

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

**County of Ventura Government Center
Hall of Justice - Pacific Conference Room
800 S. Victoria Avenue, Ventura, CA 93009**

**Monday, February 23, 2015
3:00 p.m.**

AGENDA

CALL TO ORDER / ROLL CALL

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

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

1. APPROVE MINUTES

a. [Regular Meeting of January 26, 2015](#)

2. APPROVAL ITEMS

a. [Q4 Quality Report](#)

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

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

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

**Ventura County Medi-Cal Managed Care Commission (VCMCC) dba
Gold Coast Health Plan February 23, 2015 Commission Meeting Agenda (continued)**
LOCATION: County of Ventura Government Center - Hall of Justice – Pacific Conference Room
800 S. Victoria Avenue, Ventura, CA 93009
TIME: 3:00 p.m.
PAGE: 2 of 2

- b. [Ethics Policy](#)
- c. [Investment Policy](#)
- d. [Credentialing Policy](#)
- e. [Sponsorship Policy](#)
- f. [Reorganization and Structure of Committees](#)

3. ACCEPT AND FILE ITEMS

- a. Special Investigation Ad Hoc Committee Report
- b. [CEO Update](#)
- c. [CFO Update - December Financials](#)
- d. [COO Update](#)
- e. [CIO Update](#)
- f. [Health Services Update](#)

CLOSED SESSION

a. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LTIGATION

Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of
Section 54956.9: Number of cases: Unknown

b. CONFERENCE WITH LABOR NEGOTIATORS

Agency designated representatives: Stacy Diaz, Scott Campbell and Gold Coast
Health Plan Commissioners
Unrepresented employee: Chief Executive Officer

COMMENTS FROM COMMISSIONERS

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

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ENSURE ACCESSIBILITY TO THIS MEETING.

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on March 23, 2015 at 3:00 p.m. in the County of Ventura Government Center - Hall of Administration Lower Plaza Assembly Room , 800 S. Victoria Avenue, Ventura, CA

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**Medi-Cal Managed Care Commission
(VCMGCC) dba Gold Coast Health Plan (GCHP)
Commission Meeting Minutes
January 26, 2015
(Not official until approved)**

CALL TO ORDER

Chair Araujo called the meeting to order at 3:03 p.m. in Hall of Administration - Lower Plaza Assembly Room at the County of Ventura Government Center, 800 S. Victoria Avenue, Ventura, CA 93009.

SWEAR IN OF NEW COMMISSIONER

Darren Lee was sworn in by Clerk of the Board McGinley.

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 Glycer, Private Hospitals / Healthcare System

Michelle Laba, MD, Ventura County Medical Center Executive Committee

Darren Lee, Private Hospitals / Healthcare System

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

Ruth Watson, Chief Operations Officer and Interim Chief Executive Officer

John Meazzo, Interim Chief Financial Officer

Traci R. McGinley, Clerk of the Board

Scott Campbell, Legal Counsel

Brandy Armenta, Compliance Director

Stacy Diaz, Human Resources Director

Anne Freese, Pharmacy Director

Guillermo Gonzalez, Government Relations Director

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
Nancy Wharfield, MD, Associate Chief Medical Officer

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of November 24, 2014

Commissioner Fisher moved to approve the Regular Meeting Minutes of November 24, 2014. Commissioner Pupa seconded. The motion carried with the following votes:

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

To accommodate the consultant's schedule, the Legislative Update Informational Item was heard next.

5. INFORMATIONAL ITEMS

a. Legislative Update and State Budget Presentation – Don Gilbert and Trent Smith of Edelstein Gilbert Robson & Smith, LLC (GCHP Legislative Advocate)

Don Gilbert stated that this last election brought a lot of changes; many of the committees will have new members as well as leaders. One of the largest changes occurred earlier in the day; the Governor announced that Jennifer Kent was appointed as the Director of Health Care Services. He and Trent have worked with Jennifer over the years; she is a good appointment and knows the issues. He closed stating that his firm will continue to meet with the Department of Health Care Services staff, as well as the Director, to keep them apprised of topics relevant to the Plan.

Trent Smith reported on regulations that would impact the Plan.

- The most significant bill they believe will be introduced would require COHS to obtain Knox Keene licenses. COHS are the only plans currently exempt, but the Department of Health Care Services contract has most of the same requirements as a Knox Keene license.
- At the end of 2014 the federal government ruled that the MCO tax and other similar types of arrangements are no longer viable as currently defined. The State brought in approximately \$1 billion per year of federal funds by using this type of tax structure and unless the State comes up with a new tax, it will no longer obtain these funds. He explained that the problem with a new tax is that it would apply to both Commercial and Medi-Cal Plans.
- The Governor has put \$300 million aside to fund the unexpected expense last year of the Hepatitis C medications; and
- The Governor seems to be pushing those covered by California Children Services (some of the most ill children) into Managed Care; this will be a very controversial topic.

Commissioner Dial asked about overtime pay for the in-home personal caregiver services, as at both the federal and state levels, these workers have not been paid overtime. Trent Smith explained that it has now been ruled that these workers are entitled to a 7% pay increase and that the MCO tax is needed to help fund this increase.

Commissioner Dial asked about the assisted suicide bill that was introduced and whether it would be funded through managed care. Trent Smith responded that they will have to look into the possible effects on managed care.

2. CONSENT ITEMS

a. Accept and File CFO Update – October and November Financials

Interim CFO Meazzo reviewed the CFO Update and provided a general overview of the financials.

Commissioner Dial asked how it was determined that the expenses were reduced with the AE adjustment. Interim CEO Watson explained that the TNE for this population is not showing an 85% MLR, and that this was similar experience to other Medi-Cal Plans. The Plans are concerned that the State's 20% rate cuts for the AE population are premature as the utilization data is not complete.

In response to questions from Chair Araujo regarding the TNE and membership, Financial Analysis Director Turner explained that TNE is driven by health care costs. If we make an adjustment as we did in November, it lowers the TNE.

Commissioner Dial moved to approve the CFO Update – December Financials. 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.

3. APPROVAL ITEMS

a. Provider Reimbursement Increases

Interim CEO Watson reviewed the report with the Commission.

Commissioner Pupa asked if the \$7.2 million line of credit with the County was under review by the State. Interim CEO Watson explained that discussions are on hold because the State requires GCHP's audited financial statement before they will allow payback of the line of credit to the County. The Special Investigation must be completed before GCHP can re-engage the auditors to complete the audit and obtain an audited financial statement.

Commissioner Alatorre asked if the State provided the Plan with an extension. Interim CEO Watson responded that a deadline has not been provided, but the Plan keeps the State informed on the status of the Special Investigation.

Interim CEO Watson explained that the Plan included pediatricians in the rate increase proposal because they are a huge and tactical part of the provider network and make up the largest percentage of independent providers that are not capitated. Commissioner Fisher asked if any other options were discussed. Interim CEO Watson responded that this is just the start of the reimbursement increase evaluation process.

The Plan will work with Providers to develop quality programs for additional reimbursement for the Adult Expansion (AE) population. Programs need to be designed around that specific population. A program that focuses on members plan-wide will not satisfy the State MLR corridor for AE.

Commissioner Fisher asked how the increases will affect FQHC's. Interim CEO Watson responded that it was her understanding that it provides the funds sooner, but does not change the ultimate reimbursement since that is set by the federal government. However, the Plan can do some pay for performance or reimburse for other programs that FQHC's might desire to do for this population.

Chair Araujo asked about the effect on safety-net providers in the County who have larger numbers of FQHC's and rural clinics, and other cost reimbursement methods. CEO Watson responded that it would affect them the same. Chair Araujo encouraged staff to find other ways of augmenting these types of providers.

Interim CEO Watson stated that GCHP will partner with Plan providers for their feedback and ideas around ways to develop these programs. The Plan will put together big picture parameters on how the program will look, along with funding.

Commissioner Dial asked how the Plan would reimburse for HEDIS quality items, etc. Interim CEO Watson explained that staff was working on options.

Interim CEO Watson stressed that this needed to be done with the providers, but we need to do this as partners and make sure any pay for performance programs are data driven and auditable.

Chair Araujo stated that other types of providers were discussed during the Executive / Finance Committee, and he would like to see those included as well.

Commissioner Alatorre stated that there was a \$27 million profit from last year, and without the reserves, the Plan's net income is \$68 million. In response to Commissioner Dial's inquiry about whether the Plan should use a portion of the funds to look at pay for performance programs, Commissioner Alatorre, explained that the Executive / Finance Committee discussed rate increases that included risk pool arrangements and pay for performance programs such as reimbursements for Patient Centered Medical Home certification.

Interim CEO Watson said it would serve the Plan well to invest in these types of programs.

Commissioner Glyer moved to approve the Provider Reimbursement Increases. 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. DHCS Contract Amendment A15

Interim CEO Watson reviewed the report with the Commission.

Commissioner Dial moved to approve the DHCS Contract Amendment A15 and authorize the CEO to execute the amendment. 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.

4. ACCEPT AND FILE ITEMS

a. Special Investigation Ad Hoc Committee Report

Commissioner Fisher reported that an initial rough draft report is anticipated February 17, 2015. To date, \$581,296 has been spent. We will see that start to trickle down over the next few weeks.

b. CEO Update

Interim CEO Watson reviewed the written CEO Update with the Commission.

Commissioner Glyer asked about the large increase in compliance calls. Compliance Director Armenta explained that the calls came through the compliance hotline; however they were not related to compliance. The calls were all member-related and were either grievance or customer service calls.

c. COO Update

Interim CEO Watson presented the report.

Chair Araujo asked for clarification around the definition of Financial and Procedural Accuracy. He requested a report that showed the accuracy results on an annualized basis.

