.

FULL SCOPE MEDI-CAL FOR ALL CHILDREN REGARDLESS OF IMMIGRATION STATUS

Governor Brown allocated $188.2 million in his budget to provide full scope benefits to the 185,000 undocumented children in California. Estimates for Ventura County vary widely but we believe will be close to 3k to 4k children under the age of 19 who qualify.

We received notification from the Department of Health Care Services that 2,917 children are currently in restricted status (emergency and OB services only) and are expected to be Gold Coast Health Plan members with a June 1st eligibility effective date. (As of May 16th these restricted members were considered eligible for fee-for-service Medi-Cal benefits.)

Unknown to the Plan is the number of new enrollees who may apply for Medi-Cal. There have been significant outreach efforts by DHCS as well as other philanthropic organizations.

All new enrollees are required to select a PCP and we expect many of the transitional members to select a PCP at locations where they were being served previously such as Clinicas del Camino Real, Incorporated, Kaiser Permanente Child Health Program, or the Ventura County Health Care Agency Ace Program for Kids.

Regardless, GCHP stands ready to meet the needs of this newly enrolled population with over 200 pediatric and family practice providers open to new children.

5TH ANNUAL COMMUNITY RESOURCE FAIR, SATURDAY, MAY 14, PLAZA PARK, OXNARD, CA

On Saturday, May 14, 2016, Gold Coast Health Plan (GCHP) held its annual Community Resource Fair at Plaza Park in downtown Oxnard. A total of **43** information booths were on display including **38** community organizations and 5 GCHP Departments (Health Education, Member Services, Care Management, Disease Management and Pharmacy).

Approximately **316** children and families attended the event. Health Screenings for blood pressure, blood glucose, and body mass index (BMI) were conducted during the event.

GCHP received certificates of appreciation from several distinguished elected officials including Ventura County Supervisor John C. Zaragoza, Mayor of Oxnard Pro Tem, Carmen Ramirez, Field Representative Allison Maginot for Senator Hannah-Beth Jackson, and Field Representative Jason Barnes for Congresswomen Julia Brownley.

FEDERAL LEGISLATIVE UPDATE:

Centers for Medicare and Medicaid Services (CMS): Medicaid Managed Care Rule

On May 6, CMS published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care final rule in the Federal Register. The rule aims to align key rules with those of other health insurance coverage programs and strengthen the consumer experience. The final rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade.
Major provisions of the rule will take effect between one and three years.

Examples of the provisions are the following:

- Provider Networks
    - Online provider directories need to be updated within 30 days as oppose to the original proposal of three days.
- Credentialing
    - CMS allowed states to delegate credentialing to Medicaid Managed Care Plans.
- Actuarial Soundness
    - Actuaries will have to certify rates for each rate cell as oppose to certifying rate ranges.
    - Takes effect on July 1, 2018.
- Minimum Medical Loss (MLR) Ratio
    - Minimum of eight-five percent MLR.
    - Takes effect on or after July 1, 2017.

- Appeals and Grievances
  - Grievances must be resolved within 90 days.
  - Appeals must be resolved within 30 days.
  - Expedited appeals must be resolved within 72 hours.
  - Takes effect on or after July 1, 2017.
- Communications
  - Ensures information is accessible to individuals with Limited English Proficiency such as provider directories, member handbooks, appeal and grievance notices, and other informational notices.
  - Information and assessment of managed care plan financial performance, encounter data reporting, enrollment, evaluation of managed care plan performance on quality measures, sanctions and corrective action plans, and audit results must be available on the plan website.

The Government relations staff will continue to analyze the rule and provide the Commission with further details.

CALIFORNIA LEGISLATIVE UPDATE:

Governor Brown's May Revise Budget Proposal

On May 13, Governor Brown released his Fiscal Year (FY) 2016-17 Budget May Revise. Overall, the Governor continues to advocate for prudent spending and a continued increase in the Rainy Day Fund. The total budget proposed for the Health and Human Services Agency is a total of $141 billion ($33 billion General Fund [GF] and $108 billion in other funding). The revised budget reflects additional spending in General Funds to pay for new mandates related to the Medicaid Managed Care Rule released by CMS earlier this month.

Significant adjustments pertaining to the Medi-Cal program are the following:

- A total of $2.2 billion in federal funds for the new Medi-Cal 2020 waiver. The waiver includes the Public Hospital Redesign and Incentives Medi-Cal (PRIME), the Global Payment Program, Whole Person Care Pilots, and Dental Transformation initiatives.
- A total of $180.2 million GF, an increase of $86.4 million, to provide federally required Behavioral Health Treatment services.
- A total of $188.2 million GF, an increase of $45.4 million to provide full-scope Medi-Cal benefits to 185,000 children.
- An increase of $5 million GF, an addition of 38 positions to implement the provisions under the Medicaid Managed Care Rule. The Rule is related to beneficiary grievances, provider networks, program integrity, and financing.

The projected Medi-Cal enrollment for FY 2016-17 is 14.1 million. Starting in 2017, the State assumes a five percent share of cost for the optional expansion population. By 2020-21, the Federal share will decrease to ninety percent and the State will be responsible for ten percent of the costs.

Due to the passage of the Managed Care Organization (MCO) tax earlier this year, the GF spending is reduced by approximately $1.1 billion in FY 2016-17, and more than $1.7 billion in 2017-18 and 2018-19. The May revision also includes a decrease in GF revenue of $300 million in FY 2016-17 to account for a reduction in insurance tax and corporation tax revenue from affected health plans.

The following are significant investments made possible by the MCO tax:

- A total of $287 million GF for various developmental services programs, including rate adjustments for community-based providers serving individuals with developmental disabilities.
- An increase of $135 million GF for Medi-Cal rates for Intermediate Care Facilities for the Developmentally Disabled and forgiveness of recoupments for Distinct Part Nursing Facilities.

The Assembly and Senate Budget Subcommittees will hear the May Revise issues in the coming week and finalize their budgets by the week of May 23. Any differences will go to Budget Conference Committee for resolution and then the final budget will go to the Governor in time to meet the June 15 budget deadline.

COMPLIANCE:

Gold Coast Health Plan (GCHP) successfully closed out the DHCS Medical Audit Corrective Action Plan (CAP) on March 16, 2016. GCHP was notified on February 25, 2016 by Audits & Investigations (A&I) the annual medical audit for 2016 will take place, April 25, 2016 through May 6, 2016. GCHP had to submit pre-audit documentation material to A&I by March 18, 2016. The review period for the medical audit is April 1, 2015 through March 31, 2016. GCHP anticipates the final report and or CAP being issued in July/August 2016.

The DHCS corrective action plan, Financial (Addendum A) remains open and the plan continues to submit items on a monthly basis as required and defined by the CAP.

GCHP continues to meet all regulatory contract submission requirements. In addition to routine deliverables GCHP provides weekly and monthly reports to DHCS as a part of ongoing monitoring activities. All regulatory agency inquiries and requests are handled timely and requested information is provided within the specified required timeframe(s). Compliance staff is actively engaged in sustaining contract compliance. With the transition of ABA services on February 1, 2016 additional weekly and daily reporting has been required.

GCHP compliance staff conducted a six month claims follow up audit on GCHP vision service provider and mental health behavioral organization (MBHO). The onsite audits occurred during the second and third week of May 2016.

The compliance dashboard is attached for reference and includes information on but is not limited to: staff trainings, fraud referrals, HIPAA breaches, delegate audits.

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COMPLIANCE REPORT 2016

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
Hotline A confidential telephone and web-based process to collect info on compliance, ethics, and FWA	Referrals *one referral can be sent to multiple referral agencies*	9	4	10	6									29
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0	0	0	0									0
Hotline Referral *FWA	Department of Justice	0	0	0	0									0
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	9	4	7	5									25
Hotline Referral	External Agency (i.e. HSA)	0	0	0	0									0
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	0	0	3	1									4
Delegation Oversight The committee's function is to ensure that delegated activities of subcontracted entities are in compliance with standards set forth from GCHP contract with DHCS and all applicable regulations	Delegated Entities	8	8	8	8									32
	Reporting Requirements Reviewed **	62	64	54	86									266
	Audits conducted	4	0	1	0									5
Delegation Oversight	Letters of Non-Compliance	0	0	1	0									1
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	2	0	0	0									2
Audits External regulatory entities evaluate GCHP compliance with contractual obligations.	Total	0	1	0	1									2
	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	0	0	0	0									0
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0	0	0	0									0
	HEDIS Compliance Audit (HSAG)	0	1	0	0									1
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2012*	0	0	0	0									0
	DHCS Medical Audit	0	0	0	1									1
Fraud, Waste & Abuse The Fraud Waste and Abuse Prevention process is intended to prevent, detect, investigate, report and resolve suspected and /or actual FWA in GCHP daily operations and interactions, whether internal or external.	Total Investigations	9	4	10	6									29
	Investigations of Providers	0	0	0	1									1
	Investigations of Members	9	4	10	5									28
	Investigations of Other Entities	0	0	0	0									0
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0	0	0	0									0

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
HIPAA	Referrals	1	4	2	3									10
Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	State Notification	1	4	2	3									10
	Federal Notification	0	4	0	0									4
	Member Notification	0	0	0	1									1
	HIPAA Internal Audits Conducted	0	1	0	0									1
Training	**Training Sessions**	20	15	27	12									74
Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Fraud, Waste & Abuse Prevention (Individual Training)	6	3	7	2									18
	Fraud, Waste & Abuse Prevention (Member Orientations)	6	6	6	6									24
	Code of Conduct	2	3	7	2									14
	HIPAA (Individual Training)	6	3	7	2									18
	HIPAA (Department Training)	0	0	0	0									0

** Reporting Requirements are defined by functions delegated and contract terms. Revised contracts, amendments or new requirements form DHCS may require additional requirements from subcontractors as a result the number is fluid
** Audits- Please note multiple audits have been conducted on the Plan, however many occurred in 2012 and 2013 and will be visible on the annual comparison dashboard
** This report is intended to provide a high level overview of certain components of the compliance department and does not include/reflect functions the department is responsible for on a daily basis.

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AGENDA ITEM NO. 10

TO: Gold Coast Health Plan Commission

FROM: Ruth Watson, Chief Operating Officer (COO)

DATE: May 23, 2016

SUBJECT: Chief Operating Officer Update

OPERATIONS UPDATE:

Membership Update – May 2016

Gold Coast Health Plan (GCHP) has experienced incremental membership gains over the past few months; the net increase in May was 650 members. As of May 1, 2016, GCHP's new membership is 204,619 and has increased by 86,107 (72.7%) since the beginning of Medi-Cal Expansion in January 2014. The cumulative new membership since January 1, 2014 is summarized as follows:

Aid Code	# of New Members
L1 – Low Income Health Plan (LIHP)	1,407
M1 – Adult Expansion	52,898
7U – CalFresh Adults	1,820
7W – CalFresh Children	433
7S – Parents of 7Ws	478
Traditional Medi-Cal	29,071
Total New Membership 1/1/14 – 5/1/16	86,107

Adult Expansion members (aid code M1) represent 61.4% of GCHP's new membership since the start of Medi-Cal Expansion.

