Financial Performance Review and Action Plan

- Open and frank dialogue between commissioners and staff
- Legal disclaimer: *cannot discuss rates*

10.12 Nondisclosure and Confidentiality. HOSPITAL and PLAN will not disclose the payment provisions of this Agreement except as may be required by law.

FY 16/17 AE MLR - Estimate Due to State		As of 10/1/19
Tab - 16-17 MLR Calculator		
Net Capitation Payments		
7/1/16-12/31/16		$ 152,610,032
1/1/17-6/30/17		149,451,741
		302,061,773
	85%	256,752,507
Allowed Medi-Cal Expenses		
7/1/16-12/31/16		123,623,510
1/1/17-6/30/17		125,354,734
		248,978,244
Difference - Due to State		**7,774,263**
Amount estimated to be disallowed - AB 85 25%		**3,683,948**
TOTAL Estimated due to State		**$ 11,458,211**
Rounded		11,460,000
Prior Estimate		**$6,856,976**
Entry Cr. Account 2060 Dr. 4010 Unearned Premium (Adult Expansion)		**4,603,024**

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	Date of Service FY 18/19	Net Adjustments		FYTD F/S
Total Revenue	**$ 717,025,433**	**$ 889,930**	**1**	**$ 717,915,364**
Capitation	$ 59,776,743			
Pharmacy	$ 134,566,717			
FFS	$ 503,552,163			
Provider Reserve	$ 2,095,681			
Directed Payments	$ 12,460,819			
Medical and Care Management	$ 14,080,687			
Reinsurance	$ (1,416,559)			
Recoveries	$ (2,079,464)			
Total Medical	**$ 723,036,787**	**$ 9,412,657**	**2**	**$ 732,449,444**
Total G&A	**$ 46,655,880**			**$ 46,655,880**
Interest Income/Other	**$ 4,679,537**			**$ 4,679,537**
Net Loss	**$ (47,987,697)**	**$ (8,522,726)**		**$ (56,510,423)**

1. Net of downward adjustment for 16/17 AE MLR and Hep C recoup, both A/R and liability write off's with insufficient documentation, and revenue associated with prior year service dates.
2. Prior period change in estimate (equates to 1.3% of the annual medical expense).

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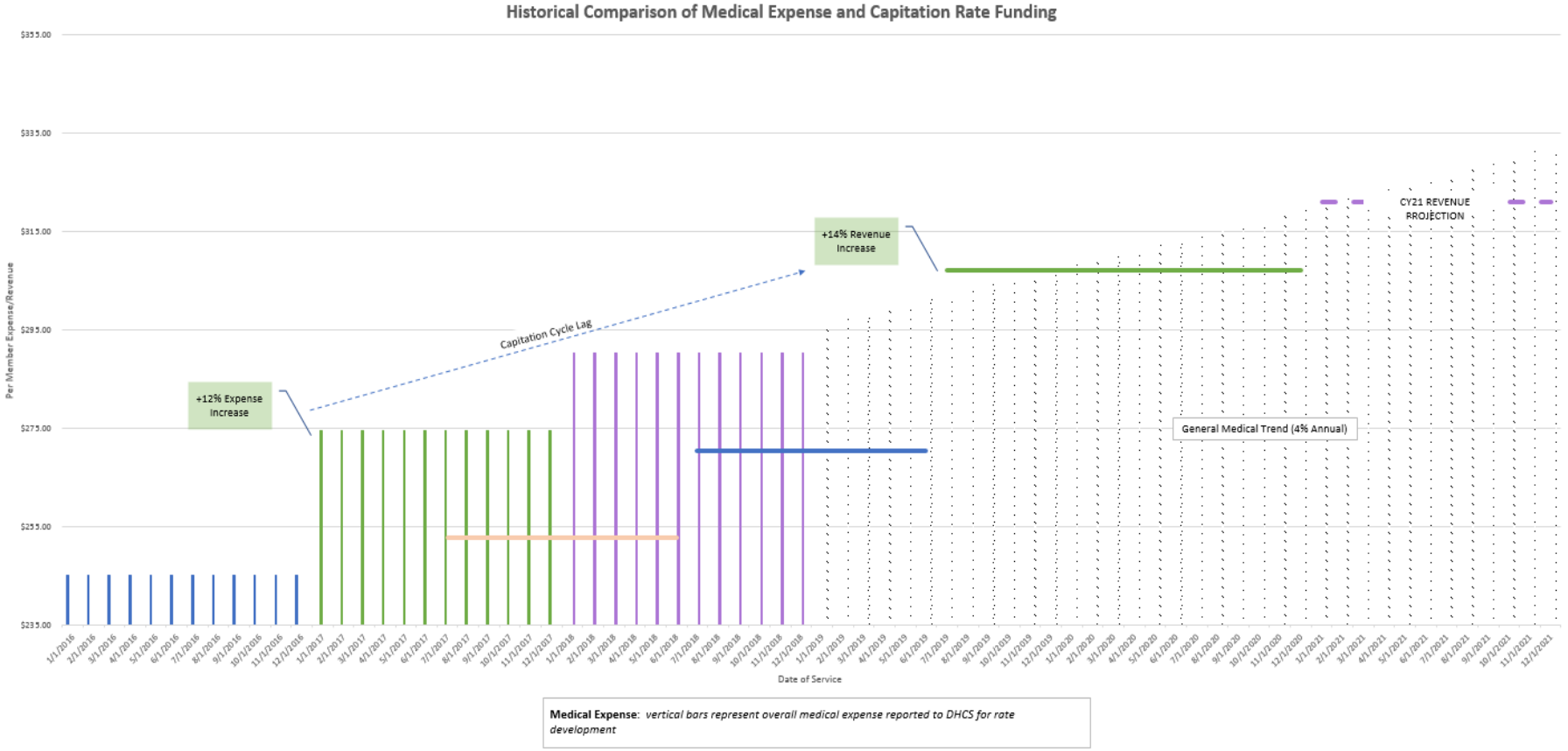

Overview:

• This chart includes historical medical expense aggregated across all populations and services for each calendar year through 2018 using vertical columns. The horizontal lines represent capitation funding for medical services, excluding the components for administrative expenses and risk margin. To the extent that the horizontal lines exceed the vertical bars, the capitation funding is sufficient.

