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

2240 E. Gonzales, Suite 200, Oxnard, CA 93036
Monday, March 25, 2013
3:00 p.m.

AGENDA

CALL TO ORDER / ROLL CALL

PUBLIC COMMENT

1. APPROVE MINUTES
- a. Regular Meeting of February 25, 2012

2. APPROVAL ITEMS
- a. Tatum Contract Amendment
- b. ACS Contract Ratification

3. ACCEPT AND FILE ITEMS
- a. CEO Update
- b. January Financials

4. INFORMATIONAL ITEMS
- a. Tatum Work Update
- b. Medi-Cal Expansion / Bridge / Covered California

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

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

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

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba
Gold Coast Health Plan March 25, 2013 Commission Meeting Agenda *(continued)*
PLACE: 2240 E. Gonzalez, Room 200, Oxnard, CA
TIME: 3:00 p.m.

CLOSED SESSIONS

Closed Session Conference with Legal Counsel – Existing Litigation pursuant to Government Code Section 54956.9 Sziklai v. Gold Coast Health Plan *et al,* VCSC Case No. 56-2012-00428086-CU-WT-VTA

Closed Session Conference with Legal Counsel – Existing Litigation pursuant to Government Code Section 54956.9 Hernandez v. Ventura County Medi-Cal Managed Care Commission, VCSC Case No. 56-2012-00427535-CU-OE-VTA

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

Closed Session Conference with Legal Counsel – Anticipated Litigation Significant Exposure to Litigation pursuant to Government Code Section 54956.9(b) (One Case)

Closed Session pursuant to Government Code Section 54957(e)
Public Employee Performance Evaluation
Title: Chief Executive Officer

Announcement from Closed Session, if any.

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

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

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

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

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Commission Meeting Minutes
February 25, 2013
(Not official until approved)

CALL TO ORDER

Chair Gonzalez called the meeting to order at 3:04 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

The Pledge of Allegiance was recited.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Maylee Berry, Medi-Cal Beneficiary Advocate
Anil Chawla, MD, Clinicas del Camino Real, Inc.
Lanyard Dial, MD, Ventura County Medical Association
Laurie Eberst, Private Hospitals / Healthcare System
David Glyer, Private Hospitals / Healthcare System
Robert Gonzalez, MD, Ventura County Health Care Agency
Peter Foy, Ventura County Board of Supervisors (arrived at 3:07 p.m.)
Catherine Rodriguez, Ventura County Medical Health System

EXCUSED / ABSENT COMMISSION MEMBERS
John Fankhauser, MD, Ventura County Medical Center Executive Committee
Robert S. Juarez, Clinicas del Camino Real, Inc.

STAFF IN ATTENDANCE
Michael Engelhard, CEO
Nancy Kierstyn Schreiner, Legal Counsel
Michelle Raleigh, CFO
Traci R. McGinley, Clerk of the Board
Charlie Cho, MD, Chief Medical Officer
Nancy Wharfield, MD, Associate Medical Officer
Sherry Bennett, Provider Network Manager
Guillermo Gonzalez, Government Relations Director
Lupe Gonzalez, Manager of Health Education & Disease Management
Jennifer Palm, Health Services Manager
Debbie Rieger, Consultant
Melissa Scrymgeour, IT Director
Lyndon Turner, Finance Manager

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

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of January 28, 2013

Commissioner Berry moved to approve the Regular Meeting Minutes of January 28, 2013. Commissioner Dial seconded. The motion carried. **Approved 8-0.**

Supervisor Peter Foy arrived.

SWEAR-IN OF COMMISSIONER

Peter Foy was sworn in as a newly appointed Commissioner of the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan by the Clerk of the Board.

2. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Engelhard reviewed his written report with the Commission.

Chair Gonzalez asked if services provided under Healthy Families would be at Medi-Cal rates after the transition, to which CEO Engelhard responded yes. Further discussion was held as to the transition and the fact that the fee differences are significant enough that some private practitioners may no longer provide services under Healthy Families.

b. December Financials

CFO Raleigh provided an overview of the financials and noted that they had been reviewed in detail by the Executive / Finance Committee on February 7, 2013. The Plan is progressing better than Staff anticipated. Discussion was held regarding LTC's, the percentage cost and costs per member. CEO Engelhard added that Staff is creating a workgroup to look at LTC costs because they represent such a large cost per member.

Commissioner Eberst moved to accept and file the December Financials. Commissioner Dial seconded. The motion carried. **Approved 9-0.**

3. APPROVAL ITEMS

a. County Line of Credit (LOC)

CEO Engelhard reviewed his written report. Staff submitted a plan (the Financial Forecast delivered on December 11, 2012 as part of the CAP response) to the State

regarding the TNE, but has not received comments back. As part of the financial forecast, the State indicated that the Plan needed additional capital support. CEO Engelhard explained that the terms of the new Line of Credit (LOC) would be similar to the current LOC. CEO Engelhard closed noting that the Plan is moving in the right direction, but the existing TNE deficit needs to be addressed.

Commissioner Eberst moved to authorize the CEO to move forward with the Letter of Credit after the Executive / Finance Committee reviews the terms of the current Line of Credit. Commissioner Glyer seconded. The motion carried. **Approved 9-0.**

b. Intergovernmental Transfer (IGT)

CEO Engelhard reviewed his report and added that IGT's are used to bring additional Medicaid funds into counties. An IGT might give the Plan another way to meet the TNE reserve requirements. The size is still being determined by DHCS at this time. Once GCHP receives final quantification of the maximum IGT amount, the executed agreements would need to be returned to the State within approximately thirty (30) to sixty (60) days. Additionally, the IGT requires Centers for Medicare and Medicaid Services (CMS) approval. If approved, it is expected that the IGT funding would occur before September 30, 2013.

Commissioner Foy moved to authorize the CEO to continue to work through the IGT and have discussions with the State and County. Commissioner Dial seconded. The motion carried. **Approved 9-0.**

c. Quality Improvement Plan

CMO Cho reviewed his report which highlighted the Quality Improvement (QI) Plan, its goals and achievements. The mission and purpose of the QI Program is "to improve the health and well-being of the people of Ventura County by providing access to high quality medical services." Accordingly, the QI Program strives to continuously improve the care and quality of service for GCHP's members. The QI Program involves all aspects of operations and is therefore organized to include virtually all departments of GCHP.

Commissioner Dial moved to accept, file and approve the Quality Improvement Plan. Commissioner Foy seconded. The motion carried. **Approved 9-0.**

4. CONSENT ITEMS

a. FY 2012-13 Financial Audit Contract

Commissioner Dial moved to approve the Consent Item. Commissioner Eberst seconded. The motion carried. **Approved 8-0**, as Commissioner Foy was not in the room**.**

5. INFORMATIONAL ITEMS

a. Utilization Management / Case Management Initiatives

Dr. Wharfield provided an overview of Utilization and Care Management (UM/CM). The Utilization Management Department is staffed by nurses who specialize in prior authorization, continued stay review, or discharge planning. Requests are reviewed against Milliman Care Guidelines (16th Edition), a national evidence-based review resource. A provider may respond to a denial with a request for Peer to Peer Consultation or with an Appeal. Case Management is performed by specially trained nurses and 1 social worker and provides 1:1 facilitation of care through a personalized care plan which engages the support of family and health care providers.

The areas of focus for UM/CM for 2013 are inpatient utilization, readmission rate, and emergency room utilization.

Inpatient Utilization: the utilization of inpatient services can be impacted through the use of improved continued stay reviews, enhanced discharge planning, and intensified home health follow-up at discharge.

Readmission Rate: This rate can be improved by enhancing discharge planning, home visits and CM referral.

ER Utilization: ER visits and top diagnoses for those visits were presented. ER utilization can be managed through member education, implementing a 24 nurse advice line, CM for over utilizers and partnering with ER rooms to receive real-time encounter data.

b. Provider Advisory Committee (PAC) Update

CEO Engelhard explained that the information covers the PCP rate increase under the Affordable Care Act. The item was reviewed in great detail at the recent PAC meeting, but the Plan is waiting on the State to provide all required guidelines on implementation.

c. Financial Forecast Update

CEO Engelhard highlighted that this update shows additional detail on how Staff is tracking the financial forecast that was submitted to the State. CFO Raleigh added that the Plan is ahead of schedule in terms of progress and results.

d. Healthy Families Transition to Medi-Cal

CEO Engelhard noted that the Healthy Families Transition material was presented to the PAC at its last meeting as well. Staff will bring proposals of how the network will look in order to take care of the transitional members, out-reach plans; as well as how the Plan will work with the community about the changes in benefits between Healthy Families and Medi-Cal.

e. Medical Management System Replacement

CEO Engelhard stated that the Executive / Finance Committee saw this item as well; the Plan is doing an RFP on a Medical Management System.

f. Tatum Work Update

CEO Engelhard noted that the information provided covers areas that the consultants are assisting GCHP.

g. Incurred But Not Reported (IBNR) Information

Chair Gonzalez stressed that the IBNR presentation is very important for Commissioners and people in general that are not in health care plans to review in order to understand the IBNR and TNE better.

COMMENTS FROM COMMISSIONERS

Commissioner Dial complimented Dr. Cho for taking on the formulary and for providing one that is both broad in coverage and provides cost savings to the Plan.

Chair Gonzalez complimented CEO Engelhard on the recent hires to the Plan and added that the Plan appears to be working its way out of its problems.

Commissioner Foy added that he was glad it was going the right way and that it was good to see all of the things going on in the Plan and at the Commission.

Commissioner Berry thanked Dr. Cho for taking on all of the work that he does at the Plan.

CLOSED SESSION

Legal Counsel Kierstyn Schreiner explained the purpose of the Closed Session items.

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 5:15 p.m. regarding the following items:

Closed Session Conference with Legal Counsel – Existing Litigation pursuant to Government Code Section 54956.9 Sziklai v. Gold Coast Health Plan *et al* VCSC Case No. 56-2012-00428086-CU-WT-VTA

Closed Session Conference with Legal Counsel – Existing Litigation pursuant to Government Code Section 54956.9 Hernandez v. Ventura County Medi-Cal Managed Care Commission-VCSC Case No. 56-2012-00427535-CU-OE-VTA

Closed Session pursuant to Government Code Section 54957(e)
Public Employee Performance Evaluation
Title: Chief Executive Officer

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 5:55 p.m.

Legal Counsel Kierstyn Schreiner announced that there was no reportable action.

ADJOURNMENT

Meeting adjourned at 5:59 p.m.

AGENDA ITEM 2a

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, Chief Executive Officer

Date: March 25, 2013

RE: Request for Contract Extension

SUMMARY:
Gold Coast Health Plan (GCHP or "Plan") requests the extension of the Tatum contract for two Consultants. The Plan is requesting to extend the contract for the following:

1. Interim Chief Operating Officer services, and
2. Senior IT / Operations Consultant providing project management and technical support for upcoming Plan-to-Plan transitions and project management services.

BACKGROUND:
The Gold Coast Health Plan Commission retained Tatum beginning in April 2012 to assist the Plan with stabilizing the organization both operationally and financially. The relationship with Tatum has continued at various levels of support since that time.

In November, the Plan extended the contract for this support from Tatum's resources through the end of March 2013 to address needs primarily related to the work on the DHCS Corrective Action Plan (CAP). The monthly cost of these three consultants is $100,000. That work has been completed.

The existing contract amendment, which expires on March 31, 2013, is for three professional consultants doing work as:

1. Interim Chief Operating Officer
2. Senior IT / Operational Consultant
3. Plan Operations Consultant

The Plan is moving into another important phase which will require considerable efforts above what existing staff can provide. Among these efforts are:

- Preparing for the Healthy Families transition into Medi-Cal, increasing membership by approximately 20,000 effective August 1, 2013 but requiring planning to begin in early 2013.
- Implementing multiple plan-to-plan, fully-delegated, capitated contracts. This will require the Plan to significantly increase its oversight and compliance programs

since GCHP will be the regulator for the delegated sub-contractor. Senior leadership will be required to coordinate these efforts.

- Implementing the PCP rate increase as required by the Affordable Care Act (ACA). The Plan is waiting for guidance from DHCS on implementation.
- Implementing DRGs July 1, 2013 for all out of network hospitals
- Supporting work to increase the auto-adjudication rate of clean claims to at or greater than 60% by June 30, 2013. This is part of a commitment made by the Plan to DHCS emanating from the October 2012 CAP.
- Responding to the DHCS Medical Audit Review which was conducted in December 2012. The Plan has not received the final report from DHCS as of now, it expects to receive it shortly and that it will contain actions that will require significant resources to address.

