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

Regular Meeting
Monday, May 22, 2017, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

ROLL CALL

PROCLAMATION AND COMMENDATIONS

Introduction of New Employee, Jean Halsell, Human Resources Executive Director.

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

Community Outreach and Engagement Presentation

Staff: Lupe Gonzalez, Director of Health Education, Outreach, Cultural & Linguistics Services

CONSENT CALENDAR

1. **Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of April 24, 2017**

   Staff: Tracy Oehler, Clerk of the Board

   RECOMMENDATION: Approve the minutes.

FORMAL ACTION ITEMS

2. March 2017 Year to Date Financials

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION: Accept and file March 2017 Fiscal Year to Date Financials.

3. Approval of Benefit Enhancement – Continuous Glucose Monitoring (ARCH)

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

RECOMMENDATION: Approve continuous glucose monitoring as a benefit for Gold Coast Health Plan members.

4. Approval of Benefit Enhancement – Panniculectomy (ARCH)

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

RECOMMENDATION: Approve panniculectomy as a benefit for Gold Coast Health Plan members.

5. Quality Improvement Committee 2017 First Quarter Report

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

RECOMMENDATION: Accept and file the Quality Improvement Committee 2017 First Quarter Report.

REPORTS

6. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

7. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

8. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

9. Chief Diversity Officer (CDO) Update

RECOMMENDATION: Accept and file the report.

10. Chief Information & Strategy Officer (CISO) Update

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

11. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Name of Case: Script Care v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan, Case No. 56-2017-00492349 CV-WM-VTA

12. PUBLIC EMPLOYEE EVALUATION
Title: Chief Diversity Officer

OPEN SESSION

FORMAL ACTION ITEMS

13. Consider Proposed Expansion of Human Resources/Cultural Diversity Subcommittee and Direction to Subcommittee and Chief Diversity Officer

Staff: Joseph T. Ortiz, General Counsel

RECOMMENDATION: Consider the appointment of additional Subcommittee members and provide guidance to the Subcommittee and Chief Diversity Officer.

14. Chief Diversity Officer Travel and Expenses and Signature Authority

Staff: Joseph T. Ortiz, General Counsel

RECOMMENDATION: Approve Chief Diversity Officer Travel and Expense policy and approve guidelines on Signature Authority.

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on June 26, 2017, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, 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 Monday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

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

April 24, 2017 Regular Meeting Minutes

DRAFT

CALL TO ORDER

Commissioner Darren Lee called the meeting to order at 2:02 p.m. in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D. (arrived 2:04 p.m.), Narcisa Egan, Laura Espinosa (arrived at 4:42 p.m.), Peter Foy, Michele Laba, M.D. (arrived at 2:08 p.m.), Darren Lee, Gagan Pawar, M.D., Catherine Rodriguez, and Jennifer Swenson.

Absent: None.

PROCLAMATIONS AND COMMENDATIONS

Commissioner Lee introduced new employee, Douglas Freeman, Chief Diversity Officer.

PUBLIC COMMENT

None.

CONSENT CALENDAR

Commissioner Dial moved to approve the Consent Calendar. Commissioner Swenson seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: Commissioner Foy.

ABSENT: Commissioners Espinosa and Laba.

Commissioner Lee declared the motion carried.

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of February 27, 2017

RECOMMENDATION: Approve the minutes.

2. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of March 27, 2017

RECOMMENDATION: Approve the minutes.

3. Approval of Contract Extension with Etonien LLC for Internal Audit Services

RECOMMENDATION: Approve the contract with Etonien LLC for internal audit services with a one-year extension for $120,000 with a not to exceed amount of $322,645.

4. Approval of Contract Extension with Mary Beth Liggett, RN, an Independent Contractor, for Concurrent Utilization Review of Long Term Care (LTC) and Skilled Nursing Facility (SNF) Members

RECOMMENDATION: Approve the contract extension with Mary Beth Liggett, RN, an independent contractor, for concurrent utilization review of LTC and SNF members with a two-year extension for $210,000 with a not to exceed amount of $409,400.

5. Approval of Contract Extension with TBJ Consulting, an Independent Contractor, for Human Resources Consulting Services

RECOMMENDATION: Approve the contract extension with TBJ Consulting, an independent contractor, for human resources consulting services with a six-week extension for $112,000 with a not to exceed amount of $160,000.

FORMAL ACTION ITEMS

6. February 2017 Year to Date Financials

RECOMMENDATION: Accept and file February 2017 Fiscal Year to Date Financials.

Patricia Mowlavi, Chief Financial Officer, reported for the first eight-month period, Gold Coast Health Plan's (Plan) performance included a gain in net assets of $6.2 million and noted the contributions to health care costs over the past years has increased from 81% to 92% indicating additional funds are getting into the community.

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

AYES: Commissioners Alatorre, Atin, Dial, Egan, Foy, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Espinosa and Laba.

Commissioner Lee declared the motion carried.

Commissioner Laba arrived at 2:08 p.m.

7. Approval of Contract with Gorman Health Group LLC with an Engagement Team Consisting of Ten Gorman Resources with Relevant Expertise in Sales, Marketing and Strategy, Network, Healthcare Analytics, Compliance and Operational Performance to Complete the Project Work with an Estimated Level of Effort of 525 Hours Commencing May 1, 2017 and Ending June 20, 2017 for a Feasibility Study of a Dual Eligible Special Needs Plan

RECOMMENDATION: Approve the contract with Gorman Health Group LLC for a feasibility study of a dual eligible special needs plan for eight weeks with a not to exceed amount of $179,900.

Dale Villani, Chief Executive Officer, stated at the March 17, 2017 Strategic Planning meeting, there was discussion regarding the Plan participating in a dual eligible Special Needs Plan (D-SNP). Gorman Health Group LLC (Gorman) was previously contracted to perform a feasibility study in order to evaluate the Plan's participation and the new contract is phase two in which Gorman will provide an in depth analysis on whether or not this is a viable option for Ventura County.

A discussion followed between the Commissioners and staff regarding phase one consisting of an initial high-level review of the market and the number of eligibles; the necessity of the study as it will provide key factors like network contract rates and utilization management Medicaid space in determining the Plan's participation; the study providing calculations for the estimated start-up costs, break even timeline, and additional revenue; and how this model would allow for the coordinated care of members.

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

AYES: Commissioners Alatorre, Atin, Dial, Egan, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Espinosa.

Commissioner Lee declared the motion carried.

REPORTS

8. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

Mr. Villani stated there have been some personnel changes including Dr. Al Reeves' retirement on July 7, 2017 and a recruitment had been initiated; Ralph Oyaga's resignation as Executive Director of Government Regulatory and External Relations effective May 3, 2017; and the selection of a new Human Resources Executive Director who is scheduled to begin on May 15, 2017.

Invitations have been distributed for the Opioid Policy Summit scheduled for May 5, 2017, from 8:30 a.m. to 12:00 p.m. at the Ventura Beach Marriott with national speakers discussing strategies to address the opioid epidemic in Ventura County.

Mr. Oyaga stated the Alternative Resources for Community Health (ARCH) grant-making program was officially launched and requests for applications went live on the Plan's website on April 7, 2017. The three areas of social determinants of health selected were access to care, access to healthy foods, and the neighborhood and built environment. The deadline for applications is May 1, 2017, and a list of approved grants will be submitted to the Commission at the June 26 meeting.

Lupe Gonzalez, Director of Health Education Disease Management and Health Education, announced the sixth annual resource fair is scheduled for May 13, 2017, with 43 agencies participating.

Mr. Villani stated the CMS Mega Rule major contract amendment is currently in draft status and has been submitted to CMS for their review. The projected implementation date is schedule for July 1, 2017, though there may be 60-day delay. Additionally, the State legislature has recently introduced two new companion bills on how to implement the changes created by the Mega Rule. The intergovernmental transfers process will be changing to a prospective payment system, which will set a percentage above base contract rates affecting how the pass through payments will go to the County hospitals and UC hospitals.

On March 17, 2017, the Department of Health Care Services (DHCS) issued a corrective action plan (CAP) relative to the Provider Network 274 File, which is a new requirement for provider network data reporting. The Plan is complying with the CAP and is submitting timelines and updates to DHCS on a biweekly basis. There are no financial sanctions currently associated with the CAP.

The Pharmacy Benefit Manager conversion with OptumRx is on schedule for June 1, 2017, and the Script Care protest hearing is scheduled for the first week of May.

Lastly, the DHCS annual medical audit begins on June 5, 2017.

9. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

Ruth Watson, COO, stated membership is at 202,338 and reflects a net loss of 905 members from March 2017 through April 2017 mostly due to the lack of re-determination from the prior year and members being terminated as they no longer meet the qualifications. A handout was given to the Commission to replace page 53 of the packet as the goal line had been corrected on the Average Speed of Answer chart. The new director has been working on developing quality metrics to be provided to the ASO vendor. Ms. Watson stated information is available identifying in county and out of county facilities as well as the reasons why there are contracts with out of county facilities. Some of the reasons are whether it is a tertiary hospital needed for transplant care, a trauma center for pediatrics, and facilities added due to their close proximity to each end of the County. Once the document is finalized, it will be emailed to the Commissioners.

A discussion followed between the Commissioners and staff regarding how the County is responsible for the behavioral health patient population that consists of the seriously mentally ill and substance abuse cases, while the Plan covers the mild and moderate cases. Clarification was made on how the auto assignment calculations for the County are dependent upon which primary care physicians are available in that location and staff will research what percentage of eligible Adult Expansion members assigned to the County per AB 85 as the required percentage has changed. The Commission expressed concern regarding the correlation between the CAP placed by the DHCS and the Plan's addition of specialty physicians. Staff explained the CAP is a short-term data problem and in order to contract with the medical groups it had to include all of the physicians, not just individual specialists. Additionally, it was clarified the primary care is focused inside the County and any referrals out the County is required to go through an approval process.

10. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

Dr. Reeves, CMO, stated going forward Dr. Nancy Wharfield would provide the Health Services update on a quarterly basis.

11. Chief Diversity Officer (CDO) Update

RECOMMENDATION: Accept and file the report.

Douglas Freeman, CDO, reviewed the 2015-2017 Diversity and Inclusion information, which consisted of an introduction and factual study, the 2015-2016 Human Resources/Cultural Diversity Subcommittee action points, and a summary

of the CDO reports. He stated at the next Subcommittee meeting scheduled for April 10 a diversity inclusion strategy, which would define the diversity inclusion blueprint, would be presented with an outline of what is to be expected of the document. Mr. Freeman stated the other report would be the executive summary with the key strategic pillars around the diversity inclusion blueprint.

A discussion followed between the Commissioners and staff regarding the attached 2015-2017 Diversity and Inclusion report being sent to the Ventura County Board of Supervisors (BOS); the preparation of quarterly updates with distribution to both Mike Powers, Chief Executive Officer, County of Ventura and the BOS; and the development of a roadmap and a framework for the strategic outline by June, 2017.

The Commission unanimously agreed to accept and file Agenda Items No. 8 through 11.

Scott Campbell, General Counsel, announced Closed Session Agenda Item No. 12 Conference with Legal Counsel – Signification Exposure to Litigation concerning the Office of Inspector General.

CLOSED SESSION

The Commission adjourned to Closed Session at 3:16 p.m.

12. CONFERENCE WITH LEGAL COUNSEL – SIGNIFICANT EXPOSURE TO LITIGATION

Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case

OPEN SESSION

The Regular Meeting reconvened at 4:03 p.m.

Mr. Campbell stated there was no reportable action taken.

Mr. Campbell stated Commissioners Alatorre and Pawar would be recusing themselves from Agenda Item No. 13 – Considerations for Plan-to-Plan Contracts due to the potential of this matter concerning a possible contract with a subsidiary of Clinicas del Camino Real and discussion under 1090 of the broad rules of engagement that Commissioners can be involved.

DISCUSSION

13. Considerations for Plan-to-Plan Contracts

Mr. Villani gave a presentation on Medi-Cal Managed Care Plan to Plan (P2P) contracting, which included why a plan would enter into a contract with another plan. The reasons cited included to create a stronger network, reduce risk, or gain a synergy from the two entities working together. He noted Margaret Tatar from Health Management Associates (HMA) provided input into the presentation, but

could not attend tonight's meeting, and would be available if needed at the next Commission meeting in June.

A discussion followed between the Commissioners and staff regarding the Plan's current contract with Kaiser; the State's mandate to enter into this contract order to provide a continuity of care for families; and how Kaiser is paid by a pass through payment process.

Mr. Villani stated none of the County Organized Health Systems (COHS) currently have a plan-to-plan contract, as it does not generally fit the model. An overview of the Plan's contract with other entities was reviewed along with the delegation of items like credentialing, utilization management, and quality as well as those that entail financial risks. Key plan considerations were reviewed including establishing the participation criteria for a full risk partner; securing DHCS' approval to enter into a contract with another plan; defining clearly delineated responsibilities; negotiated rate criteria; the impact on provider/vendor subcontract payments; the impact to the current employee workforce; and the member and provider care coordination and support. The bottom line in deciding to participate in a P2P is determining if it make good business sense to the Plan, the community, and the members.

Commissioner Espinosa arrived at 4:42 p.m.

Mr. Villani noted that anything we do as a public entity where we go out to market to contract with another plan is if a Request for Proposal (RFP) is required, whether the dollar value is impactful enough to warrant a RFP, and what value is gained though a P2P. He stated if the Plan is interested in pursuing a P2P, Ms. Tatar's recommendation was a RFP should be implemented. He noted, as there has been a lot of discussion about P2P contracts in the County, the Plan could consider the implementation of a small pilot program and evaluating if a company could take the required risks and provide greater value or synergies Per the County's direction, the Plan must have a boilerplate drafted and have the State's approval before pursuing this option.

A discussion followed between the Commissioners and staff regarding the staffing impact if the Plan enters into a P2P contract; the possibility of using a sole source model in special situations as opposed to using a RFP model; how a P2P contract would shift the Plan's administration burden but not decrease it; and how transparency is essential and a P2P contract would need to make sense for the patients and the Plan.

Mr. Campbell stated if the Plan was to issue a RFP, there are a number of items to be considered like what type of program the Plan wants and ultimately the state of California will need to approve the contract including how the contract was awarded.

Dr. Enrique de la Garza, a representative from America's Health Plan, spoke in support of Agenda Item No. 13 – Considerations for Plan-to-Plan Contracts.

A discussion followed between the Commissioners and staff regarding the timeframe being dependent upon the DHCS' medical audit and how the State will not review anything new until the Mega Rule amendments are implemented with the plans. The Commission expressed concern regarding exploring other business lines, as the Plan is currently busy and if it is advisable to pursue them as this time. Mr. Villani stated the best resource to determine this option is HMA, which has actuaries and the staff to perform a feasibility study whether this would be a sound business decision.

A copy of the presentation is on file.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 5:27 p.m.

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Patricia Mowlavi, Chief Financial Officer

DATE: May 22, 2017

SUBJECT: March 2017 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached March 2017 fiscal year-to-date (FYTD) financial statements (unaudited) of Gold Coast Health Plan ("Plan") for the Commission to accept and file. The Executive/Finance Committee did not review these financials.

BACKGROUND/DISCUSSION:

The staff has prepared the March 2017 FYTD 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 nine-month period ended March 31, 2017, the Plan's performance was a gain in net assets of $6.6 million, which was $9.0 million higher than budget. Cost of health care was lower than budget, driven by timing of the ARCH program. Administrative savings were realized through lower than projected administrative expenses – most notably those expenses related to projects and those whose variability are determined by membership levels.

Membership – March's membership of 205,829 was 7,525 members below budget. For FYTD membership is 1,871,966 or 30,042 below budget.

Revenue – March FYTD net revenue was $514.5 million or $0.5 million above budget due to a favorable membership mix with more Adult Expansion members than expected. On a PMPM basis, FYTD revenue was $4.60 above budget.

MCO Tax – MCO tax is a pre-determined liability in accordance with Senate Bill X2-2 passed in October 2016. The Plan's MCO tax liability for FY2017 is $84.1 million, accrued at a rate of approximately $7.0 million per month. $63.1 million of MCO tax has been expensed FYTD. The next MCO tax payment (third of four) of $21.0 million was paid in early April 2017.

Health Care Costs – Health care costs through March 31, 2017 were $473.4 million or $3.0 million below budget. The FYTD MLR was 92.0%, 0.7% lower than budget.

Adult Expansion Population 85% Medical Loss Ratio – The Balance Sheet contains a $131.3 million reserve for potential Medi-Cal capitation revenue to be pay back to the DHCS under the terms of the MLR contract language.

	Expansion Population			Classic Population
	1/1/14-6/30/15 MLR Period 1	7/1/15-6/30/16 MLR Period 2	7/1/16-3/31/17 MLR Period 3	7/1/16-3/31/17
Total Revenue (net of MCO tax)	361,237,234	293,172,661	202,394,898	308,415,574
Total Estimated Medical Expense	206,719,452	238,300,734	183,953,337	289,475,302
	57.2%	81.3%	90.9%	93.9%
Total MLR Reserve	**118,168,494**	**13,101,452**	**-**	

Administrative Expenses – March FYTD administrative costs were $36.8 million or $4.2 million below budget. As a percentage of revenue, administrative costs (or ACR) were 7.1% versus 8.0% for budget.

Cash and Medi-Cal Receivable – At March 31, the Plan had $534.0 million in cash and short-term investments and $66.2 million in Medi-Cal Receivable for an aggregate amount of $600.2 million. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $280.3 million. The AE repayment is expected to commence in July 2017.

Investment Portfolio – At March 31, 2017, the value of the investments (all short term) was $259.0 million. The portfolio included Cal Trust $50.8 million; Ventura County Investment Pool $85.7 million; LAIF CA State $63.4 million; Bonds and Commercial Paper $59.1 million.

RECOMMENDATION:

Staff requests that the Commission accept and file the March 2017 financial package.

CONCURRENCE:

N/A

ATTACHMENT:

March 2017 Financial Package

FINANCIAL PACKAGE
For the month ended March 31, 2017

TABLE OF CONTENTS

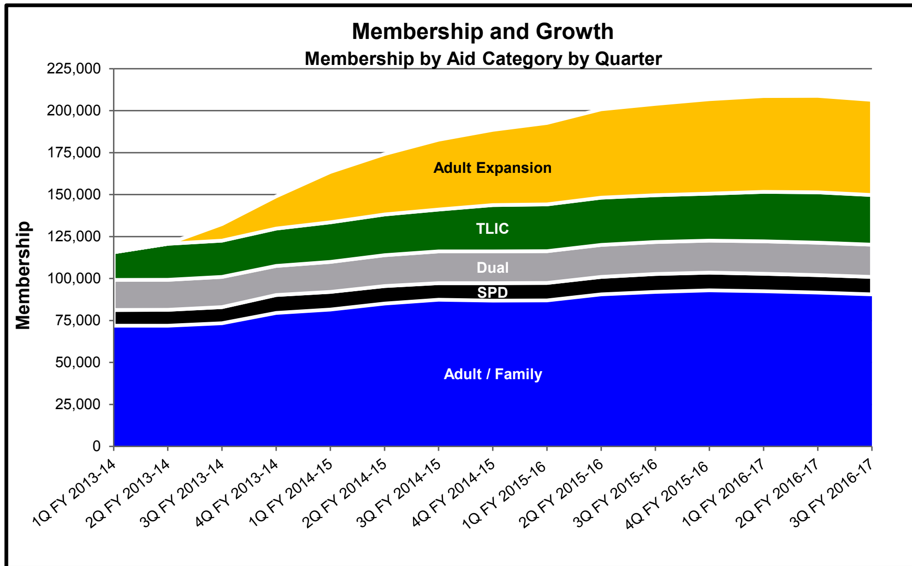
- Financial Overview
- Financial Performance Dashboard
- Cash and Operating Expense Requirements

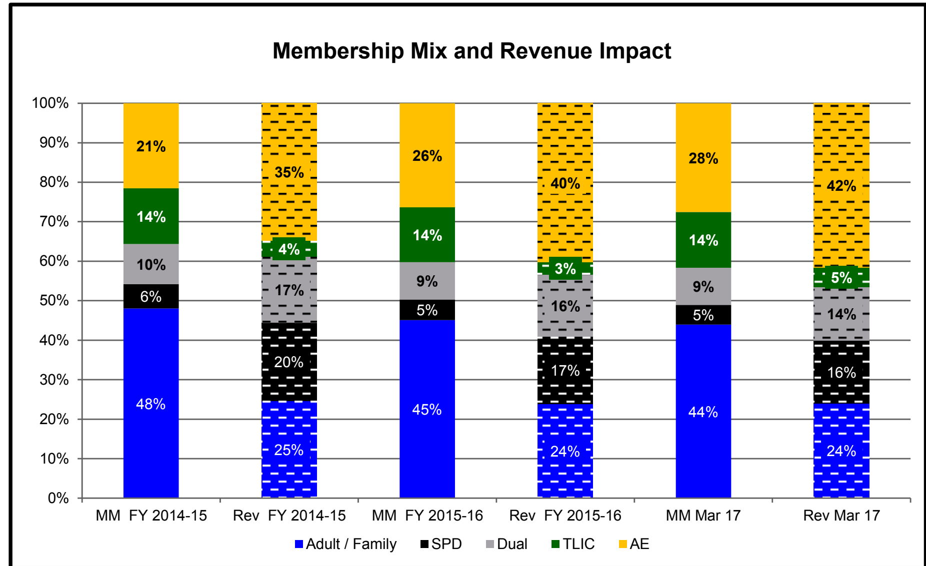
APPENDIX

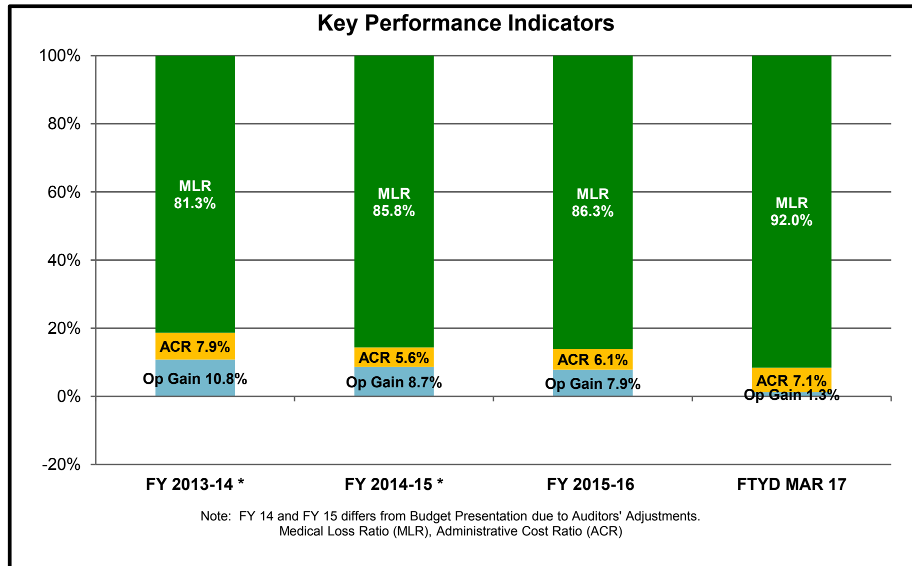
- Statement of Financial Positions
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows
- Membership
- Paid Claims and IBNP Composition
- Pharmacy Cost & Utilization Trends

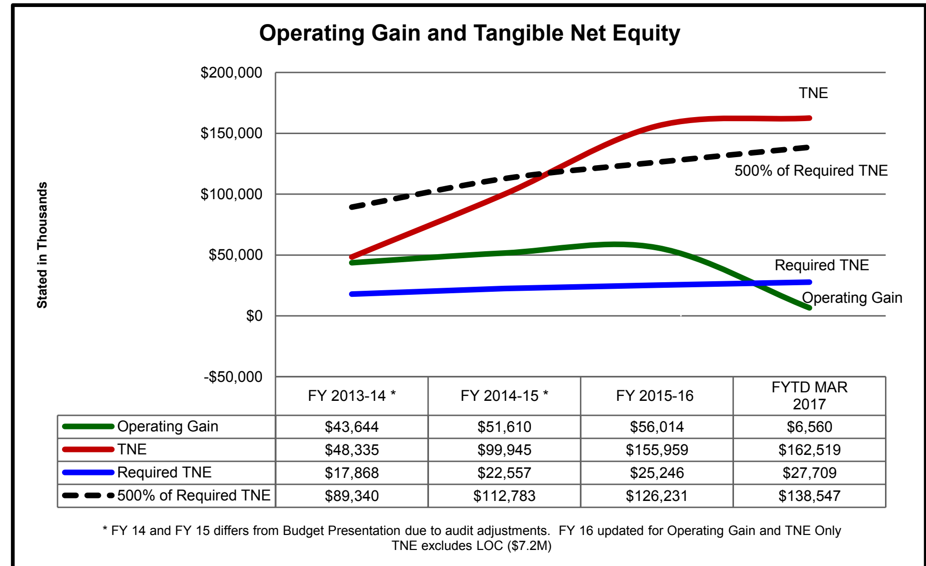
Description	AUDITED FY 2011-12	AUDITED FY 2012-13	AUDITED FY 2013-14	AUDITED FY 2014-15	AUDITED FY 2015-16	FY 2016-17 JUL - SEP 16	OCT - DEC 16	JAN 17	FEB 17	MAR 17	FYTD MAR 17	Budget Comparison Budget FYTD	Variance Fav / (Unfav)
Member Months	**1,258,189**	**1,223,895**	**1,553,660**	**2,130,979**	**2,413,136**	**626,084**	**626,419**	**206,664**	**206,970**	**205,829**	**1,871,966**	**1,902,008**	(30,042)
Revenue	**304,635,932**	**315,119,611**	**402,701,476**	**595,607,370**	**675,629,602**	**148,815,746**	**190,063,083**	**57,908,938**	**57,932,359**	**59,807,026**	**514,527,152**	**514,026,827**	500,325
pmpm	*242.12*	*257.47*	*259.20*	*279.50*	*279.98*	*237.69*	*303.41*	*280.21*	*279.91*	*290.57*	*274.86*	*270.25*	4.60
Health Care Costs	**287,353,672**	**280,382,704**	**327,305,832**	**509,183,268**	**583,149,780**	**155,478,257**	**156,886,345**	**53,139,878**	**52,442,783**	**55,481,377**	**473,428,639**	**476,399,713**	2,971,074
pmpm	*228.39*	*229.09*	*210.67*	*238.94*	*241.66*	*248.33*	*250.45*	*257.13*	*253.38*	*269.55*	*252.90*	*250.47*	(2.43)
% of Revenue	94.3%	89.0%	81.3%	85.5%	86.3%	104.5%	82.5%	91.8%	90.5%	92.8%	92.0%	92.7%	0.67%
Admin Exp	**18,891,320**	**24,013,927**	**31,751,533**	**34,814,049**	**38,256,908**	**12,063,462**	**12,399,366**	**4,088,911**	**3,886,007**	**4,350,212**	**36,787,957**	**40,944,297**	4,156,339
pmpm	*15.01*	*19.62*	*20.44*	*16.34*	*15.85*	*19.27*	*19.79*	*19.79*	*18.78*	*21.14*	*19.65*	*21.53*	1.87
% of Revenue	6.2%	7.6%	7.9%	5.8%	5.7%	8.1%	6.5%	7.1%	6.7%	7.3%	7.1%	8.0%	0.82%
Non-Operating Revenue / (Expense)					**1,790,949**	**596,568**	**647,800**	**334,894**	**326,906**	**343,025**	**2,249,192**	**879,585**	1,369,607
pmpm					*0.74*	*0.95*	*1.03*	*1.62*	*1.58*	*1.67*	*1.20*	*0.46*	0.74
% of Revenue					0.3%	0.4%	0.3%	0.6%	0.6%	0.6%	0.4%	0.2%	0.27%
Total Increase / (Decrease) in Unrestricted Net Assets	**(1,609,063)**	**10,722,980**	**43,644,110**	**51,610,053**	**56,013,863**	**(18,129,405)**	**21,425,172**	**1,015,043**	**1,930,476**	**318,463**	**6,559,748**	**(2,437,597)**	8,997,345
pmpm	*(1.28)*	*8.76*	*28.09*	*24.22*	*23.21*	*(28.96)*	*34.20*	*4.91*	*9.33*	*1.55*	*3.50*	*(1.28)*	4.79
% of Revenue	-0.5%	3.4%	10.8%	8.7%	8.3%	-12.2%	11.3%	1.8%	3.3%	0.5%	1.3%	-0.5%	1.75%
YTD													
100% TNE	16,769,368	16,138,440	17,867,986	22,556,530	25,246,284	26,097,131	27,075,526	27,648,155	27,569,584	27,709,401	27,709,401	27,979,090	(269,689)
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Minimum Required TNE	6,036,972	10,974,139	17,867,986	22,556,530	25,246,284	26,097,131	27,075,526	27,648,155	27,569,584	27,709,401	27,709,401	27,979,090	(269,689)
GCHP TNE	**(6,031,881)**	**11,891,099**	**55,535,211**	**107,145,264**	**155,959,127**	**137,829,722**	**159,254,894**	**160,269,936**	**162,200,412**	**162,518,875**	**162,518,875**	**150,619,559**	**11,899,316**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**37,667,225**	**84,588,734**	**130,712,843**	**111,732,591**	**132,179,367**	**132,621,781**	**134,630,827**	**134,809,474**	**134,809,474**	**122,640,469**	**12,169,005**
% of Required TNE level			**311%**	**475%**	**618%**	**528%**	**588%**	**580%**	**588%**	**587%**	**587%**	**538%**	

FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING MARCH 31, 2017



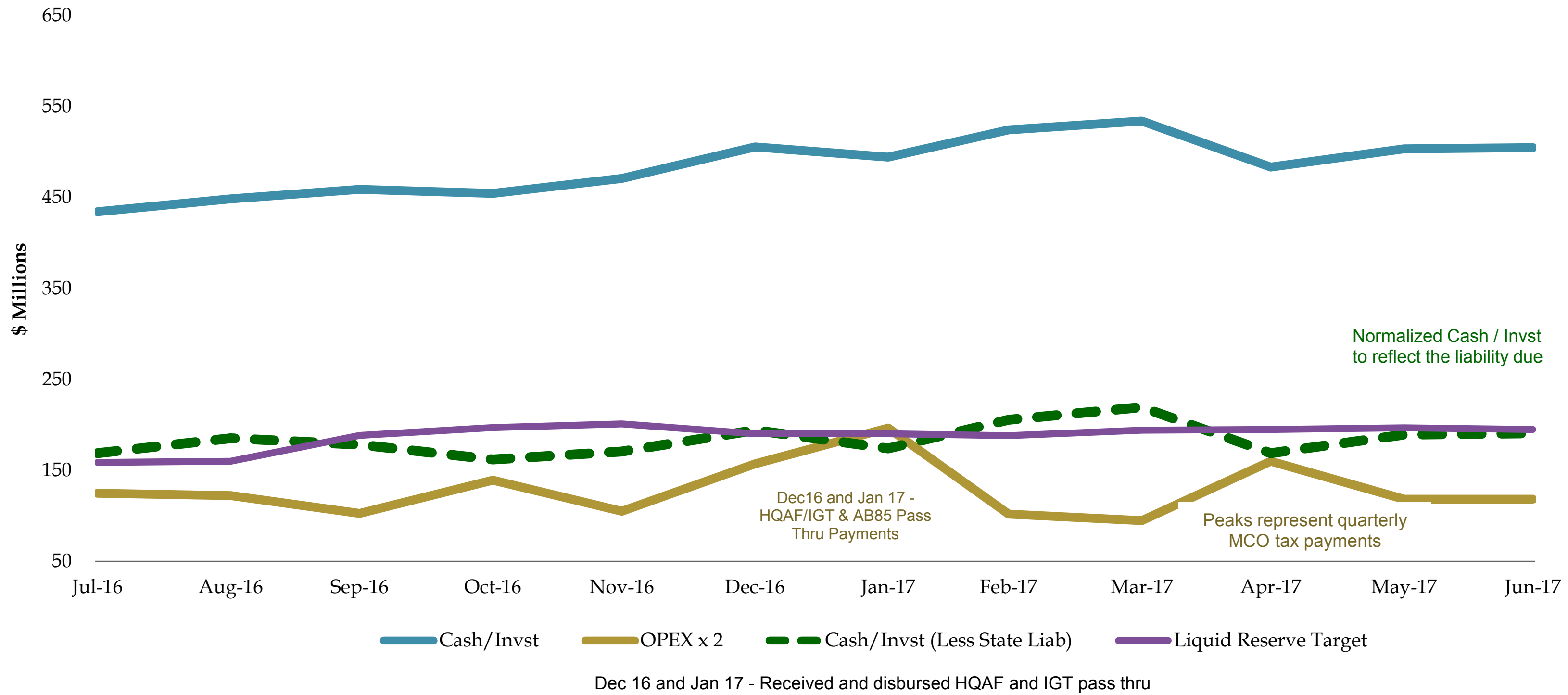






	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FYTD MAR 2017
Operating Gain	$43,644	$51,610	$56,014	$6,560
TNE	$48,335	$99,945	$155,959	$162,519
Required TNE	$17,868	$22,557	$25,246	$27,709
500% of Required TNE	$89,340	$112,783	$126,231	$138,547

* 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)


GOLD COAST HEALTH PLAN
FY 2016 - 17
Cash & Operating Expense Requirements
650
550
450
350
250
150
50
$ Millions
Normalized Cash / Invst
to reflect the liability due
Dec16 and Jan 17 -
HQAF/IGT & AB85 Pass
Thru Payments
Peaks represent quarterly
MCO tax payments
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Cash/Invst
OPEX x 2
Cash/Invst (Less State Liab)
Liquid Reserve Target
Dec 16 and Jan 17 - Received and disbursed HQAF and IGT pass thru

For the month ended March 31, 2017

APPENDIX

- Statement of Financial Position
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows
- Membership
- Paid Claims and IBNP Composition
- Pharmacy Cost & Utilization Trends

STATEMENT OF FINANCIAL POSITION

	03/31/17	02/28/17	01/31/17
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 275,089,340**	**$ 235,471,944**	**$ 205,592,579**
Total Short-Term Investments	**258,959,818**	**288,884,145**	**288,731,539**
Medi-Cal Receivable	66,185,676	66,972,133	90,685,076
Interest Receivable	624,606	483,116	492,742
Provider Receivable	481,141	373,828	694,327
Total Accounts Receivable	**67,291,423**	**67,829,077**	**91,872,144**
Total Prepaid Accounts	1,681,886	1,749,644	1,570,694
Total Other Current Assets	133,545	133,545	133,545
Total Current Assets	**603,156,013**	**594,068,356**	**587,900,502**
Total Fixed Assets	**2,462,002**	**2,509,454**	**2,579,009**
Total Assets	**$ 605,618,015**	**$ 596,577,810**	**$ 590,479,511**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 55,118,983	$ 51,907,342	$ 48,376,620
Claims Payable	13,955,262	13,432,317	14,122,248
Capitation Payable	57,064,473	56,990,011	56,948,813
Physician ACA 1202 Payable	591,696	591,696	591,696
AB 85 Payable	1,464,483	1,468,678	2,946,203
Accounts Payable	2,434,125	2,174,458	2,121,634
Accrued ACS	1,668,962	1,652,846	1,691,089
Accrued Expenses	156,614,148	155,195,354	155,700,648
Accrued Premium Tax	20,519,903	13,513,936	8,767,157
Accrued Payroll Expense	1,374,754	1,181,933	1,198,599
Total Current Liabilities	**310,806,788**	**298,108,571**	**292,464,707**
Long-Term Liabilities:			
DHCS - Reserve for Capitation Recoup	131,269,946	135,269,946	136,769,946
Other Long-term Liability-Deferred Rent	1,022,406	998,881	974,922
Total Long-Term Liabilities	**132,292,352**	**136,268,827**	**137,744,868**
Total Liabilities	**443,099,140**	**434,377,398**	**430,209,575**
Net Assets:			
Beginning Net Assets	155,959,127	155,959,127	155,959,127
Total Increase / (Decrease in Unrestricted Net Assets)	6,559,748	6,241,285	4,310,809
Total Net Assets	**162,518,875**	**162,200,412**	**160,269,936**
Total Liabilities & Net Assets	**$ 605,618,015**	**$ 596,577,810**	**$ 590,479,511**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR NINE MONTHS ENDED MARCH 31, 2017

	March 2017 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	1,871,966	1,902,008	(30,042)
Revenue			
Premium	$ 573,947,693	$ 577,747,097	$ (3,799,404)
Reserve for Rate Reduction	3,350,000	(1,864,359)	5,214,359
MCO Premium Tax	(63,137,221)	(61,855,911)	(1,281,311)
Total Net Premium	**514,160,472**	**514,026,827**	**133,645**
Other Revenue:			
Miscellaneous Income	366,680	0	366,680
Total Other Revenue	366,680	**0**	366,680
Total Revenue	**514,527,152**	**514,026,827**	**500,325**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	49,823,806	45,269,267	(4,554,539)
FFS Claims Expenses:			
Inpatient	97,979,057	95,243,511	(2,735,546)
LTC / SNF	88,108,918	86,427,243	(1,681,675)
Outpatient	39,654,807	36,946,829	(2,707,978)
Laboratory and Radiology	2,487,315	2,184,656	(302,659)
Emergency Room	16,323,766	16,218,991	(104,775)
Physician Specialty	40,192,700	43,038,501	2,845,800
Primary Care Physician	11,077,866	14,055,168	2,977,302
Home & Community Based Services	13,798,170	11,826,937	(1,971,233)
Applied Behavior Analysis Services	3,569,175	1,078,156	(2,491,019)
Mental Health Services	5,845,894	3,111,453	(2,734,441)
Pharmacy	86,680,990	88,123,448	1,442,458
Provider Reserve	266,667	9,105,362	8,838,696
Other Medical Professional	2,170,536	1,872,791	(297,744)
Other Medical Care	201,880	0	(201,880)
Other Fee For Service	6,038,872	5,697,332	(341,540)
Transportation	1,082,895	1,165,081	82,186
Total Claims	415,479,509	416,095,461	615,952
Medical & Care Management Expense	9,073,949	10,508,206	1,434,256
Reinsurance	780,718	4,526,779	3,746,061
Claims Recoveries	(1,729,343)	0	1,729,343
Sub-total	8,125,325	15,034,985	6,909,660
Total Cost of Health Care	**473,428,639**	**476,399,713**	**2,971,074**
Contribution Margin	**41,098,513**	**37,627,115**	**3,471,398**
General & Administrative Expenses:			
Salaries, Wages & Employee Benefits	16,991,170	17,939,098	947,928
Training, Conference & Travel	323,491	446,634	123,143
Outside Services	20,709,941	21,904,301	1,194,359
Professional Services	2,878,432	4,816,052	1,937,620
Occupancy, Supplies, Insurance & Others	4,958,872	6,346,418	1,387,545
Care Management Credit	(9,073,949)	(10,508,206)	(1,434,256)
Total G & A Expenses	**36,787,957**	**40,944,297**	**4,156,339**
Total Operating Gain / (Loss)	**$ 4,310,556**	**$ (3,317,182)**	**$ 7,627,738**
Non Operating			
Revenues - Interest	2,249,192	879,585	1,369,607
Total Non-Operating	2,249,192	879,585	1,369,607
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 6,559,748**	**$ (2,437,597)**	**$ 8,997,345**
Net Assets, Beginning of Year	155,959,127		
Net Assets, End of Year	162,518,875		

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

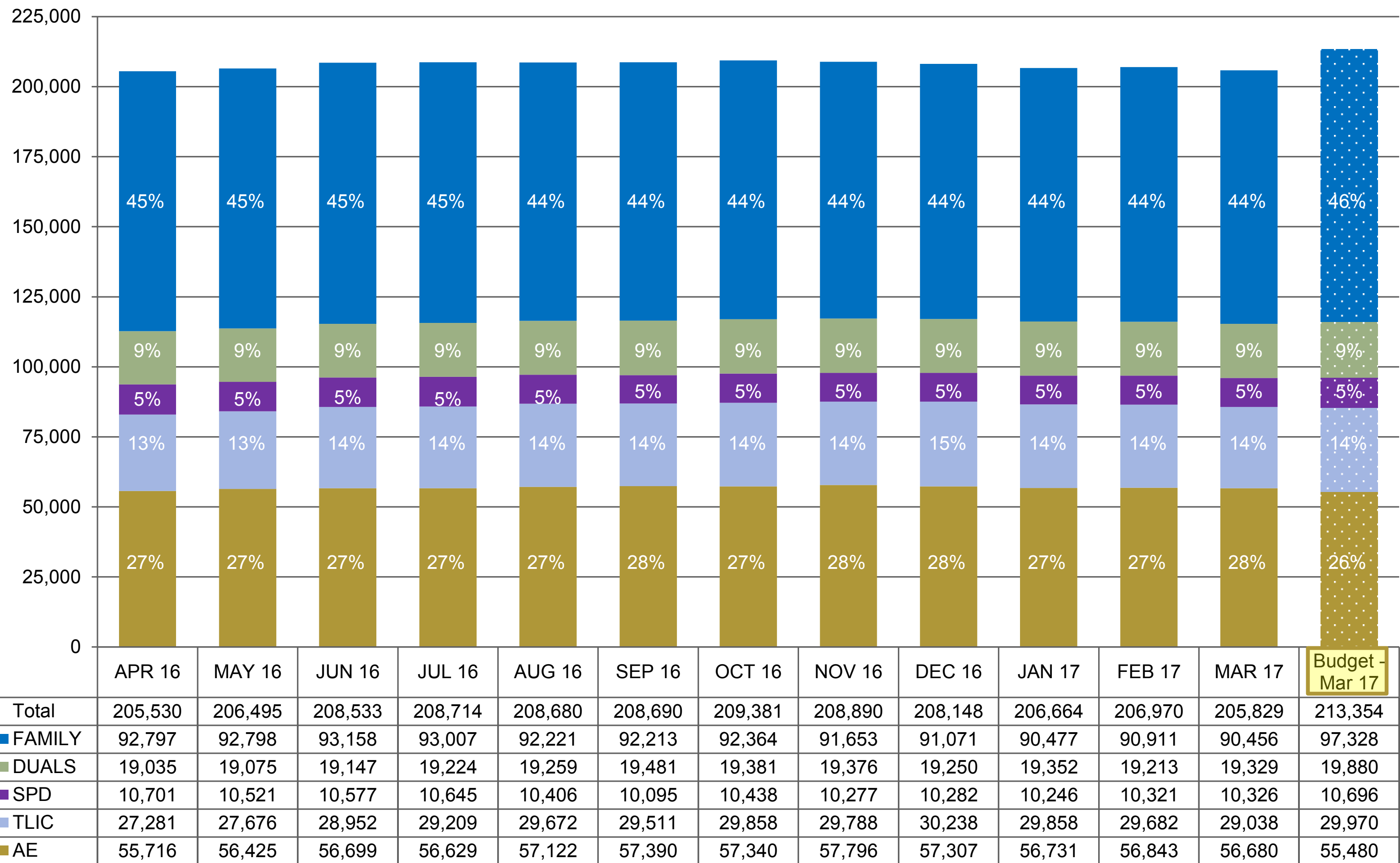
	FY 2016-17 Monthly Trend			Current Month		
	DEC 16	Jan 17	Feb 17	MARCH 2017		Variance
				Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	208,148	206,664	206,970	205,829	213,354	(7,525)
Revenue:						
Premium	$ 63,330,543	$ 63,165,021	$ 63,438,477	$ 62,813,120	$ 64,748,990	$ (1,935,870)
Reserve for Rate Reduction	(900,000)	1,650,000	1,500,000	4,000,000	(200,040)	4,200,040
MCO Premium Tax	(7,007,063)	(7,005,835)	(7,006,118)	(7,006,094)	(6,935,413)	(70,681)
Total Net Premium	**55,423,480**	**57,809,187**	**57,932,359**	**59,807,026**	**57,613,536**	**2,193,490**
Other Revenue:						
Miscellaneous Income	266,929	99,751	0	0	0	0
Total Other Revenue	266,929	99,751	0	0	0	0
Total Revenue	**55,690,409**	**57,908,938**	**57,932,359**	**59,807,026**	**57,613,536**	**2,193,490**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,078,661	5,071,929	5,029,586	5,227,526	5,074,056	(153,470)
FFS Claims Expenses:						
Inpatient	9,534,211	10,137,221	9,355,847	12,784,974	10,686,257	(2,098,717)
LTC / SNF	9,091,987	5,498,137	11,439,236	9,891,367	9,641,049	(250,317)
Outpatient	4,979,461	6,695,529	4,477,337	4,028,914	4,145,265	116,351
Laboratory and Radiology	146,314	310,758	226,793	312,311	245,295	(67,016)
Emergency Room	1,635,653	2,082,908	2,113,200	2,177,348	1,818,920	(358,428)
Physician Specialty	4,532,550	5,003,052	3,959,094	4,747,630	4,833,882	86,252
Primary Care Physician	1,326,796	1,481,695	1,176,119	1,175,549	1,578,007	402,458
Home & Community Based Services	1,302,526	2,343,302	1,805,214	1,459,004	1,333,237	(125,767)
Applied Behavior Analysis Services	274,227	555,128	460,227	621,128	120,355	(500,773)
Mental Health Services	456,716	2,036,393	892,933	542,188	348,433	(193,755)
Pharmacy	9,263,820	9,506,656	9,204,612	10,301,143	9,871,116	(430,027)
Provider Reserve	0	100,000	0	166,667	1,019,317	852,650
Other Medical Professional	230,300	220,980	241,561	293,662	210,188	(83,474)
Other Medical Care	200,983	0	234	0	0	0
Other Fee For Service	561,433	752,515	630,149	601,990	638,134	36,144
Transportation	114,725	142,606	115,093	91,625	130,340	38,715
Total Claims	43,651,702	46,866,880	46,097,649	49,195,501	46,619,796	(2,575,705)
Medical & Care Management Expense	1,022,900	1,036,138	1,085,264	1,066,266	1,194,104	127,838
Reinsurance	260,296	172,390	231,721	256,032	507,783	251,751
Claims Recoveries	(301,825)	(7,459)	(1,439)	(263,948)	0	263,948
Sub-total	981,371	1,201,069	1,315,547	1,058,350	1,701,887	643,537
Total Cost of Health Care	**49,711,735**	**53,139,878**	**52,442,783**	**55,481,377**	**53,395,738**	**(2,085,638)**
Contribution Margin	**5,978,674**	**4,769,060**	**5,489,576**	**4,325,650**	**4,217,798**	**107,852**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	1,960,636	1,995,362	1,749,737	1,982,336	2,079,959	97,624
Training, Conference & Travel	33,663	19,453	44,206	28,317	44,331	16,014
Outside Services	2,371,432	2,299,058	2,246,393	2,353,686	2,463,287	109,601
Professional Services	222,513	216,954	187,769	438,247	425,340	(12,907)
Occupancy, Supplies, Insurance & Others	525,375	594,220	743,167	613,892	708,608	94,716
Care Management Credit	(1,022,900)	(1,036,138)	(1,085,264)	(1,066,266)	(1,194,104)	(127,838)
Total G & A Expenses	**4,090,719**	**4,088,911**	**3,886,007**	**4,350,212**	**4,527,421**	**177,209**
Total Operating Gain / (Loss)	**1,887,955**	**680,149**	**1,603,570**	**(24,562)**	**(309,622)**	**285,061**
Non Operating:						
Revenues - Interest	273,090	334,894	326,906	343,025	64,229	278,795
Total Non-Operating	**273,090**	**334,894**	**326,906**	**343,025**	**64,229**	**278,795**
Total Increase / (Decrease) in Unrestricted Net Assets	**2,161,044**	**1,015,043**	**1,930,476**	**318,463**	**(245,393)**	**563,856**
Full Time Employees				**184**	**200**	**16**

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

	FY 2016-17 Monthly Trend			MARCH 2017		Variance
	DEC 16	Jan 17	Feb 17	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	208,148	206,664	206,970	205,829	213,354	(7,525)
Revenue:						
Premium	304.26	305.64	306.51	305.17	303.48	1.69
Reserve for Rate Reduction	(4.32)	7.98	7.25	19.43	(0.94)	20.37
MCO Premium Tax	(33.66)	(33.90)	(33.85)	(34.04)	(32.51)	(1.53)
Total Net Premium	**266.27**	**279.73**	**279.91**	**290.57**	**270.04**	**20.53**
Other Revenue:						
Miscellaneous Income	1.28	0.48	0.00	0.00	0.00	0.00
Total Other Revenue	1.28	0.48	0.00	0.00	0.00	0.00
Total Revenue	**267.55**	**280.21**	**279.91**	**290.57**	**270.04**	**20.53**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	24.40	24.54	24.30	25.40	23.78	(1.62)
FFS Claims Expenses:						
Inpatient	45.80	49.05	45.20	62.11	50.09	(12.03)
LTC / SNF	43.68	26.60	55.27	48.06	45.19	(2.87)
Outpatient	23.92	32.40	21.63	19.57	19.43	(0.15)
Laboratory and Radiology	0.70	1.50	1.10	1.52	1.15	(0.37)
Emergency Room	7.86	10.08	10.21	10.58	8.53	(2.05)
Physician Specialty	21.78	24.21	19.13	23.07	22.66	(0.41)
Primary Care Physician	6.37	7.17	5.68	5.71	7.40	1.68
Home & Community Based Services	6.26	11.34	8.72	7.09	6.25	(0.84)
Applied Behavior Analysis Services	1.32	2.69	2.22	3.02	0.56	(2.45)
Mental Health Services	2.19	9.85	4.31	2.63	1.63	(1.00)
Pharmacy	44.51	46.00	44.47	50.05	46.27	(3.78)
Provider Reserve	0.00	0.48	0.00	0.81	4.78	3.97
Other Medical Professional	1.11	1.07	1.17	1.43	0.99	(0.44)
Other Medical Care	0.97	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	2.70	3.64	3.04	2.92	2.99	0.07
Transportation	0.55	0.69	0.56	0.45	0.61	0.17
Total Claims	209.71	226.78	222.73	239.01	218.51	(20.50)
Medical & Care Management Expense	4.91	5.01	5.24	5.18	5.60	0.42
Reinsurance	1.25	0.83	1.12	1.24	2.38	1.14
Claims Recoveries	(1.45)	(0.04)	(0.01)	(1.28)	0.00	1.28
Sub-total	4.71	5.81	6.36	5.14	7.98	2.83
Total Cost of Health Care	238.83	257.13	253.38	269.55	**250.27**	**(19.28)**
Contribution Margin	**28.72**	**23.08**	**26.52**	**21.02**	**19.77**	**1.25**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	9.42	9.66	8.45	9.63	9.75	0.12
Training, Conference & Travel	0.16	0.09	0.21	0.14	0.21	0.07
Outside Services	11.39	11.12	10.85	11.44	11.55	0.11
Professional Services	1.07	1.05	0.91	2.13	1.99	(0.14)
Occupancy, Supplies, Insurance & Others	2.52	2.88	3.59	2.98	3.32	0.34
Care Management Credit	(4.91)	(5.01)	(5.24)	(5.18)	(5.60)	(0.42)
Total G & A Expenses	19.65	19.79	18.78	21.14	21.22	0.09
Total Operating Gain / (Loss)	9.07	3.29	7.75	(0.12)	(1.45)	1.33
Non Operating:						
Revenues - Interest	1.31	1.62	1.58	1.67	0.30	1.37
Total Non-Operating	1.31	1.62	1.58	1.67	0.30	1.37
Total Increase / (Decrease) in Unrestricted Net Assets	10.38	4.91	9.33	1.55	(1.15)	2.70

STATEMENT OF CASH FLOWS	JAN 17	FEB 17	MAR 17	FYTD
Cash Flows Provided By Operating Activities				
Net Income (Loss)	1,015,043	1,930,476	318,463	6,559,748
Adjustments to reconciled net income to net cash provided by operating activities				-
Depreciation on fixed assets	45,001	47,677	47,452	470,635
Amortization of discounts and premium	(35,153)	(35,451)	(38,568)	(30,953)
Changes in Operating Assets and Liabilites				-
Accounts Receivable	(1,991,734)	24,043,067	537,654	62,714,849
Prepaid Expenses	(32,205)	(178,950)	67,758	(76,760)
Accounts Payable	9,755,235	(3,460,945)	(2,093,274)	77,900,286
Claims Payable	(2,846,760)	(648,733)	597,407	5,756,568
MCO Tax liablity	(12,486,415)	4,746,779	7,005,967	14,943,908
IBNR	(10,002,295)	3,530,722	3,211,641	(1,192,409)
Net Cash Provided by Operating Activities	(16,579,284)	29,974,642	9,654,501	167,045,872
Cash Flow Provided By Investing Activities				
Proceeds from Restricted Cash & Other Assets				-
Proceeds from Investments	20,000,000	-	30,000,000	75,000,000
Proceeds for Sales of Property, Plant and Equipment				-
Payments for Restricted Cash and Other Assets				-
Purchase of Investments	(20,019,829)	(117,156)	(37,105)	(110,661,100)
Purchase of Property and Equipment	(29,199)	21,879	-	(387,897)
Net Cash (Used In) Provided by Investing Activities	(49,027)	(95,277)	29,962,895	(36,048,998)
Cash Flow Provided By Financing Activities				
None	-			-
Net Cash Used In Financing Activities	-	-	-	-
Increase/(Decrease) in Cash and Cash Equivalents	(16,628,311)	29,879,365	39,617,397	130,996,874
Cash and Cash Equivalents, Beginning of Period	222,220,890	205,592,579	235,471,944	144,092,466
Cash and Cash Equivalents, End of Period	205,592,579	235,471,944	275,089,340	275,089,340

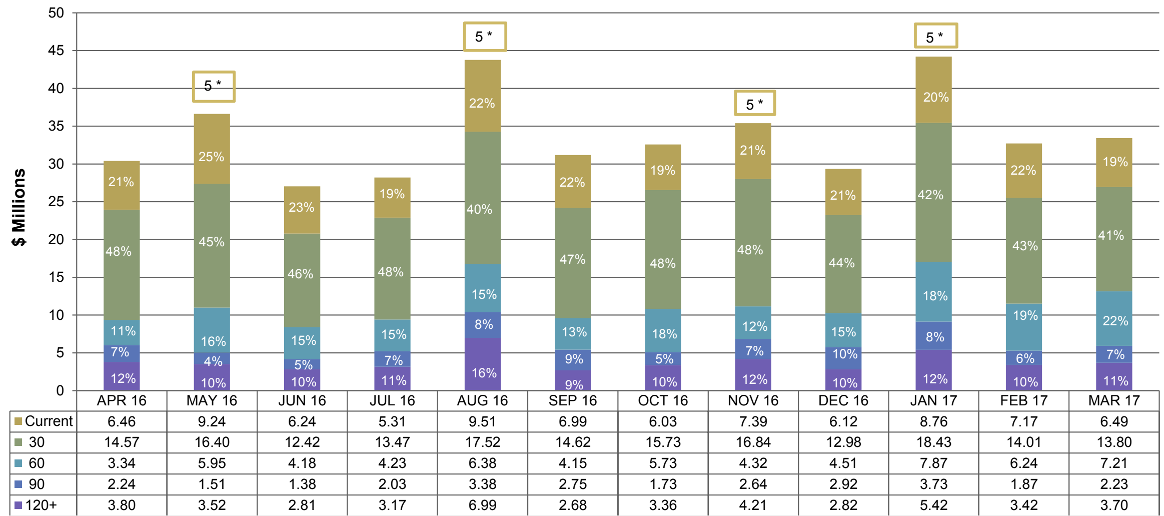
GOLD COAST HEALTH PLAN



	APR 16	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	Budget - Mar 17
Total	205,530	206,495	208,533	208,714	208,680	208,690	209,381	208,890	208,148	206,664	206,970	205,829	213,354
FAMILY	92,797	92,798	93,158	93,007	92,221	92,213	92,364	91,653	91,071	90,477	90,911	90,456	97,328
DUALS	19,035	19,075	19,147	19,224	19,259	19,481	19,381	19,376	19,250	19,352	19,213	19,329	19,880
SPD	10,701	10,521	10,577	10,645	10,406	10,095	10,438	10,277	10,282	10,246	10,321	10,326	10,696
TLIC	27,281	27,676	28,952	29,209	29,672	29,511	29,858	29,788	30,238	29,858	29,682	29,038	29,970
AE	55,716	56,425	56,699	56,629	57,122	57,390	57,340	57,796	57,307	56,731	56,843	56,680	55,480

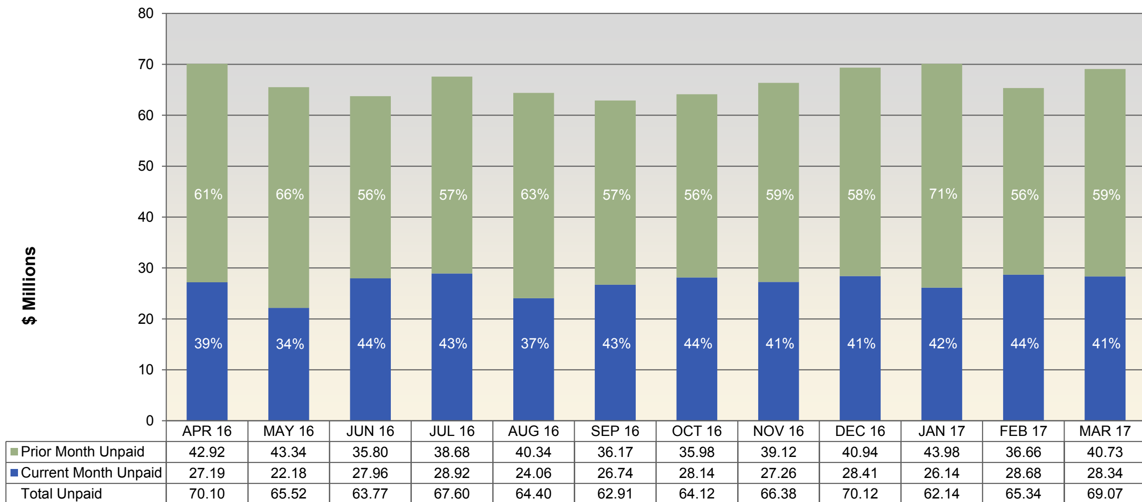
SPD = Seniors and Persons with Disabilities TLIC = Targeted Low Income Children AE = Adult Expansion

GOLD COAST HEALTH PLAN
MARCH 2017



	APR 16	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17
Current	6.46	9.24	6.24	5.31	9.51	6.99	6.03	7.39	6.12	8.76	7.17	6.49
30	14.57	16.40	12.42	13.47	17.52	14.62	15.73	16.84	12.98	18.43	14.01	13.80
60	3.34	5.95	4.18	4.23	6.38	4.15	5.73	4.32	4.51	7.87	6.24	7.21
90	2.24	1.51	1.38	2.03	3.38	2.75	1.73	2.64	2.92	3.73	1.87	2.23
120+	3.80	3.52	2.81	3.17	6.99	2.68	3.36	4.21	2.82	5.42	3.42	3.70

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.

