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, March 24, 2014
3:00 p.m.

AMENDED AGENDA

CALL TO ORDER / ROLL CALL

RECOGNITION
Recognition of Retiring CMO Charles Cho, MD

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

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

1. APPROVE MINUTES
- a. Regular Meeting of January 27, 2014

2. CONSENT ITEMS
- a. Provider Advisory Committee (PAC) Charter Policy and Procedure
- b. Extension of Auditors Contract (McGladrey)
- c. ICD-10 Vendor Selection

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

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

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

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba
Gold Coast Health Plan March 24, 2014 Commission Meeting Agenda *(continued)*
PLACE: 2240 E. Gonzalez, Room 200, Oxnard, CA
TIME: 3:00 p.m.

3. APPROVAL ITEMS
a. Election of Vice-Chair

4. ACCEPT AND FILE ITEMS
a. CEO Update
b. December and January Financials

5. INFORMATIONAL ITEMS
a. CMO Update
b. Health Services Update
c. ACA 1202 Update

CLOSED SESSION

Closed Session pursuant to Government Code Section 54957(e)
Public Employee Performance Evaluation
Title: Chief Executive Officer

Closed Session Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9 - United States of America et al. ex re Donald Gordon, v. Gold Coast Health Plan, et al, United States District Court, Central District, Case Number: CV 11-5500-IFW (AJWx)

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 April 28, 2014 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

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

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

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

January 27, 2014

(Not official until approved)

CALL TO ORDER

Vice Chair Juarez called the meeting to order at 3:04 p.m. in the Lower Plaza Assembly Room at the County Hall of Administration, 800 S. Victoria Avenue, Ventura, CA 93009.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE

David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
May Lee Berry, Medi-Cal Beneficiary Advocate
Lanyard Dial, MD, Ventura County Medical Association
Peter Foy, Ventura County Board of Supervisors (arrived at 3:06 p.m.)
David Glyer, Private Hospitals / Healthcare System
Laurie Harting *(previously Laurie Eberst)*, Private Hospitals / Healthcare System
Robert S. Juarez, Clinicas del Camino Real, Inc.
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Gagan Pawar, MD, Clinicas del Camino Real, Inc.

EXCUSED / ABSENT COMMISSION MEMBERS

Eileen Fisler, Ventura County Health Care Agency
Robert Gonzalez, MD, Ventura County Health Care Agency

STAFF IN ATTENDANCE

Michael Engelhard, Chief Executive Officer
Nancy Kierstyn Schreiner, Legal Counsel
Michelle Raleigh, Chief Financial Officer
Traci R. McGinley, Clerk of the Board
Brandy Armenta, Compliance Director
Sherri Bennett, Network Operations Director
Charles Cho, MD, Chief Medical Officer (2011-2013)
Stacy Diaz, Human Resources Director
Guillermo Gonzalez, Government Relations Director
Lupe Gonzalez, Manager of Health Education & Disease Management
Steven Lalich, Communications Director
Allen Maithel, Controller
Al Reeves, MD, Chief Medical Officer
Melissa Scrymgeour, Chief Information Officer
Lyndon Turner, Financial Analysis Director
Ruth Watson, Chief Operations Officer
Nancy Wharfield, MD, Medical Director Health Services

The Pledge of Allegiance was recited.

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

PUBLIC COMMENT

Christina Velasco, Clinicas del Camino Real CFO, expressed concern about the treatment of LIHP and Adult Expansion members as Administrative Members versus fully capitated.

Vice-Chair Juarez suggested that Ms. Velasco and GCHP CMO Dr. Al Reeves meet on this matter.

Commissioner Pawar stated that she had this concern as well for her patients; there is a longer waiting period for her Administrative Members to get into see specialists.

1. APPROVE MINUTES

a. Regular Meeting of November 18, 2013

Commissioner Foy moved to approve the Regular Meeting Minutes of November 18, 2013. Commissioner Glyer seconded. The motion carried. **Approved 7-0** with the following vote:

AYE:	Araujo, Berry, Dial, Foy, Glyer, Laba and Pawar.
NAY:	None.
ABSTAIN:	Juarez and Harting.
ABSENT:	Fisler and Gonzalez.

AGENDA CHANGE

2b. Provider Advisory Committee (PAC) Charter Policy and Procedure

Staff requested that Item 2b, *Provider Advisory Committee (PAC) Charter Policy and Procedure* be removed from the Agenda to be heard at a future date uncertain.

Commissioner Laba moved to approve the amended Agenda. Commissioner Foy seconded. The motion carried. **Approved 9-0** with the following vote:

AYE:	Araujo, Berry, Dial, Foy, Glyer, Harting, Juarez, Laba and Pawar.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Fisler and Gonzalez.

2. APPROVAL ITEMS

a. Consumer Advisory Committee (CAC) Membership

COO Watson reviewed the written report with the Commission.

Commissioner Berry moved to appoint Michelle Gerardi to the CAC for a one year term. Commissioner Dial seconded. The motion carried. **Approved 9-0** with the following vote:

AYE: Araujo, Berry, Dial, Foy, Glyer, Harting, Juarez, Laba and Pawar.
NAY: None.
ABSTAIN: None.
ABSENT: Fisler and Gonzalez.

c. Ratification of Lease - 711 Daily Drive, Camarillo, CA

CEO Engelhard reviewed the written report, noted that the correct number of current GCHP employees is 120 and highlighted the amenities at the Daily Drive location.

Commissioner Glyer questioned the current leases at the Lombard and Gonzalez locations. CEO Engelhard explained that the facility at Lombard was on a month-to-month contract and the Gonzales lease is the subject of a Closed Session Item.

Commissioner Foy moved to ratify the lease for 711 Daily Drive, Camarillo, California. Commissioner Harting seconded. The motion carried. **Approved 9-0** with the following vote:

AYE: Araujo, Berry, Dial, Foy, Glyer, Harting, Juarez, Laba and Pawar.
NAY: None.
ABSTAIN: None.
ABSENT: Fisler and Gonzalez.

d. Amended FY 2013-14 Budget

CFO Raleigh reviewed the written report with the Commission and highlighted the following key items that have been reflected in the amended budget:

1. Expenses associated with relocating;
2. New rates for new Member populations and other rates clarified by the State; and
3. The Administrative Expenses increased primarily to reflect costs associated with the above two items and additional contract requirements.

Commissioner Foy moved to adopt the updated FY 2013-14 Budget. Commissioner Harting seconded. The motion carried. **Approved 9-0** with the following vote:

AYE: Araujo, Berry, Dial, Foy, Glyer, Harting, Juarez, Laba and Pawar.
NAY: None.
ABSTAIN: None.
ABSENT: Fisler and Gonzalez.

3. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Engelhard reviewed the written report with the Commission.

b. October and November Financials

CFO Raleigh reviewed the Financial Report and confirmed that the Executive / Finance Committee had reviewed and recommended approval of the October and November Financials.

c. Quality Improvement Annual Report

Dr. Cho, 2011-2013 GCHP CMO, reviewed the written Annual Quality Improvement report and presentation contained in the agenda packet, as well as two additional pages provided (3c-48a and 3c-53a).

Commissioner Dial moved to approve all of the Accept and File Items. Commissioner Foy seconded. The motion carried. **Approved 9-0** with the following vote:

AYE:	Araujo, Berry, Dial, Foy, Glyer, Harting, Juarez, Laba and Pawar.
NAY:	None.
ABSTAIN:	None.
ABSENT:	Fisler and Gonzalez.

4. INFORMATIONAL ITEMS

a. Health Services Update

Medical Director for Health Services, Dr. Wharfield, reviewed the written report and noted that the Plan needs to continue educating Members on when and how to obtain services because emergency room utilization is still high.

b. ACA Implementation Update

COO Watson and Medical Director for Health Services, Dr. Wharfield briefly reviewed the presentation contained in the packet.

c. Proposed 2014-15 State Budget Update

Commissioners had no questions regarding Informational Item 4c and the Item was not reviewed.

d. Legislative Update (Year-End)

CEO Engelhard briefly reviewed the Legislative Update.

COMMENTS FROM COMMISSIONERS

None.

CLOSED SESSION

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

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 5:37 p.m. regarding the following items:

1. **Closed Session Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9**
   a. Fields v. Ventura County, et al. United States District Court, Central District, Case Number: CV-13-07357-FMO-RZ
   b. United States of America et al. ex re Donald Gordon, v. Gold Coast Health Plan, et al, United States District Court, Central District, Case Number: CV 11-5500-IFW (AJWx)
   c. Sziklai et al. v. Ventura County Medi-Cal Managed Care Commission et al; Ventura County Superior Court, Case Number 56-2012-00428086
   d. Cressena Hernandez v. Ventura County Medi-Cal Managed Care Commission et al, Ventura County Superior Court, Case Number 56-2012-00427535-CU-OE-VTA

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

3. **Conference with Real Property Negotiators Pursuant to Government Code Section 54956.8**

   Agency Designated Representatives: Nancy Kierstyn Schreiner, legal counsel, Michael Engelhard, CEO, Stacy Diaz, HR Director

   - **Property Owners and Subject Real Property:**
     County of Ventura
     2220 E. Gonzales Road, Suite 200, Oxnard, CA
     Under Negotiation: Price and Term of Payment

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 6:08 p.m.

Legal Counsel Kierstyn Schreiner stated that there was no reportable action taken in Closed Session.

ADJOURNMENT

Meeting adjourned at 6:08 p.m.

AGENDA ITEM 2a

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operations Officer

Date: March 24, 2014

RE: Provider Advisory Committee Charter Policy and Procedure

SUMMARY:
The Ventura County Medi-Cal Managed Care Commission (VCMMCC) enabling ordinance 4409 (April 2010) and the California Department of Health Care Services, Medi-Cal Managed Care Division, both require the establishment of a provider based committee, hereinafter referred to as the Provider Advisory Committee (PAC). The ordinance requires, at a minimum, that this committee meet quarterly and make recommendations, review policies and programs, explore issues and discuss how the plan may best fulfill its mission.

The Commission determined that the PAC would consist of ten members with one dedicated seat representing the Ventura County Health Care Agency (VCHCA). Each of the appointed members, with the exception of the designated VCHCA seat position, would serve a two-year term, have no term limits, and individuals could apply for reappointment. The ten voting members would represent various professional disciplines and / or constituencies, which include: Allied Health Services, Community Clinics, Hospital, Long Term Care, Non-Physician Medical Practitioners, Nurses, Physician and Traditional / Safety Net.

BACKGROUND / DISCUSSION:
The role of the Provider Advisory Committee is to consider and analyze situations of concern and bring its recommendations to the Commission for its consideration.

The Plan has not successfully held a PAC meeting since February, 2013, due to an inability to accomplish quorum (the PAC is a ten member committee and is required to have at least six members present to hold a meeting). Three members have resigned their positions, leaving only seven active members. GCHP would like to actively recruit for committee members; however, the current Provider Advisory Committee Charter does not outline a process or procedure for this to occur.

The Plan has developed the attached "*Policy and Procedure (P&P), DRAFT Provider Advisory Committee Charter*", for the Commission's review and consideration. The P&P clearly outlines the composition of and requirements of the PAC membership, as well as procedures for the recruitment, nomination, and assignment of PAC members.

The policy includes a proposed timeline for an annual recruitment process. This process was delayed in 2014 pending Commission approval. The recruitment of PAC members will begin immediately following approval, following the steps listed in the timeline.

FISCAL IMPACT:
There is no fiscal impact to the Plan.

RECOMMENDATION:
Approval of and authority to implement *"Policy and Procedure (P&P), Provider Advisory Committee Charter".*

CONCURRENCE:
N/A

Attachments:
Policy and Procedure (P&P), DRAFT Provider Advisory Committee Charter
Provider Advisory Committee (PAC) Nomination Process Timeline

Policies and Procedures	
Title: DRAFT- Provider Advisory Committee Charter	Policy Number: XXXXXXXXXXX

Purpose:

The Ventura County Medi-Cal Managed Care Commission (Commission) enabling ordinance 4409 (April 2010) and the California Department of Health Care Services, Medi-Cal Managed Care Division, both require the establishment of a provider based advisory committee. Hereinafter referred to as the Provider Advisory Committee (PAC). The ordinance requires, at a minimum, that this committee meet quarterly and make recommendations, review policies and programs, explore issues and discuss how the Plan may best fulfill its mission.

Policy:

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

B. For the purpose of this policy, PAC shall also be referred to as advisory committee.

C. Commission encourages provider involvement in the GCHP program.

D. Advisory committee members shall recuse themselves from voting or from decisions where a conflict of interest may exist.

E. The composition of the PAC shall reflect the diversity of the health care consumer and provider community. All advisory committee members shall have direct or indirect contact with GCHP Members.

F. In accordance with ordinance (4409, April 2011) the Commission established the PAC. The PAC is comprised of ten (10) voting members, each seat representing a constituency that works with GCHP and its Members.

    1. One (1) of the ten (10) positions is a standing seat represented by the Ventura County Health Care Agency (VCHCA)
    2. The remaining nine (9) members shall serve alternating two year terms with no limits on the number of terms a representative may serve.
        a. The two year term shall coincide with GCHP's fiscal year (i.e. July 1st through June 30th).
    3. PAC may include, but is not limited to, individuals representing, or that represent the interest of:
        a. Allied health services providers;
        b. Community Clinics;
        c. Hospitals;
        d. Long Term Care;
        e. Home Health / Hospice;

f. Nurse;

g. Physician;

h. Traditional / Safety Net;

i. VCHCA

G. PAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats in accordance with this policy.

1. The advisory committee shall conduct an annual recruitment and nomination process.

    a. At the end of each fiscal year, approximately half of the seats' terms expire, alternating between five (5) vacancies one (1) year and five (5) vacancies the subsequent year.

2. The advisory committee shall conduct a recruitment and nomination process if a seat is vacated mid-term.

    a. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full two (2) year term.

H. On an annual basis the PAC shall select a Chairperson from its membership to coincide with the annual recruitment and nomination process. GCHP's Director of Network Operations shall act as Interim Chairperson until this position is filled.

I. To establish a nomination ad hoc subcommittee, PAC chairperson shall ask for three (3) to four (4) volunteers of PAC. PAC members, who are being considered for reappointment, cannot participate in their respective nomination ad hoc subcommittee.

1. Each PAC nomination subcommittee shall:

    a. Review, evaluate, and select a prospective candidate of each of the open seats, in accordance with "Procedure-Section E "of this policy.

    b. Forward the prospective candidate(s) to the advisory committee for review and approval.

2. Following approval from the advisory committee, the candidates and recommendation of the advisory committee shall be forwarded to the Commission for review and approval.

J. The Commission shall review and have final approval for all appointments and reappointments to the advisory committee.

K. Advisory committee members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered

excused if an advisory committee member provides notification of an absence to GCHP staff prior to the advisory committee meeting. GCHP staff shall inform the Chief Executive Officer, and Clerk of the Board of the Commission when an advisory committee member fails to attend two (2) consecutive regularly scheduled meetings.

Procedure:

A. PAC composition
    1. The composition of the PAC shall reflect the cultural diversity and special needs of the GCHP membership.
    2. Specific agency representatives shall serve on the advisory committee as standing members.
        a. VCHCA shall have one seat designated.

B. PAC meeting frequency
    1. PAC shall meet at least quarterly.
    2. PAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting during fourth quarter for the oncoming year.
    3. Attendance by a simple majority of appointed members shall constitute a quorum.

C. PAC recruitment process
    1. GCHP Clerk of the Board shall post on the GCHP website an Annual Appointment List on, or before, December 31 of each year The Clerk of the Board shall also post said List per government code requirements. GCHP shall include, but not be limited to, the following notification methods for impending vacancies:
        a. All California Government Code requirements.
        b. Outreach to Provider communities
        c. Placement of Annual Appointment List on the GCHP website
        d. Advertisement of vacancies in GCHP monthly Provider Operations Bulletin
    2. Prospective candidates shall submit their application to GCHP in accordance with GCHP requirements.
    3. Advisory committee chairperson shall inquire of its membership whether there are interested candidates who wish to be considered as a chairperson for the upcoming year.

D. PAC nomination evaluation process

1. Advisory committee chairperson shall request members, who are not being considered for reappointment, to volunteer to serve on the nominations ad hoc subcommittee.
2. Prior to the PAC nomination ad hoc subcommittee meetings:
    a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the Applicant Evaluation Tool.
    b. Ad hoc subcommittee members shall individually evaluate and select a chairperson.
    c. At the discretion of the ad hoc subcommittee, GCHP may contact a prospective candidate and / or their references for additional information and background information.
3. Ad hoc subcommittee shall convene to discuss and select a chairperson and recommend candidates for expiring seats by using the findings for the Applicant Evaluation Tool, the attendance record if relevant, and the prospective candidate's references.
4. In the event that there is a lack of quorum due to vacancies on the PAC, GCHP will develop an internal panel to perform the evaluation process. The panel shall include at a minimum GCHP's Chief Medical Officer, Chief Executive Officer, Medical Director, Director of Network Operations and Director of Health Services.

E. PAC selection and approval process for prospective chairpersons and advisory committee candidates

1. Upon selection of a recommendation for chairperson and a slate of candidates, the Ad hoc subcommittee shall forward its recommendation to the PAC for review and approval.
2. Following PAC approval, the slate of candidates shall be submitted to the Commission for review and final approval.
3. Following Commission appointment, the new PAC members shall be effective when sworn in by the Clerk of the Board at the scheduled third quarter PAC Meeting.
4. GCHP shall provide new PAC members with a new member orientation.

Attachments:

References:

Revision History:

Review Date	Revised Date	Approved By

PROVIDER ADVISORY COMMITTEE (PAC)

NOMINATION PROCESS TIMELINE

ACTION	TIMELINE
Clerk of the Board will post Annual Appointment List on GCHP Website.	Annually by December 31
Prepare Notice of Vacancy for expiring seats and submit to GCHP Communications for placement on GCHP Website Director	Annually between December 8-15
Form PAC ad hoc nominations subcommittee 1. Recruit volunteers for applicants of Chair position 2. Recruit members for ad hoc nominations subcommittee	Annually during first quarter PAC meeting
Deadline for applications at GCHP for PAC Annual Vacancies (by February 2nd) – (GCHP will accept applications year-round)	Annually by February 2
Send Nominations binders with REDACTED applications to all members of ad hoc nominations subcommittees for individual review and scoring	Annually by February 10
Convene PAC ad hoc nominations subcommittee to review and recommend to PAC • Proposed slate of candidates • Proposed Chairperson	Annually by February 15
Proposed candidates / Chair presented for consideration to full PAC	Annually during first or second quarter PAC meeting, depending on date of meeting.
Proposed candidates presented to Commission during April Commission meeting for approval	Annually during April Commission Meeting
Notify new PAC members of their selection after Board approval	Annually between May 1-15
Appointed members are sworn in by clerk of board officially take new positions	Annually during third quarter PAC meeting and other times as needed.
New PAC representatives attend first Committee meeting. New chairperson presides.	Annually during third quarter PAC meeting and other times as needed

NOTE: **If a PAC vacancy occurs at any other time, the above timeline will begin immediately using the same sequence of events as above with revised start and end dates to ensure that no PAC seat remains vacant and a quorum can be reached.**

AGENDA ITEM 2b

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: March 24, 2014

RE: FY 2013-14 Financial Audit Contract

SUMMARY:
Staff is requesting approval from the Commission to utilize McGladrey LLP (McGladrey) to perform the Plan's FY 2013-14 financial audit.

BACKGROUND / DISCUSSION:
The Plan's contract with DHCS requires an annual audit be performed on the Plan's financial statements. This audit provides confidence to the community and the Commission that the Plan's financial condition is accurately represented and that proper controls are in place. To meet these needs, the Plan hires a firm qualified to perform this annual financial audit.

In 2011, the Plan solicited a Request for Proposal (RFP) for auditing services and selected McGladrey after a thorough review and evaluation process. McGladrey has performed the financial audits for the Plan's year prior to go live (i.e., year ending 06/30/11) and the two years following (i.e., year ending 06/30/12 and 06/30/13). During the course of these audits, McGladrey has gained an understanding of the Plan staff, processes, systems, and finances.

Staff is recommending that the Plan use McGladrey for the FY 2013-14 audit. This recommendation is being made for several reasons, including:

- McGladrey has been working with the Plan since start-up and will be able to leverage relationships, knowledge of systems and operations,
- McGladrey has performed professionally and is dedicated to meeting the State deadlines,
- McGladrey has experience working with other health plans nationally and the local Medi-Cal market, and
- The audit pre-work for the FY 2013-14 year will start immediately, which makes performing a procurement and completing contract negotiations very difficult in that timeframe. Plan staff has been busy with the implementation many Affordable Care

Act provisions, including the transition of the County's Low Income Health Program and the implementation of an expanded mental health benefit.

- There is no requirement in Sarbanes Oxley Act of 2002, or SOX, (which outlines enhanced standards for public companies, boards, management and public accounting firms) or from the National Association of Insurance Commissioners to change auditor firm. There is a requirement to change the audit partner at least every five years.

McGladrey is providing an updated engagement letter with a quote that will need to be signed by Plan's Executive / Finance Committee Chair, the Plan's CEO and CFO.

FISCAL IMPACT:
McGladrey's quote to perform the FY 2013-14 financial audit is expected to be approximately $105,000 plus out of pocket expenses. The FY 2012-13 financial audit was $97,000 plus out of pocket expenses of approximately $21,000.

RECOMMENDATION:
Staff proposes to utilize McGladrey for the FY 2013-14 audit and seeks the Commission's approval.

CONCURRENCE:
N/A

Attachments:
None.

AGENDA ITEM 2c

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operations Officer

Date: March 24, 2014

RE: ICD-10 Implementation Vendor

SUMMARY:
In December 2013, Gold Coast Health Plan (GCHP or Plan) began an RFP process to select a vendor to assist the Plan in achieving compliance with the Centers for Medicare and Medicaid (CMS) mandate that all HIPAA-covered entities convert from ICD-9-CM to ICD-10-CM / PCS code sets by October 1, 2014. It is the Plan's recommendation to move forward with Optimity Advisors (Optimity) as the vendor of choice and allow the Chief Executive Officer (CEO) to enter into an agreement with Optimity to assist with GCHP's ICD-10 implementation project.

BACKGROUND:
The International Classification of Diseases (ICD) is the standardized medical coding tool that is used throughout the health care industry to define the health state of the patient. These diagnostic and hospital procedure codes are the cornerstone of Health Information. The ninth version, ICD-9, currently in use in the United States, does not reflect today's treatment, reporting and payment processes. The CMS has issued a mandate that all covered entities must be able to transmit and accept the new ICD-10-CM and ICD-10-PCS code sets by October 1, 2014.

In July, GCHP officially launched a project to ensure readiness and compliance with this CMS regulatory requirement. The Plan's key goals for this project are as follows:

- Comply with the mandate to transmit and accept the new ICD-10 code sets by October 1, 2014
- Receive and process claims using the new ICD-10 code sets with minimal to no disruption to GCHP members and providers
- Ensure GCHP's ability to report on quality measures
- Ensure accurate representation of GCHP data for internal and external reporting
- Support our provider community through assessment, training and testing to ensure a smooth ICD-10 transition

Although GCHP's core administration (IKA) and medical management (Medhok) systems are ICD-10 compliant, staff determined that addressing the gaps identified an ICD-10 readiness assessment would require the Plan to engage in a professional services agreement with a vendor for planning and project management services. In October 2013, GCHP conducted an RFP process with the goal of seeking a professional services vendor with ICD-10 experience to assist the plan with ICD-10 implementation. GCHP outreached to ten vendors to participate in the selection process, four of which showed interest; only one vendor, Optimity Advisors (Optimity), chose to participate in the RFP process.

The Plan is targeting to sign a contract with the selected vendor by late-February in order to meet the October 1, 2014 federal mandate.

DISCUSSION:
The transition from ICD-9-CM to ICD-10-CM / PCS represents one of the largest administrative changes in the health care industry in over 30 years. The impact to resources, business practice, technology, and staffing is substantial. ICD-10 will provide higher-quality information for measuring healthcare service quality, safety and efficacy. With a lack of ICD-10 expertise nationwide, healthcare organizations are competing for the consulting expertise and resources to guide them through the ICD-10 transition.

GCHP has completed a readiness assessment to identify risks and determine the scope of work for ICD-10 remediation. The Plan's goal is to complete an ICD-10 implementation project and meet the October 1, 2014 compliance mandate.

Optimity has conducted several ICD-10 implementation projects, including a three-year project leading the ICD-10 assessment and implementation for another County Organized Health System (COHS).

The selection team, made up of GCHP's Chief Operations Officer, Director of Operations, Chief Information Officer, and other subject matter experts, have - through the RFP selection process – made the decision to contract with Optimity.

FISCAL IMPACT:
The estimated implementation cost for services provided by Optimity is comprised of the services of a part time project manager and a full time business analyst to manage the project, identify and document work streams and critical path deliverables, develop testing plans, protocols, checklist and training documents as well as track project deliverables. The total cost of the proposal is $306,000, based on a 7-month timeline, with an hourly rate inclusive of travel. GCHP will assume responsibility for all post implementation support.

Staff estimates that additional costs may be incurred for the purchase of a cross-walk tool, services of a certified coder to analyze and map the codes, provider outreach and education materials, provider technical support and internal / external testing resources.

The budget approved at the January 27, 2014 Commission Meeting included $400,000 for ICD-10 implementation, assuming $44,444 per month for 9 months. There is no net fiscal impact by approving the recommended vendor contract as the dollars were previously budgeted.

RECOMMENDATION:
Optimity is the preferred vendor, providing the Plan with proven expertise in ICD-10 remediation, as well as experience assisting another COHS plan.

The GCHP selection team concludes that Optimity strikes the best balance of industry experience, ICD-10 expertise, availability and cost.

It is the Plan's recommendation to move forward with Optimity as the vendor of choice and allow the CEO to enter into an agreement with Optimity to provide professional services to assist the Plan with ICD-10 implementation.

CONCURRENCE:
N/A

Attachments:
None.

AGENDA ITEM 4a

To: Gold Coast Health Plan Commission

From: Michael Engelhard, Chief Executive Officer

Date: March 24, 2014

Re: CEO Update

COMMISSION

On March 11, 2014, the Ventura County Board of Supervisors appointed two new members to the Gold Coast Health Plan Commission and re-affirmed the continued service of three others, in accordance with the County Ordinance. Existing Commissioners Dr. David Araujo, Dr. Michelle Laba, and Dr. Gagan Pawar were all re-appointed to their Commission seats. The new appointments are as follows and were effective March 15, 2014:

- Dee Pupa was appointed to fill the vacancy created for the seat formerly held by Eileen Fisler. The term of this appointment ends on March 15, 2016.
- Clinicas del Camino Real recommended Antonio Alatorre to fill the seat of its Chief Executive Officer or designee. The term of this seat will expire March 15, 2018. This seat was previously held by Clinicas CEO Roberto Juarez.

