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

Regular Meeting
Monday, June 27, 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

PLEDGE OF ALLEGIANCE

ROLL CALL

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.

PRESENTATIONS

1. Community Partner Collaborative Presentation

Staff: Vickie Lemmon, Director of Health Services

CONSENT CALENDAR

2. Approval of Ventura County MediCal Managed Care Commission Meeting Regular Minutes of April 25, 2016.

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the minutes.

711 East Daily Drive, Suite 106, Camarillo, CA 93010-6082 | Member Services: 888-301-1228 | Administration: 805-437-5500 | Fax: 805-437-5132

3. Approval of Ventura County MediCal Managed Care Commission Meeting Regular Minutes of May 23, 2016.

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the minutes.

FORMAL ACTION ITEMS

4. April 2016 Fiscal Year to Date Financials

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION: Accept and file April 2016 Fiscal Year to Date Financials.

5. State of California Department of Health Care Services Contract Amendment 22

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Approve and authorize the Chief Executive Officer to execute Amendment 22 to the Department of Health Care Services Contract, adjusting the Adult Expansion population 2014/2015 capitation rates and revising the Medical Loss Ratio calculation language.

6. Quality Improvement Committee 2016 First Quarter Report

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

RECOMMENDATION: Accept and file the Quality Improvement Committee 2016 First Quarter Report.

7. Pay-for-Performance Program to Improve Children's Access to Care (ARCH)

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

RECOMMENDATION: Approve the Pay-for-Performance Program to Improve Children's Access to Care.

REPORTS

8. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

9. Chief Operations Officer (COO) Update

RECOMMENDATION: Accept and file the report.

10. Health Services Update

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

11. PUBLIC EMPLOYEE APPOINTMENT
Chief Diversity Officer

12. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Scott Campbell, General Counsel
Unrepresented employee: Chief Diversity Officer

13. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case

14. 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

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on July 25, 2016, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Camarillo, CA 93010.

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 Tuesday, June 21, 2016, at 5:00 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: Vickie Lemmon, Director of Health Services

DATE: June 27, 2016

SUBJECT: Community Partner Collaboration Presentation: Identify Care Gaps, Create Efficiencies, and Drive Results

VERBAL PRESENTATION

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Gold Coast Health Plan Care Management Collaborates with Community Partners to:

Identify Care Gaps,

Create Efficiencies &

Drive Results

Vickie Lemmon, RN, MSN, PHN
Director Health Services

Integrity
Accountability
Collaboration
Trust
Respect

711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

Community Partners:

California Children Services (CCS)

Child Health Disability and Prevention program (CHDP)

Tri-Counties Regional Center (TCRC)

Help Me Grow (funded by First Five)

Public Health-Children's Health Promotion

Public Health Nursing Maternal Child Health

Public Health Women Infants and Children (WIC)

VC-PACT

Pact between VC Agencies to promote the continuum of care for children with special health care needs. This is a California Community Collaborative (5Cs) funded by Lucile Packard Foundation for Children's Health currently administered by VC Public Health

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Presenting today:

Vickie Lemmon, RN, MSN, PHN
Director of Health Services GCHP

Dee Johnston, RN, BA, CCM
Manager of Care Management Services GCHP

Patty Chan
PH Division Manager, Children's Medical Services Director, Ventura County Public Health

Evy Criswell
CHDP Deputy Director, PHN Manager, Children's Health Programs

Pauline Preciado
CHDP Program Coordinator, Ventura County Public Health

Linda Bays, MPH, MCHES
Staff/Services Manager, Ventura County Public Health

Seleta Dobrosky
Supervising PHN, Ventura County Public Health

Cindy Reed
Help Me Grow Ventura County, Program Coordinator

Myra Medina, DPT, PH-CC
Supervisor, Conejo Medical Therapy Unit, CCS Project Coordinator, VC-Pact

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Collaborative Projects

- Breast Pumps
- Developmental Screening
- CCS Medical Home (A Six Sigma Kaizen Project)
- Turn Around Time (TAT) for GCHP members under age 21 who may be eligible for CCS
- Referrals to GCHP Care Management from community partners and providers
- GCHP Care Management hotline
- VC PACT

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GCHP/CHDP/WIC Collaborative Project: Support Breastfeeding

GCHP received feedback from WIC and the Breastfeeding Coalition of Ventura County that our members were having difficulty obtaining quality breast pumps. A quality breast pump can often make the difference for successful breastfeeding.

This project involved:

- Soliciting feedback from lactation consultants about the efficacy of specific pumps
- Working with GCHP Provider Network Operations to ensure we had sufficient contracts with vendors who would sell and rent the higher quality pumps at Medi-Cal rates
- Identifying other barriers to successful breastfeeding and exploring ways to reduce the barriers
- Monitor claims for breast pumps with expected increase
- Explore opportunities to partner further with WIC to offer lactation support soon after mom and baby are discharged from hospital

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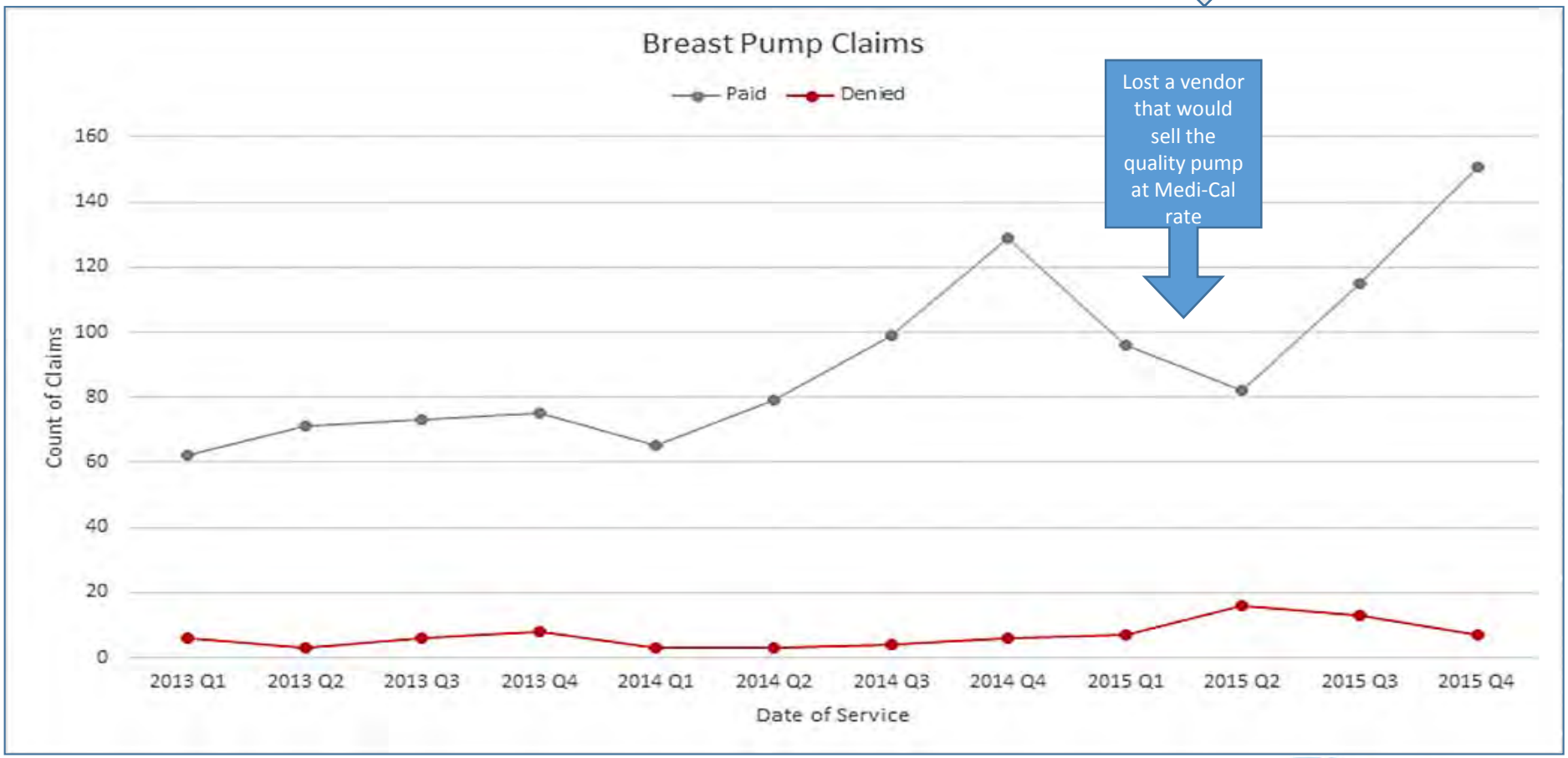
GCHP/CHDP/WIC Collaborative Project: Breast Pumps

Measure:
Claims Count

Results



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GCHP/CHDP/Help Me Grow Collaborative Project

Increase developmental screenings of children 1-3 years of age in order achieve early identification of developmental delay. This has been accepted as a formal project for GCHP by DHCS.

Measure:
By 06/30/2017, increase the utilization of standardized child developmental screening tools during well-child exams in children ≤ 24 months of age at the CMH CFH Arneill Road clinic from 0.77% to 15%.

Results: In Progress

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CCS/GCHP Kaizen for Medical Home Collaborative Project

This project focused on identifying root causes of the mismatch of CCS medical home and assigned GCHP PCP, and implementing changes to increase the match. This is important to ensure that member's clinical information is going to the correct medical home for timely and appropriate coordination of care of the member.

Measure:
% of correct matches
(baseline measure was 40%)

Results:
Planned audit in July 2016

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Decrease GCHP/CCS turnaround time (TAT)

GCHP frequently receives requests for services for members under the age of 21 that are potentially CCS eligible. (Note: providers also submit requests directly to CCS and these cases are not part of this measure). The time of receipt of request to the time GCHP renders a decision is referred to as the turnaround time (TAT). The TAT is dependent on the following process:

1. GCHP receives the request for service and forwards to CCS, advising the provider the request has been forwarded as the condition and service are possibly CCS eligible
2. CCS obtains additional information from the provider and parent of the member in order to make an eligibility decision
3. GCHP monitors the state PEDI system for the CCS decision
4. Once the decision by CCS is documented, GCHP completes the review by either approving (because the service is not CCS eligible) or denying (CCS has approved)

GCHP pulled a report in March 2016 that measures the TAT for CCS cases, and noted the TAT for the 1st QTR 2016 was 17 calendar days. GCHP and CCS met to review current processes and found opportunities to create efficiencies. The preliminary data for the second QTR (through May) demonstrates a notable decrease in TAT. We plan to track this measure going forward and to continue to look for opportunities to decrease even further.

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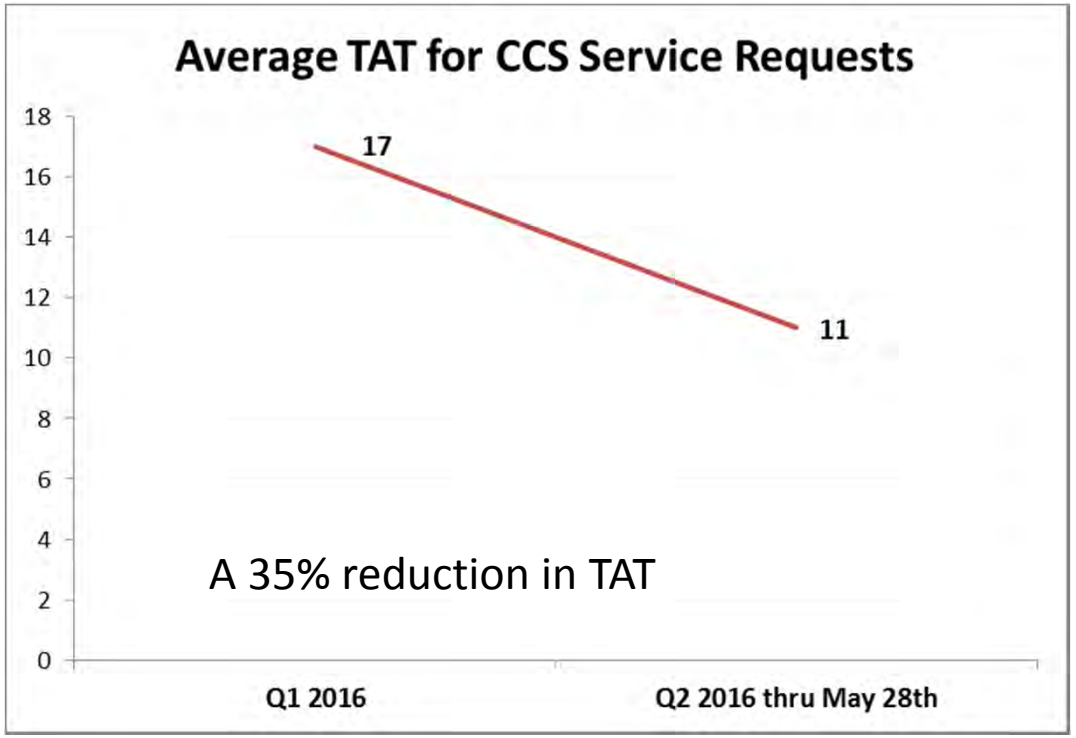
Improve GCHP/CCS turnaround time (TAT)

What we changed:

- The process is most efficient when the provider submits directly to CCS (not GCHP)
- However, if the provider does submit to GCHP first, it is more efficient for GCHP to forward the request and clinical information to CCS rather than asking the provider to re-fax
- GCHP added a face sheet when faxing the request to CCS that includes information required for CCS to process the request
- Both GCHP and CCS established a clinical liaison to communicate daily and as needed on urgent and expedited requests

Measure: TAT

Results:



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Back to Agenda

Increase referrals to GCHP Care Management (CM) Process Improvement

It is well established that care management can improve member health, decrease hospital readmissions, and reduce ER visits. In an effort to market our services we:

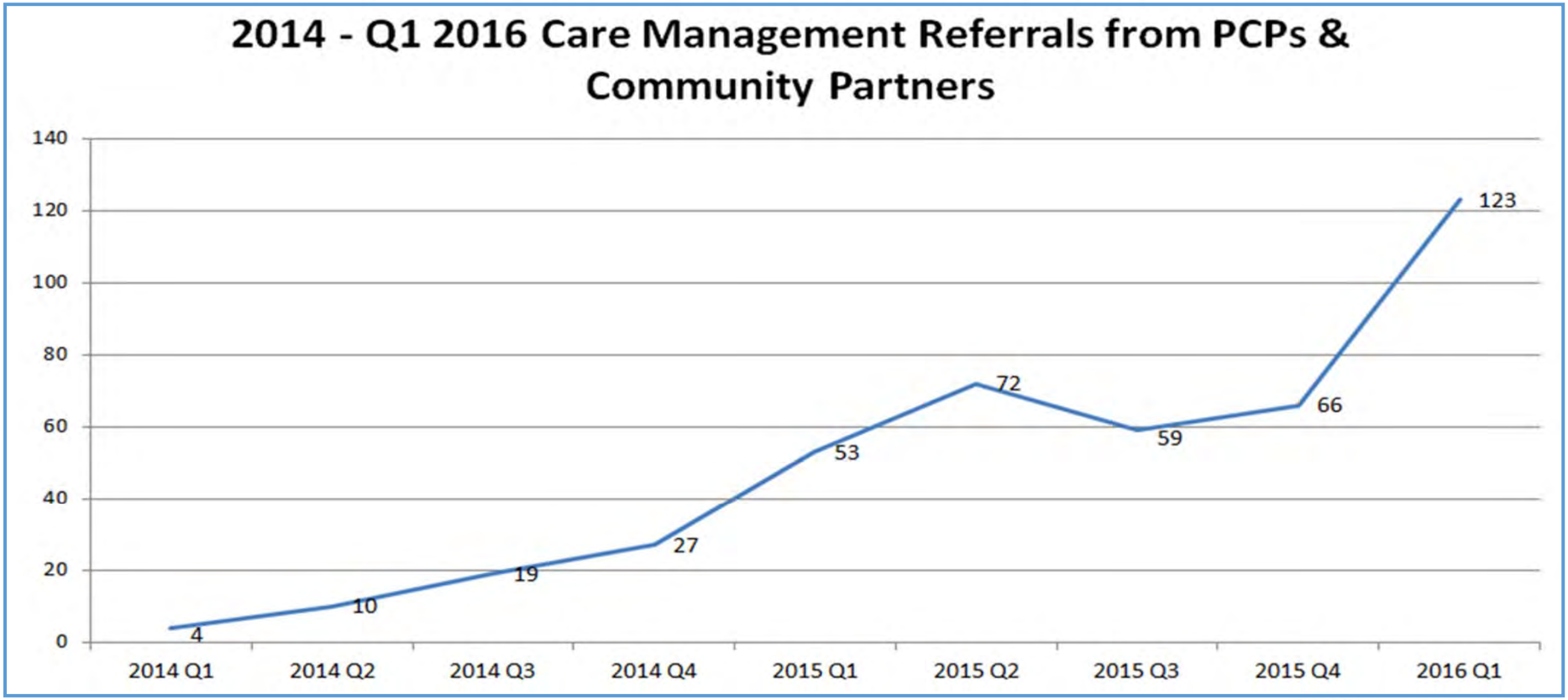
- Provided education to community partners about GCHP CM and invited community partners to present their programs to GCHP CM.
- Increased our collaborative meetings with the regional center (TCRC) to monthly in order to case conference more frequently on mutual members
- Visited providers to explain our care management program and how to do referrals
- Submitted articles with every provider newsletter highlighting CM services
- Partnered with member services and attended the Community Advisory Committee to provide information

Back to Agenda
Page 16 of 136

Increase referrals to GCHP Care Management (CM) Process Improvement

Measure:
Count of Referrals from Community Partners & Providers

Results



Back to Agenda

Public Health (PH) Nursing Collaboration

PH nurses (PHNs) in the field have face to face contact with members in our community, and offer programs that GCHP members benefit from. We established quarterly meetings with the PHNs to explain our services and to learn about the PH programs offered to our members. This shared knowledge helps GCHP case manage our members better, and provides the field nurses with knowledge of how to refer to GCHP CM. Additionally, based on feedback from the PHNs, GCHP opened a phone line dedicated to referrals coming from our community partners.

VC-PACT

A pact between Ventura County Agencies to promote the continuum of care for children with special health care needs.

- A California Community Care Coordination Collaborative (5Cs) funded by Lucile Packard Foundation for Children's Health currently administered by Ventura County Public Health (VCPH).
- This project is part of a national initiative supported by the Health Resources and Services Administration (HRSA) and the Federal Maternal Child Health Bureau (MCHB).
- The VC-Pact coalition serves as a resource to work on system gaps in services for Children with Special Health Care Needs (CSHCN) and particularly addresses family strengths
- Framework: Five Protective Factors

Back to Agenda
Page 19 of 136

VC PACT GOALS:

1. Increase awareness of programs in the county with key contacts to assist in appropriate and timely referral.
2. Improve continuum of care by providing additional care coordination through case reviews to elicit system change

Gold Coast Health Plan supports the Strengthening Families and the 5 Protective Factors.

- As the Medi-Cal managed care plan for Ventura County, we also serve many of the children with special care needs.
- Working collaboratively with the many programs and agencies in Ventura County that serve these children will result in greater efficiency and improved health outcomes as we reduce duplication of effort through enhanced communication.

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Summary

- GCHP Care Management is committed to partnering with other agencies that serve our members
- We are committed to helping our providers with the coordination of care for their patients, often involving more than one agency
- We are committed to helping our members attain needed services that ultimately help them regain their optimal level of health

Member Story # 1

This member lost her job in July of 2015. She lived in her car for a while until a local church helped her find a room with an elderly lady. She is still searching for a job and struggling to get back on her feet. Both CM and disease management are helping her. She was informed at her doctor's office that she had diabetes and stated she left terrified and not understanding what it meant or what to do.

"Then Blanca Robles at Gold Coast Health Plan told me about you (the CM and DM nurses). That was one of the best things that has ever happened for me!

When we spoke, you took the time to fully explain what being Diabetic meant. You explained the medications and helped me understand the importance of taking them at the same time and 12 hours between. You told me about nutrition, meal planning and portion control. I am no longer scared because you gave me the tools to handle my Diabetes.

You are so patient, caring and kind. You took the time to answer all of my questions and never made me feel rushed. You make me feel valued as a person and I have not felt valued in a very long time.

I am so grateful that you are in my life, so thankful that you are my Diabetes Coach!"

Back to Agenda
Page 22 of 136

Member Story # 2

Member is a 62yo woman who is a retired attorney and was assistant district attorney in Hawaii, and retired Law professor.

The member has a history of squamous cell esophageal cancer. She is receiving palliative chemotherapy for her cancer. She has recently lost all of her vision in one eye and mostly sees black floaters in the other. She struggles with bipolar disorder, hypothyroidism, anxiety and depression, panic attacks, irregular heartbeats, and DJD. She currently has sepsis and is on IV home medication via a PICC line. Member states she needs assistance to clean and maintain her home and is unable to stand.

The RNCM has successfully assisted the member in finding a clinical trial. The SWCM has reached out to the Action Foundation a volunteer agency who assists in locating private individuals willing to donate their time and services to others in need. A group of women in the community who own house cleaning services have gotten together and collectively donate their services to individuals with a cancer diagnosis. The cleaning crew is scheduled to go to the member's home for a full day and do a deep cleaning of the entire house. When the member was called she began to cry and said it was the best day of her life. I never expected this, it is a wonderful gift. She was overjoyed at the thought of having a clean home something that she has not been able to do for herself in many months.

Member Comments

- “I have never experienced such an amazing program from a health Insurance company such as GCHP. Judy has been inspirational and instrumental in the recovery of my health. If it was not for Judy, I don't believe I would have made it this far. I am forever grateful! I understand Judy has a number of cases in CM. However, she finds the time to give me a call back each and every time I need her. I truly feel a ray of strength from Judy who helped me rise above my depression. Judy has made my life that much easier”.
- “ I would like to thank you guys and congratulate you for the good experience. I don't know what I would have done without Monika's help. I felt frustrated with all the appointments and she helped me. God will repay you in every way for all that you do.”
- “Lifesaving and life changing this service has made a change in my life. Lee Ann opened the sunshine.”
- “Kathy was on top of everything, she is awesome, I appreciate her so much. If it wasn't for Kathy to push the referral to be seen for the vomiting I would have still been sick. I love the fact I can call her in the future and would like to meet her.”
- Nothing, everything is perfect. Since birth it has been difficult with Leonard having special needs and finding a PCP that will help but Edgar has been a great help, most help she’s had in years. Made her feel like she had someone on her side for once. Edgar made her feel supported.

Medical Home

What is a medical home?

- A medical home is a partnership between the patient and family, in cooperation with specialists and support from the community.

*** Your primary care provider (PCP) can also be your medical home.**

A PCP is your personal doctor who will provide and arrange all of your medical health care needs. The PCP takes responsibility for the ongoing care of their patients.

Advantages of a Medical Home:

- Understands the regular and special health needs of a child
- Coordinates care
- Answers questions
- Partners with families and knows the family well
- Connects families to community resources
- Communicates with other community resources and pediatric specialty services
- Provides patient and family education
- Oversees and manages a child's overall health

Please contact your PCP with any health related questions.

VENTURA COUNTY PUBLIC HEALTH
A Department of Ventura County Health Care Agency

Gold Coast Health Plan™
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AGENDA ITEM NO. 2

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

April 25, 2016 Regular Meeting Minutes

CALL TO ORDER

Commissioner Anthony Alatorre called the meeting to order at 3:03 p.m. in the Lower Plaza Assembly Room at the County of Ventura Government Center – Hall of Administration, 800 South Victoria Avenue, Ventura, California.

PLEDGE OF ALLEGIANCE

Commissioner Alatorre led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., Dee Pupa, and Jennifer Swenson (arrived 3:24 p.m.)

PUBLIC COMMENT

Amy Cansler, Script Care Vice President, requested the Commission to either move forward with the top two finalists' presentations or engage in a proactive longer extension of the current contract for Agenda Item No. 8 Pharmacy Benefits Manager Contract Extension.

Frank Messina, Script Care General Counsel, proposed two options regarding Agenda Item No. 8 Pharmacy Benefits Manager Contract Extension: an additional three one month extension option or a 36 month extension option.

Earl Hurst, Magellan Rx Management Senior Vice President and General Manager, spoke on behalf of the company's capability in regards to Agenda Item No. 8, Pharmacy Benefits Manager Contract Extension.

Shareh Ghani, Magellan Rx Management Chief Medical Officer, spoke on behalf of the company's capability in regards to Agenda Item No. 8, Pharmacy Benefits Manager Contract Extension.

Susan Whitewood, COPD Access to Community Health Project Director, spoke on behalf of Dr. Higgins, Dr. Underwood, Dr. Landon, and Dr. Bajwa in support of Agenda Item No. 6 Benefit Enhancement – Pulmonary Rehabilitation.

Commissioner Swenson arrived at 3:24 p.m.

Rob Coppola, Magellan Rx Management Vice President of Medicaid Sales, spoke on behalf of the company's capability in regards to Agenda Item No. 8, Pharmacy Benefits Manager Contract Extension.

OATH OF OFFICE

The Clerk of the Board administered the oath of office to Commissioner Swenson.

CONSENT ITEMS

1. February 22, 2016 Regular Meeting and March 9, 2016 Special Meeting Minutes

RECOMMENDATION

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

Commissioner Lee moved to approve the minutes as corrected. Commissioner Fisher seconded. The vote was as follows:

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Laba, Lee, Pupa, and Swenson.

NOES: None.

ABSTAIN: Commissioners Foy and Pawar.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

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

RECOMMENDATION

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

Dale Villani, Chief Executive Officer, gave the staff report.

Commissioner Foy moved to approve the recommendation. Commissioner Fisher seconded. The vote was as follows:

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

FORMAL ACTION ITEMS

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

RECOMMENDATION

Adopt Resolution No. 2016-01 as presented.

Scott Campbell, General Counsel, gave the staff report.

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

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

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

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

Mr. Campbell gave the staff report and noted the election of individual members to these positions does not create any additional conflict of interest that would otherwise exist.
Commissioner Lee and Commissioner Fisher were nominated for Chairperson. Commissioner Fisher declined.

The voice vote carried unanimously to elect Commissioner Lee as Chairperson.

Commissioner Pupa and Commissioner Alatorre were nominated for Vice Chairperson.

A roll call vote was as follows:

Commissioner Pupa for Vice Chairperson: Commissioners Atin, Foy, Lee, Laba, and Swenson.

Commissioner Alatorre for Vice Chairperson: Commissioners Alatorre, Fisher, and Pawar.

Abstaining: Commissioners Dial and Pupa.

The roll call vote carried 5-3-2, Commissioner Pupa was elected Vice Chairperson.

The Executive/Finance Committee appointments were made per the Commission's By-Laws: Commissioners Lee, Pupa, and Swenson.

Commissioner Alatorre was nominated and by unanimous consent, appointed to the Executive/Finance Committee.

Commissioner Fisher was nominated and by unanimous consent, appointed to the Executive/Finance Committee.

Commissioner Lee assumed the Chairperson's position for the remainder of the meeting.

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

RECOMMENDATION

Appoint a new committee member to the HRCD Committee.

Mr. Campbell gave the staff report.

Commissioner Lee was nominated and by unanimous consent, appointed to the HRCD Committee.

6. Benefit Enhancement – Pulmonary Rehabilitation

RECOMMENDATION

Approve pulmonary rehabilitation as presented.

Nancy Wharfield, M.D., Associate Chief Medical Officer, gave the staff report.

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

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

7. Benefit Enhancement - Podiatry

RECOMMENDATION

Approve podiatry rehabilitation as presented.

Dr. Wharfield gave the staff report.

A discussion followed between the Commissioners and staff clarifying the fiscal impact is an additional $72,000.

