Gold Coast Health Plan℠
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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, January 28, 2013
3:00 p.m.

AGENDA

CALL TO ORDER / ROLL CALL

PUBLIC COMMENT / CORRESPONDENCE

1. APPROVE MINUTES
- a. Regular Meeting of November 26, 2012

2. ACCEPT AND FILE ITEMS
- a. CEO Update
- b. October and November Financials
- c. Pending Capitation Rate Issues

3. APPROVAL ITEMS
- a. FY 2012-13 Revised Budget (including Financial Forecast provided to DHCS in response to CAP)
- b. FY 2011-12 Audit Results (including presentation by McGladrey LLP, Financial Statements & Report to Audit Committee)

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, 2220 E. GONZALES ROAD, SUITE 200, OXNARD, CA.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT 805/981-5340. 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 January 28, 2013 Commission Meeting Agenda *(continued)*
PLACE: 2240 E. Gonzalez, Room 200, Oxnard, CA
TIME: 3:00 p.m.

4. CONSENT ITEMS

a. DHCS Contract Amendment for Healthy Families
b. BRG Contract Amendment Ratification

5. INFORMATIONAL ITEMS

a. Medical Management System Replacement
b. Tatum Work Update
c. Healthy Families Transition to Medi-Cal
d. State Budget Update
e. QI Report
f. Real Estate Update

CLOSED SESSION

Closed Session Conference with Legal Counsel – Existing Litigation pursuant to Government Code Section 54956.9 Sziklai v. Gold Coast Health Plan *et al* VCSC Case No. 56-2012-00428086-CU-WT-VTA

Announcement from Closed Session, if any.

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on February 25, 2013 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

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

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Commission Meeting Minutes
November 26, 2012
(Not official until approved)

CALL TO ORDER

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

The Pledge of Allegiance was recited.

ROLL CALL

COMMITTEE MEMBERS PRESENT
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Maylee Berry, Medi-Cal Beneficiary Advocate
Anil Chawla, MD, Clinicas del Camino Real, Inc.
Lanyard Dial, MD, Ventura County Medical Association
John Fankhauser, MD, Ventura County Medical Center Executive Committee
David Glyer, Private Hospitals / Healthcare System
Robert Gonzalez, MD, Ventura County Health Care Agency
Kathy Long, Ventura County Board of Supervisors
Robert S. Juarez, Clinicas del Camino Real, Inc.
Catherine Rodriguez, Ventura County Medical Health System

EXCUSED / ABSENT COMMITTEE MEMBERS
Laurie Eberst, Private Hospitals / Healthcare System

STAFF IN ATTENDANCE
Michael Engelhard, CEO
Nancy Kierstyn Schreiner, Legal Counsel
Michelle Raleigh, CFO
Sonia DeMarta, Controller
Traci R. McGinley, Clerk of the Board
Charlie Cho, MD, Chief Medical Officer
Stefani Conley, Interim Human Resources Director
Guillermo Gonzalez, Government Relations Director
Steven Lalich, Communications Manager

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

PUBLIC COMMENT / CORRESPONDENCE

Maria Tello, Paloma 10 Productions, sought assistance with an earthquake emergency preparedness training video for the Mixteco Community. She stated that her goal is to prepare the community for any number of emergencies and build trust in the community. The film could later be used with voice over for any number of dialects. The cost is approximately $9,000 and she is hoping to make this a collaborative effort. To-date, MICOP – the Mixteco / Indigena Community Organizing Project - and several other local organizations are involved in this effort and Ms. Tello asked if Gold Coast Health Plan would support the effort.

CEO Engelhard stated that staff would discuss this and determine if it is an appropriate project for GCHP.

1. APPROVE MINUTES

a. Regular Meeting of October 22, 2012

Clerk McGinley noted that Legal Counsel Kierstyn Schreiner's name needed to be corrected and the Title of Item 2a should read as follows: "**a. Health Education – Group Needs Assessment (GNA) Findings**"

Chair Gonzalez noted that the last sentence of the second paragraph of Item 2 should read as follows: "Chair Gonzalez responded that there is a contract between Clinicas and the County."

Commissioner Berry moved to approve the Regular Meeting Minutes of October 22, 2012 as amended. Commissioner Chawla seconded. The motion carried. **Approved 10-0.**

2. CEO REPORT

CEO Engelhard introduced Michelle Raleigh, GCHP's new CFO. CFO Raleigh stated that she was looking forward to working with the Commission and was excited to be at the Plan.

CEO Engelhard reviewed his written report with the Commission.

3. ACCEPT AND FILE ITEMS

a. September Financials

CFO Raleigh and Controller DeMarta reviewed the financials which had been presented to the Executive Finance Committee at the November 6, 2012 Meeting.

There was discussion about the IBNR and the required adjustments.

CFO Raleigh reported that the State has requested the Plan to group claims in a specific manner in order that all plans in the state are reporting consistently.

Commissioner Araujo requested information on what items are contained in the long-term care expenditures line item on the financial report. Staff will provide information on how the claims get grouped into the service categories.

Commissioner Araujo moved to accept and file the September Financials. Commissioner Rodriguez seconded. The motion carried. **Approved 10-0.**

4. APPROVAL ITEMS

a. Extension of Tatum Contract

CEO Engelhard reviewed his report.

Commissioner Dial moved to extend the Tatum contract for Debbie Rieger until November 30, 2012. Commissioner Glyer seconded. The motion carried. **Approved 10-0.**

b. Benefits Update and Request for Approval

CEO Engelhard reviewed his report.

Commissioner Dial moved to give the CEO authority to enter into contracts when the final benefits and carrier are selected. Commissioner Berry seconded.

Discussion was held regarding the cost to the Plan. Given that the Plan has only about 50 employees, this puts the Plan into a higher cost rating pool for health benefits as compared to employers with larger numbers of employees. CEO Engelhard reported that the cost is approximately $700,000 for health, dental and vision for 50 employees and their families and that in order to keep the rate of increase down for the Plan that employees are being asked to contribute more out-of-pocket expenses for their health benefits.

The motion carried. **Approved 10-0.**

c. DHCS Contract Amendment

CEO Engelhard reviewed his written report which asked for the Commission to give the CEO the authority to execute an amendment to the DHCS contract to incorporate new medical management and reporting requirements for the management of the Seniors and Persons with Disabilities (SPD) population.

Commissioner Juarez moved to approve execution of the DHCS Contract Amendment by the CEO. Commissioner Araujo seconded. The motion carried. **Approved 10-0.**

d. Request for Additional Resources

CEO Engelhard reviewed his written report.

Discussion was held regarding the jobs currently outsourced by GCHP, the financial impact of the additional positions and whether there was adequate funding for 25 additional employees, the number of positions for the size of the plan.

The top priority positions were highlighted: utilization management and case management, data analysis, claims oversight and review, provider contracting and provider relations.

Commissioner Juarez moved to authorize hiring of up to 15 staff and come back in January to review the financial forecast, including staffing plan. Commissioner Long seconded. The motion carried. **Approved 10-0.**

Commission Fankhauser expressed his concern that this was the 3rd extension of the Tatum Contract. CEO Engelhard explained that upon his arrival at the Plan, the contract with Tatum was set to expire. Subsequently the Plan has received the CAP and the medical review audit notification. In order to address these regulatory needs and to finish the work of remediating existing issues with the Plan's systems and operations, the contract needs to be extended.

Commissioner Juarez stressed the importance that GCHP obtain the knowledge that Tatum consultants have acquired prior to their departure. CEO Engelhard agreed and further stated that there will be a monthly progress report on the Commission Agenda regarding Tatum.

Commissioner Long moved to extend the Tatum contract not to exceed 120 days, with monthly reports to Commission. Commissioner Rodriguez seconded. The motion carried. **Approved 10-0.**

e. Continuation of Legal Services with Nordman Cormany Hair & Compton LLP

CEO Engelhard reviewed his report.

Commissioner Juarez requested that legal billings be separated for Commission level work versus health plan issues like contracting, litigation, etc.

Commissioner Long moved to allow the CEO authority to continue requesting legal services from Nordman Cormany Hair & Compton LLP as the CEO deems necessary within budgetary and funding constraints. Commissioner Glyer seconded. The motion carried. **Approved 10-0.**

RECESS:

A recess was called at 5:06 p.m. The meeting was reconvened at 5:14 p.m.

CLOSED SESSION

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

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 5:15 p.m. regarding the following item:

> **Conference with Legal Counsel-Anticipated litigation significant exposure to litigation pursuant to Government Code section 54956.9 (b). (One case)**

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 5:45 p.m.

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

1. **In re Application to file Late Claim Audra Lucas- Recommendation grant late claim application for processing**

Commissioner Dial moved to grant late claim application for processing of Audra Lucas. Commissioner Long seconded. The motion carried. **Approved 10-0.**

2. **In re Claim of Audra Lucas-Reject claim**

Commissioner Dial moved to reject the Claim of Audra Lucas. Commissioner Juarez seconded. The motion carried. **Approved 10-0.**

COMMENTS FROM COMMISSIONERS

Commissioner Dial noted that he had met with CEO Engelhard and believes the Commission needs to support the CEO.

Commissioner Long thanked the staff and the work that they do.

ADJOURNMENT

Meeting adjourned at 5:47 p.m.

AGENDA ITEM 2a

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, CEO

Date: January 28, 2013

Re: CEO Update

DHCS Update

- Corrective Action Plan: The final deadline for submissions listed in the CAP is December 31, 2012 and GCHP completed the work on all but two items. Those items are:

    - 60% Auto Adjudication Rate: the CAP identified this as a target rate for claims to be auto adjudicated by the claims system. This figure a target figure given to GCHP that is not a contract requirement nor an industry standard figure. Given this, GCHP has improved the AA rate from under 20% earlier this year to more than 35% by the second week of December 2012. GCHP has been working with ACS using Six Sigma project principles to achieve an AA rate of greater than 60% before the end of FY2012-13.
    - Hiring of a Chief Operating Officer: the CAP identified five key positions that were to be hired, including COO and CFO. Four of the five positions have been filled. The COO recruitment continues and staff is working to finding the right candidate for this important position.

    Some key achievements since the receipt of the CAP on October 4, 2012 are:

    - Financial Plan / TNE Recovery Plan: Staff developed a detailed financial plan showing how it will become TNE compliant. The plan was submitted on December 11, 2012. Details will be discussed as a report in Section 4c of the Commission materials.
    - Claims Inventory Reduction: In August 2012, the number of claims sitting in inventory rose back to more than 60,000. The CAP set a target of 15,000 claims in inventory. In late December, the claims inventory was under 15,000 claims, a reduction of nearly 75% from the August high.
    - Submission of Encounter Data (35C Files): to date, GCHP has submitted claims / encounter data to DHCS for the four months of July – October 2012. All this data has been reviewed and approved by DHCS. The submission schedule for these files continues into 2013.

- Hiring of Key Staff: the Plan has filled four key positions. The professionals filling these positions have brought expertise and stability to the Plan.

Compliance: The Department of Health Care Services (DHCS) auditors were onsite the week of December 10th, 2012 conducting a routine medical audit. The audit included looking at all facets of medical management, access and availability, grievance and appeals, quality improvement, delegation oversight and administrative capacity. The Plan anticipates a formal exit conference, which will review the preliminary report by the auditors in February 2013.

- Compliance continues to work with all staff on corrective action items, and the Plan continues to adhere to the deadlines requested by the department.

Space Planning / Real Estate

- Office Lease: Plan is looking at new additional temporary space, negotiating short-term lease, terms are being finalized and will be within the CEO's authority.

Operations Update

- Claims Processing:
  - Inventory was reduced to under 15,000 claims. This represents three days' worth of claims receipts.
  - Turnaround times continue to improve with 98% of claims being paid within 30 days for November and December as compared to 82% for period of July-December 2012. The state requirement is 90% within 30 days.
  - New claims editing software was implemented in January 2013.
  - The auto-adjudication rate at the end of December is about 35%, an improvement from under 20% earlier this year, but the Plan is working with ACS to get this rate to above 60% by the end of this fiscal year.
  - Claims Recovery work on overpayments and duplicate payments has begun.
  - Audit of the claims system configuration will be completed this week. The resource performing audit has direct Medi-Cal managed care plan experience.
  - Inventory Trend Comparison and Inventory Trend Graph are attached.

- IT:
  - Production implementation of Milliman MedInsight for analytical reporting - System loaded with plan data back to July 2011; end user training conducted, and data validation in progress.
  - Verisk data file submissions for 2013 HEDIS reporting
  - Filled IT open position – Jackie Attebery in Business Systems Analyst role.

- Customer Service: graphs on call center statistics and grievance and appeals are attached.

Government Relations

- Healthy Families Program Transition to Medi-Cal:
    - California Assembly Bill (AB) 1494 mandates the transition of HFP beneficiaries to Medi-Cal managed care. Approximately 863,000 children are expected to transition into Medi-Cal managed care between January and September 2013.
    - Phase 1a of the four-phase transition of the Healthy Families Program (HFP) to Medi-Cal is scheduled to begin January 1, 2013. DHCS sent the federally required 30-day notice to beneficiaries involved in the Phase 1a transition on December 1, 2012.
    - Ventura County's HFP beneficiaries will transition to GCHP in Phase III, scheduled to begin August 1, 2013.
    - On December 31, 2012, DHCS received federal approval from CMS to implement the transition of the Healthy Families Program to Medi-Cal effective January 1, 2013.

- Healthy Families Program Contract Amendment: To comply with AB 1494, DHCS requires that Gold Coast Health Plan amend its Medi-Cal contract with DHCS. The proposed contract amendment requires GCHP to report to DHCS on specified transition implementation issues including: the number of grievances related to access to care; continuity of care requests and outcomes; as well as changes to provider networks. GCHP's CEO submitted a memo to Executive Committee Members to request authority to sign the proposed HFP contract amendment.

- Medi-Cal Benefits for HFP Transitioned Children: HFP beneficiaries transitioned to Medi-Cal will continue to have access to the full range of Medi-Cal benefits and services including:
    - CHDP and Vaccines for Children (VFC)
    - Dental services covered through Denti-Cal
    - Vision services covered through VSP
    - Behavioral health services covered through the Ventura County Mental Health
    - No co-payments
    - Some members, those above 150% of the federal poverty level, will continue to pay premiums ($13 per child / month, $39 per family / month maximum)
    - Ventura County Human Services Agency will have final eligibility determination

- Community Outreach to Members Re: HFP Transition to Medi-Cal: GCHP's Government Relations and Communications staff will conduct an aggressive and effective communication and outreach effort to Members in early January 2013. GCHP is committed to ensuring that children have minimal or no disruptions in coverage. Moreover, GCHP anticipates a seamless transition because Ventura County's HFP and Medi-Cal provider networks are similar.

  Additionally GCHP staff is engaged in weekly meetings and dialogue with the state DHCS to receive updated information about the transition process and next steps. GCHP staff will serve a critical support role as HFP beneficiaries are transitioned into Medi-Cal and become new members of GCHP.

- Rates for Children Transitioned from HFP to Medi-Cal: On December 14th, GCHP's CFO and Finance Manager attended the DHCS-sponsored all-plan rate meeting in Sacramento. DHCS has proposed an initial rate of $77.90 per member per month for HFP transitioned children to Medi-Cal. According to DHCS these rates will only be effective for three months and will be changed for Phases II and III. DHCS expects to develop a single rate for the entire HFP population by late March 2013.

- Primary Care Provider Rate Increase Under the Affordable Care Act (ACA): The federal Centers for Medicare and Medicaid Services (CMS) released the final rule regarding Medicaid Primary Care Provider (PCP) increases to Medicare levels. Medi-Cal managed care plans (including GCHP) are still waiting for guidance and specific rates from the State. DHCS has indicated that the ACA rate increase will be retroactive to January 1, 2013. Key provisions of the CMS final rule allow state flexibility on how they verify services are delivered through managed care. CMS rules also allow states to work with health plans to determine the appropriate verification methodology and excludes increased PCP rates for FQHCs and RHCs

- Court Decision and AB 97 Provider Rate Cuts: In light of the federal court decision in early December to lift the injunction on DHCS-proposed ten percent provider rate cuts, it is unclear whether DHCS will implement the rate reductions on a retroactive basis. GCHP's current rates do not include the AB 97 rate reduction. A DHCS policy on AB 97 rate cuts is not expected until the state budget is released on or about January 10, 2013.

Consumer Advisory Committee

The Consumer Advisory Committee (CAC) Charter was adopted as presented. The CAC Goals and Objectives were discussed, will be changed to reflect input and presented at the March 13, 2013 CAC meeting. The revised CAC Goals and Objectives will be published prior to the next CAC meeting currently scheduled for 03/13/2013.

Gold Coast Health Plan (GCHP) staff presented information on the new non-emergency medical transportation (NEMT) vendor, Ventura Transit System. The new vendor was awarded the contract after a detailed RFP process. Services by Ventura Transit System are scheduled to begin on February 1, 2013. CAC members were expressed support for the new contract and believe it is a positive step for the members. The CAC requested that information regarding the NEMT benefit be given to GCHP members.

The improved Spanish abandonment rate for phone calls to the Call Center was discussed along with the Grievance and Appeals Monthly Trend Report. CAC members discussed the increase in grievances filed in July August and GCHP will report back on the cause of the temporary increase during those months. The winter's member newsletter will be in homes near the end of January. The Resource Fair held October 21, 2012 was viewed as a positive experience for members, and CAC members hoped that future Fairs will be held in other regions of the county.

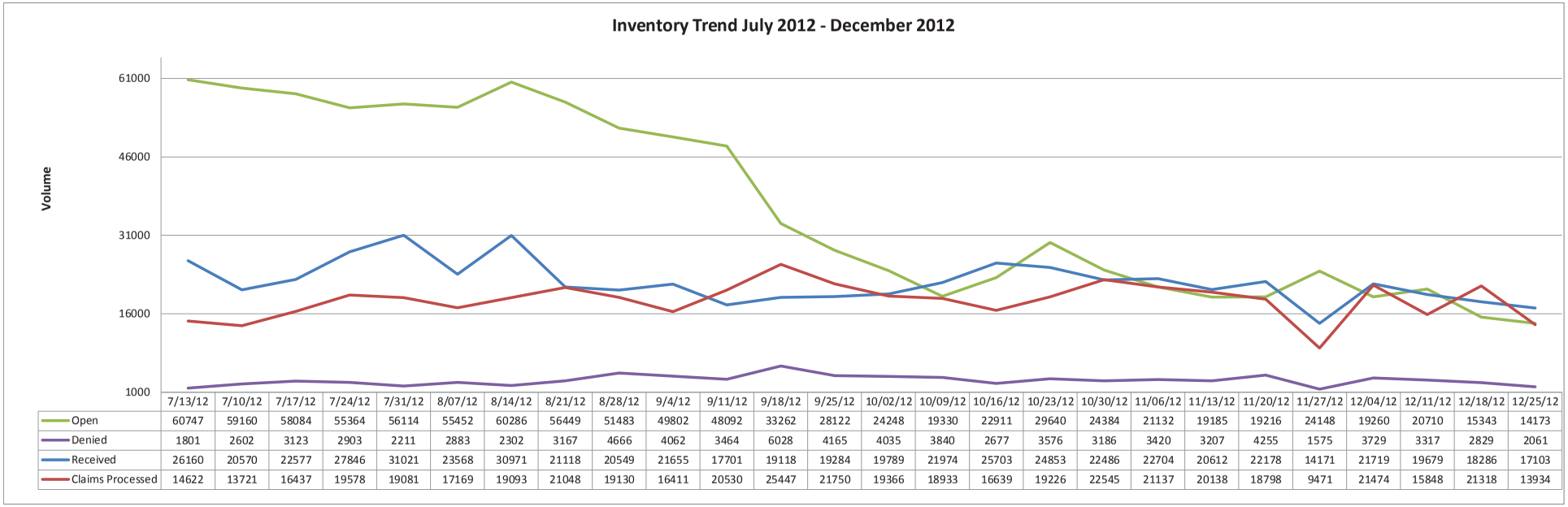
The Community-Based Adult Services (CBAS) transition is complete. CAC members indicated a desire to see GCHP promote CBAS and other programs within the community. Case Management has been stepped up enhancing care for those members not qualified for CBAS. A group Needs Assessment has been completed and results sent to the State.

Casa Pacifica is having problems with foster children being turned away for services. GCHP and CAC members will work together on a resolution. Curtis Updike, a CAC member notified GCHP that the Health Services Agency is changing its rules on qualifications for Cal Fresh (Food Stamps) and that more people will now qualify for Cal Fresh assistance. CAC member presented information on new Pre-Existing Condition Insurance Plan.

Gold Coast Health Plan - Inventory Trend Comparison

From 07/13/12 thru 12/25/12

Week	Open	Denied	Received	Claims Processed
7/13/12	60747	1801	26160	14622
7/10/12	59160	2602	20570	13721
7/17/12	58084	3123	22577	16437
7/24/12	55364	2903	27846	19578
7/31/12	56114	2211	31021	19081
8/07/12	55452	2883	23568	17169
8/14/12	60286	2302	30971	19093
8/21/12	56449	3167	21118	21048
8/28/12	51483	4666	20549	19130
9/4/12	49802	4062	21655	16411
9/11/12	48092	3464	17701	20530
9/18/12	33262	6028	19118	25447
9/25/12	28122	4165	19284	21750
10/02/12	24248	4035	19789	19366
10/09/12	19330	3840	21974	18933
10/16/12	22911	2677	25703	16639
10/23/12	29640	3576	24853	19226
10/30/12	24384	3186	22486	22545
11/06/12	21132	3420	22704	21137
11/13/12	19185	3207	20612	20138
11/20/12	19216	4255	22178	18798
11/27/12	24148	1575	14171	9471
12/04/12	19260	3729	21719	21474
12/11/12	20710	3317	19679	15848
12/18/12	15343	2829	18286	21318
12/25/12	14173	2061	17103	13934



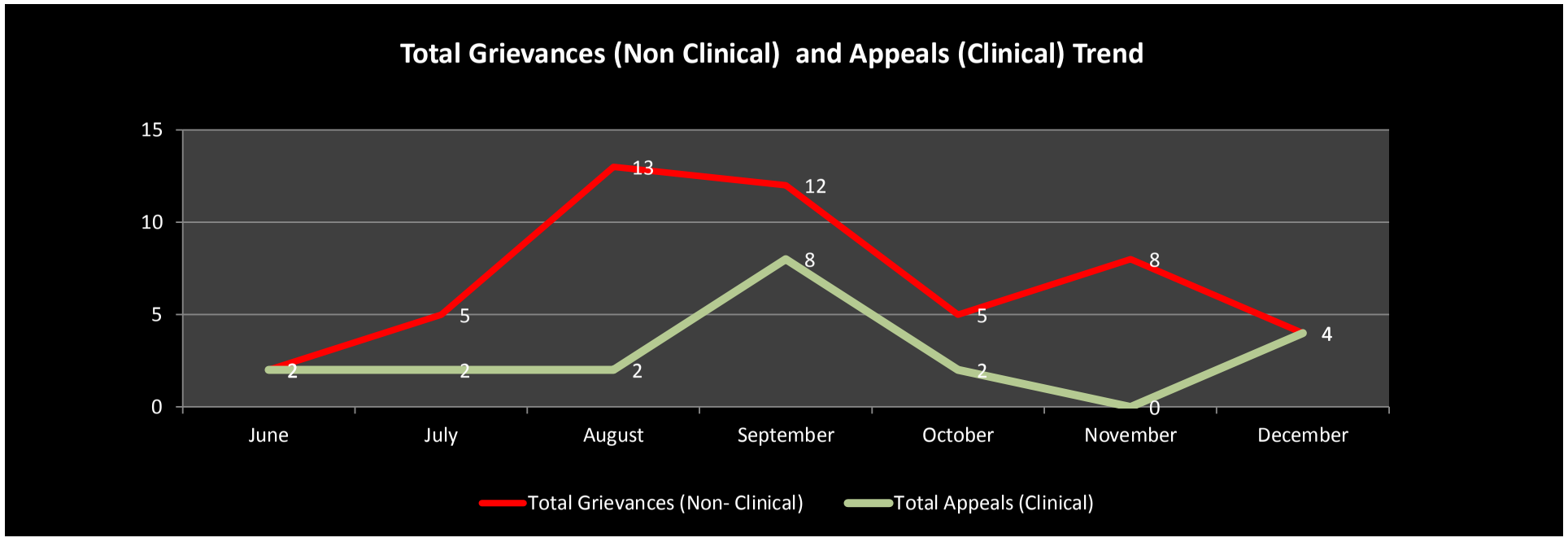
	7/13/12	7/10/12	7/17/12	7/24/12	7/31/12	8/07/12	8/14/12	8/21/12	8/28/12	9/4/12	9/11/12	9/18/12	9/25/12	10/02/12	10/09/12	10/16/12	10/23/12	10/30/12	11/06/12	11/13/12	11/20/12	11/27/12	12/04/12	12/11/12	12/18/12	12/25/12
Open	60747	59160	58084	55364	56114	55452	60286	56449	51483	49802	48092	33262	28122	24248	19330	22911	29640	24384	21132	19185	19216	24148	19260	20710	15343	14173
Denied	1801	2602	3123	2903	2211	2883	2302	3167	4666	4062	3464	6028	4165	4035	3840	2677	3576	3186	3420	3207	4255	1575	3729	3317	2829	2061
Received	26160	20570	22577	27846	31021	23568	30971	21118	20549	21655	17701	19118	19284	19789	21974	25703	24853	22486	22704	20612	22178	14171	21719	19679	18286	17103
Claims Processed	14622	13721	16437	19578	19081	17169	19093	21048	19130	16411	20530	25447	21750	19366	18933	16639	19226	22545	21137	20138	18798	9471	21474	15848	21318	13934

Gold Coast Health Plan

Member Grievances And Appeals Trend

June thru December 2012

	Trend (June thru December 2012)						
G & A Totals:	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Total Grievances (Non- Clinical)	2	5	13	12	5	8	4
Total Appeals (Clinical)	2	2	2	8	2	0	4
Action Taken:							
Acknowledgement Letters	4	7	15	20	7	8	8
Resolutions	1	7	5	4	15	4	10
Pending Non clinical	1	0	10	11	1	4	5
Pending clinical review	2	0	0	5	0	0	3

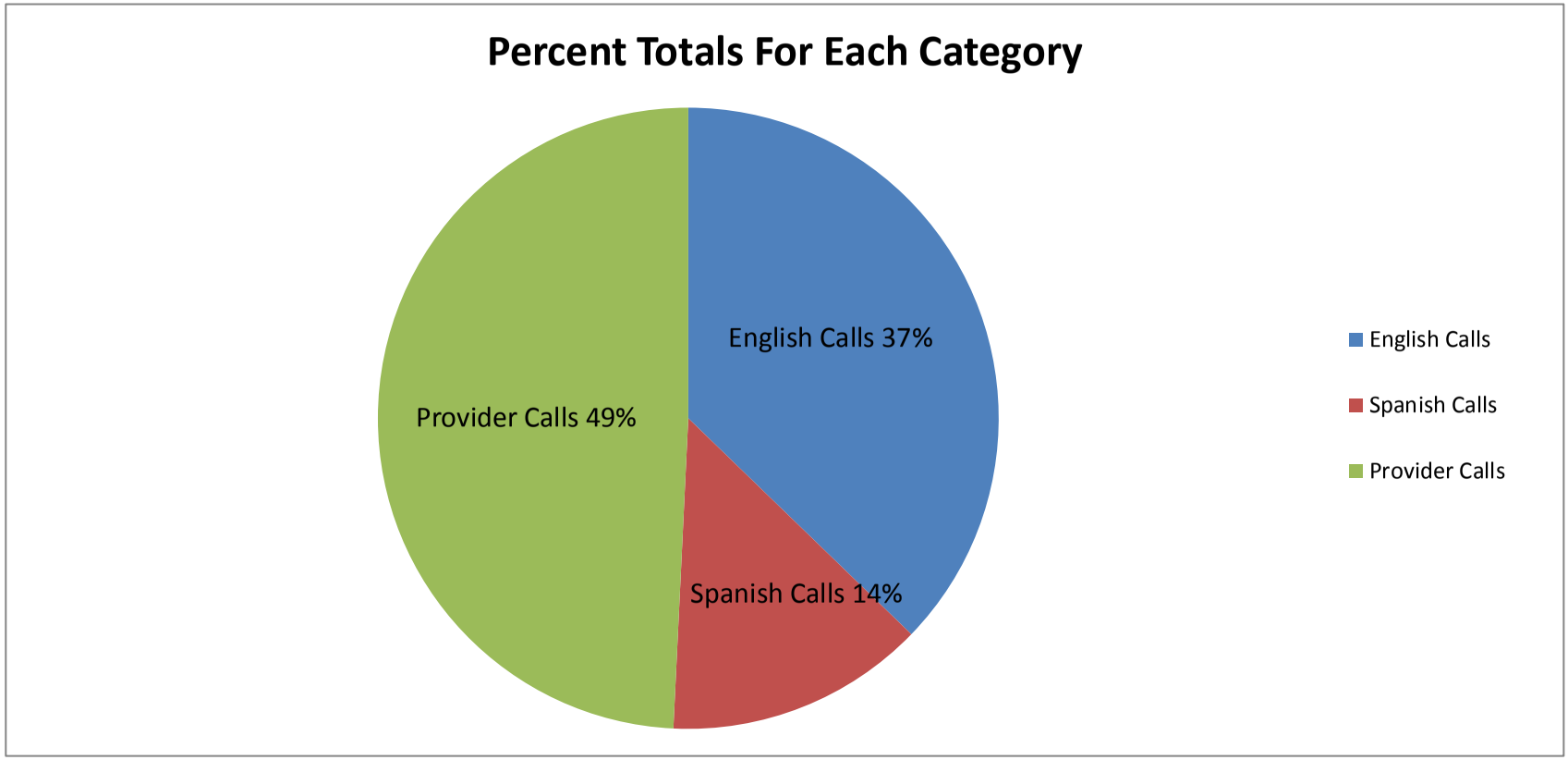


Gold Coast Health Plan

Call Center Stats

December 2012

Call Category	Calls Offered	Calls Offered (as % of total)	Calls Handled	Calls Abandoned	Abandoned Percent	Avg Speed Answer (in min)	Average Talk Time (in min)	Average Hold Time (in min)
English Calls	2216	37%	2201	15	0.68%	0.19	5.59	0.69
Spanish Calls	805	14%	799	6	0.75%	0.25	6.19	0.52
Provider Calls	2930	49%	2898	32	1.09%	0.36	5.65	1.04
Month Totals	5951	100%	5898	53	0.89%	0.28	5.70	0.84

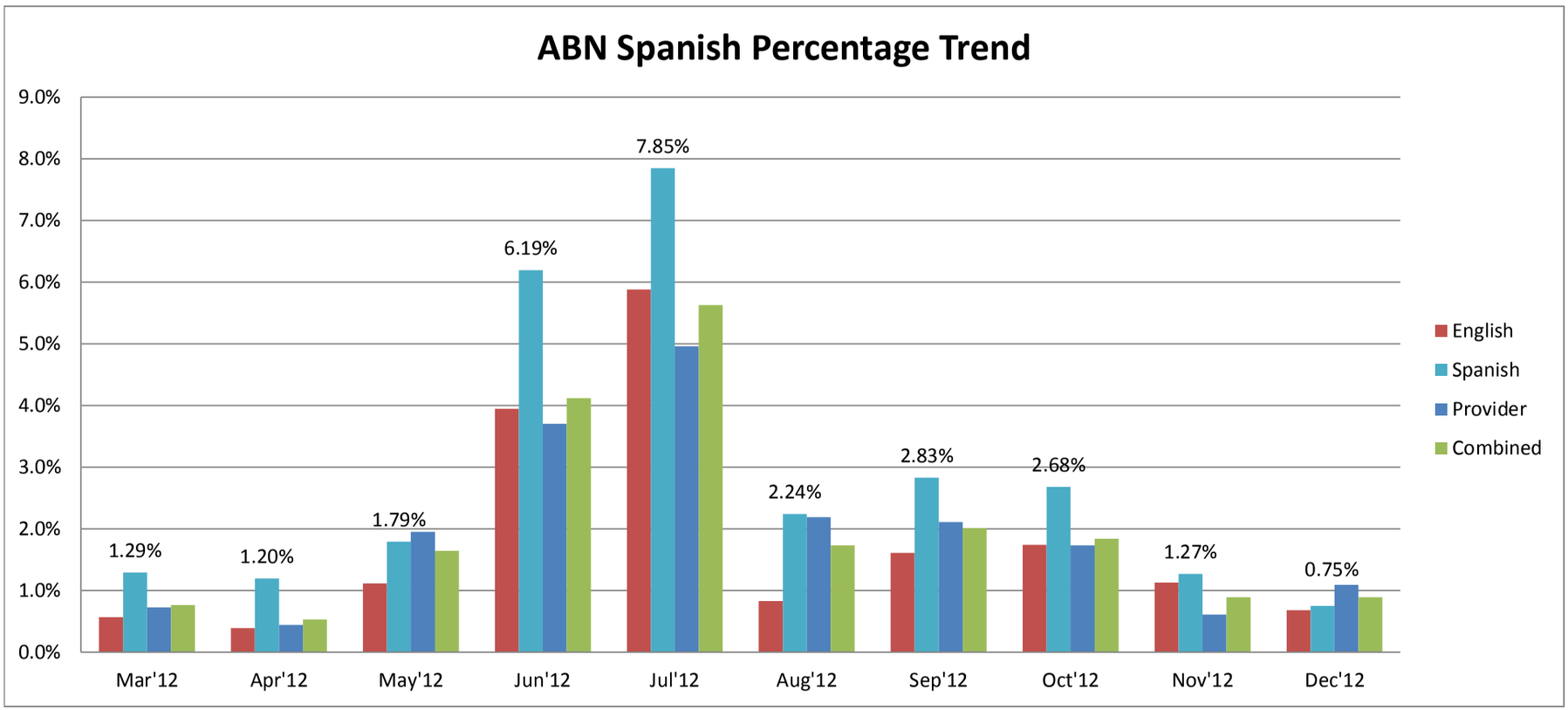


Gold Coast Health Plan

Abandon % - Monthly Comparison Trend

Category Call Type	Mar'12	Apr'12	May'12	Jun'12	Jul'12	Aug'12	Sep'12	Oct'12	Nov'12	Dec'12	Ave total per Cat. Call
English	0.57%	0.39%	1.12%	3.95%	5.88%	0.83%	1.61%	1.74%	1.13%	0.68%	1.79%
Spanish	1.29%	1.20%	1.79%	6.19%	7.85%	2.24%	2.83%	2.68%	1.27%	0.75%	2.81%
Provider	0.73%	0.44%	1.95%	3.71%	4.96%	2.19%	2.11%	1.73%	0.61%	1.09%	1.95%
Combined	0.76%	0.53%	1.64%	4.12%	5.63%	1.73%	2.01%	1.84%	0.89%	0.89%	2.01%
Average per month - excluding combined	0.84%	0.64%	1.63%	4.49%	6.08%	1.75%	2.14%	2.00%	0.98%	0.85%	

Average Total Months Mar. through Dec.	2.14%



GOLD COAST HEALTH PLAN

SUMMARY FINANCIAL RESULTS

THRU NOVEMBER 30, 2012

Rolling Monthly Actual Trend

Description	Audited FY 2011-12	FY 2012-13 JUL	AUG	SEP	OCT	NOV	YTD
Member Months	1,258,189	105,753	99,264	100,203	99,217	100,088	504,525
Revenue	**304,635,932**	**23,806,175**	**24,430,512**	**24,988,448**	**25,449,011**	**25,438,395**	**124,112,542**
pmpm	*242.12*	*225.11*	*246.12*	*249.38*	*256.50*	*254.16*	*246.00*
Health Care Costs	**287,353,672**	**21,181,745**	**28,173,162**	**22,293,643**	**24,466,891**	**22,432,966**	**118,548,408**
pmpm	*228.39*	*200.29*	*283.82*	*222.48*	*246.60*	*224.13*	*234.97*
% of Revenue	94.3%	89.0%	115.3% (A)	89.2%	96.1%	88.2%	95.5%
Admin Exp	**18,891,320**	**1,587,586**	**1,683,028**	**1,706,253**	**1,968,888**	**2,065,316**	**9,011,071**
pmpm	*15.01*	*15.01*	*16.96*	*17.03*	*19.84*	*20.63*	*17.86*
% of Revenue	6.2%	6.7%	6.9%	6.8%	7.7%	8.1%	7.3%
Net Income	**(1,609,063)**	**1,036,844**	**(5,425,678)**	**988,552**	**(986,767)**	**940,113**	**(3,446,937)**
pmpm	*(1.28)*	*9.80*	*(54.66)*	*9.87*	*(9.95)*	*9.39*	*(6.83)*
% of Revenue	-0.5%	4.4%	-22.2%	4.0%	-3.9%	3.7%	-2.8%
100% TNE	16,769,368	14,771,512	17,167,762	16,693,841	16,827,932	16,500,637	16,500,637
Required TNE	6,036,972	5,317,744	6,180,394	6,009,783	6,058,056	5,940,229	5,940,229
GCHP TNE	**(6,031,881)**	**(4,995,037)**	**(10,420,715)**	**(11,407,482)**	**(10,467,370)**	**(9,988,221)**	**(9,988,221)**

Note:

(A) August Health Care Costs include $7M IBNR addition.

