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 (VCMCCC)
da 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 (VCMC)  
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
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:

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:

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 Ca/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:

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 CalTRUST

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. Wharfild, 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:

| 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
FINANCIAL PACKAGE
For the month ended February 28, 2015

TABLE OF CONTENTS

● Financial Overview
● Membership
● Statement of Financial Positions
● Statement of Revenues, Expenses and Changes in Net Assets
● YTD Statement of Revenues, Expenses and Changes in Net Assets
● Monthly Cash Flow
● YTD Cash Flow

APPENDIX

● Cash Trend Combined
● Paid Claims and IBNP Composition
● Total Expense Composition
● Pharmacy Cost & Utilization Trends
## GOLD COAST HEALTH PLAN
### Financial Results Summary

<table>
<thead>
<tr>
<th>Description</th>
<th>AUDITED* FY 2011-12</th>
<th>AUDITED* FY 2012-13</th>
<th>UNAUDITED FY 2013-14</th>
<th>FY 2014 - 15</th>
</tr>
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<tr>
<td>Member Months</td>
<td>1,258,189</td>
<td>1,223,895</td>
<td>1,553,660</td>
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<td>Revenue</td>
<td>304,635,932</td>
<td>315,119,611</td>
<td>423,995,809</td>
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<tr>
<td>pmpm</td>
<td>242.12</td>
<td>257.47</td>
<td>272.90</td>
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<tr>
<td>Health Care Costs</td>
<td>287,353,672</td>
<td>280,382,704</td>
<td>369,321,385</td>
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<tr>
<td>pmpm</td>
<td>228.39</td>
<td>229.09</td>
<td>237.71</td>
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<tr>
<td>% of Revenue</td>
<td>94.3%</td>
<td>89.0%</td>
<td>87.1%</td>
<td></td>
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<tr>
<td>Total Increase/(Decrease) in Unrestricted Net Assets</td>
<td>(1,609,063)</td>
<td>10,722,980</td>
<td>27,922,891</td>
<td>9,280,590</td>
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<tr>
<td>pmpm</td>
<td>15.01</td>
<td>19.62</td>
<td>17.22</td>
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<tr>
<td>% of Revenue</td>
<td>6.2%</td>
<td>7.6%</td>
<td>6.3%</td>
<td></td>
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<tr>
<td>TND</td>
<td>4,031,881</td>
<td>11,891,099</td>
<td>39,813,991</td>
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<tr>
<td>TNE Excess / (Deficiency)</td>
<td>(12,068,853)</td>
<td>916,990</td>
<td>19,849,770</td>
<td>26,483,874</td>
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<tr>
<td>% of Required TNE level</td>
<td>199%</td>
<td>217%</td>
<td>244%</td>
<td>333%</td>
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<tr>
<td>% of Required TNE level (excluding $7.2 million LOC)</td>
<td>163%</td>
<td>185%</td>
<td>215%</td>
<td>298%</td>
</tr>
</tbody>
</table>

* Audited amounts reflect financial adjustments made by auditors, but exclude presentation reclassifications without P&L impact (i.e. reporting package kept the same).

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

### Budget Comparison

<table>
<thead>
<tr>
<th>Budget Comparison</th>
</tr>
</thead>
</table>
| Feb 15 | Variance
| FY | Fav/(Unfav) |
| FY 2014 - 15 | Budget |
| FY 2011-12 | 163,912 | 17,546 |
| FY 2012-13 | 17,546 | 10.7% |
| FY 2013-14 | FY 2014 - 15 |
| FY 2015 | 163,912 | 17,546 |

% of Revenue

### Tangible Net Equity (TNE)

- Minimum Required TNE
- GCHP TNE
- GCHP without LOC

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).
### Membership - Rolling 12 Month

<table>
<thead>
<tr>
<th>Month</th>
<th>FAMILY</th>
<th>DUALS</th>
<th>SPD</th>
<th>TLIC</th>
<th>AE</th>
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<td>MAR 14</td>
<td>74,978</td>
<td>18,182</td>
<td>9,635</td>
<td>21,636</td>
<td>12,486</td>
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<td>APR 14</td>
<td>76,498</td>
<td>17,109</td>
<td>10,578</td>
<td>21,226</td>
<td>16,225</td>
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<td>MAY 14</td>
<td>79,126</td>
<td>17,269</td>
<td>10,799</td>
<td>22,025</td>
<td>19,070</td>
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<td>JUN 14</td>
<td>82,783</td>
<td>17,472</td>
<td>10,771</td>
<td>23,568</td>
<td>22,574</td>
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<td>JUL 14</td>
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<td>17,780</td>
<td>10,324</td>
<td>23,794</td>
<td>27,106</td>
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<td>AUG 14</td>
<td>81,372</td>
<td>17,840</td>
<td>10,612</td>
<td>23,545</td>
<td>29,882</td>
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<td>SEP 14</td>
<td>82,191</td>
<td>18,047</td>
<td>10,461</td>
<td>23,533</td>
<td>33,118</td>
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<td>OCT 14</td>
<td>85,139</td>
<td>18,248</td>
<td>10,380</td>
<td>24,230</td>
<td>34,611</td>
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<td>NOV 14</td>
<td>84,198</td>
<td>18,381</td>
<td>10,501</td>
<td>23,496</td>
<td>34,956</td>
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<td>DEC 14</td>
<td>85,866</td>
<td>18,430</td>
<td>10,385</td>
<td>25,201</td>
<td>38,559</td>
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<td>JAN 15</td>
<td>86,679</td>
<td>19,864</td>
<td>11,800</td>
<td>24,771</td>
<td>40,303</td>
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<td>FEB 15</td>
<td>88,305</td>
<td>17,740</td>
<td>11,800</td>
<td>23,322</td>
<td>40,947</td>
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</table>

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

**SPD = Seniors and Person with Disabilities**  
**TLIC = Targeted Low Income Children**  
**AE = Adult Expansion**
### ASSETS

**Current Assets:**

<table>
<thead>
<tr>
<th>Description</th>
<th>2/28/15</th>
<th>1/31/15</th>
<th>Unaudited FY 13-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cash and Cash Equivalents</td>
<td>$278,626,873</td>
<td>$239,657,138</td>
<td>$60,176,698</td>
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<tr>
<td>Medi-Cal Receivable*</td>
<td>66,951,446</td>
<td>74,409,090</td>
<td>114,632,056</td>
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<td>Provider Receivable</td>
<td>838,001</td>
<td>820,896</td>
<td>395,129</td>
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<td>Other Receivables</td>
<td>172,085</td>
<td>171,748</td>
<td>1,821,475</td>
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<td><strong>Total Accounts Receivable</strong></td>
<td>$67,961,532</td>
<td>$75,401,733</td>
<td>$116,848,660</td>
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<tr>
<td>Total Prepaid Accounts</td>
<td>986,764</td>
<td>966,574</td>
<td>994,278</td>
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<td>Total Other Current Assets</td>
<td>81,702</td>
<td>81,702</td>
<td>81,719</td>
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<td><strong>Total Current Assets</strong></td>
<td>$347,656,871</td>
<td>$316,107,147</td>
<td>$178,101,355</td>
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<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>$1,111,807</td>
<td>$1,031,857</td>
<td>$1,163,269</td>
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<tr>
<td><strong>Total Assets</strong></td>
<td>$348,768,677</td>
<td>$317,139,004</td>
<td>$179,264,625</td>
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</table>

**LIABILITIES & NET ASSETS**

**Current Liabilities:**

<table>
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<th>1/31/15</th>
<th>Unaudited FY 13-14</th>
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</thead>
<tbody>
<tr>
<td>Incurred But Not Reported</td>
<td>$132,199,095</td>
<td>$132,779,110</td>
<td>$92,710,021</td>
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<td>Claims Payable</td>
<td>11,250,773</td>
<td>10,793,549</td>
<td>9,482,660</td>
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<td>Capitation Payable</td>
<td>4,873,728</td>
<td>4,482,814</td>
<td>2,054,265</td>
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<td>Physician ACA 1202 Payable</td>
<td>17,294,099</td>
<td>14,159,185</td>
<td>12,765,516</td>
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<td>AB85 Payable</td>
<td>5,795,708</td>
<td>4,816,682</td>
<td>1,245,284</td>
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<td>Accounts Payable</td>
<td>1,844,584</td>
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<td>2,875,709</td>
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<td>Accrued ACS</td>
<td>1,348,519</td>
<td>1,340,286</td>
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<td>Accrued Expenses</td>
<td>1,121,154</td>
<td>1,341,791</td>
<td>748,120</td>
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<td>Accrued Premium Tax</td>
<td>1,018,265</td>
<td>1,620,132</td>
<td>15,775,120</td>
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<td>Accrued Interest Payable</td>
<td>60,770</td>
<td>57,655</td>
<td>42,062</td>
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<td>Current Portion of Deferred Revenue</td>
<td>460,000</td>
<td>460,000</td>
<td>460,000</td>
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<td>Accrued Payroll Expense</td>
<td>708,123</td>
<td>627,193</td>
<td>760,032</td>
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<td><strong>Total Current Liabilities</strong></td>
<td>$177,974,818</td>
<td>$172,785,415</td>
<td>$138,918,788</td>
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**Long-Term Liabilities**

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<th>1/31/15</th>
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</thead>
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<tr>
<td>DHCS - Reserve for Capitation Recoup</td>
<td>83,120,415</td>
<td>62,538,709</td>
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<td>Other Long-Term Liability-Deferred Rent</td>
<td>344,832</td>
<td>310,488</td>
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<td>Deferred Revenue - Long Term Portion</td>
<td>153,333</td>
<td>191,667</td>
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<td>Notes Payable</td>
<td>7,200,000</td>
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<td><strong>Total Long-Term Liabilities</strong></td>
<td>$90,818,581</td>
<td>$70,240,864</td>
<td>$7,731,845</td>
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<td><strong>Total Liabilities</strong></td>
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<td>$243,026,278</td>
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**Net Assets:**

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<th>Unaudited FY 13-14</th>
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<tbody>
<tr>
<td>Beginning Net Assets</td>
<td>$32,613,991</td>
<td>$32,613,991</td>
<td>$4,691,101</td>
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<td>Total Increase/(Decrease in Unrestricted Net Assets)</td>
<td>$47,361,288</td>
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<td><strong>Total Net Assets</strong></td>
<td>$79,975,279</td>
<td>$74,112,726</td>
<td>$32,613,991</td>
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<td><strong>Total Liabilities &amp; Net Assets</strong></td>
<td>$348,768,677</td>
<td>$317,139,004</td>
<td>$179,264,625</td>
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</table>

### FINANCIAL INDICATORS

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<th>1/31/15</th>
<th>Unaudited FY 13-14</th>
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</thead>
<tbody>
<tr>
<td>Current Ratio</td>
<td>1.95 : 1</td>
<td>1.83 : 1</td>
<td>1.28 : 1</td>
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<td>Days Cash on Hand</td>
<td>213</td>
<td>223</td>
<td>34</td>
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<td>Days Cash + State Capitation Rec</td>
<td>264</td>
<td>292</td>
<td>100</td>
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<tr>
<td>Days Cash + State Capitation Rec (less Tax Liab)</td>
<td>263</td>
<td>291</td>
<td>91</td>
</tr>
<tr>
<td>NOV 14</td>
<td>DEC 14</td>
<td>JAN 15</td>
<td>FEB 15</td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership (includes retro members)</td>
<td>171,343</td>
<td>178,532</td>
<td>180,568</td>
</tr>
</tbody>
</table>

### Revenue:

- **Premium**: $64,766,272
- **Reserve for Rate Reduction**:
  - (36,753,996) (7,222,493)
- **MCO Premium Tax**:
  - (2,550,172) (930,197)

