

**Ventura County MediCal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)**

Regular Meeting

Monday, April 25, 2016, 3:00 p.m.

County of Ventura Government Center – Hall of Administration

Lower Plaza Assembly Room, 800 South Victoria Avenue, Ventura, CA 93009

AGENDA

CALL TO ORDER

ROLL CALL

OATH OF OFFICE

PUBLIC COMMENT

The public has the opportunity to address Ventura County Medi-Cal Managed Care Commission (VCMMCC) doing business as Gold Coast Health Plan (GCHP) on the agenda. Persons wishing to address VCMMCC should complete and submit a Speaker Card.

Persons wishing to address VCMMCC are limited to three (3) minutes. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission.

CONSENT CALENDAR

1. Minutes

Staff: Interim Clerk of the Board

RECOMMENDATION

Approve minutes of Regular Meeting of February 22, 2016, and Special Meeting of March 9, 2016.

2. Department of Health Care Services (DHCS) Contract Term Date Extension

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION

Approve the CEO to respond in writing to DHCS to accept the contract term date extension to December 31, 2017.

FORMAL ACTION ITEMS

3. Adoption of Resolution No. 2016-01 Amending the Bylaws to Establish Commissioners' Terms of Office

Presenter: Scott Campbell, General Counsel

RECOMMENDATION

Adopt Resolution No. 2016-01 as presented.

4. Election of Chairperson and Vice Chairperson to serve two-year terms and appointment of Executive/Finance Committee

Presenter: Scott Campbell, General Counsel

RECOMMENDATION

1. Elect a Commissioner to serve as Chairperson for a two-year term.
2. Elect a Commissioner to serve as Vice Chairperson for a two-year term.
3. Make appointments to the Executive/Finance Committee as follows:
 - a. Chairperson.
 - b. Vice Chairperson.
 - c. Private Hospital Healthcare Representative.
 - d. Ventura County Medical Health System Representative.
 - e. Clinicas Del Camino Real Representative.

5. Appointment of a New Member to the Human Resources Cultural Diversity (HRCD) Committee

Presenter: Scott Campbell, General Counsel

RECOMMENDATION

Appoint a new committee member to the HRCD Committee.

6. Benefit Enhancement – Pulmonary Rehabilitation

Staff: Nancy Wharfield, M.D., Associate Chief Medical Officer

RECOMMENDATION

Approve pulmonary rehabilitation as presented.

7. Benefit Enhancement – Podiatry

Staff: Nancy Wharfield, M.D., Associate Chief Medical Officer

RECOMMENDATION

Approve extension of podiatry services as presented.

8. Pharmacy Benefits Manager (PBM) Contract Extension

Staff: Anne Freese, Director of Pharmacy

RECOMMENDATION

Approve the extension of the current PBM contract for six (6) additional one month extensions.

9. Provider Advisory Committee Membership

Staff: Ruth Watson, Chief Operations Officer

RECOMMENDATION

Appoint the individuals listed in the report to the Provider Advisory Committee.

10. Quality Improvement 2015 Work Plan Evaluation and Yearly Quality Improvement Report

Staff: C. Albert Reeves, M.D., Chief Medical Officer

RECOMMENDATION

Approve the 2015 Quality Improvement Work Plan Evaluation and 2015 Quality Improvement Program Evaluation Summary.

11. Quality Improvement Program Description and Work Plan for 2016

Staff: C. Albert Reeves, M.D., Chief Medical Officer

RECOMMENDATION

Approve the 2016 Quality Improvement Program Description and Work Plan.

12. Policy Number QI-023 Potential Quality Issue Investigation and Resolution

Staff: C. Albert Reeves, M.D., Chief Medical Officer

RECOMMENDATION

Approve Policy Number QI-023 Potential Quality Issue Investigation and Resolution.

13. February 2016 Fiscal Year to Date Financials

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION

Accept and file the February 2016 Fiscal Year to Date Financials.

14. National Health Foundation: Ventura Recuperative Care Program

Staff: Ralph Oyaga, Executive Director for Government, Regulatory and External Relations

RECOMMENDATION

Approve the National Health Foundation sponsorship application request for thirty-eight thousand seven hundred (\$38,700) dollars for the Ventura Recuperative Care Program start-up costs.

15. Ventura County Area Agency on Aging: Senior Nutrition Program

Staff: Ralph Oyaga, Executive Director for Government, Regulatory and External Relations

RECOMMENDATION

Approve the Ventura County Area Agency on Aging sponsorship application request for twenty thousand (\$20,000) dollars for the Senior Nutrition Program.

REPORTS

16. Chief Executive Officer (CEO) Update

RECOMMENDATION

Accept the CEO Report as presented.

17. Employee Satisfaction Results

RECOMMENDATION

Accept and file the Employee Satisfaction Results.

18. Chief Medical Officer (CMO) Update

No reportable action for March Update.

19. Health Education Update

RECOMMENDATION

Accept the Health Education Report as presented.

20. Health Services Update

RECOMMENDATION

Accept the Health Services Report as presented.

21. Chief Operations Officer (COO) Update

RECOMMENDATION

Accept the COO Report as presented.

22. Network Adequacy Report

RECOMMENDATION

Accept the Network Adequacy Report as presented by Chief Operations Officer Ruth Watson.

23. Chief Information and Strategy Officer (CISO) Update

RECOMMENDATION

Accept the CISO Report as presented.

24. Chief Diversity Officer (CDO) Update

RECOMMENDATION

Accept the update as presented and provide direction on the recruitment of the Chief Diversity Officer.

CLOSED SESSION

25. CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION

Paragraph (1) of subdivision (d) of Section 54956.9

Clinicas Del Camino Real Inc. v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan, Ventura County Superior Court Case No. 56-2014-00456149-CU-BC-VTA

26. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION

Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: Two Cases

27. PUBLIC EMPLOYEE PERFORMANCE EVALUATION

Title: Chief Executive Officer

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on May 23, 2016, in the County of Ventura Government Center, Hall of Administration – Multipurpose Room, 800 South Victoria Avenue, Ventura, CA 93009.

Administrative Reports relating to this agenda are available at 711 East Daily Drive, Suite #106, Camarillo, California, during normal business hours and on <http://goldcoasthealthplan.org>. 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.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5509. Notification for accommodation must be made by the Thursday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

This agenda was posted on Wednesday, April 20, 2016 at 4:30 p.m. at the Gold Coast Health Plan Notice Board and on its website.



AGENDA ITEM NO. 1

To: Gold Coast Health Plan Commission

From: Magdalen Gutierrez-Roberts, Exec. Assistant to Ruth Watson / Interim Clerk

Date: April 25, 2016

Re: Approval of Minutes

RECOMMENDATION:

Staff requests approval of the Regular Meeting minutes of February 22, 2016, and the Special Meeting of March 9, 2016.

ATTACHMENTS:

Regular Meeting Minutes: February 22, 2016

Special Meeting Minutes: March 9, 2016

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

Antonio Alatorre
Lanyard Dial, M.D.
Supervisor Peter Foy
Michelle Laba, M.D.
Gagan Pawar, M.D.

Shawn Atin
Barry Fisher
David Glycer
Darren Lee
Dee Pupa

Dale Villani
Patricia Mowlavi
C. Albert Reeves, M.D.

Ruth Watson
Scott Campbell
Melissa Scrymgeour

February 22, 2016

The Commission met in regular session in the Lower Plaza Assembly Room at the County of Ventura Government Center – Hall of Administration, 800 South Victoria Avenue, Ventura, California. The meeting was called to order by Commissioner Alatorre at 3:06 p.m.

ROLL CALL

Present: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

Absent: Supervisor Peter Foy, and Gagan Pawar, M.D.

Commissioner Alatorre presided.

PLEDGE OF ALLEGIANCE

Commissioner Alatorre led the Pledge of Allegiance.

PUBLIC COMMENT

SPEAKERS

Members of the Public: Joe Hoffman on behalf of Oxnard Drug, Nader Djahangiri on behalf of Herbay Pharmacy – Script Care, Ali Karandish on behalf of Stan’s Drugs, Amy Cansler on behalf of Script Care, Frank Messina on behalf of Script Care, Kevin Brown on behalf of Script Care, Carlos Varela on behalf of Medicine Shoppe #387, Amani Hishmeh on behalf of Medicine Shoppe of Ojai, Mukesh “Max” Rai on behalf of Script Company Inc., Ramesh Paminaii on behalf of Medicine Shoppe #383, Christina Velasco on behalf of Clinicas del Camino Real. All of the individuals listed spoke regarding Agenda Item No. 9 – Pharmacy Benefits Manager (PBM) Request for Proposal (RFP) Finalist Selection. Diego Herrera spoke in regards to Ventura County Medical Center - Patient Safety.

DOCUMENTS

Handout: Diego Herrera.

Commissioner Foy arrived at 3:20 P.M.

CONSENT ITEMS

1. Minutes

RECOMMENDATION

Approve minutes of regular meetings of January 25, 2016 with correction on item No. 17 vote – Commissioner Glycer was not present.

Commissioner Fischer moved to approve the recommendation. Commissioner Dial seconded. The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

2. Financials – December 2015

RECOMMENDATION

To accept the Financial Reports as presented for December of 2015.

DISCUSSION

Chief Financial Officer (CFO) Patricia Mowlavi stated the financials were vetted thoroughly in the Executive / Finance committee.

Commissioner Glycer moved to approve the recommendation. Commissioner Pupa seconded. The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, David Glycer, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

FORMAL ACTION ITEMS

3. **Proposed Resolution Amending the Bylaws to Establish Commissioners' Terms of Office**

RECOMMENDATION

Receive the proposed Resolution and approve the Resolution at the March 28, 2016 Commission Meeting.

DISCUSSION

Counsel stated the Resolution would clarify election terms for both Chair and Vice Chair. Terms would be staggered.

General Counsel Scott Campbell presented the proposed resolution to amend the bylaws and adopt the change at the next Commission meeting in March. The purpose is to make certain that elections of the Chair, Vice Chair of the Commission and appointments of the Executive / Finance Committee occur after the County has completed their appointment process.

Commissioner Foy moved to receive the recommendation. Commissioner Fisher seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, David Glycer, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

4. **Approval of Healthcare Effectiveness Data and Information Set (HEDIS) Vendor**

RECOMMENDATION

To accept the vendor contract as presented.

DISCUSSION

Kim Osajda, Quality Improvement (QI) Director reviewed the process and scoring. GCHP wanted to find a vendor that knew Medicaid and was NCQA certified. The

Plan received responses from four vendors. Scoring was done by Procurement, the Director of Quality Improvement, Quality Improvement Project Manager, IT Business Solutions Manager, and a Senior Decision Support Analyst. The scoring was reviewed and two finalists were selected, Inovalon Inc. and Altegra Health. Inovalon scored highest in most major areas. They provide tools that are beneficial such as custom reports and graphing. There is a projected savings of \$100,596. The Plan would incur more training in order to use Altegra Health. The plan recommends Inovalon – implementation is projected for April 1, 2016.

Commissioner Fisher asked how long Inovalon has been in business. QI Director Osajda stated they have a majority share of the market and been in business a long time. Chief Medical Officer (CMO) Dr. Reeves added Inovalon has been highly recommended by other health plans. Commissioner Atin asked about price difference. QI Director Osajda responded there would be a projected savings of \$100,000. Commissioner Lee asked about costs for training. QI Director Osajda stated the staff would have to be trained and it would be approximately \$16,000 the first year – we would only be charged as used. Inovalon will work with GCHP whereas Altegra would need to have staff fly out to Arizona. Commissioner Foy asked what else is offered for the 10% more? These will be recording capabilities – the other vendor had temporary staff and not able to graph.

CMO Dr. Reeves stated will give monthly run of HEDIS rates to make sure how members are receiving care. A lot of pre-work is currently done at the plan, which is a significant cost internally in the IT department. Inovalon will be able to do it for GCHP. Chief Information and Strategy Officer (CISO) Melissa Scrymgeour added it is very labor intensive work to have the IT staff do the work, the Plan would need to add staff to support HEDIS.

Commissioner Dial moved to approve the recommendation. Commissioner Lee seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, David Glycer, Michelle Laba, M.D., and Darren Lee.

ABSTAIN: Dee Pupa.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

5. Approval of Fourth Quarter Quality Improvement Committee (QIC) Report

RECOMMENDATION

To accept the QIC Report as presented.

DISCUSSION

CMO Dr. Reeves informed the Commission that the Quarterly Quality Improvement Projects are the same as previously reported. Upon reviewing the report it was noted a focus group was created to improve service and satisfaction; this included 27 English speaking and 17 Spanish speaking participants. The focus group was done due to questions from the previous CAPS Survey in 2013-14. There were issues with getting care quickly and with customer service. The QI department developed the project and focus groups with members to evaluate their experience in order to improve their service and satisfaction. The group included adult members both under and over the age of 55 and parents of minor members. Sessions were offered in English and Spanish, during daytime, evenings and weekends. Participates were offered a one hundred dollar gift card; the process was approved by the Department of Health Care Services (DHCS). It was found that members were confused about the difference between member services and the call center. About 25% of participants expressed they had problems with the call center wait time, connection, lack of training, and lack of knowledge. At least 50% indicated the plan met their expectations and praised the Plan.

The State changes required all plans for Performance Improvement Process (PIP). There are multiple modules in each PIP which must be approved by DHCS. The PIP #1 was submitted in September 2015. The first PIP was to improve immunizations rates for children under two years of age. Las Islas Clinic in the VCMC system was selected for this PIP. Modules 1-3 have been submitted and approved. The PIP #2 was to improve Screening, Brief Intervention and Referral to Treatment (SBIRT). The PIP #2 was denied by the State. A new PIP was submitted and approved for Developmental Screening.

DHCS had a problem with the Plan's monitoring of the Initial Health Assessment (IHA) Facility Site Reviews. The Plan completed 28 IHA's and found five sites were below 80%. The Plan is currently working with those facilities for improvement. Potential Quality Issues (PQI) were reviewed and it was noted most were coming from Health Services Department. Commissioner Pupa asked if it was low for a Plan of our size. CMO Dr. Reeves responded he didn't know what was considered "low". The PQI class has successfully found issues between facilities that would have otherwise not been found. The Plan was able to make the facilities aware of the issues.

Dashboards were also reviewed. Baseline is high at 100% - the Plan continues to improve provider services. Pharmacy accuracy is at a high 90% Credential review was also done. There have also been some difficulties with the Call Center as far as staffing. Provider Surveys will be discussed at a later date.

The Pharmacy and Therapeutics Committee reviewed nine new drugs; five were approved and three were not. Five brand name drugs were removed due to the generics being available. Fifteen over the counter drugs were added.

It was previously reported for Credentials/Peer Review that there were three providers who had actions by the Medical Board of California. One provider issue has been closed and two providers continue to be monitored. There was one highly rated PQI – action was taken due to an issue with inappropriate medication change for a diabetic member. This involved a mid-level provider. There were 22 newly credentialed providers and one was denied due to lack of medical board certification requirement.

Culture and Linguistics had 42 Sign Language interpreter requests, six were unfulfilled; the current vendor could not comply. Director of Health Education, Dr. Guadalupe Gonzales is currently seeking additional vendors in order to fulfill needs of public.

CMO Dr. Reeves further review the Grievance and Appeals received in the 3rd quarter. Two Quality of Care grievances went to PQI and one to a State Fair Hearing which was approved. Health Services QI projects were reviewed – there is a current collaboration with California Health and Disability Prevention (CHDP). The care management graph was reviewed with the Commission. There is a significant increase noted – it is a requirement to do full case management for Seniors and Persons with Disabilities (SDP) members.

Commissioner Lee asked why 50% of expectations are not met and have those issues been addressed. CMO Dr. Reeves stated there is an issue with the Call Center and making appointments. There is an ongoing problem with the phone tree which needs to be resolved. Members are being surveyed in order to find out how long their wait time is so the issue can be pinpointed. Commissioner Foy asked if the problem with scheduling appointments was an issue with the Plan or with the providers. CMO Dr. Reeves stated the issue is at the doctor's office and getting referrals. The Plan does not require referrals for specialist within the system. Commissioner Lee asked if the connection to Panel of Provider Network. Chief Operations Officer (COO) Ruth Watson stated the panel is sufficient on paper as required but doctors don't take all patients since we are the payer of last resort. They limit how many they see per month. We are looking into higher incentives. Commissioner Lee encouraged the Plan to see if the prior panels actually allow for access. CEO Villani added the issue is reimbursement. Medi-Cal is not reimbursing enough for services. The Plan needs additional means to award and to understand if the issue is across the board or at a particular office. One idea is to do Town Hall Meetings and get feedback from the community or do a "mystery shopper" concept. It was noted there is a struggle across the state for Medi-Cal Managed Care Plans. CMO Dr. Reeves indicated GCHP is surveying approximately 350 members over a six month period and there should be answers by April 8, 2016. A new project is starting which will review records in provider offices – who refers to specialists.

Commissioner Fisher moved to approve the recommendation. Commissioner Pupa seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, David Glycer, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

6. Approval of Consultant Services for Administrative Services Only (ASO) Analysis and possible Request for Proposal (RFP)

In August 2015 the Commission decided to move forward with a RFP for a PBM and extend the current contract with ACA, the Plan's ASO provider. The Plan would like to bring in a consultant to help with the process of evaluating the contract. Located in Lexington, Kentucky, ACS processes claims, counter processing, operates the call center and has 142 staff which supports GCHP. An RFP was done and there were 3 bids. Optimity was selected due to their knowledge in county organized health systems and Medi-Cal. They will be able to identify areas of risk and complete a contract review for a comparison of state and federal best practices. There has been a consistent staffing challenge for the Call Center, which impacts customer service. Optimity will benchmark other plans and make recommendations to maintain outsourcing or build a solution in-house. Phase two will be an official recommendation will help develop the RFP and contract development. The current contract cost is approximately \$9.3 million, \$1.3 million per month. The RFP process represents 2.4% of the contract cost. The contract is volume based, the Plan is beyond the final tier and there is a need to renegotiate the contract in July. Commissioner Lee asked if Optimity would evaluate the current contract and it would look like if services were brought in-house; and if they would help negotiate to stay with the vendor. COO Watson responded she believed they would. CEO Villani added this was an important business decision for GCHP, Xerox and ACS have split and time was critical. Commissioner Lee asked if peer organizations perform these functions in-house. COO Watson stated GCHP was an outlier when it comes to outsourcing; almost all other plans have the services done in-house. Commissioner Atin asked if it was worth hiring talent in-house to help evaluate the contract in-house rather than bringing in a consultant. COO Watson responded it would be a fulltime commitment for a short window of time and there would be some people attached to this project with high skill set. Optimity was chosen because they have best experience and have done consulting for other Plans, their proposal was the best out of the three.

Commissioner Dial moved to approve the recommendation. Commissioner Atin seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, David Glycer, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

7. 711 East Daily Drive Community Room Construction Contract

The construction is going well at 770 and the third floor will be in the new space by April 18, 2016. 55 staff will move and there will then be room for expansion. There will be a shuffle within the existing space. There will be a "Community Room" constructed on the first floor. This room will be used for training sessions, community use and Commission meetings. The current contractor opted not to bid on this project since it is considered a "small" contract. Three bids were received and the most cost efficient was chosen. There is a furniture allowance of \$75,000 through BKM. The total of the project is \$295,000. Commissioner Foy asked if it was a part of the current lease and how often the room would be utilized. COO Watson stated there is a ten year lease on the space and the space will be flexible and used often.

Commissioner Dial moved to approve the request. Commissioner Lee seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, David Glycer, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

RECESS:

The meeting was recessed at 4:37 p.m.

CLOSED SESSION

Closed Session called to order at 4:43 p.m.

8. Discussion Involving Trade Secrets

Pursuant to Government Code Section 54956.87
There was no reportable action.

Closed Session was adjourned at 5:50 p.m.

OPEN SESSION

CEO Villani recused himself. Open Session reconvened at 5:52 p.m.

9. Pharmacy Benefits Manager (PBM) Request for Proposal (RFP) Finalist Selection

Dr. Anne Freese, Director of Pharmacy provided information on RFP process for the PBM. GCHP's current PMB is Script Care. The RFP is looking for a PBM who can partner with the Plan to ensure members are receiving good customer service and provide cost effective solutions for the Plan; as well as auditing and quality assurance factors. Commissioner Atin asked how rating worked in regards to network access. Dr. Freese responded that a list of network pharmacies to the PBM and asked them to provide a disruption report to list out pharmacies in the Plan's network that were not in their network, and then a list pharmacies they could potentially add to their network. The percentage of pharmacies was assessed in the network and the ability and need to contract. Commissioner Glycer asked how the Plan could be sure pharmacies were going to continue to get excellent customer service. Dr. Freese responded that member services were looked at for strength in building a call center to service the pharmacies and member needs.

Commissioner Alatorre commented there was concerns from independent pharmacies in the public comments, and asked what percentage of scripts is handled through independent pharmacies. Dr. Freese responded that she searched vendor disruption report; all were listed except for one. The Plan can direct the PBM to contract with any needed pharmacies and prioritize by the number of scripts.

Commissioner Foy asked about guarantees and the ability for the recommended PBM to have a smooth transition. Dr. Freese replied that there are minimum, performance and implementation guarantees. An additional strength in implementation is the timing; kicking off implementation prior to other plans to have a dedicated focus.

Concerns were expressed by Commissioner Fisher and Alatorre that a change in PBM would cause VCMC and Clinicas Del Camino to experience a large loss in respects to the 340B Drug Pricing Program. Dr. Freese explained changing PBMs would not interrupt the administrator for 340B with providers. GCHP would experience a change in the way processing is completes, utilizing the 340B savings arrangement. It was a requirement that the PBM would be able to handle 340B claims. The recommended PBM vendor currently works with 17 other 340B

programs and has a wealth of experience. The largest risk in the change would be to the Plan, not to the providers. Commissioner Dial asked if more information could be provided for 340B. The 340B claims process was explained by Dr. Freese to add clarification.

Commissioner Dial stated part of Closed Session was to look at rate – there are significant differences. There is a concern with administrative costs and 340b. Commissioner Foy asked about 3 year contract and options to extend. Ms. Freese stated there is a potential of 5 years total.

Commissioner Foy questioned why the Plan was looking for a new PBM. Counsel Campbell answered the contract with Script Care expires in on September 30, 2016 and the Plan was looking at an implementation date of October 1, 2016. Associates from Script Care and Commissioners discussed the possibility of extending the contract.

Commissioner Dial made a motion to bring Script Care and Magellan present to the commission. Commissioner Lee seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, David Glycer, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

10. Chief Executive Officer Update

CEO Villani recognized and thanked Commissioner Glycer for his time serving on the Commission. The Hospital Association of Southern California nominated Jennifer Swenson from Simi Valley Hospital.

The Employee Survey results have been submitted and a full report will be presented at the following meeting.

The Alternative Resources for Community Health (ARCH) PowerPoint was presented. Examples of potential opportunities to invest in the community, provider payments and programs to avoid hospital admissions were introduced.

11. Compliance Update

Brandy Armenta, Director of Compliance advised the Commission that GCHP would be audited by DHCS starting on April 25, 2016. The Corrective Action Plan remains open. Delegation Oversight continues to audit as required.

12. Chief Medical Officer (CMO) Update

CMO Dr. Reeves had no items to report.

13. Health Services Update

Associate Chief Medical Officer Dr. Wharfield reviewed the data and graph for the Health Services department.

14. Community Outreach Summary Report

Director of Health Education and Disease Management, Dr. Lupe Gonzales reviewed January events GCHP participated in. The GCHP's 5th Annual Community Resource Fair was announced, over 300 participants are expected.

15. Chief Financial Officer (CFO) Update

CFO Patricia Mowlavi announced finance has been going well. The budget and administrative costs have been favorable.

16. Chief Operations Officer (COO) Update

COO Watson expressed there were some challenges with the Call Center. Commissioner Foy inquired what the estimate of undocumented children joining the Plan is and access to care. COO Watson replied the Plan has more providers than what is required and a new pediatric group has just added.

17. Chief Information and Strategy Officer (CISO) Update

The Plan received a certification from CHP4, the Committee on Operating Rules for Information Exchange. CISO Melissa Scrymgeour stated there are a few implementations were getting ready to be kicked-off.

18. Human Resources Cultural Diversity Sub-Committee Update

Nine resumes have been submitted for the Chief Diversity Officer position. The interview panel will meet on March 4th.

Commissioner Dial moved to approve all updates. Commissioner Fisher seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, David Glycer, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

RECESS:

The meeting was recessed at 7:16 p.m.

CLOSED SESSION

Closed Session reconvened at 7:18 p.m.

Commissioner Alatorre recused himself.

18. Conference with Legal Counsel – Existing Litigation

There was no reportable action.

ADJOURNMENT

Closed Session was adjourned at 7:36 p.m.

Minutes submitted by:
Magdalen Gutierrez-Roberts
Interim Clerk of the Board

**Ventura County Medi-Cal Managed Care Commission (VCMMCC)
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**Antonio Alatorre
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**Shawn Atin
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Dale Villani
Patricia Mowlavi
C. Albert Reeves, M.D.

Ruth Watson
Scott Campbell
Melissa Scrymgeour

March 9, 2016

The Commission met in special session in the Multi-Purpose Room at the Gold Coast Health Plan building – Topa Topa Conference room located at 711 E. Daily Drive Camarillo, California. The meeting was called to order by Commissioner Alatorre at 5:07 p.m.

ROLL CALL

Present: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Darren Lee, and Dee Pupa.

Absent: Peter Foy, Michelle Laba, M.D., and Gagan Pawar, M.D.

Commissioner Alatorre presided.

FORMAL ACTION ITEMS

1. Department of Healthcare Services (DHCS) Contract Amendment A20

RECOMMENDATION

To approve and authorize the Chief Executive Officer (CEO) to execute Amendment A20.

Commissioner Dial moved to approve the recommendation. Commissioner Lee seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Supervisor Peter Foy, Michelle Laba, M.D., and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

RECESS:

The meeting was recessed at 5:11 p.m.

CLOSED SESSION

Closed Session reconvened at 5:13 p.m.

Commissioner Pawar arrived at 5:16 p.m.

a. Conference with Legal Counsel – Anticipated Litigation

There was no reportable action.

Closed Session ended at 6:03 p.m.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The Commission meeting adjourned at 6:07 p.m.

Minutes submitted by:
Magdalen Gutierrez-Roberts
Interim Clerk of the Commission

AGENDA ITEM NO. 2

To: Gold Coast Health Plan Commission
From: Dale Villani, CEO
Date: April 25, 2016
RE: DHCS Contract Term Date Extension

SUMMARY:

The Gold Coast Health Plan (GCHP) existing contract with the Department of Health Care Services (DHCS) has a term date of January 1, 2017. DHCS issued a letter to GCHP exercising the existing provisions within the contract which allows for a term date extension. DHCS is requesting the term date be extended from January 1, 2017 to December 31, 2017. GCHP must respond in writing to DHCS to accept or reject the extension.

DISCUSSION:

N/A

FISCAL IMPACT:

N/A

RECOMMENDATION:

Staff recommendation is to allow the CEO to respond in writing to DHCS to accept the contract term date extension to December 31, 2017.

AGENDA ITEM NO. 3

To: Gold Coast Health Plan Commission

From: Scott Campbell, General Counsel

Date: April 25, 2016

RE: Adopt Resolution No. 2016-01 amending the bylaws to establish that Commissioners' terms of office begin on March 15 and to require appointment of officers and committee members every two years after a new Commission takes office.

SUMMARY:

Because the initial Commission was appointed in March 2010, the Ventura County Board of Supervisors and the Commission has always used March 15 as the date that each Commissioner's term begins. This date is not formally established in either the County Ordinance or the Commission's bylaws. This proposed Resolution would amend the bylaws to formally establish March 15 as the start of each term. The bylaws currently require appointment of officers for two-year terms, commencing on January 1. This Resolution would change the timing for the appointment of new officers so that it is consistent with the beginning of the Commissioner terms. The Commission may also make appointments to the Executive/Finance Committee. Because the officers serve as members of the committee, this Resolution clarifies that committee appointments shall occur after new officers are elected. The Resolution also amends the bylaws to streamline the process for the appointment of the Chairperson and Vice-Chairperson by eliminating the role of the Executive/Finance Committee as the Nominating Committee for those positions. The bylaws require that proposed amendments to the bylaws be presented to the Commission at least two weeks prior to adoption. Hence, the proposed bylaws are submitted now so that they Commission can adopt the amendments at the March meeting.

BACKGROUND / DISCUSSION:

Ventura County Ordinance No. 4481, which established the Ventura County Medi-Cal Managed Care Commission, requires the Commission to establish bylaws containing procedures for the conduct of business that is not otherwise specified in the Ordinance. (Ord. 4481, as amended on October 6, 2015 is attached hereto; see section 1381-4.)

The Ordinance and the bylaws provide that each of the eight Commissioners appointed by the Board of Supervisors shall serve a four-year term, and the terms are staggered so that four Commissioners are reappointed every two years, in even-numbered years.

Neither the Ordinance nor the bylaws establish when the Commissioners' terms begin. The first Commission was appointed in March 2010, and therefore in every even-numbered year following the initial appointment, the Board of Supervisors has appointed (or re-appointed) four new Commissioners.

Under Article III, section (b), of the bylaws, the Commission must elect two officers to serve for the calendar year: a Chairperson and a Vice Chairperson. The term of each office begins on January 1 following the election.

The bylaws also establish the Executive/Finance Committee, which consists of the Chairperson, Vice Chairperson, one private hospital/healthcare representative, one Ventura County Medical Health System representative, and one Clinicas Del Camino Real representative. (See Art. IV, section (b).) If the Chairperson and/or Vice Chairperson are representatives from these agencies, then the Commission *must* appoint the other representative from that agency to serve on the Committee as well. Because the selection of a Chairperson and Vice Chairperson affect Commission's appointments to the Committee, the appointments logically should occur soon after the Chairperson and Vice Chairperson are elected.

At the Commission's January 25 regular meeting, staff presented reports to the Board to elect officers and appoint Executive/Finance Committee members, but staff noted that the composition of Commission was subject to change in March. The Commission directed staff to present an amendment to the bylaws to require that the officers and committee members be selected *after* a new Commission takes office.

This Resolution will make four changes to the bylaws: (1) Article II will be revised to clarify that the Commissioner terms begin on March 15; (2) Article III will be revised so that Officers must be elected at the first regular meeting following the appointment of Commissioners for a new term; (3) Article III will be revised so that Executive/Finance Committee appointments will be made at either the regular meeting in which new officers are elected or at the next regular meeting; and (4) Article III will be revised to remove "nominating officers" as a duty of the Executive/Finance Committee since the committee's composition will be decided after the Chairperson and Vice Chairperson take office and to streamline the appointment process.

FISCAL IMPACT:

None.

RECOMMENDATION:

Adopt Resolution No. 2016-01 as presented.

CONCURRENCE:

N/A

Attachment:

Resolution No. 2016-01 Ventura County Ordinance No. 4481 Gold Coast Health Plan Bylaws

RESOLUTION NO. 2016-01

A RESOLUTION OF THE VENTURA COUNTY MEDICAL MANAGED CARE COMMISSION, DOING BUSINESS AS THE GOLD COAST HEALTH PLAN AMENDING THE BYLAWS TO ESTABLISH THAT COMMISSIONERS' TERMS OF OFFICE BEGIN ON MARCH 15 AND TO REQUIRE APPOINTMENT OF OFFICERS AND COMMITTEE MEMBERS PROMPTLY THEREAFTER

WHEREAS, the Ventura County Medi-Cal Managed Care Commission, doing business as the Gold Coast Health Plan ("Commission"), was initially appointed in March of 2010;

WHEREAS, each March of even-numbered years, the Ventura County Board of Supervisors appoints new Commissioners to serve four-year terms;

WHEREAS, the Commission elects a Chairman and a Vice Chairman from amongst its membership every two years;

WHEREAS, the Commission appoints its members to serve on the Executive/Finance Committee; and

WHEREAS, the Commission desires to amend the bylaws to clarify that terms of office begin in March and to establish that the selection of officers and committee members shall occur promptly thereafter.

NOW THEREFORE BE IT RESOLVED, that the Bylaws for the Operation of the Ventura County Organized Health System shall be amended as follows:

1. In Article II, under the heading "**Selection and Terms of Commissioners**," the following sentence shall be added to the end of the first paragraph:

"The term of each subsequent appointment shall be deemed to commence on March 15 of the year of the appointment."

2. In Article III, under the heading "**Election**," paragraphs (a) and (b) shall be deleted in their entirety and replaced with the following:

"(a) The VCMMCC shall elect officers by majority vote of the members present.

(b) The election of officers shall be held at the first regular meeting of the VCMMCC after March 15 (or after the date upon which the Board of Supervisors appoints Commissioners for the present term if later than March 15) in every even-numbered year. The two-year terms of office shall be deemed to commence on March 15 of the year of the election, regardless of when the election actually occurs. The officers of the prior term shall continue to preside over any meetings and perform all other functions of their offices until new officers are elected."

3. In Article IV, under the heading “**Standing Committees**,” at paragraph (b), the following shall be added to the end of subparagraph (ii):

“Appointments to the Committee shall be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected or at the next regular meeting immediately thereafter. Appointments may also be made at any regular meeting where the appointment is necessitated by a resignation, termination, vacancy, special election of officers, or other event which results in the Committee lacking full membership.”

4. In Article IV, under the heading “**Standing Committees**” at paragraph (b), the following shall be deleted from subparagraph (iii) and the remainder of the subparagraph shall be renumbered accordingly:

~~“13. Serve as the Nominating Committee for the purpose of confirmation of candidates for Chairperson and Vice Chairperson of the VCMMCC.”~~

A copy of the Amended and Restated Bylaws with the above changes is attached as Exhibit “A.”

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission doing business as the Gold Coast Health Plan at a regular meeting on the 28rd day of March, 2016, by the following vote:

AYE:
NAY:
ABSTAIN:
ABSENT:

Chair

Attest:

Clerk of the Board

AGENDA ITEM NO. 4

To: Gold Coast Health Plan Commission

From: Scott Campbell, General Counsel

Date: April 25, 2016

RE: Election of Chairperson and Vice Chairperson to serve two-year terms and appointment of Executive/Finance Committee

SUMMARY:

Pursuant to the bylaws, the Commission must elect from its membership a Chairperson and a Vice Chairperson to serve two-year terms. The Chairperson and Vice Chairperson will both serve on the Executive/Finance Committee. Once these officers are elected, the Commission will need make appointments to fill the balance of the Executive/Finance Committee in accordance with the bylaws.

BACKGROUND / DISCUSSION:

Earlier in this meeting, the Commission adopted Resolution Number 2016-01. This resolution made four changes to the bylaws, which now require: (1) that the Commissioner terms begin on March 15; (2) that the Officers must be elected at the first regular meeting following the appointment of Commissioners for a new term; (3) that Executive/Finance Committee appointments will be made at either the regular meeting in which new officers are elected or at the next regular meeting; and (4) that the Executive/Finance Committee will not nominate officers to serve as Chairperson and Vice Chairperson.

Because the new Commissioners have just been appointed to a new term, the Commission must now elect its officers. (See Bylaws, Art. III.) The Chairperson is responsible for presiding at all meetings, executing all documents approved by the Commission, seeing that all actions of the Commission are implemented, and maintaining consultation with the Chief Executive Officer. The Vice Chairperson is responsible for performing the duties of the Chairperson in the Chairperson's absence and performing such other responsibilities as agreed upon with the Chairperson. The bylaws do not contain any specific nominating or appointment process, and therefore the officers shall be established by a majority vote of the Commissioners. Staff recommends that the Commission nominate names for Chairperson (no second is needed) and then vote on each name nominated. If no majority is reached, the list of names can be reduced to the top two vote recipients until a majority is reached. The same process may then be followed for the Vice Chairperson.

The bylaws establish the five-person Executive/Finance Committee, which must consist of the Chairperson, Vice Chairperson, one private hospital/healthcare representative, one Ventura County Medical Health System representative, and one Clinicas Del Camino Real representative. (See Art. IV, section (b).) The bylaws provide that if the Chairperson and/or Vice Chairperson is a representative from one of these three agencies, then the Commission **must** appoint another representative from that agency to serve on the Committee as well. The private hospital/healthcare representative position rotates between the two Commissioners holding these seats.

The Executive/Finance Committee is an advisory committee to the Commission. It cannot take any action on behalf of the Commission, but it does serve a number of functions. The Committee assists the CEO with planning and presentation of items to the full board, reviewing of policies, monitoring the Plan's economic performance.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Elect a Commissioner to serve as Chairperson for a two-year term.
2. Elect a Commissioner to serve as Vice Chairperson for a two-year term.
3. Make appointments to the Executive/Finance Committee as follows:
 - a. Chairperson.
 - b. Vice Chairperson.
 - c. Private Hospital Healthcare Representative:
 - d. Ventura County Medical Health System Representative)
 - e. Clinicas Del Camino Real Representative:

CONCURRENCE:

N/A

Attachment:

Gold Coast Health Plan Bylaws

**AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF
THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM**

**VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
(dba Gold Coast Health Plan)**

**Approved: October 24, 2011
Amended: April 25, 2016**

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AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM (dba Gold Coast Health Plan)

ARTICLE I

Name and Mission

The name of this Commission shall be the Ventura County Medi-Cal Managed Care Commission, hereafter referred to in these Bylaws as the VCMMCC. VCMMCC shall operate under the fictitious name, Gold Coast Health Plan.

The VCMMCC shall design and operate a program or programs, whose mission is to improve the health of its members through the provision of the best possible quality care and services. This will be accomplished by:

- (a) Delivering medical care via a contracted provider network that will improve access to primary, specialty and ancillary services;
- (b) Establishment of mechanisms to assure that medical care services meet appropriate quality of care standards;
- (c) Incorporating a plan of service delivery and implementing reimbursement mechanisms which promote the long-term viability of a locally operated Medi-Cal managed care system and the existing participating provider networks inclusive of "Safety Net" providers herein defined as Medi-Cal disproportionate share hospitals, county clinics, federally qualified health centers, and licensed rural health clinics;
- (d) Implementing a financial plan which includes the creation of a prudent reserve and which provides that if additional surplus funds accrue, they shall be used to expand access, improve benefits and augment provider reimbursement in Ventura County;
- (e) Placing a high priority on prevention, education, early intervention services and case management for enrolled recipients;
- (f) Ensuring that all obligations, statutory, contractual or otherwise, shall be the obligations of the VCMMCC and shall not be the obligations of the County of Ventura or the State of California; and
- (g) Implementing programs and procedures to ensure a high level of member satisfaction.

ARTICLE II

Commissioners

The governing board of the VCMMCC shall consist of eleven (11) voting members (“members” or “Commissioners”) who shall be legal residents of Ventura County. Members shall possess the requisite skills and knowledge necessary to design and operate a publicly managed health care delivery system.

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

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

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

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

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

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

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

(g) Consumer Representative. One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is

not otherwise represented on the Ventura County Medi-Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position.

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

Selection and Terms of Commissioners

In order to stagger terms with the intent of maintaining experienced members, in the initial cycle of appointments, the following appointees shall serve two-year terms: one of the Ventura County Medical Center Health System Representatives, the Physician Representative nominated by the Ventura County Medical Association, the Public Representative, and one Private Hospital/Healthcare System Representative. All other initial appointments and all subsequent appointments to the VCMCC shall be for four-year terms. No member may serve more than two consecutive four-year terms. Any vacancy will be filled by the Board of Supervisors for the remainder of the unexpired term and shall maintain the balance of representation on the VCMCC. The term of each subsequent appointment shall be deemed to commence on March 15 of the year of the appointment.

A member may resign effective on giving written notice to the Clerk of the VCMCC, unless the notice specifies a later date for his/her resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chairperson and the Board of Supervisors. The Clerk of the VCMCC shall enter the notice in the proceedings of the Commission. The acceptance of a resignation shall not be necessary to make it effective.

A member may be removed from the VCMCC by a 4/5 vote of the Board of Supervisors.

Nominations to the VCMCC shall be submitted to the Ventura County Executive Office, which shall be responsible for screening nominees and presenting candidates to the Board of Supervisors.

ARTICLE III

Officers

(a) Officers of the VCMCC shall be a Chairperson and Vice-Chairperson.

(b) The Chairperson and the Vice-Chairperson shall be elected by majority vote of the members in attendance at the first meeting of the VCMCC to serve for the remainder of the calendar year in which the first meeting occurs. Officers subsequently elected to these offices, pursuant to the procedures outlined under "Election" below, shall serve a term of two years or until their successor(s) has/have been duly elected.

(c) No individual shall serve more than two consecutive terms in any of the elected officer positions.

Election

- (a) The VCMMCC shall elect officers by majority vote of the members present.
- (b) The election of officers shall be held at the first regular meeting of the VCMMCC after March 15 (or after the date upon which the Board of Supervisors appoints Commissioners for the present term if later than March 15) in every even-numbered year. The two-year terms of office shall be deemed to commence on March 15 of the year of the election, regardless of when the election actually occurs. The officers of the prior term shall continue to preside over any meetings and perform all other functions of their offices until new officers are elected.
- (c) Notwithstanding the normal election process detailed in paragraphs (a) and (b) above, when circumstances warrant it, an election may be held at any time during the year. Circumstances that would warrant a special election include: one or more of the officers wishes to resign as an officer, or one or more of the officers is terminated.

Duties

- (a) The Chairperson shall:
 - 1. Preside at all meetings;
 - 2. Execute all documents approved by the VCMMCC;
 - 3. Be responsible to see that all actions of the VCMMCC are implemented; and
 - 4. Maintain consultation with the Chief Executive Officer (CEO).
- (b) The Vice-Chairperson shall:
 - 1. Exercise all the responsibilities of the Chairperson in the absence of the Chairperson; and
 - 2. In agreement with the Chairperson, perform all responsibilities mutually agreed upon.

ARTICLE IV

Standing Committees

(a) At a minimum, the VCMCC shall establish two (2) committees/advisory boards, one member/consumer based and one provider based. VCMCC staff will be responsible to gather a list of potential appointments and make recommendations to the VCMCC for membership on these boards. Each of the boards shall submit a charter to the VCMCC for approval. All meetings of standing committees shall be subject to the provisions of the Brown Act.

(b) Executive/Finance Committee.

- i. Purpose. The role of the Executive/Finance Committee shall be to assist the CEO and VCMCC accomplish its work in the most efficient and timely way. Meetings of this committee shall be at the request of the Chairperson or CEO to evaluate time sensitive matters. The Committee shall report on all of its activities to the governing board at the next regular meeting of the governing board.
- ii. Membership. The Executive/Finance Committee shall be comprised of the following five (5) Commissioners:
 1. Chairperson
 2. Vice-Chairperson
 3. Private hospital/healthcare system representative (to rotate between the two representatives following the representative's resignation from the committee)
 4. Ventura County Medical Center Health System representative
 5. Clinicas Del Camino Real representative

The CEO and Finance Director will serve as Ex-Officio members to Co-Chair the committee.

If the private hospital/healthcare system representative, the Ventura County Medical Center Health System representative and/or the Clinicas Del Camino Real representative are also the Chairperson and/or Vice-Chairperson of the governing board, then, the other Commissioner who is a representative of the same constituency or organization as the Commissioner serving as Chairperson or Vice-Chairperson shall be appointed to the Executive/Finance Committee to fill that reserved seat. For example, if the Ventura County Medical Center Health System representative and the Clinicas Del Camino Real representative are also the Chairperson and Vice-Chairperson,

respectively, of the governing board, then, the other Ventura County Medical Center Health System representative and the physician representative nominated by Clinicas Del Camino Real shall be appointed to fill the respective designated seat on the Executive/Finance Committee.