FINANCE UPDATE

DHCS Rates

DHCS held a meeting on February 11, 2014 to review rate issues, including the rate updates in progress for the last fiscal year and expected policy changes for the current fiscal year. Highlights of the meeting include:

- DHCS is in the process of submitting several rates to the Centers for Medicare and Medicare Services (CMS) for approval. Those rate submissions impacting GCHP include rates for the new Adult Expansion population (which are expected to be submitted the week of February 10, 2014 to CMS) and the new Mental Health benefit (which are expected to be submitted in early March).
- It is not certain when CMS will approve the rates; however DHCS has begun to pay GCHP the new Adult Expansion rate in January and may pay a placeholder rate for the new Mental Health Benefit in the March time period. The medical costs associated with the new mental health benefit are estimated to be $200,000 per month. GCHP would need to cover these estimated medical expenses until State reimbursement is made available.

- DHCS and their consultants reviewed the Health Insurance Provider Fee calculation, which is a new fee under the Affordable Care Act. Although GCHP does not meet the definition of a "covered entity" and therefore will not pay the fee, GCHP did ask for clarification regarding the obligation of "covered entities" that contract with us.
- DHCS reviewed components of the ACA 1202 Compliance Plan and reconciliation of payments (this is discussed more – Informational Item 5(c)).

Adult Expansion Capitation Rates
GCHP has retained Milliman (outside actuarial firm) to expedite the analysis of determining sound capitation rates for the LIHP and Medi-Cal Expansion members.

OPERATIONS UPDATE

ACA-Health Care Reform and Medicaid Expansion

Membership
GCHP membership continued to grow in March due to ACA and Medi-Cal expansion. Since January the Plan has added 12,377 new members - 8,154 from the ACE / LIHP program and 4,223 new Medi-Cal Expansion members. Total Enrollment as of March was approximately 135,000.

DHCS Outreach to CalFresh Beneficiaries
On February 3, 2014 DHCS sent notices to 12,352 CalFresh (California's food stamp program) adult beneficiaries in Ventura County advising them that they are eligible for Medi-Cal through an "Express Lane" eligibility process. A federal waiver allows DHCS to grant Medi-Cal eligibility without the need for an application or a determination for 12 months by using CalFresh income eligibility for enrolled adults. By having enrollment into CalFresh, income and residency has been established and DHCS will need to conduct necessary citizenship and identity verifications to comply with federal Medicaid regulations. In March, GCHP received the first of these members as 1,741 of the newly eligible expansion members were CalFresh beneficiaries.

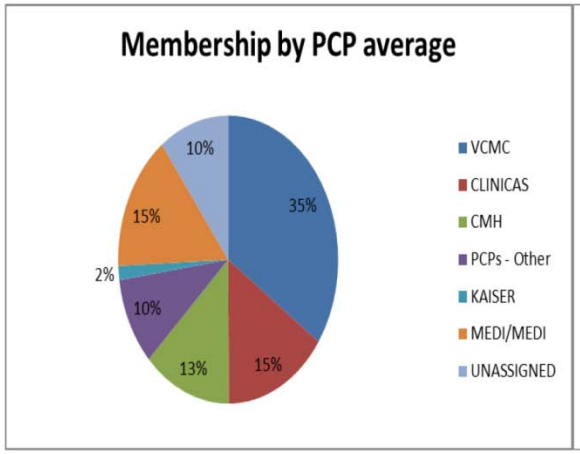
Mental Health Benefit
GCHP's contracted behavioral health management organization (BHMO), Beacon Health Strategies (Beacon), has received 1101 calls since the addition of the Mental Health Benefit in January. The daily call volume rose in February from an average of 9 calls per day in January to over 30 calls per day in February and March.

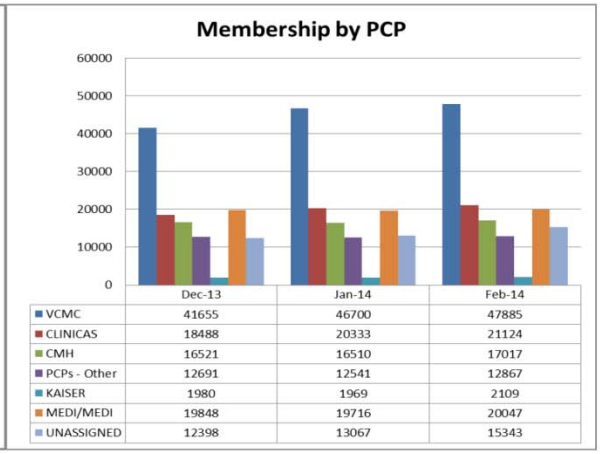
Approximately 297 members have been referred for mild to moderate behavioral health services since January. GCHP's Medical team worked collaboratively with Beacon and County Mental Health to develop training and assessment tools to identify the level of care needed. This has resulted in successful and appropriate transfers to the County Mental Health program for higher acuity mental health services.

Beacon has solicited contracts from 260 providers and 251 or 93% have signed contracts to provide behavioral health services to GCHP's members.

PCP / Member Assignment Report

The graphs below consolidate the total number of members assigned by PCP grouping.





	Dec-13	Jan-14	Feb-14
VCMC	41655	46700	47885
CLINICAS	18488	20333	21124
CMH	16521	16510	17017
PCPs - Other	12691	12541	12867
KAISER	1980	1969	2109
MEDI/MEDI	19848	19716	20047
UNASSIGNED	12398	13067	15343

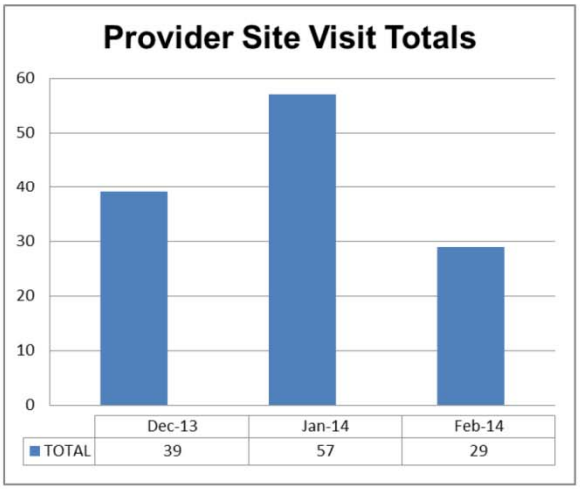
*UNASSIGNED includes Administrative Members, Share of Cost, Newly Eligible and Other Insurance

Provider Site Visit Tracking

February 2014

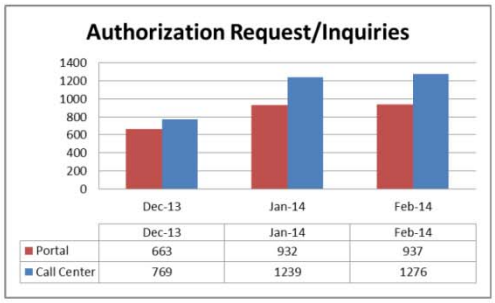
Provider Service Representatives routinely visit provider offices. These visits create opportunities for providers to ask questions and for the representatives to deliver current information and materials. Visits may be pre-scheduled at the providers request to discuss specific issues and may include representation from other GCHP business areas.

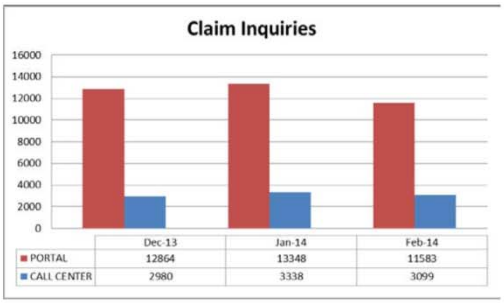
Note: February site visits dropped as a result of staffing shortage.

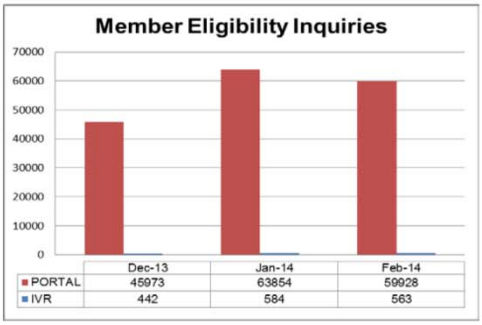


	Dec-13	Jan-14	Feb-14
TOTAL	39	57	29

Provider Portal/Call Center Usage







Claims Inventory Summary

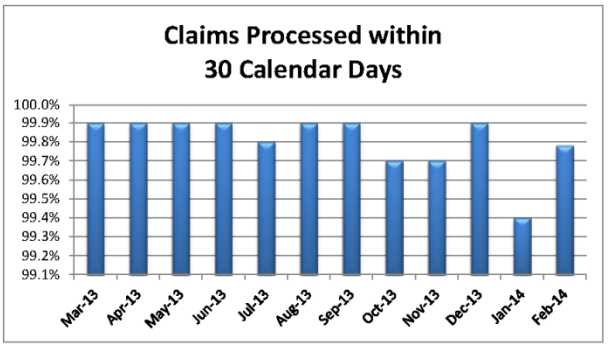
Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
16,029	9,350	12,385	16,554	16,601	21,894	22,590	21,051	24,585	12,924	13,999	13,201

Goal: 18,000 or less (based on membership as of December 2013)

Note: Increase in November 2013 was due to a bulk submission of claims from VCMC on 11/22/13 that artificially inflated the inventory for two weeks. More than 70% had been previously submitted and were denied as duplicates; an additional 20% were denied for various reasons.

Claims Processing Turnaround Time

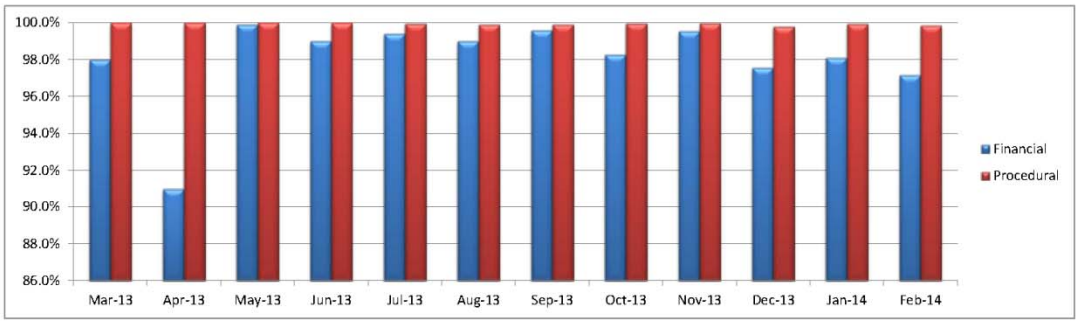
December	1-30 Days		31-45 Days		46-60 Days		Over 60 Days		Total Claims
	#	%	#	%	#	%	#	%	
Clean Claims	110,521	99.92	48	0.04	5	0	41	0.04	110,615
Contested Claims	2,835	100	0	0	0	0	0	0	2,835
Total Claims	113,356	99.92	48	0.04	5	0	41	0.04	113,450



Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
99.9%	99.9%	99.9%	99.9%	99.8%	99.9%	99.9%	99.7%	99.7%	99.9%	99.4%	99.8%

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

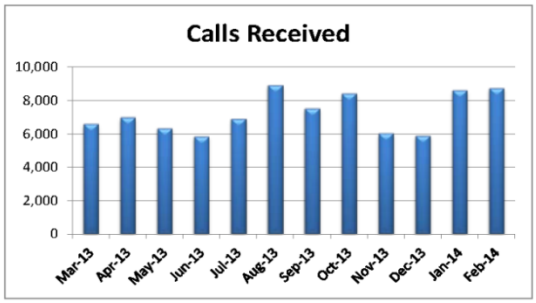
Claims Processing Accuracy

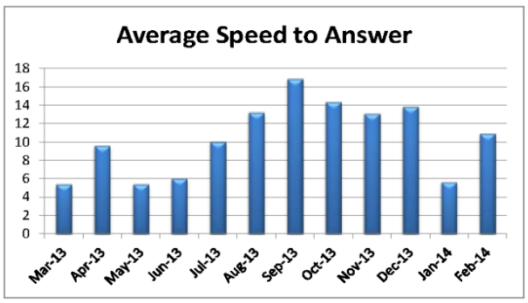


	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
Financial	98.0%	91.0%	99.9%	99.0%	99.4%	99.0%	99.59%	98.27%	99.54%	97.56%	98.10%	97.16%
Procedural	100.0%	100.0%	100.0%	100.0%	99.95%	99.9%	99.9%	99.96%	99.97%	99.79%	99.94%	99.85%

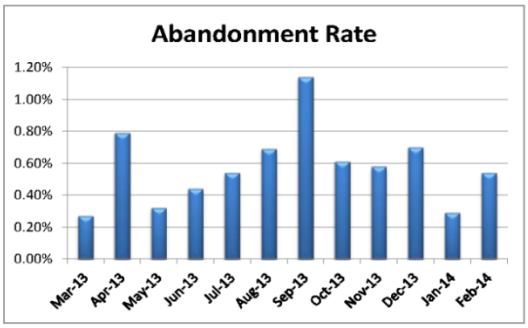
Goal:
Financial - 98% or higher
Procedural - 97% or higher

Xerox Call Center Activity

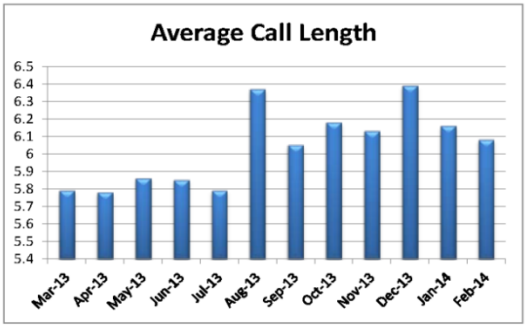




Goal: 30 seconds or less

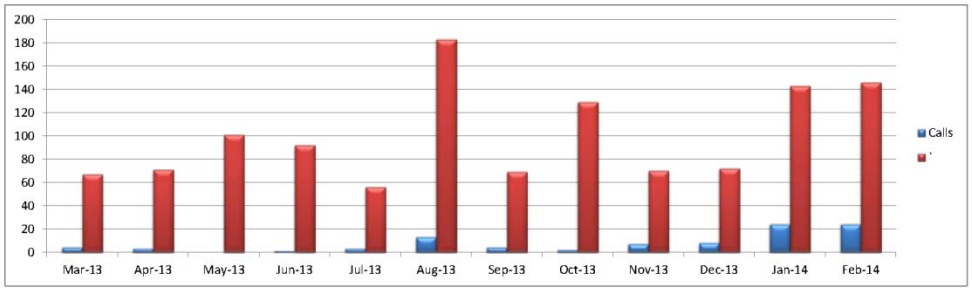


Goal: 5% or less



Goal: 7 minutes or less

Oxnard Member Services Activity



	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
Calls	4	3	0	1	3	13	4	2	7	8	24	24
`	67	71	101	92	56	183	69	129	70	72	143	146

Note: August 2013 walk-in increase due to Healthy Families transition; October 2013 increase not directly associated with one issue; January and February 2014 increase due to LIHP transition and Medi-Cal Expansion.

COMPLIANCE

The Plan submitted the following corrective action plans to the Department of Health Care Services (DHCS):

- Corrective Action Plan Addendum B (Medical): Submitted January 16, 2014
- Corrective Action Plan Addendum A (Financial): Update submitted January 30, 2014
- Facility Site Review Corrective Action: Submitted February 13, 2014

The Medical Loss Ratio Evaluation data request was provided to the Plan on January 23, 2014, with data requests due back no later than March 3, 2014. An entrance call was held on January 29, 2014 between DHCS, DMHC and the Plan. Test files were requested by DMHC and the plan submitted the files on February 13, 2014. Additional documentation was provided to DMHC on or before March 3, 2014. The Plan is working collaboratively with DMHC on follow up items requested. DMHC confirmed the audit will be a remote audit and they will not be onsite.

In January 2014, the compliance/fraud hotline received five calls. In February 2014, the Plan received five calls. As of March 10, 2014 the hotline received one call. All calls were routed to the applicable agency and or internal department.

The Plan conducted audits on three delegated credentialing medical groups in January 2014." Audit reports were provided to each medical group on March 5, 2014, and results were presented to the GCHP Compliance Committee on March 14, 2014.

GOVERNMENT AFFAIRS UPDATE

Single Statewide Drug Formulary

The California Department of Health Care Services (DHCS) has proposed to implement a single statewide drug formulary for all Medi-Cal Managed Care Plans. Most all Medi-Cal Managed Care Plans and their representative trade organizations have voiced strong opposition to this proposal.

On February 14, 2014 both the California Association of Health Plans (CAHP) and Local Health Plans of California (LHPC) submitted letters of opposition to the single statewide drug formulary proposal. These organizations believe that adoption of a single statewide formulary, without a medical rationale, will inappropriately drive up utilization of brand name drugs and significantly increase costs. In response to strong opposition received from Medi-Cal Managed Care Plans, DHCS is reconsidering enactment of this proposal and has established a stakeholder workgroup to receive stakeholder input.

FQHC / RHC Payment Reform

DHCS circulated a draft proposal for a pilot program to reform payments to federally qualified health centers (FQHC) and rural health clinics (RHC). If passed, **SB 1081** would

require the department to authorize a 3-year alternative payment methodology (APM) pilot project for FQHCs and RHCs. Under the APM pilot project, participating FQHCs would receive capitated monthly payments for each Medi-Cal managed care enrollee assigned to the FQHC in place of the wrap-around, fee-for-service per-visit payments they currently receive from DHCS. Ventura County was not selected to participate in the Pilot Program. The proposed pilot counties are: Alameda, Contra Costa, Santa Clara, San Mateo and Riverside.

Medi-Cal Pregnant Women
On January 31, 2014 DHCS posted budget trailer bill language to allow pregnant women whose incomes are between 109-208% of the federal poverty level (FPL) to have access to full-scope Medi-Cal coverage through Covered California. Pregnant women below 109% FPL will receive full-scope benefits from Gold Coast Health Plan through the Medi-Cal Program. Under this proposal commercial plans in Covered California may enroll Medi-Cal beneficiaries and get direct reimbursement from DHCS for services provided to Medi-Cal beneficiaries.

This proposal does not impact GCHP directly. Due to prevailing Medi-Cal reimbursement rates it is unclear how many commercial plans would actually participate in this program. CAHP estimates a statewide target population of approximately 8,100 individuals would be eligible for this program.

CalFresh
California received a federal waiver to automatically qualify those in the CalFresh Program into Medi-Cal. On February 5, 2014 DHCS provided plans a county by county estimate of those in the CalFresh Program under aid code category 7U. The 7U category is for those age 19 to 64 years of age who are childless adults. According to DHCS, there are 12,352 Ventura County residents in CalFresh Program who would fall under the 7U category. DHCS will be sending out another population count for the remainder CalFresh aid categories which include: 7W-those under 19 years of age and 7S-parents of eligible children.

Medi-Cal Managed Care Dashboard Report
On February 6, 2014 DHCS released its first ever Dashboard Report on Medi-Cal Managed Care. The report will be updated quarterly and then shared publicly through a webinar at each release. Starting on March 1, 2014, the report will be posted on the new DHCS monitoring website.

The current report provides information on managed care enrollment, finances and trends in grievances. In addition, the report provides comparative information on health plan quality metrics such as timeliness of prenatal care, postpartum care and readmission rates. The overall goal of the report is to increase transparency and provide a regular means updating stakeholders on the Medi-Cal Managed Care Program.

Based on the 2012 HEDIS measurement period, GCHP exceeded the Minimum Performance Level (MPL). In the area of timeliness for prenatal care, GCHP placed near the midpoint for all plans and for postpartum care, GCHP exceeded the MPL placing in the top third of all plans for 2012.

Senate Budget & Health Committee Oversight Hearing-Coordinated Care Initiative
On February 6, 2014 the Senate Budget and Senate Health Committees held an oversight hearing concerning oversight of the eight-county pilot Coordinated Care Initiative (CCI) now known as Cal MediConnect. The eight pilot counties are: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Under the CCI, dual eligibles must enroll in Medi-Cal managed care to receive their benefits.

The purpose and goal of CCI is to promote the coordination of health and social services for individuals who are dually eligible for Medicare and Medi- Cal. In 2013 DHCS postponed launch of the CCI several times. The CCI will launch in April 2014 in San Mateo County only and other counties will phase in over time, reflecting readiness of each individual pilot county. DHCS also announced that in addition to Health Net and LA Care, three other plans will be offered in Los Angeles County, these are: CareMore, Care 1st, and Molina Health Care.

Advocates indicated support for a January 1, 2015 start date, as a better timeframe for implementation of the CCI. DHCS Director Toby Douglas testified and defended the delay and timelines of the CCI, but said DHCS will continue to work with stakeholders through the implementation process.

Medi-Cal Managed Care Plans As Medicaid Certified Application Counselors
Gold Coast Health Plan submitted its application to participate in the Certified Application Counselor Program (CAC). The objective of the CAC Program is to provide information and assistance to consumers regarding Covered California and to help facilitate enrollment in Medi-Cal.

Draft regulations for the CAC Program are expected to be approved by the Covered California Executive Board by mid- March. Certified Application Counselors (CAC) will be required to undergo background checks, which will be paid for by the participating Plan. Access to CalHEERS will be granted to CACs once the individual passes the exam and clears the background check.

Long Term Care Facilities State Audit
California's Joint Legislative Audit Committee approved an audit of the state's management of long-term care (LTC) facilities. The audit request followed a number of complaints received by the legislature about LTC facilities, some of which were addressed in a January hearing of the Assembly Committees on Health and Aging & Long Term Care. One focus of the audit will be on the effectiveness of the Department of Public Health's procedures for investigating these facilities.

The State Auditor's most recent audit of LTC facilities was in 2004. In this audit the State Auditor recommended streamlining the certification and licensing of LTC facilities, as well as minimizing the overlap of oversight responsibilities across the departments of Social Services, Health Services (now Public Health and Health Care Services), and Aging. Additionally recommendations focused on the Program of All-Inclusive Care for the Elderly (PACE); Multipurpose Senior Services Program; Alzheimer's day care resource centers; and adult day health care programs, which were replaced with the Community Based Adult Services Program.

Community Based Adult Services Reauthorization
The Community Based Adult Services (CBAS) program is approved through August 31, 2014 in a federal waiver, and requires reauthorization before this time in order to continue as a Medi-Cal covered benefit. Two bills have been introduced in the legislature that contain urgency clauses to maintain CBAS as a Medi-Cal benefit. The first bill, AB 518, has been stalled in the legislature since June, 2013. The other bill, AB 1552, was introduced in January, 2014 and would require CBAS to be a Medi-Cal covered benefit in all Medi-Cal managed care plans, and as a fee-for-service benefit in all other non-managed care counties.

Legislature and Legislation
The State Legislature is in the second year of a two-year session which ends on August 31, 2014. The deadline to introduce bills in both Assembly and Senate was February 21, 2014. Senator Rod Wright (D- Baldwin Hills) and Senator Ron Calderon (D- Montebello) have taken a leave of absence pending ongoing court cases. Additionally the Assembly elected a new Speaker, Toni Atkins, who represents the San Diego area. The Senate is scheduled to elect a new Pro-Tem who is said to be Kevin de Leon. Senator DeLeon represents the downtown Los Angeles area. In this session healthcare bills will be focusing on "clean-up" legislation to complete implementation of the federal Affordable Care Act as well as legislation associated with mental health parity.

The following is a list of healthcare and Medi-Cal related bills that GCHP's Government Affairs unit is monitoring:

AB 209 **(Pan D) Medi-Cal: managed care: quality, accessibility, and utilization.**
Summary: Would require the State Department of Health Care Services to develop and implement a plan to monitor, evaluate, and improve the quality, accessibility, and utilization of health care and dental services provided through Medi-Cal managed care.

AB 369 **(Pan D) Continuity of care.**
Summary: Would require a health care service plan and a health insurer to arrange for the completion of covered services by a nonparticipating provider for a newly covered enrollee or a newly covered person under an individual health insurance policy whose prior coverage was withdrawn from the market between December 1, 2013, and March 31, 2014.

AB 809 **(Logue R) Healing arts: telehealth.**
Summary: This bill would require the health care provider initiating the use of telehealth at the originating site to obtain verbal or written consent from the patient for the use of telehealth, as specified. The bill would require that health care provider to document the consent in the patient's medical record and to transmit that documentation with the initiation of any telehealth to any distant-site health care provider from whom telehealth is requested or obtained.

AB 1174 **(Bocanegra D) Dental professionals: teledentistry under Medi-Cal.**
Summary: Would authorize a registered dental assistant who has completed a specified educational program to determine which radiographs to perform. The bill would authorize a registered dental assistant in extended functions licensed on or after January 1, 2010, a registered dental hygienist, and a registered dental hygienist in alternative practice to choose radiographs and place protective restorations, as specified.

AB 1552 **(Lowenthal D) Community-Based Adult Services: adult day health care centers.**
Summary: Would require that Community Based Adult Services (CBAS) be a Medi-Cal benefit, available at licensed and certified Adult Day Health Care centers. Requires CBAS to be included as a covered service in contracts with all managed care plans, with standards, eligibility criteria, and provisions that are at least equal to those contained in the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Medicaid Demonstration. Requires CBAS to be provided as fee-for-service for Medi-Cal beneficiaries who are not qualified for or exempt from managed care.

AB 1558 **(Hernandez D) California Health Data Organization.**
Summary: Would require the University of California to establish the California Health Data Organization and requires health plans and insurers to provide the organization, to the extent permitted by federal law, their explanations of benefits or explanations of review. Requires the organization to design and maintain a website using the data provided that allows consumers to compare the prices paid by carriers for procedures.

AB 1567 **(Chávez R) Office of Rural Health.**
Summary: Current law requires the Secretary of the Health and Welfare Agency, now known as the Secretary of California Health and Human Services, to establish the Office of Rural Health to promote coordinated planning for the delivery of health services in rural California.

AB 1595 **(Chesbro D) State Council on Developmental Disabilities.**
Summary: Would state the intent of the Legislature to enact legislation amending specified provisions pertaining to the operations, structure, and responsibilities of the State Council on Developmental Disabilities.

AB 1626 **(Maienschein R) Developmental services: habilitation.**
Summary: Current law requires providers of individualized or group-supported employment services to be paid at an hourly rate of $30.82, and requires an interim program provider to be paid a fee of $360 or $720, as specified. This bill would increase the hourly rate paid to providers of individualized and group-supported employment services to $34.24, and increase the fees paid to interim program providers to $400 and $800, respectively.

AB 1644 **(Medina D) Medi-Cal: Drug Medi-Cal Program providers.**
Summary: Would require a county or the State Department of Health Care Services, before contracting with a certified DMC provider, to obtain criminal background information to determine if the owner has been convicted of a felony or a crime involving fraud and to request subsequent arrest notification for those crimes. The bill would also limit the term of contracts with DMC providers to a maximum of 2 years.

AB 1759 **(Pan D) Medi-Cal: reimbursement rates.**
Summary: Current federal law requires the state to provide payment for primary care services furnished in the 2013 and 2014 calendar years by Medi-Cal providers with specified primary specialty designations at a rate not less than 100% of the payment rate that applies to those services and physicians under the Medicare Program. This bill would require that those payments continue indefinitely to the extent permitted by federal law but only to the extent that federal financial participation is available. The bill would authorize the State Department of Health Care Services to implement those provisions through provider bulletins without taking regulatory action until regulations are adopted and would require the department to adopt those regulations by July 1, 2017.

