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

County of Ventura Government Center
Hall of Administration - Lower Plaza Assembly Room
800 S. Victoria Avenue, Ventura, CA 93009

Monday, April 27, 2015
3:00 p.m.

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. Regular Meeting of March 24, 2015

CLOSED SESSION

a. Conference With Labor Negotiators Pursuant to Government Code Section 54957.6

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

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

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.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP) April 27, 2015 Commission Meeting Agenda *(continued)*
LOCATION: County of Ventura Government Center - Hall of Administration - Lower Plaza Assembly Room
800 S. Victoria Avenue, Ventura, CA 93009
TIME: 3:00 p.m.

Agency Designated Representatives: Scott Campbell, legal counsel; Stacy Diaz, Human Resources Director and Gold Coast Health Plan Commissioners
Unrepresented Employee: Chief Executive Officer

b. Public Employee Appointment Pursuant to Government Code Section 54957
Title: Chief Executive Officer

RETURN TO OPEN SESSION

Announcements, if any

2. CONSENT ITEMS

a. Approve Chief Executive Officer (CEO) Employment Agreement
b. Accept and File CFO Update – February Financials
c. Accept and File Investment Committee Update

3. APPROVAL ITEMS

a. Department of Health Care Services (DHCS) Contract Amendment A16
b. Investment Controls Policy and Procedures
c. Quality Improvement 2014 Work Plan Evaluation
d. Quality Improvement Committee Report – 1st Quarter 2015
e. Quality Improvement Program and Work Plan - 1st Quarter 2015

4. ACCEPT AND FILE ITEMS

a. CEO Update
b. COO Update
c. CIO Update
d. Health Services Update

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) April 27, 2015 Commission Meeting Agenda *(continued)*
LOCATION: County of Ventura Government Center - Hall of Administration - Lower Plaza Assembly Room
800 S. Victoria Avenue, Ventura, CA 93009
TIME: 3:00 p.m.

CLOSED SESSION *(continued)*

c. Conference With Legal Counsel – Anticipated Litigation
Significant Exposure to Litigation Pursuant to paragraph (2) of subdivision (d) of Section 54956.9
Number of Cases: Unknown

d. Closed Session Pursuant to Government Code Section 54957
Public Employee Performance Evaluation
Title: Interim Chief Executive Officer and Chief Operating Officer

e. Conference With Labor Negotiators Pursuant to Government Code Section 54957.6
Agency Designated Representatives: Scott Campbell, legal counsel; Stacy Diaz, Human Resources Director and Gold Coast Health Plan Commissioners
Unrepresented Employee: Interim Chief Executive Officer and Chief Operating Officer

RETURN TO OPEN SESSION

Announcements, if any

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on May 18, 2015 at 3:00 p.m. in the Hall of Justice - Pacific Conference Room at the County of Ventura Government Center, 800 S. Victoria Avenue, Ventura, CA

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Commission Meeting Minutes
March 23, 2015
(Not official until approved)

CALL TO ORDER

Chair Araujo called the meeting to order at 3:04 p.m. Hall of Justice - Pacific Conference Room at the County of Ventura Government Center, 800 S. Victoria Avenue, Ventura, CA 93009.

Pledge of Allegiance was recited.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
Antonio Alatorre, Clinicas del Camino Real, Inc.
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Barry Fisher, Ventura County Health Care Agency
David Glyer, Private Hospitals / Healthcare System
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Darren Lee, Private Hospitals / Healthcare System
Dee Pupa, Ventura County Health Care Agency

EXCUSED / ABSENT COMMISSION MEMBERS
Lanyard Dial, MD, Ventura County Medical Association
Peter Foy, Ventura County Board of Supervisors
Gagan Pawar, MD, Clinicas del Camino Real, Inc.
Vacant, Medi-Cal Beneficiary Advocate

STAFF IN ATTENDANCE
Ruth Watson, Chief Operations Officer and Interim Chief Executive Officer
John Meazzo, Interim Chief Financial Officer
Traci R. McGinley, Clerk of the Board
Scott Campbell, Legal Counsel
Brandy Armenta, Compliance Director
Stacy Diaz, Human Resources Director
Anne Freese, Pharmacy Director
Lupe Gonzalez, Director of Health Education, Outreach, Cultural and Linguistic Services
Steven Lalich, Communications 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

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of February 23, 2015

Clerk McGinley noted that the title for Item 2d should read *Credentialing Policy.*

Commissioner Fisher moved to approve the Regular Meeting Minutes of February 23, 2015 as corrected. Commissioner Alatorre seconded. The motion carried with the following votes:

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

2. CONSENT ITEMS

a. Accept and File CFO Update – January Financials

Commissioner Glyer moved to approve the January Financials. Commissioner Pupa seconded. The motion carried with the following votes:

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

3. APPROVAL ITEMS

a. Adoption of Resolutions Authorizing the Opening of Accounts with Commercial Institutions; and Adoption of Resolutions Authorizing the Investment of Monies with a Number of Government Entities and Approval to Join *Cal*TRUST, a Joint Powers Authority

Legal Counsel Campbell reviewed the report with the Commission.

Commissioner Glyer asked if the Investment Committee had met and reviewed the items. Interim CFO Meazzo advised the Commission that the Investment Committee would not be meeting for a few weeks. Legal Counsel Campbell added that the resolutions are needed to open the accounts; the funds would initially be transferred as noted in the updated staff report.

Commissioner Alatorre asked if the resolutions could be more restrictive and require two individuals to take action on the accounts. Legal Counsel Campbell responded that the resolutions are worded as the institutions requested, they no longer require two signatures for transactions. Interim CEO Watson added that GCHP's policy is more restrictive.

Commissioner Fisher asked Commissioner Glyer about his concerns regarding the Investment Committee reviewing the items. Commissioner Glyer responded that he was satisfied that the Investment Committee will review the information and make its recommendations when they meet and that the investments as noted are temporary.

Commissioner Fisher moved to adopt the resolutions authorizing the investment of funds and opening of accounts with financial and investment institutions. Commissioner Pupa seconded. The motion carried with the following votes:

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

RESOLUTION NO. 2015-001

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, DBA GOLD COAST HEALTH PLAN, AUTHORIZING THE OPENING OF A COMMERCIAL PAPER ACCOUNT WITH BANK OF THE WEST

RESOLUTION NO. 2015-002

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, DBA GOLD COAST HEALTH PLAN, AUTHORIZING THE OPENING OF A MONEY MARKET ACCOUNT AND/OR CERTIFICATES OF DEPOSIT ACCOUNT WITH MANUFACTURER'S BANK

RESOLUTION NO. 2015-003

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, DBA GOLD COAST HEALTH PLAN, AUTHORIZING THE OPENING OF A MONEY MARKET ACCOUNT WITH HERITAGE OAKS BANK

RESOLUTION NO. 2015-004

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, DBA GOLD COAST HEALTH PLAN, AUTHORIZING THE INVESTMENT OF MONIES IN THE VENTURA COUNTY TREASURY

RESOLUTION NO. 2015-005

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, DBA GOLD COAST HEALTH PLAN, AUTHORIZING THE INVESTMENT OF MONIES IN THE LOCAL AGENCY INVESTMENT FUND (LAIF)

RESOLUTION NO. 2015-006

A RESOLUTION AUTHORIZING THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, DBA GOLD COAST HEALTH PLAN, "PUBLIC AGENCY" WITHIN THE MEANING OF THAT TERM IS DEFINED BY THE CALIFORNIA GOVERNMENT CODE, TO JOIN WITH OTHER PUBLIC AGENCIES AS A PARTICIPANT OF THE INVESTMENT TRUST OF CALIFORNIA, CARRYING ON BUSINESS AS *Cal*TRUST

4. ACCEPT AND FILE ITEMS

a. Special Investigation Ad Hoc Committee Report

Commissioner Fisher reported that there are a few items in the report that must get clarified. The draft report is currently being reviewed by legal counsel for the Special Investigation Ad Hoc Committee to ensure both companies and their reports comply with the terms and conditions of the contract. Legal Counsel Campbell added that he anticipated receiving the final draft reports within a few weeks and will confirm that the reports meet the Commission's requirements before a closed session can be scheduled, most likely the third week in April. Commissioner Fisher asked that the second week be considered as well.

b. CEO Update

Interim CEO Watson reviewed the CEO Update with the Commission and highlighted the State audit. Department of Health Care Services (DHCS) concluded the annual medical review audit and staff is expecting the draft report April 13, 2015. It was also noted that membership is up to approximately 183,000 and continues to grow.

Commissioner Glyer asked for an explanation of the four State and Federal HIPAA notifications listed under the Compliance section of the report. Compliance Director Armenta explained that they were the outcome of letters inadvertently going to the incorrect Members. DHCS required a Corrective Action Plan (CAP) and those employees then received additional training regarding the matter.

d. COO Update

Interim CEO Watson presented the report and noted that claim turn-around issues had not yet been resolved. Xerox / ACS hired staff and in hopes of having less manual review of claims, auto adjudication is being reviewed as well to see if it can be increased. Staff expects to be closer to compliance in April.

Chair Araujo asked about the change in speed of answering calls. Interim CEO Watson explained that Xerox / ACS was short staffed a couple of days due to severe weather conditions. GCHP has worked with Xerox / ACS to have additional system capabilities so calls can get routed to a different site when needed.

e. CIO Update

CIO Scrymgeour reviewed the written CIO Update with the Commission.

f. Health Services Update

Associate Chief Medical Officer, Dr. Wharfield, reviewed the written report.

At the previous meeting, the Commission requested legal confirmation that the Plan could limit or terminate services with a Provider when the Medical Board takes action against that physician. CMO Dr. Reeves obtained legal confirmation that the Plan could in fact limit or terminate services. The decision to do so must be reasonable and the provider would have the right to a fair hearing. Additional discussion was held regarding the actions of the Medical Board and the fact that additional requirements had been placed on the physicians by the Medical Board.

Legal Counsel Campbell confirmed that the Plan could in fact put further restrictions on these physicians. The Commission requested that the item be scheduled in a future meeting to discuss potential parameters of reasonable additional restrictions by GCHP above and beyond the Medical Board. Chair Araujo asked that information be obtained from other COHS as well.

Commissioner Fisher moved to accept and file the Special Investigation Ad Hoc Committee Report, the CEO, CIO and Health Services Updates. Commissioner Glyer seconded. The motion carried with the following votes:

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

CLOSED SESSION

Legal Counsel Campbell explained the purpose of the Closed Session items and added that the anticipated litigation is related to the League of United Latin American Citizens (LULAC) report and request from State Agencies to access GCHP records, as well as discussion regarding CEO compensation.

COMMENTS FROM COMMISSIONERS

None.

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 3:32 p.m. regarding the following items:

CLOSED SESSION

a. Conference With Legal Counsel – Anticipated Litigation
Significant Exposure to Litigation Pursuant to paragraph (2) of subdivision (d) of Section 54956.9: Number of Cases: Unknown

b. Conference With Labor Negotiators Pursuant to Government Code Section 54957.8
Agency Designated Representatives: Scott Campbell, legal counsel; Stacy Diaz, Human Resources Director and Gold Coast Health Plan Commissioners
Unrepresented Employee: Chief Executive Officer

c. Public Employee Appointment Pursuant to Government Code Section 54957
Title: Chief Executive Officer

RETURN TO OPEN SESSION

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

Legal Counsel Campbell stated there were no announcements from Closed Session.

ADJOURNMENT

The meeting adjourned at 7:31 p.m.

AGENDA ITEM 2b

To: Gold Coast Health Plan Commission

From: John Meazzo, Interim Chief Financial Officer

Date: April 27, 2015

Re: February 2015 Financials

SUMMARY:
Staff is presenting the attached February 2015 financial statements (unaudited) of Gold Coast Health Plan (Plan) for approval by the Commission. These financials were reviewed by the Executive / Finance Committee on April 2, 2015 where the Committee recommended approval of these financials to the Commission.

BACKGROUND / DISCUSSION:
The Plan staff has prepared the February 2015 financial package, including balance sheet, statement of cash flows and income statements.

FISCAL IMPACT:

Highlights of Year-To-Date Financial Results:

On a year-to-date basis through February, the Plan's unrestricted net asset is approximately $47.4 million compared to the $11.9 million budget. These operating results have contributed to a Tangible Net Equity (TNE) level of approximately $87.2 million, which exceeds both the budget of $44.3 million by $42.9 million and the State minimum required TNE amount of $24 million by $63.2 million. As in prior reports, the Plan's TNE amount includes $7.2 million County of Ventura lines of credit. The February TNE was 364% of the State required TNE, but 136% below the average 6 County Organized Health Systems of 500%.

Highlights of February Financial Results:

Membership - February membership of 181,458 exceeded budget by 17,546 members. The majority of the growth was in the Adult Expansion (AE) category, accounting for approximately 75% of the total growth in membership.

Revenue - February net revenue was $45.0 million or $6.1 million below the budgeted amount of $51.1 million. The variance was primarily due to a $13.9 million revenue reduction related to the AE claims reserve reduction mentioned below. The revenue reduction was necessary to maintain a medical loss ratio (MLR) of 85% for this group. The reduction was partially offset by

the recognition of $3.3 million in ACA 1202 revenue. (The corresponding health care cost was recorded as well.) Growth in membership with higher capitation rates (Adult Expansion) also helped to offset the reduction. On a PMPM basis, net revenue was $248.25, or $63.63 under the budget of $311.87.

Health Care Costs – February health care costs were $36.2 million or approximately $10.6 million below budget. On a PMPM basis, reported health care costs for February were $199.28 compared to a budgeted amount of $285.35. The positive variance is largely due to the release of certain claims reserves connected to the AE population. Other highlights include:

- Capitation – Higher than budget by $0.6 million, mainly due to higher than anticipated members being covered by capitated providers. Also included are the AE members recently designated as covered by the Kaiser capitation agreement, but not contemplated in the budget.
- Outpatient – Utilization increases were noted in the Disabled category, but are somewhat offset by lower rates in Inpatient services. For example, recent PMPMs for Outpatient services increased year over year by about 5% while Inpatient rates decreased by approximately 8% for this population. Outpatient services for the Adult and Child categories were also higher, but these increases were largely volume driven (more membership).
- LTC / SNF – An additional accrual for AB 1629 rate increases was again included for Long Term Care (LTC) facilities. New rates were published by the Department of Health Care Services (DHCS) in late January. However, a recent announcement by DHCS indicated that the rates contained errors, and a revision date has not been communicated. In addition, LTC services were higher in February for the Aged Dual and LTC Dual categories.
- Pharmacy – Lower than expected utilization in the AE category, again contributed to savings of approximately $4.5 million. Last month, Pharmacy costs appeared to be gaining momentum. On a PMPM basis, January AE Pharmacy was $51.77 as compared to $45.50 in December, and $41.54 in November. February Pharmacy costs have moderated somewhat, now at $46.57 PMPM.
- Physician ACA 1202 – The final portion of the ACA 1202 Physician increase was recognized in February in the amount of $3.2 million. $2.9 million was paid in March 2015 and an additional amount of $2.7 million was calculated for payment.
- Adult Expansion Reserve – Approximately $3.7 million related to March 2014 was released pursuant to the planned IBNP alignment methodology disclosed in the prior month. Additional reserves of $9.7 million, which would have been added for February 2015 under the previous book-to-budget method, were disregarded to avoid increasing the AE reserve balance. The release and avoidance of these reserves affected most categories of service.

In January 2015 the Plan initiated a measured and prudent convergence strategy which will gradually move AE claims reserves from the State rate methodology (85% of capitation revenue) to the traditional IBNR model. A proxy of similar Aid categories was used for the AE population to develop model completion factors. These modeled completion factor

percentages were applied to AE claims data as an alternate method of claims development. Based on this analysis claims aged one year or more were deemed complete or nearly complete and excess reserves were released. In addition, the budget rates for the near months (less than one year old) will be systematically reduced to avoid adding new reserves while maintaining the 85% MLR.

- Administrative Expenses - For the month of February, overall operational costs were $3.1 million or $85,000 over budget. Higher than budgeted legal fees and outside services were offset by positive variance due to lower personnel and related personnel expenses. The following were the primary contributors to the large variances:
- Outside Services (ACS / Xerox and Beacon Health Strategies) – over budget by $119,000 due to growth in membership.
- Legal Fees – over budget by $256,000 due to continued legal services and ongoing services associated with the investigation being overseen by the Special Investigation Ad Hoc Committee. Year to date legal expenses of $1.86 million exceeded the budget by $1.60 million.
- Consulting – under budget by $120,000 due to increase use of in-house services and delays in budgeted projects.
- Advertising and Promotion – under budget by $110,000 due to timing differences in Outreach program implementation.

Cash + Medi-Cal Receivable – The total of Cash and Medi-Cal Premium Receivable balances of $346 million reported as of February 28, 2015. This total includes pass-through payments for Managed Care Organizations (MCO) tax of $1 million and AB 85 of $5.8 million. Excluding the impact of the pass through amount, the total of Cash and Medi-Cal Receivable balance as of February 28, 2015 was $339 million or $172.4 million better than the budgeted level of $166.3 million.

Investment Portfolio - The investment Committee held its first meeting on March 27, 2015. The committee:

- Approved the Investment Committee Charter
- Approved investment of $5000 for investment advisor professional fees (approximately 25 hours). The advisor services will be to provide an independent review of the investment policy; Investment Committee responsibilities and allocation of funds
- Approved the CFO to Chair the Investment Committee and the members as follows:
    - John Meazzo, Chair
    - Dee Pupa, Member
    - Lyndon Turner, Director of Financial Analysis, Member
    - Allen Maithel, Controller, Member
    - Open for investment advisor

- Agreed that based upon the level of investment management at the pooled fund accounts and the low yield on investments, an advisor to manage the investments would not be warranted at this time.

RECOMMENDATION:
Staff requests that the Commission approve the February 2015 financial package.

CONCURRENCE:
N/A

Attachments:
February 2015 Financial Package

Gold Coast Health Plan℠
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FINANCIAL PACKAGE
For the month ended February 28, 2015

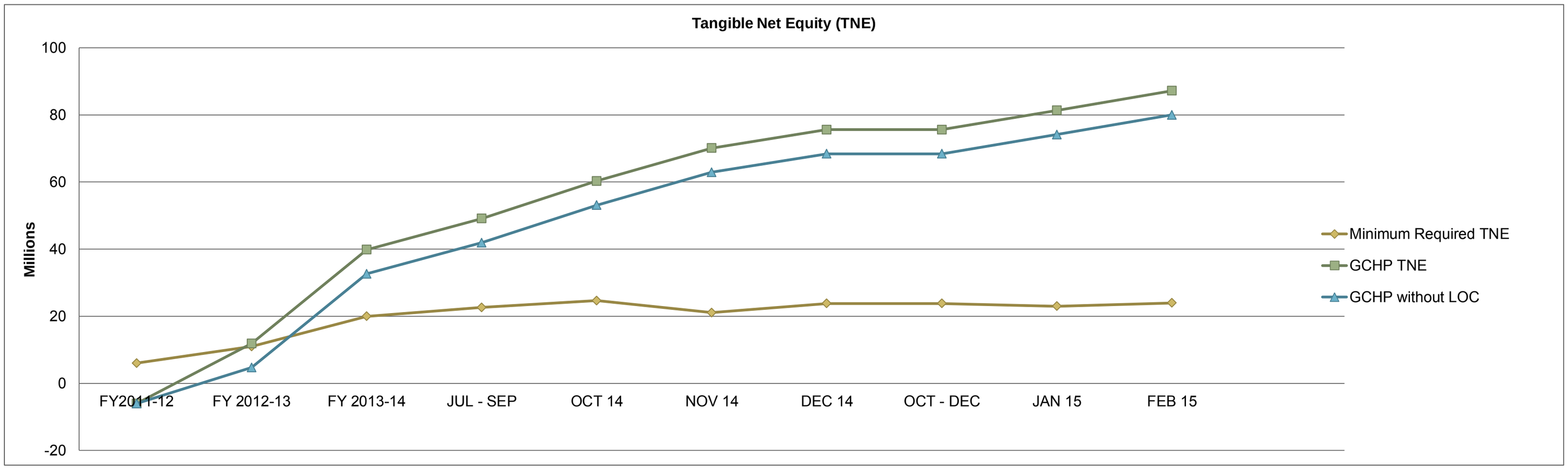
TABLE OF CONTENTS

APPENDIX

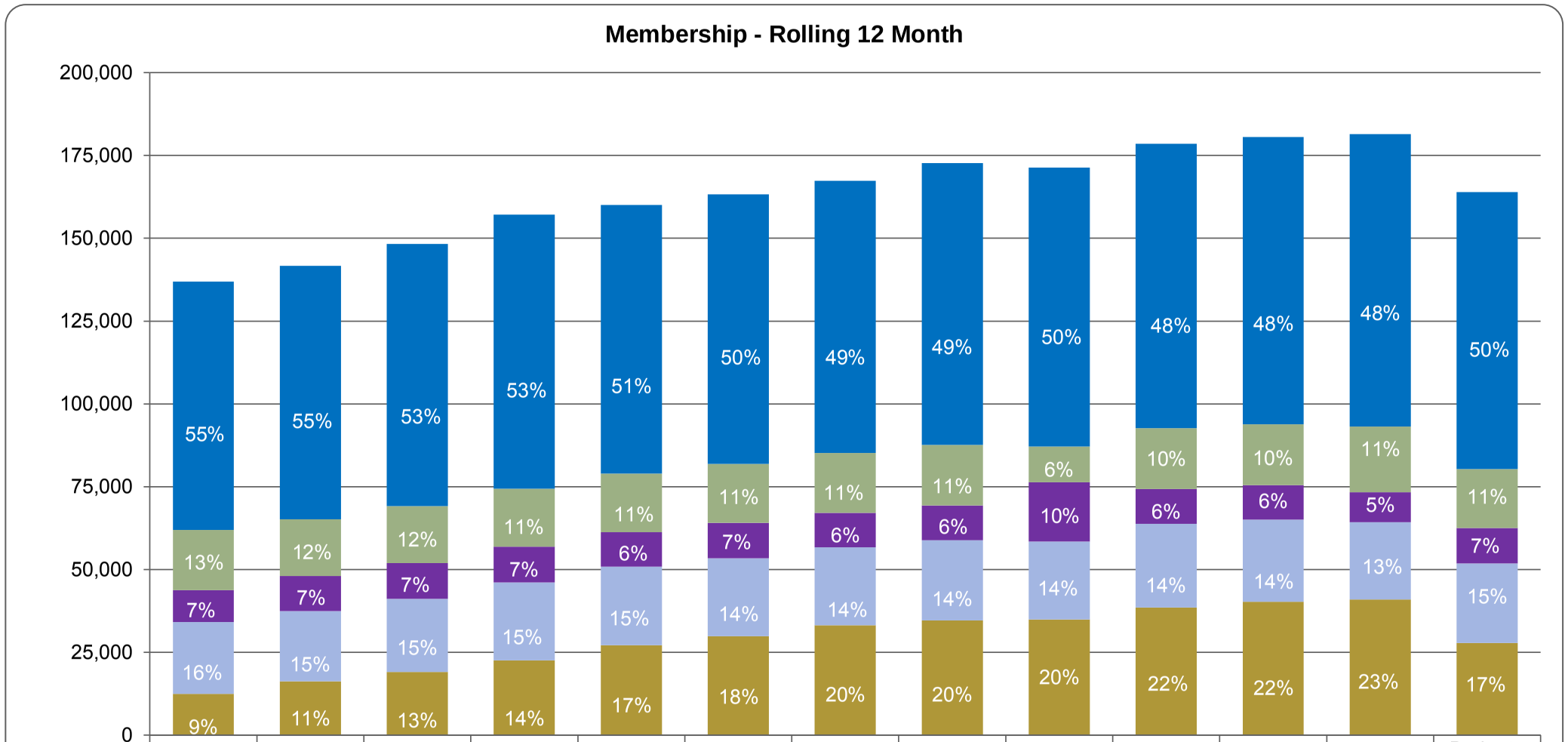
GOLD COAST HEALTH PLAN
Financial Results Summary

Description	AUDITED* FY2011-12	AUDITED* FY 2012-13	UNAUDITED FY 2013-14	FY 2014 - 15 JUL - SEP	OCT 14	NOV 14	DEC 14	OCT - DEC	JAN 15	FEB 15	Budget Comparison Budget Feb 15	Variance Fav/(Unfav)	Variance Fav/(Unfav) %
Member Months	**1,258,189**	**1,223,895**	**1,553,660**	490,686	172,729	171,343	178,532	522,604	180,568	181,458	**163,912**	17,546	10.7 %
Revenue	**304,635,932**	**315,119,611**	**423,995,809**	**158,761,380**	**56,934,456**	**25,538,171**	**59,563,938**	**142,036,566**	**37,959,896**	**45,092,826**	**51,137,714**	(6,044,888)	(11.8)%
pmpm	*242.12*	*257.47*	*272.90*	*323.55*	*329.62*	*149.05*	*333.63*	*271.79*	*210.22*	*248.50*	*311.98*	(63.48)	(20.3)%
Health Care Costs	**287,353,672**	**280,382,704**	**369,321,385**	**141,486,486**	**42,774,442**	**12,855,002**	**50,947,617**	**106,577,061**	**29,428,716**	**36,161,087**	**46,772,544**	10,611,456	22.7 %
pmpm	*228.39*	*229.09*	*237.71*	*288.34*	*247.64*	*75.02*	*285.37*	*203.93*	*162.98*	*199.28*	*285.35*	86.07	30.2 %
% of Revenue	94.3%	89.0%	87.1%	89.1%	75.1%	50.3%	85.5%	75.0%	77.5%	80.2%	91.5%	11.3%	12.3 %
Admin Exp	**18,891,320**	**24,013,927**	**26,751,533**	**7,994,304**	**2,954,018**	**2,883,649**	**3,132,315**	**8,969,982**	**2,802,558**	**3,069,187**	**2,986,531**	(82,656)	(2.8)%
pmpm	*15.01*	*19.62*	*17.22*	*16.29*	*17.10*	*16.83*	*17.54*	*17.16*	*15.52*	*16.91*	*18.22*	1.31	7.2 %
% of Revenue	6.2%	7.6%	6.3%	5.0%	5.2%	11.3%	5.3%	6.3%	7.4%	6.8%	5.8%	-1.0%	(16.5)%
Total Increase/(Decrease) in Unrestricted Net Assets	**(1,609,063)**	**10,722,980**	**27,922,891**	**9,280,590**	**11,205,997**	**9,799,520**	**5,484,006**	**26,489,523**	**5,728,622**	**5,862,553**	**1,378,640**	4,483,913	325.2 %
pmpm	*(1.28)*	*8.76*	*17.97*	*18.91*	*64.88*	*57.19*	*30.72*	*50.69*	*31.73*	*32.31*	*8.41*	23.90	284.1 %
% of Revenue	-0.5%	3.4%	6.6%	5.8%	19.7%	38.4%	9.2%	18.6%	15.1%	13.0%	2.7%	10.3%	382.2 %
YTD													
100% TNE	16,769,368	16,138,440	19,964,221	22,600,707	24,668,181	21,069,622	23,789,982	23,789,982	22,974,997	23,957,363	25,492,695	(1,535,332)	(6.0)%
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Minimum Required TNE	6,036,972	10,974,139	19,964,221	22,600,707	24,668,181	21,069,622	23,789,982	23,789,982	22,974,997	23,957,363	25,492,695	(1,535,332)	(6.0)%
GCHP TNE	**(6,031,881)**	**11,891,099**	39,813,991	**49,094,581**	**60,300,578**	**70,100,097**	**75,584,104**	75,584,104	81,312,726	87,175,279	**44,268,594**	**42,906,685**	**96.9 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**19,849,770**	**26,493,874**	**35,632,397**	**49,030,475**	**51,794,122**	**51,794,122**	**58,337,729**	**63,217,916**	**18,775,899**	**44,442,017**	**236.7 %**
% of Required TNE level			**199%**	**217%**	**244%**	**333%**	**318%**	**318%**	**354%**	**364%**	**174%**		
% of Required TNE level (excluding $7.2 million LOC)			**163%**	**185%**	**215%**	**299%**	**287%**	**287%**	**323%**	**334%**	**145%**		

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).



