Gold Coast Health Plan℠
A Public Entity

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, September 28, 2015
3:00 PM

AGENDA

CALL TO ORDER / ROLL CALL

PUBLIC COMMENT Comments are limited to three (3) minutes. Those wishing to comment must complete and submit a Speaker Card to the Clerk of the Board.

- **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 August 24, 2015

2. APPROVAL ITEMS

a. Appointment to Consumer Advisory Committee (CAC)

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

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

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.

b. Appointment to Provider Advisory Committee (PAC)
c. Department of Health Care Services (DHCS) Contract Amendment (Number to be determined)
d. Adoption of Audit Committee Charter
e. Adoption of a Cultural Diversity Program, Including the Creation of an Human Resources, Cultural Diversity Subcommittee to Among Other Things, Initiate a Diversity Intervention Project, a Cultural Diversity Hotline and Potential Agreement with the Ventura County Human Resources Division or a Third Party to Facilitate the Initiation of the Diversity Intervention Project.

3. ACCEPT AND FILE ITEMS

a. CEO Update
b. CFO Update - June 2015 Financials
c. COO Update
d. CIO Update
e. CMO / Health Services Update
f. Compliance Update

CLOSED SESSION

a. **Public Employee Performance Evaluation**
Pursuant to Government Code Section 54957
Title: Chief Executive Officer
b. **Conference with Legal Counsel -** Existing Litigation
Name of Case: Guillermo Gonzalez v. Gold Coast Health Plan, EEOC Claim Nos. 480-2014-02364 and 480-2015-01070
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: 3

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

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba
Gold Coast Health Plan September 28, 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 PM

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on October 26, 2015 at County of Ventura Government Center - Hall of Administration, Lower Plaza Assembly Room, 800 S. Victoria Avenue, Ventura, CA 93009

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

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Commission Meeting Minutes
August 24, 2015
(Not official until approved)

CALL TO ORDER

Chair Araujo called the meeting to order at 3:00 p.m. Hall of Justice - Pacific Conference Room at the County of Ventura Government Center, 800 S. Victoria Avenue, Ventura, CA 93009.

The 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
Lanyard Dial, MD, Ventura County Medical Association
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 (arrived at 3:02 p.m.)
Gagan Pawar, MD, Clinicas del Camino Real, Inc.
Dee Pupa, Ventura County Health Care Agency

EXCUSED / ABSENT COMMISSION MEMBERS
Peter Foy, Ventura County Board of Supervisors
Vacant, Medi-Cal Beneficiary Advocate

STAFF IN ATTENDANCE
Dale Villani, Chief Executive Officer
Patricia Mowlavi, Chief Financial Officer
Traci R. McGinley, Clerk of the Board
Scott Campbell, Legal Counsel
Brandy Armenta, Compliance Director
Susana Enriquez, Public Relations Manager
Mike Foord, IT Infrastructure Manager
Anne Freese, Pharmacy Director
Jeffery Gauthier, Facilities Manager
Guillermo Gonzalez, Government Relations Director
Lupe Gonzalez, Director of Health Education, Outreach, Cultural and Linguistic Services
Steven Lalich, Communications Director
Tami Lewis, Operations Director
Allen Maithel, Controller

Kim Osajda, Quality Improvement Director
Al Reeves, MD, Chief Medical Officer
Melissa Scrymgeour, Chief Information Officer
Lyndon Turner, Financial Analysis Director
Ruth Watson, Chief Operations Officer
Nancy Wharfield, MD, Associate Chief Medical Officer

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of June 22, 2015

Commissioner Fisher moved to approve the Regular Meeting Minutes of June 22, 2015. Commissioner Lee seconded. The motion carried with the following votes:

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

2. APPROVAL ITEMS

a. Department of Health Care Services (DHCS) Contract Amendments A17 and A19

CEO Villani reviewed the report with the Commission, noting that Amendment A17 adjusts the FY 2013-14 capitation rates to reflect the Intergovernmental Transfer (IGT) and Amendment A19 outlines additional Senior and Persons with Disabilities (SPD) reporting requirements.

Commissioner Glyer moved to approve and authorize the CEO to execute DHCS contract amendments A17 and A19. Commissioner Dial seconded. The motion carried with the following votes:

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

b. Quality Improvement Committee Report – 2nd Quarter

CMO Reeves reviewed the report with the Commission. He explained that the Department of Health Care Services (DHCS) selects approximately 28 out of 80 NCQA HEDIS measures and expects the Plan to reach the 25th percentile of all managed Medicaid plans in the United States.

He reported that overall the Plan's scores improved significantly from 2012 and 2013. The Plan was in the 75th percentile for treatment of diabetics, including retinal eye exams. There were three measures of particular importance to the Plan: Counseling for Nutrition and Physical Activity and Well-Child Visits in the 3rd, 4th, 5th and 6th years of life. If the Plan had had not met the 25th percentile in those measures, the Plan would have been placed under a Corrective Action Plan (CAP) by DHCS.

In response to Commissioner Fisher's question about the Plan's improved scores, CMO Reeves explained that the Plan did have a number of HEDIS improvement projects such as: GCHP's optometry services vendor identifies members that have diabetes and sends letters to remind them to get their eyes checked. The Plan also had a member incentive and offered movie tickets to members that had their diabetic eye screening if required. GCHP is also meeting with providers and reviewing the measures.

Commissioner Glyer asked about the decline in monitoring patients on persistent medications. CMO Reeves responded that the Plan was concerned about the decline, upon researching the matter, instead of having the tests completed every 12 months, some providers are having the tests done every 16-18 months. The Plan will be reminding providers that it expect the tests to be done yearly. The Plan has identified the Members in this category and is sending letters advising them of the need to have the tests completed.

CMO Reeves noted that the Plan needs to improve access to care for children; it has not yet met the 25th percentile in this area. The Plan has identified and sent letters to the families that have children in this age group. The Plan developed an incentive program: when a child has their exam their name is being placed into a raffle. The Plan is providing 10 - $25 gift certificates per month for the raffle.

CMO Reeves noted that to encourage Members to get a post-partum check-up, the Plan will send a gift box of diapers and a cap and booties. The Plan is continuing the same incentive program for eye check and movie ticket. It's the Plan's goal to be in the 50-75th percentile for all of our measures.

A state-wide quality improvement project was mandated by the State to measure readmissions. The project was reformulated at the beginning of the year and the Plan concentrated on just one hospital for three months, Community Memorial Hospital (CMH). Through that project we identified high risk members being readmitted and identified medication disruption and homelessness as the main causes of readmission. The Plan is working on ways to possibility correct those issues and have now moved that project over to Ventura County Medical Center (VCMC). Although the State decided they are not going to have the State-wide project, the Plan will continue the project in the hopes of preventing readmissions.

Commissioner Glyer asked about the 184 provider disputes under Administrative Grievances. Tami Lewis, Operations Director explained that these were typically incorrectly processed claims.

CMO Reeves briefly reviewed the Behavior Health Utilization information. Commissioner Alatorre asked if Beacon was still under a CAP. CMO Reeves confirmed that they are still under a CAP for the timeliness of their claims. GCHP continues to work with them and is working with them to improve some access issues as well.

Commissioner Dial moved to approve the report. Commissioner Fisher seconded. The motion carried with the following votes:

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

c. Authorization to Begin Process to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT)

CEO Villani reviewed the report with the Commission.

Commissioner Alatorre noted that the fiscal impact was much lower than previous IGTs. COO Watson explained that it is approximately 50% of the estimated IGT amount. These are preliminary dollars that have not yet been federally matched.

Commissioner Glyer moved to authorize and direct the Chief Executive Officer to submit a proposal to the California Department of Health Care Services (DHCS) to begin the process to secure additional Medi-Cal Funds through an Intergovernmental Transfer (IGT). Commissioner Lee seconded. The motion carried with the following votes:

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

3. ACCEPT AND FILE ITEMS

a. **CEO Update**

CEO Villani reviewed his report with the Commission. He noted that the Plan had adopted the following core values: Integrity, Accountability, Collaboration, Trust and Respect.

CEO Villani updated the Commission on the Pharmacy Benefits Manager (PBM) RFP and noted that there are seven prospective PBMs, not six. GCHP is awaiting an opinion from the Fair Political Practices Commission (FPPC) as to whether Milliman, GCHP's RFP vendor, can participate in scoring the RFPs.

CEO Villani updated the Commission on SB 260, the Knox Keene Licensing of County Organized Health System (COHS) Plans. It is currently in the appropriations committee, if it doesn't come out for a full vote it could go into the next legislative cycle. That

timeframe would not be as eminent for GCHP, but the Plan believes it is moving forward and will be faced with Knox Keene requirements.

Commissioner Glyer asked what financial sanctions were placed on one of the Plan's delegates with regard to a Corrective Action Plan (As indicated under the Compliance Update). Compliance Director Armenta responded that the sanction was a 10% administrative hold, per the contract. Commissioner Glyer asked if they would eventually get that money back. CEO Villani explained that it may be restored to 100%, but they would not receive previously docked payments. Legal Counsel Campbell added that this is the second time the delegate has not been in compliance. The first time the Plan withheld the 10% but gave it back once the delegate was in compliance. Because this was the second time, the Plan assessed the 10% sanction.

b. CFO Update – May 2015 Financials

CFO Mowlavi reported that the month of May was relatively uneventful, but well highlighted on pages 82 and 83 of the report. She provided an overview of the fiscal year to date information.

Commissioner Pupa asked about the Lines of Credit (LOC) payback to the County. Financial Analysis Director Turner explained that the State has been very clear that they are not willing to give the Plan the opportunity to repay the LOC until they have the audit results from FY 2013-14. McGladrey is close to completing that audit and once it has been completed it will be forwarded to the State.

Commissioner Alatorre asked about the balance of funds from the ACA 1202 Payments. Financial Analysis Director Turner explained that one provider is having a 1099 issue and the Plan believes there is large ACA 1202 payment for that provider. COO Watson added that the remaining balance is not yet known. Commissioner Alatorre asked about the deadline. CFO Mowlavi responded that she believed it was the end of the calendar year. COO Watson confirmed that once the remaining amount is known staff will update the Commission.

c. COO Update

COO Watson presented the report highlighting the additional office space needed by GCHP and the growth in membership. The Plan is working with a different division of Xerox and will be working with them regarding call center issues the Plan is starting to experience.

d. CIO Update

CIO Scrymgeour reviewed her report and noted that roughly 40% of the projects are strategic in nature. Of those, there are seven requests for proposals (RFPs) for new systems and/or services. The Plan is focused on pursuing new solutions and partnerships to support membership increases and a growing organization. The PMO is currently managing 14 active projects, closing 2 projects and kicking off 4 new projects since the beginning of the FY 2014- fiscal year.

e. Health Services Update

Associate Chief Medical Officer Dr. Wharfield reviewed the report.

Chair Araujo asked how the number of bed days are kept so low. Dr. Wharfield explained that some of it is due to utilization management; a lot of administrative work goes into getting Members transitioned from hospitals to appropriate lower care facilities. Chair Araujo asked if GCHP was doing something different than other plans. Dr. Wharfield responded that it most likely has to do with the membership makeup.

Commissioner Glyer asked about the use of observation status, if they were used more would they drive down the number of bed days. Dr. Wharfield noted that it was possible, she does not specifically know about each plan, but generally they are not included.

Chair Araujo asked CFO Mowlavi if she recalled what they were at LA Care. She explained that they just recently changed products and there is a big mixed component across the plans.

Commissioner Pupa moved to accept and file the CEO, CFO (May 2015 Financials), COO and Health Services Updates. Commissioner Alatorre seconded. The motion carried with the following votes:

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

4. INFORMATIONAL ITEMS

a. Special Investigation Update

CEO Villani explained that he would be providing a high level perspective of the initial investigation, findings and the progress GCHP has made in getting processes in place. This was a very comprehensive investigation; every receipt, financial statement and document were reviewed. Main areas were on accounting, financial information, and misuse of funds, payroll, and other major allegations. Errors were made and there was lack of backup information. Some of the accounts receivable processes could have been managed better, but there was no willful intent to mislead. CEO Villani noted that he believed what was most important from the Commission's and organization's standpoint is that what occurred back in 2012 and 2013 in terms of errors and mistakes, lack of backup documentation, etc. has been corrected going forward. Is there sound financial processes and controls in place? Things could have been done better, there were errors, but there was no willful reporting of wrong information. Major allegations were unfounded

The Plan is trying to move forward and wants to make sure that processes and improvements are sound, that there are controls, checks and balances. That the Plan has systems backed-up and redundancies where they are needed.

The Plan has had a series of different leaders come in and put in more controls around activities. One of the first areas was to put a Senior Buyer in place, Clifford Waites, a

gentleman with extensive background on how to manage a procurement process and controls. He has written detailed policies and procedures and established a purchasing card system which about 22 people have specific restrictions, purposes and dollar limits. He has placed a rigorous bidding processes around any of the contracts that are over $50,000 and ensures that every contract over $100,000 comes to the Commission for approval.

Commissioner Glyer asked how long Mr. Waites has been with the Plan and how long the procedures have been in place. CEO Villani responded that Mr. Waites started with the Plan in May 2014 and has been putting these processes in place. The Plan has not yet brought in an internal auditor.

Commissioner Fisher stated 22 cards seemed excessive and would leave a lot of room for potential error, but it sounds like you have it segregated for each person.

COO Watson added that the cards are very restrictive; her limit is $2,000 and is only for travel, the controls are such that it would not allow her to use it for anything else. It is very limited, prescribed, automated and very hard to abuse.

CEO Villani stated that he does not necessarily disagree that 22 cards are the right number; however, it has all been based on previous purchasing patterns. We can monitor it over time and see if it needs to be cut back in any way.

Another area that there was a lot of focus and discussion around was the Human Resources Department. The Plan has engaged an administrative expert, Vicki Hewlett, to take a hard look at the overall policies. With the director position now being vacant, she is assisting with the recruitment as well. We have really looked at what we need for the department and have elevated it to a Senior Director position. Part of the recruitment is looking at hiring the most diverse candidates that we can find, the search has been expanded to reach out to different areas where the candidates can give us the equity we need.This is an important part of our senior leadership team.

The Plan's policies and procedures are a cut and paste from RGS. We are in the processes of drafting a whole series of new policies and procedures, and personnel rules. This will need to be brought back to the Commission for their review and approval.

The Plan also has too many job titles and no job families. We want people to have the opportunity to move and progress within any of the different families and eliminate the multitude of different job descriptions.

Another area of importance is around who and how policy is approved within GCHP. Government Relations Director Guillermo Gonzalez chairs the Policy Review Committee, and there is a rigorous and structured process and legal review to get policies reviewed and approved before they come to the Commission.

The Plan continues to look at the timecard and payroll system, ADP. We have created a cross functional committee that is looking at the ADP functionality. There has been

ongoing discussion around the vacation balances that are in ADP versus what HR currently shows for vacation balances and there is a manual audit process that verifies that the two line up. Our goal is to have an automated system plug in.

There was some discussion around making sure the Plan had a robust employee assistance program. That has been in place since 2012.

Fraud Waste and Abuse training is handled annually and the Fraud Waste and Abuse hotline is also available.

The last area was around accounting practices; I believe one of the most important things is to have the checks and balances. Having the internal audit activity is new, we have not had that before and we will present that back to the Commission. This is a huge portion of the check and balance, making sure that what we are doing is being verified and does not report into finance. It is an independent reporting activity.

We are confident that the Accounts Receivable reconcilable processes we have in place are adequate, but we can certainly make it better.

Commissioner Alatorre asked if the internal auditor would have a direct line to the Commission such as Compliance. CEO Villani stated that he believes it will be something similar.

Chair Araujo asked if CEO Villani was envisioning a regular report from the internal auditor. CEO Villani, without committing to anything yet, he did envision that the Commission would hear independently as to what they are observing, reporting and tracking.

Those are the main areas of focus that I wanted to take a few minutes and talk about, in terms of additional controls. Errors were made, but we think going forward we are putting the correct process and controls in place.

Commissioner Alatorre asked about plans on cultural competency.

CEO Villani responded that it is an annual training requirement. The Plan engaged an outside trainer who came in and trained all supervisors and above. We completed that training, it is done. It was senior management assessment that the person doing the training was not the best. The decision was made that before we roll it out for all employees, and our goal is before the end of the year to have it complete. Is to get a more qualified instructor. The level of content and materials presented were focused enough on the work place.

Commissioner Alatorre asked about equity, fairness and promotional opportunities and salary increases. CEO Villani responded that all of the pay ranges were reviewed. There is a Commission approved pay range for all staff. Some staff were outside that pay range, very few, but those were staff that were moved into their pay ranges. Everyone is now within the approved pay ranges. There is equity in terms of approved pay ranges

and aligned to the current rolls. There is a process by which annual reviews are done for all employees. That is a hard requirement, if we haven't been doing it then we will be doing it. Now, we are about to finish our goals and the annual reviews should tie back to the goals and our accomplishment of those goals. We talk about who gets an increase each year, there are merit increases that are tied to performance. We want to have a fair and equitable annual review process tied to organizational goals as approved by the Commission and then be able to score people against their performance. The scale we use now is 0-5. Typically in my history, if you are a 3 you are doing everything in your job description. Some individuals may never get increases due to their performance. There are other things out there that are broader discussion, like market adjustments. One of the things that Vicky is looking at is the equity of the salaries. This will go back to the Commission as to what is the equity of overall salaries compared to the industry. That is discussion for a future date to come back and discuss with the Commission. That could drive some market adjustments.

Chair Araujo suggested that in future meetings maybe a short report of how things are going as things are being changed

CEO Villani stated that he will include that in the CEO Update.

COMMENTS FROM COMMISSIONERS

Commissioner Pupa commended staff of the HEDIS measures. From a Knox Keene licensing standpoint, I understand staff's concern. $1 million may be a little low for licensing in terms of overall project costs.

COO Watson since I share your concern about the dollar amount, we do have probably the next fiscal year to make it happen so it gives us time should the budget turn out to be low.

Chair Araujo thanked CEO Villani for the report and all of the things that have already been in place. We are looking forward to hearing updates as the months go on. I did also want to bring it the Commission that at the last Executive / Finance Committee Meeting the Committee discussed meeting every two months. Then also bring up to the Commission if it wanted to change its schedule. Legal Counsel Campbell stated that the most appropriate way would be to amend the bylaws. Chair Araujo stated that will have to be made as an agenda items at a later date.

CLOSED SESSION

Legal Counsel Campbell explained the purposes of the Closed Session Items.

CLOSED SESSION

The Commission adjourned to Closed Session at 4:37 p.m. regarding the following items

a. **Conference with Legal Counsel** - Existing Litigation
Pursuant to Government Code Section 54956.9
Clinicas Del Camino Real Inc. v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan. Ventura County Superior Court Case Number 56-2014- 00456149-CU-BC-VTA

b. **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

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 6:30 p.m.

Legal Counsel Campbell stated that no reportable action was taken in Closed Session.

ADJOURNMENT

Meeting adjourned at 6:31 p.m.

Gold Coast Health Plan℠
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AGENDA ITEM 2.a.

TO: Gold Coast Health Plan Commission

FROM: Ruth Watson, COO

DATE: September 28, 2015

RE: Appointment to Consumer Advisory Committee (CAC)

SUMMARY:

The Consumer Advisory Committee (CAC) currently has five (5) seats up for appointment: the Beneficiary Member or the Parent / Guardian of a Beneficiary Member seat is currently vacant due to a resignation and needs to be filled to the unexpired term of August, 2016; the other four (4) seats are full term and expire August, 2017.

BACKGROUND / DISCUSSION:

Ventura County Board of Supervisor's enabling ordinance (Ordinance No. 4409, April 2010) and GCHP's contract with the California Department of Health Care Services required the establishment of a member / consumer based committee.

This Committee meets at least quarterly and makes recommendations, reviews policies and programs, explores issues and discusses how the Plan may fulfill its mission. The Commission originally established the Consumer Advisory Committee (CAC) to be comprised of ten (10) members with two permanent seats – one (1) for the Ventura County Health Care Agency and one (1) for the Ventura County Human Services Agency. In 2013, the Commission expanded the Committee by adding an eleventh seat designated for a Beneficiary Member or the Parent / Guardian of a Beneficiary Member.

Each of the appointed members, with the exception of the two permanent seats, serves a two-year term, and individuals can apply for re-appointment as there are no term limits.

The eleven (11) voting members represent a constituency served by the Plan. Committee members may include representation from the following:

- County Health Care Agency
- County Human Services Agency
- Child Welfare Services Agency

Members with:

- Chronic Medical Conditions
- Disabilities
- Special needs

Other Medi-Cal beneficiaries:

- Foster Children
- Persons with Disabilities and Special Needs
- Seniors

GCHP received one (1) application for the Beneficiary Member or Parent / Guardian of Beneficiary Member Seat which is currently vacant and needs to be filled to the unexpired term of August, 2016.

Beneficiary Member or Parent / Guardian of Beneficiary Member
Gilda Macias has been a volunteer with the Salvation Army Community Service programs. She assisted the Youth Director with after-school programs, worked in the Food Pantry and provided support to the administrative office.

Four (4) current members of the CAC have requested to remain on the Committee. Following is a brief biography for those members along with the seat they hold:

Medi-Cal Beneficiaries
Alicia Flores is the CEO of La Hermandad which is an organization whose mission is to address the legal, social, education, and economical inequities facing immigrants, their families, youth and the senior population. Alicia and her organization are strong advocates for their population. Alicia Flores is also an Accredited Representative by the Board of Immigration Appeals and belongs to the Congress of California Seniors.

Persons with Special Needs
Laurie Jordan works for the Rainbow Connection FRC at the Tri-Counties Regional Center. Laurie has been with the Rainbow Connection for over twenty (20) years providing

information, training and support for children and adults with developmental disabilities and their families. Laurie also serves as a community representative on the Policy Topics subcommittee for the state ICC for Early Start. She is currently the secretary for the Community Advisory Committee for the Special Education Local Plan Area and on the Children's Services Committee of the Mental Health Board.

Seniors

Katharine Raley is the HICAP Program Manager for the County of Ventura Area Agency on Aging. She holds an AA degree in liberal arts with emphasis on healthcare and psychology. She has over forty (40) years of experience working in healthcare as a medical office manager and medical assistant for family and specialty medical practices. In September of 2006, she was awarded the Social Security Administration Regional Commissioner's Citation for providing community education on the new Medicare Prescription Part D Plans and Low Income Subsidy Program to Ventura County Medicare and Medi-Cal Beneficiaries. She states, "I always make time for projects that will help our senior population."

Persons with Disabilities

Paula Johnson is currently employed with The ARC of Ventura County as the Director of Clinical Services. She has many years working with individuals and families of adults with developmental disabilities. Her educational background includes a Master's Degree in Education and a Bachelor's Degree in Behavioral Psychology.

FISCAL IMPACT:

N/A

RECOMMENDATION:

Staff requests that the Commission appoint Members to the Consumer Advisory Committee as described above.

CONCURRENCE:

N/A

Attachments:

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AGENDA ITEM 2.b.

TO: Gold Coast Health Plan Commission

FROM: Ruth Watson, COO

DATE: September 28, 2015

RE: Appointment to Provider Advisory Committee (PAC)

SUMMARY:

The Plan has been actively recruiting applicants to fill the eleven member Provider Advisory Committee. (PAC). PAC has not convened since February 2013 as the Plan was challenged in the efforts to obtain enough applications to establish a quorum. The recruitment process has been successful and staff is presenting five (5) applicants for appointment by the Commission.

BACKGROUND / DISCUSSION:

The Ventura County Medi-Cal Managed Care Commission enabling Ordinance 4409 (April 2010) and the California Department of Health Care Services, Medi-Cal Managed Care Division contract, both require the establishment of a provider based advisory committee. Hereinafter referred to as the Provider Advisory Committee (PAC).

The ordinance requires, at a minimum, that this committee meet quarterly and make recommendations, review policies and programs, explore issues and discuss how the health plan may best fulfill its mission. The Commission established the Provider Advisory Committee (PAC) to be comprised of ten (10) voting members, with one (1) of the ten (10) positions a standing seat represented by the Ventura County Health Care Agency (VCHCA). The remaining nine (9) members serve alternating two-year terms, have no terms limits and can apply for reappointment.

In the past, the Plan has struggled to establish a quorum and PAC has not been able to meet since February 12, 2013 In order to establish a committee able to achieve a quorum of voting members to meet quarterly, GCHP has been actively recruiting with contracted providers seeking committed participants. Staff is presenting six (6) applicants for PAC membership for Commission approval. If all the applications are acceptable to the Commission, PAC meetings should begin to be scheduled in October, with actual meetings taking place no later than November of 2015.

The PAC may include, but is not limited to, individuals representing, or that represent the interest of:

a. Allied health services providers;
b. Community Clinics;
c. Hospitals;
d. Long Term Care;
e. Home Health / Hospice;
f. Nurse;
g. Physician;
h. Traditional / Safety Net;
i. VCHCA

Following is a biography of VCHCA's member.

Bryan Wong, Chief Medical Officer
Ventura County Medical Center
Experience: Practicing Family Physician since 2003 in the County of Ventura. Previously held the position of Medical Director of the Academic Family Medicine Center, a primary care clinic in Ventura. Also, associated with the Ventura County Health Care Agency (VCHCA).

Following is a brief biography of the applicants.

Sue Andersen, Vice President / Chief Financial Officer (CFO)
Health Central Coast Service Area
Experience: CFO for the Central Coast Service Area, overseeing financials for 5 hospitals, a home health care agency, 4 surgery centers, and over 100 primary and specialist physicians.

Inna Berger, President & Chief executive Officer (CEO)
Oxnard Family Circle Adult Day Health Care Center
Experience: Co-founded Oxnard Family Circle Adult Health Care Center in 2002. The Center is a community based day program, which provides an array of therapeutic and social services designed to maximize the independence of those who are living with a physical, mental or developmental challenges.

Will Garand, Vice President
Community Memorial Health System
Experience: Over 24 years in the health care industry, working with health plans, hospitals and physician organizations.

David A. Fein, Reimbursement Manager
Shield Healthcare

Experience: Over 14 years of health care experience – 8 years working directly with Medi-Cal and managed care plans on policy, reimbursement and regulatory issues. Currently Vice President of the California Association of Medical Product Suppliers (CAMPS) which is the state trade association for DME/HME.

Fred Deharo, Chief Operating Officer (COO)
Clinicas del Camino Real, Inc.
Experience: 35 years in the Community Clinic arena. Previously Associated with Clinicas del Camino Real, Inc. from 1994 to 1998. Then appointed to the Chancellor's Advisory Committee for the University of California, Riverside (UCR) new School of Medicine and served on its Graduate Medical Education Committee (GMEC) that supervised the residency training programs organized by UCR. Prior to rejoining Clinicas in 2015, worked with Inland Empire Health Plan (IEHP) and Molina Healthcare of California to improve or create access to care for their Medi-Cal members.

FISCAL IMPACT:

N/A

RECOMMENDATION:

Staff requests that the Commission appoint Members to the Provider Advisory Committee as follows.

Term Expiring June 30 2017: Sue Anderson, Inna Berger and Will Garand
Term Expiring June 30, 2016: David Fein and Fred Deharo.

CONCURRENCE:

N/A

Attachments:

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AGENDA ITEM 2.c.

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, CEO

DATE: September 28, 2015

RE: Department of Health Care Services (DHCS) Contract Amendment (Number to be determined)

SUMMARY:

The Department of Health Care Services (DHCS) submitted Package 16 to Centers for Medicare and Medicaid Services (CMS) on August 31, 2015 which extends contract term dates for multiple Health Plans to December 31, 2016. Package 16 for GCHP extends the existing term date of June 30, 2016 to December 31, 2016. The intent is to align multiple Health Plan contracts with consistent start and term dates so renegotiations can occur efficiently.

DHCS has not assigned a contract amendment number, however the Plan is being proactive by bringing it before the commission for approval so the amendment can be executed in the event it comes to the Plan while the commission is on break during the month of December.

BACKGROUND / DISCUSSION:

N/A

FISCAL IMPACT:

None.

RECOMMENDATION:

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

CONCURRENCE:

N/A

Attachments:

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AUDIT COMMITTEE CHARTER

PURPOSE
To assist the Commission in fulfilling its oversight responsibilities for the financial reporting process, the system of internal controls, the audit process, the process for monitoring compliance with laws and regulations and Gold Coast Health Plan's (GCHP) Code of Conduct and all applicable conflicts of interest laws and regulations.

AUTHORITY
The Audit Committee has authority to conduct or authorize investigations into any matters within its scope of responsibility. It is empowered to:

- Appoint, compensate, and oversee the work of any registered public accounting firm employed by the organization up to $500,000.00.
- Resolve any disagreements between management and auditors regarding financial reporting.
- Pre-approve all audit activities including projects that may not be in the audit plan.
- Retain counsel, accountants, or others to advise the Committee or assist in the conduct of an investigation, in accordance with GCHP procurement policy.
- Request and obtain information from the Plan that it requires – said requests shall be made of the Chief Executive Officer.
- Meet with Plan's officers, external auditors, or counsel, as necessary.

COMPOSITION
The Audit Committee will consist of at least three and no more than six members of the Commission. The Commission will appoint Committee members. Unless a chair is elected by the Commission, the members of the Committee may designate a chair by majority vote of the Committee.

Each Committee member will be "financially literate", as defined as being able to read and understand fundamental financial statements, including a company's balance sheet, income statement and cash flow statement. At least one member shall be designated as the "financial expert", as defined by having past employment experience in finance or accounting, requisite professional certification in accounting, or any other comparable experience or background that results in the individual being financially sophisticated. This would include having been a chief executive officer, chief financial officer, or other senior officer with financial oversight responsibilities.