	L1	M1	7U	7W	7S
May 16	1,407	52,898	1,820	433	478
Apr 16	1,596	51,769	1,910	462	549
Mar 16	1,800	50,648	2,015	510	620
Feb 16	1,873	50,185	2,110	549	579
Jan 16	1,953	49,653	2,205	608	736

	L1	M1	7U	7W	7S
Dec 15	2,129	49,456	2,285	573	287
Nov 15	2,298	47,527	2,395	628	354
Oct 15	2,515	46,138	2,525	682	354
Sep 15	2,698	44,260	2,654	733	360
Aug 15	3,039	42,465	2,766	746	380
Jul 15	3,218	40,948	2,918	770	355
Jun 15	3,413	39,283	2,986	781	353
May 15	3,908	37,519	3,083	813	379
Apr 15	4,102	35,582	3,162	831	381
Mar 15	4,965	34,350	3,236	856	396
Feb 15	6,128	31,203	3,342	872	442
Jan 15	6,508	30,107	3,390	872	478

	L1	M1	7U	7W	7S
Dec 14	6,972	27,176	3,204	589	15
Nov 14	7,289	24,060	3,254	599	14
Oct 14	7,443	23,569	3,312	296	11
Sep 14	7,568	21,944	3,368	606	5
Aug 14	7,726	18,585	3,400	624	4
Jul 14	7,839	15,606	3,453	667	4
Jun 14	7,975	10,910	3,515	691	3
May 14	8,118	7,279	3,680	714	0
Apr 14	8,134	4,514	3,584	684	0
Mar 14	8,154	2,482	1,741	0	0
Feb 14	8,083	1,550	0	0	0
Jan 14	7,618	183	0	0	0

AB 85 Capacity Tracking – 31,111 Adult Expansion members have been assigned to VCMC as of May 2016. VCMC's target enrollment is 65,765 and is currently at 47.3% of the enrollment target.

March 2016 Operations Summary

The **Claims Inventory** at the end of March was 24,059; this equates to a Days Receipt on Hand (DROH) of 2.9 days compared to a DROH maximum goal of 5 days. GCHP received approximately 8,400 claims per day in March. Monthly claim receipts from April 2015 through March 2016 are as follows:

Month	Total Claims Received	Receipts per Day
March 2016	193,881	8,429
February 2016	176,656	8,833
January 2016	154,770	8,146
December 2015	170,897	7,768
November 2015	142,247	7,902
October 2015	156,109	7,095
September 2015	164,510	7,834
August 2015	152,840	7,278
July 2015	162,237	7,374
June 2015	171,806	7,809
May 2015	160,992	8,050
April 2015	146,198	6,645

The **Claims Turnaround Time (TAT)** for March was 99.5% vs the regulatory requirement of processing 90% of clean claims within 30 calendar days. The **Financial Claims Processing Accuracy** for March was 99.94% vs a goal of ≥ 98% and the **Procedural Claims Processing Accuracy** was 99.98% vs a goal of ≥ 97%.

The **Call Volume** for March exceeded the 10,000 call threshold for the first time in several months. The number of calls received in March was 10,337. The 12-month average ending March 31st was 9,593 calls per month. The combined (Member, Provider and Spanish lines) **Average Speed to Answer (ASA)** for March was 3.0 seconds vs the SLA goal of ≤ 30 seconds. The combined **Abandonment Rate** was 0.12% vs the SLA goal of ≤ 5%. The combined **Average Call Length** decreased slightly to 7.51 minutes from the prior month. This **Call Center Phone Quality** for March was 93.0% versus a goal of 95% or higher. The decrease was driven by new hires and pointed to areas for where additional training for these new agents is needed.

The **Grievance and Appeals** team received 13 member grievances and 131 provider claim payment grievances during March. The 13 member grievances equate to 0.06 grievances per 1,000 members.

Type of Member Grievances	Number of Grievances
Quality of Care	7
Quality of Service	2
Accessibility	1
Benefits/Coverage	1
Billing	1
Service – VSP	1
Total Member Grievances	**13**

There were two clinical appeals in March; one was upheld and one was overturned. There were no State Fair Hearing cases in March.

SB 75 – Full Scope Medi-Cal for All Children
The implementation of SB 75 occurred on May 1, 2016, as scheduled. DHCS provided a file for the Transition Population (children under the age of 19 who were enrolled in restricted scope Medi-Cal with unsatisfactory immigration status) to GCHP towards the end of April. The file identified 2,917 children in Ventura County who will be automatically transitioned into full scope coverage with GCHP on June 1, 2016 (these children will have fee-for-service Medi-Cal for the month of May). The New Enrollee Population (children under the age of 19 who meet all eligibility requirements for SB 75 but were not enrolled in the Medi-Cal program at the implementation of SB 75) were able to start applying for Medi-Cal on May 16, 2016.

Member Orientation Meetings
A total of 39 members (35 English, 4 Spanish) have attended Member Orientation meetings from January through April 2016. Of the 39 members, 28 indicated they learned about the meeting as a result of the informational flyer included in each new member packet.

Behavioral Health Treatment (BHT) Transition
The transition of BHT services from the regional centers to managed care plans continues. GCHP members who previously received BHT services at the regional center have been transitioning since February, based on month of birth, as long as they could be transitioned safely. GCHP is required to send 60-day and 30-day notices to all transitioning members and has sent out the following notices:

Transition Month	60-Day Notices Sent	30-Day Notices Sent
February 2016 (Jan & Feb birth month)	12/1/15	1/1/16
March 2016 (Mar & Apr birth month)	1/1/16	2/1/16
April 2016 (May & Jun birth month)	2/1/16	3/1/16
May 2016 (Jul & Aug birth month)	3/1/16	4/1/16
June 2016 (Sep & Oct birth month)	4/1/16	5/1/16
July 2016 (Nov & Dec birth month)	5/1/16	

In the most recent list of members identified as receiving BHT services at the regional center, DHCS included several members that were not previously included on any lists provided to us. These members were added to the group of members receiving their 60-day notice on May 1st and will transition in July. DHCS has indicated they may continue to identify additional BHT members receiving services at the regional centers; as such, the transition will continue until August 2016.

Administrative Services Organization (ASO) Evaluation
The Commission approved the selection of Optimity Advisors (Optimity) at the February meeting to 1) assist GCHP in determining if the current contract with our ASO vendor provides the necessary value for Medi-Cal administrative services and 2) is the most effective approach for the ongoing support of these functions. High level project goals include:

- Review and analyze the current ASO contract against requirements and internal performance expectations
- Identify coverage gaps, concerns and issues with contract terms and regulatory requirements
- Gather market analysis, financial models and Service Level Agreements (SLAs) for contract comparison
- Provide recommendations on alternatives around outsourcing vs. insourcing opportunities
- Build a vendor-specific Assessment Scorecard based on performance of current vendor
- Analyze leading practices in similar markets to create a side-by-side comparison of vendors with a focus on service offerings, costs, SLAs and performance
- Develop a Total Cost of Ownership (TCO) summary
- Assist with RFP and contract development, as necessary, based on needs directly related to the above analysis and subsequent recommendations

Based on the results of work completed during March and April, GCHP instructed Optimity to focus the TCO analysis on three areas to bring in-house – the call center, claims processing and encounter data processing. These three areas provide the greatest opportunity in terms of key differentiating capabilities as it relates to performance and how we are viewed by our members and providers. Optimity is scheduled to present GCHP with the Vendor Assessment Report and TCO Summary on May 13, 2016.

Noteworthy Activities – Additional projects/activities that Operations continues to lead or be involved in:

- **IVR Optimization** – GCHP is making revisions to the IVR to improve the customer experience for both members and providers through better messaging and consolidation of prompts. Changes should be in place by the end of June.

- **Fraud Waste & Abuse (FWA)/Cost Containment RFI/RFP** – Procurement issued a Request For Information (RFI) on April 19, 2016 to identify vendor offerings which will assist GCHP in our FWA and Cost Containment activities. RFI responses were due by May 6, 2016 and are currently being evaluated. A Request For Proposal is targeted for release by the end of May.

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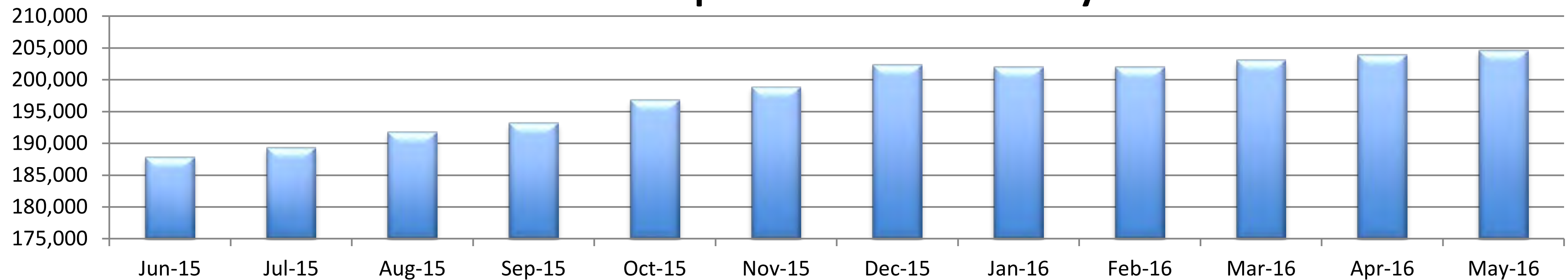
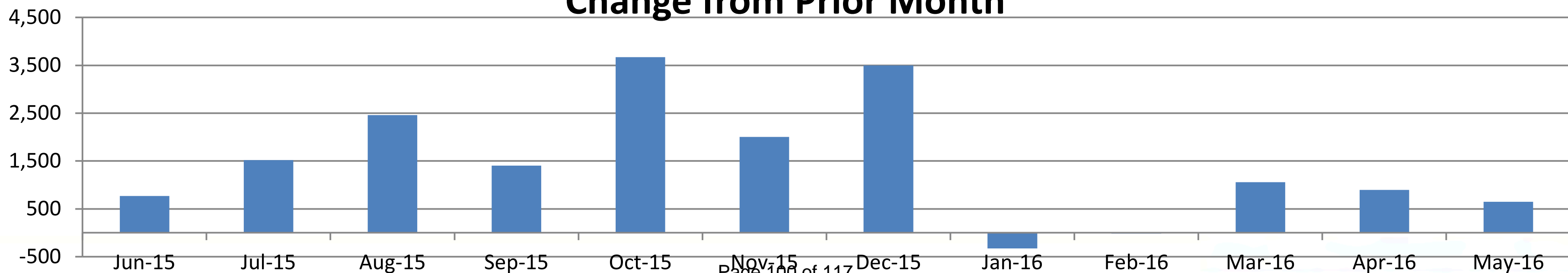
GCHP Membership