Financial Statement Overview

FOR THE MONTH ENDED NOVEMBER 30, 2012

Summary of Key P&L Drivers

Summary & Income Statement:

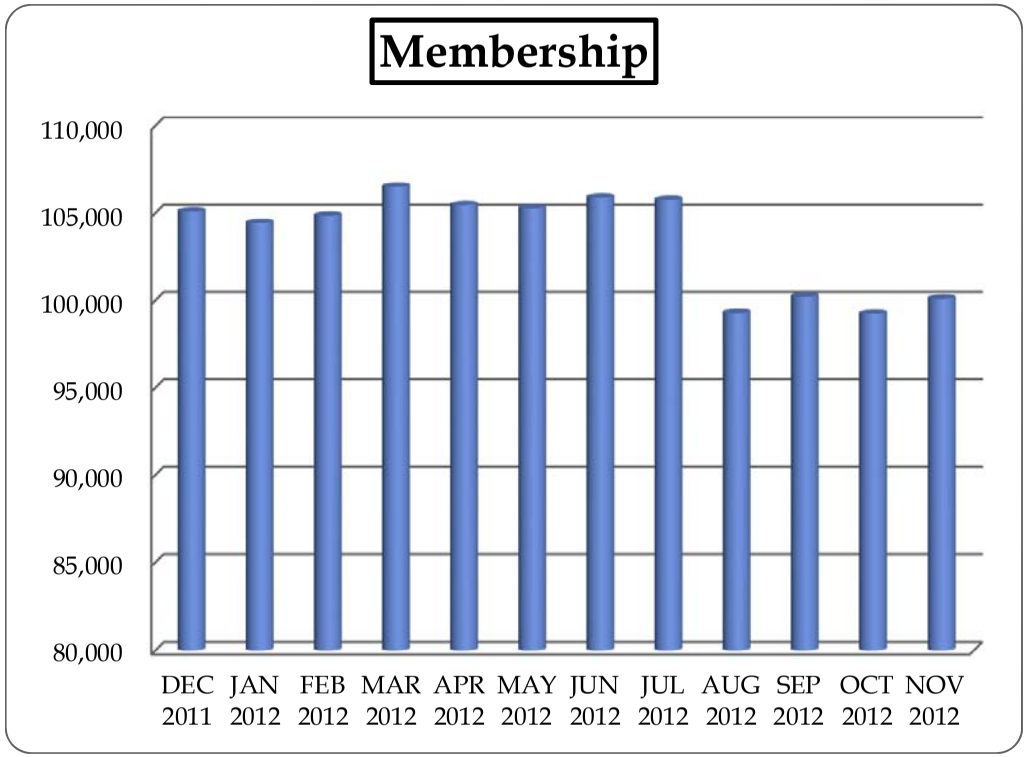
- **Revenue** – increased due to additional CBAS capitation received (new services were provided in October).
- **Health Care Costs** – increased in October due to adjustments to claims reserves, with reductions in November due to reflection of reinsurance recoveries and other claims recoveries.
- **Administrative Expense**s have increased due to:
    - use of consultants (e.g., BRG, Milliman),
    - legal services (e.g., provider contracting, review of personnel policies and benefits),
    - mailing/postage charges, and
    - claims interest payments (in October).

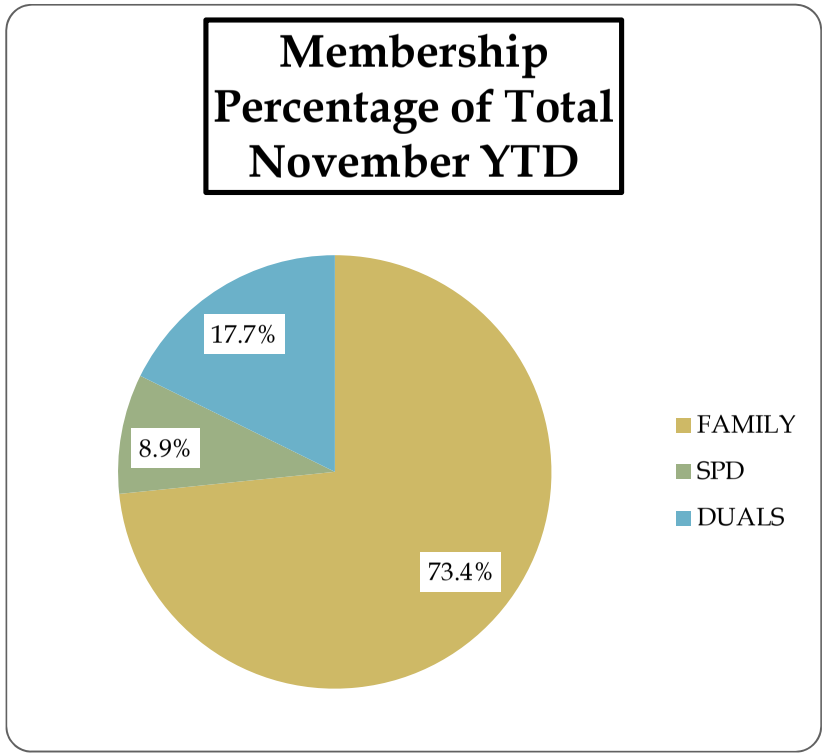
Gold Coast Health Plan

Enrollment Dashboard

For The Month Ended November 30, 2012

AID CATEGORY	FY 2011- 2012 Q1	Q2	Q3	Q4	Total YTD	(% of total)	FY 2012 - 2013 Jul'12	Aug'12	Sep'12	Oct'12	Nov'12	Nov'12 YTD	(% of total)
FAMILY	229,938	233,321	233,148	233,985	930,392	73.9%	78,219	72,581	73,550	72,554	73,275	370,180	73.4%
SPD	27,446	27,726	28,017	28,207	111,396	8.9%	9,422	8,765	8,903	9,030	8,997	45,117	8.9%
DUALS	53,159	54,256	54,595	54,391	216,401	17.2%	18,112	17,918	17,750	17,633	17,816	89,229	17.7%
Total	310,543	315,303	315,760	316,583	**1,258,189**	**100.0%**	105,753	99,264	100,203	99,217	**100,088**	504,526	100.0%



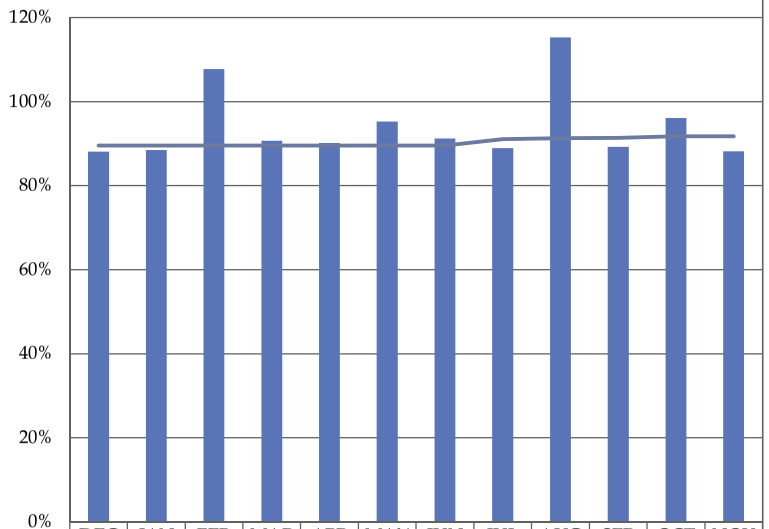


Gold Coast Health Plan

Medical Cost Trend

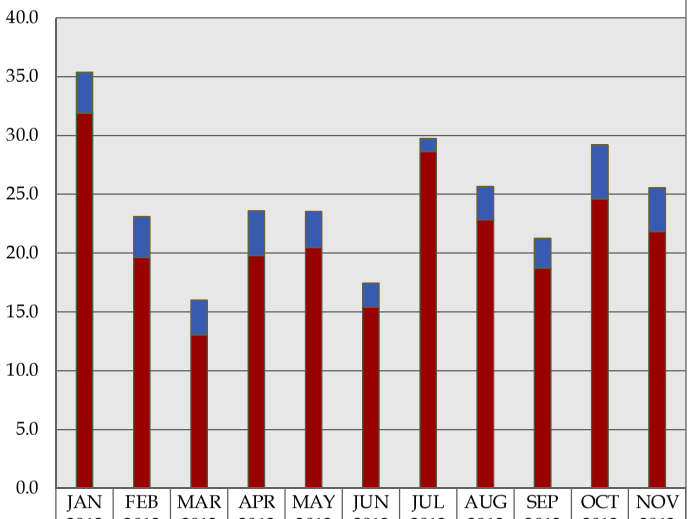
For The Month Ended November 30, 2012

Medical Loss Ratio (MLR)



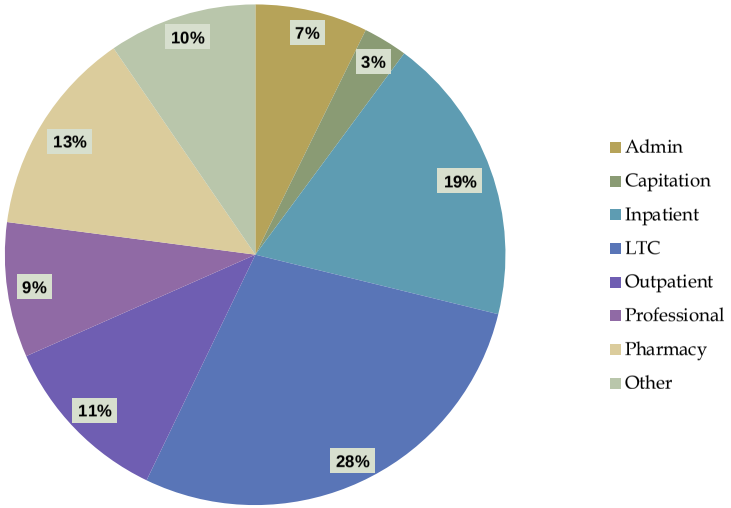
	DEC 2011	JAN 2012	FEB 2012	MAR 2012	APR 2012	MAY 2012	JUN 2012	JUL 2012	AUG 2012	SEP 2012	OCT 2012	NOV 2012
% of Revenue	88.1%	88.5%	107.8%	90.7%	90.1%	95.3%	91.3%	89.0%	115.3%	89.2%	96.1%	88.2%
% of Budget Revenue	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	91.1%	91.3%	91.4%	91.8%	91.8%

Paid Claims Composition ($ millions)

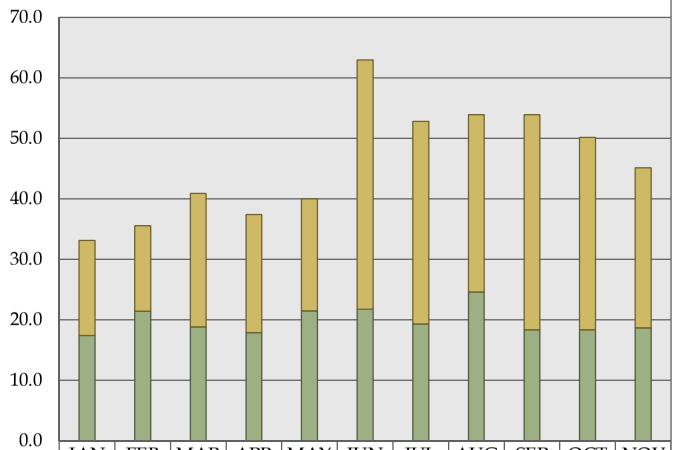


	JAN 2012	FEB 2012	MAR 2012	APR 2012	MAY 2012	JUN 2012	JUL 2012	AUG 2012	SEP 2012	OCT 2012	NOV 2012
Current Mo Paid	3.46	3.49	2.98	3.80	3.08	2.04	1.11	2.83	2.53	4.61	3.70
Prior Mo Paid	31.90	19.62	13.04	19.78	20.45	15.40	28.63	22.83	18.72	24.60	21.84

Total Expenditures November YTD



IBNP Composition ($ millions)



	JAN 2012	FEB 2012	MAR 2012	APR 2012	MAY 2012	JUN 2012	JUL 2012	AUG 2012	SEP 2012	OCT 2012	NOV 2012
Prior Mo Unpaid	15.71	14.15	22.10	19.55	18.54	41.23	33.48	29.30	35.53	31.78	26.44
Current Mo Unpaid	17.42	21.43	18.84	17.88	21.49	21.74	19.32	24.62	18.39	18.39	18.72

Gold Coast Health Plan

Script Care Plan Utilization and Cost Trend

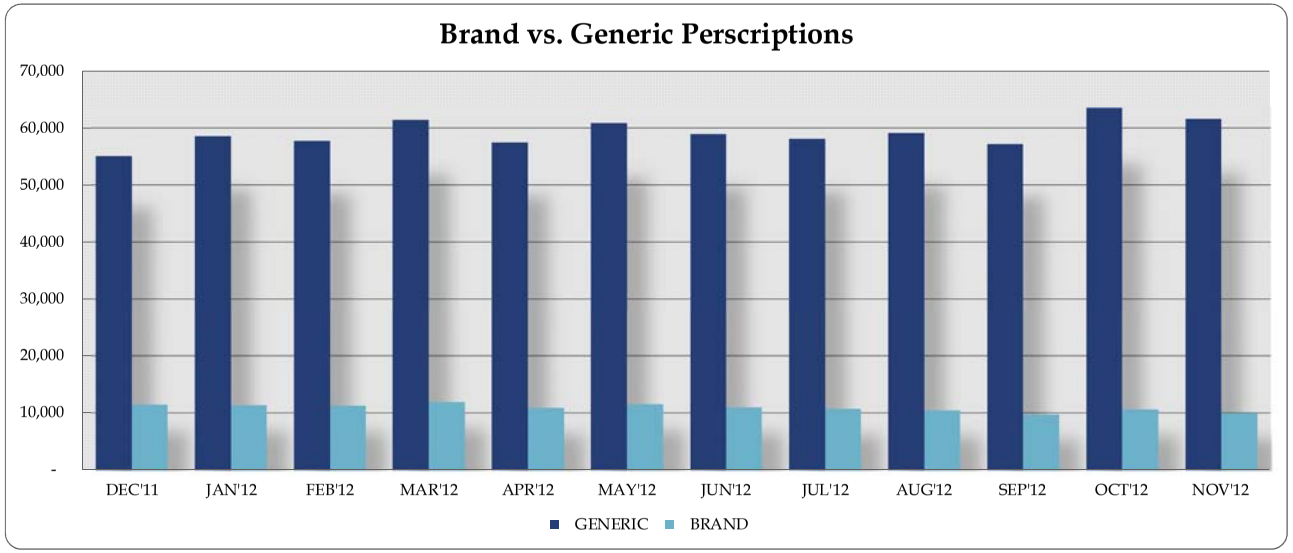
For The Month Ended November 30, 2012

	DEC'11	JAN'12	FEB'12	MAR'12	APR'12	MAY'12	JUN'12	JUL'12	AUG'12	SEP'12	OCT'12	NOV'12	BUDGET	FAV/ (UNFAV)
Enrollment [1]	101,243	100,636	100,768	101,439	101,272	101,041	101,207	96,540	95,797	96,669	96,447	96,907	97,637	(1,190)
Utilization [2]	23,000	23,775	23,926	24,981	23,349	24,216	23,089	22,167	22,373	22,638	24,071	23,659		
% (enrollment)	***22.7%***	***23.6%***	***23.7%***	***24.6%***	***23.1%***	***24.0%***	***22.8%***	***23.0%***	***23.4%***	***23.4%***	***25.0%***	***24.4%***		
Number Of Claims Paid [2]														
BRAND	11,482	11,421	11,267	11,903	10,888	11,617	11,052	10,757	10,499	9,743	10,685	10,013	18,873	8,188
GENERIC	55,093	58,588	57,714	61,435	57,443	60,861	58,950	58,183	59,204	57,199	63,537	61,625	56,618	(6,919)
Total	66,575	70,009	68,981	73,338	68,331	72,478	70,002	68,940	69,703	66,942	74,222	71,638	75,695	1,473
pmpm	*0.66*	*0.70*	*0.68*	*0.72*	*0.67*	*0.72*	*0.69*	*0.71*	*0.73*	*0.69*	*0.77*	*0.74*	*0.78*	0.01
BRAND %	**17.2%**	**16.3%**	**16.3%**	**16.2%**	**15.9%**	**16.0%**	**15.8%**	**15.6%**	**15.1%**	**14.6%**	**14.4%**	**14.0%**	**24.9%**	**10.5%**
GENERIC %	**82.8%**	**83.7%**	**83.7%**	**83.8%**	**84.1%**	**84.0%**	**84.2%**	**84.4%**	**84.9%**	**85.4%**	**85.6%**	**86.0%**	**74.8%**	**-10.8%**
Plan Cost [2]														
BRAND	1,963,430	1,815,536	1,816,430	1,908,982	1,951,084	1,939,649	2,056,168	1,908,700	2,077,303	1,804,984	1,994,454	1,813,487		
GENERIC	1,254,143	1,304,658	1,259,202	1,348,636	1,293,842	1,370,173	1,273,925	1,277,492	1,380,952	1,333,405	1,491,109	1,437,940		
Total	$ 3,217,573	$ 3,120,194	$ 3,075,632	$ 3,257,618	$ 3,244,925	$ 3,309,822	$ 3,330,093	$ 3,186,191	$ 3,458,255	$ 3,138,389	$ 3,485,563	$ 3,251,427	$ 3,208,877	$ (276,685)
pmpm	*$31.78*	*$31.00*	*$30.52*	*$32.11*	*$32.04*	*$32.76*	*$32.90*	*$33.00*	*$36.10*	*$32.47*	*$36.14*	*$33.55*	*$32.87*	*($3.27)*
avg. claim cost (Br & Gen)	*$48.33*	*$44.57*	*$44.59*	*$44.42*	*$47.49*	*$45.67*	*$47.57*	*$46.22*	*$49.61*	*$46.88*	*$46.96*	*$45.39*	*$42.39*	*($4.57)*
BRAND %	**61.0%**	**58.2%**	**59.1%**	**58.6%**	**60.1%**	**58.6%**	**61.7%**	**59.9%**	**60.1%**	**57.5%**	**57.2%**	**55.8%**		
GENERIC %	**39.0%**	**41.8%**	**40.9%**	**41.4%**	**39.9%**	**41.4%**	**38.3%**	**40.1%**	**39.9%**	**42.5%**	**42.8%**	**44.2%**		
avg. claim cost (Brand)	*$171.00*	*$158.96*	*$161.22*	*$160.38*	*$179.20*	*$166.97*	*$186.04*	*$177.44*	*$197.86*	*$185.26*	*$186.66*	*$181.11*		
avg. claim cost (Generic)	*$22.76*	*$22.27*	*$21.82*	*$21.95*	*$22.52*	*$22.51*	*$21.61*	*$21.96*	*$23.33*	*$23.31*	*$23.47*	*$23.33*		

Note:

1) The actual stats obtained from California Department of Health Care Services.

2) The actual stats obtained from Script Care, Ltd.



Gold Coast Health Plan

Comparative Balance Sheet

November 30, 2012

	11/30/12	10/31/12	6/30/12
ASSETS			
Current Assets			
Total Cash and Cash Equivalents	**$ 36,352,153**	**$ 18,135,512**	**$ 25,554,098**
Medi-Cal Receivable	-	24,278,541	28,534,938
Provider Receivable	3,709,193	3,296,761	6,539,541
Other Receivables	1,503,174	204,363	2,148,270
Total Accounts Receivable	**5,212,367**	**27,779,666**	**37,222,748**
Total Prepaid Accounts	1,082,002	1,120,980	185,797
Total Other Current Assets	1,172,982	1,172,982	375,000
Total Current Assets	**$ 43,819,505**	**$ 48,209,140**	**$ 63,337,644**
Total Fixed Assets	**163,831**	**167,392**	**176,028**
Total Assets	**$ 43,983,336**	**$ 48,376,532**	**$ 63,513,672**
LIABILITIES & FUND BALANCE			
Current Liabilities			
Incurred But Not Reported	$ 36,644,957	$ 41,516,421	$ 52,610,898
Claims Payable	8,512,814	8,652,494	10,357,609
Capitation Payable	907,950	755,447	633,276
Accrued Premium Reduction	2,779,176	2,320,990	1,914,157
Accounts Payable	2,018,804	2,915,569	845,045
Accrued ACS	-	-	200,000
Accrued Expenses	200,000	200,000	-
Accrued Premium Tax	37	-	602,900
Current Portion of Deferred Revenue	460,000	460,000	460,000
Accrued Payroll Expense	416,748	372,875	-
Current Portion Of Long Term Debt	333,333	375,000	500,000
Total Current Liabilities	**$ 52,273,820**	**$ 57,568,795**	**$ 68,123,886**
Long-Term Liabilities			
Other Long-term Liability	-	-	41,667
Deferred Revenue - Long Term Portion	1,188,333	1,226,667	1,380,000
Total Long-Term Liabilities	**1,188,333**	**1,226,667**	**1,421,667**
Total Liabilities	**$ 53,462,153**	**$ 58,795,462**	**$ 69,545,553**
Beginning Fund Balance	(6,031,881)	(6,031,881)	(4,422,819)
Net Income Current Year	(3,446,936)	(4,387,049)	(1,609,062)
Total Fund Balance	**(9,478,817)**	**(10,418,930)**	**(6,031,881)**
Total Liabilities & Fund Balance	**$ 43,983,336**	**$ 48,376,532**	**$ 63,513,672**

Financial Statement Overview

FOR THE MONTH ENDED NOVEMBER 30, 2012

Summary of Key Balance Sheet Drivers

- **Cash & Medi-Cal Receivable –** cash increased due to receipt of October & November capitation in November, resu Medi-Cal Receivable.
- **November IBNR** – decreased due to continued accelerated claims payments.
- **Accrued Premium Reduction-** continue to reserve for AB97 rate reduction and awaiting response from DHCS now that ruling has been made in favor of the State (i.e., provider payment reductions are allowed).
- **Accrued payroll expenses** – increased as a result of the transition to in-house payroll and benefits processing.

Gold Coast Health Plan

Statement of Cash Flows

Months Ended October 31 and November 30, 2012

	OCT '12	NOV '12
Cash Flow From Operating Activities		
Collected Premium	$ 25,139,412	$ 50,127,822
Miscellaneous Income	13,390	9,004
Paid Claims		
Medical & Hospital Expenses	(22,991,510)	(24,033,717)
Pharmacy	(3,209,024)	(3,824,079)
Capitation	(620,832)	(755,447)
Reinsurance of Claims	(225,239)	-
Reinsurance Recoveries		
Payment of Withhold / Risk Sharing Incentive		
Paid Administration	(1,782,287)	(3,306,941)
Repay Initial Net Liabilities		
MCO Taxes Expense		-
Net Cash Provided by Operating Activities	**(3,676,089)**	**18,216,641**
Cash Flow From Investing/Financing Activities		
Proceeds from Paid in Surplus/Issuance of Stock	-	-
Costs of Capitalization	-	-
Net Acquisition of Property/Equipment	-	-
Net Cash Provided/(Used) by Investing/Financing	**-**	**-**
Net Cash Flow	**$ (3,676,089)**	**$ 18,216,641**
Cash and Cash Equivalents (Beg. of Period)	21,811,601	18,135,512
Cash and Cash Equivalents (End of Period)	18,135,512	36,352,153
	$ (3,676,089)	**$ 18,216,641**
Adjustment to Reconcile Net Income to Net Cash Flow		
Net (Loss) Income	(986,767)	940,113
Depreciation & Amortization	3,554	3,561
Decrease/(Increase) in Receivables	439,539	22,567,298
Decrease/(Increase) in Prepaids & Other Current Assets	(1,176,935)	38,978
(Decrease)/Increase in Payables	567,170	(394,705)
(Decrease)/Increase in LT Liabilities	(80,000)	(80,000)
Change in MCO Tax Liability	1,170,493	37
Changes in Claims and Capitation Payable	(2,861,309)	12,824
Changes in IBNR	(751,833)	(4,871,464)
	(3,676,089)	18,216,641
Net Cash Flow from Operating Activities	**$ (3,676,089)**	**$ 18,216,641**

Gold Coast Health Plan

Statement of Cash Flows

Five Months Ended November 30, 2012

	NOV '12 YTD
Cash Flow From Operating Activities	
Collected Premium	$ 153,256,917
Miscellaneous Income	65,495
Paid Claims	
Medical & Hospital Expenses	(108,685,698)
Pharmacy	(17,826,190)
Capitation	(3,256,135)
Reinsurance of Claims	(949,930)
Reinsurance Recoveries	-
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(10,026,617)
Repay Initial Net Liabilities	-
MCO Taxes Expense	(1,774,300)
Net Cash Provided/(Used) by Operating Activities	**10,803,542**
Cash Flow From Investing/Financing Activities	
Proceeds from Paid in Surplus/Issuance of Stock	-
Costs of Capitalization	-
Net Acquisition of Property/Equipment	(5,487)
Net Cash Provided/(Used) by Investing/Financing	**(5,487)**
Net Cash Flow	**$ 10,798,055**
Cash and Cash Equivalents (Beg. of Period)	25,554,098
Cash and Cash Equivalents (End of Period)	36,352,153
	$ 10,798,055
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	(3,446,936)
Depreciation & Amortization	17,684
Decrease/(Increase) in Receivables	32,010,381
Decrease/(Increase) in Prepaids & Other Current Assets	(1,694,187)
(Decrease)/Increase in Payables	2,455,526
(Decrease)/Increase in LT Liabilities	(400,000)
Change in MCO Tax Liability	(602,864)
Changes in Claims and Capitation Payable	(1,570,121)
Changes in IBNR	(15,965,941)
	$ 10,803,542
Net Cash Flow from Operating Activities	**$ 10,803,542**

APPENDIX

Gold Coast Health Plan
Income Statement Comparison
For The Period Ended November 30, 2012

	2012 Actual Monthly Trend			November 2012 Month-To-Date		Variance
	Aug	Sep	Oct	Actual	Budget	Fav/(Unfav)
Membership	95,797	96,669	96,447	96,907	97,637	(730)
Revenue:						
Premium	$24,965,442	$23,459,154	$25,524,694	$25,519,637	$26,065,005	$ (545,368)
Reserve for Rate Reduction	(587,278)	894,648	(126,771)	(128,543)	(589,433)	460,890
MCO Premium Tax	-	584,793	(635)	(37)	(612,528)	612,491
Total Net Premium	**24,378,164**	**24,938,595**	**25,397,288**	**25,391,057**	**24,863,044**	**528,012**
Other Revenue:						
Interest Income	14,015	11,519	13,390	9,004	15,639	(6,635)
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	0
Total Other Revenue	52,349	49,853	51,724	47,338	**53,972**	(6,634)
Total Revenue	**24,430,512**	**24,988,448**	**25,449,011**	**25,438,395**	**24,917,016**	**521,378**
Medical Expenses:						
Capitation	622,092	620,832	755,447	907,950	627,055	(280,895)
Incurred Claims:						
Inpatient	5,672,169	4,249,910	4,592,634	4,542,801	4,198,601	(344,200)
LTC/SNF	8,671,611	6,291,550	6,933,988	6,858,363	7,029,011	170,648
Outpatient	3,404,140	2,561,831	2,750,021	2,735,387	2,515,890	(219,497)
Laboratory and Radiology	285,780	215,187	231,690	229,447	210,700	(18,747)
Emergency Room Facility Services	659,819	497,489	533,516	529,753	486,391	(43,362)
Physician Specialty Services	2,584,677	1,940,550	2,280,039	2,111,295	1,900,745	(210,550)
Pharmacy	3,458,256	3,138,389	3,485,563	3,251,427	3,208,877	(42,550)
Other Medical Professional	345,204	274,599	288,240	288,957	199,287	(89,670)
Other Medical Care Expenses	1,510	627	606	-		-
Other Fee For Service Expense	1,978,126	1,459,626	1,589,710	1,570,885	1,418,008	(152,877)
Transportation	383,168	284,846	308,025	306,198	271,763	(34,435)
Total Claims	27,444,459	20,914,605	22,994,031	22,424,513	21,439,273	(985,240)
Medical & Care Management Expense	541,067	534,999	556,393	587,293	588,251	958
Reinsurance	224,994	223,207	225,239	224,722	227,494	2,772
Claims Recoveries	(659,450)	-	(64,218)	(1,711,511)		1,711,511
Sub-total	106,611	758,206	717,413	(899,496)	**815,745**	1,715,241
Total Cost of Health Care	**28,173,162**	**22,293,643**	**24,466,891**	**22,432,966**	**22,882,073**	**449,107**
Contribution Margin	**(3,742,650)**	**2,694,805**	**982,120**	**3,005,428**	**2,034,943**	**970,485**
General & Administrative Expenses:						
Salaries and Wages	308,137	268,413	388,828	323,624	344,783	21,159
Payroll Taxes and Benefits	155,252	64,735	62,808	72,886	139,919	67,033
Total Travel and Training	6,977	11,156	6,690	5,784	1,094	(4,690)
Outside Service - ACS	856,106	942,882	890,492	1,052,244	876,424	(175,820)
Outside Service - RGS	12,571	-	245	-	0	-
Outside Services - Other	11,092	109,202	104,166	17,311	17,892	581
Accounting & Actuarial Services	18,120	9,818	85,290	44,311	5,000	(39,311)
Legal Expense	4,468	42,522	12,196	67,921	11,500	(56,421)
Insurance	3,424	10,766	10,792	11,846	3,255	(8,591)
Lease Expense - Office	11,869	11,869	18,289	15,879	13,420	(2,459)
Consulting Services Expense	125,727	112,076	191,975	330,613	44,640	(285,973)
Translation Services	85	819	2,812	590	748	158
Advertising and Promotion Expense	-	-	3,150	-	0	-
General Office Expenses	89,227	56,656	84,636	78,657	70,921	(7,736)
Depreciation & Amortization Expense	1,806	6,958	3,554	3,561	2,139	(1,422)
Printing Expense	22,538	1,727	2,538	1,670	1,685	15
Shipping & Postage Expense	2,535	230	21	606	522	(84)
Interest Exp	53,094	56,424	100,407	37,812	21,853	(15,959)
Total G & A Expenses	**1,683,028**	**1,706,253**	**1,968,888**	**2,065,316**	**1,555,795**	**(509,520)**
Net Income / (Loss)	**$ (5,425,678)**	**$ 988,552**	**$ (986,767)**	**$ 940,113**	**$ 479,148**	**$ 460,964**

Gold Coast Health Plan
PMPM Income Statement Comparison
For The Period Ended November 30, 2012

	2012 Actual Monthly Trend			Nov'12 Month-To-Date		Variance
	Aug	Sep	Oct	Actual	Budget	Fav/(Unfav)
Members (Member/Months)	95,797	96,669	96,447	96,907	97,637	(730)
Revenue:						
Premium	258.26	242.08	263.39	263.34	266.96	(3.62)
Reserve for Rate Reduction	(6.08)	9.23	(1.31)	(1.33)	(6.04)	4.71
MCO Premium Tax	-	6.03	(0.01)	(0.00)	(6.27)	6.27
Total Net Premium	**252.18**	**257.35**	**262.08**	**262.01**	**254.65**	**7.37**
Other Revenue:						
Interest Income	0.14	0.12	0.14	0.09	0.16	(0.07)
Miscellaneous Income	0.40	0.40	0.40	0.40	0.39	0.00
Total Other Revenue	**0.54**	**0.51**	**0.53**	**0.49**	**0.53**	**(0.04)**
Total Revenue	**252.72**	**257.86**	**262.61**	**262.50**	**255.20**	**7.30**
Medical Expenses:						
Capitation	6.44	6.41	7.80	9.37	6.42	2.95
Incurred Claims:						
Inpatient	58.68	43.86	47.39	46.88	43.00	3.88
LTC/SNF	89.70	64.92	71.55	70.77	71.99	(1.22)
Outpatient	35.21	26.44	28.38	28.23	25.77	2.46
Laboratory and Radiology	2.96	2.22	2.39	2.37	2.16	0.21
Emergency Room Facility Services	6.83	5.13	5.51	5.47	4.98	0.48
Physician Specialty Services	26.74	20.02	23.53	21.79	19.47	2.32
Pharmacy	35.77	32.39	35.97	33.55	32.87	0.69
Other Medical Professional	3.57	2.83	2.97	2.98	2.04	0.94
Other Medical Care Expenses	0.02	0.01	0.01	-	-	-
Other Fee For Service Expense	20.46	15.06	16.40	16.21	14.52	1.69
Transportation FFS	3.96	2.94	3.18	3.16	2.78	0.38
Total Claims	283.90	215.82	237.28	231.40	219.58	11.82
Medical & Care Management	5.60	5.52	5.74	6.06	6.02	0.04
Reinsurance	2.33	2.30	2.32	2.32	2.33	(0.01)
Claims Recoveries	(6.82)	-	(0.66)	(17.66)	-	(17.66)
Sub-total	1.10	7.82	7.40	(9.28)	8.06	(17.34)
Total Cost of Health Care	291.44	230.62	253.68	231.49	234.36	(2.87)
Contribution Margin	(38.72)	27.88	10.18	31.01	**20.84**	**10.17**
Administrative Expenses						
Salaries and Wages	3.19	2.77	4.01	3.34	3.53	(0.19)
Payroll Taxes and Benefits	1.61	0.67	0.65	0.75	1.43	(0.68)
Total Travel and Training	0.07	0.12	0.07	0.06	0.01	0.05
Outside Service - ACS	8.86	9.73	9.19	10.86	8.98	1.88
Outside Service - RGS	0.13	-	0.00	-	-	-
Outside Services - Other	0.11	1.13	1.07	0.18	0.18	(0.00)
Accounting & Actuarial Services	0.19	0.10	0.88	0.46	0.05	0.41
Legal Expense	0.05	0.44	0.13	0.70	0.12	0.58
Insurance	0.04	0.11	0.11	0.12	0.03	0.09
Lease Expense -Office	0.12	0.12	0.19	0.16	0.14	0.03
Consulting Services Expense	1.30	1.16	1.98	3.41	0.46	2.95
Translation Services	0.00	0.01	0.03	0.01	0.01	(0.00)
Advertising and Promotion Expense	-	-	0.03	-	-	-
General Office Expenses	0.92	0.58	0.87	0.81	0.73	0.09
Depreciation & Amortization Expense	0.23	0.02	0.03	0.02	0.02	(0.00)
Printing Expense	0.03	0.00	0.00	0.01	0.02	(0.01)
Shipping & Postage Expense	0.55	0.58	1.04	0.39	0.01	0.38
Interest Exp	-	-	-	-	0.22	(0.22)
Total Administrative Expenses	**17.41**	**17.61**	**20.32**	**21.31**	**15.93**	**5.38**
Net Income / (Loss)	**(56.13)**	**10.20**	**(10.18)**	**9.70**	**4.91**	**4.79**

Gold Coast Health Plan

Income Statement Comparison

For The Five Months Ended November 30, 2012

	Nov'12 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership	482,360	484,942	(2,582)
Revenue:			
Premium	$ 124,392,336	$ 126,953,870	$ (2,561,534)
Reserve for Rate Reduction	(535,378)	(2,945,693)	2,410,315
MCO Premium Tax	(1,579)	(2,983,416)	2,981,837
Total Net Premium	**123,855,380**	**121,024,761**	**2,830,619**
Other Revenue:			
Interest Income	65,495	76,172	(10,677)
Miscellaneous Income	191,667	191,666	1
Total Other Revenue	257,162	**267,838**	(10,676)
Total Revenue	**124,112,542**	**121,292,599**	**2,819,943**
Medical Expenses:			
Capitation	3,530,808	3,133,709	(397,099)
Incurred Claims:			
Inpatient	23,111,114	20,982,515	(2,128,599)
LTC/SNF	35,042,445	31,948,631	(3,093,814)
Outpatient	13,882,957	12,573,165	(1,309,792)
Laboratory and Radiology	1,166,196	1,052,972	(113,224)
Emergency Room Facility Services	2,690,329	2,430,741	(259,588)
Physician Specialty Services	10,764,769	9,498,975	(1,265,794)
Pharmacy	16,519,825	16,036,369	(483,456)
Other Medical Professional	1,460,751	996,072	(464,679)
Other Medical Care Expenses	3,579	-	(3,579)
Other Fee For Service Expense	8,009,227	7,086,498	(922,729)
Transportation	1,554,573	1,357,999	(196,574)
Total Claims	114,205,767	103,963,937	(10,241,830)
Medical & Care Management Expense	2,736,567	2,775,470	38,904
Reinsurance	1,123,100	1,129,914	6,814
Claims Recoveries	(3,047,834)	-	3,047,834
Sub-total	811,833	3,905,384	3,093,552
Total Cost of Health Care	**118,548,408**	**111,003,030**	**(7,545,377)**
Contribution Margin	**5,564,134**	**10,289,569**	**(4,725,435)**
General & Administrative Expenses:			
Salaries and Wages	1,600,749	1,699,111	98,362
Payroll Taxes and Benefits	464,649	618,666	154,017
Total Travel and Training	32,078	30,650	(1,428)
Outside Service - ACS	4,606,659	4,355,311	(251,348)
Outside Service - RGS	23,674	21,847	(1,827)
Outside Services - Other	252,028	240,610	(11,418)
Accounting & Actuarial Services	157,538	125,000	(32,538)
Legal Expense	140,707	57,500	(83,207)
Insurance	40,252	16,275	(23,977)
Lease Expense - Office	69,775	67,100	(2,675)
Consulting Services Expense	881,710	183,200	(698,510)
Translation Services	5,326	3,724	(1,602)
Advertising and Promotion Expense	6,650	2,500	(4,150)
General Office Expenses	355,046	317,719	(37,327)
Depreciation & Amortization Expense	17,684	9,363	(8,321)
Printing Expense	30,859	23,710	(7,149)
Shipping & Postage Expense	16,964	15,562	(1,402)
Interest Exp	308,723	108,448	(200,275)
Total G & A Expenses	**9,011,071**	**7,896,296**	**(1,114,775)**
Net Income / (Loss)	**$ (3,446,936)**	**$ 2,393,273**	**$ (3,610,660)**

Gold Coast Health Plan *Updated:* *1/23/2013*

The following chart represents a list of potential State capitation rate adjustments that have not been fully defined and/or reflected in GCHP's rates. This list will be updated as additional information is provided by the State.