SB 491 **(Hernandez D) Nurse practitioners.**
Summary: This bill would authorize a nurse practitioner to perform without physician supervision certain acts that nurse practitioners are authorized to practice in consultation with a physician under current law, if the nurse practitioner meets specified experience and certification requirements.

SB 780 **(Jackson D) Health care coverage.**
Summary: Would delete the requirements with regard to preferred provider organizations. The bill would change the timing of the 75-day filing to 45 days prior to the termination date for a contract between a health care service plan

that is not a health maintenance organization and a provider group or general acute care hospital, and would not prohibit the plan from sending the notice to the enrollees prior to the filing being reviewed and approved by the Department of Managed Health Care. The bill would distinguish between enrollees of an assigned group provider and enrollees of an unassigned group provider for purposes of whether the filing is required to be submitted to the department.

SB 932 **(Anderson R) General acute care hospitals: supplemental or special services.**
Summary: Current law provides for the licensure and regulation of health facilities, including general acute care hospitals, by the State Department of Public Health. Current law prohibits a general acute care hospital, as defined, from holding itself out as providing a service that requires a supplemental or special service unless the hospital has first obtained approval from the department to operate that service.

SB 959 **(Hernandez D) Health care coverage: small group and individual markets: single risk pool: index rate**
Summary: Affordable Care Act (ACA) requires that the index rate be adjusted based on Exchange user fees and expected payments and charges under certain risk adjustment and reinsurance programs. This bill would require that the index rate also be adjusted based on Exchange user fees, as specified under ACA. Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

SB 964 **(Hernandez D) Health care service plans: medical surveys.**
Summary: Would specify that plans providing services to Medi-Cal beneficiaries only are not exempt from the medical survey with respect to quality management, utilization review, timely access, network adequacy, and any other access and availability requirements.

SB 972 **(Torres D) California Health Benefit Exchange: board: membership.**
Summary: This bill would increase the number of board members from 5 to 7, with the 2 additional board members being appointed by the Governor. The bill would also add marketing of health insurance products, information technology system management, management information systems, and consumer service delivery research and best practices to the list of areas of expertise.

SB 974 **(Anderson R) California Health Benefit Exchange: confidentiality of personal information.**
Summary: Would prohibit the Exchange, or any of its employees, agents, subcontractors, representatives, or partners from disclosing an individual's

personal information, as defined, to any other person or entity without explicit permission from the individual. The bill would also require the Exchange to report a disclosure of personal information in violation of these provisions to the individuals affected and to the appropriate policy committees of the Legislature within 5 business days of the date the disclosure is discovered.

SB 986 **(Hernandez D) Medi-Cal: managed care: seniors and persons with disabilities.**
Summary: Would require the State Department of Health Care Services to ensure that the managed care health plans participating in the demonstration project provide timely access to out-of-network providers for new individual members and fully comply with the continuity of care requirements.

SB 1000 **(Monning D) Public health: sugar-sweetened beverages: safety warnings.**
Summary: Would establish the Sugar-Sweetened Beverage Safety Warning Act, which would prohibit a person from distributing, selling, or offering for sale a sugar-sweetened beverage in a sealed beverage container, or a multipack of sugar-sweetened beverages, in this state unless the beverage container or multipack bears a specified safety warning, as prescribed.

SB 1002 **(De León D) Medi-Cal: redetermination.**
Summary: Would require a county, when a redetermination is performed due to a change in circumstances, and the county received the information about the change in circumstance in a CalFresh application, or gathered the information about the change in circumstances during a CalFresh redetermination, and the beneficiary is determined eligible to receive CalFresh benefits, to begin the new 12-month eligibility period on a date that would align the beneficiary's Medi-Cal eligibility period with his or her household CalFresh certification period. The bill would also require the county, in certain circumstances, to begin a new 12-month Medi-Cal eligibility period that would align a beneficiary's eligibility period with his or her CalFresh household certification period.

SB 1005 **(Lara D) Health care coverage: immigration status.**
Summary: This bill would make the California Health Exchange Program inclusive to all Californians (regardless of immigration status) within state government and would require that by January 1, 2016, the enrollment into qualified health plans of individuals who are not eligible for full-scope Medi-Cal coverage and would have been eligible to purchase coverage through the Exchange if not for their immigration status. The bill would require the board to provide premium subsidies and cost-sharing reductions to eligible individuals that are the same as the premium assistance and cost-sharing reductions the individuals would have received through the Exchange.

HEALTH EDUCATION AND COMMUNITY OUTREACH UPDATE

Gold Coast Health Plan continues to participate in community education and outreach activities throughout the county. The health education and outreach team conducted the following activities during the months of January and February 2014.

GCHP Health Education and Outreach Department sponsored two events at the Oaks Mall in Thousand Oaks. Staff prepared an information table and was able to answer questions related to GCHP Medi-Cal Program and the Affordable Care Act. Staff continues to participate in school based outreach events, community health fairs, and in events sponsored by social service agencies. Staff is working with several school districts and Neighborhood for Learning (NfL) Centers throughout the county to increase awareness of the Medi-Cal Program benefits and locations to apply for Medi-Cal.

During the month February, GCHP partnered with several organizations to increase awareness about the Affordable Care Act and Medi-Cal Program benefits. On Saturday, February 8, 2014, staff participated in Healthy Heart Fair at The Collections Riverpark Mall in Oxnard.

Activities
Overall GCHP health education and outreach staff participated and / or will participate in 29 outreach activities and community network meetings throughout the county. Below is a list of events / activities:

Date	Event / Activities
01/03	La Hermandad – Food Distribution at Oxnard Police Activities League (PAL)
01/07	One Stop Community Multi-Service Program in Ventura
01/08	GCHP- Presentation at Oxnard Mexican Consulate
01/14	VCMC Baby Steps – OB Celebration at VCMC
01/15	West Park Community Center Food Distribution
01/17	Ventura County Office of Education Resource Fair “Taking it to the Teachers”
01/18	Community Informational Event at the Thousand Oaks Mall
01/21	Resource Fair at Fremont Intermediate School ELAC Parent Meeting
01/21	Resource Fair at Fremont Intermediate School ELAC Parent Meeting
01/21	GCHP- New Member Orientation Meeting (English)
01/22	GCHP- Presentation at Oxnard Mexican Consulate
01/23	GCHP- New Member Orientation Meeting (Spanish)
01/25	Jornadas Sabatina Resource Fair and Presentation at Oxnard Mexican Consulate
01/26	Jornadas Dominical Resource Fair at Oxnard Mexican Consulate
01/29	Agency 101 Resource Fair - Ventura County Children's System of Care
02/05	Covered California Forum at St. John’s Hospital (Spanish)
02/05	Ventura County Transition Project / VCOE – Transition Fairs
02/07	Sheridan Way Family Center – Women’s Health Breakfast
02/08	Community Informational Event at the Thousand Oaks Mall

02/08 Healthy Heart Fair at The Collection Riverpark
02/11 VCMC Baby Steps Program – OB Celebration
02/11 Ventura County Transition Project / VCOE – Transition Fairs
02/14 La Hermandad – Food Distribution at Oxnard Police Activities League (PAL)
02/18 GCHP- New Member Orientation Meeting (English)
02/19 West Park Community Center Food Distribution
02/20 GCHP Presentation at First 5 Ventura County – El Rio NFL
02/20 GCHP- New Member Orientation Meeting (Spanish)
02/24 GCHP Presentation at First 5 Ventura County – El Rio NFL
02/25 Ventura County Transition Project / VCOE – Transition Fairs

For additional information about upcoming health education and community outreach events, please refer to the GCHP Website at www.goldcoasthealthplan.org for date and time of events. If you have any additional questions, please send an email to Outreach@goldchp.org.

AGENDA ITEM 4b

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: March 24, 2014

Re: December 2013 and January 2014 Financials

SUMMARY

Staff is presenting the attached December, 2013 and January, 2014 financial statements of Gold Coast Health Plan (Plan) for approval by the Commission.

BACKGROUND / DISCUSSION

The Plan has prepared the December 2013 and January 2014 financial package, including balance sheets, income statements and statements of cash flows.

Note that the budget amounts reflect the updated FY 2013-14 budget approved by the Commission on 01/27/14.

FISCAL IMPACT

Year-To-Date Results

On a year-to-date basis, the Plan's net income is approximately $11.5 million compared to $9.8 million assumed in the budget. These operating results have contributed to a Tangible Net Equity (TNE) level of approximately $23.4 million, which exceeds both the budget of $21.7 million by $1.7 million and the State required TNE amount as of January 31, 2014 of $14.5 million (84% of $17.3 million) by $8.9 million.

Note that beginning with the month of December, the required TNE increased as the phased-in percentage was raised (i.e., required TNE phase-in percentage increased from 68% to 84%). The required TNE phase-in percentage will remain at 84% until June 30, 2014 when it will be increased to 100%. The Plan's TNE amount includes $7.2 million in lines of credit with the County of Ventura.

December & January Results

Other items to note for the monthly results are reflected below.

Membership

- The Plan's December membership was 120,275 which was lower than budget by 43 members.
- The Plan's January membership was 127,509 which was lower than budget by 926 members.

Revenue

Highlights of revenue for both months are summarized in the table below.

	December	January
Net Revenue	• $27.7 million or $0.4 million lower than budget of $28.1 million. • On a per member per month (PMPM) basis, net revenue was $230.35 PMPM or $3.63 PMPM less than the budget of $233.98 PMPM.	• $38.4 million or $4.7 million better than budget of $33.7 million. • On a PMPM basis, net revenue was $301.21 PMPM or $38.82 PMPM greater than the budget of $262.39 PMPM.
Drivers of Variances to Budget	• Long-Term Care revenues were approximately $0.21 million lower than budget due to negative retroactivity. • Enrollment mix resulted in additional revenue shortfalls of approximately $0.19 million.	• $5.2 million in ACA §1202 funds which were originally treated as a (non-revenue) pass-through item in the budget were included in the revenue for January. The reason to for the change to include these payments as revenue was based on additional information provided by the State. An offset in medical expense is explained below.
Additional Comments		• New Adult Expansion population (which included members transitioning from the County's Low Income Health Program) generated an additional $5.7 million in revenue. This revenue was included in the budget, but produces a large increase when compared with December's revenue. • Note revenue for expanded mental health benefits was not reflected in January.

Health Care Costs

Highlights for health care costs for both months are summarized below.

	December	January
Health Care Costs	• $23.5 million or approximately $1.0 million lower than budget. • On a PMPM basis, reported health care costs for December were $195.02 versus a budgeted amount of $203.66.	• $33.7 million or approximately $3.7 million higher than budget. • On PMPM basis, reported health care costs for January were $264.69 versus a budgeted amount of $233.98.
Drivers of Variances to Budget	▪ Net reinsurance recoveries and provider refunds reported of $1.8 million which were not included in the budget. ▪ Long Term Care (LTC)/Skilled Nursing Facility expenses were above budget by $0.95 million. It was noted that two of the Plan's larger LTC providers had an extremely high percentage of claims paid in December relating to prior months. This pattern caused an increase in the reserve and the resulting expense.	• Net reinsurance recoveries and provider refunds of $0.7 million account for a portion of the budget variance. • Pharmacy expense was lower than budget by $1.3 million, a result of the budgeted pharmacy component for the new Adult Expansion population (based on estimates provided by the State). Actual results revealed that the utilization for this group was much lower due to a ramp-up effect. • January LTC costs were also above budget by $0.93 million. Payments in this month included $0.57 million to an out-of-area facility for service dates of October through December 2013. • Physician ACA §1202 payments of $5.2 million were accrued as a medical expense to complement the revenue for this item. *
Additional Comments	▪ Pharmacy, while lower than budget by $0.27 million, was higher than the previous month by $0.18 million due to increased utilization heading into the winter illness season.	• Health care costs also included accrued expenses for the new Adult Expansion population. These medical expenses were estimated based on information contained in State rate packages. • Mental health costs were also accrued for the first time with the initiation of this expanded benefit. These medical expenses were estimated based on information contained in State rate packages.

* Note that as a temporary measure, the Plan has accrued the majority of the ACA §1202 payments received by the State as medical expense (the remaining small portion of these funds were set aside to pay for related MCO taxes). Future adjustments may be necessary after the Plan fully analyzes the State's reconciliation process with regards to ACA §1202 payments.

Administrative Expenses

- December 2013 - Overall administrative costs were approximately $2.0 million or $0.06 million better than budget. The main reason for the variance was that Consulting expense was $0.07 million lower than budget.
- January 2014 - Overall administrative costs were approximately $2.2 million or $0.03 million better than budget.

Cash + Medi-Cal Receivable - The total of Cash and Medi-Cal Premium Receivable balances of $98.0 million reported as of January 31, 2014 included a MCO Tax component amounting to $14.6 million. Excluding the impact of the tax, the total of Cash and Medi-Cal Receivable balance as of January 31, 2014 was $83.5 million, or $5.3 million better than the budgeted level of $78.2 million.

Note: the FY2012-13 Hospital Quality Assurance Fees (HQAF) funds received by the State in November were distributed to the hospitals in December.

Fixed Assets – During these months, the work continued at the Plan's new location at 711 East Daily Drive. The targeted move-in date is the first week of April. Capital expenditures for the new facility are expected to be $682,000 and were approved by the Commission in January 2014. The cost incurred through January is approximately $35,000.

Plan's new Medical Management System (MMS) was implemented in the month of December 2013. The projected cost of the MMS was $1.43 million and was approved by the Commission in June 2013 for the current fiscal year. Cost incurred for the project to-date is approximately $1.02 million.

RECOMMENDATION
Staff proposes that the Plan's Commission approve and accept both the December, 2013 and January, 2014 financial packages.

CONCURRENCE
N/A

Attachments
December, 2013 Financial Package
January, 2014 Financial Package

Gold Coast Health Plan℠
A Public Entity

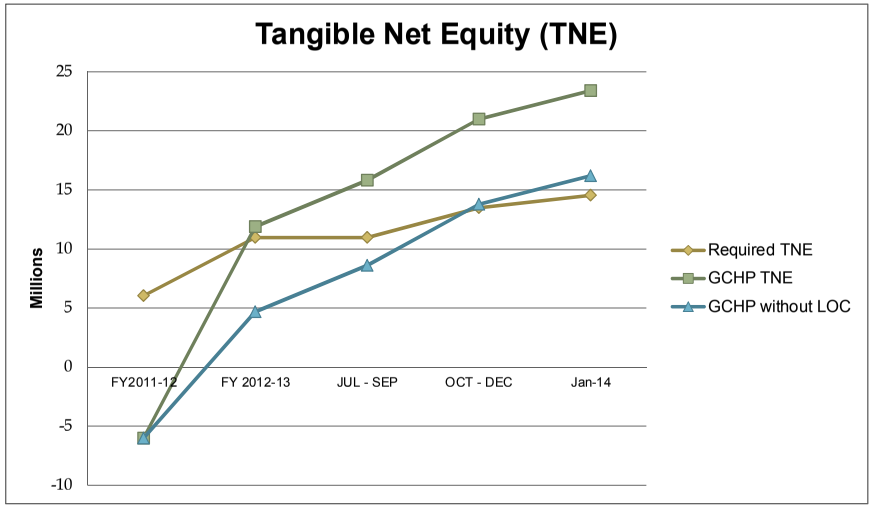
FINANCIAL PACKAGE
For the month ended January 31, 2014

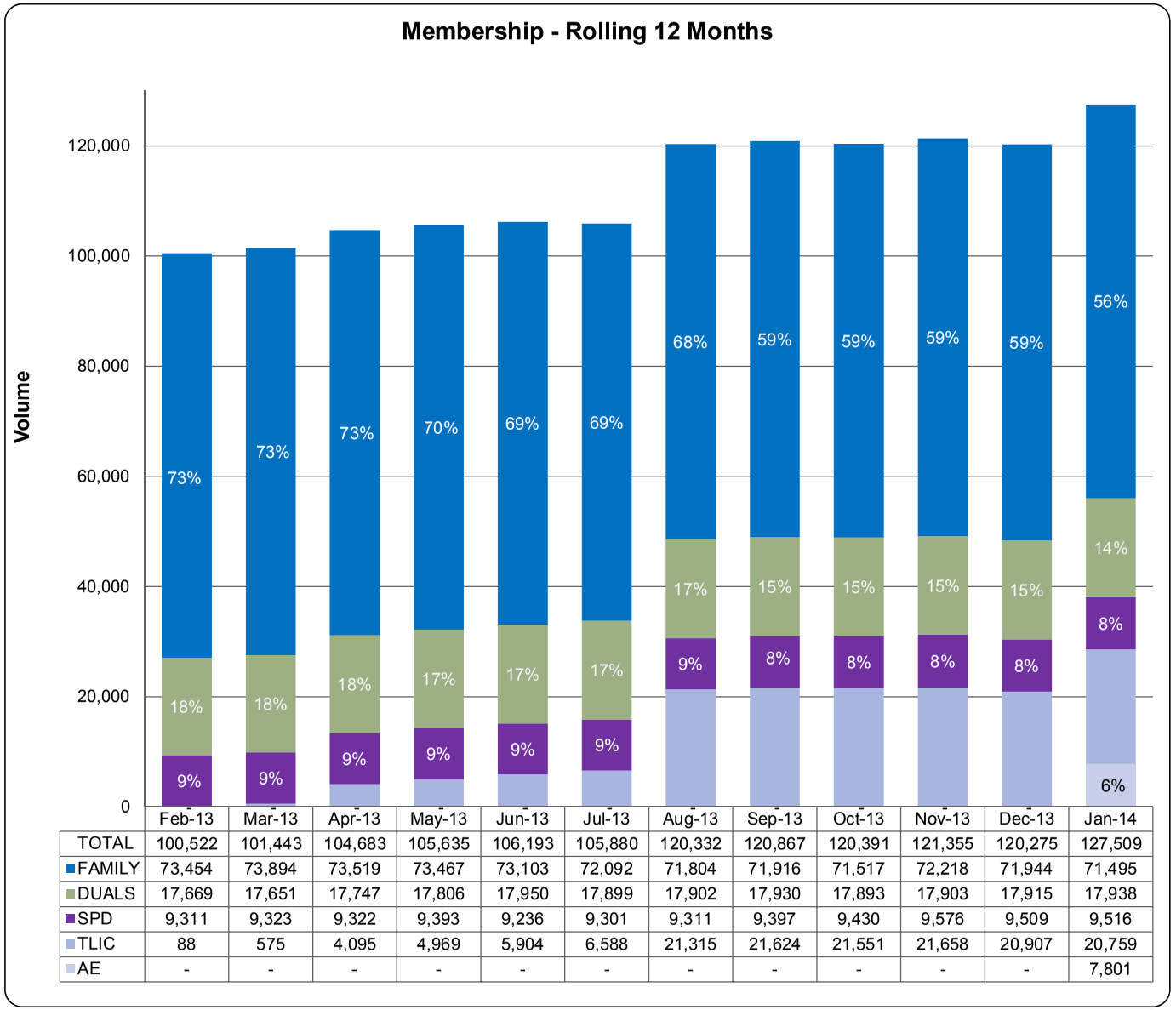
TABLE OF CONTENTS

Financial Overview

Description	AUDITED FY2011-12	AUDITED FY 2012-13	UNAUDITED FY 2013-14 Actual JUL - SEP	OCT - DEC	Jan-14	YTD	Budget Comparison Budget YTD	Variance Fav/(Unfav)	Variance Fav/(Unfav) %
Member Months	**1,258,189**	**1,223,895**	347,079	362,021	127,509	**836,609**	**837,581**	(972)	(0.1)%
Revenue	**304,635,932**	**315,119,611**	**81,988,709**	**84,070,456**	**38,407,105**	**204,466,270**	**200,206,676**	4,259,593	2.1 %
pmpm	*242.12*	*257.47*	*236.22*	*232.23*	*301.21*	*244.40*	*239.03*	5.37	2.2 %
Health Care Costs	**287,353,672**	**280,382,704**	**71,875,533**	**72,867,512**	**33,750,593**	**178,493,638**	**175,841,586**	(2,652,052)	(1.5)%
pmpm	*228.39*	*229.09*	*207.09*	*201.28*	*264.69*	*213.35*	*209.94*	(3.41)	(1.6)%
% of Revenue	94.3%	89.0%	87.7%	86.7%	87.9%	87.3%	87.8%	-0.5%	-0.6%
Admin Exp	**18,891,320**	**24,013,927**	**6,202,007**	**6,014,475**	**2,245,874**	**14,462,357**	**14,558,971**	96,614	0.7 %
pmpm	*15.01*	*19.62*	*17.87*	*16.61*	*17.61*	*17.29*	*17.38*	0.10	0.5 %
% of Revenue	6.2%	7.6%	7.6%	7.2%	5.8%	7.1%	7.3%	0.2%	2.7%
Net Income	**(1,609,063)**	**10,722,980**	**3,911,169**	**5,188,469**	**2,410,637**	**11,510,274**	**9,806,119**	1,704,155	17.4 %
pmpm	*(1.28)*	*8.76*	*11.27*	*14.33*	*18.91*	*13.76*	*11.71*	2.05	17.5 %
% of Revenue	-0.5%	3.4%	4.8%	6.2%	6.3%	5.6%	4.9%	0.7%	14.9%
100% TNE	16,769,368	16,138,440	16,112,437	16,056,217	17,306,044	17,306,044	16,563,298	742,746	4.5 %
% TNE Required	36%	68%	68%	84%	84%	84%	84%		
Required TNE	6,036,972	10,974,139	10,956,457	13,487,223	14,537,077	14,537,077	13,913,170	623,907	4.5 %
GCHP TNE	**(6,031,881)**	**11,891,099**	**15,802,268**	**20,990,738**	**23,401,375**	**23,401,375**	**21,697,219**	**1,704,156**	**7.9 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**4,845,810**	**7,503,516**	**8,864,298**	**8,864,298**	**7,784,049**	**1,080,249**	**13.9 %**

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





	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
TOTAL	100,522	101,443	104,683	105,635	106,193	105,880	120,332	120,867	120,391	121,355	120,275	127,509
FAMILY	73,454	73,894	73,519	73,467	73,103	72,092	71,804	71,916	71,517	72,218	71,944	71,495
DUALS	17,669	17,651	17,747	17,806	17,950	17,899	17,902	17,930	17,893	17,903	17,915	17,938
SPD	9,311	9,323	9,322	9,393	9,236	9,301	9,311	9,397	9,430	9,576	9,509	9,516
TLIC	88	575	4,095	4,969	5,904	6,588	21,315	21,624	21,551	21,658	20,907	20,759
AE	-	-	-	-	-	-	-	-	-	-	-	7,801

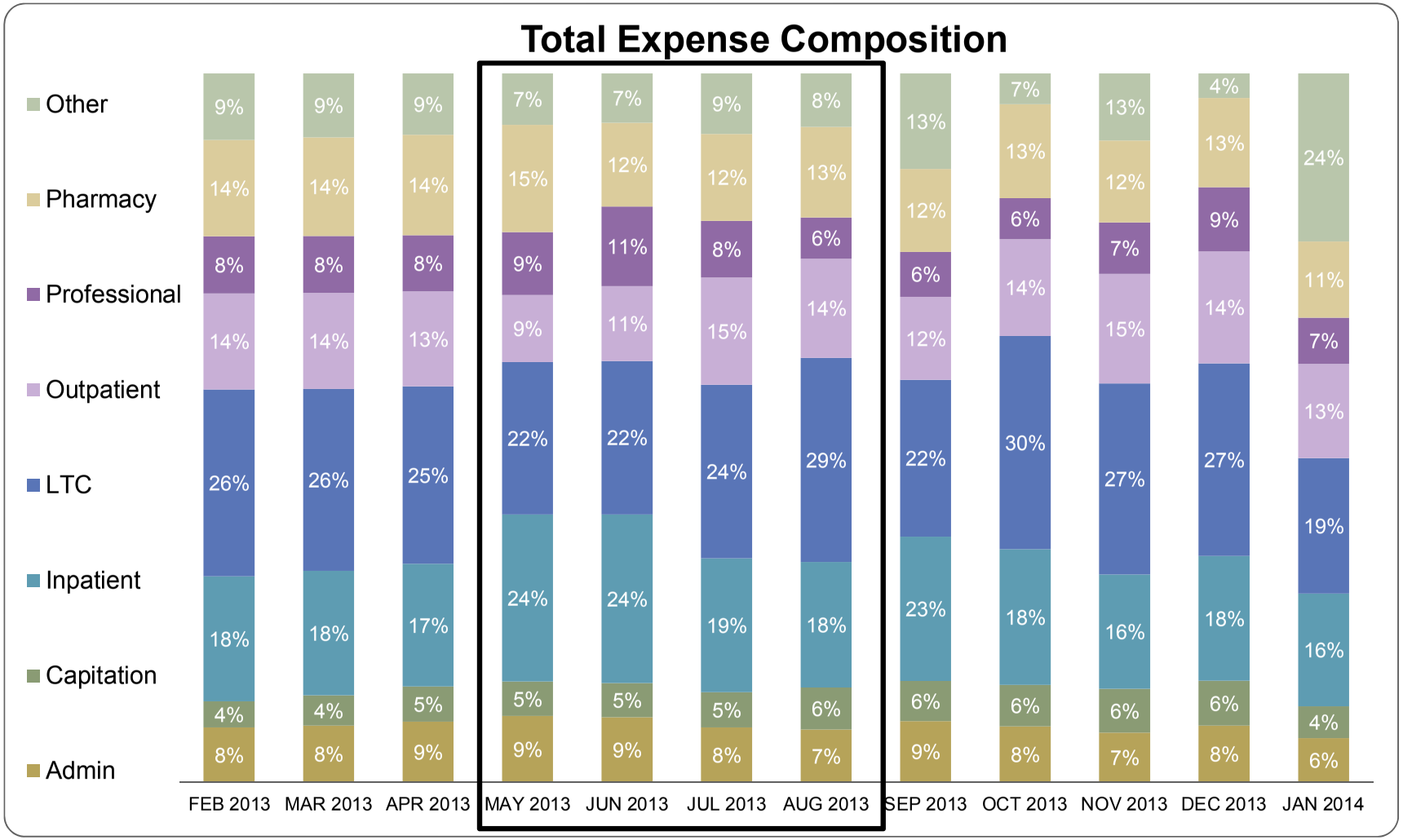
SPD = Seniors and Persons with Disabilities
TLIC = Targeted Low Income Children

