Gold Coast Health Plan℠
A Public Entity

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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, November 18, 2013
3:00 p.m.

AGENDA

CALL TO ORDER / ROLL CALL

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 October 28, 2013

2. APPROVAL ITEMS

a. Governmental Advocacy Services Contract Renewal
b. DHCS Contract Amendment(s)
c. Pharmacy Benefit Manager (PBM) Oversight Vendor Contract
d. FY 2012-13 Audited Financial Statements (presented by McGladrey)

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 November 18, 2013 Commission Meeting Agenda *(continued)*
PLACE: 2240 E. Gonzalez, Room 200, Oxnard, CA
TIME: 3:00 p.m.

3. ACCEPT AND FILE ITEMS

a. CEO Update
b. September Financials (Unaudited)

4. INFORMATIONAL ITEMS

a. CMO and Health Services Update
b. ACA Implementation Update

CLOSED SESSION

a. 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 Manager
Michael Slater, real estate agent of CBRE

Property Owners and Subject Real Property: 711 Building LLC, 711 Daily Drive, Camarillo, CA 93010
Under Negotiation: Price and Term of Payment

b. Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9 Lucas v. Regional Government Services et al, VCSC Case No. 56-2013-00432444-CU-CE-VTA

c. Public Employee Performance Evaluation Pursuant to Government Code Section 54957 Title: Chief Executive Officer

Announcement from Closed Session, if any.

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

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba
Gold Coast Health Plan November 18, 2013 Commission Meeting Agenda *(continued)*
PLACE: 2240 E. Gonzalez, Room 200, Oxnard, CA
TIME: 3:00 p.m.

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on January 27, 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
October 28, 2013
(Not official until approved)

CALL TO ORDER

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

SWEAR-IN OF COMMISSIONER

Clerk of the Board Traci McGinley swore in Dr. Michelle Laba and Dr. Gagan Pawar as newly appointed Commissioners of the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
May Lee Berry, Medi-Cal Beneficiary Advocate
Eileen Fisler, Ventura County Health Care Agency
Peter Foy, Ventura County Board of Supervisors
David Glyer, Private Hospitals / Healthcare System
Robert Gonzalez, MD, Ventura County Health Care Agency
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
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Lanyard Dial, MD, Ventura County Medical Association
Laurie Eberst, Private Hospitals / Healthcare System

STAFF IN ATTENDANCE
Michael Engelhard, CEO
Nancy Kierstyn Schreiner, Legal Counsel
Michelle Raleigh, CFO
Traci R. McGinley, Clerk of the Board
Ruth Watson, COO
Melissa Scrymgeour, IT Director
Nancy Wharfield, MD, Medical Director Health Services
Guillermo Gonzalez, Government Relations Director
Luis Aguilar, Member Services Manager
Brandy Armenta, Compliance Officer
Stacy Diaz, Human Resources Manager

Connie Harden, Member Services
Steven Lalich, Communications Manager
Lyndon Turner, Finance Manager

Stuart Busby, Chief-Capitated Rates Development Division of California Department Health Care Services (DHCS) was also in attendance.

The Pledge of Allegiance was recited.

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

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of September 23, 2013

Commissioner Juarez noted that he has voted on the Corrective Action Plan (CAP) in the past and should have been allowed to vote on Agenda Item *3a. Revised Corrective Action Plan (CAP)* at the last meeting. Legal Counsel Schreiner reiterated that Commissioner Juarez was required to recuse himself due to the particular issues being discussed at that time.

Commissioner Foy moved to approve the Regular Meeting Minutes of September 23, 2013. Commissioner Berry seconded. The motion carried with Commissioner Juarez voting no. **Approved 7-1**.

2. APPROVAL ITEMS

a. Consumer Advisory Committee (CAC) – Beneficiary Member

COO Watson reviewed the written report and explained that a great deal of time was unsuccessfully spent attempting to locate a Beneficiary Member for the CAC; however, parents of beneficiaries were interested in serving on the CAC. She requested that the Committee Beneficiary Member seat be changed to "Beneficiary Member or Parent / Guardian of a Beneficiary Member." COO Watson announced that she was just notified that a beneficiary member may submit an application later in the day.

Commissioner Foy moved to approve expanding the criteria of the Beneficiary Member Consumer Advisory Committee seat be a Beneficiary Member or Parent / Legal Guardian of a GCHP Member. Commissioner Glyer seconded. The motion carried. **Approved 8-0.**

3. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Engelhard reviewed the written report with the Commission.

b. August Financials (Unaudited)

CFO Raleigh reviewed the Financial report and noted that the Executive / Finance Committee recommended approval of the August Financials. She highlighted the following items:

- One major provider implemented an electronic health records system so their claims have been low but are now being submitted,
- Net income is ahead of budget, and
- Revenue is approximately $700,000 less than anticipated (mostly due to estimated CBAS revenue which is being clarified with the State).

Discussion was held regarding the average number of prescriptions per member and the fact that children typically utilize this service much less than other Members.

Commissioner Juarez moved to accept and file the CEO Update and Unaudited August Financials. Commissioner Fisler seconded. The motion carried. **Approved 8-0.**

4. INFORMATIONAL ITEMS

a. AB 85 – Health and Human Services
b. ACA / Medi-Cal Mental Health Benefit Vendor Selection

Chair Gonzalez reminded the Commission that the information was provided in the packet for review. There were no objections so the Informational Items were not presented orally.

COMMENTS FROM COMMISSIONERS

Commissioner Juarez stated that he was informed that GCHP's files were left at Nordman, Cormany, Hair and Compton. Legal Counsel Schreiner assured Commissioner Juarez that all files were transferred to her new law firm with the exception of one insurance file that still needs to be transferred.

Chair Gonzalez thanked Dr. Michelle Laba and Dr. Gagan Pawar for agreeing to participate in the Commission.

Commissioner Laba stated that she is a pediatrician and has been on staff at Ventura County Medical Center for sixteen years.

Commissioner Pawar explained that she is an obstetrician in family medicine and has been with Clinicas del Camino Real for approximately three years.

CLOSED SESSION

Due to the number of Commissioners not present, Chair Gonzalez requested the CEO Evaluation Closed Session Item be postponed until the following meeting.

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

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 3:52 p.m. regarding the following item:

Closed Session - Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9 Lucas v. Regional Government Services et al, VCSC Case No. 56-2013-00432444-CU-CE-VTA

Item Postponed

Closed Session - Public Employee Performance Evaluation Pursuant to Government Code Section 54957 Title: Chief Executive Officer -

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 4:26 p.m.

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

ADJOURNMENT

Meeting adjourned at 4:28 p.m.

AGENDA ITEM 2a

To: GCHP Commissioners

From: Guillermo Gonzalez

Date: November 18, 2013

Re: Contract Renewal for Governmental Advocacy Services

SUMMARY:
The purpose of this memo is to request authorization to renew a consulting agreement between Gold Coast Health Plan (GCHP) and Edelstein Gilbert Robson & Smith (EGRS). This agreement was for consulting services to GCHP on matters related to state of California-related governmental advocacy services.

BACKGROUND:
In September 2012 GCHP issued a request for quotes (RFQ) for governmental advocacy services relevant to managed care organizations in California. Five firms were identified and each was sent an RFQ. The five firms included: Edelstein, Gilbert, Robson & Smith; Isenberg O'Haren; Capitol Advocacy; Ferguson Group; and SGR.

Of the five firms listed above, only EGRS returned a quote to GCHP. On October 9, 2012, GCHP entered into a one-year agreement with EGRS for the period covering October 15, 2012 through October 14, 2013. The cost of these services totaled $60,000.00 per year and is paid on a monthly retainer basis.

Edelstein, Gilbert, Robson and Smith have extensive and long-standing experience in providing governmental advocacy services to public health plans in California. Their client list includes four of the other five County Organized Health Systems (COHS) plans. Because of this, EGRS was able to provide services to GCHP on a wide range of state advocacy issues quickly and efficiently.

GCHP has greatly benefitted from EGRS' health care expertise and experience. EGRS has long-term relationships with policymakers in the State Legislature and Department of Health Care Services (DHCS) and has leveraged those relationships to win favorable support for GCHP's efforts to stabilize its financial and operational status. Additionally, EGRS has identified and tracked relevant legislation for GCHP, and provided input on legislation impacting both GCHP and the Medi-Cal Program. Lastly, EGRS has assisted GCHP management in preparation of presentations to policymakers and provided periodic written legislative reports to GCHP's Governing Commission.

RECOMMENDATION:
Edelstein, Gilbert, Robson and Smith has indicated that they would renew the contract with Gold Coast Health Plan with no rate increase for the FY 2013-14 fiscal year. Therefore Staff recommends renewal of the EGRS contract with GCHP for one more year at an annual rate of $60,000.00. This would bring the lifetime-do-date contract amount to $120,000.00, necessitating the request for Commission approval of this contract.

CONCURRENCE:
N/A.

Attachments:
None.

AGENDA ITEM 2b

To: GCHP Commissioners

From: Michael Engelhard

Date: November 18, 2013

Re: GCHP-DHCS Contract Amendments

SUMMARY:
The purpose of this memo is to request authorization for the Chief Executive Officer to execute amendments to the Gold Coast Health Plan (GCHP) contract with the California Department of Health Care Services (DHCS).

BACKGROUND:
The federal Affordable Care Act (ACA) provides states the opportunity to expand Medicaid or Medi-Cal coverage for single adults without children, ages 19-64, with incomes of up to 138% of the federal poverty level (FPL) based on modified adjusted gross income. In accordance with the ACA and for other changes related to the State budget, GCHP anticipates receiving contract amendments from DHCS.

Contract Amendments:
The benefit structure for the Medi-Cal expansion population is expected to be the same as it is for the current Medi-Cal population. Amendments to the GCHP-DHCS contract are likely to include: state capitation rates; aid code changes; continuity of care obligations; policy and procedure requirements; as well as deliverables to DHCS regarding readiness and reporting requirements. Included below are, but not limited to, items pending contract amendments by program area:

Program / Contract Area	Amendment
ACA: • Medi-Cal Expansion (MCE), including LIHP and MAGI changes • Mental Health • ACA Provider Rate Increase	The LIHP, MAGI and Mental Health contract amendments will be part of one amendment.
State Budget: • MCO Tax • AB 97 Provider Reductions • AB 85	Revised capitation rates will be updated to include the MCO tax of 2.35% for FY 2012-13 and the gross premium tax of 3.9375% for FY 2013-14. It is expected that the State will provide rates reflecting the impact of AB 97 and AB 85 provider reductions.

FISCAL IMPACT:
The revised State capitation rates for both FY 2012-13 and FY 2013-14 are expected to cover the costs associated with the above changes including costs for Medi-Cal expansion and the integration of mental health and substance use benefits. The remaining items such as the MCO Tax are typically passed through to the respective parties.

RECOMMENDATION:
GCHP's Commission will not be meeting in the month of December 2013. As contract amendments may need to be executed in December, staff recommends approval of authorization for the Chief Executive Officer to execute amendments to the GCHP primary contract with DHCS.

CONCURRENCE:
N/A

Attachments:
None.

AGENDA ITEM 2c

To: Gold Coast Health Plan Commissioners

From: Sherri Tarpchinoff Bennett, Director, Network Operations

Date: November 18, 2013

RE: Pharmacy Benefit Manager (PBM) Oversight Services

SUMMARY:
As part of the Consolidated Corrective Action Plan ("CAP") supplied by the California Department of Health Care Services ("DHCS") to Gold Coast Health Plan ("Plan" or "GCHP") on September 18, 2013, the Plan is required to increase its delegated oversight of its pharmacy operations. To address a key element of that oversight function, the Plan proposed in its response to hire a consulting firm to perform the oversight of the Plan's Pharmacy Benefits Manager ("PBM").

BACKGROUND / DISCUSSION:
GCHP issued a Request for Proposal (RFP) for Pharmacy Benefit Manager (PBM) Oversight Services on September 6, 2013. The RFP was sent to three PBM Oversight Service vendors and was posted to the GCHP Website.

The RFP requested proposals for a one or two-year contract period, beginning November 1, 2013, and ending October 31, 2014 (these dates will change due to the timing of final contract execution and board approval). The parties may mutually agree to a renewal of the contract in two-year intervals, or at any interval that is advantageous to GCHP.

The primary purpose of the RFP for a PBM oversight service is to contract with a vendor to oversee the Pharmacy Benefit Manager contract and the services provided by Script Care, Ltd. Proposals submitted in response to the solicitation were to comply with the instructions and procedures contained within RFP.

Six vendors responded affirmatively, although one was disqualified for untimely submission. An internal scoring committee was developed and each vendor was evaluated and scored based on their responses in the following categories:

- References (client satisfaction)
- Company Overview / Experience
    - Years of experience

  - Experience with Private / Public Sector
  - Staff Qualifications
- Ability to meet objectives of the scope of work
- Cost Proposal – Including administrative and implementation costs

Vendor	Points Awarded (100 Possible)
Pro-Pharma	96.0
IPC Evergreen Rx	80.5
Milliman Inc.	66.3
ARMS Rx	64.4
Excelsior Solutions	41.0

In addition to earning the highest overall score in the bid evaluation process, Pro-Pharma's bid was also the lowest cost of the five vendors who submitted qualified proposals.

FISCAL IMPACT:
The Plan is still negotiating final contract terms with the selected vendor, Pro-Pharma. The two-year contract is expected to be worth approximately $100,000-$110,000.

RECOMMENDATION:
Subject to review by legal counsel, authorize and direct the Chief Executive Officer to execute an agreement with the selected PBM oversight vendor, Pro-Pharma.

CONCURRENCE:
N/A

Attachments:
None.

AGENDA ITEM 2d

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: November 18, 2013

Re: FY 2012-13 Audit Results

SUMMARY:
Staff is presenting the results of the FY 2012-13 (07/01/12-06/30/13) financial audit of Gold Coast Health Plan (GCHP or Plan) for review by the Commission. The Plan's auditor, McGladrey, will be presenting findings of the financial audit to the Commission on November 18th. Staff did review the audit results during the November 7, 2013 Executive / Finance Committee meeting when the Committee recommended approval of the FY 2012-13 financial audit.

The following bullets summarize the audit findings:

1. Auditor's report reflects an "unqualified opinion" (i.e., there were no issues that would impact the financials),
2. Audit adjustments include one large, positive adjustment that was identified by Plan management due to information being received from DHCS after the end of the audit period, and
3. Auditor' findings reflect improvement on the internal control-related findings.

BACKGROUND / DISCUSSION:
The Plan engaged McGladrey LLP (McGladrey) to perform a financial audit for the FY 2012-13 year. McGladrey had also performed financial audits for the Plan for the prior two fiscal years. Performing an annual audit is a requirement of the Plan's contract with the State of California's Department of Health Care Services.

The primary purpose of the audit is for stakeholders to gain assurance that the Plan's financial statements are properly presented, are free of material misstatements and have been prepared in conformity with accounting principles generally accepted in the U.S. The auditor's report for FY 2012-13 resulted in an unqualified opinion; no issues were reported that would have an adverse effect on the Plan's financial results.

A secondary (but important) purpose of the audit is to test and comment on the Plan's design, implementation and maintenance of a system of internal controls that have a relationship with financial reporting. McGladrey's report contained no Material Weaknesses in internal controls for FY 2012-13, as compared to three in the preceding year. Significant

Deficiencies were identified in three areas, but the comments largely reflect issues that had been identified by earlier the year and are in the process of being addressed.

The auditor's findings resulted in only two adjustments that affected net income (resulting in an overall net increase) and related to timing issues for claims payments and processing. This is a significant improvement over the prior year's six significant adjustments.

FISCAL IMPACT:
For FY 2012-13 the following audit adjustments were made to the unaudited 06/30/13 financial statements:

Adjustment	Impact on Financial Statements
Identified by Plan Management – Revenue Adjustments	
• Final State Rates	$ 4,087,976
• MCO Tax	7,337,759
Total Increase in Revenue	$11,425,735
Identified by Auditors – Health Care Expense Adjustments	
• Claim processed and accrued in month following close	$ 43,046
• Voided claim payment recorded after year-end close	(109,908)
Total Decrease in Health Care Expenses	$ (66,862)
Gross Increase in Operating Income	$11,492,597
Increase in Administrative Expense (MCO Tax Reclassification)	(7,337,759)
Increase in Net Income	$ 4,154,838

Additional audit adjustment items are presentation reclassifications, meaning the auditors recommend a different way to group the information on the financial statements. These items do not impact the ending financial position of the Plan.

The increase in net income also impacts the Plan's ending tangible net equity (TNE) position at 06/30/13:

Unaudited TNE at 06/30/13:	$ 7,736,261
Audit Adjustments:	4,154,838
Audited TNE at 06/30/13:	$11,891,100

Therefore, the Plan exceeds the TNE requirement at 06/30/13 of $10,974,140 by approximately $916,960.

RECOMMENDATION:
Staff proposes that the Commission approve and accept the FY2012-13 audit results.

CONCURRENCE:
Executive / Finance Committee (11/07/13).

Attachments:

- Presentation of the 2013 Financial Statement Audit Results for Gold Coast Heath Plan (McGladrey)
- Audited Financial Statements (McGladrey)
- Report to Executive / Finance Committee (McGladrey)

Presentation of the 2013 Financial Statement Audit Results for Gold Coast Heath Plan

November 18, 2013

McGladrey

Assurance ▪ Tax ▪ Consulting

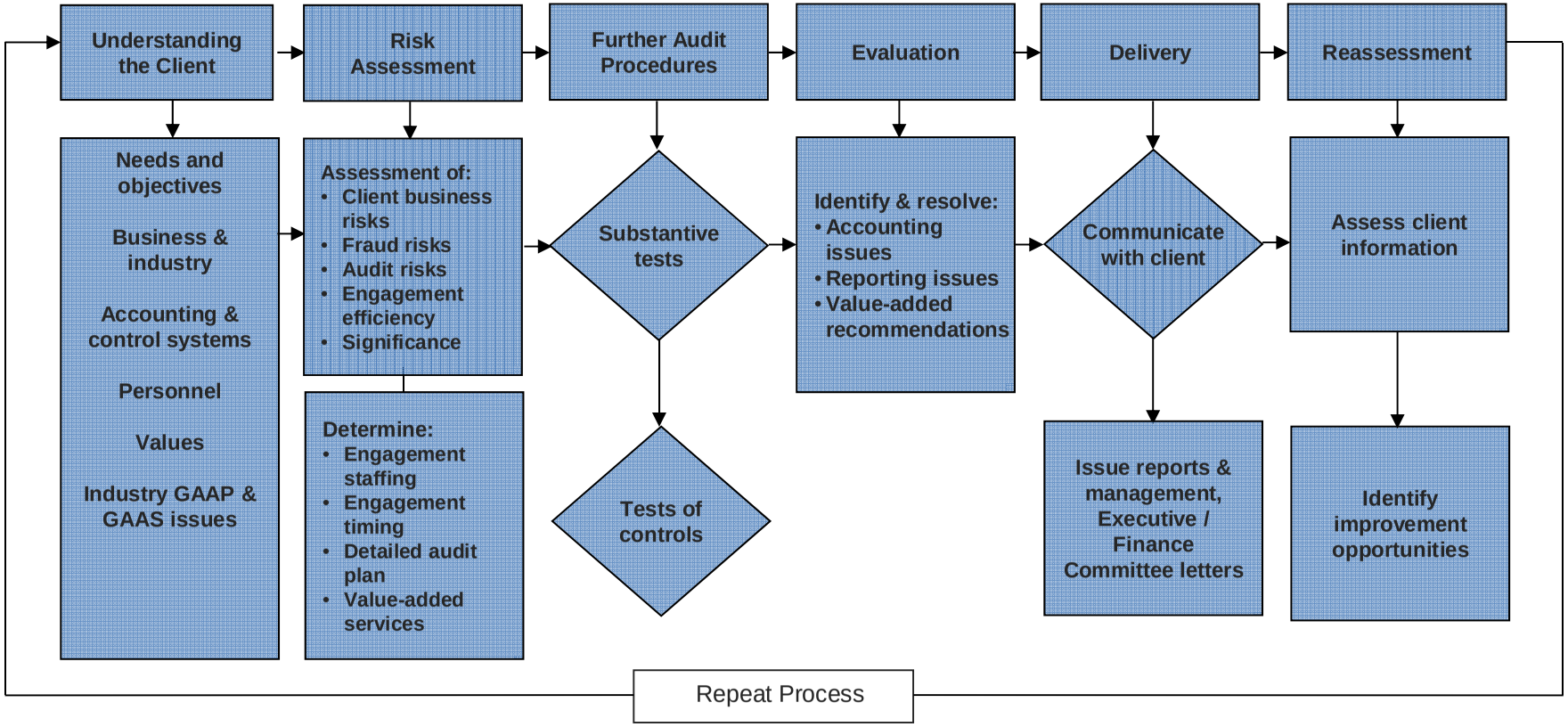
Agenda

- Overview of the audit approach
- Review the Report to the Executive/Finance Committee
- Letter Communicating Significant Deficiencies in Internal Controls Over Financial Reporting
- Management Letter
- Financial Indicators
- Summarized Financial Statements

McGladrey

Overview of the Audit Approach

We support a process of continuous communication throughout the year. The process for conducting the audit itself is broken into the following components:



McGladrey

Report to the Executive/Finance Committee

Area of Required Communication	McGladrey Comment/Response/Result
Auditor's Responsibility Under Professional Standards	We are responsible for obtaining reasonable assurance about whether the financial statements are prepared in accordance with U.S. generally accepted accounting principles and are free of material misstatement, whether caused by error or fraud.
Accounting Policies and Practices – Alternative Accounting Policies and Practices	We did not discuss with management any alternative treatments within generally accepted accounting principles.
Accounting Policies and Practices – Adoption Of, or Changes In, Accounting Practices	Gold Coast Health Plan (GCHP) did not adopt any significant new accounting policies, nor have there been any other changes in existing significant accounting policies during the current period.

McGladrey

Report to the Executive/Finance Committee

Area of Required Communication	McGladrey Comment/Response/Result
Accounting Policies and Practices – Significant or Unusual Transactions	During fiscal 2013, GCHP received approximately $34,153,000 of supplemental revenue from the Department of Health Care Services (DHCS) as a hospital quality assurance fee. GCHP passed these funds through to providers. These amounts were not reflected in the 2013 statement of revenues, expenses and changes in net position or the balance sheet, as the amounts passed through to the providers do not meet requirements for revenue recognition under Government Accounting Standards.

McGladrey

Report to the Executive/Finance Committee

Area of Required Communication	McGladrey Comment/Response/Result
Accounting Policies and Practices – Significant or Unusual Transactions	During fiscal 2013, GCHP entered into an agreement with DHCS to receive an intergovernmental transfer (IGT) of $26,759,000. In accordance with the agreement, approximately $25,595,000 of the funds that were received from the IGT was passed through to Ventura County Medical Center (VCMC) which is owned and operated by the County of Ventura. Under Government Accounting Standards, the amount that was passed through to VCMC is not reported on the statement of revenues, expenses and changes in net position or the balance sheet. GCHP retained approximately $535,000 of the IGT for costs to administer the IGT contract, and recorded this amount in capitation revenue in fiscal 2013.

McGladrey

Report to the Executive/Finance Committee

Area of Required Communication	McGladrey Comment/Response/Result
Accounting Policies and Practices – Management's Judgments and Accounting Estimates	Particularly sensitive accounting estimates include: • Valuation and collectability of receivables, including provider receivables • Reinsurance recoverable • Reserve for claims liability (Incurred but not reported = IBNR) and claims payable • Premium revenue and premium reserve(s) • Reserve for premium deficiency (PDR) • Litigation and other claims

McGladrey

Report to the Executive/Finance Committee

Area of Required Communication	McGladrey Comment/Response/Result
Basis of Accounting	DHCS has raised concerns to GCHP about its operational results and financial status. As a result of these concerns, GCHP is currently operating under a corrective action plan (CAP) by the DHCS. GCHP's ability to continue as a going concern is dependent on its progress and resolution of the concerns raised in the DHCS CAP. See Note 2 to the audited financial statements for additional disclosures regarding this matter. We noted the progress made by management of GCHP during 2013 in the areas of operational results and financial status, including GCHP's achievement of compliance with Tangible Net Equity (TNE) requirement. We also reviewed management's plans to mitigate the adverse effects of such conditions and events. The financial statements were prepared on the assumption that GCHP will continue as a going concern. We have included an emphasis-of-matter paragraph in our audit report to reflect these facts.

McGladrey

Report to the Executive/Finance Committee

Area of Required Communication	McGladrey Comment/Response/Result
Audit Adjustments	Adjustments recorded to the original trial balance during the audit resulted in an increase to net position of approximately $4,155,000 and include the following: Identified as a result of audit procedures: ▪ Record a liability and increase claims expense by approximately $43,000. ▪ Reduce claims expense and increase cash for duplicate claims payments of approximately $110,000. Identified by management: ▪ Increase capitation revenue by approximately $11,426,000, which included Managed Care Organization (MCO) tax of approximately $7,338,000, resulting in a receivable of approximately $4,139,000 and accrued expenses of approximately $51,000 for final rates from the DHCS after year-end.

McGladrey

Report to the Executive/Finance Committee

Area of Required Communication	McGladrey Comment/Response/Result
Uncorrected Misstatements	Errors identified in our claims testing resulted in projected overpayments of $318,000 for fiscal 2013.
Disagreements With Management	None.
Consultations With Other Accountants	We are not aware of any consultations management had with other accountants about accounting or auditing matters.
Significant Issues Discussed With Management	We discussed the monitoring status and operational and reporting issues identified by the State monitor and the DHCS, TNE status, and going concern matters disclosed in the audited financial statements.
Difficulties Encountered in Performing the Audit	None.

McGladrey

Report to the Executive/Finance Committee

Other Communications and Reports	Executive Summary
Qualifications Letter	Communicates the engagement team's qualifications to perform GCHP's financial statement audit.
Representation Letter	Documents the responsibility management has taken for the financial statements of GCHP.
Independence Letter	Affirms our independence with respect to GCHP.