DISCUSSION:

The Plan has been aggressively interviewing and recruiting for a Chief Operating Officer candidate to fill this important role. To date, a candidate has not been hired. Having an experienced COO is critical to the success of GCHP. Without a person lined up to take on this role, the Plan needs to continue to rely on Tatum to supply GCHP with an Interim COO. The COO role will been instrumental in leading the efforts for following activities, to name just a few:

1. Staff development, training and realignment to meet Operations needs.
2. Continued management of the ACS / Xerox relationship. The state of the relationship between ACS, IKA and Gold Coast Health Plan is much improved and this is in no small part due to the efforts of the Interim COO.
3. Achieving the above-mentioned auto-adjudication target.
4. Managing some of the operations-oriented work previously performed by the outgoing Plan Operations Consultant.
5. Ensuring the Operations and Provider Network Management Departments are ready for the Healthy Families transition.

The other items listed above in the Background section are largely project-based or time-limited activities that require an experienced person to lead and / or coordinate the efforts of these items, particularly the Plan-to-Plan and related delegated provider issues. Once the new contracts are implemented and issues ironed out, this resource will no longer be needed.

RECOMMENDATION:

- Extend the Tatum contract for up to 90 days with a focus on Chief Operating Officer services and critical health plan transition support. The cost for the two Tatum principals is between $75,000 and $80,000 per month.

CONCURRENCE:
N/A

Attachments:
None.

AGENDA ITEM 2b

To: Gold Coast Health Plan Commissioners

From: Michelle Raleigh, Chief Financial Officer

Date: March 25, 2013

RE: ACS Contract Amendment

SUMMARY:
Staff is seeking ratification of an ACS Health Administration, Inc. (ACS) contract amendment that extended services related to medical management. This extension aligns with the January 1, 2014 scheduled implementation of Gold Coast Health Plan's (GCHP or Plan) new medical management system (MMS). The amendment is effective March 1, 2013 and also reflects a reduction to prior rates.

BACKGROUND / DISCUSSION:
When GCHP was formed, the Plan entered into an agreement with ACS, a division of Xerox Corp., to provide the core systems, staff, operations, and application development support to process and administer membership, claims, and customer service. The original ACS proposal did not account for a MMS solution. GCHP entered into a subsequent agreement with ACS to provide a medical management system (titled "ICMS")which included a provision for ACS to provide nurse staffing to GCHP to support the medical management function.

Included in the medical management services of the ACS contract, nurses utilize tools (e.g., computers, Milliman Care Guidelines software) to provide case and utilization management. This service also includes the use of ICMS. This section of the ACS contract, for nursing, ICMS and other services, had an original expiration date of June 30, 2013.

At the February 28, 2013 GCHP Commission meeting, GCHP staff reported that it is currently pursuing the procurement of a new medical management system. This new system is expected to be operational by January 1, 2014 and will provide for a full replacement of ICMS. Since the existing medical management contract with ACS will expire at that point, GCHP will absorb certain services covered in that agreement. Examples of these services are that nurses will become GCHP employees (vs. ACS employees), GCHP will provide work tools like computers and pay for licenses like the Milliman Care Guidelines.

In anticipation of all these changes, GCHP staff have met with ACS and reviewed various options. Staff determined that the best option consisted of extending the contract from June 30, 2013 to December 31, 2013 and allowing for the flexibility of a month-to-month contract thereafter if needed. This extension aligns with the implementation of the new medical management system on January 1, 2014. Other options were either to have the contract expire on June 30, 2013 (where there would not be time to re-procure the MMS system) or to extend a modified contract with ACS where ACS would only provide the access to the ICMS system at rates more expensive than the current contract.

Staff was able to negotiate a reduced price for the contract extension with expected savings (when compared to current contract rate structure) of approximately $220,000 for period of March 1, 2013 to December 31, 2013.

FISCAL IMPACT:
Overall savings are estimated to be $220,000 (when compared to current contract rates) over the extension period of March 1, 2013 – December 31, 2013.

RECOMMENDATION:
Staff is requesting that the Commission ratify this ACS contract amendment related to medical management.

CONCURRENCE:
N/A.

Attachments:
None.

AGENDA ITEM 3a

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, CEO

Date: March 25, 2013

Re: CEO Update

CHIEF MEDICAL OFFICER UPDATE

Podiatry

Medical care by podiatrists is a non-benefit for GCHP, and these cases must be cared for by orthopedists. Many of these procedures are relatively simple surgical procedures either in the hospital or in outpatient clinics but must be taken care of by specialists. Most of these cases have been cared for at VCMC, but lately the last orthopedist has withdrawn his services leaving no orthopedic specialist, who is willing to take care of these cases at Medi-Cal fee rate. Fortunately, VCMC has podiatrists who are willing to take care of these cases at Medi-Cal rate. If these cases are not properly taken care of in timely manner, complications may cause unnecessary suffering as well as causing costly hospitalizations, which could have been avoided by simple outpatient procedures. Furthermore, in cases of complicated hospital cases they might be transported to an out of County tertiary centers for lack of orthopedists in the County. As a reference VCMC ran their experience data on these procedures from the beginning of GCHP operation of 07/1/11 through 10/31/12 for the 15 months period, which included 55 codes. The total charges for them were $396,720 for which $43,672 were paid by GCHP on the Medi-Cal fee schedule. Annualized, this would come to $34,937.

GCHP staff will bring to the April Commission meeting an action to approve payment for services of podiatrists to treat these conditions at an annual cost of what estimate to be less than $40,000. The alternative of using non contracted orthopedists will be substantially higher even without counting untold amount of costs involved in the event of some of these cases ending up in tertiary hospitals.

Monthly Pharmacy Data

The January monthly report indicated an increase in PMPM pharmacy cost to $36.57. This was largely attributed to the flu epidemic and significant increase of use of Tamiflu and Azithromycin along with the continuing of use of Benefix (for a hemophiliac patient). Data for February indicates that the PMPM pharmacy cost declined to $31.89 to be more in-line with recent experience.

There was no use of Benefix for February and that was a partial contributing factor to the lower costs in February as compared to January. However, Benefix is now administered every other month and has already been dispensed on 3/14 for $140,000, which will probably costs GCHP about $100,000. It will be added to the March statement, will have upward trend for the March PMPM. However, the use of Tamiflu and Azithromycin continued at about the same pace as January.

NCQA HEDIS 2013 Compliance Audit - March 12, 2013
Lead GCHP Facilitator: Julie Booth, Quality Improvement Team

Key Dates

- April 19, 2013 – Preliminary rates due to Health Services Advisory Group (HSAG). The health plan has no prior year data to compare to, and HSAG will use National benchmark data for a first year plan.
- May 15, 2013 – Deadline to complete review of Medical Records
- June 1, 2013 – Medicaid for CA - deadline will probably be June 3rd (Monday). All data needs to be entered into Interactive Data Set Submission (IDSS) or the health plan will be reported to the State. The data will be locked into IDSS no later than June 10th with a final lock date on June 17, 2013 and submission of data to the National Committee on Quality Assurance (NCQA)

Audit Feedback

- Initial report from HSAG will be received in 2 weeks from on-site audit date.
    - Health plan has an opportunity to review low rates
    - Determine what quality improvements are in place to increase rates
- HSAG final report is due on July 15th for all plans.
    - Individual final report is similar to the initial report.
    - HSAG does not provide the comparison of all plans.

Audit Findings
Overall the auditors said GCHP did very well for first year plan. Findings include the following:

- Retro-Eligibility issues although not our responsibility does affect us.
    - Retro claims in Enrollment
        - 6-8 months of retroactivity identified can be excluded from our measures. Some other COHS do not report these. Suggested we discuss with other COHS how they handle their retroactive enrollment.
    - Newborn' s linked to mothers ID
        - Newborn claim to remain under mother until it receives its own member number. Suggestion to find a way to link the newborn claims

paid under the mother to the newborns own member number, then link the two numbers.

- Oversight of vendor data should be an area of focus by the health plan. Suggestion that the Plan monitor at least by volume on a monthly basis:
  - Prescription data, lab data, claims and encounter data
  - Need to monitor that we are receiving all the data throughout the year.
- Medical Record Review
  - The goal is to have less medical record review, by increasing our volume administrative data (claims). The medical record review process can be expensive.
  - The Plan needs to ensure that all encounter data is collected appropriately and on a timely basis.
- Provider Data
  - Provider data is good; recommended we track monthly submissions by provider.
- Supplemental Data
  - Need to obtain documentation from State on how the California Immunization Registry (CAIR) registry data is validated. The documentation must be sent to HSAG for approval.
  - Future supplemental databases - get approval from HSAG auditors first prior to using them in the HEDIS measures.
- Preliminary rates
  - The April 5th data refresh to Verisk from GCHP may improve our administrative and hybrid rates.
  - The auditor suggested the reason some of our rates are low may be related to missing lab values. The Plan is looking into this.

FINANCE UPDATE

Intergovernmental Transfer (IGT) Update

Gold Coast Health Plan (GCHP or Plan) is continuing to work with the State and the County to determine how the Intergovernmental Transfer (IGT) will be structured. The IGT may help temporarily fund a portion of the Plan's tangible net equity (TNE) deficit. The Plan is awaiting available funding calculations from the State and is developing a work plan outlining the steps and deadlines.

Line Of Credit Support from County of Ventura

GCHP has formally requested an additional $5 million dollar line of credit (LOC) from the County of Ventura (per letter sent to the County on March 14, 2013). This LOC is in addition to the $2.2 million dollar LOC that was drawn down in December, 2012. These LOCs will help temporarily fund a portion of the Plan's TNE deficit. The additional $5 million dollar LOC will require approval by the County of Ventura Board of Supervisors.

Drawing down on both lines of credit was recommended by the State, as part of the Corrective Action Plan.

Financial Forecast Refresh

Per the State's February 26, 2013 Request for Additional Information letter, the Plan has "refreshed" or updated the financial forecast provided on December 11, 2011. The refresh included a thorough review and update of all 19 "savings" initiatives covering activities related to improving the Plan's financial position (e.g., revenue increase and expense decrease) and decreasing the TNE deficit. The financial results of this revised forecast were similar to the December 11, 2012 version and reflected the Plan achieving TNE compliance during FY2013-14. No new initiatives were identified; the timing of implementation and value of certain initiatives were updated from the original forecast. Details of this refresh of the financial forecast will be reviewed at the April 4, 2013 Executive/Finance Committee meeting.

HEALTHY FAMILIES TRANSITION UPDATE

Overview

In June 2012, the Legislature passed Assembly Bill (AB) 1494 which provides for the transition of all HFP subscribers to Medi-Cal. This transition has begun state-wide. In Ventura County, the transition of the Healthy Families Program (HFP) will be on August 1, 2013.

Current Ventura County enrollment in the HFP as of February 2013 is as follows:

Plan	Enrollment as of 2/28/2013
Ventura County Health Plan	10,432
Anthem Blue Cross	5,517
Kaiser	2,961
Total	18,910

It should be noted that countywide HFP enrollment is down from nearly 20,139 seen in December. The Plan expects the enrollment in the legacy Healthy Families program to continue to decline until the August 1, 2013 transition date for Ventura County since children who would have otherwise enrolled in HFP (which would have offset normal monthly disenrollment) are now being enrolled directly into Medi-Cal.

Primary tenets of the Healthy Families Program transition are:

- Ensure access to and continuity of care,
- Facilitate a smooth transition,
- Ensure a minimum of disruption in services,

- Maintain existing eligibility gateways.

A key component to ensuring the primary tenets listed above is providing, to the extent possible, that children have access to their existing care providers. As such, GCHP has been in contact with VCHP, Anthem and Kaiser about their current Healthy Families enrollment. A status of those discussions is provided below:

VCHP intends to facilitate the transfer of the membership to GCHP. GCHP is meeting with VCHP staff regarding the nature of the transfer. It is the Plan's intention to meet the requirements of continuity of care with that membership. As per state requirements GCHP will need to offer the member the option of retaining their current provider, assuming that provider will accept Medi-Cal rates, or selecting a provider in the GCHP Network. Currently, all but 20 of the PCP's in the VCMC network are in the GCHP network.

Anthem has indicated that is does not wish to participate as a sub-contractor to GCHP for the HFP transitioned members. Currently the GCHP network includes 68 of their PCP's or 33% of Anthem's PCP network. GCHP is in discussions with Anthem's subcontracted IPAs to determine possible contracting arrangements. In order to meet the bigger objective of continuity of care, GCHP staff is evaluating contracting alternatives, including Primary Care Contract, Primary care/ Specialty Contract, or individual provider contracting. All of these contracting models are currently in place with GCHP. If a PCP is unwilling to contract with the Plan, the continuity of care goal can still be achieved for the member if the provider is willing to accept Medi-Cal FFS rates for up to 12 months. After that time both the Plan and provider would need to enter into a contract or the member would be re-assigned to a contracted Medi-Cal provider.