GOLD COAST HEALTH PLAN



	MAR 14	APR 14	MAY 14	JUN 14	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	Budget - Feb 15
Total	136,917	141,636	148,289	157,168	160,085	163,251	167,350	172,729	171,343	178,532	180,568	181,458	163,912
FAMILY	74,978	76,498	79,126	82,783	81,081	81,372	82,191	85,139	84,198	85,866	86,679	88,305	83,621
DUALS	18,182	17,109	17,269	17,472	17,780	17,840	18,047	18,248	10,853	18,381	18,430	19,864	17,740
SPD	9,635	10,578	10,799	10,771	10,324	10,612	10,461	10,501	17,840	10,525	10,385	9,020	10,699
TLIC	21,636	21,226	22,025	23,568	23,794	23,545	23,533	24,230	23,496	25,201	24,771	23,322	24,024
AE	12,486	16,225	19,070	22,574	27,106	29,882	33,118	34,611	34,956	38,559	40,303	40,947	27,828

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

Note: Beginning in Apr 14 actual membership reflects new Dual definition as implement by DHCS. Prior months have not been

Statements of Financial Position

	2/28/15	1/31/15	Unaudited FY 13-14
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 278,626,873**	**$ 239,657,138**	**$ 60,176,698**
Medi-Cal Receivable*	66,951,446	74,409,090	114,632,056
Provider Receivable	838,001	820,896	395,129
Other Receivables	172,085	171,748	1,821,475
Total Accounts Receivable	**67,961,532**	**75,401,733**	**116,848,660**
Total Prepaid Accounts	986,764	966,574	994,278
Total Other Current Assets	81,702	81,702	81,719
Total Current Assets	**347,656,871**	**316,107,147**	**178,101,355**
Total Fixed Assets	**1,111,807**	**1,031,857**	**1,163,269**
Total Assets	**$ 348,768,677**	**$ 317,139,004**	**$ 179,264,625**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 132,199,095	$ 132,779,110	$ 92,710,021
Claims Payable	11,250,773	10,793,549	9,482,660
Capitation Payable	4,873,728	4,482,814	2,054,265
Physician ACA 1202 Payable	17,294,099	14,159,185	12,765,516
AB85 Payable	5,795,708	4,816,682	1,245,284
Accounts Payable	1,844,584	307,017	2,875,709
Accrued ACS	1,348,519	1,340,286	0
Accrued Expenses	1,121,154	1,341,791	748,120
Accrued Premium Tax	1,018,265	1,620,132	15,775,120
Accrued Interest Payable	60,770	57,655	42,062
Current Portion of Deferred Revenue	460,000	460,000	460,000
Accrued Payroll Expense	708,123	627,193	760,032
Total Current Liabilities	**177,974,818**	**172,785,415**	**138,918,788**
Long-Term Liabilities			
DHCS - Reserve for Capitation Recoup	83,120,415	62,538,709	0
Other Long-term Liability-Deferred Rent	344,832	310,488	71,845
Deferred Revenue - Long Term Portion	153,333	191,667	460,000
Notes Payable	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	**90,818,581**	**70,240,864**	**7,731,845**
Total Liabilities	**268,793,398**	**243,026,278**	**146,650,634**
Net Assets:			
Beginning Net Assets	32,613,991	32,613,991	4,691,101
Total Increase/(Decrease in Unrestricted Net Assets	47,361,288	41,498,735	27,922,890
Total Net Assets	**79,975,279**	**74,112,726**	**32,613,991**
Total Liabilities & Net Assets	**$ 348,768,677**	**$ 317,139,004**	**$ 179,264,625**

FINANCIAL INDICATORS			
Current Ratio	1.95 : 1	1.83 : 1	1.28 : 1
Days Cash on Hand	213	223	34
Days Cash + State Capitation Rec	264	292	100
Days Cash + State Capitation Rec (less Tax Liab)	263	291	91

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY2014-15 Monthly Trend			Current Month		
	NOV 14	DEC 14	JAN 15	FEB 15		Variance
				Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	171,343	178,532	180,568	181,458	163,912	17,546
Revenue:						
Premium	$ 64,766,272	$ 67,600,543	$ 57,987,902	$ 60,901,975	$ 53,175,623	$ 7,726,352
Reserve for Rate Reduction	(36,753,996)	(7,222,493)	(18,562,220)	(13,980,481)	0	(13,980,481)
MCO Premium Tax	(2,550,172)	(930,197)	(1,552,396)	(1,913,763)	(2,093,790)	180,027
Total Net Premium	**25,462,104**	**59,447,852**	**37,873,286**	**45,007,731**	**51,081,833**	**(6,074,102)**
Other Revenue:						
Miscellaneous Income	38,333	68,651	38,333	38,333	38,333	(0)
Total Other Revenue	38,333	68,651	38,333	38,333	38,333	(0)
Total Revenue	**25,500,437**	**59,516,503**	**37,911,620**	**45,046,064**	**51,120,166**	**(6,074,103)**
Medical Expenses:						
Capitation (PCP, Specialty, Kasier, NEMT & Vision)	2,932,938	3,004,545	4,913,161	3,459,155	2,814,913	(644,242)
FFS Claims Expenses:						
Inpatient	(3,366,301)	10,389,370	6,798,007	4,843,204	10,541,724	5,698,520
LTC/SNF	8,603,699	9,058,853	5,668,717	10,126,507	7,582,483	(2,544,024)
Outpatient	154,989	4,421,489	2,102,800	2,533,435	2,765,512	232,077
Laboratory and Radiology	(658,499)	1,239,938	407,913	46,028	842,791	796,763
Physician ACA 1202	0	4,942,182	0	3,134,914	*0*	(3,134,914)
Emergency Room	(526,608)	1,773,425	1,748,011	1,042,118	1,634,308	592,190
Physician Specialty	1,150,877	4,232,969	2,992,152	1,791,663	3,394,856	1,603,193
Primary Care Physician	263,568	3,187,156	2,395,610	673,648	2,712,474	2,038,826
Home & Community Based Services	1,315,061	1,429,964	1,689,076	775,691	835,715	60,024
Applied Behavior Analysis Services	0	392	532	8,265	0	(8,265)
Mental Health Services	464,368	642,434	890,605	415,979	772,329	356,350
Pharmacy	4,772,776	5,436,966	6,101,836	5,532,105	9,987,699	4,455,593
Adult Expansion Reserve	0	(3,500,000)	(8,100,000)	0	0	0
Other Medical Professional	(64,226)	409,206	170,093	111,261	285,034	173,773
Other Medical Care	0	38	387	0	0	0
Other Fee For Service	(3,254,779)	1,744,277	437,370	250,180	960,209	710,029
Transportation	58,244	792,920	206,816	75,730	334,964	259,234
Total Claims	8,913,169	46,201,577	23,509,925	31,360,727	42,650,098	11,289,371
Medical & Care Management Expense	911,817	1,075,547	1,058,868	1,016,692	1,107,559	90,868
Reinsurance	471,741	(206,923)	441,960	502,015	199,973	(302,042)
Claims Recoveries	(374,663)	872,871	(495,199)	(177,502)	0	177,502
Sub-total	1,008,895	1,741,495	1,005,629	1,341,205	1,307,533	(33,672)
Total Cost of Health Care	**12,855,002**	**50,947,617**	**29,428,716**	**36,161,087**	**46,772,544**	**10,611,456**
Contribution Margin	**12,645,435**	**8,568,886**	**8,482,904**	**8,884,977**	**4,347,623**	**4,537,355**
General & Administrative Expenses:						
Salaries and Wages	587,651	724,287	673,399	711,273	843,621	132,348
Payroll Taxes and Benefits	151,578	265,074	212,026	189,329	233,503	44,174
Travel and Training	8,957	9,763	4,732	10,869	11,893	1,024
Outside Service - ACS	1,331,496	1,370,254	1,342,906	1,349,555	1,230,389	(119,166)
Outside Services - Other	136,226	143,598	140,431	151,651	154,144	2,493
Accounting & Actuarial Services	37,386	10,000	10,000	14,585	0	(14,585)
Legal	355,504	378,862	169,276	289,180	33,333	(255,847)
Insurance	16,863	18,265	16,863	33,940	14,583	(19,357)
Lease Expense - Office	63,048	63,318	67,130	64,785	64,354	(431)
Consulting Services	5,420	9,194	12,434	12,475	133,066	120,591
Translation Services	10,895	401	4,125	3,990	7,083	3,093
Advertising and Promotion	5,684	147	5,237	2,057	112,839	110,782
General Office	125,251	87,687	85,544	182,426	92,627	(89,800)
Depreciation & Amortization	16,530	16,530	16,530	16,530	26,388	9,858
Printing	739	0	21,486	1,089	12,365	11,276
Shipping & Postage	1,362	17,239	2,088	22,696	1,342	(21,354)
Interest	26,385	15,949	17,143	9,641	15,000	5,359
Total G & A Expenses	**2,880,974**	**3,130,570**	**2,801,351**	**3,066,072**	**2,986,531**	**(79,541)**
Total Operating Gain/(Loss)	**9,764,461**	**5,438,317**	**5,681,553**	**5,818,905**	**1,361,092**	**4,457,813**
Non Operating						
Revenues - Interest	37,734	47,435	48,276	46,762	17,548	29,214
Expenses - Interest	2,675	1,746	1,207	3,115	0	(3,115)
Total Non-Operating	**35,059**	**45,690**	**47,070**	**43,647**	**17,548**	**26,099**
Total Increase/(Decrease) in Unrestricted Net Assets	**9,799,520**	**5,484,006**	**5,728,622**	**5,862,553**	**1,378,640**	**4,483,913**
Full time employees				**150**	**169**	**19**

PMPM Statement of Revenues, Expenses and Changes in Net Assets

	NOV 14	DEC 14	JAN 15	FEB 15 Actual	FEB 15 Budget	Variance Fav/(Unfav)
Membership (includes retro members)	171,343	178,532	180,568	181,458	163,912	17,546
Revenue:						
Premium	377.99	378.65	321.14	335.63	324.41	11.21
Reserve for Rate Reduction	(214.51)	(40.45)	(102.80)	(77.05)	0.00	(77.05)
MCO Premium Tax	(14.88)	(5.21)	(8.60)	(10.55)	(12.77)	2.23
Total Net Premium	**148.60**	**332.98**	**209.75**	**248.03**	**311.64**	**(63.61)**
Other Revenue:						
Interest Income	0.00	0.00	0.00	0.00	0.00	0.00
Miscellaneous Income	0.22	0.38	0.21	0.21	0.23	(0.02)
Total Other Revenue	0.22	0.38	0.21	0.21	0.23	(0.02)
Total Revenue	**148.83**	**333.37**	**209.96**	**248.25**	**311.87**	**(63.63)**
Medical Expenses:						
Capitation (PCP, Specialty, Kasier, NEMT & Vision)	17.12	16.83	27.21	19.06	17.17	(1.89)
FFS Claims Expenses:						
Inpatient	(19.65)	58.19	37.65	26.69	64.31	37.62
LTC/SNF	50.21	50.74	31.39	55.81	46.26	(9.55)
Outpatient	0.90	24.77	11.65	13.96	16.87	2.91
Laboratory and Radiology	(3.84)	6.95	2.26	0.25	5.14	4.89
Physician ACA 1202	0.00	27.68	0.00	17.28	0.00	(17.28)
Emergency Room	(3.07)	9.93	9.68	5.74	9.97	4.23
Physician Specialty	6.72	23.71	16.57	9.87	20.71	10.84
Primary Care Physician	1.54	17.85	13.27	3.71	16.55	12.84
Home & Community Based Services	7.68	8.01	9.35	4.27	5.10	0.82
Applied Behavior Analysis Services	0.00	0.00	0.00	0.05	0.00	(0.05)
Mental Health Services	2.71	3.60	4.93	2.29	4.71	2.42
Pharmacy	27.86	30.45	33.79	30.49	60.93	30.45
Adult Expansion Reserve	0.00	(19.60)	(44.86)	0.00	0.00	0.00
Other Medical Professional	(0.37)	2.29	0.94	0.61	1.74	1.13
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	(19.00)	9.77	2.42	1.38	5.86	4.48
Transportation	0.34	4.44	1.15	0.42	2.04	1.63
Total Claims	52.02	258.79	130.20	172.83	260.20	87.37
Medical & Care Management Expense	5.32	6.02	5.86	5.60	6.76	1.15
Reinsurance	2.75	(1.16)	2.45	2.77	1.22	(1.55)
Claims Recoveries	(2.19)	4.89	(2.74)	(0.98)	0.00	0.98
Sub-total	5.89	9.75	5.57	7.39	7.98	0.59
Total Cost of Health Care	**75.02**	**285.37**	162.98	199.28	**285.35**	**86.07**
Contribution Margin	**73.80**	**48.00**	**46.98**	**48.96**	**26.52**	**22.44**
General & Administrative Expenses:						
Salaries and Wages	3.43	4.06	3.73	3.92	5.15	1.23
Payroll Taxes and Benefits	0.88	1.48	1.17	1.04	1.42	0.38
Travel and Training	0.05	0.05	0.03	0.06	0.07	0.01
Outside Service - ACS	7.77	7.68	7.44	7.44	7.51	0.07
Outside Services - Other	0.80	0.80	0.78	0.84	0.94	0.10
Accounting & Actuarial Services	0.22	0.06	0.06	0.08	0.00	(0.08)
Legal	2.07	2.12	0.94	1.59	0.20	(1.39)
Insurance	0.10	0.10	0.09	0.19	0.09	(0.10)
Lease Expense - Office	0.37	0.35	0.37	0.36	0.39	0.04
Consulting Services	0.03	0.05	0.07	0.07	0.81	0.74
Translation Services	0.06	0.00	0.02	0.02	0.04	0.02
Advertising and Promotion	0.03	0.00	0.03	0.01	0.69	0.68
General Office	0.73	0.49	0.47	1.01	0.57	(0.44)
Depreciation & Amortization	0.10	0.09	0.09	0.09	0.16	0.07
Printing	0.00	0.00	0.12	0.01	0.08	0.07
Shipping & Postage	0.01	0.10	0.01	0.13	0.01	(0.12)
Interest	0.15	0.09	0.09	0.05	0.09	0.04
Total G & A Expenses	16.81	17.54	15.51	16.90	18.22	1.32
Total Operating Gain/(Loss)	56.99	30.46	31.46	32.07	8.30	23.76
Non Operating						
Revenues - Interest	0.22	0.27	0.27	0.26	0.11	0.15
Expenses - Interest	0.02	0.01	0.01	0.02	0.00	(0.02)
Total Non-Operating	0.20	0.26	0.26	0.24	0.11	0.13
Unrestricted Net Assets	57.19	30.72	31.73	32.31	8.41	23.90

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
For Eight Months Ended February 28, 2015

	FEB 15 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	1,375,316	1,281,294	94,022
Revenue			
Premium	$ 475,516,757	$ 403,930,998	$ 71,585,759
Reserve for Rate Reduction	(76,519,190)	0	(76,519,190)
MCO Premium Tax	(15,776,768)	(15,904,783)	128,015
Total Net Premium	**383,220,798**	**388,026,215**	**(4,805,416)**
Other Revenue:			
Miscellaneous Income	336,985	306,664	30,321
Total Other Revenue	336,985	**306,664**	30,321
Total Revenue	**383,557,783**	**388,332,879**	**(4,775,096)**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	25,183,665	21,605,329	(3,578,335)
FFS Claims Expenses:			
Inpatient	63,580,683	79,242,164	15,661,481
LTC/SNF	69,925,406	60,132,485	(9,792,921)
Outpatient	21,798,738	20,961,974	(836,764)
Laboratory and Radiology	4,706,106	6,066,680	1,360,574
Physician ACA 1202	8,077,096	0	(8,077,096)
Emergency Room	10,299,696	12,257,242	1,957,546
Physician Specialty	22,767,920	25,891,301	3,123,380
Primary Care Physician	16,552,269	20,063,405	3,511,136
Home & Community Based Services	10,635,427	6,678,389	(3,957,038)
Applied Behavior Analysis Services	9,189	0	(9,189)
Mental Health Services	4,579,347	5,967,481	1,388,135
Pharmacy	43,949,226	72,101,885	28,152,659
Adult Expansion Reserve	(8,100,000)	0	8,100,000
Other Medical Professional	1,772,095	2,129,460	357,366
Other Medical Care	756	0	(756)
Other Fee For Service	5,863,574	7,424,077	1,560,503
Transportation	2,086,544	2,452,539	365,995
Total Claims	278,504,068	321,369,080	42,865,012
Medical & Care Management Expense	8,117,207	8,521,677	404,470
Reinsurance	2,634,062	1,563,179	(1,070,882)
Claims Recoveries	(785,652)	0	785,652
Sub-total	9,965,617	10,084,856	119,239
Total Cost of Health Care	**313,653,350**	**353,059,266**	**39,405,916**
Contribution Margin	**69,904,433**	**35,273,613**	**34,630,820**
General & Administrative Expenses:			
Salaries and Wages	5,402,583	6,547,477	1,144,894
Payroll Taxes and Benefits	1,571,164	1,734,893	163,729
Travel and Training	85,661	185,974	100,314
Outside Service - ACS	10,515,670	9,629,180	(886,490)
Outside Services - Other	1,028,270	1,104,765	76,495
Accounting & Actuarial Services	129,226	250,000	120,774
Legal	1,859,194	266,666	(1,592,528)
Insurance	156,861	116,667	(40,195)
Lease Expense - Office	511,821	514,832	3,011
Consulting Services	238,143	999,814	761,671
Translation Services	35,064	56,664	21,600
Advertising and Promotion	17,250	207,872	190,622
General Office	847,066	1,279,981	432,915
Depreciation & Amortization	128,170	188,850	60,680
Printing	62,824	148,662	85,838
Shipping & Postage	70,115	153,362	83,247
Interest	131,162	120,000	(11,162)
Total G & A Expenses	**22,790,244**	**23,505,658**	**715,415**
Total Operating Gain/(Loss)	**$ 47,114,189**	**$ 11,767,955**	**$ 35,346,235**
Non Operating			
Revenues - Interest	292,886	133,297	159,588
Expenses - Interest	45,787	0	(45,787)
Total Non-Operating	247,099	133,297	113,801
Total Increase/(Decrease) in Unrestricted Net Assets	47,361,288	11,901,252	35,460,036
Net Assets, Beginning of Year	32,613,991		
Net Assets, End of Year	79,975,279		

Statement of Cash Flows - Monthly

	FEB 15	JAN 15	DEC 14
Cash Flow From Operating Activities			
Collected Premium	$ 75,979,999	$ 65,158,436	$ 76,497,908
Miscellaneous Income	46,762	48,276	47,435
State Pass Through Funds	9,450,060	2,598,890	1,619,462
Paid Claims			
Medical & Hospital Expenses	(22,042,511)	(22,846,193)	(26,863,207)
Pharmacy	(6,738,450)	(6,128,544)	(5,297,236)
Capitation	(3,068,241)	(2,997,785)	(2,939,560)
Reinsurance of Claims	(502,015)	(487,795)	(476,754)
State Pass Through Funds Distributed	(9,701,452)	(2,811,581)	(1,234,422)
Paid Administration	(1,729,687)	(4,626,082)	(3,518,102)
MCO Tax Received / (Paid)	(2,614,091)	(3,969,326)	(5,327,887)
Net Cash Provided/ (Used) by Operating Activities	**39,080,373**	**23,938,297**	**32,507,638**
Cash Flow From Investing/Financing Activities			
Net Acquisition of Property/Equipment	(110,638)	(12,875)	0
Net Cash Provided/(Used) by Investing/Financing	**(110,638)**	**(12,875)**	**0**
Net Cash Flow	**$ 38,969,735**	**$ 23,925,422**	**$ 32,507,638**
Cash and Cash Equivalents (Beg. of Period)	239,657,138	215,731,716	183,224,078
Cash and Cash Equivalents (End of Period)	278,626,873	239,657,138	215,731,716
	$ 38,969,735	**$ 23,925,422**	**$ 32,507,638**
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	5,862,553	5,728,622	5,484,006
Depreciation & Amortization	30,689	30,689	30,689
Decrease/(Increase) in Receivables	7,440,201	4,671,870	7,914,675
Decrease/(Increase) in Prepaids & Other Current Assets	(20,190)	70,705	95,643
(Decrease)/Increase in Payables	5,523,148	(43,607,863)	10,245,526
(Decrease)/Increase in Other Liabilities	20,577,717	62,534,720	(4,284)
Change in MCO Tax Liability	(601,867)	(2,219,500)	(4,306,255)
Changes in Claims and Capitation Payable	848,138	4,512,479	1,254,427
Changes in IBNR	(580,015)	(7,783,425)	11,793,211
	39,080,373	23,938,297	32,507,638
Net Cash Flow from Operating Activities	**$ 39,080,373**	**$ 23,938,297**	**$ 32,507,638**

Statement of Cash Flows - YTD

	FEB 15
Cash Flow From Operating Activities	
Collected Premium	$ 533,673,160
Miscellaneous Income	292,886
State Pass Through Funds	45,291,888
Paid Claims	
Medical & Hospital Expenses	(186,917,124)
Pharmacy	(47,748,777)
Capitation	(22,382,138)
Reinsurance of Claims	(3,929,401)
State Pass Through Funds Distributed	(43,373,661)
Paid Administration	(24,561,533)
MCO Taxes Received / (Paid)	(31,705,149)
Net Cash Provided/(Used) by Operating Activities	**218,640,150**
Cash Flow From Investing/Financing Activities	
Net Acquisition of Property/Equipment	(189,975)
Net Cash Provided/(Used) by Investing/Financing	**(189,975)**
Net Cash Flow	**$ 218,450,175**
Cash and Cash Equivalents (Beg. of Period)	60,176,698
Cash and Cash Equivalents (End of Period)	278,626,873
	$ 218,450,175
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	47,361,288
Depreciation & Amortization	241,438
Decrease/(Increase) in Receivables	48,887,128
Decrease/(Increase) in Prepaids & Other Current Assets	7,531
(Decrease)/Increase in Payables	9,736,235
(Decrease)/Increase in Other Liabilities	83,086,735
Change in MCO Tax Liability	(14,756,855)
Changes in Claims and Capitation Payable	4,587,576
Changes in IBNR	39,489,074
	218,640,150
Net Cash Flow from Operating Activities	**$ 218,640,150**

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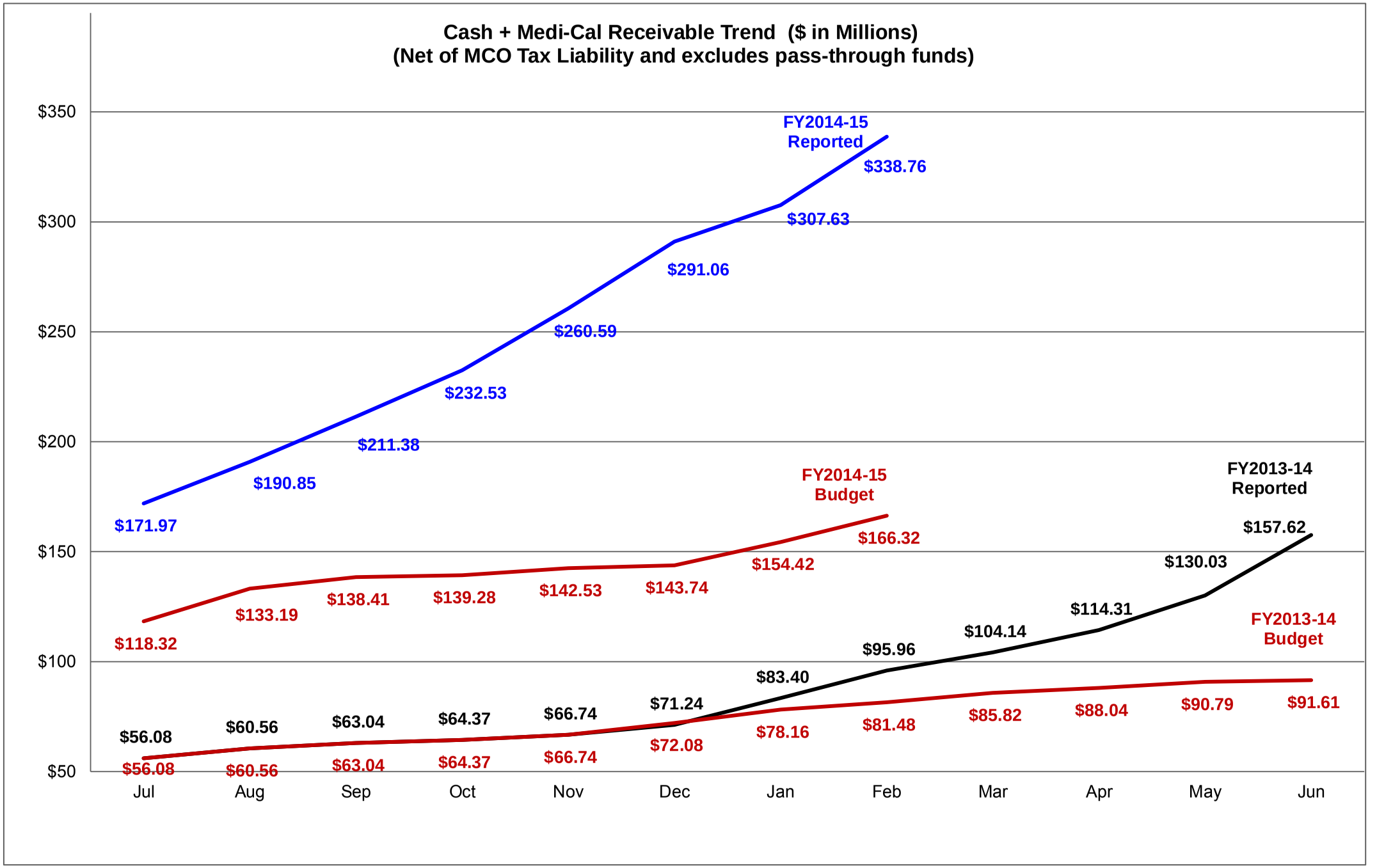
For the month ended February 28, 2015

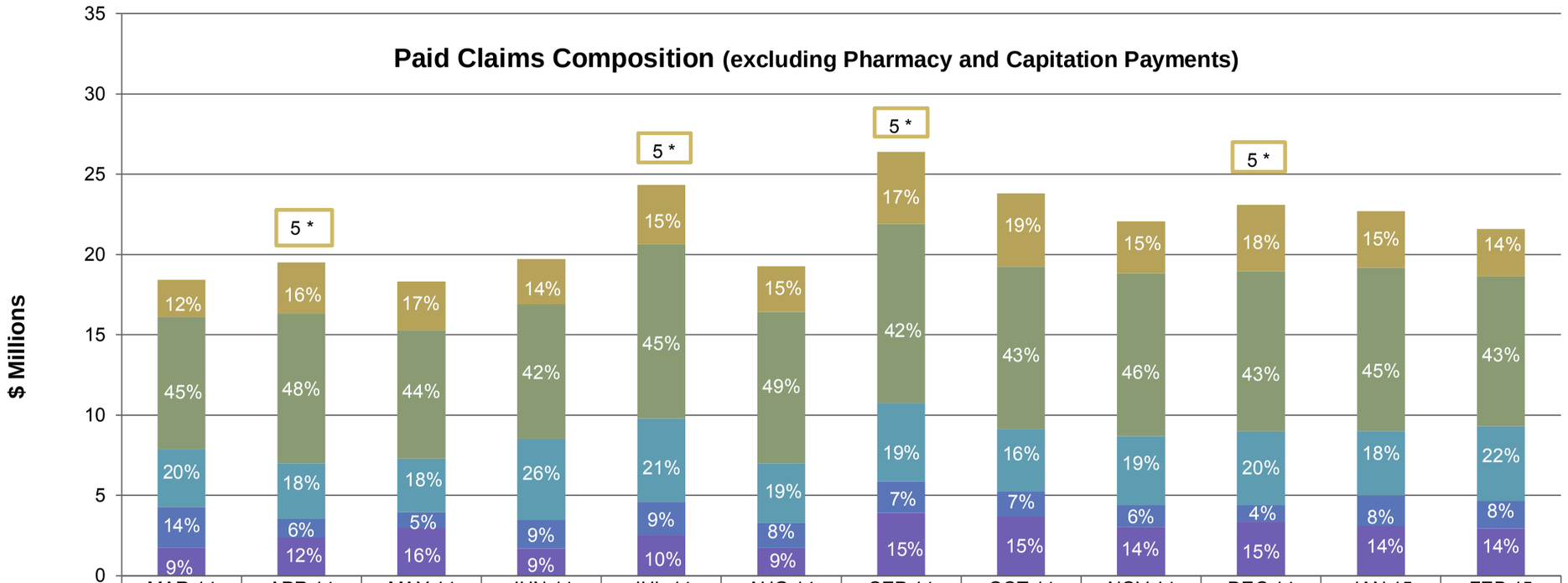
APPENDIX

- Cash Trend Combined
- Paid Claims and IBNP Composition
- Total Expense Composition
- Pharmacy Cost Trend
- Pharmacy Cost & Utilization Analysis

GOLD COAST HEALTH PLAN
FEB 15

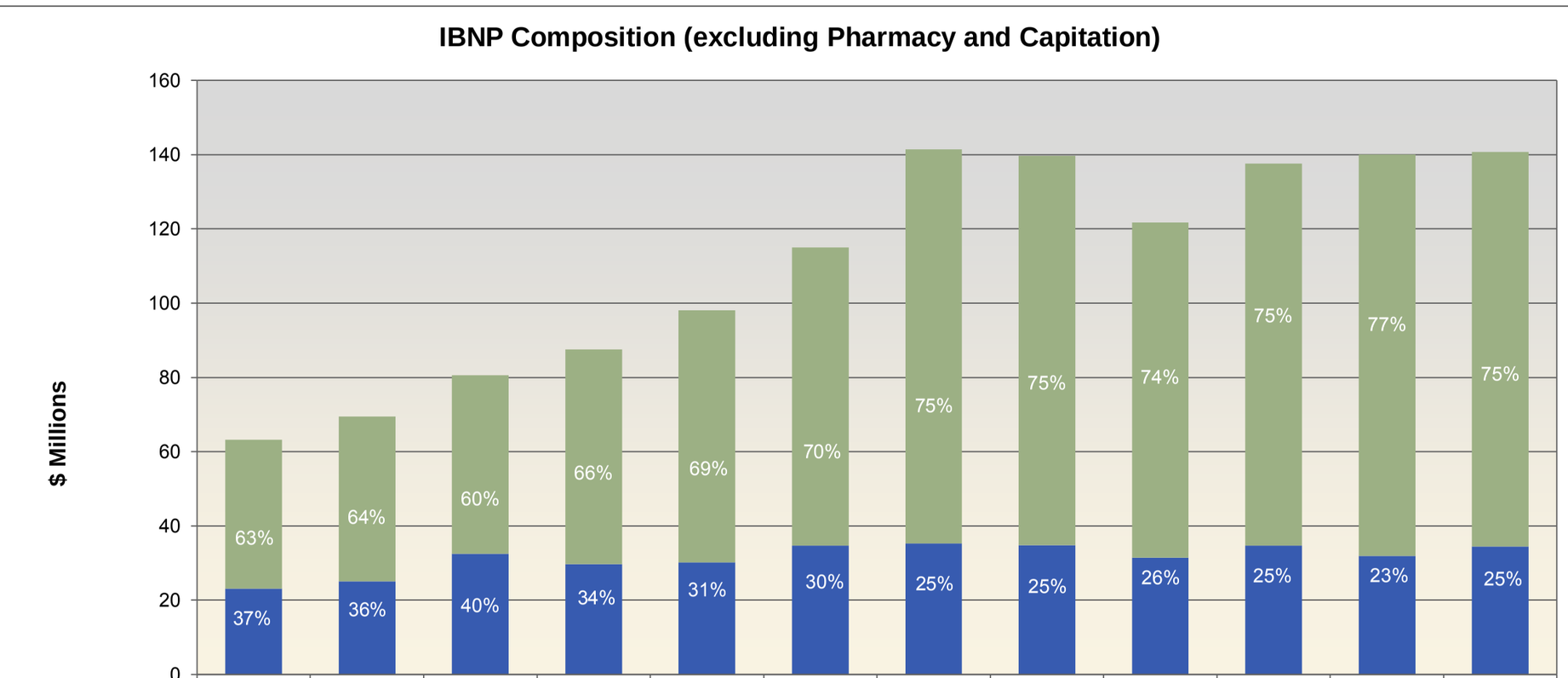


GOLD COAST HEALTH PLAN
FEB 15



	MAR 14	APR 14	MAY 14	JUN 14	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15
Current	2.30	3.20	3.05	2.84	3.70	2.85	4.50	4.57	3.25	4.14	3.50	2.93
30	8.24	9.33	7.99	8.35	10.85	9.42	11.15	10.13	10.15	9.96	10.20	9.36
60	3.60	3.44	3.32	5.04	5.20	3.69	4.90	3.89	4.29	4.61	4.00	4.65
90	2.54	1.18	1.00	1.80	2.10	1.58	1.95	1.56	1.35	1.03	1.90	1.70
120+	1.75	2.37	2.97	1.70	2.50	1.73	3.90	3.66	3.05	3.35	3.10	2.95