Each Committee member must be able to function independently, in the best interests of GCHP, with no conflict of interest and in conformance with GCHP's Code of Conduct and all applicable conflict of interest laws and regulations.

MEETINGS
The Committee will meet at least four times a year, with authority to convene additional meetings, as circumstances require in accordance with the Brown Act. All Committee members are expected to attend each meeting. The Committee will invite members of management, auditors or others to attend meetings and provide pertinent information, as necessary.

RESPONSIBILITIES
The Committee will carry out the following responsibilities:

Financial Statements

- Review significant accounting and reporting issues, including complex or unusual transactions and other areas of higher concern for the Committee, and recent professional and regulatory pronouncements, and understand their impact on the financial statements.
- Review with management and the external auditors the results of the audit, including any findings or difficulties encountered.
- Review the annual financial report, and consider whether it is complete, consistent with information known to Committee members, and reflects appropriate accounting principles.
- Review other sections of the annual report and related regulatory filings before release and consider the accuracy and completeness of the information.
- Review with management and the external auditors all matters required to be communicated to the Committee under generally accepted auditing standards.
- Understand how management develops interim financial information, and the nature and extent of internal and external auditor involvement.

Internal Control

- Understand the scope of internal and external auditors' review of internal control over financial reporting, and obtain reports on significant findings and recommendations, together with management's response.
- Consider the effectiveness of the Plan's internal control system, including information technology security and controls.
- Consider efficiencies of satisfying compliance and other regulatory requirements through effective internal controls.

Internal Audit

- Approve the Internal Audit Policy and Procedures.
- Approve the annual audit plan and all major changes to the plan. Review the internal audit activity's performance relative to its plan.

- Review with the Internal Auditor (known as Chief Audit Executive (CAE) in Best Practices) the internal audit budget, resource plan, activities, and organizational structure of the internal audit function.
- Review the effectiveness of the internal audit function, including conformance with The Institute of Internal Auditors' Definition of Internal Auditing, Code of Ethics, and the *International Standards for the Professional Practice of Internal Auditing.*

Compliance

- Review the effectiveness of the system for monitoring compliance with laws and regulations and the results of management's investigation and follow-up (including disciplinary action) of any instances of non-compliance.
- Review the findings of any examinations by regulatory agencies, and any auditor observations.
- Review the process for communicating the Code of Conduct to Plan personnel, and for monitoring compliance therewith.
- Obtain regular updates from management and Plan legal counsel regarding compliance matters.

Reporting Responsibilities

- Regularly report to the Commission about Committee activities, issues, and related recommendations.
- Provide an open avenue of communication between internal audit, the external auditors, the Executive / Finance Committee and the Commission.
- Report annually to the Commission, describing the Committee's composition, responsibilities, and how they were discharged, and any other information required by rule, including approval of non-audit services.
- Review any other reports concerning organization issues that relate to Committee responsibilities.

Other Responsibilities

- Perform other activities related to this charter as requested by the Commission.
- Institute and oversee special investigations as needed.
- Review and assess the adequacy of the Committee's charter annually, any changes to said charter must be presented to the Commission for approval and ensure appropriate disclosure as may be required by law or regulation.
- Confirm annually that all responsibilities outlined in this charter have been carried out.

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AGENDA ITEM 2.e.

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, CEO

DATE: September 28, 2015

RE: Adoption of a Cultural Diversity Program, Including the Creation of an Human Resources, Cultural Diversity Subcommittee to Among Other Things, Initiate a Diversity Intervention Project, a Cultural Diversity Hotline and Potential Agreement with the Ventura County Human Resources Division or a Third Party to Facilitate the Initiation of the Diversity Intervention Project.

SUMMARY:

The Gold Coast Health Plan (Plan) and the Commission are committed to maintaining a workplace that is diverse and culturally sensitive. The Executive staff, working with the Plan's employees and the Commission, are committed to implementing measures that will improve diversity and cultural sensitivity within the Plan. The recommended action would establish a Cultural Diversity Program, which would include two initial measures: (1) the creation of a Cultural Diversity Subcommittee of the Commission, and (2) the establishment of a cultural diversity hotline. Additionally, pending the hiring of a Chief Diversity Officer, the Commission is asked to consider directing staff to enter into a contract with the Ventura County Human Resources Division or a third party to assist with initiation of the Cultural Diversity Program.

BACKGROUND / DISCUSSION:

The Commission is being asked to take several actions that, in conjunction with concurrent actions of the Board of Supervisors, will take positive steps towards the establishment of a Cultural Diversity Program. Executive staff has been committed to developing measures that will continue to further this goal and has met with the County of Ventura to discuss the proposed measures.

Upon the effective date of an ordinance, if adopted, the Plan would establish the new position of Chief Diversity Officer. The Chief Diversity Officer will be appointed by the Commission

and will have responsibility to implement a Cultural Diversity Program. The Chief Diversity Officer will also have authority to take disciplinary action against an employee, except the Chief Executive Officer, for failure to comply with the Cultural Diversity Program. It is the intent of the Board of Supervisors that the Chief Diversity Officer will work closely with the Commission and Chief Executive Officer, especially on matters involving disciplinary issues.

In conjunction with actions of the Board of Supervisors, staff is recommending that the Commission take two actions at this time: The first is the creation of a Cultural Diversity Subcommittee. The proposed Subcommittee will report directly to the Commissioners and will be responsible for overseeing the Plan's Cultural Diversity Program. In particular, the Subcommittee will be responsible for working with the Human Resources Department on the recruitment of the Chief Diversity Officer and in the development of a Diversity Intervention Project. The purpose of the Diversity Intervention Project is to create and implement increased cultural diversity programs, such as completing a baseline cultural survey, overseeing additional training and ongoing needs assessment, and other measures supporting cultural diversity. The Commission is asked to determine the size and membership of the Subcommittee. Legal advice to the Subcommittee will be provided by Joseph Ortiz, a partner in the Labor and Employment Practice Group of Best Best & Krieger, LLP., the Plan's general counsel.

The second recommendation is to establish a cultural diversity hotline. The proposed hotline would be monitored by an independent third party and would provide a mechanism for employees to lodge complaints or comments about cultural diversity issues that arise related to employment within the Plan. Staff intends to contract out for the hotline service and any investigations of complaints will be overseen by the Chief Diversity Officer and the Human Resources Department.

Finally, as it will take some time to recruit and hire a Chief Diversity Officer, the Commission may consider entering into an agreement with the Ventura County Human Resources Division to begin creating and implementing the Diversity Intervention Program and the hotline on the Plan's behalf until an official is appointed as the Chief Diversity Officer. Alternatively, as the Plan is about to hire a new Director of Human Resources, the Commission can have the new Human Resources Director assume this function until the Chief Diversity Officer is hired. Lastly, the Commission could contract with a third party for this function until the Chief Diversity Officer is hired. Staff is currently gathering information on these options and will discuss these in more detail at the Commission meeting.

FISCAL IMPACT:

Establishment of the Subcommittee will not result in any immediate fiscal impacts. The Diversity Intervention Program is likely to have fiscal impacts, but the extent of such impacts are unknown at this time.

The mandated hiring of the Chief Diversity Officer and any staff will incur salary plus support costs.

Establishment of the hotline will require the Plan to incur costs for a toll-free telephone number, as well as costs for a third party to monitor and report on calls received.

The costs of any agreement with the County or a third party will be based on the scope of services requested to be performed.

RECOMMENDATION:

Staff recommends the following:

1. That the Commission establish a Cultural Diversity Subcommittee to be tasked with developing a Diversity Intervention Project.
2. That the Commission establish a cultural diversity hotline and hiring of a third party to monitor and work with Plan staff on following up on reports made to the hotline.
3. That the Commission discuss and provide direction on whether to enter an agreement with the Ventura County Department of Human Resources or a third party to implement the Diversity Intervention Program until a Chief Diversity Officer is appointed or keep the function in house pending the hiring of a Chief Diversity Officer.

CONCURRENCE:

N/A

Attachments:

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AGENDA ITEM 3.a.

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, CEO

DATE: September 28, 2015

RE: CEO Update

GOVERNMENT RELATIONS:

End of the California Legislative Session

On September 11, 2015 the State Legislature adjourned and ended the first year of a two-year legislative session. The bill (SB 260) that would have required all COHS plans to be Knox-Keene licensed did not pass in the legislature. The bill's author and supporters of SB 260 have indicated their intent to reintroduce the bill in January 2016. A number of Medi-Cal related bills were passed and sent to Governor Brown for signature. Among these were: AB 1231 which proposes to include nonmedical transportation as part of the Medi-Cal schedule of benefits. SB 137 requires that health plan online provider directories be updated at least weekly. SB 36 authorizes DHCS to request a temporary extension for the existing 1115 waiver if CMS has not approved the waiver renewal by November 1, 2015. AB 187 Extends the carve-out of California Children's Services (CCS) from Medi-Cal managed care until January 1, 2017.

Per State Constitution Governor Brown has until October 11, 2015 to either sign or veto the bills on his desk or they become law.

Managed Care Organization Tax

The Legislature and the Governor, as well as commercial health plans, could not come to agreement on an alternative managed care organization tax (MCO Tax) in the legislative session that ended on September 11, 2015. Governor Brown has called an extraordinary session of the Legislature to address the MCO Tax issue and fund state road and infrastructure projects. The Administration is hopeful that an alternative MCO Tax solution can be found by late fall of this year.

Since 2005 California has used several versions of an MCO Tax to annually generate approximately $1.2 billion for the Medi-Cal program. In July 2014 the Centers for Medicare and Medicaid Services (CMS) ruled that California's MCO Tax structure is not compliant with federal law. The CMS gave California until the end of the 2016 legislative session to propose

a federally compliant MCO Tax or eliminate it altogether.

Medi-Cal Coverage for Undocumented Children
Approximately 120,000 beneficiaries will transition from limited to full-scope Medi-Cal no sooner than May 1, 2016. Beneficiaries in private health plans including Kaiser Permanente are NOT included in this number. Only beneficiaries with limited-scope aid codes are accounted in this tally.

DHCS is working with commercial health plans to send out information to their beneficiaries regarding the upcoming changes. The target date for managed care enrollment is scheduled no sooner than July 1, 2016. Sixty (60) day notices will be sent to beneficiaries no sooner than May 1, 2016. DHCS has indicated that no new aid codes will be used for this expansion population.

Ventura Council for Seniors Medical Transportation Forum
On September 16, 2015, GCHP's Director of Government Affairs participated in the Ventura Council for Seniors Medical Transportation Forum held at the Salvation Army Silvercrest Retirement Residence in Ventura.

The purpose of this forum was to provide information to seniors and persons with disabilities on transportation resources available in Ventura County. Legislation (AB 1231) was passed by the Legislature to include nonmedical transportation as part of the Medi-Cal schedule of benefits subject to utilization controls and federally permissible time and distance standards. Currently the Medi-Cal program offers nonemergency medical transportation to beneficiaries via contracted providers. AB 1231 proposes to cover the cost of transportation by passenger car, taxicab, or any other form of public or private conveyance not contracted by a health plan.

Attached for your reference is a comprehensive list of Medi-Cal legislation that was debated during this session of the State Legislature.

Legislative Bills

Bill	Summary	Potential Impact to GCHP
AB 187: Medi-Cal managed care: California Children's Services Program**.** **Status:** Sent to the Governor **Impact:** **Low**	Extends the carve-out of California Children's Services (CCS) from Medi-Cal managed care until January 1, 2017.	CCS services would be carved out from GCHP until January 2017.
AB 366: Medi-Cal Annual Access Monitoring Report. **Status:** Held in Senate Appropriations Committee **Impact:** **Low**	Requires DHCS, by March 15, 2016, and annually thereafter by February 1st, to submit to the Legislature, and post on DHCS' website a Medi-Cal access monitoring report providing an assessment of access to care in Medi-Cal. DHCS would be required to hold a public meeting to present the access monitoring report annually.	Minimal impact to GCHP.
AB 1018: Medi-Cal: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). **Status:** Held in Senate Appropriations Committee **Impact:** **Low**	Requires DHCS and the Department of Education to convene a joint task force to examine the delivery of mental health services to children eligible for EPSDT. The taskforce is required to submit a report to the Legislature on key findings and recommendations.	At this time the impact is unknown.
AB 1117: Medi-Cal Vaccination Rates. **Status:** Held in Senate Appropriations Committee **Impact:** Unknown	Establishes a pilot program in Medi-Cal to reward Medi-Cal managed care organizations and providers for vaccinating children younger than two years of age.	No impact to GCHP if it does not participate in the pilot project.
AB 1231: Medi-Cal: Non-medical Transportation. **Status:** Sent to the Governor **Impact:** **Medium**	Adds to the schedule of benefits non-medical transportation services for covered specialty care that is subject to utilization controls and federally permissive time and distance standards.	Potential annual costs to health plans for this service may be significant. However, the actual cost of mandating Non-medical Transportation (NMT) as a covered benefit in Medi-Cal will depend on several factors, including the number of members requiring specialty services which are subject to uncertainty and change.

Legislative Bills

Bill	Summary	Potential Impact to GCHP
AB 1299: Specialty Mental Health Services: Foster Children. **Status:** Held in Senate Appropriations Committee. **Impact: Medium to High**	Requires that foster youth placed outside their county of original jurisdiction are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program standards and requirements.	GCHP would be required to cover mild to moderate mental health conditions. GCHP may see a flux in membership.
AB 1162: Medi-Cal: Tobacco Cessation. **Status:** Sent to the Governor **Impact: Medium**	Includes at a minimum four quit attempts per year with no required break between attempts, requires at least four tobacco cessation counseling sessions per quit attempt, and a 12 week treatment regime of any medication approved by the FDA including over-the-counter medication. At least one prescription medication and all over-the-counter medications shall be available without prior authorization.	GCHP currently follows the DHCS policy guidance put forth in September 2014. AB 1162 would require GCHP to cover the additional proposed benefits described in the bill summary section.
SB 2X 14: Tobacco: electronic cigarettes: taxes: managed care organization provider tax: in-home supportive services **Status:** Held in Senate Floor **Impact: High**	Institutes an MCO tax, increases Medi-Cal provider rates, restores the 7% cut in In-Home Supportive Services hours, and increases provider rates in the regional center system.	Based on the MCO tax tiered proposal, GCHP would be required to pay a $22 pmpm tax (rate for plans with membership up to 275,000).
SB 4: Health Care Coverage: Immigration Status. **Status:** Sent to the Governor **Impact: High**	Provides Medi-Cal coverage to all eligible children under 19 years old regardless of immigration status. Transition of children in restricted scope Medi-Cal to full-scope Medi-Cal will commence after the Director of DHCS determines that the systems have been programmed for implementation but no sooner than May 1, 2016.	The FY 2015-16 state budget includes full-scope Medi-Cal coverage for all eligible children regardless of immigration status up to age 19. GCHP enrollment is expected to increase.
SB 33: Medi-Cal: Estate Recovery. **Status:** Moved to Inactive File **Impact: Low**	Limits the Medi-Cal estate recovery to only those services required to be covered under the federal Medicaid law. Would eliminate estate recovery against the estate of a surviving spouse of a deceased Medi-Cal beneficiary.	No Impact to GCHP.

Legislative Bills

Bill	Summary	Potential Impact to GCHP
SB 36: Medi-Cal: demonstration project. **Status**: Sent to the Governor **Impact: High**	Authorizes DHCS to request a temporary extension for the existing 1115 waiver if CMS has not approved the 1115 waiver renewal before November 1, 2015. The proposed "Medi-Cal 2020" waiver is expected to bring between $15-$20 billion to Medi-Cal over a five year period.	There are additional pilot demonstration programs in the waiver that GCHP could participate in such as health homes and workforce development pilot programs.
SB 137: Health Care Coverage: Provider Directories. **Status:** Sent to the Governor **Impact: High**	Requires the online provider directory to be updated at least weekly. Authorizes health plans to delay payment or reimbursement owed to a provider or provider group after steps have been taken to obtain a response to the provider.	Requires GCHP to update its online provider directory on a weekly basis.
SB 260: Medi-Cal: County Organized Health Systems. **Status:** Moved to Inactive File **Impact: High**	Requires County Organized Health Services (COHS) plans to become fully Knox Keene licensed within 18 months of enactment.	Subjects GCHP to all current and proposed laws / regulations under the Knox Keene Act and the Department of Managed Health Care. Undetermined staffing and administrative costs.
SB 586: California Children's Services Program. **Status:** Held in Assembly Committee on Health. **Impact: Low**	Requires DHCS to enter into contracts with one or more Kids Integrated Delivery System (KIDS) to provide CCS and Medi-Cal services to eligible children. Makes permanent, the CCS "carve-out" of services from Medi-Cal managed care.	Would permanently "carve-out" CCS services from GCHP.
SB 614: Medi-Cal: mental health services: peer, parent, and family support specialist certification. **Status:** Moved to Inactive File **Impact: Unknown**	Requires DHCS to establish a program for certifying peer and family support specialists (PFSS) and seek federal waivers or state plan amendments to implement the certification program.	Uncertain impact on Medi-Cal managed care plans that provide mental health services to Medi-Cal beneficiaries when the mental illness is not severe.

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AGENDA ITEM 3.b.

TO: Gold Coast Health Plan Commission

FROM: Patricia Mowlavi, CFO

DATE: September 28, 2015

RE: CFO Update - June 2015 Financials

SUMMARY:

Staff is presenting the attached unaudited fiscal year ending June 30, 2015 financial statements (FY 2014-15) of Gold Coast Health Plan (Plan) to accept and file. The Executive / Finance Committee did not meet in September to review the FY 2014-15 financials.

BACKGROUND / DISCUSSION:

The staff has prepared the FY 2014-15 financial package, including statement of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Highlights:

Overall performance – For the fiscal year ending June 30, 2015, the Plan's gain in unrestricted net assets was approximately $51.6 million compared to the $17.7 million budget. The favorable variance was driven by strong membership growth and lower than anticipated cost of health care.

Tangible Net Equity – Favorable operating results contributed to a Tangible Net Equity (TNE) level of approximately $107.1 million, which exceeded both the budget of $50.0 million by $57.2 million and the State minimum required TNE amount of $22.6 million by $84.6 million. June's TNE was 443% of the State required TNE, excluding the $7.2 million County of Ventura lines of credit (LOC).

Membership – June membership of 194,664 exceeded budget by 28,880 members. The average monthly members for FY 2014-15 were approximately 48,110 greater (or approximately 577,000 member months) than the previous fiscal year, resulting in an increase of 37% in total membership. The increase was primarily in the Adult Expansion (AE) category, accounting for 64% of the total growth in membership.

Revenue – Fiscal year to date, net revenue was $596.2 million or $315,000 favorable to budget. Net revenue increased by $193.5 million or 48% in FY 2014-15 over FY 2013-14; largely due to the increase in membership with higher capitation rates (Adult Expansion). The average net revenue per-member-per-month was $279.79 for FY 2014-15; approximately 8% higher than FY 2013-14.

Revenue includes an $89.4 million reserve for rate reductions associated with AE. This reserve represents an expected refund, to the Department of Health Care Services (DHCS), of rate overpayments (DHCS is paying at 7/1/14 rates rather than the 1/1/15 published rates) and the anticipated refund of revenue to achieve a medical loss ratio (MLR) of 85%, for this aid category. (The MLR is calculated by dividing health care costs by revenue.)

Health Care Costs – For the Year, health care costs were $509.2 million or $33.9 million favorable to budget. Health care cost increased by $181.9 million or 56% in FY 2014-15 over FY 2013-14, driven by increased membership. The MLR for the current year is 85% versus 81% in FY 2013-14. Additional detail by major line item follows:

- Capitation – For the year, capitation was $95.3 million or $62.3 million over budget. The Enhanced Adult Capitation program was launched in June, with the effect of recognizing nearly $53.0 million of previously reserved claims expense as capitation. The remaining variance was due to stronger than budgeted membership growth.
- Fee for Service – For the year, total claims expense was $398.6 million compared to a budget of $494.7 million. While there was some movement of services between categories, the overall variance is comprised of the $44.0 million in Pharmacy savings and the re-casting of $53.0 million in AE FFS expense as capitation.
- LTC / SNF – New AB1629 rates were published by DHCS in late January. However, a later announcement by DHCS indicated that the rates contained errors and delayed final processing until the rates were corrected. Increases had been accrued through the year and the final settlement of the rate adjustments was made at the end of June.
- Pharmacy – For the year, overall Pharmacy was $69.1 million or $44.0 million favorable to budget. Lower than expected utilization in the AE category contributed to savings, however AE Pharmacy has been trending higher.

Administrative Expenses – For the year, administrative costs totaled $35.4 million or $313,000 unfavorable to budget. Operating expenses increased by $3.7 million or 12% in FY 2014-15 over the prior fiscal year. The primary contributors to the year-over-year increase

and unfavorable variance were legal expenses and operating expenses driven by membership such as Outside Services (ACS / Beacon).

The administrative cost ratio (ACR) for the year ended June 30, 2015 was 6.0% as compared to 7.9% in FY 2013-14. (The ACR is calculated by dividing administrative expenses by total revenue.)

Cash and Medi-Cal Receivable – Total Cash and Medi-Cal Premium Receivable balances were $352.1 million, as of June 30, 2015. This includes pass-through payments for AB 85 of $3.8 million and Managed Care Organizations (MCO) tax of $3.7 million. Excluding the impact of the pass through amount, the total of Cash and Medi-Cal Receivable balance as of June 30, 2015 was $344.6 million or $170.5 million better than the budgeted level of $174.1 million.

Investment Portfolio – As of June 30, 2015, the value the investments are as follows:

- Short-term Investments $165.1 million: Cal Trust $60.1 million; Ventura County Investment Pool $55.0 million; Commercial paper and bonds $50.0 million.
- Long-term Investments (Bonds) $24.6 million.

RECOMMENDATION:

Staff requests the Commission accept and file the unaudited FY 2014-15 financial statements package.

CONCURRENCE:

N/A

Attachments:

June 2015 Financials

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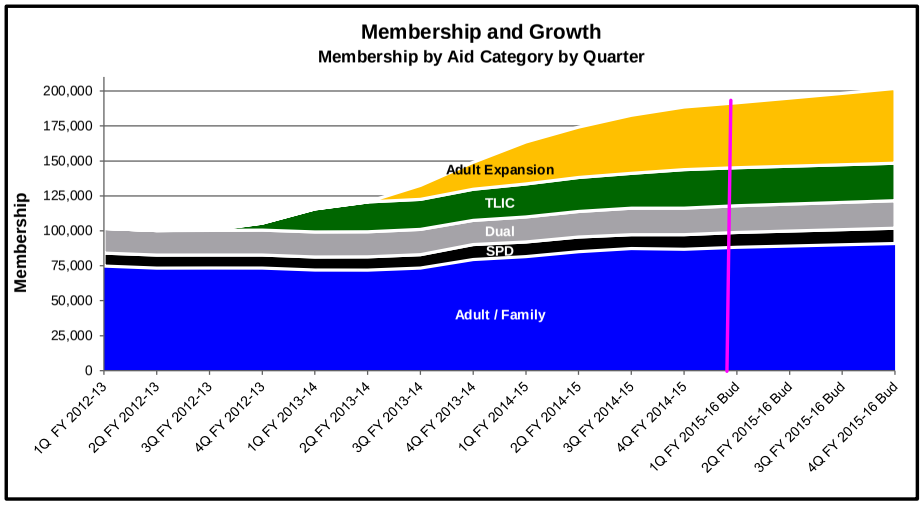
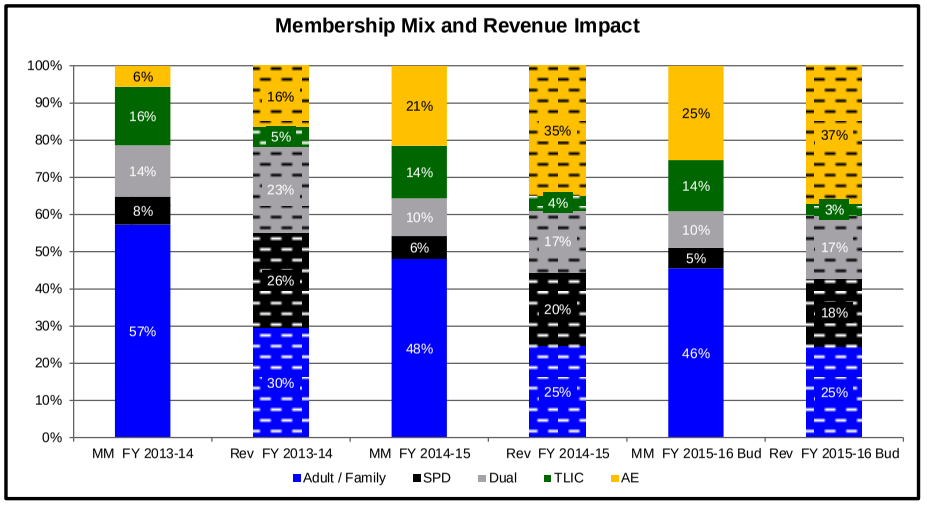
FINANCIAL PACKAGE
For the month ended June 30, 2015

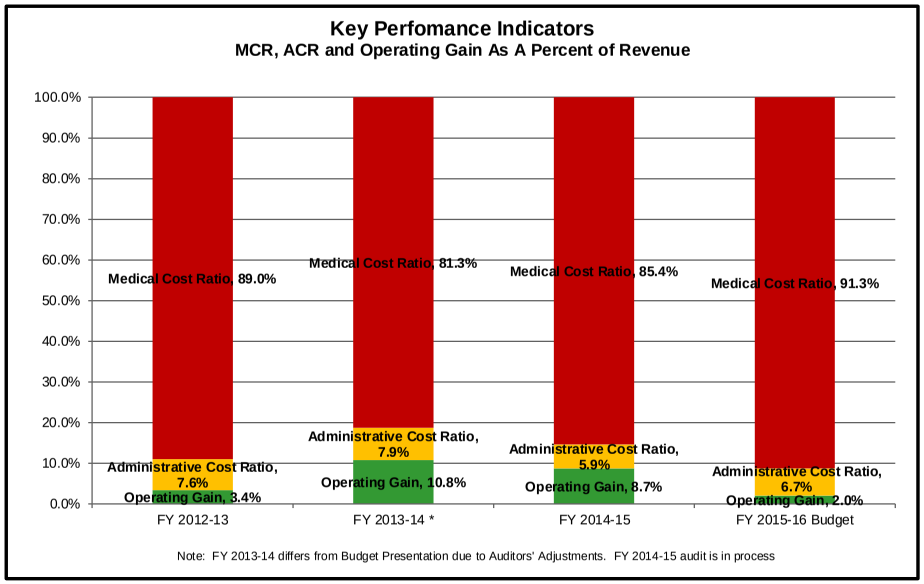
TABLE OF CONTENTS

APPENDIX

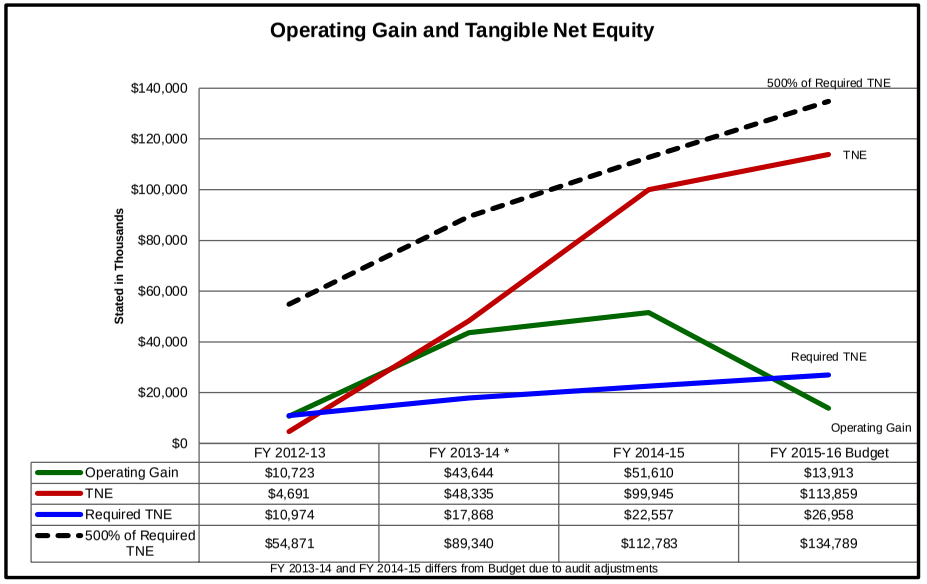
Financial Performance
For Fiscal Year Ending June 30, 2015







Note: FY 2013-14 differs from Budget Presentation due to Auditors' Adjustments. FY 2014-15 audit is in process