Operations Director Lewis reported that the ACS contract contains service levels around financial and procedural accuracy. The financial section is based on a random audit of 2% of the claims processed during the course of the month and they must be at 98% accuracy. Procedural accuracy is when the dollar amount was correct, but other data was not correct. Director Lewis explained that there were two months in 2014 where the financial accuracy metric was below standard because there were high dollar claims included in the audit which skewed the overall accuracy rates.

d. CIO Update

CIO Scrymgeour provided a review of the CIO Update.

e. Health Services Update

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

Commissioner Fisher moved to Accept and File Agenda Items 4a through 4e. 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.

COMMENTS FROM COMMISSIONERS

None.

CLOSED SESSION

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 3:48 p.m. regarding the following items:

- a. Public Employee Appointment Pursuant to Government Code Section 54957**
Title: Chief Financial Officer

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 4:49 p.m.

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

ADJOURNMENT

Meeting adjourned at 4:49 p.m.



**Gold Coast
Health PlanSM**
A Public Entity



Quality Improvement Committee Report

4th Quarter 2014

C. Albert Reeves, MD, CMO

www.goldcoasthealthplan.org

Quality Improvement

Quality Improvement Projects (QIP)

2a-2

Diabetic Retinal Eye Exam

- Health Services Advisory Group (HSAG) evaluated the 1st year report, scored as partially met
- Plan resubmitted QIP as a Plan-Do-Study-Act (PDSA) project for the member incentive program
- Results evaluated with the 2015 HEDIS Survey

All-Cause Readmissions

- January 2013 – December 2013
- Results were submitted to HSAG on 09/30/14, score partially met
- QIP has been reworked
- GCHP will be working with 1 hospital to identify at-risk hospitalized members and coordinate between GCHP and the hospital to lower readmissions
- Results will be evaluated in 3 months

HEDIS

- Measures not meeting the minimum performance level in 2014:
 - Well-child visits in the 3rd, 4th, 5th, and 6th years of life
 - Counseling for Nutrition and Physical Activity
- PDSA developed and was approved by HSAG

Cervical Cancer Screening

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

New Member Orientation Participation

- PDSA developed
- Study conducted from July to November 2014
- Participation increased 448%
- 64% of the increase could be attributed to the intervention
- Notification added to new member packets

Quality Improvement Activities

Facility Site Reviews

- 8 completed
- 1 Corrective Action Plan (CAP) which was closed

Medical Record Reviews

- 9 reviews, all being compliant with the Initial Health Assessment (IHA)

Potential Quality Issues (PQI) Reviews

- 25 total to date (3rd Q)
- 9 cases completed and closed
- All lower level findings to be trended

One pharmacy case resulted in an educational program and a change in the process for members to get emergency and temporary prescriptions.

Quality Improvement Dashboard

Gold Coast Health Plan HEDIS Measures -- Quality of Care Indicators																		
LEGEND: Dark Green = performance ≥ P90, Yellow = performance ≥ P50, Red = performance ≤ P25																		
Measure	Description	Responsible Department	Benchmark Source	Benchmark	2012 Rate	P10	P25 (MPL)	P50	P75	P90 (HPL)	2013 Rate	2014 Rate	2015 Q1	2015 Q2	2015 Q3	2015 Q4	2015 Rate	
(AAB) Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis																		
AAB (Bronchitis)	The percentage of adults 18-64 years old with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or within three days after the episode start date	Quality Improvement	HEDIS		13.87	14.88	17.92	22.14	28.18	35.45	18.24							
(CAP) Children and Adolescents' Access to Primary Care Practitioners																		
CAP: age 12-24 months	The percentage of members who had a visit with a PCP.	Quality Improvement	HEDIS		82.51	92.37	95.51	96.89	97.84	98.49	97.37							
CAP: age 25 months - 6 years					63.09	82.76	86.37	89.39	91.29	93.60	86.27							
CAP: age 7 to 11					NR	83.43	87.77	90.88	93.26	95.25	82.26							
CAP: age 12 to 19					NR	81.35	86.09	89.58	91.85	93.77	79.18							
(LBP) Use of Imaging Studies for Low Back Pain																		
LBP	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MR, CT scan) within 28 days of the diagnosis.	Quality Improvement	HEDIS		76.95	68.31	71.52	75.23	79.26	82.34	77.07							
(MMA) Medication Management for People with Asthma																		
Medication Compliance 50%: 5-64	The percentage of member 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment	Quality Improvement	HEDIS		NR	NA	NA	NA	NA	NA	NR							
Medication Compliance 50%: Total					NR	40.74	44.83	50.94	56.37	61.66	48.92							
Medication Compliance 75%: 5-64					NR	NA	NA	NA	NA	NA	NR							
Medication Compliance 75%: Total					NR	19.20	22.17	27.65	32.89	38.71	28.03							

Gold Coast Health Plan HEDIS Measures -- Quality of Care Indicators																		
LEGEND: Dark Green = performance ≥ P90; Yellow = performance ≥ P50; Red = performance ≤ P25																		
Measure	Description	Responsible Department	Benchmark Source	Benchmark	2012 Rate	P10	P25 (MPL)	P50	P75	P90 (HPL)	2013 Rate	2014 Rate	2015 Q1	2015 Q2	2015 Q3	2015 Q4	2015 Rate	
(MPM) Annual Monitoring for Patients on Persistent Medications																		
ACE Inhibitors or ARBs	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.	Quality Improvement	HEDIS		86.73	80.80	84.58	87.06	89.19	91.21	88.47							
					88.46	83.72	87.50	90.82	93.15	94.95	93.33							
					86.28	79.98	83.76	86.74	89.11	91.30	89.51							
(CCS) Cervical Cancer Screening																		
CCS	The percentage of women 24-64 years old who had at least one Pap test during the past 3 years	Quality Improvement	HEDIS		57.66	47.22	58.99	66.38	71.91	76.64	60.58							
(CBP) Controlling High Blood Pressure																		
CBP	The percentage of members that were 18-85 years of age with a dx of hypertension and adequately controlled BP (<140/90) during the measurement year.	Quality Improvement	HEDIS		61.56	44.77	50.00	56.20	62.97	69.55	54.01							
(CDC) Comprehensive Diabetes Care																		
CDC: A1c Testing	The percentage of members that received a subset of services essential to diabetes management	Quality Improvement	HEDIS		81.75	75.91	79.23	83.21	87.32	90.97	85.16							
CDC: Poor A1c control (> 9.0%); lower rate is better					56.20	31.14	35.76	43.02	52.58	59.48	45.50							
CDC: Good A1c control (< 8.0%); higher rate is better					37.96	34.58	39.80	48.57	53.77	58.64	45.50							
CDC: Diabetic Eye Exam					42.58	37.14	44.37	54.43	62.46	67.64	45.74							
CDC: LDL Testing					78.83	66.79	71.03	76.28	80.54	83.52	79.56							
CDC: LDL Control (<100 mg/dL)					33.58	21.76	27.90	34.69	40.03	43.80	28.47							
CDC: Nephropathy Monitoring					79.81	69.76	75.00	79.28	82.74	85.85	78.10							
CDC: Blood Pressure (<140/90 mm Hg)					62.29	45.67	53.74	60.93	68.17	74.55	61.31							

Gold Coast Health Plan HEDIS Measures -- Quality of Care Indicators																	
LEGEND: Dark Green = Performance ≥ P90, Yellow = Performance ≥ P50, Red = Performance ≤ P25																	
Measure	Description	Responsible Department	Benchmark Source	Benchmark	2012 Rate	P10	P25 (MPL)	P50	P75	P90 (HPL)	2013 Rate	2014 Rate	2015 Q1	2015 Q2	2015 Q3	2015 Q4	2015 Rate
(CIS) Childhood Immunization Status																	
CIS	The percentage of children 2 years of age that had DTaP, IPV, MMR, Hib, HepB, VZV, Pneumococcal Conjugate (Combo 3)	Quality Improvement	HEDIS		80.05	61.95	66.08	72.88	78.30	83.32	75.43						
(IMA) Immunizations for Adolescents																	
IMA	Adolescents who received one meningococcal vaccine on or between the members 11th and 13th birthday and one Tdap or Td on or between the members 10th and 13th birthdays. Combo	Quality Improvement	HEDIS		65.21	50.93	58.06	68.59	77.08	85.64	60.34						
(PPC) Prenatal and Postpartum Care																	
PPC 1: Timeliness of Prenatal Care	The percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.	Quality Improvement	HEDIS		80.78	70.59	79.85	85.88	89.72	92.82	83.94						
PPC 2: Postpartum Care	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.				63.99	50.69	57.91	63.99	70.20	73.83	59.37						
(W34) Well Child Visits in Years 3-6																	
W34	The percentage of members that that were 3, 4, 5, or 6 years of age and had 1 or more well care visits with a PCP during the measurement year.	Quality Improvement	HEDIS		61.80	60.81	67.40	72.26	78.51	82.08	64.23						
(WCC) Weight Assessment for Children																	
WCC: BMI %	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	Quality Improvement	HEDIS		42.09	22.87	37.96	52.31	69.68	80.24	43.80						
WCC: Nutrition					42.09	31.02	47.45	59.11	67.91	75.18	43.31						
WCC: Physical Activity					30.41	20.92	34.55	46.23	55.26	64.72	28.71						

¹ 2012 rates reflect measurement year data from January 1, 2012, through December 31, 2012.

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

³ Shaded cells indicate measurements conducted only once annually.

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

Shaded cells indicate measurements conducted only once annually.

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

¹ 2012 rates reflect measurement year data from January 1, 2012, through December 31, 2012.