Appointments to the Committee shall be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected or at the next regular meeting immediately thereafter. Appointments may also be made at any regular meeting where the appointment is necessitated by a resignation, termination, vacancy, special election of officers, or other event which results in the Committee lacking full membership.

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.
2. Assist the CEO in the planning or presentation of items for governing board consideration.
3. Assist the CEO or VCOMMCC staff in the initial review of draft policy statements requiring governing board approval.
4. Assist the CEO in the ongoing monitoring of economic performance by focusing on budgets for pre-operational and operational periods.
5. Review proposed State contracts and rates, once actuary has reviewed and made recommendations.
6. Review proposed contracts for services over the assigned dollar value/limit of the CEO.
7. Establish basic tenets for payment-provider class and levels as related to Medi-Cal rates:
 - o PCP
 - o Specialists
 - o Hospitals o LTC
 - o Ancillary Providers
8. Recommend auto-assignment policies for beneficiaries who do not select a Primary Care Provider.
9. Review and recommend provider incentive program structure.
10. Review investment strategy and make recommendations.
11. On an annual basis, develop the CEO review process and criteria.

12. Serve as Interview Committee for CEO/CMO/CFO.

13. Assist the governing board and/or the CEO in determining the appropriate committee, if any, to best deal with questions or issues that may arise from time-to-time.

14. Develop long-term and short-term business plans for review and approval by the governing board.

15. Undertake such other activities as may be delegated from time-to-time by the governing board.

iv. Limitations on Authority. The Executive/Finance Committee shall not have the power or authority in reference to any of the following matters:

1. Adopting, amending or repealing any bylaw.

2. Making final determinations of policy.

3. Approving changes to the budget or making major structural or contractual decisions (such as adding or eliminating programs).

4. Filling vacancies or removing any Commissioner.

5. Changing the membership of, or filling vacancies in, the Executive/Finance Committee.

6. Hiring or firing of senior executives, but may make recommendations to the governing board as to their appointment, dismissal or ongoing performance.

7. Taking any action on behalf of the governing board unless expressly authorized by the governing board.

ARTICLE V

Special Committees

Members may be asked to participate on a subcommittee, task force or special project as part of their responsibilities. The VCMMCC may establish a committee(s) or advisory board(s) for any purpose that will be beneficial in accomplishing the work of the VCMMCC.

ARTICLE VI

Meetings

- (a) All meetings shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code relating to meetings of local agencies ("Brown Act").
- (b) A regular meeting shall be held monthly. The VCMMCC shall by resolution establish the date, time and location for the monthly meeting. A regular meeting may, for cause, be rescheduled by the Chairperson with 72 hour advance notice.
- (c) Closed session items shall be noticed in compliance with Government Code section 54954.5.
- (d) Special meetings may be called, consistent with the Brown Act, by the Chairperson or by a quorum of the VCMMCC. Notice of such special meeting shall conform to the Brown Act.
- (e) Any meeting at which at least a quorum cannot attend, or for which there is no agenda item requiring action may be cancelled by the Chairperson with 72 hour advance notice.
- (f) A quorum shall be defined as one person more than half of the appointed members of the VCMMCC. For these purposes, "appointed members" excludes unfilled positions and those vacated by resignation or removal. Unless otherwise expressly stated in these bylaws, a majority vote of members present and constituting a quorum shall be required for any VCMMCC action.
- (g) After three (3) absences of any member during a fiscal year, the reasons for the absences will be reviewed by the VCMMCC and it may notify the Board of Supervisors of the absences, if it deems this action appropriate. Three or more absences from regular meetings may be cause for the VCMMCC to recommend dismissal of that member to the Board of Supervisors.

Conduct of Meetings

- (a) The Chairperson shall adhere to the order of items as posted on the agenda. Modifications to the order of the agenda may be made to the extent that (on the advice of counsel) the rearrangement of the agenda items does not violate the spirit or intent of the Brown Act.
- (b) All motions or amendments to motions require a second in order to be considered for action. Upon a motion and a second the item shall be open for discussion before the call for the vote.

(c) Voice votes will be made on all items as read. An abstention will not be recognized except for a legal conflict of interest. In furtherance of the foregoing, an abstention or refusal to vote (not arising from a legal conflict of interest) shall be deemed a vote with the majority of those Commissioners who do vote, except when there is a tie vote and the motion or action fails. For example, if there are 7 Commissioners present at a meeting (none of whom are subject to a legal conflict of interest), (i) a motion passes with 3 votes in favor and 4 Commissioners abstaining, (ii) a motion passes with 3 votes in favor, 2 votes against and 2 Commissioners abstaining; and (iii) a motion fails with 3 votes in favor, 3 votes against and 1 Commissioner abstaining.

(d) A call for a point of order shall have precedence over all other motions on the floor.

(e) Without objection, the Chairperson may continue or withdraw any item. In the event of an objection, a motion to continue or reset an item must be passed by a majority of the members present. A motion to continue or reset an item shall take precedence over all other motions except for a point of order.

(f) An amendment to a motion must be germane to the subject of the motion, but it may not intend an action contrary to the motion. There may be an amendment to the motion and an amendment to an amendment, but no further amendments. In the event the maker of the original motion accepts the amendment(s), the original motion shall be deemed modified. In the event the maker of the original motion does not accept the amendment(s), the amendment(s) shall be voted separately and in reverse order of proposal.

(g) Where these Bylaws do not afford an adequate procedure in the conduct of a meeting, the Chairperson may defer to the most current edition of Robert's Rules of Order, to resolve parliamentary questions.

(h) The Chairperson shall be permitted to make motions and vote on all matters to the same extent and subject to the same limitations as other Commissioners.

ARTICLE VII

Powers and Duties

The VCMMCC is responsible for all of the activities described in Article I of these Bylaws and in its enabling ordinance. In furtherance of such responsibility, the VCMMCC shall have the following powers and duties and shall:

(a) Advise the Chief Executive Officer (CEO) and request from the CEO information it deems necessary;

(b) Conduct meetings and keep the minutes of the VCMMCC;

(c) Provide for financial oversight through various actions and methodologies such as the preparation and submission of an annual statement of financial affairs and an estimate of the amount of funding required for expenditures, approval of an annual

budget, receipt of monthly financial briefings and other appropriate action in support of its financial oversight role;

(d) Evaluate business performance and opportunity, and review and recommend strategic plans and business strategies;

(e) Establish, support and oversee the quality, service utilization, risk management and fraud and abuse programs;

(f) Encourage VCOMMCC members to actively participate in VCOMMCC committees as well as subcommittees;

(g) Comply with and implement all applicable federal, state and local laws, rules and regulations as they become effective;

(h) Provide for the resolution of or resolve conflict among its leaders and those under its leadership;

(i) Respect confidentiality, privacy and avoid any real or potential conflict of interest; and

(j) Receive and take appropriate action, if warranted, based upon reports presented by the CEO (or designated individual). Such reports shall be prepared and submitted to the VCOMMCC at least annually.

ARTICLE VIII

STAFF

The VCOMMCC shall employ personnel and contract for services as necessary to perform its functions. The permanent staff employed by the VCOMMCC shall include, but not be limited to, a Chief Executive Officer (CEO), Clerk and Assistant Clerk.

Chief Executive Officer

The CEO shall have the responsibility for day to day operations, consistent with the authority conferred by the VCOMMCC. The CEO is responsible for coordinating all activities of the County Organized Health System.

The CEO shall:

(a) Direct the planning, organization, and operation of all services and facilities;

(b) Direct studies of organizations, operations, functions and activities relating to economy, efficiency and improvement of services;

- (c) Direct activities which fulfill all duties mandated by federal or state law, regulatory or accreditation authority, or VCMMCC board resolution, and shall bring any conflict between these laws, regulations, resolutions or policy to the attention of the VCMMCC;
- (c) Appoint and supervise an executive management staff, and such other individuals as are necessary for operations. The CEO may delegate certain duties and responsibilities to these and other individuals where such delegated duties are in furtherance of the goals and objectives of the VCMMCC;
- (d) Retain and appoint necessary personnel, consistent with all policies and procedures, in furtherance of the VCMMCC's powers and duties; and
- (f) Implement and enforce all policies and procedures, and assure compliance with all applicable federal and state laws, rules and regulations.

Clerk

The Clerk shall:

- (a) Perform the usual duties pertaining to secretaries;
- (b) Cause to be kept, a full and true record of all VCMMCC meetings and of such special meetings as may be scheduled;
- (c) Cause to be issued notices of regular and special meetings;
- (d) Maintain a record of attendance of members and promptly report to the VCMMCC any member whose position has been vacated; and
- (e) Attest to the Chair or Vice-Chair's signature on documents approved by the VCMMCC.

Assistant Clerk

The Assistant Clerk shall perform the duties of the Clerk in the Clerk's absence.

ARTICLE IX

Rules of Order

The Chairperson shall be responsible for maintaining decorum during VCMMCC meetings. All motions, comments, and questions shall be made through the Chairperson. Any decision by the Chairperson shall be considered final unless an appeal of the decision is requested and passed by a majority of the VCMMCC members present.

ARTICLE X

Amendments

(a) These Bylaws may be amended by an affirmative vote of a majority of the voting members of the VCMMCC. A full statement of a proposed amendment shall be submitted to the VCMMCC at least two weeks prior to the meeting at which the proposed amendment is scheduled to be voted upon.

(b) The Bylaws shall be reviewed annually and amendments to the Bylaws may be proposed by any VCMMCC member.

(c) Bylaws may be suspended on an ad hoc basis upon the affirmative vote of a majority of the VCMMCC members present.

ARTICLE XI

Nondiscrimination Clause

The VCMMCC or any person subject to its authority shall not discriminate against or in favor of any person because of race, gender, religion, color, national origin, age, sexual orientation or disability with regard to job application procedures, hiring, advancement, discharge, compensation, training or other terms or condition of employment of any person employed by or doing business with the VCMMCC or any person subject to its direction pursuant to federal, state or local law.

ARTICLE XII

Conflict of Interest and Ethics

VCMMCC members are subject to conflict of interest laws, including Government Code section 1090 and the 1974 Political Reform Act (Government Code section 8100 et seq.), as modified by Welfare and Institutions Code section 14087.57, and must identify and disclose any conflicts and refrain from participating in any manner in such matters in accordance with the applicable statutes. Members of the VCMMCC agree to adhere to all relevant standards established by state or federal law regarding ethical behavior.

ARTICLE XIII

Dissolution

Pursuant to California Welfare & Institutions Code, section 14087.54:

(a) In the event the Commissioners determine that VCMMCC may no longer function for the purposes for which it was established, at the time that VCMMCC's then existing

obligations have been satisfied or VCMMCC's assets have been exhausted, the Board of Supervisors may by ordinance terminate the VCMMCC.

(b) Prior to the termination of the VCMMCC, the Board of Supervisors shall notify the State Department of Health Care Services ("DHCS") of its intent to terminate VCMMCC. The DHCS shall conduct an audit of VCMMCC's records within 30 days of the notification to determine the liabilities and assets of VCMMCC. The DHCS shall report its findings to the Board of Supervisors within 10 days of completion of the audit. The Board of Supervisors shall prepare a plan to liquidate or otherwise dispose of the assets of VCMMCC and to pay the liabilities of VCMMCC to the extent of VCMMCC's assets, and present the plan to the DHCS within 30 days upon receipt of these findings.

(c) Upon termination of the VCMMCC by the Board of Supervisors, the County of Ventura shall manage any remaining assets of VCMMCC until superseded by a DHCS-approved plan. Any liabilities of VCMMCC shall not become obligations of the County of Ventura upon either the termination of the VCMMCC or the liquidation or disposition of VCMMCC's remaining assets.

(d) Any assets of VCMMCC shall be disposed of pursuant to provisions contained in the contract entered into between the state and VCMMCC.

AGENDA ITEM NO. 5

To: Gold Coast Health Plan Commissioners

From: Joseph T. Ortiz, Best Best & Krieger LLP- Diversity Subcommittee

Date: April 25, 2016

Re: Diversity Subcommittee Vacancy

SUMMARY:

The Diversity Subcommittee spearheaded the effort to make diversity and inclusion a priority at Gold Coast Health Plan (GCHP). The Subcommittee helped facilitate diversity training, needs assessment, and the creation and pending selection of the GCHP Chief Diversity Officer position, among other things. Unfortunately, due to a vacancy, the Subcommittee now must respectfully request that the Commission appoint a replacement.

BACKGROUND / DISCUSSION:

On September 28, 2015, the GCHP created its Diversity Subcommittee. Subcommittee reports directly to the Commission and is responsible for recruitment of the Chief Diversity Officer and the development of a cultural diversity programs, such as employee surveys, training, and ongoing needs assessments, among other things. Initially, Commissioners Antonio Alatorre and David Glycer volunteered and were appointed to the Subcommittee. Shortly thereafter, they were joined by Commissioner Shawn Atin. These three Commissioners filled the Subcommittee.

After having served four distinguished years on the Commission, Commissioner Glycer's term ended in March of 2016. His position on the Subcommittee also ended. The Subcommittee is deeply thankful for his service and guidance and respectfully requests the Commission appoint a replacement Subcommittee member.

FISCAL IMPACT:

None at this time.

RECOMMENDATION:

Staff recommends that the Commission appoint a Commissioner to the Diversity Subcommittee to fill the vacancy.

CONCURRENCE:

N/A

AGENDA ITEM NO. 6

To: Gold Coast Health Plan Commission
From: Nancy Wharfield, MD, Associate Chief Medical Director
Date: April 25, 2016
RE: Benefit Enhancement – Pulmonary Rehabilitation

SUMMARY:

Gold Coast Health Plan (GCHP) seeks to add pulmonary rehabilitation services for COPD as a benefit.

BACKGROUND:

Pulmonary rehabilitation services are not a benefit under Fee for Service Medi-Cal. As a managed care Medi-Cal plan, GCHP can elect to add benefits that can further the goals of the Institute for Healthcare Improvement Triple Aim:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

DISCUSSION:

The benefits of pulmonary rehabilitation align with the framework of the Triple Aim.

Pulmonary rehabilitation is defined by the American Thoracic Society and the European Respiratory Society as a comprehensive intervention based on a thorough patient assessment followed by patient tailored therapies that include, but are not limited to, exercise training, education, and behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors. Benefits of pulmonary rehabilitation include decreased shortness of breath, improved health-related quality of life, fewer days of hospitalization, and decreased health-care utilization.

Pulmonary rehabilitation is indicated primarily for patients with chronic obstructive pulmonary disease (COPD) with moderate to severe respiratory dysfunction which is correlated with increased utilization of services. It consists of approximately 36 one hour sessions. This once in a lifetime benefit would require prior authorization.

FISCAL IMPACT:

The fiscal impact of offering pulmonary rehabilitation services to our members is expected to be at least neutral to cost saving.

A review of literature¹ indicates pulmonary rehabilitation results in reduced hospital days². The cost of 36 one hour sessions is approximately \$1200/member. GCHP estimates there are a little over 400 members with COPD. Of this group, only members with moderate to severe COPD would be eligible for pulmonary rehabilitation. A reduction in 1 hospital day/ eligible member would result in a positive return on investment.

The Plan will periodically monitor cost and utilization data to determine return on investment for this service.

RECOMMENDATION:

The Plan recommends the Commission approve pulmonary rehabilitation as a benefit for Gold Coast Health Plan members.

¹ Sources of literature reviewed include Cochrane Database of Systematic Reviews, UpToDate, American Thoracic Society, and European Respiratory Society.

² Reported ranges of reduction in hospital days varies by study. Examples of average reduction in hospital days ranges from 2 ½ to 9.6.

AGENDA ITEM NO. 7

To: Gold Coast Health Plan Commission
From: Nancy Wharfield, MD, Associate Chief Medical Officer
Date: April 25, 2016
RE: Benefit Enhancement - Podiatry

SUMMARY:

Gold Coast Health Plan (GCHP) seeks to allow podiatry services as a benefit to all members in any setting regardless of Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) status.

BACKGROUND:

Before January 2009, Podiatry was a Medi-Cal benefit for all members. On January 1, 2009, Assembly Bill X3 5 excluded Podiatry as a Medi-Cal benefit except for members in the Optional Benefit Exclusion (OBE) category:

- Pregnant women when a lack of Podiatry care would affect the pregnancy outcome
- Members residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility-Developmentally Disabled (ICF/DD)
- Children under the age of 21

Many Medi-Cal Managed Care plans in existence before 2009, elected to continue to extend the Podiatry benefit to all members rather than restrict it to the OBE group. When GCHP began operations in 2011, the Podiatry benefit was administered in accordance with the OBE restriction.

As part of an effort to improve access to Podiatry and Orthopedic services, the GCHP Commission approved the Plan's request to contract with Podiatrists for the provision of podiatry services including surgical procedures in April 2013.

On January 26, 2015, the Department of Health Care Services (DHCS) issued All Plan Letter 15-003 informing Medi-Cal managed care plans that Podiatry services are reimbursable by Medi-Cal when provided to any Medi-Cal beneficiary in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

DISCUSSION:

The ability to refer to a Podiatrist is a valuable resource for primary care physicians who identify members needing additional care for bunions, diabetic foot care, or surgical interventions.

Approximately 70% of GCHP members are assigned to receive care in an FQHC setting. Allowing the remaining 30% of members assigned to non-FQHC clinics to take advantage of a podiatry benefit would fairly distribute this care to all GCHP members. Specialty care with a podiatrist for advanced diabetic foot ulcers should be a benefit for all GCHP members, not just those assigned to an FQHC. Further, allowing podiatrists to perform foot and ankle surgeries on all members would minimize the impact to orthopedic surgery capacity in our network. Last, including both FQHC and non-FQHC podiatry providers in our network, reduces the impact to our members when FQHC podiatry capacity is disrupted.

FISCAL IMPACT:

An analysis of claims for the twelve month period of October 1, 2014 through September 30, 2015 shows that there have been approximately 2,300 unique Non-FQHC members that have used Podiatry services. The PMPY cost for podiatry services for these utilizing members was \$29.15, or an annual cost of approximately \$66,000. In continuing to extend podiatry services to members assigned to receive care in non-FQHC clinics, the expected annual total at the current membership level would be approximately \$72,000.

RECOMMENDATION:

GCHP recommends the Commission approve extension of podiatry services to all members in any setting regardless of Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) status.

AGENDA ITEM NO. 8

To: Ventura County Medi-Cal Managed Care Commission
From: Anne Freese, PharmD, Director of Pharmacy
Date: April 25, 2016
RE: PBM Contract Extension

SUMMARY:

Gold Coast Health Plan (GCHP or the Plan) contracts with a Pharmacy Benefits Manager (PBM) in order to provide pharmacy benefit services to its members. The contract with the current PBM, Script Care LTD. (SCL), terminates on September 30, 2016. The contract does contain a provision to allow for three (3) additional one month extensions.

GCHP is requesting approval from the Commission to sign an additional contract amendment that changes the provision of three (3) additional one month extensions to six (6) additional one month extensions.

BACKGROUND:

SCL was selected as the PBM for GCHP in 2010 for an initial 5 year term beginning on the plan go live date. SCL provides a full suite of PBM services including prescription claim adjudication, pharmacy network access, and utilization management (UM) services for GCHP. In the best interest of the Plan, GCHP conducted an RFP process to select the best business partner moving forward.

GCHP has conducted a detailed and thorough selection process for a PBM, with a potential implementation date of October 1, 2016, if a new PBM is selected. The Commission has not yet awarded the RFP and additional contract extensions are needed in order to ensure that the Plan maintains an active contract for PBM services until the RFP is awarded or other action is taken.

While SCL will sign the attached extension, they have approached staff about an alternative extension of 36 months. This would, in effect, award the new PBM contract to SCL. Because the selection process is not complete, and because the new contract will be an entirely new contract and not an extension of the existing contract, staff is not in favor of extending the PBM contract for an additional 36 months.

RECOMMENDATION:

GCHP Staff's recommendation is to extend the current PBM contract for six (6) additional one month extensions.

**SECOND EXTENSION AMENDMENT TO
A MANAGED PRESCRIPTION DRUG AGREEMENT
MANAGED BY SCRIPT CARE, LTD., FOR GOLD COAST HEALTH PLAN**

This Second Extension Amendment (“Amendment”) to the “A Managed Prescription Drug Agreement Managed by Script Care, Ltd. for Ventura County Medi-Cal Managed Care Commission, as amended and revised (“Agreement”), is entered into by and between Ventura County Medi-Cal Managed Care Commission, a public entity doing business as Gold Coast Health Plan (“Commission”) and Script Care, Ltd. (“Contractor”).

RECITALS

- A. Contractor and Commission are parties to the Agreement effective July 1, 2011; and
- B. The parties desire to further amend certain terms of the Agreement through this Amendment; and
- C. Therefore, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree to amend the terms of the Agreement, as follows:

AMENDED TERMS

1. Defined Terms: Unless otherwise defined herein, the capitalized terms used herein shall have the same meanings set forth in the Agreement.
2. Section 24, subsection b. should be revised as follows: Subsection b. of Section 24 shall be amended to read as follows:

Commission may unilaterally renew this Agreement for six (6) terms of one (1)-month each after expiration of the Extended Term. Commission shall provide Contractor with thirty (30) days prior written notice of such renewal.
3. Effective Date: The effective date of this Amendment shall be April 25, 2016 (“Effective Date”).
4. Except as otherwise amended hereunder, all other terms of the Agreement shall remain in full force and effect. If the terms of this Amendment conflict with any term of the Agreement, the terms of this Amendment shall prevail.

IN WITNESS WHEREOF, Contractor and Commission have delivered and executed this Amendment by their respectively authorized representatives.

Dated Effective April 25, 2016.

SCRIPT CARE, LTD.

**VENTURA COUNTY MEDI-CAL
MANAGED CARE COMMISSION dba
GOLD COAST HEALTH PLAN**

By: _____

By: _____

Printed Name: _____

Printed Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

AGENDA ITEM NO. 9

To: Gold Coast Health Plan Commissioners

From: Ruth Watson, Chief Operations Officer

Date: April 25, 2016

Re: Provider Advisory Committee (PAC) Membership

SUMMARY:

The Plan has been actively recruiting for applicants to fill the eleven member Provider Advisory Committee. (PAC) This Committee has not been convened since February 2013 as the Plan has been challenged in its efforts to obtain the number of attendees required to establish a quorum. In September 2015, we presented six (6) candidates to the Commission for approval, and all were approved. In addition to the previous applications submitted, we present the following three (3) additional applications for approval by the Commission. With the number of Committee members at nine (9), there should not be an issue regarding establishing a quorum.

BACKGROUND / DISCUSSION:

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 contract, 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 health plan may best fulfill its mission. Gold Coast Health Plan (GCHP) has referred to this committee as the Provider Advisory Committee (PAC), and PAC had its initial meeting in July of 2011. PAC is scheduled to meet on a quarterly basis. The current structure of the committee is to have ten (10) voting members, with one (1) of the ten (10) positions a standing seat represented by the Ventura County Health Care Agency (VCHCA). The remaining nine (9) members serve alternating two-year terms, have no terms limits and can apply for reappointment.

In the past, the Plan has struggled to establish a quorum and PAC has not been able to meet since February 12, 2013. In order to establish a committee able to achieve a quorum of voting members to meet quarterly, GCHP has been actively recruiting with contracted

providers seeking committed participants. In September of 2015 six (6) applicants for PAC membership were submitted and approved by the Commission. An additional three (3) applications are being submitted and if approved, the total number of PAC members shall be nine (9), which will enhance the ability of the Committee to have a quorum. PAC meetings should begin to be scheduled in April, with actual meetings taking place no later than May of 2016.

The 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

RECOMMENDATION:

Staff requests that the Commission appoint the following individuals to the Provider Advisory Committee as follows.

- | | |
|-------------------------|------------------------------|
| 1. Sim Mandelbum | Term to Expire June 30, 2017 |
| 2. Joan Buck-Plassmeyer | Term to Expire June 30, 2017 |
| 3. S. Marsha Smith | Term to Expire June 30, 2017 |

APPLICATION BACKGROUND:

- | | |
|--------------------|--|
| 1. Sim Mandelbaum: | President/ Owner
U.S. Skilled Serve, Inc. |
|--------------------|--|

Experience: Mr. Mandelbaum has over 25 years' experience in the Long Term Care industry and owns and operates U.S. Skilled Serve which owns 14 skilled nursing facilities, 2 of which are in Ventura. Mr. Mandelbaum is a volunteer EMT, and is a member of the Long Beach Memorial Medical Center Collaborative Committee.

2. Joan Buck-Plassmeyer: Owner & Chief Executive Officer (CEO)
Los Robles Homecare Services, Inc.

Experience: Founded Los Robles Homecare Services, Inc. in 2000, and currently has a staff of over 100 employees. Los Robles Homecare Services provides a full range of home health services throughout Ventura County. Ms. Buck-Plassmeyer has her MSR in Nursing from DePaul University in Chicago. She is past president of the American Cancer Society for 2000 -2002, CHAP Board of Review member in Washington D.C. 2008-2014, and past President, Ventura County Homecare Association, 2002-2005.

3. S. Marsha Smith: Regional General Manager
Option Care

Experience: Option Care is a division of Walgreens. Ms. Smith has been associated with the home infusion industry for over 30 years. In her capacity as General Manager for Option Care she is responsible for the Option Care branches between San Luis Obispo and Ventura counties. She manages over 65 employees, including pharmacists, nurses, pharmacy techs and intake and reimbursement staff.

CONCURRENCE:

N/A

Attachments:

Applications for the proposed PAC Members:

1. Sim Mandelbaum
2. Joan Buck- Plassmeyer
3. S. Marsha Smith

AGENDA ITEM NO. 10

To: Gold Coast Health Plan Commission

From: C. Albert Reeves, MD, Chief Medical Officer

Date: April 25, 2016

RE: Quality Improvement 2015 Work Plan Evaluation and Yearly Quality Improvement Report Approval

SUMMARY:

The Quality Improvement Department developed a work plan at the beginning of 2015 and updated that work plan through the year. With the conclusion of 2015 the Department has evaluated the 2015 work plan to assess the accomplishments with relation to the goals outlined in the work plan. In addition the Quality Improvement Department has evaluated the needs of the Plan for additional quality improvement activities and the ability of Plan's resources to accomplish the work plan.

BACKGROUND:

Managed care health plans are required by DHCS and NCQA to have a quality work plan for each calendar year. That work plan outlines the expectations of projects and work to be done during the year. At the end of a year, it is expected that the Plan will evaluate the accomplishments relative to the work plan for the year.

RECOMMENDATION:

GCHP is requesting the Commission approve the 2015 Quality Improvement Work Plan Evaluation and the 2015 Quality Improvement Program Evaluation Summary.

CONCURRENCE:

N/A

Attachments:

2015 Quality Improvement Program Evaluation Summary
2015 Quality Improvement Work Plan Evaluation



**Gold Coast
Health Plan**SM
A Public Entity

Quality Improvement Program Evaluation Summary

2015

Al Reeves, M.D.

Chief Medical Officer

Approved March 29, 2016 by Quality Improvement Committee (QIC)

Approved <Month Day, Year> by Ventura County Medi-Cal Managed Care Commission (VCMMCC)

Overview

The overall goal of the 2015 Gold Coast Health Plan Quality Improvement (QI) Program Evaluation is to assess the effectiveness of the organization's QI Program with respect to quality, accessibility, safety of clinical care, quality of service, and member experience. Committees, departments and data analysts annually analyze and evaluate the effectiveness of the prior year's Quality Improvement Work Plan.

Oversight and Approval

The annual QI Program Evaluation is reviewed and approved annually by the Quality Improvement Committee (QIC). Committee members and department managers provide input for the evaluation.

The annual QI Work Plan serves as the roadmap for the QI Program and lists measurable objectives for key indicators and includes interventions to improve performance. The QI Work Plan is developed largely from recommendations from the annual QI Program Evaluation. Areas of significant focus include partially resolved and unresolved activities from the previous year. These activities include clinical and service improvement activities that have the greatest potential impact on quality of care, service and patient safety. The work plan also reflects the contractual requirements of GCHP.

The Chief Medical Officer reviews the 2015 QI Program Evaluation, 2016 QI Program Description and 2016 QI Work Plan with the Ventura County Medi-Cal Managed Care Commission (VCMACC) dba Gold Coast Health Plan (GCHP) which is accountable to review and approve these documents.

Overall Effectiveness Summary

Adequate resources were dedicated to program activities. The resources and infrastructure were adequate to support a positive impact on the care and quality of services of the Plan's members. Highlights of the quality accomplishments for clinical and service performance include:

- Developed and implemented a Diabetes Disease Management Program
- Successfully developed and implemented a mandatory Department of Health Care Services (DHCS) Improvement Project for the following HEDIS[®] measure; Annual Monitoring for Patients on Persistent Medications. While we do not have the final HEDIS rates, our preliminary rates indicate that this measure met the goal of increasing the rates above the DHCS minimum performance level.
- Successfully implemented the first of two Department of Health Care Services (DHCS) Performance Improvement Projects in collaboration with a clinic partner; improve the rates of immunizations for two year olds

- Developed and implemented two member incentive programs to improve the rates of well-child and postpartum exams
- Conducted eleven (11) focus groups

The information below provides a summary of the objectives and related goals and indicates if the goals were met or were not met. The 2015 QI Work Plan Evaluation contains the detailed qualitative and quantitative analyses of the Plan’s numerous initiatives and strategies to strengthen the QI Program and to provide direction to the 2016 QI Work Plan.

Objective: Improve Quality and Safety of Clinical Care Services

Met:

- Diabetes Clinical Practice Guidelines reviewed and approved
- Preventive Health Guidelines reviewed and approved
- DHCS Performance Improvement Project (PIP) Topic 1 selected and approved by DHCS
- DHCS PIP Topic 2 submitted to DHCS by deadline

The objectives related to advancing prevention, HEDIS[®] measures, and over/under utilization will be analyzed and reported once the final HEDIS[®] rates are available in July and upon release of the CAHPS[®] survey results by Health Services Advisory Group (HSAG).

Objective: Improve Quality of Nonclinical Services

Met:

- Availability of Practitioners

Not Met

- Primary Care Access Standards
- Specialty Care Access Standards
- After Hours Availability Standards
- Practitioner Availability: Cultural Needs & Preferences

The Provider Satisfaction Survey was completed; however the results were just received from the vendor. The results, analysis, and any recommended interventions will be presented at a later date.

Objective: Improve Patient Safety

Met

- Completed Initial and Tri-annual Facility Site Reviews
- Completed Physical Accessibility Site Reviews

Objective: Member Experience

DHCS is currently conducting the CAHPS® survey. The survey will not be completed until May 2016 at which time HSAG will analyze the data and send the results to the Plan. Upon receipt of the report, the results will be presented to the appropriate committees and to the Commission.

In 2014 The Myers Group performed an Off-Season CAHPS® survey. Results of that survey were received by the Plan in December of 2014. Based upon the analysis of those results, we planned and completed eleven (11) focus groups in 2015 to identify the causes of member dissatisfaction.

Objective: Health Plan Quality

Met

- 2015 QI Program Description revised and approved
- 2014 QI Program Work Plan Evaluation presented and approved
- 2015 QI Program Work Plan presented and approved
- All delegation oversight activities were completed

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality and Safety of Clinical Care Services					
NCQA QI 9	Diabetes Clinical Practice Guideline (CPG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant CPGs Distribute if necessary	Q4 2015	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of each of the CPGs Distribute guidelines to appropriate practitioners	MAC
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Completed approved at MAC 1/29/15– no substantive changes made.					
RESULTS (Qualitative Analysis) NA					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					
NCQA QI 9	Preventive Health Guideline (PHG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant PHGs Distribute if necessary	Q4 2015	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of two PHGs Distribute guidelines to appropriate practitioners	MAC
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Completed approved at MAC 7/24/15– no substantive changes made.					
RESULTS (Qualitative Analysis Analysis) NA					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality and Safety of Clinical Care Services					
Advance Prevention					
DHCS	Increase percentage of members who smoke who report being counseled to quit in prior 6 months	90%	Q4 2015	Measure during IHA monitoring Educate providers based on results of IHA monitoring Measure during 2016 CAHPS	QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate until CAHPS survey results received from DHCS, survey currently underway					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					
DHCS	Increase percentage of members who smoke who report a provider discussed tobacco cessation medication in the prior 6 months	60%	Q4 2015	Measure during IHA monitoring Educate providers based on results of IHA monitoring Measure during 2016 CAHPS	QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate until CAHPS survey results received from DHCS, survey currently underway					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality and Safety of Clinical Care Services					
HEDIS® Measures					
DHCS	Postpartum Care – Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Increase rates by 5% over previous measurement year	Q4 2015	Develop member education mailings Explore possible use of <i>text4baby</i> program for use in educating members Promote use of GCHP <i>Pregnancy E-newsletter</i> Provide provider performance feedback by means of 2014 HEDIS report cards Develop and implement member incentive program; partner with CPSP staff at clinics to help promote	Health Education QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					
DHCS	Childhood Immunization – percentage of children 2 years of age that had DtaP, IPV, MMR, HiB, HepB, VZV and pneumococcal conjugate (Combo 3)	Increase rates by 5% over previous measurement year	Q4 2015	Member newsletter article on importance of getting immunizations Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services Promote GCHP <i>New Parent E-newsletter</i> Develop and implement member incentive program and promote during HEDIS results visits with clinics	Health Education QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality and Safety of Clinical Care Services					
DHCS	Immunizations for Adolescents (Combo 1) – percentage of adolescents 13 years of age who received a meningococcal vaccine on or between the member’s 11 th and 13 th birthday and Tdap or Td on or between the member’s 10 th and 13 th birthdays (Combo1)	Increase rates by 5% over previous measurement year	Q4 2015	Member newsletter article on importance of getting immunizations Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services Develop and implement member incentive program and promote during HEDIS results visits with clinics	Health Education QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					
DHCS	Controlling High Blood Pressure – percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90)	Maintain rate above MPL Increase rates by 5% over previous measurement year	Q4 2015	Investigate why rates decreased over previous measurement year via medical record review Provide provider performance feedback by means of 2014 HEDIS report cards Develop and implement interventions based on results of medical record review Member newsletter article on how to control blood pressure	QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					
DHCS	Well Child Visits in Third, Fourth, Fifth and Sixth Years – percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year	Increase rates by 5% over previous measurement year	Q4 2015	Develop and implement member incentive program Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services	QI

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

				Develop and implement member incentive program and promote during HEDIS results visits with clinics	
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					
DHCS	Children and Adolescents' access to Primary Care Practitioners – percentage of members 12 months – 19 years of age who had a visit with a PCP	Meet or exceed DHCS MPL	Q4 2015	Develop and implement member incentive program, promote during HEDIS results visits with clinics Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services	QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					
DHCS	Counseling for Nutrition and Physical Activity for Children and Adolescents – percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling	Meet or exceed DHCS MPL	Q4 2015	Provide provider performance feedback by means of 2014 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates	QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality and Safety of Clinical Care Services					
Over/Under Utilization					
DHCS	Appropriate Testing for Children with Pharyngitis - percentage of children 2 – 18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A strep test.	Meet or exceed DHCS MPL; 2014 rate of 41.49 was below the NCQA 10 th percentile	Q4 2015	Provide provider performance feedback by means of 2014 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					
DHCS	Appropriate Treatment for Children with Upper Respiratory Infection - percentage of children 3 months – 18 years of age who were diagnosed with an upper respiratory infection (URI) and were not dispensed an antibiotic prescription.	Meet or exceed NCQA 90 th Percentile	Q4 2015	Provide provider performance feedback by means of 2014 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					
DHCS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis - percentage of adults 18 – 64 years of age with a diagnosis of acute bronchitis who were not	Meet or exceed NCQA 50 th Percentile	Q4 2015	Provide provider performance feedback by means of 2014 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

	dispensed an antibiotic prescription.				
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					
DHCS	Ambulatory Care- Summarizes Utilization of Ambulatory Care Outpatient Visits – per 1,000 Member Months	Meet Medi-Cal Managed Care Performance Dashboard Rate	Q4 2015	Analyze data to determine clinic that is outlier Send report to clinic for investigation of low rates Meet with clinic to discuss results of investigation and implement interventions based on outcome of investigation	QI QI IT Operations
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality and Safety of Clinical Care Services					
Quality Improvement Projects					
DHCS	External PIP: TBD by DHCS	Select topic and submit to DHCS for approval by September 30, 2015		Determine PIP topic Approval by QIC Submit proposal form to DHCS Submit Modules as directed by DHCS <ul style="list-style-type: none"> • Modules 1 & 2 • Modules 3,4 and 5 submit separately 	QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Met.					
RESULTS (Qualitative Analysis) Immunizations for 2 Year Olds chosen and approved by QIC on 9/29/15. PIP topic proposal submitted to DHCS/HSAG and approved on 9/30/15. Modules 1 & 2 submitted and passed after second submission. Module 3 submission date is Feb 2016.					
BARRIER ANALYSIS Initial submission of Modules 1& 2 did not pass. Clinic having difficulties pulling data and generating report. GHCP submitted data collection tool to clinic for approval, clinic approved tool. Modules 1& 2 resubmission to DHCS 1/6/16. DHCS/HSAG informed GCHP on 1/13/16 that modules passed. Currently working on Module 3 with clinic.					
NEXT STEPS Continue working with clinic to complete and submit Module 3 to DHCS/HSAG by 2/29/16.					
DHCS	Internal PIP	Select topic and submit to DHCS by January 2016	January 2016	Determine PIP topic Approval by QIC Submit proposal form to DHCS	QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Goal met.					
RESULTS (Qualitative Analysis) Screening, Brief Intervention, and Referral to Treatment (SBIRT) as second topic approved at QIC on 12/10/15. Submitted topic proposal to DHCS/HSAG on 1/25/15.					
BARRIER ANALYSIS Notification by DHCS/HSAG on 2/4/16 suggesting another topic due to statistically significant changes in other measures.					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

GCHP	Internal PIP: Increase retinal eye exam for diabetic members	Increase rate by 5% over previous year rate	Q4 2015	Member incentive letters Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services VSP letter to members Report quarterly to QIC	Health Education QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Unable to evaluate, HEDIS results not available until July					
RESULTS (Qualitative Analysis)					
BARRIER ANALYSIS					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality of Nonclinical Services					
NCQA QI 5 DHCS	<p>Primary Care Access Members are offered:</p> <ul style="list-style-type: none"> • Non-urgent primary care within 10 business days of request • Urgent care within 24 hours <p>Specialty Care Access Members are offered:</p> <ul style="list-style-type: none"> • Non-urgent specialty care appointment within 15 business days • Non-urgent ancillary services within 15 business days 	Standards met for minimum of 90% of providers	Q4 2015	Monitor performance and complaints relating to appointments Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met	Network Operations Grievances and Appeals
EVALUATION OF 2015 WORK PLAN					
<p>RESULTS (Quantitative Analysis) Goal not met.</p> <p>Appointment Access results:</p> <p>Primary Care Access Non-urgent PCP appointment within 10 business days 87.8% Urgent Care within 24 hours 75.4%</p> <p>Specialty Care Access Non-urgent specialty care appointment within 15 business days 54.1% Non-urgent ancillary appointment within 15 business days 88.9%</p> <p>Grievances A total of 27 Access to Care grievances were received in 2015. Of these 27 grievances four (4) were related to Primary Care Access and four (4) were related to Specialty Care Access.</p>					
<p>A RESULT (Qualitative Analysis) There was a 20% decrease in grievances related to Access to Care from 2014 to 2015. In 2015 a total of 27 grievances related to Access of Care were received compared to 34 grievances in 2014. The number of grievances related to Primary Care Access decreased from six (6)</p>					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

in 2014 to four (4) in 2015. Grievances related to Specialty Care Access also decreased over the same time period; 13 in 2014 versus four (4) in 2015.

The result of the access survey was received in March, 2016. A total of 141 providers were sampled in this survey. Those specialties selected were the same as those pre-determined by DMHC for access review in 2015. The breakdown of specialties included in the survey was 90 PCPs and 51 Specialists. 90 PCPS (100%) completed the survey. However not enough of the specialist within each specialty type responded to make the specialty results valid. None of the access standards met the goal.

BARRIER ANALYSIS Poor completion rate for Specialists.

NEXT STEPS Meet with providers within the network to determine obstacles preventing timely access, and in those cases where access is due to limited number of contracted providers in a specialty type, outreach to those providers not currently under contract for that specific specialty.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
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Objective: Improve Quality of Nonclinical Services

DHCS	After Hours Availability <ul style="list-style-type: none"> Members are able to reach a provider after hours 	Standards met for 90 % of providers	Q4 2015	Monitor performance and complaints relating to after-hours availability Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met	Network Operations Grievances and Appeals
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EVALUATION OF 2015 WORK PLAN

RESULTS (Quantitative Analysis) Goal Not Met; Survey not completed.

RESULTS (Qualitative Analysis) NA

BARRIER ANALYSIS NA

NEXT STEPS Plan is to perform survey in 2016 using Industry Collaboration Effort.

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

DHCS	Availability of Practitioners	Ratios: 1 PCP 1:2000 Total Physicians 1: 1200 Physician Supervision to Non-Physician Practitioner Ratio Nurse Practitioners 1:4 Physician Assistants 1:4 Network maintained PCP located within 30 minutes or 10 miles		Conduct monthly ratio analysis and monthly distance analysis using a Quest Analytics tool for primary care and high volume specialties Identify gaps and implement corrective action plan Monitor progress towards action plans to maintain or improve our time and distance standards Report bi-annual ratio analysis and annual time and distance findings to QIC	Network Operations
EVALUATION OF 2015 WORK PLAN					
<p>RESULTS (Quantitative Analysis) Goal Met. Results of the Quest Analytics indicate that ratios for PCPs are 1:857 and total physician ratio is 1:177. Standard of 30 minutes and 10 miles was met based on our quantitative results shown below. Average distance to PCP is .8 miles while average time is 1.1 minutes.</p>					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Employees With and Without Access										
City	Employee		Provider		With Access ¹		Without Access ¹		Average Distance	Average Time
	#	#	#	%	#	%	1	1		
Hendrix, CA	3	0	3	100.0	0	0.0	2.1	2.8		
Camarillo, CA	6,044	131	6,044	100.0	0	0.0	0.3	0.9		
Canoga Park, CA	21	0	21	100.0	0	0.0	6.0	9.7		
Chatsworth, CA	17	0	17	100.0	0	0.0	7.0	9.3		
Filmrock, CA	5,376	22	5,376	100.0	0	0.0	0.3	0.8		
Frazier Park, CA	1	0	0	0.0	1	100.0	27.9	30.4		
Malibu, CA	26	0	26	100.0	0	0.0	6.2	9.7		
Manteca, CA	0	0	0	0.0	0	100.0	16.4	20.0		
Moorpark, CA	5,175	11	5,175	100.0	0	0.0	1.3	1.0		
Newbury Park, CA	4,076	21	4,076	100.0	0	0.0	1.3	1.3		
Oak Park, CA	657	0	657	100.0	0	0.0	4.8	5.8		
Oak View, CA	1,164	2	1,164	100.0	0	0.0	0.6	0.8		
Ojai, CA	3,507	39	3,507	100.0	0	0.0	1.9	2.1		
Orlando, CA	66,834	332	66,834	100.0	0	0.0	0.5	0.9		
Piru, CA	775	1	775	100.0	0	0.0	4.3	4.6		
Port Hueneme, CA	5,312	5	5,312	100.0	0	0.0	0.7	1.3		
Santa Paula, CA	10,744	63	10,744	100.0	0	0.0	0.5	0.5		
Simi Valley, CA	16,310	85	16,310	100.0	0	0.0	1.1	1.5		
Sonoma, CA	477	0	477	100.0	0	0.0	3.5	4.0		
Thousand Oaks, CA	8,169	50	8,169	100.0	0	0.0	0.9	1.1		
Ventura, CA	21,737	311	21,721	99.7	66	0.3	1.0	1.3		
West Hills, CA	69	0	69	100.0	0	0.0	6.4	8.5		
Westlake Village, CA	312	32	312	100.0	0	0.0	0.6	0.6		
Grand Totals	162,824	1,105	162,549	99.9	75	0.1	0.9	1.1		

RESULTS (Qualitative Analysis) 99.9% of our population have access to their PCP within the required time and distance standard.