List of Pending Rate Issues ***DRAFT***

Item	Description	Effective Date	Status
AB97	10% rate reduction for certain providers and services. Lawsuit finalized in December, 2012 allowing DHCS to reduce provider rates. Ninth Circuit Court Appeal pending.	7/1/11 - current	As part of the draft State budget, DHCS has verbally stated that reductions will be made retroactively and prospectively for the Medi-Cal FFS program and that managed care rates would be adjusted prospectively. Additionally, 'efficiency adjustments' may be made to reduce State capitation rates (see item further down in table).
SB335 - Hospital Quality Assurance Fee (QAF)	State capitation rates will be increased to reflect payments that would be made to hospitals. Payments will then be made to hospitals.	7/1/11-12/31/16	DHCS notified plans on 12/14/12 that the QAF would be instituted retroactively.
Retroactive Enrollment	Plan is no longer responsible for a portion of retroactive eligibility time period of members.	7/1/12 - current	GCHP has posed questions to clarify policy and methodology.
Healthy Families Transition (HFT)	Healthy Families will transition to Medi-Cal beginning 1/1/13 (new HFT members will enroll in Medi-Cal), with transition of all HF members on 8/1/13. Approximately 20,000 children are expected to transition.	1/1/2013 & ongoing	DHCS sent GCHP draft rates on 11/3/12 for the 1/1/13-3/31/13 time period.
Primary care reimbursement to Medicare fee schedules	Increase of certain primary care services performed by certain physicians will be paid at least the Medicare fee schedules, per the Affordable Care Act	1/1/13-12/31/14	DHCS is determining whether rates will be adjusted or whether adjustment will take place outside of the rates.
New SPD Requirements	For new Seniors and Persons with Disabilities (SPDs or Non-Dual Aged/Disabled population), additional requirements are in effect (e.g., risk assessments)	1/1/2013	Not clear whether GCHP will receive any rate adjustments for additional requirements.
Medi-Cal Expansion	Expansion of population to 133% FPL per Affordable Care Act	1/1/2014	DHCS has not provided information on how rates will be calculated.
Efficiency Adjustments	Efficiency adjustments (e.g., reductions) could be applied to the State rates, examples include:1) MAC pharmacy adjustment 2) Potentially preventable admissions 3) Other	TBD	Pending additional information from the State.
Rate Structure Changes	1) Adult/Family split into two age groups (<18 and >= 18) 2) Duals defined as either Part A or Part B to both Part A and B	7/1/2013	RDT submitted for FY2013-14 rate development reflected these changes.
DRG	DRGs will be used to set out-of-network payments for emergency and post-stabilization services provided to plan members, consistent with Medi-Cal FFS program.	7/1/2013	An All Plan Letter (APL) has been distributed for comment and a formal letter should be released in the coming weeks.
Medi-Cal Eligibility Definition Change	The use of Modified Adjusted Gross Income (MAGI) to determine eligibility for Medi-Cal is expected to increase enrollment. This is required under the Affordable Care Act.	1/1/2014	Pending information from State
Annual Rate Increase	Draft FY12-13 State budget reflects an overall 2.97% rate increase for managed care plans.	7/1/2013	Budget information being reviewed to determine if rate change can be calculated for GCHP.
Gross Premium Tax (GPT)	Extends the GPT past 6/30/12	TBD	Pending information from State
In-Home Supportive Services (IHSS)	Implementation of 20% reduction in member hours of IHSS. State assuming successful resolution of court case.	11/1/13-TBD	Pending information from State

AGENDA ITEM 3a

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: January 28, 2013

RE: FY2012-13 Revised Budget

SUMMARY:
Staff is proposing a revised budget for FY2012-13 that incorporates new information not available at the time the original FY2012-13 budget was approved in August 2012. This item requests the Commission's approval of a revised FY2012-13 budget.

As part of the 10/4/12 Corrective Action Plan ("CAP"), Gold Coast Health Plan ("GCHP" or "the Plan") was required to provide a financial forecast to State (see attached presentation for the Commission's review) which demonstrated how the Plan would achieve Tangible Net Equity ("TNE") compliance. The forecast projected revenues and expenses through 6/30/14 and incorporated many initiatives identified by staff. Therefore, the financial forecast included updated revenues and expenses for this current fiscal year (FY2012-13) and forms the basis for the revised FY2012-13 budget. The revised FY2012-13 budget presented for approval reflects additional updates since the financial forecast was submitted to the State on December 11, 2012.

BACKGROUND / DISCUSSION:
During the August 27, 2012 Commission meeting, the Commission approved the FY2012-13 budget. This budget was based on information available at that point in time regarding the Plan's revenue and expenses. Since the development of that budget, additional information has been made available. New information includes updated revenue estimates, health care costs, and administrative costs (including a new analysis of staffing needs):

- Revenue Estimates – In addition to updated estimates of the Plan's membership to reflect more actual experience (including some retroactive enrollment adjustments), the Plan's estimated revenue has been updated to reflect the following:
  - the additional revenue expected due to correct coding of members, and
  - the estimated new members gained as part of the Healthy Families Transition.

- Health Care Costs - During the first year of the Plan's operations, health care costs were recorded using the "book-to-budget" approach developed by the Plan's actuaries. This approach is common for new health plans that do not have history upon which to base estimates of health care costs.

  On October 4, 2012, the Plan received the CAP in which the State expressed concerns over the Plan's TNE position. These concerns were largely driven by the State Monitor's estimate of health care costs, which were materially higher than those originally estimated by the Plan. Further analysis by the Plan and its actuaries confirmed that medical costs were higher than originally estimated. The result of these higher health care costs, coupled with the identification of changes that needed to be made, were the basis upon which the Plan used to develop operational optimization initiatives to bring costs down as outlined in the CAP response via the financial forecast. For example, the following items were identified as changes that needed to be made, and were quantified and reflected in the revised FY2012-13 budget:

  - Collecting and processing claims overpayments,
  - Coordinating benefit payments with other insurance coverage,
  - Enhanced claims payment edits,
  - Collecting amounts due from Plan's reinsurance vendor,
  - Re-contracting with providers, and
  - Enhancement of utilization and case management of members.

- Administrative Costs - As the Plan developed actions to address the TNE concerns, it became evident that existing budgeted administrative costs would not allow the Plan to achieve its objectives of the cost control and revenue optimization. The updated administrative budget includes an increase in the resources (e.g., staffing, consulting) needed to put the Plan on a path towards meeting its TNE requirement within the three-year phase-in period for new health plans. Not having sufficient resources at the Plan would jeopardize the ability of the Plan to achieve the TNE remediation plan outlined in the CAP response to the State. To highlight, the budget reflects:

  - Updated estimated consulting fees in response to audit recommendations and system replacement,
  - Updated legal expenses based on more recent experience,
  - Expenses associated with additional, temporary space,
  - Additional staffing requested to implement initiatives and perform ongoing requirements (to an estimated FTE count of 84 by 6/30/13), and
  - Updated ACS fees due to the changes in membership.

FISCAL IMPACT:
Based on the updated information available to staff, the updated FY2012-13 budget shows a decrease in operating income from $6.0 million (in the original budget) to the revised $4.1 million.

Additional information is provided in the attached budget presentation and detailed financial statements.

RECOMMENDATION:
Staff recommends that the Commission approve the revised FY2012-13 budget, including permission to proceed with the necessary hiring of 14 staff in addition to the 15 approved during the November 28, 2012 Commission meeting.

Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan
Financial Forecast Overview
Commission Meeting

January 28, 2013

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Gold Coast Health Plan℠
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Agenda

- Financial Forecast
- Tangible Net Equity (TNE) Requirements
- Other Opportunities
- Next Steps

Financial Forecast - Summary

As part of the 10/4/12 Correction Action Plan (CAP) response, Gold Coast Health Plan (GCHP) prepared a financial forecast that:

- Was submitted to DHCS on 12/11/12
- Projected revenues and expenses through 6/30/14 (at which time GCHP is expected to reach 100% of the TNE requirement, which is phased-in over 36 months)
- Reflected the impact of 19 key initiatives currently underway and those planned
- Demonstrated GCHP achieving tangible net equity (TNE) requirements without any outside support (e.g., line of credit) as of 6/30/14

Financial Forecast Quantification – Guiding Principles

As the financial forecast was developed, GCHP followed these guiding principles:

- Be conservative and reasonable
- Reflect savings as they would be realized
- Calculate savings based on data and analysis, not merely assumptions
- Project costs using 16 months of actual experience as baseline
- Use a stable enrollment base (no Healthy Families or Medi-Cal expansion included)
- Assume stable delivery system composition

Financial forecast was reviewed with Berkeley Research Group LLC (monitor appointed by the State)

Financial Forecast – Key Initiatives

GCHP has identified 19 key initiatives covering the following areas:

Areas	Number of Initiatives
Correct coding of members	2
Collecting and processing overpayments, coordinating benefit payments, enhancing claims payment edits, and collecting from reinsurance vendor	8
Provider re-contracting	4
Enhanced utilization and case management	3
Managing administrative budget & TNE requirements	2

Financial Forecast – Dollar Impact of Key Initiatives – Conservative Estimates Used

Annualized impact of initiatives on TNE*:

	Annualized Impact (in millions)	Range of Annualized Impact (in millions)
Increased Revenue	$2.4	$2.4-$3.5
Net reduction to Medical Expenses	$23.8	$20.6-$32.7
Increased Administrative Expenses	($1.2)	($1.1-$1.3)
Incorporation of lines of credit	$8.2	$2.2-$8.2

** Note sign (i.e., positive, negative) of amounts in table indicate the impact on TNE. For example, reductions to medical expenses are noted as positive above because they improve GCHP's TNE position.*

Financial Forecast – Income Statement Findings

Description	Audited Results	2012-13	2013-14 Forecast	3 Year
	FY 2011-12	TOTAL	TOTAL	Average
Member Months	1,258,189	1,197,342	1,168,472	1,208,001
Revenue	**304,635,931**	**305,107,282**	**303,707,815**	**304,483,676**
Health Care Costs	**287,353,673**	**280,797,667**	**265,200,724**	**277,784,021**
% of Revenue	94.3%	92.0%	87.3%	91.2%
Admin Exp	**18,891,321**	**20,603,172**	**19,698,148**	**19,730,880**
% of Revenue	6.2%	6.8%	6.5%	6.5%
Net Income	**(1,609,062)**	**3,706,443**	**18,808,942**	**6,968,774**
% of Revenue	-0.5%	1.2%	6.2%	2.3%

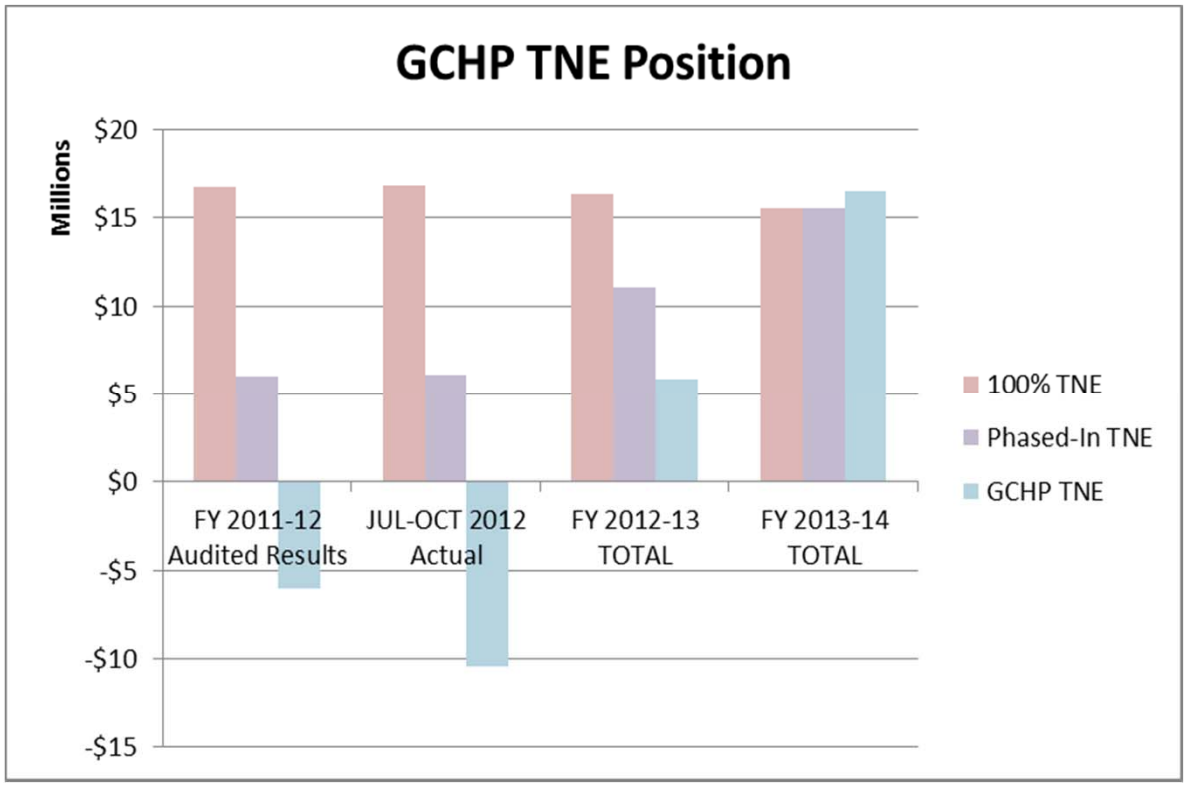
- Membership is stable - leading to steady revenue
- Health care costs impacted by the majority of the initiatives
- Administrative costs at their highest in FY2012-13 due to consulting support and decrease the following year
- Net income varies by year based on impacts noted above

Note – FY2012-13 includes an additional increase of $7M in estimated incurred but not reported (IBNR) health care costs which was included to be conservative.

Financial Forecast – Income Statement Findings

- Majority of initiatives are begun in FY2012-13 with full impact realized in FY2013-14
- FY2013-14 reflects:
  - the first full year of stable operations,
  - the full impact of one-time benefits of key initiatives, and
  - a time when efficiencies are realized and managed care principals are enhanced to aid GCHP member care
- Three year average is a reasonable estimate of what GCHP performance should have been

TNE Requirements



GCHP is projected to meet the full TNE requirement by 6/30/2014

Other Opportunities

- Review of rates
- Financial forecast is conservative because:
  - Estimates incorporate the lower end of savings ranges
  - No State capitation rate increase is assumed between FY2012-13 and FY2013-14
  - New populations (Healthy Families and Medi-Cal expansion) have not been incorporated, where GCHP could leverage existing infrastructure to increase net operating margin from higher enrollment
  - Delivery model contracting changes not currently incorporated into the model (e.g., Plan-to-Plan contracting which will increase capitation and lower TNE requirements)

Next Steps

- Provide ongoing updates on financial forecast results

Gold Coast Health Plan℠
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Gold Coast Health Plan

Revised FY2012-13 Budget
Commission Meeting

January 28, 2013

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Agenda

- Background
- Highlights
  - ►Overall
  - ►Membership
  - ►Revenue
  - ►Health Care Costs
  - ►Administrative Expenses
  - ►Tangible Net Equity
- Next Steps

Background

- Original FY 2012-13 Budget approved by Commission in August, 2012
- Revised Budget:
  - ►Reflects the submission of CAP Financial Forecast to the State (on 12/11/12) which:
    - o Covered Two Years (7/1/12-6/30/14)
    - o Reflected impact of several initiatives (underway and planned) that impacted revenue and expenses
  - ►Incorporates updated information since submission of Financial Forecast

Highlights - Overall

	Original FY2012-13 Budget	Revised FY2012-13 Budget
Financials ($ Millions)		
Net Revenue	$ 295.9	$ 305.9
Health Care Costs	271.3	280.2
Admin Expense	18.5	21.6
Net Income	$ 6.0	$ 4.1

Highlights - Membership

Overall Member Months increased from 1.169M to 1.205M between prior and revised budget due to:

- More current experience being utilized
- Some retroactivity that continued into this fiscal year
- Incorporation of former Healthy Families eligible enrollments (approximately 500/month) to begin in February 2013

Highlights - Revenue

Revenue ($ Millions)	
Original Approved Budget	$ 295.9
Enrollment Changes	3.1
LTC Coding Initiative	1.2
AB97 Reserve Revision (LTCs)	5.6
Revised Net Revenue	$ 305.9

- Revenue changes driven by changes in Membership
- LTC Coding initiative places members into appropriate aid code
- AB97 Reserve was adjusted to reflect only non-LTC portion based on clarification from State

Highlights – Health Care Costs

Health Care Costs ($ Millions)	
Original Approved Budget	$ 271.3
Claims Experience Revision	14.5
Experience Adjusted Run Rate	$ 285.8
Enrollment Changes	4.7
Cost Reduction Initiatives	(10.2)
Revised Health Care Costs	$ 280.2

- Health Care costs were updated from original 'book to budget' estimates to reflect additional IBNR estimates
- Health Care Cost increases driven by changes in membership
- Cost Reduction initiatives reflected (see next slide)

Highlights – Health Care Costs

GCHP has identified many key initiatives covering the following areas:

Areas	Number of Initiatives
Correct coding of Members	2
Collecting and processing overpayments, coordinating benefit payments, enhancing claims payment edits, and collecting from reinsurance vendor	8
Provider re-contracting	4
Enhanced utilization and case management	3

Highlights – Administrative Expenses

Administrative Expense ($Millions)	
Original Approved Budget	$ 18.5
Salaries	0.5
Benefits	(0.6)
Consulting/Outside Services/Temps	2.2
Legal	0.1
ACS Mgmt Fees-Membership Changes	0.6
Interest Expense	0.1
Other Administrative	0.2
Total Administrative Expense	$ 21.6

Increase in overall administrative expenses due to:

- Additional staff (see next slide)
- Expected increased use of consultants/temps and legal services to implement initiatives and staff appropriately
- Increase in ACS fees due to membership changes

Partially offset by decrease in benefit expenses

Highlights – Administrative Expenses

- Additional staff is needed to implement initiatives and put the Plan on a path towards meeting its TNE requirement within the three-year phase-in period
- Not having sufficient resources at the Plan would jeopardize the ability of the Plan to achieve the TNE remediation plan outlined in the CAP response to DHCS
- Counts shown below to arrive at estimated 84 employees by 6/30/13:

Staff adopted in 8/27/12 Budget	55
Additional Approved Staff per 11/28/12 Commission Mtg.	15
Proposed New GCHP Additions	14
Total Projected GCHP Employees by 6/30/13	84

Highlights - Tangible Net Equity

Impact on TNE ($ millions)	
Phased-in Requirement	$ 11.1
Estimated TNE @ 6/30/13	6.3
TNE Excess/(Deficiency)	$ (4.8)

- According to the TNE phase-in approach, the Plan should reach 68% of required TNE by the end of FY2012-13.
- As of 6/30/13, the Plan is projected to remain at a deficit since the full impact of initiatives are not yet realized.
- Budget assumes $8.2M in subordinated debt commitments ($2.2M original County Line of Credit + $6.0M additional support).

Next Steps

- Receive Commission's approval on revised budget
- Provide ongoing updates on budget versus actual financials

GOLD COAST HEALTH PLAN

BUDGET RECONCILIATION

FY2012-13

Summary Comparison	Original Budget	Revised Budget
Membership	1,169,083	1,204,549
Financials ($ Millions)		
Net Revenue	$ 295.9	$ 305.9
Health Care Costs	271.3	280.2
Admin Expense	18.5	21.6
Net Income	$ 6.0	$ 4.1

Revenue	
Original Approved Budget	$ 295.9
Enrollment Changes	3.1
LTC Coding Initiative	1.2
AB97 Reserve Revision (LTCs)	5.6
Revised Net Revenue	$ 305.9

Health Care Costs ($ Millions)	
Original Approved Budget	$ 271.3
Claims Experience Revision	14.5
Experience Adjusted Run Rate	285.8
Enrollment Changes	4.7
Cost Reduction Initiatives	(10.2)
Revised Health Care Costs	$ 280.2

Administrative Expense ($ Millions)	
Original Approved Budget	$ 18.5
Salaries	0.5
Benefits	(0.6)
Consulting/Outside Services/Temps	2.2
Legal	0.1
ACS Mgmt Fees - membership changes	0.6
Interest expense	0.1
Other Administrative	0.2
Total Administrative Expense	$ 21.6

Gold Coast Health Plan

Enrollment Comparison

	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	Percent
2012-13 Original Budget														
FAMILY / ADULT	70,377	70,395	70,412	70,430	70,447	70,465	70,483	70,500	70,518	70,536	70,553	70,571	845,686	72.3%
AGED	1,150	1,150	1,151	1,151	1,151	1,151	1,152	1,152	1,152	1,153	1,153	1,153	13,819	1.2%
DISABLED	7,764	7,766	7,768	7,770	7,772	7,774	7,776	7,778	7,780	7,781	7,783	7,785	93,296	8.0%
LONG TERM CARE	76	76	76	76	76	76	76	76	76	76	76	76	913	0.1%
AGED DUAL	8,809	8,811	8,813	8,816	8,818	8,820	8,822	8,824	8,827	8,829	8,831	8,833	105,853	9.1%
DISABLED DUAL	7,203	7,205	7,207	7,208	7,210	7,212	7,214	7,216	7,217	7,219	7,221	7,223	86,555	7.4%
LTC DUAL	905	905	905	906	906	906	906	907	907	907	907	907	10,875	0.9%
BCCTP	256	256	256	256	256	256	256	256	257	257	257	257	3,076	0.3%
CBAS	-	-	-	1,000	1,000	1,001	1,001	1,001	1,001	1,002	1,002	1,002	9,009	0.8%
	96,540	**96,564**	**96,588**	**97,612**	**97,637**	**97,661**	**97,686**	**97,710**	**97,734**	**97,759**	**97,783**	**97,808**	**1,169,083**	**100.0%**
2012-13 Revised Budget														
FAMILY / ADULT	70,377	72,581	73,550	72,534	73,350	73,366	73,384	73,402	73,420	73,439	73,457	73,475	876,334	72.8%
AGED	1,150	1,009	1,126	1,176	1,209	1,210	1,210	1,210	1,210	1,210	1,210	1,210	14,140	1.2%
DISABLED	7,764	7,756	7,738	7,860	8,007	8,009	8,011	8,013	8,016	8,018	8,020	8,022	95,234	7.9%
LONG TERM CARE	76	-	39	85	71	71	73	72	72	72	72	72	775	0.1%
AGED DUAL	8,809	9,245	9,139	9,062	9,061	9,063	9,066	9,068	9,070	9,072	9,074	9,077	108,806	9.0%
DISABLED DUAL	7,203	7,471	7,463	7,361	7,330	7,331	7,333	7,335	7,337	7,339	7,340	7,342	88,186	7.3%
LTC DUAL	905	969	908	881	913	913	913	913	913	914	914	914	10,970	0.9%
BCCTP	256	233	240	238	241	241	241	241	241	241	242	242	2,898	0.2%
HEALTHY FAMILIES	-	-	-	-	-	-	-	500	985	1,455	1,912	2,354	7,207	0.6%
	96,540	**99,264**	**100,203**	**99,197**	**100,182**	**100,205**	**100,231**	**100,255**	**100,279**	**100,304**	**100,329**	**100,354**	**1,204,549**	**100.0%**
Summary														
Family	70,377	72,581	73,550	72,534	73,350	73,366	73,384	73,902	74,405	74,894	75,369	75,830	883,541	73.4%
SPD	9,246	8,998	9,143	9,359	9,528	9,531	9,535	9,537	9,539	9,541	9,543	9,546	113,046	9.4%
Dual	16,917	17,685	17,510	17,304	17,304	17,308	17,312	17,316	17,320	17,324	17,329	17,333	207,962	17.3%
	96,540	**99,264**	**100,203**	**99,197**	**100,182**	**100,205**	**100,231**	**100,755**	**101,264**	**101,760**	**102,241**	**102,708**	**1,204,549**	**100.0%**

Changes Driven By:

- Continuing retroactivity from prior fiscal year. Original budget assumed all retroactivity would stop as of July 1, 2012.
- CBAS participants originally treated as a separate category of membership. Now recognized as existing members receiving CBAS benefits.
- Assumption of Former Healthy Families members (approximately 500/month) to begin in Februay 2013.
- Original budget used 12 months of history as base. Proposed revised budget based on 16 months of actual enrollment, trended forward.
- Shift between categories changes mix (higher Family/Adult) and resulting revenue and related health care costs.

Gold Coast Health Plan

FY July 1, 2012 - June 30, 2013

Proposed Revised Budget

	ACTUAL FY 2012-13				FORECAST FY 2012-13								
	Jul-12	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**FY 2012-13 Total**
Enrollment-Members	96,540	95,797	96,669	96,447	96,471	96,495	96,519	97,043	97,553	98,047	98,528	98,994	1,165,104
Retroactivity	-	3,467	3,534	2,750	3,711	3,710	3,711	3,711	3,712	3,712	3,713	3,714	39,445
Member Months	**96,540**	**99,264**	**100,203**	**99,197**	**100,182**	**100,205**	**100,231**	**100,755**	**101,264**	**101,760**	**102,241**	**102,708**	**1,204,549**
Average Membership													100,379
Revenue													
Premium	24,923,409	24,965,442	23,459,154	25,524,694	25,729,904	25,733,880	25,752,316	26,044,075	26,086,196	26,128,637	26,169,876	26,210,507	306,728,091
Reserve for Retro Rate Adj	(587,433)	(587,278)	894,648	(126,771)	(126,925)	(126,943)	(127,013)	(127,039)	(127,064)	(127,094)	(127,123)	(127,154)	(1,423,189)
Adjusted Revenue	**24,335,976**	**24,378,164**	**24,353,802**	**25,397,923**	**25,602,979**	**25,606,937**	**25,625,303**	**25,917,036**	**25,959,132**	**26,001,543**	**26,042,753**	**26,083,353**	**305,304,902**
Interest Income	17,566	14,015	11,519	13,390	15,438	15,440	15,451	15,626	15,652	15,677	15,702	15,726	181,204
Other Income	38,333	38,333	38,333	38,333	38,333	38,333	38,333	38,333	38,333	38,333	38,333	38,333	460,000
Total Gross Revenue	**24,391,875**	**24,430,512**	**24,403,655**	**25,449,647**	**25,656,751**	**25,660,711**	**25,679,088**	**25,970,996**	**26,013,117**	**26,055,554**	**26,096,788**	**26,137,412**	**305,946,106**
MCO Tax	585,700	-	(584,793)	635	772	772	773	781	783	784	785	786	7,778
Net Revenue	**23,806,175**	**24,430,512**	**24,988,448**	**25,449,011**	**25,655,979**	**25,659,939**	**25,678,315**	**25,970,214**	**26,012,335**	**26,054,770**	**26,096,003**	**26,136,626**	**305,938,328**
Health Care Costs													
Capitation	624,487	622,092	620,832	755,447	945,476	945,701	945,928	946,159	946,391	946,624	946,859	947,095	10,193,091
Claims													
Inpatient	10,340,533	14,343,780	10,541,460	11,526,622	11,411,345	11,412,061	11,273,289	11,056,422	10,422,584	10,400,772	10,175,436	10,183,142	133,087,446
Outpatient	3,105,422	4,349,739	3,274,508	3,515,227	3,606,621	3,607,488	3,739,458	3,677,684	3,511,204	3,510,235	3,490,346	3,498,266	42,886,197
Professional	2,111,961	2,929,881	2,215,149	2,568,278	2,163,307	2,163,762	2,132,730	2,098,402	2,016,288	2,022,036	2,033,642	2,044,933	26,500,369
Pharmacy	3,186,191	3,458,256	3,138,389	3,485,563	3,133,266	3,133,998	3,135,205	3,141,557	3,147,735	3,153,795	3,159,694	3,165,457	38,439,105
Other	1,684,052	2,362,804	1,745,099	1,898,341	1,868,582	1,868,895	1,803,124	1,767,518	1,760,328	1,757,104	1,758,762	1,760,416	22,035,026
Reinsurance	(387,716)	(434,456)	223,207	161,020	233,423	233,477	(1,566,463)	233,594	233,651	233,709	233,766	233,825	(368,963)
Care Management	516,815	541,067	534,999	556,393	586,003	599,938	615,650	640,129	684,775	708,694	721,416	722,445	7,428,324
Total Claims	**20,557,258**	**27,551,070**	**21,672,811**	**23,711,444**	**23,002,546**	**23,019,619**	**21,132,994**	**22,615,306**	**21,776,564**	**21,786,346**	**21,573,062**	**21,608,483**	**270,007,503**
Total Health Care Costs	**21,181,745**	**28,173,162**	**22,293,643**	**24,466,891**	**23,948,022**	**23,965,320**	**22,078,922**	**23,561,465**	**22,722,955**	**22,732,970**	**22,519,920**	**22,555,578**	**280,200,595**
Administrative Expenses	1,587,586	1,683,028	1,706,253	1,968,888	1,886,470	1,857,217	1,851,174	1,787,516	1,948,664	1,828,741	1,757,098	1,755,704	21,618,337
Net Income	**1,036,844**	**(5,425,678)**	**988,552**	**(986,767)**	**(178,513)**	**(162,599)**	**1,748,220**	**621,234**	**1,340,715**	**1,493,059**	**1,818,985**	**1,825,344**	**4,119,396**
Ratio Analysis													
Revenue													
Premium	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%
Interest Income	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
Other Income	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%
Total Gross Revenue	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
MCO Tax	2.4%	0.0%	-2.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Net Revenue	**97.6%**	**100.0%**	**102.4%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Health Care Costs													
Capitation	2.6%	2.5%	2.5%	3.0%	3.7%	3.7%	3.7%	3.6%	3.6%	3.6%	3.6%	3.6%	3.3%
Claims													
Inpatient	43.4%	58.7%	42.2%	45.3%	44.5%	44.5%	43.9%	42.6%	40.1%	39.9%	39.0%	39.0%	43.5%
Outpatient	13.0%	17.8%	13.1%	13.8%	14.1%	14.1%	14.6%	14.2%	13.5%	13.5%	13.4%	13.4%	14.0%
Professional	8.9%	12.0%	8.9%	10.1%	8.4%	8.4%	8.3%	8.1%	7.8%	7.8%	7.8%	7.8%	8.7%
Pharmacy	13.4%	14.2%	12.6%	13.7%	12.2%	12.2%	12.2%	12.1%	12.1%	12.1%	12.1%	12.1%	12.6%
Other	7.1%	9.7%	7.0%	7.5%	7.3%	7.3%	7.0%	6.8%	6.8%	6.7%	6.7%	6.7%	7.2%
Reinsurance	-1.6%	-1.8%	0.9%	0.6%	0.9%	0.9%	-6.1%	0.9%	0.9%	0.9%	0.9%	0.9%	-0.1%
Care Management	2.2%	2.2%	2.1%	2.2%	2.3%	2.3%	2.4%	2.5%	2.6%	2.7%	2.8%	2.8%	2.4%
Total Claims	**86.4%**	**112.8%**	**86.7%**	**93.2%**	**89.7%**	**89.7%**	**82.3%**	**87.1%**	**83.7%**	**83.6%**	**82.7%**	**82.7%**	**88.3%**
Total Health Care Costs	**89.0%**	**115.3%**	**89.2%**	**96.1%**	**93.3%**	**93.4%**	**86.0%**	**90.7%**	**87.4%**	**87.3%**	**86.3%**	**86.3%**	**91.6%**
Administrative Expenses	6.7%	6.9%	6.8%	7.7%	7.4%	7.2%	7.2%	6.9%	7.5%	7.0%	6.7%	6.7%	7.1%

Gold Coast Health Plan

FY July 1, 2012 - June 30, 2013

Proposed Revised Budget

	ACTUAL FY 2012-13				FORECAST FY 2012-13								
	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	FY 2012-13 Total
Net Income	**4.4%**	**-22.2%**	**4.0%**	**-3.9%**	**-0.7%**	**-0.6%**	**6.8%**	**2.4%**	**5.2%**	**5.7%**	**7.0%**	**7.0%**	**1.3%**
Impact on TNE:													
Required TNE	14,771,512	17,167,762	16,693,841	16,827,932	16,783,346	16,756,296	16,487,753	16,477,235	16,413,394	16,364,306	16,315,363	16,277,102	16,277,102
Phased in Percentage	36%	36%	36%	36%	36%	52%	52%	52%	52%	52%	52%	68%	68%
Phased in Requirement	5,317,744	6,180,394	6,009,783	6,058,056	6,042,004	8,713,274	8,573,631	8,568,162	8,534,965	8,509,439	8,483,989	11,068,430	11,068,430
Monthly TNE	(4,995,037)	(10,420,715)	(9,432,163)	(10,418,930)	(10,597,444)	(8,560,042)	(6,811,822)	(6,190,589)	1,150,126	2,643,186	4,462,170	6,287,515	6,287,515
TNE Excess / (Deficiency)	(10,312,782)	(16,601,109)	(15,441,945)	(16,476,986)	(16,639,448)	(17,273,316)	(15,385,454)	(14,758,751)	(7,384,838)	(5,866,253)	(4,021,818)	(4,780,915)	(4,780,915)
	-33.8%	-60.7%	-56.5%	-61.9%	-63.1%	-51.1%	-41.3%	-37.6%	7.0%	16.2%	27.3%	38.6%	
Beginning Equity	(6,031,881)	(4,995,037)	(10,420,715)	(9,432,163)	(10,418,930)	(10,597,444)	(10,760,042)	(9,011,822)	(8,390,589)	(7,049,874)	(5,556,814)	(3,737,830)	(3,737,830)
Net Income/(Loss)	1,036,844	(5,425,678)	988,552	(986,767)	(178,513)	(162,599)	1,748,220	621,234	1,340,715	1,493,059	1,818,985	1,825,344	1,825,344
Ending Equity	(4,995,037)	(10,420,715)	(9,432,163)	(10,418,930)	(10,597,444)	(10,760,042)	(9,011,822)	(8,390,589)	(7,049,874)	(5,556,814)	(3,737,830)	(1,912,485)	(1,912,485)
Subordinated Debt	-	-	-	-	-	2,200,000	2,200,000	2,200,000	8,200,000	8,200,000	8,200,000	8,200,000	8,200,000
Ending TNE	(4,995,037)	(10,420,715)	(9,432,163)	(10,418,930)	(10,597,444)	(8,560,042)	(6,811,822)	(6,190,589)	1,150,126	2,643,186	4,462,170	6,287,515	6,287,515