McGladrey

Letter Communicating Significant Deficiencies in Internal Controls over Financial Reporting

Other Communications and Reports	Executive Summary
Letter Communicating Control Deficiencies – Overview	When we encounter deficiencies in internal controls, we group them into one of three categories: ▪ Material Weakness – potential for material impact to the financial statements ▪ Significant Deficiency – warrants the attention of the Finance & Audit Committee ▪ Control Deficiency – Inconsequential

McGladrey

Letter Communicating Significant Deficiencies in Internal Controls over Financial Reporting

Other Communications and Reports	Executive Summary
Letter Communicating Control Deficiencies – Significant Deficiencies	We identified significant deficiencies in the following areas: ▪ Claims processing and claims reserves ▪ Segregations of duties in accounting, payroll administration, and IT network access ▪ Accounts receivable reconciliations and allowances
Letter Communicating Control Deficiencies – Mitigation of 2012 Deficiencies	In 2012, we reported the following: Material weaknesses: ▪ Monitoring and Reporting Compliance with the DHCS ▪ Claims Processing and Claims Reserves ▪ Segregation of Duties and Internal Policies Significant deficiencies: ▪ Accounts Receivable ▪ Accounting Department Resources

McGladrey

Management Letter

Other Communications and Reports	Executive Summary
Management Letter	This letter includes comments, observations and suggestions relating to the following areas: ▪ Internal audit function at GCHP ▪ Professional services provider contracts

McGladrey

Key Financial Indicators

	2013	2012
Current ratio	124.3%	92.9%
Days cash on hand	60	30
Days cash on hand - including receivable from the State	74	63
Average days in medical claims liability	53	81
Medical expenses as a percentage of capitation revenue	87.0%	92.3%
Administrative expenses, including Managed Care Organization (MCO) tax, as a percentage of capitation revenue	9.5%	8.2%
Operating margin	3.5%	-0.4%
Actual Tangible Net Equity	$ 11,891,000	$ (6,032,000)
Required Tangible Net Equity	$ 10,974,000	$ 6,037,000

McGladrey

Financial Results – Balance Sheets

	2013		2012		Change
Assets					
Current Assets					
Cash and cash equivalents	**$ 50,817,760**	*78.8%*	**$ 25,554,098**	*40.2%*	$ 25,263,662
Capitation receivable	**11,683,076**	*18.1%*	**28,534,938**	*44.9%*	(16,851,862)
Provider receivable	**1,161,379**	*1.8%*	**6,539,541**	*10.3%*	(5,378,162)
Reinsurance receivable	**300,398**	*0.5%*	**2,148,270**	*3.4%*	(1,847,872)
Prepaid expenses and other assets	**334,421**	*0.5%*	**560,797**	*0.9%*	(226,376)
Total current assets	**64,297,034**		**63,337,644**		959,390
Capital Assets, net	**230,914**	*0.4%*	**176,028**	*0.3%*	54,886
Total assets	**$ 64,527,948**		**$ 63,513,672**		$ 1,014,276

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Financial Results – Balance Sheets

Liabilities and Net Position	**2013**		**2012**		Change
Current Liabilities					
Medical claims liability	**$ 39,649,779**	*61.4%*	**$ 62,968,509**	*99.1%*	$ (23,318,730)
Capitation payable	**1,002,624**	*1.6%*	**633,276**	*1.0%*	369,348
	40,652,403		**63,601,785**		(22,949,382)
Accounts payable	**1,751,421**	*2.7%*	**886,715**	*1.4%*	864,706
Premium reserve	**-**	*0.0%*	**1,914,155**	*3.0%*	(1,914,155)
Accrued implementation costs and admin. services	**-**	*0.0%*	**500,000**	*0.8%*	(500,000)
Implementation advance, current	**460,000**	*0.7%*	**460,000**	*0.7%*	-
Accrued payroll and employee benefits	**605,937**	*0.9%*	**-**	*0.0%*	605,937
Accrued premium tax and other	**8,247,087**	*12.8%*	**802,900**	*1.3%*	7,444,187
Total current liabilities	**51,716,848**		**68,165,555**		(16,448,707)
Implementation Advance, less current portion	**920,000**	*1.4%*	**1,380,000**	*2.2%*	(460,000)
Line of Credit	**7,200,000**	*11.2%*	**-**	*0.0%*	7,200,000
Total liabilities	**59,836,848**		**69,545,555**		(9,708,707)
Net Position					
Invested in capital assets, net of related debt	**230,914**	*0.4%*	**176,028**	*0.3%*	54,886
Restricted - required tangible net equity	**3,774,000**	*5.8%*	**-**	*0.0%*	3,774,000
Unrestricted net position (deficit)	**686,186**	*1.1%*	**(6,207,911)**	*-9.8%*	6,894,097
Total net position (deficit)	**4,691,100**		**(6,031,883)**		10,722,983
Total liabilities and net position (deficit)	**$ 64,527,948**		**$ 63,513,672**		1,014,276

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Financial Results – Revenues, Expenses, and Changes in Net Position

	2013		2012		Change
Operating revenues:					
Capitation revenues	**$ 319,147,345**		**$ 310,260,446**		$ 8,886,899
Operating expenses:					
Medical expenses	**277,645,025**	*90.1%*	**286,245,088**	*91.9%*	8,600,063
Administrative expenses	**30,442,366**	*9.9%*	**25,390,128**	*8.1%*	(5,052,238)
Total operating expenses	**308,087,391**		**311,635,216**		3,547,825
Operating gain (loss)	**11,059,954**		**(1,374,770)**		12,434,724
Nonoperating revenues and expenses					
Investment income	**114,010**	*0.0%*	**169,056**		(55,046)
Net rental income and expenses	**(450,981)**	*-0.1%*	**(403,350)**		(47,631)
Total nonoperating revenues and expenses	**(336,971)**		**(234,294)**		(102,677)
Increase (decrease) in net assets position	**$ 10,722,983**		**$ (1,609,064)**		$ 12,332,047

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Contact Information

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

McGladrey

McGladrey LLP

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October 30, 2013

Ms. Michelle Raleigh
Chief Financial Officer
Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036

Dear Ms. Raleigh:

In accordance with your request, we are attaching the accompanying PDF file, which contains an electronic final version of the financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (GCHP or the Plan) for the years ended June 30, 2013 and 2012. We understand that your request for the electronic copy has been made as a matter of convenience. You understand that electronic transmissions are not entirely secure and that it is possible for confidential financial information to be intercepted by others.

These financial statements and our report(s) on them are not to be modified in any manner. This final version supersedes all prior drafts. Any preliminary draft version of the financial statements previously provided to you in an electronic format should be deleted from your computer, and all printed copies of any superseded preliminary draft versions should likewise be destroyed.

Professional standards and our firm policies require that we perform certain additional procedures whenever our reports are included, or we are named as accountants, auditors or "experts," in a document used in a public or private offering of equity or debt securities. Accordingly, as provided for and agreed to in the terms of our arrangement letter, GCHP will not include our reports, or otherwise make reference to us, in any public or private securities offering without first obtaining our consent. Any request to consent is also a matter for which separate arrangements will be necessary. After obtaining our consent, GCHP also agrees to provide us with printer's proofs or masters of such offering documents for our review and approval before printing, and with a copy of the final reproduced material for our approval before it is distributed. In the event our auditor/client relationship has been terminated when GCHP seeks such consent, we will be under no obligation to grant such consent or approval.

Thank you for the opportunity to serve you.

Sincerely,

Steve Draxler

Steven J. Draxler, Partner
612.376.9590

wpd
Attachment

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

Financial Statements
With Independent Auditor's Report Thereon
June 30, 2013 and 2012

McGladrey

Assurance • Tax • Consulting

Contents

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

Management's Discussion and Analysis

The intent of the Management's Discussion and Analysis is to provide readers with an overview of the Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan's (GCHP or the Plan) financial activities for the fiscal years ended June 30, 2013 and 2012. This overview is provided in conjunction with the Plan's fiscal 2013 (July 1, 2012 through June 30, 2013) audit. Readers should review this overview in conjunction with GCHP's financial statements and accompanying notes to the financial statements to enhance their understanding of the financial performance.

GOLD COAST HEALTH PLAN OVERVIEW

On June 2, 2009, the Ventura County Board of Supervisors approved the implementation of a county-organized health system (COHS) model to transition the Ventura County Medi-Cal members from a fee-for-service model to a managed care model. Ordinance 4409 (April 2010) established the Ventura County Medi-Cal Managed Care Commission as an oversight entity. The Commission's 11 members oversee a single plan—Gold Coast Health Plan—to serve Ventura County Medi-Cal beneficiaries. The year ended June 30, 2012, was Gold Coast's first full year of operation as a health plan. Hence, this document provides an overview of the Plan's second year of operations and comparisons to year one of operations.

As a COHS, the Plan has an exclusive contract (the Contract) with the State of California (the State) Department of Health Care Services (DHCS) to arrange for the provision of health care services to Ventura County's approximately 106,000 Medi-Cal beneficiaries at June 30, 2013. The Plan receives virtually 100 percent of its revenue in the form of capitation from the State of California.

OVERVIEW OF THE FINANCIAL STATEMENTS

This annual report consists of financial statements and notes to those statements, which reflect GCHP's financial position and results of operations for the fiscal years ended June 30, 2013 and 2012. The financial statements of GCHP include the balance sheet, statement of revenues, expenses and changes in net position (deficit), statement of cash flows, and notes to the financial statements.

- The balance sheet includes all of GCHP's assets and liabilities, using the accrual basis of accounting.
- The statement of revenues, expenses and changes in net position (deficit) presents the results of operating activities during the fiscal year and the resulting increase (decrease) in net position.
- The statement of cash flows reports the net cash provided by operating activities, as well as other sources, and uses of cash from investing, capital and related financing activities.

The following discussion and analysis addresses GCHP's overall program activities.

FINANCIAL HIGHLIGHTS

- As of June 30, 2013 and 2012, total assets were $64,528,000 and $63,514,000, respectively, and total liabilities were $59,837,000 and $69,546,000, respectively.
- Current liabilities at June 30, 2013, were $51,717,000, compared with $68,166,000 at June 30, 2012, a 24 percent decrease. Current liabilities included claim liabilities of $39,650,000 and $62,969,000 at June 30, 2013 and 2012, respectively. The Plan's claim liability calculation for fiscal 2013 was based on an improved methodology instituted during the year, which used historical payment experience and takes into account other changes in operations to estimate reserves. The current methodology is different from that used in fiscal year 2012 because of the availability of expanded claims payment data and actuarial information.
- The Plan's total net position increased by $10,723,000, or 177.8 percent, during fiscal 2013. This increase in net position was attributable to results of operations and enabled the Plan to raise its net position at June 30, 2013, to $4,691,000 from a net deficit of $6,032,000 at June 30, 2012.

Table 1—Condensed Balance Sheets as of June 30
(Dollars in Thousands)

			Change From 2012	
	2013	2012	Amount	Percentage
Assets				
Current assets	$ 64,297	$ 63,338	$ 959	1.5%
Capital assets, net	231	176	55	31.3%
Total assets	$ 64,528	$ 63,514	$ 1,014	1.6%
Liabilities				
Current liabilities	$ 51,717	$ 68,166	$ (16,449)	(24.1)%
Line of credit	7,200	-	7,200	100.0%
Other liabilities	920	1,380	(460)	(33.3)%
Total liabilities	59,837	69,546	(9,709)	(14.0)%
Net Position (Deficit)				
Invested in capital assets	231	176	55	31.3%
Restricted—required tangible net equity	3,774	-	3,774	100.0%
Unrestricted net position (deficit)	686	(6,208)	6,894	111.1%
Total net position (deficit)	4,691	(6,032)	10,723	177.8%
Total liabilities and net position (deficit)	$ 64,528	$ 63,514	$ 1,014	1.6%

The Contract with the DHCS required GCHP to meet and maintain a minimum level of tangible net equity (TNE). TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets. As prescribed by the Contract and California State statute, GCHP is following a TNE phase-in plan whereby the Plan is required to meet 68 percent and 36 percent of the TNE requirements at June 30, 2013 and 2012, respectively. The Plan will be required to meet 100 percent of the TNE requirements at June 30, 2014. At June 30, 2013, GCHP's actual TNE was approximately $11,891,000, versus a TNE deficit of approximately $6,032,000 at June 30, 2012. TNE requirements require positive TNE amounts of approximately $10,974,000 and $6,037,000 for June 30, 2013 and 2012, respectively. Therefore, the Plan has exceeded the required TNE levels at June 30, 2013.

GCHP has drawn on two subordinated lines of credit from the County of Ventura during fiscal 2013, for a total of $7,200,000. The purpose of the lines of credit is to assist GCHP in meeting its TNE requirements. Interest expense on the borrowed amounts is calculated based upon the Ventura County Treasury Pool rate (approximately 0.498 percent at June 30, 2013). Accrued interest payable at June 30, 2013, was approximately $9,700. Repayment of the borrowed amount and accrued interest is not required until GCHP meets 100 percent of the minimum TNE and the County of Ventura has obtained written approval from the DHCS to request repayment of the credit lines.

RESULTS OF OPERATIONS

As mentioned above, GCHP's fiscal 2013 operations and nonoperating expenses resulted in a $10,723,000 increase in net position. The following table shows the changes in revenues and expenses for 2013 compared to 2012, which was GCHP's first year of operations.

Table 2—Revenues, Expenses and Changes in Net Position (Deficit) for Fiscal Years Ended June 30
(Dollars in Thousands)

			Change From 2012	
	2013	2012	Amount	Percentage
Capitation revenues	$ 319,147	$ 310,260	$ 8,887	2.9%
Total operating revenues	319,147	310,260	8,887	2.9%
Provider capitation	11,159	7,535	3,624	48.1%
Claim payments to providers and facilities	224,185	239,056	(14,871)	(6.2)%
Prescription drugs	41,118	36,022	5,096	14.1%
Other medical	7,557	6,069	1,488	24.5%
Reinsurance recoveries	(6,374)	(2,437)	(3,937)	161.6%
Total health care expenses	277,645	286,245	(8,600)	(3.0)%
Salaries, benefits and compensation	6,311	4,056	2,255	55.6%
Professional fees	15,217	12,835	2,382	18.6%
General administrative fees	1,138	878	260	29.6%
Supplies, occupancy, insurance and other	386	232	154	66.4%
Premium tax	7,339	7,362	(23)	(0.3)%
Depreciation	51	27	24	88.9%
Total administrative expenses	30,442	25,390	5,052	19.9%
Total operating expenses	308,087	311,635	(3,548)	(1.1)%
Operating gain (loss)	11,060	(1,375)	12,435	904.4%
Interest income	114	169	(55)	(32.5)%
Interest expense	(451)	(403)	(48)	(11.9)%
Total nonoperating revenues and expenses	(337)	(234)	(103)	44.0%
Increase (decrease) in net position (deficit)	10,723	(1,609)	12,332	766.4%
Total net position (deficit), beginning of year	(6,032)	(4,423)	(1,609)	(36.4)%
Total net position (deficit), end of year	$ 4,691	$ (6,032)	$ 10,723	177.8%

ENROLLMENT, CAPITATION REVENUE AND HEALTH CARE EXPENSES

Enrollment

Enrollment is divided into aid categories, which correspond to specific rates of capitation to be received by the Plan from the State. During fiscal 2013, the Plan served an average of 102,234 members per month, compared to an average of 104,850 in fiscal 2012. The decreases in enrollment were largely the result of a State policy change regarding the Plan's responsibility for covering health care costs for members that were deemed retroactively eligible for Medi-Cal. In fiscal 2012, the State allowed qualifying members to enroll retroactively for a period of up to 12 months. The table below compares average monthly membership by aid categories for fiscal 2013 and fiscal 2012.

Table 3—Medi-Cal Enrollment by Aid Category
(Shown as Average Member Months)

Enrollment Category	2013	2012
Family/Adult	70,867	77,533
Aged	1,226	1,208
Disabled	7,938	8,002
Long-Term Care	72	73
Aged—Dual	8,900	9,362
Disabled—Dual	7,236	7,505
Long-Term Care—Dual	897	912
BCCTP	238	255
TLIC	4,860	-
Total average monthly enrollment	102,234	104,850

Significant aid categories are defined as follows: Family/Adult include families, children and poverty-level members who qualify for the CalWORKs and TANF federal welfare programs. Aged includes individuals who are 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy if their income and resources are within the Medi-Cal limits. Disabled includes individuals who met the criteria for disability set by the Social Security Administration and the State Program-Disability and Adult Program Division. Long-Term Care includes frail, elderly, nonelderly adults with disabilities and children with developmental disabilities and other disabling conditions requiring long-term care services. Breast and Cervical Cancer Treatment Program (BCCTP) provides cancer treatment for eligible low-income California residents who are screened by the Cancer Detection Program: Every Woman Counts (CDP:EWC) or Family Planning, Access, Care and Treatment (Family PACT) programs and found to be in need of treatment for breast and/or cervical cancer. Targeted Low Income Children (TLIC) refers to former Healthy Families Program (HFP) enrollees that began transitioning to Medi-Cal (pursuant to Assembly Bill 1494), as allowed under federal law, in January 2013. "Dual" coverage refers to enrollees who are eligible for both Medicare (part A, B or D) and Medi-Cal benefits.

Capitation Revenue

Revenue for fiscal 2013 was $319,147,000 (net of reinsurance premiums of $2,738,000), or 2.9 percent greater than fiscal 2012, which is impacted primarily by shifts in membership mix and rate changes as determined by the DHCS. In addition, beginning in October 2012, the Plan was reimbursed by the DHCS via a capitation rate paid for members qualifying for Community Based Adult Services (CBAS). Members using CBAS are accounted for within the aid categories mentioned previously with capitation payments to the Plan being recognized as revenue.

Premium revenue (capitation received by the Plan from the State) is determined by rates set by the State at the beginning of the plan year and generally are effective for the entire year. The State provided updated rates during the fiscal year, which were not reduced for provider payment changes noted in Assembly Bill (AB) 97. In June 2013, the State announced that there would be no financial consequences resulting from AB 97 for the fiscal year ended June 30, 2013. As such, the reserve previously established for AB 97 of $1,914,000 was no longer needed and released.

The State finalized its budget effective July 1, 2013, and indicated that premium revenue continues to be subject to a Managed Care Organization (MCO) tax of 2.35 percent for fiscal 2013.

Health Care Expenses
Aggregate health care expenses were $277,645,000 in fiscal 2013, compared to $286,245,000 in fiscal 2012. The Plan's medical loss ratio, or health care expenses as a percent of operating revenues (net of MCO taxes), was 87.0 percent in fiscal 2013, compared to 92.3 percent in fiscal 2012.

Note the following regarding the components of the health care expenses:

1. Provider capitation represents monthly payments for members assigned to primary care providers who have agreed to accept risk to provide specific services (when needed) to their members. Rates are fixed by contract and are generally known at the beginning of the fiscal year. Total provider capitation increased by 48.1 percent from fiscal 2012 to fiscal 2013 due to:

    a. An expanded capitation arrangement with one of the Plan's major networks to also provide specialty services under a capitated payment

    b. A capitation contract with a vendor to provide vision benefits for all members (this contract went into effect in mid fiscal 2012)

    c. A new capitation contract with a vendor to provide nonemergency transportation services for all members effective in fiscal 2013

2. Estimated claims expense to providers on a fee-for-service basis decreased 6.2 percent from $239,056,000 in fiscal 2012 to $224,185,000 in fiscal 2013. The decrease was due to a greater focus on medical management efforts resulting in lower utilization of services, improved claims processing operations, and enhanced claims recovery efforts.

3. Pharmacy costs were $5,096,000, or 14.1 percent greater in fiscal 2013 than in fiscal 2012. The increase resulted from higher member utilization and unit cost of prescriptions. Fiscal 2013 utilization increased from the prior year primarily due to fiscal 2012 utilization being lower than expected during the first six months of operations as members and providers transitioned to a managed care benefit. Unit costs increased by 12.4 percent for brand drugs and were flat for generic drugs. Generic drug utilization increased from 82.6 percent to 86.4 percent in fiscal 2013 as compared to fiscal 2012.

    During June 2013, the Plan instituted a new fee schedule through the Pharmacy Benefit Manager for the majority of generic drugs, resulting in an estimated reduction in pharmacy expense of $600,000 for the month of June 2013. These savings are expected to continue throughout fiscal 2014.

4. Reinsurance recoveries exceeded reinsurance premiums. Total reinsurance recoveries resulted in a $6,374,000 reduction to health care expenses.

ADMINISTRATIVE EXPENSES

Total administrative expenses were approximately $30,442,000 in fiscal 2013, compared to $25,390,000 in fiscal 2012, for an increase of $5,052,000 as reflected in the following components:

1. Personnel expenses (i.e., salaries, benefits and compensation) for fiscal 2013 were $6,311,000, versus $4,056,000 for fiscal 2012. The increase was primarily due to personnel additions to support the organization, both on a temporary and full-time basis. In addition to supporting typical growth of a new organization, the hiring of staff was in response to a directive contained in the Corrective Action Plan or CAP (reference the Regulatory Action section following) issued to GCHP by the DHCS. The CAP stated that the Plan needed to fill specific management positions, which was complied with by the end of fiscal year 2013.

2. Professional fees for fiscal 2013 were $15,217,000, compared to $12,835,000 in fiscal 2012, for an increase of $2,382,000. The increase was necessary to provide the Plan with assistance to perform certain technical functions and specialized tasks provided by consultants for which the Plan could not yet perform internally. Professional fees also include the consulting costs of the monitor appointed by the State. The monitoring is expected to continue until such time as when GCHP has satisfactorily met the terms set forth in the CAP with the DHCS.

3. General administrative expenses in fiscal 2013 were $1,524,000 and included occupancy, supplies insurance and other operating expenses. The increase over $1,110,000 in fiscal 2012 was in support of additional staff and expanded Plan management activities.

REGULATORY ACTION

As mentioned above, GCHP is required by the DHCS to maintain certain levels TNE. Regulatory TNE levels are determined by formula and are based on specified percentages of revenue and medical expenses. As a new plan, the requirement allows for a phase-in period in which the Plan was required to meet 68 percent of calculated TNE at June 30, 2013. Driven by its operating performance as well as the line-of-credit draws, the Plan's TNE at June 30, 2013, was approximately $11,891,000, which exceeded the required TNE amount of $10,974,000.

Table 4—Tangible Net Equity (TNE)
(Dollars in Thousands)

	June 30, 2013	June 30, 2012
Actual TNE, beginning balance	$ (6,032)	$ (4,423)
Change in net position	10,723	(1,609)
Note payable	7,200	-
Actual TNE, ending balance	$ 11,891	$ (6,032)
Required TNE position	$ 10,974	$ 6,037

McGladrey

Independent Auditor's Report

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

Report on the Financial Statements
We have audited the accompanying financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (GCHP or the Plan), as of and for the years ended June 30, 2013 and 2012, and the related notes to the financial statements, which collectively comprise GHCP's basic financial statements as listed in the table of contents.

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

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of GCHP as of June 30, 2013 and 2012, and the related revenues, expenses and changes in net position (deficit) and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter
As discussed in Note 2 to the financial statements, the California Department of Health Care Services (DHCS) requires that GCHP meet and maintain a minimum level of tangible net equity (TNE) and comply with several other operational and reporting requirements. As of June 30, 2013 and 2012, GCHP was out of compliance with various operational and reporting requirements as outlined in the State's corrective action plan. As of June 30, 2013, GCHP's TNE exceeded the required level, but was below the required threshold at June 30, 2012. GCHP continues to work with DHCS in response to the corrective action plan in order to achieve full compliance. While a corrective action plan has been developed and GCHP is responsive to it, the ultimate resolution of these matters is not determinable at this time.

Other Matters

Required Supplementary Information
Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 6 be presented to supplement the financial statements. Such information, although not a part of the financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audit of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

McGladrey LLP

Minneapolis, Minnesota
October 30, 2013

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

Balance Sheets
June 30, 2013 and 2012

Assets	**2013**	2012
Current Assets		
Cash and cash equivalents	**$ 50,817,760**	$ 25,554,098
Accounts receivable:		
Capitation receivable	**11,683,076**	28,534,938
Provider receivables, net of allowance of $1,086,155 and $245,452, respectively	**1,161,379**	6,539,541
Reinsurance and other receivables, net of allowance of $-0- and $166,346, respectively	**300,398**	2,148,270
Prepaid expenses and other assets	**334,421**	560,797
Total current assets	**64,297,034**	63,337,644
Capital Assets, net of accumulated depreciation of $77,685 and $26,896, respectively	**230,914**	176,028
Total assets	**$ 64,527,948**	$ 63,513,672
Liabilities and Net Position (Deficit)		
Current Liabilities		
Medical claims liability and capitation payable:		
Medical claims liability	**$ 39,649,779**	$ 62,968,509
Capitation payable	**1,002,624**	633,276
	40,652,403	63,601,785
Accounts payable	**1,751,421**	886,715
Premium reserve	**-**	1,914,155
Accrued implementation costs and administrative services	**-**	500,000
Implementation advance, current	**460,000**	460,000
Accrued payroll and employee benefits	**605,937**	-
Accrued premium tax and other	**8,247,087**	802,900
Total current liabilities	**51,716,848**	68,165,555
Implementation Advance, less current portion	**920,000**	1,380,000
Line of Credit	**7,200,000**	-
Total liabilities	**59,836,848**	69,545,555
Commitments and Contingencies		
Net Position (Deficit)		
Net invested in capital assets	**230,914**	176,028
Restricted—required tangible net equity	**3,774,000**	-
Unrestricted net position (deficit)	**686,186**	(6,207,911)
Total net position (deficit)	**4,691,100**	(6,031,883)
Total liabilities and net position (deficit)	**$ 64,527,948**	$ 63,513,672

See Notes to Financial Statements.

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

Statements of Revenues, Expenses and Changes in Net Position (Deficit)
Years Ended June 30, 2013 and 2012

	2013	2012
Operating revenues:		
Capitation revenues (net of reinsurance premiums of $2,737,697 and $1,108,585, respectively)	**$ 319,147,345**	$ 310,260,446
Total operating revenues	**319,147,345**	310,260,446
Operating expenses:		
Health care expenses:		
Provider capitation	**11,159,035**	7,534,863
Claim payments to providers and facilities	**224,184,527**	239,056,472
Prescription drugs	**41,118,154**	36,022,296
Other medical	**7,557,496**	6,068,910
Reinsurance recoveries	**(6,374,187)**	(2,437,453)
Total health care expenses	**277,645,025**	286,245,088
Administrative expenses:		
Salaries, benefits and compensation	**6,311,239**	4,056,153
Professional fees	**15,217,023**	12,834,921
General administrative fees	**1,137,820**	877,750
Supplies, occupancy, insurance and other	**386,056**	232,253
Premium tax	**7,339,439**	7,362,155
Depreciation	**50,789**	26,896
Total administrative expenses	**30,442,366**	25,390,128
Total operating expenses	**308,087,391**	311,635,216
Operating gain (loss)	**11,059,954**	(1,374,770)
Nonoperating revenues and expenses:		
Interest income	**114,010**	169,056
Interest expense	**(450,981)**	(403,350)
Total nonoperating revenues and expenses	**(336,971)**	(234,294)
Increase (decrease) in net position (deficit)	**10,722,983**	(1,609,064)
Net position (deficit), beginning of year	**(6,031,883)**	(4,422,819)
Net position (deficit), end of year	**$ 4,691,100**	$ (6,031,883)

See Notes to Financial Statements.

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

Statements of Cash Flows
Years Ended June 30, 2013 and 2012

	2013	2012
Cash Flows From Operating Activities		
Capitation revenues received and other	**$ 336,287,564**	$ 284,748,247
Reinsurance premiums paid	**(2,737,697)**	(1,108,585)
Payments to providers and facilities	**(293,368,373)**	(231,331,114)
Payments of premium tax	**(604,579)**	(6,759,254)
Payments of administrative expenses	**(21,070,607)**	(20,306,312)
Net cash provided by operating activities	**18,506,308**	25,242,982
Cash Flows From Capital and Related Financing Activities		
Purchases of capital assets	**(105,675)**	(115,287)
Interest payments	**(450,981)**	(403,350)
Proceeds from line of credit	**7,200,000**	-
Net cash provided by (used in) capital and related financing activities	**6,643,344**	(518,637)
Cash Flows From Investing Activities		
Interest income	**114,010**	169,056
Net cash provided by investing activities	**114,010**	169,056
Net increase in cash and cash equivalents	**25,263,662**	24,893,401
Cash and Cash Equivalents, beginning of year	**25,554,098**	660,697
Cash and Cash Equivalents, end of year	**$ 50,817,760**	$ 25,554,098
Reconciliation of Operating Gain (Loss) to Net Cash Provided by Operating Activities		
Operating gain (loss)	**$ 11,059,954**	$ (1,374,770)
Adjustments to reconcile operating gain (loss) to net cash provided by operating activities:		
Depreciation	**50,789**	26,896
Changes in assets and liabilities:		
Accounts receivable	**24,077,896**	(37,213,593)
Prepaid expenses and other assets	**226,376**	(520,670)
Medical claims liability	**(22,949,382)**	63,601,785
Accounts payable	**864,706**	839,338
Premium reserve	**(1,914,155)**	1,914,155
Implementation advance and accrued implementation costs	**(960,000)**	(960,000)
Accrued premium tax and other liabilities	**8,050,124**	(1,070,159)
Net cash provided by operating activities	**$ 18,506,308**	$ 25,242,982

See Notes to Financial Statements.