Income Statement Monthly Trend

	2014 Actual Monthly Trend				Current Month		
	SEP 2013	OCT 2013	NOV 2013	DEC 2013	JAN 2014 Actual	JAN 2014 Budget	Variance Fav/(Unfav)
Membership (includes retro members)	120,867	120,391	121,355	120,275	127,509	128,435	(926)
Revenue:							
Premium	$ 29,602,003	$ 29,980,945	$ 29,108,732	$ 29,047,006	$ 40,250,143	$ 35,297,957	$ 4,952,186
Reserve for Rate Reduction	-	(278,508)	(282,654)	(281,754)	(425,684)	(257,319)	(168,364)
MCO Premium Tax	(1,068,828)	(1,149,386)	(1,114,454)	(1,110,666)	(1,467,377)	(1,389,857)	(77,519)
Total Net Premium	**28,533,175**	**28,553,050**	**27,711,624**	**27,654,585**	**38,357,083**	**33,650,781**	**4,706,303**
Other Revenue:							
Interest Income	11,819	15,509	8,658	12,031	11,688	10,942	746
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	38,333	-
Total Other Revenue	50,152	53,842	46,991	50,364	50,021	49,276	746
Total Revenue	**28,583,327**	**28,606,892**	**27,758,615**	**27,704,949**	**38,407,105**	**33,700,056**	**4,707,048**
Medical Expenses:							
Capitation (PCP, Specialty, NEMT & Visio	1,533,277	1,597,311	1,616,715	1,610,161	1,609,561	1,650,055	40,494
FFS Claims Expenses:							
Inpatient	5,531,725	5,200,045	4,229,618	4,491,812	5,733,670	6,326,311	592,642
LTC/SNF	6,003,374	8,189,391	7,051,854	6,923,947	6,871,300	5,940,293	(931,007)
Outpatient	2,281,073	2,762,602	3,112,769	3,189,204	3,582,927	3,157,336	(425,591)
Laboratory and Radiology	96,573	101,182	149,563	111,157	352,687	378,305	25,618
Physician ACA 1202	**-**	**-**	**-**	**-**	***5,167,335***	**-**	***(5,167,335)***
Emergency Room	803,936	847,968	788,033	729,901	850,311	869,041	18,730
Physician Specialty	1,725,887	1,575,483	1,903,339	2,305,009	2,353,215	2,504,938	151,723
Mental Health Services	-	-	-	-	225,017	191,722	(33,295)
Pharmacy	3,172,116	3,599,699	3,026,831	3,210,998	3,863,088	5,173,254	1,310,166
Incentives - P4P			-				-
Other Medical Professional	249,684	25,851	153,013	149,068	141,578	153,634	12,056
Other Medical Care	1,621	-	-	3,608	(1,935)	-	1,935
Other Fee For Service	2,100,151	1,998,727	1,800,032	1,645,707	2,634,006	2,579,370	(54,636)
Transportation	178,553	73,220	88,442	67,551	86,625	83,656	(2,969)
Total Claims	22,144,693	24,374,168	22,303,494	22,827,961	31,859,823	27,357,861	(4,501,963)
Medical & Care Management Expense	746,163	738,701	722,455	830,780	824,092	846,533	22,441
Reinsurance	277,448	(1,222,910)	277,386	(1,553,135)	(395,380)	196,506	591,886
Claims Recoveries	104,688	(432,352)	(564,043)	(259,182)	(147,503)	-	147,503
Sub-total	1,128,300	(916,560)	435,798	(981,537)	281,209	1,043,039	761,830
Total Cost of Health Care	**24,806,270**	**25,054,919**	**24,356,007**	**23,456,586**	**33,750,593**	**30,050,954**	**(3,699,640)**
Contribution Margin	**3,777,057**	**3,551,973**	**3,402,608**	**4,248,363**	**4,656,511**	**3,649,102**	**1,007,409**
General & Administrative Expenses:							
Salaries and Wages	453,818	497,163	575,414	592,047	596,197	611,397	15,200
Payroll Taxes and Benefits	114,103	119,840	124,386	151,109	187,611	142,307	(45,304)
Travel and Training	10,686	13,879	10,975	4,315	4,276	17,535	13,260
Outside Service - ACS	1,190,847	958,836	912,065	940,933	968,191	975,095	6,903
Outside Services - Other	33,271	24,974	757	19,158	79,142	79,569	427
Accounting & Actuarial Services	46,568	70,000	(71,621)	12,500	56,250	13,333	(42,917)
Legal	54,932	45,876	67,706	88,066	114,004	36,340	(77,664)
Insurance	12,517	12,057	13,138	13,265	9,615	10,792	1,177
Lease Expense - Office	28,480	22,503	28,480	25,980	28,480	28,480	-
Consulting Services	264,998	118,908	(17,517)	42,604	46,831	82,978	36,146
Translation Services	2,778	4,225	1,638	3,602	8,387	2,417	(5,970)
Advertising and Promotion	-	-	3,985	1,883	-	27,431	27,431
General Office	77,654	100,062	98,180	115,766	96,638	108,331	11,693
Depreciation & Amortization	6,492	7,015	7,015	7,015	7,015	9,541	2,526
Printing	5,605	26,510	20,347	2,022	10,344	64,688	54,344
Shipping & Postage	1,016	11,395	13,389	562	14,021	58,405	44,384
Interest	37,708	107,768	45,473	18,828	18,873	10,118	(8,755)
Total G & A Expenses	**2,341,473**	**2,141,010**	**1,833,810**	**2,039,656**	**2,245,874**	**2,278,758**	**32,883**
Net Income / (Loss)	**$ 1,435,584**	**$ 1,410,963**	**$ 1,568,798**	**$ 2,208,708**	**$ 2,410,637**	**$ 1,370,345**	**$ 1,040,292**

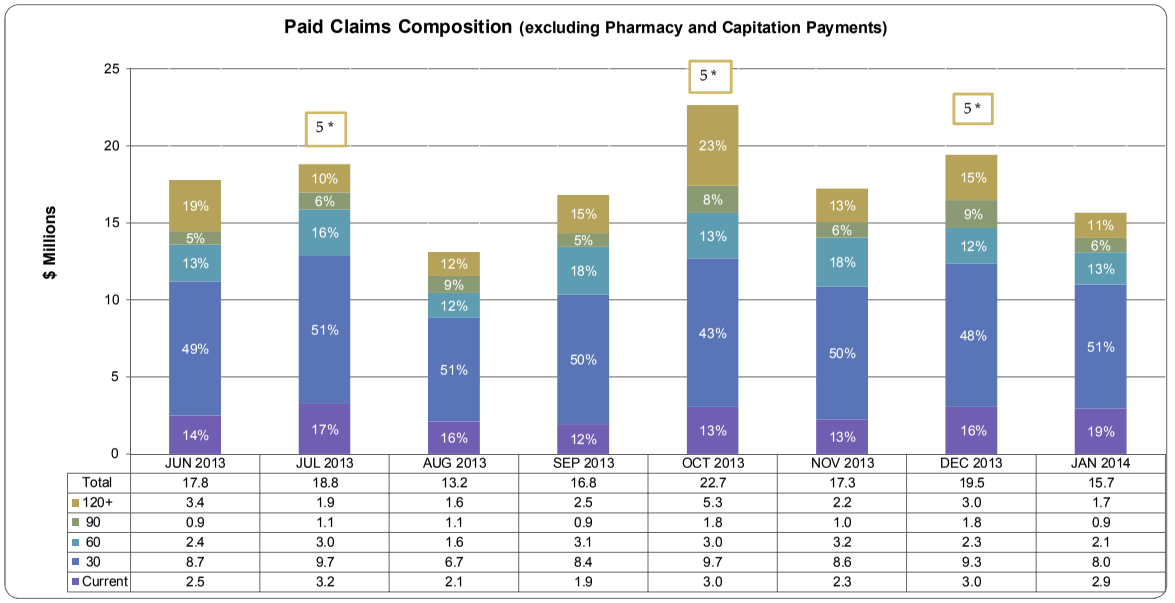
PMPM Income Statement Comparison

	2014 Actual Monthly Trend				Jan '14 Month-To-Date		Variance
	SEP 2013	OCT 2013	NOV 2013	DEC 2013	Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	120,867	120,391	121,355	120,275	127,509	128,435	(926)
Revenue:							
Premium	244.91	249.03	239.86	241.50	315.67	274.83	40.83
Reserve for Rate Reduction	-	(2.31)	(2.33)	(2.34)	(3.34)	(2.00)	(1.33)
MCO Premium Tax	(8.84)	(9.55)	(9.18)	(9.23)	(11.51)	(10.82)	(0.69)
Total Net Premium	**236.07**	**237.17**	**228.35**	**229.93**	**300.82**	**262.01**	**38.81**
Other Revenue:							
Interest Income	0.10	0.13	0.07	0.10	0.09	0.09	0.01
Miscellaneous Income	0.32	0.32	0.32	0.32	0.30	0.30	0.00
Total Other Revenue	**0.41**	**0.45**	**0.39**	**0.42**	**0.39**	**0.49**	**(0.09)**
Total Revenue	**236.49**	**237.62**	**228.74**	**230.35**	**301.21**	**262.39**	**38.82**
Medical Expenses:							
Capitation (PCP, Specialty, NEMT & Visio	12.69	13.27	13.32	13.39	12.62	12.85	(0.22)
FFS Claims Expenses:							
Inpatient	45.77	43.19	34.85	37.35	44.97	49.26	4.29
LTC/SNF	49.67	68.02	58.11	57.57	53.89	46.25	(7.64)
Outpatient	18.87	22.95	25.65	26.52	28.10	24.58	(3.52)
Laboratory and Radiology	0.80	0.84	1.23	0.92	2.77	2.95	0.18
Physician ACA 1202	-	-	-	-	40.53	-	(40.53)
Emergency Room	6.65	7.04	6.49	6.07	6.67	6.77	0.10
Physician Specialty	14.28	13.09	15.68	19.16	18.46	19.50	1.05
Mental Health Services	-				1.76	-	(1.76)
Pharmacy	26.24	29.90	24.94	26.70	30.30	40.28	9.98
Other Medical Professional	2.07	0.21	1.26	1.24	1.11	1.20	0.09
Other Medical Care	0.01	-	-	0.03	(0.02)	-	0.02
Other Fee For Service	17.38	16.60	14.83	13.68	20.66	20.08	(0.57)
Transportation	1.48	0.61	0.73	0.56	0.68	0.65	(0.03)
Total Claims	183.22	202.46	183.79	189.80	249.86	213.01	(36.85)
Medical & Care Management Expense	6.17	6.14	5.95	6.91	6.46	6.59	0.13
Reinsurance	2.30	(10.16)	2.29	(12.91)	(3.10)	1.53	4.63
Claims Recoveries	0.87	(3.59)	(4.65)	(2.15)	(1.16)	-	1.16
Sub-total	9.34	(7.61)	3.59	(8.16)	2.21	8.12	5.92
Total Cost of Health Care	205.24	208.11	200.70	195.02	264.69	233.98	(30.71)
Contribution Margin	31.25	29.50	28.04	35.32	36.52	**28.41**	**8.11**
General & Administrative Expenses:							
Salaries and Wages	3.75	4.13	4.74	4.92	4.68	4.76	0.08
Payroll Taxes and Benefits	0.94	1.00	1.02	1.26	1.47	1.11	(0.36)
Travel and Training	0.09	0.12	0.09	0.04	0.03	0.14	0.10
Outside Service - ACS	9.85	7.96	7.52	7.82	7.59	7.59	(0.00)
Outside Services - Other	0.28	0.21	0.01	0.16	0.62	0.62	(0.00)
Accounting & Actuarial Services	0.39	0.58	(0.59)	0.10	0.44	0.10	(0.34)
Legal	0.45	0.38	0.56	0.73	0.89	0.28	(0.61)
Insurance	0.10	0.10	0.11	0.11	0.08	0.08	0.01
Lease Expense - Office	0.24	0.19	0.23	0.22	0.22	0.22	(0.00)
Consulting Services	2.19	0.99	(0.14)	0.35	0.37	0.65	0.28
Translation Services	0.02	0.04	0.01	0.03	0.07	0.02	(0.05)
Advertising and Promotion	-	-	0.03	0.02	-	0.21	0.21
General Office	0.64	0.83	0.81	0.96	0.76	0.84	0.09
Depreciation & Amortization	0.05	0.06	0.06	0.06	0.06	0.07	0.02
Printing	0.05	0.22	0.17	0.02	0.08	0.50	0.42
Shipping & Postage	0.01	0.09	0.11	0.00	0.11	0.45	0.34
Interest	0.31	0.90	0.37	0.16	0.15	0.08	(0.07)
Total G & A Expenses	**19.37**	**17.78**	**15.11**	**16.96**	**17.61**	**17.74**	**0.13**
Net Income / (Loss)	**11.88**	**11.72**	**12.93**	**18.36**	**18.91**	**10.67**	**8.24**



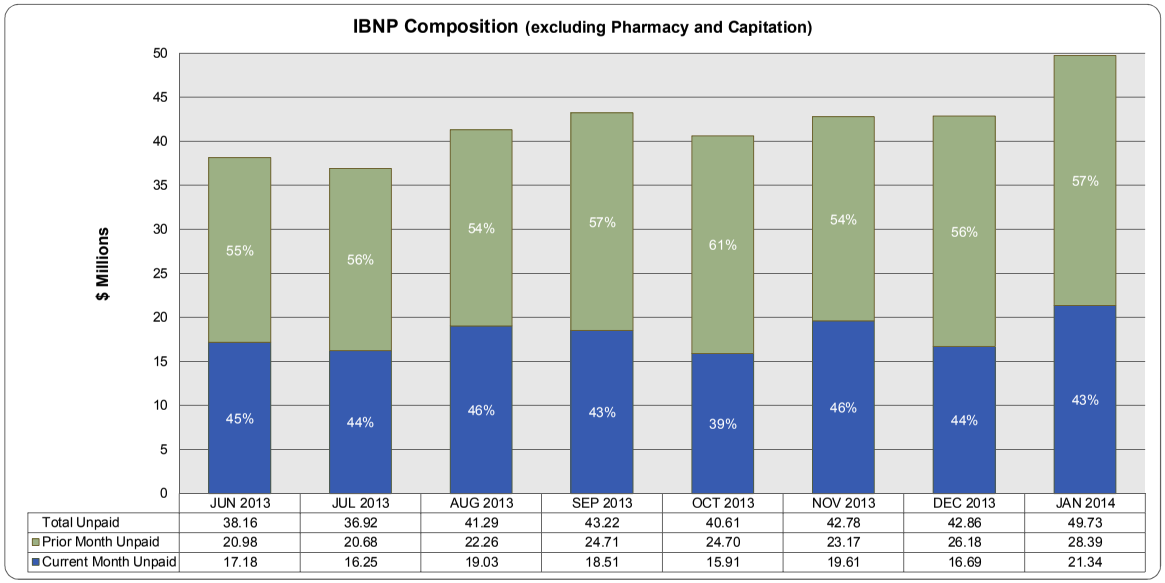
In May 2013, GCHP changed its method of distributing Health Care Costs (HCC) across categories of service. Prior months utilized an allocation methodology. The methodology was updated to utilize payment information by different categories of services. Further changes have been made with the assumption of the TLIC population and its affect on various categories of service. Therefore, the months of May - August represent the transitioning to a new methodology.

Beginning January 2014, "Other" category includes ACA 1202 physician supplement and mental health expenses.



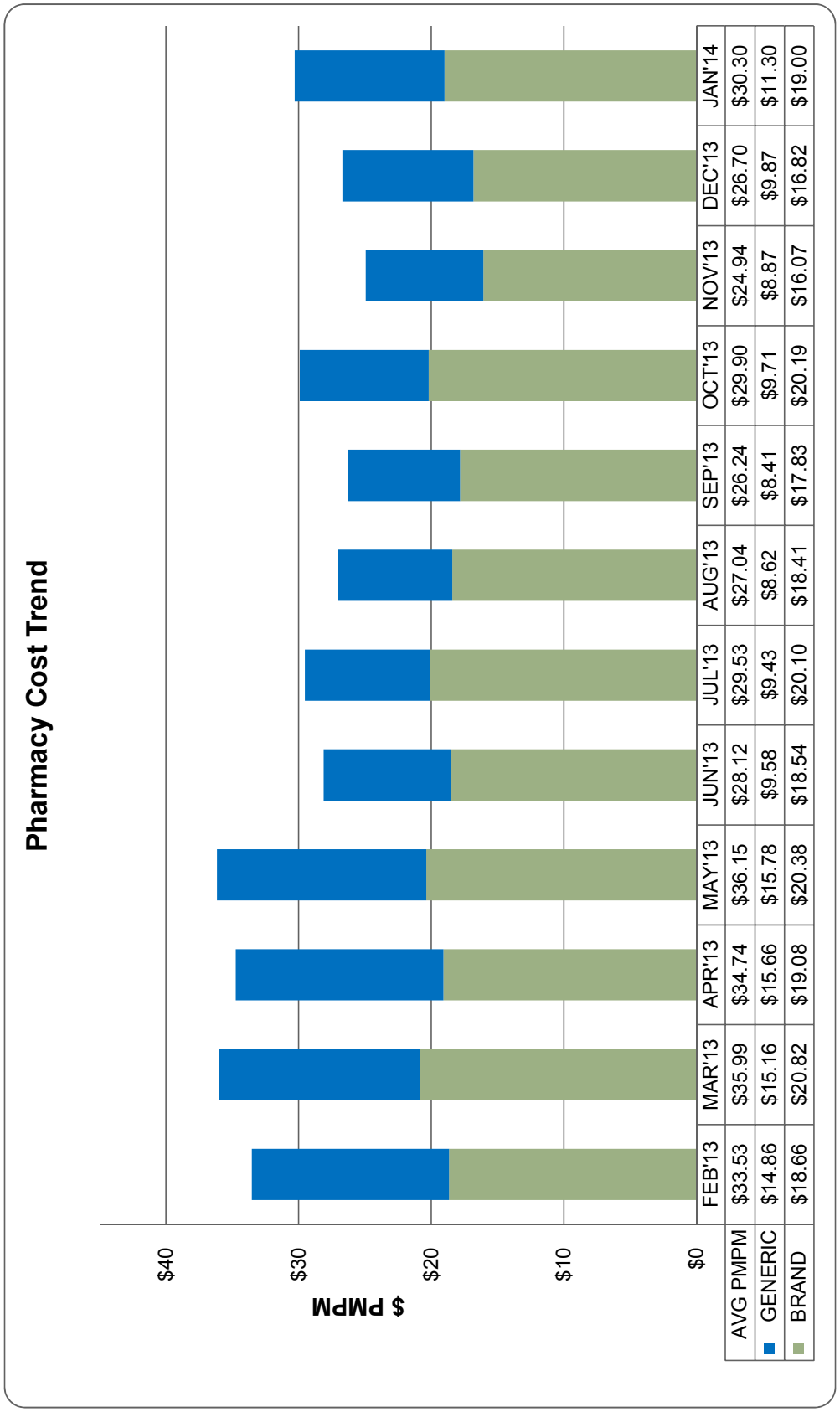
	JUN 2013	JUL 2013	AUG 2013	SEP 2013	OCT 2013	NOV 2013	DEC 2013	JAN 2014
Total	17.8	18.8	13.2	16.8	22.7	17.3	19.5	15.7
120+	3.4	1.9	1.6	2.5	5.3	2.2	3.0	1.7
90	0.9	1.1	1.1	0.9	1.8	1.0	1.8	0.9
60	2.4	3.0	1.6	3.1	3.0	3.2	2.3	2.1
30	8.7	9.7	6.7	8.4	9.7	8.6	9.3	8.0
Current	2.5	3.2	2.1	1.9	3.0	2.3	3.0	2.9

Note: **Paid Claims Composition** - reflects adjusted medical claims payment lag schedule.
* Months Indicated with 5* represent months for which there were 5 claim payments. For all other months, 4 claim payments were made.

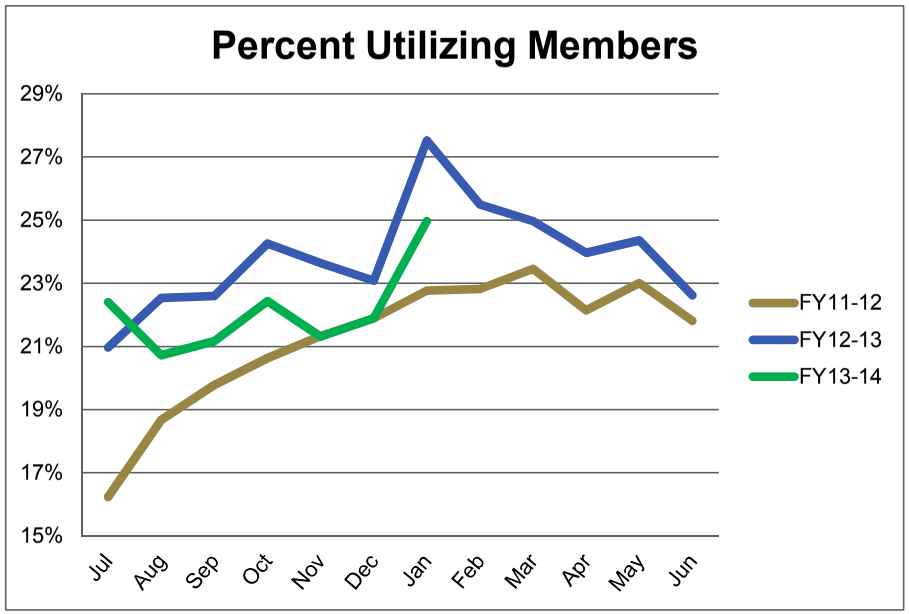


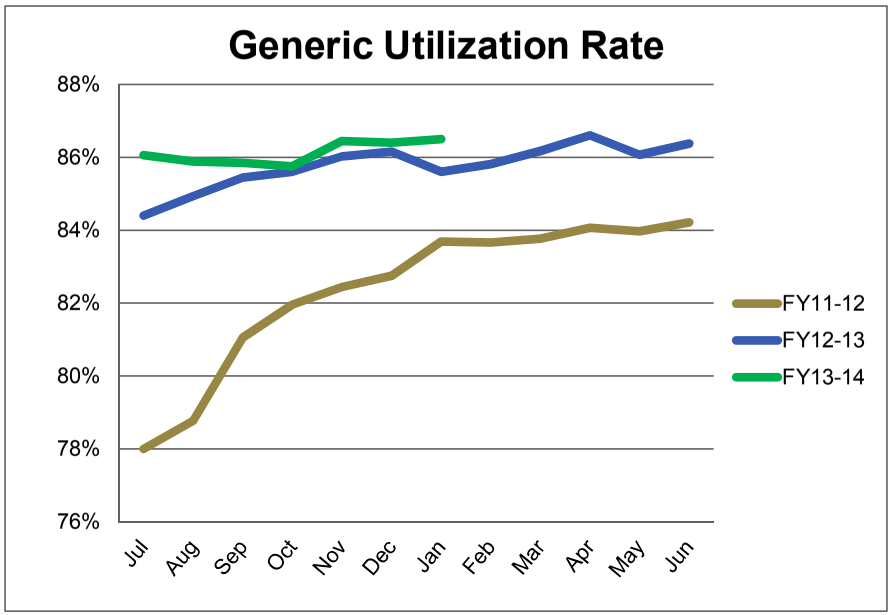
	JUN 2013	JUL 2013	AUG 2013	SEP 2013	OCT 2013	NOV 2013	DEC 2013	JAN 2014
Total Unpaid	38.16	36.92	41.29	43.22	40.61	42.78	42.86	49.73
Prior Month Unpaid	20.98	20.68	22.26	24.71	24.70	23.17	26.18	28.39
Current Month Unpaid	17.18	16.25	19.03	18.51	15.91	19.61	16.69	21.34

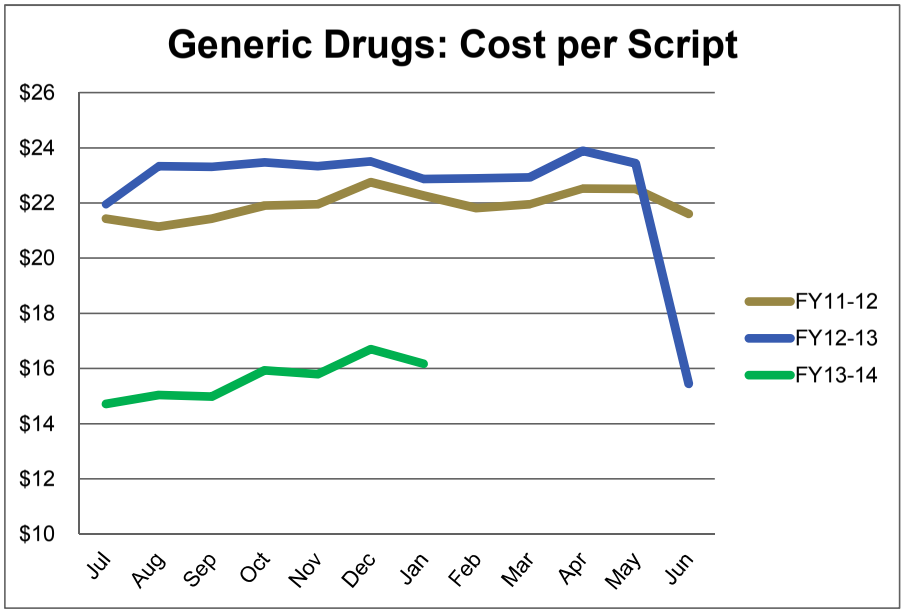
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