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

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

8. Pharmacy Benefits Manager (PBM) Contract Extension

RECOMMENDATION

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

At 3:58 p.m. Mr. Villani recused himself as he had previously owned stock in Magellan.

Anne Freese, Director of Pharmacy, gave the staff report.

A discussion followed between Commissioners and staff regarding: the contract extension giving the Commission additional time to complete the Request for Proposals, which will produce a new contract with new terms by next spring; the transition time if switching PBMs would be six months; and the status of the current RFP would be discussed in closed session.

The Commission unanimously agreed to hold the item until after closed session discussion.

At 4:05 p.m. Mr. Villani returned to the Commission meeting.

9. Provider Advisory Committee Membership

RECOMMENDATION

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

Ruth Watson, Chief Operations Officer, gave the staff report. She stated that in addition to the three individuals listed in the staff report, one more individual needs to be appointed as Sue Anderson is stepping down from the committee.

Commissioner Foy moved to approve the appointment of Sim Mandelbum, Joan Buck-Plassmeyer, S. Marsha Smith, and Richard Montminy to the Provider Advisory Committee membership. Commissioner Atin seconded.

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

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

RECOMMENDATION

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

C. Albert Reeves, M.D., Chief Medical Officer, stated as yearly requirements, an evaluation of the previous years' Quality Improvement Work Plan and the current 2016 Work Plan, are to be provided to the Commission.

Kim Osada, Quality Improvement Director, gave the staff report.

A discussion followed between the Commissioners and staff addressing concerns regarding the inability to evaluate programs when data from HEDIS is unavailable. Suggestions made from the Commission included changing the verbiage to "preliminary data" and asked staff to consider how to provide the report so it more accurately reflects staff's efforts. Staff stated the finalized HEDIS results will be presented at the August Commission meeting. Clarification was made that per Department of Health Care Services' requirements, the Commission needs to approve the Work Plan by a certain date and going forward, the HEDIS rates can be provided on a quarterly basis.

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

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

11. Quality Improvement Program Description and Work Plan for 2016

RECOMMENDATION

Approve the 2016 Quality Improvement Program Description and Work Plan.

Ms. Osada gave the staff report.

A discussion followed between the Commissioners and staff concerning the definition of “minority” as being both ethnicity or underserved and gave staff direction to change “minority” to “disparity”.

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

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

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

RECOMMENDATION

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

Dr. Reeves gave the staff report.

Commissioner Foy moved to approve the recommendation. Commissioner Pawar seconded.

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

13. February 2016 Fiscal Year to Date Financials

RECOMMENDATION

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

Patricia Mowlavi, Chief Financial Officer, gave the staff report.

Staff noted the February report does not reflect the loan repayment made to the County of Ventura.

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

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

14. National Health Foundation: Ventura Recuperative Care Program (ARCH)

RECOMMENDATION

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

Ralph Oyaga, Executive Director for Government, Regulatory and External Relations, gave the staff report.

Staff clarified the amount is a one-time startup cost.

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

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

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

RECOMMENDATION

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

Mr. Oyaga gave the staff report.

Staff clarified the amount is a one-time sponsorship.

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

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

REPORTS

16. Chief Executive Officer (CEO) Update

Mr. Villani announced Tracy Oehler as the new Clerk of the Board, thanked Maddie Guiterrez-Roberts for acting as Interim Clerk of the Board, welcomed new Commissioner Swenson, and congratulated Commissioner Fisher on his upcoming retirement.

Update highlights included: the repayment of the line of credit to the County of Ventura, which demonstrates to the Department of Health Care Services (DHCS) Gold Coast Health Plan's increasing financial stability. However, there is still a financial CAP in effect.

DHCS is presently conducting the annual medical audit which focuses on six areas. The exit conference is expected to be conducted in June.

Ms. Watson will be addressing SB 75 - Full Scope Medi-Cal for All Children. The State is estimating 2,917 children for Ventura County, but speculation is the actual number of children will be higher.

17. Employee Satisfaction Results

Mr. Villani introduced Vicki Hewlett, Interim Chief Diversity Officer, and Niosha Sharoori. He stated the survey was an important foundational element to the Plan's mission and values and included questions approved by the Human Resources/Cultural Diversity Committee about diversity. The employee response rate was 75% and over 80% of employees would recommend working at GCHP.

Ms. Hewlett and Ms. Sharoori gave a PowerPoint presentation on the employee satisfaction survey and reviewed the results. Overall results were positive and illustrated confidence that GCHP supports diversity. A handout of the slides was distributed and is on file. Areas of opportunity include compensation, promotion and performance review process, training/coaching, and openness.

Commissioners requested GCHP to continue its emphasis on diversity concerns, of being sensitive to the smaller groups in the workplace, and acknowledged the high participation level and positive survey results.

18. Chief Medical Officer (CMO) Update

None.

19. Health Education Update

Lupe Gonzalez, MPH, PhD, Director of Health Education, Outreach, Cultural and Linguistic Services, gave a summary of activities for the months of February and March 2016. Two upcoming events are the 5th Annual Community Resource Fair on May 14 at Plaza Park in Oxnard and a "Diabetes Day" community resource fair on June 11 at Pacific High School in Oxnard in a partnership with the American Diabetes Association. Seven sponsorships were awarded and one letter of support was approved.

20. Health Services Update

Dr. Wharfield stated there was a 44% decrease in the average bed days per 1,000 members per calendar year due to tighter utilization processes. Pregnancy related diagnoses continue to surpass all other admitting diagnoses for calendar year 2015 and current year to date.

21. Chief Operations Officer (COO) Update

Ms. Watson highlighted SB 75 – Full Scope Medi-Cal for All Children, which will impact two populations of children. The first group is the transition population and is comprised of the 2,900 children previously discussed by CEO Villani. The second group is the new enrollee population, which are children under the age of 19 who meet all eligibility requirements for SB 75, but are not currently enrolled in the Medi-Cal program. These children will need to apply for Medi-Cal through the current application process, but cannot apply for coverage until May 16, 2016. DHCS is estimating that approximately 55,000 undocumented children under the age of 19 are currently eligible statewide and are not enrolled, and that 50% will obtain coverage over a 12-month period once the program is operational. It is believed this figure is an underestimation due to the State's agricultural industry. One of the challenges for this group is the issue of being on restricted Medi-Cal. When the Medi-Cal Expansion population was brought on, there was a year moratorium on redetermination. The new group will have to do a redetermination within a month of their original determination date. There is concern this could cause a fall from the roles thereby creating difficulties in managing care. GCHP is working in partnership with the County to reach out to the Plan's members to help navigate the program and assist in redetermination.

The Commission expressed concern about the increase in members and whether there were sufficient providers to fulfill the members' needs. It was stated from a ratio perspective, the Plan has sufficient providers to serve this membership. The issue is the providers' willingness to see the members and limitations placed on the number of children seen. To help mitigate this issue, GCHP is working on pay for performance programs to incentivize providers, possibly sponsoring pediatricians to come to Ventura County, and rate increases across the board.

It was noted the Commission had approved at the February meeting the selection of Optimity Advisors to assist in the review of the existing administrative services contract with Xerox. The project kick-off date occurred March 17. Optimity Advisors has conducted interviews with all internal stakeholders and are in the process of gathering industry financial information regarding service benchmarks for analysis in preparation of completing the vendor assessment report.

22. Network Adequacy Report

Ms. Watson stated the overall network has increased by 8.6%, predominately in the areas of primary care, specialty services, and long term care facilities. GCHP has contracts with all of the 18 long term care facilities located in the County.

GCHP meets or exceeds member to provider ratios for primary care and top specialty services, as well as provider to member geographical standards for primary care and top specialty services. It was reiterated there are adequate specialty provider resources to support the Plan's membership with the continuing challenge of ensuring members are seen on a timely basis.

A discussion followed between the Commission and staff regarding closing the gap rate to be more competitive; the lack of certain sub specialties in the County; the use of the emergency room for primary medical care; utilizing Alternative Resources for Community Health (ARCH) programs to incentivize providers; the need to strategize on how to close the gaps in provider access measurements; how to reduce the administrative burden on providers as Medi-Cal requires extensive reporting; the availability of money to fund the ARCH programs; and the need for better metrics regarding appointment availability.

Staff noted there was formula error on page 205 and the PCPs – General Pediatrics total number should be 199.

Staff is working on three pilots for pay for performance programs with implementation scheduled by the end of the fiscal year. The pilots consist of an encounter data submission program, an enhancement reimbursement program for the required data for Pre Intervention Referral Treatment, and a patient navigator program. Future incentive programs are also being vetted.

23. Chief Information and Strategy Officer (CISO) Update

A discussion occurred between the Commission and staff about the availability of data on how quickly Helpdesk Service Tickets are closed. Melissa Scrymgeour, CISO, stated the project steering committee is working on a very aggressive project portfolio for next fiscal year with focus on regulatory compliance, business operations, and operational efficiencies. One of the projects is the member facing mobile application for a diabetes management program text messaging campaign.

24. Chief Diversity Officer (CDO) Update

Mr. Campbell stated the diversity interview panel met with three individuals last Wednesday and another meeting is scheduled for April 26. Once the process is finalized, the candidates will be brought to the Commission on May 23 or June 27 for interviews.

Commissioner Dial moved to accept and file Agenda Item Nos. 16 through 24. Commissioner Foy seconded.

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

Mr. Campbell stated there would be three closed items: the existing litigation with Clinicas; anticipated litigation involving the PBM Request for Proposals and as the facts are unknown to the plaintiffs and will not be disclosed; and the performance evaluation for the Chief Executive Officer. The Clinicas representatives will recuse themselves from Agenda Item No. 25 and Mr. Villani will recuse himself from Agenda Item No. 26 due to previous stock ownership in Magellan.

CLOSED SESSION

The Commission adjourned to Closed Session at 5:50 p.m. regarding the following items:

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

OPEN SESSION

The Regular Meeting reconvened at 6:56 p.m.

Mr. Campbell reported for Agenda Item No. 26, the Commissioners unanimously directed staff to prepare an agenda item for an upcoming special meeting formally rejecting all current bids received for the pharmacy benefit manager (“PBM”) Request for Proposals (“RFP”) process. The Commissioners want to be more active in the selection process. The Commissioners also want the RFP responses to include greater detail on the proposers’ plans to work with local pharmacies as well as a discussion regarding the 340B drug pricing program. The decision to direct staff to prepare staff report rejecting the

current bids was also due to the Commission's concern that CEO Dale Villani's attendance at two of the three interviews raised potential conflict of interest issues given Mr. Villani's ownership of some shares in Magellan, one of the companies that submitted a proposal. Mr. Villani did not attend the interview with Magellan. There was no evidence that Mr. Villani's participation in the two other interviews had any effect on the scoring or outcome of the RFP. However, in abundance of caution, the Commissioners felt it was in the Plan's best interest to reject all bids and restart the process.

8. Pharmacy Benefits Manager (PBM) Contract Extension

RECOMMENDATION

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

Commissioner Lee moved to approve the contract amendment be extended for six additional one month extensions for a total of nine months. Commissioner Foy seconded.

AYES: Commissioners Alatorre, Atin, Dial, Fisher, Foy, Laba, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

ADJOURNMENT

The meeting was adjourned at 6:59 p.m.

AGENDA ITEM NO. 3

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

May 23, 2016 Regular Meeting Minutes

CALL TO ORDER

Commissioner Darren Lee called the meeting to order at 3:04 p.m. in the Lower Plaza Assembly Room at the County of Ventura Government Center – Hall of Administration, 800 South Victoria Avenue, Ventura, California.

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Barry Fisher, Darren Lee, Gagan Pawar, M.D., Dee Pupa, and Jennifer Swenson

Absent: Commissioners Lanyard Dial, Peter Foy, and Michelle Laba, M.D.

PUBLIC COMMENT

David Cruz, Ventura County resident, invited the Commission to appear on his community outreach program.

SPECIAL PRESENTATIONS

1. Sponsorship Award to National Health Foundation

2. Sponsorship Award to Ventura County Area Agency on Aging

The Commission unanimously agreed to hear the special presentations once both recipients arrived.

FORMAL ACTION ITEMS

3. Pharmacy Benefits Manager (PBM) Request for Proposals

RECOMMENDATION

Reject all proposals from the Request for Proposals (RFP) that staff initiated on November 6, 2015; and provide direction to staff to either: (i) open a revised RFP to all proposers, or (ii) limit a revised RFP to the three finalists identified in the current RFP process.

Scott Campbell, General Counsel, stated due to prior ownership of Magellan stock, Chief Executive Officer Dale Villani will recuse himself and Chief Operating Officer Ruth Watson will recuse herself due to nature of the Request for Proposal (RFP) and the potential for appeal.

General Counsel Campbell stated the reasons for the recommendation is there is a potential of a conflict of interest challenge due to the interview process with the prior RFP panel; the Commission has indicated it wants the RFP to have an additional focus on the ability of the proposers to be able to serve the local pharmacies as stated by the pharmacists at the February 22, 2016 meeting; and to address the 340B issues. If all the bids are rejected, the new RFP should be ready by the end of the week, the proposals can be evaluated within 30 days, and the interviews with the finalists are scheduled for July. Additionally, the Commission's rules allow for the Commission to submit the new RFP to the three candidates.

Kevin Brown, Script Care President, spoke in favor of Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals.

Keely Michalk, Script Care Director of Provider Quality Assurance, spoke in favor of Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals.

Amy Cansler, Script Care Vice President, spoke in favor of Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals.

Andrew Kugler, Mayer Brown LLP, General Counsel for Script Care, spoke in favor of Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals.

Earl Hurst, Magellan Rx Management Senior Vice President and General Manager, spoke in opposition of Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals.

Mara Mitchel, Magellan Rx Management Senior Vice President of Strategic Operations, spoke in opposition of Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals.

Tony Zappa, pharmacist representing Magellan Rx Management, spoke in opposition of Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals.

Rob Coppola, Magellan Rx Management Vice President of Medicaid Sales, spoke in opposition of Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals.

Ron Foll, Magellan Rx Management Senior Legal Counsel, addressed the conflict of interest issue concerning the Plan's CEO citing Government Code (G.C.) 1091.5

and spoke in opposition of Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals.

Jennifer Dauer, Diepenbrock Elkin Gleason LLP, outside counsel for Magellan Rx Management, spoke in opposition of Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals.

The Commission unanimously agreed to hear Agenda Item No. 3, Pharmacy Benefits Manager Request for Proposals after the Closed Session.

General Counsel Campbell stated per G.C.1091.5, the Ventura County representatives do not have conflict of interest as salary received from the County does not to qualify.

Commissioner Alatorre stated he did not have a conflict of interest and would not be recusing himself.

General Counsel Campbell noted additional information was received from Magellan today that pertains to the non-existence of the conflict of interest, which will be discussed in Closed Session.

Mr. Villani and Ms. Watson returned to the meeting.

SPECIAL PRESENTATIONS

1. Sponsorship Award to National Health Foundation

Kelly Bruno, representative for the National Health Foundation, received the sponsorship award.

2. Sponsorship Award to Ventura County Area Agency on Aging

Victoria Jump, representative for the Senior Nutrition Program, received the sponsorship award.

FORMAL ACTION ITEMS

4. March 2016 Fiscal Year to Date Financials

RECOMMENDATION

Accept and file March 2016 Fiscal Year to Date Financials.

Patricia Mowlavi, Chief Financial Officer, noted the Department of Health Care Services gave the Plan permission to repay line of credit to the County of Ventura and as of March 2016, the Plan's Tangible Net Equity (TNE) is at 545% of the State required minimum.

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

AYES: Commissioners Alatorre, Atin, Fisher, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial, Foy, and Laba.

Commissioner Lee declared the motion carried.

5. Fiscal Year 2016/2017 Budget

RECOMMENDATION

Approve Fiscal Year 2016/2017 Budget and the staffing levels.

Ms. Mowlavi stated due to the Plan's stable financial position, it will allow for additional investments in improving the health of the Plan's members by supporting its providers, and per the federal government's direction, is committed to moving towards outcome and value based performance.

Key budget assumptions included:

- Anticipated flat growth of 6,000 members
- 4.8% reduction in revenue rates driven by the 13.9% reduction for the Adult Expansion rates
- $12.1 million investment in Alternative Resources for Community Health (ARCH) program
- Administrative expenses budgeted to remain flat at 6.7% of revenue
- TNE projected to be at 498% of the state required minimum

Staff gave a budget presentation which included:

- The ARCH program
- Value Based Contracting: Triple Aim of Health Care
- Impact of the Center for Medicare and Medicaid Services approved regulations for Medicaid
- Breakdown of how the revenue received from the State is applied
- Increase in provider reimbursement rates
- $2.8 million for one time investments for strategic projects
- Estimations of the number of SB 75 enrollees
- Projection of a 84% Medical Loss Ratio by the end of next year
- $170 million reduction in cash/investment by August/September which was created by the State's overpayments
- Little change in membership mix and revenue impact from last fiscal year
- Intentional draw down of the TNE

- Medical Cost Ratio budgeted at 92%
- Breakdown of health care costs
- Employee investments
- Focus on how project investments align with the Plan's strategic initiatives

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

AYES: Commissioners Alatorre, Atin, Fisher, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial, Foy, and Laba.

Commissioner Lee declared the motion carried.

6. Internal Audit Report, Revenue

RECOMMENDATION

Approve the Internal Audit Report.

Martin Haisma, Certified Information System Analyst, Certified Internal Auditor, Project Management Professional, Etonien Consulting, stated there were three insignificant findings in the review of the revenue policy and procedures, which have been remediated, and is currently conducting a review around Human Resources, Payroll, and Office Expenditures.

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

AYES: Commissioners Alatorre, Atin, Fisher, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial, Foy, and Laba.

Commissioner Lee declared the motion carried.

7. Reinsurance for High Cost Claims Policy Renewal

RECOMMENDATION

Approve and authorize binding reinsurance for high cost claims policy renewal with StarLine per the quote estimate.

Ms. Mowlavi stated the current reinsurance policy will expire on June 30, 2016. Beecher Carlson, the Plan's insurance broker, received five bids. The StarLine quote was the lowest received with a rate reduction of $453,000 and there is a possibility of a refund from the prior year's premium.

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

AYES: Commissioners Alatorre, Atin, Fisher, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial, Foy, and Laba.

Commissioner Lee declared the motion carried.

8. Ventura County Behavioral Health Overdose Rescue Project Sponsorship Application Request (ARCH)

RECOMMENDATION

Approve the Ventura County Behavioral Health Overdose Rescue Project sponsorship application request for fifty-one thousand three hundred dollars ($51,300) for 1,000 naloxone overdose rescue kits.

Commissioner Fisher recused himself as he is the Director of the Ventura County Health Care Agency.

Ralph Oyaga, Executive Director for Government, Regulatory and External Relations, gave the staff report and noted the kits come with information and training.

Dan Hicks, Ventura County Behavioral Health ADP Prevention Manager, stated the County loses 80 to 100 people each year from accidental opiate overdose, which is part of a national epidemic. Opiate overdose is the gradually cessation of breathing allowing time to respond and anyone with the proper training can legally administer the naloxone in response to an overdose crisis. A handout of overdose statistics was distributed and is on file.

A discussion followed between Commissioners and staff regarding the clarification of the contents and distribution of the kits; the benefit to current members who are at high risk of accidental overdose; ARCH requests being funded by excess resources for the current fiscal year and a budget set for fiscal year 2016/2017; and the data collection of confirmed overdose reversals.

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

AYES: Commissioners Alatorre, Atin, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: Commissioner Fisher.

ABSENT: Commissioners Dial, Foy, and Laba.

Commissioner Lee declared the motion carried.

Commissioner Fisher returned to the Commission meeting.

REPORTS

9. Chief Executive Officer (CEO) Update

Mr. Villani highlighted the 5th Annual Community Resource Fair held on Saturday, May 14, 2016, at Park Place in Oxnard and thanked Lupe Gonzalez and the Health Education, Community Outreach team for their great work on the event.

10. Chief Operations Officer (COO) Update

Ms. Watson stated staff is producing new information regarding membership churn statistics and is working with the County to reach out to members who are approaching the end of the redetermination period to prevent them from falling off and coming back retroactively.

11. Health Services Update

Nancy Wharfield, M.D., Associate Chief Medical Officer, noted the reporting period data was relatively flat.

12. Health Education Update

C. Albert Reeves, M.D., Chief Medical Officer, stated Lupe Gonzalez, MPH, PhD, Director of Health Education, Outreach, Cultural and Linguistic Services, is available for questions on the Community Outreach Summary report.

Commissioner Fisher moved to accept and file the reports. Commissioner Pupa seconded.

AYES: Commissioners Alatorre, Atin, Fisher, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial, Foy, and Laba.

Commissioner Lee declared the motion carried.

COMMENTS FROM COMMISSIONERS

Mr. Campbell stated staff will be polling the Commissioners regarding availability for the next four Commission meetings.

Commissioner Lee noted in past discussions it had been proposed to move to electronic packets and would like to revisit the topic.

Mr. Campbell announced the Closed Sessions items are the ones listed on the Agenda and on Agenda Item No. 16 Conference with Legal Counsel – Anticipated Litigation, is to discuss the PBM RFP statements, due to the threats of litigation in writing and orally, with Mr. Villani and Ms. Watson recusing themselves for the same reasons as previously noted in Item No. 3. On Agenda Item No. 17 Conference with Legal Counsel – Existing Litigation, the two representatives from Clinicas will be recusing themselves.

CLOSED SESSION

The Commission adjourned to Closed Session at 4:46 p.m. regarding the following items:

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

14. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Scott Campbell, General Counsel
Unrepresented employee: Chief Executive Officer

15. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Diversity Officer

16. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: Two Cases

17. 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

OPEN SESSION

The Regular Meeting reconvened at 6:15 p.m.

Mr. Campbell stated that no reportable action was taken for Agenda Item Nos. 13, 14, 15, and 16.

3. Pharmacy Benefits Manager Request for Proposals

Staff: Scott Campbell, General Counsel

RECOMMENDATION

Reject all proposals from the Request for Proposals (RFP) that staff initiated on November 6, 2015; and provide direction to staff to either: (i) open a revised RFP to all proposers, or (ii) limit a revised RFP to the three finalists identified in the initial RFP process.

Commissioner Fisher moved to reject all proposals from the Request for Proposals that staff initiated on November 6, 2015, and directed staff to limit a revised RFP to the three finalists identified in the prior RFP process. Commissioner Pawar seconded.

AYES: Commissioners Alatorre, Atin, Fisher, Lee, Pawar, Pupa, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial, Foy, and Laba.

Commissioner Lee declared the motion carried.

CLOSED SESSION

The Commission adjourned to Closed Session at 6:17 p.m. regarding the following item:

17. 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

OPEN SESSION

The Regular Meeting reconvened at 6:34 p.m.

Commissioner Lee stated that no reportable action was taken for Agenda Item No. 17.

ADJOURNMENT

The meeting was adjourned at 6:35 p.m.

AGENDA ITEM NO. 4

TO: Gold Coast Health Plan Commission

FROM: Patricia Mowlavi, CFO

DATE: June 27, 2016

SUBJECT: April 2016 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached fiscal year to date (FYTD) April 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 May and June.

BACKGROUND/DISCUSSION:

The staff has prepared the FYTD April 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 ten months ended April 30, 2016, the Plan's gain in net assets was approximately $34.6 million. This represents a $23.1 million favorable variance to budget which was largely due to the continued growth in membership in the Adult Expansion ("AE") category of aid. Other performance contributors included, 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 $134.5 million, which is $43.0 million better than budget.

Membership – April membership of 205,530 exceeded budget by 4,862 members. As in the prior months, the AE and Adult / Family categories continue to be the catalysts for membership growth, accounting for almost 94% of the total FYTD enrollment growth.

Revenue – FYTD, net revenue was $557.1 million or $25.9 million favorable to budget. The positive variance resulted primarily from better than anticipated membership for AE with higher capitation rates.

For the year, revenue includes a $19.1 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 continues to pay at the 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 $267.9 million. Beginning in January, the DHCS started to recoup the AE rate overpayment through monthly reductions of its payment to the Plan. Year-to-date, a total of $51.8 million has been was deducted, including $17.3 million in April.

Health Care Costs – FYTD health care costs were $490.9 million or $5.8 million above budget. For the year, the MLR was 88.1% versus budget of 91.3%.

Some health care cost items of note include:

- Capitation – FYTD, capitation was $83.8 million or $24.8 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 $393.5 million compared to a budget of $405.5 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 $81.1 million or $3.7 million unfavorable to budget. This variance was offset by specialty drug reimbursement which appears in revenue.

Administrative Expenses – FYTD, administrative costs were $33.1 million or $2.6 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 5.9% versus 6.7% for budget. (The ACR is calculated by dividing administrative expenses by total revenue.)

Cash and Medi-Cal Receivable – At April 30, 2016, the Plan had $420.9 million in cash and short term investments and $62.6 million in Medi-Cal Receivable for an aggregate amount of $483.5 million. The cash amount also included pass-through payments for AB 85 of $1.9 million and Managed Care Organizations (MCO) tax of $3.3 million. Excluding the impact of these amounts, the combined cash and short term investment amount would be $415.7 million. A couple of significant items of note regarding the Plan's cash position: (1) a significant portion of the cash will be used for repayments of amounts owed to the State of California ($267.9 million) with approximately half the amount owed expected to be paid within the next 12 months and (2) consistent with prior years, and as expected, the end of the State's fiscal year also means that there will be a long delay in the State paying the Plan. The Plan has been informed that the next payment will not be until July

at the earliest and will be most likely be in August. Until the next payment, the Plan expects cash usage to be approximately $150 - $175 million to cover health care and operating expenses.

Investment Portfolio – As of April 30, 2016, the value of the investments were as follows:

- Short-term Investments $233.7 million: Cal Trust $80.4 million; Ventura County Investment Pool $85.2 million; LAIF CA State $63.1 million; Bonds $5.0 million.
- Long-term Investments (Bonds) $19.4 million.

RECOMMENDATION:

Staff requests that the Commission accept and file the April 2016 financial statements.

