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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, October 28, 2013
3:00 p.m.

AGENDA

CALL TO ORDER / ROLL CALL

SWEAR IN NEW COMMISSIONERS
Dr. Michelle Laba and Dr. Gagan Pawar

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 September 23, 2013

2. **APPROVAL ITEMS**
   a. Consumer Advisory Committee (CAC) – Beneficiary Member

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 October 28, 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. August Financials (Unaudited)

4. INFORMATIONAL ITEMS

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

CLOSED SESSION

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

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

Announcement from Closed Session, if any.

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on November 18, 2013 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

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

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

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Commission Meeting Minutes
September 23, 2013
(Not official until approved)

CALL TO ORDER

Chair Gonzalez called the meeting to order at 3:04 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
May Lee Berry, Medi-Cal Beneficiary Advocate
Lanyard Dial, MD, Ventura County Medical Association
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.

EXCUSED / ABSENT COMMISSION MEMBERS
Laurie Eberst, Private Hospitals / Healthcare System
Vacant, Clinicas del Camino Real, Inc.
Vacant, Ventura County Medical Center Executive Committee

STAFF IN ATTENDANCE
Michael Engelhard, CEO
Nancy Kierstyn Schreiner, Legal Counsel (arrived at 3:04 p.m.)
Michelle Raleigh, CFO
Ruth Watson, COO
Traci R. McGinley, Clerk of the Board
Charlie Cho, MD, Chief Medical Officer
Melissa Scrymgeour, IT Director
Sherri Bennett, Director of Network Operations
Brandy Armenta, Compliance Officer
Guillermo Gonzalez, Government Relations Director
Steven Lalich, Communications Manager
Jenny Palm, Health Services Director
Lyndon Turner, Finance Manager

The Pledge of Allegiance was recited.

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

Introductions
Stuart Busby, Chief-Capitated Rates Development Division of California Department Health Care Services (DHCS).

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of August 26, 2013

Commissioner Foy moved to approve the Regular Meeting Minutes of August 26, 2013. Commissioner Berry seconded. The motion carried with Commissioner Juarez abstaining. **Approved 7-0**.

2. APPROVAL ITEMS

a. Adopt 2014 Commission Meeting Calendar

Commissioner Foy moved to adopt the 2014 Commission Meeting Calendar. Commissioner Juarez seconded. The motion carried. **Approved 8-0.**

b. Consumer Advisory Committee (CAC) Membership

COO Watson provided an overview of the written report and stated that the proposed outreach and timeline was approved by the CAC and it created an ad hoc committee to review applications. The selection of a candidate will then be presented for approval by the CAC at its December Committee Meeting. That information will then be presented at the January Commission Meeting.

Commissioner Berry moved to approve the outreach and timeline plan to recruit a Medi-Cal beneficiary to the CAC and increase the board to an eleven member committee with a Medi-Cal beneficiary seat once the Commission appoints said Medi-Cal beneficiary. Commissioner Glyer seconded. The motion carried. **Approved 8-0.**

c. AB 97 Implementation

Network Operations Director Bennett reviewed the written report explaining GCHP's analysis of the financial impact to the Plan if the provider rate reductions from AB 97 are implemented. She added that as a follow-up to the written report, it was determined that ICF-DD providers are not impacted by this cut.

Discussion was held regarding emergency transportation, the requirements for the Plan to provide the service, the criteria for Members to utilize it and the cost to the Plan.

Commissioner Foy moved to approve the proposed AB 97 implementation with the condition that the emergency transportation services are monitored. Commissioner Araujo seconded. The motion carried. **Approved 8-0.**

d. ACA / Medi-Cal Mental Health Benefit Vendor Selection

CMO Dr. Cho discussed the requirements that have been placed on Medi-Cal managed care plans to provide mental health services. He reviewed the written report requesting authorization to enter into a contract with a vendor selected through an emergency procurement process. GCHP anticipates that the change in the capitation rate will be equivalent to the administrative and benefits costs; however, DHCS has not finalized the benefit parameters and rates. Information was solicited from three vendors that provide mental health benefits management with Medi-Cal experience (Beacon Health Solutions, Optum and The Holman Group).

Discussion was held regarding the importance of providers having the same cultural background as the Member receiving the benefits.

Public Comment #1

Dr. Enrique De La Garza, Chief Executive Officer of Americas Health Plan (AHP), requested GCHP allow AHP to provide information to be considered with the other vendors. Dr. De La Garza stated that AHP has an extensive network, through Clinicas del Camino Real which has over 40 years of experience. He added that translation services would not be an issue as they have a large number of staff that interpret, not just translate. He requested the vendor selection process be revisited and local options be considered.

Commissioner Juarez expressed concern that the procurement policy was not being followed. COO Watson explained that this was a request to proceed through emergency procurement due to the January 1, 2014 implementation date imposed by the State. CEO Engelhard added that GCHP found these three vendors after discussing options with other managed care plans.

The Commission expressed concern that the State has not provided the benefit levels and rates. CEO Engelhard explained that GCHP does not expect to receive that information until mid-November.

Commissioner Dial stressed the importance of utilizing a company that has a proven record of providing these services. Discussion was held as to the need of proceeding immediately, given the State's deadline. CEO Engelhard explained that the process is expected to take between 90-120 days.

Commissioner Foy moved to provide the CEO with the authority to contract for managed behavioral health services but that any local company that wishes to be considered be given the opportunity for the contract. Commissioner Glyer seconded. The motion carried. **Approved 7-1**, with Commissioner Juarez voting no.

3. ACCEPT AND FILE ITEMS

a. Revised Corrective Action Plan (CAP)

CEO Engelhard reviewed the written report with the Commission and explained that the revised CAP includes a new Medical CAP as a result of the Medical Audit Review of the November 1, 2011 - October 31, 2012 period. GCHP has until October 18, 2013, 30-days from receipt of the new CAP, in which to provide a plan of action and timeframe for remedy.

Public Comment #1

Arnoldo Torres, Senior Vice-President of Government Relations of AHP indicated that AHP met with California State Assembly Member Jeff Gorell's Chief of Staff. He went on to state that there is a difference of opinion regarding the letter contained in the packet from DHCS about GCHP's ability to move forward with the Plan-to-Plan agreement. He stated that AHP believes the Plan-to-Plan agreement would greatly assist GCHP in fulfilling the requirements of the CAP. Mr. Torres added that there are many community members that believe DHCS is not taking the correct opinion.

Commissioner Berry began discussing issues contained in the September 18, 2013 letter from DHCS and initiated discussion concerning Americas Health Plan (AHP) Plan-to-Plan contract with GCHP.

After discussion between Legal Counsel Schreiner and Commissioner Juarez regarding the possible impacts to AHP and Clinicas del Camino Real, Inc. as the wholly owned shareholder of AHP, and Commissioner Juarez as CEO of Clinicas, Commissioner Juarez recused himself and left the room.

Commissioner Berry continued, stressing the importance of GCHP reaching compliance. Commissioner Foy added that the State has made it very clear that it wants GCHP to focus and devote all its time and effort on the issues in the CAP.

Chair Gonzalez stated that he understands the State's direction, although this is the Commission of GCHP, the State regulates the Plan so it needs to follow the State's direction. He added that this CAP will require much of staff's attention.

Public Comment #2

Christine Velasco, Clinicas CFO, asked for an explanation of the Conflict of Interest for Commissioner Juarez versus other Commissioners. Legal Counsel Schreiner explained the Fair Political Practice Commission (FPPC) process for analysis of conflicts of interest.

Commissioner Foy moved to accept and file the Revised Corrective Action Plan. Commissioner Fisler seconded. The motion carried. **Approved 7-0**, with Commissioner Juarez recused.

Commissioner Juarez returned to the room.

RECESS

A brief recess was called at 4:32 p.m., the meeting reconvened at 4:37 p.m.

b. CEO Update

CEO Engelhard reviewed the written report with the Commission.

Commissioner Foy moved to accept and file the CEO Update. Commissioner Eberst seconded. The motion carried. **Approved 8-0.**

c. July Financials (Unaudited)

(Inventory Trend, Page 3c-7a was provided to the Commission.) The Executive Finance Committee did not review the financials because the September Committee Meeting was canceled so CFO Raleigh reviewed the material in-depth. She noted that GCHP's net income is ahead of budget which also helps obtain Tangible Net Equity (TNE) faster. CFO Raleigh closed adding that GCHP is currently in the middle of the FY 2012-13 financial audit.

Commissioner Foy moved to accept and file the Unaudited July Financials. Commissioner Glyer seconded. The motion carried. **Approved 8-0.**

d. CMO Update & QI Quarterly Report

CMO Dr. Cho reviewed the written report and noted that the official HEDIS publication has not yet been released; however GCHP was advised by HSAG (the State's audit contractor for HEDIS reporting) that it met or exceeded the minimum performance level on 15 of the 25 Measures; however, on 10 measures it did not meet the minimum level. For being a first year plan, HSAG was very complimentary. Many of the areas that GCHP received lower performance levels were typically due to lack of documentation from physicians. For instance, the information does not show up for HEDIS if a Member obtains Cervical Cancer Screening through a family planning clinic.

Commissioner Dial asked if GCHP paid for the lab work regardless of where the Member received the screening, which might be a way to get better numbers. Dr. Cho responded that this matter would be researched.

Commissioner Juarez asked if GCHP could review data and determine which providers were and were not documenting well. Dr. Cho confirmed that the Plan was currently reviewing the data. GCHP needs to educate the providers on how the information needs to be recorded; therefore the item will be covered in the Provider Newsletter. Dr. Cho provided another example of when services are capitated and how that sometimes leads to more limited data; Vision Service Plan (VSP) has been unable to provide information as to whether Members being seen have diabetes; therefore GCHP does not know if there is an access problem or if it is a lack of documentation.

Discussion was held regarding the "Top 10 Drugs" reports. Dr. Cho noted that 10% of the total drug expenses are specialty drugs, which are standard for immune system conditions and cancer.

With regard to the Monthly Calls by Queue report, concern was raised regarding the average wait time and the fact that there was a longer waiting period for Spanish Speaking Members. Dr. Cho noted that this has come up in the past. COO Watson added that a majority of representatives at the call center are bilingual; however those representatives are on other calls as well.