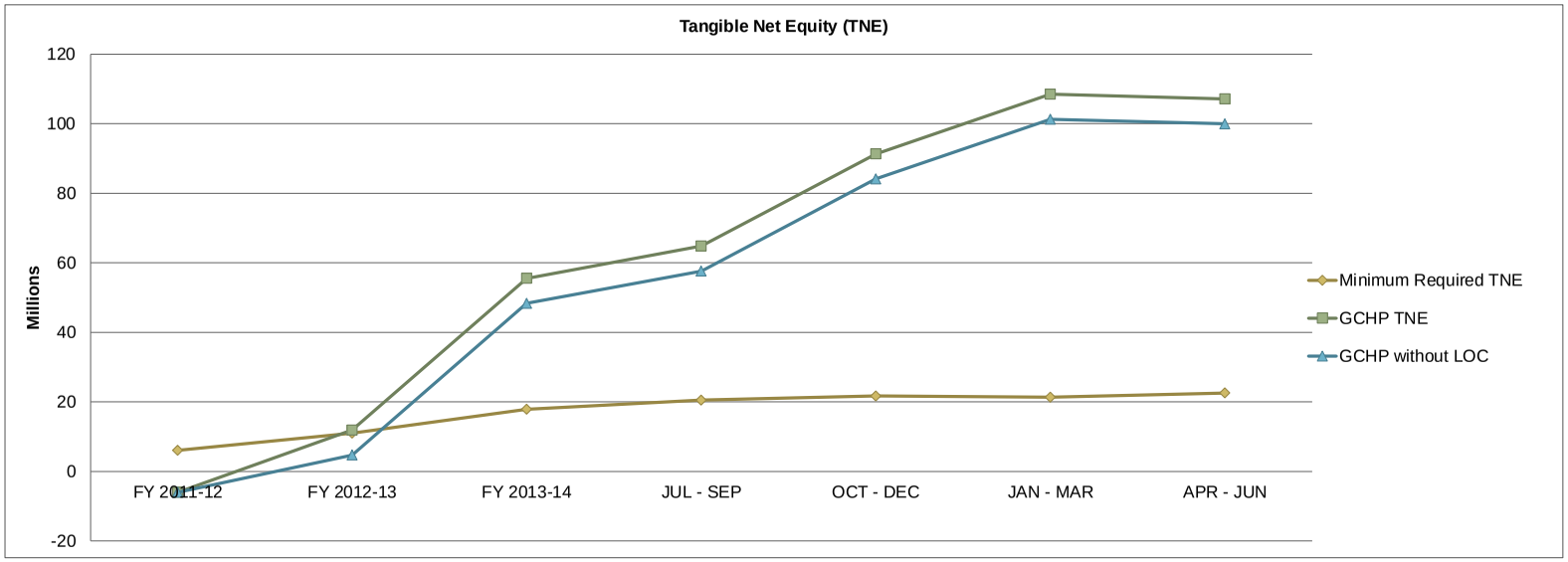
	FY 2012-13	FY 2013-14 *	FY 2014-15	FY 2015-16 Budget
Operating Gain	$10,723	$43,644	$51,610	$13,913
TNE	$4,691	$48,335	$99,945	$113,859
Required TNE	$10,974	$17,868	$22,557	$26,958
500% of Required TNE	$54,871	$89,340	$112,783	$134,789

FY 2013-14 and FY 2014-15 differs from Budget due to audit adjustments

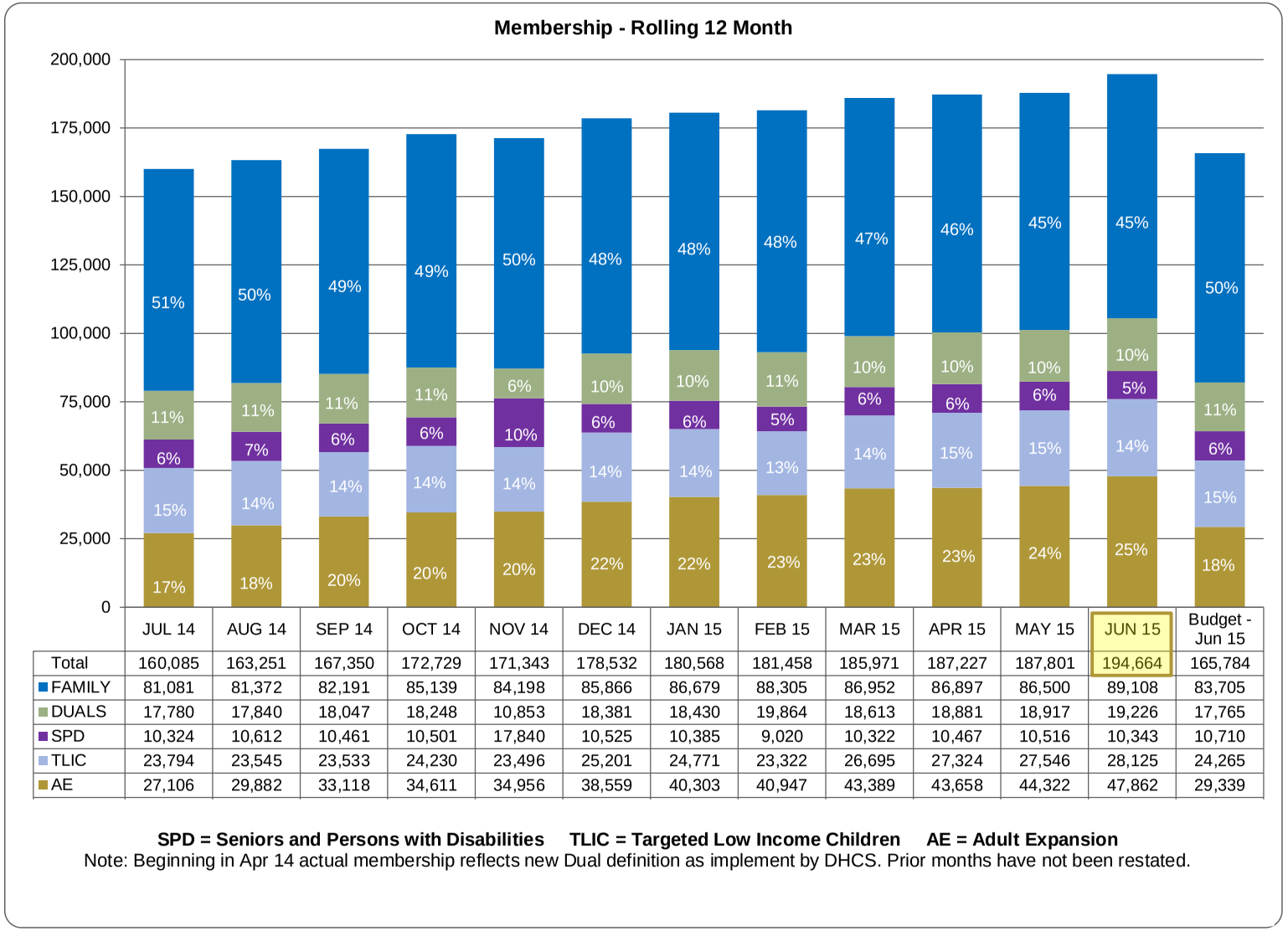
GOLD COAST HEALTH PLAN
Financial Results Summary

Description	AUDITED* FY 2011-12	AUDITED* FY 2012-13	UNAUDITED FY 2013-14	FY 2014-15 JUL - SEP	FY 2014-15 OCT - DEC	FY 2014-15 JAN - MAR	FY 2014-15 APR - JUN	FY 2014-15 FY 2014-15	Budget Comparison Budget YTD	Budget Comparison Variance Fav / (Unfav)	Budget Comparison Variance Fav / (Unfav)%
Member Months	**1,258,189**	**1,223,895**	**1,553,660**	**490,686**	**522,604**	**547,997**	**569,692**	**2,130,979**	**1,941,580**	189,399	9.8 %
Revenue	**304,635,932**	**315,119,611**	**402,701,476**	**158,761,380**	**142,036,566**	**123,095,167**	**172,326,168**	**596,219,281**	**595,903,739**	315,543	0.1 %
pmpm	*242.12*	*257.47*	*259.20*	*323.55*	*271.79*	*224.63*	*302.49*	*279.79*	*306.92*	(27.13)	(8.8)%
Health Care Costs	**287,353,672**	**280,382,704**	**327,305,832**	**141,486,486**	**106,577,061**	**96,973,428**	**164,146,293**	**509,183,268**	**543,045,560**	33,862,292	6.2 %
pmpm	*228.39*	*229.09*	*210.67*	*288.34*	*203.93*	*176.96*	*288.13*	*238.94*	*279.69*	40.75	14.6 %
% of Revenue	94.3%	89.0%	81.3%	89.1%	75.0%	78.8%	95.3%	85.4%	91.1%	5.7 %	6.3 %
Admin Exp	**18,891,320**	**24,013,927**	**31,751,533**	**7,994,304**	**8,969,982**	**8,943,041**	**9,518,632**	**35,425,960**	**35,113,175**	(312,785)	(0.9)%
pmpm	*15.01*	*19.62*	*20.44*	*16.29*	*17.16*	*16.32*	*16.71*	*16.62*	*18.08*	1.46	8.1 %
% of Revenue	6.2%	7.6%	7.9%	5.0%	6.3%	7.3%	5.5%	5.9%	5.9%	(0.0)%	(0.8)%
Total Increase / (Decrease) in Unrestricted Net Assets	**(1,609,063)**	**10,722,980**	**43,644,110**	**9,280,590**	**26,489,523**	**17,178,698**	**(1,338,757)**	**51,610,053**	**17,745,003**	33,865,050	190.8 %
pmpm	*(1.28)*	*8.76*	*28.09*	*18.91*	*50.69*	*31.35*	*(2.35)*	*24.22*	*9.14*	15.08	165.0 %
% of Revenue	-0.5%	3.4%	10.8%	5.8%	18.6%	14.0%	-0.8%	8.7%	3.0%	5.7%	190.7 %
YTD											
100% TNE	16,769,368	16,138,440	17,867,986	20,504,473	21,693,747	21,318,823	22,556,530	22,556,530	26,401,872	(3,845,342)	(14.6)%
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%		
Minimum Required TNE	6,036,972	10,974,139	17,867,986	20,504,473	21,693,747	21,318,823	22,556,530	22,556,530	26,401,872	(3,845,342)	(14.6)%
GCHP TNE	**(6,031,881)**	**11,891,099**	**55,535,211**	**64,815,801**	**91,305,324**	**108,484,021**	**107,145,264**	**107,145,264**	49,982,694	**57,162,570**	**114.4 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**37,667,225**	**44,311,328**	**69,611,576**	**87,165,198**	**84,588,734**	**84,588,734**	**23,580,821**	**61,007,912**	**258.7 %**
% of Required TNE level			**311%**	**316%**	**421%**	**509%**	**475%**	**475%**	**189%**		
% of Required TNE level (excluding $7.2 million LOC)			**271%**	**281%**	**388%**	**475%**	**443%**	**443%**	**162%**		

Note: TNE amount includes $7.2 million related to the Lines of Credit (LOC) from Ventura County.
* Audited amounts reflect financial adjustments made by auditors, but exclude presentation reclassifications without P&L impact (i.e. reporting package kept the same).



GOLD COAST HEALTH PLAN



	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	JUN 15	Budget - Jun 15
Total	160,085	163,251	167,350	172,729	171,343	178,532	180,568	181,458	185,971	187,227	187,801	194,664	165,784
FAMILY	81,081	81,372	82,191	85,139	84,198	85,866	86,679	88,305	86,952	86,897	86,500	89,108	83,705
DUALS	17,780	17,840	18,047	18,248	10,853	18,381	18,430	19,864	18,613	18,881	18,917	19,226	17,765
SPD	10,324	10,612	10,461	10,501	17,840	10,525	10,385	9,020	10,322	10,467	10,516	10,343	10,710
TLIC	23,794	23,545	23,533	24,230	23,496	25,201	24,771	23,322	26,695	27,324	27,546	28,125	24,265
AE	27,106	29,882	33,118	34,611	34,956	38,559	40,303	40,947	43,389	43,658	44,322	47,862	29,339

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

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

Statement of Financial Position

	06/30/15	05/31/15	04/30/15	Unaudited FY 2013-14
ASSETS				
Current Assets:				
Total Cash and Cash Equivalents	**$ 57,218,141**	**$ 107,850,902**	**$ 156,092,662**	**$ 60,176,698**
Total Short-Term Investments	**165,090,357**	**205,076,483**	**205,047,085**	**0**
Medi-Cal Receivable	129,782,958	69,107,424	8,498,119	119,538,688
Interest Receivable	208,010	287,272	204,622	0
Provider Receivable	579,482	591,258	585,800	395,129
Other Receivables	979,647	172,194	171,605	1,821,475
Total Accounts Receivable	**131,550,096**	**70,158,148**	**9,460,146**	**121,755,292**
Total Prepaid Accounts	766,831	823,387	1,006,954	994,278
Total Other Current Assets	81,702	81,702	81,702	81,719
Total Current Assets	**354,707,127**	**383,990,623**	**371,688,548**	**183,007,987**
Total Fixed Assets	**1,084,113**	**1,086,020**	**1,089,289**	**1,163,269**
Total Long-Term Investments	**24,647,362**	**24,670,537**	**24,693,694**	**0**
Total Assets	**$ 380,438,602**	**$ 409,747,179**	**$ 397,471,531**	**$ 184,171,256**
LIABILITIES & NET ASSETS				
Current Liabilities:				
Incurred But Not Reported	$ 52,372,146	$ 55,781,033	$ 62,367,135	$ 40,304,158
Claims Payable	13,747,426	14,281,478	11,070,028	9,482,660
Capitation Payable	34,466,106	17,313,542	16,742,499	12,444,575
Physician ACA 1202 Payable	10,965,642	11,160,498	11,160,498	12,765,516
AB 85 Payable	3,818,147	6,454,343	7,996,045	2,325,587
Accounts Payable	3,449,087	648,141	2,047,893	2,875,709
Accrued ACS	1,480,556	2,811,440	1,428,930	0
Accrued Expenses	6,249,194	6,139,852	6,350,385	5,748,120
Accrued Premium Tax	3,641,573	119,599	4,282,566	15,925,782
Accrued Interest Payable	70,711	67,968	66,047	42,062
Current Portion of Deferred Revenue	460,000	460,000	460,000	460,000
Accrued Payroll Expense	1,152,720	942,711	789,471	760,032
Total Current Liabilities	**131,873,310**	**116,180,605**	**124,761,498**	**103,134,200**
Long-Term Liabilities:				
DHCS - Reserve for Capitation Recoup	140,970,602	168,470,602	154,785,278	24,970,000
Other Long-term Liability-Deferred Rent	449,427	415,985	379,891	71,845
Deferred Revenue - Long Term Portion	0	38,333	76,667	460,000
Notes Payable	7,200,000	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	**148,620,029**	**176,124,920**	**162,441,836**	**32,701,845**
Total Liabilities	**280,493,338**	**292,305,525**	**287,203,334**	**135,836,045**
Net Assets:				
Beginning Net Assets	48,335,211	48,335,211	48,335,211	4,691,101
Total Increase / (Decrease in Unrestricted Net Assets)	51,610,053	69,106,443	61,932,986	43,644,110
Total Net Assets	**99,945,264**	**117,441,654**	**110,268,197**	**48,335,211**
Total Liabilities & Net Assets	**$ 380,438,602**	**$ 409,747,179**	**$ 397,471,531**	**$ 184,171,256**

FINANCIAL INDICATORS				
Current Ratio	2.69 : 1	3.31 : 1	2.98 : 1	1.77 : 1
Days Cash on Hand	67	250	292	116
Days Cash + State Capitation Rec	107	306	299	347
Days Cash + State Capitation Rec (less Tax Liab)	106	305	295	316

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2014-15 Monthly Trend			Current Month		
	MAR 15	APR 15	MAY 15	JUNE 15		Variance
				Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	185,971	187,227	187,801	194,664	165,784	28,880
Revenue:						
Premium	$ 59,433,011	$ 60,117,248	$ 60,609,305	$ 57,237,879	$ 54,390,188	$ 2,847,691
Reserve for Rate Reduction	(14,663,168)	(12,032,264)	(13,685,324)	27,500,000	0	27,500,000
MCO Premium Tax	(4,806,046)	(2,083,799)	(2,386,510)	(3,344,080)	(2,141,614)	(1,202,466)
Total Net Premium	**39,963,798**	**46,001,185**	**44,537,471**	**81,393,799**	**52,248,574**	**29,145,225**
Other Revenue:						
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	(0)
Total Other Revenue	38,333	38,333	38,333	38,333	38,333	(0)
Total Revenue	**40,002,131**	**46,039,519**	**44,575,805**	**81,432,133**	**52,286,907**	**29,145,225**
Medical Expenses:						
Capitation (PCP, Specialty, Kasier, NEMT & Vision)	4,052,943	4,334,304	4,406,664	57,292,433	2,868,959	(54,423,474)
FFS Claims Expenses:						
Inpatient	5,097,394	6,477,031	6,776,899	7,345,269	10,827,474	3,482,205
LTC / SNF	5,762,933	6,819,386	6,139,754	6,314,577	7,616,693	1,302,116
Outpatient	2,281,965	2,230,932	2,355,940	7,358,224	2,831,126	(4,527,098)
Laboratory and Radiology	162,651	11,628	196,578	(2,687,938)	880,293	3,568,231
Emergency Room	1,194,168	1,010,132	1,052,564	2,005,556	1,680,489	(325,067)
Physician Specialty	2,021,708	2,379,637	2,605,488	10,079,684	3,466,750	(6,612,933)
Primary Care Physician	934,447	774,095	830,822	(8,639,511)	2,804,258	11,443,769
Home & Community Based Services	956,829	812,703	698,217	1,287,871	836,758	(451,113)
Applied Behavior Analysis Services	11,165	14,727	20,429	27,547	0	(27,547)
Mental Health Services	678,589	684,279	697,231	703,182	784,837	81,655
Pharmacy	6,006,966	6,129,485	6,312,066	6,691,948	9,428,704	2,736,756
Adult Expansion Reserve	0	0	0	8,100,000	0	(8,100,000)
Other Medical Professional	151,825	74,024	150,919	16,819	293,511	276,692
Other Medical Care	0	341	0	0	0	0
Other Fee For Service	660,972	641,698	627,872	(322,299)	974,907	1,297,206
Transportation	(50,918)	108,496	65,367	(764,134)	347,585	1,111,719
Total Claims	25,870,693	28,168,594	28,530,146	37,516,794	42,773,386	5,256,592
Medical & Care Management Expense	1,079,869	1,087,702	1,112,867	1,102,685	1,127,045	24,359
Reinsurance	480,408	492,016	535,763	(258,261)	202,257	460,518
Claims Recoveries	(100,289)	(778)	(89,868)	(84,767)	0	84,767
Sub-total	1,459,988	1,578,939	1,558,762	759,657	1,329,301	569,644
Total Cost of Health Care	**31,383,625**	**34,081,837**	**34,495,572**	**95,568,884**	**46,971,646**	**(48,597,238)**
Contribution Margin	**8,618,506**	**11,957,681**	**10,080,233**	**(14,136,751)**	**5,315,261**	**(19,452,012)**
General & Administrative Expenses:						
Salaries and Wages	736,114	683,270	840,098	789,369	874,947	85,578
Payroll Taxes and Benefits	195,625	192,640	197,312	265,818	239,262	(26,557)
Travel and Training	8,984	11,020	14,277	38,926	13,227	(25,699)
Outside Service - ACS	1,447,875	1,398,128	1,327,673	1,488,853	1,243,734	(245,119)
Outside Services - Other	153,238	235,597	164,778	168,960	123,879	(45,081)
Accounting & Actuarial Services	5,415	10,000	10,000	10,000	5,000	(5,000)
Legal	188,244	226,134	68,274	173,994	33,334	(140,660)
Insurance	32,538	39,441	38,039	53,714	14,583	(39,130)
Lease Expense - Office	65,957	65,957	68,687	63,689	64,354	665
Consulting Services	37,106	22,212	93,310	45,523	48,069	2,546
Translation Services	5,466	8,166	4,909	7,143	7,087	(56)
Advertising and Promotion	1,178	1,041	7,060	17,774	5,839	(11,935)
General Office	131,637	72,685	120,899	221,608	88,275	(133,333)
Depreciation & Amortization	18,111	19,444	19,444	19,905	32,850	12,945
Printing	365	21,226	19,038	10,792	13,365	2,573
Shipping & Postage	25,648	187	13,128	29,252	1,342	(27,910)
Interest	15,268	41,678	10,774	39,373	15,000	(24,373)
Total G & A Expenses	**3,068,769**	**3,048,826**	**3,017,700**	**3,444,694**	**2,824,147**	**(620,546)**
Total Operating Gain / (Loss)	**5,549,737**	**8,908,856**	**7,062,533**	**(17,581,445)**	**2,491,113**	**(20,072,558)**
Non Operating:						
Revenues - Interest	40,314	78,069	112,844	87,799	17,949	69,850
Expenses - Interest	2,528	2,749	1,921	2,743	0	(2,743)
Total Non-Operating	**37,785**	**75,320**	**110,923**	**85,056**	**17,949**	**67,107**
Total Increase / (Decrease) in Unrestricted Net Assets	**5,587,523**	**8,984,176**	**7,173,456**	**(17,496,389)**	**2,509,062**	**(20,005,451)**
Full Time Employees				**159**	**169**	**10**

PMPM Statement of Revenues, Expenses and Changes in Net Assets

	MAR 15	APR 15	MAY 15	JUNE 15 Actual	JUNE 15 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	185,971	187,227	187,801	194,664	165,784	28,880
Revenue:						
Premium	319.58	321.09	322.73	294.03	328.08	(34.04)
Reserve for Rate Reduction	(78.85)	(64.27)	(72.87)	141.27	0.00	141.27
MCO Premium Tax	(25.84)	(11.13)	(12.71)	(17.18)	(12.92)	(4.26)
Total Net Premium	**214.89**	**245.70**	**237.15**	**418.12**	**315.16**	**102.96**
Other Revenue:						
Interest Income	0.00	0.00	0.00	0.00	0.00	0.00
Miscellaneous Income	0.21	0.20	0.20	0.20	0.23	(0.03)
Total Other Revenue	0.21	0.20	0.20	0.20	0.23	(0.03)
Total Revenue	**215.10**	**245.90**	**237.36**	**418.32**	**315.39**	**102.93**
Medical Expenses:						
Capitation (PCP, Specialty, Kasier, NEMT & Vision)	21.79	23.15	23.46	294.31	17.31	(277.01)
FFS Claims Expenses:						
Inpatient	27.41	34.59	36.09	37.73	65.31	27.58
LTC / SNF	30.99	36.42	32.69	32.44	45.94	13.51
Outpatient	12.27	11.92	12.54	37.80	17.08	(20.72)
Laboratory and Radiology	0.87	0.06	1.05	(13.81)	5.31	19.12
Emergency Room	6.42	5.40	5.60	10.30	10.14	(0.17)
Physician Specialty	10.87	12.71	13.87	51.78	20.91	(30.87)
Primary Care Physician	5.02	4.13	4.42	(44.38)	16.92	61.30
Home & Community Based Services	5.15	4.34	3.72	6.62	5.05	(1.57)
Applied Behavior Analysis Services	0.06	0.08	0.11	0.14	0.00	(0.14)
Mental Health Services	3.65	3.65	3.71	3.61	4.73	1.12
Pharmacy	32.30	32.74	33.61	34.38	56.87	22.50
Adult Expansion Reserve	0.00	0.00	0.00	41.61	0.00	(41.61)
Other Medical Professional	0.82	0.40	0.80	0.09	1.77	1.68
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	3.55	3.43	3.34	(1.66)	5.88	7.54
Transportation	(0.27)	0.58	0.35	(3.93)	2.10	6.02
Total Claims	139.11	150.45	151.92	192.73	258.01	65.28
Medical & Care Management Expense	5.81	5.81	5.93	5.66	6.80	1.13
Reinsurance	2.58	2.63	2.85	(1.33)	1.22	2.55
Claims Recoveries	(0.54)	(0.00)	(0.48)	(0.44)	0.00	0.44
Sub-total	7.85	8.43	8.30	3.90	8.02	4.12
Total Cost of Health Care	168.76	182.03	183.68	490.94	**283.33**	**(207.61)**
Contribution Margin	**46.34**	**63.87**	**53.68**	**(72.62)**	**32.06**	**(104.68)**
General & Administrative Expenses:						
Salaries and Wages	3.96	3.65	4.47	4.06	5.28	1.22
Payroll Taxes and Benefits	1.05	1.03	1.05	1.37	1.44	0.08
Travel and Training	0.05	0.06	0.08	0.20	0.08	(0.12)
Outside Service - ACS	7.79	7.47	7.07	7.65	7.50	(0.15)
Outside Services - Other	0.82	1.26	0.88	0.87	0.75	(0.12)
Accounting & Actuarial Services	0.03	0.05	0.05	0.05	0.03	(0.02)
Legal	1.01	1.21	0.36	0.89	0.20	(0.69)
Insurance	0.17	0.21	0.20	0.28	0.09	(0.19)
Lease Expense - Office	0.35	0.35	0.37	0.33	0.39	0.06
Consulting Services	0.20	0.12	0.50	0.23	0.29	0.06
Translation Services	0.03	0.04	0.03	0.04	0.04	0.01
Advertising and Promotion	0.01	0.01	0.04	0.09	0.04	(0.06)
General Office	0.71	0.39	0.64	1.14	0.53	(0.61)
Depreciation & Amortization	0.10	0.10	0.10	0.10	0.20	0.10
Printing	0.00	0.11	0.10	0.06	0.08	0.03
Shipping & Postage	0.14	0.00	0.07	0.15	0.01	(0.14)
Interest	0.08	0.22	0.06	0.20	0.09	(0.11)
Other/ Miscellaneous Expenses	0.00	0.00	0.00	0.00	0.00	0.00
Total G & A Expenses	16.50	16.28	16.07	17.70	17.04	(0.66)
Total Operating Gain / (Loss)	29.84	47.58	37.61	(90.32)	15.03	(105.34)
Non Operating:						
Revenues - Interest	0.22	0.42	0.60	0.45	0.11	0.34
Expenses - Interest	0.01	0.01	0.01	0.01	0.00	(0.01)
Total Non-Operating	0.20	0.40	0.59	0.44	0.11	0.33
Total Increase / (Decrease) in Unrestricted Net Assets	30.05	47.99	38.20	(89.88)	15.13	(105.01)

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
For Twelve Months Ended June 30, 2015

	JUNE 15 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	2,130,979	1,941,580	189,399
Revenue			
Premium	$ 712,914,200	$ 619,637,488	$ 93,276,712
Reserve for Rate Reduction	(89,399,946)	0	(89,399,946)
MCO Premium Tax	(28,397,202)	(24,398,226)	(3,998,976)
Total Net Premium	**595,117,052**	**595,239,262**	**(122,210)**
Other Revenue:			
Miscellaneous Income	490,318	459,996	30,322
Total Other Revenue	490,318	**459,996**	30,322
Total Revenue	**595,607,370**	**595,699,258**	**(91,888)**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	95,270,009	32,998,748	(62,271,261)
FFS Claims Expenses:			
Inpatient	89,277,276	122,115,724	32,838,449
LTC / SNF	94,962,055	90,547,197	(4,414,858)
Outpatient	36,025,799	32,186,308	(3,839,491)
Laboratory and Radiology	2,389,026	9,530,569	7,141,543
Physician ACA 1202	8,077,096	0	(8,077,096)
Emergency Room	15,562,116	18,908,693	3,346,578
Physician Specialty	39,854,437	39,648,552	(205,885)
Primary Care Physician	10,452,121	31,140,287	20,688,166
Home & Community Based Services	14,391,047	10,023,856	(4,367,191)
Applied Behavior Analysis Services	83,056	0	(83,056)
Mental Health Services	7,342,627	9,087,757	1,745,130
Pharmacy	69,089,690	113,063,298	43,973,608
Adult Expansion Reserve	0	0	0
Other Medical Professional	2,165,682	3,290,560	1,124,878
Other Medical Care	1,097	0	(1,097)
Other Fee For Service	7,471,817	11,301,270	3,829,453
Transportation	1,445,355	3,823,603	2,378,248
Total Claims	398,590,295	494,667,675	96,077,379
Medical & Care Management Expense	12,500,330	13,010,410	510,079
Reinsurance	3,883,987	2,368,728	(1,515,259)
Claims Recoveries	(1,061,353)	0	1,061,353
Sub-total	15,322,964	15,379,138	56,174
Total Cost of Health Care	**509,183,268**	**543,045,560**	**33,862,292**
Contribution Margin	**86,424,102**	**52,653,698**	**33,770,404**
General & Administrative Expenses:			
Salaries and Wages	8,451,434	9,993,060	1,541,625
Payroll Taxes and Benefits	2,422,559	2,685,918	263,359
Travel and Training	158,869	254,575	95,706
Outside Service - ACS	16,178,199	14,583,794	(1,594,405)
Outside Services - Other	1,750,842	1,691,978	(58,864)
Accounting & Actuarial Services	164,641	280,000	115,359
Legal	2,515,840	400,000	(2,115,840)
Insurance	320,593	175,000	(145,593)
Lease Expense - Office	776,112	772,248	(3,864)
Consulting Services	436,294	1,394,584	958,290
Translation Services	60,747	85,000	24,253
Advertising and Promotion	44,303	263,808	219,505
General Office	1,393,894	1,636,526	242,632
Depreciation & Amortization	205,073	311,243	106,170
Printing	114,246	214,162	99,916
Shipping & Postage	138,329	191,280	52,951
Interest	238,256	180,000	(58,256)
Total G & A Expenses	**35,370,232**	**35,113,175**	**(257,057)**
Total Operating Gain / (Loss)	**$ 51,053,870**	**$ 17,540,523**	**$ 33,513,347**
Non Operating			
Revenues - Interest	611,911	204,480	407,431
Expenses - Interest	55,728	0	(55,728)
Total Non-Operating	556,183	204,480	351,703
Total Increase / (Decrease) in Unrestricted Net Assets	$ 51,610,053	$ 17,745,003	$ 33,865,050
Net Assets, Beginning of Year	48,335,211		
Net Assets, End of Year	99,945,264		