ATTACHMENT:

April 2016 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended April 30, 2016

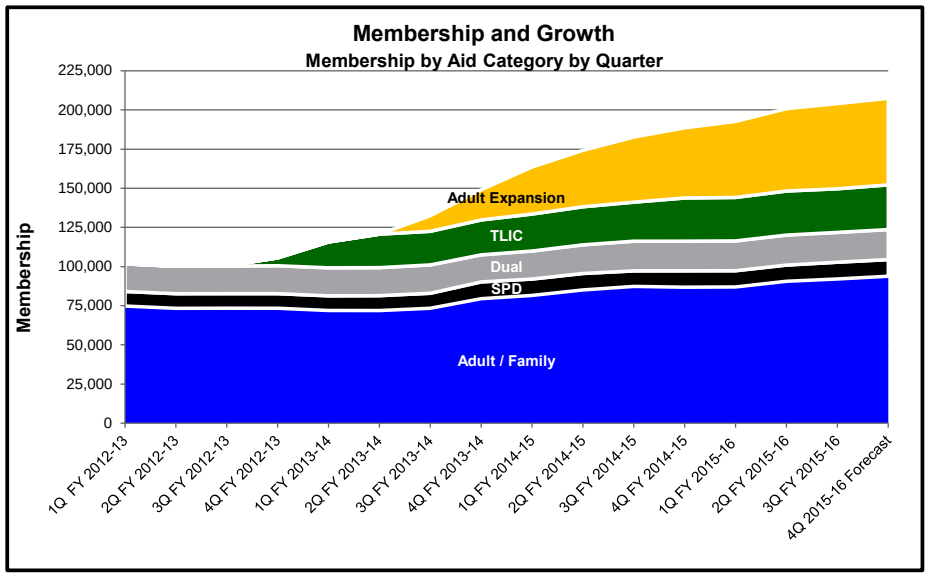
TABLE OF CONTENTS

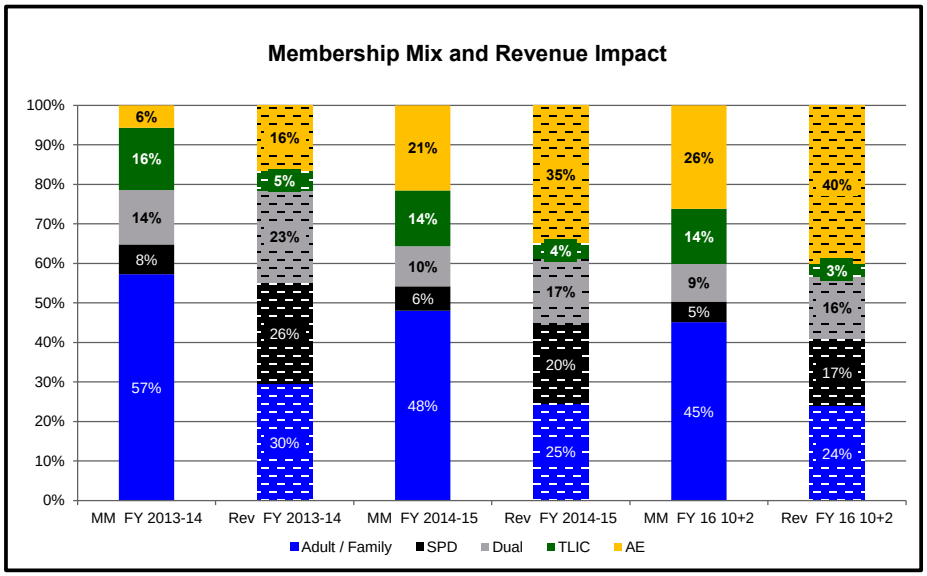
APPENDIX

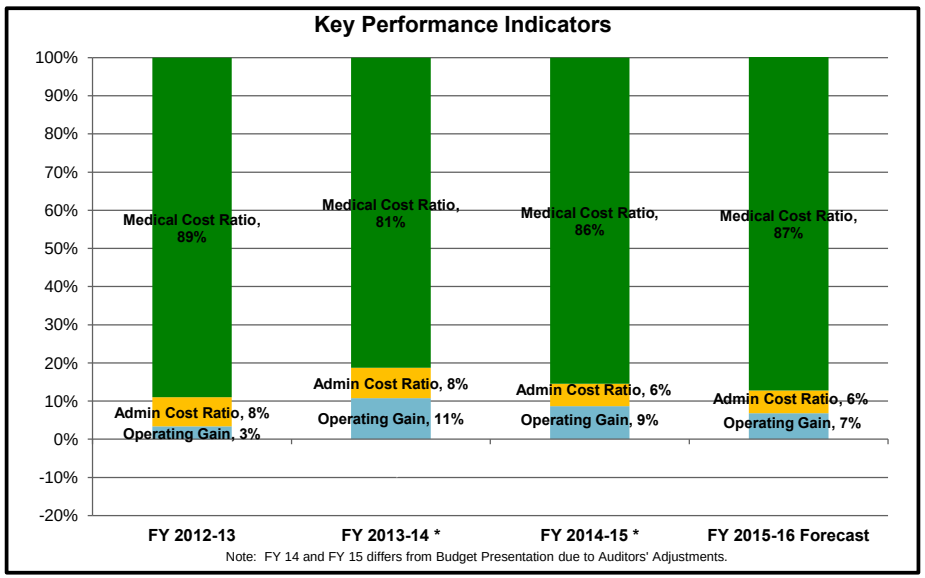
Description	AUDITED FY 2011-12	AUDITED FY 2012-13	AUDITED FY 2013-14	AUDITED FY 2014-15	FY 2015-16 JUL - SEP 15	FY 2015-16 OCT - DEC 15	FY 2015-16 JAN - MAR 16	FY 2015-16 APR 16	FY 2015-16 APR 16 FYTD	Budget Comparison Budget FYTD	Budget Comparison Variance Fav / (Unfav)	Budget Comparison Variance Fav / (Unfav)%
Member Months	**1,258,189**	**1,223,895**	**1,553,660**	**2,130,979**	**578,056**	**602,390**	**612,456**	**205,530**	**1,998,432**	**1,955,217**	43,215	2.2 %
Revenue	**304,635,932**	**315,119,611**	**402,701,476**	**595,607,370**	**162,960,677**	**159,744,239**	**175,131,344**	**59,280,903**	**557,117,162**	**531,223,386**	25,893,776	4.9 %
pmpm	*242.12*	*257.47*	*259.20*	*279.50*	*281.91*	*265.18*	*285.95*	*288.43*	*278.78*	*271.70*	7.08	2.6 %
Health Care Costs	**287,353,672**	**280,382,704**	**327,305,832**	**509,183,268**	**137,845,237**	**142,711,885**	**156,369,522**	**53,926,029**	**490,852,672**	**485,004,842**	(5,847,830)	(1.2)%
pmpm	*228.39*	*229.09*	*210.67*	*238.94*	*238.46*	*236.91*	*255.32*	*262.38*	*245.62*	*248.06*	2.44	1.0 %
% of Revenue	94.3%	89.0%	81.3%	85.5%	84.6%	89.3%	89.3%	91.0%	88.1%	91.3%	3.2 %	3.5 %
Admin Exp	**18,891,320**	**24,013,927**	**31,751,533**	**34,814,049**	**9,154,093**	**9,477,262**	**10,357,492**	**4,088,628**	**33,077,475**	**35,684,948**	2,607,473	7.3 %
pmpm	*15.01*	*19.62*	*20.44*	*16.34*	*15.84*	*15.73*	*16.91*	*19.89*	*16.55*	*18.25*	1.70	9.3 %
% of Revenue	6.2%	7.6%	7.9%	5.8%	5.6%	5.9%	5.9%	6.9%	5.9%	6.7%	0.8 %	11.6 %
Non-Operating Revenue / (Expense)					**327,034**	**441,716**	**466,424**	**176,883**	**1,412,057**	**982,885**	429,172	43.7 %
pmpm					*0.57*	*0.73*	*0.76*	*0.86*	*0.71*	*0.50*	0.20	40.6 %
% of Revenue					0.2%	0.3%	0.3%	0.3%	0.3%	0.2%	0.1%	37.0 %
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**	**8,870,753**	**1,443,129**	**34,599,072**	**11,516,481**	23,082,591	200.4 %
pmpm	*(1.28)*	*8.76*	*28.09*	*24.22*	*28.18*	*13.28*	*14.48*	*7.02*	*17.31*	*5.89*	11.42	193.9 %
% of Revenue	-0.5%	3.4%	10.8%	8.7%	10.0%	5.0%	5.1%	2.4%	6.2%	2.2%	4.0%	186.5 %
YTD												
100% TNE	16,769,368	16,138,440	17,867,986	22,556,530	21,819,072	22,591,994	24,405,592	25,882,936	25,882,936	26,580,464	(697,528)	(2.6)%
% 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	24,405,592	25,882,936	25,882,936	26,580,464	(697,528)	(2.6)%
GCHP TNE	**(6,031,881)**	**11,891,099**	**55,535,211**	**107,145,264**	**123,433,646**	**131,430,454**	**133,101,207**	**134,544,336**	134,544,336	**91,495,859**	**43,048,477**	**47.0 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**37,667,225**	**84,588,734**	**101,614,573**	**108,838,460**	**108,695,615**	**108,661,400**	**108,661,400**	**64,915,395**	**43,746,005**	**67.4 %**
% of Required TNE level			**311%**	**475%**	**566%**	**582%**	**545%**	**520%**	**520%**	**344%**		
% of Required TNE level (excluding $7.2 million LOC)			**271%**	**443%**	**533%**	**550%**	**545%**	**520%**	**520%**	**317%**		

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

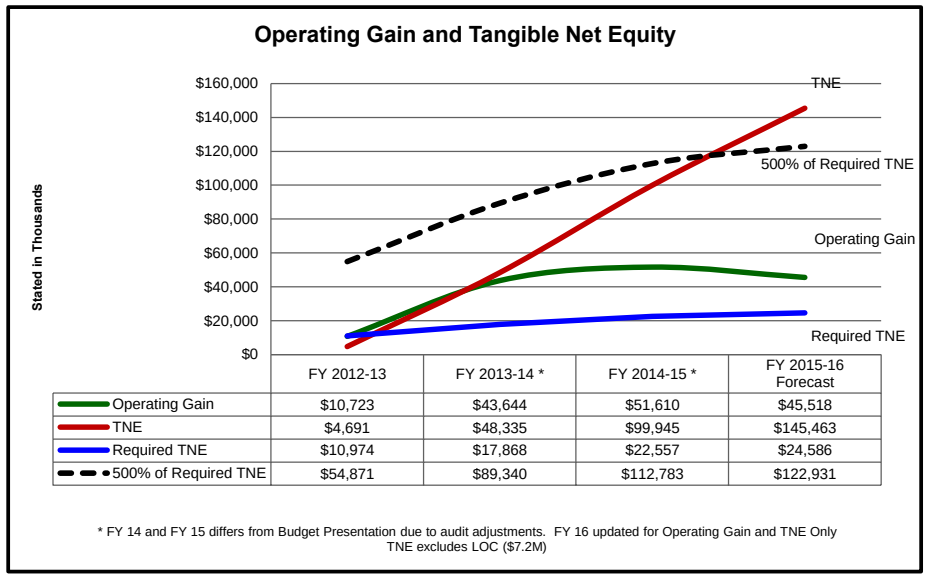
FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING APRIL 30, 2016







Note: FY 14 and FY 15 differs from Budget Presentation due to Auditors' Adjustments.



	FY 2012-13	FY 2013-14 *	FY 2014-15 *	FY 2015-16 Forecast
Operating Gain	$10,723	$43,644	$51,610	$45,518
TNE	$4,691	$48,335	$99,945	$145,463
Required TNE	$10,974	$17,868	$22,557	$24,586
500% of Required TNE	$54,871	$89,340	$112,783	$122,931

* FY 14 and FY 15 differs from Budget Presentation due to audit adjustments. FY 16 updated for Operating Gain and TNE Only
TNE excludes LOC ($7.2M)

Note: 10+2 indicates 10 months of actual results followed by 2 months of forecasts

Back to Agenda

Gold Coast Health Plan℠
A Public Entity

For the month ended April 30, 2016

APPENDIX

- Statement of Financial Positions
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Financial Positions
- YTD Cash Flow
- Monthly Cash Flow
- Cash Trend Combined
- Membership
- Total Expense Composition
- Paid Claims and IBNP Composition
- Pharmacy Cost & Utilization Trends

STATEMENT OF FINANCIAL POSITION

	04/30/16	03/31/16	02/29/16	Audited FY 2014 - 15
ASSETS				
Current Assets:				
Total Cash and Cash Equivalents	**$ 187,241,603**	**$ 183,075,433**	**$ 204,233,778**	**$ 57,218,141**
Total Short-Term Investments	**233,687,190**	**233,529,909**	**225,463,017**	**165,090,357**
Medi-Cal Receivable	62,553,746	64,292,235	64,081,474	129,782,958
Interest Receivable	427,102	461,810	382,485	208,010
Provider Receivable	256,964	305,404	428,925	579,482
Other Receivables	171,605	171,958	171,958	979,647
Total Accounts Receivable	**63,409,417**	**65,231,408**	**65,064,842**	**131,550,096**
Total Prepaid Accounts	971,983	1,152,318	1,301,437	766,831
Total Other Current Assets	133,545	133,545	133,545	81,702
Total Current Assets	**485,443,739**	**483,122,613**	**496,196,618**	**354,707,127**
Total Fixed Assets	**2,070,160**	**1,329,168**	**1,241,489**	**1,084,113**
Total Long-Term Investments	**19,397,763**	**19,418,836**	**19,439,894**	**24,647,362**
Total Assets	**$ 506,911,662**	**$ 503,870,618**	**$ 516,878,001**	**$ 380,438,602**
LIABILITIES & NET ASSETS				
Current Liabilities:				
Incurred But Not Reported	$ 64,894,380	$ 61,218,949	$ 57,889,688	$ 52,372,146
Claims Payable	10,139,605	10,265,571	15,089,156	13,747,426
Capitation Payable	44,150,454	40,034,217	36,329,863	34,466,106
Physician ACA 1202 Payable	9,528,709	9,600,012	9,600,012	10,965,642
AB 85 Payable	1,887,116	1,858,433	1,850,953	3,818,147
Accounts Payable	3,236,898	511,934	543,183	3,449,087
Accrued ACS	1,648,834	1,636,075	1,631,285	1,480,556
Accrued Expenses	98,197,894	107,437,725	111,793,052	6,249,194
Accrued Premium Tax	3,298,700	4,656,097	3,891,138	3,641,573
Accrued Interest Payable	0	0	99,494	70,711
Current Portion of Deferred Revenue	76,667	115,000	153,333	460,000
Accrued Payroll Expense	1,103,838	1,005,125	763,573	1,152,720
Total Current Liabilities	**238,163,094**	**238,339,138**	**239,634,731**	**131,873,310**
Long-Term Liabilities:				
DHCS - Reserve for Capitation Recoup	133,444,946	131,694,946	135,494,946	140,970,602
Other Long-term Liability-Deferred Rent	759,286	735,327	709,422	449,427
Notes Payable	0	0	7,200,000	7,200,000
Total Long-Term Liabilities	**134,204,232**	**132,430,273**	**143,404,368**	**148,620,029**
Total Liabilities	**372,367,326**	**370,769,411**	**383,039,099**	**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	34,599,072	33,155,943	33,893,639	51,610,053
Total Net Assets	**134,544,336**	**133,101,207**	**133,838,903**	**99,945,264**
Total Liabilities & Net Assets	**$ 506,911,662**	**$ 503,870,618**	**$ 516,878,001**	**$ 380,438,602**

FINANCIAL INDICATORS				
Current Ratio	2.04 : 1	2.03 : 1	2.07 : 1	2.69 : 1
Days Cash on Hand	218	196	257	67
Days Cash + State Capitation Rec	250	226	295	107
Days Cash + State Capitation Rec (less Tax Li	248	224	293	106

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR TEN MONTHS ENDING APRIL 30, 2015

	April 2016 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	1,998,108	1,955,217	42,891
Revenue			
Premium	$ 596,972,246	$ 583,222,494	$ 13,749,752
Reserve for Rate Reduction	(19,075,000)	(30,623,870)	11,548,870
MCO Premium Tax	(21,465,258)	(21,758,571)	293,313
Total Net Premium	**556,431,987**	**530,840,053**	**25,591,934**
Other Revenue:			
Miscellaneous Income	685,175	383,333	301,842
Total Other Revenue	685,175	**383,333**	301,842
Total Revenue	**557,117,162**	**531,223,386**	**25,893,776**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	83,810,264	58,992,471	(24,817,793)
FFS Claims Expenses:			
Inpatient	91,571,380	100,062,619	8,491,239
LTC / SNF	88,889,905	91,166,244	2,276,339
Outpatient	36,936,296	32,242,322	(4,693,974)
Laboratory and Radiology	3,124,996	2,274,080	(850,916)
Emergency Room	15,887,383	13,124,834	(2,762,549)
Physician Specialty	37,763,611	42,360,031	4,596,420
Primary Care Physician	12,275,981	13,318,010	1,042,029
Home & Community Based Services	12,360,388	12,481,313	120,925
Applied Behavior Analysis Services	758,933	1,310,146	551,213
Mental Health Services	3,726,826	4,506,915	780,089
Pharmacy	81,120,769	77,254,201	(3,866,568)
Provider Reserve	0	5,787,773	5,787,773
Other Medical Professional	1,911,012	2,098,551	187,539
Other Medical Care	1,032	0	(1,032)
Other Fee For Service	5,989,147	6,064,521	75,374
Transportation	1,205,599	1,449,304	243,705
Total Claims	393,519,445	405,500,864	11,981,419
Medical & Care Management Expense	13,140,077	17,703,517	4,563,440
Reinsurance	2,059,055	2,807,990	748,936
Claims Recoveries	(1,676,169)	0	1,676,169
Sub-total	13,522,963	20,511,507	6,988,544
Total Cost of Health Care	**490,852,672**	**485,004,842**	**(5,847,830)**
Contribution Margin	**66,264,490**	**46,218,544**	**20,045,946**
General & Administrative Expenses:			
Salaries and Wages	7,551,408	8,765,685	1,214,277
Payroll Taxes and Benefits	2,040,864	2,647,639	606,775
Travel and Training	206,304	507,987	301,683
Outside Service - ACS	16,007,834	15,116,933	(890,901)
Outside Services - Other	1,512,710	1,818,661	305,951
Accounting & Actuarial Services	217,673	222,000	4,328
Legal	1,282,263	875,000	(407,263)
Insurance	325,641	271,680	(53,961)
Lease Expense - Office	793,640	869,400	75,760
Consulting Services	907,080	1,337,833	430,753
Advertising and Promotion	60,528	65,246	4,718
General Office	1,446,280	2,305,118	858,838
Depreciation & Amortization	219,235	370,865	151,630
Printing	64,651	163,175	98,524
Shipping & Postage	94,668	131,255	36,587
Interest	346,697	216,471	(130,226)
Total G & A Expenses	**33,077,475**	**35,684,948**	**2,607,473**
Total Operating Gain / (Loss)	**$ 33,187,015**	**$ 10,533,596**	**$ 22,653,419**
Non Operating			
Revenues - Interest	1,445,932	1,000,000	445,932
Expenses - Interest	33,876	17,115	(16,761)
Total Non-Operating	1,412,057	982,885	429,172
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 34,599,072**	**$ 11,516,481**	**$ 23,082,591**
Net Assets, Beginning of Year	99,945,264		
Net Assets, End of Year	134,544,336		

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2015-16 Monthly Trend			Current Month		
	JAN 16	FEB 16	MAR 16	APRIL 2016		Variance
				Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	202,945	203,981	205,206	205,530	200,668	4,862
Revenue:						
Premium	$ 60,525,329	$ 60,531,080	$ 61,560,475	$ 61,368,425	$ 58,428,417	$ 2,940,008
Reserve for Rate Reduction	(2,100,000)	(2,110,000)	3,800,000	(1,750,000)	(1,622,916)	(127,084)
MCO Premium Tax	(2,383,185)	(2,383,411)	(2,423,944)	(375,856)	(2,236,717)	1,860,861
Total Net Premium	**56,042,144**	**56,037,668**	**62,936,531**	**59,242,569**	**54,568,784**	**4,673,785**
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	**56,080,478**	**56,076,002**	**62,974,864**	**59,280,903**	**54,607,117**	**4,673,785**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	8,597,538	9,085,138	8,798,713	8,910,531	5,656,787	(3,253,744)
FFS Claims Expenses:						
Inpatient	9,397,915	7,392,640	12,503,077	10,955,509	10,492,792	(462,717)
LTC / SNF	9,940,604	7,895,479	10,257,828	9,453,929	9,286,783	(167,146)
Outpatient	3,126,572	3,379,287	4,852,606	3,309,821	3,356,669	46,848
Laboratory and Radiology	544,597	278,498	197,693	251,864	238,088	(13,776)
Emergency Room	1,534,104	1,672,260	2,487,940	1,867,611	1,362,119	(505,492)
Physician Specialty	3,148,079	4,054,445	5,109,877	4,469,065	4,428,445	(40,620)
Primary Care Physician	1,165,162	1,110,036	2,054,272	1,351,441	1,374,918	23,477
Home & Community Based Services	1,468,164	1,158,925	1,323,347	1,432,175	1,271,641	(160,534)
Applied Behavior Analysis Services	82,896	58,589	200,187	109,735	163,333	53,598
Mental Health Services	318,802	298,271	434,177	387,574	467,192	79,618
Pharmacy	8,140,173	8,431,109	9,377,773	8,840,622	8,043,909	(796,713)
Provider Reserve	0	0	0	0	597,869	597,869
Other Medical Professional	259,041	165,970	292,238	249,687	218,791	(30,896)
Other Medical Care	0	293	0	0	0	0
Other Fee For Service	549,506	599,049	655,014	678,196	625,054	(53,142)
Transportation	97,684	114,225	152,782	104,234	150,982	46,748
Total Claims	39,773,299	36,609,076	49,898,811	43,461,462	42,078,585	(1,382,877)
Medical & Care Management Expense	1,325,198	1,185,612	1,344,784	1,301,636	1,874,943	573,307
Reinsurance	133,103	291,461	291,220	292,601	296,091	3,490
Claims Recoveries	(611,548)	(274,027)	(78,857)	(40,201)	0	40,201
Sub-total	846,753	1,203,046	1,557,148	1,554,036	2,171,034	616,998
Total Cost of Health Care	**49,217,590**	**46,897,260**	**60,254,672**	**53,926,029**	**49,906,406**	**(4,019,623)**
Contribution Margin	**6,862,888**	**9,178,742**	**2,720,192**	**5,354,874**	**4,700,711**	**654,163**
General & Administrative Expenses:						
Salaries and Wages	794,596	740,575	866,810	767,490	941,603	174,113
Payroll Taxes and Benefits	239,223	217,016	221,933	221,391	293,341	71,950
Travel and Training	19,361	40,568	35,035	20,844	39,201	18,357
Outside Service - ACS	1,614,744	1,613,004	1,637,111	1,670,227	1,550,291	(119,936)
Outside Services - Other	140,276	183,036	173,053	175,025	193,462	18,437
Accounting & Actuarial Services	1,680	6,895	18,300	24,060	0	(24,060)
Legal	155,481	130,846	183,477	541,187	87,500	(453,687)
Insurance	32,588	32,588	32,588	32,177	27,168	(5,009)
Lease Expense - Office	66,034	110,467	110,467	110,467	86,940	(23,527)
Consulting Services	152,043	82,510	38,009	261,268	140,644	(120,624)
Advertising and Promotion	2,721	3,803	2,849	2,956	1,973	(983)
General Office	105,893	131,842	160,291	159,493	178,426	18,933
Depreciation & Amortization	21,247	21,153	21,153	32,100	46,562	14,462
Printing	9,836	376	19,515	11,514	14,245	2,731
Shipping & Postage	29,771	108	3,610	22,178	8,144	(14,034)
Interest	25,541	9,282	98,188	36,253	22,162	(14,091)
Total G & A Expenses	**3,411,034**	**3,324,069**	**3,622,389**	**4,088,628**	**3,631,662**	**(456,966)**
Total Operating Gain / (Loss)	**3,451,854**	**5,854,672**	**(902,197)**	**1,266,246**	**1,069,049**	**197,197**
Non Operating:						
Revenues - Interest	152,995	153,877	169,594	176,883	100,000	76,883
Expenses - Interest	1,361	3,588	5,092	0	34	34
Total Non-Operating	**151,634**	**150,288**	**164,501**	**176,883**	**99,966**	**76,917**
Total Increase / (Decrease) in Unrestricted Net Assets	**3,603,488**	**6,004,961**	**(737,696)**	**1,443,129**	**1,169,015**	**274,114**
Full Time Employees				**183**	**204**	**21**

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

	JAN 16	FEB 16	MAR 16	APRIL 2016 Actual	APRIL 2016 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	202,945	203,981	205,206	205,530	200,668	4,862
Revenue:						
Premium	298.24	296.75	299.99	298.59	291.17	7.42
Reserve for Rate Reduction	(10.35)	(10.34)	18.52	(8.51)	(8.09)	(0.43)
MCO Premium Tax	(11.74)	(11.68)	(11.81)	(1.83)	(11.15)	9.32
Total Net Premium	**276.14**	**274.72**	**306.70**	**288.24**	**271.94**	**16.31**
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	(0.00)
Total Other Revenue	0.19	0.19	0.19	0.19	0.19	(0.00)
Total Revenue	**276.33**	**274.91**	**306.89**	**288.43**	**272.13**	**16.30**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	42.36	44.54	42.88	43.35	28.19	(15.16)
FFS Claims Expenses:						
Inpatient	46.31	36.24	60.93	53.30	52.29	(1.01)
LTC / SNF	48.98	38.71	49.99	46.00	46.28	0.28
Outpatient	15.41	16.57	23.65	16.10	16.73	0.62
Laboratory and Radiology	2.68	1.37	0.96	1.23	1.19	(0.04)
Emergency Room	7.56	8.20	12.12	9.09	6.79	(2.30)
Physician Specialty	15.51	19.88	24.90	21.74	22.07	0.32
Primary Care Physician	5.74	5.44	10.01	6.58	6.85	0.28
Home & Community Based Services	7.23	5.68	6.45	6.97	6.34	(0.63)
Applied Behavior Analysis Services	0.41	0.29	0.98	0.53	0.81	0.28
Mental Health Services	1.57	1.46	2.12	1.89	2.33	0.44
Pharmacy	40.11	41.33	45.70	43.01	40.09	(2.93)
Provider Reserve	0.00	0.00	0.00	0.00	2.98	2.98
Other Medical Professional	1.28	0.81	1.42	1.21	1.09	(0.12)
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	2.71	2.94	3.19	3.30	3.11	(0.18)
Transportation	0.48	0.56	0.74	0.51	0.75	0.25
Total Claims	195.98	179.47	243.16	211.46	209.69	(1.77)
Medical & Care Management Expense	6.53	5.81	6.55	6.33	9.34	3.01
Reinsurance	0.66	1.43	1.42	1.42	1.48	0.05
Claims Recoveries	(3.01)	(1.34)	(0.38)	(0.20)	0.00	0.20
Sub-total	4.17	5.90	7.59	7.56	10.82	3.26
Total Cost of Health Care	242.52	229.91	293.63	262.38	**248.70**	**(13.67)**
Contribution Margin	**33.82**	**45.00**	**13.26**	**26.05**	**23.43**	**2.63**
General & Administrative Expenses:						
Salaries and Wages	3.92	3.63	4.22	3.73	4.69	0.96
Payroll Taxes and Benefits	1.18	1.06	1.08	1.08	1.46	0.38
Travel and Training	0.10	0.20	0.17	0.10	0.20	0.09
Outside Service - ACS	7.96	7.91	7.98	8.13	7.73	(0.40)
Outside Services - Other	0.69	0.90	0.84	0.85	0.96	0.11
Accounting & Actuarial Services	0.01	0.03	0.09	0.12	0.00	(0.12)
Legal	0.77	0.64	0.89	2.63	0.44	(2.20)
Insurance	0.16	0.16	0.16	0.16	0.14	(0.02)
Lease Expense - Office	0.33	0.54	0.54	0.54	0.43	(0.10)
Consulting Services	0.75	0.40	0.19	1.27	0.70	(0.57)
Advertising and Promotion	0.01	0.02	0.01	0.01	0.01	(0.00)
General Office	0.52	0.65	0.78	0.78	0.89	0.11
Depreciation & Amortization	0.10	0.10	0.10	0.16	0.23	0.08
Printing	0.05	0.00	0.10	0.06	0.07	0.01
Shipping & Postage	0.15	0.00	0.02	0.11	0.04	(0.07)
Interest	0.13	0.05	0.48	0.18	0.11	(0.07)
Other/ Miscellaneous Expenses	0.00	0.00	0.00	0.00	0.00	0.00
Total G & A Expenses	16.81	16.30	17.65	19.89	18.10	(1.80)
Total Operating Gain / (Loss)	17.01	28.70	(4.40)	6.16	5.33	0.83
Non Operating:						
Revenues - Interest	0.75	0.75	0.83	0.86	0.50	0.36
Expenses - Interest	0.01	0.02	0.02	0.00	0.00	0.00
Total Non-Operating	0.75	0.74	0.80	0.86	0.50	0.36
Total Increase / (Decrease) in Unrestricted Net Assets	17.76	29.44	(3.59)	7.02	5.83	1.20