Note 1. Organization and Operations

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

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

Note 2. Compliance With the DHCS and Restricted Net Position

GCHP is required to meet and maintain a minimum level of tangible net equity (TNE) as established by the Contract. TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets. As prescribed by the Contract and California State Statute, GCHP is following a TNE phase-in plan, whereby GCHP is required to meet 68 percent and 36 percent of the TNE requirements at June 30, 2013 and 2012, respectively.

Required and actual TNE are as follows:

	June 30	
	2013	2012
Actual TNE, beginning balance	$ (6,032)	$ (4,423)
Change in net position	10,723	(1,609)
Note payable	7,200	-
Actual TNE, ending balance	$ 11,891	$ (6,032)
Required TNE	$ 10,974	$ 6,037

In prior years, GCHP was not able to maintain compliance with certain operational requirements of the Contract. As a result of this noncompliance, DHCS put a corrective action plan in place that addresses key areas of noncompliance in the TNE and other requirements, such as improving plan staffing, filling certain key positions, improving claims processing capabilities, developing information technology resources, and timely and accurately filing paid claims and encounter data with the DHCS. The DHCS is monitoring GCHP's financial status and compliance with operational and reporting requirements.

In the event the Plan does not comply with these requirements, the DHCS has the authority to take actions for noncompliance with the requirements imposed upon the Plan. Such actions include, but are not limited to, imposition of sanctions upon the Plan, assessment of damages, installation of temporary management, or termination of the contract with the DHCS to arrange for the provision of health care services to Ventura County's beneficiaries.

Note 2. Compliance With the DHCS and Restricted Net Position (Continued)

During 2013, GCHP made substantial progress toward full compliance with the DHCS operational and reporting requirements, including becoming TNE compliant as of June 30, 2013. The ability of GCHP to continue as a going concern is dependent on the results of these matters. The financial statements have been prepared on the going concern basis, which assumes the realization of assets and liquidation of liabilities in the normal course of operations. The financial statements do not include any adjustments relating to the recoverability or classification of recorded asset amounts or the amounts or classification of liabilities, should the Plan be unable to continue as a going concern.

Note 3. Summary of Significant Accounting Policies

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

Accounting basis and standards: GCHP uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis, using the economic resources measurement focus. The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB).

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

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

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

Custodial credit risk—deposits: Custodial credit risk is the risk that in the event of a bank failure GCHP may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. At June 30, 2013 and 2012, all accounts were covered by posted collateral.

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

Note 3. Summary of Significant Accounting Policies (Continued)

During the year ended June 30, 2013, the Plan received approximately $34,153,000 of supplemental fee revenue from the DHCS as a hospital quality assurance fee as a result of Senate Bill (SB) 335. GCHP passed these funds through to providers. These amounts were not reflected in the 2013 financial statements, as the amounts passed through to the providers do not meet requirements for revenue recognition under *Government Accounting Standards*.

During fiscal 2013, GCHP entered into an agreement with the DHCS to receive an intergovernmental transfer (IGT) through a capitation rate increase of $26,759,000. Under the agreement, approximately $26,224,000 of the funds that were received from the IGT passed through to a provider. Under *Government Accounting Standards*, the amounts that will be passed through to providers are not reported on the statement of revenues, expenses and changes in net position or the balance sheet. GCHP retains approximately $535,000 of the IGT, for costs to administer the IGT contract, and recorded this amount in capitation revenue.

Capitation receivable is carried at original invoice amount less an estimate made for doubtful receivables based on a review of all outstanding amounts on a monthly basis. Management determines the allowance for doubtful accounts by regularly evaluating individual receivables and considering payment history, financial condition and current economic conditions. Subsequent adjustments to the contracted rates or enrollments are recognized in the period the adjustment is determined.

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

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

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

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

Depreciation and amortization are calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The estimated useful lives of three to seven years are used for furniture, fixtures, computer equipment and software. Leasehold improvements are depreciated over the life of the lease or estimated useful life, whichever is shorter. Depreciation expense for the years ended June 30, 2013 and 2012, was approximately $51,000 and $27,000, respectively.

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

Note 3. Summary of Significant Accounting Policies (Continued)

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

Premium deficiency reserves: GCHP performed an analysis of its expected future health care and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve would be accrued. A premium deficiency reserve was not required at June 30, 2013 or 2012.

Accounts payable and accrued expenses: GCHP is required to estimate certain expenses, including payroll, payroll taxes and professional services fees, as of each balance date and make appropriate accruals based on these estimates. Estimates are affected by the status and timing of services provided relative to the actual level of services performed by the service providers. The date on which certain services commence, the level of services performed on or before a given date, and the cost of services are often subject to judgment. These judgments are based upon the facts and circumstances known at the date of the financial statements. For the periods presented in the financial statements, there were no material adjustments to the estimates for payroll, payroll taxes and professional services fees.

Accrued compensated absences: GCHP's policy permits eligible employees to accrue vacation based on their individual employment agreements. Unused vacation may be carried over into subsequent years, up to limits indicated in their employment agreements. Accumulated vacation will be paid to the employee upon separation from service with GCHP. All compensated absences are accrued and recorded in accordance with GASB Statement No. 16, *Accounting for Compensated Absences*, and are included in accrued payroll and employee benefits in the accompanying balance sheets.

Premium reserve: Assembly Bill (AB) 97 was passed by the State of California Assembly during fiscal year 2011 and received necessary approval from the Centers for Medicare & Medicaid Services in fiscal year 2012. The bill included premium rate cuts that resulted in an overall 2.2 percent reduction in the Plan's rates. GCHP continued to receive capitation payments at original rates and recorded a reserve for the expected reductions pertaining to the fiscal years for which rates were not yet finalized. As of June 30, 2012, a premium reserve of approximately $1,914,000 was reported as a liability. In June 2013, GCHP was notified by the State of California that there would be no financial impact resulting from AB 97 for the respective fiscal years for which the reserve amount pertained. As such, the reserves for those respective years were no longer needed and were released. There was no premium reserve balance at June 30, 2013.

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

Note 3. Summary of Significant Accounting Policies (Continued)

Net position: During fiscal 2013, the Plan retrospectively adopted the provisions of GASB Statement No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position*. This guidance impacted the financial statements by changing the term "net assets" to "net position." Net position is broken down into three categories, defined as follows:

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

Restricted: This component of net position consists of external constraints placed on net asset use by creditors (such as through debt covenants), grantors, contributors, or law or regulations of other governments (including TNE requirements). It also pertains to constraints imposed by law or constitutional provisions or enabling legislation.

Unrestricted: This component of net position consists of net position that does not meet the definition of "restricted" or "net invested in capital assets."

Premium taxes: The State of California requires a premium tax at a rate of 2.35 percent of the Medi-Cal capitated revenue. Premium tax expense for the years ended June 30, 2013 and 2012, was approximately $7,339,000 and $7,362,000, respectively.

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

Operating revenues and expenses: GCHP's statement of revenues, expenses and changes in net position (deficit) distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services, as well as the costs of administration. Claims adjustment expenses are an estimate of the cost to process the claims and are included in operating expenses. Nonexchange revenues and expenses are reported as nonoperating revenues and expenses.

Defined contribution plan: GCHP has adopted, and its employees are participants in, the California Public Agencies Self-Directed Tax-Advantaged Retirement System (CPA STARS). CPA STARS is a California public trust organized under the laws of the State of California and includes the STARS 401(a) Retirement Plan (the 401 Plan), which is a retirement plan under Section 401(a) of the Internal Revenue Code. GCHP participation in the 401 Plan is defined by the 401(a) Trust Agreement and the 401 Plan Agreement between GCHP and CPA STARS.

All regular employees participate in the CPA STARS 401 Plan. Employee contributions to the 401 Plan are not allowed. GCHP makes employer contributions to the 401 Plan in an amount annually determined under the 401 Plan Agreement. For the years ended June 30, 2013 and 2012, GCHP contributions to the 401 Plan were $416,000 and $273,000, respectively.

Note 3. Summary of Significant Accounting Policies (Continued)

Deferred compensation plan: GCHP has adopted, and its employees are participants in, the CPA STARS 457(b) deferred compensation plan (the 457 Plan). The 457 Plan was created in accordance with Internal Revenue Code Section 457 and permits employees to defer a portion of their annual salary until future years. GCHP participation in the 457 Plan is defined by the 457 Trust Agreement between GCHP and CPA STARS. Employee participation in the 457 Plan is voluntary, and GCHP does not make any contributions. As such, there were no GCHP employer contributions for fiscal years 2013 and 2012.

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

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

Accounting pronouncements not yet adopted: The following GASB Statements will be effective for GCHP in future periods: Statement No. 65, *Items Previously Reported as Assets and Liabilities,* reclassifies certain items currently being reported as assets and liabilities as deferred outflows of resources and deferred inflows of resources. In addition, this statement recognizes certain items currently being reported as assets and liabilities as outflows of resources and inflows of resources.

Statement No. 66, *Technical Corrections—2012,* amends Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues,* by removing the provision that limits fund-based reporting of a state and local government's risk-financing activities to the general fund and the internal service fund type. This statement also amends Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements,* by modifying the specific guidance on accounting for (1) operating lease payments that vary from a straight-line basis, (2) the difference between the initial investment (purchase price) and the principal amount of a purchased loan or group of loans, and (3) servicing fees related to mortgage loans that are sold when the stated service fee rate differs significantly from a current (normal) servicing fee rate.

The provisions for these statements are effective for GCHP's year ending June 30, 2014. Management has not yet completed their assessment of these pending statements; however, they are not expected to have a material effect on the overall financial statement presentation.

Note 4. Administrative Services Agreements

Affiliated Computer Services (ACS): On June 23, 2010, GCHP entered into a five-year agreement with ACS to provide certain operational services through June 30, 2016. Compensation for these services is based on a per-member, per-month cost at varying membership levels. These costs are recorded as expenses in the period incurred. Total expenses for services provided for the years ended June 30, 2013 and 2012, were approximately $10,964,000 and $11,473,000, respectively, and are reported in professional fees.

The agreement also calls for ACS to provide implementation services. The cost for these services of $1,000,000 was expensed in fiscal year 2011. The amount was payable in 24 monthly payments of $41,667 beginning with the operational start date of July 1, 2011. At June 30, 2013 and 2012, $-0- and $500,000, respectively, was recorded as accrued implementation costs.

Note 4. Administrative Services Agreements (Continued)

ACS provided GCHP with an advance payment of $2,300,000 in 2011. According to the terms of the agreement, should GCHP terminate the agreement prior to the end of the stated five-year term, GCHP is required to repay any unamortized portion to ACS. The implementation payment is recorded as a liability and is amortized ratably over a 60-month term ending June 30, 2016. The amortization is recognized as a reduction in administrative expense. At June 30, 2013 and 2012, $1,380,000 and $1,840,000, respectively, were recorded as an accrued implementation advance.

On March 3, 2011, GCHP entered into an agreement with ACS Health Administration, Inc. (an affiliate of ACS) to provide medical management services under the supervision of GCHP's management team. Total expense for the years ended June 30, 2013 and 2012, was approximately $3,003,000 and $2,230,000, respectively. Medical management services expense is included in other medical expenses.

Regional Government Services (RGS): Until August 31, 2012, RGS provided staffing and human resources support to GCHP, and all salaries and benefits were compensated through RGS. Included in the RGS benefits were a deferred compensation plan created in accordance with Internal Revenue Code Section 457 and a 403(b) defined contribution supplemental retirement plan. Workers' compensation, commercial and general liability insurance, and crime insurance policies are obtained by RGS though the California Joint Powers Insurance Agency (CJPIA). In addition to reimbursement of the direct cost of the salaries, benefits and insurance premiums, administrative fees were paid to RGS of approximately $23,000 and $113,000 for the years ended June 30, 2013 and 2012, respectively.

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

Script Care services: On February 1, 2011, GCHP entered into a five-year agreement with Script Care to provide pharmacy administration and management services. Script Care services are specific to the prescription benefit drug program for GCHP Medi-Cal beneficiaries. Total expense for Script Care services was approximately $3,190,000 and $2,743,000 for the years ended June 30, 2013 and 2012, respectively. Script care services expense is included in other medical expenses.

Note 5. Capital Assets

Capital asset activity during the years ended June 30, 2013 and 2012, consisted of the following:

	Balance June 30, 2012	Increases	Decreases	Balance June 30, 2013
Capital assets:				
Leasehold Improvements	$ -	$ 30,000	$ -	$ 30,000
Software and equipment	119,555	3,394	-	122,949
Furniture and fixtures	83,369	5,487	-	88,856
Construction in progress	-	66,794	-	66,794
Total capital assets	202,924	105,675	-	308,599
Less accumulated depreciation and amortization for:				
Leasehold improvements	-	7,857	-	7,857
Software and equipment	19,024	25,344	-	44,368
Furniture and fixtures	7,872	17,588	-	25,460
Total accumulated depreciation	26,896	50,789	-	77,685
Total capital assets, net	$ 176,028	$ 54,886	$ -	$ 230,914

	Balance June 30, 2011	Increases	Decreases	Balance June 30, 2012
Capital assets:				
Software and equipment	$ 87,637	$ 31,918	$ -	$ 119,555
Furniture and fixtures	-	83,369	-	83,369
Total capital assets	87,637	115,287	-	202,924
Less accumulated depreciation and amortization for:				
Software and equipment	-	19,024	-	19,024
Furniture and fixtures	-	7,872	-	7,872
Total accumulated depreciation	-	26,896	-	26,896
Total capital assets, net	$ 87,637	$ 88,391	$ -	$ 176,028

Note 6. Medical Claims Liability

Medical claims liability consists of the following:

	June 30 2013	2012
Claims payable or pending approval	$ 9,748,676	$ 10,357,609
Capitation payable	1,002,624	633,276
Provisions for claims incurred but not yet reported and other	29,901,103	52,610,900
	$ 40,652,403	$ 63,601,785

Note 6. Medical Claims Liability (Continued)

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

The following is a reconciliation of the medical claims liability for the years ended June 30:

	2013	2012
Beginning balance	$ 63,601,785	$ -
Incurred:		
Current	282,922,900	286,245,088
Prior	(5,277,875)	-
Total incurred	277,645,025	286,245,088
Paid:		
Current	235,044,463	231,331,114
Prior	58,323,910	-
Total paid	293,368,373	231,331,114
Net balance at end of year	47,878,437	54,913,974
Provider and reinsurance receivables on paid claims, beginning	(8,687,811)	-
Provider and reinsurance receivables on paid claims, ending	1,461,777	8,687,811
Medical claims liability and capitation payable at end of year	$ 40,652,403	$ 63,601,785

The liabilities recorded at June 30, 2012, were reduced by approximately $5,278,000 during 2013 to recognize that actual claims experience was less than previously estimated.

Note 7. Long-Term Liabilities

GCHP has a $7,200,000 subordinated line of credit available from the County of Ventura through July 2014, with an option to extend for an additional two years. The purpose of the subordinated line of credit is to assist GCHP in meeting its TNE requirements. Repayment of the note is not required until the Plan meets 100 percent of the minimum TNE and the County of Ventura obtains written approval from the DHCS to request repayment.

Note 7. Long-Term Liabilities (Continued)

In December 2012 and May 2013, GCHP drew $2,200,000 and $5,000,000, respectively, on the subordinated line of credit. The outstanding debt balance at June 30, 2013, was $7,200,000. There were no outstanding balances on the line of credit at June 30, 2012. Interest expense on the borrowed amount is calculated based upon the monthly Ventura County Treasury Pool rate (approximately 0.498 percent at June 30, 2013). Accrued interest payable at June 30, 2013, was approximately $9,700 and is included in other accrued liabilities.

Activity in the line of credit, implementation advance and accrued implementation costs for the years ended June 30, 2013 and 2012, was as follows:

	Balance June 30, 2012	Additions	Reductions	Balance June 30, 2013	Due Within One Year
Implementation advance	$ 1,840,000	$ -	$ 460,000	$ 1,380,000	$ 460,000
Accrued implementation costs	500,000	-	500,000	-	-
Line of credit	-	7,200,000	-	7,200,000	-
Total long-term liabilities	$ 2,340,000	$ 7,200,000	$ 960,000	$ 8,580,000	$ 460,000

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

Note 8. Commitments and Contingencies

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

Years Ending June 30,	Minimum Lease Payments
2014	$ 261,374
2015	221,374
2016	133,330
2017	6,364
2018	2,213
Thereafter	-

Litigation: Through the course of ordinary business, the Plan could become party to various legal actions and subject to various claims arising as a result. During the fiscal year ended June 30, 2012, two lawsuits were filed against RGS and the Plan by former employees of RGS. As a result, the Plan has recorded a liability for these contingencies. It is the opinion of management that the ultimate resolution of such claims will not have a material adverse effect on the financial statements.

Note 8. Commitments and Contingencies (Continued)

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

Patient Protection and Affordable Care Act: In March 2010, the President signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Healthcare Reform Legislation), which considerably transforms the U.S. health care system and increases regulations within the U.S. health insurance industry. This legislation is intended to expand the availability of health insurance coverage to millions of Americans. The Healthcare Reform Legislation contains provisions that take effect from 2010 through 2018, with most measures effective in 2014. The total impact of the Healthcare Reform Legislation is unknown, and impact of the Healthcare Reform Legislation on the operations of GCHP is being evaluated.

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October 30, 2013

Dr. Robert Gonzalez
Executive/Finance Committee Chair
Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036

Dear Dr. Gonzalez:

In accordance with your request, we are attaching the accompanying PDF file, which contains an electronic final version of the report to the Executive/Finance Committee for Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (GCHP or the Plan) for the year ended June 30, 2013. We understand that your request for the electronic copy has been made as a matter of convenience. You understand that electronic transmissions are not entirely secure and that it is possible for confidential financial information to be intercepted by others.

This report is not to be modified in any manner. This final version supersedes all prior drafts. Any preliminary draft version of this report previously provided to you in an electronic format should be deleted from your computer, and all printed copies of any superseded preliminary draft versions should likewise be destroyed.

Professional standards and our firm policies require that we perform certain additional procedures whenever our reports are included, or we are named as accountants, auditors or "experts," in a document used in a public or private offering of equity or debt securities. Accordingly, as provided for and agreed to in the terms of our arrangement letter, GCHP will not include our reports, or otherwise make reference to us, in any public or private securities offering without first obtaining our consent. Any request to consent is also a matter for which separate arrangements will be necessary. After obtaining our consent, GCHP also agrees to provide us with printer's proofs or masters of such offering documents for our review and approval before printing, and with a copy of the final reproduced material for our approval before it is distributed. In the event our auditor/client relationship has been terminated when GCHP seeks such consent, we will be under no obligation to grant such consent or approval.

Thank you for the opportunity to serve you.

Sincerely,

Steve Draxler

Steven J. Draxler, Partner
612.376.9590

wpd
Attachment

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

Report to the Executive/Finance Committee
October 30, 2013

McGladrey

Assurance • Tax • Consulting

McGladrey LLP

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October 30, 2013

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

Attention: Members of the Executive/Finance Committee

We are pleased to present this report related to our audit of the financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (GCHP or the Plan) for the year ended June 30, 2013. This report summarizes certain matters required by professional standards to be communicated to you in your oversight responsibility for the GCHP financial reporting process.

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

McGladrey LLP

Contents

Required Communications

Generally accepted auditing standards (AU-C 260, *The Auditor's Communication With Those Charged With Governance*) require the auditor to promote effective two-way communication between the auditor and those charged with governance. Consistent with this requirement, the following summarizes our responsibilities regarding the financial statement audit as well as observations arising from our audit that are significant and relevant to your responsibility to oversee the financial reporting process.

Area	Comments
Our Responsibilities With Regard to the Financial Statement Audit	Our responsibilities under auditing standards generally accepted in the United States of America have been described to you in our arrangement letter dated January 24, 2013.
Overview of the Planned Scope and Timing of the Financial Statement Audit	We have issued a separate communication regarding the planned scope and timing of our audit and have discussed with you our identification of and planned audit response to significant risks of material misstatement.
Accounting Policies and Practices	**Preferability of Accounting Policies and Practices** Under generally accepted accounting principles, in certain circumstances, management may select among alternative accounting practices. In our view, in such circumstances, management has selected the preferable accounting practice. **Adoption of, or Change in, Accounting Policies** Management has the ultimate responsibility for the appropriateness of the accounting policies used by GCHP. The Plan did not adopt any significant new accounting policies, nor have there been any changes in existing significant accounting policies during the current period. **Significant or Unusual Transactions** In fiscal 2013, under California Senate Bill (SB) 335, GCHP received approximately $34,153,000 of supplemental fee revenue from the State of California Department of Health Care Services (DHCS) as a hospital quality assurance fee. GCHP passed these funds through to providers. These amounts were not reflected in the 2013 financial statements, as the amounts passed through to the providers do not meet requirements for revenue recognition under Governmental Accounting Standards Board (GASB) Statement No. 24. During fiscal 2013, GCHP entered into an agreement with the DHCS to receive an intergovernmental transfer (IGT) through a capitation rate increase of $26,759,000. Under the agreement, approximately $25,595,000 of the funds that were received from the IGT in August 2013 were passed through to Ventura County Medical Center (VCMC). Under GASB No. 24, the amount that will be passed through to VCMC are not reported on the statement of revenues, expenses and changes in net position (deficit) or the balance sheet. GCHP retains approximately $535,000 of the IGT, for costs to administer the IGT contract, and recorded this amount in capitation revenue in fiscal 2013. We did not identify any other significant or unusual transactions or significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

Area	Comments
	Management's Judgments and Accounting Estimates Summary information about the process used by management in formulating particularly sensitive accounting estimates and about our conclusions regarding the reasonableness of those estimates is in the attached Summary of Accounting Estimates.
Basis of Accounting	During the audit, we noted the following events or conditions that raised concerns about GCHP's ability to continue as a going concern: The DHCS has raised concerns to GCHP about the operational results and financial status of GCHP. As a result of these concerns, GCHP is currently operating under a corrective action plan (CAP) by the DHCS. GCHP's ability to continue as a going concern is dependent on its progress and resolution of the concerns raised in the DHCS CAP. See Note 2 to the audited financial statements for additional disclosures regarding this matter. We reviewed management's plans that are intended to mitigate the adverse effects of such conditions or events. Based on our review, we have concluded that the Plan's disclosures with respect to the CAP are adequate. The financial statements were prepared on the assumption that the Plan will continue as a going concern. We have included an emphasis-of-matter paragraph in our audit report to reflect these facts.
Audit Adjustments	Adjustments recorded to the original trial balance during the audit resulted in an increase to net position of approximately $4,155,000 and include the following: Identified as a result of audit procedures: • Record a liability and increase claims expense by approximately $43,000. • Reduce claims expense and increase cash for duplicate claims payments of approximately $110,000. Identified by management: • Increase capitation revenue by approximately $11,426,000, net of Managed Care Organization (MCO) tax of approximately $7,338,000, resulting in a receivable of approximately $4,139,000 and accrued expenses of approximately $51,000 for final rates from the DHCS after year-end.
Uncorrected Misstatements	Uncorrected misstatements are summarized in the attached Summary of Uncorrected Misstatements.

Area	Comments
Disagreements With Management	We encountered no disagreements with management over the application of significant accounting principles, the basis for management's judgments on any significant matters, the scope of the audit, or significant disclosures to be included in the financial statements.
Consultations With Other Accountants	We are not aware of any consultations management had with other accountants about accounting or auditing matters.
Significant Issues Discussed With Management	We discussed the monitoring status and operational and reporting issues identified by the DHCS, the TNE status, and DHCS compliance matters disclosed in the audited financial statements.
Significant Difficulties Encountered in Performing the Audit	We did not encounter any significant difficulties in dealing with management during the audit.
Letter Communicating Significant Deficiencies in Internal Control Over Financial Reporting	We have separately communicated the significant deficiencies in internal control over financial reporting identified during our audit of the financial statements, and this communication is attached as Exhibit A.
Significant Written Communications Between Management and Our Firm	Copies of significant written communications between our firm and the management of the Plan, including the representation letter provided to us by management, are attached as Exhibits B through E.

Ventura County Medi-Cal Managed Care Commission/ dba Gold Coast Health Plan
Summary of Accounting Estimates
Year Ended June 30, 2013

Accounting estimates are an integral part of the preparation of financial statements and are based upon management's current judgment. The process used by management encompasses their knowledge and experience about past and current events and certain assumptions about future events. You may wish to monitor throughout the year the process used to determine and record these accounting estimates. The following describes the significant accounting estimates reflected in the Plan's June 30, 2013, financial statements.

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

Estimate	Accounting Policy	Management's Estimation Process	Basis for Our Conclusions on Reasonableness of Estimate
Reserve for claims liability and claims payable	Management establishes claims liability based on estimates of the ultimate cost of claims in process and provision for claims incurred but not paid (IBNP).	The estimate of the claims liability is based on historical claim patterns and certain management assumptions. Management uses subsequent claims run-out and prior claims experience to determine the amount of the estimated liability. Milliman, an independent actuarial firm, was engaged to provide an opinion on the adequacy of the IBNP claims reserve at June 30, 2013.	We tested the propriety of management's information, and we read the independent actuary's report. Our internal actuary performed a corroborative estimate of the claims liability. Based on our procedures, the estimates appear reasonable.
Premium revenue and premium reserve	Capitation revenue is recognized in the period it is earned. Revenue adjustments are recorded in the period they can be reasonably determined.	During 2013, GCHP has recorded revenue based on 2012 capitation rates. When final 2013 rates were available, management adjusted revenue to final rates.	We tested GCHP capitation revenue using estimated data provided by the State of California and management's analysis. We also reviewed the journal entry made and supporting documentation to adjust revenue to the final rates. Based on our procedures, the estimates appear reasonable.
Reserve for premium deficiency	A premium deficiency reserve is recorded when there is an expected loss in the subsequent year from contracts that have been committed to at year-end.	Management performs periodic analysis of its expected future health care costs and maintenance costs by line of business to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued.	We reviewed the propriety of management's analysis, including the 2014 financial forecast. Based on our procedures, the estimates appear reasonable.

Ventura County Medi-Cal Managed Care Commission/
dba Gold Coast Health Plan
Summary of Uncorrected Misstatements
Year Ended June 30, 2013

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

Description	Increase (Decrease) in Assets	(Increase) Decrease Liabilities	(Increase) Decrease Net Assets (Deficit)	(Increase) Decrease in Revenue	Increase (Decrease) in Expense
Current-year misstatements:					
Projected overpayment of claims	$ -	$ 318,000	$ -	$ -	$ (318,000)
				$ -	$ (318,000)
Close revenue/expense to net assets (deficit)	-	-	(318,000)		
Net effect on net assets (deficit)	$ -	$ 318,000	$ (318,000)		

Exhibit A—Letter Communicating Significant Deficiencies in Internal Control Over Financial Reporting

McGladrey LLP

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October 30, 2013

Ventura County Medi-Cal Managed Care Commission/
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2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036

Attention: Members of the Executive/Finance Committee

In planning and performing our audit of the financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (GCHP or the Plan) as of and for the year ended June 30, 2013, in accordance with auditing standards generally accepted in the United States of America, we considered the Plan's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of GCHP's internal control. Accordingly, we do not express an opinion on the effectiveness of GCHP's internal control.