Gold Coast Health Plan

Fiscal Year July 1, 2012 - June 30, 2014

Forecasted Balance Sheet

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Petty Cash	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Cash -Operating Account	14,005,983	8,688,893	5,584,970	5,539,892	2,930,208	2,892,050	2,849,747	2,764,928	2,766,282	2,697,149	2,658,637	2,640,763
Cash - Claims Payment	(13,247,979)	(9,025,998)	(4,620,157)	(3,263,116)	(6,029,829)	(6,065,822)	(5,494,586)	(5,907,672)	(5,793,827)	(5,700,878)	(5,623,485)	(5,559,776)
Money Market Account	25,478,652	22,636,111	20,845,788	15,857,736	18,139,694	20,071,282	22,258,421	22,139,330	28,919,586	29,811,827	31,224,596	32,773,488
Medi-Cal Receivable	26,815,002	25,211,484	23,893,260	24,278,541	25,729,904	25,733,880	25,752,316	26,044,075	26,086,196	26,128,637	26,169,876	26,210,507
Provider Receivable	2,987,065	3,684,655	4,119,730	3,296,761	2,967,085	2,670,376	2,403,339	2,163,005	1,946,704	1,752,034	1,576,830	1,419,147
Other Receivables	1,179,918	32,923	206,215	204,363	207,185	208,520	18,251	16,169	17,465	12,204	18,858	8,231
Prepaid - General	789,062	793,805	799,168	802,946	799,949	796,952	793,955	790,958	787,961	784,964	781,968	778,971
Prepaid License Fees	266,217	237,167	217,193	224,477	200,295	176,113	151,932	127,751	103,569	79,388	170,081	273,747
Prepaid Insurance	37,663	48,445	97,541	93,557	82,765	71,973	61,181	50,389	39,597	28,805	18,013	7,221
Deposits	375,000	-	3,125	1,172,982	1,172,982	1,172,982	3,125	3,125	3,125	3,125	3,125	3,125
Computer Systems & Software	202,924	202,924	208,411	208,411	213,211	219,611	227,611	280,811	385,011	393,011	394,611	394,611
Accum Amortization	(28,702)	(30,508)	(37,466)	(41,020)	(44,654)	(48,394)	(52,268)	(57,029)	(63,526)	(70,157)	(76,814)	(83,472)
Total Assets	58,861,806	52,480,901	51,318,779	48,376,532	46,369,795	47,900,525	48,974,024	48,416,840	55,199,144	55,921,109	57,317,298	58,867,565
Claims Payable	11,962,403	9,348,134	11,648,418	8,652,494	8,454,955	8,341,639	8,185,582	7,935,414	7,763,982	7,610,986	7,521,673	7,450,731
Capitation Payable	624,487	622,092	620,832	755,447	945,476	945,701	945,928	946,159	946,391	946,624	946,859	947,095
Incurred But Not Reported	40,833,998	44,563,385	42,268,254	41,516,421	40,816,055	40,414,300	39,861,006	38,974,046	38,366,242	37,823,804	37,507,148	37,255,625
Payable to State	2,501,588	3,088,866	2,194,218	2,320,990	2,447,914	2,574,858	2,701,870	2,828,909	2,955,973	3,083,067	3,210,190	3,337,344
Accounts Payable	4,244,099	559,928	1,352,456	2,915,569	447,395	406,379	377,966	269,168	335,994	215,396	158,680	154,734
Accrued Expenses	200,000	200,000	200,000	200,000	196,854	178,807	166,305	118,434	147,837	94,774	69,819	68,083
Accrued Payroll Taxes	-	-	33,862	38,754	35,512	39,460	43,049	48,528	56,240	59,477	59,477	59,477
Accrued ACS	-	1,108,943	1,189,575	-	1,179,134	1,170,855	1,171,098	1,199,420	1,227,601	1,255,645	1,271,889	1,276,337
Accrued RGS	-	-	-	-	-	-	-	-	-	-	-	-
Accrued Scriptcare	-	-	-	-	242,828	242,885	242,978	243,471	243,949	244,419	244,876	245,323
Accrued CQS	-	-	-	-	-	-	-	-	-	-	-	-
Accrued Premium Tax	1,188,600	1,188,600	(1,170,493)	-	772	1,544	2,316	3,098		784	1,569	2,355
Current Portion of Deferred Revenue	460,000	460,000	460,000	460,000	460,000	460,000	460,000	460,000	460,000	460,000	460,000	460,000
Accrued Payroll Expense	-	-	272,153	334,121	218,677	242,473	266,081	299,116	343,134	361,273	361,273	361,273
Current Portion Of Long Term Debt	500,000	458,333	416,667	375,000	333,333	291,666	249,999	208,332	166,665	124,998	83,331	41,664
Deferred Revenue - Long Term Portion	1,341,667	1,303,333	1,265,000	1,226,667	1,188,333	1,150,000	1,111,667	1,073,333	1,035,000	996,667	958,333	920,000
Other Long-term Liability	-	-	-	-	-	-	-	-	-	-	-	-
Subordinated Loan	-	-	-	-	-	2,200,000	2,200,000	2,200,000	8,200,000	8,200,000	8,200,000	8,200,000
Fund Balance	(4,995,037)	(10,420,715)	(9,432,163)	(10,418,930)	(10,597,444)	(10,760,042)	(9,011,822)	(8,390,589)	(7,049,874)	(5,556,814)	(3,737,830)	(1,912,485)
Total Liab & Fund Balance	58,861,806	52,480,901	51,318,779	48,376,532	46,369,795	47,900,525	48,974,025	48,416,840	55,199,135	55,921,100	57,317,289	58,867,556

Gold Coast Health Plan

Fiscal Year July 1, 2012 - June 30, 2014

Forecasted Cash Flow Statement

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Cash Flow from Operating Activities												
Collected Premium	26,055,912	25,981,682	25,672,026	25,012,642	24,151,617	25,602,961	25,606,868	25,625,277	25,917,011	25,959,102	26,001,514	26,042,722
Interest Income	17,566	14,015	11,519	13,390	15,438	15,440	15,451	15,626	15,652	15,677	15,702	15,726
Paid Claims												
Inpatient	(15,589,171)	(13,751,592)	(10,538,890)	(13,392,261)	(11,868,431)	(11,674,243)	(11,663,043)	(11,628,548)	(10,807,646)	(10,743,934)	(10,373,545)	(10,340,362)
Outpatient	(4,681,669)	(4,170,158)	(3,273,709)	(4,084,183)	(3,751,085)	(3,690,367)	(3,868,743)	(3,867,990)	(3,640,925)	(3,626,052)	(3,558,301)	(3,552,276)
Professional	(3,183,948)	(2,808,920)	(2,214,609)	(2,983,967)	(2,249,959)	(2,213,472)	(2,206,465)	(2,206,986)	(2,090,780)	(2,088,751)	(2,073,236)	(2,076,505)
Pharmacy	(4,803,434)	(3,315,480)	(3,137,624)	(4,049,718)	(3,258,770)	(3,205,999)	(3,243,599)	(3,304,120)	(3,264,028)	(3,257,851)	(3,221,211)	(3,214,330)
Captitation	(633,276)	(624,487)	(622,092)	(620,832)	(755,447)	(945,476)	(945,701)	(945,928)	(946,159)	(946,391)	(946,624)	(946,859)
All Other FFS	(2,538,842)	(2,265,255)	(1,744,674)	(2,205,597)	(1,943,429)	(1,911,832)	(1,865,464)	(1,858,980)	(1,825,363)	(1,815,078)	(1,793,004)	(1,787,596)
Reinsured Claims	584,513	416,519	(223,153)	(187,082)	(242,773)	(238,841)	1,620,620	(245,681)	(242,283)	(241,420)	(238,318)	(237,435)
Admin Expenes	1,945,099	(2,674,719)	(2,160,671)	(1,959,784)	(3,474,810)	(2,329,376)	(951,222)	(2,345,133)	(2,286,586)	(2,484,249)	(2,493,263)	(2,424,374)
Provider Receivable	3,552,475	(697,589)	(435,075)	822,969	329,676	296,708	267,038	240,334	216,300	194,670	175,203	157,683
MCO Tax Expense	-	-	(1,779,786)	-	-	-	-	-	(3,871)	-	-	-
Net cash provided (used) by Ops	725,225	(3,895,984)	(446,737)	(3,634,424)	(3,047,973)	(294,495)	2,765,740	(522,130)	1,041,322	965,724	1,494,917	1,636,395
Cash Flow from Investing/Financing												
Proceeds Subordinated Debt					-	2,200,000	-	-	6,000,000	-	-	-
Costs of Capitalization												
Net Prop & Equip	-	-	-	-	(4,800)	(6,400)	(8,000)	(53,200)	(104,200)	(8,000)	(1,600)	-
Origination of ACS Debt												
Debt Payments	(41,667)	(41,667)	(41,667)	(41,667)	(41,667)	(41,667)	(41,667)	(41,667)	(41,667)	(41,667)	(41,667)	(41,667)
Net Cash Provided (Used) by Inv/Fin	(41,667)	(41,667)	(41,667)	(41,667)	(46,467)	2,151,933	(49,667)	(94,867)	5,854,133	(49,667)	(43,267)	(41,667)
Net Cash Flow	683,558	(3,937,651)	(488,404)	(3,676,090)	(3,094,440)	1,857,438	2,716,073	(616,997)	6,895,455	916,057	1,451,650	1,594,728
Cash & Equiv at Beg of Period	25,554,099	26,237,657	22,300,006	21,811,602	18,135,512	15,041,072	16,898,510	19,614,582	18,997,586	25,893,040	26,809,098	28,260,748
Cash & Equiv at End of Period	26,237,657	22,300,006	21,811,602	18,135,512	15,041,072	16,898,510	19,614,582	18,997,586	25,893,040	26,809,098	28,260,748	29,855,476

Gold Coast Health Plan
Fiscal Year July 1, 2012 - June 30, 2013
Total Administrative Expense

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	FY 2012-13
Salaries	282,167	315,360	224,188	344,101	355,120	394,604	430,490	485,284	562,400	594,773	594,773	594,773	**5,178,033**
Benefits	131,322	184,440	79,386	77,403	82,235	90,342	101,672	112,949	123,867	127,773	127,773	127,773	**1,366,933**
Temp Labor	69,302	39,093	82,854	102,453	46,322	36,924	41,434	41,434	47,434	10,510	4,510	4,510	**526,780**
EE Recruitment	5,942	12,839	15,695	22,238	-	-	-	-	-	-	-	-	**56,714**
Staff Training & Seminars	-	-	-	-	500	700	500	5,500	700	500	6,000	700	**15,100**
Conferences	-	200	2,872	850	500	1,700	300	-	2,500	300	1,000	400	**10,622**
Outside Services - ACS	864,935	856,106	942,882	890,492	937,905	929,597	929,810	934,145	938,358	942,453	946,432	950,298	**11,063,412**
Outside Services - Scriptcare	237,843	247,496	244,920	256,070	242,828	242,885	242,978	243,471	243,949	244,419	244,876	245,323	**2,937,059**
Care Management - ACS	207,353	206,427	227,511	217,237	241,229	241,259	241,289	265,275	289,243	313,192	325,457	326,039	**3,101,510**
Outside Services - RGS	10,858	12,571	-	245	-	-	-	-	-	-	-	-	**23,674**
Outside Services - Other	11,007	12,932	109,502	106,043	22,194	27,264	22,264	22,194	72,264	72,194	22,264	22,194	**522,315**
Consulting Services	123,478	127,117	112,076	191,975	397,630	357,897	305,592	155,960	157,960	34,550	26,550	26,550	**2,017,335**
Translation Services	1,409	2,113	1,100	3,199	1,405	1,405	1,405	1,408	21,410	21,413	21,415	21,417	**99,099**
Meetings & Events	36	1,923	1,441	2,537	-	-	-	-	-	-	-	-	**5,938**
Travel - Airlines	728	2,056	3,394	1,679	-	910	2,710	-	500	1,960	-	200	**14,137**
Travel - Hotels	1,117	1,993	1,895	2,768	-	293	1,750	-	-	1,750	-	-	**11,565**
Travel - Auto & Transportation	1,363	588	2,050	1,074	94	1,388	913	104	1,153	916	100	1,095	**10,840**
Travel - Meals	294	216	592	254	-	402	420	-	150	420	-	150	**2,898**
Travel - Misc./Tips	-	-	-	-	-	-	50	-	-	50	-	-	**100**
Non-Capital Furniture & Equipment	580	18,177	(1,908)	2,058	3,300	4,400	500	15,700	18,200	5,500	1,100	-	**67,607**
Non-Capital Equipment - Computer	5,650	1,752	221	7,181	-	-	-	-	-	-	-	-	**14,804**
Software Licenses	24,590	37,759	17,153	29,547	26,983	26,983	26,983	26,983	26,983	26,983	26,983	43,233	**341,162**
Lease - Office	11,869	11,869	11,869	18,289	16,630	16,630	16,630	27,630	27,630	27,630	27,630	27,630	**241,936**
Office & Operating Supplies	1,632	5,069	13,016	7,040	6,364	6,677	7,433	8,238	9,714	10,102	10,102	10,102	**95,486**
Shipping & Postage	13,572	2,535	230	21	2,734	475	11,281	1,713	1,678	1,689	12,456	1,624	**50,008**
Printing	3,217	23,340	2,463	3,850	10,383	2,791	9,662	7,351	7,648	35,681	14,169	7,461	**128,016**
Repairs & Maintenance	631	90	6,214	3,049	665	666	666	666	667	705	705	705	**15,429**
Telephone Services/Internet Charges	3,159	10,644	7,059	6,688	4,375	4,755	5,600	5,904	7,044	7,351	7,351	7,351	**77,281**
Charitable Contributions	-	1,500	-	-	-	-	-	-	-	-	-	-	**1,500**
Advertising & Promotions Expense	3,500	-	-	3,150	-	2,500	-	-	2,500	-	-	2,500	**14,150**
Insurance	3,424	3,424	10,766	10,792	10,792	10,792	10,792	10,792	10,792	10,792	10,792	10,792	**114,742**
Legal	13,600	4,468	42,522	12,196	32,350	32,350	32,350	32,350	32,350	16,850	16,850	16,850	**285,086**
Accounting & Actuarial	-	18,120	9,818	85,290	15,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	**163,227**
Bank Fees	37	347	540	946	-	-	-	-	-	-	-	-	**1,871**
Meals & Entertainment	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Committee & Advisory Fees	1,250	1,250	-	1,600	1,200	600	1,200	1,625	1,200	600	200	2,000	**12,725**
Professional Dues, Fees, & Licenses	5,427	5,381	5,434	8,506	5,036	5,276	5,386	5,036	5,921	5,076	8,136	5,641	**70,254**
Subscriptions & Publications	319	-	116	500	-	250	65	-	-	375	-	-	**1,625**
Depreciation/ Amortization Expense	1,806	1,806	6,958	3,554	3,634	3,741	3,874	4,761	6,497	6,631	6,657	6,657	**56,576**
Interest Expense	60,986	53,094	56,424	100,407	5,065	5,700	5,825	6,172	7,727	9,299	9,234	9,180	**329,114**
Total	**2,104,402**	**2,224,094**	**2,241,252**	**2,525,280**	**2,472,473**	**2,457,154**	**2,466,824**	**2,427,644**	**2,633,439**	**2,537,435**	**2,478,515**	**2,478,148**	**29,046,661**
Care Management	516,815	541,067	534,999	556,393	586,003	599,938	615,650	640,129	684,775	708,694	721,416	722,445	**7,428,324**
Administrative	1,587,586	1,683,028	1,706,253	1,968,888	1,886,470	1,857,217	1,851,174	1,787,516	1,948,664	1,828,741	1,757,098	1,755,704	**21,618,337**
Total	**2,104,402**	**2,224,094**	**2,241,252**	**2,525,280**	**2,472,473**	**2,457,154**	**2,466,824**	**2,427,644**	**2,633,439**	**2,537,435**	**2,478,515**	**2,478,148**	**29,046,661**

Gold Coast Health Plan
Staffing Budget: FY 2012-13

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Gold Coast Health Plan FTEs	39	43	43	47	50	54	59	66	78	83	84	84
Temporary Help	4	4	4	3	4	-	2	3	3	1	-	-
	43	47	47	50	54	54	61	69	81	84	84	84

Gold Coast Health Plan
Fiscal Years July 1, 2012 - June 30, 2013
Total Administrative Expense

	Original Budget	Revised Budget	Version Changes
Salaries	**4,630,210**	**5,178,033**	547,823
Benefits	**2,000,926**	**1,366,933**	(633,993)
Temp Labor	**217,375**	**526,780**	309,405
EE Recruitment	**39,000**	**56,714**	17,714
Staff Training & Seminars	**6,800**	**15,100**	8,300
Conferences	**7,615**	**10,622**	3,007
Outside Services - ACS	**10,495,936**	**11,063,412**	567,477
Outside Services - Scriptcare	**2,985,376**	**2,937,059**	(48,317)
Care Management - ACS	**2,744,922**	**3,101,510**	356,589
Outside Services - RGS	**21,847**	**23,674**	1,827
Outside Services - Other	**371,134**	**522,315**	151,181
Consulting Services	**388,080**	**2,017,335**	1,629,255
Translation Services	**16,645**	**99,099**	82,453
Meetings & Events	**5,166**	**5,938**	772
Travel - Airlines	**11,785**	**14,137**	2,352
Travel - Hotels	**8,328**	**11,565**	3,237
Travel - Auto & Transportation	**12,835**	**10,840**	(1,995)
Travel - Meals	**3,326**	**2,898**	(428)
Travel - Misc./Tips	**210**	**100**	(110)
Non-Capital Furniture & Equipment	**37,000**	**67,607**	30,607
Non-Capital Equipment - Computer	**48,800**	**14,804**	(33,996)
Software Licenses	**308,136**	**341,162**	33,026
Lease - Office	**161,040**	**241,936**	80,896
Office & Operating Supplies	**53,954**	**95,486**	41,532
Shipping & Postage	**40,819**	**50,008**	9,189
Printing	**51,827**	**128,016**	76,190
Repairs & Maintenance	**8,289**	**15,429**	7,140
Telephone Services/Internet Charges	**23,064**	**77,281**	54,217
Charitable Contributions	**-**	**1,500**	1,500
Advertising & Promotions Expense	**10,000**	**14,150**	4,150
Insurance	**39,060**	**114,742**	75,682
Legal	**138,000**	**285,086**	147,086
Accounting & Actuarial	**160,000**	**163,227**	3,227
Bank Fees	**-**	**1,871**	1,871
Meals & Entertainment	**-**	**-**	-
Committee & Advisory Fees	**31,000**	**12,725**	(18,275)
Professional Dues, Fees, & Licenses	**62,172**	**70,254**	8,082
Subcriptions & Publications	**7,800**	**1,625**	(6,175)
Depreciation/ Amortization Expense	**24,336**	**56,576**	32,240
Interest Expense	**260,521**	**329,114**	68,593
Total	**25,433,333**	**29,046,661**	**3,613,328**
Care Management	**6,908,534**	**7,428,324**	519,789
Administrative	**18,524,799**	**21,618,337**	3,093,539
Total	**25,433,333**	**29,046,661**	**3,613,328**

Presentation of the 2012 Audit Results for Gold Coast Heath Plan

January 28, 2013

McGladrey

McGladrey & Pullen, LLP
Certified Public Accountants

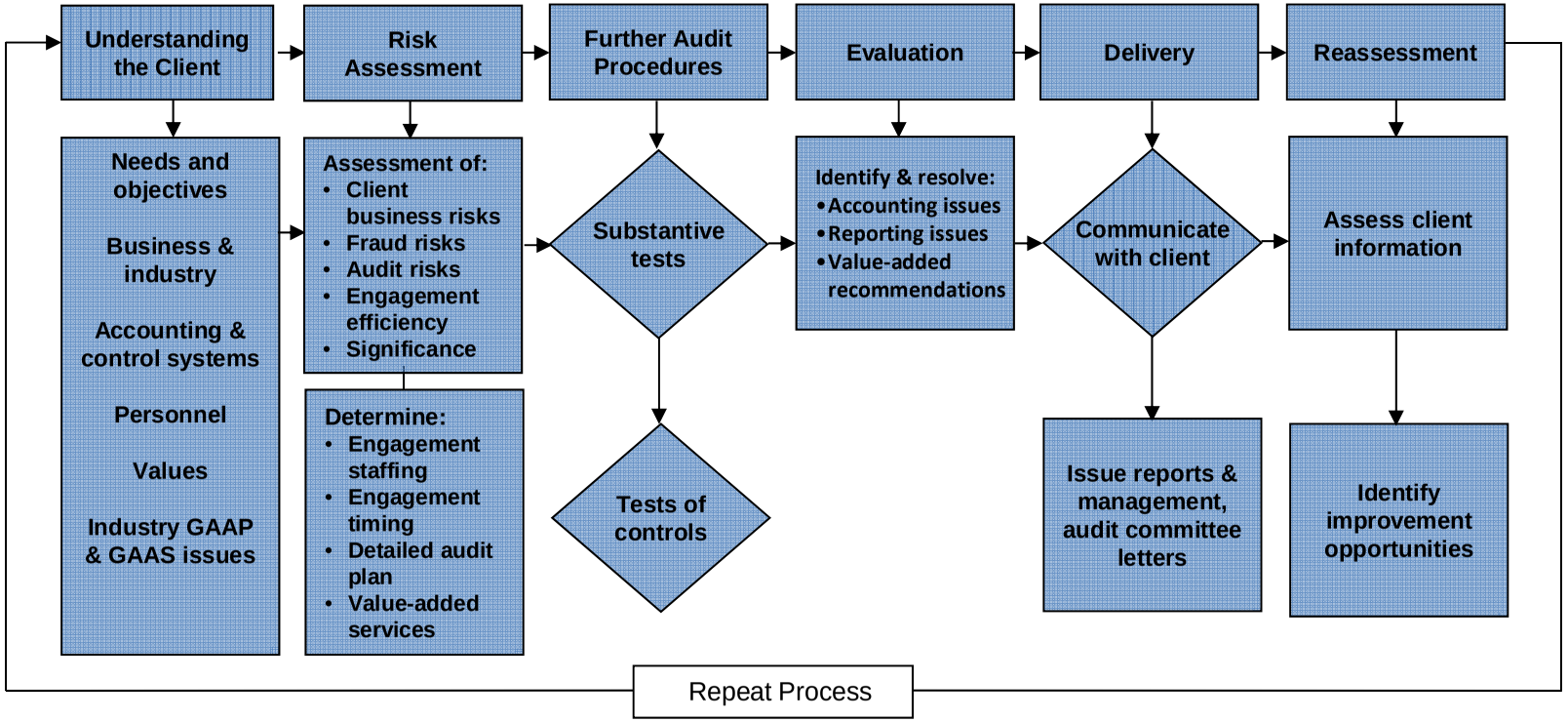
Agenda

- Overview of the audit approach
- Review the Report to the Audit Committee
- Letter Communicating Significant Deficiencies and Material Weaknesses
- Management Letter
- Financial indicators
- Review the summarized financial statements
- Closing comments

McGladrey

Overview of the Audit Approach

We support a process of continuous communication throughout the year. The process for conducting the audit itself is broken into four components:
(1) Preplanning, (2) Planning, (3) Fieldwork and (4) Reviews.



Report to the Audit Committee

Area of Required Communication	McGladrey Comment/Response/Result
Auditor's Responsibility Under Professional Standards	We are responsible for obtaining reasonable assurance about whether the financial statements are prepared in accordance with U.S. generally accepted accounting principles and are free of material misstatement, whether caused by error or fraud.
Accounting Practices	In 2012, management initially applied accounting policies and began to record the following material transactions: • Capitation receivable and capitation revenue • Provider receivables • Reinsurance • Incurred but not reported (IBNR) medical claims liability (including implicit and explicit reserves) and claims expense • Capitation payable and capitation expense • Premium reserve

Report to the Audit Committee (Continued)

Area of Required Communication	McGladrey Comment/Response/Result
Accounting Practices (continued):	In 2012, Gold Coast adopted GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements.* This statement is intended to enhance the usefulness of the codification of governmental accounting and financial reporting standards by incorporating guidance that previously could only be found in certain FASB and AICPA pronouncements. Gold Coast did not adopt any other significant new accounting policies, nor have there been any other changes in existing significant accounting policies during the current period. We did not discuss with management any alternative treatments within generally accepted accounting principles.

Report to the Audit Committee (Continued)

Area of Required Communication	McGladrey Comment/Response/Result
Accounting Practices (continued):	**Significant or Unusual Transactions** During the year, the state of California Department of Health Care Services (DHCS) raised concerns to Gold Coast about the financial status of Gold Coast relative to the ability of Gold Coast to process provider claims and the accuracy of the financial reporting. At the request of the DHCS, Gold Coast agreed to retain a monitor to review its operations. During the year and subsequent to year-end, Gold Coast recorded material adjustments to the Incurred But Not Reported (IBNR) claims liability. Gold Coast's financial results also resulted in a deficiency in tangible net equity (TNE) requirements. We did not identify any other significant or unusual transactions or significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

Report to the Audit Committee (Continued)

Area of Required Communication	McGladrey Comment/Response/Result
Management's Judgments and Accounting Estimates	Particularly sensitive accounting estimates include: • Valuation and collectibility of receivables, including provider receivables • Reinsurance recoverable • Reserve for claims liability (IBNR) and capitation payable • Premium revenue and premium reserve • Reserve for premium deficiency (PDR) • Litigation and other claims
Financial Statement Disclosures	Key financial statement disclosures include: • Going concern of Gold Coast • Revenue recognition policies • Estimated liability for IBNR, medical claims liability and claims expense • Administrative services agreements • Tangible net equity requirements • Commitments and contingencies

Report to the Audit Committee (Continued)

Area of Required Communication	McGladrey Comment/Response/Result
Audit Adjustments	• See the attached Summary of Recorded Audit Adjustments
Uncorrected Misstatements	• See the attached Summary of Uncorrected Misstatements

Report to the Audit Committee (Continued)

Ventura County Medi-Cal Managed Care Commission / dba Gold Coast Health Plan
Schedule Of Audit Adjustments
June 30, 2012

	Effect—Debit (Credit)				
Description	Assets	Liabilities	Net Assets	Revenue	Expense
Identified by management:					
Increase claims liability based on estimate	$ -	$ (15,966,000)	$ -	$ -	$ 15,966,000
Reduce premium reserve for amended rates based on AB-97	-	4,786,000	-	(4,786,000)	-
Increase claims expense for augmented rates due to providers	-	(1,073,000)	-	-	1,073,000
Recognize change in fixed asset capitalization policy	82,000	-	-	-	(82,000)
Identified as a result of audit procedures:					
Reduce claims expense for duplicate claims	1,814,000	-	-	-	(1,814,000)
Recognize contingent legal liability	-	(200,000)	-	-	200,000
Correct overstatement of provider receivable	(141,000)	-	-	-	141,000
Recognize allowance on reinsurance recovery receivable	(166,000)	-	-	-	166,000
				$ (4,786,000)	$ 15,650,000
Close revenue/expense to net assets (deficit)			10,864,000		
Net effect on net assets (deficit)	$ 1,589,000	$ (12,453,000)	$ 10,864,000		

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Report to the Audit Committee (Continued)

Ventura County Medi-Cal Managed Care Commission / dba Gold Coast Health Plan
Schedule Of Uncorrected Misstatements
June 30, 2012

Description	Increase (Decrease) in Assets	(Increase) Decrease Liabilities	(Increase) Decrease Net Assets (Deficit)	(Increase) Decrease in Revenue	Increase (Decrease) in Expense
Current-year misstatements:					
Adjust claims expense and claims payable for projected misstatement	$ -	$ (1,029,000)	$ -	$ -	$ 1,029,000
				$ -	$ 1,029,000
Close revenue/expense to net assets (deficit)	-	-	1,029,000		
Net effect on net assets (deficit)	$ -	$ (1,029,000)	$ 1,029,000		

McGladrey

Report to the Audit Committee (Continued)

Other Communications and Reports	McGladrey Comment/Response/Result
Disagreements With Management	We encountered no disagreements with management over the application of significant accounting principles, the basis for management's judgments on any significant matters, the scope of the audit, or significant disclosures to be included in the financial statements.
Consultations With Other Accountants	We are not aware of any consultations management had with other accountants about accounting or auditing matters during 2012.
Significant Issues Discussed With Management	We discussed the timing of the issuance of the audited financial statements relative to the DHCS due date of October 31. We also discussed the monitoring status and operational and reporting issues identified by the monitor and the DHCS, the TNE shortfall, and going concern matters disclosed in the audited financial statements.
Difficulties Encountered in Performing the Audit	We did not encounter any difficulties in dealing with management.

Report to the Audit Committee (Continued)

Other Communications and Reports	Executive Summary
Qualifications Letter	Communicates the engagement team's qualifications to perform Gold Coast's financial statement audit.
Representation Letters	Documents the responsibility management has taken for the financial statements of Gold Coast.
Independence Letter	Communicates our independence with respect to Gold Coast.
Letter Communicating Significant Deficiencies and Material Weaknesses	We have separately communicated the significant deficiencies and material weaknesses identified during our audit of the financial statements.
Management Letter	See separate communication of suggestions for management.

Evaluation of Control Deficiencies

Evaluation of control deficiencies is a matter of auditor judgment. Control deficiencies are evaluated individually and in aggregate based on the following criteria:

Likelihood	+	**Potential Impact**	=	**Type of Deficiency**
Reasonable Possibility		Material		Material Weakness
Reasonable Possibility		Merits attention by those charged with governance		Significant Deficiency
Remote Possibility		Inconsequential		Control Deficiency

Letter Communicating Significant Deficiencies and Material Weaknesses

MATERIAL WEAKNESSES

- Monitoring and Reporting Compliance with the California Department of Health Care Services
- Claims Processing and Claims Reserves
- Segregation of Duties and Internal Policies

SIGNIFICANT DEFICIENCIES

- Accounts Receivable
- Accounting Department Resources

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Management Letter

BUSINESS SUGGESTIONS FOR GOLD COAST HEALTH PLAN

- Internal Audit Function
- Professional Services Provider Contracts

Financial Indicators

	2012
Current ratio	92.9%
Days cash on hand	30
Days cash on hand - including receivable from the State	63
Operating margin	-0.4%
Average days in medical claims liability	81
Medical expenses as a percentage of capitation revenue	92.3%

Financial Results — Balance Sheet

	2012	
Assets		
Current Assets		
Cash and cash equivalents	**$ 25,554,098**	**40.2%**
Capitation receivable	**28,534,938**	**44.9%**
Provider receivable	**6,539,541**	**10.3%**
Reinsurance receivable	**2,148,270**	**3.4%**
Prepaid expenses and other assets	**560,797**	**0.9%**
Total current assets	**63,337,644**	
Total assets	**$ 63,513,672**	

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Financial Results — Balance Sheet

Liabilities and Net Assets	**2012**	
Current Liabilities		
Medical claims liability	**$ 62,968,509**	**90.5%**
Capitation payable	**633,276**	**0.9%**
	63,601,785	
Accounts payable	**886,715**	**1.3%**
Premium reserve	**1,914,155**	**2.8%**
Accrued implementation costs and administrative serv	**500,000**	**0.7%**
Implementation advance, current	**460,000**	**0.7%**
Accrued premium tax and other	**802,900**	**1.2%**
Total current liabilities	**68,165,555**	
Implementation Advance, less current portion	**1,380,000**	**2.0%**
Total liabilities	**69,545,555**	
Net Assets		
Invested in capital assets, net of related debt	**176,028**	**-2.9%**
Unrestricted net deficit	**(6,207,911)**	**102.9%**
Total net assets	**(6,031,883)**	
Total liabilities and net assets	**$ 63,513,672**	

Financial Results — Revenues, Expenses and Changes in Net Assets

	2012	
Operating revenues:		
Capitation revenues	$ 310,260,446	100.0%
Total operating revenues	310,260,446	
Operating expenses:		
Medical expenses	286,245,088	91.9%
Administrative expenses	25,390,128	8.1%
Total operating expenses	311,635,216	
Operating loss	(1,374,770)	
Nonoperating revenues and expenses		
Investment income	169,056	0.1%
Net rental income and expenses	(403,350)	-0.1%
Total nonoperating revenues and expenses	(234,294)	
Decrease in net assets (deficit)	$ (1,609,064)	

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Data portrayed in the above graphic presentation was derived from Gold Coast's Consolidated financial statements, which were audited by McGladrey LLP. The data should be read in conjunction with Gold Coast's consolidated financial statements and the auditor's report thereon.

Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan

Financial Statements
(With Independent Auditor's Report Thereon)
June 30, 2012

Contents

Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan

Management's Discussion and Analysis

The intent of management's discussion and analysis of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan's (Gold Coast or the Plan) financial performance is to provide readers with an overview of the Plan's financial and operational activities for the year ended June 30, 2012. Readers should review this summation in conjunction with Gold Coast's financial statements and accompanying notes to the financial statements to enhance their understanding of Gold Coast's financial performance.

GOLD COAST OVERVIEW

On June 2, 2009, the Ventura County Board of Supervisors approved the implementation of a county-organized health system (COHS) model to transition Ventura County's Medi-Cal beneficiaries from the State of California's fee-for-service program to a managed care model. Ordinance 4409 (April 2010) established the Ventura County Medi-Cal Managed Care Commission as an oversight entity. The Commission's 11 members oversee a single plan—Gold Coast Health Plan—to serve Ventura County (the County) Medi-Cal beneficiaries. The Plan began operations in July 2011.

As a COHS, Gold Coast entered into an exclusive contract with the State of California (the State) to arrange for the provision of health care services to the County's approximately 105,000 Medi-Cal beneficiaries. As the single contracting entity with the State for the administration of the Medi-Cal program for the County, all members who qualify for full-scope Medi-Cal are mandatorily enrolled in Gold Coast Health Plan. The Plan receives nearly 100 percent of its revenue in the form of capitation from the State.

Gold Coast's operations for the period ended June 30, 2011, consisted primarily of activities in support of the formation and startup of the health plan prior to the effective date of its contract with the State. Consequently, there were no revenues earned during this period, and the operations consisted entirely of administrative activities. The year ended June 30, 2012, represented the first full year of operations as a health plan and is analyzed in this document.

FINANCIAL HIGHLIGHTS

At June 30, 2012, Gold Coast had current assets consisting of approximately $25,554,000 in cash, $37,223,000 in accounts receivable, and $561,000 in prepaid expenses and other assets. Capital assets, net of depreciation, amounted to approximately $176,000. Current liabilities consisted of approximately $63,602,000 in medical claims and capitation payable, $887,000 in accounts payable, $1,914,000 in accrued premium reserves, $960,000 in implementation costs and advances, and $803,000 in accrued premium tax and other expenses. Long-term liabilities amounted to $1,380,000. Total net deficit at June 30, 2012, amounted to approximately $6,032,000.

RESULTS OF OPERATIONS

For the year ended June 30, 2012:

- Operating revenues totaled approximately $310,260,000
- Total claims and other medical expenses amounted to approximately $286,245,000
- Administrative fees and nonoperating revenues and expenses totaled approximately $25,156,000 and included:
  - Salaries and benefits of approximately $4,056,000
  - Professional fees for contracted vendors of approximately $12,835,000
  - General and administrative expenses, including postage and printing, of approximately $878,000
  - Total premium tax incurred of approximately $7,362,000
  - Other expenses totaling approximately $259,000
  - Interest expense (net of interest income) of approximately $234,000

The final result for the year ended June 30, 2012, was a decrease in net assets of approximately $1,609,000.