#### Total Net Premium
- 25,462,104
- 59,447,852
- 37,873,286
- 45,007,731
- 51,081,833
- (6,074,102)

#### 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)
- **Outpatient**: 154,989
- **Laboratory and Radiology**: (658,499)
- **Emergency Room**: (526,608)
- **Physician ACA 1202**: 0
- **Physician Specialty**: 1,150,877
- **Primary Care Physician**: 263,568
- **Home & Community Based Services**: 1,315,061
- **Applied Behavior Analysis Services**: 0
- **Mental Health Services**: 464,368
- **Pharmacy**: 4,772,776
- **Other Medical Professional**: (64,226)
- **Other Medical Care**: 0
- **Other Fee For Service**: (3,254,779)
- **Transportation**: 58,244

#### 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
- 8,568,866
- 6,482,904
- 8,894,577
- 4,347,623
- 4,537,355

### General & Administrative Expenses:

- **Salaries and Wages**: 587,651
- **Payroll Taxes and Benefits**: 151,578
- **Travel and Training**: 8,957
- **Outside Service - ACS**: 1,331,496
- **Outside Services - Other**: 136,226
- **Accounting & Actuarial Services**: 37,386
- **Legal**: 355,504
- **Insurance**: 16,863
- **Lease Expense - Office**: 63,048
- **Depreciation & Amortization**: 16,530
- **Consulting Services**: 5,420
- **Translation Services**: 10,695
- **Advertising and Promotion**: 5,684
- **General Office**: 125,251
- **Translation Services**: 10,895
- **Printing**: 739
- **Shipping & Postage**: 1,362
- **Interest**: 26,385

#### 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

### Unrestricted Net Assets:

- **Full time employees**: 150
- **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
# PMPM Statement of Revenues, Expenses and Changes in Net Assets

<table>
<thead>
<tr>
<th></th>
<th>NOV 14</th>
<th>DEC 14</th>
<th>JAN 15</th>
<th>FEB 15</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
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</thead>
<tbody>
<tr>
<td><strong>Membership (includes retro members)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>171,343</td>
<td>178,532</td>
<td>180,568</td>
</tr>
<tr>
<td><strong>Revenue:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Premium</td>
<td>377.99</td>
<td>378.65</td>
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<td>324.41</td>
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<tr>
<td>Reserve for Rate Reduction</td>
<td>(214.51)</td>
<td>(40.45)</td>
<td>(102.80)</td>
<td>(77.05)</td>
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<td>(77.06)</td>
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<tr>
<td>MCO Premium Tax</td>
<td>(14.88)</td>
<td>(5.21)</td>
<td>(8.60)</td>
<td>(10.55)</td>
<td>(12.77)</td>
<td>2.23</td>
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<tr>
<td><strong>Total Net Premium</strong></td>
<td>148.60</td>
<td>332.98</td>
<td>209.75</td>
<td>248.03</td>
<td>311.87</td>
<td>(63.63)</td>
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<tr>
<td><strong>Other Revenue:</strong></td>
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<tr>
<td>Interest Income</td>
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<tr>
<td>Miscellaneous Income</td>
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<td>0.21</td>
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<tr>
<td><strong>Total Other Revenue</strong></td>
<td>0.22</td>
<td>0.38</td>
<td>0.21</td>
<td>0.21</td>
<td>0.23</td>
<td>(0.02)</td>
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</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>148.83</td>
<td>333.37</td>
<td>209.96</td>
<td>248.25</td>
<td>311.87</td>
<td>(63.63)</td>
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<td><strong>Medical Expenses:</strong></td>
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<tr>
<td>Capitation (PCP, Specialty, Kaiser, NEMT &amp; Vision)</td>
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<td>27.21</td>
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<td><strong>Total Claims</strong></td>
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<td>Claims Recoveries</td>
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<td><strong>Sub-total</strong></td>
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<td><strong>Total Cost of Health Care</strong></td>
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<td><strong>Contribution Margin</strong></td>
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<td><strong>General &amp; Administrative Expenses:</strong></td>
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<td>Salaries and Wages</td>
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<td>Advertising and Promotion</td>
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</tr>
<tr>
<td><strong>Total G &amp; A Expenses</strong></td>
<td>16.81</td>
<td>17.54</td>
<td>15.51</td>
<td>16.90</td>
<td>18.22</td>
<td>1.32</td>
<td></td>
</tr>
<tr>
<td><strong>Total Operating Gain/(Loss)</strong></td>
<td>56.99</td>
<td>30.46</td>
<td>31.46</td>
<td>32.07</td>
<td>8.30</td>
<td>23.76</td>
<td></td>
</tr>
<tr>
<td><strong>Non Operating</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenues - Interest</td>
<td>0.22</td>
<td>0.27</td>
<td>0.27</td>
<td>0.26</td>
<td>0.11</td>
<td>0.15</td>
<td></td>
</tr>
<tr>
<td>Expenses - Interest</td>
<td>0.02</td>
<td>0.01</td>
<td>0.01</td>
<td>0.02</td>
<td>0.00</td>
<td>(0.02)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Non-Operating</strong></td>
<td>0.20</td>
<td>0.26</td>
<td>0.26</td>
<td>0.24</td>
<td>0.11</td>
<td>0.13</td>
<td></td>
</tr>
<tr>
<td><strong>Unrestricted Net Assets</strong></td>
<td>57.19</td>
<td>30.72</td>
<td>31.73</td>
<td>32.31</td>
<td>8.41</td>
<td>23.90</td>
<td></td>
</tr>
</tbody>
</table>
## STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

For Eight Months Ended February 28, 2015

### Membership (includes retro members)

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,375,316</td>
<td>1,281,294</td>
<td>94,022</td>
</tr>
</tbody>
</table>

### Revenue

<table>
<thead>
<tr>
<th>Revenue Type</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>$475,516,757</td>
<td>$403,930,998</td>
<td>$71,585,759</td>
</tr>
<tr>
<td>Reserve for Rate Reduction</td>
<td>(76,519,190)</td>
<td>0</td>
<td>(76,519,190)</td>
</tr>
<tr>
<td>MCO Premium Tax</td>
<td>(15,776,768)</td>
<td>(15,904,783)</td>
<td>128,015</td>
</tr>
<tr>
<td><strong>Total Net Premium</strong></td>
<td><strong>383,220,798</strong></td>
<td><strong>388,026,215</strong></td>
<td><strong>(4,805,416)</strong></td>
</tr>
</tbody>
</table>

### Other Revenue:

<table>
<thead>
<tr>
<th>Revenue Type</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous Income</td>
<td>336,985</td>
<td>306,664</td>
<td>30,321</td>
</tr>
<tr>
<td><strong>Total Other Revenue</strong></td>
<td><strong>336,985</strong></td>
<td><strong>306,664</strong></td>
<td><strong>30,321</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>383,557,783</strong></td>
</tr>
</tbody>
</table>

### Medical Expenses:

<table>
<thead>
<tr>
<th>Medical Expenses</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation (PCP, Specialty, Kaiser, NEMT &amp; Vision)</td>
<td>25,183,665</td>
<td>21,605,329</td>
<td>(3,578,335)</td>
</tr>
<tr>
<td><strong>FSA Claims Expenses</strong></td>
<td><strong>25,183,665</strong></td>
<td><strong>21,605,329</strong></td>
<td><strong>(3,578,335)</strong></td>
</tr>
<tr>
<td>Inpatient</td>
<td>63,580,683</td>
<td>79,242,164</td>
<td>15,661,481</td>
</tr>
<tr>
<td>LTC/SNF</td>
<td>69,925,406</td>
<td>60,132,485</td>
<td>(9,792,921)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>21,798,738</td>
<td>20,661,974</td>
<td>(1,136,764)</td>
</tr>
<tr>
<td>Laboratory and Radiology</td>
<td>4,706,106</td>
<td>6,066,680</td>
<td>1,360,574</td>
</tr>
<tr>
<td>Physician ACA 1202</td>
<td>8,077,096</td>
<td>0</td>
<td>(8,077,096)</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>10,299,696</td>
<td>12,257,242</td>
<td>1,957,546</td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>22,767,920</td>
<td>25,891,301</td>
<td>3,123,380</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>16,552,269</td>
<td>20,063,405</td>
<td>3,511,136</td>
</tr>
<tr>
<td>Home &amp; Community Based Services</td>
<td>10,635,427</td>
<td>6,783,389</td>
<td>(3,852,038)</td>
</tr>
<tr>
<td>Applied Behavior Analysis Services</td>
<td>9,189</td>
<td>0</td>
<td>(9,189)</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>4,579,347</td>
<td>5,967,481</td>
<td>1,388,135</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>43,949,226</td>
<td>72,101,885</td>
<td>28,152,659</td>
</tr>
<tr>
<td>Adult Expansion Reserve</td>
<td>(8,100,000)</td>
<td>0</td>
<td>8,100,000</td>
</tr>
<tr>
<td>Other Medical Professional</td>
<td>1,772,095</td>
<td>2,129,460</td>
<td>357,365</td>
</tr>
<tr>
<td>Other Medical Care</td>
<td>756</td>
<td>0</td>
<td>(756)</td>
</tr>
<tr>
<td>Other Fee For Service</td>
<td>5,863,574</td>
<td>7,424,077</td>
<td>1,560,503</td>
</tr>
<tr>
<td>Transportation</td>
<td>2,096,544</td>
<td>2,452,539</td>
<td>355,995</td>
</tr>
<tr>
<td><strong>Total Claims</strong></td>
<td><strong>278,504,068</strong></td>
<td><strong>321,369,080</strong></td>
<td><strong>42,865,012</strong></td>
</tr>
<tr>
<td>Medical &amp; Care Management Expense</td>
<td>8,117,207</td>
<td>8,521,677</td>
<td>404,470</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>26,346,062</td>
<td>1,563,179</td>
<td>(1,070,882)</td>
</tr>
<tr>
<td>Claims Recoveries</td>
<td>(785,652)</td>
<td>0</td>
<td>785,652</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>9,965,617</strong></td>
<td><strong>10,084,856</strong></td>
<td><strong>119,239</strong></td>
</tr>
<tr>
<td><strong>Total Cost of Health Care</strong></td>
<td><strong>313,653,350</strong></td>
<td><strong>353,059,266</strong></td>
<td><strong>39,405,916</strong></td>
</tr>
</tbody>
</table>

### General & Administrative Expenses:

<table>
<thead>
<tr>
<th>General &amp; Administrative Expenses:</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Wages</td>
<td>5,402,583</td>
<td>6,547,477</td>
<td>1,144,894</td>
</tr>
<tr>
<td>Payroll Taxes and Benefits</td>
<td>1,571,164</td>
<td>1,734,893</td>
<td>163,729</td>
</tr>
<tr>
<td>Travel and Training</td>
<td>85,661</td>
<td>185,974</td>
<td>100,314</td>
</tr>
<tr>
<td>Outside Service - ACS</td>
<td>10,515,670</td>
<td>9,629,180</td>
<td>(886,490)</td>
</tr>
<tr>
<td>Outside Services - Other</td>
<td>1,028,270</td>
<td>1,104,765</td>
<td>76,495</td>
</tr>
<tr>
<td>Accounting &amp; Actuarial Services</td>
<td>129,226</td>
<td>250,000</td>
<td>120,774</td>
</tr>
<tr>
<td>Legal</td>
<td>1,859,194</td>
<td>266,666</td>
<td>(1,592,528)</td>
</tr>
<tr>
<td>Insurance</td>
<td>156,861</td>
<td>116,667</td>
<td>(40,195)</td>
</tr>
<tr>
<td>Lease Expense - Office</td>
<td>511,821</td>
<td>514,832</td>
<td>3,011</td>
</tr>
<tr>
<td>Consulting Services</td>
<td>238,143</td>
<td>999,814</td>
<td>761,671</td>
</tr>
<tr>
<td>Translation Services</td>
<td>35,064</td>
<td>56,664</td>
<td>21,600</td>
</tr>
<tr>
<td>Advertising and Promotion</td>
<td>17,250</td>
<td>207,872</td>
<td>190,622</td>
</tr>
<tr>
<td>General Office</td>
<td>847,066</td>
<td>1,279,981</td>
<td>432,915</td>
</tr>
<tr>
<td>Depreciation &amp; Amortization</td>
<td>128,170</td>
<td>188,850</td>
<td>60,680</td>
</tr>
<tr>
<td>Printing</td>
<td>62,824</td>
<td>148,662</td>
<td>85,838</td>
</tr>
<tr>
<td>Shipping &amp; Postage</td>
<td>70,115</td>
<td>153,362</td>
<td>83,247</td>
</tr>
<tr>
<td>Interest</td>
<td>131,162</td>
<td>120,000</td>
<td>(11,162)</td>
</tr>
<tr>
<td><strong>Total G &amp; A Expenses</strong></td>
<td><strong>22,790,244</strong></td>
<td><strong>23,505,658</strong></td>
<td><strong>715,415</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Operating Gain/(Loss)</strong></td>
<td><strong>47,114,189</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non Operating</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues - Interest</td>
<td>292,886</td>
<td>133,297</td>
<td>159,588</td>
</tr>
<tr>
<td>Expenses - Interest</td>
<td>45,787</td>
<td>0</td>
<td>(45,787)</td>
</tr>
<tr>
<td><strong>Total Non-Operating</strong></td>
<td><strong>247,099</strong></td>
<td><strong>133,297</strong></td>
<td><strong>113,801</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Increase/(Decrease) in Unrestricted Net Assets</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Assets, Beginning of Year</strong></td>
<td>32,613,991</td>
</tr>
<tr>
<td><strong>Net Assets, End of Year</strong></td>
<td>79,975,279</td>
</tr>
</tbody>
</table>
### Statement of Cash Flows - Monthly