The approach with Kaiser is different from those for VCHP and Anthem.

In June 2012, the Legislature passed Assembly Bill (AB) 1494 which provides for the transition of all HFP subscribers to Medi-Cal.

In June 2012, Kaiser approached the State to consider the development of an agreement whereby Kaiser will retain its HFP members upon their transition into Medi-Cal through a direct contractual relationship with DHCS. As a direct contractual relationship in the existing managed care county delivery systems throughout California is not possible due to state and federal statutes, DHCS, Kaiser and the Medi-Cal managed care plans developed two agreements to address the HFP transition and future Medi-Cal enrollment.

DHCS / Kaiser / Plan Agreement
The first agreement is a nonbinding agreement between DHCS, Kaiser and the managed care plans. This template has already been signed by DHCS and Kaiser. It indicates that it sets forth a framework for a seamless transition of care for current Kaiser Members in the

HFP and Medi-Cal beneficiaries who were Kaiser Members or family-linked within the previous twelve months.

The three-way agreement includes the following provisions:

1. DHCS, Kaiser and managed care plans will work to develop a contract template for the subcontract between plans and Kaiser.
2. A centralized oversight and compliance process will be created to oversee Kaiser's obligations under the contract. The agreement indicates that this process will be conducted and funded by DHCS unless otherwise agreed to by the parties.
3. The COHS plans such as Gold Coast Health Plan will assign to Kaiser new Medi-Cal members currently or previously enrolled with Kaiser in the previous twelve months or family-linked in the previous twelve months. Aside from the link to previous Kaiser coverage, the existing GCHP auto-assignment policy will remain intact.
4. The agreement does not restrict the ability of Medi-Cal beneficiaries to choose a different provider than Kaiser during or after the beneficiary has been assigned to Gold Coast Health Plan.

Kaiser / Plan Agreement
The second agreement, between Kaiser and the managed care plan, is titled "Care Continuity Agreement" and defines the beneficiaries for whom the managed care plan will ensure transition to Kaiser as:

1. Individuals who are eligible for Medi-Cal on and after January 1, 2014 under Medi-Cal expansion and who enroll in Gold Coast Health Plan and are assigned to Kaiser;
2. HFP beneficiaries who are Kaiser members on the effective date of the transition; and,
3. Beneficiaries who are eligible for Medi-Cal or HFP after the effective date of the transition and who were Kaiser members or family-linked within the previous twelve months. This agreement has been signed by Kaiser but does not include aid codes on the attachments.

The two-way agreement includes the following provisions:

1. This Agreement indicates that it may be terminated only upon execution of an amendment to the parties, and that the terms of this Agreement will be re-evaluated in five years.
2. Kaiser may enter into a direct contract with DHCS if Kaiser is unable to reach a subcontracting agreement with Plan.

As of March 19, 2013, this contracting arrangement with Kaiser has been agreed to in thirteen (13) separate counties across the state. Another seven (7) counties, excluding

Ventura/Gold Coast Health Plan, are expected to enact this arrangement to facilitate the transition of the Healthy Families children into Medi-Cal.

DHCS Items

GCHP is re-submitting the Plan-to-Plan boilerplate contract template to DHCS for approval. The contract template was originally submitted to DHCS in October. In December the Plan received notice that the template was not approved. On February 15, DHCS provided the Plan with items to be resolved and re-submitted within 60 days to be re-reviewed. GCHP complied by submitted responses to the state before the 60 deadline.

AGENDA ITEM 3b

To: Gold Coast Health Plan Commissioners

From: Michelle Raleigh, Chief Financial Officer

Date: March 25, 2013

RE: January, 2013 Financials

SUMMARY:
Staff is presenting the attached January, 2013 financial statements of Gold Coast Health Plan (Plan) for approval by the Commission.

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

FISCAL IMPACT:
When compared to budget on a year-to-date basis, the Plan is overall doing better than expected, with an actual net loss of $1.3 million compared to a projected net loss of approximately $3.0 million. These positive results contribute to the Plan's smaller tangible net equity (TNE) deficit as compared to expectations as of January 31, 2013.

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

- Membership – The Plan had 672 more members than budgeted for the month which consisted of a larger portion of the "Family", "Dual", and "Targeted Low Income Children (TLIC)" members.
- Revenue – The mix of members drove a lower-than-anticipated revenue per member per month (PMPM) average. Also contributing to the revenue PMPM being lower than budget was due to lower CBAS revenue.
- Health Care Costs – Three primary items contributed to the differences between the actual ($233.76 PMPM) and budgeted costs ($228.81 PMPM):
    - Higher pharmacy expenses driven primarily by increased utilization associated with winter illnesses.
    - Timing and amount of reinsurance recoveries ($1.8M expected in January where $1.3M was actually received in November).

- Partially offset by lower incurred by not reported reserve estimates for remaining medical expenses.

- Administrative Expenses – Overall operational costs were higher than anticipated by $1.83 PMPM primarily due to the following items:
  - Increased salary and benefit costs associated with the transition of the old benefit package to the new benefit package.
  - Higher than expected general office expense (covering repairs and maintenance), office supplies, legal fees, and software licenses. These costs are primarily associated with the increase in staffing level and the reconfiguration of employee work space.
  - Higher than expected interest expense as the Plan reduced inventory and paid out claims.
- Cash – The cash balance as of the end of January was over $39 million since the Plan received the December and January capitation payment in January. Per the financial forecast, revised budget, and under direction from the State, the Plan continues to monitor the cash balance. This balance includes the $2.2 million line of credit.

RECOMMENDATION:

Staff proposes the Commission to approve the January, 2013 financial statements. The Executive / Finance Committee also provided recommendation on this action during the 03/07/2013 meeting.

CONCURRENCE:
Executive / Finance Committee (03/07/2013)

ATTACHMENTS:
January, 2013 Financial Package

Gold Coast Health Plan℠
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FINANCIAL PACKAGE
FOR THE MONTH ENDED JANUARY 31, 2013

TABLE OF CONTENTS

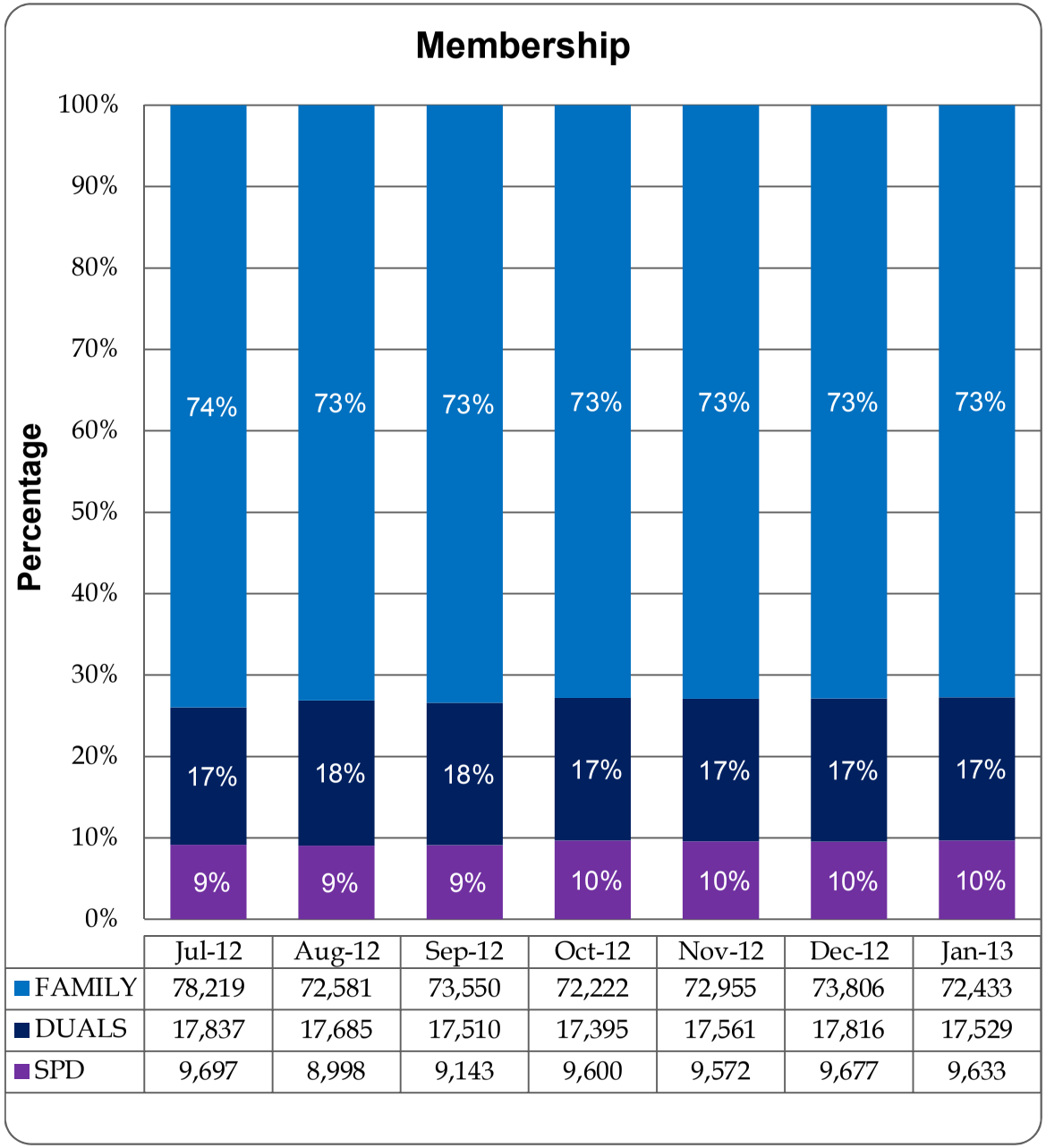
FINANCIAL OVERVIEW

Description	Audited FY 2011-12	FY 2012-13 Actual				Budget YTD	Variance Fav/(Unfav) $	Change %
		July - Sep	Oct - Dec	Jan'13	YTD			
Member Months	1,258,189	305,220	300,604	99,595	705,419	695,821	9,598	1.4 %
Revenue	**304,635,932**	73,225,136	76,563,668	**25,291,754**	**175,080,558**	**175,668,378**	(587,820)	(0.3)%
pmpm	*242.12*	*239.91*	*254.70*	*253.95*	*248.19*	*252.46*	(4.27)	(1.7)%
Health Care Costs	**287,353,672**	71,648,550	68,967,923	**22,713,884**	**163,330,357**	**166,107,704**	2,777,347	1.7 %
pmpm	*228.39*	*234.74*	*229.43*	*228.06*	*231.54*	*238.72*	7.19	3.0 %
% of Revenue	94.3%	97.8%	90.1%	89.8%	93.3%	94.6%		
Admin Exp	**18,891,320**	4,976,867	6,036,079	**2,041,565**	**13,054,511**	**12,540,615**	(513,896)	(4.1)%
pmpm	*15.01*	*16.31*	*20.08*	*20.50*	*18.51*	*18.02*	(0.48)	(2.7)%
% of Revenue	6.2%	6.8%	7.9%	8.1%	7.5%	7.1%		
Net Income	**(1,609,063)**	(3,400,282)	1,559,667	**536,305**	**(1,304,310)**	**(2,979,941)**	1,675,631	(56.2)%
pmpm	*(1.28)*	*(11.14)*	*5.19*	*5.38*	*(1.85)*	*(4.28)*	2.43	(56.8)%
% of Revenue	-0.5%	-4.6%	2.0%	2.1%	-0.7%	-1.7%		
100% TNE	16,769,368	16,693,841	16,308,936	16,270,934	16,270,934	16,487,753	(216,819)	(1.3)%
% TNE Required	36%	36%	52%	52%	52%	52%		
Required TNE	6,036,972	6,009,783	8,480,647	8,460,886	8,460,886	8,573,631	(112,746)	(1.3)%
GCHP TNE	**(6,031,881)**	**(9,432,163)**	**(5,672,496)**	**(5,136,192)**	**(5,136,192)**	**(6,811,822)**	1,675,631	(24.6)%
TNE Excess / (Deficiency)	**(12,068,853)**	**(15,441,946)**	**(14,153,143)**	**(13,597,077)**	**(13,597,077)**	**(15,385,454)**	1,788,377	(11.6)%