Total Membership as of May 1, 2016 – 204,619

*New Members Added Since January 2014 – 86,107



	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Active Membership	187,801	189,321	191,783	193,195	196,857	198,863	202,362	202,037	202,019	203,075	203,969	204,619



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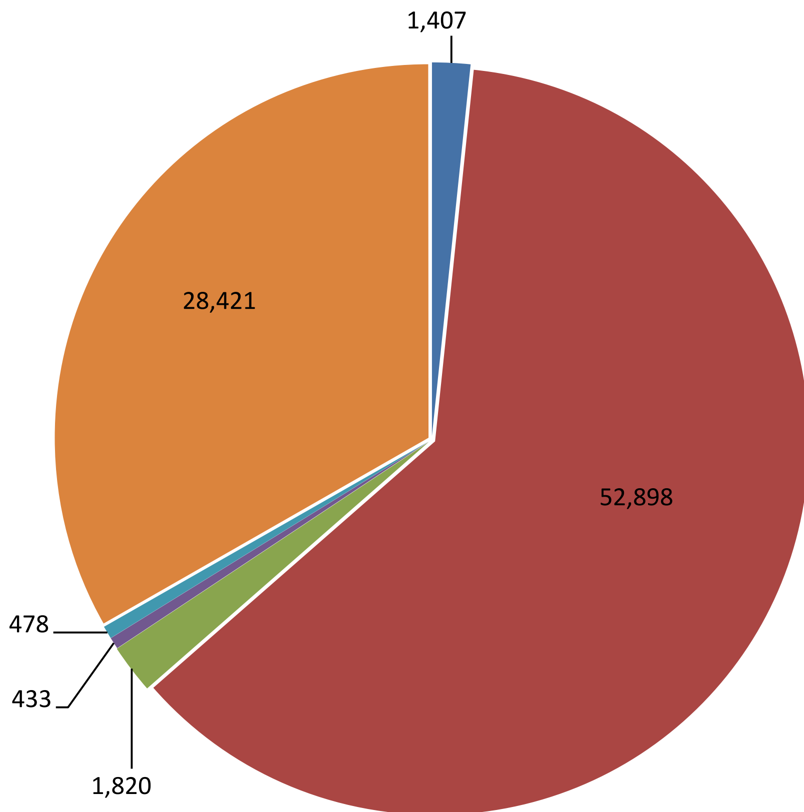
Membership Growth

GCHP New Membership Breakdown



- L1 - Low Income Health Plan - 1.65%
- M1 - Medi-Cal Expansion - 61.90%
- 7U - CalFresh Adults - 2.13%
- 7W - CalFresh Children - 0.51%
- 7S - Parents of 7Ws - 0.56%
- Traditional Medi-Cal - 33.26%

GCHP Membership Churn Summary – FY 2015-16

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Membership from Prior Month	187,801	189,321	191,783	193,185	196,857	198,863	202,362	202,037	202,019	203,075	203,969
Prior Month Members Inactive in Current Month	5,352	4,448	5,280	3,371	4,141	3,236	6,906	6,139	6,078	5,723	5,642
Sub-total	182,449	184,873	186,503	189,814	192,716	195,627	195,456	195,898	195,941	197,352	198,327
Percentage of Inactive Members from Prior Month	2.85%	2.35%	2.75%	1.74%	2.10%	1.63%	3.41%	3.04%	3.01%	2.82%	2.77%
Current Month New Members	5,068	5,241	5,383	5,503	5,015	5,454	5,794	4,215	5,059	4,742	4,368
Sub-total	187,517	190,114	191,886	195,317	197,731	201,081	201,250	200,113	201,000	202,094	202,695
Percentage of New Members Reflected in Current Membership	2.68%	2.73%	2.79%	2.80%	2.52%	2.70%	2.87%	2.09%	2.49%	2.32%	2.13%
Retroactive Member Additions	1,804	1,669	1,299	1,540	1,132	1,281	787	1,906	2,075	1,875	1,924
Active Current Month Membership	**189,321**	**191,783**	**193,185**	**196,857**	**198,863**	**202,362**	**202,037**	**202,019**	**203,075**	**203,969**	**204,619**
Percentage of Retroactive Members Reflected in Current Membership	0.95%	0.87%	0.67%	0.78%	0.57%	0.63%	0.39%	0.94%	1.02%	0.92%	0.94%

GCHP Auto Assignment by PCP/Clinic as of May 1, 2016

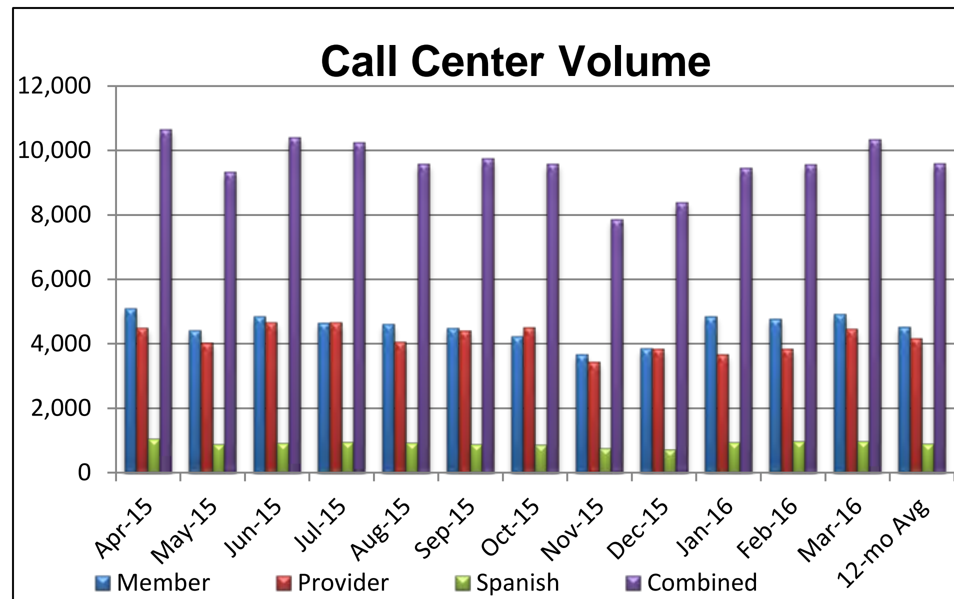
	May-16		Apr-16		Mar-16		Feb-16		Jan-16		Dec-15	
	Count	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
AB85 Eligible	**1,329**		**1,807**		**1,188**		**1,591**		**1,292**		**1,066**	
VCMC	996	74.94%	1,355	74.99%	891	75.00%	1,193	74.98%	969	75.00%	799	74.95%
Balance	333	25.06%	452	25.01%	297	25.00%	398	25.02%	323	25.00%	267	25.05%
Regular Eligible	**1,317**		**1,335**		**1,076**		**1,250**		**944**		**1,051**	
Regular + AB85 Balance	**1,650**		**1,787**		**1,373**		**1,648**		**1,267**		**1,318**	
Clinicas	396	24.00%	426	23.84%	272	19.81%	305	18.51%	251	19.81%	269	20.41%
CMH	171	10.36%	217	12.14%	165	12.02%	193	11.71%	144	11.37%	142	10.77%
Independent	52	3.15%	33	1.85%	23	1.68%	34	2.06%	23	1.82%	39	2.96%
VCMC	1,031	62.48%	1,111	62.17%	913	66.50%	1,116	67.72%	849	67.01%	868	65.86%
Total Assigned	**2,646**		**3,142**		**2,264**		**2,841**		**2,236**		**2,117**	
Clinicas	396	14.97%	426	13.56%	272	12.01%	305	10.74%	251	11.23%	269	12.71%
CMH	171	6.46%	217	6.91%	165	7.29%	193	6.79%	144	6.44%	142	6.71%
Independent	52	1.97%	33	1.05%	23	1.02%	34	1.20%	23	1.03%	39	1.84%
VCMC	2,027	76.61%	2,466	78.49%	1,804	79.68%	2,309	81.27%	1,818	81.31%	1,667	78.74%