#### Cash Flow From Operating Activities

<table>
<thead>
<tr>
<th></th>
<th>FEB 15</th>
<th>JAN 15</th>
<th>DEC 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collected Premium</td>
<td>$75,979,999</td>
<td>$65,158,436</td>
<td>$76,497,908</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>46,762</td>
<td>48,276</td>
<td>47,435</td>
</tr>
<tr>
<td>State Pass Through Funds</td>
<td>9,450,060</td>
<td>2,598,890</td>
<td>1,619,462</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th></th>
<th>FEB 15</th>
<th>JAN 15</th>
<th>DEC 14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>39,080,373</td>
<td>23,938,297</td>
<td>32,507,638</td>
</tr>
</tbody>
</table>

#### Cash Flow From Investing/Financing Activities

<table>
<thead>
<tr>
<th></th>
<th>FEB 15</th>
<th>JAN 15</th>
<th>DEC 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Acquisition of Property/Equipment</td>
<td>$(110,638)</td>
<td>$(12,875)</td>
<td>0</td>
</tr>
</tbody>
</table>

**Net Cash Provided/(Used) by Investing/Financing**

<table>
<thead>
<tr>
<th></th>
<th>FEB 15</th>
<th>JAN 15</th>
<th>DEC 14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$(110,638)</td>
<td>$(12,875)</td>
<td>0</td>
</tr>
</tbody>
</table>

**Net Cash Flow**

<table>
<thead>
<tr>
<th></th>
<th>FEB 15</th>
<th>JAN 15</th>
<th>DEC 14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$38,969,735</td>
<td>$23,925,422</td>
<td>$32,507,638</td>
</tr>
</tbody>
</table>

#### Cash and Cash Equivalents (Beg. of Period)

<table>
<thead>
<tr>
<th></th>
<th>FEB 15</th>
<th>JAN 15</th>
<th>DEC 14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>239,657,138</td>
<td>215,731,716</td>
<td>183,224,078</td>
</tr>
</tbody>
</table>

#### Cash and Cash Equivalents (End of Period)

<table>
<thead>
<tr>
<th></th>
<th>FEB 15</th>
<th>JAN 15</th>
<th>DEC 14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>278,626,873</td>
<td>239,657,138</td>
<td>215,731,716</td>
</tr>
</tbody>
</table>

**Adjustment to Reconcile Net Income to Net Cash Flow**

<table>
<thead>
<tr>
<th></th>
<th>FEB 15</th>
<th>JAN 15</th>
<th>DEC 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net (Loss) Income</td>
<td>5,862,553</td>
<td>5,728,622</td>
<td>5,484,006</td>
</tr>
<tr>
<td>Depreciation &amp; Amortization</td>
<td>30,689</td>
<td>30,689</td>
<td>30,689</td>
</tr>
<tr>
<td>Decrease/(Increase) in Receivables</td>
<td>7,440,201</td>
<td>4,671,870</td>
<td>7,914,675</td>
</tr>
<tr>
<td>Decrease/(Increase) in Prepaids &amp; Other Current Assets</td>
<td>(20,190)</td>
<td>70,705</td>
<td>95,643</td>
</tr>
<tr>
<td>(Decrease)/Increase in Payables</td>
<td>5,523,148</td>
<td>(43,607,863)</td>
<td>10,245,526</td>
</tr>
<tr>
<td>(Decrease)/Increase in Other Liabilities</td>
<td>20,577,717</td>
<td>62,534,720</td>
<td>(4,284)</td>
</tr>
<tr>
<td>Change in MCO Tax Liability</td>
<td>(601,867)</td>
<td>(2,219,500)</td>
<td>(4,306,255)</td>
</tr>
<tr>
<td>Changes in Claims and Capitation Payable</td>
<td>848,138</td>
<td>4,512,479</td>
<td>1,254,427</td>
</tr>
<tr>
<td>Changes in IBNR</td>
<td>(580,015)</td>
<td>(7,783,425)</td>
<td>11,793,211</td>
</tr>
</tbody>
</table>

**Net Cash Flow from Operating Activities**

<table>
<thead>
<tr>
<th></th>
<th>FEB 15</th>
<th>JAN 15</th>
<th>DEC 14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$39,080,373</td>
<td>$23,938,297</td>
<td>$32,507,638</td>
</tr>
</tbody>
</table>
Statement of Cash Flows - YTD

FEB 15

Cash Flow From Operating Activities

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collected Premium</td>
<td>$ 533,673,160</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>292,886</td>
</tr>
<tr>
<td>State Pass Through Funds</td>
<td>45,291,888</td>
</tr>
<tr>
<td><strong>Paid Claims</strong></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Hospital Expenses</td>
<td>(186,917,124)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>(47,748,777)</td>
</tr>
<tr>
<td>Capitation</td>
<td>(22,382,138)</td>
</tr>
<tr>
<td>Reinsurance of Claims</td>
<td>(3,929,401)</td>
</tr>
<tr>
<td>State Pass Through Funds Distributed</td>
<td>(43,373,661)</td>
</tr>
<tr>
<td>Paid Administration</td>
<td>(24,561,533)</td>
</tr>
<tr>
<td>MCO Taxes Received / (Paid)</td>
<td>(31,705,149)</td>
</tr>
<tr>
<td><strong>Net Cash Provided/(Used) by Operating Activities</strong></td>
<td><strong>218,640,150</strong></td>
</tr>
</tbody>
</table>

Cash Flow From Investing/Financing Activities

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Acquisition of Property/Equipment</td>
<td>(189,975)</td>
</tr>
<tr>
<td><strong>Net Cash Provided/(Used) by Investing/Financing</strong></td>
<td><strong>(189,975)</strong></td>
</tr>
</tbody>
</table>

**Net Cash Flow**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and Cash Equivalents (Beg. of Period)</td>
<td>60,176,698</td>
</tr>
<tr>
<td>Cash and Cash Equivalents (End of Period)</td>
<td>278,626,873</td>
</tr>
<tr>
<td><strong>Net Cash Flow</strong></td>
<td><strong>$ 218,450,175</strong></td>
</tr>
</tbody>
</table>

Adjustment to Reconcile Net Income to Net Cash Flow

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Income/(Loss)</td>
<td>47,361,288</td>
</tr>
<tr>
<td>Depreciation &amp; Amortization</td>
<td>241,438</td>
</tr>
<tr>
<td>Decrease/(Increase) in Receivables</td>
<td>48,887,128</td>
</tr>
<tr>
<td>Decrease/(Increase) in Prepaids &amp; Other Current Assets</td>
<td>7,531</td>
</tr>
<tr>
<td>(Decrease)/Increase in Payables</td>
<td>9,736,235</td>
</tr>
<tr>
<td>(Decrease)/Increase in Other Liabilities</td>
<td>83,086,735</td>
</tr>
<tr>
<td>Change in MCO Tax Liability</td>
<td>(14,756,855)</td>
</tr>
<tr>
<td>Changes in Claims and Capitation Payable</td>
<td>4,587,576</td>
</tr>
<tr>
<td>Changes in IBNR</td>
<td>39,489,074</td>
</tr>
<tr>
<td><strong>Net Cash Flow from Operating Activities</strong></td>
<td><strong>$ 218,640,150</strong></td>
</tr>
</tbody>
</table>
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
Cash + Medi-Cal Receivable Trend ($ in Millions)  
(Net of MCO Tax Liability and excludes pass-through funds)
For Reporting Period:

10/1/2012 0 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
60 3.60 3.44 3.32 5.04 5.20 3.69 4.90 3.89 4.29 4.61 4.00 1.70
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 2.27 1.70 2.50 1.73 3.90 3.66 3.05 3.35 3.10 2.56

For the month ended February 28, 2014

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.

Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.
## GOLD COAST HEALTH PLAN

### Total Expense Composition

#### Note: November 14 reflects an adjustment in medical expenses as a result of the Adult Expansion allowance for revenue recoup.

<table>
<thead>
<tr>
<th>Other</th>
<th>Pharmacy</th>
<th>Professional</th>
<th>Outpatient</th>
<th>LTC</th>
<th>Inpatient</th>
<th>Capitation</th>
<th>Admin</th>
</tr>
</thead>
<tbody>
<tr>
<td>16%</td>
<td>14%</td>
<td>6%</td>
<td>9%</td>
<td>26%</td>
<td>12%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>15%</td>
<td>10%</td>
<td>14%</td>
<td>9%</td>
<td>14%</td>
<td>6%</td>
<td>17%</td>
<td>9%</td>
</tr>
<tr>
<td>30%</td>
<td>9%</td>
<td>9%</td>
<td>14%</td>
<td>24%</td>
<td>17%</td>
<td>9%</td>
<td>18%</td>
</tr>
<tr>
<td>15%</td>
<td>15%</td>
<td>18%</td>
<td>13%</td>
<td>19%</td>
<td>6%</td>
<td>9%</td>
<td>16%</td>
</tr>
<tr>
<td>11%</td>
<td>12%</td>
<td>19%</td>
<td>14%</td>
<td>22%</td>
<td>13%</td>
<td>17%</td>
<td>21%</td>
</tr>
<tr>
<td>12%</td>
<td>28%</td>
<td>14%</td>
<td>12%</td>
<td>17%</td>
<td>24%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>14%</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>19%</td>
<td>20%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>13%</td>
<td>17%</td>
<td>13%</td>
<td>13%</td>
<td>20%</td>
<td>23%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>13%</td>
<td>16%</td>
<td>6%</td>
<td>12%</td>
<td>24%</td>
<td>22%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>14%</td>
<td>16%</td>
<td>7%</td>
<td>12%</td>
<td>15%</td>
<td>24%</td>
<td>5%</td>
<td>6%</td>
</tr>
</tbody>
</table>

### MAR 14 - FEB 15

- **FEB 15:**
  - Other: 16%
  - Pharmacy: 14%
  - Professional: 6%
  - Outpatient: 9%
  - LTC: 26%
  - Inpatient: 12%
  - Capitation: 9%
  - Admin: 8%  

- **MAR 14:**
  - Other: 14%
  - Pharmacy: 16%
  - Professional: 7%
  - Outpatient: 12%
  - LTC: 20%
  - Inpatient: 22%
  - Capitation: 5%
  - Admin: 6%

- **APR 14:**
  - Other: 15%
  - Pharmacy: 10%
  - Professional: 14%
  - Outpatient: 14%
  - LTC: 18%
  - Inpatient: 21%
  - Capitation: 6%
  - Admin: 6%