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

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

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

SIGNIFICANT DEFICIENCIES

CLAIMS PROCESSING AND CLAIMS RESERVES

Claims processing: Accurate payment of claims is the basis for estimating the claims liability and maintaining provider relationships and contract compliance. Because the claims liability is a significant estimate, errors in the claims payment systems could have a material impact on the financial statements.

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

While the number or errors detected in the 2013 audit were less significant than in the 2012 audit, we noted that certain medical claims selected for testing were not adjudicated properly. Each of the improperly adjudicated claims had been manually adjudicated using incorrect provider contract rates. The Plan has significantly improved the medical claims auto-adjudication rate; therefore, these errors will likely continue to decline. However, manual adjudication of certain claims increases the likelihood of processing errors, so we suggest implementing additional controls over manually adjudicated claims.

We recommend the following:

- Management should continue to perform audits on the procedures performed by third-party vendors who process claims information.

- Consider requiring ACS and other vendors that process financial data to undergo an audit of their processes and controls and obtain a Service Organization Controls (SOC 1) report or, alternatively, perform similar processes using resources internal to GCHP to understand and test the operating effectiveness of these key third-party vendor controls, as GCHP relies on these systems for appropriate financial reporting.

- Assure claims are being processed appropriately by implementing or continuing to use the following controls:

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

  - Continue to review processes and procedures to assess whether claims were processed accurately.

  - Continue to consistently follow and monitor formal information technology (IT) change mangement policies that govern all types of IT changes (upgrade, patch, vendor-initiated, emergency, etc.) made by either ACS or GCHP.

  - GCHP should continue to monitor ACS policies and procedures and assure these policies are in place for adjudication of claims and IT controls, particularly in absence of a SOC 1 report.

Claims reserves: We commend GCHP management on the implementation of monitoring procedures both throughout the year and through obtaining a mid-year opinion from an independent actuary to assure incurred but not paid (IBNP) claims reserves are appropriately set. The accuracy of IBNP assessments is a key estimate in the financial statements.

We recommend continuing to monitor IBNP levels monthly and recommend evaluating the policy on calculating premium deficiency reserves, including whether the Plan includes interest income in the calculation. In addition, we suggest estimating reinsurance recoveries on IBNP. An actuary can assist with the determination of such accruals as premium deficiency reserves, pharmacy accruals, reinsurance recoveries, and capitation payable.

SEGREGATION OF DUTIES AND INTERNAL POLICIES

Segregation of duties—accounting: An effective system of internal accounting control contemplates an adequate segregation of duties so that no one individual handles a transaction from its initiation to its completion. While GCHP has added personnel during the year, the limited number of accounting and finance personnel at GCHP prevents a proper segregation of accounting functions necessary to assure adequate internal control. As a result, some aspects of internal accounting control that rely upon adequate segregation of duties were not effective for the entirety of the year.

Management employees perform monthly analytical and review procedures on key accounts and transactions; however, there is limited documented oversight to these functions other than a review of the financial statements by the chief executive officer, chief financial officer, and/or the Commission. This may create an opportunity to misappropriate assets and misrepresent financial position. Supervision and periodic review procedures can assist in mitigating the lack of proper segregation of duties.
During our audit, we noted that while management reviewed and approved check runs and bank reconciliations, formal written evidence of approval or review was not always available. In conjunction with the segregation of duties deficiency noted earlier, this lack of controls heightens the risk of misappropriated assets and financial statement errors.

The lack of monitoring controls also leaves GCHP vulnerable to accounting errors. While less significant than errors detected in the 2012 audit, we identified two audit adjustments in accounts payable and cash reconciliations in the fiscal 2013 audit. We recommend GCHP continue to review and monitor its processes for recording and reviewing all entries to ensure proper financial reporting and adherence to generally accepted accounting principles (GAAP).

While additional personnel are added to the finance department, we recommend GCHP continue working to eliminate conflicting or combined duties through segregation of duties, to the extent possible with the resources available, and to put more formalized compensating supervisory controls in place, including requiring dual signatures on significant disbursements. In addition, we recommend implementing formal approval processes for monthly reconciliations, as we noted instances where approval was not readily identified.

Segregation of duties—payroll: The Plan began processing payroll during fiscal year 2013. In review over access controls, we noted the user listing indicated several users with super-user capability. The super-user access allows an employee to initiate and approve transactions. We recommend limiting personnel with super-user status. Also, we understand that GCHP has implemented formal approval processes, noting supervisory signoffs of all payroll changes. Lastly, we recommend, any changes initiated by the super users should be reviewed for appropriateness.

Segregation of duties—IT: During our review of IT controls, we noted that there is currently an informal process to periodically review GCHP Windows network access.

We recommend that the Plan draft and implement a formal procedure around periodic user account review, at least annually, and expand to include Multiview. We recommend that the Plan consistently follow the process to check for terminated employees and that access rights are commensurate with job responsibilities. A formal policy for administering user access should be developed, including the utilization of an access request form for tracking the access administration process, including request, approval, and implementation of privileges, as well as strong password policies. There should also be a process to assure that terminated employee access is removed promptly. These steps will ensure that access is appropriate for job responsibilities and conflicting job duties are minimized.

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

ACCOUNTS RECEIVABLE RECONCILIATIONS AND ALLOWANCES

GCHP has a number of accounts receivable from providers, the reinsurer, and for capitation receivable. The allowance for doubtful accounts on receivable balances is a significant estimate and is determined by management. We noted that the reconciliations for accounts receivable balances included all activity incurred during the fiscal year, but didn't necessarily identify the receivable balance by paying entity at year-end. Without a schedule that identifies which party will pay the amount to be collected, it is difficult to assess the allowance for doubtful accounts.

A point-in-time reconciliation of accounts receivable and assessment of the collectibility of accounts receivable should be performed monthly to assure interim financials properly reflect the best estimate of the expected value of accounts receivable. We recommend this assessment be based on knowledge of the customer and assessment of their ability to pay, aging, collection terms and historical collection rates. Any significant write-offs should be communicated to the Executive/Finance Committee on a timely basis.

In addition, we identified an error in the cash reconciliation in both 2012 and 2013 due to an error in reconciling outstanding checks in the claims account.

CLOSING

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

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

McGladrey LLP

Significant Written Communications Between Management and Our Firm

Exhibit B—Qualifications Letter

McGladrey LLP

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October 30, 2013

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

Attention: Members of the Executive/Finance Committee

We have audited, in accordance with auditing standards generally accepted in the United States of America, the financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (GCHP or the Plan) for the years ended June 30, 2013 and 2012, and have issued our report thereon dated October 30, 2013. In connection therewith, we advise you as follows:

1. We are independent certified public accountants with respect to GCHP and conform to the standards of the profession as contained in the Code of Professional Conduct and pronouncements of the American Institute of Certified Public Accountants, and the Rules of Professional Conduct of the California Board of Public Accountancy.

2. The engagement partner and engagement director, who are certified public accountants, have 17 years and 13 years, respectively, of experience in public accounting and are experienced in auditing insurance companies. Members of the engagement team, 83 percent of whom have had experience in auditing insurance companies and 83 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

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

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

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

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

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

4. We will retain the workpapers prepared in the conduct of our audit until the California Department of Health Care Services has filed a Report of Examination covering fiscal 2013, but not longer than seven years. After notification to GCHP, we will make the workpapers available for review by the California Department of Health Care Services at the offices of the insurer, at our offices, at the offices of the California Department of Health Care Services, or at any other reasonable place designated by the California Department of Health Care Services. Furthermore, in the conduct of the aforementioned periodic review by the California Department of Health Care Services, photocopies of pertinent audit workpapers may be made (under the control of the accountant), and such copies may be retained by the California Department of Health Care Services.

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

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

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

McGladrey LLP

Exhibit C—Representation Letter

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

October 30, 2013

McGladrey LLP
801 Nicollet Avenue
11th Floor, West Tower
Minneapolis, MN 55402-2526

This representation letter is provided in connection with your audit of the financial statements of Ventura County Medi-Cal Managed Care Commission / dba Gold Coast Health Plan (GCHP or the Plan) which comprise the balance sheet as of June 30, 2013 and the related statements of revenues, expenses and changes in net position, cash flows, and the related notes to the financial statements for the year, then ended. We confirm that we are responsible for the fair presentation in the financial statements of financial position, results of operations, and cash flows in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP).

We confirm, to the best of our knowledge and belief, as of October 30, 2013, the following representations made to you during your audit:

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit arrangement letter dated January 24, 2013, for the preparation and fair presentation of the financial statements referred to above in accordance with U.S. GAAP.
2. GCHP uses enterprise fund accounting and is a county organized health system operating in Ventura County, California
3. GCHP is not reported as a component unit of any governmental entity. The financial statements referred to above present only GCHP and do not purport to, and do not, present fairly the financial position, change in financial position, or cash flows of the County of Ventura, California.
4. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.
5. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable and reflect our judgment based on our knowledge and experience about past and current events and our assumptions about conditions we expect to exist and courses of action we expect to take.
6. There are no undisclosed related party relationships or transactions to be accounted for or disclosed.
7. All events subsequent to the date of the financial statements and for which U.S GAAP requires adjustment or disclosure have been adjusted or disclosed.
8. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.

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

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

    As of June 30, 2012, GCHP's tangible net equity (TNE) requirement had not been met. GCHP has been working with the California Department of Health Care Services (DHCS) in this regard. DHCS has developed a corrective action plan to assist the Plan in achieving compliance with TNE and other operational and reporting requirements. We believe that the Plan will be able to accomplish the items on the corrective action plan within the time frames required. The ability of GCHP to continue as a going concern will be impacted by the results of these actions. While DHCS has the authority to require the Plan to merge with another plan or cease business, we have had no communication, written or verbal, from DHCS that indicates that they plan to exercise this authority. We believe that GCHP has taken appropriate action to ensure the Plan's ability to continue as a going concern.

11. We agree with the findings of specialists engaged by us in evaluating loss reserves and have adequately considered the qualifications of the specialists in determining the amounts and disclosures used in the financial statements and underlying accounting records. We did not give or cause any instructions to be given to specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialists.

12. The loss reserve specialist used by management in estimating the loss and loss adjustment expense reserves had a sufficient level of competence and experience in loss reserving, including knowledge about the types of insurance written by the Plan as well as an understanding of the appropriate methods for calculating such reserve estimates. We recognize we are responsible for the actuarial amounts and balances and, in our opinion, all such amounts are fairly presented.

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

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

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

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

17. The liability for unpaid claims (and claims adjustment expenses) includes estimates of amounts due on reported claims and claims that have been incurred but that were not reported as of June 30, 2013. Such estimates are based on actuarial projections applied to historical claim payment data. Such liabilities represent the Plan's best estimate of amounts that are reasonable and adequate to discharge the Plan's obligations for claims incurred but unpaid as of June 30, 2013.

18. Claims adjustment expenses have been paid in advance based on a per member-per month arrangement with ACS Health Administration, Inc. (ACS). ACS has the contractual obligation to continue claims adjustment activities for incurred claims until such claims have been properly adjudicated.
19. We have informed you of all uncorrected misstatements.

Information Provided

20. We have provided you with:
    a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation, and other matters.
    b. Additional information that you have requested from us for the purpose of the audit.
    c. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
    d. Minutes of the meetings of commissioners and committees of commissioners, or summaries of actions of recent meetings for which minutes have not yet been prepared.
21. All transactions have been recorded in the accounting records and are reflected in the financial statements.
22. We have disclosed to you the results of our assessment of risk that the financial statements may be materially misstated as a result of fraud. We are not aware of any fraud related to financial reporting.
23. We have no knowledge of allegations of fraud or suspected fraud, affecting the entity's financial statements involving:
    a. Management.
    b. Employees who have significant roles in the internal control.
    c. Others where the fraud could have a material effect on the financial statements.
24. We have no knowledge of any allegations of fraud or suspected fraud affecting the entity's financial statements received in communications from employees, former employees, analysts, regulators, or others.
25. We have no knowledge of noncompliance or suspected noncompliance with laws and regulations whose effects should be considered when preparing financial statements other than noted in #10 above.
26. We are not aware of any undisclosed pending or threatened litigation and claims whose effects should be considered when preparing the financial statements.
27. We have disclosed to you the identity of the entity's related parties and all the related-party relationships and transactions of which we are aware.
28. We have informed you of all significant deficiencies in the design or operation of internal controls that could adversely affect the entity's ability to record, process, summarize, and report financial data.

29. There have been no reports of regulatory examinations that have been completed in the past year and we have informed you that no such examinations are currently in process other than the activities related to the corrective action by DHCS. We are not aware of any allegations of noncompliance that should be considered for disclosure or as a basis for recording a loss contingency.
30. We have made available to you all significant contracts and agreements and have communicated to you all significant oral agreements. We have complied with all aspects of contractual agreements that would have a material effect on the statutory financial statements in the event of noncompliance. We have also informed you of all oral agreements for which signed documents have not yet been prepared through October 30, 2013.
31. There have been no communications from regulatory agencies concerning noncompliance with, or deficiencies in, financial reporting practices other than the letter regarding "Consolidated Corrective Action Plan for Gold Coast Health Plan" dated September 18, 2013 (and prior versions), which has been provided to you.
32. We have estimated GCHP capitation revenue based on signed DHCS contract amendments and the most recent rate information available to us.
33. We believe that MCO tax should not be accrued on CBAS revenues as it was not included in our revenue rates.
34. We expect that GCHP will continue as a going concern through June 30, 2014.
35. GCHP uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB).
36. We have determined that we are not required to follow the Annual Financial Reporting Model Regulation (Model Audit Rule) as promulgated by the National Association of Insurance Commissioners.
37. During the course of your audit, you may have accumulated records containing data that should be reflected in our books and records. All such data have been so reflected. Accordingly, copies of such records in your possession are no longer needed by us and should be treated according to HIPAA and our signed Business Associate Agreement.

As of and for the Year Ended June 30, 2013

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

Description	Increase (Decrease) in Assets	(Increase) Decrease Liabilities	(Increase) Decrease Net Assets (Deficit)	(Increase) Decrease in Revenue	Increase (Decrease) in Expense
Current-year misstatements:					
Adjust claims expense and claims payable for projected overpayment	$ -	$ 318,115	$ -	$ -	$ (318,115)
				$ -	$ (318,115)
Close revenue/expense to net assets (deficit)	-	-	(318,115)		
Net effect on net assets (deficit)	$ -	$ 318,115	$ (318,115)		

Respectfully,

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

Michael Engelhard, Chief Executive Officer

Date Signed 10/30, 2013

Michelle Raleigh, Chief Financial Officer

Date Signed 10/30, 2013

Lyndon Turner, Finance Manager

Date Signed OCTOBER 30, 2013

Exhibit D—Independence Letter

McGladrey LLP

801 Nicollet Mall
West Tower Ste 1100
Minneapolis, MN 55402-2526
O 612.332.4300
www.mcgladrey.com

October 30, 2013

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

Attention: Members of the Executive/Finance Committee

We were engaged to audit the financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (GCHP) as of and for the year ended June 30, 2013, and have issued our report thereon.

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

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

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

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

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

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

McGladrey LLP

Exhibit E—Management Letter

McGladrey LLP

801 Nicollet Mall
West Tower Ste 1100
Minneapolis, MN 55402-2526
O 612.332.4300
www.mcgladrey.com

October 30, 2013

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

Attention: Members of the Executive/Finance Committee

This letter includes comments, observations and suggestions with respect to matters that came to our attention in connection with our audit of the financial statements of Ventura County Medi-Cal Managed Care Commission/dba Gold Coast Health Plan (GCHP or the Plan) for the year ended June 30, 2013. We have repeated the following comments from our prior audit because they are still applicable for our audit of the current financial statements. These items are offered as constructive suggestions to be considered part of the ongoing process of modifying and improving GCHP's practices and procedures.

INTERNAL AUDIT FUNCTION

The Executive/Finance Committee's commitment to the improvement of GCHP's operations should include an ongoing commitment to develop and enhance the performance capabilities of an internal audit function.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

  5) Checks and check-writing capabilities are secured.

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

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

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

PROFESSIONAL SERVICES PROVIDER CONTRACTS

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

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

CLOSING

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

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

McGladrey LLP

AGENDA ITEM 3a

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, CEO

Date: November 18, 2013

Re: CEO Update

COMPLIANCE

Compliance submitted three corrective action plans (CAP) to The Department of Health Care Services (DHCS) between October 18, 2013 and October 30, 2013. The CAP submission consisted of: Medical, Financial and Facility Site Review.

Compliance has received 10 calls so far for the fourth quarter on the fraud hotline. 7 cases were received in October and 3 cases were received in November to date. All calls received were non fraud cases and were referred to appropriate departments for follow up. Calls included grievances, customer service related questions and questions on the notice of privacy practices. Compliance staff attended the quarterly Department of Justice Fraud meetings held in Los Angeles on November 5, 2013.

Delegation Oversight continues to evaluate current operations and refine and redefine processes. On November 8, 2013 letter were sent out to all three medical groups who are delegated for credentialing. Staff will perform onsite audits in December for all three groups. In addition other delegated services are tentatively slated for January 2014 audit. Delegation Oversight staff is an active participant in Industry Collaborative Effort (ICE) and will attend a two day ICE conference on November 14 & 15, 2013.

MEDICAL LOSS RATIO EVALUATION

The Plan received a notice from the State Department of Health Care Services (DHCS) that the State Department of Managed Health Care (DMHC) will be performing a medical loss ratio evaluation for the 2012-13 fiscal year (i.e., 07/01/12-06/30/13) on behalf of DHCS. DMHC previously performed a medical loss ratio evaluation on the Plan for the period 07/01/11-12/31/11. These evaluations typically involve testing the information supporting the Plan's financial statements. The Plan is expecting to receive a notification letter from DMHC the week of November 11, 2013 which should include more details regarding required documentation and general scope of review.

MEDICAL MANAGEMENT SYSTEM (MMS) IMPLEMENTATION

As communicated in the October 28, 2013 GCHP Commission CEO Update, the Plan is on-schedule to implement the new MedHOK Medical Management System (MMS) the week of December 9, 2013, ahead of the original late first quarter 2014 target. The MedHOK system will replace the current ICMS MMS provided by Xerox.

With roughly three weeks remaining in the implementation schedule, the core project team (consisting of GCHP, MedHOK and Xerox resources) are wrapping up final system and user acceptance testing, training of the Health Services staff, and system cutover planning in preparation for go-live. The MedHOK team has proven to be a valued and committed partner throughout the implementation process.

In conjunction with the MedHOK MMS implementation, the Plan is preparing to transition the Xerox nurses to GCHP employees effective January 1, 2014.

GOVERNMENT AFFAIRS UPDATE

The following is a summary of Government Affairs-related activities for the month of November 2013. The State Legislature remains in recess and will reconvene on December 1, 2013.

California Association of Health Insuring Organization Board Meeting

On Friday November 8, 2013 GCHP's Director of Government Relations and CEO attended the California Association of Health Insuring Organization's (CAHIO) Board meeting held at the offices of Cen Cal Health Plan in Santa Barbara. Topics discussed included:

- Dashboard Initiative
- Integration of Behavioral Health Services to Medi-Cal Managed Care
- County Organized Health System Model Issue Brief
- Bridge Plan Participation
- ACA-Low Income Health Program (LIHP) Outreach Strategies

Dashboard Initiative

An update was provided concerning the Department of Health Care Services' (DHCS) advisory workgroup consisting of plan representatives from Kaiser, LA Care, Health Plan San Mateo, and DHCS staff. The goal of the workgroup is to develop a mechanism for ongoing monitoring of the Medi-Cal managed care program as well to gauge plan performance. The workgroup has two essential tasks: 1) design dashboards for the Medi-Cal Managed Care Division and the California Healthcare Foundation (CHCF) in the above mentioned areas; and 2) prepare recommendations and a report for public distribution. The project is funded in part by the CHCF and will conduct focused case studies in Monterey and Solano Counties.

Integration of Behavioral Health Services to Medi-Cal Managed Care

On November 1, 2013 DHCS sent notice to all Medi-Cal beneficiaries statewide informing them that effective January 1, 2014, the Medi-Cal Program will cover mental health services and substance use disorder services. Medi-Cal beneficiaries who qualify will be able to

receive the following mental health benefits through Medi-Cal Managed Care Plans and Medi-Cal Fee-For-Service:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

Substance use disorder services will include:

- Voluntary Inpatient Detoxification
- Intensive Outpatient Treatment Services
- Residential Treatment Services
- Outpatient Drug Free Services
- Narcotic Treatment Services

Current GCHP Efforts

GCHP has entered into an agreement with a vendor, Beacon to implement and administer the new expanded mental health benefits for GCHP. Both GCHP and Beacon are actively working to develop a robust behavioral health provider network. Meetings are also being held with other key stakeholders and providers of mental health services such as Clinicas Del Camino Real.

Plans are expected to submit their behavioral health provider network lists to DHCS by December 1, 2013. Additionally plans are required to execute provider agreements and a new memorandum of understanding (MOU) with their respective county behavioral health agency. Reimbursement rates and rate categories are still in development by DHCS and are expected to be provided to plans by mid-November. Lastly, DHCS is in the process of defining the "bright line" or where responsibilities lie for covered services between county mental health agencies and Medi-Cal managed care plans.

Bridge Plan Participation

Plans discussed jointly hiring a consultant to prepare a joint overview and assessment of the infrastructure and operational requirements for COHS Plans to participate in the Bridge Plan Option. The intent of the Bridge Plan is to allow individuals and families who become ineligible for Medi-Cal due to an increase of income to remain in a Medi-Cal managed care plan and facilitate continuity of care.

The CAHIO consultant would provide a high-level overview of the operational and regulatory requirements for participation in Covered California as a Qualified Health Plan (QHP) and the Covered California Bridge Plan. The overview would identify and discuss the operational systems, processes, and infrastructure necessary to participate in Covered California as a QHP and Bridge Plan, as well as the programmatic and market-based criteria that member plans will need to work within including but not limited to: Accreditation; Offering Requirements; Licensure; Health Care Quality; Risk Adjustment; and Funds Flow.

ACA-LIHP Outreach Strategies
CAHIO member plans discussed their outreach activities relevant to ACA and transition of the LIHP Program to Medi-Cal managed care. These activities consisted of attending public forums and events in addition to partnering and co-hosting with community-based organizations as well as with elected officials to provide informational events concerning health care reform and the ACA. GCHP staff participate in weekly calls with DHCS concerning the transition of LIHP Program enrollees to GCHP and Medi-Cal managed care.

Also, a GCHP project manager has been assigned to coordinate and manage the LIHP transition to GCHP. As of October 2013 there were approximately 8,859 individuals with incomes between 0 to 133% of the federal poverty level (FPL) in Ventura County's LIHP or ACE Program. Another 2,745 LIHP / ACE Program enrollees had incomes between 133.1% to 200% of the FPL.

ACA-Health Care Reform and Medicaid Expansion
In addition to the ongoing work to integrate behavioral health services into Medi-Cal managed care and the LIHP transition to Medi-Cal, GCHP staff continues to work with stakeholders and community partners concerning changes, implementation and expansion of the Medi-Cal Program in the following areas: DHCS-Plan contract amendments; primary care physician rate increase; and assignment of newly eligible Medi-Cal beneficiaries under AB 85.

OUTREACH

The health education and outreach team conducted the following outreach activities during the months of September through November 2013.

Activities
During the period covering September through November 2013, Gold Coast Health Plan (GCHP) participated in community education and outreach events throughout the county. GCHP's community outreach events consisted of partnering with school and youth based groups, faith-based organizations, senior and persons with disabilities, community college students, county health and social service agencies. Additionally, staff also participated in community networking meetings.

School and Youth – Based Groups
During the months of October and November GCHP's outreach and health education staff held outreach and informational sessions for parents at Sheridan Way Elementary School concerning the Affordable Care Act (ACA) and changes to the Medi-Cal Program. Also, in September GCHP health and outreach staff participated in the 8th Annual Day for Kids event at the Boys & Girls Clubs, Martin V. Smith Youth Center in Oxnard. GCHP staff made contact with approximately 300 families and provided health education and information on the Medi-Cal Program as well as information about Covered California and health care reform. Staff also

participated in the MICOP Community Parent event held at Harrington Elementary School. Total number of youth and families reached at the above mentioned events was over 375.

Faith-Based Organizations
In October GCHP's outreach and health education staff participated in Our Lady of Guadalupe Church, Sai-Baba Health Fair. At this event GCHP staff provided information about GCHP and Medi-Cal Program expansion of benefits including the eligibility requirements. A total of 199 outreach encounters were reported. Of the 199, a total of 113 or 56% of the encounters were specific of health care reform and the affordable care act.

Outreach to Senior and Persons with Disabilities
In November GCHP's outreach and health education staff attended the 4th Annual Senior Summit. This event was hosted by the Ventura County Board of Supervisors and County Health Care Agency and took place on the Campus of California State University Channel Islands.

During the month of October GCHP staff provided information on GCHP benefits and changes to the Medi-Cal Program during the Ventura County Area on Agency "Wisdom and Protection in Your Golden Years" Resource Fair held at the Santa Paula Senior Center.

GCHP outreach and health education staff participated in the "Empowering the Caregiver Resource Fair" sponsored by the Alzheimer's Association and the Oxnard Family Circle, a community based adult service center (CBAS).

Additionally, outreach and education staff held an information booth at the Rainbow Connection Family Resource Fair at the Ocean View Pavilion Community Center in Port Hueneme. Information about health care reform and health education literature was provided to the public. Staff was also available to address questions related to changes in the Medi-Cal Program and GCHP covered benefits.

A total of 145 seniors and persons with disabilities were reached during outreach and education activities listed above. A total of 239 health education and health care form literature was provided. Of the 239 handouts, approximately eighty-four (84) or 35% of the handouts were related directly to the affordable care act and contact information to Medi-Cal enrollment counselors and call center.

Community College
GCHP sponsored an information booth during the Binational Health Week Fair held at Ventura College Market Place. Health education materials were distributed to students and attendees. Additionally, GCHP staff answered questions regarding health care reform, changes to eligibility for the Medi-Cal Program, and made referrals to health resources in the community.

A total of 67 outreach encounters were reported during this event. A total of 183 handouts on health education and health care reform were provided. Of the 183 handouts, approximately

49% of the materials provided to participants related to Medi-Cal Program and contact information about enrollment and eligibility.