Statement of Cash Flows - Monthly

	JUN 15	MAY 15	APR 15
Cash Flow From Operating Activities			
Collected Premium	$ -	$ -	$ 66,932,156
Miscellaneous Income	89,520	112,844	78,069
State Pass Through Funds	-	-	2,139,715
Paid Claims			
Medical & Hospital Expenses	(35,377,714)	(25,562,731)	(30,629,285)
Pharmacy	(6,796,493)	(6,784,343)	(6,410,487)
Capitation	(40,139,869)	(3,835,620)	(3,767,160)
Reinsurance of Claims	(549,442)	(535,763)	(529,803)
State Pass Through Funds Distributed	(5,895,955)	(1,541,703)	(1,532,177)
Paid Administration	(1,939,953)	(3,508,393)	(1,737,229)
MCO Tax Received / (Paid)	-	(6,549,477)	(1,651,004)
Net Cash Provided / (Used) by Operating Activities	**(90,609,905)**	**(48,205,186)**	**22,892,795**
Cash Flow From Investing / Financing Activities			
Net Acquisition of Investments	40,009,301	(6,241)	(179,737,508)
Net Acquisition of Property / Equipment	(32,157)	(30,333)	(24,727)
Net Cash Provided / (Used) by Investing / Financing	**39,977,144**	**(36,574)**	**(179,762,235)**
Net Cash Flow	**$ (50,632,761)**	**$ (48,241,760)**	**$ (156,869,440)**
Cash and Cash Equivalents (Beg. of Period)	107,850,902	156,092,662	312,962,102
Cash and Cash Equivalents (End of Period)	57,218,141	107,850,902	156,092,662
	$ (50,632,761)	**$ (48,241,760)**	**$ (156,869,440)**
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	(17,496,389)	7,173,456	8,984,176
Depreciation & Amortization	34,063	33,602	33,602
Decrease / (Increase) in Receivables	(61,391,948)	(60,698,003)	(70,360)
Decrease / (Increase) in Prepaids & Other Current Assets	56,556	183,567	(127,154)
(Decrease) / Increase in Payables	(1,038,895)	(1,614,317)	2,337,526
(Decrease) / Increase in Other Liabilities	(27,504,892)	13,683,085	18,939,718
Changes in Withhold / Risk Incentive Pool	-	-	-
Change in MCO Tax Liability	3,521,974	(4,162,967)	800,379
Changes in Claims and Capitation Payable	16,618,512	3,782,493	1,159,564
Changes in IBNR	(3,408,886)	(6,586,102)	(9,164,657)
	(90,609,905)	(48,205,186)	22,892,795
Net Cash Flow from Operating Activities	**(90,609,905)**	**(48,205,186)**	**22,892,795**

Statement of Cash Flows - YTD

	JUNE 15
Cash Flow From Operating Activities	
Collected Premium	$ 735,416,586
Miscellaneous Income	613,633
State Pass Through Funds	51,814,653
Paid Claims	
Medical & Hospital Expenses	(314,335,619)
Pharmacy	(73,521,544)
Capitation	(73,266,303)
Reinsurance of Claims	(6,024,817)
State Pass Through Funds Distributed	(53,789,513)
Paid Administration	(36,542,950)
MCO Taxes Received / (Paid)	(43,289,146)
Net Cash Provided / (Used) by Operating Activities	**187,074,980**
Cash Flow From Investing / Financing Activities	
Net Acquisition of Investments	(189,737,719)
Net Acquisition of Property / Equipment	(295,818)
Net Cash Provided / (Used) by Investing / Financing	**(190,033,537)**
Net Cash Flow	**$ (2,958,557)**
Cash and Cash Equivalents (Beg. of Period)	60,176,698
Cash and Cash Equivalents (End of Period)	57,218,141
	$ (2,958,557)
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income / (Loss)	51,610,053
Depreciation & Amortization	374,974
Decrease / (Increase) in Receivables	(9,794,804)
Decrease / (Increase) in Prepaids & Other Current Assets	227,464
(Decrease) / Increase in Payables	2,669,032
(Decrease) / Increase in Other Liabilities	115,918,184
Change in MCO Tax Liability	(12,284,209)
Changes in Claims and Capitation Payable	26,286,298
Changes in IBNR	12,067,989
	187,074,980
Net Cash Flow from Operating Activities	**$ 187,074,980**

Gold Coast Health Plan℠
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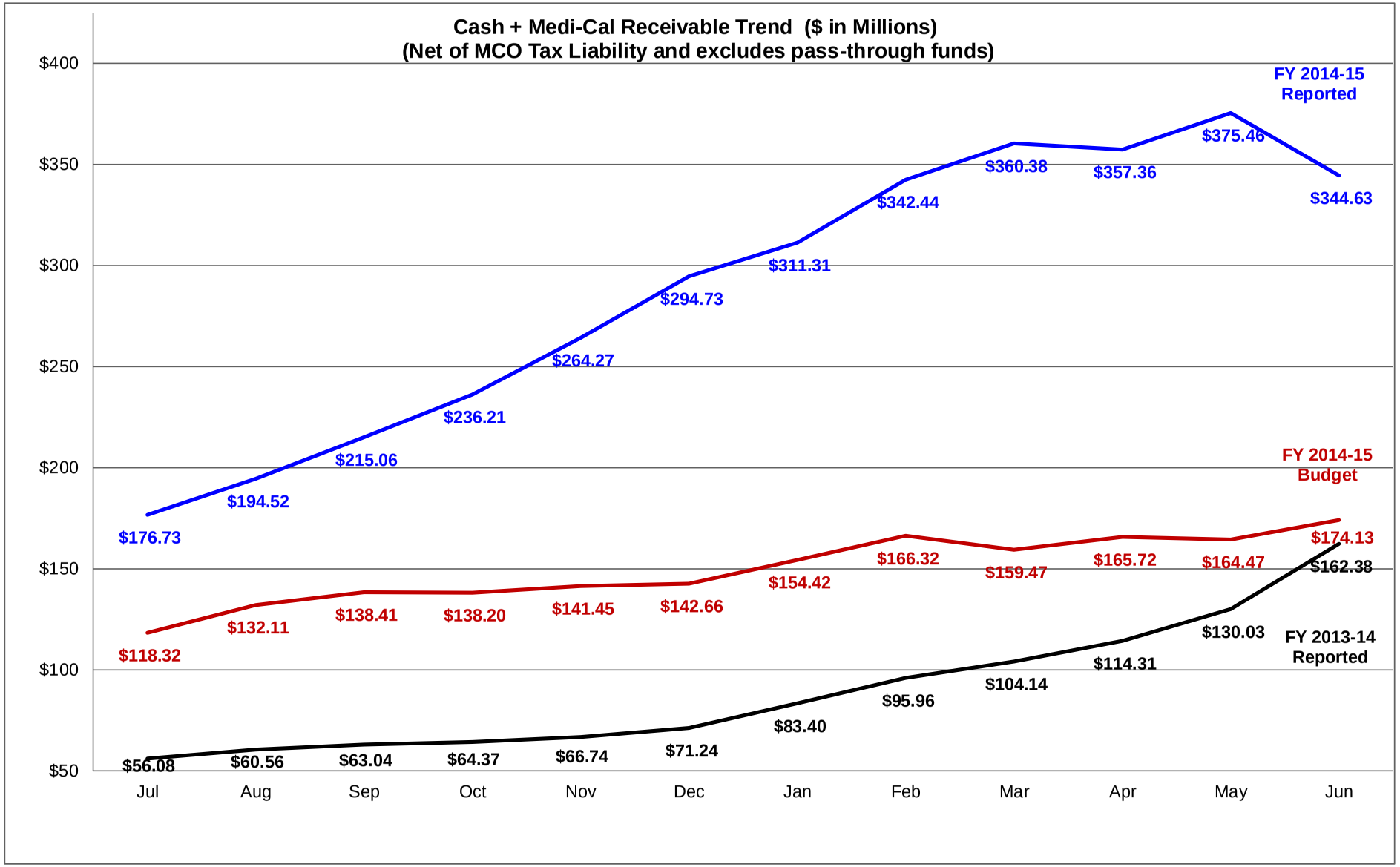
For the month ended June 30, 2015

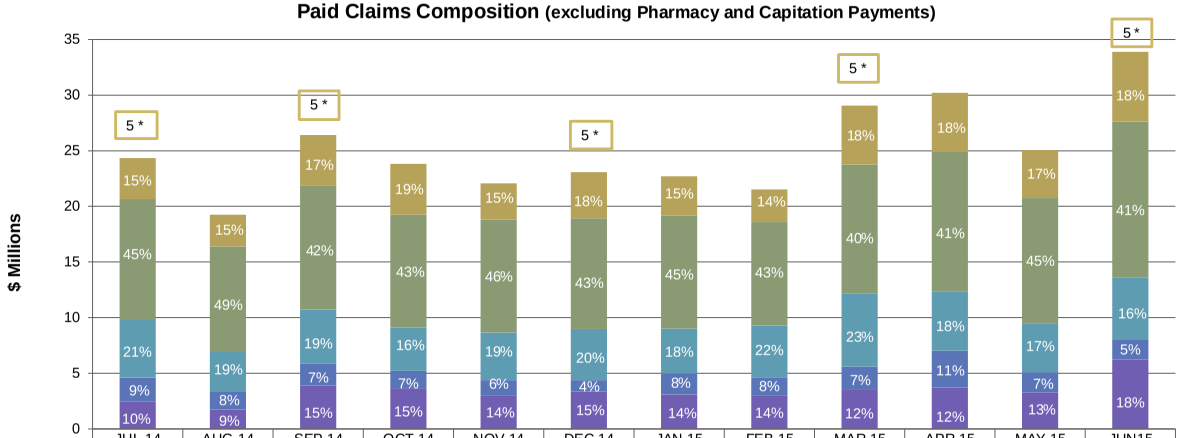
APPENDIX

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

GOLD COAST HEALTH PLAN
JUNE 2015



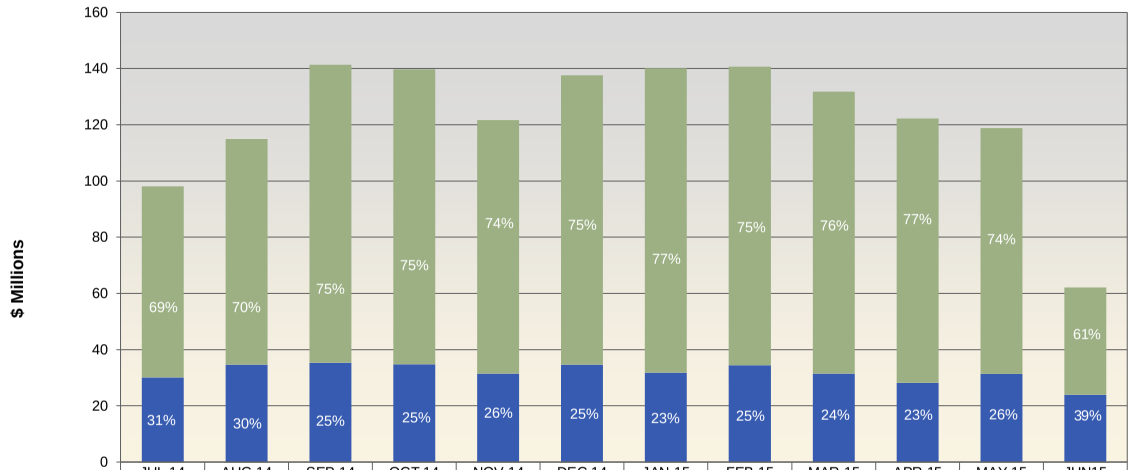
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	JUN15
Current	3.70	2.85	4.50	4.57	3.25	4.14	3.50	2.91	5.30	5.32	4.30	6.26
30	10.85	9.42	11.15	10.13	10.15	9.96	10.20	9.30	11.63	12.52	11.31	14.05
60	5.20	3.69	4.90	3.89	4.29	4.61	4.00	4.64	6.56	5.34	4.36	5.50
90	2.10	1.58	1.95	1.56	1.35	1.03	1.90	1.68	2.01	3.31	1.81	1.81
120+	2.50	1.73	3.90	3.66	3.05	3.35	3.10	2.97	3.57	3.73	3.28	6.26

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

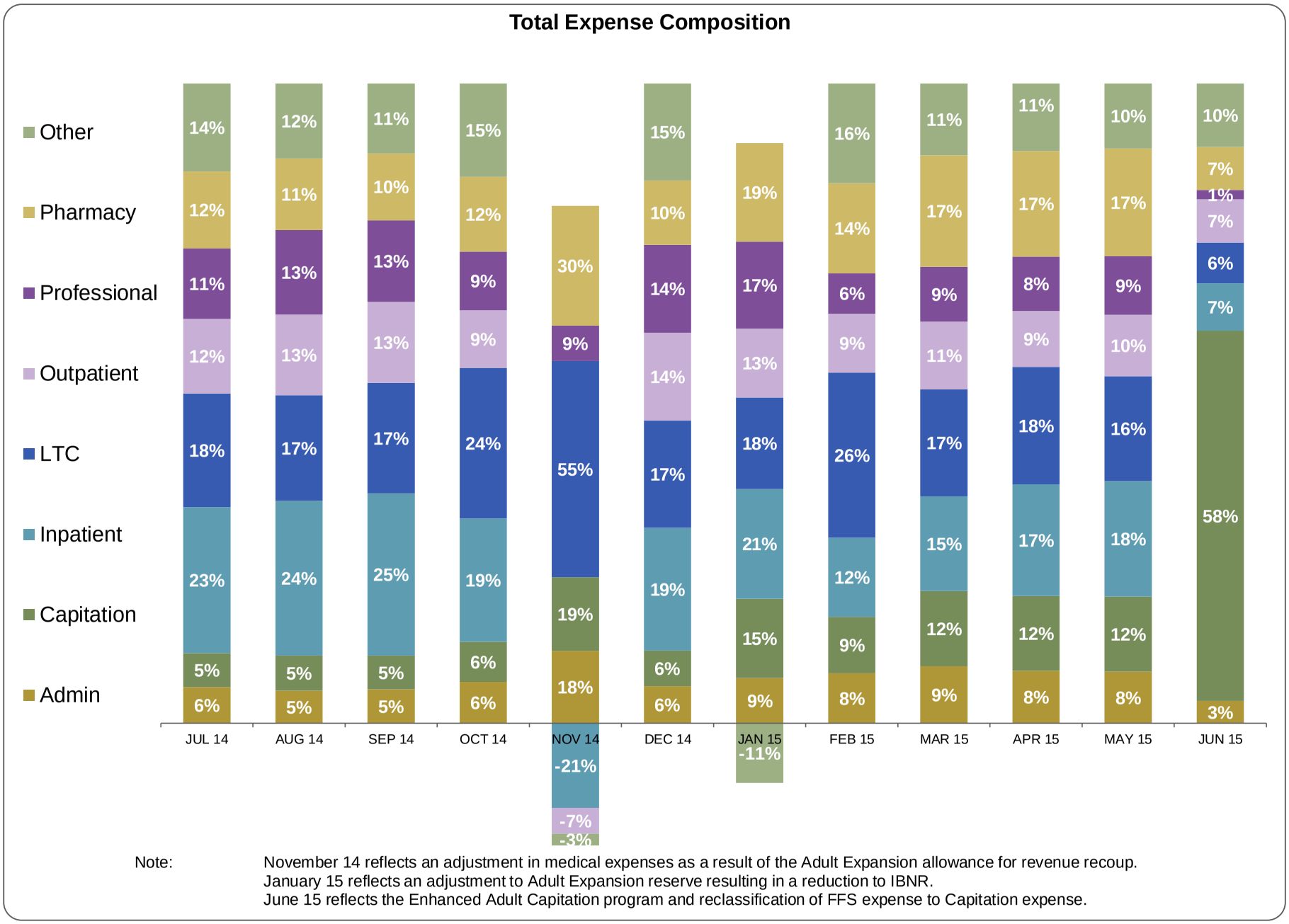
IBNP Composition (excluding Pharmacy and Capitation)



	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	JUN15
Prior Month Unpaid	67.93	80.29	106.07	104.95	90.22	102.84	108.19	106.23	100.37	94.05	87.42	38.18
Current Month Unpaid	30.14	34.67	35.33	34.78	31.45	34.71	31.86	34.48	31.46	28.17	31.40	23.99
Total Unpaid	98.06	114.96	141.40	139.73	121.67	137.55	140.05	140.71	131.82	122.22	118.82	62.17

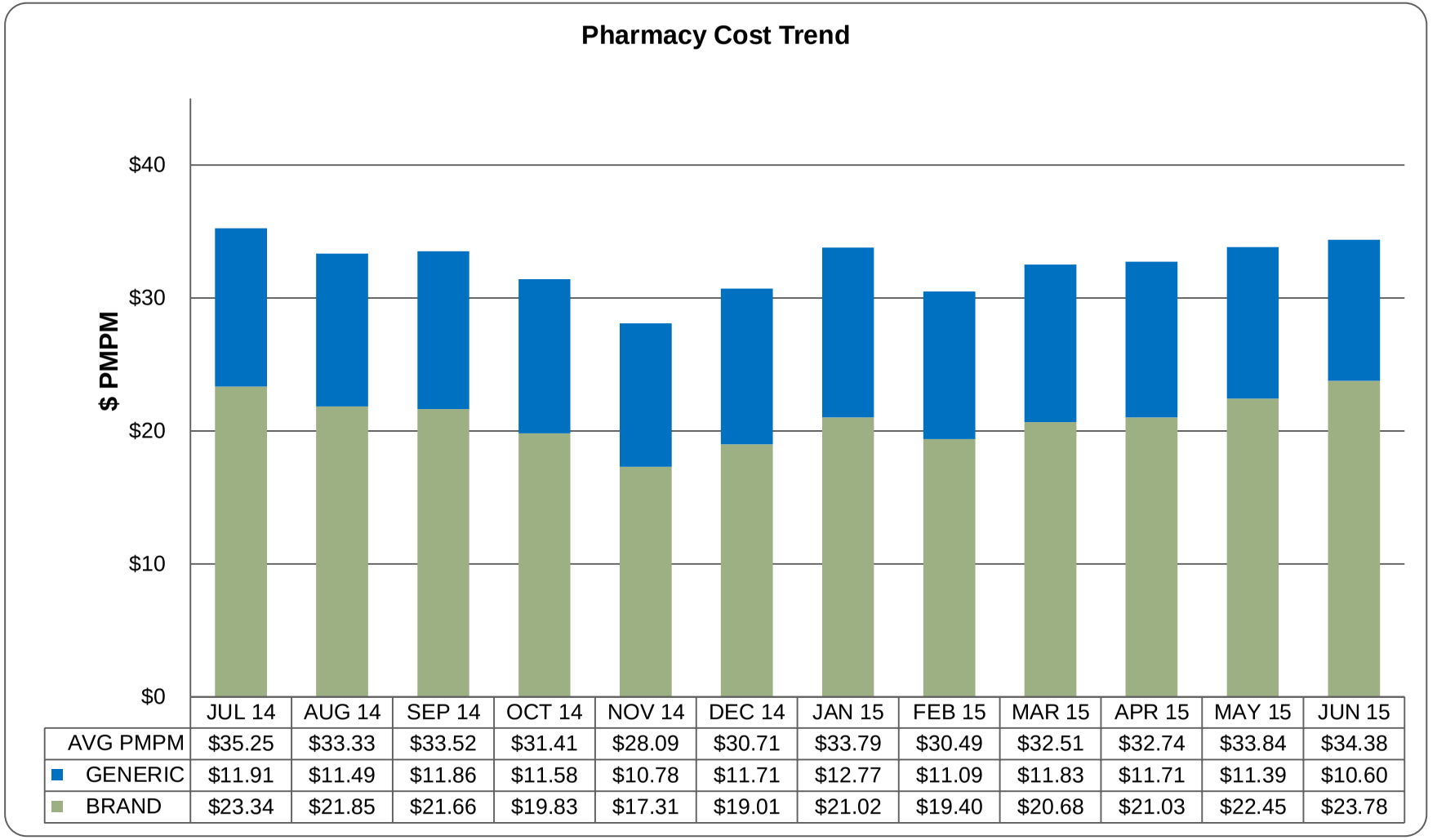
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

GOLD COAST HEALTH PLAN



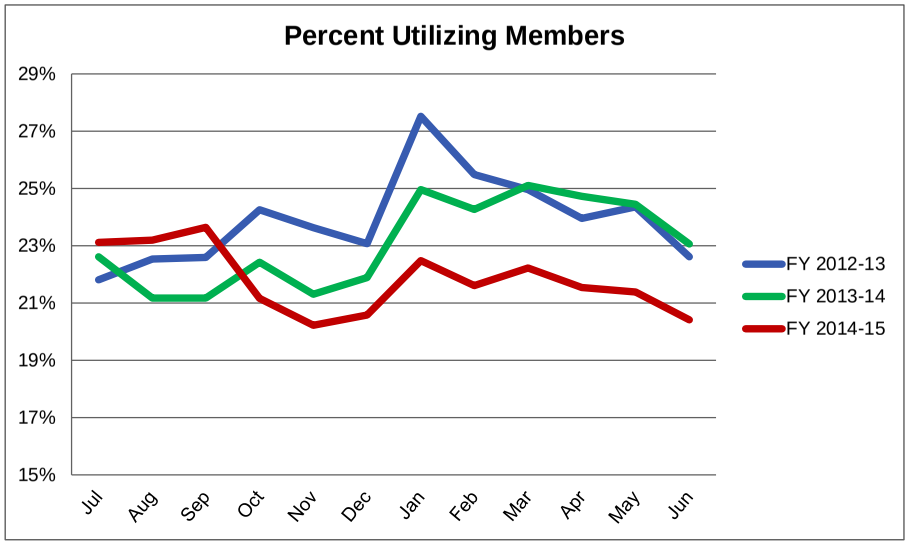
Note: November 14 reflects an adjustment in medical expenses as a result of the Adult Expansion allowance for revenue recoup.
January 15 reflects an adjustment to Adult Expansion reserve resulting in a reduction to IBNR.
June 15 reflects the Enhanced Adult Capitation program and reclassification of FFS expense to Capitation expense.

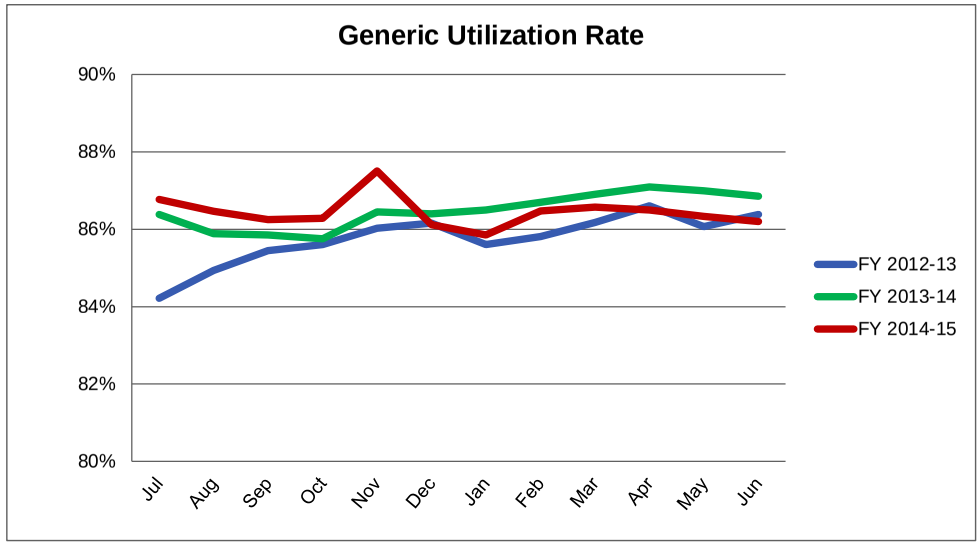
GOLD COAST HEALTH PLAN



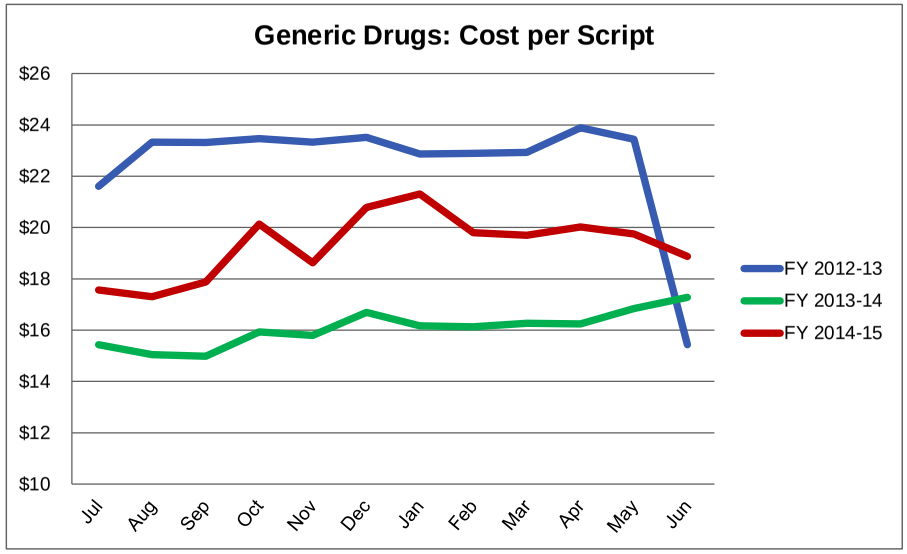
	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	JUN 15
AVG PMPM	$35.25	$33.33	$33.52	$31.41	$28.09	$30.71	$33.79	$30.49	$32.51	$32.74	$33.84	$34.38
GENERIC	$11.91	$11.49	$11.86	$11.58	$10.78	$11.71	$12.77	$11.09	$11.83	$11.71	$11.39	$10.60
BRAND	$23.34	$21.85	$21.66	$19.83	$17.31	$19.01	$21.02	$19.40	$20.68	$21.03	$22.45	$23.78

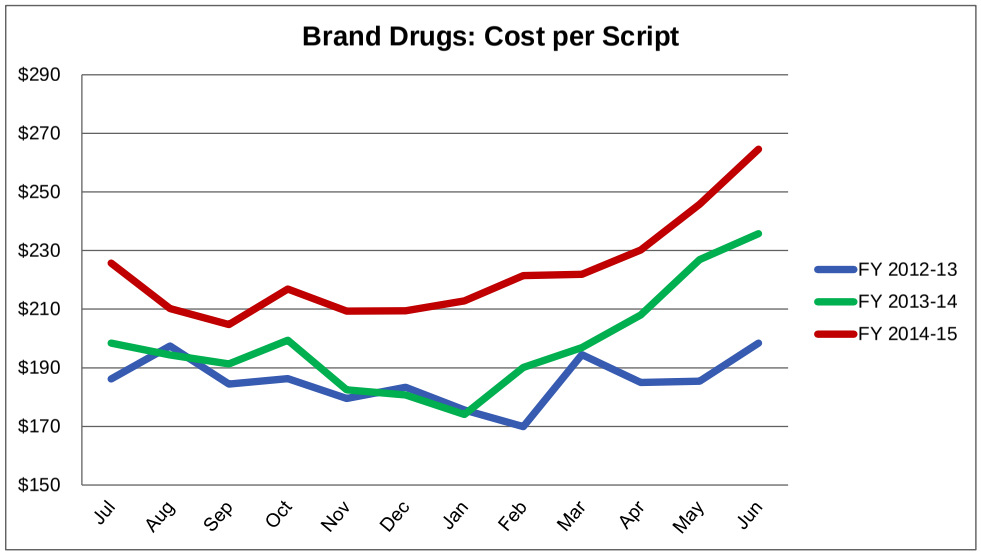
GOLD COAST HEALTH PLAN
Pharmacy Analysis





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





Effective June 2013, New Maximum Allowable Cost (MAC) Schedule was implemented, reducing cost of generic drugs

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AGENDA ITEM 3.c.

TO: Gold Coast Health Plan Commission

FROM: Ruth Watson, COO

DATE: September 28, 2015

RE: COO Update

OPERATIONS UPDATE

Membership Update – September 2015

Gold Coast Health Plan (GCHP) had a net membership increase of 1,402 this month, bringing the total number of members to 193,185 as of September 1, 2015. GCHP's membership has increased by 74,673 or 63% since January 2014. The cumulative new membership since January 1, 2014 is summarized as follows:

Aid Code	# of New Members
L1 – Low Income Health Plan (LIHP)	2,698
M1 – Adult Expansion	44,260
7U – CalFresh Adults	2,654
7W – CalFresh Children	733
7S – Parents of 7Ws	360
Traditional Medi-Cal	23,968
Total New Membership 1/1/14 – 9/1/15	74,673

Members assigned to a M1 aid code continues to increase. All other Medi-Cal Expansion aid codes, with the exception of 7S, decreased either due to re-determination into other aid codes or loss of coverage. GCHP had 87 potential new members transitioning from Covered CA as of September 1, 2015; 65 were identified as new to GCHP on the September eligibility file from DHCS.

	15-Jul	15-Aug	15-Sep	15-Oct	15-Nov	15-Dec
L1	3,218	3,039	2,698	0	0	0
M1	40,948	42,465	44,260	0	0	0
7U	2,918	2,766	2,654	0	0	0
7W	770	746	733	0	0	0
7S	355	380	360	0	0	0

	15-Jan	15-Feb	15-Mar	15-Apr	15-May	15-Jun
L1	6,508	6,128	4,965	4,102	3,908	3,413
M1	30,107	31,203	34,350	35,582	37,519	39,283
7U	3,390	3,342	3,236	3,162	3,083	2,986
7W	872	872	856	831	813	781
7S	478	442	396	381	379	353

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

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

AB 85 Capacity Tracking – VCMC has a total of 29,042 Adult Expansion members assigned to them as of September 2015. VCMC's target enrollment is 65,765 and is currently at 44.2% of the enrollment target.