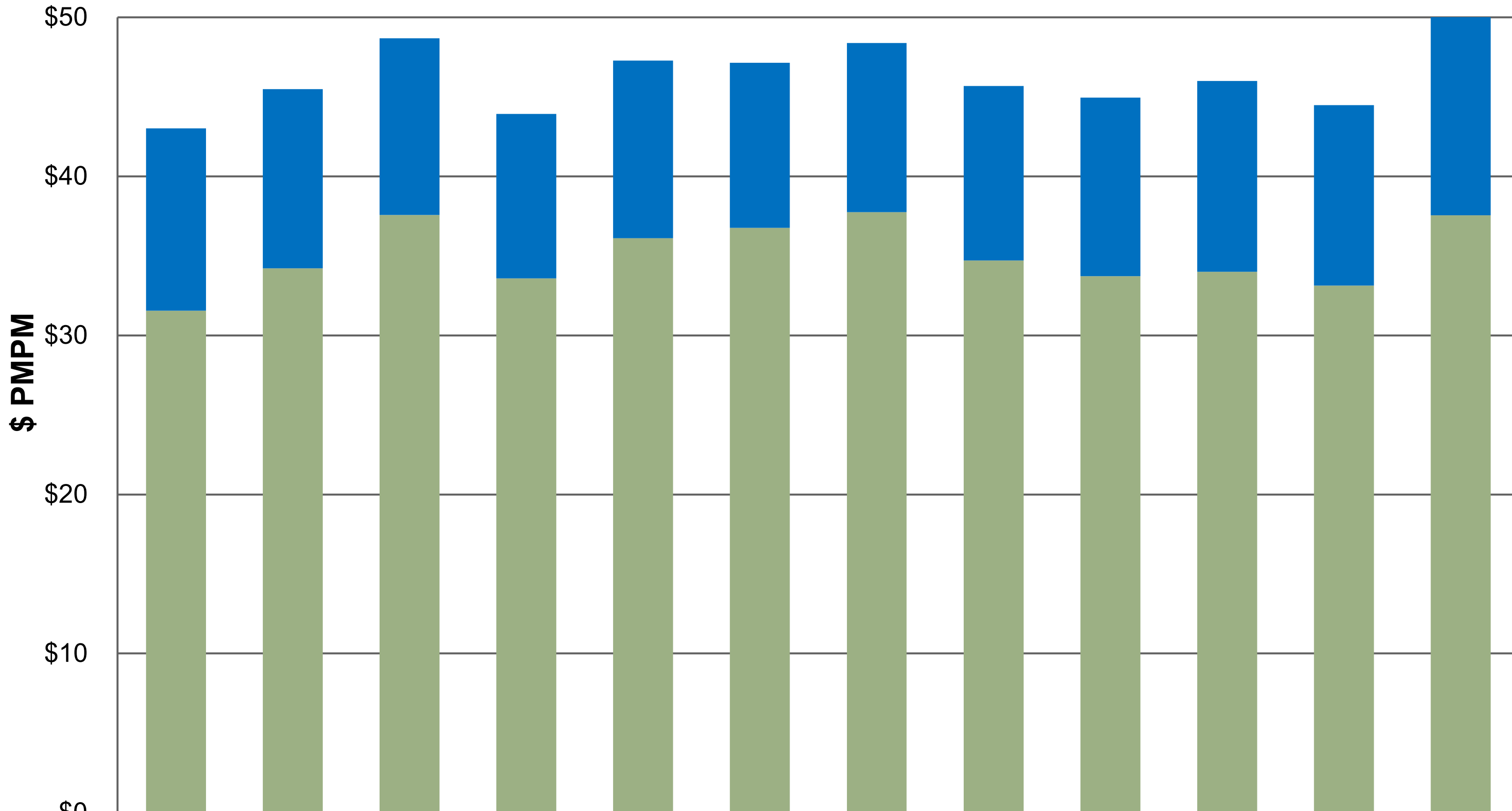


	APR 16	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17
Prior Month Unpaid	42.92	43.34	35.80	38.68	40.34	36.17	35.98	39.12	40.94	43.98	36.66	40.73
Current Month Unpaid	27.19	22.18	27.96	28.92	24.06	26.74	28.14	27.26	28.41	26.14	28.68	28.34
Total Unpaid	70.10	65.52	63.77	67.60	64.40	62.91	64.12	66.38	70.12	62.14	65.34	69.07

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

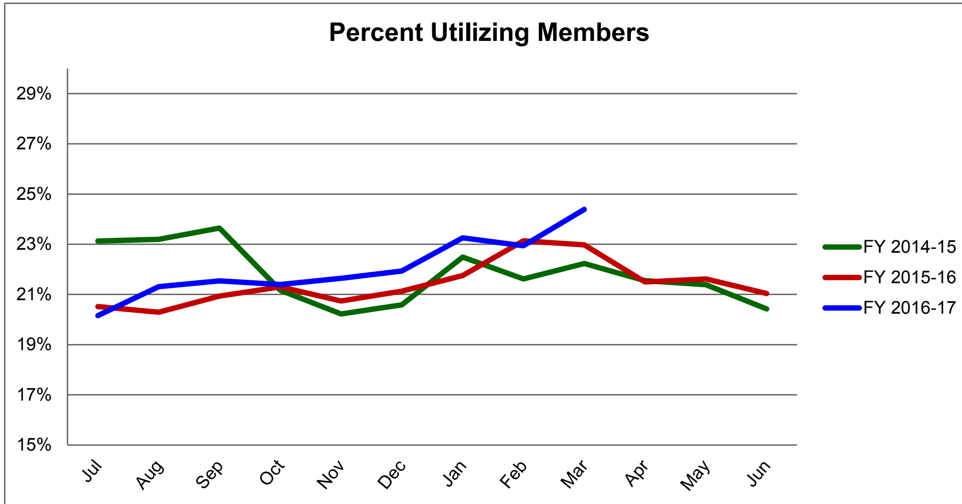
GOLD COAST HEALTH PLAN

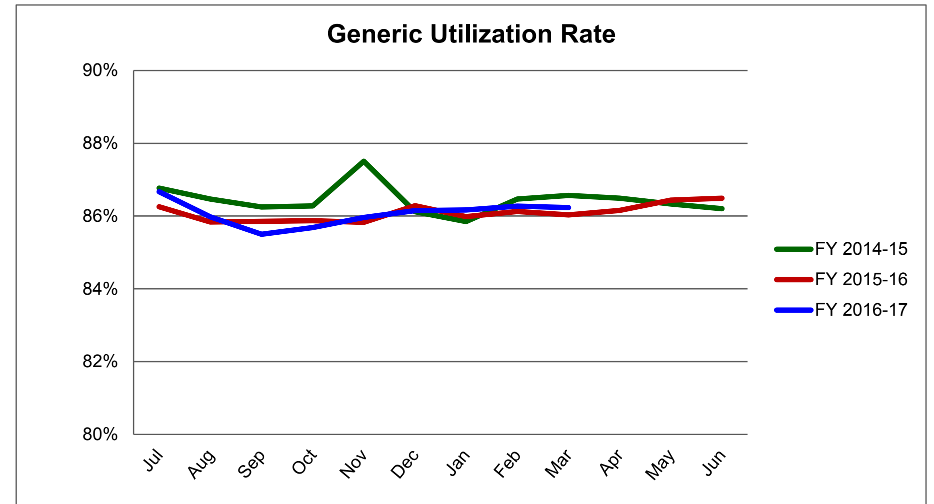
Pharmacy Cost Trend



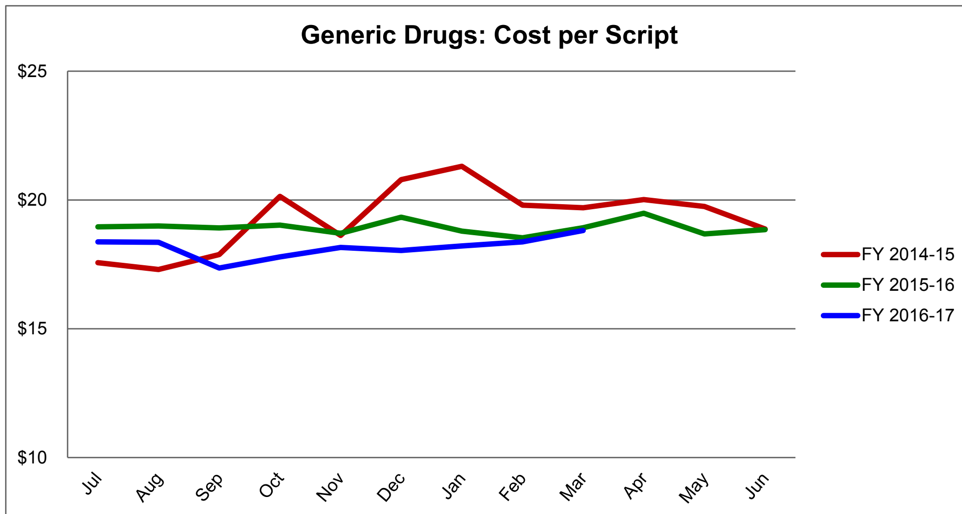
	APR 16	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17
AVG PMPM	$43.01	$45.48	$48.67	$43.93	$47.28	$47.15	$48.38	$45.69	$44.95	$46.00	$44.47	$50.59
GENERIC	$11.47	$11.26	$11.09	$10.34	$11.17	$10.39	$10.64	$10.97	$11.23	$12.00	$11.34	$13.03
BRAND	$31.55	$34.22	$37.58	$33.59	$36.11	$36.77	$37.74	$34.71	$33.73	$34.00	$33.13	$37.55

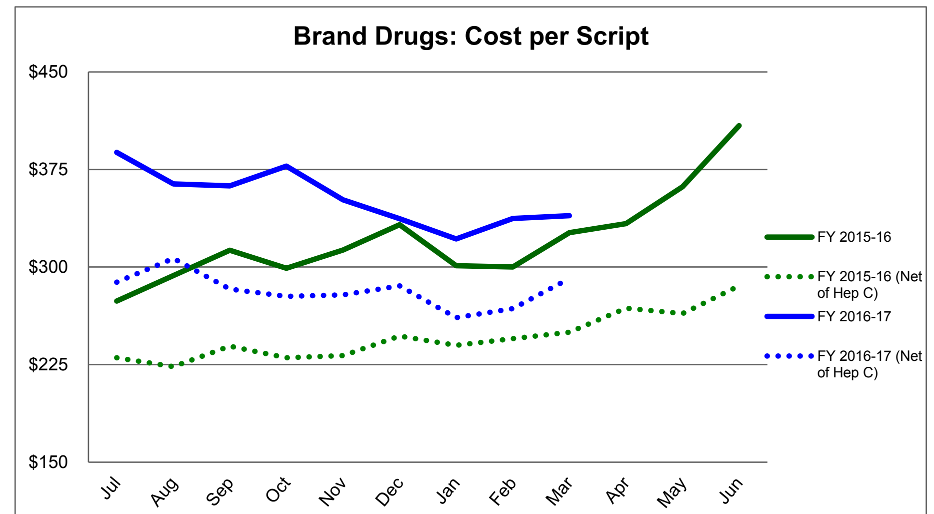
GOLD COAST HEALTH PLAN
PHARMACY ANALYSIS





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





AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Associate Chief Medical Officer

DATE: May 22, 2017

SUBJECT: Benefit Enhancement – Continuous Glucose Monitoring

SUMMARY:

Gold Coast Health Plan (GCHP) seeks to allow continuous glucose monitoring as a benefit.

BACKGROUND:

Continuous Glucose Monitoring (CGM) consists of a subcutaneously inserted sensor that measures interstitial glucose and delivers glucose values to a recording device.

The American Association of Clinical Endocrinologists and American College of Endocrinology state the benefits of continuous glucose monitoring are:

- CGM improves glycemic control, reduces hypoglycemia, and may reduce overall costs of diabetes management
- CGM is likely to reduce costs associated with hypoglycemia and severe hyperglycemia by alerting patients to impending or actual low or high glucose values. This may facilitate prompt action and prevent hospitalizations
- Data supports CGM-associated improvements in A1C

Source: https://www.aace.com/files/guidelines/PrePrintContinuousGlucoseMonitoring.pdf

DISCUSSION:

The GCHP Health Services Department would require prior authorization for this service. Medical necessity would be determined using MCG's Clinical Guidelines. Long term continuous glucose monitoring is appropriate for Type 1 diabetics on an intensive insulin regimen (3 or more insulin injections/day). Short-term continuous glucose monitoring (1 week or less) is appropriate for Type 1 diabetics when additional information about blood glucose is needed to detect very low or very high blood sugars.

FISCAL IMPACT:

GCHP estimates there are currently less 275 members who would be eligible for this benefit.

The current annual cost for standard home glucose monitoring for these members is about $4,000. The average annual cost of continuous glucose monitoring is approximately $10,000. Therefore, continuous glucose monitoring would add an additional $6,000/year for appropriate glucose monitoring for these members.

It is anticipated that the benefit of improved glycemic control will reduce overall costs of diabetes management, including hospitalization.

RECOMMENDATION:

GCHP recommends the Commission approve continuous glucose monitoring as a benefit.

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Associate Chief Medical Officer

DATE: May 22, 2017

SUBJECT: Benefit Enhancement - Panniculectomy

SUMMARY:

Gold Coast Health Plan (GCHP) seeks to allow panniculectomy as a benefit.

BACKGROUND:

Panniculectomy is the surgical removal of excess abdominal skin and fat without tightening of underlying muscles. (Tightening of underlying abdominal muscles is called abdominoplasty). After patients with morbid obesity undergo massive weight loss, excess abdominal skin can become the source of a variety of complications, including candidal intertrigo, dermatitis, lymphedema, ischemic panniculitis, and restricted mobility that impairs further weight loss.

Currently, neither panniculectomy nor abdominoplasty are Medi-Cal benefits. GCHP seeks to allow panniculectomy only as a benefit. GCHP is not seeking to add abdominoplasty as a benefit.

DISCUSSION:

The GCHP Health Services Department would require prior authorization for this service. Medical necessity would be determined using MCG's Clinical Guidelines. MCG Guidelines require documentation of skin complications with failure of conservative therapy, a panniculus interfering with activities of daily living, and stable weight.

From CY 2014 through CY 2016, GCHP approved about 65 bariatric surgeries annually. About 12% of bariatric patients qualify for panniculectomy.

FISCAL IMPACT:

The average cost of a panniculectomy is $3,000 to $4,000. GCHP has averaged eight panniculectomies per year over the last three years.

Therefore, it is estimated that this benefit enhancement would have an annual cost of about $32,000.

It is anticipated that provision of a panniculectomy benefit will reduce costs associated with treatment of skin complications.

RECOMMENDATION:

GCHP recommends the Commission approve panniculectomy as a benefit.

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: May 22, 2017

SUBJECT: Quality Improvement Committee Report

RECOMMENDATION:

To accept and file the Quality Improvement Committee 2017 First Quarter Report.

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

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Quality Improvement Committee Report

First Quarter 2017

Commission Meeting May 22, 2017

C. Albert Reeves, MD, CMO

Integrity
Accountability
Collaboration
Trust
Respect

Quality Improvement 3/28

Quality Improvement											
Legend:											
Met or exceeded Benchmark											
Did not meet Benchmark											
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**Interventions**
Facility Site Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS site audit criteria met.	DHCS/ Title 22	80%	**99%**	**92%**	**99%**	**99%**	**98%**	**NR**		
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%**	**NR**		
Medical Record Quality Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS medical record audit criteria met.	DHCS/ Title 22	80%	**96%**	**88%**	**93%**	**95%**	**93%**	**NR**		
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%**	**88%**	**100%**	**100%**	**100%**	**NR**		
Coordination of Care	The overall percentage of applicable DHCS Coordination of Care criteria met as determined by medical record audits.	NA	Tracking	**100%**	**93%**	**98%**	**98%**	**100%**	**NR**		

No Initial or Periodic FSR's or MRR's were required during Q4 2016

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GCHP Improvement Projects

1. Performance Improvement Project (PIP) #1 – Childhood Immunizations – 2 year olds

- Project is ongoing at Las Islas Family Medical Clinic.
- Currently in stage 4 – testing the proposed interventions which are to identify members not fully immunized, and reach out to the families to schedule appointments for the immunizations.
- Status as of February 2017 – Rate 79.31% (goal 77.66% and baseline 67.66%)

  96.24% of calls result in an appointment

  96.95% of appointments are kept

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GCHP Improvement Projects

2. Performance Improvement Project (PIP) #2 – increase the utilization of standardized Child Developmental Screening Tools Project.

- In Module 4 – Testing the interventions

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2016 HEDIS Improvement Projects

Mandated HEDIS Improvement Projects due to the measures scoring below the minimum performance level (MPL). These 2 improvement projects continue but will be concluding soon.

1. Well-Child Exams in the 3rd, 4th, 5th and 6th Years of Life

   We completed the first of 2 Plan-Do-Study-Act trials at 2 clinics, West Ventura Clinic and Las Posas Clinic, and surpassed the goal of increasing the rate by 5%. We will be doing another 6 week trials at 2 other Clinics. Report to DHCS on May.

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2. Cervical Cancer Screening

   The 1st of 2 PDSA trials was completed 12/31/2016 at 2 clinics. Almost met the 5% improvement goal. Another 3 month trial will be done at 2 other clinics.

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Other Quality Improvement Activities

1. Initial Health Assessment (IHA) Monitoring – an IHA is to be done on any new member within 120 days of enrollment in GCHP. DHCS expects the Plan to monitor for compliance.

   The GCHP goal is 90% compliance.

   129 sites surveyed – 84 (65%) above 90%, and 45 (35%) below. Primary reasons for failing the IHA monitoring are absent or incomplete Staying Healthy Assessment and missing TB Risk Assessment. Clinics received counseling regarding the reasons for failure – including a copy of the audit form and explanation, clinic staff training, 1 on 1 training of new staff.

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Facility Site Reviews – new providers are reviewed at time of contracting, and existing primary care providers are reviewed every 3 years.

- 0 new sites were reviewed therefore, all were completed.
- 8 interim sites were reviewed and all passed.

Physical Accessibility Review Survey – an office review for high volume specialists

- 112 of 112 were completed in 2016 – all passed.

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Initial Health Assessment Completions – 4th Quarter

Reviews conducted – 123

Pass 84 – 68%

Fail 39 – 32%

Primary reason for failure – not completing the Staying Health Assessment.

GCHP continues to coach clinics with failed rates to make changes to improve.

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Children's Access to Primary Care – Pay for Performance Program

A pay for performance program to improve the HEDIS Rate for children 25 months to 19 years has been started at the three largest clinic groups. It will measure the improvement of rates in 2017 with the rates in 2015. The program will conclude July 15, 2018 with the finalization of the 2017 HEDIS rates.

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Approval of Updated Quality Policies

The Quality Improvement Committee approved updated versions of the following policies:

1. Medical Records Requirements
2. Communicable Disease Reporting Requirements
3. Provider Preventable Conditions Reporting Requirements

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Compliance Delegation Oversight

Delegation Oversight : Assessment of Delegated Quality Activities										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**Interventions**
Delegation of UM	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 5; NCQA Standard UM 15	DHCS Contract	**100%**[5]	**100%**	**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%**[6]	**100%**	**NA**	**NA**	**100%**		
Delegation of QI	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard QI 12	DHCS Contract	**100%**[7]	**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%**[7]	**NA**	**NA**	**NA**	**100%**		
Delegation of Claims	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 8	DHCS Contract	**100%**	**NA**	**100%**	**100%**	**100%**		

[5] 2015 data available for Q2 and Q4 only.

[6] 2015 data available for Q1 and Q2 only.

[7] 2015 data available for Q1 and Q4 only.

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Delegation Oversight

Claims Processing

1. Beacon Health Strategies (BHS) – An on-site audit done on Jan.24 and 25 showed improvement but BHS was not fully in compliance. There will be ongoing desk audits and oversight and the ten percent (10%) administrative payment withhold will continue.
2. Conduent – An on-site audit was done on Feb. 8 and 9. Conduent did not comply with the pre-audit claims pull request. Therefore, the audit could not be completed. GCHP has given coaching and a mock audit has been done and GCHP will return for another audit in Q2 or 3.
3. Vision Service Plan (VSP) – found to be out of compliance in several areas. Notice has been given and a follow-up audit will be done.

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Delegation Oversight

Credentialing:

Credentialing audits were done on CDCR, CMH and VCMC on Jan 20, 26, and 27. All were 100% compliant.

Utilization Management (UM), Quality Improvement (QI), Member Rights (RR)

Beacon Health Strategies – a registered nurse completed a desk-top audit and on-site audit on Feb. 20 and 21. The results have not yet been fully analyzed and BHS has not yet been informed of the results.

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Pharmacy

Pharmacy											
Legend:											
Met or exceeded Benchmark											
Did not meet Benchmark											
Measure	**Description**	**Responsible Department**	**Compliance Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**Interventions**
PA Accuracy	All prior authorization requests were decided in accordance with GCHP clinical criteria.	Pharmacy	DHCS Contract	99%	98%	97.67%	98.21%	100%	99%		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	99%	98%	100.00%	100%	100%	100%		
Appropriate Decision Language on PA	All denied prior authorization requests contained appropriate and specific rationale for the denial	Pharmacy	DHCS Contract	99%	98%	99.86%	99.89%	99%	99%		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	Met	N/A	Met	Met	Met		
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	Met		

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Pharmacy and Therapeutics

Newly Approved Drugs and Formulary Management

3 New Drugs or new drug combinations were reviewed:

- 1 approved to be added to the formulary because it provides significant clinical advantages.
- 2 drugs were denied formulary placement as not providing a significant new therapy.

DHCS Comparability Required Additions

DHCS requires managed plans to have drugs comparable to the fee-for-service formulary available. The following were added at the direction of DHCS:

- Certain IV Solutions
- Certain IV solutions used for intravenous nutrition.

Pharmacy and Therapeutics

DHCS requirement to remove prior authorization requirements on 8 drugs – we feel that there are reasonable reasons for these prior authorization requirements and the Committee agreed that the Plan should appeal these requirement removals to DHCS.

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Credentials/Peer Review

Credentials										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	Description	Benchmark Source	Benchmark	2015	2016 Q1	2016 Q2	2016 Q3	2016 Q4	Quarterly Trend	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	100%	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	98%	96%	97%	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 transition 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	None	None	None	None		

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Credentials/Peer Review

Credentials										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**Interventions**
Timeliness of processing of initial applications	Initial applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	**93%**	**96%**	**95%**	**97%**	**98%**		
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	**95%**	**95%**	**94%**	**96%**	**98%**		
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	**93%**	**91%**	**92%**	**98%**	**96%**		
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	**98%**	**96%**	**95%**	**96%**	**94%**		

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Credentials/Peer Review

Policy review and approval:

1. Contract Compliance Monitoring
2. Credentialing for Organizational Providers
3. Fair Hearing Policy
4. Provider Credentialing Policy

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Credentials/Peer Review

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

- 3 providers on probation by the Medical Board of California (MBC).
- 3 providers with accusations, but no action taken by the MBC.
- 1 provider arrested for issues of prescribing controlled medications. The provider has no actions by the MBC and the legal action is pending.

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Credentials/Peer Review

Credentialing

- 14 new providers were approved.
- 1 provider (midlevel) was pended to determine the procedures that he/she would be doing.
- 86 providers were recredentialed.
- 4 facilities were newly credentialed and 1 recredentialed

Peer Review

- No highly rated PQI's reported
- All cases reviewed and rated low and trended.
- Follow-up on a provider with previous quality issues – medical records were reviewed for 5 members and all were satisfactory.
- 1 case at a contracted hospital with a member injury – the hospital was contacted and the case was reviewed and a defective piece of equipment was removed from service.
- 1 case involving a significant surgical complication was sent for outside review by 2 reviewers from different specialties with very different conclusions. Waiting for a response from the surgeon.

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Cultural and Linguistics

Cultural & Linguistics (C&L)									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**Interventions**
Sign Language Services	Percent of sign language services fulfilled	DHCS/Title 22	100%	79%[1]	79%	96%[2]	100%[2]		

[1] 2016 Q1 Rate corrected due to calculation error

[2] 2016 Q3 & Q4 Rates include requests that were cancelled and fulfilled after appointment was rescheduled

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Health Education, Cultural Linguistic Services

Outreach Activities 4th Quarter:

Events – 38

Participants contacted – 2888

1st Quarter 2017 – organized the educational event on Lesbian, Bisexual, Gay, Transgender Care

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- Quality Improvement projects for HEDIS Measures – Postpartum Visit Promotion and Cervical Cancer Screening Promotion – reaching out to members who are non-compliant.
- Interpreter services – 609 requests for interpreter and 33 in-person interpreter services at the time of services
- Sign Language – 57 requests with 100% fulfillment

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Grievance and Appeals

Grievance & Appeals										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Compliance Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**Interventions**
Resolution Turnaround Times (TAT) Grievances	100% TAT within 30 calendar days	GCHP		76%	100%	99%	99%	99%		
Post Service TAR Provider Appeals Processing Time - Resolution	The percentage of provider appeals processed within 30 business days from receipt.	GCHP		100%	100%	94%	100%	100%		
Provider Grievances: Complaint, Appeal, or Inquiry	Timely resolution of provider grievances	GCHP		66%	100%	98%	99%	98%		
Monitoring of Complaints	Member complaints are monitored at a minimum of every six months to assess for trends/outliers	GCHP	Monitoring	100%	100%	100%	100%	100%		

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Grievance and Appeals

Grievances Received – 4th Quarter 2016

Total Grievances – 495 (298 in 2015)

- 468 Administrative Grievances: top 3 – Claims billing disputes 311, Claim Payment – 75, Post Service retro authorization - 24
- 27 Clinical – Top 3 are – 16 quality of care (none serious on review), Quality of Service – 2 , Accessibility -2 Quality of care – Delay in care 13, Inappropriate Provider care – 2, Plan denial of care - 1

Clinical Appeals – 21 cases: 7 upheld, 6 overturned, 7 pending, 1 withdrawn

State Fair Hearings – cases: 2 – 1 denied, 1 withdrawn

Quality Workgroup Reviews – 1 referred for PQI

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Member Services

Call Center Statistics – 4th Quarter 2016

Member Services										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Compliance Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**Interventions**
Call Center - Aggregate Average Speed of Answer (ASA)	Average Speed to Answer (in seconds)		<= 30 seconds	57.5	79.0	12.0	8.0	19.0		
Call Center - Aggregate Abandonment Rate	Percentage of aggregate Abandoned calls to Call Center		<= 5%	16.7%	3.50%	0.30%	0.40%	1.00%		
Call Center - Aggregate Call Center Call Volume	Monitored to ensure adequate staffing and identification of systemic issues.			117,039	29,820	30,084	31,003	30,161		

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Gold Co... Health P...