Commissioner Dial moved to accept and file the CMO Update and QI Quarterly Report. Commissioner Araujo seconded. The motion carried. **Approved 8-0.**

5. INFORMATIONAL ITEMS

It was noted that minutes from the Consumer Advisory Committee (CAC) and the Provider Advisory Committee (PAC) were provided for the meetings noted below:

a. Consumer Advisory Committee Meeting Minutes of March 13, 2013 and June 12, 2013

b. Provider Advisory Committee Meeting Minutes of February 12, 2013 and March 21, 2013

COMMENTS FROM COMMISSIONERS

Commissioner Berry reported that COO Watson did an excellent job presenting the items to the CAC at the last meeting, goals were presented and overall it was a very productive meeting.

CLOSED SESSION

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

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 5:31 p.m. regarding the following items:

1. 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 CBR

a. **Property Owners and Subject Real Property:** Brentwood Riverpark, LLC, 2901 N. Ventura, Oxnard, CA 93036
Under Negotiation: Price and Term of Payment

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

c. **Property Owners and Subject Real Property:** LBA Realty Fund II LLC, 5300 Adolfo Road, Camarillo, CA 93012
Under Negotiation: Price and Term of Payment

2. **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

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 6:03 p.m.

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

ADJOURNMENT

Meeting adjourned at 6:05 p.m.

AGENDA ITEM 2a

To: Gold Coast Health Plan Commissioners

From: Ruth Watson, COO

Date: October 28, 2013

RE: Consumer Advisory Committee - Beneficiary Member Recruitment

SUMMARY:
The Commission directed staff to develop a plan to recruit a Medi-Cal beneficiary as a member of the Consumer Advisory Committee (CAC) expanding the existing CAC from ten to eleven members which was approved by the Commission at the September 23, 2013 Commission Meeting.

Staff has taken the following steps to recruit a GCHP beneficiary member:

- Solicited input from existing and past CAC Members for Medi-Cal beneficiary members. Seven potential candidates were provided; all declined, were parents of beneficiaries or were no longer GCHP members.
- Staff reached out to several GCHP Members all of whom declined.
- Recruiting efforts were made at New Member Orientation (NMO) meetings. One father expressed interest and was advised that the he does not qualify as the open CAC seat is for a direct beneficiary only.
- A request for CAC applicants was placed on GCHPs Website and has not yielded a response.
- Staff used Provider Operations Bulletins and Town Hall Meetings to ask providers to help identify a beneficiary member for CAC. There has been no response to this request.
- GCHP staff has reached out to members at Health Fairs and GCHP outreach events the members declined to apply.
- The following Community Based Organizations (CBO) have been contacted by email, by phone and in person. The results were that one family member expressed interest but no Medi-Cal beneficiaries have been identified.
    - The ARC of Ventura County
    - Tri-Counties Regional Center
    - La Hermandad
    - St. Johns Community Network
    - LULAC
    - MICOP

After repeated efforts, staff has been unable to identify any GCHP beneficiary members who are interested in serving on the CAC; therefore staff is requesting that the Commission expand the criteria for a CAC beneficiary member to include the parent or legal guardian of a Gold Coast Health Plan (GCHP) member as a possible candidate for the Committee.

Children comprise sixty three per cent of GCHP's membership. These children are represented by parents or legal guardians responsible for navigating the healthcare system to insure that their children's health care needs are met. They have a unique perspective and their input on the committee would be invaluable to the Committee as it fulfills the duties stated in the CAC charter "To ensure a member centered delivery system that promotes optimal health outcomes and member experiences. Through CAC input, we will inform the Plan of member needs by engaging our members to communicate their needs to the Plan."

BACKGROUND / DISCUSSION:
The Consumer Advisory Committee (CAC) was established as a requirement of the VCMMCC enabling ordinance, DHCS and the Medi-Cal Managed Care Division. The Commission determined that the CAC would consist of two permanent seats; one for the Ventura County Health Care Agency and one for the Ventura County Human Services Agency. The other eight seats would represent the following populations: Foster Children, Medi-Cal Beneficiaries, Beneficiaries with Chronic Medical Conditions, Persons with Disabilities, Seniors, and Persons with Special Needs. The seats held by other agencies were for a two-year term. The original CAC was recruited via personal telephone calls to various agencies in the community beginning in January 2011.

When recruiting members for the upcoming term of the CAC, a search was conducted by outreach to many different CBOs, recommendations of current CAC members and advertising on our website. Throughout the search, no beneficiary members applied for a seat on the Committee.

RECOMMENDATION:
That the Commission approve expanding the criteria of a CAC beneficiary member to include a parent or legal guardian of a GCHP member.

CONCURRENCE:
N/A

Attachments:
None.

AGENDA ITEM 3a

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, CEO

Date: October 28, 2013

Re: CEO Update

Conference Participation

Michelle Raleigh, CFO, presented at the Society of Actuaries Annual meeting in San Diego on October 23, 2013. CFO Raleigh was part of a panel presentation on Medicaid and the Affordable Care Act, where her presentation focused on the California Medicaid market.

Several senior staff members attended the California Association of Health Plan's (CAHP) annual conference in Huntington Beach, CA from October 21-23, 2013. The theme of this year's conference was "Opening the Doors" as California and CAHP member health plans have prepared to "open doors" on the upcoming changes in health care related to the Affordable Care Act (ACA).

Hospital Quality Assurance Fee (HQAF) Funds

The Plan received a portion of HQAF funds for the FY 2012-13 time period. As outlined in Senate Bill 335, the Plan will distribute these funds to hospitals within 30 days consistent with a distribution method provided by the California Hospital Association.

ACA Section 1202 - Increased Medicaid Payment to Primary Care Physicians (PCP)

GCHP has completed development of the system solution to implement the PCP payment rate adjustments. The Plan is currently on-schedule to complete testing and training of the solution by October 25, 2013.

The State automated self-attestation process went live July 22, 2013. Since that time, the Plan has worked closely with providers to confirm they complete and submit the required information in order to receive payment for eligible services. Additionally, GCHP has designated a section on the GCHP website provider portal to include detailed information related to this mandate. Two provider town hall sessions are scheduled for November 12 and November 13, 2013, to review the payment process and explanation of payment.

The State has not yet funded the managed care plans to pass the increase to the providers, however GCHP is targeting November 2013 to complete all system and policy and procedure activities to ensure the ability to process the increases once funding is received.

ACA Program Expansion – LIHP Transition to Medi-Cal

On September 10, 2013 GCHP, together with Ventura County Health Care Agency (VCHCA) and the Health Services Agency (HSA) kicked off the Low Income Health Program (LIHP) transition project. The LIHP is comprised of two parts:

- Medicaid Coverage Expansion (MCE), which covers individuals with family incomes between 0%-133% of the Federal Poverty Level (FPL) and,
- Health Care Coverage Initiative (HCCI), which covers individuals with family incomes between 134%-200% of FPL.

In Ventura County, the LIHP program, also known as ACE (Access Coverage and Enrollment Program for Adults), is administered by Ventura County Health Care Agency (VCHCA) and is designed to provide individuals with comprehensive outpatient and inpatient services, including specialty care. On January 1, 2014 the MCE population and a portion of the HCCI population will transition from the ACE program into Medi-Cal. Weekly project management meetings between the GCHP and VCHCA take place to ensure timely and collaborative communication, working toward a common goal of seamlessly transitioning this member population to GCHP. Workgroups are being created to address member outreach, communications and education, continuity of care (CM & UM), and any technology changes to implement the changes.

Medical Management System (MMS) Implementation

GCHP is nearing completion of a 5-month implementation project to deploy the new MedHOK Medical Management System (MMS) that will replace the current MMS provided by Xerox.

Over the past 20 weeks, a core team of GCHP, MedHOK and Xerox project resources have worked together to gather requirements, establish data and network connections, map and load data, develop workflows and configure the MedHOK system in preparation for go-live. In September, MedHOK resources completed a week of on-site training for GCHP Health Services personnel who, in turn, will train the rest of the Health Services staff. Training began on October 14, 2013 and will continue over the next six weeks. Currently, the Plan is targeting the week of December 9, 2013 to implement the MedHOK MMS, ahead of the original target date of late first quarter of 2014.

GOVERNMENT AFFAIRS

ACA and State Health Insurance Exchange

Covered California opened the state health insurance exchange and began accepting health insurance coverage applications on Tuesday October 1, 2013. As expected there was high demand on, and use of, the Covered California health exchange website as well as a heavy call volume to the designated call center. Despite technical glitches that are being addressed Covered California Director, Peter Lee, stated that between October 1, 2013 and October 5, 2013 approximately 987,400 people visited the exchange website. Another 59,000 phone calls

were received by the call center and 28,000 people completed their applications to enroll in a health insurance plan, many for the first time.

Despite the shutdown of the federal government, the Medicare and Medicaid Programs will not be affected as those programs are funded through dedicated trust fund accounts.

Basic Health Plan

On September 20, 2013 the Centers for Medicare and Medicaid Services (CMS) released proposed rules for the basic health plan (BHP) option. The BHP option would allow states to provide alternative coverage for low-income individuals, with incomes between 138%-200% of the federal poverty level, who would otherwise be eligible to purchase coverage through a state-run health insurance exchange. CMS previously postponed implementation of the basic health plan option until January 2015.

The CMS proposed rule(s) include the following:

- Requirements for state submitted BHP Blueprints
- Eligibility and enrollment requirements for standard health plan coverage offered through the BHP
- Requirements for the benefits covered by standard health plans
- Requirements for state use and oversight of BHP federal funds.

Public comments on the proposed CMS rules for the BHP are due to CMS by November 25, 2015.

California Medical Association Petition Against AB 97 Cuts

The California Medical Association (CMA) filed a petition with the U.S. Supreme Court to review the Ninth Circuit Court's decision on AB 97 provider rate reductions. The CMA petition is requesting the Supreme Court's review of the lower court's decision, which allowed the state Department of Health Care Services (DHCS) to implement 10% provider rate cuts in the Medi-Cal Program for specific providers. According to the CMS petition, DHCS did not review cost data for services subjected to the rate reduction. CMA argues that the AB 97 rate cuts for many services are actually below a provider's own cost for providing care.

Mental Health Benefit Integration into Medi-Cal Schedule of Benefits

Starting on January 1, 2014 all health plans must offer behavioral health services as part of the ten essential health benefits under the ACA. GCHP's health services staff continues to work with stakeholders to ensure an adequate mental health provider network and meet the short timeline for integrating this new benefit into managed care.