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Results						
Legend: Green = Met or exceeded Benchmark Red = Did not meet Benchmark If no color: Have not received the "All-Plan Comparison Report" to Date						
Measure	Description	Benchmark Source	2013 Benchmark	2013 Medi-Cal Managed Care Average Score	2013	2013 Health Statewide Plan Ranking
(CAHPS 5.0) Consumer Assessment of Healthcare Providers and Systems - Medi-Cal Adult & Child Survey Scores Combined (previously broken out until HSAG began reporting them together in 2010)						
Overall Rating of Health Plan	Top-box responses for composite measures were responses of "Usually" or "Always", "A lot" or "Yes" presented.	2013 Gold Coast Health Plan CAHPS Report, DHCS	NA	59.8%	52.6%	NA
Overall Rating of All Health Care			NA	52.2%	51.1%	NA
Overall Rating of Personal Doctor			NA	64.7%	67.8%	NA
Overall Rating of Specialist Seen Most Often			NA	66.9%	65.9%	NA

* Scores based on Global Ratings Top-Box Rates

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

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

Medical Advisory Committee: Audits, Utilization Management and Clinical Support									
Health Services									
UM Authorization Processing Time									
Measure	Description	Responsible Department	Benchmark Source	Benchmark	2013	2014 Q1	Q2	Q3	Q4
Pre-service Turnaround Request Processing Time	The % of requests processed ≤ 5 working days from receipt of information necessary to make the determination.	Health Services	DHCS/ Title 22	95%				93.41%	
Post Service Turnaround Request Provider Appeals Processing Time - Acknowledgement Letter	The percentage of appeal notifications sent to providers within 5 business days from receipt of appeal.	Health Services	Joint Medical Audit (DHS & DMHC) 1.3	95%				NA	
Concurrent Review	Combined Urgent and Standard	Health Services	DHCS/ Title 22					NA	
Provider Turnaround Request Denials	Number of denied authorizations divided by total number of authorizations. (Excludes RAFs.)	Health Services	DHCS/ Title 22	Tracking				NA	
Provider Turnaround Request Denials Overturned	Beginning 1/1/2010 - Number of denials overturned or modified divided by total number of appeals. Includes pre-service & post-service Auth, RAF & MRF appeals.	Health Services	DHCS/ Title 22	Tracking				NA	
Clinical Utilization Management									
Inter-rater Reliability Analysis	Measurement of the consistency with which UM staff apply criteria/guidelines for determining medical necessity.	Health Services	DHCS/ Title 22	90%				NA	
UM Criteria & Review									
UM Criteria Revisions	Annual review and adoption of UM criteria that are objective and based on medical evidence.	Health Services	H&S Code 1367.01, 1363.5; Title 22 53860(c)(3); DHCS Contract 08-85212, NCOA: UM 2					NA	

Delegation Oversight : Assessment of Delegated Quality Activities									
Legend: Green = Met or Exceeded Benchmark Red = Did Not Meet Benchmark									
Measure	Description	Benchmark Source	Benchmark	2013	2014 Q1	Q2	Q3	Q4	
Delegation of UM	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 5; NCQA Standard UM 15	DHCS Contract		NA	100%	100%	NA	
Delegation of CR	Number required & percentage of current delegates assessed	Exhibit A, Attachment 4; NCQA Standard CR 9	DHCS Contract 10-87128		100%	NA	NA	NA	
Delegation of QI	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard QI 12	DHCS Contract		NA	NA	100%	100%	
Delegation of RR	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard RR 7	DHCS Contract		NA	NA	100%	100%	
Delegation of Claims	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 8	DHCS Contract		NA	100%	100%	100%	

Provider Credentials: Ensuring Quality of Provider Network										
Legend: Green = Met or Exceeded Benchmark Red = Did Not Meet Benchmark	Measure	Description	Responsible Department	Benchmark Source	Benchmark	2013	2014 Q1	Q2	Q3	Q4
Access Indicators										
	Monitoring of Medicare/Medicaid sanctions	An OIG query is performed on every provider at the time of initial and re-credentialing	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				100%	
	Monitoring of sanctions and limitations on licensure	An Medical Board of California (MBOC) query is performed on every provider at the time of initial and re-credentialing. Other state licensing boards are also queried as needed	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				100%	
	Monitoring of complaints	Member complaints are monitored at a minimum of every six months to assess for trends/outliers	Credentialing	DHCS/ Title 22	Biannually				NA	
		Member complaint data is considered during re- credentialing via the use of threshold criteria	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				NA	
		Quality of Care concerns are reviewed at a minimum of every 6 months and are forwarded to Credentials/Peer Review Committee (CPRC) as Indicated.	Credentialing	DHCS/ Title 22	Biannually				NA	
	Monitoring of adverse events	HIPDB queries are performed within 180 days prior to the date of initial and re-credentialing	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				100%	
	Timeliness of provider notification of credentialing decisions	Providers will be notified of the credentialing decision in writing within 60 days	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				100%	
	Timeliness of verifications	All credentialing verifications are performed within 180 days (or 360 days) prior to the credentialing date, as required	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				100%	
	# of provider terminations for quality issues	Credentials/Peer Review Committee (CPRC) denial of a credentialing application for quality issues will cause termination of the provider from the network	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				None for Q3	
	# of fair hearings as a result of adverse credentialing actions	Providers are afforded the right to a fair hearing in the event of an adverse credentialing decision	Credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC				None for Q3	
Service Indicators										
	Timeliness of processing of initial applications	Initial applications will be processed within 90 days	Credentialing	DHCS/ Title 22	Standard met for 90% of applications received				100%	
	Timeliness of processing of re-credentialing applications	Recredentialing applications will be processed within 90 days	Credentialing	DHCS/ Title 22	Standard met for 90% of applications received				99%	
Quality Indicators (under NIMC purview)										
	Timeliness of Physician Recredentialing	Percent of physicians recredentialled within 36 months of the last approval date		NCOA: CR Standards	Standard met for 90% of providers				90%	
	Continuous Monitoring of Allied Providers	Percent of allied providers' expirable elements that are current		NA	Standard met for 90% of elements				NA	
	Timeliness of Organization Reassessment	Percent of organizations reassessed within 36 months of the last assessment		NCOA: CR Standards	Standard met for 90% of providers				NA	

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

Cultural & Linguistics										
Legend: Green = Met or Exceeded Benchmark Red = Did Not Meet Benchmark										
Measure	Description	Responsible Department	Benchmark Source	Benchmark	2013	2014 Q1	Q2	Q3	Q4	
Cultural & linguistic requirements	Number of languages provided per the total number of languages requested through GCHP and interpretation	CNL	DHCS/Title 22	100%				13		
Cultural & linguistic requirements	Total number of translation requests (Excluding American Sign Language)	CNL	DHCS/Title 22	100%				18		
Cultural & linguistic requirements	Total number of American Sign Language interpreter requests.	CNL	DHCS/Title 22	100%				34		
Cultural & linguistic requirements	Total number of telephonic calls for interpreter requests.	CNL	DHCS/Title 22	100%				253		

Clinical Practice & Preventative Health Guidelines									
Legend: Green = Met or Exceeded Benchmark Red = Did Not Meet Benchmark									
Measure	Description	Responsible Department	Compliance Source	Benchmark	2013 Q4	2014 Q1	Q2	Q3	Q4
Clinical Practice									
Clinical Practice Guideline Adoption	Development and/or adoption of non-preventive clinical practice guidelines for the provision of acute and chronic medical services every two years.	ACMO	DHCS/ Title 22	Approval by Committee					
Clinical Practice Guideline Distribution	Distribution of non-preventive clinical practice guidelines for the provision of acute and chronic medical services to applicable practitioners every two years.	ACMO	DHCS/ Title 22	Distribution to Applicable Providers					
Preventive Health									
Preventive Health Guideline Adoption	Development and/or adoption of preventive guidelines every two years.	Health Education	DHCS/ Title 22	Approval by Committee					
Preventive Health Guideline Distribution	Distribution of preventive guidelines every two years.	Health Education	DHCS/ Title 22	Distribution to Applicable Providers					

Pharmacy and Therapeutics

Pharmacy Benefit Manager (PBM) Oversight

Reviewed all denials and 10% of approvals

- 99% appropriate decision
- 100% timely decision
- 85.7% appropriate denial language

Pharmacy Inter-Rater Reliability (IRR)

IRR Review

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

FDA Newly Approved Drugs

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

- Approved 9 out of 13 drugs because of significant clinical advantages
- 2 older drugs added
 - 1 brand drug of a generic medication because of an improved delivery system

Pharmacy Spend Review

Figure 1:

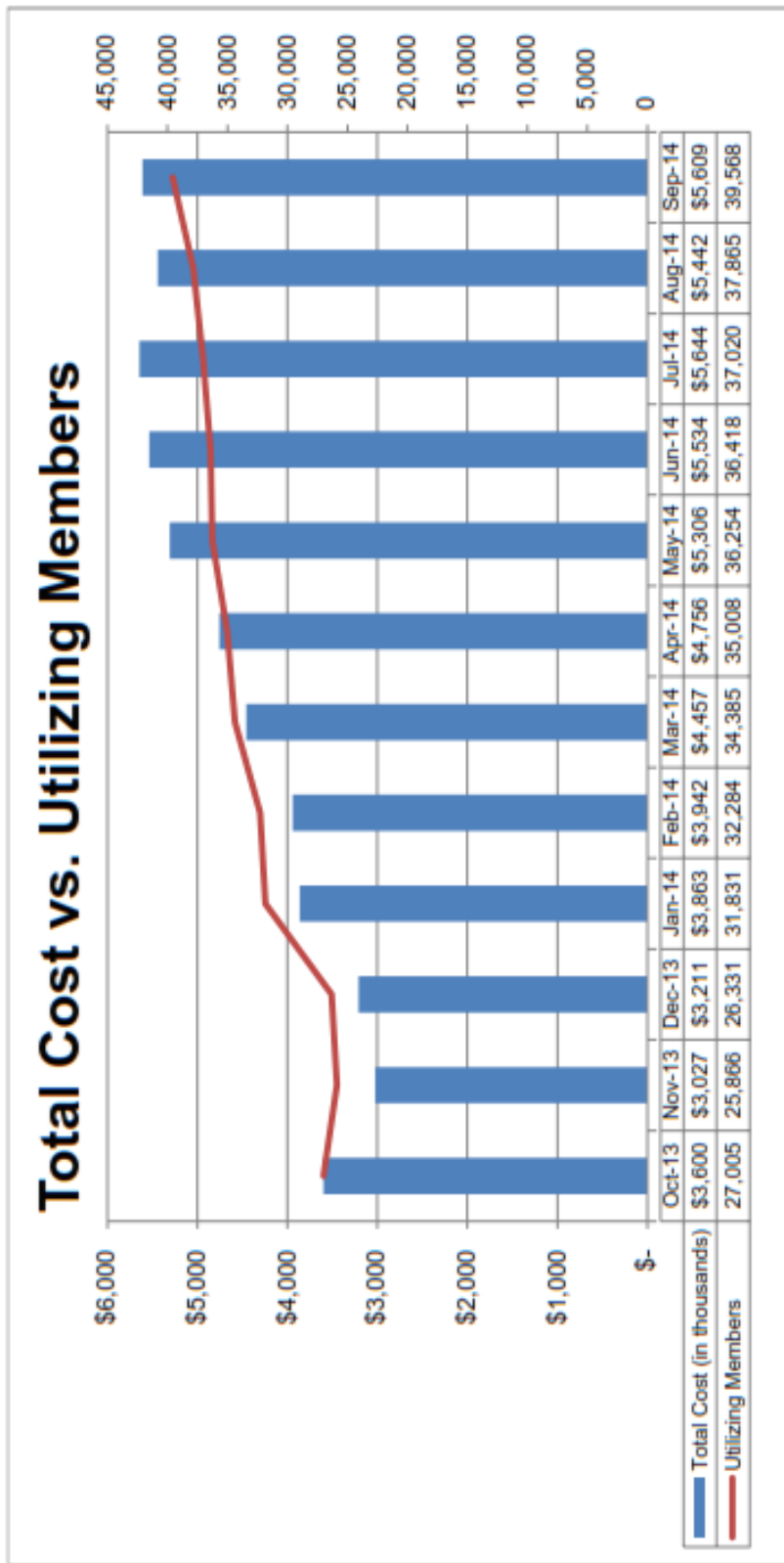


Figure 2:

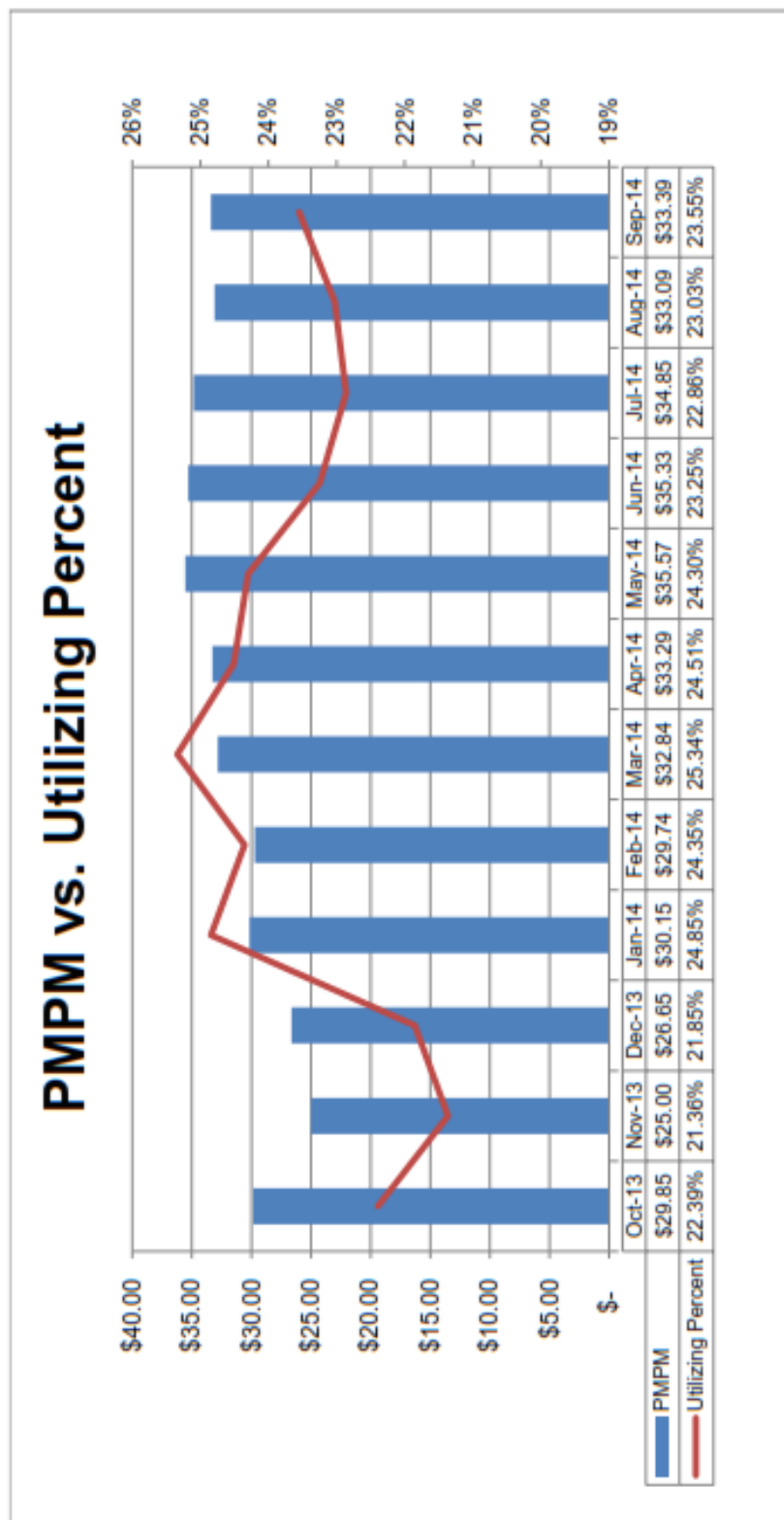
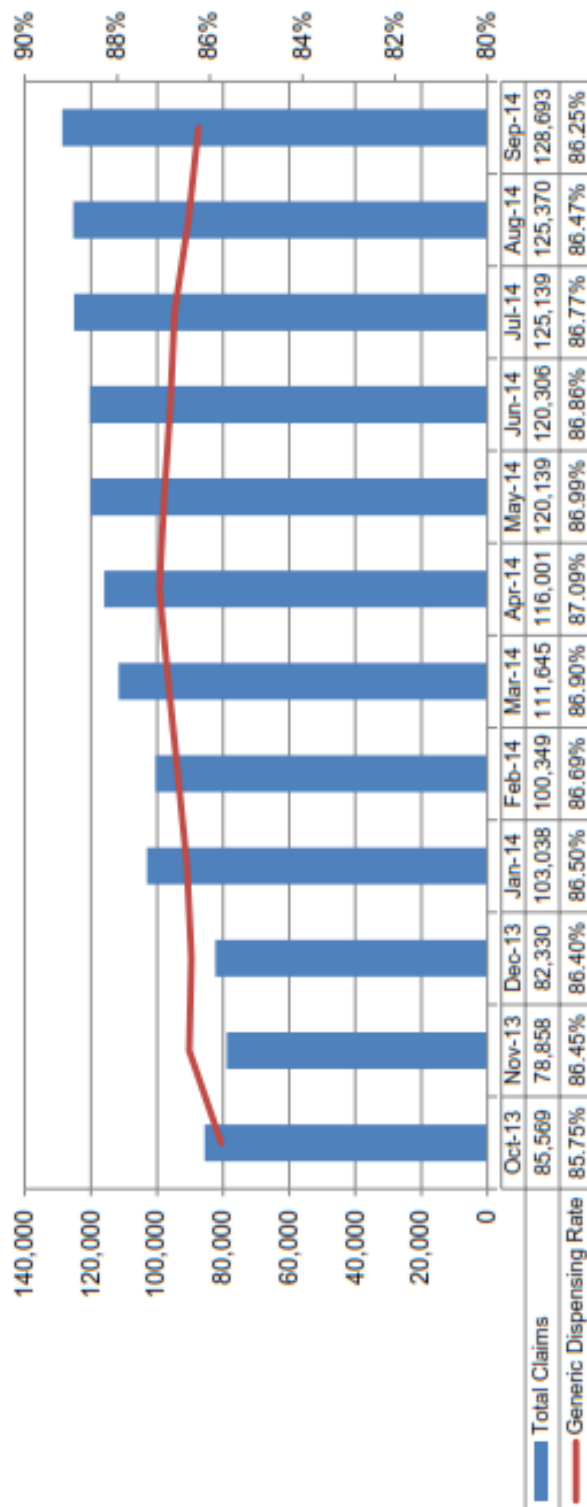


Figure 3:

Total Claims vs. GDR



Credentials/Peer Review

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

- 1 provider completed mandated training and has no ongoing restrictions
- 1 provider on 10 years probation and required to submit regular updates to the MBC and has restrictions, copies of his MBC updates to GCHP

MBC Actions (cont.)

- 1 provider on 5 years probation and must adhere to several terms and conditions, copies of the MBC reports to GCHP
- 1 provider has a proposed license suspension action but continues to have a valid license pending a hearing – GCHP is following.

