CALL TO ORDER / ROLL CALL

PUBLIC COMMENT A Speaker Card must be completed and submitted to the Clerk of the Board by anyone wishing to comment:

- **Public Comment** – Comments regarding items not on the agenda but within the subject matter jurisdiction of the Commission.
- **Agenda Item Comment** – Comments within the subject matter jurisdiction of the Commission pertaining to a specific item on the agenda. The speaker is recognized and introduced by the Commission Chair during Commission’s consideration of the item.

1. **APPROVE MINUTES**
   a. Special Meeting of September 29, 2014
   b. Regular Meeting of October 27, 2014

2. **CONSENT ITEMS**
   a. CFO Update - September Financials

Meeting Agenda available at [http://www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)
3. **APPROVAL ITEMS**
   a. DHCS Contract Amendments A14 and A02
   b. AB 1234 Ethics Training
   c. Administrative Services Organization (ASO) / Pharmacy Benefits Management (PBM) RFP Proposal

4. **ACCEPT AND FILE ITEMS**
   a. Special Investigation Ad Hoc Committee Report
   b. CEO Update
   c. COO Update
   d. CIO Update
   e. Health Services Update
   f. Non-Emergency Medical Transportation

**CLOSED SESSION**

a. Conference with Legal Counsel – Existing Litigation Pursuant to Paragraph (1) of Subdivision (d) of Government Code Section 54956.9.
   i. Cressena Hernandez v. Ventura County Medi-Cal Managed Care Commission, et al. Ventura County Superior Court Case Number 56-2012-00427535-CU-OE-VTA
   ii. Clinicas Del Camino Real Inc. v. Ventura County Medi-Cal Managed Care Commission 1dba Gold Coast Health Plan. Ventura County Superior Court Case Number 56-2014-00456149-CU-BC-VTA

b. Public Employee Appointment Pursuant to Government Code Section 54957
   Title: Chief Executive Officer

Meeting Agenda available at [http://www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)
c. Conference with Legal Counsel – Significant Exposure to Litigation Pursuant to Paragraph (2) of Subdivision (d) of Government Code Section 54956.9 (Two Cases)

RETURN TO OPEN SESSION

Announcement from Closed Session, if any.

3. APPROVAL ITEMS (continued)
   d. Waiver of Attorney-Client and Closed Session Privileges

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on January 26, 2015 at 3:00p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard, CA 93036.
Notice of said meeting was duly given in the time and manner prescribed by law. Affidavit of compliance is on file in the Clerk of the Board’s Office.

CALL TO ORDER

Chair Araujo called the meeting to order at 3:03 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
Antonio Alatorre, Clinicas del Camino Real, Inc.
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Lanyard Dial, MD, Ventura County Medical Association
Barry Fisher, Ventura County Health Care Agency
Peter Foy, Ventura County Board of Supervisors (arrived 3:41 p.m.)
David Glyer, Private Hospitals / Healthcare System
Gagan Pawar, MD, Clinicas del Camino Real, Inc.
Dee Pupa, Ventura County Health Care Agency
Robert Wardwell, Private Hospitals / Healthcare System

EXCUSED / ABSENT COMMISSION MEMBERS
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Vacant, Medi-Cal Beneficiary Advocate

STAFF IN ATTENDANCE
Ruth Watson, Chief Operations Officer and Interim Chief Executive Officer
Michelle Raleigh, Chief Financial Officer
Traci R. McGinley, Clerk of the Board
Brandy Armenta, Compliance Director
Stacy Diaz, Human Resources Director
Mike Foord, IT Infrastructure Manager
Anne Freese, Pharmacy Director
Guillermo Gonzalez, Government Relations Director
Steven Lalich, Communications Director
Vickie Lemmon, Health Services Director
Tami Lewis, Operations Director
Allen Maithel, Controller
Al Reeves, MD, Chief Medical Officer
Melissa Scrymgeour, Chief Information Officer
Lyndon Turner, Financial Analysis Director
Nancy Wharfield, MD, Associate Chief Medical Officer
The Pledge of Allegiance was recited.

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

PUBLIC COMMENT

None.

1. APPROVAL ITEMS

a. **Representation Agreement with the County of Ventura for Legal Services**

Chair Araujo explained that the agreement would allow the Commission and the Plan to engage the County of Ventura, County Counsel's Office for legal representation services.

Commissioner Fisher moved to approve the representation agreement with the County of Ventura County Counsel Office. Commissioner Fisher noted that county counsel John Polich was present and was the original attorney for the Commission until it was able to obtain outside counsel. Commissioner Pupa seconded.

In response to Commissioner Dial's question; Commissioner Fisher responded that if needed, County Counsel would be available for staff; however, GCHP staff does work with other legal firms.

Commissioner Alatorre asked how long County Counsel's Services would be used. Chair Araujo responded that it would be until new regular general counsel was obtained.

The motion carried with the following votes:

- **AYE:** Araujo, Dial, Fisher, Glyer, Pawar, Pupa and Wardwell.
- **NAY:** Alatorre.
- **ABSTAIN:** None.
- **ABSENT:** Foy and Laba.

Counsel Polich then took his seat at the dais.

2. APPROVE MINUTES

a. **Regular Meeting of August 25, 2014**

Commissioner Fisher moved to approve the Meeting Minutes of August 25, 2014. Commissioner Dial seconded. The motion carried with the following votes:

- **AYE:** Araujo, Dial, Fisher, Glyer, Pawar, Pupa and Wardwell.
- **NAY:** None.
- **ABSTAIN:** Alatorre.
- **ABSENT:** Foy and Laba.
1. APPROVAL ITEMS (Continued)

   b. Conflict of Interest Code
   Interim CEO Watson reviewed the written report explaining that as required, the Commission directed staff to conduct a biennial review of the Conflict of Interest Code. A number of changes were required due to new positions, revised job titles and descriptions.

   It was noted that a page was missing from the agenda item, Clerk McGinley offered to pull the information up on the computer.

   Commissioner Fisher moved to approve the Resolution updating the Conflict of Interest Code. Commissioner Dial seconded. The motion carried with the following votes:

   NAY: None.
   ABSTAIN: None.
   ABSENT: Foy and Laba.

RESOLUTION NO. R2014-002

A RESOLUTION OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION dba Gold Coast Health Plan UPDATING DESIGNATED EMPLOYEES, OFFICERS AND DISCLOSURE CATEGORY LIST FOR POLITICAL REFORM ACT AND FAIR POLITICAL PRACTICES REQUIREMENTS (CONFLICT OF INTEREST AND RESCINDING THE CONFLICT OF INTEREST CODE AMENDED PURSUANT TO RESOLUTION NO. R2012-003)

c. Business Property Liability Insurance Policy
   CFO Raleigh reviewed the written report with the Commission. The current policy with Hartford Insurance expires September 30, 2014. Three companies provided quotes to the Plan’s insurance brokers, Beecher Carlson. CFO Raleigh recommended purchasing the basic Business Insurance policy with Chubb at the increased levels and the additional umbrella policy (shown below). She explained that it would provide adequate coverage for increased growth at limits no less than the current policy.

<table>
<thead>
<tr>
<th>Property</th>
<th>Chubb - Quote 2 with $2 Million Umbrella**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building</td>
<td>N/A</td>
</tr>
<tr>
<td>Business Personal Property (BPP)</td>
<td>$566,174</td>
</tr>
<tr>
<td>Electronic Data Processing (EDP)</td>
<td>$857,136</td>
</tr>
<tr>
<td>Deductible</td>
<td>$1,000</td>
</tr>
<tr>
<td>General Liability</td>
<td>$2 Million Umbrella**</td>
</tr>
<tr>
<td>General Aggregate</td>
<td>$4 million</td>
</tr>
<tr>
<td>Each Occurrence</td>
<td>$3 million</td>
</tr>
<tr>
<td>Advertising Injury and Personal Injury</td>
<td>$3 million</td>
</tr>
<tr>
<td>Medical Expense</td>
<td>$10,000</td>
</tr>
<tr>
<td>Damage to Rented Premises</td>
<td>$3 million</td>
</tr>
<tr>
<td>Employee Benefits (endorsement)</td>
<td></td>
</tr>
</tbody>
</table>
Commissioner Dial moved to approve purchasing the basic Business Insurance policy with Chubb at the increased levels and the additional umbrella policy. Commissioner Glyer seconded. The motion carried with the following votes:

NAY: None.
ABSTAIN: None.
ABSENT: Foy and Laba.

**d. Approval of Recommended Search Firm for CEO Position**

Chair Araujo stated that Human Resources Director Diaz would present the report she prepared on behalf of the ad hoc committee. Director Diaz then reviewed the written report.

Commissioner Alatorre stated that he had not received notice of the meeting, but understood that he was a member of the ad hoc committee. Director Diaz stated that she contacted Chair Araujo when she had not heard back from Commissioner Alatorre and Chair Araujo requested that it move forward.

Interim CEO Watson asked if the ad hoc committee could select the firm so it would not be delayed. Counsel Polich responded that when the ad hoc committee was formed the Commission would have had to give the committee that ability. He added that if the Commission delegates decision making authority to an ad hoc committee, then that ad hoc committee is subject to the Brown Act, but if the Commission forms an ad hoc committee that does not make a decision and only reports back to the Commission, then that committee can meet privately as it would not be governed by the Brown Act.

Commissioner Fisher recommended that a Special Commission meeting be scheduled so it would not be delayed.

Commissioner Glyer noted that subject to the parameters in the Agenda Report, he would be open to delegating the authority to the ad hoc committee so this was not delayed further.

Commissioner Dial recommended moving forward since the Commission was informed at the previous Commission meeting that this was the premier search firm.

Commissioner Fisher moved to schedule a Special Commission meeting within the next two weeks which will allow time for the ad hoc committee to convene and review the proposals. Commissioner Pawar seconded. The motion carried with the following votes:

e. **Waive General Counsel Attorney-Client and Closed Session Privileges and Protection – Special Investigation Ad Hoc Committee Consultants**

Chair Araujo announced that the item was not being considered and was being pulled from the agenda.

3. **ACCEPT AND FILE ITEMS**

   a. **Special Investigation Ad Hoc Committee Report**

   Commissioner Fisher noted that Scott Howard, legal counsel for the Special Investigation Ad Hoc Committee was present should the Commission have any questions. Commissioner Fisher then reviewed the written report with the Commission, emphasizing that the investigation had expanded and expenses are expected to total between $586,000 and $636,000 approximately.

   b. **CEO Update**

   Interim CEO Watson presented the CEO update and announced that the Pharmacy information would not be reviewed at this time but detailed information will be going to the Commission at a later time.

   Commissioner Foy arrived at 3:41 pm

   c. **July Financials**

   CFO Raleigh reviewed the July Financial package with the Commission. Discussion was held regarding the growth in membership. CFO Raleigh highlighted that the Tangible Net Equity (TNE) levels are at approximately 182% of the State required minimum which includes the Lines of Credit (LOC) from the County of Ventura of $7.2 million.

   d. **CIO Update**

   CIO Scrymgeour briefly reviewed the written CIO update and highlighted the GCHP Projects At a Glance sheet on page 3d-5.

   e. **Behavioral Health Benefit for Autism Spectrum Disorder**

   Associate CMO Wharfield reviewed the written report with the Commission.

   f. **COO Update**

   Interim CEO Watson presented the COO Update. Commissioner Alatorre asked how many members were being auto assigned. Interim CEO Watson responded that she should be able to have that information at the next Commission Meeting.

   g. **Health Services Update**

   Associate Medical Director Dr. Wharfield reviewed the written report.

Commissioner Pupa moved to accept and file the Special Investigation Ad Hoc Committee Report, CEO Update, July Financials, CIO Update, Behavioral Health Benefit...
for Autism Spectrum Disorder, COO Update and Health Services Update. Commissioner Fisher seconded. The motion carried with the following votes:

NAY: None.
ABSTAIN: None.
ABSENT: Laba.

CLOSED SESSION

Chair Araujo explained the purpose of the Closed Session items.

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 3:57 pm regarding the following items:

a. Public Employee Release Pursuant to Government Code Section 54954(e)

b. Public Employee Appointment Pursuant to Government Code Section 54957(b) Title: General Legal Counsel

c. Conference with Legal Counsel - Anticipated Litigation - Significant Exposure to Litigation Pursuant to Government Code Section 54956.9(b) – (One Case)

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 7:30 p.m.

Chair Araujo announced that the Commission unanimously voted to release legal counsel Nancy Kierstyn Schreiner, Anderson Kill Wood & Bender, P.C., from general counsel duties. He closed stating that no additional reportable action was taken.

ADJOURNMENT

Meeting adjourned at 7:33 p.m.
CALL TO ORDER

Chair Araujo called the meeting to order at 3:03 p.m. in Suite 200 of the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
Antonio Alatorre, Clinicas del Camino Real, Inc.
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Barry Fisher, Ventura County Health Care Agency
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Gagan Pawar, MD, Clinicas del Camino Real, Inc.
Dee Pupa, Ventura County Health Care Agency
Robert Wardwell, Private Hospitals / Healthcare System

EXCUSED / ABSENT COMMISSION MEMBERS
Lanyard Dial, MD, Ventura County Medical Association
Peter Foy, Ventura County Board of Supervisors
David Glyer, Private Hospitals / Healthcare System
Vacant, Medi-Cal Beneficiary Advocate

STAFF IN ATTENDANCE
Ruth Watson, Chief Operations Officer and Interim Chief Executive Officer
Michelle Raleigh, Chief Financial Officer
Traci R. McGinley, Clerk of the Board
John Polich, County Counsel
Brandy Armenta, Compliance Director
Stacy Diaz, Human Resources Director
Anne Freese, Pharmacy Director
Guillermo Gonzalez, Government Relations Director
Steven Lalich, Communications Director
Vickie Lemmon, Health Services Director
Tami Lewis, Operations Director
Allen Maithel, Controller
Al Reeves, MD, Chief Medical Officer
Melissa Scrymgeour, Chief Information Officer
Lyndon Turner, Financial Analysis Director
Nancy Wharfield, MD, Associate Chief Medical Officer

The Pledge of Allegiance was recited.
Language Interpreting and Translating services were provided by GCHP from Lourdes González Campbell and Associates.

PUBLIC COMMENT

None.

1. APPROVE MINUTES

   a. **Special Meeting of September 29, 2014**
   Clerk McGinley noted that staff member Anne Freese, Pharmacy Director, was not present at the meeting. Commissioner Alatorre stated that the minutes do not adequately reflect the discussion held during Item 2d, Approval of Recommended Search Firm for CEO Position and requested the Clerk of the Board review the recording and the minutes be brought back to the Commission.

   Chair Araujo stated that the recording will be reviewed and minutes will be revised and brought back for approval.

2. APPROVAL ITEMS

   a. **Affordable Care Act (ACA) Section 1202 Payments**
   CFO Raleigh reviewed the written report with the Commission.

   Interim CEO Watson added that these are pediatricians and PCPs that have large Medi-Cal practices.

   Commissioner Pupa asked what other plans in the State were doing. CFO Raleigh responded that the plans that have this issue have not gone back to recoup.

   Commissioner Alatorre stated that the Plan needed something in writing from DHCS or CMS because federal law requires Medi-Cal or Medicare over-payments be recouped.

   Interim CEO Watson advised the Commission that it was the legal opinion of the Plan’s contract compliance attorney that these payments are considered a bump, not an overpayment.

   Commissioner Wardwell moved that the Plan not recoup the additional supplemental Affordable Care Act (ACA) Section 1202 payments of approximately $112,000 for the January 1, 2013 through June 30, 2013 time period. Commissioner Fisher seconded. The motion carried with the following votes:

   AYE: Araujo, Fisher, Laba and Wardwell.
   NAY: Alatorre, Pawar and Pupa.
   ABSTAIN: None.
   ABSENT: Dial, Foy and Glyer.
b. **Quality Improvement Committee Report – 3<sup>rd</sup> Quarter 2014**

CMO Reeves reviewed the Quality Improvement Committee Report with the Commission.

Commissioner Pupa moved to approve the Quality Improvement Committee Report - 3<sup>rd</sup> Quarter 2014. Commissioner Alatorre seconded. The motion carried with the following votes:

- **AYE:** Alatorre, Araujo, Fisher, Laba, Pawar, Pupa and Wardwell.
- **NAY:** None.
- **ABSTAIN:** None.
- **ABSENT:** Dial, Glyer and Foy.


c. **Compliance Officer Report – 3<sup>rd</sup> Quarter 2014**

Compliance Director Armenta reviewed the Compliance Report. A number of health plans are receiving corrective actions plans because they did not perform audits of their delegation oversight. Director Armenta assured the Commission that the Compliance Department has implemented a very robust monitoring and reporting system.

Commissioner Pupa moved to approve the Compliance Report. Commissioner Alatorre seconded. The motion carried with the following votes:

- **AYE:** Alatorre, Araujo, Fisher, Laba, Pawar, Pupa and Wardwell.
- **NAY:** None.
- **ABSTAIN:** None.
- **ABSENT:** Dial, Glyer and Foy.

d. **CEO Search Firm**

Human Resources Director Diaz reported that the ad hoc committee met on October 6, 2014 to review and discuss the Executive Search Firm Proposals. The ad hoc committee and staff recommend Witt / Kieffer as the executive search firm to manage the recruitment for Chief Executive Officer.

Commissioner Fisher moved to approve the CEO Search Firm of Witt / Kiefer. Commissioner Pupa seconded. The motion carried with the following votes:

- **AYE:** Alatorre, Araujo, Fisher, Laba, Pawar, Pupa and Wardwell.
- **NAY:** None.
- **ABSTAIN:** None.
- **ABSENT:** Dial, Glyer and Foy.

e. **General Counsel Support**

Interim CEO Watson reviewed the report with the Commission. Staff recommended Best, Best and Krieger (BB&K) as the top candidate to represent the Commission and the Plan as General Legal Counsel.

Commissioner Alatorre moved to approve Best, Best and Krieger (BB&K) as General Legal Counsel and authorize Interim CEO Watson to enter into an agreement with BB&K
for no less than 12 months. Commissioner Fisher seconded. The motion carried with the following votes:

NAY: None.
ABSTAIN: None.
ABSENT: Dial, Glyer and Foy.

f. **Lease Amendment / Additional Office Space**
Interim CEO Watson reviewed the written report.