Plans expect contract amendments and mental health reimbursement rate information from DHCS sometime in mid-November 2013.

Healthy Families Program (HFP) Transition

Generally the HFP transition to Medi-Cal went smoothly in Ventura County. Approximately 90% of children were assigned to a primary care physician. The remainder of the children were auto assigned to primary care physicians. Throughout the transition, GCHP staff reached out to families via direct phone contact and in person new member orientations as well as radio announcements to raise awareness and inform families about where to go to get assistance with transition-related questions. Providers also contacted families to select a PCP during the first several weeks after the August 1 transition date. These efforts combined to minimize the number of members requiring PCP auto-assignment.

Enacted Medi-Cal Legislation

The following is a summary of Medi-Cal related bills that were approved by the State Legislature and signed into law by Governor Brown. Under the State Constitution, October 13, 2013 was the last day for the Governor to sign or veto bills passed by the Legislature.

- **SB 126 Health Care Coverage: Pervasive Developmental Disorder or Autism**
  Summary: Current law requires health care service plan contracts and health insurance policies to provide benefits for specified conditions, including coverage for behavioral health treatment, as defined, for pervasive developmental disorder or autism. These provisions are inoperative on July 1, 2014, and are repealed on January 1, 2015. This bill extends the operation of these provisions until January 1, 2017.

- **SB 239 Medi-Cal: Quality Assurance Fees: Distinct Part Skilled Nursing Facilities**
  Summary: Subject to federal approval, this bill imposes a hospital quality assurance fee on certain general acute care hospitals. This bill would, subject to federal approval, requires that moneys in the Hospital Quality Assurance Revenue Fund shall be continuously appropriated during the first program period of January 1, 2014, to December 31, 2016, for certain purposes, including paying for health care coverage for children, and making supplemental payments for certain services to private hospitals and increased capitation payments to Medi-Cal managed care plans.

- **SB 493 Advance Pharmacy Practice**
  Summary: This bill updates pharmacy law by establishing advanced practice pharmacist (APP) recognition. The APP designation permits the pharmacist to administer certain drug therapies (in consultation with the PCP) to patients. The bill also authorizes the CA Board of Pharmacy to set a fee, not to exceed $300, for the issuance and renewal of APP recognition. This law becomes effective January 1, 2014.

- **SB 494 Health Care Providers**
  Summary: This bill requires a health care service plan to ensure that there is at least one full-time equivalent primary care physician for every 2,000 enrollees. This bill would, until January 1, 2019, authorize the assignment of up to an additional 1,000 enrollees, as specified, to a primary care physician for each full-time equivalent non-physician medical practitioner supervised by that physician.

AGENDA ITEM 3b

To: Gold Coast Health Plan Commissioners

From: Michelle Raleigh, Chief Financial Officer

Date: October 28, 2013

Re: August, 2013 Financials (Unaudited)

SUMMARY:

Staff is presenting the attached August, 2013 financial statements (unaudited) of Gold Coast Health Plan (Plan) for approval by the Commission. This financial package was reviewed in detail by the Executive / Finance Committee on October 3rd. During this meeting, the Executive / Finance Committee recommended approval of the August, 2013 financial statements to the Plan's Commission.

BACKGROUND / DISCUSSION:

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

FISCAL IMPACT:

The Plan's financial operating performance resulted in a positive variance as compared to budget for August. On a year-to-date basis, net income is approximately $2.5 million compared to $2.0 million assumed in the budget. These operating results have contributed to the month-end Tangible Net Equity (TNE) level of approximately $10.3 million, which exceeds budget of $8.0 million by nearly $2.3 million. The required TNE as of August 30, 2013 is $10.7 million (68% of $15.7 million) which is approximately $431,000 higher than the Plan's current TNE level of $10.3 million.

Other items to note include:

Membership - The Plan's July membership was 120,332 and exceeded budget by approximately 276 members. As expected, membership mix for August shifted with the final transition of the Healthy Families population to Medi-Cal [indicated as the Targeted Low Income Children (TLIC) population], where its percentage of total membership increased to 18%, up 12% from July.

Revenue – August net revenue was $26.7 million which is below the budgeted total of $27.4 million. On a per member per month (PMPM) basis, net revenue was

$222.09 PMPM compared to the budget of $228.49 PMPM. The slight differences between actual and budgeted membership is due to enrollment mix.

There are several points to be made regarding revenue:

- Community Adult Based Services (CBAS) - Also contributing to this variance is the confirmation[1] from the Department of Health Care Services (DHCS) that the monthly capitation rates will include payment for CBAS in the FY 2013-14 rates, which had been paid for separately until June 30, 2013. The Plan and the State are discussing the methodology used to include the CBAS payment in the monthly capitation payment to confirm that the Plan will continue to receive funds comparable to historical reimbursement.
- Sales Tax - It is important to note at the time the budget was finalized, a tax was not expected to be applied to the Plan's capitation rates. However, in the final State budget passed on June 27, 2013, a new tax was incorporated under Senate Bill 78. Therefore, the tax of 3.9375% has been applied to the Plan's actual premium rates. This tax is then reserved for separately and is comparable to the budgeted revenue on a net revenue basis. Note the tax is expected to be a budget-neutral pass-through item.

Health Care Costs – Health care costs for August were $762,000 below budget. Continuing recovery efforts also contributed to lower health care costs. On a PMPM basis, reported health care costs for August were $195.90 versus a budgeted amount of $202.70.

Please also note the following for August:

- Paid claims were low (by an estimated $860,000) for the month due to one of the Plan's major provider's delay in claims submission primarily driven by the implementation of a new Electronic Health Records (EHR) system. This estimate was developed by comparing the average payments made to this provider for the seven months prior to August to the actual payments in August. This estimate has been reflected in the incurred but not paid (IBNP) amount for the month of August.
- The IBNP methodology was updated to reflect the transition of the TLIC members and recognized that their health care expenses would be less on a PMPM basis than the Plan's traditional population.

[1] The Plan received an updated draft FY 2012-13 rate package on September 13, 2013 and an updated draft FY 2013-14 rate package on September 17, 2013 (also refer to Executive / Finance Committee Item 3a). The FY 2013-14 rate package reflected the inclusion of CBAS services.

Administrative Expenses - Overall operational costs were $81,000 or $0.71 PMPM under budget. Areas impacting administrative expenses were:

- Savings from lower than projected fees associated with continued support services provided by ACS.
- Timing of certain expenditures with some expected expenditures pushed into the future (e.g., Xerox SOC-1 audit, printing and mailings).
- Savings from lower than forecasted personnel costs due to differences in timing of new hires versus that projected in the budget.
- Savings were offset by higher expenses for outside services to support on-going operations.

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 of $91.3 million reported as of August 31, 2013 included an IGT payment of $25.6 million. It should be noted that the majority of this amount was disbursed in early September 2013. Excluding the impact of the IGT payment, the total of Cash and Medi-Cal Receivable balance as of August 31, 2013 was $65.7 million, or $8.9 million better than a budgeted level of $56.8 million.

Fixed Assets – The Plan is in the early stages of installing a new Medical Management System (MMS). The expected cost of the MMS is $1.43 million and was approved by the Commission in June 2013 for the current fiscal year. Cost incurred to date for the project is $384,000.

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

CONCURRENCE:
Executive / Finance Committee at the October 3, 2013 Meeting.

Attachments:
August, 2013 Financial Package

Gold Coast Health Plan℠
A Public Entity

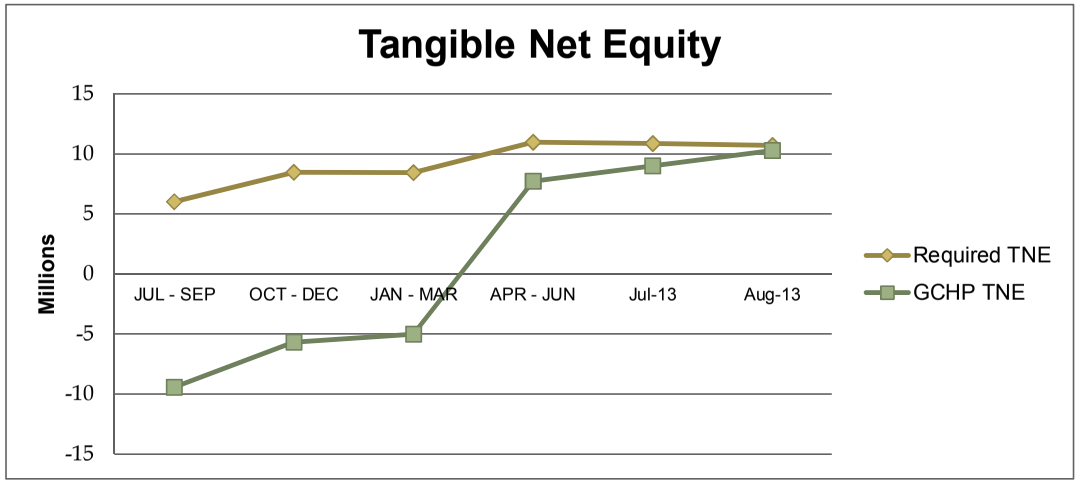
FINANCIAL PACKAGE
For the month ended August 31, 2013