BARRIER ANALYSIS Goal Met, no barriers presently identified.

NEXT STEPS Continue to monitor availability of practitioners annually.

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality of Nonclinical Services					
Practitioner Availability: Cultural Needs & Preferences					
NCQA QI 5 DHCS	Practitioner Availability: Cultural and Linguistics Needs & Preferences: Assess the cultural, ethnic and linguistic needs of our members	Complete Annual Assessment	Q4 2015	Analyze the demographic needs of our members to identify opportunities for improvement	Cultural and Linguistics
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Not Met, Assessment was not completed.					
RESULTS (Qualitative Analysis) NA					
BARRIER ANALYSIS No barriers presently identified.					
NEXT STEPS Work with Member Services to analyze demographic needs of our members in order to determine if opportunities for improvement exist and provider network needs to be adjusted.					
NCQA DHCS	Assess the provider network and adjust the availability of providers within the network, if necessary, to meet membership needs and preferences	Complete Annual Assessment	Q4 2015	Monitor how effectively the practitioner network meets the needs and preferences of our members	Network Operations
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Not Met, Assessment was not completed.					
RESULTS (Qualitative Analysis) NA					
BARRIER ANALYSIS No barriers presently identified.					
NEXT STEPS Work with Member Services to analyze demographic needs of our members in order to determine if opportunities for improvement exists and the provider network needs to be adjusted.					
	Provider Satisfaction Survey	Complete Survey	Q4 2015	Analyze results and identify opportunities for improvement Develop and implement interventions as needed to improve rates	Network Operations

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

EVALUATION OF 2015 WORK PLAN

RESULTS (Quantitative Analysis) NA Unable to evaluate at this time due to results of survey just received from vendor.

RESULTS (Qualitative Analysis) NA

BARRIER ANALYSIS NA

NEXT STEPS Results will be analyzed and presented to senior leadership and presented to the Commission at a later date.

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Patient Safety					
DHCS	Complete Initial and Tri-annual Facility Site Reviews Complete Interim Reviews	100%	Year End 2015	Monitor FSR database Submit bi-annual reports to DHCS	FSR Nurse QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Met					
RESULTS (Qualitative Analysis) All site reviews completed for 2015 and bi-annual reports submitted to DHCS.					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					
DHCS	Complete Physical Accessibility Site Reviews	100%	Year End 2015	Compile reports for high volume/ancillary specialists Submit report to State Complete PARs for new provider sites	FSR Nurse QI
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Met					
RESULTS (Qualitative Analysis) All PARs completed for 2015. Reports completed and submitted to DHCS.					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					
NCQA DHCS	Improve Safe Clinical Practice	Tracking	Ongoing	Monitor site visit results from practitioner credentialing Monitor member complaints involving clinical quality of care concerns (safety)	Credentialing/Peer Review Grievances and Appeals
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Met					
RESULTS (Qualitative Analysis) Four (4) site visits were completed in 2015 based on grievances received, no issues were found for any site. Results of these visits are reported to Credentialing Coordinator for consideration during the recredentialing process. Grievances continue to be monitored and site visits completed within 30 days as needed.					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Member Experience: CAHPS, Complaints/Grievances					
DHCS	Conduct annual assessment of complaints and grievances, and CAHPS results to identify opportunities for improvement	<p>Meet or exceed 50th percentile for :</p> <ul style="list-style-type: none"> Getting Needed Care (2014 rate =78.2%) Getting Care Quickly (2014 rate =79.8%) <p>Customer Service (2014 rate =82.7%)</p> <p>Shared Decision Making (2014 rate =49.7%)</p>	Q4 2015	<p>Member Interventions:</p> <ul style="list-style-type: none"> Article in member newsletter regarding access standards Develop and implement process to assist members in obtaining appointments when requested <p>Provider Interventions:</p> <ul style="list-style-type: none"> Article in POB regarding required access standards Provider access survey Q2 2015; follow up with providers not meeting standards <p>Customer Service Interventions:</p> <ul style="list-style-type: none"> Monitor results/reports of after call survey performed by call center; follow up if issues identified <p>Monitor complaints and grievances Measure during 2016 CAHPS</p> <p>POB article regarding shared decision making</p> <p>Conduct Focus Groups</p> <p>Conduct Monthly Access Tracking Survey (6 months July to December) – upon completion present findings to clinics</p>	<p>Member Services QI Health Services</p> <p>Network Operations</p> <p>Operations</p> <p>Grievances and Appeals</p> <p>QI</p> <p>QI QI</p>
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) We are unable to determine if our goal was met for this objective because the next CAHPS survey will be conducted by the					

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

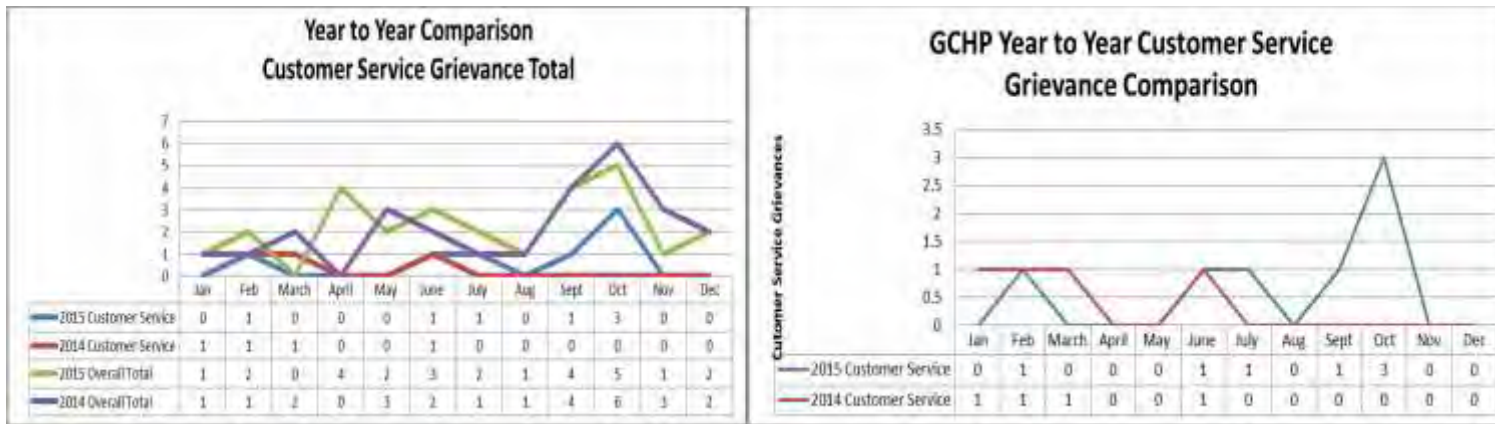
Health Services Advisory Group beginning in February 2016 and will end May 2016.

Call Center: An after-call survey of the call center was completed in 2015.

Focus Groups: A total of eleven (11) focus groups were conducted in 2015.

Monthly Access Tracking Survey: A Monthly Access Tracking Survey was begun in July 2015. The purpose of the survey is to measure member experience with their physician, specifically in the areas of access to care and physician communication. Members who have had a recent visit with a doctor are included in this survey. The goal is to have a sample size of 1200 eligible members surveyed, targeting 350 completed surveys per month. A final report will be available on April 8, 2016. The results of the finding will be shared with the leadership of those clinics that were surveyed.

Complaints and Grievances:



RESULTS (Qualitative Analysis)

Call Center: The 2015 results of the after-call survey performed by the call center showed some dissatisfaction related to the Interactive Voice Response System (IVRS). 19.11% of the callers that answered the question about their satisfaction using the IVRS were not satisfied. A review of the IVRS, which looked at prompts and self-service options, was completed in December 2015 and identified areas for improvement. Changes to the IVRS are expected to be completed in the second quarter of 2016.

Complaints and Grievances: There were 27 grievances received in 2015 versus 26 grievances in 2014 involving grievances against GHCP. There were a total of 7 grievances related to customer service in 2015 compared to 4 received in 2014. When compared to the total volume of grievances against GCHP received in 2015 (26), grievances related to customer service comprise 26% of that total versus 15% in 2014. Based on the low volume of these types of grievances there does not appear to be a trend in the increase of member grievances related to customer service.

Focus Groups: Focus groups were conducted in October for both English and Spanish speaking members. Groups were conducted for both adults as well as for parent of children. The purpose of these groups was to assess the experiences of the plan's members in order to improve their experience and satisfaction since some of the questions on the CAHPS® survey did not allow the plan to discern between issues with their provider or the plan itself.

78 members were recruited, however only 44 participated despite a gift card incentive and transportation being provided. Results of these focus groups

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

indicated that members were unaware of the difference between the Call Center and GCHP Member Services.

- **Customer Service:** Members indicated they were experiencing challenges with the phone system including dropped call, the amount of time required to get connected, lack of training and/or knowledge of the representatives and lack of follow-up by representatives.
- **Providers:** Eleven (11) of the participants indicated scheduling of appointment with providers presented challenges. Scheduling of appointments with a specialist indicated that there were long wait times, not being able to get an appointment on the same needed when they felt they needed to see someone right away.
- **GCHP:** Among members whose experience did not measure up to their expectations issues included:
 - Challenges in getting approved for coverage
 - Challenges finding the right primary care physician
 - Challenges in making appointments, getting access to specialists and accessing care after the work day

The challenge most often cited by participating members was that of getting an approval for a referral through Gold Coast. Eight of the 19 participants who responded to this prompt had some challenge getting a referral to a specialist. Concerns included the amount of time waiting for the approval, the miscommunication (or lack of communication) between the doctor's office and Gold Coast, a 'hostile' representative, and lost paperwork.

Monthly Access Tracking Survey: A final report will be available on April 8, 2016. The results of the finding will be shared with the leadership of those clinics that were surveyed as well as with senior leadership within GCHP.

Member and Provider Education: Access standards were published in the member newsletter in Summer 2015 as well as in the October 2015 Provider Operations Bulletin.

BARRIER ANALYSIS

No barriers were identified as the result of the CAHPS is not available at this time. However results of the Provider Access Survey have not been received from the vendor (ICE).

NEXT STEPS: Call Center: Implement changes to the IVR include elimination of some of the options on the member and provider menus, rearranging options to allow calls to flow more logically and adding clarity to the prompt messages.

Complaints and Grievances: Monitoring and trending of grievances related to customer service will continue in 2016 and results reported to Member Services as well as the Quality Improvement Committee.

Provider Access Survey: The plan is to schedule more frequent visits to primary care offices to determine the access availability of primary care services.

2015 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Health Plan Quality					
NCQA DHCS	<ul style="list-style-type: none"> Update QI Program Description Complete 2014 QI Program Evaluation Develop and Implement 2015 QI Program Work Plan 	100%	April 2015 April 2015 April 2015	<ol style="list-style-type: none"> Review and revise annual QI Program Description, Work Plan and Evaluation Obtain approval of 2015 QI Program and Work Plan and Evaluation of 2014 QI Program Evaluate the adequacy of resources, committee structure, practitioner participation and leadership involvement in the QI Program in order to restructure or change the QI Program for subsequent year as necessary 	Chief Medical Officer QI Director Quality Improvement Committee
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Goal met. QI Program Description and Work Plan approved at QIC on March 31, 2015 and at Ventura County Medi-Cal Managed Care Commission meeting on April 27, 2015.					
RESULTS (Qualitative Analysis) NA					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					
NCQA DHCS	Completion of Delegation Oversight Delegated Activities <ul style="list-style-type: none"> Credentialing QI UM Members' Rights Claims 	100%	Q4 2015	<ol style="list-style-type: none"> Complete audits Issue CAPs as applicable Follow-up on CAPs as applicable Report to Compliance Committee and QIC 	Compliance
EVALUATION OF 2015 WORK PLAN					
RESULTS (Quantitative Analysis) Goal Met, 100% of audits completed.					
RESULTS (Qualitative Analysis) Completed all audits as defined in the 2015 annual audit schedule and reported outcomes to QI & Compliance Committees, CAPS issued and monitored as required.					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					
Attach UM Work Plan to QI Work Plan					
Monitoring via use of Dashboard					

AGENDA ITEM NO. 11

To: Gold Coast Health Plan Commission
From: C. Albert Reeves, MD, Chief Medical Officer
Date: April 25, 2016
RE: Quality Improvement Program Description and Work Plan for 2016

SUMMARY:

The Quality Improvement Department has reviewed the Plan's Quality Improvement Program Description and made revisions for 2016. In addition the department has developed a 2016 Work Plan. The Quality Improvement Committee has approved the 2016 Quality Improvement Program Description and Work Plan submits these documents to the Commission for approval.

BACKGROUND:

Managed care health plans are required by DHCS and NCQA to have a quality improvement program description and work plan for each calendar year. The work plan outlines the expectations of projects and work to be done during the year. The work plan is based upon the requirements of DHCS and of NCQA as well as quality issues that have been identified by the Quality Improvement Department and other departments of GCHP.

RECOMMENDATION:

GCHP is requesting the Commission to approve the 2016 Quality Improvement Program Description and Work Plan.

CONCURRENCE:

N/A

Attachments:

2016 Quality Improvement Program Description
2016 Quality Improvement Work Plan

GOLD COAST HEALTH PLAN
2015-2016 QUALITY IMPROVEMENT
PROGRAM

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I. MISSION AND PURPOSE

Mission

Gold Coast Health Plan's mission is to improve the health ~~and well being of the people of Ventura County by providing access to high quality medical services of our members~~ through the provision of high quality care and services. In line with that goal, Gold Coast Health Plan's Quality Improvement Program will strive to continuously improve the care and quality of service for its members in partnership with its contracted provider network as exhibited by its dedication to the concept of measurement and re-measurement, and documenting strong actions taken and results.

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Vision

Compassionate care accessible to all for a healthy community.

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Purpose:

The purpose of the Gold Coast Health Plan (GCHP) Quality Improvement (QI) Program is to achieve high quality and optimal clinical outcomes in all departmental programs reflecting the State mission to preserve and improve the health of all Californians. The QI Program provides the framework for Gold Coast to continually monitor, evaluate and improve the quality of care, safety and services provided to all members, practitioners/providers and external/internal customers. The program provides an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services. Core values of the program include maintaining respect and diversity for members, providers and employees.

To accomplish this GCHP's QI Program aligns its efforts with the current version of the Department of Health Care Services (DHCS) Strategy for Quality Improvement in Health Care.

This foundation for a quality strategy is anchored in three linked goals of the "Triple Aim": improve health; enhance quality of health care services, including the patient experience; and reduce DHCS per-capita health program costs.

The QI Program consists of the following elements:

- A. QI Program Description
- B. Annual QI Program Evaluation
- C. Annual QI Work Plan
- D. Quality Improvement Activities
- E. QI Committee Structure
- F. Policies and Procedures

II. AUTHORITY AND RESPONSIBILITY

The Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) will promote, support, and have ultimate accountability, authority,

and responsibility for a comprehensive and integrated Quality Improvement (QI) Program. The VCMACC is ultimately accountable for the quality of care and services provided to Members but will delegate supervision, coordination, and operation of the program to the Chief Executive Officer and Quality Improvement Department under the supervision of the Chief Medical Officer and its QI Committee. The [VCMACCBoard](#) will approve the overall QI Plan, Work Plan and QI annual report; the CMO will be responsible for the day-to-day oversight of the QI Program. The [VCMACCBoard](#) will receive operational information through regular reports from the CMO and/or the Health Services Department in conjunction with the operations of its various Committees as described below.

To address the scope of the Plan's QI Program goals and objectives, the structure consists of the Quality Improvement Committee (QIC) supported by eight subcommittees that meet at least quarterly:

1. Medical Advisory Committee (MAC)
2. Pharmacy & Therapeutics (P&T) Committee
3. Utilization Management (UM) Committee
4. Health Education (HE) & Cultural Linguistics (CL) Committee
5. Credentials Committee
6. Network Management Committee
7. Member Services Committee
8. Grievance & Appeals (G&A) Committee

To further support the community involvement and achieve Plan's QI goals and objectives, the [VCMACCCommission](#) organized two committees reporting directly to them: the Provider Advisory and Member/Consumer Advisory.

A chart depicting the complete [VCMACCCommission](#) organizational structure is provided on the following pages. In addition, an organizational chart is attached depicting the key reporting relationships and discharge of QI Program activities by GCHP staff position and title. Specific roles and responsibilities are delineated in the following sections.

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

Membership

GCHP is governed by the eleven (11) member VCMACC. Commission members are appointed for two or four year terms, and member terms are staggered.

Members of the VCOMMCC are appointed by a majority vote of the Board of Supervisors.

III. PROGRAM SCOPE

The scope of the Quality Improvement Program will include the non-discriminatory quality and availability of all medically necessary, covered clinical care and service for Plan Members. The monitoring, evaluation and prioritization of issues reflects the population served. Provisions will be made for cultural and linguistic appropriateness based on the annual Group Needs Assessment (GNA). The scope of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:
 - Preventive services
 - Chronic disease management
 - Prenatal care
 - Family planning services
 - Behavioral health care services
 - Medication management
 - Coordination and Continuity of Care
2. Quality of nonclinical services including, but not limited to:
 - Accessibility
 - Availability
 - Member satisfaction surveys
 - Grievance process
 - Cultural and Linguistic Services
3. Patient safety initiatives including, but not limited to:
 - Facility site reviews
 - Credentialing of practitioners
 - Peer review
 - Sentinel event monitoring
 - Health Education
4. A QI focus which represents
 - All care settings

- All types of services
- All demographic groups

Delegation of Quality Improvement

Delegation is the formal process by which the health plan gives an external entity the authority to perform certain functions on its behalf. These functions may include quality improvement, utilization management, credentialing/recredentialing and grievance and appeals. GCHP retains accountability for ensuring the function is being performed according to expectation and standards. GCHP will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation. GCHP will only delegate activities to entities who have demonstrated the ability to perform those duties, and who have the mechanisms in place to document the activities and produce associated reports, prior to delegation of that activity. GCHP retains the right to delegate these functions. Any delegated functions are fully described in a mutually agreed upon signed and written formal delegation agreement between the Plan and each delegated entity, and includes an effective date. All agreements clearly define GCHP's and the delegate's specific duties, responsibilities, activities, reporting requirements and identifies how GCHP will monitor and evaluate the delegate's performance. The agreement also includes the Plan's right to resume the responsibility for conducting the delegated function should the delegated entity fail to meet GCHP standards.

GCHP conducts ongoing oversight, evaluation and monitoring of the delegate. At a minimum, an annual audit is conducted. Corrective action plans are implemented based upon areas of non-compliance. Delegated entities are required to submit at least semi-annually reports to GCHP according to the reporting schedule specified in the delegation agreement. Audit results and outcomes of corrective action plans are reported to QIC.

IV. QI PROGRAM GOALS, OBJECTIVES AND METHODOLOGY

The QI Program goals include:

- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care
- Measure and enhance member satisfaction with the quality of care and services provided by our network providers
- Maintain compliance with state and federal regulatory requirements
- Identify opportunities and make improvements based on measurement, validation and interpretation of data
- Provide oversight of delegated entities to ensure compliance with Gold Coast standards as well as State and Federal regulatory requirements

The Program Objectives include the following:

- To integrate the QI Program with other operational functions of GCHP

- To conduct an annual evaluation of the QI Program
- To establish and conduct an annual review of quality and performance improvement projects (QIPs) related to significant aspects of clinical and non-clinical services
- To identify opportunities for improvement through analysis of information collected from Healthcare Effectiveness Data and Information Set (HEDIS®) and utilization management patterns of care
- To encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve the manner by which care and service are delivered.

• GCHP addresses the needs of our members with complex as well as non-complex health needs through our Care Management Program. GCHP offers case management programs for the coordination of health care and for continuity of care. Through the provision of care coordination, targeted education and resource management GCHP promotes member wellness, autonomy, and appropriate use of services and financial resources. Members are referred to the case management program by self-referral, referrals by caregivers, providers, internal departments; hospitals and GCHP discharge planners, community agencies, as well as review of data and utilization patterns.

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Performance Improvement Methodology

GCHP utilizes the Institute for Health Care Improvement (IHI) Model for Improvement. Staff is encouraged to achieve improvement continuously by using the “Rapid Cycle Small Test of Change Methodology.”

GCHP uses the “Plan-Do-Study-Act Cycle” (PDSA) to implement and test the effectiveness of changes. This model focuses on identifying improvement opportunities and changes, and measuring improvements. The PDSA cycle guides the test of a change to determine if the change is an improvement.



V. PROGRAM ORGANIZATION, OVERSIGHT AND EVALUATION

CHIEF MEDICAL OFFICER

The Chief Executive Officer has appointed the Chief Medical Officer (CMO) as the designated physician to support the QI Program by providing day to day oversight and management of quality improvement activities.

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

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

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

ASSOCIATE CHIEF MEDICAL OFFICER

The Associate Chief Medical Officer assists in the functions of the Health Services Department by collaborating with the Chief Medical Officer, Health Services Staff, Quality Improvement Department, Grievance and Appeals Department, and other GCHP staff. This collaboration allows the ACMO to oversee and carry out utilization management decisions, resolve clinical complaints and appeals and monitor clinical quality improvement programs. Key performance and quality of care indicators and criteria are established and reported to the QIC by the ACMO. The ACMO also serves on committees as directed by the CMO including the QIC, CPR, P&T, UM/CM and MAC.

DIRECTOR OF QUALITY IMPROVEMENT

The QI Director is a California licensed Registered Nurse. The QI Director is responsible for working with sub-committee chairs and appropriate departments to ensure all quality monitors; analysis and improvement initiatives are in place. The Director works with the QIC, subcommittees and leadership to educate all health plan staff on the importance and role in quality improvement, communication, analysis and reporting.

The Director is a mentor for all department heads and works with them to implement processes that will create both efficient and quality services.

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

Specific roles and responsibilities include but are not limited to:

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

The QI Director oversees staff consisting of an adequate number of Registered Nurses with the requirement to fulfill QI responsibilities, and other staff that includes a QI Project Manager, Senior Quality Improvement HEDIS[®] Analyst, a QI Data Analyst, a Credentialing Coordinator and the Administrative Assistant.

QI PROGRAM EVALUATION

The QI Program is evaluated annually. This includes a review and revision of the QI Program Description, evaluation of the prior year's QI Work Plan, and the development of current year's QI Work Plan to ensure ongoing performance improvement.

An annual written evaluation of the QI Program is completed during the first quarter of each calendar year. The evaluation is reviewed and approved by the QIC and VCMMCC and includes at least the following:

- A description of completed and ongoing QI activities that addresses quality and safety of clinical care provided to GCHP members, including trended measures and an analysis of barriers to success.
- A description of completed and ongoing QI activities that address service quality and the experience of care for GCHP members, including trended measures and an analysis of barriers to success.
- Analysis and evaluation of the overall effectiveness of the QI Program (structure, communication, resources, practitioner participation), including progress toward influencing network-wide safe clinical practices and addressing the cultural and linguistic needs of GCHP members.
- Recommendation for changes to the QI Program to make it more effective.

VI. ANNUAL WORK PLAN

The Annual QI Work Plan serves as the roadmap for the QI Program and lists measurable objectives for key indicators and includes interventions to improve performance. The QI Work Plan is developed largely from recommendations from the annual QI Program Evaluation. Areas of significant focus include partially resolved and unresolved activities from the previous year. These activities include clinical and service improvement activities that have the greatest potential impact on quality of care, service and patient safety. The work plan also reflects the contractual requirements of GCHP.

At a minimum, the QI Work Plan includes a clear description of the monitoring and improvement activities, the specific timeframe and responsible parties for conducting the activities. Activities and outcomes are compared to predetermined goals. Improvement activities identified during the year and other changes may be made to the QI Work Plan as presented to the QIC and VCMMCC for approval on an ongoing basis. The QIC oversees the prioritization and implementation of clinical and non-clinical Work Plan initiatives. The QI Work Plan is assessed and updated at a minimum, semi-annually, and is included as part of the Annual QI Program Evaluation.

GCHP views this as a living document that reflects ongoing progress on QI activities and a tool to focus improvement efforts throughout the year and evaluate progress against the objectives. This continuous quality improvement effort will help GCHP achieve its mission to improve the health and well-being of the people of Ventura County by providing access to high quality medical services.

Quality Improvement activities that measure and monitor access to care include the following:

- Access and Availability Studies;
- Initial Health Assessment monitoring; and
- GeoAccess Studies

Quality Improvement activities that measure and monitor provider and member satisfaction include the following:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- Member Grievance Review; ~~and~~
- Provider Satisfaction Survey; and
- Focus Groups

Quality Improvement activities that evaluate preventive and chronic care as well as coordination, collaboration and patient safety include the following:

- HEDIS;
- Coordination of Care Studies; ~~and~~
- Facility Site Reviews; and
- Potential Quality Issue Investigation

Quality Improvement activities that evaluate GCHP's ability to serve a culturally and linguistically diverse membership include the following:

- Annual provider language study;
- Annual cultural and linguistic study;
- Ongoing monitoring of interpreter service and use; ~~and~~
- Ongoing monitoring of grievances; and
- Conduct focus groups to determine how to meet needs of minority members

Quality Improvement activities that evaluate GCHP's quality of care include the following:

- Credentialing and Recredentialing activities; and
- Peer Review Activities

Communication and Feedback

Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings and announcements. Providers are educated regarding quality improvement initiatives via on-site quality visits, provider newsletter, Provider Operations Bulletin and the GCHP website. Specific HEDIS® performance feedback is communicated to providers ~~and~~ includes via a HEDIS® report card and listings of members who need specific services.

VII. PROGRAM RESOURCES DEDICATED TO QUALITY IMPROVEMENT

QI Program Resources- Multidisciplinary Staff

Resources for the QI Program come from various department staff in addition to the leadership roles described in the Program Oversight section of this document.

Support for improvement initiatives related to case management, disease management, utilization management and other clinical process improvement measures and outcomes is provided by Health Services and QI staff.

Quality initiatives related to Service including member satisfaction and those related to complaints and appeals are supported by Member Services and Grievance and Appeals staff.

Quality initiatives related to provider network and provider communication is supported by Network Operations staff.

Credentialing and peer review functions are supported by QI staff.

The quality improvement staff assists the Director in assessing data for improvement opportunities. They work with other departments to assist in planning and implementing activities that will improve care or service.

Responsibilities include but are not limited to the following:

- Assist in creating the annual QI Plan document

- Assist in coordination of HEDIS® data collection and analysis of results
- Work with other departments to gather information for the annual QI Review
- Assist in developing activities for the annual QI work plan
- Assist the QI Director as required
- Credential and recredential providers and facilities

OTHER QI RESOURCES

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

QI Program Resources- Program and Tools

GCHP has dedicated resources to the acquisition of programs and tools that promote high quality services for our members. These include but are not limited to:

- Online Member Administration Support – provider directories, health plan benefit summaries, drug formularies and claim forms
- Online Provider Resources – eligibility and benefit look-up, claims submittal, formulary information, forms
- Online Member Education and Engagement Resources – members are offered access to comprehensive clinical information in the Health Library on our website

QI Tools, Resources and Sources of Data

GCHP utilizes tools and resources that provide standards, benchmarks, guidelines, best practices, and measurement and evaluation methodologies to assist in guiding our improvement strategies. These resources include:

- *National initiatives and measurement sets* such as Consumer Assessment of Healthcare Providers and Systems (CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS®), Quality Compass
- *Government issues laws, regulations and guidance* including those from DHCS, CMS, the U.S. Preventive Services Taskforce (USPSTF), and National Institutes of Health (NIH)
- *Healthcare Quality Improvement Organizations* such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), and the Agency for Healthcare Research and Quality (AHRQ)

QI Program Resources- Data, Information and Analytics Support

GCHP's QI Program monitors and evaluates performance and information from many different sources throughout the organization including but not limited to:

- Enrollment data, demographic data, including race, ethnicity and language preference data, is collected to monitor health care quality and for identifying and reducing health disparities among our patient population
- Claims data (utilization by diagnosis/procedure, provider, treatment/medications, site of care, etc.)

- Case management and disease management reports to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the care spectrum
- Complaint and appeal data, including investigational data (type of complaints, timeliness and/or appropriateness of resolution)
- Ongoing tracking and trending of quality of care or serious reportable event data to identify patient safety issues and assess provider qualifications
- Member and provider survey data to assess satisfaction with services and operations
- Credentialing process data to measure timeliness of application processing and quality of network providers
- Network adequacy/accessibility measurement data to assess provider availability and accessibility
- HEDIS[®] data to assess the effectiveness of clinical care and services

VIII. QUALITY COMMITTEES AND SUBCOMMITTEES

1. Quality Improvement Committee (QIC)

QIC Charter:

The QIC is the principal organizational unit that will have delegated authority to monitor, evaluate and report to the VCMMCC on all component elements of the GCHP's Quality Improvement System outlined in this Plan. The Committee shall have a minimum of 8 voting members and be chaired by the by the GCHP Chief Medical Officer (CMO) and facilitated by the Director, Quality Improvement. Membership will consist of the chairs of the 8 QI Subcommittees and at least one Commissioner and at least one practicing physician in the community. The Committee shall meet at least quarterly. Ad hoc committees, however, will meet on an as-needed basis. The Committee will critically examine and make recommendations on all quality functions of GCHP described in this policy and by California and Federal regulatory authorities as appropriate.

It is the responsibility of the QIC and its subcommittees to assure that QI activities encompass the entire range of services provided and include all demographic groups, care settings, and types of service. The committee reviews recommendations from the all Plan committees and makes recommendations on their implementation. The VCMMCC is updated quarterly or as frequently to demonstrate follow-up on all finding and required action by the Chair of the QIC or designee via a report which may include QIC minutes, information packet, data dashboard, or other communication mechanism. All of the Plan's Committees are required to maintain confidentiality and avoid conflict of interest.

An annual QI Report is submitted to the VCMMCC the first quarter of the calendar year addressing:

- A. Quality improvement activities such as:

- i. Utilization Reports
 - ii. Review of the quality of services rendered
 - iii. HEDIS results
 - iv. Quality Improvement Projects- status and/or results
 - v. Satisfaction Survey Results
 - vi. Collaborative initiatives- status and/or results
- B. Success in improving patient care, and outcomes, and provider performance.
- C. Opportunities for improvement.
- D. Overall effectiveness of quality monitoring and review activities or specific areas that require remedial action as indicated in the annual report issued by the state's EQRO.
- E. Effectiveness in performing quality management functions and achieving goals and objectives through quality monitoring programs will be measured and reported.
- F. Presentation of the QI Plan including recommendations for revision identified as a result of the Review.

QIC Objectives:

- Ensure communication process is in place to adequately track action items and work plan and enable horizontal and lateral communication as well as closing the loop when issues are resolved.
- Ensure QIC members can have a candid discussion about barriers to achieve quality goals and objectives, and to facilitate the removal of such barriers.

QIC Responsibilities:

- Facilitate data-driven indicator development for monitoring Access, Care and Service and Quality Improvement Projects interventions.
- Review quarterly committee meeting minutes, action item logs and reports regarding monitoring of health plan functions and activities. Suggest interventions or corrective actions that adhere to the rapid cycle improvement methodologies.
- Oversee the annual review, analysis and evaluation for achievement of goals and effectiveness of the QIP, quality improvement policies and procedure and QI Work Plan for presentation.
- Recommend policy changes or implementation of new policies to GCHP's Administration and Commission.

QIC Membership:

- Chief Medical Officer (Chair)

- Director, of Quality Improvement
- Director, of Health Education & Cultural Linguistics
- Associate Chief Medical Officer
- Director of Operations
- Quality Improvement Staff (as needed)
- Director of Network Operations
- Director of Pharmacy
- Director of Compliance
- Director, Health Services
- Practitioner Representatives
- CEO, Ex Officio

QIC Reporting Structure:

The QIC reports to the VCMMCC. The Chair of the QIC ensures that quarterly reports are submitted to the VCMMCC.

Meeting Frequency:

The QIC meets at a minimum quarterly.

2. Medical Advisory Committee (MAC)

Purpose:

The purpose of the MAC is to:

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

Function:

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

- Clinical Care Guidelines
- Preventive Care Guidelines
- Provider Grievance Process
- Provider Satisfaction Issues
- Provider Materials
- Quality Improvement Activities
- Provider Access Standards

- Provider Contracting Issues
- Clinical Service Delivery
- Utilization Data
- HEDIS Measures

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

Membership:

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

Meeting Frequency:

The committee meets at a minimum on a quarterly basis.

3. Member Services Committee (MSC)

MSC Charter:

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

MSC Objectives:

- Ensure GCHP members have an understanding of their health care system and know how to obtain care and services when they need them.
- Ensure GCHP members will have their concerns resolved quickly and effectively and have the right to voice complaints or concerns without fear of discrimination.
- Ensure GCHP members can trust that the confidentiality of their information will be respected and maintained.
- Ensure members have access to information on languages spoken in physician offices to better aid them in the selection of a primary care physician.
- Have access to appropriate language interpreter services at no charge when receiving medical care.
- Ensure GCHP members can reach the Member Services Department quickly and be confident in the information they receive.
- Utilize the CAHP survey to identify service indicators for improvement.
- Ensure GCHP's Member Rights and Responsibilities policy is distributed to members and providers.
- Ensure that GCHP's member materials are developed in a culturally appropriate format.
- Interface with other GCHP committees to improve service delivery to members.

MSC Membership:

- Director of Operations
- Director of Network Operations
- Manager of Member Services (Chair)
- Manager of Grievance and Appeals or designee
- Quality Improvement Representative
- Director of Health Services
- Director, of Health Education & Cultural Linguistics
- Director of Communications (Ad Hoc)
- Compliance Specialist

Meeting Frequency:

The MSC meets quarterly at a minimum.

4. Grievance and Appeals Committee (G&A)

G&A Charter:

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

G&A Objectives:

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

G&A Committee Membership:

- ~~Associate Chief Medical Officer~~
- Manager of Grievance and Appeals (Chair)
- Sr. Grievance and Appeals Specialist
- Associate Chief Medical Officer
- Director of Network Operations or Designee
- Manager of Member Services or Designee
- Director of Quality Improvement ~~Director~~ or Designee
- Director of Health Services or Designee

- Compliance Specialist
- Director of Operations
- Director of Health Education & Cultural Linguistics or Designee
- Director of Pharmacy

Meeting Frequency:

The committee meets quarterly.

5. Network Planning Committee (NPC)

NPC Charter:

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

NPC Objectives:

- Ensure GCHP providers have an understanding of the health plan and health network and know how to obtain services they need for their patients.
- Ensure GCHP providers will have their concerns resolved quickly and effectively, and have the right to voice complaints or concerns without fear of termination.
- Ensure GCHP providers have access to accurate and timely eligibility information to ensure prompt medical care to members.
- Ensure GCHP providers have access to appropriate language assistance, including interpreter services, to ensure prompt medical care for their patients.
- Ensure GCHP providers can reach Provider Services, Health Services, Member Services, and Claims departments quickly and be confident in the information they receive.
- Maintain a reporting calendar that delineates reports to be submitted for the Committee's review, the reporting frequency, and the months that reports are due.
- Evaluate overall effectiveness of applicable service, quality, and improvement activities to identify areas of improvement for services rendered to GCHP providers.
- Develop, maintain, and disseminate GCHP's provider materials in alignment with the health plan's strategic goals for provider education and satisfaction.
- Oversee the resulting data from provider satisfaction surveys, inquiries, complaints, appeals, PCP requests for member reassignment, and terminations to identify areas of opportunity for improvement in services to GCHP providers.
- Ensure that provider network meets DHCS standards and that there is adequate capacity to meet member needs.

NPC Membership:

- Director of Network Operations (Chair)

- Chief Medical Officer
- Associate Chief Medical Officer
- Provider Relations Representative
- Director of Health Services or designee
- Director of Quality Improvement
- Director, [of](#) Health Education & Cultural Linguistics

Meeting Frequency:

The committee meets at a minimum quarterly.

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

Committee Charter:

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

UM/CM Responsibilities:

Responsibilities include but are not limited to the following:

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

Membership:

- Associate Chief Medical Officer (Chair)
- Director of Health Services
- Manager of Case Management
- Manager of Utilization Management
- ~~Case Management Nurse Representative~~
- Lead UM Nurse/Trainer
- MD Reviewer
- ~~Health Services Project Manager~~
- ~~UM Nurse Representative~~
- Director of Quality Improvement
- ~~Director, Health Education & Cultural Linguistics~~
- Chief Medical Officer

Meeting Frequency:

The UM/CM Committee meets quarterly at a minimum.

7. Health Education & Cultural Linguistics Committee (HE/CL)

Purpose:

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

Functions:

- Ensure the Group Needs Assessment (GNA) is completed to determine a baseline for serving education and cultural /language needs.
- Work with other areas and the CMO to prioritize health education needs.
- Ensure opportunities are available to educate members on disease process, preventive care, plan processes and all other areas essential to good member health.
- Assist providers in educating Plan members.
- Ensure written materials are at a reading level consistent with Plan membership needs and are no greater than the sixth grade reading level.
- Educate Plan staff on specific cultural barriers that might hinder the delivery of optimal health care.
- As needed, the Health Education and Cultural Linguistic Committees will meet separately to review specific program goals and objectives. Members for the

Health Education Committee will consist of the same membership as the Cultural and Linguistic Committee with expectation of:

Membership:

- Director of Health Education & Cultural Linguistics (Chair)
- Chief Medical Officer
- Associate Chief Medical Officer
- Director of Health Services or designee
- Manager of Case Management or designee
- Director of Communications
- Manager of Member Services or designee
- Director of Network Operations or designee
- Quality Improvement Representative
- Cultural and Linguistic Specialist
- Health Education Specialist

Meeting Frequency:

The committee meets at a minimum quarterly.

8. Credentials/Peer Review (CPR) Committee

Purpose:

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

Functions:

Credentialing Responsibilities:

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

Peer Review Responsibilities:

- Review results of provider profiling when available and suggest methods to feed information back to network providers
- Review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns and determine corrective action when necessary

Membership:

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

Meeting Frequency:

The committee meets quarterly.

9. Pharmacy & Therapeutics (P&T) Committee

Purpose:

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

Function:

- Maintenance of a drug formulary based on an objective evaluation of efficacy, safety and cost-effectiveness of medications that is reviewed and updated at least quarterly
- Assess, review and determine formulary status for all new drugs approved by the FDA and all drugs added to the Medi-Cal Fee For Service List of Contract Drugs
- Review and approve all matters pertaining to the use of medication, including development of prescribing guidelines and protocols and procedures to promote high quality and cost-effective drug therapy
- Provide oversight of the prior authorization process to ensure that medications are reviewed consistently according to the approved guidelines
- Review and evaluation of analyses including but not limited to population demographics, morbidities, health risks, and provider-specific and plan-wide utilization patterns for enrolled members
- Any other issues related to pharmacy quality and usage

Membership:

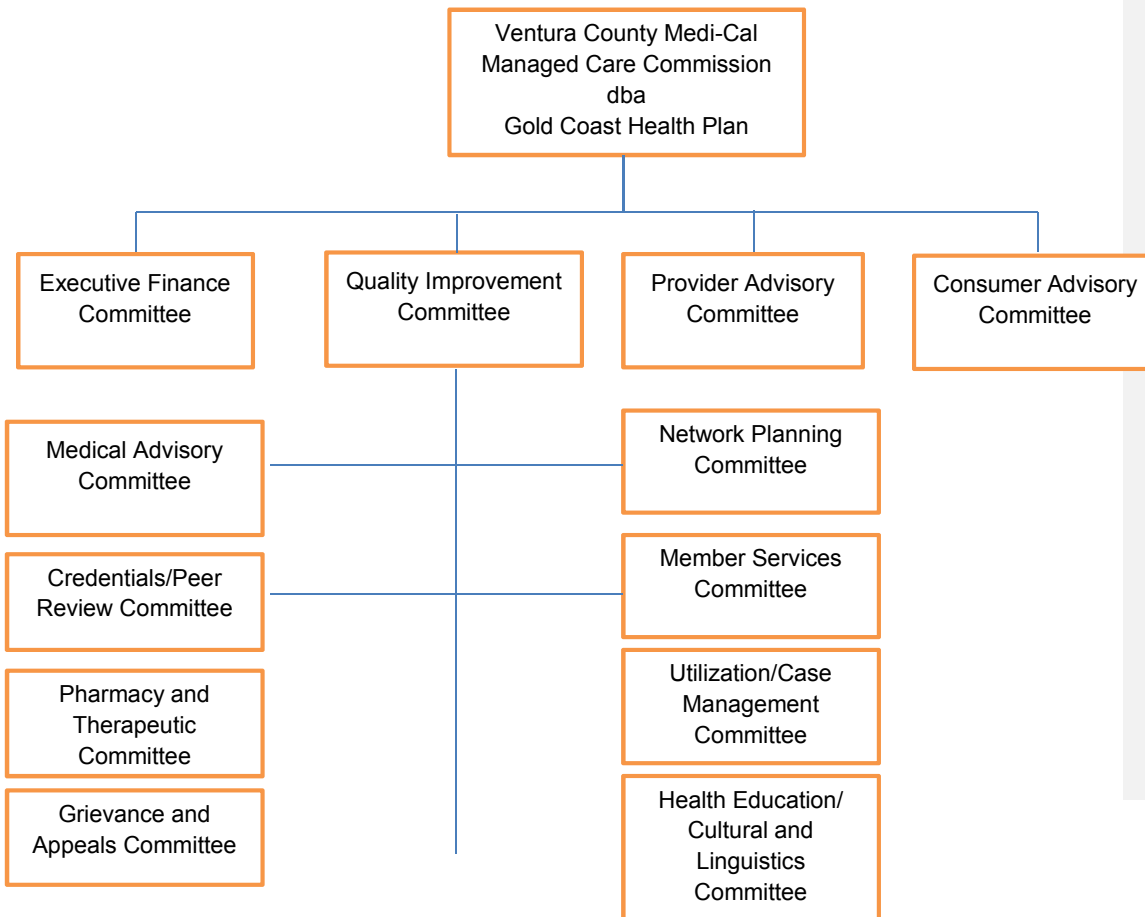
The P&T Committee members include but are not limited to GCHP's Chief Medical Officer (Chair), PBM representative, GCHP's Director of Pharmacy Services, physicians, and representatives of a variety of clinical specialties.

Meeting Frequency:

The committee meets quarterly.