Commissioner Fisher moved to approve the Lease Amendment for Additional Office Space. Commissioner Alatorre seconded. The motion carried with the following votes:

NAY: None.
ABSTAIN: None.
ABSENT: Dial, Glyer and Foy.

g. **2015 Commission Meeting Calendar**
Commissioner Fisher moved to approve the 2015 Commission Meeting Calendar. Commissioner Alatorre seconded. The motion carried with the following votes:

NAY: None.
ABSTAIN: None.
ABSENT: Dial, Glyer and Foy.

h. **DHCS Contract Amendment A13**
Interim CEO Watson reviewed the DHCS Contract Amendment A13 which updates the Plan’s FY 2013-14 capitation rates for the traditional Medi-Cal population.

Commissioner Wardwell moved to approve the amendment and authorize the Interim CEO to execute DHCS Contract Amendment A13. Commissioner Alatorre seconded. The motion carried with the following votes:

NAY: None.
ABSTAIN: None.
ABSENT: Dial, Glyer and Foy.

3. **ACCEPT AND FILE ITEMS**

a. **Special Investigation Ad Hoc Committee Report**
Commissioner Fisher provided an update on the current progress of the investigation. Atkinson, Andelson, Loya, Ruud & Romo, the human resource firm, has interviewed 19 individuals, 10 more are scheduled through November 5, 2014 and anticipate 25 additional interviews prior to December 15, 2014. Vicenti, Lloyd and Stuzman, the financial firm, has interviewed 2 additional individuals since September, have scheduled
4 for the next two weeks and anticipates scheduling 7 interviews with a possibility of a follow-up interview with some of the individuals.

Commissioner Fisher noted the total Invoice Costs to Date:

- **AALRR** $91,548.99 through September 2014
- **VLS** $58,328.30 through September 2014
- **Guidepost Solutions** $5,654.24 through September 20, 2014
  - (company downloading the information off computers).
- **Discovia** $3,870.75 through September 20, 2014
  - (company sifts through all of the data).

The estimated date for completion continues to be the end of January 2015.

Chair Araujo stated that the Commission was originally advised that the investigation would cost approximately $750,000; but when the Commission delegated contracting authority to the Special Investigation Ad Hoc Committee no limit was set. Counsel Polich stated that the Commission could place a limit at any time and any future activities of the firms involved could then be prioritized.

Commissioner Fisher reported that legal counsel of the Special Investigation Ad Hoc Committee reviews each of the invoices and has requested adjustments. He suggested that if the costs get close to $700,000 the item could be addressed.

Interim CEO Watson stated that due to possible scheduling issues any interviews with Health Services staff should be conducted prior to December due to the DHCS on-site medical audit. Commissioner Fisher requested an e-mail with that information which he will forward to the consultants.

b. **CEO Update**
Interim CEO Watson reviewed the CEO Update with the Commission.

c. **August Financials**
CFO Raleigh reviewed the August Financial package with the Commission.

Commissioner Pupa asked about repayment of the Lines of Credit (LOC) to the County of Ventura. CFO Raleigh replied that negotiations with the state and the county have completed and legal staff is reviewing the contract amendment. The State requested additional information on the financials, staff hopes to have additional information in order to present this at the next Executive Finance Committee Meeting.

Commissioner Alatorre asked about the status of an increase to the CAP rates. CFO Raleigh replied that this would be looked into this quarter.

d. **COO Update**
Interim CEO Watson presented the COO Update.

e. **CIO Update**
CIO Scrymgeour provided a review of the CIO Update.
f. **Health Services Update**  
Associate Chief Medical Officer, Dr. Wharfield, reviewed the written report.

Commissioner Fisher moved to approve the Special Investigation Ad Hoc Committee Report, CEO Update, August Financials, COO Update, CIO Update and the Health Services Update. Commissioner Wardwell seconded. The motion carried with the following votes:

- **AYE:** Alatorre, Araujo, Fisher, Laba, Pawar, Pupa and Wardwell.
- **NAY:** None.
- **ABSTAIN:** None.
- **ABSENT:** Dial, Glyer and Foy.

**COMMENTS FROM COMMISSIONERS**

Commissioners Alatorre and Pawar announced that they would recuse themselves from Closed Session Item a(ii) and Item b if it is regarding Clinicas.

Chair Araujo noted that Interim CEO Watson was doing a great job. Commissioners Pupa and Wardwell agreed.

**CLOSED SESSION**

Chair Araujo explained the purpose of the Closed Session items.

**ADJOURN TO CLOSED SESSION**

The Commission adjourned to Closed Session at 5:02 p.m. regarding the following items:

- **a. Closed Session Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9**
  - i. Cressena Hernandez v. Ventura County Medi-Cal Managed Care Commission, et al, Ventura County Superior Court, Case Number 56-2012-00427535-CUOE-VTA
  - ii. Clinicas Del Camino Real Inc. v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan. Ventura County Superior Court Case Number 56-2014-00456149-CU-BC-VTA

- **b. Conference with Legal Counsel - Anticipated Litigation Significant Exposure to Litigation Pursuant to Government Code Section 54956.9 (b).** (One case)

**RETURN TO OPEN SESSION**

The Regular Meeting reconvened at 6:26 pm.

Chair Araujo announced that no reportable action was taken.
ADJOURNMENT

Meeting adjourned at 6:30 pm.
AGENDA ITEM 2a

To: Gold Coast Health Plan Commission

From: John Meazzo, Interim Chief Financial Officer

Date: November 24, 2014

Re: CFO Update - September 2014 Financials

SUMMARY
Staff is presenting the attached September 2014 financial statements (unaudited) of Gold Coast Health Plan (Plan) for approval by the Commission. These financials were reviewed by the Executive / Finance Committee on November 6, 2014, where the Committee recommended approval of these financials to the Commission.

BACKGROUND / DISCUSSION
The Plan staff has prepared the September 2014 financial package, including balance sheet, income statements and statements of cash flows. The Plan also reflected adjustments after closing FY 2013-14, since these will be made as part of the audit (and are reflected in the June 2014 period which flow through September 2014). Management anticipates additional adjustments when the audit is finalized.

FISCAL IMPACT

Highlights of YTD financials include:
On a year-to-date (YTD) basis, the Plan’s net income was approximately $9.3 million compared to $4.7 million assumed in the budget. These operating results have contributed to a Tangible Net Equity (TNE) level of approximately $49.1 million, which exceeds both the budget of $37 million (by $12.1 million) and the State minimum required TNE amount of $22.6 million (by $26.5 million).

Please note the Plan's TNE amounts noted in the financial package include the $7.2 million in lines of credit with the County of Ventura. Also, as of the end of the September 2014, the Plan’s TNE is:

- 217% of the minimum State-required TNE level and
- 185% of the minimum State-required TNE level, excluding the lines of credit of $7.2 million
Note also that these TNE amounts include adjustments to FY 2013-14 results after closing the year at June 30, 2014. These adjustments were primarily identified by management and result in a fund balance increase from $30.4 to $32.6 million as of June 30, 2014. The Plan has included these because they will be reflected as part of the FY 2013-14 audit.

**Highlights of monthly financials include:**

**Membership** - September membership of 167,350 exceeded budget by 8,549 members. The majority of membership growth is in Adult Expansion (AE) category, where membership was 9,954 higher than budget. In the Adult / Family category, membership was 1,326 below budgeted estimates (possibly due to redeterminations). Current membership is 39% higher than at December 31, 2013 and 38% year-over-year.

**Revenue** – September net revenue is $57.7 million, which exceeded the budgeted amount of $47.6 million, by $10.1 million. On a per-member-per-month (PMPM) basis, net revenue was $344.78 PMPM which was $44.84 PMPM better than budget of $299.94 PMPM. The favorable results were driven by:

- Membership growth being greater than anticipated in total, with significantly more members than expected in higher capitation rate cells. This contributed to $6.8 million of the positive variance.
- New revenue stream for the Hepatitis C drugs supplemental payment; which amounted to $1.5 million for the last 3 periods (July through September 2014).
- New draft FY 2014-15 capitation rates were received from the State in October (which were applied retroactively to July), amounting to $1.8 million adjustments to revenue.

**Health Care Costs** – September health care costs were $50.1 million or $7.2 million more than budget. On a PMPM basis, September health care costs were $299.66 PMPM versus a budgeted amount of $270.34 PMPM. Increases in AE membership of 9,954 over budget accounted for approximately $6.2 million of negative variance, and is largely responsible for negative variances in almost every service category, but is displaying a reasonable month-to-month trend reflecting the recent membership increases. The exception was again Pharmacy where costs were $2.9 million below budget. Other specific contributors to September’s budget variances include:

- Inpatient – Ongoing billing difficulties at a provider prompted the Plan to add an additional $2.6 million to reserves.
- LTC / SNF – The Plan continues to hold reserves related to AB 1629 rate increases. An amount of $0.1 million was added in anticipation of new AB 1629 rates effective August 1, 2014. September LTC costs also included a higher than normal recognition of costs related to prior months. The added number of days billed for
July and prior months exceeded the yearly average for trailing months by 30%, and added approximately $0.5 million to LTC expense.

- Pharmacy – The increase in utilization among the new AE population has not achieved the rate as expected in the budget, contributing a positive variance of $5.3 million. These savings have been partially offset to due increases in other costs such as Solvaldi, resulting in a net favorable variance of $2.9 million.

Additional reserves were added across categories of service, as a continuation of the additions made in August at the recommendation of the Plan’s actuaries. This contributed to the negative variances in nearly every category, representing another $1.4 million in added expense.

As disclosed in prior months, the current financials continue to reflect a targeted 85% medical loss ratio (MLR) for overall medical expenses specific to the AE population. The expenses for this new population are still uncertain and are currently less than 85% MLR on a calendar year-to-date basis. The Plan has included the difference in its Incurred But Not Paid (IBNP) calculation. Note that for the AE population:

- Medical expenses continue to be estimated from State rate packages (which reflect a 91% MLR) and will be evaluated as claims data is received, and
- Pharmacy expenses have been less than budget.

Administrative Expenses – For the month of September, overall operational costs were approximately $264,000 lower than budgeted expenses. The following primary factors contributed to this lower than expected expense:

- Lower personnel expenses due to timing of new hires.
- Lower consulting services were due to delay in starting new projects that are in budget.
- Lower general office expense due to timing of purchases of equipment for anticipated new employees.
- Overall administrative expenses were lower, which was offset by higher legal expenses.

Cash + Medi-Cal Receivable - The total of Cash and Medi-Cal Premium Receivable balances of $246.7 million was reported as of September 30, 2014. This total includes pass-through payments for MCO tax of $11.1 million, Internal Governmental Transfer payments of $24.0 million and Hospital Quality Assurance Fee anticipated payments of $0.3 million. Excluding the impact of these pass-through amounts, the total of Cash and Medi-Cal Receivable balance as of September 30, 2014 was $211.4 million, or $73 million better than the budgeted level of $137.4 million.

RECOMMENDATION
Staff proposes that the Commission approve and accept the September, 2014 financial statements.
CONCURRENCE
N/A

Attachment
September 2014 Financial Package
FINANCIAL PACKAGE
For the month ended September 30, 2014

TABLE OF CONTENTS

- Financial Overview
- Membership
- Income Statement
- Balance Sheet

APPENDIX

- Cash Trend Combined
- Paid Claims and IBNP Composition
- Monthly Cash Flow
- YTD Cash Flow
- YTD Income Statement
- Total Expenditure Composition
- Pharmacy Cost & Utilization Trends
Financial Overview

**AUDITED** | **AUDITED** | **UNAUDITED FY 2013-14 Actual** | **FY 2014-15**
--- | --- | --- | ---
**Description** | **FY2011-12** | **FY 2012-13** | **JUL - SEP** | **OCT - DEC** | **JAN - MAR** | **APR-JUN** | **JUL-SEP** | **Budget** | **Comparison** | **Variance Favorable (Unfavorable)** | **%**
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
**Member Months** | 1,258,189 | 1,223,895 | 347,079 | 362,021 | 397,467 | 447,093 | 490,686 | 475,349 | 15,337 | 3.2% |
**Revenue** | 3,946,835,932 | 3,151,119,611 | 81,988,709 | 84,070,456 | 112,028,121 | 145,908,523 | 158,761,380 | 142,297,062 | 14,644,318 | 11.6% |
**pmpm** | 242.12 | 257.47 | 236.22 | 232.23 | 281.86 | 326.35 | 323.55 | 299,35 | 24.20 | 8.1% |
**Health Care Costs** | 2,873,535,872 | 2,803,82,704 | 71,875,533 | 72,867,512 | 98,914,429 | 125,663,911 | 141,486,486 | 128,511,378 | (12,975,108) | (10.1)% |
**pmpm** | 228.39 | 229.09 | 207.09 | 201.28 | 248.86 | 281.07 | 288.34 | 270.35 | (17.99) | (6.7)% |
**% of Revenue** | 94.3% | 89.0% | 86.7% | 86.3% | 86.1% | 89.1% | 90.3% | 90.3% | -1.2% | -1.3% |
**Admin Exp** | 18,891,320 | 24,013,927 | 6,202,007 | 6,014,475 | 7,937,941 | 8,917,151 | 12,306,671 | 9,280,590 | 1,096,838 | 12.1% |
**pmpm** | 15.01 | 19.62 | 17.87 | 16.61 | 17.75 | 16.29 | 20.13 | 19.13 | 14.8% |
**% of Revenue** | 6.2% | 7.6% | 7.6% | 7.2% | 5.9% | 5.4% | 5.0% | 6.4% | 4.1% | 21.2% |
**Net Income** | (1,609,063) | 10,722,980 | 3,911,169 | 5,188,469 | 5,286,582 | 9,280,590 | 4,694,542 | 4,586,048 | 97.7% |
**pmpm** | (1.28) | 8.76 | 11.27 | 14.33 | 16.40 | 27.53 | 18.91 | 9.58 | 9.04 | 91.5% |
**% of Revenue** | -0.5% | 3.4% | 4.8% | 6.2% | 5.8% | 8.4% | 5.8% | 3.3% | 2.5% | 77.2% |
**100% TNE** | 16,769,368 | 16,138,440 | 16,112,437 | 16,056,217 | 18,539,458 | 19,964,221 | 22,600,707 | 21,799,390 | 801,317 | 3.7% |
**% TNE Required** | 36% | 68% | 68% | 84% | 84% | 100% | 100% | 100% | 100% |
**Minimum Required TNE** | 6,036,972 | 10,974,139 | 10,956,457 | 13,487,223 | 15,573,145 | 19,964,221 | 22,600,707 | 21,799,390 | 801,317 | 3.7% |
**GOHP TNE** | (6,831,681) | 11,991,099 | 15,832,268 | 20,909,738 | 27,507,320 | 39,013,001 | 49,094,581 | 37,039,771 | 12,054,809 | 32.5% |
**TNE Excess / (Deficiency)** | (12,068,833) | 916,960 | 4,645,810 | 7,553,356 | 12,39,168 | 19,849,770 | 26,493,874 | 15,240,381 | 11,253,492 | 73.8% |

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

* Audited amounts reflect financial adjustments made by auditors, but exclude presentation reclassifications without P&L impact (i.e. reporting package kept the same).
Note: Beginning in Apr ‘14 actual membership reflects new Duals definition as implemented by DHCS. Prior months have not been restated.
## Income Statement Monthly Trend

<table>
<thead>
<tr>
<th>FY 2013-14</th>
<th>FY 2014-15 Monthly Trend</th>
<th>Current Month</th>
</tr>
</thead>
</table>
|             | JUN 2014* | JUL 2014* | AUG 2014* | SEPTEMBER 2014* | Varia
c| Actual | Budget | Fav / (Unfav) |

### Membership (includes retro members)
- FY 2013-14: 157,168
- JUN 2014*: 160,085
- JUL 2014*: 163,459
- AUG 2014*: 167,350
- SEPTEMBER 2014*: 158,801
- Variance: 5,459

### Revenue:

#### General & Administrative Expenses:
- Premium: $61,669,657
- Reserve for Rate Reduction: 2,096,754
- MCO Premium Tax: (2,751,314)
- Total Net Premium: 61,015,097

#### Other Revenue:
- Membership (includes retro members):
  - FY 2013-14: 157,168
  - JUN 2014*: 160,085
  - JUL 2014*: 163,459
  - AUG 2014*: 167,350
  - SEPTEMBER 2014*: 158,801
- Total Other Revenue: 555,740

### Other Revenue:
- Interest Income: 16,066
- Miscellaneous Income: 539,674
- Total Other Revenue: 555,740

### Total Revenue:
- FY 2013-14: 61,015,097
- JUN 2014*: 49,561,663
- JUL 2014*: 51,384,288
- AUG 2014*: 57,630,180
- SEPTEMBER 2014*: 47,575,792
- Variance: 10,054,388

### Medical Expenses:
- Capitation (PCP, Specialty, Kasier, NEMT, & Vision):
  - FY 2013-14: 2,438,071
  - JUN 2014*: 2,547,502
  - JUL 2014*: 2,665,459
  - AUG 2014*: 2,796,518
  - SEPTEMBER 2014*: 2,659,496
  - Variance: (137,021)

### FFS Claims Expenses:
- Inpatient:
  - FY 2013-14: 9,862,886
  - JUN 2014*: 10,931,208
  - JUL 2014*: 11,741,392
  - AUG 2014*: 13,423,209
  - SEPTEMBER 2014*: 14,775,505
  - Variance: (3,745,900)

### Physician ACA 1302:
- FY 2013-14: 8,542,740
- JUN 2014*: 1,000,000
- JUL 2014*: 1,000,000
- AUG 2014*: 1,000,000
- SEPTEMBER 2014*: 1,000,000

### Total Cost of Health Care:
- FY 2013-14: 49,786,183
- JUN 2014*: 45,233,656
- JUL 2014*: 46,104,742
- AUG 2014*: 50,148,088
- SEPTEMBER 2014*: 42,930,814
- Variance: (7,217,274)

### Contribution Margin:
- FY 2013-14: 11,784,654
- JUN 2014*: 4,380,483
- JUL 2014*: 5,343,866
- AUG 2014*: 7,550,545
- SEPTEMBER 2014*: 4,699,654
- Variance: 2,850,891

### General & Administrative Expenses:
- Salaries and Wages:
  - FY 2013-14: 592,779
  - JUN 2014*: 677,265
  - JUL 2014*: 625,238
  - AUG 2014*: 690,867
  - SEPTEMBER 2014*: 817,837
  - Variance: 126,970