FISCAL YEAR 2011–12 ENROLLMENT, PREMIUM REVENUE, AND MEDICAL EXPENSES

Enrollment

Enrollment is divided into significant aid categories, which correspond to specific rates of capitation to be received by the Plan from the State. Actual plan enrollment for the year ended June 30, 2012, compared favorably to the budget for the period. The average monthly enrollment is as follows:

Enrollment Category	Fiscal Year 2011–12 Actual Members	Fiscal Year 2011–12 Budgeted Members
Family/Adult	77,533	74,975
Aged—Medi-Cal	1,208	1,250
Disabled—Medi-Cal	8,002	7,774
Long-Term Care—Medi-Cal	73	70
Aged—Dual	9,362	9,118
Disabled—Dual	7,505	7,396
Long-Term Care—Dual	912	873
BCCTP	255	250
Total average monthly enrollment	104,850	101,706

"Dual" coverage refers to enrollees who are eligible for both Medicare and Medi-Cal benefits. "BCCTP" is the Breast and Cervical Cancer Treatment Program, which provides cancer treatment for eligible, low-income California residents who are screened by approved cancer detection programs.

The positive variances in enrollment were largely the result of retroactivity. During fiscal year 2011–12, the state allowed members to enroll retroactively for a period of up to 12 months. Beginning in July 2012, the state policy has curtailed retroactive enrollment.

Premium Revenue

Premium revenue (i.e., capitation received by the Plan from the State) is determined by rates set by the State. Rates are expressed on a per member, per month (PMPM) basis, and generally are effective for the entire year. However, during fiscal year 2011–12, state budget reforms called for premium rate cuts, which translated to an overall 2.2 percent reduction in the Plan's rates. This action (AB97) has been challenged via legal action by several entities within California, and the outcome on the implementation of the rate cuts is not yet certain. Due to this uncertainty, the Plan has received capitation payments at the original rates, but has recorded a reserve for the difference. A comparison of the rates and the resulting revenue is as follows:

Enrollment Category	Fiscal Year 2011–12 Original PMPM Rates	Fiscal Year 2011–12 PMPM Rates With AB97 Reduction
Family/Adult	$ 131.64	$ 130.34
Aged—Medi-Cal	521.14	520.99
Disabled—Medi-Cal	832.79	826.55
Long-Term Care—Medi-Cal	7,027.51	6,732.03
Aged—Dual	233.69	224.19
Disabled—Dual	197.32	189.36
Long-Term Care—Dual	4,494.06	4,216.68
BCCTP	1,062.47	1,058.01

	Fiscal Year 2011–12 Original Revenue	Fiscal Year 2011–12 Revenue With AB97
Total revenue	$ 313,283,000	$ 306,583,000

Subsequent to the passage of the state budget for fiscal year 2011–12, the legislature passed a trailer bill, ABX1-19, which restored the rates associated with care provided by long-term care (LTC) facilities to be paid in fiscal year 2012–13. Whereas an initial premium reduction of $6.7 million was expected, the recapture of the LTC rates added back $4.8 million to revenues. All premium revenue is subject to a 2.35 percent Managed Care Organization (MCO) tax.

Medical Expenses

Initially, medical expenses for fiscal year 2011–12 were recorded using actuarial assumptions regarding enrollment trends, utilization and medical costs as applied to historical data for years prior to the Plan's effective date. As a new plan, Gold Coast did not possess an adequate claims payment history generally required to fully develop a robust incurred but not reported (IBNR) model, which mature health plans use in the estimation of medical costs.

Consequently, a book to budget methodology was employed whereby medical costs were estimated by using the following rates for major categories of medical costs applied to actual enrollment during fiscal year 2011–12:

Health Care Cost Category	Fiscal Year 2011–12 Budgeted Rate (PMPM)
Inpatient Hospital	$ 36.53
Long-Term Care Facility	67.32
Outpatient Hospital	21.43
Laboratory and Radiology Expense	2.29
Emergency Room Facility	3.99
Physician Specialty Services	19.17
Other Medical Professional	2.00
Pharmacy	35.00
Other Fee-for-Service Expense	14.60
Transportation Expense	2.92
Total health care costs	$ 205.25

During the first year of operations, these IBNR assumptions present the largest risk to the Plan's operations. Medical claims typically need long periods of time to run out, as submission delays, processing times and retroactive enrollment can affect the time elapsed from the date of service to actual payment.

The collection of accurate payment data was also affected by other issues regarding Gold Coast's claims experience, including a claims inventory backlog in the early part of the fiscal year resulting from claims system configuration challenges. Consequently, claims payments and their timeliness were negatively impacted. As a result, the final estimation of medical costs and the associated IBNR liability was determined by the Plan's actuaries to be much higher than the amount determined by the original book to budget approach. An additional $16 million was added to the Plan's reserves, which caused a net loss for the Plan's first year of operations. Management believes that the IBNR is conservatively estimated based on the available data.

Sub-capitated Medical Expenses
In addition to fee-for-service medical payments made to the Plan's providers, capitation payments were made to primary care providers (PCP) performing specific primary care services. Rates are determined by the Plan and fixed by contract with participating providers. This "sub-capitation" is paid for three categories of enrollment (Family/Adult, Aged and Disabled) with payment rates for fiscal year 2011–2012 as follows:

Enrollment Category	Fiscal Year 2011–12 Sub-capitation PCP Rate (PMPM)
Family/Adult	$ 8.38
Aged—Medi-Cal	10.99
Disabled—Medi-Cal	12.06

Total sub-capitation payments to providers amounted to $7.5 million in fiscal year 2011–12, which is significantly below the approved budget amount of $8.5 million because not all enrolled members were assigned to a capitated physician.

REGULATORY ACTION

As a regulated entity, Gold Coast is required by the California Department of Health Care Services (DHCS) to maintain certain levels of capital or tangible net equity (TNE). Regulatory capital levels are determined by formula and are based on specified percentages of revenue and medical expenses. As a new plan, the requirement allows for a phase-in period in which the Plan was required to meet 36 percent of calculated TNE by June 30, 2012. Due to the net loss sustained in fiscal 2012, the Plan was deficient in meeting this requirement.

Due to this deficiency and other operational concerns, Gold Coast was directed to follow a corrective action plan (CAP) issued by the DHCS. The CAP contains steps that the Plan is obligated to take in order to correct the deficiency and address related financial and operational issues. Gold Coast has met key due dates for certain deliverables under the CAP and is working closely with its state-assigned monitor/consultant. The Plan has plans to cure the current deficiency and achieve long-term viability.

Gold Coast also has received a commitment of $2.2 million in the form of an unsecured line of credit from the County. To date, the Plan has not drawn on any funds on this line of credit. The Plan may seek an additional capital commitment from the County if needed.

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Independent Auditor's Report

To the Commission
Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan

We have audited the accompanying balance sheet of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (Gold Coast) as of June 30, 2012, and the related statements of revenues, expenses and changes in net assets (deficit), and cash flows for the year then ended. These financial statements are the responsibility of Gold Coast's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Gold Coast's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As discussed in Note 3, the financial statements referred to above present only Gold Coast and do not purport to, and do not, present fairly the financial position, changes in financial position, or cash flows of Ventura County, California, in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Gold Coast as of June 30, 2012, and the changes in its net assets and its cash flows for the year then ended, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 2 to the financial statements, the California Department of Health Care Services (DHCS) requires that Gold Coast meet and maintain a minimum level of tangible net equity (TNE) and comply with several other operational and reporting requirements. As of June 30, 2012, Gold Coast's tangible net equity was below the required threshold, and Gold Coast was out of compliance with various operational and reporting requirements. Gold Coast has developed and submitted to the DHCS a corrective action plan to get the Plan into compliance with TNE and other operational and reporting requirements. While a corrective action plan has been developed, the ultimate resolution of these matters is not determinable at this time and may result in Gold Coast being required to either merge with another financially viable managed care plan or dissolve operations.

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 5 be presented to supplement the financial statements. Such information, although not a part of the financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audit of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

McGladrey LLP

Minneapolis, Minnesota
November 30, 2012

Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan

Balance Sheet
June 30, 2012

Assets	
Current Assets	
Cash and cash equivalents	$ 25,554,098
Accounts receivable:	
Capitation receivable	28,534,938
Provider receivables, net of allowance of $245,452	6,539,541
Reinsurance and other receivables, net of allowance of $166,346	2,148,270
Prepaid expenses and other assets	560,797
Total current assets	63,337,644
Capital Assets, net of accumulated depreciation of $26,897 (Note 5)	176,028
Total assets	$ 63,513,672
Liabilities and Net Assets (Deficit)	
Current Liabilities	
Medical claims liability and capitation payable (Note 6):	
Medical claims liability	$ 62,968,509
Capitation payable	633,276
	63,601,785
Accounts payable	886,715
Premium reserve	1,914,155
Accrued implementation costs and administrative services (Note 4)	500,000
Implementation advance, current (Notes 4 and 7)	460,000
Accrued premium tax and other	802,900
Total current liabilities	68,165,555
Implementation Advance, less current portion (Notes 4 and 7)	1,380,000
Total liabilities	69,545,555
Commitments and Contingencies (Notes 2, 4 and 8)	
Net Assets (Deficit) (Note 2)	
Invested in capital assets, net of related debt	176,028
Unrestricted net deficit	(6,207,911)
Total net assets (deficit)	(6,031,883)
Total liabilities and net assets (deficit)	$ 63,513,672

See Notes to Financial Statements.

Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan

Statement of Revenues, Expenses and Changes in Net Assets (Deficit)
Year Ended June 30, 2012

Operating revenues:	
Capitation revenues (net of reinsurance premiums of $1,108,585)	$ 310,260,446
Total operating revenues	310,260,446
Operating expenses:	
Medical expenses (Note 6):	
Provider capitation	7,534,863
Claim payments to providers and facilities	239,056,472
Prescription drugs	36,022,296
Other medical (Note 4)	6,068,910
Reinsurance recoveries	(2,437,453)
Total medical expenses	286,245,088
Administrative expenses:	
Salaries, benefits and compensation (Note 4)	4,056,153
Professional fees (Note 4)	12,834,921
General administrative fees	877,750
Supplies, occupancy, insurance and other	232,253
Premium tax	7,362,155
Depreciation	26,896
Total administrative expenses	25,390,128
Total operating expenses	311,635,216
Operating loss	(1,374,770)
Nonoperating revenues and expenses:	
Interest income	169,056
Interest expense	(403,350)
Total nonoperating revenues and expenses	(234,294)
Decrease in net assets (deficit)	(1,609,064)
Net assets (deficit), beginning of year	(4,422,819)
Net assets (deficit), end of year	$ (6,031,883)

See Notes to Financial Statements.

Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan

Statement of Cash Flows
Year Ended June 30, 2012

Cash Flows From Operating Activities	
Premiums received and other	$ 284,748,247
Reinsurance premiums paid	(1,108,585)
Payments to providers and facilities	(231,331,114)
Payments of premium tax	(6,759,254)
Payments of administrative expenses	(20,306,312)
Net cash provided by operating activities	25,242,982
Cash Flows From Capital and Related Financing Activities	
Purchases of capital assets	(115,287)
Interest payments	(403,350)
Net cash used in capital and related financing activities	(518,637)
Cash Flows From Investing Activities	
Interest income	169,056
Net cash provided by investing activities	169,056
Net increase in cash and cash equivalents	24,893,401
Cash and Cash Equivalents, beginning of year	660,697
Cash and Cash Equivalents, end of year	$ 25,554,098
Reconciliation of Operating Loss to Net Cash Provided by Operating Activities	
Operating loss	$ (1,374,770)
Adjustments to reconcile operating loss to net cash provided by operating activities:	
Depreciation	26,896
Changes in assets and liabilities:	
Accounts receivable	(37,213,593)
Prepaid expenses and other assets	(520,670)
Medical claims liability	63,601,785
Accounts payable	839,338
Premium reserve	1,914,155
Implementation advance ad accrued implementation costs	(960,000)
Accrued premium tax and other liabilities	(1,070,159)
Net cash provided by operating activities	$ 25,242,982

See Notes to Financial Statements.

Note 1. Organization and Operations

Organizational structure: Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (Gold Coast or the Plan) is a county-organized health system (COHS) organized to serve primarily Medi-Cal beneficiaries in Ventura County, California. The formation of Gold Coast was approved by the Board of Supervisors of the County of Ventura in December 2009 through the adoption of Ordinance No. 4409.

As a COHS, Gold Coast maintains an exclusive contract (the Contract) with the state of California Department of Health Care Services (DHCS) to arrange for the provision of health care services to Ventura County's approximately 105,000 Medi-Cal beneficiaries. All of Gold Coast's revenues are earned from the State of California in the form of capitation payments based on enrollment and capitation rates as provided for in the state contract. The Plan began providing services to Medi-Cal beneficiaries in July 2011.

Note 2. Compliance With the DHCS and Restricted Net Assets

Gold Coast is required to meet and maintain a minimum level of tangible net equity (TNE) as established by the Contract. TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets. As prescribed by the Contract and California state statute, Gold Coast is following a TNE phase-in plan whereby Gold Coast is required to meet 36 percent of the TNE requirement at June 30, 2012. As of June 30, 2012, Gold Coast's TNE was a deficit of approximately $6,032,000, while the requirement was a positive TNE of approximately $6,037,000. Therefore, the Plan has not met its minimum required TNE. The Contract also requires that Gold Coast comply with several other operational and reporting requirements.

During the year ended June 30, 2012, the DHCS was made aware that Gold Coast was not meeting TNE and other operational and reporting requirements. Gold Coast is working with the DHCS with regard to its noncompliant status and has developed a corrective action plan to get the Plan into compliance with TNE and other operational and reporting requirements, including but not limited to improving plan staffing and filling certain key positions, improving claims processing capabilities, developing information technology resources, and timely and accurately filing paid claims and encounter data with the DHCS.

The DHCS has the authority to take actions for noncompliance with the requirements imposed upon the Plan. Such actions include, but are not limited to, imposition of sanctions upon the Plan, assessment of damages, installation of temporary management, or termination of the contract with the DHCS to arrange for the provision of health care services to Ventura County's beneficiaries. In the event the Plan cannot demonstrate financial solvency in accordance with contractual requirements, the DHCS may require that the Plan develop a plan to either merge with a financially viable managed care plan or to dissolve operations.

The ability of Gold Coast to continue as a going concern is dependent on the results of these matters. The financial statements have been prepared on the going concern basis, which assumes the realization of assets and liquidation of liabilities in the normal course of operations. The financial statements do not include any adjustments relating to the recoverability or classification of recorded asset amounts or the amounts or classification of liabilities should the Plan be unable to continue as a going concern.

Note 3. Summary of Significant Accounting Policies

Basis of presentation: The Plan is a county-organized health system governed by an 11-member Commission appointed by Ventura County. Gold Coast is not reported as a component unit of any governmental entity. These financial statements present only Gold Coast and do not purport to, and do not, present fairly the financial position, changes in financial position, or cash flows of Ventura County, California, in conformity with accounting principles generally accepted in the United States of America.

Accounting basis and standards: Gold Coast uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB). In 2012, Gold Coast adopted GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements,* with no impact to its financial statements.

Financial statement presentation: Gold Coast applies the provisions of GASB Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments* (Statement 34), as amended by GASB Statement No. 37, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments: Omnibus*, and GASB Statement No. 38, *Certain Financial Statement Note Disclosures.* These statements establish financial reporting standards for all state and local governments and related entities and primarily relate to presentation and disclosure requirements.

Use of estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Fair value of financial instruments: The carrying amounts of cash and cash equivalents approximate fair value because of the short maturity of these financial instruments. The carrying amounts reported in the balance sheet for capitation receivable, provider receivables, reinsurance and other receivables, prepaid expenses and other assets, medical claims liability and capitation payable, accounts payable, premium reserve, accrued premium tax and other liabilities approximate their fair values, as they are expected to be realized within the next fiscal year.

Cash and cash equivalents: Cash and cash equivalents include highly liquid instruments purchased with an original maturity of three months or less when purchased.

Custodial credit risk—deposits: Custodial credit risk is the risk that in the event of a bank failure Gold Coast may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. At June 30, 2012, all accounts are covered by posted collateral.

Note 3. Summary of Significant Accounting Policies (Continued)

Capitation receivable: Capitation receivable is carried at original invoice amount less an estimate made for doubtful receivables based on a review of all outstanding amounts on a monthly basis. Management determines the allowance for doubtful accounts by regularly evaluating individual receivables and considering payment history, financial condition and current economic conditions. During fiscal 2012, the DHCS allowed members to enroll retroactively for a period of up to 12 months. Beginning in July 2012, the state policy curtailed retroactive enrollment. At the time of the issuance of these financial statements, the Medi-Cal rates for fiscal year 2012 remain pending. The 2012 revenue was recognized based on the rates paid by the DHCS during the year. Management anticipates receiving final rates in the third quarter of fiscal year 2013. Subsequent adjustments to the contracted rates or enrollments are recognized in the period the adjustment is determined.

Provider receivables: Provider receivables are recorded for amounts advanced to providers and for claim refunds due from providers. Management determines the allowance for doubtful accounts by regularly evaluating individual receivables and considering payment history, financial condition and current economic conditions.

Reinsurance: In the normal course of business, the Plan seeks to reduce the loss that may arise from events that cause unfavorable medical claims results by reinsuring certain levels of risk in various areas of exposure with a reinsurer. Amounts recoverable from reinsurance are estimated in a manner consistent with the development of the medical claims liability.

Amounts recoverable from reinsurers that relate to paid and unpaid claims are classified as assets, net of an allowance for any estimated uncollectible amounts, and as a reduction to medical expenses incurred. Reinsurance premiums paid are netted against capitation revenue.

Capital assets: Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs and minor replacements are charged to expense when incurred.

Depreciation and amortization are calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The estimated useful lives of three to seven years are used for furniture, fixtures, computer equipment and software. Depreciation expense for the year ended June 30, 2012, was approximately $27,000.

Medical claims liability, capitation payable and medical expenses: Gold Coast establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for claims incurred but not yet reported, which is actuarially determined based on historical claims payment experience and other statistics. Such reserves are continually monitored and reviewed with any adjustments made as necessary in the period the adjustment is determined. Management believes that the claims liability is adequate and fairly stated; however, this liability is based on estimates, and the ultimate liability may differ from the amount provided.

Gold Coast has provider services agreements with several health networks in Ventura County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network.

Premium deficiency reserves: Gold Coast performed an analysis of its expected future health care and maintenance costs to determine whether such costs will exceed anticipated future revenues under the contracts entered into as of June 30, 2012. Should expected costs exceed anticipated revenues, a premium deficiency reserve would be accrued. A premium deficiency reserve was not required at June 30, 2012.

Note 3. Summary of Significant Accounting Policies (Continued)

Accounts payable and accrued expenses: Gold Coast has contracted with Regional Government Services (RGS) for employee services. All employee expenses are accrued as services are provided, including compensated absences, which are accrued and recorded in accordance with GASB Statement No. 16, *Accounting for Compensated Absences*, and are included in accrued payroll and employee benefits. Implementation costs are accrued as services are performed over the term of the contract (see Note 4). As of September 1, 2012, Gold Coast has terminated its contract with RGS and assumed responsibilities for its own employment agreements and benefits.

Premium reserve: Assembly Bill 97 was passed by the state of California Assembly during fiscal year 2011 and received necessary approval from the Centers for Medicare & Medicaid Services in fiscal year 2012. The bill included premium rate cuts, which resulted in an overall 2.2 percent reduction in the Plan's rates. However, Assembly Bill X1 19 was later passed, which restored the rates associated with care provided by long-term care facilities. For the year ended June 30, 2012, the total capitation rates received in excess of the final approved rates amounted to approximately $1,914,000 and have been reported as a liability at June 30, 2012.

Implementation advance: The implementation advance represents cash received from Affiliated Computer Services (ACS) in accordance with an agreement with them for implementation services (see Note 4). Amounts received in advance are amortized on a straight-line basis over the five-year contractual period of the agreement and are recognized as a reduction of administrative expenses beginning July 2011.

Net assets: Net assets are broken down into two categories, defined as follows:

Invested in capital assets, net of related debt: This component of net assets consists of capital assets, including restricted capital assets, net of accumulated depreciation and reduced by the outstanding balances of any bonds, notes or other borrowings that are attributable (if any) to the acquisition, construction or improvement of those assets.

Unrestricted: This component of net assets consists of net assets that do not meet the definition of "restricted" or "invested in capital assets, net of related debt" in accordance with GASB Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments*, and Statement No. 38, *Certain Financial Statement Note Disclosures*.

Revenue recognition: Capitation revenue is received from the DHCS each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the DHCS contract. Enrollment and the capitation rates are subject to retrospective changes by the DHCS. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the DHCS for these retrospective changes in estimates. These estimates are continually monitored and reviewed, with any changes in estimates recognized in the period when determined.

Premium taxes: The state of California Assembly passed Assembly Bill (AB) 1422, the California Children and Families Act of 1998, in fiscal year 2010 to subsidize the Children's Insurance Program (CHIP) by requiring a premium tax at a rate of 2.35 percent of the Medi-Cal's capitated revenue. Premium tax expense of approximately $7,362,000 was recognized during the year ended June 30, 2012.

Administrative expenses: Administrative expenses are recognized as incurred and consist of administrative expenses that directly relate to the implementation and operation costs of the Plan. Capitation contract acquisition costs are expensed in the period incurred.

Note 3. Summary of Significant Accounting Policies (Continued)

Operating revenues and expenses: Gold Coast's statement of revenues, expenses and changes in net assets (deficit) distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services as well as the costs of administration. Claims adjustment expenses are an estimate of the cost to process the incurred but not reported (IBNR) claims and are included in operating expenses. Non-exchange revenues and expenses are reported as nonoperating revenues and expenses.

Income taxes: Gold Coast operates under the purview of the Internal Revenue Code, Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, Gold Coast is not subject to federal or state taxes. Accordingly, no provision for income tax has been recorded in the accompanying financial statements.

Risk management: The Plan is exposed to various risks of loss from torts, business interruption, errors and omissions, and natural disasters. Commercial insurance coverage is purchased by Gold Coast for claims arising from such matters. No claims have exceeded commercial coverage.

Note 4. Administrative Services Agreements

Affiliated Computer Services (ACS): On June 23, 2010, Gold Coast entered into a five-year agreement with ACS to provide certain operational services through June 30, 2016. Compensation for these services is based on a per member per month cost at varying membership levels. The agreement also calls for a monthly management fee. These costs are recorded as expenses in the period incurred. Total expenses for services provided for the year ended June 30, 2012, were approximately $11,473,000 and are reported as professional fees.

The agreement also calls for ACS to provide implementation services. The cost for these services of $1,000,000 was expensed in fiscal year 2011. The amount is payable in 24 monthly payments of $41,667 beginning with the operational start date of July 1, 2011. At June 30, 2012, $500,000 was recorded as accrued implementation costs.

ACS provided Gold Coast with an advance payment of $2,300,000 in fiscal year 2011. According to the terms of the agreement, should Gold Coast terminate the agreement prior to the end of the stated five-year term, Gold Coast is required to repay any unamortized portion to ACS. The implementation payment is recorded as a liability and is amortized ratably over a 60-month term ending June 30, 2016. The amortization is recognized as a reduction in administrative expense. At June 30, 2012, $1,840,000 was recorded as an accrued implementation advance.

On March 3, 2011, Gold Coast entered into an agreement with ACS Health Administration, Inc. (an affiliate of ACS) to provide medical management services under the supervision of Gold Coast's management team. Total expense for the year ended June 30, 2012, was approximately $2,230,000 and is included in other medical expenses.

Note 4. Administrative Services Agreements (Continued)

Regional Government Services (RGS): RGS provides staffing and human resources support to Gold Coast. As such, all salaries and benefits are compensated through RGS. Included in the RGS benefits are a deferred compensation plan created in accordance with Internal Revenue Code Section 457 and a 403(b) defined contribution supplemental retirement plan. Workers' compensation, commercial and general liability insurance and crime insurance policies are obtained by RGS though the California Joint Powers Insurance Agency (CJPIA). In addition to reimbursement of the direct cost of the salaries, benefits and insurance premiums, administrative fees were paid to RGS of approximately $113,000 for the year ended June 30, 2012.

Effective September 1, 2012, the contract between Gold Coast and RGS was terminated, and all employees and human resources services were assumed by the Plan.

Script Care services: On February 1, 2011, Gold Coast entered into a five-year agreement with Script Care to provided pharmacy administration and management services. Script Care services are specific to the prescription benefit drug program for Gold Coast Medi-Cal beneficiaries. Total expense for Script Care services was approximately $2,743,000 for the year ended June 30, 2012, and is included in other medical expenses.

Note 5. Capital Assets

Capital asset activity during the year ended June 30, 2012, consisted of the following:

	Balance June 30, 2011	Increases	Decreases	Balance June 30, 2012
Capital assets:				
Software and equipment	$ 87,638	$ 31,918	$ -	$ 119,556
Furniture and fixtures	-	83,369	-	83,369
Total capital assets	87,638	115,287	-	202,925
Less accumulated depreciation for:				
Software and equipment	-	19,025	-	19,025
Furniture and fixtures	-	7,872	-	7,872
Total accumulated depreciation	-	26,897	-	26,897
Total capital assets, net	$ 87,638	$ 88,390	$ -	$ 176,028

Note 6. Medical Claims Liability

Medical claims liability consists of the following:

Claims payable or pending approval	$ 10,357,609
Capitation payable	633,276
Provisions for claims incurred but not yet reported	52,610,900
	$ 63,601,785

Note 6. Medical Claims Liability (Continued)

The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been incurred but not yet reported. Gold Coast estimates accrued claims payable based on historical claims payments and other relevant information. Estimates are continually monitored and reviewed, and as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of claims paid is dependent on future developments, management is of the opinion that the accrued medical claims payable is adequate.

The following is a reconciliation of the accrued claims liability for the year ended June 30, 2012:

Beginning balance	$ -
Incurred:	
Current	286,245,088
Prior	-
Total incurred	286,245,088
Paid:	
Current	231,331,114
Prior	-
Total paid	231,331,114
Net balance at end of year	54,913,974
Provider and reinsurance receivables on paid claims	8,687,811
Medical claims liability and capitation payable at end of year	$ 63,601,785

Note 7. Long-Term Liabilities

Activity in the implementation advance and accrued implementation costs for the year ended June 30, 2012, was as follows:

	Balance June 30, 2011	Additions	Reductions	Balance June 30, 2012	Due Within One Year
Implementation advance	$ 2,300,000	$ -	$ 460,000	$ 1,840,000	$ 460,000
Accrued implementation costs	1,000,000	-	500,000	500,000	500,000
Total long-term liabilities	$ 3,300,000	$ -	$ 960,000	$ 2,340,000	$ 960,000

Note 8. Commitments and Contingencies

Line of credit: Gold Coast has a $2,200,000 unsecured line of credit available from the County of Ventura through July 2014, with an option to extend for an additional two years. Interest on advances is based upon the Ventura County Treasury Pool rate (approximately 0.67 percent at June 30, 2012). Gold Coast had no outstanding balance on the line of credit at June 30, 2012, and there were no draws during the year ended June 30, 2012.

Lease commitments: Gold Coast leases office space and equipment under long-term operating leases with minimum annual payments as follows:

Years Ending June 30,	Minimum Lease Payments
2013	$ 169,800
2014	171,814
2015	176,710
2016	106,459
2017	337

Litigation: Through the course of ordinary business, the Plan could become party to various legal actions and subject to various claims arising as a result. During the fiscal year ended June 30, 2012, a suit was filed against RGS and the Plan by a former employee. As a result, the Plan has recorded a liability for this contingency.

Regulatory matters: The health care industry is subject to numerous laws and regulations of federal, state and local governments. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties. Other than the matters discussed in Note 2, management believes that Gold Coast is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

Patient Protection and Affordable Care Act: In March 2010, the President signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Healthcare Reform Legislation), which considerably transforms the U.S. health care system and increases regulations within the U.S. health insurance industry. This legislation is intended to expand the availability of health insurance coverage to millions of Americans. The Healthcare Reform Legislation contains provisions that take effect from 2010 through 2018, with most measures effective in 2014. The total impact of the Healthcare Reform Legislation is unknown, as many aspects of the legislation require additional guidance and clarification to be provided by the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, and the National Association of Insurance Commissioners. The impact of the Healthcare Reform Legislation on the operations of Gold Coast is being evaluated.

Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan

Report to the Audit Committee
November 30, 2012

McGladrey

Assurance ▪ Tax ▪ Consulting

McGladrey

November 30, 2012

Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
2220 E. Gonzales Road, Ste. 200
Oxnard, CA 93036

Attention: Members of the Audit Committee

We are pleased to present this report related to our audit of the financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (Gold Coast) for the year ended June 30, 2012. This report summarizes certain matters required by professional standards to be communicated to you in your oversight responsibility for Gold Coast's financial reporting process.

This report is intended solely for the information and use of the Commission, Executive/Finance Committee, Audit Committee, and management and is not intended to be, and should not be, used by anyone other than these specified parties. It will be our pleasure to respond to any questions you have regarding this report. We appreciate the opportunity to be of service to Gold Coast.

McGladrey LLP

Contents

Required Communications

Statement on Auditing Standards No. 114 requires the auditor to communicate certain matters to keep those charged with governance adequately informed about matters related to the financial statement audit that are, in our professional judgment, significant and relevant to their responsibilities in overseeing the financial reporting process. The following summarizes these communications:

Area	Comments
Auditor's Responsibility Under Professional Standards	Our responsibility under auditing standards generally accepted in the United States of America has been described to you in our arrangement letter dated September 19, 2012.
Accounting Practices	**Adoption of, or Change in, Accounting Policies** Management has the ultimate responsibility for the appropriateness of the accounting policies used by Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (Gold Coast). In 2012, management initially applied accounting policies and began to record the following material transactions: • Capitation receivable and capitation revenue • Provider receivables • Reinsurance • Incurred but not reported (IBNR) medical claims liability (including implicit and explicit reserves) and claims expense • Capitation payable and capitation expense • Premium reserve In 2012, Gold Coast adopted GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements.* This statement is intended to enhance the usefulness of the codification of governmental accounting and financial reporting standards and reduces the complexity of locating and using authoritative literature needed to prepare state and local governments' financial reports by incorporating guidance that previously could only be found in certain FASB and AICPA pronouncements. This statement incorporates into GASB's authoritative literature the applicable guidance previously presented in the following pronouncements issued before November 30, 1989: FASB Statements and Interpretations, Accounting Principles Oversight Board Opinions, and Accounting Research Bulletins of the AICPA's Committee on Accounting Procedure.

Area	Comments
Accounting Practices (Continued)	Gold Coast did not adopt any other significant new accounting policies, nor have there been any other changes in existing significant accounting policies during the current period. **Significant or Unusual Transactions** During the year, the state of California Department of Health Care Services (DHCS) raised concerns to Gold Coast about the financial status of Gold Coast relative to the ability of Gold Coast to process provider claims and the accuracy of the financial reporting. At the request of the DHCS, Gold Coast agreed to retain a monitor to review its operations. Also during the year, Gold Coast recorded material adjustments to the IBNR claims liability. Gold Coast has also made additional adjustments to the June 30, 2012, IBNR claims liability subsequent to year-end. Gold Coast's financial results also resulted in a deficiency in tangible net equity (TNE) requirements. We did not identify any other significant or unusual transactions or significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus. **Alternative Treatments Discussed With Management** We did not discuss with management any alternative treatments within generally accepted accounting principles for accounting policies and practices related to material items during the current audit period.
Management's Judgments and Accounting Estimates	Summary information about the process used by management in formulating particularly sensitive accounting estimates and about our conclusions regarding the reasonableness of those estimates is in the attached Summary of Accounting Estimates.
Financial Statement Disclosures	In our meeting with you in December 2012, we will discuss the following items as they relate to the neutrality, consistency and clarity of the disclosures in the financial statements: • Going concern of Gold Coast • Revenue recognition • Estimated liability for IBNR medical claims liability and claims expense • Administrative services agreements • Tangible net equity requirements • Commitments and contingencies

Area	Comments
Audit Adjustments	Audit adjustments are summarized in the attached Summary of Recorded Audit Adjustments.
Uncorrected Misstatements	Uncorrected misstatements are summarized in the attached Summary of Uncorrected Misstatements.
Disagreements With Management	We encountered no disagreements with management over the application of significant accounting principles, the basis for management's judgments on any significant matters, the scope of the audit, or significant disclosures to be included in the financial statements.
Consultations With Other Accountants	We are not aware of any consultations management had with other accountants about accounting or auditing matters during 2012.
Significant Issues Discussed With Management	We discussed the timing of the issuance of the audited financial statements relative to the DHCS due date of October 31. We also discussed the monitoring status and operational and reporting issues identified by the monitor and the DHCS, the TNE shortfall, and going concern matters disclosed in the audited financial statements.
Difficulties Encountered in Performing the Audit	We did not encounter any difficulties in dealing with management during the audit.
Letter Communicating Significant Deficiencies and Material Weaknesses	We have separately communicated the significant deficiencies and material weaknesses identified during our audit of the financial statements, and this communication is attached as Exhibit D.
Certain Written Communications Between Management and Our Firm	Copies of certain written communications between our firm and the management of Gold Coast are attached as Exhibits A, B, C and E.

Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
Summary of Accounting Estimates
Year Ended June 30, 2012

Accounting estimates are an integral part of the preparation of financial statements and are based upon management's current judgment. The process used by management encompasses their knowledge and experience about past and current events and certain assumptions about future events. You may wish to monitor, throughout the year, the process used to compute and record these accounting estimates. The following describes the significant accounting estimates reflected in Gold Coast's June 30, 2012, financial statements:

Area	Accounting Policy	Estimation Process	Comments
Valuation and collectibility of receivables, including provider receivables	Revenues and their related receivables are based on contract terms and are reduced to their estimated net collectible amounts. Management estimates an allowance for accounts receivable balances when deemed appropriate. Amounts determined to be uncollectible are written off.	Management reviews aged accounts receivable balances to determine specific accounts that require an allowance for uncollectibility based on the ability to collect the receivable balance.	We tested the propriety of management's information and performed testing of subsequent receipts. Based on our procedures, an adjustment was made to adjust provider receivables.
Reinsurance recoverable	Gold Coast seeks to reduce the loss that may arise from large claims by reinsuring certain levels of risk with a reinsurer. Amounts recoverable from reinsurers that relate to paid claims are classified as assets, net of an allowance for any estimated uncollectible amounts, and as a reduction to medical expenses incurred.	Management calculates reinsurance recoveries by reviewing claims paid and claims expected to be paid that exceed reinsured loss thresholds. Management then reviews these estimated recoveries receivable based on terms of the contract with the reinsurer and for collectibility based on aging.	We tested management's process for calculating the amount of reinsurance recoverable and made an adjustment to increase the allowance for reinsurance recoveries receivable.

Area	Accounting Policy	Estimation Process	Comments
Reserve for claims liability and capitation payable (IBNR)	Management establishes claims liability based on estimates of the ultimate cost of claims in process and provision for claims incurred but not yet reported.	The estimate of the claims liability is based on historical claim patterns and certain management assumptions. Management uses subsequent claims run-out and prior claims experience to determine the amount of the estimated liability. Milliman, an independent actuarial firm, was engaged to provide an opinion on the adequacy of the incurred but not reported claims reserve at June 30, 2012. Berkeley Research Group (BRG), an independent consulting firm, also provided a range for the incurred but not reported claims reserve at June 30, 2012.	We tested the propriety of management's information, and we read the independent actuary's report. Our internal actuary performed a corroborative estimate of the claims liability, and we reviewed the journal entry made to adjust IBNR to the independent actuary's estimate. Based on our procedures, the estimates appear reasonable.
Premium revenue and premium reserve	Capitation revenue is recognized in the period it is earned. Retroactive revenue adjustments are recorded in the period they can be reasonably determined.	During 2012, Gold Coast has recorded revenue based on expected 2012 capitation rates. Final 2012 Medi-Cal capitation rates were not issued by the State prior to the date the financial statements were finalized.	We tested Medi-Cal capitation revenue using estimated data provided by the state of California and management's analysis. Based on our procedures, the estimates appear reasonable.
Reserve for premium deficiency	A premium deficiency reserve is recorded when there is an expected loss in the subsequent year from contracts that have been committed to at year-end.	Management performs periodic analysis of its expected future health care costs and maintenance costs by line of business to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued.	We reviewed the propriety of management's analysis. Based on our procedures, the estimates appear reasonable.

Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
Summary of Recorded Audit Adjustments
Year Ended June 30, 2012

Description	Effect—Debit (Credit)				
	Assets	Liabilities	Net Assets	Revenue	Expense
Identified by management:					
Increase claims liability based on estimate	$ -	$ (15,966,000)	$ -	$ -	$ 15,966,000
Reduce premium reserve for amended rates based on AB-97	-	4,786,000	-	(4,786,000)	-
Increase claims expense for augmented rates due to providers	-	(1,073,000)	-	-	1,073,000
Recognize change in fixed asset capitalization policy	82,000	-	-	-	(82,000)
Identified as a result of audit procedures:					
Reduce claims expense for duplicate claims	1,814,000	-	-	-	(1,814,000)
Recognize contingent legal liability	-	(200,000)	-	-	200,000
Correct overstatement of provider receivable	(141,000)	-	-	-	141,000
Recognize allowance on reinsurance recovery receivable	(166,000)	-	-	-	166,000
				$ (4,786,000)	$ 15,650,000
Close revenue/expense to net assets (deficit)			10,864,000		
Net effect on net assets (deficit)	$ 1,589,000	$ (12,453,000)	$ 10,864,000		

Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
Summary of Uncorrected Misstatements
Year Ended June 30, 2012

During the course of our audit, we accumulated uncorrected misstatements that were determined by management to be immaterial, both individually and in the aggregate, to the balance sheet, results of operations, and cash flows and to the related financial statement disclosures. Following is a summary of those differences:

Description	Increase (Decrease) in Assets	(Increase) Decrease Liabilities	(Increase) Decrease Net Assets (Deficit)	(Increase) Decrease in Revenue	Increase (Decrease) in Expense
Current-year misstatements:					
Adjust claims expense and claims payable for projected misstatement	$ -	$ (1,029,000)	$ -	$ -	$ 1,029,000
				$ -	$ 1,029,000
Close revenue/expense to net assets (deficit)	-	-	1,029,000		
Net effect on net assets (deficit)	$ -	$ (1,029,000)	$ 1,029,000		

Exhibit A—Qualifications Letter

McGladrey

Qualifications Letter of Independent Auditors

Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
2220 E. Gonzales Road, Ste. 200
Oxnard, CA 93036

Attention: Members of the Audit Committee

We have audited, in accordance with auditing standards generally accepted in the United States of America, the balance sheet of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (Gold Coast) as of June 30, 2012, and the related statements of revenues, expenses and changes in net assets, and cash flows for the year then ended, and have issued our report thereon dated November 30, 2012. In connection therewith, we advise you as follows:

1. We are independent certified public accountants with respect to Gold Coast and conform to the standards of the profession as contained in the Code of Professional Conduct and pronouncements of the American Institute of Certified Public Accountants.

2. The engagement partner and engagement director, who are certified public accountants, have 16 years and 12 years, respectively, of experience in public accounting and are experienced in auditing insurance companies. Members of the engagement team, 86 percent of whom have had experience in auditing insurance companies and 100 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

3. We understand that Gold Coast intends to file its audited financial statements and our report thereon with the California Department of Health Care Services and that the California Department of Health Care Services will be relying on that information in monitoring and regulating the financial condition of Gold Coast.

   While we understand that an objective of issuing a report on the financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, Gold Coast and the California Department of Health Care Services should understand that the objective of an audit of financial statements in accordance with auditing standards generally accepted in the United States of America is to form an opinion and issue a report on whether the financial statements present fairly, in all material respects, the assets, liabilities, net assets, results of operations, and cash flows in accordance with accounting principles generally accepted in the United States of America.

Consequently, under auditing standards generally accepted in the United States of America, we have the responsibility, within the inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether caused by error or fraud, and to exercise due professional care in the conduct of the audit. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatement resulting from fraud. Because of the characteristics of fraud, a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material misstatements caused by error or fraud may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit means that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of Gold Coast to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in conformity with accounting principles generally accepted in the United States of America.

The California Department of Health Care Services should exercise due diligence to obtain whatever other information may be necessary for the purpose of monitoring and regulating the financial position of Gold Coast and should not rely solely upon the independent auditor's report.

4. We will retain the workpapers prepared in the conduct of our audit until the California Department of Health Care Services has filed a Report of Examination covering fiscal 2012, but not longer than seven years. After notification to Gold Coast, we will make the workpapers available for review by the California Department of Health Care Services at the offices of the insurer, at our offices, at the offices of the California Department of Health Care Services, or at any other reasonable place designated by the California Department of Health Care Services. Furthermore, in the conduct of the aforementioned periodic review by the California Department of Health Care Services, photocopies of pertinent audit workpapers may be made (under the control of the accountant), and such copies may be retained by the California Department of Health Care Services.

5. The engagement partner has served in that capacity with respect to Gold Coast since 2011, is authorized by the California Board of Public Accountancy to practice public accounting in the state of California through a Privilege to Practice Public Accounting, and is a member in good standing of the American Institute of Certified Public Accountants.

6. To the best of our knowledge and belief, we are in compliance with the requirements of section 7 of the NAIC *Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This communication is intended solely for the information and use of the Commission, Audit Committee, Executive/Finance Committee, and management of Gold Coast and is not intended to be, and should not be, used by anyone other than these specified parties.

McGladrey LLP

Minneapolis, Minnesota
November 30, 2012

Exhibit B—Representation Letter

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

November 30, 2012

Mr. Steve Draxler, Partner
McGladrey LLP
801 Nicollet Avenue
11th Floor, West Tower
Minneapolis, MN 55402-2526

Dear Mr. Draxler:

In connection with your audit of the balance sheet of Ventura County Medi-Cal Managed Care Commission / dba Gold Coast Health Plan (Gold Coast or the Plan) as of June 30, 2012 and the related statement of revenues, expenses and changes in net assets and cash flows for the year then ended, we confirm that we are responsible for the fair presentation in the balance sheet, results of operations, and cash flows in conformity with accounting principles generally accepted in the United States of America.

We confirm, to the best of our knowledge and belief, as of November 30, 2012 the following representations made to you during your audit.

1. The financial statements referred to above are fairly presented in conformity with accounting principles generally accepted in the United States of America.
2. Gold Coast uses enterprise fund accounting and is a county organized health system of Ventura County, California.
3. Gold Coast is not reported as a component unit of any governmental entity. The financial statements referred to above present only Gold Coast and do not purport to, and do not, present fairly the financial position, changes in financial position, or cash flows of Ventura County, California.
4. We have made available to you all:
    a. Financial records and related data.
    b. Minutes of the meetings of directors and committees of directors or summaries of actions of recent meetings for which minutes have not yet been prepared.
5. We have made available to you all significant contracts and agreements and have communicated to you all significant oral agreements. We have complied with all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance. We have also informed you of all oral agreements for which signed documents have not yet been prepared through November 30, 2012.
6. We have no knowledge of fraud or suspected fraud affecting the entity involving:
    a. Management,
    b. Employees who have significant roles in the internal control, or
    c. Others where the fraud could have a material effect on the financial statements.

7. We acknowledge our responsibility for the design and implementation of programs and controls to provide reasonable assurance that fraud is prevented and detected.
8. We have no knowledge of any allegations of fraud or suspected fraud affecting Gold Coast received in communications from employees, former employees, analysts, regulators, or others.
9. We have informed you of all significant deficiencies, including material weaknesses, in the design or operation of internal controls that could adversely affect Gold Coast's ability to record, process, summarize, and report financial data.
10. There have been no communications from regulatory agencies concerning noncompliance with, or deficiencies in, financial reporting practices other than the letter regarding "Corrective Action Plan Pursuant to Contract with Department of Health Care Services" in early October, 2012, which has been provided to you.
11. We have no plans or intentions that may materially affect the carrying value or classification of assets. In that regard:
    a. Gold Coast has no significant amounts of idle property and equipment.
    b. Gold Coast has no plans or intentions to discontinue the operations of any subsidiary or division or to discontinue any significant product lines.
    c. We expect that Gold Coast will continue as a going concern through June 30, 2013.
12. The following have been properly recorded and/or disclosed in the financial statements:
    a. Lines of credit or similar arrangements.
    b. All leases and material amounts of rental obligations under long-term leases.
    c. All significant estimates and material concentrations known to management that are required to be disclosed in accordance with the AICPA's Statement of Position 94-6, *Disclosure of Certain Significant Risks and Uncertainties*. Significant estimates are estimates at the balance sheet date that could change materially within the next year. Concentrations refer to volumes of business, revenues, available sources of supply, or markets for which events could occur that would significantly disrupt normal finances within the next year.
13. We are responsible for making the accounting estimates included in the financial statements. Those estimates reflect our judgment based on our knowledge and experience about past and current events and our assumptions about conditions we expect to exist and courses of action we expect to take. In that regard, adequate provisions have been made:
    a. To reduce receivables, including reinsurance, capitation, and provider receivables, to their estimated net collectable amounts.
    b. For expected premium rate and enrollment adjustments applicable to periods through June 30, 2012.
    c. For any material loss to be sustained in the fulfillment of or from the inability to fulfill any commitments.
    d. For the best estimate of medical claims liabilities and capitation payable, including the estimate for premium deficiency reserve.

14. There are no:

    a. Material transactions that have not been properly recorded in the accounting records underlying the financial statements.

    b. Violations or possible violations of laws or regulations whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency. In that regard, we specifically represent that we have not been designated as, or alleged to be, a "potentially responsible party" by the Environmental Protection Agency in connection with any environmental contamination.

    c. Other material liabilities or gain or loss contingencies that are required to be accrued or disclosed in accordance with the Risks and Uncertainties Topic of the FASB Accounting Standards Codification.

    d. Arrangements with financial institutions involving compensating balances or other arrangements involving restrictions on cash balances.

    e. Guarantees, whether written or oral, under which the Plan is contingently liable.

    f. Anticipated withdrawals of funds in material amounts from Plan by outside parties for any reason aside from the normal course of business.

    g. Derivative financial instruments.

    h. Liens or encumbrances on assets or other pledges of assets.

    i. Amounts of contractual obligations for plant construction and/or purchase of real property, equipment, other assets, and intangibles.

    j. Security agreements in effect under the Uniform Commercial Code.

    k. Agreements to repurchase assets previously sold.

    l. Liabilities that are subordinated to any other actual or possible liabilities of the Plan.

    m. Investments in debt or equity securities.

    n. Related-party relationships, transactions, and related amounts receivable or payable, including sales, purchases, loans, transfers, leasing arrangements, and guarantees.

    o. Employee-related related liabilities due to the nature of the agreement with Regional Governmental Services.

15. There are no unasserted claims or assessments that our lawyer has advised us are probable of assertion and must be disclosed in accordance with the Contingencies Topic of the FASB Accounting Standards Codification and/or GASB Statement No.10 other than the following:

    During the fiscal year ended June 30, 2012, a suit was filed against the Plan by a former employee alleging harassment. Counsel has estimated that the range of requested damages will be between 150,000 and $200,000. As a result, the Plan has recorded a liability of $200,000 for this contingency.

16. The Plan has satisfactory title to all owned assets.

17. We have complied with all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance except for the following:

    As of June 30, 2012, Gold Coast's tangible net equity requirement was not met. Gold Coast is working with the California Department of Health Care Services (DHCS) with regard to its non-

compliant status and has developed a corrective action plan to get the Plan into compliance with TNE and other operational and reporting requirements. We believe that we will be able to accomplish the items on the corrective action plan within the time frames required. The ability of Gold Coast to continue as a going concern is dependent on the results of these actions. While DHCS has the authority to require the Plan to merge with another plan or cease business, we have had no communication, written or verbal, from DHCS that indicates that they plan to exercise this authority. We believe that Gold Coast has taken appropriate action to assure the Plan's ability to continue as a going concern.

18. All reported receivables represent valid claims. Premiums receivable represent valid claims against the policyholders indicated and do not include amounts for policies written subsequent to the balance sheet date. An adequate provision has been made for uncollectible amounts, discounts, and allowances that may be incurred in the collection of receivables.

19. The reinsurance contracts provided to you represent all of the Company's agreements with respect to its ceding and assuming reinsurance activities, and there are no modifications, either written or oral, of the terms of the Company's reinsurance contracts or additional reinsurance agreements that have not yet been provided to you.

20. We have determined that Gold Coast's reinsurance ceded contract meets the criteria of FAS No. 113, *Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts*, to be accounted for as reinsurance, and have been given appropriate accounting recognition and disclosure in the financial statements.

21. All reported reinsurance recoverable amounts, less applicable allowances, are collectible, however, the Company remains primarily liable in the event that the reinsurers do not honor these obligations. We are unaware of any material adverse change in the financial condition of the Company's reinsurers that might raise concern regarding their ability to honor their reinsurance commitments.

22. No deferred acquisition costs have been recorded as the Plan's policy is to expense these costs as incurred.

23. The loss reserve specialist used by management in estimating the loss reserves had a sufficient level of competence and experience in loss reserving, including knowledge about the type of insurance written by the Plan as well as an understanding of the appropriate methods for calculating such reserve estimates. We recognize we are responsible for the actuarial amounts and balances and, in our opinion; all such amounts are fairly presented. The data provided to the actuary was accurate and appropriate.

24. The liability for unpaid claims includes estimates of amounts due on reported claims and claims that have been incurred but that were not reported as of June 30, 2012. Such estimates are based on actuarial projections applied to historical claim payment data. Such liabilities represent the Company's best estimate of amounts that are reasonable and adequate to discharge the Company's obligations for claims incurred but unpaid as of June 30, 2012.

25. No premium deficiency reserve is required as of June 30, 2012.

26. Claims adjustment expenses have been paid in advance based on a per member-per month arrangement with ACS Health Administration, Inc. ACS has the contractual obligation to continue claim adjustment activities for incurred claims until such claims have been properly adjudicated.

27. Certain capitalized fixed assets totaling $24,533 were not ready for their intended purpose or placed into service as of June 30, 2012. Accordingly, depreciation of these assets did not occur prior to June 30, 2012 and are appropriately reflected in the financial statements.

28. The reserve for premium rate adjustments (AB97) and the subsequent restoration of long-term care rates (ABX1-19) are properly recorded in fiscal year 2012 and, on a net basis, are estimated to be approximately $1,914,000.

29. The estimated amounts that may be paid to providers in relation to the Provider Rate Increase Budget Act of 98 and the 43.44% augmentation rates to outpatient hospital facilities is $1,072,904. Augmentation payments to providers are not a legally-enforceable liability and we do not expect providers to demand payment of these augmented rates.

30. There have been no reports of regulatory examinations that have been completed in the past year and we have informed you that there are no examinations currently in process. We are not aware of any allegations of noncompliance that should be considered for disclosure or as a basis for recording a loss contingency.

31. Gold Coast uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB). In 2012, Gold Coast adopted GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements,* with no impact to its financial statements.

32. We have determined that we are not required to follow the Annual Financial Reporting Model Regulation (Model Audit Rule) as promulgated by the National Association of Insurance Commissioners.

33. We are responsible for determining that significant events or transactions that have occurred since the balance sheet date and through November 30, 2012 have been recognized or disclosed in the financial statements. No events or transactions have occurred subsequent to the balance sheet date and through November 30, 2012 that would require recognition or disclosure in the financial statements. We further represent that as of November 30, 2012, the financial statements were complete in a form and format that complied with accounting principles generally accepted in the United States of America, and all approvals necessary for issuance of the financial statements had been obtained.

34. During the course of your audit, you may have accumulated records containing data that should be reflected in our books and records. All such data have been so reflected. Accordingly, copies of such records in your possession are no longer needed by us.

35. All balance sheet and income statement accounts have been reconciled to the underlying books and records without exception as of June 30, 2012.

As of and for the year ended June 30, 2012, we believe that the effects of the uncorrected misstatements aggregated by you and summarized below are immaterial, both individually and in the aggregate to the financial statements taken as a whole. For purposes of this representation, we consider items to be material, regardless of their size, if they involve the misstatement or omission of accounting information that, in light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Description	Increase (Decrease) In Assets	(Increase) Decrease Liabilities	(Increase) Decrease Net Assets (Deficit)	(Increase) Decrease In Revenue	Increase (Decrease) In Expense
Current-year misstatements:					
Adjust claims expense and claims payable for projected misstatement	$ -	$ (1,029,000)	$ -	$ -	$ 1,029,000
				$ -	$ 1,029,000
Close revenue/expense to net assets (deficit)	-	-	1,029,000		
Net effect on net assets (deficit)	$ -	$ (1,029,000)	$ 1,029,000		

Respectfully,

Ventura County Medi-Cal Managed Care Commission / dba Gold Coast Health Plan

Michael Engelhard
Chief Executive Officer
Date Signed November 30, 2012

Sonia DeMarta
Controller
Date Signed November 30, 2012

Lyndon Turner
Accounting Manager
Date Signed November 30, 2012

Exhibit C—Independence Letter

McGladrey

Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
2220 E. Gonzales Road, Ste. 200
Oxnard, CA 93036

Attention: Members of the Audit Committee

We were engaged to audit the financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (Gold Coast) as of and for the year ended June 30, 2012, and have issued our report thereon.

Our audit was conducted in accordance with audit and related professional practice standards of the American Institute of Certified Public Accountants (AICPA) and the independence standards of the *Government Auditing Standards* (GAS), issued by the Comptroller General of the United States. Independence from Gold Coast is crucial to the performance of our audit services. We have been asked to communicate the following to the Audit Committee of Gold Coast:

1. Disclose, in writing, all relationships between our firm and Gold Coast that, in our professional judgment, may reasonably be thought to bear on independence.

2. Confirm in writing that, in our professional judgment, we are independent of Gold Coast.

We are not aware of any relationship between our firm and Gold Coast that, in our professional judgment, may reasonably be thought to bear on our independence.

In our professional judgment, McGladrey LLP is independent with respect to Gold Coast within the meaning of Rule 101 of the AICPA Code of Professional Conduct as well as GAS standards.

This report is intended solely for the information and use of the Commission, Executive/Finance Committee, Audit Committee, and management and is not intended to be, and should not be, used by anyone other than these specified parties.

McGladrey LLP

Minneapolis, Minnesota
November 30, 2012

Exhibit D—Letter Communicating Significant Deficiencies and Material Weaknesses

McGladrey

Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
2220 E. Gonzales Road, Ste. 200
Oxnard, CA 93036

Attention: Members of the Audit Committee

In planning and performing our audit of the financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (Gold Coast or the Plan) as of and for the year ended June 30, 2012, in accordance with auditing standards generally accepted in the United States of America, we considered Gold Coast's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Gold Coast's internal control. Accordingly, we do not express an opinion on the effectiveness of Gold Coast's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be significant deficiencies or material weaknesses, and therefore, there can be no assurance that all deficiencies, significant deficiencies or material weaknesses have been identified. However, as discussed below, we identified certain deficiencies in internal control that we consider to be material weaknesses and other deficiencies that we consider to be significant deficiencies.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency or combination of deficiencies in internal control, such that there is a reasonable possibility that a material misstatement of the financial statements will not be prevented, or detected and corrected, on a timely basis. We consider the following deficiencies in the Plan's internal control to be material weaknesses:

MATERIAL WEAKNESSES

MONITORING AND REPORTING COMPLIANCE WITH THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

The California Department of Health Care Services (DHCS) requires that Gold Coast meet and maintain a minimum level of tangible net equity (TNE) and comply with several other operational and reporting requirements. Gold Coast is working with the DHCS with regard to its noncompliant status and has developed a corrective action plan to get the Plan into compliance with TNE and other operational and reporting requirements. The DHCS is monitoring Gold Coast's progress on areas of noncompliance.

We recommend ongoing reporting to the Commission and the Audit Committee on the status of the DHCS monitoring of the TNE requirements as well as financial and operational improvement suggestions from Berkeley Research Group, Milliman, McGladrey LLP, and other external parties.

CLAIMS PROCESSING AND CLAIMS RESERVES

Claims processing: Accurate payment of claims is relied upon for estimating the medical claims liability and maintaining provider relationships and contract compliance. As this is a significant estimate, errors in the claims payment systems frequently have a material impact on the financial statements.

During the course of the 2012 audit, we noted that certain claims selected for testing were not adjudicated properly. Each of the improperly adjudicated claims had been manually adjudicated. During the data input stage of the claims adjudication process, the individual who was manually keying in the information from the provider or facility invoice improperly keyed data. Examples of errors detected include:

- Incorrect quantity
- Incorrect contract rate
- Incorrect length of stay

The claims processing function is outsourced to third-party vendors, specifically, ACS Health Administration, Inc. (ACS) and ScriptCare Ltd. Due to the nature and susceptibility of processing data electronically, management should ensure that the necessary controls are in place and operating effectively to ensure that the data being sent to the third parties and subsequently reviewed and uploaded to Gold Coast's financial and claims system is complete and accurate.

We recommend the following:

- Management should perform an audit on the procedures performed by third-party vendors who process claims information.

- Consider requiring ACS and other vendors that process financial data to undergo an audit of their processes and controls and obtain a Service Organization Controls (SOC 1, previously referred to as a SAS 70) report, as Gold Coast relies on these systems for appropriate financial reporting.

- Implement the following controls to assure claims are being processing appropriately:

    - Implement a formal control that demonstrates fee schedule uploads are being reviewed by Gold Coast employees after the information is sent and input into ACS or changes to the state or provider fee schedules occur.

    - To leverage controls inherent in an automated (as opposed to manual) claims adjudication environment, require that all provider contracts be uploaded and processed through the claims system.

    - Implement a process and procedures to review whether claims were processed accurately.

    - Develop, implement and consistently follow a formal information technology (IT) change management policy that governs all types of IT changes (upgrade, patch, vendor-initiated, emergency, etc.) made by either ACS or Gold Coast. Preferably, this would be in a helpdesk-type ticketing system.

Claims reserves: As Gold Coast began full operations during the year ended June 30, 2012, historical data related to medical claims expense did not exist, and therefore, an established historical methodology for reserving for incurred but not reported (IBNR) claims was not available. As a result, a significant journal entry was made to increase IBNR once the independent actuary provided their opinion.
As noted earlier, Gold Coast is not meeting minimum TNE requirements, making the accuracy of IBNR assessments even more critical.

We recommend continuously monitoring IBNR levels and potentially obtaining a quarterly or mid-year opinion from an independent actuary to assure reserves are appropriately set. We also recommend evaluating the policy on calculating premium deficiency reserves, including whether the Plan includes interest income in the calculation. An actuary can assist with the determination of such accruals as premium deficiency reserves, pharmacy accruals and capitation payable.

SEGREGATION OF DUTIES AND INTERNAL POLICIES

Segregation of duties—accounting: An effective system of internal accounting control contemplates an adequate segregation of duties so that no one individual handles a transaction from its initiation to its completion. The limited number of accounting and finance personnel at Gold Coast prevents a proper segregation of accounting functions necessary to assure adequate internal control. As a result, some aspects of internal accounting control, which rely upon adequate segregation of duties, are not effective.

For example, one employee has the ability to create vendors, print checks, access disbursements, and create and post manual journal entries to the general ledger. In some instances, employees also have access to write off accounts. There is limited oversight to these functions other than a review of the financial statements by the chief executive officer, others in management, and/or the Commission. This creates an opportunity to misappropriate assets and misrepresent financial position. Supervision and periodic review procedures can assist in mitigating the lack of proper segregation of duties.

The lack of monitoring controls also leaves Gold Coast vulnerable to accounting errors. During our audit, we noted there were cutoff errors in prepaid expenses and accounts payable. We recommend Gold Coast review its processes for recording and reviewing all entries to ensure proper financial reporting and adherence to generally accepted accounting principles (GAAP).

We recommend Gold Coast continue working to eliminate conflicting duties through segregation of duties and to put compensating supervisory controls in place.

Segregation of duties—IT: During our review of IT controls, we noted that there is not a procedure developed and consistently followed for the periodic review of user access to Multiview, Windows and Go-To-My PC users. In addition, access request forms are not utilized to track the approval and authorization for permitting new hires and removing terminations from logical and physical access to information resources.

We recommend that these user lists be reviewed at least annually to check for terminated employees and that access rights are commensurate with job responsibilities. A policy for administering user access should be developed, including the utilization of an access request form for tracking the access administration process including request, approval and implementation of privileges, as well as strong password policies. There should also be a process to assure that terminated employee access is removed promptly. These steps will ensure that access is appropriate for job responsibilities and conflicting job duties are minimized.

We recommend Gold Coast eliminate conflicting duties through IT controls and segregation of duties to the extent possible and that you put compensating supervisory controls in place.

Internal policy—accounting: During our audit, we noted that management did not consistently follow Gold Coast's documented procedures requiring dual signatures or the Commission's approval for disbursements that meet certain thresholds. In conjunction with the segregation of duties deficiency noted earlier, this lack of controls heightens the risk of misappropriated assets and financial statement errors.

We recommend Gold Coast follow internal policies and have controls that prevent disbursements without proper authorization and mitigate conflicting responsibilities.

Internal policy—IT: We noted there is not a formal policy for the overall security of information technology, including access to the IT system and the physical assets.

We recommend that an overall IT security policy be developed, which describes administration, monitoring, segregation of duties, and other procedures in place that protect information assets.

Business continuation planning and recordkeeping: As is the case in many new organizations, Gold Coast has experienced turnover in management and other key personnel. In addition, the corrective action plan in place with the DHCS has created additional turnover and new positions. Any time there is turnover at a key accounting position, there is a significant learning curve to get the replacement up to speed with daily and monthly tasks, reconciliation procedures, computer and manual reports, and reports/data to be distributed to parties inside and outside Gold Coast. To assure these transitions provide little disruption to operations and reporting, management should assure all signed agreements and policies are maintained in a central location. Additionally, the maintenance of an accounting procedures manual, which details tasks performed by title/function, would facilitate performing critical functions during short-term periods along with easing any future transitions.

SIGNIFICANT DEFICIENCIES

A significant deficiency is a deficiency or combination of deficiencies in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the following control deficiencies to be significant deficiencies:

ACCOUNTS RECEIVABLE

Gold Coast has a number of accounts receivable from providers, the reinsurer, and for capitation receivable. The allowance for doubtful accounts on receivable balances is a significant estimate and is determined by management. A formal assessment of the collectibility of accounts receivable should be performed periodically (monthly) to assure interim financials properly reflect the best estimate of the expected value of accounts receivable. We recommend this assessment be based on knowledge of the customer and assessment of their ability to pay, aging, collection terms and historical collection rates. Any significant write-offs should be communicated to the Audit Committee on a timely basis.

Gold Coast has provided lump-sum advance payments, which future claims can be applied against, to a number of providers and facilities. Gold Coast does not have a formal policy for recording and allowing for these types of arrangements. In addition, there were no formal agreements drafted with these providers, and payment terms were not defined.

We recommend Gold Coast create internal policies and procedures as well as draft formal agreements with providers to ensure proper financial reporting, proper claims payment processes, and safeguarding of assets.

ACCOUNTING DEPARTMENT RESOURCES

We noted Gold Coast is experiencing delays in its accounting and reporting processes due to an inundated accounting department. Timely and accurate financial information can significantly assist senior management and the Commission by facilitating relevant oversight and budgetary control and quickly addressing cash flow and other issues. We recommend the Plan hire additional resources to support the accounting function.

CLOSING

We appreciate the opportunity to be of service to Gold Coast and would be happy to assist you in addressing and implementing any of the suggestions in this letter.

This communication is intended solely for the information and use of the Commission, Executive/Finance Committee, Audit Committee, and management of Gold Coast and is not intended to be, and should not be, used by anyone other than these specified parties.

McGladrey LLP

Minneapolis, Minnesota
November 30, 2012

Exhibit E—Management Letter

McGladrey

Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
2220 E. Gonzales Road, Ste. 200
Oxnard, CA 93036

Attention: Members of the Audit Committee

This letter includes comments, observations and suggestions with respect to matters that came to our attention in connection with our audit of the financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (Gold Coast or the Plan) for the year ended June 30, 2012. We have repeated the following comments from our prior audit because they are still applicable for our audit of the current financial statements. These items are offered as constructive suggestions to be considered part of the ongoing process of modifying and improving Gold Coast's practices and procedures.

INTERNAL AUDIT FUNCTION

The Audit Committee's commitment to the improvement of Gold Coast's operations should include an ongoing commitment to develop and enhance the performance capabilities of an internal audit function.

While a formal internal audit function is not required, we recommend the Plan begin developing a department that can effectively execute the functions of an internal audit department. We suggest the implementation of this department over time as Gold Coast develops into an established entity. The objectives of an internal audit function are to assist the Audit Committee and management in the effective discharge of their responsibilities by furnishing them with analyses, recommendations and risk mitigation suggestions concerning the activities reviewed. This involves going beyond the accounting and financial records to regularly test financial cycles and specific areas of risk.

By establishing an internal audit function, more accurate and timely data will be available regarding operational activities in various departments. This will allow financial services to better monitor their financial activities, as well as strengthen the existing internal control structure and provide more timely identification and resolution of issues.

We recommend an internal audit function with some of the following attributes:

- The internal audit function should be based on a thorough risk assessment. The risk assessment should then drive an annual plan, which is followed by the internal audit function. The annual plan should be developed by the internal audit function, with input from management and the Audit Committee, and should focus on key risk areas. The audit plan should encompass the entirety of Gold Coast's operations, including all transaction cycles, departments, internal controls, etc.

- The internal audit staff should have no direct responsibilities for nor authority over any of the activities reviewed. Therefore, the internal audit review and appraisal does not in any way relieve other employees of Gold Coast of the responsibilities assigned to them.

- In some cases, it may be logical to enlist the use of specialists to assist in the audit or compliance projects. In those circumstances, the internal staff should closely oversee and review the analyses performed.

- Gold Coast should provide the internal audit personnel full access to all records and personnel relevant to the subject under review.

In addition to the orthodox internal audit approach, which concerns itself with control testing, detection and prevention of fraud, and deviations from Gold Coast policies, the activities of an internal audit function should also include operational auditing. Operational auditing is an objective appraisal of the activities of a department or service within an organization with a view toward evaluating the efficiency and effectiveness of various activities within a department or service organization. Some examples of successful operational auditing include:

- Medical claims processing—The claims processing cycle is the backbone of Gold Coast. Ensuring appropriate payment processing according to contractual fee schedules, efficient flow of member information, and accurate data collection for actuary assessment and financial reporting is paramount in every insurance organization. Internal audit should play a vital role in overseeing and supporting Gold Coast through claims processing cycle auditing.

- Administrative services management—While a focus on the medical claims expense is important for any insurance provider, the cost of professional services accounts for a significant portion of Gold Coast's operating budget. Assuring that professional service providers have the capability to adequately process and report activity is essential. The internal audit function can have a positive impact on managing and monitoring the design, transaction integrity and reporting measures, in both a financial and operational aspect, for professional service contracts.

- Cash receipts and disbursements—Gold Coast should ensure that there are policies and procedures in place related to the following:

  1) Segregation of duties in the cash receipt and disbursement cycles is adequate.

  2) Accounts payable invoices are processed timely in order to maximize discounts and avoid finance/late charges.

  3) Accounts payable invoices are properly canceled so as to avoid a duplicate payment.

  4) Proper authorization is obtained before payments are made, and vendor listings are periodically reviewed.

  5) Checks and check writing capabilities are secured.

  6) Bank statements are reviewed and reconciled on a monthly basis.

- Business risk management—The auditing profession has issued an auditing standard that encourages organizations to consider their own fraud prevention controls and programs. As a result, we encourage management to consider what the risks are related to potential fraud and what procedures are in place or should be put into place to reduce the risks. This is a role that could be assumed by an internal audit function.

- Significant new systems—While internal audit should not be overwhelmed with special projects, this department can be a valuable source for testing of specific areas identified by finance, risk management, legal counsel or the compliance function.

PROFESSIONAL SERVICES PROVIDER CONTRACTS

Gold Coast engages external professional services providers for a significant portion of its back-office functions. We recommend that Gold Coast pursue clauses in these administrative contracts limiting Gold Coast's exposure for errors made by the professional service provider. This clause should limit the period that Gold Coast will compensate for errors made in claims or payroll processing (i.e., 12 months), and would not allow for compensation over an indefinite period of time.

Additionally, during our review of Gold Coast's contract with ACS, we noted there is a level of ambiguity regarding which party (Gold Coast or ACS) is financially responsible for processing run-out claims upon termination or expiration of the contract. We recommend management work with ACS to add clarity to this provision of the contract and that management ensures the accounting records properly reflect the clarified understanding between the parties to the contract.

CLOSING

We appreciate the opportunity to be of service to Gold Coast and would be happy to assist you in addressing and implementing any of the suggestions in this letter.

This letter is intended solely for the information and use of the Commission, Executive/Finance Committee, Audit Committee, and management of Gold Coast and is not intended to be, and should not be, used by anyone other than these specified parties.

McGladrey LLP

Minneapolis, Minnesota
November 30, 2012

AGENDA ITEM 4a

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, CEO

Date: January 28, 2013

RE: Healthy Families Program Contract Amendment

SUMMARY:
California Assembly Bill (AB) 1494 mandates the transition of Healthy Families Program (HFP) beneficiaries to Medi-Cal managed care over a one year period beginning no sooner than January 1, 2013.

To comply with AB 1494, the California Department of Health Care Services (DHCS) requires that Gold Coast Health Plan (GCHP) amend its Medi-Cal contract with DHCS. The proposed contract amendment requires GCHP to report to DHCS on specified transition implementation issues including: number of grievances related to access to care; continuity of care requests and outcomes; as well as changes to provider networks.

Gold Coast Health Plan's Governing Commission by-laws require Commission approval of contract amendments. The purpose of this memo is to request approval and delegate authority to GCHP's CEO for signing the HFP contract amendment.

STAFF RECOMMENDATION:
Approve and grant authority to GCHP's CEO to sign the HFP contract amendment.

BACKGROUND:
On December 21st, DHCS transmitted via e-mail HFP contract amendments to GCHP and asked that the Plan sign the amendment no later than December 26, 2012. GCHP is unable to sign the proposed HFP amendment until it receives approval from its governing body. While GCHP's full Commission does not meet again until January 28, 2013, GCHP's Executive/Finance Committee can act on GCHP's behalf.

GCHP has approximately 20,000 HFP enrollees in Ventura County that are scheduled to transition to Medi-Cal managed care in Phase III of the four-phase transition plan, so HFP members in Ventura County will become GCHP Medi-Cal enrollees on August 1, 2013. Approximately 863,000 children statewide are expected to transition into Medi-Cal managed care between January and September 2013.

FINANCIAL CONSIDERATION:
GCHP received a **draft** rate package from DHCS on 11/5/12 which included a blended capitation rate of $77.90 per member per month (PMPM) for the 1/1/13-3/31/13 time period This would be paid for those newly enrolled Medi-Cal children that would have traditionally been part of the HFP. DHCS provided a high level overview of how these rates were established during the 12/14/12 rate meeting. GHCP is preparing questions in response to that information to better understand the rate development process and the pending items in order for DHCS to finalize the rates.

Assuming these same rates would be paid to GCHP on 8/1/13 and the monthly enrollment of 20,103 (count provided by DHCS in the rate package), additional monthly revenue would be approximately $1.57 million dollars with an expected FY13-14 revenue increase of $17.2 million dollars. In the rate development, DCHS included an administrative load of 11% of premium ($8.57 PMPM) and risk/profit/contingency margin of 2% ($1.56 PMPM).

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM 4b

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, Chief Executive Officer

Date: January 28, 2013

RE: Ratify BRG Contract Extension

SUMMARY:
In September 2012, the California Department of Health Care Services (DHCS) informed Gold Coast Health Plan (GCHP or Plan) that it intended to have the Plan's Monitor, Berkeley Research Group (BRG), physically on-site at GCHP required an increase in the level of BRG's analysis and oversight. Correspondingly, at DHCS's direction, BRG submitted a new scope of work and proposed budget to GCHP. Given the timing of the receipt and review of the scope of work, GCHP's CEO signed the letter on November 29, 2012. This Consent Item requests the Commission's ratification of this action by the Plan's CEO.

BACKGROUND:
In early 2012, the DHCS placed a consulting firm on-site at GCHP to monitor and oversee Plan operations and the Plan's financial condition. BRG was on-site at GCHP until approximately May of 2012, after which time the monitor continued to oversee plan operations from a remote location.