• Traditionally, DHCS has relied upon historical experience reported by each health plan to develop Medi-Cal capitation rates. As an example, CY 2016 expense was the primary foundation for FY 2018-19 capitation rate development. DHCS incorporated adjustments to reflect anticipated changes in expense for this 2.5 year gap which can be seen as the difference between the expense shown in the blue vertical bars and the solid blue horizontal revenue line. Typically, these adjustments reflect statewide assumptions that may not be appropriate to match actual changes for any individual health plan.

• Due largely to changes in provider contracting, expense increased by approximately 12% from CY 2016 to CY 2017. This rate of growth was not reflected in DHCS' rate development until the CY 2017 experience was utilized to develop the FY 2019-20 capitation rates. This has caused significant strain on net income through June 2019, but a combination of the revenue increase in July 2019 and continued monitoring of medical expense growth should yield income stability.

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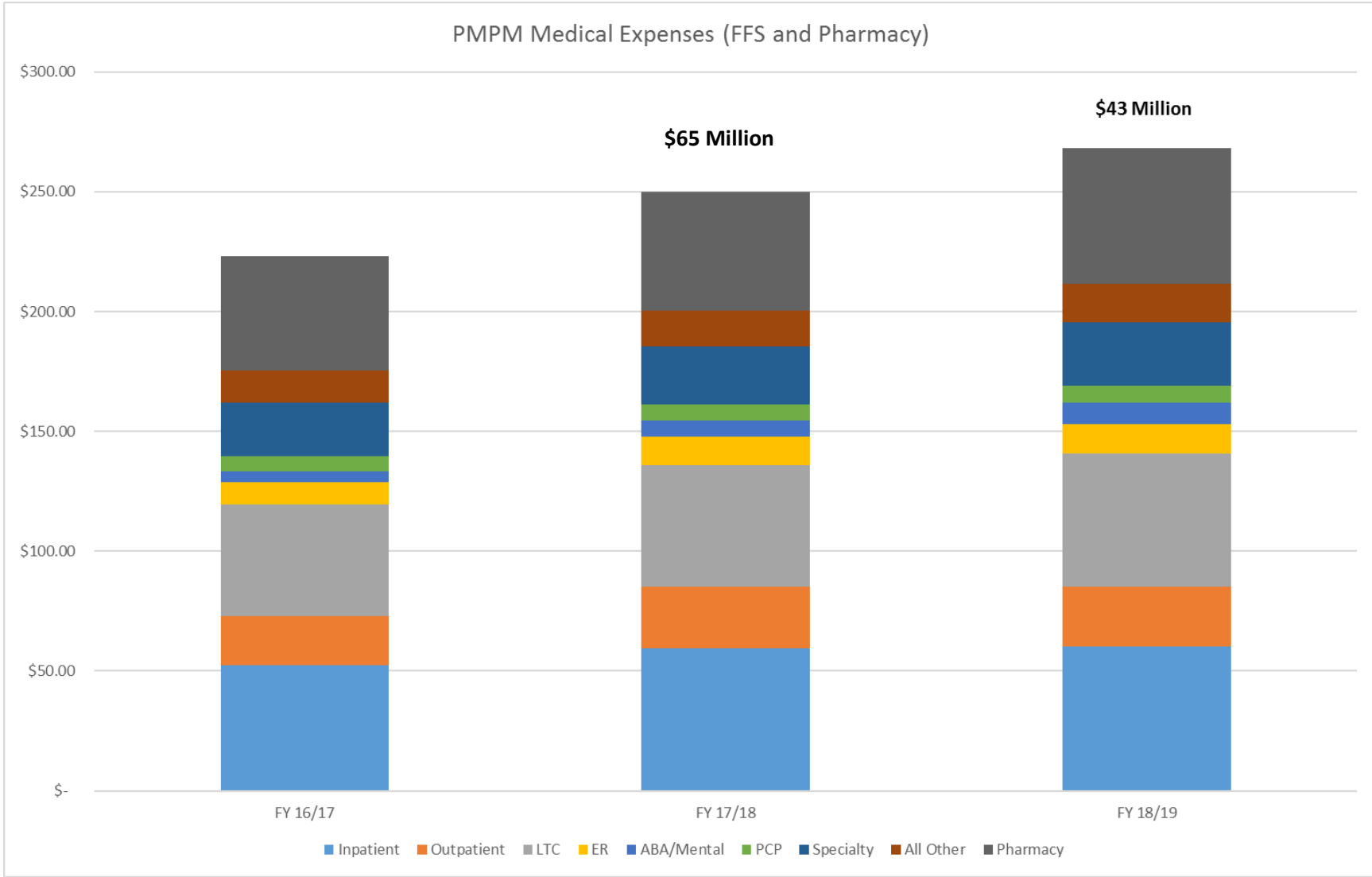