### Total & G & A Expenses:
- FY 2013-14: 2,777,289
- JUN 2014*: 2,719,481
- JUL 2014*: 2,472,120
- AUG 2014*: 2,802,703
- SEPTEMBER 2014*: 3,066,520
- Variance: 263,817

### Net Income / (Loss):
- FY 2013-14: $9,007,365
- JUN 2014*: $1,681,002
- JUL 2014*: $2,871,746
- AUG 2014*: $4,747,842
- SEPTEMBER 2014*: $1,633,134
- Variance: $3,114,708

### Full time employees:
- FY 2013-14: 139
- JUN 2014*: 159
- JUL 2014*: 20

The monthly trend data includes various financial metrics such as membership counts, revenue and expenses, and contribution margins for different months.
### PMPM Income Statement Comparison

|                | JUN 2014 | JUL 2014 | AUG 2014 | Actual | Budget | Varia
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Membership (includes retro members)</td>
<td>157,168</td>
<td>160,085</td>
<td>163,251</td>
<td>167,350</td>
<td>158,801</td>
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<td><strong>Revenue:</strong></td>
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<td>Premium</td>
<td>392.38</td>
<td>322.33</td>
<td>334.09</td>
<td>358.48</td>
<td>311.87</td>
<td>46.61</td>
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<td>Reserve for Rate Reduction</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>MCO Premium Tax</td>
<td>(17.51)</td>
<td>(12.74)</td>
<td>(13.11)</td>
<td>(14.12)</td>
<td>(12.28)</td>
<td>(1.84)</td>
</tr>
<tr>
<td><strong>Total Net Premium</strong></td>
<td>388.22</td>
<td>309.60</td>
<td>320.98</td>
<td>344.37</td>
<td>299.59</td>
<td>44.78</td>
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<td><strong>Other Revenue:</strong></td>
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<td></td>
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<tr>
<td>Interest Income</td>
<td>0.10</td>
<td>0.09</td>
<td>0.16</td>
<td>0.18</td>
<td>0.10</td>
<td>0.08</td>
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<td>Miscellaneous Income</td>
<td>3.43</td>
<td>0.24</td>
<td>0.24</td>
<td>0.23</td>
<td>0.24</td>
<td>(0.01)</td>
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<tr>
<td><strong>Total Other Revenue</strong></td>
<td>3.54</td>
<td>0.33</td>
<td>0.40</td>
<td>0.41</td>
<td>0.54</td>
<td>(0.13)</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>391.75</td>
<td>309.92</td>
<td>321.38</td>
<td>344.78</td>
<td>299.94</td>
<td>44.84</td>
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<td><strong>Medical Expenses:</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Capitation (PCP, Specialty, Kasier, NEMT)</td>
<td>15.51</td>
<td>15.91</td>
<td>16.65</td>
<td>16.71</td>
<td>16.75</td>
<td>0.04</td>
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<td>Inpatient</td>
<td>62.75</td>
<td>68.28</td>
<td>73.34</td>
<td>80.21</td>
<td>60.94</td>
<td>(19.27)</td>
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<td>LTC / SNF</td>
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<td>53.27</td>
<td>50.17</td>
<td>54.66</td>
<td>47.17</td>
<td>(7.49)</td>
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<td>Outpatient</td>
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<td>20.61</td>
<td>19.72</td>
<td>22.07</td>
<td>16.17</td>
<td>(5.90)</td>
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<td>Laboratory and Radiology</td>
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<td>5.38</td>
<td>6.77</td>
<td>7.12</td>
<td>4.59</td>
<td>(2.53)</td>
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<tr>
<td>Physician ACA 1202</td>
<td>60.72</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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<td>Emergency Room</td>
<td>10.73</td>
<td>8.70</td>
<td>11.69</td>
<td>10.86</td>
<td>9.42</td>
<td>(1.45)</td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>13.09</td>
<td>21.61</td>
<td>21.59</td>
<td>21.08</td>
<td>20.02</td>
<td>(1.05)</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>-</td>
<td>11.35</td>
<td>18.48</td>
<td>19.30</td>
<td>15.33</td>
<td>(3.97)</td>
</tr>
<tr>
<td>Home &amp; Community Based Services</td>
<td>-</td>
<td>7.44</td>
<td>8.73</td>
<td>10.33</td>
<td>5.25</td>
<td>(5.08)</td>
</tr>
<tr>
<td>Applied Behavior Analysis Services</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Mental Health Services</td>
<td>1.90</td>
<td>1.20</td>
<td>3.70</td>
<td>4.01</td>
<td>4.64</td>
<td>0.63</td>
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<td>Pharmacy</td>
<td>47.94</td>
<td>36.10</td>
<td>33.99</td>
<td>33.02</td>
<td>53.05</td>
<td>20.03</td>
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<td><strong>Adul Expansion Reserve</strong></td>
<td>-</td>
<td>6.25</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>Other Medical Professional</td>
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<td>1.75</td>
<td>2.05</td>
<td>2.03</td>
<td>1.63</td>
<td>(0.40)</td>
</tr>
<tr>
<td>Other Medical Care</td>
<td>0.00</td>
<td>-</td>
<td>-</td>
<td>0.00</td>
<td>-</td>
<td>(0.00)</td>
</tr>
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<td>Other Fee For Service</td>
<td>30.55</td>
<td>16.83</td>
<td>8.30</td>
<td>7.94</td>
<td>5.77</td>
<td>(2.17)</td>
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<td>Transportation</td>
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<td>0.95</td>
<td>2.12</td>
<td>2.27</td>
<td>1.87</td>
<td>(0.40)</td>
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<td><strong>Total Claims</strong></td>
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<td>260.66</td>
<td>274.91</td>
<td>245.85</td>
<td>(29.06)</td>
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<td>Medical &amp; Care Management Expense</td>
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<td>5.86</td>
<td>6.64</td>
<td>6.12</td>
<td>6.52</td>
<td>0.40</td>
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<td>Reinsurance</td>
<td>(5.94)</td>
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<td>2.77</td>
<td>2.69</td>
<td>1.22</td>
<td>(1.47)</td>
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<td>Claims Recoveries</td>
<td>(4.32)</td>
<td>0.40</td>
<td>1.28</td>
<td>(0.77)</td>
<td>-</td>
<td>-</td>
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<td><strong>Total Cost of Health Care</strong></td>
<td>316.77</td>
<td>282.56</td>
<td>282.42</td>
<td>299.66</td>
<td>270.34</td>
<td>(29.32)</td>
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<tr>
<td><strong>Contribution Margin</strong></td>
<td>74.98</td>
<td>27.36</td>
<td>33.38</td>
<td>45.12</td>
<td>29.59</td>
<td>15.52</td>
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<td><strong>General &amp; Administrative Expenses:</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and Wages</td>
<td>3.77</td>
<td>4.23</td>
<td>3.91</td>
<td>4.13</td>
<td>5.15</td>
<td>1.02</td>
</tr>
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<td>Payroll Taxes and Benefits</td>
<td>0.97</td>
<td>1.36</td>
<td>0.98</td>
<td>1.15</td>
<td>1.33</td>
<td>0.18</td>
</tr>
<tr>
<td>Travel and Training</td>
<td>0.09</td>
<td>0.06</td>
<td>0.06</td>
<td>0.07</td>
<td>0.27</td>
<td>0.20</td>
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<td>Outside Service - ACS</td>
<td>7.50</td>
<td>7.74</td>
<td>7.94</td>
<td>7.64</td>
<td>7.52</td>
<td>(0.12)</td>
</tr>
<tr>
<td>Outside Services - Other</td>
<td>0.66</td>
<td>0.59</td>
<td>0.64</td>
<td>0.74</td>
<td>1.05</td>
<td>0.31</td>
</tr>
<tr>
<td>Accounting &amp; Actuarial Services</td>
<td>0.22</td>
<td>0.12</td>
<td>0.07</td>
<td>0.09</td>
<td>0.28</td>
<td>0.19</td>
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<td>Legal</td>
<td>2.38</td>
<td>0.93</td>
<td>0.40</td>
<td>1.21</td>
<td>0.21</td>
<td>(1.00)</td>
</tr>
<tr>
<td>Insurance</td>
<td>0.08</td>
<td>0.15</td>
<td>0.14</td>
<td>0.04</td>
<td>0.09</td>
<td>0.05</td>
</tr>
<tr>
<td>Lease Expense - Office</td>
<td>0.59</td>
<td>0.40</td>
<td>0.40</td>
<td>0.38</td>
<td>0.41</td>
<td>0.03</td>
</tr>
<tr>
<td>Consulting Services</td>
<td>0.82</td>
<td>0.26</td>
<td>0.35</td>
<td>0.34</td>
<td>1.08</td>
<td>0.74</td>
</tr>
<tr>
<td>Translation Services</td>
<td>0.03</td>
<td>0.02</td>
<td>0.02</td>
<td>0.04</td>
<td>0.04</td>
<td>0.01</td>
</tr>
<tr>
<td>Advertising and Promotion</td>
<td>0.06</td>
<td>0.03</td>
<td>-</td>
<td>-</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>General Office</td>
<td>0.68</td>
<td>0.69</td>
<td>0.19</td>
<td>0.69</td>
<td>1.18</td>
<td>0.49</td>
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<tr>
<td>Depreciation &amp; Amortization</td>
<td>0.10</td>
<td>0.09</td>
<td>0.09</td>
<td>0.10</td>
<td>0.15</td>
<td>0.05</td>
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<tr>
<td>Printing</td>
<td>0.04</td>
<td>0.01</td>
<td>0.05</td>
<td>0.16</td>
<td>0.21</td>
<td>0.05</td>
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<tr>
<td>Shipping &amp; Postage</td>
<td>0.00</td>
<td>0.00</td>
<td>0.15</td>
<td>0.01</td>
<td>0.14</td>
<td>0.13</td>
</tr>
<tr>
<td>Interest</td>
<td>(0.31)</td>
<td>0.12</td>
<td>0.05</td>
<td>(0.04)</td>
<td>0.09</td>
<td>0.14</td>
</tr>
<tr>
<td><strong>Total G &amp; A Expenses</strong></td>
<td>17.67</td>
<td>16.99</td>
<td>15.44</td>
<td>16.75</td>
<td>19.31</td>
<td>2.56</td>
</tr>
<tr>
<td><strong>Net Income / (Loss)</strong></td>
<td>57.31</td>
<td>10.36</td>
<td>17.94</td>
<td>28.37</td>
<td>10.28</td>
<td>18.09</td>
</tr>
</tbody>
</table>

*Includes FY 2013-14 pre-audit adjustments identified by management
## Comparative Balance Sheet

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<thead>
<tr>
<th></th>
<th>9/30/2014*</th>
<th>8/31/2014*</th>
<th>7/31/2014*</th>
<th>6/30/2014*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
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</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Total Cash and Cash Equivalents</td>
<td>$231,485,135</td>
<td>$124,801,815</td>
<td>$61,568,613</td>
<td>$60,176,698</td>
</tr>
<tr>
<td>Provider Receivable*</td>
<td>15,195,193</td>
<td>79,042,443</td>
<td>121,322,683</td>
<td>114,632,056</td>
</tr>
<tr>
<td>Other Receivables</td>
<td>171,752</td>
<td>173,540</td>
<td>534,822</td>
<td>1,821,475</td>
</tr>
<tr>
<td>Total Accounts Receivable</td>
<td>16,106,096</td>
<td>79,627,019</td>
<td>122,309,171</td>
<td>116,848,660</td>
</tr>
<tr>
<td>Total Prepaid Accounts</td>
<td>1,171,614</td>
<td>1,073,641</td>
<td>1,172,196</td>
<td>994,278</td>
</tr>
<tr>
<td>Total Other Current Assets</td>
<td>79,079</td>
<td>79,079</td>
<td>79,079</td>
<td>81,719</td>
</tr>
<tr>
<td>Total Current Assets</td>
<td>248,841,925</td>
<td>205,581,555</td>
<td>185,129,058</td>
<td>178,101,355</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>1,138,882</td>
<td>1,162,985</td>
<td>1,173,456</td>
<td>1,163,269</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$249,980,807</td>
<td>$206,744,540</td>
<td>$186,302,514</td>
<td>$179,264,625</td>
</tr>
<tr>
<td><strong>LIABILITIES &amp; FUND BALANCE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incurred But Not Reported</td>
<td>$137,733,151</td>
<td>$120,657,083</td>
<td>$105,577,791</td>
<td>$92,710,021</td>
</tr>
<tr>
<td>Claims Payable</td>
<td>6,990,115</td>
<td>9,737,671</td>
<td>8,427,358</td>
<td>9,482,660</td>
</tr>
<tr>
<td>Capitation Payable</td>
<td>2,350,613</td>
<td>2,253,578</td>
<td>2,142,484</td>
<td>2,054,265</td>
</tr>
<tr>
<td>Physician ACA 1202 Payable</td>
<td>12,765,516</td>
<td>12,765,516</td>
<td>12,765,516</td>
<td>12,765,516</td>
</tr>
<tr>
<td>AB85 Payable</td>
<td>(74,330)</td>
<td>913,541</td>
<td>813,240</td>
<td>1,245,284</td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>1,810,396</td>
<td>247,671</td>
<td>1,420,993</td>
<td>2,875,709</td>
</tr>
<tr>
<td>Accrued Payroll Expense</td>
<td>25,231,225</td>
<td>864,925</td>
<td>945,771</td>
<td>748,120</td>
</tr>
<tr>
<td>Accrued Premium Tax</td>
<td>11,074,806</td>
<td>12,082,489</td>
<td>9,939,310</td>
<td>15,775,120</td>
</tr>
<tr>
<td>Accrued Interest Payable</td>
<td>49,694</td>
<td>47,215</td>
<td>44,662</td>
<td>42,062</td>
</tr>
<tr>
<td>Current Portion of Deferred Revenue</td>
<td>460,000</td>
<td>460,000</td>
<td>460,000</td>
<td>460,000</td>
</tr>
<tr>
<td>Accrued Payroll Expense</td>
<td>700,999</td>
<td>596,812</td>
<td>558,034</td>
<td>760,032</td>
</tr>
<tr>
<td>Total Current Liabilities</td>
<td>200,367,231</td>
<td>161,874,522</td>
<td>144,299,960</td>
<td>138,918,788</td>
</tr>
<tr>
<td><strong>Total Long-Term Liabilities</strong></td>
<td>7,718,995</td>
<td>7,723,278</td>
<td>7,727,562</td>
<td>7,731,845</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>208,086,226</td>
<td>169,597,801</td>
<td>152,027,522</td>
<td>146,650,634</td>
</tr>
<tr>
<td>Beginning Fund Balance</td>
<td>32,613,991</td>
<td>32,613,991</td>
<td>32,613,991</td>
<td>4,691,101</td>
</tr>
<tr>
<td>Net Income Current Year</td>
<td>9,280,590</td>
<td>4,532,748</td>
<td>1,661,002</td>
<td>27,922,890</td>
</tr>
<tr>
<td><strong>Total Fund Balance</strong></td>
<td>41,894,581</td>
<td>37,146,739</td>
<td>34,274,993</td>
<td>32,613,991</td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Fund Balance</strong></td>
<td>$249,980,807</td>
<td>$206,744,540</td>
<td>$186,302,514</td>
<td>$179,264,625</td>
</tr>
</tbody>
</table>

### FINANCIAL INDICATORS

<table>
<thead>
<tr>
<th></th>
<th>Excluding IGT &amp; HQAF</th>
<th>Including IGT &amp; HQAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Ratio</td>
<td>1.28 : 1</td>
<td>1.28 : 1</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>117</td>
<td>131</td>
</tr>
<tr>
<td>Days Cash + State Capitation Rec</td>
<td>125</td>
<td>140</td>
</tr>
<tr>
<td>Days Cash + State Capitation Rec (less Tax Liab)</td>
<td>119</td>
<td>133</td>
</tr>
</tbody>
</table>

*Includes FY2013-2014 pre-audit adjustments identified by management
For the month ended September 30, 2014

APPENDIX

- Cash Trend Combined
- Paid Claims and IBNP Composition
- Monthly Cash Flow
- YTD Cash Flow
- YTD Income Statement
- Total Expenditure Composition
- Pharmacy Cost & Utilization Trends
Cash + Medi-Cal Receivable Trend ($ in Millions)
(Net of MCO Tax Liability and excludes pass-through funds)
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.

Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.
## Statement of Cash Flows - Monthly

<table>
<thead>
<tr>
<th></th>
<th>SEP '14</th>
<th>AUG '14</th>
<th>JULY '14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flow From Operating Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collected Premium</td>
<td>$122,309,818</td>
<td>$94,832,281</td>
<td>$45,212,063</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>30,121</td>
<td>25,986</td>
<td>14,142</td>
</tr>
<tr>
<td>State Pass Through Funds</td>
<td>27,751,370</td>
<td>1,882,392</td>
<td>717,413</td>
</tr>
<tr>
<td><strong>Paid Claims</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Hospital Expenses</td>
<td>(26,782,919)</td>
<td>(19,339,369)</td>
<td>(23,318,973)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>(5,743,287)</td>
<td>(6,254,420)</td>
<td>(5,751,973)</td>
</tr>
<tr>
<td>Capitation</td>
<td>(2,543,846)</td>
<td>(2,557,362)</td>
<td>(2,464,945)</td>
</tr>
<tr>
<td>Reinsurance of Claims</td>
<td>(449,539)</td>
<td>(444,200)</td>
<td>(637,110)</td>
</tr>
<tr>
<td>State Pass Through Funds Distributed</td>
<td>(1,079,935)</td>
<td>(2,224,871)</td>
<td>-</td>
</tr>
<tr>
<td>Paid Administration</td>
<td>(2,790,272)</td>
<td>(2,668,390)</td>
<td>(4,432,355)</td>
</tr>
<tr>
<td>MCO Tax Received / (Paid)</td>
<td>(4,011,599)</td>
<td>-</td>
<td>(7,908,088)</td>
</tr>
<tr>
<td><strong>Net Cash Provided/ (Used) by Operating Activities</strong></td>
<td>$106,689,910</td>
<td>$63,252,047</td>
<td>$1,430,176</td>
</tr>
<tr>
<td><strong>Cash Flow From Investing/Financing Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from Line of Credit</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Repayments on Line of Credit</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Acquisition of Property/Equipment</strong></td>
<td>(6,590)</td>
<td>(18,845)</td>
<td>(38,262)</td>
</tr>
<tr>
<td><strong>Net Cash Provided/(Used) by Investing/Financing</strong></td>
<td>(6,590)</td>
<td>(18,845)</td>
<td>(38,262)</td>
</tr>
<tr>
<td><strong>Net Cash Flow</strong></td>
<td>$106,683,320</td>
<td>$63,233,203</td>
<td>$1,391,914</td>
</tr>
<tr>
<td>Cash and Cash Equivalents (Beg. of Period)</td>
<td>124,801,815</td>
<td>61,568,613</td>
<td>60,176,698</td>
</tr>
<tr>
<td>Cash and Cash Equivalents (End of Period)</td>
<td>231,485,135</td>
<td>124,801,815</td>
<td>61,568,613</td>
</tr>
<tr>
<td><strong>Net Cash Flow from Operating Activities</strong></td>
<td>$106,689,910</td>
<td>$63,252,047</td>
<td>$1,430,176</td>
</tr>
<tr>
<td><strong>Adjustment to Reconcile Net Income to Net Cash Flow</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net (Loss) Income</td>
<td>4,747,842</td>
<td>2,871,746</td>
<td>1,661,002</td>
</tr>
<tr>
<td>Depreciation &amp; Amortization</td>
<td>30,692</td>
<td>29,316</td>
<td>28,075</td>
</tr>
<tr>
<td>Decrease/(Increase) in Receivables</td>
<td>63,520,923</td>
<td>42,682,152</td>
<td>(5,460,511)</td>
</tr>
<tr>
<td>Decrease/(Increase) in Prepaids &amp; Other Current Assets</td>
<td>(97,973)</td>
<td>98,554</td>
<td>(175,278)</td>
</tr>
<tr>
<td>(Decrease)/Increase in Payables</td>
<td>25,074,845</td>
<td>(1,069,316)</td>
<td>(683,706)</td>
</tr>
<tr>
<td>(Decrease)/Increase in Other Liabilities</td>
<td>(4,284)</td>
<td>(4,284)</td>
<td>(4,284)</td>
</tr>
<tr>
<td>Change in MCO Tax Liability</td>
<td>(1,007,683)</td>
<td>2,143,179</td>
<td>(5,835,810)</td>
</tr>
<tr>
<td>Changes in Claims and Capitation Payable</td>
<td>(2,650,521)</td>
<td>1,421,408</td>
<td>(967,083)</td>
</tr>
<tr>
<td>Changes in IBNR</td>
<td>17,076,068</td>
<td>15,079,291</td>
<td>12,867,771</td>
</tr>
<tr>
<td><strong>Net Cash Flow from Operating Activities</strong></td>
<td>$106,689,910</td>
<td>$63,252,047</td>
<td>$1,430,176</td>
</tr>
</tbody>
</table>

2a-14
Statement of Cash Flows - YTD

SEP 2014 YTD

Cash Flow From Operating Activities
Collected Premium $ 262,354,162
Miscellaneous Income 70,249
State Pass Through Funds 30,351,175

Paid Claims
Medical & Hospital Expenses (69,441,261)
Pharmacy (17,749,681)
Capitation (7,566,153)
Reinsurance of Claims (1,530,849)
State Pass Through Funds Distributed (3,304,807)
Paid Administration (9,891,017)
Repay Initial Net Liabilities -
MCO Taxes Received / (Paid) (11,919,687)
Net Cash Provided/(Used) by Operating Activities 171,372,133

Cash Flow From Investing/Financing Activities
Proceeds from Line of Credit -
Repayments on Line of Credit -
Net Acquisition of Property/Equipment (63,696)
Net Cash Provided/(Used) by Investing/Financing (63,696)

Net Cash Flow $ 171,308,437

Cash and Cash Equivalents (Beg. of Period) 60,176,698
Cash and Cash Equivalents (End of Period) 231,485,135

$ 171,308,437

Adjustment to Reconcile Net Income to Net Cash Flow

Net Income/(Loss) 9,280,590
Depreciation & Amortization 88,084
Decrease/(Increase) in Receivables 100,742,564
Decrease/(Increase) in Prepaids & Other Current Assets (174,696)
(Decrease)/Increase in Payables 23,321,824
(Decrease)/Increase in Other Liabilities (12,851)
Change in MCO Tax Liability (4,700,314)
Changes in Claims and Capitation Payable (2,196,197)
Changes in IBNR 45,023,130

171,372,133

Net Cash Flow from Operating Activities $ 171,372,133
### Income Statement
For Month Ended September 30, 2014

<table>
<thead>
<tr>
<th>September '14</th>
<th>Year-To-Date</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
</tr>
</tbody>
</table>

| Membership (includes retro members) | 490,686 | 475,349 | 15,337 |

<table>
<thead>
<tr>
<th>Revenue</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Favorable / Unfavorable</td>
</tr>
<tr>
<td>Premium</td>
<td>$165,075,998</td>
<td>$147,959,127</td>
<td>$17,116,872</td>
</tr>
<tr>
<td>MCO Premium Tax</td>
<td>(6,499,867)</td>
<td>(6,825,891)</td>
<td>(673,977)</td>
</tr>
<tr>
<td><strong>Total Net Premium</strong></td>
<td><strong>158,576,131</strong></td>
<td><strong>142,133,236</strong></td>
<td><strong>16,442,895</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Revenue:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest Income</td>
<td>70,249</td>
<td>48,827</td>
<td>21,423</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>115,000</td>
<td>114,999</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Other Revenue</strong></td>
<td><strong>185,249</strong></td>
<td><strong>163,826</strong></td>
<td><strong>21,424</strong></td>
</tr>
</tbody>
</table>

| **Total Revenue** | **158,761,380** | **142,297,062** | **16,464,318** |

<table>
<thead>
<tr>
<th>Medical Expenses:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td>36,095,803</td>
<td>28,882,830</td>
<td>(7,212,974)</td>
</tr>
<tr>
<td><strong>LTC/SNF</strong></td>
<td>25,708,068</td>
<td>22,463,452</td>
<td>(3,244,616)</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>10,180,497</td>
<td>7,670,180</td>
<td>(2,510,317)</td>
</tr>
<tr>
<td><strong>Laboratory and Radiology</strong></td>
<td>3,316,897</td>
<td>2,164,955</td>
<td>(971,943)</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>5,081,735</td>
<td>4,462,355</td>
<td>(619,380)</td>
</tr>
<tr>
<td><strong>Physician Specialty</strong></td>
<td>10,451,224</td>
<td>9,551,061</td>
<td>(900,163)</td>
</tr>
<tr>
<td><strong>Primary Care Physician</strong></td>
<td>8,005,694</td>
<td>7,256,078</td>
<td>(749,616)</td>
</tr>
<tr>
<td><strong>Home &amp; Community Based Services</strong></td>
<td>4,319,035</td>
<td>2,502,436</td>
<td>(1,816,599)</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td>1,455,596</td>
<td>2,202,459</td>
<td>746,863</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>16,746,750</td>
<td>25,365,839</td>
<td>8,619,089</td>
</tr>
<tr>
<td><strong>Other Medical Professional</strong></td>
<td>349,054</td>
<td>773,859</td>
<td>(424,805)</td>
</tr>
<tr>
<td><strong>Other Medical Care</strong></td>
<td>331</td>
<td>-</td>
<td>(331)</td>
</tr>
<tr>
<td><strong>Other Fee For Service</strong></td>
<td>5,353,012</td>
<td>2,741,665</td>
<td>(2,611,347)</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td>870,105</td>
<td>882,690</td>
<td>12,585</td>
</tr>
<tr>
<td><strong>Total Claims</strong></td>
<td>129,346,104</td>
<td>116,869,757</td>
<td>(12,476,347)</td>
</tr>
<tr>
<td><strong>Medical &amp; Care Management Expense</strong></td>
<td>3,025,101</td>
<td>3,112,564</td>
<td>87,463</td>
</tr>
<tr>
<td><strong>Reinsurance</strong></td>
<td>965,020</td>
<td>579,926</td>
<td>(385,094)</td>
</tr>
<tr>
<td><strong>Claims Recoveries</strong></td>
<td>140,783</td>
<td>-</td>
<td>(140,783)</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>4,430,904</td>
<td>3,692,491</td>
<td>(438,413)</td>
</tr>
<tr>
<td><strong>Total Cost of Health Care</strong></td>
<td>141,466,486</td>
<td>128,560,819</td>
<td>(12,905,667)</td>
</tr>
<tr>
<td><strong>Contribution Margin</strong></td>
<td>17,274,894</td>
<td>15,785,684</td>
<td>3,489,211</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General &amp; Administrative Expenses:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salaries and Wages</strong></td>
<td>1,993,369</td>
<td>2,427,843</td>
<td>434,474</td>
</tr>
<tr>
<td><strong>Payroll Taxes and Benefits</strong></td>
<td>567,351</td>
<td>619,342</td>
<td>51,990</td>
</tr>
<tr>
<td><strong>Travel and Training</strong></td>
<td>31,694</td>
<td>85,622</td>
<td>53,927</td>
</tr>
<tr>
<td><strong>Outside Service - ACS</strong></td>
<td>3,789,222</td>
<td>3,574,322</td>
<td>(214,900)</td>
</tr>
<tr>
<td><strong>Outside Services - Other</strong></td>
<td>320,103</td>
<td>410,278</td>
<td>90,175</td>
</tr>
<tr>
<td><strong>Accounting &amp; Actuarial Services</strong></td>
<td>462,256</td>
<td>135,000</td>
<td>327,256</td>
</tr>
<tr>
<td><strong>Legal</strong></td>
<td>416,663</td>
<td>100,000</td>
<td>(316,663)</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td>53,778</td>
<td>43,750</td>
<td>(10,028)</td>
</tr>
<tr>
<td><strong>Lease Expense - Office</strong></td>
<td>190,223</td>
<td>193,062</td>
<td>2,839</td>
</tr>
<tr>
<td><strong>Consulting Services</strong></td>
<td>154,660</td>
<td>481,282</td>
<td>326,622</td>
</tr>
<tr>
<td><strong>Translation Services</strong></td>
<td>11,445</td>
<td>21,249</td>
<td>9,804</td>
</tr>
<tr>
<td><strong>Advertising and Promotion</strong></td>
<td>4,024</td>
<td>41,447</td>
<td>37,423</td>
</tr>
<tr>
<td><strong>General Office</strong></td>
<td>288,547</td>
<td>722,807</td>
<td>434,259</td>
</tr>
<tr>
<td><strong>Depreciation &amp; Amortization</strong></td>
<td>45,608</td>
<td>59,171</td>
<td>13,563</td>
</tr>
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<td>39,218</td>
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<td>29,881</td>
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<td><strong>Interest</strong></td>
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<tr>
<td><strong>Total G &amp; A Expenses</strong></td>
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<td>9,091,142</td>
<td>1,096,838</td>
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</table>

| **Net Income / (Loss)** | $9,280,590 | $4,694,542 | $4,586,048 |
For the month ended February 28, 2014

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<th>NOV'13</th>
<th>DEC'13</th>
<th>JAN'14</th>
<th>FEB'14</th>
<th>MAR'14</th>
<th>APR'14</th>
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<td>$23.34</td>
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<td>$21.66</td>
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</table>

Pharmacy Cost Trend
AGENDA ITEM 3a

To: Gold Coast Health Plan Commission
From: Ruth Watson, Interim CEO
Date: November 24, 2014
Re: DHCS Contract Amendments A14 and A02

SUMMARY
The State of California Department of Health Care Services (DHCS) establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A14 reflects changes to Gold Coast Health Plan (GCHP or Plan) capitation rates for FY 2013-14. Amendment A02 reflects changes to GCHP’s capitation rates for the period July 1, 2013 through December 31, 2014.

BACKGROUND / DISCUSSION
GCHP received a contract amendment from the DHCS on November 5, 2014 which updated the Plan’s FY 2013-14 capitation rates for the traditional Medi-Cal population (i.e. no change to Targeted Low Income Children (TLIC) and Adult Expansion rates) as follows:

- Rate period commencing January 1, 2014
  - Includes first half of CY 2014 Affordable Care Act Section 1202 funds to be paid to qualifying providers performing specific services
  - Revises the effective date of aid code “7S” from July 1, 2014 to January 1, 2014

GCHP received a contract amendment from the DHCS on November 19, 2014 which updated the Plan’s FY 2013-14 capitation rates for the Medi-Cal populations receiving Hyde benefits as follows:

- This is a revision to the current Amendment 02 and updates Hyde capitation rates back to July 1, 2013. The Hyde capitation rates are paid to GCHP for non-Federally covered abortions.
  - Family / Adult Hyde capitation rates are revised from July 1, 2103 to December 31, 2014
  - Hyde benefits are extended to the Adult Expansion population through capitation rates effective for the period January 1, 2014 to December 31, 2014.
FISCAL IMPACT
Amendment A14 memorializes the rates included on the rate package received by GCHP on September 18, 2014. These rates were identified by GCHP management as post-closing (fiscal year) adjustments and will be reflected in the audited financials. This amendment is expected to increase revenue by approximately $4.9 million in anticipated ACA 1202 funds for the January 1, 2014 to June 30, 2014 time period (second half of FY 2013-14). Aid code “7S” is associated with Adult Expansion members that are now part of the “Family” aid group. Enrollment in this code has been insignificant.

Amendment A02 reduces the Family / Adult rate for FY 2013-14 and increases it for the first half of FY 2014-15. The addition of Hyde benefits for the Adult Expansion population as of January 1, 2014 was not known prior to this amendment. Overall, the impact is minimal due to the size of the rates.

RECOMMENDATION
Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendments A14 and A02.

CONCURRENCE
N/A

Attachments
None
AGENDA ITEM 3b

To: Gold Coast Health Plan Commissioners
From: Scott H. Campbell, General Counsel
Date: November 24, 2014
Re: Assembly Bill 1234 Ethics Training Requirements

SUMMARY:
Assembly Bill 1234 (AB 1234) requires members of the legislative body of any local government agency to receive two hours of ethics training every two years if the local agency provides any type of compensation, salary, stipend, or reimbursement of expenses. Even if not required, ethics training is recommended. Because the training covers the Brown Act, conflicts of interest and ethics, it is recommended that the Plan require such training of Commissioners and senior staff.

BACKGROUND / DISCUSSION:
AB 1234, adopted in 2005, requires two hours of training every two years for certain members of the legislative body of any local government agency. The training covers various topics related to public service and ethics, including conflict of interest laws, gift limitations, bribery laws, prohibitions on the use of public funds, open meeting requirements, Public Records Act requirements, competitive bidding requirements, etc.

The AB 1234 requirement only applies if the agency provides any compensation, salary, stipend, or reimbursement of expenses. (Government Code Section 53235(a).) While many public boards, including the Commission, do not provide any form of compensation to board members, most do reimburse expenses, such as travel costs, that are necessarily incurred in the performance of their duties. We are informed that no such compensation or reimbursement is provided to the Commissioners.

Even if the training is not mandatory, it is recommended for all Commissioners and other senior Plan officials. AB 1234 provides that the Commissioners may require themselves and staff they designate to take the training. (Government Code Section 53235.2(a).) Such training is recommended because from time to time situations will arise in which public officials may have a conflict of interest. Receiving regular trainings in the requirements assists in understanding where there may be a conflict and where it is necessary to seek legal advice. The training also provides general background in laws such as the Brown Act that commonly affect the public business and govern how the Plan conducts its public meetings.

There are several ways to receive the training. The Plan’s General Counsel, Best Best & Krieger, often provides the training and can arrange a special meeting to present the training to
the Commission as a whole. The Fair Political Practices Commission provides a free web-based training at [www.fppc.ca.gov](http://www.fppc.ca.gov) or the Commissioners may attend a group training which is offered from time to time.

**FISCAL IMPACT:**
If an attorney presents the training, there will be a charge for the attorney’s time. If the Commissioners individually attend the training, then there will be no fiscal impact if the training is done through the FPPC’s website. If the Commissioners attend a group training, there may be a fiscal impact if the costs of the training are paid for by the Plan.

**RECOMMENDATION:**
Provide direction to staff to draft a policy requiring that Commissioners and designated senior staff complete AB 1234 training every two years. Such training should be completed as soon as possible so that the Commissioners and senior staff can take advantage of the training. If the Commission chooses not to require AB 1234 training, then staff should be directed to prepare a policy prohibiting Commissioners from receiving reimbursement of any expenses incurred in the performance of their duties.

**CONCURRENCE:**
N/A

**Attachments:**
None.
AGENDA ITEM 3c

To: Gold Coast Health Plan Commission

From: Ruth Watson, Interim CEO / COO

Date: November 24, 2014

RE: Administrative Services Organization (ASO) / Pharmacy Benefits Manager (PBM) RFP Proposal

SUMMARY:
Gold Coast Health Plan (GCHP or Plan) entered into contracts with ACS Health Administration, Inc. (ACS / Xerox) and Script Care, Ltd., (SCL) prior to Plan go-live on July 1, 2011. ACS / Xerox functions as the Plan’s Administrative Services Organization (ASO), performing services such as claims processing and call center activities. SCL is the Plan’s Pharmacy Benefits Manager (PBM). The initial five (5) year contracts for both vendors terminate June 30, 2016, with an evergreen clause for SCL to renew annually with a timeline for notification of intent to term.

Conducting dual Request for Proposal (RFP) processes, awarding contracts, and the potential of two (2) new vendor implementations occurring simultaneously introduces significant financial, operational, business process and resource capacity risk to the Plan. To determine which contract should go out to bid, staff considered the following key factors:

- Plan financial and operational impact
- Regulatory landscape and industry trends
- Contractual costs
- Historical and current operational performance

Based on the analysis, staff determined that the PBM contract requires more immediate attention to ensure Plan pharmacy operations establish best practices for long-term success. As such, the staff recommendation is to:

1. Extend the ACS / Xerox contract for a period of one (1) year, commencing July 1, 2016, with an option for two additional yearly renewals, and
2. Send the PBM contract out to bid.

