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

2240 E. Gonzales, Suite 200, Oxnard, CA 93036
Monday, February 24, 2014
3:00 p.m.

CANCELLED DUE TO LACK OF QUORUM

CALL TO ORDER / ROLL CALL

RECOGNITION
Recognition of Retiring CMO Charles Cho, MD

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

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

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

2. **APPROVAL ITEMS**
   a. Provider Advisory Committee (PAC) Charter Policy and Procedure
   b. Extension of Auditors Contract (McGladrey)
   c. ICD10 Vendor Selection

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

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

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

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba
Gold Coast Health Plan February 24, 2014 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. December Financials

4. INFORMATIONAL ITEMS

a. CMO / Health Services Update

CLOSED SESSION

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

2. Closed Session Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9

a. United States of America et al. ex re Donald Gordon, v. Gold Coast Health Plan, et al, United States District Court, Central District, Case Number: CV 11-5500-IFW (AJWx)
b. Sziklai et al. v. Ventura County Medi-Cal Managed Care Commission et al; Ventura County Superior Court, Case Number 56-2012-00428086

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 March 24, 2014 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

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

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

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

January 27, 2014

(Not official until approved)

CALL TO ORDER

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

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE

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

EXCUSED / ABSENT COMMISSION MEMBERS

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

STAFF IN ATTENDANCE

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

The Pledge of Allegiance was recited.

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

PUBLIC COMMENT

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

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

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

1. APPROVE MINUTES

a. Regular Meeting of November 18, 2013

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

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

AGENDA CHANGE

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

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

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

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

2. APPROVAL ITEMS

a. Consumer Advisory Committee (CAC) Membership

COO Watson reviewed the written report with the Commission.

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

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

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

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

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

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

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

d. Amended FY 2013-14 Budget

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

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

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

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

3. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Engelhard reviewed the written report with the Commission.

b. October and November Financials

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

c. Quality Improvement Annual Report

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

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

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

4. INFORMATIONAL ITEMS

a. Health Services Update

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

b. ACA Implementation Update

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

c. Proposed 2014-15 State Budget Update

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

d. Legislative Update (Year-End)

CEO Engelhard briefly reviewed the Legislative Update.

COMMENTS FROM COMMISSIONERS

None.

CLOSED SESSION

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

ADJOURN TO CLOSED SESSION

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

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

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

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

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

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

RETURN TO OPEN SESSION

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

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

ADJOURNMENT

Meeting adjourned at 6:08 p.m.

AGENDA ITEM 2a

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operations Officer

Date: February 24, 2014

RE: Provider Advisory Committee Charter Policy and Procedure

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

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

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

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

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

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

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

CONCURRENCE:
N/A

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

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

Purpose:

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

Policy:

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

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

C. Commission encourages provider involvement in the GCHP program.

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

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

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

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

e. Home Health/Hospice;

f. Nurse;

g. Physician;

h. Traditional/Safety Net;

i. VCHCA

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

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

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

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

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

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

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

1. Each PAC nomination subcommittee shall:

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

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

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

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

K. Advisory committee members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if an advisory committee member provides notification of an absence to GCHP staff prior to the advisory committee meeting. GCHP staff shall inform the Chief Executive Officer, and Clerk of the Board of the Commission when an advisory committee member fails to attend two (2) consecutive regularly scheduled meetings.

Procedure:

A. PAC composition

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

B. PAC meeting frequency

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

C. PAC recruitment process

1. GCHP Clerk of the Board shall post on the GCHP website an Annual Appointment List on, or before, December 31 of each year The Clerk of the Board shall also post said List per government code requirements. GCHP shall include, but not be limited to, the following notification methods for impending vacancies:
    a. All California Government Code requirements.
    b. Outreach to Provider communities
    c. Placement of Annual Appointment List on the GCHP website
    d. Advertisement of vacancies in GCHP monthly Provider Operations Bulletin

2. Prospective candidates shall submit their application to GCHP in accordance with GCHP requirements.
3. Advisory committee chairperson shall inquire of its membership whether there are interested candidates who wish to be considered as a chairperson for the upcoming year.

D. PAC nomination evaluation process

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

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

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

4. GCHP shall provide new PAC members with a new member orientation.

Attachments:

References:

Revision History:

Review Date	Revised Date	Approved By

PROVIDER ADVISORY COMMITTEE (PAC) NOMINATION PROCESS TIMELINE

ACTION	TIMELINE
Clerk of the Board will post Annual Appointment Liston GCHP Website.	Annually by December 31
Prepare ads for expiring seats and submit to Communications Director • § Communication Dept. approval •	Annually by December 8- 15
1. Ask for volunteers at March meetings to apply for Chair position 2. Ask for three to four PAC volunteers for Nominations ad hoc committee	Annually during first quarter PAC meeting
Deadline for applications at GCHP for Annual Vacancies(by February 2nd) – (GCHP will accept applications year-round)	Annually by February 2
Send Nominations binders with REDACTED applications to all members of Nominations ad hoc subcommittees for individual review and scoring	Annually by February 10
Convene PAC ad hoc subcommittee to review and recommend candidates/Chair to full Committee • Proposed slate of candidates • Proposed Chairperson	Annually by February 15
Submit FYI to execs regarding Nominations ad hoc recommendations for slate of candidates and Chairs	Annually w/in one week of ad hoc subcommittee review and recommendations
Proposed candidates/Chairs presented for consideration to full PAC Committees	Annually during first or second quarter PAC meeting depending on date of meeting.
Proposed candidates presented to Commission during April Commission meeting for consideration (and other appropriate times when a vacancy occurs)	Annually during April Commission Meeting
Thank departing members at June or July meeting	Annually during second quarter PAC meeting
Notify new PAC members of their selection after Board approval	Annually between May 1 - 15
Appointed members are sworn in by clerk of board officially take new positions	Annually during third quarter PAC and other times as needed.
New PAC representatives attend first Committee meeting. New chairperson presides.	Annually during third quarter PAC meeting and other times as needed

AGENDA ITEM 2b

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: February 24, 2014

RE: FY 2013-14 Financial Audit Contract

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

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

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

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

- McGladrey has been working with the Plan since start-up and will be able to leverage relationships, knowledge of systems and operations,
- McGladrey has performed professionally and is dedicated to meeting the State deadlines,
- McGladrey has experience working with other health plans nationally and the local Medi-Cal market, and
- The audit pre-work for the FY2013-14 year will start early in 2014, which makes performing a procurement and completing contract negotiations very difficult in that timeframe. Plan staff has been busy with the implementation many Affordable Care

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

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

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

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

CONCURRENCE:
N/A

Attachments:
None.

AGENDA ITEM 2c

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operations Officer

Date: February 24, 2014

RE: ICD-10 Implementation Vendor

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

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

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

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

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

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

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

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

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

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

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

GCHP has budgeted $400,000 for ICD-10 implementation, assuming $40,000 per month for 10 months. Staff estimates that additional costs may be incurred for the purchase of a cross-walk tool, services of a certified coder to analyze and map the codes, provider outreach and education materials, provider technical support and internal/external testing resources.

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

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

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

CONCURRENCE:
N/A

Attachments:
None.

AGENDA ITEM 3a

To: Gold Coast Health Plan Commission

From: Michael Engelhard, Chief Executive Officer

Date: February 24, 2014

Re: CEO Update

COMMISSION

Commissioner Fisler has resigned from her position at the County and therefore the position on the GCHP Commission. The County is in process of finding a replacement.

FINANCE UPDATE

DHCS Rates

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

- DHCS is in the process of submitting several rates to the Centers for Medicare and Medicare Services (CMS) for approval. Those rate submissions impacting GCHP include rates for the new Adult Expansion population (which are expected to be submitted the week of February 10, 2014 to CMS) and the new Mental Health benefit (which are expected to be submitted in early March).
- It is not certain when CMS will approve the rates; however DHCS has begun to pay GCHP the new Adult Expansion rate in January and may pay a placeholder rate for the new Mental Health Benefit in the February / March time period. The medical costs associated with the new mental health benefit are estimated to be $200,000 per month. GCHP would need to cover these estimated medical expenses until State reimbursement is made available.
- DHCS and their consultants reviewed the Health Insurance Provider Fee calculation, which is a new fee under the Affordable Care Act. Although GCHP does not meet the definition of a “covered entity” and therefore will not pay the fee, GCHP did ask for clarification regarding the obligation of “covered entities” that contract with us.
- DHCS reviewed components of the ACA 1202 Compliance Plan and reconciliation of payments (this is discussed more in the next item).

ACA 1202 Physician Payment
The following are updates related to the ACA 1202 Physician Payment increase:

- Gold Coast Health Plan (GCHP) has received funding from California Department of Health Care Services (DHCS) for the ACA 1202 PCP Rate increase for period of January 1, 2013 to June 30, 2013. GCHP has begun to process retroactive payments to eligible, attested providers. Subsequent payments will be processed as funding is received from DHCS.

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

- GCHP has revised and resubmitted (on January 31, 2014) an updated version of the required DHCS compliance plan to DHCS for final review and approval.

- DHCS communicated the process that will take place to reconcile payments received by GCHP to payments made to GCHP providers. Staff is currently analyzing the reconciliation clarifications provided by DHCS on February 11, 2014 and determining any impact to process and payment amounts.

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

OPERATIONS UPDATE

ACA-Health Care Reform and Medicaid Expansion

Membership
GCHP membership continued to grow in February due to ACA and Medi-Cal expansion. Since January the Plan has added 9,633 new members - 8,083 from the ACE / LIHP program and 1,550 new Medi-Cal Expansion members. Total Enrollment as of February was approximately 131,000.