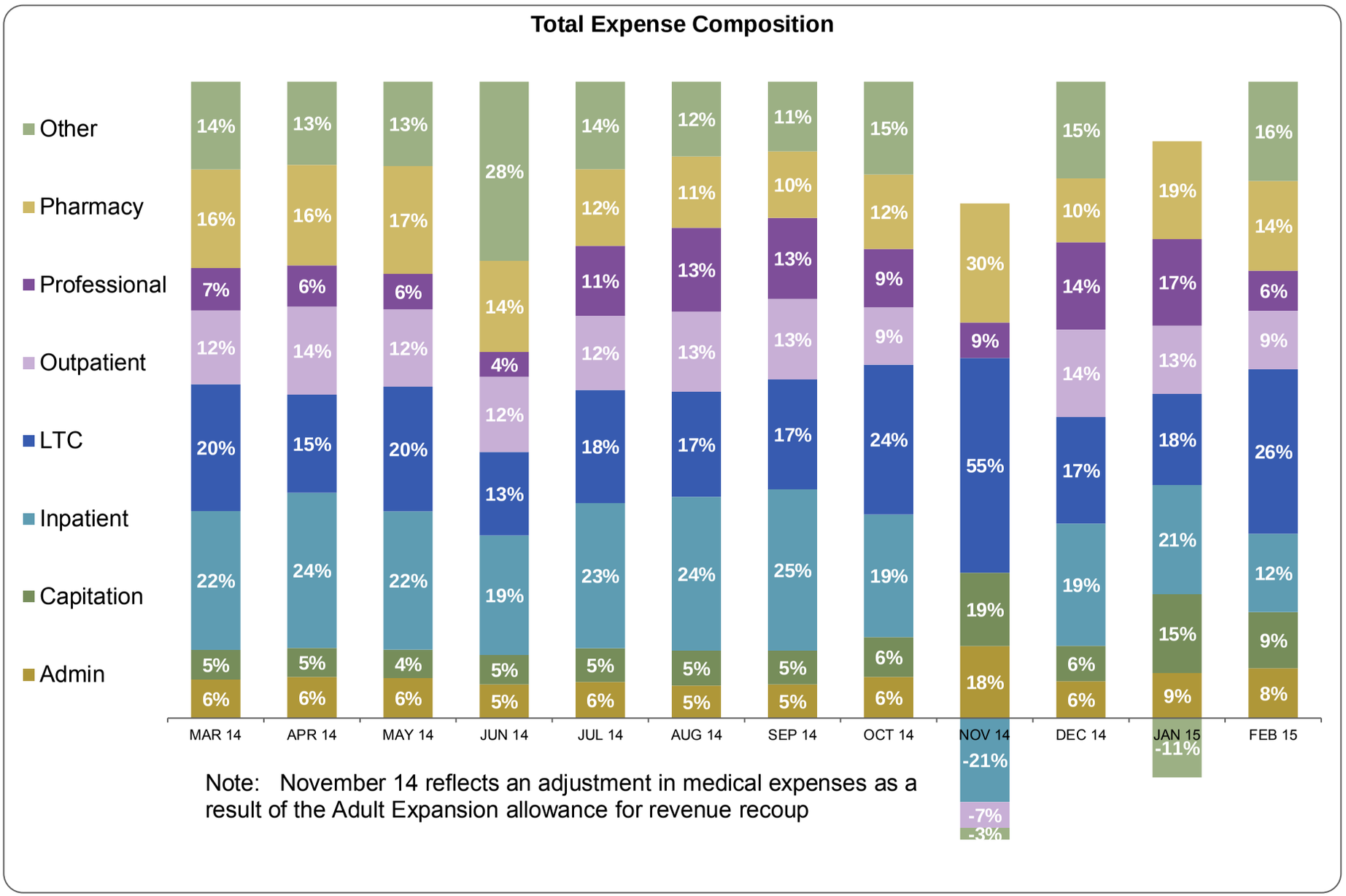
Note: Paid Claims Composition - reflects adjusted medical claims payment lag schedule.
* Months Indicated with 5* represent months for which there were 5 claim payments. For all other months, 4 claim payments were made.



	MAR 14	APR 14	MAY 14	JUN 14	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15
Prior Month Unpaid	40.10	44.38	48.09	57.90	67.93	80.29	106.07	104.95	90.22	102.84	108.19	106.23
Current Month Unpaid	23.14	25.09	32.44	29.69	30.14	34.67	35.33	34.78	31.45	34.71	31.86	34.48
Total Unpaid	63.24	69.47	80.53	87.59	98.06	114.96	141.40	139.73	121.67	137.55	140.05	140.71

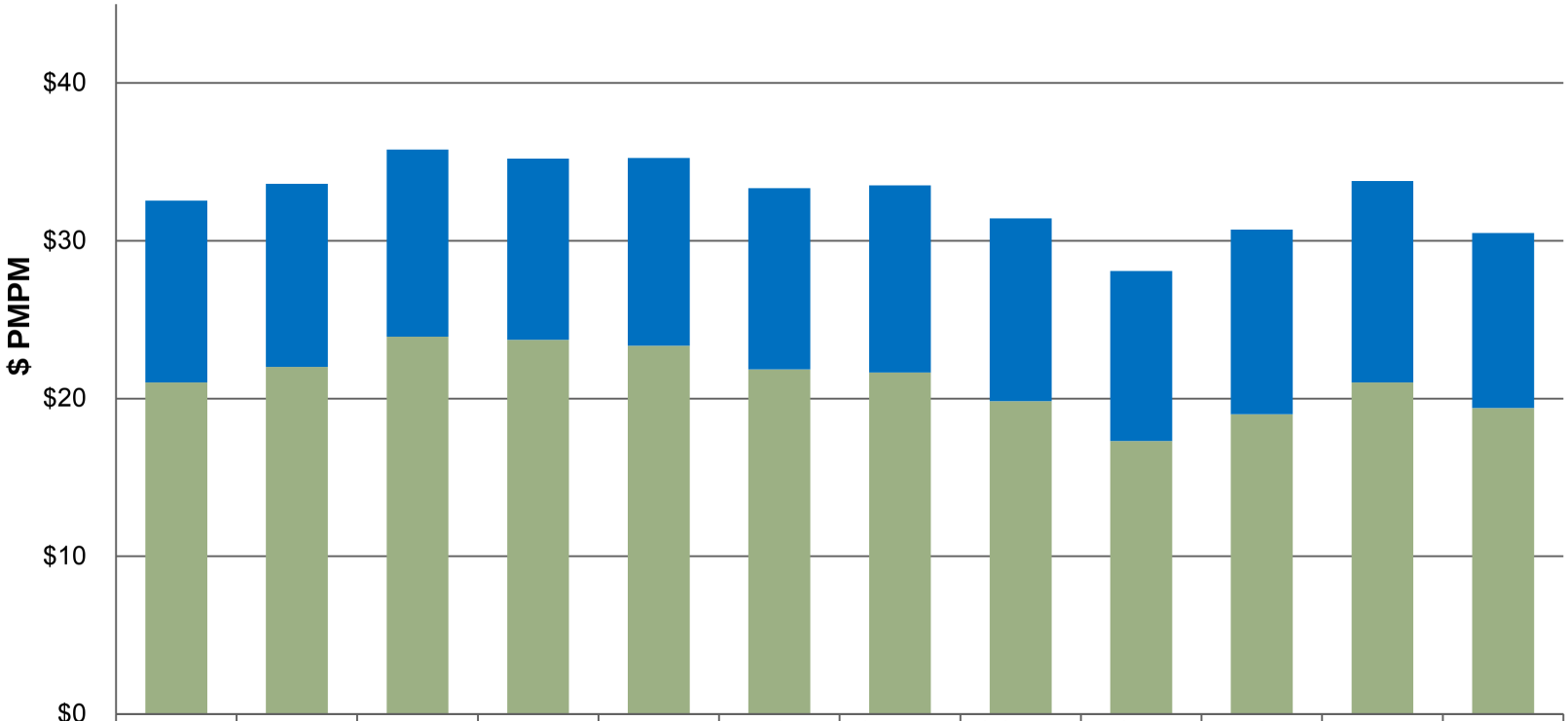
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

GOLD COAST HEALTH PLAN



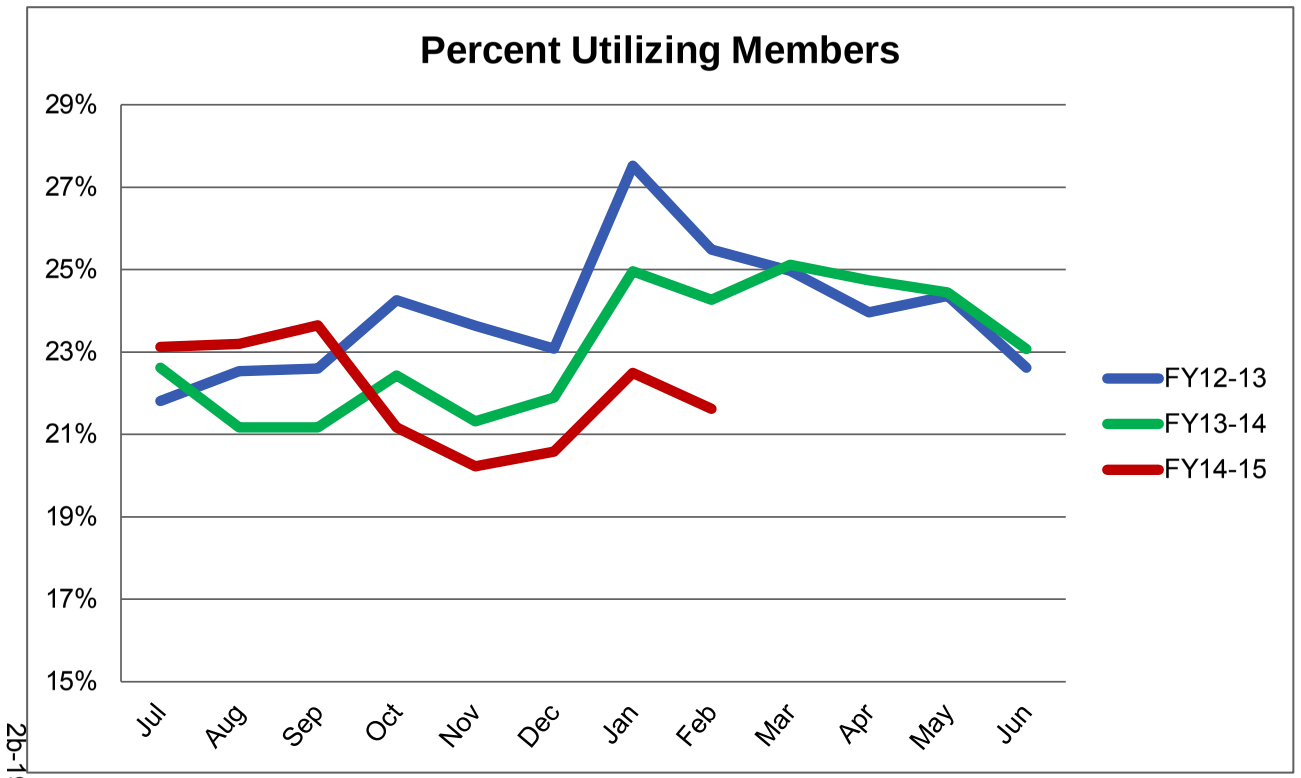
GOLD COAST HEALTH PLAN

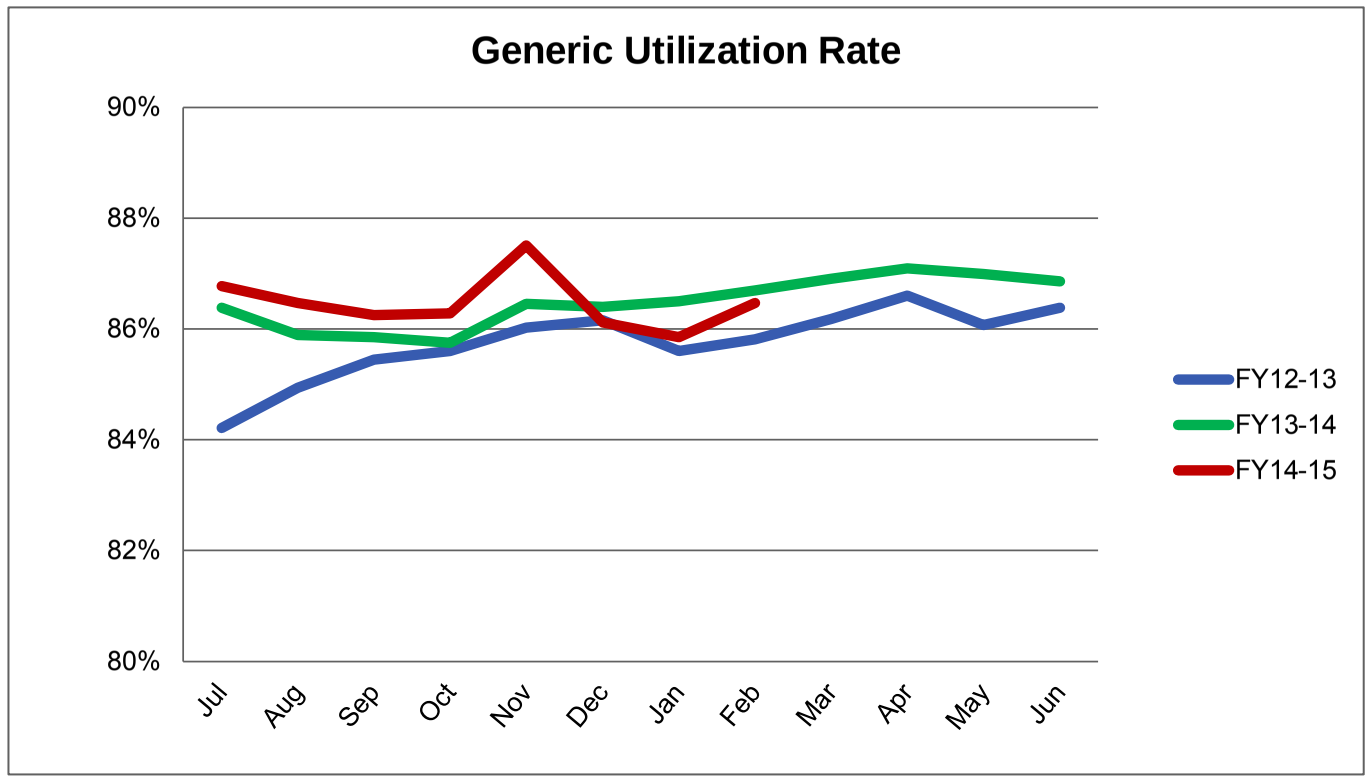
Pharmacy Cost Trend

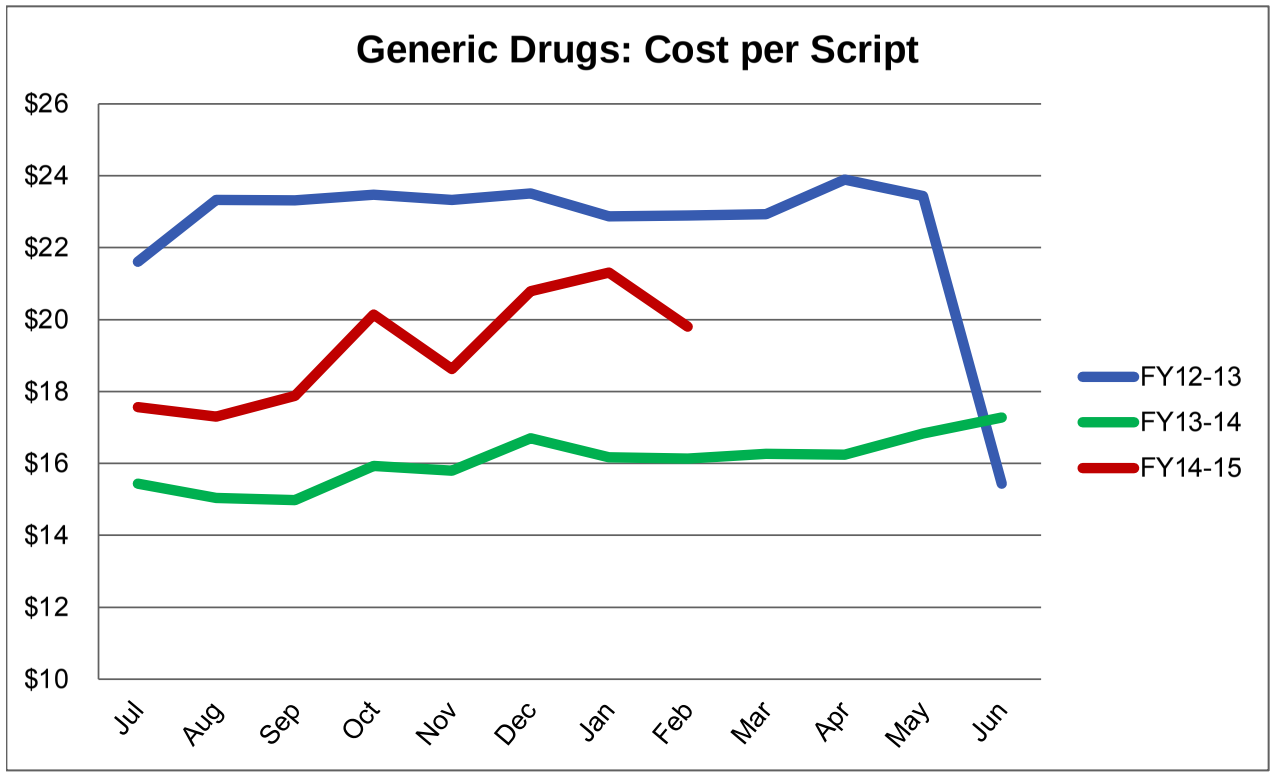


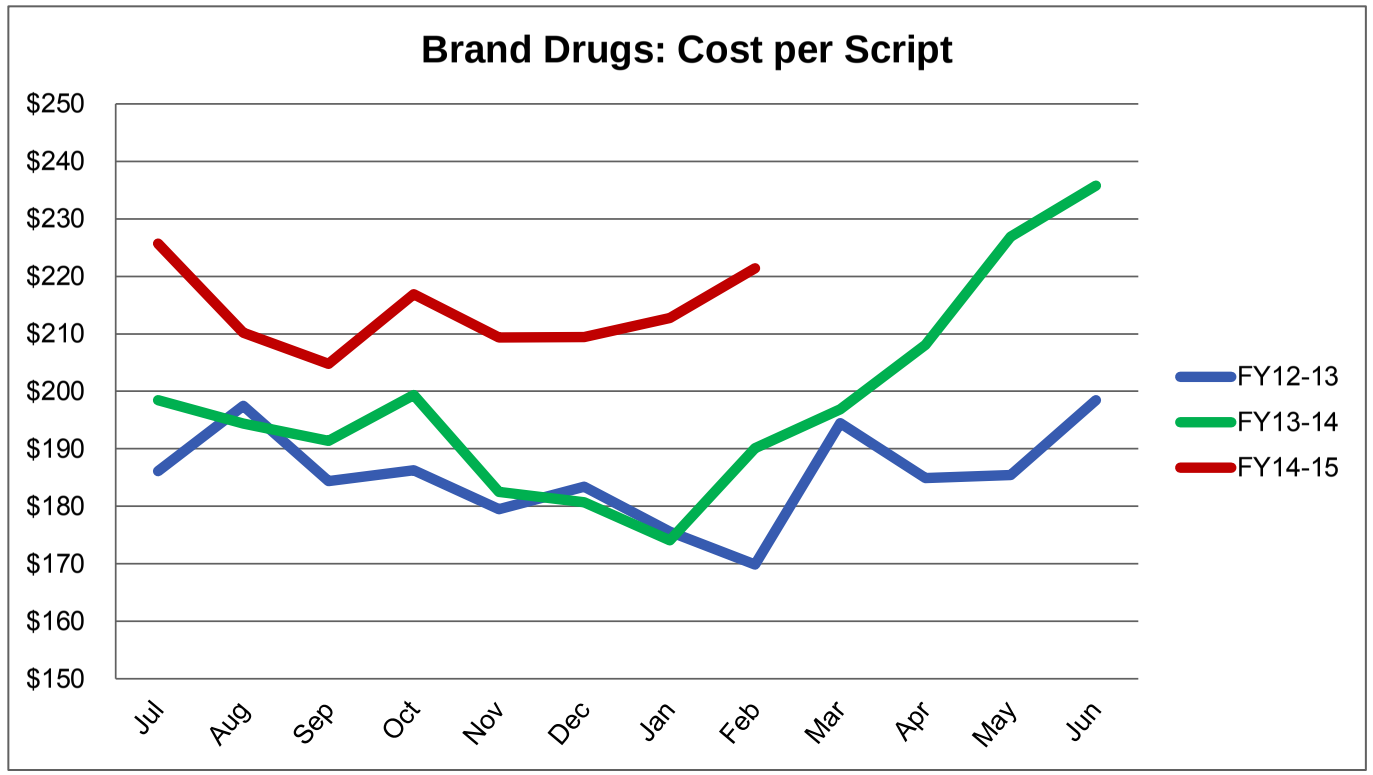
	MAR 14	APR 14	MAY 14	JUN 14	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15
AVG PMPM	$32.55	$33.60	$35.78	$35.21	$35.25	$33.33	$33.52	$31.41	$28.09	$30.71	$33.79	$30.49
GENERIC	$11.53	$11.59	$11.87	$11.49	$11.91	$11.49	$11.86	$11.58	$10.78	$11.71	$12.77	$11.09
BRAND	$21.02	$22.01	$23.92	$23.72	$23.34	$21.85	$21.66	$19.83	$17.31	$19.01	$21.02	$19.40

GOLD COAST HEALTH PLAN
Pharmcy Analysis









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INVESTMENT COMMITTEE UPDATE

April 27, 2015

COMMISSION MEETING

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Investment Committee

- First meeting held March 27, 2015
- Approved the Investment Charter
- Approved an expense in the amount of $5,000 for an investment advisor.
- Approved Committee Members
  - John Meazzo, Chair
  - Dee Pupa, Commissioner
  - Lyndon Turner, Director of Financial Analysis
  - Allen Maithel, Controller
  - Open
- Recommend Investment advisor is not required considering our current investment goals

AGENDA ITEM 3a

To: Gold Coast Health Plan Commission

From: Brandi Armenta, Compliance Director

Date: April 27, 2015

RE: Department of Health Care Services (DHCS) Contract Amendment A16

SUMMARY:
Gold Coast Health Plan received contract amendment A16 from DHCS on April 8, 2015. The amendment includes additional language relative to Senior and Persons with Disabilities (SPD).. As a County Operated Health System (COHS) plan, SPD members have always been included in the Plans membership. This contract amendment language is inclusive of additional requirements such as but not limited to risk stratification and additional reporting specific to the SPD population.

BACKGROUND / DISCUSSION:
N/A

FISCAL IMPACT:
There is no fiscal impact, but an addition of language specific for the SPD population which the Plan already has in its existing membership.

RECOMMENDATION:
Staff's recommendation is for the Commission to authorize the CEO to execute DHCS Contract Amendment A16.

CONCURRENCE:
N/A

Attachments:
N/A

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INVESTMENT CONTROLS POLICIES AND PROCEDURES

April 27, 2015

COMMISSION MEETING

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- The investment policy was adopted by GCHP in March of 2015. The investment policy addresses various areas that relate to investment mission, responsibilities, investment safeguards, etc.

- The purpose of internal controls and procedures is to identify the processes and controls that are to be followed and implemented to ensure the safety of the investments and funds.

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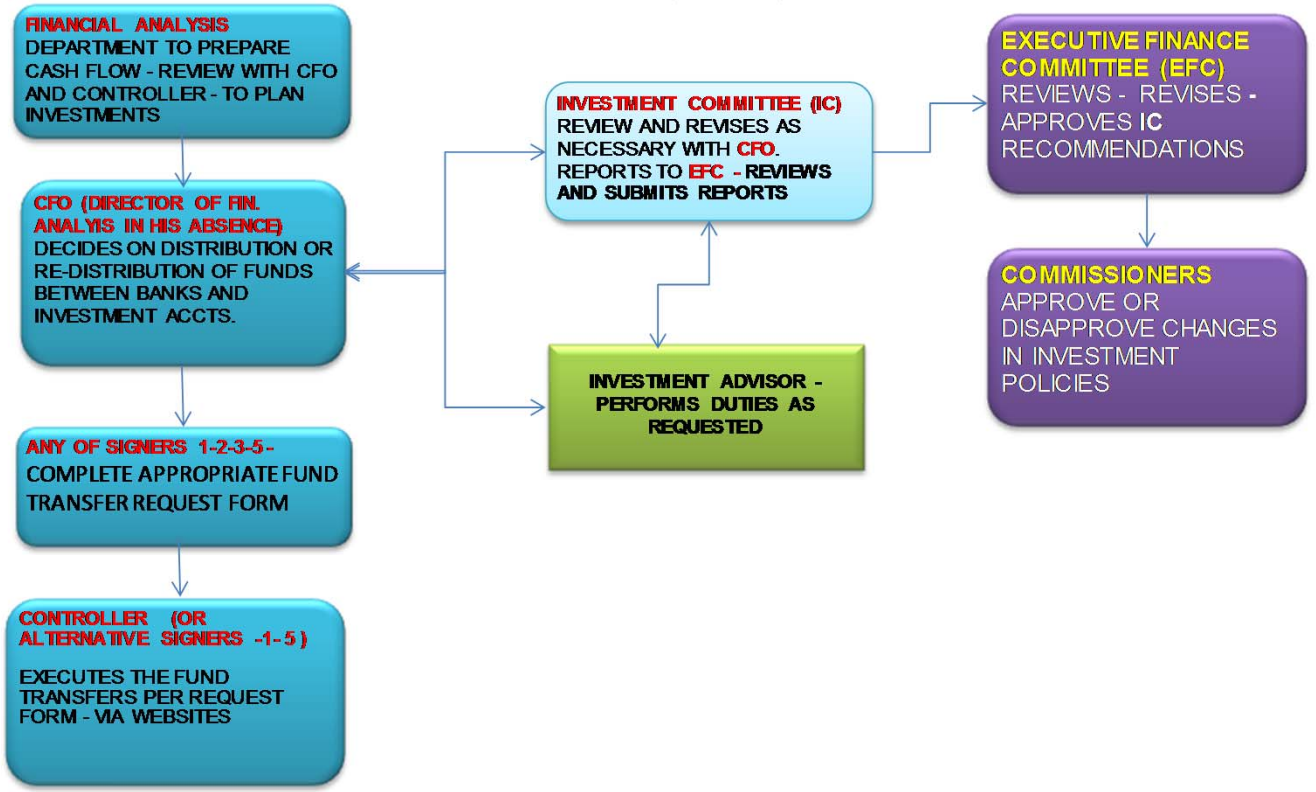
CHART 1

INVESTMENT FUNDS MANAGEMENT

INVESTMENT POLICIES - REPORTING



I. Investing and Internal Controls

A. Investment of Funds

– i. The CFO or in his absence the Director of Financial Analysis or Controller will decide on the amount/s to be transferred to any of the bank or pooled accounts (hereinafter referred to as Bank/s) based upon the cash flow. This is just for investment planning purposes and not for authorizing transfers.