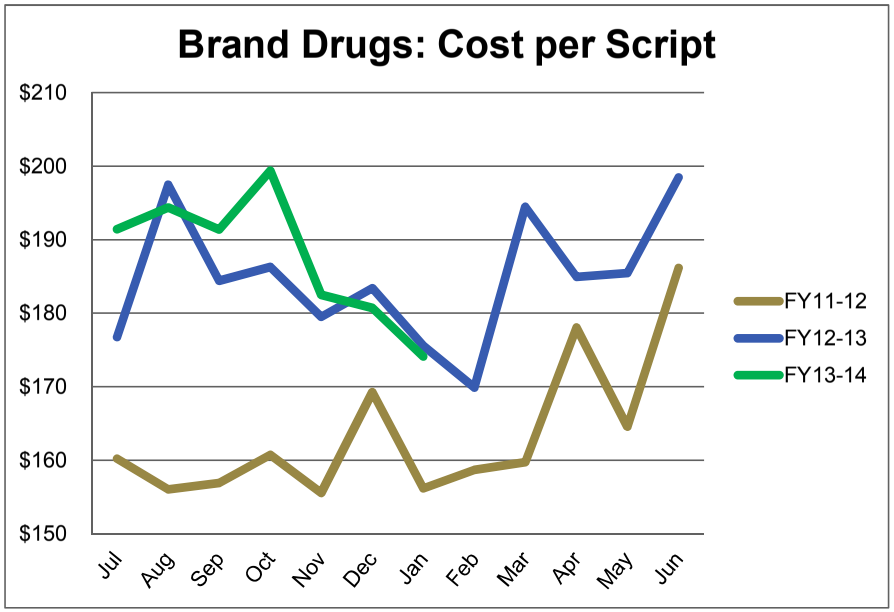


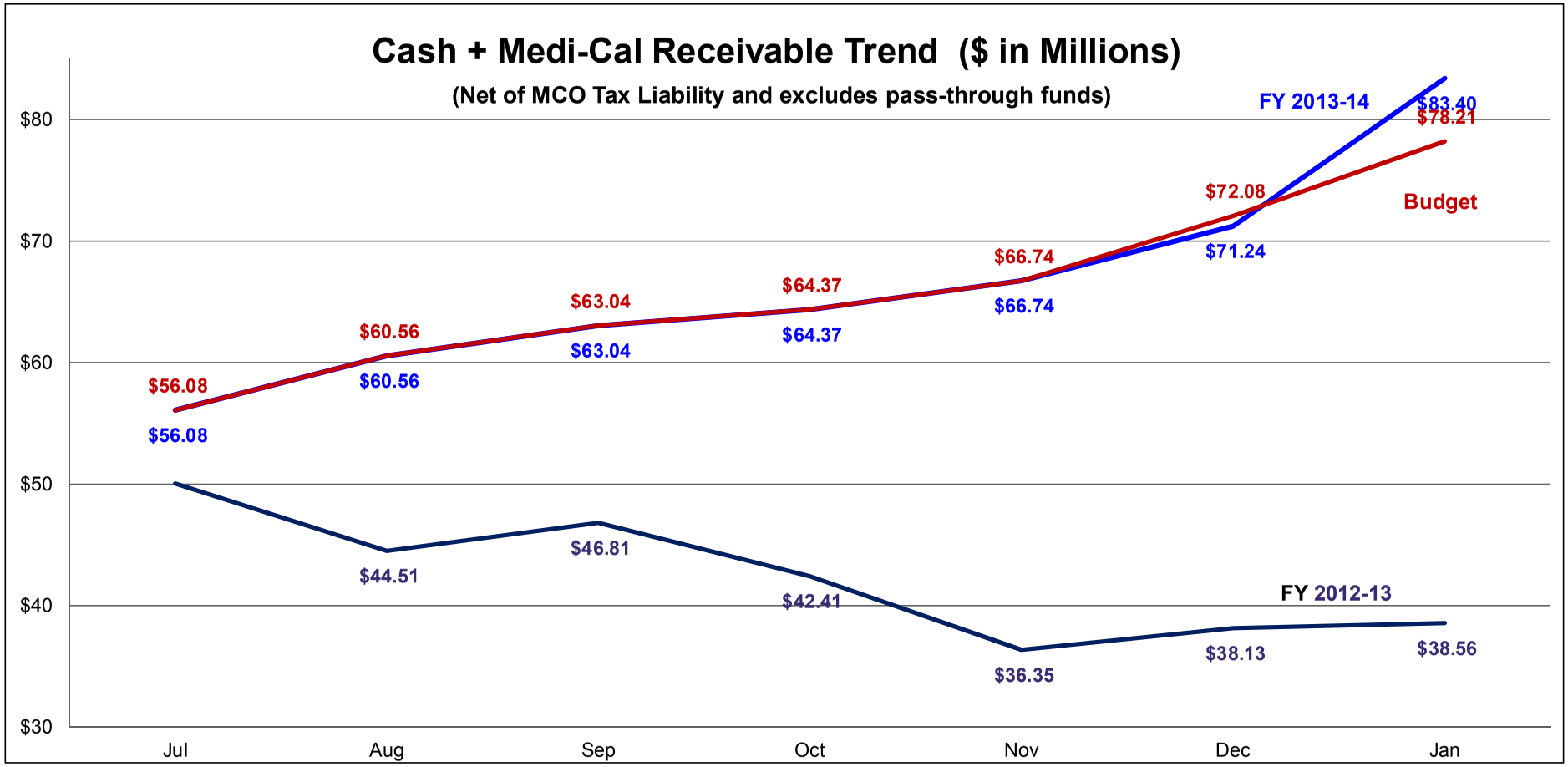
AVG PMPM	FEB'13	MAR'13	APR'13	MAY'13	JUN'13	JUL'13	AUG'13	SEP'13	OCT'13	NOV'13	DEC'13	JAN'14
GENERIC	$33.53	$35.99	$34.74	$36.15	$28.12	$29.53	$27.04	$26.24	$29.90	$24.94	$26.70	$30.30
BRAND	$14.86	$15.16	$15.66	$15.78	$9.58	$9.43	$8.62	$8.41	$9.71	$8.87	$9.87	$11.30
	$18.66	$20.82	$19.08	$20.38	$18.54	$20.10	$18.41	$17.83	$20.19	$16.07	$16.82	$19.00


Percent Utilizing Members
29%
27%
25%
23%
21%
19%
17%
15%
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY11-12
FY12-13
FY13-14


Generic Utilization Rate
88%
86%
84%
82%
80%
78%
76%
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY11-12
FY12-13
FY13-14


Generic Drugs: Cost per Script
$26
$24
$22
$20
$18
$16
$14
$12
$10
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY11-12
FY12-13
FY13-14


Brand Drugs: Cost per Script
$210
$200
$190
$180
$170
$160
$150
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY11-12
FY12-13
FY13-14


Cash + Medi-Cal Receivable Trend ($ in Millions)
(Net of MCO Tax Liability and excludes pass-through funds)
$80
$70
$60
$50
$40
$30
Jul
Aug
Sep
Oct
Nov
Dec
Jan
FY 2013-14
$83.40
$78.21
Budget
$72.08
$71.24
$66.74
$66.74
$64.37
$64.37
$63.04
$63.04
$60.56
$60.56
$56.08
$56.08
FY 2012-13
$46.81
$44.51
$42.41
$36.35
$38.13
$38.56

Gold Coast Health Plan℠
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APPENDIX

- Comparative Balance Sheet
- YTD Income Statement
- Monthly Statement of Cash Flows

Comparative Balance Sheet

	1/31/14	12/31/13	Audited FY 2012-13
ASSETS			
Current Assets			
Total Cash and Cash Equivalents	**$ 44,343,991**	**$ 41,943,461**	**$ 50,817,760**
Medi-Cal Receivable	53,691,874	42,410,897	11,683,076
Provider Receivable	440,215	800,343	1,161,379
Other Receivables	176,385	197,606	300,397
Total Accounts Receivable	**54,308,474**	**43,408,847**	**13,144,852**
Total Prepaid Accounts	763,854	492,191	324,419
Total Other Current Assets	128,805	97,899	10,000
Total Current Assets	**99,545,124**	**85,942,398**	**64,297,030**
Total Fixed Assets	**1,204,575**	**1,177,698**	**230,913**
Total Assets	**$ 100,749,699**	**$ 87,120,096**	**$ 64,527,943**
LIABILITIES & FUND BALANCE			
Current Liabilities			
Incurred But Not Reported	$ 45,833,232	$ 41,275,305	$ 29,901,103
Claims Payable	6,198,541	5,313,850	9,748,676
Capitation Payable	1,320,783	1,315,435	1,002,623
Physician ACA 1202 Payable	5,167,335	-	-
Accrued Premium Reduction	1,268,600	842,917	-
Accounts Payable	147,810	1,406,476	1,751,419
Accrued ACS	65,860	325,466	422,138
Accrued Expenses	1,056,784	745,724	477,477
Accrued Premium Tax	14,585,532	13,118,155	7,337,759
Accrued Interest Payable	30,714	27,670	9,712
Current Portion of Deferred Revenue	460,000	460,000	460,000
Accrued Payroll Expense	561,468	608,361	605,937
Total Current Liabilities	**76,696,658**	**65,439,358**	**$ 51,716,843**
Long-Term Liabilities			
Deferred Revenue - Long Term Portion	651,667	690,000	920,000
Notes Payable	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	**7,851,667**	**7,890,000**	**8,120,000**
Total Liabilities	**84,548,325**	**73,329,358**	**59,836,843**
Beginning Fund Balance	4,691,101	4,691,101	(6,031,881)
Net Income Current Year	11,510,274	9,099,638	10,722,981
Total Fund Balance	**16,201,375**	**13,790,738**	**4,691,100**
Total Liabilities & Fund Balance	**$ 100,749,699**	**$ 87,120,096**	**$ 64,527,943**

FINANCIAL INDICATORS			
Current Ratio	1.3 : 1	1.31 : 1	1.24 : 1
Days Cash on Hand	37	49	58
Days Cash + State Capitation Receivable	82	99	72
Days Cash + State Capitation Rec (less Tax Liab)	70	84	63

Income Statement
For The Seven Months Ended January 31, 2014

	Jan '14 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	836,609	837,581	(972)
Revenue:			
Premium	$ 213,464,671	$ 208,991,934	$ 4,472,737
Reserve for Rate Reduction	(1,268,600)	(1,077,119)	(191,481)
MCO Premium Tax	(8,074,338)	(8,048,757)	(25,582)
Total Net Premium	**204,121,733**	**199,866,058**	**4,255,675**
Other Revenue:			
Interest Income	76,203	72,285	3,919
Miscellaneous Income	268,333	268,333	-
Total Other Revenue	344,537	**340,618**	3,919
Total Revenue	**204,466,270**	**200,206,676**	**4,259,593**
Medical Expenses:			
Capitation (PCP, Specialty, NEMT & Vision)	10,744,434	10,800,644	56,210
FFS Claims Expenses:			
Inpatient	34,506,748	35,447,760	941,013
LTC/SNF	48,611,850	46,728,204	(1,883,646)
Outpatient	20,766,892	19,978,627	(788,265)
Laboratory and Radiology	1,146,993	1,242,494	95,502
Physician ACA 1202	5,167,335	-	(5,167,335)
Emergency Room	5,262,954	5,183,704	(79,250)
Physician Specialty	13,376,059	13,514,457	138,398
Mental Health Services	225,017	191,722	(33,295)
Pharmacy	23,253,147	24,830,163	1,577,016
Other Medical Professional	1,007,298	979,024	(28,274)
Other Medical Care	3,293	-	(3,293)
Other Fee For Service	12,552,106	12,378,501	(173,605)
Transportation	569,919	575,817	5,898
Total Claims	166,449,610	161,050,475	(5,399,135)
Medical & Care Management Expense	5,335,285	5,290,366	(44,920)
Reinsurance	(2,097,962)	(1,299,899)	798,063
Claims Recoveries	(1,937,729)	-	1,937,729
Sub-total	1,299,594	3,990,466	2,690,873
Total Cost of Health Care	**178,493,638**	**175,841,586**	**(2,652,052)**
Contribution Margin	**25,972,631**	**24,365,091**	**1,607,541**
General & Administrative Expenses:			
Salaries and Wages	3,698,108	3,698,301	193
Payroll Taxes and Benefits	932,464	871,165	(61,299)
Travel and Training	53,601	91,439	37,838
Outside Service - ACS	6,703,660	6,686,698	(16,962)
Outside Services - Other	223,686	224,975	1,289
Accounting & Actuarial Services	177,863	143,279	(34,583)
Legal	454,976	325,587	(129,389)
Insurance	82,401	81,105	(1,296)
Lease Expense - Office	188,383	190,883	2,500
Consulting Services	829,601	932,508	102,908
Translation Services	28,298	21,142	(7,155)
Advertising and Promotion	24,069	77,047	52,979
General Office	640,050	672,110	32,060
Depreciation & Amortization	45,023	50,075	5,052
Printing	68,873	135,211	66,337
Shipping & Postage	40,643	104,867	64,224
Interest	270,660	252,579	(18,081)
Total G & A Expenses	**14,462,357**	**14,558,971**	**96,614**
Net Income / (Loss)	**$ 11,510,274**	**$ 9,806,119**	**$ 1,704,155**

Statement of Cash Flows - Monthly

	JAN '14	DEC '13	NOV '13	OCT '13	JUN'13
Cash Flow From Operating Activities					
Collected Premium	$ 28,969,167	$ 28,079,945	$ 27,862,839	$ 28,237,305	$ 52,138,834
Miscellaneous Income	11,688	12,031	8,658	15,509	8,594
State Pass Through Funds	50,070		5,691,714	28,672,901	34,346,474
			-		
Paid Claims			-		
Medical & Hospital Expenses	(15,055,874)	(17,202,587)	(17,387,071)	(20,891,230)	(17,277,826)
Pharmacy	(5,426,411)	(1,690,164)	(3,787,143)	(3,504,662)	(4,009,168)
Capitation	(1,685,367)	(1,625,829)	(1,521,485)	(1,553,107)	(1,162,302)
Reinsurance of Claims	(278,035)	(278,975)	(277,386)	(281,113)	(240,430)
State Pass Through Funds Distributed		(5,691,714)	-	(28,672,901)	(34,346,474)
Paid Administration	(4,122,509)	(2,610,933)	(2,494,333)	(1,258,459)	(2,616,623)
MCO Tax Received / (Paid)	-	-	-	-	829,564
Net Cash Provided/ (Used) by Operating Activities	**2,462,729**	**(1,008,225)**	**8,095,794**	**764,243**	**27,670,643**
			-		
Cash Flow From Investing/Financing Activities			-		
Proceeds from Line of Credit			-		-
Repayments on Line of Credit	-	-	-	-	-
Net Acquisition of Property/Equipment	(62,198)	(39,754)	(169,050)	(31,263)	(31,026)
Net Cash Provided/(Used) by Investing/Financing	**(62,198)**	**(39,754)**	**(169,050)**	**(31,263)**	**(31,026)**
Net Cash Flow	**$ 2,400,530**	**$ (1,047,979)**	**$ 7,926,744**	**$ 732,980**	**$ 27,639,617**
Cash and Cash Equivalents (Beg. of Period)	41,943,461	42,991,440	35,064,697	34,331,717	23,068,235
Cash and Cash Equivalents (End of Period)	44,343,991	41,943,461	42,991,440	35,064,697	50,817,760
	$ 2,400,530	**$ (1,047,979)**	**$ 7,926,744**	**$ 732,980**	**$ 27,749,525**
Adjustment to Reconcile Net Income to Net Cash Flow					
Net (Loss) Income	2,410,637	2,208,708	1,568,798	1,410,963	4,109,976
Depreciation & Amortization	35,321	34,547	7,015	7,015	11,407
Decrease/(Increase) in Receivables	(10,899,627)	(874,196)	(1,544,001)	(1,795,333)	22,788,941
Decrease/(Increase) in Prepaids & Other Current Assets	(302,569)	851,572	(104,858)	62,856	769,972
(Decrease)/Increase in Payables	4,341,958	(6,376,146)	5,901,351	1,581,709	(1,578,838)
(Decrease)/Increase in Other Liabilities	(38,333)	(38,333)	(38,333)	(38,333)	(121,667)
Change in MCO Tax Liability	1,467,377	1,110,666	1,114,454	1,149,386	1,433,012
Changes in Claims and Capitation Payable	890,038	(507,606)	(812,202)	(4,509,964)	1,913,029
Changes in IBNR	4,557,927	2,582,563	2,003,570	2,895,944	(1,655,189)
	2,462,729	(1,008,225)	8,095,794	764,243	27,670,643
Net Cash Flow from Operating Activities	**$ 2,462,729**	**$ (1,008,225)**	**$ 8,095,794**	**$ 764,243**	**$ 27,670,643**

Statement of Cash Flows - YTD

	Jan 2014 YTD
Cash Flow From Operating Activities	
Collected Premium	$ 170,920,952
Miscellaneous Income	76,203
State Pass Through Funds	61,173,953
Paid Claims	
Medical & Hospital Expenses	(119,878,403)
Pharmacy	(24,526,532)
Capitation	(10,436,098)
Reinsurance of Claims	(1,911,585)
State Pass Through Funds Distributed	(59,959,855)
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(20,032,470)
Repay Initial Net Liabilities	-
MCO Taxes Received / (Paid)	(826,566)
Net Cash Provided/(Used) by Operating Activities	**(5,400,401)**
Cash Flow From Investing/Financing Activities	
Proceeds from Line of Credit	-
Repayments on Line of Credit	-
Net Acquisition of Property/Equipment	(1,073,368)
Net Cash Provided/(Used) by Investing/Financing	**(1,073,368)**
Net Cash Flow	**$ (6,473,768)**
Cash and Cash Equivalents (Beg. of Period)	50,817,760
Cash and Cash Equivalents (End of Period)	44,343,991
	$ (6,473,768)
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	11,510,274
Depreciation & Amortization	100,861
Decrease/(Increase) in Receivables	(41,163,622)
Decrease/(Increase) in Prepaids & Other Current Assets	(558,240)
(Decrease)/Increase in Payables	5,031,889
(Decrease)/Increase in Other Liabilities	(269,488)
Change in MCO Tax Liability	7,247,772
Changes in Claims and Capitation Payable	(3,231,976)
Changes in IBNR	15,932,129
	(5,400,401)
Net Cash Flow from Operating Activities	**$ (5,400,401)**

Gold Coast Health Plan℠
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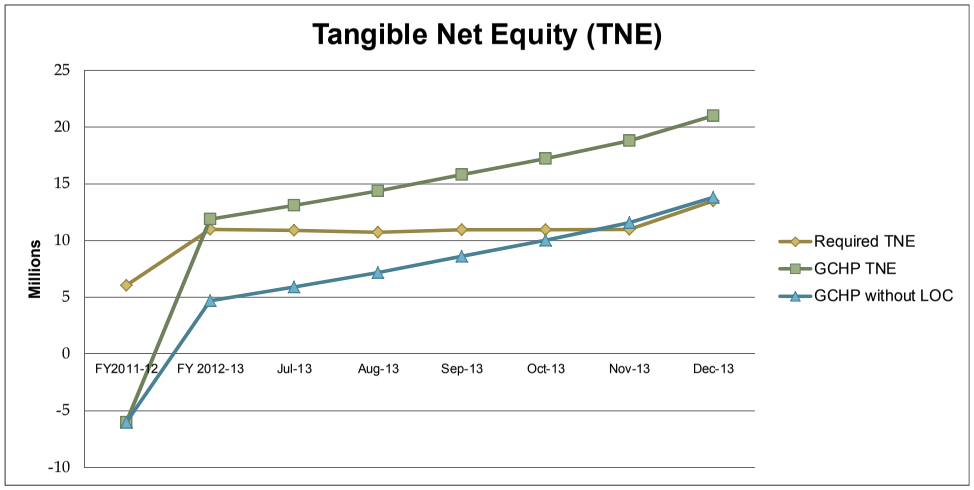
FINANCIAL PACKAGE
For the month ended December 31, 2013

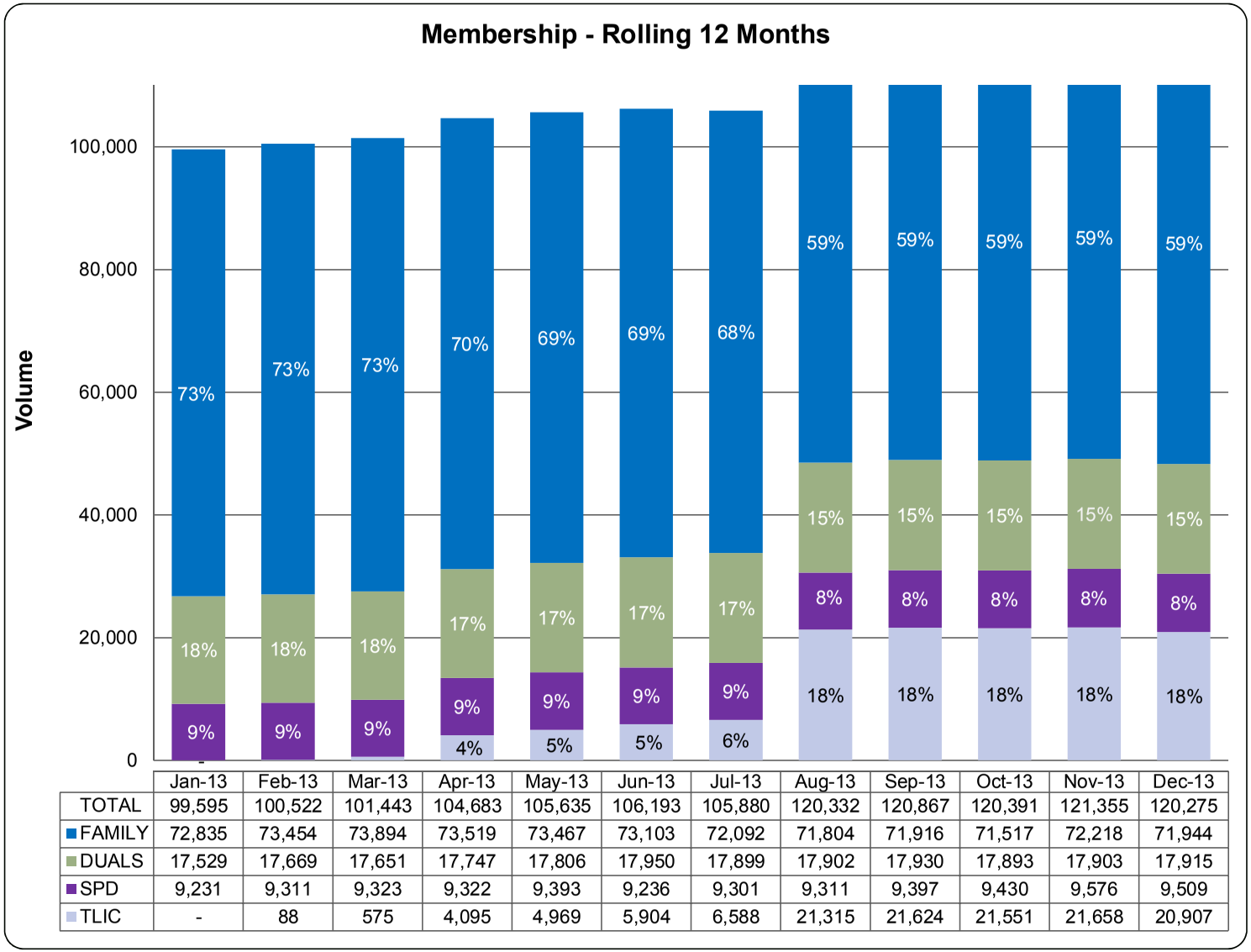
TABLE OF CONTENTS

Financial Overview

Description	AUDITED FY2011-12	AUDITED FY 2012-13	UNAUDITED FY 2013-14 Actual Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	YTD	Budget Comparison Budget YTD	Variance Fav/(Unfav)	Variance Fav/(Unfav) %
Member Months	**1,258,189**	**1,223,895**	105,880	120,332	120,867	120,391	121,355	120,275	**709,100**	**709,146**	(46)	(0.0)%
Revenue	**304,635,932**	**315,119,611**	**26,680,808**	**26,724,574**	**28,583,327**	**28,606,892**	**27,758,615**	**27,704,949**	**166,059,165**	**166,506,620**	(447,455)	(0.3)%
pmpm	*242.12*	*257.47*	*251.99*	*222.09*	*236.49*	*237.62*	*228.74*	*230.35*	*234.18*	*234.80*	(0.62)	(0.3)%
Health Care Costs	**287,353,672**	**280,382,704**	**23,496,673**	**23,572,589**	**24,806,270**	**25,054,919**	**24,356,007**	**23,456,586**	**144,743,045**	**145,790,632**	1,047,587	0.7 %
pmpm	*228.39*	*229.09*	*221.92*	*195.90*	*205.24*	*208.11*	*200.70*	*195.02*	*204.12*	*205.59*	1.46	0.7 %
% of Revenue	94.3%	89.0%	88.1%	88.2%	86.8%	87.6%	87.7%	84.7%	87.2%	87.6%	-0.4%	-0.5%
Admin Exp	**18,891,320**	**24,013,927**	**1,968,367**	**1,892,167**	**2,341,473**	**2,141,010**	**1,833,810**	**2,039,656**	**12,216,483**	**12,280,214**	63,731	0.5 %
pmpm	*15.01*	*19.62*	*18.59*	*15.72*	*19.37*	*17.78*	*15.11*	*16.96*	*17.23*	*17.32*	0.09	0.5 %
% of Revenue	6.2%	7.6%	7.4%	7.1%	8.2%	7.5%	6.6%	7.4%	7.4%	7.4%	0.0%	0.3%
Net Income	**(1,609,063)**	**10,722,980**	**1,215,767**	**1,259,818**	**1,435,584**	**1,410,963**	**1,568,798**	**2,208,708**	**9,099,638**	**8,435,774**	663,863	7.9 %
pmpm	*(1.28)*	*8.76*	*11.48*	*10.47*	*11.88*	*11.72*	*12.93*	*18.36*	*12.83*	*11.90*	0.94	7.9 %
% of Revenue	-0.5%	3.4%	4.6%	4.7%	5.0%	4.9%	5.7%	8.0%	5.5%	5.1%	0.4%	8.2%
100% TNE	16,769,368	16,138,440	16,035,509	15,766,043	16,112,437	16,107,422	16,168,860	16,056,217	16,056,217	16,118,801	(62,584)	(0.4)%
Required TNE	6,036,972	10,974,139	10,904,146	10,720,909	10,956,457	10,953,047	10,994,825	13,487,223	13,487,223	13,539,793	(52,570)	(0.4)%
GCHP TNE	**(6,031,881)**	**11,891,099**	**13,106,866**	**14,366,684**	**15,802,268**	**17,213,231**	**18,782,029**	**20,990,738**	**20,990,738**	**20,326,875**	**663,863**	**3.3 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**2,202,720**	**3,645,775**	**4,845,810**	**6,260,184**	**7,787,204**	**7,503,516**	**7,503,516**	**6,787,082**	**716,433**	**10.6 %**

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





	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
TOTAL	99,595	100,522	101,443	104,683	105,635	106,193	105,880	120,332	120,867	120,391	121,355	120,275
FAMILY	72,835	73,454	73,894	73,519	73,467	73,103	72,092	71,804	71,916	71,517	72,218	71,944
DUALS	17,529	17,669	17,651	17,747	17,806	17,950	17,899	17,902	17,930	17,893	17,903	17,915
SPD	9,231	9,311	9,323	9,322	9,393	9,236	9,301	9,311	9,397	9,430	9,576	9,509
TLIC	-	88	575	4,095	4,969	5,904	6,588	21,315	21,624	21,551	21,658	20,907