DHCS Outreach to CalFRESH Beneficiaries
On February 3, 2014 DHCS sent notices to 12,352 CalFRESH (California's food stamp program) adult beneficiaries in Ventura County advising them that they are eligible for Medi-Cal through an "Express Lane" eligibility process. A federal waiver allows DHCS to

grant Medi-Cal eligibility without the need for an application or a determination for 12 months by using CalFRESH income eligibility for enrolled adults. By having enrollment into CalFRESH, income and residency has been established and DHCS will need to conduct necessary citizenship and identity verifications to comply with federal Medicaid regulations. GCHP is expected to see an increase in membership due from CalFRESH beneficiaries beginning in March.

Mental Health Benefit

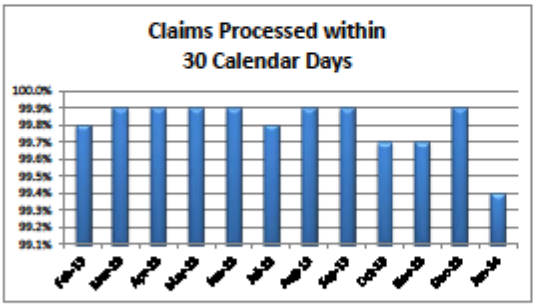
GCHP's contracted behavioral health management organization (BHMO), Beacon Health Strategies (Beacon), has received 198 member calls and 7 provider calls since the addition of the Mental Health Benefit in January. The daily call volume rose in February from an average of 9 calls per day in January to 30 calls per day in February.

Approximately 30 members have been referred for mild to moderate behavioral health services since January. GCHP's Medical team worked collaboratively with Beacon and County Mental Health to develop training and assessment tools to identify the level of care needed. This has resulted in four successful and appropriate transfers to the County Mental Health program for higher acuity mental health services.

Beacon has solicited contracts from 260 providers and 239 or 92% have signed contracts to provide behavioral health services to GCHP's members.

Claims Processing Turnaround Time

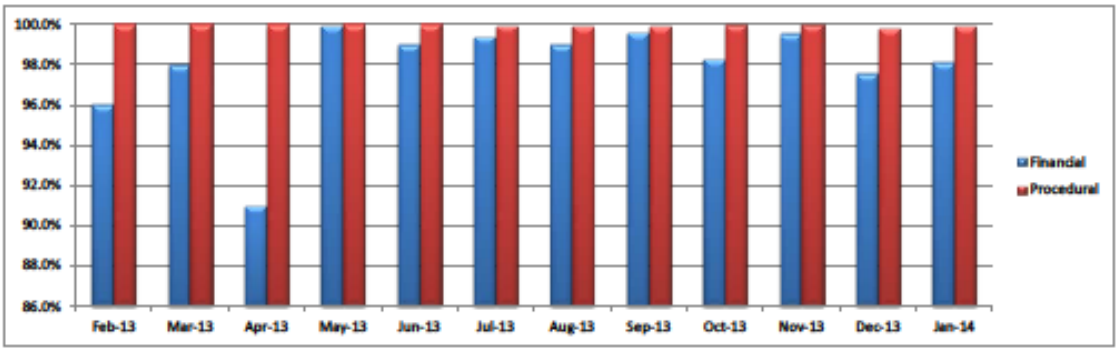
December	1-30 Days		31-45 Days		46-60 Days		Over 60 Days		Total Claims
	#	%	#	%	#	%	#	%	
Clean Claims	110,521	99.92	48	0.04	5	0	41	0.04	110,615
Contested Claims	2,835	100	0	0	0	0	0	0	2,835
Total Claims	113,356	99.92	48	0.04	5	0	41	0.04	113,450



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

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

Claims Processing Accuracy



	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
Financial	96.0%	98.0%	91.0%	99.9%	99.0%	99.4%	99.0%	99.59%	98.27%	99.54%	97.56%	98.10%
Procedural	100.0%	100.0%	100.0%	100.0%	100.0%	99.95%	99.9%	99.9%	99.96%	99.97%	99.79%	99.94%

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

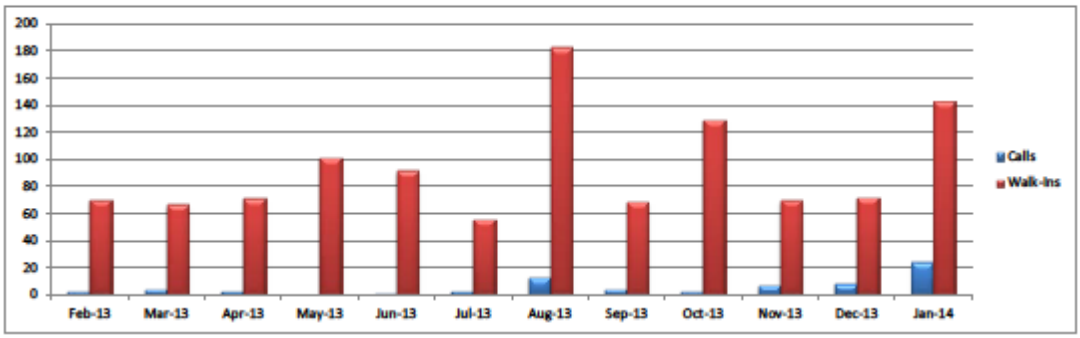
Claims Inventory Summary

Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
16,581	16,029	9,350	12,385	16,554	16,601	21,894	22,590	21,051	24,585	12,924	13,999

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

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

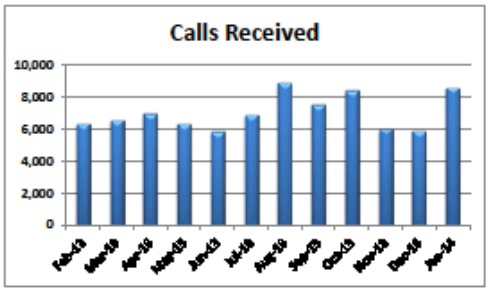
Oxnard Member Services Activity

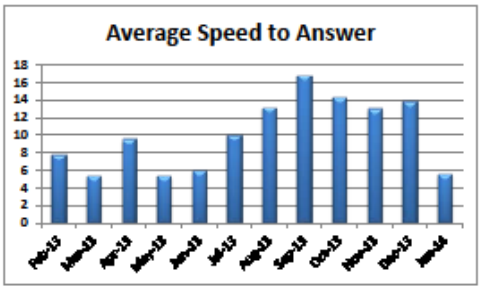


	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
Calls	2	4	3	0	1	3	13	4	2	7	8	24
Walk-Ins	70	67	71	101	92	56	183	69	129	70	72	143

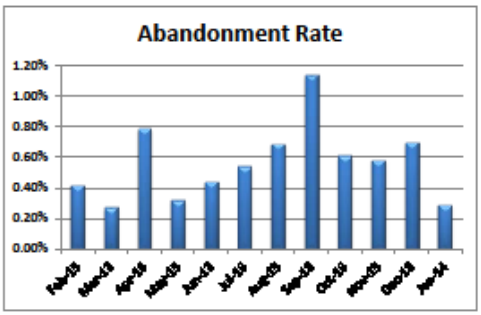
Note: August 2013 walk-in increase due to Healthy Families transition; October 2013 increase not directly associated with one issue; January 2014 increase due to LIHP transition.

Xerox Call Center Activity

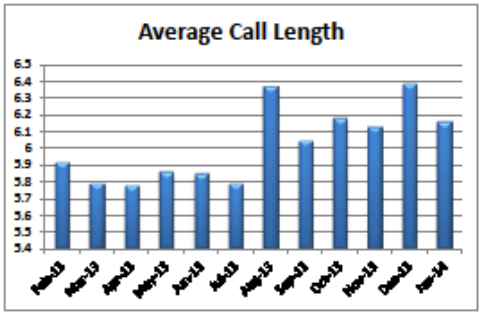




Goal: 30 seconds or less



Goal: 5% or less



Goal: 7 minutes or less

COMPLIANCE UPDATE

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

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

The Medical Loss Ratio Evaluation data request was provided to the Plan on January 23, 2014, with data requests due back no later than March 3, 2014. An entrance call was held on January 29, 2014 between DHCS, DMHC and the Plan. Test files were requested by DMHC and the Plan submitted the files on February 13, 2014. The onsite audit is slated for March 2014.

Fraud, Waste and Abuse Training is ongoing. A change for 2014 is fraud waste and abuse training will be web-based starting February 2014 as we have engaged a contract with a new vendor, Bridgefront. This training module is currently utilized by other Medi-Cal Health Plans. Compliance staff continues to attend the quarterly fraud detection meetings held by the Department of Justice.

In January 2014 the compliance / fraud hotline received five calls. In February 2014 the Plan has received five calls. All calls were routed to the applicable agency and or internal department.

All employees are required to attend HIPAA training on an annual basis. The Plan is in compliance with this requirement and all employees attend training. An unannounced HIPAA internal audit was conducted in fourth quarter of 2013 and the results were provided to leadership by department. A second audit was conducted in February 2014 and results are currently being compiled. Compliance staff is in the process of evaluating a new HIPAA training program that other health plans currently utilize. The training is robust and meets the necessary requirements.

Credentialing audits were conducted on three medical groups the Plan delegates credentialing to in January 2014. The reports from the audits are currently in the process of being finalized. The results from the credentialing audits will be presented to the delegation oversight committee, quality improvement committee and the compliance committee.

GOVERNMENT AFFAIRS UPDATE

Single Statewide Drug Formulary

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

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

FQHC / RHC Payment Reform

DHCS has circulated a draft proposal concerning payment reform for federally qualified health centers (FQHC) and rural health clinics (RHC). The California Association of Health Plans (CAHP) is collecting comments to provide to DHCS.

Medi-Cal Pregnant Women

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

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

CalFresh

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

categories which include: 7W-those under 19 years of age and 7S-parents of eligible children.