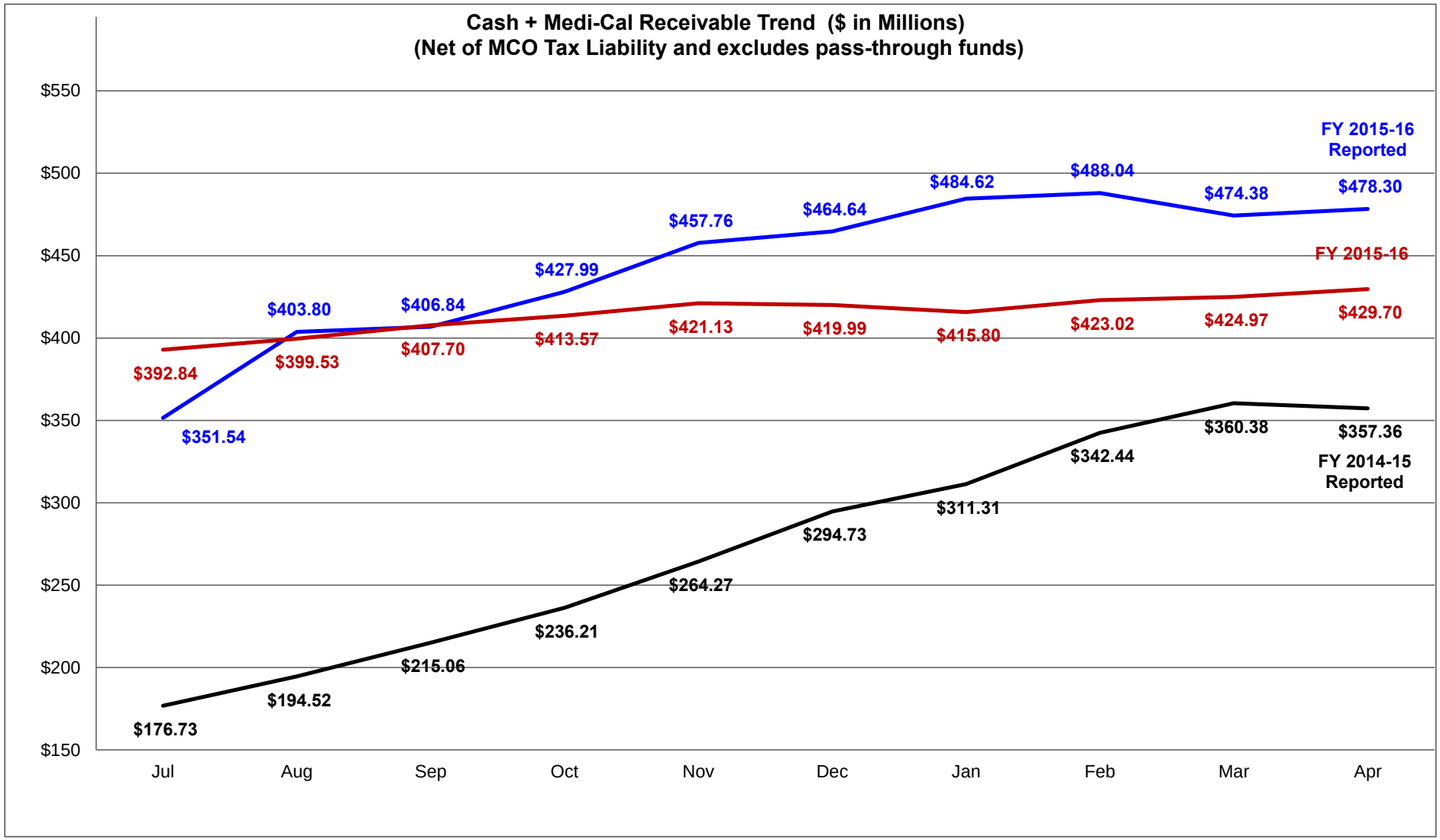
STATEMENT OF CASH FLOWS - FYTD

	APR 16
Cash Flow From Operating Activities	
Collected Premium	$ 720,356,084
Miscellaneous Income	1,098,698
State Pass Through Funds	62,239,044
Paid Claims	
Medical & Hospital Expenses	(314,999,183)
Pharmacy	(84,369,348)
Capitation	(77,332,428)
Reinsurance of Claims	(2,839,183)
State Pass Through Funds Distributed	(35,358,931)
Paid Administration	(38,815,383)
MCO Taxes Received / (Paid)	(28,409,042)
Net Cash Provided / (Used) by Operating Activities	**201,570,328**
Cash Flow From Investing / Financing Activities	
Net Acquisition / Proceeds from Investments	(63,347,233)
Net Discount / Premium Amortization of Investments	347,234
Repayment of Line of Credit	(7,200,000)
Net Acquisition of Property / Equipment	(1,346,867)
Net Cash Provided / (Used) by Investing / Financing	**(71,546,866)**
Net Cash Flow	**$ 130,023,462**
Cash and Cash Equivalents (Beg. of Period)	57,218,141
Cash and Cash Equivalents (End of Period)	187,241,603
	$ 130,023,462
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income / (Loss)	34,599,072
Depreciation & Amortization	360,820
Net Discount / Premium Amortization of Investments	(347,234)
Decrease / (Increase) in Receivables	68,140,679
Decrease / (Increase) in Prepaids & Other Current Assets	(256,996)
(Decrease) / Increase in Payables	88,417,231
(Decrease) / Increase in Other Liabilities	(7,599,130)
Change in MCO Tax Liability	(342,873)
Changes in Claims and Capitation Payable	6,076,527
Changes in IBNR	12,522,233
	201,570,328
Net Cash Flow from Operating Activities	**$ 201,570,328**

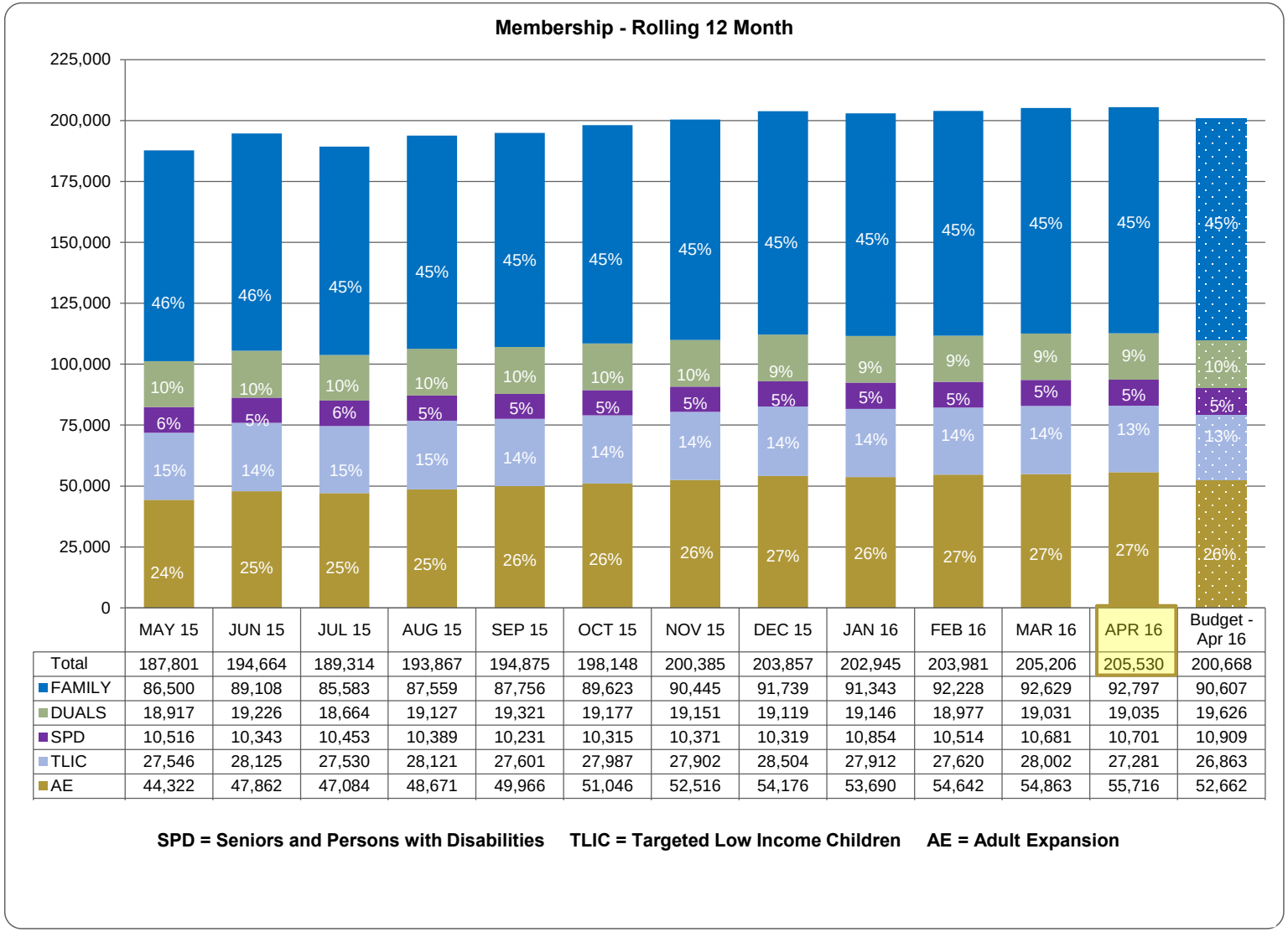
STATEMENT OF CASH FLOWS - MONTHLY

	APR 16	MAR 16	FEB 16
Cash Flow From Operating Activities			
Collected Premium	$ 53,868,144	$ 52,127,297	$ 50,212,450
Miscellaneous Income	40,676	123,759	147,908
State Pass Through Funds	2,165,793	7,185,818	1,893,015
Paid Claims			
Medical & Hospital Expenses	(31,179,213)	(42,463,530)	(25,925,285)
Pharmacy	(9,268,697)	(9,348,750)	(8,598,863)
Capitation	(4,794,294)	(5,094,359)	(4,356,051)
Reinsurance of Claims	(292,601)	(291,220)	(291,461)
State Pass Through Funds Distributed	(1,858,433)	(1,850,953)	(1,818,410)
Paid Administration	(1,599,571)	(4,171,763)	(5,966,237)
MCO Tax Received / (Paid)	(2,128,383)	(2,051,653)	(2,731,240)
Net Cash Provided / (Used) by Operating Activities	**4,953,421**	**(5,835,354)**	**2,565,825**
Cash Flow From Investing / Financing Activities			
Net Acquisition / Proceeds from Investments	(136,207)	(8,045,835)	(5,005,969)
Net Discount / Premium Amortization of Investments	136,207	45,835	5,969
Repayment of Line of Credit	-	(7,200,000)	-
Net Acquisition of Property / Equipment	(787,250)	(122,990)	(86,488)
Net Cash Provided / (Used) by Investing / Financing	**(787,250)**	**(15,322,990)**	**(5,086,488)**
Net Cash Flow	**$ 4,166,170**	**$ (21,158,345)**	**$ (2,520,663)**
Cash and Cash Equivalents (Beg. of Period)	183,075,433	204,233,778	206,754,441
Cash and Cash Equivalents (End of Period)	187,241,603	183,075,433	204,233,778
	$ 4,166,170	**$ (21,158,345)**	**$ (2,520,663)**
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	1,443,129	(737,696)	6,004,961
Net Discount / Premium Amortization of Investments	(136,207)	(45,835)	(5,969)
Depreciation & Amortization	46,258	35,311	35,311
Decrease / (Increase) in Receivables	1,821,990	(166,566)	(918,214)
Decrease / (Increase) in Prepaids & Other Current Ass	180,335	149,119	(108,120)
(Decrease) / Increase in Payables	(6,446,015)	(4,232,248)	(11,250,584)
(Decrease) / Increase in Other Liabilities	1,735,626	(3,812,429)	2,097,571
Change in MCO Tax Liability	(1,357,397)	764,959	36,947
Changes in Claims and Capitation Payable	3,990,271	(1,119,231)	9,241,560
Changes in IBNR	3,675,431	3,329,261	(2,567,640)
	4,953,421	(5,835,354)	2,565,825
Net Cash Flow from Operating Activities	**4,953,421**	**(5,835,354)**	**2,565,825**

GOLD COAST HEALTH PLAN
APRIL 2016



GOLD COAST HEALTH PLAN

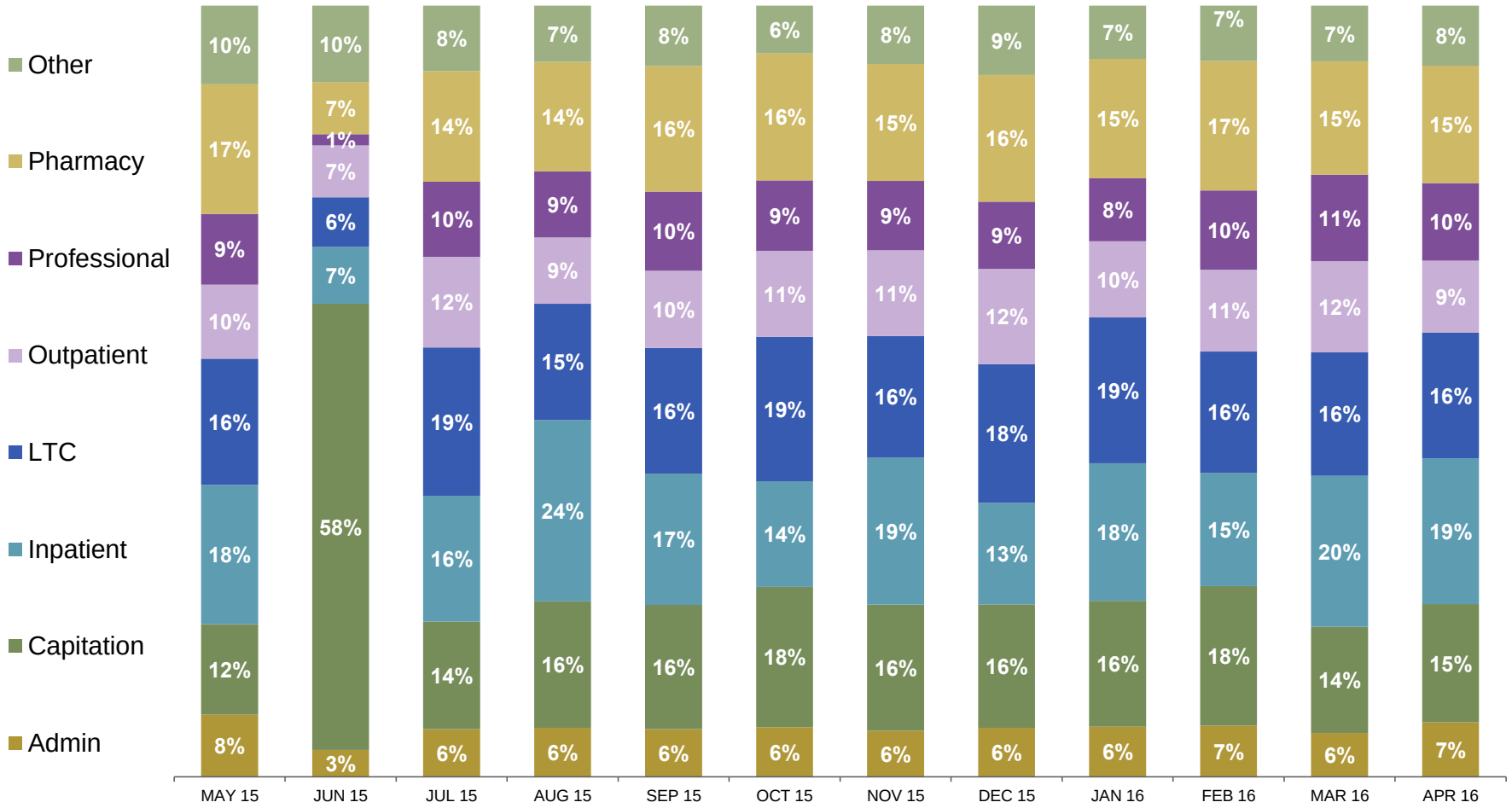


	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16	APR 16	Budget - Apr 16
Total	187,801	194,664	189,314	193,867	194,875	198,148	200,385	203,857	202,945	203,981	205,206	205,530	200,668
FAMILY	86,500	89,108	85,583	87,559	87,756	89,623	90,445	91,739	91,343	92,228	92,629	92,797	90,607
DUALS	18,917	19,226	18,664	19,127	19,321	19,177	19,151	19,119	19,146	18,977	19,031	19,035	19,626
SPD	10,516	10,343	10,453	10,389	10,231	10,315	10,371	10,319	10,854	10,514	10,681	10,701	10,909
TLIC	27,546	28,125	27,530	28,121	27,601	27,987	27,902	28,504	27,912	27,620	28,002	27,281	26,863
AE	44,322	47,862	47,084	48,671	49,966	51,046	52,516	54,176	53,690	54,642	54,863	55,716	52,662

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

GOLD COAST HEALTH PLAN

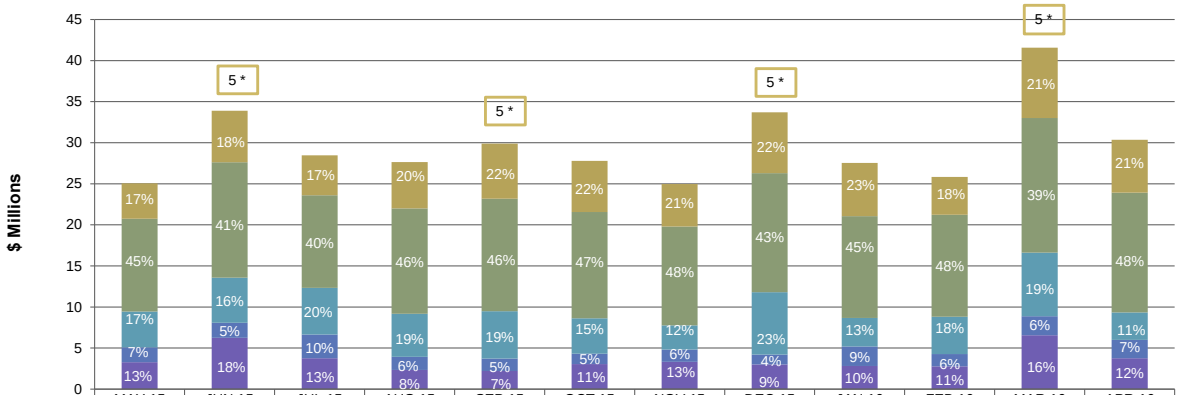
Total Expense Composition



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

GOLD COAST HEALTH PLAN
APRIL 2016

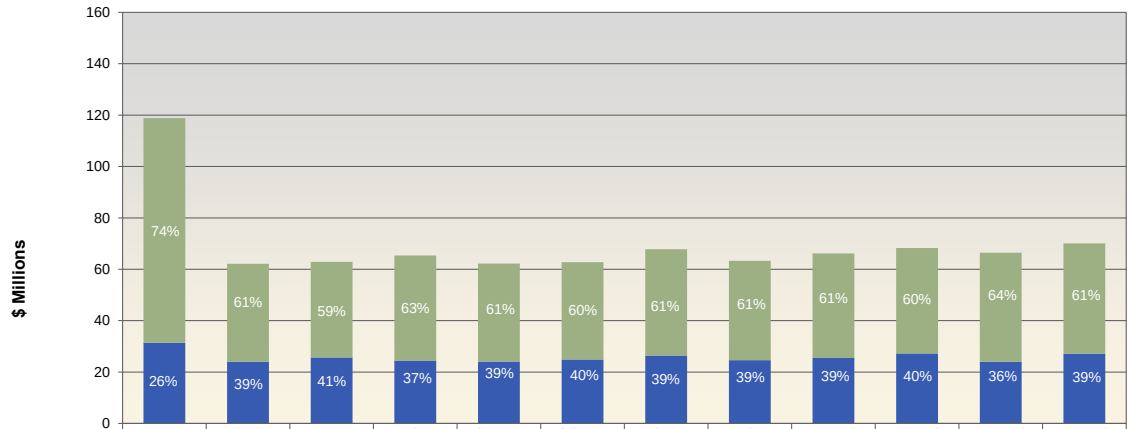
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16	APR 16
Current	4.30	6.26	4.85	5.65	6.72	6.22	5.17	7.40	6.47	4.61	8.56	6.44
30	11.31	14.05	11.29	12.83	13.70	12.95	12.05	14.50	12.40	12.40	16.40	14.57
60	4.36	5.50	5.67	5.22	5.76	4.30	2.94	7.60	3.45	4.54	7.73	3.35
90	1.81	1.81	2.89	1.61	1.51	1.26	1.50	1.20	2.38	1.50	2.33	2.23
120+	3.28	6.26	3.77	2.33	2.22	3.06	3.32	3.00	2.82	2.78	6.56	3.77

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)

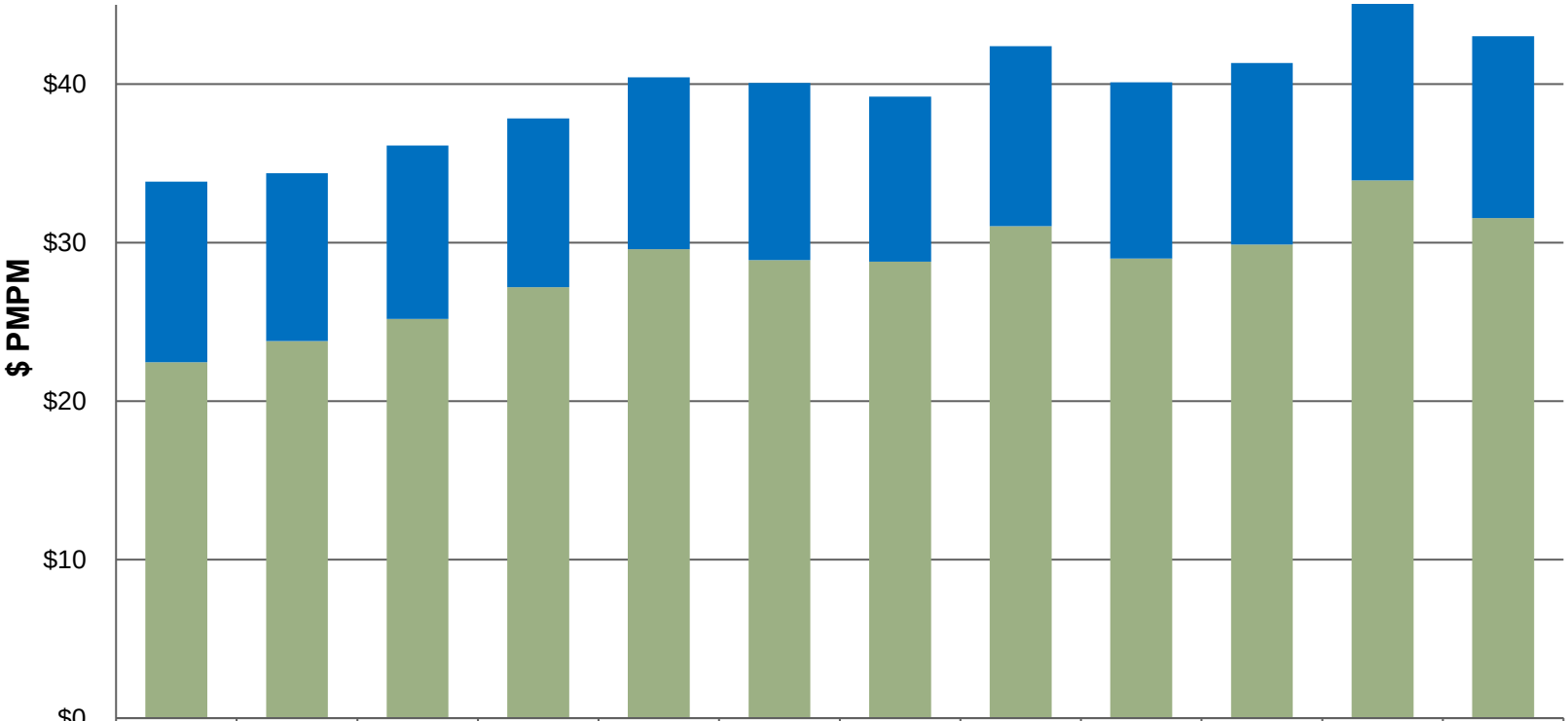


	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16	APR 16
Prior Month Unpaid	87.42	38.18	37.18	40.91	38.11	37.86	41.38	38.67	40.67	41.02	42.44	42.92
Current Month Unpaid	31.40	23.99	25.68	24.48	24.10	24.91	26.40	24.64	25.49	27.23	23.99	27.19
Total Unpaid	118.82	62.17	62.86	65.40	62.21	62.77	67.78	63.30	66.16	68.25	66.43	70.10

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.