Committee Actions

- Re-credentialled 28 providers
- Newly credentialled 5 providers
- Pended 1 applicant for reference checks
- Re-credentialled 27 facilities
- Approved new Credentialing Policy

Medical Advisory

Approved Clinical Practice Guideline for Diabetes

- “Standards of Medical Care in Diabetes 2015” -
ADA

Approved 5 Utilization Management Guidelines

- Acute Inpatient Rehabilitation Guideline
- Custodial Care Guideline
- Home Health Guideline
- Recommendations for use of vaccine Zostavax
- Services requiring prior authorization (change)

Health Education and Outreach

Recognition

- Department of Healthcare Services (DHCS) recognized GCHP as 1 of 4 Medi-Cal Health Plans to double their member calls to the California Smoker's Hotline

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

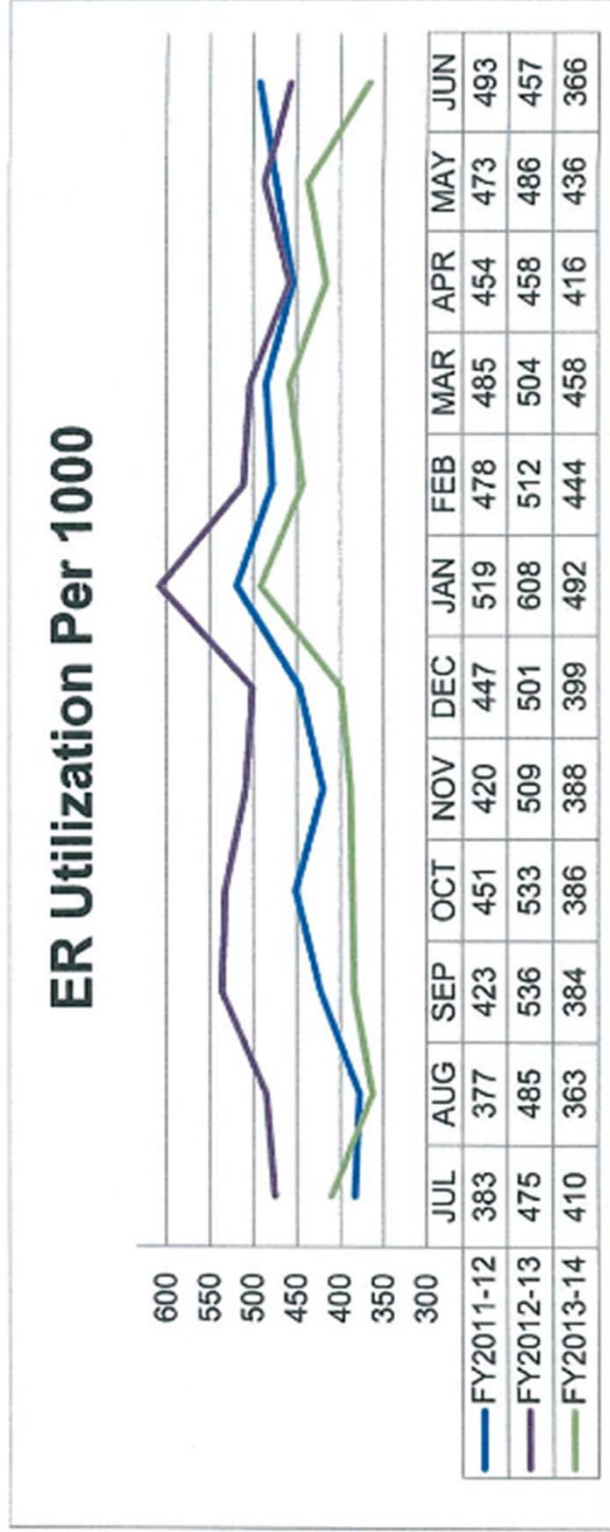
- Worked with DHCS and UCLA to provide a training event for SBIRT in the County of Ventura

Member Incentive Program

- Collaborated with the Quality Improvement Dept., Compliance and Communications to ready the Diabetic Eye Exam member incentive program to go to members early in the 4th Quarter.

Health Navigator Program

- Contacted 149 high utilizers (4+ ER visits/month)
- Many referred to Case Management
- Those contacted have had a significant decrease in ER usage



Cultural and Linguistics

Pacific Interpreters

- 253 calls using interpreters by staff
- 13 languages

Document Translation Requests

- 18 requests

American Sign Language

- 34 requests serving 15 members

Grievance and Appeals

New Grievance and Appeals Department

- Opened Oct. 1, 2014
- Stacy Luney, Manager

3rd Quarter Statistics Rate .20/1000

- 8 Administrative
- 24 Clinical
- 11 Quality of Care
- 10 Access
- 3 Inappropriate Treatment
 - Clinical grievances are reviewed by a Health Services RN
 - Cases considered to be significant for quality are referred as PQI's

Medical Appeal Cases

- 11 cases
- Medical Appeal Cases not approved on appeal go to a 2nd reviewer
- 4 cases overturned the denial on appeal
- 6 cases upheld the denial
- 1 case withdrawn

State Fair Hearings

- Members or providers may submit denials to a State Fair Hearing
- 3 cases withdrawn

Network Planning

After-hours Survey Conducted

- After-hours messaging at provider offices:
“If this is an emergency, please hang up and dial 911”
- 47 providers found to have improper messages
- Training and follow-up survey conducted
- 11 still non-compliant and received CAP
- All have successfully completed the CAP

Member Services

Medicare Part A Project

- 661 members who should qualify for Medicare Part A but are not enrolled were identified
- 386 were sent applications
- 275 referred to Qualified Medicare Beneficiary (QMB)
- 212 have become enrolled in Part A
- Significant financial benefit to GCHP

Office Inquiries – 3rd Quarter

- 112 Walk-ins
- 89 Calls

Call Center

- 31,051 Total Calls
 - 15,250 - English Speaking
 - 6,296 - Spanish Speaking
 - 12,505 - Provider Calls
- Average Speed to Answer (goal <30 sec) Compliant
- Abandonment Rate (goal <5%) Compliant

Utilization Management

Statistics: 3rd Quarter 2012, 2013, 2014

- Bed days/1000 – 332, 308, 259
(benchmark 161 – 890, variability due to reporting differences)
- Length of Stay – 4.6, 4.4, 4.8
(benchmark 3.6 – 4.7 days)

UM Statistics (cont.)

- Readmission Rate – 15.5%, 9.6%, 10.5%
(benchmark managed Medi-Cal 14.5%)
- ER visits/1000 – 518, 378, 407
(benchmark managed Medi-Cal Plans 554-877)
- UM Denial Rate – 3.25%

Care Management – 3rd Quarter 2014

- 338 Cases

Satisfaction Surveys

- August 1, 2014 through September 30, 2014
- 35 Surveys Sent
- 26 Surveys Completed
- 100% Overall Satisfied with Care Management Program

Member Feedback

“(nurse) was very caring, attentive, she cared about my condition. She called when she said she would call, very responsible. She helped me learn more about my condition, more than my doctor did. I was in pain when she called me and she helped me with getting pain medication. Even though I don’t speak her language, I can tell by the tone of her voice that she really cared”

Delegation Oversight

Beacon Health Strategies and College Health IPA (CHIPA)

- Corrective Action Plan (CAP) issued on Oct. 1, 2014
- All CAP items closed as of 12/3/14

Clinicas Del Camino Real Specialty Contract

- Corrective Action Plan issued on July 1, 2014
- All CAP items closed on Nov. 26, 2014

Vision Service Plan (VSP)

- CAP was issued to VSP on Oct. 29, 2014
- All CAP items were closed on Nov. 24, 2014

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AGENDA ITEM 2b

To: Gold Coast Health Plan Commissioners

From: Scott H. Campbell, General Counsel

Date: February 23, 2015

Re: Assembly Bill 1234 Ethics Training Requirements

SUMMARY:

Assembly Bill 1234 requires members of the legislative body of any local government agency to receive two hours of ethics training every two years if the local agency provides any type of compensation, salary, stipend, or reimbursement of expenses. Even if not required, ethics training is recommended. Because the training covers the Brown Act, conflicts of interest and ethics, it is recommended that the Plan require such training of Commissioners and senior staff. A draft policy requiring AB 1234 training has previously been provided to the Commission for review. This item is for approval of the final policy.

BACKGROUND / DISCUSSION:

AB 1234, adopted in 2005, requires two hours of training every two years for certain members of the legislative body of any local government agency. The training covers various topics related to public service and ethics, including conflict of interest laws, gift limitations, bribery laws, prohibitions on the use of public funds, open meeting requirements, Public Records Act requirements, competitive bidding requirements, etc.

The AB 1234 requirement only applies if the agency provides any compensation, salary, stipend, or reimbursement of expenses. (Government Code Section 53235(a).) While many public boards, including the Commission, do not provide any form of compensation to board members, most do reimburse expenses, such as travel costs, that are necessarily incurred in the performance of their duties. We are informed that no such compensation or reimbursement is provided to the Commissioners.

Even if the training is not mandatory, it is recommended for all Commissioners and other senior Plan officials. AB 1234 provides that the Commissioners may require themselves and staff they designate to take the training. (Government Code Section 53235.2(a).) Such training is recommended because from time to time situations will arise in which public officials may have a conflict of interest. Receiving regular trainings in the requirements assists in understanding where there may be a conflict and where it is necessary to seek legal advice. The training also provides general background in laws such as the Brown Act that commonly affect the public business and govern how the Plan conducts its public meetings. The recommended policy requires all staff members who are identified in the Plan's Conflict of

Interest Code to receive the training, as well as all members of committees that are subject to the Brown Act.

There are several ways to receive the training. The Plan's General Counsel, Best Best & Krieger, often provides the training and can arrange a special meeting to present the training to the Commission as a whole. The Fair Political Practice Commission provides a free web-based training at www.fppc.ca.gov or the Commissioners may attend a group training which is offered from time to time by other entities.