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

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

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

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

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

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

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

Draft regulations are expected to be approved at the February 20, 2014 Covered California Board meeting. Training modules are expected to begin in mid-to-late March. Certified Application Counselors (CAC) will be required to undergo background checks, which will be paid for by the participating Plan. Access to CalHEERS will be granted to CACs once the individual passes the exam and clears the background check.

Legislature and Legislation
The State Legislature is in the second year of a two-year session which ends on August 31, 2014. The deadline to introduce bills in both Assembly and Senate is February 21, 2014. The Assembly has elected a new Speaker, Toni Atkins who represents the San Diego area. The Senate is scheduled to elect a new Pro-Tem who is said to be Kevin de Leon who represents the downtown Los Angeles area. In this session healthcare bills will be focusing on "clean-up" legislation to complete implementation of the federal Affordable Care Act as well as legislation associated with mental health parity.

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

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

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

AB 809 **(Logue R) Healing arts: telehealth.**
Summary: Current law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. This bill would require the health care provider

initiating the use of telehealth at the originating site to obtain verbal or written consent from the patient for the use of telehealth, as specified. The bill would require that health care provider to document the consent in the patient's medical record and to transmit that documentation with the initiation of any telehealth to any distant-site health care provider from whom telehealth is requested or obtained.

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

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

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

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

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

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

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

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

SB 306 **(Torres D) Nursing: licensing criteria.**
Summary: Current law, the Nursing Practice Act, until January 1, 2016, provides for the licensure and regulation of registered nurses by the Board of Registered Nursing. Current law prohibits a person from engaging in the practice of nursing, as defined, without holding a license which is in an active status issued under the act, except as specified. Current law authorizes every licensee to be known as a registered nurse and to place the letters "R.N." after his or her name.

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

SB 500 **(Lieu D) Medical practice: pain management.**
Summary: Current law required the Medical Board of California to develop standards before June 1, 2002, to ensure the competent review in cases concerning the management, including, but not limited to, the undertreatment, undermedication, and overmedication of a patient's pain. This bill would require the board, on or before July 1, 2015, to update those standards. The bill would require the board to convene a task force to develop and recommend the updated standards to the board. The bill would also require the board to update those standards on or before July 1 each 5th year thereafter.

SB 506 **(Hill D) Ephedrine: retail sale.**
Summary: Would provide that it is a misdemeanor, punishable as specified, for a retail distributor, except pursuant to a valid prescription from a licensed practitioner with prescriptive authority, to sell or distribute to a person specified amounts of nonprescription products containing ephedrine, pseudoephedrine, norpseudoephedrine, or phenylpropanolamine within specified time limits, to sell or distribute any of those substances to a person whose information has generated an alert, or, except under specified conditions, to sell or distribute to a purchaser a nonprescription product containing any amount of those substances.

SB 508 **(Hernandez D) Medi-Cal: eligibility.**
Summary: Current law requires, with some exceptions, a Medi-Cal applicant's or beneficiary's income and resources be determined based on modified adjusted gross income (MAGI), as specified. Current law requires the State Department of Health Care Services to establish income eligibility thresholds for those eligibility groups whose eligibility will be determined using MAGI-based financial methods. This bill would codify the income eligibility thresholds established by the department and would make other related and conforming changes.

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

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

SB 841 **(Cannella R) University of California: medical education.**
Summary: Would express findings and declarations of the Legislature relating to the role of the University of California with respect to access to health care in the San Joaquin Valley.

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

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

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

SB 966 **(Lieu D) Drug Medi-Cal.**
Summary: Current law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal) under which the State Department of Health Care Services is authorized to enter into contracts with counties for the provision of various drug treatment services to Medi-Cal recipients, or is required to directly

arrange for the provision of these services if a county elects not to do so. Current law defines Drug Medi-Cal reimbursable services for purposes of these provisions.

SB 972 **(Torres D) California Health Benefit Exchange: board: membership.**
Summary: Current law created the California Health Benefit Exchange (Exchange) as an independent public entity in the state government, not affiliated with an agency or department. The Exchange is governed by an executive board consisting of 5 members who are residents of California. This bill would increase the number of board members from 5 to 7, with the 2 additional board members being appointed by the Governor. The bill would also add marketing of health insurance products, information technology system management, management information systems, and consumer service delivery research and best practices to the list of areas of expertise.

SB 974 **(Anderson R) California Health Benefit Exchange: confidentiality of personal information.**
Summary: Would prohibit the Exchange, or any of its employees, agents, subcontractors, representatives, or partners from disclosing an individual's personal information, as defined, to any other person or entity without explicit permission from the individual. The bill would also require the Exchange to report a disclosure of personal information in violation of these provisions to the individuals affected and to the appropriate policy committees of the Legislature within 5 business days of the date the disclosure is discovered.

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

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

SB 1002 **(De León D) Medi-Cal: redetermination.**
Summary: Would require a county, when a redetermination is performed due to a change in circumstances, and the county received the information about

the change in circumstance in a CalFresh application, or gathered the information about the change in circumstances during a CalFresh redetermination, and the beneficiary is determined eligible to receive CalFresh benefits, to begin the new 12-month eligibility period on a date that would align the beneficiary's Medi-Cal eligibility period with his or her household CalFresh certification period. The bill would also require the county, in certain circumstances, to begin a new 12-month Medi-Cal eligibility period that would align a beneficiary's eligibility period with his or her CalFresh household certification period.

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

HEALTH EDUCATION AND COMMUNITY OUTREACH UPDATE

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

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

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

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

Date	Event / Activities
01/03	La Hermandad – Food Distribution at Oxnard Police Activities League (PAL)
01/07	One Stop Community Multi-Service Program in Ventura
01/08	GCHP- Presentation at Oxnard Mexican Consulate
01/14	VCMC Baby Steps – OB Celebration at VCMC
01/15	West Park Community Center Food Distribution
01/17	Ventura County Office of Education Resource Fair "Taking it to the Teachers"
01/18	Community Informational Event at the Thousand Oaks Mall
01/21	Resource Fair at Fremont Intermediate School ELAC Parent Meeting
01/21	Resource Fair at Fremont Intermediate School ELAC Parent Meeting
01/21	GCHP- New Member Orientation Meeting (English)
01/22	GCHP- Presentation at Oxnard Mexican Consulate
01/23	GCHP- New Member Orientation Meeting (Spanish)
01/25	Jornadas Sabatina Resource Fair and Presentation at Oxnard Mexican Consulate
01/26	Jornadas Dominical Resource Fair at Oxnard Mexican Consulate
01/29	Agency 101 Resource Fair - Ventura County Children's System of Care
02/05	Covered California Forum at St. John's Hospital (Spanish)
02/05	Ventura County Transition Project / VCOE – Transition Fairs
02/07	Sheridan Way Family Center – Women's Health Breakfast
02/08	Community Informational Event at the Thousand Oaks Mall
02/08	Healthy Heart Fair at The Collection Riverpark
02/11	VCMC Baby Steps Program – OB Celebration
02/11	Ventura County Transition Project / VCOE – Transition Fairs
02/14	La Hermandad – Food Distribution at Oxnard Police Activities League (PAL)
02/18	GCHP- New Member Orientation Meeting (English)
02/19	West Park Community Center Food Distribution
02/20	GCHP Presentation at First 5 Ventura County – El Rio NFL
02/20	GCHP- New Member Orientation Meeting (Spanish)
02/24	GCHP Presentation at First 5 Ventura County – El Rio NFL
02/25	Ventura County Transition Project / VCOE – Transition Fairs

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

AGENDA ITEM 3b

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: February 24, 2014

Re: December 2013 Financials

SUMMARY

Staff is presenting the attached December, 2013 financial statements of Gold Coast Health Plan (Plan) for review by the Commission. Staff was not able to review this information with Executive / Finance Committee, as meeting on February 6th was cancelled.

BACKGROUND / DISCUSSION

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

Note that the budget amounts reflect the updated FY2013-14 budget approved by the Commission on 1/27/2014.

FISCAL IMPACT

Year-To-Date Results

On a year-to-date basis, the Plan's net income is approximately $9.1 million compared to $8.4 million assumed in the budget. These operating results have contributed to a Tangible Net Equity (TNE) level of approximately $21.0 million, which exceeds both the budget of $20.3 million by $0.7 million and the required TNE amount as of December 31st of $13.5 million (84% of $16.0 million) by $7.5 million. Note that beginning with this month, the required TNE increased with the final phase-in percentage; increasing from 68% to 84%. The required TNE phase-in percentage will remain at 84% until June 30, 2014 when it will be increased to 100%. As in prior reports, the Plan's TNE amount includes $7.2 million in lines of credit with the County of Ventura.

December Results

Other items to note for the month include:

Membership - The Plan's December membership was 120,275 which was lower than budget by 43 members.

Revenue – December net revenue was $27.7 million or $0.4 million lower than budget of $28.1 million. On a per member per month (PMPM) basis, net revenue was $230.35 PMPM or $3.63 PMPM less than the budget of $233.98 PMPM. Primary drivers contributing to the variance to budget include:

- Long-Term Care revenues were approximately $0.21 million lower than budget for the month due to negative retroactivity.
- Enrollment mix resulted in additional revenue shortfalls of approximately $0.19 million.

Health Care Costs – Health care costs for December were $23.5 million or approximately $1.0 million lower than budget. On a PMPM basis, reported health care costs for December were $195.02 versus a budgeted amount of $203.66. Primary drivers contributing to the variance to budget include:

- Reinsurance net recoveries and provider refunds reported of $1.8 million.
- Pharmacy, while lower than budget by $0.27 million, was higher than the previous month by $0.18 million due to increased utilization heading into the winter illness season.
- Long Term Care/Skilled Nursing Facility expenses were above budget by $0.95 million. It was noted that two of the Plan's larger LTC providers had an extremely high percentage of claims paid in December relating to prior months. This pattern caused an increase in the reserve calculation and the resulting expense in December.
- Outpatient hospital expense exceeded budget by $0.36 million, but was offset by lower inpatient hospital expense of $0.34 million.