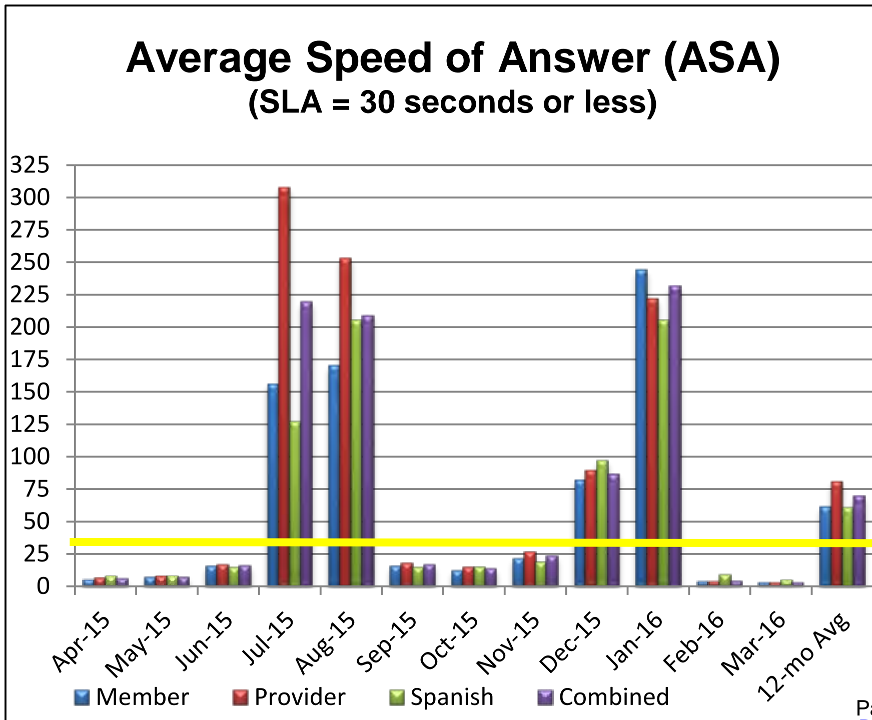
Auto Assignment Process

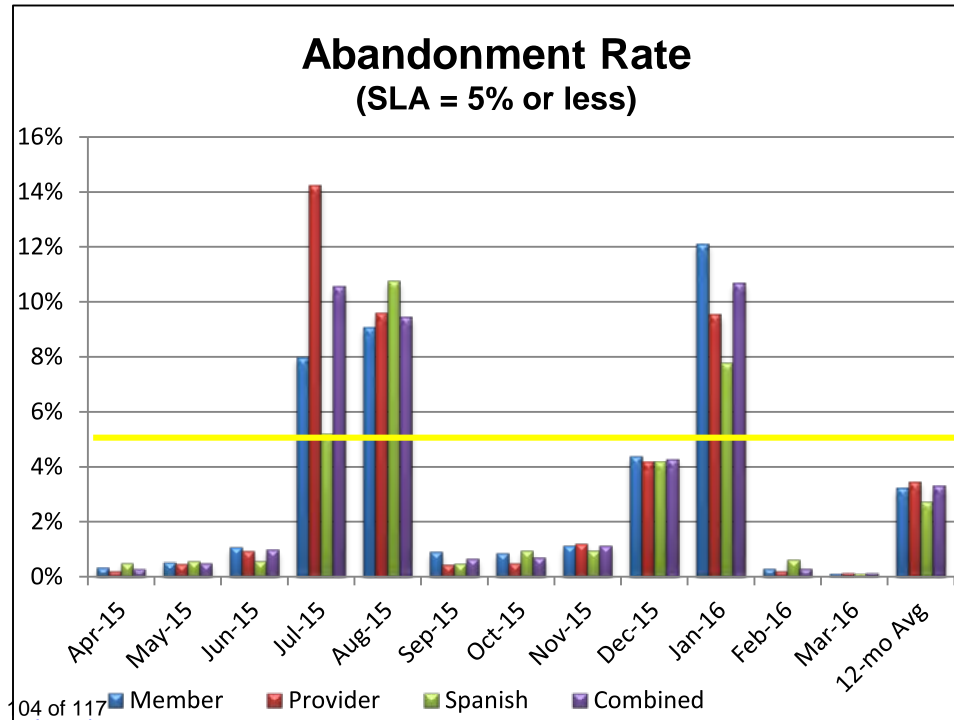
- 75% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85
- The remaining 25% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others
- The County's overall auto assignment results will be higher than 75% since they receive 75% of the AE members plus a 3:1 ratio of all other unassigned members
- VCMC's target enrollment is 65,765
  - ➢ VCMC has 31,111 assigned Adult Expansion members as of May 1, 2016 and is currently at 47.3% of capacity

GCHP Call Center Metrics – March 2016

- The number of calls rose above 10,000 for the first time since July 2015; GCHP received 10,337 calls during March
- Service Level Agreements (SLA) for ASA (3 seconds vs the goal of ≤ 30 seconds) and Abandonment Rate (0.12% vs the goal of ≤ 5%) were both met for March

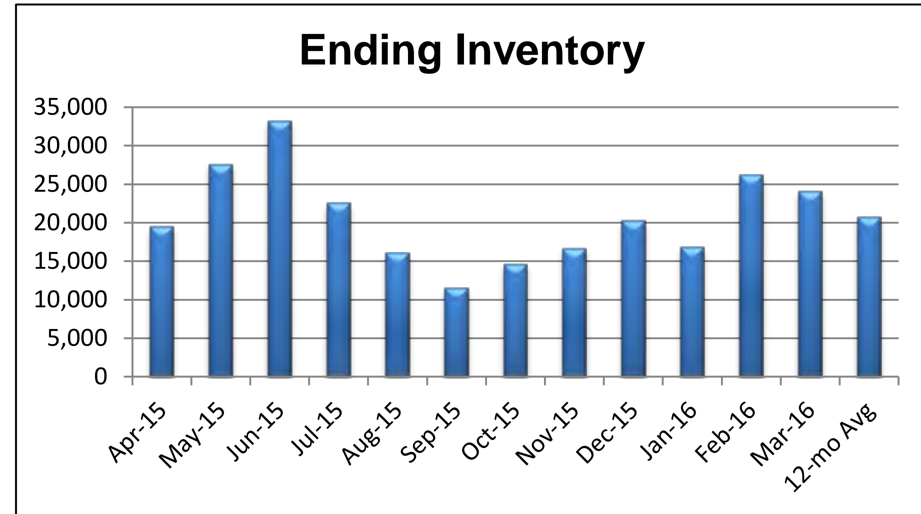


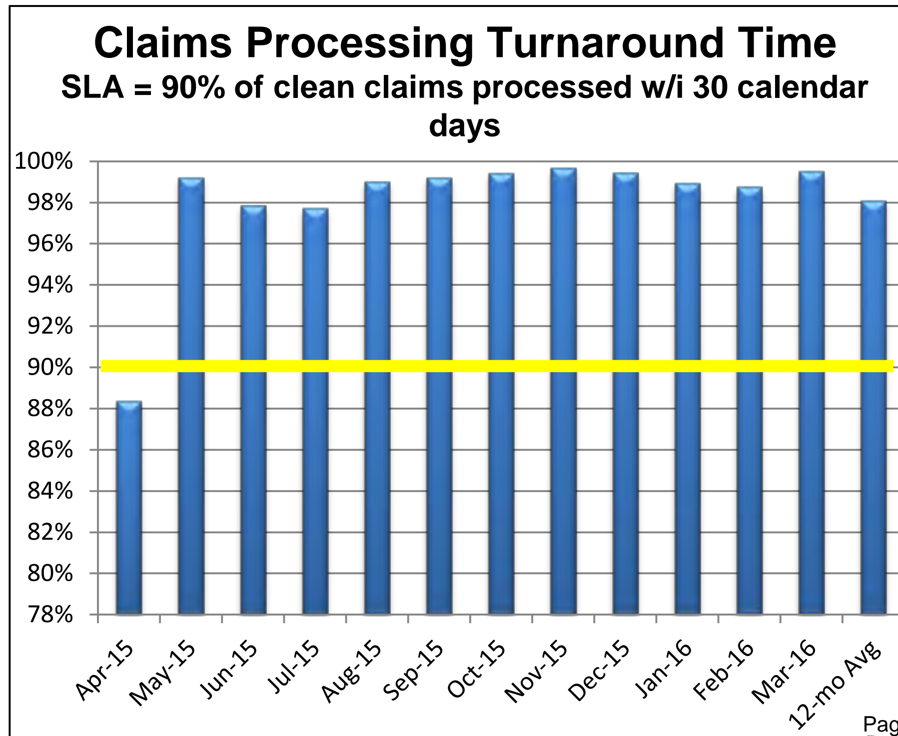


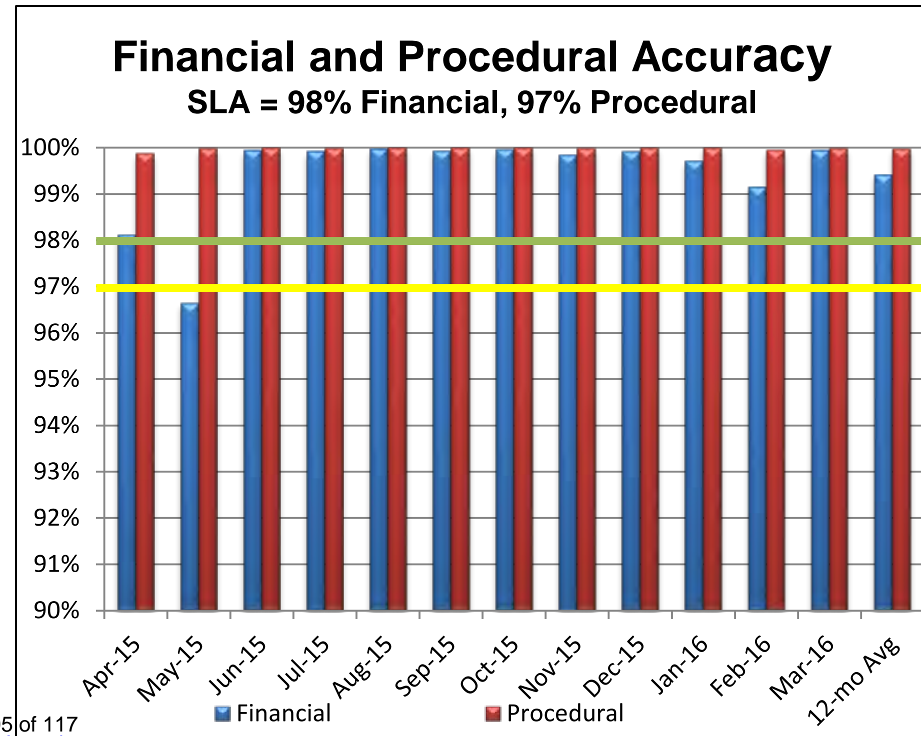


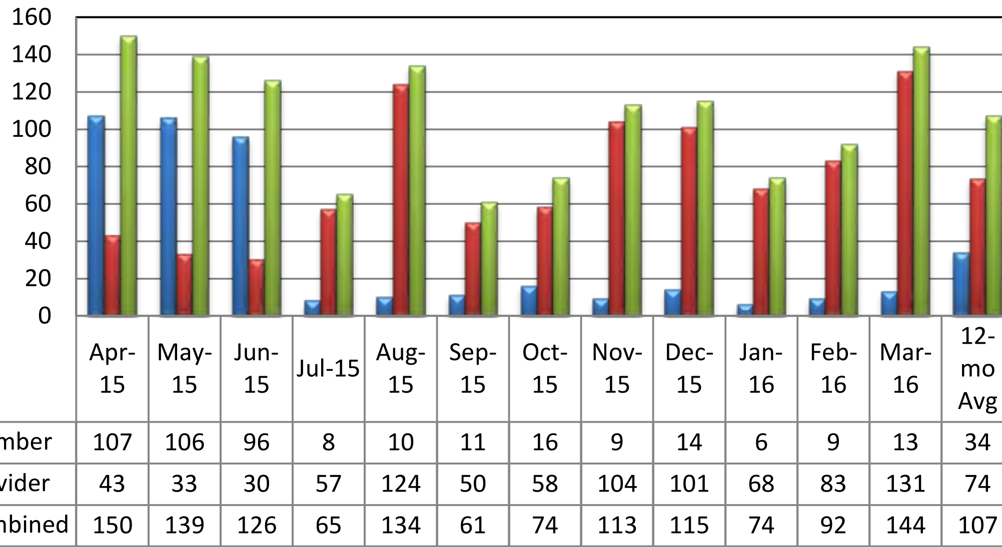
GCHP Claims Metrics – March 2016

- The 30 Day Turnaround Time (TAT) remained in compliance at 99.5%
- Ending Inventory was 24,059 which equates to a Days Receipt on Hand (DROH) of ~3 days vs a DROH ≤ 5 days
- Service Level Agreements (SLAs) for Financial Accuracy (99.94%) and Procedural Accuracy (99.98%) were both met in March