DISCUSSION:
During the summer of 2012, the DHCS continued to monitor the Plan's operations and financial condition. The Department notified the Plan in mid-September of its intention to place the Monitor, BRG, back on-site at GCHP. The primary reasons for this increased level of on-site monitoring was due to the financial condition of the Plan, the level of Tangible Net Equity (TNE) that was below state requirements, and the increase in the claims inventory backlog. The Monitor was sent in to both evaluate the Plan's performance and to provide support and analysis to Plan staff.

FISCAL IMPACT:
Fees are not to exceed $250,000.00 per month. The monthly estimate is expected to decline beginning in December.

RECOMMENDATION:
Staff recommends that the Commission ratify the action taken by the CEO on November 29, 2012.

AGENDA ITEM 5a

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, Chief Executive Officer
Melissa Scrymgeour, Director, IT

Date: January 28, 2013

RE: GCHP Medical Management System Replacement

SUMMARY:
Currently, Gold Coast Health Plan (GCHP) utilizes ICMS as its Medical Management System (MMS) to coordinate authorization of medical services for our eligible member population. ACS, our managed services provider, has informed GCHP that the ICMS system is not ICD-10 compliant and will be sunset June 2013. Consequently, GCHP must select, install and implement a new ICD-10 compliant MMS by 10/1/2014, in accordance with the CMS mandated ICD-10 deadline. ACS has committed to continued support of ICMS until GCHP has implemented the replacement MMS solution.

BACKGROUND:
When GCHP was formed, the Plan entered into an agreement with ACS, a division of Xerox Corp., to provide the core systems, staff, operations, and application development support to process and administer membership, claims, and customer service. The original ACS proposal did not account for a MMS solution. GCHP entered into a subsequent agreement for ACS to provide a medical management system (titled "ICMS"). As part of this additional agreement, ACS would also provide nurses to GCHP as part of staffing the medical management function.

DISCUSSION:
ACS does not plan to remediate ICMS for ICD-10 compliance and as such, has instructed GCHP to select a replacement MMS. ACS initially stated they would support ICMS through the end of June 2013, but has since extended support while GCHP implements the replacement system solution. Xerox conducted its own RFI / RFP process and has entered into a preferred partnership with CH Mack as a replacement solution to ICMS. However, Xerox has recommended that GCHP conduct its own selection process, and even if CH Mack is selected as the system, recommended that GCHP negotiate a separate licensing agreement.

GCHP intends to select and implement the replacement MMS by the end of calendar year 2013 in preparation for expected membership growth beginning January 2014, due

to the ACA expansion. GCHP will follow an expedited RFI/RFP process for system selection. The Plan has engaged an independent consultant with extensive experience in MMS selections, whose sole focus is to manage the selection process.

Between 1/1/13-3/31/13, we plan to identify, evaluate, and select a medical management system, including, but not limited to the following tasks:

- Survey of potential vendors using a rapid RFI process
- Secondary vendor screening (if needed)
- Create tailored requirements and scoring tools for finalist presentations
- Create key scenarios for final vendors to prepare for finalist presentations
- Coordinate and facilitate vendor presentations
- Conduct vendor references and site visits
- Create final system recommendation based on overall vendor scores

As part of the process, we will utilize key selection criteria, taking into consideration multiple factors, including:

- Business functionality / usability
- Cost
- Technology Platform (systems needs to grow with GCHP)
- Ability to meet aggressive project deadline (12/31/13)
- Vendor experience (solution expertise)

FISCAL IMPACT:
The cost of retaining the system selection consultant is approximately $20,000, whose work will be conducted over the course of 90 days. The cost to issue and evaluate the RFI / RFP will be absorbed by in-house staff. The cost of the new system will be brought to the Commission when more concrete information is available.

STAFF ACTION:
Staff will move forward with the RFI/RFP process for a medical management system replacement – target vendor selection and contract execution by 4/30/2013, and system implementation by 12/31/2013.

Tatum

January 28, 2013

Tatum Team

Cassie Undlin
Debbie Rieger
Laurel Kiichli

Tatum Status Update

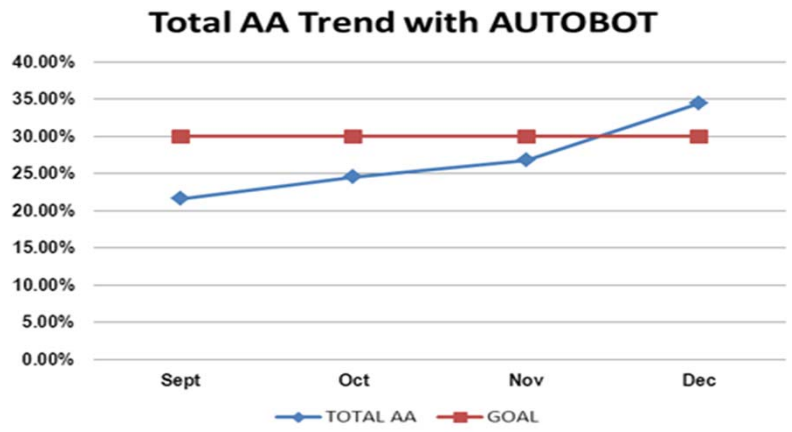
Tatum is concentrating on five primary areas for their engagement:

- *Project Management* – providing oversight on key initiatives.
- *Staff Evaluation and Development* – improving departmental cohesiveness through development of policies and procedures, making staffing recommendations and restructuring where needed.
- *Operational Optimization* – assessing the "as is" state of current operations, and recommending and/or developing tools to further enhance operations.
- *System Optimization and Configuration* – working with internal and external resources to enhance and further automate key processes.
- *Transitioning* – transferring work to GCHP staff with appropriate amount of training and documentation

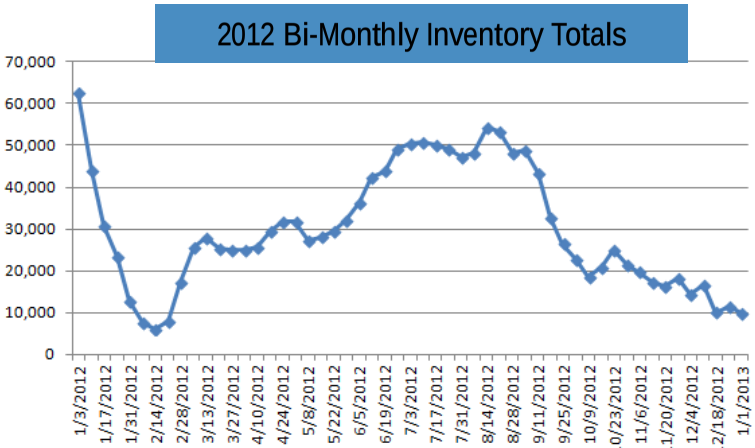
Tatum Key Accomplishments

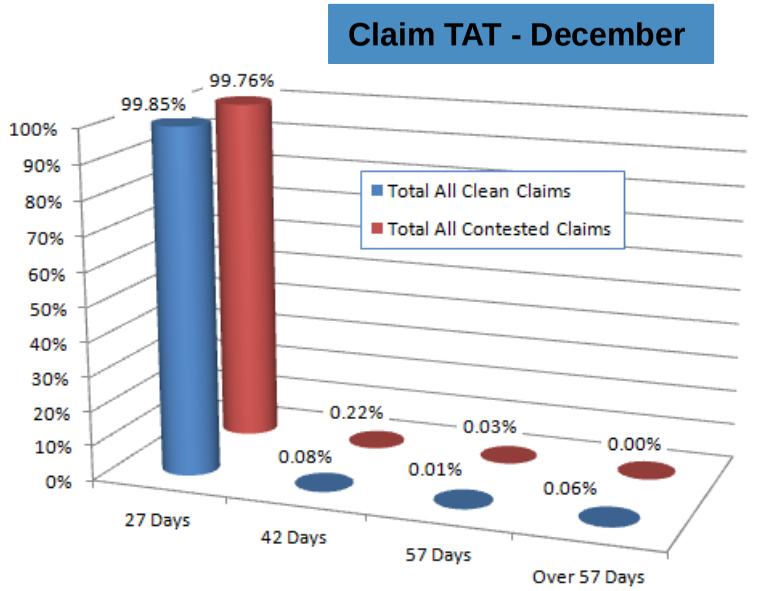
- Reduced claims backlog from a high of 55,000 to 15,000
- Increased auto adjudication rate from 22% to 34%. Currently at 43% average.
- Improved turnaround time for paid claims within 30 days from 63% to 98%
- Reduced unprocessed refund inventory from 1110 to 48. Currently maintaining <20 day turnaround time.
- Implemented claims editing software ICES
- Implemented new ikaSystem update 5.1
- Implemented Milliman Med Insight and transitioned to IT Director for continued development
- Implemented Specialty Contract
- Restructured IT department to support the business and transitioned to IT Director for continued improvement
- Restructured Provider Contracting and Services Department
- Improved internal communications
- Renegotiated Xerox nursing contract

Operational Optimization – Claims Stats



Auto Adjudicate Target:
30% by December 31, 2012
60% by June 30, 2013





The following slides track the progress on each of these initiatives. Below is the description of the various colors and comments that are utilized on the tracking tool.

GHCP Tatum Update	
Key	**Description**
●	Green - We are on track to deliver committed scope by committed deadline with committed resources/funding.
●	Yellow - We are not on track to deliver committed scope by committed deadline with committed resources/funding, but we have a plan to get back to green.
●	Red - We are not on track and we need a plan to get the project back on track.
	Grayed out: not started
Trans	Transitioned to GCHP staff
Comp	Task completed

Project Management

GHCP Tatum Update

Scope	Category	Sub-category	Dec 3	Dec 10	Dec 17	Dec 24	Dec 31	Jan 7	Jan 14	21-Jan
Project Management	Specialty Contract		🟢	🟢	🟢	🟢	🟡	🟡	🟡	🟡
	Plan to Plan tool kit		🟢	🟢	🔴	🔴	🔴	🟡	🟡	🟡
	Enrollment issues	Long Term Care aid code	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
		Medicare Part A coverage	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
		Administrative Members	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
	Long Term Care		🔴	🔴	🟡	🟡	🟡	🟡	🟡	🟡

Staff / Evaluation Development

GHCP Tatum Update

Scope	Category	Sub-category	Dec 3	Dec 10	Dec 17	Dec 24	Dec 31	Jan 7	Jan 14	21-Jan
Staff Evaluation/ Development	IT	IT leader, transition to IT Director	●	●	●	●	●	●	●	●
		Restructure IT Department	●	Trans						
		Develop Reporting Team	●	●	Trans					
	Provider Relations	Provider Relations Restructure	●	●	●	●	●	●	●	●
		Improve Provider Collaboration	●	●	●	●	●	●	●	●
		Provider Contract Development	●	●	●	●	●	●	●	●
	Member Services	Member resolution focus	●	●	●	●	●	●	●	●
		Grievance & Appeals						●	●	●
	Claims	Claims auditing	●	●	●	●	●	●	●	●
		Provider Claims Disputes Re-design	●	●	●	●	●	●	●	●
	Interdepartmental communications	Operations Committee	●	●	●	●	●	●	●	●
		Reports Committee	●	●	Trans					
	Vendor Management	Vendor Contract Manager	●	●	●	●	●	●	●	●

Operational Optimization

GHCP Tatum Update

Scope	Category	Sub-category	Dec 3	Dec 10	Dec 17	Dec 24	Dec 31	Jan 7	Jan 14	21-Jan
Operational Optimization	Claims Processing	Claims process improvement	●	●	●	●	●	●	●	●
		TAT, Inventory	●	●	●	●	●	●	●	●
		Interest Policy	●	●	●	●	●	●	●	●
		Auto Adjudication improvement	●	●	●	●	●	●	●	●
	Provider Contracting	Non-emergency medical transport	●	●	●	●	●	●	●	●
	Vendor Management	RN Rate Reductions	●	●	●	●	●	●	●	●
		ACS monitoring	●	●	●	●	●	●	●	●
		Improve Service Level and Key Performance measures	●	●	●	●	●	●	●	●
	Financial Recovery Project	Revenue generation/cost avoidance/cost savings	●	●	●	●	●	●	●	●

System Optimization and Configuration

GHCP Tatum Update										
Scope	Category	Sub-category	Dec 3	Dec 10	Dec 17	Dec 24	Dec 31	Jan 7	Jan 14	21-Jan
System Optimization and Configuration	Health Plan Tools		●	●	●	●	●	●	●	●
	Milliman		●	●	Trans					
	ICES		●	●	●	●	●	●	●	●
	System Configuration	IKA set up	●	●	●	●	●	●	●	●
	Work Flow Management	Enhance use of tool			●	●	●	●	●	●

The ultimate goal is to successfully transition the activities performed or overseen by Tatum staff to internal or external sources managed by GCHP

GHCP Tatum Update										
Scope	Category	Sub-category	Dec 3	Dec 10	Dec 17	Dec 24	Dec 31	Jan 7	Jan 14	21-Jan
Transition activities	IT Director		●	●	●	●	●	●	●	●
	COO									
	Claims Pricing		●	●	●	●	●	●	●	●
	Contracting		●	●	●	●	●			
	Milliman		●	●	Trans					
	ACS contract development		●	●	●	●	●	●	●	●

Gold Coast Health Plan℠
A Public Entity

Healthy Families Program Transition to Medi-Cal

January 28, 2013

Guillermo Gonzalez

Director, Government Relations

Overview

I. State Mandate

II. Transition Timeline

III. Expected Changes

IV. Continuity of Care

V. Member Notification & Outreach

State Mandate

- **Assembly Bill 1494**
- **Healthy Families Program Transition to Medi-Cal Managed Care**

Transition Timeline

- **Four Phases Over A One Year Period**
- **From January to September**
- **Gold Coast Health Plan – Phase III**

  August 1, 2013

HFP Transition to Medi-Cal

- HFP Enrollment in Ventura County

►Anthem Blue Cross-PPO	43	0.2%
►Anthem Blue Cross-HMO	5, 876	29.0%
►Kaiser Permanente	3,185	15.7%
►Ventura County Health Plan	11,162	55.1%
Total	20,266	

Source: MRMIB

Transitions By County

- Phase Ia- Approx. 411,654 children total in Phase Ia & Ib, Ic. January 1, 2013: Alameda, Riverside, San Bernardino, San Francisco, Santa Clara, Orange, San Mateo, and San Diego.

- Phase Ib- March 1, 2013: Contra Costa, Fresno, Kern, Kings, Madera, Tulare, Sacramento, San Diego (Health Net), Napa, Solano, Sonoma, Yolo, Monterey, Santa Cruz, Santa Barbara, and San Luis Obispo
- Phase Ic- April 1, 2013 children in a Health Net plan in the counties of: Kern, Los Angeles, Tulare, Sacramento, San Diego, San Joaquin, and Stanislaus

- Phase II- April 1, 2013. Approx. 261,060 children who are in a HFP subcontracted plan will transition to a Medi-Cal managed care plan.

- Phase III- August 1, 2013. Approx. 152,602 children not in a contracted or subcontracted Medi-Cal managed care plan will transition to a Medi-Cal managed care plan. GCHP is in Phase III.

- Phase IV- September 1, 2013. Approx. 42,753 children who reside in a county that does not Medi-Cal managed care will receive services on a fee-for-service basis.

Expected Changes

- Aid Codes
- Premiums/Family Incomes
- Eligibility Coordinated Through Ventura County Human Services Agency

Continuity of Care

- Network Adequacy
- Member Assistance
- Information

Member Notification & Outreach

- Scheduled Mailing of Notices
- Aggressive and Effective Communication Outreach Effort to Members
- Member Assistance
- Information

Assistance & Service

- **HSA Enrollment Assistance** **1 805 385-9363**
- **GCHP Member Services** **1 888 301-1228**
- **TDD/TTY Line** **1 888 310-7347**
- **State HFP Member Line** **1 886 848-9166**

- **Website: www.goldcoasthealthplan.org**

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

Gold Coast Health Plan℠
A Public Entity

Questions ?

EDELSTEIN GILBERT ROBSON & SMITH LLC

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

GOLD COAST HEALTH PLAN
CALIFORNIA STATE BUDGET UPDATE
By Don Gilbert and Trent Smith
January 18, 2013

The Legislature has returned from its holiday recess to begin the new session in earnest. As is customary, the year is beginning with the release of the Governor's proposed 2013-2014 State Budget.

With the passage of Proposition 30 – which raised both the state sales tax and income taxes on the wealthy – the state is facing the most manageable budget it has seen in years. In presenting his proposed budget, Governor Brown has claimed that for the first time in over a decade, the state is not facing an operating deficit, though California is still facing an outstanding "wall of debt" of nearly $30 billion. Furthermore, both the Department of Finance (DOF) and the Legislative Analyst's Office (LAO) have projected budget surpluses in future years.

Despite the optimistic forecast, Governor Brown has urged fiscal discipline and living within our means in his proposed budget. He is proposing to uphold the pledge he made while campaigning for Proposition 30 -- that additional revenues would be directed to education. At the same time, he is arguing that the state's welfare programs are already generous and progressive and has expressed his belief that the state cannot begin to restore funding to social welfare and healthcare programs cut in previous budgets. However, after years of cuts, it is likely that Democrats in the Legislature will want to do just that. We expect the Legislature to challenge the Governor on restoring cuts to health and welfare during the annual process to adopt a State Budget.

The Governor's budget applies the 10% provider cuts included in AB 97 from 2011 on Medi-Cal managed care plans prospectively. In fee-for-service, AB 97 provider cuts will be collected over the 24 months as part of providers' ongoing rates achieving a projected General Fund savings of $488.4 million. DHCS is prohibited from applying rate reductions retroactively on Medi-Cal managed care plans because the law requires "actuarially sound" rates. However, the Governor's budget attempts to achieve the equivalent of the retroactive payments on Medi-Cal managed care plans by imposing "efficiencies." DHCS has not defined what efficiencies they will impose, but we expect DHCS will determine what savings a retroactive provider cut would equal for Medi-Cal managed care plans and then use that same figure as the basis for an "efficiency" reduction on a dollar-for-dollar basis in future rates. The Governor's budget projects a $135 million in General Fund savings from the managed care efficiency proposal.

The Governor's plan to score savings from the AB 97 provider cuts in the upcoming budget year is contingent on the outcome of pending court cases. While a recent court

ruling went in favor of the state in allowing the 10% cuts, provider groups are planning appeals that will ultimately delay the final outcome and implementation of the cuts. There is a chance, depending on the court decisions and schedules, that the provider cuts will not be implemented in the coming budget year. However, it is always best to plan for the worst case scenario.

The Governor's budget also proposes permanently extending the Gross Premium Tax on managed care plans to generate $217.3 million in revenue. DHCS has stated that the new revenue would go towards Medi-Cal in the form of general rate increases needed to sustain the program. However, we are concerned that the new revenue would supplant existing Medi-Cal revenue, thereby allowing the state to book General Fund savings rather than augmenting the Medi-Cal program. A coordinated lobbying effort among the various Medi-Cal managed care plans will be needed to insure that the new revenue goes towards the program.

The budget also proposes extending the hospital quality assurance fee to generate $310 million. However, like the Grosse Premium Tax on managed care plans, it is uncertain if this revenue will be used to enhance the Medi-Cal program or supplant existing Medi-Cal funding to create General Fund savings.

Another noteworthy item in the budget proposal is that In Home Supportive Services (IHSS) is slated to receive $1.8 billion in General Fund dollars for 2013-14, a 4.9 percent increase.

Some changes to the Coordinated Care Initiative (CCI) were also outlined in the budget. Under the CCI, persons eligible for both Medicare and Medi-Cal (dual eligibles) will receive medical, behavioral health, long-term supports and services, and home and community-based services coordinated through a single health plan. The CCI will also enroll all dual eligibles in managed care plans for their Medi-Cal benefits. The budget changes the CCI implementation date to September 1, 2013, and provides more detail on the enrollment process in the designated counties. Specifically, enrollment in Los Angeles will be phased in over 18 months, while San Mateo County will be allowed to commence with their enrollment all at once. The remaining counties participating in the CCI, including Orange County, will proceed with enrollment over a twelve month period.

Health Care Reform and the implementation of the Affordable Care Act (ACA) will be a major focus of the Governor and Legislature in 2013. The Governor outlined two alternatives for Medicaid expansion that will be part of the ACA —a state-based approach or a county based approach. A state-based option would offer a standardized, statewide benefit package comparable to that available today in Medi-Cal,

but would exclude long-term care coverage and enroll the expansion population in the current Medi-Cal program.

A county-based expansion of Medicaid would build upon the existing Low Income Health Programs (LIHP). Counties would maintain their current responsibilities for indigent health care services. Under this option, counties would meet statewide eligibility requirements and a statewide minimum in health benefits consistent with benefits offered through Covered California. Counties could offer additional benefits, except for long-term care.

Why the two options? Statewide, counties annually receive approximately $3-4 billion in funding to care for the indigent. Many of these individuals will be eligible for Medi-Cal under the expanded program. Under an expansion of the state-based program, counties would be expected to give up approximately $1.4 billion in indigent care funding so the state could put that money into the Medi-Cal program. There is speculation that many counties have baulked at giving up that money to the state. Thus, the Governor put forth the county-based option, whereby the counties could keep funding, but also be responsible for the care of the newly eligible Medi-Cal population.

The county-based option poses some concerns for County Organized Health Systems (COHS). It is assumed that the counties already operating LIHP for the indigent could simply continue to operate the same system as a Medi-Cal program. However, in COHS counties the health plans are the only entities that are allowed to provide Medi-Cal services. It appears that under the county-based option essentially a two plan model could emerge. It is more likely that the state's expectation under the county-based option is that the counties would delegate the lives by contracting with a health plan in their area. In COHS counties it could mean the health plan would continue to contract with the state for most of the Medi-Cal services, while the county would contract with the COHS for the newly eligible population.

Obviously, there are still a lot of questions and details that need to be worked out regarding any county-based option to serve the newly eligible population. However, we are speculating that the county-based option is intended to drive the counties toward giving up $1.4 billion to the state to use towards the state Medi-Cal program. The state-based option seems like the easiest and most likely option, but some counties may be willing to go for the county option. If this is the case, the debate over the next several months could be very interesting.

Meanwhile, everyone is still awaiting the Governor to call a Special Session on health care reform. We are now told that the special session will be called by the end of January and that it will focus on ACA related matters, such as healthcare exchange

matters, that need to be resolved well in advance of January 1, 2014. Medi-Cal expansion matters would more likely be handled in the regular legislative session. However, all of the details regarding subject matter will be worked out with Legislative leadership in the coming weeks before the Special Session is called.

More details about Health Care Reform and the budget items outlined above will emerge as the Legislative Budget Committees begin hearings late in January and early in February. It is important to remember that what has been presented is the Governor's proposed budget and that the Legislature is free to adopt, reject, or amend any of the Governor's proposals. In addition, the Legislature can add new items to the budget. In this regard, many are waiting to see if the Legislature attempts to restore funding for health care and social service programs that have been cut drastically in the past several years. There will be much more to report in the coming weeks and months as we move toward the July 1 start of the new fiscal year.

Gold Coast Health Plan
Annual Quality Improvement Committee Report

The mission and purpose of the Gold Coast Health Plan Quality Improvement Program is to improve the health and well-being of the people of Ventura County by providing access to high quality medical services. In line with that goal, the GCHP QI Program will strive to continuously improve the care and quality of service for its members in partnership with its contracted provider network.

The Quality Improvement ((QI) Program involves all aspects of GCHP operations and is therefore organized to include virtually all of the departments, as shown on the Organization Chart.

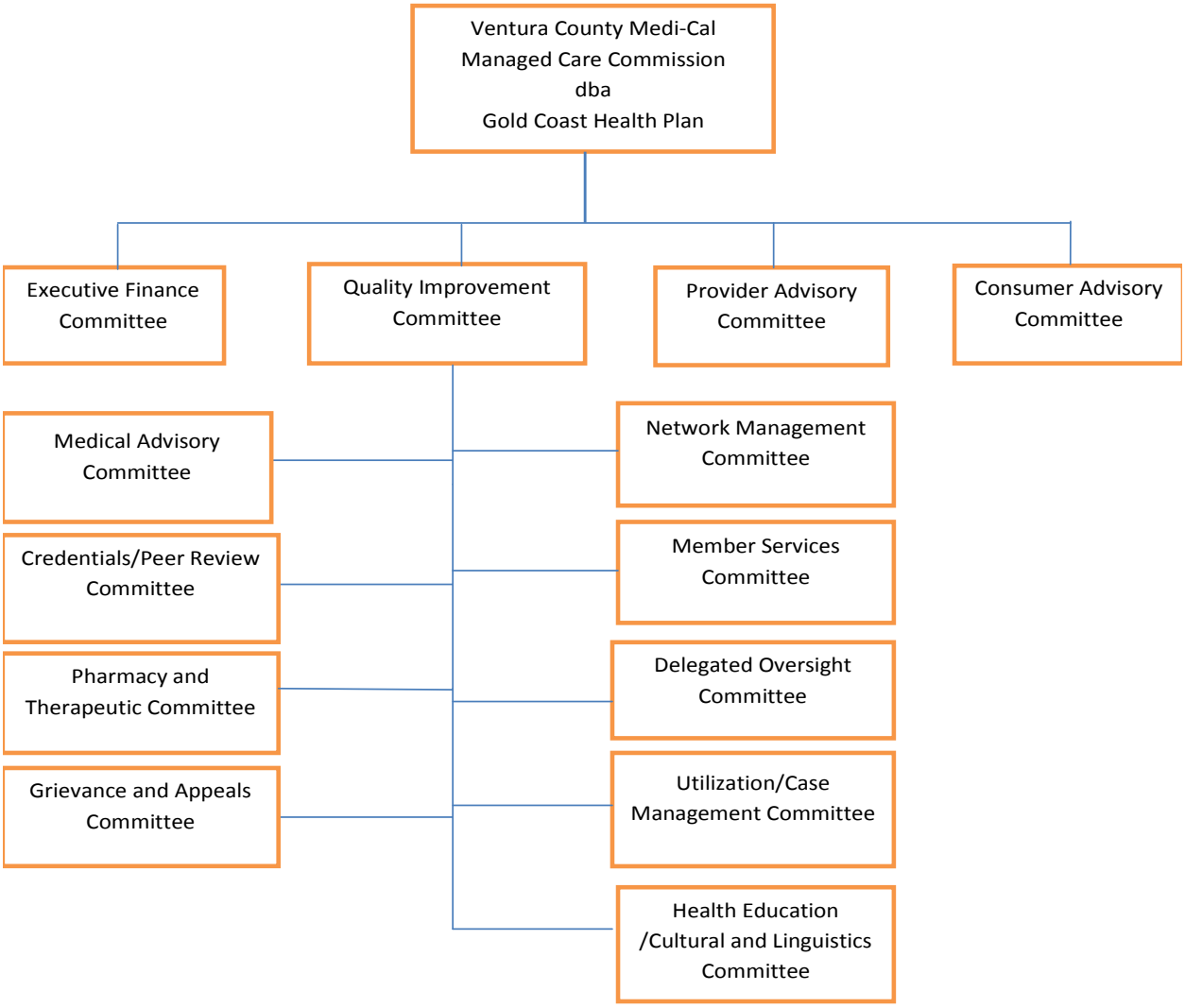
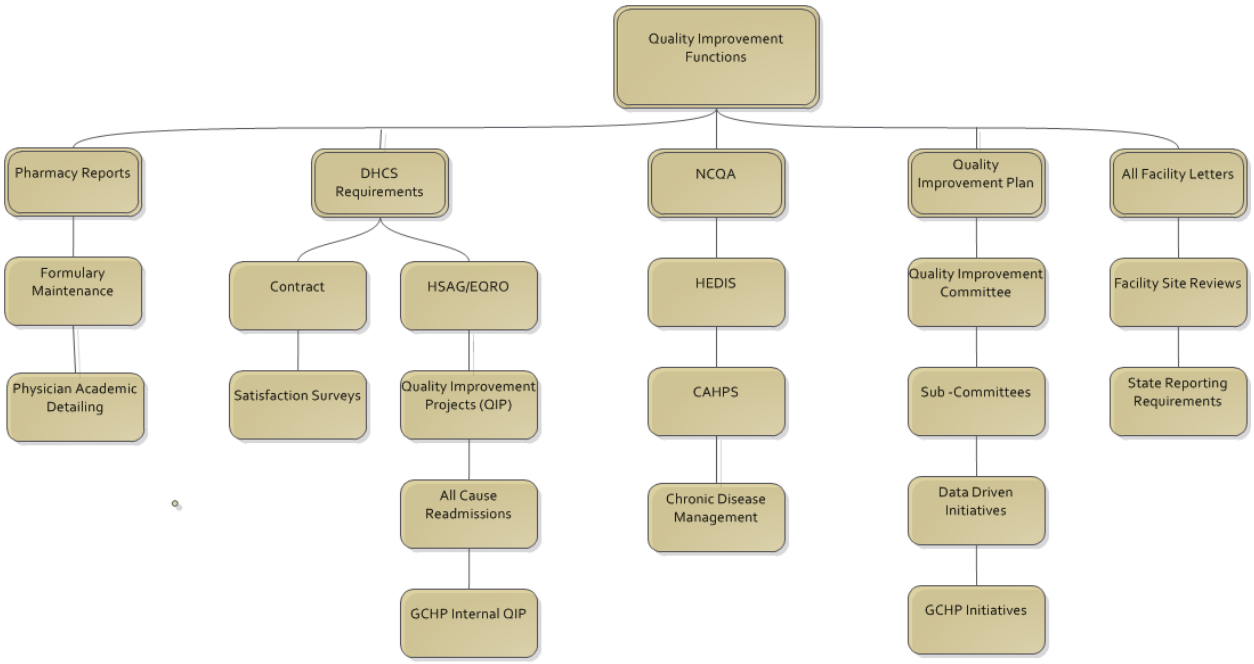


Chart from QI Plan (attached) Page 25

The Quality Improvement Department had a rather late start, due to recruitment difficulty in filling the position of its Director. Julie Booth came on board in April of 2012 and has organized the Department (see functional chart below) well with all the key staff employed in their respective positions.



QI FUNCTIONS

The following will briefly report on each of the committees. More detailed information is also available in its last Committee meeting minutes of 12/14/12, which is attached.

1) Quality Improvement Committee: Their activities and accomplishment include:
   a) Adoption of revised QI Plan at its last Committee meeting of 12/14/13. (see attached) Facility Site Review surveys are up to date. A Site Review Nurse is in process of receiving her certification.
   b) An upcoming major project in process is the mandated HEDIS measures for 2013, which will tell us how well our provider network is doing in delivering care for our members.
   c) Currently, we are participating on the State's mandated quality improvement project (QIP) to decrease hospital readmissions.
   d) Currently, the Department is participating in QI measures that include:
      - Smoking cessation in support of P & T and Health Education Committees.
      - Improvement in patient education.
      - Improvement in provider education, particularly HEDIS measures.
      - Improvement in reporting quality improvement measures using statistical process control.
      - Validation of data used for quality reporting.
2) <u>Pharmacy and Therapeutic (P & T) Committee:</u> 14 members, representing most all specialties. They render expertise in their respective field of drug uses. The pharmacy program has been one of the most robust and successful activities at GCHP. The success can be attributable to following:
   - The formulary was structured to include sufficient choices for all therapeutic categories. In addition, special attention was paid to make it user friendly so that each physician can readily select the effective and most cost effective drugs among available choices.

- Its expenses have been kept at less than $31.00/PMPM for the last 18 months of our operation. This is at or less than average when compared with five other COHS, which have been in operation for many more years.
- The generic drug use percentage has been consistently excellent now at 85%. This is the top among CHOS. I attribute this remarkable feat to well-educated and sophisticated physicians in GCHP network, who know how to select the most cost effective drugs among available options listed on the formulary.
- The key to this good utilization control of drugs is due to excellent and timely reports that Script Care, our PBM, has been providing to us from very beginning of our operation This enabled our management team and the P & T Committee to review and evaluate the main areas of interest such as the top 15 most expensive drugs. Many expensive drugs are well worth spending when their use saves lives while preventing more costly hospitalizations. However, we have been able to identify several $1 million dollars per year drugs that were no better in clinical efficacy than much cheaper drugs of same class that the P & T Committee was able to delete from the formulary. Again, this was possible mainly because of the excellent reports pointing to the areas that needed actions on.
- At the same time GCHP has also been adding a good number of new drugs to the formulary, when appropriate. Providing broad spectrum of necessary drugs is a quality issue, which has not been compromised at GCHP.
- I believe the success of this department can be measured in one way; that is there has rarely been any provider complaint concerning restrictions placed on certain drugs requiring prior authorizations. This would indicate that these restrictions have been reasonable and fair to them.
- In addition, there has been good communication with providers through the quarterly Pharmacy Newsletters informing them of pertinent items of interest. These have been not only informative but also educational.

3) Credentials Committee: 8 physician members. Most of them are either medical directors of hospitals or major clinics, who have been involved in credentialing processes. This made the operation of this committee smooth and efficient adding quality providers to the network. This group has credentialed all the network physicians carefully reviewing each file for quality of care and service.
4) Medical Advisory Committee: 14 members, representing various discipline of medicine. The primary function of this committee is to advise, recommend and make policy decisions on all matters pertaining to utilization management. This Committee has worked on approving the prior authorization list, HEDIS measurement guidelines for patient care and documentation, and most recently, is discussing telemedicine, to name a few examples.
5) Utilization and Management Committee:
    - The focus of the Utilization and Management (UM)/Case Management (CM) has been on staffing and developing processes. During the last 6 months the Department hired 3 dedicated case managers (one with CCS expertise), 2 nurses (one dedicated to transplants) and one social worker with a strong dialysis background. Future CM focus will be for chronic disease management and medication issues. This will necessitate additional staffs.
    - Some UM reports from Milliman are now available: Hospital Days/1000 is 384.3, which is higher than other COHS. Average length of stay is 5.13 days. Top ER diagnosis is URI. About half of ER visits are children ages 0-19. Now that these reports began to emerge, the committee and the Health Services will need to validate the data, after which they can be utilized for UM/CM purposes.
    - Beginning 10/1/12 the Health Services had accomplished a smooth transition of about 800 of the 1200 formally Adult Day Health Care Center members into the new CBAS program. These are mostly feeble and elderly members at high risk, and good case management is essential for preventing bad health outcome.

6) Member Services Committee:
   - This Committee reported that the membership data trend report showed a drop in membership in August 2012 due to the State discontinuing the practice of providing retroactive enrollments.
   - The Member Services now routinely tracks the Call Center benchmark goals such as abandonment rates, which is a quality issue. The QIC at its last meeting on 12/14/12 suggested categorizing calls by type/trend/resolution.
7) Grievance & Appeals Committee:
   - In the process of establishing trend reports.
8) Network Management Committee:
   - In the process of reviewing all provider contracts.
9) Delegation Oversight Committee:
   - Delegated Credentialing oversight audit was conducted recently at Clinicas del Camino Real and Community Memorial Hospital. Both passed satisfactorily. GCHP did not have to audit VCMC, as audit results from ICE were used.
10) Health Education/Cultural Linguistics Committee:
   - During the months of May and June 2012 GCHP conducted a Group Needs Assessment (GNA) to assess the health education, cultural and linguistic needs of our members. A state approved survey was mailed to a random sample of 10,000 Medi-Cal members, returning 1,362 survey for a 13% response rate. Following were helpful response data:
     a. To the question of which health topics they wanted to learn more, the top 5 were as follows: Healthy eating (44.0%), Cholesterol or heart health (34.4%), Healthy teeth (33.4%), Diabetes (31.9%), and Exercise (30.2%). On the basis of this, the GCHP Member Newsletter to be mailed in late January of 2013 contains a subject on Cholesterol.
     b. To the question of how they prefer to get health information from your health plan, overwhelming 78.8% preferred the health information mailed to their homes. The next two methods were through health plan website (10.7%) and email (7.9%).
     c. For cultural and linguistic services, 52% preferred English and 42% preferred Spanish.
   - This Department is participating in the Quit Smoking program in conjunction with the P & T Committee efforts. Taking advantage of DHCS grant allowing $20 gift card as an incentive, they are preparing literature to inform patients about this program.
   - Developing health education classes and sponsoring education events. City of Ventura and Housing Authority are providing community room for GCHP to provide education classes to the community which will include educating members on a) GCHP benefits, b) PCP selection, and c) Preventive Care. Ventura County Public Health Agency and St. John's Hospital are participating.