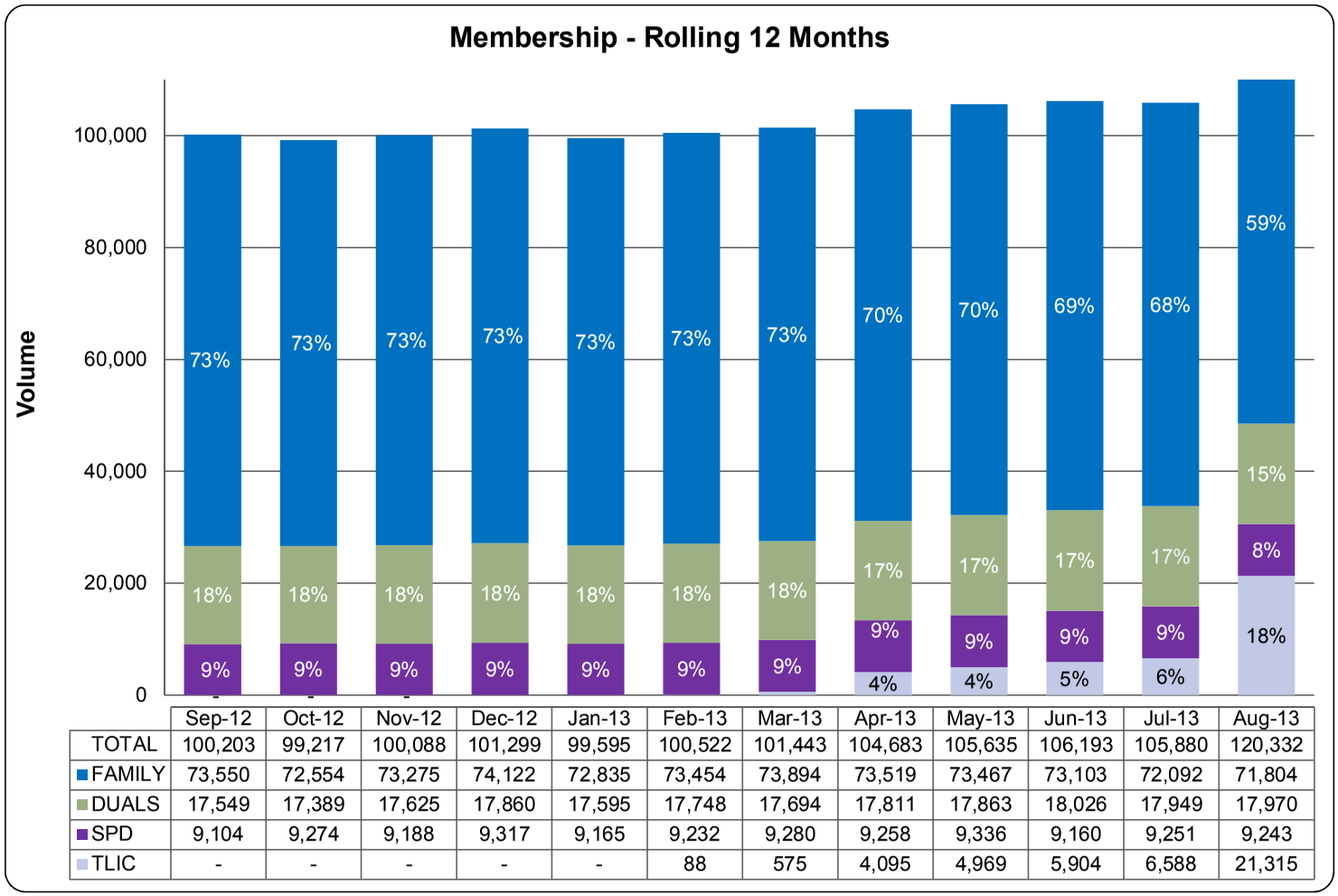
TABLE OF CONTENTS

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	YTD	Budget YTD	Variance Fav/(Unfav)	Variance Fav/(Unfav) %
Member Months	**305,220**	**300,604**	**301,560**	**316,511**	105,880	120,332	**226,212**	**225,018**	1,194	0.5 %
Revenue	**73,225,136**	**76,563,668**	**76,414,965**	**84,827,867**	**26,680,808**	**26,724,574**	**53,405,382**	**53,683,489**	(278,107)	(0.5)%
pmpm	*239.91*	*254.70*	*253.40*	*268.01*	*251.99*	*222.09*	*236.09*	*238.57*	(2.49)	(1.0)%
Health Care Costs	**71,648,550**	**68,967,923**	**69,698,937**	**70,134,156**	**23,429,811**	**23,572,589**	**47,002,401**	**47,625,242**	622,841	1.3 %
pmpm	*234.74*	*229.43*	*231.13*	*221.59*	*221.29*	*195.90*	*207.78*	*211.65*	3.87	1.8 %
% of Revenue	97.8%	90.1%	91.2%	82.7%	87.8%	88.2%	88.0%	88.7%	-0.7%	-0.8%
Admin Exp	**4,976,867**	**6,036,079**	**6,049,617**	**6,951,364**	**1,968,367**	**1,892,167**	**3,860,534**	**4,081,973**	221,439	5.4 %
pmpm	*16.31*	*20.08*	*20.06*	*21.96*	*18.59*	*15.72*	*17.07*	*18.14*	1.07	5.9 %
% of Revenue	6.8%	7.9%	7.9%	8.2%	7.4%	7.1%	7.2%	7.6%	0.4%	4.9%
Net Income	**(3,400,282)**	**1,559,667**	**666,411**	**7,742,347**	**1,282,629**	**1,259,818**	**2,542,447**	**1,976,274**	566,173	28.6 %
pmpm	*(11.14)*	*5.19*	*2.21*	*24.46*	*12.11*	*10.47*	*11.24*	*8.78*	2.46	28.0 %
% of Revenue	-4.6%	2.0%	0.9%	9.1%	4.8%	4.7%	4.8%	3.7%	1.1%	29.3%
100% TNE	16,693,841	16,308,936	16,264,038	16,141,114	16,003,415	15,749,996	15,749,996	16,266,238	(516,242)	(3.2)%
Required TNE	6,009,783	8,480,647	8,457,300	10,975,958	10,882,323	10,709,998	10,709,998	11,061,042	(351,044)	(3.2)%
GCHP TNE	**(9,432,163)**	**(5,672,496)**	**(5,006,086)**	**7,736,261**	**9,018,891**	**10,278,708**	10,278,708	**8,016,909**	2,261,799	28.2 %
TNE Excess / (Deficiency)	**(15,441,946)**	**(14,153,143)**	**(13,463,385)**	**(3,239,696)**	**(1,863,432)**	**(431,289)**	**(431,289)**	**(3,044,133)**	2,612,844	185.8 %

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

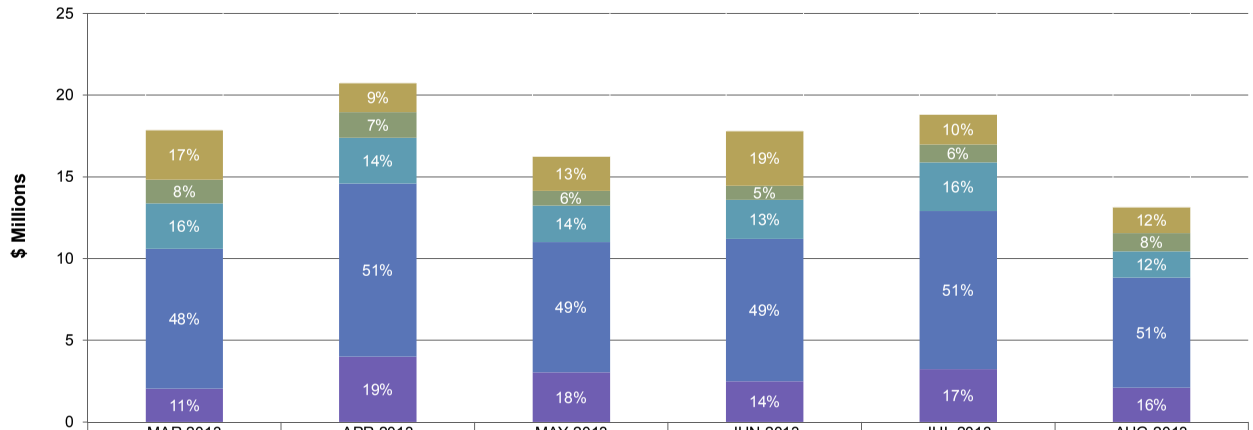




	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
TOTAL	100,203	99,217	100,088	101,299	99,595	100,522	101,443	104,683	105,635	106,193	105,880	120,332
FAMILY	73,550	72,554	73,275	74,122	72,835	73,454	73,894	73,519	73,467	73,103	72,092	71,804
DUALS	17,549	17,389	17,625	17,860	17,595	17,748	17,694	17,811	17,863	18,026	17,949	17,970
SPD	9,104	9,274	9,188	9,317	9,165	9,232	9,280	9,258	9,336	9,160	9,251	9,243
TLIC	-	-	-	-	-	88	575	4,095	4,969	5,904	6,588	21,315

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

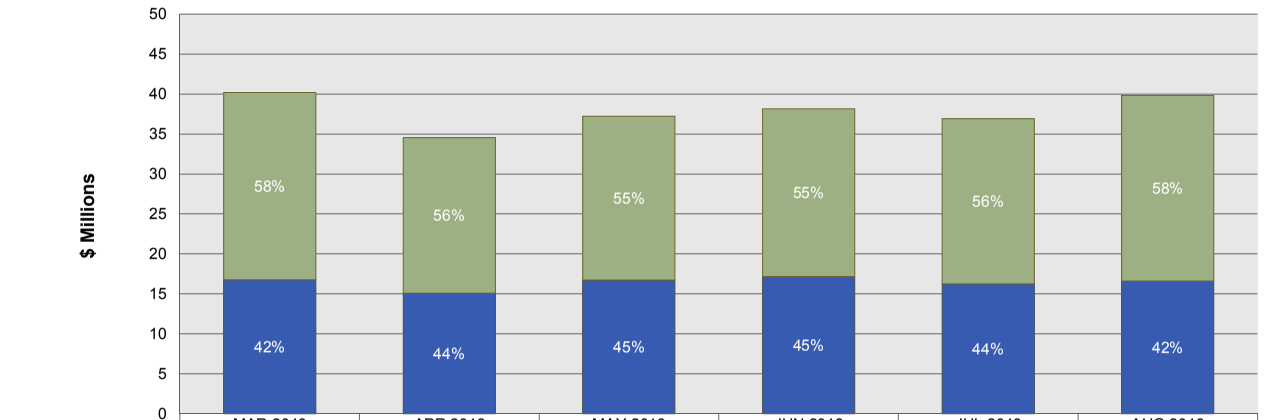
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