July 2015 Operations Summary

Claims Inventory – ended July with an inventory of 22,547; this equates to Days Receipt on Hand (DROH) of 3.1 compared to a DROH goal of 5. GCHP received approximately 7,400 claims per day in July which is ~2,000 more claims per day than received in July 2014. Monthly claim receipts from August 2014 through July 2015 are as follows:

Month	Total Claims Received	Receipts per Day
July 2015	162,237	7,374
June 2015	171,806	7,809
May 2015	160,992	8,050
April 2015	146,198	6,645
March 2015	152,948	6,952
February 2015	130,559	6,528
January 2015	127,517	6,376
December 2014	128,087	6,099
November 2014	111,182	6,177
October 2014	134,274	5,838
September 2014	119,233	5,678
August 2014	108,695	5,176

Claims Turnaround Time (TAT) – the regulatory requirement of processing 90% of clean claims within 30 calendar days was met in July with a result of 97.7%.

Claims Processing Accuracy – the financial accuracy goal of 98% or higher was met in July with a result of 99.91% and procedural accuracy exceeded the goal of 97% in July at 99.98%.

Call Volume – call volume exceeded 10,000 calls during July; the number of calls received in July was 10,246. The 12-month average is 10,040 calls per month.

Average Speed to Answer (ASA) – as mentioned during the July Commission meeting, the ASA for the month of July was not met. Xerox experienced significant staffing issues starting in June 2015, resulting in the loss of several call center agents. The combined ASA result (Member, Provider and Spanish lines) for July was 219.6 seconds vs the Service Level Agreement (SLA) goal of 30 seconds or less. Xerox was required to submit a Corrective Action Plan (CAP) outlining plans to return to SLA level requirements.

Abandonment Rate – the abandonment rate also suffered as a result of the staffing issues during the month. July's combined result was 10.56% compared to a goal of 5% or less. The CAP also addressed non-compliance with the abandonment rate.

Average Call Length – the combined result of 7.57 minutes in July was above the goal of 7.0 minutes.

Grievance and Appeals – GCHP received 8 member grievances and 57 provider grievances (related to claim payment disputes) during July. The number of member grievances received per 1,000 members was 0.04. Balance billing was removed as a grievance type as of July 1, 2015, which is consistent with the other COHS.

Type of Member Grievances	Number of Grievances
Accessibility – Lack of PCP Availability	1
Quality of Care	3
Quality of Service	4
Total Member Grievances	**8**

There were two clinical appeals in July; one was upheld and one was withdrawn. There was no State Fair Hearing activity in July.

Member Orientation Meetings – GCHP Member Services continues to offer three (3) Member Orientation meetings, in both English and Spanish, each month in various locations throughout the county. A total of 133 members (102 English, 31 Spanish) plus 18 County Employees/Others attended meetings in the first seven month of 2015 compared with a total of 47 during the same time period in 2014. GCHP continues to include an informational flyer in each new member packet to make members aware of this opportunity to learn more about GCHP and their Medi-Cal benefits.

Behavioral Health Treatment (BHT) Transition – DHCS has again delayed the transition of BHT services from the regional centers to managed care plans. The new transition date is scheduled for February 1, 2016. GCHP members currently receiving BHT services at the regional center will be transitioned over a six-month period based on month of birth. GCHP is required to provide members with 60-day and 30-day notices of this transition. GCHP had previously received approval of our notices from DHCS but the State revised the notice template and we are currently awaiting re-approval of our notices.

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

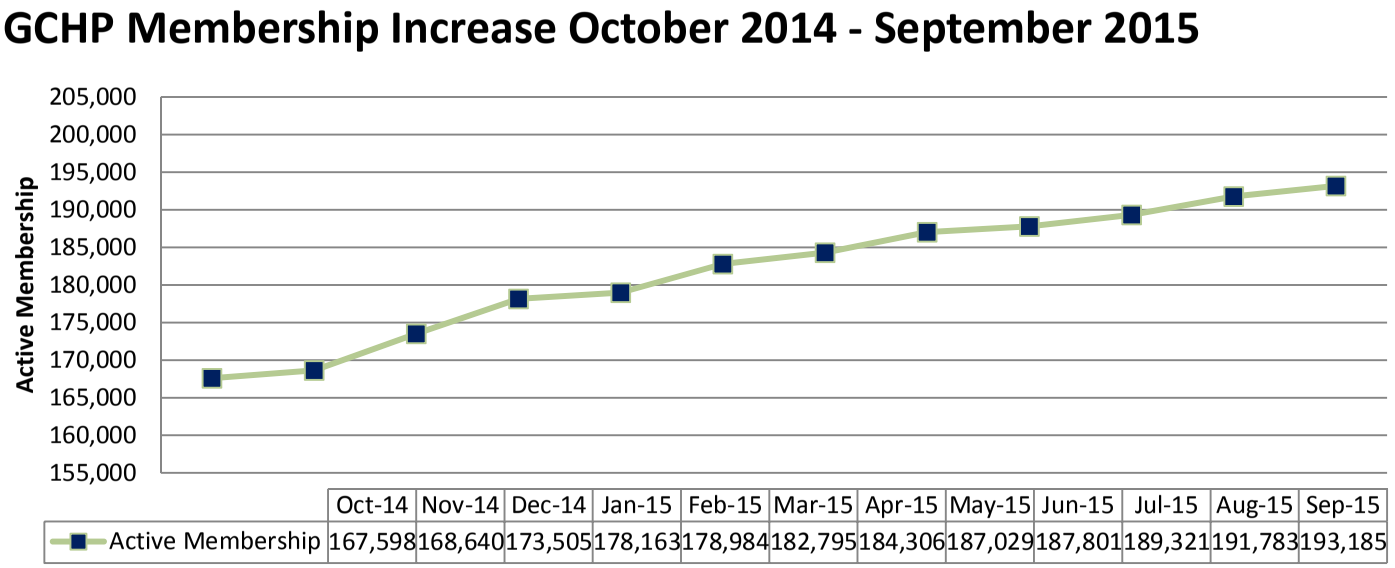
- Business Continuity Plan (BCP) – the BCP project has been completed; the Emergency Management Team (EMT), Mission Critical departments and back-ups have received training.
- ICD-10 Readiness – the compliance date of October 1, 2015 is right around the corner. Work has continued towards implementation of the new code set which is

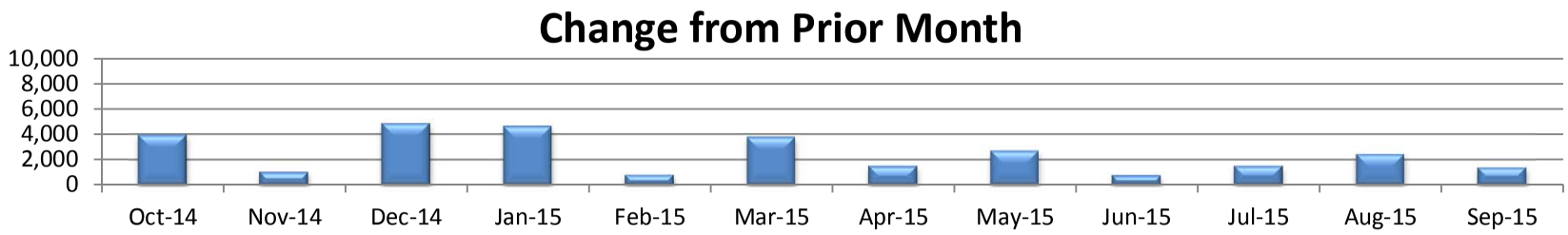
effective for dates of service on or after October 1, 2015. Testing has been underway since July and has been very successful. GCHP conducted two provider training sessions in August to assist providers in their preparation and readiness for the transition to ICD-10.

- Member Handbook – the 2015-16 Member Handbook was implemented into production beginning with July 2015 new members.
- ASO Consultant Services RFP – the RFP for consultant services to assist in the evaluation of GCHP's ASO arrangement has been released. GCHP anticipates receiving bids from four consulting firms.

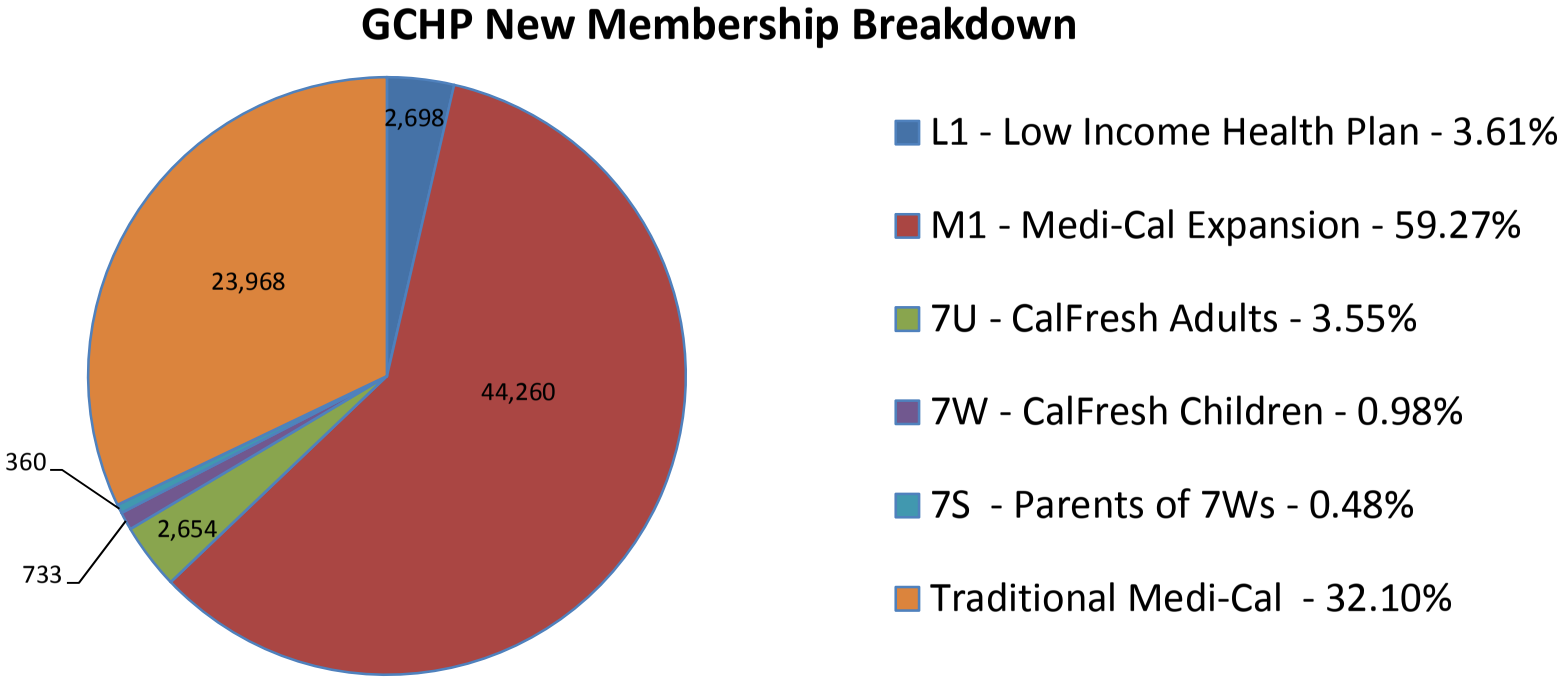
GCHP Membership

Total Membership as of September 1, 2015 – 193,185
New Members Added Since January 2014 – 74,673





Membership Growth



Note: GCHP Pended eligibility (not shown) – 878 (decreased 33 from August)

- **Members with aid code 8E – accelerated enrollment which provides immediate temporary, fee-for service, full scope Medi-Cal benefits for ages 65 and under**

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

	Sep-15		Aug-15		Jul-15		Jun-15		May-15		Apr-15	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
AB85 Eligible	**1,350**		**1,159**		**1,312**		**1,519**		**1,489**		**2,342**	
VCMC	1,012	74.96%	869	74.98%	984	75.00%	1,139	74.98%	1,116	74.95%	1,756	74.98%
Balance	338	25.04%	290	25.02%	328	25.00%	380	25.02%	373	25.05%	586	25.02%
Regular Eligible	**1,141**		**1,023**		**891**		**1,455**		**1,620**		**1,420**	
Regular + AB85 Balance	**1,479**		**1,313**		**1,219**		**1,835**		**1,993**		**2,006**	
Clinicas	275	18.59%	265	20.18%	372	30.52%	458	24.96%	508	25.49%	513	25.57%
CMH	161	10.89%	138	10.51%	156	12.80%	203	11.06%	233	11.69%	236	11.76%
Independent	46	3.11%	30	2.28%	29	2.38%	55	3.00%	53	2.66%	65	3.24%
VCMC	997	67.41%	880	67.02%	662	54.31%	1,119	60.98%	1,199	60.16%	1,192	59.42%
Total Assigned	**2,491**		**2,182**		**2,203**		**2,974**		**3,109**		**3,762**	
Clinicas	275	11.04%	265	12.14%	372	16.89%	458	15.40%	508	16.34%	513	13.64%
CMH	161	6.46%	138	6.32%	156	7.08%	203	6.83%	233	7.49%	236	6.27%
Independent	46	1.85%	30	1.37%	29	1.32%	55	1.85%	53	1.70%	65	1.73%
VCMC	2,009	80.65%	1,749	80.16%	1,646	74.72%	2,258	75.92%	2,315	74.46%	2,948	78.36%

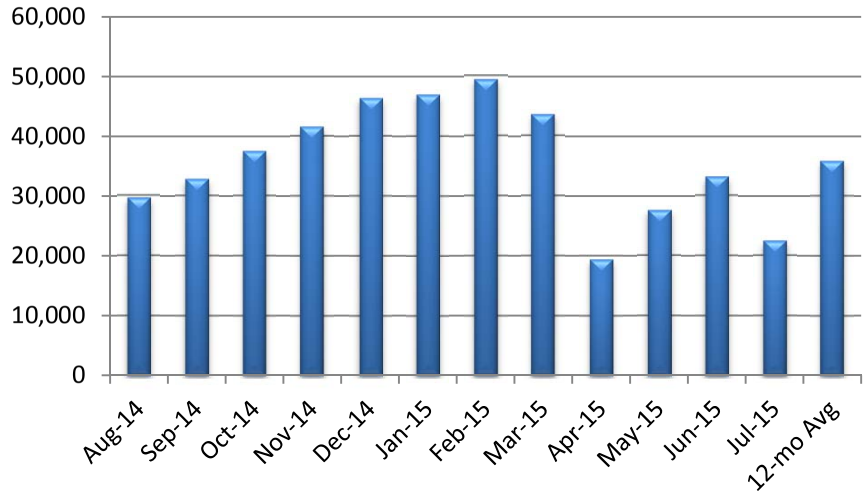
Auto Assignment Process

- 75% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85
- The remaining 25% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others
- The County's overall auto assignment results will be higher than 75% since they receive 75% of the AE members plus a 3:1 ratio of all other unassigned members
- VCMC's target enrollment is 65,765
  - VCMC has 29,042 assigned Adult Expansion members as of September 1, 2015 and is currently at 44.2% of capacity

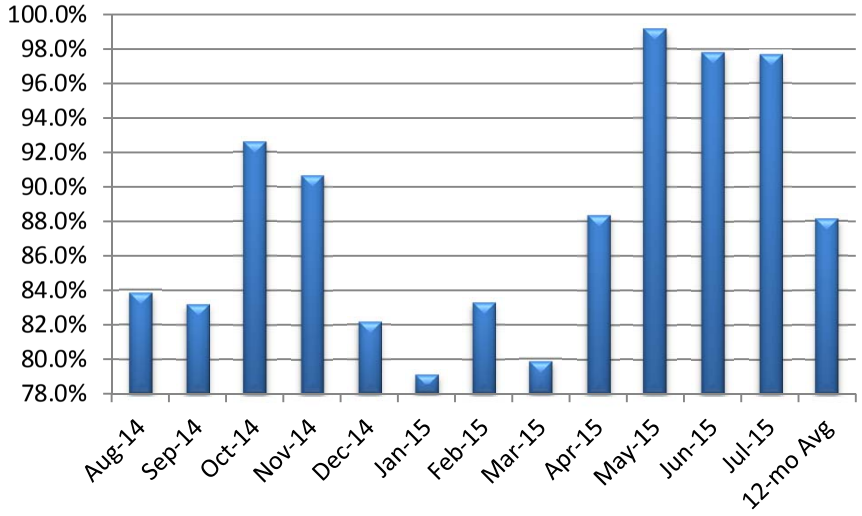
GCHP Claims Metrics – July 2015

- The 30 Day Turnaround Time (TAT) remained in compliance at 97.7%
- Ending Inventory decreased by ~10,700 claims from June which equates to a Days Receipt on Hand (DROH) of 3.1 vs a DROH goal of 5 days
- Service Level Agreements for Financial Accuracy (99.91%) and Procedural Accuracy (99.98%) were both met in July

Ending Inventory

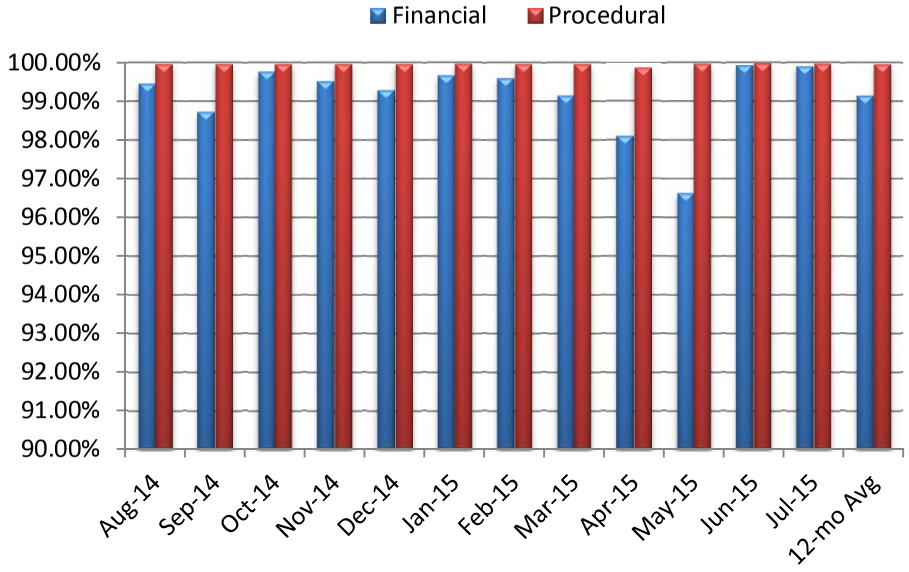


Clean Claims Processed within 30 Calendar Days



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

Financial and Procedural Accuracy

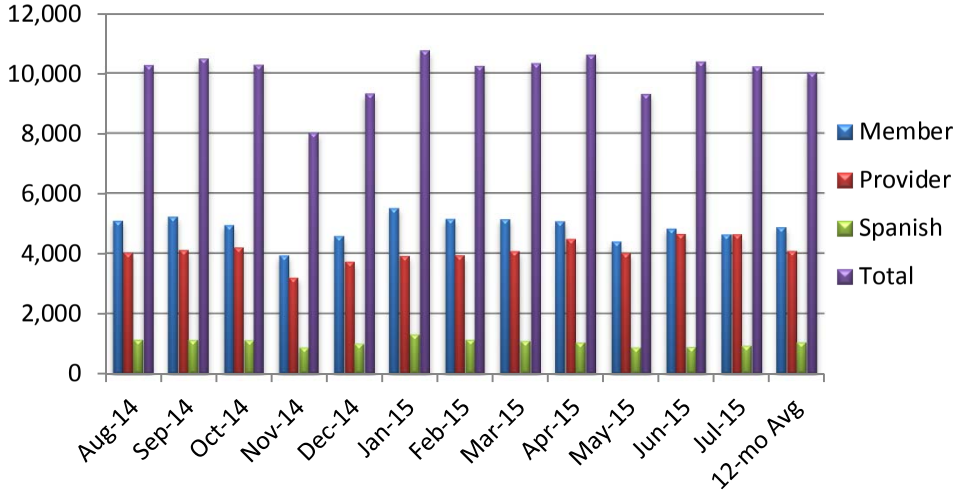


Financial Accuracy – 98% or higher
Procedural Accuracy – 97% or higher

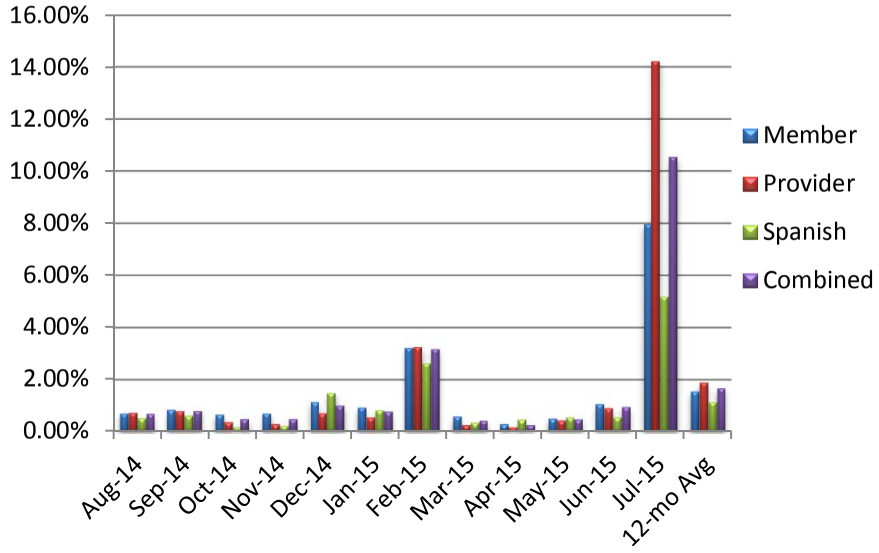
GCHP Call Center Metrics – July 2015

- Call volume decreased slightly in July; GCHP received 10,246 calls during the month
- The call center experienced some significant staffing issues in July, resulting in both the ASA and Abandonment Rate not being met
- Xerox has a corrective plan in place and is currently working to bring both SLAs back within goal

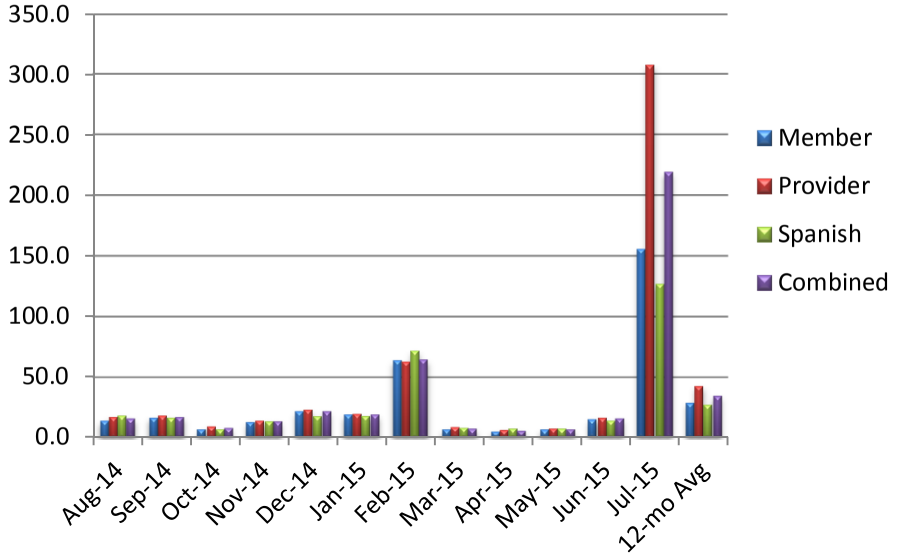
Call Center Volume



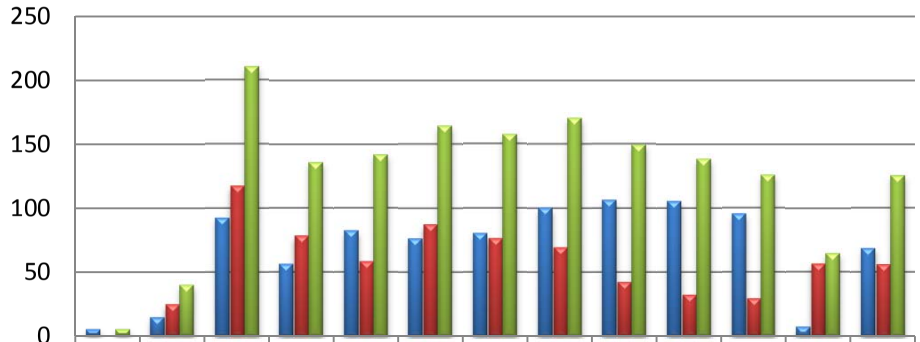
Abandonment Rate
(goal of 5% or less)



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



Total Grievances per Month

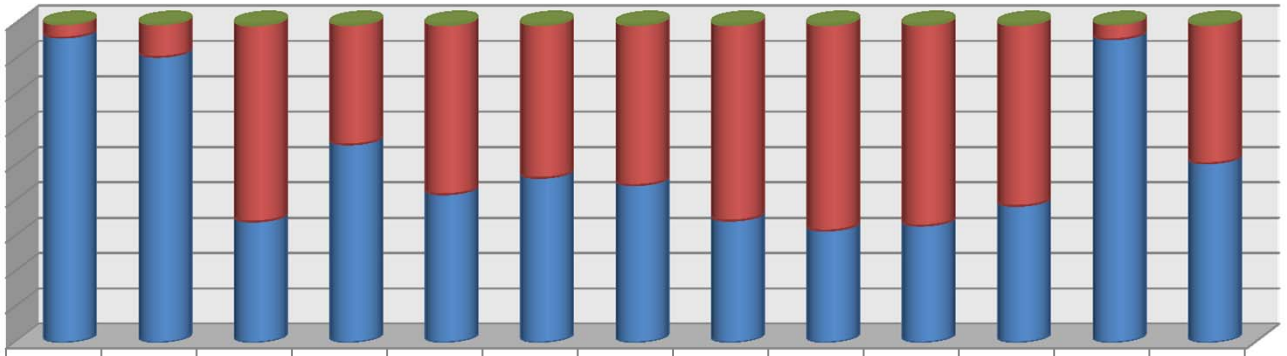


	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	12-mo Avg
Member	6	15	93	57	83	77	81	101	107	106	96	8	69
Provider	0	25	118	79	59	88	77	70	43	33	30	57	57
Combined	6	40	211	136	142	165	158	171	150	139	126	65	126

GCHP Grievance & Appeals Metrics – July 2015

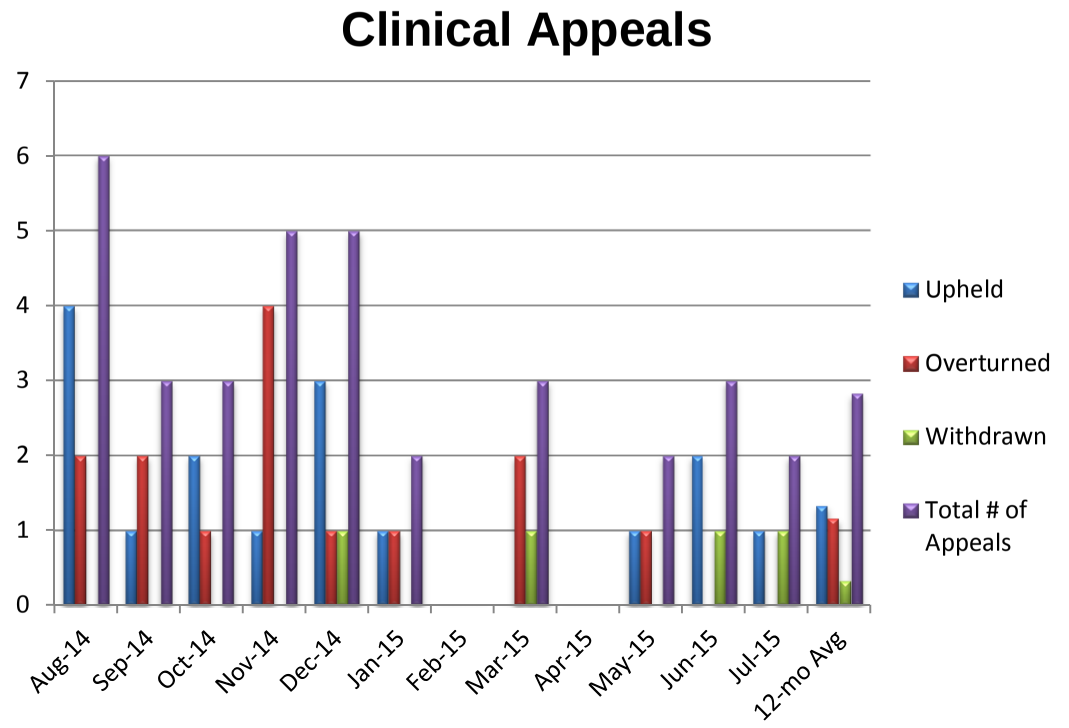
- Balance billing was removed as a grievance type as of 7/1/15 to be consistent with the other COHS; as a result, GCHP only received 65 grievances during July (8 member and 57 provider)
- GCHP received 0.04 member grievances per 1,000 members in July

Member Grievances per 1000 Members

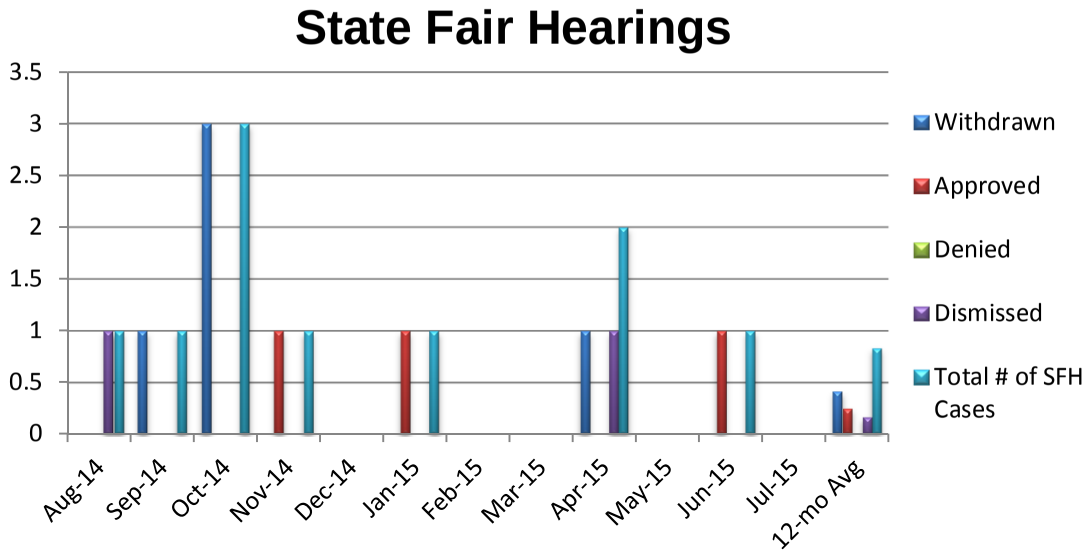


	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	12-mo Avg
# of Grievance per 1000 Members	0.04	0.09	0.55	0.34	0.48	0.43	0.45	0.55	0.58	0.57	0.51	0.04	0.39
Total Member Grievances Filed	6	15	93	57	83	77	81	101	107	106	96	8	69
Membership Count	160,427	163,630	167,598	168,640	173,505	178,163	178,984	182,795	184,306	187,029	187,801	189,321	176,850

GCHP Grievance & Appeals Metrics – July 2015



- GCHP resolved two clinical appeals in July; one was upheld and one was withdrawn



- There was no State Fair Hearing activity in July

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AGENDA ITEM 3.d.