IX. GOLD COAST HEALTH PLAN COMMITTEE ORGANIZATIONAL CHART

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





X. QUALITY COMMITTEE MEETINGS FOR CALENDAR YEAR ~~2015~~2016

Tuesday, March ~~31~~29, ~~2015~~2016

Tuesday, June ~~30~~28, ~~2015~~2016

Tuesday, September ~~29~~27, ~~2015~~2016

Tuesday, December ~~45~~13, ~~2015~~2016

Location – Executive Conference Room

AVAILABILITY OF QIP TO PRACTITIONERS AND MEMBERS

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

REFERENCES

- Gold Coast Health Plan Quality Improvement System Policy and Procedure 4a
- Gold Coast Health Plan Utilization Management Program Description
- Gold Coast Health Plan Care Management Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 13-005
- HEDIS® National Committee for Quality Assurance
- DHCS Quality Strategy
- National Quality Strategy

- Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010
- Kohn KT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 1999
- The Quality Improvement and Assessment (QIA) Guide for Medi-Cal MCPs
- The QIA Guide = available on the DHCS website at:
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx>
- Title 42, Code of Federal Regulations, Section 438.240(b) (1)
- Gold Coast Health Plan Policies and Procedures as they apply

**UTILIZATION MANAGEMENT AND CARE MANAGEMENT PROGRAM DESCRIPTION
IN A SEPARATE DOCUMENT.**

The Quality Improvement Plan was approved by the Quality Improvement Committee on March ~~34XX~~, 20152016.

The ~~2015-2016~~ Quality Improvement Program Description was approved by Ventura County Medi-Cal Managed Care Commission (VCMCC) on April ~~27XX~~, 20152016.

2016 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality and Safety of Clinical Care Services					
NCQA QI 7	Diabetes Clinical Practice Guideline (CPG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant CPGs Distribute if necessary	Q4 2016	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of each of the CPGs Distribute guidelines to appropriate practitioners	MAC
NCQA QI 7	Preventive Health Guideline (PHG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant PHGs Distribute if necessary	Q4 2016	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of two PHGs Distribute guidelines to appropriate practitioners	MAC
Advance Prevention			TBD		
DHCS	Increase percentage of members who smoke who report being counseled to quit in prior 6 months	90%	Q4 2015	Measure during IHA monitoring Educate providers based on results of IHA monitoring Measure during 2016 CAHPS	QI
DHCS	Increase percentage of members who smoke who report a provider discussed tobacco cessation medication in the prior 6 months	60%	Q4 2015	Measure during IHA monitoring Educate providers based on results of IHA monitoring Measure during 2016 CAHPS	QI
HEDIS® Measures			TBD		
DHCS	Postpartum Care – Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Increase rates by 5% over previous measurement year	Q4 2015	Develop member education mailings Explore possible use of <i>text4baby</i> program for use in educating members Promote use of GCHP <i>Pregnancy</i> E-newsletter Provide provider performance feedback	Health Education QI

2016 Gold Coast Health Plan Quality Improvement Work Plan

				by means of 2014 HEDIS report cards Develop and implement member incentive program; partner with CPSP staff at clinics to help promote	
DHCS	Childhood Immunization – percentage of children 2 years of age that had DtaP, IPV, MMR, HiB, HepB, VZV and pneumococcal conjugate (Combo 3)	Increase rates by 5% over previous measurement year	Q4 2015	Member newsletter article on importance of getting immunizations Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services Promote GCHP <i>New Parent</i> E-newsletter Develop and implement member incentive program and promote during HEDIS results visits with clinics	Health Education QI
DHCS	Immunizations for Adolescents (Combo 1) – percentage of adolescents 13 years of age who received a meningococcal vaccine on or between the member’s 11 th and 13 th birthday and Tdap or Td on or between the member’s 10 th and 13 th birthdays (Combo1)	Increase rates by 5% over previous measurement year	Q4 2015	Member newsletter article on importance of getting immunizations Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services Develop and implement member incentive program and promote during HEDIS results visits with clinics	Health Education QI
DHCS	Controlling High Blood Pressure – percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90)	Maintain rate above MPL Increase rates by 5% over previous measurement year	Q4 2015	Investigate why rates decreased over previous measurement year via medical record review Provide provider performance feedback by means of 2014 HEDIS report cards Develop and implement interventions based on results of medical record review	QI

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				Member newsletter article on how to control blood pressure	
DHCS	Well Child Visits in Third, Fourth, Fifth and Sixth Years – percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year	Increase rates by 5% over previous measurement year	Q4 2015	Develop and implement member incentive program Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services Develop and implement member incentive program and promote during HEDIS results visits with clinics	QI
DHCS	Children and Adolescents’ access to Primary Care Practitioners – percentage of members 12 months – 19 years of age who had a visit with a PCP	Meet or exceed DHCS MPL	Q4 2015	Develop and implement member incentive program, promote during HEDIS results visits with clinics Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services	QI
DHCS	Counseling for Nutrition and Physical Activity for Children and Adolescents – percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling	Meet or exceed DHCS MPL	Q4 2015	Provide provider performance feedback by means of 2014 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates	QI

2016 Gold Coast Health Plan Quality Improvement Work Plan

Over/Under Utilization

DHCS	Appropriate Testing for Children with Pharyngitis - percentage of children 2 – 18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A strep test.	Meet or exceed DHCS MPL; 2014 rate of 41.49 was below the NCQA 10 th percentile	Q4 2015	Provide provider performance feedback by means of 2014 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI
DHCS	Appropriate Treatment for Children with Upper Respiratory Infection - percentage of children 3 months – 18 years of age who were diagnosed with an upper respiratory infection (URI) and were not dispensed an antibiotic prescription.	Meet or exceed NCQA 90 th Percentile	Q4 2015	Provide provider performance feedback by means of 2014 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI
DHCS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis - percentage of adults 18 – 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	Meet or exceed NCQA 50 th Percentile	Q4 2015	Provide provider performance feedback by means of 2014 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI
DHCS	Ambulatory Care- Summarizes Utilization of Ambulatory Care Outpatient Visits – per 1,000 Member Months	Meet Medi-Cal Managed Care Performance Dashboard Rate	Q4 2015	Analyze data to determine clinic that is outlier Send report to clinic for investigation of low rates Meet with clinic to discuss results of investigation and implement interventions based on outcome of investigation	QI IT Operations

2016 Gold Coast Health Plan Quality Improvement Work Plan

Quality Improvement Projects

DHCS	External PIP: Improve the rates for Childhood Immunization Status (CIS) Combo 3 HEDIS measure	Increase rates at Las Islas Family Medical Group from 67.66% to 77.66%	June 30, 2017	<p>Submit Modules as directed by DHCS for approval</p> <ul style="list-style-type: none"> • Modules 3,4 and 5 submit separately <p>Report 3 month PDSA cycle results to QIC and DHCS/HSAG</p>	QI
DHCS	Internal PIP: Increase rates of developmental screenings	Select and engage clinic and begin modules Metric TBD	December 2016	<p>Submit Modules as directed by DHCS for approval</p> <ul style="list-style-type: none"> • Modules 1 & 2 • Modules 3, 4, and 5 submit separately 	QI

2016 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality of Nonclinical Services					
NCQA NET 2 DHCS	<p>Primary Care Access Members are offered:</p> <ul style="list-style-type: none"> Non-urgent primary care within 10 business days of request Urgent care within 24hours <p>Specialty Care Access Members are offered:</p> <ul style="list-style-type: none"> Non-urgent specialty care appointment within 15 business days Non-urgent ancillary services within 15 business days 	Standards met for minimum of 90% of providers	Q4 2016	<p>Monitor performance and complaints relating to appointments</p> <p>Report quarterly performance to QIC</p> <p>Develop and implement corrective action plans when timely access standards not met</p> <p>Conduct survey</p>	Network Operations Grievances and Appeals
DHCS	<p>After Hours Availability</p> <ul style="list-style-type: none"> Members are able to reach a provider after hours 	Standards met for 90 % of providers	<p>Q4 2016</p> <p>Q3 2016</p>	<p>Monitor performance and complaints relating to after-hours availability</p> <p>Report quarterly performance to QIC</p> <p>Develop and implement corrective action plans when timely access standards not met</p> <p>Conduct survey</p>	Network Operations Grievances and Appeals
NCQA NET 1 DHCS	Availability of Practitioners	<p>Ratios: 1 PCP 1:2000 Total Physicians 1: 1200</p> <p>Physician Supervision to Non-Physician</p>	Q4 2016	<p>Conduct bi-annual ratio analysis and annual GeoAccess analysis for primary care and high volume specialties</p> <p>Identify gaps and implement corrective action plan</p> <p>Monitor progress towards action plans to maintain or improve GeoAccess</p>	Network Operations

2016 Gold Coast Health Plan Quality Improvement Work Plan

		Practitioner Ratio Nurse Practitioners 1:4 Physician Assistants 1:4 Network maintained PCP located within 30 minutes or 10 miles		standards Report bi-annual ratio analysis and annual GeoAccess findings to QIC	
Practitioner Availability: Cultural Needs & Preferences					
NCQA NET 1 DHCS	Practitioner Availability: Cultural and Linguistics Needs & Preferences: Assess the cultural, ethnic and linguistic needs of our members	Complete Annual Assessment	Q4 2016	Analyze the demographic needs of our members to identify opportunities for improvement	Member Services Network Operations
NCQA NET 1 DHCS	Assess the provider network and adjust the availability of providers within the network, if necessary, to meet membership needs and preferences	Complete Annual Assessment	Q4 2016	Monitor how effectively the practitioner network meets the needs and preferences of our members	Network Operations
	Provider Satisfaction Survey	Complete Survey	Q4 2016	Analyze results and identify opportunities for improvement Develop and implement interventions as needed to improve rates	Network Operations

2016 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Patient Safety					
DHCS	Complete Initial and Tri-annual Facility Site Reviews Complete Interim Reviews	100%	Year End 2016	Monitor FSR database Submit bi-annual reports to DHCS	FSR Nurse QI
DHCS	Complete Physical Accessibility Site Reviews	100%	Year End 2016	Compile reports for high volume/ancillary specialists Submit report to State Complete PARs for new provider sites	FSR Nurse QI
NCQA CR 5 & 6 DHCS	Improve Safe Clinical Practice	Tracking	Ongoing	Monitor site visit results from practitioner credentialing Monitor member complaints involving clinical quality of care concerns (safety)	Credentialing/Peer Review Grievances and Appeals

2016 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Member Experience: CAHPS, Complaints/Grievances TBD					
NCQA QI 4 DHCS	Conduct annual assessment of complaints and grievances, and CAHPS results to identify opportunities for improvement	<p>Meet or exceed 50th percentile for :</p> <ul style="list-style-type: none"> Getting Needed Care (2014 rate =78.2%) Getting Care Quickly (2014 rate =79.8%) <p>Customer Service (2014 rate =82.7%)</p> <p>Shared Decision Making (2014 rate =49.7%)</p>	Q4 2015	<p>Member Interventions:</p> <ul style="list-style-type: none"> Article in member newsletter regarding access standards Develop and implement process to assist members in obtaining appointments when requested <p>Provider Interventions:</p> <ul style="list-style-type: none"> Article in POB regarding required access standards Provider access survey Q2 2015; follow up with providers not meeting standards <p>Customer Service Interventions:</p> <ul style="list-style-type: none"> Monitor results/reports of after call survey performed by call center; follow up if issues identified <p>Monitor complaints and grievances Measure during 2016 CAHPS</p> <p>POB article regarding shared decision making</p> <p>Conduct Focus Groups</p> <p>Conduct Monthly Access Tracking Survey (6 months July to December) – upon completion present findings to clinics</p>	<p>Member Services QI Health Services</p> <p>Network Operations</p> <p>Operations</p> <p>Grievances and Appeals</p> <p>QI</p> <p>QI QI</p>

2016 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Health Plan Quality					
NCQA QI 1 DHCS	<ul style="list-style-type: none"> ●Update QI Program Description ●Complete 2015 QI Program Evaluation ●Develop and Implement 2016 QI Program Work Plan 	100%	April 2016 April 2016 April 2016	<ol style="list-style-type: none"> 1. Review and revise annual QI Program Description, Work Plan and Evaluation 2. Obtain approval of 2016 QI Program and Work Plan and Evaluation of 2015 QI Program 3. Evaluate the adequacy of resources, committee structure, practitioner participation and leadership involvement in the QI Program in order to restructure or change the QI Program for subsequent year as necessary 	Chief Medical Officer QI Director Quality Improvement Committee
NCQA QI 10 DHCS	Completion of Delegation Oversight Delegated Activities <ul style="list-style-type: none"> ● Credentialing ● QI ● UM ● Members' Rights ● Claims 	100%	Q4 2016	<ol style="list-style-type: none"> 1. Complete audits 2. Issue CAPs as applicable 3. Follow-up on CAPs as applicable 4. Report to Compliance Committee and QIC 	Compliance
Attach UM Work Plan to QI Work Plan					
Monitoring via use of Dashboard					

AGENDA ITEM NO. 12

To: Gold Coast Health Plan Commission

From: C. Albert Reeves, MD, Chief Medical Officer

Date: April 25, 2016

RE: Quality Improvement Policy QI-023 Potential Quality Issue Investigation and Resolution

SUMMARY:

The Quality Improvement Department has reviewed and revised the Quality Improvement Policy QI-023 Potential Quality Issue Investigation and Resolution for 2016. In addition the policy was reviewed and approved at the Credentials/Peer Review Committee on March 10, 2016 and the Quality Improvement Committee on March 29, 2016.

BACKGROUND:

This policy describes the process for identification, reporting and processing of a Potential Quality Issue (PQI) in order to determine opportunities for improvement in the provision of care and services for our members. The policy was revised to update the current processes in place and to clarify processes for secondary review of PQIs and opportunities for contracted and non-contracted providers to respond to a PQI.

RECOMMENDATION:

GCHP is requesting the Commission to approve policy QI-023 Potential Quality Issue and Investigation Resolution.

CONCURRENCE:

N/A

Attachments:

QI-023 Potential Quality Issue Investigation and Resolution



Title: Potential Quality Issue Investigation and Resolution	Policy Number: <u>QI-023</u>
Department: Quality Improvement	Effective Date: July 1, 2014
CEO Approved:	Revised: <u>June 26, 2014/12/29/15</u>

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Purpose:

To provide a systematic method for the identification, reporting, and processing of a Potential Quality Issue (PQI), to determine opportunities for improvement in the provision of care and services to Gold Coast Health Plan (GCHP) members, and to direct appropriate actions for improvement based upon outcome, risk, frequency and severity.

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Policy:

To describe the process that Gold Coast Health Plan identifies, investigates, rates and refers Potential Quality Issues.

Definitions:

- A. A Potential Quality Issue (PQI) is defined as a suspected deviation from expected provider performance, clinical care, or outcome of care, which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues.
- B. A quality issueQuality Issue is defined as a confirmed deviation from expected provider performance, clinical care, or outcome of care, which has been determined through the PQI process to be inconsistent with professionally recognized standards of care.
- C. A providerProvider is any individual or entity engaged in the delivery of health care services licensed or certified by the State to engage in that activity in that State if such licensure or certification is required by State law or regulation.
- D. A Corrective Action Plan (CAP) is a plan approved by the Credentials/Peer Review Committee (C/PRC) to help ensure that a related Quality Issue does not occur in the future. The CAP will have clearly stated goals and time frames for completion.
- E. Severity Level: Please refer to Attachment B: Case Leveling Grid.

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Procedure:

A. IDENTIFICATION OF POTENTIAL QUALITY ISSUES

- 1. Potential Quality Issues are identified through the systematic review of a variety of data sources, including but not limited to the following sources:
 - Information gathered through concurrent, prospective, and retrospective utilization review;
 - Referrals by health plan staff;
 - Referrals by health plan providers or provider staff
 - Referrals by non-health plan contracted providers or staff
 - Facility site reviews;



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- Claims and encounter data;
- Pharmacy utilization data;
- HEDIS medical record abstraction process;
- Medical records audits;
- Phone log detail; and
- Grievances.

- The scope of PQI reporting includes services provided by:
 - Contracted and non-contracted providers, including subcontractors that provide inpatient and outpatient services;
 - Durable ~~medical equipment~~ Medical Equipment (DME) and medical supplies providers;
 - Pharmacy providers;
 - Home health providers;
 - Ancillary service providers including, but not limited to, lab, pharmacy, radiology, Emergency Medical Services (EMS) and Ventura Transit System (VTS).

B. PQI REFERRAL

- PQIs may be reported by any of the following:
 - ~~Any~~ GCHP staff member;
 - ~~Anonymous~~;
 - ~~Any member of the community~~; and
 - ~~Any contracted or non-contracted provider~~.
- A PQI is reported to the ~~Peer Review Lead (PRL)~~ Quality Improvement (QI) department by sending a completed PQI Referral Form (RF), see Attachment A, to PQIReporting@Goldchp.org. The PQI form will be located on the Plan's secured SharePoint site. The following information, at a minimum, should be documented and promptly forwarded to the ~~PRL with a cc: to the Quality Improvement Administrative Assistant (QI-AA):~~ QI department
 - ~~The~~ member's name, date of birth, sex, and Medi-Cal number;
 - ~~Admission, discharge for each admission, and/or office visit dates, if applicable~~;
 - ~~Physician/provider name(s)~~;
 - ~~Facility where problem may have occurred~~;
 - ~~The date of the suspected/reported occurrence~~;
 - ~~The date the PQI Referral Form was completed~~;
 - ~~The name and department of the individual identifying the PQI~~;
 - ~~The box marked on the referral form that most closely describes the issue~~; and

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- ~~The individual reporting the PQI should write a description of the problem in a concise, factual manner. and include the member's medical record number when applicable.~~

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C. PQI REVIEW-PRIMARY

1. Upon receipt of the RF, the QI AA or his/her designee will enter the RF into the PQI secured database. ~~and create a folder which will contain the RF, PQI Worksheet, and any materials included in the PQI submission.~~ The QI AA will notify the PRL/QI nurse, ~~by e-mail~~ that the RF has been entered and is ready for triage, ~~by hand-delivering the file to him/her.~~
2. The RF is processed within seven (7) calendar days, unless the issue is urgent. The PRL-QI nurse will triage the RF on day one for urgent issues. If the issue is urgent, the PRL-QI nurse will contact the Chief Medical Officer (CMO) / Associate Chief Medical Director (~~ACMD~~ Officer (ACMDACMO)) by phone with a follow-up secure-email by close of business. Processing of the RF includes requesting pertinent medical records. If medical records are requested from multiple providers, the twenty (20) day time limit does not begin until all requested medical records have been received. The QI AA ~~hand-delivers, notifies the PRL-QI nurse by e-mail that~~ all records ~~that~~ have arrived, ~~to the QI nurse, and the case is ready for review.~~ If during the twenty (20) day review the PRL-QI nurse discovers that additional records are required, an additional medical record request is completed and documented in the PQI secured database, given to the QI AA for follow-up. The QI AA notifies the PRL-QI nurse when additional records have arrived and the 20-day timeframe resets. During case review, professionally recognized standards of care are taken into consideration. A PQI often represents a single event or occurrence. One report alone may not represent a quality issue; however, trending of similar events may reveal a quality issue and would dictate the re-opening of a case previously reviewed or closed.
3. All PQI's are rated for member outcome (O), system issues (S), provider care (P)
4. If the PRL's-QI nurse's initial review determines that there are no provider or system issues, the case is leveled as a ~~P-0P0~~ (no provider issues) or an ~~S-0S0~~ (no system issues) and if the member outcome is a 0, ~~or 1-1, or 2,~~ the PQI is closed in the database. The PRL-QI nurse may not determine an adverse quality of care issue. If the PRL-QI nurse determines that the member needs immediate assistance beyond the scope of peer review, the appropriate information may be forwarded to other involved departments for action and follow-up. If the PRL-QI nurse determines that the PQI is beyond a PO/SO, or the outcome is a ~~2 or 3, 3 or 4~~ the case is forwarded to the CMO/~~ACMD~~ MDACMD-ACMO for secondary review.



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D. D. PQI REVIEW-SECONDARY – Providers credentialed by a contracted organization with Delegated credentialing.

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- During secondary review, the CMO/~~ACMOMD~~ACMD-ACMO may:
 - Assign a potential severity level of ~~O - 000~~-3, P0/S0 and instruct the PRL-QI nurse to close the case;
 - Assign a ~~potential~~ severity level of P1/S1 and instruct the PRL-QI nurse to trend the PQI to the provider or facility;
 - Assign a preliminary or a final potential severity level of P2/S2, ~~or P3/S3~~ and instruct the PRL-QI nurse to send a Peer Review Letter to the provider(s) of concern requesting a response to the concerns of the case. A response is required in 30 days. ~~If the provider(s) response satisfies the CMO/ACMD-ACMO concern(s) then the CMO/ACMD-ACMO may lower the rating to S1 or P1 and instruct the PRL-QI nurse to trend the case to the provider or facility and close the case or prepare the case for presentation to the Credentials/ Peer Review Committee (C/PRC);~~
 - A P2/S2 may be trended or the reviewing CMO or ACMO may send a letter to the provider or the medical director of the provider's credentialing organization to review and provide a response. A CAP may or may not be appropriate.
 - Assign a preliminary -rating of an S3 or P3 which will require a letter to the provider requesting a response or to the medical director of the provider's credentialing organization for a review by the organizations peer review committee(s) with a response with the assessment and any action taken.
 - Request that the PRL-QI nurse send the case to a consultant physician with the same specialty as the provider of concern or to an external review organization (please refer to #3 on page 4 of 9). For routine reviews the specialist or external review organization has 30 days to return the case to the PRL with a level and next steps. ~~If the review is expedited, the review should be returned to the PRL-QI nurse in 7 calendar days. The PRL-QI nurse will discuss the specialist's findings with the CMO/ACMOMD~~ACMDACMO;

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Upon receiving all responses ~~from either the practitioner~~ and consultant specialist or external review organization, assessment, if requested, the CMO/~~ACMOMD~~ACMD-ACMO will rate the case. For some cases that are rated a P2/S2 and all cases that are rated S3 or P3 or or higher the CMO/~~ACMOMD~~ACMD-ACMO will instruct the PRL-QI nurse to prepare the case for presentation to the C/PRC. Cases rated P1/2 or S/1/2 will usually be trended but ~~may or may not~~ be referred to the C/PRC.

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For cases referred to the C/PRC, that committee may alter ~~kesmakes~~ the final severity level determinations. The C/PRC may request further information or require further corrective action.



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Emergency action: If the CMO determines that a situation exists where immediate action is required to protect the life or well-being of a GCHP member or any person, or to reduce substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient or prospective patient; the CMO may summarily suspend or ~~any~~ terminate the GCHP credentialed status. See policy MP CR #9 "Fair Hearing Process for Adverse Decisions."

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E. OPPORTUNITIES TO RESPOND TO RESPOND FOR DISCUSSION BY THE PROVIDER(S) OF CONCERN

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1. ~~1. When re1. Where~~ the provider(s) of concern ~~is not a provider through a contract with a group or is not credentialed by a contracted group or is a non-contracted provider or entity and has a PQI rated has a potential Severity Level of S2-S3 or P2-P3,~~ he/she will be given an opportunity to ~~provide a written response discuss to the discuss,~~ (written/telephonic/in-person) the case. The provider(s) of concern will be given 30 calendar days to respond to the GCHP Peer Review Letter, ~~either in writing or by phone interview to with the CMO/ACMOMD.~~ If the provider of concern is a member of an organization that contracts with GCHP and is credentialed by the contracted organization, findings and ratings by the CMO/ACMO or C/PRC will be addressed to the medical director of the organization. The medical director will be given the opportunity to respond in writing to the concerns found with the case and will be required to provide the assessment by the organizations peer review process and any actions or corrective actions taken by the contracted organization.

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~~ACMDACMO~~ At a minimum, the Peer Review Letter will address the following areas:

- Patient demographics;
- Brief statement explaining purpose of quality review activities;
- Brief summary of the background of the case;
- Potential severity level;
- Confidentiality statement; and
- CMO or ACMQB signature.

2. If no response is heard from the provider of concern or the credentialing organization, ~~for the CMO/ACMD-ACMO or PRL-QI nurse will -make -conduct-~~ a telephonic inquiry with the provider or the medical director of the credentialing organization to ensure the Peer Review Letter has been ~~received and~~ received and reviewed ~~by the provider of concern.~~

3. If the provider(s) of concern or the medical director of the credentialing organization fails to provide additional information, the CMO or ~~ACMD-ACMO~~ may choose to make a decision or refer the case to the C/PRC without input.

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~~When the C/PRC receives the PQI Case for review,~~ it may again request additional information from the practitioner or the provider facility.



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4. After the provider has had the opportunity to respond and upon review of the information, the CMO or ACMD-ACMO may refer the case to the C/PRC, or request a review by a provider within the same or a similar specialty, or to an external review organization.
5. Phone conversations between a peer reviewer and CMO or ACMD-ACMO will have notes taken be documented, which and will be entered into the peer review file, and will be reflected back to the provider in a subsequent Peer Review Letter, to offer the opportunity to make corrections.

F. F. Credentials/Peer Review Committee (C/PRC) Review

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1. Information for PQI cases presented to the Credentials/Peer Review Committee (C/PRC) will include a summary of the case and material felt by the CMO to be important for the committee's review. Any response from the provider and any review materials by an independent reviewer or external review organization will be available to the committee. The C/PRC may rate the case at any level. Case dispositions will be as follows:
 - P1/S1 will be trended to the providers file.
 - P2/S2 may be trended or a letter sent to the provider or the medical director of the provider's credentialing organization with a letter to the provider or may be treated in the same manner as a P3/S3 described below.
 - P3/S3:
 - P3 will become part of the provider's re-credentialing assessment.
 - S3 Clinic Providers will be part of the FSR packet and reviewed in the site review process.
 - S3 Hospitals will be sent to Provider Contracting to address during their contract review.
2. C/PRC recommendations for cases determined to be P3/S3 may be as follows:

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- a) If the C/PRC determines Recommend that the explanation and corrective action provided by the provider or the provider's credentialing organization is not sufficient, it may rRecommend that the provider or the credentialing organization develop a Corrective Action Plan (CAP). A notice shall be given to the provider or the provider's credentialing organization within seven (7) calendar days of the recommendation of such action. Grounds for recommending a CAP include, but are not limited to:
 - Failure to provide professional services of acceptable quality as determined by the C/PRC;
 - Failure to follow GCHP utilization review policies;
 - Failure to follow GCHP quality improvement policies;
 - Failure to treat patients for whom the provider is responsible;
 - Failure to adhere to the provider contract or GCHP policies;

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- —Acts or omissions constituting unprofessional or unethical conduct;
- —Acts constituting disruptive behavior, inability to work collaboratively with others;
- —Sexual misconduct with a patient, or harassment/discrimination complaints; and
- —Failure to report adverse action by another peer review body or a hospital.

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If a CAP is initiated, it is included in the PQI case file. A CAP may include the goals, objectives, deliverables, time frames, persons responsible, follow-up and evaluation of CAPs as recommended by the C/PRC. The time frame for providers or credentialing organizations to respond to a corrective action plan is 30 days. The provider (s) of concern will be sent a reminder notice on day fifteen (15). If the CAP response is not received by GCHP by day thirty (30), a call will be placed by the PRLQI nurse. A fifteen (15) day extension may be granted for reasonable concerns. If by day forty-five (45), the CAP response has not been received, the case is then forwarded to the CMO for further determination, including review by the Credentialing Committee which may include referral to the C/PRC for review of a change in privileges. Upon completion by the provider, the CAP will be reviewed and the results will be reported to the C/PRC.

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The CAP may include, but is not limited to:

- Required attendance at continuing education program(s) applicable to the issue identified and selected by the entity requiring the CAP;
- Required training / re-training and/or certification / re-certification for performance of those procedures that require specific training and professional certification;
- Continuing concurrent trend analysis of the adverse quality issues identified in the provider's practice patterns;
- Monitoring of provider of concern's medical record documentation by physicians selected by the committee for a prescribed length of time and
- In-service training for providers and/or their staff.

If the finding is a system problem, the provider or facility will be required to correct the system defect.

b) Other PRC possible recommendations for consideration of by the Credentialing C/PRC Committee may include, but are not limited to:

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- Provider contract changes, including modification, restriction or termination of participation privileges with PHCGCHP;

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- Summary suspension: immediate suspension of credentialed status based on the need to take immediate action to protect the life or well-being of a GCHP member or any person to -reduce substantial and imminent likelihood of significant impairment of the life, health and or safety of any member or prospective member;
- Recommendation of counseling for behavior modification;
- Focused review of the provider's cases including, but not limited to:
 - Second opinion for invasive procedures;
 - Retrospective or prospective medical claims reviews;
 - Preceptorship with a physician of the same specialty or;
 - Required physician review of each request for
 - Pre-certification;
 - Institute a monitoring process through proctoring by another qualified, specialty matched provider and
 - Recommendation to the Credentialing Committee C/PRC for the suspension, restriction, or termination of the provider with PHCGCHP.

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The provider has the right to request a Fair Hearing for adverse actions reducing the provider's privileges as outlined in GCHP policy, "Fair Hearing Process for Adverse Actions". Any actions by Gold Coast Health Plan PGCHPlan that reduce or terminate a provider's privileges that are accepted or upheld by a fair hearing must be reported as described in the GCHP Policy "Reporting to Medical Board of California (MBOC), National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB): QI-025 Provider Credentialing Policy".

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3. All PRC/Credentialing Credentials/Peer Review Committee C/PRC recommendations and necessary attachments are forwarded to the CMO for coordination of any recommended action.
4. If a Quality Issue PQI has multiple providers involved in care who are separately evaluated by a clinical reviewer or the C/PRC, determinations of severity ratings will not be final until all involved providers have been assigned final severity ratings. If any data is pending for any provider to make a final determination, the other providers' determinations will be pending and notifications will not be made until all final determinations are complete.
5. For contracted providers that are not individuals (for example, hospitals, skilled nursing facilities, community clinics), where a final determination is a S1, S2, or S3; the case will be referred, in writing, to the medical director of the facility involved. This referral will request acknowledgement that the issue has been reviewed and assurance that action has been taken to prevent similar system

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issues in the future. These system issues will be tracked and trended and reviewed at the time of re-contracting of the facility. If the CMO or C/PRC determines that the system issue at a facility places our members at risk of adverse health outcomes, they may recommend that the contract with this facility be suspended or terminated.

G. G. MEDICAL RECORD REQUESTS

1. Providers are to forward a copy of the GCHP member's medical records to the QI-AA or the PRL-QI department within 15 calendar days from the date of the request.
2. If GCHP has not received the requested medical records by calendar day 10, the QI AA or PRL-QI nurse will call the provider contact and request the status of the request. The PRL-QI nurse may request the assistance from Provider Relations when necessary.
3. If GCHP does not receive a copy of the member's medical records within 20 days of the request, the PRL-QI nurse will forward the concern to the CMO for further assistance and/or direction. The CMO or ACMD-ACMO may contact the provider personally to ensure he or she is aware of the request for information.
4. Further action may be necessary, including, but not limited to termination from the Provider network.
5. If a non- contracted provider refuses to comply with the timelines, the CMO/ACMD-ACMO is notified by the PRL-QI nurse for next steps.

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H. H. CASE COMPLETION

1. Each PQI which is confirmed Quality Issues a quality issue is assigned a final severity level with action code by the CMO, ACMD-ACMO or C/PRC to denote the determined effect of the problem and action taken as a result of review.
2. All PQI cases files are kept in a secure file cabinet in the QI department and only select personnel have access to these files. All PQI Cases rated as S1 or P1 or higher will be trended in an individual provider data base file. (The Director of Quality and Performance Improvement, PRL-QI nurse, QI AA, Health Services Director, and the CMO/ACMD-ACMO are granted access to these files). Each file includes the PQI Report form, all correspondence, pertinent copies of medical records, reports and other documents associated with the review and disposition of the PQI case.

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- The provider's ~~Quality File~~quality file will be reviewed by the CMO and/or the ~~C/PRC redentials Committee~~ at the time that the provider is to be recredentialed.
- If the PQI originated as a grievance, the final rating of the PQI will be reported to the manager of the Grievance and Appeals Department.

~~I. J.~~ **REPORTING REQUIREMENTS**

- If a recommendation is made to revoke, suspend, or restrict the privileges of a provider, or to terminate the provider's agreement with GCHP, the following individuals and committees will be notified:
 - ~~•~~ • CEO of GCHP
 - ~~•~~ • [Director Network Operations](#)
 - ~~•~~ • ~~C/PRC Recommendations~~recommendations are forwarded to the next regularly scheduled Board of Commissioners.
 - ~~•~~ • The CEO of the medical group that employs the provider, if applicable, and/or the
 - ~~•~~ • Medical Director of the clinic where the provider is employed
 - ~~•~~ • The Department of Health Care Services (DHCS)

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~~J.~~ **INTER-RATER RELIABILITY (IRR)**

~~Inter-rater reliability studies will be performed quarterly to ensure cases reviewed by the PRL QI nurse were appropriately assessed a P0 or S0. Ten cases will be randomly selected for review by the CMO for the quarterly assessment. The goal is to achieve a 95% inter-rater reliability score.~~

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~~JK.~~ **RECORD RETENTION**

~~All Mmedical records received for cases with a POP0/P1/ or S0/S1 severity rating will be scanned into the GCHP system by the QI AA along with all pertinent supporting documentation. A scanned document shall constitute a "hard" copy. When scanning is complete, the documents will be destroyed. The scanned file will be maintained for a period of ten (10) years. For cases assigned a P2/S2 where a response was required, these will be scanned into the system. All all original documentation - such as certified letters, responses to letters, or policies and procedures will be kept in house along with the scanned file for a minimum of three (3) years and off site for a minimum of seven (7) additional years. All cases with a P3/S3 will be maintained in their entirety in their original format on site for three (3) years and off site for a minimum of seven (7) additional years.~~

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~~KL.~~ **CONFIDENTIALITY**

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Peer review records proceedings as well as records obtained for the quality/peer review process are protected by California Evidence Code § 1157 and are not subject to discovery when confidentiality has been maintained. To maintain confidentiality, peer review records are retained by the Quality Improvement Department and are not released to anyone for purposes other than peer review. Records are maintained in a locked file cabinet with access restricted to the CMO, ACMO, the Director of Quality ~~Performance and~~ Improvement, PRLQI nurse, the QI AA, and peer reviewers. While records are being reviewed, or during transport to peer review meetings, a QI staff person accompanies them at all times. An exception is made to this requirement if records are referred to an outside reviewer or organization. If a subpoena is served to GCHP regarding a peer review case, the PRLQI nurse may act as the "certifier of the medical records" being requested.

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ATTACHMENT A REFERRAL FORM

Potential Quality Issue Required Documentation

Please check off and submit the following ~~dept.~~department specific documentation when ~~referring a PQI to the QI Department,~~
referring a PQI to the QI Department

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[Send completed forms to PQIReporting@GoldCHP.org](mailto:PQIReporting@GoldCHP.org)

Complaints, Grievances, & Appeals

- PQI Referral Form (*see next page*)
- Grievance RN to QI Communication Form
- Other documentation that was used to determine whether case is P0/S0
- If case is **above** P0/S0 please attach the first round of medical records

Utilization Management, Pharmacy, and Claims

- PQI Referral Form (*see next page*)
- All documentation that was reviewed by your department relating to the case (e.g. medical records, TARS, remarks, case notes, etc.)

Care Coordination

- PQI Referral Form (*see next page*)
- Case Management Notes
- All other documentation that was reviewed by your department relating to the case (e.g. medical records, TARS, remarks, case notes, etc.)



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Potential Quality Issue (PQI) Report Form

Patient Name:	Last Name:	First Name:
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Member ID#:	Age:	
Reported By:	Last Name:	First Name:
Job Title:	<input type="checkbox"/> Internal: <input type="checkbox"/> External:	
Phone #:	<input type="checkbox"/> External:	
Referral Type:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Behavioral <input type="checkbox"/> Ancillary <input type="checkbox"/> Pharmacy	

Date PQI was first identified:

Date of PQI referral submission to Quality Improvement (QI) Department:

Provider of Concern:

Facility of Concern

Provider: Contracted Non-Contracted Facility:

If contracted, please indicate the facility/provider ID #:

Description of Events:

(Please describe what happened and why the case is being referred as a PQI.)

PLEASE MARK APPLICABLE INDICATORS THAT DESCRIBE THE CONCERN (Max 2)		
<input type="checkbox"/> Access/Availability	<input type="checkbox"/> Admit within 3 days of ER	<input type="checkbox"/> Assessment/Treatment/Diagnosis
<input type="checkbox"/> Communication/Coordination	<input type="checkbox"/> Continuity of Care	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Pharmacy/UM Authorizations	<input type="checkbox"/> Readmission	<input type="checkbox"/> Safety
<input type="checkbox"/> Surgical Services	<input type="checkbox"/> Delay in diagnosis/treatment	<input type="checkbox"/> Unexpected Death
<input type="checkbox"/> Unsure		



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PQI Referral Form Reference Table

<p><u>Access/Availability</u></p> <ul style="list-style-type: none"> • Complications due to a delay/omission of service by provider or plan • Excessive wait time in the PCP or Specialist's office (routine or after hours) 	<p><u>Admit within 3 days of ER</u></p> <p><u>Screening</u></p>	<p><u>Assessment/Treatment/Diagnosis</u></p> <ul style="list-style-type: none"> • Inadequate assessment, diagnosis or treatment goals • Inadequate assessment, diagnosis or treatment plan
<p><u>Communications/Conduct</u></p> <ul style="list-style-type: none"> • PCP/Specialist does not return doctor calls • Rudeness by provider or office staff • Threatened lawsuit by member against PCP/PA/Nurse/Secretary • Threatened media event by member • Culturally inappropriate remarks by PCP/specialist or staff • Allegations of sexual harassment • Allegations of discrimination • Unprofessional conduct • Staff speaking in language other than English while in the performance of their duties at a PCP/specialist or ancillary office 	<p><u>Continuity of Care</u></p> <ul style="list-style-type: none"> • Adverse outcome due to delay in referral to specialist • Delay in ordering tests/forwarding pathology/lab items to ancillary providers 	<p><u>Mental Health</u></p> <ul style="list-style-type: none"> • Failure to communicate patient's medication to PCP • Failure to communicate patient's medication to mental health provider • Inappropriate referral to a specialist or homicide patient
<p><u>Pharmacy/UM Authorizations</u></p> <ul style="list-style-type: none"> • Under-prescribing of narcotics • Inappropriate or lack of a physical assessment on patients prior to prescribing narcotics • Already terminated members on narcotics without a plan for the weaning process • Refused to follow still inpatient • Delay in completion of a TAR for medications causing a delay in member's treatment regimen 	<p><u>Readmission/UM</u></p> <ul style="list-style-type: none"> • Readmission on 30 days from discharge • Adverse outcome due to premature discharge 	<p><u>Safety</u></p> <ul style="list-style-type: none"> • Fall in ER or acute care • Report by member that conditions of facility are unsafe/dangerous
<p><u>Surgical Services</u></p> <ul style="list-style-type: none"> • Post-op diagnosis differs from pre-op • Surgical complication • Unplanned return to surgery or repeat invasive procedure • Blood loss during surgery requiring transfusion • Admission following outpatient procedure • Unexpected maternal transfer to a higher level of care • Delivery complication 	<p><u>Other:</u></p>	<p><u>Unexpected Death</u></p> <p><u>Insurance</u></p>



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Potential Quality Issue (PQI) Report Form

Patient Name: Last Name:	First Name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Member ID#:	Age:
Reported By: Last Name:	First Name:
Job Title:	<input type="checkbox"/> Internal:
Phone #:	<input type="checkbox"/> External:
Referral Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Behavioral <input type="checkbox"/> Ancillary <input type="checkbox"/> Pharmacy	

Date PQI was first identified:

Date of PQI referral submission to Quality Improvement (QI) Department:

Provider of Concern:

Facility of Concern

Provider: Contracted Non-Contracted Facility:

If contracted, please indicate the facility/provider ID #:

Description of Events:

(Please describe what happened and why the case is being referred as a PQI.)

PLEASE MARK APPLICABLE INDICATORS THAT DESCRIBE THE CONCERN (Max 2)		
<input type="checkbox"/> Access/Availability	<input type="checkbox"/> Admit within 3 days of LR	<input type="checkbox"/> Assessment/Treatment/Diagnosis
<input type="checkbox"/> Communications/Consent	<input type="checkbox"/> Continuity of Care	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Pharmacy/UM/Authorizations	<input type="checkbox"/> Readmission	<input type="checkbox"/> Safety
<input type="checkbox"/> Surgical Services	<input type="checkbox"/> Delay in diagnosis/treatment	<input type="checkbox"/> Unexpected Death
<input type="checkbox"/> Unsure		

PLEASE SEND COMPLETED FORM TO POIReporting@GoldCHP.org FOR PROCESSING



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PQI Referral Form Reference Table

<p>Access/Availability</p> <ul style="list-style-type: none"> • Complications due to a delay/absence of service by provider or plan • Excessive wait time in the PCP or Specialist's office (routine or after hours) 	<p>Admit within 3 days of ER Services</p>	<p>Assessment/Treatment/Diagnosis</p> <ul style="list-style-type: none"> • Inadequate assessment, diagnosis or treatment goals • Inadequate assessment, diagnosis or treatment plan
<p>Communications/Conduct</p> <ul style="list-style-type: none"> • PCP/Specialist does not return doctor calls • Referrals by provider or office staff • Threatened lawsuit by member against PCP / OR / Ancillary • Threatened media event by member • Culturally inappropriate remarks by PCP/ specialist or staff • Allegations of sexual harassment • Allegations of discrimination • Unprofessional conduct • Staff sending a message, other than emails, write in the performance of their duties, of a PCP /specialist or ancillary office 	<p>Continuity of Care</p> <ul style="list-style-type: none"> • Adverse outcome due to delay in referral to specialist • Delay in ordering tests/forwarding pathology / lab tests to ancillary providers 	<p>Mental Health</p> <ul style="list-style-type: none"> • Failure to communicate patient's medications to PCP • Failure to communicate patient's medications to mental health provider • Inadequate referral of a suicidal or homicidal patient
<p>Pharmacy/UM Authorizations</p> <ul style="list-style-type: none"> • Inappropriate use of narcotics • Inappropriate or lack of a physical assessment on patients prior to prescribing narcotics • Already terminated members narcotics without a plan for the weaning process • Refusal to authorize (AR) - pharmacy • Delay in completion of a TAR for medications causing a delay in the Doc's treatment regimen 	<p>Readmission/UM</p> <ul style="list-style-type: none"> • Readmission within 30 days from discharge • Adverse outcome due to premature discharge 	<p>Safety</p> <ul style="list-style-type: none"> • Fall in clinic or acute care • Report by member that conditions of facility are immediately unsafe
<p>Surgical Services</p> <ul style="list-style-type: none"> • Post-op diagnosis differs from pre-op • Surgical complications • Unplanned return to surgery or to post-operative procedure • Blood loss during surgery requiring transfusion • Admission following outpatient procedure • Unexpected maternal transfer to a higher level of care • Delivery complications 	<p>Other:</p>	<p>Unexpected Death</p> <p>Insurance</p>



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ATTACHMENT B PQI LEVELING GRID

Member Outcomes:		
Rating		
0	No negative or minimal outcome	
1	Minimal negative outcome	
2	Significant negative outcome – may include prolonged hospitalization, return to surgery, delayed diagnosis, permanent morbidity	
3	Severe negative outcome including mortality or severe permanent morbidity or potential threat to life.	
System Issues:		
S0	No system issue.	<ul style="list-style-type: none"> No action required.
S1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	<ul style="list-style-type: none"> An informal letter to the provider or facility may be sent at the CMO/AMD discretion.
S2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for minor or moderate adverse outcome to member.	<ul style="list-style-type: none"> Letter to provider or facility of concern, requesting a response. May recommend CAP and/or other interventions
S3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for significant adverse outcome to member.	<ul style="list-style-type: none"> Immediate communication to provider or facility of concern requesting a response. May recommend CAP and/or other interventions. S3's may be referred to <u>Credentialing/Credentials/Peer Review</u> Committee with recommendations from the CMO
Provider Issues		
P0	Care is appropriate.	<ul style="list-style-type: none"> -No action required.
P1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	<ul style="list-style-type: none"> An informal letter to the provider may be sent at CMO/<u>AMD</u>/<u>CMO</u> discretion.