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

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

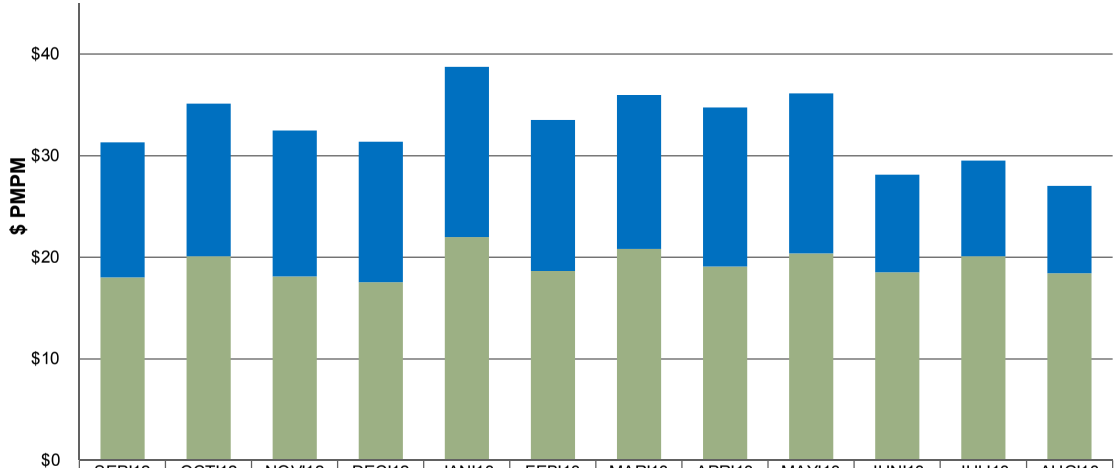
IBNP Composition (excluding Pharmacy and Capitation)



	MAR 2013	APR 2013	MAY 2013	JUN 2013	JUL 2013	AUG 2013
Total Unpaid	40.18	34.53	37.24	38.16	36.92	39.84
Prior Month Unpaid	23.39	19.45	20.50	20.98	20.68	23.25
Current Month Unpaid	16.79	15.08	16.74	17.18	16.25	16.59

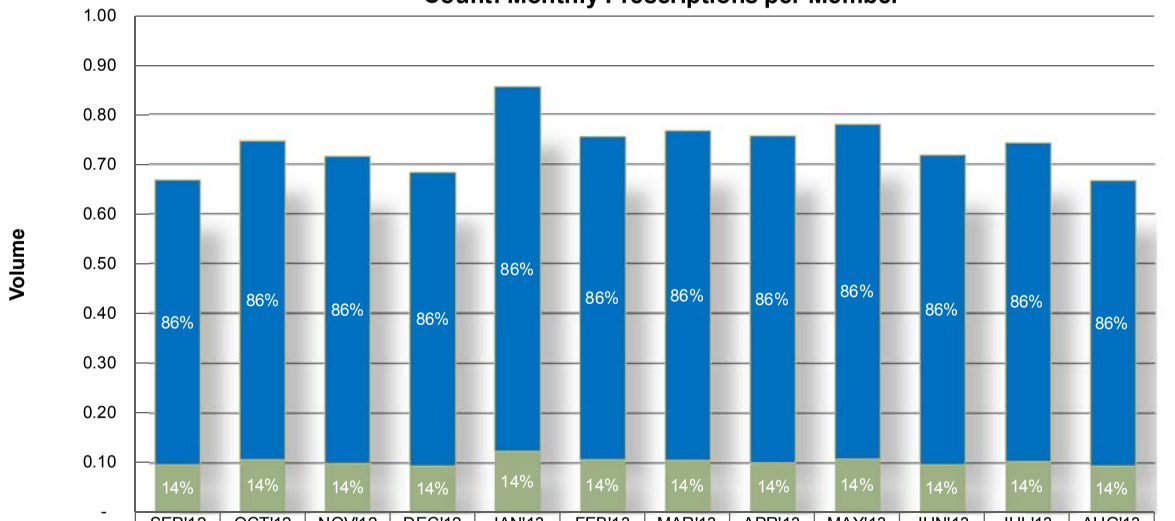
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

Pharmacy Cost Trend



	SEP'12	OCT'12	NOV'12	DEC'12	JAN'13	FEB'13	MAR'13	APR'13	MAY'13	JUN'13	JUL'13	AUG'13
AVG PMPM	$31.32	$35.13	$32.49	$31.40	$38.75	$33.53	$35.99	$34.74	$36.15	$28.12	$29.53	$27.04
GENERIC	$13.31	$15.03	$14.37	$13.86	$16.77	$14.86	$15.16	$15.66	$15.78	$9.58	$9.43	$8.62
BRAND	$18.01	$20.10	$18.12	$17.53	$21.98	$18.66	$20.82	$19.08	$20.38	$18.54	$20.10	$18.41

Count: Monthly Prescriptions per Member



	SEP'12	OCT'12	NOV'12	DEC'12	JAN'13	FEB'13	MAR'13	APR'13	MAY'13	JUN'13	JUL'13	AUG'13
TOTAL	0.67	0.75	0.72	0.68	0.86	0.76	0.77	0.76	0.78	0.72	0.74	0.67
GENERIC	0.57	0.64	0.62	0.59	0.73	0.65	0.66	0.66	0.67	0.62	0.64	0.57
BRAND	0.10	0.11	0.10	0.09	0.12	0.11	0.11	0.10	0.11	0.10	0.10	0.09