Member Services

- Interactive Voice Response (IVR) optimization is completed and has been successful.
- Explanation of Benefits (EOB) Initiative – temporarily on hold.
- Call metrics – average speed to answer, and abandonment rate goals were met.

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Network Operations

Network Operation QI Dashboard - Access and Availability										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**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	Met	**Met**		**99.9%**	**99.9%**		
# & 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	Met	**Met**		**99.6%**	**99.6%**		
Ratio of members to physicians	1:1200	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met	**Met**		**1:193**	**1:217**		
Ratio of members to PCPs	1:2000	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met	**Met**		**1:867**	**1:848**		

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Network Operations

Network Operation QI Dashboard - Access and Availability										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**Interventions**
Access to Network / Availability of Practitioners										
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	Met	**Met**		**Met**	**Met**		
After Hours Access	Providers have answering machine or service for after-hours member calls	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members		NA					Vendor in process of accumulating results
	After-hours machine messages or service staff is in threshold languages	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members		NA					Vendor in process of accumulating results
	After-hours answering machine message or service includes instructions to call 911 or go to ER in the event of an emergency	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members	NA	NA					Vendor in process of accumulating results
Time Elapsed Standards	Urgent Care appointments for services that do not require prior authorization: within 48 hours of the request for appointment	DHCS, Exhibit A, Attachment 9	Standards met for minimum of 90% of providers	NA	**Not Met**					Vendor in process of accumulating results
	Non-urgent appointments for primary care: within 10 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA	**Not Met**					Vendor in process of accumulating results
	Non-urgent appointments with specialist physicians: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA	**Not Met**					Vendor in process of accumulating results
	Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA	**Not Met**					Vendor in process of accumulating results

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Network Operations

Network Operation QI Dashboard - Access and Availability										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**2016 Q4**	**Quarterly Trend**	**Interventions**
Access to Network / Availability of Practitioners										
Appointment Availability	Availability of appointments within GCHP's standards by type of encounter	DHCS, § 7.5.4	Standards met for minimum of 95% of providers	NA	**Not Met**					In discussion with vendor to repeat survey for Q2
Provider Surveys	Measure provider satisfaction	GCHP	Satisfaction expressed in each of 6 areas for 80% of providers	**Not Met**	NA					
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**	**100%**	**100%**	**100%**		
Provider Visits	Number of Provider Services Representative provider visits	GCHP	Department goal = 100/quarter (400/year)	Met	**Met**	**167**	**121**	**104**		

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Health Services

Utilization Management Committee

Utilization Management

Legend:

Met or exceeded Benchmark

Did not meet Benchmark

Health Services

UM Authorization Processing Time

Measure	Description	Responsible Department	Benchmark Source	Benchmark	2015	2016 Q1	2016 Q2	2016 Q3	2015 Q4	Quarterly Trend	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%	98.10%	98.12%	98.05%	98.35%	98.81%	-	
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%	98.66%	98.70%	98.26%	98.10%	98.67%	-	
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%	96.78%	97.26%	95.12%	100.00%	99.79%	-	

Care Management Workload

Measure	Description	Responsible Department	Benchmark Source	Benchmark	2015	2016 Q1	2016 Q2	2015 Q3	2015 Q4	Quarterly Trend	Interventions
Total Careplans Opened	Number of care plans opened during specific reporting period. (excludes DM, Health Ed, Health Nav)	Health Services	N/A	N/A	309	301	326	298	239	-	
Total Careplans Closed	Number of care plans closed during specific reporting period. (excludes DM, Health Ed, Health Nav)	Health Services	N/A	N/A	293	270	282	288	280	-	
Average Careplans in Case Load	Average number of careplans active during specific reporting period (CM only)	Health Services	N/A	N/A	175	198	241	250	253	-	

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Utilization Management

- Turn around times meet or exceed goals and State requirements.
- Utilization measures – Hospital admits, hospital days, ER visits, appeals, and denials remain in the same ranges.
- Specialty Referrals – Monthly audits of specialty referrals for member visits fulfilled – 99% of authorizations approved resulted in the member being seen. Those that are identified as not being seen are referred for follow-up by care management.

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Utilization Management

Approvals:

1. 2016 Health Services Work Plan Evaluation
2. 2017 Care Management Program Description
3. 2017 Utilization Management Program Description
4. Delegates 2017 Program Descriptions

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AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: May 22, 2017

SUBJECT: Chief Executive Officer Update

COMMUNITY HEALTH INVESTMENTS UPDATE

Last April, through its Community Health Investments grant-making program, Gold Coast Health Plan (GCHP) released its first Request for Applications (RFA), entitled Social Determinants of Health I. Twenty-three organizations successfully completed and submitted funding requests seeking a total of $2,450,315. A vast majority of applicants, or 80%, seeks support to improve access to quality and affordable health care; 11% seek support to improve access to healthy food; and 8% seek funding to improve neighborhood and built environments. In all, we received twenty (20) applications from nonprofit organizations, two (2) from county agencies, and one (1) from a local hospital. A review committee made up of internal staff from multiple departments is scoring the applications and will meet later this week to make funding recommendations. Grant awards will be announced at the end of June 2017.

LEGISLATIVE

On Thursday, May 11, Governor Jerry Brown released his May Revise, which can be found here.

Overall, revenues are up $2.5 billion compared to the January budget; however, this is $3.3 billion below the 2016 Budget forecast. At his press conference, the Governor continued to highlight the need to keep expenditures in check given the possibility of a recession and "on-going pressure" from Washington D.C.

The May Revise only highlights changes to the Governor's January Budget; therefore, any January proposals that where not addressed in the May Revise remain part of the Governor's overall budget package.

Items of interest for Medi-Cal managed care plans in the May Revise include:

- In-Home Supportive Services (IHSS)/County Maintenance of Effort (MOE) (p. 31) – The May Revise includes General Fund (GF) assistance to help offset the counties' costs, a recalculation of the MOE and a new inflation factor to address program costs. The counties and the Administration continue to discuss this issue in hopes of reaching a final resolution.

- Current Year Medi-Cal Shortfall (p. 34) – The shortfall has decreased by roughly $620 million GF compared to the January Budget. Savings are primarily attributed to three factors: (1) savings from drug rebates in Medi-Cal managed care; (2) retro managed care rate adjustments; and (3) slower-than-expected caseload growth.

- Medi-Cal Estimate (p. 35) – The May Revise includes $495,000 ($248,000 GF) to upgrade the system used to produce the Medi-Cal Estimate. These enhancements are intended to provide more accurate estimates going forward. The Department of Health Care Services (DHCS) will issue an RFP in 2017-18 for consulting assistance to refine the current Estimate process.

- Duals (p. 35) – The May Revise maintains Cal Medi-Connect (CMC) while discontinuing the CCI.

- The May Revise also continues the mandatory enrollment of dual eligibles and Managed Long Term Services and Support (MLTSS) integration into managed care except for IHSS. Savings from Cal MediConnect are reduced by $12 million (to $8 million GF) due to fewer enrollees participating in the pilot.

- Proposition 56 (p.35) – The May Revise includes an increase of $19.8 million in Proposition 56 funds for Medi- Cal based on updated revenue projections.

- Newly Qualified Immigrants (NQI) (p. 35) – DHCS is no longer planning to transition most NQI in state-only, full-scope Medi-Cal to Covered California, citing "operational and programmatic uncertainties." As a result, the May Revise reflects an additional $48 million in GF costs.

- Palliative Care (p. 35) – The May Revise includes $1.3 million GF in 2017-18 to implement SB1004 no later than January 1, 2018.

- 340(B) Program (p. 36) – The May Revise continues to propose statutory changes to end the use of contract pharmacies in the 340(B) Program but clarifies that this change would not impact Planned Parenthood clinics as they do not use contract pharmacies. This proposal was included in the Governor's January Budget, but trailer bill language has not been released.

In terms of next steps, it is expected that DHCS will release trailer bill language shortly. The Assembly and Senate will work to finalize their budgets by the week of May 22nd. Any differences will go to the Budget Conference Committee for resolution and then the final budget will go to the Governor in time to meet the June 15 budget deadline.

COMPLIANCE

Gold Coast Health Plan (GCHP) was notified on February 7, 2017 that the Medical Audit corrective action plan (CAP) issued in November 1, 2016 has been closed. On February 8 2017, Audits and Investigations (A&I) notified GCHP that the annual onsite Medical Audit original slated for April 24, 2017 through May 5, 2017 will now occur June 5, 2017 through June 16, 2017. Staff has submit the pre-audit document material required. Compliance staff will keep the commission apprised of the audit.

On March 17, 2017, DHCS issued GCHP a CAP relative to the Provider Network 274 File, which is a new requirement for provider network data reporting. GCHP staff has been working diligently with DHCS during the entire process and has continuously kept DHCS abreast of the status of the test submissions. GCHP is complying with the CAP and submitting timelines and updates to DHCS on a biweekly basis.

GCHP continues to meet all regulatory contract submission requirements. GCHP submitted all required initial Final Rule deliverables on May 12, 2017 to DHCS. DHCS is currently reviewing the material submitted and will provide feedback to GCHP. All regulatory agency inquiries and requests are handled timely. Compliance staff is actively engaged in sustaining contract compliance.

An audit was conducted on Conduent and because of poor quality; prep and lack of material to review; compliance failed Conduent on the audit and issued a CAP. Compliance staff conducted a second audit on Conduent the week of April 24, 2017 through April 27, 2017.

An audit on our MBHO for Quality Improvement, Utilization Management and Member Rights and Responsibilities occurred February 20, 21 2017 and a CAP was issued on April 3, 2017. A CAP response was received on 04/12/2017 and the CAP was closed. GCHP MBHO remains under a CAP, for claims processing and financial sanctions are currently in place. GCHP Vision provider is also under a CAP. GCHP delegation oversight staff is working with each delegate on achieving compliance to address the deficiencies identified and ultimately close out the CAPs issued.

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

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COMPLIANCE REPORT 2017

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*	5	1	7	14									27
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0	0	0	3									3
Hotline Referral *FWA	Department of Justice	0	0	0	0									0
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	5	1	7	11									24
Hotline Referral	External Agency (i.e. HSA)	0	0	0	0									0
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	0	0	0	0									0
Delegation Oversight 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	Delegated Entities	8	8	8	8									8
	Reporting Requirements Reviewed **	71	83	68	81									303
	Audits conducted	5	1	0	1									7
Delegation Oversight	Letters of Non-Compliance	0	0	0	0									0
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	0	0	0	0									0
Audits External regulatory entities evaluate GCHP compliance with contractual obligations.	Total	0	0	0	0									0
	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	0	0	0	0									0
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0	0	0	0									0
	HEDIS Compliance Audit (HSAG)	0	0	0	0									0
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2012*	0	0	0	0									0
	DHCS Medical Audit	0	0	0	0									0
Fraud, Waste & Abuse 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.	Total Investigations	5	1	0	14									20
	Investigations of Providers	0	0	0	1									1
	Investigations of Members	5	1	0	1									7
	Investigations of Other Entities	0	0	0	1									1
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0	0	0	0									0

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
HIPAA	Referrals	6	2	4	2									14
Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	State Notification	6	2	4	2									14
	Federal Notification	0	3	0	0									3
	Member Notification	2	0	0	0									2
	HIPAA Internal Audits Conducted	0	0	1	0									1
Training	**Training Sessions**	12	2	0	3									27
Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Fraud, Waste & Abuse Prevention (Individual Training)	2	2	0	1									5
	Fraud, Waste & Abuse Prevention (Member Orientations)	6	6	0	0									12
	Code of Conduct	2	2	0	1									5
	HIPAA (Individual Training)	2	2	0	1									5
	HIPAA (Department Training)	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.

^ The large aggregates for the month of November and December represent the yearly training of full time employees and new coming Commissioners.

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: May 22, 2017

SUBJECT: Chief Operating Officer Update

OPERATIONS UPDATE

Membership Update – May 2017

As of May 1, 2017, Gold Coast Health Plan's (GCHP's) total membership is 201,514. The Plan experienced a net loss of 905 members from April 2017 through May 2017. We continue believe a contributing factor is lack of re-determinations from the prior calendar year. The cumulative total for membership by category is as follows:

Aid Code	# of New Members
L1 – Low Income Health Plan (LIHP)	505
M1 – Adult Expansion	55,331
7U – CalFresh Adults	92
7W – CalFresh Children	35
7S – Parents of 7Ws	113
Traditional Medi-Cal	26,926
Total New Membership 1/1/14 – 12/1/16	83,002

All categories of membership saw a decrease in May. Adult Expansion membership (aid code M1) decreased by two members. M1 members represent 66.66% of GCHP's membership since January 1, 2014.

	L1	M1	7U	7W	7S
May 17	505	55,331	92	35	113
Apr 17	520	55,333	94	44	163
Mar 17	560	55,539	100	48	210
Feb 17	590	55,667	113	55	243
Jan 17	646	55,551	141	50	203
	L1	M1	7U	7W	7S
Dec 16	695	55,820	521	123	240
Nov 16	770	55,567	1,057	216	314
Oct 16	919	55,103	1,227	254	374
Sep 16	1,015	54,740	1,370	280	336
Aug 16	1,162	54,237	1,470	307	361
Jul 16	1,261	53,767	1,593	346	397
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

AB 85 Capacity Tracking –Adult Expansion members assigned to VCMC as of May 2017 is 30,818. A decrease of VCMC membership of 60 members from the previous month correlates to less than 0.10% decrease in M1 enrollment. VCMC's target enrollment is 65,765 and is currently at 46.86% of their target.

March 2017 Operations Summary

The **Claims Inventory** at the end of March was 48,535; this equates to a Days Receipt on Hand (DROH) of 5.36 days compared to a DROH maximum goal of 5 days. This reflects a slight increase over the previous month. GCHP received approximately 9,061 claims per day in March. Monthly claim receipts from July 2015 through March 2017 are as follows:

Month	Total Claims Received	Receipts per Day
March	208,407	9,061
February 2017	171,343	9,018
January 2017	168,660	8,433
December 2016	190,686	9,080
November 2016	170,209	8,510
October 2016	209,638	9,983
September 2016	159,446	7,593
August 2016	180,049	7,828
July 2016	166,955	8,347
June 2016	177,246	8,057
May 2016	157,434	7,497
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

Claims processing results – Conduent met Service Level Agreements (SLAs) in the month of March.

- **Claims Turnaround Time (TAT)** for March was 93.5% vs the regulatory requirement of processing 90% of original clean claims within 30 calendar days of receipt.
- **Financial Claims Processing Accuracy** for March was 99.47% vs a goal of ≥ 98%
- **Procedural Claims Processing Accuracy** was 99.98% vs a goal of ≥ 97%.

FY2016/2017 3Q Encounter Data Quality Summary- The third quarter encounter submissions reflected 789,649 total encounters submitted. Encounter errors totaled 8,698 or an error rate of 1.1%. DCHS received all encounter data timely, without any submission issues.

1Q 2017 ENCOUNTER QUALITY			
MONTH	**SUBMITTED**	**ERRORS**	**% of ERRORS**
JANUARY	291,587	3,427	1.2%
FEBRUARY	251,287	2,332	0.9%
MARCH	246,775	2,939	1.2%
TOTALS	**789,649**	**8,698**	**1.1%**

Call Center Results – Conduent continues to work with GCHP to develop and deploy GCHP-specific training documents. Retraining and education will take place for all customer service representatives and new hire training will include all plan specific training. We continue to work with the designated Conduent staff to address and correct any deficiencies in performance. All statistics listed below reflect a combination of all call lines (provider, member, Spanish and English)

- **Call Volume** – March call volume was 12,177, which shows an increase in volume of 1,218 call or 11% over the previous month.
- **Call Volume 12-month Average** – 10,506 calls per month.
- **Average Speed to Answer (ASA) – 19.2** seconds vs the SLA goal of ≤ 30 seconds.
- **Abandonment Rate** – 0.79% vs the SLA goal of ≤ 5%.
- **Average Call Length** increased to 7.16 minutes from the prior month. The increased talk time does not pose any concerns at this time.
- **Call Center Phone Quality** – 94.5% versus a goal of 95% or higher. GCHP continues to audit and monitor quality issue and request performance improvement from Conduent.

Grievance and Appeals received 19 member grievances and 158 provider-claim payment grievances during March. The 19 member grievances equate to 0.09 grievances per 1,000 members.

Type of Member Grievances	Number of Grievances
Accessibility	1
Billing	2
Denials/Refusals	2
Benefits/Coverage	1
Quality of Service	1
Quality of Care	12
Total Member Grievances	**19**

There were five (5) clinical appeals in March; two (2) appeals were upheld and three (3) appeals were overturned. There were no State Fair Hearing cases in March.

Member Orientation Meetings
Forty-five total members (36 English, 9 Spanish) attended Member Orientation meetings for January - March 2017. Of the 45 members, nineteen indicated they learned about the meeting as a result of the informational flyer included in each new member packet.

Conduent Contract Extension/New Contract Negotiation
The existing Administrative Services contract with Conduent is currently extended through June 30, 2017. GCHP's procurement department is working with Conduent to negotiate a new contract through 2019, while GCHP pursues an RFP strategy. This will provide GCHP the option to re-vend or bring in-house various services based on the RFP response compared to the evaluation of work effort to support teams internally.

NETWORK UPDATE

Provider Network – April 2017: Slide 1

As of April 31, 2017, Gold Coast Health Plan's Provider network growth continues to remain robust. The Plan experienced a net increase of 1,668 total providers (30.7% increase) from April 2016 compared to April 2017 March 2017. For the period of March 2017 through April 2017, the Plan shows a net increase of 437 new providers or a 6.5% increase.

The majority of the provider growth has been in the Primary Care and Specialty areas. The annual percentage net increase in both these provider domains is 22.7% for Primary care providers and a 35.5% for specialists. Much of the growth in specialty physicians is related to the UCLA Medical Group Agreement and a strong focus of targeting needed physicians in the following specialty areas:

- Cardiology
- Orthopedics
- GI
- ENT
- Ophthalmology

Member PCP Assignments: Slide 2

PCP Member assignments continue to reflect the normal trends expected. The three (3) major Clinics (VCMC, Clinicas and CMH) represent 74% of the total GCHP enrollment or 155,487 members. The remaining 26% of GCHP enrollment or 54,580 are comprised of PCP other, Medi/Medi and Admin Members, unassigned and Kaiser.

Provider Site Visit Results: Slide 3

- Orientations: six (6) new provider orientations were conducted by GCHP Provider Relations Staff over the last three months. This figure is down approximately 25% due to pulling all network operations staff to focus primarily on the AB 274 project.

  Eight (8) physicians declined orientation during this reporting period due to their joining an established contracted group with GCHP. Established groups such as delegated providers have participated in previous orientations; they are familiar with GCHP policies and procedures and have the staff and capability to perform the orientation function on their own.

- Site Visits: 55 provider site visits were completed by Network Operations- Provider Relations staff. The goal for the Provider Relations team is to complete twenty (20) site visits per Provider Relations Specialists per month i.e., a total of forty (40) visits per month. These figures are down for this three-month period due to losing one of our Provider relations Specialists who moved to Colorado and the other a result of the “all hands on deck” approach utilized to address the AB 274 project.

Contracted Hospitals: Slides 4 & 5

As previously discussed, the hospital network has been expanded from 17 acute care facilities and 3 tertiary facilities in 2016 to 23 acute hospitals and 4 tertiary facilities**.** Included in the attached information deck is a list of all Gold Coast Health Plan Contracted Hospitals. This comprehensive list is provided in follow-up to a discussion item at the last commission meeting in March, where the Commissioners desired to see the extent of the Gold Coast Hospital provider network both within and outside of Ventura County. Included in this attachment are not only the hospitals contracted but also the hospital affiliation, type of facility, year contracted and the reason for contracting with each facility.

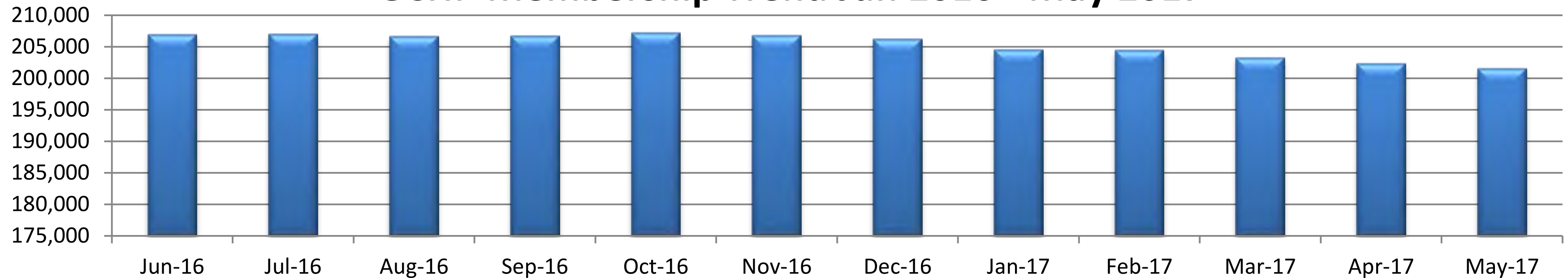
Value Based Programs: Slides 6 & 7

- **HEDIS Child Access Quality Improvement Agreement (not in slides):** all three (3) major clinics (VCMC, Clinicas and CMH are participating in this initiative. Each of the three (3) Clinics have received their initial funding for the planning implementation component under their agreements
- **Value Based Programs:** are slated to kick-off based on the program timeline noted in Slide 7. Slide 6 provides a summarization of the first phase initiatives of the value based program.

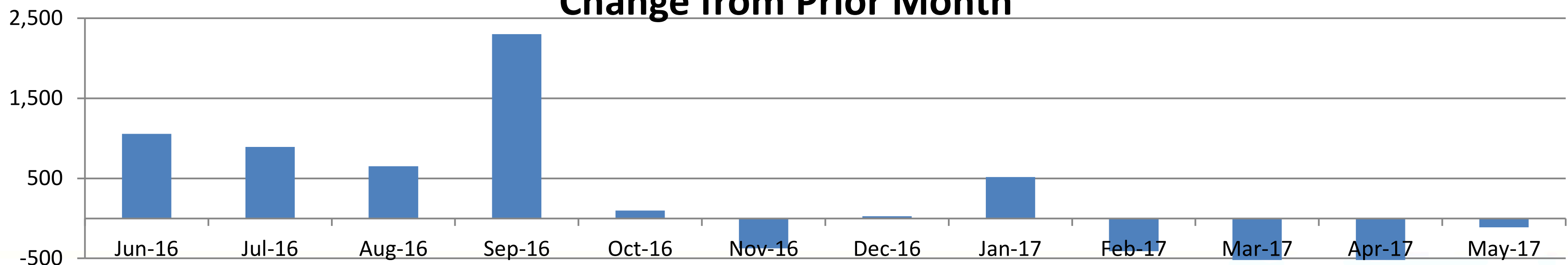
GCHP Membership

Total Membership as of May 1, 2017 – 201,514

*New Members Added Since January 2014 – 83,002



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Active Membership	206,920	207,019	206,644	206,672	207,188	206,780	206,252	204,529	204,417	203,243	202,338	201,514



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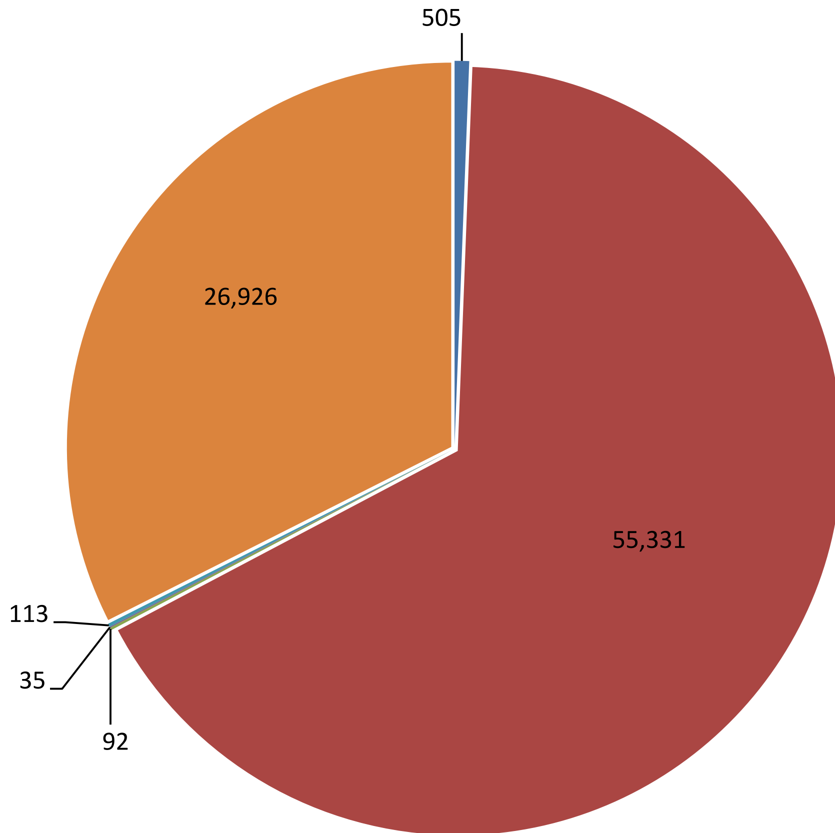
Membership Growth

GCHP New Membership Breakdown



- L1 - Low Income Health Plan - 0.61%
- M1 - Medi-Cal Expansion - 66.66%
- 7U - CalFresh Adults - 0.11%
- 7W - CalFresh Children - 0.04%
- 7S - Parents of 7Ws - 0.14%
- Traditional Medi-Cal - 32.44%

GCHP Membership Churn Summary

	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Membership from Prior Month	203,969	204,619	206,920	207,019	206,644	206,672	207,188	206,780	206,252	204,529	204,417	203,244	202,404
Prior Month Members Inactive in Current Month	5,642	5,584	5,881	6,182	6,083	5,575	6,866	6,054	8,733	6,682	7,555	8,028	7,399
Sub-total	198,327	199,035	201,039	200,837	200,561	201,097	200,322	200,726	197,519	197,847	196,862	195,216	195,005
Percentage of Inactive Members from Prior Month	2.77%	2.73%	2.84%	2.99%	2.94%	2.70%	3.31%	2.93%	4.23%	3.27%	3.70%	3.95%	3.66%
Current Month New Members	4,368	6,316	4,378	3,916	4,256	4,193	4,533	3,809	5,165	4,118	4,088	4,587	4,371
Sub-total	202,695	205,351	205,417	204,753	204,817	205,290	204,855	204,535	202,684	201,965	200,950	199,803	199,376
Percentage of New Members Reflected in Current Membership	2.13%	3.05%	2.11%	1.90%	2.06%	2.02%	2.19%	1.85%	2.53%	2.01%	2.01%	2.27%	2.16%
Retroactive Member Additions	1,924	1,569	1,602	1,891	1,855	1,898	1,855	1,717	1,845	2,452	2,294	2,601	2,828
Active Current Month Membership	**204,619**	**206,920**	**207,019**	**206,644**	**206,672**	**207,188**	**206,780**	**206,252**	**204,529**	**204,417**	**203,244**	**202,404**	**202,204**
Percentage of Retroactive Members Reflected in Current Membership	0.94%	0.76%	0.77%	0.92%	0.90%	0.92%	0.90%	0.83%	0.90%	1.20%	1.13%	1.29%	1.40%

