Gold Coast Health Plan[SM]
A Public Entity

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

2240 E. Gonzales Road, Suite 200, Oxnard, CA 93036
Monday, October 27, 2014
3:00 p.m.

AMENDED AGENDA

CALL TO ORDER / ROLL CALL

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

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

1. APPROVE MINUTES

a. Special Meeting of September 29, 2014

2. APPROVAL ITEMS

a. Affordable Care Act (ACA) Section 1202 Payments
b. Quality Improvement Committee Report – 3rd Quarter 2014
c. Compliance Officer Report – 3rd Quarter 2014
d. CEO Search Firm
e. General Counsel Support
f Lease Amendment / Additional Office Space

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

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ADMINISTRATIVE REPORTS RELATING TO THIS AGENDA AND MATERIALS RELATED TO AN AGENDA ITEM SUBMITTED TO THE COMMISSION AFTER DISTRIBUTION OF THE AGENDA PACKET ARE AVAILABLE FOR PUBLIC REVIEW DURING NORMAL BUSINESS HOURS AT THE OFFICE OF THE CLERK OF THE BOARD, 711 E. DAILY DRIVE, SUITE #106, CAMARILLO, CA. 93010

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT (805) 437-5509. REASONABLE ADVANCE NOTIFICATION OF THE NEED FOR ACCOMMODATION PRIOR TO THE MEETING (48 HOURS ADVANCE NOTICE IS PREFERABLE) WILL ENABLE US TO MAKE REASONABLE ARRANGEMENTS TO ENSURE ACCESSIBILITY TO THIS MEETING.

g. 2015 Commission Meeting Calendar
h. DHCS Contract Amendment A13

3. ACCEPT AND FILE ITEMS

a. Special Investigation Ad Hoc Committee Report
b. CEO Update
c. August Financials
d. COO Update
e. CIO Update
f Health Services Update

CLOSED SESSION

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

i. Cressena Hernandez v. Ventura County Medi-Cal Managed Care Commission et al, Ventura County Superior Court, Case Number 56-2012-00427535-CU-OE-VTA
ii. Clinicas Del Camino Real Inc. v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan. Ventura County Superior Court Case Number 56-2014-00456149-CU-BC-VTA

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

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on November 24, 2014 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

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

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Special Commission Meeting Minutes September 29, 2014

(Not official until approved)

Notice of said meeting was duly given in the time and manner prescribed by law. Affidavit of compliance is on file in the Clerk of the Board's Office.

CALL TO ORDER

Chair Araujo called the meeting to order at 3:03 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
Antonio Alatorre, Clinicas del Camino Real, Inc.
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Lanyard Dial, MD, Ventura County Medical Association
Barry Fisher, Ventura County Health Care Agency
Peter Foy, Ventura County Board of Supervisors (arrived 3:41 p.m.)
David Glyer, Private Hospitals / Healthcare System
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Gagan Pawar, MD, Clinicas del Camino Real, Inc.
Dee Pupa, Ventura County Health Care Agency
Robert Wardwell, Private Hospitals / Healthcare System

EXCUSED / ABSENT COMMISSION MEMBERS
Vacant, Medi-Cal Beneficiary Advocate

STAFF IN ATTENDANCE
Ruth Watson, Chief Operations Officer and Interim Chief Executive Officer
Michelle Raleigh, Chief Financial Officer
Traci R. McGinley, Clerk of the Board
Brandy Armenta, Compliance Director
Stacy Diaz, Human Resources Director
Mike Foord, IT Infrastructure Manager
Anne Freese, Pharmacy Director
Guillermo Gonzalez, Government Relations Director
Steven Lalich, Communications Director
Vickie Lemmon, Health Services Director
Tami Lewis, Operations Director
Allen Maithel, Controller
Al Reeves, MD, Chief Medical Officer
Melissa Scrymgeour, Chief Information Officer
Lyndon Turner, Financial Analysis Director
Nancy Wharfield, MD, Associate Chief Medical Officer

The Pledge of Allegiance was recited.

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

PUBLIC COMMENT

None.

1. APPROVAL ITEMS

a. Representation Agreement with the County of Ventura for Legal Services

Chair Araujo explained that the agreement would allow the Commission and the Plan to engage the County of Ventura, County Counsel's Office for legal representation services.

Commissioner Fisher moved to approve the representation agreement with the County of Ventura County Counsel Office. Commissioner Fisher noted that county counsel John Polich was present and was the original attorney for the Commission until it was able to obtain outside counsel. Commissioner Pupa seconded.

In response to Commissioner Dial's question; Commissioner Fisher responded that if needed, County Counsel would be available for staff; however, GCHP staff does work with other legal firms.

Commissioner Alatorre asked how long County Counsel's Services would be used. Chair Araujo responded that it would be until new regular general counsel was obtained.

The motion carried with the following votes:

AYE: Araujo, Dial, Fisher, Glyer, Laba, Pawar, Pupa and Wardwell.
NAY: Alatorre.
ABSTAIN: None.
ABSENT: Foy.

Counsel Polich then took his seat at the dais.

2. APPROVE MINUTES

a. Regular Meeting of August 25, 2014

Commissioner Fisher moved to approve the Meeting Minutes of August 25, 2014. Commissioner Dial seconded. The motion carried with the following votes:

AYE: Araujo, Dial, Fisher, Glyer, Laba, Pawar, Pupa and Wardwell.
NAY: None.
ABSTAIN: Alatorre.
ABSENT: Foy.

1. APPROVAL ITEMS *(Continued)*

b. Conflict of Interest Code

Interim CEO Watson reviewed the written report explaining that as required, the Commission directed staff to conduct a biennial review of the Conflict of Interest Code. A number of changes were required due to new positions, revised job titles and descriptions.

It was noted that a page was missing from the agenda item, Clerk McGinley offered to pull the information up on the computer.

Commissioner Fisher moved to approve the Resolution updating the Conflict of Interest Code. Commissioner Dial seconded. The motion carried with the following votes:

AYE: Alatorre, Araujo, Dial, Fisher, Glyer, Laba, Pawar, Pupa and Wardwell.
NAY: None.
ABSTAIN: None.
ABSENT: Foy.

RESOLUTION NO. R2014-002

A RESOLUTION OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION dba Gold Coast Health Plan UPDATING DESIGNATED EMPLOYEES, OFFICERS AND DISCLOSURE CATEGORY LIST FOR POLITICAL REFORM ACT AND FAIR POLITICAL PRACTICES REQUIREMENTS (CONFLICT OF INTEREST AND RESCINDING THE CONFLICT OF INTEREST CODE AMENDED PURSUANT TO RESOLUTION NO. R2012-003)

c. Business Property Liability Insurance Policy

CFO Raleigh reviewed the written report with the Commission. The current policy with Hartford Insurance expires September 30, 2014. Three companies provided quotes to the Plan's insurance brokers, Beecher Carlson. CFO Raleigh recommended purchasing the basic Business Insurance policy with Chubb at the increased levels and the additional umbrella policy (shown below). She explained that it would provide adequate coverage for increased growth at limits no less than the current policy.

Property	**Chubb - Quote 2** **with $2 Million Umbrella****
Building	N/A
Business Personal Property (BPP)	$566,174
Electronic Data Processing (EDP)	$857,136
Deductible	$1,000
General Liability	**$2 Million Umbrella****
General Aggregate	$4 million
Each Occurrence	$3 million
Advertising Injury and Personal Injury	$3 million
Medical Expense	$10,000
Damage to Rented Premises	$3 million

Employee Benefits (endorsement) • Aggregate • Each occurrence	 $4 million $3 million
Deductible	$0
Hired Non-owned Auto	**$3 Million**
PREMIUM	**$2,830 + $2,060 = 4,890**

Commissioner Dial moved to approve purchasing the basic Business Insurance policy with Chubb at the increased levels and the additional umbrella policy. Commissioner Glyer seconded. The motion carried with the following votes:

AYE: Alatorre, Araujo, Dial, Fisher, Glyer, Laba, Pawar, Pupa and Wardwell.
NAY: None.
ABSTAIN: None.
ABSENT: Foy.

d. Approval of Recommended Search Firm for CEO Position

An ad hoc committee was created at the August 25, 2014 Commission for the purpose of selecting a search firm for the CEO position. The members of said ad hoc committee are Chair Araujo, Commissioner Foy and Commissioner Alatorre.

Human Resources Director Diaz reviewed the written report. Commissioner Alatorre expressed concern as to when the ad hoc committee met because he did not participate in a meeting.

HR Director Diaz responded that she had reached out to Commissioner Alatorre on several occasions via e-mail but received no response. Since Commissioner Alatorre had not been in attendance at the previous commission meeting and was volunteered for the ad hoc committee, HR Director Diaz was asked to reach out to him to see if he was able to participate. HR Director Diaz stated that since she had not heard back from Commissioner Alatorre she assumed he was not interested in serving on this ad hoc committee.

Discussion was held regarding the timeliness of the process versus scheduling another ad hoc committee meeting to review the information. Commissioners expressed the importance of ad hoc committee members reviewing the data and having discussions to determine the best firm.

Commissioner Fisher moved that the full Ad Hoc Committee reconvene within the next two weeks to agree on a firm. Commissioner Pawar seconded. The motion carried with the following votes:

AYE: Alatorre, Araujo, Fisher, Glyer, Laba, Pawar, Pupa and Wardwell.
NAY: Dial.
ABSTAIN: None.
ABSENT: Foy.

e. Waive General Counsel Attorney-Client and Closed Session Privileges and Protection – Special Investigation Ad Hoc Committee Consultants

Chair Araujo announced that the item was not being considered and was being pulled from the agenda.

3. ACCEPT AND FILE ITEMS

a. Special Investigation Ad Hoc Committee Report

Commissioner Fisher noted that Scott Howard, legal counsel for the Special Investigation Ad Hoc Committee was present should the Commission have any questions. Commissioner Fisher then reviewed the written report with the Commission, emphasizing that the investigation had expanded and expenses are expected to total between $586,000 and $636,000 approximately.

b. CEO Update

Interim CEO Watson presented the CEO update and announced that the Pharmacy information would not be reviewed at this time but detailed information will be going to the Commission at a later time.

Commissioner Foy arrived at 3:41 pm

c. July Financials

CFO Raleigh reviewed the July Financial package with the Commission. Discussion was held regarding the growth in membership. CFO Raleigh highlighted that the Tangible Net Equity (TNE) levels are at approximately 182% of the State required minimum which includes the Lines of Credit (LOC) from the County of Ventura of $7.2 million.

d. CIO Update

CIO Scrymgeour briefly reviewed the written CIO update and highlighted the GCHP Projects At a Glance sheet on page 3d-5.

e. Behavioral Health Benefit for Autism Spectrum Disorder

Associate CMO Wharfield reviewed the written report with the Commission.

f. COO Update

Interim CEO Watson presented the COO Update. Commissioner Alatorre asked how many members were being auto assigned. Interim CEO Watson responded that she should be able to have that information at the next Commission Meeting.

g. Health Services Update

Associate Medical Director Dr. Wharfield reviewed the written report.

Commissioner Pupa moved to accept and file the Special Investigation Ad Hoc Committee Report, CEO Update, July Financials, CIO Update, Behavioral Health Benefit for Autism Spectrum Disorder, COO Update and Health Services Update. Commissioner Fisher seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Dial, Fisher, Foy, Glyer, Laba, Pawar, Pupa and Wardwell.
NAY:	None.
ABSTAIN:	None.
ABSENT:	None.

CLOSED SESSION

Chair Araujo explained the purpose of the Closed Session items.

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 3:57 pm regarding the following items:

a. **Public Employee Release Pursuant to Government Code Section 54954(e)**

b. **Public Employee Appointment Pursuant to Government Code Section 54957(b) Title:** General Legal Counsel

c. **Conference with Legal Counsel - Anticipated Litigation - Significant Exposure to Litigation Pursuant to Government Code Section 54956.9(b)** – (One Case)

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 7:30 p.m.

Chair Araujo announced that the Commission unanimously voted to release legal counsel Nancy Kierstyn Schreiner, Anderson Kill Wood & Bender, P.C., from general counsel duties. He closed stating that no additional reportable action was taken.

ADJOURNMENT

Meeting adjourned at 7:33 p.m.

AGENDA ITEM 2a

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: October 27, 2014

RE: Affordable Care Act (ACA) Section 1202 Payments

SUMMARY:
Gold Coast Health Plan (GCHP or Plan) is required to make supplemental payments to qualifying physicians as outlined in the Affordable Care Act (ACA), Section 1202. Below, GCHP provides the Commission with an update on many items related to these supplemental payments. In addition, GCHP is requesting approval to not recoup extra supplemental payments for the January 1, 2013 – June 30, 2013 time period and to process additional payments due providers for this time period using the same methodology. These extra supplemental payments were made prior to the Department of Health Care Services (DHCS) issuing final guidance.

BACKGROUND / DISCUSSION:
Pursuant to the ACA, as amended by the H.R. 4872-24 Health Care and Education Reconciliation Act of 2010, Section 1202, ACA and 42 Code of Federal Regulations 447, state Medicaid agencies are required to reimburse primary care physicians with a specialty designation of family medicine, general internal medicine or pediatric medicine, at parity with Medicare payment rates (with exceptions noted below), for specified Evaluation and Management (E&M) and Vaccine Administration services for services provided during calendar years 2013 and 2014. Examples of the calculation process are shown below.

The information below is summarized into two time periods to distinguish between the change in the calculation methodology based on additional DHCS guidance.

January 1, 2013 – June 30, 2013 Supplemental Payments
In early January 2014, GCHP received funding to pay out the ACA 1202 supplemental payments to qualifying physicians for services provided during the first six months of services of calendar year 2013. When the internal processing of this initial supplemental payment was complete (March 27, 2014), approximately $2.2 million was paid out according to GCHP's compliance plan in effect at the time the payment was made.

As GCHP was making these initial payments, DHCS alerted the Managed Care Plans (MCPs) that a change in the calculation of these supplemental payments was necessary. Supplemental payments were required to be based on "lesser of" language which necessitates consideration of the provider's reported billed charge in the calculation. This new guidance requires that supplemental payments are to be based on the difference between the

- lesser of the effective Medicare rate and the provider's billed charge field on the claim and
- the Medi-Cal rate paid.

Therefore, if the billed charge is less than the Medicare rate, the reimbursement amount would be the difference between the billed amount and the Medi-Cal rate. The example below illustrates this extra step in the calculation:

Table 1: ACA 1202 Supplemental Payment Calculation Example		
	Prior to incorporating "lesser of" language (e.g., payments made for January 1, 2013 – June 30, 2013 dates of service)	**After incorporating "lesser of" language**
a) Effective Medicare Rate	$100	$100
b) Billed Charges	$85	$85
c) Medi-Cal Rate	$40	$40
d) "Lesser of" (a) and (b)	$100	$85
e) Supplemental Payment = (d) minus (c)	$60	$45

Note this "lesser of" language was not reflected in the calculation of the initial payments made by GCHP in late March 2014. GCHP followed the DHCS-approved compliance plan in effect for that time period which did not take into account this new language due to late direction from the State. Therefore, some payments already made by GCHP to qualifying physicians were higher than if the new "lesser of" language would have been applied. Following is information on the estimated amounts of these overpayments due to the methodology change.

Table 2: Estimated January 1, 2013 – June 30, 2013 Supplemental Payments			
	(d) Total Payment	(e) Additional Supplemental Payments (not reflecting "lesser of" language)	(f) = (d) – (e) Supplemental payment incorporating "lesser of" language
a) Initial Supplemental Payments made to qualifying providers	$2.2 million	$91,000[1]	$2.1 million
b) Remaining Supplemental Payments to be made for this time period	$892,000	$21,000	$871,000
c) Total supplemental payments estimated for January 1, 2013 – June 30, 2013 (a+b)	$3.1 million	$ 112,000	$2.97 million

GCHP is seeking approval from the Commission to not recoup the extra supplemental payments for the January 1, 2013 – June 30, 2013 time period for the following reasons:

- Operational challenges – it would be difficult for the Plan to recoup these extra payments from the physicians (estimated to be 100+ hours of staff time, plus vendor fees).
- Financial considerations – the Plan is performing ahead of budget financially and therefore does not have a financial reason to incur the cost of recouping extra payments.
- Physician abrasion – the purpose of ACA 1202 was to build a strong and robust primary care system to achieve better access and quality outcomes. A recoupment effort would likely create physician abrasion and potentially retention issues for network physicians who already struggle with administratively burdensome regulations and low Medi-Cal reimbursement.
- Provider payment flexibility – it is within the Plan's decision to pay physicians more than the required supplemental payment and the new DHCS ACA 1202 payment methodology gives the MCPs more flexibility with the funds (i.e., no reconciliation of

[1] At the July 28, 2014 Commission meeting, additional information was requested regarding the number of physicians to whom overpayment was made and the range of dollars for these physicians. The range of overpayment to a total of 30 physicians is from $1.65 to $48,356. Majority of this overpayment was paid to four providers, two were paid a total of $76,915 and the other two were paid $8,210. The remaining 26 physicians were paid a total of approximately $5,400.

over/under-payments[2]). The Plan would also like to treat all qualifying providers the same for this time period.

July 1, 2013 – December 31, 2014 Supplemental Payments

GCHP proposes that from dates of service July 1, 2013 through the end of the funding (December 31, 2014), the "lesser of language" be incorporated into the calculation of the ACA 1202 supplemental payments.

Please note that the MCPs raised concerns that the "lesser of" language would reduce funds intended to be made to qualifying physicians for selected services because the "billed charge" field is sometimes populated with the Medi-Cal fee schedule amount. In these instances, the qualifying provider would not receive supplemental funds.

DHCS has requested exemption from this requirement for Child Health and Disability Prevention (CHDP) claims when providers submit a one-time attestation. This attestation will allow MCPs to pay those providers the supplemental payment rather than denying payment due to the "lesser of" requirements in federal law. DHCS believes this to be a far better approach than requiring resubmission of CHDP claims for 2013 and 2014. This exemption does not apply to non-CHDP claims.

DHCS has not yet released the final All Plan Letter (APL) with specific instructions on the calculation for CDHP services. Therefore, in the meantime, GCHP will make all supplemental payments incorporating the "lesser of" calculation for all payments. When final guidance is issued, if it is determined that additional funds can be paid (e.g., for CHDP claims), GCHP will make these payments. These payments will be made to qualifying providers as State funding is received. To date, in addition to the first six months described above, funding has been received for payments with dates of service for the August 1, 2013 – December 31, 2013 time period.

Additional Important Information

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

[2] Per June 20, 2014 letter sent to the Center for Medicare and Medicaid Services (CMS) from the DHCS, the State will switch to CMS "Model 1" where MCPs' capitation payments will include estimated additional payments under ACA 1202 and there will be no reconciliation. The suggestion to switch from "Model 2" came from MCPs after reviewing the detailed reconciliation process that would have been followed under "Model 2" and understanding that MCPs would possibly not be made whole through that process.

FISCAL IMPACT:

GCHP has estimated the impact of the ACA 1202 as shown in the following table. Note this will be adjusted as membership is finalized, data is collected, and providers attest.

Table 3: Estimated Impact of ACA 1202 Supplemental Payments			
	1/1/13-6/30/13	1/1/13-6/30/13	1/1/14-6/30/14
a) Revenue	$5.3 million	$5.0 million	$6.3 million
b) Estimated Payment Expense	$4.4 million	$4.1 million	$6.6 million
c) Net Impact (a – b)	$0.9 million	$0.9 million	($0.3 million)

RECOMMENDATIONS:

GCHP is requesting the Commission's approval to not recoup approximately $112,000 of additional supplemental payments for the January 1, 2013 – June 30, 2013 time period.

CONCURRENCE:

None

Attachments:

None

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Quality Improvement Committee Report 3rd Quarter 2014

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

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Quality Improvement Department

- Internal Quality Improvement Project (QIP) – Retinal Eye Exam – see attached report to DHCS
- Readmission Quality Improvement Project - attached report to DHCS
- HEDIS Status – Improvement Plan submitted to DHCS – attached report to DHCS
- Facility Site Reviews – All reviews for Facility Site Review (FSR) and Initial Health Assessment (IHA) have been done for 2014

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GCHP HEDIS 2012 CDC_Eye Exam Rates

Product	2012 Admin Numerator	2012 Hybrid Numerator	2012 Denominator	2012 Rate	2012 MPL	2012 MPL Difference
Medicaid	81	94	411	42.58	45.03	-2.45
SPD	105	78	411	44.53	45.03	-0.50
Non-SPD	78	103	411	44.04	45.03	-0.99

GCHP HEDIS 2013 CDC_Eye Exam Rates

2013 Admin Numerator	2013 Hybrid Numerator	2013 Denominator	2013 Rate	2013 MPL	2013 MPL Difference	2012 - 2013 Rate Change
101	87	411	45.74	44.37	+1.37	+3.16
126	55	411	44.04	44.37	-0.33	-0.49
84	90	411	42.34	44.37	-2.03	-1.70

SPD – Seniors and Persons with Disabilities
MPL – Minimum Performance Level

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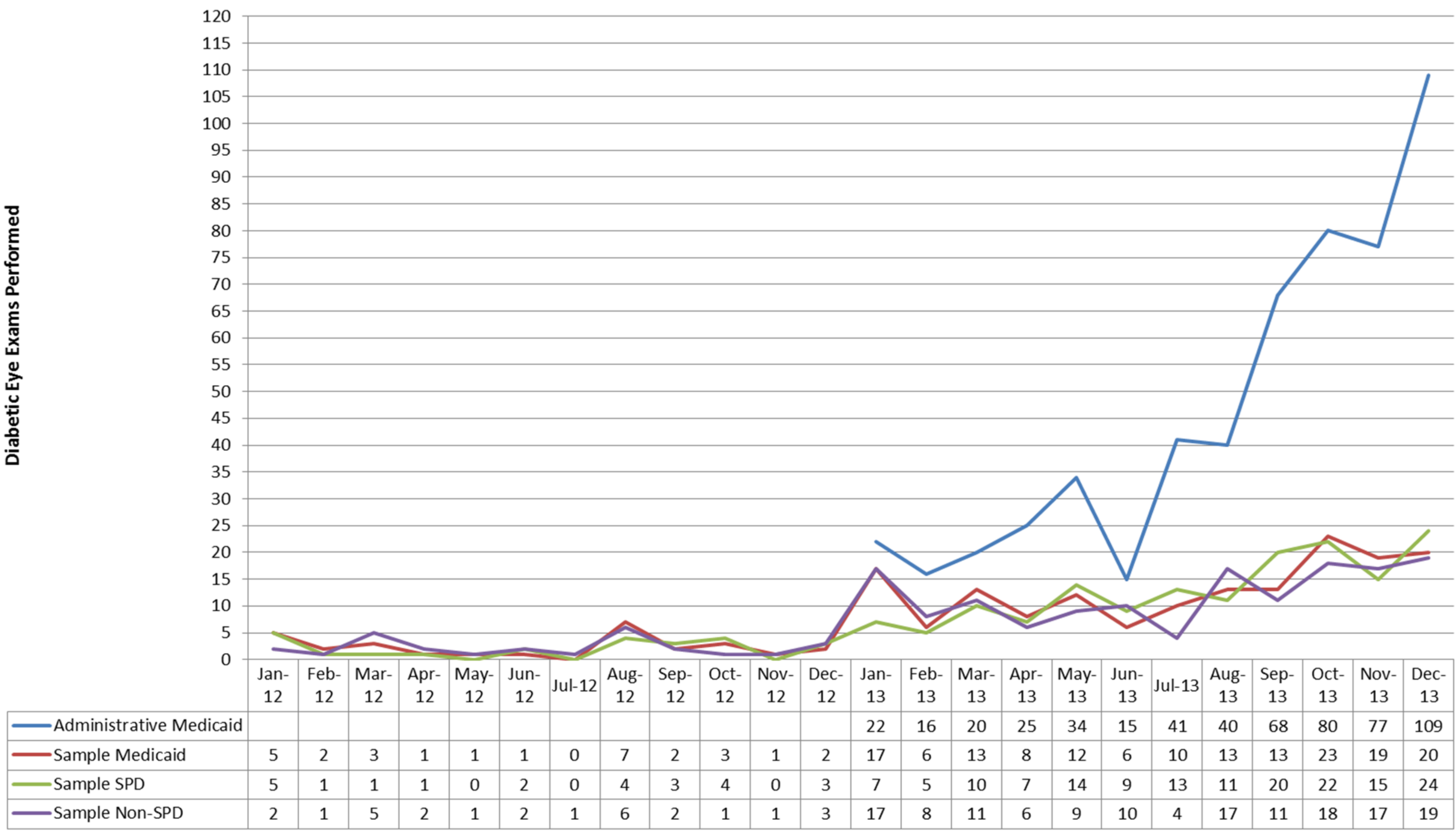
SPD – Seniors and Persons with Disabilities



	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Administrative Medicaid													22	16	20	25	34	15	41	40	68	80	77	109
Sample Medicaid	5	2	3	1	1	1	0	7	2	3	1	2	17	6	13	8	12	6	10	13	13	23	19	20
Sample SPD	5	1	1	1	0	2	0	4	3	4	0	3	7	5	10	7	14	9	13	11	20	22	15	24
Sample Non-SPD	2	1	5	2	1	2	1	6	2	1	1	3	17	8	11	6	9	10	4	17	11	18	17	19

All-Cause Readmissions (Non-HEDIS measure) HEDIS Reporting Year 2013

Population	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval
SPD	1045	242	23.16%	20.55%	25.76%
Non-SPD	530	60	11.32%	8.53%	14.11%
Total (SPD and Non SPD)	1575	302	19.17%	17.20%	21.15%

All-Cause Readmissions (Non-HEDIS measure) HEDIS Reporting Year 2014

Population	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval
SPD	883	133	15.06%	12.65%	17.48%
Non-SPD	493	47	9.53%	6.84%	12.23%
Total (SPD and Non SPD)	1376	180	13.08%	11.26%	14.90%

SPD – Seniors and Persons with Disabilities

Pharmacy and Therapeutics

- All new drugs approved by the FDA in the last quarter have been reviewed for addition to the formulary – 6 were added for significant clinical advantages
- A new formulary for Members with Medicare – Medi-Cal was approved
- Tobacco Cessation Requirements – added medications for smoking cessation and increased the quantity limits of medications for smoking cessation

Pharmacy and Therapeutics

PBM Oversight –

- Reviewed over 500 authorization requests
  - 98.5% decision appropriate
  - 100% timely
  - 85.3% denial language
- Pharmacy Inter-Rater Reliability (IRR) – 100%
- Pharmacy Use Data - Reviewed

Credentials / Peer Review Committee

- Report on actions by the Medical Board of California
  - 2 providers with recommendations to suspend their license – waiting for the required hearing to occur – their license is still valid until that time
  - 1 provider requiring training to be completed in November 2014

Credentials / Peer Review Committee

- Approved a new policy on credentialing organizational providers – compliant with National Committee for Quality Assurance Standards (NCQA)
- Credentials:
    - Re-credentialed – 19 providers
    - Newly Credentialed – 22
    - Organizational Providers - 20

Medical Advisory Committee

- Reviewed and commented on the new Potential Quality Issue (PQI) Policy, the results of the 2014 HEDIS Report, and the Provider Satisfaction Survey
- Approved a new revised Utilization Management Guideline to be used for treatment authorization – the policy now includes the use of UpToDate in addition to Milliman Care Guidelines (MCG)
- Also reviewed and approved 5 current policies

Health Education and Outreach

- 2014 – 8 Staying Healthy Assessment (SHA) trainings, 102 providers
- Screening Brief Intervention, Referral to Treatment Training (SBIRT) – Trainings will be provided by UCLA in Santa Barbara and Los Angeles – Health Education (HE) has informed & encouraged our providers to attend. GCHP is attempting to schedule a local training.
- The member incentive program for the recommended retinal screening for diabetics is going to Members soon – Members will receive 2 free movie tickets if they have the exam.

Health Education and Outreach

- In the last year the Health Navigator Program has contacted 149 high utilizers (4 or more visits per month) of the Emergency Room (ER). Many have been referred to Case Management. Those contacted have had a significant decrease in ER usage.