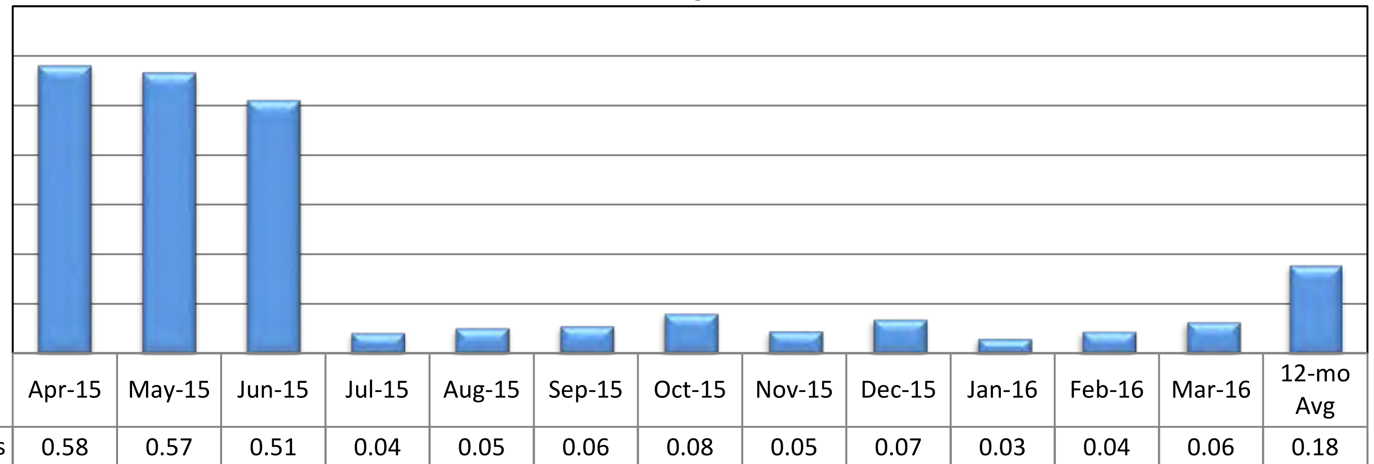




	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	12-mo Avg
Member	107	106	96	8	10	11	16	9	14	6	9	13	34
Provider	43	33	30	57	124	50	58	104	101	68	83	131	74
Combined	150	139	126	65	134	61	74	113	115	74	92	144	107

GCHP Grievance & Appeals Metrics – March 2016

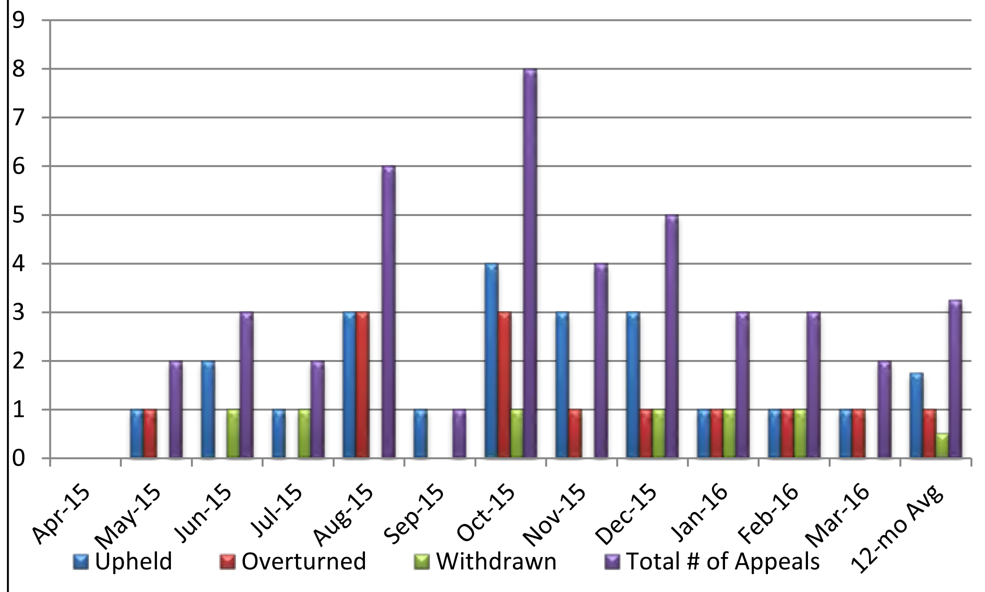
- GCHP received 13 member grievances (0.06 grievances per 1,000 members) and 131 provider grievances during March 2016
- GCHP's 12-month average for total grievances is 107; this number will decrease significantly once the grievances involving balance billing issues drop off in July



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	12-mo Avg
# of Grievance per 1000 Members	0.58	0.57	0.51	0.04	0.05	0.06	0.08	0.05	0.07	0.03	0.04	0.06	0.18

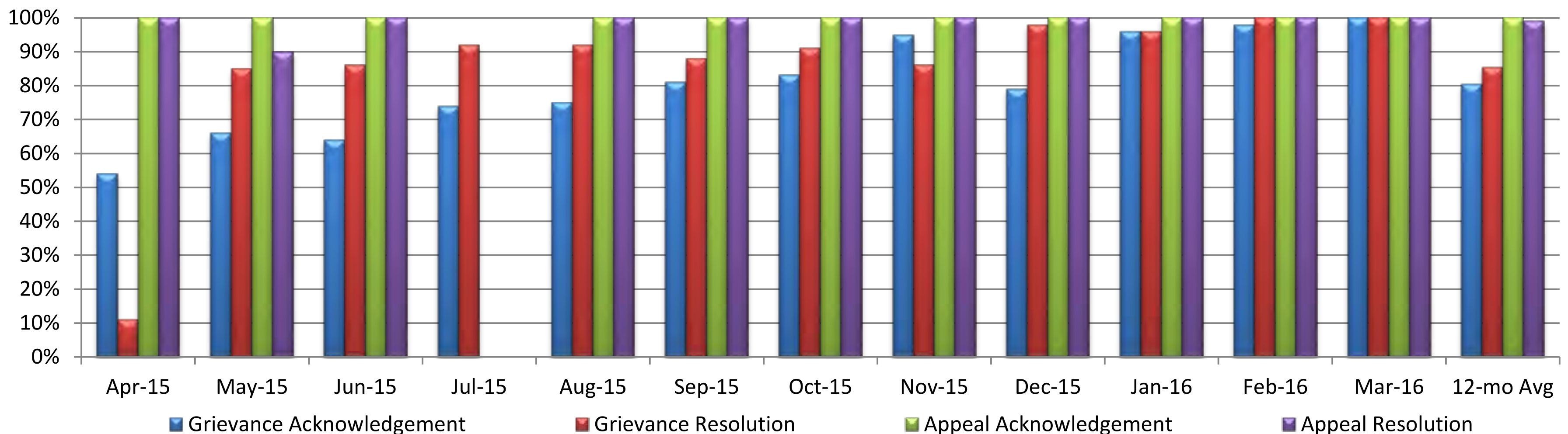
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	12-mo Avg
Membership Count	184,306	187,029	187,801	189,321	193,185	196,857	196,857	198,863	202,362	202,037	202,019	203,075	195,309
Total Member Grievances Filed	107	106	96	8	10	11	16	9	14	6	9	13	34
# of Grievance per 1000 Members	0.58	0.57	0.51	0.04	0.05	0.06	0.08	0.05	0.07	0.03	0.04	0.06	0.18

Note: Balance billing removed as a grievance type as of July 2015



GCHP Grievance & Appeals Metrics – March 2016

- GCHP resolved 2 clinical appeals in March; 1 was upheld and 1 was overturned
- TAT for grievance acknowledgement and resolution reached 100% compliance!
- TAT for appeal acknowledgement and resolution was also 100% compliant during the month of March



Note: A "blank" denotes no grievances or appeals were received during the month

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AGENDA ITEM NO. 11

TO: Gold Coast Health Plan Commission

FROM: Nancy Wharfield, Associate Chief Medical Officer

DATE: May 23, 2016

SUBJECT: Health Services Update

HEALTH SERVICES UPDATE:

Utilization data in the Health Services monthly update to the Commission is based on paid claims compiled by date of service and is lagged by 3 months to allow for partial run out of claims data. Claims data is complete at approximately 6 months. While incomplete, a 3 month lagged snapshot allows us to see an estimate of utilization without waiting for a more complete 6 month report. Administrative days are included in these calculations. Dual eligible members, Skilled Nursing Facility (SNF), and Long Term Care (LTC) data is not included in this presentation.

Utilization Summary

Inpatient utilization metrics for CY 2015 were similar and slightly improved compared with CY 2014. YTD CY 2016 is slightly improved compared with CY 2015. The percentage of Adult Expansion bed days increased in 2015 and currently accounts for nearly half of our bed days by January 2016.

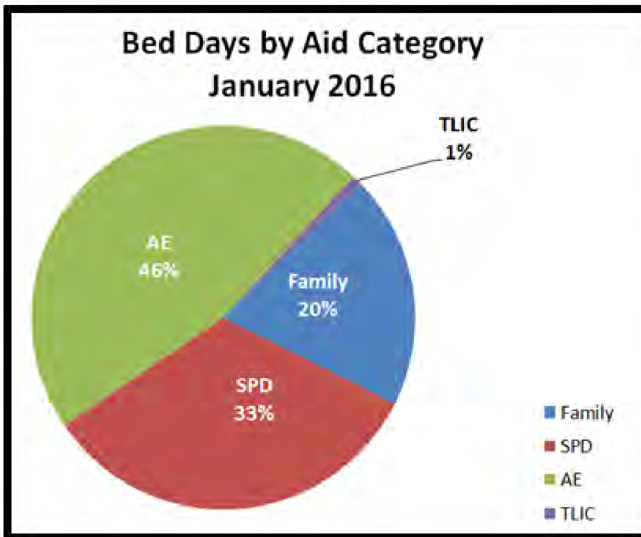
Emergency Department (ED) utilization / 1000 members for CY 2015 (452 ER visits / 1000 members) was slightly lower than CY 2014 (463 visits / 1000 members). YTD CY 2016 is similar and slightly higher than CY 2015. The Family aid code group continues to utilize over half of all ED visits.