3b-4

REQUEST TO TRANSFER FUNDS (COMPLETE PROVIDED FORMS) FORM INVEST-1

	BANKS	RABOBANK	BANK OF THE WEST	MANUFACTURERS BANK	HERITAGE OAKS BANK	TOTAL BANKS	POOLED INVESTMENTS	WELLS FARGO - CALTRUST - SHORT TERM	WELLS FARGO - CALTRUST - MEDIUM TERM	CALIFORNIA STATE TREASURER - LAIF	COUNTY OF VENTURA	TOTAL POOLED	GRAND TOTAL
3/25/2015		(50,000,000)						50,000,000					
4/2/2015		(25,000,000)			$ 25,000,000								
4/3/2015		(20,000,000)		20,000,000									

– ii. A funds transfer form (provided by banks or internal if not provided) is to be completed by staff and signed (authorized) by any of the 5 signers based upon the instructions. The Staff that actually makes the wire transfers cannot complete the transfer request form (division of responsibilities). Therefore, the fund transfer request by once signer and another signer to actuate the fund transfer. Example: the CFO completes the request form and the Controller will actuate the fund transfer by wire and faxing the completed form to appropriate Bank.

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B. Internal Controls

- i. A copy of fund transfer authorization will be provided to the Investment Accountant (ICC). The (ICC) in Finance will maintain an historical log (INVEST-1) of all transfer requests and document all confirmation data
- ii. The ICC will ensure that the transaction has cleared the Bank the following day and note such clearing date on the log. The trade or transfer confirmations will be routed directly to the ICC. The ICC will match all confirmation with the log and attach the confirmation to the transfer request.
- iii. The ICC will provide the information of the transfer to the accountant for preparation of journal entries.
- iv. Monthly statements for the pooled funds and new bank accounts will be sent to the CFO which will initial the statements and rout to the ICC. v. The ICC will perform monthly reconciliations between the general ledger and the statements received by the banks.
- vi. The ICC will maintain an investment schedule and provide the accountant with the investment income and realized and unrealized capital gains and losses. Investment income will be accrued is not readily available
- vii. The Director of Financial Analysis or CFO will monthly independently review the reconciliation prepared by the ICC with the Bank statements as well as to the log of fund transfers INVEST-1

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II. Banking controls

A. All Banks (other than Rabobank) have been instructed to:
   i. Transfer funds only to Rabobank. Funds cannot be transferred to any other banks
   ii. Paper checks will not be used for any Bank account other than Rabobank.
   iii. Not allow anyone of setting up any payees/vendors
   iv. Not allowed to transfer funds to any other entity
   v. Send an email of any transaction to the CFO and the CEO

B. Rabobank will be used as the clearing bank for all funds to be invested with any Bank.
   i. All previous procedures on use of the Rabobank to pay claims, payroll etc. have not been addressed nor changed with these procedures.
   ii. Any transfer in excess of $7 million at Rabobank, triggers a call from the bank to the CFO to validate the transfer.

Fund Transfer Bank Matrix

Transfer Limitations

BANKS	RABOBANK	BANK OF THE WEST	MANUFACTURERS BANK	HERITAGE OAKS BANK	CALTRUST	CALIFORNIA STATE TREASURER	COUNTY OF VENTURA
RABOBANK							
BANK OF THE WEST							
MANUFACTURERS BANK							
HERITAGE OAKS BANK							
POOLED INVESTMENTS							
CALTRUST							
CALIFORNIA STATE TREASURER							
COUNTY OF VENTURA							

ALLOWED TO TRANFER

NOT ALLOWED TO TRANFSER

Requested that the Banks provide the Plan to confirmin writing, adherence to our restrictions and limitations

III. Finance management of investment Transactions.

Finance will maintain documents such as pertinent information of bank and pooled funds contact information, cash flows (short and long term availability of funds) and other management and reference information.

IV. Monitoring of pooled investment

The Finance Department will monitor the valuation of investment on a monthly basis. The money market and similar deposits will not fluctuate in value and quoted at par. Other pooled investments may be quoted at a Net Asset Value (NAV) per share and will experience unrealized and realized capital gains and losses.

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V. Reporting

Finance will provide investment reports on a monthly basis with semi-annual and yearly recaps, a list of reports to be used as internal and external review of the portfolio including:

A. List of investments and funds by:
   i. Bank
   ii. Pooled funds
   iii. Individual securities

B. Provide roll forward schedule of investment deposits and investment portfolio, including cost basis, market value (if available), realized and unrealized gain and losses, current yields, yields to maturity (individual investments)

- The information will be shown in charts as well.

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VI. Investment Status

BANKS	Target		
RABOBANK		$ 40,000,000	+ CASH FLOW
BANK OF THE WEST	4/10/2015	20,000,000	
MANUFACTURERS BANK	4/3/2015	20,000,000	Funded
HERITAGE OAKS BANK	4/2/2015	25,000,000	Funded
TOTAL BANKS		$ 105,000,000	
POOLED INVESTMENTS			
WELLS FARGO - CALTRUST - SHORT TERM	3/25/2015	$ 50,000,000	Funded
WELLS FARGO - CALTRUST - MEDIUM TERM		50,000,000	
CALIFORNIA STATE TREASURER - LAIF	4/15/2015	50,000,000	
COUNTY OF VENTURA	4/10/2015	50,000,000	
TOTAL POOLED		200,000,000	
TOTAL INVESTMENT AND BANK DEPOSITS		$ 305,000,000	

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THANK YOU

AGENDA ITEM 3c

To: Gold Coast Health Plan Commission

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

Re: Quality Improvement 2014 Work Plan Evaluation Approval

Date: April 27, 2015

SUMMARY

The Quality Improvement Department developed a work plan at the beginning of 2014 and updated that work plan through the year. With the conclusion of 2014 the Department has done an evaluation of the 2014 work plan to assess the accomplishments with relation to the goals outlined in the work plan.

BACKGROUND

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

RECOMMENDATION

GCHP is requesting the Commission approve the 2014 Quality Improvement Work Plan Evaluation.

CONCURRENCE:

N/A

Attachments:

2014 Work Plan.

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. 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."	2013 Data for 2014 Measure	02/14	05/14	QI	The HEDIS 2014 reporting for 2013 data was submitted on 06/13/14. The following six measures did not meet DHCS minimum performance level (MPL):
	1. Edit and submit HEDIS Roadmap	11/13	1/14		
	2. Submit test run				
	3. Submit production run	11/14	12/14		
	4. Record retrieval	11/14	01/14		
	5. Record Abstraction	02/14	03/14		
	6. Admin Refresh	03/14	05/14		
	7. HEDIS HSAG Audit	02/14	04/14		
	8. HEDIS Submission	03/14	03/14		
	9. Summer Run	05/14	06/14		
		06/14	07/14		

Measure	Description	MPL	GHCP Rate
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Age 25 months – 6 years	Percentage of members who had a visit with a PCP	86.37	86.27
Age 7 to 11		87.77	82.26
Age 12 to 19		86.09	79.18
Well Child Visits in Years 3 – 6 (W34)			
	Percentage of members that were 3, 4, 5, or 6 years of age and had 1 or more well care visits with a PCP during the measurement year	67.40	64.23

3c-2

Weight Assessment for Children (WCC)			
Nutrition	Percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year	47.45	43.31
Physical activity		34.55	28.71

The following provider interventions were developed and implemented:

1. CHDP Provider training on HEDIS – April 16, 2014
2. Distribution of HEDIS 2013 Provider Report Card – June 2014
3. Provider education of how to collect nutrition and physical activity education on the Staying Health (SHA) form – June 2014
4. HEDIS Coding and Documentation Tips to Improve Hybrid Measurement Scores published in Provider Operations Bulletin (POB) – July 2014
5. Improve Your WCC HEDIS Measure Scores Using the Staying Healthy Assessment (SHA) Form published in POB July 2014
6. 2014 Mid-year HEDIS reports (performance feedback) with list of members with and without screenings in 2014 – September 2014
7. Provided BMI education to providers during Initial Health Assessment (IHA) audits – Summer 2014
8. Article on WCC measure rates and how to improve rates through improved billing and coding published in POB October 2014
9. Introduction to HEDIS – Informational Presentation – on web site October 2014
10. Provider updates posted on web site: Low Performing HEDIS Measure for Children & Adolescent Wellness Exams– November 2014

The following HEDIS measures declined from 2012 to 2013. However they remained above the MPL.

Measure	Description	2012	2013	Change
Controlling High Blood Pressure (CBP)*				
	Percentage of members that were 18 – 85 years of age with a diagnosis of hypertension and adequately controlled BP (<140/90) during the measurement year	61.56	54.01	- 7.55
Childhood Immunization Status (CIS)				
	Percentage of children 2 years of age that had DtaP, IPV, MMR, HiB, HepB, VZV and Pneumococcal Conjugate (Combo 3)	80.05	75.43	- 4.62
Immunization for Adolescents (IMA)				
	Adolescents who received a meningococcal vaccine on or between the member's 11th and 13th birthday and Tdap or Td on or between the member's 10th and 13th birthdays (Combo1)	65.21	60.34	- 4.87
Prenatal and Postpartum Care (PPC)				
Postpartum Care	Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	63.99	59.37	- 4.62

*Measure uses medical record review only

2014 HEDIS rates will not be available until July 2015. However, due to the decline in the rates noted above as well as the six measures that did not meet the MPL in 2013, these measures will continue to be monitored in 2015.

A member incentive program for well-child visits will be implemented in 2015 with the potential to impact the following HEDIS measures:

1. Children and Adolescents' Access to Primary Care Practitioners (CAP)
2. Well Child Visits in Years 3 – 6 (W34)
3. Weight Assessment for Children (WCC)
4. Childhood Immunization Status (CIS)
5. Immunization for Adolescents (IMA)

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.	01/14	12/14		2014 Adult CAHPS survey results from the Myers Group received December 2014. Response rate was 17.7%. To be presented to Senior Leadership for development of interventions. Areas noted to have opportunities for improvement: Getting Needed Care (78.2%) Getting Care Quickly (79.8%) Customer Service (82.7%) Shared Decision Making (49.7%)
2. Provider Satisfaction Surveys GCHP will assume responsibility to conduct, and for the monitoring, oversight, and reporting of 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.	01/14	12/14	Network Ops	2013 Provider Satisfaction Survey results presented at Network Planning Committee (NPC) and at Quality Improvement Committee (6/24/14). Loyalty analysis indicated that 72.9% of provides surveyed were indifferent; 20.6% loyal and 6.5% defection. Overall satisfaction rates (responses of "Well Above Average" and "Somewhat Above

3c-4

					Average") were as follows: • Finance Issues 21.4% • Utilization and Quality Management 27.9% • Network/Coordination of Care 30.5% • Pharmacy 19.9% • Health Plan Call Center Service Staff 33.1% • Provider Relations 43.9% • Recommend to Other Physicians' Practices 64.6% Improvement plan is to augment and improve compensation in order to improve provider satisfaction and provider loyalty to Plan. Survey for 2015 will be sent out Q2 2015.
3. Access to Care Survey	Discuss survey at QIC and document	01/04	12/14	Network Ops	The Myers Group 2013 Provider Access Appointment Availability Audit results were presented at QIC on 2/25/14. *Overall Appointment Availability:* 80% of provider offices (Primary Care Providers (PCP) and Specialist) surveyed reported appointment availability within 48 hours of request. *Urgent Appointment (within 48 hours) Availability:* 70% of PCPs were able to provide an urgent appointment within 48 hours. • If the PCP was not available, 88.9% were

					able to provide an urgent appointment with a back-up provider. • There were nine (9) PCPs identified that did not meet the standard. 84.6% of Specialists were able to provide an urgent appointment within 48 hours. • If the Specialist was not available, 60% were able to provide an urgent appointment with a back-up provider. • There were eleven (11) Specialists identified that did not meet the standard. *Non-Urgent Appointment:* 87.5% of PCPs were able to offer a non-urgent appointment within ten (10) business days. • If the PCP was not available, 100% were able to provide a non-urgent appointment with a back-up provider. • One (1) PCP did not meet the standard. 94.6% of Specialists were able to offer a non-urgent appointment within fifteen (15) business days. • If the Specialist was not available, 25% were able to provide a non-urgent appointment with a back-up provider.

3c-6

					• Three (3) Specialists did not meet the standard. *Emergency Instructions:* Forty-five (45) providers (12 PCPs; 35 Specialists) contacted after hours did not give appropriate response to “hang up and dial 911.” Results were posted in the 02/18/14 Provider Operation Bulletin along with Access to Care standards. Those providers identified by Network Operations that were not meeting specific requirements were educated by Provider Relations Representatives during Q1 and Q2 2014. Provider Relations will conduct ongoing monitoring of all providers twice a year and - issue Corrective Action Plans (CAPs) for those offices with continued non-compliance. After hours calls were conducted October 20 and 21, 2014 by Network Operations to verify that identified non-compliance for emergency instructions has been corrected. Follow-up audit results are as follows: Four (4) PCPs met all standards; eight (8) did not meet standards. Four (4) Specialists met all standards; four (4) terminated with GCHP, five (5) Specialists; after-hours protocol did not apply

					(Radiology and Podiatry, three (3) were noted to be duplicates, and eight (8) did not meet standards. CAPs were issued and all providers completed and closed their CAP. Access Survey will be repeated Q2 2015.

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 01/31/12 and 09/30/13. • Submit analysis of intervention.	01/14	09/14 Ongoing	QI/HS	Continuing to trend and monitor "All Cause Readmissions." 11/12/14 HSAG implemented new process (PDSA) to focus on implementation strategies that will result in meaningful improvement. Collaborating with HS and submitted PDSA worksheet on 12/12/14. Feedback received from HSAG and subsequent technical assistance phone call resulted in focus on process (outreach). Resubmit to HSAG by 01/5/15. Submitted to HSAG 12/31/14. Approved by HSAG on 01/8/15. To complete "Do", "Study" and "Act" documentation and submit to DHCS and HSAG no later than 04/30/15.

3C-8

1b. Internal QIP	• Internal QIP- Increase Retinal Eye Exams for diabetic patients. • Submitted internal QIP to DHCS for approval on 7/31/13 and 9/30/13. • 10/3/14 incentive letters mailed to members with diabetes. • 10/8/14 email to practitioners and office managers informing them of incentive program. • Results of targeted intervention and submission of "Do, Study, Act" portion of PDSA cycle by 4/30/15.	01/14	Ongoing	QI/HE	HEDIS MPL met for diabetic retinal eye exam 6/31/14 (GCHP rate = 45.74, MPL = 44.37). Report submitted 8/29/14. Received score of "Partially Met" due to no statistically significant improvement. 10/21/14 HSAG instructed all Plans to develop a PDSA process and target one intervention. Diabetic Eye Exam Member Incentive Project developed in July 2014 and submitted to HSAG on 11/20/14. Feedback from HSAG on 12/8/14 requested GCHP to document goal of increase in annual exam (goal is 5% increase). Resubmitted to HSAG on 12/15/14. Tentative HEDIS Rates: 2014 Summer Rate (January – May) = 10.29%; Test Run (January – September) = 42.58%. Rate Change = +32.29.

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.	01/14	12/14	UM	Completed; UM measures reported to UM, QIC and the Commission.

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.

*******<u>*Committees to develop Dashboard reporting for 2014.*</u> *Subcommittees report up to QIC quarterly; refer to QIC packets and minutes for details.*

3c-10

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	01/14	12/14		The Quality Improvement Plan and the Quality Improvement Work Plan were approved at the Quality Improvement Committee on 6/24/14.
2. Member Services Committee	• Committee Meetings • Action Plans • Call Center Measures • Annual Review	01/14	12/14		
3. Network Management Committee	• Committee Meetings • Action Plans • Annual Review	01/14	12/14		
4. Grievances & Appeals Committee	• Committee Meetings • Action Plans • G&A Measures • Annual Review	01/14	12/14		

5. Health Education Committee	• Committee Meetings • Action Plans • ED Navigator Program Review • Annual Review	01/14	12/14		
6. Cultural Linguistics Committee	• Committee Meetings • Action Plans • Annual Review	01/14	12/14		
7. Medical Advisory Committee (MAC)	• Committee Meetings • Action Plans • Annual Review • Approve & Review Medical P&Ps	01/14	12/14		
8. 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 authorizations • Develop standardized guidelines	01/14	12/14		
9. Credentials/Peer Review Committee	• Committee Meetings • Action Plans • Annual Review • Revise & review multiple provider P&Ps • Develop organizational application and task list	01/14	12/14		
10. UM Committee	• Committee Meetings • Action Plans • Annual Review • Develop utilization metrics reporting and TATs	01/14	12/14		

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 • 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.	01/14	12/14	QI	Bi-annual DHCS data submission completed for 2014. Procedures for entering data into FSR database and data submission to DHCS via database delayed due to delay in completion of FSR database. FSR nurse certification for DHCS Master Trainer completed 06/1/14. All FSRs, PARs and IHA monitoring completed. FSR database developed and being tested. Training for QI RN as Master Trainer delayed until 2015.
PARS- Physical Accessibility Site Reviews	• P&P written for PARS • Specialist Provider Volume Annual Review due 1/31/14 for submission to DHCS	01/14	12/14	QI	Policy revised to include PARs. Completed- Compiling reports for high volume/ancillary specialists. Submission to state completed 01/28/15.

Objective #7: Quality Measure 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	01/14	12/14	QI	ADA Diabetes CPG not approved at October 2014 MAC meeting. ADA and AACE CPGs to be presented at 01/29/15 meeting for approval and adoption. ADA guideline approved at MAC 01/29/15.
Disease Management Program Selection of Chronic Disease state(s) pertinent to its membership.	• Identify chronic disease for GCHP population disease management.	01/14	12/14	HS	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. ADA Diabetes CPG not approved at October 2014 MAC meeting. ADA and AACE CPGs to be presented at January 29, 2015 meeting for approval and adoption. ADA guideline approved at MAC 01/29/15. Disease management program expected to roll out early Q2 2015. Metrics to be monitored: • Active participation rates • Risk factor progression • Participation rates in educational programs

					• Member satisfaction with program • HEDIS® scores related to diabetes
Member Communication Plan	• Develop materials and mechanisms to communicate to Members • Use Website	01/14	12/14		Member newsletter published three (3) times in 2014. The newsletters are posted on the website.
Provider Communication Plan	• Develop materials and mechanisms to communicate to Providers • Use Website • Create email address & link on website for HEDIS questions • HEDIS report card				Provider Operations Bulletin published six (6) times in 2014. Provider Update published ten (10) times in 2014. HEDIS information posted on website with email address for HEDIS questions. HEDIS report cards distributed June 2014.

Gold Coast Health Plan℠
A Public Entity

Quality Improvement Committee Report

1st Quarter 2015

C. Albert Reeves, MD, CMO

www.goldcoasthealthplan.org

Quality Improvement

Quality Improvement Projects (QIP)

3d-2

Diabetic Retinal Eye Exam

- Ongoing while waiting for 2015 HEDIS Results
- Member Incentive: Movie ticket received for diabetic retinal eye exam in 2014
- 96 members received movie tickets
- Repeating this incentive in 2015

All-Cause Readmissions – Statewide Project

- Study reformulated late 2014
- Worked with 1 contracted hospital doing active discharge planning for high risk members
- 13 week PDSA (Plan, Do, Study, Act) study
- 15% readmission highly related to homelessness and behavior health comorbidities
- Conducting a new 13 week study at another hospital

3d-3

HEDIS

Improving Rates for Measures Falling Below the Medi-Cal Minimum Performance Level

3d-4

- HEDIS Improvement Projects for Well Child Visits in the 3rd, 4th, 5th, 6th years of life (W34)
- Counseling for Nutrition and Physical Activity in children and adolescents (WCC)

Cervical Cancer Screening

- April 2014 reminder letters mailed to all appropriate women who had not had their cervical cancer screening test
- Results evaluated with the 2015 HEDIS Survey
- Repeating this intervention in 2015

3d-5

Quality Improvement Activities

Facility Site Reviews

Interim FSRs				
Total number of I-FSR	Total number of I-FSR approved	Total number of critical element CAPs served	Total number of critical element CAPs completed within 10 days	Total number of critical element CAPs **not** COMPLETED within 10 DAYS
5	5	0	N/A	N/A

First Quarter of 2015						
Number of Initial Facility Suite Review	Number of Interim Site Reviews	Number of Initial Facility Review	Number of IHA MRRs Conducted tomorrow	Number of sites with no new members during audit period	Number of sites with passing IHA score above 80%	Number of sites with score below 80%
0	5	0	4	1	4	1

3d-6

Medical Record Reviews

First Quarter 2015						
Total number FSR MRR	Number of I-FSRs	Number Periodic FSRs	Number Medical Records Reviewed	Number Records (+) for screening for smoking / tobacco use	Number Records (+) for tobacco exposure or use	Number Records documenting Counseling performed
0	5	0	33	27 (89%)	3	3 (100%)

3d-7

Potential Quality Issues (PQI) Reviews

- 32 total to date (4th Quarter)

  Cases referred from:

  - Associated Medical Director - 1
  - Health Services - 23
  - Health Education - 2
  - Grievance and Appeals - 4
  - Utilization Management - 1
  - Director of Pharmacy - 1

3d-8

Quality Improvement Dashboard

3d-9

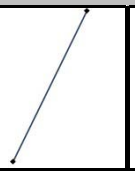
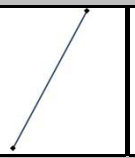
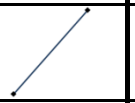
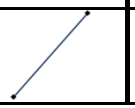
Gold Coast Health Plan HEDIS Measures -- *Quality of Care Indicators*

Legend:

Dark Green = Performance ≥ P90

Yellow = Performance ≤ P50

Red = Performance ≤P25

Measure	Description	Responsible Department	Benchmark Source	2012 Rate	P10	P25 (MPL)	P50	P75	P90 (HPL)	2013 Rate	2014 Rate	Annual Trend 2012 - 2013	Interventions
(AAB) Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis													
AAB (Bronchitis)	The percentage of adults 18-64 years old with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or within three days after the episode start date.	Quality Improvement	HEDIS	13.87	14.88	**17.92**	22.14	28.18	35.45	**18.24**			
(CAP) Children and Adolescents' Access to Primary Care Practitioners													
CAP: age 12-24 months	The percentage of members who had a visit with a PCP.	Quality Improvement	HEDIS	82.51	92.37	95.51	**96.89**	97.84	98.49	**97.37**			
CAP: age 25 months - 6 years				63.09	**82.76**	86.37	89.39	91.29	93.60	**86.27**			
CAP: age 7 to 11				NR	83.43	87.77	90.88	93.26	95.25	**82.26**			
CAP: age 12 to 19				NR	81.35	86.09	89.58	91.85	93.77	**79.18**			
(LBP) Use of Imaging Studies for Low Back Pain													
LBP	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MR, CT scan) within 28 days of the diagnosis.	Quality Improvement	HEDIS	76.95	68.31	71.52	**75.23**	79.26	82.34	**77.07**			
(MMA) Medication MaNAgement for People with Asthma													
Medication Compliance 50%: 51-64	The percentage of member 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment.	Quality Improvement	HEDIS	NR	NA	NA	NA	NA	NA	NR			
Medication Compliance 50%: Total				NR	40.74	**44.83**	50.94	56.37	61.66	**48.92**			
Medication Compliance 75%: 51-64				NR	NA	NA	NA	NA	NA	NR			
Medication Compliance 75%: Total				NR	19.20	22.17	**27.65**	32.89	38.71	**28.03**			

3d-10

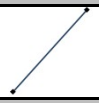
Gold Coast Health Plan HEDIS Measures -- *Quality of Care Indicators*

Legend:

Dark Green = Performance ≥ P90

Yellow = Performance ≤ P50

Red = Performance ≤P25

Measure	Description	Responsible Department	Benchmark Source	2012 Rate	P10	P25 (MPL)	P50	P75	P90 (HPL)	2013 Rate	2014 Rate	Annual Trend 2012 - 2013	Interventions
(MPM) Annual Monitoring for Patients on Persistent Medications													
ACE Inhibitors or ARBs	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.	Quality Improvement	HEDIS	86.73	80.80	84.58	**87.06**	89.19	91.21	**88.47**			
Digoxin				88.46	83.72	87.50	90.82	**93.15**	94.95	**93.33**			
Diuretics				86.28	79.98	83.76	86.74	**89.11**	91.30	**89.51**			
(CCS) Cervical Cancer Screening													
CCS	The percentage of women 24-64 years old who had at least one Pap test during the past 3 years.	Quality Improvement	HEDIS	57.66	47.22	**58.99**	66.38	71.91	76.64	**60.58**			
(CBP) Controlling High Blood Pressure													
CBP	The percentage of members that that were 18-85 years of age with a dx of hypertension and adequately controlled BP (<140/90) during the measurement year.	Quality Improvement	HEDIS	61.56	44.77	**50.00**	56.20	62.97	69.55	**54.01**			

Gold Coast Health Plan HEDIS Measures -- *Quality of Care Indicators*

Legend:

Dark Green = Performance ≥ P90

Yellow = Performance ≤ P50

Red = Performance ≤P25

Measure	Description	Responsible Department	Benchmark Source	2012 Rate	P10	P25 (MPL)	P50	P75	P90 (HPL)	2013 Rate	2014 Rate	Annual Trend 2012 - 2013	Interventions
(CDC) Comprehensive Diabetes Care													
CDC: A1c Testing	The percentage of members that received a subset of services essential to diabetes management	Quality Improvement	HEDIS	81.75	75.91	79.23	**83.21**	87.32	90.97	**85.16**			
CDC: Poor A1c control (> 9.0%); lower rate is better				56.20	31.14	35.76	**43.02**	52.58	59.48	**45.50**			
CDC: Good A1c control (< 8.0%); higher rate is better				37.96	34.58	**39.80**	48.57	53.77	58.64	**45.50**			
CDC: Diabetic Eye Exam				42.58	37.14	**44.37**	54.43	62.46	67.64	**45.74**			
CDC: LDL Testing				78.83	66.79	71.03	**76.28**	80.54	83.52	**79.56**			
CDC: LDL Control (<100 mg/dL)				33.58	21.76	**27.90**	34.69	40.03	43.80	**28.47**			
CDC: Nephropathy Monitoring				79.81	69.76	**75.00**	79.28	82.74	85.85	**78.10**			
CDC: Blood Pressure (<140/90 mm Hg)				62.29	45.67	53.74	**60.93**	68.17	74.55	**61.31**			
(CIS) Childhood Immunization Status													
CIS	The percentage of children 2 years of age that had DTaP, IPV, MMR, HiB, HepB, VZV, Pneumococcal Conjugate (Combo 3)	Quality Improvement	HEDIS	80.05	61.95	66.08	**72.88**	78.30	83.32	**75.43**			
(IMA) Immunizations for Adolescents													
IMA	Adolescents who received one meningococcal vaccine on or between the members 11th and 13th birthday and one Tdap or Td on or between the members 10th and 13th birthdays. Combo 1	Quality Improvement	HEDIS	65.21	50.93	**58.06**	68.59	77.08	85.64	**60.34**			

3d-12

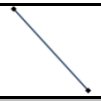
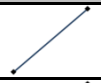
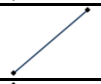
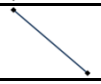
Gold Coast Health Plan HEDIS Measures -- *Quality of Care Indicators*

Legend:

Dark Green = Performance ≥ P90

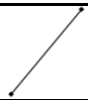
Yellow = Performance ≤ P50

Red = Performance ≤P25

Measure	Description	Responsible Department	Benchmark Source	2012 Rate	P10	P25 (MPL)	P50	P75	P90 (HPL)	2013 Rate	2014 Rate	Annual Trend 2012 - 2013	Interventions
(PPC) Prenatal and Postpartum Care													
PPC 1: Timeliness of Prenatal Care	The percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.	Quality Improvement	HEDIS	80.78	70.59	**79.85**	85.88	89.72	92.82	**83.94**			
PPC 2: Postpartum Care	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.			63.99	50.69	**57.91**	63.99	70.20	73.83	**59.37**			
(W34) Well Child Visits in Years 3-6													
W34	The percentage of members that that were 3, 4, 5, or 6 years of age and had 1 or more well care visits with a PCP during the measurement year.	Quality Improvement	HEDIS	61.80	**60.81**	67.40	72.26	78.51	82.08	**64.23**			
(WCC) Weight Assessment for Children													
WCC: BMI %	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percetile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	Quality Improvement	HEDIS	42.09	22.87	**37.96**	52.31	69.68	80.24	**43.80**			
WCC: Nutrition				42.09	**31.02**	47.45	59.11	67.91	75.18	**43.31**			
WCC: Physical Activity				30.41	**20.92**	34.55	46.23	55.26	64.72	**28.71**			

[1] 2012 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[2] 2013 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
[3] Shaded cells indicate measurements conducted only once annually.

3d-13

Quality Improvement												
Legend: Green = Met or exceeded Benchmark Red = Did not meet Benchmark												
Measure	Description	Responsible Department	Benchmark Source	Benchmark	2012	2013	2014 Q1	Q2	Q3	Q4	Quarterly Trend 2014 Q3 - 2014 Q4	Interventions
Facility Site Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS site audit criteria met.	Quality Improvement	DHCS/ Title 22	80%					98%	100%		
Facility Site Audit (Medi-Cal) - Compliance	The percentage of providers that passed facility audits without or following completion of a corrective action plan.	Quality Improvement	DHCS/ Title 22	NA					100%	100%		
Medical Record Quality Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS medical record audit criteria met.	Quality Improvement	DHCS/ Title 22	80%					94%	97%		
Medical Record Quality Audit (Medi-Cal) - Compliance	The percentage of providers that passed medical record audits without or following completion of a corrective action plan.	Quality Improvement	DHCS/ Title 22	NA					100%	100%		
Coordination of Care	The overall percentage of applicable DHCS Coordination of Care criteria met as determined by medical record audits.	Quality Improvement	NA	Tracking					100%	100%		

Shaded cells indicate measurements conducted only once annually.