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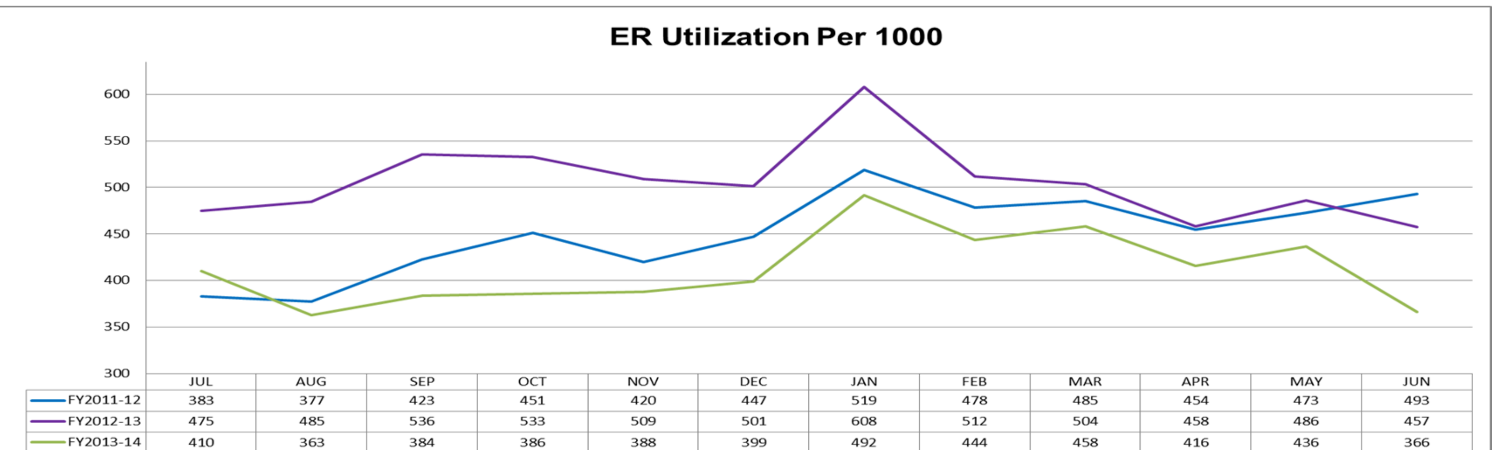
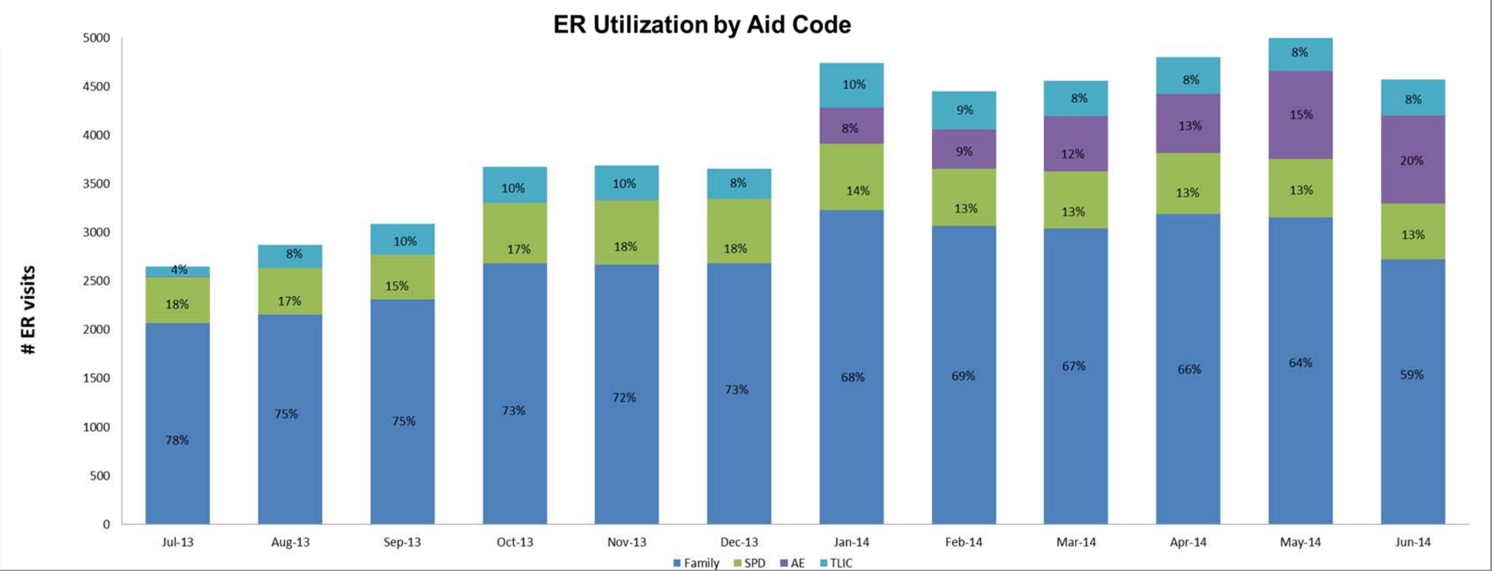
ER Utilization Graph



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY2011-12	383	377	423	451	420	447	519	478	485	454	473	493
FY2012-13	475	485	536	533	509	501	608	512	504	458	486	457
FY2013-14	410	363	384	386	388	399	492	444	458	416	436	366



Cultural and Linguistics Committee

- New policy approved regarding assessment of new hires for bilingual fluency - hires of GCHP who are considered as bilingual are assessed for their competency – 2 evaluated in 2nd Quarter 2014

- Pacific Interpreters Call Volume 2nd Quarter:
  - GCHP staff – 130
  - Providers – 66
  - Languages – 11 languages
    - Most common – Spanish
    - Others - Russian, Punjabi, Hindu, Tongan-Pacific, Japanese
  - Sign Language – 38 requests

Grievance and Appeals

- Grievance and Appeals (G & A) Improvement Project:
  - Outcome – a new Grievance and Appeals Department
  - Manager selected – Stacy Luney

- 2nd Quarter G & A Statistics: Rate .08/1000

  39 grievances, 4 appeals, 8 State Fair Hearings – all met the requirements of acknowledgement letters in 5 days and closed in 30 days

Grievance and Appeals

Grievance Categories:

- 15 administrative
- 24 clinical – primary were transportation, rude Primary Care Physician (PCP), and access issues

State Fair Hearings Outcomes:

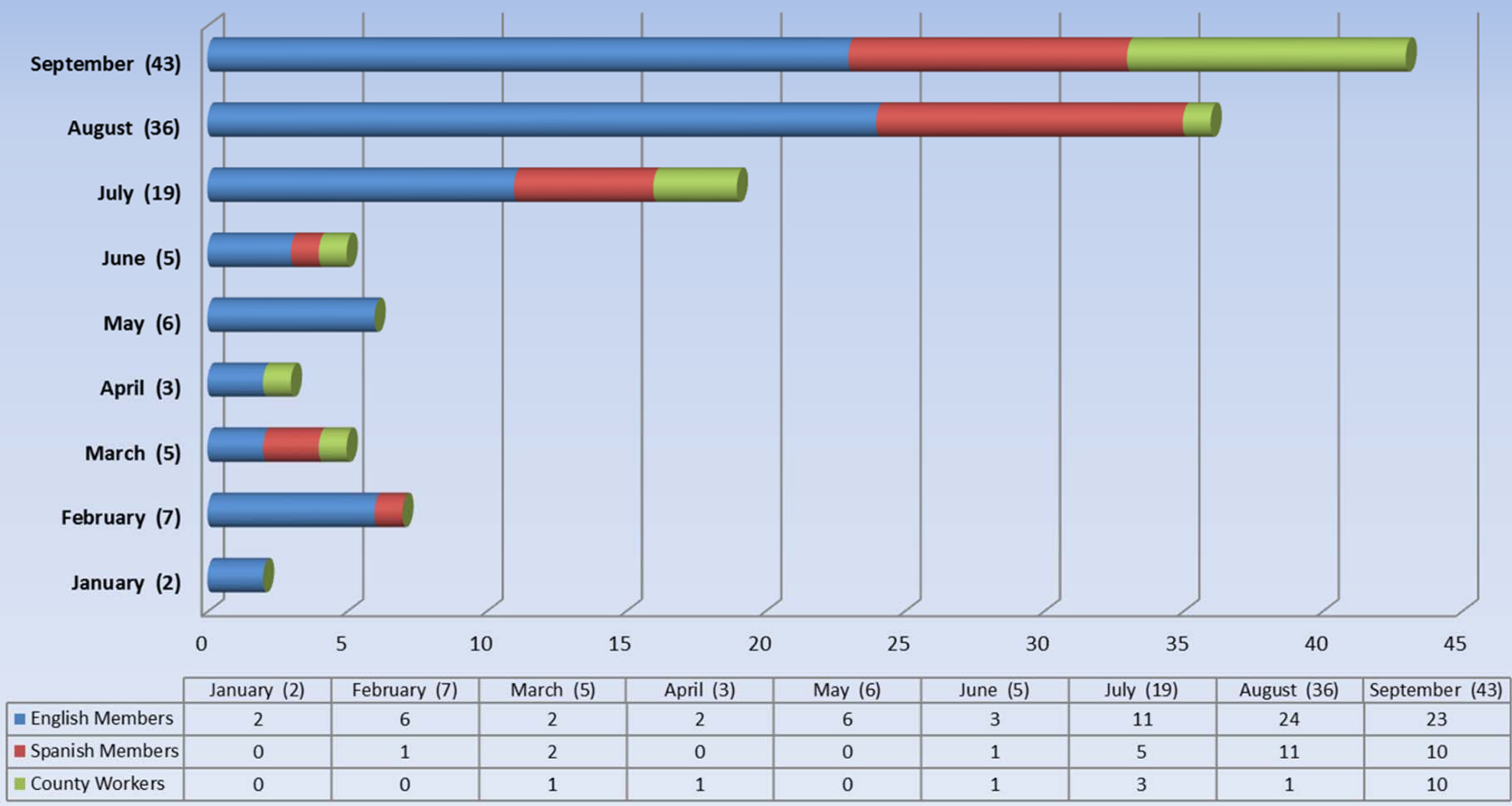
- 1 upheld the Plan
- 4 withdrawn
- 3 pended

Member Services

- Member Services Improvement Project to increase new Member participation in the New Member Orientation Meetings:
  - Expanded locations – throughout the County
  - Expanded hours – evenings and weekends
  - Included information in the new member packets

Gold Coast Health Plan[SM]
A Public Entity

Member Services



	January (2)	February (7)	March (5)	April (3)	May (6)	June (5)	July (19)	August (36)	September (43)
English Members	2	6	2	2	6	3	11	24	23
Spanish Members	0	1	2	0	0	1	5	11	10
County Workers	0	0	1	1	0	1	3	1	10

Member Services

- Call metrics:
  - 2nd Quarter Average Monthly Calls – 9718
  - Average Speed to Answer (goal less than 30 sec) - compliant
  - Abandonment Rate (goal less than 5%) - compliant

Utilization Management Committee

- Delegation Oversight – Approved the Utilization Management Program and Work Plan for both Kaiser and Clinicas del Camino Real
- UM Statistics:

  1st Quarter 2011-2012, 2012-2013, 2013-2014
  - Bed days / 1000 – 353, 264, 267
  - Length of Stay – 5.37, 4.37, 3.03
  - Readmission Rate – 14%, 11.1%, 10.5%
  - ER visits / 1000 – 494, 541, 442

Utilization Management Committee

2nd Quarter 2014

- Denial Rate (Medical Necessity): 3.08%
- Appeals: 3

  2 upheld the original decision

  1 overturned the original decision

Delegation Oversight

- Delegation oversight was reported to the Quality Improvement (QI) Committee – it is reported separately to the GCHP Commission.

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Section I –Submission Information: Complete an improvement plan (IP) form for each measure/indicator with a rate below the Minimum Performance Level (MPL) or reported as a "Not Report" (NR). Managed Care Plans (MCPs) may submit one improvement plan (IP) for all counties and all indicators in a measure group (such as Comprehensive Diabetes Control, CDC), as long as differences across counties and indicators are addressed.

Health Plan Name: **Gold Coast Health Plan**

Measure/indicator: **Weight Assessment & Counseling for Nutrition & Physical Activity for Children and Adolescents**

Submission date/type

Date:

☒ **Initial Submission**
☐ **Resubmission**
☐ **Other (please specify)**

Person Responsible for Implementing IP

Name: Helen Chtourou, RHIT *Title:* Senior Quality Improvement Project Analyst

Phone: 805-437-5592 *Email:* hchtourou@goldchp.org

Medical Director Responsible for Approving IP

Name: Al Reeves, MD *Title:* Chief Medical Officer

Phone: 805-434-5611 *Email:* areeves@goldchp.org

Section II – Measure(s) with rates below the MPL(s): Please enter below the name of each county, the measure or indicator, the Plan 2013 measurement year (MY) Rate, DHCS MPL, and the Plan MY 2014 Target Rate for improvement. Check the appropriate boxes to indicate if the measure's rate was below the MPL for the previous three MYs.

County	Measure/ Indicator	Plan 2013 MY Rate	DHCS MPL for MY 2013	Plan 2014 Target Goal Rate	Below MPL for MY 2012?		Below MPL for MY 2011?		Below MPL for MY 2010?	
					Yes	No	Yes	No	Yes	No
Ventura	WCC_Nutrition	43.31	47.45	48.00	☒	☐	☐	☐	☐	☐
Ventura	WCC_Physical Activity	28.71	34.55	35.00	☒	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
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					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Section III – Barriers and Challenges: List up to three highest priority barriers that your IP will address. Please describe the following applicable elements: 1) The factors that prevented improvement from being made or sustained, 2) Identification of new barriers since the previous year, 3)The factors leading to interventions being ineffective, 4) Whether interventions are still applicable given this most recent barrier analysis, 5) Lessons learned and how they will be applied to the current improvement plan, 6) Applicability of the barrier analysis to multiple counties with rates below the MPLs, and 7) Relevant data to quantify the magnitude of the barriers.

Description of the 1-3 highest priority barriers:

1) Three highest priority barriers:

Barrier 1: The Child Health and Disability Prevention (CHDP) well-child and well-adolescent examination periodicity schedule is not aligned with Medi-Cal and HEDIS recommendations. CHDP is a preventive program that delivers periodic health assessments and services to low income children and adolescents in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts.[1] Per CHDP's Periodicity Schedule for Health Assessment, the interval for well-child visits varies by age group: 2-3 years = 1 year interval; 4-5 years = 2 year interval; 6-8 years = 3 year interval; 9-12 years = 4 year interval; 13-16 years = 4 year intervals; 17-20 years = no interval. (Please see attached *CHDP Periodicity Schedule for Health Assessment Requirements by Age Group*). In addition, effective July 2003 the CHDP program became a "Gateway" to maximize the enrollment of uninsured children and youth in Medi-Cal[2] which has increased the population of CHDP members enrolled in Gold Coast Health Plan.

Barrier 2: Parents will not schedule well-child and adolescent visits if no vaccinations are required.

Barrier 3: Physician well-care documentation is incomplete or absent, especially for documentation pertaining to counseling for nutrition and physical activity.

2) Gold Coast Health Plan did not submit an Improvement Plan (IP) for the WCC measure in 2013 because the HEDIS 2012 measurement year results were the Health Plan's first and baseline HEDIS rate since the Health Plan initiated in July 2011. GCHP did not meet the MPL for WCC during the HEDIS Reporting Years 2013 and 2014 and no new barriers have been identified since last year.

3) A leading factor leading to ineffective intervention is the provider office's reliance and preference in complying with the CHDP's periodicity schedule, instead of the Medi-Cal guidelines and HEDIS specifications, due to mistaken presumption that reimbursement will not be provided if CHDP members receive annual well-care visits.

4) See attached Barrier Analysis

5) The primary lessons learned are:
   a. CHDP's Periodicity Schedule for Health Assessment and Wellness Visits conflicts with the HEDIS specifications, Gold Coast Health Plans coverage guidelines, and the American Academy of Pediatric recommended well-child visit guidelines.
   b. Providers and office staff need additional training on HEDIS measure specifications, documentation, and coding.

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

c. Providers are very interested and engaged with improving their HEDIS rates; the health plan will send providers a 2014 mid-year Performance Feedback Report which will inform them which of the assigned members have not received well-child visits in 2014.

d. Parents schedule fewer well-child visits for children > 2 years of age. Per provider feedback, most parents will schedule well-child visits only when immunizations are needed.

6) All California Medi-Cal Managed Care Plans cover CHDP members; consequently the barrier resulting from the conflicting CHDP guidelines are applicable to all Medi-Cal plans.

7) Gold Coast Health Plan's HEDIS 2014 rate for the Children & Adolescent Access to Primary Care Practitioners (CAP) measure reveals that children and adolescents within the WCC age group (3-17 years of age) are in the 10th NCQA national percentile for accessing a PCP. This data demonstrates that children are not accessing their PCPs as needed and the likely barriers are parental non-compliance and conflicting CHDP well-child visit guidelines.

CAP Age Group	GCHP Rate	MPL	Percentile
12-24 Months	97.37	95.51	25th
25 Months – 6 Years	**86.29**	**86.37**	**10th**
7 -11 Years	**82.26**	**87.77**	**10th**
12-19 Years	**79.18**	**86.09**	**10th**

footnotes:

[1] "CHDP Periodicity Schedule for Health Assessment Requirements by Age Groups". (January 2012). California Department of Health Care Services, System of Care Division, Children Medical Services

[2] MCP: County Organized Health System (COHS). CHDP Provider Manual. California Department of Health Care Services, System of Care Division, Children Medical Services.

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Section IV – Improvement Plan:
A. Briefly describe the following applicable elements: 1) Interventions to address the 1 to 3 highest priority barriers, 2) Timelines, 3) Anticipated effectiveness of new interventions planned, 4) Effectiveness of existing interventions, 5) Modifications to existing interventions, 6) Methods for evaluating the interventions, 7) Allocation of resources, and 8) Commitment and accountability to improving the rate to a level above the MPL. **B.** Identify at least one interim outcome for an intervention listed in IV.A above. Specify a SMART objective for the interim outcome you will use to assess progress during July 1–September 30, 2014. This will be used to evaluate your first Plan-Do-Study-Act (PDSA) cycle, as required by DHCS (APL-14-003). See instructions and examples of SMART objectives in the PDSA Cycle Worksheet.

A. Description of improvement plan:

Intervention#1: Education on GCHP Coverage Guidelines v. CHDP Guidelines

1) **Barriers:** Providers will not schedule CHDP members for annual child & adolescent well-care visits due to CHDP guidelines.
2) **Timelines:** 2013 - 2014
3) **Anticipated Effectiveness of New Intervention:** Increased provider education and awareness of GCHP coverage guidelines should engage providers to begin schedule annual well-child visits for CHDP members.
4) **Effectiveness of Existing Intervention:** N/A – This is a new intervention.
5) **Modifications to Existing Intervention:** After speaking with pediatric clinic groups and listening to the barriers they encounter, GCHP added education on CHDP v. GCHP guidelines to inform pediatric providers and their staff that GCHP reimburses for annual wellness exams, even though the CHDP periodicity schedule does not recommend or cover wellness exams annually.
6) **Methods for Evaluating Interventions:** Comparison of annual HEDIS rate measurement outcomes.
7) **Allocation of Resources:** QI Staff will develop and provide education to providers and their office staff through health plan newsletters, office visits, and trainings.
8) **Commitment & Accountability:** Comprehensive HEDIS training on children and adolescent wellness measures was provided to CHDP staff in April 2014, and the GCHP guidelines have been presented to the health plan's major clinic groups and independent providers by the QI Director and CMO during site visits in June and July 2014. The QI Department will continue to provide HEDIS education to providers. Trainings will be given by QI Staff through on-site visits and webinar trainings.

Intervention #2: Mid-Year 2014 Proactive Performance Feedback Report to Providers

1) **Barriers:** Parents schedule child and adolescent wellness visits only when immunizations are needed.
2) **Timelines:** June – August 2014
3) **Anticipated Effectiveness of New Intervention:** The Mid-Year 2014 Performance Feedback Reports will be sent to each clinic and will list all GCHP members assigned to that clinic who have and have not had a child or adolescent wellness visit in 2014. We anticipate the report will facilitate providers to contact those members who have not had a wellness visit and schedule the annual examinations instead of relying on the members' parents to schedule wellness visits. The benefit and intent of this report is to engage providers to proactively schedule preventative care visits with their members.
4) **Effectiveness of Existing Intervention:** N/A - This is a new intervention.
5) **Modifications to Existing Intervention:** N/A - This is a new intervention.
6) **Methods for Evaluating Intervention:** Look for any increases in well-child visits after reports are distributed to providers.
7) **Allocation of Resources:** QI Analysts and IT Analyst will work with HEDIS software vendor to complete a summer run of January through May 2014 claims/encounter data. QI staff will generate and distribute to providers the Mid-Year 2014 Performance Feedback Report.
8) **Commitment & Accountability:** QI Staff have committed to a 3-month timeline, from June to August 2014, to complete the integration of January –May 2014 claims/encounter data in the HEDIS software, complete a summer run, and distribute the letters to the clinics.

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Intervention #3 HEDIS Measure Training

1) **Barriers:** HEDIS measure specifications and documentation/coding guideline trainings had never been provided to GCHP's providers, which was previously a fee-for-service community of physicians. The QI Department is addressing provider education needs by continuing and improving the accessibility of HEDIS education. New education interventions will include HEDIS webinar training hosted by GCHP QI staff.
2) **Timelines:** 2013 and Ongoing
3) **Anticipated Effectiveness of New Intervention:** HEDIS training webinars will allow GCHP to more effectively and efficiently provide training to a larger provider audience.
4) **Effectiveness of Existing Intervention:** Existing interventions include provider education through: (1) GCHP Provider Report Cards for HEDIS 2012 and 2013 that were presented the health plan's major clinic groups by the CMO and QI Director; (2) Provider Operation Bulletins; and (3) onsite trainings. Effectiveness of these existing interventions is demonstrated in the increase of the BMI Percentile and Counseling for Nutrition measures rate and an overall increase in the number of measures where GCHP met or exceeded the MPL.

HEDIS Reporting Year	WCC_BMI	WCC_Counseling for Nutrition	WCC_Counseling for Physical Activity	% of Measures that Met or Exceeded the MPL
2013	43.80	43.31	28.71	60%
2014	42.09	42.09	30.41	79%

5) **Modifications to Existing Intervention:** Modifications include establishing trainings using a new forum through online webinars, to capture a larger audience, and to provide access to recorded webinars through GCHPs provider webpage.
6) **Methods for Evaluating Intervention:** Attendance of live webinars and recordings will be tracked quarterly.
7) **Allocation of Resources:** QI staff will work with the health plan's Communication Department to implement GoToMeeting web-based live interactive and recorded webinars trainings.
8) **Commitment & Accountability:** Education is an effective intervention for improving HEDIS rates because providers and their staff will increase their awareness of the HEDIS metric specifications and the quality of care documentation and coding guidelines that are measured. GCHP is committed to providing continued education to providers through provider education articles published in the Provider Operations Bulletin, coordinating with Health Education to provider education to members through Member Newsletters and Health Fairs, site visits, and creating new enhanced and more accessible education through live and recorded webinars.

Intervention #4: GCHP Provider Report Cards

1) **Barriers:** Providers cannot develop strategies for improving their HEDIS rates if they do know their HEDIS scores.
2) **Timelines:** Summer 2013; Summer 2014
3) **Anticipated Effectiveness of New Intervention:** Providers will become more engaged in scheduling preventative wellness exams if their HEDIS rates for the WCC measure is low.
4) **Effectiveness of Existing Intervention:** The Annual GCHP Provider Report Cards were initiated in the summer of 2013 to reports each clinic's HEDIS rates. Due to the providers ' increased provider awareness of the W34 measurement specification guidelines and the measurement outcomes, there was a slight increase in the reported rates for two of the three elements of the WCC measure.

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

HEDIS Reporting Year	WCC_BMI	WCC_Counseling for Nutrition	WCC_Counseling for Physical Activity
2013	43.80	43.31	28.71
2014	42.09	42.09	30.41

5) **Modifications to Existing Intervention:** No modification.
6) **Methods for Evaluating Interventions:** Comparison of annual HEDIS rate measurement outcomes.
7) **Allocation of Resources:** Using the HEDIS software**,** QI Staff generated the Provider Report Cards and the CMO and QI Director met with each clinic's administrator to present and discuss the outcomes presented in the HEDIS Provider Report Cards.
8) **Commitment & Accountability:** The QI staff created the Provider Report Cards in June 2014 and the Chief Medical Officer and QI Director meet with the clinic physicians and administrators to present the HEDIS result in July 2014.

B. SMART objective (See PDSA Cycle worksheet):

SMART Objective: By September 30, 2014, increase the percent of child and adolescent wellness visits by creating the HEDIS 2014 Provider Report Cards to report to providers how their clinics performed in 2013. Reporting these scores will motivate providers who performed poorly on the WCC measure to develop strategies to increase their rates.

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Section V – Improvement Plan Grid: Enter interventions to address each of the 1 to 3 high-priority barriers. Interventions should be measurable and include the following description: what, where, when, how, and to whom. If multiple interventions are planned, list interventions in order of effectiveness and/or highest priority (e.g., directly addresses the barrier, best practice, etc.) and include the county/counties where the intervention will be conducted. *Do not include planning activities.* Enter the targeted barrier for each intervention. If it is an existing intervention, check "yes," and indicate the duration of existing intervention prior to the implementation of the new timeline, i.e., number of weeks, months. Enter the implementation timeline for new and existing interventions, i.e., start and end date. Enter the name of the person(s) and department responsible for the implementation and evaluation of each intervention.

Intervention	Targeted (High-Priority)	Targeted	Existing Intervention	Duration of Existing	Timeline for Implementation	Responsible Person and

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

	Barrier	County/Counties	Yes	No	Intervention		Department
Education on GCHP coverage guidelines v. CHDP guidelines	Providers	Ventura	☐	☒	Ongoing	Complete	Quality Improvement
Mid-Year 2014 Performance Feedback Report	Providers	Ventura	☐	☒	3 months	3 months	Quality Improvement
HEDIS Measure Training	Providers	Ventura	☒	☐	Ongoing	3 months	Quality Improvement
GCHP Provider Report Cards	Providers	Ventura	☒	☐	2 months	2 months	Quality Imprvement
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Section I –Submission Information: Complete an improvement plan (IP) form for each measure/indicator with a rate below the Minimum Performance Level (MPL) or reported as a "Not Report" (NR). Managed Care Plans (MCPs) may submit one improvement plan (IP) for all counties and all indicators in a measure group (such as Comprehensive Diabetes Control, CDC), as long as differences across counties and indicators are addressed.

Health Plan Name: **Gold Coast Health Plan**

Measure/indicator: **Well-Child Visit in the 3rd, 4th, 5th, and 6th Years of Life**

Submission date/type

Date:

☒ **Initial Submission**
☐ **Resubmission**
☐ **Other (please specify)**

Person Responsible for Implementing IP

Name: Helen Chtourou, RHIT
Title: Senior Quality Improvement Project Analyst
Phone: 805-437-5592
Email: hchtourou@goldchp.org

Medical Director Responsible for Approving IP

Name: Al Reeves, MD
Title: Chief Medical Officer
Phone: 805-437-5611
Email: areeves@goldchp.org

Section II – Measure(s) with rates below the MPL(s): Please enter below the name of each county, the measure or indicator, the Plan 2013 measurement year (MY) Rate, DHCS MPL, and the Plan MY 2014 Target Rate for improvement. Check the appropriate boxes to indicate if the measure's rate was below the MPL for the previous three MYs.

County	Measure/ Indicator	Plan 2013 MY Rate	DHCS MPL for MY 2013	Plan 2014 Target Goal Rate	Below MPL for MY 2012?		Below MPL for MY 2011?		Below MPL for MY 2010?	
					Yes	No	Yes	No	Yes	No
Ventura	W34	64.23	67.40	MPL	☒	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
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					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Section III – Barriers and Challenges: List up to three highest priority barriers that your IP will address. Please describe the following applicable elements: 1) The factors that prevented improvement from being made or sustained, 2) Identification of new barriers since the previous year, 3)The factors leading to interventions being ineffective, 4) Whether interventions are still applicable given this most recent barrier analysis, 5) Lessons learned and how they will be applied to the current improvement plan, 6) Applicability of the barrier analysis to multiple counties with rates below the MPLs, and 7) Relevant data to quantify the magnitude of the barriers.

Description of the 1-3 highest priority barriers:

1) Three highest priority barriers:

Barrier 1**:** The Child Health and Disability Prevention (CHDP) well-child examination periodicity is not aligned with Medi-Cal and HEDIS recommendations. CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts.[1] Per CHDP's Periodicity Schedule for Health Assessment, the interval for well-child visits varies by age group: 2-3 years = 1 year interval; 4-5 years = 2 year interval; 6-8 years = 3 year interval. (Please see attached *CHDP Periodicity Schedule for Health Assessment Requirements by Age Group*). In addition, effective July 2003 the CHDP program became a "Gateway" to maximize the enrollment of uninsured children and youth in Medi-Cal[2] which has increased the population of CHDP members enrolled in Gold Coast Health Plan.

Barrier 2: Parents will not schedule well-child visits if no vaccination is required.

Barrier 3: Physician well-child visit documentation is incomplete or absent, especially for documentation pertaining to developmental history, health education and anticipatory guidance.

1) Gold Coast Health Plan did not submit an Improvement Plan (IP) for the W34 measure in 2013 because the HEDIS 2012 measurement year results were the Health Plan's first and baseline HEDIS rate since the Health Plan initiated in July 2011. GCHP did not meet the MPL for W34 during the HEDIS Reporting Years 2013 and 2014, and no new barriers have been identified since last year.
2) A leading factor leading to ineffective intervention is the provider office's reliance and preference in complying with the CHDP's periodicity schedule, instead of the Medi-Cal guidelines and HEDIS specifications, due to mistaken presumption that reimbursement will not be provided if CHDP members receive annual well-care visits.
3) See attached Barrier Analysis
4) The primary lessons learned are:
    a. CHDP's Periodicity Schedule for Health Assessment and Wellness Visits conflicts with the HEDIS specifications, Gold Coast Health Plans coverage guidelines, and the American Academy of Pediatric recommended well-child visit guidelines.

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

b. Providers and office staff need additional training on HEDIS measure specifications, documentation, and coding.
c. Providers are very interested and engaged with improving their HEDIS rates; the health plan will send providers a 2014 mid-year Performance Feedback Report which will inform them which of the assigned members have not received well-child visits in 2014.
d. Parents schedule fewer well-child visits for children > 2 years of age. Per provider feedback, most parents will schedule well-child visits only when immunizations are needed.

6) All California Medi-Cal Managed Care Plans cover CHDP members; consequently the barrier resulting from the conflicting CHDP guidelines are applicable to all Medi-Cal plans.

