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

DATE: **Monday,** November 28, 2011
TIME: 6:00 pm
PLACE: 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

AGENDA

Call to Order, Welcome and Roll Call

Public Comment / Correspondence - *Regarding Agenda Items Only*

1.	**Approve Minutes**	
	a. Meeting of October 24, 2011	*Action Required*
2.	**Accept and File Management Update**	*For Information*
3.	**Accept and File Financial Report**	
	a. Re-forecasted Budget	*Action Required*
	b. September Financials	*For Information*
	c. October Financials	*For Information*
	d. State Rate Reduction	*For Information*
4.	**Management Recommendations & Reports**	
	a. Community Outreach Presentation	*For Information*
	b. Delegation of Authority	*Action Required*
	c. Vision Benefit Management Vendor Selection	*Action Required*
	d. Claims Management Report	*Action Required*
	e. Commission 2012 Meeting Schedule	*Action Required*

Comments from Commissioners

Adjourn

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

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ADMINISTRATIVE REPORTS RELATING TO THIS AGENDA AND MATERIALS RELATED TO AN AGENDA ITEM SUBMITTED TO THE COMMISSION AFTER DISTRIBUTION OF THE AGENDA PACKET ARE AVAILABLE FOR PUBLIC REVIEW DURING NORMAL BUSINESS HOURS AT THE OFFICE OF THE CLERK OF THE BOARD, 2220 E. GONZALES ROAD, SUITE 200, OXNARD, CA.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT 805/981-5320. REASONABLE ADVANCE NOTIFICATION OF THE NEED FOR ACCOMMODATION PRIOR TO THE MEETING (48 HOURS ADVANCE NOTICE IS PREFERABLE) WILL ENABLE US TO MAKE REASONABLE ARRANGEMENTS TO ENSURE ACCESSIBILITY TO THIS MEETING.

County Medi-Cal Managed Care Commission
(VCMMCC) dba Gold Coast Health Plan (GCHP)
Commission Meeting Minutes
October 24, 2011
(Not official until approved)

CALL TO ORDER

Vice-Chair Gonzalez 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.

The Pledge of Allegiance was recited.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Maylee Berry, Medi-Cal Beneficiary Advocate
Anil Chawla, MD, Clinicas del Camino Real, Inc.
Laurie Eberst, RN, Private Hospitals / Healthcare System
John Fankhauser, MD, Ventura County Medical Center Executive Committee
Robert Gonzalez, MD, Ventura County Health Care Agency
Rick Jarvis, Private Hospitals / Healthcare System
Roberto S. Juarez, Clinicas del Camino Real, Inc.
Kathy Long, Ventura County Board of Supervisors
Catherine Rodriguez, Ventura County Medical Health System

EXCUSED / ABSENT COMMISSIONERS
Lanyard Dial, MD, Ventura County Medical Association

STAFF IN ATTENDANCE
Earl Greenia, CEO
Tin Kin Lee, Legal Counsel
Traci R. McGinley, Clerk of the Board
Brandy Armenta, Quality Improvement Specialist
Charlie Cho, MD, Chief Medical Officer
Sonia DeMarta, Accounting and Finance Manager
Andre Galvan, Project Management Specialist
Guillermo Gonzalez, Government Affairs Director
Darlane Johnsen, Chief Financial Officer
Pamela Kapustay, RN, Health Services Director
Steven Lalich, Communications Director
Audra Lucas, Administrative Assistant
Aimee Sziklai, Operations Director

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

PUBLIC COMMENT / CORRESPONDENCE

Marco Benitez stated that he is aware the Plan purchased airtime at another radio station; however, that station does not reach Mixteco members and he has only heard one GCHP commercial. He added that community members do not know about GCHP.

David Cruz, HELA President, raised concern that the Clinicas Specialty Contract is not approved. He asked when the Commission would have evening meetings to allow working members to attend. Mr. Cruz indicated that he has not received the enrollment process audit information or a response regarding families enrolled in different clinics.

Denise Templin of Clinicas expressed her concern in not receiving timely responses to requests for Medical Authorizations. She stated that she has been communicating with Pam Kapustay and the issues are being addressed.

1. APPROVAL OF MINUTES

a. Meeting of September 26, 2011

Commissioner Berry moved to approve the September 26, 2011 Meeting Minutes, Commissioner Chawla seconded. The motion carried. **Approved 10-0**.

2. MANAGEMENT UPDATE

CEO Greenia noted that Centers for Medicare and Medicaid Services (CMS) has "stopped the clock" on the changes regarding the co-payment policy and rate reductions.

CEO Greenia informed the Commission that ACS did provide additional information on the auto-assignment processes, management will review the data and bring it to a future Commission Meeting.

With the State Department of Health Care Services (DHCS) elimination of the Adult Day Health Care (ADHC) benefit from the Medi-Cal Program, the individuals currently utilizing the services will require a "needs assessment" to determine medically necessary services. The impact to members and the budget were discussed.

Evening outreach / public meetings, space needs and staffing were briefly discussed.

In response to a question from Vice-Chair Gonzales regarding the Urgent Care Policy, CMO Cho explained that if a patient goes to urgent care during normal business hours a Treatment Authorization Request (TAR) is submitted, the Member's Primary Care Physician (PCP) then determines if the Member should return to the PCP for care or be seen in urgent care. The Plan does not want to be restrictive, but must financially ensure there are no abuses to the system.

3. FINANCIAL REPORT

a. Re-forecasted Budget

CFO Johnsen noted that management re-forecasted the 2011-12 fiscal year financial plan. Revenue is re-forecast at $302,399,730 given changes in membership levels and category information. CFO Johnsen added that while it is too early to predict a stable healthcare cost pattern, the budget has been updated based on these changes.

After various line-items were discussed, there was Commission consensus that the item be tabled to allow staff to come back with an organizational / work chart, explanation of the staff increases, explanation of deviations and understanding of FTE increases, and any other additional information to allow a better understanding of finances.

b. September Financials

The Commission was presented the handout of the September Financials. CFO Johnsen indicated that she will provide more detailed per-member per-month costs in the future.

CFO Johnsen noted that there are claim processing challenges. CEO Greenia stressed management's concern and agreed with the Commission that payment delay is unacceptable. He added that ACS leadership will be on-site later in the week to work with GCHP on this matter.

In response to comments from the Commission, CFO Johnsen confirmed that this item would be re-presented to the Executive/Finance Committee when final.

4. MANAGEMENT RECOMMENDATIONS AND REPORTS

a. ScriptCare Presentation

Scott Holtmyer, R.Ph., ScriptCare presented an updated version of the PowerPoint Presentation provided in the Agenda Packet. Mr. Holtmyer reminded the Commission that prescription costs were initially greater due to the required 60-day continuum of care. The figures show the significant decrease of costs in the third month.

Mr. Holtmyer explained that with the average enrollment of 107,310 the first quarter utilization was low; however, a seasonal influx during the flu season is expected. The Pharmacy and Therapeutics Committee is working on controlling costs of high-volume and high-cost medications and increased use of generic drugs.

When asked how GCHP compares to other COHS models, Mr. Holtmyer explained that there are three factors: cost, volume and generic utilization that drive the overall costs. Per script cost started at $50 and is down to $47. Per-member per-month is below $26 while other COHS are typically around $30. Diabetic medication is also significantly less than other plans.

In response to questions raised by the Commission, CMO Cho explained that the Formulary is well designed. Drugs are not restricted due to cost alone. CMO Cho added that the Formulary is evolving: only one drug has been removed and the studies show the alternative drugs as effective.

b. Decision Support System Selection

CEO Greenia reviewed his report, stressed that this will allow several systems to communicate which will accommodate staff to better manage utilization. He added that management considered the Milliman product to be the most comprehensive system.

Questions were raised regarding the National Committee for Quality Assurance (NCQA) certification to which CEO Greenia responded that the Plan is held to NCQA standards, but not required to be certified.

Discussion was held regarding other COHS utilizing "homegrown systems" which require support from a large IT staff.

Commissioner Juarez moved to approve purchase and implementation of the Milliman system, Commissioner Fankhauser seconded. The motion carried. **Approved 8-0**, with Commissioner Rodriguez and Jarvis absent from the room.

c. Compliance Software

Commissioner Eberst moved to authorize Management to proceed with contracting for a Compliance software system with "Compliance 360", Commissioner Araujo seconded. The motion carried. **Approved 9-0**, with Commissioner Jarvis absent.

d. CEO Authority to Negotiate and Execute Provider Contracts

After CEO Greenia highlighted the written report, Vice-Chair Gonzalez clarified that his concern is the extent to which the Commission is involved in any administrative delegated services contracts. CEO Greenia responded that there could be administrative components under such contracts; the extent depends on how the model is implemented. The goal is to ensure financial viability of GCHP. The Plan receives a capitation payment and that amount is never fully assigned to the provider. Administrative costs are taken into account and GCHP retains oversight responsibility. GCHP would receive regular reports from those contractors and have full access to their records. All such contractors would be held to the same standards as the Plan.

Vice-Chair Gonzalez asked what the COHS would look like if each of the three dominate medical systems in Ventura County entered into shared or full-risk agreements. CEO Greenia responded that such a model might resemble CalOptima in Orange County. He added that he does not believe everything can be fully delegated. Discussion was held regarding full-risk contracts. CEO Greenia explained that at this time there are no full-risk contracts, but believes some systems considered this option.

Discussion was held regarding the effect delegated responsibility would have on the COHS and the Commission. Reports to the Commission would need to be detailed to ensure that the Commission is kept informed. Discussion was held as to how this would affect the relationship with ACS.

Commissioner Eberst left the meeting at 5:06 p.m.

Commissioner Juarez noted that this type of issue is typically discussed at the Executive Finance Committee and believes this discussion is centering on a particular model, not the CEO's authority. Vice-Chair Gonzalez agreed. Commissioner Araujo added that the

Commission needs feedback, reports of contracts executed, etc. CEO Greenia noted that contract information is provided in the CEO Report to Commission.

Commissioner Chawla added that other plans have entered into similar arrangements and it should not be a major concern.

Counsel Lee added that the CEO's scope of authority can be clarified and brought back to Commission.

Commissioner Fankhauser moved to delegate authority to the Executive Finance Committee to discuss, review and decide the CEO's contract authority and have it brought back to the Commission for ratification, Commissioner Long seconded. The motion carried. **Approved 8-1**, with Commissioner Juarez voting no.

e. Commission Bylaws

Counsel Lee reviewed the previous changes as noted in the document.

Commissioner Juarez moved to approve the Bylaws, Commissioner Long seconded. The motion carried. **Approved 9-0**.

COMMENTS FROM COMMISSIONERS

Commissioner Juarez announced that Clinicas had a surprise review by The Joint Commission and passed with flying colors.

Commissioner Berry stated that she would like to meet with Clinicas and the County, attend the Consumer Advisory Committee and provide monthly reports to the Commission. Her first report will be during the November Meeting.

Commissioner Chawla noted that Clinicas has had problems with vision services and is not receiving consistent information when contacting GCHP staff.

CLOSED SESSION – CEO EVALUATION

It was determined that the Closed Session would not be held.

ADJOURNMENT

The meeting adjourned at 5:55 p.m.

Chief Executive's Monthly Report to Commission
November 28, 2011

PEOPLE (Organizational Structure)

- We have added additional talent to our team:
  - Claims / Provider Research: Percy Mayfield
  - Member Services Outreach Coordinator: Erika Reyes
- Recruitment continues for: QI Director (interviewing candidates) and a Sr. Accountant.

SERVICE (Member & Provider Satisfaction, Government Affairs, Compliance)

Community Outreach & Education

- We concluded Phase 2 of the educational outreach campaign via radio, television and newsprint on Friday, November 18, 2011. The radio campaign ran for six weeks on 9 radio stations (104.7 KCAQ-FM, 105.5 KFYV-FM, 103.7 KMLA-FM, 95.9 KOCP-FM, 910 KOXR-AM, 1590 KUNX-AM, 102.9 KXLM-FM, 96.7 KLJR-FM, 100.7 KHAY).
- TV spots are airing on the USA, TNT, NICK (Nickelodeon) and Galavision networks, as well as KEYT-3 (6 pm, 11 pm and 6 am newscasts). We negotiated placement of Public Service Announcements –at no extra charge – that will air in rotation with other nonprofits/public entities for up to six additional months. Print ads will run in the Ventura County Star and Vida every other week, during the 6 week campaign.
- On October 29, staff participated in the monthly Mixteco Community Meeting at Harrington Elementary School in south Oxnard. Through a Mixteco interpreter, staff announced GCHP's agreement with clinic and hospital systems where GCHP members can access health care services in Santa Cruz and Monterey Counties.
- Over the past three weeks, staff participated in "La Hora Mixteca", a weekly radio talk show targeted to the Mixteco community. We spoke with the Mixteco listening audience about the creation of a system-wide residency initiative geared to meet the needs of agricultural workers living in Ventura County. The initiative - presumed to be the first in the State - prevents lapses in medical care and coverage and will protect GCHP's Members traveling between Ventura, Santa Cruz and Monterey Counties.