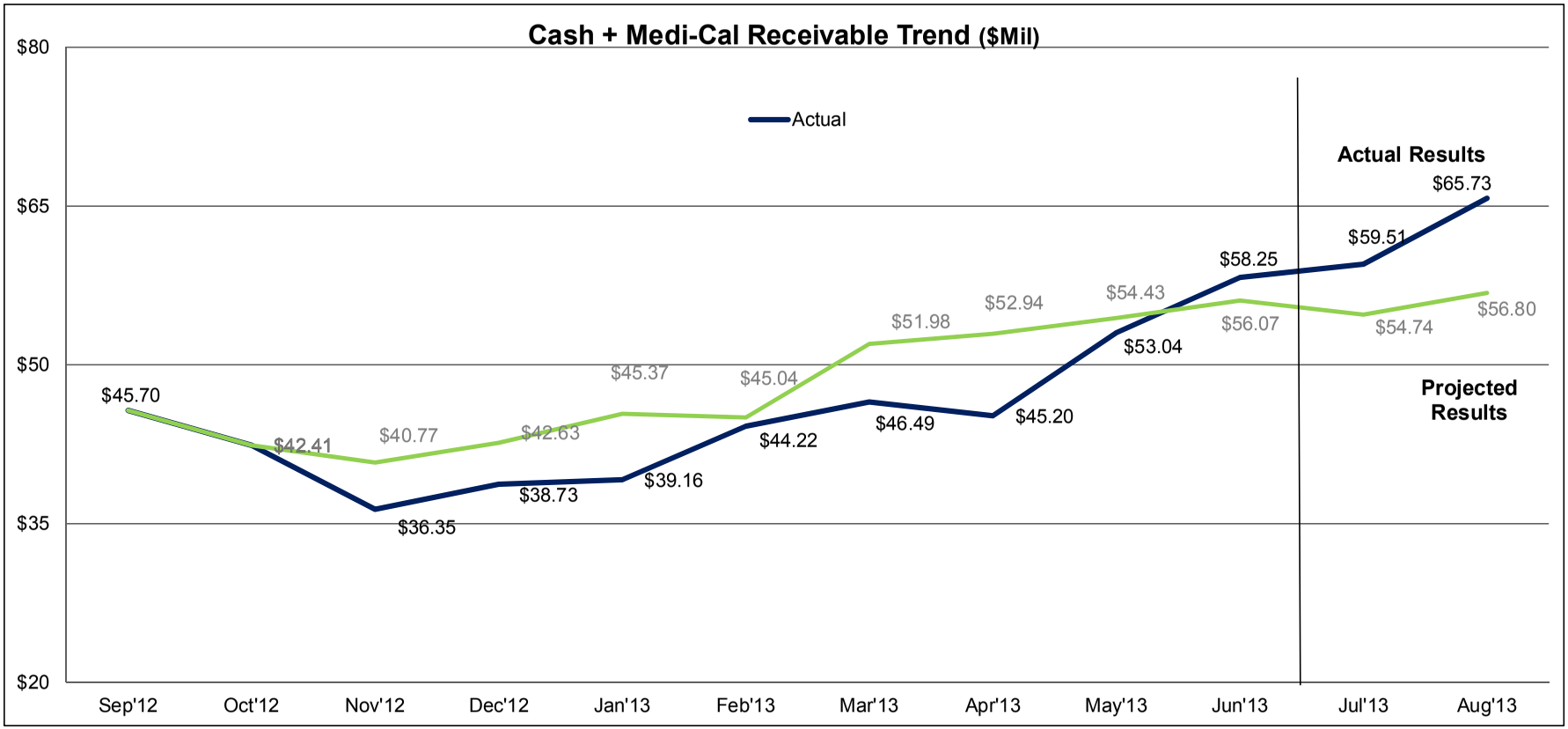
Income Statement Monthly Trend

	2013 Actual Monthly Trend			2014 Actual	Current Month		
	APR 2013	MAY 2013	JUN 2013	JUL 2013	AUG 2013		Variance
					Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	104,683	105,635	106,193	105,880	120,332	120,056	276
Revenue:							
Premium	$ 26,032,054	$ 26,048,832	$ 29,108,295	$ 27,686,491	$ 27,789,352	$ 27,514,707	$ 274,645
Reserve for Rate Reduction	1,785,047	-	1,180,078	-	-	(129,170)	129,170
MCO Premium Tax	-	-	-	(1,053,211)	(1,110,416)	-	(1,110,416)
Total Net Premium	**27,817,101**	**26,048,832**	**30,288,373**	**26,633,279**	**26,678,936**	**27,385,537**	**(706,601)**
Other Revenue:							
Interest Income	7,579	7,203	8,594	9,195	7,304	8,254	(951)
Miscellaneous Income	38,333	573,518	38,333	38,333	38,333	38,333	0
Total Other Revenue	45,912	580,721	46,927	47,529	45,637	**46,587**	(950)
Total Revenue	**27,863,013**	**26,629,553**	**30,335,300**	**26,680,808**	**26,724,574**	**27,432,125**	**(707,551)**
Medical Expenses:							
Capitation (PCP, Specialty, NEMT & Visic	1,274,651	1,226,446	1,254,306	1,270,073	1,507,335	1,724,468	217,133
Incurred Claims:							
Inpatient	4,422,556	5,955,342	6,185,239	4,850,263	4,512,661	4,007,649	(505,012)
LTC/SNF	6,404,450	5,438,652	5,774,127	6,128,764	7,333,312	6,503,554	(829,758)
Outpatient	2,682,417	1,803,363	2,132,380	2,882,860	2,955,457	2,954,949	(508)
Laboratory and Radiology	225,582	158,267	126,783	222,454	113,377	243,167	129,790
Emergency Room Facility Services	521,965	430,333	506,334	745,797	497,008	587,178	90,170
Physician Specialty Services	2,026,032	2,245,622	2,929,617	2,033,957	1,479,169	2,101,856	622,687
Pharmacy	3,626,289	3,819,028	3,092,352	3,126,910	3,253,505	3,456,194	202,689
Other Medical Professional	216,345	83,856	84,601	169,903	118,201	208,381	90,180
Other Medical Care Expenses	-	-	755	-	-	-	-
Other Fee For Service Expense	1,489,453	1,497,072	1,524,389	1,137,610	1,235,873	1,567,767	331,894
Transportation	73,499	71,310	60,991	40,124	35,404	70,401	34,997
Total Claims	21,688,588	21,502,845	22,417,569	21,338,642	21,533,967	21,701,097	167,130
Medical & Care Management Expense	894,013	722,529	732,777	742,126	730,967	725,776	(5,191)
Reinsurance	26,355	70,711	(368,913)	259,745	258,884	183,686	(75,198)
Claims Recoveries	(484,211)	(610,167)	(213,342)	(180,775)	(458,563)	-	458,563
Sub-total	436,157	183,072	150,522	821,096	531,288	909,462	378,174
Total Cost of Health Care	**23,399,396**	**22,912,363**	**23,822,397**	**23,429,811**	**23,572,589**	**24,335,027**	**762,438**
Contribution Margin	**4,463,617**	**3,717,190**	**6,512,903**	**3,250,997**	**3,151,984**	**3,097,098**	**54,887**
General & Administrative Expenses:							
Salaries and Wages	464,103	600,314	731,003	562,828	420,641	483,676	63,035
Payroll Taxes and Benefits	113,969	108,592	199,544	123,309	112,105	124,901	12,796
Total Travel and Training	5,140	13,746	2,712	3,630	5,840	24,985	19,145
Outside Service - ACS	892,178	945,040	924,744	852,085	880,703	919,621	38,918
Outside Services - Other	99,755	31,920	26,808	16,447	49,938	25,924	(24,014)
Accounting & Actuarial Services	33,046	51,270	61,489	44,003	20,164	13,333	(6,830)
Legal Expense	37,957	46,299	80,775	57,931	26,462	30,400	3,938
Insurance	9,245	10,516	7,677	11,838	9,972	10,792	820
Lease Expense - Office	26,080	25,980	7,937	25,980	28,480	25,980	(2,500)
Consulting Services Expense	286,436	443,743	229,676	172,165	201,612	160,638	(40,974)
Translation Services	1,125	4,610	3,672	4,878	2,788	2,537	(251)
Advertising and Promotion Expense	-	1,050	-	4,080	14,120	14,460	340
General Office Expenses	171,615	71,628	83,271	63,357	88,394	91,970	3,576
Depreciation & Amortization Expense	3,836	3,648	11,407	5,235	5,235	6,864	1,629
Printing Expense	5,445	3,672	12,974	2,628	1,418	25,108	23,690
Shipping & Postage Expense	10,933	179	2,120	41	219	2,725	2,506
Interest Exp	24,186	1,180	17,120	17,933	24,076	9,160	(14,916)
Total G & A Expenses	**2,185,050**	**2,363,386**	**2,402,927**	**1,968,367**	**1,892,167**	**1,973,073**	**80,906**
Net Income / (Loss)	**$ 2,278,567**	**$ 1,353,803**	**$ 4,109,976**	**$ 1,282,629**	**$ 1,259,818**	**$ 1,124,024**	**$ 135,793**

PMPM Income Statement Comparison

	2013 Actual Monthly Trend			2014 Actual	Aug'13 Month-To-Date		Variance
	APR 2013	MAY 2013	JUN 2013	JUL 2013	Actual	Budget	Fav/(Unfav)
Members (Member/Months)	101,741	105,635	106,193	105,880	120,332	120,056	276
Revenue:							
Premium	248.68	246.59	274.11	261.49	230.94	229.18	1.76
Reserve for Rate Reduction	17.05	-	11.11	-	-	(1.08)	1.08
MCO Premium Tax	-	-	-	(9.95)	(9.23)	-	(9.23)
Total Net Premium	**265.73**	**246.59**	**285.22**	**251.54**	**221.71**	**228.11**	**(6.39)**
Other Revenue:		-					
Interest Income	0.07	0.07	0.08	0.09	0.06	0.07	(0.01)
Miscellaneous Income	0.37	5.43	0.36	0.36	0.32	0.32	(0.00)
Total Other Revenue	**0.44**	**5.50**	**0.44**	**0.45**	**0.38**	**0.46**	**(0.08)**
Total Revenue	**266.17**	**252.09**	**285.66**	**251.99**	**222.09**	**228.49**	**(6.40)**
Medical Expenses:							
Capitation	12.18	11.61	11.81	12.00	12.53	14.36	(1.84)
Incurred Claims:							
Inpatient	42.25	56.38	58.25	45.81	37.50	33.38	(4.12)
LTC/SNF	61.18	51.49	54.37	57.88	60.94	54.17	(6.77)
Outpatient	25.62	17.07	20.08	27.23	24.56	24.61	0.05
Laboratory and Radiology	2.15	1.50	1.19	2.10	0.94	2.03	1.08
Emergency Room Facility Services	4.99	4.07	4.77	7.04	4.13	4.89	0.76
Physician Specialty Services	19.35	21.26	27.59	19.21	12.29	17.51	5.21
Pharmacy	34.64	36.15	29.12	29.53	27.04	28.79	1.75
Other Medical Professional	2.07	0.79	0.80	1.60	0.98	1.74	0.75
Other Medical Care Expenses	-	-	0.01	-	-	-	-
Other Fee For Service Expense	14.23	14.17	14.35	10.74	10.27	13.06	2.79
Transportation FFS	0.70	0.68	0.57	0.38	0.29	0.59	0.29
Total Claims	207.18	203.56	211.10	201.54	178.95	180.76	1.80
Medical & Care Management	8.54	6.84	6.90	7.01	6.07	6.05	(0.03)
Reinsurance	0.25	0.67	(3.47)	2.45	2.15	1.53	(0.62)
Claims Recoveries	(4.63)	(5.78)	(2.01)	(1.71)	(3.81)	-	3.81
Sub-total	4.17	1.73	1.42	7.75	4.42	8.99	4.57
Total Cost of Health Care	223.53	216.90	224.33	221.29	195.90	202.70	6.80
Contribution Margin	42.64	35.19	61.33	30.70	26.19	**25.80**	**0.40**
Administrative Expenses							
Salaries and Wages	4.43	5.68	6.88	5.32	3.50	4.03	0.53
Payroll Taxes and Benefits	1.09	1.03	1.88	1.16	0.93	1.04	0.11
Total Travel and Training	0.05	0.13	0.03	0.03	0.05	0.21	0.16
Outside Service - ACS	8.52	8.95	8.71	8.05	7.32	7.66	0.34
Outside Services - Other	0.95	0.30	0.25	0.16	0.41	0.22	(0.20)
Accounting & Actuarial Services	0.32	0.49	0.58	0.42	0.17	0.11	(0.06)
Legal Expense	0.36	0.44	0.76	0.55	0.22	0.25	0.03
Insurance	0.09	0.10	0.07	0.11	0.08	0.09	0.01
Lease Expense -Office	0.25	0.25	0.07	0.25	0.24	0.22	(0.02)
Consulting Services Expense	2.74	4.20	2.16	1.63	1.68	1.34	(0.34)
Translation Services	0.01	0.04	0.03	0.05	0.02	0.02	(0.00)
Advertising and Promotion Expense	-	0.01	-	0.04	0.12	0.12	0.00
General Office Expenses	1.64	0.68	0.78	0.60	0.73	0.77	0.03
Depreciation & Amortization Expense	0.05	0.03	0.12	0.02	0.04	0.06	0.01
Printing Expense	0.10	0.00	0.02	0.00	0.01	0.21	0.20
Shipping & Postage Expense	0.23	0.01	0.16	0.17	0.00	0.02	0.02
Interest Exp	-	-	-	-	0.20	0.08	(0.12)
Total Administrative Expenses	**20.87**	**22.37**	**22.63**	**18.59**	**15.72**	**16.43**	**0.71**
Net Income / (Loss)	**21.77**	**12.82**	**$ 38.70**	**12.11**	**10.47**	**9.36**	**1.11**

UNAUDITED


Cash + Medi-Cal Receivable Trend ($Mil)
$80
$65
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Actual
Actual Results
Projected Results
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Aug'13