- **MAY 14:**
  - Other: 15%
  - Pharmacy: 12%
  - Professional: 13%
  - Outpatient: 13%
  - LTC: 16%
  - Inpatient: 19%
  - Capitation: 6%
  - Admin: 6%

- **JUN 14:**
  - Other: 15%
  - Pharmacy: 13%
  - Professional: 13%
  - Outpatient: 13%
  - LTC: 17%
  - Inpatient: 20%
  - Capitation: 6%
  - Admin: 6%

- **JUL 14:**
  - Other: 15%
  - Pharmacy: 13%
  - Professional: 13%
  - Outpatient: 13%
  - LTC: 17%
  - Inpatient: 20%
  - Capitation: 6%
  - Admin: 6%

- **AUG 14:**
  - Other: 15%
  - Pharmacy: 13%
  - Professional: 13%
  - Outpatient: 13%
  - LTC: 17%
  - Inpatient: 20%
  - Capitation: 6%
  - Admin: 6%

- **SEP 14:**
  - Other: 15%
  - Pharmacy: 13%
  - Professional: 13%
  - Outpatient: 13%
  - LTC: 17%
  - Inpatient: 20%
  - Capitation: 6%
  - Admin: 6%

- **OCT 14:**
  - Other: 15%
  - Pharmacy: 13%
  - Professional: 13%
  - Outpatient: 13%
  - LTC: 17%
  - Inpatient: 20%
  - Capitation: 6%
  - Admin: 6%

- **NOV 14:**
  - Other: 15%
  - Pharmacy: 13%
  - Professional: 13%
  - Outpatient: 13%
  - LTC: 17%
  - Inpatient: 20%
  - Capitation: 6%
  - Admin: 6%

- **DEC 14:**
  - Other: 15%
  - Pharmacy: 13%
  - Professional: 13%
  - Outpatient: 13%
  - LTC: 17%
  - Inpatient: 20%
  - Capitation: 6%
  - Admin: 6%

- **JAN 15:**
  - Other: 15%
  - Pharmacy: 13%
  - Professional: 13%
  - Outpatient: 13%
  - LTC: 17%
  - Inpatient: 20%
  - Capitation: 6%
  - Admin: 6%

- **FEB 15:**
  - Other: 15%
  - Pharmacy: 13%
  - Professional: 13%
  - Outpatient: 13%
  - LTC: 17%
  - Inpatient: 20%
  - Capitation: 6%
  - Admin: 6%
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
INVESTMENT CONTROLS
POLICIES AND PROCEDURES

April 27, 2015
COMMISSION MEETING
• 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.
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.

   – 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.
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. 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.
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

<table>
<thead>
<tr>
<th>BANKS</th>
<th>RABOBANK</th>
<th>BANK OF THE WEST</th>
<th>MANUFACTURERS BANK</th>
<th>HERITAGE OAKS BANK</th>
<th>CALTRUST</th>
<th>CALIFORNIA STATE TREASURER</th>
<th>COUNTY OF VENTURA</th>
</tr>
</thead>
<tbody>
<tr>
<td>RABOBANK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BANK OF THE WEST</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MANUFACTURERS BANK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HERITAGE OAKS BANK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POOLED INVESTMENTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CALTRUST</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CALIFORNIA STATE TREASURER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COUNTY OF VENTURA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Requested that the Banks provide the Plan to confirm 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.
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.
## VI. Investment Status

<table>
<thead>
<tr>
<th>BANKS</th>
<th>Target</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>RABOBANK</td>
<td>$40,000,000</td>
<td>4/10/2015</td>
<td>$20,000,000</td>
</tr>
<tr>
<td>BANK OF THE WEST</td>
<td>$20,000,000</td>
<td>4/3/2015</td>
<td>Funded</td>
</tr>
<tr>
<td>MANUFACTURERS BANK</td>
<td>$20,000,000</td>
<td>4/2/2015</td>
<td>Funded</td>
</tr>
<tr>
<td>HERITAGE OAKS BANK</td>
<td>$25,000,000</td>
<td>4/2/2015</td>
<td>Funded</td>
</tr>
<tr>
<td>TOTAL BANKS</td>
<td>$105,000,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### POOLED INVESTMENTS

<table>
<thead>
<tr>
<th>POOLED INVESTMENTS</th>
<th>Date</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>WELLS FARGO - CALTRUST - SHORT TERM</td>
<td>3/25/2015</td>
<td>$50,000,000</td>
<td>Funded</td>
</tr>
<tr>
<td>WELLS FARGO - CALTRUST - MEDIUM TERM</td>
<td></td>
<td>50,000,000</td>
<td></td>
</tr>
<tr>
<td>CALIFORNIA STATE TREASURER - LAIF</td>
<td>4/15/2015</td>
<td>50,000,000</td>
<td></td>
</tr>
<tr>
<td>COUNTY OF VENTURA</td>
<td>4/10/2015</td>
<td>50,000,000</td>
<td></td>
</tr>
<tr>
<td>TOTAL POOLED</td>
<td></td>
<td>200,000,000</td>
<td></td>
</tr>
<tr>
<td>TOTAL INVESTMENT AND BANK DEPOSITS</td>
<td></td>
<td>$305,000,000</td>
<td></td>
</tr>
</tbody>
</table>
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.
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.**

<table>
<thead>
<tr>
<th>Process/Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Monitoring/Status of Milestones and Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HEDIS- Healthcare Effectiveness Data and Information Set.</td>
<td>2013 Data for 2014 Measure</td>
<td>02/14 05/14</td>
<td>QI</td>
<td>The HEDIS 2014 reporting for 2013 data was submitted on 06/13/14.</td>
</tr>
<tr>
<td>2. 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.”</td>
<td>1. Edit and submit HEDIS Roadmap</td>
<td>11/13 1/14</td>
<td>QI</td>
<td>The following six measures did not meet DHCS minimum performance level (MPL):</td>
</tr>
<tr>
<td></td>
<td>2. Submit test run</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Submit production run</td>
<td>11/14 12/14</td>
<td>QI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Record retrieval</td>
<td>11/14 01/14</td>
<td>QI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Record Abstraction</td>
<td>02/14 03/14</td>
<td>QI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Admin Refresh</td>
<td>03/14 05/14</td>
<td>QI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. HEDIS HSAG Audit</td>
<td>02/14 04/14</td>
<td>QI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. HEDIS Submission</td>
<td>03/14 03/14</td>
<td>QI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Summer Run</td>
<td>05/14 06/14 07/14</td>
<td>QI</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>MPL</th>
<th>GHCP Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Adolescents’ Access to Primary Care Practitioners (CAP)</td>
<td>Percentage of members who had a visit with a PCP</td>
<td>86.37</td>
<td>86.27</td>
</tr>
<tr>
<td>Age 25 months – 6 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 7 to 11</td>
<td></td>
<td>87.77</td>
<td>82.26</td>
</tr>
<tr>
<td>Age 12 to 19</td>
<td></td>
<td>86.09</td>
<td>79.18</td>
</tr>
</tbody>
</table>

| 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 |
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
3. Provider education of how to collect nutrition and physical activity education on the Staying Health (SHA) form – June 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

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

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>2012</th>
<th>2013</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure (CBP)*</td>
<td>Percentage of members that were 18 – 85 years of age with a diagnosis of hypertension and adequately controlled BP (&lt;140/90) during the measurement year</td>
<td>61.56</td>
<td>54.01</td>
</tr>
<tr>
<td>Childhood Immunization Status (CIS)</td>
<td>Percentage of children 2 years of age that had DtaP, IPV, MMR, HiB, HepB, VZV and Pneumococcal Conjugate (Combo 3)</td>
<td>80.05</td>
<td>75.43</td>
</tr>
<tr>
<td>Immunization for Adolescents (IMA)</td>
<td>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)</td>
<td>65.21</td>
<td>60.34</td>
</tr>
<tr>
<td>Prenatal and Postpartum Care (PPC)</td>
<td>Postpartum Care Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery</td>
<td>63.99</td>
<td>59.37</td>
</tr>
</tbody>
</table>

*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.
Objective #2: Satisfaction Surveys

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

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Satisfaction Survey (State Requirement)</td>
<td>First CAHPS Audit will be 2015 for 2014 data. Educate providers.</td>
<td>01/14</td>
<td>12/14</td>
<td>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%)</td>
</tr>
<tr>
<td>2. Provider Satisfaction Surveys</td>
<td>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.</td>
<td>01/14</td>
<td>12/14</td>
<td>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 providers surveyed were indifferent; 20.6% loyal and 6.5% defection. Overall satisfaction rates (responses of “Well Above Average” and “Somewhat Above Average”)</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Date</th>
<th>Network Ops</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04</td>
<td>Discuss survey at QIC and document</td>
</tr>
<tr>
<td>12/14</td>
<td></td>
</tr>
</tbody>
</table>

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.
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).

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
</table>
| 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 | 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. |
<table>
<thead>
<tr>
<th>1b. Internal QIP</th>
<th>01/14 Ongoing QI/HE</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Internal QIP - Increase Retinal Eye Exams for diabetic patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Submitted internal QIP to DHCS for approval on 7/31/13 and 9/30/13.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 10/3/14 incentive letters mailed to members with diabetes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 10/8/14 email to practitioners and office managers informing them of incentive program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Results of targeted intervention and submission of “Do, Study, Act” portion of PDSA cycle by 4/30/15.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>UM Monitoring</td>
<td>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.</td>
<td>01/14</td>
<td>12/14</td>
<td>UM</td>
</tr>
<tr>
<td>Over Utilization</td>
<td></td>
<td></td>
<td></td>
<td>Completed; UM measures reported to UM, QIC and the Commission.</td>
</tr>
<tr>
<td>Under Utilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate Utilization</td>
<td></td>
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</tbody>
</table>

Objective #5: Committees

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

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

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Quality Improvement Committee</td>
<td>• QI Plan Assessment&lt;br&gt;• QI Plan Review&lt;br&gt;• QI Work Plan&lt;br&gt;• Annual P&amp;P Review&lt;br&gt;• Revise PQI Policies and Procedures</td>
<td>01/14</td>
<td>12/14</td>
<td>The Quality Improvement Plan and the Quality Improvement Work Plan were approved at the Quality Improvement Committee on 6/24/14.</td>
</tr>
<tr>
<td>2. Member Services Committee</td>
<td>• Committee Meetings&lt;br&gt;• Action Plans&lt;br&gt;• Call Center Measures&lt;br&gt;• Annual Review</td>
<td>01/14</td>
<td>12/14</td>
<td></td>
</tr>
<tr>
<td>3. Network Management Committee</td>
<td>• Committee Meetings&lt;br&gt;• Action Plans&lt;br&gt;• Annual Review</td>
<td>01/14</td>
<td>12/14</td>
<td></td>
</tr>
<tr>
<td>4. Grievances &amp; Appeals Committee</td>
<td>• Committee Meetings&lt;br&gt;• Action Plans&lt;br&gt;• G&amp;A Measures&lt;br&gt;• Annual Review</td>
<td>01/14</td>
<td>12/14</td>
<td></td>
</tr>
</tbody>
</table>
| 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.**

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Site Reviews (FSR)</td>
<td>• Submit 2014 bi-annual report to DHCS</td>
<td>01/14</td>
<td>QI</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>• Develop procedures for entering data into FSR database and submission of data to DHCS</td>
<td>12/14</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>• Certify FSR Nurse as Master Trainer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Complete required FSR, PAR, IHA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop FSR Database</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Begin training for QI RN as Master Trainer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site Review Reports</td>
<td>• 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.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• P&amp;P written for PARS</td>
<td>01/14</td>
<td>QI</td>
<td>Policy revised to include PARs. Completed- Compiling reports for high volume/ancillary specialists. Submission to state completed 01/28/15.</td>
</tr>
<tr>
<td>PARS- Physical Accessibility Site Reviews</td>
<td>• Specialist Provider Volume Annual Review due 1/31/14 for submission to DHCS</td>
<td>12/14</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Practice Guidelines</td>
<td>• Approve at MAC</td>
<td>01/14</td>
<td>12/14</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>• Disseminate Guidelines to Providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diabetes Guidelines to be presented at MAC</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Disease Management Program                | • Identify chronic disease for GCHP population disease management.        | 01/14    | 12/14      | 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 Communication Plan | Develop materials and mechanisms to communicate to Members | 01/14 | 12/14 | Member newsletter published three (3) times in 2014. The newsletters are posted on the website.