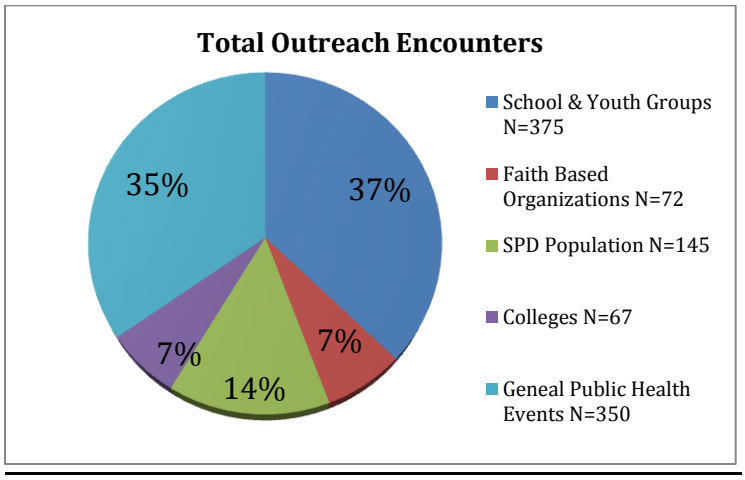
County Health and Social Service Agencies
GCHP outreach and health education staff participated in four (4) health education fairs and five (5) community food distribution events. At each of these events staff provided literature about various health education information including healthy eating, quit smoking, newborn baby enrollment information, and GCHP Newsletter. Staff also provided resource information about changes to the Medi-Cal Program and health education materials. Approximately 350 individuals and families were reached during the combined community outreach and health education events. A total of 421 handouts were given to attendees and approximately 55% or 233 of the handouts related to the changes in the Medi-Cal Program and ACA.

Summary of Community Outreach and Education Activities
Gold Coast Health Plan participated in 30 outreach activities and seven (7) community collaborative meetings:

Date	Event / Activities
11/01	La Hermandad – Food Distribution at Oxnard PAL Center
11/02	2013 Senior Summit at CSU Channel Island – Resource Fair
11/07	2nd Annual Ventura County Agricultural Networking Night at Santa Paula Agricultural Museum
11/12	VCMC Baby Steps- OB Celebration Resource Fair
11/17	Jornadas Dominicales at Oxnard Mexican Consulate
11/19	GCHP Member Orientation Meeting – English Session
11/20	West Park Community Center Food Distribution – Resource Fair
11/21	GCHP Member Orientation Meeting – Spanish Session
10/04	La Hermandad Community Food Distribution – Resource Booth
10/08	Ventura County Medical Center – Baby Steps
10/16	Sheridan Elementary School –Family Resource Fair
10/18	Rainbow Connection – Ocean View Pavilion, Port Huemene
10/19	Ventura College, Binational Health Week – Market Place Resource Fair
10/22	GCHP New Member Orientation Meeting – English Session
10/23	Ventura County Area Agency on Aging – Outreach Fair
10/24	Food Day 2013 Vegetable Garden – Resource Booth
10/24	GCHP Member Orientation Meeting – Spanish Session
10/26	Empowering the Caregiver Resource Fair at Oxnard Family Circle
10/26	MICOP Food Distribution & Community Family Event, El Rio Elementary School
10/27	Our Lady of Guadalupe Church, Sai-Baba Health Fair
10/27	Jornadas Dominicales at Oxnard Mexican Consulate
09/07	Mexican Consulate – Resource Fair Jornades Sabatinas
09/10	Ventura County Medical Center – Baby Step Resource Fair
09/13	La Hermandad Community Food Distribution – Resource Booth
09/14	Ventura County Public Health Agency- Health Fair La Colonia Del Sol 5K Walk

09/17 GCHP New Member Orientation Meeting – English Session
09/19 GCHP New Member Orientation Meeting – Spanish Session
09/21 Day for Kids Community Health and Resource Fair
09/26 Ventura County Human Service Agency – ACA Outreach Meeting
09/28 MICOP Family Community Fair

In summary, health education and outreach staff reached over 1000 individuals and families during the reporting months. The chart below highlights the groups and organizations reached during the reporting period. Additionally, over 1400 pieces of health education materials was distributed and approximately 639 ACA related literature was handed out during the reported events. Approximately 46% of all outreach events related to information about health care reform and the Medi-Cal Program.



Community Collaborative Meetings

11/07 Ventura County Public Health - Healthy Communities Collaborative
11/12 Affordable Care Act Coverage Seminar – St. John's Networking
11/14 Ventura County Children's Oral Health Collaborative
11/14 Low-Income Health Program – GCHP / VCHCA Communication Meeting
10/08 St. John's Networking Community Meeting
09/10 St. John's Networking Community Meeting
09/23 VC Public Health – Covered California Team Meeting

Affordable Care Act (ACA) and Community Collaborative Efforts

Outreach and education staff attended the Ventura County Health Care Reform Communications Committee meeting in September. This meeting was sponsored by Ventura County Human Service Agency. Community partners discussed information about outreach efforts related to the Medi-Cal Program eligibility and health care reform changes.

Additionally, GCHP prepared a response to an outreach and enrollment survey conducted by the Department of Health Care Services (DHCS). DHCS received funding from the California

Endowment for statewide outreach and education efforts to increase awareness of the Medi-Cal Program changes. GCHP participated in the survey, which is being coordinated by Ventura County Human Service Agency (VCHSA).

Future ACA and Low Income Health Program (LIHP) Outreach Strategies
GCHP's outreach and health education team will continue to participate in community health events and resource fairs. However, to continue to increase awareness about the changes to the Medi-Cal Program and health care reform, staff has identified alternative venues including shopping malls, public libraries, farmers market, childcare centers, employment centers, affordable housing authorities, and other key locations throughout the county to reach the general community about the expanded Medi-Cal Program and resources about ACA.

AGENDA ITEM 3b

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: November 18, 2013

Re: September, 2013 Financials (Unaudited)

SUMMARY

Staff is presenting the attached September, 2013 financial statements (unaudited) of Gold Coast Health Plan (Plan) for review by the Commission. Staff did review this information with the Executive / Finance Committee on November 7, 2013. The Executive / Finance Committee did recommend approval of the September, 2013 financial statements to the Plan's Commission.

BACKGROUND / DISCUSSION

The Plan has prepared the September 2013 financial package (unaudited), including balance sheets, income statements and statements of cash flows.

FISCAL IMPACT

On a year-to-date basis, the Plan's net income is approximately $4.0 million compared to $3.1 million assumed in the budget. These operating results have contributed to a Tangible Net Equity (TNE) level of approximately $11.7 million, which exceeds budget of $8.0 million (by nearly $3.7 million).

The September TNE level is approximately $765,000 above the phased-in TNE requirement as of September 30, 2013 of $10.9 million (68% of $16.1 million). This is the first time the Plan has exceeded the phased-in TNE level since the Financial Corrective Action Plan was issued in October 2012.

Other items to note include:

Membership - The Plan's September membership was 120,867 and exceeded budget by 781 members. Membership mix for September, on percentage basis, was the same as August's membership.

Revenue – September net revenue was $28.5 million or $1.1 million better than budget of $27.4 million. On a per-member-per-month (PMPM) basis, net revenue

was $236.49 PMPM compared to the budget of $228.49 PMPM. The Plan has made the following adjustments to the September revenue:

- Community Adult Based Services (CBAS) – The State has recently confirmed that the Plan will continue to receive funds comparable to historical reimbursement levels for this benefit. September's revenue includes an accrual of $1.7 million to reflect the proper CBAS revenue for July – August, as well as recognizing $0.8 million for the current month's estimated CBAS revenue.
- Adjustments to draft FY2013-14 State Capitation Rates – In the FY2013-14 draft rate package received by the Plan, the State made a reduction to the rates for certain program changes. This preliminary information suggested an approximate 2% rate reduction for certain aid categories, and the Plan has set up a reserve for this potential rate reduction. Staff is working with DHCS to verify their understanding of the draft FY2013-14 rates.

Health Care Costs – Health care costs for September were $24.8 million or approximately $568,000 above budget. On a PMPM basis, reported health care costs for September were $205.24 versus a budgeted amount of $201.84.

Please also note the following for September health care costs:

- A high-cost claim for a provider performing a transplant procedure was paid in October, but for an earlier month of service, and amounted to approximately $1.8 million (gross of anticipated recovery due from reinsurance). The amount was added to claims reserves in September.
- The incurred but not paid (IBNP) methodology has been further refined for the TLIC population with the expectation that their health care expenses would be less on a PMPM basis than the Plan's traditional population. This refinement resulted in claims expenses being shifted from one category of service to another. For example, the long term care claims expense has been reduced since these services are not expected to be provided to the TLIC population. Please note that these adjustments were made in the budgeted amounts as well.
- As previously discussed, one of the Plan's major providers implemented a new Electronic Health Records (EHR) system which has led to changes in the Plan's claims volume over the last three months. Therefore, the Plan has estimated additional pending claims in developing the IBNP.

Administrative Expenses - For the month, overall operational costs were approximately $271,000 or $2.13 PMPM above budget. The main reasons for the variance were:

- Reflecting an estimated accrual for ACS claims processing fees related to TLIC members. The ACS administrative support dollars associated with the TLIC enrollment had not been billed until the Healthy Families program fully transitioned to GCHP in August.
- Incurring higher than budgeted consulting services, primarily for the State monitor.

These increases were partially offset with savings from lower than forecasted personnel costs due to differences in timing of new hires versus that projected in the budget and delays in the occurrence of certain expected expenditures (e.g., Xerox SOC-1 audit, printing and mailings).

Cash + Medi-Cal Receivable - the Plan continues to monitor its cash balance and is continuing with cash management programs that began in February 2013. The total of Cash and Medi-Cal Premium Receivable balances was $68.7 million as of September 30, 2013, or $9.6 million better than a budgeted level of $59.1 million.

Fixed Assets – The Plan is continuing with the installment of its new Medical Management System (MMS). The expected cost of the MMS was $1.43 million as approved by the Commission in June 2013. Costs incurred to date for the project are approximately $759,000.

RECOMMENDATION
Staff proposes that the Gold Coast Health Plan Commission approve and accept the September 2013 financial package.

CONCURRENCE
Executive / Finance Committee (11/07/13)

Attachments
September, 2013 Financial Package (unaudited)

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended September 30, 2013

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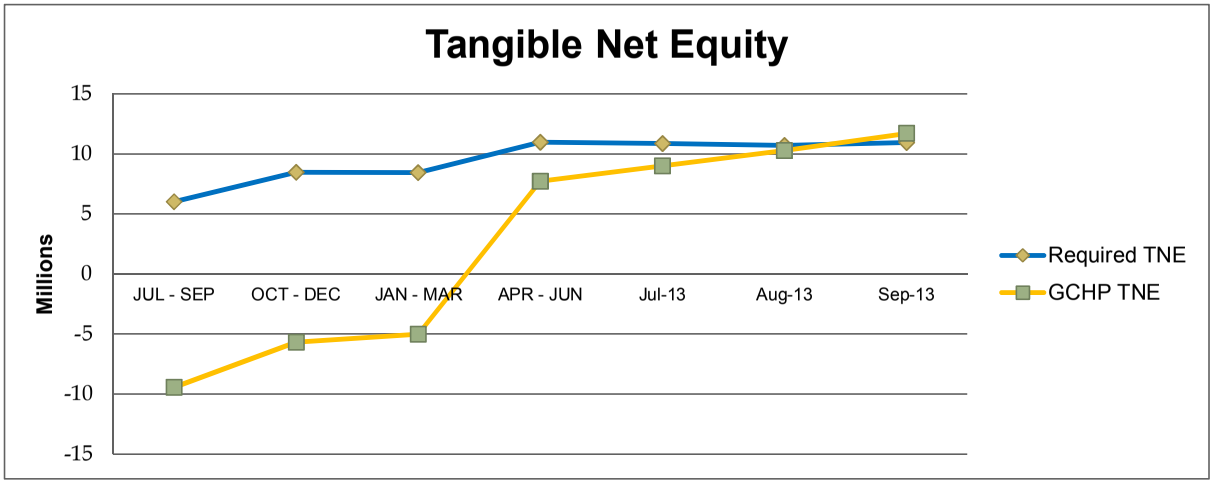
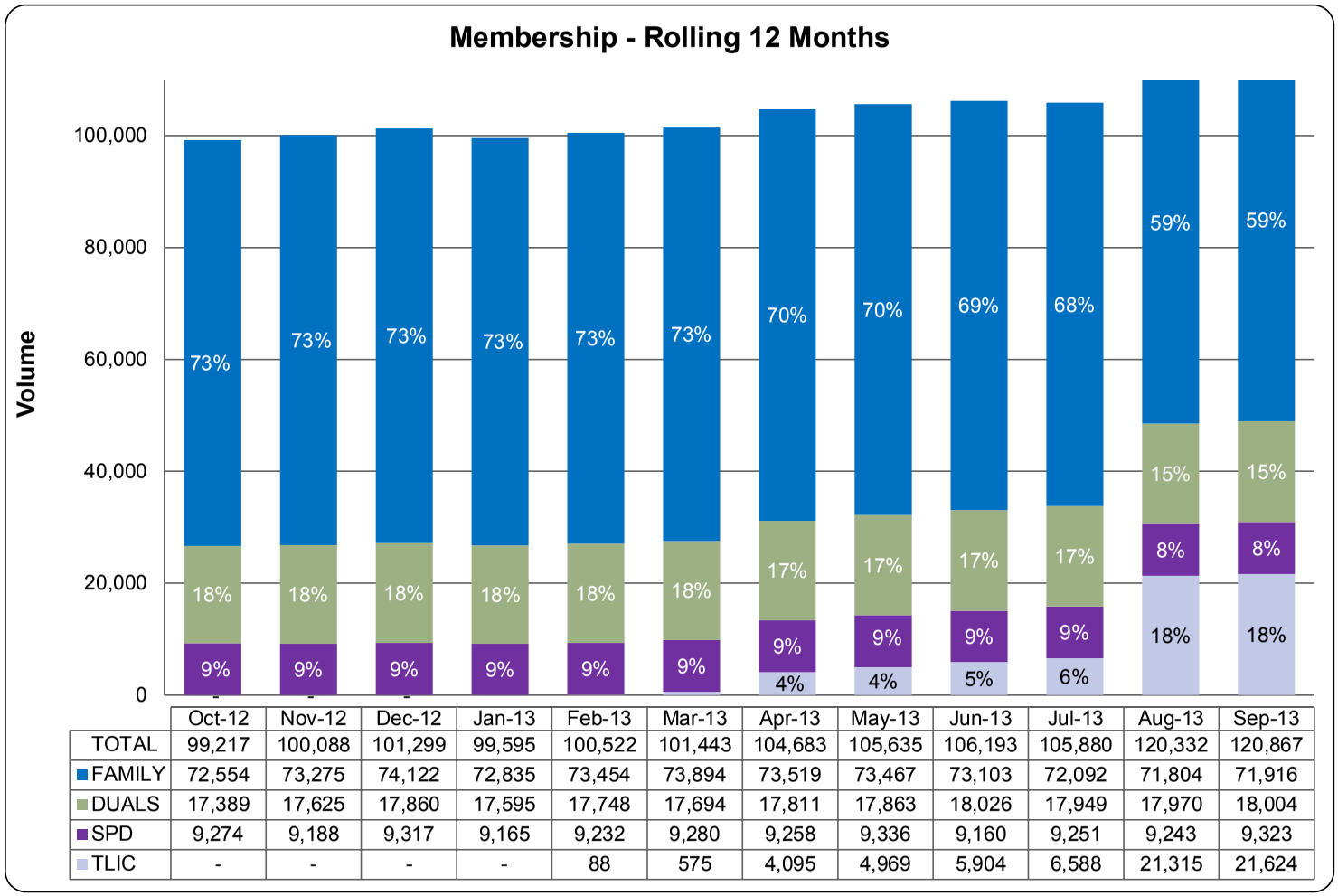
Financial Overview

Description	UNAUDITED FY 2012-13 Actual				UNAUDITED FY 2013-14 Actual				Budget Comparison		
	JUL - SEP	OCT - DEC	JAN - MAR	APR - JUN	Jul-13	Aug-13	Sep-13	YTD	Budget YTD	Variance Fav/(Unfav)	Variance Fav/(Unfav) %
Member Months	**305,220**	**300,604**	**301,560**	**316,511**	105,880	120,332	120,867	**347,079**	**345,104**	1,975	0.6 %
Revenue	**73,225,136**	**76,563,668**	**76,414,965**	**84,827,867**	**26,680,808**	**26,724,574**	**28,583,327**	**81,988,709**	**81,122,429**	866,280	1.1 %
pmpm	*239.91*	*254.70*	*253.40*	*268.01*	*251.99*	*222.09*	*236.49*	*236.22*	*235.07*	1.16	0.5 %
Health Care Costs	**71,648,550**	**68,967,923**	**69,698,937**	**70,134,156**	**23,429,811**	**23,572,589**	**24,806,270**	**71,808,671**	**71,863,663**	54,992	0.1 %
pmpm	*234.74*	*229.43*	*231.13*	*221.59*	*221.29*	*195.90*	*205.24*	*206.89*	*208.24*	1.34	0.6 %
% of Revenue	97.8%	90.1%	91.2%	82.7%	87.8%	88.2%	86.8%	87.6%	88.6%	-1.0%	-1.1%
Admin Exp	**4,976,867**	**6,036,079**	**6,049,617**	**6,951,364**	**1,968,367**	**1,892,167**	**2,341,473**	**6,202,007**	**6,157,755**	(44,252)	(0.7)%
pmpm	*16.31*	*20.08*	*20.06*	*21.96*	*18.59*	*15.72*	*19.37*	*17.87*	*17.84*	(0.03)	(0.1)%
% of Revenue	6.8%	7.9%	7.9%	8.2%	7.4%	7.1%	8.2%	7.6%	7.6%	0.0%	0.3%
Net Income	**(3,400,282)**	**1,559,667**	**666,411**	**7,742,347**	**1,282,629**	**1,259,818**	**1,435,584**	**3,978,031**	**3,101,011**	877,019	28.3 %
pmpm	*(11.14)*	*5.19*	*2.21*	*24.46*	*12.11*	*10.47*	*11.88*	*11.46*	*8.99*	2.48	27.6 %
% of Revenue	-4.6%	2.0%	0.9%	9.1%	4.8%	4.7%	5.0%	4.9%	3.8%	1.0%	26.9%
100% TNE	16,693,841	16,308,936	16,264,038	16,141,114	16,003,415	15,749,996	16,101,739	16,101,739	16,266,238	(164,498)	(1.0)%
Required TNE	6,009,783	8,480,647	8,457,300	10,975,958	10,882,323	10,709,998	10,949,183	10,949,183	11,061,042	(111,859)	(1.0)%
GCHP TNE	**(9,432,163)**	**(5,672,496)**	**(5,006,086)**	**7,736,261**	**9,018,891**	**10,278,708**	**11,714,292**	11,714,292	**8,016,909**	3,697,383	46.1 %
TNE Excess / (Deficiency)	**(15,441,946)**	**(14,153,143)**	**(13,463,385)**	**(3,239,696)**	**(1,863,432)**	**(431,289)**	**765,109**	**765,109**	**(3,044,133)**	3,809,242	225.1 %

Note:
Jul-Sep '12- Health Care Costs include $7M IBNR addition.
Budgeted TNE assumed additional $6M subordinated debt in March '13; actual LOC increase was $5M in May '13.

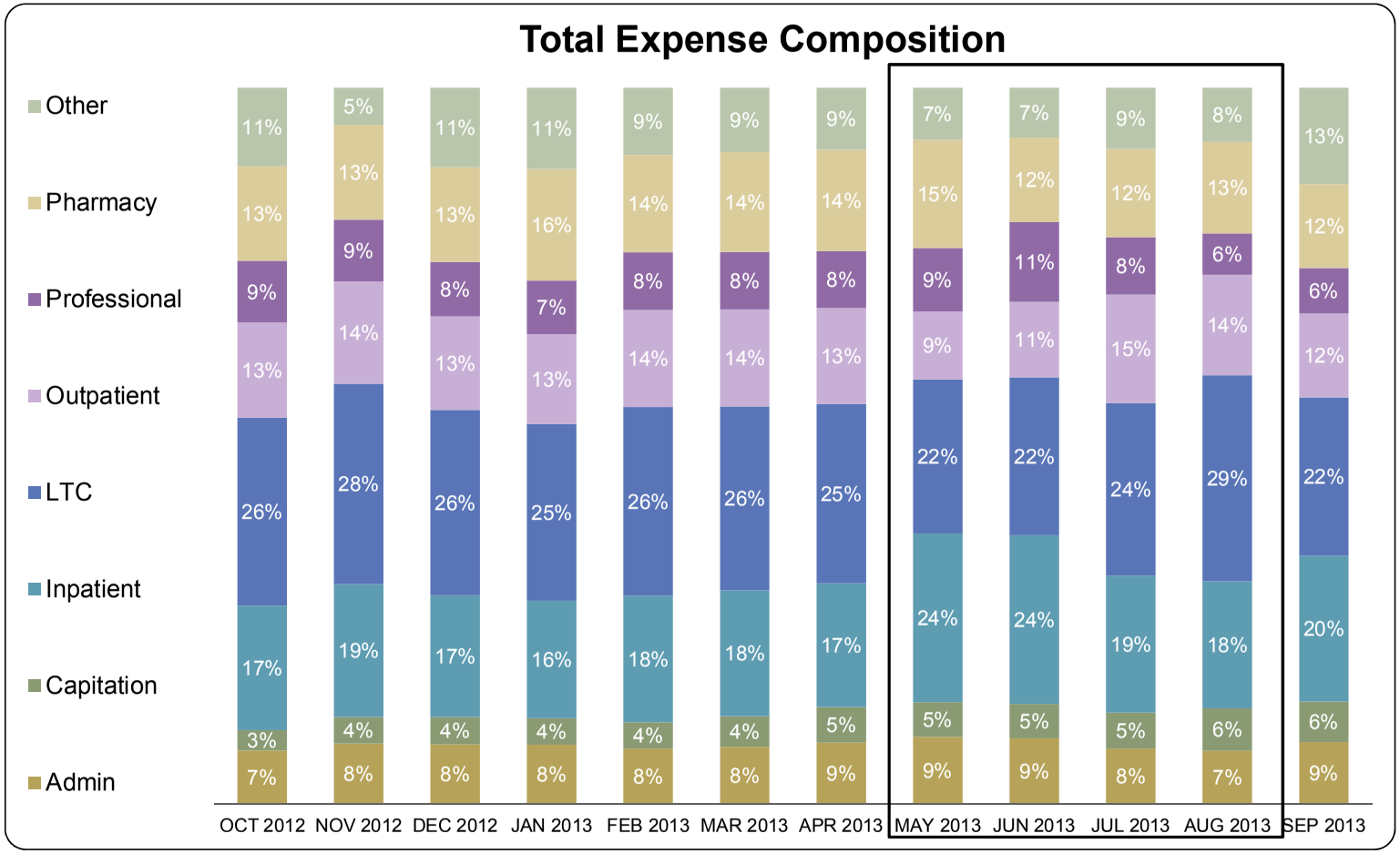




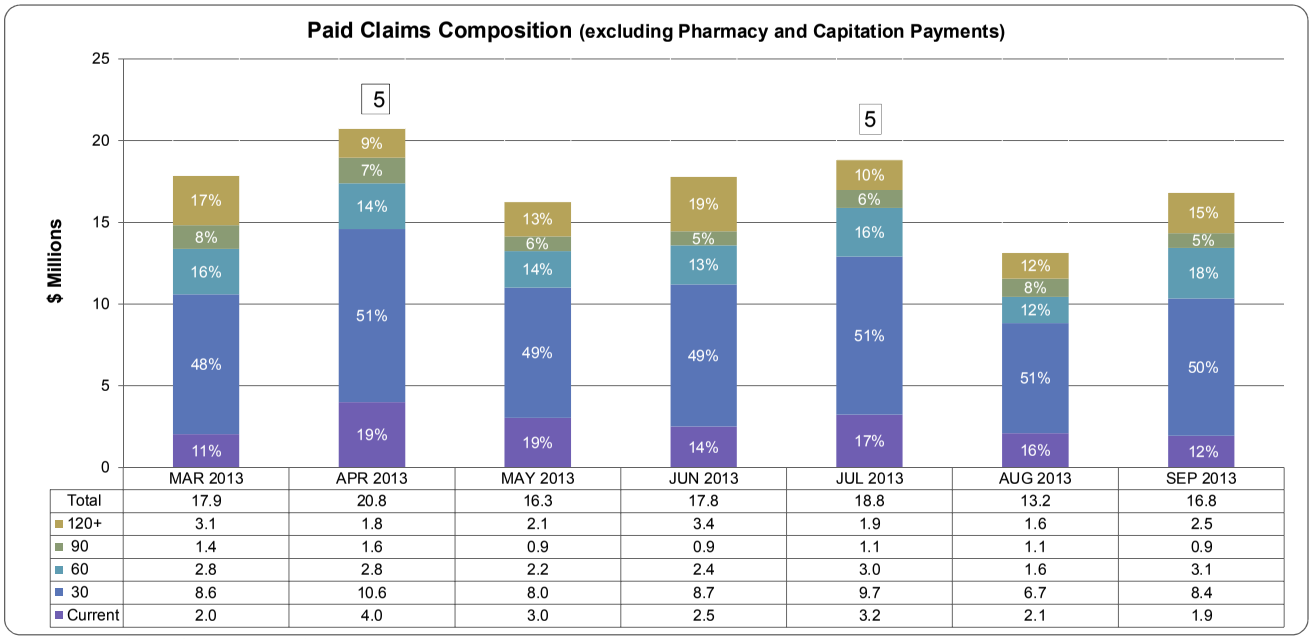
	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
TOTAL	99,217	100,088	101,299	99,595	100,522	101,443	104,683	105,635	106,193	105,880	120,332	120,867
FAMILY	72,554	73,275	74,122	72,835	73,454	73,894	73,519	73,467	73,103	72,092	71,804	71,916
DUALS	17,389	17,625	17,860	17,595	17,748	17,694	17,811	17,863	18,026	17,949	17,970	18,004
SPD	9,274	9,188	9,317	9,165	9,232	9,280	9,258	9,336	9,160	9,251	9,243	9,323
TLIC	-	-	-	-	88	575	4,095	4,969	5,904	6,588	21,315	21,624

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

UNAUDITED

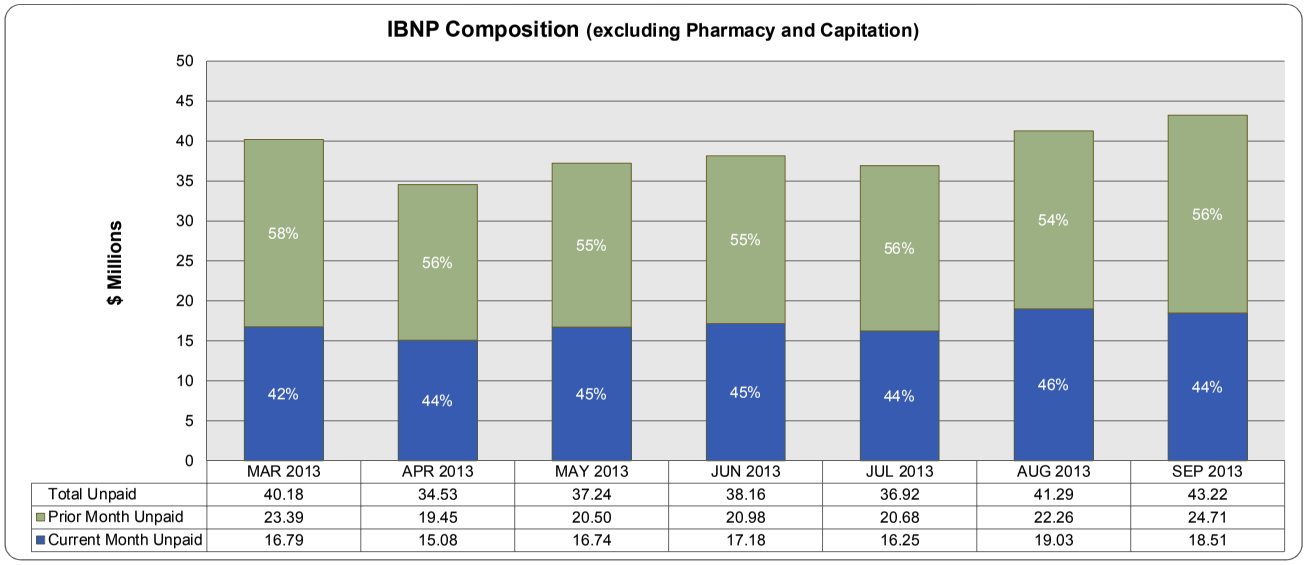


In May, GCHP changed its method of distributing Health Care Costs (HCC) across categories of service. Prior months utilized an allocation methodology. The methodology was updated to utilize payment information by different categories of services. Further changes have been made with the assumption of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