7) Gold Coast Health Plan's HEDIS 2014 rate for the Children & Adolescent Access to Primary Care Practitioners (CAP) measure reveals that children within the W34 age group (3-6 years of age) are in the 10th NCQA national percentile for accessing a PCP. GCHPs scored 86.29 which is below the DHCS MPL rate 86.37. This data demonstrates that children are not accessing their PCPs as needed and the likely barriers are parental non-compliance and conflicting CHDP well-child visit guidelines.

CAP Age Group	GCHP Rate	MPL	Percentile
12-24 Months	97.37	95.51	25th
25 Months – 6 Years	**86.29**	**86.37**	**10th**
7 -11 Years	82.26	87.77	10th
12-19 Years	79.18	86.09	10th

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Foot Notes

[1] "CHDP Periodicity Schedule for Health Assessment Requirements by Age Groups". (January 2012). California Department of Health Care Services, System of Care Division, Children Medical Services.

[2] MCP: County Organized Health System (COHS). CHDP Provider Manual. California Department of Health Care Services, System of Care Division, Children Medical Services.

Reporting Year	W34 Measure	% of Measures that Met or Exceeded the MPL
2013	61.80	60%
2014	64.23	79%

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Section IV – Improvement Plan:

A. Briefly describe the following applicable elements: 1) Interventions to address the 1 to 3 highest priority barriers, 2) Timelines, 3) Anticipated effectiveness of new interventions planned, 4) Effectiveness of existing interventions, 5) Modifications to existing interventions, 6) Methods for evaluating the interventions, 7) Allocation of resources, and 8) Commitment and accountability to improving the rate to a level above the MPL.

B. Identify at least one interim outcome for an intervention listed in IV.A above. Specify a SMART objective for the interim outcome you will use to assess progress during July 1–September 30, 2014. This will be used to evaluate your first Plan-Do-Study-Act (PDSA) cycle, as required by DHCS (APL-14-003). See instructions and examples of SMART objectives in the PDSA Cycle Worksheet.

A. Description of improvement plan:

Intervention #1: Education on GCHP Coverage Guidelines v. CHDP Guidelines

1) **Barriers:** Providers will not schedule CHDP members for annual well-child visits due to CHDP guidelines.
2) **Timelines:** 2013 - 2014
3) **Anticipated Effectiveness of New Intervention:** Increased provider education and awareness of GCHP coverage guidelines should engage providers to begin schedule annual well-child visits for CHDP members.
4) **Effectiveness of Existing Intervention:** N/A – This is a new intervention.
5) **Modifications to Existing Intervention:** After speaking with pediatric clinic groups and listening to the barriers they encounter, GCHP added education on CHDP v. GCHP guidelines to inform pediatric providers and their staff that GCHP reimburses for annual well-child exams, even though the CHDP periodicity schedule does not recommend or cover well-child exams annually.
6) **Methods for Evaluating Interventions:** Comparison of annual HEDIS rate measurement outcomes.
7) **Allocation of Resources:** QI Staff will develop and provide education to providers and their office staff through health plan newsletters, office visits, and trainings.
8) **Commitment & Accountability:** Comprehensive HEDIS training on well-child care measures was provided to CHDP staff in April 2014, and the GCHP guidelines have been presented to the health plan's major clinic groups and independent providers by the QI Director and CMO during site visits in June and July 2014. The QI Department will continue to provide HEDIS education to providers. Trainings will be given by QI Staff through on-site visits and webinar trainings.

Intervention #2: Mid-Year 2014 Proactive Performance Feedback Report to Providers

1) **Barriers:** Parents schedule well-child visits only when immunizations are needed.
2) **Timelines:** June – August 2014
3) **Anticipated Effectiveness of New Intervention:** The Mid-Year 2014 Performance Feedback Reports will be sent to each clinic and will list all GCHP members assigned to that clinic who have and have not had a well-child visit in 2014. We anticipate the report will facilitate providers to contact those members who have not had a well-child visit and schedule the annual examinations members instead of relying on the members' parents to schedule wellness visits. The benefit and intent of this report is to engage providers to proactively schedule preventative care visits with their members.
4) **Effectiveness of Existing Intervention:** N/A - This is a new intervention.
5) **Modifications to Existing Intervention:** N/A - This is a new intervention.
6) **Methods for Evaluating Intervention:** Look for any increases in well-child visits after reports are distributed to providers.
7) **Allocation of Resources:** QI Analysts and IT Analyst will work with HEDIS software vendor to complete a summer run of January through May 2014 claims/encounter data. QI staff will generate and distribute to providers the Mid-Year 2014 Performance Feedback Report.
8) **Commitment & Accountability:** QI Staff have committed to a 3-month timeline, from June to August 2014, to complete the integration of January –May 2014 claims/encounter data in the HEDIS software, complete a summer run, and distribute the letters to the clinics.

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Intervention #3 HEDIS Measure Training

1) **Barriers:** HEDIS measure specifications and documentation/coding guideline trainings had never been provided to GCHP's providers, which was previously a fee-for-service community of physicians. The QI Department is addressing provider education needs by continuing and improving the accessibility of HEDIS education. New education interventions will include HEDIS webinar training hosted by GCHP QI staff.
2) **Timelines:** 2013 and Ongoing
3) **Anticipated Effectiveness of New Intervention:** HEDIS training webinars will allow GCHP to more effectively and efficiently provide training to a larger provider audience.
4) **Effectiveness of Existing Intervention:** Existing interventions include provider education through: (1) GCHP Provider Report Cards for HEDIS 2012 and 2013 that were presented the health plan's major clinic groups by the CMO and QI Director; (2) Provider Operation Bulletins; and (3) onsite trainings. Effectiveness of these existing interventions is demonstrated in the increase of the W34 measure rate and an overall increase in the number of measures where GCHP met or exceeded the MPL. **HEDIS**

Reporting Year	W34 Measure	% of Measures that Met or Exceeded the MPL
2013	61.80	60%
2014	64.23	79%

5) **Modifications to Existing Intervention:** Modifications include establishing trainings using a new forum through online webinars, to capture a larger audience, and to provide access to recorded webinars through GCHPs provider webpage.
6) **Methods for Evaluating Intervention:** Attendance of live webinars and recordings will be tracked quarterly.
7) **Allocation of Resources:** QI staff will work with the health plan's Communication Department to implement GoToMeeting web-based live interactive and recorded webinars trainings.
8) **Commitment & Accountability:** Education is an effective intervention for improving HEDIS rates because providers and their staff will increase their awareness of the HEDIS metric specifications and the quality of care documentation and coding guidelines that are measured. GCHP is committed to providing continued education to providers through provider education articles published in the Provider Operations Bulletin, coordinating with Health Education to provider education to members through Member Newsletters and Health Fairs, site visits, and creating new enhanced and more accessible education through live and recorded webinars.

Intervention #4: GCHP Provider Report Cards

1) **Barriers:** Providers cannot develop strategies for improving their HEDIS rates if they do know their HEDIS scores.
2) **Timelines:** Summer 2013; Summer 2014
3) **Anticipated Effectiveness of New Intervention:** Providers will become more engaged in scheduling well-child exam if their HEDIS rates for the W34 measure is low.
4) **Effectiveness of Existing Intervention:** The Annual GCHP Provider Report Cards were initiated in the summer of 2013 to reports each clinic's HEDIS rates. Due to the providers' increased provider awareness of the W34 measurement specification guidelines and the measurement outcomes, there was a slight increase in the reported rates for W34: 61.80% (HEDIS 2013) to 64.23 (HEDIS 2014).
5) **Modifications to Existing Intervention:** No modification.
6) **Methods for Evaluating Interventions:** Comparison of annual HEDIS rate measurement outcomes.
7) **Allocation of Resources:** Using the HEDIS software**,** QI Staff generated the Provider Report Cards and the CMO and QI Director met with each clinic's administrator to

present and discuss the outcomes presented in the HEDIS Provider Report Cards.

8) **Commitment & Accountability:** The QI staff created the Provider Report Cards in June 2014 and the Chief Medical Officer and QI Director meet with the clinic physicians and administrators to present the HEDIS result in July 2014.

B. SMART objective (See PDSA Cycle worksheet):

SMART Objective: By September 30, 2014, increase the percent of children well-child visits by creating the HEDIS 2014 Provider Report Cards to report to providers how their clinics performed in 2013. Reporting these scores will motivate providers who performed poorly on the W34 measure to develop strategies to increase their rates.

Section V – Improvement Plan Grid: Enter interventions to address each of the 1 to 3 high-priority barriers. Interventions should be measurable and include the following description: what, where, when, how, and to whom. If multiple interventions are planned, list interventions in order of effectiveness and/or highest priority (e.g., directly addresses the barrier, best practice, etc.) and include the county/counties where the intervention will be conducted. *Do not include planning activities.* Enter the targeted barrier for each intervention. If it is an existing intervention, check "yes," and indicate the duration of existing intervention prior to the implementation of the new timeline, i.e., number of weeks, months. Enter the implementation timeline for new and existing interventions, i.e., start and end date. Enter the name of the person(s) and department responsible for the implementation and evaluation of each intervention.

Intervention	Targeted (High-Priority)	Targeted	Existing Intervention	Duration of Existing	Timeline for Implementation	Responsible Person and

Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

	Barrier	County/Counties	Yes	No	Intervention		Department
Education on GCHP coverage guidelines v. CHDP guidelines	**Providers**	**Ventura**	☐	☒	**Ongoing**	**Complete**	**Quality Improvement**
Mid-Year 2014 Performance Feedback Reports	**Providers**	**Ventura**	☐	☒	**3 months**	**3 Months**	**Quality Improvement**
HEDIS Measure Trainings	**Providers**	**Ventura**	☒	☐	**Ongoing**	**3 Months**	**Quality Improvement**
GCHP Provider Report Cards	**Providers**	**Ventura**	☒	☐	**2 months**	**2 Months**	**Quality Improvement**
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			

Updated Quality Improvement Work Plan

For Information Only and Not Approval

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2014 Quality Improvement Work Plan

The Quality Improvement Department is responsible for the monitoring and enhancement of quality improvement processes to ensure the delivery of quality customer service and access to high quality medical services for GCHP members.

Objective #1: HEDIS

GCHP must comply with the DHCS requirements for reporting performance measurement results.

Process/ Objectives	Key Tasks	TIMELINE		Lead Staff	Monitoring/Status of Milestones and Evaluation
		Start	End		
1. HEDIS – Healthcare Effectiveness Data and Information Set.	2013 Data for 2014 Measures	02/14	05/14		The HEDIS 2014 Reporting for 2013 data was submitted on 06/13/14 .
	1. Edit and submit HEDIS Roadmap.	11/13	01/14		
	2. Submit test run	11/14	12/14		
External Accountability Set (EAS) is a DHCS requirement. HEDIS complies with the EAS requirement. HEDIS measures which must adhere to the most current HEDIS reporting year specifications and to DHCS specified timelines based on “All Facility Letter”.	3. Submit production run	11/14	01/14		
	4. Record Retrieval	02/14	03/14		
	5. Record Abstraction	03/14	05/14		
	6. Admin Refresh	02/14	04/14		
	7. HEDIS HSAG Audit	03/14	-----		
	8. HEDIS Submission	05/14	06/14		
	9. Summer Run	06/14	07/14		

Objective #2: Satisfaction Surveys

GCHP must comply with the DHCS requirements for reporting Satisfaction Survey Results.

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
1. *Consumer Satisfaction Survey* ***(State Requirement)*** The EQRO – External Quality Review Organization (HSAG) is responsible for administrating the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey biennially in compliance with NCQA and AHRQ requirements. The CAHPS® surveys a sample of Medi-Cal managed care members in English and Spanish and covers services provided to adults and children. GCHP will add CAHPS survey for 2014, and every year thereafter.	First CAHPS Audit will be 2015 for 2014 data. Educate providers	Jan 2014	Dec 2014		
2. Provider Satisfaction Surveys GCHP will assume responsibility to conduct and for the monitoring, oversight and reporting the required mechanisms to assure provider satisfaction.	Must ensure that information and documentation provided by GCHP is reviewed at appropriate levels: must demonstrate this review and discussion of information in committee with any applicable interventions.	Jan 2014			Reported to MAC Committee, and QI Committee, Provider Relations working on an improvement plan.
3. Access to Care Survey	Discuss survey at QIC and document	Jan 2014			Reported to MAC Committee and QI Committee, CAP to providers not meeting standards Reassessment of those providers will be done

Objective #3 – QIP's

Quality Improvement Projects - Plans are required to conduct ongoing quality improvement projects (QIPS).

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
1a Quality and Performance Improvement Program Requirements for 2012 External Statewide QIP	External Statewide QIP – Hospital Readmissions • Participate in ongoing statewide organized meetings. • Document "all" steps in the process • Submitted baseline historical data to HSAG • Submitted barrier analysis and interventions to HSAG 1/31/2012 and 09/30/2013. • Submit analysis of intervention	Jan 2014	Sept 2014 Ongoing		Going forward will be "All Cause" Readmissions.
1b Internal QIP	• Internal QIP – Increase Retinal eye exams for diabetic patients • Submitted internal QIP to DHCS for approval on 7/31/2013 and 09/30/2013.	Jan 2014	Ongoing		HEDIS MPL met for diabetic retinal eye exam 06/13/14. Report submitted 8/29/14.

Objective #4: UM Monitoring

Plans are required to report utilization data for selected HEDIS® Use of Services measures through the contracted EQRO. DHCS medical and nurse consultants facilitate discussions of utilization data monitoring results at the quarterly Medical Directors meetings.

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
UM Monitoring *Over Utilization Under Utilization Appropriate Utilization*	Utilization measures reported quarterly with monthly data points to UM Committee, QIC and Commission report card indicators reported bi-annually to UM Committee, QIC and Clinic Directors	Jan 2014	Dec 2014		

Objective #5: Committees

GCHP shall maintain a system of accountability which includes the participation of the governing body of the health plan's organization, the designation of a quality improvement committee with oversight and performance responsibility.

**Committees to develop Dashboard reporting for 2014.*

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
1. Quality Improvement Committee Develop, implement quality Program Plan outlining structure, scope, criteria, and processes of all QI functions	• QI Plan Assessment • QI Plan Review • QI Work Plan • Annual P&P Review • Revise PQI Policies and Procedures	Jan 2014	Dec 2014		The Quality Improvement Plan and the Quality Improvement Work Plan were approved at the Quality Improvement Committee on 06/24/14. QI workplan to be evaluated regularly and amended appropriately.

2. Member Services Committee	• Committee Meetings • Action Plans • Call Center Measures • Annual Review	Jan 2014	Dec 2014		
3. Network Management Committee	• Committee Meetings • Action Plans • Annual Review	Jan 2014	Dec 2014		
4. Grievances & Appeals Committee	• Committee Meetings • Action Plans • G&A Measures • Annual Review	Jan 2014	Dec 2014		
5. Health Education/Cultural Linguistics Committee	• Committee Meetings • Action Plans • ED Navigator Program Review • Annual Review	Jan 2014	Dec 2014		
6. Medical Advisory Committee (MAC)	• Committee Meetings • Action Plans • Annual Review • Approve & Review Medical P&Ps.	Jan 2014	Dec 2014		
7. Pharmacy & Therapeutic Committee (P&T)	• Review of New Drugs • Annual Formulary Review • PBM Oversight • Review of Policies Affecting Access to Prescription Drugs • Review quantity limits • Review prior auth's. • Develop standardized guidelines.	Jan 2014	Dec 2014		

8. Credentials / Peer Review Committee	• Committee Meetings • Actions Plans • Annual Review • Revise & review multiple provider P&Ps. • Develop organizational application & task list.	Jan 2014	Dec 2014		
9. UM Committee	• Committee Meetings • Actions Plans • Annual Review • Develop utilization metrics reporting and TATs.	Jan 2014	Dec 2014		

Objective #6: Facility Site Reviews

GCHP must conduct site reviews on all primary care provider sites.

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
Facility Site Reviews (FSR) *Site Review Reports* • Plan nurse reviewers conduct the initial and tri-annual full scope reviews. Plan reviewers use the DHCS Full Scope Site Review Survey and Medical Record Review Survey forms to ensure that all contracting plans and subcontracting entities use DHCS survey standards, review criteria and scoring methodology.	• Submit 2014 bi-annual report to DHCS • Submit 2014 bi-annual report to DHCS • Develop procedures for entering data into FSR database and submission of data to DHCS • Certify FSR Nurse as Master Trainer • Complete required FSR, PAR, IHA. • Develop FSR Database • Begin training for QI RN as Master Trainer.	Jan 2014	Dec 2014		Completed for 2014.

PARS – Physical Accessibility Site Reviews	• P&P written for PARS • Specialist Provider Volume Annual Review due 1/31/2014	Jan 2014			Completed- Compiling report for high volume/ancillary.

Objective #7: Quality Measurement and Improvement

GCHP is required to have an ongoing program for quality assessment and performance improvement of the services provided to enrollees. Quality measurement and improvement standards include clinical practice guidelines, quality assessment and performance improvement program and health information systems.

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
Clinical Practice Guidelines	• Approve at MAC. • Disseminate Guidelines to Providers • Diabetes Guidelines to be presented at MAC.	Jan 2014	Dec 2014		Newly adopted Clinical Practice Guidelines are announced in the Provider Newsletter and/or on the Provider Update page of the website.
Disease Management Program Selection of Chronic Disease states pertinent to its membership.	• Identify chronic disease for GCHP population disease management. • Diabetes Guidelines to be presented at MAC.	Jan 2014	Dec 2014		The two major disease categories identified for 2014 and approved at the February QIC meeting are Diabetes and Asthma. Roadmap and framework for diabetes in process.

Member/Provider Communication Plan	• Develop materials and mechanisms to communicate to Providers and Members • Use Website • Create email address & link on website for HEDIS questions. • HEDIS report card	Jan 2014	Dec 2014		Members and providers receive a newsletter 3 times per year. The newsletters are posted on the website.

Gold Coast Health Plan[SM]
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AGENDA ITEM 2c

To: Gold Coast Health Plan Commissioners

From: Brandy Armenta, Compliance Officer / Director

Date: October 27, 2014

Re: Compliance Officer / Director Quarterly Report

The Compliance Committee is comprised of internal staff and external General Counsel. The Charter and Scope for the Compliance Committee includes but is not limited to:

- Ensure fraud, waste and abuse and HIPAA trainings are completed,
- Assist in the creation and implementation of the risk assessments,
- Monitoring progress towards completion of goals identified in the compliance work plan,
- Assist in the creation, implementation and monitoring of effective corrective actions for delegates, review the results of monitoring activities as described in delegation agreements to ensure delegate is meeting expectations and performing delegated functions appropriately and recommend corrective actions plans for delegates when deficiencies are identified.

The Compliance Committee has met during the third calendar quarter of 2014. The following items are a sample of items discussed at the meetings:

- Fraud, waste and abuse cases and current status of cases,
- Code of conduct,
- Compliance Committee charter
- Department of justice meeting information
- Delegation oversight audits and results
- Delegation oversight routine monitoring
- Compliance plan

GCHP is required to conduct delegation oversight audits on functions which are delegated. Routine reporting from delegates to the Plan is contractually required and must be actively monitored. Reporting statistics from delegates can be found in the compliance dashboard. An annual audit schedule was created and staff is working through each audit. The delegation oversight staff has conducted the following audits:

- Credentialing
- Specialty Contract

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

- MBHO
- Vision Services

The last audit for calendar year 2014 will be on the Plans transportation vendor. The audit is slated for November 2014.

The Plan received additional information from the Department of Health Care Services (DHCS) on October 1, 2014 relative to oversight auditing requirements for Kaiser. Once a final determination is confirmed by DHCS the Plan will align activities to ensure compliance. Given the active ongoing discussions relative to oversight specific to Kaiser the Plan has elected to move the onsite audit planned for November 2014 to January 2015. The Plan anticipates final resolution by DHCS soon and the Plan will conform to DHCS policy.

The Plan has issued the following corrective action plans (CAP) in 2014:

- Credentialing (3) *
- Specialty Contract (2)
- MBHO (2)
- Vision (Audit results are in review official CAP has not been issued)
  ** denotes CAP(s) have been closed; all others are at various stages of the CAP process.*

The Plan continues to monitor delegates through contractual required reporting. Reports are reviewed and when deficiencies are identified the Plan issues letters of non-compliance. This process is monitored, tracked and reported to the compliance committee. In addition the aggregate information is provided to the commission on the compliance dashboard.

The DHCS CAP, *Financial (Addendum A)* remains open, however GCHP, per DHCS instruction, was able to terminate the State appointed monitors contract as a result of continuously meeting CAP requirements. The Plan continues to submit items on a monthly basis as required by the CAP.

Compliance continues to monitor and ensure all employees and temporary employees are trained and retrained on HIPAA and Fraud, Waste and Abuse. In addition, compliance and information technology staff conducts random internal audits for HIPAA and PHI issues. Results of the audits are communicated back to the Compliance Committee as well as the leadership team.

As a component of commissioner compliance training, compliance staff will be working with commissioners in the next month for HIPAA and FWA training. The training is web based which will allow commissioner's flexibility in completely training requirements. An assigned due date will be Included in the access information for each training topic.

GCHP continues to meet all regulatory contract submission requirements. In addition all regulatory agency inquiries and requests are handled timely and required information is provided within the timeframe requested. In closing the Compliance Committee and compliance staff is actively engaged in sustained contract compliance.

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COMPLIANCE REPORT 2014

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
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	9	6	2	6	2	6	2	8			
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0	0	0	0	0	0	2	0	1			
Hotline Referral *FWA	Department of Justice	0	0	0	0	0	0	1	0	0			
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	1	5	5	2	6	2	3	1	6			
Hotline Referral	External Agency (i.e. HSA)	2	2	0	0	0	0	0	0	1			
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	2	2	1	0	0	0	1	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	8	8	8	8			
	Reporting Requirements Reviewed **	8	9	21	24	21	16	26	34	22			
	Audits conducted	3	0	0	0	1	0	0	1	1			
Delegation Oversight	Letters of Non-Compliance	0	0	0	0	0	0	1	1	3			
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	3	0	0	0	0	0	1	0	1			
Audits External regulatory entities evaluate GCHP compliance with contractual obligations.	Total	1	0	1	0	0	0	0	0	0			
	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	1	0	0	0	0	0	0	0	0			
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0	0	0	0	0	0	0	0	0			
	HEDIS Compliance Audit (HSAG)	0	0	1	0	0	0	0	0	0			
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2012*	0	0	0	0	0	0	0	0	0			
	DHCS Medical Audit *Audit was conducted in 2012*	0	0	0	0	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	9	6	2	6	2	6	4	8			
	Investigations of Providers	0	0	1	0	0	1	1	0	0			
	Investigations of Members	5	9	5	2	6	1	5	0	8			
	Investigations of Other Entities	0	0	0	0	0	0	0	0	0			
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0	1	1	0	1	0	1	0	1			
HIPAA Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	Referrals	0	3	0	1	1	2	1	4	4			
	State Notification	0	3	0	1	1	2	1	0	4			
	Federal Notification	0	0	0	0	0	0	0	0	0			
	Member Notification	0	1	0	0	0	0	0	0	1			
	HIPAA Internal Audits Conducted	0	0	0	0	1	0	0	1	0			
Training Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Training Sessions	49	11	71	44	21	27	96	18	17			
	Fraud, Waste & Abuse Prevention	22	4	63	26	6	4	8	8	5			
	Fraud, Waste & Abuse Prevention (Member Orientations)	2	2	2	2	4	4	4	0	0			
	Code of Conduct	1	1	5	7	5	7	8	3	5			
	HIPAA (Individual Training)	24	4	1	9	5	5	73	7	5			
	HIPAA (Department Training)	0	0	0	0	1	3	3	0	2			

** August - Numbers may change as the month has not ended
** 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.

AGENDA ITEM 2d

To: Gold Coast Health Plan Commission

From: Stacy Diaz, Director Human Resources

Date: October 27, 2014

RE: Executive Search Firm Selection for Chief Executive Officer

SUMMARY:
In August 2014, Gold Coast Health Plan began the Request for Proposal (RFP) process to select an executive search firm to manage the recruitment of a Chief Executive Officer for the Plan. It is the Plan's recommendation to move forward with Witt / Kieffer as the firm of choice and that the Commission authorize Gold Coast Health Plan (GCHP) to enter into an agreement with Witt / Kieffer to conduct the recruitment process for the Chief Executive Officer position.

BACKGROUND:
In August 2014, after the announcement of resignation of Chief Executive Officer, Michael Engelhard; Gold Coast Health Plan (GCHP) was asked to identify and retain an executive search firm to manage the recruitment of a new Chief Executive Officer for GCHP.

DISCUSSION:
GCHP issued a Request for Proposal (RFP) for the recruitment of Chief Executive Officer of the Plan. The RFP was sent to five (5) executive search firms, per the request of the Commission.

An Ad Hoc Committee was formed to review and discuss the proposals. The Ad Hoc Committee met on Monday, October 6, 2014 to review and discuss all options. After review and discussion, the staff and Ad Hoc Committee have recommended Witt / Kieffer for the executive search in attaining a new Chief Executive Officer. The recommendation is based on the following:

- References
- Company Overview / Experience
  - Voted top "10" in the nation
  - Years of Experience
  - Experience with Private Sectors/ Healthcare
  - Staff Qualifications

- Witt / Kieffer is currently conducting Chief Executive Officer Search in CA for another Plan
- Candidate Guarantee

FISCAL IMPACT:
Professional fees for this search assignment are one-third of the positions projected total compensation, minimum fee of $85,000. Additional fees would include out-of-pocket expenses for staff / candidate travel accommodations, advertising, education verification and any other related expenses.

RECOMMENDATION:
Witt / Kieffer is the preferred executive firm, providing the Plan with proven expertise in executive searches throughout the Nation.

The Ad Hoc Committee concludes that Witt / Kieffer strikes the best balance of industry experience and proven placement of executives.

It is the Ad Hoc Committee's recommendation to move forward with Witt / Kieffer as the executive search firm to manage the recruitment for Chief Executive Officer.

CONCURRENCE:
N/A

Attachments:
None

AGENDA ITEM 2e

To: Gold Coast Health Plan Commission

From: Ruth Watson, Interim CEO

Date: October 29, 2014

RE: General Counsel Support

SUMMARY

At the September 29, 2014 Special Commission meeting the Commission made the decision to replace the current General Counsel. The Commission delegated contract negotiation and selection of the final candidate to interim CEO, Watson.

After conducting additional review of the firm's qualifications and experience and comparison of negotiated fees, staff is recommending Best, Best and Krieger (BB&K) as the best candidate to represent the Commission and the Plan as General Counsel. GCHP is requesting approval for the Interim CEO to enter into a contract for General Counsel Legal Services with BB&K.

FISCAL IMPACT

Upon concluding negotiations with BB&K, there will be a rate increase in hourly fees of approximately 7%.

RECOMMENDATION

Staff proposes that the Commission approve and accept the staff's recommendation that BB&K is the best qualified firm to provide General Counsel Legal Services for the Commission and the Plan and authorize Interim CEO, Watson to enter into an agreement with BB&K for no less than 12 months.

CONCURRENCE

N/A

Attachments

None

AGENDA ITEM 2f

To: Gold Coast Health Plan Commission

From: Ruth Watson, Interim Chief Executive Officer

Date: October 27, 2014

RE: Lease Amendment / Additional Office Space

SUMMARY:

In November 2013 Gold Coast Health Plan (GCHP) signed a lease agreement at our new facility located at 711 E. Daily Drive, Camarillo, CA; with a relocation date of April 7, 2014. During the initial lease agreement a few suites were occupied with other tenants and were not immediately available to GCHP. The Plan had requested the Right of First Refusal (ROFR) when the additional space became available. In September 2014, GCHP was informed that an additional suite will be available mid-January of 2015. The space is approximately 1,023 usable and 1,150 rentable square feet. When combined with current space leased, GCHP's total premises will consist of 34,767 rentable square feet. It is the Plan's recommendation to move forward with the additional space expansion and request the Commission to authorize the Plan's CEO to enter into an agreement with the current landlord to lease the additional space.

BACKGROUND:

Last year when finalizing the lease for the new GCHP location, staff was aware of the potential need for additional space as membership was projected to grow, so staff requested the ROFR for additional leased space in the building should it become available. During our first six months of occupancy, the Plan has experienced a 39% increase in enrollment, which far exceeds projections for membership growth due to Medi-Cal expansion. This accelerated growth has stretched the capacity of our current space. Staff has been added to serve the needs of this new population.

As GCHP staff researches longer-term options to address the space challenges (i.e., teleworking and restacking the existing workspace), the Plan was informed in September that an additional suite, located between two of GCHP's existing leased suites would be available mid-January of 2015. Membership growth, as well as new services and regulatory requirements, will likely continue to drive an increase in Plan staffing. Leasing an office suite, contiguous to our existing space and expanding the overall square footage available will assist GCHP in meeting its immediate and future space needs.

FISCAL IMPACT:
The initial Base Rent is $1.80 per rentable square foot per month (the same as the rate in the existing gross lease) or $2,070.00 per month in additional rent. The existing lease will be amended to ensure that the lease for both spaces co-terminate at the same time and all contract terms are the same for both spaces. The lease terms would reflect the current lease to include janitorial and utility expenses. Additional costs estimated at $50,000 to include office furniture, security access, equipment, cabling and networking fees.

RECOMMENDATION:
It is recommended that the Commission authorize the Plan to move forward with the lease expansion.

CONCURRENCE:
N/A

Attachments:
None

GCHP 2015 Meeting Schedule

Meetings begin at 3:00 p.m.