Quality Improvement Committee Report
1st Quarter 2015
C. Albert Reeves, MD, CMO
Quality Improvement

Quality Improvement Projects (QIP)

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
HEDIS

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

- 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
## Facility Site Reviews

### Interim FSRs

<table>
<thead>
<tr>
<th></th>
<th>Total number of I-FSR</th>
<th>Total number of I-FSR approved</th>
<th>Total number of critical element CAPs served</th>
<th>Total number of critical element CAPs completed within 10 days</th>
<th>Total number of critical element CAPs not completed within 10 DAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### First Quarter of 2015

<table>
<thead>
<tr>
<th>Number of Initial Facility Suite Review</th>
<th>Number of Interim Site Reviews</th>
<th>Number of Initial Facility Review</th>
<th>Number of IHA MRRs Conducted tomorrow</th>
<th>Number of sites with no new members during audit period</th>
<th>Number of sites with passing IHA score above 80%</th>
<th>Number of sites with score below 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>
Medical Record Reviews

First Quarter 2015

<table>
<thead>
<tr>
<th>Total number FSR MRR</th>
<th>Number of I-FSRs</th>
<th>Number Periodic FSRs</th>
<th>Number Medical Records Reviewed</th>
<th>Number Records (+) for screening for smoking / tobacco use</th>
<th>Number Records (+) for tobacco exposure or use</th>
<th>Number Records documenting Counseling performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>5</td>
<td>0</td>
<td>33</td>
<td>27 (89%)</td>
<td>3</td>
<td>3 (100%)</td>
</tr>
</tbody>
</table>
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
Gold Coast Health Plan HEDIS Measures -- Quality of Care Indicators

Legend:
- Dark Green = Performance ≥ P90
- Yellow = Performance ≥ P75
- Red = Performance ≤ P25

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Responsible Department</th>
<th>Benchmark Source</th>
<th>2012 Rate</th>
<th>P10</th>
<th>P25</th>
<th>P50</th>
<th>P75</th>
<th>P90</th>
<th>2013 Rate</th>
<th>2014 Rate</th>
<th>Annual Trend 2012 - 2013</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>(AAB) Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis</td>
<td>AAB (Bronchitis)</td>
<td>Quality Improvement</td>
<td>HEDIS</td>
<td>13.87</td>
<td>14.88</td>
<td>17.92</td>
<td>22.14</td>
<td>28.18</td>
<td>35.45</td>
<td>18.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(CAP) Children and Adolescents' Access to Primary Care Practitioners</td>
<td>CAP: age 12-24 months</td>
<td>Quality Improvement</td>
<td>HEDIS</td>
<td>82.51</td>
<td>92.37</td>
<td>95.51</td>
<td>96.89</td>
<td>97.54</td>
<td>98.49</td>
<td>97.37</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAP: age 25 months - 6 years</td>
<td></td>
<td></td>
<td>63.09</td>
<td>82.76</td>
<td>86.37</td>
<td>89.39</td>
<td>91.29</td>
<td>93.60</td>
<td>86.27</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAP: age 7 to 11</td>
<td></td>
<td></td>
<td>NR</td>
<td>83.43</td>
<td>87.77</td>
<td>90.88</td>
<td>93.26</td>
<td>95.25</td>
<td>82.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAP: age 12 to 19</td>
<td></td>
<td></td>
<td>NR</td>
<td>81.35</td>
<td>86.09</td>
<td>89.58</td>
<td>91.85</td>
<td>93.77</td>
<td>79.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(LBP) Use of Imaging Studies for Low Back Pain</td>
<td>LBP</td>
<td>Quality Improvement</td>
<td>HEDIS</td>
<td>76.95</td>
<td>68.31</td>
<td>71.52</td>
<td>75.23</td>
<td>79.26</td>
<td>82.34</td>
<td>77.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(MMA) Medication MaNAgement for People with Asthma</td>
<td>Medication Compliance 50%: 51-64</td>
<td>Quality Improvement</td>
<td>HEDIS</td>
<td>NR</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication Compliance 50%: Total</td>
<td></td>
<td></td>
<td>NR</td>
<td>40.74</td>
<td>44.83</td>
<td>50.94</td>
<td>56.37</td>
<td>61.66</td>
<td>48.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication Compliance 75%: 51-64</td>
<td></td>
<td></td>
<td>NR</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication Compliance 75%: Total</td>
<td></td>
<td></td>
<td>NR</td>
<td>19.20</td>
<td>22.17</td>
<td>27.65</td>
<td>32.89</td>
<td>36.71</td>
<td>28.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>Description</td>
<td>Responsible Department</td>
<td>Benchmark Source</td>
<td>2012 Rate</td>
<td>P10</td>
<td>P25 (MPL)</td>
<td>P50</td>
<td>P75</td>
<td>P90 (HPL)</td>
<td>2013 Rate</td>
<td>2014 Rate</td>
<td>Annual Trend 2012 - 2013</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
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<td>--------------------------------</td>
</tr>
<tr>
<td><strong>(MPM) Annual Monitoring for Patients on Persistent Medications</strong></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Ace Inhibitors or ARBs</td>
<td>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.</td>
<td>Quality Improvement</td>
<td>HEDIS</td>
<td>86.73</td>
<td>60.80</td>
<td>64.58</td>
<td>87.06</td>
<td>89.19</td>
<td>91.21</td>
<td>88.47</td>
<td></td>
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</tr>
<tr>
<td>Digoxin</td>
<td></td>
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<td></td>
<td>88.46</td>
<td>83.72</td>
<td>87.50</td>
<td>90.82</td>
<td>93.15</td>
<td>94.95</td>
<td>93.33</td>
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<tr>
<td>Diuretics</td>
<td></td>
<td></td>
<td></td>
<td>86.28</td>
<td>79.98</td>
<td>83.76</td>
<td>86.74</td>
<td>89.11</td>
<td>91.30</td>
<td>89.51</td>
<td></td>
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</tr>
<tr>
<td><strong>(CCS) Cervical Cancer Screening</strong></td>
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<tr>
<td>CCS</td>
<td>The percentage of women 24-64 years old who had at least one Pap test during the past 3 years.</td>
<td>Quality Improvement</td>
<td>HEDIS</td>
<td>57.66</td>
<td>47.22</td>
<td>58.99</td>
<td>66.38</td>
<td>71.91</td>
<td>76.64</td>
<td>60.58</td>
<td></td>
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</tr>
<tr>
<td><strong>(CBP) Controlling High Blood Pressure</strong></td>
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<tr>
<td>CBP</td>
<td>The percentage of members that were 18-85 years of age with a dx of hypertension and adequately controlled BP (&lt;140/90) during the measurement year.</td>
<td>Quality Improvement</td>
<td>HEDIS</td>
<td>61.56</td>
<td>44.77</td>
<td>50.00</td>
<td>56.20</td>
<td>62.97</td>
<td>69.55</td>
<td>54.01</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Gold Coast Health Plan HEDIS Measures – Quality of Care Indicators

## Legend:
- **Dark Green** = Performance ≥ P90
- **Yellow** = Performance < P50
- **Red** = Performance ≤ P25

## Measure Description

### (CDC) Comprehensive Diabetes Care

| Measure                  | Description                                                                 | Responsible Department | Benchmark Source | 2012 Rate | P90 (MPL) | P25 (MPL) | P50 (HPL) | P75 (HPL) | P90 (HPL) | 2013 Rate | P90 (HPL) | P25 (HPL) | P50 (HPL) | P75 (HPL) | 2014 Rate | P90 (HPL) | P25 (HPL) | P50 (HPL) | P75 (HPL) | 2015 Interventions |
|--------------------------|------------------------------------------------------------------------------|------------------------|------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------------|
| 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     | 83.21     | 87.32     | 90.97     | 85.16     | 83.21     | 87.32     | 90.97     | 85.16     | CDC: Comprehensive Diabetes Care |
| CDC: Poor A1c control (> 9.0%); lower rate is better | Quality Improvement | HEDIS | 56.20 | 31.14 | 35.76 | 43.02 | 52.58 | 59.48 | 45.50 | 43.02 | 52.58 | 59.48 | 45.50 | 43.02 | 52.58 | 59.48 | 45.50 | 43.02 | 52.58 | 59.48 | 45.50 | CDC: Poor A1c control (> 9.0%); lower rate is better |
| CDC: Good A1c control (< 8.0%); higher rate is better | Quality Improvement | HEDIS | 37.96 | 34.58 | 39.80 | 48.57 | 53.77 | 58.64 | 45.50 | 37.96 | 34.58 | 39.80 | 48.57 | 53.77 | 58.64 | 45.50 | 37.96 | 34.58 | 39.80 | 48.57 | CDC: Good A1c control (< 8.0%); higher rate is better |
| CDC: Diabetic Eye Exam   | Quality Improvement | HEDIS | 42.58 | 37.14 | 44.37 | 54.43 | 62.46 | 67.64 | 45.74 | 42.58 | 37.14 | 44.37 | 54.43 | 62.46 | 67.64 | 45.74 | 42.58 | 37.14 | 44.37 | 54.43 | CDC: Diabetic Eye Exam |
| CDC: LDL Testing         | Quality Improvement | HEDIS | 78.83 | 66.79 | 71.03 | 76.28 | 80.54 | 83.52 | 79.56 | 78.83 | 66.79 | 71.03 | 76.28 | 80.54 | 83.52 | 79.56 | 78.83 | 66.79 | 71.03 | 76.28 | CDC: LDL Testing |
| CDC: LDL Control (<100 mg/dL) | Quality Improvement | HEDIS | 33.58 | 21.76 | 27.90 | 34.69 | 40.03 | 43.80 | 28.47 | 33.58 | 21.76 | 27.90 | 34.69 | 40.03 | 43.80 | 28.47 | 33.58 | 21.76 | 27.90 | 34.69 | CDC: LDL Control (<100 mg/dL) |
| CDC: Nephropathy Monitoring | Quality Improvement | HEDIS | 79.81 | 69.76 | 75.00 | 79.28 | 82.74 | 85.85 | 78.10 | 79.81 | 69.76 | 75.00 | 79.28 | 82.74 | 85.85 | 78.10 | 79.81 | 69.76 | 75.00 | 79.28 | CDC: Nephropathy Monitoring |
| CDC: Blood Pressure (<140/90 mm Hg) | Quality Improvement | HEDIS | 62.29 | 45.67 | 53.74 | 60.93 | 68.17 | 74.55 | 61.31 | 62.29 | 45.67 | 53.74 | 60.93 | 68.17 | 74.55 | 61.31 | 62.29 | 45.67 | 53.74 | 60.93 | CDC: Blood Pressure (<140/90 mm Hg) |

### (CIS) Childhood Immunization Status

| Measure | Description                                                                 | Responsible Department | Benchmark Source | 2012 Rate | P90 (MPL) | P25 (MPL) | P50 (HPL) | P75 (HPL) | P90 (HPL) | 2013 Rate | P90 (HPL) | P25 (HPL) | P50 (HPL) | P75 (HPL) | 2014 Rate | P90 (HPL) | P25 (HPL) | P50 (HPL) | P75 (HPL) | 2015 Interventions |
|---------|------------------------------------------------------------------------------|------------------------|------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------------|
| CIS     | The percentage of children 2 years of age that had DTP, 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     | 80.05     | 61.95     | 66.08     | 72.88     | 78.30     | 83.32     | 75.43     | 80.05     | 61.95     | 66.08     | 72.88     | CIS: Childhood Immunization Status |