GCHP Auto Assignment by PCP/Clinic as of May 1, 2017

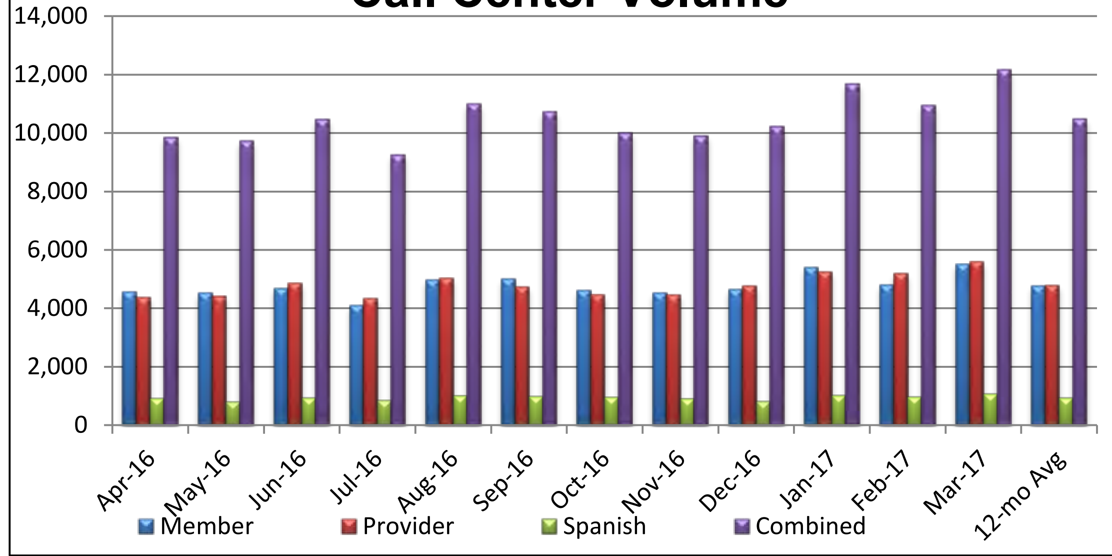
	May-17		Apr-17		Mar-17		Feb-17		Jan-17		Dec-16	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
AB85 Eligible	**1290**		**1518**		**2141**		**1357**		**1,000**		**1,030**	
VCMC	645	50.00%	759	50.00%	1070	49.98%	678	49.96%	499	49.90%	772	74.95%
Balance	645	50.00%	759	50.00%	1071	50.02%	679	50.04%	499	49.90%	258	25.05%
Regular Eligible	**983**		**1,567**		**2,121**		**1,102**		**888**		**1,161**	
Regular + AB85 Balance	**1,628**		**2,326**		**3,192**		**1,781**		**1,387**		**1,419**	
Clinicas	384	23.59%	552	23.73%	726	22.74%	396	22.23%	314	22.64%	358	25.23%
CMH	194	11.92%	299	12.85%	391	12.25%	225	12.63%	170	12.26%	185	13.04%
Independent	34	2.09%	57	2.45%	82	2.57%	33	1.85%	32	2.31%	38	2.68%
VCMC	1016	62.41%	1418	60.96%	1993	62.44%	1127	63.28%	871	62.80%	838	59.06%
Total Assigned	**2,273**		**3,085**		**4,262**		**2,459**		**1,888**		**2,191**	
Clinicas	384	16.89%	552	17.89%	726	17.03%	396	16.10%	314	16.63%	358	16.34%
CMH	194	8.53%	299	9.69%	391	9.17%	225	9.15%	170	9.00%	185	8.44%
Independent	34	1.50%	57	1.85%	82	1.92%	33	1.34%	32	1.69%	38	1.73%
VCMC	1661	73.08%	2,177	70.57%	3,063	71.87%	1,805	73.40%	1,370	72.56%	1,610	73.48%

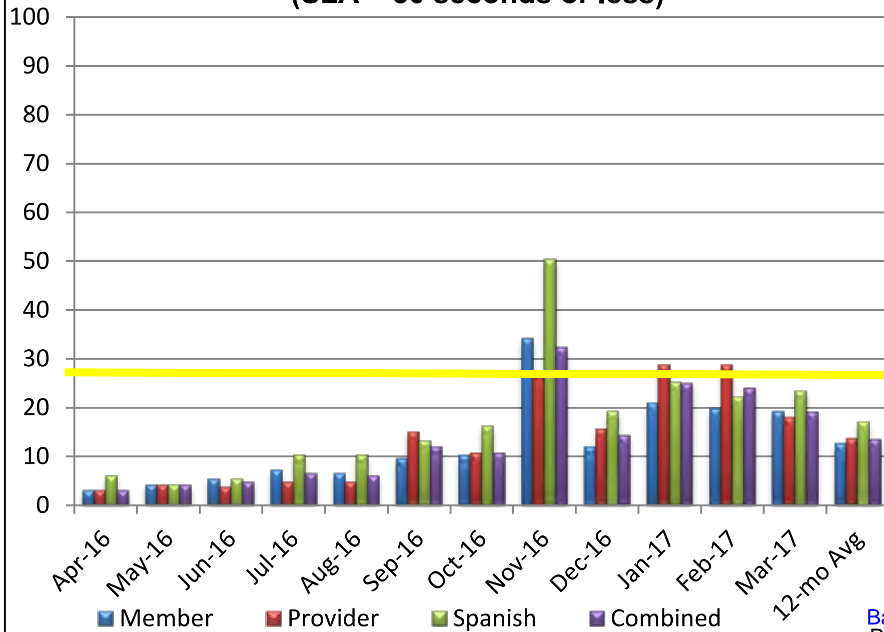
Auto Assignment Process

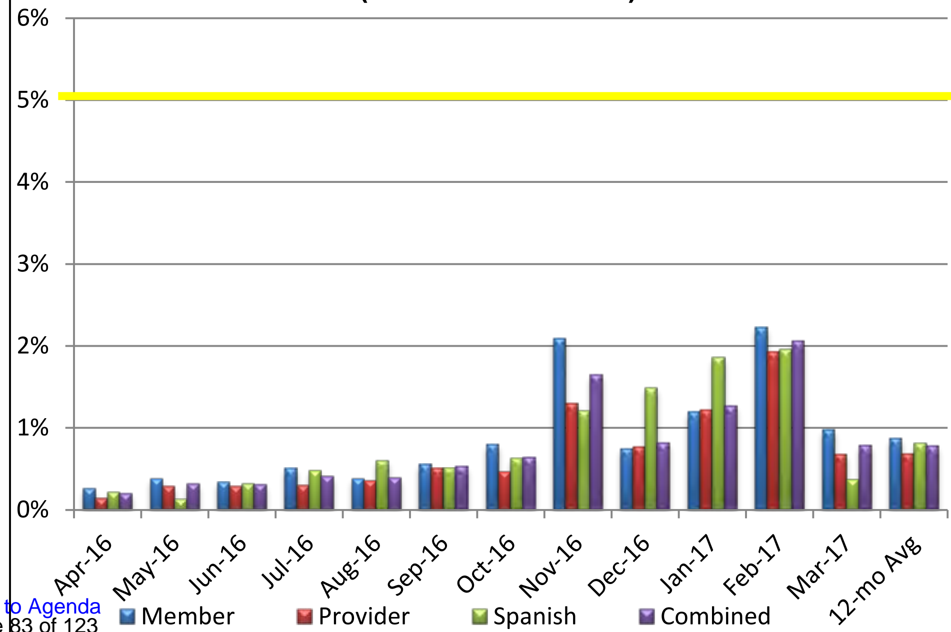
- 75% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85
- The remaining 25% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others
- The County's 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 30,818 assigned Adult Expansion members as of May 1, 2017 and is currently at 46.86% of capacity

GCHP Call Center Metrics – March 2017

- Call volume remained above 10,000 during the month; GCHP received 12,177 calls during March
- Service Level Agreements (SLA) for ASA (19.2 seconds vs the contractual requirement of ≤ 30 seconds) and Abandonment Rate (0.79% vs the contractual requirement of ≤ 5%) ASA and Abandonment Rate were met for March







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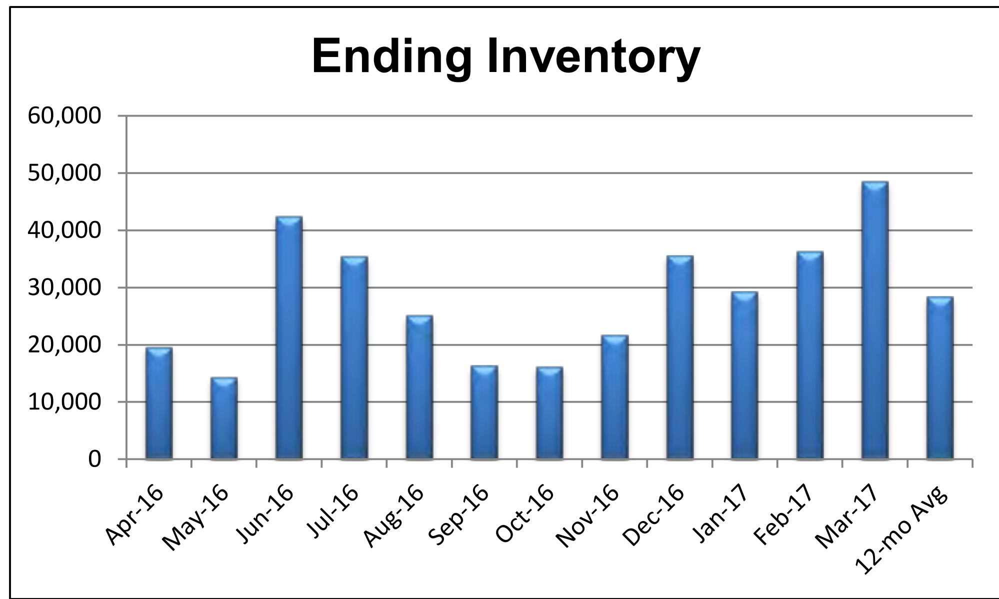
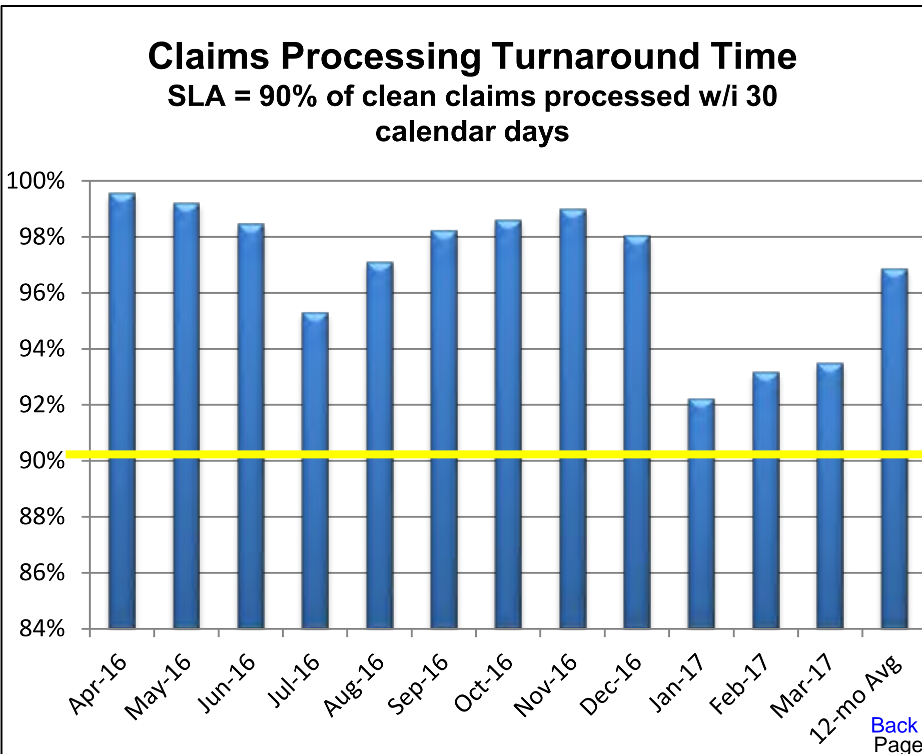
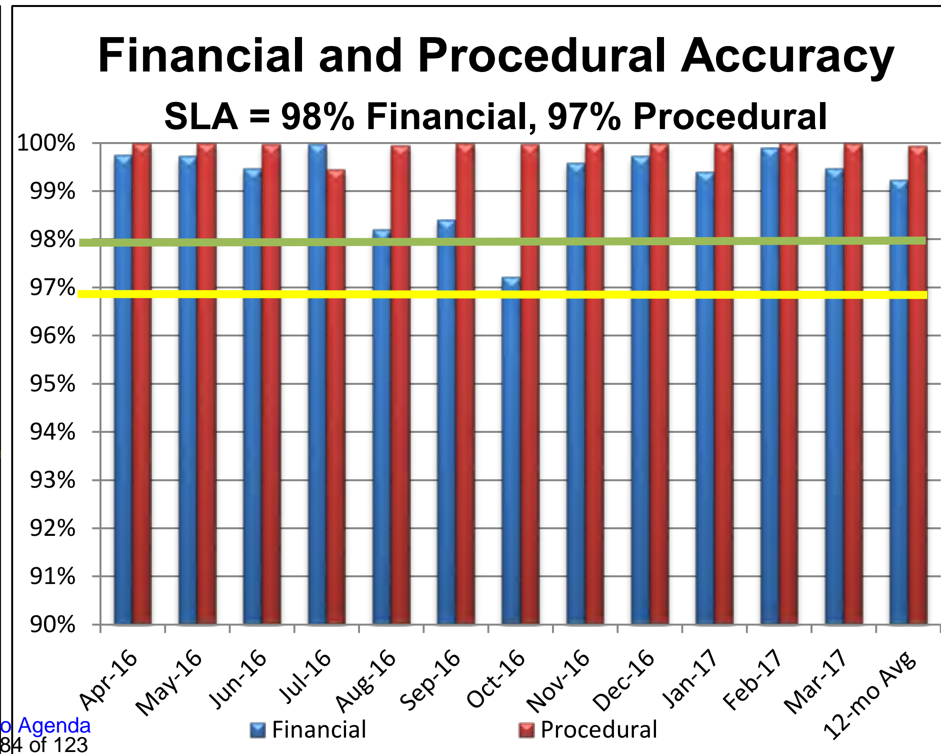
GCHP Claims Metrics – March 2017

- The 30 Day Turnaround Time (TAT) remained in compliance at 93.5% for clean claims and 70.18% for the unclean claims
- Ending Inventory was 48,535 which equates to a Days Receipt on Hand (DROH) of 5.36 days vs a target DROH ≤ 5 days
- Service Level Agreements (SLAs) for Financial Accuracy (99.47%) and Procedural Accuracy (99.98%) were both met in March







Gold Coast Health Plan
Weekly Claims Processing Dashobard
February 1, 2017 - May 31,2017

	02/01/17	02/08/17	02/15/17	02/22/17	03/01/17	03/08/17	03/15/17	03/22/17	03/29/17	04/05/17	04/12/17	04/19/17	04/26/17	05/03/17	05/10/17	05/17/17	05/24/17	05/31/17
Corrective Action Plan Tracking																		
CAP Reference																		
3c - Percentage of Claims Denied (1)	15.37%	14.68%	14.65%	18.00%	16.28%	12.32%	13.15%	11.95%	11.98%	13.02%	13.39%	15.79%	15.61%	13.02%	14.41%	13.39%	15.79%	15.61%
3e - Number of Claim Adjustments (2)	2	854	816	949	1	961	835	1,533	1,173	998	4,974	1,072	1,206	2,579	899	4,974	1,072	1,206
3f - Number of Claims Processing FTEs (3)	63	62	62	62	62	62	62	61	61	61	61	61	51	48	48	61	61	51
3g - Auto Adjudication Rate (4)	48.16%	54.63%	54.89%	56.46%	61.10%	50.10%	58.53%	61.89%	58.14%	57.25%	52.39%	42.20%	37.42%	56.76%	48.00%	52.39%	42.20%	37.42%
3g - Auto Adjudication Rate including Autobot (4)	59.52%	66.01%	66.21%	67.81%	67.45%	70.21%	70.95%	72.36%	70.55%	71.31%	65.97%	56.66%	59.76%	69.49%	59.86%	65.97%	56.66%	59.76%
4a - Number of Items in ACS Refund Check Queue (5)	279	290	265	239	234	232	187	176	150	96	98	151	121	141	71	32	151	121
4a - Number of Items in ACS Refund Check Queue > 20 Days TAT (	240	203	196	206	184	169	133	124	84	55	54	63	75	79	31	0	63	75
4a - Number of Items in Non-Indexed Refund Check Queue (5)	83	42	32	41	53	34	71	40	35	74	76	10	44	14	71	59	10	44
Claim Receipts																		
Total Claim Receipts	39,461	46,006	43,772	37,910	43,655	45,270	43,767	44,238	43,942	47,124	43,230	41,041	31,322	49,841	45,293	43,230	41,041	31,322
Average Claims Receipts (6)	7,943	8,072	8,377	8,544	8,357	8,567	8,530	8,530	8,847	8,861	8,954	8,927	8,767	8,136	8,272	8,954	8,927	8,767
Mailroom Inventory on Hand																		
Items in EDGE to be worked (8)	11	11	11	11	11	9	9	9	9	9	9	9	9	9	9	9	9	9
Claims with Front-end Errors (9)	1,178	1,170	1,302	1,395	1,487	1,594	1,974	2,343	2,180	1,871	1,176	1,180	522	1,950	1,075	1,176	1,180	522
IKA Inventory on Hand																		
Pended Inventory	28,058	28,306	28,161	31,410	34,769	31,909	35,768	39,386	41,734	45,018	42,245	43,333	34,516	35,602	32,794	42,245	43,333	34,516
Working Inventory (10)	**29,247**	**29,487**	**29,474**	**32,816**	**36,267**	**33,512**	**37,751**	**41,738**	**43,923**	**46,898**	**43,430**	**44,522**	**35,047**	**37,561**	**33,878**	**43,430**	**44,522**	**35,047**
Claims Ready to Pay (11)	3,843	3,731	4,608	3,444	4,372	4,360	4,787	4,775	4,843	3,986	4,778	4,292	3,025	4,532	6,091	4,778	4,292	3,025
Current Inventory	**33,090**	**33,218**	**34,082**	**36,260**	**40,639**	**37,872**	**42,538**	**46,513**	**48,766**	**50,884**	**48,208**	**48,814**	**38,072**	**42,093**	**39,969**	**48,208**	**48,814**	**38,072**
DROH Working Inventory (10, 12)	3.7	3.7	3.5	3.8	4.3	3.9	4.4	4.9	5.0	5.3	4.9	5.0	4.0	4.6	4.1	4.9	5.0	4.0
DROH Current Inventory (12)	4.2	4.1	4.1	4.2	4.9	4.4	5.0	5.5	5.5	5.7	5.4	5.5	4.3	5.2	4.8	5.4	5.5	4.3
Clean Claims Aging (7)																		
31 to 60 Days	3,809	3,493	3,184	2,963	2,989	3,120	3,221	3,389	2,794	2,070	3,037	2,423	2,747	1,912	2,694	3,037	2,423	2,747
61 to 90 Days	9	7	13	17	22	33	41	57	19	21	26	27	1	40	41	26	27	1
90+ Days	3	1	4	4	3	3	9	13	6	0	7	9	4	7	3	7	9	4
Total Clean Claims Aged > 30 Days	**3821**	**3501**	**3201**	**2984**	**3014**	**3156**	**3271**	**3459**	**2819**	**2091**	**3070**	**2459**	**2752**	**1959**	**2738**	**3070**	**2459**	**2752**
Contested Claims Aging (7)																		
0 to 30 Days	600	396	753	381	315	206	252	208	152	227	226	336	346	358	554	226	336	346
31 to 60 Days	62	39	94	35	52	51	100	65	50	106	170	53	37	32	23	170	53	37
61 to 90 Days	1	1	1	0	1	0	0	1	0	0	0	0	1	0	0	0	0	1
90+ Days	0	0	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	2
Aging of Total Contested Claims	**663**	**436**	**849**	**417**	**369**	**258**	**353**	**275**	**203**	**334**	**397**	**390**	**386**	**391**	**578**	**397**	**390**	**386**
Productivity																		
EDI Claims Rejected	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0
Deleted Claims (13)	1,392	794	889	900	991	917	1,198	885	968	888	1,440	641	1,091	745	958	1,440	641	1,091
Denied Claims	6,469	6,690	5,991	6,308	6,129	5,443	5,233	4,892	4,722	5,782	5,807	6,140	6,499	6,355	6,421	5,807	6,140	6,499
Allowed Claims	35,613	38,870	34,892	28,728	31,520	38,733	34,555	36,035	34,704	38,613	37,571	32,754	35,137	42,468	38,125	37,571	32,754	35,137
Actual Weekly Production (14)	42,082	45,560	40,883	35,036	37,649	44,176	39,788	40,927	39,426	44,395	43,378	38,894	41,636	48,823	44,546	43,378	38,894	41,636
Total Weekly Production (15)	**43,474**	**46,354**	**41,772**	**35,936**	**38,640**	**45,093**	**40,986**	**41,812**	**40,394**	**45,284**	**44,818**	**39,535**	**42,727**	**49,568**	**45,505**	**44,818**	**39,535**	**42,727**
Average Daily Production (16)	7,955	8,404	8,741	8,740	8,349	8,162	8,104	8,042	8,393	8,438	8,405	8,615	8,477	8,527	8,860	8,405	8,615	8,477
DWOH Working Inventory (10, 17)	3.7	3.5	3.4	3.8	4.3	4.1	4.7	5.2	5.2	5.6	5.2	5.2	4.1	4.4	3.8	5.2	5.2	4.1
DWOH Current Inventory (17)	4.2	4.0	3.9	4.1	4.9	4.6	5.2	5.8	5.8	6.0	5.7	5.7	4.5	4.9	4.5	5.7	5.7	4.5

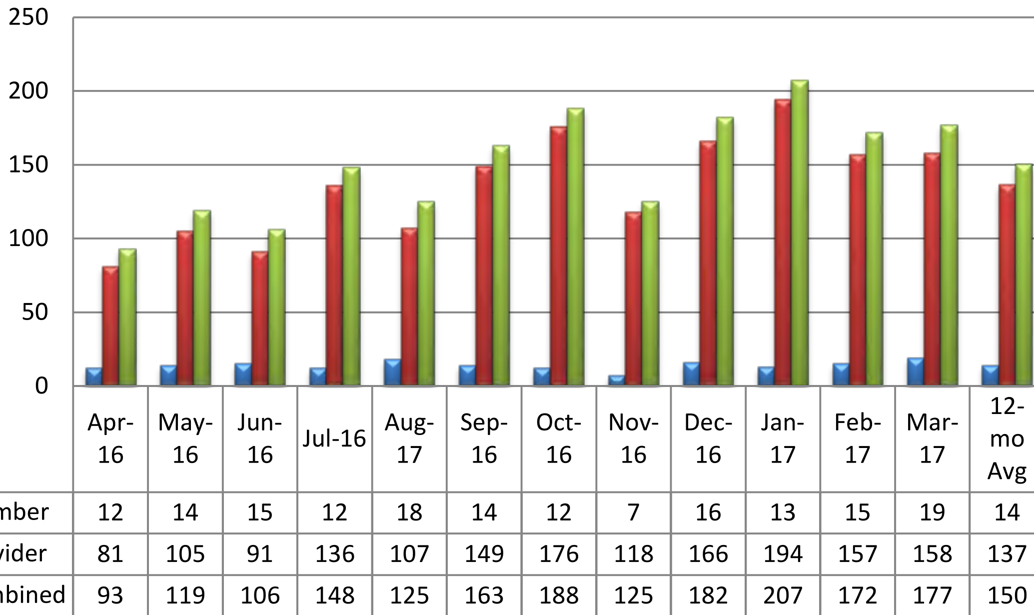
Notes:

(1) Percentage of Claims Denied is calculated as the number of Denied claims divided by Actual Weekly Production (total denied and allowed claims for the week).

Gold Coast Health Plan
Weekly Claims Processing Dashobard
February 1, 2017 - May 31,2017

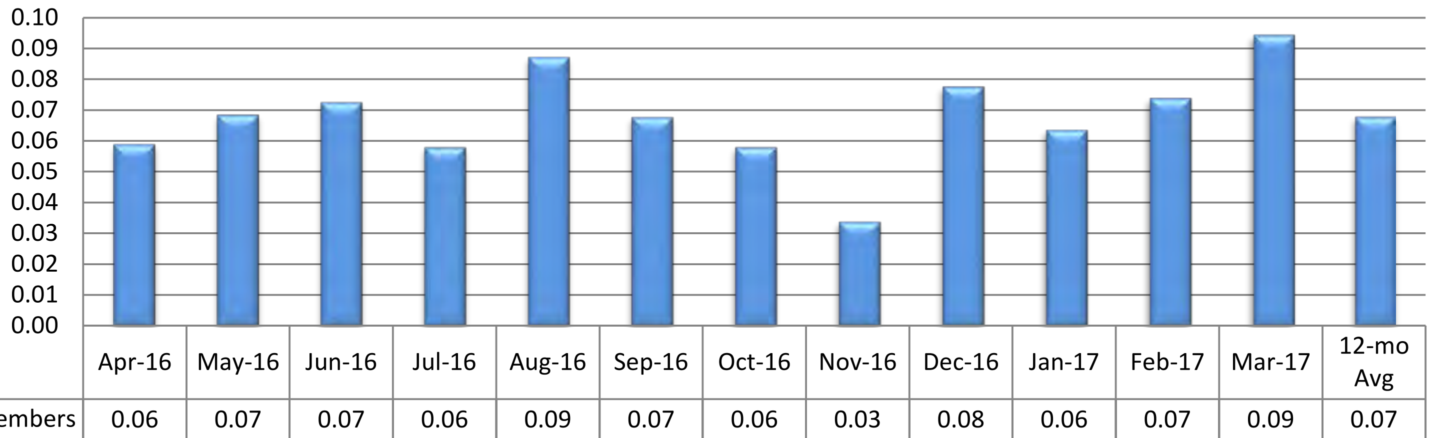
(2) Number of Claims Payment Adjustments processed in the ika claims system as reported by Xerox on the claims Financial Transaction Summary Report.
(3) Number of Xerox claims processing FTEs as reported in the Roster Report provided by Xerox.
(4) Auto Adjudication Rate calculated from "Inventory Tracking to Date" using week to date productivity totals as of Wednesday of each week.
Auto Adjudication Rate including Autobot includes claims processed with Autobot, which allows for systematic processing of claims.
(5) Number of Items in Refund Queue reflects the number reported by Xerox in the "Queue Aging Report" as of Wednesday of each week.
(6) Average Claims Receipts is calculated as the number of receipts in the past four weeks divided by 20 days.
(7) Reflects the aging reported by Xerox on the "Claims Aging Report" as of Wednesday of each week.
(8) Count of items still in EDGE process that have not been loaded into KWIK or ika.
(9) Includes claims that need additional research to determine whether or not they can be loaded into ika.
(10) Working inventory includes mailroom inventory on hand and pending claims inventory. It does not include claims that have been adjudicated and have a status of ready to pay.
(11) Claims Ready to Pay have been adjudicated and are ready for payment stream.
(12) Days Receipt on Hand (DROH) is calculated as the Working/Current Inventory divided by the Average Claim Receipts.
(13) Deleted claims have been replaced by a new claim. Deleted claims are still in ika; however, the status has been changed to deleted so the new claim can be worked.
(14) Actual Weekly Production is the total number of Denied and Allowed claims.
(15) Total Weekly Production includes Deleted, Denied and Allowed claims.
(16) Average Daily Production is calculated as the total production in the past four weeks divided by 20 days.
(17) Days Work on Hand (DWOH) is calculated as the Working/Current Inventory divided by the Average Daily Production.