Proposed October 27, 2014

Commission Meeting (4th Monday of the Month) *

*With exception of May and November due to Holidays

Holiday

Black - No Meeting Scheduled

JANUARY

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

FEBRUARY

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

MARCH

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

APRIL

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

MAY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24/31	25	26	27	28	29	30

JUNE

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

JULY

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

AUGUST

S	M	T	W	T	F	S
2	3	4	5	6	7	1/8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

SEPTEMBER

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

OCTOBER

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

NOVEMBER

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

DECEMBER

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

AGENDA ITEM 2h

To: Gold Coast Health Plan Commission

From: Ruth Watson, CEO

Date: October 27, 2014

Re: DHCS Contract Amendment A13

SUMMARY

The State of California Department of Health Care Services (DHCS) establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A13 reflects expected changes to Gold Coast Health Plan (GCHP or Plan) capitation rates for FY2013-14.

BACKGROUND / DISCUSSION

GCHP received a contract amendment from the DHCS on October 7, 2014 which updated the Plan's FY2013-14 capitation rates for the traditional Medi-Cal population (i.e., not the Adult Expansion or the Targeted Low Income Children populations) as follows:

- Rate period from July 1, 2013 to December 31, 2013
  - Increases monthly capitation rates to compensate the Plan for Community Based Adult Services (CBAS) funds that will no longer be paid through separate kick payments
  - Includes AB97 provider rate reductions for Medi-Cal only (non-Dual) populations
  - Includes second half of CY2013 Affordable Care Act Section 1202 funds to be paid to qualifying providers performing specific services
  - Includes funds for the Hospital Quality Assurance Fee (HQAF) program pursuant to SB335 to be paid to specific hospitals identified by the California Hospital Association

- Rate period commencing January 1, 2014
  - Increases monthly capitation rates to compensate the Plan for CBAS funds that will no longer be paid through separate kick payments

- Includes AB97 provider rate reductions for Medi-Cal only (non-Dual) populations
- Includes funding of new Mental Health benefit expansion, effective January 1, 2014

FISCAL IMPACT

Amendment A13 confirms that the Plan will eventually be paid the rates that were previously communicated as final by DHCS. This information was communicated by DHCS via updated rate packages received after the close of FY2013-14. These rates were identified by GCHP management as post-closing (fiscal year) adjustments and will be reflected in the audited financials. This amendment is expected to increase revenue by approximately $8.3 million for FY2013-14. Note this includes $5.0 million of expected ACA 1202 funds for the 7/1/13-12/31/13 time period. Reflecting these rates will also allow the Plan to reverse the AB97 reserves recorded last fiscal year.

The HQAF is a pass-through item with no fiscal impact.

RECOMMENDATION

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendment A13.

CONCURRENCE
N/A

Attachments
None

AGENDA ITEM 3b

To: Gold Coast Health Plan Commission

From: Ruth Watson, Interim CEO / Chief Operating Officer

Date: October 27, 2014

Re: CEO Update

GOVERNMENT RELATIONS UPDATE

Community Based Adult Services Program

Currently the Community Adult Service Program (CBAS) is authorized under an approved waiver by the federal government that expires at the end of October 2014. The California Department of Health Care Services (DHCS) submitted an amendment to the section 1115 waiver to the Center for Medicare & Medicaid Services (CMS), to extend the CBAS Program through October 31, 2015. Enhanced case management services were not included in the new DHCS - proposed waiver amendment.

In late September Governor Brown vetoed legislation (AB 1552), that would have codified the CBAS Program as a permanent Medi-Cal benefit.

Medi-Cal Managed Care Plans As Medicaid Certified Application Counselors

In early 2014 Gold Coast Health Plan submitted an application to participate in Covered California's Certified Application Counselor Program (CAC). The objective of the CAC Program is to provide information and assistance to consumers regarding Covered California and to help facilitate enrollment in Medi-Cal. Covered California will be responsible for designating, certifying and training Medi-Cal Certified Application Counselors participating in the CAC program. Medi-Cal CACs may perform the following duties:

- Provide information to individuals and all members of the public about the full range of options and insurance affordability programs for which they may be eligible for including Medi-Cal
- Assist individuals to apply for coverage through Covered California and for other health insurance affordability programs including Medi-Cal

Staff can either participate in the 3.5 day training or take the on-line self-training modules at their own pace and the certification exam can be taken at any time. Certified

Application Counselors will be required to undergo background checks, which will be paid for by the participating Plan. Access to CalHEERS will be granted to CACs once the individual passes the exam and clears the background check.

In addition to the required training, Covered California requires that participating plans enter into an MOU for plans to be eligible to serve as enrollers for Covered California and Medi-Cal.

Reimbursement Rates for BHT/ABA Services

DHCS is in the process of developing reimbursement rates for behavioral health treatment (BHT) and applied behavioral analysis (ABA) benefits in the Medi-Cal Program. DHCS is also seeking an 1115 Demonstration Waiver for the Substance Use Disorder (SUD) and Drug Medi-Cal (DMC) Program.

DHCS has asked the California Association of Health Plans (CAHP) to reach out to health plans, particularly those that have implemented behavioral health benefits commercially, to assist DHCS in their rate development. DHCS is specifically requesting that those health plans willing to provide the state information on their provider rates do so using the attached table. DHCS has indicated that once rates are developed plans will be reimbursed retroactively for providing these services to September 15, 2014.

GCHP- DHCS 2013-2014 Contract Amendment

On October 7, 2014 GCHP received an amendment to its contract with DHCS. The purpose of this amendment is to adjust the 2013-2014 capitation rates and other payment provisions. A detailed memo will be provided to GCHP Commissioners explaining the changes.

GCHP Behavioral Health Policy Forum

On October 14, 2014 GCHP held a behavioral health policy forum. Attendees included representatives from Ventura County elected officials, community based organizations and stakeholders. Discussion focused on behavioral health policy and implementation of the behavioral health benefit in the Medi-Cal Program. The intent of this policy forum and future forums is to strengthen the partnership between GCHP and its community partners and stakeholders.

Denti-Cal Subcommittees

Three Legislative Subcommittees have been created for the purpose of addressing administrative barriers, triaging protocols, and increasing the provider pool for dental services for individuals with special needs. A commercial health plan, Sutter Health, previously announced they could no longer provide anesthesia services for dental care due to increased costs.

Legislation
Below is a list of Medi-Cal related bills that were either approved or vetoed by the Governor.

AB 1552 **Community Based Adult Services**
Summary: Requires Community-Based Adult Services to be provided as a Medi-Cal benefit. **Vetoed.**

AB 2325 **Medi-Cal: Communi-Cal.**
Summary: Requires DHCS to establish a program to provide and reimburse for medical interpretation services provided to Medi-Cal enrollees with limited English proficiency. **Vetoed**

AB 2418 **Health care coverage: prescription drugs: refills.**
Summary: Requires health plan contracts and health insurance policies to allow for synchronization of prescription refills. **Vetoed**

SB 508 **Medi-Cal: eligibility.**
Summary: Establishes income eligibility thresholds pursuant with MAGI standards. Extends Medi-Cal benefits to former foster care youth up to 21 years of age. **Approved**

SB 964 **Health care coverage.**
Summary: Increases ongoing oversight of health plans, with a focus on ensuring compliance of plans with existing health care access standards in the Medi-Cal managed care and individual markets. Requires Medi-Cal MCPs to be subject to routine medical surveys by the DMHC. **Approved**

SB 1002 **Medi-Cal: redetermination.**
Summary: Requires counties to begin a new 12 month eligibility period for Medi-Cal when approving or certifying an individual's eligibility for CalFresh benefits in order to align Medi-Cal and CalFresh eligibility periods.

SB 1004 **Health care: palliative care.**
Summary: Makes palliative care a Medi-Cal benefit that is cost neutral to the General Fund.

SB 1053 **Health care coverage: contraceptives.**
Summary: Requires health plans to cover a variety of Food and Drug Administration (FDA) approved contraceptive drugs, devices, counseling, follow-up services, and voluntary sterilization procedures. Requires utilization controls for family planning services for Medi-Cal MCPs to be subject to cost-sharing requirements.

SB 1124 **Medi-Cal: estate recovery.**
Summary: Limits recovery from the estate of a deceased Medi-Cal beneficiary, to only those costs for health care services the estate is required to cover under federal law.

SB 1341 **Medi-Cal: Statewide Automated Welfare System (SAWS).**
Summary: Requires SAWS to be the system of records for Medi-Cal, and contain all Medi-Cal eligibility rules and case management functionality. Effective January 1, 2016, SAWS shall be used to generate all consumer notifications related to Medi-Cal, and CalHEERS may be used to generate notices to consumers related to the premium tax credit program.

SB 1457 **Medical care: electronic treatment authorization requests.**
Summary: Requires requests for authorization for treatment services in the Medi-Cal Program to be submitted in an electronic format determined by DHCS via DHCS' website or other electronic means designated by DHCS.

NON-EMERGENCY MEDICAL TRANSPORTATION

Non-emergency Medical Transportation (NEMT) is a Medi-Cal benefit providing transportation to covered Medi-Cal services when the member's medical and physical condition does not allow that member to travel by means of private or public conveyance.

In October 2012, Gold Coast Health Plan (GCHP or Plan) conducted a Request for Proposal (RFP) for NEMT. The objective was to contract with a transportation provider that would assume risk for and manage all NEMT benefits for eligible GCHP members in an effort to improve utilization, streamline and improve the NEMT process, and reduce Plan costs. As a result of the detailed RFP Process Ventura Transit System (VTS) was awarded the contract and began to provide NEMT services for Plan members on February 1, 2013.

At the November 24, 2014 Commission Meeting staff will present a report on the utilization, cost effectiveness and quality of NEMT provided by VTS.

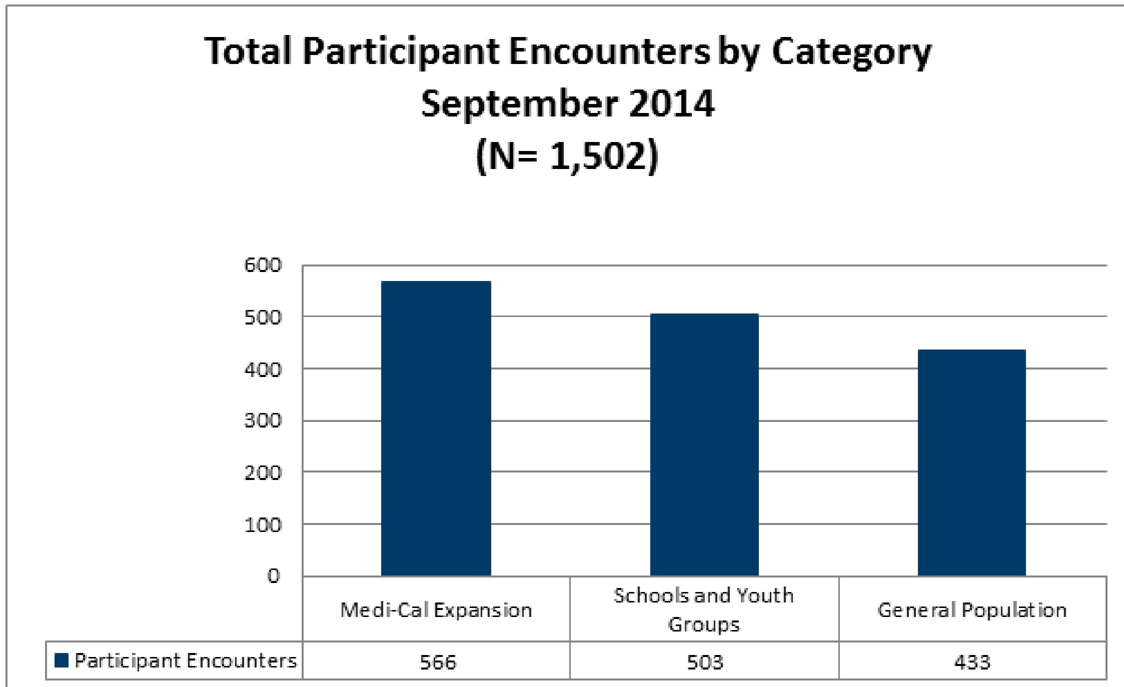
HEALTH EDUCATION AND COMMUNITY OUTREACH SUMMARY REPORT

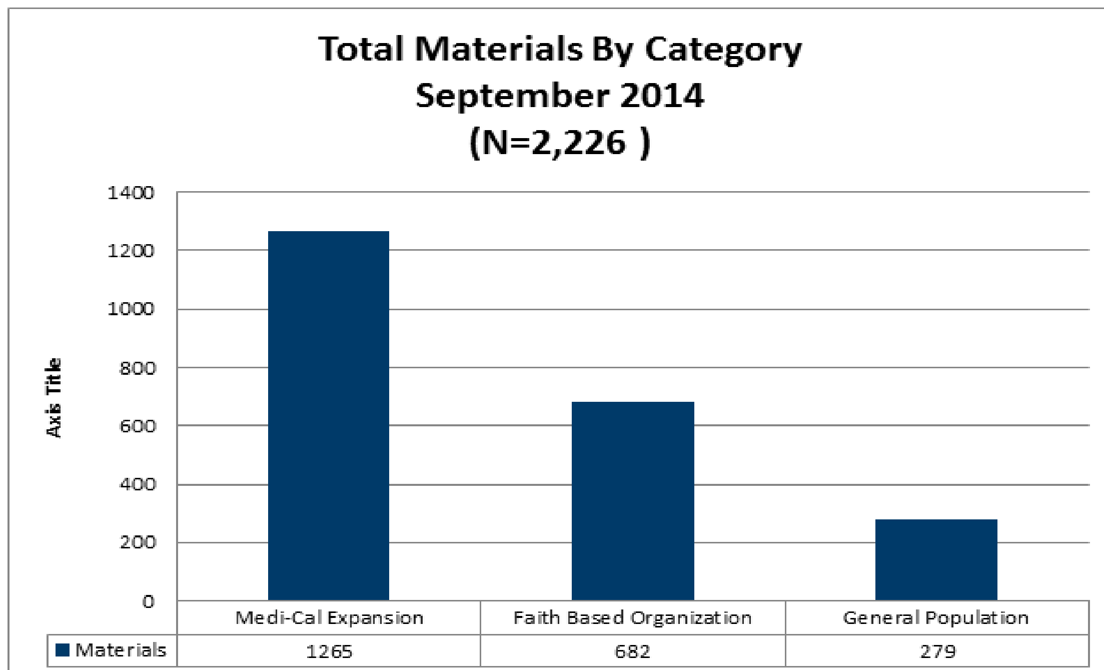
Summary
Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. Below is a summary of activities conducted by GCHP staff.

September 2014 Outreach Activities
Overall GCHP continues to reach individuals, families, and potential members through a variety of community outreach events. During the month of September GCHP staff participated in 14 community events and reached over 1,500 individuals, providing approximately 2,200 pieces of literature. Staff continues to hand out materials related to

the Affordable Care Act (ACA) and continues to reach potential individuals eligible for Medi-Cal through the ACA Medi-Cal expansion program.

Below are two charts documenting the total number of materials distributed and encounters during the month of September.





Year-to-Date Total Number of Encounters
The total number encounters reached from January 2014 – September 2014 is roughly 8,300 individuals. Information regarding GCHP and the Medi-Cal Expansion Program continues to increase.

Upcoming Health Education Activities
GCHP Health Education Department will be hosting a series of Health Education Workshops throughout the county beginning in October. Each month the theme will be in conjunction with the national public health observances calendar.

October is Breast Cancer Awareness Month - GCHP will host four Breast Cancer Awareness Workshops, speakers will focus on prevention, early detection, and treatment. GCHP will be partnering with local school districts, Ventura County Health Care Agency, Public Health Department, California's Every Woman Counts, and Community Memorial Hospital, Center for Family Health.

November is Diabetes Awareness Month – GCHP will host two Diabetes Awareness Workshops, speakers will focus on diabetes prevention and information about maintaining a healthy lifestyle. As part of the Diabetes Awareness Campaign, GCHP will be partnering with Ventura County Health Care Agency, Clinicas del Camino Real, Ventura County Human Service Agency, Community Action, MICOP and Covered California.

GCHP will host a Community Resource Fair in honor of Diabetes Awareness Month. The event will be held on Saturday, November 8, 2014, at the Oxnard Public Library from 10 a.m. to 12 p.m. The Community Resource Fair will feature guest speakers, free health screenings, resource booths, and demonstrations on how to use a glucose meter. For more information contact the Health Education Department at healtheducation@goldchp.org.

Two (2) Free Movie Tickets with Your Eye Exam
As an incentive to increase retinal eye exams among members diagnosed with diabetes mellitus, GCHP implemented a member incentive program. Members who complete their eye exam before December 31, 2014, will receive two (2) free movie tickets if they:

1. Make an appointment to get the eye exam test
2. Mail the signed and completed form in the enclosed stamped self-addressed envelope

Once the form is returned to GCHP, Health Education staff will verify the information to ensure that the criteria has been met; once criteria has been met movie theater tickets will be mailed to the member.

AGENDA ITEM 3c

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: October 27, 2014

Re: August 2014 Financials

SUMMARY

Staff is presenting the attached August 2014 financial statements (unaudited) of Gold Coast Health Plan (GCHP or Plan) for approval. The Executive / Finance Committee did not meet in October to review the August financial package.

BACKGROUND / DISCUSSION

The Plan's staff has prepared the August 2014 financial package, including balance sheet, income statements and statements of cash flows.

FISCAL IMPACT

Highlights of YTD Financials

The Plan's overall performance for the month exceeded budget. On a year-to-date (YTD) basis, the Plan's net income for the month was approximately $4.9 million compared to $3.1 million assumed in the budget. These operating results have contributed to a Tangible Net Equity (TNE) level of approximately $42.6 million, which exceeds both the budget of $35.4 million (by $7.2 million) and the State minimum required TNE amount of $22 million (by $20.6 million).

Please note the Plan's TNE amounts noted in the financial package include the $7.2 million in lines of credit with the County of Ventura. Also, as of the end of the August 2014, the Plan's TNE is:

- 194% of the minimum State-required TNE level and
- 161% of the minimum State-required TNE level, excluding the lines of credit of $7.2 million

Highlights of August Financials

Membership - August membership of 163,251 exceeded budget by 4,801 members. The majority of membership growth is in Adult Expansion (AE) category, where membership was 6,978 higher than budget. In the Adult / Family category, membership was 2,123 below budgeted estimates. Current membership is 36% higher than at December 31, 2013 and year-over-year.

Revenue – August total revenue is $51.4 million, which exceeded the budgeted amount of $47.4 million, by $4 million. On a per-member-per-month (PMPM) basis, total revenue was $315.15 PMPM which was $15.85 PMPM better than budget of $299.30 PMPM. The favorable results were driven by membership growth being greater than anticipated in total, with significantly more members than expected in higher capitation rate cells.

For the new fiscal year, DHCS contract amendment 11 rates were adjusted for known policy changes including:

- Blood factor drugs – effective July 1, 2014, these drugs will not be the responsibility of the managed care plans and the rates have been reduced by $7.38 PMPM for Aged / Disabled and $3.76 PMPM for AE.
- Mental health – effective July 1, 2014, the State will increase the mental health portion of the capitation rates by an average $2.96 PMPM to reflect estimated phase-in of the expanded benefit that begun on January 1, 2014.

Note additional revenue was not accrued for the supplemental payment for the treatment of Hepatitis C, since the State's methodology and amount was not available at the time of the August close.

Health Care Costs – Total cost of health care for August was $46.1 million or $3.2 million more than budget. On a PMPM basis, August health care costs were $282.42 PMPM or $11.76 PMPM more than the budgeted amount of $270.66 PMPM.

Primary causes for the August total dollar variance to budget include:

- Membership - Increases in AE membership of nearly 7,000 over budget accounted for approximately $3.3 million of negative variance.
- Inpatient – Several hospitals reported claims with dates of service extending back to April and beyond, causing a negative variance of $0.6 million.
- LTC / SNF – The Plan continues to hold reserves related to AB 1629 rate increases (required for the Plan to pass down to certain providers) for August 2013 that have not been paid out since the funds have not been received by the State. An amount of $0.3 million was added in anticipation of new AB 1629 rates effective August 2014, bringing the total LTC rate reserve to $1.7 million.

- Pharmacy –The increase in utilization among the new AE population has not achieved the rate as expected in the budget, contributing a positive variance of $4.7 million. These savings have been partially offset to due increases in other costs such as Solvaldi, resulting in a net favorable variance of $3.1 million.

In addition, in the course of the annual review by external actuaries, the Plan incorporated the following recommendations including:

- Adding a reserve of approximately $2.4 million to increase the probability that the Plan's booked liability is sufficient to pay the claims. Note approximately half of this amount would have been previously classified under the AE reserve.
- Including approximately $0.1 million to cover costs of processing claims beyond a six-month run-out period in the event of termination of Plan's claim processor. This Plan responsibility was recently clarified in a proposed contract amendment with the Plan's claims processor. This expense was included in the inpatient cost category since it is assumed that claims falling into this category would be expected to be mainly Inpatient claims.

The expenses for the AE population are still uncertain and for August, are estimated to be at more than a 85% medical loss ratio (MLR), therefore there is no additional reserve in the "Adult Expansion Reserve" category on the income statement. Note that for the AE population:

- Medical expenses continue to be estimated from State rate packages (which reflect a 91% MLR) and will be evaluated as claims data is received, and
- Pharmacy expenses have been less than budget.

Note that the Plan continues to hold reserves (as shown on the IBNP portion of the Balance Sheet) of approximately $9 million to date in estimated liability due to the AE MLR requirement.

Administrative Expenses – For the month of August, overall operational costs were approximately $420,000 lower than budgeted expenses. The following primary factors contributed to this lower than expected expense:

- Lower personnel (e.g., Salaries and Wages) expenses due to delays in hiring staff,
- Lower Consulting services due to delays in utilizing resources associated with new projects, and
- Lower General Office expense due to reclassifying the amortized software license expense (of Milliman Care Guidelines and MedHok) to health care expense.

Cash + Medi-Cal Receivable - The total of Cash and Medi-Cal Premium Receivable balances of $189 million reported as of August 31, 2014 included a MCO Tax

component amounting to $11.3 million. Excluding the impact of the tax and pass-through amounts to providers, the total of Cash and Medi-Cal Receivable balance as of August 31, 2014 was $176.6 million, or $43.6 million better than the budgeted level of $133.0 million.

RECOMMENDATION
Staff proposes that the Plan's Commission approve and accept the August, 2014 financial statements.

CONCURRENCE
N/A

Attachment
August 2014 Financial Package

FINANCIAL PACKAGE
For the month ended August 31, 2014

TABLE OF CONTENTS

- Financial Overview
- Membership
- Income Statement
- Balance Sheet

APPENDIX

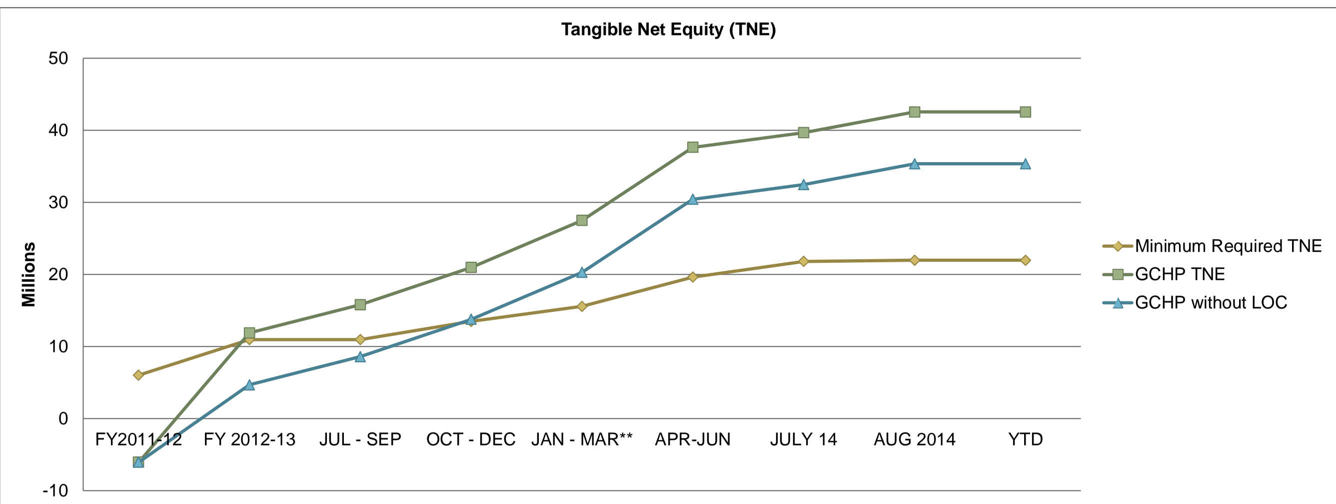
- Cash Trend Combined
- Paid Claims & IBNP
- YTD Income Statement
- Monthly Cash Flow
- YTD Cash Flow
- Total Expenditure Composition

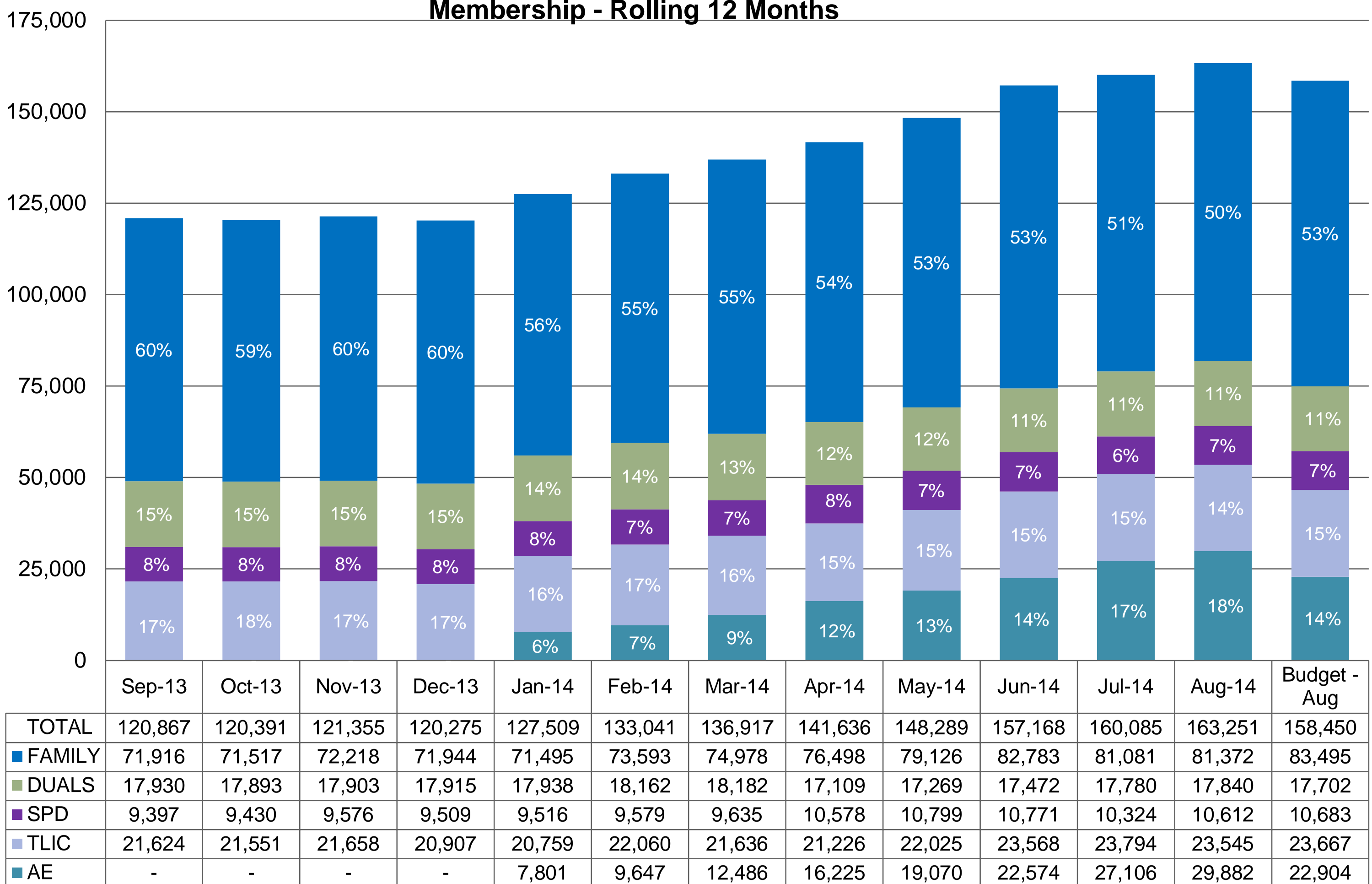
Financial Overview

Description	AUDITED* FY2011-12	AUDITED* FY 2012-13	UNAUDITED FY 2013-14 Actual JUL - SEP	OCT - DEC	JAN - MAR**	APR-JUN	FY 2014-15 JULY 14	AUG 2014	YTD	Budget Comparison Budget	Variance Fav/(Unfav)	Variance Fav/(Unfa
Member Months	**1,258,189**	**1,223,895**	347,079	362,021	397,467	447,093	160,085	163,251	323,336	**316,548**	6,788	2.1 %
Revenue	**304,635,932**	**315,119,611**	**81,988,709**	**84,070,456**	**112,028,121**	**130,864,339**	**49,614,139**	**51,448,608**	**101,062,747**	**94,666,593**	6,396,153	6.8 %
pmpm	*242.12*	*257.47*	*236.22*	*232.23*	*281.86*	*292.70*	*309.92*	*315.15*	*312.56*	*299.06*	13.50	4.5 %
Health Care Costs	**287,353,672**	**280,382,704**	**71,875,533**	**72,867,512**	**98,914,429**	**113,026,921**	**44,870,662**	**46,104,742**	**90,975,404**	**85,580,564**	(5,394,840)	(6.3)%
pmpm	*228.39*	*229.09*	*207.09*	*201.28*	*248.86*	*252.80*	*280.29*	*282.42*	*281.36*	*270.36*	(11.01)	(4.1)%
% of Revenue	94.3%	89.0%	87.7%	86.7%	88.3%	86.4%	90.4%	89.6%	90.0%	90.4%	-0.4%	-0.4%
Admin Exp	**18,891,320**	**24,013,927**	**6,202,007**	**6,014,475**	**6,597,110**	**7,687,941**	**2,719,481**	**2,472,120**	**5,191,601**	**6,024,622**	833,021	13.8 %
pmpm	*15.01*	*19.62*	*17.87*	*16.61*	*16.60*	*17.20*	*16.99*	*15.14*	*16.06*	*19.03*	2.98	15.6 %
% of Revenue	6.2%	7.6%	7.6%	7.2%	5.9%	5.9%	5.5%	4.8%	5.1%	6.4%	1.2%	19.3%
Net Income	**(1,609,063)**	**10,722,980**	**3,911,169**	**5,188,469**	**6,516,582**	**10,149,477**	**2,023,996**	**2,871,746**	**4,895,742**	**3,061,407**	1,834,334	59.9 %
pmpm	*(1.28)*	*8.76*	*11.27*	*14.33*	*16.40*	*22.70*	*12.64*	*17.59*	*15.14*	*9.67*	5.47	56.6 %
% of Revenue	-0.5%	3.4%	4.8%	6.2%	5.8%	7.8%	4.1%	5.6%	4.8%	3.2%	1.6%	49.8%
100% TNE	16,769,368	16,138,440	16,112,437	16,056,217	18,539,458	19,653,502	21,822,993	21,968,862	21,968,862	21,805,244	163,618	0.8 %
% TNE Required	36%	68%	68%	84%	84%	100%	100%	100%	100%	100%		
Minimum Required TNE	6,036,972	10,974,139	10,956,457	13,487,223	15,573,145	19,653,502	21,822,993	21,968,862	21,968,862	21,805,244	163,618	0.8 %
GCHP TNE	**(6,031,881)**	**11,891,099**	**15,802,268**	**20,990,738**	**27,507,320**	37,656,797	**39,680,792**	**42,552,539**	**42,552,539**	**35,378,486**	**7,174,053**	**20.3 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**4,845,810**	**7,503,516**	**12,397,168**	**18,003,295**	**17,857,799**	**20,583,677**	**20,583,677**	**13,573,242**	**7,010,435**	**51.6 %**

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

* Audited amounts reflect financial adjustments made by auditors, but exclude presentation reclassifications without P&L impact (i.e. reporting package kept the same).
**ACA 1202 payment ($5.2 million) received from State in January was added back to revenue and health care cost in the month of January (in the June package). This is a change from prior months because the State has finalized the ACA 1202 payment methdology.