Gold Coast Health Plan DHCS QIP Measures									
Non-HEDIS Measure	Description	Responsible Department	Benchmark Source	Benchmark	2012 Rate	2013 Rate	2014 Rate	Annual Trend 2012 - 2014	Interventions
All-Cause Readmissions									
SPD	DHCS Medi-Cal Managed Care Division requires that managed care plans calculate an overall Medi-Cal readmission rate, a readmission rate for the SPD population, and a readmission rate for the non-SPD population and address any disparities identified through barrier analysis with targeted interventions.	Quality Improvement	DHCS	NA	23.16	15.06			
Non-SPD			DHCS	NA	11.32	9.53			
Total (SPD and Non SPD)			DHCS	NA	19.17	13.08			

[1] 2012 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[2] 2013 rates reflect measurement year data from January 1, 2013, through December 31, 2013.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Results													
Legend: Green = Met or exceeded Benchmark Red = Did not meet Benchmark *If no color: Have not received the "All-Plan Comparison Report" to Date*													
Measure	**Description**	**Benchmark Source**	**2013 Benchmark**	**2013 Medi-Cal Managed Care Average Score**	**2013**	**2014 TMG Mean**	**2014 TMG 25th %**	**2014 TMG 50th %**	**2014 TMG 75th %**	**2014 TMG 90th %**	**2014 TMG Rate**	**Annual Trend 2013 - 2014**	**Interventions**
(CAHPS 5.0) Consumer Assessment of Healthcare Providers and Systems - Medi-Cal Adult & Child Survey Scores Combined (previously *broken out until HSAG began reporting them together in 2010)*													
Overall Rating of Health Plan	Top-box responses for composite measures were responses of "Usually" or "Always", "A lot" or "Yes" presented.	2013 Gold Coast Health Plan CAHPS Report, DHCS	NA	59.8%	**52.6%**	58.0%	52.6%	57.4%	64.7%	65.5%	51.0%	NA	
Overall Rating of All Health Care			NA	52.2%	**51.1%**	51.1%	48.0%	50.8%	53.5%	57.7%	49.0%	NA	
Overall Rating of Personal Doctor			NA	64.7%	**67.8%**	64.2%	61.8%	62.9%	66.8%	69.2%	71.2%	NA	
Overall Rating of Specialist Seen Most Often			NA	66.9%	**65.9%**	65.5%	61.9%	65.3%	69.1%	70.8%	68.2%	NA	

* Scores based on Global Ratings Top-Box Rates

Grievance & Appeals											
Legend: Green = Met or Exceeded Goal Red = Did Not Meet Goal											
Measure	Description	Responsible Department	Compliance Source	Benchmark	2013 Total	2014 Q1	Q2	Q3	Q4	Quarterly Trend 2014 Q2 - 2014 Q4	Interventions
Resolution Turnaround Times (TAT) Grievances	100% TAT within 30 calendar days	G&A	GCHP				100%	100%	43%		
Post Service TAR Provider Appeals Processing Time - Resolution	The percentage of provider appeals processed within 30 business days from receipt.	G&A	GCHP				100%	99%	100%		
Provider Grievances: Complaint, Appeal, or Inquiry	Timely resolution of provider grievances	G&A	GCHP				NA	NA	NA		

Medical Advisory Committee: *Audits, Utilization Management and Clinical Support*

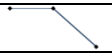
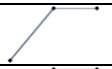
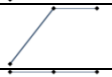
Legend:
Green = Met or Exceeded Benchmark
Red = Did Not Meet Benchmark

Health Services
UM Authorization Processing Time

Measure	Description	Responsible Department	Benchmark Source	Benchmark	2013	2014 Q1	Q2	Q3	Q4	Quarterly Trend 2014 Q3 - 2014 Q4	Interventions
Pre-service Turnaround Request Processing Time	The % of requests processed ≤ 5 working days from receipt of information necessary to make the determination.	Health Services	DHCS/ Title 22	95%				**93.41%**	98.08%		
Concurrent Review	Combined Urgent and Standard	Health Services	DHCS/ Title 22					NA	NA		
Provider Turnaround Request Denials	Number of denied authorizations divided by total number of authorizations. (Excludes RAFs.)	Health Services	DHCS/ Title 22	Tracking				NA	NA		
Provider Turnaround Request Denials Overturned	Beginning 1/1/2010 - Number of denials overturned or modified divided by total number of appeals. Includes pre-service & post-service Auth, RAF & MRF appeals.	Health Services	DHCS/ Title 22	Tracking				NA	NA		
Clinical Utilization Management											
Inter-rater Reliability Analysis	Measurement of the consistency with which UM staff apply criteria/guidelines for determining medical necessity.	Health Services	DHCS/ Title 22	90%				NA	NA		
UM Criteria & Review											
UM Criteria Revisions	Annual review and adoption of UM criteria that are objective and based on medical evidence.	Health Services	H&S Code 1367.01, 1363.5; Title 22 53860(c)(3); DHCS:Contract 08-85212, NCQA: UM 2					NA	NA		

Delegation Oversight : *Assessment of Delegated Quality Activities*

Legend:
Green = Met or Exceeded Benchmark
Red = Did Not Meet Benchmark

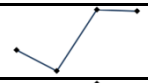
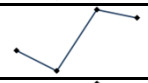
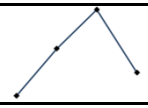
Measure	Description	Benchmark Source	Benchmark	2013	2014 Q1	Q2	Q3	Q4	Quarterly Trend 2014 Q1 - 2014 Q4	Interventions
Delegation of UM	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 5; NCQA Standard UM 15	DHCS Contract		NA	**100%**	**100%**	NA		
Delegation of CR	Number required & percentage of current delegates assessed	Exhibit A, Attachment 4; NCQA Standard CR 9	DHCS Contract 10-87128		**100%**	NA	NA	NA		
Delegation of QI	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard QI 12	DHCS Contract		NA	NA	**100%**	**100%**		
Delegation of RR	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard RR 7	DHCS Contract		NA	NA	**100%**	**100%**		
Delegation of Claims	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 8	DHCS Contract		NA	**100%**	**100%**	**100%**		

3d-19

CREDENTIALS / PEER REVIEW

Legend:
Green = Met or Exceeded Benchmark
Red = Did Not Meet Benchmark

Measure	Description	Responsible Department	Benchmark Source	Benchmark	2013	2014 Q1	Q2	Q3	Q4	Quarterly Trend 2014 Q3 - 2014 Q4	Interventions
Access Indicators											
Monitoring of Medicare/Medicaid sanctions	An OIG query is performed on every provider at the time of intitial and re-credentialing	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				**100%**	100%		
Monitoring of sanctions and limitations on licensure	An Medical Board of California (MBOC) query is performed on every provider at the time of initial and re-credentialing. Other state licensing boards are also queried as needed	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				**100%**	100%		
Monitoring of complaints	Member complaints are monitored at a minimum of every six months to assess for trends/outliers	Credentialing	DHCS/ Title 22	Biannually				NA	NA		
	Member complaint data is considered during re-credentialing via the use of threshold criteria	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				NA	NA		
Monitoring of adverse events	Quality of Care concerns are reviewed at a minimum of every 6 months and are forwarded to Credentials/Peer Review Committee (CPRC) as indicated.	Credentialing	DHCS/ Title 22	Biannually				NA	NA		
	HIPDB queries are performed within 180 days prior to the date of initial and re-credentialing	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				**100%**	100%		
Timeliness of provider notification of credentialing decisions	Providers will be notified of the credentialing decision in writing within 60 days	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				**100%**	100%		
Timeliness of verifications	All credentialing verifications are performed within 180 days (or 360 days) prior to the credentialing date, as required	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				**100%**	100%		
# of provider terminations for quality issues	Credentials/Peer Review Committee (CPRC) denial of a credentialing application for quality issues will cause termination of the provider from the network	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				None for Q3	None for Q4		
# of fair hearings as a result of adverse credentialing actions	Providers are afforded the right to a fair hearing in the event of an adverse credentialing decision	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				None for Q3	None for Q4		
Service Indicators											
Timeliness of processing of initial applications	Initial applications will be processed within 90 days	Credentialing	DHCS/ Title 22	Standard met for 90% of applications received				**100%**	100%		
Timeliness of processing of re-credentialing applications	Recredentialing applications will be processed within 90 days	Credentialing	DHCS/ Title 22	Standard met for 90% of applications received				**99%**	100%		
Quality Indicators (under NMC purview)											
Timeliness of Physician Recredentialing	Percent of physicians recredentialed within 36 months of the last approval date	Credentialing	NCQA: CR Standards	Standard met for 90% of providers				**90%**	90%		
Continuous Monitoring of Allied Providers	Percent of allied providers' expirable elements that are current	Credentialing	NA	Standard met for 90% of elements				NA	100%		
Timeliness of Organization Reassessment	Percent of organizations reassessed within 36 months of the last assessment	Credentialing	NCQA: CR Standards	Standard met for 90% of providers				NA	100%		

Member Services											
Legend: **Green = Met or Exceeded Goal** **Red = Did Not Meet Goal**											
Measure	**Description**	**Responsible Department**	**Compliance Source**	**Benchmark**	**2013**	**2014 Q1**	**Q2**	**Q3**	**Q4**	**Quarterly Trend 2014 Q1 - 2014 Q4**	**Interventions**
Call Center - Aggregate Average Speed of Answer (ASA)	Average Speed to Answer (in seconds)	Member Services		<= 30 seconds		**9.6**	**6.8**	**15.0**	**14.8**		
Call Center - Aggregate Abandonment Rate	Percentage of aggregate Abandoned calls to Call Center	Member Services		<= 5%		**0.51%**	**0.41%**	**0.71%**	**0.67%**		
Call Center - Aggregate Call Center Call Volume	Monitored to ensure adequate staffing and identification of systemic issues.	Member Services				26,267	29,156	31,572	27,683		

Cultural & Linguistics

Legend:
Green = Met or Exceeded Benchmark
Red = Did Not Meet Benchmark

Measure	Description	Responsible Department	Benchmark Source	Benchmark	2013	2014 Q1	Q2	Q3	Q4	Quarterly Trend 2014 Q3 - 2014 Q4	Interventions
Cultural & linguistic requirements	Number of languages provided per the total number of languages requested through GCHP and interpretation vendors.	CNL	DHCS/Title 22	100%				**13**	12		
Cultural & linguistic requirements	Total number of translation requests (Excluding American Sign Language)	CNL	DHCS/Title 23	100%				**18**	18		
Cultural & linguistic requirements	Total number of American Sign Language interpreter requests.	CNL	DHCS/Title 24	100%				**34**	42		
Cultural & linguistic requirements	Total number of telephonic calls for interpreter requests.	CNL	DHCS/Title 25	100%				**253**	365		

3d-22

Clinical Practice & Preventative Health Guidelines

Legend:
Green = Met or Exceeded Benchmark
Red = Did Not Meet Benchmark

Measure	Description	Responsible Department	Compliance Source	Benchmark	2013 Q4	2014 Q1	Q2	Q3	Q4	Quarterly Trend 2014 Q3 - 2014 Q4	Interventions
Clinical Practice											
Clinical Practice Guideline Adoption	Development and/or adoption of non-preventive clinical practice guidelines for the provision of acute and chronic medical services every two years.	ACMO	DHCS/ Title 22	Approval by Committee							Approved by MAC 1/29/2015
Clinical Practice Guideline Distribution	Distribution of non-preventive clinical practice guidelines for the provision or acute and chronic medical services to applicable practitioners every two years.	ACMO	DHCS/ Title 22	Distribution to Applicable Providers							
Preventive Health											
Preventive Services Guideline Adoption	Development and/or adoption of preventive guidelines every two years.	Health Education	DHCS/ Title 22	Approval by Committee				**Approved by MAC 7/24/2014**			
Preventive Services Guideline Distribution	Distribution of preventive guidelines every two years.	Health Education	DHCS/ Title 22	Distribution to Applicable Providers							

3d-23

Pharmacy and Therapeutics

Pharmacy Benefit Manager (PBM) Oversight

3d-24

Reviewed all denials and 10% of approvals

- 99% appropriate decision
- 100% timely decision
- 98.4% appropriate denial language – this is a major improvement from 1 year ago

Pharmacy Inter-Rater Reliability (IRR)

3d-25

IRR Review

- 3 pharmacists with the PBM doing prior authorizations are tested
- 100% compliance

Newly Approved Drugs and Formulary Management

3d-26

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

- 17 drugs reviewed, Approved 10 drugs because of significant clinical advantages
- Revised step therapies for diabetes drugs to align with the ADA Diabetes Guidelines
- Removed the limit of 10 prescriptions per month

Credentials/Peer Review

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

3d-27

- The Credentialing Office continues to monitor providers for their Medical Board status.
- The 3 providers included in the my last report continue to be monitored.

Peer Review Referral:

- Highly rated PQI–outcome 3, system 3, provider 3
- Member in a non-contracted hospital with poor discharge coordination resulting in additional admissions, infections and surgeries
- Committee action- letter to the hospital for review and a response
- Results – changes in their discharge procedures

3d-28

Committee Actions

- Recredentialed 32 providers
  - Conditional recredentialed:
    - 1 for 3 mo. to correct FSR non-compliance
    - 1 for 9 mo. for Medical Board Hearing
- Newly credentialed 12 providers
- Re-credentialed 1 facility
- Approved new Fair Hearing Policy

3d-29

Medical Advisory

Approved Health Plan Policies:

- Communicable Disease Reporting
- Adult Preventive Care
- Chlamydia Screening
- Prenatal Care
- Major Organ Transplants
- Adult Preventive Care
- Diabetic Clinical Practice Guidelines Approved

3d-30

Health Education and Outreach

Events:

- Annual Community Resource Fair June 6, 2015
- Other Community Events from January – June 2015: 78

3d-31

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training

3d-32

- GCHP is collaborating with UCLA to host SBIRT Training for local providers
- Training will be held on May 20, 2015 at the VCMC Campus

Member Incentive Program

- Collaborated with the Quality Improvement Dept., Compliance and Communications to ready the Diabetic Eye Exam member incentive program. Movie tickets have been provided to 96 diabetics

3d-33

Cultural and Linguistics

Pacific Interpreters

- 365 calls using interpreters by staff
- 12 languages

American Sign Language

- 42 requests serving 15 members

3d-34

Grievance and Appeals

Grievance and Appeals Department

- Member Grievances – 219
  - 188 administrative
  - 31 clinical
- Provider Grievances – 253
  - 125 claims billing
  - 55 claims payment disputes
  - 66 claims appeals
  - 6 timely filing
  - 1 refund issue

3d-35

4th Quarter Statistics

Clinical Grievances - 31

- 19 Quality of Care
  - 11 Inappropriate provider care
  - 4 Delay of care
  - 2 In-area emergency/urgent care service denied
  - 1 Poor provider attitude
  - 1 Inappropriate hospital care
- 10 Access
- 3 Inappropriate Treatment
  - Clinical grievances are reviewed by a Health Services RN
  - Cases considered to be significant for quality are referred as PQI's

3d-36

Accessibility Cases – 7

- 3 Lack of specialist availability
- 2 Excessive long wait time/ appt. schedule time
- 1 Lack of Primary Care Provider availability

Quality of Service – 1

Pharmacy/Utilization – 1

- 2 Denial/Refusals
- 1 Pharmacy denial and/or modification
- 1 Refusal to pay for equipment

Benefit/coverage - 2

- Pharmacy formulary – 2

3d-37

Medical Appeal Cases

- 10 cases
- Medical Appeal Cases not approved on appeal go to a 2nd reviewer
- 4 cases overturned the denial on appeal
- 1 case partially overturned
- 3 cases upheld the denial
- 2 cases open and in review

3d-38

State Fair Hearings

- Members or providers may submit denials to a State Fair Hearing – 5 cases
- 3 cases withdrawn
- 1 pending for medication denial
- 1 case redirected to LA County – not a GCHP member

Network Planning

GCHP is continuing to recruit member for the Provider Advisory Committee.

3d-39

ICD-10 testing – provider relations is preparing to train physician offices for ICD-10 which will be starting Oct. 1, 2015.

Member Services

Member Services Office Inquiries 4th quarter

- Walk-Ins – 126
- Calls – 60

Call Center Statistics – 4th quarter

- Average calls per month – 9227
- Average speed to answer (less than 30 sec) compliant
- Abandonment rate (less than 5% - compliant

3d-40

Utilization Management

Statistics: 4th Quarter 2014

3d-41

- Bed days/1000 – 286

  (benchmark 161 – 890, variability due to reporting differences)

- Length of Stay – 4.83

  (benchmark 3.6 – 4.7 days)

UM Statistics (cont.)

- Readmission Rate – 10.3%

  (benchmark managed Medi-Cal 14.5%)
- ER visits/1000 – 408

  (benchmark managed Medi-Cal Plans 554-877)
- UM Denial Rate – 3.0%

3d-42

Care Management – 4th Quarter 2014

- 500 new referrals

Satisfaction Surveys

- Oct. 1, 2014 through Dec. 31, 2014
- 57 Surveys offered
- 30 Surveys Completed
- 100% Overall Satisfied with Care Management Program

3d-43

Member Feedback

"(nurse) was amazing, she was my voice when I wasn't being heard. She helped me with referrals, she was in contact with my PT and PCP. Even my doctor thinks she's amazing. I feel blessed to have her as my care manager, I believe God put her in my path to help me."

3d-44

Delegation Oversight

All required delegation oversight for 2014 was completed and corrective action plans closed.

3d-45

Vision Service Plan (VSP)

- CAP was issued to VSP on Oct. 29, 2014

3d-46

AGENDA ITEM 3e

To: Gold Coast Health Plan Commission

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

Re: Quality Improvement Program and Work Plan for 2015

Date: April 27, 2015

SUMMARY

The Quality Improvement Department has developed a 2015 work plan. This plan outlines the expected work and projects that will be accomplished during the current year.

BACKGROUND

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

RECOMMENDATION

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

CONCURRENCE:

N/A

Attachments:

2015 Quality Improvement Work Plan.

GOLD COAST HEALTH PLAN
2015 QUALITY IMPROVEMENT PROGRAM

I. MISSION AND PURPOSE

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

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

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

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

The QI Program consists of the following elements:

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

II. AUTHORITY AND RESPONSIBILITY

The Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) will promote, support, and have ultimate accountability, authority, and responsibility for a comprehensive and integrated Quality Improvement (QI) Program. The VCMMCC is ultimately accountable for the quality of care and services provided to Members but will delegate supervision, coordination, and operation of the program to the Chief Executive Officer and Quality Improvement Department under the supervision of the Chief Medical Officer and its QI Committee. The Board will approve

the overall QI Plan, Work Plan and QI annual report; the CMO will be responsible for the day-to-day oversight of the QI Program. The Board will receive operational information through regular reports from the CMO and/or the Health Services Department in conjunction with the operations of its various Committees as described below.

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

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

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

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

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

Membership

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

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

III. PROGRAM SCOPE

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

1. Quality and safety of clinical care services including, but not limited to:

- Preventive services
- Chronic disease management
- Prenatal care
- Family planning services
- Behavioral health care services
- Medication management
- Coordination and Continuity of Care

2. Quality of nonclinical services including, but not limited to:

- Accessibility
- Availability
- Member satisfaction surveys
- Grievance process
- Cultural and Linguistic Services

3. Patient safety initiatives including, but not limited to:

- Facility site reviews
- Credentialing of practitioners
- Peer review
- Sentinel event monitoring
- Health Education

4. A QI focus which represents

- All care settings
- All types of services
- All demographic groups

Delegation of Quality Improvement

Delegation is the formal process by which the health plan gives an external entity the authority to perform certain functions on its behalf. These functions may include quality

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

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

IV. QI PROGRAM GOALS, OBJECTIVES AND METHODOLOGY

The QI Program goals include:

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

The Program Objectives include the following:

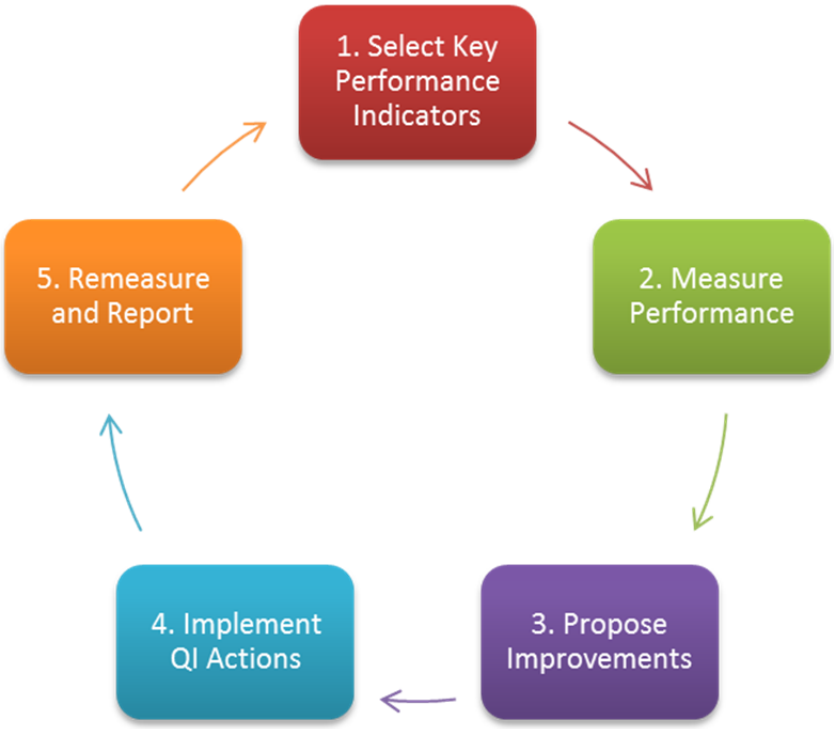
- To integrate the QI Program with other operational functions of GCHP
- To conduct an annual evaluation of the QI Program
- To establish and conduct an annual review of quality and performance improvement projects (QIPs) related to significant aspects of clinical and non-clinical services
- To identify opportunities for improvement through analysis of information collected from Healthcare Effectiveness Data and Information Set (HEDIS®) and utilization management patterns of care

- To encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve the manner by which care and service are delivered

Performance Improvement Methodology

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

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



V. PROGRAM ORGANIZATION, OVERSIGHT AND EVALUATION

CHIEF MEDICAL OFFICER

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

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

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

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

ASSOCIATE CHIEF MEDICAL OFFICER

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

DIRECTOR OF QUALITY IMPROVEMENT

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

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

Specific roles and responsibilities include but are not limited to:

- Ensuring that the annual Quality Improvement plan and work plan are created and reviewed by all appropriate areas
- Working with all appropriate departments in the creation of the annual QI review and analysis of results
- Ensuring QIC approval of all QI documents annually

- Guiding the collection of HEDIS data as mandated by contractual requirement and assisting in the development of activities to improve care
- Ensuring that appropriate principles of data collection and analysis are used by all departments when looking for improvement opportunities
- Providing educational opportunities for QI staff and other staff members key to improving care and service to better target improvement initiative

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

QI PROGRAM EVALUATION

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

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

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

VI. ANNUAL WORK PLAN

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

At a minimum, the QI Work Plan includes a clear description of the monitoring and improvement activities, the specific timeframe and responsible parties for conducting the activities. Activities and outcomes are compared to predetermined goals. Improvement activities identified during the year and other changes may be made to the QI Work Plan

as presented to the QIC and VCMMCC for approval on an ongoing basis. The QIC oversees the prioritization and implementation of clinical and non-clinical Work Plan initiatives. The QI Work Plan is assessed and updated at a minimum, semi-annually, and is included as part of the Annual QI Program Evaluation.

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

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

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

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

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

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

- HEDIS;
- Coordination of Care Studies; and
- Facility Site Reviews

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

- Annual provider language study;
- Annual cultural and linguistic study;
- Ongoing monitoring of interpreter service and use; and
- Ongoing monitoring of grievances

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

- Credentialing and Recredentialing activities; and
- Peer Review Activities

Communication and Feedback

Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings and

announcements. Providers are educated regarding quality improvement initiatives via on-site quality visits, provider newsletter, Provider Operations Bulletin and the GCHP website. Specific performance feedback is communicated to providers and includes a HEDIS® report card and listings of members who need specific services.

VII. PROGRAM RESOURCES DEDICATED TO QUALITY IMPROVEMENT

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

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

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

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

Credentialing and peer review functions are supported by QI staff.

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

Responsibilities include but are not limited to the following:

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

OTHER QI RESOURCES

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

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

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

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

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

QI Program Resources- Data, Information and Analytics Support
GCHP's QI Program monitors and evaluates performance and information from many different sources throughout the organization including but not limited to:

- Enrollment data, demographic data, including race, ethnicity and language preference data, is collected to monitor health care quality and for identifying and reducing health disparities among our patient population
- Claims data (utilization by diagnosis/procedure, provider, treatment/medications, site of care, etc.)
- Case management and disease management reports to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the care spectrum
- Complaint and appeal data, including investigational data (type of complaints, timeliness and/or appropriateness of resolution)
- Ongoing tracking and trending of quality of care or serious reportable event data to identify patient safety issues and assess provider qualifications
- Member and provider survey data to assess satisfaction with services and operations
- Credentialing process data to measure timeliness of application processing and quality of network providers
- Network adequacy/accessibility measurement data to assess provider availability and accessibility
- HEDIS® data to assess the effectiveness of clinical care and services

VIII. QUALITY COMMITTEES AND SUBCOMMITTEES

1. Quality Improvement Committee (QIC)

QIC Charter:

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

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

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

A. Quality improvement activities such as:
   i. Utilization Reports
   ii. Review of the quality of services rendered
   iii. HEDIS results
   iv. Quality Improvement Projects- status and/or results
   v. Satisfaction Survey Results
   vi. Collaborative initiatives- status and/or results

B. Success in improving patient care, and outcomes, and provider performance.

C. Opportunities for improvement.

D. Overall effectiveness of quality monitoring and review activities or specific areas that require remedial action as indicated in the annual report issued by the state's EQRO.

E. Effectiveness in performing quality management functions and achieving goals and objectives through quality monitoring programs will be measured and reported.

F. Presentation of the QI Plan including recommendations for revision identified as a result of the Review.

QIC Objectives:

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

QIC Responsibilities:

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

QIC Membership:

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

QIC Reporting Structure:

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

Meeting Frequency:

The QIC meets at a minimum quarterly.

2. Medical Advisory Committee (MAC)

Purpose:

The purpose of the MAC is to:

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

Function:

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

- Clinical Care Guidelines
- Preventive Care Guidelines
- Provider Grievance Process
- Provider Satisfaction Issues
- Provider Materials
- Quality Improvement Activities
- Provider Access Standards
- Provider Contracting Issues
- Clinical Service Delivery
- Utilization Data
- HEDIS Measures

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

Membership:

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

Meeting Frequency:

The committee meets at a minimum on a quarterly basis.

3. Member Services Committee (MSC)

MSC Charter:

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

MSC Objectives:

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

MSC Membership:

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

Meeting Frequency:

The MSC meets quarterly at a minimum.

4. Grievance and Appeals Committee (G&A)

G&A Charter:

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

G&A Objectives:

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

G&A Committee Membership:

- Associate Chief Medical Officer
- Manager of Grievance and Appeals (Chair)
- Grievance and Appeals Specialist
- Manager of Member Services or Designee
- Quality Improvement Director or Designee
- Director of Health Services or Designee
- Compliance Specialist
- Director of Operations
- Director of Health Education & Cultural Linguistics or Designee
- Director of Pharmacy

Meeting Frequency:

The committee meets quarterly.

5. Network Planning Committee (NPC)

NPC Charter:

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

NPC Objectives:

- Ensure GCHP providers have an understanding of the health plan and health network and know how to obtain services they need for their patients.

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

NPC Membership:

- Director of Network Operations (Chair)
- Chief Medical Officer
- Associate Chief Medical Officer
- Provider Relations Representative
- Director of Health Services or designee
- Director of Quality Improvement
- Director, Health Education & Cultural Linguistics

Meeting Frequency:

The committee meets at a minimum quarterly.

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

Committee Charter:

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

UM/CM Responsibilities:

Responsibilities include but are not limited to the following:

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

Membership:

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

Meeting Frequency:

The UM/CM Committee meets quarterly at a minimum.

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

Purpose:

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

Functions:

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

Membership:

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

Meeting Frequency:

The committee meets at a minimum quarterly.

8. Credentials/Peer Review (CPR) Committee

Purpose:

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

Functions:

Credentialing Responsibilities:

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

Peer Review Responsibilities:

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

Membership:

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

Meeting Frequency:

The committee meets quarterly.