Sources: Claims Financial Transaction Summary Report, GCHP Inventory Tracking to Date, Claims Aging Report, Queue Aging Report, Xerox Roster Report

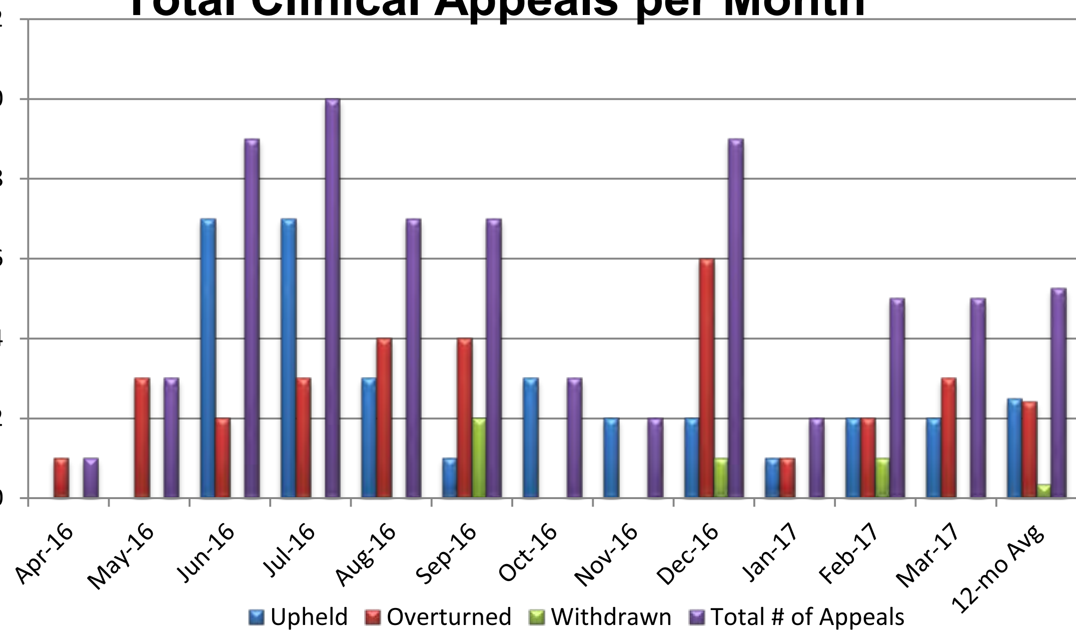


GCHP Grievance & Appeals Metrics – Mar. 2017

- GCHP received 19 member grievances (0.09 grievances per 1,000 members) and 158 provider grievances during March 2017
- GCHP's 12-month average for total grievances is 150
  - 14 member grievances per month
  - 137 provider grievances per month



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	12-mo Avg
Membership Count	203,969	204,619	206,920	207,019	206,644	206,672	207,188	206,780	206,252	204,529	203,243	201,514	205,446
Total Member Grievances Filed	12	14	15	12	18	14	12	7	16	13	15	19	14
# of Grievance per 1000 Members	0.06	0.07	0.07	0.06	0.09	0.07	0.06	0.03	0.08	0.06	0.07	0.09	0.07



GCHP Grievance & Appeals Metrics – March 2017

- GCHP had 5 clinical appeals in March; 2 Upheld and 3 Overturned
- TAT for grievance acknowledgement was non-compliant at 67% due to misrouted correspondence
- TAT for grievance resolution was non-compliant at 99%
- TAT for appeal acknowledgement and resolution were compliant at 100%.
- No State Fair Hearings were reported in March 2017

G&A Acknowledgement and Resolution TAT

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

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 12-mo Avg

Grievance Acknowledgement   Grievance Resolution   Appeal Acknowledgement   Appeal Resolution

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Gold Coast Health Plan℠
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Network Operations Dashboard

April 2017

Integrity

Accountability

Collaboration

Trust

Respect

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

PROVIDER NETWORK GROWTH FY 2016 April vs FY 2017 April

End of April 2016		End of April 2017
397	Total # of Primary Care Providers	486 (484)
4094	Total # of Specialty Physicians	5547 (5117)
17 Acute Care 3 Tertiary	Total # of Hospitals	23 Acute Care 4 Tertiary (No Change)
248	Total # of Behavioral Health Providers	358 (No Change)
235	Total # of Pharmacy Providers	239 (235)
452	Total # of All Other Providers (Home Health, Ancillaries, SNF's, CBAS, LTAC's)	457 (458)

NOTE: Numbers in red () reflect previous months figures

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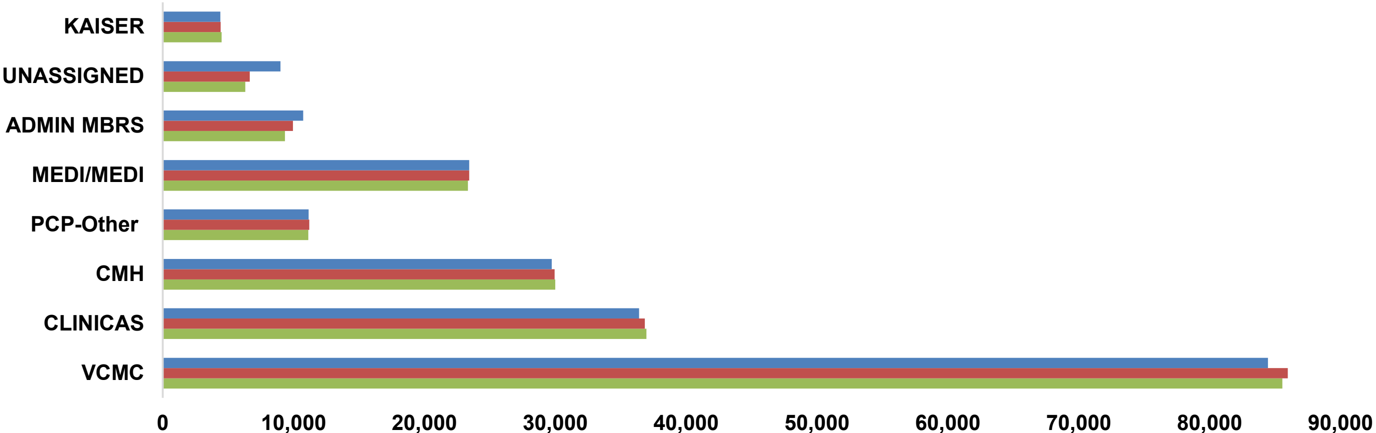
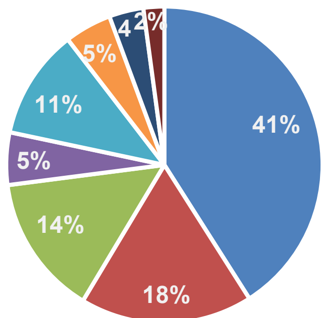
Member PCP Assignments



	VCMC	CLINICAS	CMH	PCP-Other	MEDI/MEDI	ADMIN MBRS	UNASSIGNED	KAISER
Feb-17	84,459	36,385	29,712	11,150	23,420	10,730	9,006	4,393
Mar-17	85,959	36,832	29,942	11,196	23,425	9,938	6,639	4,422
Apr-17	85,556	36,947	29,984	11,117	23,327	9,333	6,304	4,499

Average %

VCMC, CLINICAS, CMH, PCP-Other, MEDI/MEDI, ADMIN MBRS, UNASSIGNED, KAISER



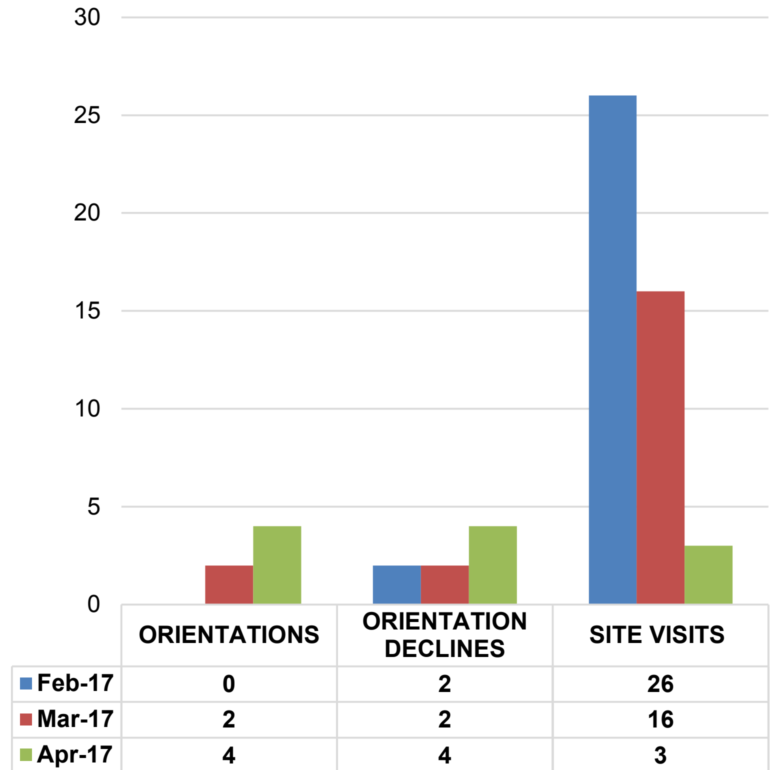
- Unassigned members are Newly Eligible/Enrolled
- Administrative Member(s)
  - Share of Cost (SOC): a Member who has Medi-Cal with a Share of Cost requirement.
  - Long-Term Care (LTC): A Member who is residing in a skilled or intermediate-care nursing facility and has been assigned an LTC Aid Code.
  - Out of Area: A Member who resides outside GCHP's service area but whose Medi-Cal case remains in Ventura County.
  - Other Health Coverage: A Member who has other health insurance that is primary to their Medi-Cal coverage; this includes Members with both Medi-Cal and commercial insurance. Medi-Cal is the payer of last resort; therefore GCHP Members with other coverage must access care through their primary insurance.

Provider Site Visits and Orientations

Provider Relations Representatives perform Orientations with newly GCHP contracted Providers and routinely visit provider offices. These visits create opportunities for providers to ask questions and for the representatives to deliver current information and materials. Visits may be pre-scheduled at the providers request to discuss specific issues or concerns and may include representation from other GCHP business areas.

Delegated groups are responsible to provide Orientation with new providers within ten (10) days of the providers effective date of hire.

A total of 8 physician's declined Orientation in Q1 due to joining an established contracted group with GCHP. Established groups participated in previous Orientations therefore are familiar with GCHP policies and procedures.



	ORIENTATIONS	ORIENTATION DECLINES	SITE VISITS
Feb-17	0	2	26
Mar-17	2	2	16
Apr-17	4	4	3

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GOLD COAST HEALTH PLAN CONTRACTED HOSPITALS

Hospital-In County	Affiliation	Type	Year Contracted	Reason For Contracting
Community Memorial Hospital	CMH	Acute	2011	In-County Facility
Los Robles Hospital and Medical Center	HCA	Acute	2011	In-County Facility
Ojai Valley Community Hospital	CMH	Acute	2011	In-County Facility
Santa Paula Hospital	VCMC	Acute	2011	In-County Facility
Simi Valley Hospital and Healthcare Services	Adventist Health	Acute	2011	In-County Facility
St. John's Pleasant Valley Hospital	Dignity Health	Acute	2011	In-County Facility
St. John's Regional Medical Center	Dignity Health	Acute	2011	In-County Facility
Ventura County Medical Center (VCMC)	VCMC	Acute	2011	In-County Facility
Hospital-Out-of-County	**Affiliation**	**Type**	**Year Contracted**	**Reason For Contracting**
Cedars-Sinai Medical Center	Cedars-Sinai Health System	Tertiary	2012	Tertiary, Quaternary and Transplant referral need
City of Hope	Non-Affiliated	Tertiary	2017	Adult and Pediatric Cancer and Transplant Facility, large # of Letters of Agreement
Children's Hospital of Los Angeles	Non-Affiliated	Tertiary	2011	Pediatric Tertiary ,Quaternary and Transplant Services. Level 1 Pediatric Trauma Ctr and Pediatric Acute Inpatient Rehab
Goleta Valley Cottage Hospital	Cottage Health System	Acute	2011	Both Santa Barbara Cottage and Goleta Cottage utilized by members living in Northwestern Ventura Co.
Keck Hospital of USC	USC	Tertiary	2011	Tertiary, Quaternary and Transplant referral need
Providence Holy Cross	Providence Health System	Acute	2012	Tertiary, Quaternary and Transplant referral need
Santa Barbara Cottage Hospital	Cottage Health system	Acute	2011	Both Santa Barbara Cottage and Goleta Cottage utilized by members living in Northwestern Ventura Co. Expanded Trauma and CCS need
Santa Ynez Valley Cottage Hospital	Cottage Health System	Acute	2011	This facility not widely utilized, but was included in the Cttage Health System hospital contract package
USC Kenneth Norris Jr. Cancer Hospital	USC	Cancer Center	2011	Adult Cancer and Transplant Facility, was included as part of Keck Hospital of USC Agreement
Providence Holy Cross Medical Center	Providence Health System	Center	2012	Contract with Providence Health System initially based on Tarzana Hospital relationship for pediatric services, which included need for CCS certfied facility. Relationship expanded to include 3 additional Providence Health System Hospitals under a single agreement.
Providence Little Company of Mary San Pedro	Providence Health System	Acute	2012	Contract with Providence Health System initially based on Tarzana Hospital relationship for pediatric services, which included need for CCS certfied facility. Relationship expanded to include 3 additional Providence Health System Hospitals under a single agreement.
Providence Saint Joseph Medical Center	Providence Health System	Center	2012	Contract with Providence Health System initially based on Tarzana Hospital relationship for pediatric services, which included need for CCS certfied facility. Relationship expanded to include 3 additional Providence Health System Hospitals under a single agreement.
Providence Tarzana Medical Center	Providence Health System	Center	2012	Contract with Providence Health System initially based on Tarzana Hospital relationship for pediatric services, which included need for CCS certfied facility. Relationship expanded to include 3 additional Providence Health System Hospitals under a single agreement.
West Hills Hospital & Medical Center	HCA	Center	2017	Burn Care (includes CCS) contract also includes acute care services. Large amount of GCHP member inpatient and outpt utilzation due to hospital being on the boarder of Ventura Co.
Ronald Regan UCLA Medical Center	Univ. California	Acute	2017	Highly utilized facility requiring many LOA's. Adult and Pediatric Tertiary, Quaternary and Transplant referral needs. Also a CCS center.

Gold Coast Health Plan
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GOLD COAST HEALTH PLAN- SPECIALTY HOSPITAL CONTRACTS

Specialty Hospital-Out-of-County	Affiliation	Type	Year Contracted	Reason For Contracting
Promise Hospital of East L.A.	Promise Healthcare	LTAC	2017	There are no Long Term Acute Care Facilities available in Ventura County. These facilities are key in the overall continuum of care and facilitating dicharge from the acute care setting to acute long term care setting for patients requiring ventilator management, complex wound care, cardio-pulmonary care and rehabilitation therapies.
Promise Hospital of East L.A. (Paramount)	Promise Healthcare	LTAC	2017	Same as above
Kindred Hospital- San Diego	Kindred Healthcare	LTAC	2016	Same as above
Kindred Hospital- Brea	Kindred Healthcare	LTAC	2016	Same as above
Kindred Hospital- Westminister	Kindred Healthcare	LTAC	2016	Same as above
Barlow Respiratory Hospital (L.A.)	Non-Affiliated	LTAC	2016	Same as above
Barlow Respiratory Hospital (Van Nuys)	Non-Affiliated	LTAC	2016	Same as above
Barlow Respiratory Hospital (Whittier)	Non-Affiliated	LTAC	2016	Same as above

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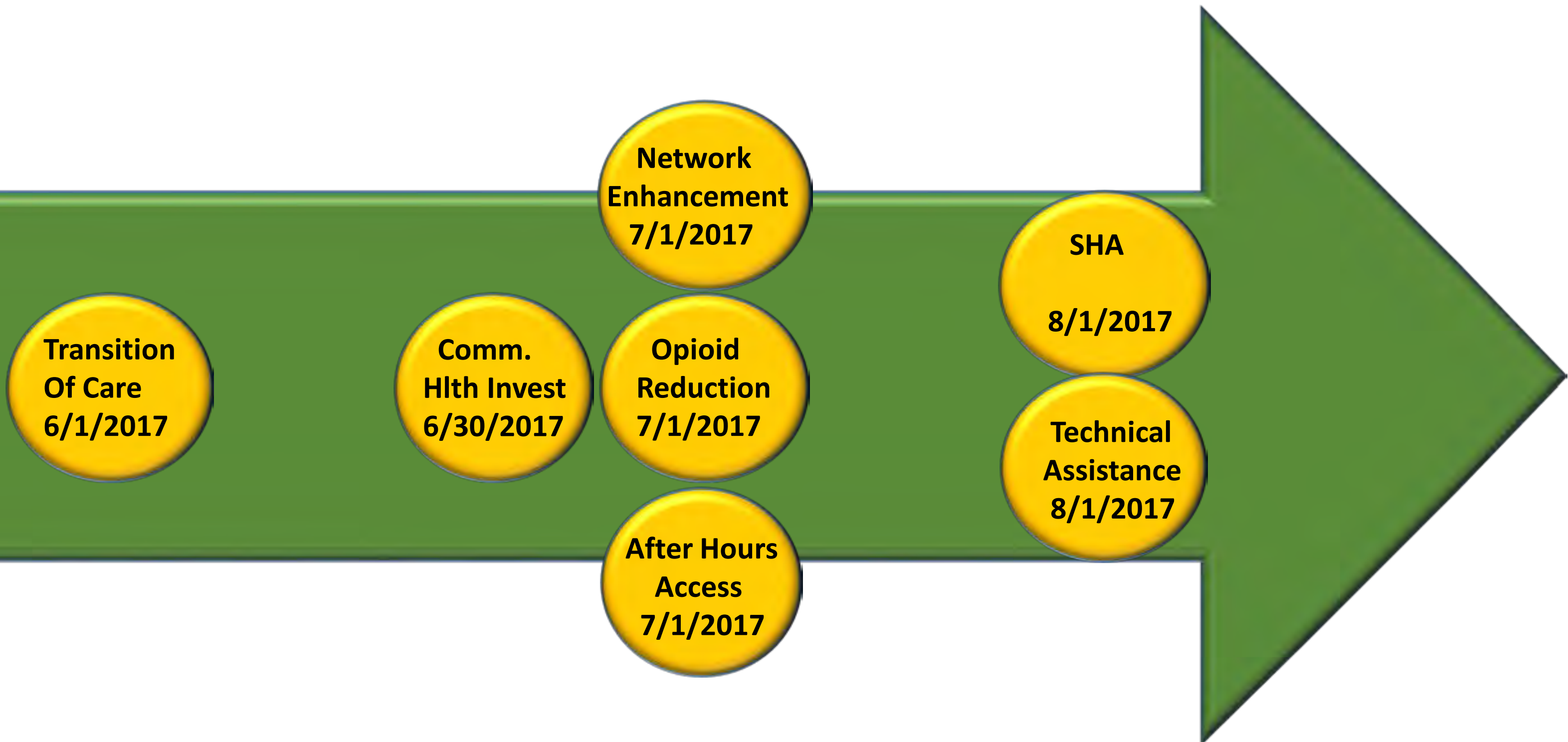
Value Based Program Summary

Initiative	Funding Level	Type	Description	Outcome
Network Enhancement	$4.5M $100K per PCP $150k/Specialist	Grant Application	PCP & Specialty Physician Recruitment	-Increase Access -Improve Patient Satisfaction
After Hours Access	$3.2M	P4P-enhanced payment rate	Expansion of provider regular business hours	-Enhanced access - Reduction in ER visits
Community Health Investments	$1.0M	Grant application	Several Programs to meet community needs	-Healthier Communities -Patient education
Transition of Care	$125k	Grant/Pilot	Enhance care transitions of Chronic disease patients	-Reduce ER utilization -Reduce Hospital re-admits
SHA	$300K X 3yrs	P4P	Development of a SHA tool to assist providers in completion of the SHA	Increase clinical compliance
Opioid Program	$60K	P4P	Enhance provider education on prescribing of opioids and alternatives	-Enhance awareness and alternatives to prescribing opioid medications.
Technical Assistance	$315K	Grant Application	TBD	TBD

VALUE BASED PROGRAM TIMELINE



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www.goldcoasthealthplan.org

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: C. Albert Reeves, Chief Medical Officer

DATE: May 22, 2017

SUBJECT: Chief Medical Officer 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 January 2017 are similar to slightly improved compared with CY 2016.

Bed days/1000 members declined by about 43% from Plan's inception in 2011 through CY2016. Bed days/1000 for January 2017 are about 10% less than CY2016 (210 v. 188). Adult Expansion members utilized the greatest number of bed days (47%) followed by SPD (29%) and Family members (24%).

Bed days/1000 for SPD members were 742 for January 2017. While the rate of bed days for SPD members is high, it does not have a strong effect on the overall plan rate of bed days per 1,000 members because SPD is such a small portion of our membership (5%).

Benchmark: While there is no Medi-Cal Managed Care Dashboard report of bed days/1000 members, review of available published data from other managed care plans range from 161 – 890/1000 members. There is variability of reporting of Administrative Days among managed care plans.

Average length of stay for CY2016 was 4.2. Average length of stay for January 2017 was 3.8.

Average length of stay for SPD members for CY2016 was 5.5 and for January 2017 was 4.8

Benchmark: No Medi-Cal Managed Care ALOS data are published in the DHCS Performance Dashboard. Average length of stay from available published data from other managed care plans range from 3.7 – 4.4. There is variability in reporting of Administrative Days among managed care plans.

Admits/1000 decreased about 10% from CY2015 to CY2016 (59 v. 53). Admits/1000 for January 2017 are 49.

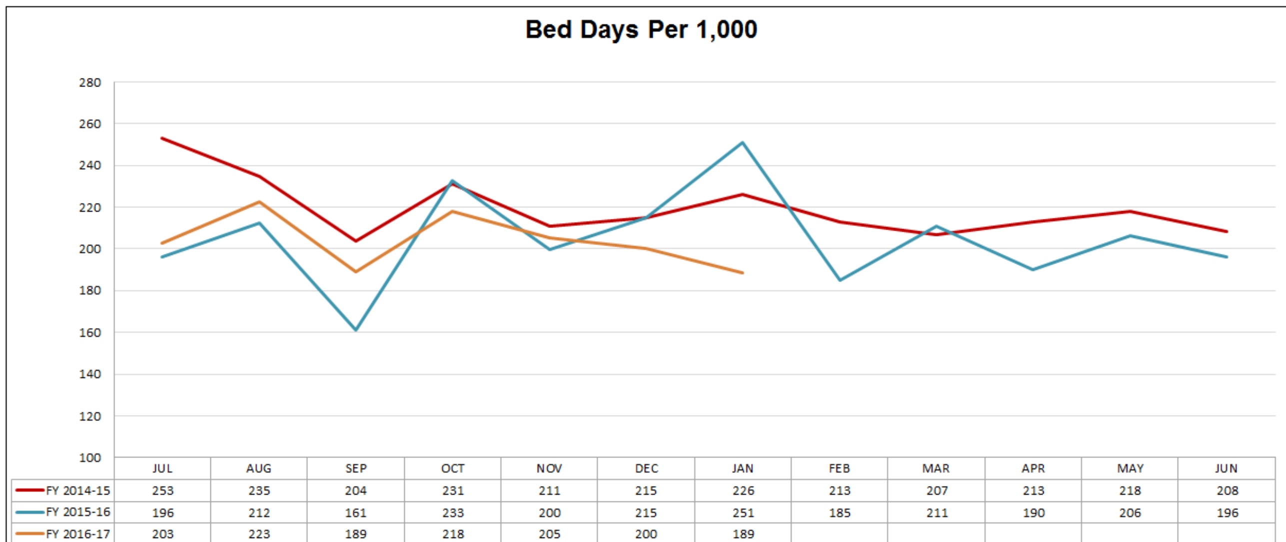
Admits/1000 SPD members are 156 for January 2017.

Benchmark: The DHCS average admits/1000 for SPD members is 458. This variation between GCHP and DCHS may be explained by the relative youth of GCHP SPD members versus DHCS SPD members. (Only 33% of GCHP SPD members are age 40 – 64 years versus 42% for the DHCS SPD population.)

ED utilization/1000 decreased by about 10% from CY 2012 through CY2016 (494 to 442). ED utilization typically peaks in January or February. ED utilization/1000 for January 2017 was 482 compared with 546 for January 2015. The family aid code group continues to utilize about half of all ED visits (52%) followed by AE members at 31%.

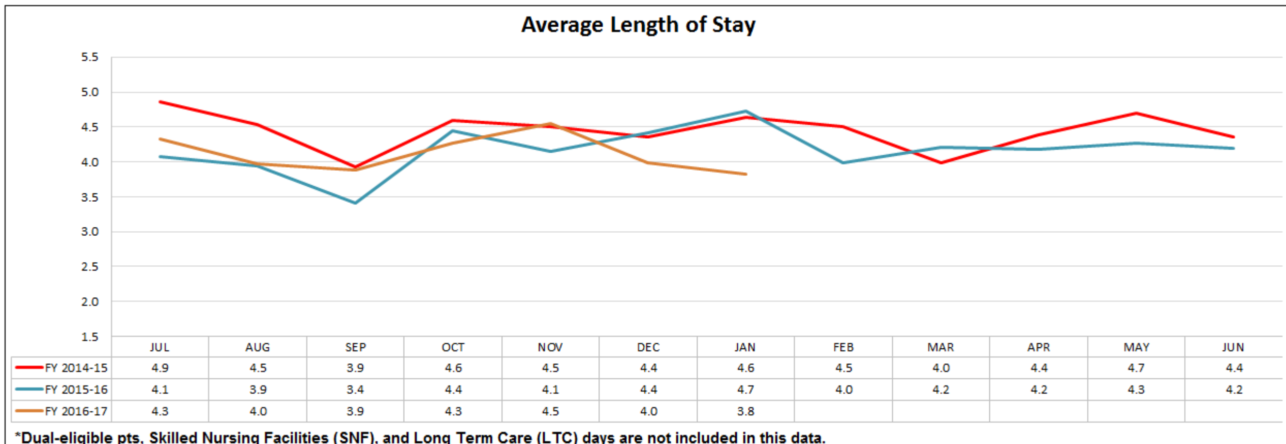
ED utilization for SPD members is 928/1000 members for January 2017.

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. The March 2017 Medi-Cal Managed Care Performance Dashboard reported SPD ED utilization to be 1065/1000 members.



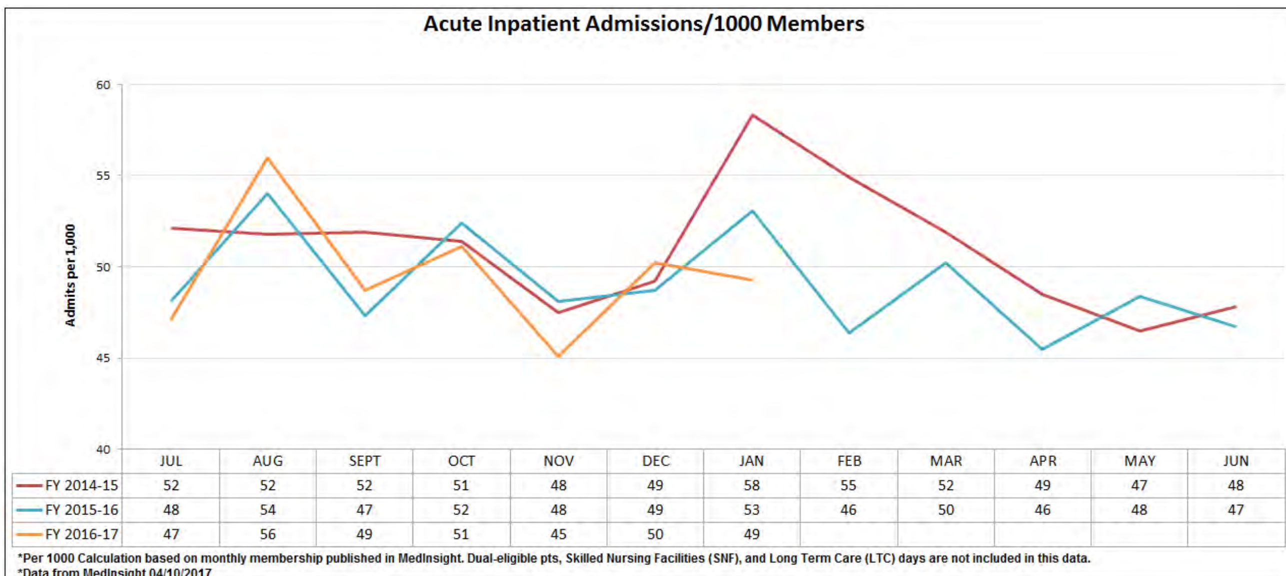
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	253	235	204	231	211	215	226	213	207	213	218	208
FY 2015-16	196	212	161	233	200	215	251	185	211	190	206	196
FY 2016-17	203	223	189	218	205	200	189					

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.



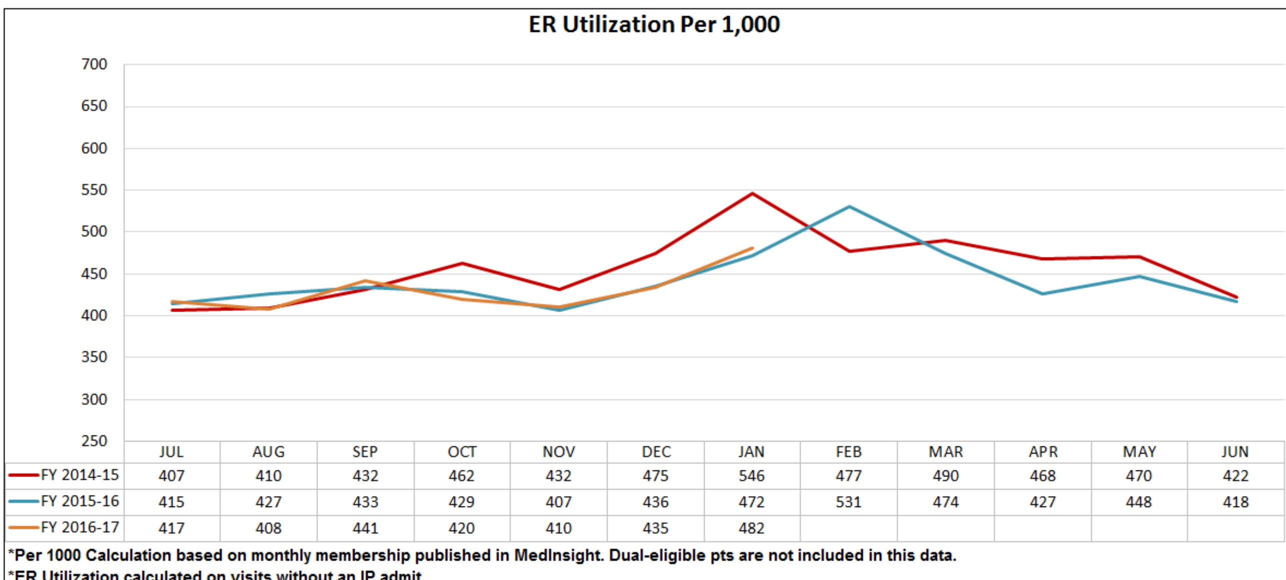
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	4.9	4.5	3.9	4.6	4.5	4.4	4.6	4.5	4.0	4.4	4.7	4.4
FY 2015-16	4.1	3.9	3.4	4.4	4.1	4.4	4.7	4.0	4.2	4.2	4.3	4.2
FY 2016-17	4.3	4.0	3.9	4.3	4.5	4.0	3.8					

*Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.