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Contracting and Policy Changes Impacting Total Health Care Spend (2016-2018)

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Look Back

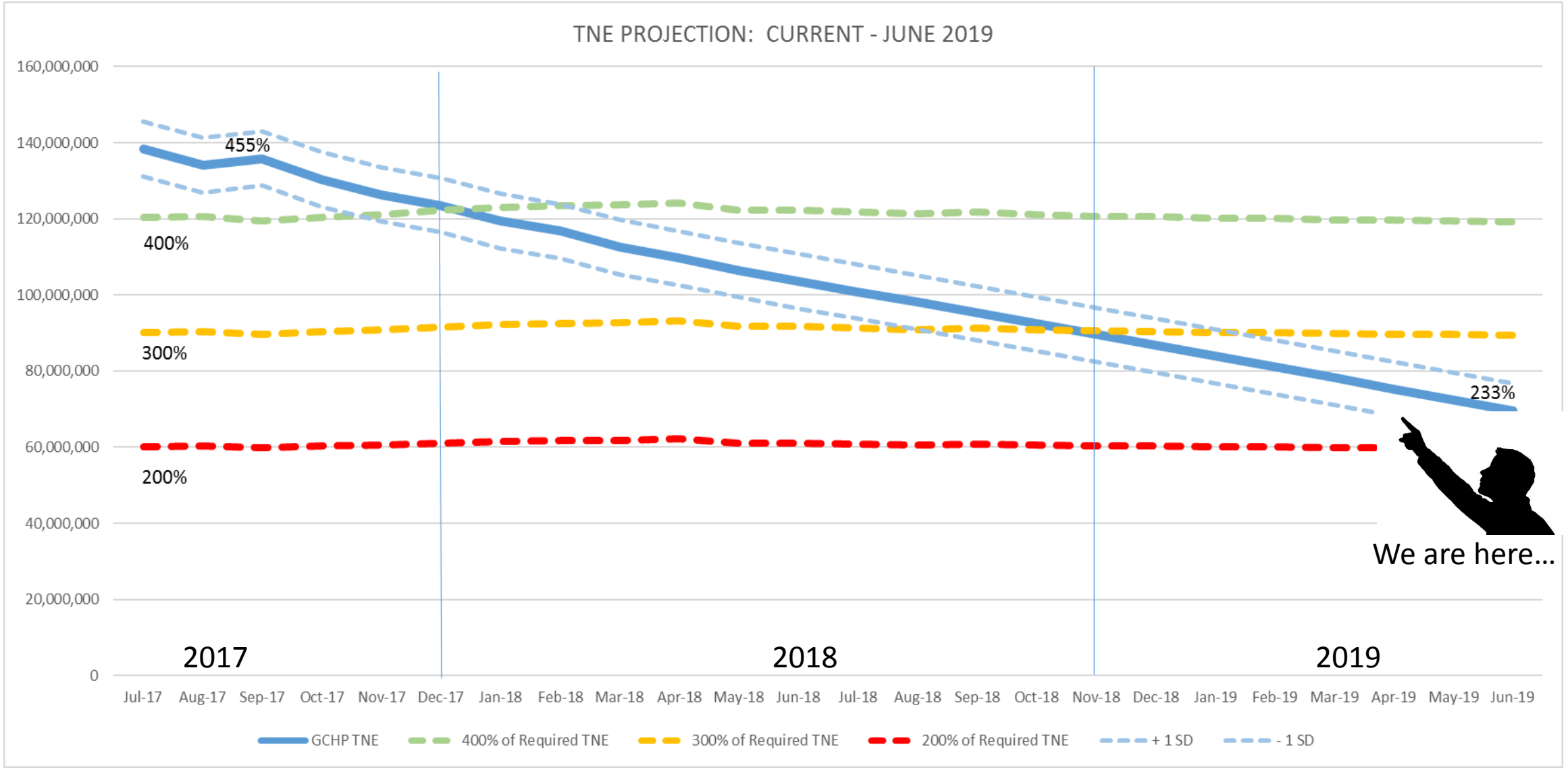
Early plan years: Contracts at 100% Medi-Cal rates but increased to ensure network adequacy and access

TNE Policy:
- 2016 TNE at 580%
- 2017 Commission set policy 400-500%
- Increased rates to providers across the board

2017 rates increased to hospitals:
- Hospital A received 16.6% increase due to contract restructuring of original 3-year agreement based on specific product lines
  - $6.5M settlement on claims disputes around contract language and payments (2018)
- Hospital B contract lapsed July 2016 and negotiations stalemated. Staff met with DHCS to discuss terming of a major hospital system.
  - Agreed to 26.6% rate increase with retro adjustment to July 2016
  - 10-month lapse in contract (paid at previous rates); $8.8M paid

2018 rates decreased to hospitals:
- Hospital A ~3.1% reduction via operational amendment
- Hospital B – 5.2% reduction

November 2017 TNE Projection Presented to Commission



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Fiscal Year 2018/19 Close Out