9. Pharmacy & Therapeutics (P&T) Committee

Purpose:

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

Function:

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

Membership:

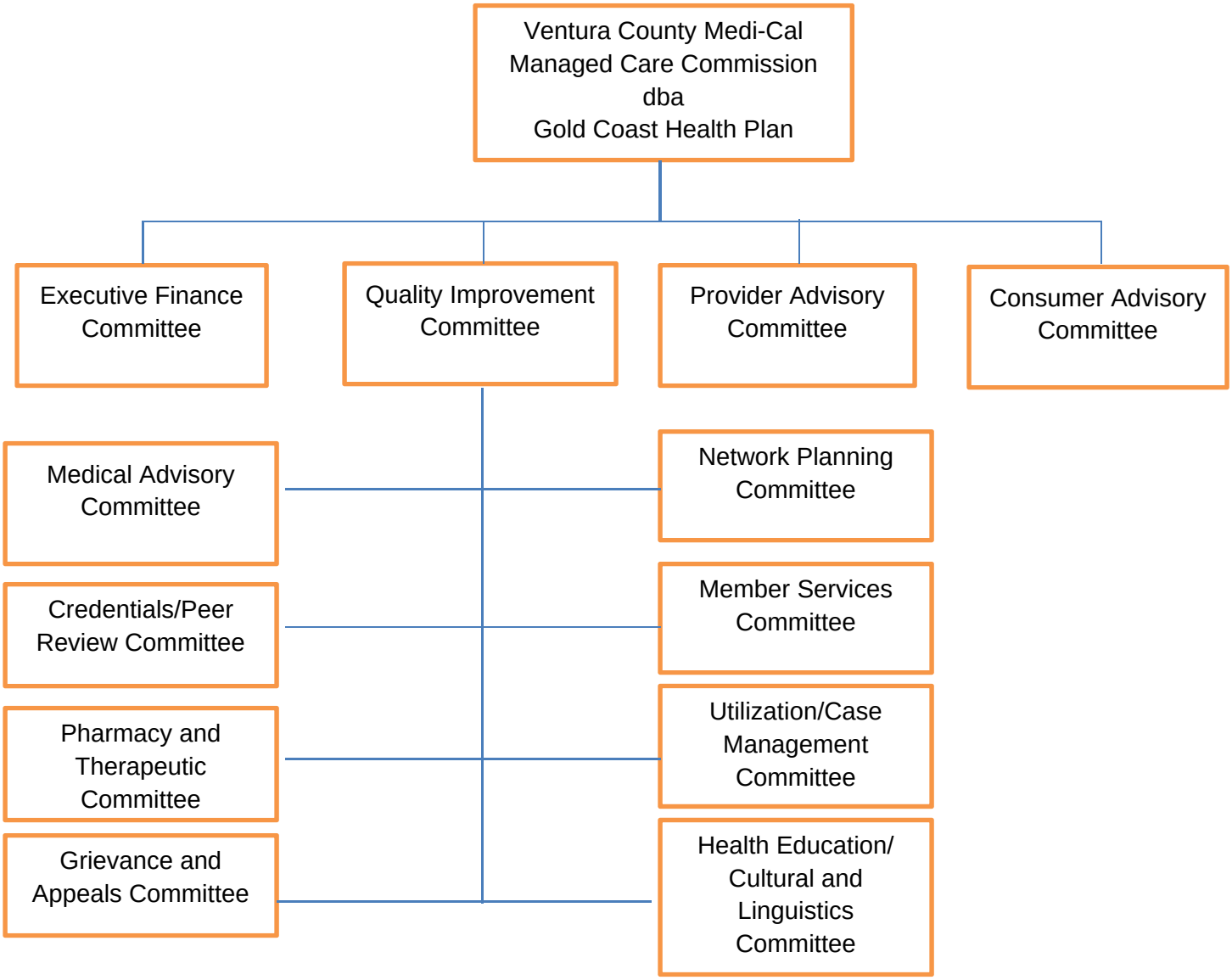
The P&T Committee members include but are not limited to GCHP's Chief Medical Officer (Chair), PBM representative, GCHP's Director of Pharmacy Services, physicians, and representatives of a variety of clinical specialties.

Meeting Frequency:

The committee meets quarterly.

IX. GOLD COAST HEALTH PLAN COMMITTEE ORGANIZATIONAL CHART

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



X. QUALITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2015

Tuesday, March 31, 2015

Tuesday, June 30, 2015

Tuesday, September 29, 2015

Tuesday, December 15, 2015

Location – Executive Conference Room

AVAILABILITY OF QIP TO PRACTITIONERS AND MEMBERS

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

REFERENCES

- Gold Coast Health Plan Quality Improvement System Policy and Procedure 4a
- Gold Coast Health Plan Utilization Management Program Description
- Gold Coast Health Plan Care Management Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 13-005
- HEDIS® National Committee for Quality Assurance
- DHCS Quality Strategy
- National Quality Strategy
- Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010
- Kohn KT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press; 1999
- The Quality Improvement and Assessment (QIA) Guide for Medi-Cal MCPs
- The QIA Guide = available on the DHCS website at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx
- Title 42, Code of Federal Regulations, Section 438.240(b) (1)
- Gold Coast Health Plan Policies and Procedures as they apply

UTILIZATION MANAGEMENT AND CARE MANAGEMENT PROGRAM DESCRIPTION IN A SEPARATE DOCUMENT.
The Quality Improvement Plan was approved by the Quality Improvement Committee on March 31, 2015.

2015 Gold Coast Health Plan Quality Improvement Work Plan

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality and Safety of Clinical Care Services					
NCQA QI 9	Diabetes Clinical Practice Guideline (CPG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant CPGs Distribute if necessary	Q4 2015	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of each of the CPGs Distribute guidelines to appropriate practitioners	MAC
NCQA QI 9	Preventive Health Guideline (PHG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant PHGs Distribute if necessary	Q4 2015	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of two PHGs Distribute guidelines to appropriate practitioners	MAC
	Advance Prevention				
DHCS	Increase percentage of members who smoke who report being counseled to quit in prior 6 months	90%	Q4 2015	Measure during IHA monitoring Educate providers based on results of IHA monitoring Measure during 2016 CAHPS	QI
DHCS	Increase percentage of members who smoke who report a provider discussed tobacco cessation medication in the prior 6 months	60%	Q4 2015	Measure during IHA monitoring Educate providers based on results of IHA monitoring Measure during 2016 CAHPS	QI
	HEDIS® Measures				
DHCS	Postpartum Care – Percentage of deliveries	Increase rates by 5% over previous	Q4 2015	Develop member education mailings Explore possible use of *text4baby*	Health Education QI

	that had a postpartum visit on or between 21 and 56 days after delivery	measurement year		program for use in educating members Promote use of GCHP *Pregnancy* E-newsletter Provide provider performance feedback by means of 2014 HEDIS report cards Meet with clinics to discuss successful practices and identify barriers and provide technical assistance/trainings on measures Share best practice strategies across provider sites	
DHCS	Childhood Immunization – percentage of children 2 years of age that had DtaP, IPV, MMR, HiB, HepB, VZV and pneumococcal conjugate (Combo 3)	Increase rates by 5% over previous measurement year	Q4 2015	Member newsletter article on importance of getting immunizations Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services Explore possible use of *text4baby* program for use in educating members Promote GCHP *New Parent* E-newsletter Meet with clinics to discuss successful practices and identify barriers and provide technical assistance/trainings on measures Develop interventions based on barriers Share best practice strategies across provider sites	Health Education QI

DHCS	Immunizations for Adolescents (Combo 1) – percentage of adolescents 13 years of age who received a meningococcal vaccine on or between the member's 11th and 13th birthday and Tdap or Td on or between the member's 10th and 13th birthdays (Combo1)	Increase rates by 5% over previous measurement year	Q4 2015	Member newsletter article on importance of getting immunizations Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services Meet with clinics to discuss successful practices and identify barriers and provide technical assistance/trainings on measures Develop interventions based on barriers Share best practice strategies across provider sites	Health Education QI
DHCS	Controlling High Blood Pressure – percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90)	Maintain rate above MPL Increase rates by 5% over previous measurement year	Q4 2015	Investigate why rates decreased over previous measurement year via medical record review Provide provider performance feedback by means of 2014 HEDIS report cards Develop and implement interventions based on results of medical record review Member newsletter article on how to control blood pressure	QI
DHCS	Well Child Visits in Third, Fourth, Fifth and Sixth Years – percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year	Increase rates by 5% over previous measurement year	Q4 2015	Develop and implement member incentive program Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services	QI

				Meet with clinics to discuss successful practices and identify barriers and provide technical assistance/trainings on measures Member newsletter article to remind members to get annual visit	Health Education
DHCS	Children and Adolescents' access to Primary Care Practitioners – percentage of members 12 months – 19 years of age who had a visit with a PCP	Meet or exceed DHCS MPL	Q4 2015	Develop and implement member incentive program Provide provider performance feedback by means of 2014 HEDIS report cards Provide quarterly member lists with members who have not received services Meet with clinics to discuss successful practices and identify barriers and provide technical assistance/trainings on measures Member newsletter article to remind members to get annual visit	QI Health Education
DHCS	Counseling for Nutrition and Physical Activity for Children and Adolescents – percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling	Meet or exceed DHCS MPL	Q4 2015	Provide provider performance feedback by means of 2014 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss successful practices and identify barriers and provide technical assistance/trainings on measures	QI
Quality Improvement Projects					
DHCS	External QIP: TBD by DHCS				
DHCS	Internal QIP: Increase retinal eye exam for diabetic members	Increase rate by 5% over previous year rate	Q4 2015	Member incentive letters Provide provider performance feedback by means of 2014 HEDIS report cards	Health Education QI

				Provide quarterly member lists with members who have not received services VSP letter to members Report quarterly to QIC Submit results to DHCS	
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Quality of Nonclinical Services					
NCQA QI 5 DHCS	**Primary Care Access** Members are offered: • Non-urgent primary care within 10 business days of request • Urgent care within 48 hours **Specialty Care Access** Members are offered: • Non-urgent specialty care appointment within 15 business days • Non-urgent ancillary services within 15 business days	Standards met for minimum of 90% of providers	Q4 2015	Monitor performance and complaints relating to appointments Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met	Network Operations Grievances and Appeals
DHCS	After Hours Availability • Members are able to reach a provider after hours	Standards met for 90 % of providers	Q4 2015	Monitor performance and complaints relating to after-hours availability Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met	Network Operations Grievances and Appeals

DHCS	Availability of Practitioners	Ratios: 1 PCP 1:2000 Total Physicians 1: 1200 Physician Supervision to Non-Physician Practitioner Ratio Nurse Practitioners 1:4 Physician Assistants 1:4 Network maintained PCP located within 30 minutes or 10 miles		Conduct bi-annual ratio analysis and annual GeoAccess analysis for primary care and high volume specialties Identify gaps and implement corrective action plan Monitor progress towards action plans to maintain or improve GeoAccess standards Report bi-annual ratio analysis and annual GeoAccess findings to QIC	Network Operations
	Practitioner Availability: Cultural Needs & Preferences				
NCQA QI 5 DHCS	Practitioner Availability: Cultural and Linguistics Needs & Preferences: Assess the cultural, ethnic and linguistic needs of our members	Complete Annual Assessment	Q4 2015	Analyze the demographic needs of our members to identify opportunities for improvement	Cultural and Linguistics
NCQA DHCS	Assess the provider network and adjust the availability of providers within the network, if necessary, to meet membership needs and preferences	Complete Annual Assessment	Q4 2015	Monitor how effectively the practitioner network meets the needs and preferences of our members	Network Operations
	Provider Satisfaction Survey	Complete Survey	Q4 2015	Analyze results and identify opportunities for improvement Develop and implement interventions	Network Operations

				as needed to improve rates	
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Dept./Committee
Objective: Improve Patient Safety					
DHCS	Complete Initial and Tri-annual Facility Site Reviews Complete Interim Reviews	100%	Year End 2015	Monitor FSR database Submit bi-annual reports to DHCS	FSR Nurse QI
DHCS	Complete Physical Accessibility Site Reviews	100%	Year End 2015	Compile reports for high volume/ancillary specialists Submit report to State Complete PARs for new provider sites	FSR Nurse QI
NCQA DHCS	Improve Safe Clinical Practice	Tracking	Ongoing	Monitor site visit results from practitioner credentialing Monitor member complaints involving clinical quality of care concerns (safety)	Credentialing/Peer Review Grievances and Appeals
Objective: Member Experience: CAHPS, Complaints/Grievances					
DHCS	Conduct annual assessment of complaints and grievances, and CAHPS results to identify opportunities for improvement	Meet or exceed 50th percentile for : Getting Needed Care (2014 rate =78.2%) Getting Care Quickly (2014 rate =79.8%)	Q4 2015	Member Interventions: • Article in member newsletter regarding access standards • Develop and implement process to assist members in obtaining appointments when requested Provider Interventions: • Article in POB regarding required access standards • Provider access survey Q2 2015; follow up with providers not meeting standards Meet with clinics to discuss access issues Meet with clinics to discuss	Member Services QI Health Services Network Operations QI

		Customer Service (2014 rate =82.7%) Shared Decision Making (2014 rate =49.7%)		successful practices and identify barriers and provide technical assistance/trainings on access issues Customer Service Interventions: • Monitor results/reports of after call survey performed by call center; follow up if issues identified Monitor complaints and grievances Measure during 2016 CAHPS POB article regarding shared decision making Convene Member Satisfaction Improvement Workgroup to identify additional improvement activities	Operations Grievances and Appeals QI QI QI
Objective: Health Plan Quality					
NCQA DHCS	●Update QI Program Description ●Complete 2014 QI Program Evaluation ●Develop and Implement 2015 QI Program Work Plan	100%	April 2015 April 2015 April 2015	1. Review and revise annual QI Program Description, Work Plan and Evaluation 2. Obtain approval of 2015 QI Program and Work Plan and Evaluation of 2014 QI Program 3. Evaluate the adequacy of resources, committee structure, practitioner participation and leadership involvement in the QI Program in order to restructure or change the QI Program for subsequent year as necessary	Chief Medical Officer QI Director Quality Improvement Committee

NCQA DHCS	Completion of Delegation Oversight Delegated Activities • Credentialing • QI • UM • Members' Rights • Claims	100%	Q4 2015	1. Complete audits 2. Issue CAPs as applicable 3. Follow-up on CAPs as applicable 4. Report to Compliance Committee and QIC	Compliance
Attach UM Work Plan to QI Work Plan					
Monitoring via use of Dashboard					

AGENDA ITEM 4a

To: Gold Coast Health Plan Commission

From: Ruth Watson, COO and Interim CEO

Date: April 27, 2015

Re: CEO Update

California Children's Services Program
The California Children's Services (CCS) Program is a joint State-county program providing medical case management and authorization of services for California children with serious chronic medical conditions. CCS services have historically been carved out from Medi-Cal managed care plans. The CCS Program is authorized through December 2015.

While the CCS Program was not included in the state's 1115 waiver application, the state DHCS is in discussion with the California Children's Hospital Association to create an ACO-type network of hospitals to provide care and coordination of services to children in the CCS Program. At the federal level, legislation has been introduced in the House of Representatives with bipartisan support. The Advancing Care for Exceptional (ACE) Kids Act of 2015 would establish a Medicaid Children's Care Coordination Program whereby designated children's hospitals would provide care coordination for children with complex conditions.

The California Children's Hospital Association proposal has generated concern among COHS plans regarding access to care issues for children not near a children's hospital. There is consensus among LHPC member plans, including GCHP, to not relinquish the CCS benefit from Medi-Cal managed care plans. LHPC supports elimination of the current bifurcated system and a move toward a whole-person approach e.g. one system of care for the child that includes primary care through a Medi-Cal managed care plan.

Children's Health Insurance Program (CHIP) Reauthorization
On April 15, the United States Senate approved, and President Obama signed into law, a two-year funding extension of the CHIP Program through FY 2017. While the CHIP Program is authorized through 2019, only a two-year funding extension through 2017 was approved by the Senate. Democrat Senators had insisted on a four-year extension of CHIP to align CHIP funding with the program's authorization period, which ends in FY 2019. Approximately 1.2 million low-income children and pregnant women receive health services that are funded through California's CHIP Programs. These programs include:

- Medicaid expansion for low-income children and pregnant women
- Optional Targeted Low Income Children's Program

1115 Waiver
On March 27, 2015 the California Department of Health Care Services (DHCS) submitted its 1115 waiver renewal application to the Centers for Medicare and Medicaid Services (CMS). The new waiver proposal dubbed "Medi-Cal 2020" is estimated to bring up to $20 billion in federal funding over a five year period for the state's Medi-Cal Program. The current 1115 Medicaid waiver expires on October 31, 2015. DHCS has set a waiver renewal implementation date of November 1, 2015.

Through the Medi-Cal 2020 waiver, the state hopes to implement various Medi-Cal Program initiatives that include: Whole Person Care Pilot Programs; Housing and Supportive Services Programs; and Workforce Development Programs. The housing and supportive services component, if approved by CMS, would allow Medi-Cal managed care plans the flexibility to fund and provide housing-based care management to utilizers of high cost services and those experiencing or at risk of homelessness. Details of the housing proposal and other initiatives are currently under development with stakeholder input.

CMS Proposed Rule Change in Medicaid Mental Health
On Monday April 6, the CMS proposed a change in Medicaid rules for behavioral health in Medicaid managed care. Under the proposed rule change states would be required to include provisions requiring parity in contracts for Medicaid managed care. The proposed rule change would prohibit states from carving out mental health or substance-abuse treatment services from Medicaid managed care contracts. The proposed rule change would also require plans to provide an explanation to plan enrollees for denying reimbursement or payment for mental health and substance-abuse services. CMS is accepting public comment on this proposed rule change until June 9, 2015.

FQHC Payment Reform
Legislation is moving through the State Legislature (SB 147) that would authorize a three-year Medi-Cal alternative payment methodology (APM) pilot program for county and community-based federally qualified health centers (FQHCs) that volunteer to participate, beginning no sooner than July 2016. The objective of the pilot is to test payment and delivery reform that promotes value over volume and ultimately delivers improved access, better care, and improved health outcomes for Medi-Cal beneficiaries.

Under the pilot, the wrap around payment from DHCS to the FQHC will be converted into a clinic-specific, per-member-per-month (PMPM) capitation rate for each category of aid included in the pilot. Health plans would pass through the wrap around capitation (aka wrap cap) from DHCS to the FQHC, which, along with the base payment the plan would have already been paying to the FQHC, ensures the FQHC is receiving a PPS-equivalent capitation per category of aid included in the pilot.

Behavioral Health Subaccount
GCHP staff participated in a DHCS-conference call to discuss the Behavioral Health Subaccount (BHS) which funds:

- Specialty Mental Health Services
- Drug Medi-Cal
- Residential perinatal drug services and treatment
- Drug court operations and other non-Drug Medi-Cal programs

The BHS account currently has approximately $1 billion to fund the above mentioned programs and services in 2014-15. The State Controller makes monthly allocations from the BHS account to counties. Base allocations for the 2014-15 fiscal years have not been set. DHCS is soliciting written comments and input from stakeholders and plans on three key questions to help establish base allocations:

- What should be the factor(s) for allocating growth? Why?
- How would the factor(s) be measured?
- How should the factors be prioritized and weighted?

Legislative Update
The State Legislature is in the first year of a two-year Legislative Session. On Monday, April 6th the State Senate and Assembly reconvened from the week-long Easter Recess. The State Senate and Assembly Health Committees held several hearings in the month of April concerning Medi-Cal provider reimbursement rates and network adequacy. The Chairmen of both Senate and Assembly Health Committees have indicated that they want build support in the legislature for the bills they introduced, AB 366 and SB 243, that would increase Medi-Cal reimbursement rates. The Governor is expected to release a revised state budget around the second the week of May. It is unclear whether the Governor's revised state budget will include any increases in Medi-Cal provider rates.

The following is an updated list of Medi-Cal bills categorized by program area that were heard in various legislative committees during the month of April. In order for these bills to be considered for the Governor's signature, they must be approved by the Legislature on or before September 11, 2015.

Finance

AB 366 (Bonta) Medi-Cal: reimbursement: provider rates-- Would require claims for payments pursuant to the inpatient hospital reimbursement methodology to be increased by a yet to be determined percentage for the 2015-16 fiscal year, and would require, commencing July 1, 2016, and annually thereafter, DHCS to increase each diagnosis-related group payment claim amount based on increases in the medical component of the California Consumer Price Index. This bill was approved by the Assembly Health Committee and sent to the Committee on Appropriations on April 15, 2015.

SB 147 (Hernandez) Federally qualified health centers--would require DHCS to authorize a 3-year alternative payment methodology pilot project for FQHCs that would be implemented in any county and FQHC willing to participate. This bill was approved by the Senate Health Committee and sent to the Committee on Appropriations on April 15, 2015.

SB 243 (Hernandez) Medi-Cal: reimbursement: provider rates-- Would require claims for payments pursuant to the inpatient hospital reimbursement methodology to be increased for the 2015-16 fiscal year, and would require, commencing July 1, 2016, and annually thereafter, DHCS to increase each diagnosis-related group payment claim amount based on increases in the medical component of the California Consumer Price Index. This bill was approved by the Senate Health Committee and sent to the Committee on Appropriations on April 22, 2015.

SB 610 (Pan) Medi-Cal: federally qualified health centers and rural health clinics: managed care contracts – Requires DHCS to finalize a new rate within 90 days after an FQHC's or RHC's submission of a scope-of-service rate change. Requires that, with respect to a new FQHC or RHC that has elected for the department to establish its reimbursement rate based on projected allowable costs, DHCS finalize that rate within 90 days after the submission of the actual cost report from the first full 12 months of operation. This bill was approved by the Senate Health Committee and sent to the Committee on Appropriations on April 22, 2015.

Health Education

AB 1162 (Holden) Medi-Cal: tobacco cessation – Provides that tobacco cessation services are covered benefits under the Medi-Cal program and requires that those services include, at a minimum, unlimited quit attempts, defined to include at least 4 counseling sessions and a 90-day treatment regimen of any medication approved by the FDA for tobacco cessation. This bill was approved by the Assembly Health Committee and sent to the Committee on Appropriations on April 21, 2015.

Pharmacy

AB 463 (Chiu) Pharmaceutical Cost Transparency—Would require manufacturers of a prescription drug, made available in California, that has a wholesale acquisition cost of $10,000 or more annually or per course of treatment, to file a report no later than May 1 of each year, with the Office of Statewide Health Planning and Development. Said reports would include the costs and profits for each qualifying drug. This bill was held over in the Assembly Health Committee.

Medi-Cal Expansion

SB 4 (Lara) Health care coverage: immigration status-- declares the intent of the Legislature to make Medi-Cal and affordable health coverage and care to all Californians, regardless of immigration status. This bill was approved by the Senate Health Committee on a 7-0 vote and sent to the Committee on Appropriations on April 15, 2015.

COMPLIANCE UPDATE

Gold Coast Health Plan (GCHP) had auditors from Audits & Investigations (A&I) a division within the Department of Health Care Services (DHCS) from February 17, 2015 through February 25, 2015. The purpose of the onsite is to conduct the annual medical audit which includes: interviewing staff, review files and processes. The review period of the audit was December 1, 2013 through November 30, 2014. The plan was slated to receive the draft report on April 13, 2015 however A & I has informed the Plan the draft report will be delayed to early May 2015 with the exact date to be determined.

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

Compliance continues to monitor and ensure all employees and temporary employees are trained and retrained on HIPAA and Fraud, Waste & Abuse. In addition, compliance and information technology staff conducts random internal audits for HIPAA and PHI issues. Compliance staff has revised all of the HIPAA privacy policies and procedures and are creating a comprehensive privacy program.

GCHP continues to meet all regulatory contract submission requirements. In addition to routine deliverables, GCHP provides weekly and monthly reports to DHCS as a part of ongoing monitoring activities. All regulatory agency inquiries and requests are handled timely and required information is provided within the required timeframe. Compliance staff is actively engaged in sustaining contract compliance.

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.

Credentialing audits for the (3) medical groups GCHP delegates credentialing to were conducted during the month of January 2015. One (1) CAP was issued on February 10, 2015 and the CAP was closed on February 17, 2015. The three medical groups are required to continue quarterly reporting during the year. The next annual credentialing audit will be conducted in January 2016. A six month follow up meeting was conducted on claims for the

specialty contract agreement on March 30, 2015. A CAP was issued on April 7, 2015 and the plan anticipates close out of the CAP soon.

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.

SPONSORSHIP AWARD UPDATE

Gold Coast Health Plan (GCHP) has approved two requests from organizations to support local fundraising activities and two requests for letters of support.

Background

GCHP awarded funding to the following agencies:

1) **Mixteco / Indigena Community Organization Project (MICOP):** The Sponsorship Committee has awarded MICOP with the sponsorship level of $1,500 (Compadre – A Beloved Partner). The review committee was impressed by the efforts made by this organization to advance the health and wellbeing of Ventura County's indigenous immigrant community. The proceeds from the Night in Oaxaca Fundraising event will support MICOP's five central programs and will reach over 5,000 individuals.

2) **Livingston Memorial Visiting Nurse Association (LVMNA)**. The Sponsorship Committee has awarded LVMNA with the sponsorship level of $1,000 (TULIP Sponsor). GCHP Sponsorship Committee was impressed by the efforts made by LVMNA to provide home health care and hospice to Ventura County's low income population. LVMNA serves the most vulnerable residents including the sick, elderly, frail, homebound, and terminally ill patients.

GCHP approved two requests for letters of support:

1) University of California Los Angeles, (UCLA), Center for Cancer Prevention and Control Research. UCLA in collaboration with MICOP requested a letter of support for a proposal to study the interventions to promote breast screening and health care access among Mixtec farmworkers in Ventura County.

2) Life After Brain Injury is a nonprofit organization that provides free support services to the brain injury community in Ventura County. A letter of support for a grant application was approved by the GCHP Sponsorship Committee.

Gold Coast Health Plan℠
A Public Entity

COMPLIANCE REPORT 2015

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*	0	1	0									
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0	0	0									
Hotline Referral *FWA	Department of Justice	0	0	0									
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	5	4	9									
Hotline Referral	External Agency (i.e. HSA)	0	0	0									
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	0	1	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									
	Reporting Requirements Reviewed **	47	33	37									
	Audits conducted	3	0	1									
Delegation Oversight	Letters of Non-Compliance	0	0	0									
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	1	1	1									
Audits External regulatory entities evaluate GCHP compliance with contractual obligations.	Total	0	2	0									
	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	0	0	0									
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0	0	0									
	HEDIS Compliance Audit (HSAG)	0	1	0									
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2014*	0	0	0									
	DHCS Medical Audit *Audit was conducted in 2014*	0	1	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	4	9									
	Investigations of Providers	0	0	0									
	Investigations of Members	5	4	9									
	Investigations of Other Entities	0	0	0									
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0	0	0									
HIPAA Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	Referrals	2	4	2									
	State Notification	1	4	2									
	Federal Notification	0	4	0									
	Member Notification	0	1	0									
	HIPAA Internal Audits Conducted	1	0	0									
Training Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	**Training Sessions**	12	4	9									
	Fraud, Waste & Abuse Prevention	4	1	3									
	Fraud, Waste & Abuse Prevention (Member Orientations)	0	1	0									
	Code of Conduct	4	1	3									
	HIPAA (Individual Training)	4	1	3									
	HIPAA (Department Training)	0	0	0									

** Reporting Requirements are defined by functions delegated and contract terms. Revised contracts, amendments or new requirements form DHCS may require additional requirements from subcontractors as a result the number is fluid
** Audits- Please note multiple audits have been conducted on the Plan, however many occurred in 2012 and 2013 and will be visible on the annual comparison dashboard
** This report is intended to provide a high level overview of certain components of the compliance department and does not include/reflect functions the department is responsible for on a daily basis.

AGENDA ITEM 4b

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer / Interim CEO

Date: April 27, 2015

Re: COO Update

OPERATIONS UPDATE

Membership Update – April 2015

Gold Coast Health Plan's membership increased by 1,511 in April, bringing our total membership to 184,306 as of April 1, 2015. GCHP's membership has increased by 65,794 since the start of Medi-Cal Expansion (55.5%). The cumulative new membership since January 1, 2014 is summarized as follows:

L1 (Low Income Health Plan) – 4,102
M1 (Adult Expansion) – 35,582
7U (CalFresh Adults) – 3,162
7W (CalFresh Children) – 831
7S (Parents of 7Ws) – 381
Traditional Medi-Cal – 21,736

M1 and Traditional Medi-Cal membership continues on an upward climb. The L1 category had the biggest decrease, which should be expected, as the LIHP population continues to be re-determined into other aid codes. GCHP received a file from DHCS on March 19, 2015 containing a list of 131 potential members transitioning from Covered CA into Medi-Cal as of April 1, 2015.

	14-Jan	14-Feb	14-Mar	14-Apr	14-May	14-Jun
L1	7,618	8,083	8,154	8,134	8,118	7,975
M1	183	1,550	2,482	4,514	7,279	10,910
7U	0	0	1,741	3,584	3,680	3,515
7W	0	0	0	684	714	691
7S						3

	14-Jul	14-Aug	14-Sep	14-Oct	14-Nov	14-Dec
L1	7,839	7,726	7,568	7,443	7,289	6,972
M1	15,606	18,585	21,944	23,569	24,060	27,176
7U	3,453	3,400	3,368	3,312	3,254	3,204
7W	667	624	606	296	599	589
7S	4	4	5	11	14	15

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	15-Jan	15-Feb	15-Mar	15-Apr	15-May	15-Jun
L1	6,508	6,128	4,965	4,102	0	0
M1	30,107	31,203	34,350	35,582	0	0
7U	3,390	3,342	3,236	3,162	0	0
7W	872	872	856	831	0	0
7S	478	442	396	381	0	0

Pregnant Women Transition – As mentioned earlier this year, Medi-Cal announced that it was expanding coverage for pregnant women beginning July 1, 2015 with an eligibility effective date of September 1, 2015. Eligible pregnant women with incomes above 60% of the Federal Poverty Level (FPL), up to and including 138% of the FPL, are eligible for full-scope Medi-Cal coverage and will be required to choose a Managed Care Plan unless an exemption applies. Prior to the expansion of eligibility, full-scope Medi-Cal coverage only extended to pregnant women from 0% up to and including 60% FPL. COHS plans were informed in March that they may see these women transitioned into their plans earlier than non-COHS plans, perhaps as early as June 1, 2015. COHS plans have raised concerns about this early transition and are engaged in weekly calls with DHCS.

March 2015 Operations Summary

Member Orientation Meetings – GCHP continues to hold Member Orientation meetings several times per month in various locations throughout the County. Interest in these meetings continues to be strong with 101 individuals (88 members, 13 others) attending a meeting in the first three months of 2015. Of the 88 members in attendance, 72 indicated they learned about the meeting via the Member Orientation meeting flyers that are included in all new member packets and 10 were via GCHP's website.

