

1. \$42 Million dollars loss in Fiscal Year 2018-19, please explain; What caused the gap, and how are you going to fix it? The Medical Loss Ratio for this year was roughly 100%, what are the contributing factors? How will this be addressed next year?

Due to the Plan's initial financial challenges at go-live in July 2011, provider reimbursement rates had been kept low for many years. With Medi-Cal expansion through the ACA, there was an influx of members, and the rates paid to the Plan by the State were initially much higher than the costs. At the end of FY 15/16, Gold Coast Health Plan's Tangible Net Equity (TNE) had grown to \$156 million, 618% of the state requirement. In order to partner with the provider community and at the direction of the Commission, GCHP increased provider rates, with a major contract change effective July 1, 2017. Significantly increasing provider rates leads to financial losses as the increased costs do not get built into capitation rates from the State for between 2-3 years. For example, the rate increase that took effect in July 2017 will not fully be incorporated into GCHP's capitation rates until January 1, 2021. In November of 2017, GCHP staff informed the Executive Finance Committee that the TNE was on a downward slope and that it would be at 228% of the required by June 2019.

The FY18-19 budget was completed at a time where the most recent financial statements were April 2018, and at the time GCHP still had TNE of \$142.2 million (429% of the state required amount). The budget projected a \$12 million loss, and it was an amount that seemed reasonable given the increase in revenue that was being projected for FY 19/20. Several transactions happened late 2018 which required the June 30, 2018 financial statements to be adjusted, and lowered the TNE to an unanticipated level:

- \$12 million removed from the AE MLR as an allowable medical expense which was required to be paid back to the State.
- \$3 million audit adjustment due to the FY 17/18 Long Term Care rate increases not being properly built into the IBNP model which is the basis for estimating medical expenses.
- \$6.5 million settlement.

At the end of October 2018, after reflecting the prior year adjustments, the Plan's TNE had dropped to \$121.4 million, and 369% of the required. It was also at this time that the actual medical expenses started to exceed the budgeted amounts significantly. Excluding the directed payments which are offset by revenue, medical expenses through April 2019 are over budget by \$43.6 million. GCHP has spent a significant amount of time researching and drilling down into medical expenses and noted the following:

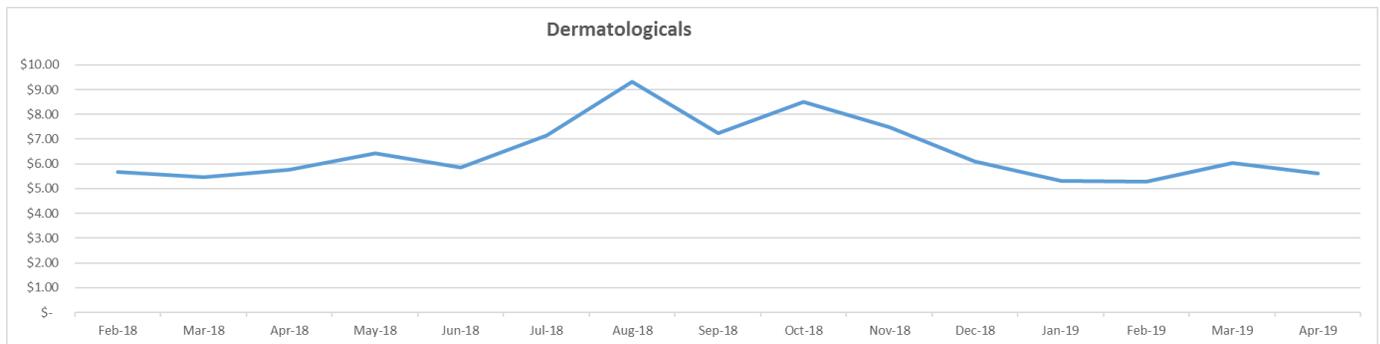
- The FY 18/19 budget was developed primarily based on CY 2017 data and it did not properly capture the impact of the contracting and other changes that had occurred in CY 2017. Based on my understanding, the following did not get reflected in the medical expense budget:

- Budget for Long Term Care – should have been at least \$3M more had it been correctly expensed in the IBNP model.
- A withhold for a provider was budgeted at net of withhold - \$2M.
- There were major contract changes effective July 1, 2017 so very little weight should have been put on the pmpm costs between 1/1-6/30/17, or an estimate should have been applied as to the impact. This would have increased the budgeted medical expenses by approximately \$15 million.

Had all of this been included, the **budgeted loss would have been approximately \$32 million.**

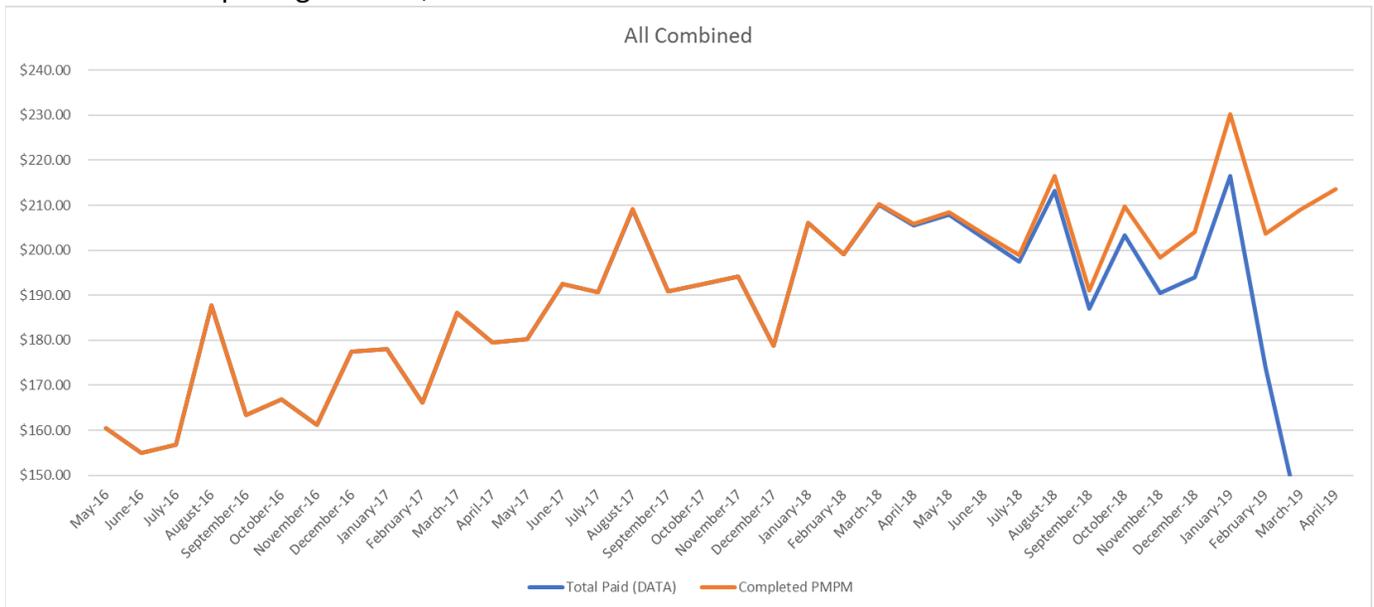
That said, there would have still been budget variances, given that the FYTD loss will exceed \$40M. As noted in prior meetings, the following contributed to the variances in the fiscal year:

- In CY 2017, dermatologicals as a component of Pharmacy expense was \$3.99 per member per month. FYTD through April, dermatologicals is \$6.80 per member month with a high of over \$9 per member per month in August 2018. This equates to an annual increase of almost \$6 million. The increase is attributed to one provider, and actions have been taken to reduce the expense. As noted, there has been a decline and the cost is remaining just under \$6 pmpm.



- The same provider noted above is also impacting Physician Specialty line item for dermatology. There was an almost \$500,000 increase in just 6 months.
- Increased benefits for behavioral and mental health, and overall ramp up in utilization. In CY 2017, the expense was \$5.51 pmpm, and in CY 2018 it was \$7.45 pmpm. That is an annual increase of almost \$2M.
- An increase in utilization for physical therapy which increased over \$600k in a 6 month period. This appears to be related to more members being referred to physical therapy as they receive behavioral health benefits.

- A significant increase of over \$1M annually in hospice services that have steadily increased as a result of the Palliative Care benefit mandated by DHCS effective 1/1/19.
- A spike in costs during the first quarter of 2019, mostly related to high dollar cases with the most notable diagnosis as sepsis. The attached graph represents the significant spike in March 2019, pmpm fee for service medical expenses increase from an average \$210 pmpm to \$230 pmpm; a one-month change equating to over \$4 million.



For the upcoming fiscal year, we improved the budget process to properly reflect any known changes. In addition, there is a 12% increase in our base revenue from DHCS. There is also a \$5M budget assumption of medical expense savings that will need to be achieved through contracting and other changes.

2. Tangible Net Equity has declined below commission’s approved policy; What are the significant investment projects? TNE requirement is 280%; this concerns me, please explain.

The projects are outlined on page 10 and 11 of the FY19-20 budget document. The most significant projects are already in progress and have been approved by the Commission. These projects are foundational to the plan, and while they are a current investment, they are critical to future success.

TNE is estimated to be at 280% of the DHCS required amount. While not optimal, it is still above the threshold for creating a regulatory issue.

3. What is happening with the Capitation Rate for the providers? How will it affect healthcare services to our membership if the capitation rate is reduced?

The budget does not incorporate a reduction to Capitation for the providers. That said, there is \$5 million of assumed medical savings built into the budget. Staff continues to explore ways to achieve savings while minimizing the impact to both members and the provider community. This is not an easy task, but as noted in question 2, the current TNE levels cannot continue to decline in the upcoming fiscal year.

4. What are the significant projects that GCHP is investing in to reduce future demands and requirements?

See page 10 and 11 of the FY19-20 budget document for explanations of the projects.

5. 2% increase of medical expenses and 92.5 medical loss ratio is another concern, please explain

There are various costs that GCHP does not control and must factor into the budget. These are outlined on page 3 of the budget document. The amount of medical savings to be achieved through contracting changes was minimized in order to limit any potential impact on the providers and members.

6. 204 FTEs; what is the distribution of GCHP personnel, for example per department and programs?; Are there any vacant positions that should not be budgeted?

There is a list of number of positions by department on page 7 of the budget document. GCHP has reviewed vacant positions and determined if it is feasible to eliminate them. We will continue to assess positions as they are vacated throughout the fiscal year. In some cases, we repurposed positions to a more critical area to limit the need to add more positions to the budget. GCHP has been conservative in adding new positions the past couple of years. GCHP cannot continue to meet the workload demands and increasing regulatory requirements if staff is reduced. Staff is actively looking to improve processes and maximize current resources to limit new hires in this upcoming fiscal year and beyond.

Also note, a 6% vacancy factor is built in to the budget to account for normal staff attrition.

7. What is the FTE Administrative Personnel Percentage consist of? 7.4% cost; is this correct?

Total administrative expenses, including projects, is 7.4% of the revenue. Salaries and related expenses are \$26.5 million or 3.4% of revenue.

8. Finally, \$776,443,373 is the total budget; GCHP ends up with \$1.5M; this concerns me, please explain

I need some clarification on this question which hopefully we have an opportunity to discuss. The estimated surplus is \$1.5 Million which is a very small margin on a significant budget. If medical expenses are 1% different than the estimates, it would be a \$5.7 million loss. In general, a surplus allows GCHP to rebuild reserves and position us invest back into the community.

9. What does BHT mean – Cash Flow?

Medi-Cal covers all medically necessary behavioral health treatment (BHT) for eligible beneficiaries under 21 years of age. This may include children with autism spectrum disorder (ASD) as well as children for whom a physician or psychologist determines it is medically necessary.

BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction, and promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD.

Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

Thank you for the questions, please let me know if I have fully answered them!