BACKGROUND / DISCUSSION:
The ASO and PBM are strategic arrangements supporting Plan administrative and pharmacy operations.
Under the ASO arrangement, ACS / Xerox provides the core administrative functions on behalf of the Plan. These functions include:

- Claims Processing – Mailroom, Scanning / Optical Character Recognition (OCR), Electronic Data Interchange (EDI), Workflow automation / Contact tracking, System configuration, Claim adjudication, Claim Adjustments, Claim dispute resolution, Claim payment recovery (through Xerox Recovery Services)
- Call Center – Member and provider calls
- Fulfillment – Member materials (Member Handbook, ID cards, Provider Directory, Ad hoc mailings)
- Encounter Data Submission to DHCS
- Standard and Ad Hoc Reporting
- Systems Support and Configuration (Core Administration Processing System (IKA), IVR, ACD, Scanning & Workflow, Provider Portal, Contact Tracking)
- Staffing to support all services (112 FTE)

As the Plan’s PBM, SCL performs the following functions on behalf of GCHP:

- Claim Adjudication
- Utilization Management: prior authorization initial determinations including letters / notification submission
- Initial Formulary Development
- State Encounter Data Submission
- DME Rebate Administration
- Call Center / Pharmacy Help Desk
- Standard Reporting
- Pharmacy Network
- Clinical Pharmacist Support

Pharmacy costs represent roughly 15% of total Plan expenses, with the utilization of the recent Adult Expansion population still a relatively unknown in regard to additional RX expenses. Plan administrative costs represent 6% of total expenses, on average. The growth of pharmacy costs as a portion of total health care spend has resulted in increased regulatory oversight at both the Federal and State levels. GCHP must ensure that any PBM vendor has the ability to support the Plan as it navigates DHCS audits, efficiency analyses, and other regulatory needs. Additionally, future programs, projects and initiatives undertaken by GCHP will undoubtedly require a PBM vendor with foresight and knowledge of the regulatory landscape. This may include the Coordinated Care Initiative (Duals Demonstration project), additional lines of business such as a Medicare Advantage plan, Knox Keene licensure, and/or NCQA accreditation.

---

1 Average Plan RX and Administrative expenses for period Mar 2014-Aug 2014
Source: 10/27/2014 GCHP Commission Packet; Item 3C - August 2014 Financials; Total Expense Composition
The Plan’s administrative expenses average $2.6 million monthly. Under the ASO arrangement, GCHP pays $1.2 million monthly to ACS / Xerox for administrative services which represents 46% of the total monthly expense.

**ACS / Xerox**

During the first 12-18 months of Plan operations, GCHP experienced a number of operational and technical challenges with the ASO arrangement, resulting in instances of non-compliance with regulatory and contractual standards, as identified in the State Financial CAP issued in 2012.

Two key issues identified in the Financial CAP involved the claims inventory and the auto adjudication rate.

GCHP set a target of five (5) Days Receipts on Hand (DROH) which is calculated by determining the average daily claim receipts in a given month and dividing that number into the ending monthly inventory. This calculation is a common, industry standard claim inventory measurement and provides flexibility for a higher inventory resulting from increased membership. The monthly DROH has remained between 5-7 days for the past 18 months with the higher numbers directly attributed to greater than expected membership increases that required ACS / Xerox to add more staff than originally forecasted.

The 60% auto adjudication rate was established by the State assigned Plan monitor, Berkley Research Group (BRG), as part of their monitoring responsibilities. ACS / Xerox reached the 60% auto adjudication target in June 2013, but did not sustain it until January 2014. Since that time, ACS / Xerox has consistently maintained the 60% auto adjudication level. (Attachment A, Table 4) The Plan’s 60% auto-adjudication target is consistent with the auto adjudication rate for other Medicaid plans and comparable with other County Organized Health Systems (COHS).

GCHP continues to monitor ACS / Xerox to ensure their compliance with both requirements.

ACS / Xerox has demonstrated significant improvement in their ASO services since July, 2011 as evidenced by their Service Level Agreement (SLA) performance, and their work in partnering with GCHP to successfully implement key initiatives, such as the Healthy Families and Low Income Health Plan (LIHP) transitions, and Medi-Cal expansion related to the Affordable Care Act (ACA). (Refer to Attachment A for ACS / Xerox SLA Performance Metrics.)

**Script Care**

As the Plan’s PBM, SCL has functioned solely in the capacity as directed by the Plan. Several areas of deficiency were identified by DHCS during the Medical Review Audit. In response to the Medical Audit CAP, the Plan was required to provide more robust oversight of the PBM to assess the following utilization management (UM) standards:

1. Accuracy of the Decision: The case decision (as approved or denied) is made in agreement with plan clinical criteria
2. Timeliness: The case was decided in the DHCS required timeframe of “24 hours, or 1 business day”

3. Accuracy of the Denial Language: The denial reason is specific to the reason the case was denied, includes the name of other therapy that is recommended to be tried before the requested therapy is approved, and includes proper grammar, spelling, and sentence syntax

Note: The goal for each element is to achieve 100% compliance.

Under the significant guidance and oversight by the Plan’s Pharmacy Director, hired in November 2013, SCL has improved in meeting the compliance goal for these standards. (Refer to Attachment B for SCL KPI Performance.)

Considerations
In determining which contract should go out to bid, staff also considered the scope and complexity of each potential implementation. Should the Plan select a new PBM, the transition effort would be significant, with typical implementations requiring 9-12 months duration.

In contrast, changes to the ASO arrangement would have an even more significant financial, operational, business process and technical impact. A decision to contract with a new ASO vendor or bring the services (or portions of the services) in-house is a minimum two (2) year project and would require significant expansion of and investment in Plan office space, infrastructure, information systems, staffing, and operational procedures.

Key considerations include:

- Claims & Call Center
  o Staffing costs – Kentucky vs. California (Table 9)
  o Office Space
- IT Infrastructure and Systems
  o Staffing
  o Information Systems / Technology Services
- Core Administration Processing System
- Automated call handling and routing (IVR/ACD)
- Customer Contact Tracking
- Scanning/Workflow
- Provider portal
- EDI
- Encounter Data Management
- Fulfillment
  o Disaster Recovery and Security Controls
  o Data Center Facility
- Ongoing operating costs
  o IT Support
  o Software / Hardware Licensing / Subscription Fees
FISCAL IMPACT

Major Cost Considerations

1. **Current ASO / PBM Administrative Expenses**

<table>
<thead>
<tr>
<th></th>
<th>FY 2011-12</th>
<th>FY 2012-13</th>
<th>FY 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS / Xerox</td>
<td>$14,112,601</td>
<td>$14,470,966</td>
<td>$12,844,795</td>
</tr>
<tr>
<td>SCL</td>
<td>$2,743,337</td>
<td>$3,190,225</td>
<td>$4,107,041</td>
</tr>
</tbody>
</table>

2. **Current Annual Medical Pharmacy Spend:**

<table>
<thead>
<tr>
<th></th>
<th>FY 2011-12</th>
<th>FY 2012-13</th>
<th>FY 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Spend</td>
<td>$287,353,673</td>
<td>$280,382,704</td>
<td>$369,321,385</td>
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<tr>
<td>Pharmacy</td>
<td>$36,022,296</td>
<td>$41,118,154</td>
<td>$55,354,634</td>
</tr>
<tr>
<td>Medical</td>
<td>$251,331,377</td>
<td>$239,264,550</td>
<td>$313,966,751</td>
</tr>
<tr>
<td>Pharmacy % of Spend</td>
<td>12.5%</td>
<td>14.7%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

3. **In-Sourcing ACS / Xerox Services** (high level cost estimates for major spend categories):

   a. Estimated Staffing Costs (in-house salary costs, including benefits, based on current ACS / Xerox staffing level of 112 FTE): $8,465,873 annually.
   b. Estimated Facilities Costs (building only, this does not include the supporting systems and infrastructure): 200 sf per person @ $1.80/sf which will result in an overhead cost of $360 per employee, or $483,840 annually.
   c. Infrastructure, Systems, and Implementation Services

4. **RFP Consulting Services**: Based on the scope and complexity of these contracts, the Plan requires outside consulting services to assist with the RFP and support vendor selection and procurement. A conservative estimate for RFP consulting costs is between $130,000-156,000, which is included in the FY 2014-15 budget.
RECOMMENDATION
Based on the financial and performance analysis findings around the ASO and PBM contracts, GCHP is requesting the Commission’s approval to:

1. Send the PBM contract out to bid.
2. Extend the ACS / Xerox contract for ASO services for one (1) year, beginning July 1, 2016, with an option for two (2) additional yearly extensions.
   a. This process would include a re-evaluation of the existing contract payment terms including pricing.
3. Select and execute contract with an external consultant to assist the Plan with the PBM RFP process.

Upon completion of the PBM RFP, Staff will provide a formal recommendation to the Commission, along with supporting financial analysis.

CONCURRENCE:
None

Attachments:
A. ASO OBJECTIVES AND SLA PERFORMANCE
B. PBM OBJECTIVES AND SLA PERFORMANCE

References:
None
AGENDA ITEM 3C; ATTACHMENT A – ASO OBJECTIVES AND ACS / XEROX SLA PERFORMANCE

ASO
The objective of the ASO is to provide medical benefits administration that meets current Plan needs and provides a platform for continued future growth and development.

The following are necessary functions, skills and abilities of an ASO partner:
- Strong understanding of Medi-Cal and Medicare rules and regulations around claims processing and upstream / downstream supporting functions
- Operational infrastructure to support CMS and State required clinical measures (due to best practices and new regulatory requirements) and other clinical initiatives such as HEDIS and NCQA
- Flexible, scalable core administration processing system to efficiently and accurately process operational transactions, new requirements and integration with other Plan systems
- Ability to accept, create and utilize regulatory required, industry standard electronic transactions and code sets.
- Ability to manage capitation payments and reporting
- Robust / timely reporting and data sharing capabilities
- Multilingual call center with Plan-specific reporting capabilities
- Cost containment capabilities (COB, Auditing, Recovery)
- Program integrity activities including extensive fraud, waste, and abuse (FWA) capabilities

The ACS / Xerox contract contains specific performance requirements, referred to as Service Level Agreements (SLA), which ACS / Xerox must meet on a monthly basis. Failure to meet any given SLA results in a financial penalty. The following SLAs are incorporated into the ACS / Xerox contract:

- Claims Turnaround Time (TAT) – 90% of clean claims processed within 30 calendar days (Table 1)
- Claims Financial Accuracy – 98% or higher (increasing to 99% with next contract amendment) (Table 2)
- Claims Procedural Accuracy – 97% or higher (Table 3)
- Auto Adjudication Rate – 60% or higher (Table 4)
- Call Center Average Speed of Answer (ASA) – 30 second or less (Table 5)
- Call Center Abandonment Rate – 5% or less (changing to 3% with next contract amendment) (Table 6)
- Monthly Eligibility File Load – within 2 business days of receipt (Table 7)
• System Availability – system available 99% of scheduled uptime (increasing to 99.5% with next contract amendment) (Table 8)

The following tables demonstrate how ACS / Xerox has performed against these SLAs since contract execution:

Table 1 – % of Claims Processed within 30 calendar days – 90% or higher

<table>
<thead>
<tr>
<th></th>
<th>July-11</th>
<th>October-11</th>
<th>January-12</th>
<th>April-12</th>
<th>July-12</th>
<th>October-12</th>
<th>January-13</th>
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<th>July-13</th>
<th>October-13</th>
<th>January-14</th>
<th>April-14</th>
<th>July-14</th>
<th>October-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
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<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
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<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
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</tbody>
</table>

*Membership increase of 40% since January 2014 has resulted in missed SLA results

Table 2 – Financial Accuracy – 98% or higher

<table>
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</thead>
<tbody>
<tr>
<td>Actual</td>
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<td>0.82</td>
<td>0.84</td>
<td>0.86</td>
<td>0.88</td>
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<td>0.92</td>
<td>0.94</td>
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<td>0.96</td>
<td>0.94</td>
<td>0.92</td>
<td>0.94</td>
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<td>0.98</td>
<td>0.98</td>
<td>0.96</td>
<td>0.94</td>
</tr>
<tr>
<td>Goal</td>
<td>0.8</td>
<td>0.82</td>
<td>0.84</td>
<td>0.86</td>
<td>0.88</td>
<td>0.9</td>
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<td>0.98</td>
<td>0.98</td>
<td>0.96</td>
<td>0.94</td>
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</tbody>
</table>

*Xerox focused on responding to the increased inventory due to member growth, which resulted in decreased financial quality. When Xerox re-focused on quality, results improved but production decreased, as shown in Table 1.
Table 3 – Procedural Accuracy – 97% or higher

Table 4 – Auto Adjudication Rate – 60% or higher
Table 5 – Average Speed to Answer (ASA) – 30 seconds or less

Table 6 – Abandonment Rate – 5% or less
Table 7 – Enrollment File Load – 100% within 2 business days of receipt

<table>
<thead>
<tr>
<th>Date</th>
<th>Enrollment File Load (within 2 business days) - Actual</th>
<th>Enrollment File Load (within 2 business days) - Goal</th>
</tr>
</thead>
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<tr>
<td>July-11</td>
<td>0.984</td>
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<tr>
<td>October-14</td>
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</tr>
</tbody>
</table>

Table 8 – System Availability – 99% or higher during scheduled uptime

<table>
<thead>
<tr>
<th>Date</th>
<th>System Availability - Actual</th>
<th>System Availability - Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>July-11</td>
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AGENDA ITEM 3C; ATTACHMENT B – PBM OBJECTIVES AND SCL SLA PERFORMANCE

PBM

The objective of the PBM is to accurately administer the pharmacy benefits of the Plan and provide a platform for continued future growth and development.

The following are necessary functions, skills, and abilities of a PBM partner:

- Demonstrated understanding of the Medi-Cal and Medicare oversight and regulatory setting
- Operations infrastructure to support and impact clinical measures and other best practices such as HEDIS, NCQA, and CMS STARS clinical measures
- Be a strategic partner with the ability and insight to anticipate and communicate new regulatory requirements
- Policies and procedures establishing best practices
- Aggressive contracting with pharmacy network to ensure access to industry standard rates and best practices
- Flexible, scalable core administration processing system to efficiently and accurately process operational transactions, new requirements and integration with other Plan systems
- Ability to accept, create and utilize regulatory required, industry standard electronic transactions and code sets
- Cost containment capabilities (COB, auditing, recovery)
- Ability to coordinate and administer 340B drug pricing
- Call center with plan-specific reporting capabilities
  - Supported languages
  - Segmented volume reports (pharmacy, provider, member)
- Program integrity activities including extensive fraud, waste, and abuse (FWA) capabilities including onsite and desktop pharmacy auditing
- Process for evaluation of new drugs for formulary consideration

GCHP monitors a variety of key performance indicators (KPI) to assess PBM performance. Samplings of a few of the KPIs are listed here:

1. Utilization Management (UM) Compliance Statistics
2. Cost Trends: Per Member Per Month
3. Cost Trends: Dollars Per Script
**Utilization Management (UM) Compliance Statistics**

UM oversight strives to mimic the oversight conducted by DHCS during the Medical Review Audit. The oversight samples cases on a daily and weekly basis. One hundred percent (100%) of denied cases are reviewed and 10% of approved cases are approved. The following 3 standards for each case are assessed:

1. **Accuracy of the Decision:** the case decision (as approved or denied) is made in agreement with plan clinical criteria
2. **Timeliness:** the case was decided in the DHCS required timeframe of “24 hours, or 1 business day”
3. **Accuracy of the Denial Language:** the denial reason is specific to the reason the case was denied, includes the name of other therapy that is recommendation to be tried before the requested therapy is approved, and includes proper grammar, spelling, and sentence syntax

The goal for each element is to achieve 100% compliance.

**Table 1 – Review of Accuracy of Decision**

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</table>
Table 2 – Review of Timeliness of Decision

Timeliness of Decision

Table 3 – Review of Accuracy of Denial Language

Accuracy of Denial Language

Cost Trends: Per Member Per Month (PMPM)
The graph below documents the performance of the pharmacy benefit as compared to other COHS with similar benefits and carve-outs. The six COHS in California have various carve-outs of the pharmacy benefits for CCS eligible members, HIV/AIDS medications and antipsychotics. Only 2 other COHS have carve-outs that match those of GCHP exactly.

PMPM is a global assessment of the overall performance of the benefit assessing drug pricing, utilization, and drug mix.
Table 4 – PBM PMPM Cost Trend Comparison

Cost Trends: Dollars Per Script ($ Per Script)
The graph below documents the performance of the pharmacy benefit as compared to other similar COHS for the measurement of Dollars per Script. This measurement provides an assessment of how well the formulary is performing with a global assessment of drug pricing as negotiated by the PBM.