Gold Coast Health Plan℠
A Public Entity

APPENDIX

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

Comparative Balance Sheet

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

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

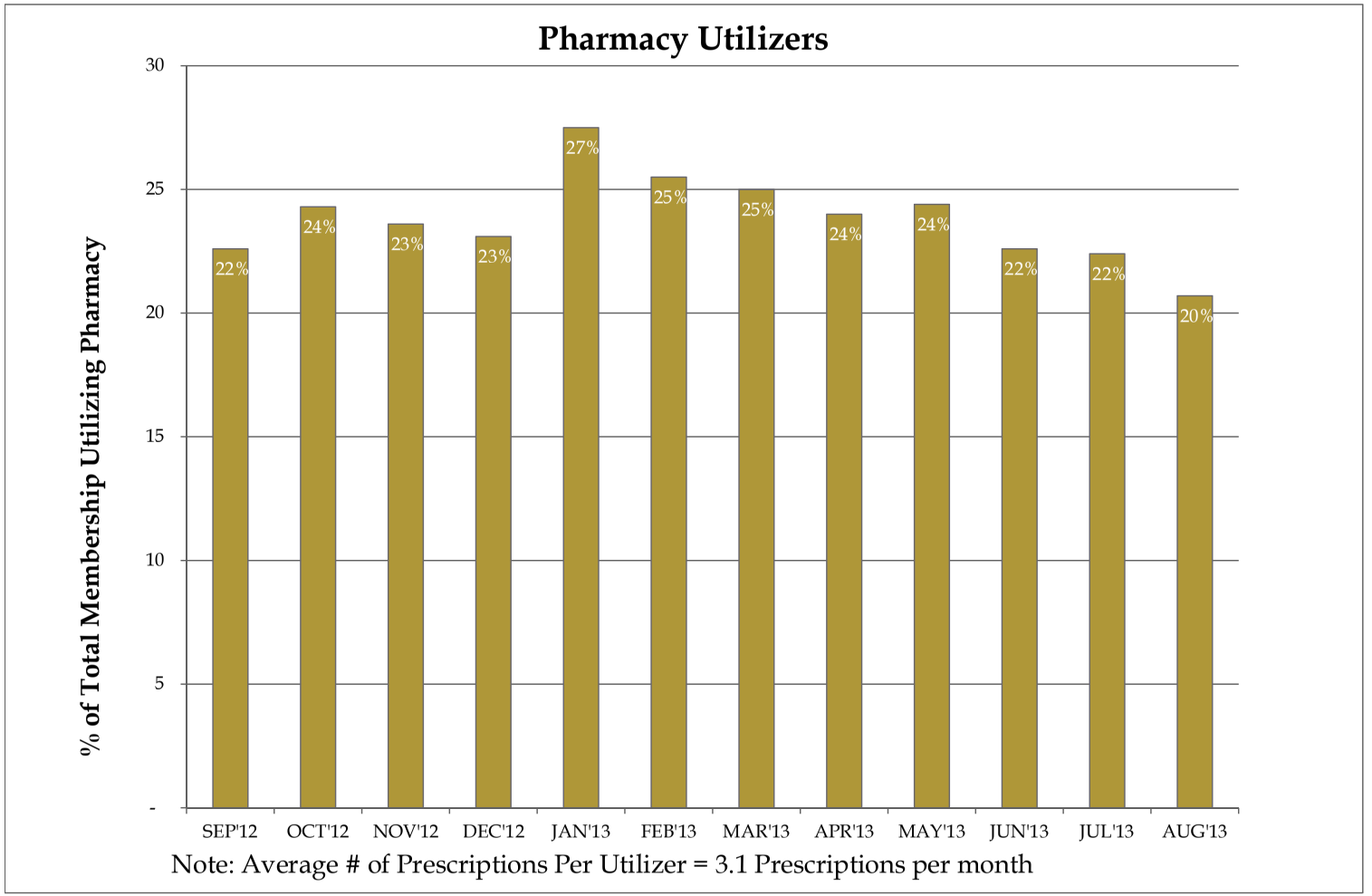
Income Statement
For The Two Months Ended August 31, 2013

	Aug'13 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	226,212	225,018	1,194
Revenue:			
Premium	$ 55,475,843	$ 53,848,976	$ 1,626,867
Reserve for Rate Reduction	-	(258,308)	258,308
MCO Premium Tax	(2,163,627)	-	(2,163,627)
Total Net Premium	**53,312,216**	**53,590,668**	**(278,452)**
Other Revenue:			
Interest Income	16,499	16,155	345
Miscellaneous Income	76,667	76,666	1
Total Other Revenue	93,166	**92,821**	345
Total Revenue	**53,405,382**	**53,683,489**	**(278,107)**
Medical Expenses:			
Capitation	2,777,408	3,010,373	232,965
Incurred Claims*			
Inpatient	9,362,924	7,916,088	(1,446,836)
LTC/SNF	13,462,076	13,005,465	(456,611)
Outpatient	5,838,317	5,832,117	(6,200)
Laboratory and Radiology	335,831	474,145	138,314
Emergency Room Facility Services	1,242,805	1,127,159	(115,646)
Physician Specialty Services	3,513,126	4,004,946	491,820
FQHC Services Capitation	-		-
Professional FFS Expense	-		-
Pharmacy	6,380,415	6,814,561	434,146
Incentives - P4P	-		-
Other Medical Professional	288,104	416,622	128,518
Other Medical Care Expenses	-	-	-
Other Fee For Service Expense	2,373,483	3,116,302	742,819
Transportation	75,528	136,311	60,783
Total Claims	42,872,609	42,843,716	(28,893)
Medical & Care Management Expense	1,473,093	1,426,876	(46,217)
Reinsurance	(779,185)	344,277	1,123,462
Claims Recoveries	658,476	-	(658,476)
Sub-total	1,352,384	1,771,153	418,769
Total Cost of Health Care	**47,002,401**	**47,625,242**	**622,841**
Contribution Margin	**6,402,981**	**6,058,247**	**344,734**
General & Administrative Expenses:			
Salaries and Wages	983,469	958,986	(24,483)
Payroll Taxes and Benefits	235,414	247,256	11,841
Total Travel and Training	9,470	42,153	32,683
Outside Service - ACS	1,732,788	1,848,884	116,096
Outside Service - CQS	-	-	-
Outside Service - RGS	-	-	-
Outside Service - Script Care	-	-	-
Outside Services - Other	66,385	103,648	37,263
Accounting & Actuarial Services	64,166	101,667	37,500
Legal Expense	84,393	60,800	(23,593)
Insurance	21,810	21,584	(226)
Lease Expense - Office	54,460	51,960	(2,500)
Consulting Services Expense	373,777	344,276	(29,501)
Translation Services	7,666	5,325	(2,341)
Advertising and Promotion Expense	18,200	28,580	10,380
General Office Expenses	151,751	192,326	40,575
Depreciation & Amortization Expense	10,470	13,478	3,008
Printing Expense	4,046	26,526	22,480
Shipping & Postage Expense	260	16,250	15,990
Interest Exp	42,010	18,275	(23,734)
Total G & A Expenses	**3,860,534**	**4,081,973**	**221,439**
Net Income / (Loss)	**$ 2,542,447**	**$ 1,976,274**	**$ 566,173**

Statement of Cash Flows - Monthly

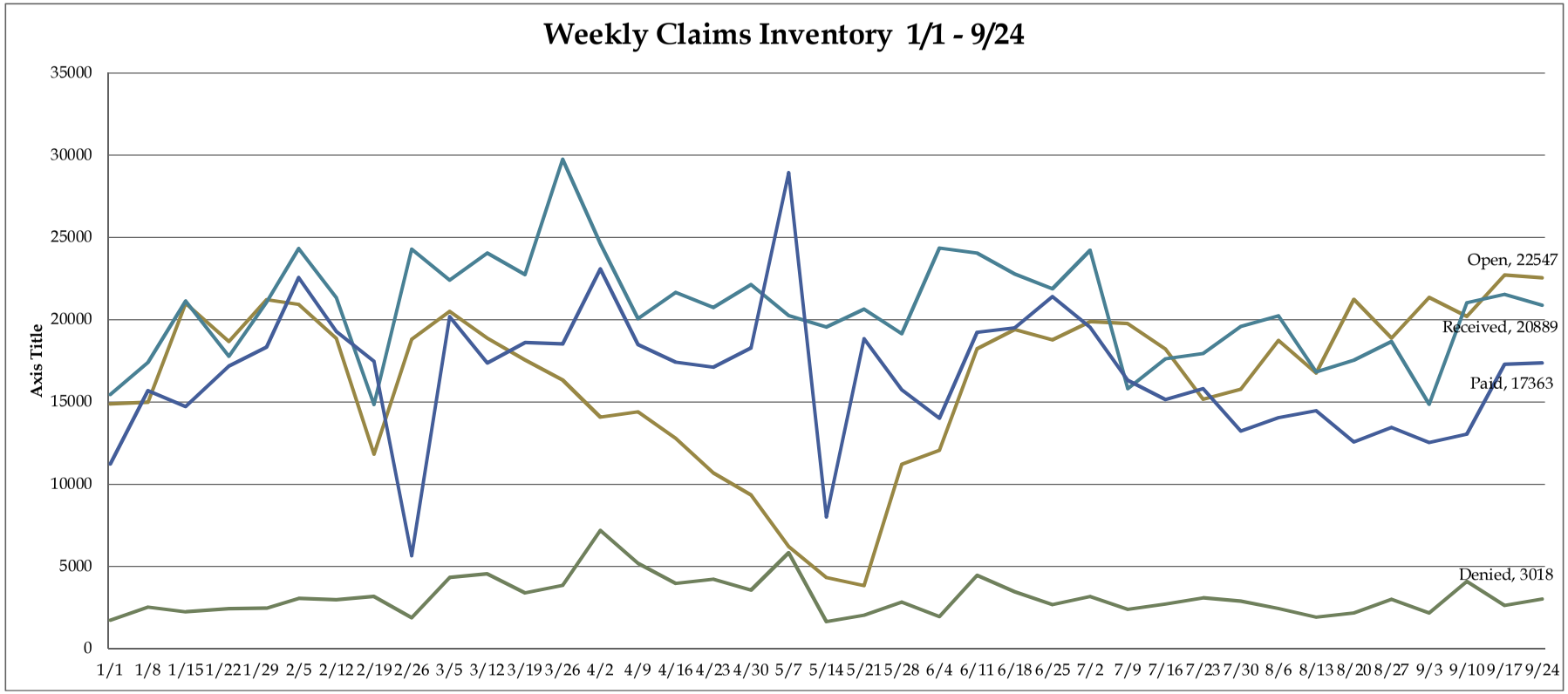
	AUG '13	JUL '13	JUN'13
Cash Flow From Operating Activities			
Collected Premium	$ 56,847,242	$ -	$ 52,138,834
Miscellaneous Income	542,489	9,195	8,594
State Pass Through Funds	25,595,240	-	34,346,474
Paid Claims			
Medical & Hospital Expenses	(13,601,172)	(18,926,200)	(17,277,826)
Pharmacy	(3,569,832)	(2,994,857)	(4,009,168)
Capitation	(1,274,000)	(1,257,418)	(1,162,302)
Reinsurance of Claims	(258,884)	(259,745)	(240,430)
HQAF Funds Distributed		-	(34,346,474)
Paid Administration	(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	**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	(384,074)	(10,815)	(31,026)
Net Cash Provided/(Used) by Investing/Financing	**(384,074)**	**(10,815)**	**(31,026)**
Net Cash Flow	**$ 61,406,480**	**$ (26,429,890)**	**$ 27,639,617**
Cash and Cash Equivalents (Beg. of Period)	24,277,962	50,707,852	23,068,235
Cash and Cash Equivalents (End of Period)	85,684,442	24,277,962	50,707,852
	$ 61,406,480	**$ (26,429,890)**	**$ 27,639,617**
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	1,259,818	1,282,629	4,109,976
Depreciation & Amortization	5,235	5,235	11,407
Decrease/(Increase) in Receivables	29,475,719	(27,334,427)	22,788,941
Decrease/(Increase) in Prepaids & Other Current Assets	50,054	(875,404)	769,972
(Decrease)/Increase in Payables	24,720,848	1,172,860	(1,578,838)
(Decrease)/Increase in Other Liabilities	(38,333)	(80,000)	(121,667)
Change in MCO Tax Liability	1,739,259	226,645	1,433,012
Changes in Claims and Capitation Payable	3,220,107	(4,087,314)	1,913,029
Changes in IBNR	1,357,848	3,270,701	(1,655,189)
	61,790,554	(26,419,075)	27,670,643
Net Cash Flow from Operating Activities	**$ 61,790,554**	**$ (26,419,075)**	**$ 27,670,643**