Administrative Expenses - For the month, overall operational costs were approximately $2.0 million or $0.06 million better than budget. The main reason for the variance was that Consulting expense was $0.07 million lower than budget.

Cash + Medi-Cal Receivable - The total of Cash and Medi-Cal Premium Receivable balances of $84.3 million reported as of December 31, 2013 included a MCO Tax component amounting to $13.1 million. Excluding the impact of the tax, the total of Cash and Medi-Cal Receivable balance as of December 31, 2013 was $71.2 million, or $0.8 million lower than the budgeted level of $72.0 million.

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

Fixed Assets – During the month, the Plan's new Medical Management System (MMS) was implemented. The projected cost of the MMS was $1.43 million and was approved by the Commission in June 2013 for the current fiscal year. Cost incurred for the project through December is approximately $991,000.

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

CONCURRENCE
N/A

Attachments
December, 2013 Financial Package

Gold Coast Health Plan℠
A Public Entity

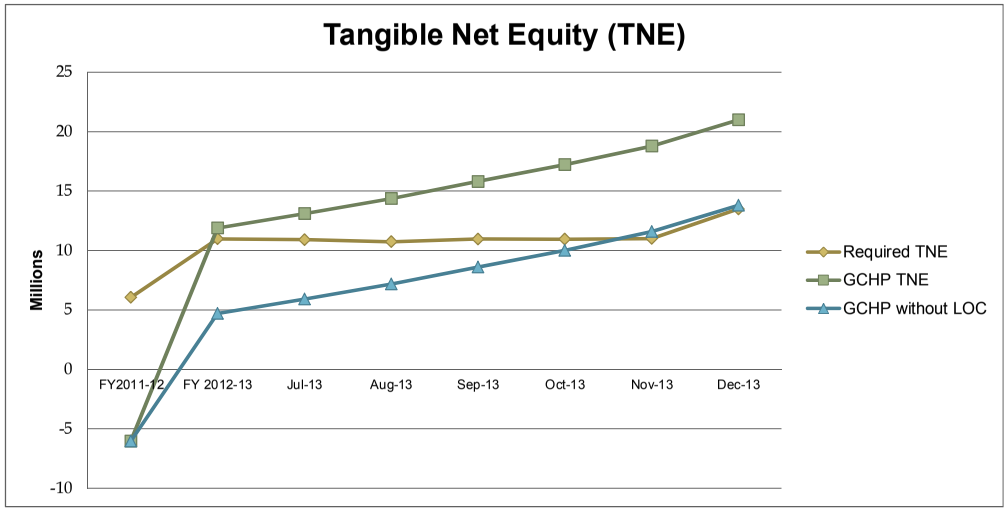
FINANCIAL PACKAGE
For the month ended December 31, 2013

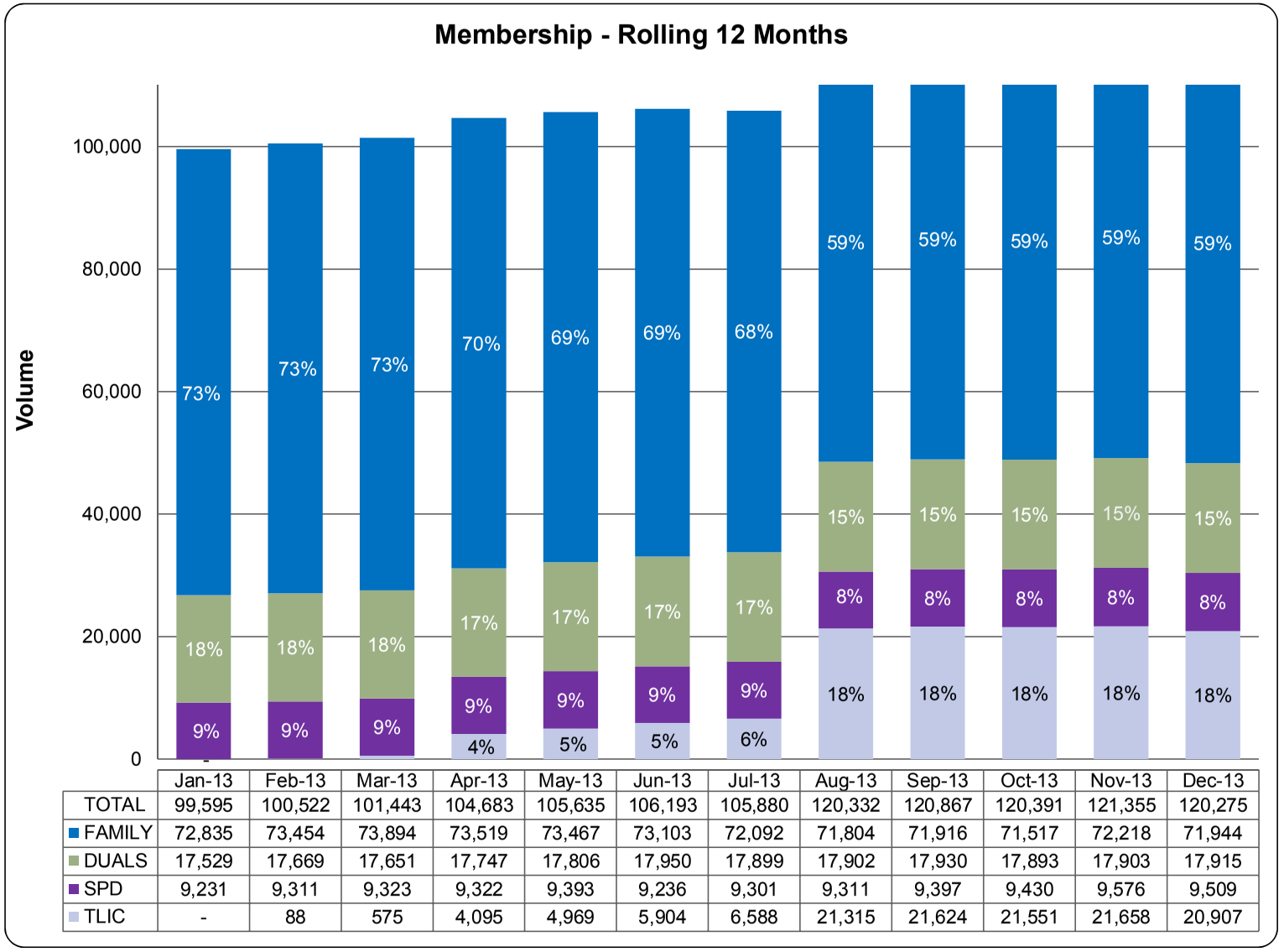
TABLE OF CONTENTS

Financial Overview

Description	AUDITED FY2011-12	AUDITED FY 2012-13	UNAUDITED FY 2013-14 Actual Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	YTD	Budget Comparison Budget YTD	Variance Fav/(Unfav)	Variance Fav/(Unfav) %
Member Months	**1,258,189**	**1,223,895**	105,880	120,332	120,867	120,391	121,355	120,275	**709,100**	**709,146**	(46)	(0.0)%
Revenue	**304,635,932**	**315,119,611**	**26,680,808**	**26,724,574**	**28,583,327**	**28,606,892**	**27,758,615**	**27,704,949**	**166,059,165**	**166,506,620**	(447,455)	(0.3)%
pmpm	*242.12*	*257.47*	*251.99*	*222.09*	*236.49*	*237.62*	*228.74*	*230.35*	*234.18*	*234.80*	(0.62)	(0.3)%
Health Care Costs	**287,353,672**	**280,382,704**	**23,496,673**	**23,572,589**	**24,806,270**	**25,054,919**	**24,356,007**	**23,456,586**	**144,743,045**	**145,790,632**	1,047,587	0.7 %
pmpm	*228.39*	*229.09*	*221.92*	*195.90*	*205.24*	*208.11*	*200.70*	*195.02*	*204.12*	*205.59*	1.46	0.7 %
% of Revenue	94.3%	89.0%	88.1%	88.2%	86.8%	87.6%	87.7%	84.7%	87.2%	87.6%	-0.4%	-0.5%
Admin Exp	**18,891,320**	**24,013,927**	**1,968,367**	**1,892,167**	**2,341,473**	**2,141,010**	**1,833,810**	**2,039,656**	**12,216,483**	**12,280,214**	63,731	0.5 %
pmpm	*15.01*	*19.62*	*18.59*	*15.72*	*19.37*	*17.78*	*15.11*	*16.96*	*17.23*	*17.32*	0.09	0.5 %
% of Revenue	6.2%	7.6%	7.4%	7.1%	8.2%	7.5%	6.6%	7.4%	7.4%	7.4%	0.0%	0.3%
Net Income	**(1,609,063)**	**10,722,980**	**1,215,767**	**1,259,818**	**1,435,584**	**1,410,963**	**1,568,798**	**2,208,708**	**9,099,638**	**8,435,774**	663,863	7.9 %
pmpm	*(1.28)*	*8.76*	*11.48*	*10.47*	*11.88*	*11.72*	*12.93*	*18.36*	*12.83*	*11.90*	0.94	7.9 %
% of Revenue	-0.5%	3.4%	4.6%	4.7%	5.0%	4.9%	5.7%	8.0%	5.5%	5.1%	0.4%	8.2%
100% TNE	16,769,368	16,138,440	16,035,509	15,766,043	16,112,437	16,107,422	16,168,860	16,056,217	16,056,217	16,118,801	(62,584)	(0.4)%
Required TNE	6,036,972	10,974,139	10,904,146	10,720,909	10,956,457	10,953,047	10,994,825	13,487,223	13,487,223	13,539,793	(52,570)	(0.4)%
GCHP TNE	**(6,031,881)**	**11,891,099**	**13,106,866**	**14,366,684**	**15,802,268**	**17,213,231**	**18,782,029**	**20,990,737**	**20,990,737**	**20,326,875**	**663,862**	**3.3 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**2,202,720**	**3,645,775**	**4,845,810**	**6,260,184**	**7,787,204**	**7,503,514**	**7,503,514**	**6,787,082**	**716,432**	**10.6 %**