### (IMA) Immunizations for Adolescents

| Measure | Description                                                                 | Responsible Department | Benchmark Source | 2012 Rate | P90 (MPL) | P25 (MPL) | P50 (HPL) | P75 (HPL) | P90 (HPL) | 2013 Rate | P90 (HPL) | P25 (HPL) | P50 (HPL) | P75 (HPL) | 2014 Rate | P90 (HPL) | P25 (HPL) | P50 (HPL) | P75 (HPL) | 2015 Interventions |
|---------|------------------------------------------------------------------------------|------------------------|------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------------|
| IMA     | Adolescents who received one meningococcal vaccine on or between the members 11th and 13th birthday and one Td 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     | 65.21     | 50.93     | 58.06     | 68.59     | 77.08     | 85.64     | 60.34     | 65.21     | 50.93     | 58.06     | 68.59     | IMA: Immunizations for Adolescents |
### Gold Coast Health Plan HEDIS Measures – Quality of Care Indicators

**Legend:**
- **Dark Green** = Performance ≥ P90
- **Yellow** = Performance < P50
- **Red** = Performance ≤ P25

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Responsible Department</th>
<th>Benchmark Source</th>
<th>2012 Rate</th>
<th>P10 (MPL)</th>
<th>P25</th>
<th>P50</th>
<th>P75</th>
<th>2013 Rate</th>
<th>P10</th>
<th>P25</th>
<th>P50</th>
<th>P75</th>
<th>2014 Rate</th>
<th>Annual Trend 2012 - 2013</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(PPC) Prenatal and Postpartum Care</strong></td>
<td></td>
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<tr>
<td>PPC 1: Timeliness of Prenatal Care</td>
<td>The percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.</td>
<td>Quality Improvement</td>
<td>HEDIS</td>
<td>80.78</td>
<td>70.59</td>
<td><strong>79.85</strong></td>
<td>85.88</td>
<td>89.72</td>
<td>92.82</td>
<td><strong>83.94</strong></td>
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<tr>
<td>PPC 2: Postpartum Care</td>
<td>The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</td>
<td></td>
<td></td>
<td>63.99</td>
<td>50.69</td>
<td><strong>57.91</strong></td>
<td>63.99</td>
<td>70.20</td>
<td>73.83</td>
<td><strong>59.37</strong></td>
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<tr>
<td><strong>(W34) Well Child Visits in Years 3-6</strong></td>
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<tr>
<td>W34</td>
<td>The 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.</td>
<td>Quality Improvement</td>
<td>HEDIS</td>
<td>61.80</td>
<td><strong>60.81</strong></td>
<td>67.40</td>
<td>72.26</td>
<td>78.51</td>
<td>82.08</td>
<td><strong>64.23</strong></td>
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<tr>
<td><strong>(WCC) Weight Assessment for Children</strong></td>
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<tr>
<td>WCC: BMI %</td>
<td>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 percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.</td>
<td>Quality Improvement</td>
<td>HEDIS</td>
<td>42.09</td>
<td>22.87</td>
<td><strong>37.96</strong></td>
<td>52.31</td>
<td>69.68</td>
<td>80.24</td>
<td><strong>43.80</strong></td>
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<tr>
<td>WCC: Nutrition</td>
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<tr>
<td>WCC: Physical Activity</td>
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</tr>
</tbody>
</table>

2. 2013 rates reflect measurement year data from January 1, 2013, through December 31, 2013.
3. Shaded cells indicate measurements conducted only once annually.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Responsible Department</th>
<th>Benchmark Source</th>
<th>Benchmark</th>
<th>2012</th>
<th>2013</th>
<th>2014 Q1</th>
<th>2014 Q2</th>
<th>2014 Q3</th>
<th>2014 Q4</th>
<th>Quarterly Trend 2014 Q3 - 2014 Q4</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Site Audit (Medi-Cal) - Scoring</td>
<td>The overall percentage of applicable DHCS site audit criteria met.</td>
<td>Quality Improvement</td>
<td>DHCS/ Title 22</td>
<td>80%</td>
<td>98%</td>
<td>100%</td>
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</tr>
<tr>
<td>Facility Site Audit (Medi-Cal) - Compliance</td>
<td>The percentage of providers that passed facility audits without or following completion of a corrective action plan.</td>
<td>Quality Improvement</td>
<td>DHCS/ Title 22</td>
<td>NA</td>
<td>100%</td>
<td>100%</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Medical Record Quality Audit (Medi-Cal) - Scoring</td>
<td>The overall percentage of applicable DHCS medical record audit criteria met.</td>
<td>Quality Improvement</td>
<td>DHCS/ Title 22</td>
<td>80%</td>
<td>94%</td>
<td>97%</td>
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</tr>
<tr>
<td>Medical Record Quality Audit (Medi-Cal) - Compliance</td>
<td>The percentage of providers that passed medical record audits without or following completion of a corrective action plan.</td>
<td>Quality Improvement</td>
<td>DHCS/ Title 22</td>
<td>NA</td>
<td>100%</td>
<td>100%</td>
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</tr>
<tr>
<td>Coordination of Care</td>
<td>The overall percentage of applicable DHCS Coordination of Care criteria met as determined by medical record audits.</td>
<td>Quality Improvement</td>
<td>NA</td>
<td>Tracking</td>
<td>100%</td>
<td>100%</td>
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</tbody>
</table>

Legend:
Green = Met or exceeded Benchmark
Red = Did not meet Benchmark

Shaded cells indicate measurements conducted only once annually.
Gold Coast Health Plan DHCS QIP Measures

<table>
<thead>
<tr>
<th>Non-HEDIS Measure</th>
<th>Description</th>
<th>Responsible Department</th>
<th>Benchmark Source</th>
<th>Benchmark</th>
<th>2012 Rate</th>
<th>2013 Rate</th>
<th>2014 Rate</th>
<th>Annual Trend 2012 - 2014</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Cause Readmissions</td>
<td></td>
<td></td>
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<tr>
<td>SPD</td>
<td>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.</td>
<td>Quality Improvement</td>
<td>DHCS</td>
<td>NA</td>
<td>23.16</td>
<td>15.06</td>
<td></td>
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<tr>
<td>Non-SPD</td>
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<tr>
<td>Total (SPD and Non SPD)</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Benchmark Source</th>
<th>2013 Benchmark</th>
<th>2013 Medi-Cal Managed Care Average Score</th>
<th>2014 Benchmark</th>
<th>2014 TMG Mean 2014</th>
<th>2014 TMG 25th %</th>
<th>2014 TMG 50th %</th>
<th>2014 TMG 75th %</th>
<th>2014 TMG 90th %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Rating of Health Plan</td>
<td>Top-box responses for composite measures were responses of &quot;Usually&quot; or &quot;Always&quot;. &quot;A lot&quot; or &quot;Yes&quot; presented.</td>
<td>2013 Gold Coast Health Plan CAHPS Report, DHCS</td>
<td>NA</td>
<td>59.8%</td>
<td>52.6%</td>
<td>51.0%</td>
<td>50.0%</td>
<td>53.3%</td>
<td>64.7%</td>
</tr>
<tr>
<td>Overall Rating of All Health Care</td>
<td></td>
<td></td>
<td>NA</td>
<td>53.2%</td>
<td>51.1%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>57.7%</td>
</tr>
<tr>
<td>Overall Rating of Personal Doctor</td>
<td></td>
<td></td>
<td>NA</td>
<td>54.7%</td>
<td>52.6%</td>
<td>51.8%</td>
<td>51.8%</td>
<td>56.8%</td>
<td>66.2%</td>
</tr>
<tr>
<td>Overall Rating of Specialist Seen Most Often</td>
<td></td>
<td></td>
<td>NA</td>
<td>56.6%</td>
<td>55.3%</td>
<td>56.5%</td>
<td>56.5%</td>
<td>66.1%</td>
<td>70.3%</td>
</tr>
</tbody>
</table>

* Scores based on Global Ratings Top-Box Rates
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Responsible Department</th>
<th>Compliance Source</th>
<th>Benchmark</th>
<th>2013 Total</th>
<th>2014 Q1</th>
<th>2014 Q2</th>
<th>2014 Q3</th>
<th>2014 Q4</th>
<th>Quarterly Trend 2014 Q2 - 2014 Q4</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution Turnaround Times (TAT) Grievances</td>
<td>100% TAT within 30 calendar days</td>
<td>G&amp;A</td>
<td>GCHP</td>
<td></td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>43%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Service TAR Provider Appeals Processing Time - Resolution</td>
<td>The percentage of provider appeals processed within 30 business days from receipt.</td>
<td>G&amp;A</td>
<td>GCHP</td>
<td></td>
<td></td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Grievances: Complaint, Appeal, or Inquiry</td>
<td>Timely resolution of provider grievances</td>
<td>G&amp;A</td>
<td>GCHP</td>
<td></td>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**
- **Green** = Met or Exceeded Goal
- **Red** = Did Not Meet Goal
### Medical Advisory Committee: Audits, Utilization Management and Clinical Support

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

#### Health Services

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Responsible Department</th>
<th>Benchmark Source</th>
<th>Benchmark</th>
<th>2014 Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Quarterly Trend 2013 - 2014 Q4</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preservice Turnaround Request Processing Time</td>
<td>The % of requests processed ≤ 5 working days from receipt of information necessary to make the determination.</td>
<td>Health Services</td>
<td>DHCS/ Title 22</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>Combined Urgent and Standard</td>
<td>Health Services</td>
<td>DHCS/ Title 22</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
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<td>NA</td>
<td></td>
</tr>
<tr>
<td>Provider Turnaround Request Denials</td>
<td>Number of denied authorizations divided by total number of authorizations. (Excludes RAFs.)</td>
<td>Health Services</td>
<td>DHCS/ Title 22</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
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<td>NA</td>
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</tr>
<tr>
<td>Provider Turnaround Request Denials Overturned</td>
<td>Beginning 1/1/2010 - Number of denials overturned or modified divided by total number of appeals. Includes pre-service &amp; post-service Auth, RAF &amp; MRF appeals.</td>
<td>Health Services</td>
<td>DHCS/ Title 22</td>
<td>NA</td>
<td>NA</td>
<td></td>
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<td>NA</td>
<td></td>
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<tr>
<td>Clinical Utilization Management</td>
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<tr>
<td>Inter-rater Reliability Analysis</td>
<td>Measurement of the consistency with which UM staff apply criteria/guidelines for determining medical necessity.</td>
<td>Health Services</td>
<td>DHCS/ Title 22</td>
<td>90%</td>
<td></td>
<td></td>
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<td>NA</td>
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<tr>
<td>UM Criteria &amp; Review</td>
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<tr>
<td>UM Criteria Revisions</td>
<td>Annual review and adoption of UM criteria that are objective and based on medical evidence.</td>
<td>Health Services</td>
<td>DHCS, Code 1597.01, 1363.5, Title 22, SHRM (u3), DHCS Contact 08-8124, NCQA, UM 2</td>
<td>NA</td>
<td>NA</td>
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</table>
### Delegation Oversight - Assessment of Delegated Quality Activities