	MAR 2013	APR 2013	MAY 2013	JUN 2013	JUL 2013	AUG 2013	SEP 2013
Total	17.9	20.8	16.3	17.8	18.8	13.2	16.8
120+	3.1	1.8	2.1	3.4	1.9	1.6	2.5
90	1.4	1.6	0.9	0.9	1.1	1.1	0.9
60	2.8	2.8	2.2	2.4	3.0	1.6	3.1
30	8.6	10.6	8.0	8.7	9.7	6.7	8.4
Current	2.0	4.0	3.0	2.5	3.2	2.1	1.9

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

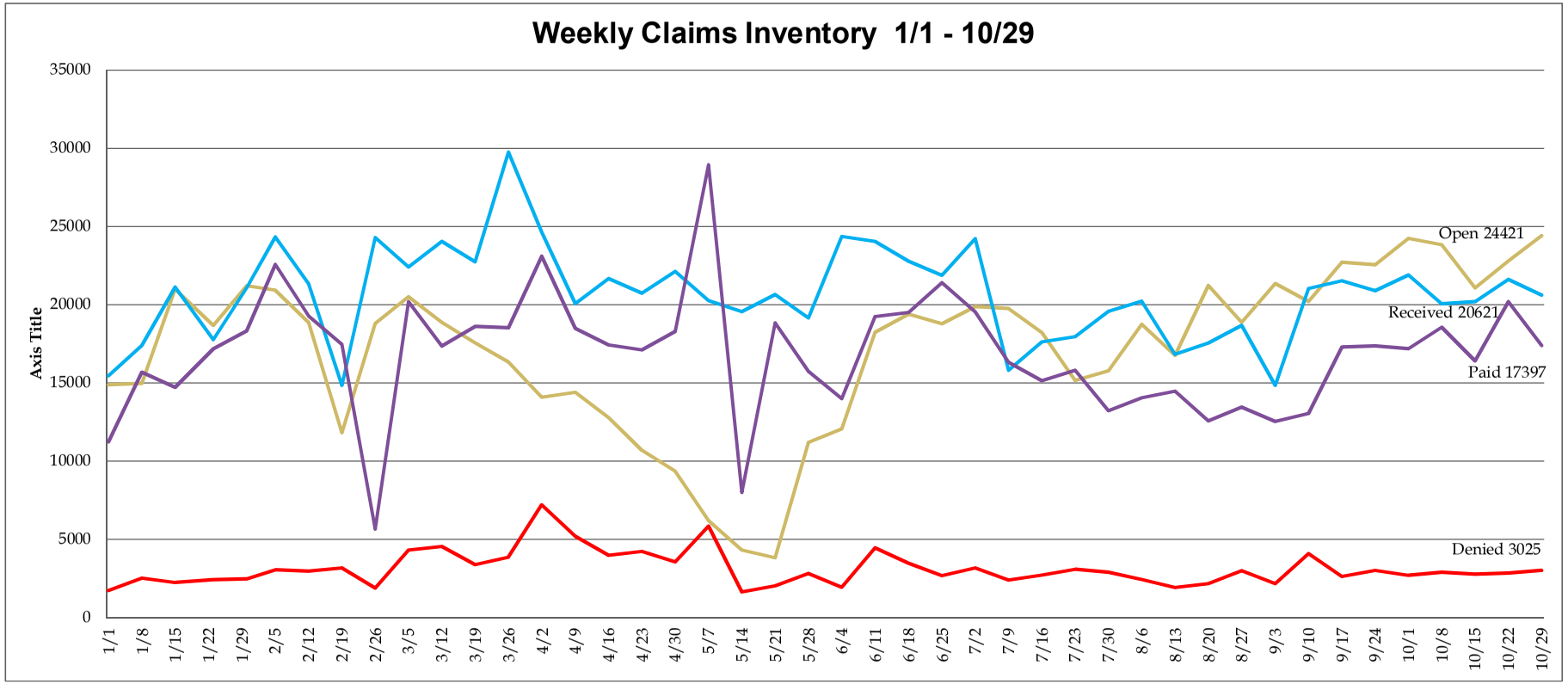


	MAR 2013	APR 2013	MAY 2013	JUN 2013	JUL 2013	AUG 2013	SEP 2013
Total Unpaid	40.18	34.53	37.24	38.16	36.92	41.29	43.22
Prior Month Unpaid	23.39	19.45	20.50	20.98	20.68	22.26	24.71
Current Month Unpaid	16.79	15.08	16.74	17.18	16.25	19.03	18.51

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

Month*	Open	Denied	Received	Paid	#GCHP Bus days	Avg Rcvd in month	Avg Pd in month
January	90,753	11,373	92,840	77,166	21	4,421	3,675
February	70,430	11,082	84,799	64,971	18	4,711	3,610
March	73,283	16,127	98,974	74,680	21	4,713	3,556
April	61,317	24,156	109,242	94,418	22	4,966	4,292
May	25,572	12,353	79,625	71,522	23	3,462	3,110
June	68,479	12,549	93,073	74,156	24	3,878	3,090
July	88,800	14,262	95,194	80,054	23	4,139	3,481
August	75,617	9,534	73,286	54,548	22	3,331	2,479
September	86,822	11,906	78,322	60,230	21	3,730	2,868
October	116,383	14,238	104,407	89,742	23	4,539	3,902
Average	*75,746*	*13,758*	*90,976*	*74,149*	*22*	*4,189*	*3,406*

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



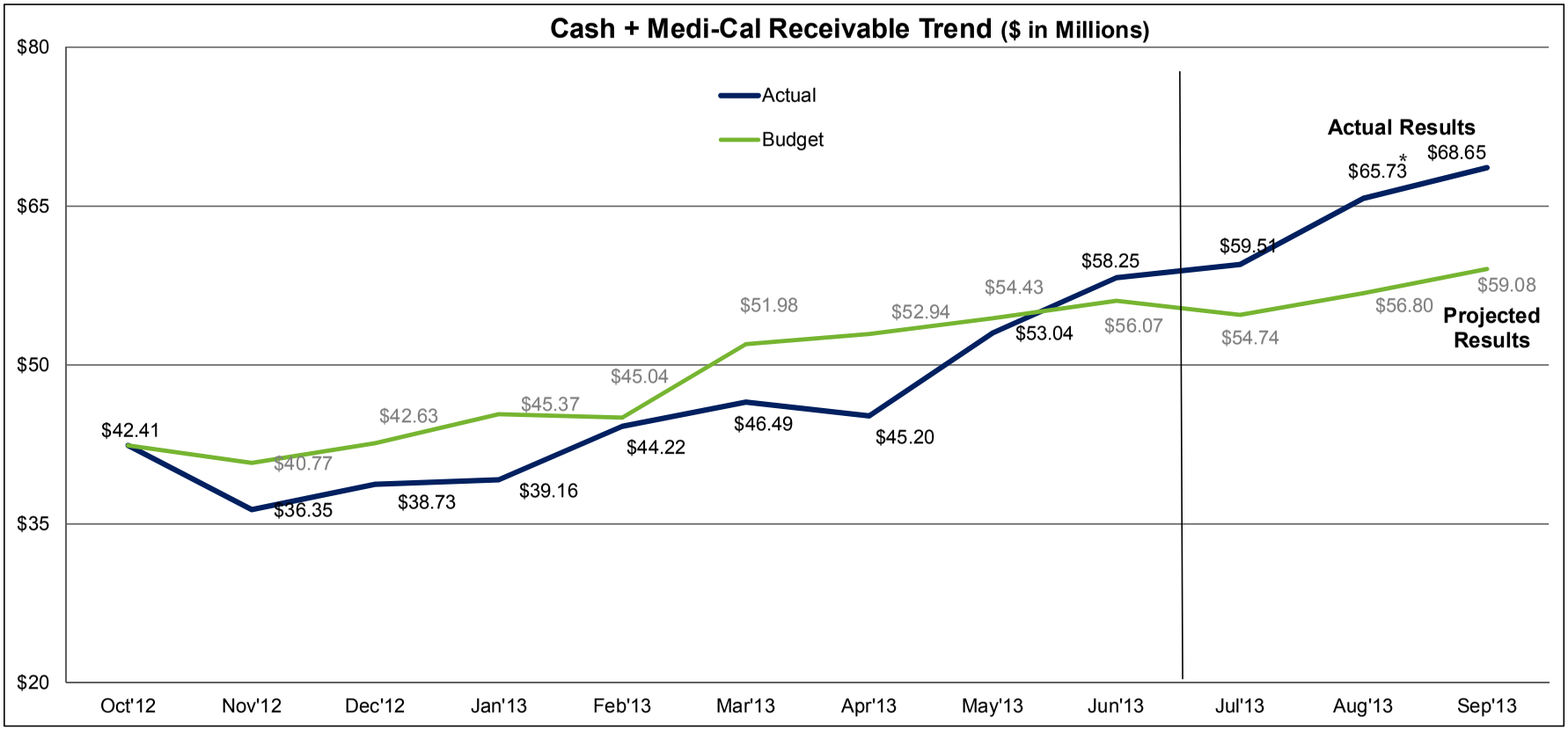
Open: Current claim inventory ready to be processed.
Received: Claims received this week to be processed.
Denied: Claims processed this week with a denial.
Paid: Claims processed this week with a payment.

Income Statement Monthly Trend

	2013 Actual Monthly Trend			2014 Actual Monthly Trend		Current Month		
	APR 2013	MAY 2013	JUN 2013	JUL 2013	AUG 2013	SEP 2013		Variance
						Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	104,683	105,635	106,193	105,880	120,332	120,867	120,086	781
Revenue:								
Premium	$ 26,032,054	$ 26,048,832	$ 29,108,295	$ 27,686,491	$ 27,789,352	$ 29,602,003	$ 27,521,553	$ 2,080,450
Reserve for Rate Reduction	1,785,047	-	1,180,078	-		-	(129,202)	129,202
MCO Premium Tax	-	-	-	(1,053,211)	(1,110,416)	(1,068,828)	-	(1,068,828)
Total Net Premium	**27,817,101**	**26,048,832**	**30,288,373**	**26,633,279**	**26,678,936**	**28,533,175**	**27,392,351**	**1,140,824**
Other Revenue:								
Interest Income	7,579	7,203	8,594	9,195	7,304	11,819	8,256	3,562
Miscellaneous Income	38,333	573,518	38,333	38,333	38,333	38,333	38,333	0
Total Other Revenue	45,912	580,721	46,927	47,529	45,637	50,152	**46,589**	3,563
Total Revenue	**27,863,013**	**26,629,553**	**30,335,300**	**26,680,808**	**26,724,574**	**28,583,327**	**27,438,940**	**1,144,387**
Medical Expenses:								
Capitation (PCP, Specialty, NEMT & Visic	1,274,651	1,226,446	1,254,306	1,270,073	1,507,335	1,533,277	1,637,117	103,840
Incurred Claims:								
Inpatient	4,422,556	5,955,342	6,185,239	4,850,263	4,512,661	5,531,725	4,383,586	(1,148,139)
LTC/SNF	6,404,450	5,438,652	5,774,127	6,128,764	7,333,312	6,003,374	6,880,907	877,533
Outpatient	2,682,417	1,803,363	2,132,380	2,882,860	2,955,457	2,281,073	2,768,250	487,177
Laboratory and Radiology	225,582	158,267	126,783	222,454	113,377	96,573	93,378	(3,195)
Emergency Room Facility Services	521,965	430,333	506,334	745,797	497,008	803,936	772,753	(31,183)
Physician Specialty Services	2,026,032	2,245,622	2,929,617	2,033,957	1,479,169	1,725,887	1,854,331	128,444
Pharmacy	3,626,289	3,819,028	3,092,352	3,126,910	3,253,505	3,172,116	3,260,456	88,340
Other Medical Professional	216,345	83,856	84,601	169,903	118,201	249,684	122,796	(126,888)
Other Medical Care Expenses	-	-	755	-	-	1,621	-	(1,621)
Other Fee For Service Expense	1,489,453	1,497,072	1,524,389	1,137,610	1,235,873	2,100,151	1,505,480	(594,671)
Transportation	73,499	71,310	60,991	40,124	35,404	178,553	77,195	(101,358)
Total Claims	21,688,588	21,502,845	22,417,569	21,338,642	21,533,967	22,144,693	21,719,131	(425,562)
Medical & Care Management Expense	894,013	722,529	732,777	742,126	730,967	746,163	698,440	(47,723)
Reinsurance	26,355	70,711	(368,913)	259,745	258,884	277,448	183,732	(93,716)
Claims Recoveries	(484,211)	(610,167)	(213,342)	(180,775)	(458,563)	104,688	-	(104,688)
Sub-total	436,157	183,072	150,522	821,096	531,288	1,128,300	882,172	(246,127)
Total Cost of Health Care	**23,399,396**	**22,912,363**	**23,822,397**	**23,429,811**	**23,572,589**	**24,806,270**	**24,238,421**	**(567,849)**
Contribution Margin	**4,463,617**	**3,717,190**	**6,512,903**	**3,250,997**	**3,151,984**	**3,777,057**	**3,200,519**	**576,538**
General & Administrative Expenses:								
Salaries and Wages	464,103	600,314	731,003	562,828	420,641	453,818	515,454	61,636
Payroll Taxes and Benefits	113,969	108,592	199,544	123,309	112,105	114,103	131,825	17,722
Total Travel and Training	5,140	13,746	2,712	3,630	5,840	10,686	23,934	13,248
Outside Service - ACS	892,178	945,040	924,744	852,085	880,703	1,190,847	959,836	(231,012)
Outside Services - Other	99,755	31,920	26,808	16,447	49,938	33,271	22,455	(10,816)
Accounting & Actuarial Services	33,046	51,270	61,489	44,003	20,164	46,568	53,333	6,766
Legal Expense	37,957	46,299	80,775	57,931	26,462	54,932	30,400	(24,532)
Insurance	9,245	10,516	7,677	11,838	9,972	12,517	10,792	(1,725)
Lease Expense - Office	26,080	25,980	7,937	25,980	28,480	28,480	25,980	(2,500)
Consulting Services Expense	286,436	443,743	229,676	172,165	201,612	264,998	140,638	(124,360)
Translation Services	1,125	4,610	3,672	4,878	2,788	2,778	2,967	189
Advertising and Promotion Expense	-	1,050	-	4,080	14,120	-	11,460	11,460
General Office Expenses	171,615	71,628	83,271	63,357	88,394	77,654	117,335	39,682
Depreciation & Amortization Expense	3,836	3,648	11,407	5,235	5,235	6,492	6,864	372
Printing Expense	5,445	3,672	12,974	2,628	1,418	5,605	5,228	(377)
Shipping & Postage Expense	10,933	179	2,120	41	219	1,016	2,725	1,709
Interest Exp	24,186	1,180	17,120	17,933	24,076	37,708	9,425	(28,283)
Total G & A Expenses	**2,185,050**	**2,363,386**	**2,402,927**	**1,968,367**	**1,892,167**	**2,341,473**	**2,070,651**	**(270,822)**
Net Income / (Loss)	**$ 2,278,567**	**$ 1,353,803**	**$ 4,109,976**	**$ 1,282,629**	**$ 1,259,818**	**$ 1,435,584**	**$ 1,129,868**	**$ 305,716**

PMPM Income Statement Comparison

	2013 Actual Monthly Trend			2014 Actual Monthly Trend		Sep'13 Month-To-Date		Variance
	APR 2013	MAY 2013	JUN 2013	JUL 2013	AUG 2013	Actual	Budget	Fav/(Unfav)
Members (Member/Months)	101,741	105,635	106,193	105,880	120,332	120,867	120,086	781
Revenue:								
Premium	248.68	246.59	274.11	261.49	230.94	244.91	229.18	15.73
Reserve for Rate Reduction	17.05	-	11.11	-	-	-	(1.08)	1.08
MCO Premium Tax	-	-	-	(9.95)	(9.23)	(8.84)	-	(8.84)
Total Net Premium	**265.73**	**246.59**	**285.22**	**251.54**	**221.71**	**236.07**	**228.11**	**7.97**
Other Revenue:		-						
Interest Income	0.07	0.07	0.08	0.09	0.06	0.10	0.07	0.03
Miscellaneous Income	0.37	5.43	0.36	0.36	0.32	0.32	0.32	(0.00)
Total Other Revenue	**0.44**	**5.50**	**0.44**	**0.45**	**0.38**	**0.41**	**0.46**	**(0.05)**
Total Revenue	**266.17**	**252.09**	**285.66**	**251.99**	**222.09**	**236.49**	**228.49**	**7.99**
Medical Expenses:								
Capitation	12.18	11.61	11.81	12.00	12.53	12.69	13.63	(0.95)
Incurred Claims:								
Inpatient	42.25	56.38	58.25	45.81	37.50	45.77	36.50	(9.26)
LTC/SNF	61.18	51.49	54.37	57.88	60.94	49.67	57.30	7.63
Outpatient	25.62	17.07	20.08	27.23	24.56	18.87	23.05	4.18
Laboratory and Radiology	2.15	1.50	1.19	2.10	0.94	0.80	0.78	(0.02)
Emergency Room Facility Services	4.99	4.07	4.77	7.04	4.13	6.65	6.43	(0.22)
Physician Specialty Services	19.35	21.26	27.59	19.21	12.29	14.28	15.44	1.16
Pharmacy	34.64	36.15	29.12	29.53	27.04	26.24	27.15	0.91
Other Medical Professional	2.07	0.79	0.80	1.60	0.98	2.07	1.02	(1.04)
Other Medical Care Expenses	-	-	0.01	-	-	0.01	-	(0.01)
Other Fee For Service Expense	14.23	14.17	14.35	10.74	10.27	17.38	12.54	(4.84)
Transportation FFS	0.70	0.68	0.57	0.38	0.29	1.48	0.64	(0.83)
Total Claims	207.18	203.56	211.10	201.54	178.95	183.22	180.86	(2.35)
Medical & Care Management	8.54	6.84	6.90	7.01	6.07	6.17	5.82	(0.36)
Reinsurance	0.25	0.67	(3.47)	2.45	2.15	2.30	1.53	(0.77)
Claims Recoveries	(4.63)	(5.78)	(2.01)	(1.71)	(3.81)	0.87	-	(0.87)
Sub-total	4.17	1.73	1.42	7.75	4.42	9.34	8.72	(0.62)
Total Cost of Health Care	223.53	216.90	224.33	221.29	195.90	205.24	201.84	(3.39)
Contribution Margin	42.64	35.19	61.33	30.70	26.19	31.25	**26.65**	**4.60**
Administrative Expenses								
Salaries and Wages	4.43	5.68	6.88	5.32	3.50	3.75	4.29	0.54
Payroll Taxes and Benefits	1.09	1.03	1.88	1.16	0.93	0.94	1.10	0.15
Total Travel and Training	0.05	0.13	0.03	0.03	0.05	0.09	0.20	0.11
Outside Service - ACS	8.52	8.95	8.71	8.05	7.32	9.85	7.99	(1.86)
Outside Services - Other	0.95	0.30	0.25	0.16	0.41	0.28	0.19	(0.09)
Accounting & Actuarial Services	0.32	0.49	0.58	0.42	0.17	0.39	0.44	0.06
Legal Expense	0.36	0.44	0.76	0.55	0.22	0.45	0.25	(0.20)
Insurance	0.09	0.10	0.07	0.11	0.08	0.10	0.09	(0.01)
Lease Expense -Office	0.25	0.25	0.07	0.25	0.24	0.24	0.22	(0.02)
Consulting Services Expense	2.74	4.20	2.16	1.63	1.68	2.19	1.17	(1.02)
Translation Services	0.01	0.04	0.03	0.05	0.02	0.02	0.02	0.00
Advertising and Promotion Expense	-	0.01	-	0.04	0.12	-	0.10	0.10
General Office Expenses	1.64	0.68	0.78	0.60	0.73	0.64	0.98	0.33
Depreciation & Amortization Expense	0.04	0.03	0.11	0.05	0.04	0.05	0.06	0.00
Printing Expense	0.05	0.03	0.12	0.02	0.01	0.05	0.04	(0.00)
Shipping & Postage Expense	0.10	0.00	0.02	0.00	0.00	0.01	0.02	0.01
Interest Exp	0.23	0.01	0.16	0.17	0.20	0.31	0.08	(0.23)
Total Administrative Expenses	**20.87**	**22.37**	**22.63**	**18.59**	**15.72**	**19.37**	**17.24**	**(2.13)**
Net Income / (Loss)	**21.77**	**12.82**	**38.70**	**12.11**	**10.47**	**11.88**	**9.41**	**2.47**



* Actual Cash + Medi-Cal Receivable for August, 2013 $91.3 million and included $25.6 million intergovernmental fund transfer (IGT) amounts paid to the County in early September.

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APPENDIX

- Comparative Balance Sheet
- YTD Income Statement
- Monthly Statement of Cash Flows
- Pharmacy Cost Trend
- Pharmacy Comparative Charts

Comparative Balance Sheet

	9/30/13	8/31/13	7/31/13	6/30/13
ASSETS				
Current Assets				
Total Cash and Cash Equivalents	**$ 34,331,717**	**$ 85,684,442**	**$ 24,277,962**	**$ 50,707,852**
Medi-Cal Receivable	34,315,221	5,637,672	35,230,747	7,543,835
Provider Receivable	543,912	1,030,614	914,174	1,161,379
Other Receivables	196,943	196,032	195,116	300,397
Total Accounts Receivable	**35,056,076**	**6,864,319**	**36,340,038**	**9,005,611**
Total Prepaid Accounts	1,389,660	1,176,495	1,226,549	351,145
Total Other Current Assets	10,000	10,000	10,000	10,000
Total Current Assets	**$ 70,787,453**	**$ 93,735,256**	**$ 61,854,548**	**$ 60,074,607**
Total Fixed Assets	**986,207**	**615,332**	**236,494**	**230,913**
Total Assets	**$ 71,773,660**	**$ 94,350,588**	**$ 62,091,042**	**$ 60,305,520**
LIABILITIES & FUND BALANCE				
Current Liabilities				
Incurred But Not Reported	$ 33,793,228	$ 34,529,652	$ 33,171,805	$ 29,901,103
Claims Payable	11,193,958	8,633,379	5,648,707	9,748,676
Capitation Payable	1,265,100	1,250,713	1,015,278	1,002,623
Accrued Premium Reduction	-	-	-	-
Accounts Payable	491,915	1,466,215	2,000,411	1,693,432
Accrued ACS	1,252,499	1,214,024	1,191,571	422,138
Accrued RGS	-	-	-	-
Accrued Expenses	727,856	26,052,342	522,166	477,477
Accrued Premium Tax	9,692,383	9,252,398	7,513,140	7,286,494
Accrued Interest Payable	18,546	15,920	12,869	9,712
Current Portion of Deferred Revenue	460,000	460,000	460,000	460,000
Accrued Payroll Expense	358,882	353,902	654,538	605,937
Current Portion Of Long Term Debt	-	-	-	41,667
Total Current Liabilities	**$ 59,254,367**	**$ 83,228,546**	**$ 52,190,484**	**$ 51,649,258**
Long-Term Liabilities				
Deferred Revenue - Long Term Portion	805,000	843,333	881,667	920,000
Notes Payable	7,200,000	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	**8,005,000**	**8,043,333**	**8,081,667**	**8,120,000**
Total Liabilities	**$ 67,259,367**	**$ 91,271,879**	**$ 60,272,151**	**$ 59,769,258**
Beginning Fund Balance	536,262	536,262	536,262	(6,031,881)
Net Income Current Year	3,978,031	2,542,447	1,282,629	6,568,143
Total Fund Balance	**4,514,293**	**3,078,709**	**1,818,891**	**536,262**
Total Liabilities & Fund Balance	**$ 71,773,660**	**$ 94,350,588**	**$ 62,091,042**	**$ 60,305,520**

FINANCIAL INDICATORS				
Current Ratio	1.19 : 1	1.13 : 1	1.19 : 1	1.16 : 1
Days Cash on Hand	38	101	29	27
Days Cash + State Capitation Receivable	76	108	70	63

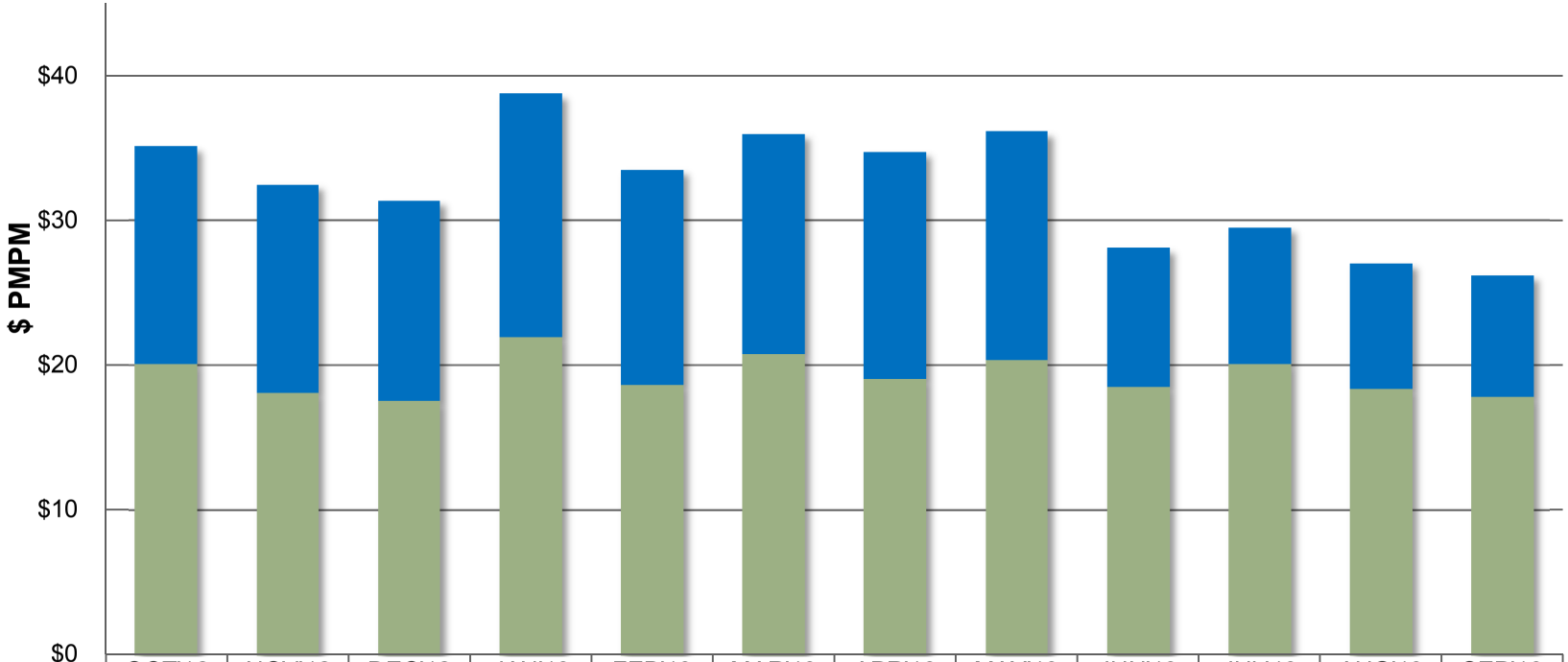
Income Statement
For The Three Months Ended September 30, 2013