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





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

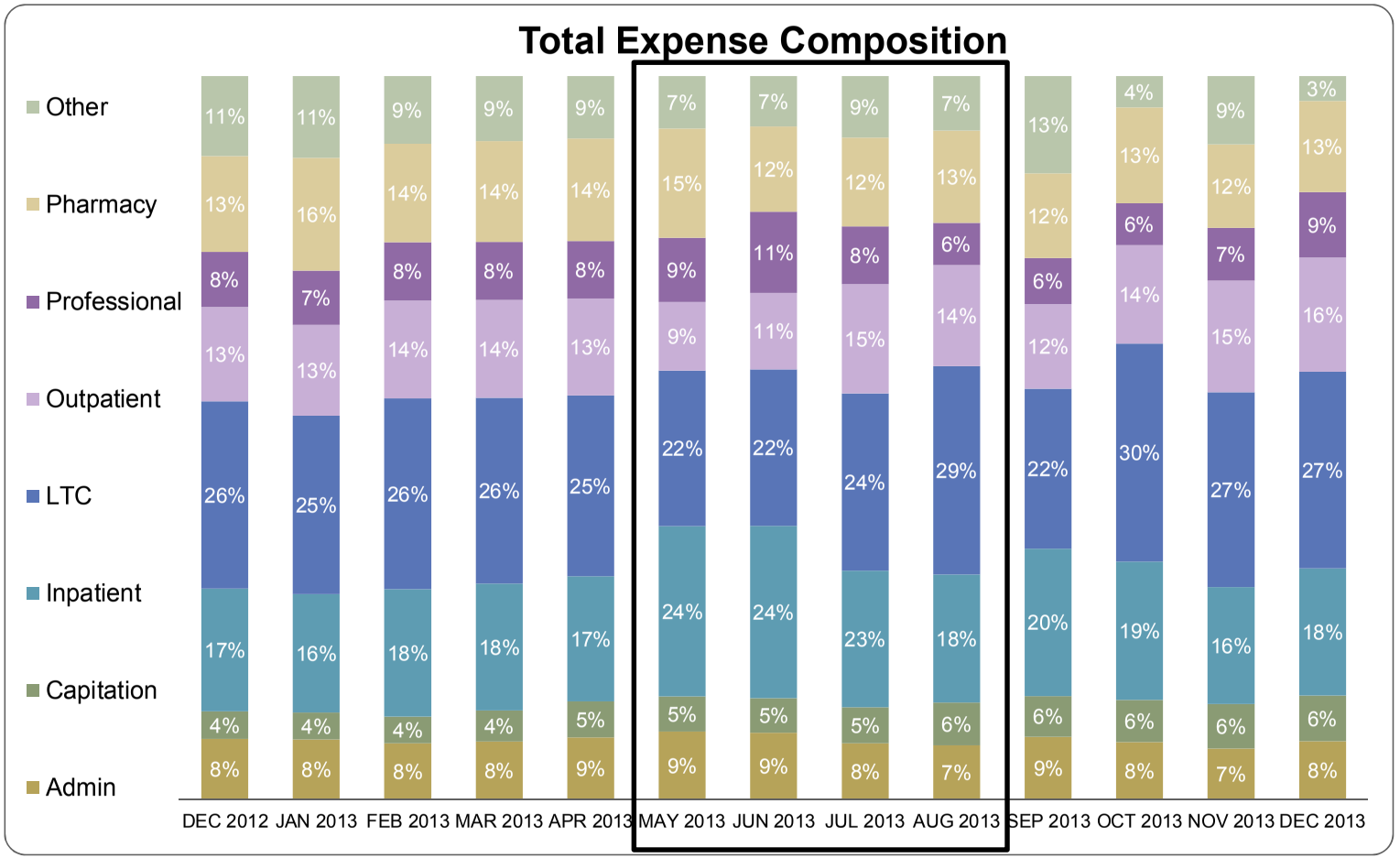
SPD = Seniors and Persons with Disabilities
TLIC = Targeted Low Income Children

Income Statement Monthly Trend

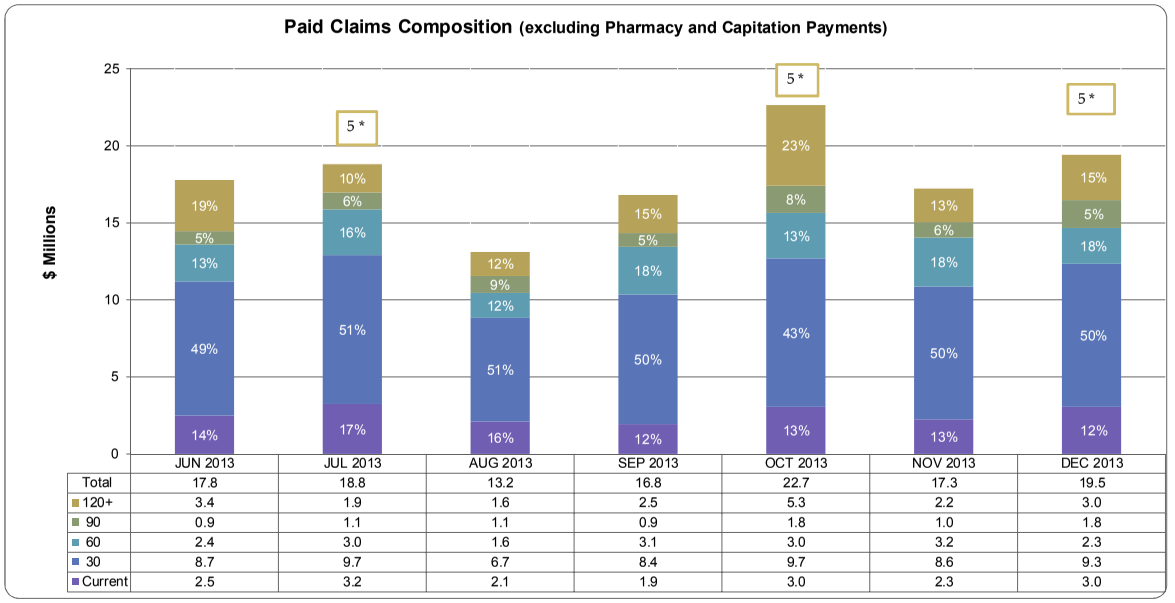
	2014 Actual Monthly Trend				Current Month		
	AUG 2013	SEP 2013	OCT 2013	NOV 2013	DEC 2013		Variance
					Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	120,332	120,867	120,391	121,355	120,275	120,318	(43)
Revenue:							
Premium	$ 27,789,352	$ 29,602,003	$ 29,980,945	$ 29,108,732	$ 29,047,006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

PMPM Income Statement Comparison

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

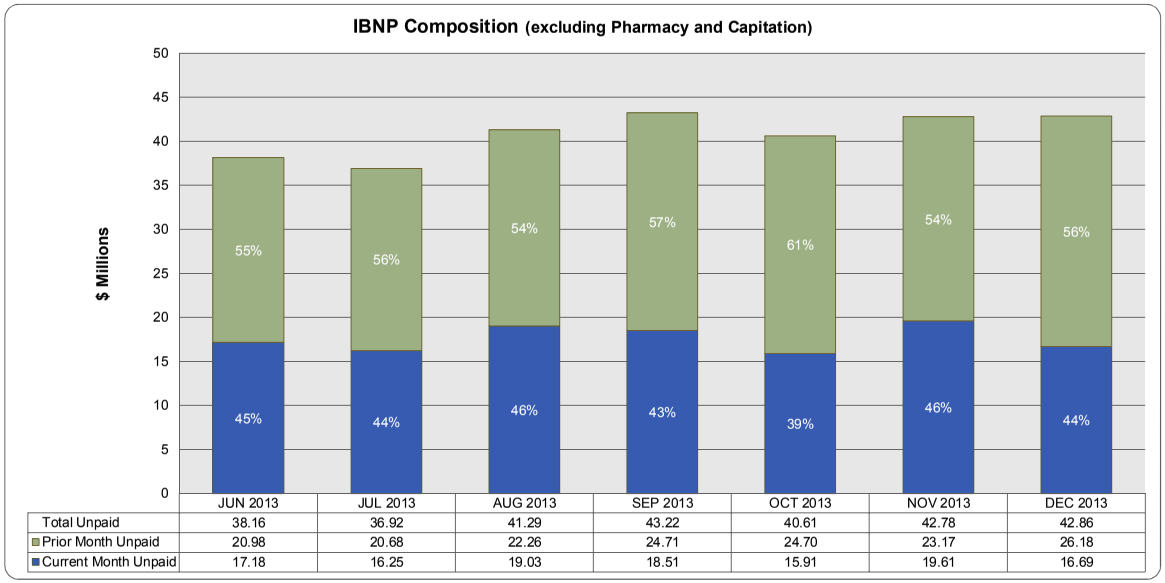


In May, GCHP changed its method of distributing Health Care Costs (HCC) across categories of service. Prior months utilized an allocation methodology. The methodology was updated to utilize payment information by different categories of services. Further changes have been made with the assumption of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