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Benchmark Source</th>
<th>Benchmark</th>
<th>2013</th>
<th>2014</th>
<th>Quarterly Trend</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegation of UM</td>
<td>Number required &amp; percentage of current delegates assessed</td>
<td>10-871.28 Exhibit A, Attachment 5; NCQA Standard UM 15; DHCS Contract</td>
<td>NA</td>
<td>100%</td>
<td>100%</td>
<td>NA</td>
<td></td>
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<tr>
<td>Delegation of CR</td>
<td>Number required &amp; percentage of current delegates assessed</td>
<td>Exhibit A, Attachment 4; NCQA Standard CR 9; DHCS Contract 10-87128</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Delegation of QI</td>
<td>Number required &amp; percentage of current delegates assessed</td>
<td>10-871.28 Exhibit A, Attachment 4; NCQA Standard QI 12; DHCS Contract</td>
<td>NA</td>
<td>NA</td>
<td>100%</td>
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<tr>
<td>Delegation of RR</td>
<td>Number required &amp; percentage of current delegates assessed</td>
<td>10-871.28 Exhibit A, Attachment 4; NCQA Standard RR 7; DHCS Contract</td>
<td>NA</td>
<td>NA</td>
<td>100%</td>
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<tr>
<td>Delegation of Claims</td>
<td>Number required &amp; percentage of current delegates assessed</td>
<td>10-871.28 Exhibit A, Attachment 8; DHCS Contract</td>
<td>NA</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Measure</td>
<td>Description</td>
<td>Responsible Department</td>
<td>Benchmark Source</td>
<td>2013 Q1</td>
<td>2013 Q2</td>
<td>2013 Q3</td>
<td>2013 Q4</td>
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<tr>
<td>Access Indicators</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Monitoring of Medicare/Medicaid sanctions</td>
<td>An OIG query is performed on every provider at the time of initial and re-credentialing</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>Standard met for 100% of files presented to CPRC</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Monitoring of sanctions and limitations on licensure</td>
<td>An OIG query is performed on every provider at the time of initial and re-credentialing. Other state licensing boards are also queried as needed</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>Standard met for 100% of files presented to CPRC</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Monitoring of complaints</td>
<td>Member complaints are monitored at a minimum of every 6 months to assess for tendencies</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring of adverse events</td>
<td>Quality of Care concerns are reviewed at a minimum of every 6 months and are forwarded to Credentials/Peer Review Committee (CPRC) as indicated</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIPAA queries are performed within 180 days prior to the date of initial and re-credentialing</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>Standard met for 100% of files presented to CPRC</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeliness of provider notification of credentialing decisions</td>
<td>Providers will be notified of the credentialing decision in writing within 60 days</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeliness of verifications</td>
<td>All credentialing verifications are performed within 180 days (or 360 days) prior to the credentialing date, as requested</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of provider terminations for quality issues</td>
<td>Credentials/Peer Review Committee (CPRC) denial of a credentialing application for quality issues will cause termination of the provider from the network</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>Standard met for 100% of files presented to CPRC</td>
<td>None for Q3</td>
<td>None for Q4</td>
<td></td>
</tr>
<tr>
<td># of fair hearings as a result of adverse credentialing actions</td>
<td>Providers are afforded the right to a fair hearing in the event of an adverse credentialing decision</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>Standard met for 100% of files presented to CPRC</td>
<td>None for Q3</td>
<td>None for Q4</td>
<td></td>
</tr>
<tr>
<td>Service Indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Timeliness of processing of initial applications</td>
<td>Initial applications will be processed within 90 days</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>Standard met for 90% of applications received</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Timeliness of processing of recredentialing applications</td>
<td>Recredentialing applications will be processed within 90 days</td>
<td>Credentialing</td>
<td>DHCS/ Title 22</td>
<td>Standard met for 90% of applications received</td>
<td>99%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Quality Indicators (under NMC purview)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Timeliness of Physician Recredentialing</td>
<td>Percent of physicians recredentialing within 36 months of the last approval date</td>
<td>Credentialing</td>
<td>NCQA, CR Standards</td>
<td>Standard met for 90% of providers</td>
<td>90%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Continuous Monitoring of Allied Providers</td>
<td>Percent of allied providers' expirable elements that are current</td>
<td>Credentialing</td>
<td>NA</td>
<td>Standard met for 90% of providers</td>
<td>NA</td>
<td>100%</td>
<td></td>
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<tr>
<td>Timeliness of Organization Assessment</td>
<td>Percent of organizations reassesed within 36 months of the last assessment</td>
<td>Credentialing</td>
<td>NCQA, CR Standards</td>
<td>Standard met for 90% of providers</td>
<td>NA</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>Description</td>
<td>Responsible Department</td>
<td>Compliance Source</td>
<td>Benchmark</td>
<td>2013</td>
<td>2014 Q1</td>
<td>2014 Q2</td>
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<td>----------------------------------------------</td>
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</tr>
<tr>
<td>Call Center - Aggregate Average Speed of Answer (ASA)</td>
<td>Average Speed to Answer (in seconds)</td>
<td>Member Services</td>
<td>&lt;= 30 seconds</td>
<td>9.6</td>
<td>6.8</td>
<td>15.0</td>
<td>14.8</td>
</tr>
<tr>
<td>Call Center - Aggregate Abandonment Rate</td>
<td>Percentage of aggregate Abandoned calls to Call Center</td>
<td>Member Services</td>
<td>&lt;= 5%</td>
<td>0.51%</td>
<td>0.41%</td>
<td>0.71%</td>
<td>0.67%</td>
</tr>
<tr>
<td>Call Center - Aggregate Call Center Call Volume</td>
<td>Monitored to ensure adequate staffing and identification of systemic issues.</td>
<td>Member Services</td>
<td></td>
<td>26,267</td>
<td>29,156</td>
<td>31,572</td>
<td>27,683</td>
</tr>
</tbody>
</table>
### Cultural & Linguistics

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Responsible Department</th>
<th>Benchmark Source</th>
<th>Benchmark Source</th>
<th>2013</th>
<th>2014 Q1</th>
<th>2014 Q2</th>
<th>2014 Q3</th>
<th>2014 Q4</th>
<th>2014 Q3 - 2014 Q4</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural &amp; linguistic requirements</td>
<td>Number of languages provided per the total number of languages requested through GCHP and interpretation vendors.</td>
<td>CNL</td>
<td>DHCS/Title 22</td>
<td>100%</td>
<td></td>
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</tr>
<tr>
<td>Cultural &amp; linguistic requirements</td>
<td>Total number of translation requests (Excluding American Sign Language)</td>
<td>CNL</td>
<td>DHCS/Title 23</td>
<td>100%</td>
<td>18</td>
<td>18</td>
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<tr>
<td>Cultural &amp; linguistic requirements</td>
<td>Total number of American Sign Language interpreter requests.</td>
<td>CNL</td>
<td>DHCS/Title 24</td>
<td>100%</td>
<td>34</td>
<td>42</td>
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<tr>
<td>Cultural &amp; linguistic requirements</td>
<td>Total number of telephonic calls for interpreter requests.</td>
<td>CNL</td>
<td>DHCS/Title 25</td>
<td>100%</td>
<td>253</td>
<td>365</td>
<td></td>
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<tr>
<td>Measure</td>
<td>Description</td>
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<td>Compliance Source</td>
<td>Benchmark</td>
<td>2013 Q4</td>
<td>2014 Q1</td>
<td>2014 Q2</td>
<td>2014 Q3</td>
<td>2014 Q4</td>
<td>Quarterly Trend 2014 Q3 - 2014 Q4</td>
<td>Interventions</td>
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<tr>
<td><strong>Clinical Practice</strong></td>
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<tr>
<td>Clinical Practice Guideline Adoption</td>
<td>Development and/or adoption of non-preventive clinical practice guidelines for the provision of acute and chronic medical services</td>
<td>ACMO</td>
<td>DHCS/ Title 22</td>
<td>Approval by Committee</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Approved by MAC 1/29/2015</td>
</tr>
<tr>
<td>Clinical Practice Guideline Distribution</td>
<td>Development and/or adoption of non-preventive clinical practice guidelines for the provision of acute and chronic medical services to applicable practitioners every two years.</td>
<td>ACMO</td>
<td>DHCS/ Title 22</td>
<td>Distribution to Applicable Providers</td>
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<tr>
<td><strong>Preventive Health</strong></td>
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<tr>
<td>Preventive Services Guideline Adoption</td>
<td>Development and/or adoption of preventive guidelines every two years.</td>
<td>Health Education</td>
<td>DHCS/ Title 22</td>
<td>Approval by Committee</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Approved by MAC 7/24/2014</td>
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<tr>
<td>Preventive Services Guideline Distribution</td>
<td>Development and/or adoption of preventive guidelines every two years.</td>
<td>Health Education</td>
<td>DHCS/ Title 22</td>
<td>Distribution to Applicable Providers</td>
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</tr>
</tbody>
</table>
Pharmacy Benefit Manager (PBM) Oversight

- 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)

IRR Review
• 3 pharmacists with the PBM doing prior authorizations are tested
• 100% compliance
Newly Approved Drugs and Formulary Management

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

- 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.

Credentials/Peer Review
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
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
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
Health Education and Outreach

Events:

- Annual Community Resource Fair June 6, 2015
- Other Community Events from January – June 2015: 78
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training

- 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.
Cultural and Linguistics

Pacific Interpreters

• 365 calls using interpreters by staff
• 12 languages

American Sign Language

• 42 requests serving 15 members
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
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
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
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

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.

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
Utilization Management

Statistics: 4th Quarter 2014

- 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%
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
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.”
All required delegation oversight for 2014 was completed and corrective action plans closed.
• CAP was issued to VSP on Oct. 29, 2014
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

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VII. Program Resources 11
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   ii. Medical Advisory Committee 15
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   iv. Grievance and Appeals Committee 17
   v. Network Planning Committee 17
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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:

- **Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan**
  - Executive Finance Committee
  - Quality Improvement Committee
  - Provider Advisory Committee
  - Consumer Advisory Committee
  - Medical Advisory Committee
  - Network Planning Committee
  - Member Services Committee
  - Pharmacy and Therapeutic Committee
  - Utilization/Case Management Committee
  - Grievance and Appeals Committee
  - Health Education/Cultural and Linguistics Committee
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
- 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.asp
- 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.
## Objective: Improve Quality and Safety of Clinical Care Services

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Dept./Committee</th>
</tr>
</thead>
</table>
| NCQA QI 9   | Diabetes Clinical Practice Guideline (CPG) review and adoption at least every two years | Review of relevant CPGs       | Q4 2015                | Review and approval by Medical Advisory Committee (MAC)  
Annualy measure performance against at least two important aspects of each of the CPGs  
Distribute guidelines to appropriate practitioners                                                                 | MAC                         |
|             | Distribution of guidelines to practitioners                           | Distribute if necessary       |                        |                                                                                                                 |                             |
| NCQA QI 9   | Preventive Health Guideline (PHG) review and adoption at least every two years | Review of relevant PHGs       | Q4 2015                | Review and approval by Medical Advisory Committee (MAC)  
Annualy measure performance against at least two important aspects of two PHGs  
Distribute guidelines to appropriate practitioners                                                                 | MAC                         |
|             | Distribution of guidelines to practitioners                           | Distribute if necessary       |                        |                                                                                                                 |                             |

### 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         |
|-------------|---------------------------------------------------------------------------------------|-------------------------------------|------------------------|------------------------------------------------------------------------------------------------------------------|-----------------------------|
### 2015 Gold Coast Health Plan Quality Improvement Work Plan

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

Health Education QI
## 2015 Gold Coast Health Plan Quality Improvement Work Plan

<table>
<thead>
<tr>
<th>DHCS</th>
<th>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)</th>
<th>Increase rates by 5% over previous measurement year</th>
<th>Q4 2015</th>
<th>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</th>
<th>Health Education QI</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHCS</td>
<td>Controlling High Blood Pressure – percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (&lt;140/90)</td>
<td>Maintain rate above MPL Increase rates by 5% over previous measurement year</td>
<td>Q4 2015</td>
<td>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</td>
<td>QI</td>
</tr>
<tr>
<td>DHCS</td>
<td>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</td>
<td>Increase rates by 5% over previous measurement year</td>
<td>Q4 2015</td>
<td>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</td>
<td>QI</td>
</tr>
</tbody>
</table>
# 2015 Gold Coast Health Plan Quality Improvement Work Plan

| 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 | 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 | DHCS | 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  
Member newsletter article to remind members to get annual visit | DHCS | QI | Health Education |

## Quality Improvement Projects

| DHCS | External QIP: TBD by DHCS | Increase rate by 5% over previous year rate | Q4 2015 | Member incentive letters  
Provide provider performance feedback by means of 2014 HEDIS report cards | DHCS | Health Education | QI |
## 2015 Gold Coast Health Plan Quality Improvement Work Plan