TO: Gold Coast Health Plan Commission

FROM: Melissa Scrymgeour, CIO

DATE: September 28, 2015

RE: CIO Update

IT Infrastructure

GCHP is entering into a strategic pricing agreement with Insight for the purchase of Microsoft products, computing equipment, and peripherals.

As the Plan explored new technology procurement strategies to meet future growth and business needs while controlling costs, we learned of an existing provision in the CA Public Contract Code that allows government entities to leverage buying power through cooperative purchasing agreements.

Under this code, the Department of General Services (DGS) Procurement Division established a Software Cooperative Agreement (SCA) with Microsoft (MS) that allows other government entities like GCHP to use the same pricing terms for the purchase of Microsoft products. DGS confirmed that GCHP is qualified to participate in the existing SCA as negotiated by the County of Riverside, CA. The County of Riverside agreement extends the pricing terms for Microsoft Enterprise Agreement software licenses for Riverside County and surrounding Government Agencies within the State of California.

One special condition of the SCA is that the Plan must purchase MS products from a pre-authorized list of five MS certified value added resellers. GCHP selected Insight due to their distribution capabilities and their ability to warehouse hardware product.

Through the SCA MS cost agreement, GCHP estimates a savings of roughly 20% (approximately $136k) this fiscal year on budgeted MS software, computing equipment, servers and peripherals.

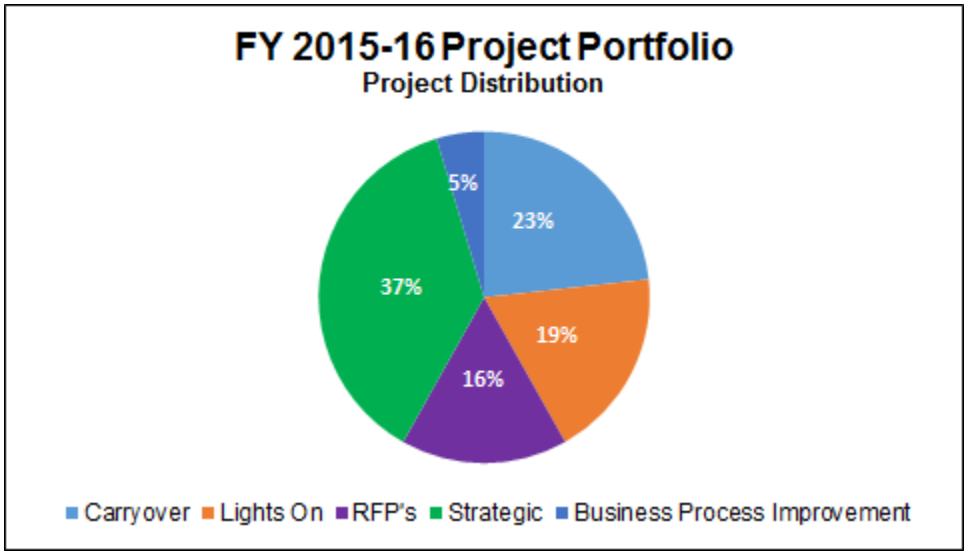
Project Management Office (PMO)

The FY 2015-16 updated Project Portfolio now consists of the following approved initiatives for the

upcoming fiscal year:

- Ten (10) active carryover projects from FY 2014-15.
- Seven (7) Requests for Proposals (RFP) for new systems, services, and/or strategic consulting support.
- Eight (8) “Lights On” projects, including software and server upgrades, as well as office expansion and reconfiguration.
- Sixteen (16) projects supporting GCHP strategic tenants around quality, provider network maintenance, member, provider and community engagement, communications, finance, administrative services, and technology and analytics.
- *Two (2) Business Process Improvement initiatives to evaluate and improve operational processes for covered benefits and services. Another initiative addresses Member satisfaction through focus groups.

*Newly approved at August 2015 Project Steering Committee meeting.



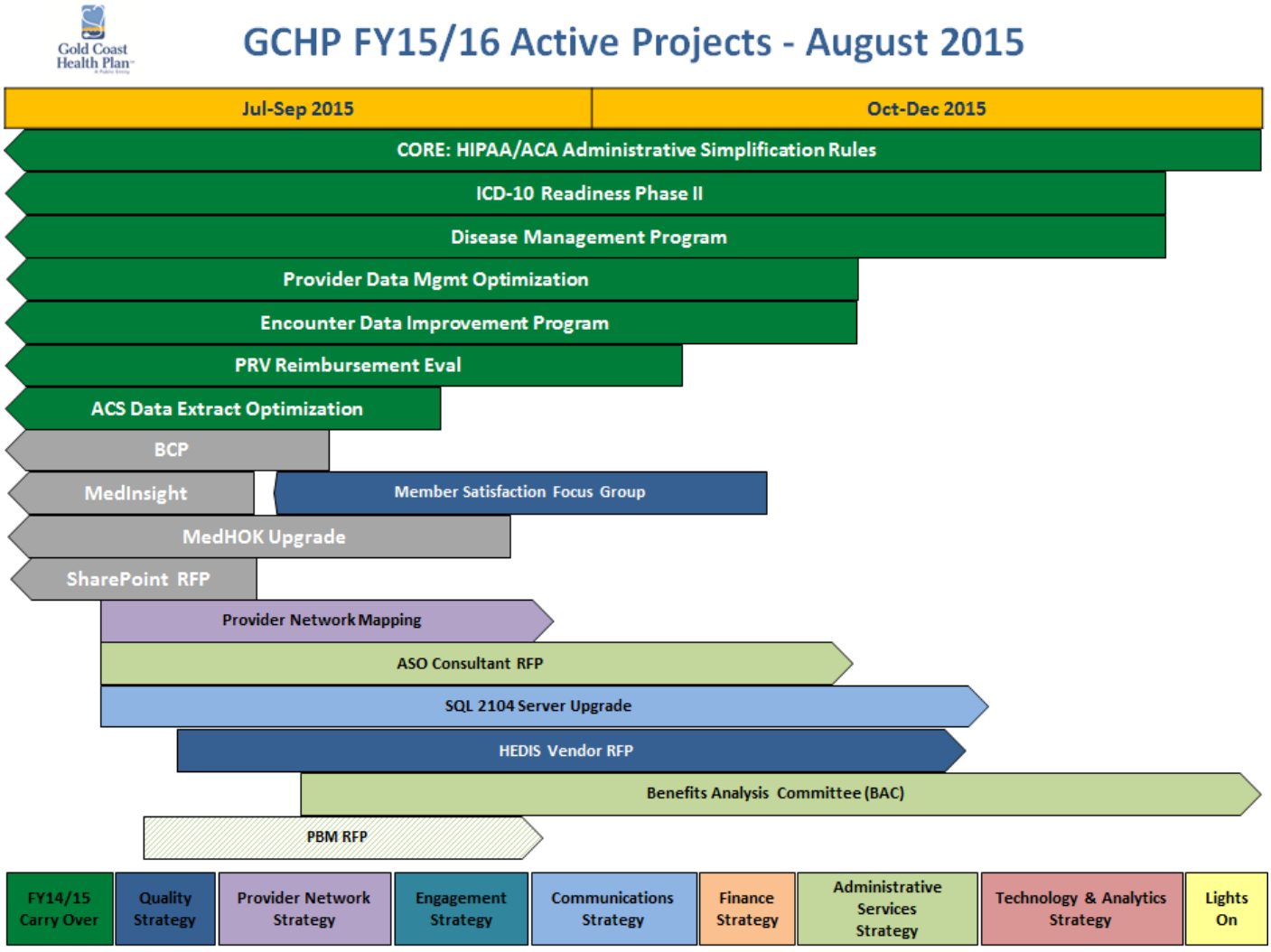
PMO Project Activity Highlights through August 2015:

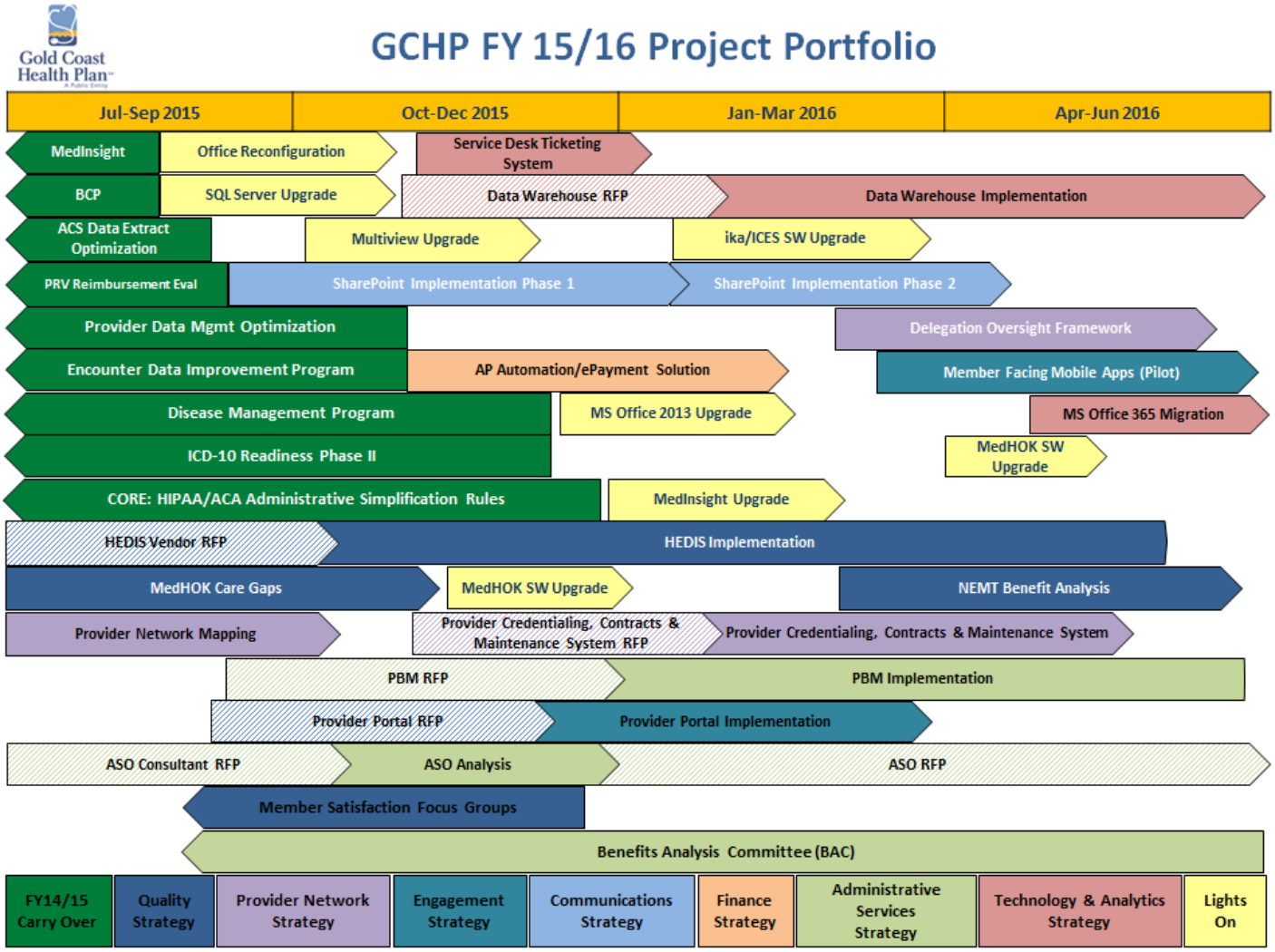
- Closed MedInsight Upgrade.
- RFP Initiatives for the ASO Evaluation Consultant and HEDIS Vendor are in progress.
- CORE-HIPAA/ACA Administrative Simplification Rules: Executed project change order with Edifecs to extend the project implementation from November to December 2015. The total budget impact for the four week extension is $10k. The extension is driven by additional time built into the project plan for file extract solution design and development. The cost of the schedule change is within the total project budget approved at the May 18, 2015

Commission Meeting.

Upcoming PMO Portfolio Activity:

- ICD-10 Readiness Phase II: Continue ICD-10 testing. Testing efforts will continue until go live on October 1, 2015.
- CORE-HIPAA / ACA Administrative Simplification Rules: Begin development and testing phases targeting November 2015.
- MedHOK Upgrade: Complete upgrade. The upgrade was rescheduled from August to September due to extended time required to complete user acceptance testing.
- Conduct member satisfaction focus groups.
- Complete Provider Mapping Software implementation.




Gold Coast Health Plan
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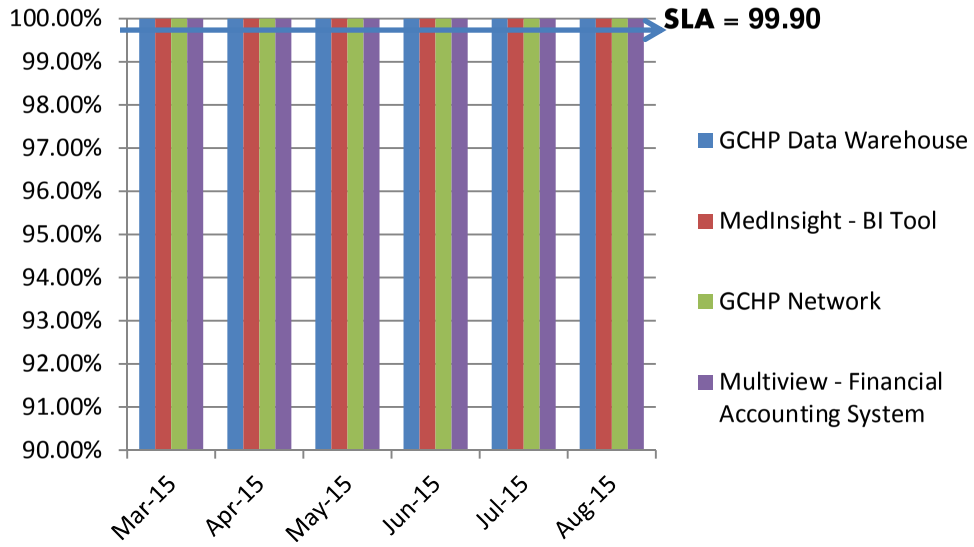
GCHP FY 15/16 Project Portfolio
Jul-Sep 2015
Oct-Dec 2015
Jan-Mar 2016
Apr-Jun 2016
MedInsight
Office Reconfiguration
Service Desk Ticketing System
BCP
SQL Server Upgrade
Data Warehouse RFP
Data Warehouse Implementation
ACS Data Extract Optimization
Multiview Upgrade
ika/ICES SW Upgrade
PRV Reimbursement Eval
SharePoint Implementation Phase 1
SharePoint Implementation Phase 2
Provider Data Mgmt Optimization
Delegation Oversight Framework
Encounter Data Improvement Program
AP Automation/ePayment Solution
Member Facing Mobile Apps (Pilot)
Disease Management Program
MS Office 2013 Upgrade
MS Office 365 Migration
ICD-10 Readiness Phase II
MedHOK SW Upgrade
CORE: HIPAA/ACA Administrative Simplification Rules
MedInsight Upgrade
HEDIS Vendor RFP
HEDIS Implementation
MedHOK Care Gaps
MedHOK SW Upgrade
NEMT Benefit Analysis
Provider Network Mapping
Provider Credentialing, Contracts & Maintenance System RFP
Provider Credentialing, Contracts & Maintenance System
PBM RFP
PBM Implementation
Provider Portal RFP
Provider Portal Implementation
ASO Consultant RFP
ASO Analysis
ASO RFP
Member Satisfaction Focus Groups
Benefits Analysis Committee (BAC)
FY14/15 Carry Over
Quality Strategy
Provider Network Strategy
Engagement Strategy
Communications Strategy
Finance Strategy
Administrative Services Strategy
Technology & Analytics Strategy
Lights On

FY 2015-16 GCHP Projects:

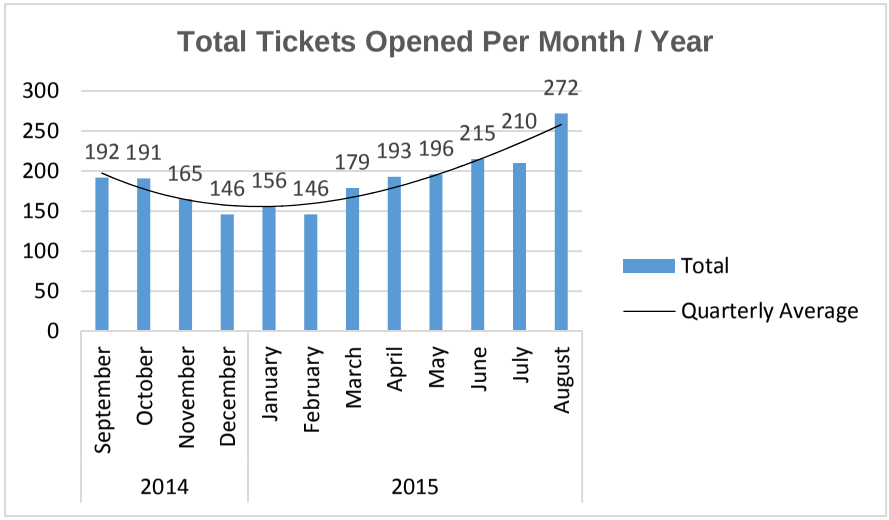
- **Healthcare Effectiveness Data and Information Set (HEDIS) Vendor Request for Proposal (RFP) and Implementation:** RFP and possible implementation of new HEDIS solution.
- **Care Gaps Implementation:** Implement Care Gaps module for member care coordination.
- **Provider Network Mapping:** Implement geographic mapping tool to analyze the GCHP health care network for optimized accessibility.
- **Provider Portal RFP and Implementation:** RFP and possible implementation of new provider portal.
- **Administrative Services Organization (ASO) Consultant RFP, Analysis and ASO RFP:** RFP for a consultant to help analyze and evaluate the GCHP core administrative services model, make recommendations, and support the ASO RFP process.
- **Pharmacy Benefits Manager (PBM) RFP and Implementation:** RFP and possible implementation of new PBM.
- **Provider Credentialing, Contracts and Maintenance System RFP & Implementation:** RFP and implementation of new system(s) to manage, support and optimize provider credentialing, contracting, and maintenance processes.
- **Non-Emergency Medical Benefit (NEMT) Analysis:** Analyze and evaluate alternatives to existing NEMT benefit.
- **SharePoint Implementation Phases 1 and 2:** Complete SharePoint environment redesign and deployment, including a GCHP intranet.
- **Accounts Payable (AP) Automation/ePayment Solution:** Evaluate and implement a solution to automate and streamline AP processes.
- **Data Warehouse RFP & Implementation:** RFP and implementation of an enterprise data warehouse for optimized reporting and analytics.
- **Service Desk Ticketing System:** Implement solution to track, manage, and help streamline support of desktop and application issues.
- **Delegation Oversight Framework:** Institute standard delegation and oversight requirements, policies, and procedures for establishing provider contracts.
- **Member Facing Mobile Apps Pilot:** Analyze member engagement needs and pilot mobile communication apps.

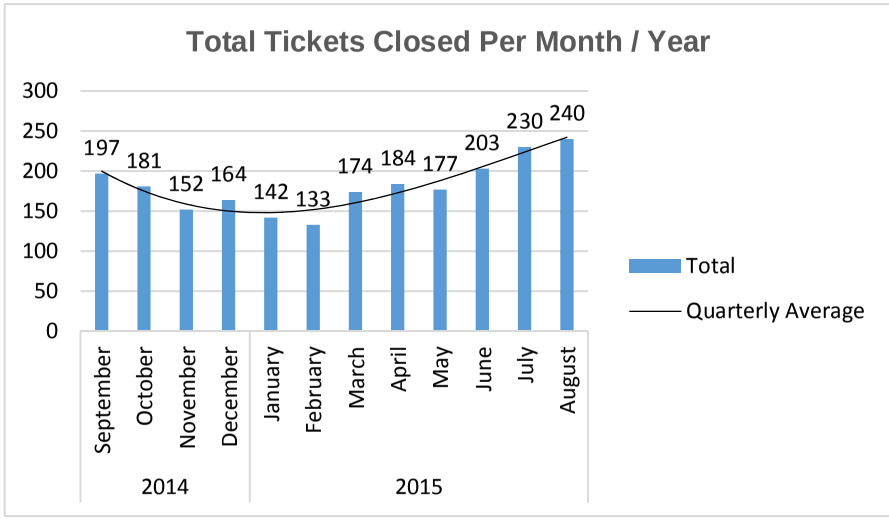
- **Office Expansion and Reconfiguration:** Office expansion project which will include the reconfiguration of the current location, in addition to acquiring new office space to accommodate growth and future expansion.
- **Microsoft SQL 2014 Upgrade:** Version upgrade and landscape redesign of GCHP SQL server environment.
- **Multiview Upgrade:** Software version upgrade for Multiview financial system.
- **Microsoft Office 2013 Upgrade:** Upgrade all employee machines to Microsoft Office 2013.
- **Ika/ICES Upgrade:** Software version upgrade for Xerox/ACS core administration processing and claims editing systems.
- **MedHOK Upgrade:** Software version upgrade for MedHOK medical management system.
- **MedInsight Upgrade:** Software version upgrade for MedInsight Business Intelligence (BI) tool; includes transition to hosted solution.
- **Member Satisfaction Focus Groups:** Conduct and analysis results of member focus groups to improve the Plan services**.**
- **Benefits Analysis Committee (BAC):** Thorough evaluation, impact analysis, remediation (as appropriate) of process and systems, and development of a tool to manage the covered benefits and services.

GCHP IT Metrics – August 2015



GCHP Helpdesk Service Ticket Trending





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AGENDA ITEM 3.e.

TO: Gold Coast Health Plan Commission

FROM: Nancy Wharfield, Associate CMO

DATE: September 28, 2015

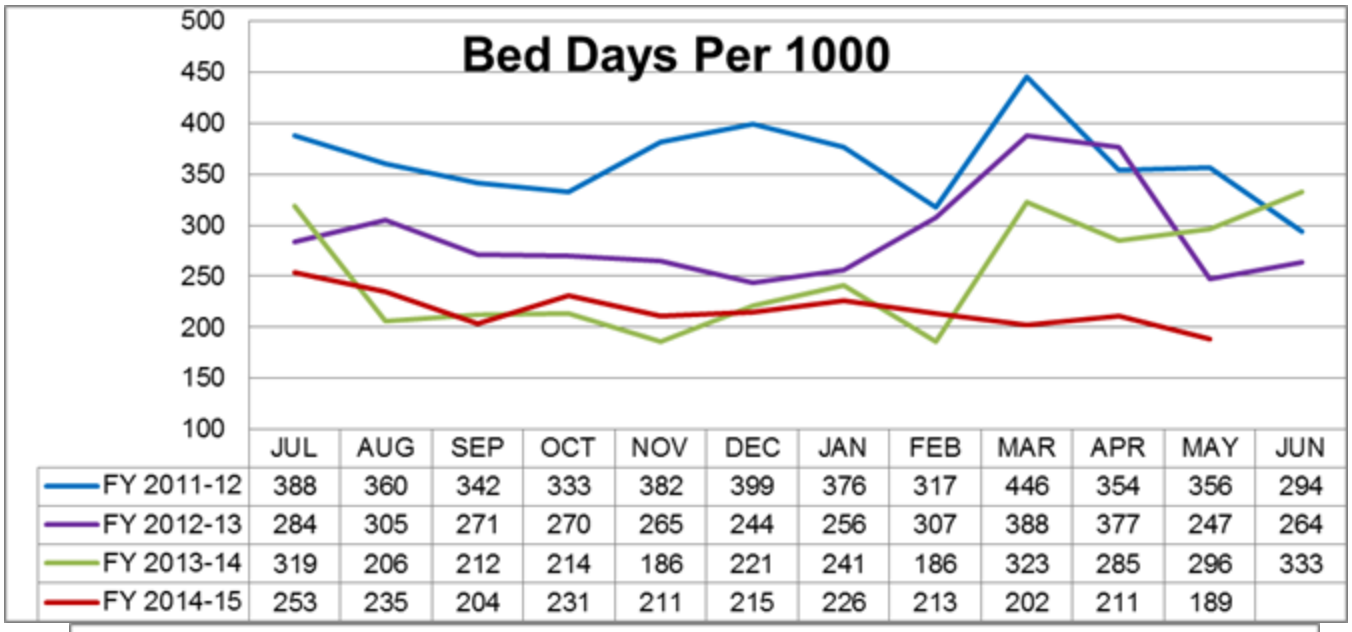
RE: CMO / Health Services Update

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

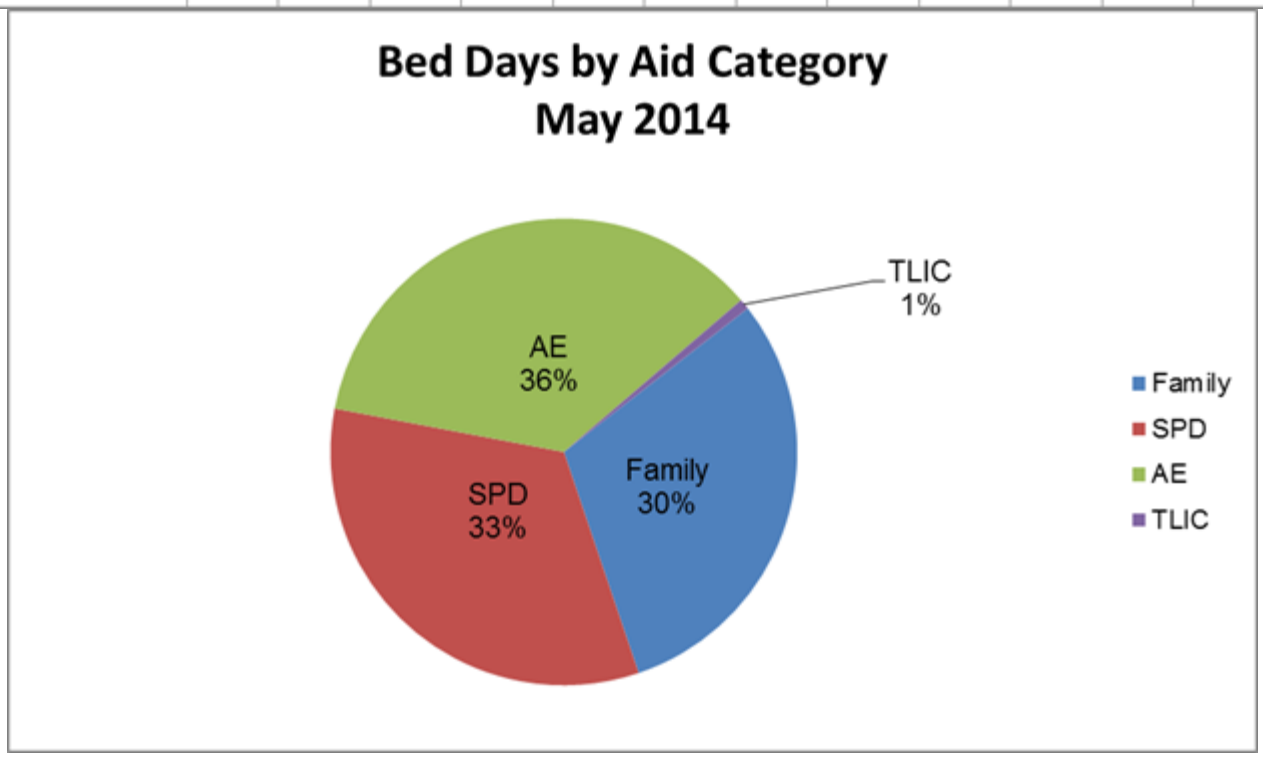
Bed Days/1000 Members

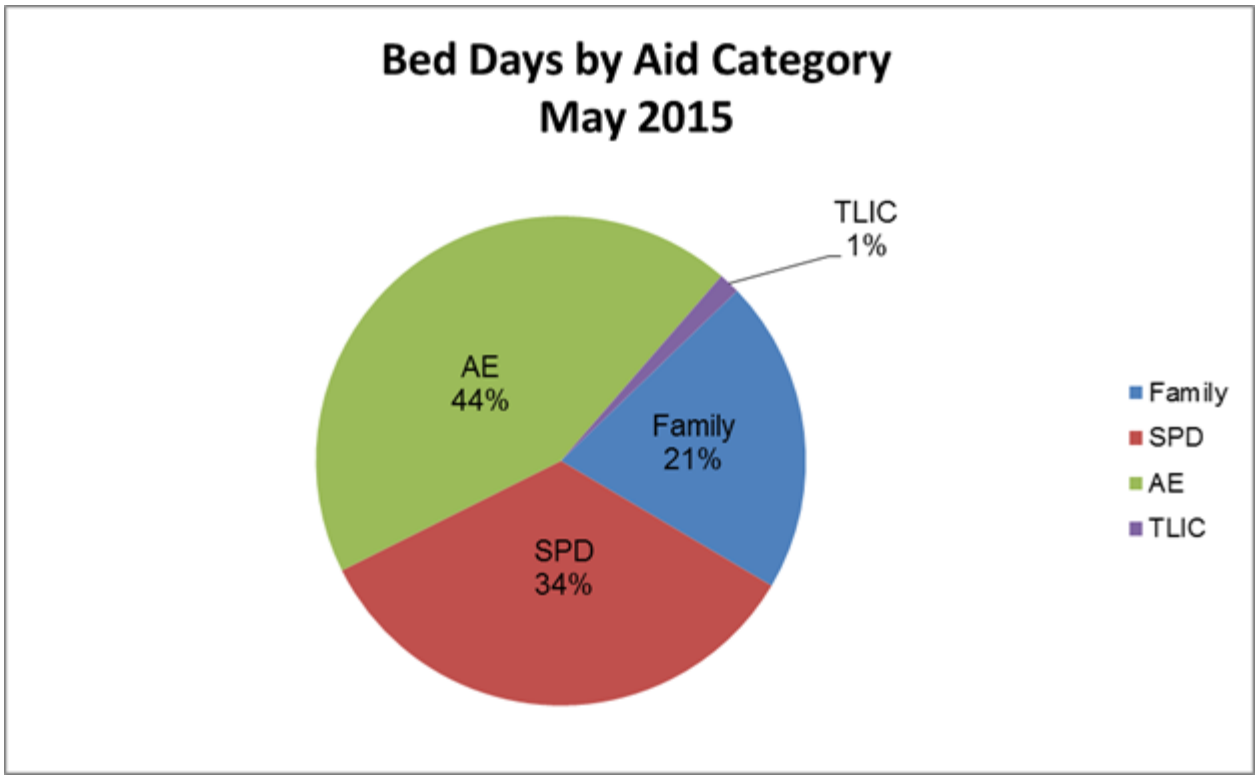
Bed days/1000 members for FY 2014-15 declined from summer through fall and winter and average 217 for FY YTD. A March peak in bed days/1000 members seen in other years of operation has not been reproduced in 2015. The percent of bed days utilized by AE members increased from May 2014 compared to May 2015 while Family bed days decreased.