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

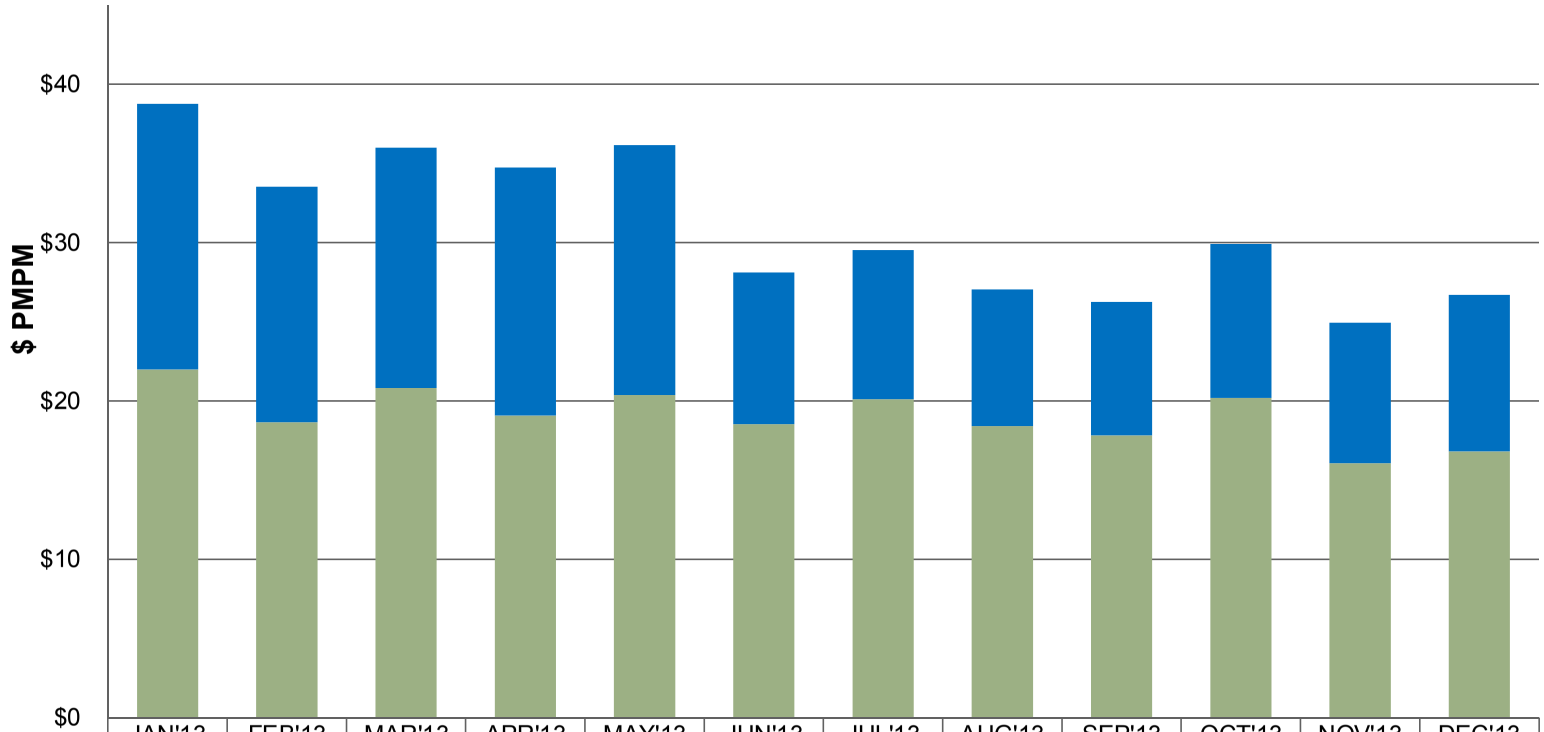
Note: **Paid Claims Composition** - reflects adjusted medical claims payment lag schedule.
* Months Indicated with 5* represent months for which there were 5 claim payments. For all other months, 4 claim payments were made.



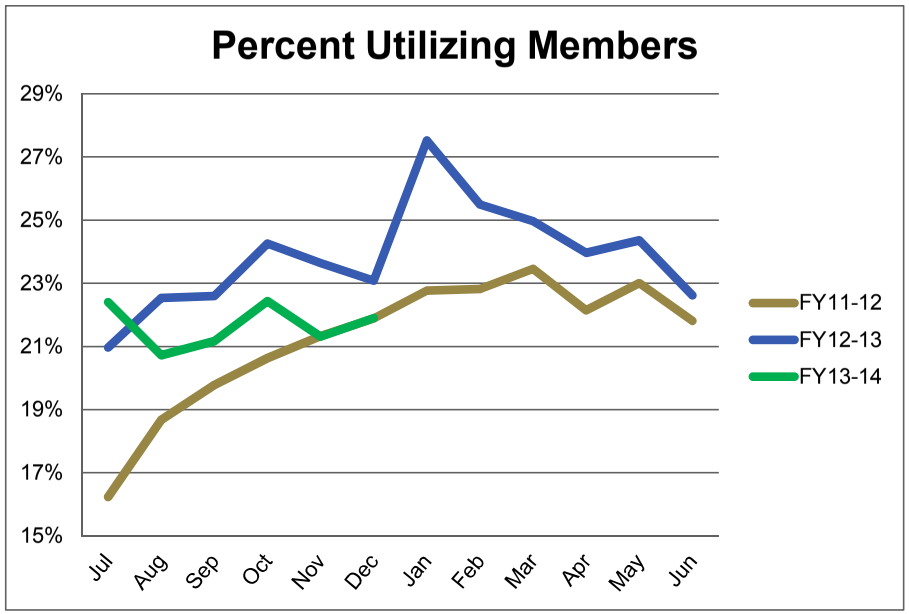
	JUN 2013	JUL 2013	AUG 2013	SEP 2013	OCT 2013	NOV 2013	DEC 2013
Total Unpaid	38.16	36.92	41.29	43.22	40.61	42.78	42.86
Prior Month Unpaid	20.98	20.68	22.26	24.71	24.70	23.17	26.18
Current Month Unpaid	17.18	16.25	19.03	18.51	15.91	19.61	16.69

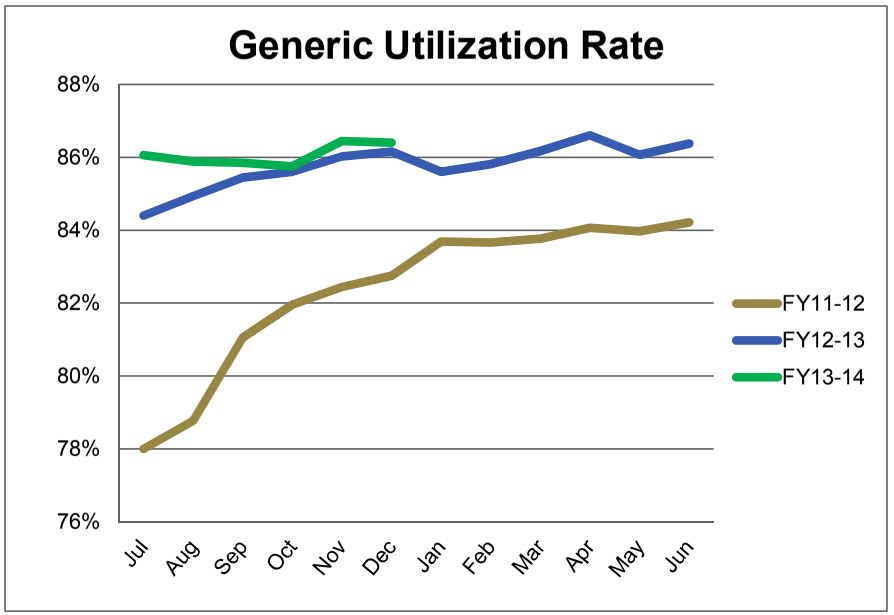
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