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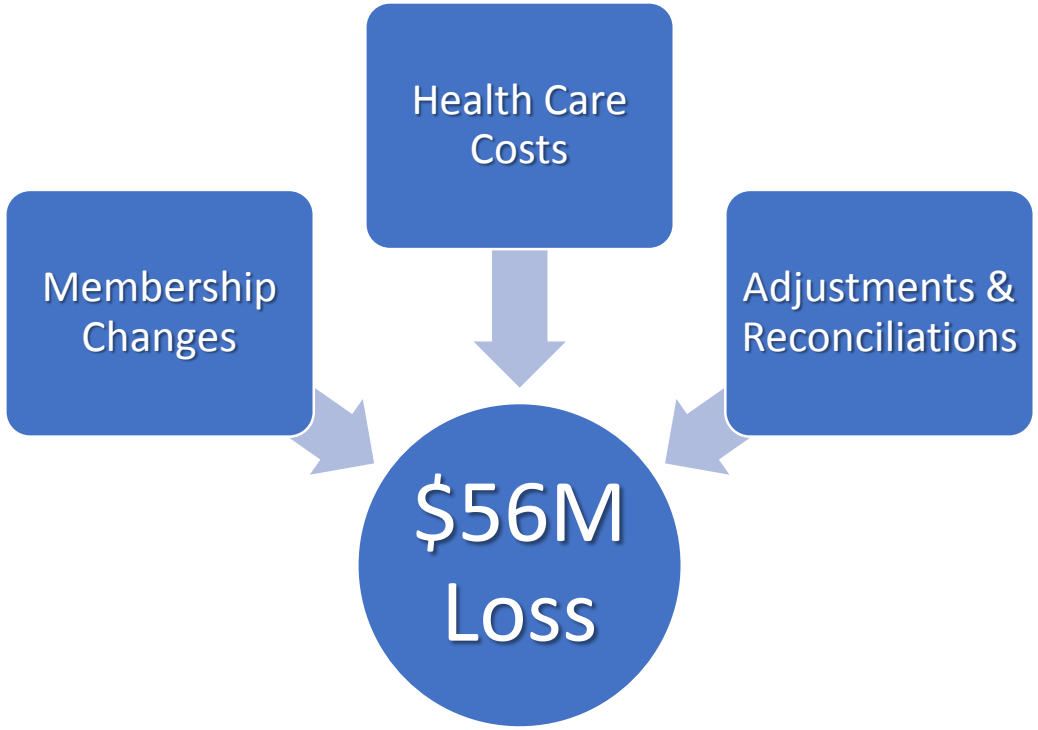
FY 18/19 Performance



How Did We Get Here?

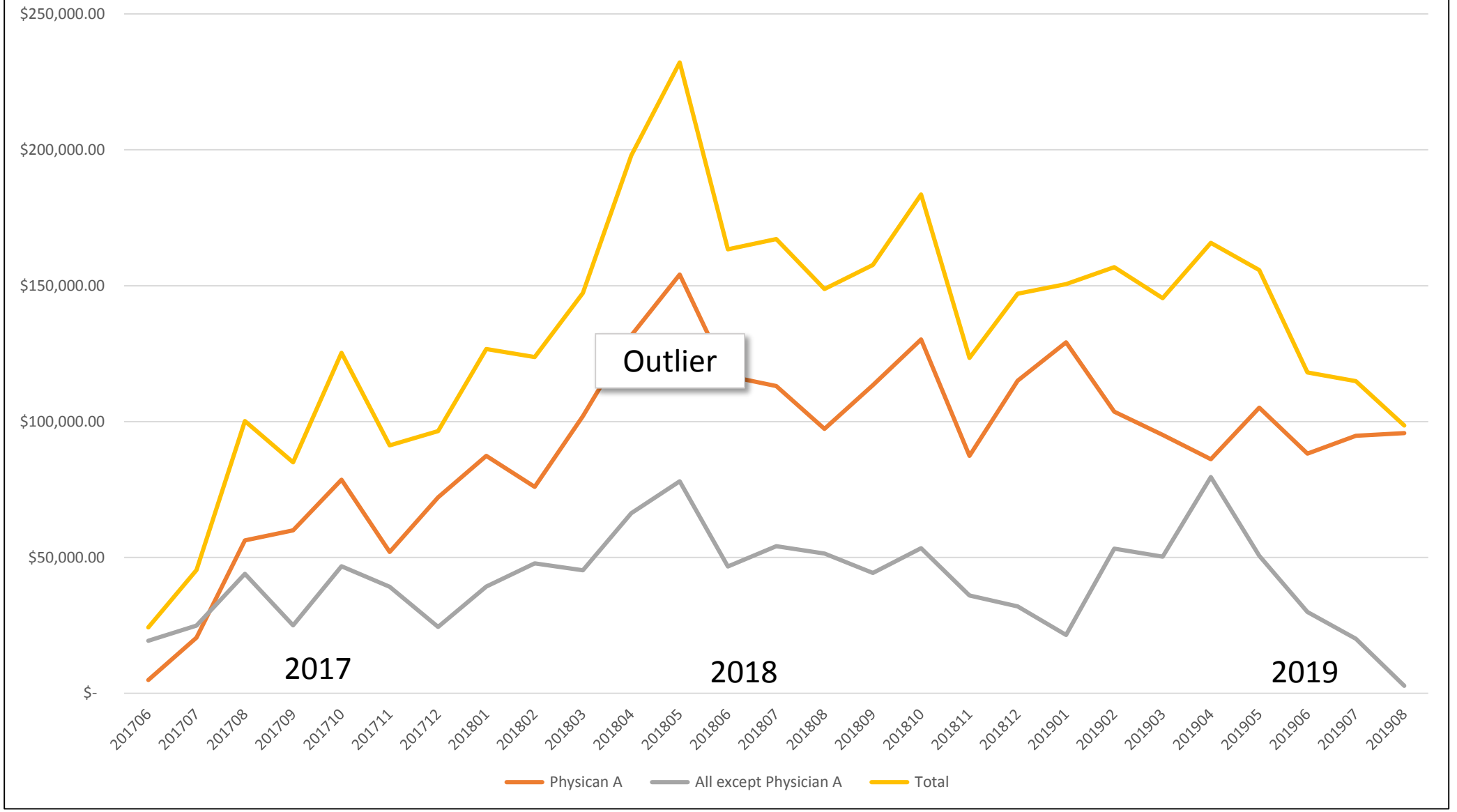
Key driver: Health Care Costs

- Budget: $660M
- Actual: $732M
- Utilization and contract rates
- Underfunded mandates