Benchmark: Reports of bed days/1000 from available published managed care plan data range from 161– 890/1000 members. There is variability of reporting of Administrative days among managed care plans.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2011-12	388	360	342	333	382	399	376	317	446	354	356	294
FY 2012-13	284	305	271	270	265	244	256	307	388	377	247	264
FY 2013-14	319	206	212	214	186	221	241	186	323	285	296	333
FY 2014-15	253	235	204	231	211	215	226	213	202	211	189	

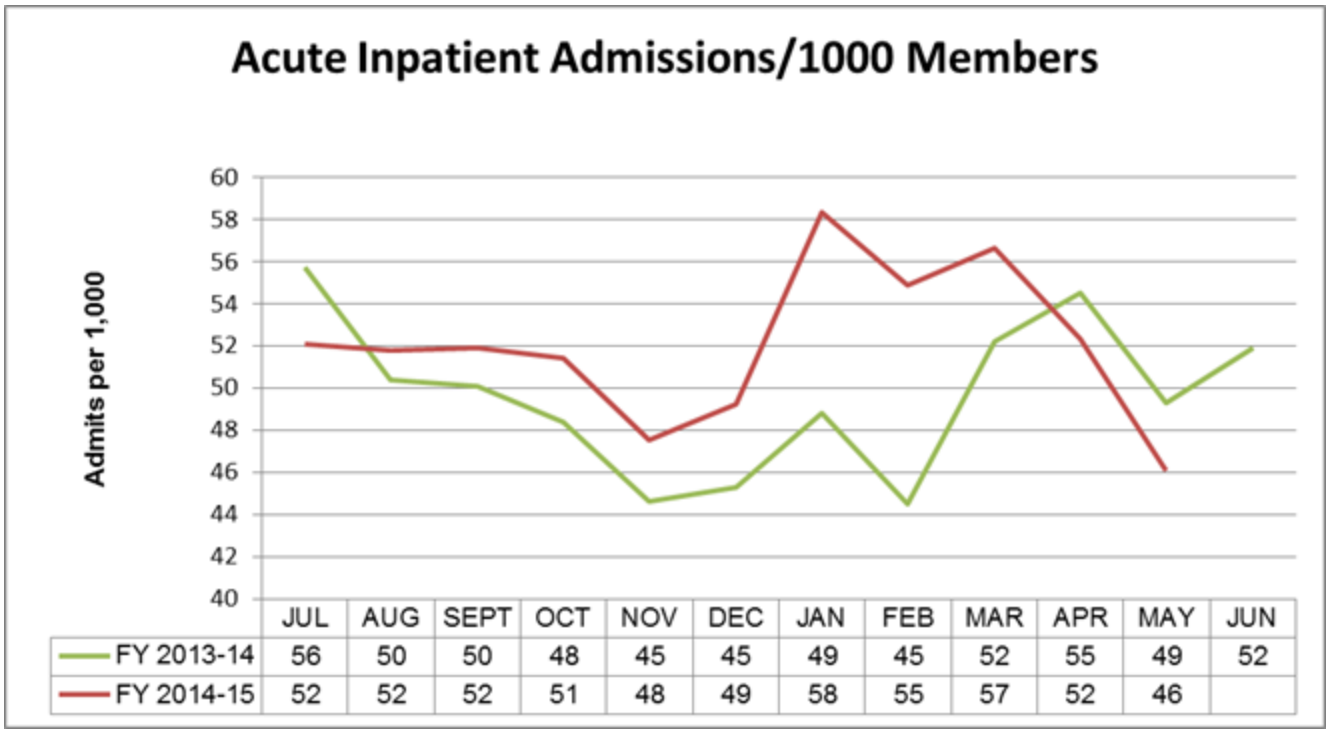




Inpatient Admissions/1000 Members

For CY 2014, average inpatient hospital admissions/1000 members were 50 with a peak in April and July. For YTD CY 2015, average inpatient hospital admissions/1000 members are 52.

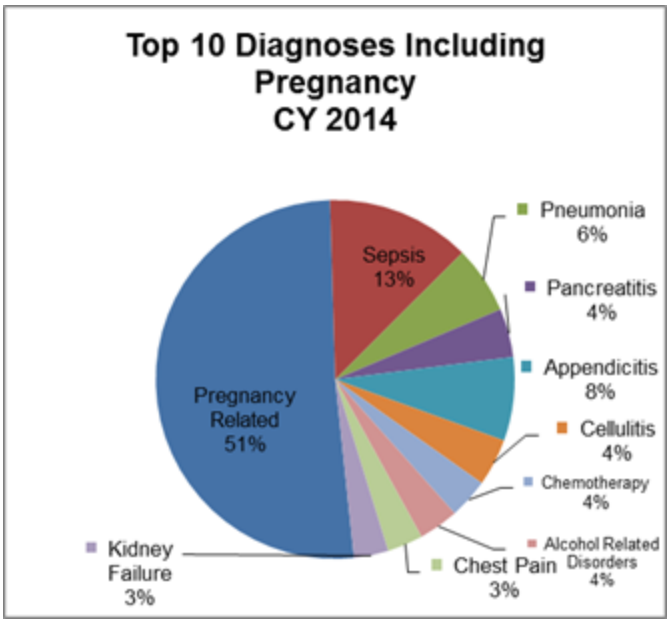
Benchmark: Reports of inpatient hospital admissions/1000 members from available published managed care plan data range from 68-71.

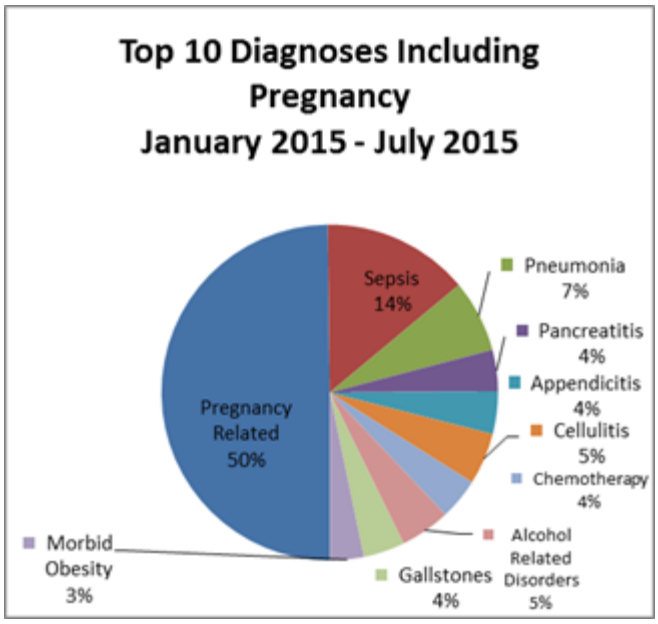


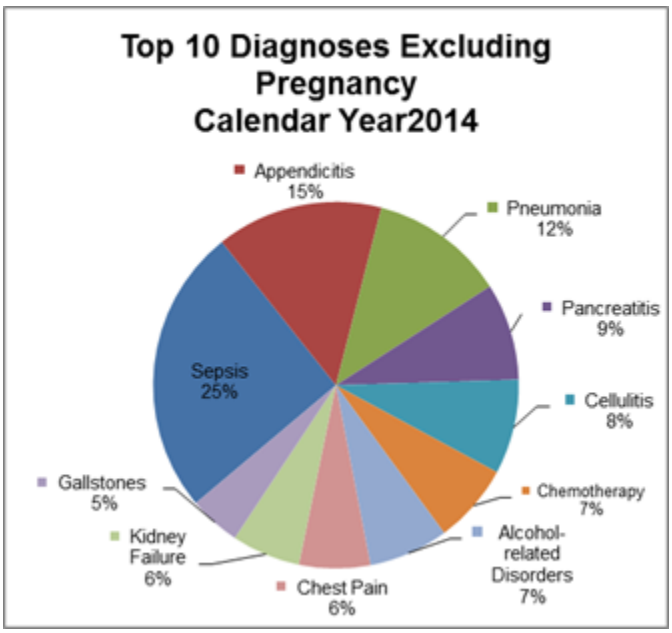
	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2013-14	56	50	50	48	45	45	49	45	52	55	49	52
FY 2014-15	52	52	52	51	48	49	58	55	57	52	46	

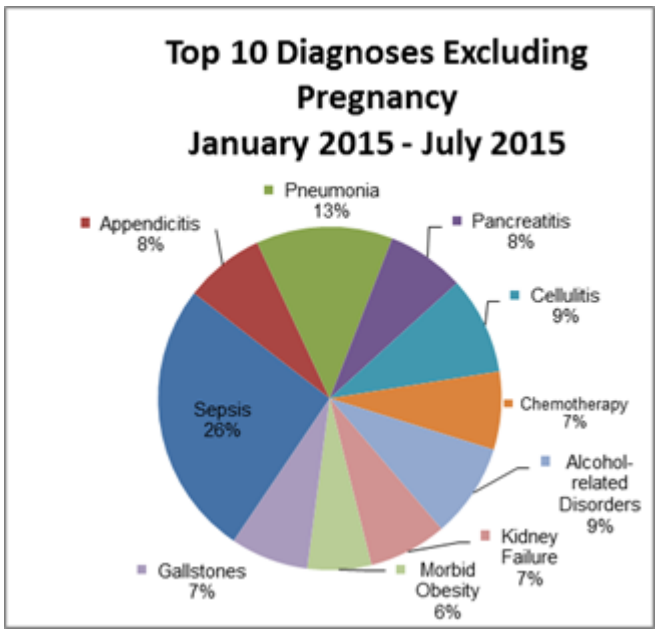
Top Admitting Diagnoses

Pregnancy related diagnoses overshadow all other diagnoses for CY 2014 and YTD CY 2015. Pneumonia and sepsis were also top diagnoses for CY 2014 and 2015. When pregnancy is excluded, sepsis, appendicitis, and pneumonia comprise approximately half of the remaining diagnoses for both CY 2014 and CY 2015 YTD.





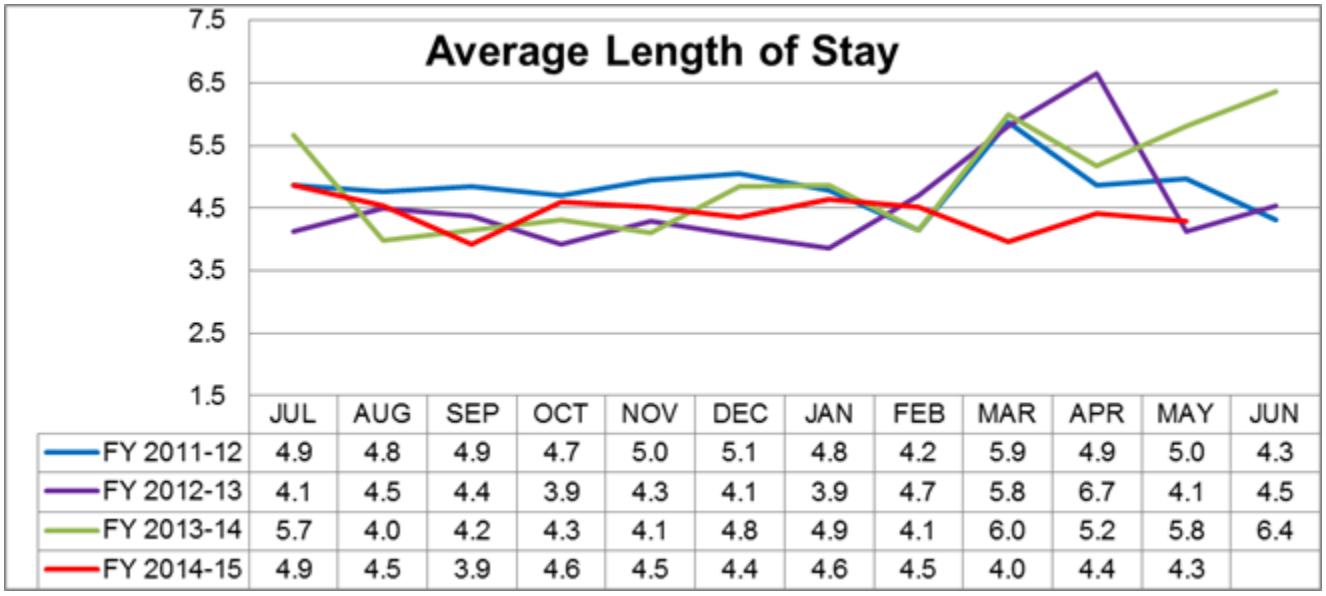




Average Length of Stay

The average length of stay for FY 2014-15 through May is 4.4. Average length of stay for CY 2014 was 4.9. The increase in length of stay seen in prior years in March – April has not been reproduced in FY 2014-15.

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



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2011-12	4.9	4.8	4.9	4.7	5.0	5.1	4.8	4.2	5.9	4.9	5.0	4.3
FY 2012-13	4.1	4.5	4.4	3.9	4.3	4.1	3.9	4.7	5.8	6.7	4.1	4.5
FY 2013-14	5.7	4.0	4.2	4.3	4.1	4.8	4.9	4.1	6.0	5.2	5.8	6.4
FY 2014-15	4.9	4.5	3.9	4.6	4.5	4.4	4.6	4.5	4.0	4.4	4.3	

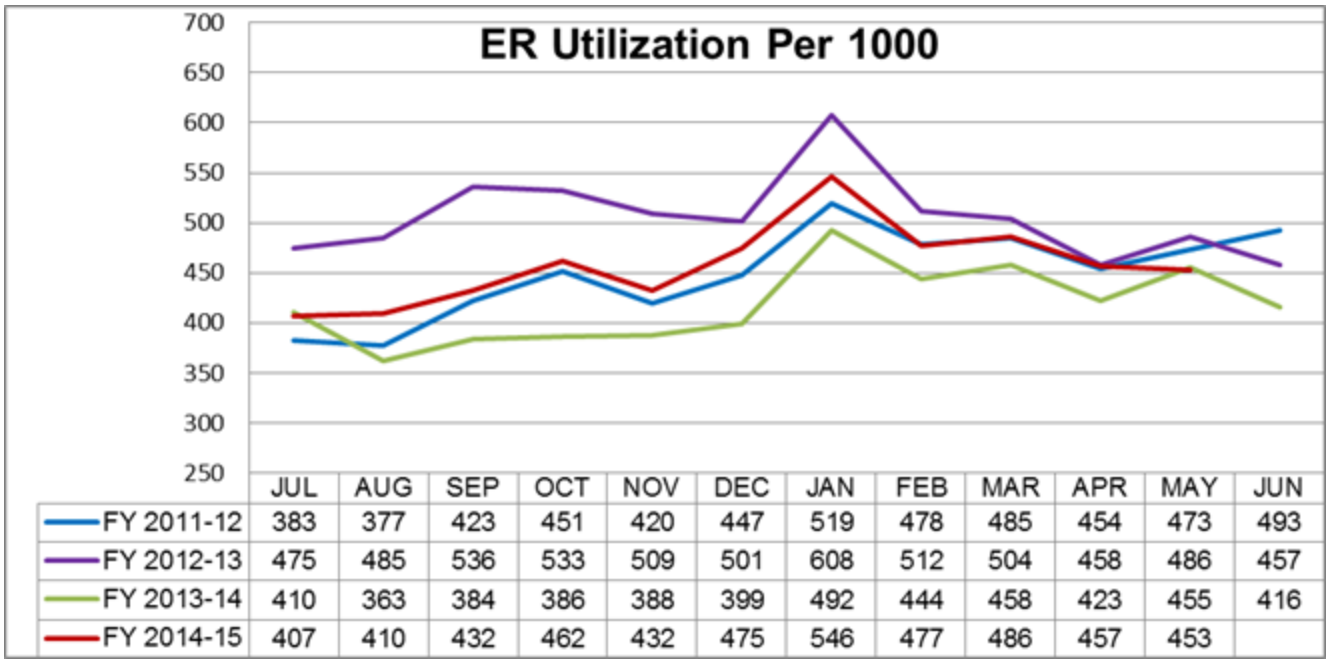
ER Utilization

ER utilization/1000 members declined from the seasonal January peak seen each year of operation. ER utilization for FY 2014-15 YTD averages 458 visits/1000 members and is higher than the average for the same period in FY 2013-14 (414). Average ER visits/1000 members for CY 2014 were 442. The percent of ER utilization by AE members increased approximately 1.5 in May 2015 compared to May 2014.

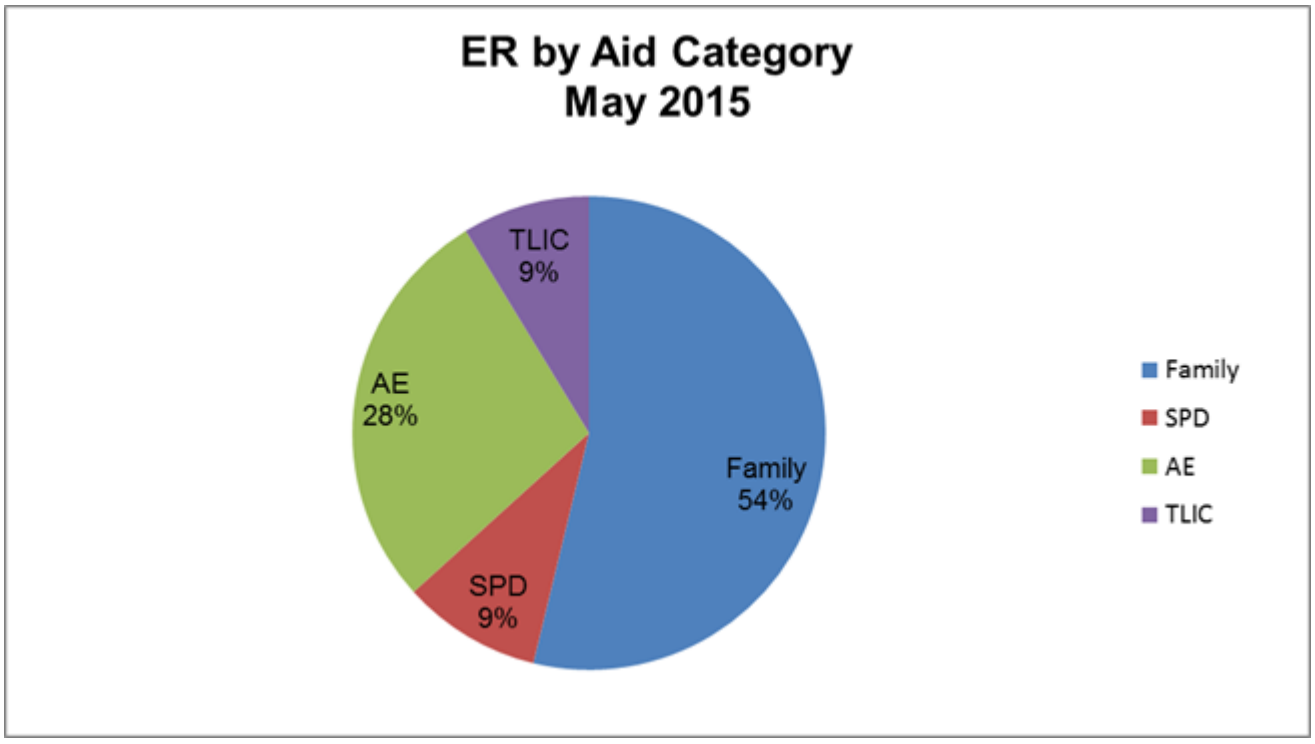
Benchmark: ER utilization/1000 members from available published data from other managed care plans ranges from 554-877.

The June 16, 2015 DHCS Medi-Cal Managed Care Performance Dashboard reported 39 ER visits/1000 member months statewide for all managed care plans in FY 2013-14. GCHP ***ER utilization/1000 member months*** for the same period was also 39.

The June 2015 DHCS Medi-Cal Managed Care Performance Dashboard reports 3 ***ER visits with an inpatient admission/1000 member months*** for FY 2013-14. GCHP ***ER visits with an inpatient admission/1000 member months*** was also 3 for the same period.



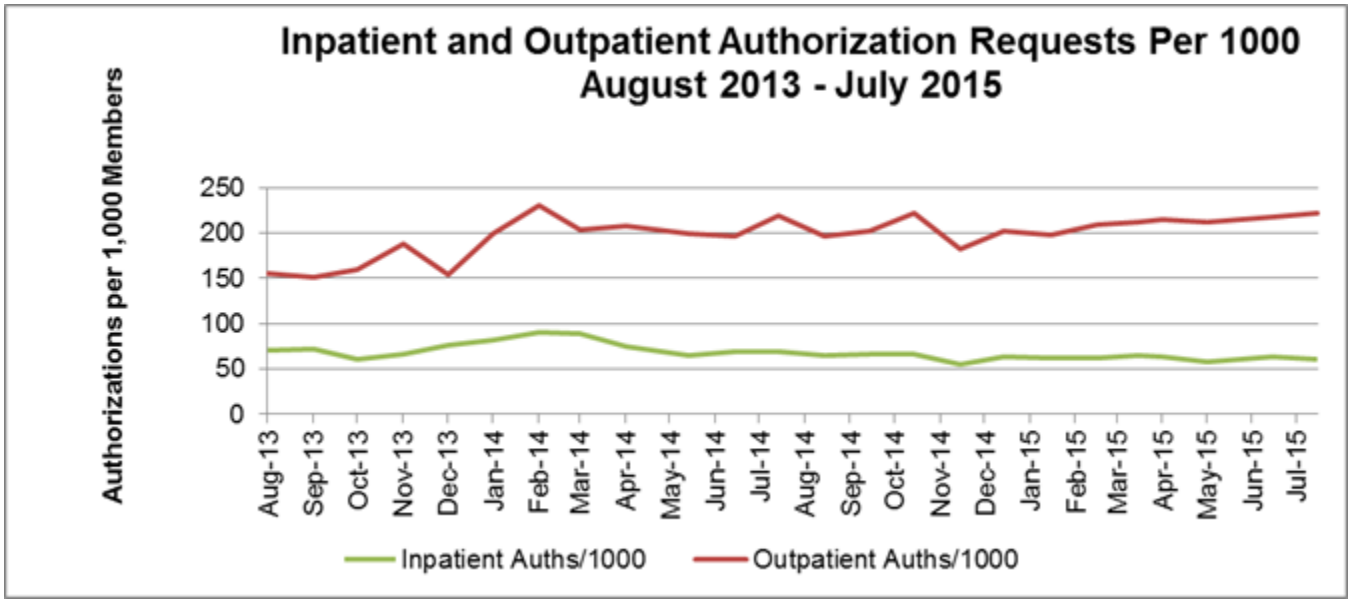
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2011-12	383	377	423	451	420	447	519	478	485	454	473	493
FY 2012-13	475	485	536	533	509	501	608	512	504	458	486	457
FY 2013-14	410	363	384	386	388	399	492	444	458	423	455	416
FY 2014-15	407	410	432	462	432	475	546	477	486	457	453	

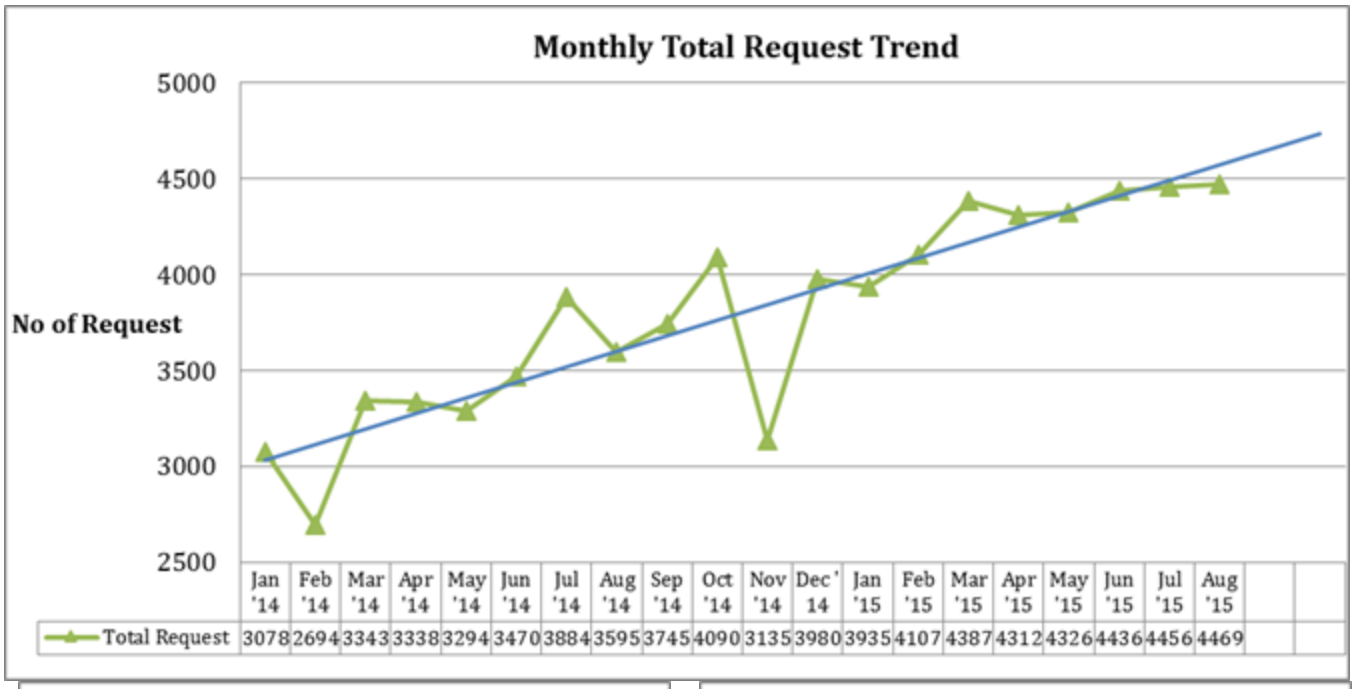


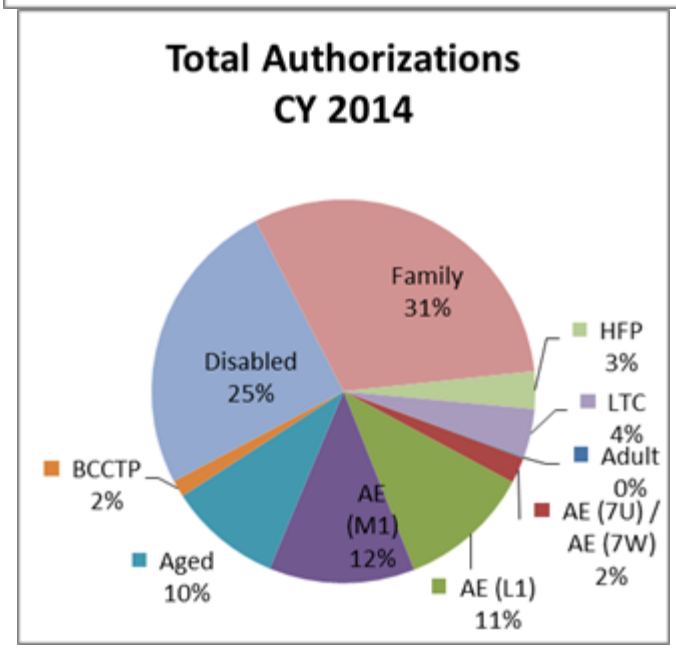
Authorization Requests

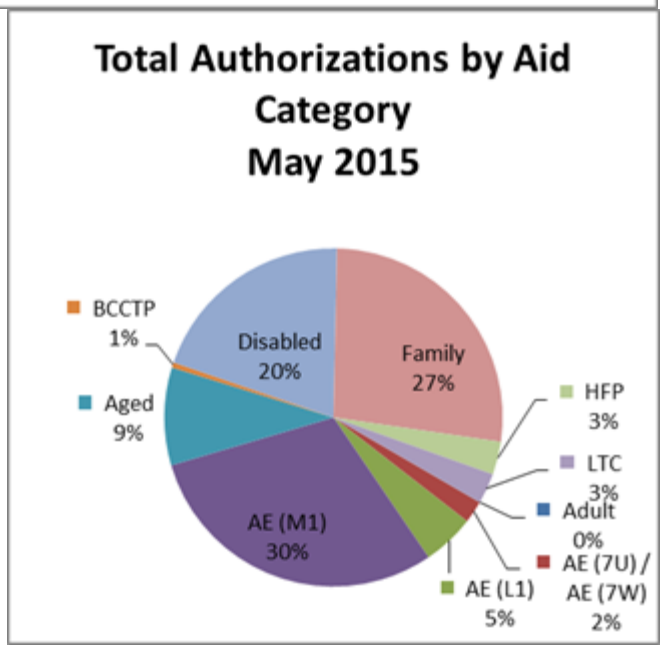
Requests for outpatient service continue to outnumber requests for inpatient service. Outpatient service requests for July 2015 were 222/1000 members are drifting towards the peak seen in February of 2014 (230). Requests for inpatient service have declined from a peak in February 2014 and average 62 requests/1000 members for CY 2015.