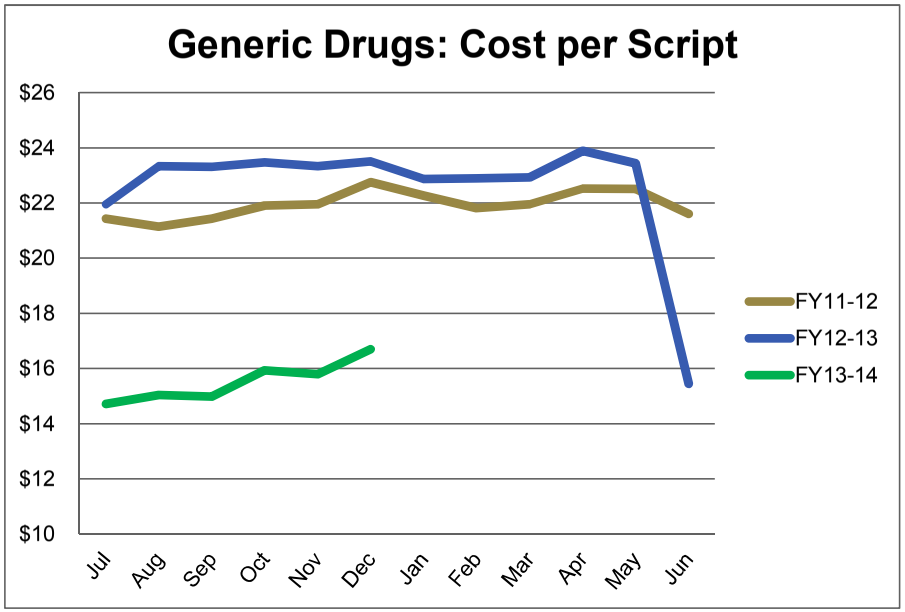
Pharmacy Cost Trend

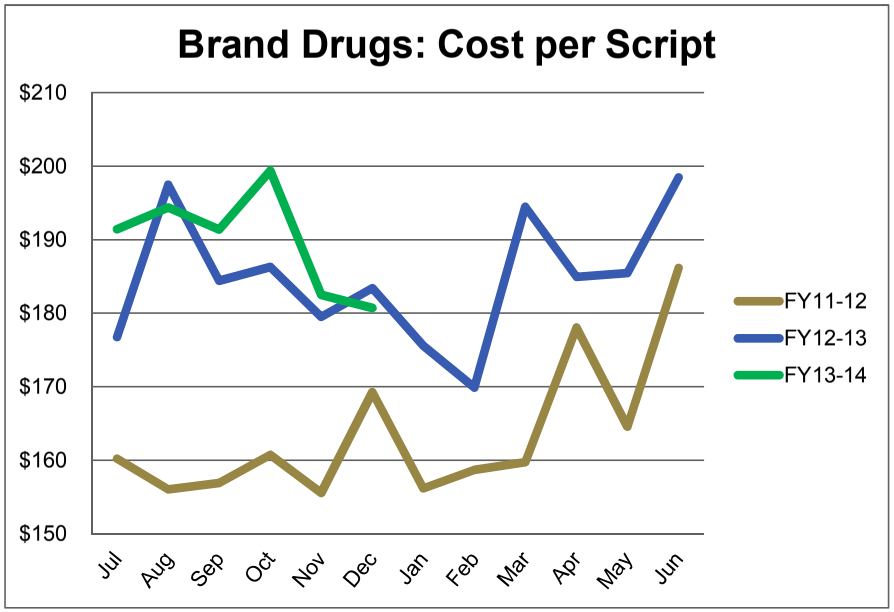


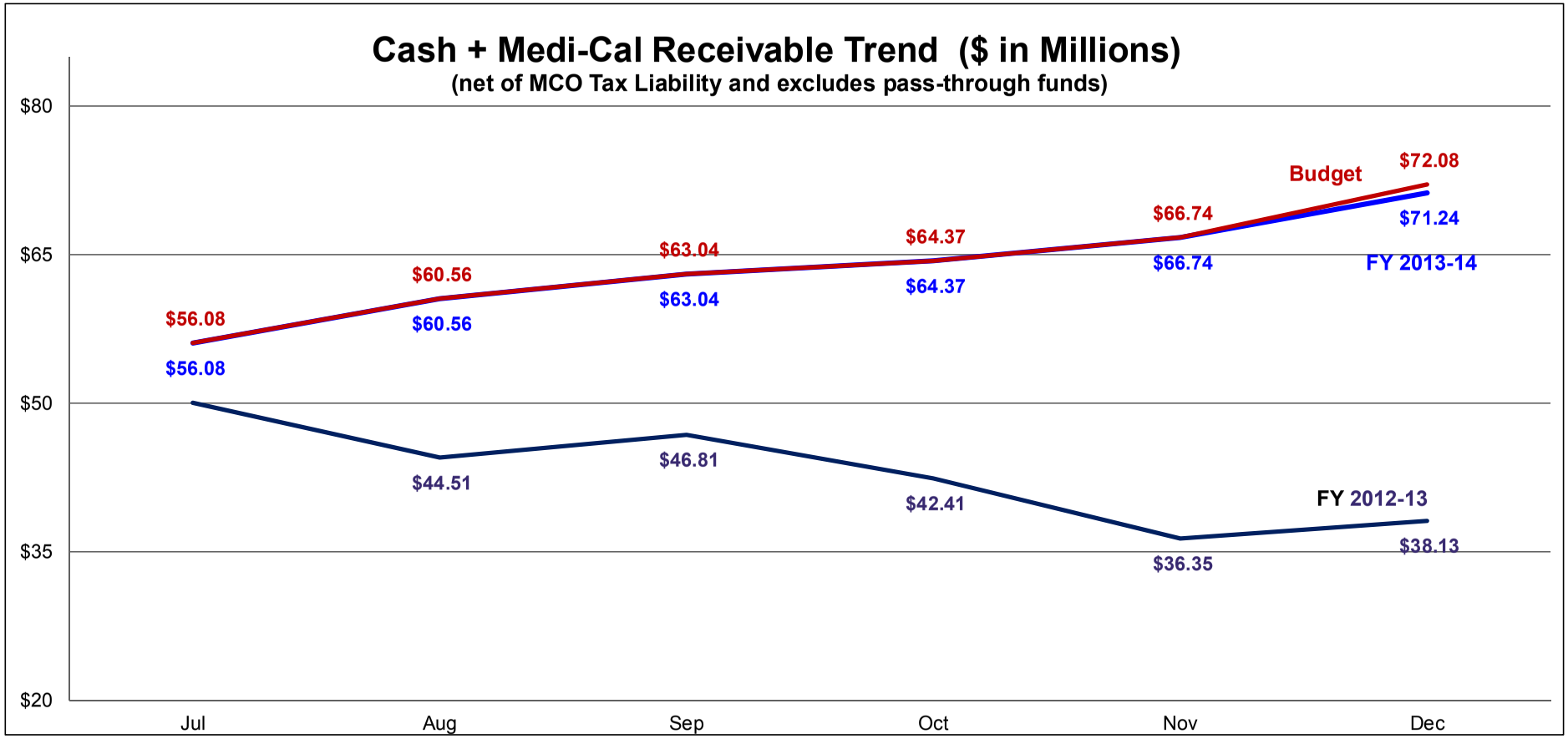
	JAN'13	FEB'13	MAR'13	APR'13	MAY'13	JUN'13	JUL'13	AUG'13	SEP'13	OCT'13	NOV'13	DEC'13
AVG PMPM	$38.75	$33.53	$35.99	$34.74	$36.15	$28.12	$29.53	$27.04	$26.24	$29.90	$24.94	$26.70
GENERIC	$16.77	$14.86	$15.16	$15.66	$15.78	$9.58	$9.43	$8.62	$8.41	$9.71	$8.87	$9.87
BRAND	$21.98	$18.66	$20.82	$19.08	$20.38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


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


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


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


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


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

Gold Coast Health Plan℠
A Public Entity

APPENDIX

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

Comparative Balance Sheet

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

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

Income Statement
For The Six Months Ended December 31, 2013

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

Statement of Cash Flows - Monthly

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

Statement of Cash Flows - YTD

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

AGENDA ITEM 4a

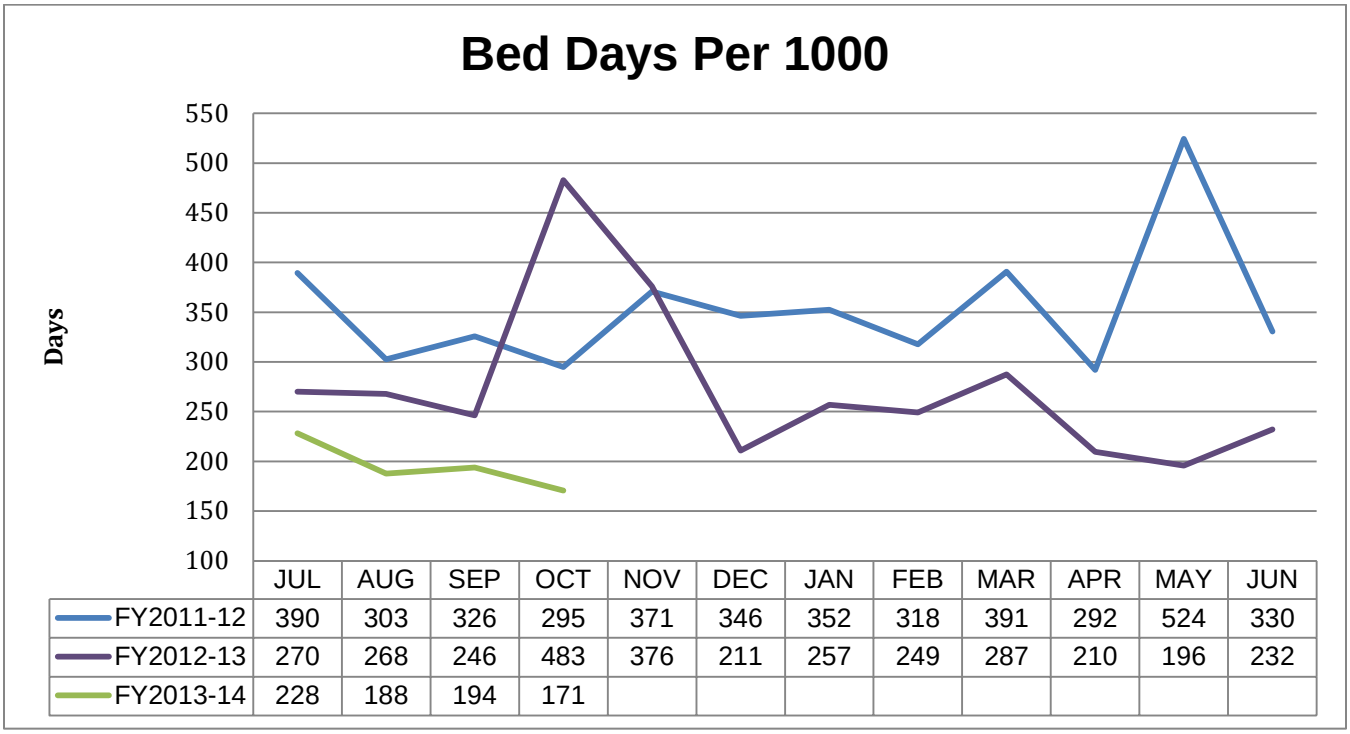
To: Gold Coast Health Plan Commissioners