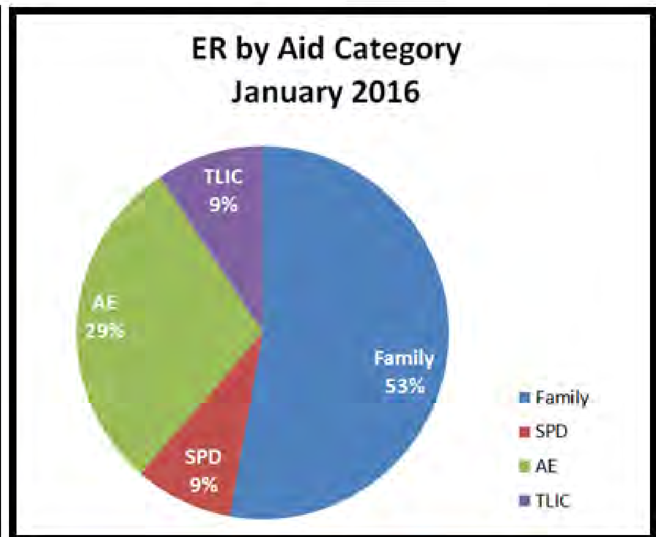
Benchmark: The September 17, 2015 DHCS Medi-Cal Managed Care Performance Dashboard reported 36 ER visits / 1000 member months statewide for all managed care plans for October 2013 – September 2014. GCHP ER utilization / 1000 member months for the same period was 38.

Utilization Per 1000		
	2015	2016 YTD
Inpatient		
Bed days/1000	212	208
Admits/1000	50	50
Average LOS	4	4
ED Utilization		
ED Cases / 1000	452	454
* Data from MedInsight 4/11/16. Data excludes Duals, LTC and SNF.		

Total Volume		
	2015 Total	2016 YTD
Inpatient		
Bed days	36,087	3,168
Admissions	8,555	762
ED Utilization		
ED Cases	77,127	6,926
* Data from MedInsight 4/11/16. Data excludes Duals, LTC and SNF.		

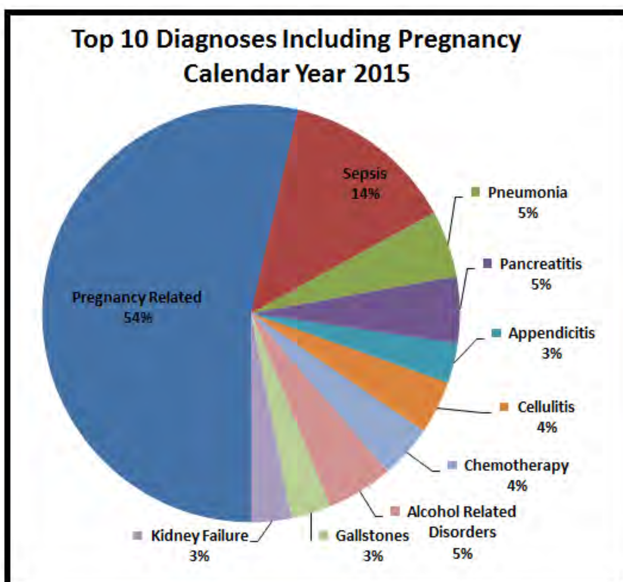
Monthly Averages		
	2015	2016 YTD
Inpatient		
Bed days	3,007	3,168
Admissions	713	762
ED Utilization		
ED Cases	6,427	6,926
* Data from MedInsight 4/11/16. Data excludes Duals, LTC and SNF.		

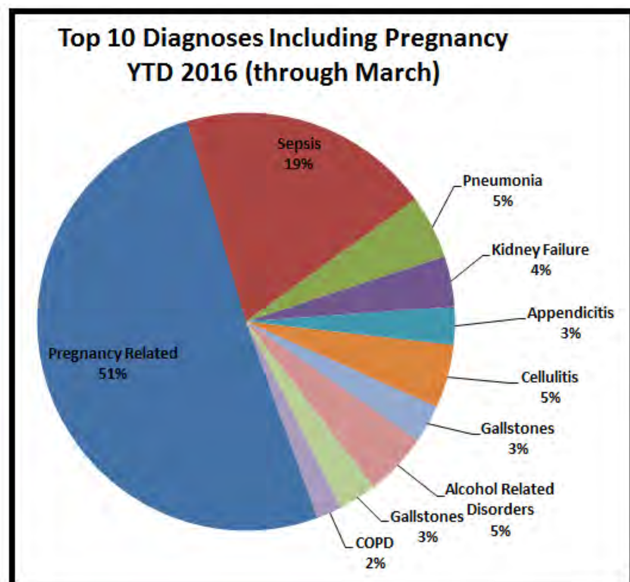


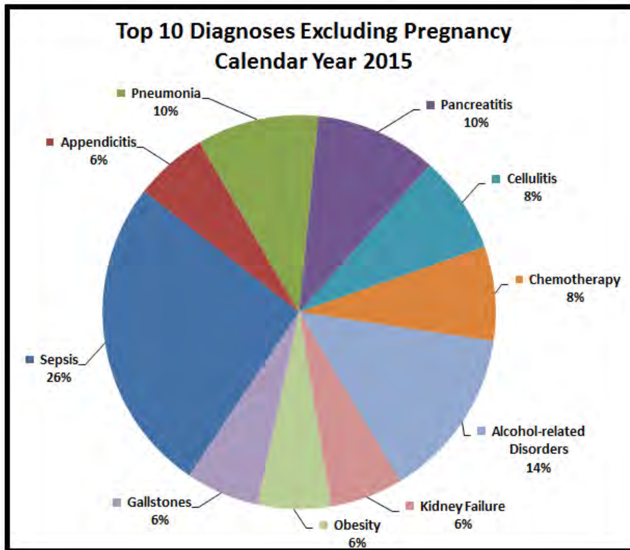


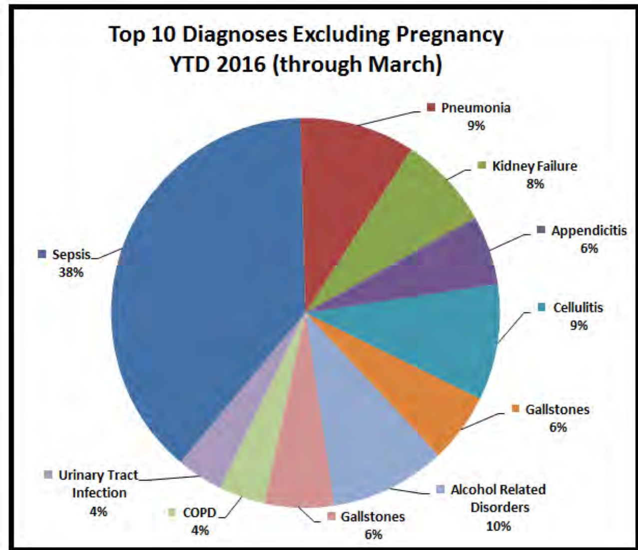
Top Admitting Diagnoses

Pregnancy related diagnoses continue to overshadow all other admitting diagnoses for CY 2015 and YTD 2016. Pneumonia, appendicitis, cellulitis, and sepsis were also top diagnoses for CY 2014 – YTD 2016. When pregnancy is excluded, sepsis, alcohol-related disorders, pneumonia, and pancreatitis are the leading diagnoses for both CY 2014 through YTD 2016.