	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Budget - Aug
TOTAL	120,867	120,391	121,355	120,275	127,509	133,041	136,917	141,636	148,289	157,168	160,085	163,251	158,450
FAMILY	71,916	71,517	72,218	71,944	71,495	73,593	74,978	76,498	79,126	82,783	81,081	81,372	83,495
DUALS	17,930	17,893	17,903	17,915	17,938	18,162	18,182	17,109	17,269	17,472	17,780	17,840	17,702
SPD	9,397	9,430	9,576	9,509	9,516	9,579	9,635	10,578	10,799	10,771	10,324	10,612	10,683
TLIC	21,624	21,551	21,658	20,907	20,759	22,060	21,636	21,226	22,025	23,568	23,794	23,545	23,667
AE	-	-	-	-	7,801	9,647	12,486	16,225	19,070	22,574	27,106	29,882	22,904

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

Note: Beginning in Apr '14 actual membership reflects new Duals definition as implemented by DHCS. Prior months have not been restated.

Income Statement Monthly Trend

	FY2013-14 Monthly Trend		FY2014-15	Current Month		
	MAY 2014	JUN 2014	JUL 2014	AUGUST 2014		Variance
				Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	148,289	157,168	160,085	163,251	158,450	4,801
Revenue:						
Premium	$ 45,197,814	$ 47,173,118	$ 51,600,376	$ 53,483,243	$ 49,311,952	$ 4,171,290
Reserve for Rate Reduction	-	1,253,837	-	-	-	-
MCO Premium Tax	(1,779,698)	(1,954,702)	(2,038,713)	(2,098,955)	(1,941,658)	(157,296)
Total Net Premium	**43,418,115**	**46,472,254**	**49,561,663**	**51,384,288**	**47,370,294**	**4,013,994**
Other Revenue:						
Interest Income	12,448	16,066	14,142	25,986	16,273	9,713
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	0
Total Other Revenue	50,782	54,399	52,476	64,320	54,606	9,714
Total Revenue	**43,468,897**	**46,526,653**	**49,614,139**	**51,448,608**	**47,424,900**	**4,023,708**
Medical Expenses:						
Capitation (PCP, Specialty, Kasier, NEMT & Vision)	1,851,892	2,438,071	2,547,502	2,665,459	2,649,691	(15,767)
FFS Claims Expenses:						
Inpatient	9,002,937	6,708,899	10,931,208	11,741,392	9,627,164	(2,114,228)
LTC/SNF	8,116,213	7,439,023	8,528,443	8,031,837	7,484,256	(547,581)
Outpatient	3,312,183	3,062,231	3,330,983	3,156,219	2,556,601	(599,618)
Laboratory and Radiology	629,923	800,113	861,924	1,083,721	721,604	(362,117)
Physician ACA 1202	-	-	-	-	-	-
Emergency Room	1,093,890	1,514,158	1,392,675	1,870,862	1,487,407	(383,455)
Physician Specialty	2,306,001	2,046,830	3,460,004	3,456,254	3,166,874	(289,380)
Primary Care Physician	-	-	1,816,595	2,958,535	2,418,590	(539,945)
Home & Community Based Services	-	-	1,191,776	1,398,107	834,147	(563,960)
Mental Health Services	297,327	298,328	192,419	592,375	734,148	141,773
Pharmacy	7,006,271	7,534,160	5,779,140	5,441,839	8,511,429	3,069,590
Adult Expansion Reserve	-	-	1,000,000	-	-	-
Other Medical Professional	224,924	251,042	280,403	328,398	257,942	(70,456)
Other Medical Care	-	387	-	-	-	-
Other Fee For Service	4,329,381	4,800,761	2,694,956	1,329,307	913,824	(415,483)
Transportation	77,615	142,371	151,798	338,849	294,211	(44,638)
Total Claims	36,396,665	34,598,303	41,612,325	41,727,695	39,008,197	(2,719,498)
Medical & Care Management Expense	921,915	1,363,457	938,131	1,062,453	1,034,716	(27,737)
Reinsurance	(120,034)	(934,004)	71,281	444,200	193,309	(250,890)
Claims Recoveries	(237,943)	(316,634)	(298,578)	204,936	-	(204,936)
Sub-total	563,938	112,819	710,834	1,711,588	1,228,025	(483,563)
Total Cost of Health Care	**38,812,496**	**37,149,193**	**44,870,662**	**46,104,742**	**42,885,914**	**(3,218,828)**
Contribution Margin	**4,656,402**	**9,377,460**	**4,743,477**	**5,343,866**	**4,538,986**	**804,880**
General & Administrative Expenses:						
Salaries and Wages	662,308	592,779	677,265	625,238	792,287	167,050
Payroll Taxes and Benefits	158,128	152,969	217,432	157,153	206,336	49,183
Travel and Training	7,786	13,484	10,309	8,842	21,506	12,664
Outside Service - ACS	1,167,563	1,179,130	1,239,331	1,271,873	1,191,443	(80,430)
Outside Services - Other	214,869	103,733	93,663	102,727	122,550	19,823
Accounting & Actuarial Services	(7,071)	35,136	19,300	11,928	60,000	48,073
Legal	134,879	124,593	149,329	64,492	33,333	(31,159)
Insurance	11,949	11,914	23,885	22,707	14,583	(8,124)
Lease Expense - Office	63,318	92,081	63,318	63,318	64,354	1,036
Consulting Services	35,325	128,446	42,333	55,974	200,426	144,452
Translation Services	5,152	4,711	2,673	2,890	7,083	4,193
Advertising and Promotion	-	9,010	4,024	-	12,839	12,839
General Office	91,250	107,081	141,963	30,438	97,000	66,562
Depreciation & Amortization	15,108	15,133	13,916	15,158	19,821	4,663
Printing	1,312	6,227	1,576	7,947	12,365	4,418
Shipping & Postage	318	237	423	23,377	21,342	(2,035)
Interest	35,144	(49,375)	18,742	8,058	15,000	6,942
Total G & A Expenses	**2,597,338**	**2,527,289**	**2,719,481**	**2,472,120**	**2,892,268**	**420,149**
Net Income / (Loss)	**$ 2,059,063**	**$ 6,850,171**	**$ 2,023,996**	**$ 2,871,746**	**$ 1,646,718**	**$ 1,225,028**
Full time employees				**136**	**156**	**20**

PMPM Income Statement Comparison

	MAY 2014	JUN 2014	JUL 2014	AUGUST 2014 Actual	AUGUST 2014 Budget	Variance Fav/(Unfav)
Membership (includes retro members)	148,289	157,168	160,085	163,251	158,450	4,801
Revenue:						
Premium	304.80	300.14	322.33	327.61	311.21	16.40
Reserve for Rate Reduction	-	7.98	-	-	-	-
MCO Premium Tax	(12.00)	(12.44)	(12.74)	(12.86)	(12.25)	(0.60)
Total Net Premium	**292.79**	**295.69**	**309.60**	**314.76**	**298.96**	**15.80**
Other Revenue:						
Interest Income	0.08	0.10	0.09	0.16	0.10	0.06
Miscellaneous Income	0.26	0.24	0.24	0.23	0.24	(0.01)
Total Other Revenue	**0.34**	**0.35**	**0.33**	**0.39**	**0.54**	**(0.15)**
Total Revenue	**293.14**	**296.03**	**309.92**	**315.15**	**299.30**	**15.85**
Medical Expenses:						
Capitation (PCP, Specialty, Kasier, NEMT & Vision)	12.49	15.51	15.91	16.33	16.72	0.40
FFS Claims Expenses:						
Inpatient	60.71	42.69	68.28	71.92	60.76	(11.16)
LTC/SNF	54.73	47.33	53.27	49.20	47.23	(1.97)
Outpatient	22.34	19.48	20.81	19.33	16.14	(3.20)
Laboratory and Radiology	4.25	5.09	5.38	6.64	4.55	(2.08)
Physician ACA 1202	-	-	-	-	-	-
Emergency Room	7.38	9.63	8.70	11.46	9.39	(2.07)
Physician Specialty	15.55	13.02	21.61	21.17	19.99	(1.18)
Primary Care Physician	-	-	11.35	18.12	15.26	(2.86)
Home & Community Based Services	-	-	7.44	8.56	5.26	(3.30)
Mental Health Services	2.01	1.90	1.20	3.63	4.63	1.00
Pharmacy	47.25	47.94	36.10	33.33	53.72	20.38
Adult Expansion Reserve				-		-
Other Medical Professional	1.52	1.60	1.75	2.01	1.63	(0.38)
Other Medical Care	-	0.00	-	-	-	-
Other Fee For Service	29.20	30.55	16.83	8.14	5.77	(2.38)
Transportation	0.52	0.91	0.95	2.08	1.86	(0.22)
Total Claims	245.44	220.14	259.94	255.60	246.19	(9.42)
Medical & Care Management Expense	6.22	8.68	5.86	6.51	6.53	0.02
Reinsurance	(0.81)	(5.94)	0.45	2.72	1.22	(1.50)
Claims Recoveries	(1.60)	(2.01)	(1.87)	1.26	-	(1.26)
Sub-total	3.80	0.72	4.44	10.48	7.75	(2.73)
Total Cost of Health Care	**261.74**	**236.37**	**280.29**	**282.42**	**270.66**	**(11.76)**
Contribution Margin	**31.40**	**59.67**	**29.63**	**32.73**	**28.65**	**4.09**
General & Administrative Expenses:						
Salaries and Wages	4.47	3.77	4.23	3.83	5.00	1.17
Payroll Taxes and Benefits	1.07	0.97	1.36	0.96	1.30	0.34
Travel and Training	0.05	0.09	0.06	0.05	0.14	0.08
Outside Service - ACS	7.87	7.50	7.74	7.79	7.52	(0.27)
Outside Services - Other	1.45	0.66	0.59	0.63	0.77	0.14
Accounting & Actuarial Services	(0.05)	0.22	0.12	0.07	0.38	0.31
Legal	0.91	0.79	0.93	0.40	0.21	(0.18)
Insurance	0.08	0.08	0.15	0.14	0.09	(0.05)
Lease Expense - Office	0.43	0.59	0.40	0.39	0.41	0.02
Consulting Services	0.24	0.82	0.26	0.34	1.26	0.92
Translation Services	0.03	0.03	0.02	0.02	0.04	0.03
Advertising and Promotion	-	0.06	0.03	-	0.08	0.08
General Office	0.62	0.68	0.89	0.19	0.61	0.43
Depreciation & Amortization	0.10	0.10	0.09	0.09	0.13	0.03
Printing	0.01	0.04	0.01	0.05	0.08	0.03
Shipping & Postage	0.00	0.00	0.00	0.14	0.13	(0.01)
Interest	0.24	(0.31)	0.12	0.05	0.09	0.05
Total G & A Expenses	**17.52**	**16.08**	**16.99**	**15.14**	**18.25**	**3.11**
Net Income / (Loss)	**13.89**	**43.59**	**12.64**	**17.59**	**10.39**	**7.20**

Comparative Balance Sheet

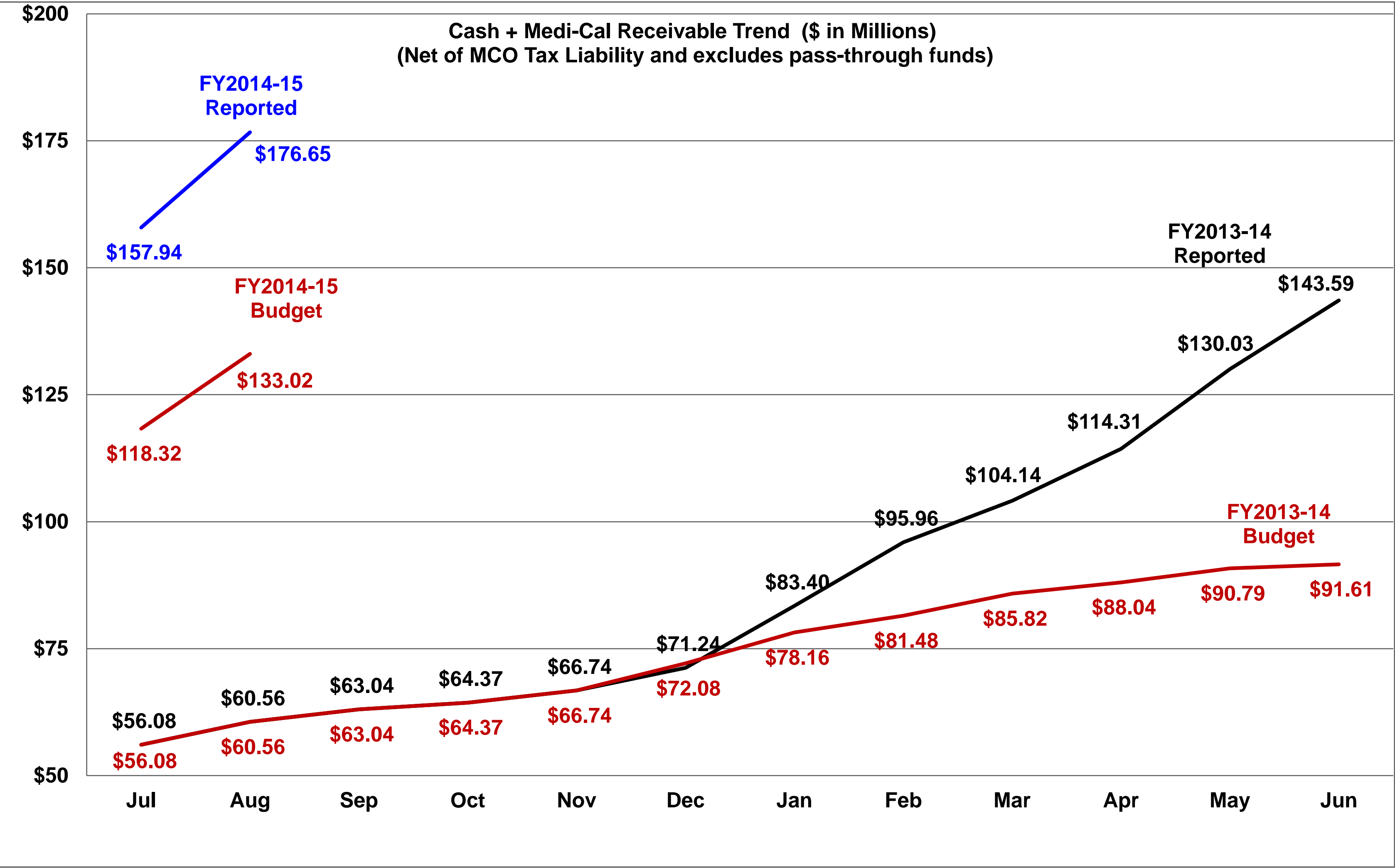
	August 31, 2014	July 31, 2014	June 30, 2014	Audited FY 2012-13
ASSETS				
Current Assets				
Total Cash and Cash Equivalents	**$ 124,801,815**	**$ 61,568,613**	**$ 60,176,698**	**$ 50,817,760**
Medi-Cal Receivable*	64,217,509	106,497,750	99,807,123	11,683,076
Provider Receivable	411,036	451,665	395,129	1,161,379
Other Receivables	173,540	534,822	1,458,481	300,397
Total Accounts Receivable	**64,802,086**	**107,484,237**	**101,660,733**	**13,144,852**
Total Prepaid Accounts	1,073,641	1,172,196	1,151,757	324,419
Total Other Current Assets	79,079	79,079	81,719	10,000
Total Current Assets	**190,756,622**	**170,304,125**	**163,070,907**	**64,297,030**
Total Fixed Assets	**1,162,985**	**1,173,456**	**1,163,269**	**230,913**
Total Assets	**$ 191,919,606**	**$ 171,477,581**	**$ 164,234,176**	**$ 64,527,943**
LIABILITIES & FUND BALANCE				
Current Liabilities				
Incurred But Not Reported	$ 117,199,839	$ 102,120,547	$ 89,252,777	$ 29,901,103
Claims Payable	9,737,671	8,427,358	9,482,660	9,748,676
Capitation Payable	2,253,578	2,142,484	2,054,265	1,002,623
Physician ACA 1202 Payable	3,222,776	3,222,776	3,222,776	-
AB85 Payable	1,079,935	979,634	1,411,679	
Accrued Premium Reduction	842,917	842,917	842,917	-
Accounts Payable	247,671	1,420,993	2,875,629	1,751,419
Accrued ACS	1,248,022	1,204,802	-	422,138
Accrued Expenses	614,925	695,771	655,679	477,477
Accrued Premium Tax	11,292,429	9,149,250	14,985,060	7,337,759
Accrued Interest Payable	47,215	44,662	42,062	9,712
Current Portion of Deferred Revenue	460,000	460,000	460,000	460,000
Accrued Payroll Expense	596,812	558,034	760,032	605,937
Current Portion Of Long Term Debt	-	-	-	-
Other Current Liabilities	-	-	-	-
Total Current Liabilities	**148,843,790**	**131,269,227**	**126,045,534**	**51,716,843**
Long-Term Liabilities				
Other Long-term Liability-Deferred Rent	139,945	105,895	71,845	-
Deferred Revenue - Long Term Portion	383,333	421,667	460,000	920,000
Notes Payable	7,200,000	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	**7,723,278**	**7,727,562**	**7,731,845**	**8,120,000**
Total Liabilities	**156,567,068**	**138,996,789**	**133,777,380**	**59,836,843**
Beginning Fund Balance	30,456,797	30,456,797	4,691,101	(6,031,881)
Net Income Current Year	4,895,742	2,023,996	25,765,696	10,722,981
Total Fund Balance	**35,352,539**	**32,480,792**	**30,456,797**	**4,691,100**
Total Liabilities & Fund Balance	**$ 191,919,606**	**$ 171,477,581**	**$ 164,234,176**	**$ 64,527,943**
	-			

FINANCIAL INDICATORS				
Current Ratio	1.28 : 1	1.3 : 1	1.29 : 1	1.24 : 1
Days Cash on Hand	77	39	46	58
Days Cash + State Capitation Receivable	117	106	121	72
Days Cash + State Capitation Rec (less Tax Liab)	110	100	110	63

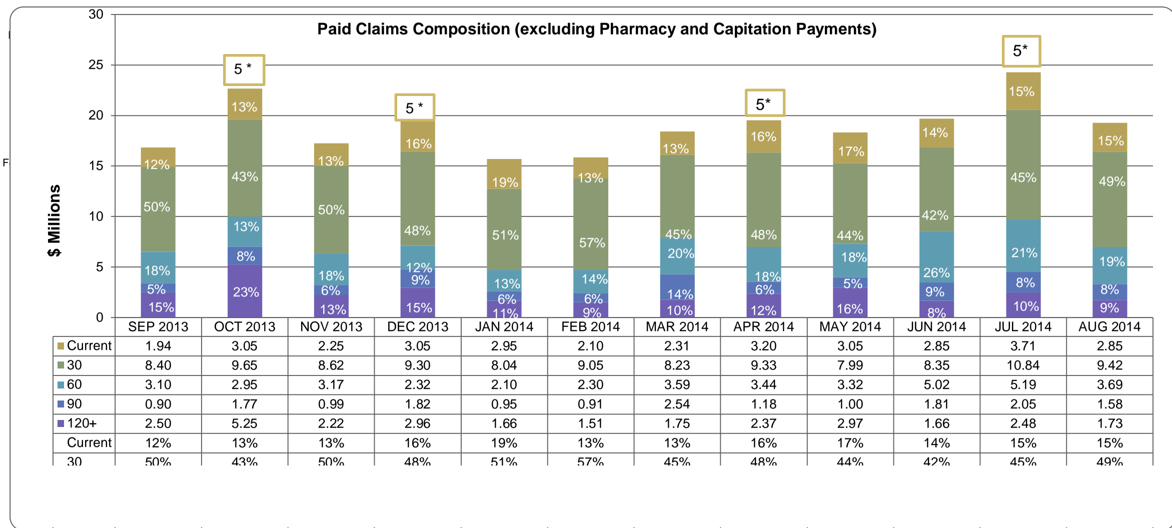
For the month ended August 31, 2014

APPENDIX

- Cash Trend combined
- Paid Claims & IBNP composition
- Monthly Cash Flow
- YTD Cash Flow
- Income Statement YTD
- Total Expenditure Composition
- Pharmacy Cost & Utilization Trends

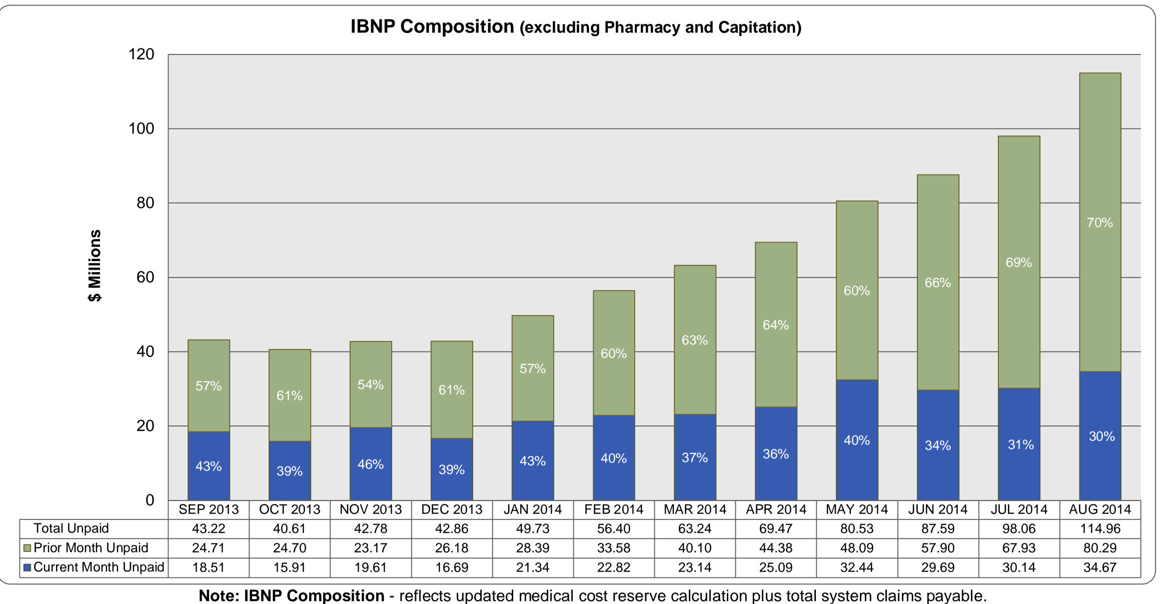


Cash + Medi-Cal Receivable Trend ($ in Millions)
(Net of MCO Tax Liability and excludes pass-through funds)
$200
$175
$150
$125
$100
$75
$50
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2014-15 Reported
$157.94
$176.65
FY2014-15 Budget
$118.32
$133.02
FY2013-14 Reported
$56.08
$60.56
$63.04
$64.37
$66.74
$71.24
$83.40
$95.96
$104.14
$114.31
$130.03
$143.59
FY2013-14 Budget
$56.08
$60.56
$63.04
$64.37
$66.74
$72.08
$78.16
$81.48
$85.82
$88.04
$90.79
$91.61



	SEP 2013	OCT 2013	NOV 2013	DEC 2013	JAN 2014	FEB 2014	MAR 2014	APR 2014	MAY 2014	JUN 2014	JUL 2014	AUG 2014
Current	1.94	3.05	2.25	3.05	2.95	2.10	2.31	3.20	3.05	2.85	3.71	2.85
30	8.40	9.65	8.62	9.30	8.04	9.05	8.23	9.33	7.99	8.35	10.84	9.42
60	3.10	2.95	3.17	2.32	2.10	2.30	3.59	3.44	3.32	5.02	5.19	3.69
90	0.90	1.77	0.99	1.82	0.95	0.91	2.54	1.18	1.00	1.81	2.05	1.58
120+	2.50	5.25	2.22	2.96	1.66	1.51	1.75	2.37	2.97	1.66	2.48	1.73
Current	12%	13%	13%	16%	19%	13%	13%	16%	17%	14%	15%	15%
30	50%	43%	50%	48%	51%	57%	45%	48%	44%	42%	45%	49%

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.