Action Item
Board approval of QI Plan

Quality Improvement Committee
Report to the Board of Commissioners
4th Qtr 2012

Quality Improvement Committee (QIC):

1. GCHP is in the process of setting up for the abstraction of the HEDIS measurement data for our first submission. HEDIS vendors are now in place. QI is working with IT to export the claims data to the vendor based on HEDIS specifications. We will also be working with physician offices should a medical record be needed.
2. The Delegation Oversight (DO) Program is in the process of setting up its program for Utilization Review as well as other aspects of DO.
3. A Facility Site Review Nurse was hired and is in training to become what is referred to as a "Master Trainer." A process is also being set up to manage the ongoing facility site reviews (FSR), medical record reviews (MRR) and physical accessibility review survey (PARS).
4. The State mandated Quality Improvement Project (QIP) to avoid readmissions to the acute hospital for Seniors and Persons with Disabilities (SPD) population has been underway. After intense discussion of barriers that need to be overcome to avoid readmission, the consensus recommendation was to focus on the barrier of education at discharge, particularly with medication self-administration. The next step will be to develop improvement interventions which will be discussed at a future meeting.
5. The Quality Improvement Plan was finalized for 2013. There are nine QIC subcommittees as follows.

Member Services Committee

1. The Membership Data Trend report showed a drop in membership in August 2012 to due to the State discontinuing the practice of providing retroactive enrollments.

Grievances & Appeals Committee

1. Dr. Wharfield will be chairing the G& A Committee in the future.
2. Dr. Fankhauser asked to see more detail in G&A report such as type of G&A.
3. Reports will be developed and presented.

Network Management Committee

1. Sherri Bennett's new title was announced: Provider Network Manager over Provider Relations and Contracts.
2. The current physician network system is robust and will begin focus on what new providers GCHP needs to be added to the network.
3. A contracting focus will be on finding cost effective ways of providing services, such as infusion therapy, to members.
4. It was confirmed that GCHP will not need to credential and contract with hospital clinical staff such as radiologists because NCQA doesn't require health plans to credential these types of providers; however, radiologists at free standing facilities will continue to be credentialed and Nurse Practitioners.

Delegation Oversight Committee

1. Reviewed and updated two policies: (1) Utilization Management and (2) Credentialing and Re-credentialing at the Delegation Oversight Committee and will send policies to the State for approval.
2. Clinicas del Camino Real and Community Memorial Hospital both passed their credentialing audits and the results were reviewed at the Delegation Oversight Committee. It was noted the audit results from ICE were used for Ventura County Medical Center so GCHP did not have to audit VCMC.

Utilization Management (UM)/Case Management (CM) Committee

1. UM/CM focus has been on staffing and developing processes. Case Management has hired 3 dedicated Case Managers (one with CCS expertise), two nurses (one dedicated to transplants) and one social worker with a strong dialysis background.
2. With recent data UM/CM can begin to be proactive vs. reactive. Utilization Management reports from Milliman are now available. Hospital days per 1,000 are 384.3. Other COHS show a little lower. Average LOS inpatient stay is 5.13 days. Top ER diagnosis is URI. About half of the ER visits are children ages 0 – 19. Access may be one of the reasons for the high URI ER visits.
3. The future focus for Case Management is chronic disease management and medication issues.

Health Education/Cultural Linguistics Committee

1. Cultural linguistic services are being tracked by a form to track translation services and accuracy of translations to patients.
2. Group Needs Assessment is pending state approval. 52% preferred English and 42% preferred Spanish. 60% of patients under age 20, 25% of patients ages 21-64 and 14% of patients over age 65.
3. Health Education developing health education classes and sponsoring education events. City of Ventura and Housing Authority are providing community rooms for GCHP to provide education classes to the community which will include educating members on 1) GCHP benefits, 2) PCP selection, and 3) Preventive Care. The Public Health Agency, County of Ventura, and Saint John's are participating.
4. The Quit Smoking program will be implemented by the first quarter in 2013. DHCS and DPH met with Dr. Cho and GCHP's Clinical Pharmacist regarding receipt of a special grant, which GCHP P & T and the HE/CL Committees fully intend to utilize for the Quit Smoking program. A $20.00 gift card is provided but patient must ask for it and GCHP is preparing literature to inform patients.

Credentialing/Peer Review Committee

1. Physician participation is good with 6 out of 8 physician committee members attending the last meeting.
2. At last Committee meeting, 14 out of 15 new physicians had their credentialing packets approved to join GCHP network. The application for one OB/GYN is pending.

Pharmacy & Therapeutics (P&T) Committee

1. Physician participation is good with 10 out of 14 physician committee members attending the last meeting.
2. Total cost for the last 6 month period of the report was almost 20 million compared to previous period which was 18.5 million. One of the reasons for the increase was due to one drug for a hemophiliac patient which cost ½ to 1 million.
3. Generic use 84.5%; October 2011 – March 2012 saw a 1.41% increase in generic utilization. GCHP physicians prescribe more generic drugs than other COHS. Plan cost increased 6.6% period over period and prescription volume increase 3.1%.
4. Total cost per prescription increased by $1.57 to $47.19.
5. Single source brands accounted for 15% of volume for 58% of cost.
6. Specialty drugs account for 22% of total cost.
7. 3827 diabetics on meds, 5620 on testing supplies for 18.6% drug spend. $131.31 in costs for diabetics compared to $12.34 for non-diabetics. The number of diabetics is low compared to State and National averages. However, due to GCHP significantly higher population between 0-20, the figure may accurate and is in the process of being validated via ICD9 coding.
8. Drug utilization reviews are conducted each meeting. For example, Singular was the top drug for expenses costing nearly $1 million for the year. However, it was widely used inappropriately especially for acute asthma, when this drug is not the first line of therapy. There has been intensive physician education on proper prescribing of Singular and its costs; and the use is dropping. In addition, GCHP is working on ways to identify patients who are high utilizers of anti-asthmatics and providing patients education.
9. Dr. Cho and the clinical pharmacist are routinely analyzing the top 15 drugs at its weekly meeting to find ways to be cost effective and to be sure of proper use of drugs. Physician profiles and academic detailing are planned for next year.
10. The CMO notes that drugs are expensive, but hospitalization is more expensive and there needs to be a balance. There are many experts on the P/T Committee that provide suggestions. A review of specialty drugs is underway for next year.

Medical Advisory (MAC) Committee

1. Physician participation is good with 9 out of 14 physician committee members attending the last meeting.
2. Committee members reviewed diabetes and smoking cessation practice guidelines based on HEDIS requirements. Other guidelines reviewed were enteral nutrition, and ultrasound use.
3. Dr. Wharfield is tracking high volume ED patients so that GCHP can assist them with their care. She is working on developing a similar model as CMH's Intensive Care Program.
4. A subcommittee of the MAC was established to create a prior authorization form to include clearance of contraindications Zostavax injection.

GOLD COAST HEALTH PLAN
2013 QUALITY IMPROVEMENT PROGRAM

12/18/12 Final Draft

I. MISSION AND PURPOSE

Gold Coast Health Plan's mission is to improve the health and well-being of the people of Ventura County by providing access to high quality medical services. In line with that goal, Gold Coast Health Plan's Quality Improvement Program will strive to continuously improve the care and quality of service for its members in partnership with its contracted provider network. GCHP's quality program is centralized at the Plan under the Chief Medical Officer and is not delegated to any other entities.

Accountability:

The Quality Improvement Committee chaired by the Chief Medical Officer is accountable for:

1. Assigning responsibility for monitoring and evaluating activities.

2. Delineating the scope of quality of care, quality of service, and patient safety provided by the organization.

3. Identifying important aspects of quality of care, quality of service, and patient safety provided by the organization.

4. Using measurable indicators to routinely and systematically monitor aspects of care, service and safety based on current knowledge or proven industry methodologies.

5. Identifying comparable benchmarks and/or thresholds and goals for meaningful, industry- standard, performance indicators.

6. Monitoring the important aspects of quality of care, quality of service, and patient safety, by collecting and organizing data for each indicator.

7. Evaluating quality of care and service when benchmarks and/or goals are reached, or when measurements fall outside thresholds, and identify opportunities to improve or correct problems.

8. Identifying barriers to improvement that are directly associated with continued improvement and mitigating barriers and resolving identified problems.

9. Designing relevant, strong and timely interventions and taking action to improve or correct identified problems.

10. Evaluating the effectiveness of those actions using comparable measurements.

11. Communicating results to the relevant committees, individuals, departments and to appropriate committees, GCHP's executive leadership and Commission.

12. Re-evaluating performance at appropriate intervals using comparable measurements; assessing performance relative to benchmarks, thresholds and/or goals; and identifying remaining barriers. Based on findings, implementing new and/or improved interventions as necessary.

13. Continuing the QI cycle as warranted.

This document describes how this general approach to quality monitoring and improvement is achieved at GCHP. This is accomplished through a description of the QIP's scope, goals and objectives, a narrative description of the quality committee structure, concluding with tables of organization showing reporting relationships, membership, a yearly meeting calendar and GCHP's policy concerning the availability of QI documents. To ensure appropriate resources to support the quality function, an organization-wide Work Plan (separate document) is annually developed in congruence with the QIP and GCHP's Strategic Plan. To ensure successful performance of the QIP, GCHP's leadership is responsible to set appropriate goals and objectives for staff and those involved in the QI process.

II. SCOPE, GOALS & OBJECTIVES

The *scope* of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:

    - Preventive services
    - Chronic disease management
    - Prenatal care
    - Family planning services
    - Behavioral health care services
    - Medication Management
    - Coordination and Continuity of care

2. Quality of nonclinical services including, but not limited to:

    - Accessibility

- Availability
- Member satisfaction surveys
- Grievance process
- Cultural and Linguistic appropriateness
- Availability

2. Patient safety initiatives including, but not limited to:

- Facility site reviews
- Credentialing of practitioners
- Peer review
- Sentinel event monitoring
- Health Education

4. A QI focus which represents
   - All care settings
   - All types of services
   - All demographic groups

The *goal* of the QIP is to ensure the objective and systematic monitoring, evaluation and pursuit of opportunities to improve, and resolve identified problems.
GCHP's Quality Improvement Committee oversees the monitors established by GCHP's committees. Performance indicators are tracked to maintain a continuous focus on the Plan's operational and clinical priorities for improvement.

III. VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (VCMMCC) AS GOVERNING BODY: INTERNAL DELEGATION OF QUALITY ACTIVITIES

The Ventura County Medi-Cal Managed Care Commission (VCMMCC) approved delegation of quality activities to GCHP. The Quality Improvement Program is under the direct oversight of the Health Plan Chief Medical Officer, who, through the Quality Improvement Committee, will guide and oversee all activities in place to continuously monitor plan quality initiatives. The Commission's quality improvement role will continue to include the approval of the QI Program annually. In addition, VCMMCC will receive quarterly updates to the QI Work plan for review and comment.

Membership

GCHP is governed by an eleven (11) member Ventura County Medi-Cal Managed Care

Commission (VCMMCC). Commission members are appointed for two or four year terms, and member terms are staggered.

Members of the VCMMCC are appointed by a majority vote of the Board of Supervisors and consist of the following:

- Three members shall be practicing physicians who serve a significant number of Medi-Cal beneficiaries in Ventura County. One shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Association, one shall be selected from a list with a minimum of three (3) nominees submitted by Clinicas Del Camino Real and one shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center Executive Committee; (Physician Representatives)

- Two members shall be representatives of private hospitals and healthcare systems operating within Ventura County and shall be selected from a list with a minimum of three (3) nominees submitted by the Hospital Association of Southern California. Nominees shall be from different hospitals and healthcare systems. The two appointed members shall not be affiliated with the same hospital or healthcare system; (Private Hospital/Healthcare System Representatives)

- One member shall be a representative of the Ventura County Medical Center Health System and shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center administration; (Ventura County Medical Center Health System Representative)

- One member shall be a member of the Board of Supervisors, nominated and selected by the Board; (Public Representative)

- One member shall be the chief executive officer of Clinicas del Camino Real or designee nominated by the Clinicas del Camino Real chief executive officer and approved by the Ventura County Board of Supervisors; (Clinicas Del Camino Real Representative)

- One member shall be the Ventura County Health Care Agency Director or designee nominated by the Health Care Agency Director and approved by the Board of Supervisors; (County Official)

- One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is not otherwise represented on the Ventura County Medi-Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position; (Consumer Representative)

- One member shall be the Ventura County Medical Center Family Medicine Residency Program Director or Faculty Designee and approved by the Board of Supervisors. (Ventura County Medical Center Health System Representative)

There are two Committees which report to the VCMMCC. These committees are the:

- Provider Advisory Committee
- Consumer Advisory Committee

Information discussed in these two committees which is relevant to the delivery of quality service health care to plan members, is communicated to the appropriate Plan committee for discussions and action. The committees' function and membership are described below.

Consumer Advisory Committee (CAC)

Purpose:

The CAC provides member and community input to GCHP's policies and operations. The CAC reviews and comments on GCHP proposed policies and actions that may affect plan members.

Function:

- Provide input for service enhancements upon review of trends of member dissatisfaction
- Review and provide input regarding Member Rights and Responsibilities, member communication and educational materials.
- Review and provide feedback on the cultural appropriateness of material for limited English proficient (LEP) members.
- Make recommendations regarding possible changes to enhance the member experience with GCHP.

Membership:

The Member Services Manager is responsible for membership recruitment, retention and coordination of meetings and agendas. The Member Services Manager serves as the Chairman and is a non-voting member of the Committee. Membership consists of 10 individuals who represent community and consumer interests. Members may not directly earn their income from the provision of medical services. Each of the appointed members serves a two-year term. Individuals may apply for re- appointment if desired, as there are no term limits.

The ten voting members represent various constituencies who serve the Medi-Cal population

Committee members may include representation from the following:

- County Health Care Agency
- County Human Services Agency
- Children Welfare Services Agency

Members with:

- Chronic Medical Conditions
- Disabilities
- Special needs
- Seniors
- Other Medical beneficiaries

Meeting Frequency:

The committee meets quarterly at a minimum.

Provider Advisory Committee

Purpose:

The Provider Advisory Committee (PAC) is a venue for providers to give input on GCHP's policies and operations.

Function:

The roll of the PAC is to consider and analyze situations of concern and bring its recommendations to the Commission for its consideration.

Feedback from the PAC is relayed to the appropriate GCHP committee or department for any necessary action.

Membership:

Membership is comprised of five or more physician or non-physician members as well as a maximum of two pharmacists representing the contracted provider community for GCHP's programs. In addition, non-voting members consist of the Manager of Provider Network, who serves as the Chair person and other GCHP staff relevant to the discussion of issues of concern

Meeting Frequency:

The committee meets at a minimum on a quarterly basis.

V. QUALITY COMMITTEES

1. Quality Improvement Committee (QIC)

QIC Charter

The QIC is responsible for the monitoring and enhancement of organization-wide quality improvement processes to ensure the delivery of quality customer service and access to high quality medical services. It is accountable to the Ventura County Medi-Cal Managed Care Commission. It is the responsibility of the QIC to assure that QI activities encompass the entire range of services provided and include all demographic groups, care settings, and types of service. The committee reviews policy recommendations from the all Plan committees and makes recommendations on their implementation. The Ventura County Medi-Cal Managed Care Commission is updated via the QIC minutes, at least, quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The QIC continually strives for excellence and quality in health care delivery and service to GCHP's members, providers, internal customers and the community by pursuing meaningful and measurable activities to improve and perfect processes, outcomes, and satisfaction. Committee minutes are maintained and submitted to VCMMCC quarterly. GCHP ensures that the rules of confidentiality are maintained in quality improvement discussions. An annual quality improvement report is submitted to VCMMCC which includes a comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements, including but not limited to, the collection of aggregate data on utilization, review of HEDIS measures, outcomes/findings from Quality Improvement Projects (QIP's) and member/provider satisfaction survey results and actions.

QIC Objectives

- Ensure quality committees have access to timely information to ensure prompt implementation of quality improvement

initiatives.

- Ensure QIC members can have a candid discussion about barriers to achieve quality goals and objectives, and to facilitate the removal of such barriers.

QIC Responsibilities:

- Recommend policy changes or implementation of new policies to GCHP's Administration and Commission.

- Ensure indicators established for monitoring Access, Care and Service and Quality Improvement Projects are appropriate and will lead to improvement

- Review quarterly committee reports regarding monitoring of health plan functions and activities. Suggest interventions or corrective actions to ensure follow-up when indicated.

- Oversee the development and annual review of the QIP, quality improvement activities (QIAs) and projects, Quality improvement Work Plan, and Work Plan Evaluation.

- Oversee the annual analysis and evaluation of the effectiveness of quality improvement activities, and achievement of Work Plan goals.

QIC Membership:

- Chief Medical Officer
- VCMMCC Commissioners
- Director of Quality Improvement
- Manager, Health Education and Cultural Linguistics
- Director of Government Relations
- Director of Health Services
- Manager of Member Services
- Quality Improvement Staff
- Medical Director, Health Services
- Manager of Provider Network Manager
- Project Manager, Delegation Oversight

- CEO, Ex Officio

QIC Reporting Structure:

The QIC reports to the Ventura County Medi-Cal Managed Care Commission. The Chair of the QIC ensures that quarterly reports are submitted to the VCCMMC.

Meeting frequency:

The QIC meets at a minimum quarterly.

2. Medical Advisory Committee (MAC)

Purpose:

The purpose of the MAC is to*:*

- Offer input to GCHP regarding issues related to the delivery of medical care to the GCHP membership
- Provide input regarding issues of concern to the physician community
- Provide guidance on quality of care concerns
- Offer input on local medical care practices that may affect Health Plan Operations

Function:

The Committee may include, but is not limited to, the following:

- Clinical Care Guidelines
- Preventive Care Guidelines
- Provider Grievance Process
- Provider Satisfaction Issues
- Provider Materials
- Quality Improvement activities
- Provider Access standards
- Provider contracting issues
- Clinical Service Delivery
- Utilization Data
- HEDIS measures

Feedback from the MAC is relayed to the QIC as well as other QI committees where data may be relevant to process improvements.

Membership:

Membership is comprised of physicians representing the contracted provider community for GCHP's programs. The Chief Medical Officer will serve as Chairman and will ensure that the membership has adequate specialty representation.

Meeting Frequency

The committee meets at a minimum on a quarterly basis.

3. Member Services Committee (MSC)

MSC Charter

The MSC oversees those processes that assist GCHP's members in navigating GCHP's system. This committee provides oversight of service indicators, analyzes results and suggests the implementation of actions to correct or improve service levels. Through monitoring of appropriate indicators, MSC will identify areas of opportunity to improve processes and implement interventions.

MSC Objectives

- Ensure GCHP members have an understanding of their health care system and know how to obtain care and services when they need them.
- Ensure GCHP members will have their concerns resolved quickly and effectively and have the right to voice complaints or concerns without fear of discrimination.
- Ensure GCHP members can trust that the confidentiality of their information will be respected and maintained.
- Ensure members have access to information on languages spoken in physician offices to better aid them in the selection of a primary care physician.
- Have access to appropriate language interpreter services at no charge when receiving medical care

- Ensure GCHP members can reach the Member Services Department quickly and be confident in the information they receive.

- Review service indicators and data from Member Satisfaction Surveys to identify areas for improvement in services rendered to GCHP members.

- Ensure GCHP's Member Rights and Responsibilities policy is distributed to members and providers.

- Ensure that GCHP's member materials are developed in a culturally appropriate format.

- Interface with other GCHP committees to improve service delivery to members.

MSC Membership

- Manager of Member Services (Chair)
- Manager of Provider Network
- Member/Grievance Coordinator
- Sr. Quality Improvement Project Manager
- Director of Health Services
- Manager of Health Education & Cultural Linguistics
- Manager of Communications (ad hoc)
- Compliance Specialist

Meeting Frequency:

The MSC meets quarterly at a minimum.

4. Grievance and Appeals Committee

G&A Charter

The Grievance and Appeal Committee monitors expressions of dissatisfaction from members. Information gathered is used to improve the delivery of service and care to Gold Coast members.

G&A Objectives

- Review and respond to all grievances timely and in writing
- Review issues for patterns which may require process changes
- Review all grievances and appeals that may affect the quality of care delivered to members
- Ensure all GCHP departments are educated on the appropriate process for communicating member grievances and appeals to the correct area for resolution
- Ensure that issues needing intervention are routed to the appropriate area for discussion and intervention

G&A committee Membership

- Medical Director, Health Services (Chair)
- Grievance and Appeals Coordinator
- Manager of Member Services or Designee
- Quality Improvement Director or Designee
- Director of Health Services or Designee
- Compliance Specialist

Meeting Frequency:

The Committee meets quarterly.

5. Network Management Committee (NMC)

NMC Charter:

The NMC monitors data and reports to ensure that GCHP maintains an adequate network of providers for the provision of health care services to members. The committee addresses issues related to service delivery to providers and suggests actions to improve provider education and satisfaction.

NMC Objectives:

- Ensure GCHP providers have an understanding of the health plan and health network and know how to obtain services they need for their patients.

- Ensure GCHP providers will have their concerns resolved quickly and effectively, and have the right to voice complaints or concerns without fear of termination.

- Ensure GCHP providers have access to accurate and timely eligibility information to ensure prompt medical care to members.

- Ensure GCHP providers have access to appropriate language assistance, including interpreter services, to ensure prompt medical care for their patients.

- Ensure GCHP providers can reach Provider Services, Health Services, Member Services, and Claims departments quickly and be confident in the information they receive.

- Maintain a reporting calendar that delineates reports to be submitted for the committee's review, the reporting frequency, and the months that reports are due.

- Evaluate overall effectiveness of applicable service, quality, and improvement activities to identify areas of improvement for services rendered to GCHP providers.

- Develop, maintain, and disseminate GCHP's provider materials in alignment with the health plan's strategic goals for provider education and satisfaction.

- Oversee the resulting data from provider satisfaction surveys, inquiries, complaints, appeals, PCP requests for member reassignment, and terminations to identify areas of opportunity for improvement in services to GCHP providers.

NMC Membership:

- Manager of Provider Network (Chair)
- Chief Medical Officer
- Medical Director, Health Services
- Provider Relations Representative
- Director of Health Services or designee
- Director of Quality Improvement

- Manager, Health Education and Cultural Linguistics

Meeting Frequency:

The committee meets at a minimum quarterly

6. Delegation Oversight Committee (DOC)

DOC Charter

The Delegation Oversight Committee (DOC) is responsible for developing and overseeing agreements between GCHP and its delegated entities. The National Committee for Quality Assurance (NCQA) defines delegation as: "a formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed appropriately. An organization is ultimately accountable for all functions performed within its purview, whether performed by the MCO itself, by a delegate or by any sub delegates".

The DOC reviews pre-delegation assessments, draft delegation agreements, and oversee delegated functions for quality and other regulatory compliance. If opportunities for improvement are identified through the oversight process, the DOC may implement interventions or recommend corrective actions for the delegate.

DOC Objectives:

- Monitor the ability of delegates to perform delegated functions.
- Ensure delegation agreements clearly delineate the responsibilities of both the delegate and the delegator.
- Review the results of monitoring activities as described in the delegation agreement to ensure delegate is meeting expectations and performing delegated functions appropriately.
- Recommend corrective actions as needed when opportunities for improvement are identified.
- Recommend that delegation agreements be terminated if delegate is unable or unwilling to meet expectations despite appropriate interventions or requests for corrective actions.

- Review delegates' reports to ensure compliance with delegation agreements and identify potential areas for improvement.

- Evaluate overall effectiveness of delegation arrangements.

- Oversee the appropriate development and administration of relevant policies and procedures and delegation agreements, including periodic review and revision.

DOC Membership:

- QI Project Manager, Delegation Oversight (Chair)
- QI Project Manager, Credentialing
- Sr. Quality Improvement Project Manager
- QI Project Manager, Facility Site Review Nurse
- Manager of Member Services
- Manager of Claims
- CFO or designee
- Manager, Utilization Management
- Manager of Health Education/Cultural Linguistic
- Ad hoc members as needed

Meeting Frequency:

The committee meets at a minimum quarterly.

7. Utilization/Case Management Committee (UM/CM)

Committee Charter:

The UM/CM committee is charged with reviewing and approving clinical policies, clinical initiatives and programs before implementation. This committee reports to the QIC quarterly. It is responsible for annually providing input on GCHP's clinical strategies, such as clinical guidelines, utilization management criteria, disease and case management protocols, and the implementation of new medical technologies.

UM/CM Responsibilities

Responsibilities include but are not limited to the following:

- Annual Review and approval of the UM and CM Program Documents
- Review and approval of program documents addressing the needs of special populations. This includes but may not be limited to Children with Special Health Care Needs (CSHCN) and Seniors and Persons with Disabilities (SPD)
- Suggest and collaborate with other departments to address areas of patient safety. This may include but is not limited to medication safety and child safety.
- Annual adoption of preventive health criteria and medical care guidelines with guidance on how to disseminate criteria and ensure proper education of appropriate staff.
- Review of the timeliness, accuracy and consistency of the application of medical policy as it is applied to medical necessity reviews
- Review utilization and case management monitors to identify opportunities for improvement.
- Review data from Member Satisfaction Surveys to identify areas for improvement.
- Ensure policies are in place to review, approve and disseminate UM criteria and medical policies used in review when requested.
- Review at least, annually the Inter Rater Reliability Test results of UM staff involved in decision–making (RN's and MD's) and take appropriate actions for staff that fall below acceptable mark.
- Interfaces with other GCHP committees for trends, patterns, corrective actions and outcomes of reviews.

Membership:

- Medical Director, Health Services (Chair)
- Director of Health Services
- Manager of Case Management
- Manager of Utilization Management

- Case Management Nurse Representative
- Lead UM Nurse/Trainer
- MD Reviewer
- Health Services Project Manager
- UM Nurse Representative
- Director of Quality Improvement
- Manager, Health Education and Cultural Linguistics
- Chief Medical Officer

Meeting Frequency:

The UM/CM Committee meets quarterly at a minimum.

8. HEALTH EDUCATION/CULTURAL LINGQUISTICS COMMITTEE (HE/CL)

Purpose:

The purpose of the HE/CL committee is to assess the cultural and language needs of the Plan population. The committee will be responsible to ensure materials of all types are available in languages other than English to appropriately accommodate members with Limited English Proficiency (LEP) skills. The HE/CL Committee will review data to assist GCHP staff and providers to better understand unique characteristics of the varied population. The committee will assist in developing cultural sensitivity training and ensure that those that serve the population are appropriately trained.

Functions:

- Ensure the Group Needs Assessment (GNA) is completed to determine a baseline for serving education and cultural /language needs.
- Work with other areas and the CMO to prioritize health education needs.
- Ensure opportunities are available to educate members on disease process, preventive care, plan processes and all other areas essential to good member health.
- Assist providers in educating Plan members.

- Ensure written materials are at a reading level consistent with Plan membership needs and are no greater than the sixth grade reading level.

- Educate Plan staff on specific cultural barriers that might hinder the delivery of optimal health care.

Membership:

- Manager of Health Education, Cultural and Linguistic Services (Chair)
- Director of Health Services or designee
- Manager of Communications or designee
- Manager of Member Services or designee
- Manager of Provider Network
- Quality Improvement Representative

Meeting Frequency:

The committee meets at a minimum quarterly

9. Credentials/Peer Review (C/PR) Committee

Purpose:

The Credentials/Peer Review Committee provides guidance and peer input into GCHP's provider credentialing and practitioner peer review process.

Functions:

Credentialing Responsibilities:

- Provide guidance and comments on GCHP's provider credentialing process.
- Review and make decisions for initial credentialing and recredentialing for participation in GCHP's provider network.
- Review the provider credentialing policy annually and make recommendations for change

Peer Review Responsibilities:

- Review results of provider profiling when available and suggest methods to feed information back to network providers

- Review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns and determine corrective action when necessary.

Membership:

The Committee will consist of seven to nine (7-9) physicians and the CMO who will be the chairperson. To assure due process in the performance of peer review investigations, the Chief Medical Officer shall appoint other physician consultants as necessary to obtain relevant clinical expertise and representation by an appropriate mix of physician types and specialties. The Medical Director, Health Services will be an ad hoc member with a vote to the committee.

Meeting Frequency:

The committee meets quarterly.

10. Pharmacy & Therapeutics (P&T) Committee

Purpose:

The P&T Committee serves as the advisory committee to GCHP for the development and implementation of a plan-wide medication management program. The P&T Committee is responsible to provide guidance on development of a formulary to ensure optimal efficacy, safety, and cost-effectiveness of drug therapy.

Function:

- Maintenance of a drug formulary based on an objective evaluation of efficacy, safety and cost-effectiveness of medications.
- Serve in an advisory capacity to GCHP for all matters pertaining to the use of medication, including development of prescribing guidelines, protocols and procedures to promote high quality and cost-effective drug therapy.
- Review and evaluation of analyses including but not limited to population demographics, morbidities, health risks, and provider-specific and plan-wide utilization patterns for enrolled members.
- Any other issues related to pharmacy quality and usage.

Membership:

The P&T Committee members include but are not limited to GCHP's Chief Medical Officer (Chair), PBM representative, GCHP's Director of Pharmacy Services, physicians, and representatives of a variety of clinical specialties. Medical Director, Health Services is an ad hoc committee member with a vote.

Meeting Frequency:

The committee meets quarterly.

IV. RESOURCES DEDICATED TO QUALITY IMPROVEMENT

CHIEF MEDICAL OFFICER

Responsibilities:

The Chief Medical Officer has the overall responsibility for the clinical direction of GCHP's QIP. The Chief Medical Officer ensures that the QIP is adequate to monitor the full scope of clinical services rendered, and that identified problems are resolved and corrective actions are initiated when necessary and appropriate.

The Chief Medical Officer serves on the QIC, C/PR, P&T, UM/CM, NMC and MAC Committees. The Chief Medical Officer works directly with all GCHP department heads and executive team members. Further, as Chief Medical Officer and a member of the Quality Improvement Committee, the Chief Medical Officer annually oversees the approval of the clinical appropriateness of the Quality Improvement Program.

Reporting Responsibility:

The Chief Medical Officer reports to and is supervised by the Chief Executive Officer. The Chief Medical Officer's job description also specifies that the Chief Medical Officer has the ability and responsibility to inform the Chief Executive Officer, and if necessary the Commission, if at any time the Chief Medical Officer believes his/her clinical decision-making ability is being adversely hindered by administrative or fiscal consideration.

DIRECTOR OF QUALITY IMPROVEMENT

The QI Director is responsible for ensuring all quality monitors; appropriate analysis and improvement initiative are in place. The Director ensures that all health plan staff is educated on the importance of quality and how each staff member plays a

role in the quality improvement process. The Director is a mentor for all department heads and works with them to implement processes that will create both efficient and quality service.

The Director reports to the CMO and ensures that he/she is updated on any deficiencies and proposed improvement activities.

Specific roles and responsibilities include but are not limited to:

- Ensuring that the annual Quality Improvement plan and work plan are created and reviewed by all appropriate areas
- Working with all appropriate departments in the creation of the annual QI review and analysis of results
- Ensuring QIC approval of all QI document annually
- Guiding the collection of HEDIS data as mandated by contractual requirement and assisting in the development of activities to improve care
- Ensuring that appropriate principles of data collection and analysis are used by all departments when looking for improvement opportunities
- Providing educational opportunities for QI staff and other staff members key to improving care and service to better target improvement initiative

QUALITY IMPROVEMENT SPECIALIST (S)
The quality improvement specialists assist the director in assessing data for improvement opportunities. They work with other departments to assist in planning and implementing activities that will improve care or service.

Responsibilities include but are not limited to the following:

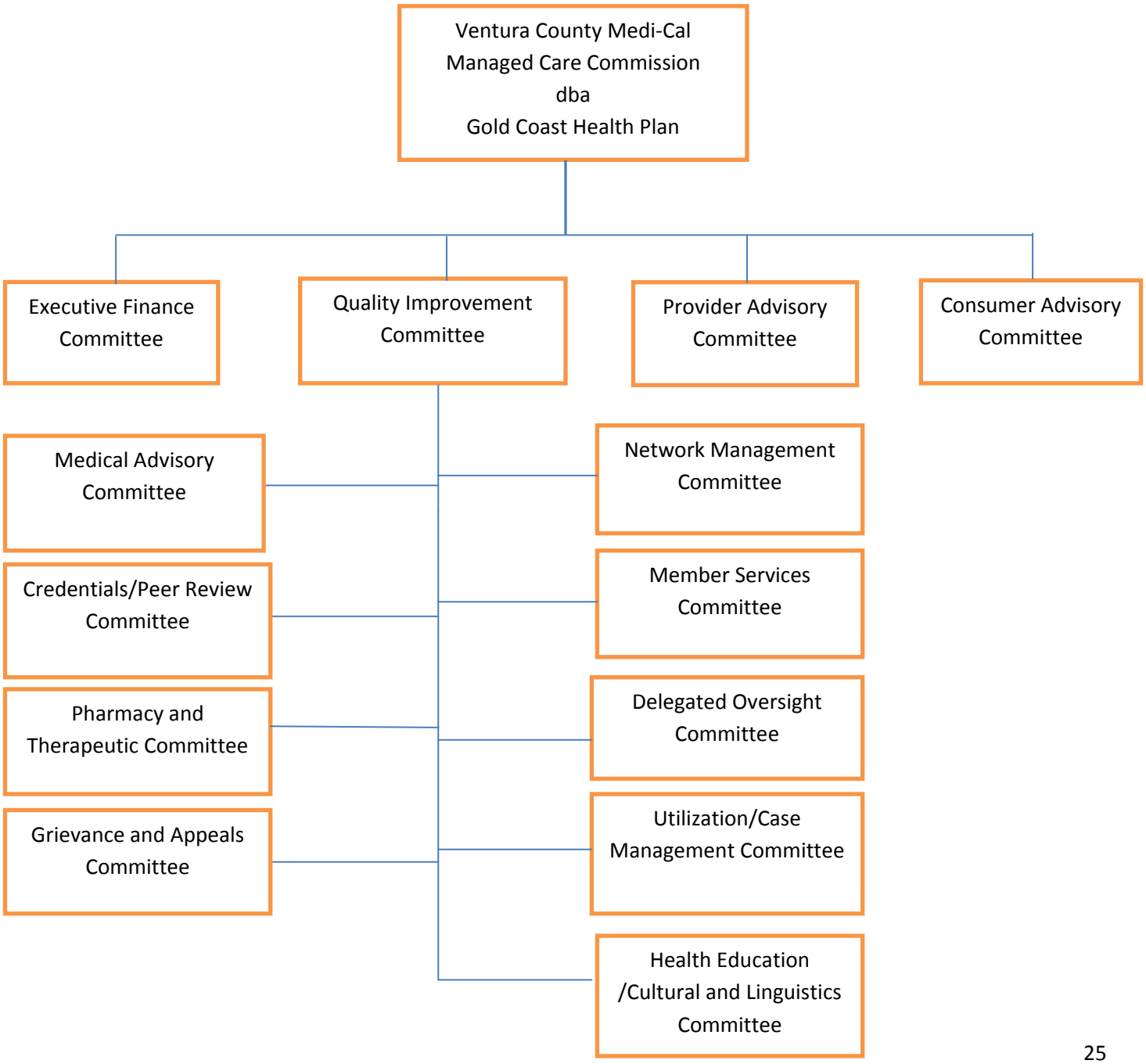
- Assist in creating the annual QI Program document
- Assist in coordination of HEDIS data collection and analysis of results
- Work with other departments to gather information for the annual QI Review
- Assist in developing activities for the annual QI work plan
- Assist the QI Director as required

OTHER QI RESOURCES

Staff from other departments will contribute to the QI process. They will continue to identify areas for improvement. Department staff will be deployed to assist in creating and implementing quality improvement initiatives. All GCHP staff will be educated on their role in the QI process.

GOLD COAST HEALTH PLAN
COMMITTEE ORGANIZATIONAL CHART

The following organizational chart shows the key GCHP committees that advise the Ventura County Medi-Cal Managed Care Commission and their reporting relationships:



X. QUALITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2013

Thursday February 7, 2013

Thursday May 2, 2013

Thurs day August 1, 2013

Thurs day November 7, 2013

AVAILABILITY OF QIP TO PRACTITIONERS AND MEMBERS

The QIP is available on GCHP's website at www.goldcoasthealthplan.org. Printed copies are available upon request.

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION (INCORPORATED AS A SEPARATE DOCUMENT)