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

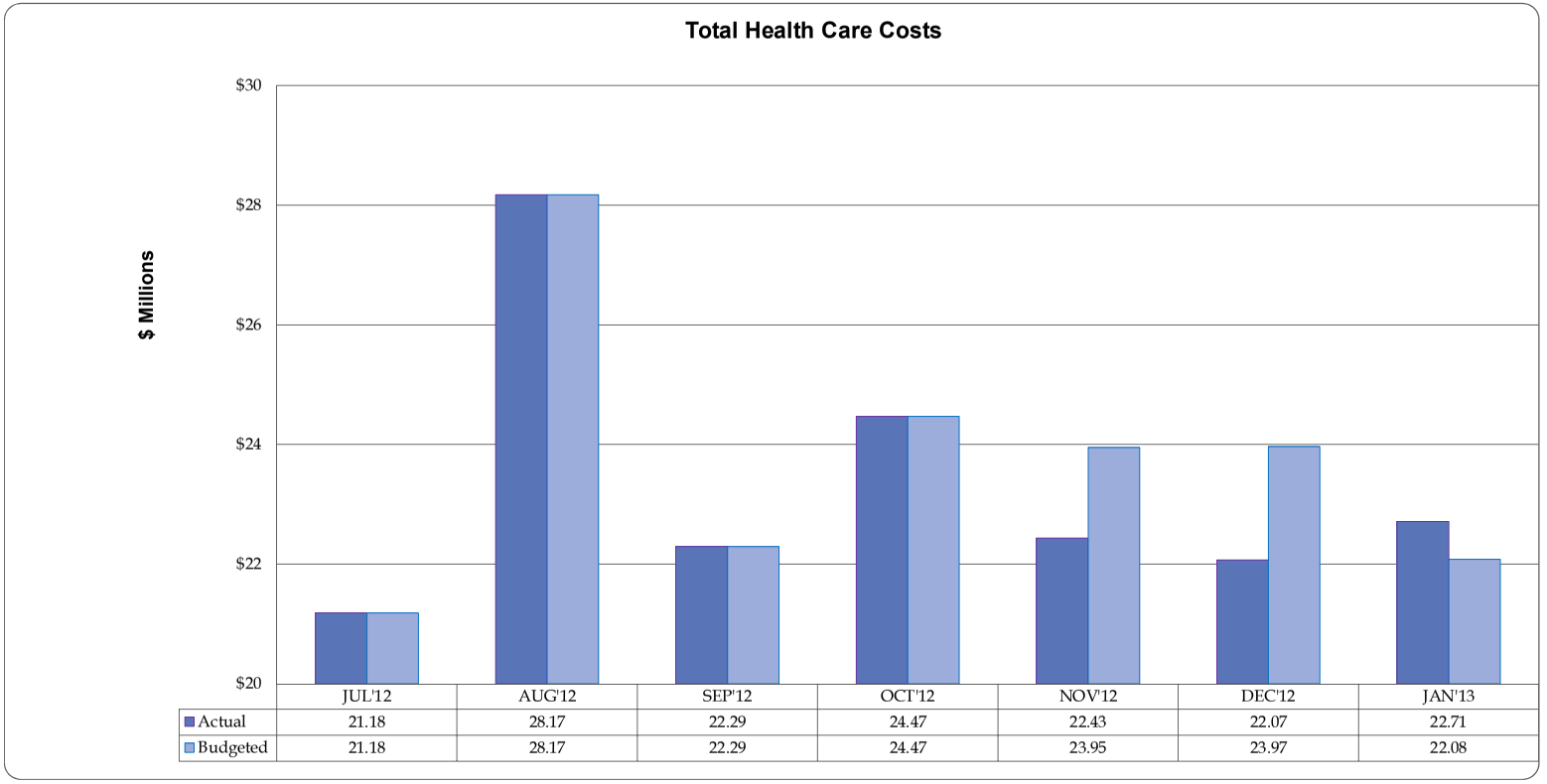
Key Drivers:

- **Member Months -** a favorable variance is attributed to an increase in Family and Duals members.
- **Revenue -** an unfavorable variance is due to negative retroactivity in Aged and Disabled categories; CBAS enrollment is lower than anticipated.
- **Health Care Costs -** a favorable variance is due to accelerated claims payments resulting in lower IBNP.
- **Administrative Costs -** an unfavorable variance is attributed to difference in timing related to new hires, accounting/actuarial fee and legal assistance fees.



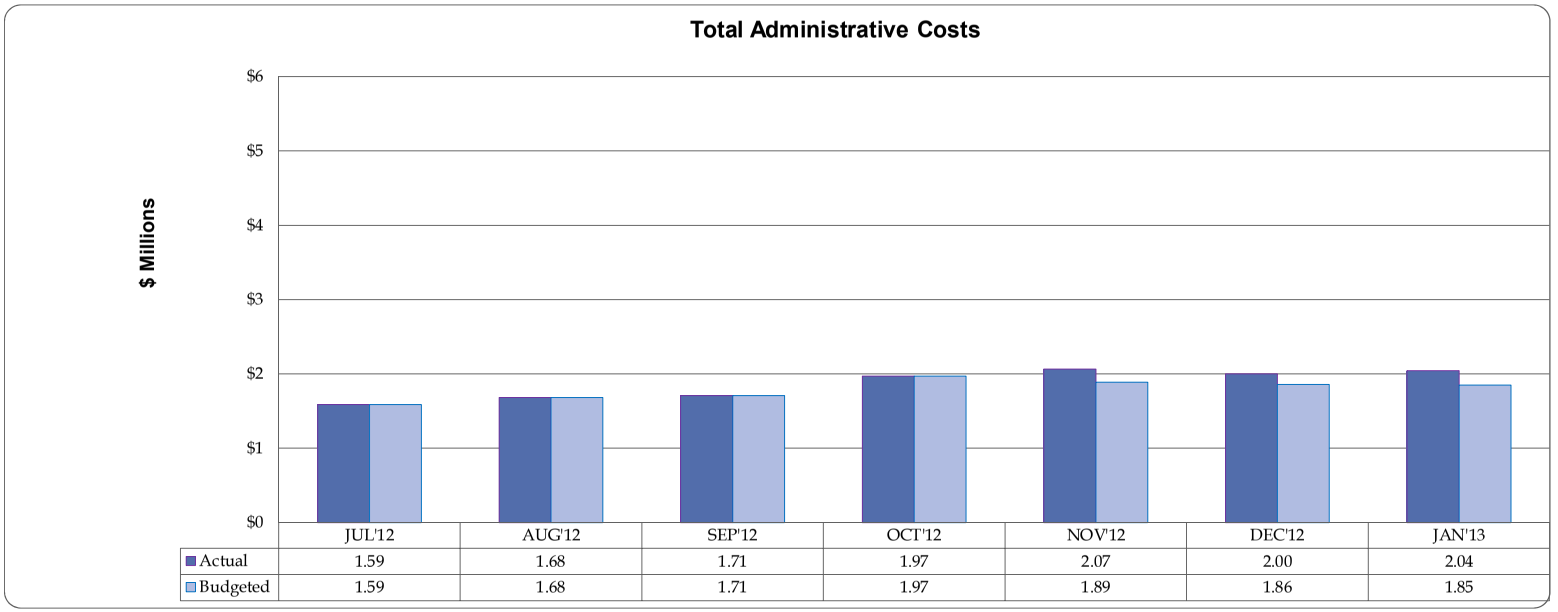
	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
FAMILY	78,219	72,581	73,550	72,222	72,955	73,806	72,433
DUALS	17,837	17,685	17,510	17,395	17,561	17,816	17,529
SPD	9,697	8,998	9,143	9,600	9,572	9,677	9,633

Total	**105,753**	**99,264**	**100,203**	**99,217**	**100,088**	**101,299**	**99,595**

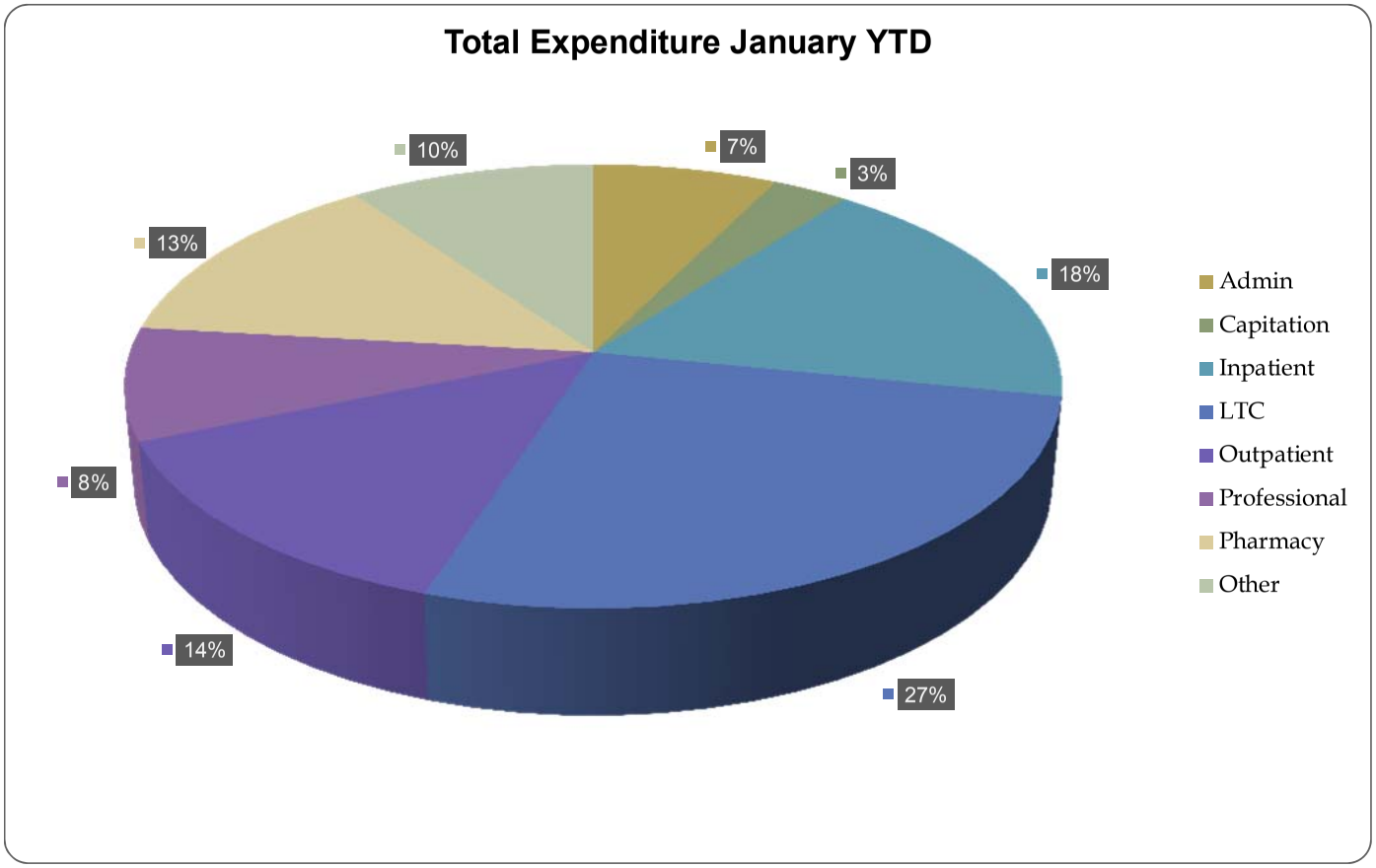


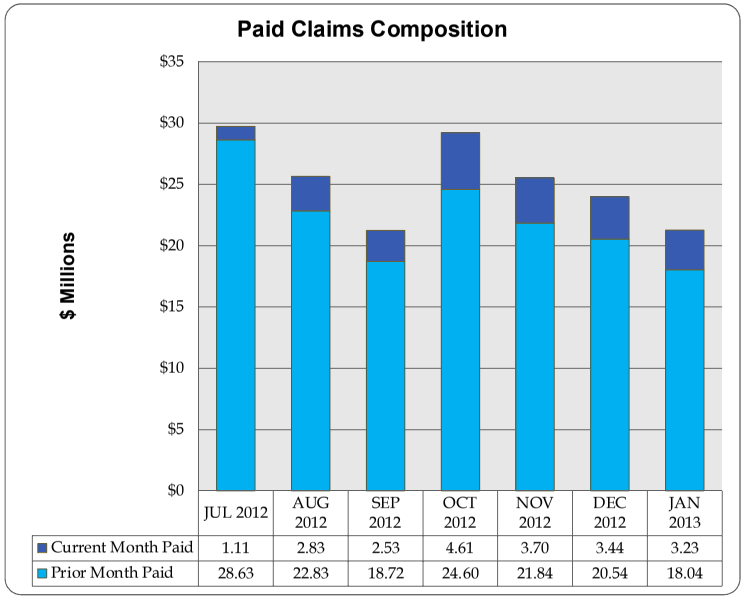
	JUL'12	AUG'12	SEP'12	OCT'12	NOV'12	DEC'12	JAN'13
Actual	21.18	28.17	22.29	24.47	22.43	22.07	22.71
Budgeted	21.18	28.17	22.29	24.47	23.95	23.97	22.08

Note:
Total Health Care Costs- Aug'12 reflects IBNR adjustment.