Claims Inventory – ended March with an inventory of 43,639 (down ~6,000 from February); this equates to Days Receipt on Hand (DROH) of 6 compared to a DROH goal of 5. GCHP received close to 7,000 claims per day in March which is an increase of 1,900 claims per day from a year ago. Monthly claim receipts from April 2014 through March 2015 are as follows:

Month	Total Claims Received	Receipts per Day
April 2014	110,855	5,039
May 2014	108,312	5,158
June 2014	116,474	5,546
July 2014	117,136	5,324
August 2014	108,695	5,176
September 2014	119,233	5,678
October 2014	134,274	5,838
November 2014	111,182	6,177
December 2014	128,087	6,099

January 2015	127,517	6,376
February 2015	130,559	6,528
March 2015	152,948	6,952

Claims Turnaround Time (TAT) – the regulatory requirement of processing 90% of clean claims within 30 calendar days was not met in March (79.9%) but is trending upwards in April. TAT continues to be impacted by the increased volume of claims which can be attributed to GCHP's increased membership. Xerox engaged the services of a temporary claims processing firm to augment existing staff in order to address the current inventory level; those resources starting processing claims the week of March 30th. As of mid-April, the inventory had dropped to ~30,000 and the TAT was improving.

Claims Processing Accuracy – financial accuracy remained above goal (98%) in March at 99.16%. Procedural accuracy also exceeded the goal (97%) for March at 99.97%.

Call Volume – call volume remained above 10,000 calls during March in spite of some weather-related challenges early in the month; the number of calls received in March was 10,352.

Average Speed to Answer (ASA) – the call center in Lexington experienced severe weather during the month and was forced to close on March 5th. However, lessons learned from the closure in February and advanced planning made for a positive outcome. Arrangements were made to divert calls to another location during the closure where representatives took messages that were returned by call center staff the following day. The call center was up and running on March 6th at full staffing so callers did not experience the high wait times that occurred in February. As a result, GCHP exceeded the goal of answering calls within 30 seconds or less. The combined results (Member, Provider and Spanish lines) for March were 7.8 seconds.

Abandonment Rate – the call center returned to normal abandonment rate results following February's weather-related increase. The goal is 5% or less of the calls received being abandoned; March's combined results were 0.44%.

Average Call Length – the combined result of 7.86 minutes in March was above the goal of 7.0 minutes.

AB 85 Capacity Tracking – VCMC has a total of 25,093 Adult Expansion members assigned to them as of March 2015. VCMC's target enrollment is 65,765 and is currently at 38% of the enrollment target.

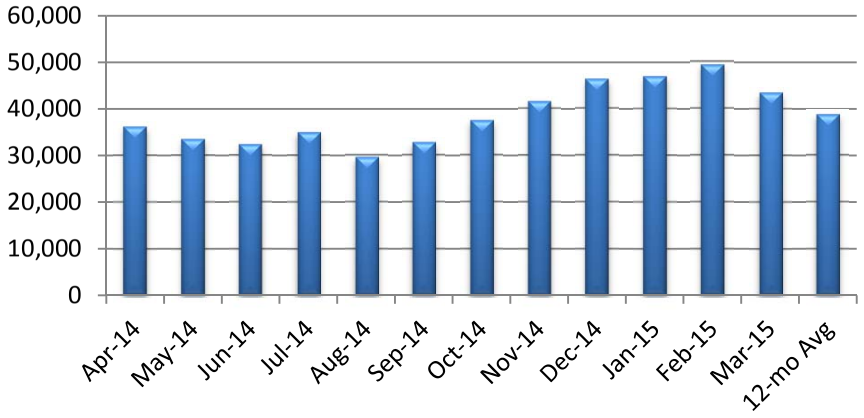
Noteworthy Activities – Operations continues to lead or be involved in the following projects:

- Business Continuity Plan – Business Impact Analysis interviews are being conducted with key staff in all areas of GCHP to identify mission critical functions.
- ICD-10 Readiness – work continues towards implementation of the new code set which is effective for dates of service on or after October 1, 2015. Testing is scheduled to begin in May.
- Crossover Claims – implementation activities continued during the month. Providers will not have to submit paper claims with Medicare Explanation of Benefits (MEOBs) for dates of service on or after April 1, 2015. The crossover claims file produced by DHCS will only contain Medicare Part B (professional and outpatient services) claims so facilities will need to continue to submit paper claims and MEOBs for Part A (inpatient services) claims.
- Plan Selection – PCP selection during sign-up via Covered California; information matched once Medi-Cal beneficiary becomes a GCHP member. DHCS has again delayed the implementation for non-COHS plans to no earlier than February 2016. Implementation for COHS plans would follow shortly thereafter.

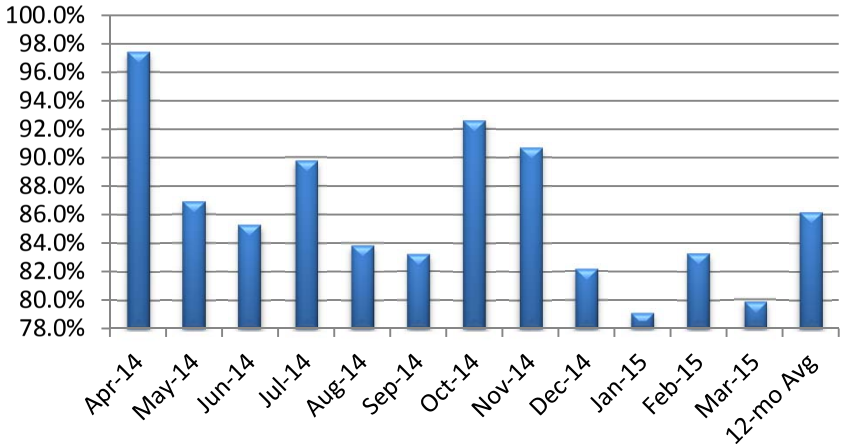
GCHP Claims Metrics – March 2015

- 30 Day Turnaround Time (TAT) was not met in March; 79.9% of clean claims were processed within 30 calendar days but results are trending upwards in April
- Ending Inventory decreased by 6,000 claims from February and equals 6 Days Receipt on Hand (DROH) compared to goal of 5 days
- Financial and Procedural Accuracy both exceeded required Service Levels

Ending Inventory

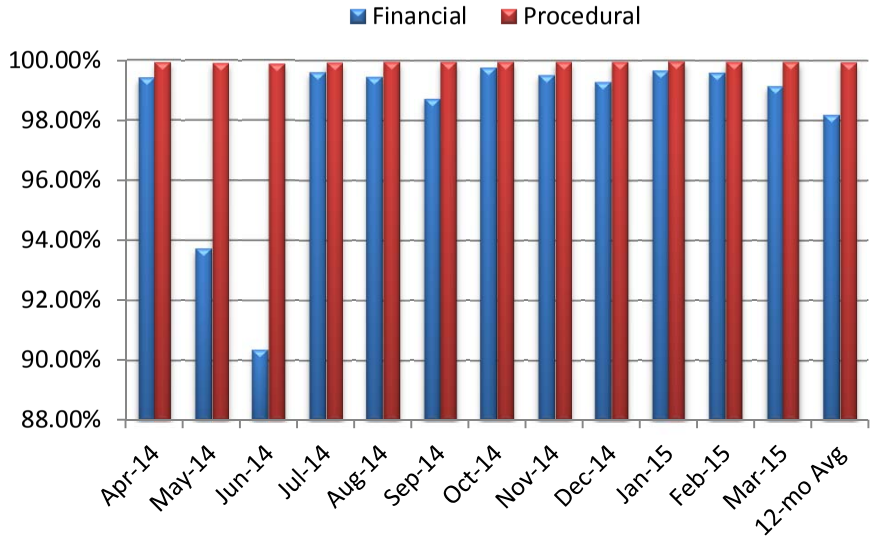


Clean Claims Processed within 30 Calendar Days



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

Financial and Procedural Accuracy

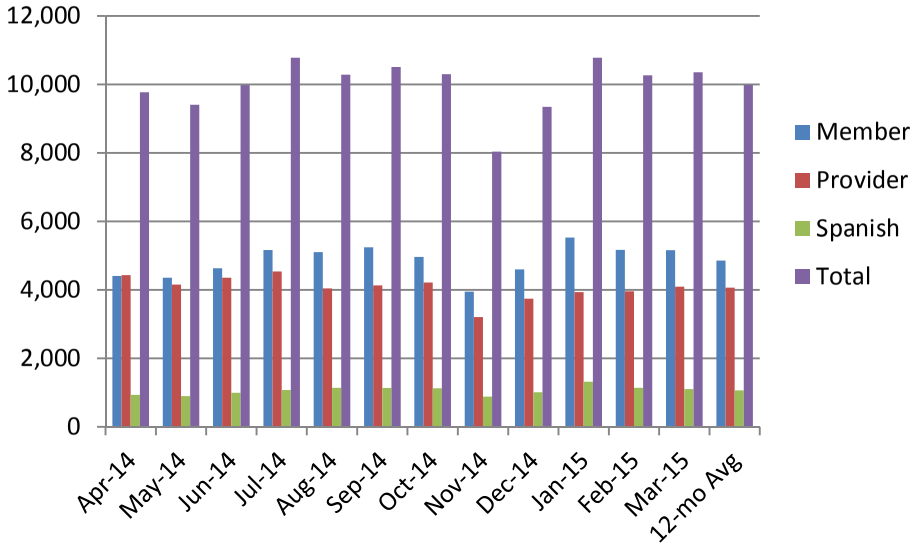


Financial Accuracy – 98% or higher
Procedural Accuracy – 97% or higher

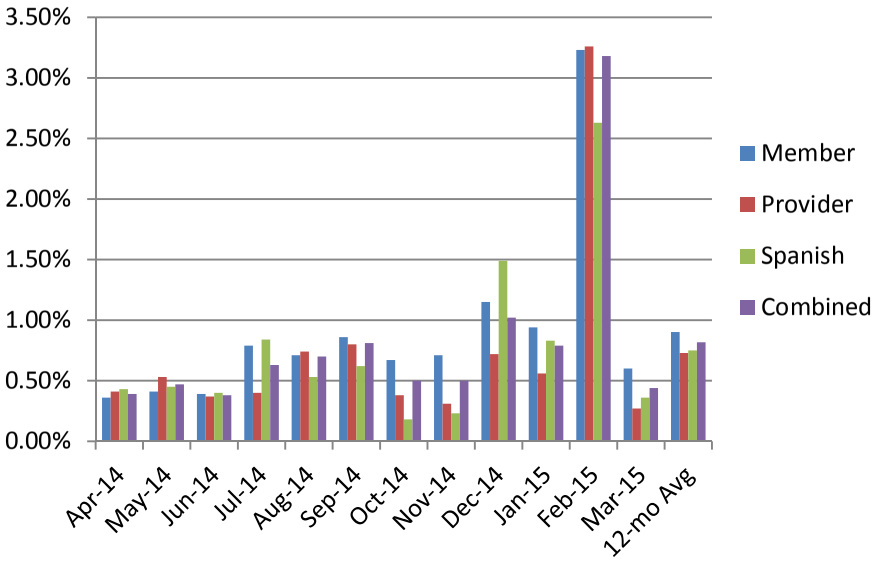
GCHP Call Center Metrics – March 2015

- Call volume remained above 10,000 calls for the month (10,352)
- ASA (7.8 seconds) and Abandonment Rate (0.44%) were both well within goal

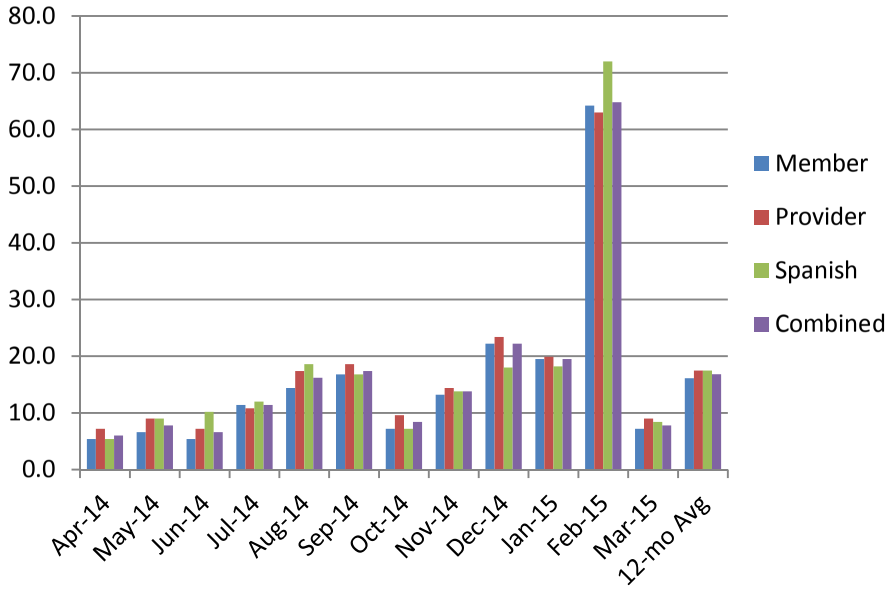
Call Center Volume



Abandonment Rate
(goal is 5% or less)



Average Speed of Answer



GCHP Auto Assignment by PCP/Clinic as of April 1, 2015

	Apr-15		Mar-15		Feb-15		Jan-15		Dec-14		Nov-14	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
AB85 Eligible	**2,342**		**1,609**		**2,248**		**1,311**		**1,350**		**1,390**	
VCMC	1,756	74.98%	1,206	74.95%	1,686	75.00%	983	74.98%	1,012	74.96%	1,042	74.96%
Balance	586	25.02%	403	25.05%	562	25.00%	328	25.02%	338	25.04%	348	25.04%
Regular Eligible	**1,420**		**1,277**		**3,069**		**1,357**		**1,215**		**1,462**	
Regular + AB85 Balance	**2,006**		**1,680**		**3,631**		**1,685**		**1,553**		**1,810**	
Clinicas	513	25.57%	421	25.06%	793	21.84%	373	22.14%	323	20.80%	433	23.92%
CMH	236	11.76%	193	11.49%	339	9.34%	178	10.56%	160	10.30%	197	10.88%
Independent	65	3.24%	37	2.20%	68	1.87%	48	2.85%	43	2.77%	40	2.21%
VCMC	1,192	59.42%	1,029	61.25%	2,431	66.95%	1,086	64.45%	1,027	66.13%	1,140	62.98%
Total Assigned	**3,762**		**2,886**		**5,317**		**2,668**		**2,565**		**2,852**	
Clinicas	513	13.64%	421	14.59%	793	14.91%	373	13.98%	323	12.59%	433	15.18%
CMH	236	6.27%	193	6.69%	339	6.38%	178	6.67%	160	6.24%	197	6.91%
Independent	65	1.73%	37	1.28%	68	1.28%	48	1.80%	43	1.68%	40	1.40%
VCMC	2,948	78.36%	2,235	77.44%	4,117	77.43%	2,069	77.55%	2,039	79.49%	2,182	76.51%

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
- AB 85 assignment began in March 2014 for members eligible in January 2014
  - VCMC has 25,093 assigned Adult Expansion members as of March 2015
  - VCMC's target enrollment is 65,765 and is currently at 38% of capacity

AGENDA ITEM 4c

To: Gold Coast Health Plan Commission

From: Melissa Scrymgeour, Chief Information Officer

Date: April 27, 2015

Re: CIO Update

Infrastructure and Systems

GCHP recently completed the IT Disaster Recovery (DR) Project. The purpose of the project was to develop and test a documented process and set of procedures to provide a defined Information Technology (IT) infrastructure that would effectively support core GCHP business functions after a disaster and during the defined recovery period.

The project included two phases:

1. Execute Xerox / ACS DR Test – GCHP to review results. (Completed 06/30/14)
2. Procurement of a DR vendor to provide an offsite disaster recovery solution for GCHP internal systems and execution of DR test. (Completed 03/31/15)

The final solution is a virtual DR offering, utilizing a Disaster as a Service (DraaS) platform. The DraaS solution represents a cost effective disaster recovery approach while meeting GCHP business recovery time (RTO) and recovery point objectives (RPO). Solution configuration began in mid-January 2015, and completed in March 2015, with the successful execution of the DR test.

Project Management Office (PMO)

Since the March Commission meeting, the Plan closed five projects, kicked off one new project and approved one new regulatory project to add to the portfolio. The PMO currently has a total of 11 active projects on the approved GCHP project portfolio.

April 2015 PMO Project Activity Highligjts:

· Closed IT Disaster Recovery Project
· Closed Information Security Program (Operationalize)
· Closed MedHOK SPD

· Closed MedHOK ACG-Risk Stratification
· Closed PBM - Vendor for RFP Support
· Implementepd Crossover Claims
· Kicked off MedInsight Upgrade

May 2015 PMO Planned Project Activity Highlights:

Start ICD-10 Testing Phase
· Complete IKA system upgrade
· Kick off Provider Data Management Optimization (PDMO) project

FY 2014-15 GCHP Projects:

- **ICD-10 Readiness (Phase 1 & Phase 2):**
  Transition all systems and providers from ICD-9 to ICD-10 by the revised Center for Medicaid and Medicare Services (CMS) mandated date of 10/15/15.

- **Disease Management (DM) Program (Roadmap & 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 Survey:**
  Gauge and measure member satisfaction with GCHP, as requested by the Commission.

- **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 (RFP & Implementation):**
  Contractual requirement to draft plan for critical business process resumption in the event of an emergency.

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

- **Crossover Claims:**
  Further optimizes claims processing accuracy and efficiencies to appropriately handle claims where a portion is covered by Medicare.

- **Information Security Program (Operationalize):**
  Required to ensure ongoing HIPAA and HITECH (Health Information Technology for Economic and Clinical Health Act-2009) compliance.

- **Social Media Policy & Roadmap:**
  Establish a communication strategy via social media platforms to members, providers and the general community.

- **ACA Core Administrative Simplification Rules (CORE):**
  Regulatory requirement to utilize standard electronic transaction sets as defined under the Affordable Care Act.

- **HR Flexible Work Program-Telework Policy**:
  Implement initiatives to attract and retain staff. Under consideration are a telework strategy, employee recognition, and flexible work schedules.

- **Pharmacy Benefits Manager (PBM) Implementation:**
  Consulting Vendor for RFP creation, RFP and possible implementation of new PBM.

- **MedHOK ACG-Risk Stratification:**
  Implement MedHOK ACG module for member risk stratification. Supports the GCHP disease management program.

- **Provider Contracts & Capitation Rebasing Evaluation (Phase 1 & Phase 2):**
  Evaluation of provider capitation rates.

- **MedInsight Upgrade:**
  Upgrade of the existing Milliman MedInsight Business Intelligence (BI) Tool; moving from and on premise to hosted solution.

- **Provider Portal Evaluation:**
  Evaluate provider portal solutions in effort to streamline provider online experience for eligibility and claim inquiries, and authorization requests. Supports Plan "valued and trusted partner" strategy.

- **MedHOK SPD:**
  Implement MedHOK functional enhancements to meet State SPD assessment and reporting requirements.

- **MedHOK MMS Post Implementation:**
  Implement system fixes to resolve MedHOK post-implementation issues.

- **ICES / IKA Upgrades:**
  Software version upgrade for core administration processing and claims editing systems.

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

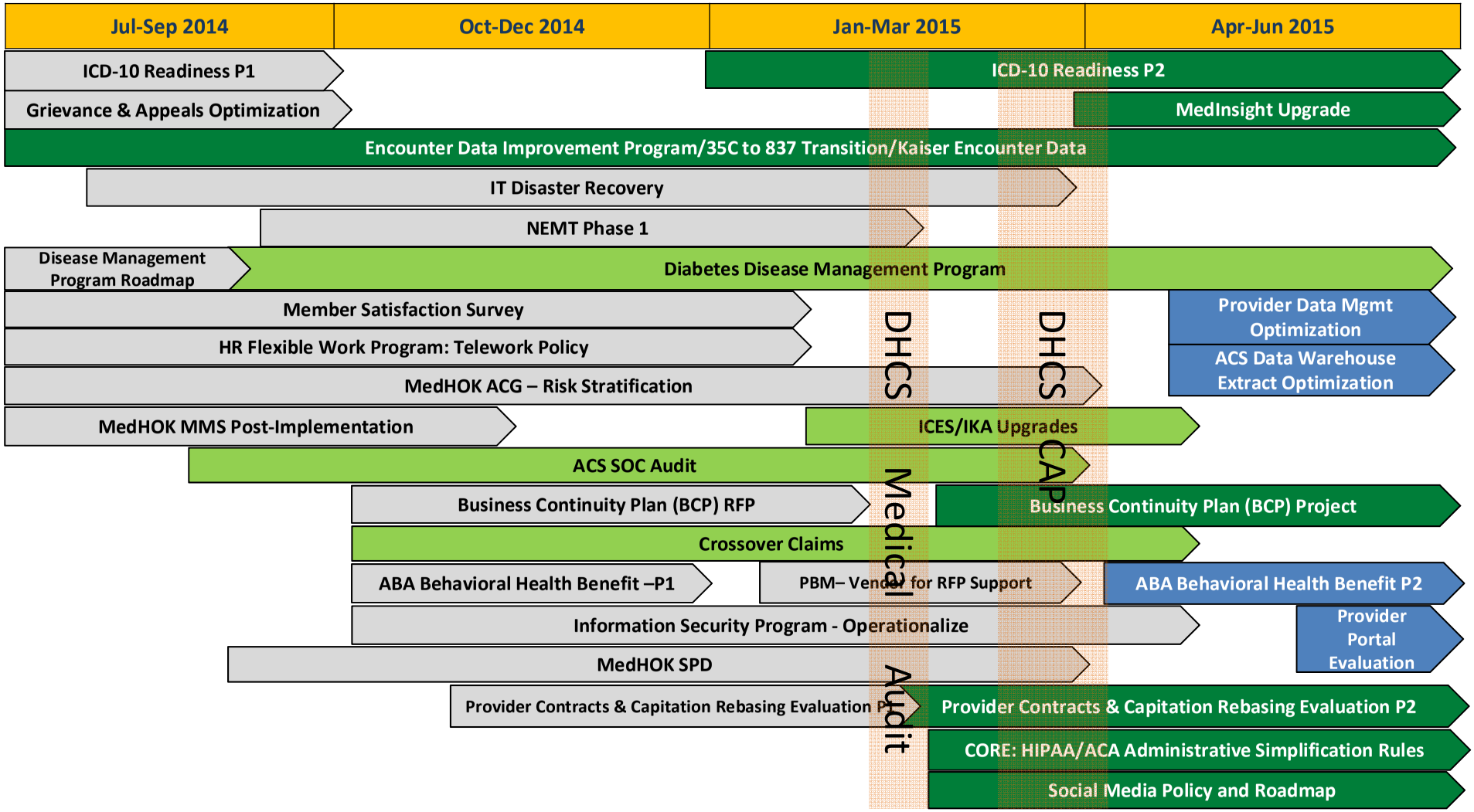
- **Non-Emergent Medical Transportation (NEMT)-(Phase 1 & Phase 2):**
  Modify non-emergent medical transportation processes to ensure sustained regulatory and contractual compliance. Analyze and evaluate alternatives to existing benefit.

- **Behavioral Health Benefit for Autism Spectrum Disorder (ABA)- (Phase 1 & Phase 2):**
  Regulatory requirement to introduce Applied Behavioral Analysis (ABA). ABA a treatment for Autism Spectrum Disorder (ASD) effective 09/15/14.

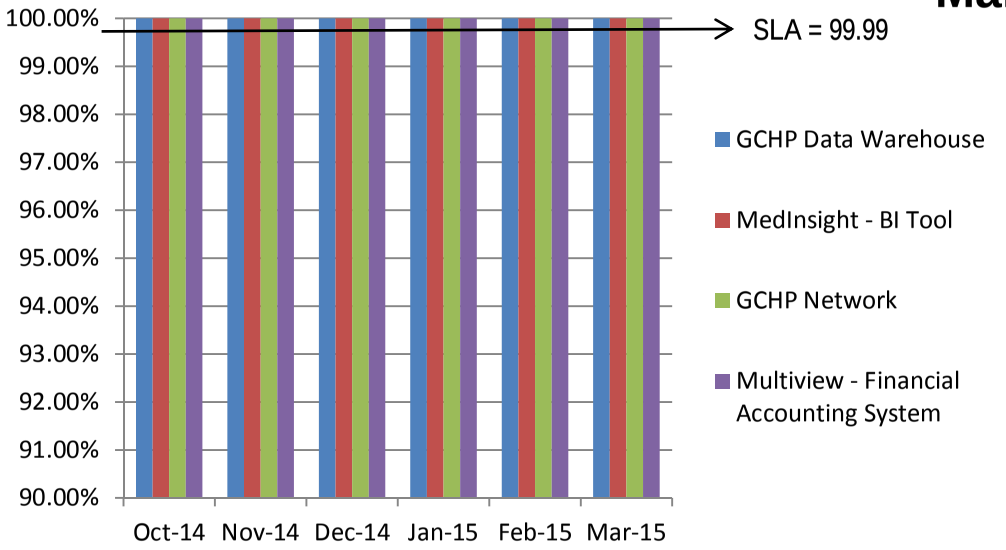
- **Provider Data Management Optimization (PDMO) Project:**
  Optimization of the collection, maintenance and storage of Plan provider data to support business needs and ensure ongoing regulatory compliance.

04/2015: GCHP Projects "At a Glance"

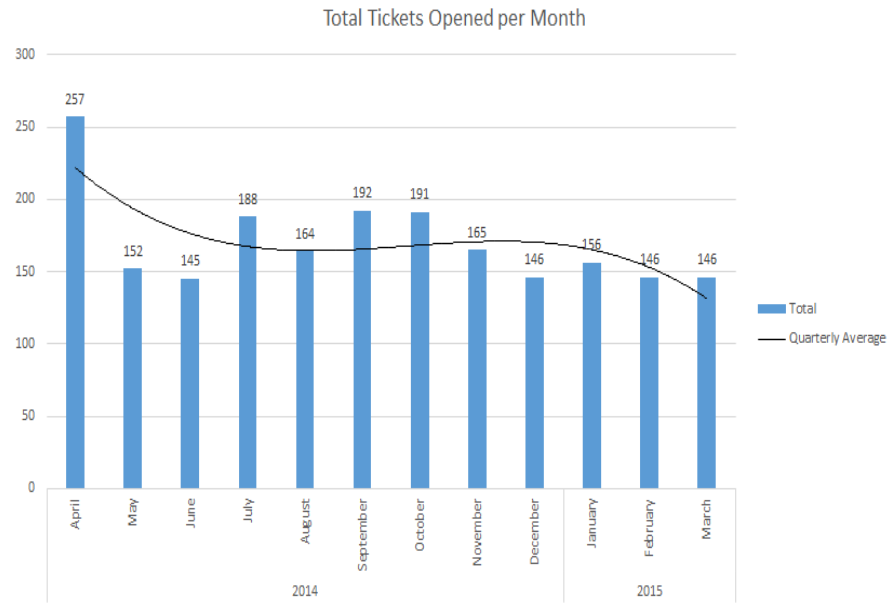
LEGEND:
GREEN- Active Projects (Lighter GREEN reflects Project Extensions)
BLUE –Approved FY14/15 Projects
Dark BLUE-Delayed Start
GREY-Closed