	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	52	52	52	51	48	49	58	55	52	49	47	48
FY 2015-16	48	54	47	52	48	49	53	46	50	46	48	47
FY 2016-17	47	56	49	51	45	50	49					

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.
*Data from MedInsight 04/10/2017

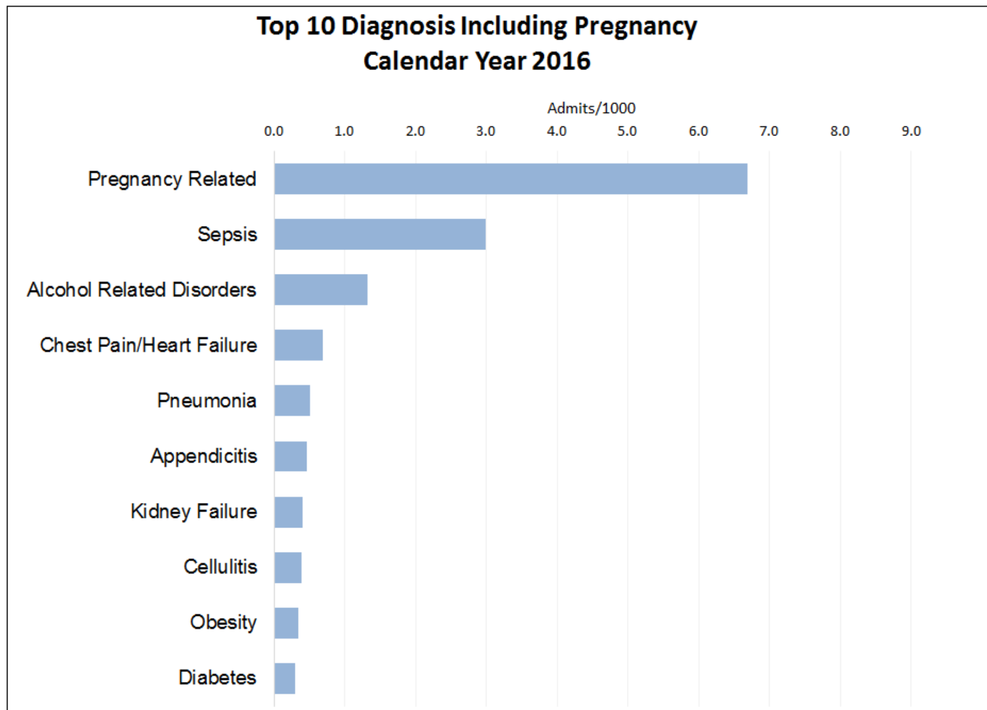


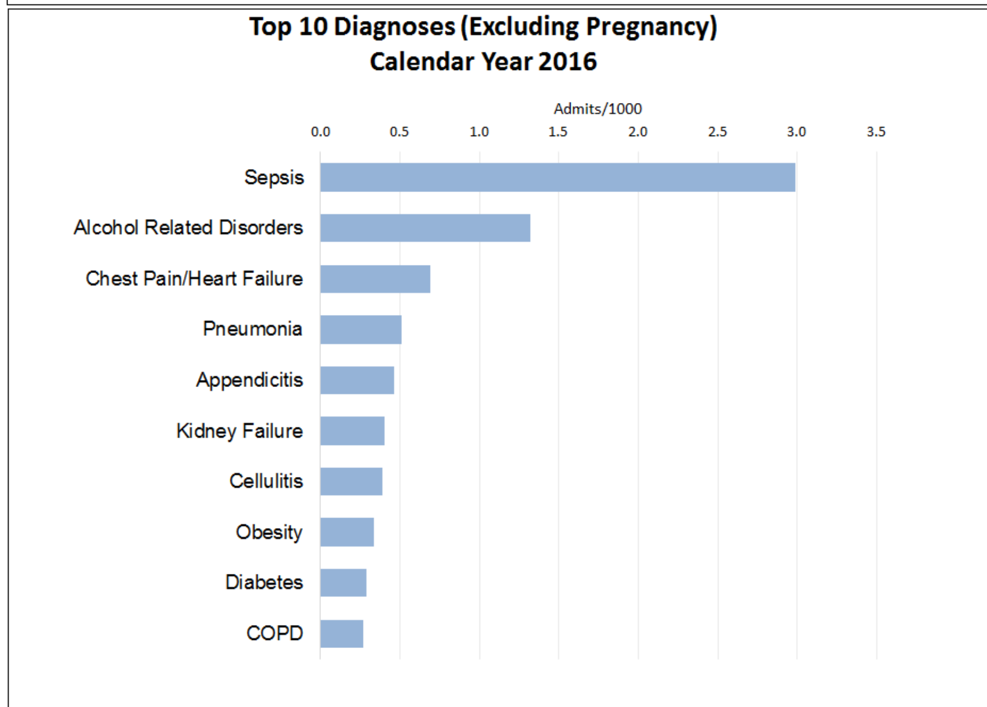
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	407	410	432	462	432	475	546	477	490	468	470	422
FY 2015-16	415	427	433	429	407	436	472	531	474	427	448	418
FY 2016-17	417	408	441	420	410	435	482					

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts are not included in this data.
*ER Utilization calculated on visits without an IP admit

TOP ADMITTING DIAGNOSES

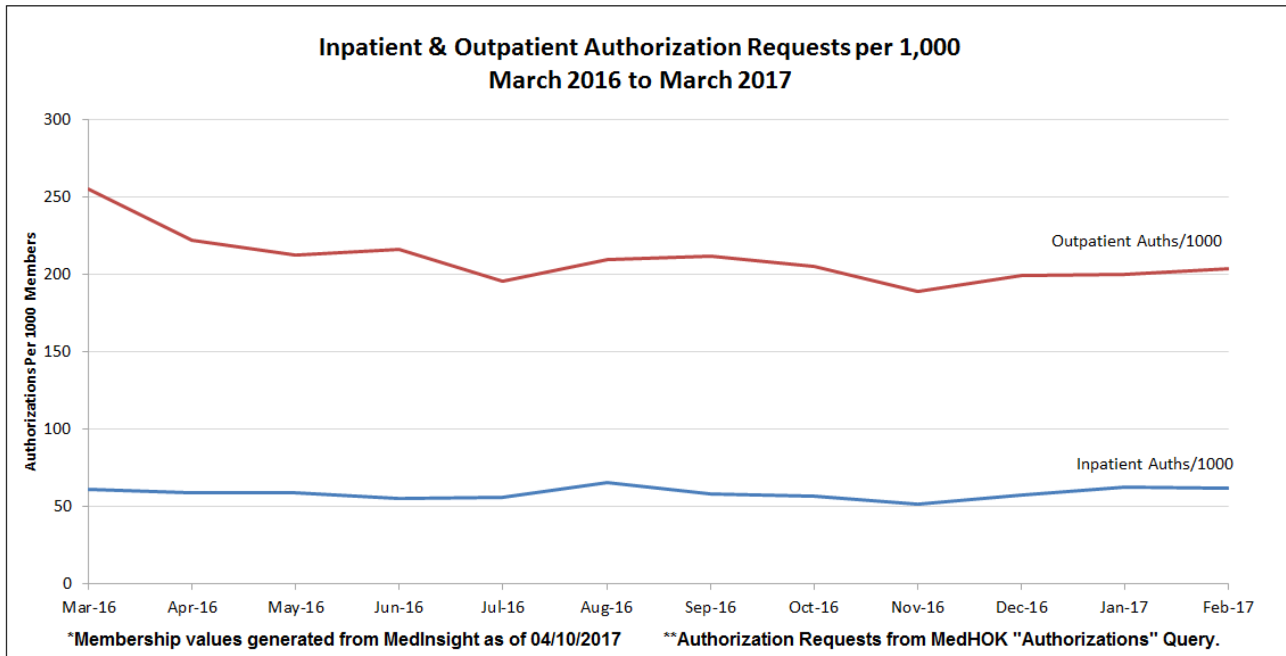
Pregnancy related diagnoses and sepsis continued to dominate top admitting diagnoses for CY 2016. For members admitted with a primary diagnosis of sepsis, secondary diagnoses were cancer, heart disease, liver or renal transplant, and diabetes were secondary diagnoses.

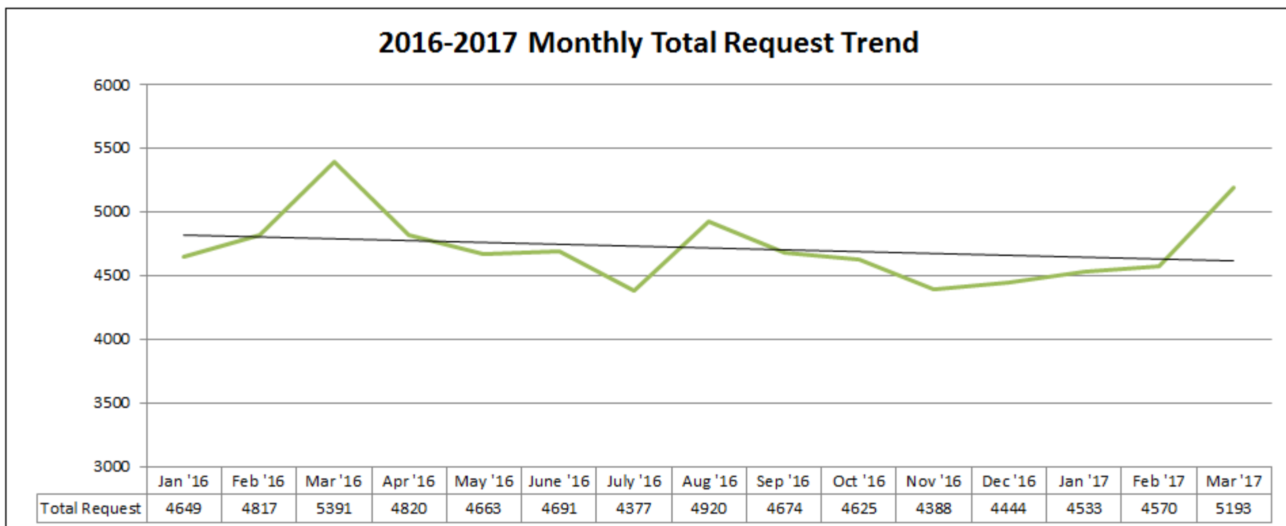




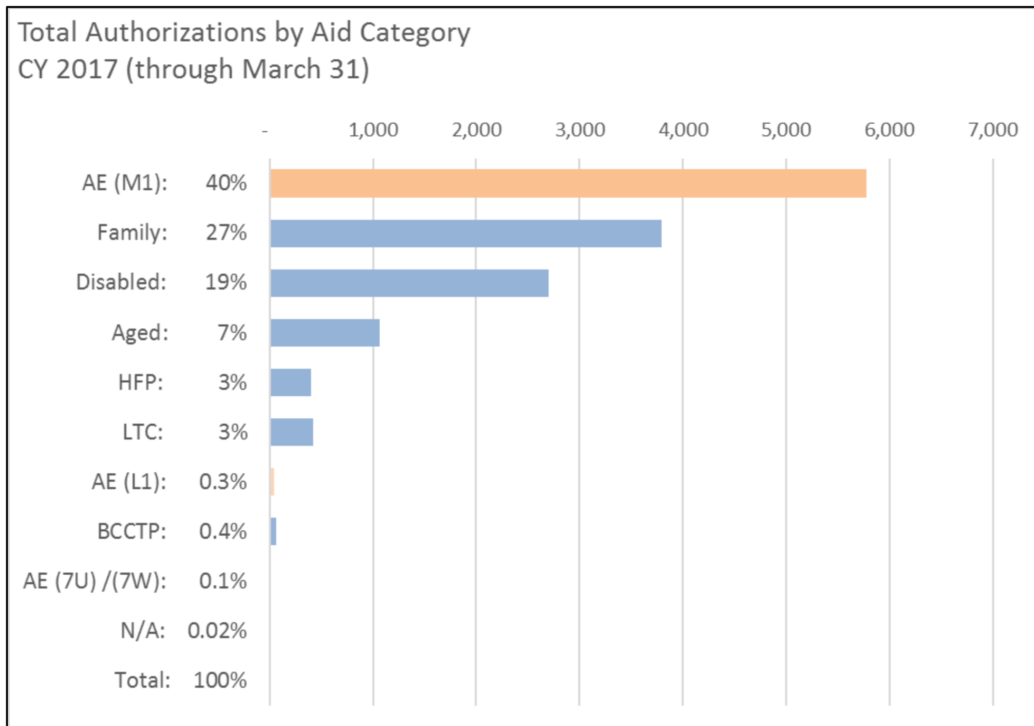
AUTHORIZATION REQUESTS

For CY2016, requests for outpatient service outnumbered requests for inpatient service by about four times. Requests for outpatient service declined to 213 requests/1000 members in CY 2016 from a peak of 255/1000 in March of 2016. Most authorizations are for M1, Family, and Disabled aid code groups.



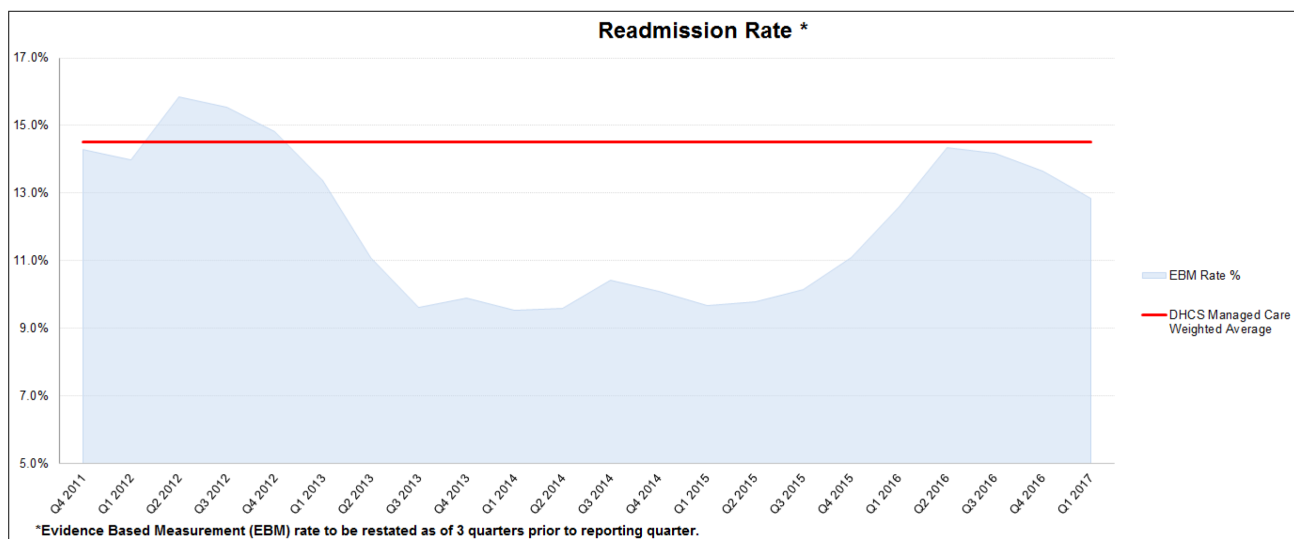


	Jan '16	Feb '16	Mar '16	Apr '16	May '16	June '16	July '16	Aug '16	Sep '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17
Total Request	4649	4817	5391	4820	4663	4691	4377	4920	4674	4625	4388	4444	4533	4570	5193



Readmission Rate
The readmission rate has declined from a recent peak in Q2 of 2016 to 12.8%.

Benchmark: The Medi-Cal Managed Care Dashboard readmission benchmark is 14.5%



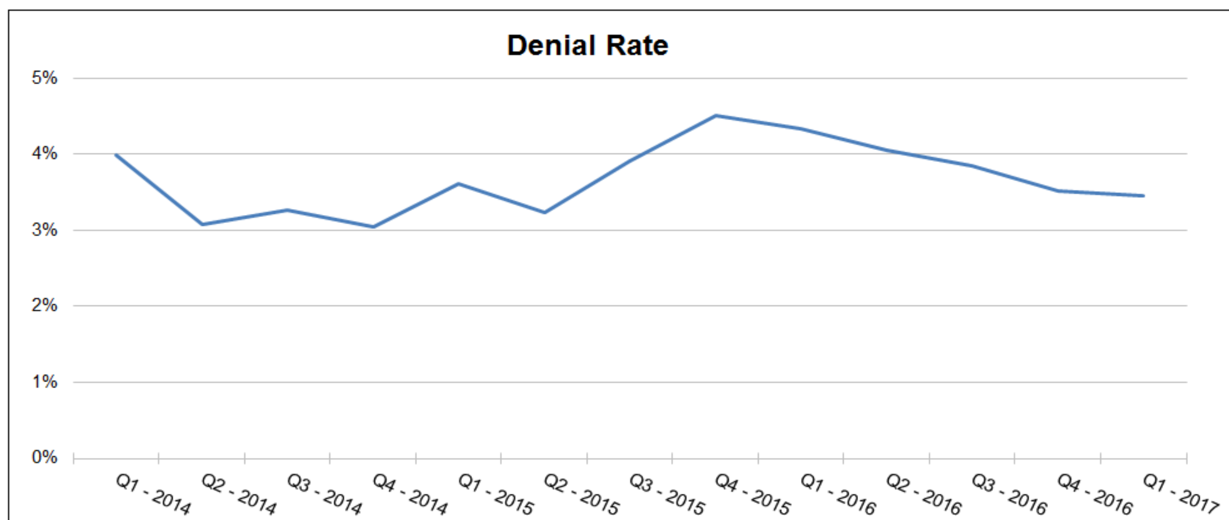
Clinical Grievances and Appeals
For CY2016, there were an average of 30 grievances/quarter. There were 34 clinical grievances in Q1 2017. Most grievances (85%) were characterized as quality of care issues. Only 2% of grievances were characterized as access issues for CY 2016. Access issues comprised 0.6% of grievances for Q1 2017.

QTR	Grievance Total	Appeals Total	Upheld	Partial Overturn	Overturned	Withdrawn	Dismissed
2016							
Q1	26	9	3 (34%)	-	4 (44%)	1 (11%)	1 (11%)
Q2	32	9	7 (78%)	-	2 (22%)	-	-
Q3	33	24	7 (29%)	-	14 (58%)	1 (5%)	-
Q4	27	21*	7 (33%)	-	6 (29%)	1 (5%)	-
2017							
Q1	34	15	6 (40%)	-	8 (53%)	1 (7%)	-

*Q4 2016 total appeals includes 7 (33%) in progress.

Denial Rate
Denial rate is calculated by dividing all not medically necessary denials by all requests for service. Denials for duplicate requests, member ineligibility, rescinded requests, other health coverage, or CCS approved case are not included in this calculation.

The denial rate has ranged between 2.7% and 4.5% since 2013. The average denial rate for CY 2016 was 3.9% and for Q1 of 2017 was 3.5%.



PHARMACY BENEFIT PERFORMANCE AND TRENDS

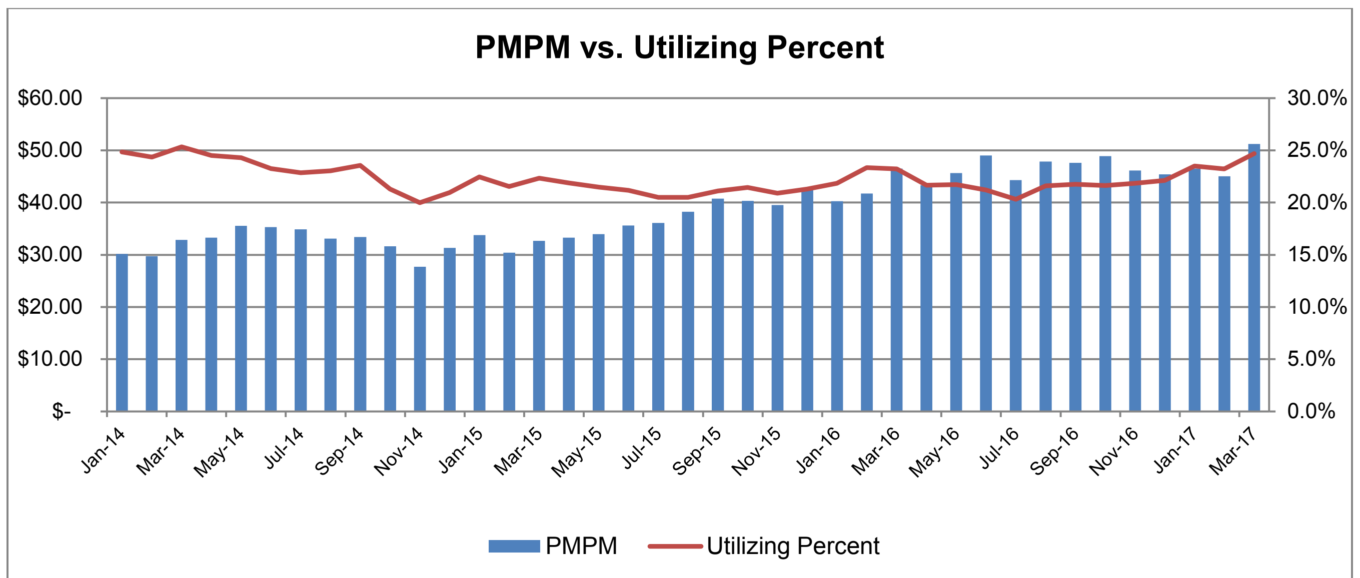
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO's operational membership counts, and invoice data. The data shown is through the end of the first calendar quarter of 2017. Although minor changes may occur to the data going forward due to the potential of claim adjustments from audits and/or member reimbursement requests, the data is generally considered complete due to point of sale processing of pharmacy data.

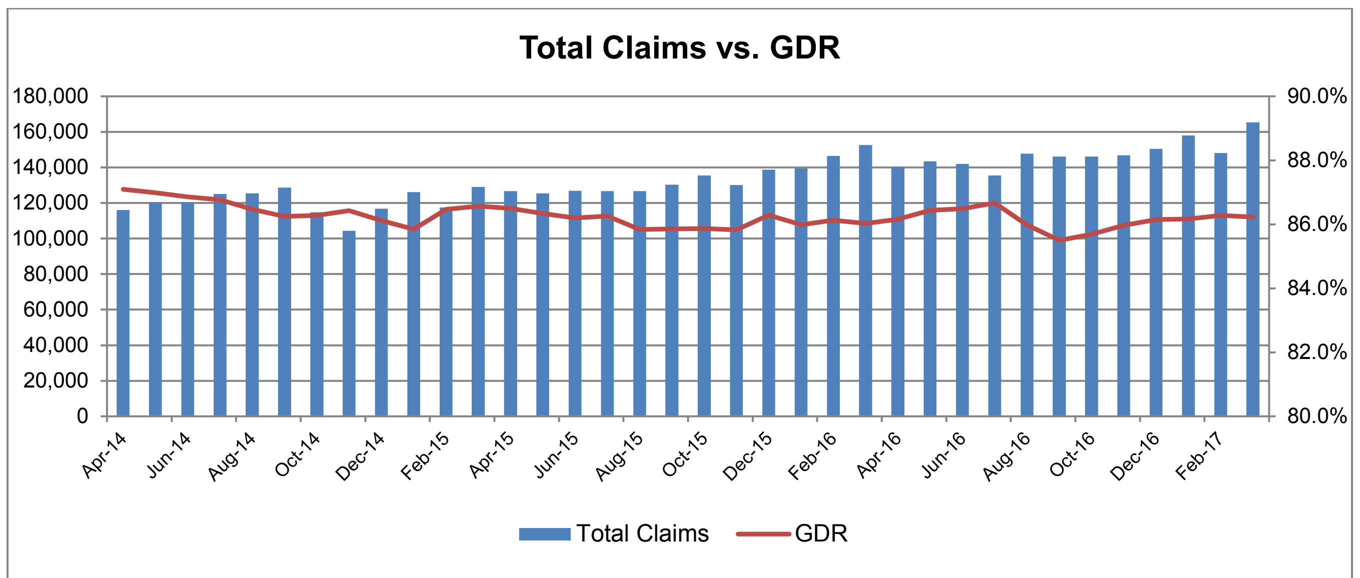
GCHP has seen a slight membership drop in 2017, while utilization has generally remained flat. Slight cost declines occurred in November and December 2016, however costs increased again in January and March 2017.

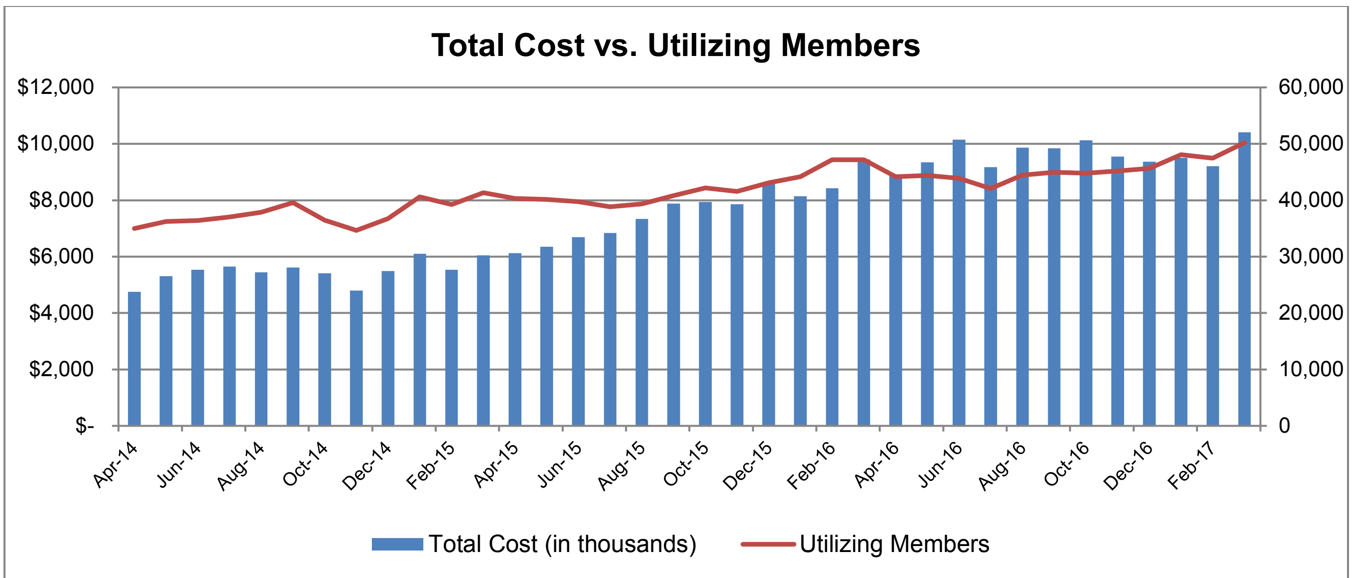
Hepatitis C continues to be a major driver of pharmacy costs though cost has decreased since the peak in May 2016. Formulary changes and the implementation of preferred products to align with DHCS kick payment utilization and cost assumptions has resulted in the Plan estimating to recoup all costs related to Hepatitis C in January and March 2017. This trend is expected to continue through June. However, the kick payment rate will likely be adjusted for FY17-18 and will impact this trend.