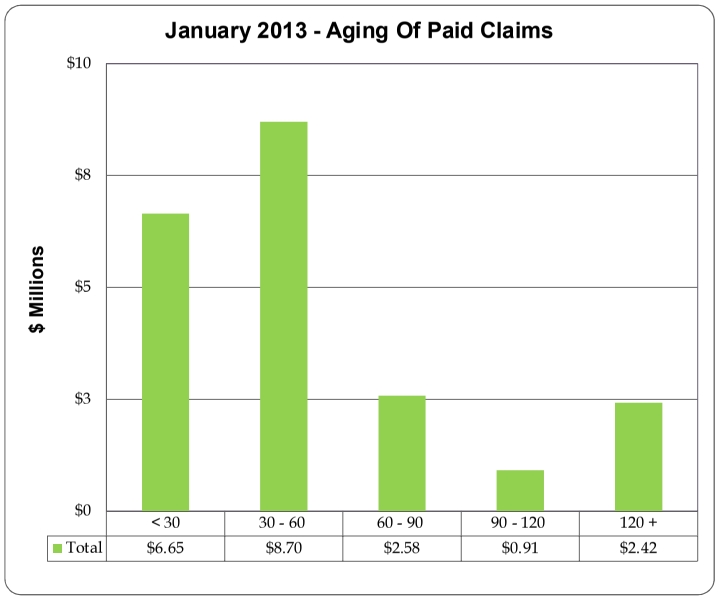


	JUL'12	AUG'12	SEP'12	OCT'12	NOV'12	DEC'12	JAN'13
Actual	1.59	1.68	1.71	1.97	2.07	2.00	2.04
Budgeted	1.59	1.68	1.71	1.97	1.89	1.86	1.85


Total Expenditure January YTD
10%
7%
3%
13%
18%
8%
14%
27%
Admin
Capitation
Inpatient
LTC
Outpatient
Professional
Pharmacy
Other



	JUL 2012	AUG 2012	SEP 2012	OCT 2012	NOV 2012	DEC 2012	JAN 2013
Current Month Paid	1.11	2.83	2.53	4.61	3.70	3.44	3.23
Prior Month Paid	28.63	22.83	18.72	24.60	21.84	20.54	18.04

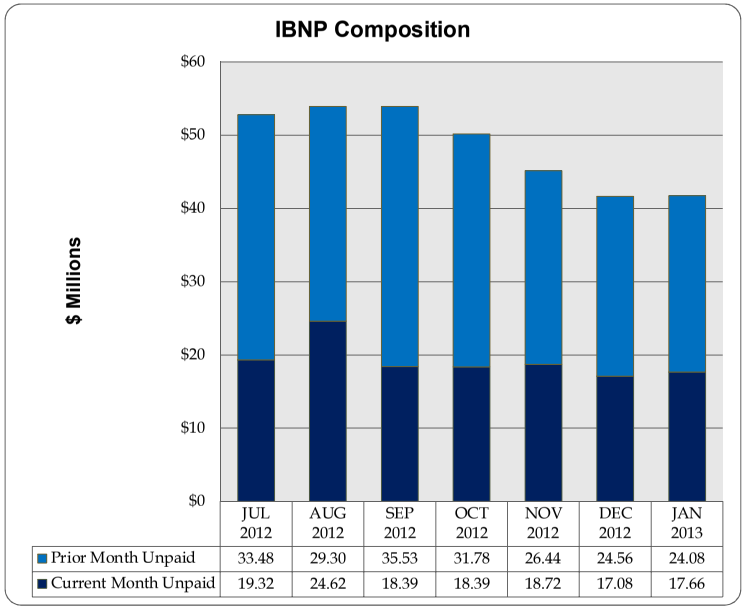


	< 30	30 - 60	60 - 90	90 - 120	120 +
Total	$6.65	$8.70	$2.58	$0.91	$2.42

Total Paid Claims	$29.74	$25.66	$21.25	$29.21	$25.54	$23.98	$21.27

Note:

Paid Claims Composition- reflects adjusted medical claims payment lag schedule and pharmacy reports.



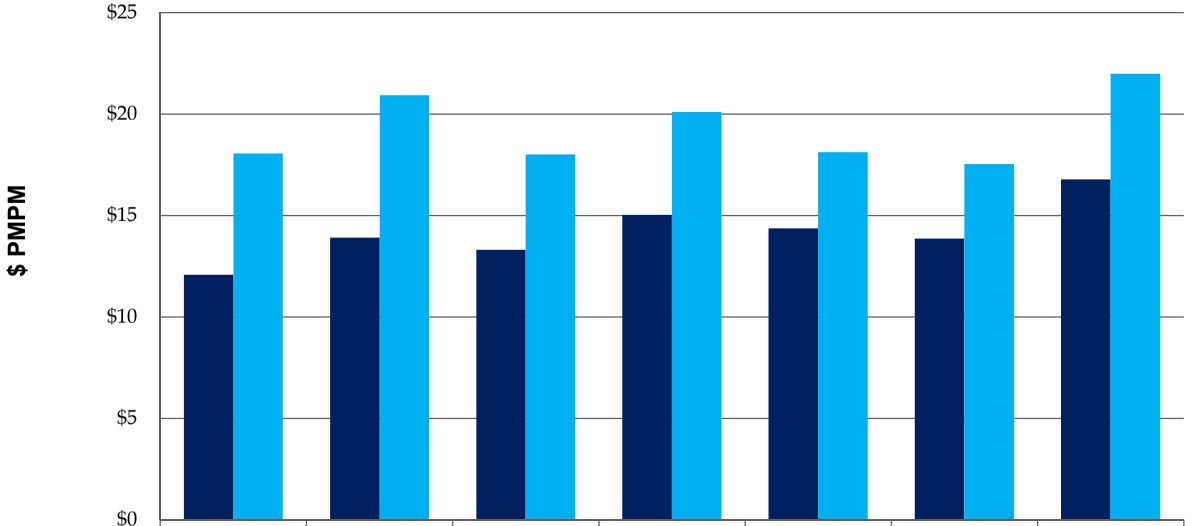
	JUL 2012	AUG 2012	SEP 2012	OCT 2012	NOV 2012	DEC 2012	JAN 2013
Prior Month Unpaid	33.48	29.30	35.53	31.78	26.44	24.56	24.08
Current Month Unpaid	19.32	24.62	18.39	18.39	18.72	17.08	17.66

Total Reserves	$52.80	$53.92	$53.92	$50.17	$45.16	$41.64	$41.74

Note:

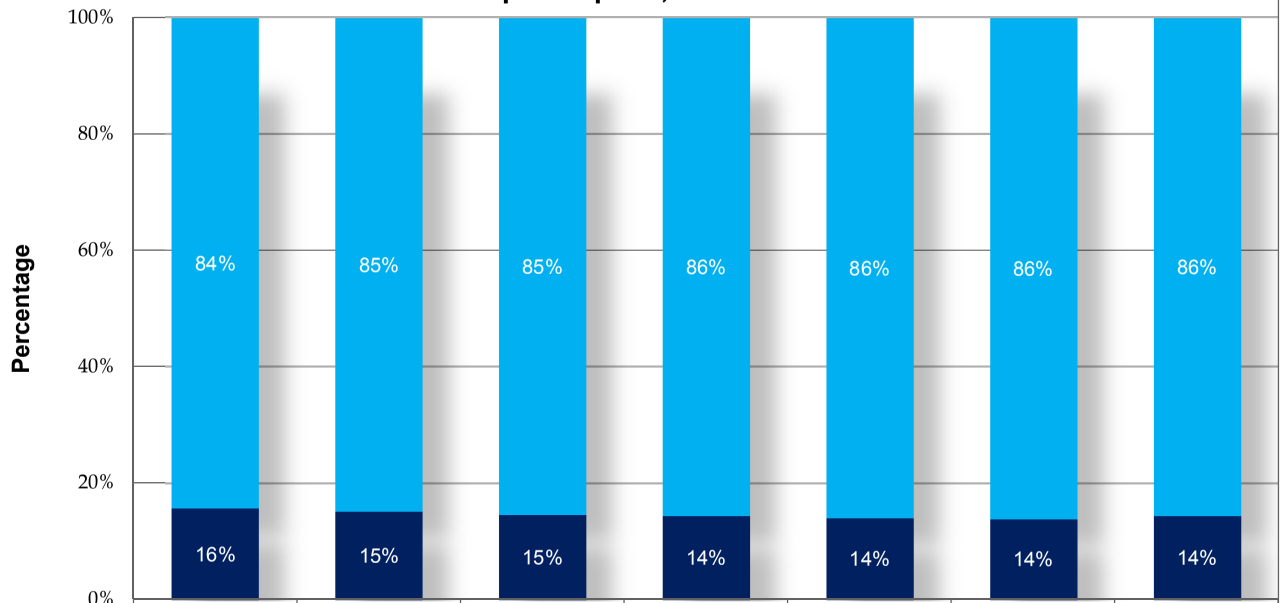
IBNP Composition- reflects updated medical cost reserve calculation (e.g., calculation of current month incurred claims less current month paid, plus prior month liability less prior month liablity less prior paid in current month). Total reserve ties to IBNR and Claims Payable balance on the Balance Sheet.

Pharmacy Cost Trend



	JUL'12	AUG'12	SEP'12	OCT'12	NOV'12	DEC'12	JAN'13
GENERIC	$12.08	$13.91	$13.31	$15.03	$14.37	$13.86	$16.77
BRAND	$18.05	$20.93	$18.01	$20.10	$18.12	$17.53	$21.98

Prescriptions per 1,000 Members

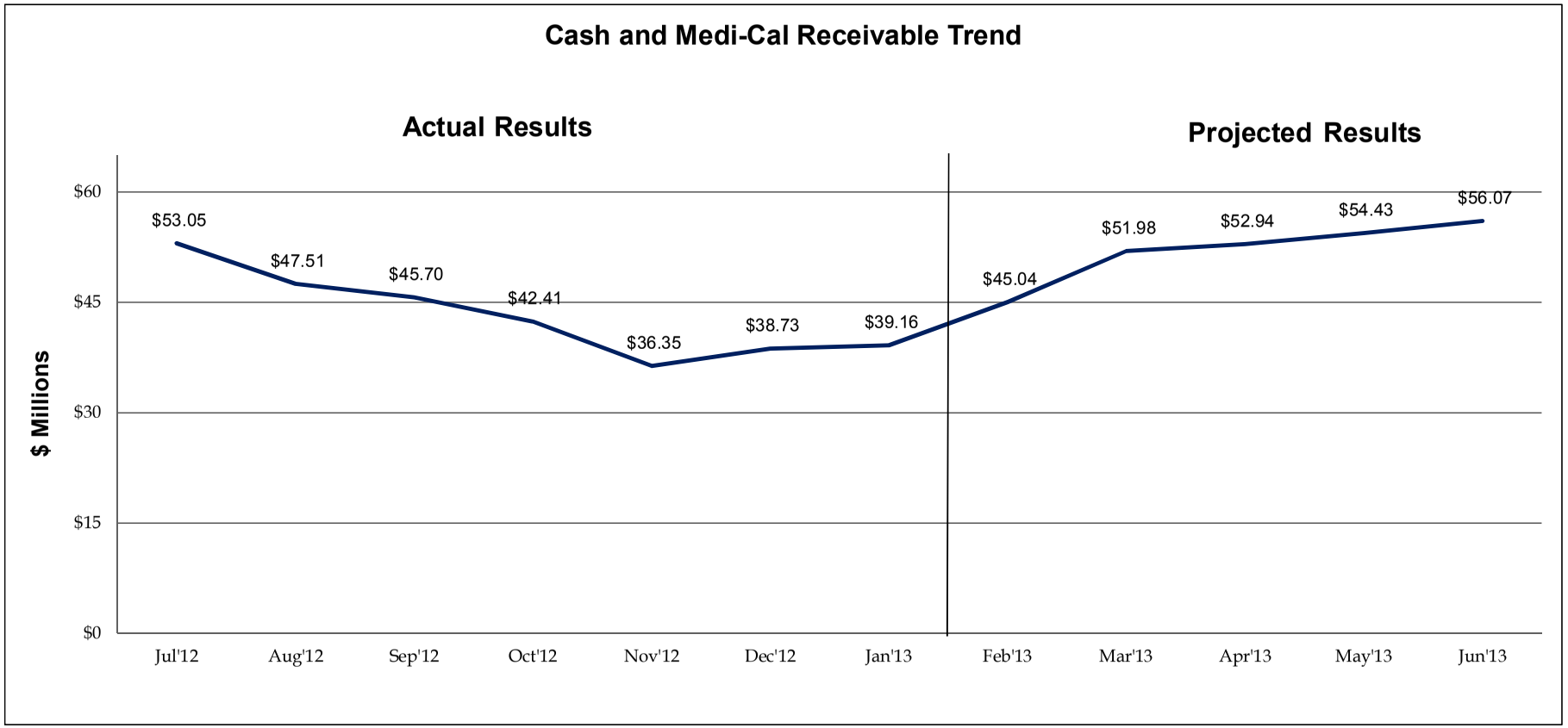


	JUL'12	AUG'12	SEP'12	OCT'12	NOV'12	DEC'12	JAN'13
GENERIC	6,602	7,157	6,850	7,685	7,388	7,075	8,799
BRAND	1,221	1,269	1,167	1,292	1,201	1,137	1,480