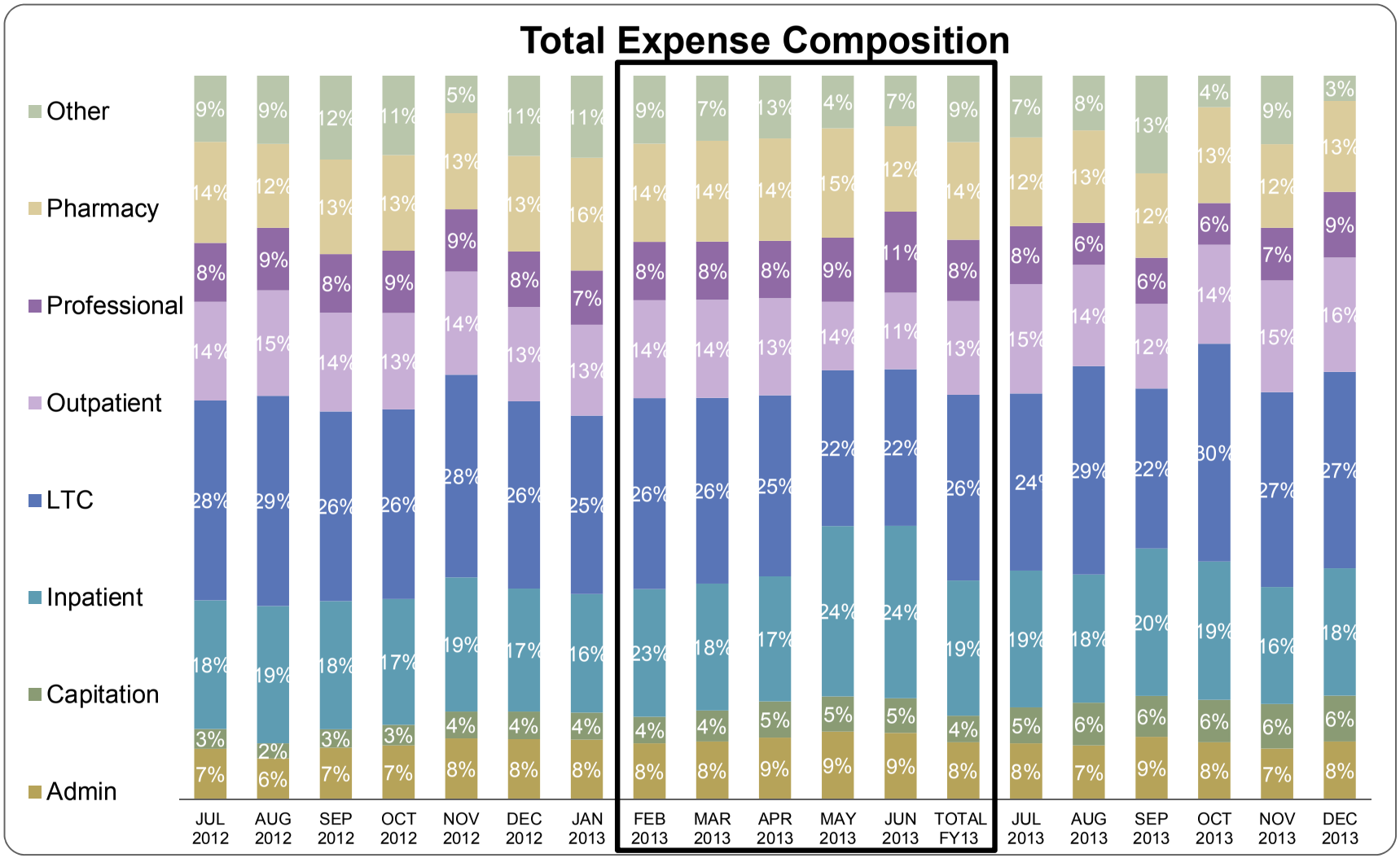
SPD = Seniors and Persons with Disabilities
TLIC = Targeted Low Income Children

Income Statement Monthly Trend

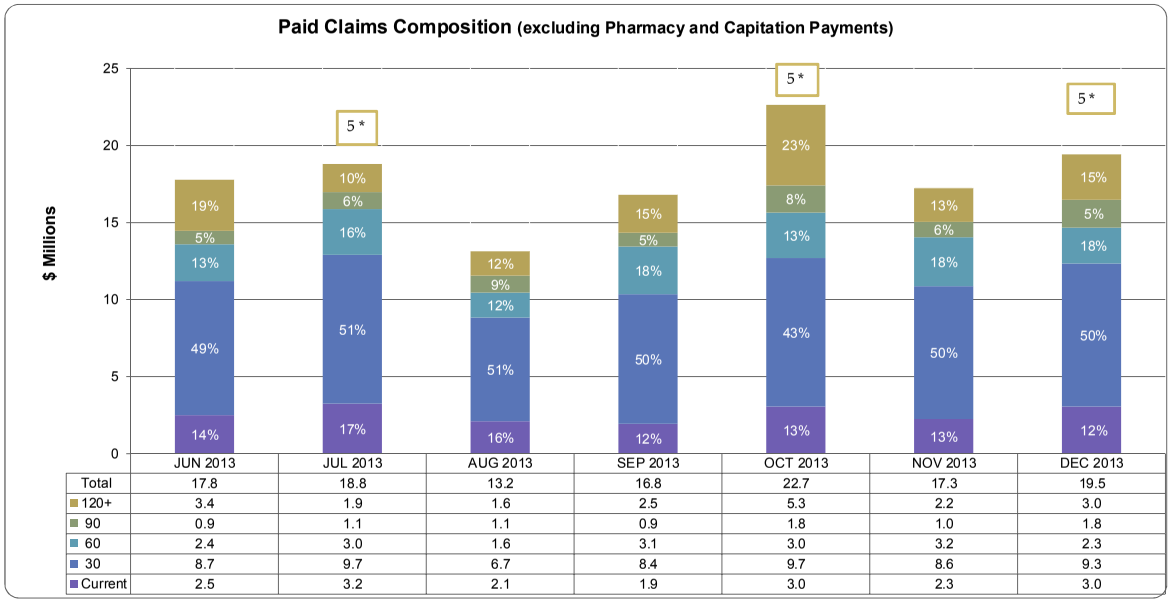
	2014 Actual Monthly Trend				Current Month		
	AUG 2013	SEP 2013	OCT 2013	NOV 2013	DEC 2013		Variance
					Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	120,332	120,867	120,391	121,355	120,275	120,318	(43)
Revenue:							
Premium	$ 27,789,352	$ 29,602,003	$ 29,980,945	$ 29,108,732	$ 29,047,006	$ 29,526,455	$ (479,449)
Reserve for Rate Reduction	-	-	(278,508)	(282,654)	(281,754)	(258,638)	(23,116)
MCO Premium Tax	(1,110,416)	(1,068,828)	(1,149,386)	(1,114,454)	(1,110,666)	(1,162,604)	51,938
Total Net Premium	**26,678,936**	**28,533,175**	**28,553,050**	**27,711,624**	**27,654,585**	**28,105,213**	**(450,628)**
Other Revenue:							
Interest Income	7,304	11,819	15,509	8,658	12,031	8,858	3,173
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	38,333	-
Total Other Revenue	45,637	50,152	53,842	46,991	50,364	47,191	3,173
Total Revenue	**26,724,574**	**28,583,327**	**28,606,892**	**27,758,615**	**27,704,949**	**28,152,404**	**(447,455)**
Medical Expenses:							
Capitation (PCP, Specialty, NEMT & Visi	1,507,335	1,533,277	1,597,311	1,616,715	1,610,161	1,625,878	15,717
FFS Claims Expenses:							
Inpatient	4,512,661	5,531,725	5,200,045	4,229,618	4,491,812	4,840,183	348,371
LTC/SNF	7,333,312	6,003,374	8,189,391	7,051,854	6,923,947	5,971,308	(952,639)
Outpatient	2,955,457	2,281,073	2,762,602	3,112,769	3,189,204	2,826,531	(362,673)
Laboratory and Radiology	113,377	96,573	101,182	149,563	111,157	181,041	69,884
Emergency Room	497,008	803,936	847,968	788,033	729,901	631,921	(97,980)
Physician Specialty	1,479,169	1,725,887	1,575,483	1,903,339	2,305,009	2,291,684	(13,325)
Pharmacy	3,253,505	3,172,116	3,599,699	3,026,831	3,210,998	3,477,848	266,850
Other Medical Professional	118,201	249,684	25,851	153,013	149,068	108,738	(40,330)
Other Medical Care	-	1,621	-	-	3,608	-	(3,608)
Other Fee For Service	1,235,873	2,100,151	1,998,727	1,800,032	1,645,707	1,525,117	(120,590)
Transportation	35,404	178,553	73,220	88,442	67,551	76,418	8,867
Total Claims	21,533,967	22,144,693	24,374,168	22,303,494	22,827,961	21,930,789	(897,172)
Medical & Care Management Expense	730,967	746,163	738,701	722,455	830,780	763,420	(67,360)
Reinsurance	258,884	277,448	(1,222,910)	277,386	(1,553,135)	184,087	1,737,222
Claims Recoveries	(458,563)	104,688	(432,352)	(564,043)	(259,182)	-	259,182
Sub-total	531,288	1,128,300	(916,560)	435,798	(981,537)	947,506	1,929,043
Total Cost of Health Care	**23,572,589**	**24,806,270**	**25,054,919**	**24,356,007**	**23,456,586**	**24,504,173**	**1,047,587**
Contribution Margin	**3,151,984**	**3,777,057**	**3,551,973**	**3,402,608**	**4,248,363**	**3,648,231**	**600,132**
General & Administrative Expenses:							
Salaries and Wages	420,641	453,818	497,163	575,414	592,047	577,040	(15,007)
Payroll Taxes and Benefits	112,105	114,103	119,840	124,386	151,109	135,115	(15,995)
Travel and Training	5,840	10,686	13,879	10,975	4,315	28,893	24,578
Outside Service - ACS	880,703	1,190,847	958,836	912,065	940,933	917,068	(23,865)
Outside Services - Other	49,938	33,271	24,974	757	19,158	20,020	862
Accounting & Actuarial Services	20,164	46,568	70,000	(71,621)	12,500	20,833	8,333
Legal	26,462	54,932	45,876	67,706	88,066	36,340	(51,726)
Insurance	9,972	12,517	12,057	13,138	13,265	10,792	(2,473)
Lease Expense - Office	28,480	28,480	22,503	28,480	25,980	28,480	2,500
Consulting Services	201,612	264,998	118,908	(17,517)	42,604	109,366	66,761
Translation Services	2,788	2,778	4,225	1,638	3,602	2,417	(1,185)
Advertising and Promotion	14,120	-	-	3,985	1,883	27,431	25,548
General Office	88,394	77,654	100,062	98,180	115,766	136,133	20,366
Depreciation & Amortization	5,235	6,492	7,015	7,015	7,015	9,541	2,526
Printing	1,418	5,605	26,510	20,347	2,022	14,015	11,993
Shipping & Postage	219	1,016	11,395	13,389	562	20,402	19,840
Interest	24,076	37,708	107,768	45,473	18,828	9,502	(9,326)
Total G & A Expenses	**1,892,167**	**2,341,473**	**2,141,010**	**1,833,810**	**2,039,656**	**2,103,387**	**63,731**
Net Income / (Loss)	**$ 1,259,818**	**$ 1,435,584**	**$ 1,410,963**	**$ 1,568,798**	**$ 2,208,708**	**$ 1,544,844**	**$ 663,863**

PMPM Income Statement Comparison

	2014 Actual Monthly Trend				Dec '13 Month-To-Date		Variance
	AUG 2013	SEP 2013	OCT 2013	NOV 2013	Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	120,332	120,867	120,391	121,355	120,275	120,318	(43)
Revenue:							
Premium	230.94	244.91	249.03	239.86	241.50	245.40	(3.90)
Reserve for Rate Reduction	-	-	(2.31)	(2.33)	(2.34)	(2.15)	(0.19)
MCO Premium Tax	(9.23)	(8.84)	(9.55)	(9.18)	(9.23)	(9.66)	0.43
Total Net Premium	**221.71**	**236.07**	**237.17**	**228.35**	**229.93**	**233.59**	**(3.66)**
Other Revenue:							
Interest Income	0.06	0.10	0.13	0.07	0.10	0.07	0.03
Miscellaneous Income	0.32	0.32	0.32	0.32	0.32	0.32	0.00
Total Other Revenue	**0.38**	**0.41**	**0.45**	**0.39**	**0.42**	**0.47**	**(0.05)**
Total Revenue	**222.09**	**236.49**	**237.62**	**228.74**	**230.35**	**233.98**	**(3.64)**
Medical Expenses:							
Capitation (PCP, Specialty, NEMT & Visi	12.53	12.69	13.27	13.32	13.39	13.51	(0.13)
FFS Claims Expenses:							
Inpatient	37.50	45.77	43.19	34.85	37.35	40.23	2.88
LTC/SNF	60.94	49.67	68.02	58.11	57.57	49.63	(7.94)
Outpatient	24.56	18.87	22.95	25.65	26.52	23.49	(3.02)
Laboratory and Radiology	0.94	0.80	0.84	1.23	0.92	1.50	0.58
Emergency Room	4.13	6.65	7.04	6.49	6.07	5.25	(0.82)
Physician Specialty	12.29	14.28	13.09	15.68	19.16	19.05	(0.12)
Pharmacy	27.04	26.24	29.90	24.94	26.70	28.91	2.21
Other Medical Professional	0.98	2.07	0.21	1.26	1.24	0.90	(0.34)
Other Medical Care	-	0.01	-	-	0.03	-	(0.03)
Other Fee For Service	10.27	17.38	16.60	14.83	13.68	12.68	(1.01)
Transportation	0.29	1.48	0.61	0.73	0.56	0.64	0.07
Total Claims	178.95	183.22	202.46	183.79	189.80	182.27	(7.52)
Medical & Care Management Expense	6.07	6.17	6.14	5.95	6.91	6.35	(0.56)
Reinsurance	2.15	2.30	(10.16)	2.29	(12.91)	1.53	14.44
Claims Recoveries	(3.81)	0.87	(3.59)	(4.65)	(2.15)	-	2.15
Sub-total	4.42	9.34	(7.61)	3.59	(8.16)	7.88	16.04
Total Cost of Health Care	195.90	205.24	208.11	200.70	195.02	203.66	8.64
Contribution Margin	26.19	31.25	29.50	28.04	35.32	**30.32**	**5.00**
General & Administrative Expenses:							
Salaries and Wages	3.50	3.75	4.13	4.74	4.92	4.80	(0.13)
Payroll Taxes and Benefits	0.93	0.94	1.00	1.02	1.26	1.12	(0.13)
Travel and Training	0.05	0.09	0.12	0.09	0.04	0.24	0.20
Outside Service - ACS	7.32	9.85	7.96	7.52	7.82	7.62	(0.20)
Outside Services - Other	0.41	0.28	0.21	0.01	0.16	0.17	0.01
Accounting & Actuarial Services	0.17	0.39	0.58	(0.59)	0.10	0.17	0.07
Legal	0.22	0.45	0.38	0.56	0.73	0.30	(0.43)
Insurance	0.08	0.10	0.10	0.11	0.11	0.09	(0.02)
Lease Expense - Office	0.24	0.24	0.19	0.23	0.22	0.24	0.02
Consulting Services	1.68	2.19	0.99	(0.14)	0.35	0.91	0.55
Translation Services	0.02	0.02	0.04	0.01	0.03	0.02	(0.01)
Advertising and Promotion	0.12	-	-	0.03	0.02	0.23	0.21
General Office	0.73	0.64	0.83	0.81	0.96	1.13	0.17
Depreciation & Amortization	0.04	0.05	0.06	0.06	0.06	0.08	0.02
Printing	0.01	0.05	0.22	0.17	0.02	0.12	0.10
Shipping & Postage	0.00	0.01	0.09	0.11	0.00	0.17	0.16
Interest	0.20	0.31	0.90	0.37	0.16	0.08	(0.08)
Total G & A Expenses	**15.72**	**19.37**	**17.78**	**15.11**	**16.96**	**17.48**	**0.52**
Net Income / (Loss)	**10.47**	**11.88**	**11.72**	**12.93**	**18.36**	**12.84**	**5.52**

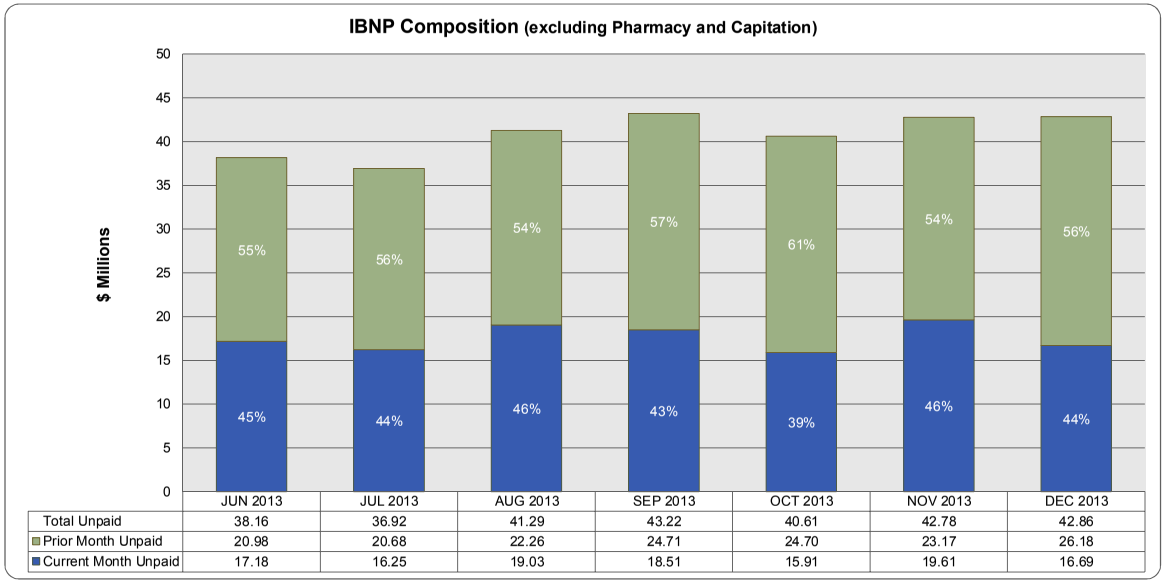


In May, GCHP changed its method of distributing Health Care Costs (HCC) across categories of service. Prior months utilized an allocation methodology. The methodology was updated to utilize payment information by different categories of services. Further changes have been made with the assumption of the TLIC population and its affect on various categories of service.
Therefore, the months of May - August represent the transitioning to a new methodology.



	JUN 2013	JUL 2013	AUG 2013	SEP 2013	OCT 2013	NOV 2013	DEC 2013
Total	17.8	18.8	13.2	16.8	22.7	17.3	19.5
120+	3.4	1.9	1.6	2.5	5.3	2.2	3.0
90	0.9	1.1	1.1	0.9	1.8	1.0	1.8
60	2.4	3.0	1.6	3.1	3.0	3.2	2.3
30	8.7	9.7	6.7	8.4	9.7	8.6	9.3
Current	2.5	3.2	2.1	1.9	3.0	2.3	3.0

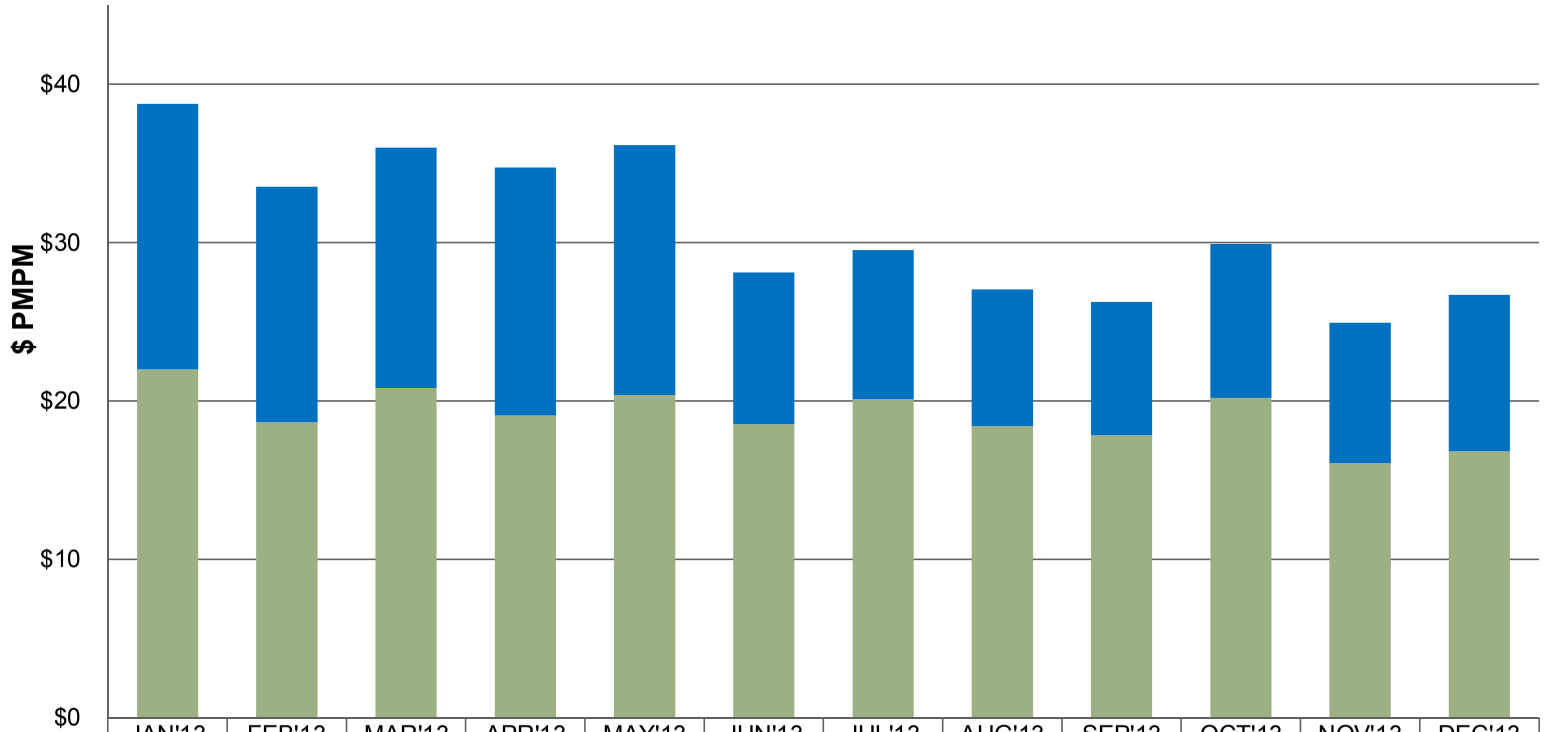
Note: **Paid Claims Composition** - reflects adjusted medical claims payment lag schedule.
* Months Indicated with 5* represent months for which there were 5 claim payments. For all other months, 4 claim payments were made.



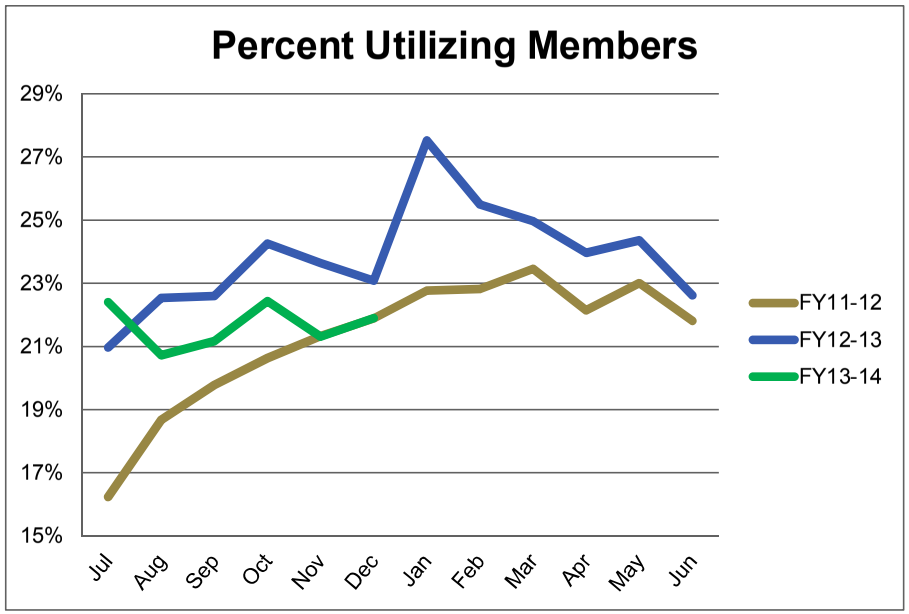
	JUN 2013	JUL 2013	AUG 2013	SEP 2013	OCT 2013	NOV 2013	DEC 2013
Total Unpaid	38.16	36.92	41.29	43.22	40.61	42.78	42.86
Prior Month Unpaid	20.98	20.68	22.26	24.71	24.70	23.17	26.18
Current Month Unpaid	17.18	16.25	19.03	18.51	15.91	19.61	16.69

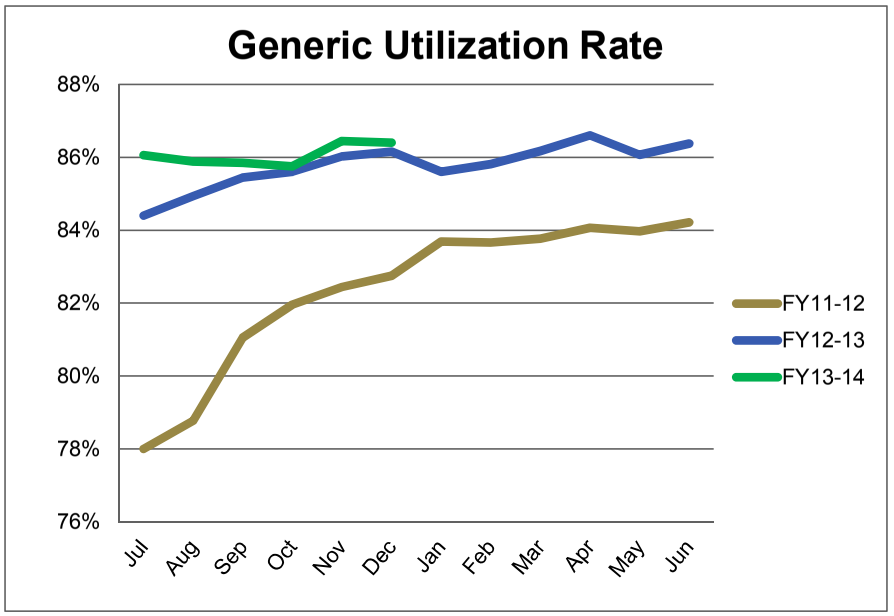
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