From: Dr. Nancy Wharfield, Health Services Medical Director

Date: February 24, 2014

Re: Health Services Update

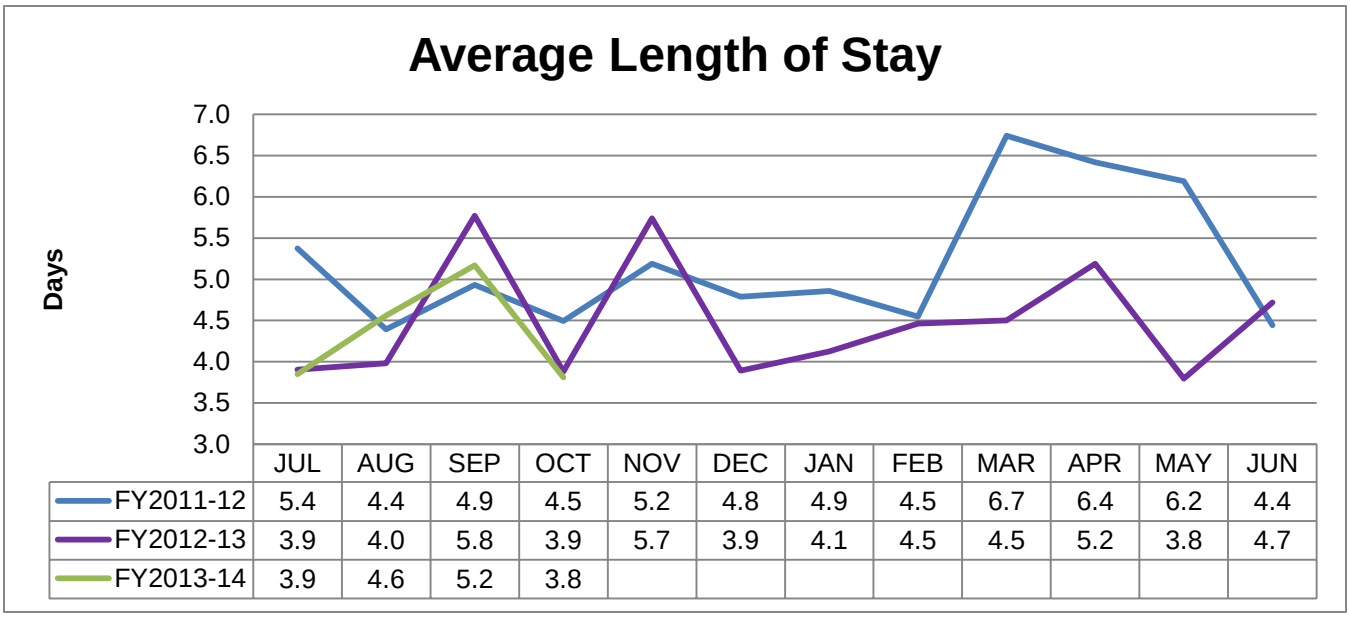
Inpatient Utilization
Inpatient bed days / 1000 members continues below 200 for August through October 2014. Improved bed days for the current fiscal year reflect increased number review staff and improved training. This information is based on paid claims and is lagged by 6 months to allow for adequate run-out of the data.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY2011-12	390	303	326	295	371	346	352	318	391	292	524	330
FY2012-13	270	268	246	483	376	211	257	249	287	210	196	232
FY2013-14	228	188	194	171								

Average Length of Stay

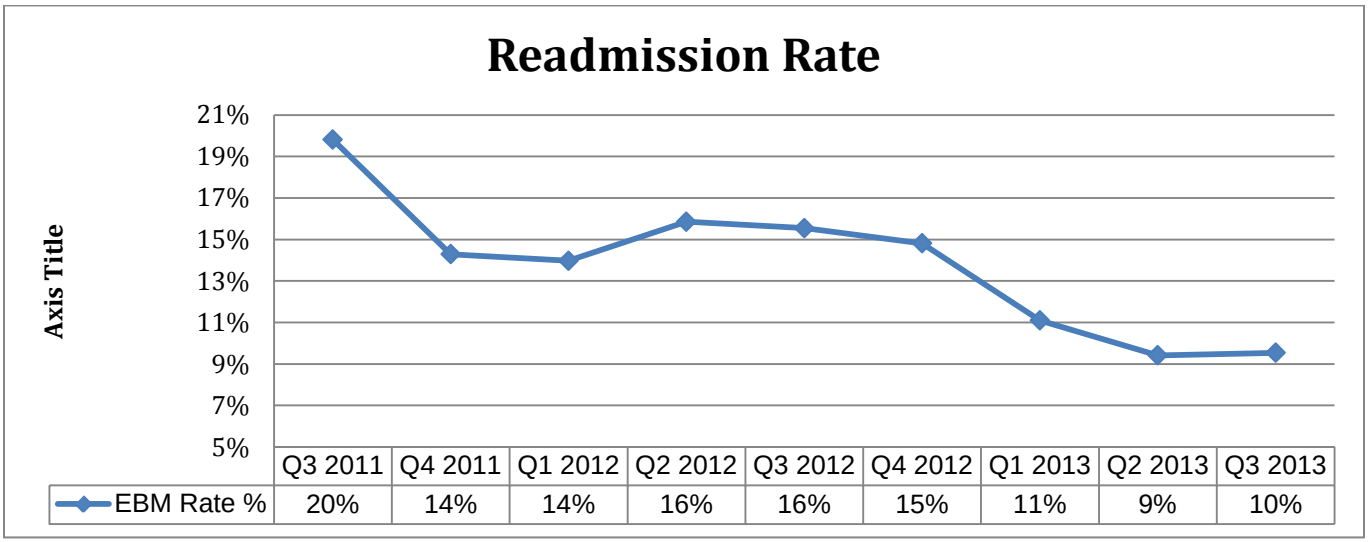
Length of stay has risen in each year of operation in September. Average length of stay by fiscal year continues to decline.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY2011-12	5.4	4.4	4.9	4.5	5.2	4.8	4.9	4.5	6.7	6.4	6.2	4.4
FY2012-13	3.9	4.0	5.8	3.9	5.7	3.9	4.1	4.5	4.5	5.2	3.8	4.7
FY2013-14	3.9	4.6	5.2	3.8								

Readmission Rate

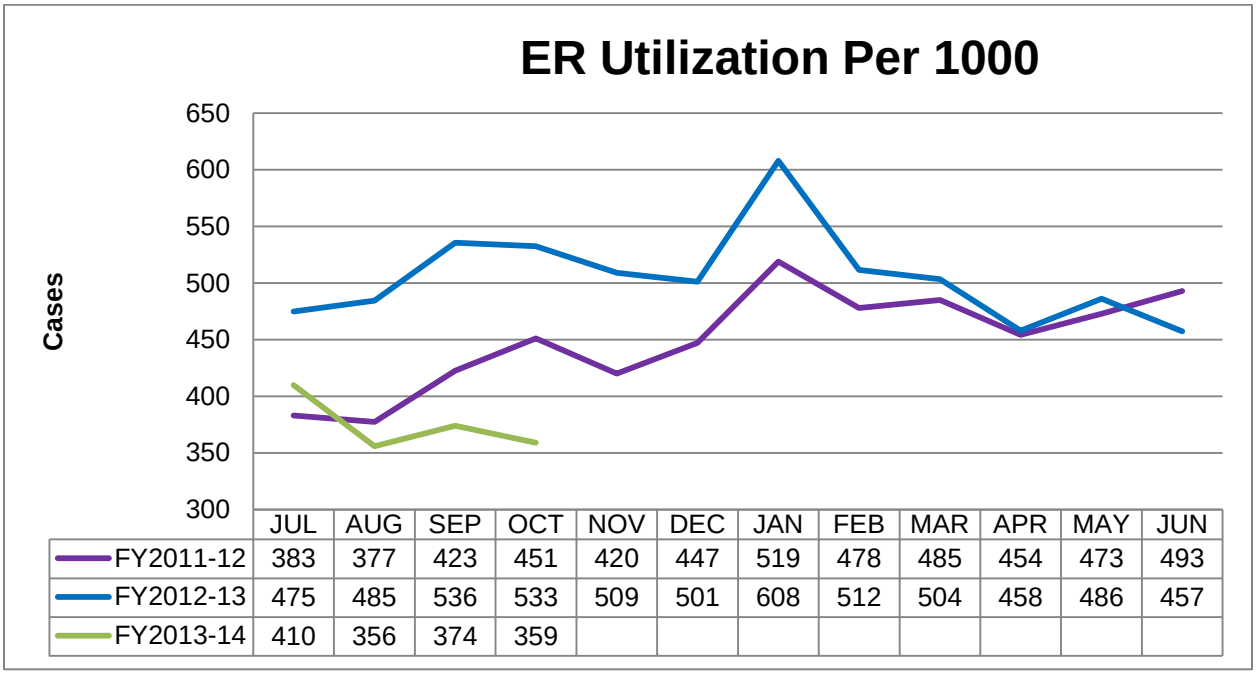
The all cause 30 day readmission rate has plateaued for the last 3 quarters. Plans to hire an onsite discharge nurse are in place to facilitate Transition Care for our most fragile members will enhance our efforts to prevent readmissions.



	Q3 2011	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013
EBM Rate %	20%	14%	14%	16%	16%	15%	11%	9%	10%

ER Utilization

Emergency room utilization per 1000 members is shown in the chart below. Significant improvement is shown for FY 2013-2014. Health Navigators continue to reach out to high utilizers to educate members regarding appropriate alternatives to emergency department visits and connect members to Care Management.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY2011-12	383	377	423	451	420	447	519	478	485	454	473	493
FY2012-13	475	485	536	533	509	501	608	512	504	458	486	457
FY2013-14	410	356	374	359								