Government Affairs

- GCHP submitted a non-binding letter of intent to the Centers for Medicare & Medicaid Services (CMS) for consideration to participate in the Comprehensive Primary Care Initiative. This initiative will help primary care practices deliver higher quality, better coordinated, and more patient-centered care. Approximately 30% of our Members are seniors and persons with disabilities who have Medicare coverage. Under this initiative, Medicare will work with commercial and State managed healthcare plans and offer bonus payments to primary care doctors who better coordinate care for their

patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients.

State Medicaid Rates

- We received our updated capitation payment rates from the State, reflecting reductions mandated by AB 97 (Medicaid Provider Rate Reduction, Co-payments and Service Caps). Overall, the reduction (2.19%) was less than anticipated. It is important to note that because co-payments are still under review by CMS, additional reductions can be anticipated. The revised rates and impact are summarized below:

	Per Member, Per Month			Average Enrollment	Annual Total Capitation	
Aid-Category	Old Rate	New Rate	Change		New	Old
Family & Adult	131.64	130.34	0.99%	74,931	117,198,078	118,367,002
Aged Dual	233.69	224.19	4.07%	9,095	24,468,097	25,504,927
Aged Medi-Cal	521.14	520.99	0.03%	1,233	7,708,568	7,710,787
BCCTP	1,062.47	1,058.01	0.42%	250	3,174,030	3,187,410
Disabled Dual	197.32	189.36	4.03%	7,384	16,778,811	17,484,131
Disabled Medi-Cal	832.79	826.55	0.75%	7,786	77,226,220	77,809,235
LTC Dual	4,494.06	4,216.68	6.17%	868	43,920,939	46,810,129
LTC Medi-Cal	7,027.51	6,732.03	4.20%	66	5,331,768	5,565,788
TOTAL			-2.19%		295,806,510	302,439,409

Member Services

- The newly hired bilingual Community Outreach Specialist will educate members via various means, such as attending outreach events, health fairs and community activities. Erika Reyes has extensive experience helping Med-Cal members on the provider side while working as a registration clerk at Las Islas Family Medical Group in Oxnard; she helped develop a relationship with the Mexican Consulate in Oxnard and with Promotoras and Promotores.
- A favorable outcome was accomplished with GCHP's third State Fair Hearing case ending with withdrawal of the grievance by the member after working closely with DHCS. This is the second time GCHP resolved a case before the hearing.

QUALITY (Comprehensive Medical Management)

- The Health Services team successfully assisted a member with chronic kidney failure and behavioral issues in need of dialysis treatment three times a week. No dialysis units would accept the member because of behavioral issues. The member was hospitalized for dialysis treatments as a last resort. Staff worked diligently to explore alternatives to provide outpatient dialysis. Our Health Educator accompanied the member during the first visit at an outpatient dialysis center in Simi Valley and provided psychosocial support.
- Our Health Educator continues to work with various providers and community agencies. Some recent examples:
    - Coordinated a referral from Human Service Agency to assist a member in need of nutrition and parenting education. Currently working with WIC and their nutritional support services.

- Ventura County Public Health – Health Educator attended Nutrition Program and community collaborative "Community Garden Project" CDC grant funded program.
- A Lean VC – Health Educator attended monthly meeting. Currently serving on the Provider Health Education and Training Planning Committee.

- The Credentials Committee met on November 17 and received the credentialing audit report of three delegated groups by Dr. Nancy Wharfield, our Associate Medical Director. The results of the audit were favorable: all satisfied the established criteria. The Committee also discussed the outsourcing of vision care benefit management and had no concerns regarding quality and credentialing of participating optometrists.

Adult Day Health Care (ADHC)

- The State reached a settlement with ADHC centers that essentially preserves the program through February 2012. ADHC Centers will have the opportunity to apply to be providers under a new program called Community-Based Adult Service (CBAS). From March through June of 2012, CBAS will be a carved-out benefit under Managed Care, and beginning July 1, CBAS will only be available for those beneficiaries in Managed Care where it is available. During this time, DHCS will work with the plans to determine an appropriate rate for these services under managed care as well as any associated contract and program changes necessary to make the program effective.

Provider Outreach

- Health Services staff met with various providers over the past few weeks; some examples:
  - October 24: Met with CCS Ventura staff to discuss paneling providers, CCS denials for CCS-eligible conditions treated by non-CCS providers.
  - November 2: Met with WIC program staff regarding workflow for authorization of infant formulas and required paperwork from provider.
  - November 9: Met with Buena Vista Hospice to discuss care coordination.
  - November 15: Met with USC organ transplant team to establish workflows and service coordination.

ACCESS (Robust Provider Network)

- Staff continues efforts to expand our contracted provider network both in Ventura County and contiguous areas of Los Angeles & Santa Barbara counties. Our comprehensive now consists of:

Provider Type	Number of Contracts	Number of Providers
Primary Care Providers	23	102 Physicians; 148 mid-level practitioners
Specialist Physicians	125	1,748
Hospitals	8	12
Long-Term Care Facilities	15	16
Laboratories	11	35

Pharmacies	1 (ScriptCare)	97
Home Health / Hospice	16	19
Optometrists	27	48
Other Providers	143	184

- The Provider Advisory Committee met on November 10. The policy on urgent care centers was presented to the committee. The draft minutes from the meeting are included in this package as an information item.

FINANCE (Optimize Rates, Ensure Long-Term Viability)

- We have re-forecasted revenue and health care costs based on emerging enrollment trends. The re-forecasted budget for the current fiscal year, which was reviewed by the Executive-Finance Committee is included in this packet for Commission final review and action.

Respectfully submitted,

Earl G. Greenia
Chief Executive Officer

GOLD COAST HEALTH PLAN

PROVIDER ADVISORY COMMITTEE MINUTES

Date: Thursday, November 10, 2011

Location: Conference Room, Ventura County Health Care Plan
2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036

Moderator: Paul Roberts, GCHP Director of Provider Relations & Provider Contracting

Members Present:

Mike Lurie, Centers for Family Health, Community Memorial Health System
Mark Minnis, Livingston Memorial Visiting Nurse Association
Clive Salmon, DPM, Podiatrist
Joyce Weckl, RN, Certified Nurse Midwife
Brett Zaer, Superior Mobility Durable Medical Equipment

Staff Present:

Charles Cho, MD, GCHP Chief Medical Officer
Nancy Wharfield, MD, Associate Medical Director
Steve Lalich, GCHP Director of Communications
Andre Galvan, Project Specialist, Member Services
Kathleen Garner, Provider Relations Representative
Rebecca Wright, GCHP Provider Relations Representative

I. **Call to order.** Mr. Roberts called the meeting to order at 3:30pm. He introduced himself and the Plan staff present. He welcomed Committee Members and asked all parties to please introduce themselves.

II. **Approval of minutes.** The July 7, 2011 minutes had previously been sent out to all members for review. No needed corrections or revisions were noted and the minutes were unanimously approved as read.

III. **Status Report of Health Plan Operations Since Start-Up.** Mr. Roberts introduced the document titled "Status of Providing Network Contracting" located in the Meeting Agenda packet. He gave an oral presentation of the document detailing current status of the growing provider network by type of contract. He explained the progress that has been going on in provider contracting since the July 1 "go-live" date. He clarified why Letters of Intent are still in process and why the numbers are so large. Mr. Roberts pointed out that prior to the go live date the State evaluated our network and concluded Gold Coast Health Plan had proven a robust and complete provider network with State standards having been met. GCHP had to go outside of the county to secure providers for organ and bone marrow transplants and that function was filled by contracting with USC, Children's Hospital Los Angeles and City of Hope. Shortly after start-up, some holes were found in our network in specialty areas, where specialties were required but for the most part providers were not willing to take Medi-Cal. To cover these specialties it has been necessary to contract with providers outside of Ventura County and so the Plan is now expanding into Los Angeles and Santa Barbara counties for the most part. It was noted that historically, the County has been short of beds for Skilled Nursing Facilities so it has been

necessary to go outside of the County to secure additional contracts with those providers too.

Mr. Roberts stated that management appreciates patience shown from the providers while we work to resolve the claims problems that have been encountered in an untried system. There have been a lot of problems with the way claims have both been submitted by provider and processed by the Plan. Mr. Lurie asked about our electronic claims processing capabilities. Mr. Roberts replied that the ACS/EDI Gateway system is available for free so providers can bill electronically; but clearinghouses that are used must be tested to ensure compatibility. The Plan is not able to pay providers electronically yet and physical checks must be produced. Electronic payments and automatic electronic cross-over for Medi-Medi claims from Medicare to the Plan for Medi-Cal payments under dual coverage will be coming down the road but are not available at present.

Mr. Roberts reported the changes in Medi-Cal membership; at startup there were 105,000 beneficiaries and that figure is now up to 110,000. Members outside of the County have been identified in our Plan. They are working through County Agencies in Los Angeles and Santa Barbara to track down and deal with it the best they can.

IV. **Report on Changes to Plan Formulary and Successful Physician Compliance.** Doctor Cho reported on ScriptCare the Pharmacy Benefits Manager for the Plan. Under the State plan, all drugs were allowed. When the State passed responsibility over to Gold Coast Health Plan, they stream-lined the medicines offered to be cost-effective. There is a broad scope of medicines for the doctors to choose from, and the Plan formulary has about 800 drugs when in most commercial plans they have only about 500 drugs, so the program is very rich. Dr. Cho stated his aim was to provide the most cost effective drugs. It is easy to see that by physicians selecting drugs based on the cost, and by using generics the formulary has become very much cost controlled. Doctors seem to be choosing the right drugs for the right reasons. The State was spending about 16% of its total budget on Rx, the usual commercial plan is spending about 14% and we want to bring it down to about 13%. ScriptCare has very good reporting and they made a good presentation to the Commission at its last meeting. The plan has not received any complaints from doctors. There are weekly ongoing meetings with the Pharmacy and Therapeutics Committee that has been very effective. The Plan does require prior authorization for some expensive medications, and some medicines are provided via "step therapy" [i.e., where a lower level drug must be tried first before moving up to the next level of medication]. One drug, Nexium, was removed from the Formulary because it was so expensive and it consumed a large percentage of the total prescription drug benefit. It was felt that lower-cost substitutes were adequate. The Plan will see what experience looks like after flu season is over. The Formulary is posted at the Gold Coast Health Plan website and is also available for doctors using ePocrates Rx.

V. **Report on Initiative to Secure Vision Benefits Plan Management Firm.** The Plan has been going through a process for contracting with a vision care provider to take over management of the Vision Benefit. This would work like what is being done using ScriptCare as the Plan's Pharmacy Benefits Manager.

Mr. Roberts went through the process for soliciting, evaluating and contracting with a vision care benefits provider which ended with four (4) organizations interested in bidding for our services. The scoring was done in an objective manner, based on a variety of parameters including their reporting capabilities, prior experience with other County Organized Health Systems ("COHS"), strength of the provider network, ease of administration, price and other factors. One important stipulation was that the existing Plan providers would have to be included in the organization's panel of providers. The evaluation process ended up with two (2) best bidders and face-to-face meetings were held. A group of Plan executives that completed the bidding process including the CMO, CFO, COO and Mr. Roberts have come up with a unanimous decision for moving forward with a contract. They are now preparing

management's recommendation which is ready to be presented to the Commission by Mr. Greenia at its next meeting on November 28. It is believed that this was a fair and objective process with a clear "best of breed" potential vendor that had been selected. Hopefully by the beginning of the year or soon thereafter the Plan will be making an announcement to all Providers and Members. Mr. Roberts will be going through a presentation with the Committee once approved by the Commission. Because there is ample experience with the other COHS Plans implementing this same exact option no problem is foreseen in the Plan getting State approval.

VI. **Report on Follow-Up to First Study Topic: Urgent Care Policy.** This required exhaustive research which culminated in a revision to the Plan's current Policy and Procedures that has now been reviewed and approved by the State. Mr. Roberts presented the Urgent Care Policy, number 9.A(5). He pointed out the State wanted some new language added in Page 1, Section VI requiring physician supervision at urgent care centers for after-hours calls. The new language inserted in page 2, Item XII, Section B.2 were our Plan revisions related to handling of Member care during normal business hours that will require PCP authorization to pay the claim versus services rendered outside normal PCP office hours that do not require PCP authorization.

It was noted that of the 110,000 Members enrolled in Gold Coast Health Plan, 70,000 are "regular" managed care Members who are required to select a PCP and seek referrals and such through their PCP. The other 30,000 beneficiaries are "Administrative Members" who do not have to select a PCP and can go to "any willing Medi-Cal provider." The Urgent Care Policy does not affect any of the Plan's Administrative Members. As for the regular Members, if a Member presents outside normal business hours such as nights, weekends or holidays then there will be no problem and the urgent care claim will be honored and paid. However, during regular business hours we expect the urgent care center to seek direction from the assigned PCP. A simple phone call to the PCP will suffice. The urgent care center must submit the Urgent Care Authorization Treatment Request Form with its claim ("UC TAR Form") if the PCP directs the urgent care center to see the patient. The UC TAR Form is in the Agenda Packet.

Mike Lurie stated CMH's claims need to get paid, and that there are apparent system problems since claims for after-hours and weekends are not being paid. Mr. Roberts said he was not aware of that and he would follow-up and look into that problem.

Doctor Warfield and Doctor Cho are drafting a letter to send out telling all physicians and urgent care centers of the new policy and asking all of the urgent care offices to stock the UC TAR Form.

The question was asked as to what differentiates an Administrative from a regular Member. Mr. Roberts responded that there are basically four conditions that qualify a Member to be classified as Administrative. These include: a Member residing in a Long Term Care Facility; a Member whose permanent address of record is outside Ventura County; a Member who has a share-of-cost [a monthly deductible that must be met in order to be eligible for Medi-Cal benefits during that month] and Members who have "dual coverage" or Coordination of Benefits through a primary health insurance company. In accordance with Medi-Cal rules and regulations, Gold Coast Health Plan is always the payor of last resort and is never considered primary if there is other health insurance coverage.

VII. **New Study Topic: Referrals to Out-Of-Network Providers.** Mr. Roberts said that out-of-network referrals would be the focus for our next study. He noted the attachment in the packet that details the current status with respect to organ transplant cases. [All HIPAA identifying information was removed.] He introduced Doctor Wharfield, the Plan's Associate Medical Director and asked her to please address the Committee and discuss this topic.

Doctor Warfield said with transplants they tried to honor the sixty (60) day continuity of care provision that was required by our State contract, which sometimes worked and sometimes it didn't. There is a lot of demand for non par provider services both inside and outside the County. She is working on a communication piece to be sent to our network physicians asking for cooperation. Many patients are going out-of-network to UCLA and it's a big feat to try to move them to USC, our contracted provider. USC requires about two (2) months to get patients into the system. The financial implications are horrendous because these out-of-network providers won't accept Medi-Cal rates. Our Clinical Team will be meeting face-to-face with the USC Clinical Team this monthy to try and cut down waiting time.

Looking at the detailed organ transplant report, Mr. Lurie asked why there is so much more volume than was thought. Mr. Roberts stated the volume of these cases is way beyond the reported claims experience of the State prior to start-up or the calculations or expectations of our actuaries. We are all at a loss in trying to explain the huge numbers of Medi-Cal beneficiaries in need of organ transplants.

VIII. **Discussion of Potential Study Topics for Committee Review**

Mr. Roberts asked the Members if anyone had any ideas or suggestions about future topics or matters that should be brought to Committee. He stated that if Committee Members had any ideas later they should feel free to call him or send an email.

Clive Salmon, DPM, suggested we take a look at Podiatry benefits. Dr. Salmon said that he had sent in an email request for information to clarify some benefit concerns. Mr. Roberts stated that he did provide Dr. Salmon with an immediate email response and included some references from the State. He added that he had also referred the matter to Aimee Sziklai, our interim Chief Operating Officer, for more detailed follow-up. He was wondering if that wasn't enough information for the issue posed. Dr. Salmon said he did not recall seeing that information and Mr. Roberts stated he would resend the rules to him to make sure he had a satisfactory response to his request. Dr. Salmon noted that the durable goods being dispensed out of his office were being denied and asked about our rules for orthotics. Mr. Roberts replied that a report would be run to see which codes were being denied and why there was no payment. Again, he would ask Ms. Sziklai to look into this and get back to Dr. Salmon.

Mr. Roberts said one of the issues that might be a good topic for study would be how to handle the forthcoming decrease in Medi-Cal rates. Will the plan go back retroactively and re-price already paid claims? How will overpayments be handled? What are the rates going to be? And what about the upcoming Member co-payments and yearly office visit limits? Mr. Roberts concluded that the State is not yet clear on how it will handle these important issues. He reported that both the California Medical Society and Hospital Association conclude that providers will not want to participate and they are threatening to sue the State to stop the planned reductions.

Mike Minnis stated he was very unhappy about the lack of the Plan's response to their reported problems. Livingston did receive a cash advance but when are the claims processing problems going to be resolved? He stated they did not get a response from anyone on their plea for help including Earl.

IX. **Proposal to Establish Routine Schedule for Quarterly Meetings.** There was discussion of potential meeting times and dates. It was agreed that late afternoons are best. The second Thursday of the month is working. The next meeting is scheduled for February 9, 2012 from 3:30 PM to 5:00 PM.

X. **Meeting Adjournment.** The meeting adjourned at 5:00 pm.

Minutes Recorded and Respectfully Submitted By:

Rebecca Wright, Provider Relations Representative
Gold Coast Health Plan

Minutes Reviewed and Approved By:

Paul R. Roberts, Director of Provider Relations and Provider Contracting
Gold Coast Health Plan

GOLD COAST HEALTH PLAN
Executive Summary

Reforecasted Financial Plan
November 23, 2011

Summary

As a result of emerging membership data and enhances understanding of the operational requirements, the company has prepared a reforecast of its fiscal year 2011-2012 financial plan. While it is too early to make any significant revisions to original health care cost assumption, adjustments to enrollment, revenue and general and administrative expenses have been made. The first two months of the reforecast include the actual financial results from July and August.

Membership

Average membership and total member months forecasted to be 98,624 and 1,183,491 respectively. Based on the membership through the first quarter of fiscal year 2011-2012, the reforecast has revised average membership to 101,614 and total member months to 1,219,362; an increase of 3.0%. It has been noted that the membership mix by aid category differs than originally forecasted. The current reforecast also revises the membership distribution.

Aid Category	Revised Member Months	Revised Average Membership	% of Total	Original Member Months	Original Average Membership	% of Total
Adult/Family	899,703	74,975	73.7%	846,623	70,552	71.5%
Aged - Medi-cal	15,005	1,250	1.2%	116,699	9,725	9.9%
Disabled - Medi-Cal	93,283	7,774	7.7%	13,349	1,112	1.1%
Long Term Care - Medi-Cal	841	70	0.1%	2,215	185	0.2%
Aged - Dual	109,411	9,118	9.0%	95,403	7,950	8.1%
Disabled - Dual	88,758	7,396	7.3%	95,670	7,973	8.1%
Long Term Care - Dual	10,481	873	0.9%	13,026	1,086	1.1%
BCCTP	2,994	250	0.2%	598	50	0.1%
Total	**1,220,476**	**101,706**	**100.0%**	**1,183,583**	**98,632**	**100.0%**

Revenue

The original forecast of Premium Revenue was $299,306,209 for the current fiscal year or $252.90 on a per member per month basis. Revenue in the current reforecast is revised to $295,988,04 or $242.52. While membership increased by 3%, revenue on a per member per month basis decreased 2% due to the membership mix changes noted above and a 2% reduction in premium as a result of AB 97; provider rate reductions.

Health Care Costs

Underlying assumptions for health care costs have not been revised with the exception of pharmacy. Health Care Costs in the original budget were forecasted to be $258,185,698. The revised estimate is $260,165,408, an increase of about 1.0%. While increased membership drove an increase in health care costs, these increases were partially offset by actual costs for Pharmacy and Primary Care Capitation which have

had positive variances to budget. Capitation is lower partially as a result of how it was originally budgeted.

The original assumption was that capitation was estimated for total membership in the three eligible aid categories; Adult/Family, Aged and Disabled. Actual capitation is lower because within these categories there are share of cost members that do not require the selection of a primary care physician. Future reforecasts will be adjusted to reflect the impact of share of cost membership.

Pharmacy costs for the first three months also have a positive variance from the original budget. Analysis of these costs indicate that utilization is lower than expected with less than 20% of the membership utilizing the benefit. While utilization is trending slightly upward, we are seeing a downward trend in the cost per Rx as the 60 day continuity of care has expired. Due to these factors the forecast for pharmacy costs has been reduced by slightly less that 1%.

General & Administrative Expense

The general and administrative expense forecast has been revised to reflect emerging operational requirements. While the overall increase is not significant there are certain categories that vary significantly. The most significant changes in terms of percent change and dollar change are: Salaries and Benefits, ACS, Scriptcare, and CQS.

Salaries & Benefits:

The increase primarily reflects staffing increases in the areas of Medical Management, Health Services, Claims, Provider Relations, Operations and Community Outreach. Attached is a narrative identifying those changes and the underlying justification.

Outside Services – ACS:

ACS fees are based on a per member per month basis, therefore as membership increase so do the fees. Increased membership accounted for approximately $400,000 of the increase. The remaining is an estimate of the financial impact of change orders.

Outside Services – Scriptcare:

Forecasted fees for Scriptcare have been reduced significantly based on the emerging actual fees. Fees are lower for two reasons:

- Lack of data to estimate the volume of scripts resulted in an assumption of substantially higher fees.
- Current utilization, as noted in health care costs is lower than forecasted

Outside Services – CQS:

Cost for CQS has increased by approximately $1.1 million. As with ACS, CQS fees are based on a per member per month basis. The financial impact of

increased membership is minimal; approximately $40,000. The majority of the increased cost for CQS is the result of the increase in staffing and printing and postage which was not included in the original CQS agreement. Overall increase breaks down as follows:

➢ 2 Additional Nurses – July	$280,000
➢ 3 Additional Nurses – October	315,000
➢ 4 Additional Nurses – February	310,000
Total Increased Staffing	**$905,000**
➢ Print and Postage	198,000
➢ Additional Membership	40,000
Total Increase	**$1,143,000**

Gold Coast Health Plan

Fiscal Year July 1, 2011 - June 30, 2012

Reforecasted P & L - 11.23.2011

	9.2011 Reforecast	Original Budget	Variance Inc/(Dec)	% Change
Member Months	**1,220,476**	**1,183,491**	**36,985**	**3.1%**
Average Membership	101,706	98,624	3,082	3.1%
Revenue				
Premium	297,646,272	299,306,219	(1,659,947)	-0.6%
Reserve for Retro Rate Decrease	(1,658,225)	-	(1,658,225)	-100.0%
Adjusted Revenue	**295,988,047**	**299,306,219**	**(3,318,172)**	-1.1%
Interest Income	150,684	631,077	(480,393)	-76.1%
Other Income	459,996	-	459,996	
Total Gross Revenue	**296,598,728**	**299,937,296**	**(3,338,568)**	-1.1%
MCO Tax	6,844,897	7,033,698	(188,801)	-2.7%
Net Revenue	**289,753,831**	**292,903,598**	**(3,149,767)**	**-1.1%**
			-	
Health Care Costs			-	
Capitation	8,456,054	9,784,244	(1,328,190)	-13.6%
			-	
Claims			-	
Inpatient	127,223,256	122,922,032	4,301,224	3.5%
Outpatient	34,824,166	32,806,669	2,017,497	6.1%
Professional	25,955,036	25,057,241	897,795	3.6%
Pharmacy	39,767,317	46,885,297	(7,117,980)	-15.2%
Other	20,712,712	20,730,215	(17,503)	-0.1%
Reinsurance	1,110,633	-	1,110,633	
Reinsurance Recoveries				
Total Claims	**249,593,119**	**248,401,454**	**1,191,665**	**0.5%**
			-	
Total Health Care Costs	**258,049,174**	**258,185,698**	**(136,524)**	**-0.1%**
			-	
Administrative Expenses	24,225,121	24,216,977	8,144	0.0%
			-	
Net Income	**7,479,536**	**10,500,923**	**(3,021,387)**	**-28.8%**
TNE Required	**15,006,802**	**16,406,665**		
Phased -In requirement	3,001,360	5,906,399		
Excess TNE	**(1,165,059)**	**2,560,440**		

Gold Coast Health Plan

Fiscal Year July 1, 2011 - June 30, 2012

Reforecasted G&A 11.23.2011

	Revised	Original	Change Inc/(Dec)	% Change
Salaries	3,796,608	2,805,588	991,020	35.3%
Benefits	1,343,154	974,942	368,212	37.8%
Other Employee Expenses	166,999	78,000	88,999	114.1%
Outside Services - ACS	11,254,856	10,492,015	762,841	7.3%
Outside Services - Scriptcare	3,071,587	6,764,223	(3,692,636)	-54.6%
Outside Services - CQS	2,403,306	1,290,112	1,113,194	86.3%
Outside Services - RGS	132,001	243,947	(111,946)	-45.9%
Outside Services - Other	323,950	60,000	263,950	439.9%
Other Professional Services	183,112	360,000	(176,888)	-49.1%
Meetings & Events	9,514	-	9,514	100.0%
Travel	83,472	12,000	71,472	595.6%
Non-Capital Furniture & Equipment	59,136	18,216	40,920	224.6%
Non-Capital Equipment - Computer	38,471	21,600	16,871	78.1%
Software Licenses	139,086	87,240	51,846	59.4%
Lease - Office	234,720	169,580	65,140	38.4%
Office & Operating Supplies	91,364	88,800	2,564	2.9%
Shipping & Postage	98,304	274,611	(176,307)	-64.2%
Printing	251,540	357,589	(106,049)	-29.7%
Telephone Services/Internet Charges	22,472	-	22,472	100.0%
Advertising & Promotions Expense	247,399	-	247,399	100.0%
Insurance	37,970	60,000	(22,030)	-36.7%
Committee & Advisory Fees	33,600	-	33,600	100.0%
Professional Dues, Fees, & Licenses	61,719		61,719	100.0%
Subcriptions & Publications	33,831	-	33,831	100.0%
Depreciation/ Amortization Expense	17,532	-	17,532	100.0%
Interest Expense	5,175	28,514	(23,339)	-81.9%
Other Misc Expense	84,245	30,000	54,245	180.8%
Total	**24,225,121**	**24,216,977**	**8,145**	**0.0%**

		Salaries & Benefits					
					Revised Salaries & Benefits		
Position	**Status**	**Original Budget**	**Deletions**	**Additions**	**Salaries**	**Benefits**	**Total**
CEO	Hired	269,500			200,769	69,767	270,537
Executive Assistant	Hired	94,325			60,231	20,930	81,161
Aministrative Assistant	Hired	67,375			50,192	17,442	67,634
Aministrative Assistant	Hired	67,375			50,196	17,443	67,638
Compliance Specialist	Hired			105,509	78,300	27,209	105,509
CFO	Hired	235,813			175,663	61,043	236,706
Finance Manager	Hired	134,750			110,423	38,372	148,795
Finance Analyst	Hired	87,588			75,005	26,064	101,069
Finance Analyst	TBH	87,588			43,500	15,116	58,616
Finance Analyst	TBH	87,588			32,500	11,294	43,794
Accounting Assistant	Hired	60,638			45,173	15,698	60,871
IT Director		161,700	(161,700)		-	-	-
System Manager	Hired	107,800			108,409	37,672	146,081
Web Programer		89,727	(89,727)		-	-	-
Data Base/Business Analyst	TBH			63,118	46,841	16,277	63,118
CMO	Hired	256,025			230,891	80,235	311,126
Pharmacy Director	Hired			158,978	117,980	40,998	158,978
Assistant Medical Director	Hired			129,845	96,360	33,485	129,845
QI Manager	TBH	114,538			93,696	32,559	126,255
QI Coordinator	TBH	114,538			39,000	13,553	52,553
QI Coordinator	TBH			43,659	32,400	11,259	43,659
Health Services Director *	Hired	161,700			120,462	41,860	162,322
HS Manager	Hired			128,505	95,365	33,139	128,505
Health Educator	Hired			94,688	70,269	24,419	94,688
Clinical Operations Specialist	Hired			56,272	41,760	14,512	56,272
Health Services Administrator	Hired			54,105	40,152	13,953	54,105
Med Mgmt Reporting Specialist	TBH			32,771	24,320	8,451	32,771
Provider Relations Director	Hired	161,700			120,462	41,860	162,322
Provider Relations Service Rep II	Hired	83,545			65,250	22,674	87,924
Provider Relations Service Rep II	Hired	83,545			57,235	19,889	77,124
Provider Relations Service Rep II	TBH			43,238	32,087	11,150	43,238
Provider Relations Administrator	Hired			70,340	52,200	18,140	70,340
Sr. Director Operations	TBH			250,409	185,832	64,577	250,409
Member Services Director	TBH	134,750			70,000	24,325	94,325
Member Services Manager	Hired	114,538			90,346	31,395	121,741
MS Lead Rep 1-Grievance Coordinator	Hired	60,638			40,154	13,953	54,107
MS Representative	TBH			40,430	30,004	10,426	40,430
Community Outreach Specialist	Hired			27,048	20,073	6,975	27,048
Claims Director	Hired	161,700			120,462	41,860	162,322
Sr. Claims Auditor	TBH			81,162	60,232	20,931	81,162
Claims Auditor	Hired	87,588			61,241	21,281	82,522
Claims Auditor	Hired	87,588			43,573	15,142	58,715
Claims Research	TBH			54,115	40,159	13,955	54,115
Claims Research	TBH			40,430	30,004	10,426	40,430
Grievance Coordinator	Hired			81,172	60,239	20,933	81,172
Project Manager		121,275	(121,275)		-	-	-
Government Relations Director	Hired	161,700			120,462	41,860	162,322
Human Resources Director	Hired	161,700			120,462	41,860	162,322
HR Representative	TBH			28,247	20,963	7,285	28,247
Communications Director	Hired	161,700			120,462	41,860	162,322
Total		**3,780,530**	**(372,702)**	**1,584,041**	**3,641,757**	**1,265,510**	**4,907,267**
Total Positions		31	(3)	19	47		

Reconciliation

Budgeted S&B	3,780,530	Revised S&B	4,907,267
Deleted Positions	(372,702)	Equity Adjustment	161,700
Unbudgeted Positions	1,584,041	Merit Increase	114,925
Timing and Salary Differences	(84,601)	**S&B w/increases**	**5,183,892**
Revised S&B	**4,907,267**		

Note: Merit increases do not include CEO, CFO or CMO

Benefits @ 34.75%

Management's Discussion and Analysis
of Additional Staffing Requirements

Medical Management

Quality Improvement Coordinator: The addition of a Quality Improvement Coordinator is a replacement for an original employee who has since switched positions. Although originally budgeted to begin prior to the plan's commencement date, a QI Specialist was not hired until early July, resulting in some initial savings. Since QI is a complex function, a consultant was engaged on a temporary basis to assist the original employee in developing and implementing the QI program. When the initial QI employee transferred, the consultant agreed to devote additional time and stay on to continue developing the QI program for up to six months, while GCHP searches for suitable candidates to fill the permanent QI positions. After a director is hired, GCHP needs to continue recruiting for a Quality Improvement Coordinator. In working with the consultant, it was learned that the effort required to fulfill state regulations is nearly as onerous for a small plan such as GCHP as for a large plan. It is anticipated that the two positions in QI will face a full schedule to comply with the reporting requirements.

Pharmacy Director: The State required that GCHP have its own Pharmacy Director before commencing operations. In response, a qualified clinical pharmacist was hired who wanted a part-time position, but who in the near future could increase the commitment according to the plan's needs. Currently, GCHP is spending little on this position by requiring services of no more than 2-4 hours per week. Since the PBM, Script Care, provides a dedicated, full-time Clinical Pharmacist, the combination was initially a viable solution. However, GCHP's drug plan can realize significant savings with proper formulary management and academic detailing by an in-house pharmacist. Therefore, a full-time Director of Pharmacy should be added by January of 2012 to realize the full potential of savings.

Assistant Chief Medical Officer (half-time): For COHS and Local Initiatives with more than 100,000 members, the demands of the CMO position are too great for one individual. GCHP was able to recruit a physician with exceptional Utilization Management experience in a large health plan. The incumbent is efficient and effective, and has been averaging no more than 12 hours per week. The hours are expected to increase up to half-time, as this individual becomes more involved in other activities extending beyond UM. The additional support will allow the CMO to better concentrate on larger strategic and managerial issues.

Health Services

Manager, Care Coordination: This position is responsible for the implementation, evaluation and oversight of programs and functions that directly impact the cost of care and quality of the care to Gold Coast Health Plan members, including:

- monitoring and improving the CM and UM programs

- managing and directing the daily operations of all CM and UM staff activities performed by licensed health care professionals to reduce utilization metrics such as member metrics (bed days/per 1,000, discharges per 1,000)
- overseeing case managers and their activities related to CM for targeted members who are at risk because of medically complex or serious conditions, or who have the potential for complex or high-cost health care needs
- providing direct support to utilization management nurses to assist them in effectively and efficiently implementing the UM processes, with the goal of meeting quality care that is medically indicated and at the appropriate setting, including discharge planning and the identification of ongoing needs of the members throughout the various health care settings.

Health Educator: The Health Educator plans, develops, and coordinates health education programs designed to prevent disease, promote health, and prolong life; directs and participates in needs assessment, development of program plans, and goals and objectives. The Health Educator also performs the State mandated group needs assessments to identify educational needs of GCHP members and ensures that health education and preventive programs are easily accessible and appropriate to the cultural and linguistic needs of our Member population; identifies community resources and establishes relationships for health education programs and services and ensures GCHP collaboration.

Clinical Operations Specialist: The Clinical Operations Specialist coordinates non-clinical utilization/case management activities under the direction of a Registered Nurse (RN). This individual coordinates and collaborates with internal and external resources to support UM/CM efforts. The Clinical Operations Specialist actively collaborates with providers and other internal customers to facilitate the care needs of the Gold Coast Health Plan Medicaid member.

Health Services Administrator: This position provides administrative, secretarial and clerical support to others in the office. The individual is proficient in all office equipment, such as fax machines, printers and copiers, as well as computers and business software (KWIK, IKA, ICMS).

Medical Management Reporting Specialist: The Medical Management Reporting Specialist will establish data accuracy and validity of information derived from a variety of systems. This individual will perform data analysis using statistical techniques, and assist in the preparation and delivery of decision support reports to both internal and external customers through analysis of confidential clinical and financial data. The Reporting Specialist will track and prepare State mandated and ad hoc reports for Medical Management, Utilization Management, and Case Management.

Member Services

Member Services Representative: A bilingual FTE is needed to service our Spanish and English speaking walk-in members and lend support to internal member service processes of grievance and appeals and call center reporting. This individual will help

update policies and procedures determined by GCHP and update member materials as required. The Member Services Rep will also assist with ad hoc member reporting requirements within specified timeframes established by either regulatory/accreditation agencies or member/provider needs.

Community Outreach Specialist: There is a need for a bilingual (English and Spanish) FTE to perform community outreach. This individual will be responsible for assisting in activities to help educate membership through various means. Anticipated programs include attending outreach events, health fairs and community activities at the grass roots level. The Community Outreach Specialist will also provide training materials and participate in networking through externally sponsored events and with potential contracting providers, when possible.

Claims

Senior Claims Auditor: This position is needed for direct daily supervision of Auditors' activities and projects including prepayment auditing. Additionally, the Sr. Auditor will develop post payment audit programs under the direction of the Claims Director, and will also provide direct supervision of Auditors' activities on post payment recovery audits. The Sr. Auditor is needed for daily monitoring of all Provider Inquiry Claims Research projects to assure timeliness and accuracy and provider satisfaction and will assist in escalated provider inquiries. The Sr. Auditor will assure the activities overseen are meeting regulatory compliance requirements, and will assure timely and accurate completion and filing of all required regulatory and oversight reporting. The Sr. Auditor will be responsible for the management and maintenance of DHCS or CMS audit schedules or readiness visits, including preparation and reports on audit activity to designated and corporate management. The individual will develop audit programs for oversight and monitoring of ACS and other vendor activities related to claims administration or Call Center activity related to Provider Grievances and Claims activities. The Sr. Auditor will manage the process for accurate and timely completion of corrective action plans resulting from health plan and vendor self-audit findings and will assure that all required corrective action plans are filed timely and that corrective actions outlined in the CAP actually take place.

Provider Inquiry Claims Research (2): These positions are necessary to augment both the ACS Call Center and GCHP Provider Relations with resources trained in analyzing and resolving complex claims issues that cannot be answered by Call Center staff or Provider Relations. The Researchers act as Claims experts in researching complex issues escalated from ACS Provider Inquiry Call Center or from GCHP Provider Relations. The inquiries may be telephonic or through email. These individuals research claims issues in close coordination with ACS to resolve the issues within the claims system and assist ACS in determining the appropriate course of action. The Researchers also monitor ACS resolution activities, and upon completion, follow up with providers with as needed.

Provider Grievance Coordinator: This position is a required function to be performed by the health plan, but was not contemplated in the earlier budget. Because the vast

majority of provider grievances and provider dispute resolutions (PDRs) are claims-related, it was decided to put this position under the direction of the Claims Dept. The Coordinator receives and processes provider grievances and PDR requests that are directed to the health plan. This individual provides direction to delegated entities for claims related issues PDRs (ACS and ScriptCare currently) and performs oversight and monitoring of delegated entities PDR processing. The Coordinator also performs Third Party Liability responsibilities as required by DHCS.

Provider Relations

Provider Relations Specialist: An additional Provider Relations resource was needed because present staff was clearly overwhelmed by the amount of requests for Single Patient Agreements ("SPA") or Letters of Agreement ("LOA") for non-par providers. GCHP did not anticipate the extraordinarily high number of non-par provider requests that are being received and are required to be processed. These consume much time and special handling for services to be rendered outside of GCHP's normal contracted network.

Human Resources

Human Resources Representative: This position is needed to assist in recruiting activities to ensure that, as a start-up, GCHP can consistently attract quality personnel with the proper expertise and temperament. This individual will also provide support during the hiring process as the paperwork and review required is intensive and often more burdensome than in the private sector. The position will assist with the administration of benefits and payroll, with the expectation of bringing more processes in house and away from RGS.

Gold Coast Health Plan
Balance Sheet
Period Ended September 30, 2011

ASSETS	
Current Assets	
Petty Cash	$ 1,000.00
Cash - Restricted	0
Cash -Operating Account	1,439,267.93
Cash - Payroll Checking Account	0.00
Cash - Claims Payment	0.00
Cash - Capitation Payment	0.00
Cash - Pharmacy Payment	0.00
Money Market Account	46,017,067.00
Total Cash and Cash Equivalents	**47,457,334.93**
Medi-Cal Receivable	1,699,239.22
Provider Receivable	3,401,124.97
Other Receivables	17,822.15
Total Accounts Receivable	**5,118,186.34**
Total Prepaid Accounts	36,273.57
Total Other Current Assets	320,000.00
Total Current Assets	**52,931,794.84**
Total Fixed Assets	**83,255.95**
Total Assets	**53,015,050.79**
LIABILITIES	
Current Liabilities	
Incurred But Not Reported	38,264,238.63
Claims Payable	5,820,607.00
Capitation Payable	665,126.81
Accrued Premium Reduction	1,658,224.65
Accounts Payable	35,580.27
Accrued Expenses	92,337.70
Accrued ACS	364,282.93
Accrued RGS	53,013.62
Accrued Scriptcare	-
Accrued CQS	81,666.00
Accrued Premium Tax	1,764,533.90
Current Portion of Deferred Revenue	460,000.00
Accrued Payroll Expense	-
Accrued Payroll Tax Expense	-
Accrued Vacation	-
Current Portion Of Long Term Debt	500,000.00
Other Current Liabilities	-
Total Current Liabilities	**49,759,611.51**
Long-Term Liabilities	
Other Long-term Liability	416,666.66
Deferred Revenue - Long Term Portion	1,725,000.01
Notes Payable	-
Total Long-Term Liabilities	**2,141,666.67**
Total Liabilities	**51,901,278.18**
Beginning Fund Balance	(4,422,819.09)
Net Income Current Year	5,536,591.70
Total Fund Balance	**1,113,772.61**
Total Liabilities & Fund Balance	**53,015,050.79**

Gold Coast Health Plan
Income Statement
Period Ended September 30, 2011

	SEP 2011	Budget	Variance Fav/(Unfav)	YTD	Budget	Variance Fav/(Unfav)
Members (Member/Months)	101,470.00	98,046.28	3,424	304,990	293,640	11,350
Revenues						
Premium	25,934,155	24,793,919	1,140,237	76,744,774	74,255,593	2,489,181
Reserve for Retro-Active Rate Reduction	(1,658,225)	-	(1,658,225)	(1,658,225)	-	(1,658,225)
Interest Income	11,251	40,846	(29,595)	17,067	78,682	(61,615)
Miscellaneous Income	38,333	-	38,333	115,000	-	115,000
Total Revenues	**24,325,515**	**24,834,765**	**(509,250)**	**75,218,616**	**74,334,275**	**884,341**
MCO Tax	585,154	582,657	2,497	1,764,534	1,745,006	19,528
Net Revenue	**23,740,361**	**24,252,108**	**(511,747)**	**73,454,082**	**72,589,269**	**864,813**
Cost of Health Care						
Capitation	665,127	810,507	145,380	1,835,476	2,427,396	591,920
Claims						
Inpatient	10,785,794	10,182,611	(603,183)	32,150,024	30,496,019	(1,654,005)
Outpatiernt	3,982,971	2,717,638	(1,265,333)	9,688,451	8,139,085	(1,549,366)
Professional	2,223,939	2,075,691	(148,248)	6,574,195	6,216,510	(357,685)
Pharmacy	2,747,049	3,883,883	1,136,834	7,725,303	11,631,885	3,906,582
Reinsurance	92,338	-	(92,338)	277,541	-	(277,541)
Reinsurance Recoveries	-		-			-
Incentives - P4P	-		-			-
Other	836,785	1,717,249	880,464	4,387,568	5,143,008	755,440
Total Claims	**20,668,876**	**20,577,072**	**(91,804)**	**60,803,082**	**61,626,507**	**823,425**
Total Cost of Health Care	**21,334,003**	**21,387,579**	**53,576**	**62,638,559**	**64,053,903**	**1,415,344**
Administrative Expenses						
Total Salaries Benefits and Compensation	357,470	308,578	(48,892)	1,059,520	925,733	(133,787)
Total Travel and Training	5,675	1,000	(4,675)	17,653	3,000	(14,653)
Outside Service - ACS	977,228	873,928	(103,300)	2,830,436	2,617,892	(212,544)
Outside Service - CQS	245,530	106,870	(138,660)	478,563	320,068	(158,495)
Outside Service - RGS	9,114	20,200	11,086	27,131	60,599	33,468
Outside Service - Script Care	201,481	560,334	358,854	543,774	1,678,152	1,134,378
Outside Services - Other	2,376	20,000	17,624	8,090	60,000	51,910
Accounting & Actuarial Services	5,504		(5,504)	18,445		(18,445)
Legal Expense	17,667		(17,667)	17,667		(17,667)
Insurance	5,421	5,000	(421)	11,338	15,000	3,662
Lease Expense -Office	13,040	14,640	1,600	39,120	43,920	4,800
Consulting Services Expense	12,338	5,000	(7,338)	24,069	15,000	(9,069)
Translation Services	444	-	(444)	1,475	-	(1,475)
Advertising and Promotion Expense	33,842	-	(33,842)	90,731	-	(90,731)
General Office Expenses	37,047	25,333	(11,714)	99,021	76,000	(23,021)
Depreciation Expense	-		-	-		-
Depreciation & Amortization Expense	1,461	1,655	194	4,382	4,965	583
Printing Expense	2,890	12,000	9,110	4,763	36,000	31,237
Shipping & Postage Expense	(8,910)	5,000	13,910	(2,421)	15,000	17,421
Interest Exp	-	722	722	5,175	2,383	(2,792)
Gain/(Loss) on Disposal of Assets	-			-		
Other/ Miscellaneous Expenses	-			-		
Total Administrative Expenses	**1,919,616**	**1,960,260**	**40,644**	**5,278,932**	**5,873,712**	**594,780**
Net Income	**486,741**	**904,268**	**(417,527)**	**5,536,592**	**2,661,654**	**2,874,938**

Gold Coast Health Plan
Statement of Cash Flows
Quarter Ended September 30, 2011

Cash Flow From Operating Activities	
Collected Premium	75,045,534
Miscellaneous Income	24,951
Paid Claims	
Medical & Hospital Expenses	(16,851,221)
Pharmacy	(2,888,402)
Capitation	(1,835,476)
Reinsurance of Claims	(185,203)
Reinsurance Recoveries	-
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(6,513,545)
Repay Initial Net Liabilities	-
MCO Taxes Expense	-
Net Cash Provided by Operating Activities	-
Cash Flow From Investing/Financing Activities	
Proceeds from Paid in Surplus/Issuance of Stock	-
Costs of Capitalization	-
Net Acquisition of Property/Equipment	-
Net Cash Provided by Investing/Financing	-
Net Cash Flow	**46,796,637**
Cash and Cash Equivalents (Beg. of Period)	660,697
Cash and Cash Equivalents (End of Period)	47,457,335
	46,796,637
Adjustment to Reconcile Net Income to Net Cash Flow	
Net (Loss) Income	5,536,592
Depreciation & Amortization	4,382
Decrease/(Increase) in Receivables	(5,109,032)
Decrease/(Increase) in Prepaids & Other Current Assets	(316,147)
(Decrease)/Increase in Payables	(1,293,555)
(Decrease)/Increase in Borrowings	(198,333)
Purchase of fixed Assets	-
Changes in Withhold / Risk Incentive Pool	-
Change in Income Tax Liability	1,764,534
Changes in Claims and Capitation Payable	8,143,958
Changes in IBNR	38,264,239
	46,796,637
Net Cash Flow from Operating Activities	**46,796,637**

Gold Coast Health Plan
Balance Sheet
Period Ended October 31, 2011

ASSETS		
Current Assets		
Petty Cash	$	1,000
Cash - Restricted		0
Cash -Operating Account		345,546
Cash - Payroll Checking Account		-
Cash - Claims Payment		-
Cash - Capitation Payment		-
Cash - Pharmacy Payment		-
Money Market Account		30,032,415
Total Cash and Cash Equivalents		**30,378,961**
Medi-Cal Receivable		27,789,454
Provider Receivable		5,886,813
Other Receivables		19,537
Total Accounts Receivable		**33,695,803**
Total Prepaid Accounts		31,267
Total Other Current Assets		320,000
Total Current Assets		**64,426,032**
Total Fixed Assets		**81,795**
Total Assets		**64,507,827**
LIABILITIES		
Current Liabilities		
Incurred But Not Reported		39,830,843
Claims Payable		12,903,445
Capitation Payable		625,098
Accrued Premium Reduction		2,215,176
Accounts Payable		57,088
Accrued Expenses		-
Accrued ACS		855,022
Accrued RGS		62,879
Accrued Scriptcare		-
Accrued CQS		-
Accrued Premium Tax		2,361,663
Current Portion of Deferred Revenue		460,000
Accrued Payroll Expense		-
Accrued Payroll Tax Expense		-
Accrued Vacation		-
Current Portion Of Long Term Debt		500,000
Other Current Liabilities		-
Total Current Liabilities		**59,871,214**
Long-Term Liabilities		
Other Long-term Liability		375,000
Deferred Revenue - Long Term Portion		1,686,667
Notes Payable		-
Total Long-Term Liabilities		**2,061,667**
Total Liabilities		**61,932,881**
Beginning Fund Balance		(4,422,819)
Net Income Current Year		6,997,765
Total Fund Balance		**2,574,946**
Total Liabilities & Fund Balance		**64,507,827**

Gold Coast Health Plan
Income Statement
Period Ended October 31, 2011

	OCT 2011	Budget	Variance Fav/(Unfav)	YTD	Budget	Variance Fav/(Unfav)
Members (Member/Months)	101,619	98,213	3,406	406,609	391,853	14,756
Revenues						
Premium	26,300,397	24,836,068	1,464,329	103,045,171	99,091,661	3,953,510
Reserve for Retro-Active Rate Reduction	(556,951)	-	(556,951)	(2,215,176)	-	(2,215,176)
Interest Income	15,348	47,261	(31,913)	32,415	125,943	(93,528)
Miscellaneous Income	38,333	-	38,333	153,333	-	153,333
Total Revenues	**25,797,127**	**24,883,329**	**913,798**	**101,015,743**	**99,217,604**	**1,798,139**
MCO Tax	597,129	583,648	13,481	2,361,663	2,328,654	33,009
Net Revenue	**25,199,998**	**24,299,681**	**900,317**	**98,654,080**	**96,888,950**	**1,765,130**
Cost of Health Care						
Capitation	625,098	811,885	186,787	2,460,575	3,239,281	778,707
Claims						
Inpatient	11,029,560	10,199,922	(829,638)	43,179,584	40,695,941	(2,483,643)
Outpatiernt	4,676,651	2,722,258	(1,954,393)	14,365,102	10,861,343	(3,503,759)
Professional	1,264,110	2,079,220	815,110	7,838,305	8,295,730	457,425
Pharmacy	2,884,784	3,890,485	1,005,701	10,610,088	15,522,370	4,912,282
Reinsurance	94,616	-	(94,616)	372,157	-	(372,157)
Reinsurance Recoveries	-		-	-		-
Incentives - P4P	-		-	-		-
Other	970,276	1,720,168	749,892	5,357,845	6,863,176	1,505,331
Total Claims	**20,919,998**	**20,612,053**	**(307,945)**	**81,723,080**	**82,238,560**	**515,480**
Total Cost of Health Care	**21,545,096**	**21,423,938**	**(121,158)**	**84,183,655**	**85,477,841**	**1,294,186**
Administrative Expenses						
Total Salaries Benefits and Compensation	366,471	308,578	(57,893)	1,425,991	1,234,310	(191,681)
Total Travel and Training	4,504	1,000	(3,504)	22,156	4,000	(18,156)
Outside Service - ACS	951,956	875,228	(76,728)	3,782,391	3,493,120	(289,271)
Outside Service - CQS	251,186	107,052	(144,133)	729,749	427,120	(302,629)
Outside Service - RGS	9,321	20,200	10,879	36,452	80,798	44,346
Outside Service - Script Care	223,467	561,287	337,820	767,241	2,239,439	1,472,198
Outside Services - Other	12,321	20,000	7,679	20,411	80,000	59,589
Accounting & Actuarial Services	1,244		(1,244)	19,689		(19,689)
Legal Expense	(7,542)		7,542	10,124		(10,124)
Insurance	2,959	5,000	2,041	14,297	20,000	5,703
Lease Expense -Office	13,040	14,640	1,600	52,160	58,560	6,400
Consulting Services Expense	2,711	5,000	2,289	26,780	20,000	(6,780)
Translation Services	831	-	(831)	2,305	-	(2,305)
Advertising and Promotion Expense	49,239	-	(49,239)	139,970	-	(139,970)
General Office Expenses	14,090	25,333	11,243	113,111	101,333	(11,778)
Depreciation Expense	-		-	-		-
Depreciation & Amortization Expense	1,461	1,655	194	5,843	6,620	777
Printing Expense	144,933	12,000	(132,933)	149,696	48,000	(101,696)
Shipping & Postage Expense	151,539	5,000	(146,539)	149,119	20,000	(129,119)
Interest Exp	-	650	650	5,175	3,033	(2,142)
Gain/(Loss) on Disposal of Assets	-			-		
Other/ Miscellaneous Expenses	-			-		
Total Administrative Expenses	**2,193,728**	**1,962,622**	**(231,106)**	**7,472,660**	**7,836,333**	**363,673**
Net Income	**1,461,174**	**913,121**	**548,053**	**6,997,765**	**3,574,776**	**3,422,989**

Gold Coast Health Plan
Statement of Cash Flows
Month Ended October 31, 2011

Cash Flow From Operating Activities	
Collected Premium	$210,946
Miscellaneous Income	28,704
Paid Claims	
Medical & Hospital Expenses	(10,453,597)
Pharmacy	(4,390,591)
Capitation	(625,498)
Reinsurance of Claims	(186,954)
Reinsurance Recoveries	-
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(1,661,383)
Repay Initial Net Liabilities	-
MCO Taxes Expense	-
Net Cash Provided by Operating Activities	(17,078,374)
Cash Flow From Investing/Financing Activities	
Proceeds from Paid in Surplus/Issuance of Stock	-
Costs of Capitalization	-
Net Acquisition of Property/Equipment	-
Net Cash Provided by Investing/Financing	-
Net Cash Flow	**(17,078,374)**
Cash and Cash Equivalents (Beg. of Period)	47,457,335
Cash and Cash Equivalents (End of Period)	30,378,961
	(17,078,374)
Adjustment to Reconcile Net Income to Net	
Cash Flow	
Net (Loss) Income	1,461,174
Depreciation & Amortization	1,461
Decrease/(Increase) in Receivables	(28,577,617)
Decrease/(Increase) in Prepaids & Other Current Assets	5,007
(Decrease)/Increase in Payables	348,109
(Decrease)/Increase in Borrowings	(80,000)
Purchase of fixed Assets	-
Changes in Withhold / Risk Incentive Pool	-
Change in Income Tax Liability	597,129
Changes in Claims and Capitation Payable	7,599,760
Changes in IBNR	1,566,604
	(17,078,374)
Net Cash Flow from Operating Activities	**(17,078,374)**

Gold Coast Health Plan℠
A Public Entity

Ventura County Medi-Cal Managed Care Commission

2240 East Gonzales Road
Suite 200
Oxnard, CA 93036
6:00 PM
November 28, 2011

Gold Coast Health Plan℠
A Public Entity

Educational Outreach

Summary of Events

- 50+ Information Sessions / Town Hall Events
- Estimated More Than 1,000 Attendees
- Medi-Cal Beneficiaries, Providers & Agency Professionals
- Local Media Outreach
- Hosted Media Events

Gold Coast Health Plan℠
A Public Entity

Venues

- **Ventura County Health Care Agency**

  - ✓ Academic Family Medicine Center (Ventura)
  - ✓ Santa Paula Hospital – Library (Santa Paula)
  - ✓ Santa Paula Community Center (Santa Paula)
  - ✓ Moorpark Family Medical Clinic (Moorpark)
  - ✓ Sierra Vista Family Medical Clinic (Sierra Vista)
  - ✓ Las Islas North (Oxnard)
  - ✓ Conejo Valley Family Medical Group (Thousand Oaks)
  - ✓ Fillmore
  - ✓ Magnolia Family Clinic (Oxnard)
  - ✓ Las Posas Family Medical Group (Camarillo)
  - ✓ West Ventura Medical Clinic (Ventura)

Gold Coast Health Plan℠
A Public Entity

Venues

- **Clinicas del Camino Real**
  - ✓ Oxnard
  - ✓ Ojai Valley Community Health Center
  - ✓ Ventura
  - ✓ Fillmore
  - ✓ Santa Paula
  - ✓ Newbury Park
- **Community Memorial Hospital (CMH)**
  - ✓ Fillmore Center for Family Health
  - ✓ Vineyard Center for Family Health
- **Tri Counties Regional Center**
  - ✓ Oxnard (2x)
  - ✓ Simi Valley

Gold Coast Health Plan℠
A Public Entity

Venues

- **Ventura County Interagency Transition Coordinating Council (ITCC)**
  - ✓ Ventura
- **Ventura County Behavioral Health Department**
  - ✓ Oxnard
- **Livingston Memorial**
  - ✓ Ventura
- **The ARC**
  - ✓ Ventura
- **Ventura County Office of Education**
  - ✓ Camarillo
- **McKevett Elementary School**
  - ✓ Santa Paula

Gold Coast Health Plan℠
A Public Entity

Venues

- **Human Services Agency**
  - ✓ Santa Paula
  - ✓ Simi Valley
- **Rainbow Connection**
  - ✓ Oxnard
- **Women Infants Children (WIC)**
  - ✓ Oxnard
- **California Self Directed Services**
  - ✓ Ventura
- **Health Insurance Counseling & Advocacy Program (HICAP)**
  - ✓ Ventura (2x)

Gold Coast Health Plan℠
A Public Entity

Venues

- **Adult Protective Services**
  - ✓ Ventura
- **St. John's Regional Medical Center**
  - ✓ Oxnard
- **Department of Vocational Rehabilitation (DOR)**
  - ✓ Oxnard
- **Adult Day Health Care**
  - ✓ Oxnard (3x)
  - ✓ Simi Valley
- **MICOP**
  - ✓ Oxnard

Gold Coast Health Plan℠
A Public Entity

Venues

- **McKenna Elementary School**
  - ✓ Oxnard
- **Ventura Home Care Association**
  - ✓ Ventura
- **Valley Home Medical Supply**
  - ✓ Oxnard
- **GCHP Freedom Center**
  - ✓ Camarillo

Gold Coast Health Plan℠
A Public Entity

Media Campaign

Radio, TV, Newsprint

May 2011 – November 2011

Gold Coast Health Plan℠
A Public Entity

Media Campaign

- Multi-Phased Approach
- Radio / TV / Newsprint
- Strategic Media Buy

Gold Coast Health Plan℠
A Public Entity

Media Campaign

- **Phase 1**
  - ✓ **Pre Go-Live**
    - ❖ **Radio / Newsprint**
      - **(6 weeks May 23rd – July 1st)**
- **Phase 2**
  - ✓ **3rd Quarter 2011**
    - ❖ **Radio / Newsprint / TV**
      - **(6 weeks Oct 11th – Nov 18th)**
- **Phase 3**
  - ✓ **1st Quarter 2012**
    - ❖ **Radio / Newsprint / TV / Billboards**

Radio Vendors

Phase 1

Laser Communications

Radio Lazer 102.9 FM

La mejor 96.7 aes

KOXR 910 AM

Gold Coast Broadcasting

q104.7 FM 805's HIP, HOP, and R&B

Live 105.5 FM Today's Hit Music

Rewind 95.9 fm Feel Good Favorites

RadioFórmula 1590 AM Oxnard • Ventura • Santa Barbara

La "M"

La M 103.7 FM Todos los días!

Radio Vendors

Laser Communications

Phase 2

Radio LAZER 102.9 FM

la mejor 96.7 aes

KOXR 910 AM

Gold Coast Broadcasting

q104.7 FM 805's HIP, HOP, and R&B

Live 105.5 FM TODAY'S HIT MUSIC

Rewind 95.9 fm FEEL GOOD FAVORITES

RadioFórmula 1590 AM Oxnard • Ventura • Santa Barbara

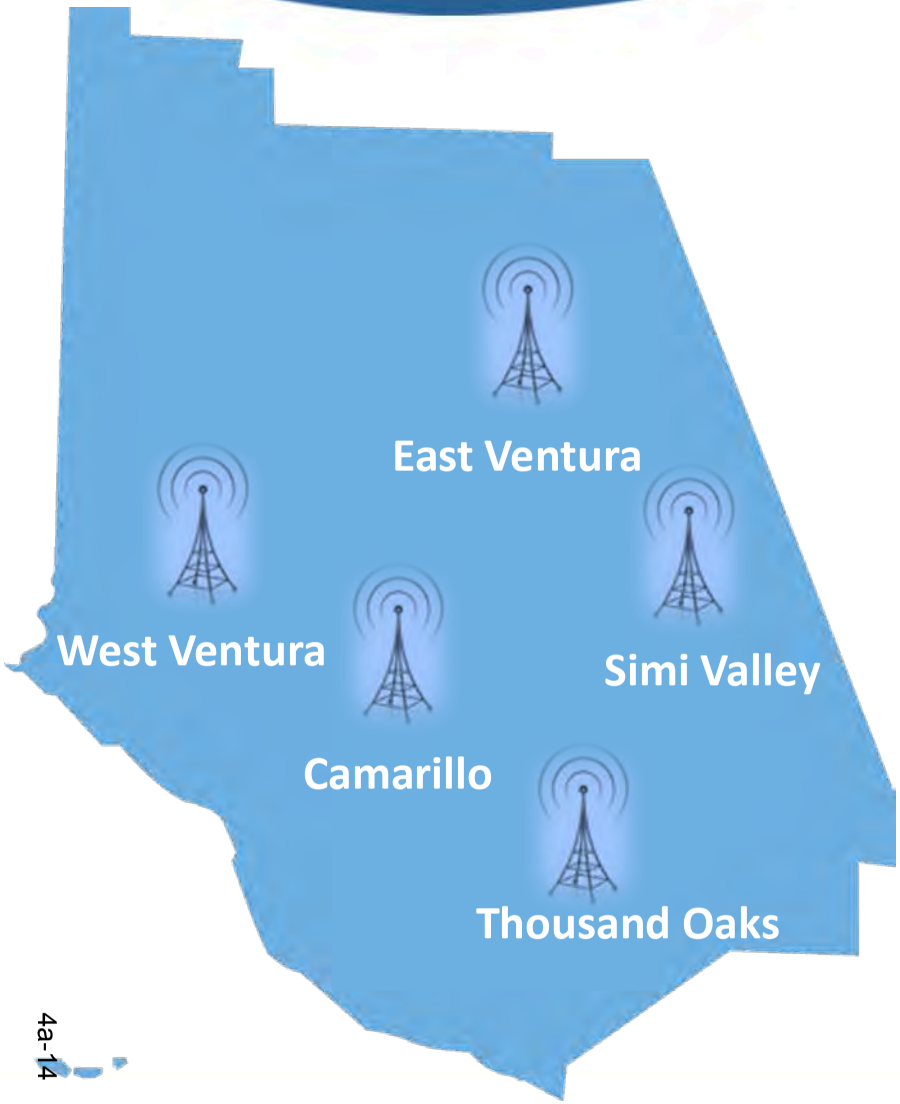
La "M"

La M 103.7 FM Todos los días!

100.7 KHAY California Country!

Cumulus Broadcasting

Gold Coast Health Plan℠
A Public Entity



Radio Campaign

East Ventura
- Oxnard
- Port Hueneme
- Santa Paula
- Fillmore
- Piru
- Ojai
- Mira Monte
- Meiners Oaks

Thousand Oaks
- Newbury Park
- Casa Conejo
- Oak Park
- Agoura Hills
- Westlake

West Ventura
- Ventura
- Oak View

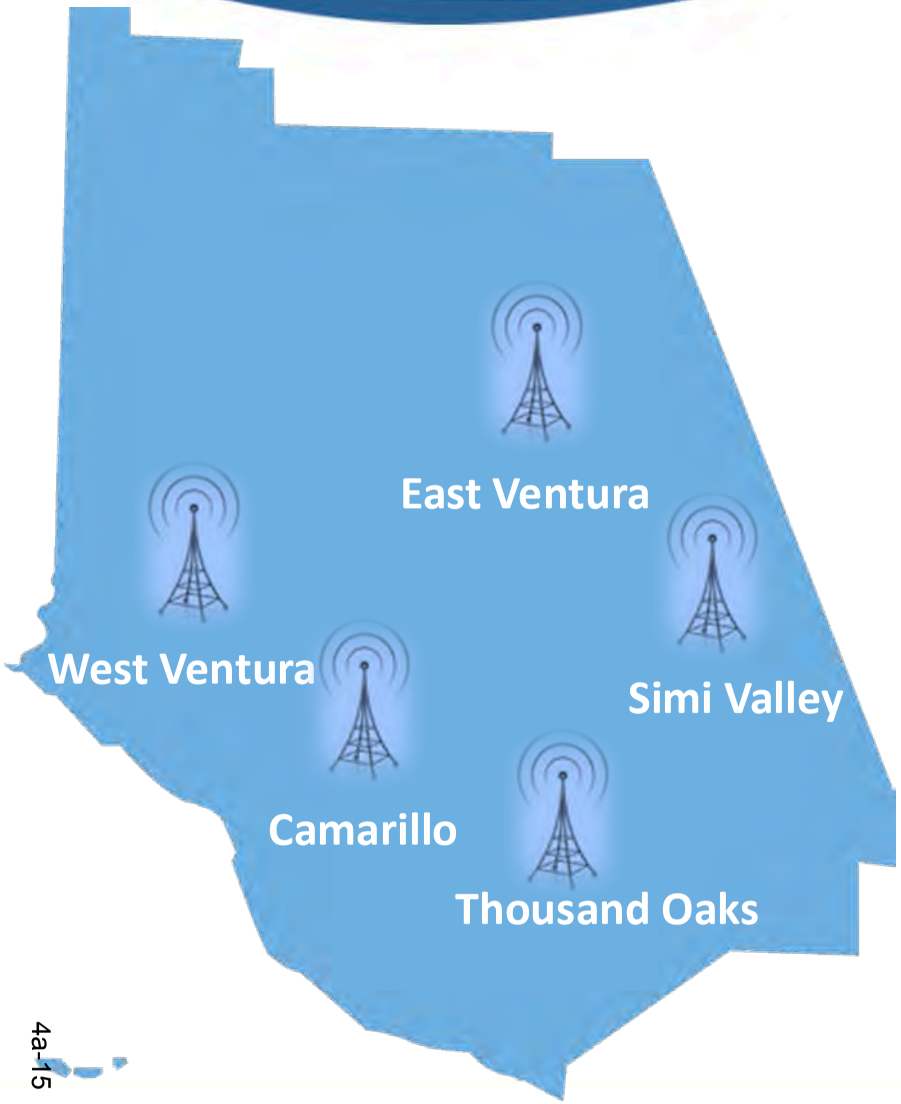
Camarillo
- Somis

Simi Valley
- Moorpark

Gold Coast Health Plan℠
A Public Entity

Radio Campaign

Phase 1



- 8 Stations
- 45 :60 Commercials For 6 Weeks
- 270 Commercial / Station
- 2,160 Total Commercials
- 430,400 Listeners; Ages 12+ Avg 15x
- 6,435,000 Gross Impressions

English

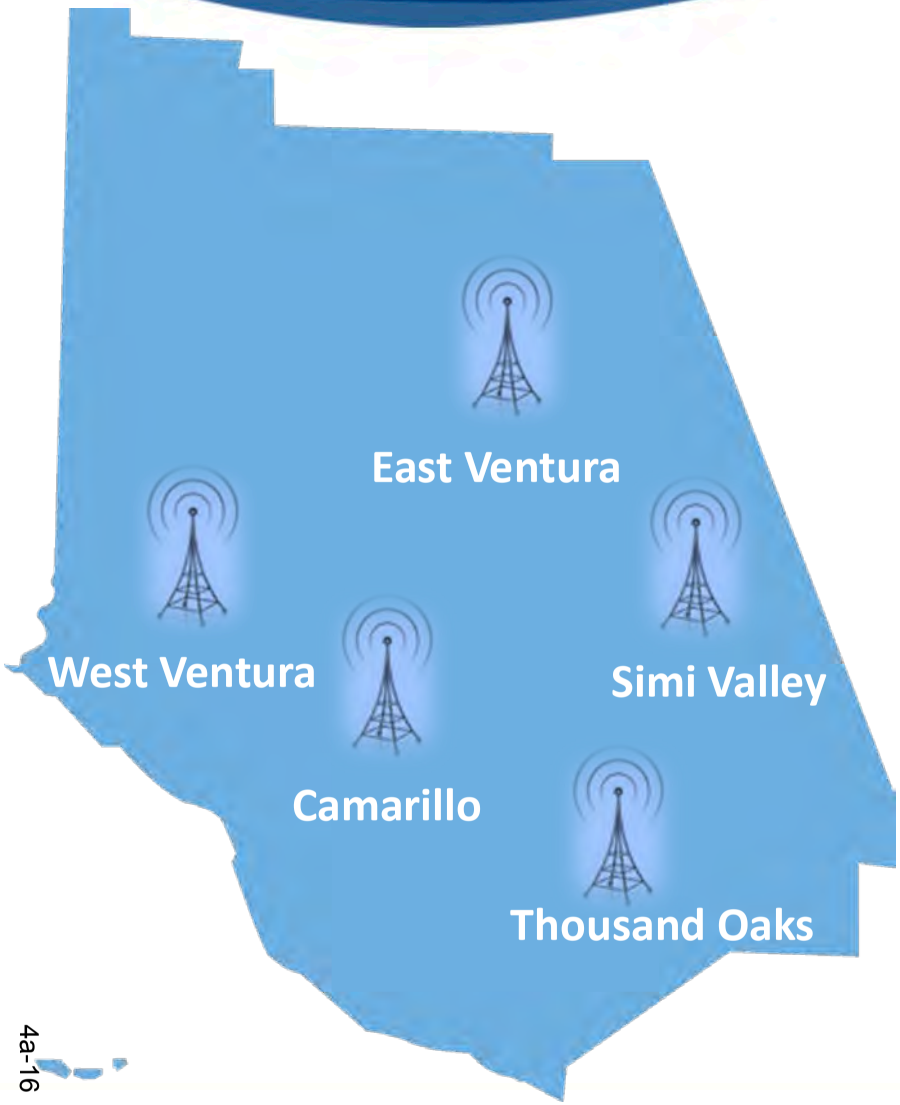
Spanish

* © Arbitron Inc.
The Media Rating Council (MRC) accredits this service.

Gold Coast Health Plan℠
A Public Entity

Radio Campaign

* Phase 2



- 9 Stations
- 33 :60 Commercials For 6 Weeks
- 198 Commercial/Station
- 1,584 Total Commercials
- 265,500 Listeners; Ages 12+ Avg 14.6x
- 3,876,300 Gross Impressions

English

Spanish

* © Arbitron Inc.
The Media Rating Council (MRC) accredits this service.

Newsprint Vendors

Ventura County Star

Vida

Gold Coast Health Plan℠
A Public Entity

Media Campaign

Television

Oct 2011 – November 2011

TV

Time Warner Cable

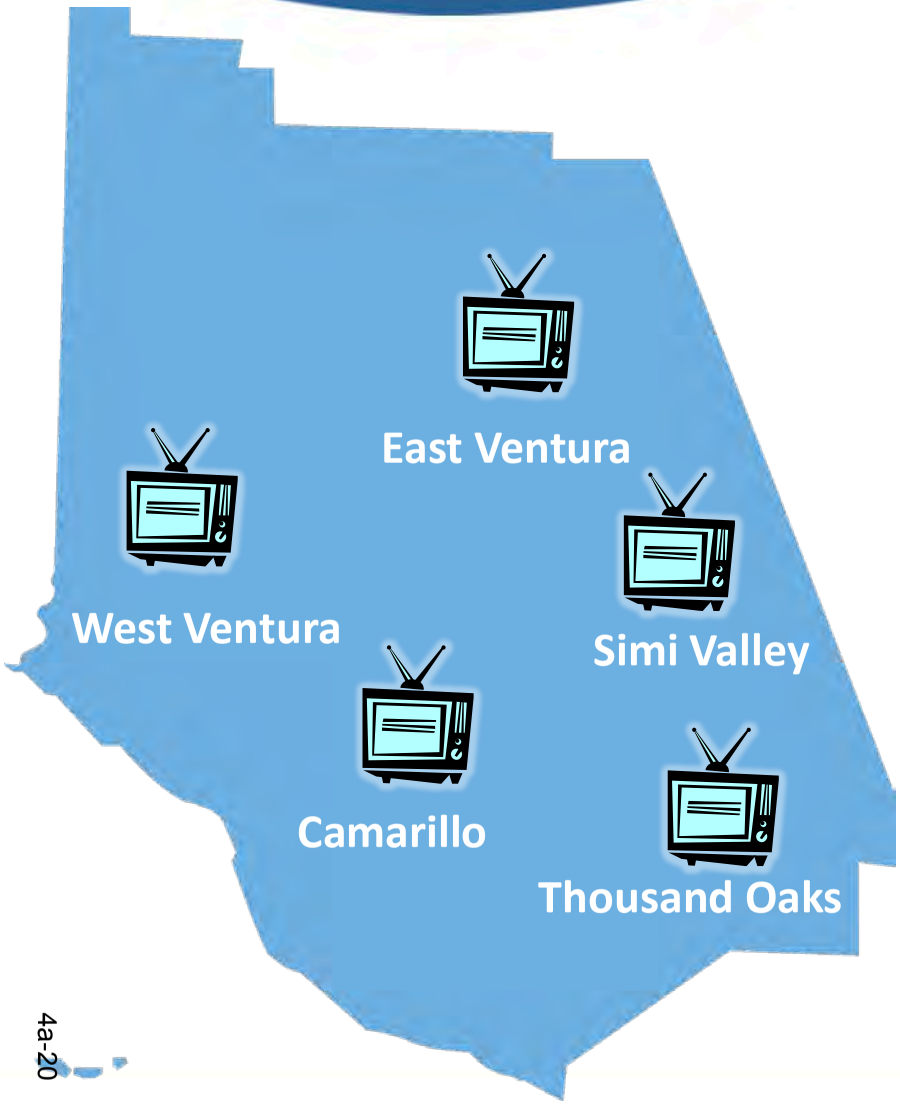
TNT
usa network
Galavisión
nick

Smith Media, LLC

KEYT 3
Santa Barbara
keyt.com

Gold Coast Health Plan℠
A Public Entity

TV Campaign



East Ventura
- Oxnard
- Port Hueneme
- Santa Paula
- Fillmore
- Piru
- Ojai
- Mira Monte
- Meiners Oaks

Thousand Oaks
- Newbury Park
- Casa Conejo
- Oak Park
- Agoura Hills
- Westlake

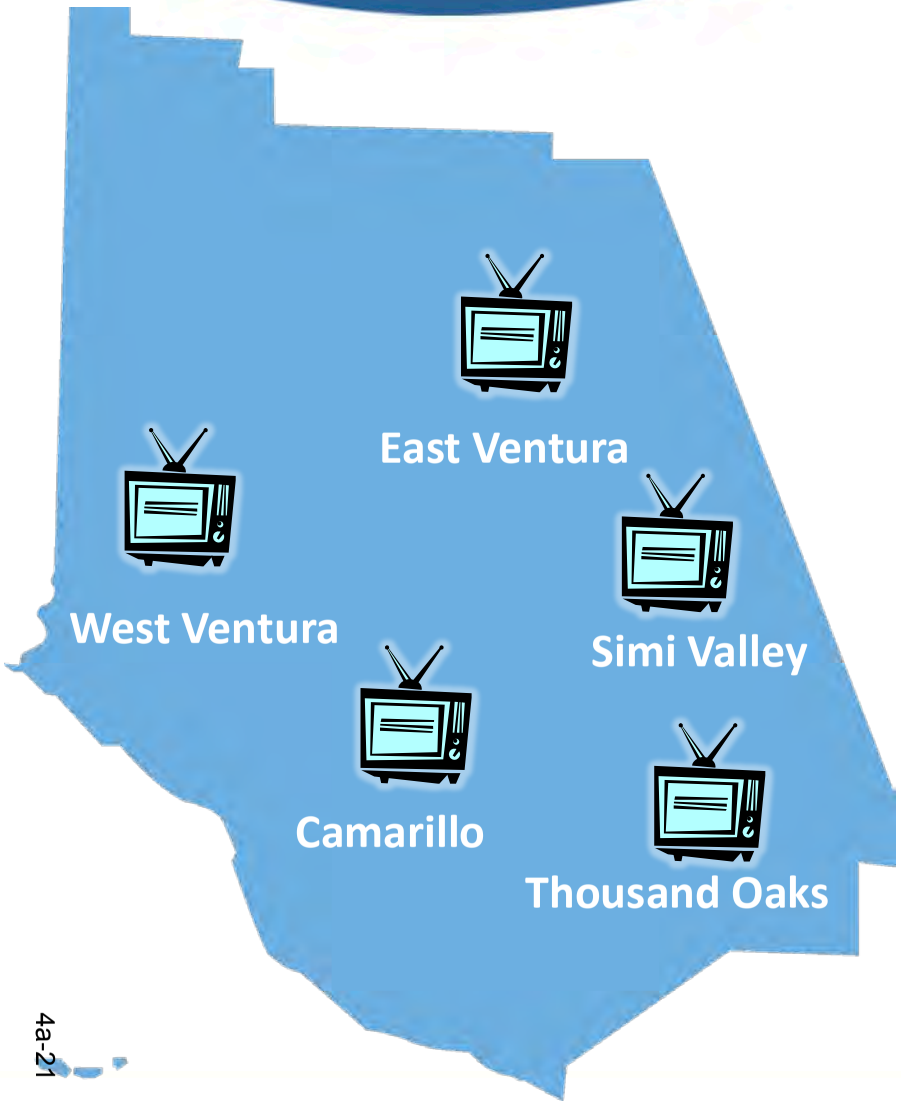
West Ventura
- Ventura
- Oak View

Camarillo
- Somis

Simi Valley
- Moorpark

Gold Coast Health Plan℠
A Public Entity

TV Campaign



* Phase 2

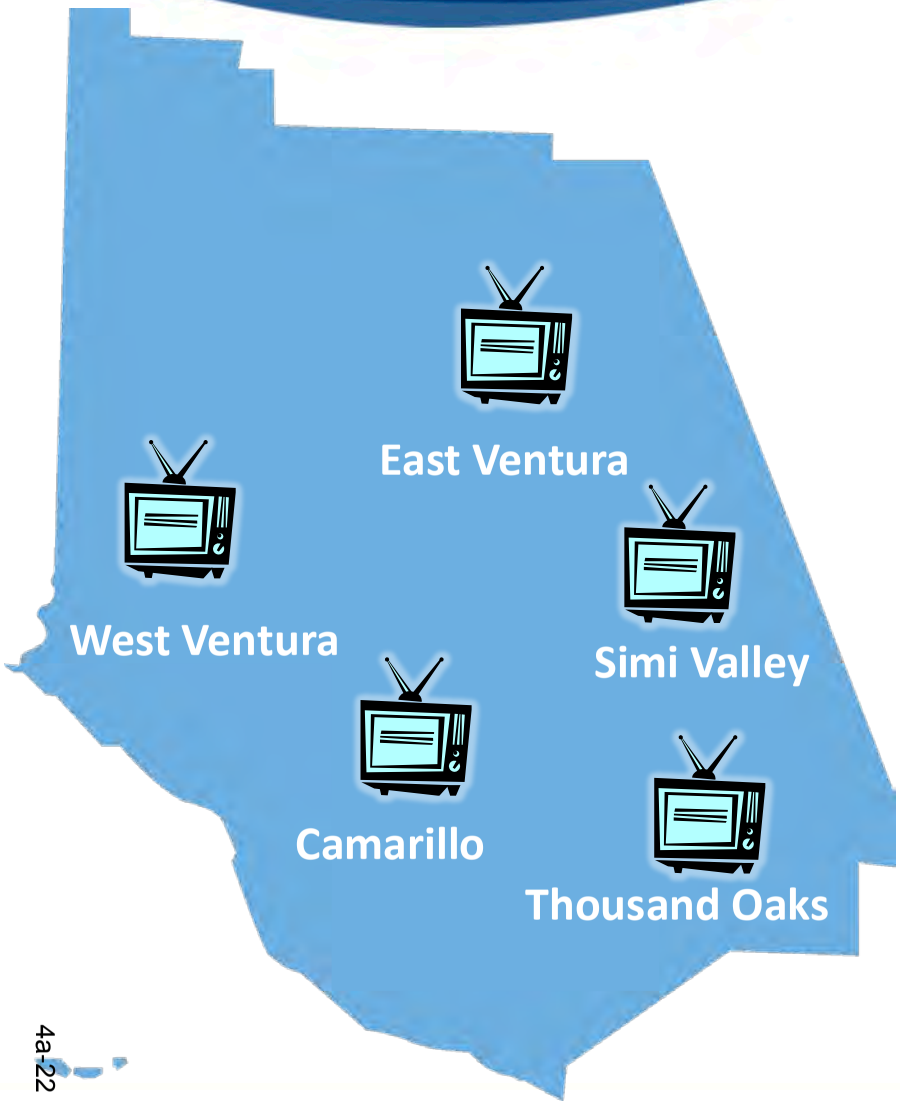
KEYT 3 Santa Barbara
keyt.com

- 19 :30 Commercials For 6 Weeks
- 114 Total Commercials
- 346,878 Viewers Ventura; Ages 18+ Avg 7.6x
- 1,211,888 Gross Impressions

* © Nielsen Audience Estimates

Gold Coast Health Plan℠
A Public Entity

TV Campaign



* Phase 2

- 307 :30 Commercials For 6 Weeks
- 1,839 Total Commercials
- 156,641 Subscribers; By Household
- 752,847 Gross Impressions

* © Nielsen Audience Estimates

AGENDA ITEM 4-B

To: VCMCMCC

From: Earl Greenia, CEO

Date: November 28, 2011

Re: Delineation of Authority

Recommendation: That the Commission approve a policy defining those actions reserved for the Commission and those actions delegated to Management.

Background:
Recent discussions highlighted the need to define the delineation of authority. It would be advantageous for the Commission to set specific guidelines as to what types of issues or items require Commission approval and what types of issues or decisions delegated to Management.

The policy would not impact or revise the type or number of issues brought to the Commission as informational items or reports. Adoption of this policy would not prohibit nor prevent the Commission from taking up any issue or item of its choosing to potentially take action on. The intent is to:

- Focus the Commission's attention on those issues of significance and importance,
- Maintain a balance between the Commission's oversight of Management activities, without "acting as Management," and
- Establish a documented and consistent policy and pattern of those issues to be considered by the Commission, and those issues to be delegated.

Discussion:
The attached policy was developed and discussed at the Executive-Finance Committee meeting on November 9, 2011 and is presented to the Commission for final review and ratification.

Delineation of Authority

1. The following types of actions are subject to Commission approval:

General

- Broad organizational policies relating to GCHP's mission, vision and values.
- GCHP Strategic Plan.
- Selection, termination and evaluation of Chief Executive Officer.
- Contracts or contract amendments with California Department of Health Services.
- Any specific action the Commission chooses to consider through motion and vote.

Legal

- Actions inherent as a body politic (organization, bylaw revisions, etc.).
- Actions relevant to the powers and responsibilities as specified in the enabling ordinance.
- Actions relating to potential or ongoing legal actions.
- Any action required of the Commission due to legal or contractual obligations.
- Agreements or commitments relating to or with State or federal regulators.

Financial

- Selection of Independent Audit Firm, with input provided by Management.
- Review and acceptance of Independent Audit Report.
- Review and acceptance of unaudited financial reports provided by Management.
- Annual Budget and subsequent re-forecasts if any.
- Investment policy

2. Any actions not specified as being the responsibility of the Commission are delegated to the CEO including, but not limited to:

- Negotiation and execution of provider contracts. As new model contracts are developed, Management will present such models to the Executive-Finance Committee as an informational item.
- Negotiation and execution of vendor contracts, subject to thresholds established by the Commission (Reference: “VCMMCC CEO Signing Authority for Contractual Agreements for Administrative Goods and Services,” approved on June 28, 2010).
- Authority to select, hire, evaluate, terminate and compensate all employees, including the Chief Medical Officer and Chief Financial Officer.
- Management will inform the Commission of changes in senior executive positions.
- Authority to establish and amend the staffing plan, provided that any changes to the staffing plan do not change the number of budgeted full-time equivalent employees by more than 10% and that the change does cause exceed the total budget.
- Management will develop a salary range schedule for each established position. While the schedule is not subject to Commission approval, it will be presented to the Commission on an annual basis as an information item.

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AGENDA ITEM 4-C

To: VCMCMCC

From: Earl Greenia, CEO

Date: November 28, 2011

Re: Vision Benefit Plan Vendor Selection

Recommendation: That the Commission authorize Management to proceed with contracting with Vision Service Plan (VSP) to administer GCHP's vision care benefits.

Background: As noted during the Commission meeting in August, given the complex nature of Medi-Cal vision care benefits, Management solicited competitive bids from various vendors (with Knox-Keene licenses) to administer this program. Discussion with other Medi-Cal Plans suggests that out-sourcing management of the benefit can be more cost-effective. This approach is similar to the use of ScriptCare to manage our pharmacy benefits plan.

Overview of Service

- GCHP would contract with the vendor and pay a fixed per-member, per-month premium.
- GCHP would delegate credentialing to a NCQA-certified vendor.
- The vendor would make effort to contract with all current GCHP optometrists.
- Services would be provided to our Members via this contracted network.
- The vendor would adjudicate claims, pay providers and provide reports to GCHP.
- Our ACS contract would be revised to eliminate this work from its scope.
- DHCS approval would have to be secured.
- GCHP providers and Members would be given advance notice of the changes.

Evaluation Method: All eleven California-licensed vision care plans were contacted. Seven do not work in the Medi-Cal market and were thus eliminated. The remaining four were interested in a possible contract and were solicited for proposals. Four complete bid proposals were received and were carefully evaluated on the factors of price, network adequacy, Medi-Cal HMO experience, capabilities, financial strength, reference checks, and value-added services. The objective analysis the proposals eliminated the two least-competitive proposals. The two finalists were asked for additional clarifications and face-to-face meetings. A unanimous decision was reached by the evaluation team (CMO, CFO, COO, Director of Provider Relations and Contracting) to recommend VSP as the Gold Coast Health Plan contract.

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For purposes of this report, all equal or nearly equal comparisons were eliminated such as credentialing practices, reporting capabilities, reference checks, network, project timelines, ease of administration, etc. Only differentiating factors are listed:

EVALUATION ELEMENT	VSP	MARCH VISION CARE
Membership Size	56 million	3 million
States with Plan Operations	50	16 and District of Columbia
Medi-Cal Experience	Medi-Cal COHS Plans: Partnership, CalOptima	Medi-Cal Plans: Molina, Alameda Alliance, etc.
Contract Terms on Rates	Two Years	One Year
Price to Gold Coast	$0.63 PMPM	$0.88 PMPM

Other considerations:

- VSP is an experienced leader in this industry.
- VSP has robust credentialing and reporting capabilities with excellent references.
- VSP's rate is lower than our historical costs as analyzed by our consulting actuary, Milliman.
- VSP has value-added extras such as preventive eye-care programs for our Members.
- VSP evidences excellent PCP and physician communication programs.

AGENDA ITEM 4-D

To: VCMCMCC

From: Earl Greenia, CEO

Date: November 28, 2011

Re: Claims Processing

Since go-live on July 1, both GCHP and ACS have worked diligently to complete the development and configuration of multiple systems, to provide medical management capabilities to efficiently and efficiently manage member care, costs and to ensure timely payment to providers.

To date, 71% of the claims submitted by providers have been paid; 16% have been in a pend or unpaid for 30 or fewer days; and the remaining 13% in a pend/unpaid status for more than 30 days. This has degraded stakeholder confidence, especially among providers. Management has voiced its concerns to ACS leadership; both parties have worked together to prioritize efforts and are working together to resolve the problems.

Claim processing delays have originated from both the paper and electronic submission of claims. There are two major root-cause of the problem:

- Mailroom Processing Delays
- System Pended Claims

<u>Mailroom</u>
The mailroom delay in processing paper claims has stemmed from technical challenges within ACS, including OCR (optical character recognition) limitations of scanning equipment, identification of claim and correspondence types for indexing and placement into the appropriate work queue, and supervisory deficiencies within the ACS mailroom.

GCHP and ACS have met on a daily basis, to remedy the significant backlogs. The mailroom backlog as of October 31, was 19,617 claims, with an earliest receipt date of October 11, 2011, By November 21, the backlog was reduced to 5,243 claims, with an earliest receipt date of November 11, 2011. This significant, favorable reduction is attributed to:

- Adding 22 more data entry operators to the ACS staff on November 1.
- Extending work schedules to Saturdays until backlogs are eliminated.
- Daily productivity and inventory monitoring by GCHP and ACS.
- Data-entry system enhancements.
- Increased auditing of data entry keying to ensure better quality.

We expect the mailroom backlog to be eliminated by December 5. Further, improved automation and loading of claims into the system have reduced the number of rejected claims, and enhanced automation and logic will have a material impact prospectively.

System Pended Claims

Upon entry of the claims into the claims processing system, several challenges have presented based upon specific pend codes, originating from both systemic and technical/functional causes. The top five pend codes are:

- 320 – Contract Not Found
- 813 – General Fee Schedule
- 204 – Unknown Modifier
- P10/208 – Invalid NDC Code
- 505 – Possible Duplicate Claim

Overall, the total pended claim population breaks down as follows:

- 49% can be worked by ACS without further input from GCHP
- 50% need further input and guidance from GCHP before further process (e.g., pricing and contract information)
- The remainder need to be jointly worked.

Of these top five identified pend codes, the first three have the most significant impact on operations. The 320 pend code, for example, impacts approximately 60-65% of providers, with the three largest provider systems accounting for an estimated 70% of the total pended volume.

The 320 pend code encompasses those claims where there is no ability to accurately identify provider payee information. In some cases, there may be inaccurate or missing provider data within the GCHP/ACS databases or missing data on the claim.

Working together, GCHP and ACS have formulated the following technical actions:

- Any group or professional submitting claims under the VCMC, CMH or Clinicas TIN will be considered PAR
- ACS will update workflows, complete train-the-trainer sessions on PAR provider loading and contract connections, and then train ACS specialists
- Any provider submitting claims under a TIN that is not on file will considered Non-PAR and claims will be worked by ACS in receipt order.
- Any provider submitting claims under a TIN that is on file and has all non-PAR contracts attached should be considered non-PAR and will be worked by ACS in receipt order
- Any provider or professional submitting claims under a TIN that is on file and has contracts attached (exclusive of VCMC, CMH and Clinicas) will be submitted to GCHP for contract review and determination of PAR/Non-PAR status.

Multiple system enhancements have been developed and entered into production by ACS to reduce the number of claims rejecting for the 320 pend. For example, the reject rate

prior to the enhanced logic implementation was approximately 43% on November 1; the rate is now approximately 23%. While this reduced reject rate will have a positive impact going forward, the manual review of the existing claims residing in this pend queue remains, and is a priority for both parties. Based upon current estimates of incoming claims volume and current staffing, GCHP expects the backlog to be within an acceptable and normal (e.g., within timeliness requirements) within thirty days.

The 813 pend code indicates that a price has not been established for a particular line item charge submitted by a provider – the majority are miscellaneous drug and medical supply items. We have identified 367 charge codes that do not have a Medi-Cal established price and are in the process of establishing the price. We expect to finalize the pricing logic by December 16.

The 204 pend code encompasses those claims where a valid modifier is not present on the claim. ACS estimated that 80% of the claims in this queue are erroneously pended for systemic issues. ACS expects to implement a system enhancement by November 30 to correct and then subsequently re-process the affected claims. The will be reviewed by ACS claims processing staff. Outreach to providers for billing errors will be undertaken by GCHP staff.

For the P10/208 pend codes, outreach to providers for billing errors and invalid NDC codes, appropriate and required for clean claims submission and timely processing.

Daily production/operations calls are held to discuss ongoing issues, including systemic and functional challenges by both parties, and to resolve both provider issues and pricing.

GCHP is increasing the Claims department staff by two employees to specifically triage and resolve claims issues as they arise, and to coordinate with ACS and the provider community to ensure direct communication and prompt resolution of issues.

Working with ACS, we expect the pend queues to be significantly reduced no later than mid-January.

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2012 Meeting Schedule

Black - No Meeting Scheduled
Commission Meeting (4th Monday of the Month) *
Executive Finance Committee Meeting (Wednesday before Commission *
*With exception of May due to Memorial Day

JANUARY

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DECEMBER

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