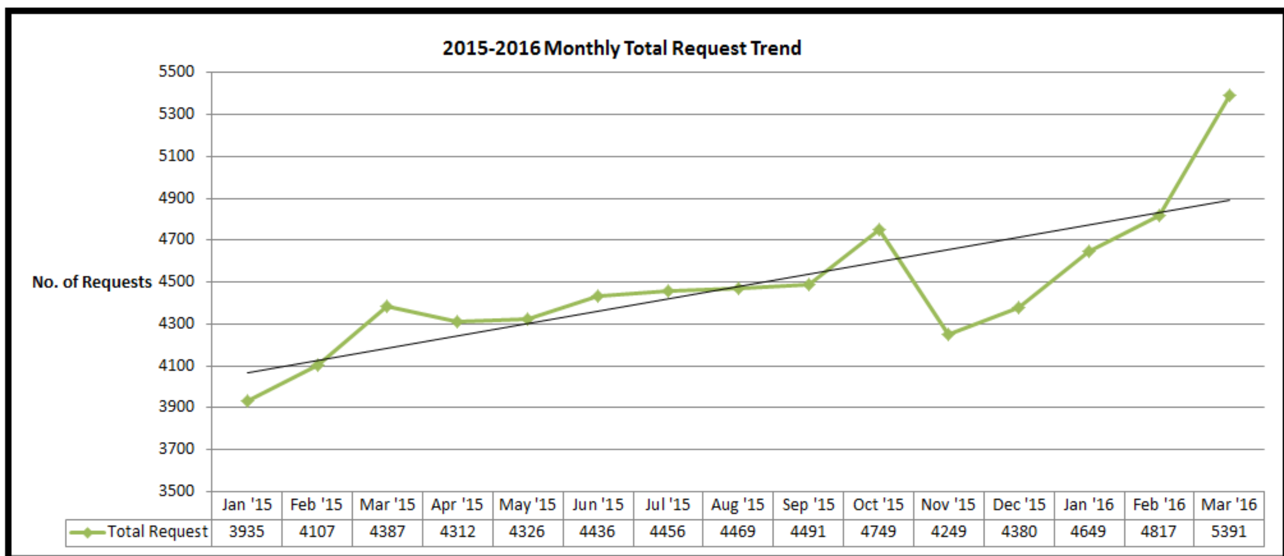




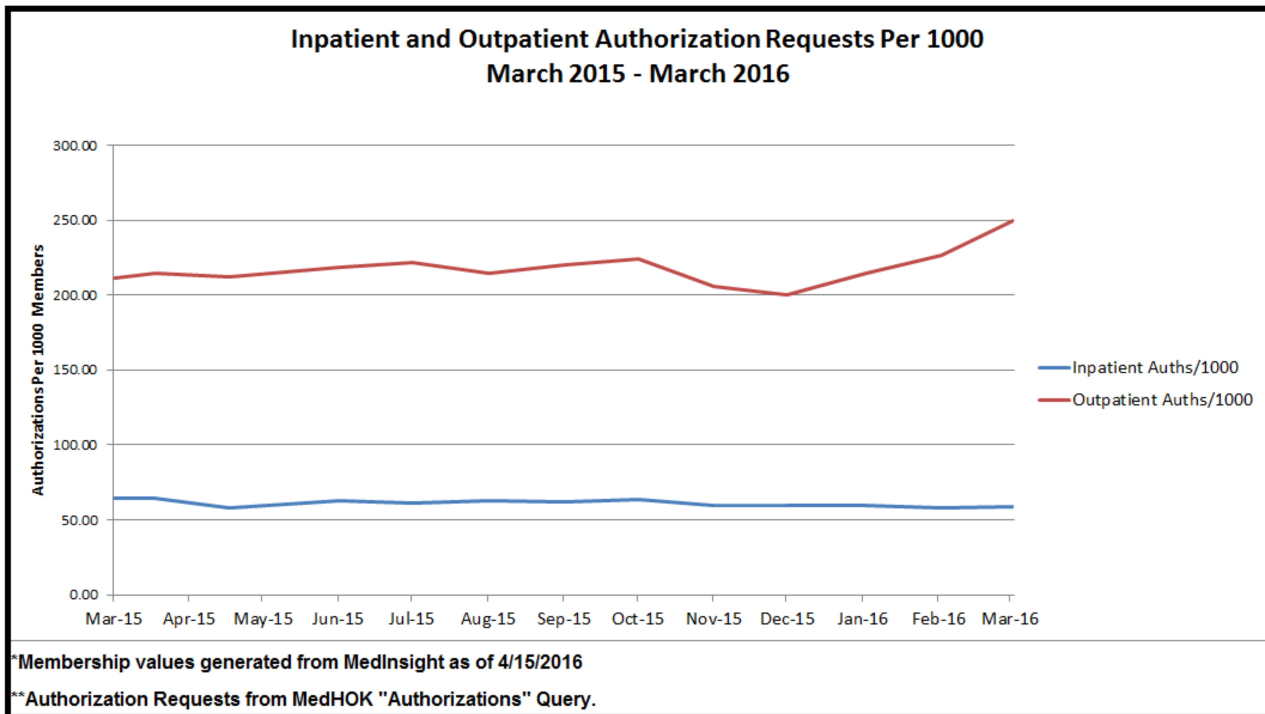


Authorization Requests

Requests for outpatient service continue to outnumber requests for inpatient service. Outpatient service requests for CY 2015 were 214 / 1000 members compared to 230 /1000 members for YTD 2016. Requests for inpatient service for CY 2015 were 62 / 1000 members compared to 59 / 1000 members for YTD 2016.



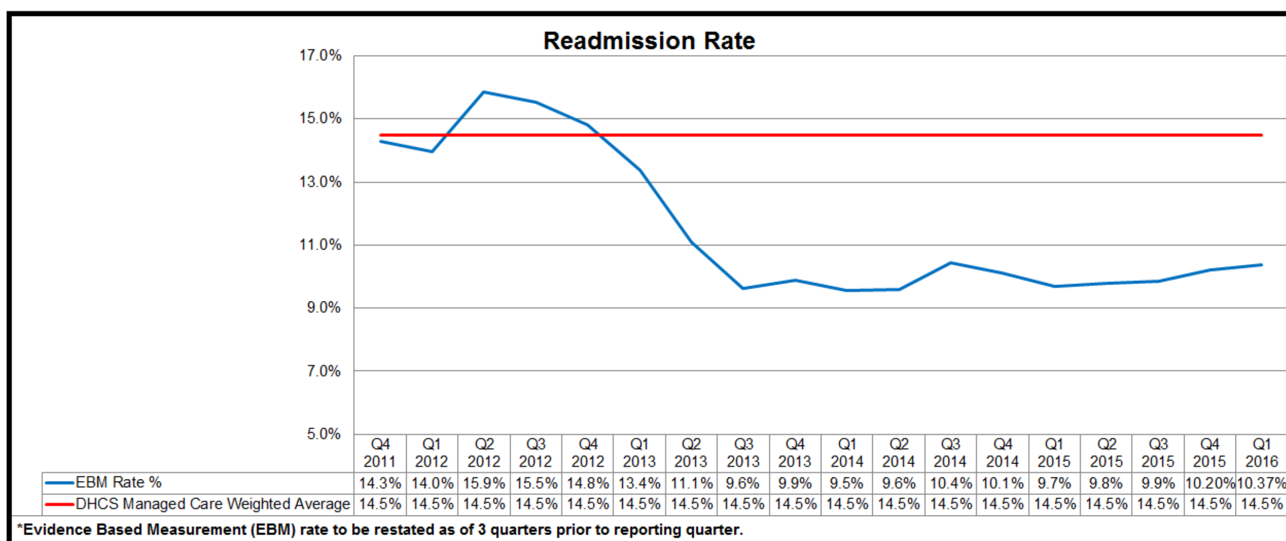
	Jan '15	Feb '15	Mar '15	Apr '15	May '15	Jun '15	Jul '15	Aug '15	Sep '15	Oct '15	Nov '15	Dec '15	Jan '16	Feb '16	Mar '16
Total Request	3935	4107	4387	4312	4326	4436	4456	4469	4491	4749	4249	4380	4649	4817	5391



Readmission Rate

The readmission rate has remained between 9.5% and 10.4% since the 3rd quarter of 2013.

Benchmark: The weighted average for the HEDIS 2013 All Cause Readmission Rate from the February 2014 Medi-Cal Managed Care Performance Dashboard is approximately 14.5%.



	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016
EBM Rate %	14.3%	14.0%	15.9%	15.5%	14.8%	13.4%	11.1%	9.6%	9.9%	9.5%	9.6%	10.4%	10.1%	9.7%	9.8%	9.9%	10.20%	10.37%
DHCS Managed Care Weighted Average	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%

*Evidence Based Measurement (EBM) rate to be restated as of 3 quarters prior to reporting quarter.

Clinical Grievances and Appeals
For CY 2015, the average number of clinical grievances/quarter was 32. There were 26 clinical grievances for Q1 2016. There was an average of 9 appeals/ quarter for CY 2015 – Q1 2016.

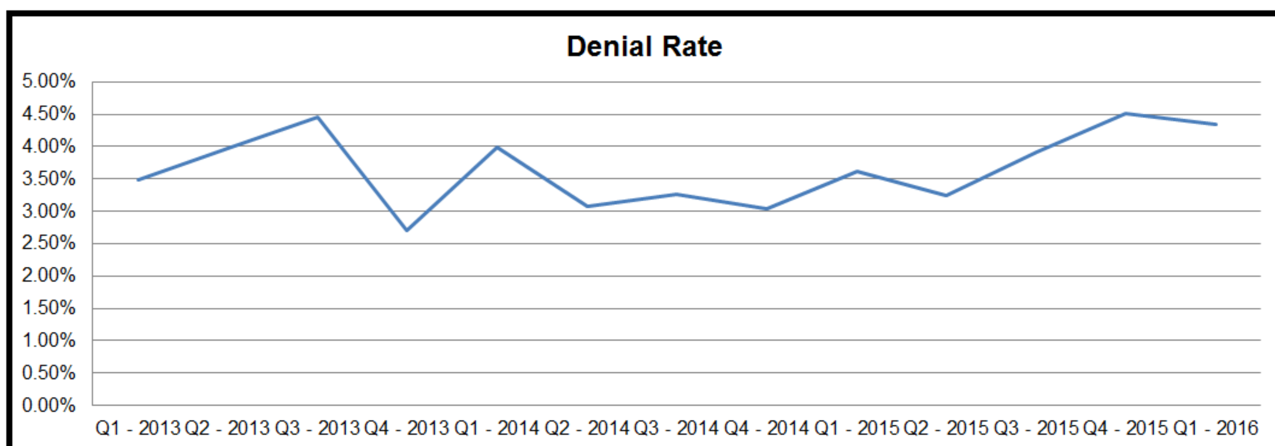
Benchmark: For Q3 2015, 79% of all GCHP grievances were about quality issues and 17% were about access. The September 17, 2015 Medi-Cal Managed Care Performance Dashboard reports 38 % of Q1 2015 grievances statewide were about quality issues and 16% were about access.

Clinical Grievances & Appeals

QTR	Grievance Total	Appeals Total	Upheld	Partial Overturn	Overturned	Withdrawn	Dismissed
2015							
Q1	41	4	1 (25%)	-	3 (75%)	-	-
Q2	34	6	3 (50%)	-	3 (50%)	-	-
Q3	24	8	4 (50%)	-	4 (50%)	-	-
Q4	29	19	11 (58%)	-	5 (26%)	3 (16%)	-
2016							
Q1	26	9	3 (34%)	-	4 (44%)	1 (11%)	1 (11%)

Denial Rate
Denial rate is calculated by dividing all not medically necessary denials by all requests for service. Denials for duplicate requests, member ineligibility, rescinded requests, other health coverage, or CCS approved case are not included in this calculation.

Since 2013, the denial rate has ranged between 2.7% and 4.5%. The average denial rate for CY 2015 was 3.8% and for YTD 2016 is 4.3%.



AGENDA ITEM NO. 12

TO: Gold Coast Health Plan Commission

FROM: Lupe Gonzalez, MPH, PhD, Director of Health Education, Outreach, Cultural and Linguistic Services

DATE: May 23, 2016

SUBJECT: Community Outreach Summary Report – April 2016

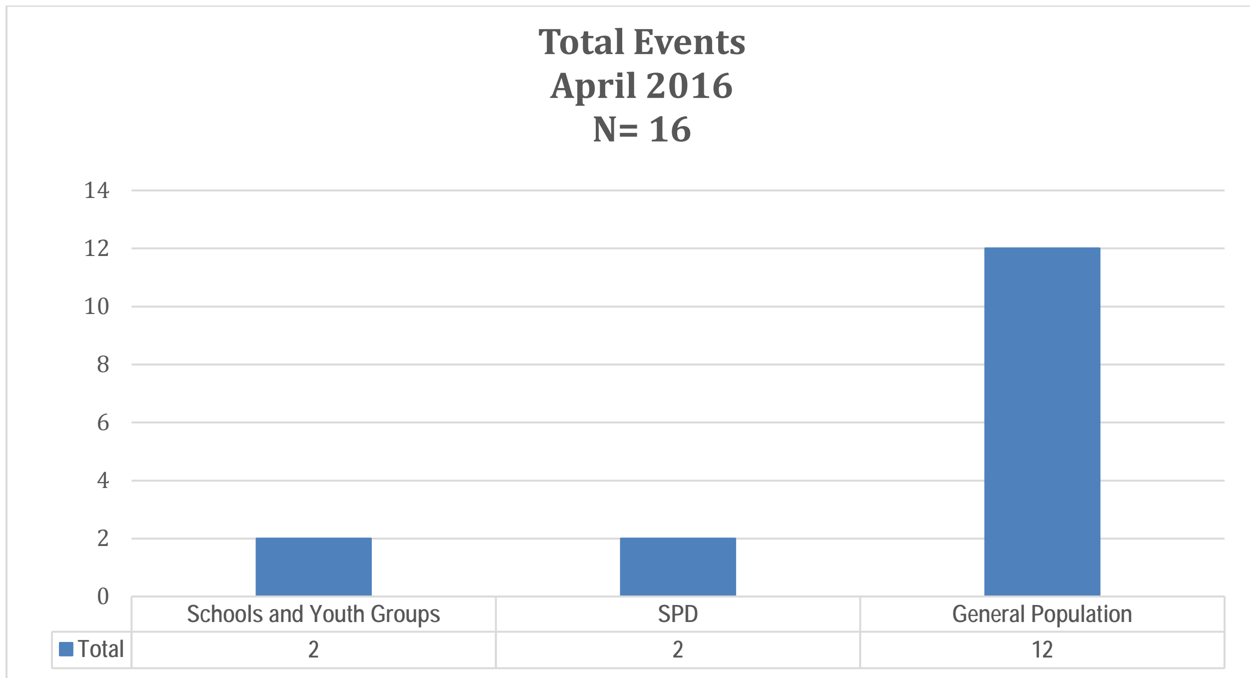
SUMMARY:

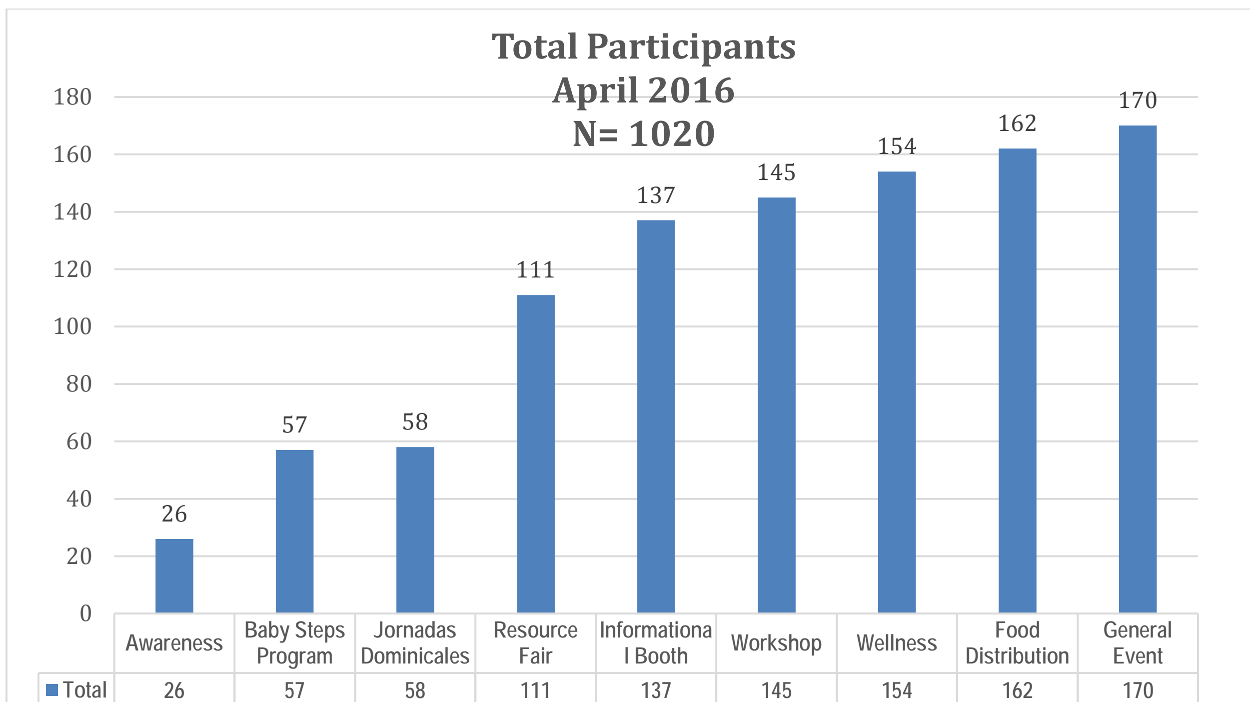
Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. The health education and outreach team maintains a positive presence in the community by working with various county public health departments, community based organizations, schools, senior centers, faith-based centers and social service agencies.

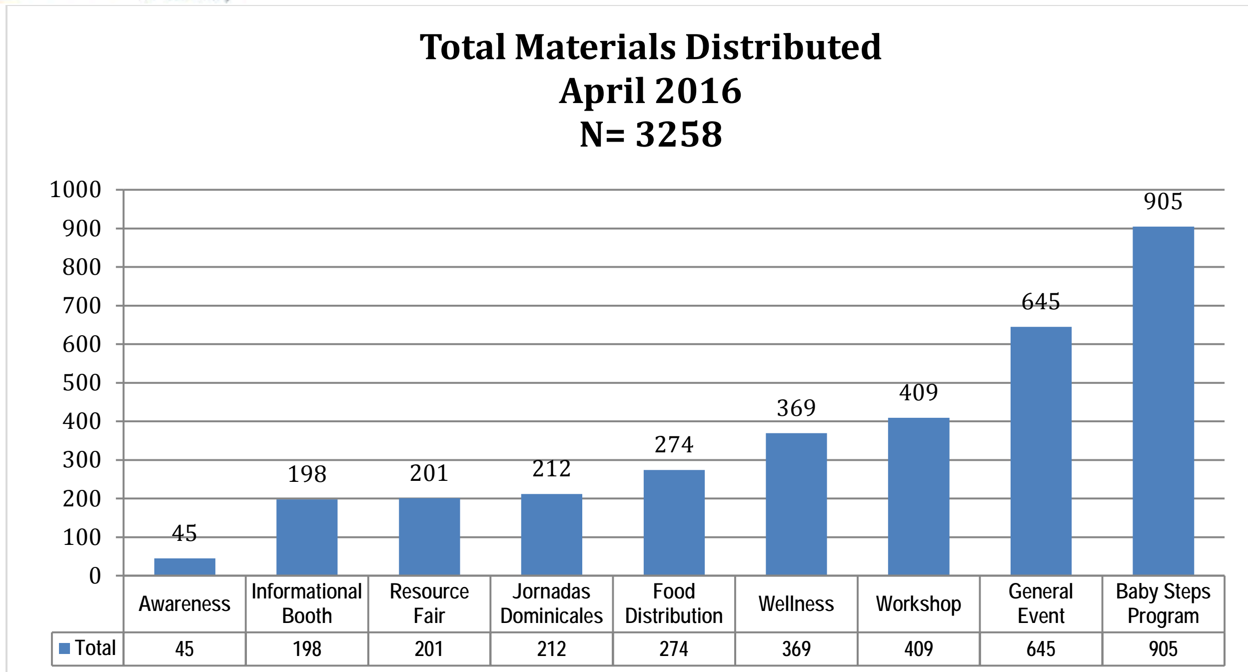
Below is a summary of activities during the month of April.

Outreach Activities – April 2016

GCHP participated in 16 community health education and outreach events. The majority of individuals contacted were from events that focused on reaching the general population and low-income families. A total of 1,020 participants were met and 3,258 health information materials were distributed. Below are charts that highlight the total number of events, participants, and materials distributed during the month of April.


Total Events
April 2016
N= 16
14
12
10
8
6
4
2
0
Schools and Youth Groups
SPD
General Population
Total
2
2
12


Total Participants
April 2016
N= 1020
180
160
140
120
100
80
60
40
20
0
26
57
58
111
137
145
154
162
170
Awareness
Baby Steps Program
Jornadas Dominicales
Resource Fair
Informationa l Booth
Workshop
Wellness
Food Distribution
General Event
Total
26
57
58
111
137
145
154
162
170



	Awareness	Informational Booth	Resource Fair	Jornadas Dominicales	Food Distribution	Wellness	Workshop	General Event	Baby Steps Program
Total	45	198	201	212	274	369	409	645	905

Outreach Events

The 5th Annual Community Resource Fair was held Saturday, May 14, from 10:00 AM to 2:00 PM at Plaza Park in downtown Oxnard. The event hosted more than 40 local health and social service organizations including free health screening, child development, behavioral health, diabetes education, employment resources, and much more. GCHP had several exhibit booths highlighting resources from various departments including Health Education, Care Management, Member Services, and Pharmacy. Information about the resource fair may be found on the GCHP website.

www.goldcoasthealthplan.org
5th Annual Community Resource Fair
Free Health Screenings
Entertainment
Resource Booths
Giveaways
Saturday, May 14, 2016
10:00 am – 2:00 pm
Plaza Park, Downtown Oxnard
500 S. 'C' Street, Oxnard, CA 93030
For more information please call the Health Education Department at:
805.437.5500
or email outreach@goldchp.org
Gold Coast Health Plan
If you need interpreter services or special assistance to participate, please contact us by April 22, 2016.

www.goldcoasthealthplan.org
5a Feria Anual de Recursos Comunitarios
Exámenes de Salud Gratuitos
Entretenimiento
Mesas de Recursos
Regalos
sábado, 14 de mayo de 2016
10:00 am – 2:00 pm
La Placita en el Centro de Oxnard
500 S. 'C' Street, Oxnard, CA 93030
Para más información por favor llame al Departamento de Educación para la Salud al:
805.437.5500
O por email outreach@goldchp.org
Gold Coast Health Plan
Si necesita servicios de intérprete o asistencia especial para participar, por favor comuníquese con nosotros antes del 22 de abril de 2016.

Upcoming Outreach Events

The American Diabetes Association is partnering with GCHP and other local health care agencies to host a "Diabetes Day" community resource fair. The resource fair will be held on Saturday, June 11, at Pacifica High School in Oxnard. The event will feature health screenings, cooking demonstrations, physical activities (Zumba demonstration) and much more. The event is still in the planning process and more information will be available on the GCHP website.

Sponsorship Award Update

Summary

The Gold Coast Health Plan (GCHP) Sponsorship Committee reviewed and funded the following sponsorship application in April:

- **Mixteco/Indigena Community Organizing Project (MICOP):** The committee has approved funding MICOP's Night in Oaxaca fundraising event by providing sponsorship at the $2,500 Tequio level. GCHP is proud of MICOP's work and efforts to build a strong and healthy community for the indigenous community and their families in Ventura County.

The Commission Board has approved the following two requests for funding:

- **VENTURA COUNTY AREA AGENCY ON AGING**: The committee approved $20,000 to partner with the VCAAA's Senior Nutrition Program (SNP) for Ventura County's aged 60+ population, adults with one or more disabilities and their caregivers. The program provides daily home-delivered meal services and has a proven outcome of improving the health and well-being of older adults and those who live alone.

- **NATIONAL HEALTH FOUNDATION**: The committee also approved $38,700 to partner with NHF to promote expansion of their Recuperative Care Program to Ventura County. This program would model the two Los Angeles County sites by providing hospitals a discharge option for homeless clients who are not sick enough to remain in the hospital, but too sick to return to the streets or temporary shelters. In addition to helping these clients recover from injury and illness, many of these homeless individuals are connected to critical social and healthcare services.