Areas of Focus:

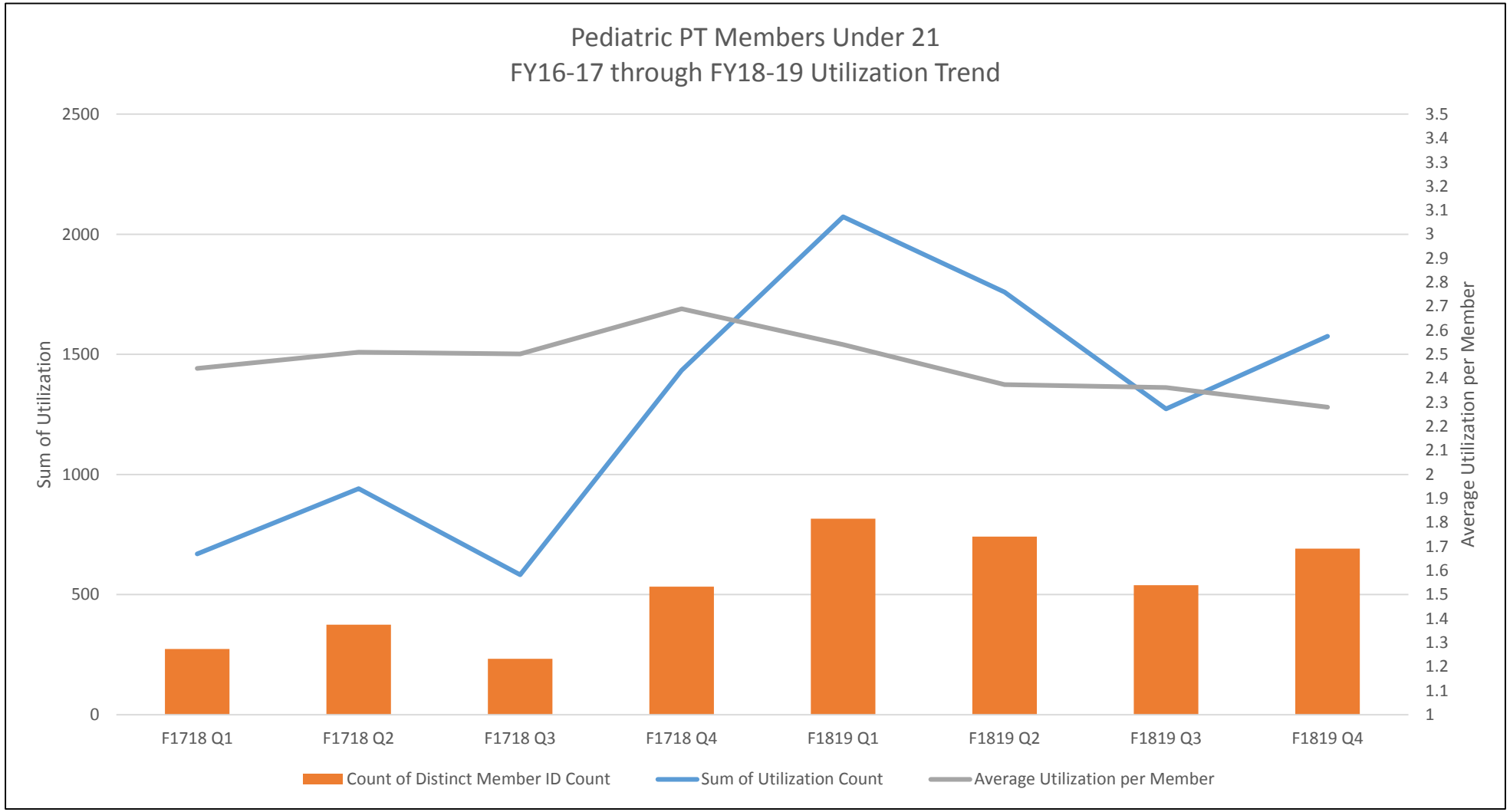
• Hospital	• Long Term Care
• Pharmacy	• Specialty Care – Dermatology, PT