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P2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for minor or moderate adverse outcome to member.	<ul style="list-style-type: none"> • <u>Peer Review</u> Letter to provider <u>of concern</u>, requesting a response. • May recommend CAP and/or other interventions.
P3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for significant adverse outcome to member.	<ul style="list-style-type: none"> • Immediate communication to provider of concern requesting a response. • May recommend CAP and/or other interventions. • P3's may be referred by the CMO to the <u>Credentialing /PRCredentials/Peer Review</u> Committee with recommendations.

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Attachments:

- A. Referral Form
- B. Case Leveling Grid

References:

Policy No.: 4H - Fair Hearing Process for Adverse Decisions

Policy No.: [QI-014 025 – Reporting to Medical Board of California \(MBOC\), National Practitioner Data Bank \(NPDB\) and Healthcare Integrity and Protection Data Bank \(HIPDB\) Provider Credentialing Policy](#)

[Policy No.: MP CR #9 “Fair Hearing Process for Adverse Decisions”](#)

NCQA Standards CR6 – Ongoing Monitoring

[California Evidence Code § 1157](#)

PQI Reporting Email Address: PQIReporting@GoldCHP.org

[PQI Referral Form located on SharePoint.](#)

Revision History:

Review Date	Revised Date	Approved By
June 30, 2014	June 26, 2014	Policy Review Committee
<u>December 01, 2014</u>		<u>Ruth Watson, COO (Interim CEO)</u>

AGENDA ITEM NO. 13

To: Gold Coast Health Plan Commission

From: Patricia Mowlavi, CFO

Date: April 25, 2016

Re: February 2016 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached fiscal year to date (FYTD) February 2016 financial statements (unaudited) of Gold Coast Health Plan (Plan) for the Commission to accept and file. The Executive / Finance Committee did not meet in March or April.

BACKGROUND / DISCUSSION:

The staff has prepared the FYTD February 2016 financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Financial Highlights

Overall Performance – For the eight months ended February 29, 2016, the Plan's gain in unrestricted net assets was approximately \$33.9 million on revenues of \$434.9 million. This represents a \$24.6 million favorable variance to budget which was largely due to the continued growth in membership in the Adult Expansion (AE) category of aid. Also contributing to the variance was lower than anticipated health care and administrative costs.

Tangible Net Equity – The Plan's operating performance has increased the Tangible Net Equity (TNE) amount to approximately \$141.0 million, which is \$51.8 million better than budget. The Plan's TNE (excluding the \$7.2 million County of Ventura lines of credit) is at 564% of the State required TNE. The sharp rise in the TNE multiple has been assisted, in part, by an increase in capitated arrangements which are excluded from the required TNE calculation. Note the \$7.2 million County of Ventura lines of credit with associated accrued interest were paid in full in March 2016.

Membership – February membership of 203,981 exceeded budget by 5,657 members. The increase in membership was primarily in the Adult Expansion (AE) category, which accounted for 64% of the total enrollment growth for the month.

Revenue – FYTD, net revenue was \$434.9 million or \$12.4 million favorable to budget. The positive variance was primarily due to increase in membership with higher capitation rates (Adult Expansion).

For the year, revenue includes a \$21.1 million reserve for rate reductions associated with AE. This reserve represents an expected refund, to Department of Health Care Services (DHCS), for rate overpayments (DHCS was paying at July 1, 2014 rates rather than the July 1, 2015 published rates) and the anticipated refund of revenue to achieve a medical loss ratio (MLR) of 85%, for this aid category. (The MLR is calculated by dividing health care costs by revenue.). The combined total due back to the DHCS, for both rate overpayment and 85% MLR portion, is \$237.2 million. The DHCS has started to recoup the AE rate overpayment, and a total of \$34.5 million was deducted from January and February's payments.

Health Care Costs – FYTD health care costs were \$376.7 million or \$9.0 million lower than budget. For the year, the MLR was 86.6% versus budget of 91.3%.

Some health care cost items of note include:

- Capitation – FYTD, capitation was \$66.1 million or \$18.8 million unfavorable to budget. The unfavorable variance was driven by the Enhanced Adult Expansion Capitation program, which was revised effective July 2015, as well as higher than budgeted capitated membership growth.
- Fee for Service – FYTD, total claims expense was \$300.2 million compared to a budget of \$321.7 million. While there was some movement of services between categories, the overall variance was driven by lower than expected Inpatient and Specialty Physician costs.
- Pharmacy – FYTD, overall Pharmacy expense was \$62.9 million or \$1.7 million unfavorable to budget. This variance was offset by specialty drug reimbursement which appears in revenue.

Administrative Expenses – FYTD, administrative costs were \$24.3 million or \$3.3 million lower than budget. Savings were realized due to delays in new hires and related costs associated with personnel. These savings were somewhat offset by higher expenses in outside services, which are primarily driven by membership.

The administrative cost ratio (ACR) for FYTD was 5.6% versus 6.5% for budget. (The ACR is calculated by dividing administrative expenses by total revenue.)

Cash and Medi-Cal Receivable – At February 29, 2016, the Plan had \$429.7 million in cash and short term investments and \$64.1 million in Medi-Cal Receivable for an aggregate amount of \$493.8 million. The cash amount also included pass-through payments for AB 85 of \$1.9 million and Managed Care Organizations (MCO) tax of \$3.9 million. Excluding the impact of these amounts, the cash amount would be \$424.0 million. Note that a significant portion of the cash will be used for repayments of amounts owed to the State of California (\$237.2 million) and the County of Ventura (\$7.2 million). The \$7.2 million due to the County of Ventura and related accrued interest was paid in full in March 2016, and approximately half the amount owed to the State of California is expected to be paid within the next 12 months.

Investment Portfolio – As of February 29, 2016, the value of the investments were as follows:

- Short-term Investments \$225.5 million: Cal Trust \$80.3 million; Ventura County Investment Pool \$80.1 million; LAIF CA State \$50.0 million; Bonds \$5.0 million.
- Long-term Investments (Bonds) \$19.4 million.

Intergovernmental Transfer (IGT) Update

On August 24, 2015 the Commission granted GCHP authorization to begin the process to secure additional Medi-Cal funds through an IGT. At that time, DHCS offered a preliminary rate range of 50% of the estimated available amount for the 2014-15 rate year. In collaboration with the funding entity (VCMC), the necessary proposal and other documents were submitted to initiate the process. On March 14, 2016, GCHP received a letter from DHCS indicating the full amount available and reiterated the conditions for participation. GCHP and VCMC again submitted updated documents. Additional letters and agreements will be forthcoming from DHCS as the process continues. State officials indicated that the preliminary approval from CMS should be received in order to receive the first one-half payment in late May 2016. The second payment is anticipated in the August-September time frame.

RECOMMENDATION:

Staff requests that the Commission accept and file the February 2016 financial statements

CONCURRENCE:

N/A

ATTACHMENT:

February 2016 Financial Package



**Gold Coast
Health Plan**SM
A Public Entity

FINANCIAL PACKAGE

For the month ended February 29, 2016

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- Financial Performance Dashboard

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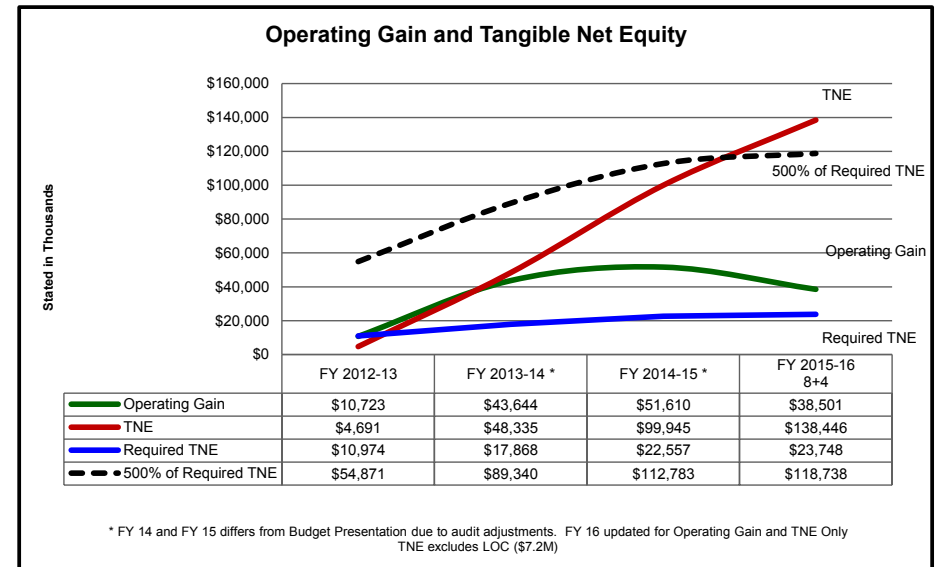
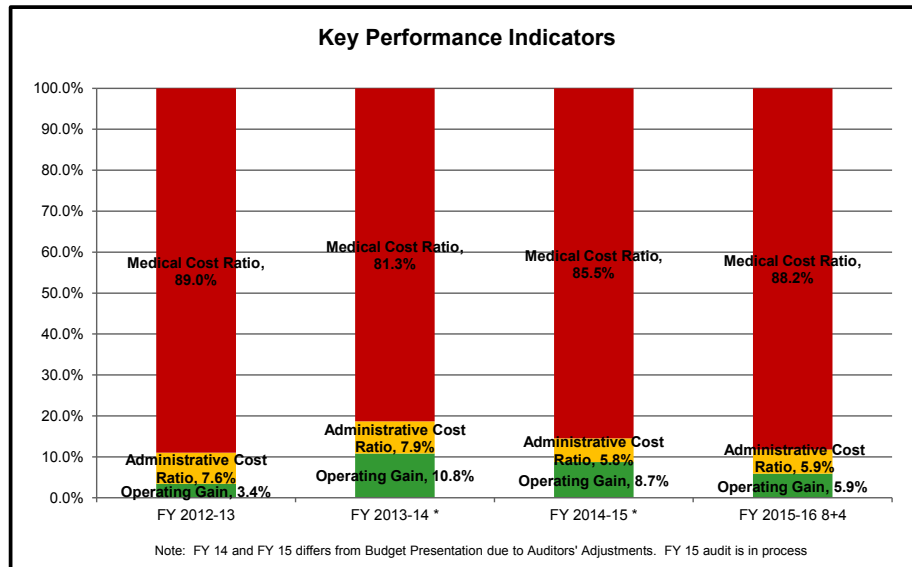
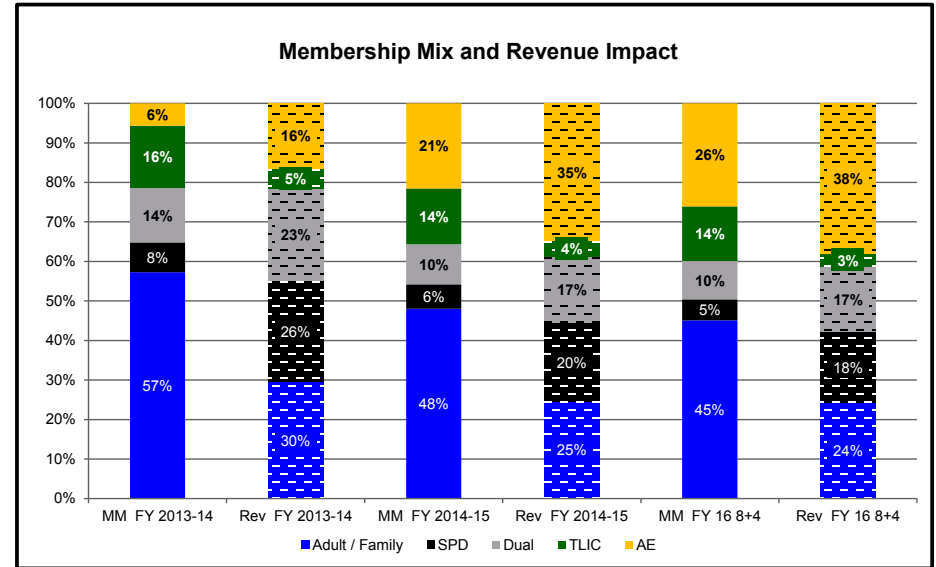
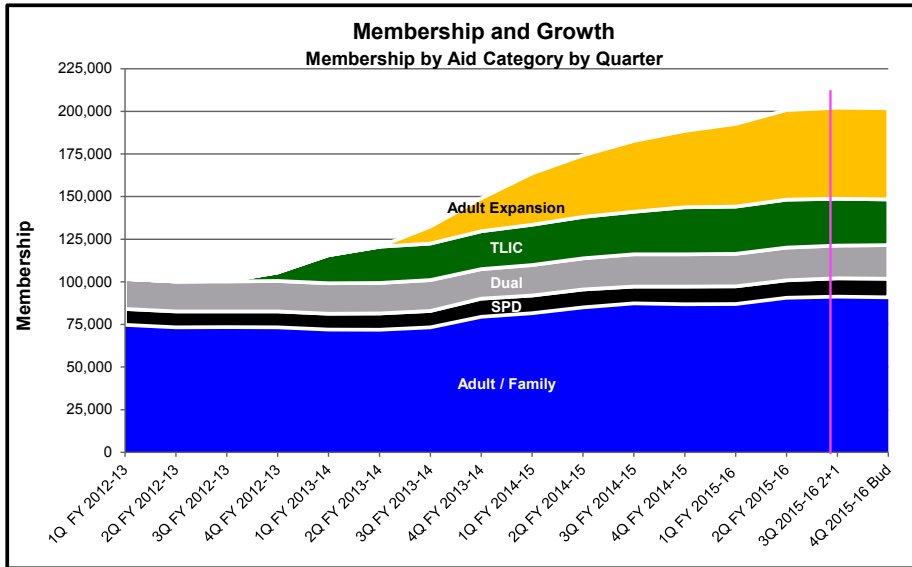
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**GOLD COAST HEALTH PLAN
FINANCIAL RESULTS SUMMARY**

Description	AUDITED	AUDITED	AUDITED	AUDITED	FY 2015-16					Budget Comparison		
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	JUL - SEP	OCT - DEC 15	JAN 16	FEB 16	FEB 16 FYTD	Budget FYTD	Variance Fav / (Unfav)	Variance Fav / (Unfav)%
Member Months	1,258,189	1,223,895	1,553,660	2,130,979	578,056	602,390	202,945	203,981	1,587,372	1,555,060	32,312	2.1 %
Revenue	304,635,932	315,119,611	402,701,476	595,607,370	162,960,677	159,744,239	56,080,478	56,076,002	434,861,395	422,503,017	12,358,378	2.9 %
<i>pmpm</i>	242.12	257.47	259.20	279.50	281.91	265.18	276.33	274.91	273.95	271.70	2.25	0.8 %
Health Care Costs	287,353,672	280,382,704	327,305,832	509,183,268	137,845,237	142,711,885	49,217,590	46,897,260	376,671,971	385,642,688	8,970,717	2.3 %
<i>pmpm</i>	228.39	229.09	210.67	238.94	238.46	236.91	242.52	229.91	237.29	247.99	10.70	4.3 %
% of Revenue	94.3%	89.0%	81.3%	85.5%	84.6%	89.3%	87.8%	83.6%	86.6%	91.3%	4.7 %	5.1 %
Admin Exp	18,891,320	24,013,927	31,751,533	34,814,049	8,827,059	9,035,546	3,259,400	3,173,781	24,295,786	27,554,203	3,258,417	11.8 %
<i>pmpm</i>	15.01	19.62	20.44	16.34	15.27	15.00	16.06	15.56	15.31	17.72	2.41	13.6 %
% of Revenue	6.2%	7.6%	7.9%	5.8%	5.4%	5.7%	5.8%	5.7%	5.6%	6.5%	0.9 %	14.3 %
Total Increase / (Decrease) in Unrestricted Net Assets	(1,609,063)	10,722,980	43,644,110	51,610,053	16,288,381	7,996,808	3,603,488	6,004,961	33,893,639	9,306,126	24,587,513	264.2 %
<i>pmpm</i>	(1.28)	8.76	28.09	24.22	28.18	13.28	17.76	29.44	21.35	5.98	15.37	256.8 %
% of Revenue	-0.5%	3.4%	10.8%	8.7%	10.0%	5.0%	6.4%	10.7%	7.8%	2.2%	5.6%	253.9 %
YTD												
100% TNE	16,769,368	16,138,440	17,867,986	22,556,530	21,819,072	22,591,994	24,084,473	23,747,521	23,747,521	26,365,290	(2,617,769)	(9.9)%
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%	100%		
Minimum Required TNE	6,036,972	10,974,139	17,867,986	22,556,530	21,819,072	22,591,994	24,084,473	23,747,521	23,747,521	26,365,290	(2,617,769)	(9.9)%
GCHP TNE	(6,031,881)	11,891,099	55,535,211	107,145,264	123,433,646	131,430,454	135,033,942	141,038,903	141,038,903	89,285,795	51,753,107	58.0 %
TNE Excess / (Deficiency)	(12,068,853)	916,960	37,667,225	84,588,734	101,614,573	108,838,460	110,949,469	117,291,381	117,291,381	62,920,505	54,370,876	86.4 %
% of Required TNE level			311%	475%	566%	582%	561%	594%	594%	339%		
% of Required TNE level (excluding \$7.2 million LOC)			271%	443%	533%	550%	531%	564%	564%	311%		

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

**FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING FEBRUARY 29, 2016**



Note: 8+4 indicates 8 months of actual results followed by 4 months of forecasts



For the month ended February 29, 2016

APPENDIX

- Statement of Financial Positions
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STATEMENT OF FINANCIAL POSITION

	02/29/16	01/31/16	12/31/15	Audited FY 2014 - 15
ASSETS				
Current Assets:				
Total Cash and Cash Equivalents	\$ 204,233,778	\$ 206,754,441	\$ 187,837,453	\$ 57,218,141
Total Short-Term Investments	225,463,017	220,436,007	220,367,591	165,090,357
Medi-Cal Receivable	64,081,474	63,104,725	62,093,422	129,782,958
Interest Receivable	382,485	425,810	360,157	208,010
Provider Receivable	428,925	440,971	376,294	579,482
Other Receivables	171,958	175,122	174,887	979,647
Total Accounts Receivable	65,064,842	64,146,628	63,004,760	131,550,096
Total Prepaid Accounts	1,301,437	1,193,317	1,538,044	766,831
Total Other Current Assets	133,545	133,545	133,545	81,702
Total Current Assets	496,196,618	492,663,938	472,881,394	354,707,127
Total Fixed Assets	1,241,489	1,190,313	935,810	1,084,113
Total Long-Term Investments	19,439,894	19,460,935	19,481,959	24,647,362
Total Assets	\$ 516,878,001	\$ 513,315,185	\$ 493,299,163	\$ 380,438,602
LIABILITIES & NET ASSETS				
Current Liabilities:				
Incurred But Not Reported	\$ 57,889,688	\$ 60,457,328	\$ 58,777,984	\$ 52,372,146
Claims Payable	15,089,156	10,270,198	9,502,532	13,747,426
Capitation Payable	36,329,863	31,907,261	27,603,356	34,466,106
Physician ACA 1202 Payable	9,600,012	9,600,012	10,076,883	10,965,642
AB 85 Payable	1,850,953	1,818,410	1,835,505	3,818,147
Accounts Payable	543,183	590,696	411,484	3,449,087
Accrued ACS	1,631,285	3,245,276	3,231,286	1,480,556
Accrued Expenses	111,793,052	121,461,780	113,717,565	6,249,194
Accrued Premium Tax	3,891,138	3,854,191	3,821,943	3,641,573
Accrued Interest Payable	99,494	95,906	94,545	70,711
Current Portion of Deferred Revenue	153,333	191,667	230,000	460,000
Accrued Payroll Expense	763,573	720,057	630,605	1,152,720
Total Current Liabilities	239,634,731	244,212,780	229,933,687	131,873,310
Long-Term Liabilities:				
DHCS - Reserve for Capitation Recoup	135,494,946	133,384,946	131,284,946	140,970,602
Other Long-term Liability-Deferred Rent	709,422	683,517	650,076	449,427
Notes Payable	7,200,000	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	143,404,368	141,268,463	139,135,022	148,620,029
Total Liabilities	383,039,099	385,481,243	369,068,709	280,493,338
Net Assets:				
Beginning Net Assets	99,945,264	99,945,264	99,945,264	48,335,211
Total Increase / (Decrease in Unrestricted Net ,	33,893,639	27,888,678	24,285,190	51,610,053
Total Net Assets	133,838,903	127,833,942	124,230,454	99,945,264
Total Liabilities & Net Assets	\$ 516,878,001	\$ 513,315,185	\$ 493,299,163	\$ 380,438,602

FINANCIAL INDICATORS

Current Ratio	2.07 : 1	2.02 : 1	2.06 : 1	2.69 : 1
Days Cash on Hand	257	244	233	67
Days Cash + State Capitation Rec	295	279	268	107
Days Cash + State Capitation Rec (less Tax Li	293	277	266	106

**STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR EIGHT MONTHS ENDING FEBRUARY 29, 2015**

	February 2016 Year-To-Date		Variance Fav / (Unfav)
	Actual	Budget	
Membership (includes retro members)	1,587,372	1,555,060	32,312
Revenue			
Premium	\$ 474,043,346	\$ 466,890,037	\$ 7,153,309
Reserve for Rate Reduction	(21,125,000)	(27,388,306)	6,263,306
MCO Premium Tax	(18,665,458)	(17,305,380)	(1,360,078)
Total Net Premium	434,252,888	422,196,351	12,056,536
Other Revenue:			
Miscellaneous Income	608,508	306,666	301,842
Total Other Revenue	608,508	306,666	301,842
Total Revenue	434,861,395	422,503,017	12,358,378
Medical Expenses:			
<u>Capitation (PCP, Specialty, Kaiser, NEMT & Vision)</u>	66,101,020	47,735,401	(18,365,619)
<u>FFS Claims Expenses:</u>			
Inpatient	68,112,794	79,188,647	11,075,853
LTC / SNF	69,178,148	72,631,056	3,452,908
Outpatient	28,773,869	25,559,322	(3,214,547)
Laboratory and Radiology	2,675,439	1,800,356	(875,083)
Emergency Room	11,531,832	10,411,979	(1,119,853)
Physician Specialty	28,184,669	33,547,285	5,362,616
Primary Care Physician	8,870,268	10,578,064	1,707,796
Home & Community Based Services	9,604,866	9,943,339	338,473
Applied Behavior Analysis Services	449,011	983,353	534,342
Mental Health Services	2,905,076	3,576,311	671,235
Pharmacy	62,902,373	61,239,404	(1,662,969)
Provider Reserve	0	4,596,416	4,596,416
Other Medical Professional	1,369,087	1,663,021	293,934
Other Medical Care	1,032	0	(1,032)
Other Fee For Service	4,655,937	4,818,662	162,725
Transportation	948,583	1,148,731	200,148
Total Claims	300,159,171	321,685,946	21,526,775
Medical & Care Management Expense	10,493,657	14,002,004	3,508,347
Reinsurance	1,475,234	2,219,337	744,103
Claims Recoveries	(1,557,111)	0	1,557,111
Sub-total	10,411,780	16,221,341	5,809,561
Total Cost of Health Care	376,671,971	385,642,688	8,970,717
Contribution Margin	58,189,424	36,860,329	21,329,095
General & Administrative Expenses:			
Salaries and Wages	5,917,108	6,925,629	1,008,521
Payroll Taxes and Benefits	1,597,540	2,074,416	476,876
Travel and Training	150,425	422,707	272,282
Outside Service - ACS	12,700,496	12,025,194	(675,302)
Outside Services - Other	1,164,631	1,424,236	259,605
Accounting & Actuarial Services	175,313	222,000	46,688
Legal	557,600	700,000	142,400
Insurance	260,876	217,344	(43,532)
Lease Expense - Office	572,706	695,520	122,814
Consulting Services	607,803	1,021,546	413,743
Advertising and Promotion	54,723	42,633	(12,090)
General Office	1,126,496	1,883,089	756,593
Depreciation & Amortization	165,982	279,229	113,247
Printing	33,622	125,485	91,863
Shipping & Postage	68,880	105,867	36,987
Interest	212,257	172,264	(39,993)
Total G & A Expenses	25,366,458	28,337,159	2,970,701
Total Operating Gain / (Loss)	\$ 32,822,966	\$ 8,523,170	\$ 24,299,796
Non Operating			
Revenues - Interest	1,099,456	800,000	299,456
Expenses - Interest	28,783	17,044	(11,739)
Total Non-Operating	1,070,672	782,956	287,716
Total Increase / (Decrease) in Unrestricted Net Assets	\$ 33,893,639	\$ 9,306,126	\$ 24,587,513
Net Assets, Beginning of Year	99,945,264		
Net Assets, End of Year	<u>133,838,903</u>		

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2015-16 Monthly Trend			Current Month		
	NOV 15	DEC 15	JAN 16	FEBRUARY 2016		Variance
				Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	200,385	203,857	202,945	203,981	198,324	5,657
Revenue:						
Premium	\$ 59,641,624	\$ 60,609,835	\$ 60,525,329	\$ 60,531,080	\$ 57,385,957	\$ 3,145,123
Reserve for Rate Reduction	(4,057,000)	(4,300,000)	(2,100,000)	(2,110,000)	(1,583,261)	(526,739)
MCO Premium Tax	(2,348,389)	(2,386,513)	(2,383,185)	(2,383,411)	(2,197,231)	(186,180)
Total Net Premium	53,236,235	53,923,322	56,042,144	56,037,668	53,605,465	2,432,203
Other Revenue:						
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	(0)
Total Other Revenue	38,333	38,333	38,333	38,333	38,333	(0)
Total Revenue	53,274,568	53,961,656	56,080,478	56,076,002	53,643,798	2,432,203
Medical Expenses:						
<u>Capitation (PCP, Specialty, Kaiser, NEMT & Vision)</u>	8,427,985	8,416,645	8,597,538	9,085,138	5,544,592	(3,540,546)
<u>FFS Claims Expenses:</u>						
Inpatient	9,783,188	6,939,460	9,397,915	7,392,640	10,270,912	2,878,272
LTC / SNF	8,114,443	9,457,002	9,940,604	7,895,479	9,210,244	1,314,765
Outpatient	3,888,244	4,874,113	3,126,572	3,379,287	3,296,343	(82,944)
Laboratory and Radiology	417,957	253,526	544,597	278,498	233,215	(45,283)
Emergency Room	1,408,873	1,384,893	1,534,104	1,672,260	1,339,489	(332,771)
Physician Specialty	3,574,803	3,527,663	3,148,079	4,054,445	4,340,689	286,244
Primary Care Physician	1,058,710	1,051,572	1,165,162	1,110,036	1,355,258	245,222
Home & Community Based Services	1,161,347	1,351,551	1,468,164	1,158,925	1,261,057	102,132
Applied Behavior Analysis Services	67,271	56,046	82,896	58,589	163,586	104,997
Mental Health Services	278,330	296,508	318,802	298,271	459,677	161,406
Pharmacy	7,785,843	8,641,594	8,140,173	8,431,109	7,898,735	(532,374)
Provider Reserve	0	0	0	0	589,162	589,162
Other Medical Professional	213,077	116,294	259,041	165,970	214,712	48,742
Other Medical Care	0	0	0	293	0	(293)
Other Fee For Service	554,146	786,864	549,506	599,049	616,602	17,553
Transportation	137,567	106,588	97,684	114,225	148,217	33,992
Total Claims	38,443,800	38,843,673	39,773,299	36,609,076	41,397,898	4,788,822
Medical & Care Management Expense	1,276,963	1,410,289	1,325,198	1,185,612	1,819,369	633,758
Reinsurance	284,242	287,084	133,103	291,461	289,078	(2,383)
Claims Recoveries	(82,534)	316,981	(611,548)	(274,027)	0	274,027
Sub-total	1,478,672	2,014,354	846,753	1,203,046	2,108,447	905,401
Total Cost of Health Care	48,350,456	49,274,672	49,217,590	46,897,260	49,050,937	2,153,677
Contribution Margin	4,924,112	4,686,984	6,862,888	9,178,742	4,592,861	4,585,881
General & Administrative Expenses:						
Salaries and Wages	664,080	787,225	794,596	740,575	899,128	158,553
Payroll Taxes and Benefits	186,552	174,678	239,223	217,016	279,882	62,866
Travel and Training	16,969	12,853	19,361	40,568	45,991	5,423
Outside Service - ACS	1,642,121	1,628,393	1,614,744	1,613,004	1,532,710	(80,294)
Outside Services - Other	161,411	125,073	140,276	183,036	180,089	(2,947)
Accounting & Actuarial Services	17,380	78,148	1,680	6,895	0	(6,895)
Legal	47,671	98,593	155,481	130,846	87,500	(43,346)
Insurance	34,973	25,161	32,588	32,588	27,168	(5,420)
Lease Expense - Office	66,034	66,034	66,034	110,467	86,940	(23,527)
Consulting Services	19,345	81,081	152,043	82,510	175,644	93,134
Advertising and Promotion	6,116	0	2,721	3,803	0	(3,803)
General Office	126,141	183,685	105,893	131,842	259,074	127,232
Depreciation & Amortization	20,768	20,768	21,247	21,153	44,567	23,414
Printing	1,512	700	9,836	376	23,445	23,069
Shipping & Postage	2,938	81	29,771	108	3,054	2,946
Interest	33,702	49,638	25,541	9,282	21,929	12,647
Total G & A Expenses	3,047,714	3,332,111	3,411,034	3,324,069	3,667,121	343,052
Total Operating Gain / (Loss)	1,876,398	1,354,873	3,451,854	5,854,672	925,740	4,928,933
Non Operating:						
Revenues - Interest	152,335	154,302	152,995	153,877	100,000	53,877
Expenses - Interest	5,930	4,436	1,361	3,588	35	(3,553)
Total Non-Operating	146,405	149,867	151,634	150,288	99,965	50,323
Total Increase / (Decrease) in Unrestricted Net Assets	2,022,803	1,504,740	3,603,488	6,004,961	1,025,705	4,979,256
Full Time Employees				172	204	32

PMPM - STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	NOV 15	DEC 15	JAN 16	FEBRUARY 2016		Variance
				Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	200,385	203,857	202,945	203,981	198,324	5,657
Revenue:						
Premium	297.64	297.32	298.24	296.75	289.35	7.39
Reserve for Rate Reduction	(20.25)	(21.09)	(10.35)	(10.34)	(7.98)	(2.36)
MCO Premium Tax	(11.72)	(11.71)	(11.74)	(11.68)	(11.08)	(0.61)
Total Net Premium	265.67	264.52	276.14	274.72	270.29	4.43
Other Revenue:						
Interest Income	0.00	0.00	0.00	0.00	0.00	0.00
Miscellaneous Income	0.19	0.19	0.19	0.19	0.19	(0.01)
Total Other Revenue	0.19	0.19	0.19	0.19	0.19	(0.01)
Total Revenue	265.86	264.70	276.33	274.91	270.49	4.42
Medical Expenses:						
<u>Capitation (PCP, Specialty, Kaiser, NEMT & Vision)</u>	42.06	41.29	42.36	44.54	27.96	(16.58)
<u>FFS Claims Expenses:</u>						
Inpatient	48.82	34.04	46.31	36.24	51.79	15.55
LTC / SNF	40.49	46.39	48.98	38.71	46.44	7.73
Outpatient	19.40	23.91	15.41	16.57	16.62	0.05
Laboratory and Radiology	2.09	1.24	2.68	1.37	1.18	(0.19)
Emergency Room	7.03	6.79	7.56	8.20	6.75	(1.44)
Physician Specialty	17.84	17.30	15.51	19.88	21.89	2.01
Primary Care Physician	5.28	5.16	5.74	5.44	6.83	1.39
Home & Community Based Services	5.80	6.63	7.23	5.68	6.36	0.68
Applied Behavior Analysis Services	0.34	0.27	0.41	0.29	0.82	0.54
Mental Health Services	1.39	1.45	1.57	1.46	2.32	0.86
Pharmacy	38.85	42.39	40.11	41.33	39.83	(1.51)
Provider Reserve	0.00	0.00	0.00	0.00	2.97	2.97
Other Medical Professional	1.06	0.57	1.28	0.81	1.08	0.27
Other Medical Care	0.00	0.00	0.00	0.00	0.00	(0.00)
Other Fee For Service	2.77	3.86	2.71	2.94	3.11	0.17
Transportation	0.69	0.52	0.48	0.56	0.75	0.19
Total Claims	191.85	190.54	195.98	179.47	208.74	29.27
Medical & Care Management Expense	6.37	6.92	6.53	5.81	9.17	3.36
Reinsurance	1.42	1.41	0.66	1.43	1.46	0.03
Claims Recoveries	(0.41)	1.55	(3.01)	(1.34)	0.00	1.34
Sub-total	7.38	9.88	4.17	5.90	10.63	4.73
Total Cost of Health Care	241.29	241.71	242.52	229.91	247.33	17.42
Contribution Margin	24.57	22.99	33.82	45.00	23.16	21.84
General & Administrative Expenses:						
Salaries and Wages	3.31	3.86	3.92	3.63	4.53	0.90
Payroll Taxes and Benefits	0.93	0.86	1.18	1.06	1.41	0.35
Travel and Training	0.08	0.06	0.10	0.20	0.23	0.03
Outside Service - ACS	8.19	7.99	7.96	7.91	7.73	(0.18)
Outside Services - Other	0.81	0.61	0.69	0.90	0.91	0.01
Accounting & Actuarial Services	0.09	0.38	0.01	0.03	0.00	(0.03)
Legal	0.24	0.48	0.77	0.64	0.44	(0.20)
Insurance	0.17	0.12	0.16	0.16	0.14	(0.02)
Lease Expense - Office	0.33	0.32	0.33	0.54	0.44	(0.10)
Consulting Services	0.10	0.40	0.75	0.40	0.89	0.48
Advertising and Promotion	0.03	0.00	0.01	0.02	0.00	(0.02)
General Office	0.63	0.90	0.52	0.65	1.31	0.66
Depreciation & Amortization	0.10	0.10	0.10	0.10	0.22	0.12
Printing	0.01	0.00	0.05	0.00	0.12	0.12
Shipping & Postage	0.01	0.00	0.15	0.00	0.02	0.01
Interest	0.17	0.24	0.13	0.05	0.11	0.07
Other/ Miscellaneous Expenses	0.00	0.00	0.00	0.00	0.00	0.00
Total G & A Expenses	15.21	16.35	16.81	16.30	18.49	2.19
Total Operating Gain / (Loss)	9.36	6.65	17.01	28.70	4.67	24.03
Non Operating:						
Revenues - Interest	0.76	0.76	0.75	0.75	0.50	0.25
Expenses - Interest	0.03	0.02	0.01	0.02	0.00	(0.02)
Total Non-Operating	0.73	0.74	0.75	0.74	0.50	0.23
Total Increase / (Decrease) in Unrestricted Net Assets	10.09	7.38	17.76	29.44	5.17	24.27

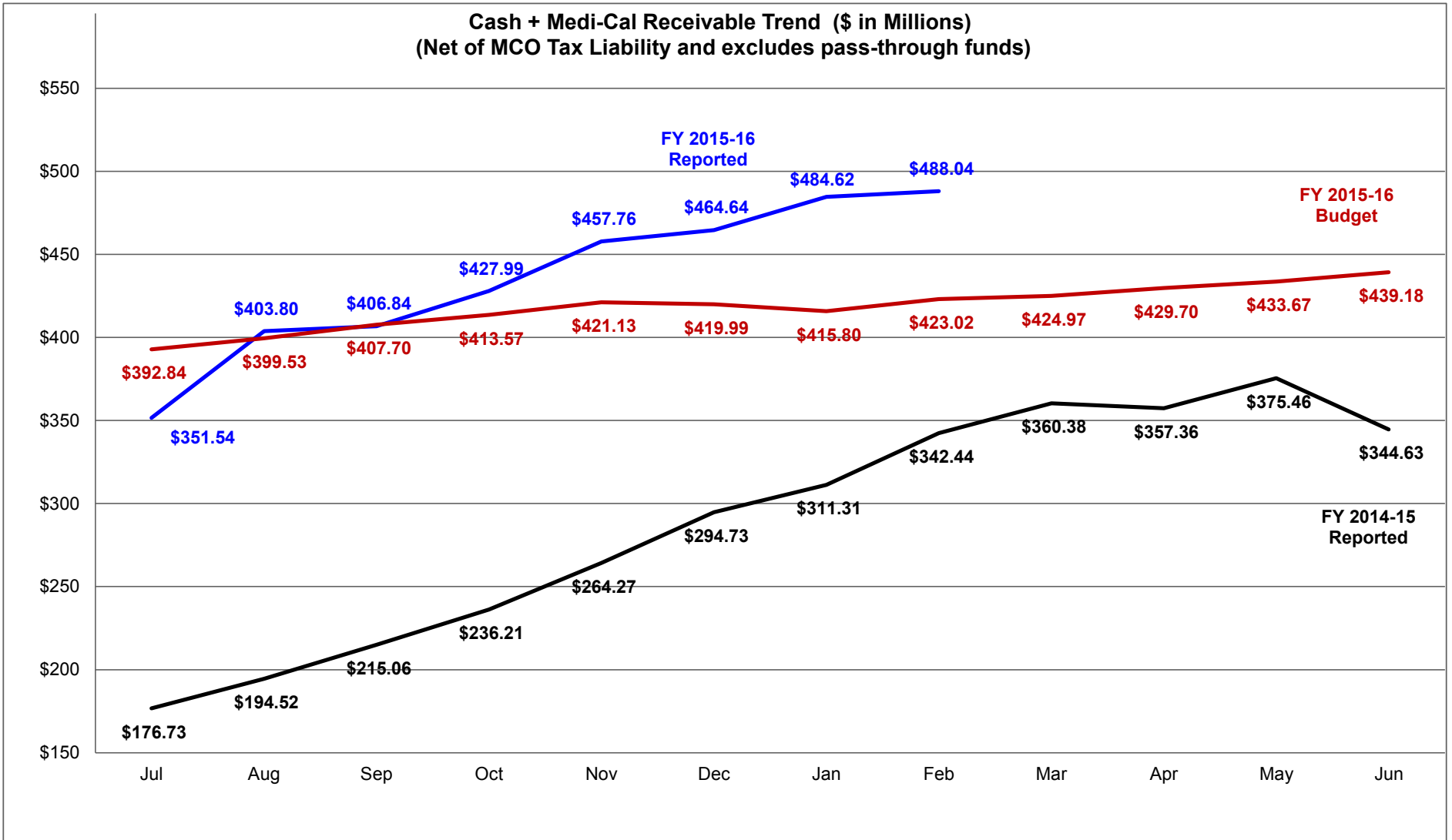
STATEMENT OF CASH FLOWS - FYTD

	FEB 16
Cash Flow From Operating Activities	
Collected Premium	\$ 614,360,643
Miscellaneous Income	934,264
State Pass Through Funds	52,887,434
<u> Paid Claims</u>	
Medical & Hospital Expenses	(241,356,439)
Pharmacy	(65,751,901)
Capitation	(67,443,775)
Reinsurance of Claims	(2,255,362)
State Pass Through Funds Distributed	(31,649,545)
Paid Administration	(33,044,050)
MCO Taxes Received / (Paid)	(24,229,006)
Net Cash Provided / (Used) by Operating Activities	202,452,262
Cash Flow From Investing / Financing Activities	
Net Acquisition / Proceeds from Investments	(55,165,191)
Net Discount / Premium Amortization of Investments	165,192
Net Acquisition of Property / Equipment	(436,626)
Net Cash Provided / (Used) by Investing / Financing	(55,436,626)
Net Cash Flow	\$ 147,015,636
Cash and Cash Equivalents (Beg. of Period)	57,218,141
Cash and Cash Equivalents (End of Period)	204,233,778
	\$ 147,015,636
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income / (Loss)	33,893,639
Depreciation & Amortization	279,250
Net Discount / Premium Amortization of Investments	(165,192)
Decrease / (Increase) in Receivables	66,485,254
Decrease / (Increase) in Prepaids & Other Current Assets	(586,449)
(Decrease) / Increase in Payables	99,095,494
(Decrease) / Increase in Other Liabilities	(5,522,327)
Change in MCO Tax Liability	249,565
Changes in Claims and Capitation Payable	3,205,486
Changes in IBNR	5,517,542
	202,452,262
Net Cash Flow from Operating Activities	\$ 202,452,262