Comparative Balance Sheet

	1/31/13	12/31/12	Audited FY 2011 - 2012	Notes
ASSETS				
Current Assets				
Total Cash and Cash Equivalents	**$ 39,161,003**	**$ 13,304,588**	**$25,554,098**	
Medi-Cal Receivable	-	25,430,325	28,534,938	
Provider Receivable	5,743,629	3,848,142	6,539,541	Pending provider reconciliation payment
Other Receivables	190,415	198,400	2,148,270	
Total Accounts Receivable	**5,934,043**	**29,476,867**	**37,222,748**	
Total Prepaid Accounts	1,191,986	1,077,780	185,797	
Total Other Current Assets	192,977	205,810	375,000	
Total Current Assets	**$ 46,480,008**	**$ 44,065,045**	**$63,337,644**	
Total Fixed Assets	**160,117**	**160,278**	**176,028**	
Total Assets	**$ 46,640,125**	**$ 44,225,323**	**$63,513,672**	
LIABILITIES & FUND BALANCE				
Current Liabilities				
Incurred But Not Reported	$ 32,454,949	$ 34,800,130	$52,610,895	
Claims Payable	9,278,055	6,834,979	10,357,609	
Capitation Payable	921,432	917,020	633,276	
Accrued Premium Reduction	3,169,234	2,579,492	1,914,157	
Accounts Payable	3,203,158	1,762,278	886,715	Timing of invoices (e.g., ACS)
Accrued ACS	-	-	200,000	
Accrued Expenses	247,724	200,000	-	
Accrued Premium Tax	604,395	604,458	602,900	
Accrued Interest Payable	1,468	-	-	
Current Portion of Deferred Revenue	460,000	460,000	460,000	
Accrued Payroll Expense	74,235	297,795	-	Change in payroll cycle
Current Portion Of Long Term Debt	250,000	291,667	500,000	
Other Current Liabilities	-	-	-	
Total Current Liabilities	**$ 50,664,649**	**$ 48,747,819**	**$68,165,553**	
Long-Term Liabilities				
Deferred Revenue - Long Term Portion	1,111,667	1,150,000	1,380,000	
Notes Payable	2,200,000	2,200,000	-	
Total Long-Term Liabilities	**3,311,667**	**3,350,000**	**1,380,000**	
Total Liabilities	**$ 53,976,316**	**$ 52,097,819**	**$69,545,553**	
Beginning Fund Balance	(6,031,881)	(6,031,881)	(4,422,819)	
Net Income Current Year	(1,304,310)	(1,840,615)	(1,609,062)	
Total Fund Balance	**(7,336,191)**	**(7,872,496)**	**(6,031,881)**	
Total Liabilities & Fund Balance	**$ 46,640,125**	**$ 44,225,323**	**$63,513,672**	

FINANCIAL INDICATORS			
Current Ratio	91.7%	90.4%	92.9%
Days Cash on Hand	47	17	30
Days Cash + State Capitation Receivable	47	48	64


Cash and Medi-Cal Receivable Trend
Actual Results
Projected Results
$ Millions
$60
$45
$30
$15
$0
$53.05
$47.51
$45.70
$42.41
$36.35
$38.73
$39.16
$45.04
$51.98
$52.94
$54.43
$56.07
Jul'12
Aug'12
Sep'12
Oct'12
Nov'12
Dec'12
Jan'13
Feb'13
Mar'13
Apr'13
May'13
Jun'13

Statement of Cash Flows

	JAN'13	DEC'12
Cash Flow From Operating Activities		
Collected Premium	$ 51,269,535	$ -
Miscellaneous Income	3,889	7,899
Paid Claims		
Medical & Hospital Expenses	(19,544,086)	(21,362,731)
Pharmacy	(3,419,551)	(1,843,831)
Capitation	(917,020)	(907,950)
Reinsurance of Claims	(225,793)	(667,195)
Reinsurance Recoveries		
Payment of Withhold / Risk Sharing Incentive		
Paid Administration	(1,307,167)	(2,248,058)
Repay Initial Net Liabilities		
MCO Taxes Expense	-	1,774,300
Net Cash Provided/ (Used) by Operating Activities	**25,859,807**	**(25,247,565)**
Cash Flow From Investing/Financing Activities		
Proceeds from Line of Credit	-	2,200,000
Repayments on Line of Credit	-	-
Net Acquisition of Property/Equipment	(3,392)	-
Net Cash Provided/(Used) by Investing/Financing	**(3,392)**	**2,200,000**
Net Cash Flow	**$ 25,856,414**	**$(23,047,565)**
Cash and Cash Equivalents (Beg. of Period)	13,304,588	36,352,153
Cash and Cash Equivalents (End of Period)	39,161,003	13,304,588
	$ 25,856,414	**$(23,047,565)**
Adjustment to Reconcile Net Income to Net Cash Flow		
Net (Loss) Income	536,305	1,606,322
Depreciation & Amortization	3,554	3,554
Decrease/(Increase) in Receivables	23,542,824	(24,264,500)
Decrease/(Increase) in Prepaids & Other Current Assets	(101,372)	971,395
(Decrease)/Increase in Payables	1,856,253	(575,163)
(Decrease)/Increase in Other Liabilities	(80,000)	(80,000)
Change in MCO Tax Liability	(63)	604,422
Changes in Claims and Capitation Payable	2,447,488	(1,668,765)
Changes in IBNR	(2,345,181)	(1,844,828)
	25,859,807	(25,247,565)
Net Cash Flow from Operating Activities	**$ 25,859,807**	**$(25,247,565)**

Gold Coast Health Plan℠
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APPENDIX

Income Statement Comparison

	2012 Actual Monthly Trend			Jan-13 Month-To-Date		Variance	Explanation
	Oct	Nov	Dec	Actual	Budget	Fav/(Unfav)	
Membership	96,447	96,907	97,745	97,167	96,495	672	
Revenue:							
Premium	$ 25,524,694	$ 25,519,637	$ 25,759,968	$ 25,377,074	$25,752,316	$ (375,242)	
Reserve for Rate Reduction	(126,771)	(128,543)	(129,959)	(127,606)	(127,013)	(593)	
MCO Premium Tax	(635)	(37)	21	63	(773)	836	
Total Net Premium	**25,397,288**	**25,391,057**	**25,630,030**	**25,249,532**	**25,624,530**	**(374,998)**	
Other Revenue:							
Interest Income	13,390	9,004	7,899	3,889	15,451	(11,562)	
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	0	
Total Other Revenue	51,724	47,337	46,233	42,223	**53,784**	(11,561)	
Total Revenue	**25,449,011**	**25,438,394**	**25,676,263**	**25,291,754**	**25,678,314**	**(386,560)**	
Medical Expenses:							
Capitation	755,447	907,950	917,020	921,432	945,928	24,496	
Incurred Claims:							
Inpatient	4,592,634	4,542,801	4,093,335	4,054,978	4,420,970	365,992	
LTC/SNF	6,933,988	6,858,363	6,228,689	6,107,181	6,852,319	745,138	
Outpatient	2,750,021	2,735,387	2,458,657	2,438,523	2,977,172	538,649	
Laboratory and Radiology	231,690	229,447	206,113	204,418	230,705	26,287	
Emergency Room Facility Services	533,516	529,753	474,523	472,684	531,581	58,897	
Physician Specialty Services	2,280,039	2,111,295	1,838,999	1,849,915	1,880,699	30,784	
Pharmacy	3,485,563	3,251,427	3,180,407	3,859,639	3,135,205	(724,434)	Higher utilization and costs due to winter illness
Other Medical Professional	288,240	288,957	332,271	199,667	252,031	52,364	
Other Medical Care Expenses	606	-	732	-		-	
Other Fee For Service Expense	1,589,710	1,570,885	1,426,578	1,401,900	1,545,011	143,111	
Transportation	308,025	306,198	275,536	299,590	258,113	(41,477)	
Total Claims	22,994,031	22,424,513	20,515,839	20,888,495	22,083,807	1,195,312	
Medical & Care Management Expens	556,393	587,293	560,329	666,197	615,650	(50,547)	Script Care mgmt fees driven by higher Pharmacy utilization
Reinsurance	225,239	224,722	225,793	225,793	233,537	7,744	
Claims Recoveries	(64,218)	(1,711,511)	(150,917)	11,968	(1,800,000)	(1,811,968)	Timing of actual recoveries
Sub-total	717,413	(899,496)	635,205	903,958	**(950,813)**	(1,854,771)	
Total Cost of Health Care	**24,466,891**	**22,432,967**	**22,068,065**	**22,713,884**	**22,078,922**	**(634,962)**	
Contribution Margin	**982,120**	**3,005,427**	**3,608,198**	**2,577,870**	**3,599,392**	**(1,021,522)**	
General & Administrative Expenses:							
Salaries and Wages	388,828	323,624	354,451	474,339	372,782	(101,557)	Increase due to timing related to new hires
Payroll Taxes and Benefits	62,808	72,886	88,331	106,130	79,091	(27,039)	
Total Travel and Training	6,690	5,784	2,996	1,546	6,643	5,097	
Outside Service - ACS	890,492	1,052,244	916,305	883,861	929,810	45,949	Budgeted additional fees based on historical averages
Outside Services - Other	104,166	17,311	44,810	28,663	19,564	(9,099)	
Accounting & Actuarial Services	85,290	44,311	37,529	25,350	5,000	(20,350)	Actual expense includes consulting fees which will be reclassed in the future months
Legal Expense	12,196	67,921	41,114	47,724	32,350	(15,374)	
Insurance	10,792	11,846	9,245	9,245	10,792	1,547	
Lease Expense - Office	18,289	15,879	15,977	15,983	16,630	647	
Consulting Services Expense	191,975	330,613	379,747	312,781	305,592	(7,189)	
Translation Services	2,812	590	4,101	328	765	437	
Advertising and Promotion Expense	3,150	-	2,645	196	0	(196)	
General Office Expenses	84,636	78,657	48,327	76,509	42,433	(34,076)	Repairs and maintenance, office supplies, software licenses
Depreciation & Amortization Expense	3,554	3,561	3,554	3,554	3,874	320	
Printing Expense	2,538	1,670	1,276	14,767	8,742	(6,025)	
Shipping & Postage Expense	21	606	21,825	395	11,281	10,886	
Interest Exp	100,407	37,812	29,643	40,195	5,825	(34,370)	Process claims from prior months
Total G & A Expenses	**1,968,888**	**2,065,315**	**2,001,876**	**2,041,565**	**1,851,174**	**(190,391)**	
Net Income / (Loss)	**$ (986,767)**	**$ 940,112**	**$ 1,606,322**	**$ 536,305**	**$ 1,748,218**	**$(1,211,914)**	