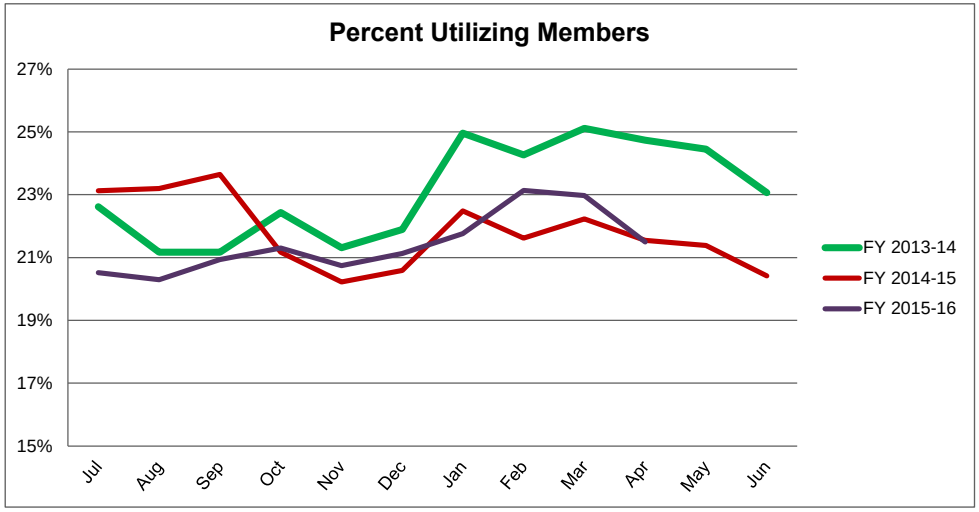
GOLD COAST HEALTH PLAN

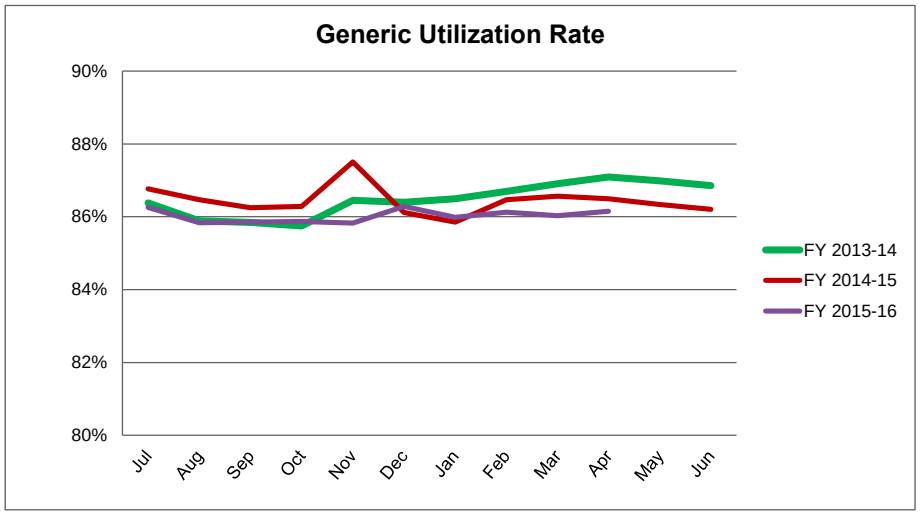
Pharmacy Cost Trend



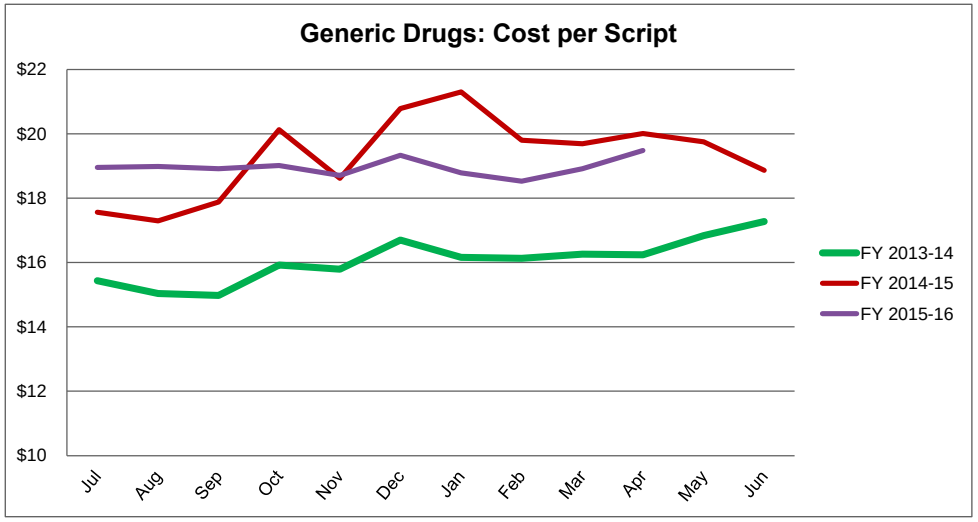
	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16	APR 16
AVG PMPM	$33.84	$34.38	$36.13	$37.84	$40.43	$40.07	$39.21	$42.39	$40.11	$41.33	$46.03	$43.01
GENERIC	$11.39	$10.60	$10.94	$10.66	$10.86	$11.17	$10.42	$11.35	$11.11	$11.45	$12.11	$11.47
BRAND	$22.45	$23.78	$25.19	$27.18	$29.58	$28.90	$28.79	$31.04	$29.00	$29.88	$33.92	$31.55

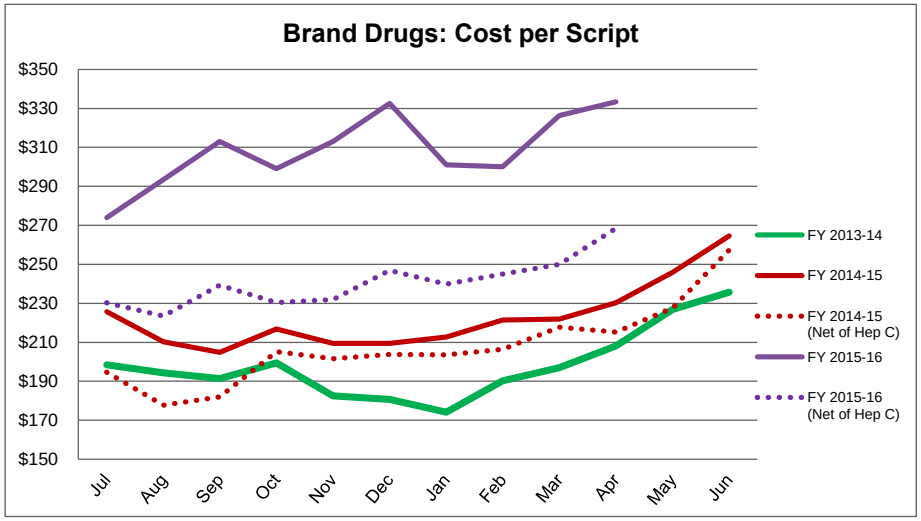
GOLD COAST HEALTH PLAN
PHARMACY ANALYSIS





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





AGENDA ITEM NO. 5

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, CEO

DATE: June 27, 2016

SUBJECT: State of California Contract Amendment A22

SUMMARY:

The State of California Department of Health Care Services (DHCS) establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A22 reflects expected changes to Gold Coast Health Plan (GCHP or Plan) capitation rates for FY2014-15.

BACKGROUND/DISCUSSION:

GCHP received a contract amendment from DHCS on May 24, 2016 which updates the Plan's FY2014-15 capitation rates for a certain Medi-Cal aid code as follows:

- The amendment adjusts the FY2014-15 rate for the second half of the fiscal year for the Adult Expansion (AE) population. The amended rate includes additional rate range funding for the county facility pursuant to Assembly Bill (AB) 85.
- The amendment also contains minor language changes related to the definitions of the Medical Loss Ratio calculation specific to the AE population.

FISCAL IMPACT:

Amendment A22 memorializes rates included in a rate package received by GCHP on December 12, 2014. The decreased capitation rates for the FY2014-15 apply to the AE population only. As the Plan had recorded revenue based on the rates in the rate package, there is no impact to the Plan's net assets. The AB85 funding included in the rates has been treated as a pass-through item and has not impacted the Plan's net assets.

RECOMMENDATION:

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendment A22.

AGENDA ITEM NO. 6

TO: Gold Coast Health Plan Commission

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

DATE: June 27, 2016

SUBJECT: Quality Improvement Committee Report

RECOMMENDATION:

To accept and file the 2016 First Quarter Quality Improvement Committee Report.

Gold Coast Health Plan℠
A Public Entity

Quality Improvement Committee Report

1st Quarter 2016

Commission Meeting 6/27/16

C. Albert Reeves, MD, CMO

Integrity
Accountability
Collaboration
Trust
Respect

HEDIS

2016 Status (March 29, 2016)

- This year's HEDIS project is well underway.
- Schedule:
  - 1st production run February 25, 2016
  - List of records for hybrid chart review (411) February 4, 2016
  - 2nd production run April 15, 2016
  - Last day for hybrid chart review May 15, 2016
  - NCQA locks results June 15, 2016
  - NCQA final certification July 15, 2016

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HEDIS

1. Diabetic Retinal Eye Exam Member Incentive – Preliminary results for HEDIS 2015 indicate that the rate will be high. This project is not carried over to 2016.

2. Cervical Cancer Screening – reminder letters – HEDIS Preliminary rates are low. Waiting for 2nd administrative run and chart review. Will review this project for effectiveness.

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HEDIS

3. Children and Adolescents Access to Primary Care Providers Member Incentive – HEDIS Based upon the 1st administrative run:

   For the W34 measure, we did not meet our goal of increasing the admin rate by 5%. For the CAP measure, we met our goal of meeting the MPL for the 12-24 age group; however this rate decreased by 1.01 percentage points. In contrast, the other three age groups in the CAP measure had improved rates, but these increased rates did not meet the MPL.

   Note: The preliminary 2015 MY rate may increase after the Admin Refresh in April 2016 that will capture any claims lags.

HEDIS

4. Postpartum Exam Member Incentive – HEDIS Based upon the 1st administrative run:

   We almost met our goal of increasing the 2015 MY postpartum care administrative HEDIS rate by at least 5%. The 2015 preliminary admin rate increased 4.17 percentage points from 50.61 for the 2014 MY to 54.78 for the 2015 MY. However, due to expected claims lags resulting from contractual arrangements that allow providers to bill for services up to 180 days after services are rendered, the preliminary rates may increase after more 2015 postpartum claims are captured in the April 2016 admin refresh.

HEDIS

5. Medication Management in People on Persistent Medications - HEDIS
   Based upon the 1st administrative run:

We were only 0.38 points from meeting our goal to increase the combined rate of medication monitoring labs at seventeen VCMC clinics by 5% from 85.48% to 90.48%, the expansion of the performance feedback reports had positive results and enabled us to identify barriers that are preventing the improvement of the MPM measure.

HEDIS

5. (Cont'd)

The increase in labs completed by non-compliant members demonstrates that this intervention helps providers identify members who are missing labs. Of the 560 noncompliant members with no labs, providers ordered labs for 42.32% (237 members) but only 28.4% (159 members) completed their labs during the three-month study period. The study shows that providers are receptive to the reports but further analysis at the clinic level will help determine which clinics were less receptive and may need additional outreach.

HEDIS

6. Reduce Inappropriate Dispensing of Antibiotics and Increase Strep-Testing for Pharyngitis – Based on preliminary 1st run rates:

II. Analysis of Rates

HEDIS Measure	Q1 2015 Rate	Q2 2015 Rate	Q3 2015 Rate	Q4 2015 Rate	Benchmark Goal	Goal Met?	2014 MY Rate	2014 - 2015 Rate Change
Appropriate Treatment for Children with Upper Respiratory Infection	94.84	94.53	95.29	94.81*	94.39	Yes	92.67	+2.14
Appropriate Testing for Children with Pharyngitis	44.62	46.94	50.34	51.20*	58.28	No	41.49	+9.71
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	21.83	24.72	30.96	26.12*	24.33	Yes	21.15	+4.97

** The preliminary 2015 MY rate may change after Admin Refresh in April 2016*

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Approvals

- QI -023 Potential Quality Issue Investigation and Resolution Policy
- Quality Improvement 2015 Work Plan Evaluation
- Quality Improvement 2016 Program Description
- Quality Improvement 2016 Work Plan

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California Performance Improvement Projects (PIP)

PIP #1 – Immunizations for Two Year Olds

Goal is to increase the rate of immunization given to 2 year olds.

Status: Working with Las Islas Clinic that has the largest number of children with the lowest rate of immunizations.

There are 5 modules total – 3 modules completed.
Training on modules 4 & 5 by HSAG in April 2016.

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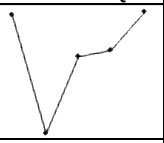
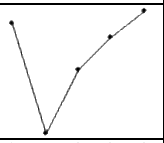
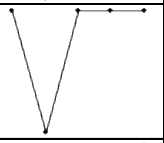
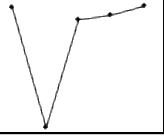
California Performance Improvement Projects (PIP)

PIP #2 – Increasing the rate of SBIRT was proposed to DHCS but was denied.

GCHP has identified that there is a low rate of developmental screening of our members.

A project to increase the rate of developmental screening was submitted to DHCS and was approved.

Quality Improvement

Quality Improvement										
Legend:										
Green = Met or exceeded Benchmark										
Red = Did not meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014***	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend 2014 - 2015 Q2**	**Interventions**
Facility Site Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS site audit criteria met.	DHCS/ Title 22	80%	**99%**	**81%**	**93%**	**94%**	**100%**		
Facility Site Audit (Medi-Cal) - Compliance	The percentage of providers that passed facility audits without or following completion of a corrective action plan.	DHCS/ Title 22	NA	**100%**	**100%**	**100%**	**100%**	**100%**		
Medical Record Quality Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS medical record audit criteria met.	DHCS/ Title 22	80%	**96%**	**72%**	**86%**	**93%**	**99%**		
Medical Record Quality Audit (Medi-Cal) - Compliance	The percentage of providers that passed medical record audits without or following completion of a corrective action plan.	DHCS/ Title 22	NA	**100%**	**50%**	**100%**	**100%**	**100%**		
Coordination of Care	The overall percentage of applicable DHCS Coordination of Care criteria met as determined by medical record audits.	NA	Tracking	**100%**	**76%**	**97%**	**98%**	**100%**		

*2014 data available for Q2, Q3, and Q4 only. No Initial or Periodic FSR's or MRR's were required during 2014 Q1

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Pharmacy and Therapeutics

P&T Committee reviews all drugs newly approved by the FDA

Newly Approved Drugs and Formulary Management

12 New Drugs or new drug combinations were reviewed

- 8 approved to be added to the formulary because they provide significant clinical advantages
- 4 drugs were denied formulary placement

2 drugs requested by providers were reviewed and added

6 Brand Name Drugs were removed due to new generics now available

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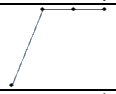
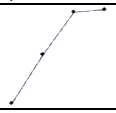
Pharmacy

Pharmacy										
Legend:										
Green = Met or Exceeded Goal										
Red = Did Not Meet Goal										
Measure	**Description**	**Responsible Department**	**Compliance Source**	**Benchmark**	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend 2015**	**Interventions**
PA Accuracy	All prior authorization requests were decided in accordance with GCHP clinical criteria.	Pharmacy	DHCS Contract	100%	97.83%	97.75%	98.50%	97.67%		Weekly meetings with the PBM to clarify criteria and expectations for the decisions. Any approvals that the plan believes should have been denied, will remain and not be overturned. Any denials that the plan believes should have been approved are overturned and the member and physician are made aware of the approval.
PA Timliness	All prior authorization requests were completed within 1 business day.	Pharmacy	DHCS Contract	100%	99.57%	100%	100%	100%		
Appropriate Decision Language on PA	All denied prior authorization requests contained appropriate and specific rationale for the denial	Pharmacy	DHCS Contract	100%	94.93%	97.50%	99.70%	99.86%		GCHP is reviewing the denial language that is sent out and making revisions to the pre-set language as needed; this is an annual exercise and will continue going forward. Existing interventions include a second review of the language for all spelling, punctuation and grammar checks.
Annual Review of all UM Criteria	The P&T committee must review all utilization management criteria at least annually.	Pharmacy	GCHP	Met	NA	NA	Met	NA		
Review of New FDA Approved Drugs	The P&T committee must review all new FDA approved drugs and/or all drugs added to the Medi-Cal FFS Contract Drug List.	Pharmacy	DHCS Contract	Met	Met	Met	Met	Met		

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Credentials/Peer Review

Monitoring of Medical Board of California (MBC) Actions against GCHP Providers

- The 2 providers on probation continue to be monitored and have been compliant

Credentialing

- 121 new providers approved – 1 to be monitored
- 8 providers recredentialed
- 7 facilities credentialed

Credentials/Peer Review

Peer Review

- 19 PQI's were submitted :
  - 14 were rated and closed, 4 are open, 1 not a PQI
  - 5 high rated cases presented to the committee
    - 1 case rated a 3 for outcome and system has been reviewed by the facility and procedures changed to prevent recurrence

Credentials/Peer Review

- 1 case identified an issue where procedures were not followed causing potential injury and increased costs – the facility has completed in-service reviews with staff to prevent a recurrence

- 2 cases of member elopement from a facility. Procedures of the facility have been reviewed and changed

- 1 case of continuity of care at a tertiary facility reviewed by the facility and continuity improved

Credentials/Peer Review

Credentials										
Legend:										
Green = Met or Exceeded Benchmark										
Red = Did Not Meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014***	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend 2014 - 2015 Q2**	**Interventions**
Access Indicators										
Monitoring of Medicare/Medicaid sanctions	An OIG query is performed on every provider at the time of intitial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%	100%	100%		
Monitoring of sanctions and limitations on licensure	An Medical Board of California (MBOC) query is performed on every provider at the time of initial and re-credentialing. Other state licensing boards are also queried as needed	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%	100%	100%		
Monitoring of Complaints	Member complaint data is considered during re-credentialing.	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	NA	NA	NA	NA	NA		
Monitoring of adverse events	Quality of Care concerns are reviewed at a minimum of every 6 months and are forwarded to Credentials/Peer Review Committee (CPRC) as indicated.	DHCS/ Title 22	Biannually	NA	100%	100%	100%	100%		
	HIPDB queries are performed within 180 days prior to the date of initial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%	100%	100%		
Timeliness of provider notification of credentialing decisions	Providers will be notified of the credentialing decision in writing within 60 days	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%	100%	100%		
Timeliness of verifications	All credentialing verifications are performed within 180 days prior to the credentialing date, as required	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	90%	100%	100%		GCHP Compliance changed the audit tool used by Credentialing from NCQA to ICE which requires audits within 180 days instead of the historical 365 days. Any historical files that were previously on a 365 day audit cycle will transistion to a 180 days audit and be caught up over the next 2 quarters.
# of provider terminations for quality issues	Credentials/Peer Review Committee (CPRC) denial of a credentialing application for quality issues will cause termination of the provider from the network	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	None for Q3 and Q4	None for Q1	None for Q2	None for Q3			

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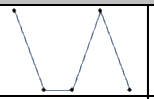
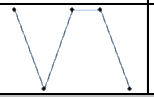
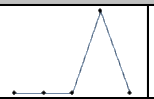
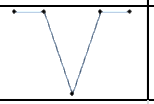
Credentials/Peer Review

Credentials										
Legend:										
Green = Met or Exceeded Benchmark										
Red = Did Not Meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014***	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend 2014 - 2015 Q2**	**Interventions**
Service Indicators										
Timeliness of processing of initial applications	Initial applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	100%	90%	90%	100%	90%		
Timeliness of processing of re-credentialing applications	Recredentialing applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	100%	90%	100%	100%	90%		
Quality Indicators (under NMC purview)										
Timeliness of Physician Recredentialing	Percent of physicians recredentialed within 36 months of the last approval date	NCQA: CR Standards	Standard met for 90% of providers	90%	90%	90%	100%	90%		
Continuous Monitoring of Allied Providers	Percent of allied providers' expirable elements that are current	NA	Standard met for 90% of elements	100%	100%	100%	100%	100%		
Timeliness of Organization Reassessment	Percent of organizations reassessed within 36 months of the last assessment	NCQA: CR Standards	Standard met for 90% of providers	100%	100%	90%	100%	100%		
*2014 data available forQ3 and Q4 only.										

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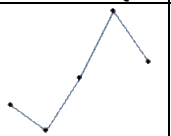
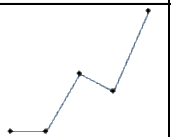
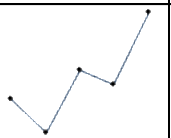
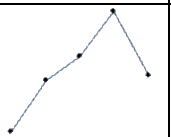
Medical Advisory

Approved Health Plan Policies

- HS-044 Intravenous Sedation and General Anesthesia for Dental Services Policy and Procedures
- Intravenous Sedation and General Anesthesia for Dental Services Guidelines
- Diabetes Clinical Guidelines 2016
- Disease Management – Future Targeted Disease Selection – Asthma possible before moving to the next type of sedation

Cultural and Linguistics

Requests for language interpreters – 2,334 in 2015 (55% increase)

Cultural & Linguistics										
Legend:										
Green = Met or Exceeded Benchmark										
Red = Did Not Meet Benchmark										
NR = **Not Reported**										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014***	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend 2014 - 2015 Q2**	**Interventions**
Cultural & linguistic requirements	Number of languages provided per the total number of languages requested through GCHP and interpretation vendors.	DHCS/Title 22	NA	**13**	**11**	**14**	**18**	**15**		
Cultural & linguistic requirements	Total number of translation requests (Excluding American Sign Language)	DHCS/Title 23	NA	**18**	**18**	**35**	**30**	**54**		
Cultural & linguistic requirements	Total number of American Sign Language interpreter requests.	DHCS/Title 24	NA	**38**	**29**	**46**	**42**	**62**		
Cultural & linguistic requirements	Total number of telephonic calls for interpreter requests.	DHCS/Title 25	NA	**309**	**497**	**580**	**748**	**509**		
*2014 data available for Q3 and Q4 only.										

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Health Education

- Diabetes Education Classes in association with clinics
- Diabetes Education Directory – classes by other organizations
- Community Health Education Workshops

Health Navigator Program

- Retinal Eye Exam Member Incentive
- Reach members with diabetes for the disease management program

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Grievance and Appeals

Grievances Received – 4th Quarter

Total Grievances – 298

- Administrative Grievances – 269
- Clinical – 29

Top 3 Reasons for Grievances: Provider Disputes, Quality of Care, and Quality of Service

Clinical Appeals – 19 cases – 9 upheld, 5 overturned, 2 withdrawn, 2 dismissed and 1 in progress

State Fair Hearings – 5 cases – 1 approved, 1 denied, 1 withdrawn, 2 dismissed

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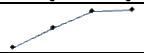
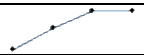
Grievance and Appeals

The Quality Workgroup reviewed a total of 56 quality issues and 20 were referred as PQI's for review.

Grievance & Appeals										
Legend:										
Green = Met or Exceeded Goal										
Red = Did Not Meet Goal										
Measure	**Description**	**Compliance Source**	**Benchmark**	**2014***	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend 2014 Q2 - 2015 Q2**	**Interventions**
Resolution Turnaround Times (TAT) Grievances	100% TAT within 30 calendar days	GCHP		81%	42%	70%	94%	97%		
Post Service TAR Provider Appeals Processing Time - Resolution	The percentage of provider appeals processed within 30 business days from receipt.	GCHP		100%	100%	100%	100%	100%		
Provider Grievances: Complaint, Appeal, or Inquiry	Timely resolution of provider grievances	GCHP		NA	16%	60%	93%	94%		
Monitoring of Complaints	Member complaints are monitored at a minimum of every six months to assess for trends/outliers	GCHP	Monitoring	NA	100%	100%	100%	100%		
*2014 data available for Q2, Q3 and Q4 only.										

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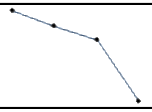
Member Services

Call Center Statistics – 4th Quarter

Member Services										
Legend: **Green = Met or Exceeded Goal** **Red = Did Not Meet Goal**										
Measure	**Description**	**Compliance Source**	**Benchmark**	**2014**	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend * 2014 - 2015 Q2**	**Interventions**
Call Center - Aggregate Average Speed of Answer (ASA)	Average Speed to Answer (in seconds)		<= 30 seconds	**11.6**	**30.7**	**9.8**	**148.4**	**41.0**		Significant staffing issues occurred again in November and continued into December, resulting in the ASA not being met in December. Corrective plan was initiated by Xerox.
Call Center - Aggregate Abandonment Rate	Percentage of aggregate Abandoned calls to Call Center		<= 5%	**0.58%**	**1.47%**	**57.00%**	**6.90%**	**1.60%**		Significant staffing issues occurred again in November and continued into December, resulting in the ASA not being met in December. Corrective plan was initiated by Xerox.
Call Center - Aggregate Call Center Call Volume	Monitored to ensure adequate staffing and identification of systemic issues.			114,678	31,393	30,369	29,563	25,714		
*Quarterly Trend for "Call Center - Aggregate Call Center Call Volumn" incorporates volumn counts for 2015 quarters only.										

- BHT Transition – Member Services Manager Aguilar reported that GCHP has been sending out the 60 and 30-day transition notices as required by DHCS.
- IVR Optimization – GCHP has reviewed the system to make it more efficient and less cumbersome for members and providers. We have submitted the request to Xerox and have targeted the end of April 2016 for the changes to be in place.
- Call Center Metrics – 4th quarter 2015 metrics for calls, average speed to answer, abandonment rate and walk-in/calls were presented.

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Network Operations

Contracts Recently Completed

- Camarillo/Oxnard Anesthesiology Medical Group
- Ventura Anesthesiology Medical Group
- Spanish Hills Surgery Center
- Channel Islands Surgery Center
- Conejo Valley Surgery Center
- Los Robles Home Health Care
- Allied Healthcare Professionals
- West Gastroenterology Medical Group
- Premier Physical Therapy and Associates
- Laurel Canyon Dialysis Center
- Children's Hospital L.A. and Medical Group

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Network Operations

Network Operation QI Dashboard - Access and Availability									
Legend:									
Green = Met or Exceeded Benchmark									
Red = Did Not Meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend 2015**	**Interventions**
Access to Network / Availability of Practitioners									
# & geographic distribution of PCPs	Network of PCPs located within 30 minutes or 10 miles of a member's residence to ensure each member has a PCP who is available and physically present at the service site for sufficient time to ensure access for assigned members upon member's request or when medically required and to personally manage the member on an on-going basis.	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	NA	NA	Met	Met		
# & geographic distribution of SCPs	Adequate numbers and types of specialists within the network through staffing, contracting, or referral to accommodate members' need for specialty care.	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	NA	NA	Met	Met		
Ratio of members to physicians	1:1200	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met	Met	Met	Met		
Ratio of members to PCPs	1:2000	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met	Met	Met	Met		
Acceptable driving times and/or distances to primary care sites	30 minutes or 10 miles of member's residence	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	NA	NA	Met	Met		

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Network Operations

Network Operation QI Dashboard - Access and Availability									
Legend:									
Green = Met or Exceeded Benchmark									
Red = Did Not Meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend 2015**	**Interventions**
Access to Network / Availability of Practitioners									
Provider Training	Number of new PCPs / Providers receiving orientation within 10 days of contracting (Note: Provider is offered an orientation within 10 days, but may be completed within 30 days, or if provider declines training, a declination req'd)	DHCS Exhibit A, Attachment 7	100% within 10 days of contracting	Met	Met	Met	Met		

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Health Services
Utilization Management Committee

Approval of:

- 2016 UM Work Plan
- 2016 UM Program Description
- 2016 Care Management (CM) Program Description
- Home Health Guideline – reapproved
- IV Sedation and General Anesthesia for Dental Services Adopted
- Zostavax Guideline – retired
- 2015 UM Work Plan Evaluation
- 2015 CM Work Plan Evaluation

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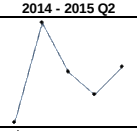
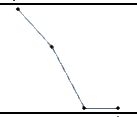
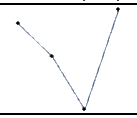
Health Services
Utilization Management Committee

Utilization Management											
Legend:											
Green = Met or Exceeded Benchmark											
Red = Did Not Meet Benchmark											
Health Services											
UM Authorization Processing Time											
Measure	**Description**	**Responsible Department**	**Benchmark Source**	**Benchmark**	**2014***	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend 2014 - 2015 Q2**	**Interventions**
Turn around time for standard prior authorization	Percentage of requests processed ≤ 5 working days from receipt of information necessary to make the determination.	Health Services	NCQA; contract, Title 22	95%	96%	100%	98%	97%	98%		
Turn around time for expedited prior authorization	Percentage of authorizations processed within 3 days of receiving the request	Health Services	NCQA; contract, Title 22	95%	NR	100%	99%	98%	98%		
Turn around time for post service	Percentage of decisions made within 30 calendar days of receipt of request (NCQA, contract, Title 22)	Health Services	NCQA; contract, Title 22	95%	NR	98%	97%	95%	98%		
*2014 data available for Q3 and Q4 only.											

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Compliance
Delegation Oversight

Delegation Oversight : *Assessment of Delegated Quality Activities*										
Legend:										
Green = Met or Exceeded Benchmark										
Red = Did Not Meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014**	**2015 Q1**	**2015 Q2**	**2015 Q3**	**2015 Q4**	**Quarterly Trend 2014 - 2015 Q2**	**Interventions**
Delegation of UM	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 5; NCQA Standard UM 15	DHCS Contract	100%[1]	NA	100%	NA	100%		
Delegation of CR	Number required & percentage of current delegates assessed	Exhibit A, Attachment 4; NCQA Standard CR 9	DHCS Contract 10-87128	100%[2]	100%	100%	NA	NA		
Delegation of QI	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard QI 12	DHCS Contract	100%[3]	NA	NA	NA	100%		
Delegation of RR	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard RR 7	DHCS Contract	100%[4]	NA	NA	NA	100%		
Delegation of Claims	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 8	DHCS Contract	100%[5]	100%	100%	100%	100%		

[1]2014 data available for Q2 and Q3 only.
[2]2014 data available for Q1 only.
[3]2014 data available for Q3 and Q4 only.
[4]2014 data available for Q2, Q3 and Q4 only.

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AGENDA ITEM NO. 7

TO: Gold Coast Health Plan Commission

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

DATE: June 27, 2016

SUBJECT: Pay-for-Performance Program to Improve Children's Access to Care

SUMMARY:

As part of Gold Coast Health Plan's ARCH Program, the Plan seeks to improve children's access to care as measured in the 2016 Healthcare Effectiveness Data and Information Set (HEDIS) Measure for access for children by offering to providers caring for children a pay-for-performance program to develop strategies to improve access to care for children.