	Sep'13 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	347,079	345,104	1,975
Revenue:			
Premium	$ 85,077,846	$ 81,370,529	$ 3,707,317
Reserve for Rate Reduction	-	(387,510)	387,510
MCO Premium Tax	(3,232,455)	-	(3,232,455)
Total Net Premium	**81,845,391**	**80,983,019**	**862,372**
Other Revenue:			
Interest Income	28,318	24,411	3,907
Miscellaneous Income	115,000	114,999	1
Total Other Revenue	143,318	**139,410**	3,908
Total Revenue	**81,988,709**	**81,122,429**	**866,280**
Medical Expenses:			
Capitation	4,310,685	4,573,743	263,058
Incurred Claims*			
Inpatient	14,894,649	13,069,884	(1,824,765)
LTC/SNF	19,465,450	20,515,776	1,050,326
Outpatient	8,119,390	8,253,677	134,287
Laboratory and Radiology	432,404	278,412	(153,992)
Emergency Room Facility Services	2,046,741	2,304,001	257,260
Physician Specialty Services	5,239,013	5,528,782	289,769
Pharmacy	9,552,531	9,601,112	48,581
Other Medical Professional	537,788	366,123	(171,665)
Other Medical Care Expenses	1,621	-	(1,621)
Other Fee For Service Expense	4,473,634	4,488,665	15,032
Transportation	254,081	230,162	(23,919)
Total Claims	65,017,302	64,636,594	(380,708)
Medical & Care Management Expense	2,219,256	2,125,316	(93,940)
Reinsurance	796,077	528,009	(268,068)
Claims Recoveries	(534,649)	-	534,649
Sub-total	2,480,684	2,653,325	172,642
Total Cost of Health Care	**71,808,671**	**71,863,663**	**54,992**
Contribution Margin	**10,180,038**	**9,258,767**	**921,271**
General & Administrative Expenses:			
Salaries and Wages	1,437,287	1,474,440	37,153
Payroll Taxes and Benefits	349,517	379,081	29,563
Total Travel and Training	20,156	66,087	45,931
Outside Service - ACS	2,923,635	2,808,720	(114,915)
Outside Services - Other	99,655	126,103	26,447
Accounting & Actuarial Services	110,734	155,000	44,266
Legal Expense	139,325	91,200	(48,125)
Insurance	34,327	32,376	(1,951)
Lease Expense - Office	82,940	77,940	(5,000)
Consulting Services Expense	638,775	484,914	(153,861)
Translation Services	10,444	8,821	(1,623)
Advertising and Promotion Expense	18,200	40,880	22,680
General Office Expenses	229,404	309,661	80,256
Depreciation & Amortization Expense	16,962	20,342	3,380
Printing Expense	9,651	35,516	25,865
Shipping & Postage Expense	1,276	18,975	17,699
Interest Expense	79,718	27,701	(52,018)
Total G & A Expenses	**6,202,007**	**6,157,755**	**(44,252)**
Net Income / (Loss)	**$ 3,978,031**	**$ 3,101,011**	**$ 877,019**

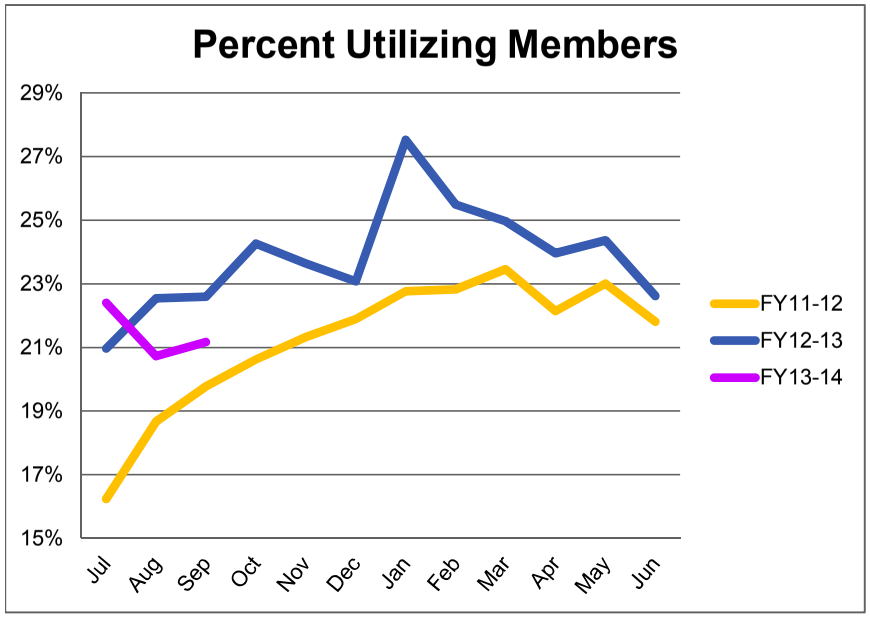
Statement of Cash Flows - Monthly

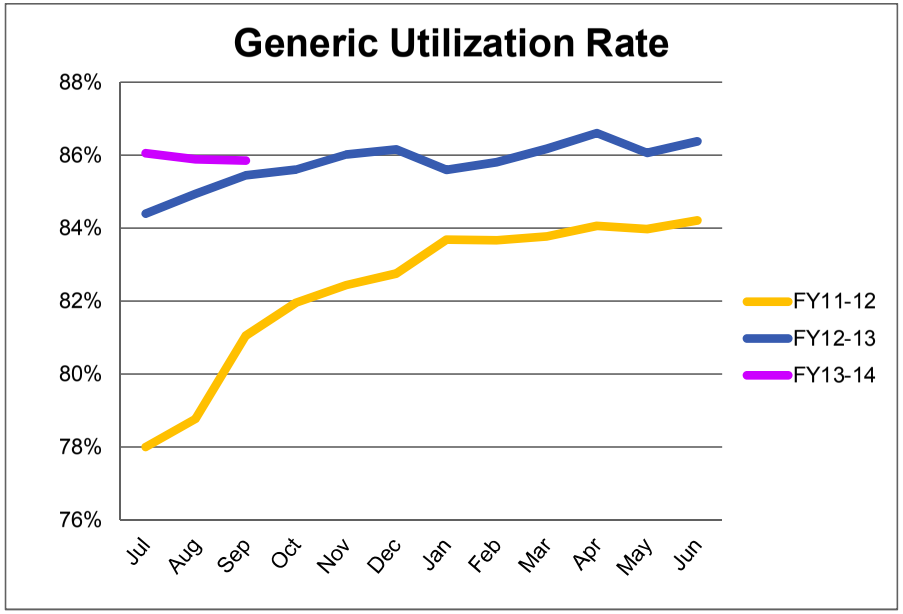
	SEP '13	AUG '13	JUL '13	JUN'13
Cash Flow From Operating Activities				
Collected Premium	$ 924,454	$ 56,847,242	$ -	$ 52,138,834
Miscellaneous Income	11,819	542,489	9,195	8,594
State Pass Through Funds	-	25,595,240	-	34,346,474
Paid Claims				
Medical & Hospital Expenses	(16,704,362)	(13,601,172)	(18,926,200)	(17,277,826)
Pharmacy	(3,553,463)	(3,569,832)	(2,994,857)	(4,009,168)
Capitation	(1,518,891)	(1,274,000)	(1,257,418)	(1,162,302)
Reinsurance of Claims	(277,448)	(258,884)	(259,745)	(240,430)
HQAF Funds Distributed	(25,595,240)		-	(34,346,474)
Paid Administration	(4,263,381)	(3,119,372)	(2,163,484)	(2,616,623)
MCO Tax Received / (Paid)	-	628,843	(826,566)	829,564
Net Cash Provided/ (Used) by Operating Activities	**(50,976,513)**	**61,790,554**	**(26,419,075)**	**27,670,643**
Cash Flow From Investing/Financing Activities				
Proceeds from Line of Credit		-	-	-
Repayments on Line of Credit	-	-	-	-
Net Acquisition of Property/Equipment	(376,213)	(384,074)	(10,815)	(31,026)
Net Cash Provided/(Used) by Investing/Financing	**(376,213)**	**(384,074)**	**(10,815)**	**(31,026)**
Net Cash Flow	**$ (51,352,725)**	**$ 61,406,480**	**$ (26,429,890)**	**$ 27,639,617**
Cash and Cash Equivalents (Beg. of Period)	85,684,442	24,277,962	50,707,852	23,068,235
Cash and Cash Equivalents (End of Period)	34,331,717	85,684,442	24,277,962	50,707,852
	$ (51,352,725)	**$ 61,406,480**	**$ (26,429,890)**	**$ 27,639,617**
Adjustment to Reconcile Net Income to Net Cash Flow				
Net (Loss) Income	1,435,584	1,259,818	1,282,629	4,109,976
Depreciation & Amortization	6,492	5,235	5,235	11,407
Decrease/(Increase) in Receivables	(28,192,911)	29,475,719	(27,334,427)	22,788,941
Decrease/(Increase) in Prepaids & Other Current Assets	(213,165)	50,054	(875,404)	769,972
(Decrease)/Increase in Payables	(26,252,704)	24,720,848	1,172,860	(1,578,838)
(Decrease)/Increase in Other Liabilities	(38,333)	(38,333)	(80,000)	(121,667)
Change in MCO Tax Liability	439,985	1,739,259	226,645	1,433,012
Changes in Claims and Capitation Payable	2,574,965	3,220,107	(4,087,314)	1,913,029
Changes in IBNR	(736,424)	1,357,848	3,270,701	(1,655,189)
	(50,976,513)	61,790,554	(26,419,075)	27,670,643
Net Cash Flow from Operating Activities	**$ (50,976,513)**	**$ 61,790,554**	**$ (26,419,075)**	**$ 27,670,643**

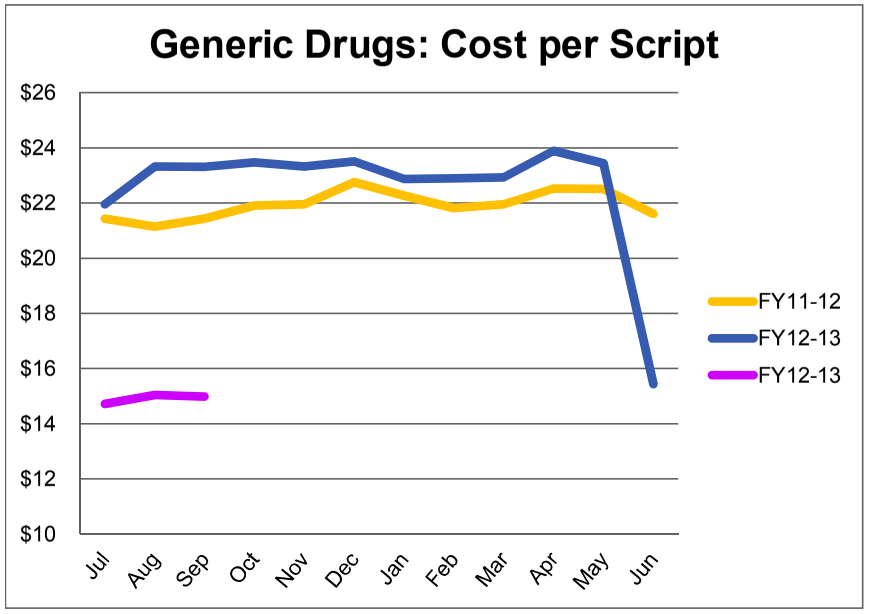
Pharmacy Cost Trend

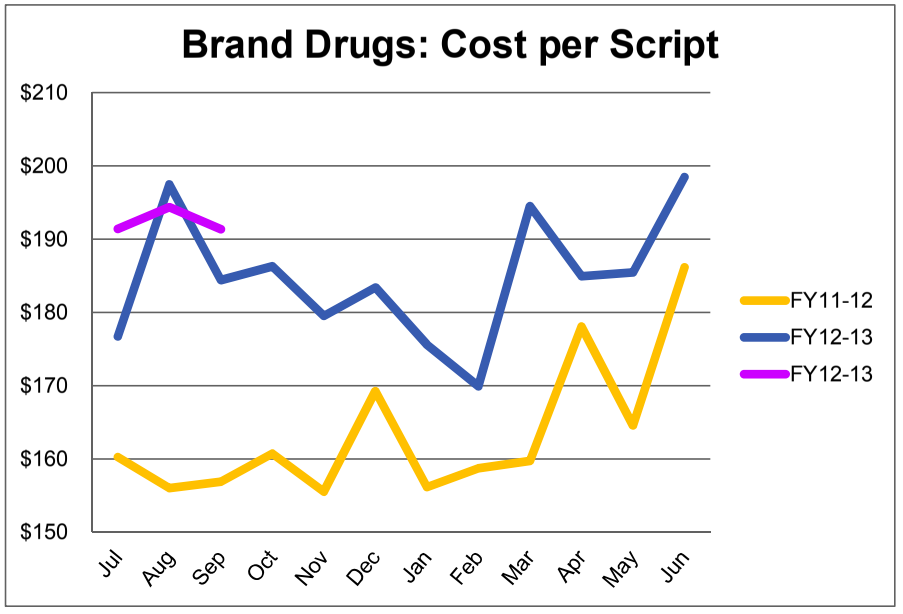


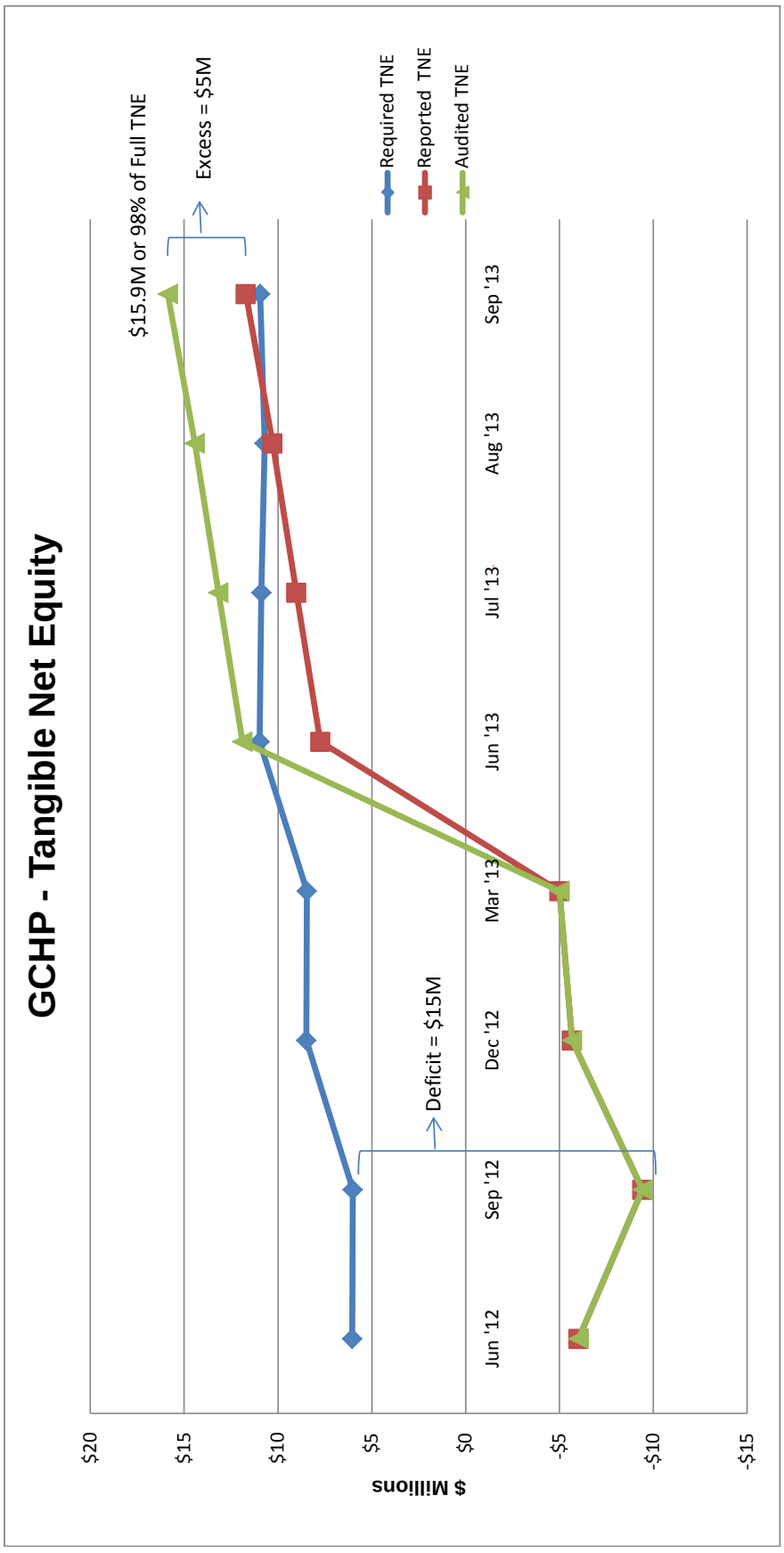
	OCT'12	NOV'12	DEC'12	JAN'13	FEB'13	MAR'13	APR'13	MAY'13	JUN'13	JUL'13	AUG'13	SEP'13
AVG PMPM	$35.13	$32.49	$31.40	$38.75	$33.53	$35.99	$34.74	$36.15	$28.12	$29.53	$27.04	$26.24
GENERIC	$15.03	$14.37	$13.86	$16.77	$14.86	$15.16	$15.66	$15.78	$9.58	$9.43	$8.62	$8.41
BRAND	$20.10	$18.12	$17.53	$21.98	$18.66	$20.82	$19.08	$20.38	$18.54	$20.10	$18.41	$17.83


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
FY12-13


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
FY12-13


GCHP - Tangible Net Equity
$ Millions
$20
$15
$10
$5
$0
-$5
-$10
-$15
Jun '12
Sep '12
Dec '12
Mar '13
Jun '13
Jul '13
Aug '13
Sep '13
Required TNE
Reported TNE
Audited TNE
$15.9M or 98% of Full TNE
Excess = $5M
Deficit = $15M

AGENDA ITEM 4a

To: Gold Coast Health Plan Commissioners

From: Charles Cho, MD, CMO
Nancy Wharfield, MD, Medical Director – Health Services

Date: November 18, 2013

Re: CMO & Health Services Update

HEDIS Update

HEDIS data has been organized to reflect HEDIS performance at the clinic level. Clinic Medical Directors will be contacted to review HEDIS reports in order to prepare for next year.

Pharmacy Reports

Top 10 Drugs by Dollar October 2013			
Medication	# of Scripts	Amount Paid	Amount Paid / Rx
BENEFIX	1	$120,316.80	$120,316.80
LANTUS	567	$108,296.89	$191.00
ADVAIR DISKU	458	$98,262.10	$214.55
VENTOLIN HFA	2026	$77,258.33	$38.13
CARIMUNE NF	4	$61,742.16	$15,435.54
REVLIMID	6	$58,505.08	$9,750.85
METHYLPHENID	496	$57,239.18	$115.40
NEULASTA	11	$50,259.92	$4,569.08
DIVALPROEX	481	$49,089.80	$102.06
HUMALOG	224	$46,810.84	$208.98

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Gold Coast Health Plan

Pharmacy Plan Analysis
July 1, 2013 – September 30, 2013
vs.
April 1, 2013 – June 30, 2013

Prepared by: Scott Holtmyer, R.Ph.
sholtmyer@scriptcare.com

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PLAN OVERVIEW

	Apr-Jun 2013	Jul-Sep 2013	
Average Enrollment	108,749	119,644	10.02%
Utilizing Members	40,596	40,383	-0.52%
Total Rx	238,127	238,165	0.02%
Brand Rx	32,515	33,506	3.05%
Generic Rx	205,612	204,659	-0.46%
Generic Utilization	86.35%	85.93%	-0.41%
Total Cost	$10,537,669	$9,552,531	-9.35%
Member Paid	$0	$0	
Plan Paid	$10,537,669	$9,552,531	-9.35%
Total Cost PMPM	$32.30	$26.61	-17.60%
Member Paid PMPM	$0.00	$0.00	
Plan Paid PMPM	$32.30	$26.61	-17.60%
Total Cost Per Rx	$44.25	$40.11	-9.36%
Member Paid Per Rx	$0.00	$0.00	
Plan Paid Per Rx	$44.25	$40.11	-9.36%
Rx PMPM	0.73	0.66	-9.09%
Member Paid/Total Cost	0.00%	0.00%	

Utilization % decreased from 37.3% to 33.8%

Generic utilization decreased slightly to 85.93%

Cost decreased $985,138 period over period

Plan cost per prescription decreased $4.14 period over period and Rx PMPM decreased to 0.66

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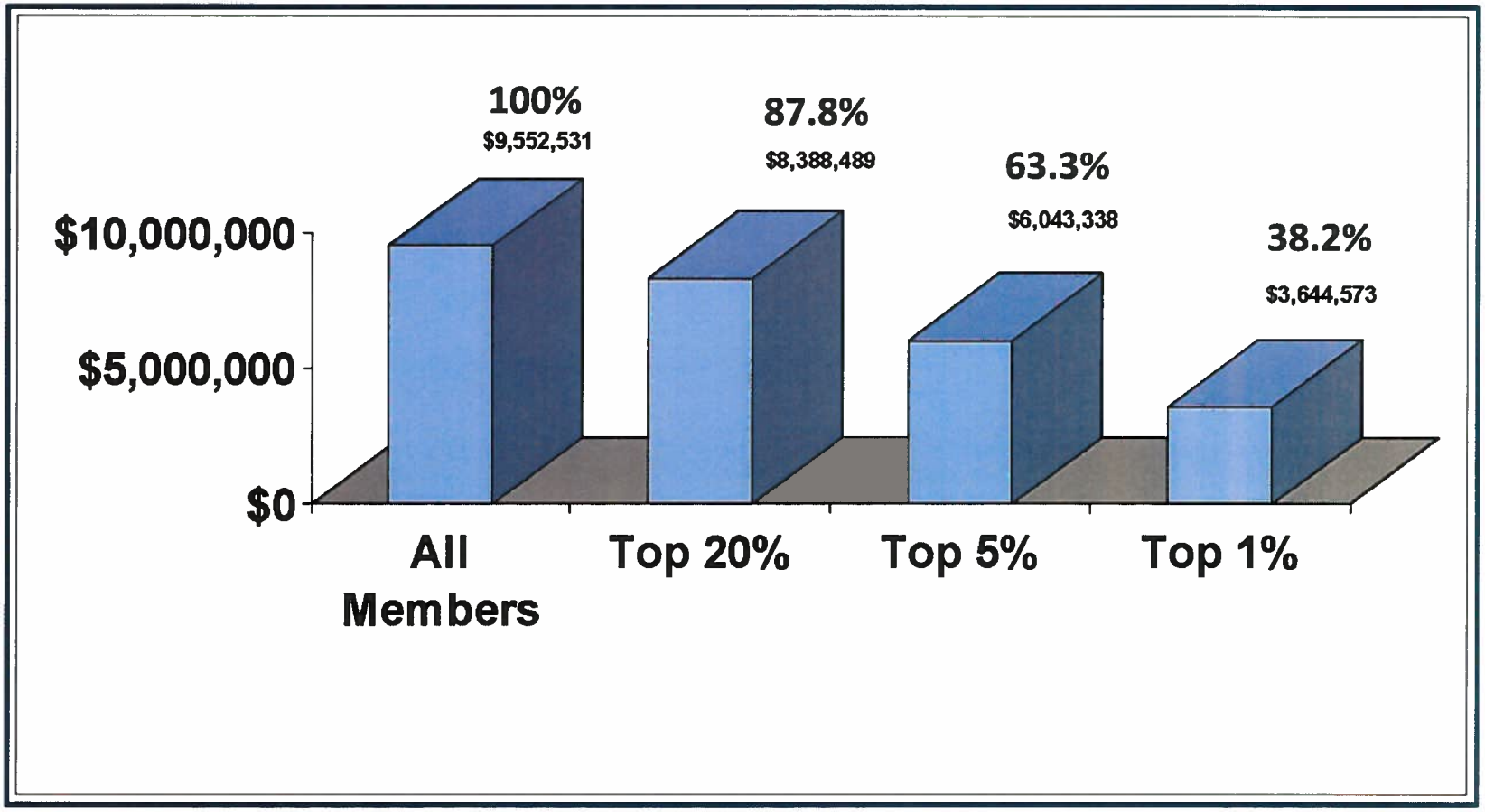
UTILIZATION BY HIGHEST USERS



Comments:

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Drug Variance – Top 15 Drugs

	Apr-Jun 2013		Jul-Sep 2013		Plan Paid Variances - Increase/(Decrease)			
	Rx	Plan Paid	Rx	Plan Paid	Total	= Rx	+ Paid/Rx	
ADVAIR DISKU - Antiasthmatic	1,063	$257,323	1,119	$275,801	$18,478	$13,556	$4,922	
LANTUS - Antidiabetic	1,338	$237,156	1,430	$275,529	$38,373	$16,307	$22,066	
BENEFIX - Misc. Hematological	1	$128,683	2	$186,451	$57,768	$128,683	($70,915)	
VENTOLIN HFA - Antiasthmatic	3,964	$173,330	4,234	$184,336	$11,006	$11,806	($800)	
REVLIMID - Assorted Classes	12	$119,223	17	$162,560	$43,337	$49,676	($6,339)	
HUMIRA PEN - Analgesics-Anti-Inflammatory	41	$111,037	53	$159,051	$48,015	$32,499	$15,516	
NEULASTA - Hematopoitic Agents	53	$212,775	38	$152,824	($59,952)	($60,219)	$268	
GLEEVEC - Antineoplastics	14	$116,044	16	$145,889	$29,845	$16,578	$13,267	
DIVALPROEX - Anticonvulsant	1,313	$106,361	1,315	$143,367	$37,006	$162	$36,844	
METHYLPHENID - Stimulants/Anti-Obesity Anorexiants	999	$119,162	1,091	$135,560	$16,398	$10,974	$5,424	
CYMBALTA - Antidepressants	428	$107,395	463	$127,985	$20,589	$8,782	$11,807	
HUMALOG - Antidiabetic	499	$100,049	560	$120,128	$20,079	$12,230	$7,849	
TRUETEST - Diagnostic Products	2,589	$103,803	2,632	$107,168	$3,365	$1,724	$1,641	
PATANOL - Ophthalmic	806	$109,518	820	$106,102	($3,416)	$1,902	($5,318)	
JANUVIA - Antidiabetic	484	$112,692	442	$105,140	($7,553)	($9,779)	$2,226	
	13,604	$2,114,552	14,232	$2,387,890	$273,337	$234,881	$38,457	

Five of the top 15 drugs by cost are specialty. Benefix had the greatest increase in cost and Neulasta had the greatest decreased in cost period over period.