STATEMENT OF CASH FLOWS - MONTHLY

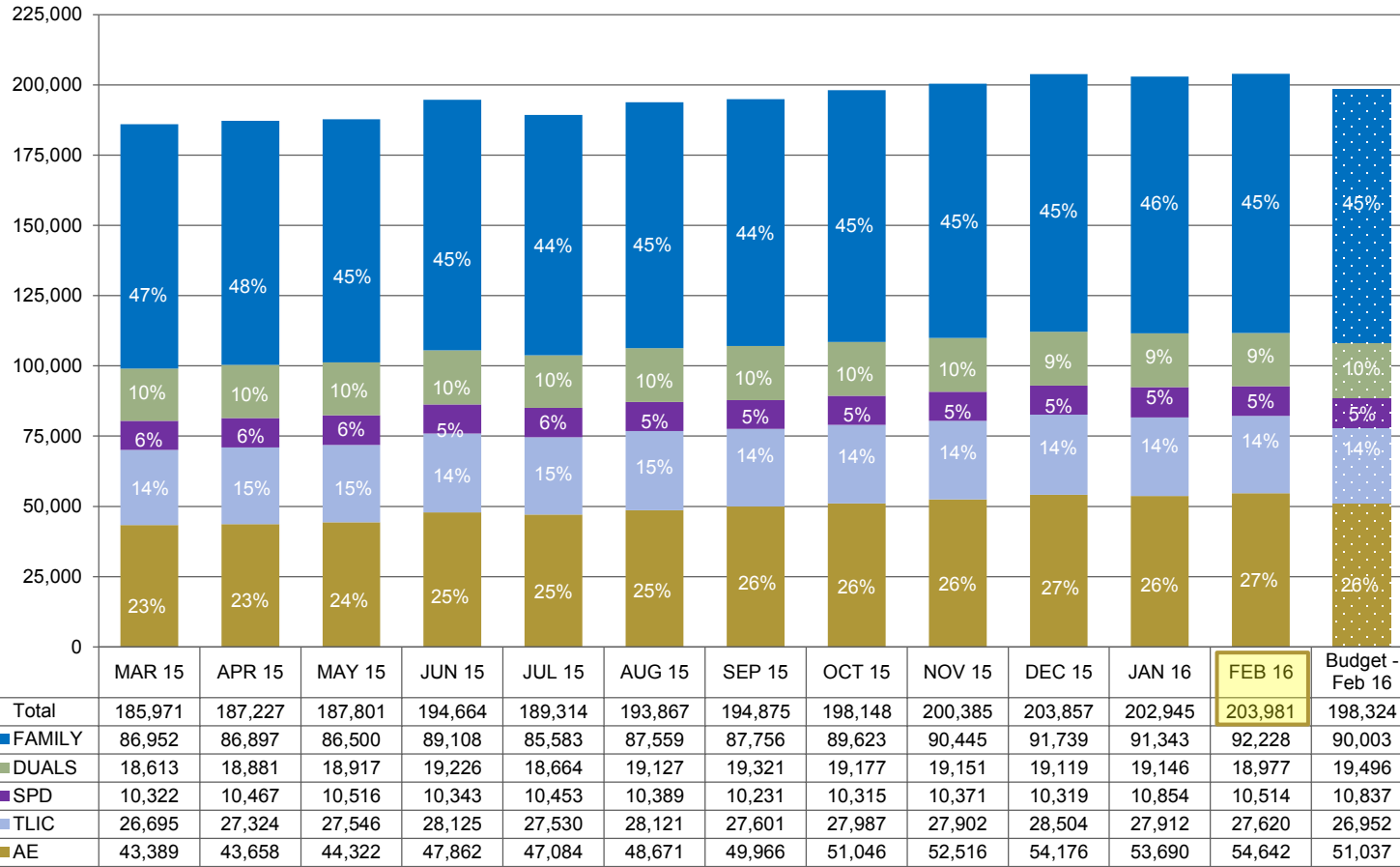
	FEB 16	JAN 16	DEC 15
Cash Flow From Operating Activities			
Collected Premium	\$ 50,212,450	\$ 67,256,791	\$ 67,706,561
Miscellaneous Income	147,908	105,604	116,280
State Pass Through Funds	1,893,015	1,910,810	1,852,286
<u>Paid Claims</u>			
Medical & Hospital Expenses	(25,925,285)	(29,020,122)	(40,122,381)
Pharmacy	(8,598,863)	(8,859,251)	(8,510,048)
Capitation	(4,356,051)	(4,431,554)	(9,971,024)
Reinsurance of Claims	(291,461)	(292,101)	(287,084)
State Pass Through Funds Distributed	(1,818,410)	(1,835,505)	(1,779,287)
Paid Administration	(5,966,237)	(2,888,898)	(5,092,623)
MCO Tax Received / (Paid)	(2,731,240)	(2,738,879)	(3,067,869)
Net Cash Provided / (Used) by Operating Activities	2,565,825	19,206,896	844,813
Cash Flow From Investing / Financing Activities			
Net Acquisition / Proceeds from Investments	(5,005,969)	(47,392)	44,961,978
Net Discount / Premium Amortization of Investments	5,969	47,392	38,022
Net Acquisition of Property / Equipment	(86,488)	(289,909)	(14,601)
Net Cash Provided / (Used) by Investing / Financing	(5,086,488)	(289,909)	44,985,399
Net Cash Flow	\$ (2,520,663)	\$ 18,916,988	\$ 45,830,212
Cash and Cash Equivalents (Beg. of Period)	206,754,441	187,837,453	142,007,241
Cash and Cash Equivalents (End of Period)	204,233,778	206,754,441	187,837,453
	\$ (2,520,663)	\$ 18,916,988	\$ 45,830,212
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	6,004,961	3,603,488	1,504,740
Net Discount / Premium Amortization of Investments	(5,969)	(47,392)	(38,022)
Depreciation & Amortization	35,311	35,406	34,927
Decrease / (Increase) in Receivables	(918,214)	(1,141,868)	(89,400)
Decrease / (Increase) in Prepays & Other Current As:	(108,120)	344,727	2,327
(Decrease) / Increase in Payables	(11,250,584)	7,534,264	6,186,151
(Decrease) / Increase in Other Liabilities	2,097,571	2,095,108	(1,099,649)
Change in MCO Tax Liability	36,947	32,248	(300,412)
Changes in Claims and Capitation Payable	9,241,560	5,071,570	(3,674,522)
Changes in IBNR	(2,567,640)	1,679,343	(1,681,327)
	2,565,825	19,206,896	844,813
Net Cash Flow from Operating Activities	2,565,825	19,206,896	844,813

**GOLD COAST HEALTH PLAN
FEBRUARY 2016**



GOLD COAST HEALTH PLAN

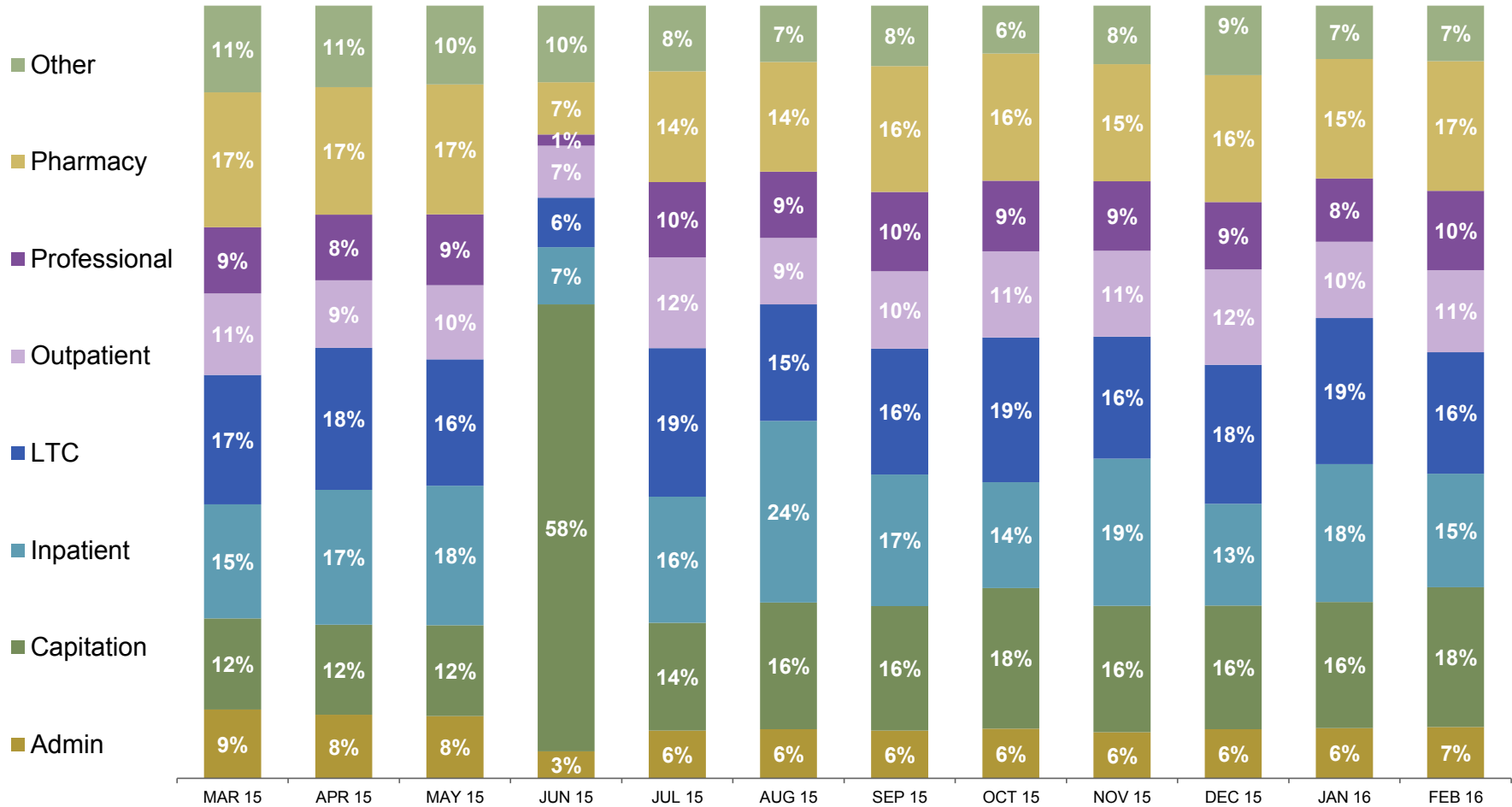
Membership - Rolling 12 Month



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

GOLD COAST HEALTH PLAN

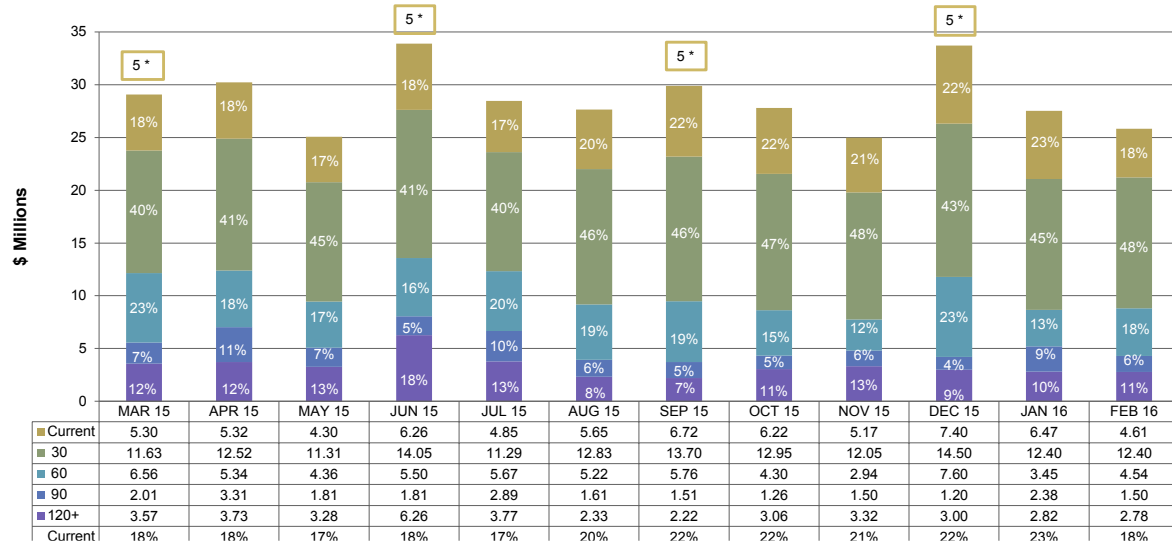
Total Expense Composition



Note: June 15 reflects the Enhanced Adult Capitation program and reclassification of fee-for-service expense to capitation expense.

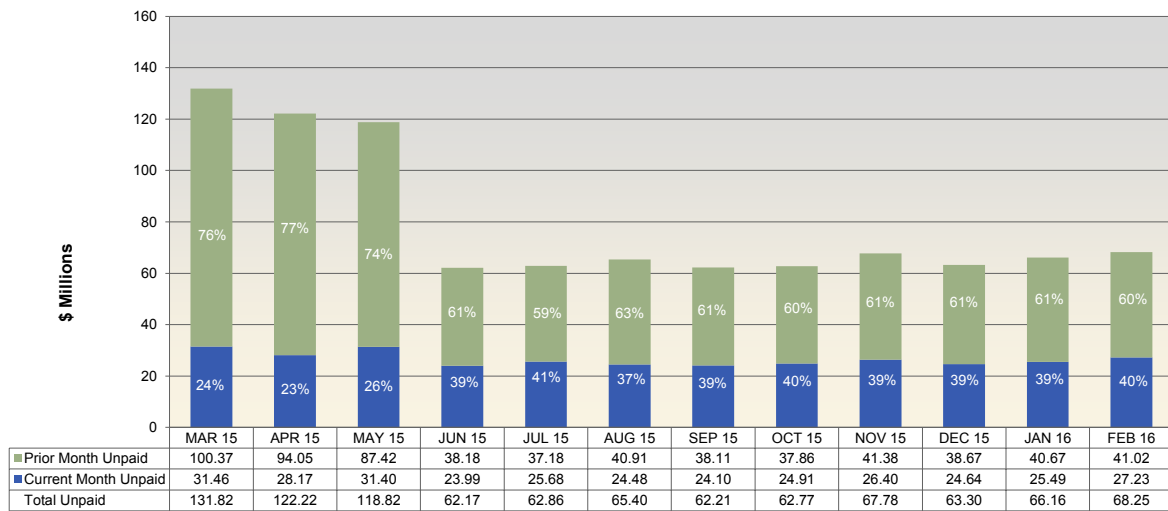
**GOLD COAST HEALTH PLAN
FEBRUARY 2016**

Paid Claims Composition (excluding Pharmacy and Capitation Payments)



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.

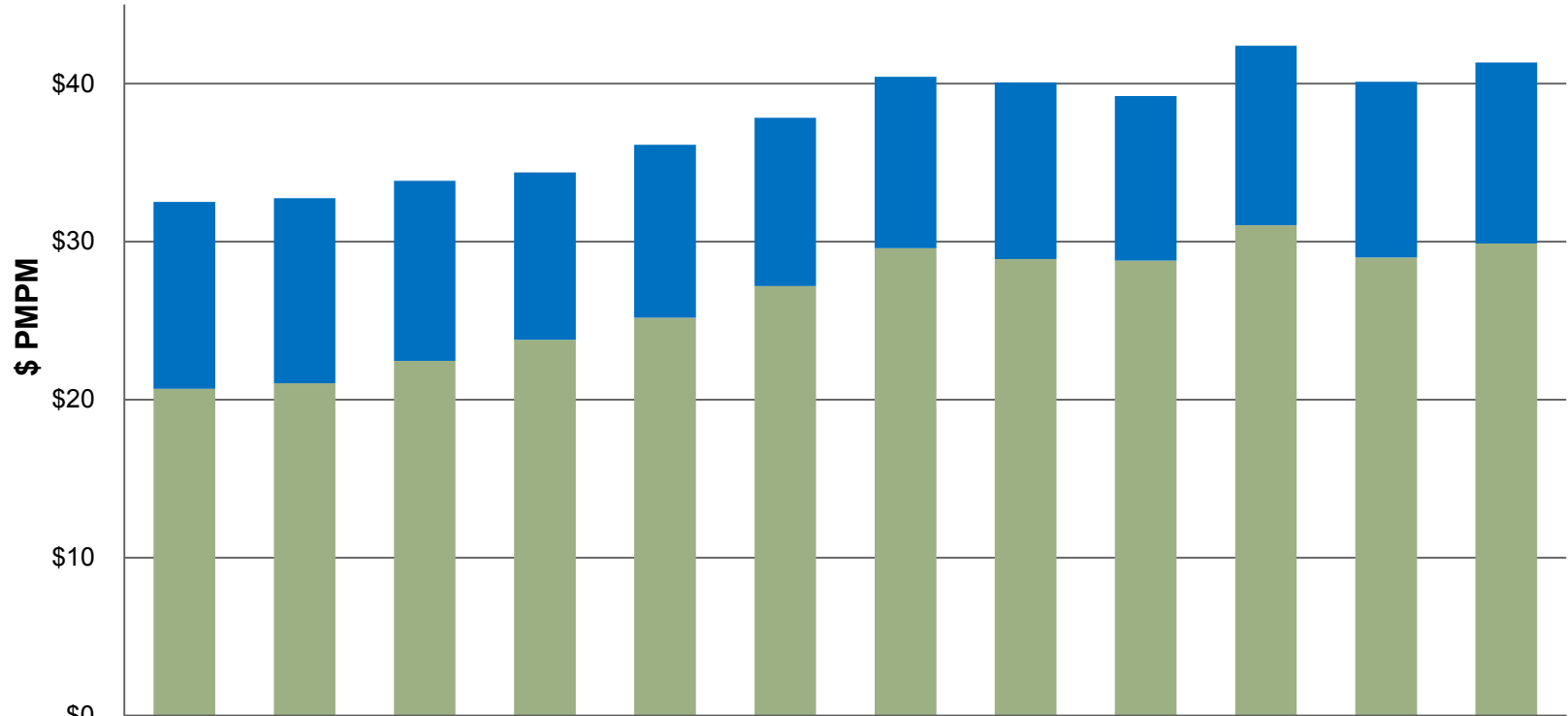
IBNP Composition (excluding Pharmacy and Capitation)



Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.
June 2015 - reflects the Enhanced Adult Capitation program and reclassification of fee-for-service expense to capitation expense.

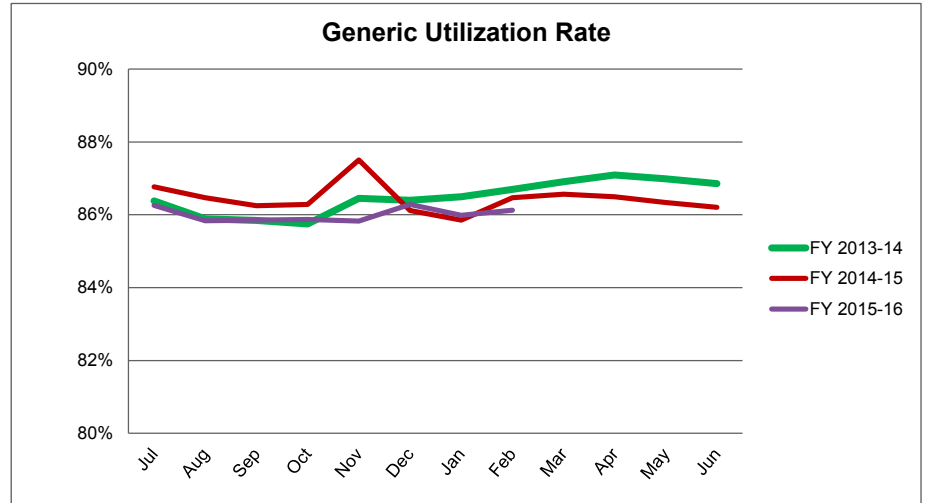
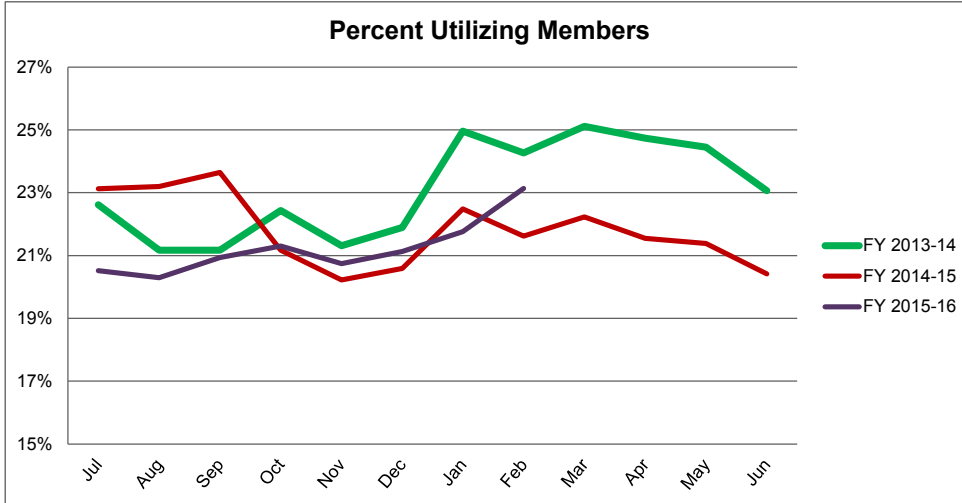
GOLD COAST HEALTH PLAN

Pharmacy Cost Trend

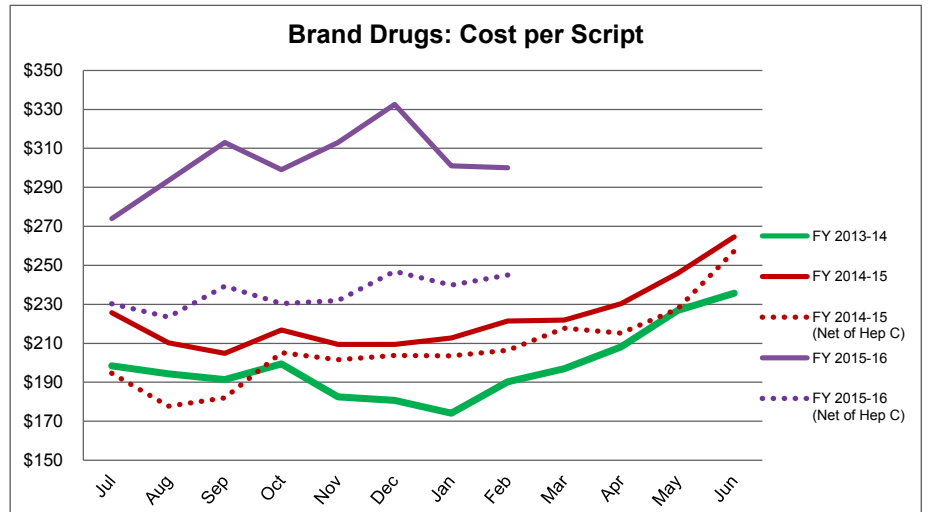
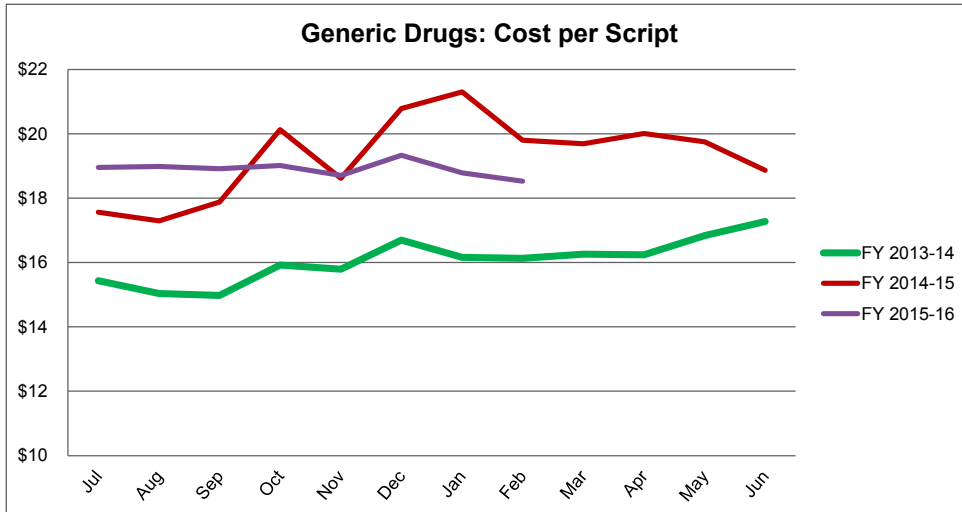


	MAR 15	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16
AVG PMPM	\$32.51	\$32.74	\$33.84	\$34.38	\$36.13	\$37.84	\$40.43	\$40.07	\$39.21	\$42.39	\$40.11	\$41.33
■ GENERIC	\$11.83	\$11.71	\$11.39	\$10.60	\$10.94	\$10.66	\$10.86	\$11.17	\$10.42	\$11.35	\$11.11	\$11.45
■ BRAND	\$20.68	\$21.03	\$22.45	\$23.78	\$25.19	\$27.18	\$29.58	\$28.90	\$28.79	\$31.04	\$29.00	\$29.88

**GOLD COAST HEALTH PLAN
PHARMACY ANALYSIS**



Effective Oct 14, Dual members were responsible for prescription copays, lowering the percentage of utilizing members.



AGENDA ITEM NO. 14

To: Gold Coast Health Plan Commission

From: Ralph Oyaga, Executive Director Governmental, Regulatory and External

Date: April 25, 2016

RE: National Health Foundation: Ventura Recuperative Care Program

SUMMARY:

Staff is recommending approval to award funds in the amount of thirty-eight thousand seven hundred (\$38,700) dollars to the National Health Foundation (NHF) to start a recuperative care program in Ventura County for individuals who are homeless and in need of housing after being discharged from the hospital. Per the Gold Coast Health Plan (GCHP) Sponsorship Policy HE/CL-007, requests for financial participation above five thousand (\$5,000) dollars require the prior approval of the Commission.

BACKGROUND:

GCHP has a sponsorship program that provides funding for events and programs that serve the Medi-Cal and medically indigent community in Ventura County. As part of the new Alternative Resources for Community Health (ARCH) program, GCHP seeks to sponsor programs that focus on social determinants of health, such as homelessness. NHF has requested start-up funds for their Ventura Recuperative Care Program, an innovative model of delivering care to people experiencing homelessness that helps reduce costly avoidable hospitalizations and readmissions by providing temporary housing as a discharge option, coupled with necessary medical oversight these patients need to reduce their likelihood of returning to the Hospital Emergency Department after discharge.

A recent United Way Homeless Cost Study found that individuals who are chronically homeless have a difficult time taking care of their mental and physical health while living on the streets or in emergency shelters, and they are shown to have disproportionate rates of acute and chronic illnesses which drive high rates of hospital utilization. The lack of housing complicates hospital discharge planning and subsequent recovery. Rest, medication adherence, wound care and other treatment are extremely difficult, if not impossible for homeless individuals. Unsanitary conditions may cause open wounds to become infected, clean bandages become filthy, washing facilities are generally unavailable, and medication requiring refrigeration quickly becomes compromised. All this leads to high rates of hospital readmissions. In addition, hospitals have reported keeping homeless patients in their hospitals up to four additional days due to lack of

safe and appropriate discharge options. The cost associated with these increased lengths of inpatient stays is substantial for both hospitals and health plans.

DISCUSSION:

NHF has been working over the past year on a needs assessment for Ventura County and found that, on average, approximately 95 out of 379 hospital patients would qualify for recuperative care on a monthly basis. These are homeless patients who are not sick enough to remain in the hospital, but are too sick to return to the streets or temporary shelters. Through intensive care management, care managers help individuals/members identify the root causes of their health issues, work to overcome those challenges, facilitate connections within the community that support a patient's continual improvement, and provides a transition from hospital to housing for many.

NHF, in collaboration with The Salvation Army and other social service organizations in Ventura County, has secured facilities for a program with 12 beds. Additional beds can be added as needed. The program will be supported by a predetermined payment by both the County and private hospitals based on their percentage of need. The program has the potential of serving between 225 and 275 individuals annually with an average length of stay at 10 to 14 days.

The start-up funds from GCHP will allow NHF to hire critical staff 30 days prior to the program start date, to allow for staff education and training at NHF's facilities. This will ensure a smooth opening for patients, staff and partnering hospitals.

FISCAL IMPACT:

\$38,700 fiscal impact to be funded through the Alternative Resources for Community Health (ARCH) program.

RECOMMENDATION:

Staff recommends approval of the sponsorship application from the National Health Foundation (NHF) requesting an amount of thirty-eight thousand seven hundred (\$38,700) dollars, which represents the start-up cost for their Ventura Recuperative Care Program.

AGENDA ITEM NO. 15

To: Gold Coast Health Plan Commission
From: Ralph Oyaga, Executive Director Governmental, Regulatory and External
Date: April 25, 2016
RE: Ventura County Area Agency on Aging: Senior Nutrition Program

SUMMARY:

Staff is recommending approval to award funds in the amount of twenty thousand (\$20,000) dollars to the Ventura County Area Agency on Aging (VCAAA). Per the Gold Coast Health Plan (GCHP) Sponsorship Policy HE/CL-007, requests for financial participation above five thousand (\$5,000) dollars require the prior approval of the Commission.

BACKGROUND:

GCHP has a sponsorship program that provides funding for events and programs that serve the Medi-Cal and medically indigent community in Ventura County. As part of the new Alternative Resources for Community Health (ARCH) program, GCHP seeks to sponsor programs that focus on social determinants of health, such as access to nutritious food.

VCAAA is requesting funds to cover the cost of providing an additional 2,666 nutritionally compliant meals to seniors who reside in Ventura County through the Senior Nutrition Program. This program provides both congregate and home-delivered meal service to individuals 60 years or older who are assessed as “food insecure”, meaning they lack consistent access to adequate food due to lack of money or other resources. This includes individuals who are unable to travel to and from congregate meal sites. VCAAA services include the procurement, preparation, transport and service of congregate and home-delivered meals, nutrition education, nutrition screening, and nutrition counseling.

DISCUSSION:

VCAAA estimates that about 86,240 people in Ventura County or approximately 10% of the population in the County are food insecure. Applying this rate to the senior citizen population of 160,000, it is estimated that 10% or 16,500 senior citizens are food insecure. Currently, VCAAA serves only 3,109 of those individuals.

In addition to helping to reduce hunger and food insecurity, this program also promotes socialization by breaking down the barriers of isolation and loneliness. Studies show that providing daily home-delivered meal services improves the health and well-being of older adults, particularly those who receive daily-delivered meals (as opposed to weekly frozen meals) and those who live alone.

The funds from Gold Coast Health Plan will allow VCAAA to purchase an additional 2,666 meals at a cost of approximately \$7.50 per meal, and will allow VCAAA to reach more isolated older individuals in our community, especially those who are extremely frail and vulnerable. VCAAA will work with GCHP staff to establish a program that provides meals to targeted GCHP members who are at high risk of readmissions.

FISCAL IMPACT:

\$20,000 fiscal impact to be funded through the Alternative Resources for Community Health (ARCH) program.

RECOMMENDATION:

Staff recommends approval by the Commission of the sponsorship application from VCAAA for an amount of twenty thousand (\$20,000) dollars.

AGENDA ITEM NO. 16

To: Gold Coast Health Plan Commission

From: Dale Villani, Chief Executive Officer

Date: April 25, 2016

Re: Chief Executive Officer Update

TRACY J. OEHLER, NEW GCHP CLERK OF THE COMMISSION:

Tracy joins the Plan from her previous positions with the City of South Bend, IN and the City of Moorpark, CA, where she served in various administrative positions including Deputy City Clerk for the City of Moorpark. Our sincere appreciation goes out to Maddie Gutierrez who did a great job filling in as the Interim Clerk of the Commission.

BOARD OF SUPERVISORS APPROVES COMMISSIONERS:

The Ventura County Board of Supervisors has approved the reappointment of Supervisor Peter Foy, Commissioners Dee Pupa and Dr. Lanyard Dial through March 15, 2020. Jennifer Swenson was approved as a new Commissioner through March 15, 2020.

VENTURA COUNTY LINE OF CREDIT REPAYMENT:

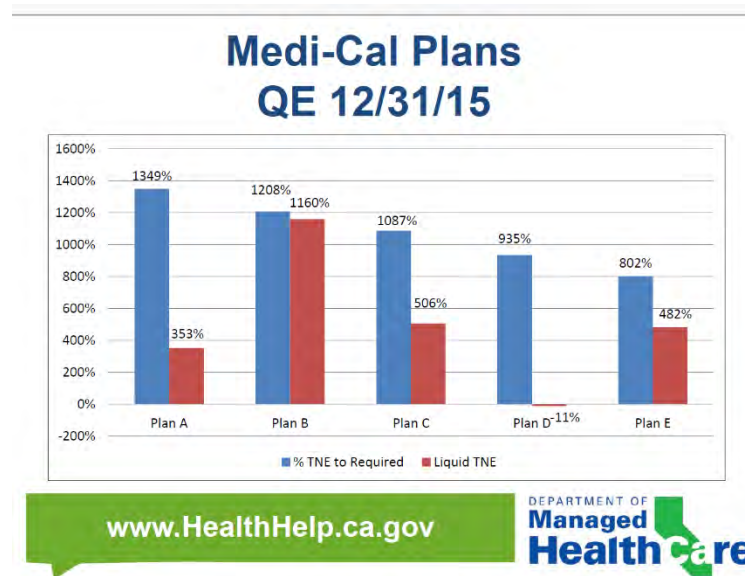
Gold Coast Health Plan received approval on March 25, 2016 from the California Department of Health Care Services (DHCS) to repay a \$7.2 million line of credit to Ventura County. GCHP repaid the loan on Monday, March 28.

The county – at the direction of DHCS – issued a \$7.2 million revolving line of credit to help the Plan meet the state’s required level of financial reserves, known as tangible net equity (TNE), which at the time was 8.5 million dollars. In October 2014, GCHP requested that the state allow payback of the loan; however, the request was put on hold by the state until an audit of GCHP’s finances was completed.

DEPARTMENT OF MANAGED CARE SERVICES (DMCS) FINANCIAL SOLVENCY STANDARDS BOARD (FSSB):

At the meeting of the FSSB on March 16, 2016 the subject of Tangible Net Equity (TNE) at commercial, Medicare, and Medi-Cal health plans was discussed. The subject of “excess” TNE was discussed without clearly defining what constitutes excess. DMHC did note that the local

health plans, like GCHP, invest a portion of their TNE in the local community. The meeting was attended by GCHP CFO Patricia Mowlavi. The graphic below was presented as an example of Medi-Cal Plans TNE. GCHP TNE is currently 564% of required TNE (284% Liquid TNE).



GOLD COAST HEALTH PLAN CEO INVITED TO JOIN HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA (HASC) MEDI-CAL TASK FORCE: PROMOTING ACCESSIBILITY AND SUSTAINABILITY OF MEDI-CAL IN LOCAL COMMUNITIES:

The Medi-Cal Task Force will work with the local public Medi-Cal managed care health plans (Local Initiatives and County Organized Health Systems -COHS), community health centers, medical groups and local safety net and non-safety net hospitals to identify best practices and remove barriers that prevent the delivery of coordinated, high quality, appropriate and efficient health care. Through this convening process, HASC hopes to strengthen ties with the local public Medi-Cal managed care plans and support their sustainability, improve access, and improve the delivery system and continuum of care at the local level. The Medi-Cal Task Force will develop recommendations that incorporate the Triple Aim and focus on using the medical home model with robust care management and aligned incentives. The recommendations will also address the structure and financing to ensure patients are able to access high quality appropriate care throughout the continuum.

GOLD COAST HEALTH PLAN CEO PRESENTS AT NORTHERN CALIFORNIA STATE OF REFORM:

On April 6, 2016, CEO Villani participated in a panel presentation on County Led Initiatives to Improve System Health. The Conference was held at the Sacramento Convention Center. The other panelist were David Pomaville, Director, Department of Public Health, Fresno County, and Kimi Watkins- Tartt: Deputy Director, Public Health Department, Alameda County.

VENTURA COUNTY COMMUNITY REINVESTMENT MEETINGS AND DISCUSSIONS:

Plan representatives met with the Ventura County Area Agency on Aging on March 11 to discuss the Senior Nutrition Program and opportunities to support meal distribution to members throughout the county. Victoria Jump, Marleen Canniff, and Brian Murphy discussed the Senior Nutrition Program and frozen and hot meal distribution serving 3,901 seniors throughout 11 cities in Ventura County.

On March 11, 2016 the Plan met with Audra Strickland, Regional Vice President, Hospital Association of Southern California, and Kelly Bruno, President & CEO, National Health Foundation, to discuss their recuperative care program. This program partners with local hospitals to transition hospitalized homeless members into local community shelters. In Ventura County NHF is partnered with the Salvation Army.

Ralph Oyaga, Executive Director, Government, Regulatory and External Relations received sponsorship requests from both of these organizations and is presenting these for approval under our new Alternative Resources for Community Health (ARCH) initiative.



GCHP 2016 EMPLOYEE SURVEY, DIVERSITY RESULTS, AND FOCUS GROUP FINDINGS AND ACTIONS:

The Plan contracted with Amplitude Research to conduct the 2016 Employee Survey with results presented in February 2016. The overall response rate was 75% with 132 employees completing the survey. GCHP is very pleased with the overall results and the 81% satisfaction among employees working at GCHP.

Vicki Hewlitt who serves as the interim Chief Diversity Officer for GCHP will present the overall survey findings as well as the detailed diversity questions which serves as our baseline for ongoing improvements. Highlights include:

- “Supports diversity and inclusion” (79% expressed agreement with this statement)
- “Clearly and regularly communicates about and demonstrates the importance of diversity” (75%)

Niosha Shakoori, Founder, clarusHR, conducted diversity focus groups based on the survey results and will present her findings to the Commission.

COMPLIANCE UPDATE:

Gold Coast Health Plan (GCHP) successfully closed out the DHCS Medical Audit Corrective Action Plan (CAP) on March 16, 2016. GCHP was notified on February 25, 2016 by Audits & Investigations (A&I) the annual medical audit for 2016 will take place, April 25, 2016 through May 6, 2016. GCHP had to submit pre-audit documentation material to A&I by March 18, 2016. The review period for the medical audit is April 1, 2015 through March 31, 2016.

The DHCS corrective action plan, Financial (Addendum A) remains open and the plan continues to submit items on a monthly basis as required and defined by the CAP.

Compliance continues to monitor and ensure all employees and temporary employees are trained and retrained on HIPAA and Fraud, Waste & Abuse. Compliance staff has revised and created new HIPAA privacy policies and procedures. Compliance staff has developed a comprehensive privacy program. A privacy work plan is in the process of being implemented for 2016, and staff is working on all facets of the work plan to ensure goals are achieved.

GCHP continues to meet all regulatory contract submission requirements. In addition to routine deliverables GCHP provides weekly and monthly reports to DHCS as a part of ongoing monitoring activities. All regulatory agency inquiries and requests are handled timely and requested information is provided within the specified required timeframe(s). Compliance staff is actively engaged in sustaining contract compliance. With the transition of ABA services on February 1, 2016 additional weekly and daily reporting has been required.

GCHP compliance committee continues to meet in accordance with the compliance committee charter. The committee met on February 25, 2015. The committee reviewed and discussed the following items: delegation reports, delegation audit results, HIPAA privacy program updates, and the upcoming DHCS medical audit. The committee also reviewed the scores from the last internal HIPAA privacy desk audit conducted at the Plan by compliance staff.

FEDERAL LEGISLATIVE UPDATE

Centers for Medicare and Medicaid Services (CMS): Mental Health Parity

On March 30, 2016, CMS published the final rule “Medicaid and Children’s Health Insurance Programs; Mental Health Parity and Addiction Equity of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans.” The rule aims to strengthen access to mental health and substance use services for people with Medicaid or CHIP coverage by aligning protections already required of health plans in the commercial market.

The Government Relations staff has begun analyzing the implications the rule will have on GCHP and will provide a full analysis in the coming weeks.

Congressional Legislative Bill

Summary: HR 3716, Ensuring Access to Quality Medicaid Providers Act, authored by Republican Larry Bucshon, would require each Medicaid or CHIP provider, whether the provider participates on a fee-for-service (FFS) basis or within the network of a managed care organization (MCO), to enroll with the state by providing specified identifying information. When notifying the Department of Health and Human Services (HHS) that a provider has been terminated under a state plan, the state must submit this information as well as information regarding the termination date and reason. HHS shall review such termination notifications and, if appropriate, include them in a database or similar system, as specified by the bill.

Analysis: HR 3716 would require all Medi-Cal providers, FFS and managed care, to enroll with the DHCS FFS Provider Enrollment Division. The Association for Community Affiliated Plans (ACAP) will begin tracking this bill as it is likely it will be sent to the President for signature. HR 3716 has already moved out of the House of Representatives and is waiting to be heard in the Senate Finance Committee which oversees the Medicaid program. The Local Health Plans of California (LHPC) will meet with the Department of Health Care Services (DHCS) to determine if the department has taken an official position on the matter.

CALIFORNIA LEGISLATIVE UPDATE

State of Reform Health Policy Conference

The goal of the conference was to provide a framework for the discussion of the most pressing challenges facing health care today. Topics included were the proposed health care initiatives at the ballot in 2016, emerging health care trends in the Legislature and a Q&A with the Democratic and Republican leadership regarding health care.

It is predicted that there will be over 15 ballot measures in November's ballot. The California Hospital Association has introduced a ballot measure, the Medi-Cal Funding and Accountability Act, which would prohibit the Legislature and the Administration from imposing a provider fee (tax) on hospitals unless the funds are used to pay for hospital care provided to Medi-Cal patients. The California Medical Association is currently collecting signatures to qualify the California Healthcare, Research and Prevention Tobacco Tax Act of 2016. The initiative proposes to increase the state's tobacco tax from 0.87 cents to \$2.87 a pack. The funding will be used for the state's health care programs.

Margaret Tatar, former Assistant Deputy Director for DHCS, stated the policy issues to pay close attention to are: the Medi-Cal budget, the Medicaid Managed Care Mega rule, and controlling health care costs. The Democratic leadership stated that their main priorities were the integration of physical and mental health, health care transparency, and increasing the healthcare workforce.

Assembly Budget Subcommittee on Health and Human Services

The Assembly Budget Subcommittee on Health and Human Services heard a number of agenda items presented by DHCS regarding mental health services. The proposed budget includes \$396.5 million to fund medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. Assemblymember Thurmond asked if minors were eligible for Drug Medi-Cal services. Karen Baylor, Deputy Director, Mental Health and Substance Use Disorder Services, stated that under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), minors were eligible for these services.

The subcommittee heard a proposal presented by the Drug Policy Alliance which requested \$3 million (GF) in order for DHCS to implement a community grant program for the distribution of naloxone kits to first responders, patients, families, and at-risk drug users. According to advocates, an average of 2,700 Californians die from opioid overdoses annually.

The subcommittee took no action on any of the proposed budget items. Action will be taken during the May revise.

Legislative Bills Update

The following is a list of Medi-Cal bills that were heard in various legislative committees during the month of April.

AB 1795 (Atkins) Breast Cancer Treatment

Summary: Extends coverage for breast and cervical cancer for low-income uninsured or underinsured individuals to include individuals of any age who are symptomatic or are age 40 and older, and removes the timeframe of 24 months for covered services to "as meets eligibility requirements."

Analysis: This bill is expected to have minimal impact to GCHP. AB 1795 targets women who are currently enrolled in the Breast and Cervical Cancer Treatment program (BCCTP). There are currently 169 beneficiaries enrolled under the BCCTP at GCHP.

AB 2084 (Wood) Comprehensive Medication Management

Summary: Establishes a Comprehensive Medication Management (CCM) program as a covered benefit in the Medi-Cal program.

Analysis: AB 2084 is sponsored by the California Pharmacists Association. AB 2084 stems from SB 493 (Chaptered in 2013) which expanded the scope of practice for pharmacists. AB 2084 would allow pharmacists to be reimbursed for clinical services such as the CMM program. LHPC submitted a letter of concern stating that AB 2084 would add to the costs and administrative complexity of the Medi-Cal program without truly benefiting members with the highest needs.

AB 2207 (Wood) Medi-Cal Dental Program

Summary: Would require Medi-Cal managed care plans to provide dental health screenings for eligible beneficiaries and refer them to appropriate Medi-Cal dental providers.

Analysis: AB 2207 goes beyond what is currently required by plans under the current contract. Both the California Association of Health Plans (CAHP) and LHPC are concerned with language that would require plans to provide care coordination for dental services. At the February DHCS' CEO Meeting, LHPC asked DHCS to further specify what DHCS meant by coordination of services. DHCS was unable to provide a clear answer and stated it did not intend to change current contract requirements. LHPC and CAHP will meet with DHCS to discuss the intent of the bill.

AB 2372 (Burke) Health Care Coverage: HIV Specialists

Summary: AB 2372 would allow for an enrollee to choose a specialist physician, including an HIV specialist, as their Primary Care Provider (PCP).

Analysis: CAHP took an oppose position and argues that AB 2372 would hinder a health plan's ability to meet network adequacy standards. According to CAHP, network adequacy standards

are more stringent for PCPs than for specialists. Additionally, it would be extremely difficult for plans to comply with time and distance standards for PCPs due to the relatively limited number of HIV specialists throughout the state.

AB 2394 (Eduardo Garcia) Medi-Cal: Non-Medical Transportation

Summary: AB 2394 would add to the schedule of benefits nonmedical transportation, as defined, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services.

Analysis: LHPC took a support if amended position because the bill does not provide the needed clarity that health plan rates will reflect the inclusion of transportation when provided as specified by the bill. Under the current managed care rate-setting process, health plans would be required to cover the service for up to two years without receiving payment.

AB 2810 (Eggman) Aid-In-Dying Prescription Drugs: Coverage for Medi-Cal Beneficiaries

Summary: Would require coverage for an aid-in-dying drug prescription to be provided to a Medi-Cal beneficiary who meets the qualifications of the End of Life Option Act and who requests a prescription in accordance with that act, and would require the cost for those services to be provided with state-only funds. The bill would authorize the department to implement, interpret, or make specific its provisions by all-county letters or similar instructions, without taking regulatory action, until the time regulations are adopted, as specified. The bill's provisions would be repealed on January 1, 2026.