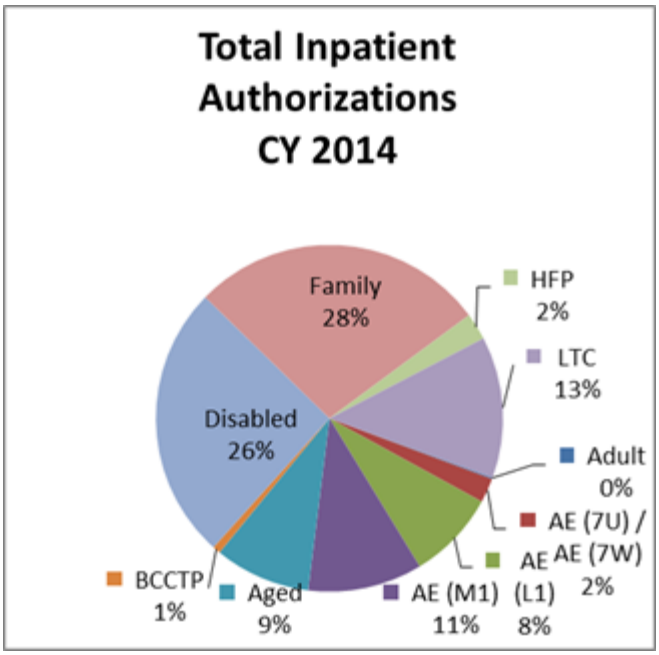
In May 2015, AE members accounted about 1/3 of all service requests and represented approximate 1/4 of GCHP membership. Within the AE group, requests for service by M1 members more than doubled from May 2014 to May 2015.

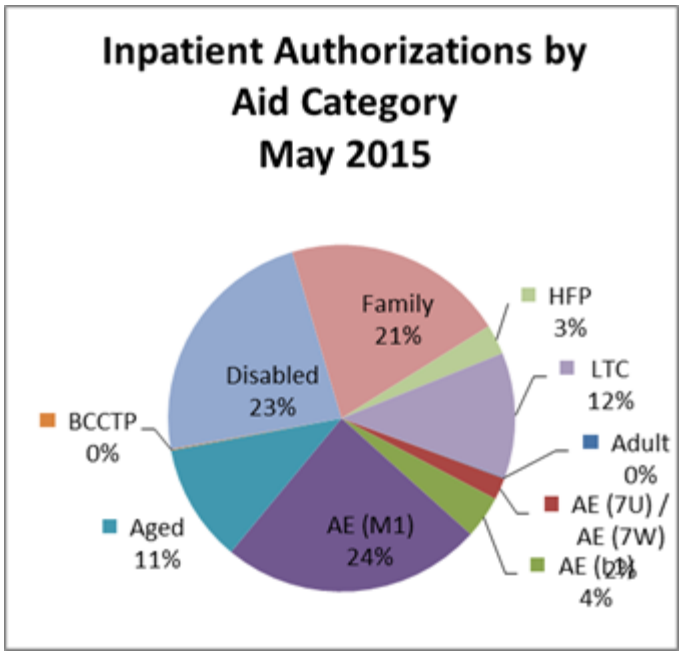


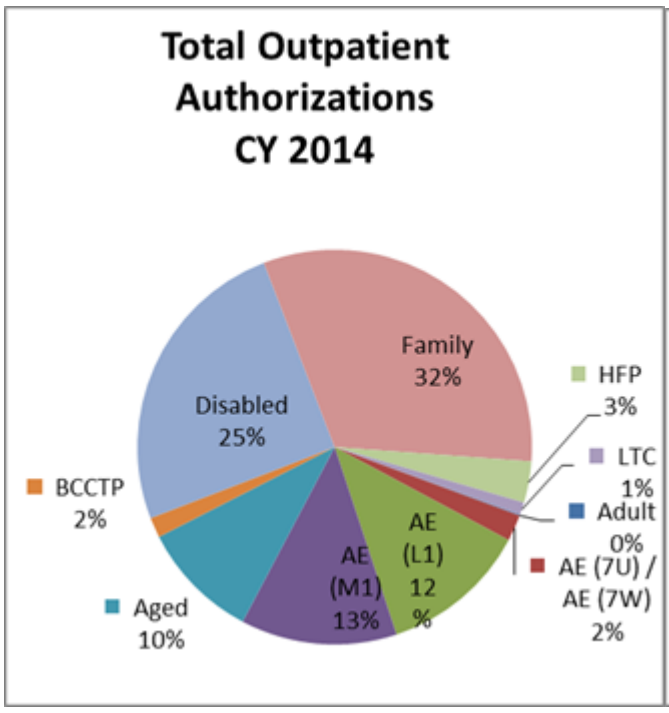

Monthly Total Request Trend
No of Request
5000
4500
4000
3500
3000
2500
Jan '14 Feb '14 Mar '14 Apr '14 May '14 Jun '14 Jul '14 Aug '14 Sep '14 Oct '14 Nov '14 Dec '14 Jan '15 Feb '15 Mar '15 Apr '15 May '15 Jun '15 Jul '15 Aug '15
Total Request 3078 2694 3343 3338 3294 3470 3884 3595 3745 4090 3135 3980 3935 4107 4387 4312 4326 4436 4456 4469

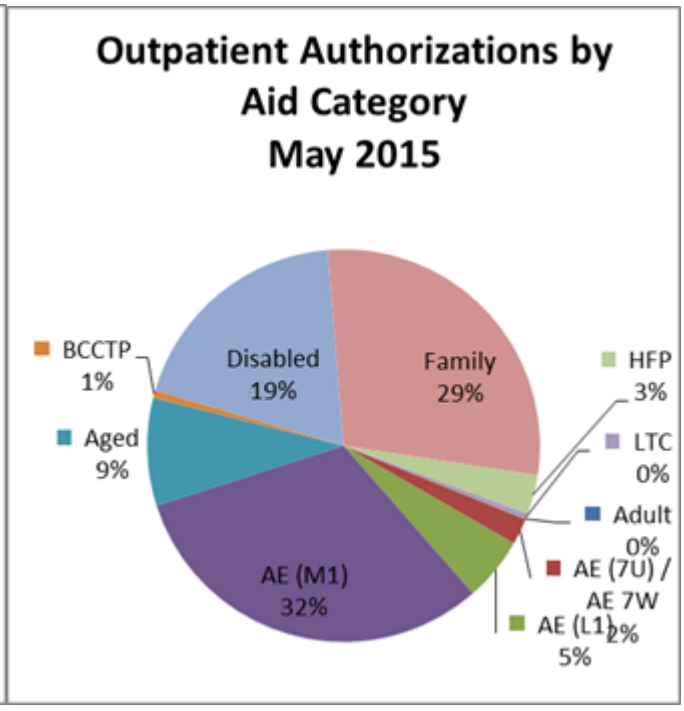

Total Authorizations
CY 2014
Family 31%
HFP 3%
LTC 4%
Adult 0%
AE (7U) / AE (7W) 2%
AE (L1) 11%
AE (M1) 12%
Aged 10%
BCCTP 2%
Disabled 25%


Total Authorizations by Aid Category
May 2015
Family 27%
HFP 3%
LTC 3%
Adult 0%
AE (7U) / AE (7W) 2%
AE (L1) 5%
AE (M1) 30%
Aged 9%
BCCTP 1%
Disabled 20%





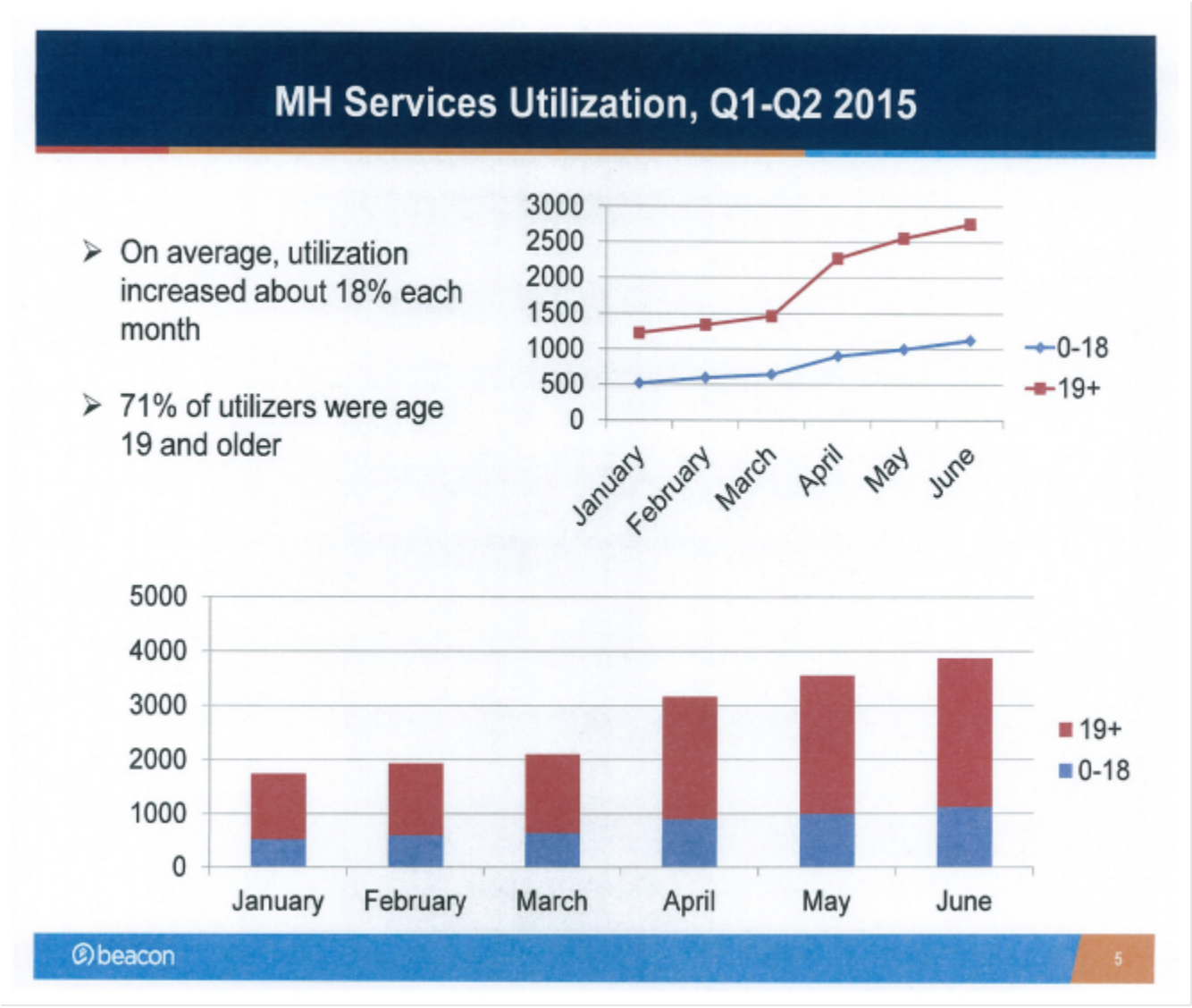


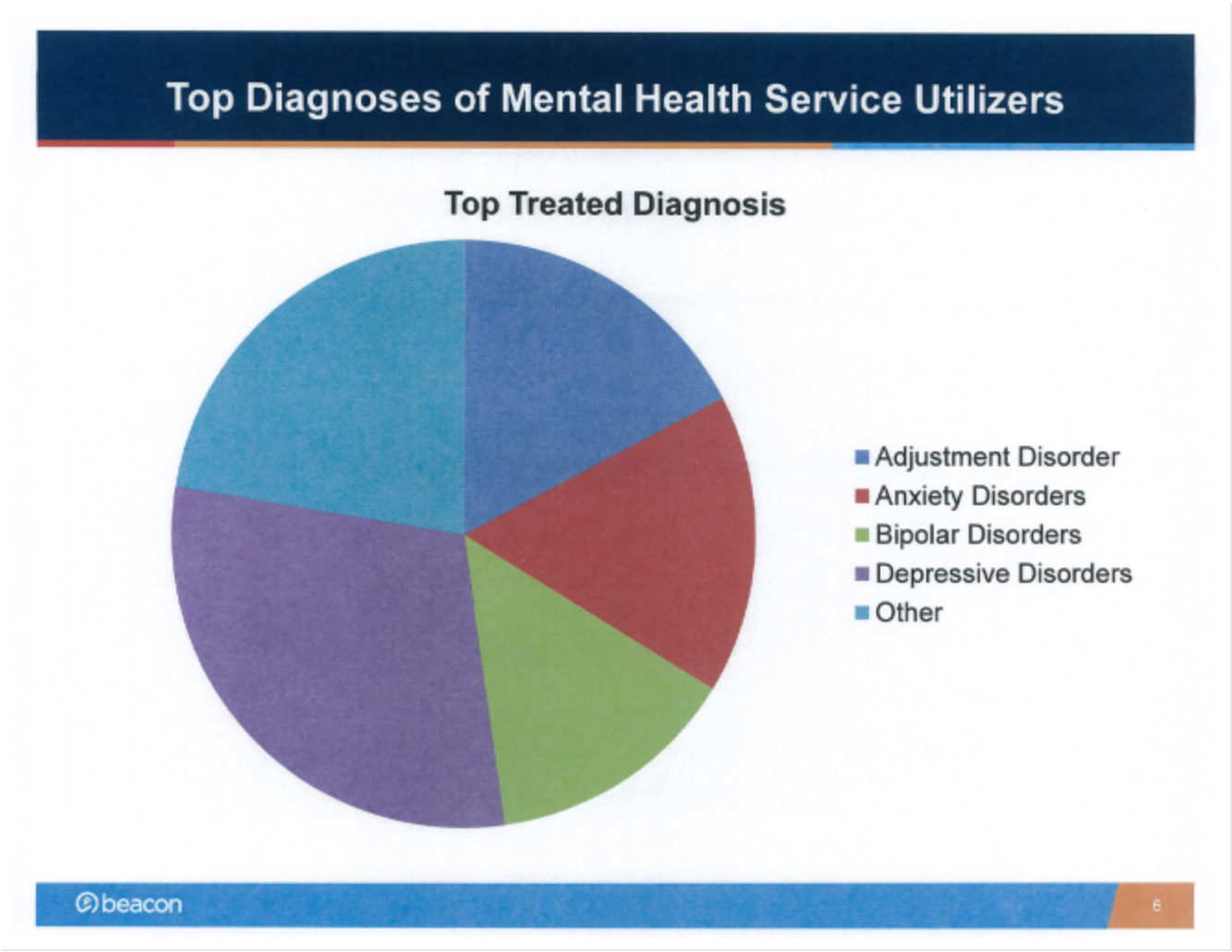


Mental Health Services Utilization

Outpatient mental health visits approximately doubled from January 2015 to June 2015. The number of referrals for mild to moderate behavioral consultation increased more than 1.5 times in

Q2 of 2015. Most mental health care is for depression followed by anxiety, adjustment and bipolar disorders. As of Q2 2015, 22 members are receiving applied behavioral analysis (ABA) services for autism spectrum disorder.``




Top Diagnoses of Mental Health Service Utilizers
Top Treated Diagnosis
Adjustment Disorder
Anxiety Disorders
Bipolar Disorders
Depressive Disorders
Other
beacon
6

BHT/ABA Utilization

Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Utilization	
	9/15/14 – 7/3/15
# of calls received/inquiries regarding BHT services	51
# referred for comprehensive diagnostic evaluation	3
# completed comprehensive diagnostic evaluation	2
# referred for assessment	20
# completed assessment	17
# of beneficiaries currently receiving BHT services	22

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OUTREACH UPDATE

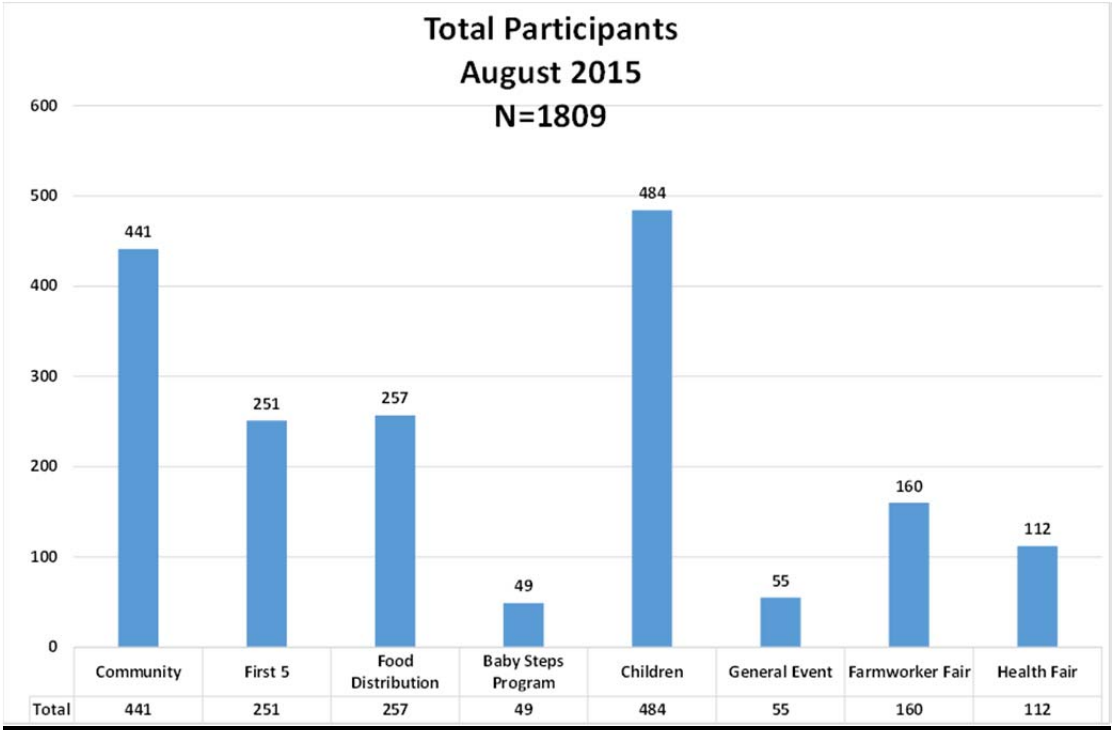
Summary

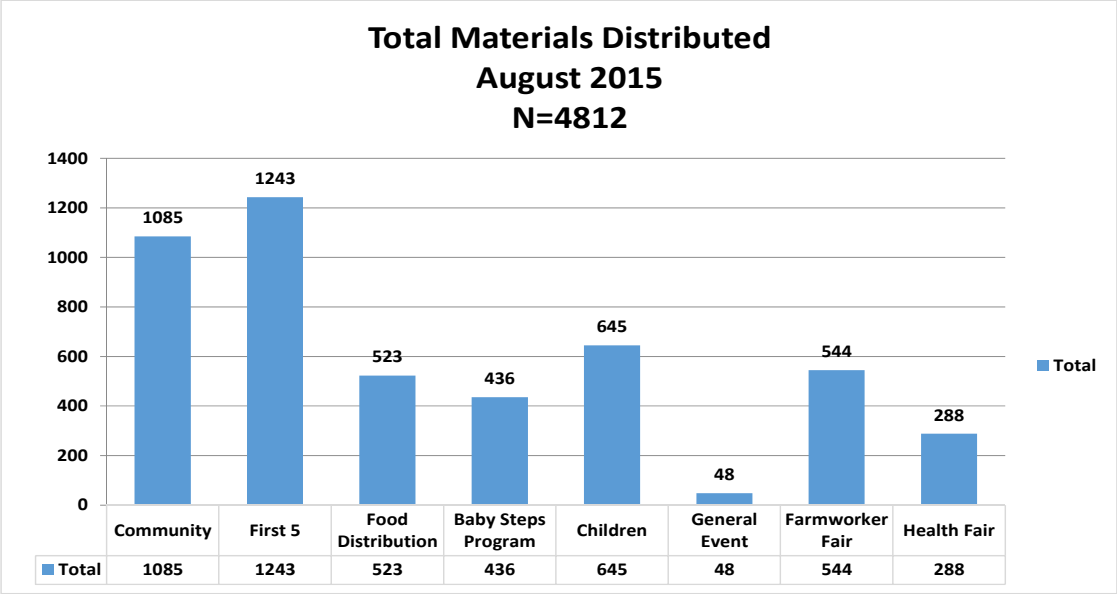
Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. The health education and outreach team conducted the following activities during the month of August.

Outreach Events – August 2015

During the month of August, GCHP's health education and outreach team participated in 15 different community based resource and health fairs. The majority (60%) of individuals reached were from events that reached the general population including GCHP members. Approximately (20%) of outreach events focused on school and youth groups. The team also participated in food distribution events held throughout various locations in the county.

A total of 1,809 individuals were reached and approximately 4,812 education materials were distributed to various groups and organizations. Below are two charts that highlight the total number of participants reached and materials distributed during the month of August.





Sponsorship Award Update

Summary

Gold Coast Health Plan (GCHP) Sponsorship Committee reviewed two sponsorship applications in August. Both sponsorship applications were funded.

Background

The following organizations and/or events were recommended for funding:

- **31st Annual Light Up A Life Celebration:** The review committee awarded Livingston Memorial Visiting Nurse Association (LMVNA) with $1000 for the 31st Annual Light Up A Life Celebration. The review committee was impressed by the efforts made by LMVNA's hospice services for the sick, handicapped, elderly, terminally ill and housebound to advance the health and wellbeing of Ventura County's local community.

- **Ventura County Public Health (VCPH)**: The review committee awarded $500 to VCPH for a Physician Forum - Reducing Perinatal Risk. The review committee was impressed by the continued efforts that protect and promote the health and well-being of Ventura County's local community.

Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM 3.f.

TO: Gold Coast Health Plan Commission

FROM: Brandy Armenta, Director of Compliance

DATE: September 28, 2015

RE: 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- 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 issued the draft report on July 8, 2015. The draft report was in conjunction with the exit conference between: A&I, DHCS and GCHP staff on July 8, 2015. The Plan had 15 calendar days to provide additional material to demonstrate compliance and or additional clarification information. A&I will review the material and issue a final CAP which was slated for late August or beginning of September 2015. The Plan is currently pending receipt of the final CAP.

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. GCHP Compliance Officer and Compliance Manager attended the Department of Justice quarterly Fraud meeting in Los Angeles on September 8, 2015. In addition, compliance & 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 developed 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 Compliance Committee continues to meet on a monthly basis. The committee reviewed a status update by compliance staff relative to the delegate who is currently under a financial sanction. The delegate remains under the Plan imposed financial sanction, the CAP remains open and additional reporting requirements have been requested for monitoring. Onsite meetings between executive staff at GCHP and the delegate have also occurred. The delegate is committed to addressing the issues and the Plan continues to monitor performance on the CAP. The Plan is committed to holding all delegates accountable.

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.

A six month follow up audit was conducted on May 4, 2015 specific to claims processing on our mental health behavioral organization (MBHO). A CAP was issued on May 14, 2015 and remains open. A routine annual audit on utilization management audit was conducted on the specialty contract delegate on June 9, 2015. A CAP was issued to the delegate on July 13, 2015. The delegate responded however the deficiencies were not addressed to achieve compliance therefore the CAP will remain open and a second CAP letter was issued on August 31, 2015. The Plan is pending a response from the delegate.

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.

Gold Coast Health Plan℠
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COMPLIANCE REPORT 2015

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Hotline A confidential telephone and web-based process to collect info on compliance, ethics, and FWA	Referrals *one referral can be sent to multiple referral agencies*	0	1	0	0	1	0	0	0				
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0	0	0	0	0	0	1	0				
Hotline Referral *FWA	Department of Justice	0	0	0	0	0	0	0	0				
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	5	4	9	4	6	2	0	4				
Hotline Referral	External Agency (i.e. HSA)	0	0	0	0	0	0	0	0				
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	0	1	0	0	0	0	1	0				
Delegation Oversight	Delegated Entities	8	8	8	8	8	8	8	8				
The committee's function is to ensure that delegated activities of subcontracted entities are in compliance with standards set forth from GCHP contract with DHCS and all applicable regulations	Reporting Requirements Reviewed **	72	57	47	70	66	55	72	74				
	Audits conducted	3	0	2	1	1	1	2	0				
Delegation Oversight	Letters of Non-Compliance	0	0	0	2	1	1	1	1				
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	1	1	1	1	1	1	1	0				
Audits	Total	0	2	0	0	0	0	0	0				
External regulatory entities evaluate GCHP compliance with contractual obligations.	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	0	0	0	0	0	0	0	0				
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0	0	0	0	0	0	0	0				
	HEDIS Compliance Audit (HSAG)	0	1	0	0	0	0	0	0				
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2014*	0	0	0	0	0	0	0	0				
	DHCS Medical Audit *Audit was conducted in 2014*	0	1	0	0	0	0	0	0				
Fraud, Waste & Abuse	Total Investigations	5	4	9	4	6	2	1	4				
The Fraud Waste and Abuse Prevention process is intended to prevent, detect, investigate, report and resolve suspected and /or actual FWA in GCHP daily operations and interactions, whether internal or external.	Investigations of Providers	0	0	0	0	1	0	0	0				
	Investigations of Members	5	4	9	4	5	2	1	4				
	Investigations of Other Entities	0	0	0	0	0	0	0	0				
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0	0	0	0	0	0	0	0				
HIPAA	Referrals	2	4	2	1	1	1	1	0				

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	State Notification	1	4	2	1	1	1	1	0				
	Federal Notification	0	4	0	0	0	0	0	0				
	Member Notification	0	1	0	2	1	0	0	0				
	HIPAA Internal Audits Conducted	1	0	0	0	0	0	0	1				
							^^						
Training	**Training Sessions**	12	4	9	3	12	151	39	8				
Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Fraud, Waste & Abuse Prevention	4	1	3	1	4	73	19	4				
	Fraud, Waste & Abuse Prevention (Member Orientations)	0	1	0	0	0	0	0	0				
	Code of Conduct	4	1	3	1	4	5	1	1				
	HIPAA (Individual Training)	4	1	3	1	4	73	19	4				
	HIPAA (Department Training)	0	0	0	0	0	0	0	0				

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

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

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

^^Training Sessions: 5 new employees, along with 68 yearly training.