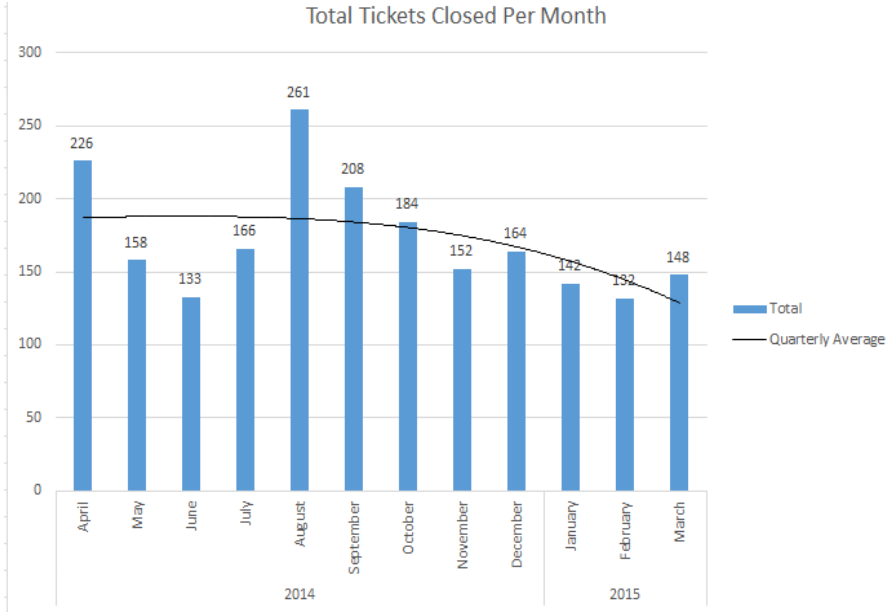


GCHP IT Metrics – March 2015



GCHP Helpdesk Service Ticket Trending





AGENDA ITEM 4d

To: Gold Coast Health Plan Commission

From: Dr. Nancy Wharfield, Associate Chief Medical Officer

Date: April 27, 2015

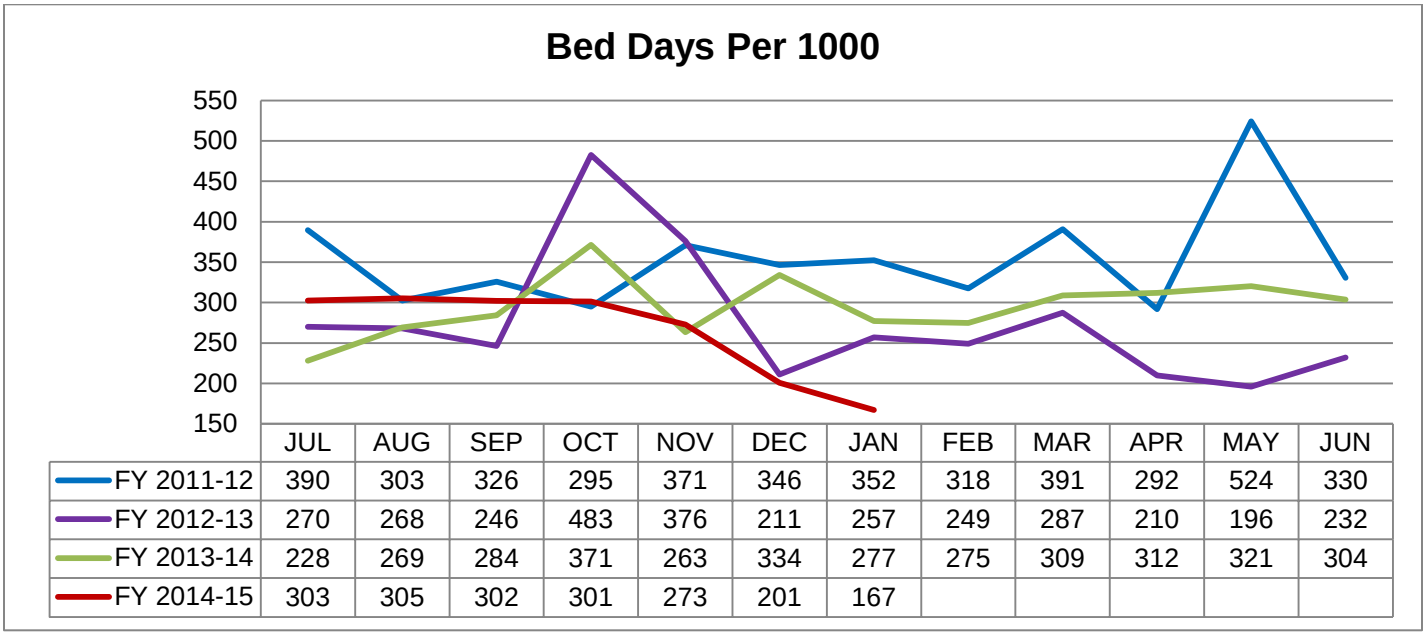
Re: Health Services Update

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

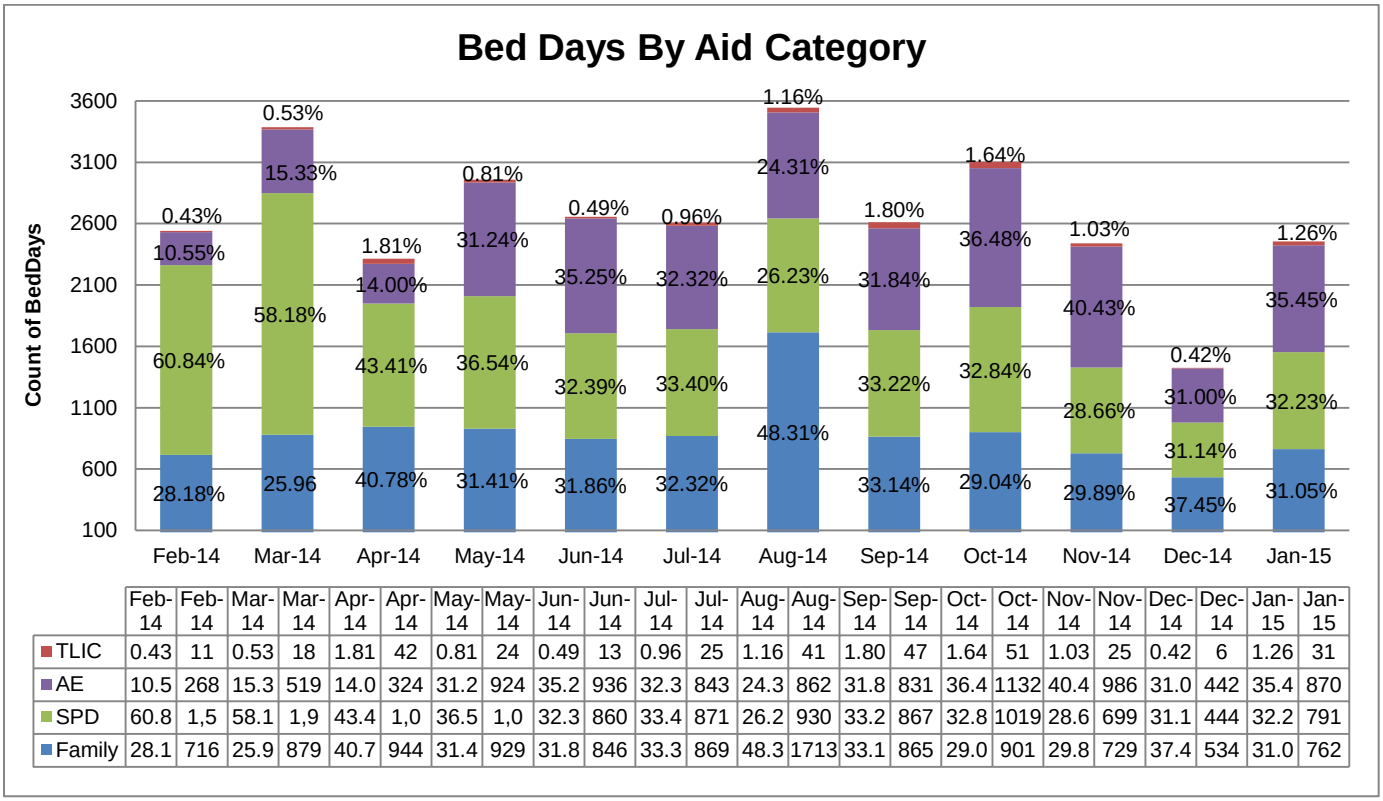
Inpatient Utilization

Bed days/1000 members continued to decline from fall to winter and fell below 200/1000 members. Family aid code members continue to show a slightly higher percentage of bed days than SPD and Adult Expansion aid code groups.

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 2011-12	390	303	326	295	371	346	352	318	391	292	524	330
FY 2012-13	270	268	246	483	376	211	257	249	287	210	196	232
FY 2013-14	228	269	284	371	263	334	277	275	309	312	321	304
FY 2014-15	303	305	302	301	273	201	167					

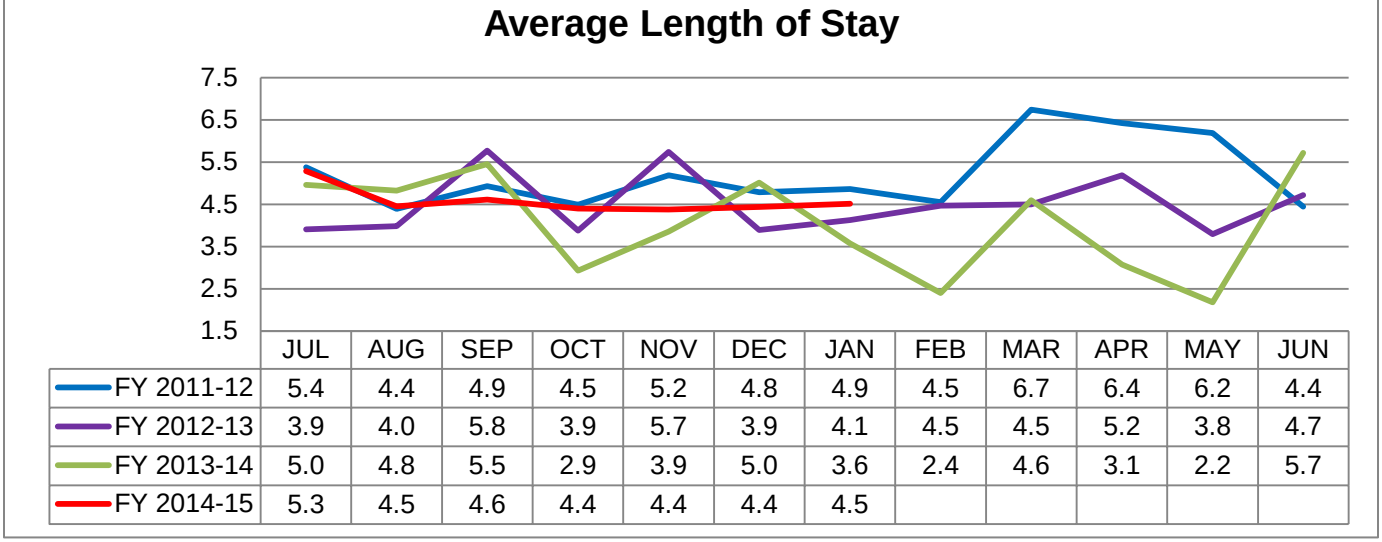


	Feb-14	Feb-14	Mar-14	Mar-14	Apr-14	Apr-14	May-14	May-14	Jun-14	Jun-14	Jul-14	Jul-14	Aug-14	Aug-14	Sep-14	Sep-14	Oct-14	Oct-14	Nov-14	Nov-14	Dec-14	Dec-14	Jan-15	Jan-15
TLIC	0.43	11	0.53	18	1.81	42	0.81	24	0.49	13	0.96	25	1.16	41	1.80	47	1.64	51	1.03	25	0.42	6	1.26	31
AE	10.5	268	15.3	519	14.0	324	31.2	924	35.2	936	32.3	843	24.3	862	31.8	831	36.4	1132	40.4	986	31.0	442	35.4	870
SPD	60.8	1,5	58.1	1,9	43.4	1,0	36.5	1,0	32.3	860	33.4	871	26.2	930	33.2	867	32.8	1019	28.6	699	31.1	444	32.2	791
Family	28.1	716	25.9	879	40.7	944	31.4	929	31.8	846	33.3	869	48.3	1713	33.1	865	29.0	901	29.8	729	37.4	534	31.0	762

Average Length of Stay

Average length of stay has plateaued at approximately 4.5 since August 2014.

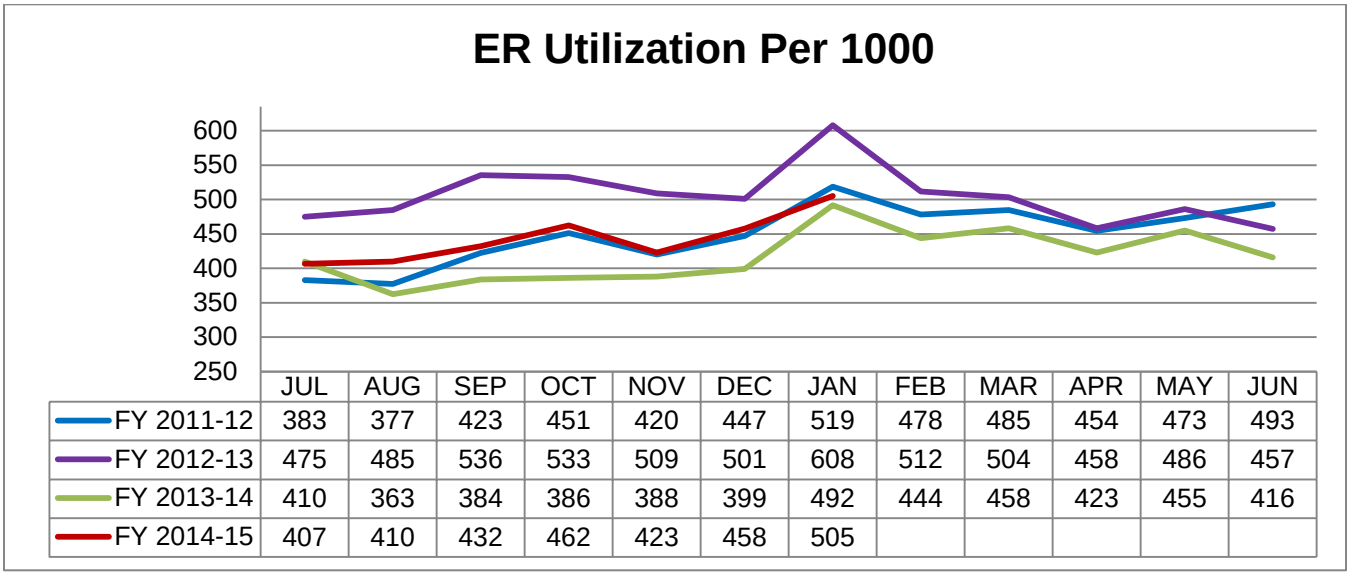
Benchmark: Average length of stay from available published data from other managed care plans range from 3.6 – 4.7. There is variability in reporting of Administrative days among managed care plans.



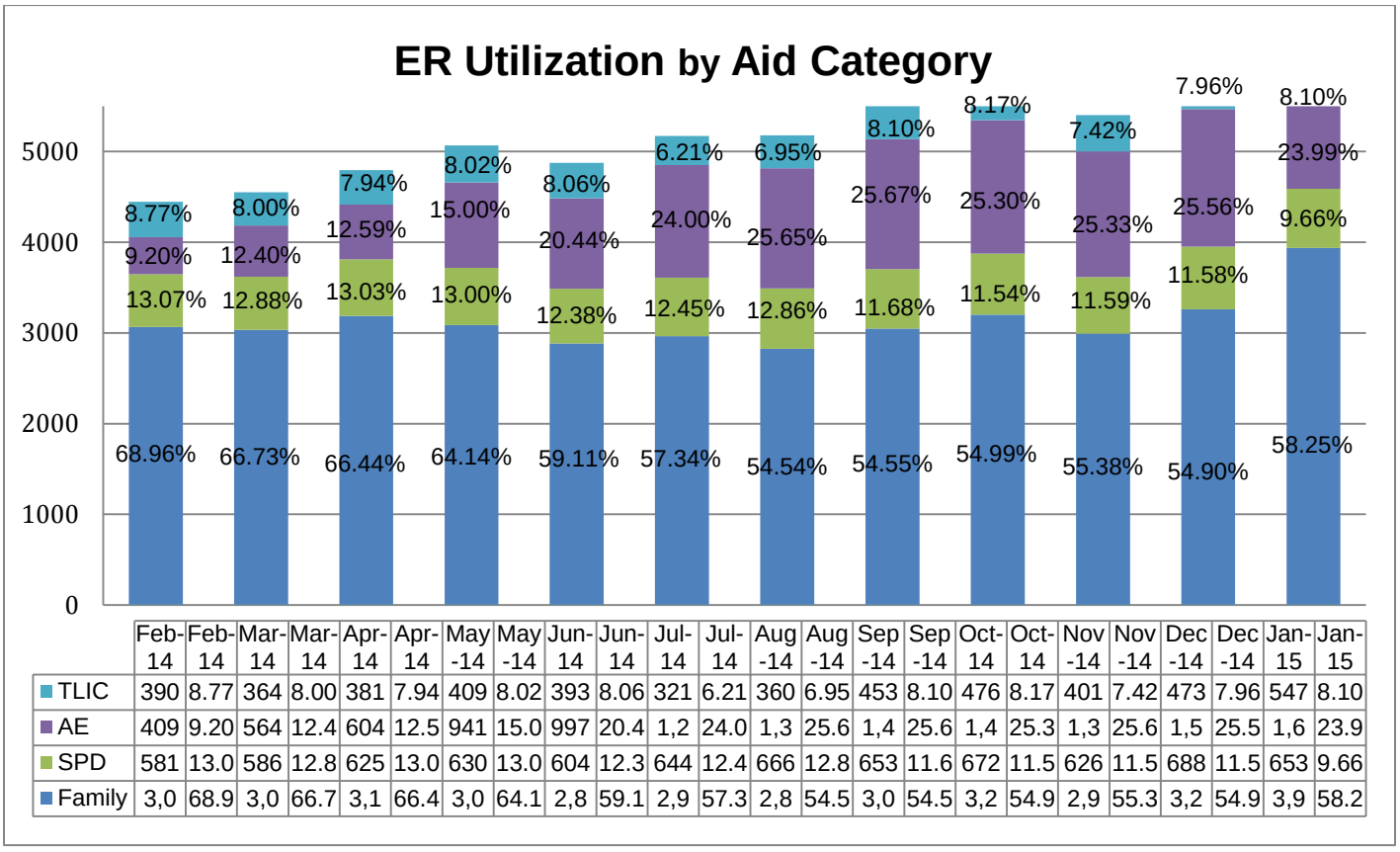
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2011-12	5.4	4.4	4.9	4.5	5.2	4.8	4.9	4.5	6.7	6.4	6.2	4.4
FY 2012-13	3.9	4.0	5.8	3.9	5.7	3.9	4.1	4.5	4.5	5.2	3.8	4.7
FY 2013-14	5.0	4.8	5.5	2.9	3.9	5.0	3.6	2.4	4.6	3.1	2.2	5.7
FY 2014-15	5.3	4.5	4.6	4.4	4.4	4.4	4.5					

ER Utilization

The seasonal winter peak for ER utilization is reproduced in January 2015. Year-to-date ER utilization for FY 2014-15 averages 442 compared with an average of 418 for FY 2013-14. The highest percentage of ER utilization continues to be by Family aid code group members followed by the AE group.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2011-12	383	377	423	451	420	447	519	478	485	454	473	493
FY 2012-13	475	485	536	533	509	501	608	512	504	458	486	457
FY 2013-14	410	363	384	386	388	399	492	444	458	423	455	416
FY 2014-15	407	410	432	462	423	458	505					

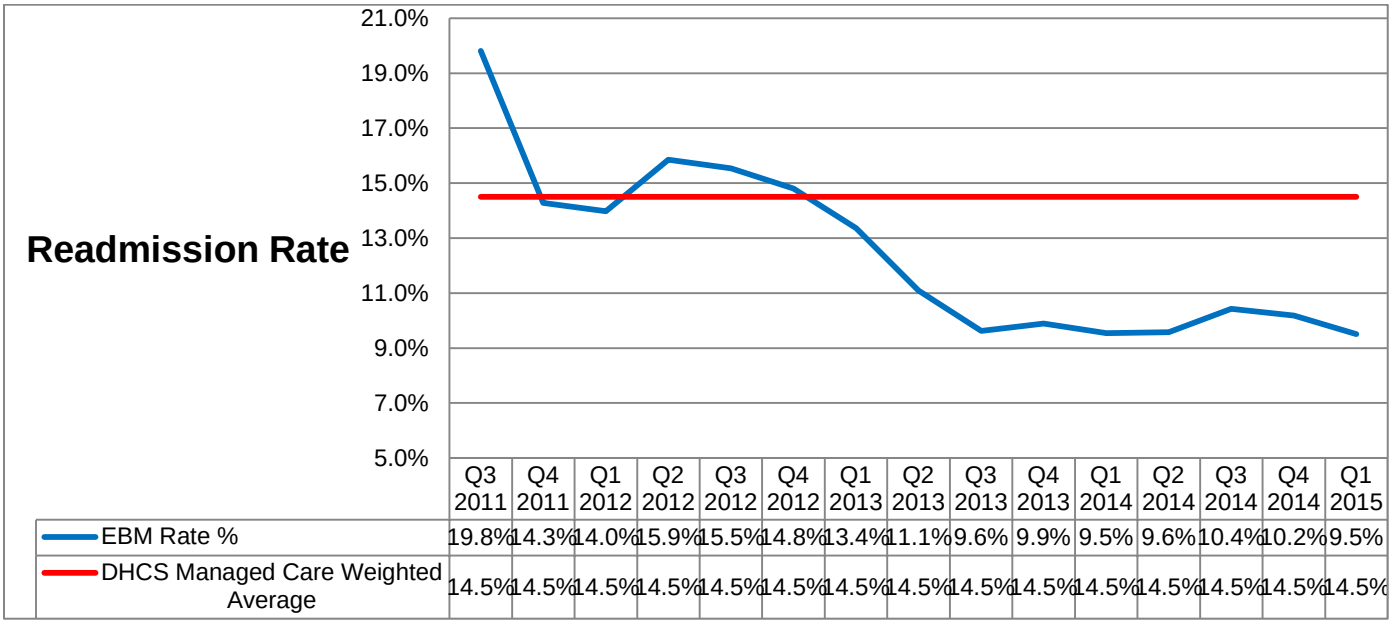


	Feb-14	Feb-14	Mar-14	Mar-14	Apr-14	Apr-14	May-14	May-14	Jun-14	Jun-14	Jul-14	Jul-14	Aug-14	Aug-14	Sep-14	Sep-14	Oct-14	Oct-14	Nov-14	Nov-14	Dec-14	Dec-14	Jan-15	Jan-15
TLIC	390	8.77	364	8.00	381	7.94	409	8.02	393	8.06	321	6.21	360	6.95	453	8.10	476	8.17	401	7.42	473	7.96	547	8.10
AE	409	9.20	564	12.4	604	12.5	941	15.0	997	20.4	1,2	24.0	1,3	25.6	1,4	25.6	1,4	25.3	1,3	25.6	1,5	25.5	1,6	23.9
SPD	581	13.0	586	12.8	625	13.0	630	13.0	604	12.3	644	12.4	666	12.8	653	11.6	672	11.5	626	11.5	688	11.5	653	9.66
Family	3,0	68.9	3,0	66.7	3,1	66.4	3,0	64.1	2,8	59.1	2,9	57.3	2,8	54.5	3,0	54.5	3,2	54.9	2,9	55.3	3,2	54.9	3,9	58.2

Readmission Rate

The readmission rate has remained between 9.5% and 10.5% since the 3td quarter of 2013.

Benchmark: The weighted average for the HEDIS 2013 All Cause Readmission Rate from the February 2014 Medi-Cal Managed Care Performance Dashboard is approximately 14.5%. It is indicated by the red line in the following graph.

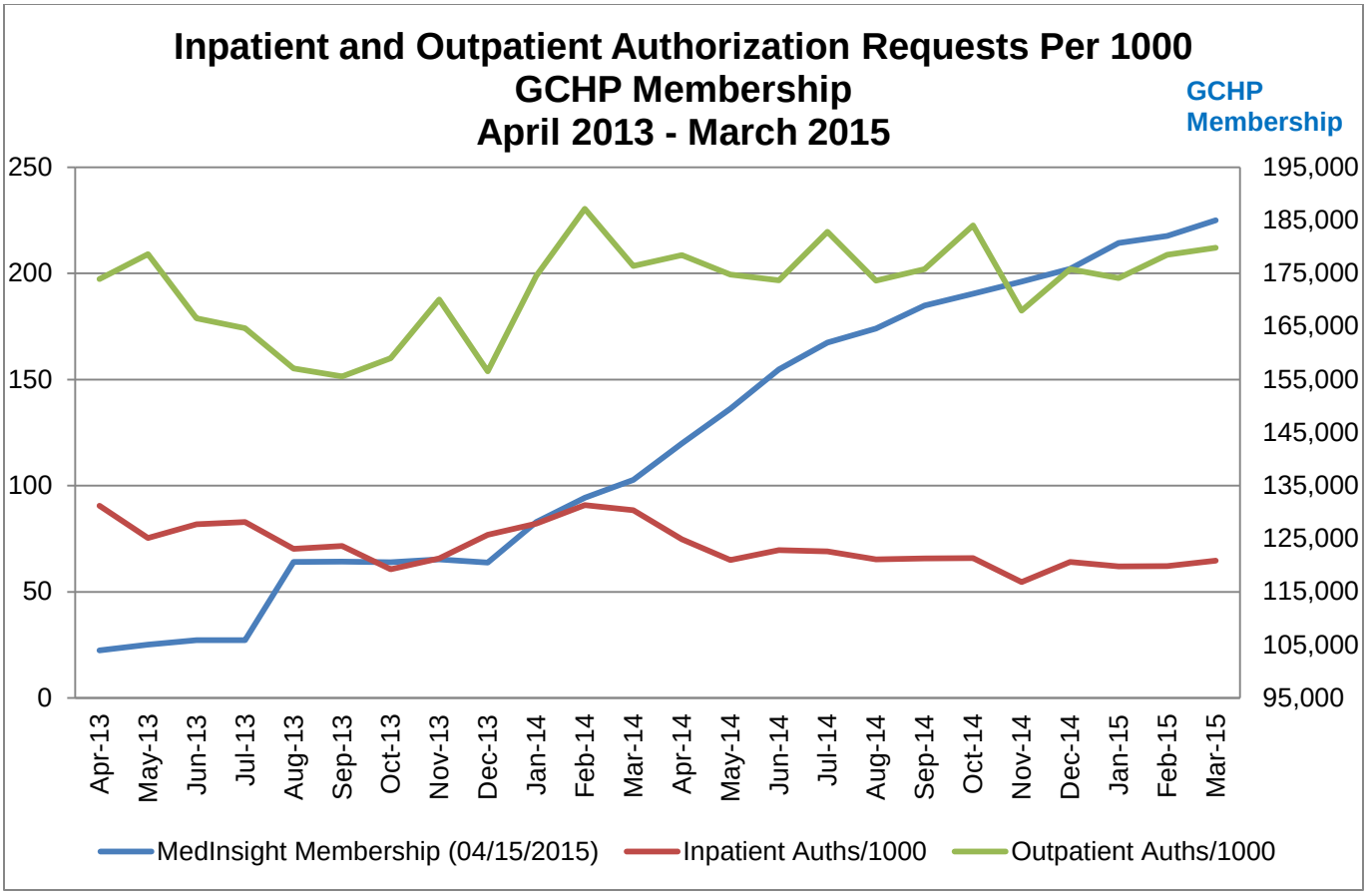


	Q3 2011	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015
EBM Rate %	19.8%	14.3%	14.0%	15.9%	15.5%	14.8%	13.4%	11.1%	9.6%	9.9%	9.5%	9.6%	10.4%	10.2%	9.5%
DHCS Managed Care Weighted Average	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%

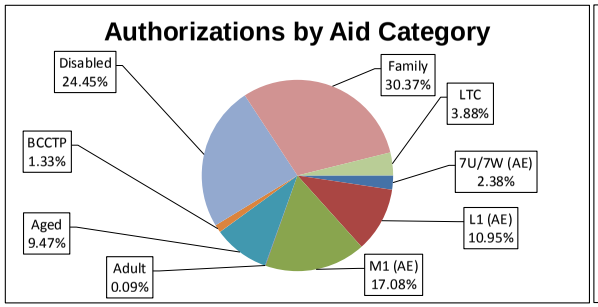
Authorization Requests

For calendar year 2014, requests for outpatient service outnumbered requests for inpatient service approximately 3:1. Requests for outpatient service have continued to increase since January 2015. Requests for inpatient service reached a plateau at 75/1000 members or below since April 2014.

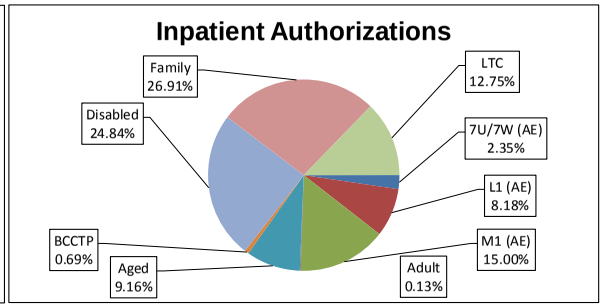
Among Medi-Cal adult expansion members new to Gold Coast Health Plan since January 1, 2014, requests for service for M1 and L1 groups predominated. For non-adult expansion members, service requests were led by the Family and Disabled groups.


Inpatient and Outpatient Authorization Requests Per 1000
GCHP Membership
April 2013 - March 2015
GCHP Membership
250
200
150
100
50
0
195,000
185,000
175,000
165,000
155,000
145,000
135,000
125,000
115,000
105,000
95,000
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
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
MedInsight Membership (04/15/2015)
Inpatient Auths/1000
Outpatient Auths/1000

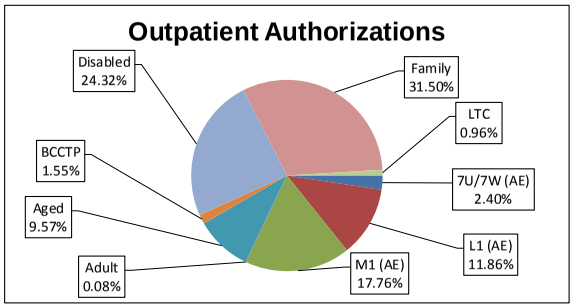
Gold Coast Health Plan Authorizations by Aid Category
January 2014 - March 2015



7U/7W (AE)	1,222
L1 (AE)	5,613
M1 (AE)	8,756
Adult	47
Aged	4,853
BCCTP	684
Disabled	12,535
Family	15,567
LTC	1,988
Total Auths	51,265



7U/7W (AE)	298
L1 (AE)	1,038
M1 (AE)	1,903
Adult	16
Aged	1,162
BCCTP	87
Disabled	3,152
Family	3,414
LTC	1,617
Total Auths	12,687



7U/7W (AE)	924
L1 (AE)	4,575
M1 (AE)	6,853
Adult	31
Aged	3,691
BCCTP	597
Disabled	9,383
Family	12,153
LTC	371
Total Auths	38,578

Data Source: MedHOK Authorizations by Aid Code Query on 04/16/2015

Clinical Grievances and Appeals

For calendar year 2014, the average number of clinical grievances/quarter was 30. For Q1 2015, there were 41 clinical grievances. Approximately half (56%) were regarding quality of care issues and 22% were about access to care issues.

Clinical Grievances

Quarter	Total Number
Q1 2014	22
Q2 2014	34
Q3 2014	32
Q4 2014	31
Q1 2015	41

For calendar year 2014, the average number of appeals/quarter was 8. For Q1 2015, there were 5 grievances.

Appeals

Quarter	Total	Upheld	Partial Overturn	In Progress	Overturned
Q1 2014	10	8 (80%)	-	-	2 (20%)
Q2 2014	3	2 (67%)	-	-	1 (33%)
Q3 2014	10	6 (60%)	-	-	4 (40%)
Q4 2014	10	3 (30%)	1 (10%)	2 (20%)	4 (40%)
Q1 2015	5	1 (20%)	0	2 (40%)	2 (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 calendar year 2013 was 3.66% and for 2014 was 3.34%. The denial rate for Q1 2015 was 3.57%.