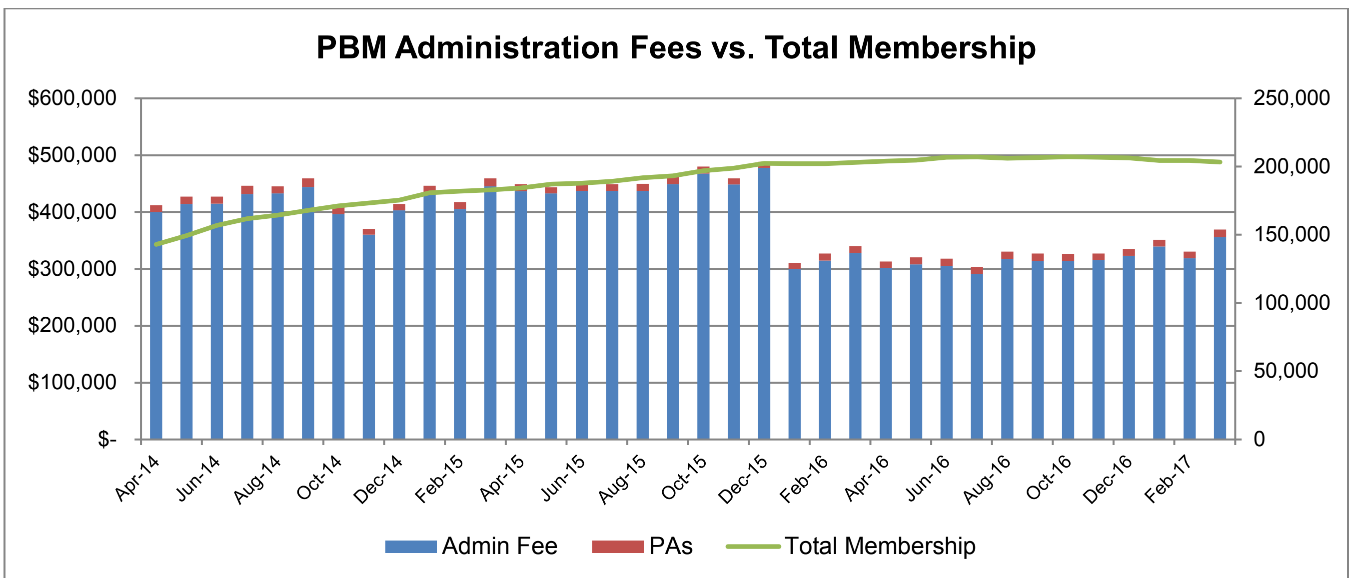
For a focused look at GCHP's pharmacy costs related to the diabetic population, drug spend continues to be more than double the costs related to non-diabetic members and the PMPM for diabetic members is more than five times that of non-diabetic members. Approximately 40% of all drugs costs for diabetic members is in the age group of 50 to 59. As these members mature into the 65+ age category, costs will to shift to Medicare.

PHARMACY COST TRENDS:

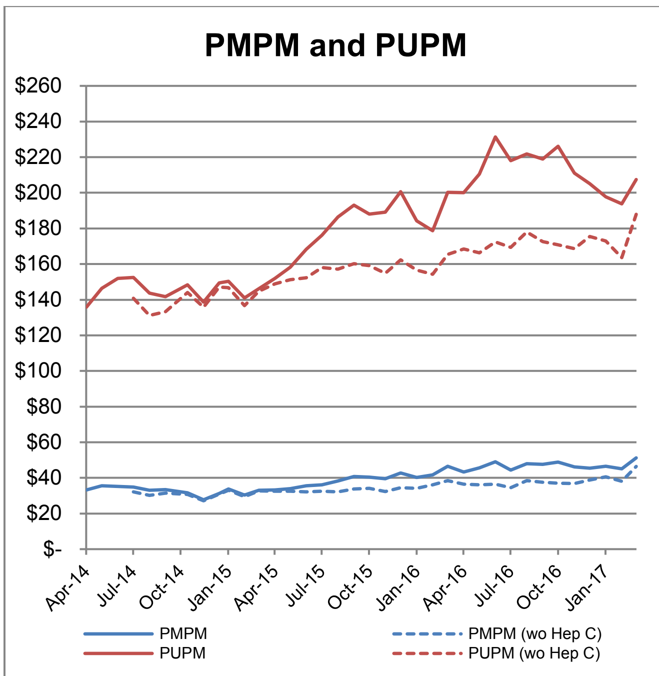


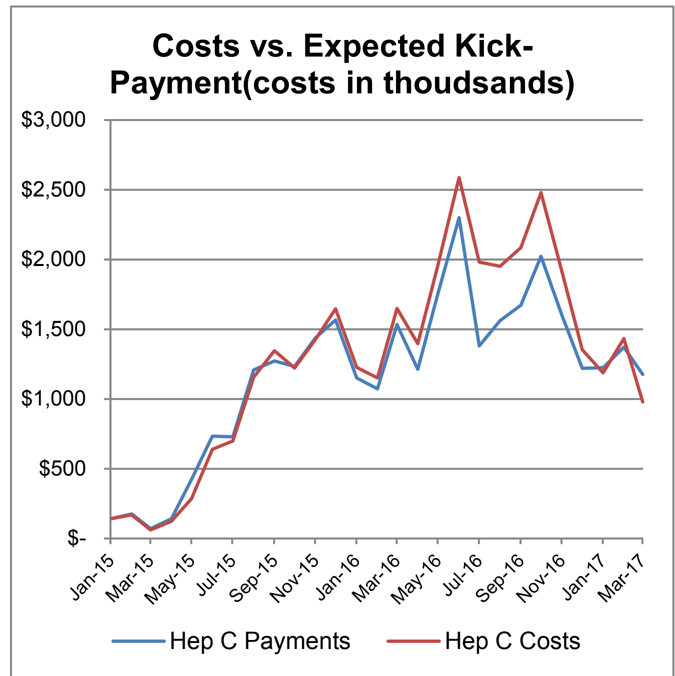



Total Cost vs. Utilizing Members
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
60,000
50,000
40,000
30,000
20,000
10,000
0
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Total Cost (in thousands)
Utilizing Members

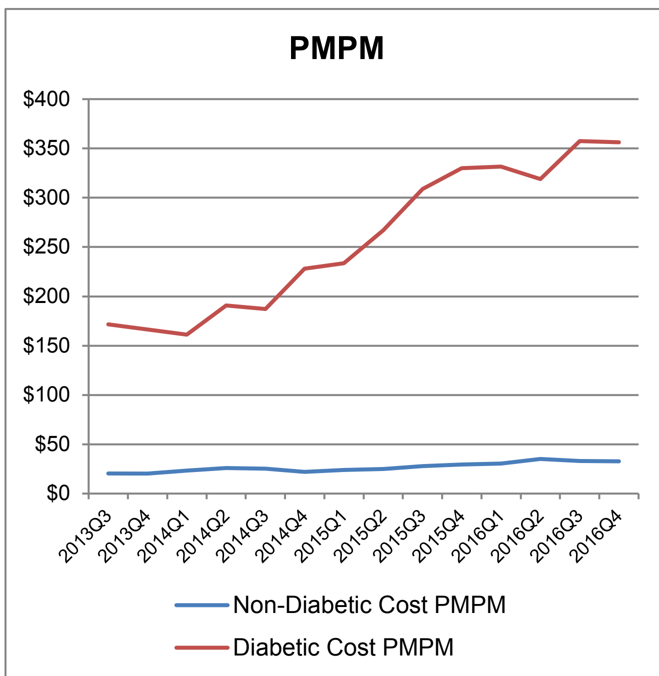

PBM Administration Fees vs. Total Membership
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
250,000
200,000
150,000
100,000
50,000
0
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Admin Fee
PAs
Total Membership

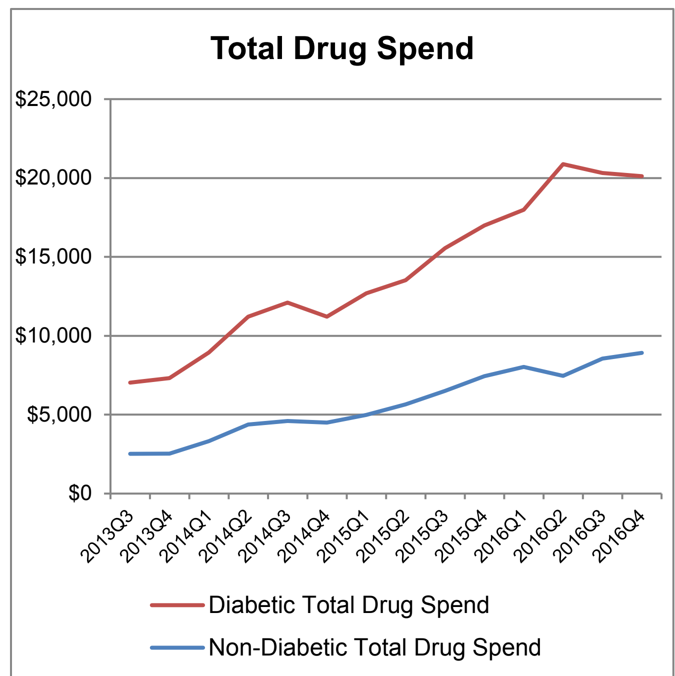
HEPATITIS C FOCUS:

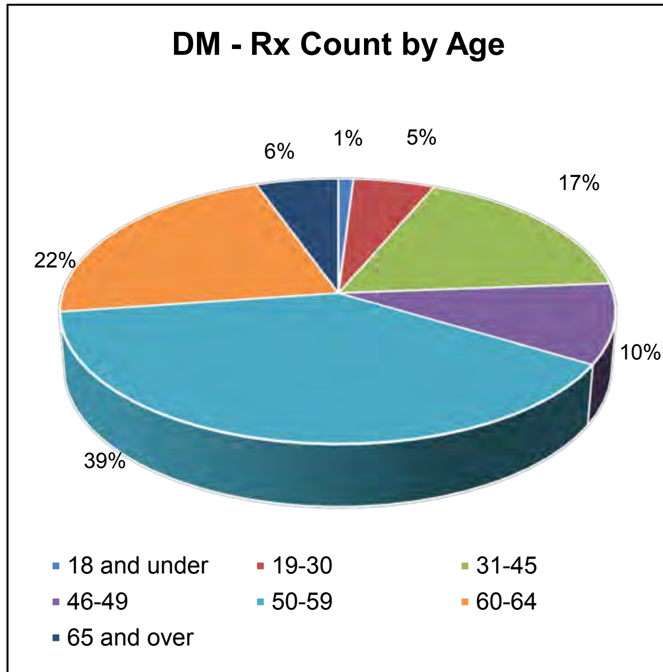


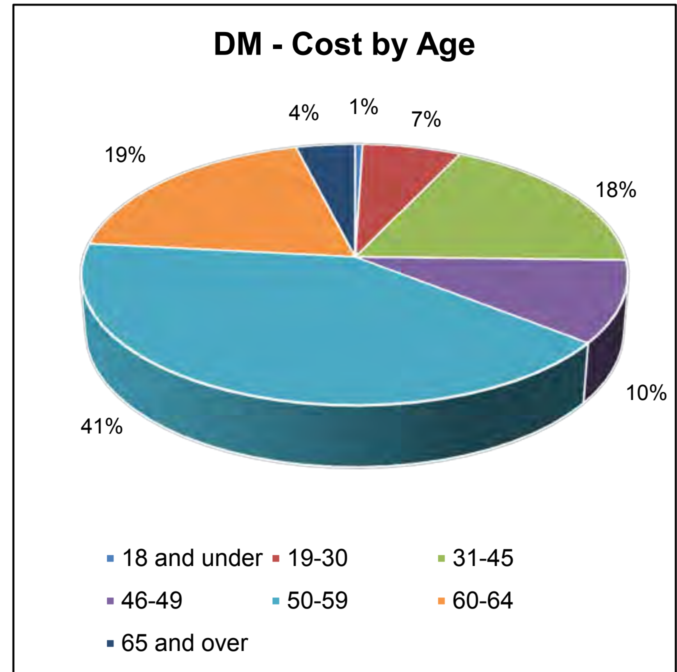


DIABETES FOCUS:






DM - Rx Count by Age
1%
5%
17%
10%
39%
22%
6%
18 and under
19-30
31-45
46-49
50-59
60-64
65 and over


DM - Cost by Age
1%
7%
18%
10%
41%
19%
4%
18 and under
19-30
31-45
46-49
50-59
60-64
65 and over

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Douglas Freeman, Chief Diversity Officer

DATE: May 22, 2017

SUBJECT: Chief Diversity Officer Update

Diversity and Inclusion Strategic Framework

On April 10, 2017, Douglas Freeman commenced work as the first Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Chief Diversity Officer (CDO).

Mr. Freeman's first major task was to start the process of developing a Diversity and Inclusion Blueprint, the strategic document that would serve as the pathway for building the GCHP Diversity Initiative. In order to build the document, he needed to collect data in the form of HR IT system information. Typical data includes EEOC representation reports, and employee engagement information.

Mr. Freeman is also responsible for collecting diversity-Return on Investment (d-ROI) data, information which helps to show hard-dollar value, based on demographic disparities in the workforce and member populations. In the case of GCHP, the CDO has conferred with Supervisor Zaragoza's team, to launch a "non-traditional" model of d-ROI impact, in the form of economic development. This first of-its-kind approach in Ventura County and nationally, leverages hard-to-find, fast-growth, diverse suppliers from outside the region to Ventura County, and encourages hiring of Ventura County locals and GCHP members to work for the diverse supplier organization.

Finally, Mr. Freeman is engaged on a broad stakeholder interview tour, which involves collecting data from County Leadership, the GCHP Commissioners, Community leaders, and employees (Chiefs, Directors, Managers and Frontline).

As a result of this comprehensive and systematic process, Mr. Freeman has the empirical data to propose the D&I Framework's 3 strategic pillars:

1. Compliance
2. Workforce/Workplace
3. Members/Community

Within each pillar are set of clearly identified foundational "gaps" that the strategy will rectify, once the D&I Blueprint has been completed and supported by all key stakeholders.

While admittedly outside of the parameters of a “traditional” CDO, the new GCHP/Ventura County customized d-ROI is an estimated $270M* over 10 years, or an ROI of approximately 265 times the diversity budget investment of 2017 and 2018*

(*based on financial forecasts, not actual proven outcomes- these forecasts are based on future assumptions such as a standard 2%+ US GDP rate, which may or may not occur.)

Gold Coast Health Plan: D&I Blueprint Framework

Presented to VCMMCC
May 22, 2017

Integrity
Accountability
Collaboration
Trust
Respect

Gold Coast Health Plan D&I Blueprint Framework

INCLUSIVE LEADERSHIP

Build and sustain an environment where our employees are embraced and valued for who they are so that they can reach their full potential, enabling Gold Coast to provide cost-effective, best-in-class Plan Services, to continuously improve Members' Quality of Care

COMPLIANCE

Establish foundational diversity policies, practices and procedures, while dramatically reducing investigations

WORKFORCE/ WORKPLACE

Recruit, Retain and Develop Talent by Building a Culture of Inclusion, Engagement and High Performance

MEMBERS/ COMMUNITY

Identify and Ameliorate Disparities in Care that adversely impact diverse members, while developing new models of diverse community investment

DIVERSITY RETURN ON INVESTMENT (d-ROI)

Infrastructure Foundations

Compliance (Mandatory Activities)

Code of Conduct Policy

Diversity and Inclusion Mission Statement

Diversity Hotline Employee Rollout

Completion of 2017 Investigations

Lawsuit/Grievances Support

Diversity Councils

Diversity Metrics as Major Component of All Employee Evaluations

Diversity Dashboard:
Compliance/
Workforce & Workplace/
Members & Community

Workforce/Workplace

Diversity Recruitment Fair

Diversity Department Webpage

New Employee Engagement and Inclusion Survey to drive Retention

Inclusive Leadership Training to ensure effective Skills Development

Launch of Cross-Demographic Employee Resource Group

Executive and Middle Management Diversity Councils

Workforce-ROI Calculator

Grassroots Diverse "Employer of Choice" Marketing/Branding/PR

Members/Community

Community Partner Inclusive Leadership Training Certifications

CDO Community Partner/Stakeholder Engagement Activities

Diverse Supplier Economic Development to Ventura County

Diverse Supplier Hiring Fair with GCHP members and community (Date TBD)

Members Quality of Care Disparity Analysis and Interventions

Member-ROI Calculator

2018/19 Inclusion Forum (Date TBD); 2017/18: Inclusion Forum Corporate Recruitment Fundraising Tour (Dates TBD)

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Melissa Scrymgeour, Chief Information and Strategy Officer

DATE: May 22, 2017

SUBJECT: CISO Update

FY16/17 Project Portfolio

Q1 2017 Highlights:

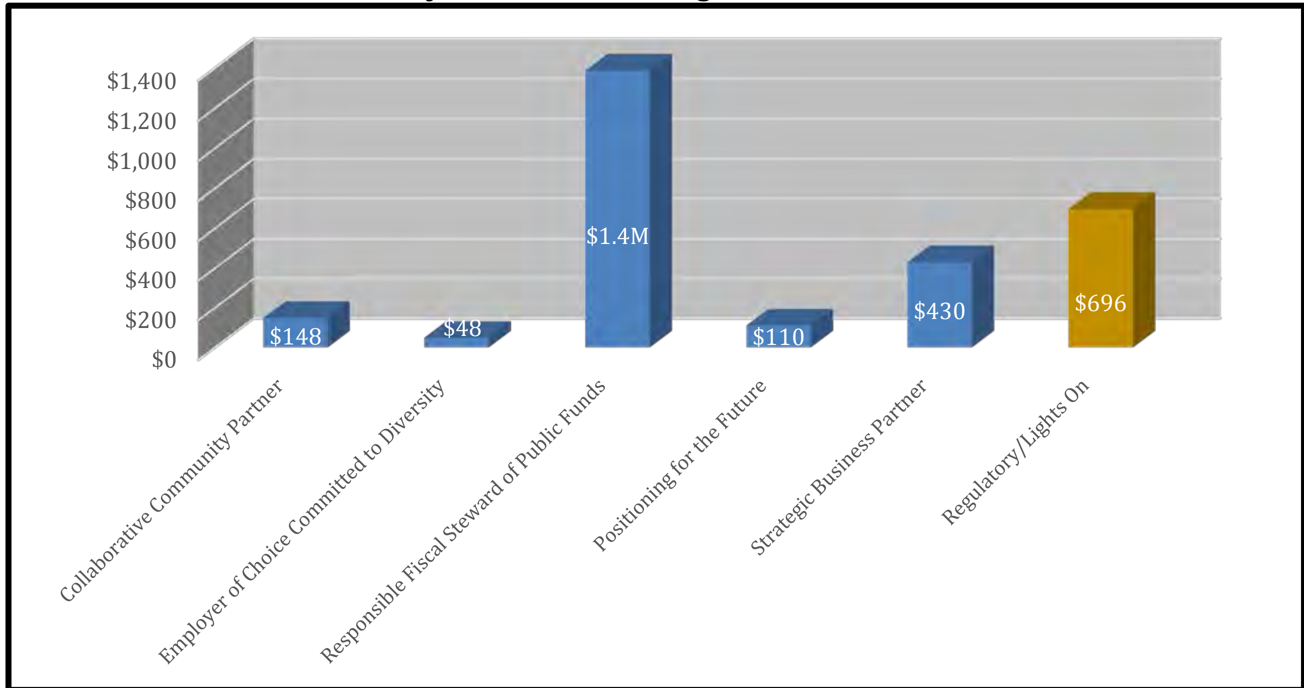
- DHCS 274 Provider File Submission – DHCS accepted the Plan's Phase IV test file. The Plan is pending final approval from DHCS to move into production.
- The Optum PBM implementation is on-schedule for a 6/1/2017 implementation go-live.
- Completed implementation of Inovalon, the Plan's new HEDIS vendor.
- Completed the evaluation of Mental Behavioral Health Organization (MBHO) contract performance and delivery options for mental and behavioral health benefits.

Project work is currently underway for the following:

- Implementation of new budgeting and forecasting software for added capabilities and efficiencies. The Plan is using this new technology to support the FY17/18 budget process.
- Implementing enhanced functionality in Plan financial system to optimize purchasing activities through purchase order automation.
- Kicked off upgrade to the MedHOK Medical Management System (MMS), targeted for implementation in Q1 2018. This new software version includes enhanced functionality and a new care management user interface expected to provide significant efficiencies in workflow and care management processes.
- Planning for implementation of SB1004 and Palliative Care benefit. SB1004 establishes standards and provides technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services.

Portfolio planning for FY17/18 is currently underway.

Table 1: FY 16/17 GCHP Project Portfolio Budget



AGENDA ITEM NO. 13

To: Gold Coast Health Plan Commissioners

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

Date: May 22, 2017

Re: Proposed Expansion of Diversity Subcommittee and Direction to Subcommittee and Chief Diversity Officer

SUMMARY:

The Diversity Subcommittee requests that the Commission consider additional appointments to Subcommittee membership and provide the Chief Diversity Officer (CDO) guidance on scope and his work interaction with the new Subcommittee.

As the Commission is aware, the Subcommittee spearheaded the effort to make diversity and inclusion a priority at GCHP, as well as the selection and hiring of the Chief Diversity Officer (CDO). The Diversity Subcommittee must now work with the recently hired CDO to integrate the position and move establish policies and procedures to govern the diversity and inclusion work. At present, the Subcommittee has three appointees: Commissioners Antonio Alatorre, Shawn Atin, and Laura Espinoza. Given busy schedules, the absence of a single member from a Diversity Subcommittee meeting can seriously hinder decision-making. As such, Commissioner Atin has requested the Commission consider appointing additional Subcommittee members.

BACKGROUND/ DISCUSSION:

On or about September 28, 2015, the GCHP established its three-person Diversity Subcommittee for the purpose of developing the Plan's diversity and inclusion program, as well as selecting and hiring a CDO. Early on, the Subcommittee established a standing monthly meeting on the third Monday of each month. Other meetings are scheduled as needed. Unfortunately, because of work schedules, Subcommittee meetings have sometimes had difficulty establishing quorum. Further, even if quorum is establish with one member absent, the remaining Subcommittee members find it difficult to address difficult or contested matters with only two votes. Since the beginning of this calendar year, the Subcommittee has failed to reach quorum on two occasions and had only two members present on two occasions. As the CDO has worked for a month, it is appropriate at this time to provide direction to the Diversity Subcommittee and CDO on goals for the immediate future.

FISCAL IMPACT:

N/A

RECOMMENDATION:

Staff recommends that the Commission consider the appointment of additional Diversity Subcommittee members and provide guidance to the Diversity Subcommittee and CDO.

CONCURRENCE:

N/A

ATTACHMENTS:

N/A

AGENDA ITEM NO. 14

To: Gold Coast Health Plan Commissioners

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

Date: May 22, 2017

Re: Chief Diversity Officer Travel & Expenses and Signature Authority

SUMMARY:

The Diversity Subcommittee requests that the Commission consider and approve guidelines for the Chief Diversity Officer's (CDO) travel and expenses, as well as signature authority.

BACKGROUND/ DISCUSSION:

The Diversity Subcommittee was formed by the Commission on September 18, 2015, for the purpose of facilitating development and implementation of a Diversity Program at Gold Coast Health Plan, including but not limited to the creation and recruitment of a CDO. The Diversity Subcommittee developed and recommended the recent hiring of current CDO, Douglas Freeman. A copy of the CDO Job Description is attached as Exhibit 1.

As the Commission is aware, the CDO does not report to the GCHP Chief Executive Officer. Instead, he reports directly to the Commission. As such, there are currently no express policies or guidelines related to Travel and Expense or Signature Authority that are applicable to the CDO. The Subcommittee anticipates that the Commission will want the CDO to follow the general GCHP practices and adhere to general GCHP limits related to travel, expenses, and signature authority.

FISCAL IMPACT:

None at this time.

RECOMMENDATION:

As to travel and expense, staff recommends that the CDO's travel and expenditures be subject to the general travel and expense limits applicable to all GCHP employees, with the caveat that travel and expenses budgeted by the CDO be approved by the Chair of the Diversity Subcommittee.

As to signature authority, staff recommends that the CDO be provided an authorization limit of up to $25,000 – consistent with that authorization limit provided to a Department Director. Expenses over $25,000 must be approved by the Commission, which may delegate approval authority to the Diversity Subcommittee.

CONCURRENCE:

N/A

ATTACHMENTS:

Exhibit 1: CDO Job Description

EXHIBIT 1

GOLD COAST HEALTH PLAN

TITLE: **Job Description – Chief Diversity Officer**
Dated: **November 2015**
Exempt, Contracted, At-Will
Salary Range: Level 29

POSITION SUMMARY

The Chief Diversity Officer (CDO) will be responsible for the design and implementation of diversity programs that support Gold Coast Health Plan's objectives. The ideal candidate will have extensive experience creating and managing diversity and inclusion programs, and will excel at developing both internal and external partnerships that drive our success. The incumbent will drive engagement, strategy, execution, and accountability for all diversity and inclusion initiatives across Gold Coast Health Plan (GCHP).

ESSENTIAL FUNCTIONS

The CDO will actively promote dignity and professionalism in the workplace in a manner that protects the right of employees to be free from illegal discrimination, harassment, and retaliation due to any protected status. Discrimination, harassment, and retaliation are contrary to the values of the GCHP, and the GCHP will not tolerate unlawful discrimination on the basis of sex, race, color, ancestry, religion, national origin, ethnicity, age (40 and over), disability, sexual orientation, gender identity or expression, marital status, medical condition, veteran status or any other protected characteristic protected by state or federal employment law, nor will it tolerate related and thus unlawful, harassment/retaliation.

The CDO will collaborate with all stakeholders to create a workplace culture where all GCHP employees are responsible for conducting themselves in a manner consistent with the above-stated values; and where failure to do so will lead to prompt and appropriate administrative action including, but not limited to, counseling, training, written warning, written reprimand, suspension, demotion, or dismissal.

Working directly for, and at the will of only, the Commission overseeing the GCHP and doing so within the context of both Title VII of the Civil Rights Act (CRA) and the California Fair Employment and Housing Act (FEHA), the CDO will independently:

- Consult with GCHP staff, community members, and/or other interested parties to develop periodic recommendations for policy and procedural changes designed to improve GCHP operations within the context of Title VII of the CRA and the California FEHA.

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QUALIFICATIONS

- Bachelor's degree, along with 5-10 years of progressive diversity and inclusion experience with a health plan/business or experience managing strategic company-wide Diversity and Inclusion initiatives; managed care experience a plus.
- Ability to work independently and in groups, while managing multiple priorities in a fast paced, fluid environment.
- Excellent interpersonal and influencing skills, including the ability to effectively coach leaders, build relationships and leverage resources within the department and across the organization to advance GCHP's strategy.
- Experience with change management, organizational design, talent/performance management, and strategic planning.
- Strong internal customer relationship management skills.
- Understands the challenges of, and thrives in, a heavily regulated organization.
- Ability to work collaboratively and openly with cross-functional teams.
- Creative approach to problem solving with a humble, team-oriented and optimistic attitude.
- Superior communication and presentation skills.

PHYSICAL REQUIREMENTS

Ability to communicate orally with the Commission, Plan management, staff, and the public in face-to-face, one-on-one and group settings. Regularly use a telephone for communication. Use office equipment such as a personal computer, copier and facsimile machines. Sit and/or stand for extended time periods. Hearing and vision required to be within normal ranges. Carry, push, pull, reach and lift up to 25 lbs. routinely. Read at, above, and below shoulder height. Occasionally stoop, kneel or crouch. Sufficient manual dexterity required to operate equipment.

CONDUCT STANDARD

Interact with the Commission, Plan Staff, Plan employees, customers, and the public in a positive, cooperative, and supportive manner. Maintain the highest standards regarding diversity and inclusion.

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- Investigate/review and evaluate allegations of employment-related, illegally discriminatory acts/statements/omissions in, or arising from, the GCHP workplace OR causes such to occur.

- Deem what employment-related audits of the GCHP workplace environment might need be conducted and either conducts such audit(s) or causes the same.

- Evaluate GCHP Management's response to employee complaints and/or directions given it by the CDO.

- Direct GCHP Management, Supervision, and/or line-staff on employment-related matters to avoid actual, or (if possible) perceived, illegality with respect to employment decisions and to thus limit GCHP's exposure to employment related lawsuits.

- Direct, as the CDO deems most appropriate, the GCHP response to inappropriate acts/statements/omissions by member of GCHP staff, up to and possibly including, dismissal from employment.

- Respond to employment-related inquiries/allegations from employees, the EEOC, the DFEH, or private attorneys representing active, past, or former employees.

- Efficiently direct the activities of assigned staff and/or contractors in support or pursuit of the foregoing activities.

- Provide periodic and/or special confidential, personnel/employment-related reports to the Commission on GCHP employment-related matters.

- Perform other related responsibilities/duties as deemed necessary by the Commission and/or the CDO.

ANCILLARY FUNCTIONS

- Consult with management, human resources, and legal counsel regarding diversity issues.

- Create or update all policies necessary for the implementation of the GCHP's diversity program.

- Arrange diversity-related training classes, workshops, and conference trips.

- Attend Commission and Diversity Subcommittee meetings.

- Perform related duties and responsibilities as required.

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