Specialty: Dermatology Expense June 2016-August 2019

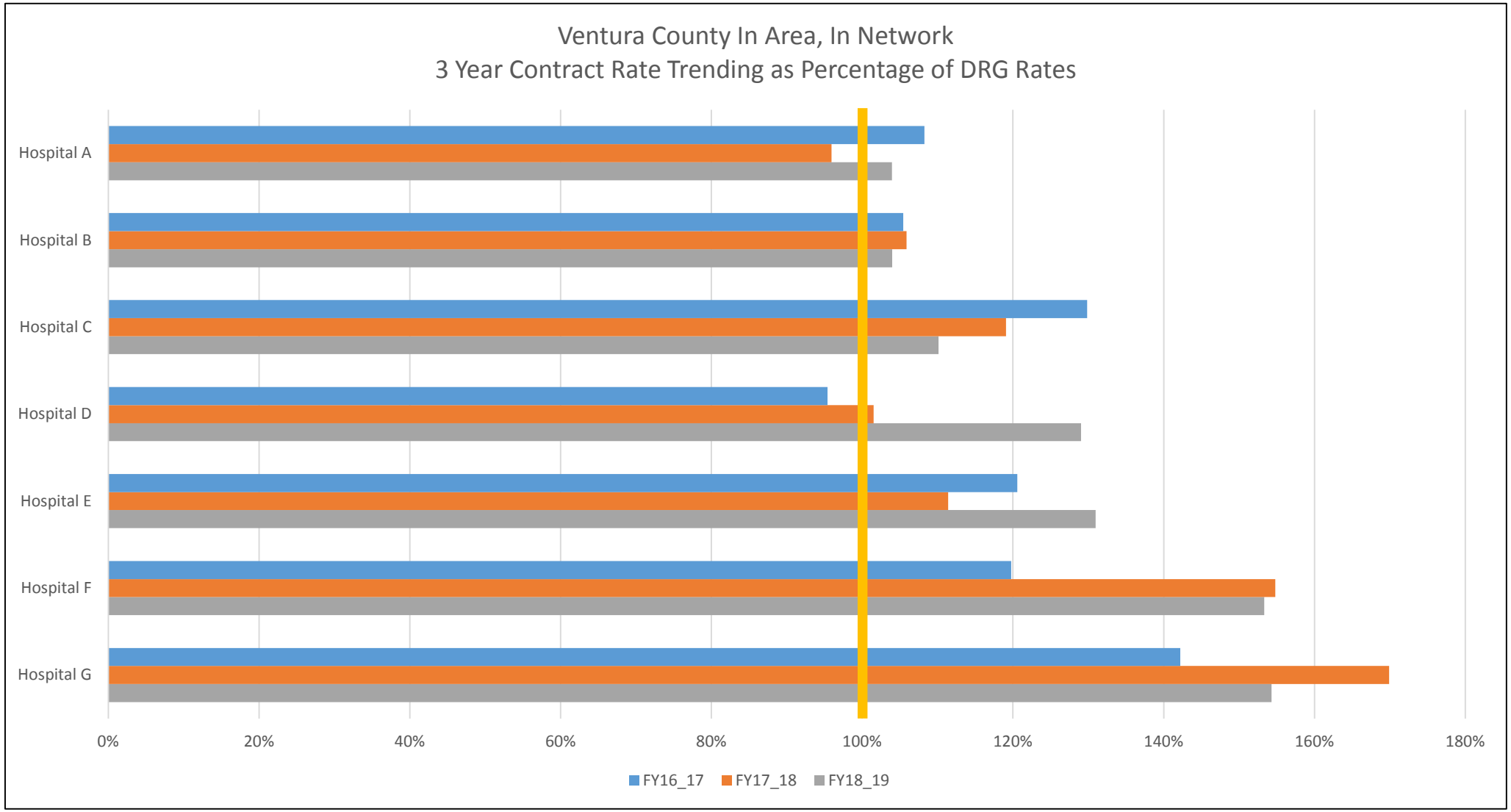


Data Source: MedInsight
Data through 8/2019 – consider incompletion factors due to lag.

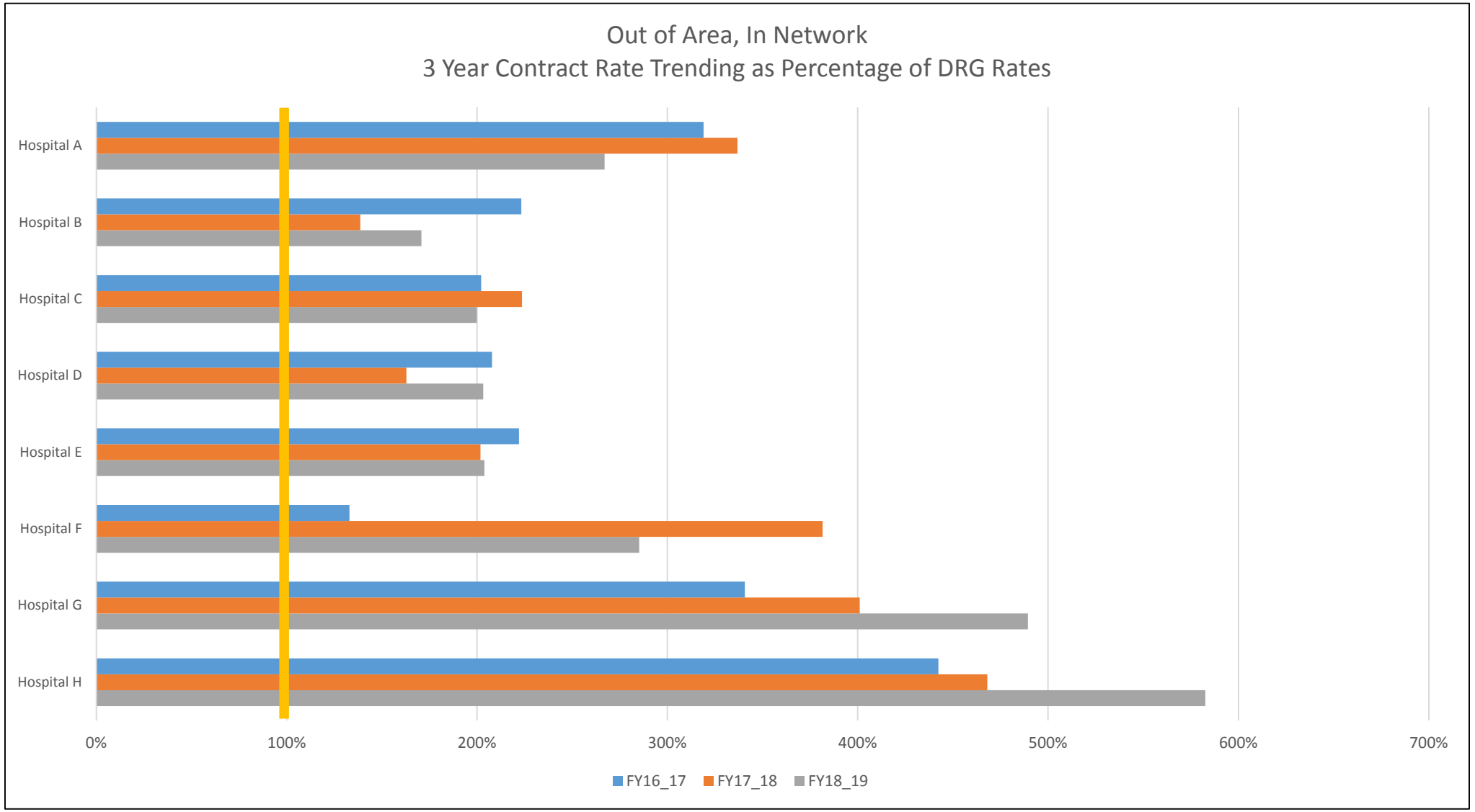
Pediatric PT Utilization Increase Analysis