BACKGROUND:

Gold Coast Health Plan has failed to meet the Department of Health Care Services requirement to reach the 25th percentile for the children's access to care HEDIS Measure three (3) years in a row. The Plan attempted by various means to improve the score and access by offering a member incentive and by providing providers with the names of members not seen in the first half of the year. The scores have improved but the scores have not reached the required 25th percentile. The Plan is proposing to improve access with a pay-for-performance program to incentivize providers to institute programs to increase visits by children.

DISCUSSION:

The Plan will budget 1.4 million dollars for this pay-for-performance program. The amount made available to any group or provider will be roughly related to the ratio of eligible children assigned to that group or provider. One-third of the monies available will be paid to the group or provider when the group or provider has submitted an acceptable proposal for their program to improve access. Examples of strategies that would be considered would be:

- Expanded office hours to evenings or weekends
- Adding providers who care for children
- Outreach to their assigned members who have been identified as not being seen in the year and making appointments for them
- Improving the provider's encounter data submitted to the Plan

To be eligible for the pay-for-performance component of this program, the group or provider must submit a progress report to the plan on September 30, 2016, and December 31, 2016, which shows that their proposed strategies have been instituted.

The group or provider will receive a defined monetary payment if they achieve a 5%, 7.5% or 10% improvement in their access for children for the 2016 measurement year as reported on the National Committee for Quality Assurance Certified result released on July 15, 2017. If all groups and providers develop an acceptable program and achieve a 10% improvement in the HEDIS Score the Plan will score well above the 25th percentile and the entire 1.4 million dollars will be paid. If any of the groups or providers do not participate or achieve the maximum results the monies not paid will return to the Plan's Alternative Resources for Community Health Program Fund.

RECOMMENDATION:

The Plan recommends the Commission approve the Children's Access to Care Pay-for-Performance Program.

AGENDA ITEM NO. 8

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, Chief Executive Officer (CEO)

DATE: June 27, 2016

SUBJECT: Chief Executive Officer Update

MEDICAID MANAGED CARE FINAL RULE "MEGA RULE"

The Medicaid Managed Care rule takes effect on July 5, 2016. Many of the provisions that take effect next month were unchanged from the 2002 rule. Examples include enrollee rights, capitation payments made to managed care plans, and actuarial soundness. Managed care plans are expected to remain compliant with the 2002 regulations until the implementation dates of the specified rule take effect. Major provisions of the rule take effect in one to three years.

Provisions Effective July 1, 2017

Delivery System Reform: Pass-Through Payments to Providers

- Limits the ability of states to make supplemental payments via health plans.
- The health plans cannot be tied to providing Intergovernmental Payments; payments made by the plans must be based on utilization, delivery of services, and performance/quality.
- The "Mega Rule" provides a ten year transition period for hospital supplemental payments and a five year transition for physician and nursing facility supplemental payments.

Grievance & Appeals

- The grievance and appeals requirements were revised in the final rule to align with Medicare Advantage and Quality Health Plan standards.
- Members are required to complete one level of internal appeal at the plan before moving to the State Fair Hearing process. If a plan fails to comply with appeal timeframes the member can file for a State Fair Hearing.
- Benefits must continue for the duration of the appeal and State Fair Hearing process.

Program Integrity

- Plans are required to suspend payment to a network provider when the state determines a credible allegation of fraud exists.

Care Coordination Activities

- Broadens care coordination to include all care (not just primary care).
- Managed care organization services must be coordinated with services from community and social support providers.

Recordkeeping

- Sets a 10 year standard record retention schedule and requirements for plans and their subcontractors.
- Records must be kept of member grievance and appeal records, Medical Loss Ratio (MLR) reports, and monitoring and program integrity documentation.

Provisions Effective July 1, 2018

Actuarial Soundness & Rate Development

- Rate ranges are no longer permissible and actuaries are required to certify each rate cell.
- However, the Centers for Medicare and Medicaid Services (CMS) provides states with a 1.5% flexibility to move rates above or below the certified rate cell without having to obtain CMS approval for the new rate cell.

Network Adequacy

- States are required to develop time and distance standards for the following specialists
    - Primary Care
    - Specialty Care
    - Behavioral Health (mental health and Substance Use Disorder (SUD) for both adult and pediatric)
    - Hospitals
    - Pharmacy Services
- States must take telemedicine into consideration for setting time and distance standards.
- Plans are required to certify their provider networks annually.

Beneficiary Support System

- States must develop and implement a beneficiary support system for beneficiaries both prior to and after enrollment in a plan.
- The support system must be accessible via phone, internet, and in-person as well as via auxiliary aids and services when requested.

Quality Rating System (QRS)

- CMS will establish a common framework for all states contracting with Managed Care Organizations (MCOs) to use in implementing a quality rating system.
- The system must align with the Marketplace QRS.
- CMS will conduct a public engagement process to develop a proposed QRS framework and methodology.
- Publication of the proposed QRS in the Federal Register with opportunity to comment, followed by notice of the final Medicaid and Children's Health Insurance Program (CHIP) QRS expected in 2018.
- States will have flexibility to adopt an alternative QRS with CMS approval.
- States will have three years to implement a QRS following final notice in the Federal Register

Provisions Effective July 1, 2019

Medical Loss Ratio (MLR) Requirement

- Actuarially-sound rates must be set to allow plans to reach 85% MLR.

The Department of Health Care Services (DHCS) is currently analyzing the impact the "Mega Rule" will have in California. The DHCS analysis will be released sometime this summer. The Government Relations team will provide the Commission with updates as necessary.

CALIFORNIA LEGISLATIVE UPDATE

State Budget

On Wednesday, June 15th, the Legislature approved the state budget; Governor Brown must approve the budget before July 1, 2016 when the new fiscal year begins. It is likely the Governor will not line veto any items in the budget, since many items were highly negotiated between the Legislature and the Governor before being approved by the Legislature. The budget totals $122.5 billion and makes a $2 billion deposit into the Proposition 2 Rainy Day Fund bringing the total reserve to $8.4 billion.

The following are approved budget items relevant to Medi-Cal:

- **Restoration of Acupuncture as a Medi-Cal benefit**: $3.7 million General Fund (GF) in the first year $4.4 million ongoing GF. Benefit restoration begins on July 1, 2016.
- **Funding for Medi-Cal Interpreters:** Provides $3 million for one-time support of multi-county pilot program, including a study, on the availability and reimbursement of certified in-person language interpreters for Medi-Cal beneficiaries. The funding is contingent upon enactment of legislation that establishes the pilot program.
- **1115 Waiver:** Approves $10.8 million ($5.4 million GF) to support implementation of the new waiver.
- **Health Homes:** Provides $1 million (federal and special funds) for three years to implement the Health Homes Program.
- **Estate Recovery:** Limits estate recovery under Medi-Cal to those services required to be collected under federal law.
    - Limits the definition “estate” to include only the real and personal property and other assets required to be collected by federal law.
    - Prohibits recovery from the estate of a deceased Medi-Cal member who is survived by spouse or registered domestic partner.
    - Budget year costs are $5.7 million GF; $28.9 million GF in out years.

Legislative Bills Update

Friday, June 3rd, was the last day for each house to pass bills introduced in their house of origin. The table below provides a summary of the legislative bills that can potentially impact Gold Coast Health Plan. These legislative bills are waiting to be heard in their respective committee.

Gold Coast Health Plan's Priority Tracking Legislative Bills Table
June 2016

Bill # & Subject	Description	Location & Notes
	Autism	
SB 1034 (Mitchell) Health Care Coverage: Autism	SB 1034 would require that a treatment plan be reviewed no more than once every 6 months, unless a shorter period is recommended by the qualified autism service provider. Prohibits lack of parent or caregiver participation from being used to deny or reduce medically necessary behavioral health treatment. Prohibits the setting, location or time of the treatment from being used as a reason to deny treatment. Prohibits this provision from being construed to require coverage for services that are included in a member's individualized education program.	• Referred to Assembly Committee on Health
	Mandates	
AB 1763 (Gipson) Health Care Coverage: Colorectal Cancer Screening	Requires coverage of new screenings and diagnostics with three levels of screenings: standard, high risk and over 50.	• Referred to Senate Committee on Health •
AB 1831 (Low) Health Care Coverage: Prescription Drugs: Refills	Requires ophthalmic product refills at 70% of the predicted days use.	• Referred to Senate Committee on Health
AB 2507 (Gordon) Telehealth: Access	Adds video communications, telephone communications, email communications, and synchronous text or chat conferencing to the definition of telehealth, and allows required prior consent for telehealth services to be digital as well as oral or written.	• Held in Assembly Appropriations Committee
SB 999 (Pavley) Contraceptives: Annual Supply	Requires plans on or after January 1, 2017, to cover, and authorizes pharmacists to dispense, 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.	• Referred to Assembly Committee on Business and Professions

Reproductive Health		
SB 960 (Hernandez, Leno and McGuire) Medi-Cal: Telehealth: Reproductive Health Care	SB 960 would expand access to reproductive services by requiring Medi-Cal reimbursement for those services delivered through telehealth.	• Held in the Senate Appropriations Committee
Health Plan Regulations		
SB 1135 (Monning) Notice of Timely Access to Care	Requires health plans, including Medi-Cal managed care plans to notify enrollees and contracted providers about information on timely access to care standards and information on timely access to care standards and interpreter services, at least annually.	• Referred to Assembly Committee on Health
Provider Issues/Networks		
AB 2372 (Burke) Health Care Coverage: HIV Specialists	Allows for an enrollee to choose a specialist physician, including an AIDS specialist, as their PCP	• Held in the Assembly Appropriations Committee
Medi-Cal/Public Programs		
AB 1696 (Holden) Tobacco Cessation	Requires that tobacco cessation services to include the following: a minimum of four quit attempts per year, at least four tobacco cessation counseling sessions per quit attempt, and 12 week treatment regimen of any medication approved by the FDA.	• Referred to Senate Committee on Health
AB 1795 (Atkins) Health Care Programs: Cancer	Extends coverage for breast and cervical cancer for low-income uninsured or underinsured individuals to include individuals of any age who are symptomatic and age 40 and older, and removes the timeframe of 24 months to "as meets eligibility requirements."	• Referred to Senate Committee on Health
AB 2084 (Wood with co-author Senator Stone) Comprehensive Medication Management	Establishes a comprehensive medication management (CCM) program as a covered benefit in the Medi-Cal program.	• Held in the Assembly Appropriations Committee
AB 2207 (Wood) Medi-Cal Dental Program	Requires Medi-Cal managed care plans to provide dental health screenings for eligible beneficiaries and refer them to appropriate Medi-Cal dental providers.	• Referred to Senate Committee on Health
AB 2394 (Garcia, Eduardo) Medi-Cal: nonmedical transportation	SB 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.	• Referred to Senate Committee on Heath

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. GCHP anticipates the final report and or CAP being issued in July/August 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.

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 staff conducted a six month claims follow up audit on GCHP vision service provider and mental health behavioral organization (MBHO). The onsite audits occurred during the second and third week of May 2016. Both audits identified deficiencies and corrective action plans were issued.

Commissioners will receive an email from GCHP compliance department, which will include training login information for HIPAA and Fraud, Waste and Abuse (FWA). Commissioners may have a requirement from their employers to complete HIPAA and FWA trainings; however the training required from GCHP is tailored to managed care. Commissioners will also receive GCHP's code of conduct, with a request for attestation via signature. Compliance staff is available for any questions commissioners may have on the trainings.

The compliance dashboard is attached for reference and includes information on but is not limited to: staff trainings, fraud referrals, HIPAA breaches, delegate audits.

COMPLIANCE REPORT 2016

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
Hotline A confidential telephone and web-based process to collect info on compliance, ethics, and FWA	Referrals *one referral can be sent to multiple referral agencies*	9	4	10	6	6								35
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0	0	0	0	0								0
Hotline Referral *FWA	Department of Justice	0	0	0	0	0								0
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	9	4	7	5	6								31
Hotline Referral	External Agency (i.e. HSA)	0	0	0	0	0								0
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	0	0	3	1	0								4
Delegation Oversight	Delegated Entities	8	8	8	8	8								40
The committee's function is to ensure that delegated activities of subcontracted entities are in compliance with standards set forth from GCHP contract with DHCS and all applicable regulations	Reporting Requirements Reviewed **	62	64	54	86	59								325
	Audits conducted	4	0	1	0	2								7
Delegation Oversight	Letters of Non-Compliance	0	0	1	0	0								1
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	2	0	0	0	0								2
Audits	Total	0	1	0	1	0								2
External regulatory entities evaluate GCHP compliance with contractual obligations.	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	0	0	0	0	0								0
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0	0	0	0	0								0
	HEDIS Compliance Audit (HSAG)	0	1	0	0	0								1
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2012*	0	0	0	0	0								0
	DHCS Medical Audit	0	0	0	1	0								1
Fraud, Waste & Abuse	Total Investigations	9	4	10	6	6								35
The Fraud Waste and Abuse Prevention process is intended to prevent, detect, investigate, report and resolve suspected and /or actual FWA in GCHP daily operations and interactions, whether internal or external.	Investigations of Providers	0	0	0	1	1								2
	Investigations of Members	9	4	10	5	5								33
	Investigations of Other Entities	0	0	0	0	0								0
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0	0	0	0	0								0

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
HIPAA	Referrals	1	4	2	3	0								10
Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	State Notification	1	4	2	3	0								10
	Federal Notification	0	4	0	0	0								4
	Member Notification	0	0	0	1	0								1
	HIPAA Internal Audits Conducted	0	1	0	0	0								1
						***								
Training	**Training Sessions**	20	15	27	12	49								123
Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Fraud, Waste & Abuse Prevention (Individual Training)	6	3	7	2	21								39
	Fraud, Waste & Abuse Prevention (Member Orientations)	6	6	6	6	6								30
	Code of Conduct	2	3	7	2	1								15
	HIPAA (Individual Training)	6	3	7	2	21								39
	HIPAA (Department Training)	0	0	0	0	0								0

** Reporting Requirements are defined by functions delegated and contract terms. Revised contracts, amendments or new requirements form DHCS may require additional requirements from subcontractors as a result the number is fluid

** Audits- Please note multiple audits have been conducted on the Plan, however many occurred in 2012 and 2013 and will be visible on the annual comparison dashboard

** This report is intended to provide a high level overview of certain components of the compliance department and does not include/reflect functions the department is responsible for on a daily basis.

***Training Sessions: 1 new employee, along with 20 yearly training.

PRESS UPDATE

Medi-Cal plan’s funding effort targets the homeless, shut-ins, opioid abusers

By Tom Kisken of the Ventura County Star

Dan Levine's health relies not only on doctor's visits and medications but also on meals of meat loaf, mashed potatoes, carrots and peas.

The braces on both legs make it difficult for the 72-year-old survivor of bone marrow cancer to go grocery shopping. Buying food is limited too by a budget that leans on Social Security. Every two weeks, the former real estate agent from Ventura receives 10 frozen meals along with bread, milk, snap peas, salads and other essentials. The food comes through a meal delivery service that received $20,000 from a new Gold Coast Health Plan program invented to broaden health care.

Levine parcels out the chicken, beef and fish meals, along with the occasional $5 meal he buys from Kentucky Fried Chicken, to last two weeks until another delivery arrives.

"It bridges the gap between being hungry and trying to figure out if I have enough money from Social Security to buy some food," he said.

The Gold Coast Health Plan, launched five years ago, provides Medi-Cal insurance to more than 200,000 low-income Ventura County residents. Once immersed in red, the publicly-funded plan has built reserves that allow it to spend about two cents from every dollar of revenue on a new program called Alternative Resources for Community Health. That adds up to $12.1 million.

The spending program orbits around finding different ways to help people's health. One involves tackling addiction. About $51,000 of ARCH's $12.1 million budget will be spent on kits that include nasal spray or syringes of the medication naloxone. It is used to help people breathe and reverse potentially fatal overdoses caused by opioids ranging from heroin to painkillers like Percocet. Ventura County Behavioral Health Department leaders say their pilot program involving naloxone has brought proof of 32 overdoses that were reversed. They say the money from ARCH will bring 1,000 more naloxone kits.

"There is a crisis in this country of opioid use. We're not immune that," said Dr. C. Albert Reeves, chief medical officer for the Gold Coast Health Plan. In Ventura County, 85 deaths in 2014 were linked to opiate overdose.

"If we can save some lives from overdoses, that money is well spent," he said.

Saving in the long term by spending now is the heartbeat of ARCH. Much of the $12 million will be spent on incentives to doctors and others. Still being formulated, the money will link financial rewards not to the number of services provided but to health outcomes.

"The goal is to provide better care at less cost," Reeves said.

Time to recuperate

Homeless people on Medi-Cal have nowhere to go when they're discharged from a hospital. They end up back on the streets, don't fully recuperate and often land back in an emergency room. Or they never leave the hospital.

"We have members that are filling hospital beds that we are paying for ... because they don't have a place to go," Reeves said.

Some believe the answer is more time to recover. The nonprofit National Health Foundation is working on the launch of a program where hospitals would discharge homeless people to a recuperative care program based at Salvation Army in Ventura. The $600,000 program still needs final approval from the Ventura County Board of Supervisors but, as planned, would be funded by hospitals across Ventura County. ARCH has committed to providing $38,700 in startup costs.

"We're hoping for it to open in the fall," said Kelly Bruno, CEO of the National Health Foundation.

The $20,000 from ARCH for meals delivered to people like Dan Levine goes through the Ventura County Area Agency on Aging. In Ventura and Oxnard, meals are delivered by FOOD Share. The money is a small piece of the program's funding but it allows for 3,000 more meals, meaning a maxed-out program can expand.

If they're like Levine, they learn to budget the meals. He's a Mormon who plans on offering oranges from trees at his home to FOOD Share, envisioning the fruit delivered to shut-ins.

"We have to help each other," Levine said, trying to explain how he's aided by meals delivered twice a month.

"It's enough to sustain me," he said.

AGENDA ITEM NO. 9

TO: Gold Coast Health Plan Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: June 27, 2016

SUBJECT: COO Update

OPERATIONS UPDATE

Membership Update – June 2016

Gold Coast Health Plan (GCHP) had a net increase of 2,301 members this month. GCHP's membership as of June 1, 2016 is 206,920 and includes SB 75 Transition Population children (please refer to SB 75 Update below for additional details). GCHP's membership has increased by 88,408 (74.6%) 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)	1,349
M1 – Adult Expansion	53,864
7U – CalFresh Adults	1,703
7W – CalFresh Children	386
7S – Parents of 7Ws	424
Traditional Medi-Cal	30,682
Total New Membership 1/1/14 – 6/1/16	88,408

Adult Expansion members (aid code M1) represent 60.9% of GCHP's new membership since the start of Medi-Cal Expansion.

	L1	M1	7U	7W	7S
Jun 16	1,349	53,864	1,703	386	424
May 16	1,407	52,898	1,820	433	478
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 – 32,048 Adult Expansion members have been assigned to VCMC as of June 2016. VCMC's target enrollment is 65,765 and is currently at 48.7% of the enrollment target.

April 2016 Operations Summary

The **Claims Inventory** at the end of April was 19,562; this equates to a Days Receipt on Hand (DROH) of 2.5 days compared to a DROH maximum goal of 5 days. GCHP received approximately 7,700 claims per day in April. Monthly claim receipts from May 2015 through April 2016 are as follows:

Month	Total Claims Received	Receipts per Day
April 2016	162,287	7,728
March 2016	193,881	8,429
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

The **Claims Turnaround Time (TAT)** for April was 99.6% vs the regulatory requirement of processing 90% of clean claims within 30 calendar days. The **Financial Claims Processing Accuracy** for April was 99.74% vs a goal of ≥ 98% and the **Procedural Claims Processing Accuracy** was 99.99% vs a goal of ≥ 97%.

The **Call Volume** for April dropped below the 10,000 call threshold during the month. The number of calls received in April was 9,869. The 12-month average ending April 30th was 9,529 calls per month. The combined (Member, Provider and Spanish lines) **Average Speed to Answer (ASA)** for April was 3.0 seconds vs the SLA goal of ≤ 30 seconds. The combined **Abandonment Rate** was 0.20% vs the SLA goal of ≤ 5%. The combined **Average Call Length** increased slightly to 7.63 minutes from the prior month. This **Call Center Phone Quality** for April was 93.0% versus a goal of 95% or higher. The results continue to be driven by new hires where additional training is needed.

The **Grievance and Appeals** team received 12 member grievances and 81 provider claim payment grievances during April. The 12 member grievances equate to 0.06 grievances per 1,000 members.

Type of Member Grievances	Number of Grievances
Benefits/Coverage	3
Quality of Care	3
Quality of Service	3
Denials/Refusals	2
Eligibility	1
Total Member Grievances	**12**

There was one clinical appeal in April which was overturned. There were no State Fair Hearing cases in April.

SB 75 – Full Scope Medi-Cal for All Children
DHCS previously informed GCHP that Ventura County had a total of 2,917 children who were in restricted scope that would be eligible for full scope Medi-Cal as of May 1, 2016 and would transition to GCHP as of June 1, 2016.

Upon receipt of the June 834 eligibility file, GCHP performed an analysis of the file by comparing it to the data provided to us by DHCS. Of the 2,917 potential new members, 2,149 children or approximately 74%, transitioned to GCHP on June 1, 2016. The following is a breakdown of the analysis:

New members as of 6/1/16 - 2,149
No Status - 672 (included in the 834 file but had no status so unable to load them into Ika)
Not Included - 64 (not included in the 834 file at all)
On-going - 28 (already GCHP members)
On-going w/SOC - 2 (not eligible with GCHP until Share of Cost is satisfied)
On Hold - 2 (DHCS or Ventura County has placed the eligibility determination on hold)

The primary focus is on the 672 children that were included in the 834 file but have no status. GCHP reached out to DHCS for information regarding the "No Status" as well as the "Not Included" members. DHCS has advised all health plans that approximately 80% of the children in restricted scope transitioned on June 1, 2016 and anticipates that the remainder should transition on July 1, 2016.

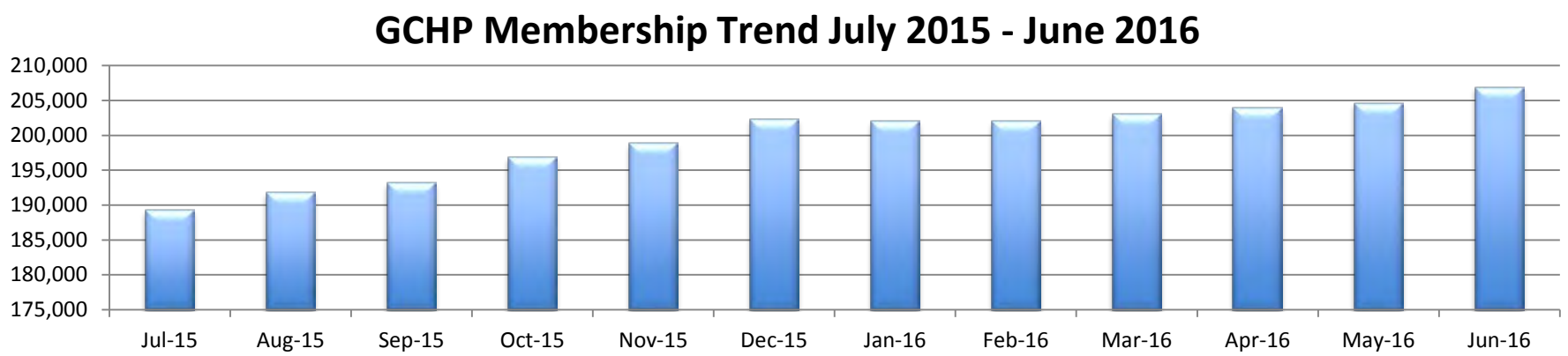
Member Orientation Meetings
A total of 49 members (42 English, 7 Spanish) have attended Member Orientation meetings from January through May 2016. Of the 49 members, 31 indicated they learned about the meeting as a result of the informational flyer included in each new member packet.

Administrative Services Organization (ASO) Evaluation
GCHP is evaluating the Vendor Assessment Report and Total Cost of Ownership (TCO) Summary prepared by Optimity and presented to staff on May 13, 2016. The TCO analysis focused on three functions to consider for insourcing – the call center, claims processing and encounter data processing. These three areas provide the greatest opportunity in terms of key differentiating capabilities as it relates to performance and how we are viewed by our members and providers. Senior Leadership will be reviewing recommendations at the upcoming Strategic Planning Session.