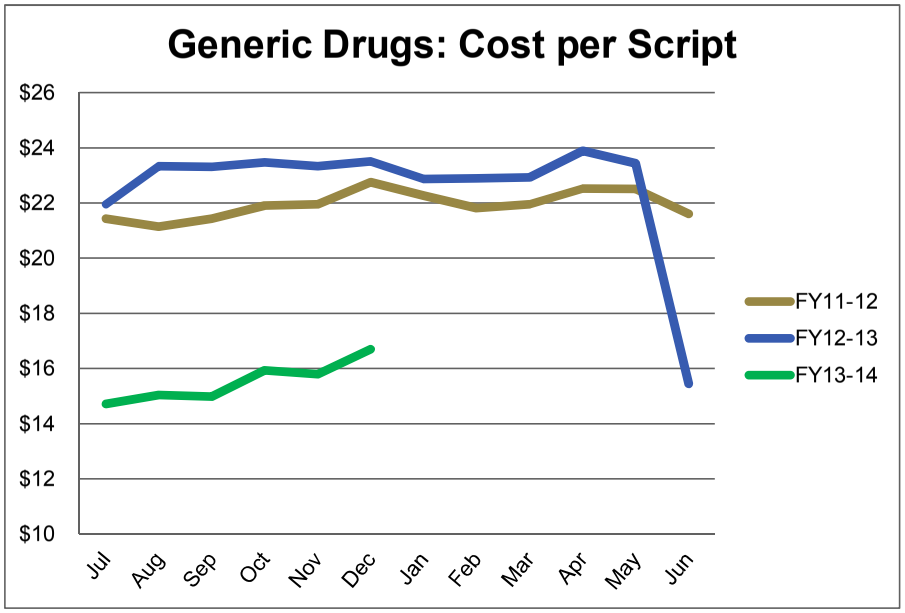
Pharmacy Cost Trend

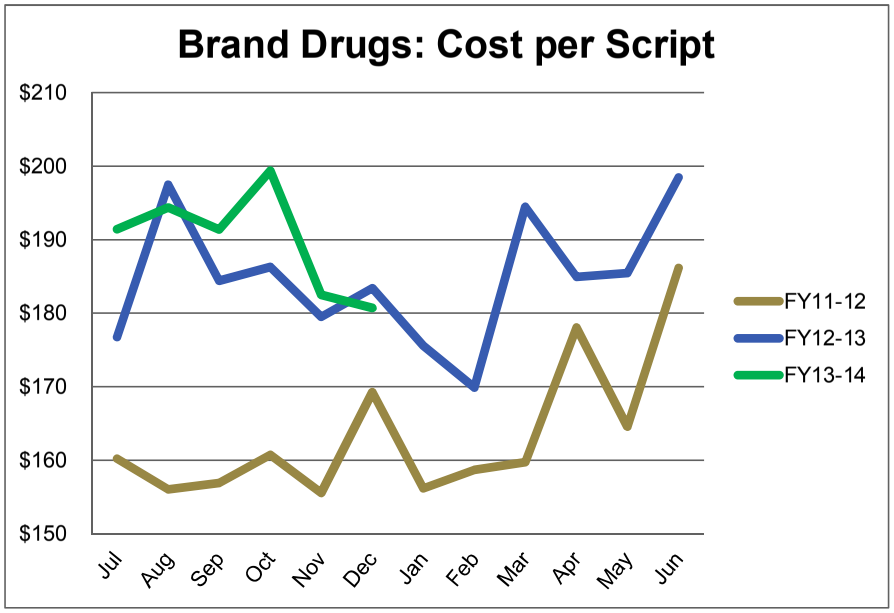


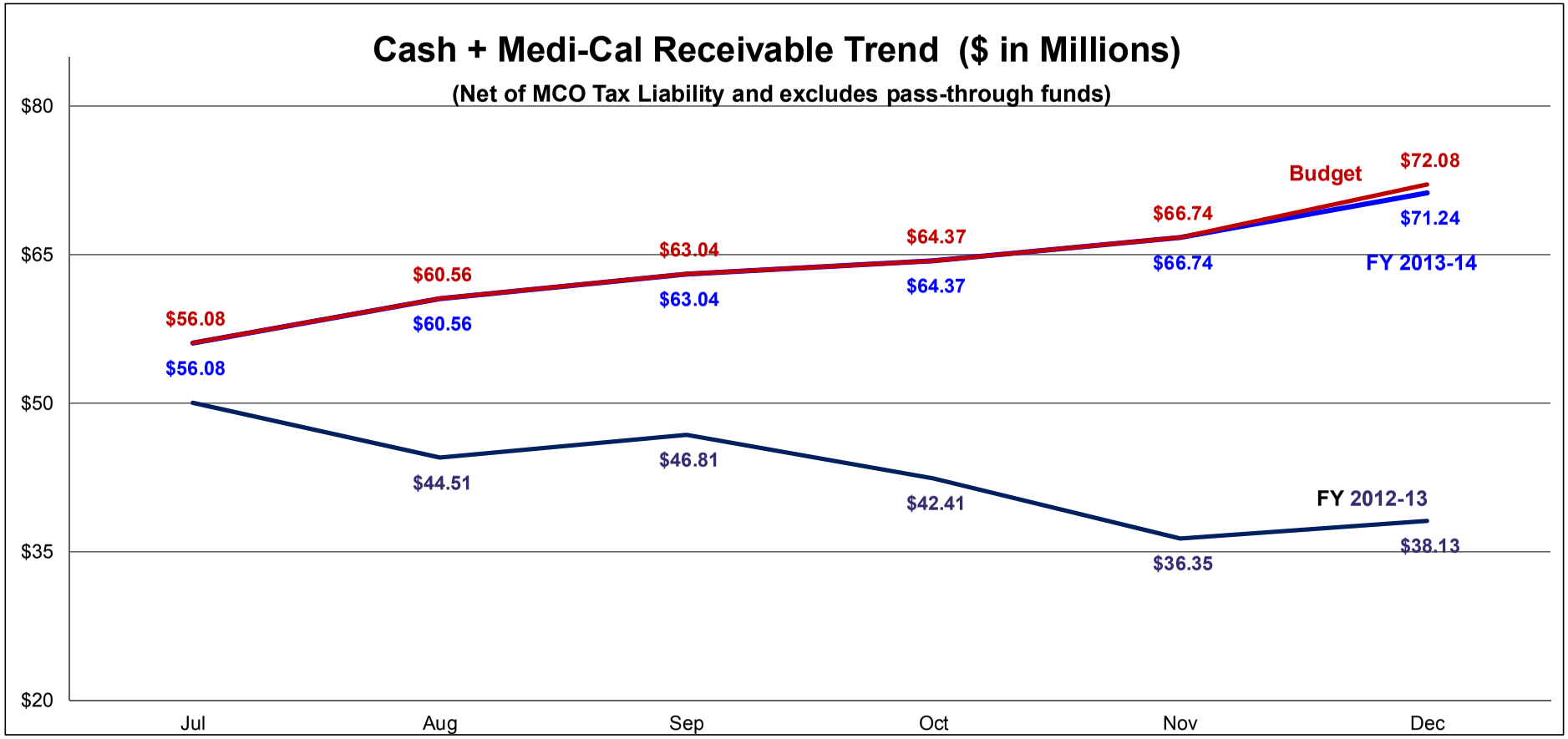
	JAN'13	FEB'13	MAR'13	APR'13	MAY'13	JUN'13	JUL'13	AUG'13	SEP'13	OCT'13	NOV'13	DEC'13
AVG PMPM	$38.75	$33.53	$35.99	$34.74	$36.15	$28.12	$29.53	$27.04	$26.24	$29.90	$24.94	$26.70
GENERIC	$16.77	$14.86	$15.16	$15.66	$15.78	$9.58	$9.43	$8.62	$8.41	$9.71	$8.87	$9.87
BRAND	$21.98	$18.66	$20.82	$19.08	$20.38	$18.54	$20.10	$18.41	$17.83	$20.19	$16.07	$16.82


Percent Utilizing Members
29%
27%
25%
23%
21%
19%
17%
15%
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY11-12
FY12-13
FY13-14


Generic Utilization Rate
88%
86%
84%
82%
80%
78%
76%
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY11-12
FY12-13
FY13-14


Generic Drugs: Cost per Script
$26
$24
$22
$20
$18
$16
$14
$12
$10
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY11-12
FY12-13
FY13-14


Brand Drugs: Cost per Script
$210
$200
$190
$180
$170
$160
$150
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY11-12
FY12-13
FY13-14


Cash + Medi-Cal Receivable Trend ($ in Millions)
(Net of MCO Tax Liability and excludes pass-through funds)
$80
$65
$50
$35
$20
Jul
Aug
Sep
Oct
Nov
Dec
Budget
$72.08
$71.24
FY 2013-14
$56.08
$60.56
$63.04
$64.37
$66.74
$56.08
$60.56
$63.04
$64.37
$66.74
FY 2012-13
$38.13
$44.51
$46.81
$42.41
$36.35

Gold Coast Health Plan℠
A Public Entity

APPENDIX

- Comparative Balance Sheet
- YTD Income Statement
- Monthly Statement of Cash Flows

Comparative Balance Sheet

	12/31/13	11/30/13	Audited FY 2012-13
ASSETS			
Current Assets			
Total Cash and Cash Equivalents	**$ 41,943,461**	**$ 42,991,440**	**$ 50,817,760**
Medi-Cal Receivable	42,410,897	41,443,995	11,683,076
Provider Receivable	800,343	891,907	1,161,379
Other Receivables	197,606	198,749	300,397
Total Accounts Receivable	**43,408,847**	**42,534,651**	**13,144,852**
Total Prepaid Accounts	492,191	1,352,582	324,419
Total Other Current Assets	97,899	89,079	10,000
Total Current Assets	**85,942,398**	**86,967,753**	**64,297,030**
Total Fixed Assets	**1,177,698**	**1,172,491**	**230,913**
Total Assets	**$ 87,120,096**	**$ 88,140,244**	**$ 64,527,943**
LIABILITIES & FUND BALANCE			
Current Liabilities			
Incurred But Not Reported	$ 41,275,305	$ 38,692,742	$ 29,901,103
Claims Payable	5,313,850	5,804,043	9,748,676
Capitation Payable	1,315,435	1,332,849	1,002,623
Accrued Premium Reduction	842,917	561,162	-
		-	
Accounts Payable	1,406,476	1,908,253	1,751,419
Accrued ACS	325,466	1,133,907	422,138
Accrued Expenses	745,724	6,247,863	477,477
Accrued Premium Tax	13,118,155	12,007,489	7,337,759
Accrued Interest Payable	27,670	24,626	9,712
Current Portion of Deferred Revenue	460,000	460,000	460,000
Accrued Payroll Expense	608,361	456,947	605,937
Total Current Liabilities	**65,439,358**	**68,629,880**	**$ 51,716,843**
Long-Term Liabilities			
Deferred Revenue - Long Term Portion	690,000	728,333	920,000
Notes Payable	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	**7,890,000**	**7,928,333**	**8,120,000**
Total Liabilities	**73,329,358**	**76,558,213**	**59,836,843**
Beginning Fund Balance	4,691,101	4,691,101	(6,031,881)
Net Income Current Year	9,099,638	6,890,930	10,722,981
Total Fund Balance	**13,790,738**	**11,582,031**	**4,691,100**
Total Liabilities & Fund Balance	**$ 87,120,096**	**$ 88,140,244**	**$ 64,527,943**

FINANCIAL INDICATORS			
Current Ratio	1.31 : 1	1.27 : 1	1.24 : 1
Days Cash on Hand	49	49	58
Days Cash + State Capitation Receivable	99	97	72
Days Cash + State Capitation Rec (less Tax Liab)	84	83	63

Income Statement
For The Six Months Ended December 31, 2013

	Dec '13 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	709,100	709,146	(46)
Revenue:			
Premium	$ 173,214,528	$ 173,693,977	$ (479,449)
Reserve for Rate Reduction	(842,917)	(819,800)	(23,116)
MCO Premium Tax	(6,606,962)	(6,658,899)	51,938
Total Net Premium	**165,764,650**	**166,215,278**	**(450,628)**
Other Revenue:			
Interest Income	64,515	61,342	3,173
Miscellaneous Income	230,000	230,000	-
Total Other Revenue	294,516	**291,342**	3,173
Total Revenue	**166,059,165**	**166,506,620**	**(447,455)**
Medical Expenses:			
Capitation (PCP, Specialty, NEMT & Vision)	9,134,873	9,150,589	15,717
FFS Claims Expenses:			
Inpatient	28,773,078	29,121,449	348,371
LTC/SNF	41,740,550	40,787,911	(952,639)
Outpatient	17,183,965	16,821,292	(362,673)
Laboratory and Radiology	794,306	864,190	69,884
Emergency Room	4,412,643	4,314,663	(97,980)
Physician Specialty	11,022,844	11,009,519	(13,325)
Pharmacy	19,390,059	19,656,909	266,850
Other Medical Professional	865,720	825,390	(40,330)
Other Medical Care	5,229	-	(5,229)
Other Fee For Service	9,918,100	9,799,131	(118,969)
Transportation	483,294	492,161	8,867
Total Claims	134,589,787	133,692,615	(897,172)
Medical & Care Management Expense	4,511,193	4,443,833	(67,360)
Reinsurance	(1,702,582)	(1,496,405)	206,177
Claims Recoveries	(1,790,226)	-	1,790,226
Sub-total	1,018,385	2,947,428	1,929,043
Total Cost of Health Care	**144,743,045**	**145,790,632**	**1,047,587**
Contribution Margin	**21,316,120**	**20,715,988**	**600,132**
General & Administrative Expenses:			
Salaries and Wages	3,101,910	3,086,904	(15,007)
Payroll Taxes and Benefits	744,853	728,858	(15,995)
Travel and Training	49,326	73,904	24,578
Outside Service - ACS	5,735,468	5,711,603	(23,865)
Outside Services - Other	144,545	145,406	862
Accounting & Actuarial Services	121,613	129,946	8,333
Legal	340,972	289,247	(51,726)
Insurance	72,786	70,313	(2,473)
Lease Expense - Office	159,903	162,403	2,500
Consulting ServiceS	782,769	849,531	66,761
Translation Services	19,911	18,725	(1,185)
Advertising and Promotion	24,069	49,616	25,548
General Office	543,412	563,779	20,366
Depreciation & Amortization	38,007	40,533	2,526
Printing	58,530	70,523	11,993
Shipping & Postage	26,622	46,462	19,840
Interest	251,787	242,460	(9,326)
Total G & A Expenses	**12,216,483**	**12,280,214**	**63,731**
Net Income / (Loss)	**$ 9,099,638**	**$ 8,435,774**	**$ 663,863**

Statement of Cash Flows - Monthly

	DEC '13	NOV '13	OCT '13	JUN'13
Cash Flow From Operating Activities				
Collected Premium	$ 28,079,945	$ 27,862,839	$ 28,237,305	$ 52,138,834
Miscellaneous Income	12,031	8,658	15,509	8,594
State Pass Through Funds		5,691,714	28,672,901	34,346,474
		-		
Paid Claims		-		
Medical & Hospital Expenses	(17,202,587)	(17,387,071)	(20,891,230)	(17,277,826)
Pharmacy	(1,690,164)	(3,787,143)	(3,504,662)	(4,009,168)
Capitation	(1,625,829)	(1,521,485)	(1,553,107)	(1,162,302)
Reinsurance of Claims	(278,975)	(277,386)	(281,113)	(240,430)
State Pass Through Funds Distributed	(5,691,714)	-	(28,672,901)	(34,346,474)
Paid Administration	(2,610,933)	(2,494,333)	(1,258,459)	(2,616,623)
MCO Tax Received / (Paid)	-	-	-	829,564
Net Cash Provided/ (Used) by Operating Activities	**(1,008,225)**	**8,095,794**	**764,243**	**27,670,643**
		-		
Cash Flow From Investing/Financing Activities		-		
Proceeds from Line of Credit		-		-
Repayments on Line of Credit	-	-	-	-
Net Acquisition of Property/Equipment	(39,754)	(169,050)	(31,263)	(31,026)
Net Cash Provided/(Used) by Investing/Financing	**(39,754)**	**(169,050)**	**(31,263)**	**(31,026)**
Net Cash Flow	**$ (1,047,979)**	**$ 7,926,744**	**$ 732,980**	**$ 27,639,617**
Cash and Cash Equivalents (Beg. of Period)	42,991,440	35,064,697	34,331,717	23,068,235
Cash and Cash Equivalents (End of Period)	41,943,461	42,991,440	35,064,697	50,817,760
	$ (1,047,979)	**$ 7,926,744**	**$ 732,980**	**$ 27,749,525**
Adjustment to Reconcile Net Income to Net Cash Flow				
Net (Loss) Income	2,208,708	1,568,798	1,410,963	4,109,976
Depreciation & Amortization	34,547	7,015	7,015	11,407
Decrease/(Increase) in Receivables	(874,196)	(1,544,001)	(1,795,333)	22,788,941
Decrease/(Increase) in Prepaids & Other Current Assets	851,572	(104,858)	62,856	769,972
(Decrease)/Increase in Payables	(6,376,146)	5,901,351	1,581,709	(1,578,838)
(Decrease)/Increase in Other Liabilities	(38,333)	(38,333)	(38,333)	(121,667)
Change in MCO Tax Liability	1,110,666	1,114,454	1,149,386	1,433,012
Changes in Claims and Capitation Payable	(507,606)	(812,202)	(4,509,964)	1,913,029
Changes in IBNR	2,582,563	2,003,570	2,895,944	(1,655,189)
	(1,008,225)	8,095,794	764,243	27,670,643
Net Cash Flow from Operating Activities	**$ (1,008,225)**	**$ 8,095,794**	**$ 764,243**	**$ 27,670,643**

Statement of Cash Flows - YTD

	Dec '13 YTD
Cash Flow From Operating Activities	
Collected Premium	$ 141,951,785
Miscellaneous Income	64,515
State Pass Through Funds	61,123,883
Paid Claims	
Medical & Hospital Expenses	(104,822,529)
Pharmacy	(19,100,121)
Capitation	(8,750,730)
Reinsurance of Claims	(1,633,550)
State Pass Through Funds Distributed	(59,959,855)
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(15,909,961)
Repay Initial Net Liabilities	-
MCO Taxes Received / (Paid)	(826,566)
Net Cash Provided/(Used) by Operating Activities	**(7,863,129)**
Cash Flow From Investing/Financing Activities	
Proceeds from Line of Credit	-
Repayments on Line of Credit	-
Net Acquisition of Property/Equipment	(1,011,169)
Net Cash Provided/(Used) by Investing/Financing	**(1,011,169)**
Net Cash Flow	**$ (8,874,299)**
Cash and Cash Equivalents (Beg. of Period)	50,817,760
Cash and Cash Equivalents (End of Period)	41,943,461
	$ (8,874,299)
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	9,099,638
Depreciation & Amortization	65,540
Decrease/(Increase) in Receivables	(30,263,995)
Decrease/(Increase) in Prepaids & Other Current Assets	(255,672)
(Decrease)/Increase in Payables	689,931
(Decrease)/Increase in Other Liabilities	(231,155)
Change in MCO Tax Liability	5,780,396
Changes in Claims and Capitation Payable	(4,122,014)
Changes in IBNR	11,374,202
	(7,863,129)
Net Cash Flow from Operating Activities	**$ (7,863,129)**

AGENDA ITEM 5a

To: Gold Coast Health Plan Commissioners

From: Albert Reeves, MD, CMO

Date: March 24, 2014

Re: CMO Update

CMO UPDATE

Quality Improvement Committee

The Quality Improvement Committee of Gold Coast Health Plan met on February 25, 2014.

The Proceedings and reports are:

1. Old business
   a. The Plan continues to work on the Internal Quality Improvement Project to improve
   Diabetic members receiving a retinal eye exam to check for eye damage from diabetes.
   b. The Plan continues with a Quality Improvement Project for members who are at high risk for readmission to contact the members to be sure that all needs are met to prevent the need for readmission.
   c. Facility site review – the Plan is required to document that providers are complying with the Initial Health Assessment of new members. The requirement is 80% or better compliance. All contracted physician health networks are in compliance with this standard.
   d. HEDIS – the Quality Improvement (QI) Department staff are in the middle of the 2014 HEDIS Season and they are in the process of locating members for inclusion in the HEDIS audit and chart reviews. The QI Staff is working diligently to capture all of the appropriate documentation to maximize the Plan's results. The metrics for the 2014 HEDIS Survey are the same as in 2013. The Minimum Performance Levels have changed slightly. Since receiving the results of the 2013 HEDIS results, the Plan has particularly focused on the low performance levels for improvement.
   e. The Plan is participating as part of a cooperative on substance abuse with the Association of Community Affiliated Plans (ACAP).

2. New Business
   a. The QI department has identified the top diagnoses based upon several types of categories of data including pharmacy data, ICD-9 claims, HEDIS etc.
      - The top diagnoses identified are diabetes and asthma.
      - The committee approved these 2 chronic diseases as those upon which the Plan will focus for improved outcomes, including a possible disease management program.
      - The QI Committee approved the review of the 2013 Quality Improvement Work Plan.
   b. Pharmacy and Therapeutics Committee:
      - The Plan is required to review new drugs approved by the FDA. The Committee reviewed 59 new drugs; 23 were approved and 36 were denied.
      - The Committee reviewed the Utilization Management guidelines and quantity limits for the drugs on the formulary.
      - Pharmacy Director Anne Freese, PharmD, reported on audits of ScriptCare for appropriate utilization review
        – 98.7% of cases were reviewed appropriately;
        – 100% were reviewed on a timely basis; and
        – 80.5% had appropriate denial language (this was a CAP item from the State)
      - A Pharmacy Credentialing audit was conducted in support of the State CAP.
        There were 4 deficiencies identified and the Plan issued a Corrective Action Plan (CAP) to ScriptCare. ScriptCare has corrected all four areas and the CAP has been closed.
      - Pharmacy Director Anne Freese, PharmD, and Gold Coast Staff are working with ScriptCare to put in place a workable process to identify prescriptions that should by covered by California Children's Services (CCS).
   c. Credentials / Peer Review Committee:
      - It was reported to the Committee that within the next 6 months a large number of providers will need to be re-credentialed since providers are re-credentialed every 3 years and the Plan will have been operating for 3 years effective July 1, 2014.
      - All re-credentialed providers must have a Facility Site Review performed as well.
   d. Medical Advisory Committee:
      - The committee voted to approve changes in the services requiring prior authorization and removed requirements for obstetrical ultrasounds, dialysis, family planning, HIV testing and abortion services.
      - The Committee also approved some adult podiatry services for serious foot problems that in most instances would usually be treated by

orthopedists. The contracted orthopedists refer most foot problems to podiatry.

e. Health Education / Cultural Linguistics and Outreach Committee:
   - Reports on training of providers for the Staying Healthy Assessment (SHA) and the Screening Brief Intervention Referral for Treatment (SBIRT) which is required by DHCS. This training has been delivered at provider offices and at two Provider Town Hall Meetings.
   - It was reported that the Group Needs Assessment was completed – there were 10,000 surveys mailed to randomly selected members, 5,000 in English and 5,000 in Spanish. Another 150 surveys were delivered in person with Mixteco Members. Fifteen hundred and eleven (1,511) surveys were returned and the data will be used to develop new programs during the upcoming year.

f. Grievance and Appeals Committee: see Dr. Wharfield's report.

g. Network Planning Committee:
   - Reported on Provider Portal access studies. The provider portal is primarily used to check member eligibility. The call center has limited capacity to receive provider calls regarding eligibility; therefore, the provider portal has prevented the call center from being overwhelmed with eligibility calls.
   - The Access to Care and After Hours Survey Results done by the Myers Group was presented to the Committee.
     - 80% of provider offices reported appointment availability within 48 hours of request.
     - 70% of PCP's were able to provide an urgent appointment within 48 hours.
     - 84.6% of Specialists were able to provide an urgent appointment within 48 hours.
     - 87.5% of PCP providers were able to offer a non-urgent appointment within 10 days.
     - 94.6% of Specialists were able to offer a non-urgent appointment with 15 days.
   - The Provider Relations Department has identified providers that are not meeting requirements for appointments and have communicated with those providers for correction. Those providers will be re-surveyed and if there is continued non-compliance a formal Corrective Action Plan (CAP) will be initiated.
   - The Provider After-Hours audit was presented. Provider Relations has identified providers that are not meeting requirements for After Hours and Waiting Times and will reach out to those providers for further education. Continued non-compliance will result in issuance of a formal CAP.

h. Delegation Oversight Committee:
   - The Plan has submitted ongoing remediation plans and policies and procedures to DHCS for those areas identified in the Consolidated

Corrective Action Plan received by GCHP in September 2013 for the Medical Review Audit performed in December 2012. The Plan is awaiting acceptance and close out of the CAP by DHCS.

- The Plan hired a Compliance Specialist in Sept. 2013 and a Delegation Oversight Auditor in February 2014.
- The Plan has conducted credentialing audits on three physician groups in January 2014; reports from the audits are currently being finalized. Further audits will be conducted within the next 6 months to include coverage determination reviews, formulary adjudication and billed charges.

i. Member Services Committee:
   - Reported on the addition of new members to the Plan and the procedures that were implemented to add those new members. Member services will expand member orientation meetings to new locations throughout the county beginning in April.

j. Utilization Management Committee: see Dr. Wharfield's report.