Per the grey line, we can see that average utilization per member is decreasing- a reflection of the efficacy of the strategies that have been put in place.



Based on Top 15 Paid Hospitals FY18-19
Dates of Service: FY2016-19
Excludes Duals; Excludes SNF
Source: 3M DRG Pricer/ MedInsight/IKA



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Dates of Service: FY2016-19
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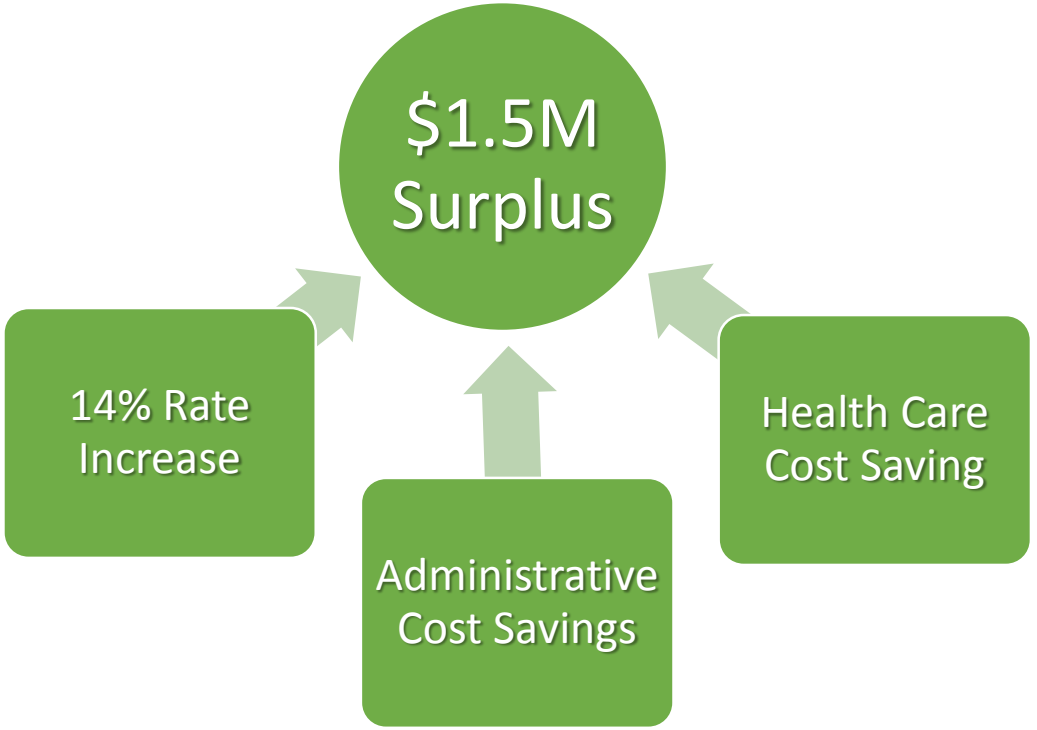
Source: 3M DRG Pricer/ MedInsight/IKA

FY 19/20 Focus

Actions

- Renegotiating contracts (Steve)
  - Driving to break-even
  - Balance savings against future revenue
- Clinical initiatives
  - CCS Cost Avoidance
  - Proactive Care Management
  - Overutilization Controls
- Administrative Cost Savings
  - Reorganization complete
  - Staff capacity stretched
  - Conduent = 42% of admin budget