Analysis: AB 2810 is the continuation of the End of Life Option Act passed in October 2015. According to GCHP Lobbyists, there is a good chance that AB 2810 will not move along the legislative cycle as DHCS is already working on making this a covered benefit under Medi-Cal. However, if the bill did move forward the author's office believes the cost of these drugs would eventually be built into plan rates and reimbursed by DHCS. Additionally, Valent Pharmaceuticals, the company that makes the most commonly used aid-in-dying drug, doubled its drug price last year after passage of the End of Life Option Act. The cost of the drug is more than \$3,000.

SB 999 (Pavley) Health Insurance: Contraceptives: Annual Supply

Summary: Would require a health care service plan or a health insurance policy issued, amended, or renewed on or after January 1, 2017, to cover a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time by a prescriber, pharmacy, or onsite at a location licensed or authorized to dispense drugs or supplies.

SB 999 is sponsored by Planned Parenthood Affiliates of California, Family Health Council, and NARAL Pro-Choice California. CAHP opposes SB 999 because it exceeds the parameters for Medi-Cal managed care.

Analysis: The revised APL 16-003, Family Planning Services Policy for Contraceptive Supplies, released by DHCS on Friday, April 1, states that effective May 1, 2016 GCHP must pay for up to thirteen cycles of oral contraceptives and such quantity must be dispensed in an onsite clinic and billed by a qualified family provider.

SB 1135 (Monning) Health Care Coverage: Notice of Timely Access to Care

Summary: SB 1135 would require a health care service plan, including a Medi-Cal managed care plan, or health insurer to provide an enrollee or an insured with information regarding consumer assistance provided by the licensing agency, as specified. The bill would also require a health care service plan or a health insurer to provide a contracting health care provider with specified information relating to the provision of referrals or health care services in a timely manner.

SB 1135 is sponsored by the Western Center on Law and Poverty.

Analysis: Senator Monning recently amended SB 1135 to require Medi-Cal managed care plans to provide enrollees with timely access rules and the appropriate telephone number to file a grievance. However, Medi-Cal managed care plans are already required to provide this information to beneficiaries. GCHP already makes this information available in the member handbook and in the member newsletter.

SB 1308 (Nguyen) Medi-Cal: County Organized Health Systems

Summary: Would prohibit a County Organized Health System (COHS) from using administrative and operational funds for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modification.

Analysis: Senator Nguyen pulled SB 1308 from the Senate Health Committee hearing on Wednesday, April 6 and will not pursue the issue any further this year. It appears that the Senator did not have enough votes to move the bill out of committee.

SB 1361 (Nielsen) Medi-Cal: Eyeglasses

Summary: SB 1361 would restore coverage of one pair of eyeglasses provided every two years to an individual 21 years of age or older unable to meet DMV vision standards.

SB 1361 is sponsored by VSP Global and the California Optometric Association.

Analysis: Currently GCHP only provides eyeglasses every two years to individuals up to age 21. It is unclear what the cost would be to GCHP if required to provide this benefit. Neither CAHP nor LHPC have taken an official position.



AGENDA ITEM NO. 17

To: Gold Coast Health Plan Commission
From: Dale Villani, CEO / Danita Fulton, Sr. Director of Human Resources
Date: April 25, 2016
RE: Employee Satisfaction Survey – Summary of Results

SUMMARY:

GCHP conducted an Employee Satisfaction Survey in January 2016. GCHP employees demonstrated strong positive responses regarding the four main sub-categories of the survey – Company/Senior Leadership/Immediate Manager/Job-Compensation.

BACKGROUND:

Gold Coast Health Plan (GCHP) commissioned Amplitude Research, Inc. to conduct an Employee Satisfaction Survey of all GCHP employees. Survey completion was at 75% with an overall 81% satisfaction rate.



AGENDA ITEM NO. 18

To: Gold Coast Health Plan Commission
From: C. Albert Reeves, Chief Medical Officer
Date: April 25, 2016
RE: CMO Update

There is no reportable action for the months of March and April.

AGENDA ITEM NO. 19

To: Gold Coast Health Plan Commission

From: Lupe Gonzalez, MPH, PhD, Director of Health Education, Outreach, Cultural and Linguistic Services

Date: April 25, 2016

RE: Community Outreach Summary Report – February and March 2016

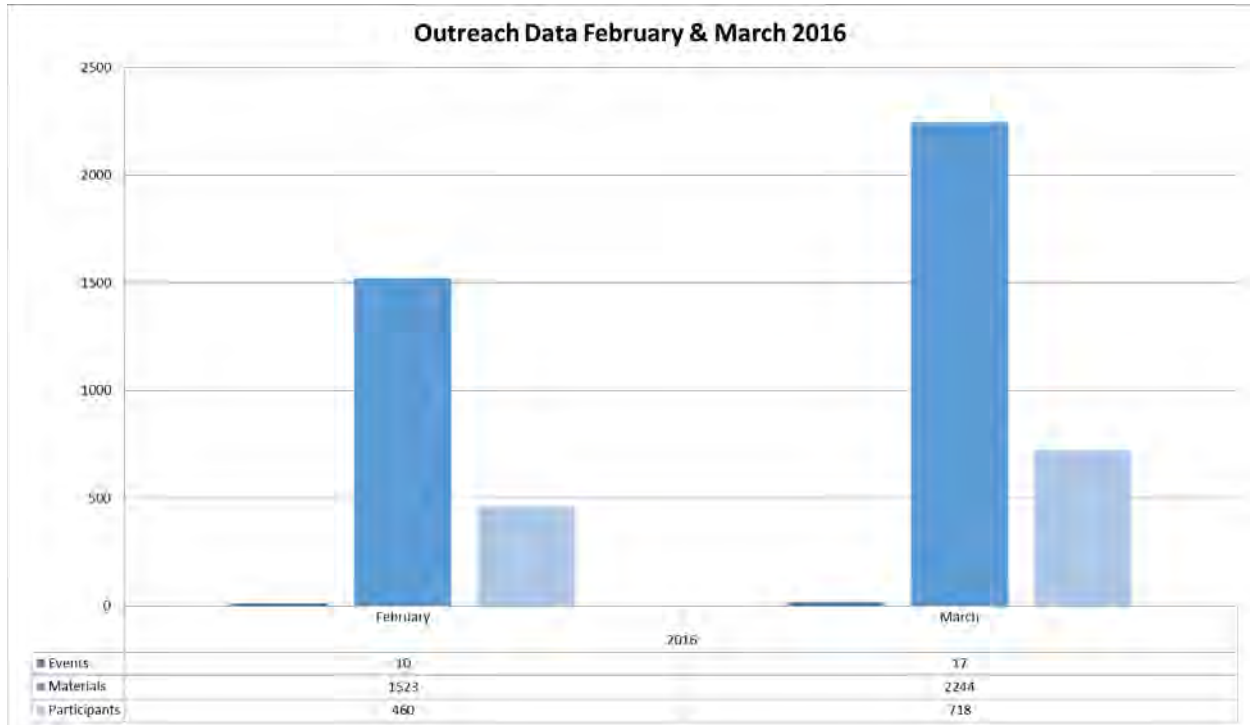
Summary

Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. The health education and outreach team maintains a positive presence in the community by working with various county public health departments, community based organizations, schools, senior centers, faith-based centers and social service agencies.

Below is a summary of activities during the months of February and March 2016.

Outreach Activities – February and March 2016

GCHP participated in 27 community health education and outreach events. The majority of individuals contacted were from events that focused on reaching the general population and low-income families. A total of 1,178 participants were reached and 3,767 health information materials were distributed. Included is a chart that highlights the total number of participants and materials distributed during the months of February and March.



Upcoming Outreach Events

The 5th Annual Community Resource Fair will be held Saturday, May 14, from 10:00 AM to 2:00 PM at Plaza Park in downtown Oxnard. The event will host more than 40 local health and social service organizations including free health screening, child development, behavioral health, diabetes education, employment resources, and much more. GCHP will have several exhibit booths highlighting resources from various departments including Health Education, Care Management, Member Services, and Pharmacy. Information about the resource fair may be found on the GCHP website.

The American Diabetes Association is partnering with GCHP and other local health care agencies to host a “Diabetes Day” community resource fair. The resource fair will be held on Saturday, June 11, at Pacifica High School in Oxnard. The event will feature health screenings, cooking demonstrations, physical activities (Zumba demonstration) and much more. The event is still in the planning process and more information will be available on the GCHP website.

Sponsorship Award Update

Summary

Gold Coast Health Plan (GCHP) Sponsorship Committee reviewed and funded the following sponsorship applications in February and March:

- **CAREGIVERS:** The review committee awarded CAREGIVERS with \$1,250 (Clover Level) for the 24th Annual Wearin' O' the Green event. The review committee was impressed by the efforts made by CAREGIVERS to advance the health and wellbeing of homebound frail seniors in Ventura County by compassionate volunteer caregiving.
- **CDA Cares:** The review committee also awarded the California Dental Association (CDA), Ventura, with \$2,500 in support of the free dental clinic to be held at the Ventura County Fairgrounds on April 16-17, 2016. The free clinic will be open to individuals in Ventura County having difficulty accessing dental care, including uninsured, underinsured, unemployed, adults and children, and others who are in need of oral health care. Care is provided at no cost by dental professionals donating their time and skills.
- **Copa Ventanilla 2016:** The Ventanilla de Salud (Windows of Health) has been awarded \$800 to help support their health fair and soccer tournament in Oxnard on May 1, 2016. This non-profit organization provides access to primary health care services, health insurance coverage, and promotes a culture of preventive health care among individuals and their families.
- **Simi Valley Council on Aging (COA):** The review committee has also awarded the Simi Valley COA \$300 to support their 12th Annual Wellness Expo to be held on April 20, 2016 at the Simi Valley Senior Center. The goal of the Wellness Expo is to promote health and wellness services for seniors living in Ventura County.
- **INLAKECH CULTURAL ARTS:** The review committee awarded the Inlakech Center with a \$2,000 donation to support the purchase of uniforms and instruments, and their vision to create a safe and healthy cultural artistic learning environment for youth and the elderly in Ventura County.
- **VENTURA COUNTY PUBLIC HEALTH (VCPH):** The VCPH has been awarded \$1,550 to support the implementation of their pilot program on childhood obesity prevention at the Academic Family Care Clinic. Funding will be used to support the pilot program and seed money to support the implementation of the program across all VCMC clinics.

- **BOYS & GIRLS CLUB OF SANTA CLARA VALLEY (BGCSCV):** The BGCSCV has been awarded \$5,000 to help support their *Promoting Change Through Health, Fitness & Nutrition Initiative* which will increase awareness and access to healthy foods and beverages; encourage physical fitness and sustain a safe place for children to be active. The program will also engage parents by using informational material and activities focused on healthy eating and physical activity.

The GCHP Sponsorship Committee approved the following request for letter of support:

- **VENTURA COUNTY PUBLIC HEALTH (VCPH):** VCPH's proposal is seeking funding through the California Accountable Communities for Health Initiative (CACHI) grant to improve the health of the Santa Paula community and achieve greater health equity among its residents. GCHP hopes to join the Santa Paula Accountable Community for Health (SPACH) Partnership's vision of achieving integration of high quality medical care, behavioral health services, and social services to realize measurable population health improvements for Santa Paula residents through the implementation and tracking of evidence-based interventions that address the priority areas of tobacco use, obesity, and behavioral health needs.

The GCHP Sponsorship Committee recommended approval of two requests that exceeded the committee's approval limit and therefore seeks approval from the Commission:

- **VENTURA COUNTY AREA AGENCY ON AGING (VCAAA):** The committee approved \$20,000 to partner with the VCAAA's Senior Nutrition Program (SNP) for Ventura County's aged 60+ population, adults with one or more disabilities and their caregivers. The program provides daily home-delivered meal services and has a proven outcome of improving the health and well-being of older adults and those who live alone.
- **NATIONAL HEALTH FOUNDATION (NHF):** The committee also approved \$38,700 to partner with NHF to promote expansion of their Recuperative Care Program to Ventura County. This program would model the two Los Angeles County sites by providing hospitals a discharge option for homeless clients who are not sick enough to remain in the hospital, but too sick to return to the streets or temporary shelters. In addition to helping these clients recover from injury and illness, many of these homeless individuals are connected to critical social and healthcare services.



5th Annual Community

Resource Fair

- * Free Health Screenings
- * Entertainment
- * Resource Booths
- * Giveaways

Saturday, May 14, 2016

10:00 am – 2:00 pm

Plaza Park, Downtown Oxnard

500 S. 'C' Street, Oxnard, CA 93030

For more information please call the
Health Education Department at:

805.437.5500

or email outreach@goldchp.org



**Gold Coast
Health Plan**SM
A Public Entity

If you need interpreter services or special assistance
to participate, please contact us by April 22, 2016.



5ª Feria Anual de Recursos

Comunitarios

- * Exámenes de Salud Gratuitos
- * Entretenimiento
- * Mesas de Recursos
- * Regalos

sábado, 14 de mayo de 2016

10:00 am – 2:00 pm

La Placita en el Centro de Oxnard
500 S. 'C' Street, Oxnard, CA 93030

Para más información por favor llame al
Departamento de Educación para la Salud al:

805.437.5500

O por email outreach@goldchp.org



**Gold Coast
Health Plan**SM
A Public Entity

Si necesita servicios de intérprete o asistencia especial para participar, por favor comuníquese con nosotros antes del 22 de abril de 2016.



AGENDA ITEM NO. 20

To: Gold Coast Health Plan Commission
From: Nancy Wharfield, Associate CMO
Date: April 25, 2016
RE: Health Services Update

HEALTH SERVICES UPDATE

Utilization data in the Health Services monthly update to the Commission is based on paid claims compiled by date of service and is lagged by 3 months to allow for partial run out of claims data. Claims data is complete at approximately 6 months. While incomplete, a 3 month lagged snapshot allows us to see an estimate of utilization without waiting for a more complete 6 month report. Administrative days are included in these calculations. Dual eligible members, Skilled Nursing Facility (SNF), and Long Term Care (LTC) data is not included in this presentation.

Utilization Summary

Inpatient utilization metrics for CY 2015 are similar and slightly improved compared with CY 2014. The yearly average of bed days/1000 members has declined over 44% since Plan's inception.

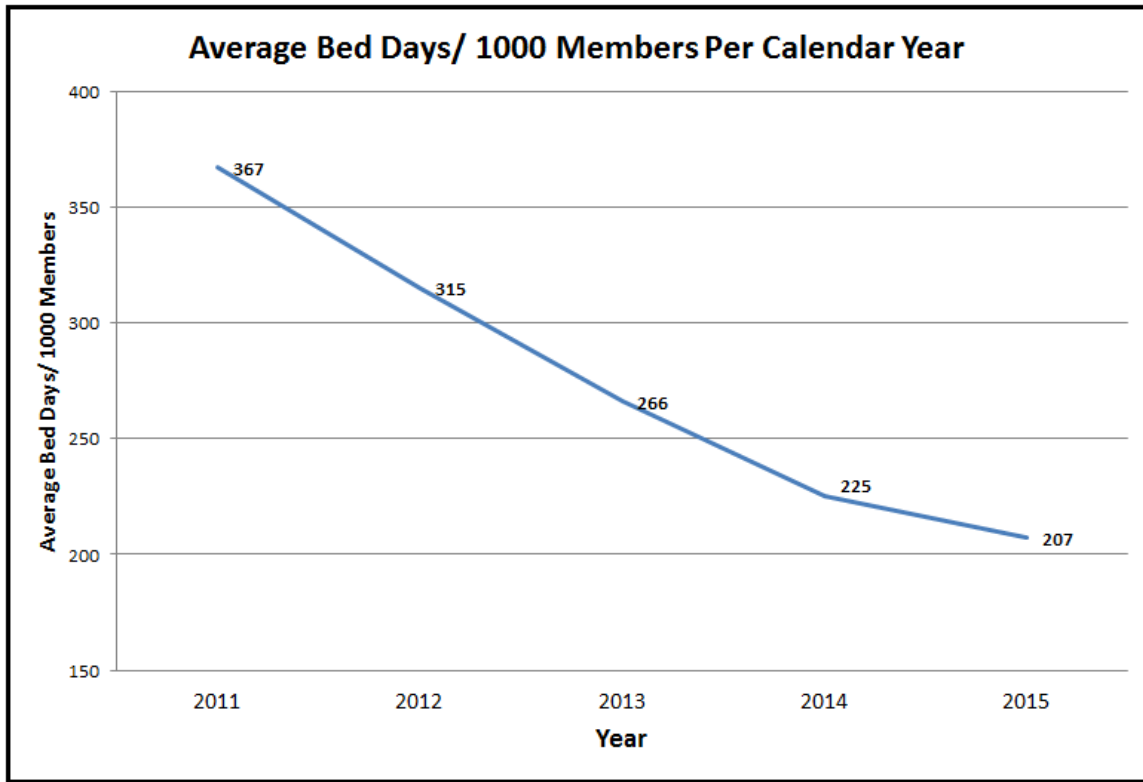
Emergency Department (ED) utilization / 1000 members for CY 2015 (449 ER visits / 1000 members) was slightly lower than CY 2014 (463 visits / 1000 members).

Benchmark: The September 17, 2015 DHCS Medi-Cal Managed Care Performance Dashboard reported 36 ER visits / 1000 member months statewide for all managed care plans for October 2013 – September 2014. GCHP ER utilization / 1000 member months for the same period was 38.

Utilization Per 1000		
	2014	2015 CY
Inpatient		
Bed days/1000	225	207
Admits/1000	51	50
Average LOS	4.4	4
ED Utilization		
ED Cases / 1000	462.88	448.84
* Data from MedInsight 1/29/16. Data excludes Duals, LTC and SNF.		

Total Volume		
	2014 Total	2015 CY
Inpatient		
Bed days	30,474	35,251
Admissions	6,926	8,453
ED Utilization		
ED Cases	62,828	76,533
* Data from MedInsight 3/22/16. Data excludes Duals, LTC and SNF.		

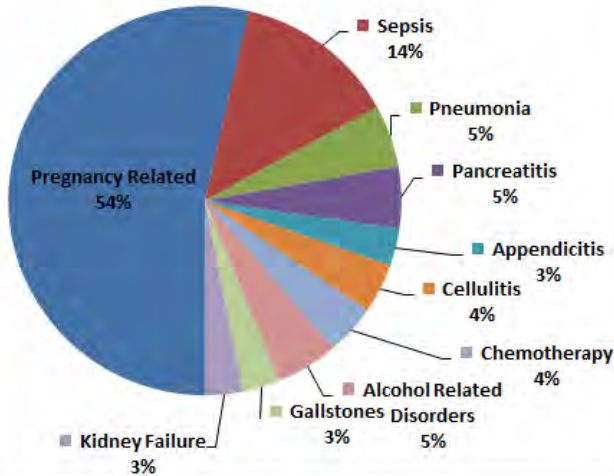
Monthly Averages		
	2014	2015 CY
Inpatient		
Bed days	2,540	2,938
Admissions	577	704
ED Utilization		
ED Cases	5,236	6,378
* Data from MedInsight 3/22/16. Data excludes Duals, LTC and SNF.		



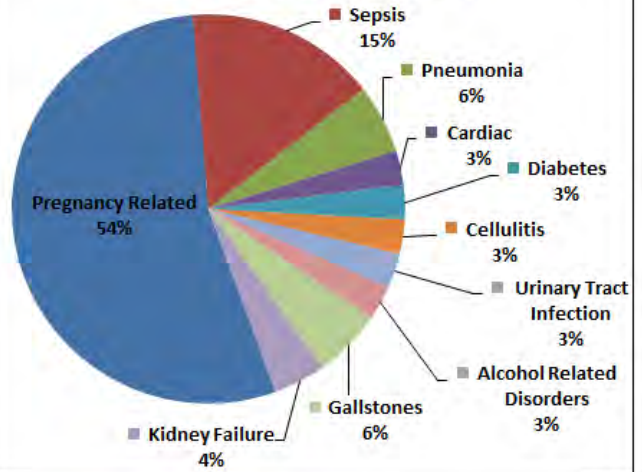
Top Admitting Diagnoses

Pregnancy related diagnoses continue to overshadow all other admitting diagnoses for CY 2015 and YTD 2015. Pneumonia, appendicitis, cellulitis, and sepsis were also top diagnoses for CY 2014 – YTD 2016. When pregnancy is excluded, sepsis, alcohol-related disorders, pneumonia, and pancreatitis are the leading diagnoses for both CY 2014 through YTD 2016.

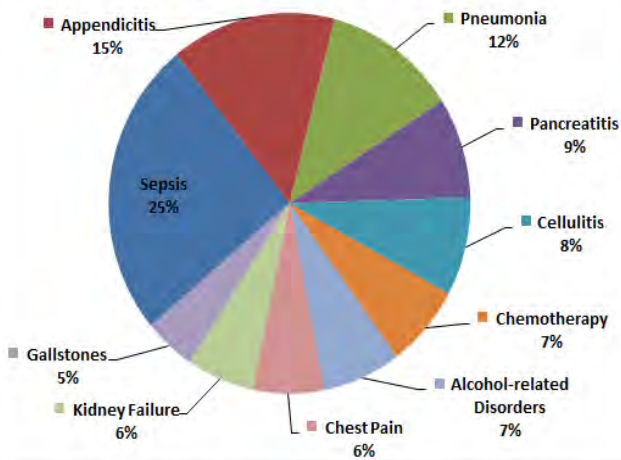
**Top 10 Diagnoses Including Pregnancy
Calendar Year 2015**



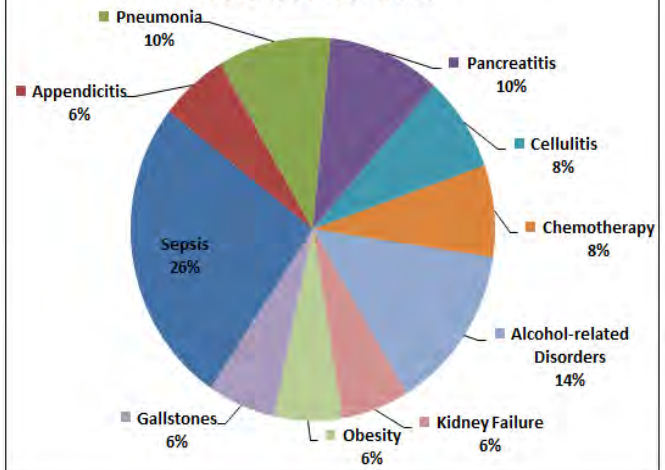
**Top 10 Diagnoses Including Pregnancy
YTD 2016 (through Feb)**



**Top 10 Diagnoses Excluding Pregnancy
Calendar Year 2014**

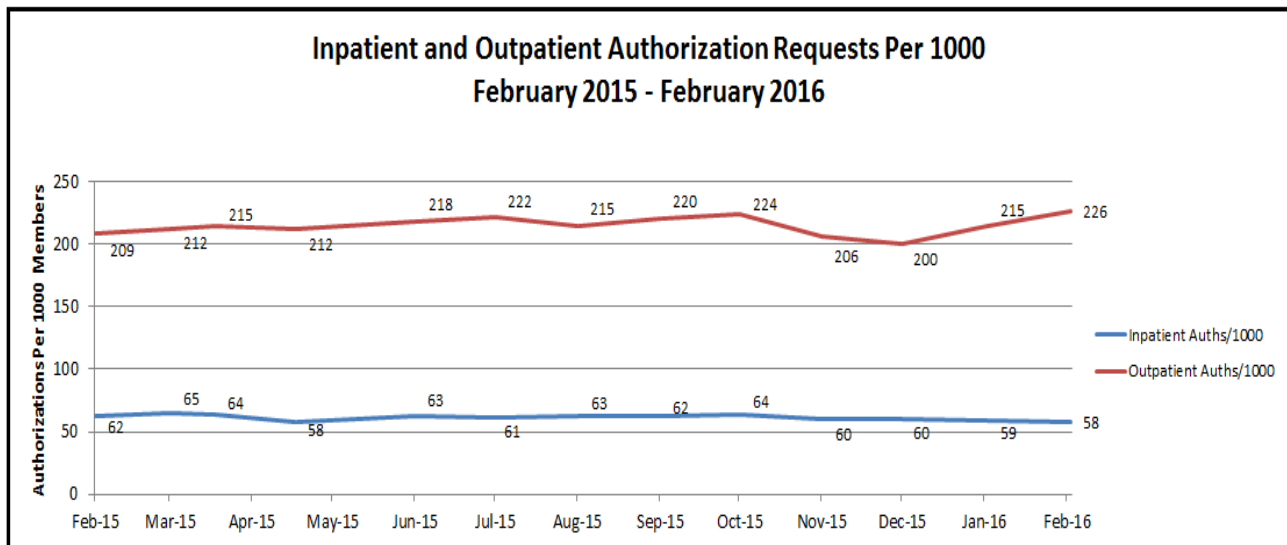
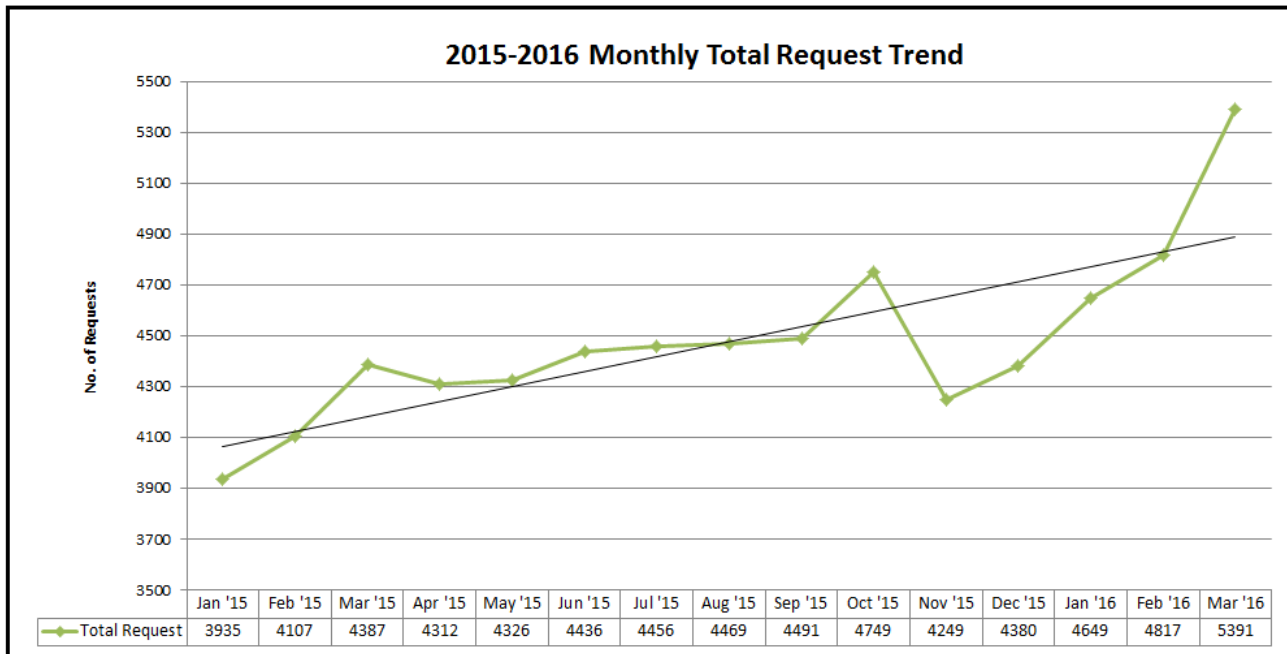


**Top 10 Diagnoses Excluding Pregnancy
Calendar Year 2015**



Authorization Requests

Requests for outpatient service continue to outnumber requests for inpatient service. Outpatient service requests for YTD CY 2015 were 214 / 1000 members compared to 220 /1000 members for YTD 2016. Requests for inpatient service for YTD 2015 were 62 / 1000 members compared to 59 / 1000 members for YTD 2016.



*Membership values generated from MedInsight as of 3/28/2016

**Authorization Requests from MedHOK "Authorizations" Query.

AGENDA ITEM NO. 21

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: April 25, 2016

Re: COO Update

OPERATIONS UPDATE

Membership Update – April 2016

Gold Coast Health Plan (GCHP) had a net increase of 894 members in April 2016. As of April 1, 2016, GCHP's new membership is 203,969 and has increased by 85,457 (72.1%) since the beginning of Medi-Cal Expansion in January 2014. The cumulative new membership since January 1, 2014 is summarized as follows:

Aid Code	# of New Members
L1 – Low Income Health Plan (LIHP)	1,596
M1 – Adult Expansion	51,769
7U – CalFresh Adults	1,910
7W – CalFresh Children	462
7S – Parents of 7Ws	549
Traditional Medi-Cal	29,171
Total New Membership 1/1/14 – 4/1/16	85,457

Adult Expansion members (aid code M1) represent 61% of GCHP's new membership since the start of Medi-Cal Expansion.

	L1	M1	7U	7W	7S
Apr 16	1,596	51,769	1,910	462	549
Mar 16	1,800	50,648	2,015	510	620
Feb 16	1,873	50,185	2,110	549	579
Jan 16	1,953	49,653	2,205	608	736

	L1	M1	7U	7W	7S
Dec 15	2,129	49,456	2,285	573	287
Nov 15	2,298	47,527	2,395	628	354
Oct 15	2,515	46,138	2,525	682	354
Sep 15	2,698	44,260	2,654	733	360
Aug 15	3,039	42,465	2,766	746	380
Jul 15	3,218	40,948	2,918	770	355
Jun 15	3,413	39,283	2,986	781	353
May 15	3,908	37,519	3,083	813	379
Apr 15	4,102	35,582	3,162	831	381
Mar 15	4,965	34,350	3,236	856	396
Feb 15	6,128	31,203	3,342	872	442
Jan 15	6,508	30,107	3,390	872	478

	L1	M1	7U	7W	7S
Dec 14	6,972	27,176	3,204	589	15
Nov 14	7,289	24,060	3,254	599	14
Oct 14	7,443	23,569	3,312	296	11
Sep 14	7,568	21,944	3,368	606	5
Aug 14	7,726	18,585	3,400	624	4
Jul 14	7,839	15,606	3,453	667	4
Jun 14	7,975	10,910	3,515	691	3
May 14	8,118	7,279	3,680	714	0
Apr 14	8,134	4,514	3,584	684	0
Mar 14	8,154	2,482	1,741	0	0
Feb 14	8,083	1,550	0	0	0
Jan 14	7,618	183	0	0	0

AB 85 Capacity Tracking – VCMC has a total of 31,001 Adult Expansion members assigned to them as of April 2016. VCMC's target enrollment is 65,765 and is currently at 47.1% of the enrollment target.

February 2016 Operations Summary

Claims Inventory – ended February with an inventory of 26,196; this equates to Days Receipt on Hand (DROH) of 2.9 days compared to a DROH maximum goal of 5 days. GCHP received approximately 8,800 claims per day in February. Monthly claim receipts from March 2015 through February 2016 are as follows:

Month	Total Claims Received	Receipts per Day
February 2016	176,656	8,833
January 2016	154,770	8,146
December 2015	170,897	7,768
November 2015	142,247	7,902
October 2015	156,109	7,095
September 2015	164,510	7,834
August 2015	152,840	7,278
July 2015	162,237	7,374
June 2015	171,806	7,809
May 2015	160,992	8,050
April 2015	146,198	6,645
March 2015	152,948	6,952

Claims Turnaround Time (TAT) – the regulatory requirement of processing 90% of clean claims within 30 calendar days was met in February with a result of 98.7%.

Claims Processing Accuracy – the financial accuracy goal of 98% or higher was met in February with a result of 99.15%; procedural accuracy exceeded the goal of 97% in February at 99.98%.

Call Volume – call volume increased slightly in February but has not exceeded 10,000 calls for the month since July 2015; the number of calls received in February was 9,568. The 12-month average is 9,594 calls per month.

Average Speed to Answer (ASA) – following two months of non-compliance which was previously discussed with the Commission, the ASA was back in compliance in February. The combined ASA result (Member, Provider and Spanish lines) for February was 4.2 seconds versus the SLA goal of 30 seconds or less.

Abandonment Rate – the Abandonment Rate also returned to expected levels in February. The combined result was 0.28% versus the SLA goal of 5% or less.

Average Call Length – the combined result for Average Call Length rose slightly to 7.60 minutes from the prior month. Xerox continues to actively work with the call center agents to improve call handling time.

Call Center Phone Quality – call quality for February was 95.0% versus a goal of 95%.

Grievance and Appeals – GCHP received 9 member grievances and 83 provider grievances (related to claim payment disputes) during February. The number of member grievances received per 1,000 members was 0.04.

Type of Member Grievances	Number of Grievances
Quality of Care	7
Billing	1
Accessibility – Transportation Issue	1
Total Member Grievances	9

There were three clinical appeals in February; one was upheld, one was overturned and one was withdrawn. There were four State Fair Hearing cases in February; one was withdrawn, one was denied and two were dismissed.

SB 75 – Full Scope Medi-Cal for All Children

Under a new law that will be implemented no sooner than May 1, 2016, children under 19 years of age are eligible for full-scope Medi-Cal benefits regardless of immigration status, as long as they meet all other eligibility requirements.

There are two populations of children impacted by this change in Medi-Cal coverage:

- New Enrollee Population – Children under the age of 19 who meet all eligibility requirements for SB 75 but are not enrolled in the Medi-Cal program at the implementation of SB 75. These children will need to apply for Medi-Cal through the current application process.
 - New enrollees can apply for coverage no sooner than May 16, 2016.
 - DHCS is estimating that approximately 55,000 undocumented children under the age of 19 are currently eligible statewide but not enrolled and believes 50% will obtain coverage over a 12-month period, once the program is operational.
- Transition Population – Children under the age of 19 who are currently enrolled in restricted scope Medi-Cal with unsatisfactory immigration status.
 - DHCS has estimated that Ventura County has ~2,900 children who currently have restricted scope Medi-Cal. These children will be covered by Fee-For-Service Medi-Cal during May and will automatically transition to GCHP on June 1, 2016.

Any delays in DHCS’s implementation will impact the start date of this program.

Member Orientation Meetings – A total of 31 members (27 English, 4 Spanish) attended Member Orientation meetings through March 2016. GCHP continues to include an informational flyer in each new member packet to make members aware of this opportunity to learn more about GCHP and their Medi-Cal benefits.

Behavioral Health Treatment (BHT) Transition – The transition of BHT services from the regional centers to managed care plans began February 1, 2016. GCHP members who have been receiving BHT services at the regional center are transitioning over a six-month period, based on month of birth, as long as they can be transitioned safely. GCHP is required to send 60-day and 30-day notices to all transitioning members and has sent out the following notices:

Transition Month	60-Day Notices Sent	30-Day Notices Sent
February 2016 (Jan & Feb birth month)	12/1/15	1/1/16
March 2016 (Mar & Apr birth month)	1/1/16	2/1/16
April 2016 (May & Jun birth month)	2/1/16	3/1/16
May 2016 (Jul & Aug birth month)	3/1/16	4/1/16
June 2016 (Sep & Oct birth month)	4/1/16	

Administrative Services Organization (ASO) Evaluation – The Commission approved the selection of Optimity Advisors (Optimity) at the February meeting to assist GCHP in determining if the current contract with our ASO vendor provides the necessary value for Medi-Cal administrative services and is the most effective approach for the ongoing support of these functions. High level project goals include:

- Review and analyze the current ASO contract against requirements and internal performance expectations
- Identify coverage gaps, concerns and issues with contract terms and regulatory requirements
- Gather market analysis, financial models and Service Level Agreements (SLAs) for contract comparison
- Provide recommendations on alternatives around outsourcing vs. insourcing opportunities
- Build a vendor-specific Assessment Scorecard based on performance of current vendor
- Analyze leading practices in similar markets to create a side-by-side comparison of vendors with a focus on service offerings, costs, SLAs and performance
- Develop a Total Cost of Ownership (TCO) summary
- Assist with RFP and contract development based on needs directly related to above analysis and subsequent recommendations

The project kick-off occurred on March 17, 2016. Optimity has conducted interviews with all internal stakeholders and is gathering industry financial and service benchmarks for analysis in preparation for completing the Vendor Assessment Report.

Noteworthy Activities – Additional projects/activities that Operations continues to lead or be involved in:

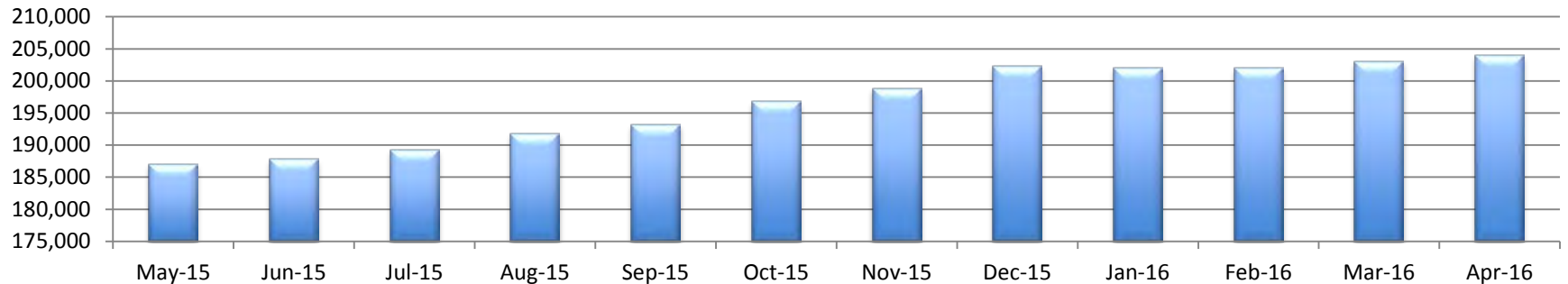
- **IVR Optimization** – GCHP is making revisions to the IVR to improve the customer experience for both members and providers through better messaging and consolidation of prompts. Implementation is targeted for mid-May.
- **Fraud Waste & Abuse (FWA)/Cost Containment RFI/RFP** – Working with Procurement to issue an RFI to identify vendor offerings which will assist GCHP in our FWA and Cost Containment activities.