	SEP 2013	OCT 2013	NOV 2013	DEC 2013	JAN 2014	FEB 2014	MAR 2014	APR 2014	MAY 2014	JUN 2014	JUL 2014	AUG 2014
Total Unpaid	43.22	40.61	42.78	42.86	49.73	56.40	63.24	69.47	80.53	87.59	98.06	114.96
Prior Month Unpaid	24.71	24.70	23.17	26.18	28.39	33.58	40.10	44.38	48.09	57.90	67.93	80.29
Current Month Unpaid	18.51	15.91	19.61	16.69	21.34	22.82	23.14	25.09	32.44	29.69	30.14	34.67

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

Statement of Cash Flows - Monthly

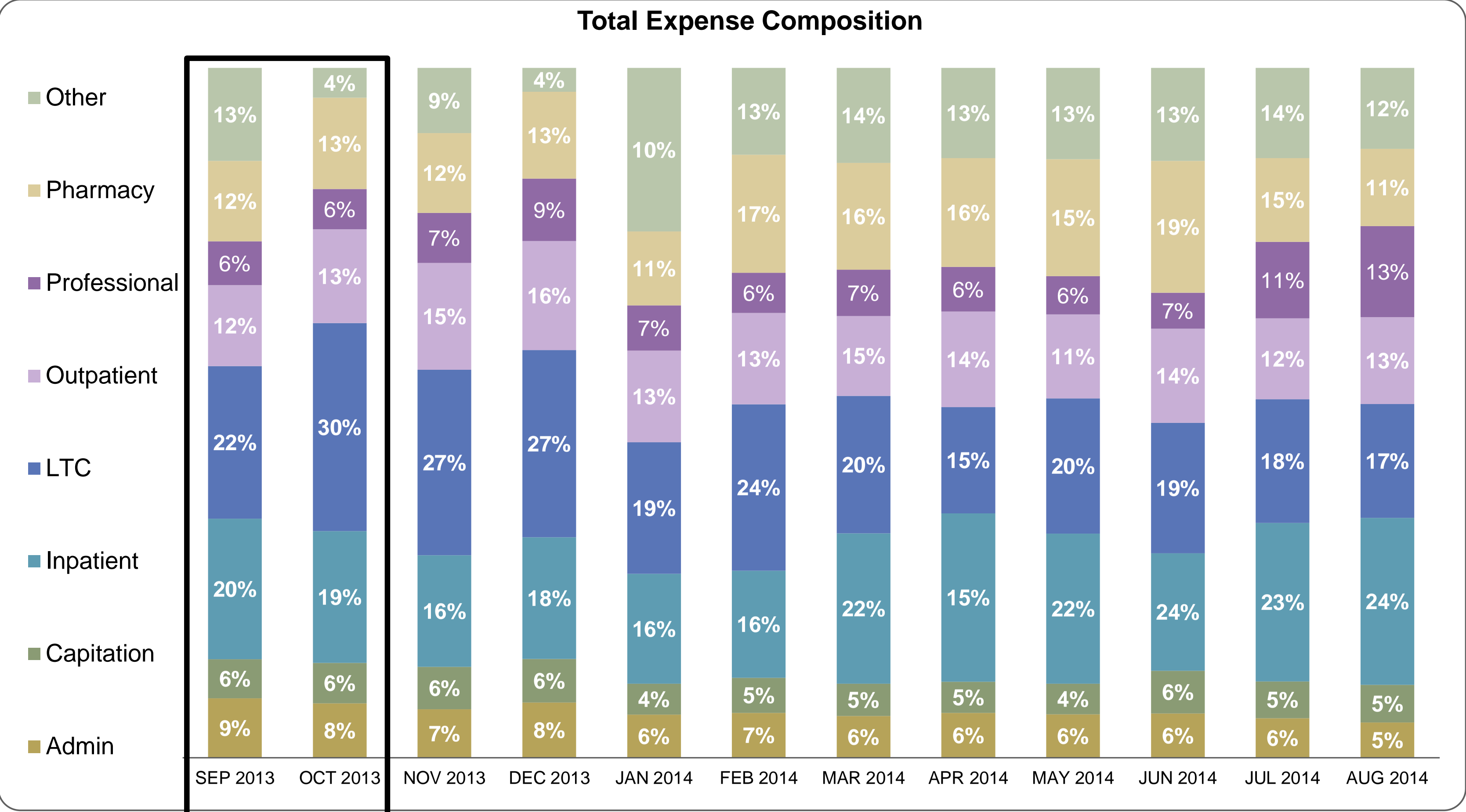
	AUG '14	JULY '14	JUNE '14
Cash Flow From Operating Activities			
Collected Premium	$ 94,832,281	$ 45,212,063	$ -
Miscellaneous Income	25,986	14,142	16,066
State Pass Through Funds	1,882,392	717,413	-
Paid Claims			
Medical & Hospital Expenses	(19,339,369)	(23,318,973)	(19,798,531)
Pharmacy	(6,254,420)	(5,751,973)	(5,842,805)
Capitation	(2,557,362)	(2,464,945)	(1,913,772)
Reinsurance of Claims	(444,200)	(637,110)	(352,660)
State Pass Through Funds Distributed	(2,224,871)	-	(684,016)
Paid Administration	(2,668,390)	(4,432,355)	(3,093,374)
MCO Tax Received / (Paid)	-	(7,908,088)	
Net Cash Provided/ (Used) by Operating Activities	**63,252,047**	**1,430,176**	**(31,669,093)**
Cash Flow From Investing/Financing Activities			
Proceeds from Line of Credit			
Repayments on Line of Credit	-	-	-
Net Acquisition of Property/Equipment	(18,845)	(38,262)	3,774
Net Cash Provided/(Used) by Investing/Financing	**(18,845)**	**(38,262)**	**3,774**
Net Cash Flow	**$ 63,233,203**	**$ 1,391,914**	**$ (31,665,320)**
Cash and Cash Equivalents (Beg. of Period)	61,568,613	60,176,698	91,842,018
Cash and Cash Equivalents (End of Period)	124,801,815	61,568,613	60,176,698
	$ 63,233,203	**$ 1,391,914**	**$ (31,665,320)**
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	2,871,746	2,023,996	6,850,171
Loss on asset disposal	-	-	-
Depreciation & Amortization	29,316	28,075	(64,170)
Decrease/(Increase) in Receivables	42,682,152	(5,823,505)	(49,406,500)
Decrease/(Increase) in Prepaids & Other Current Assets	98,554	(17,799)	(99,024)
(Decrease)/Increase in Payables	(1,069,316)	(841,185)	(714,584)
(Decrease)/Increase in Other Liabilities	(4,284)	(4,284)	33,512
Changes in Withhold / Risk Incentive Pool	-	-	-
Change in MCO Tax Liability	2,143,179	(5,835,810)	1,988,140
Changes in Claims and Capitation Payable	1,421,408	(967,083)	1,305,279
Changes in IBNR	15,079,291	12,867,771	8,438,082
	63,252,047	1,430,176	(31,669,093)
Net Cash Flow from Operating Activities	**$ 63,252,047**	**$ 1,430,176**	**$ (31,669,093)**

Income Statement
For Two Month Ended August 31, 2014

	August '14 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	323,336	316,548	6,788
Revenue			
Premium	$ 105,083,619	$ 98,433,254	$ 6,650,365
Reserve for Rate Reduction	-	-	-
MCO Premium Tax	(4,137,668)	(3,875,809)	(261,858)
Total Net Premium	**100,945,951**	**94,557,444**	**6,388,507**
Other Revenue:			
Interest Income	40,129	32,483	7,646
Miscellaneous Income	76,667	76,666	1
Total Other Revenue	116,795	**109,149**	7,647
Total Revenue	**101,062,747**	**94,666,593**	**6,396,153**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & \	5,212,961	5,289,635	76,674
FFS Claims Expenses:			
Inpatient	22,672,600	19,205,577	(3,467,023)
LTC/SNF	16,560,280	14,972,709	(1,587,572)
Outpatient	6,487,202	5,102,025	(1,385,177)
Laboratory and Radiology	1,945,645	1,436,832	(508,814)
Physician ACA 1202	-	-	-
Emergency Room	3,263,537	2,966,814	(296,723)
Physician Specialty	6,916,257	6,321,384	(594,873)
Primary Care Physician	4,775,130	4,821,411	46,281
Home & Community Based Services	2,589,883	1,668,029	(921,854)
Mental Health Services	784,794	1,466,037	681,243
Pharmacy	11,220,979	16,941,166	5,720,187
Other Medical Professional	608,801	514,431	(94,371)
Other Medical Care	-	-	-
Other Fee For Service	4,024,263	1,825,237	(2,199,026)
Transportation	490,647	586,284	95,637
Total Claims	83,340,020	77,827,935	(5,512,085)
Medical & Care Management Expense	2,000,584	2,076,806	76,221
Reinsurance	515,481	386,189	(129,292)
Claims Recoveries	(93,642)	-	93,642
Sub-total	2,422,423	2,462,994	40,572
Total Cost of Health Care	**90,975,404**	**85,580,564**	**(5,394,840)**
Contribution Margin	**10,087,343**	**9,086,029**	**1,001,314**
General & Administrative Expenses:			
Salaries and Wages	1,302,502	1,610,006	307,504
Payroll Taxes and Benefits	374,584	408,120	33,535
Travel and Training	19,151	42,495	23,344
Outside Service - ACS	2,511,204	2,380,376	(130,829)
Outside Service - RGS	-	-	-
Outside Services - Other	196,390	243,195	46,806
Accounting & Actuarial Services	31,228	90,000	58,773
Legal	213,821	66,666	(147,155)
Insurance	46,592	29,167	(17,425)
Lease Expense - Office	126,635	128,708	2,073
Consulting Services	98,307	309,602	211,295
Translation Services	5,563	14,166	8,603
Advertising and Promotion	4,024	25,968	21,944
General Office	172,401	534,898	362,497
Depreciation & Amortization	29,074	36,031	6,956
Printing	9,523	42,540	33,017
Shipping & Postage	23,800	32,684	8,884
Interest	26,800	30,000	3,200
Other/ Miscellaneous Expenses	-	-	-
Total G & A Expenses	**5,191,601**	**6,024,622**	**833,021**
Net Income / (Loss)	**$ 4,895,742**	**$ 3,061,407**	**$ 1,834,334**

Statement of Cash Flows - YTD

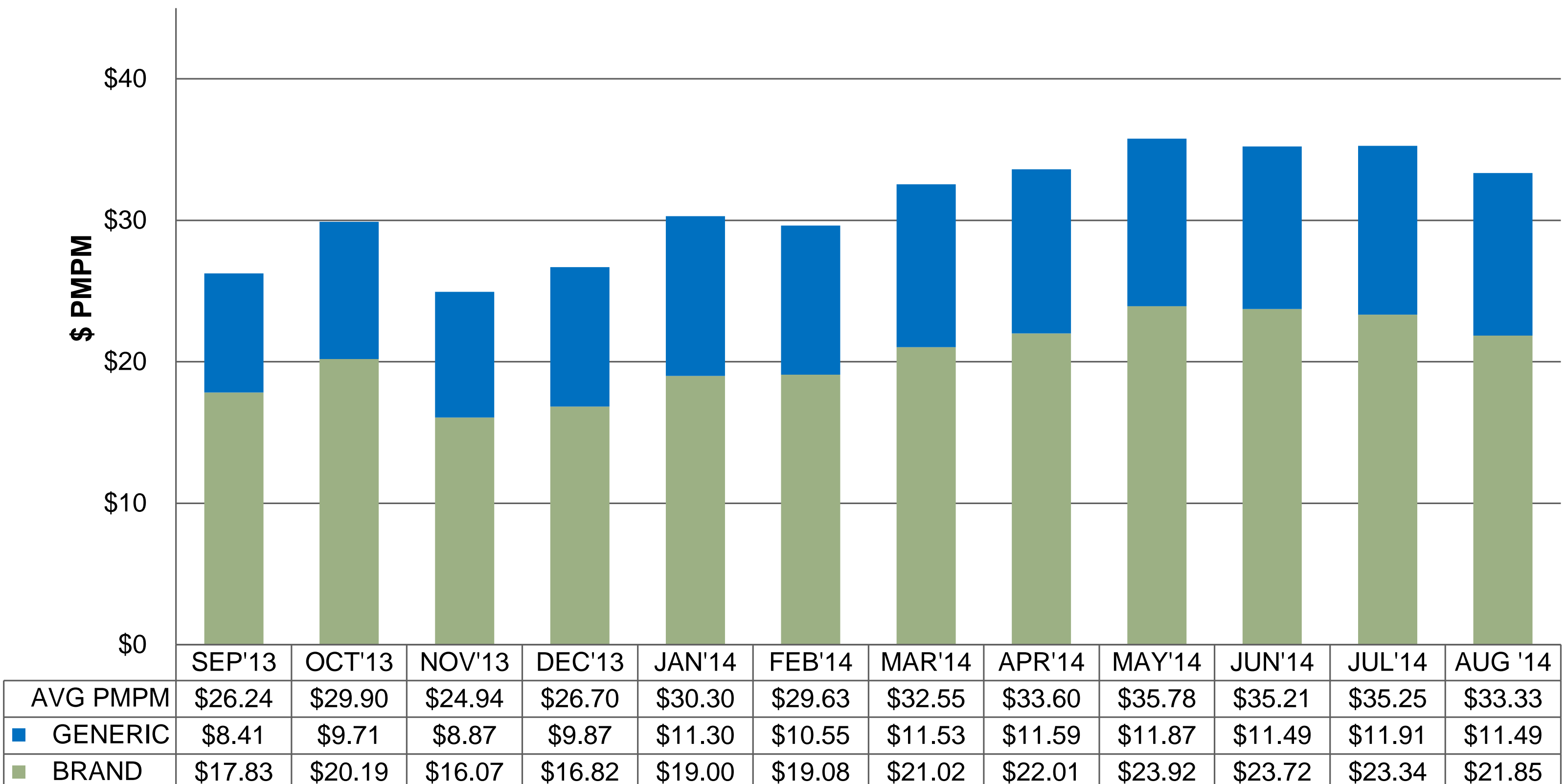
	AUG 2014 YTD
Cash Flow From Operating Activities	
Collected Premium	$ 140,044,345
Miscellaneous Income	40,129
State Pass Through Funds	2,599,805
Paid Claims	
Medical & Hospital Expenses	(42,658,341)
Pharmacy	(12,006,394)
Capitation	(5,022,306)
Reinsurance of Claims	(1,081,309)
State Pass Through Funds Distributed	(2,224,871)
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(7,100,745)
Repay Initial Net Liabilities	-
MCO Taxes Received / (Paid)	(7,908,088)
Net Cash Provided/(Used) by Operating Activities	**64,682,224**
Cash Flow From Investing/Financing Activities	
Proceeds from Line of Credit	-
Repayments on Line of Credit	-
Net Acquisition of Property/Equipment	(57,107)
Net Cash Provided/(Used) by Investing/Financing	**(57,107)**
Net Cash Flow	**$ 64,625,117**
Cash and Cash Equivalents (Beg. of Period)	61,568,613
Cash and Cash Equivalents (End of Period)	124,801,815
	$ 63,233,203
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	4,895,742
Depreciation & Amortization	57,391
Decrease/(Increase) in Receivables	36,858,647
Decrease/(Increase) in Prepaids & Other Current Assets	80,755
(Decrease)/Increase in Payables	(1,910,500)
(Decrease)/Increase in Other Liabilities	(8,567)
Change in MCO Tax Liability	(3,692,631)
Loss on asset disposal	-
Changes in Claims and Capitation Payable	454,325
Changes in IBNR	27,947,062
	64,682,224
Net Cash Flow from Operating Activities	**$ 64,682,224**



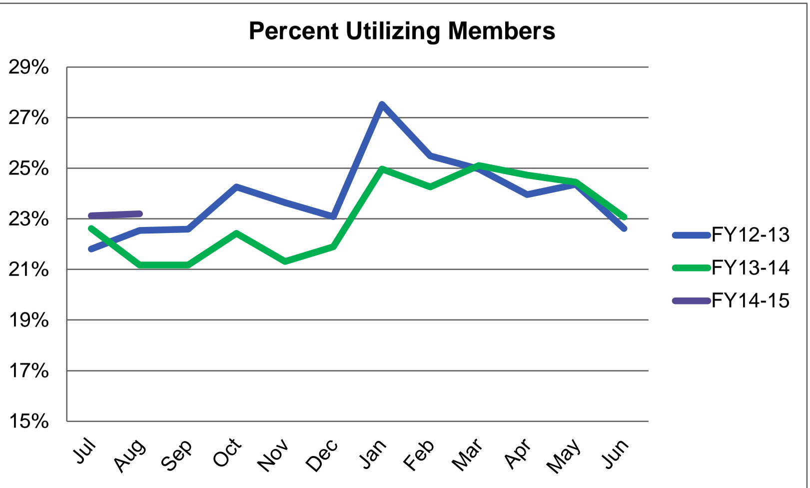
In May 2013, GCHP changed its method of distributing Health Care Costs (HCC) across categories of service. Prior months utilized an allocation methodology. The methodology was updated to utilize payment information by different categories of services. Further changes have been made with the assumption of the TLIC population and its affect on various categories of service. Therefore, the months of May - August represent the transitioning to a new methodology.

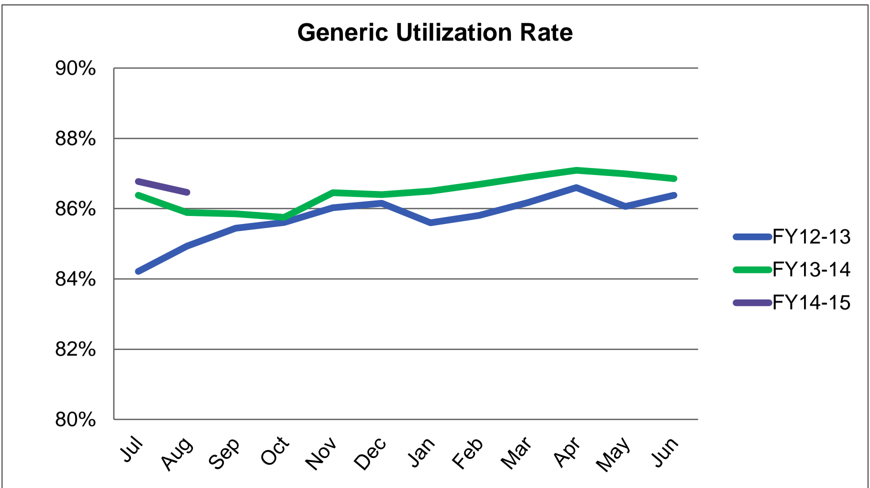
Beginning January 2014, "Other" category includes ACA 1202 physician supplement and mental health expenses.

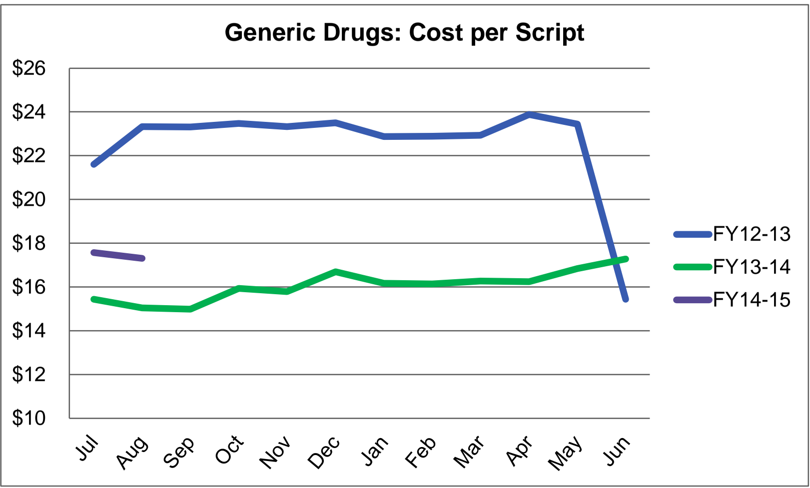
Pharmacy Cost Trend

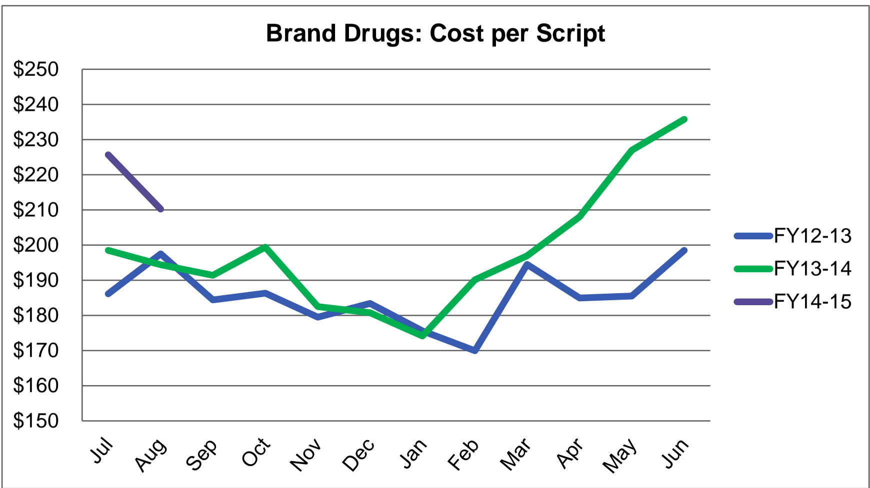


	SEP'13	OCT'13	NOV'13	DEC'13	JAN'14	FEB'14	MAR'14	APR'14	MAY'14	JUN'14	JUL'14	AUG '14
AVG PMPM	$26.24	$29.90	$24.94	$26.70	$30.30	$29.63	$32.55	$33.60	$35.78	$35.21	$35.25	$33.33
GENERIC	$8.41	$9.71	$8.87	$9.87	$11.30	$10.55	$11.53	$11.59	$11.87	$11.49	$11.91	$11.49
BRAND	$17.83	$20.19	$16.07	$16.82	$19.00	$19.08	$21.02	$22.01	$23.92	$23.72	$23.34	$21.85


Percent Utilizing Members
29%
27%
25%
23%
21%
19%
17%
15%
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY12-13
FY13-14
FY14-15


Generic Utilization Rate
90%
88%
86%
84%
82%
80%
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY12-13
FY13-14
FY14-15


Generic Drugs: Cost per Script
$26
$24
$22
$20
$18
$16
$14
$12
$10
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY12-13
FY13-14
FY14-15


Brand Drugs: Cost per Script
$250
$240
$230
$220
$210
$200
$190
$180
$170
$160
$150
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY12-13
FY13-14
FY14-15

AGENDA ITEM 3d

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: October 27, 2014

Re: COO Update

OPERATIONS UPDATE

Membership

Gold Coast Health Plan continued to see growth on the October Enrollment file, adding 4,238 members to the Plan. GCHP's membership as of October 1, 2014 is 167,598, which represents an increase of 47,086 members (approximately 39%) since January 1, 2014. The cumulative new membership since January 1st is summarized as follows:

L1 (Low Income Health Plan) – 7,443
M1 (Adult Expansion) – 23,569
7U (CalFresh Adults) – 3,312
7W (CalFresh Children) – 296
Traditional Medi-Cal – 12,466

Members with Traditional aid codes accounted for the majority of October's growth, adding 3,104 new members. Membership in all Medi-Cal Expansion aid codes, with the exception of M1, continued to decrease in October:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
L1	7,618	8,083	8,154	8,134	8,118	7,975	7,839	7,726	7,568	7,443
M1	183	1,550	2,482	4,514	7,279	10,910	15,606	18,585	21,944	23,569
7U	0	0	1,741	3,584	3,680	3,515	3,453	3,400	3,368	3,312
7W	0	0	0	684	714	691	667	624	606	296

Member Orientation Meetings – the GCHP Member Services department has worked to increase the attendance of members at Member Orientation Meetings. Meetings are now held in multiple locations throughout the county and include Saturday and evening sessions. The most significant impact has been the inclusion of meeting information in new member packets. A total of 28 members attended meetings during the first six month of

2014. We started including the informational flyer in member packets beginning July 2014 and 98 members have attended orientation meetings during July, August and September.

September 2014 Operations Summary

Claims Inventory – ended the month with an inventory of 32,872 claims; this equates to Days Receipt on Hand (DROH) of 7 days. We received approximately 10,500 more claims in September than the prior month. Claim receipts from January through September are as follows:

- January - 91,130
- February - 90,048
- March - 109,857
- April - 110,855
- May - 108,312
- June - 116,474
- July - 117,136
- August - 108,695
- September - 119,233

Claims TAT – the regulatory requirement of processing 90% of clean claims within 30 calendar days was not met in September. The results for September were 83.2%; Xerox is on track to meet this metric for October.

Claims Processing Accuracy – financial accuracy remained on goal in September with results coming in at 98.74%. Procedural accuracy also exceeded the goal in August at 99.97%.

Call Volume – call volume continues to increase and remained above 10,000 for the third straight month. GCHP received 10,508 calls in the month of September.

Average Speed to Answer – we continue to exceed the goal of answering calls within 30 seconds or less. The combined results for September were 17.4 seconds.

Abandonment Rate – the abandonment rate continues to remain exceedingly low. The goal is 5% or less of the calls received being abandoned; we have remained below 1% for 12 consecutive months.

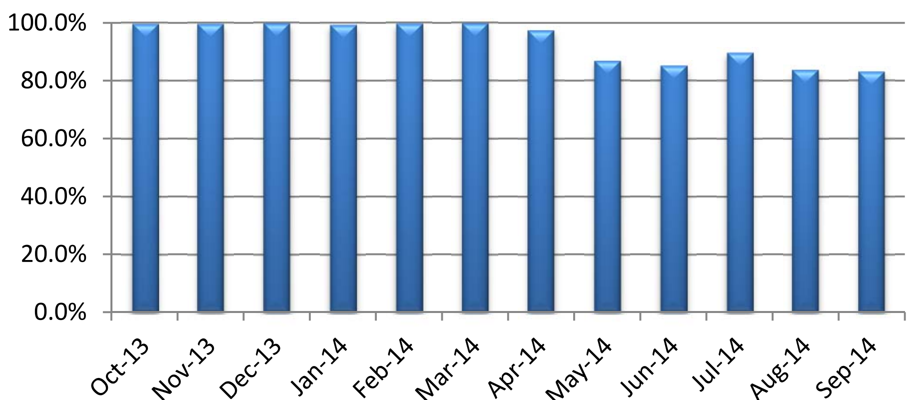
Average Call Length – the combined result of 6.63 minutes in September met the goal of 7 minutes or less although the provider and Spanish calls were slightly over 7 minutes during month.

Noteworthy Activities – Operations continues to lead or be involved in the following projects:

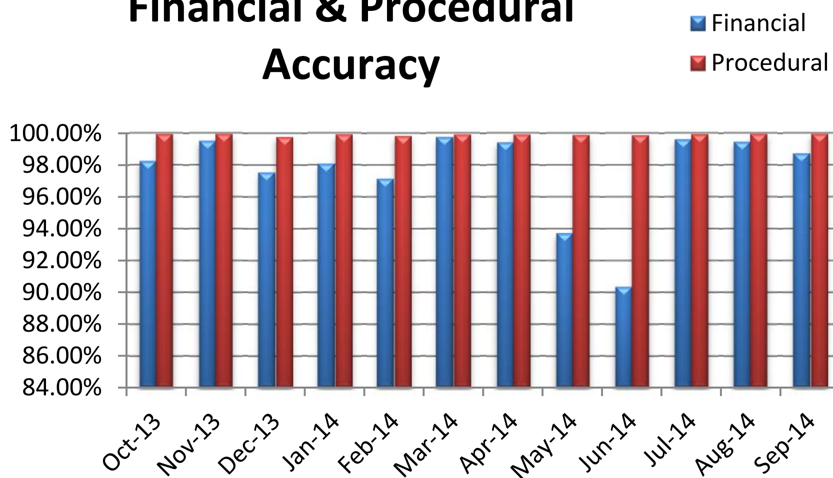
- 35C to 837 Encounter Data Transition – DHCS continued to maintain an effective date of October 1, 2014 for this project even though the State has not completed testing with any plans statewide. DHCS will allow plans to submit in the old format until November 12, 2014. GCHP has moved successfully through all phases of testing to date and anticipates moving into production in November.
- Encounter Data Improvement Project (EDIP) – improve the quality of the data sent to DHCS in order to meet new quality measures established by the State beginning January 2015.
- Grievance and Appeals Improvement Project – the Grievance & Appeals Department officially launched on October 1, 2014 and marked the occasion with an Open House so GCHP employees could visit the department and learn more about Grievance & Appeals.
- ICD-10 Readiness – regulatory requirement to implement new code set effective October 1, 2015.
- Crossover Claims – preliminary project work commenced August 2014
- Plan Selection – PCP selection during sign-up via Covered California; information matched once Medi-Cal beneficiary becomes a GCHP member. DHCS has canceled the monthly conference calls with the COHS and is currently focusing on non-COHS plans.