FY 19/20 Budget



PROVIDER CONTRACTING RATE RE-ADJUSTMENT STRATEGY

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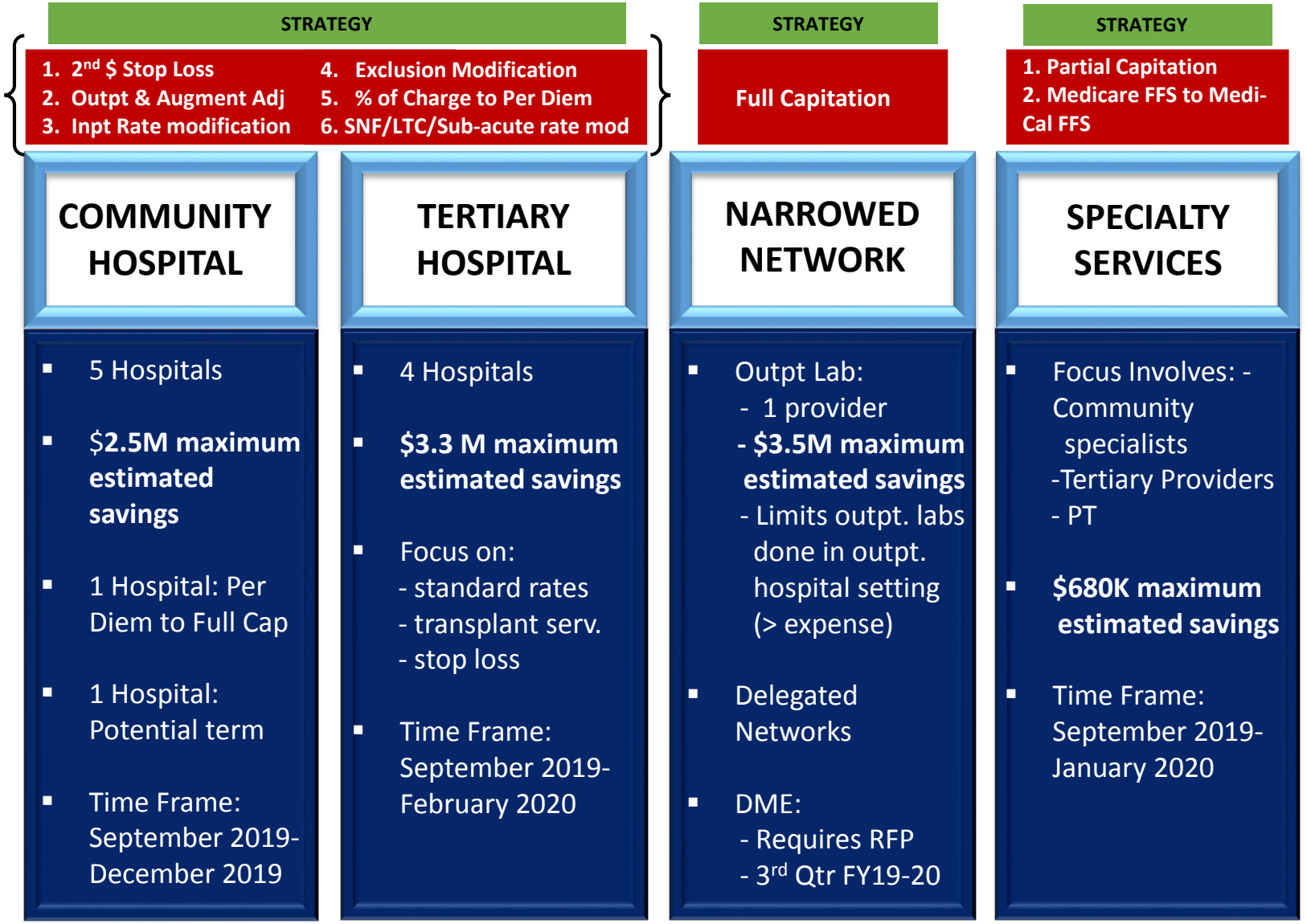

Conduent Contract Performance Review

- GCHP implemented enabling activities and functions to compensate for vendor performance
- Lack of oversight and accountability
- Downstream impacts to business and provider payment

EXAMPLES:

CLAIMS

- Compound Drug Pricing
- DRG Pricing
- Staff expertise
- PDR overall volume increase resulting in PGR (Plan Level)
- Interest Payments (Pended Claims)
- Manual processes
- CAP open for 2017 & 2018
- Contract load configurations and lack of QA testing

CALL CENTER:

- 6-month backlog on Provider calls relative to claims inquiry
- Call Center Agents skill limitations
- Eligibility system limitation loads resulting in delay for downstream loads

Initial Observations By Functional Area

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Compliance

- Access to call center data, audits, reports and recorded calls has been difficult. This lack of transparency may impact compliance reporting accuracy.

Provider Network and Operations

- There are two separate processes and databases to support Provider Data. This results in inaccurate claims payment and has Authorization implications. (PMDB, Conduent manual entry based on spreadsheet).

Utilization Management

- Due to incorrect data and system limitations, a significant amount of manual work is required to ensure that Authorization data is passed correctly to the Claims system.
- Claims interest driven by Auth Appeal.

Finance and Revenue Management

- Conduent is not following established processes for approving financial transactions.
- System limitations result in significant manual processes for A/P transactions.

- Claims are pending for member eligibility issues. There is a lag in the timing of Conduent to Eligibility for correction. In some cases this isn't happening.
- Member load takes up to 48 hours and enrollment data audits are two months in arrears.
- 25 agents field 11,000 calls per month.

Membership

- A common theme is that the Conduent claims examiners are not equipped to make adjudication decisions. They are often routing claims to Gold Coast that could be adjudicated by Conduent with research on the part of Conduent.
- LPI was identified as a problem. $540K in interest was paid in the prior fiscal year.
- Encounter data submittal error resolution in manual resulting in 20 hours per month in manual intervention.
- Large spike in claims greater than 30 days started Q3 2018.

Claims and Encounters

- Provider inquiry queues are running a 6-Month backlog.
- There was feedback that call statistics is lacking and routing of Tier 1, Tier 2 and Tier 3 call issues may not be handled according to contractual obligations.

Customer Service and QA

fluidEDGE consulting