Table 5 – PBM Dollars Per Script Comparison
ADMINISTRATIVE SERVICES ORGANIZATION (ASO) / PHARMACY BENEFITS MANAGER (PBM) RFP PROPOSAL

Ruth Watson
Interim CEO / COO
November 24, 2014
GCHP Core Administrative Contracts

• Administrative Services Organization
  – ACS Health Administration, Inc. (ACS/Xerox)
  – Contract Terminates June 30, 2016

• Pharmacy Benefits Manager
  – Script Care, LTD. (SCL)
  – Contract Terminates June 30, 2016
Project Scope

**ASO**
- Consultant RFP
- Consultant Selection
- Vendor RFP
- Vendor Selection
- Implementation*

**PBM**
- Consultant RFP
- Consultant Selection
- Vendor RFP
- Vendor Selection
- Implementation*

*Should a new vendor be selected.
Project Timelines
Proposal

• Begin an RFP process for one vendor so selection and implementation (if applicable) is completed with appropriate resources by 6/30/2016

• Extend the contract for one vendor for a year with two additional one year extensions
  – Costs will be associated with contract extension to include terms, scope and pricing
Requirements

- Fundamental understanding of the regulatory setting of Medi-Cal, Medi-Cal Managed Care & Medicare
- Strategic partner with insight into new regulatory requirements
- Support of clinical initiatives (NCQA, HEDIS)
- Flexible, scalable core administrative system
- Ability to accept, generate, and utilize all applicable industry standard electronic transactions
- ICD-10 compliance
- Robust program integrity activities
- Robust and timely data sharing and reporting capabilities
- Multilingual call center with plan specific reporting
- Cost containment capabilities
Vendor Specific Requirements

**ASO:**
- Ability to manage capitation payments and reporting
- Provider and Member Web Portals

**PBM:**
- Pharmacy network development and contracting
- Ability to coordinate/administer 340b drug pricing
- Aid in evaluation of new drugs
ASO Review

Accomplishments

• Service Level Agreements
• Claims Inventory
• Auto-Adjudication Rate
• Infrastructure/Resource Support
• Good Business Partner

Challenges

• Recent Inconsistent Turnaround Time (TAT)
• Crossover Claims Process
• Encounter Data Completeness
• Core System Flexibility
ASO: Service Level Agreements (SLA)

- **Claims Results**
  - Turnaround Time within 30 days (DHCS requirement)
  - Financial Accuracy (industry standard)
  - Procedural Accuracy (industry standard)
  - Auto-Adjudication Rate (established by BRG)

- **Call Center Stats**
  - ASA (industry standard)
  - Abandonment Rate (industry standard)

- **System Results**
  - System Availability (industry standard)
  - Enrollment File Load (DHCS requirement)
ASO: Infrastructure/Resource

- **Personnel**
  - 112 staff members supporting GCHP
  - Estimate annual salary costs with GCHP rates: $8,500,000

- **Call Center, Network & Infrastructure**
  - Infrastructure: between $5M to $7M to bring in house
  - Facility Space: approximately $483,000 annually
  - Disaster Recovery: depends on solution design
ASO: Work in Progress

• Claims TAT following Medi-Cal Expansion
  – Membership > 160,000 4 months sooner than expected

• Crossover Claims
  – Improvement project is underway with expected implementation in 2015Q1

• Encounter Data Improvement Program
  – Active improvement project, nearing phase 1 completion
PBM Review

Accomplishments

• Key Performance Indicators
  – Utilization Management (UM) Statistics
  – Per Member Per Month Costs
  – $ Per Script
• 340b Administration

Challenges

• Industry & regulatory expertise & best practices
• Delegation oversight
• Cost containment strategies
PBM: Ongoing Oversight

- Formulary
- Utilization Management
- Pharmacy Credentialing & Contracting
- DME Rebate Administration
- Claims Audits
PBM: Future Regulatory Challenges

- Update of 42 CFR 438, the Medicaid Managed Care Regulations
- Increased program integrity requirements from DHCS
- Specialty Pharmacy
- Generic Drug Pricing
Summary

ACS / Xerox

• Operational challenges during the first year of providing ASO services which included instances of non-compliance with regulatory and contractual standards

• Remarkable improvements in business operations evidenced by the Service Level Agreement (SLA) performance metrics and pending internal improvement projects
Script Care

- Significant regulatory and industry challenges are anticipated to affect pharmacy over the next several years.
- An RFP for a PBM vendor would allow GCHP to determine the best PBM partner for the Plan.
Recommendation

1. Extend the contract with ACS / Xerox for one year with two additional one year extensions
2. Send the PBM contract out to bid
AGENDA ITEM 4a

To: Gold Coast Health Plan Commissioners
From: Barry Fisher, Special Investigation Ad Hoc Committee Chair
Date: November 24, 2014
Re: Special Investigation Ad Hoc Committee Status Report

SUMMARY:
The following is the November 2014 status report from the Special Investigation Ad Hoc Committee outlining the progress of the investigations into allegations involving workplace issues and financial improprieties, including revised estimated budgets due to additional work, and estimated time for completing the investigations.

STATUS
Both firms (Atkinson Andelson Loya Rudd & Romo (AALRR) and Vicenti Lloyd & Stutzman (VLS) continue to conduct interviews and obtain and review documents. They have also begun using a firm which specializes in electronic Discovery to process, filter and cull data from computers and email servers and create a searchable database. The firm is Discovia and is performing work in three phases under a Master Services Agreement.

- Phase 1 – obtaining information from the hard drives of four employees and placing the data from three of those employees onto Discovia’s platform. The cost for this phase is estimated at $43,658 and includes 120 GB of data.

- Phase 2 - included collecting emails from seven employees from the server and performing the necessary work to create a searchable database for emails relevant to the investigation. The majority of the work necessary under Phase 2 was at the request of AALRR to prepare for interviews under a compressed interview schedule. The cost for this phase is estimated at $15,537 and includes 61.9 GB of data.

- Phase 3 - involves a request by VLS to the fourth employee’s (not originally included in Phase 1) hard drive information on Discovia’s platform. In addition, VLS has requested “My Documents” data for specified employees. The cost for this phase is estimated at $20,528 and includes 49.9 GB of data.

All the data extracted from hard drives and the server(s) require ingestion, searching, culling and batching to develop a searchable database. The cost of Discovia’s work is intended to reduce attorney and forensic accountant time and charges for hand searching or other individual document review of 231.8 GB of data.
To date the data sources have yielded 1,276,513 searchable documents, of which 522,574 have been promoted to hosted review. This figure does not include hard copies of documents received from Gold Coast, which now number over 1000. There are additional documents which are forthcoming.

A total of 29 witnesses have been interviewed by both AALRR and VLS. AALRR has another 12 interviews scheduled between November 18 and December 5, with 11 additional interviews planned before December 22. There may be further follow-up interviews which will be scheduled for early January.

**ESTIMATED BUDGETS**
The work of AALRR will exceed the original budget estimate of $150,000 to $200,000. The primary reason noted for the increase is that witness interviews are taking much longer than anticipated (some require multiple days) and certain witnesses have added allegations which need to be addressed. The revised budget is now estimated at $250,000 to $300,000.

VLS appears on target to complete their scope of work within the estimated budget of $435,740.

The budget for the work performed by Discovia on behalf of the attorneys and forensic accountants is estimated at $79,723 for all three phases of work. There is an additional cost of hosting the searchable data on their database. This cost is estimated at $3,000 per month, which we would seek to end once the report from AALRR and VLS is finalized. We cannot at this time quantify any cost savings as a result of the work being performed by Discovia. Suffice it to say that the goal is a reduction in attorney and forensic accountant time and associated cost.

**FISCAL IMPACT**
The total cost of the investigations with the revisions as noted herein, is now estimated at between $765,463 and $815,463.

**ESTIMATED DATE FOR COMPLETION**
The estimated date for completion and final report remains at end of January 2015.

**RECOMMENDATION:**
It is recommended that the Commission accept and file the November 2014 status report of the Special Investigations Ad Hoc Committee.
AGENDA ITEM 4b

To: Gold Coast Health Plan Commission

From: Ruth Watson, Interim CEO / Chief Operating Officer

Date: November 24, 2014

Re: CEO Update

COMPLIANCE UPDATE

Gold Coast Health Plan (GCHP) is slated for a Department of Health Care Services (DHCS) medical audit in February 2015. Auditors from Audits and Investigations (A&I) will be onsite for approximately two weeks. Pre-audit data and documents will be requested by A&I prior to the onsite audit.

The DHCS corrective action plan, Financial (Addendum A) remains open, however GCHP per DHCS instruction was able to terminate the State appointed monitors contract as a result of continuously meeting requirements. The Plan continues to submit items on a monthly basis as required by the CAP.

Compliance continues to monitor and ensure that all employees and temporary employees are trained and retrained on HIPAA and Fraud, Waste & Abuse. In addition, compliance & information technology staff conducts random internal audits for HIPAA and PHI issues. As a component of commissioner compliance training, compliance has sent out notifications and login information to all commissioners relative to the course required and timeframes for completion.

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 required information is provided within the required timeframe. Compliance staff is actively engaged in sustaining contract compliance.

GCHP is required to conduct delegation oversight audits on functions which are delegated. Routine reporting from delegates to the Plan is contractually required and must be actively monitored. Reporting statistics from delegates can be found in the compliance dashboard. An annual audit schedule was created and staff is working through each audit. The delegation oversight staff has conducted the following audits:
The last audit for calendar year 2014 will be on the Plan’s transportation vendor, Ventura Transit System (VTS). The audit is slated for November 24, 2014.

The Plan received additional information from the Department of Health Care Services (DHCS) on October 1, 2014 relative to oversight auditing requirements for Kaiser. Once a final determination is confirmed by DHCS the Plan will align activities to ensure compliance. Given the active ongoing discussions relative to oversight specific to Kaiser the Plan has elected to move the onsite audit planned for November 2014 to January 2015. The Plan anticipates final resolution by DHCS soon and the Plan will conform to DHCS policy.

The Plan has issued the following corrective action plans in 2014:

- Credentialing (3) *
- Specialty Contract (2)
- MBHO (2)
- Vision (2)

* denotes CAP(s) have been closed; all others are at various stages of the CAP process.

The Plan continues to monitor delegates through contractual required reporting. Reports are reviewed and when deficiencies are identified the Plan issues letters of non-compliance. This process is monitored, tracked and reported to the compliance committee. In addition the aggregate information is provided to the commission on the compliance dashboard.

FINANCE UPDATE

FY 2013-14 Audit
The Plan has been working very closely with external auditors (McGladrey) to finalize the audit, which was originally due to the State on October 31, 2014. Recently, McGladrey has informed the Plan that there will be extended delays in finalizing the audit, primarily caused by the allegations raised by LULAC and the fact that there is an investigation that has not yet been completed.

Lines of Credit
Gold Coast Health Plan has two subordinated lines of credit with the County of Ventura.
(County). The Plan has drawn the full amount of the lines, totaling $7,200,000. The original loan agreements call for full repayment by December 31, 2014, subject to approval by the California Department of Health Care Services (DHCS).

GCHP is currently in discussions with the County and DHCS to extend repayment to June 30, 2015. The current proposal for repayment is that GCHP would first maintain 150% of required TNE (excluding subordinated debt) for three consecutive months (following the FY 2013-14 audit). Payments would be made in equal monthly installments, based on an appropriate amortization schedule, with the final payment due before June 30, 2015. Loan payments would be suspended in the event that the Plan failed to generate positive net income or fell below the 150% of TNE threshold. If such an event were to occur, GCHP would suspend payment until the month following its achievement of the required threshold.

The repayment proposal is subject to the completion of GCHP’s annual audit and DHCS approval. The Plan has informed DHCS of its intent to repay the line of credit according to the above terms, however no time frame for approval has been communicated by DHCS personnel. Due to above mentioned delays associated with completing the FY 2013-14 audit, it is unlikely that the proposal will be approved this month as originally planned.

GOVERNMENT RELATIONS UPDATE

1115 Waiver Renewal
California is currently in the fourth year of its five-year demonstration “Bridge to Reform” 1115 Waiver. The 1115 Bridge to Reform Waiver will expire on October 31, 2015. California will be seeking a renewal of its 1115 Waiver to be effective November 1, 2015.

The 1115 Bridge to Reform Waiver funded the entire Medi-Cal managed care program which also includes the CBAS program and the Coordinated Care Initiative. The 1115 Bridge to Reform Waiver also enabled California to implement an early expansion of Medicaid under the Affordable Care Act (ACA).

DHCS has established five separate workgroups to develop concepts on: 1) Provider / Managed Care Plan incentive programs; 2) Safety Net Reform – Disproportionate Share Hospitals / Safety Net Care Pool bundled payments; 3) a Delivery System Reform Incentive Program (DSRIP); 4) Medicaid - funded Shelter / Housing; and 5) Workforce Development.

The workgroup participants are from Medi-Cal managed care plans and are considered subject matter experts in California’s delivery system infrastructure and 1115 Waivers. Two other waiver renewal concepts and workgroups, focusing on a redesign of the California Children's Services (CCS) Program and the Federally Qualified Health Centers (FQHC) payment reform, will also be developed. The 1115 Waiver Renewal expert stakeholder
workgroups will all convene in Sacramento for three to five sessions, continuing through early February 2015.

Local Health Plans of California - LHPC Legislative Briefing
On November 18, 2014 Gold Coast Health Plan’s Director of Government Affairs participated in a legislative briefing to legislators and their staff at the state capitol. The briefing provided new legislators and their staff a refresher course on the public plan model and how the LHPC plans are doing under the ACA initiatives. The briefing also provided plan staff the opportunity to meet some of the key policy and budget staff in the state capitol.

With a projected enrollment of 11.5 million, California’s Medi-Cal program is the largest Medicaid program in the United States. Approximately 30% of the state’s population now receives healthcare through the Medi-Cal program.

Supreme Court Announcement
On November 7, 2014 the Supreme Court of the United States announced that they will take up the case of King v. Burwell. The central issue in this case is whether federal subsidies should be available to all Americans who qualify or only to those who purchase health insurance through exchanges established by a state. If the court decides against allowing subsidies in federally-facilitated exchanges, health insurance premiums for people in federal health exchanges will increase significantly. Currently twenty-six states have federally - facilitated and subsidized health exchanges. It is expected that the court will decide on the King v. Burwell case sometime in late spring or early summer of 2015.

State Legislature
The State Legislature reconvenes on January 5, 2015. Per state constitution the Governor must submit his proposed state budget to the Legislature by January 10, 2015. The legislature must pass a state budget by June 15, 2015 or state legislators forfeit their pay for every day that a budget is not passed.

Mid Term Elections
The state mid-term elections on November 4, 2014 resulted in three key victories for the Republican Party in California’s state legislature. These victories enabled Republicans to pick up enough legislative seats to end the Democrats’ supermajorities in both chambers. The significance of the two-thirds supermajority is that it allows the majority party to raise taxes, put measures on the statewide ballot, and override gubernatorial vetoes without support from the minority party. For your reference, GCHP’s legislative advocacy firm Edelstein, Gilbert, Robson and Smith provided the attached summary of the November elections.
HEALTH EDUCATION AND COMMUNITY OUTREACH SUMMARY REPORT

Summary
Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. Below is a summary of activities conducted by GCHP staff.

October 2014 Outreach Activities
Overall GCHP continues to reach individuals, families, and potential members through a variety of community outreach events. During the month of October GCHP staff participated in 26 community events and approximately 1,300 individuals, providing approximately 3,800 pieces of literature. Staff continues to hand out materials related to the Affordable Care Act (ACA) and continues to reach potential individuals eligible for Medi-Cal through the ACA Medi-Cal expansion program.

Year-to-Date Total Number of Participants Reached
The total number participants reached from January 2014 – October 2014 is roughly 9,600 individuals. Information regarding GCHP and the Medi-Cal Expansion Program continues to increase as we approach open enrollment for Covered California and the Medi-Cal expansion program.
**Health Education Activities**
October was Breast Cancer Awareness Month – GCHP hosted three breast health awareness workshops and partnered with community based agencies, schools, GCHP Network Providers and Hospitals to promote breast cancer awareness.

Health education and outreach staff continue to participate in hospital based health fairs for pregnant women. Staff distributes materials related to prenatal care, car seat safety, newborn referral form for Medi-Cal enrollment, tobacco cessation programs for pregnant women, nutrition education, and other materials related to preventive care.

The Health Navigator Program, also known as Community Health Workers / Promotoras, are peer - educators trained to reach members who frequent the emergency room three or more times per month for preventable conditions. The health navigators encourage the member to follow-up with their Primary Care Provider (PCP) and when appropriate make a referral for case management.

In order to encourage members to avoid emergency room visits for non-emergency problems, the Health Education Department prepared a brochure on contracted Urgent Care Centers in Ventura County. The Urgent Care brochure will document the urgent care locations, hours of operation, and contact information. The Urgent Care brochure will be available in English and Spanish. The brochure was reviewed by the Medical Advisory Committee (MAC) during their quarterly meeting. The MAC made suggestions which were incorporated into the brochure.
2014 ELECTION UPDATE
by Don Gilbert, Mike Robson, and Trent Smith
November 10, 2014

We previously provided a preview of the November election with an eye towards some of the contested races that might impact the 2015-16 legislative and budget agenda of the Governor and the California Legislature.

As we noted in our electoral preview, while the outcome of many races could be predicted, there were several races where it was unclear which party and/or which candidate would win the seat. Again, as noted in our preview, California will still have strong Democrat majorities in both houses of the Legislature following the election. However, the Democrats will not enjoy two-thirds supermajorities in either house of the Legislature.

Governor
Governor Brown easily won re-election with approximately 59 percent of the vote. The Governor had a $20 million plus campaign account. It was only a question of how large his victory would be, whether his victory would help Democrats down the ticket, and whether he would campaign for others on the ballot.

In the end, he spent his campaign money on Propositions 1 (Water Bond) and Proposition 2 (Spending Limits) and appeared in some campaign rallies for some Democrats in tight races. However, his strength at the top of the ticket did not translate down to Democrats in close races.

Statewide Officers
The Democratic candidates and incumbents once again swept all of the other statewide offices. However, most observers noted that the seriously underfunded Republican candidates presented strong challenges and with some additional funding might have been able to win some races. These strong challenges are evidence that the Republican tide that rolled across the nation did have impact in California, though no statewide victories came about.

Legislature
As noted above, Republicans won enough seats previously held by Democrats to deny the two-thirds supermajority. As we noted in our pre-election report, the significance of the two-thirds vote is that if all Democrats vote as a bloc, there is the ability to pass tax increases and place constitutional amendments on the statewide ballot.
State Senate
In the Senate, the Democrats entered the November election holding exactly 27 seats that comprise a supermajority. There were three Senate races in play that would either add to or subtract from that number.

Orange County Senate District 34 -- Janet Nguyen (R) vs. Jose Solorio (D)
This was the Senate race most observers focused on early because it was an open race without an incumbent and the Republican candidate’s strong victory in the primary showed that it had the most potential to change party hands.

Janet Nguyen, a Republican County Supervisor from Orange County, defeated Jose Solorio, who is a former Assemblyman and current community college board trustee. Because the Democrats enjoy a five percent registration advantage, it was expected to be a close race. In the end, however, Ms. Nguyen easily defeated Mr. Solorio by a 59-40 percent margin.

Central Valley Senate District 14 -- Senator Andy Vidak (R) vs. Luis Chavez (D)
Despite running with a 20 point disadvantage in party registration, Republican Senator Andy Vidak once again showed his cross-party appeal and easily won re-election on a 55-44 percent vote.

The Republicans also held on to another Central Valley seat with higher Democrat registration in the race involving incumbent Senator Anthony Cannella. Senator Cannella ran 33 points ahead of registration and easily won re-election to his last term in the Senate.

Sacramento County Senate District 6 -- Dr. Richard Pan (D) vs. Assembly Member Roger Dickinson (D)
In our election preview, we also highlighted a Senate race between two Democrats in Sacramento County. This contest would prove to be one of the most expensive races in the state with outside interest groups spending almost $5 million in the race.

In the end, the more moderate, business-oriented, doctor-backed Democrat, Dr. Pan, defeated the trial lawyer-backed candidate, Roger Dickinson, by six percentage points.