FISCAL IMPACT:

If an attorney presents the training, there will be a charge for the attorney's time. If the Commissioners individually attend the training, then there will be no fiscal impact if the training is done through the FPPC's website. If the Commissioners attend a group training, there may be a fiscal impact if the costs of the training are paid for by the Plan.

RECOMMENDATION:

Approve a policy requiring that Commissioners and designated senior staff complete AB 1234 training every two years. Such training should still be completed as soon as possible so that the Commissioners and senior staff can take advantage of the training.

CONCURRENCE:

N/A

Attachments:

AB 1234 Ethics Training Policy



Title: Gold Coast Health Plan Ethics Policy	Policy Number:
Department: Executive	Effective Date:
CEO Approved:	Revised:

Purpose:

Assembly Bill 1234 (Salinas 2005) requires members of a local agency legislative body who receive any type of compensation, salary, or stipend or reimbursement for actual and necessary expenses incurred in the performance of official duties to receive at least two hours of ethics training every two years. The purpose of this Policy is to establish an ethics training requirement for the Commission and designated persons. AB 1234 also allows the Commission to designate which employees, agents, and consultants must take the ethics training and allows the Commission to enact a policy requiring the Commissioners to take ethics training.

Policy:

All Commissioners, committee members, and designated employees shall receive at least two hours of ethics training every two years. Each Commissioner, committee member, and designated employee who has not completed AB 1234 training for the two-year cycle ending on December 31, 2014, shall complete the training within three months of the effective date of this Policy. Each new Commissioner, committee member or designated employee who has not completed AB 1234 training for the two-year cycle ending on December 31 of the year immediately preceding his or her assuming office shall complete the training within three months of the first date of service with Gold Coast Health Plan.

Definitions:

“Committee members” means members of any committee which must comply with the Ralph M. Brown Act.

“Designated employee” means any employee who is required to file Form-700 Statements of Economic Interest by the Gold Coast Health Plan’s Conflict of Interest Code, as amended from time to time.

Procedure:

1. Ethics training shall be provided in accordance with criteria approved by the Fair Political Practices Commission and the Attorney General to meet the requirements of AB 1234.
2. The Clerk of the Board shall provide Commissioners, committee members and designated employees information on the training available to meet the requirements of this Policy.
3. Each Commissioner, committee member, and designated employee who serves a local agency other than the Gold Coast Health Plan is only required to satisfy the requirements of this Policy once every two years, regardless of the number of agencies he or she serves.
4. Each Commissioner, committee member, and designated employee shall provide a certificate to the Clerk of the Board, indicating the dates upon which



Title: Gold Coast Health Plan Ethics Policy	Policy Number:
Department: Executive	Effective Date:
CEO Approved:	Revised:

he or she attended ethics training. The certificate shall identify the person or entity that provided the training.

5. The Clerk of the Board shall maintain records, indicating that each Commissioner, committee member, and designated employee satisfied his or her duties under this Policy. These records shall be maintained for at least five (5) years after the training and are subject to disclosure under the Public Records Act.

Attachments:

None.

References:

AB 1234 (Salinas, 2005) Local Agencies: Compensation and Ethics

Revision History:

Review Date	Revised Date	Approved By

AGENDA ITEM 2c

To: Gold Coast Health Plan Commission

From: John Meazzo, Interim CFO

Date: February 23, 2015

Re: Investment Policy

SUMMARY:

Gold Coast Health Plan (GCHP or Plan) staff has drafted an Investment Policy, which has been review by counsel and reviewed and approved by the Plan's Policy Review Committee. The purpose of this Investment Policy is to ensure GCHP's funds are prudently invested according to Gold Coast Health Plan Commissioners' objectives of preserving capital, providing necessary liquidity and achieving a market-appropriate rate of return through economic cycles.

BACKGROUND / DISCUSSION:

GCHP's cash position has greatly improved over the past two years. The improvement is the result of several operational initiatives, better care management and higher state capitation rates provided for the Adult Expansion (AE) population. New programs often experience a ramp-up period in which costs take an extended time to catch up with the associated revenue received. This has been the case with the AE population and has added to the Plan's temporarily elevated cash levels.

Higher cash balances also present a challenge for banks holding deposits of public funds. Balances in excess of the FDIC insured limit are required to be collateralized by the banks. Collateral is an added layer of cost to the bank and is generally offset by offering lower earnings on deposits. GCHP is now faced with such a situation.

In order to meet the challenge of managing the Plan's cash balances, Staff has prepared an investment policy. The main objectives of the policy are ensuring safety of principal, return on investment and providing a proper level of liquidity to meet operational needs.

The investment policy delegates authority to the CFO and/or qualified investment advisors and provides a detailed schedule of acceptable investment vehicles that is intended to serve as a framework for the construction of an investment portfolio. Allowable investments follow

California Government Code sections as referenced within, and restrictions are clearly noted. The policy was constructed based on research of other public agencies' investment policies.

FISCAL IMPACT:

Based on current market conditions, the expected increase in returns is estimated between \$200,000 and \$300,000, annually. Any increases in associated banking or investment advisory fees are expected to be offset by increased earnings on investments.

RECOMMENDATION:

Staff is recommending the Commission approve and authorize the CFO to implement the Investment Policy.

CONCURRENCE:

N/A

Attachments:

Investment Policy



Title: Gold Coast Health Plan Investment Policy	Policy Number: FI-XXX
Department: Finance	Effective Date:
CEO Approved:	Revised:

Purpose:

This Investment Policy sets forth the investment guidelines for all Operating Funds and Board- Designated Reserve Funds (also referred to as Assigned) of Gold Coast Health Plan (GCHP). The objective of this Investment Policy is to ensure GCHP's funds are prudently invested according to Gold Coast Health Plan Commissioners' objectives to preserve capital, provide necessary liquidity and to achieve a market-average rate of return through economic cycles.

Investments may only be made as authorized by this Investment Policy. The GCHP Investment Policy conforms to the California Government Code sections 53600 et seq. (the Code) as well as customary standards of prudent investment management. Irrespective of these policy provisions, should the provisions of the Code or any other applicable law be or become more restrictive than those contained herein, such provisions will be considered immediately incorporated into the Investment Policy. GCHP shall also comply with investment requirements contained within contracts that the GCHP may have with any government funding agencies, and such requirements shall be considered incorporated into this policy.

Policy:

1. OBJECTIVES

GCHP's investment objectives, in order of priority, are as follows:

- A. Safety of Principal - Safety of principal is the foremost objective of GCHP. Each investment transaction shall seek to ensure that the risks of capital losses are minimized, including risks arising from institutional default, broker-dealer default, or erosion of market value of securities. GCHP shall seek to preserve principal by mitigating the two types of risk, credit risk and market risk, to the extent reasonable under the circumstances. Liquidity - Liquidity is the second most important objective of GCHP. The portfolio shall contain investments for which there is a secondary market or which otherwise offer the flexibility to be sold or liquidated within a reasonable amount time as set forth in this Policy with minimal risk of loss of either the principal or interest based upon then prevailing rates.
- B. Total Return –GCHP's portfolio shall be designed to earn a competitive rate of return (i.e., yield) within the confines of the California Government Code, this policy, and procedural structure.

The length of term for all investments shall be commensurate with the short, medium, and long-term cash flow needs of GCHP. Market risk, the risk of market value fluctuations due to overall changes in the general level of interest rates, shall be mitigated by matching maturity dates, to the extent possible, with GCHP's



Title: Gold Coast Health Plan Investment Policy	Policy Number: FI-XXX
Department: Finance	Effective Date:
CEO Approved:	Revised:

expected cash flow draws. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return. Consideration will be given to debt securities that would trigger capital gains or losses as market interest rates fluctuate.

II. PRUDENCE

GCHP's Commissioners and GCHP officials and employees authorized to make investment decisions on behalf of GCHP are trustees and fiduciaries subject to the prudent investor standard.

The standard of prudence to be used by investment officials shall be the "prudent person" standard as defined in Code Section 53600.3 and shall be applied in the context of managing an overall portfolio.

THE PRUDENT PERSON STANDARD: When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of GCHP, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency.

III. ETHICS AND CONFLICTS OF INTEREST

GCHP's officers and employees involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions. GCHP's officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with GCHP, and they are not permitted to have any personal financial or investment holdings that could be materially related to the performance of GCHP's investments.

IV. DELEGATION OF AUTHORITY

Authority to manage GCHP's investment program is derived from the policies established by the Commissioners. Management responsibility for the investment program is hereby delegated to GCHP's Chief Financial Officer (CFO). The CFO may recommend an independent licensed Investment Advisor and/or the investment department (trust department) with the current bank relationship (Advisors) to assist in managing the investment portfolio based upon the investment policies. The



Title: Gold Coast Health Plan Investment Policy	Policy Number: FI-XXX
Department: Finance	Effective Date:
CEO Approved:	Revised:

Advisor will be responsible to implement and comply with this policy and to ensure that the investment objectives are met.

The CFO may also invest funds in certain pre-established investments as stated herein.

The CFO shall be responsible for all actions undertaken and shall establish a system of controls to regulate the activities of one or more independent advisors and subordinate investment staff.