PMPM Income Statement Comparison

	2012 Actual Monthly Trend			Jan'13 Month-To-Date		Variance
	Oct	Nov	Dec	Actual	Budget	Fav/(Unfav)
Members (Member/Months)	96,447	96,907	97,745	97,167	96,495	672
Revenue:						
Premium	264.65	263.34	263.54	261.17	266.88	(5.71)
Reserve for Rate Reduction	(1.31)	(1.33)	(1.33)	(1.31)	(1.32)	0.00
MCO Premium Tax	(0.01)	(0.00)	0.00	0.00	(0.01)	0.01
Total Net Premium	**263.33**	**261.31**	**262.21**	**259.86**	**265.55**	**(5.70)**
Other Revenue:						
Interest Income	0.14	0.09	0.08	0.04	0.16	(0.12)
Miscellaneous Income	0.40	0.40	0.39	0.39	0.40	(0.00)
Total Other Revenue	**0.54**	**0.49**	**0.47**	**0.43**	**0.53**	**(0.10)**
Total Revenue	**263.87**	**262.50**	**262.69**	**260.29**	**266.11**	**(5.82)**
Medical Expenses:						
Capitation	7.83	9.37	9.38	9.48	9.80	(0.32)
Incurred Claims:						
Inpatient	47.62	46.88	41.88	41.73	45.82	4.08
LTC/SNF	71.89	70.77	63.72	62.85	71.01	8.16
Outpatient	28.51	28.23	25.15	25.10	30.85	5.76
Laboratory and Radiology	2.40	2.37	2.11	2.10	2.39	0.29
Emergency Room Facility Services	5.53	5.47	4.85	4.86	5.51	0.64
Physician Specialty Services	23.64	21.79	18.81	19.04	19.49	0.45
Pharmacy	36.14	33.55	32.54	39.72	32.49	(7.23)
Other Medical Professional	2.99	2.98	3.40	2.05	2.61	0.56
Other Medical Care Expenses	0.01	-	0.01	-	-	-
Other Fee For Service Expense	16.36	16.21	14.59	14.43	16.01	1.58
Transportation FFS	3.19	3.16	2.82	3.08	2.67	(0.41)
Total Claims	236.64	231.40	209.89	214.98	228.86	13.88
Medical & Care Management	5.77	6.06	5.73	6.86	6.38	(0.48)
Reinsurance	2.34	2.32	2.31	2.32	2.42	0.10
Claims Recoveries	(0.67)	(17.66)	(1.54)	0.12	(18.65)	(18.78)
Sub-total	7.38	(9.28)	6.50	9.30	(9.39)	(18.70)
Total Cost of Health Care	253.68	231.49	225.77	233.76	228.81	(4.95)
Contribution Margin	10.18	31.01	36.91	26.53	**37.30**	**(10.77)**
Administrative Expenses						
Salaries and Wages	4.03	3.34	3.63	4.88	3.86	(1.02)
Payroll Taxes and Benefits	0.65	0.75	0.90	1.09	0.82	(0.27)
Total Travel and Training	0.07	0.06	0.03	0.02	0.07	0.05
Outside Service - ACS	9.23	10.86	9.37	9.10	9.64	0.54
Outside Services - Other	1.08	0.18	0.46	0.29	0.20	(0.09)
Accounting & Actuarial Services	0.88	0.46	0.38	0.26	0.05	(0.21)
Legal Expense	0.13	0.70	0.42	0.49	0.34	(0.16)
Insurance	0.11	0.12	0.09	0.10	0.11	0.02
Lease Expense -Office	0.19	0.16	0.16	0.16	0.17	0.01
Consulting Services Expense	1.99	3.41	3.89	3.22	3.17	(0.05)
Translation Services	0.03	0.01	0.04	0.00	0.01	0.00
Advertising and Promotion Expense	0.03	-	0.03	0.00	-	(0.00)
General Office Expenses	0.88	0.81	0.49	0.79	0.44	(0.35)
Depreciation & Amortization Expense	0.03	0.02	0.01	0.04	0.04	0.00
Printing Expense	0.00	0.01	0.22	0.15	0.09	(0.06)
Shipping & Postage Expense	1.04	0.39	0.30	0.00	0.12	0.11
Interest Exp	-	-	-	0.41	0.06	(0.35)
Total Administrative Expenses	**20.41**	**21.31**	**20.48**	**21.01**	**19.18**	**(1.83)**
Net Income / (Loss)	**(10.23)**	**9.70**	**16.43**	**5.52**	**18.12**	**(12.60)**

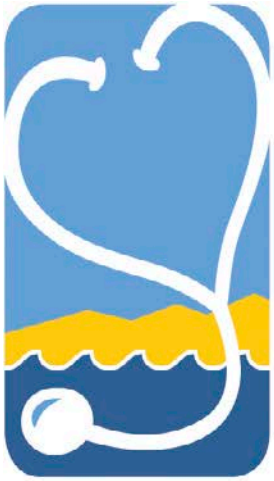
Income Statement Comparison
For The Seven Months Ended January 31, 2013

	Jan'13 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership	677,272	674,939	2,333
Revenue:			
Premium	$ 175,529,379	$ 176,088,799	$ (559,420)
Reserve for Rate Reduction	(792,943)	(787,715)	(5,228)
MCO Premium Tax	(1,495)	(3,859)	2,364
Total Net Premium	**174,734,942**	**175,297,225**	**(562,283)**
Other Revenue:			
Interest Income	77,283	102,820	(25,537)
Miscellaneous Income	268,333	268,333	(0)
Total Other Revenue	345,616	**371,153**	(25,537)
Total Revenue	**175,080,558**	**175,668,378**	**(587,820)**
Medical Expenses:			
Capitation	5,369,260	5,459,963	90,703
Incurred Claims:			
Inpatient	31,259,427	31,947,185	687,758
LTC/SNF	47,378,315	48,901,905	1,523,590
Outpatient	18,780,137	19,794,308	1,014,171
Laboratory and Radiology	1,576,727	1,634,838	58,111
Emergency Room Facility Services	3,637,536	3,769,316	131,780
Physician Specialty Services	14,453,684	14,350,175	(103,509)
Pharmacy	23,559,871	22,670,867	(889,004)
Other Medical Professional	1,992,689	1,934,892	(57,797)
Other Medical Care Expenses	4,311		(4,311)
Other Fee For Service Expense	10,837,705	11,116,993	279,288
Transportation	2,129,700	2,113,905	(15,795)
Total Claims	155,610,101	158,234,384	2,624,283
Medical & Care Management Expense	3,963,092	3,950,864	(12,228)
Reinsurance	1,574,687	1,598,816	24,129
Claims Recoveries	(3,186,783)	(3,136,323)	50,460
Sub-total	2,350,996	2,413,357	62,361
Total Cost of Health Care	**163,330,357**	**166,107,704**	**2,777,347**
Contribution Margin	**11,750,201**	**9,560,674**	**2,189,527**
General & Administrative Expenses:			
Salaries and Wages	2,429,539	2,318,606	(110,933)
Payroll Taxes and Benefits	659,111	607,981	(51,130)
Total Travel and Training	36,620	38,925	2,305
Outside Service - ACS	6,406,824	6,351,726	(55,098)
Outside Service - RGS	23,674	23,674	0
Outside Services - Other	325,500	298,338	(27,162)
Accounting & Actuarial Services	220,417	138,227	(82,190)
Legal Expense	229,545	169,836	(59,709)
Insurance	58,742	60,782	2,040
Lease Expense - Office	101,735	103,786	2,051
Consulting Services Expense	1,574,238	1,612,216	37,978
Translation Services	9,755	7,030	(2,725)
Advertising and Promotion Expense	9,491	9,150	(341)
General Office Expenses	479,882	407,351	(72,531)
Depreciation & Amortization Expense	24,792	25,372	580
Printing Expense	46,902	49,265	2,363
Shipping & Postage Expense	39,185	30,848	(8,337)
Interest Exp	378,561	287,502	(91,059)
Total G & A Expenses	**13,054,511**	**12,540,615**	**(513,896)**
Net Income / (Loss)	**$ (1,304,310)**	**$ (2,979,941)**	**$ 1,675,631**

Statement of Cash Flows

	JAN '13 YTD
Cash Flow From Operating Activities	
Collected Premium	$ 204,526,452
Miscellaneous Income	77,284
Paid Claims	
Medical & Hospital Expenses	(149,592,515)
Pharmacy	(23,089,572)
Capitation	(5,081,105)
Reinsurance of Claims	(1,842,918)
Reinsurance Recoveries	-
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(13,581,842)
Repay Initial Net Liabilities	-
MCO Taxes Expense	-
Net Cash Provided/(Used) by Operating Activities	**11,415,784**
Cash Flow From Investing/Financing Activities	
Proceeds from Line of Credit	2,200,000
Repayments on Line of Credit	-
Net Acquisition of Property/Equipment	(8,879)
Net Cash Provided/(Used) by Investing/Financing	**2,191,121**
Net Cash Flow	**$ 13,606,904**
Cash and Cash Equivalents (Beg. of Period)	25,554,098
Cash and Cash Equivalents (End of Period)	39,161,003
	$ 13,606,904
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	(1,304,310)
Depreciation & Amortization	24,792
Decrease/(Increase) in Receivables	31,288,705
Decrease/(Increase) in Prepaids & Other Current Assets	(824,165)
(Decrease)/Increase in Payables	3,694,946
(Decrease)/Increase in Other Liabilities	(518,333)
Change in MCO Tax Liability	1,495
Changes in Claims and Capitation Payable	(791,398)
Changes in IBNR	(20,155,946)
	11,415,784
Net Cash Flow from Operating Activities	**$ 11,415,784**

Tatum



Gold Coast Health Plan℠

A Public Entity

March 25, 2013

Tatum Team

Cassie Undlin
Debbie Rieger
Laurel Kiichli

4a-1

Tatum Status Update

Tatum is concentrating on five primary areas for their engagement:

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

Tatum Key Member and Provider Benefits

- Membership Services
  - Restructured call center to separate member and provider calls to improve service levels
  - Proactively working with Members who qualify for Medicare Part A services to get coverage in order to shift the burden of inpatient costs to Medicare.
  - Refinement of the Grievance and Appeal process.
- Network Management
  - Implemented monthly provider operations bulletin
  - Evaluated and implemented pricing policies resulting in reducing inventory, improving turnaround time, and cost savings
- Long Term Care
  - Review and implement changes in Long Term Care claims processing, improving accuracy of payments
  - Implement contracting strategy focused on level of care, to improve the member experience
  - Working proactively with facilities and H.S.A. to get aid codes updated sooner in order to increase reimbursement.
- ikaSystems review
  - Phase 1 of the systems review completed and implemented, changes that result in improvements in accuracy and efficiency
  - Implemented weekly meeting with ikaSystems and Xerox
- Better tools for Medical Management
  - Implement Health Plan Tools software that will allow us to evaluate and score the health risk of SPD and other high risk members

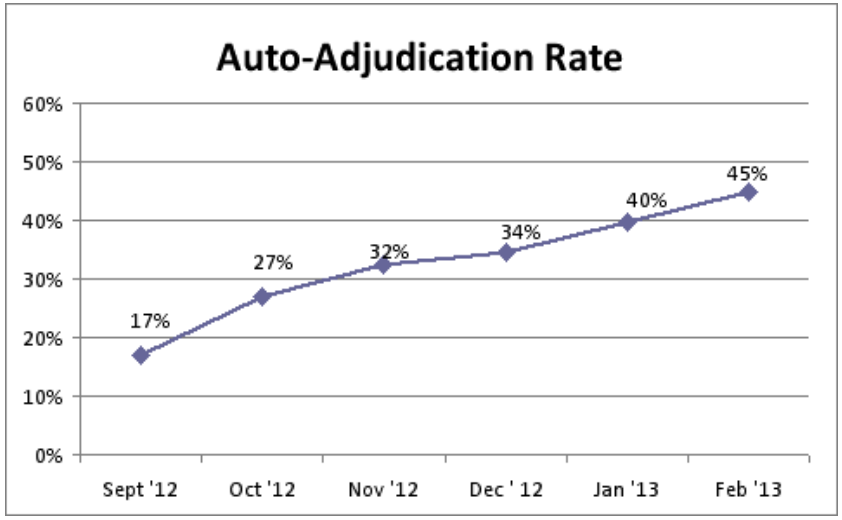
Tatum Key Accomplishments

- Reduced claims backlog from a high of 55,000 to 15,000
- Increased auto adjudication rate from 22% to 45%.
- Improved turnaround time for paid claims within 30 days from 63% to 99%
- Reduced unprocessed refund inventory from 1110 to 48. Currently maintaining <20 day turnaround time.
- Restructured Member Services and Provider Contracting and Services Departments
- Improved internal communications, through the Operations Committee
- Renegotiated Xerox nursing contract, resulting in an annual savings of $220,000