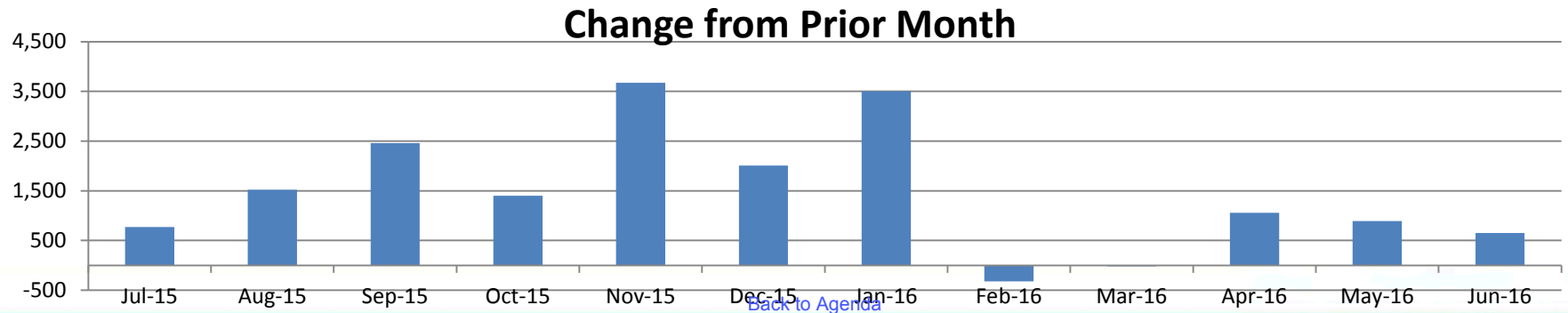
GCHP Membership

Total Membership as of June 1, 2016 – 206,920

*New Members Added Since January 2014 – 88,408

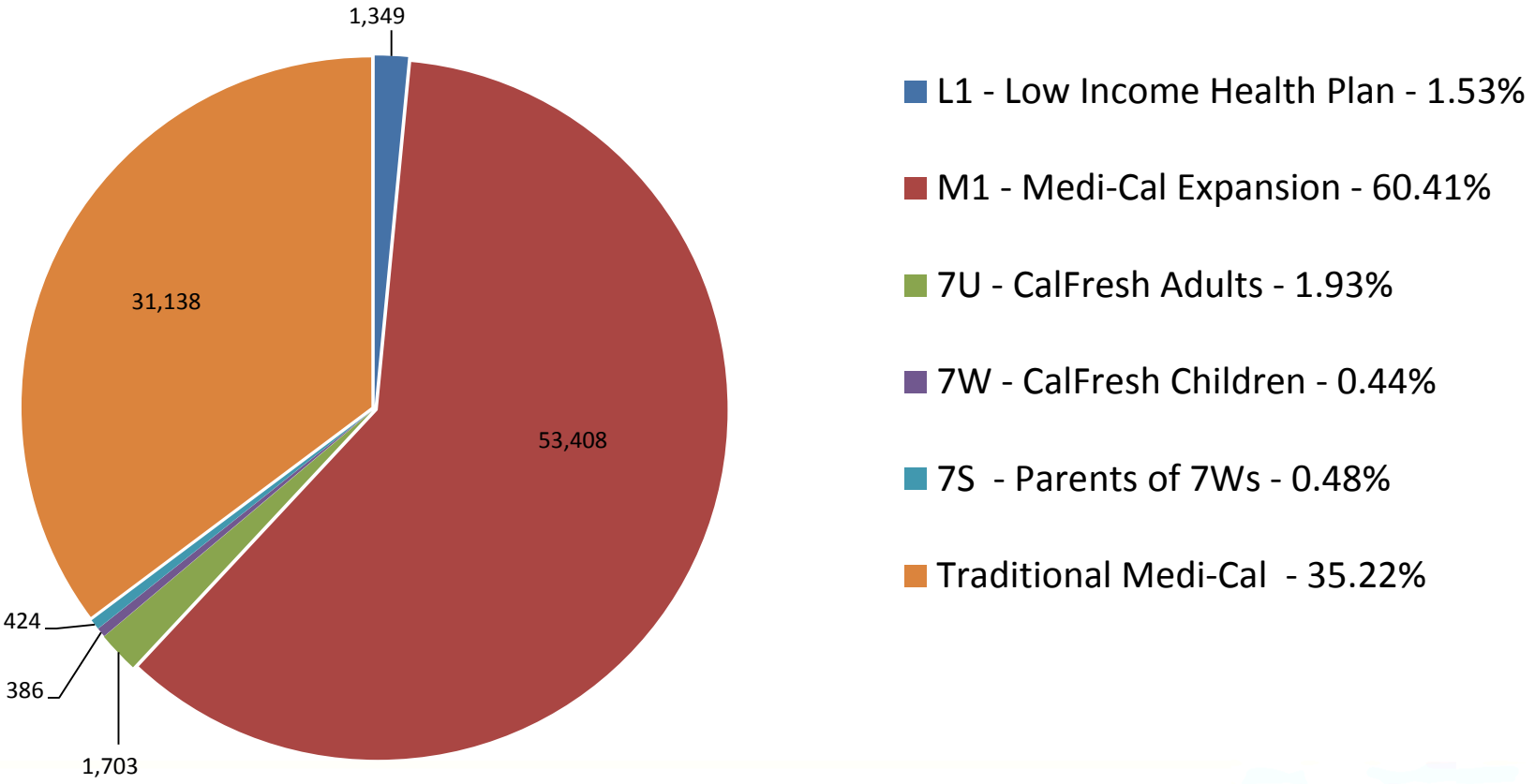


	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Active Membership	189,321	191,783	193,195	196,857	198,863	202,362	202,037	202,019	203,075	203,969	204,619	206,920



Membership Growth

GCHP New Membership Breakdown



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	May-16	Jun-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	203,969	204,619
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	5,642	5,584
Sub-total	182,449	184,873	186,503	189,814	192,716	195,627	195,456	195,898	195,941	197,352	198,327	199,035
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%	2.77%	2.73%
Current Month New Members	5,068	5,241	5,383	5,503	5,015	5,454	5,794	4,215	5,059	4,742	4,368	6,316
Sub-total	187,517	190,114	191,886	195,317	197,731	201,081	201,250	200,113	201,000	202,094	202,695	205,351
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%	2.13%	3.05%
Retroactive Member Additions	1,804	1,669	1,299	1,540	1,132	1,281	787	1,906	2,075	1,875	1,924	1,569
Active Current Month Membership	**189,321**	**191,783**	**193,185**	**196,857**	**198,863**	**202,362**	**202,037**	**202,019**	**203,075**	**203,969**	**204,619**	**206,920**
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%	0.94%	0.76%

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

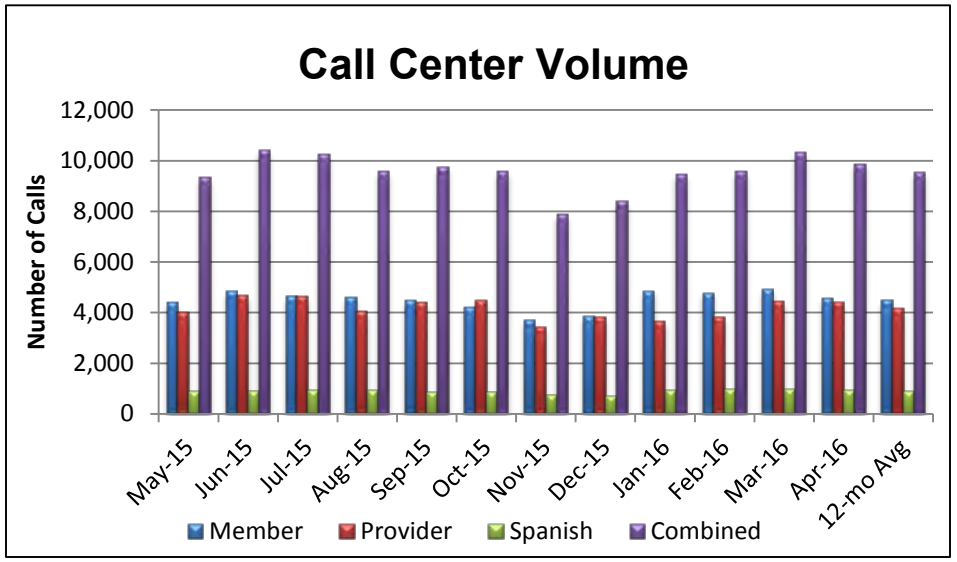
	Jun-16		May-16		Apr-16		Mar-16		Feb-16		Jan-16	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
AB85 Eligible	**1,075**		**1,329**		**1,807**		**1,188**		**1,591**		**1,292**	
VCMC	806	74.98%	996	74.94%	1,355	74.99%	891	75.00%	1,193	74.98%	969	75.00%
Balance	269	25.02%	333	25.06%	452	25.01%	297	25.00%	398	25.02%	323	25.00%
Regular Eligible	**815**		**1,317**		**1,335**		**1,076**		**1,250**		**944**	
Regular + AB85 Balance	**1,084**		**1,650**		**1,787**		**1,373**		**1,648**		**1,267**	
Clinicas	237	21.86%	396	24.00%	426	23.84%	272	19.81%	305	18.51%	251	19.81%
CMH	128	11.81%	171	10.36%	217	12.14%	165	12.02%	193	11.71%	144	11.37%
Independent	38	3.51%	52	3.15%	33	1.85%	23	1.68%	34	2.06%	23	1.82%
VCMC	681	62.82%	1,031	62.48%	1,111	62.17%	913	66.50%	1,116	67.72%	849	67.01%
Total Assigned	**1,890**		**2,646**		**3,142**		**2,264**		**2,841**		**2,236**	
Clinicas	237	12.54%	396	14.97%	426	13.56%	272	12.01%	305	10.74%	251	11.23%
CMH	128	6.77%	171	6.46%	217	6.91%	165	7.29%	193	6.79%	144	6.44%
Independent	38	2.01%	52	1.97%	33	1.05%	23	1.02%	34	1.20%	23	1.03%
VCMC	1,487	78.68%	2,027	76.61%	2,466	78.49%	1,804	79.68%	2,309	81.27%	1,818	81.31%

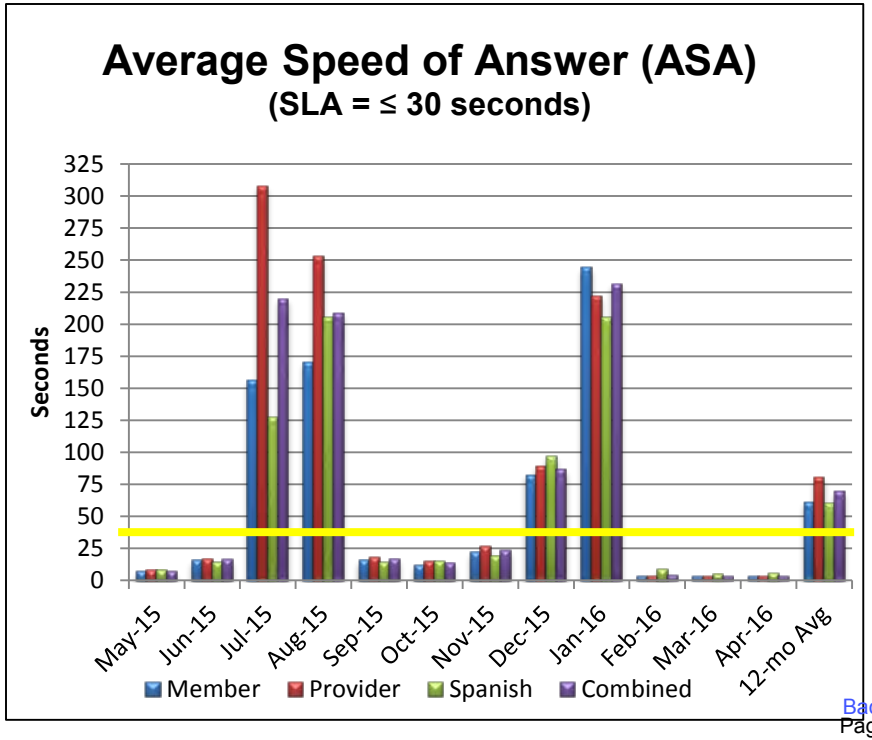
Auto Assignment Process

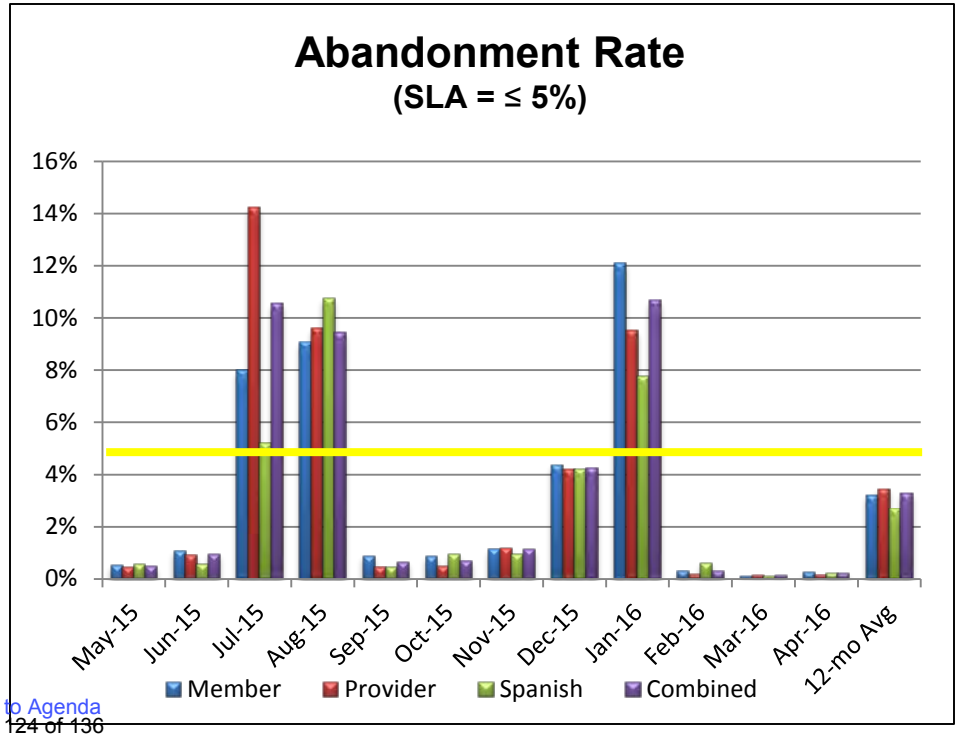
- 75% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85
- The remaining 25% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others
- The County's 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 32,048 assigned Adult Expansion members as of June 1, 2016 and is currently at 48.7% of capacity

GCHP Call Center Metrics – April 2016

- Call volume dropped below 10,000 during the month; GCHP received 9,869 calls during April
- Service Level Agreements (SLA) for ASA (3 seconds vs the goal of ≤ 30 seconds) and Abandonment Rate (0.20% vs the goal of ≤ 5%) were both met for April

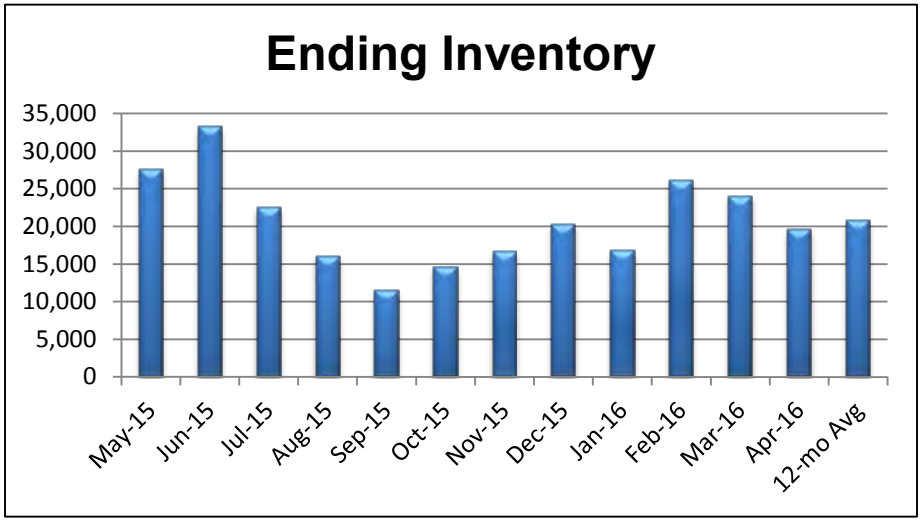


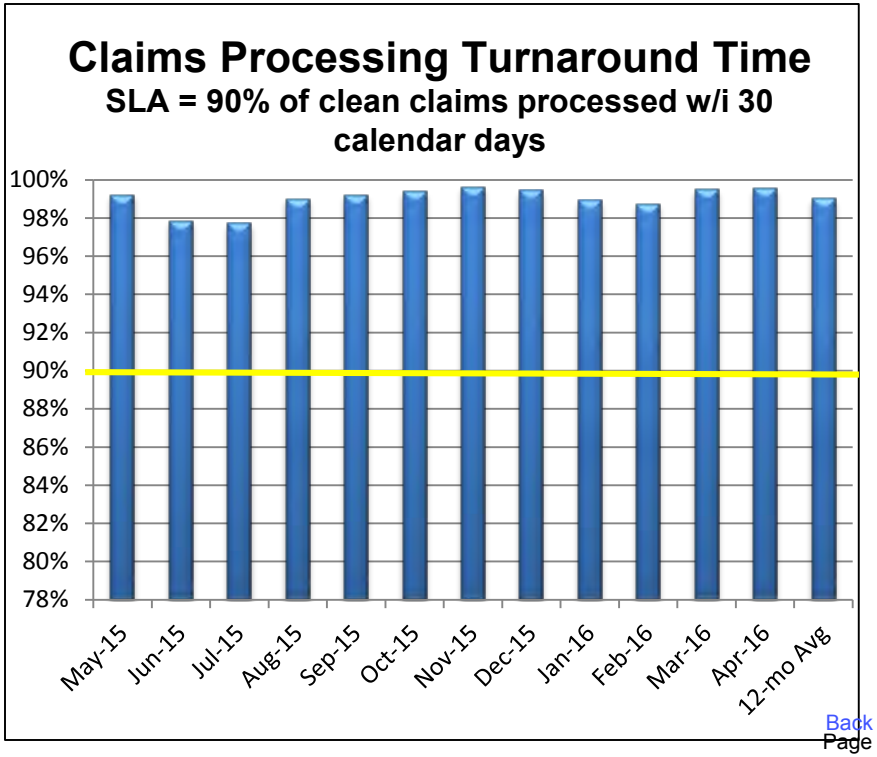


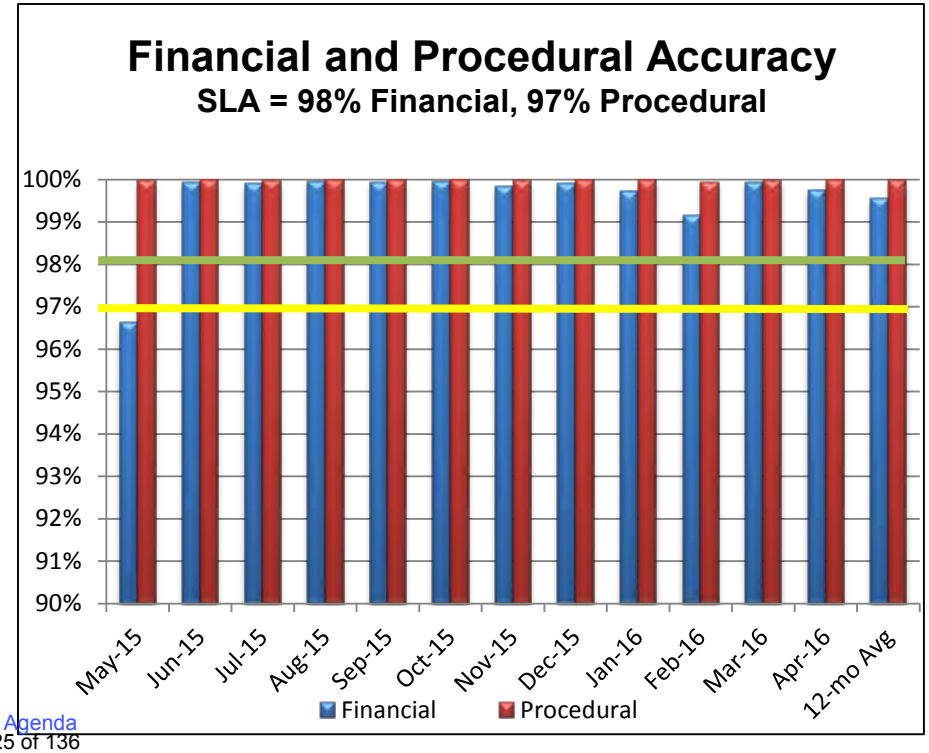


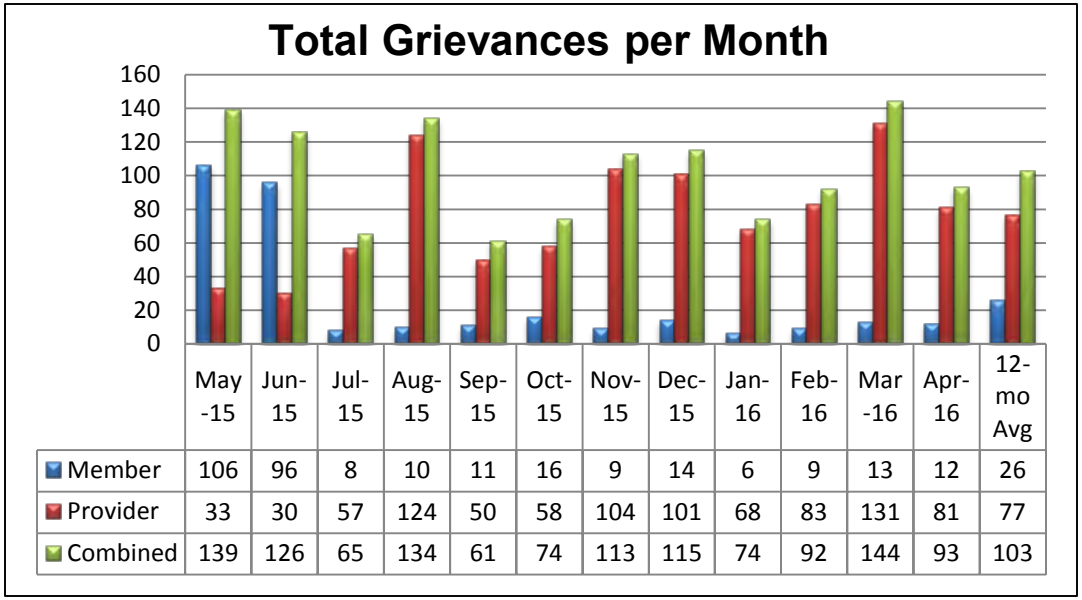
GCHP Claims Metrics – April 2016

- The 30 Day Turnaround Time (TAT) remained in compliance at 99.6%
- Ending Inventory was 19,562 which equates to a Days Receipt on Hand (DROH) of ~3 days vs a DROH ≤ 5 days
- Service Level Agreements (SLAs) for Financial Accuracy (99.74%) and Procedural Accuracy (99.97%) were both met in April





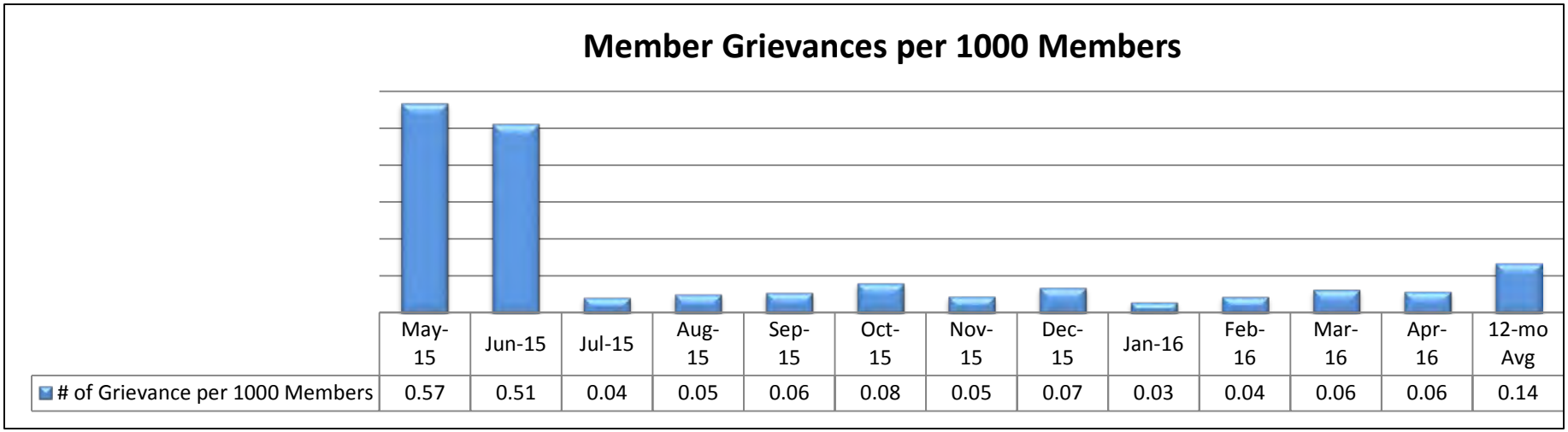




	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	12-mo Avg
Member	106	96	8	10	11	16	9	14	6	9	13	12	26
Provider	33	30	57	124	50	58	104	101	68	83	131	81	77
Combined	139	126	65	134	61	74	113	115	74	92	144	93	103

GCHP Grievance & Appeals Metrics – April 2016

- GCHP received 12 member grievances (0.06 grievances per 1,000 members) and 81 provider grievances during April 2016
- GCHP's 12-month average for total grievances is 103; this number will decrease significantly once the grievances involving balance billing issues drop off in July

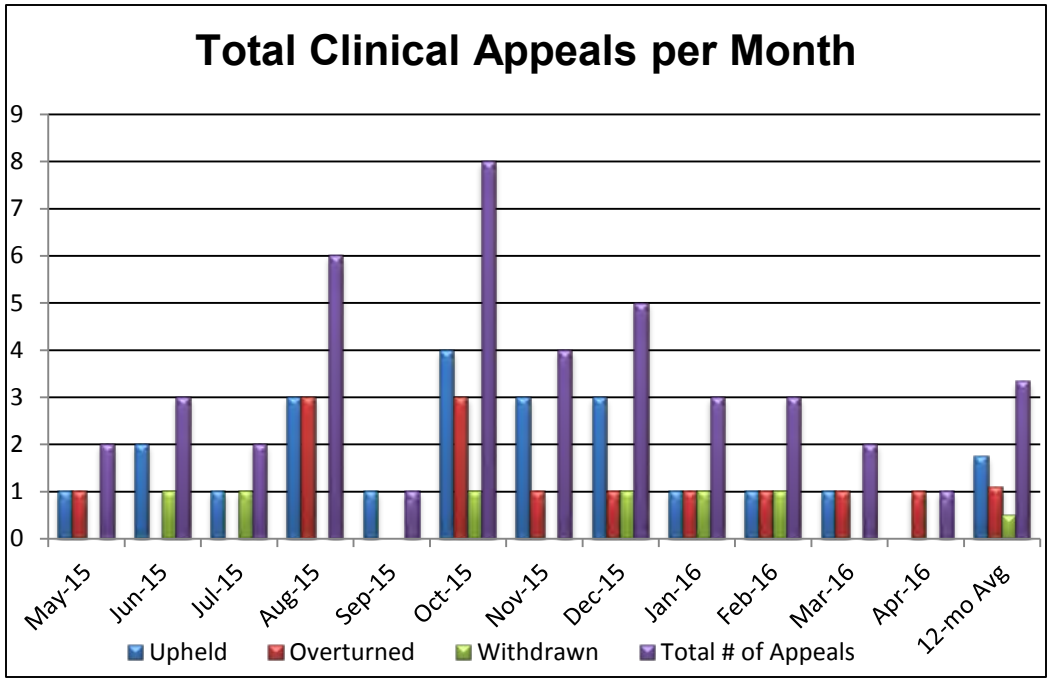


	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	12-mo Avg
# of Grievance per 1000 Members	0.57	0.51	0.04	0.05	0.06	0.08	0.05	0.07	0.03	0.04	0.06	0.06	0.14

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	12-mo Avg
Membership Count	187,029	187,801	189,321	193,185	196,857	196,857	198,863	202,362	202,037	202,019	203,075	203,969	196,948
Total Member Grievances Filed	106	96	8	10	11	16	9	14	6	9	13	12	26
# of Grievance per 1000 Members	0.57	0.51	0.04	0.05	0.06	0.08	0.05	0.07	0.03	0.04	0.06	0.06	0.14

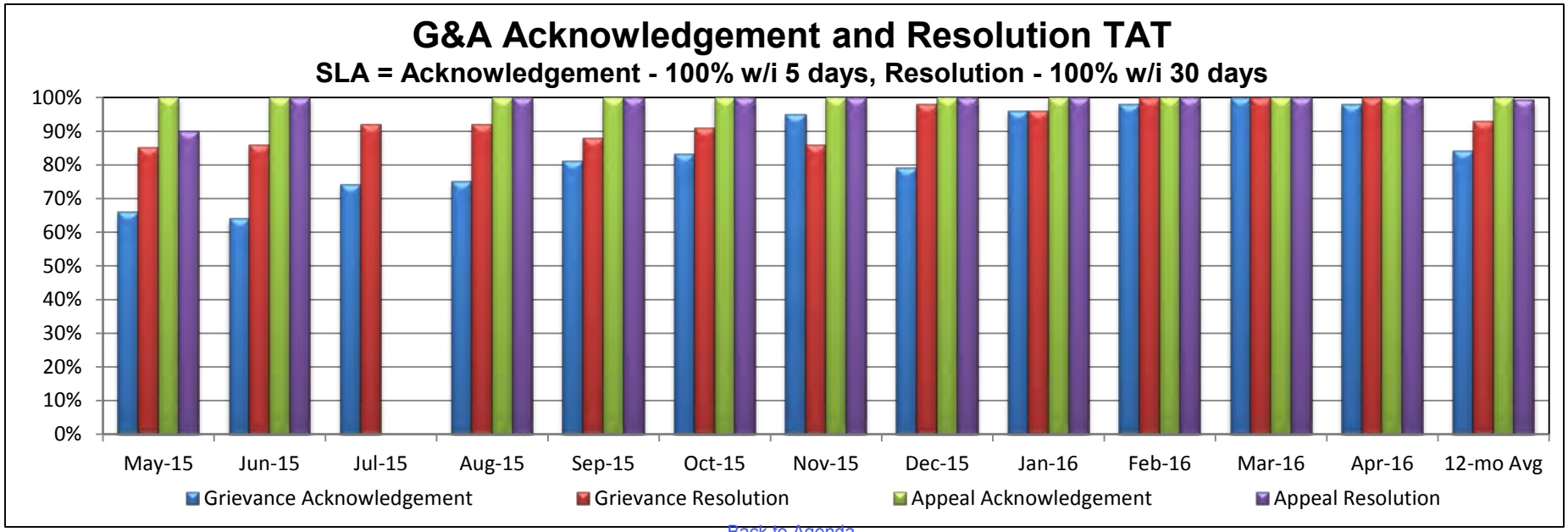
Note: Balance billing removed as a grievance type as of July 2015

Back to Agenda



GCHP Grievance & Appeals Metrics – April 2016

- GCHP overturned 1 clinical appeal in April
- TAT for grievance acknowledgement was non-compliant at 98% due to late receipt of grievances from Xerox
- TAT for appeal acknowledgement and resolution was compliant during the month of April



Note: A "blank" denotes no grievances or appeals were received during the month

AGENDA ITEM NO. 10

TO: Gold Coast Health Plan Commission

FROM: Nancy Wharfield, Associate CMO

DATE: May 23, 2016

SUBJECT: 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 YTD 2016 are similar to slightly improved compared with CY 2015. SPD and Adult Expansion aid code groups each account for about 80% of bed days in CY 2016 followed by the Family aide code group at about 20%.