### Objective: Improve Quality of Nonclinical Services

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Dept./Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCQA QI 5</strong> DHCS</td>
<td><strong>Primary Care Access</strong> &lt;br&gt; Members are offered: &lt;br&gt; • Non-urgent primary care within 10 business days of request &lt;br&gt; • Urgent care within 48 hours</td>
<td>Standards met for minimum of 90% of providers</td>
<td>Q4 2015</td>
<td>Monitor performance and complaints relating to appointments &lt;br&gt; Report quarterly performance to QIC &lt;br&gt; Develop and implement corrective action plans when timely access standards not met</td>
<td>Network Operations Grievances and Appeals</td>
</tr>
<tr>
<td><strong>Specialty Care Access</strong> &lt;br&gt; Members are offered: &lt;br&gt; • Non-urgent specialty care appointment within 15 business days &lt;br&gt; • Non-urgent ancillary services within 15 business days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DHCS</strong></td>
<td><strong>After Hours Availability</strong> &lt;br&gt; Members are able to reach a provider after hours</td>
<td>Standards met for 90% of providers</td>
<td>Q4 2015</td>
<td>Monitor performance and complaints relating to after-hours availability &lt;br&gt; Report quarterly performance to QIC &lt;br&gt; Develop and implement corrective action plans when timely access standards not met</td>
<td>Network Operations Grievances and Appeals</td>
</tr>
</tbody>
</table>

Provide quarterly member lists with members who have not received services  
VSP letter to members  
Report quarterly to QIC  
Submit results to DHCS

Provide quarterly member lists with members who have not received services  
VSP letter to members  
Report quarterly to QIC  
Submit results to DHCS
### 2015 Gold Coast Health Plan Quality Improvement Work Plan

| 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 |
|------|--------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|

<table>
<thead>
<tr>
<th><strong>Practitioner Availability: Cultural Needs &amp; Preferences</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCQA QI 5 DHCS</strong></td>
</tr>
<tr>
<td>Practitioner Availability: Cultural and Linguistics Needs &amp; Preferences: Assess the cultural, ethnic and linguistic needs of our members</td>
</tr>
<tr>
<td><strong>NCQA DHCS</strong></td>
</tr>
<tr>
<td>Assess the provider network and adjust the availability of providers within the network, if necessary, to meet membership needs and preferences</td>
</tr>
<tr>
<td><strong>Provider Satisfaction Survey</strong></td>
</tr>
<tr>
<td>Complete Survey</td>
</tr>
</tbody>
</table>
## 2015 Gold Coast Health Plan Quality Improvement Work Plan

<table>
<thead>
<tr>
<th>Required By</th>
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<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Dept./Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective: Improve Patient Safety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHCS</td>
<td>Complete Initial and Triannual Facility Site Reviews Complete Interim Reviews</td>
<td>100%</td>
<td>Year End 2015</td>
<td>Monitor FSR database Submit bi-annual reports to DHCS</td>
<td>FSR Nurse QI</td>
</tr>
<tr>
<td>DHCS</td>
<td>Complete Physical Accessibility Site Reviews</td>
<td>100%</td>
<td>Year End 2015</td>
<td>Complete reports for high volume/ancillary specialists Submit report to State Complete PARs for new provider sites</td>
<td>FSR Nurse QI</td>
</tr>
<tr>
<td>NCQA</td>
<td>Improve Safe Clinical Practice</td>
<td>Tracking</td>
<td>Ongoing</td>
<td>Monitor site visit results from practitioner credentialing Monitor member complaints involving clinical quality of care concerns (safety)</td>
<td>Credentialing/Peer Review Grievances and Appeals</td>
</tr>
</tbody>
</table>

| **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 |
<table>
<thead>
<tr>
<th>Objective: Health Plan Quality</th>
<th>Customer Service (2014 rate = 82.7%)</th>
<th>Shared Decision Making (2014 rate = 49.7%)</th>
<th>successful practices and identify barriers and provide technical assistance/trainings on access issues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Customer Service Interventions:</td>
<td>Monitor results/reports of after call survey performed by call center; follow up if issues identified</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Monitor complaints and grievances Measure during 2016 CAHPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>POB article regarding shared decision making</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Convene Member Satisfaction Improvement Workgroup to identify additional improvement activities</td>
</tr>
</tbody>
</table>

| NCQA DHCS                      | Update QI Program Description        | 100%                                      | April 2015                                               |
|                                | Complete 2014 QI Program Evaluation  |                                      | April 2015                                               |
|                                | Develop and Implement 2015 QI Program Work Plan |                                      | 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 |

<table>
<thead>
<tr>
<th>Operations</th>
<th>Grievances and Appeals QI QI QI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Medical Officer QI Director Quality Improvement Committee</td>
<td></td>
</tr>
</tbody>
</table>
### 2015 Gold Coast Health Plan Quality Improvement Work Plan

| NCQA DHCS | Completion of Delegation Oversight Delegated Activities | 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 |
| --- | --- | --- | --- | --- |
| | Credentialing  
| | QI  
| | UM  
| | Members’ Rights  
| | Claims | | | |

---

**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 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.
### COMPLIANCE REPORT 2015

<table>
<thead>
<tr>
<th>Category</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
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<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
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<td>3</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
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</tr>
</tbody>
</table>

** 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.

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

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Claims</th>
<th>TAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>127,517</td>
<td>6,376</td>
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<tr>
<td>February</td>
<td>130,559</td>
<td>6,528</td>
</tr>
<tr>
<td>March</td>
<td>152,948</td>
<td>6,952</td>
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</table>
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

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
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 Highlights:

· Closed IT Disaster Recovery Project
· Closed Information Security Program (Operationalize)
· Closed MedHOK SPD
· Closed MedHOK ACG-Risk Stratification
· Closed PBM - Vendor for RFP Support
· Implemented 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):**

- **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"

**ICD-10 Readiness**
- Jul-Sep 2014
- P1
- Oct-Dec 2014
- P2

**Grievance & Appeals Optimization**
- Jul-Sep 2014

**Encounter Data Improvement Program**
- 35C to 837 Transition
- Kaiser Encounter Data
- Oct-Dec 2014

**IT Disaster Recovery**
- Oct-Dec 2014

**NEMT Phase 1**
- Oct-Dec 2014

**Diabetes Disease Management Program**
- Disease Management Program Roadmap
- Member Satisfaction Survey
- HR Flexible Work Program: Telework Policy
- MedHOK ACG – Risk Stratification
- MedHOK MMS Post-Implementation

**MedHOK MMS Post-Implementation**
- Jul-Sep 2014

**MedHOK SPD**
- Jul-Sep 2014
- Provider Contracts & Capitation Rebasin Evaluation P2

**Provider Portal Evaluation**
- Jul-Sep 2014
- ABA Behavioral Health Benefit P2

**Business Continuity Plan (BCP) Project**
- Jul-Sep 2014
- Business Continuity Plan (BCP) RFP

**PBM – Vendor for RFP Support**
- Jul-Sep 2014

**Information Security Program - Operationalize**
- Jul-Sep 2014

**MedHOK SOC Audit**
- Jul-Sep 2014

**DHCS CAP Audit**
- Jul-Sep 2014

**ICES/IKA Upgrades**
- Jul-Sep 2014

**DHCS Medical Audit**
- Jul-Sep 2014

**Provider Contracts & Capitation Rebasin Evaluation P2**
- Jul-Sep 2014

**CORE: HIPAA/ACA Administrative Simplification Rules**
- Jul-Sep 2014

**Social Media Policy and Roadmap**
- Jul-Sep 2014

**LEGEND:**
- GREEN - Active Projects (Lighter GREEN reflects Project Extensions)
- BLUE – Approved FY14/15 Projects
- Dark BLUE-Delayed Start
- GREY-Closed
GCHP Helpdesk Service Ticket Trending

GCHP IT Metrics – March 2015

SLA = 99.99

- GCHP Data Warehouse
- MedInsight - BI Tool
- GCHP Network
- Multiview - Financial Accounting System

GCHP Helpdesk Service Ticket Trending

Total Tickets Opened per Month

Total Tickets Closed Per Month
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.
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.
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.

ER Utilization Per 1000

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

ER Utilization by Aid Category

<table>
<thead>
<tr>
<th>Aid Category</th>
<th>Feb-14</th>
<th>Feb-Mar-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
<th>Oct-14</th>
<th>Nov-14</th>
<th>Dec-14</th>
<th>Jan-14</th>
<th>Feb-15</th>
</tr>
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<tbody>
<tr>
<td>TLIC</td>
<td>390</td>
<td>8.77%</td>
<td>364</td>
<td>8.00%</td>
<td>381</td>
<td>8.94%</td>
<td>409</td>
<td>8.02%</td>
<td>393</td>
<td>8.66%</td>
<td>321</td>
<td>6.95%</td>
<td>453</td>
<td>8.10%</td>
</tr>
<tr>
<td>AE</td>
<td>409</td>
<td>9.20%</td>
<td>564</td>
<td>12.40%</td>
<td>604</td>
<td>15.00%</td>
<td>941</td>
<td>20.44%</td>
<td>997</td>
<td>24.00%</td>
<td>25.5%</td>
<td>12.45%</td>
<td>11.54%</td>
<td>11.59%</td>
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<tr>
<td>SPD</td>
<td>581</td>
<td>13.0%</td>
<td>586</td>
<td>12.8%</td>
<td>625</td>
<td>13.0%</td>
<td>630</td>
<td>12.3%</td>
<td>604</td>
<td>12.4%</td>
<td>666</td>
<td>11.6%</td>
<td>653</td>
<td>11.5%</td>
</tr>
<tr>
<td>Family</td>
<td>3.0</td>
<td>68.9%</td>
<td>3.0</td>
<td>66.7%</td>
<td>3.1</td>
<td>66.4%</td>
<td>3.0</td>
<td>64.1%</td>
<td>2.8</td>
<td>59.1%</td>
<td>3.2</td>
<td>54.5%</td>
<td>3.0</td>
<td>54.9%</td>
</tr>
</tbody>
</table>

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

The readmission rate has remained between 9.5% and 10.5% since the 3rd 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.

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

Inpatient Auths/1000
Outpatient Auths/1000

MedInsight Membership (04/15/2015)

0 50 100 150 200 250

105,000 115,000 125,000 135,000 145,000 155,000 165,000 175,000 185,000 195,000
0 50 100 150 200 250
Gold Coast Health Plan Authorizations by Aid Category
January 2014 - March 2015

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

Prepared by B. Johnson on 4/20/2015
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.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total Number</th>
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<tbody>
<tr>
<td>Q1 2014</td>
<td>22</td>
</tr>
<tr>
<td>Q2 2014</td>
<td>34</td>
</tr>
<tr>
<td>Q3 2014</td>
<td>32</td>
</tr>
<tr>
<td>Q4 2014</td>
<td>31</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>41</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total</th>
<th>Upheld</th>
<th>Partial Overturn</th>
<th>In Progress</th>
<th>Overturned</th>
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</thead>
<tbody>
<tr>
<td>Q1 2014</td>
<td>10</td>
<td>8 (80%)</td>
<td>-</td>
<td>-</td>
<td>2 (20%)</td>
</tr>
<tr>
<td>Q2 2014</td>
<td>3</td>
<td>2 (67%)</td>
<td>-</td>
<td>-</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Q3 2014</td>
<td>10</td>
<td>6 (60%)</td>
<td>-</td>
<td>-</td>
<td>4 (40%)</td>
</tr>
<tr>
<td>Q4 2014</td>
<td>10</td>
<td>3 (30%)</td>
<td>1 (10%)</td>
<td>2 (20%)</td>
<td>4 (40%)</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>5</td>
<td>1 (20%)</td>
<td>0</td>
<td>2 (40%)</td>
<td>2 (40%)</td>
</tr>
</tbody>
</table>

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%.