This race will be viewed as a textbook example of the impact of the open primary in California, whereby two candidates of one party face-off in a general election and voters of the other party, as well as independent voters, become the swing voters who decide the outcome of the election.
State Assembly
Assembly Democrats entered the November election one seat above the 54 vote supermajority, with 55 seats. Unlike the Senate, there were a greater number of races in play with the prospect of impacting the partisan breakdown in the Assembly.

Also of interest, were some close Democrat vs. Democrat races that pitted moderate Democrats against more liberal Democrats.

Antelope Valley AD 36 -- Steve Fox (D) vs. Tom Lackey (R)
As we noted in our pre-election report, the incumbent Assemblyman Steve Fox would be hard-pressed to hold on to this seat, which he unexpectedly won in 2012. That was a correct assumption as the challenger easily won this seat by 23 percentage points.

Orange County AD 65 -- Assembly Member Sharon Quirk-Silva (D) vs. Young Kim (R)
We previously noted that this would be a close race. It was not. The Republican challenger defeated the incumbent Democrat in this traditionally Republican area by 11 percentage points.

Ventura County AD 44 -- Jacqui Irwin (D) vs. Rob McCoy (R)
We previously reported that this race represented a seat held by a Republican where the Democrats had a strong candidate and a chance to win. That was a correct assumption. As of this writing, Thousand Oaks City Councilmember Jacqui Irwin is leading by 2.6 percentage points and is expected to hang on to her election-night victory.

Contra Costa County AD 16 -- Catharine Baker (R) vs. Tim Sbranti (D)
We highlighted this race in our preview due to the interesting primary election that brought these candidates to November. Baker, the Republican, was the top vote-getter in the open primary. Mr. Sbranti came in second after a bruising, nasty fight with another Democrat, Steve Glazer, who ran as an anti-public employee union, political outsider. Mr. Sbranti, a former California Teacher union official, prevailed in the primary with significant financial support from the teachers and public employee unions. This seat favors the Democrats in the General Election due to a seven point advantage in registration. However, Mr. Glazer and some other high-profile Democrats supported the Republican, Catharine Baker, in this race.

It was a close race, and in what could only be called a stunning defeat of the powerful California Teachers Association, Catharine Baker won by 3.4 percentage points. It is the first time in quite some time that a Republican will represent a Bay Area district.
Los Angeles County AD 66 -- Assemblyman Al Muratsuchi (D) vs. David Hadley (R)
This contest was not highlighted in our election preview. This race pitted a moderate Democrat against a Republican in a seat that has traditionally been represented by a Democrat. Given the power of incumbency and his relative moderation within the Democratic Caucus, it was expected that Assemblyman Muratsuchi would win a close election. Instead, the challenger rode the Republican tide and is currently holding on to a 1.6 percent victory with ballots still being counted.

Democrat vs. Democrat Races
In addition to Pan vs. Dickinson, there were a number of other Democrats running against each other in the November election due to the top-two primary rules. In the past, these extremely safe Democratic seats would have gone to a traditional liberal Democrat. But with the new rules, these are races where the relatively small number of Republican and independent voters in these Democratic strongholds have the ability to sway the election.

- **AD 7 -- Steve Cohn vs. Kevin McCarty** in Sacramento.
  Kevin McCarty defeated the local Chamber of Commerce endorsed Steve Cohn 58-41 percent.
- **AD 9 -- Jim Cooper vs. Darrell Fong** in Sacramento.
  A coalition of business groups spent heavily to help elect Jim Cooper who won by almost 10 percent.
- **AD 15 -- Tony Thurmond vs. Elizabeth Echols** in Richmond/Berkeley.
  In probably the most liberal district in the state, a coalition of blue collar labor and businesses groups backed Tony Thurmond to an eight point victory over Berkeley City Council member Echols.
- **AD 17 -- David Chiu vs. David Campos** in San Francisco.
  In very liberal and progressive San Francisco, the regional high technology leaders supported Board of Supervisor President David Chiu’s victory over David Campos.
- **SD 26 -- Ben Allen vs. Sandra Fluke** for the State Senate in Los Angeles.
  Santa Monica City Councilman easily defeated Democratic activist Sandra Fluke by 21 percentage points.

As noted above ballots are still being counted in various races. Nonetheless, we think these results will hold.
Conclusion
When the Legislature convenes, the Assembly will be comprised of 52 Democrats and 28 Republicans.

The Senate will have 25 Democrats and 14 Republicans plus a vacancy. There will be additional immediate vacancies, with one current Democratic Senator and two Republicans being sworn into Congress which will trigger special elections in March.

The Legislature will be sworn into office on December 1 and legislation can be introduced on that day. The 2015 Legislative Session will begin in earnest after the holidays on January 5.
AGENDA ITEM 4c

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: November 24, 2014

Re: COO Update

OPERATIONS UPDATE

Membership

Gold Coast Health Plan experienced minimal growth on the November Enrollment file, adding 1,042 members to the Plan. GCHP’s membership as of November 1, 2014, is 168,640, which represents an increase of 48,128 members or 40% since January 1, 2014. The cumulative new membership since January 1, 2014 is summarized as follows:

L1 (Low Income Health Plan) – 7,289
M1 (Adult Expansion) – 24,060
7U (CalFresh Adults) – 3,254
7W (CalFresh Children) – 599
7S (Parents of 7Ws) – 14
Traditional Medi-Cal – 12,466

November’s growth was split fairly evenly between Members with Traditional aid codes (460) and M1 (491). Of note is the increase in the 7W category which had dropped to 296 in October and is now at 599.

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<tr>
<td>L1</td>
<td>7,618</td>
<td>8,083</td>
<td>8,154</td>
<td>8,134</td>
<td>8,118</td>
<td>7,975</td>
<td>7,839</td>
<td>7,726</td>
<td>7,568</td>
<td>7,443</td>
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<td>M1</td>
<td>183</td>
<td>1,550</td>
<td>2,482</td>
<td>4,514</td>
<td>7,279</td>
<td>10,910</td>
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<td>18,585</td>
<td>21,944</td>
<td>23,569</td>
<td>24,060</td>
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<tr>
<td>7U</td>
<td>0</td>
<td>0</td>
<td>1,741</td>
<td>3,584</td>
<td>3,680</td>
<td>3,515</td>
<td>3,453</td>
<td>3,400</td>
<td>3,368</td>
<td>3,312</td>
<td>3,254</td>
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<td>7W</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>684</td>
<td>714</td>
<td>691</td>
<td>667</td>
<td>624</td>
<td>606</td>
<td>296</td>
<td>599</td>
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<td>7S</td>
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<td>5</td>
<td>11</td>
<td>14</td>
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14-14-1
September 2014 Operations Summary

Claims Inventory – ended the month with an inventory of 35,536 claims; this equates to Days Receipt on Hand (DROH) of 6 days as our average daily claims receipt during October was 5,828 per day. We received approximately 15,000 more claims in October than the prior month. Claim receipts from January through October are as follows:

<table>
<thead>
<tr>
<th>Month</th>
<th>Claims Received</th>
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<tbody>
<tr>
<td>January</td>
<td>91,130</td>
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<tr>
<td>February</td>
<td>90,048</td>
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<tr>
<td>March</td>
<td>109,857</td>
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<tr>
<td>April</td>
<td>110,855</td>
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<tr>
<td>May</td>
<td>108,312</td>
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<tr>
<td>June</td>
<td>116,474</td>
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<tr>
<td>July</td>
<td>117,136</td>
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<tr>
<td>August</td>
<td>108,695</td>
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<tr>
<td>September</td>
<td>119,233</td>
</tr>
<tr>
<td>October</td>
<td>134,274</td>
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</table>

Claims TAT – the regulatory requirement of processing 90% of clean claims within 30 calendar days was met in October. The result for October was 92.62%.

Claims Processing Accuracy – financial accuracy remained on goal in October with results coming in at 99.78%. Procedural accuracy also exceeded the goal in October at 99.97%.

Call Volume – call volume remained above 10,000 for the fourth straight month. GCHP received 10,300 calls in the month of October.

Average Speed to Answer – we continue to exceed the goal of answering calls within 30 seconds or less. The combined results for October were 8.4 seconds.

Abandonment Rate – the abandonment rate continues to remain exceedingly low. The goal is 5% or less of the calls received being abandoned; we have remained below 1% for 12 consecutive months.

Average Call Length – the combined result of 6.53 minutes in October met the goal of 7 minutes or less although the Provider and Spanish calls were slightly over 7 minutes during month.

Noteworthy Activities – Operations continues to lead or be involved in the following projects:
• 35C to 837 Encounter Data Transition – DHCS continued to maintain an effective date of October 1, 2014 for this project even though the State has not completed testing with any plans statewide. DHCS will allow plans to submit in the old format until November 12, 2014. GCHP continued testing with DHCS during October and anticipates moving into production in November.

• Encounter Data Improvement Project (EDIP) – improve the quality of the data sent to DHCS in order to meet new quality measures established by the State beginning January 2015.

• ICD-10 Readiness – regulatory requirement to implement new code set effective October 1, 2015.

• Crossover Claims – preliminary project work commenced August 2014

• Plan Selection – PCP selection during sign-up via Covered California; information matched once Medi-Cal beneficiary becomes a GCHP member. DHCS has indicated that the current focus is on non-COHS plans.
GCHP Claims Metrics – October 2014

- 30 Day Turnaround Time was met in October with 92% of clean claims processed within 30 calendar days
- Ending Inventory equals 6 Days Receipt on Hand (DROH) compared to goal of 5 days
- Financial and Procedural Accuracy both exceeded required Service Levels

Clean Claims Processed within 30 Calendar Days

Financial and Procedural Accuracy

Regulatory requirement – 90% of clean claims must be processed within 30 calendar days

Financial Accuracy – 98% or higher
Procedural Accuracy – 97% or higher
GCHP Call Center Metrics – October 2014

- Call volume remained above 10,000 calls received during the month
- Abandonment rate and ASA remain well within goal

Abandonment Rate
(goal is 5% or less)

Average Speed of Answer (ASA)
(goal is 30 seconds or less)
GCHP Membership allocation – October 2014

- Membership counts by PCP as of first day of each month.
- Unassigned members are Newly Eligible / Enrolled
- ADMIN members count is the remainder after deducting those with Medicare Coverage but includes those with SOC and OHI.
GCHP Auto Assignment by PCP/Clinic as of November 1, 2014

<table>
<thead>
<tr>
<th></th>
<th>Nov-14</th>
<th>Oct-14</th>
<th>Sep-14</th>
<th>Aug-14</th>
<th>Jul-14</th>
<th>Jun-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AB85 Eligible</strong></td>
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</tr>
<tr>
<td>Count</td>
<td>1,390</td>
<td>2,494</td>
<td>2,726</td>
<td>3,687</td>
<td>2,775</td>
<td>2,250</td>
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<tr>
<td>%</td>
<td>74.96%</td>
<td>74.98%</td>
<td>74.98%</td>
<td>74.99%</td>
<td>74.99%</td>
<td>74.98%</td>
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<tr>
<td><strong>VCMC</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>1,042</td>
<td>1,870</td>
<td>2,044</td>
<td>2,765</td>
<td>2,081</td>
<td>1,687</td>
</tr>
<tr>
<td>%</td>
<td>74.96%</td>
<td>74.98%</td>
<td>74.98%</td>
<td>74.99%</td>
<td>74.99%</td>
<td>74.98%</td>
</tr>
<tr>
<td><strong>Balance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>348</td>
<td>624</td>
<td>682</td>
<td>922</td>
<td>694</td>
<td>563</td>
</tr>
<tr>
<td>%</td>
<td>25.04%</td>
<td>25.02%</td>
<td>25.02%</td>
<td>25.01%</td>
<td>25.01%</td>
<td>25.02%</td>
</tr>
</tbody>
</table>

|               |        |        |        |        |        |        |
| **Regular Eligible** |        |        |        |        |        |        |
| Count         | 1,462  | 1,631  | 2,192  | 1,698  | 2,512  | 1,584  |

|               |        |        |        |        |        |        |
| **Regular + AB85 Balance** |        |        |        |        |        |        |
| Count         | 1,810  | 2,255  | 2,874  | 2,620  | 3,206  | 2,147  |
| %             | 23.92% | 23.46% | 23.17% | 23.85% | 20.24% | 22.62% |

|               |        |        |        |        |        |        |
| **Clinicas**  |        |        |        |        |        |        |
| Count         | 433    | 529    | 666    | 610    | 649    | 478    |
| %             | 23.92% | 23.46% | 23.17% | 23.85% | 20.24% | 22.62% |

|               |        |        |        |        |        |        |
| **CMH**       |        |        |        |        |        |        |
| Count         | 197    | 261    | 314    | 282    | 330    | 212    |
| %             | 10.88% | 11.57% | 10.93% | 10.76% | 10.29% | 9.87%  |

|               |        |        |        |        |        |        |
| **Independent** |        |        |        |        |        |        |
| Count         | 40     | 57     | 69     | 52     | 64     | 44     |
| %             | 2.21%  | 2.53%  | 2.40%  | 1.98%  | 2.00%  | 2.05%  |

|               |        |        |        |        |        |        |
| **VCMC**      |        |        |        |        |        |        |
| Count         | 1,140  | 1,408  | 1,825  | 1,676  | 2,163  | 1,413  |
| %             | 62.98% | 62.44% | 63.50% | 63.97% | 67.47% | 65.81% |

|               |        |        |        |        |        |        |
| **Total Assigned** |        |        |        |        |        |        |
| Count         | 2,852  | 4,125  | 4,918  | 5,385  | 5,287  | 3,834  |
| %             | 15.18% | 12.82% | 13.54% | 11.33% | 12.28% | 12.47% |

|               |        |        |        |        |        |        |
| **Clinicas**  |        |        |        |        |        |        |
| Count         | 433    | 529    | 666    | 610    | 649    | 478    |
| %             | 15.18% | 12.82% | 13.54% | 11.33% | 12.28% | 12.47% |

|               |        |        |        |        |        |        |
| **CMH**       |        |        |        |        |        |        |
| Count         | 197    | 261    | 314    | 282    | 330    | 212    |
| %             | 6.91%  | 6.33%  | 6.38%  | 5.24%  | 6.24%  | 5.53%  |

|               |        |        |        |        |        |        |
| **Independent** |        |        |        |        |        |        |
| Count         | 40     | 57     | 69     | 52     | 64     | 44     |
| %             | 1.40%  | 1.38%  | 1.40%  | 0.97%  | 1.21%  | 1.15%  |

|               |        |        |        |        |        |        |
| **VCMC**      |        |        |        |        |        |        |
| Count         | 2,182  | 3,278  | 3,869  | 4,441  | 4,244  | 3,100  |
| %             | 76.51% | 79.47% | 78.67% | 82.47% | 80.27% | 80.86% |

**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
- AB85 assignment began in March 2014 for members eligible in January 2014
AGENDA ITEM 4d

To: Gold Coast Health Plan Commission

From: Melissa Scrymgeour, Chief Information Officer

Date: November 24, 2014

Re: CIO Update

Infrastructure and Systems

On November 18, 2014, MedHOK implemented the final production release to address the remaining post-implementation priority issues discovered since initial go-live. GCHP IT staff, along with MedHOK resources, continues to monitor for any post implementation impact, with a target to close out the task force and move to a regular MedHOK system release schedule and operational support model in December.

Project Management Office (PMO)

The GCHP project portfolio consists of 26 major Plan initiatives approved for FY 2014-15. Of the total projects, 15 are currently in "active" status, while the remainder are in various stages of analysis and planning.

Listed below are the PMO project activity highlights for November:

- Closed Grievance and Appeals Optimization project
- Extended the first phase of the Non-Emergent Medical Transportation (NEMT) project by 90 days to allow for State required review and approval of new Member Notification materials
- Completed internal analysis and evaluation of the ACS / Xerox Administrative Services Organization (ASO) and Script Care Pharmacy Benefits Manager (PBM) contracts
- Re-evaluated project priorities and resource availability based on the rescheduling of the DHCS Medical Audit from December 2014 to February 2015
- Began initial analysis and planning in preparation for kickoff of Provider Contracts and Capitation Rebasbing Evaluation project

Planned for December:

- Close MedHOK Post-Implementation, SPD, and ACG-Risk Stratification projects
- Close Member Satisfaction Survey
- Kickoff Provider Contracts and Capitation Rebasbing Evaluation
- Kickoff ICES / IKA Upgrade
• Kickoff ACA Core Administrative Simplification Rules (CORE)

FY 2014-15 GCHP Projects:

• **ICD-10 Readiness**: Transition all systems and providers from ICD-9 to ICD-10 by the revised Center for Medicaid and Medicare Services (CMS) mandated date of October 15, 2015.

• **Disease Management (DM) Program**: Contractually required. Introduce formal DM program to better manage health outcomes for targeted member population. The initial Diabetes program will benefit roughly 10,000 members and help build a model for other diseases (CHF, COPD, and Prenatal).

• **Member Satisfaction**: Gauge and measure member satisfaction with GCHP, as requested by the Commission.

• **Xerox/ACS Service Organization Control (SOC) Audit**: Recommended by Plan financial auditor.

• **Encounter Data Improvement Project (EDIP)**: Contractual requirement for State EDIP initiative. The State requires managed care plans to submit complete, accurate, timely and reasonable encounter data in a HIPAA compliant file format.

• **Delegation & Oversight Framework**: Institute standard delegation and oversight requirements, policies, and procedures for establishing provider contracts.

• **Business Continuity Planning**: Contractual requirement to draft plan for critical business process resumption in event of emergency.

• **Disaster Recovery Planning**: Contractual requirement to draft plan for data and system recovery in event of emergency for business critical functions.

• **Crossover Claims**: Further optimizes claims processing accuracy and efficiencies to appropriately handle claims where a portion is covered by Medicare.

• **Operationalize Information Security Program** – Required to ensure ongoing HIPAA and HITECH (Health Information Technology for Economic and Clinical Health Act-2009) compliance.

• **Social Media Policy & Roadmap**: Establish a communication strategy via social media platforms to members, providers and the general community.
• **ACA Core Administrative Simplification Rules (CORE):** Regulatory requirement to utilize standard electronic transaction sets as defined under the Affordable Care Act.

• **HR Flexible Work Program:** Implement initiatives to attract and retain staff. Under consideration are a telework strategy, employee recognition, and flexible work schedules.

• **ASO or PBM RFP:** Vendor evaluation and RFP for Xerox /ACS (ASO) or Scriptcare (PBM). Both contracts expire in June 2016.