The CFO and/or investment advisor/s shall mitigate risk by following these guidelines:

- A. Pre-qualifying financial institutions with which it will do business through the utilization of Moody's Credit Review Service, Standard and Poor's Financial Institutions Ratings, and Moody's Commercial Paper Record.
- B. Diversifying the portfolio so that the failure of any one issuer or backer will not place any undue financial burden on the GCHP. Spreading investments over different investment types minimizes the impact a singular industry/investment class can have on the portfolio. Spreading investments over multiple credits/issuers within an investment type minimizes the credit exposure of the portfolio to any single firm/institution.
- C. Monitor all GCHP investments on a daily basis to anticipate and respond appropriately to a significant reduction in the credit worthiness of a depository.
- D. Structuring GCHP's portfolio so that securities mature at times to meet GCHP's ongoing cash needs. Spreading investments over various maturities minimizes the risk of portfolio depreciation due to a rise in interest rates. An unforeseen liquidity need allows no options if "all your eggs are in one basket."
- E. Restructure of the GCHP's portfolio to minimize the loss of market value or cash flow.
- F. Constructing a portfolio that will consist of securities with active secondary and resale markets. Any investment for which no secondary market exists, such as time deposits, shall not exceed 375 days and no investment shall have a maturity of more than 5 years (to minimize capital losses).



Title: Gold Coast Health Plan Investment Policy	Policy Number: FI-XXX
Department: Finance	Effective Date:
CEO Approved:	Revised:

V. GUIDELINES FOR INVESTMENT

The CFO shall maintain and instruct the investment advisor to adhere to these investment protocols:

A. Liquidity

The GCHP's portfolio will be structured so that securities will mature at or about the same time as cash is needed to meet demands and in accordance with the economic projections mentioned above.

B. Yield

The CFO and Advisors shall always attempt to obtain a competitive rate of return on any investment type consistent with the required safety, liquidity, and other parameters of this policy, departmental procedures, and the laws of the State of California.

C. Internal Controls

The CFO shall establish a system of internal controls, which shall be documented in writing. The controls shall be designed to prevent losses of public funds arising from fraud, employee error, and misrepresentation by third parties, as well as unanticipated changes in financial markets.

D. Safekeeping of Securities

To protect against potential losses caused by the collapse of individual securities dealers, all securities owned by the GCHP, including collateral on repurchase agreements shall be held in safekeeping by a third party bank trust department, acting as agent for the GCHP under the terms of a custody agreement executed by the bank and the GCHP CFO. All trades executed between GCHP and a dealer will settle on a delivery vs. payment basis with a custodial bank. All security transactions engaged in by the CFO be countersigned by a second Finance Department official or employee, who the CFO has authorized to countersign security transactions.

E. Rating

With the exception of Local Agency Investment Fund (LAIF), insured deposits, and U.S. Finance and Government Agency issues, investments shall be placed only in those instruments and institutions rated favorably as determined by GCHP's CFO with the assistance of Moody's Commercial Paper Record, Moody's Credit Report, and the S & P Financial Institutions Ratings Service.



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If the rating of any depository drops during the course of time with which the GCHP has placed an investment, the investment will be matured at the earliest possible convenience.

If anyone security rating drops below A-1 or P-1 resulting in a split rating, the investment will be sold if no significant loss of principal is involved or matured at the earliest possible convenience. These sales must be approved by the CFO.

F. Financial Benchmarks

GCHP's portfolio shall be designed to attain a market-average rate of return through economic cycles given an acceptable level of risk. The performance benchmark for the investment portfolio will be based upon the market indices for short-term investments of comparable risk and duration. These performance benchmarks will be determined by the GCHP's CFO with the assistance of an independent advisor and will be reviewed by the Executive Finance Committee on a semi-annual basis.

G. Periodic Review of the Investment Policy

The CFO is responsible for providing the Executive Finance Committee with this recommended Investment Policy. The Executive Finance Committee is responsible for recommending the Investment Policy to the GCHP Commissioners for final approval. This Investment Policy shall be reviewed and approved by the GCHP Commissioners at a public meeting pursuant to Section 53646 (a) of the California Government Code.

H. Collateralization

Collateralization is required on two types of investments: bank deposits in excess of the current insurance limit and repurchase agreements.

Bank deposits in excess of \$250,000, or the current prevailing U.S. government insurance guarantee, may only be invested with financial institutions which participate in the California Local Agency Security Program (LASP) administered by the California Department of Financial Institutions. LASP provides for collateral requirements, oversight and monitoring, and reporting by financial institutions.

Collateral is also required for repurchase agreements. The market value of securities that underlie a repurchase agreement shall not be allowed to fall below 102% of the value of the repurchase agreement and the value shall be



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adjusted no less than quarterly. Securities that can be pledged for collateral shall consist only of securities permitted in this policy.

I. Securities Lending

Investment securities shall not be lent to an Investment Manager, broker or any other entity.

J. Leverage

The investment portfolio, or investment portfolios, cannot be used as collateral to obtain additional investable funds.

K. Other Investments

Any investment not specifically referred to herein will be considered a prohibited investment.

L. Underlying Nature of Investments

GCHP shall not make investments in organizations which have a line of business that is visibly in conflict with the interests of public health (which shall be defined by the GCHP Commissioners). Furthermore, GCHP shall not make investments in organizations with which it has a business relationship through contracting, purchasing or other arrangements.

M. Derivatives

Investments in derivative securities are not allowed, except as to U.S. Finance STRIPS.

N. Investments

Investments shall be made in the securities presented on exhibit 1.

VI. REPORTING AND REVIEW

The CFO is responsible for directing GCHP's investment program and for compliance with this policy pursuant to the delegation of authority to invest funds or to sell or exchange securities. The CFO shall make a semi-annual report to the Executive Finance Committee, and the GCHP Commissioners.



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A. Procedures performed by the CFO

1. The Operating Funds and Board-Designated (allocated) Reserve Funds targeted average maturities will be established and reviewed periodically.
2. Investment diversification and portfolio performance will be reviewed semi- annually to ensure that risk levels and returns are reasonable and that investments are diversified in accordance with this policy.

VII. QUALIFICATIONS OF BROKERS, DEALERS, AND FINANCIAL INSTITUTIONS

The CFO shall transact business with Advisors, broker/dealer or with direct issuers, broker/dealers licensed by the State, National, or State chartered bank or savings institutions and primary government dealers designated by the Federal Reserve.

Any investment advisor or broker/dealer interested in conducting business with GCHP must have an office within the State of California and is required to fill out an extensive questionnaire maintained by the CFO. This questionnaire is then reviewed and approved by the Finance Committee and upon acceptance, permits GCHP to deal with the broker/dealer.

No broker/dealer may have made political contributions greater than the limits expressed in Rule G-37 of the Municipal Securities Rule Making Body to the CFO, Board of Supervisors, or candidate for those offices.

The Finance staff shall investigate dealers with which it will conduct business in order to determine: if the firm is adequately capitalized and meets the Federal Reserve's minimum capital requirements for broker/dealer operations, makes markets in securities appropriate to the GCHP's investment policy, the individual covering the account has a minimum of three years dealing with large institutional accounts, and receives three favorable recommendations from other short term cash portfolio managers.

GCHP may engage the support services of outside investment advisors in regard to its investment program, so long as it can be clearly demonstrated that these services produce a net financial or necessary financial protection of the GCHP financial resources. Investment advisors shall follow this policy, State law and other such written instructions as provided by the Treasurer.

VIII. DUTIES AND RESPONSIBILITIES OF THE EXECUTIVE FINANCE COMMITTEE:

- A. The CFO with or without the assistance of an independent investment advisor and staff are responsible for the day-to-day management of GCHP's



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investment portfolio. The GCHP's Commissioners are responsible for approval of GCHP's Investment Policy. The Finance Committee shall not make or direct the GCHP staff to make any particular investment, purchase any particular investment product, or do business with any particular investment companies or brokers. It shall not be the purpose of the Executive Finance Committee to advise on particular investment decisions of GCHP.

- B. The duties and responsibilities of the Executive Finance Committee shall consist of the following:
1. Review any changes to GCHP's Investment Policy before consideration by the GCHP's Commissioners and recommend revisions, as necessary.
 2. Review semi-annually GCHP's investment portfolio for conformance to the GCHP Investment Policy diversification and maturity guidelines, and make recommendations as appropriate.
 3. Perform such additional duties and responsibilities as may be required from time to time by specific action and direction of the GCHP's Commissioners.

Interview investment advisors chosen by the CFO and propose the investment advisor of choice to the GCHP's Commissioners for contracting.

Attachments:

Exhibit 1:

Investment of Surplus: California Government Code Section §§53600-53610

Deposit of Funds: California Government Code Section §§53630-53686

References:

Investment of Surplus: California Government Code Section §§53600-53610

Deposit of Funds: California Government Code Section §§53630-53686

Federal Bankruptcy Code



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Revision History:

Review Date	Revised Date	Approved By



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EXHIBIT 1

Investment of Surplus: California Government Code Section §§53600-53610
Deposit of Funds: California Government Code Section §§53630-53686

1. INVESTMENT DESCRIPTION

1.1 U.S. Agencies

The purchase of U.S. agency securities shall be limited to issues of the Federal Farm Credit Banks, Federal Home Loan Banks, Federal Home Loan Mortgage Corp. (Freddie Mac), Student Loan Marketing Association (Sallie Mae), Tennessee Valley Authority (TVA), the Federal National Mortgage Corporation (Fannie Mae), Federal Agricultural Mortgage Corporation (Farmer Mac), or in obligations, participations, or other instruments of, or issued by, a federal agency or a United States government-sponsored or backed entity. TVA notes shall be limited to \$300 million. The maximum maturity of any one agency investment shall not exceed 1150 days.

1.2 Commercial Paper

Commercial Paper is a short term unsecured promissory note issued to finance short term credit needs. Commercial Paper eligible for investment must be of “prime” quality of the highest ranking or of the highest letter and numerical rating as provided for by Standard and Poor's Corporation or Moody's Investors Service, Inc. Eligible paper is further limited to issuing corporations that are organized and operating within the United States and have total assets in excess of \$500 million and an “A” or higher rating for the issuer's debt, other than commercial paper, if any, as provided for by Moody's Investors Service, Inc. or Standard and Poor's Corporation. Purchases of eligible Commercial Paper may not exceed 270 days to maturity nor represent more than 10 percent of the outstanding paper of an issuing corporation. Purchases of Commercial Paper may not exceed 40 percent of the GCHP's surplus money that may be invested. No more than 10 percent of the GCHP's surplus money available for investing may be invested in the outstanding paper of any single issuing corporation. The CFO shall establish a list of approved Commercial Paper issuers in which investments may be made.