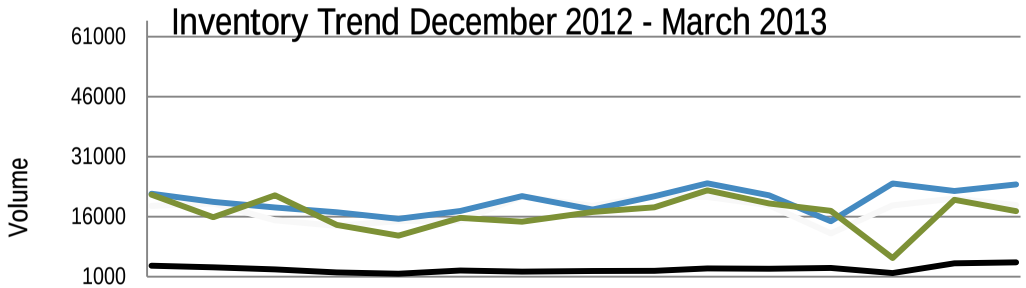
Tatum Key Accomplishments

- Recovery Services management of vendor
- QI/HSAG encounter questionnaire submitted
- Finalized interest policy based on legal review
- Reorganized Member Services to focus on problem resolution
- Personnel change made to switch Vendor Contract Manager and Member Services Manager
- Improved Consumer Advisory Committee involvement
- Finalized injection administrative fee policy based on State clarification to reduce future claim costs

Operational Optimization – Claims Stats:



Auto Adjudicate Target:
30% by December 31, 2012
60% by June 30, 2013



	12/04/12	12/11/12	12/18/12	12/25/12	01/01/13	01/08/13	01/15/13	01/23/13	01/30/13	02/05/13	02/12/13	02/19/13	02/26/13	03/05/13	03/12/13
Open	18694	19308	15085	13677	14874	14975	21001	18680	21223	20933	18868	11822	18807	20512	18878
Denied	3729	3317	2829	2061	1726	2523	2235	2426	2463	3051	2970	3179	1882	4326	4555
Received	21719	19679	18286	17103	15461	17404	21133	17770	21072	24324	21336	14844	24295	22416	24047
Paid	21474	15848	21318	13934	11238	15685	14722	17190	18331	22569	19287	17464	5651	20191	17363

4a-6

The following slides track the progress on each of these initiatives. Below is the description of the various colors and comments that are utilized on the tracking tool.

GHCP Tatum Update	
Key	**Description**
●	Green - We are on track to deliver committed scope by committed deadline with committed resources/funding.
●	Yellow - We are not on track to deliver committed scope by committed deadline with committed resources/funding, but we have a plan to get back to green.
●	Red - We are not on track and we need a plan to get the project back on track.
	Grayed out: not started
Trans	Transitioned to GCHP staff
Comp	Task completed

4a-7

Project Management

GHCP Tatum Update

Scope	Category	Sub-category	Jan 27	Feb 3	Feb 10	Feb 17	Feb 24	Mar 3	Mar 10	Mar 17
Project Management	Specialty Contract		🟢	🟢	🟢	🟢	🟡	🟡	🟢	🟢
	Plan to Plan tool kit		🔴	🔴	🔴	🟡	🟡	🟡	🟡	🟡
	Enrollment issues	Long Term Care aid code	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
		Medicare Part A coverage	🟢	🟢	🟢	🟢	🟢	🟡	🟡	🟡
		Administrative Members	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
	Long Term Care		🔴	🔴	🟡	🟡	🟢	🟢	🟢	🟢

4a-8

Staff / Evaluation Development

GHCP Tatum Update

Scope	Category	Sub-category	Jan 27	Feb 3	Feb 10	Feb 17	Feb 24	Mar 3	Mar 10	Mar 17
Staff Evaluation/ Development	IT	IT leader, transition to IT Director	●	●	●	●	Comp	Comp	Comp	Comp
		Restructure IT Department	Trans	Trans	Trans	Trans	Comp	Comp	Comp	Comp
		Develop Reporting Team	Trans	Trans	Trans	Trans	Comp	Comp	Comp	Comp
	Provider Relations	Provider Relations Restructure	●	●	●	●	●	●	●	●
		Improve Provider Collaboration	●	●	●	●	●	●	●	●
		Provider Contract Development	●	●	●	●	●	●	●	●
	Member Services	Member resolution focus	●	●	●	●	●	●	●	●
		Grievance & Appeals	●	●	●	●	●	●	●	●
	Claims	Claims auditing	●	●	●	●	●	●	●	●
		Provider Claims Disputes Re-design	●	●	●	●	●	●	●	●
	Interdepartmental communications	Operations Committee	●	●	●	●	●	●	●	●
		Reports Committee	●	●	Trans	Comp				
	Vendor Management	Vendor Contract Manager	●	●	●	●	●	●	●	●

4a-9

Operational Optimization

GHCP Tatum Update

Scope	Category	Sub-category	Jan 27	Feb 3	Feb 10	Feb 17	Feb 24	Mar 3	Mar 10	Mar 17
Operational Optimization	Claims Processing	Claims process improvement	●	●	●	●	●	●	●	●
		TAT, Inventory	●	●	●	●	●	●	●	●
		Interest Policy	●	●	●	●	comp	comp	comp	comp
		Auto Adjudication improvement	●	●	●	●	●	●	●	●
	Provider Contracting	Non-emergency medical transport	●	●	●	●	comp	comp	comp	comp
	Vendor Management	RN Rate Reductions	●	●	●	●	comp	comp	comp	comp
		ACS monitoring	●	●	●	●	●	●	●	●
		Improve Service Level and Key Performance measures	●	●	●	●	●	●	●	●
	Financial Recovery Project	Revenue generation/cost avoidance/cost savings	●	●	●	●	●	●	●	●

4a-10

System Optimization and Configuration

GHCP Tatum Update

Scope	Category	Sub-category	Jan 27	Feb 3	Feb 10	Feb 17	Feb 25	Mar 3	Mar 10	Mar 17
System Optimization and Configuration	Health Plan Tools		●	●	●	●	Comp			
	Milliman		Trans	Trans	Trans	Trans	Comp			
	ICES		●	●	●	●	Comp			
	System Configuration	IKA set up	●	●	●	●	●	●	●	●
	Work Flow Management	Enhance use of tool	●	●	●	●	●	●	●	●

4a-11

The ultimate goal is to successfully transition the activities performed or overseen by Tatum staff to internal or external sources managed by GCHP

Scope	Category	Sub-category	Jan 27	Feb 3	Feb 10	Feb 17	Feb 24	Mar 3	Mar 10	Mar 17
Transition activities	IT Director		●	●	●	●	Comp			
	COO									
	Claims Pricing		●	●	●	●	●	●	●	●
	Provider Contracting		●	●	●	●	Comp	Comp	Comp	Comp
	Milliman		Trans	Trans	Trans	Trans	Comp			
	ACS contract development		●	●	●	●	●	●	●	●
	Member Service Manager								●	Comp

4a-12

AGENDA ITEM 4b

To: Gold Coast Health Plan Commissioners

From: Guillermo Gonzalez , Director of Government Relations

Re: Narrow Bridge Health Plan

Date: March 25, 2013

SUMMARY:
On February 26, 2013 the California Health Exchange Board, now known as Covered California, met and approved the Medi-Cal Narrow Bridge Plan Proposal.

BACKGROUND:
On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA). In accordance with the ACA, states have the option to establish health benefit exchanges to facilitate the purchase of qualified health plans (QHPs) by individuals and employers by January 1, 2014. Under the ACA, states have the flexibility to offer basic health plans that provide minimum essential coverage. The ten essential health benefits that plans must include are:

- Ambulatory patient services and Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care

The basic health program (BHP) is an optional coverage program under the ACA that would allow states to use federal tax subsidy dollars to offer subsidized coverage for individuals with incomes between 139-200% of the federal poverty level (FPL). These individuals would otherwise be eligible to purchase coverage through state health insurance exchanges. The federal Department of Health and Human Services (HHS) has indicated that they will delay implementation of the BHP option until 2015. Instead the California Legislature is considering and is expected to approve a “narrow bridge plan” proposal.

DISCUSSION:
Under the Medi-Cal narrow bridge proposal those who become ineligible for Medi-Cal due to an increase of income would be permitted to stay with the same Medi-Cal plan. Proponents argue that Medi-Cal narrow bridge plans would facilitate continuity of care, allow family members to enroll in the same plan, and keep families together.
Narrow bridge plans would offer the lowest-cost silver plan so that eligible enrollees could obtain the federal cost sharing subsidies. Bridge plans will be required to offer both silver and gold tier products. Covered California will offer five levels of health plan coverage: platinum, gold, silver, bronze, and a catastrophic plan.. The bronze plan pays 60 percent of expected health care costs. The silver plan will pay 70 percent; gold, 80 percent and platinum, 90 percent.

State legislation (SBX1 3) was introduced to include the narrow bridge plan proposal and is set for hearing in the State Senate Health Committee on March 20th. Additionally DHCS and the Centers for Medicare and Medicaid (CMS) are involved in on-going discussions regarding the implementation of a broad bridge program in future years. The broad bridge plan would make enrollment available to anyone with incomes up to 200% of FPL regardless of their connection to Medi-Cal. The California Exchange Board has recommended that individuals eligible for the narrow bridge plan between January 2014 and April 2014 be eligible for 4 months of transitional Medi-Cal coverage and be given the option to enroll in any other QHP through the Covered California website. A UC Berkeley-UCLA study estimates that over 670,000 people will be eligible for the narrow bridge program in 2014.

RECOMMENDATION:
Staff recommends further analysis of federal rules concerning Medicaid bridge plans as they become available. This memo was provided for information purposes only. No action is requested at this time.

CONCURRENCE:
N/A.

Attachments:
Covered California Letter

March 11, 2013

Mr. Gary Cohen
Deputy Administrator & Director
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Re: Request for Approval of Bridge Program

Dear Mr. Cohen:

I am writing to request approval of Covered California's proposal to establish a Bridge Program. This proposal provides a strategy that builds on federal guidance and promotes the twin goals of affordability and continuity of care.

Our proposal has been endorsed by the Covered California Board, and has the support of Governor Brown and his Administration. The state legislation that is needed for implementation has been introduced by Senator Ed Hernandez, the Chair of the Senate Health Committee.

In developing our Bridge proposal, our underlying objective has been to develop an approach that encourages greater enrollment among those with the lowest income who are eligible for subsidies. Bridge plans that offer greater affordability and continuity of care will give consumers an important choice they will value, while still allowing them to choose from among all plans and product offered by Covered California.

The resolution adopted by the Covered California Board envisions a two-pronged strategy:

- **Begin Implementation in 2014.** Covered California would, contingent on federal approval, begin the administrative process in 2013 to allow low cost "Bridge" plan options to be offered as soon as possible in 2014. Covered California would negotiate contracts with qualified Medi-Cal Managed Care plans that serve as a "bridge" plan between Medicaid/CHIP coverage and private insurance. Consistent with federal guidance, this proposal would allow individuals transitioning from Medi-Cal or Medi-Cal/CHIP coverage to Covered California to stay with the same issuer and provider network. It would also allow family members to be covered by a single issuer with the same provider network. These Bridge plans could offer very low out of pocket premiums for their transitioning enrollees through contracts with Covered

California. An April 1, 2014 implementation date is assumed due to timing challenges related to the development of information technology functionality issues. Based on this date, the UC Berkeley Center for Labor Research and Education estimates first year enrollment to be between 670,000 and 840,000.

To foster maximum participation of Medi-Cal Managed Care plans and their Bridge plans, the Qualified Health Plan certification process would be streamlined.

- **Conduct Further Discussions with the Federal Government and Research on Potential of Expanding Eligibility for Bridge Plans.** Covered California would continue working with our federal partners to develop a potential proposal that would broaden the eligibility for Bridge plans and would allow participation of Californians up to 200% of FPL. This eligibility expansion would require additional research and assessment of potential marketplace implications and implementation challenges.

Our proposal, which is described in the attached policy brief, addresses the specific issues that were outlined in CMS guidance on Bridge Programs. In addition, we are attaching the proposed statutory language that would establish the Bridge Program, and our enrollment projections from the U.C. Berkeley Center for Labor Research and Education.

We are ready to move forward and look forward to working with you and your staff to fully address any policy or implementation concerns. We are, of course, mindful of the aggressive timeline that is required for launching the Bridge program in 2014 and we hope to begin work as soon as possible.

Thank you for considering our proposal and we welcome the opportunity to work together with you and your staff.

Sincerely,

Peter V. Lee
Executive Director

Attachments