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A029A - Top Utilized Drugs by Dollars

A029A_Rpt

Report Criteria Group(s) = GCHP, GCHPA, GCHPB, GCHPC, GCHPD, GCHPE, GCHPF, GCHPG, GCHPH, GCHPI, GCHPJ, GCHPK, GCHPL, GCHPM, GCHPN, GCHPO, GCHPP, GCHPQ
Cycles between 2/1/2014 and 2/28/2014

Desc	# Scripts	Amt Paid	Amt Paid/ RX	Ingred. Cost	Ingred. Cost/ 30 days	Ind.*	Maint	Form	Therapeutic Class
SOVALDI	8	$228,893.20	$28,611.65	$228,883.20	$30,654.00	N	N	N	ANTIVIRALS/Hepatitis C Agents
LANTUS	649	$124,289.60	$191.51	$123,237.10	$216.52	N	Y	I	ANTIDIABETICS/Human Insulin
ADVAIR DISKU	488	$110,352.58	$226.13	$109,784.33	$245.22	N	Y	I	ANTIASTHMATIC AND BRONCHODILATOR
VENTOLIN HFA	2158	$85,992.37	$39.85	$83,194.87	$57.48	N	Y	I	ANTIASTHMATIC AND BRONCHODILATOR
GLEEVEC	6	$67,268.14	$11,211.36	$67,257.64	$11,209.61	N	N	I	ANTINEOPLASTICS AND ADJUNCTIVE
METHYLPHENID	489	$56,535.16	$115.61	$55,890.16	$119.37	Y	Y	I	ADHD/ANTI-NARCOLEPSY/ANTI-
DIVALPROEX	492	$54,844.33	$111.47	$54,329.33	$118.07	Y	Y	I	ANTICONVULSANTS/Valproic Acid
HYDROCO/APAP	3346	$49,974.19	$14.94	$46,220.44	$25.43	Y	N	I	ANALGESICS - OPIOID/Hydrocodone Combinations
HUMIRA PEN	15	$48,885.23	$3,259.02	$48,861.23	$3,308.89	N	Y	I	ANALGESICS - ANTI-INFLAMMATORY/Anti-TNF-
XELODA	17	$43,995.82	$2,587.99	$43,971.07	$4,296.85	N	N	I	ANTINEOPLASTICS AND ADJUNCTIVE
HUMALOG	210	$43,676.49	$207.98	$43,410.49	$252.19	N	Y	I	ANTIDIABETICS/Human Insulin
AMPHETAMINE	345	$43,410.12	$125.83	$42,949.87	$131.01	Y	Y	I	ADHD/ANTI-NARCOLEPSY/ANTI-
CARIMUNE NF	3	$42,786.52	$14,262.17	$42,782.77	$14,924.22	N	N	I	PASSIVE IMMUNIZING AGENTS/Immune Serums
JANUVIA	172	$41,734.03	$242.64	$41,548.28	$250.84	N	Y	I	ANTIDIABETICS/Dipeptidyl Peptidase-4 (DPP-4)
TRUETEST	1066	$41,108.41	$38.56	$39,154.66	$38.78	N	Y	N	DIAGNOSTIC PRODUCTS/Diagnostic Tests
DULOXETINE	180	$38,741.64	$215.23	$38,569.14	$235.90	Y	Y	I	ANTIDEPRESSANTS/Serotonin-Norepinephrine
MORPHINE SUL	255	$34,673.26	$135.97	$34,520.76	$145.51	Y	N	I	ANALGESICS - OPIOID/Opioid Agonists
VYVANSE	160	$33,091.87	$206.82	$32,824.37	$211.36	N	Y	I	ADHD/ANTI-NARCOLEPSY/ANTI-
FLOVENT HFA	241	$31,951.24	$132.58	$31,647.49	$160.62	N	Y	I	ANTIASTHMATIC AND BRONCHODILATOR
BUDESONIDE	120	$30,690.27	$255.75	$30,540.52	$356.23	Y	Y	I	ANTIASTHMATIC AND BRONCHODILATOR
VIMPAT	49	$30,185.01	$616.02	$30,132.51	$626.46	N	Y	N	ANTICONVULSANTS/Anticonvulsants - Misc.
TAMIFLU	225	$29,762.35	$132.28	$29,431.10	$141.63	N	N	N	ANTIVIRALS/Neuraminidase Inhibitors
PATANOL	255	$28,970.85	$113.61	$28,496.10	$169.15	N	N	I	OPHTHALMIC AGENTS/Ophthalmic Antiallergic
ENBREL SRCLK	12	$28,697.38	$2,391.45	$28,678.38	$2,430.37	N	Y	I	ANALGESICS - ANTI-INFLAMMATORY/Soluble Tumor
SYMBICORT	151	$27,676.59	$183.29	$27,520.59	$201.96	N	Y	I	ANTIASTHMATIC AND BRONCHODILATOR
LETAIRIS	4	$27,405.01	$6,851.25	$27,405.01	$6,851.25	N	Y	I	CARDIOVASCULAR AGENTS - MISC./Pulmonary
OXYCONTIN	54	$27,254.72	$504.72	$27,199.72	$609.86	N	N	I	ANALGESICS - OPIOID/Opioid Agonists
SPIRIVA	171	$26,887.20	$157.24	$26,737.70	$158.40	N	Y	I	ANTIASTHMATIC AND BRONCHODILATOR
TYVASO REFIL	2	$26,619.21	$13,309.61	$26,619.21	$14,260.29	N	Y	N	CARDIOVASCULAR AGENTS - MISC./Prostaglandin
NEULASTA	9	$26,121.42	$2,902.38	$26,113.92	$4,304.49	N	N	N	HEMATOPOIETIC AGENTS/Granulocyte Colony-
COPAXONE	6	$26,103.67	$4,350.61	$26,095.17	$4,349.20	N	Y	I	PSYCHOTHERAPEUTIC AND NEUROLOGICAL
LYRICA	116	$25,916.18	$223.42	$25,801.18	$227.52	N	Y	I	ANTICONVULSANTS/Anticonvulsants - Misc.
TACROLIMUS	69	$25,448.09	$368.81	$25,341.09	$398.03	Y	Y	I	ASSORTED CLASSES/Macrolide Immunosuppressants
GABAPENTIN	1387	$24,082.92	$17.36	$22,536.17	$17.32	Y	Y	I	ANTICONVULSANTS/Anticonvulsants - Misc.
LEVEMIR	112	$23,717.89	$211.77	$23,491.14	$228.88	N	Y	I	ANTIDIABETICS/Human Insulin
	13042	$1,657,742.96	$127.11	$1,641,176.71	$161.70				

*Indicator: M,N = Brand no generic available; O = Brand with generic available; Y = generic

Gold Coast Health Plan℠
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Hepatitis C Treatment

Monday, March 24, 2014

Albert Reeves, MD
Chief Medical Officer

www.goldcoasthealthplan.org

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Hepatitis C and Sovaldi

1. Hepatitis C is a chronic viral infection of the liver
2. Usually infection occurs through contact with a blood product, particularly injection of a blood product into the body such as blood transfusion or using drugs intravenously
3. Most people do not know that they have hepatitis C and are not ill from it until the later stages.
4. Hepatitis C can lead to cirrhosis, liver failure and liver cancer.
5. In 2007 the age-adjusted mortality rate among patients with HCV in the United States was 4.6 per 100,000 persons per year, a rate that was higher than that seen for HIV (4.2 deaths per 100,000 persons per year)
6. Hepatitis C leads to significant medical costs treating the complications of cirrhosis which include gastrointestinal bleeding, wasting, ascites (fluid collection in the abdomen) and cancer of the liver. Advanced cirrhosis and liver cancer result in the need for liver transplantation.

Treatment of Hepatitis C

1. Antiviral therapy is the cornerstone of treatment of chronic hepatitis C and the goal of antiviral therapy is to eradicate the hepatitis C virus which is predicted by attainment of a sustained virologic response (SVR). Attaining an SVR has been associated with decreases in all-cause mortality, liver-related death , need for liver transplantation, hepatocellular carcinoma , and other liver-related complications.
2. The mainstay of treatment for years was a combination of peginterferon (interferon) weekly injections and ribavirin for 48 weeks.
   a. SVR is between 40 and 80 percent depending on the genotype
   b. Side effects including anemia, low white blood counts, flu-like side effects, and neuropsychiatric side often lead to discontinuation
   c. Cost for a course of treatment $37,000.

Treatment of Hepatitis C (cont'd)

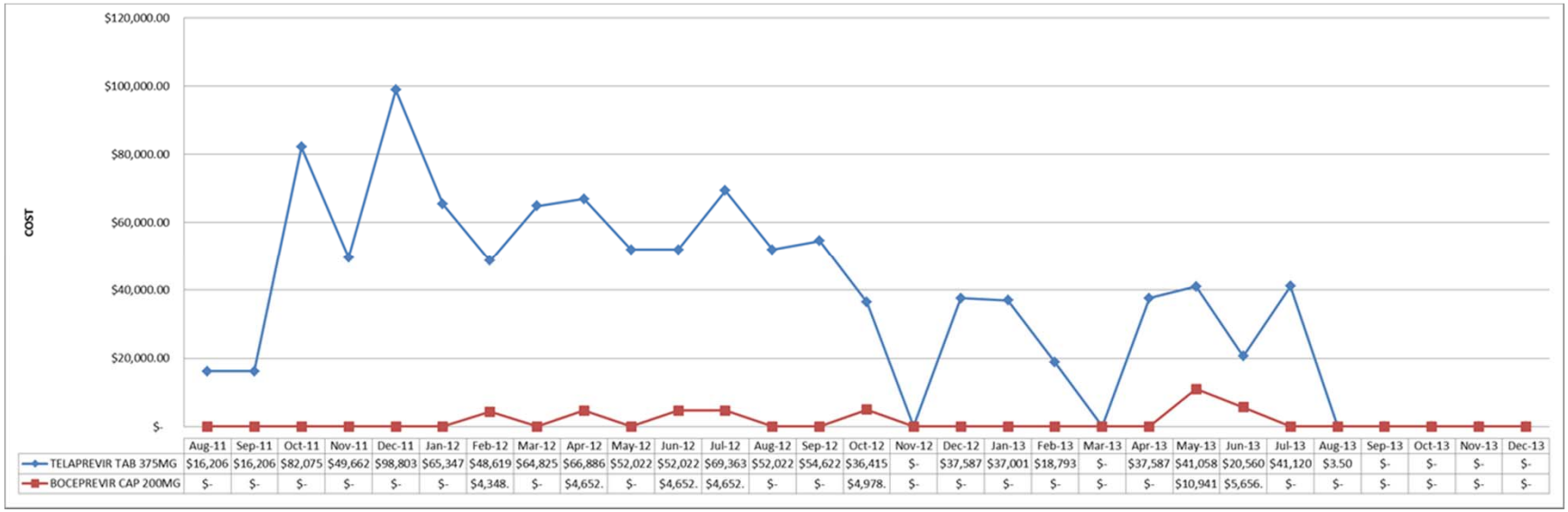
3. 2 new antiviral medications were approved by the FDA in April and May 2011 – telaprevir (Incivek) and boceprevir (Victrelis)
   a. Telaprevir regimen – given with peginterferon alfa and ribavirin, telaprevir given 2X a day for 12 weeks and the other drugs for 24 or 48 weeks. (genotype 1). Cost for a course of therapy to treat genotype 1 to SVR - $103,000.
   b. Boceprevir regimen – boceprevir for 24 weeks and peginterferon and ribavirin for 28 weeks (genotype 1)

      Cost for a course of therapy for genotype 1 to SVR - $104,000.

      Outcome for both for previously untreated patients – 67% - 75% SVR

      Gold Coast experience from 7/2011 – present with telaprevir and boceprevir:

COST AND UTILIZATION OF TELAPREVIR AND BOCEPREVIR



	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
TELAPREVIR TAB 375MG	$16,206	$16,206	$82,075	$49,662	$98,803	$65,347	$48,619	$64,825	$66,886	$52,022	$52,022	$69,363	$52,022	$54,622	$36,415	$-	$37,587	$37,001	$18,793	$-	$37,587	$41,058	$20,560	$41,120	$3.50	$-	$-	$-	$-
BOCEPREVIR CAP 200MG	$-	$-	$-	$-	$-	$-	$4,348.	$-	$4,652.	$-	$4,652.	$4,652.	$-	$-	$4,978.	$-	$-	$-	$-	$-	$-	$10,941	$5,656.	$-	$-	$-	$-	$-	$-

Treatment of Hepatitis C (cont'd)

4. Sofosbuvir (Sovaldi) was released in Dec. 2013.
   - Regimen – sofosbuvir 12 weeks, peginterferon and ribavirir – 12 weeks (genotype 1)
     - Also indicated for genotypes 2,3, and 4
     - Also indicated for patients with co-infection with HIV
     - Also indicated for patients with hepatocellular cancer awaiting transplant
   - Cost for course of therapy to treat genotype 1 to SVR –
   - Outcomes – 89% SVR (genotype 1)
   - Advantages besides better outcomes – shorter course of therapy and less side effects
   - Can be given without interferon for those unable to take interferon
   - Cost for course of therapy to SVR $120,000.
   - Consider savings of avoiding the need for treatments for complications of Hepatitis C including avoiding need for transplantation and related costs post transplant.

AGENDA ITEM 5b

To: Gold Coast Health Plan Commissioners

From: Dr. Nancy Wharfield, Health Services Medical Director

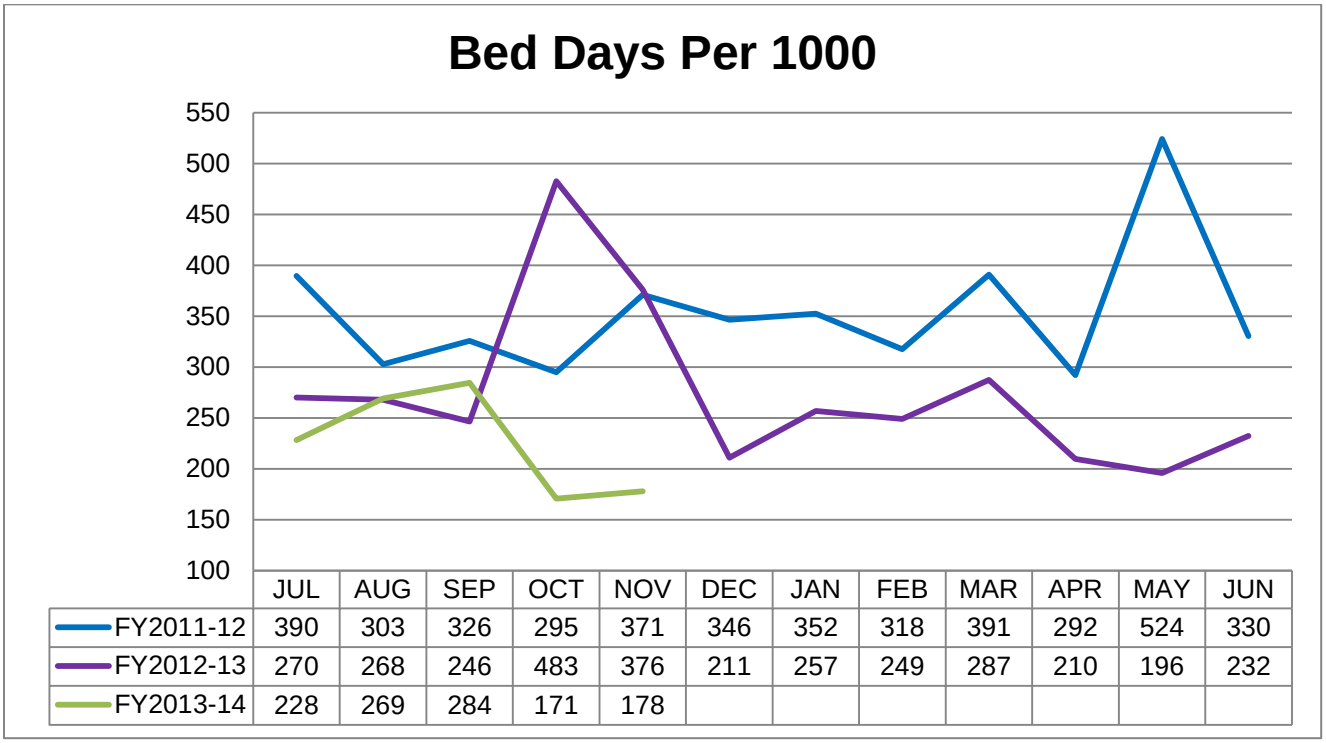
Date: March 24, 2014

Re: Health Services Update

Inpatient Utilization

Inpatient bed days / 1000 members showed a decline from a peak in September 2013 and plateaued below 200 beginning October 2013.

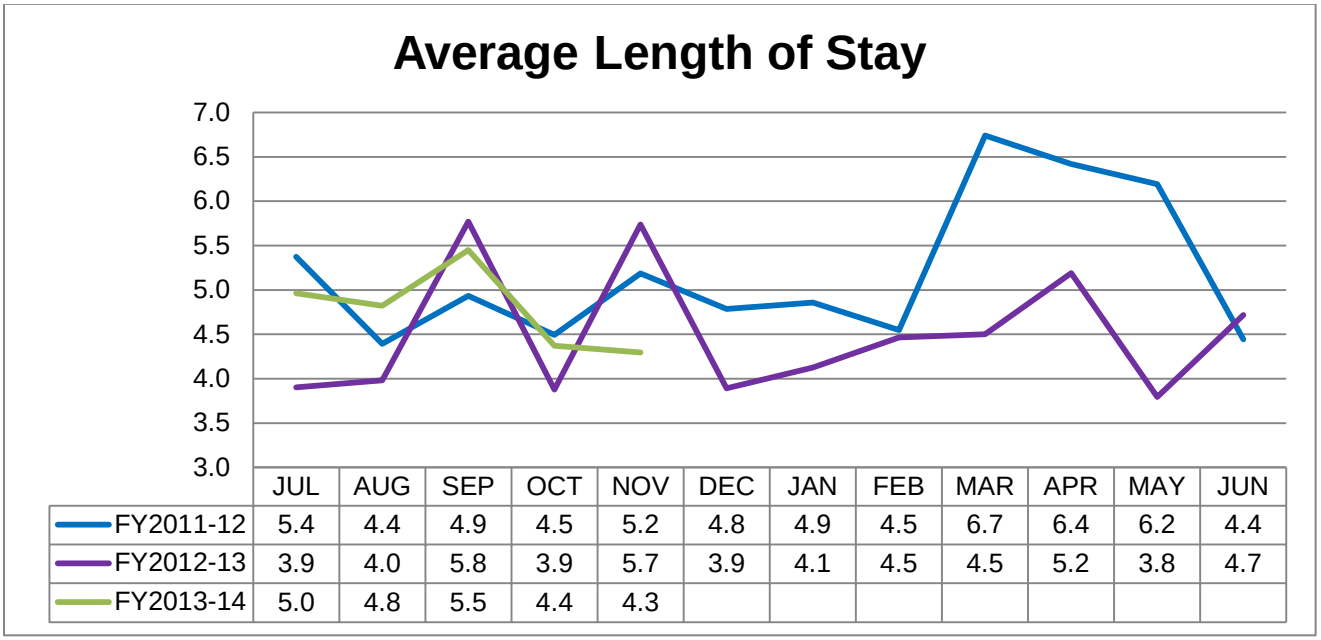
Inpatient days / 1000 members and average length of stay calculations are based on paid claims and are lagged by 3 months to allow for adequate run-out of the data. Administrative days are included in the acute inpatient bed day and average length of stay calculations. Dual-eligible patients, SNF, and LTC days are not included in this data.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY2011-12	390	303	326	295	371	346	352	318	391	292	524	330
FY2012-13	270	268	246	483	376	211	257	249	287	210	196	232
FY2013-14	228	269	284	171	178							

Average Length of Stay

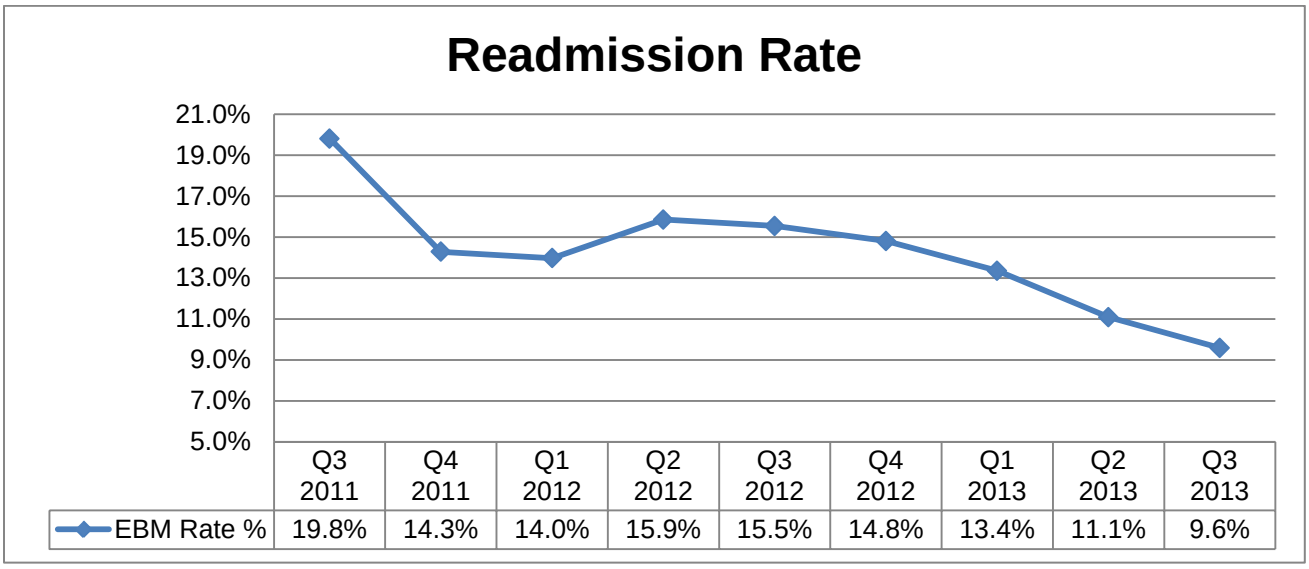
Average length of inpatient stay showed a decline from a peak in September 2013.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY2011-12	5.4	4.4	4.9	4.5	5.2	4.8	4.9	4.5	6.7	6.4	6.2	4.4
FY2012-13	3.9	4.0	5.8	3.9	5.7	3.9	4.1	4.5	4.5	5.2	3.8	4.7
FY2013-14	5.0	4.8	5.5	4.4	4.3							

Readmission rate

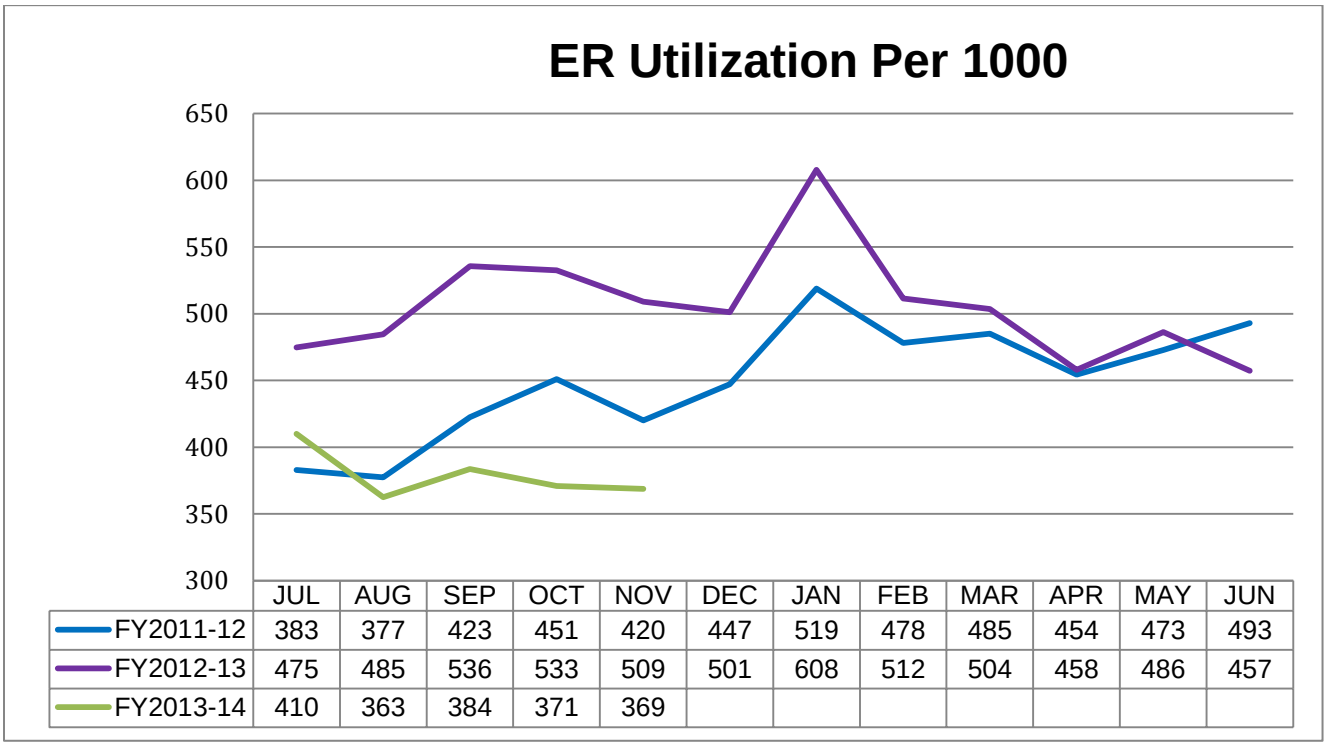
The all cause 30-day readmission rate continues to decline. An On-Site Discharge Nurse has been hired this month. After training on the medical management system is complete, she will begin work on-site at Ventura County Medical Center to facilitate Transition Care for our most fragile members. It is expected that these efforts will help prevent unnecessary readmissions but may contribute to a decreased length of stay as well.



	Q3 2011	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013
EBM Rate %	19.8%	14.3%	14.0%	15.9%	15.5%	14.8%	13.4%	11.1%	9.6%

ER Utilization

Emergency room utilization per 1000 members shows significant improvement from prior fiscal years. Utilization plateaued in October and November 2013. Health Navigators and Care Managers continue to reach out to our highest utilizers to educate them regarding appropriate alternatives to emergency department visits. Efforts are currently underway to obtain real time emergency room census information in order to give more timely feedback to members and their providers.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY2011-12	383	377	423	451	420	447	519	478	485	454	473	493
FY2012-13	475	485	536	533	509	501	608	512	504	458	486	457
FY2013-14	410	363	384	371	369							

AGENDA ITEM 5c

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: March 24, 2014

RE: Affordable Care Act (ACA), Section 1202

SUMMARY:
Gold Coast Health Plan (GCHP) may be at-risk for some portion of supplemental payments owed to qualifying physicians as required by the Affordable Care Act (ACA), Section 1202. This determination is based on information provided during a State Department of Health Care Services (DHCS) meeting on February 11, 2014, where the ACA Section 1202 reconciliation methodology was provided. Additional updates regarding ACA Section 1202 are provided below.

BACKGROUND / DISCUSSION:
Pursuant to the ACA, as amended by the H.R. 4872-24 Health Care and Education Reconciliation Act of 2010, Section 1202, ACA and 42 Code of Federal Regulations 447 requires state Medicaid agencies to reimburse primary care physicians with a specialty designation of family medicine, general internal medicine or pediatric medicine, at parity with Medicare payment rates, for specified Evaluation and Management (E&M) and Vaccine Administration services for services provided during 2013 and 2014.

To make these enhanced payments, the State has opted to utilize the prospective capitation risk model with retrospective “100% true-up” reconciliation. Under this approach, the estimated provider payment increases will be reflected in prospective managed care plan (MCP)-specific capitation payments and the MCP will be required to collect from physicians and then submit to DHCS the qualifying encounters for which supplemental payments were made.

During a meeting between DHCS and the MCPs on February 11, 2014, the Department reviewed the reconciliation process in detail for the first time. During this meeting, it was disclosed that there would not in fact be a “100% true-up”. Although the Department will reconcile to the MCP’s actual utilization of services, there was not a step in the process to reconcile to differences unit cost. In other words, DHCS will make the MCPs whole by taking into account differences between what was assumed in the capitation rate and actual experience for utilization (i.e., services), but will not take into account differences between what was included the MCP’s capitation rate and actual experience for differences in unit cost. Hence, there is not a “100% true-up” and MCPs may not get reimbursed for

differences between what the State assumed to be the increase in payment rate to Medicare levels and what GCHP actually experienced as the increase in payment rate.

GCHP (individually and through associations) is continuing to discuss this concern with the DHCS.

Additional information regarding the ACA Section 1202 include the following:

- DHCS has communicated that the due date for providers to attest is December 31, 2014 in order to qualify for the increased payments. Providers have received monthly notifications via the GCHP monthly Provider Operations Bulletin that have detailed requirements and instructions pertaining to the attestation on the State site. Information has also been presented during provider town hall meetings.

- GCHP has revised and resubmitted (on January 31, 2014) an updated version of the required DHCS compliance plan to DHCS for final review and approval. DHCS provided a letter on March 3, 2014 stating that the Plan's compliance plan has been accepted.

FISCAL IMPACT:
GCHP has received a capitation payment of $5 million for services provided from January 1, 2013 to June 30, 2013. GCHP is in process of paying physicians approximately $2 million for services performed during this period (to those physicians that have attested and submitted a W-9 form). GCHP expects to make additional payments to providers for this time period once providers attest and complete the W-9 paperwork.

Although the initial capitation rate payment from DHCS covers this initial payment to the qualifying providers, GCHP has estimated that as much as $1 million of the $6.3 million of payments may ultimately not be reimbursed by the State based on the reconciliation methodology. This is a result of the fact that based on GCHP staff's analysis; the Plan's increase from Medi-Cal to Medicare levels is approximately 16% higher, on average, than what the State assumed in the capitation rate development.