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THERAPEUTIC CLASS VARIANCE

	Apr-Jun 2013		Jul-Sep 2013		Plan Paid Variances - Increase/(Decrease)			
	Rx	Plan Paid	Rx	Plan Paid	Total	=	Rx	+ Paid/Rx
Antiasthmatic	10,813	$949,529	10,965	$918,429	($31,100)		$13,348	($44,448)
Antidiabetic	12,634	$857,947	12,965	$856,355	($1,593)		$22,477	($24,070)
Antineoplastics	918	$475,658	964	$582,385	$106,727		$23,835	$82,892
Anticonvulsant	12,792	$655,492	13,188	$563,720	($91,772)		$20,292	($112,064)
Stimulants/Anti-Obesity Anorexiants	3,462	$538,907	3,633	$566,144	$27,238		$26,618	$619
Analgesics-Anti-Inflammatory	10,854	$468,513	10,642	$497,831	$29,318		($9,151)	$38,469
Dermatological	8,063	$297,082	8,714	$406,479	$109,397		$23,986	$85,411
Analgesics-Narcotic	14,550	$482,890	14,958	$373,644	($109,246)		$13,541	($122,786)
Assorted Classes	544	$339,725	531	$349,874	$10,149		($8,118)	$18,267
Misc. Cardiovascular	91	$367,813	70	$292,420	($75,393)		($84,880)	$9,487
Antidepressants	15,287	$480,901	15,644	$270,017	($210,884)		$11,231	($222,115)
Ophthalmic	4,953	$278,626	4,515	$267,744	($10,882)		($24,639)	$13,757
Misc. Psychotherapeutic and Neurological Agents	628	$267,672	683	$253,513	($14,159)		$23,443	($37,601)
Misc. Endocrine	1,753	$253,962	1,778	$250,231	($3,730)		$3,622	($7,352)
Misc. GI	1,100	$223,388	1,112	$242,102	$18,714		$2,437	$16,277
All Others	139,685	$3,599,565	137,803	$2,861,643	($737,922)		($48,498)	($689,425)
	238,127	$10,537,669	238,165	$9,552,531	($985,139)		$9,543	($994,682)

Dermatological had the greatest increase in cost period over period

Antidepressants had the greatest idecrease in cost period over period

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Gold Coast Health Plan Diabetic Overview

Usage from 7/1/13-9/30/13

- 3,485 Members on medication for Diabetes
- 2,959 Members on medication used testing supplies
- 20,685 Prescriptions processed
  - 12,965 processed for medications ($856,355)
  - 7,720 processed for supplies ($196,477)
- $1,052,832 plan cost (11.0% of total drug spend)

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Diabetic Overview, Cont.

The following table identifies the number of Gold Coast Health Plan members who have co-morbidities. This is the number of concurrent disease states.

Diabetes Only	2 co-morbidities	3 co-morbidities	4 co-morbidities	5 co-morbidities
1,236	1,379	1,318	695	268

The following table identifies the co-morbidities of Gold Coast Health Plan members with diabetes.

Hypertension	Hyperlipidemia	Depression	Ulcers	Asthma
2,544	1,964	901	944	843

HEALTH EDUCATION UPDATE

Health Education, Cultural and Linguistic Program Updates
The Health Education Department has added a Cultural and Linguistic Specialist, Health Education Specialist, and Outreach Representative to the team.

Health Education, Cultural and Linguistic Workgroup
Staff participated in the Department of California Health Care (DHCS) Health Education, Cultural and Linguistic (HE/CL) Workgroup in October. Health education, cultural and linguistic items discussed during the statewide meeting included the DHCS All Plan Letter regarding the implementation of the Staying Healthy Assessment (SHA) also known as the Individual Health Education Behavioral Assessment (IHEBA), health care reform, Affordable Care Act (ACA) cultural and linguistic core elements, and preventive health care services.

Revisions to the Policy and Procedures for the implementation and monitoring of the IHEBA were submitted to DHCS for approval. DHCS granted an extension to health plans for the implementation of the IHEBA. Members of the HE/CL Committee developed and standardized training materials for providers. Health education and quality improvement staff are partnering with GCHP's Provider Network Operations to train Plan providers about the implementation of the Individual Health Assessment (IHA) and IHEBA.

Health Education, Cultural and Linguistic Committees
The Health Education, Cultural and Linguistic Committee meetings is scheduled for later this month. Health education program materials will be presented during the November Quality Improvement Committee meeting.

Staff completed the Group Needs Assessment (GNA) Update Report for 2013. The GNA report highlights demographic changes, health disparities, changes in HEDIS findings, health education, cultural and linguistic, quality improvement programs and resources.

Health Education Program Activities
Diabetes: November is diabetes awareness month. The next member newsletter contains information about diabetes awareness and screening. The newsletter is scheduled be in homes next month. Health education staff is working with IT and quality improvement departments to gather data on diabetic members to develop a diabetes health education program. Health education staff met with case management department to identify literature to members. Staff continues to work with GCHP Communication Department to identify a system to post the GCHP Diabetes Resource Directory on the website.

Tobacco Education: At the HE/CL Workgroup meeting in October 2013, DHCS health education representatives discussed the statewide Medi-Cal Quit Smoking Program. Quit smoking promotional materials are available for health plans. GCHP received poster and post cards in English and Spanish. Materials are used during health fairs and staff is working with provider relation's staff to distribute materials.

GCHP prepared a quit smoking resource guide with local smoking cessation support groups and counseling. Health education staff is working with the Chief Medical Officer (CMO) and the P&T Committee to distribute materials at local pharmacies.

Prenatal Care and Outreach Activities: Staff continues to participate in monthly hospital based OB resource fair. New parent kits, prenatal care information, and newborn enrollment information is made available to participants.

Health Navigator Program: Staff continues to follow-up with members who frequent the emergency room for preventable conditions and assist members with scheduling appointments with their primary care provider. Preliminary findings were reported to the Medical Advisory Committee (MAC) in September. Staff is working with IT Department to identify current members who frequent the emergency room for avoidable conditions.

Cultural and Linguistic (C&L) Activities: Staff coordinated two (3) cultural sensitivity trainings including: 1) Behavioral health services and resources; 2) Alcohol and drug programs and services; and 3) How to access an interpreter by Pacific Interpreters.

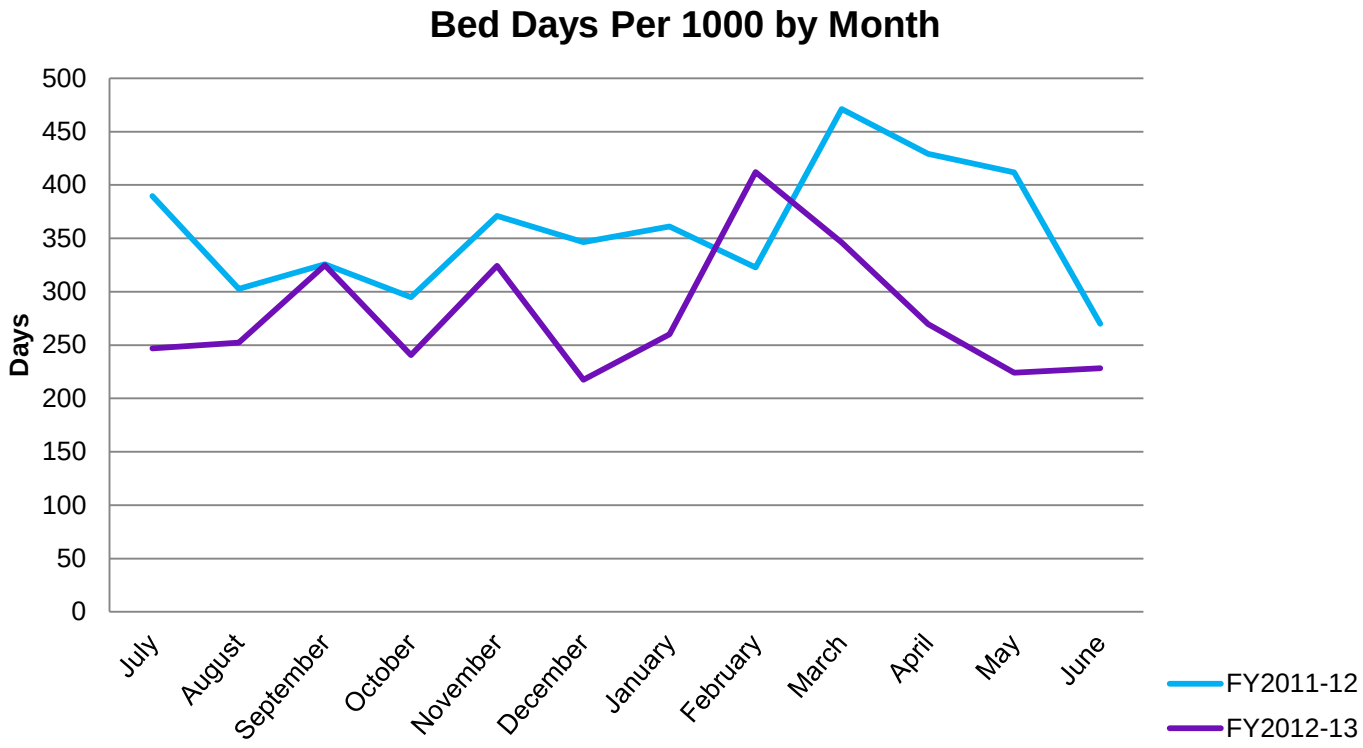
Overall program evaluation of training sessions were reported as excellent/very good and the majority found the training to be very helpful. Cultural and Linguistic program activities were report to the Medical Advisory Committee in September. Additionally, C&L program policies are currently being re-evaluated to streamline the request for translations and interpreting services. A new policy for testing bilingual staff was prepared and submitted to DHCS for review and approval.

HEALTH SERVICES UPDATE

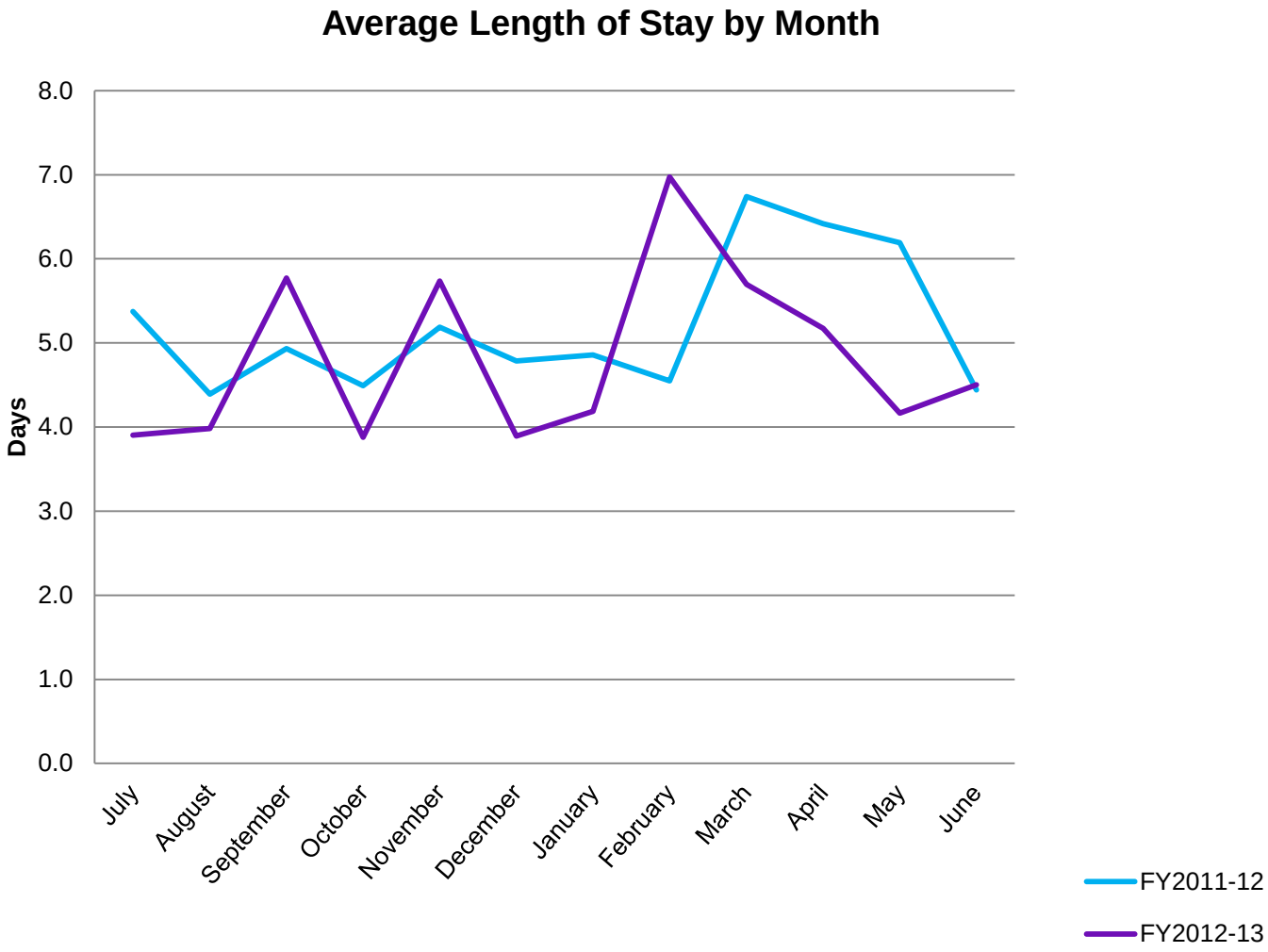
Inpatient Utilization / Average Length of Stay

Inpatient days / 1000 members is shown in the graph below. Please note that skilled nursing facility stays and dual eligible members are excluded from this data. Highest days / 1000 and average length of stay for the past 2 years occurred in February - March.

Year to year bed days/1000 trend by month is down due to increased utilization and care management staff, improved guideline reviews, and improved access to medical records and census information from facilities. Bed days / 1000 for FY 2011-12 were 332, for FY 2012-13 291, and for FY 2013-14 year to date 219.



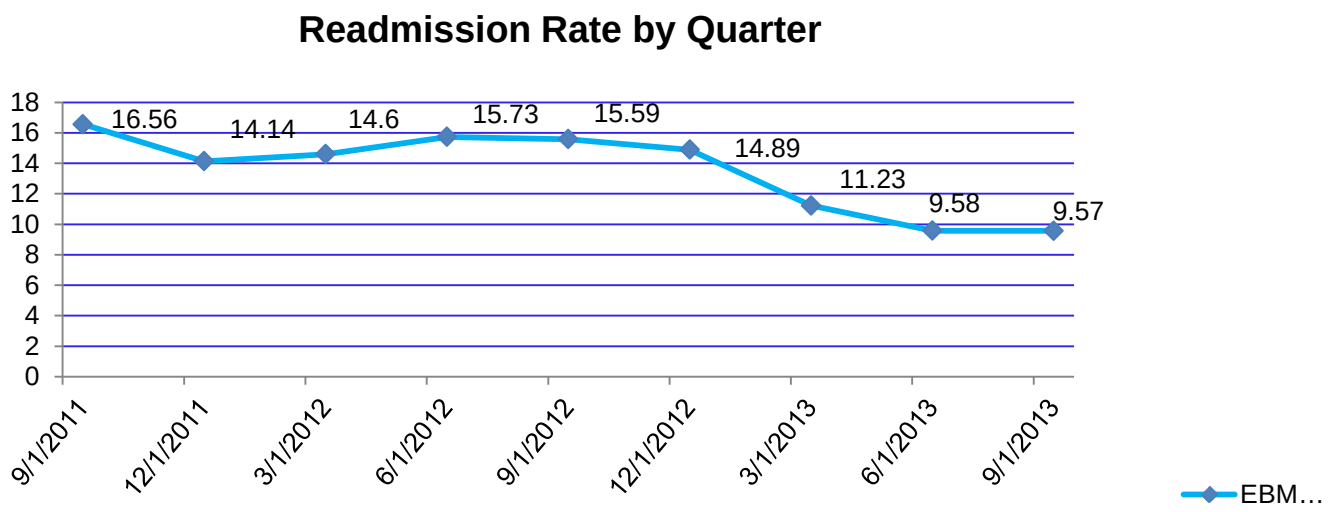
Average length of stay has declined and plateaued from FY 2011-12 to FY 2012-13 Average length of stay for FY 2011-12 was 4.8 days, for FY 2012-13 4.56 days, and for FY 2013-14 year to date 4.52 days.



Readmission Rate

All cause readmission rate trends are shown below. Reduced readmissions are a result of enhanced discharge planning efforts for our members at highest risk of readmission. The Discharge Planner assists with facilitation of receipt of DME, verification of discharge follow-up appointment, and coordination with care managers and home health nurses.

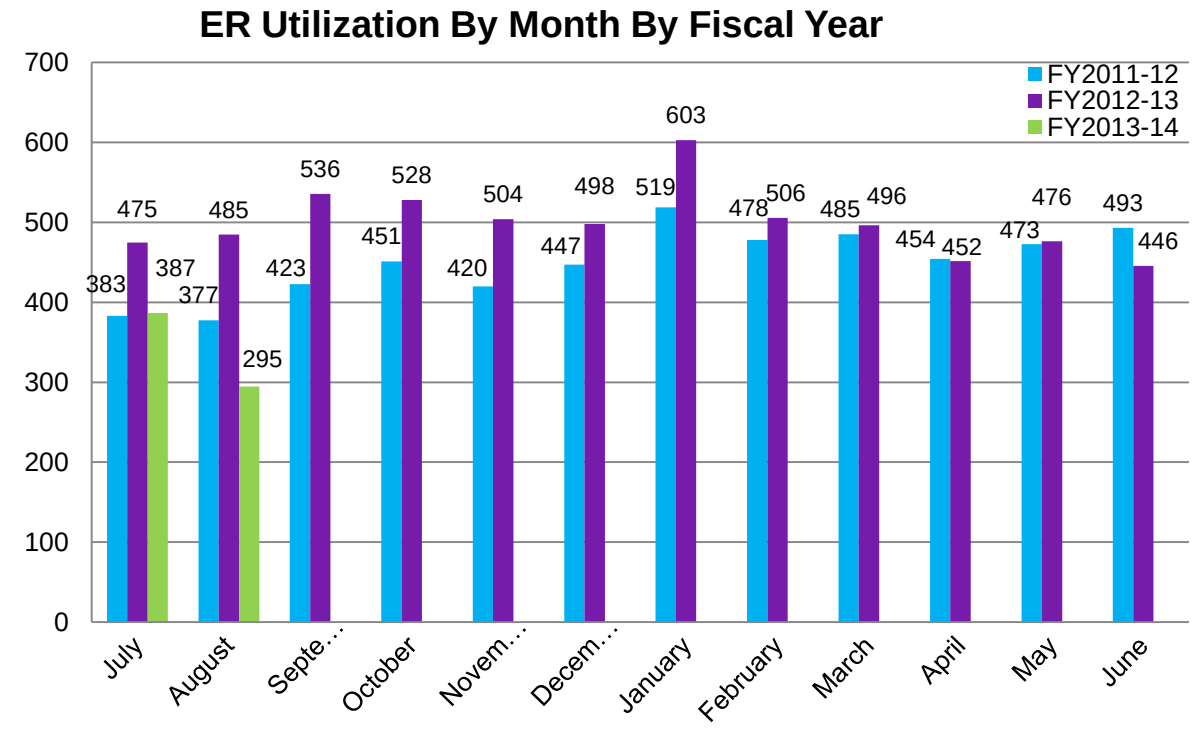
Gold Coast Health Plan has posted a position for an onsite nurse to further anticipate and facilitate discharge planning efforts.



ER Utilization

Emergency room utilization is shown by month for year to year comparison. Highest utilization has been in January.

While utilization increased from 2011 to 2012, the downward trend in utilization beginning June 2012 – 2013 is explained by our ER initiative. Currently, Care Navigators contact members after an ER visit to educate members about their PCP and UC care availability and also about what constitutes emergency care. Gold Coast Health Plan will now add to these efforts by informing PCPs about ER utilization by their members.



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ACA Expansion Program Commission Update

Monday, November 18, 2013

www.goldcoasthealthplan.org

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Objectives

Provide Current Program Status

- LIHP
- Optional Expansion
- Mental Health Expansion
  - ► MBHO Implementation
  - ► MOU with County-June 2014

LIHP Status

- Transition PCP Assignment/Linkage
  - ►Current Membership Distribution:
    - o 75% VCMC & 25% Clinicas
    - o Anticipate 100% linkage
  - ►DHCS to share Member information the first part of December
  - ►BAA being executed with VCHCA-
    - o To facilitate exchange of data for care coordination
  - ►Tested Methodology to be used to link members to their medical home

LIHP Status

- Member Outreach & Notification
  - ►DHCS Notifications-
    - o90 Day (10/4/13) – LIHP
    - o60 Day (11/1/13) – DHCS
    - o30 Day (12/1/13) – DHCS
  - ►Member outreach (post cards/flyers)
    - oCollaboration with VCHCA to distribute
  - ►GCHP LIHP Welcome letter submitted to DHCS for approval

LIHP Status

- Partnership Efforts
  - ►Case Management “task force”
  - ►Joint Communications Workgroup
  - ►Project Management meetings

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LIHP-Eligibility Comparison

Eligibility Requirements	LIHP	MediCal*
Citizenship or Residency Status (5 yr)	Y	Y
Residency-Ventura County	Y	Y
Income (MCE: 0-133% FPL)	Y	100-138%
Age (19-64)	Y	Y
Not Eligible for Medi-Cal or AIM	Y	N/A
Asset Test (going away 1/1/14)	N	?
* After January 1, 2014 Expansion		

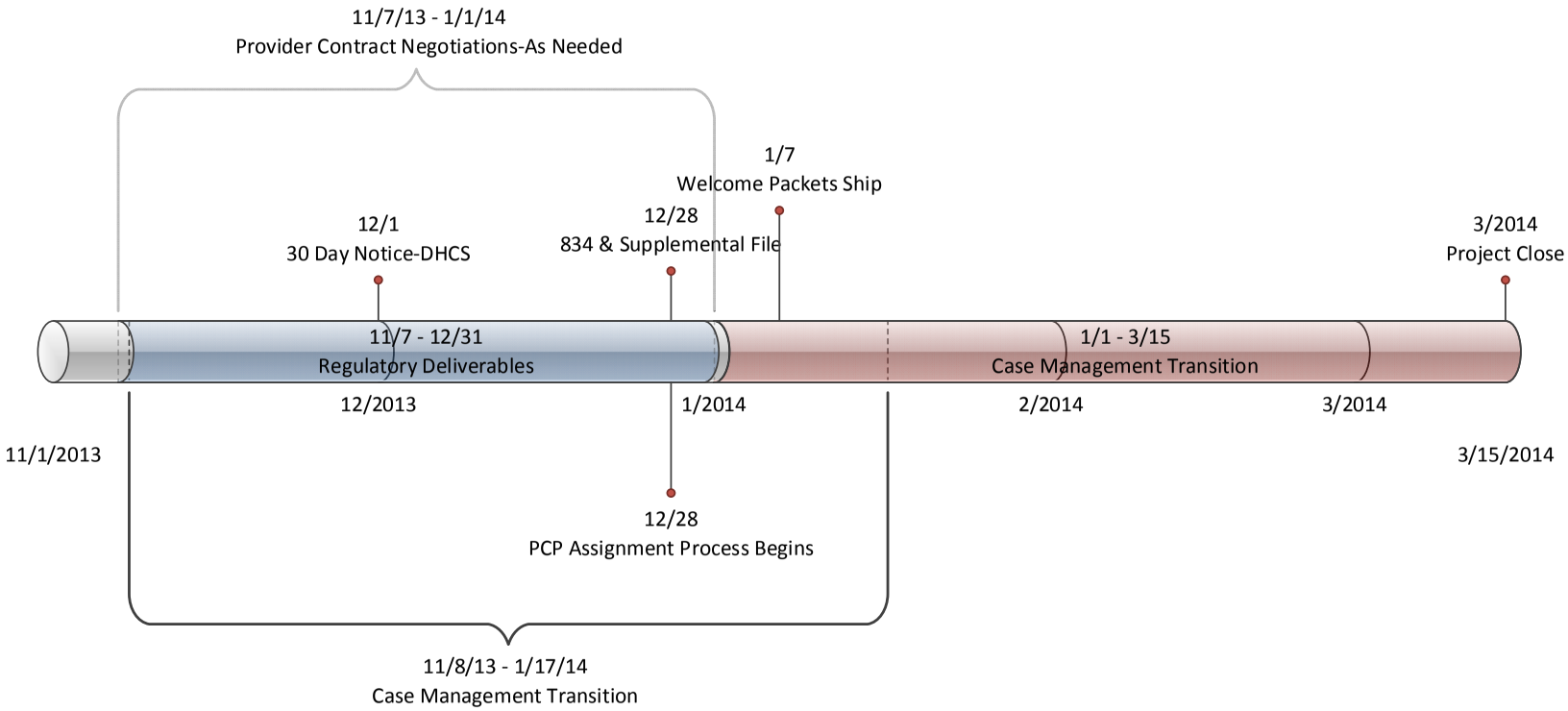
LIHP-Benefit Comparison

- DHCS to provide Benefit Crosswalk for mandated benefits
- Additional services provided by the county for ACE Members
- GCHP to identify variances and develop messaging for members and providers

LIHP-Cost & Utilization

- VCHCA is a Paragraph 14 county
  - ►Certified Public Expenditure Based
  - ►Provide services, incur costs, submit costs & get reimbursed at 50% cost
  - ►No Claims data
- Upon Execution of BAA, VCHCA will share requested utilization data

LIHP Timeline



Anticipated Regulatory Deliverables (12/1-12/31):

- Contract Amendment-pending
- Continuity of care-Requirements & Reporting-Pending
- Policies & Procedures-pending
- Updated EOC-pending DHCS template language
- Rates & Rate Categories-pending

Technical Work Effort (12/1-12/31):

- Aid Code Mapping (to include new MAGI Codes
- Update/configure ika (codes, rates, etc)-Pending
- Data Mapping (834/supplemental)
- Provider linking/assignment
- Update / Test fulfillment process (Welcome Letter, EOC & ID Card)

LIHP-Providers

- Provider Reimbursement
  - ►FFS until an appropriate capitation rate can be developed
  - ►Possibly CAP & FFS reimbursement- Depending on Aid Code (similar to admin members)
- Provider Contracting
  - ►Will be required if contracted rate change

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Behavioral Health Benefits

- January 1, 2014 all health plans must provide behavioral benefits
- Behavioral health benefit will be covered by Medi-Cal Managed Care - GCHP
- Provides expanded benefits for mild to moderate behavioral health conditions
- Expanded substance abuse treatment benefit

Optional Expansion

- Newly Eligible Income Range
  - ► 100-133% + 5% bonus = 138% Federal Poverty Level (FPL)
- New Modified Adjusted Gross Income (MAGI) Aid Codes
- Benefits will mirror what is currently provided in Fee-For-Service Medi-Cal

Optional Expansion

- Challenges-
  - ►Unknown health status of the 133-138% FPL population
  - ►No Pre-Authorization or Claims history will be available

Expansion Outreach

- Communications Team plan to develop
  - ►Radio Ads
  - ►Flyers
  - ►Notifications
  - ►Joint Communications with VCHCA
  - ►Piggyback on County Outreach Grants
  - ►Community Events

Next Steps

- Contract Amendment
- Reporting
- Staffing
- Communications & Outreach