• **MedHOK ACG-Risk Stratification:** Implement MedHOK ACG module for member risk stratification.

• **Provider Contracts & Capitation Rebasings Evaluation:** Evaluation of provider capitation rates.

• **MedHOK Provider Portal:** Implement MedHOK provider portal to streamline provider online experience for eligibility and claim inquiries, and authorization requests. Supports Plan “valued and trusted partner” strategy.

• **Provider Credentialing System (PCS) RFP & Implementation:** Selection and procurement of provider data and credentialing management software.

• **MedHOK SPD:** Implement MedHOK functional enhancements to meet State SPD assessment and reporting requirements.

• **MedHOK MMS Post Implementation:** Implement system fixes to resolve MedHOK post-implementation issues.

• **ICES/IKA Upgrades:** Software version upgrade for claims processing system.

• **Data Warehouse Extract Optimization:** Implement improvements to the nightly IKA data extract process for GCHP reporting.

• **Non-Emergent Medical Transportation (NEMT):** Modify non-emergent medical transportation processes to ensure sustained regulatory and contractual compliance. Analyze and evaluate alternatives to existing benefit.
• **Behavioral Health Benefit for Autism Spectrum Disorder:** Regulatory requirement to introduce Applied Behavioral Analysis (ABA) as a treatment for Autism Spectrum Disorder (ASD) effective September 15, 2014.
### 11/2014: GCHP Projects “At a Glance”

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<tbody>
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<td>ICD-10 Readiness Phase 1</td>
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<td>ICD-10 Readiness Phase 2</td>
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<td>Grievance &amp; Appeals Optimization</td>
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<td>Encounter Data Improvement Program/35C to 837 Transition/Kaiser Encounter Data</td>
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<td>IT Disaster Recovery</td>
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<td>Member Satisfaction Survey</td>
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<td>HR Flexible Work Program: Telework Policy</td>
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<td>ACS Data Warehouse-Extract Optimization</td>
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<td>MedHOK ACG – Risk Stratification</td>
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<td>MedHOK MMS Post-Implementation</td>
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<td>ACS SOC Audit</td>
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<td>Business Continuity Plan (BCP)</td>
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<td>Crossover Claims</td>
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<td>ABA Behavioral Health Benefit</td>
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<td>Information Security Program - Operationalize</td>
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<td>MedHOK SPD</td>
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<td>CORE: HIPAA/ACA Administrative Simplification Rules</td>
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<td>Provider Contracts &amp; Capitation Rebasing Evaluation</td>
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<td>ICES/IKA Upgrades</td>
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<td>Provider Portal - MedHOK</td>
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<td>Delegation Oversight Framework</td>
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<td>Social Media Policy and Roadmap</td>
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<td>ASO (Xerox/ACS) – Vendor for RFP Support</td>
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<td>PBM (Scriptcare) – Vendor for RFP Support</td>
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<td>OR</td>
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<tr>
<td>ASO RFP</td>
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<tr>
<td>PBM RFP</td>
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</table>

**LEGEND:**
- GREEN – Active Projects (Lighter GREEN reflects Project Delays/Extensions)
- BLUE – Proposed FY14/15 Projects
- Dark BLUE-Delayed Start
- ORANGE-Closed
AGENDA ITEM 4e

To: Gold Coast Health Plan Commission

From: Dr. Nancy Wharfield, Associate Chief Medical Officer

Date: November 24, 2014

Re: 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 are complete at approximately 6 months. While incomplete, a 3 month lagged snapshot allows us to see an estimate of utilization without waiting 6 months. Administrative days are included in these calculations. Dual eligible members, SNF, and LTC data are not included in this data.

Inpatient Utilization

Bed days / 1000 members remains under 300 and Family, SPD, and AE aid code categories each continue to account for about 1/3 of bed day utilization for August 2014.

Benchmark: Reports of bed days / 1000 members from available published data from other managed care plans range from 161 – 890/1000 members. There is variability of reporting of Administrative Days among managed care plans.
Average Length of Stay

Average length of stay remains low compared to prior years and at 3.1 or below since April 2014. A trend of increased length of stay from summer to fall each year is reproduced in the current year.

Benchmark: Average length of stay from available published data from other managed care plans range from 3.6 – 4.1. There is variability in reporting of Administrative Days among managed care plans.
ER Utilization

ER Utilization remains low compared to prior years and at mid-400s or below since February 2014. Family aid code group members continue to show the highest percentage of ER utilization.

Benchmark: ER utilization / 1000 members from available published data from other managed care plans range from 554 – 877. For July 2013 through May 2014, Gold Coast Health Plan average utilization / 1000 member months (including Duals) is 32 compared with the 2013 DHCS Managed Care Dashboard report of about 40-60 ER visits / 1000 member months.
Authorization Requests

Requests for outpatient service continue to outnumber requests for inpatient service. Requests for outpatient service continue to increase while requests for inpatient service have reached a plateau at 75/1000 members or below for the last 6 months.
Among Medi-Cal expansion members new to Gold Coast Health Plan since January 1, 2014, service requests for M1 members nearly equal requests for L1 members.

**Gold Coast Health Plan Authorizations by Aid Code**
**January - September 2014**

<table>
<thead>
<tr>
<th>Aid Code</th>
<th>Authorizations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>7U/7W</td>
<td>790</td>
<td>2.16%</td>
</tr>
<tr>
<td>L1</td>
<td>4,219</td>
<td>11.54%</td>
</tr>
<tr>
<td>M1</td>
<td>3,995</td>
<td>10.93%</td>
</tr>
<tr>
<td>All Other Aid Codes</td>
<td>27,563</td>
<td>75.38%</td>
</tr>
</tbody>
</table>

Total Authorizations: 36,567

- **Inpatient Authorizations**
  - 7U/7W: 215 (2.33%)
  - L1: 784 (8.49%)
  - M1: 863 (9.35%)
  - All other Aid Codes: 7,371 (79.83%)
  - Total Inpatient Authorizations: 9,233

- **Outpatient Authorizations**
  - 7U/7W: 575 (3.10%)
  - L1: 3,435 (12.57%)
  - M1: 3,132 (11.46%)
  - All Other Aid Codes: 20,192 (73.87%)
  - Total Outpatient Authorizations: 27,334

Data Source: MedHOK Authorizations by Aid Code Query on 11/02/2014
AGENDA ITEM 4f

To: Gold Coast Health Plan Commissioners

From: Ruth Watson, Interim CEO / COO

Date: November 24, 2014

RE: Non-Emergency Medical Transportation – Ventura Transit System Update

SUMMARY:
On July 1, 2013, Gold Coast Health Plan (GCHP or Plan) entered into an agreement with Ventura Transit System (VTS) to provide non-emergency medical transportation (NEMT) to its members.

BACKGROUND / DISCUSSION:
The Plan issued a Request for Proposal (RFP) for NEMT services on October 12, 2012. The RFP was sent to nine NEMT vendors, including four Ventura County vendors, and was posted to the Plan’s website.

The primary purpose of the RFP was to engage a vendor to provide all services relative to NEMT on a countywide basis. The goal was to align with a business partner to improve this function and reduce costs relative to this member service. Additionally, the Plan required a NEMT vendor that was compliant with all the various regulations of Ventura County, as well as all state and federal regulations applicable to Medi-Cal.

The RFP included requests for two, three and four-year contract periods, with the intent to implement the program on January 1, 2013.

Six vendors responded affirmatively; two vendors were disqualified based on cost alone. An internal scoring committee was developed and each vendor was evaluated and scored based on their responses in the following categories:

- Network Management / Access – Ease of Administration
  - Current network in Ventura County
  - Locally owned/operated
  - Phone service
- Quality Improvement Criteria
- Experience
- References
- Accreditation
- Ability to meet objectives of the scope of work
- Cost Proposal
Table 1: NEMT RFP Vendor Scoring

<table>
<thead>
<tr>
<th>NEMT Vendor</th>
<th>Total Points Awarded (110 Possible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventura Transit System (VTS)</td>
<td>99</td>
</tr>
<tr>
<td>American Logistics Company</td>
<td>94.1</td>
</tr>
<tr>
<td>Logisticare</td>
<td>94</td>
</tr>
<tr>
<td>Access2Care</td>
<td>89.8</td>
</tr>
<tr>
<td>Total Transit (disqualified)</td>
<td>0</td>
</tr>
<tr>
<td>TMS (disqualified)</td>
<td>0</td>
</tr>
</tbody>
</table>

In addition to earning the highest overall score in the bid evaluation process, VTS’s bid was also the lowest cost of the five vendors who submitted qualified proposals. VTS is also a local Ventura County vendor that employs over 300 people.

VTS began providing services on February 1, 2013, on a month-to-month, fee for service (FFS) basis due to a delay in final contract approval by the California Department of Healthcare Services (DHCS). The full contract was executed on July 1, 2013.

**FISCAL IMPACT:**
Cost proposals were submitted by each vendor, which were weighted and added to the overall RFP scoring. (Table 1: NEMT RFP Vendor Scoring)

In 2012, the Plan paid an equivalent of $1.91 per-member / per-month (PMPM) for NEMT services. Based on the Plan’s membership and the increase in services per member at the time of the analysis, staff calculated that the PMPM cost for providing the services directly in 2013 would be approximately $1.98. This calculation was based on escalating membership and utilization, was for claim reimbursement only, and did not include staffing or system costs. VTS was the lowest bidder at $1.80 PMPM, which included a fully staffed call center and utilization management services. VTS’s rate has since been increased to $1.82 PMPM to include transportation services outside of Ventura County when needed.

VTS provides the Plan with monthly encounter data that includes the member demographics and type of the ride provided. Since this contract is based on a PMPM pricing per trip, mileage was not required and is not included in encounter data. Prior to this contract, the Plan reimbursed individual providers based on type of ride, as well as mileage for each ride. Therefore, it is not possible to compare VTS’s cost of service to the Medi-Cal fee-for-service fee schedule.
Plan savings have been calculated using the estimated $1.98 PMPM cost to the Plan versus the VTS contract rate of $1.82 PMPM. Actual Plan membership was used from the July 1, 2013 inception of the NEMT contract.

Table 2: NEMT Estimated Savings

<table>
<thead>
<tr>
<th>NEMT Estimated Savings February 2013 – September 2014</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated NEMT FFS claim costs at $1.98 PMPM</td>
<td>$9,398,845</td>
</tr>
<tr>
<td>Actual FFS/Capitated claim costs at $1.82 PMPM</td>
<td>$8,605,978</td>
</tr>
<tr>
<td>GCHP Estimated Total Savings (19 mos.)</td>
<td>$792,867</td>
</tr>
<tr>
<td>GCHP Estimated Annual Savings</td>
<td>$500,758</td>
</tr>
</tbody>
</table>

OVERALL PERFORMANCE:

The number of members who qualify for the NEMT benefit is relatively small when compared to the Plan’s total membership. The total number of unique members who have accessed the NEMT benefit is 865 resulting in 132,249 trips. In general, VTS has performed well in providing NEMT services to GCHP members and issues have been resolved quickly and collaboratively.

Table 3: VTS Grievances Summary

<table>
<thead>
<tr>
<th>GCHP Member Grievance Report – Transportation Issues</th>
<th>Vendor Name: Ventura Transit System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievance Type</td>
<td>Number of Grievances</td>
</tr>
</tbody>
</table>
| Access to Care                                       | 4                     | • Medi-Cal medical necessity requirement – financial hardship is not a qualification
|                                                      |                       | • Rude driver/dispatcher                  |
|                                                      |                       | • 48-hour advance notice is required for standard trip - service denied without 48-hour notice |
| Accessibility                                        | 1                     | • Driver late - member late or missed appointment |
| Total                                                | 5                     |                                           |

Work in Progress:

• Encounter Data - The Plan has been working with VTS to insure that accurate and timely encounter data is submitted. GCHP issued a corrective action plan to VTS in
September 2014, and has since seen improvement in encounter data submissions. Staff continues to monitor VTS performance in this area.

- Prior Authorization – The Plan is currently working on a project to optimize the NEMT services review and prior-authorization process, which is being led by the Health Services department. Staff has developed an optimized process, with a goal to rollout the changes with all parties – VTS, members, and providers - effective March 1, 2015.

**CONCURRENCE:**
N/A

**Attachments:**
None.
AGENDA ITEM 3d

To: Gold Coast Health Plan Commissioners

From: Barry Fisher, Special Investigation Ad Hoc Committee Chair

Date: November 24, 2014

Re: Waiver of Attorney-Client and Closed Session Privileges

SUMMARY:
The Special Investigation Ad Hoc Committee requests the Commission to consider and authorize former General Counsel through the law firm of Anderson Kill or any prior law firm(s) to disclose attorney-client and closed session communications, including documents, and further authorize former General Counsel to provide reports, notes and other documents to the investigators (Atkinson Andelson Loya Rudd & Romo (AALRR) and Vicenti Lloyd & Stuzman CPA's (VLS) (hereinafter collectively referred to as “investigative teams”) retained to conduct an investigation into certain allegations of human resources / employment / workplace issues and allegations of financial improprieties, as alleged in reports submitted by the League of United Latin American Citizens (LULAC).

In order to aid in their investigation, the investigation teams have requested to interview Gold Coast Health Plan’s (GCHP) former General Counsel. In order to permit former General Counsel to provide documents and assist through an interview, the former General Counsel and her law firm, Anderson Kill require the Commission to authorize disclosure of attorney-client and closed session privileged communications. In addition, the investigative teams are requesting that former General Counsel and the law firm of Anderson Kill turn over all client documents to the investigative teams as the teams deem necessary to investigate allegations in the LULAC reports and information gleaned from interviews.

An attorney has an ethical obligation to turn over to a client all pleadings and other documents reasonably necessary for client representation (Cal State Bar rule 3-700D). However, waivers of the attorney-client and closed session privileges require authorization from the client.

BACKGROUND
The League of United Latin American Citizens-Ventura County (LULAC) submitted two reports outlining allegations of human resource / employment / workplace concerns and allegations of financial improprieties. The firms of Atkinson Andelson Loya Rudd & Romo (AALRR) and Vicenti Lloyd & Stuzman CPA's (VLS) (hereinafter collectively referred to as “investigative teams”) were retained to conduct the investigations. The Ad Hoc Committee’s legal counsel, Scott Howard of The Howard Law Group, received a request to interview the former General Counsel and obtain documents which the investigative teams believe to be relevant to their
investigations. Former General Counsel and their firm have requested the Commission, as the client, to waive the attorney-client and closed session privileges, and authorize former General Counsel to respond to questions from the investigative teams. Ethically, former General Counsel and her firm are seeking what any attorney would, and should, seek prior to divulging attorney-client privileged information to anyone other than the client. The former General Counsel and her law firm have been cooperative and professional and merely require the waiver of the privileges before providing information which may be covered by the privileges.

Under California law, the Ventura County Medi-Cal Managed Care Commission (Commission) is the client and therefore the holder of the attorney-client privilege (Cal. Evidence Code 953) and is able to waive same. Likewise with respect to any confidential communications which have occurred in a closed session held under the Ralph M. Brown Act (Open Meetings Law), the Commission holds the privilege and can waive it (Cal. Government Code 54963(a).

The Work Product protection doctrine exists to protect an attorney’s impressions and opinions and is invoked when a party seeks to obtain documents covered by the doctrine (Cal. Code of Civil Procedure 2018.010 et seq.). Under this doctrine the attorney has the right to object to releasing his / her documents, including reports which include attorney's opinions, conclusions, legal research, theories, or impressions. The “privilege” is held by the attorney and somewhat conflicts with State Bar rule 3-700D which requires an attorney to provide a client with pleadings and other documents reasonably necessary for client representation.

The investigative teams are of the understanding that there are reports and other documents which are directly related to the allegations in the LULAC reports.

Based on the foregoing, the Special Investigation Ad Hoc Committee is seeking a limited waiver by the Commission of the attorney-client privilege and closed session privilege, as well as authorizing former General Counsel to provide reports, notes and other documents deemed necessary by the investigative teams to conduct their investigation, which reports, notes and other documents have not already been provided to the Commission or management staff of GCHP (e.g. CEO, CFO, COO).

**FISCAL IMPACT**
There should be no fiscal impact regarding this specific request, unless former General Counsel seeks to invoice the Commission for her time spent in an interview and the time of counsel providing her with representation.

**RECOMMENDATION**
It is recommended that the Commission authorize former General Counsel to disclose attorney-client and closed session communications to the investigative teams as limited to information necessary for the investigative teams to conduct the investigation. The information and documents are with respect to allegations outlined in the LULAC reports dated May 27,
2014 and June 12, 2014, and all other allegations raised during interviews with GCHP’s officers and employees and representatives of LULAC conducted by the investigative teams. It is also recommended the Commission authorize former General Counsel and her law firm to provide to investigative teams those notes, reports and other documents not already provided to the Commission or GCHP management staff.

CONCURRENCE
N/A

Attachments
A motion is attached for your consideration.
PROPOSED MOTION REGARDING WAIVER OF ATTORNEY

Move that the Ventura County Medi-Cal Managed Care Commission dba as Gold Coast Health Plan (GCHP) hereby authorizes former General Counsel Nancy Schreiner through the law firm of Anderson Kill or any prior law firm(s) (collectively “Counsel”), to disclose attorney-client and closed session communications between Counsel and the GCHP or any employee(s) of GCHP, to the investigation teams retained through the Special Investigation Ad Hoc Committee. The investigation teams have been directed by GCHP to investigate allegations contained in two reports (May 27 and June 12, 2014) from the League of United Latin American Citizens-Ventura County (LULAC) and other allegations conveyed to the investigative teams in the course of their investigation into the LULAC report allegations, including interviews with current and former employees of GCHP, and interviews of members, or representatives of, or connected to LULAC (collectively, “the allegations”). The disclosure is limited to information deemed necessary by the investigative team to conduct their investigation into “the allegations”.

GCHP’s former General Counsel is further authorized and directed to provide to GCHP’s investigative teams those notes, reports, files, and other documents deemed necessary by the investigative teams for the limited purpose to conduct their investigation into “the allegations” which have not previously been provided to GCHP or management staff of the GCHP) (e.g. CEO, CFO, COO).

Nothing in this motion shall constitute a waiver of the attorney-client and closed session privileges for any purpose except as provided herein, or to any individual or organization not affiliated with GCHP, its Special Investigation Ad Hoc Committee or the investigative teams.

AYES:
NOES:
ABSTAIN:
ABSENT: