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

2240 E. Gonzales, Suite 200, Oxnard, CA 93036
Monday, August 26, 2013
3:00 p.m.

AGENDA

CALL TO ORDER / ROLL CALL

SWEAR IN OF NEW COMMISSIONER
Eileen Fisler

PUBLIC COMMENT

1. **APPROVE MINUTES**
   a. Regular Meeting of July 22, 2013

2. **APPROVAL ITEMS**
   a. Workers Compensation
   b. Dissolution of Committees
   c. CAC Member Appointments

3. **ACCEPT AND FILE ITEMS**
   a. CEO Update
   b. CMO Update
   c. June Financials

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

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

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

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba
Gold Coast Health Plan August 26, 2013 Commission Meeting Agenda *(continued)*
PLACE: 2240 E. Gonzalez, Room 200, Oxnard, CA
TIME: 3:00 p.m.

4. INFORMATIONAL ITEMS

a. FY2013-14 Regulatory Projects Update
b. Plan-to-Plan Updates *(Oral Report)*
c. Medi-Cal Legislative Update
d. AB 97 Update
e. Health Care Reform Update
f. Healthy Families Update

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on September 20, 2013 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

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

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

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

July 22, 2013

(Not official until approved)

CALL TO ORDER

Chair Gonzalez called the meeting to order at 3:08 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
May Lee Berry, Medi-Cal Beneficiary Advocate
Anil Chawla, MD, Clinicas del Camino Real, Inc.
John Fankhauser, MD, Ventura County Medical Center Executive Committee
Peter Foy, Ventura County Board of Supervisors (arrived at 3:15 p.m.)
David Glyer, Private Hospitals / Healthcare System
Robert Gonzalez, MD, Ventura County Health Care Agency

EXCUSED / ABSENT COMMISSION MEMBERS
Lanyard Dial, MD, Ventura County Medical Association
Laurie Eberst, Private Hospitals / Healthcare System
Robert S. Juarez, Clinicas del Camino Real, Inc.
Vacant Seat, Ventura County Medical Health System

STAFF IN ATTENDANCE
Michael Engelhard, CEO
Nancy Kierstyn Schreiner, Legal Counsel (arrived at 3:15 p.m.)
Michelle Raleigh, CFO
Ruth Watson, COO
Traci R. McGinley, Clerk of the Board
Charlie Cho, MD, Chief Medical Officer
Guillermo Gonzalez, Government Relations Director
Jenny Palm, Health Services Director
Brandy Armenta, Compliance Officer
Sherri Bennett, Provider Network Manager
Sonia DeMarta, Controller
Steven Lalich, Communications Manager
Lyndon Turner, Finance Manager

The Pledge of Allegiance was recited.

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

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of June 24, 2013

Commissioner Berry moved to approve the Regular Meeting Minutes of June 24, 2013. Commissioner Araujo seconded. The motion carried. **Approved 6-0.**

Commissioner Foy and Legal Counsel Kierstyn Schreiner arrived.

2. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Engelhard reviewed his report and highlighted several topics including: 1) The update on the timing of the new Medical Management System (MMS), the vendor believes can be up and running before the Plan's goal of January 1, 2014, which will allow side-by-side testing of the new and current systems; 2) The status of the Diagnostic Related Groups (DRG) rates implementation replacing the Rogers Rates that have been in use for non-contracted hospital rates; and 3) GCHP has outgrown its current locations and again started working with the previously selected real estate broker to locate needed office and meeting space.

CMO Dr. Cho reviewed the CMO Report portion of the CEO's report and noted that the pharmacy costs were lower in June than recent months, significantly due to the pharmacy Maximum Allowable Cost (MAC) adjustments for generic drugs. GCHP has received complaints from some pharmacies regarding those changes. The Plan is reviewing those items to determine if there are any issues other than pricing which is due to the delayed impact of managed care. Script Care is also researching these complaints and will be providing a report to the Pharmacy & Therapeutics (P&T) Committee at the end of the quarter. CMO Dr. Cho stressed that GCHP's MAC pricing is in line with other managed Medi-Cal plans MAC lists.

Ruth Watson, COO, provided the update on the Healthy Families Transition.

b. May Financials

CFO Raleigh noted that the financials are typically reviewed and approved by the Executive Finance Committee prior to the item coming before Commission; however, July's Executive Finance Committee Meeting was cancelled. She advised the Commission that the Plan is performing ahead of budget. GCHP has updated how costs are categorized in order to be more in line with how the State collects this data.

Discussion was held regarding health care costs; CFO Raleigh noted that additional medical services, as well as the non-emergency transportation services, have been capitated. GCHP will capitate services where possible and where it makes sense to do so. After CFO Raleigh reviewed the additional staffing requirements, discussion was held regarding how the addition of staff will reduce the Plan's historic use of consultants.

Discussion was held regarding Claims Inventory and the balance between paying vendors timely versus GCHP's cash on hand totals. Chair Gonzalez requested that Claims Inventory be included in the Commission package as well.

CFO Raleigh reviewed the May Pharmacy figures which were higher than April's results; however the utilization percentage of generic medication remained essentially the same.

GCHP believes medical expenses have gone up due to the higher than anticipated number of Healthy Families Members added each month, contributing to the costs over budget. However, due to the higher total number of members, health care costs spread across membership (on a PMPM basis) is lower than budget.

CFO Raleigh closed by noting that there has been a positive turnaround in the Tangible Net Equity (TNE), of approximately $10 million, since June 30, 2012.

Commissioner Chawla moved to approve the Accept and File Items as presented. Commissioner Glyer seconded. The motion carried. **Approved 7-0.**

5. INFORMATIONAL ITEMS

a. State Budget Update

Government Affairs Director Guillermo Gonzalez updated the Commission on the State Budget just approved by the Governor. Some adult dental, as well as basic mental health services have been restored. The Efficiency Factor and the limit of 7 doctor visits per year have been eliminated. The MCO tax rate for FY 2013-14 is $2.35%; going up to approximately 4% in the 2014-2016 budgets and will sunset at the end of FY 2016.

b. Health Services Update

Health Services Director Jenny Palm reviewed the written agenda report expressing that the Plan continues to work hard to lower total inpatient hospital bed days. Detailed case reviews are regularly done and a process was recently developed to track provider preventable conditions. Also, GCHP is continuing work with the MedHOK system vendor on the workflow and the many available needed functions of the system.

Further discussion was held regarding the number of bed days at in–County hospitals versus and out-of-county hospital bed days. Health Services Director Palm explained that the out-of-county stays are typically longer as they are mostly transplant or other higher acuity cases that cannot be treated at an in-county facility. Commissioner Araujo requested receiving information on Skilled Nursing Facilities (SNF) days as well.

c. CMO Update

CMO Dr. Cho reviewed his report noting that drug costs have been high, but the top 10 drugs by prescription are all in the generic category.

Chair Gonzalez noted that Vicodin has the largest use and asked if GCHP has data showing how many patients are utilizing this specific drug and the maximum quantity used per month. Such a report may show problem areas. CMO Dr. Cho responded that the Plan is attempting to identify cancer patients so those Members are not tracked in the same manner because their drug usage is different than other Members. Commissioner Araujo added that it would be helpful to know how many long-acting narcotics are prescribed. CMO Dr. Cho noted that the P&T Committee has been discussing that issue as well. The Pain Management Specialist believes long-acting pain medication should be utilized as well and these issues will continue to be discussed at the P&T Committee.

d. Plan-to-Plan Contract Approval Update

CEO Engelhard reviewed his written report providing the Commission with the background information. Due to the Corrective Action Plan (CAP) the State advised GCHP to cease work on the Plan-to-Plan. However, in a letter dated July 9, 2013, the State indicated that it would review Plan-to-Plan contracts on a case-by-case basis in the future.

Chair Gonzalez asked if there has been any further discussion of having the CAP removed. CEO Engelhard responded that it was his understanding that the State would review the CAP after the Plan has met the TNE requirements.

CEO Engelhard added that GCHP wants to see what the State will require for readiness from both sides. In a Plan-to-Plan arrangement, GCHP would become the “regulator” and would be held responsible by the State if there are problems with the plan-to-plan subcontractor. In addition, the State wants to ensure that GCHP has performed adequate due diligence to ensure that the subcontractor is ready to operate as a health plan and that it can meet the requirements of the Medi-Cal program. CEO Engelhard added that some readiness would be easy to complete since AHP is built on the Clinicas clinic system, but GCHP will still be required to evaluate that AHP can operate as a health plan. GCHP is still working with AHP on several contract points and is developing readiness tools that the State will review and augment as necessary. Locally, there may be a desire to move forward on this, but since GCHP is under a CAP, the decision to move forward depends upon the State.

Arnold Torres, Senior Vice-President of Government Relations, and Enrique De La Garza, CEO, of AmericasHealth Plan addressed the Board to express their support of a proposed full-risk, delegated contracted between GCHP and AHP. They ask the Board to support this request and for a letter of support from the Board as a whole, or a letter from the CEO and Board Chair.

Discussion was held as to readiness issues and how the Healthy Families program would affect the Plan-to-Plan with AHP. CEO Engelhard explained that GCHP staff will be spread too thin to have them go into effect at the same time. With regard to the readiness issues, CEO Engelhard explained that the State wants to see how GCHP will ensure that AHP will meet the terms of the contract.

Discussion was held regarding the restrictions the CAP places on GCHP and that it is imperative that GCHP is ready to move forward and that it financially moves in the right direction. CEO Engelhard added that if providers in the community do not receive payment due to AHP not being successful, the State would look to GCHP to make good on those payments. GCHP would have paid capitation to a subcontractor, and then would then be obligated to pay those providers as well. This is a financial risk of a delegated, capitated contract.

Commissioner Araujo noted that this process has been difficult and asked the CEO about possible pitfalls the Commission and Plan may have if it proceeds. CEO Engelhard responded that anytime there is a change there is a possibility that it may not work. In the short term, the Plan can delegate risk within the capitated amounts which assists the Plan with its financial stability. This could be an innovative model; an FQHC-based HMO is a fairly new operating model. From a member perspective to the degree that AHP brings different providers into the Medi-Cal program, it could be of some benefit to the people who choose to be in AHP. These are some of the potential benefits of this relationship which is most likely why the Commission decided to go in this direction more than a year ago and why the Plan continues to pursue the contract. CEO Engelhard continued explaining that there is always the oversight issue, if there are contract compliance issues it will take additional resources and time for GCHP to work through issues with CAPs and monitoring and oversight of the new health plan.

Commissioner Fankhauser requested that the agreement include language that ensures patients are not sent out of the County for specialty care that is available in the County in order to continue to support safety-net specialty care that has been developed.

Chair Gonzalez clarified that much of this is wrapped up in GCHP's CAP and there was the threat of GCHP not remaining viable. A lot of work has been done by staff to turn that around which puts GCHP in the position of potentially moving forward and AHP has requested a letter be sent from the entire Commission.

Legal Counsel Kierstyn Schreiner noted that in order to determine whether the Commission wants to send a letter to the State, the item would need to be agendized at a future meeting. After further discussion, Chair Gonzalez noted that a Special Meeting prior to August 7, 2013, may need to be scheduled. Legal Counsel Kierstyn Schreiner added that generally when the Chair makes a representation it is on behalf of the Commission and after a vote.

a. Healthy Families Transition / Outreach Update

COO Watson reviewed the report and updated the Commission on the transition. The majority of individuals in the Healthy Families program are not GCHP's members until August 1, 2013. GCHP will not have time to fully test the system because it will not receive membership information until a few days before the transition. GCHP is trying to go above and beyond to help members choose providers so members do not fall into auto-assignment. Some of these new members have been seeing physicians that are not willing to contract with GCHP. Kaiser will be a straight transfer and the County does not assign PCPs. GCHP will be utilizing the Health Resources and Services Administration (HRSA) method and will look to see if members have seen a provider in the last twelve months. The next step would be to link them to any family members. GCHP will temporarily add six bilingual staff in the call center and have longer hours in order to assist Members through this transition.

COO Watson added that to reach out to providers, GCHP has scheduled town hall meetings, meetings with hospitals and clinics, as well as outlined changes in the provider newsletter. GCHP has also done radio spots reminding Members of the transition and the changes, there will also be ads once it has changed.

COMMENTS FROM COMMISSIONERS

None.

CLOSED SESSION

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

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 5:09 p.m. regarding the following items:

Closed Session Conference with Legal Counsel – Anticipated Litigation significant exposure to litigation pursuant to Government Code section 54956.9. (One Case)

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 5:23 p.m.

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

ADJOURNMENT

Meeting adjourned at 5:26 p.m.

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AGENDA ITEM 2a

To: Gold Coast Health Plan Commissioners

From: Michelle Raleigh, Chief Financial Officer

Date: August 26, 2013

Re: Ratification of Workers Compensation Contract

SUMMARY:
Gold Coast Health Plan's (GCHP) contract with The Hartford for workers compensation coverage expires on August 31, 2013. The Plan's insurance broker, Beecher Carlson, has prepared a proposal of options for coverage year (CY) 2013-14. GCHP staff presented the analysis and recommendation to the Executive / Finance Committee on August 1, 2013. The Executive / Finance Committee authorized the Plan to continue Workers Compensation coverage through The Hartford. The Plan is requesting ratification from the Commission.

BACKGROUND / DISCUSSION:
GCHP began utilizing The Hartford to provide workers compensation coverage on September 1, 2012 when it terminated its agreement with Regional Government Services for human resources and payroll services.

The Hartford's annual contract expires on August 31, 2013. Therefore, Plan staff requested that Beecher Carlson, obtain bids from workers compensation carriers. Bids were obtained from two carriers with key premium information summarized below. Note the base rates have decreased in the new CY due to reclassification as an administrative organization.

	Projected Payroll Expense $5,458,208		Estimated Payroll Expense $11,163,917	
Coverage Year	**9/1/12 - 8/31/13**		**9/1/13 - 8/31/14**	
	The Hartford		**The Hartford**	**State Fund**
Cost				
Estimated Annual Premium	$84,600		$93,800	$118,400
Base Rate (per $100 PR)	$1.55		$0.84	$1.06
Coverage				
Bodily Injury By Accident - Each Accident	$1,000,000		$1,000,000	$1,000,000
Bodily Injury By Disease - Policy Limit	$1,000,000		$1,000,000	$1,000,000
Bodily Injury By Disease - Each Employee	$1,000,000		$1,000,000	$1,000,000

The Plan recommends continuing coverage with The Hartford because:

- They offer lower estimated annual premium for equivalent coverage level and
- It is administratively simpler to continue coverage with an existing carrier.

FISCAL IMPACT:
Premiums will increase by approximately $9,200 ($93,800 - $84,600) for CY 2013-14 when compared to CY 2012-13, driven by higher payroll expenses.

RECOMMENDATION:
Staff requests that the Commission ratifies the Executive / Finance Committee recommendation of continuing the workers compensation insurance with The Hartford Company for CY 2013-14.

CONCURRENCE:
Executive / Finance Committee

Attachments:
N/A

AGENDA ITEM 2b

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, Chief Executive Officer
Traci R. McGinley, Clerk of the Board

Date: August 26, 2013

RE: Committee Designations (Dissolution of Committees)

SUMMARY:
On June 25, 2012, the following committee structures were presented to the Commission: Executive / Finance Committee, Compliance Committee, Consumer Advisory Council (Consumer Advisory Committee), Physician Advisory Council (Provider Advisory Committee), Audit Committee, Compensation Committee and the Quality Improvement Committee .

BACKGROUND / DISCUSSION:
There are two types of advisory committees in which a legislative body can establish to give input to business matters.

An "advisory committee" (i.e., a committee composed solely of less than a quorum of the members of the legislative body) that has a continuing subject matter jurisdiction is a **standing committee**, whereas an advisory committee without a continuing subject matter jurisdiction is an **ad hoc committee**. Ad hoc committees are exempt from the Brown Act's meeting requirements (Government Code § 54952(b). However, standing committees must comply with the Brown Act's requirements for meeting notices and agenda, must be open to the public, and the public must be allowed to comment during the meeting.

The longer an ad hoc committee is in place, the more it becomes questionable whether it is a standing committee or an ad hoc committee. There is little guidance available on the length of time an ad hoc committee may be in place. However, it is good practice that an ad hoc committee should not be in place longer than six months. The California Attorney General has given the following example as a proper ad hoc committee:

> "Advisory committee comprised of two city councilmembers for the purpose of producing a report in six months on downtown traffic congestion: This committee is an exempt advisory committee because it is comprised solely of less than a quorum of the members of the city council. It is not a standing committee because it is charged with accomplishing a specific task in a short period of time, i.e., it is a limited term ad hoc committee."
> (Office of the Attorney General, Guide to the Brown Act (2003), p. 6.)

The Commission currently has two ad hoc committees (i.e. Audit Committee and Compensation Committee) and five standing committees (i.e. Executive / Finance Committee, Compliance Committee, Consumer Advisory Committee, Provider Advisory Committee and the Quality Improvement Committee).

As a requirement of the enabling ordinance and DHCS, the Plan must have the Executive / Finance Committee, Provider Advisory Committee and the Consumer Advisory Committee, therefore those standing committees will continue.

FISCAL IMPACT:
None.

RECOMMENDATION:
The Audit Committee only has a single member and therefore it is recommended that Audit Committee activities be consolidated in the Executive Finance Committee duties.

The Compensation Committee met in 2012 to establish pay grades and ranges for the Plan. That work is complete. If pay grades / ranges need to be updated, a new Ad Hoc can be assembled for such a purpose.

Compliance Committee work will be replaced with quarterly updates to the Full Commission by the Plan's Compliance Officer.

Therefore, staff recommends that the Commission disband the following three ad hoc committees: Audit Committee, Compensation Committee and the Compliance Committee as they are over six months old and would otherwise be required to be designated as standing committees.

CONCURRENCE:
N/A

Attachments:
Resolution Dissolving the Audit Committee, Compensation Committee, and the Compliance Committee.

RESOLUTION NO. _____

A RESOLUTION OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION dba Gold Coast Health Plan DISSOLVING THE AUDIT COMMITTEE, COMPENSATION COMMITTEE AND THE COMPLIANCE COMMITTEE

WHEREAS, the Compliance Committee, Audit Committee and the Compensation Committee were created on June 25, 2012; and

WHEREAS, ad hoc committees are created to perform a specific task in a relatively short period of time and should be dissolved when the task is completed and the final report is given and are composed solely of less than a quorum of the legislative body; and

WHEREAS, standing committees must comply with the Brown Act's requirements for meeting notices and agenda, must be open to the public, and the public must be allowed to comment during the meeting.

WHEREAS, the Audit Committee, Compensation Committee and the Compliance Committee were created as ad hoc committees; and the Commission desires to disband said Committees; and

WHEREAS, should the need arise, ad hoc committees could again be created to address these issues; and

NOW THEREFORE, BE IT RESOLVED, that the Commission hereby resolves to disband the Audit Committee, Compliance Committee and the Compensation Committee.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan at a regular meeting on the ____ day of August, 2013, by the following vote:

AYE:
NAY:
ABSTAIN:
ABSENT:

_____
Robert Gonzalez, Chair

Attest:

_____
Traci R. McGinley, Clerk of the Board

AGENDA ITEM 2c

To: Gold Coast Health Plan Commissioners

From: Luis Aguilar, Manager Member Services

Date: August 26, 2013

Re: Consumer Advisory Committee

SUMMARY:
The first two-year term of the Consumer Advisory Committee (CAC) ended with the June 12, 2013 meeting. In order to stagger the seats so all positions do not end at the same time in the future, it is recommended that this year four of the seats be appointed for only a one year term. Vacancies are filled by the Commission for the remainder of the unexpired term.

The Plan recruited new members for the CAC through means of advertising on the GCHP website, outreach to various organizations and recommendations from current board members.

BACKGROUND / DISCUSSION:
Ventura County Board of Supervisor's enabling ordinance (Ordinance No. 4409, April 2010) and the California Department of Health Care Services, Medi-Cal Managed Care Division, required the establishment of a member / consumer based committee. This committee meets at least quarterly and makes recommendations, reviews policies and programs, explores issues and discusses how the plan may fulfill its mission. The Commission established the Committee size as ten members: with two permanent seats; one for the Ventura County Health Care Agency (VCHCA) and one for the Ventura County Human Services Agency. Each of the appointed members, with the exception of permanent seats, would serve a two-year term, and individuals could apply for re-appointment as there are no term limits. The constituencies are:

- Foster Children
- Medi-Cal Beneficiaries
- Chronic Medical Conditions
- Persons with Disabilities and Special Needs
- Seniors
- County Health Care Agency
- County Human Services Agency

Following is a brief biography on the two members which hold the permanent seats:

County Human Service Agency – Permanent Seat – No Term Limit

Curtis S. Updike currently serves as the Deputy Director of the Ventura County Human Services Agency where he oversees Medi-Cal and CalFresh (formerly known as Food Stamps) eligibility determination. Prior to his selection as Deputy Director in 2005, he served as manager of the County's East County Intake and Eligibility Center from 2002 to 2005. The East County IEC processes intake and continuing cases in Medi-Cal and Food Stamps. Before joining HSA, he served as the Chief of Staff for County Supervisor Kathy Long and Field Deputy for Supervisor Maggie Kildee. Curtis Updike holds an Associate's degree in Business, a Bachelor's in Mass Communications and a Masters in Public Administration.

County Health Care Agency – Permanent Seat – No Term Limit

Ruben Juarez works as a Community Service Worker in the County of Ventura Public Health Agency. His primary responsibilities include facilitating monthly parent meetings at schools and agriculture farms in Oxnard, Camarillo, Somis, and other rural regions. Ruben interviews, translates and assists Spanish monolingual parents with completing applications for health care coverage. Ruben Juarez is a member of the Ventura County Head Start Health Advisory Committee. A long- time resident of Oxnard, Mr. Jurez has a unique understanding of the challenges parents face in accessing and using the Medi-Cal Program.

Three additional members of the committee have requested to remain on the committee. Following is a brief biography on those members along with the seat they hold and the length of term proposed this cycle:

Seniors – 2 Year Seat

Katharine Raley is the HICAP Program Manager for the County of Ventura Area Agency on Aging. She holds an AA degree in liberal arts with emphasis on healthcare and psychology. She has over forty years of experience working in healthcare, as a medical office manager, and medical assistant for family and specialty medical practices. In September of 2006, she was awarded the Social Security Administration Regional Commissioner's Citation for providing community education on the new Medicare Prescription Part D Plans and Low Income Subsidy Program to Ventura County Medicare and Medi-Cal Beneficiaries. She states, "I always make time for projects that will help our senior population."

Foster Children – 1 Year Seat

Frisa Herrera has been employed at Casa Pacifica since March 1999, as both the Clinic Administrator and Medi-Cal biller. Casa Pacifica serves abused, neglected, and severally emotionally disturbed children and adolescents from the tri-county regions of Southern California. Frisa has a unique understanding and familiarity with the needs of foster children. She is deeply committed to serve the needs of foster children and it is her stated goal to, "be the voice for the foster community in Ventura County."

Medi-Cal Beneficiaries – 1 Year Seat

Norma Gomez has worked as an interpreter, educator, and case manager with the Mixteco Indigena Community Organization Project (MICOP) in Oxnard since 2000. As an educator to the Mixteco Community, she leads workshops and group activities to provide information on nutrition, health, and parenting. She also provides case management and conducts follow-up home visits with the Mixteco Community. She assists Mixteco residents with completing applications for disability, unemployment, school, Medi-Cal, Food Stamps, passport applications, etc. Norma facilitates, "Aprendiendo con Mama y Papa" (Learning with Mother and Father), educational workshops for Mixteco and Latino migrant farm worker children.

GCHP received five new applications for the remaining five seats. Staff proposes the following applicants be approved for the listed seat and term:

Persons with Disabilities – 2 Year Term

Lilliana Coria is currently employed with The ARC of Ventura County. She has over 10 years working with individuals and families of adults with developmental disabilities. Her education background includes a Bachelor's Degree in Sociology and a Master's Degree in Psychology – Marriage and Family Therapy. Lilliana has assisted with coordinating volunteer sites for The ARC such as Food Share, Senior Garden, the Rescue Mission, etc. She also takes part in the health resource fairs answering questions and explaining resources available.

Medi-Cal Beneficiaries – 1 Year Term

Rita Duarte-Weaver has been working for the Ventura County Public Health Department Rita for the last 13 years. As part of her employment she conducts regular outreach on Medi-Cal and Health Care for Kids program for the last 11 years. Rita has extensive knowledge of Medi-Cal and how to assist our population.

Beneficiaries with Chronic Medical Conditions – 1 Year Term

Pedro Mendoza is employed by the Tri-Counties Regional Center as the Benefits Coordinator. He is currently working in building relationships with community resources to work together to best serve the families at Tri-Counties. Pedro assists families with SSI, IHSS, Medi-Cal and issues they may have with services. Pedro works with the Area Board 9, Consumers Rights Advocates and Family Resource Centers to put on seminar for the families he serves.

Persons with Special Needs – 2 Year Term

Laurie Jean Jordan works for the Rainbow Connection FRC at the Tri-Counties Regional Center. Laurie has been with the Rainbow Connection for over 20 years providing information, training and support for children and adults with developmental disabilities and their families. Laurie also serves as a community representative on the Policy Topics subcommittee for the state ICC for Early Start. She is currently the secretary for the Community Advisory Committee for the Special Education Local Plan Area and on the Children's Services Committee of the Mental Health Board.

Medi-Cal Beneficiaries – 2 Year Term

Alicia Flores is the CEO of La Hermandad which is an organization whose mission is to address the legal, social, education, and economical inequities facing immigrants, their families, youth and the senior population. Alicia and her organization are strong advocates for their population. Alicia Flores is also an Accredited Representative by the Board of Immigration Appeals and belongs to the Congress of California Seniors.

RECOMMENDATION:

Staff requests that the Commission appoint the Consumer Advisory Committee as described above.

CONCURRANCE:

N/A

Attachments:

Committee Applications

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AGENDA ITEM 3a

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, CEO

Date: August 26, 2013

Re: CEO Update

Department of Health Care Services (DHCS)

On July 25, 2013, DHCS requested additional information from the Plan in regards to its FY 2013-14 Financial Forecast. The Plan provided updated, detailed financial forecasts for the 07/01/13 – 06/30/14 time period with varying assumptions based on the request to provide three scenarios: best, intermediate and worst case scenarios.

The CEO attended the quarterly Medi-Cal Managed Care Division All Plan CEO meeting on Tuesday August 20, 2013 in Sacramento. The meetings are designed to facilitate a two-way dialogue between DHCS leadership and Medi-Cal managed care plan CEOs. The agenda included the following topics:

- Encounter Data Improvement Project
- Health Plan Performance
- Rates
- CalHEERS Outreach for Medi-Cal Expansion and Covered California
- Mental Health Managed Care Benefits
- Medi-Cal Behavioral Integration
- MCO Tax
- Bridge Plan Proposal in California
- Implementation of Healthcare Acquired Conditions Rules

Other topics not germane to GCHP included updates on Rural Expansion update and the Coordinated Care Initiative (Cal MediConnect delayed until April 1, 2014).

Compliance

Gold Coast Health Plan (The Plan) underwent an onsite medical audit, conducted by audits and investigations in December 2012. The audit period reviewed was November 1, 2011 thru October 31, 2012. Given the audit period, many of the findings were self-identified by The Plan and were in the process of being corrected or resources being identified needed to correct areas of risk. The Plan's response is currently under review by DHCS and pending final review and approval. The Plan anticipates receipt of a final letter from DHCS that outlines definitive findings and timelines. The Plan anticipates being in receipt of the letter by end of August contingent upon DHCS workload.

Delegation Oversight is currently redefining processes. The Plan utilized a third party vendor Provencio Advisory Service (PAS) to evaluate our existing delegation oversight process. Phase one included credentialing and multispecialty contract. Phase one of their reviews has been concluded and based upon feedback the Plan is redefining and developing improved oversight functions. The Plan anticipates implementing some of the areas PAS identified based on their analysis that included: document requests from delegated groups, interviews with Plan staff, interviews with delegated groups and their professional expertise. Some of the areas the Plan will launch in the near future include but are not limited to: Annual audit schedules (communicated on an annual basis to delegated partners), increase in communication, and enhanced reporting. Delegation oversight staff will implement a new required report for delegated credentialing, the quarterly ICE tool.

Compliance staff continues to attend and is an active participant on the quarterly anti-fraud meetings held by the Department of Justice. Staff actively reports suspected fraud, waste and abuse cases to DHCS in accordance with the contract between GCHP and DHCS. Compliance staff has revised notice of privacy practices to ensure compliance with the Omnibus rule and this will be posted on GCHP website and will be mailed out to members.

HITECH Omnibus Project

January 2013 ushered in the final rules of the Health Insurance Portability and Accountability Act (HIPAA) enacted in 1996, and the Health Information Technology for Economic and Clinical Health Act (HITECH) introduced in 2009 as part of the Stimulus Bill. The 2013 HITECH Omnibus "Megarule", passed January 23, 2013 and effective March 27, 2013 has a compliance deadline of September 23, 2013.

The final rule provides for the following:

- Enhanced patient privacy protections
- Provides individuals new rights to their health information
- Strengthens the government's enforcement and application of penalties under the law through the expanded definition of a business associate (BA), making BA's liable for impermissible uses and / or disclosure of PHI, and tiered penalty structure for noncompliance

With the September deadline approaching, here is a review of what GCHP has been working on to meet the revised requirements:

1. Update GCHP Notice of Privacy Practice (NPP) to comply with final privacy rule - Complete
2. Update GCHP Business Associate Agreement (BAA) to comply with final privacy rule - Complete
3. Update GCHP infrastructure and computing equipment to comply with final rule - In Progress; on-track to complete by September 23, 2013.
4. Review and revise privacy and security policies and procedures to comply with the final rule - In progress; on-track to complete by September 23, 2013.

Affordable Care Act – Increased Medicaid Payment for Primary Care Physicians

On July 28, 2013, Medi-Cal released the Self-Attestation form, instructions and eligibility requirements on the Medi-Cal Website:

http://files.medi-cal.ca.gov/pubsdoco/aca/aca_form_landing.asp.

Eligible providers are required to self-attest prior to receiving the enhanced rates; the time-frame for this process has not been established yet by DHCS. GCHP will extract information from this provider database at the end of September and will use this data to determine which providers qualify for increased payments.

It is important to note that GCHP is required to provide payment directly to the eligible ***rendering*** provider. Therefore, all self-attesting providers must provide the Plan with a "*W9*" and complete the "*GCHP ACA Provider Information Form*" in addition to completing the Medi-Cal Self-Attestation process with DHCS. The "*GCHP ACA Provider Information Form"* and "*W9*" can be found on the GCHP website at www.goldcoasthealthplan.org.

Payment to providers that have met the aforementioned criteria will be made once GCHP receives payment from DHCS (anticipated in the fall). Initially, providers will receive a one-time true-up payment, retroactive to January 1, 2013; all subsequent payments will be made monthly. An explanation of payment, detailing the date of service, type of service, and amount of the increase will be sent with each check. .

DHCS requires all plans to submit a compliance plan by September 30, 2013 showing how the enhanced payments will be paid to the rendering physicians. GCHP has developed a plan that meets all of the DHCS' requirements. This compliance plan was presented to the Provider Advisory Committee (PAC) on August 20, 2013 for review and comment before submittal to DHCS for final approval.

The Plan has been diligent in providing updates to the provider network as they become available. Town Hall meetings were held in April and in July / August outlining the eligibility requirements, as well as providing instructions on how to self-attest. GCHP has included monthly updates in the Provider Operations Bulletin and Provider Relations Representatives have visited contracted provider offices to keep providers apprised of updates and informed of the State's requirement that providers must complete the self-attestation process with DHCS in order to receive the additional payments.

Quality Improvement (QI) Report

The QI Department is in the process known as the "Summer Run" of Healthcare Effectiveness Data and Information Set (HEDIS) data. This run will provide us with the data used for HEDIS from January 1-June 30, 2013 and will give us results for each measure using just claims / encounter data.

The reason this is important is that it will tell us where the Plan is meeting targets and where the Plan is not meeting target for the 2014 HEDIS data submission of the Plan's 2013

data. The Plan can work with providers to address the lack of information or documentation should one exist. Although this process does not give us medical record abstracted data, the goal is to try to get as many data "hits' through claims and encounter data relieving the burden of chart review from both the provider, who has to give us the medical records, and the Plan that has to review them.

Simultaneously, the HEDIS 2013 data submission, which is the Plan's 2012 data, should be finalized and ready for presentation by October 2013, which will establish the Plan's baseline performance results. The overall objective is to consistently demonstrate improvement with all the clinical measures.

GOVERNMENT AFFAIRS UPDATE

Affordable Care Act and Medicaid Expansion

This topic will be discussed in a presentation provided by Gold Coast health Plan's (GCHP) CEO, Michael Engelhard. In summary, as a result of Medicaid expansion under the Affordable Care Act (ACA), the transition of the Healthy Families Program to Medi-Cal managed care, ACE Program and uninsured enrollment, GCHP's total enrollment is expected to increase forty-five to fifty percent from the 98,000 members the Plan had in December 2012 to approximately 148,000 members by the end of 2014 and beyond.

Healthy Families Transition Monthly Monitoring Report to the Legislature

Also on August 15th DHCS released its monthly monitoring report, as required by the State Legislature, on the Healthy Families Transition to Medi-Cal for the period of July 1 through July 30, 2013. According to the report, of the 846,016 children enrolled in the Healthy Families Program, a total of 614,495 have transitioned into a Medi-Cal managed care plan through June 2013.

Healthy Families Transition to GCHP and Medi-Cal Managed Care

GCHP staff are conducting new member orientations, and contacting families via telephone to assist them and ensure a smooth transition to GCHP. Also GCHP has run radio announcements in English and Spanish to raise awareness concerning the transition to Medi-Cal managed care. Staff is also collaborating with community and agency partners to reach out to families impacted by the transition.

Integration of Mental Health Benefits Into Medi-Cal Managed Care

As mandated by the federal Affordable Care Act, beginning January 1, 2014 all health plans, including those in Medi-Cal managed care, will be required to offer ten essential health benefits. One of the ten benefits includes mental health and substance use disorder services. The California Association of Health Plans (CAHP) has requested that DHCS clarify and establish responsibilities between the Medi-Cal plans and county mental health providers.

According to CAHP, level of care and severity classifications present a challenging workflow process for which clear obligations and coordination processes must be established between plans and county mental health prior to the benefit going into effect. Plans are concerned that

the short implementation timeline i.e. January 1, 2014 will be difficult for plans to meet due to the administrative and procedural changes that plans must make to accommodate the demand for such services. A workgroup consisting of health plan executives and DHCS management has been established to develop recommendations for a successful integration of mental health and substance use disorder services

Medi-Cal Legislation

See GCHP Government Affairs Legislative Update Report.

AGENDA ITEM 3b

To: Gold Coast Health Plan Commissioners

From: Charles Cho, MD, CMO

Date: August 26, 2013

Re: CMO Update

PHARMACY UPDATE

When the MAC update for pharmacy reimbursement was implemented in June of 2013, the total PMPM costs dropped to $28.18 from the previous month of $35.06 (per ScriptCare reports). This trend is continuing into July, 2013 where the total PMPM was at $28.48, in spite of heavy use of expensive specialty drugs (anti-neoplastic and anti-rheumatic medications) in the top 10. These 4 specialty drugs, Gleevec, Carimune, Neulasta, and Humira, alone cost $204,768 in July per the Top 10 Drugs by Dollar report.

The Top 10 drugs by Rx (number of prescriptions) are again all generics, which continue to show good prescribing pattern by our network physicians. The number one drug being prescribed is the short acting pain narcotic, Hydrocodone / APAP (Vicodin and Norco), with the number of scripts at 2,986. This far outdistances the number two drug, Metformin, a diabetic medicine, where prescriptions totaled 1,832 for the month. Attached are the ScriptCare reports for the Top 10 drugs in three different categories.

The Plan and ScriptCare management team and the P & T Committee have been studying the habit of prescribers and users of the widely used Hydrocodone / APAP prescription, as a top priority seeking the appropriateness of its use while preventing abuses. Richard Kleinberger, Pharm.D at ScriptCare and Julie Booth, the GCHP Quality Improvement Director are heavily involved in gathering data on Vicodin / Norco use. They are analyzing members receiving greater than quantity limits of 93 tablets over 31 days, and the providers who are writing the prescriptions. They are also breaking them down by type of prescribers distinguishing them between PCPs and Oncologists. One possible solution is to identify those oncology patients with cancer, who will be allowed more liberal doses of narcotics, versus those non-cancer patients who require stricter control in order to prevent abuses. ScriptCare is currently looking into installing a program to identify the cancer patients in their system.

HEALTH EDUCATION UPDATE

Health Education, Cultural and Linguistic Committee

The Health Education Committee met on August 15, 2013 and reviewed the Staying Healthy Assessment also known as the Individual Health Education Behavioral Assessment (IHEBA) tool. The Plan has received and reviewed Policy Letter 13-001 and is working with other Medi-Cal managed care plans seeking clarification and an extension from DHCS.

The IHEBA tool per age specific groups were reviewed and items were discussed. Representation from Case Management felt the survey questions were good and indicated that they will be sharing the questionnaires with other CMs during their staff meeting.

Health Education Referrals

The Health Education referrals continue to be made through the Plan's case management unit. The majority of referrals have been for social service support and disease management.

During the reporting period between May – July 2013 there were 22 health education referrals, some were from providers, but the majority were from GCHP Case Management. Health education materials provided during this reporting period included (but not limited to) the following topics: Nutrition Education, Diabetes and Weight Management, Quit Smoking, Parenting and Breastfeeding, COPD, and social services support (ie., Food Share, behavioral health, and member rights and responsibilities).

Health Education Initiatives

The Health Education Department is working with the Quality Improvement Department to develop health education initiatives to improve performance measures that were insufficient in meeting the benchmark. A letter has been submitted to DHCS for approval regarding the mailing of health education materials to members

Tobacco Cessation and Quit Smoking Resource Guide has been translated and staff is currently verifying phone numbers before final production.

Diabetes Education Directory and Support Groups

There are over 46 listings of diabetes education support groups and/or education classes in the community. A list of diabetes education directory of network providers and community based agencies has been prepared. Staff is working on having this information posted on the GCHP website.

Training by GCHP Health Education Staff

The following trainings have been attended by GCHP: 1) Tobacco Cessation Program – Integrating Tobacco Cessation on May 22, 2013. The training was conducted by the VC Public Health Department. 2) "Re-Think your Drink" Health Education Training "Train the Trainer" on July 17, 2013 sponsored by the Ventura County Public Health Department.

The Group Needs Assessment (GNA)
The GNA will incorporate HEDIS measures and a Summary Report is due October 15, 2013.

Prenatal Care & Newborn Baby Referral Program
GCHP has adopted a program from Santa Cruz County called, "Baby Gateway Program" which focuses on increasing the enrollment of newborns to Medi-Cal when the mom has restricted Medi-Cal or full scope Medi-Cal. GCHP Health Education Department is also piloting a program called, "**Newborn Baby Enrollment Program**" which focuses on increase awareness prenatal care and completion of the Medi-Cal Newborn Referral Form.

GCHP Health Education is working with Ventura County Medical Center, Baby Steps- OB Celebration and staff attends a health fair for women planning to deliver their baby at the VCMC Hospital. .GCHP attended our first Baby Steps Program and handed out over 35 Newborn Referral Forms. Staff will continue to work with VCMC on a monthly bases and will work to expand the program other hospitals.

Health Education Outreach and Health Fairs

06/04/13	St. John's Networking Meeting
06/14/13	City of Ventura Housing Authority – Health Education Presentation
06/12/13	GCHP CAC Meeting – Health Education Overview Presentation
06/19/13	City of Ventura Housing Authority – Health Education Presentation – Quit Smoking Presentation
06/26/13	GCHP Health Education Overview – In-service to VC Public Health HIV/AIDS Office Staff
06/28/13	Ventura Unified School District (VCSD) – DATA Middle School Health Fair
07/05/13	VCSD E.P. Foster Elementary School – Lunchtime Health Fair
07/10/13	The Wellness Center at the Center Point Mall Oxnard
07/11/13	Silver Circle – Health Education Presentation for Seniors
07/12/13	American Cancer Society – Introduction Meeting
07/12/13	Westpark Community Center – Lunchtime Health Fair for students
07/15/13	CHDP and GCHP Monthly Meeting
07/17/13	RE-Think Your Drink – VC Public Health Department – "Train-the-Trainer"
07/19/13	VCSD Montalvo Elementary School – Lunchtime Health Fair for kids
07/26/13	VCSD Saticoy Elementary School – Lunchtime Health Fair for Kids
07/30/13	GCHP Provider Town Hall Meeting – Health Education Overview
08/06/13	GCHP New Member Orientation Meeting – English Session
08/06/13*	CenterPoint Mall - Resource Fair
08/07/13*	CenterPoint Mall - Resource Fair
08/08/13*	CenterPoint Mall - Health Resource Fair
08/07/13	City of Ventura Housing Authority – Planning Meeting
08/08/13	GCHP New Member Orientation Meeting – Spanish Session
08/11/13*	Clinicas Del Camino Real – National Health Center Week- Health Fair
08/13/13*	Amigo Baby Oxnard College- Community Outreach
08/13/13	GCHP New Member Orientation Meeting – English Session

08/13/13 VCHCA Baby Steps – Newborn Baby Enrollment Outreach
08/14/13 Healthy Community Collaborative, VC Public Health Department
08/15/13 GCHP New Member Orientation Meeting – Spanish Session
08/20/13 GCHP New Member Orientation Meeting – English Session
08/22/13 GCHP New Member Orientation Meeting – Spanish Session
08/27/13 GCHP New Member Orientation Meeting – English Session
08/29/13 GCHP New Member Orientation Meeting – Spanish Session
(*) Outreach Events

Health Education staff participated and/or will be participating in a total of 27 Health Education / Health Fairs and Outreach staff has attended a total of 5 community outreach events.

Cultural and Linguistic Services
Cultural and Linguistic Specialist was hired on August 12, 2013, and is currently working on request for translation services, cultural and linguistic materials packets for providers, and other interpreter services.

ER Health Navigator Program
The Health Navigator continues to track and report on all ER contracts made so far. Data was recently referred to the Claims Department for review. Based on the review made by the Manager of Claims, it appears that the Medi-Cal Website may not be the most updated system to verify eligibility. It was recommended that we verify eligibility in IKA through the Claims system.

This program is great in concept in identifying frequent utilizers of emergency rooms, who they are, what PCPs they belong to, reasons for their visits in an ultimate attempt to change the behavior of both members and PCPs for more appropriate use of ERs. The data collected and the Navigator efforts so far have been preliminary. Further report will be made, when more data are collected and useful conclusion is made.

MEDICAL MANAGEMENT - TRANSITION CARE PROGRAM
Program Goals
The Gold Coast Health Plan Transition Care Program is being developed to improve care transition from the hospital to other settings and seeks to reduce readmissions for high-risk members. The goals of this program are to improve the transition from the hospital inpatient setting to other care settings, improve quality of care, reduce readmissions for high-risk members, and create cost savings.

Selection Criteria
Our discharge planner and concurrent stay review nurses collaborate to determine which patients will benefit from this program. Selection criteria address factors such as diagnosis

and co-morbidities, psycho-social factors, and history of multiple admissions and frequent emergency room use. Examples of selection criteria include:

- Over the age of 70
- Multiple diagnosis and co-morbidities
- Impaired mobility
- Impaired self-care skills
- Poor cognitive status
- Catastrophic injury or illness
- Homelessness
- Poor social supports
- Chronic illness
- Anticipated long term health care needs (e.g. new diabetic)
- Substance abuse
- History of multiple hospital admissions
- History of multiple emergent care use

Interventions

Our discharge planner assists in placing patients who will not be return home in the appropriate level of care. For members returning to the home setting, the discharge planner's critical interventions assist in arranging home infusion, arranging follow-up appointments, ensuring that prescriptions have been filled, arranging transportation, and referring members to our Care Management program when appropriate.

Results

The first month of this program 8/46 (17%) members selected for the program were readmitted within 30 days. The second month 1/38 (3%) were readmitted within 30 days. The drop in readmissions for month 2 reflects refinements in approaches to selection and intervention and the additional of a non-clinical assistant to support the discharge planner.

Looking Forward

Many transition care models include a post-discharge home visit within 24-48 hours in order to assess completeness of interventions (e.g. was the correct DME delivered), discover additional barriers to successful home transition (e.g. lack of food in the home), and facilitate information exchange between the patient, caregivers, medical providers, and care managers. Gold Coast Health Plan is working to see how we can most effectively introduce a home visit element into our program.

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Top 10 Drugs by Dollar

July 2013

Medication	# of Scripts	Amount Paid	Amount Paid/ Rx
LANTUS	506	$86,348.90	$170.65
ADVAIR DISKU	413	$86,092.32	$208.46
GLEEVEC	6	$59,523.96	$9,920.66
VENTOLIN HFA	1,311	$50,294.43	$38.36
CARIMUNE NF	4	$49,286.41	$12,321.60
NEULASTA	12	$48,109.34	$4,009.11
HUMIRA PEN	17	$47,848.23	$2,814.60
DIVALPROEX	627	$45,919.14	$73.24
CYMBALTA	196	$45,791.91	$233.63
HUMALOG	211	$40,032.91	$189.73

SCRIPT CARE, LTD.

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Top 10 Drugs by Rx

July 2013

Medication	# of Scripts	Amount Paid	Amount Paid/ Rx
HYDROCO/APAP	2,986	$27,727.15	$9.29
METFORMIN	1,832	$6,846.32	$3.74
OMEPRAZOLE	1,645	$9,755.07	$5.93
IBUPROFEN	1,482	$4,798.81	$3.24
LEVOTHYROXIN	1,441	$6,308.70	$4.38
LISINOPRIL	1,373	$3,772.99	$2.75
VENTOLIN HFA	1,311	$50,294.43	$38.36
AMOXICILLIN	1,297	$8,411.64	$6.49
AMLODIPINE	1,086	$2,466.75	$2.27
LORATADINE	1,080	$4,564.67	$4.23

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Top 10 Drugs by Therapeutic Class

July 2013

Code	Therapeutic Class	# of Scripts	Amount Paid
27	Antidiabetic	4,408.00	$283,770.18
44	Antiasthmatic	3,259.00	$278,595.24
21	Antineoplastics	331.00	$199,584.25
72	Anticonvulsant	4,551.00	$184,158.14
61	Stimulants/Anti-Obesity Anorexiants	1,078.00	$172,728.01
66	Analgesics-Anti-Inflammatory	3,365.00	$167,390.14
90	Dermatological	2,709.00	$139,422.91
65	Analgesics-Narcotic	5,140.00	$123,441.25
40	Misc. Cardiovascular	24.00	$111,696.67
99	Assorted Classes	184.00	$106,351.44
27	Antidiabetic	4,408.00	$283,770.18
44	Antiasthmatic	3,259.00	$278,595.24

SCRIPT CARE, LTD.

AGENDA ITEM 3c

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: August 26, 2013

Re: June, 2013 Financials (Unaudited)

SUMMARY:
Staff is presenting the attached June, 2013 financial statements (unaudited) of Gold Coast Health Plan (Plan) for review by the Commission. Staff reviewed the financial package in detail with the Executive / Finance Committee on August 1st. At that meeting, the Executive / Finance Committee recommended approval of the June, 2013 financial statements to the Plan's Commission.

BACKGROUND / DISCUSSION:
The Plan has prepared the June 2013 financial package (unaudited), including balance sheets, income statements and statements of cash flows reflecting monthly and year-to-date information.

FISCAL IMPACT:
Highlights of **the year-to-date** financials include:

Overall, the Plan's performance was ahead of budget, with an annual net income of $6.6 million compared to a budgeted net income of approximately $4.1 million. The primary driver of this positive variance was due to higher capitation rates paid to the Plan.

The month's positive net income contributed to a significant improvement in the Plan's Tangible Net Equity (TNE). As a result, the June year-end TNE is a positive $7.7 million. The primary differences between the budgeted TNE of approximately $6.3 million and the actual TNE are that the budgeted TNE did not include an assumption of the rate increase or reversal of AB97 reserves[1], but included the assumption that the additional line of credit (LOC) would be $1 million more than the actual funding.

[1] AB97 reserves were held for potential provider rate reductions. DHCS confirmed on July 12, 2013 that these reductions would be reflected in the Plan's capitation rates beginning in September 2013, allowing the Plan to reverse prior period reserves.

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

This month's net income of $4.1 million included the recognition of $2.7 million in revenue due to the FY2012-13 State capitation rate increases[2]. In addition, the Plan reversed $1.2 million of AB97 reserves related to the current fiscal year. Excluding these items, June's net income would have been approximately $0.2 million.

Other items to note include:

Membership - The Plan had 2,927 more members than budgeted for the month with larger than expected enrollment in the Dual and Targeted Low Income Children (TLIC) categories.

Revenue - Total revenue was higher than anticipated by an average $32.70 per member per month (PMPM). Excluding the special items mentioned above, the revenue would have resulted in a $4.58 lower average PMPM. Lower than expected membership in the Aged, Disabled and LTC categories contributed to the variance.

Health Care Costs - June's actual total health care costs ($225.52 PMPM) when compared to budgeted costs ($219.61 PMPM) varied by $5.91 or 2.6%. The variance was due to the Plan increasing the incurred but not paid (IBNP) reserves due to an uptick in open claims. The increase was mitigated somewhat by favorable net reinsurance and claims recoveries which were higher than expected. Also, pharmacy costs were lower than budgeted due to the initiation of a new MAC pricing schedule for generic drugs. It is expected that the savings will continue into the new fiscal year.

Fluctuations reflected in the various categories of services are the result of a change in GCHP's method of distributing Health Care Costs (HCC) across categories of service[3]. The budget utilized a prior allocation methodology, while actual HCC uses current payment information. This change will more accurately reflect true HCC, as it is based on actual claims payments rather than estimates.

Administrative Expenses - Overall operational costs were higher than anticipated by $5.65 PMPM. Expenses were impacted by the following items:

- Higher than projected fees associated with
  - continued temporary support provided by Tatum and
  - consulting fees from extended engagement of State monitor and IT / project management consulting
- Higher than expected legal and accounting due to timing of services.
- The increase was partially offset by lower than budgeted ACS management fees and translation services.

[2] Incorporated State capitation rates as reflected in DHCS Contract Amendments 6 & 7.
[3] HCC reallocation was effective with the May, 2013 financial statements.

Cash + Medi-Cal Receivable – the Plan continues to monitor its cash balance and is continuing with cash management programs that began in February. The Cash and Medi-Cal Premium Receivable balances of $58.3 million exceeded the budget of $56.1 million by $2.2 million, or 4%. This positive variance was achieved despite the $1.0 million difference between the budgeted and actual LOC funding.

RECOMMENDATION:
Staff proposes that the Plan's Commission approve and accept the June, 2013 financial package.

CONCURRENCE:
Executive / Finance Committee (08/01/13)

Attachments:
June, 2013 Financial Package

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FINANCIAL PACKAGE
For the month ended June 30, 2013

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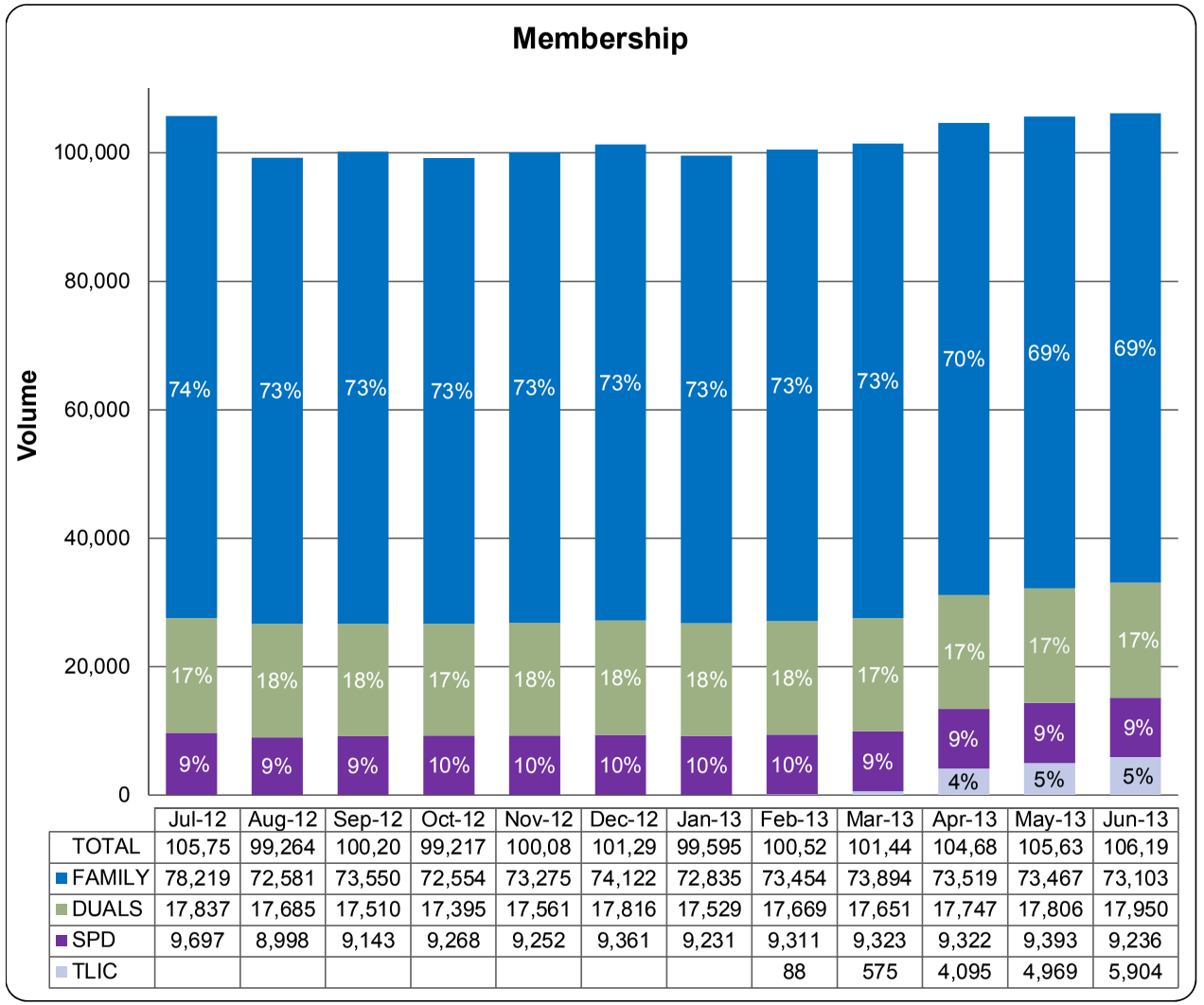
Financial Overview

Description	AUDITED	UNAUDITED FY 2012-13 Actual								Budget YTD	Variance Fav/(Unfav)	Variance Fav/(Unfav) %
	FY2011-12	JUL - SEP	OCT - DEC	JAN - MAR	Apr-13	May-13	Jun-13	APR - JUN	YTD			
Member Months	**1,258,189**	**305,220**	**300,604**	**301,560**	104,683	105,635	106,193	**316,511**	**1,223,895**	1,204,549	19,346	1.6 %
Revenue	**304,635,932**	**73,225,136**	**76,563,668**	**76,414,965**	**27,863,013**	**26,629,553**	**30,335,300**	**84,827,867**	**311,031,635**	**305,938,328**	5,093,307	1.7 %
pmpm	*242.12*	*239.91*	*254.70*	*253.40*	*266.17*	*252.09*	*285.66*	*268.01*	*254.13*	*253.99*	0.15	0.1 %
Health Care Costs	**287,353,672**	**71,648,550**	**68,967,923**	**69,698,937**	**23,399,396**	**22,912,363**	**23,822,397**	**70,134,156**	**280,449,566**	**280,200,594**	(248,972)	(0.1)%
pmpm	*228.39*	*234.74*	*229.43*	*231.13*	*223.53*	*216.90*	*224.33*	*221.59*	*229.15*	*232.62*	3.47	1.5 %
% of Revenue	94.3%	97.8%	90.1%	91.2%	84.0%	86.0%	78.5%	82.7%	90.2%	91.6%		
Admin Exp	**18,891,320**	**4,976,867**	**6,036,079**	**6,049,617**	**2,185,050**	**2,363,386**	**2,402,927**	**6,951,364**	**24,013,927**	**21,618,338**	(2,395,589)	(11.1)%
pmpm	*15.01*	*16.31*	*20.08*	*20.06*	*20.87*	*22.37*	*22.63*	*21.96*	*19.62*	*17.95*	(1.67)	(9.3)%
% of Revenue	6.2%	6.8%	7.9%	7.9%	7.8%	8.9%	7.9%	8.2%	7.7%	7.1%		
Net Income	**(1,609,063)**	**(3,400,282)**	**1,559,667**	**666,411**	**2,278,567**	**1,353,803**	**4,109,976**	**7,742,347**	**6,568,143**	**4,119,396**	2,448,747	(59.4)%
pmpm	*(1.28)*	*(11.14)*	*5.19*	*2.21*	*21.77*	*12.82*	*38.70*	*24.46*	*5.37*	*3.42*	1.95	(56.9)%
% of Revenue	-0.5%	-4.6%	2.0%	0.9%	8.2%	5.1%	13.5%	9.1%	2.1%	1.3%		
100% TNE	16,769,368	16,693,841	16,308,936	16,264,038	16,241,914	16,160,773	16,141,114	16,141,114	16,141,114	16,277,102	(135,988)	(0.8)%
% TNE Required	36%	36%	52%	52%	52%	52%	68%	68%	68%	68%		
Required TNE	6,036,972	6,009,783	8,480,647	8,457,300	8,445,795	8,403,602	10,975,958	10,975,958	10,975,958	11,068,430	(92,472)	(0.8)%
GCHP TNE	**(6,031,881)**	**(9,432,163)**	**(5,672,496)**	**(5,006,086)**	**(2,727,518)**	**3,626,285**	**7,736,261**	**7,736,261**	**7,736,261**	**6,287,515**	1,448,746	(23.0)%
TNE Excess / (Deficiency)	**(12,068,853)**	**(15,441,946)**	**(14,153,143)**	**(13,463,385)**	**(11,173,313)**	**(4,777,317)**	**(3,239,696)**	**(3,239,696)**	**(3,239,696)**	**(4,780,915)**	1,541,219	32.2 %

Note:

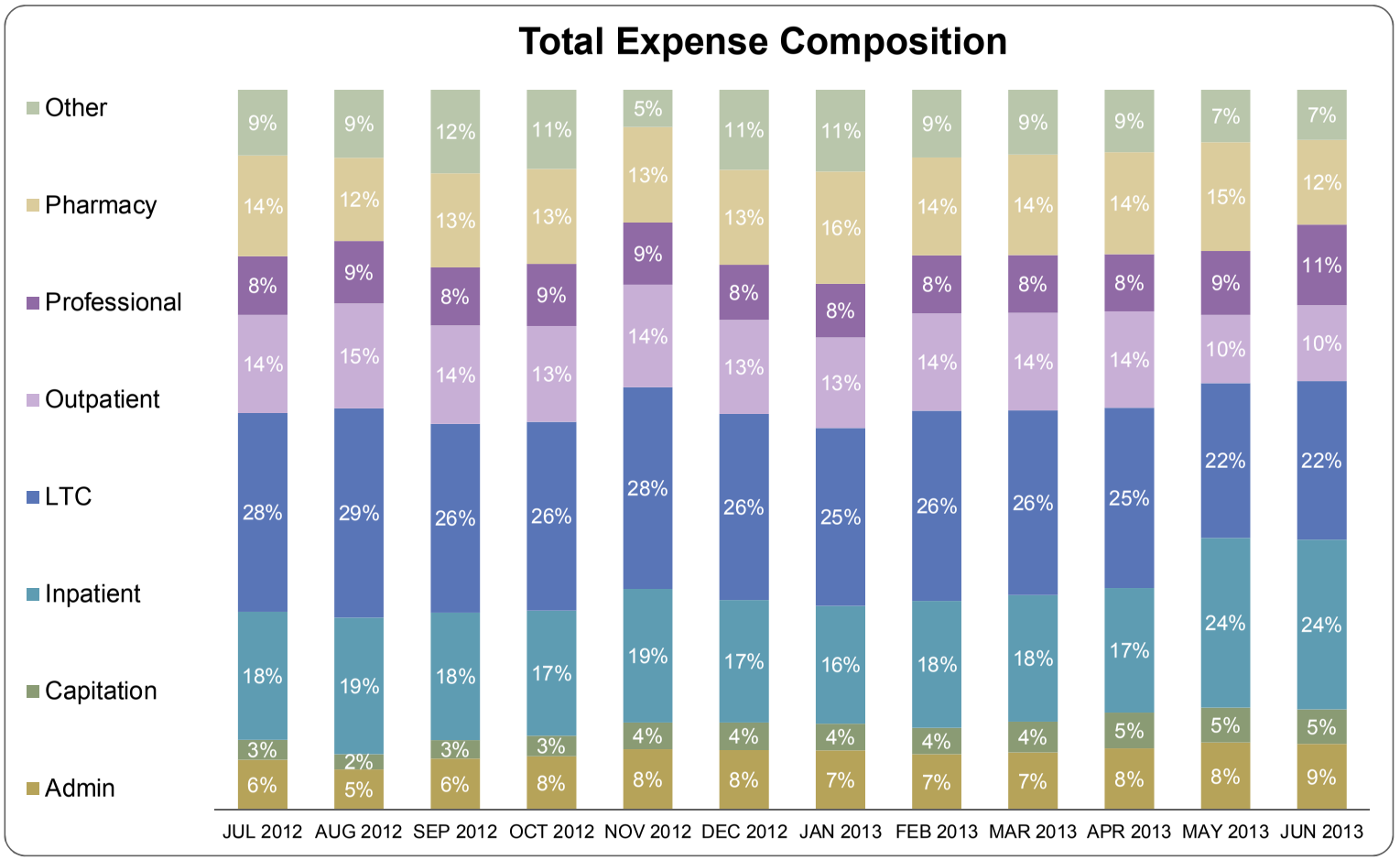
Jul-Sep- Health Care Costs include $7M IBNR addition.

Budgeted TNE assumed additional $6M subordinated debt in March '13; actual LOC increase was $5M in May '13.

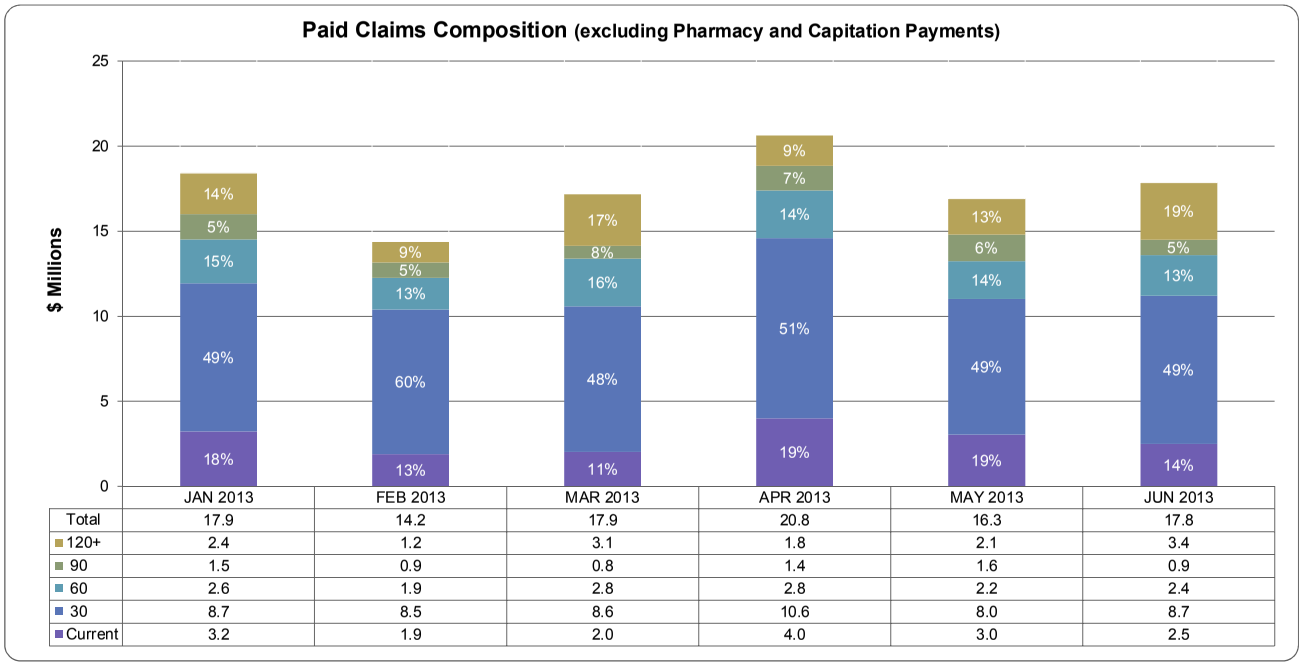


	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
TOTAL	105,75	99,264	100,20	99,217	100,08	101,29	99,595	100,52	101,44	104,68	105,63	106,19
FAMILY	78,219	72,581	73,550	72,554	73,275	74,122	72,835	73,454	73,894	73,519	73,467	73,103
DUALS	17,837	17,685	17,510	17,395	17,561	17,816	17,529	17,669	17,651	17,747	17,806	17,950
SPD	9,697	8,998	9,143	9,268	9,252	9,361	9,231	9,311	9,323	9,322	9,393	9,236
TLIC								88	575	4,095	4,969	5,904

SPD = Seniors and Persons with Disabilities
TLIC = Targeted Low Income Children

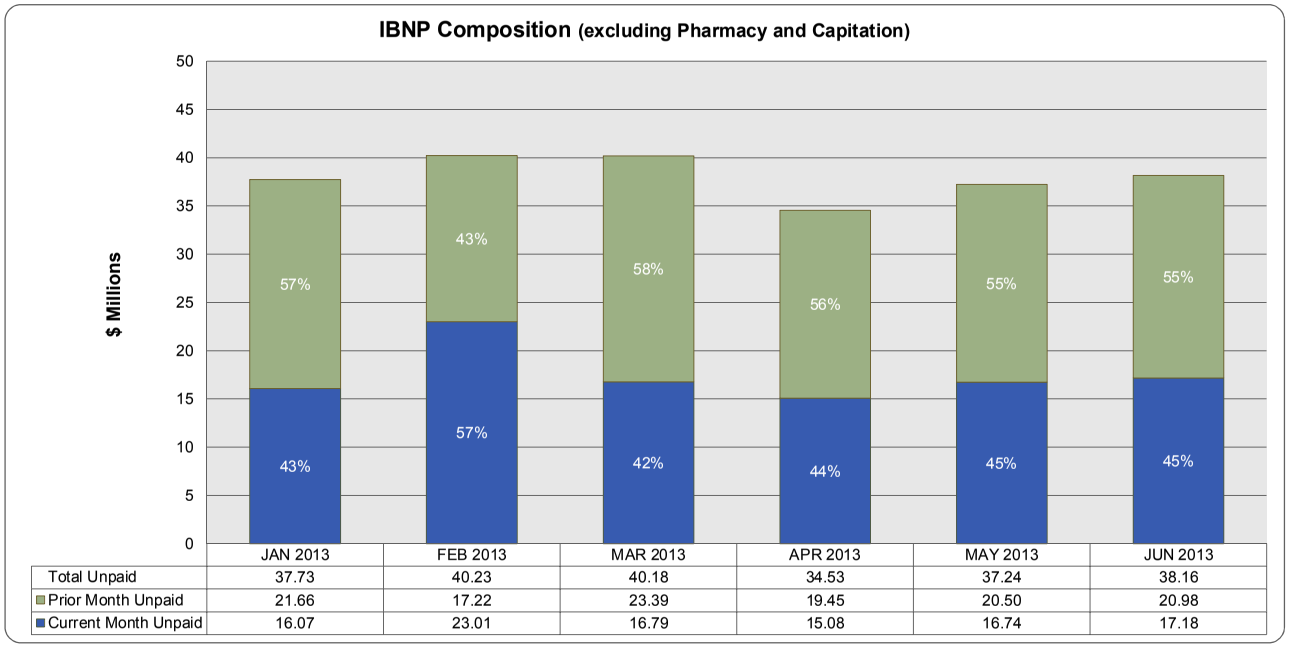


In May, GCHP changed its method of distributing Health Care Costs (HCC) across categories of service. Prior months utilized an allocation methodology. The methdology was updated to utilize payment information by differrent categories of services. This change will more accurately reflect true HCC, as it is based on actual claims payments rather than estimates.



	JAN 2013	FEB 2013	MAR 2013	APR 2013	MAY 2013	JUN 2013
Total	17.9	14.2	17.9	20.8	16.3	17.8
120+	2.4	1.2	3.1	1.8	2.1	3.4
90	1.5	0.9	0.8	1.4	1.6	0.9
60	2.6	1.9	2.8	2.8	2.2	2.4
30	8.7	8.5	8.6	10.6	8.0	8.7
Current	3.2	1.9	2.0	4.0	3.0	2.5

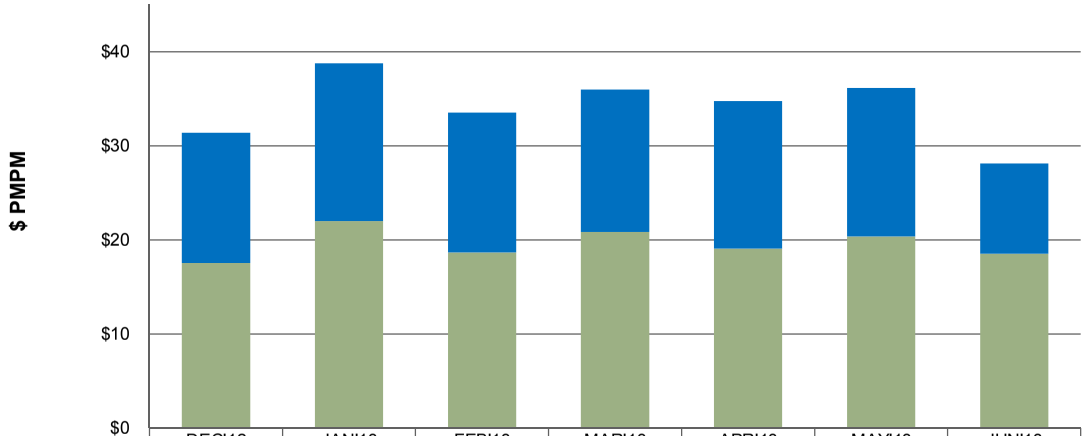
Note: **Paid Claims Composition** - reflects adjusted medical claims payment lag schedule.



	JAN 2013	FEB 2013	MAR 2013	APR 2013	MAY 2013	JUN 2013
Total Unpaid	37.73	40.23	40.18	34.53	37.24	38.16
Prior Month Unpaid	21.66	17.22	23.39	19.45	20.50	20.98
Current Month Unpaid	16.07	23.01	16.79	15.08	16.74	17.18

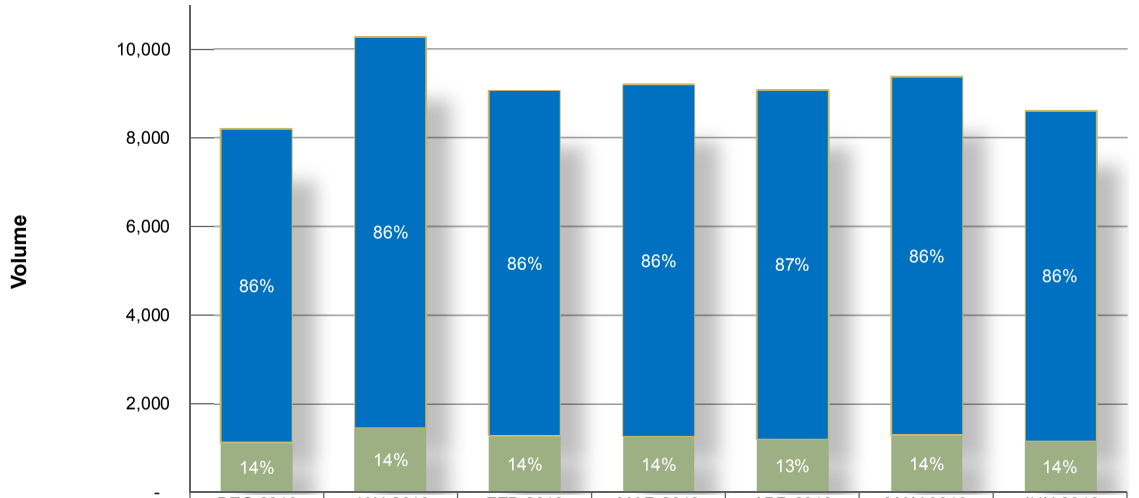
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

Pharmacy Cost Trend



	DEC'12	JAN'13	FEB'13	MAR'13	APR'13	MAY'13	JUN'13
AVG PMPM	$31.40	$38.75	$33.53	$35.99	$34.74	$36.15	$28.12
GENERIC	$13.86	$16.77	$14.86	$15.16	$15.66	$15.78	$9.58
BRAND	$17.53	$21.98	$18.66	$20.82	$19.08	$20.38	$18.54

Annualized Prescriptions per 1,000 Members



	DEC 2012	JAN 2013	FEB 2013	MAR 2013	APR 2013	MAY 2013	JUN 2013
TOTAL	8,211	10,279	9,079	9,208	9,084	9,383	8,620
GENERIC	7,075	8,799	7,791	7,935	7,867	8,076	7,446
BRAND	1,137	1,480	1,288	1,273	1,217	1,307	1,174

Income Statement
For The Twelve Months Ended June 30, 2013

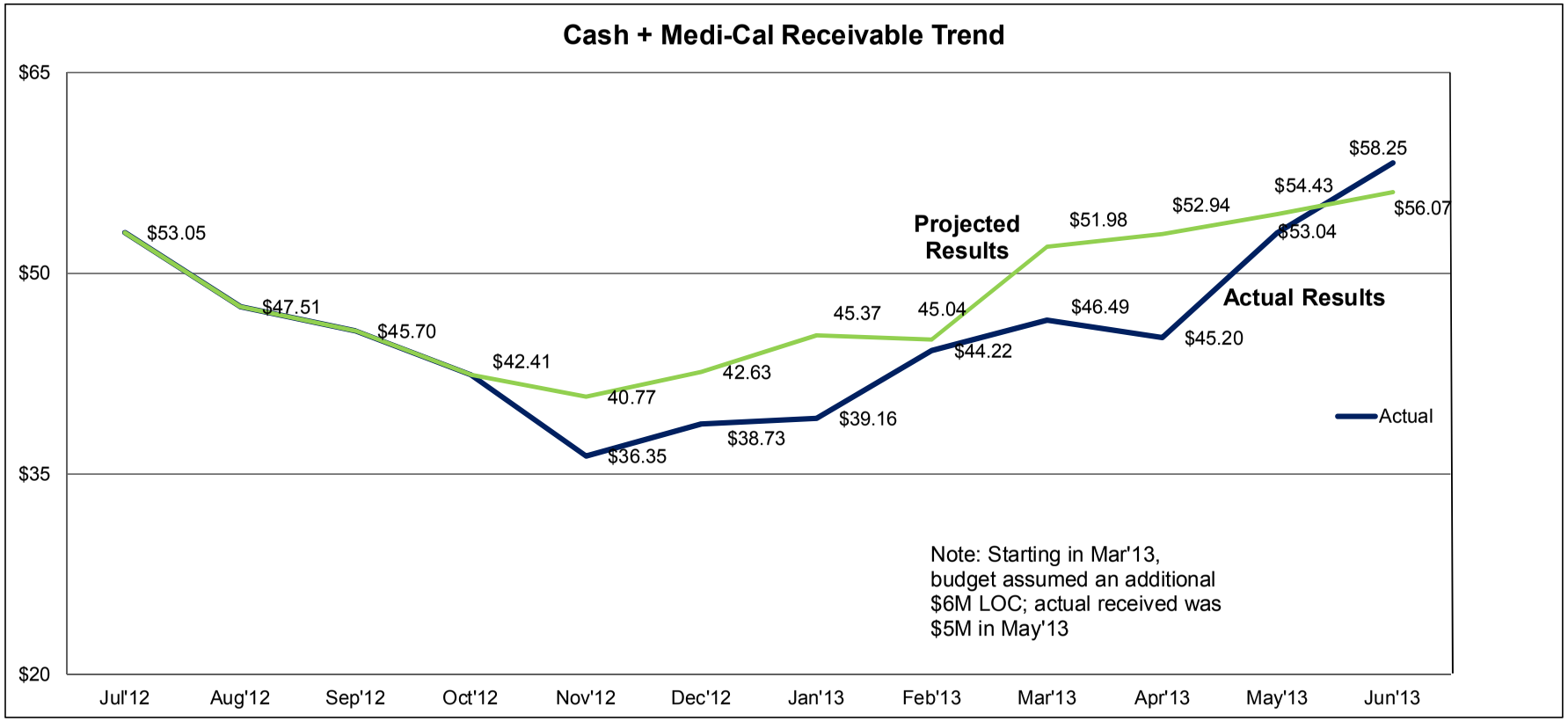
	Jun'13 Year-To-Date		Variance	
	Actual	Budget	Fav/(Unfav)	Comments
Membership (includes retro members)	1,223,337	1,204,549	18,788	*TLIC membership growth larger than expected*
Revenue:				
Premium	$ 308,009,966	$ 306,728,091	$ 1,281,875	*Includes $2.7M State rate increase adjustment*
Reserve for Rate Reduction	1,914,156	(1,423,189)	3,337,345	*Includes release of $1.9M FY2011-12 and $1.2M FY2012-13 AB97 r*
MCO Premium Tax	(1,680)	(7,778)	6,098	
Total Net Premium	**309,922,441**	**305,297,124**	**4,625,317**	
Other Revenue:				
Interest Income	114,009	181,204	(67,195)	
Miscellaneous Income	995,185	460,000	535,185	*Includes $535K FY2011-12 IGT admin fee*
Total Other Revenue	1,109,194	**641,204**	467,990	
Total Revenue	**311,031,635**	**305,938,328**	**5,093,307**	
Medical Expenses:				
Capitation	11,159,035	10,193,091	(965,944)	*Now includes some Specialty Physician, NEMT and Vision*
Incurred Claims*				
Inpatient	56,793,410	50,769,377	(6,024,033)	
LTC/SNF	78,259,796	82,318,068	4,058,272	
Outpatient	30,804,439	34,403,929	3,599,490	
Laboratory and Radiology	2,541,419	2,770,237	228,818	
Emergency Room Facility Services	6,143,374	5,712,032	(431,342)	
Physician Specialty Services	25,758,126	23,339,828	(2,418,298)	
Pharmacy	41,118,154	38,439,105	(2,679,049)	
Other Medical Professional	2,884,039	3,160,541	276,502	
Other Medical Care Expenses	5,713		(5,713)	
Other Fee For Service Expense	18,435,685	18,664,265	228,580	
Transportation	2,625,381	3,370,761	745,380	
Total Claims	265,369,537	262,948,143	(2,421,394)	
Medical & Care Management Expense	7,557,484	7,428,323	(129,161)	
Reinsurance	(141,858)	(368,963)	(227,105)	*Timing of recoveries lags expected receipts*
Claims Recoveries	(3,494,632)	-	3,494,632	*Additional provider recoveries not allocated to specific categories of service. Additionally, claims recoveries efforts enhanced due to assignment of an employee dedicated to recover overpayments*
Sub-total	3,920,994	7,059,360	3,138,366	
Total Cost of Health Care	**280,449,566**	**280,200,594**	**(248,972)**	
Contribution Margin	**30,582,069**	**25,737,734**	**4,844,335**	
General & Administrative Expenses:				
Salaries and Wages	5,056,803	4,696,377	(360,426)	*Actual salaries were in line with budgeted amounts, YTD variance results entirely from the use of temporary labor*
Payroll Taxes and Benefits	1,254,386	1,107,651	(146,735)	
Total Travel and Training	67,666	64,573	(3,093)	
Outside Service - ACS	10,963,938	11,063,412	99,474	
Outside Service - RGS	23,674	23,674	0	
Outside Services - Other	538,615	495,948	(42,667)	
Accounting & Actuarial Services	406,111	468,027	61,916	
Legal Expense	450,167	285,086	(165,081)	*Greater than anticipated expenses for provider contract review*
Insurance	104,670	114,742	10,072	
Lease Expense - Office	213,692	241,936	28,244	
Consulting Services Expense	3,271,648	1,708,986	(1,562,662)	*State monitor continued beyond budget assumption of Jan end date*
Translation Services	22,860	90,893	68,033	
Advertising and Promotion Expense	10,541	14,150	3,609	
General Office Expenses	996,755	690,210	(306,545)	*Variance due to additional lease space, hiring expenses, and association fees*
Depreciation & Amortization Expense	50,789	56,576	5,787	
Printing Expense	72,360	116,975	44,615	
Shipping & Postage Expense	58,272	50,008	(8,264)	
Interest Exp	450,981	329,114	(121,867)	
Total G & A Expenses	**24,013,927**	**21,618,338**	**(2,395,589)**	
Net Income / (Loss)	**$ 6,568,143**	**$ 4,119,396**	**$ 2,448,747**	

*In May, GCHP changed its method of distributing Health Care Costs (HCC) across categories of service. Prior months utilized an allocation methodology. The methdology was updated to utilize payment information by differrent categories of services. This change will more accurately reflect true HCC, as it is based on actual claims payments rather than estimates.

Comparative Balance Sheet

	6/30/13	5/31/13	Audited FY 2011 - 2012
ASSETS			
Current Assets			
Total Cash and Cash Equivalents	**$ 50,707,852**	**$ 23,068,235**	**$ 25,554,098**
Medi-Cal Receivable	7,543,835	29,970,926	28,534,938
Provider Receivable	1,161,379	1,681,329	6,539,541
Other Receivables	300,397	142,297	2,148,270
Total Accounts Receivable	**9,005,611**	**31,794,552**	**37,222,748**
Total Prepaid Accounts	351,145	1,117,992	185,797
Total Other Current Assets	10,000	13,125	375,000
Total Current Assets	**$ 60,074,607**	**$ 55,993,904**	**$ 63,337,644**
Total Fixed Assets	**230,913**	**211,294**	**176,028**
Total Assets	**$ 60,305,520**	**$ 56,205,197**	**$ 63,513,672**
LIABILITIES & FUND BALANCE			
Current Liabilities			
Incurred But Not Reported	$ 29,901,103	$ 31,556,293	$ 52,610,895
Claims Payable	9,748,676	7,820,587	10,357,609
Capitation Payable	1,002,623	1,017,683	633,276
Accrued Premium Reduction	-	1,180,078	1,914,157
Accounts Payable	1,693,432	1,897,301	886,715
Accrued ACS	422,138	1,172,318	200,000
Accrued Expenses	477,477	362,000	-
Accrued Premium Tax	7,286,494	5,853,482	602,900
Accrued Interest Payable	9,712	5,780	-
Current Portion of Deferred Revenue	460,000	460,000	460,000
Accrued Payroll Expense	605,937	170,057	-
Current Portion Of Long Term Debt	41,667	125,000	500,000
Total Current Liabilities	**$ 51,649,258**	**$ 51,620,578**	**$ 68,165,553**
Long-Term Liabilities			
Other Long-term Liability	-	-	-
Deferred Revenue - Long Term Portion	920,000	958,333	1,380,000
Notes Payable	7,200,000	7,200,000	-
Total Long-Term Liabilities	**8,120,000**	**8,158,333**	**1,380,000**
Total Liabilities	**$ 59,769,258**	**$ 59,778,912**	**$ 69,545,553**
Beginning Fund Balance	(6,031,881)	(6,031,881)	(4,422,819)
Net Income Current Year	6,568,143	2,458,166	(1,609,062)
Total Fund Balance	**536,262**	**(3,573,715)**	**(6,031,881)**
Total Liabilities & Fund Balance	**$ 60,305,520**	**$ 56,205,197**	**$ 63,513,672**

FINANCIAL INDICATORS			
Current Ratio	1.16 : 1	1.08 : 1	0.93 : 1
Days Cash on Hand	58	27	30
Days Cash + State Capitation Receivable	67	63	64


Cash + Medi-Cal Receivable Trend
$65
$50
$35
$20
Jul'12
Aug'12
Sep'12
Oct'12
Nov'12
Dec'12
Jan'13
Feb'13
Mar'13
Apr'13
May'13
Jun'13
$53.05
$47.51
$45.70
$42.41
$40.77
42.63
45.37
45.04
$51.98
$52.94
$54.43
$56.07
Projected Results
$36.35
$38.73
$39.16
$44.22
$46.49
$45.20
$53.04
$58.25
Actual Results
Actual
Note: Starting in Mar'13, budget assumed an additional $6M LOC; actual received was $5M in May'13

Gold Coast Health Plan℠
A Public Entity

APPENDIX

- Income Statement Monthly Trend
- PMPM Income Statement by Month
- Statement of Cash Flows - Monthly
- Statement of Cash Flows - YTD

Income Statement Monthly Trend

	2013 Actual Monthly Trend			Current Month			
	MAR 2013	APR 2013	MAY 2013	JUN 2013		Variance	
				Actual	Budget	Fav/(Unfav)	
Membership (includes retro members)	101,443	104,683	105,635	105,635	102,708	2,927	
Revenue:							
Premium	$ 25,821,551	$ 26,032,054	$ 26,048,832	$ 29,108,295	$ 26,210,507	$ 2,897,788	*Includes $2.7M rate increase adjustment*
Reserve for Rate Reduction	(167,680)	1,785,047	-	1,180,078	(127,154)	1,307,232	*Release of FY2012-13 AB97 reserves*
MCO Premium Tax	(182)	-	-	-	(786)	786	
Total Net Premium	**25,653,689**	**27,817,101**	**26,048,832**	**30,288,373**	**26,082,567**	**4,205,806**	
Other Revenue:							
Interest Income	6,873	7,579	7,203	8,594	15,726	(7,132)	
Miscellaneous Income	38,333	38,333	573,518	38,333	38,333	0	
Total Other Revenue	45,206	45,912	580,721	46,927	**54,059**	(7,132)	
Total Revenue	**25,698,895**	**27,863,013**	**26,629,553**	**30,335,300**	**26,136,626**	**4,198,674**	
Medical Expenses:							
Capitation (PCP, Specialty, NEMT & Visi	1,123,027	1,274,651	1,226,446	1,254,306	947,095	(307,211)	
Incurred Claims:							
Inpatient	4,594,575	4,422,556	5,955,342	6,185,239	3,510,918	(2,674,321)	
LTC/SNF	6,718,243	6,404,450	5,438,652	5,774,127	6,672,224	898,097	
Outpatient	2,776,364	2,682,417	1,803,363	2,132,380	2,925,977	793,597	
Laboratory and Radiology	232,801	225,582	158,267	126,783	228,019	101,236	
Emergency Room Facility Services	537,953	521,965	430,333	506,334	344,269	(162,065)	
Physician Specialty Services	2,102,513	2,026,032	2,245,622	2,929,617	1,800,436	(1,129,181)	
Pharmacy	3,650,281	3,626,289	3,819,028	3,092,352	3,165,457	73,105	*Reflects new MAC pricing for generic drugs*
Other Medical Professional	225,650	216,345	83,856	84,601	244,497	159,896	
Other Medical Care Expenses	647	-	-	755	-	(755)	
Other Fee For Service Expense	1,574,293	1,489,453	1,497,072	1,524,389	1,509,035	(15,354)	
Transportation	102,868	73,499	71,310	60,991	251,382	190,391	
Total Claims	22,516,189	21,688,588	21,502,845	22,417,569	20,652,214	(1,765,355)	
			-				
Medical & Care Management Expe	631,474	894,013	722,529	732,777	722,445	(10,332)	
Reinsurance	227,620	26,355	70,711	(368,913)	233,825	602,738	
Claims Recoveries	(407,819)	(484,211)	(610,167)	(213,342)	-	213,342	
Sub-total	451,275	436,157	183,072	150,522	956,270	805,748	
Total Cost of Health Care	**24,090,491**	**23,399,396**	**22,912,363**	**23,822,397**	**22,555,579**	**(1,266,818)**	
Contribution Margin	**1,608,404**	**4,463,617**	**3,717,190**	**6,512,903**	**3,581,047**	**2,931,856**	
General & Administrative Expenses:							
Salaries and Wages	457,668	464,103	600,314	731,003	483,411	(247,592)	*Actual wages below budget due primarily to delays in planned new hirings. This was offset by temporary labor expenses and updated payroll*
Payroll Taxes and Benefits	91,493	113,969	108,592	199,544	103,302	(96,242)	
Total Travel and Training	4,398	5,140	13,746	2,712	2,545	(167)	
Outside Service - ACS	904,052	892,178	945,040	924,744	950,298	25,554	
Outside Services - Other	24,294	99,755	31,920	26,808	19,494	(7,314)	
Accounting & Actuarial Services	18,828	33,046	51,270	61,489	30,400	(31,089)	*Variance to timing of audit work*
Legal Expense	24,015	37,957	46,299	80,775	16,850	(63,925)	*Reflects legal fees incurred but not yet invoiced*
Insurance	9,245	9,245	10,516	7,677	10,792	3,115	
Lease Expense - Office	25,980	26,080	25,980	7,937	27,630	19,693	
Consulting Services Expense	401,116	286,436		229,676	1,150	(228,526)	*Variance results from IT & project management consultants and State Monitor services*
			443,743				
Translation Services	2,515	1,125	4,610	3,672	20,777	17,105	
Advertising and Promotion Expense	-	-	1,050	-	2,500	2,500	
General Office Expenses	86,891	171,615	71,628	83,271	62,552	(20,719)	*Unbudgeted expenses for associations dues*
Depreciation & Amortization Expense	3,554	3,836	3,648	11,407	6,657	(4,750)	
Printing Expense	1,722	5,445	3,672	12,974	6,541	(6,433)	
Shipping & Postage Expense	5,507	10,933	179	2,120	1,624	(496)	
Interest Exp	28,423	24,186	1,180	17,120	9,180	(7,940)	
Total G & A Expenses	**2,089,699**	**2,185,050**	**2,363,386**	**2,402,927**	**1,755,703**	**(647,224)**	
Net Income / (Loss)	**$ (481,295)**	**$ 2,278,567**	**$ 1,353,803**	**$ 4,109,976**	**$ 1,825,344**	**$ 2,284,632**	

PMPM Income Statement Comparison

	2013 Actual Monthly Trend			May'13 Month-To-Date		Variance
	MAR 2013	APR 2013	MAY 2013	Actual	Budget	Fav/(Unfav)
Members (Member/Months)	98,520	101,741	105,635	105,635	102,708	2,927
Revenue:						
Premium	262.09	255.87	246.59	275.56	255.19	20.36
Reserve for Rate Reduction	(1.70)	17.55	-	11.17	(1.24)	12.41
MCO Premium Tax	(0.00)	-	-	-	(0.01)	0.01
Total Net Premium	**260.39**	**263.33**	**246.59**	**286.73**	**253.95**	**32.78**
Other Revenue:			-			
Interest Income	0.07	0.07	0.07	0.08	0.15	(0.07)
Miscellaneous Income	0.39	0.38	5.43	0.36	0.37	(0.01)
Total Other Revenue	**0.46**	**0.43**	**5.50**	**0.44**	**0.53**	**(0.09)**
Total Revenue	**260.85**	**263.77**	**252.09**	**287.17**	**254.48**	**32.70**
Medical Expenses:						
Capitation	11.40	12.53	11.61	11.87	9.22	2.65
Incurred Claims:						
Inpatient	46.64	43.47	56.38	58.55	34.18	(24.37)
LTC/SNF	68.19	62.95	51.49	54.66	64.96	10.30
Outpatient	28.18	26.37	17.07	20.19	28.49	8.30
Laboratory and Radiology	2.36	2.22	1.50	1.20	2.22	1.02
Emergency Room Facility Services	5.46	5.13	4.07	4.79	3.35	(1.44)
Physician Specialty Services	21.34	19.91	21.26	27.73	17.53	(10.20)
Pharmacy	37.05	35.64	36.15	29.27	30.82	1.55
Other Medical Professional	2.29	2.13	0.79	0.80	2.38	1.58
Other Medical Care Expenses	0.01	-	-	0.01	-	(0.01)
Other Fee For Service Expense	15.98	14.64	14.17	14.43	14.69	0.26
Transportation FFS	1.04	0.72	0.68	0.58	2.45	1.87
Total Claims	228.54	205.32	203.56	212.22	201.08	(11.14)
Medical & Care Management	6.41	8.79	6.84	6.94	7.03	0.10
Reinsurance	2.31	0.26	0.67	(3.49)	2.28	5.77
Claims Recoveries	(4.14)	(4.76)	(5.78)	(2.02)	-	2.02
Sub-total	4.58	4.13	1.73	1.42	9.45	8.02
Total Cost of Health Care	244.52	223.53	216.90	225.52	219.61	(5.91)
Contribution Margin	16.33	42.64	35.19	61.65	**34.87**	**26.79**
Administrative Expenses						
Salaries and Wages	4.65	4.56	5.68	6.92	4.71	(2.21)
Payroll Taxes and Benefits	0.93	1.12	1.03	1.89	1.01	(0.88)
Total Travel and Training	0.04	0.05	0.13	0.03	0.02	(0.00)
Outside Service - ACS	9.18	8.77	8.95	8.75	9.25	0.50
Outside Services - Other	0.25	0.98	0.30	0.25	0.19	(0.06)
Accounting & Actuarial Services	0.19	0.32	0.49	0.58	0.30	(0.29)
Legal Expense	0.24	0.37	0.44	0.76	0.16	(0.60)
Insurance	0.09	0.09	0.10	0.07	0.11	0.03
Lease Expense -Office	0.26	0.26	0.25	0.08	0.27	0.19
Consulting Services Expense	4.07	2.82	4.20	2.17	0.01	(2.16)
Translation Services	0.03	0.01	0.04	0.03	0.20	0.17
Advertising and Promotion Expense	-	-	0.01	-	0.02	0.02
General Office Expenses	0.88	1.69	0.68	0.79	0.61	(0.18)
Depreciation & Amortization Expense	0.04	0.04	0.03	0.11	0.06	(0.04)
Printing Expense	0.02	0.05	0.03	0.12	0.06	(0.06)
Shipping & Postage Expense	0.06	0.11	0.00	0.02	0.02	(0.00)
Interest Exp	0.29	0.24	0.01	0.16	0.09	(0.07)
Total Administrative Expenses	**21.21**	**20.68**	**22.37**	**22.75**	**17.09**	**(5.65)**
Net Income / (Loss)	**(4.89)**	**21.57**	**12.82**	**38.91**	**17.77**	**21.14**

Statement of Cash Flows - Monthly

	JUN'13	MAY'13
Cash Flow From Operating Activities		
Collected Premium	$ 52,138,834	$ 25,564,446
Miscellaneous Income	8,594	7,203
HQAF Funds Received	34,346,474	-
Paid Claims		
Medical & Hospital Expenses	(17,277,826)	(16,067,915)
Pharmacy	(4,009,168)	(4,005,123)
Capitation	(1,162,302)	(1,212,755)
Reinsurance of Claims	(240,430)	(3,873)
HQAF Funds Distributed	(34,346,474)	
Paid Administration	(2,616,623)	(3,062,066)
MCO Tax Received / (Paid)	829,564	-
Net Cash Provided/ (Used) by Operating Activities	**27,670,643**	**1,219,917**
Cash Flow From Investing/Financing Activities		
Proceeds from Line of Credit	-	5,000,000
Repayments on Line of Credit	-	-
Net Acquisition of Property/Equipment	(31,026)	(2,013)
Net Cash Provided/(Used) by Investing/Financing	**(31,026)**	**4,997,987**
Net Cash Flow	**$ 27,639,617**	**$ 6,217,904**
Cash and Cash Equivalents (Beg. of Period)	23,068,235	16,850,331
Cash and Cash Equivalents (End of Period)	50,707,852	23,068,235
	$ 27,639,617	**$ 6,217,904**
Adjustment to Reconcile Net Income to Net Cash Flow		
Net (Loss) Income	4,109,976	1,353,803
Depreciation & Amortization	11,407	3,648
Decrease/(Increase) in Receivables	22,788,941	(1,401,202)
Decrease/(Increase) in Prepaids & Other Current Assets	769,972	89,138
(Decrease)/Increase in Payables	(1,578,838)	(335,292)
(Decrease)/Increase in Other Liabilities	(121,667)	(80,000)
Change in MCO Tax Liability	1,433,012	600,764
Changes in Claims and Capitation Payable	1,913,029	(1,920,243)
Changes in IBNR	(1,655,189)	2,909,301
	27,670,643	1,219,917
Net Cash Flow from Operating Activities	**$ 27,670,643**	**$ 1,219,917**

Statement of Cash Flows - YTD

	Jun '13 YTD
Cash Flow From Operating Activities	
Collected Premium	$ 336,042,267
Miscellaneous Income	114,009
HQAF Funds Received	34,346,474
Paid Claims	
Medical & Hospital Expenses	(233,904,478)
Pharmacy	(44,681,081)
Capitation	(10,411,964)
Reinsurance of Claims	(2,772,746)
HQAF Funds Distributed	(34,346,474)
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(26,502,482)
MCO Taxes Received / (Paid)	175,900
Net Cash Provided/(Used) by Operating Activities	**18,059,427**
Cash Flow From Investing/Financing Activities	
Proceeds from Line of Credit	7,200,000
Repayments on Line of Credit	-
Net Acquisition of Property/Equipment	(105,674)
Net Cash Provided/(Used) by Investing/Financing	**7,094,326**
Net Cash Flow	**$ 25,153,754**
Cash and Cash Equivalents (Beg. of Period)	25,554,098
Cash and Cash Equivalents (End of Period)	50,707,852
	$ 25,153,754
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	6,568,143
Depreciation & Amortization	50,789
Decrease/(Increase) in Receivables	28,217,138
Decrease/(Increase) in Prepaids & Other Current Assets	199,652
(Decrease)/Increase in Payables	207,823
(Decrease)/Increase in Other Liabilities	(918,333)
Change in MCO Tax Liability	6,683,594
Changes in Claims and Capitation Payable	(239,586)
Changes in IBNR	(22,709,792)
	18,059,427
Net Cash Flow from Operating Activities	**$ 18,059,427**

Gold Coast Health Plan - Inventory Trend Comparison

From 01/01/13 thru 07/23/13

Week	Open	Denied	Received	Paid
1/1	14874	1726	15461	11238
1/8	14975	2523	17404	15685
1/15	21001	2235	21133	14722
1/23	18680	2426	17770	17190
1/30	21223	2463	21072	18331
2/5	20933	3051	24324	22569
2/12	18868	2970	21336	19287
2/19	11822	3179	14844	17464
2/26	18807	1882	24295	5651
3/5	20512	4326	22416	20191
3/12	18878	4555	24047	17363
3/19	17553	3387	22754	18610
3/26	16340	3859	29757	18516
4/2	14086	7200	24626	23089
4/9	14403	5195	20073	18495
4/16	12792	3977	21664	17426
4/23	10686	4224	20747	17122
4/30	9350	3560	22132	18286
5/7	6206	5843	20257	28942
5/14	4326	1643	19563	8005
5/21	3833	2037	20647	18838
5/28	11207	2830	19158	15737
6/4	12066	1946	24365	14007
6/11	18237	4458	24056	19238
6/18	19399	3466	22777	19508
6/25	18777	2679	21875	21403
7/2	19881	3167	24219	19547
7/9	19755	2399	15808	16321
7/16	18225	2719	17630	15148
7/23	15165	3086	17953	15812

*inventory day late due to delayed payment run

*inventory day late due to delayed payment run

*Check run time moved from 5:30pm to 12:00pm. Claims processed after 12pm will reflect on next report.

Month*	Open	Denied	Received	Paid	#GCHP Bus days	Avg Rcvd in month	Avg Pd in month
January	90753	11373	92840	77166	21	4,421	3,675
February	70430	11082	84799	64971	18	4,711	3,610
March	73283	16127	98974	74680	21	4,713	3,556
April	61317	24156	109242	94418	22	4,966	4,292
May	25572	12353	79625	71522	23	3,462	3,110
June	68479	12549	93073	74156	24	3,878	3,090
July	73026	11371	75610	66828	23	3,287	2,906

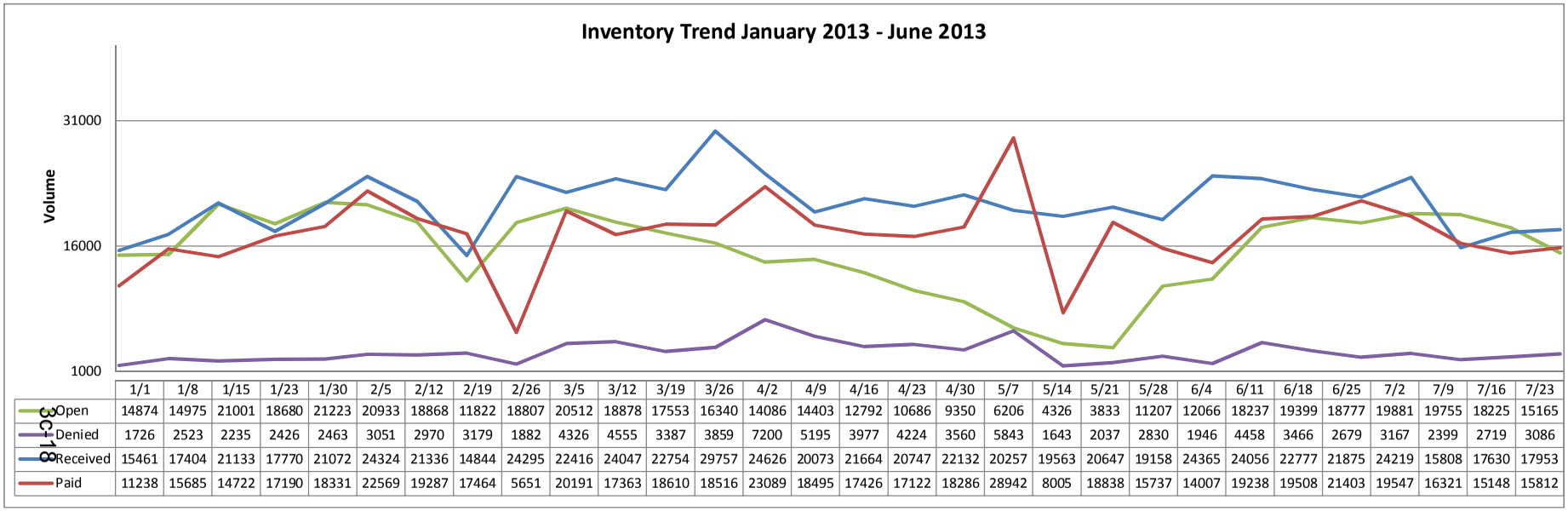
* Counts of claims may actually span an earlier or later month than shown and are summarized according to weekly check run.

Open: Current claim inventory ready to be processed.

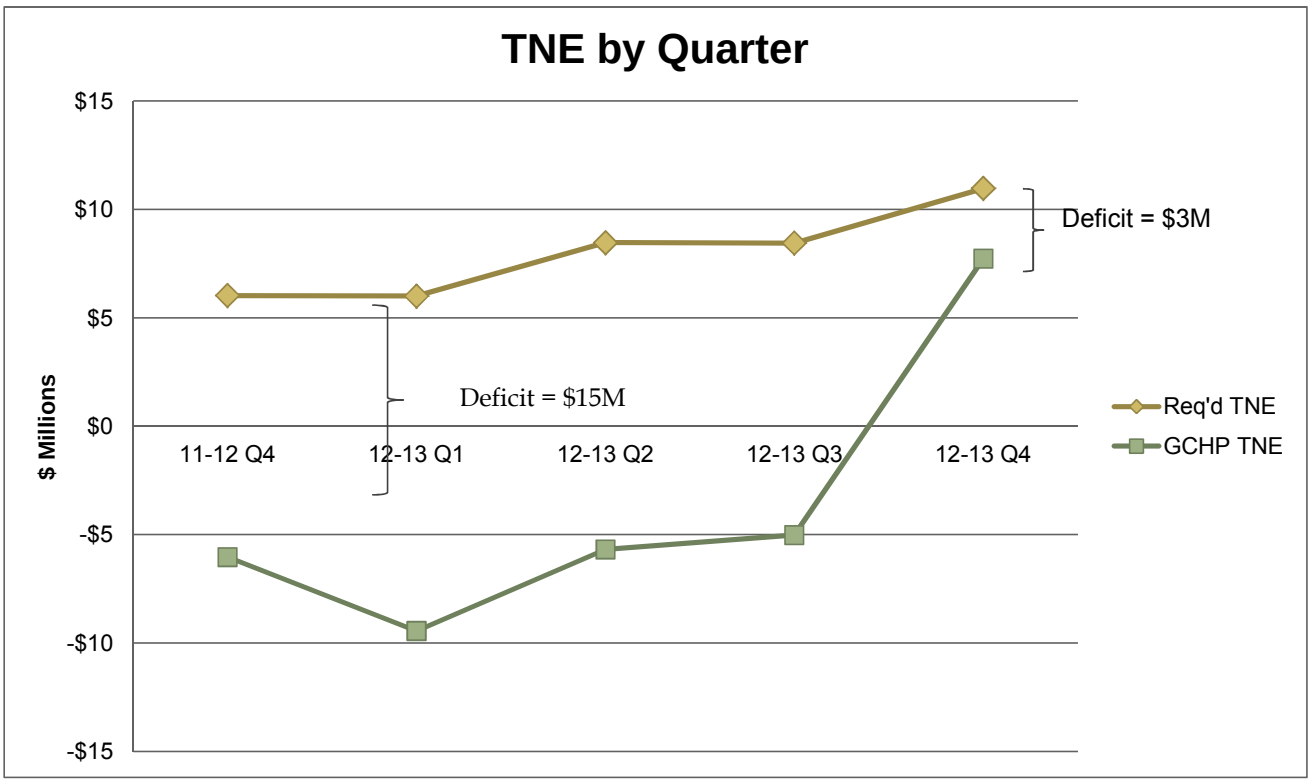
Denied: Claims processed this week with a denial.

Received: Claims received this week to be processed.

Paid: Claims processed this week with a payment.



	1/1	1/8	1/15	1/23	1/30	2/5	2/12	2/19	2/26	3/5	3/12	3/19	3/26	4/2	4/9	4/16	4/23	4/30	5/7	5/14	5/21	5/28	6/4	6/11	6/18	6/25	7/2	7/9	7/16	7/23
Open	14874	14975	21001	18680	21223	20933	18868	11822	18807	20512	18878	17553	16340	14086	14403	12792	10686	9350	6206	4326	3833	11207	12066	18237	19399	18777	19881	19755	18225	15165
Denied	1726	2523	2235	2426	2463	3051	2970	3179	1882	4326	4555	3387	3859	7200	5195	3977	4224	3560	5843	1643	2037	2830	1946	4458	3466	2679	3167	2399	2719	3086
Received	15461	17404	21133	17770	21072	24324	21336	14844	24295	22416	24047	22754	29757	24626	20073	21664	20747	22132	20257	19563	20647	19158	24365	24056	22777	21875	24219	15808	17630	17953
Paid	11238	15685	14722	17190	18331	22569	19287	17464	5651	20191	17363	18610	18516	23089	18495	17426	17122	18286	28942	8005	18838	15737	14007	19238	19508	21403	19547	16321	15148	15812



		Actual	Required	Deficit
Tangible Net Equity (TNE)	**@ 6/30/12**	$ (6,031,881)	$ 6,036,972	$ (12,068,853)
1st Quarter Net Income (7/1/12-9/30/12)		(3,400,282)	6,009,783	(15,441,946)
TNE	@ 9/30/12 - Low Point	(9,432,163)	6,009,783	(15,441,946)
Changes from 10/1/12-6/30/13				
	Net Income	9,968,424		
	Lines of Credit	7,200,000		
TNE	@ 6/30/13	$ 7,736,261	$ 10,975,958	$ (3,239,696)
From Low Point:				
Actual TNE improved by:		$ 17,168,424		
TNE Requirement grew by:			$ 4,966,175	
Deficit improved by:				$ 12,202,250

AGENDA ITEM 4a

To: Gold Coast Health Plan Commissioners

From: Melissa Scrymgeour, Director IT

Date: August 26, 2013

RE: GCHP Regulatory Projects Update FY 2013-14

Over the past 12 months, Gold Coast Health Plan (GCHP or Plan) has made great progress in improving financial and operational stability, as demonstrated in consistent month-over-month financial improvements, increased capital support and improvement in the Plan's Tangible Net Equity (TNE) position. The Plan has increased staffing to address corrective actions required by the State, to strengthen the Plan's infrastructure and to improve operational processes. While the majority of GCHP and vendor resources were focused around these projects and continue to work on these areas, there is a significant amount of work required to deliver mandated State program changes and Federal health care reform projects, many of which are slated to go live January 1, 2014.

In February 2013, GCHP established a project management (PM) function managed within the Information Technology (IT) department to take a consolidated look at all key projects across the Plan, and establish criteria and processes for prioritization, planning, resource assignment, management and execution. In addition to the PM function, the Plan also formalized a GCHP Project Steering Committee consisting of senior executive leadership to review current project status, and prioritize new project requests. All approved projects are assigned a dedicated project manager.

The below list of regulatory projects are currently in progress or planned to start in the next 30-60 days:

- DRG rates for non-contracted hospitals
- SPD transition
- HITECH Omnibus Rule implementation
- Healthy Families Program Transition to Medi-Cal
- Affordable Care Act (ACA) Physician Rate Adjustment
- ICD-10 Risk Assessment / ICD-10 Remediation / Readiness Transition
- ikaClaims and ICES software upgrades (must upgrade software versions for ICD-10 compliance)
- AB 97 provider rate reduction analysis and implementation
- MedHOK Medical Management System (MMS) Implementation (must replace current MMS as it is not ICD-10 compliant)

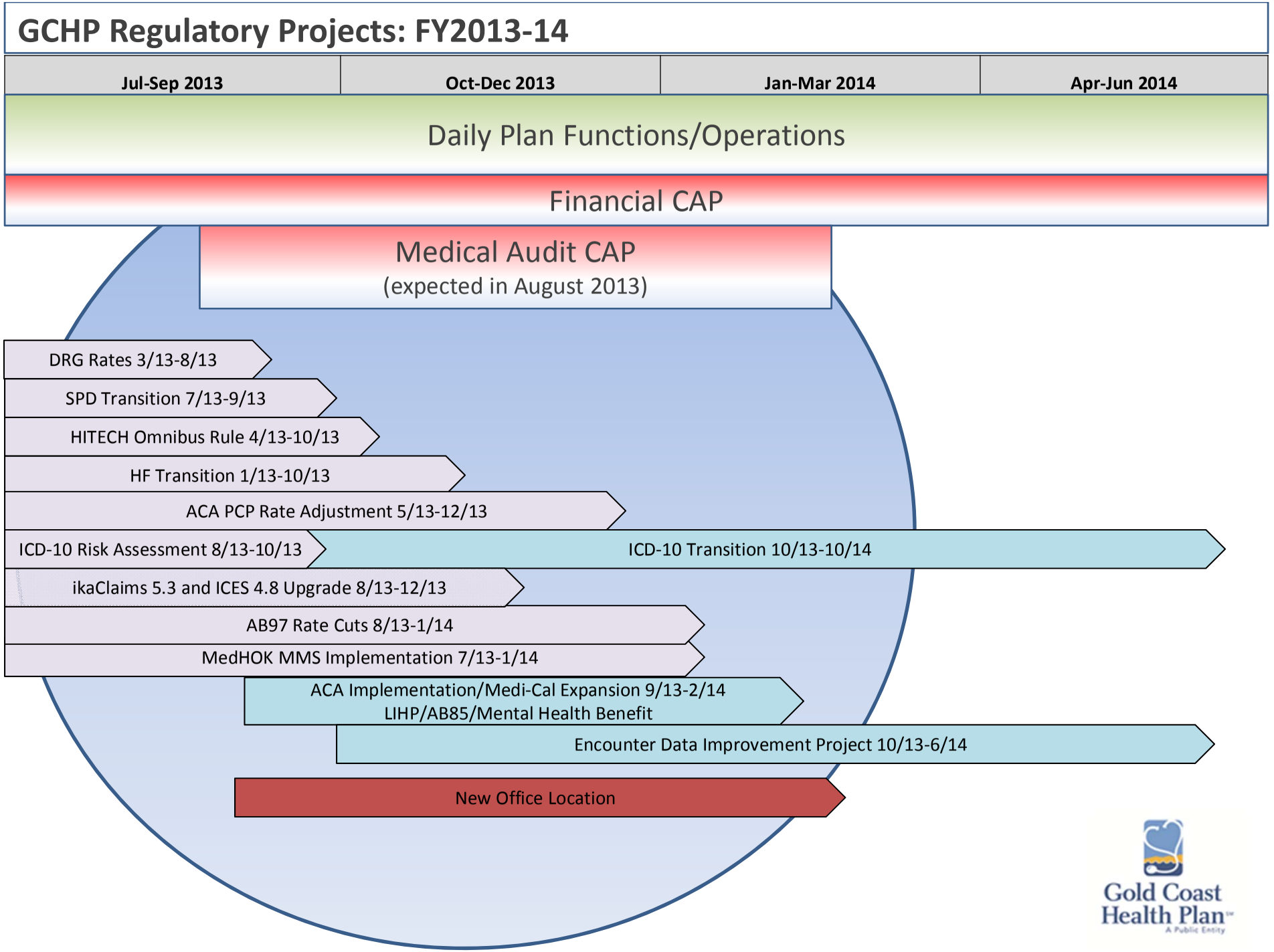
- ACA Implementation / Medi-Cal Expansion
  - LIHP Transition
  - Preparation for non-LIHP newly eligible populations
  - AB85 implementation
  - Mental Health Benefit
- Encounter Data Improvement Project

In addition to the non-optional regulatory projects, the Plan must consider office relocation. Last year, the Commission approved the hiring of a broker to look at new office space. During that time, GCHP was placed under a State financial CAP and a decision was made to postpone the office search until the Plan's financial position improved. Currently, GCHP is at a critical juncture as the current office space is close to maximum capacity and impacts the Plan's ability to fill approved FY 2013-14 positions as well as the Plan's ability to appropriately hold member meetings, provide for adequate parking, meeting space, etc. GCHP is currently identifying potential new office locations and will bring options back to the Commission for discussion when appropriate.

These critical projects are layered on top of the daily Plan operations and the State Financial CAP, where GCHP continuous to focus on claims process improvements, HEDIS annual reporting, UM / CM processes, member and provider outreach, and the implementation of a new business analytics function to improve reporting and data analysis support in order for GCHP make better business decisions. The Plan is also preparing for DHCS to transmit a Medical Audit Review CAP before the end of August. Resources will need to allocate and work begin immediately to address issues raised in the CAP.

This report is intended to provide information to the Commission about the critical nature of work required of the Plan over the next 6-9 months.

GCHP Regulatory Projects: FY2013-14



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AGENDA ITEM 4c

To: Gold Coast Health Plan Commissioners

From: Guillermo Gonzalez, Director of Government Affairs

Re: Government Affairs Legislative Update

Date: August 26, 2013

AB 209 **(Pan D) Medi-Cal: Managed Care: Quality, Accessibility, And Utilization.**
Introduced: 01/30/13 **Last Amended:** 04/09/13
Status: 06/25/13-Read second time. Ordered to third reading in Senate Health Committee.

Summary: Would require the State Department of Health Care Services to develop and implement a plan, as specified, to monitor, evaluate, and improve the quality, accessibility, and utilization of health care and dental services provided through Medi-Cal managed care. The bill would require the department to appoint an advisory committee, with specified responsibilities, for the purpose of making recommendations to the department and to the Legislature in order to improve quality and access in the delivery of Medi-Cal managed care services. The bill would be implemented to the extent that funding is provided in the annual budget act or federal, private, or other non-General Fund monies are available.

AB 411 **(Pan D) Medi-Cal: Performance Measures.**
Introduced: 02/15/13 **Last Amended:** 07/02/13
Status: 08/12/13-In committee: Placed on Senate Approps suspense file.

Summary: Would require all Medi-Cal managed care plans to link individual level data collected as a part of analyzing their Healthcare Effectiveness Data and Information Set (HEDIS) measures, to patient identifiers in a manner that allows for an analysis of disparities in medical treatment by certain characteristics and to submit that data to the DHCS annually. The DHCS would be required to make individual level data available for research purposes. The bill would further require the department to stratify, in the aggregate, that data by certain characteristics and to develop a report, which would be published on the DHCS Internet Web site.

AB 676 **(Fox D) Health Care Coverage: Post Discharge Care Needs.**
Introduced: 02/21/13 **Last Amended:** 04/10/13
Status: 05/24/13-Failed Deadline pursuant to Rule 61(a) (5). Assembly 2 Year Bill

Summary: Would prohibit health care service plans, health insurers, and the DHCS or Medi-Cal managed care plans, from causing an enrollee, insured, or beneficiary to remain in a general acute care hospital or an acute psychiatric hospital if the attending physician on the medical staff has determined that the individual no longer requires inpatient hospital care. The bill would require the health care service plan, health insurer, or the DHCS or Medi-Cal managed care plan to perform specified duties within 24 hours of receipt of notice of the discharge.

AB 900 **(Alejo D) Medi-Cal: Reimbursement: Distinct Part Nursing Facilities.**
Introduced: 02/22/13 **Last Amended:** 06/25/13
Status: 08/13/13-In committee: Placed on Senate Appropriation Committee Suspense File

Summary: Current law requires, except as otherwise provided, Medi-Cal provider payments to be reduced by 1% or 5%, and provider payments for specified non-Medi-Cal programs to be reduced by 1%, for dates of service on and after March 1, 2009, and until June 1, 2011. Current law requires Medi-Cal provider payments and payments for specified non-Medi-Cal programs to be reduced by 10% for dates of service on and after June 1, 2011. This bill would instead require that this payment reduction not apply to skilled nursing facilities that are a distinct part of a general acute care hospital, for dates of service on or after July 1, 2013, subject to necessary federal approvals.

ABX1 1 **(John A. Pérez D) Medi-Cal: Eligibility.**
Introduced: 01/28/13 **Last Amended:** 06/14/13
Status: 06/27/13-Chaptered by Secretary of State. Chapter 3, Statutes of 2013 14 First Extraordinary Session.

Summary: Would, commencing January 1, 2014, implement various provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended, by, among other things, modifying provisions relating to determining eligibility for certain groups. The bill would extend Medi-Cal eligibility to specified adults and would require that income eligibility be determined based on modified adjusted gross income (MAGI). The bill would prohibit the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI.

ABX1 2 **(Pan D) Health Care Coverage.**
Introduced: 01/29/13 **Last Amended:** 04/01/13
Status: 05/09/13-Chaptered by Secretary of State. Chapter 1, Statutes of 2013-14 First Extraordinary Session.

Summary: Would require an insurer, on and after October 1, 2013, to offer, market, and sell all of the insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the insurer provides or arranges for the provision of health care services, as specified, but would require insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. The bill would prohibit these insurers from imposing any preexisting condition exclusion upon any individual and from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified.

SB 126 **(Steinberg D) Health Care Coverage: Pervasive Developmental Disorder Or Autism**
Introduced: 01/22/13 **Last Amended:** 08/08/13
Status: 08/08/13-From committee with author's amendments. Read second time and amended. Re- referred to Assembly Appropriations Committee

Summary: Current law requires health care service plan contracts and health insurance policies to provide benefits for specified conditions, including coverage for behavioral health treatment, as defined, for pervasive developmental disorder or autism, except as specified. A willful violation of these provisions with respect to health care service plans is a crime. These provisions are inoperative on July 1, 2014, and are repealed on January 1, 2015. This bill would extend the operation of these provisions until January 1, 2017. By extending the operation of provisions establishing crimes, the bill would impose a state-mandated local program.

SB 239 **(Hernandez D) Medi-Cal: Hospitals: Quality Assurance Fee.**
Introduced: 02/12/13 **Last Amended:** 08/14/13
Status: 08/14/13-From committee with author's amendments. Read second time and amended. Re-referred to Assembly Committee on Health.

Summary: Would, subject to federal approval, impose a hospital quality assurance fee, as specified, on certain general acute care hospitals from January 1, 2014, through December 31, 2015, to be deposited into the Hospital Quality Assurance Revenue Fund. This bill would, subject to federal approval, provide that moneys in the Hospital Quality Assurance Revenue Fund shall, upon appropriation by the Legislature, be available only for certain purposes, including paying for health care coverage for children, as specified, and making supplemental payments for certain services to private hospitals, increased capitation payments to Medi-Cal managed care plans, and increased payments to mental health plans.

SB 640 **(Lara D) Medi-Cal: Reimbursement: Provider Payments.**
Introduced: 02/22/13 **Last Amended:** 05/24/13

Status: 05/24/13-From committee with author's amendments. Read second time and amended. Re- referred to Senate Committee on Appropriations

Summary: Current law requires, except as otherwise provided, Medi-Cal provider payments and payments for specified non-Medi-Cal programs to be reduced by 10% for dates of service on and after June 1, 2011. This bill would instead require that, to the extent permitted by federal law, this payment reduction not apply to skilled nursing facilities or sub-acute care units that are a distinct part of a general acute care hospital, intermediate care or other specified facilities serving developmentally disabled individuals, or specified Medi-Cal provider payments for fee-for-service benefits, including payments to pharmacies, for dates of service on or after June 1, 2011.

SBX1 1 **(Hernández D) Medi-Cal: Eligibility.**
Introduced: 01/28/13 **Last Amended:** 06/14/13
Status: 06/27/13-Chaptered by Secretary of State. Chapter 4, Statutes of 2013-14 First Extraordinary Session.
Location: 06/27/13 CHAPTERED

Summary: Would, commencing January 1, 2014, implement various provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended, by, among other things, modifying provisions relating to determining eligibility for certain groups. The bill would, in this regard, extend Medi-Cal eligibility to specified former foster children. The bill would also add, commencing January 1, 2014, mental health services and substance use disorder services included in the essential health benefits package, as adopted by the state and approved by the United States Secretary of Health and Human Services, to the schedule of Medi-Cal benefits, as specified.

SBX1 2 **(Hernandez D) Health Care Coverage.**
Introduced: 01/28/13 **Last Amended:** 04/01/13
Status: 05/09/13-Chaptered by Secretary of State. Chapter 2, Statutes of 2013-14 First Extraordinary Session.
Location: 05/09/13 CHAPTERED

Summary: Would require a health care service plan, on and after October 1, 2013, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services, as specified, but would require plans to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. The bill would prohibit these health care service plans from imposing any preexisting condition exclusion upon any individual and from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified.

SBX1 3 **(Hernandez D) Health Care Coverage: Bridge Plan.**
Introduced: 02/05/13 **Last Amended:** 06/19/13
Status: 07/11/13-Chaptered by the Secretary of State, Chapter Number 5, Statutes of 2013 First Extraordinary Session
Location: 07/11/13-S. CHAPTERED

Summary: Current law, the federal Patient Protection and Affordable Care Act, requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. This bill would exempt a bridge plan product, as defined, from that latter requirement. The eligible populations for the Bridge plan are:

- New Covered California enrollees who were previously enrolled in Medi-Cal Managed Care Plans.
- Family members eligible for coverage in Covered California whose families include enrollees in Medi-Cal Managed Care Plans participating in the program.
- Parent(s) or caretaker relative of a Medi-Cal enrolled child.

Bridge plans must offer a plan that is equal to or less than the lowest-cost available silver plan

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

GOLD COAST HEALTH PLAN
CALIFORNIA LEGISLATIVE UPDATE
By Don Gilbert, Mike Robson, and Trent Smith
August 12, 2013

The Legislature has made the implementation of the Affordable Care Act (ACA) a priority for the 2013 Legislative Session. As they begin their final month of work, the Legislature may shift focus to another politically charged health related matter – amending the Medical Injury Compensation Reform Act of 1975.

Commonly known as MICRA, the Medical Injury Compensation Reform Act caps at $250,000, the amount that can be awarded for pain and suffering in medical malpractice lawsuits. Trial attorneys argue that MICRA is outdated and insufficient to cover prolonged effects of doctor negligence. They further argue that if MICRA were adjusted to account for inflation, the appropriate MICRA cap would be approximately $1.2 million. Some consumer groups are joining the trial lawyers in an effort to adjust the MICRA cap to a level closer to $1.2 million.

However, doctors and insurance companies argue that raising the MICRA cap so significantly will lead to higher malpractice insurance rates and ultimately lead to doctors leaving California to practice elsewhere. Many hospitals, nurses, community clinics, local governments, labor unions, and others have also voiced similar concerns with regards to the potential impact on the costs of health care.

Senate President pro Tempore Steinberg has suggested that all sides should come to the table in the closing weeks of the legislative session to see if a compromise can be reached. It is unclear at this point in the session if such a monumental agreement can be reached in such a short period of time.

It is more likely that this issue is headed to the ballot via an initiative. The Consumer Attorneys of California, which represent the trial attorneys, and California Watchdog, a Santa Monica based consumer group, have filed papers with the Secretary of State to take the matter directly to voters.

In addition to lifting the MICRA cap to about $1.1 million for non-economic damages in medical malpractice cases, the initiative also would include further annual increases to account for inflation. In addition, the proposed initiative would mandate random drug and alcohol testing for physicians who practice in hospitals and surgery centers. Another portion of the initiative requires physicians and pharmacists to use a data base to track potential abuse of certain powerful and addictive medications, such as pain killers.

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The initiative would likely spur a very expensive campaign for the 2014 ballot. Lawyers, doctors, hospitals, and insurance companies – all with very deep pockets – would surely pour millions into such a campaign.

So, in the last month of session, can the Legislature bring the interested parties together and pass a compromise measure that heads-off a costly ballot campaign? In our judgment, a legislative solution is unlikely to arise, especially considering the time constraints of the session. That does not mean that the Legislature will not try to reach a compromise rather than let voters decide on an "all or nothing" ballot proposal.

Some political strategists suggest that it would be better for the legislative leadership to allow a ballot measure to move forward rather than forcing legislators to cast a tough vote that would upset some key supporters. Other politicos fear that a costly ballot measure in 2014 will drain the political coffers of major donors, leaving less to spend on legislative campaigns. No matter whom you want to believe, it is still unlikely that a legislative deal on MICRA emerges simply because it is too large of an issue for the Legislature to wrap its arms around in four short weeks. Furthermore, the Legislature would prefer not to make any of its major political supports mad by supporting one side over the other.

We will be watching this issue closely as the session comes to an end – and beyond – as the political dynamics will surely "spill-over" and impact other unrelated policy debates.

AGENDA ITEM 4d

To: Gold Coast Health Plan Commissioners

From: Michelle Raleigh, Chief Financial Officer
Sherri Bennett, Provider Relations Manager

Date: August 26, 2013

RE: Assembly Bill 97 Update

SUMMARY:
The State is proceeding with implementing provider reductions for specific provider types under Assembly Bill 97 (AB97). These reductions will result in lower capitation rates being paid to Gold Coast Health Plan (Plan) beginning October 1, 2013. The Plan discussed this with the Executive / Finance Committee on August 1st and will need to work with the Commission to determine which of the AB97 provider reductions should result in reduced rates being paid to Plan providers.

BACKGROUND / DISCUSSION:
On June 14, 2013, the United States Court of Appeals for the Ninth Circuit denied a plaintiffs' motion for a stay of its mandate in this case, clearing the way for California to implement the 10 percent payment reductions for specific Medi-Cal providers according to AB97.

The Fiscal Year 2013-14 State budget clarified that these provider reductions would be made retroactively for the State's fee-for-service program. However, the reduction to managed care plans' capitation rates would be made prospectively. In an August 14th memo (attached), DHCS clarified that capitation rates would be reduced beginning October 1, 2013 to reflect AB97 provider reductions. The previous effective date for managed care was September 1, 2013. The memo states that additional information will be provided via an All Plan Letter in the near future. In the meantime, the Plan is submitting questions to the State to clarify which services and providers will be reduced when developing capitation rates.

The Plan previously estimated the impact of the AB97 rate reduction will reduce the Plan's revenue by approximately $1.4 million annually. This estimate is expected to be lower to account for the new guidance regarding reductions that will not impact managed care rates. Determination of the updated fiscal impact is pending further analysis once additional information is received from the State.

As part of the Plan's analysis, staff will:

- Review historical utilization and paid claim information by provider type,
- Discuss potential impacts on access and determine alternatives, and
- Draft a recommendation to provide to the Commission re: which reductions to pass onto providers.

The Plan remains under a Corrective Action Plan (CAP) from the State of California, as originally outlined in October 2012. A primary aspect of that CAP concerns the Plan's deficit related to the State's Tangible Net Equity (TNE) requirement. In order to meet the TNE requirement (according to the State's phased-in TNE schedule), the Plan must consider passing on any remaining rate reductions to the appropriate providers in FY2013-14.

The Plan will present additional analysis to the Commission to quantify the impact on each provider class and to seek the Commission's recommendation on implementing the AB97 rate reductions.

Attachments:
DHCS August 14th memo.

Implementation of AB 97 Reductions

The Department of Health Care Services (DHCS) is announcing today the implementation plan for the provider payment reductions required pursuant to Assembly Bill 97 (Chapter 3, Statutes of 2011). AB 97 requires DHCS to implement 10% provider payment reductions to most categories of services in Medi-Cal fee-for-service (FFS) as well as actuarially equivalent reductions in Medi-Cal managed care.

DHCS received federal approval for the reductions, effective June 1, 2011, but has been prevented from implementing many of these reductions due to a court injunction in the *Managed Pharmacy Care, et al v. Kathleen Sebelius, et al* case. On June 14, 2013, the United States Court of Appeals for the Ninth Circuit denied the plaintiffs' motion for a stay of mandate in this case, allowing the implementation of all of the AB 97 Medi-Cal provider 10% payment reductions.

Providers affected by the earlier court injunction that blocked the payment reductions will soon have a 10% prospective payment reduction applied to all claims they submit for services. The chart below shows the date on which providers will begin to see the reductions.

Provider Categories	Date
Medical Transportation	9/5/2013
Dental	9/5/2013
Durable Medical Equipment/Medical Supplies	10/24/2013
Pharmacy	1/9/2014
Physician/Clinic	1/9/2014
Distinct Part Nursing Facility Level B (PT 17 & AC 1,2,3)	1/9/2014

Additionally, since the 10% payment reduction is effective for services provided on or after June 1, 2011, DHCS will also begin recouping a percentage of provider payments to recover overpaid funds during this retroactive period. These retroactive payment recoveries will not occur until after the prospective 10% payment reductions are implemented. DHCS will provide at least sixty (60) day advanced notification of scheduled recoveries.

FFS Payments

In order to preserve and protect access to care for Medi-Cal members, DHCS is also announcing the following provider payment reduction exemptions, subject to federal approval of State Plan Amendments (SPA):

- Nonprofit dental pediatric surgery centers that provide at least 99% of their services under general anesthesia to children with severe dental disease under age 21 will be exempted prospectively from the 10% payment reduction. After required public notice, the effective date of this prospective exemption will be in the near future.

- Distinct part nursing facilities, Level B, classified as rural or frontier, based upon the California Medical Service Study Area's definitions, will be exempted prospectively from the 10% payment reductions and will not be subject to the rate freeze at the 2008-09 levels on a prospective basis. After required public notice, the effective date of this prospective exemption will also be in the near future.

- Certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions, such as hemophilia, multiple sclerosis, hepatitis and others will be exempt from the 10% payment reduction. DHCS has submitted a SPA (SPA 12-014) to exempt these categories of drugs, with an effective date for the exemption of March 31, 2012.

Managed Care

As noted above, DHCS is required to make actuarially equivalent reductions to Medi-Cal managed care. Such reductions will be effective on October 1, 2013, on a prospective basis only. DHCS previously announced that given the differences between managed care and FFS, reductions to pharmacy would not be applied in managed care. DHCS is now announcing that specialty physician services in Medi-Cal managed care will not be subject to a reduction. Guidance on the Medi-Cal managed care implementation will be issued soon in an All Plan Letter.

Future information may be found at www.medi-cal.ca.gov.

Gold Coast Health Plan℠
A Public Entity

Health Care Reform

Presented to the
Gold Coast Health Plan Commission

August 26, 2013

Michael Engelhard, CEO

Gold Coast Health Plan

www.goldcoasthealthplan.org

4e-1

Health Care Reform

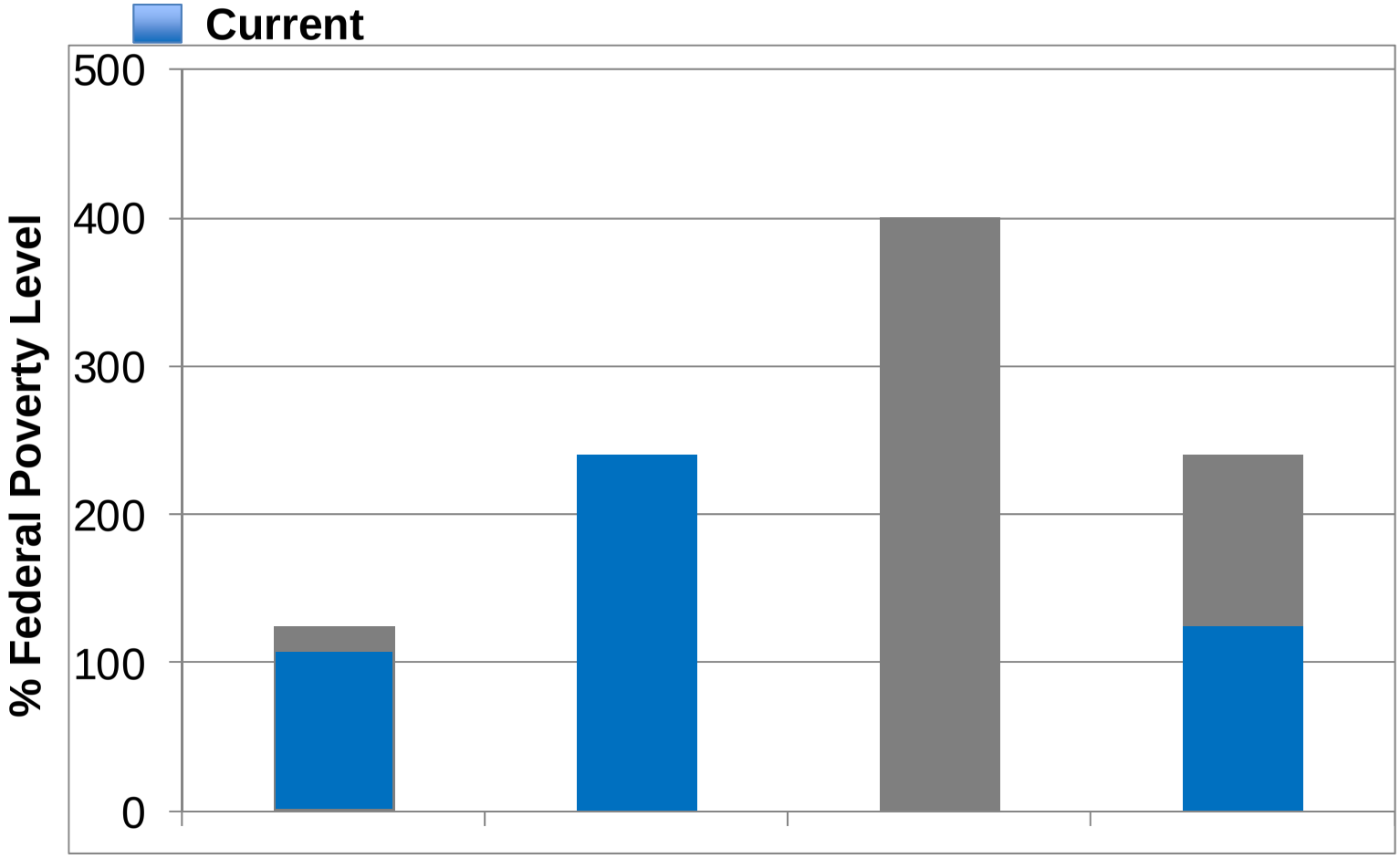
- Covered California (Health Benefit Exchange)
- Medi-Cal Expansion
- Bridge Plan Proposal
- GCHP Readiness
- GCHP Outreach

Health Care Reform: What is coming in 2014?

- Expansion of Medicaid-eligibility up to 138% FPL
- Individual Mandate
- Employer Mandate deferred until 2015
- Coverage & Subsidies Begin In Health Benefits Exchange
- Coverage Enhancements
  - Parents can cover children up to age 26*
  - No pre-existing condition exclusions*
  - No lifetime cap on medical costs or benefits (delayed)
- Bridge Health Plan Option - April 2014

* Already implemented

Income Eligibility Levels- 2014



* LIHP – Low Income Health Plan

CA Health Benefit Exchange aka Covered California

- California's Health Benefit Exchange
  - 19 geographical exchanges

- First open enrollment period
  - October 1, 2013 to March 31, 2014
  - Coverage effective January 1, 2014

- 2.2 million will be eligible statewide by 2019 *(UCLA Center for Health Policy)

- Four "metal" plan ratings ranging from 60%-90% coverage; members pay out of pocket for portion not covered

Covered California- Health Plans

- **Ventura County Health Care Plan in 2015**
- Alameda Alliance for Health
- Anthem Blue Cross of California-Individual Market Only
- Blue Shield of California
- Chinese Community Health Plan
- Contra Costa Health Plan
- Health Net
- Kaiser Permanente
- L.A. Care Health Plan
- Molina Healthcare
- Sharp Healthcare
- Valley Health Plan
- Western Health Advantage

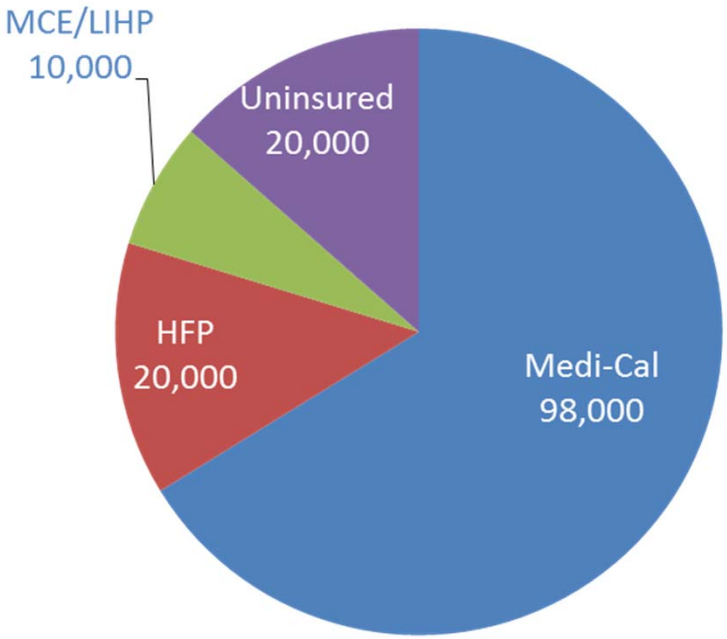
Medi-Cal Expansion

- About 7 million covered currently in California
- About 1 million are currently eligible but not enrolled
- Approximately 2.2 million will be newly eligible

Source: UCLA Center for Health Policy

Medi-Cal/GCHP Enrollment Will Increase Approximately 45-50 Percent in 2013 and Beyond

Legacy Medi-Cal Population (as of 12/31/2012)	**98,000**
Expansion Population	
• **ACE MCE**	**10,000**
• **Uninsured***	**20,000**
• **Healthy Families ****	**20,000**



* Estimated enrollment over 12-24 months
**Approx. 6,000 of these enrollees have been enrolled into GCHP since January 2013

Medi-Cal Expansion Benefits

*Must include 10 essential health benefits:

1. Ambulatory outpatient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health & substance use disorder svcs-ACA requirement
6. Prescription drugs
7. Rehabilitative and habilitative services
8. Laboratory services
9. Preventive care and chronic disease management
10. Pediatric services, including oral and vision care

*Source: http://www.coveredca.com/coverage_basics.html

State proposing the MCE benefits mirror existing Medi-Cal benefits, unless mandated by ACA.

Long-Term Care benefit proposed by DHCS as long as "asset test" is approved by CMS. If not, then LTC will not be a MCE benefit.

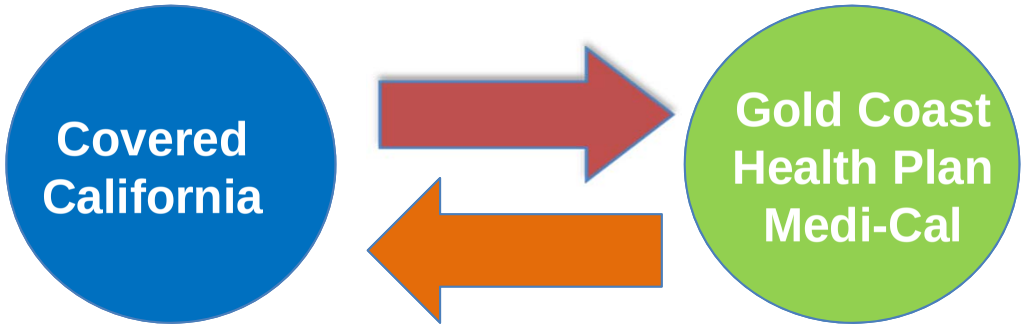
Medi-Cal Expansion – Federal Support

- State's costs for newly eligible:
  - Covered 100% by federal government in first three years of expansion
  - Gradually drops to 90 percent federal funding in 2020 and beyond
  - States must implement full expansion to receive these funds

- Increases reimbursement for primary care providers and certain specialists to Medicare equivalent rates for 2013-14 only.

Delivery System Challenges

- Increased need for behavioral health services and care coordination
- Provider stability if newly eligible beneficiaries switch providers frequently
- Challenges due to churn between Exchange and Medi-Cal: continuity of care, affordability, health outcomes



Bridge Plan

- State Legislature authorized Bridge Plan policy through SBX3 1
- Governor signed SBX3 1 into law on July 11, 2013
- Five-year sunset from date of federal approval still pending

Objectives of the Bridge Plan:

- Establish a health plan for low-income individuals and parents of Medi-Cal and HFP-eligible individuals who move between Medi-Cal and Covered California
- Promotes continuity of coverage and care
- Reduce disruptions in continuity of care associated with changes in health plans
- Create access to more affordable coverage

Bridge Plan Eligibility Limited To:

- Incomes between 139 % to 250% of FPL
- Individuals previously enrolled in Medi-Cal Managed Care Plan
- Members of a household in which there is a Medi-Cal or HFP enrollee if they are counted as part of the Modified Adjusted Gross Income household.
- Parent(s) or caretaker relative of a Medi-Cal enrolled child.

Health Plan Criteria For Bridge Plan

- Only Medi-Cal Managed Care Plans can offer Bridge Plan
- Must be certified as a Qualified Health Plan (QHP)
  - Maintain medical loss ratio (MLR) of 85%
  - Must apply for and meet standards for licensure under the Knox-Keene Health Care Service Plan Act
  - Exempted from the requirement to sell products within each of the five levels of coverage available in Covered California but must offer at least one silver-level plan

Bridge Plan Factors for GCHP Consideration

- Financial viability-Plans must offer option equal to 2nd lowest cost silver plan
- Actuarial and Operational Analysis Pending
- Ongoing administrative costs for workload increases due to oversight are undetermined e.g. premium collection, network adequacy, member participation in Exchange
- Plans must apply for Knox-Keene licensing
  - Additional reporting and oversight from DMHC
- Network adequacy
- Organizational bandwidth between now an April 2014

- **Can GCHP be ready by April 2014?**

Gold Coast Readiness for Medicaid Expansion

- Partner with County, health care partners, and community stakeholders to ensure smooth transition
  - Provider network analysis and utilization patterns
  - Ensure continuity of care (prescriptions, authorizations for pending treatment, etc.)

- Operational readiness review to identify gaps and resource needs
  - Increased staffing based upon identified needs
    - Ex: additional call center staff, new member orientations, media outreach campaign to raise member awareness

State Outreach Activities

- Covered California launched outreach & awareness campaign in July 2013
  - $43 million in federal funds for outreach grants
  - Guiding principle: encourage enrollment
  - Reach eligible populations “where they live, work and play”
- The California Endowment pledged $225 million over the next four years to boost enrollment in Medi-Cal and increase number of PCPs

GCHP Outreach Activities

- Coordination with County, Healthcare Partners, Community Stakeholders
- Radio-Media Campaign and Internet Messaging
- New Member Orientations
- Telephone Outreach Campaign
- Health Fairs & Workshops
- Schools and Youth Day Camps
- Public Events and Community Festivals

Gold Coast Health Plan's Mission

To Improve the Health of Our Members Through the Provision of the Best Possible Quality Care and Services

Contact GCHP
888-301-1228
www.goldcoasthealthplan.org

Questions ?

Gold Coast Health Plan℠
A Public Entity

Healthy Families Program Transition to Medi-Cal

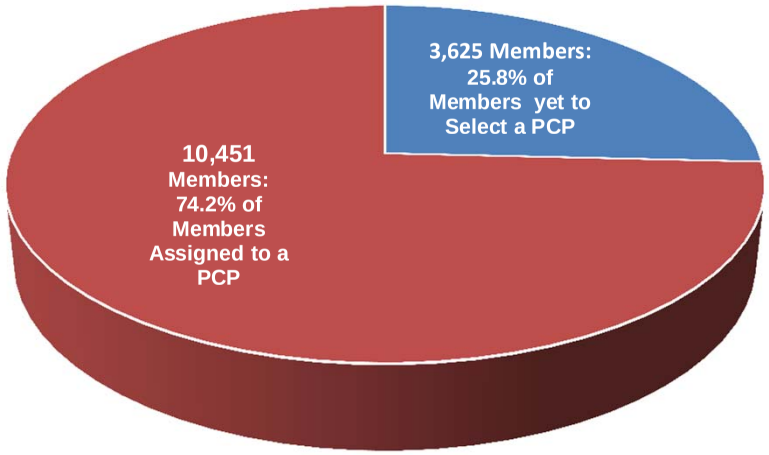
Presented to the
Gold Coast Health Plan Commission

August 26, 2013

Michael Engelhard, CEO
Gold Coast Health Plan

PCP Assignment-The Summary

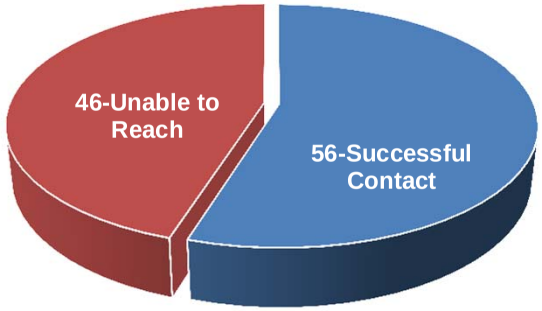
PCP Assignment Statistics



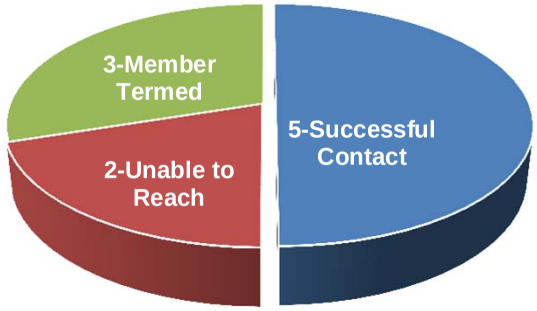
74.2% of Transitioned Healthy Family Members have been assigned to their PCP of record from their previous Plan or have selected a PCP.

Pre-Authorizations-Behavioral Health

Transitioned Behavioral Health Cases
(Total 102)-Anthem
Outreach Complete

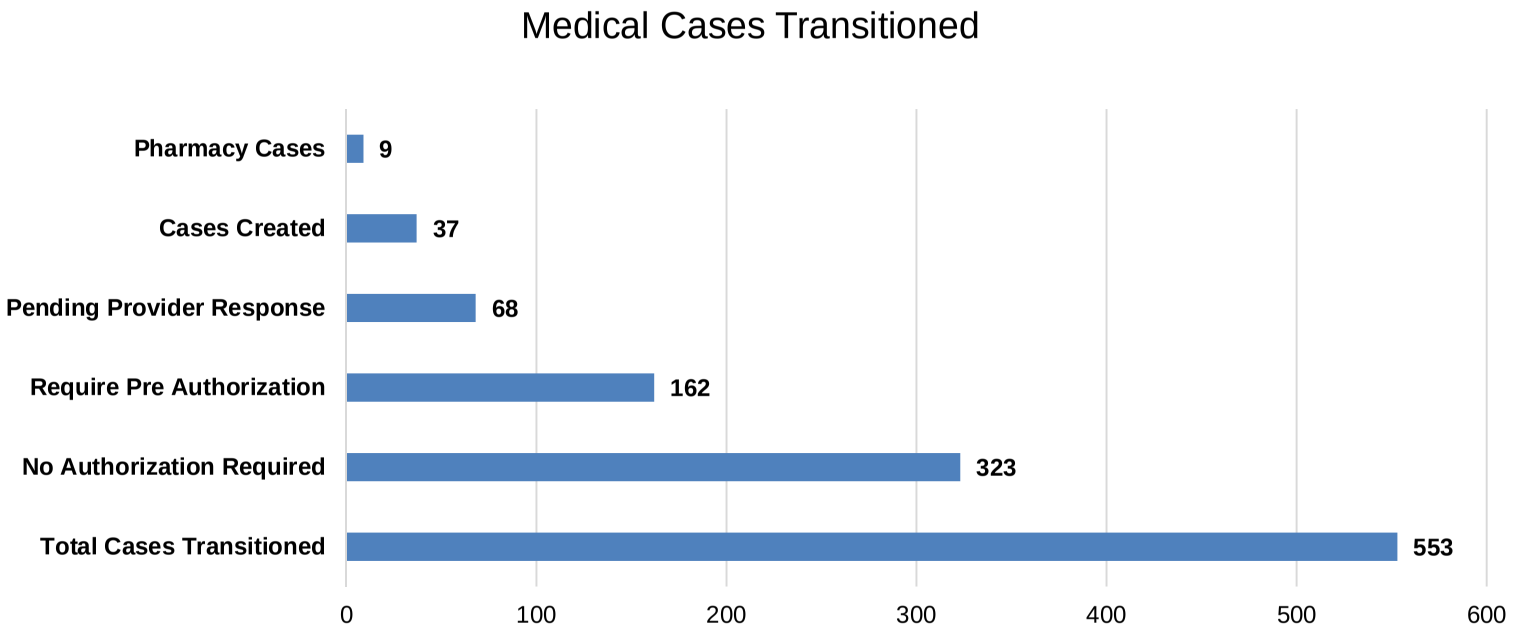


Transitioned ABA Cases-VCHCP
Outreach Complete



In total, 259 Behavioral Health cases were transitioned from the previous plans. Of that, 112 were open authorizations. GCHP also warm transitioned care for 7 Severely Emotional Disturbance (SED) cases to the County for treatment.

Pre-Authorizations-Med Surgical Outreach



Call Center Statistics

Week Ending August 12, 2013				
Total Healthy Family Calls:	**Current Call Volume:**	**Previous Call Volume (2months):**	**Outbound Calls:**	**Continuity of Care (COC) Issues**
719	1955	540	537	2