	SEP'12	OCT'12	NOV'12	DEC'12	JAN'13	FEB'13	MAR'13	APR'13	MAY'13	JUN'13	JUL'13	AUG'13
Member months	100.2	99.2	100.1	101.3	99.6	100.5	101.4	104.7	105.6	106.2	105.9	120.3
% Utilization	23	24	24	23	28	26	25	24	24	23	22	21
% (enrollment)	***22.6%***	***24.3%***	***23.6%***	***23.1%***	***27.5%***	***25.5%***	***25.0%***	***24.0%***	***24.4%***	***22.6%***	***22.4%***	***20.7%***
Average # Prescriptions	2.96	3.08	3.03	2.97	3.11	2.97	3.07	3.16	3.21	3.18	3.32	3.22



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
Average	*71,230*	*13,705*	*89,484*	*72,416*	*22*	*4,150*	*3,351*

* 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.

AGENDA ITEM 4a

To: Gold Coast Health Plan Commissioners

From: Guillermo Gonzalez, Government Relations Director

Date: October 28, 2013

Re: AB 85 Mandates

SUMMARY:
Assembly Bill 85 (AB 85) imposed mandates on Medi-Cal managed care plans and was included as budget trailer language in the approved FY 2013-14 State budget. AB 85 requires the Department of Health Care Services (DHCS) to implement a process for the realignment of county-state health funds, and capture health fund savings which result from implementation of the federal Affordable Care Act (ACA) in California.

DHCS has yet to clarify final rules, implementation guidelines, and reimbursement rates to public hospitals and health systems (PHHS) as contained in AB 85.

BACKGROUND:
Through the Disproportionate Share Hospital (DSH) Program the federal government provides funding to hospitals that treat medically indigent or uninsured patients. Under health care reform, county costs for indigent health care are expected to decrease as uninsured individuals obtain health care coverage made possible by the ACA. Effective January 1, 2014, the State will reduce county health care realignment funding by an average of 60% or approximately $300 million in aggregate for the first six months of ACA implementation.

Further funding reductions to counties are expected in subsequent years as more individuals become insured. AB 85 sets up a process by which counties can lessen the magnitude of these reductions by receiving higher reimbursement at actual cost from managed care plans for services provided to newly assigned and eligible Medi-Cal beneficiaries.

AB 85 is intended to assist the counties offset the reductions in health care funding as described above and via other program changes not outlined above.

In addition to the realignment funding structure changes between the State and counties, AB 85 contains provisions and requirements that impact Medi-Cal managed

care plans including Gold Coast Health Plan (GCHP).These provisions and requirements include:

1) A requirement that begins 12/31/13 through 12/31/16, by which Medi-Cal managed care plans assign 75% of new Medi-Cal expansion members that do not choose a Primary Care Physician (PCP) to primary care clinics / PCPs that are part of the county PHHS. As the Commission is aware, a significant percentage of members that enroll with GCHP do not pro-actively choose a PCP. GCHP then assigns those members using an 'auto-assignment' methodology that takes into account member location, PCP access and availability, age and sex of the individual, family linkage, spoken language, safety net providers (3 to 1 ratio) and then randomly assigns the member to a PCP that meets the appropriate criteria.

   Under the new requirements of AB 85, 75% of the new Medi-Cal expansion members that do not choose a PCP must be directed to a county affiliated clinic or PCP. From January 1, 2017 and thereafter Medi-Cal managed care plans will assign, by default, 50% of members who do not choose a PCP to one within a county health system or until the county health system meets or exceeds its enrollment capacity. This default assignment scenario will only apply to those members who have accessed care within the county hospital system two to three times in the previous 12 months.

2) 100% cost reimbursement – AB 85 requires GCHP to ultimately pay the County PHHS at 100% of their cost for providing health care services to Medi-Cal expansion members.

   Medi-Cal managed care plans have recommended that the State develop the following process:
   (a) Medi-Cal managed care plans make normal payments to the county health care system per existing contracts.
   (b) The State and counties reconcile the difference between our payments and 100% of their cost.
   (c) State provides payments to Medi-Cal managed care plans for the difference and Medi-Cal managed care plans pass through those funds to the counties.

   DHCS has not agreed to the above recommendations at this time.

3) Facilitate additional funds to the PHHS through an increase within the Medi-Cal managed care plans rate range payments from the State. Each fiscal year the State uses actuaries to develop a rate range for Medi-Cal payments to Medi-Cal managed care plans. By policy, the State pays plans at the bottom of the rate range. AB 85 requires the State to pay Medi-Cal managed care plans at

75% of the rate range with those additional funds to be passed through to the PHHS for the Medi-Cal expansion population.

Notably Med-Cal managed care plans were not involved with any of the negotiations between the State and counties regarding the language and requirements of AB 85.

DISCUSSION:
The default member assignment provisions of AB 85 will require GCHP to develop / program two distinct auto-assignment processes, one for new Medi-Cal expansion members and one for all other members. Key issues include:

1) Once the revised auto-assignment process meets the 75% ratio, or target volume as determined by the PHHS, the special auto-assignment program will end and the Medi-Cal managed care plans usual auto-assignment program will be run.

2) The initial assignment of a Member not choosing a PCP will be as described above, Members have the right to change their PCPs on a monthly basis so Member churn can create a monthly change to the auto-assignment process as membership at the 75% threshold may be met one month and move under the threshold the next month.

3) Given the significant Member assignment to the County clinics that will occur due to this requirement, GCHP will work with the County to insure that Member access and availability standards, as defined by DHCS, are met. Current regulations require a physician to patient ratio of 1:2000, meaning one physician to every 2,000 patients. It is unclear what impact the default assignment will have on a PHHS, and whether it will require DHCS to revise capacity criteria for counties similar to the current physician to patient ratio regulation.

4) 100% cost reimbursement – Medi-Cal managed care plans are working with the State and County to finalize the mechanism for these payments but at least for the first year (2014) it appears that the mechanism will be retroactive reconciliation and pass through of additional funds.

5) 75% rate range pass through – Medi-Cal managed care plans are requesting to be paid at 100% (top) of the rate range and then pass through 75% of the rate charge as required to the counties.

6) Medi-Cal managed care plans are also requesting that the State provide funds to cover administrative expenses related to the above changes.

GCHP intends to work closely with the County and DHCS to successfully implement all provisions and requirements under AB 85.

FISCAL IMPACT:
GCHP expects that rates to implement AB 85 will be sufficient to cover pass-through costs and administrative expenses to implement the program.

RECOMMENDATION:
Pending further guidance from DHCS, this is intended for informational purposes only. No action is requested at this time.

CONCURRENCE:
N/A

Attachments:
None.

AGENDA ITEM 4b

To: Gold Coast Health Plan Commissioners

From: Nancy Wharfield, MD, Medical Director, Health Services

Date: October 28, 2013

Re: Managed Behavioral Health Organization (MBHO) Emergency Procurement

SUMMARY:
On September 23, 2013, Gold Coast Health Plan sought and obtained approval from the Commission to procure an MBHO to assist in provision of the new Medi-Cal non-specialty mental health benefit as defined by the Department of Health Care Services, effective January 1, 2014. The Commission also directed staff to solicit input from local interested parties.

BACKGROUND / DISCUSSION:
Gold Coast Health Plan submitted a questionnaire on September 26, 2013 to five organizations to determine readiness to provide these services. Three of the five organizations responded affirmatively to the information request. The three organizations that returned the questionnaire by the October 2, 2013 deadline were evaluated and scored in the following six categories:

1. Company overview / experience – including core services, accreditation, financial statements
2. Scope of administrative services – including utilization and case management, call center, claims payment, quality, reporting, and grievance and appeals
3. Implementation – including standard approach, experience and capability for rapid implementation
4. Network Management – including current network and ability to build a network quality utilizing existing resources and credentialing
5. Systems / Security / Reporting – including description of information systems for administration, utilization management, and case management, information protocols related to HIPAA and HITECH
6. Cost - including administrative and implementation costs

Reference calls were made for the 2 top scoring organizations.

OUTCOME:
Based on the above analysis, Gold Coast Health Plan has selected Beacon Health Strategies as our preferred MBHO. Beacon Health Strategies is an NCQA and URAC accredited MBHO

with 17 years of experience. They currently provide services to 20 Medicaid plans in 21 states. Today, Beacon is under agreement with three Medi-Cal Managed Care Organizations. While Beacon is well-equipped to provide a turnkey solution for core administrative services, they are also working to understand and anticipate the upcoming challenges of implementing the new Medi-Cal benefit, including the opportunity to facilitate coordination of medial and behavioral health services.

Beacon Health Strategies is completing their review of a Letter of Intent and Business Associate Agreement submitted on October 11, 2013. The implementation kick off meeting is scheduled for the week of October 21, 2013.

FINANCIAL IMPACT:
The Plan is still negotiating final contract terms with Beacon while in the process of executing a Letter of Intent. Cost proposals were submitted by each vendor with per member per month pricing for a two-year contract. This pricing also included any projected "one-time only" implementation costs. A comparative analysis of the cost proposals demonstrated that Beacon's pricing was the most cost-effective for the Plan. The following table provides the detail of the three pricing proposals:

MBHO	PMPM Y1	PMPM Y2	Annualized PMPM Cost Y1	Annualized PMPM Cost Y2	Implementation Costs	Total
Beacon Health Strategies	$.072	$.074	$1,019,520	$1,047,540	$25,000	$2,092,360
Optum	$1.19	$1.19	$1,685.040	$1,685.040	$300,000	$3,670,080
The Holman Group	$1.08	$1.08	$1,529,280	$1,529,280	$.00	$3,058,560

CONCURRENCE:
N/A

Attachments:
None.