GCHP Membership

Total Membership as of April 1, 2016 – 203,969

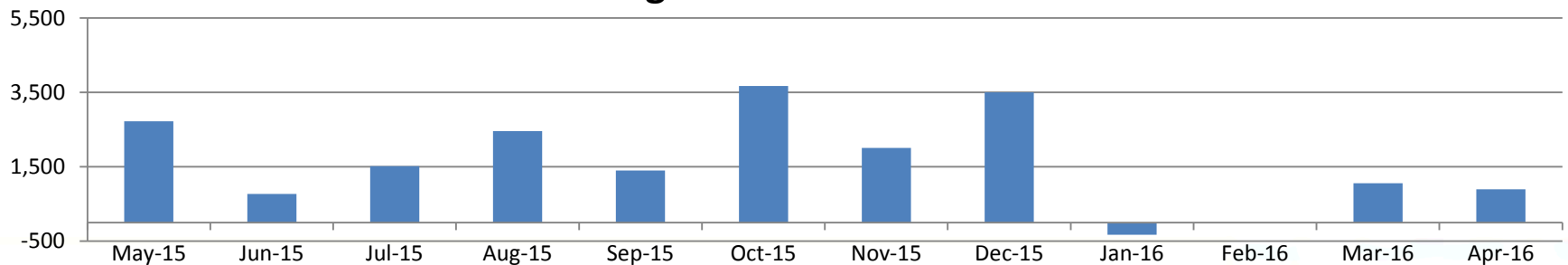
*New Members Added Since January 2014 – 85,457

GCHP Membership Trend May 2015 - April 2016

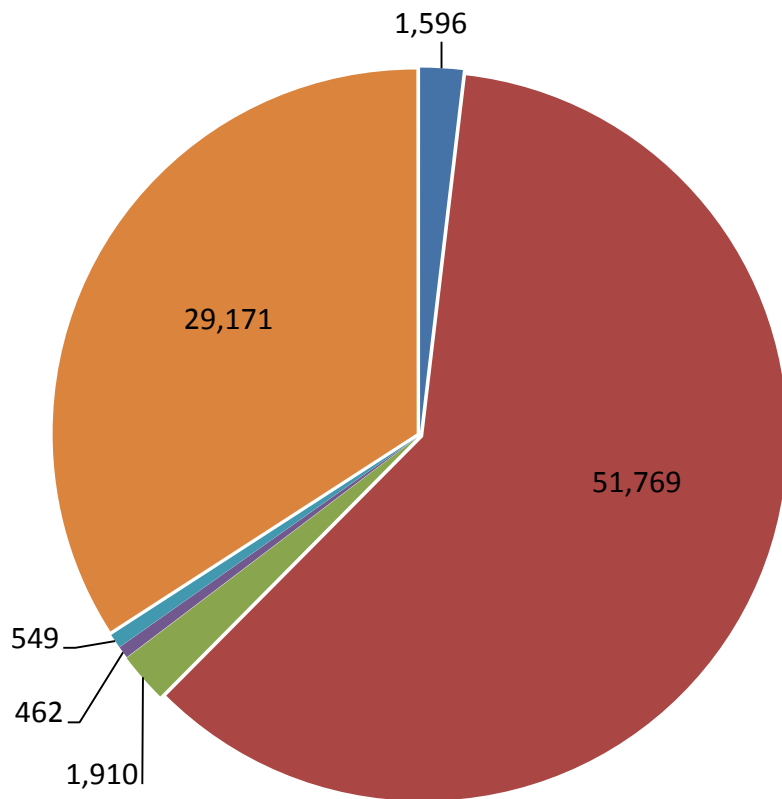


	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Active Membership	187,029	187,801	189,321	191,783	193,195	196,857	198,863	202,362	202,037	202,019	203,075	203,969

Change from Prior Month



Membership Growth



GCHP New Membership Breakdown

- L1 - Low Income Health Plan - 1.87%
- M1 - Medi-Cal Expansion - 60.58%
- 7U - CalFresh Adults - 2.24%
- 7W - CalFresh Children - 0.54%
- 7S - Parents of 7Ws - 0.64%
- Traditional Medi-Cal - 34.14%

GCHP Membership Churn Summary – FY 2015-16

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Membership from Prior Month	187,801	189,321	191,783	193,185	196,857	198,863	202,362	202,037	202,019	203,075
Prior Month Members Inactive in Current Month	5,352	4,448	5,280	3,371	4,141	3,236	6,906	6,139	6,078	5,723
Sub-total	182,449	184,873	186,503	189,814	192,716	195,627	195,456	195,898	195,941	197,352
Percentage of Inactive Members from Prior Month	2.85%	2.35%	2.75%	1.74%	2.10%	1.63%	3.41%	3.04%	3.01%	2.82%
Current Month New Members	5,068	5,241	5,383	5,503	5,015	5,454	5,794	4,215	5,059	4,742
Sub-total	187,517	190,114	191,886	195,317	197,731	201,081	201,250	200,113	201,000	202,094
Percentage of New Members Reflected in Current Membership	2.68%	2.73%	2.79%	2.80%	2.52%	2.70%	2.87%	2.09%	2.49%	2.32%
Retroactive Member Additions	1,804	1,669	1,299	1,540	1,132	1,281	787	1,906	2,075	1,875
Active Current Month Membership	189,321	191,783	193,185	196,857	198,863	202,362	202,037	202,019	203,075	203,969
Percentage of Retroactive Members Reflected in Current Membership	0.95%	0.87%	0.67%	0.78%	0.57%	0.63%	0.39%	0.94%	1.02%	0.92%

GCHP Auto Assignment by PCP/Clinic as of April 1, 2016

	Apr-16		Mar-16		Feb-16		Jan-16		Dec-15		Nov-15	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
AB85 Eligible	1,807		1,188		1,591		1,292		1,066		1,075	
VCMC	1,355	74.99%	891	75.00%	1,193	74.98%	969	75.00%	799	74.95%	806	74.98%
Balance	452	25.01%	297	25.00%	398	25.02%	323	25.00%	267	25.05%	269	25.02%
Regular Eligible	1,335		1,076		1,250		944		1,051		1,008	
Regular + AB85 Balance	1,787		1,373		1,648		1,267		1,318		1,277	
Clinicas	426	23.84%	272	19.81%	305	18.51%	251	19.81%	269	20.41%	268	20.99%
CMH	217	12.14%	165	12.02%	193	11.71%	144	11.37%	142	10.77%	176	13.78%
Independent	33	1.85%	23	1.68%	34	2.06%	23	1.82%	39	2.96%	26	2.04%
VCMC	1,111	62.17%	913	66.50%	1,116	67.72%	849	67.01%	868	65.86%	807	63.19%
Total Assigned	3,142		2,264		2,841		2,236		2,117		2,083	
Clinicas	426	13.56%	272	12.01%	305	10.74%	251	11.23%	269	12.71%	268	12.87%
CMH	217	6.91%	165	7.29%	193	6.79%	144	6.44%	142	6.71%	176	8.45%
Independent	33	1.05%	23	1.02%	34	1.20%	23	1.03%	39	1.84%	26	1.25%
VCMC	2,466	78.49%	1,804	79.68%	2,309	81.27%	1,818	81.31%	1,667	78.74%	1,613	77.44%

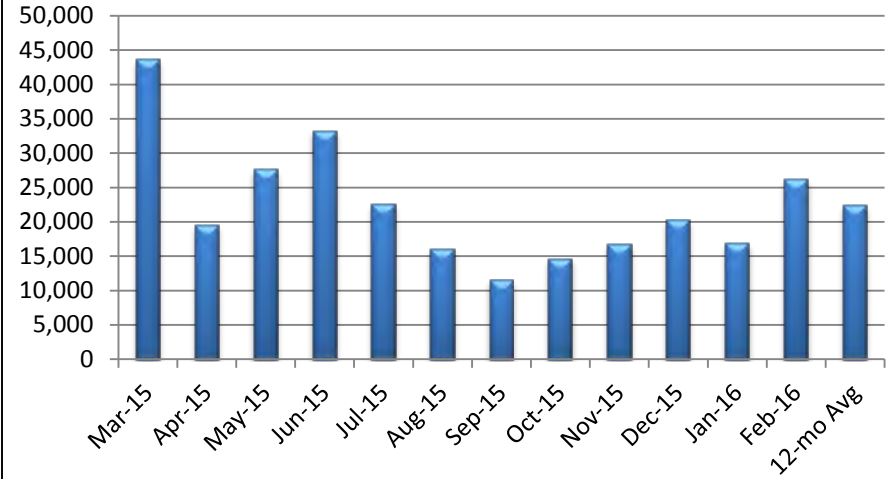
Auto Assignment Process

- 75% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85
- The remaining 25% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others
- The County's overall auto assignment results will be higher than 75% since they receive 75% of the AE members plus a 3:1 ratio of all other unassigned members
- VCMC's target enrollment is 65,765
 - VCMC has 31,001 assigned Adult Expansion members as of April 1, 2016 and is currently at 47.1% of capacity

GCHP Claims Metrics – February 2016

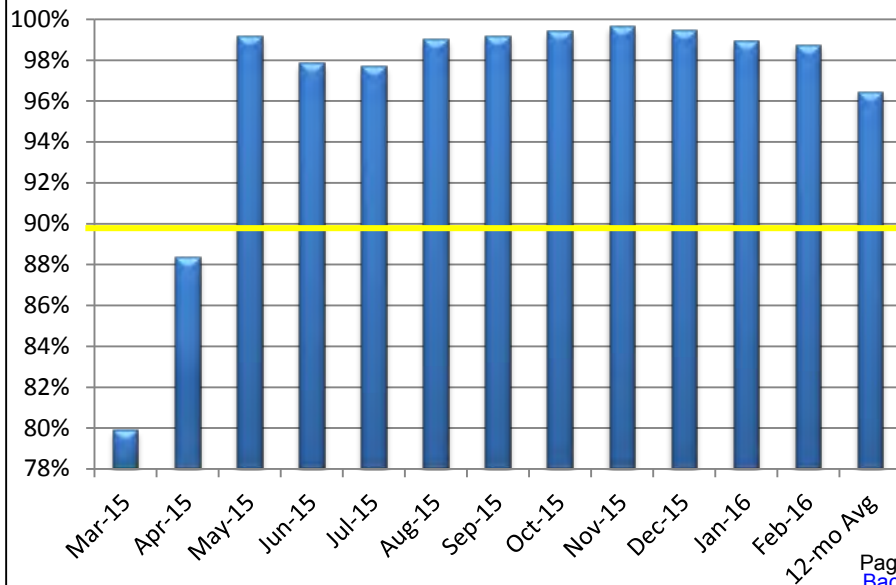
- The 30 Day Turnaround Time (TAT) remained in compliance at 98.7%
- Ending Inventory was 26,196 which equates to a Days Receipt on Hand (DROH) of 3 days vs a DROH maximum goal of 5 days
- Service Level Agreements (SLA) for Financial Accuracy (99.15%) and Procedural Accuracy (99.94%) were both met in February

Ending Inventory



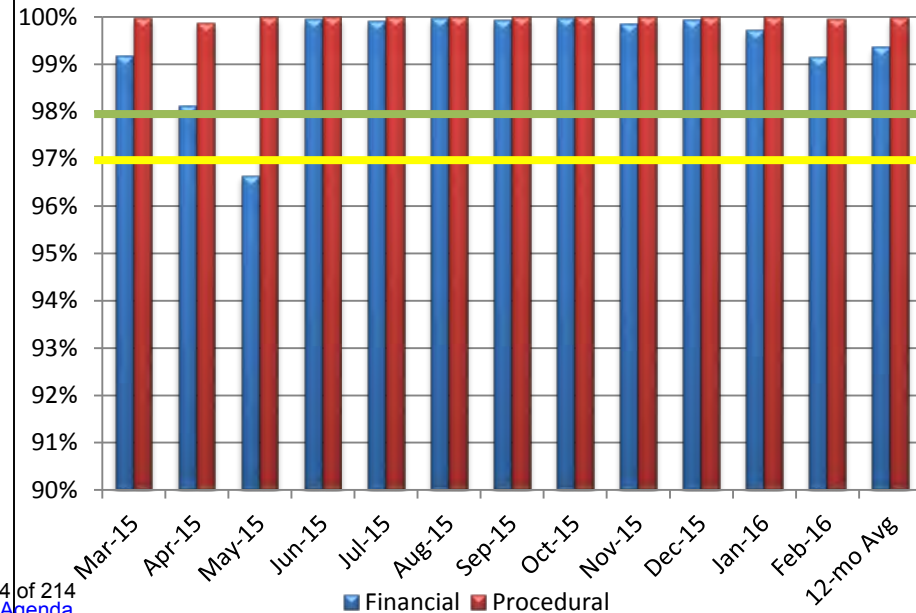
Claims Processing Turnaround Time

SLA = 90% of clean claims processed w/i 30 calendar days



Financial and Procedural Accuracy

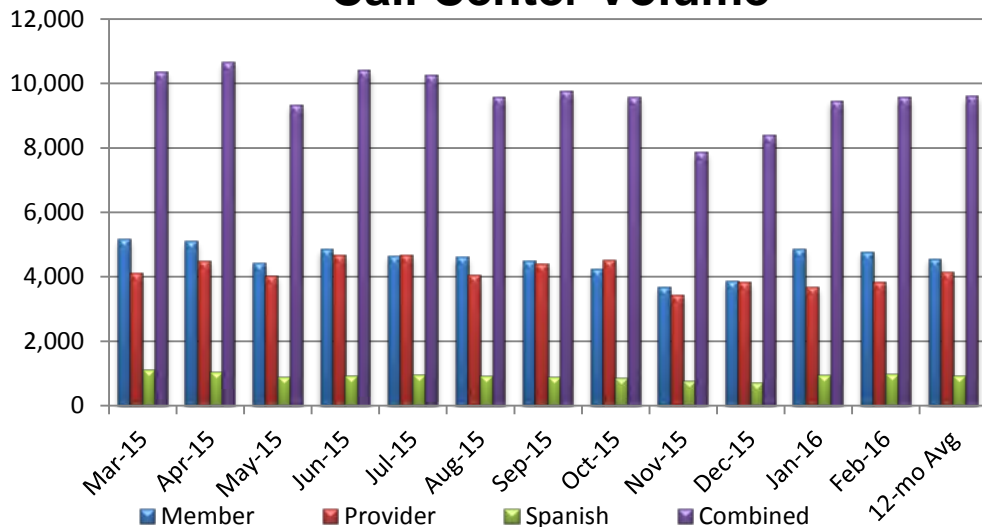
SLA = 98% Financial, 97% Procedural



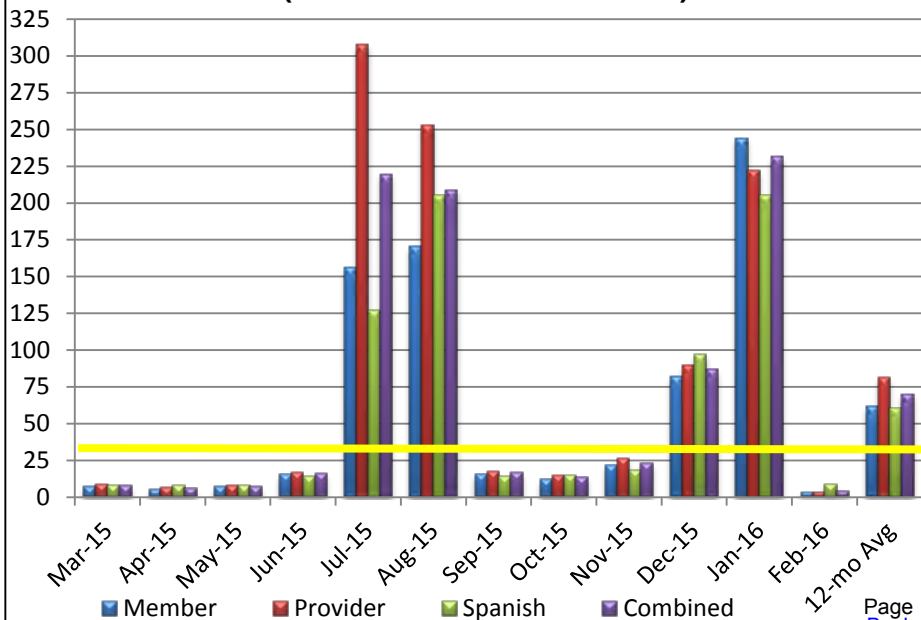
GCHP Call Center Metrics – February 2016

- Call volume increased slightly in February but still remained below 10,000; GCHP received 9,568 calls during the month
- The Service Level Agreements (SLA) for ASA (4.2 seconds vs the goal of 30 seconds or less) and Abandonment Rate (0.28% vs the goal of 5% or less) were both met for February

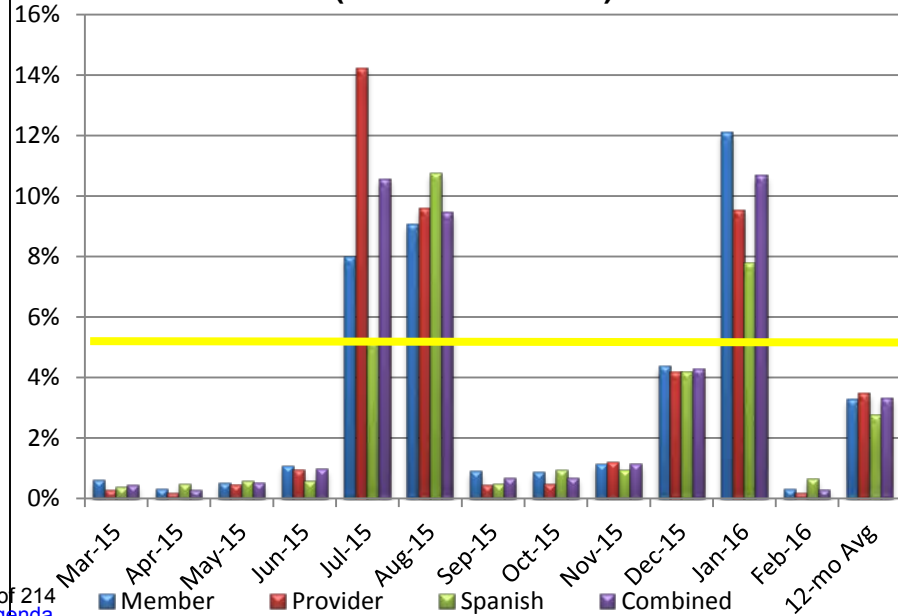
Call Center Volume



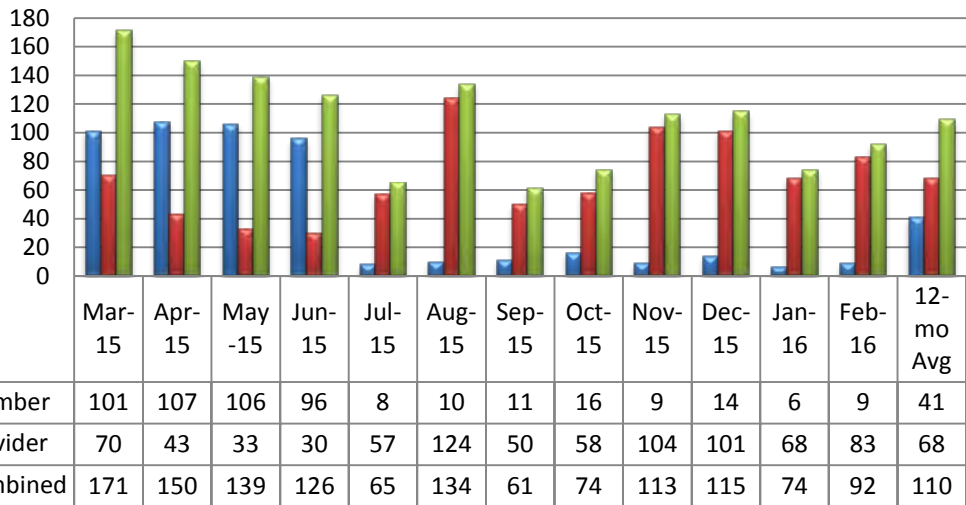
Average Speed of Answer (ASA) (SLA = 30 seconds or less)



Abandonment Rate (SLA = 5% or less)



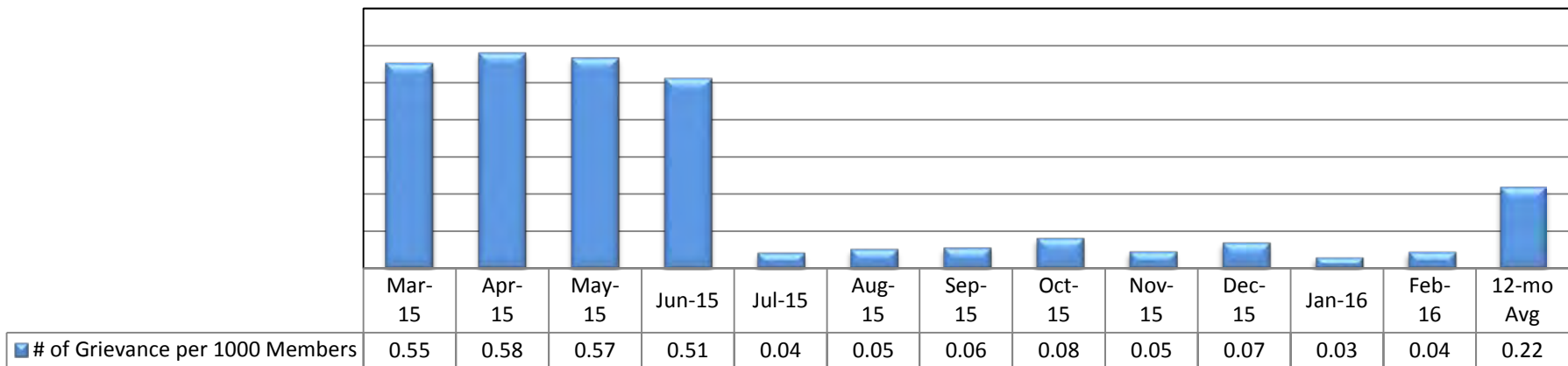
Total Grievances per Month



GCHP Grievance & Appeals Metrics – February 2016

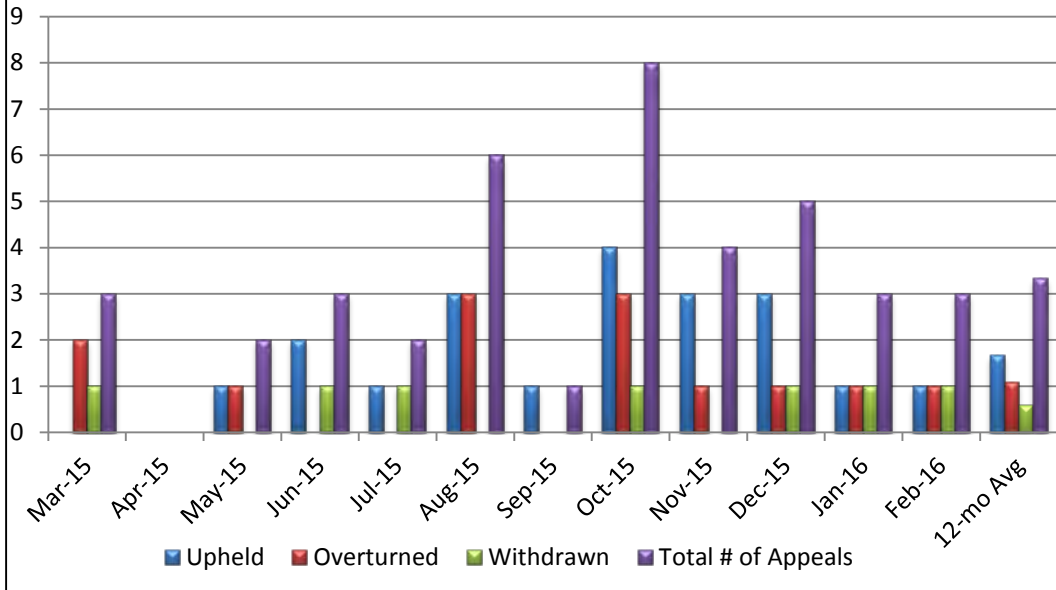
- GCHP received 9 member grievances (0.04 grievances per 1,000 members) and 83 provider grievances during February 2016
- GCHP's 12-month average for total grievances is 110 but is skewed due to the inclusion of balance billing in member grievances until July 2015

Member Grievances per 1000 Members



	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	12-mo Avg
Membership Count	182,795	184,306	187,029	187,801	189,321	193,185	196,857	196,857	198,863	202,362	202,037	202,019	193,619
Total Member Grievances Filed	101	107	106	96	8	10	11	16	9	14	6	9	41
# of Grievance per 1000 Members	0.55	0.58	0.57	0.51	0.04	0.05	0.06	0.08	0.05	0.07	0.03	0.04	0.22

Total Clinical Appeals per Month

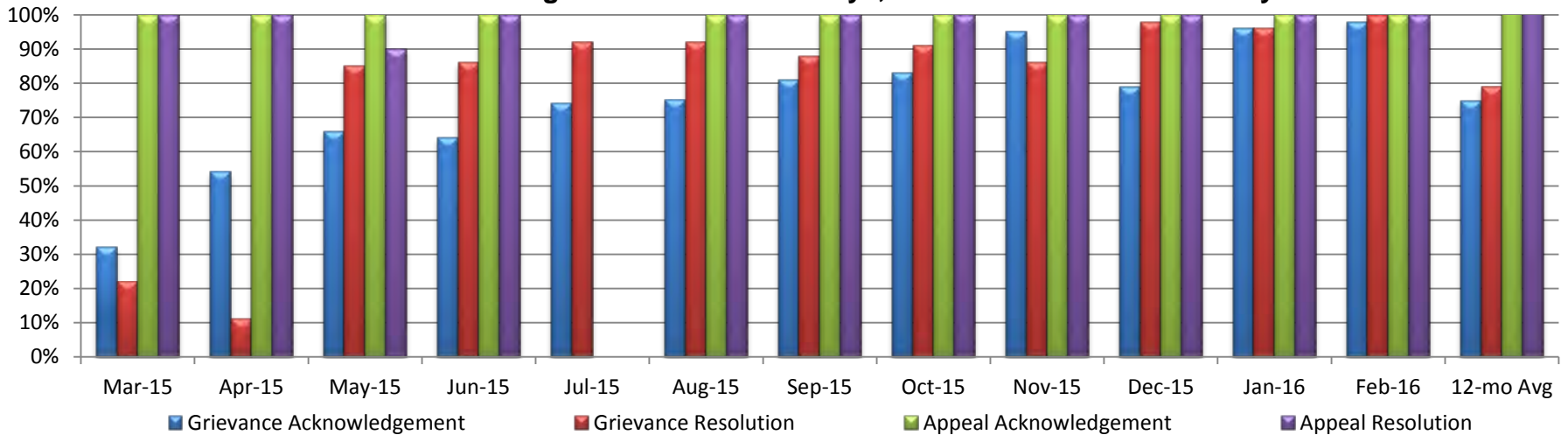


GCHP Grievance & Appeals Metrics – February 2016

- GCHP resolved 3 clinical appeals in February; 1 was upheld, 1 was overturned and 1 was withdrawn
- Grievance acknowledgement TAT is approaching compliance
- TATs for appeal acknowledgement and resolution were both in compliance during the month of February

G&A Acknowledgement and Resolution TAT

SLA = Acknowledgement - 100% w/i 5 days, Resolution - 100% w/i 30 days



Note: A "blank" denotes no grievance or appeal received during the month



AGENDA ITEM NO. 22

To: Gold Coast Health Plan Commission
From: Ruth Watson, Chief Operating Officer
Date: April 25, 2016
RE: Network Adequacy and Access Report

SUMMARY:

The purpose of the attached report is to provide the Commission with information regarding the progress Gold Coast Health Plan has made in expanding its contracted provider network and meeting members' primary care and specialty needs.

A detailed PowerPoint presentation will be provided inclusive of an Executive Summary.

ATTACHMENT:

Network Adequacy and Access Report

Gold Coast Health Plan

Network Access & Adequacy Report

April 26, 2016

Executive Summary

- Over the last 2 years Gold Coast Health Plan's Network Operations Department Has Increased the Overall Network by 8.6%, predominantly in the areas of Primary Care, Specialty Services and Long Term Care Facilities
- Gold Coast Health Plan Meets or Exceeds Member to Provider Ratios for Primary Care and Top Specialty Services
- Gold Coast Health Plan Meets or Exceeds Provider to Member Geographical Standards for Primary Care and Top Specialty Services
- Based on an Analysis of Gold Coast Health Plan Top Adult and Pediatric Specialty Services by Member Visits, There Are Adequate Specialty Provider Resources to Support Plan Membership
- Pediatric Sub-Specialty Services are Significantly Represented with 589 Contracted Providers, the majority of which are supported through Children's Hospital of Los Angeles
 - there are few pediatric sub-specialists within the Ventura County service area
 - acute and pediatric tertiary/quaternary services are not provided in Ventura County, patients must travel to Los Angeles for care
- In light of the Plan's Success in Network Expansion, Additional Opportunities Exist to Meet Member's Needs:
 - Ambulatory Care Centers
 - Hospital Based Physician
 - Urgent Care Centers
 - Specialty Area's where there is higher than average Out-of-network utilization (adult cardiology, behavioral health, neurology)
- Gold Coast Health Plan's Timely Access Results Survey Reflect Above Average Results with opportunities for improvement in urgent care appointments and Non-urgent Specialist Appointments

Provider to Member Ratio Standard and Results

PCP & Top Specialty Areas	Providers	Members	P:M Ratios	Standard
PCPs (FP/GP, IM, Peds)	220	203,074	1:923	1:2000
Specialists (Combined)	161	203,074	1:1261	1:2000

*Provider counts are unique by Physician within service area

Provider to Member Geographical Distribution Standard and Results

PCP & Top 5 Specialty	Average Distance	% of Members w/ Access	Standard for Drive Distance	Standard for % of Members w/ Access
PCP (FP/GP, IM, PED)	1.5	99.9%	10 miles	95%
Specialists;	1.8	99.5%	10 miles	95%

*Unique by Physician within service area

CY2015 Network Utilization by Top Adult and Pediatric Specialties

CY2015 Claims Data	IN NETWORK						OUT OF NETWORK					
	PROVIDER COUNT			VISITS			PROVIDER COUNT			VISITS		
	In Area	Out of Area	Grand Total	In Area	Out of Area	Grand Total	In Area	Out of Area	Grand Total	In Area	Out of Area	Grand Total
Cardiovascular Disease	17	1	18	10,738	1,202	11,940	-	-	-	-	-	-
Dermatology	4	11	15	2,893	51	2,944	18	25	43	458	83	541
Gastroenterology	20	21	41	6,745	849	7,594	18	105	123	1,870	358	2,228
General Surgery	21	56	77	2,955	190	3,145	20	166	186	636	1,022	1,658
Neurology	10	43	53	1,589	282	1,871	24	120	144	1,241	490	1,731
OB/GYN	49	36	85	33,060	754	33,814	22	117	139	509	334	843
Ophthalmology	28	38	66	13,879	1,201	15,080	15	138	153	1,175	983	2,158
Orthopaedic Surgery	16	14	30	1,828	112	1,940	44	100	144	1,192	546	1,738
Pediatric Cardiology	5	16	21	1,030	724	1,754	-	-	-	-	-	-
Pediatric Gastroenterology	2	18	20	24	197	221	-	-	-	-	-	-
Pediatric Surgery	7	16	23	474	344	818	-	-	-	-	-	-
Pediatric Hematology / Oncology	1	4	5	532	135	667	-	-	-	-	-	-
Pediatric Neurology	3	13	16	173	74	247	-	-	-	-	-	-
Pediatric Ophthalmology	-	13	13	-	128	128	-	-	-	-	-	-
Pediatric Orthopaedic Surgery	8	14	22	-	63	63	-	-	-	-	-	-

Network Analysis - Adults

PCPs & Top Specialty Services (excludes Peds.)	Providers w/in Service Area	Providers out of area	Total
PCPs (FP/GP, Internal Med)	171	9	247
Specialists (Combined)	202	385	587
Cardiology	22	52	74
Dermatology	4	24	28
Gastroenterology	35	32	67
General Surgery	24	58	82
OB/GYN	47	44	91
Ophthalmology	42	56	98
Orthopedics	15	37	52
TOTALS	562	697	1,259

**Provider counts are unique counts by Physician*

Network Analysis - Pediatrics

PCP Peds + Pediatric Sub-Specialties	*Providers w/in Service Area	*Providers Out of Area	Total
PCPs- General Pediatrics	49	150	110
Peds Sub-specialties;			
Cardiology	6	16	22
Dermatology	1	7	8
Endocrinology	2	13	15
Gastroenterology	3	14	17
Hematology / Oncology	2	11	13
Ophthalmology	2	13	15
Orthopedic Surgery	0	17	17
Neurology	3	18	21
Rheumatology	7	10	17
All Other Peds. Specialties	14	233	247
TOTALS	87	502	589

**Provider counts are unique counts by Physician*

Contracted Network Provider Trend Data CY 2014-2016 (March)

Provider Type	2014	2015	2016	% Increase
PCP	206	279	357	73.3%
Specialists	2,290	2,359	2,363	31.9%
Acute & Rehab Hospitals	15	15	15	0.0%
Community Health Centers	57	62	62	8.7%
Pharmacies	221	230	235	6.3%
SNF/Long Term Care Facilities	22	22	23	2.7%
ICF/DD	49	51	52	2.0%
LTAC	2	2	2	0.0%
TOTALS	2,862	3,020	3,109	8.6%

Timely Access Appointment Availability 2015/16

Appointment Type	Standard	Results
Urgent care appointments (no pre-auth required)	24 hrs.	80.6%
Non-urgent Primary Care appointment	10 business days	87.8%
Non-urgent Specialists appointment	15 business days	54.1%
Non-urgent Ancillary services for diagnosis or treatment	15 business days	88.9%
Waiting time in office	< 45 min.	89.1%

- Based on DMHC Standards
- Survey conducted with ICE (Industry Collaboration Effort)
- Target 90% rate
- Participation of 30 Health Plans (Commercial, Medicare, Medi-Cal)
- GCHP results exceeded most of the 30 Health Plans

AGENDA ITEM NO. 23

To: Gold Coast Health Plan Commission

From: Melissa Scrymgeour, CISO

Date: April 25, 2016

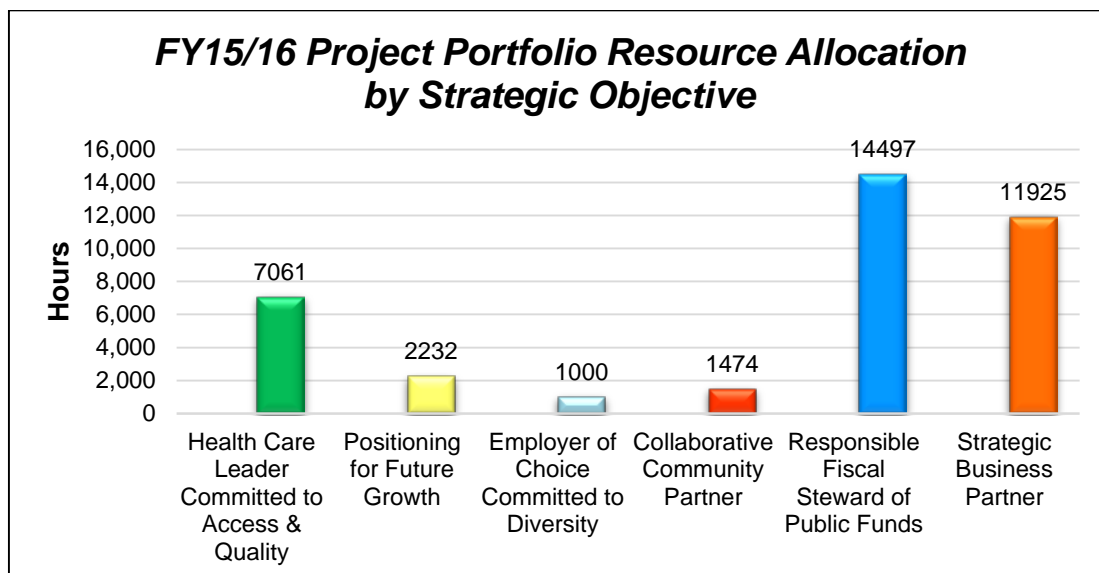
RE: CISO Update

PMO Project Activity Highlights through March 2015

- Closed the following projects:
 - Benefits Analysis Committee (BAC)
 - SQL 2014 Upgrade
- Conducted pre-planning for Inovolan (HEDIS) Implementation
- Kicked off the following projects:
 - Member Facing Mobile Apps Pilot – Text messaging campaigns
 - ASO Analysis

Upcoming PMO Portfolio Activity:

- Launch GCHP intranet “*Gold Coast Compass*”



Based on the Plan's current resource availability and the regulatory initiatives currently underway, the following projects were deferred for the remainder of FY15/16 and will be reevaluated for next fiscal year:

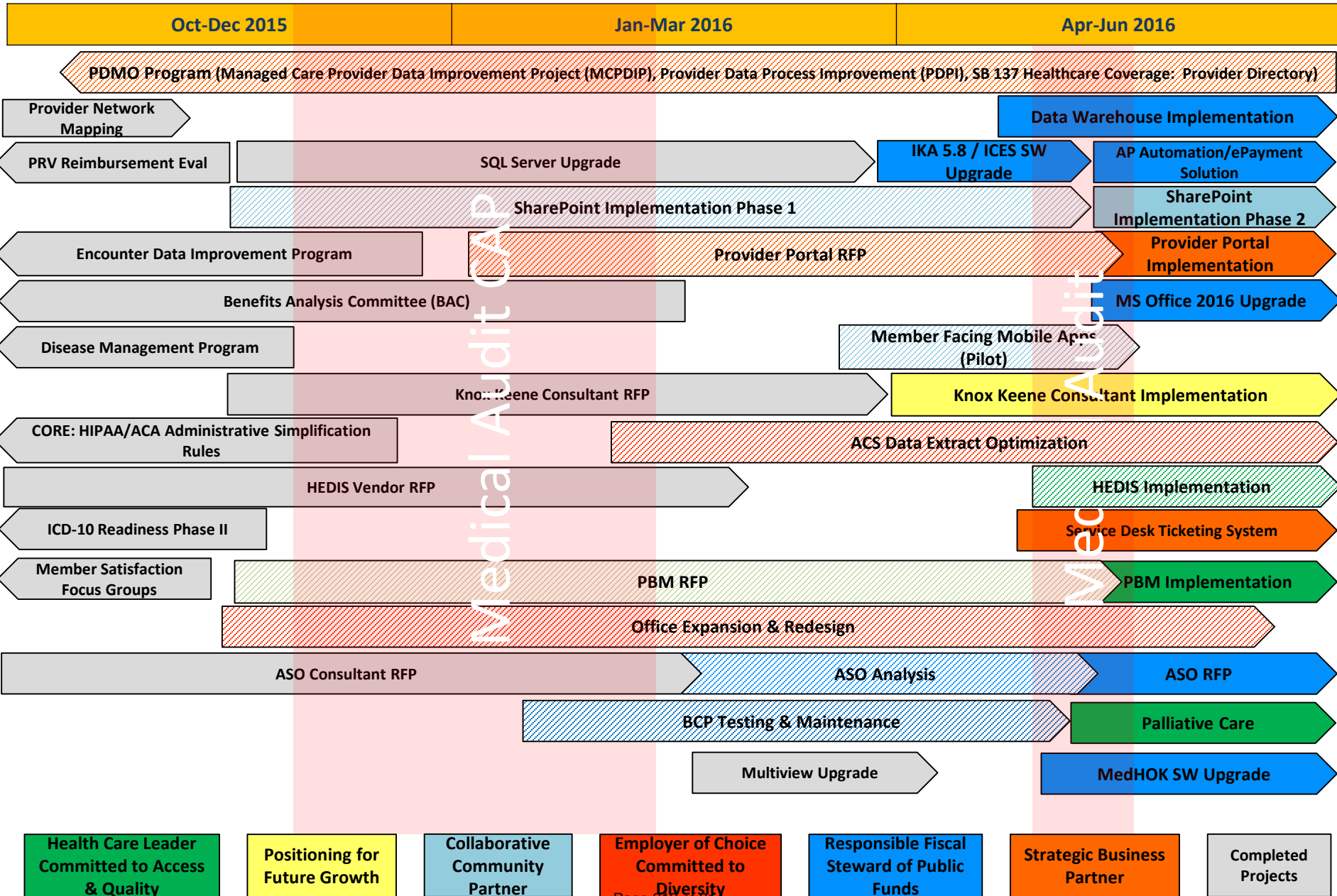
- Care Gaps
- Non-emergency Medical Transportation (NEMT)
- Provider Credentialing, Contracting and Maintenance System RFP & Implementation

FY 2015-16 GCHP Projects:

- **Healthcare Effectiveness Data and Information Set (HEDIS) Vendor Request for Proposal (RFP) and Implementation:** RFP implementation of new HEDIS solution.
 - **Involan Implementation:** Implementation of new HEDIS solution.
- **Provider Network Mapping Software:** Implement geographic mapping tool to analyze the GCHP health care network for optimized accessibility.
- **Provider Portal RFP and Implementation:** RFP and possible implementation of new provider portal.
- **Administrative Services Organization (ASO) Consultant RFP, Analysis and ASO RFP:** RFP for a consultant to help analyze and evaluate the GCHP core administrative services model, make recommendations, and support the ASO RFP process.
- **Pharmacy Benefits Manager (PBM) RFP and Implementation:** RFP and possible implementation of new PBM.
- **Provider Credentialing, Contracts and Maintenance System RFP & Implementation:** RFP and implementation of new system(s) to manage, support and optimize provider credentialing, contracting, and maintenance processes.
- **SharePoint Redesign Phases 1 and 2:** Complete SharePoint environment redesign and deployment, including a GCHP intranet.
- **Accounts Payable (AP) Automation/ePayment Solution:** Evaluate and implement a solution to automate and streamline AP processes.
- **Data Warehouse:** Implementation of an enterprise data warehouse for optimized reporting and analytics.
- **Service Desk Ticketing System:** Implement solution to track, manage, and help streamline support of desktop and application issues.
- **Member Facing Mobile Apps Pilot:** Analyze member engagement needs and pilot mobile communication apps.
- **Office Reconfiguration:** Office expansion project which will include the reconfiguration of the current location, in addition to acquiring new office space to accommodate growth and future expansion.
- **Microsoft SQL 2014 Upgrade:** Version upgrade and landscape redesign of GCHP SQL server environment.
- **Multiview Upgrade:** Software version upgrade for Multiview financial system.

- **Microsoft Office 2013 Upgrade:** Upgrade all employee machines to Microsoft Office 2013.
- **Ika/ICES Upgrade:** Software version upgrade for Xerox/ACS core administration processing and claims editing systems.
- **MedHOK Upgrade:** Software version upgrade for MedHOK medical management system.
- **MedInsight Upgrade:** Software version upgrade for MedInsight Business Intelligence (BI) tool; includes transition to hosted solution.
- **Member Satisfaction Focus Groups:** Conduct and analyze results of member focus groups to improve the Plan services.
- **Benefits Analysis Committee (BAC):** Establish framework and ongoing process to optimize benefits analysis for the Plan.
- **Business Continuity Plan (BCP) Maintenance:** Test critical pieces of the BCP and establish operational procedures for annual testing and ongoing maintenance.
- **PDMO Program:** Evaluation, remediation and implementation of Provider data submissions to DHCS and internal Plan process improvements

GCHP FY 2015-16 Project Portfolio (Reforecast)



Medical Audit CAP

Health Care Leader Committed to Access & Quality

Positioning for Future Growth

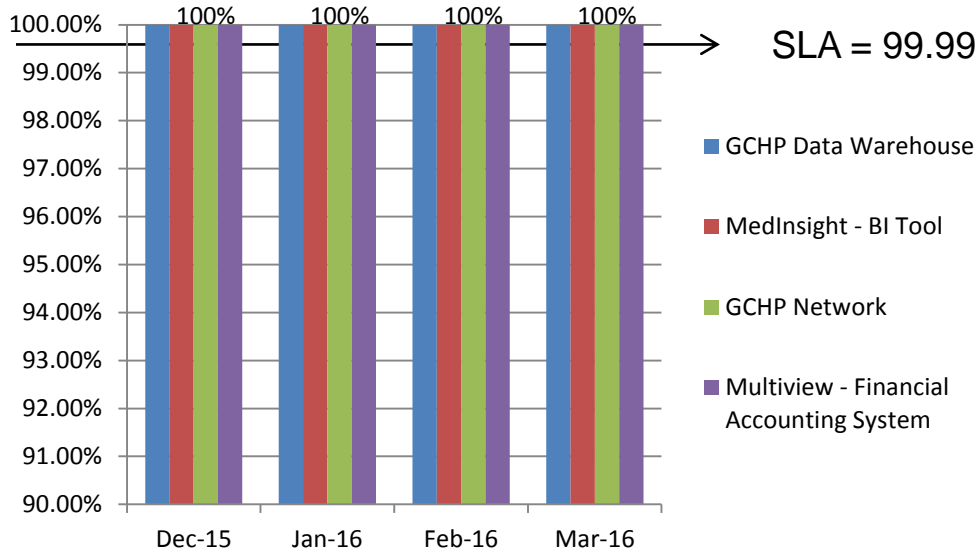
Collaborative Community Partner

Employer of Choice Committed to Diversity

Responsible Fiscal Steward of Public Funds

Strategic Business Partner

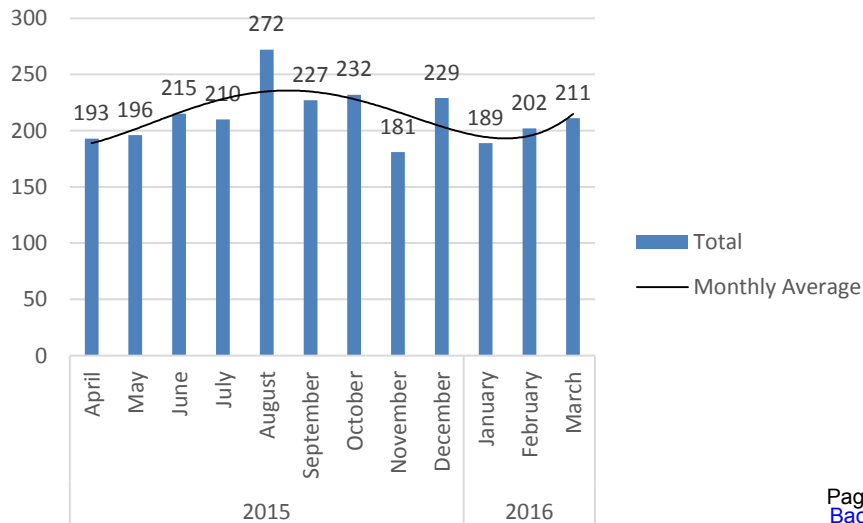
Completed Projects



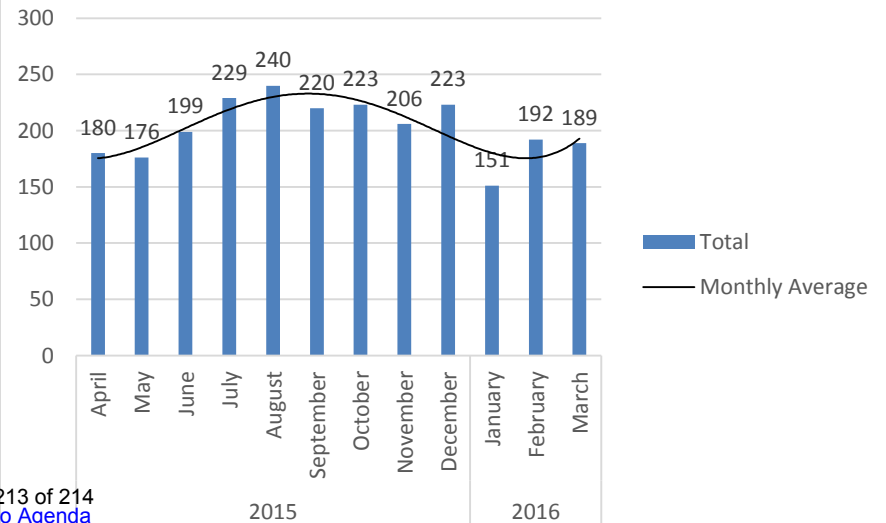
GCHP IT Metrics – March 2016

GCHP Helpdesk Service Ticket Trending

Total Tickets Opened Per Month



Total Tickets Closed Per Month





AGENDA ITEM NO. 24

To: Gold Coast Health Plan Commission
From: Scott Campbell, General Counsel
Date: April 25, 2016
RE: Chief Diversity Officer Update

VERBAL REPORT

RECOMMENDATION:

Accept the update as presented and provide direction on the recruitment of the Chief Diversity Officer.