GCHP Claims Metrics – September 2014

- 30 Day Turnaround Time was not met during September but is trending towards goal in October
- Ending Inventory equals 7 Days Receipt on Hand (DROH) compared to goal of 5 days
- Financial and Procedural Accuracy both exceeded required Service Levels



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

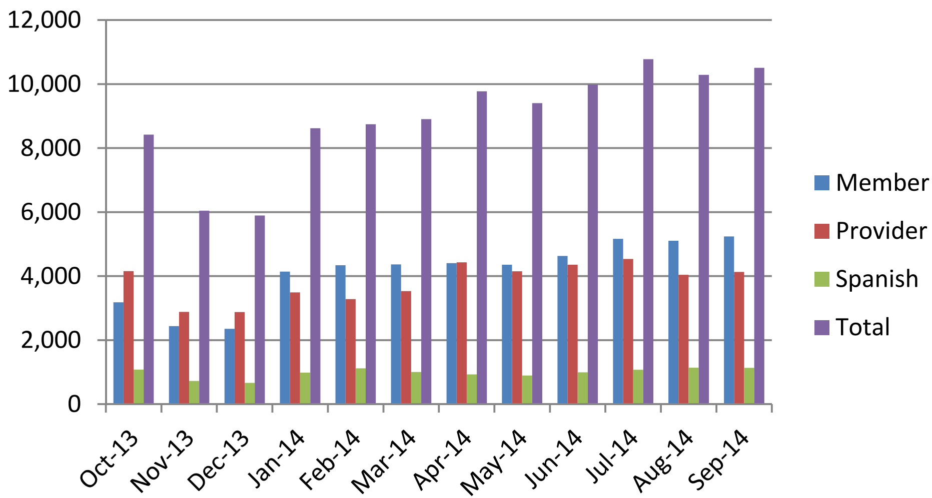


Financial Accuracy – 98% or higher
Procedural Accuracy – 97% or higher

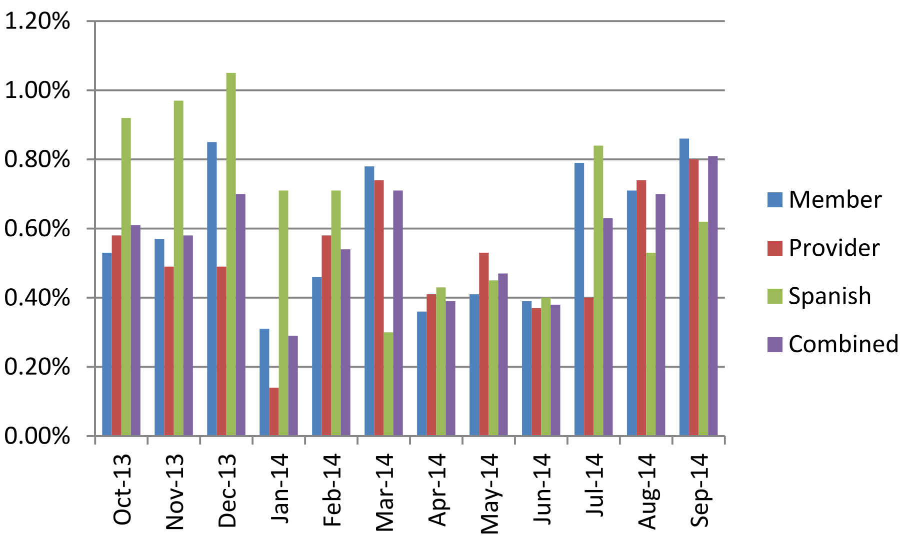
GCHP Call Center Metrics – September 2014

- Call volume exceeded 10,000 for the third month in a row
- Abandonment rate and ASA remain well within goal

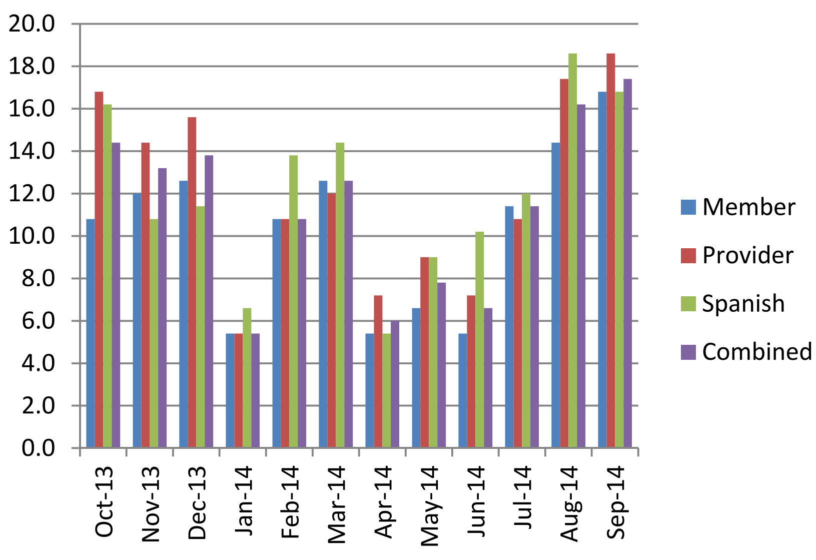
Call Center Volume



Abandonment Rate
(goal is 5% of less)

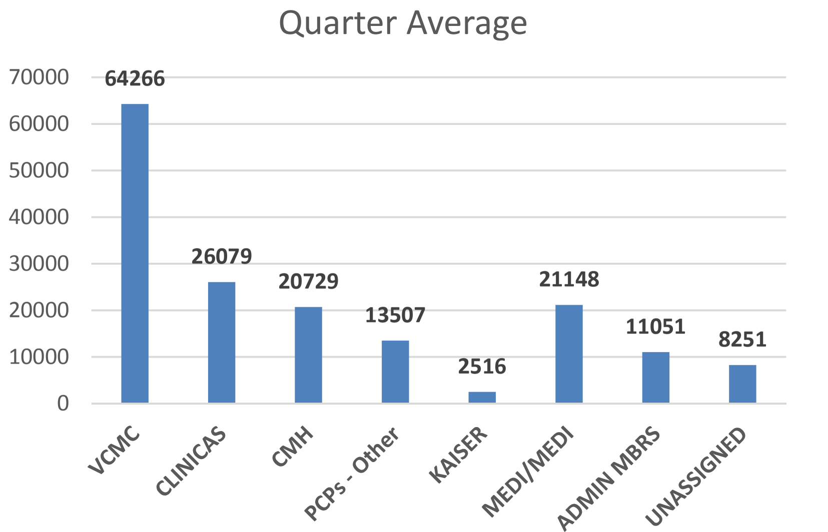


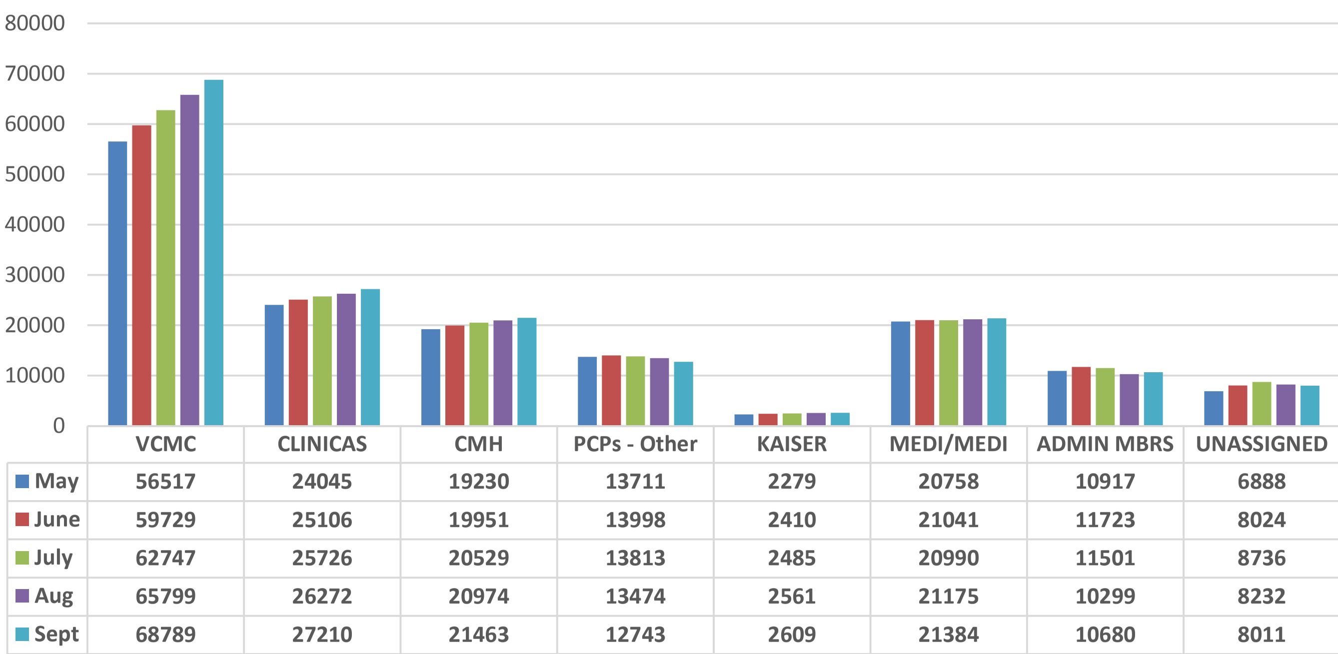
Average Speed of Answer (ASA)
(goal is 30 seconds or less)



GCHP Membership allocation – September 2014

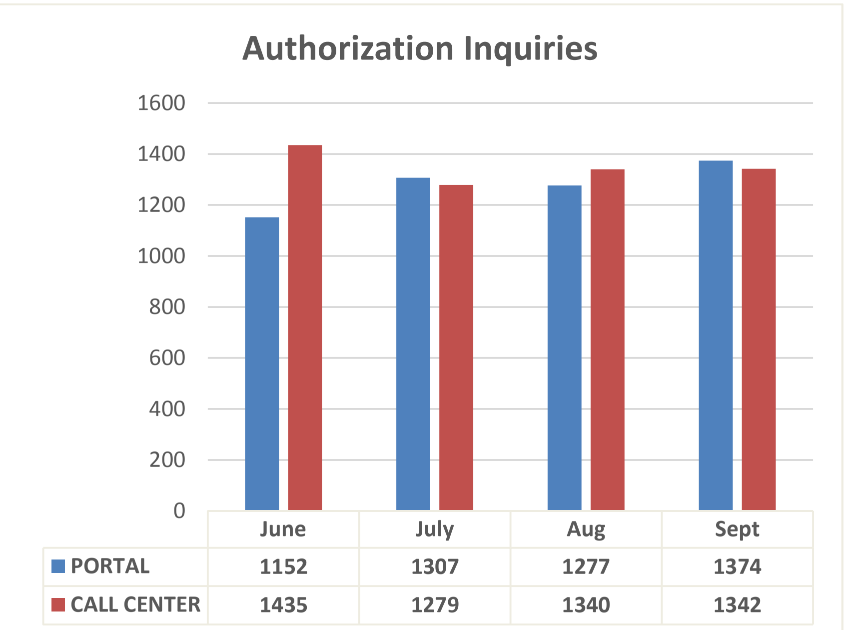
- Membership counts by PCP as of first day of each month.
- Unassigned members are Newly Eligible/Enrolled
- ADMIN members count is the remainder after deducting those with Medicare Coverage but includes those with SOC and OHI.

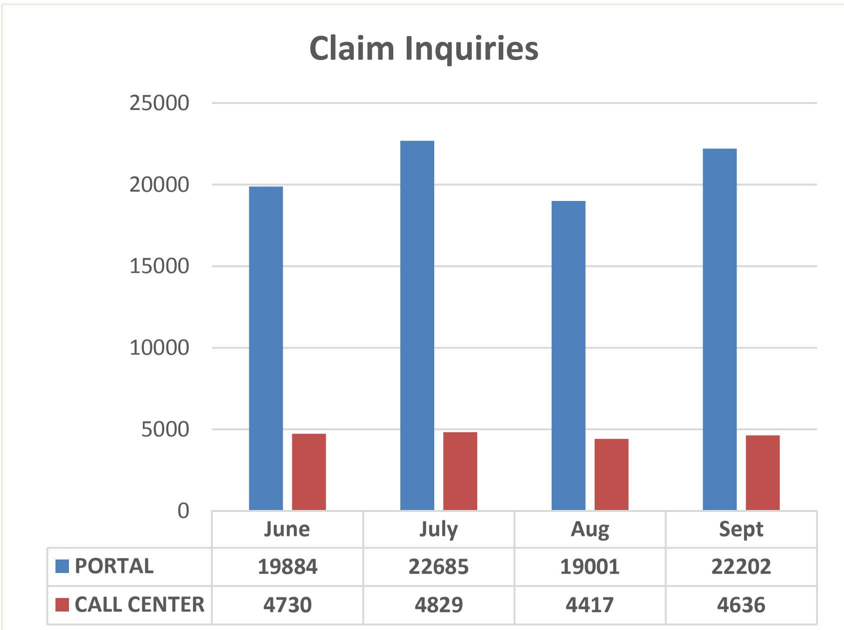


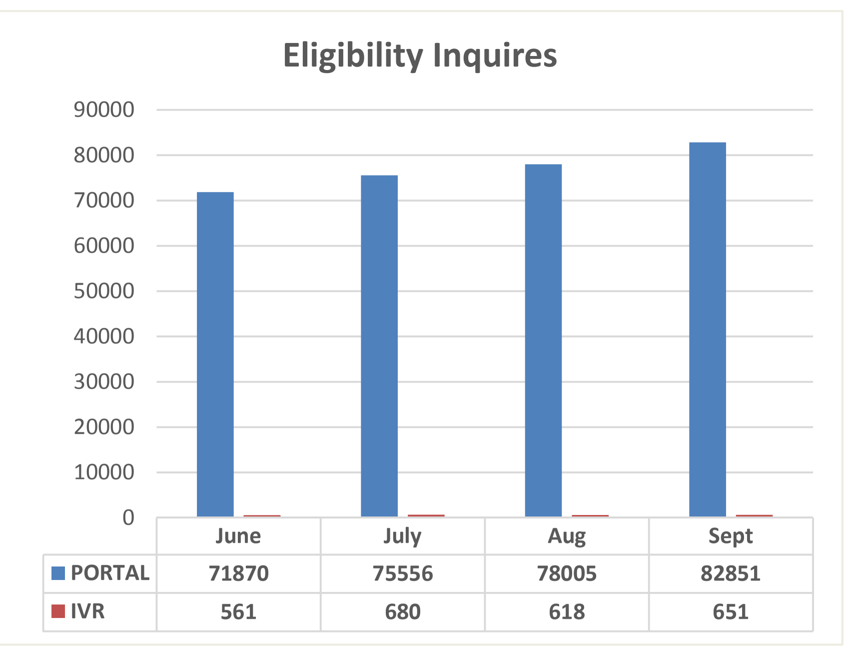


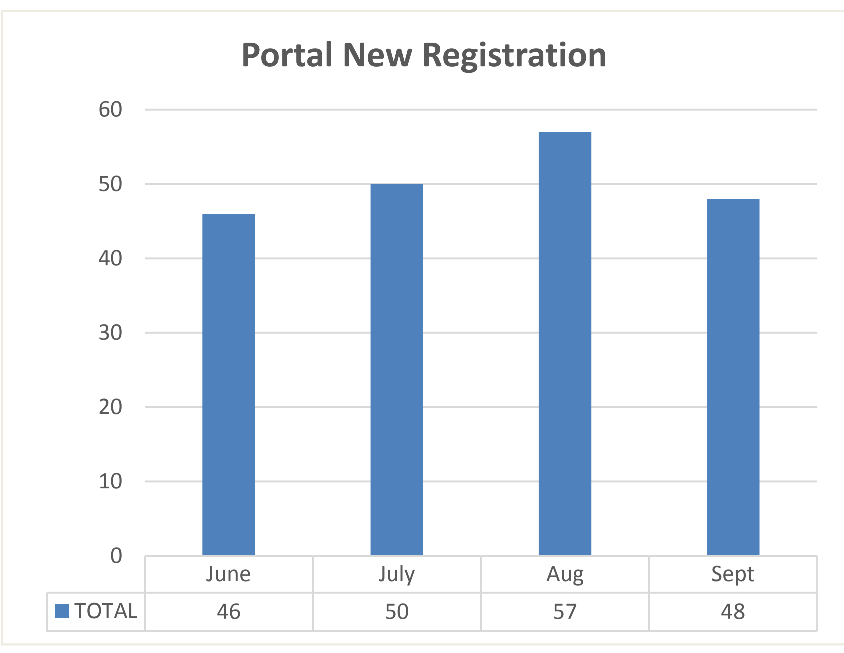
	VCMC	CLINICAS	CMH	PCPs - Other	KAISER	MEDI/MEDI	ADMIN MBRS	UNASSIGNED
May	56517	24045	19230	13711	2279	20758	10917	6888
June	59729	25106	19951	13998	2410	21041	11723	8024
July	62747	25726	20529	13813	2485	20990	11501	8736
Aug	65799	26272	20974	13474	2561	21175	10299	8232
Sept	68789	27210	21463	12743	2609	21384	10680	8011

GCHP Provider Portal/Call Usage









GCHP Auto Assignment by PCP/Clinic as of October 1, 2014

	Oct-14		Sep-14		Aug-14		Jul-14		Jun-14		May-14		Apr-14		Mar-14		Feb-14		Jan-14	
	Count	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
AB85 Eligible	**2,494**		**2,726**		**3,687**		**2,775**		**2,250**		**2,535**		**2,598**		**176**					
VCMC	1,870	74.98%	2,044	74.98%	2,765	74.99%	2,081	74.99%	1,687	74.98%	1,901	74.99%	1,948	74.98%	132	75.00%				
Balance	624	25.02%	682	25.02%	922	25.01%	694	25.01%	563	25.02%	634	25.01%	650	25.02%	44	25.00%				
Regular Eligible	**1,631**		**2,192**		**1,698**		**2,512**		**1,584**		**1,162**		**1,456**		**1,160**		**911**		**998**	
Regular + AB85 Balance	**2,255**		**2,874**		**2,620**		**3,206**		**2,147**		**1,796**		**2,106**		**1,204**		**911**		**998**	
Clinicas	529	23.46%	666	23.17%	610	23.28%	649	20.24%	478	22.26%	396	22.05%	481	22.84%	265	22.01%	183	20.09%	210	21.04%
CMH	261	11.57%	314	10.93%	282	10.76%	330	10.29%	212	9.87%	185	10.30%	184	8.74%	116	9.63%	70	7.68%	77	7.72%
Independent	57	2.53%	69	2.40%	52	1.98%	64	2.00%	44	2.05%	56	3.12%	53	2.52%	48	3.99%	37	4.06%	35	3.51%
VCMC	1,408	62.44%	1,825	63.50%	1,676	63.97%	2,163	67.47%	1,413	65.81%	1,159	64.53%	1,388	65.91%	775	64.37%	621	68.17%	676	67.74%
Total Assigned	**4,125**		**4,918**		**5,385**		**5,287**		**3,834**		**3,697**		**4,054**		**1,336**					
Clinicas	529	12.82%	666	13.54%	610	11.33%	649	12.28%	478	12.47%	396	10.71%	481	11.86%	265	19.84%				
CMH	261	6.33%	314	6.38%	282	5.24%	330	6.24%	212	5.53%	185	5.00%	184	4.54%	116	8.68%				
Independent	57	1.38%	69	1.40%	52	0.97%	64	1.21%	44	1.15%	56	1.51%	53	1.31%	48	3.59%				
VCMC	3,278	79.47%	3,869	78.67%	4,441	82.47%	4,244	80.27%	3,100	80.86%	3,060	82.77%	3,336	82.29%	907	67.89%				

	Dec-13		Nov-13		Oct-13		Sep-13		Aug-13		Jul-13		Jun-13		May-13		Apr-13		Mar-13		Feb-13		Jan-13	
	Count	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Regular Eligible	**749**		**1,002**		**2,468**		**1,263**		**878**		**1,247**		**1,336**		**830**		**1,419**		**1,755**		**505**		**1,560**	
Clinicas	152	20.29%	212	21.16%	506	20.50%	276	21.85%	182	20.73%	300	24.06%	398	29.79%	258	31.08%	401	28.26%	706	40.23%	114	22.57%	378	24.23%
CMH	58	7.74%	79	7.88%	190	7.70%	100	7.92%	69	7.86%	113	9.06%	126	9.43%	65	7.83%	156	10.99%	144	8.21%	55	10.89%	174	11.15%
Independent	27	3.60%	32	3.19%	70	2.84%	42	3.33%	35	3.99%	46	3.69%	40	2.99%	33	3.98%	62	4.37%	30	1.71%	32	6.34%	80	5.13%
VCMC	512	68.36%	679	67.76%	1702	68.96%	845	66.90%	592	67.43%	788	63.19%	772	57.78%	474	57.11%	800	56.38%	875	49.86%	304	60.20%	928	59.49%

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
- AB85 assignment began in March 2014 for members eligible in January 2014

Gold Coast Health Plan[SM]
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM 3e

To: Gold Coast Health Plan Commission

From: Melissa Scrymgeour, Chief Information Officer

Date: October 27, 2014

Re: CIO Update

Infrastructure and Systems

As reported during the September 29, 2014 Commission Meeting, GCHP has experienced a number of post-implementation issues with the MedHOK Medical Management (MMS) system that have prevented the Plan from recognizing the full benefits of the solution. GCHP Health Services Staff is able to use MedHOK to perform standard functions around utilization and case management, ensuring members receive timely and medically necessary medical. A task force comprised of GCHP business, IT and MedHOK resources is actively working through a prioritized list of remaining open issues. The most recent changes were implemented the last week of September. Two additional releases are scheduled over the next four to six weeks to address the remaining issues.

In addition to the production support activities listed above, the team continues to make progress on several MedHOK related project activities:

- MedHOK ACG Module Implementation - The ACG risk stratification tool will be useful in the development and build out of the GCHP Disease Management program.
- MedHOK SPD Enhancements - System changes required to meet State requirements for assessing, tracking and reporting case management needs for the GCHP SPD member population.
- GCHP Grievance and Appeals (G&A) Optimization - Enhancements to the G&A module were successfully implemented on October 1, 2014.

Project Management Office (PMO)

The GCHP Project Portfolio as of October 2014 consists of 26 projects either in active or planned status. Here is a summary of the accomplishments for October:

- "Grievance and Appeals Improvement Project" went live on October 1, and is currently in post-implementation monitoring, with a target to close in November.
- Closed "Disease Management Program Roadmap" project.
- Closed "ICD-10 Readiness" project.

At this time, 45% of the portfolio supports regulatory and contractual requirements and the remaining 55% are strategic or "lights on" in nature.

FY 2014-15 GCHP Projects:

- **ICD-10 Readiness:** Transition all systems and providers from ICD-9 to ICD-10 by the revised Center for Medicaid and Medicare Services (CMS) mandated date of October 15, 2015.

- **Disease Management (DM) Program:** Contractually required. Introduce formal DM program to better manage health outcomes for targeted member population. The initial Diabetes program will benefit roughly 10,000 Members and help build a model for other diseases (CHF, COPD, and Prenatal).

- **Member Satisfaction:** Gauge and measure member satisfaction with GCHP, as requested by the Commission.

- **Grievance & Appeals Optimization:** Enhance grievance and appeals processes to ensure sustained regulatory and contractual compliance.

- **Xerox / ACS Service Organization Control (SOC) Audit:** Recommended by Plan financial auditor.

- **Encounter Data Improvement Project (EDIP):** Contractual requirement for State EDIP initiative. The State requires managed care plans to submit complete, accurate, timely and reasonable encounter data in a HIPAA compliant file format.

- **Delegation & Oversight Framework:** Institute standard delegation and oversight requirements, policies, and procedures for establishing provider contracts.

- **Business Continuity Planning:** Contractual requirement to draft plan for critical business process resumption in event of emergency.

- **Disaster Recovery Planning:** Contractual requirement to draft plan for data and system recovery in event of emergency for business critical functions.

- **<u>Crossover Claims:</u>** Further optimizes claims processing accuracy and efficiencies to appropriately handle claims where a portion is covered by Medicare.
- **<u>Operationalize Information Security Program</u>** – Required to ensure ongoing HIPAA and HITECH (Health Information Technology for Economic and Clinical Health Act-2009) compliance.
- **<u>Social Media Policy & Roadmap:</u>** Establish a communication strategy via social media platforms to members, providers and the general community.
- **<u>ACA Core Administrative Simplification Rules (CORE):</u>** Regulatory requirement to utilize standard electronic transaction sets as defined under the Affordable Care Act.
- **<u>HR Flexible Work Program:</u>** Implement initiatives to attract and retain staff. Under consideration are a telework strategy, employee recognition, and flexible work schedules
- **<u>ASO or PBM RFP:</u>** Vendor evaluation and RFP for Xerox / ACS (ASO) *<u>or</u>* Scriptcare (PBM). Both contracts expire in June 2016.
- **<u>MedHOK ACG-Risk Stratification:</u>** Implement MedHOK ACG module for member risk stratification.
- **<u>Provider Contracts & Capitation Rebasing Evaluation:</u>** Evaluation of provider capitation rates.
- **<u>MedHOK Provider Portal:</u>** Implement MedHOK provider portal to streamline provider online experience for eligibility and claim inquiries, and authorization requests. Supports Plan "valued and trusted partner" strategy.
- **<u>Provider Credentialing System (PCS) RFP & Implementation:</u>** Selection and procurement of provider data and credentialing management software.
- **<u>MedHOK SPD*:</u>** Implement MedHOK functional enhancements to meet State SPD assessment and reporting requirements.
- **<u>MedHOK MMS Post Implementation*:</u>** Implement system fixes to resolve MedHOK post-implementation issues.
- **<u>ICES / IKA Upgrades*:</u>** Software version upgrade for claims processing system.

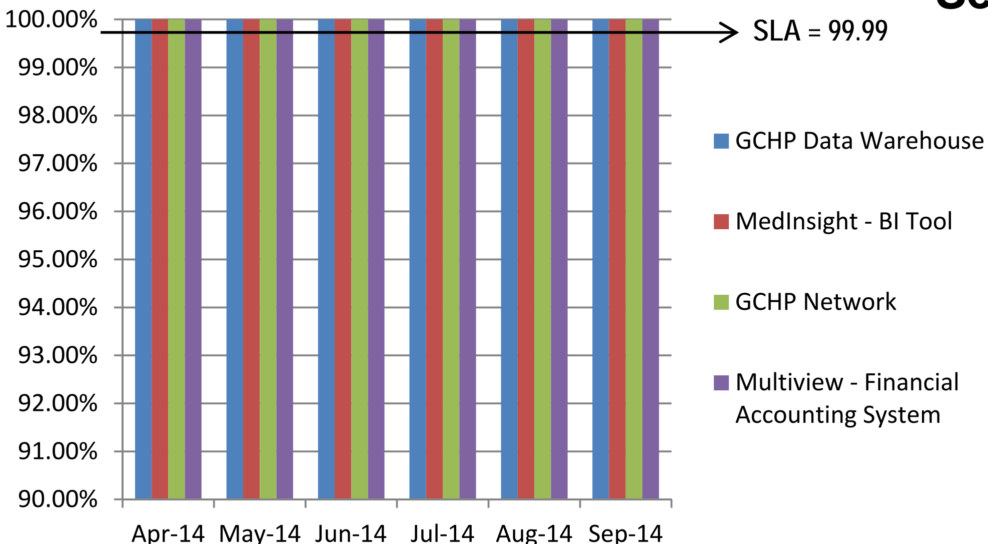
- **Data Warehouse Extract Optimization*:** Implement improvements to the nightly IKA data extract process for GCHP reporting.

- **Non-Emergent Medical Transportation (NEMT)*:** Modify non-emergent medical transportation processes to ensure sustained regulatory and contractual compliance. Analyze and evaluate alternatives to existing benefit.

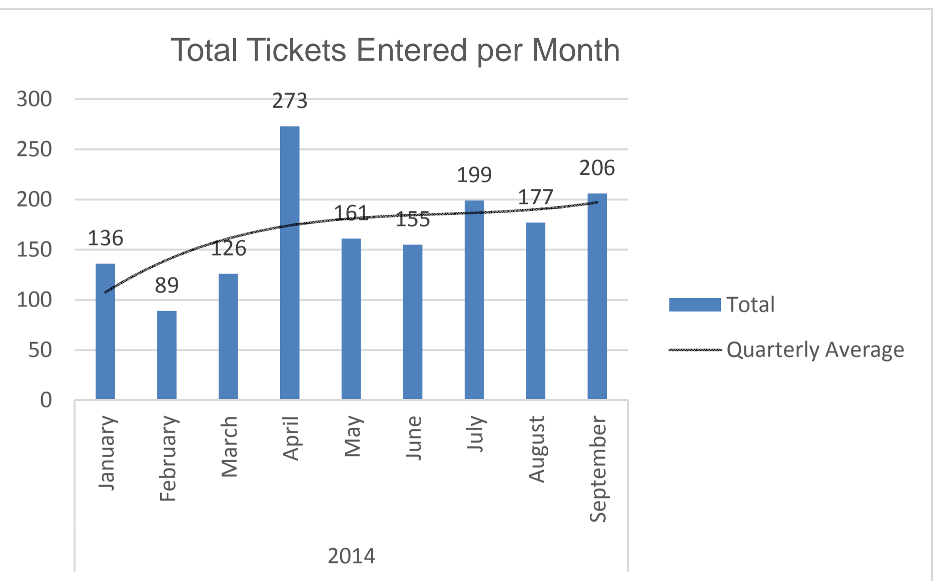
- **Behavioral Health Benefit for Autism Spectrum Disorder*:** Regulatory requirement to introduce Applied Behavioral Analysis (ABA) as a treatment for Autism Spectrum Disorder (ASD) effective September 15, 2014.

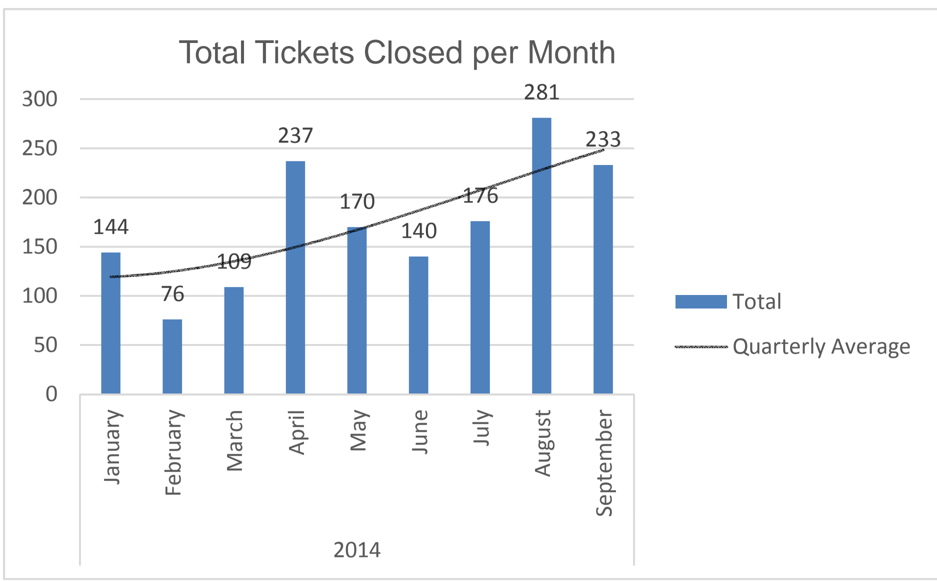
*Reflects “New” projects added since the May 19, 2014 Commission meeting.