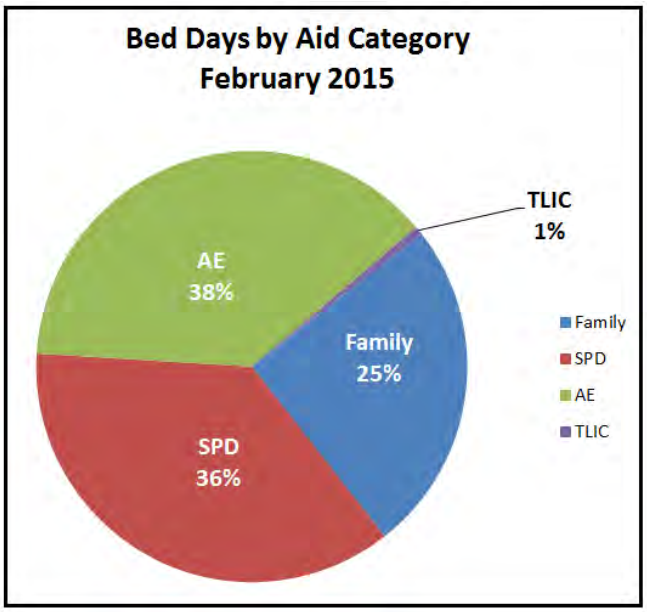
Emergency Department (ED) utilization / 1000 members for YTD 2016 (486 ER visits / 1000 members) is slightly lower than CY 2015 (495 visits / 1000 members). The Family aid code group continues to utilize over half of all ED visits.

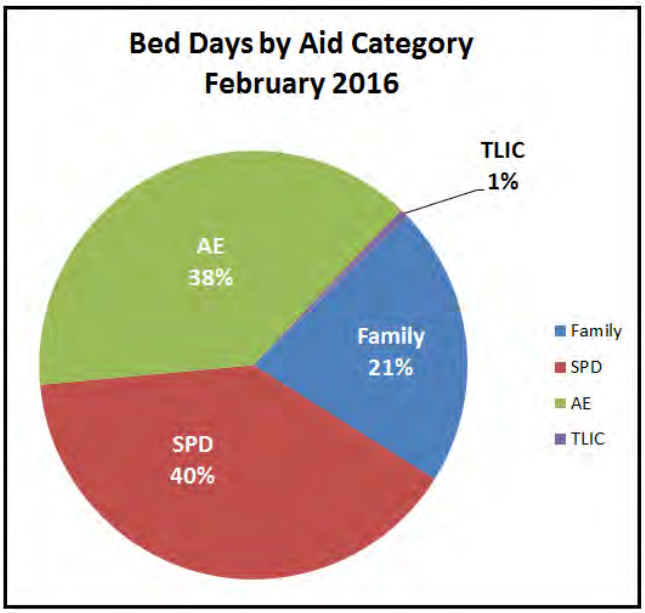
Benchmark: The September 17, 2015 DHCS Medi-Cal Managed Care Performance Dashboard reported 36 ER visits / 1000 member months statewide for all managed care plans for October 2013 – September 2014. GCHP ER utilization / 1000 member months for the same period was 38.

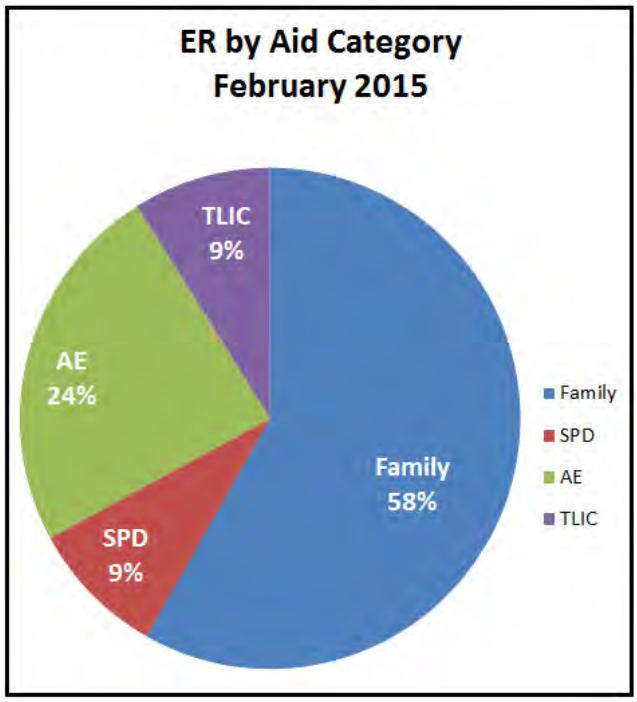
Utilization Per 1000		
	2015	2016 YTD
Inpatient		
Bed days/1000	234	203
Admits/1000	55	47
Average LOS	4	4
ED Utilization		
ED Cases / 1000	495	486
* Data from MedInsight 4/12/16. Data excludes Duals, LTC and SNF.		

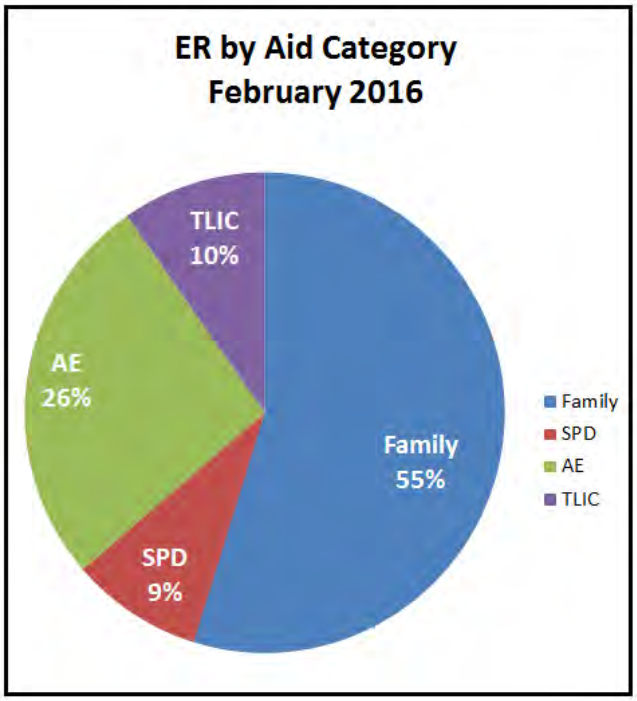
Total Volume		
	2015 Total	2016 YTD
Inpatient		
Bed days	36,616	6,194
Admissions	8,598	1,440
ED Utilization		
ED Cases	77,403	14,818
* Data from MedInsight 5/11/16. Data excludes Duals, LTC and SNF.		

Monthly Averages		
	2015	2016 YTD
Inpatient		
Bed days	3,051	3,097
Admissions	717	720
ED Utilization		
ED Cases	6,450	7,409
* Data from MedInsight 5/11/16. Data excludes Duals, LTC and SNF.		



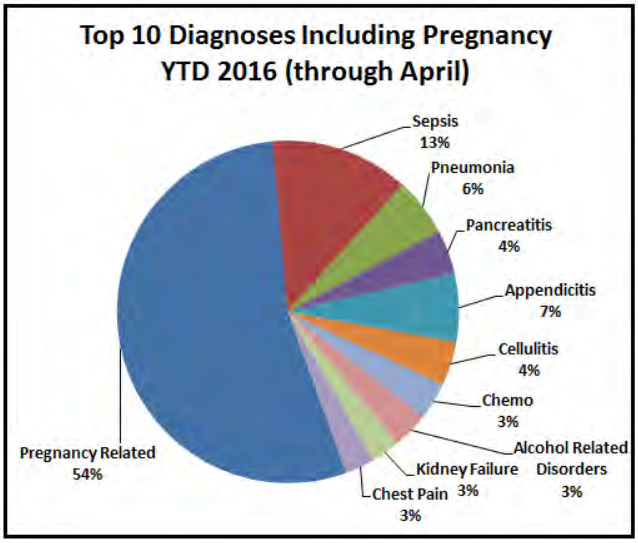


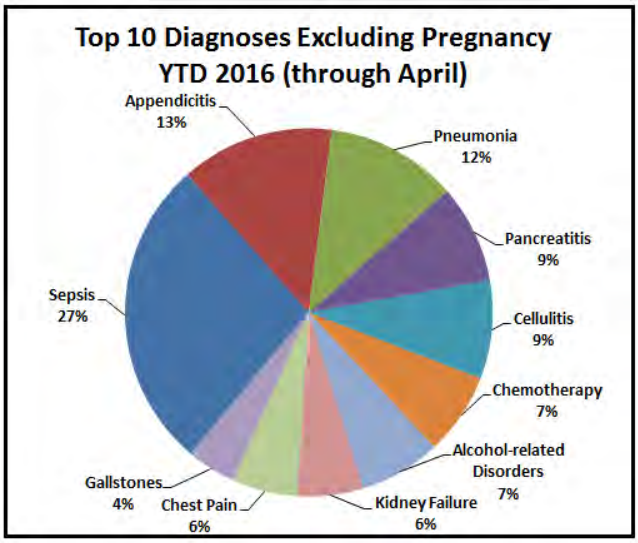




Top Admitting Diagnoses

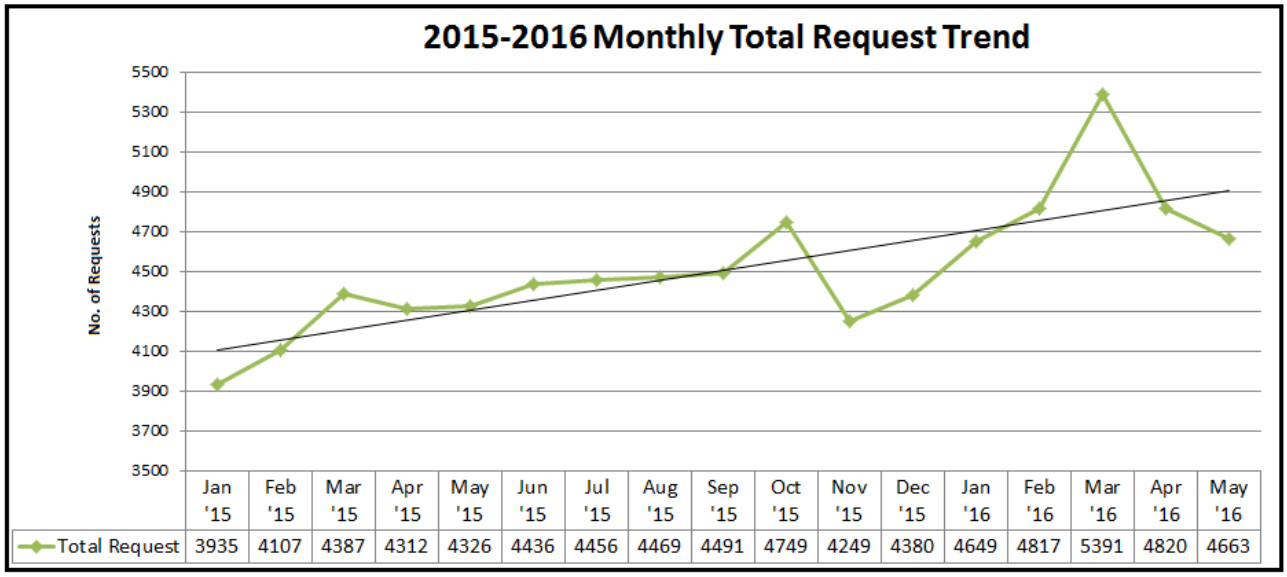
Pregnancy related diagnoses continue to overshadow all other admitting diagnoses for CY 2015 and YTD 2016. Pneumonia, appendicitis, and sepsis were also top diagnoses for CY 2014 – YTD 2016. When pregnancy is excluded, sepsis, alcohol-related disorders, pneumonia, and pancreatitis are the leading diagnoses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



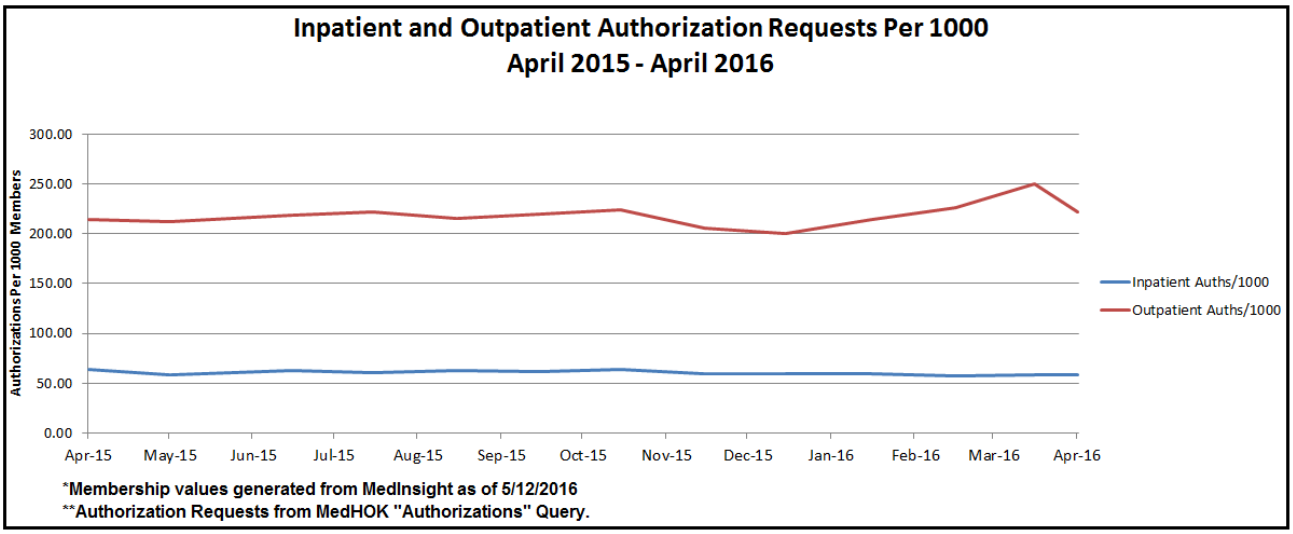


Authorization Requests

Requests for outpatient service continue to outnumber requests for inpatient service. Outpatient service requests for CY 2015 were 214 / 1000 members compared to 228 /1000 members for YTD 2016. Requests for inpatient service for CY 2015 were 62 / 1000 members compared to 59 / 1000 members for YTD 2016.



	Jan '15	Feb '15	Mar '15	Apr '15	May '15	Jun '15	Jul '15	Aug '15	Sep '15	Oct '15	Nov '15	Dec '15	Jan '16	Feb '16	Mar '16	Apr '16	May '16
Total Request	3935	4107	4387	4312	4326	4436	4456	4469	4491	4749	4249	4380	4649	4817	5391	4820	4663



END OF LIFE SERVICES

The Department of Health Care Services (DHCS) has provided Medi-Cal Managed Care Plans with guidance regarding end of life services mandated under the End of Life Option Act (AB x2-15), signed into law October 2015, through All Plan Letter (APL) 16-006.

The End of Life Option Act became effective June 9, 2016 and establishes a benefit to permit terminally ill individuals age 18 or older to make a request to be prescribed aid-in-dying medications. Two physicians, one “attending” and one “consulting” physician, must each independently determine that the individual has a terminal disease with a prognosis of six months or less, and has the capacity to make medical decisions. Provision of these services by health care providers is voluntary, and refusal to provide these services will not place any physician at risk for civil, criminal, or professional penalties.

DHCS has indicated in APL 16-006 that end of life services, including consultations and the prescription of aid-in-dying drug, are a carve-out to Medi-Cal Managed Care plans. Therefore, these services are delivered and payable only under Fee for Service (FFS) Medi-Cal.

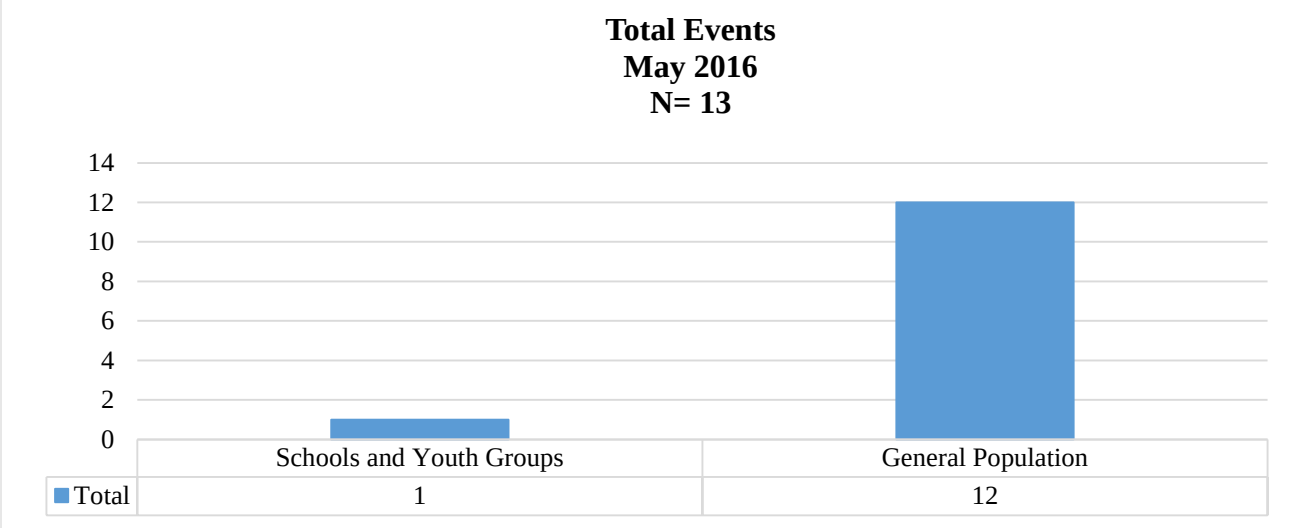
Medi-Cal Managed Care providers who are not enrolled with DHCS as FFS providers, or who choose not to provide end of life services, may document the beneficiary’s oral request in the medical record, and should advise beneficiaries that they should seek these services with an appropriate FFS provider.

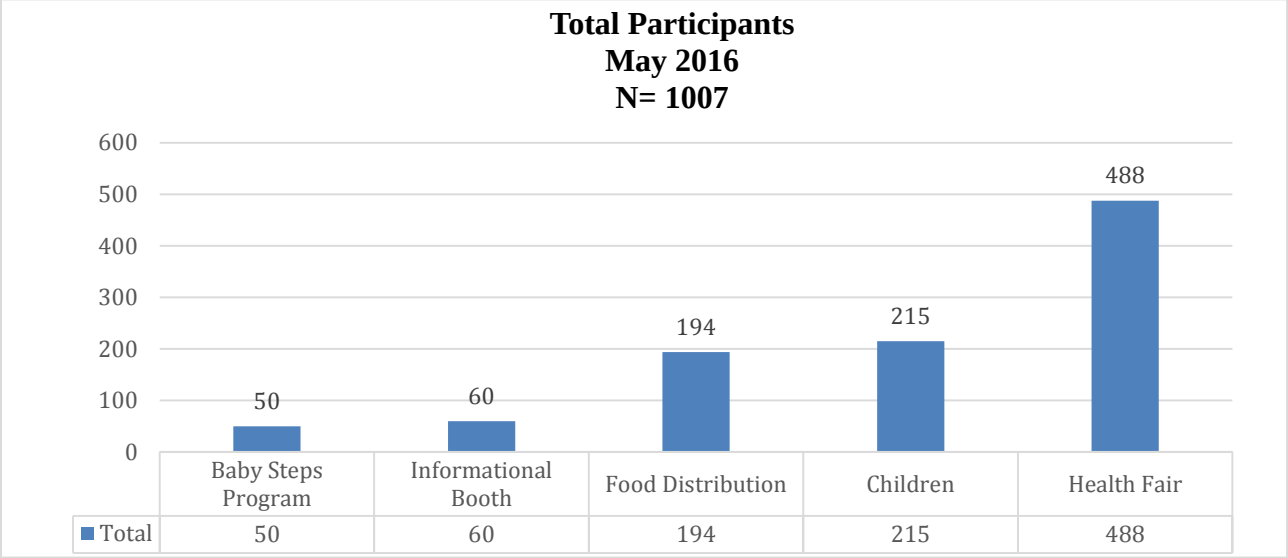
Medi-Cal Managed Care providers who are enrolled with DHCS as FFS providers who elect to provide end of life services, and will bill for such services to FFS Medi-Cal. Pharmacies providing end of life medications will bill FFS Medi-Cal. DHCS will make additional information available to FFS providers regarding their roles and responsibilities through an upcoming Medi-Cal Provider Manual update.

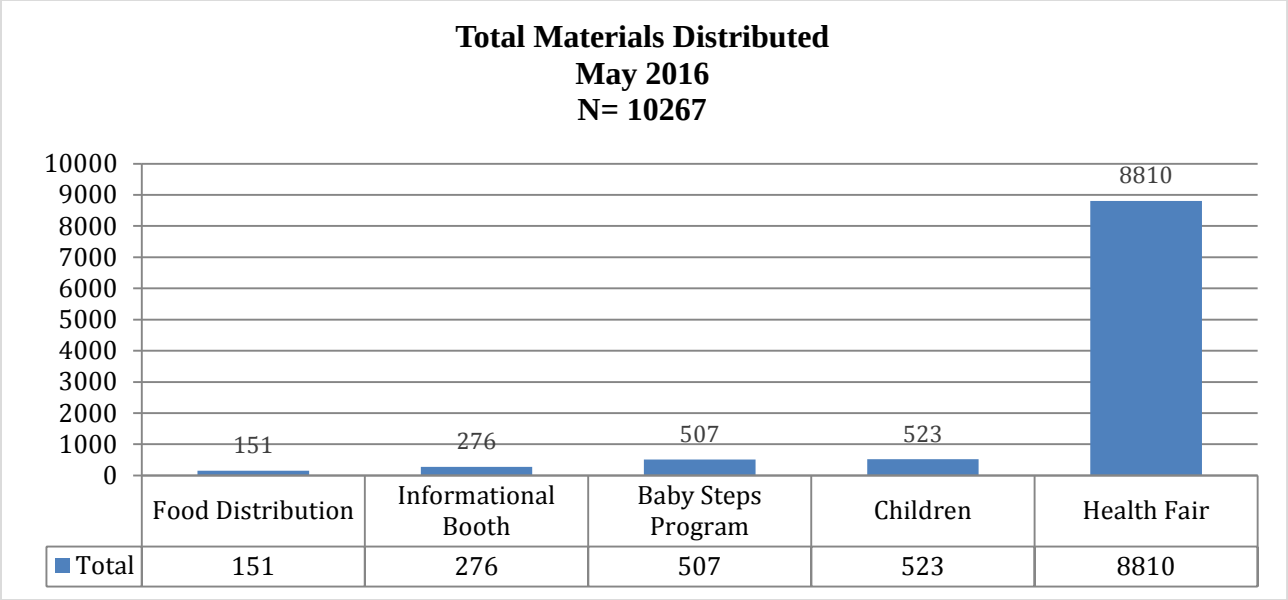
Of note, the APL specifies that beneficiaries are responsible for finding a Medi-Cal FFS physician who can provide end of life care.

COMMUNITY OUTREACH ACTIVITIES – MAY 2016

GCHP participated in 13 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 1,007 participants were reached and 10,267 health information materials were distributed. Below are charts that highlight the total number of events, participants, and materials distributed during the month of May.







Outreach Events

On Saturday, May 14, GCHP held its annual Community Resource Fair at Plaza Park in downtown Oxnard. A total of 43 information booths were on display including 38 community organizations (see below) and five (5) GCHP departments (i.e., Health Education, Member Services, Care Management, Disease Management and Pharmacy). Approximately 316 children and families attended this event.

List of Participating Agencies

American Cancer Society	Magnolia Family Medical Clinic – VCMC
American Heart Association	MICOP
Among Friends Adult Day Health Care Center	Oxnard Fire Department
Beacon Health Options	Oxnard Neighborhood for Learning – First 5
Boys and Girls Club of Greater Oxnard	Planned Parenthood
OASIS Catholic Charities	Shield Health Care
Center for Employment Training	The City of Ventura Police Dept. Crash Car
Child Development Resources	Tri-County GLAD
Clinicas del Camino Real	United Parents
CMH – Center for Family Health	Ventura County Area Agency on Aging
Community Action of Ventura County	Ventura County Behavioral Health Alcohol and Drug Programs – Prevention Services
County of Ventura Child Support	Ventura County Health Care Agency – Mobile Medical Clinic
El Centrito Family Learning Centers	Ventura County Public Health – CHDP
Employment Development Department	Ventura County Public Health Chronic Disease Prevention
Every Woman Counts	Ventura College – Nursing Students
FOOD Share	Ventanilla de Salud
Health Insurance & Counseling Program	VSP

Interface Children & Family Services	Ventura Transit System, Inc.
Kids and Family Together	Livingston Memorial Visiting Nurse Assn.

Participants were able to receive free blood pressure and glucose screenings through the Ventura County Health Care Agency – Mobile Medical Clinic (staffed by the Las Islas Clinic) and Clinicas del Camino Real. Ventura College Nursing students performed body mass index (BMI) screening. The Oxnard Fire Department offered CPR demonstration and the City of Ventura Police Department, in collaboration with Ventura County Behavioral Health, displayed the DUI Crashed Car Trailer. Other youth and family activities included physical fitness walk, face painting, Zumba demonstration, musical entertainment and dance group (Folklorico) by INLAKECH Cultural Arts Centers. Several other social service agencies were also available to provide information and resources to participants.

GCHP Employee Participation

GCHP had a total of 53 employees who participated in the community resource fair. Gold Coast Health Plan had five (5) information booths representing various departments including Pharmacy, Care Management, Disease Management, Member Services, and Health Education. A total of 1,085 encounters were made by the various departments, below is a breakdown of the adults, seniors and children that were reached during the event. Approximately 42% of the encounters reached by GCHP were under the age of 18, 47% were adults and 10% seniors.

GCHP Department	Adults	Seniors	Minors	Totals
Pharmacy Department	72	22	53	147
Care Management Dept.	73	20	90	183
Disease Management Dept.	120	2	67	189
Member Services	43	23	47	113
Health Education	133	31	113	277
Health Education - Kids Zone	65	20	91	176

Certificate of Appreciation from Elected Officials

GCHP received certificates of appreciation from several distinguished elected officials including Ventura County Supervisor John C. Zaragoza, Mayor of Oxnard Pro Tem, Carmen Ramirez, Field Representative Allison Maginot for Senator Hannah-Beth Jackson, and Field Representative Jason Barnes for Congresswomen Julia Brownley.

Community Health Education Classes

GCHP Health Education Department conducts various community health education workshops and/or classes throughout the community. During the reporting period, a total of four (4) community health education classes were conducted and a total of 46 individuals were reached. Below is a chart that outlines the community health education classes/workshops and the city in which they were held.