GCHP IT Metrics – September 2014



GCHP Helpdesk Service Ticket Trending





10/2014: GCHP Projects "At a Glance"

LEGEND:
GREEN- Active Projects (Lighter GREEN reflects Project Delays/Extensions)
BLUE – Proposed FY14/15 Projects
Dark BLUE-Delayed Start

Apr-Jun 2014 | Jul-Sep 2014 | Oct-Dec 2014 | Jan-Mar 2015 | Apr-Jun 2015

- ICD-10 Readiness Phase I
- ICD-10 Readiness Phase 2
- Grievance & Appeals Optimization
- Encounter Data Improvement Program/35C to 837 Transition/Kaiser Encounter Data
- IT Disaster Recovery
- NEMT Phase 1
- NEMT Phase 2
- Diabetes Disease Management Program
- Member Satisfaction Survey
- HR Flexible Work Program: Telework Policy
- ACS Data Warehouse-Extract Optimization
- MedHOK ACG – Risk Stratification
- MedHOK MMS Post-Implementation
- ACS SOC Audit
- Business Continuity Plan (BCP)
- Crossover Claims
- ABA Behavioral Health Benefit
- Information Security Program - Operationalize
- Delegation Oversight Framework
- MedHOK SPD
- CORE: HIPAA/ACA Administrative Simplification Rules
- Provider Contracts & Capitation Rebasing Evaluation
- ICES/IKA Upgrades
- Provider Portal - MedHOK
- Social Media Policy and Roadmap
- ASO (Xerox/ACS) – Vendor for RFP Support
- ASO RFP
- OR
- PBM (Scriptcare) – Vendor for RFP Support
- PBM RFP

DHCS Medical Audit

10/2014: GCHP Projects "At a Glance"

LEGEND:
GREEN- Active Projects (Lighter GREEN reflects Project Delays/Extensions)
BLUE – Proposed FY14/15 Projects
Dark BLUE-Delayed Start

Apr-Jun 2014 | Jul-Sep 2014 | Oct-Dec 2014 | Jan-Mar 2015 | Apr-Jun 2015

DHCS Medical Audit

ICD-10 Remediation Phase 2
Encounter Data Improvement Program/35C to 837 Transition/Kaiser Encounter Data
Disease Management Program-Roadmap
Diabetes Disease Management Program
Delegation Oversight Framework
HR Flexible Work Program: Telework Policy
ACS Data Warehouse-Extract Optimization
NEMT Phase 2
CORE: HIPAA/ACA Administrative Simplification Rules
Provider Contracts & Capitation Rebasing Evaluation
Business Continuity Plan (BCP)
Provider Portal - MedHOK
Crossover Claims
Social Media Policy and Roadmap
Information Security Program - Operationalize
Provider Credentialing & Contracts System RFP (Propose moving to FY15/16)
ACS SOC Audit
ASO (Xerox/ACS) – Vendor for RFP Support
ASO RFP
OR
PBM (Scriptcare) – Vendor for RFP Support
PBM RFP

AGENDA ITEM 3f

To: Gold Coast Health Plan Commission

From: Dr. Nancy Wharfield, Associate Chief Medical Officer

Date: October 27, 2014

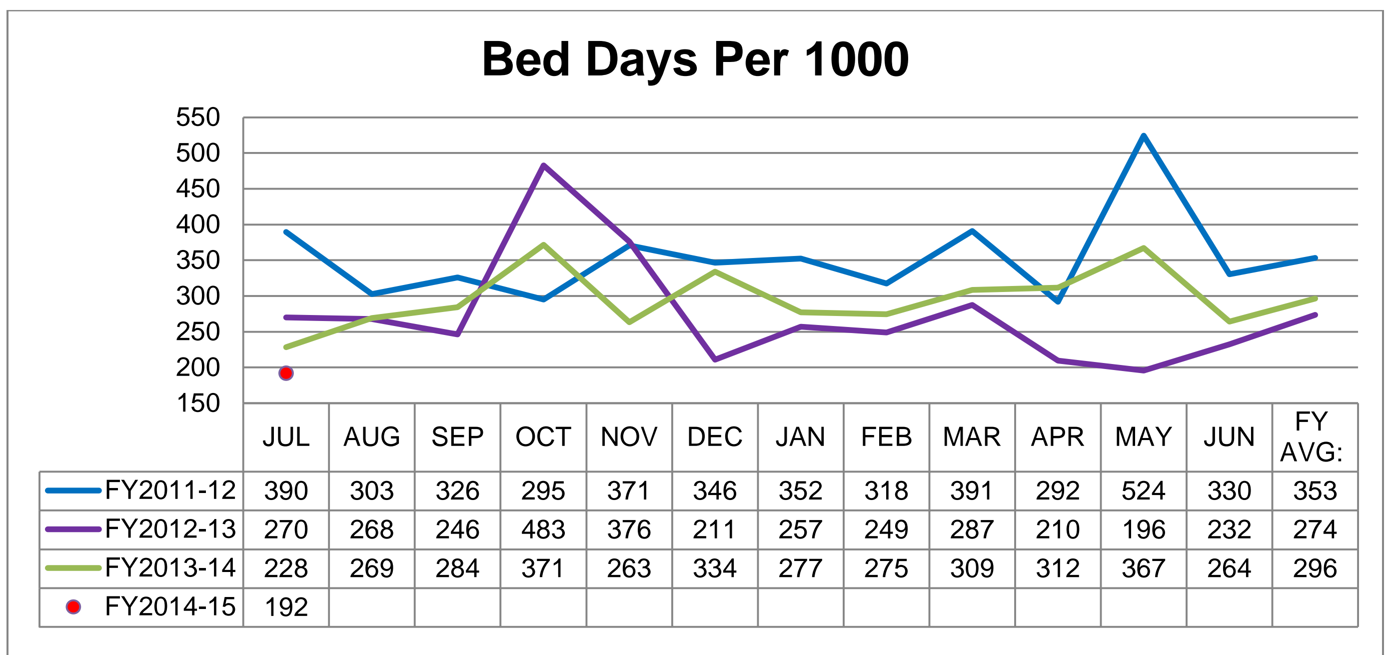
Re: Health Services Update

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 are complete at approximately 6 months. While incomplete, a 3 month lagged snapshot allows us to see an estimate of utilization without waiting 6 months. Administrative days are included in these calculations. Dual eligible members, SNF, and LTC data are not included in this data.

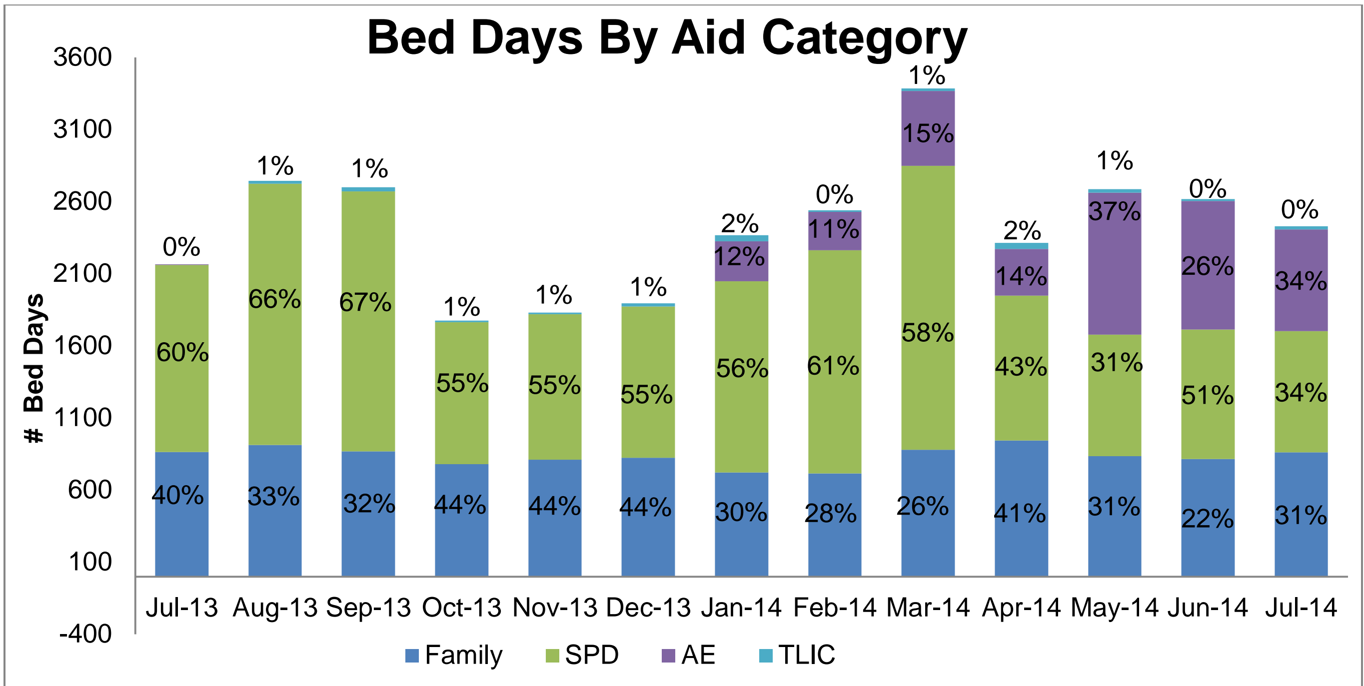
Inpatient Utilization

Bed days/1000 members remains under 300 and Family, SPD, and AE aid code categories each account for about 1/3 of bed day utilization for July 2014.

Benchmark: Reports of bed days/1000 members from 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.



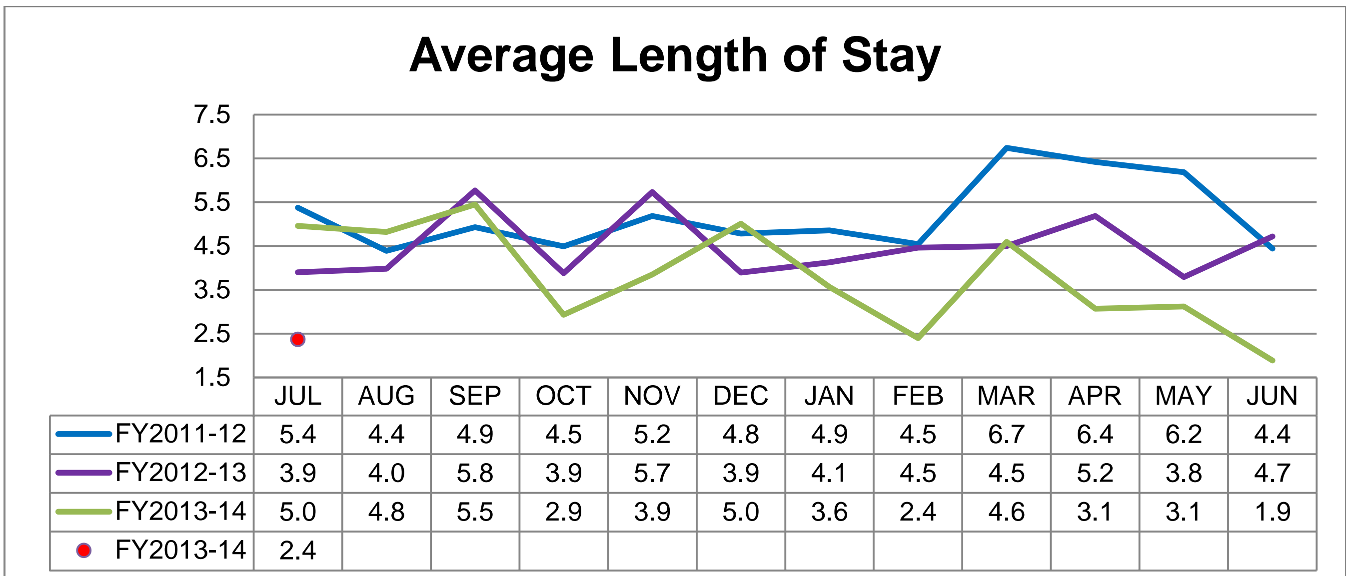
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FY AVG:
FY2011-12	390	303	326	295	371	346	352	318	391	292	524	330	353
FY2012-13	270	268	246	483	376	211	257	249	287	210	196	232	274
FY2013-14	228	269	284	371	263	334	277	275	309	312	367	264	296
FY2014-15	192												



Average Length of Stay

Average length of stay remains low compared to prior years and at 3.1 or below since April 2014.

Benchmark: Average length of stay from available published data from other managed care plans range from 3.6 – 4.1. There is variability in reporting of Administrative Days among managed care plans.

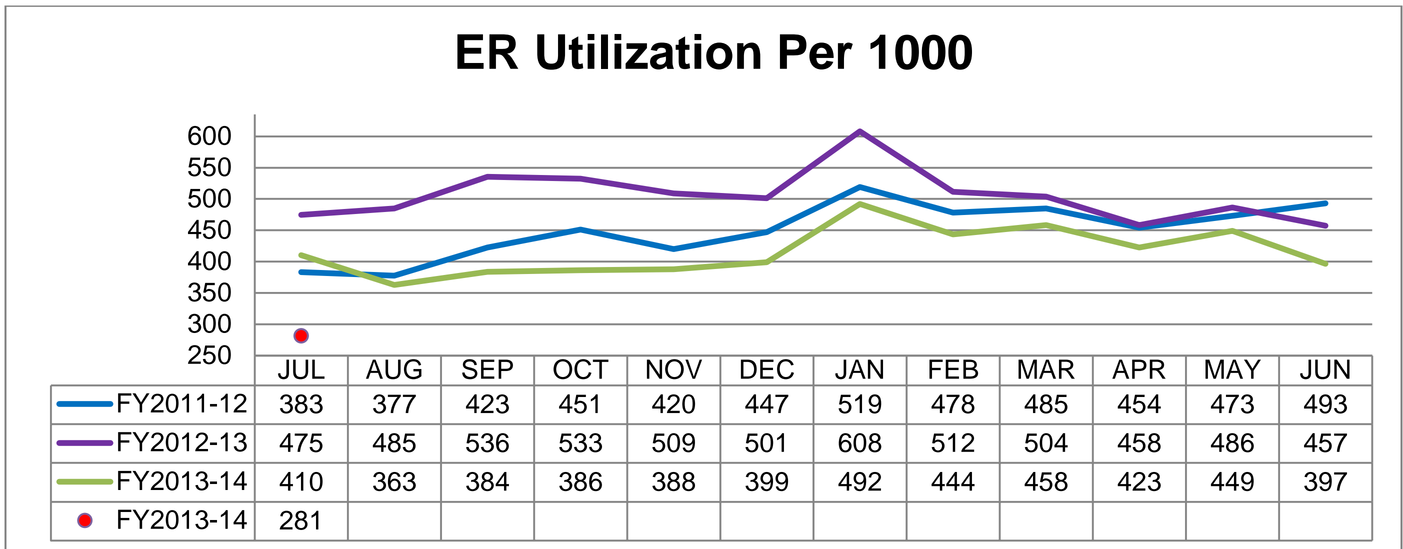


	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY2011-12	5.4	4.4	4.9	4.5	5.2	4.8	4.9	4.5	6.7	6.4	6.2	4.4
FY2012-13	3.9	4.0	5.8	3.9	5.7	3.9	4.1	4.5	4.5	5.2	3.8	4.7
FY2013-14	5.0	4.8	5.5	2.9	3.9	5.0	3.6	2.4	4.6	3.1	3.1	1.9
FY2013-14	2.4											

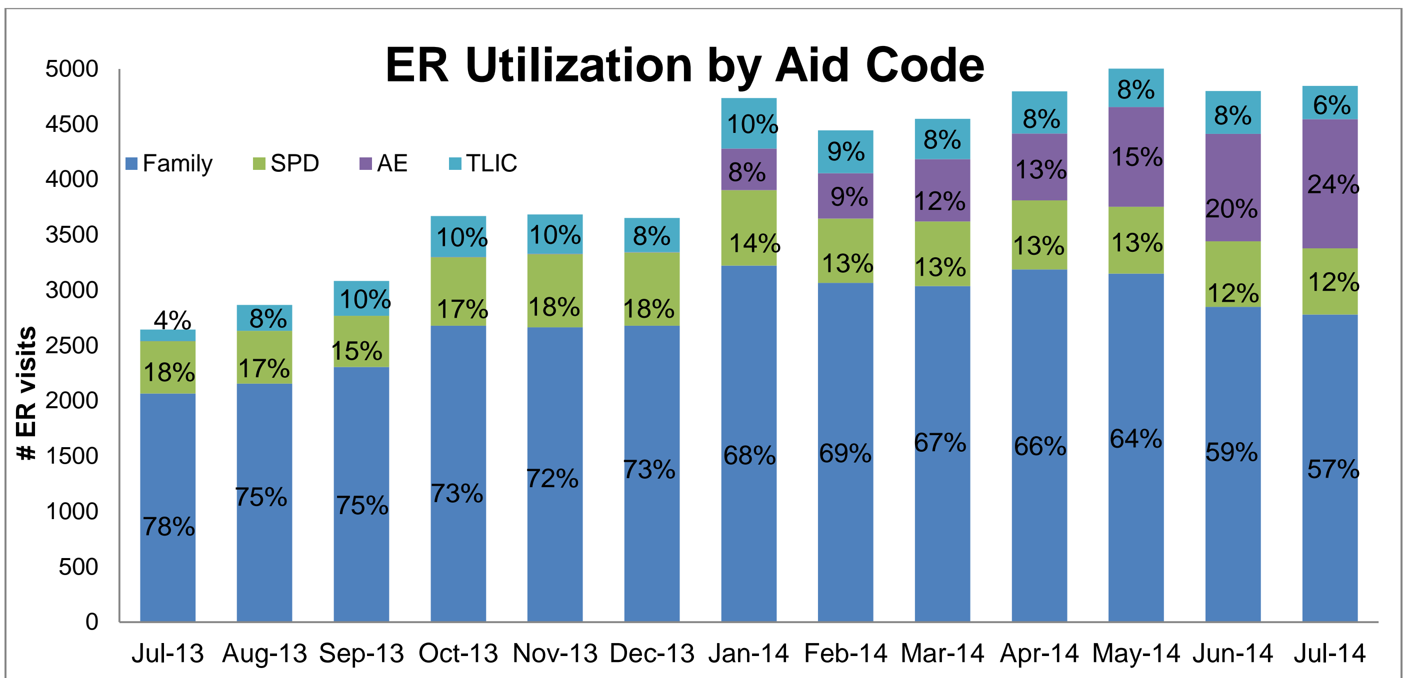
ER Utilization

ER Utilization remains low compared to prior years and seasonal variation with a peak in late spring followed by decline in utilization in summer continues. Family aid code group members continue to show the highest percentage of ER utilization.

Benchmark: ER utilization/1000 members from available published data from other managed care plans range from 554 – 877. For July 2013 through May 2014, Gold Coast Health Plan average utilization/1000 member months (including Duals) is 32 compared with the 2013 DHCS Managed Care Dashboard report of about 40-60 ER visits/1000 member months.



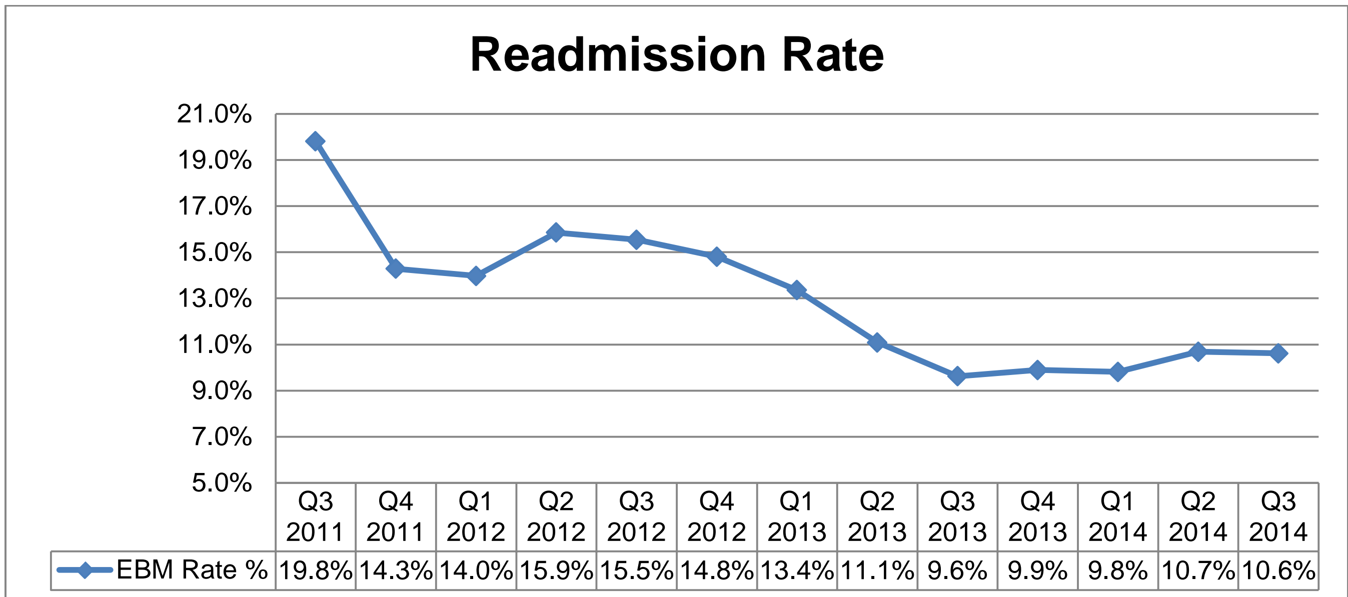
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY2011-12	383	377	423	451	420	447	519	478	485	454	473	493
FY2012-13	475	485	536	533	509	501	608	512	504	458	486	457
FY2013-14	410	363	384	386	388	399	492	444	458	423	449	397
FY2013-14	281											



Readmission Rate

Readmission rate has remained between 9.6% and 10.7% for the past 5 quarters.

Benchmark: The weighted average for the HEDIS 2013 All Cause Readmission Rate from the Medi-Cal Managed Care Performance Dashboard is approximately 14.5%.

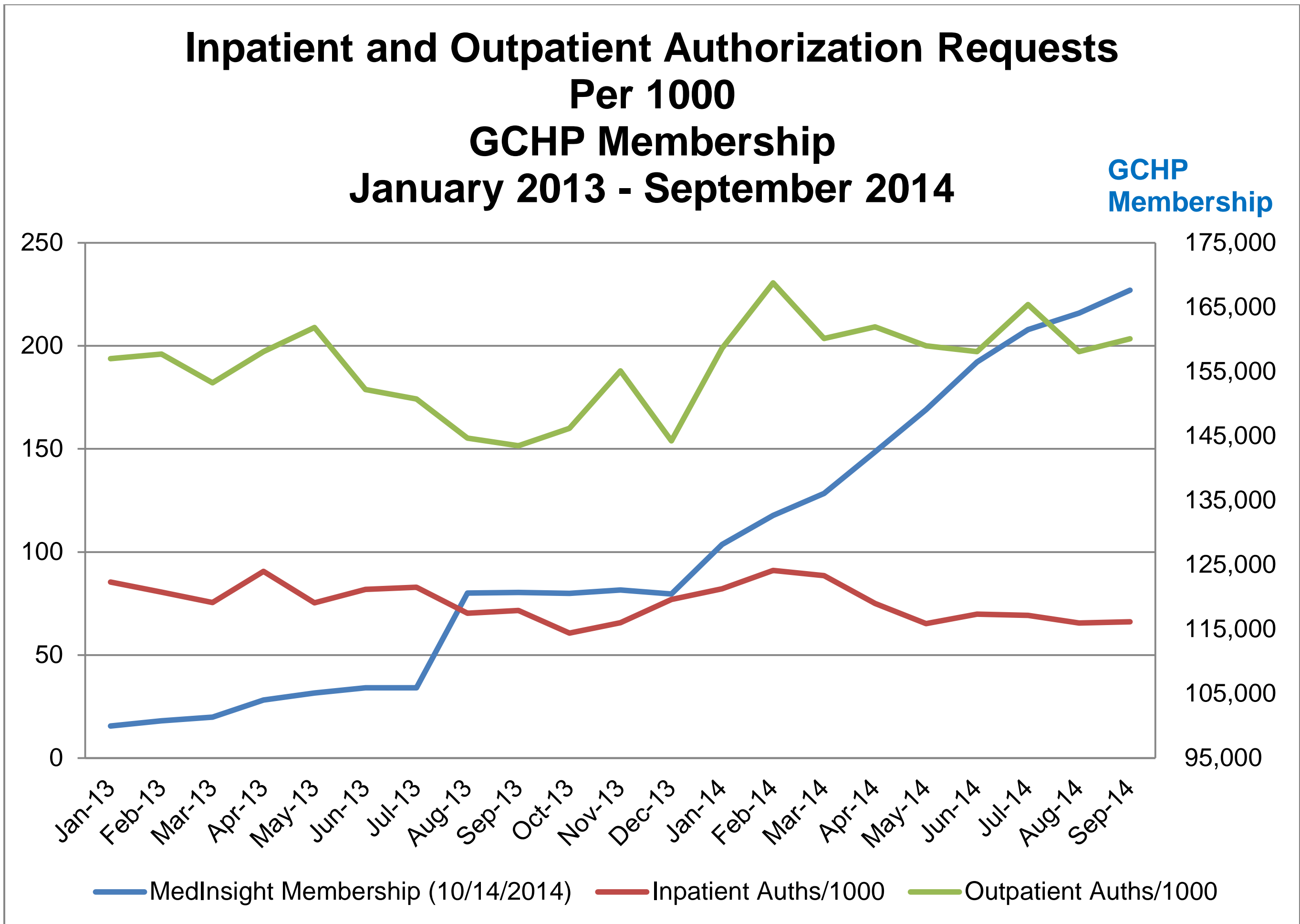


	Q3 2011	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014
EBM Rate %	19.8%	14.3%	14.0%	15.9%	15.5%	14.8%	13.4%	11.1%	9.6%	9.9%	9.8%	10.7%	10.6%

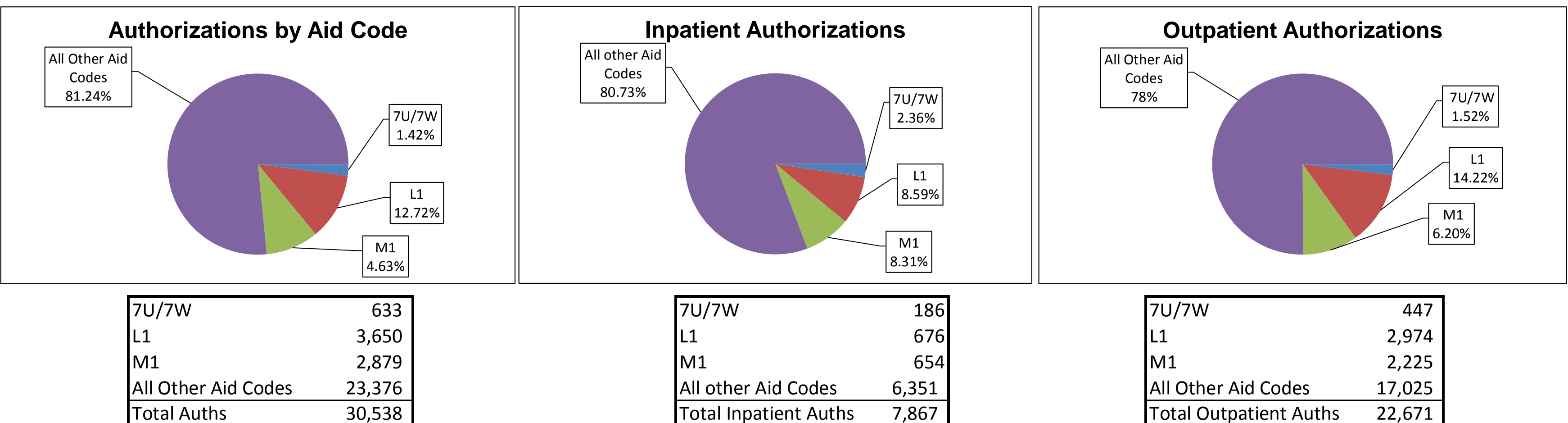
Authorization Requests

Requests for outpatient service continue to outnumber requests for inpatient service. Outpatient requests for service/1000 members peaked in February 2014 and July 2014. Requests for inpatient service have reached a plateau at 75/1000 members or below for the last 6 months.

Among Medi-Cal expansion members new to Gold Coast Health Plan since January 1, 2014, outpatient services requests for L1 members continue to predominate.


Inpatient and Outpatient Authorization Requests
Per 1000
GCHP Membership
January 2013 - September 2014
GCHP Membership
250
200
150
100
50
0
175,000
165,000
155,000
145,000
135,000
125,000
115,000
105,000
95,000
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
MedInsight Membership (10/14/2014)
Inpatient Auths/1000
Outpatient Auths/1000

Gold Coast Health Plan Authorizations by Aid Code
January - September 2014



Aid Code	Authorizations
7U/7W	633
L1	3,650
M1	2,879
All Other Aid Codes	23,376
Total Auths	30,538

Aid Code	Inpatient Authorizations
7U/7W	186
L1	676
M1	654
All other Aid Codes	6,351
Total Inpatient Auths	7,867

Aid Code	Outpatient Authorizations
7U/7W	447
L1	2,974
M1	2,225
All Other Aid Codes	17,025
Total Outpatient Auths	22,671

Data Source: MedHOK Authorizations by Aid Code Query on 10/02/2014

Grievance and Appeals

The number of grievances for Q3 2014 is essentially unchanged from Q2 2014. Grievances/1000 member months remains low and comparable to the incidence of grievances reported by other COHS on the DHCS Managed Care Dashboard.

Grievances

	Total Number
Q4 2013	28
Q1 2014	22
Q2 2014	34
Q3 2014	32

Appeals

Quarter	Total	Upheld	Overturned
Q4 2013	1	1 (100%)	0
Q1 2014	10	8 (80%)	2 (20%)
Q2 2014	3	2 (67%)	1 (33%)
Q3 2014	10	6 (60%)	4 (40%)

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.

Average denial rate for 2013 was 3.66% and for Q1 – Q3 of 2014 is 3.45%.