1.3 Medium Term Notes and Deposit Notes

The California Government Code restricts investment in Medium Term Corporate Notes of a maximum of five years maturity issued by corporations operating in the United States. Securities eligible for investment must be rated in the top three note rates categories (Moody's designates AAA, A2, A, Standard & Poor's designates



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(AAA, AA, A). Medium term corporate notes may not exceed 5 percent of the GCHP's portfolio and may not have a maturity of longer than 24 months

1.4 U. S. Government

United States Finance Bills, Notes, and Bonds are backed by the full faith and credit of the United States Government. There shall be no limitation as to the percentage of the portfolio which can be invested in this category. The maturity of a security is limited to a maximum of three years.

1.5 Bankers Acceptances

A Bankers Acceptance is a draft or bill of exchange accepted by a bank or trust company and brokered to investors in the secondary market. Bankers Acceptances may be purchased for a period of up to 180 days and in an amount not to exceed 40 percent of surplus funds with no more than 30 percent of the surplus funds in the Bankers Acceptances of any one commercial bank. The CFO shall establish a list of those banks deemed most credit worthy for the investment in Bankers Acceptances.

1.6 Negotiable Certificates of Deposit

Negotiable Certificates of Deposit (NCD) are issued by commercial banks, foreign banks, and thrift institutions against funds deposited for a specified period of time and earn specified or variable rates of interest. The CFO may invest up to 30 percent of surplus funds in NCD's. Negotiable certificates of deposit shall be limited to those institutions rated "AA" or better by Moody's and "AA" or better by Standard and Poor's C.D. Rating Service.

NCD's differ from other Certificates of Deposit in that they are liquid securities which are traded in secondary markets. The maximum term to maturity of any NCD shall be 6 months. The CFO shall establish a list of eligible domestic commercial banks, thrifts and state licensed foreign banks (Yankee Certificates of Deposit) which will be eligible for investment.

1.7 Certificates of Deposit

Certificates of Deposit are deposits by the CFO in commercial banks or savings and loan associations within the State of California and pass the same ratings criteria as outlined under the above mentioned section "Negotiable Certificates of Deposit." Local institutions shall receive preference for deposits up to \$250,000 if competitive rates are offered. These investments are non-negotiable. The maximum term to maturity shall not exceed 375 days and shall be insured by the FDIC.



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1.8 Repurchase agreements

The GCHP may invest in repurchase agreements with banks and dealers of primary dealer status recognized by the Federal Reserve with which the GCHP has entered into a repurchase contract which specifies terms and conditions of repurchase agreements. The maturity of repurchase agreements shall not exceed 90 days. The market value of securities used as collateral for repurchase agreements shall be monitored daily by the Chief Investment Officer and will not be allowed to fall below 102% valued quarterly of the value of the repurchase agreement.

In order to conform with provisions of the Federal Bankruptcy Code which provide for the liquidation of securities held as collateral for repurchase agreements, the only securities acceptable as collateral shall be certificates of deposit, commercial paper, eligible bankers' acceptances, or securities that are direct obligations of, or that are fully guaranteed as to principal and interest by the United States or any agency of the United States. Furthermore, this collateral shall not exceed five years to maturity.

There shall be a \$75 million dollar limitation in repurchase agreements entered into with any one institution.

1.9 Local Agency Investment Fund

The Local Agency Investment Fund ("LAIF") is a fund controlled by the State Treasury for the purpose of investing local agency funds that are not required for immediate needs. GCHP may determine the length of time for which its investments will be on deposit in the LAIF account. The LAIF account pays interest quarterly. There shall be no limitation as to the percentage of the portfolio which can be invested in this category, unless a limitation is established by LAIF.

1.10 County Pooled Investment Funds

GCHP may invest funds with the County Treasurer that are not required for immediate needs. GCHP may withdraw the funds in accordance with criteria established by the County for withdrawals from the County Treasury. The County Treasury apportions interest quarterly. The CFO may invest up to 20% of surplus funds in the County Treasury.

1.11 Ineligible Investments

Investments not described above as authorized investments or not identified in the following schedule are ineligible for purchase. The policy specifically prohibits the investment of any funds in common stock, financial futures, options, inverse floaters, range notes, or mortgage-derived, interest-only strips. Government Code Section



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53601.6 also prevents the investment in any security that could result in zero interest accrual if held to maturity. The limitation in this Section does not apply to investments in shares of beneficial interest issued by diversified management companies registered under the Investment Company Act of 1940 that are authorized pursuant to Government Code Section 53601 (I).

2. PARTIAL INVESTMENTS REFERENCE SCHEDULE:

Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
U.S Treasury Obligations	53601(b)	No Limit	5 Years	None	Notes, bonds, bills
U.S. Agency Obligations	53601(f)	No Limit	5 Years	None	Federal agency or U.S. government sponsored enterprise obligations, participations, or other instruments
State Obligations (CA and others)	53601(c) and (d)	No Limit	5 Years	Underlying A, A-1	<ul style="list-style-type: none"> Registered state warrants, treasury notes or bonds of California Registered treasury notes or bonds from any of the other 49 states
California Local Agency Bonds	53601(e)	No Limit	5 Years	Underlying A, A-1	Bonds, notes, warrants or other evidence of indebtedness of any local agency within California
Corporate Medium Term Notes	53601(k)	<ul style="list-style-type: none"> To be determined by the Investment Committee 	5 Years	A	Issued by <ul style="list-style-type: none"> Domestic corporations or Depository institutions licensed by the United States of any state and operating in the United States



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Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
Negotiable Certificates of Deposit	53601(l)	<ul style="list-style-type: none">To be determined by the Investment Committee	5 Years	A	<ul style="list-style-type: none">Issued by nationally or state-chartered banks; savings or federal associations; state of federal credit unions; or federally licensed or state licensed branches of foreign banks.AndPer 53638 deposits may not exceed bank shareholder equity; total net worth of depository savings or federal association; unimpaired capital and surplus of a credit union; unimpaired capital and surplus of industrial loan companies
Supranationals	53601(q)	<ul style="list-style-type: none">To be determined by the Investment Committee	5 Years	AAA	U.S. dollar denominated senior unsecured unsubordinated obligations issued by or unconditionally guaranteed by: <ul style="list-style-type: none">International Bank for Reconstruction and DevelopmentInternational Finance CorporationInter-American Development Bank
Bankers' Acceptances	53601(g)	<ul style="list-style-type: none">To be determined by the Investment Committee	180 Days	A-1	



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Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
Commercial Paper	53601(h)	<ul style="list-style-type: none">To be determined by the Investment Committee	270 Days	A-1	<ul style="list-style-type: none">Corporation must be organized and operating within the United States; have assets in excess of \$500 million; and have at least an A rating on its long term debt, if any; orCorporation must be organized within the United States as a special purpose corporation, trust, or limited liability company; have program wide credit enhancements including, but not limited to over collateralization, letters of credit or a surety bond.
Repurchase Agreements	53601(j)	No Limit	30 Days	N/A	<ul style="list-style-type: none">Subject to a Master Repurchase Agreement with a Primary Dealer approved by the Commission;Comply with Government Code 53601(j)



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Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
Bank Deposits – Collateralized or FDIC Insured	53630 et seq.	No Limit	5 Years	Satisfactory rating from national bank rating service from CRA review	<ul style="list-style-type: none"> Amounts up to \$250,000 per institution are insured by the FDIC Amounts over the insurance limit must be placed with financial institutions participating in the California Local Agency Security Program, providing for collateralization of public funds Per 53638 deposits may not exceed bank shareholder equity; total net worth of depository savings or federal association; unimpaired capital and surplus of a credit union; unimpaired capital and surplus of industrial loan companies Treasurer may waive collateral for the portion of nay deposits insured pursuant to federal law The use of private sector entities authorized by 53601.8 to assist in the placement of deposits are NOT permitted
Local Agency Investment Fund (“LAIF”)	16429.1 et seq.	To be determined by the Investment Committee	N/A	N/A	



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Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
County Pooled Investment Funds	53684	<ul style="list-style-type: none">To be determined by the Investment Committee	N/A	None	
Joint Powers Authority Pool	53601(p)	<ul style="list-style-type: none">To be determined by the Investment Committee	N/A	None	JPA must be: <ul style="list-style-type: none">Organized pursuant to Section 6509.7;Invest in securities in 53601 subdivisions (a) to (o); andRetain investment advisor register or exempt from advisor register or exempt from registration with the SEC, with at least 5 year's experience, and has assets under management in excess of \$500 million.
Money Market Funds	53601(l)	<ul style="list-style-type: none">To be determined by the Investment Committee	N/A	Fund must either have the highest ranking by not less than 2 NRSROs	Retain an investment adviser registered or exempt from registered or exempt from registration with the SEC with 5 years' experience managing money market funds in excess of \$500 million



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Authorized Investment	Govt. Code	Maximum Percentage	Maximum Maturity	Minimum Quality*	Other Constraints
Mutual Funds	53601(l)	<ul style="list-style-type: none">To be determined by the Investment Committee	N/A	Fund must either have the highest ranking by not less than 2 NRSROs	<ul style="list-style-type: none">Fund must invest in securities that comply with the investment restrictions of 53601(a) through (k) and (n) through (o); andRetain an investment adviser registered or exempt from registration with the SEC with 5 years' experience managing money market funds in excess of \$500 million.

Exhibit 1 – Investment Policy – Description of Key Investments

Banks Urge Big Customers to Take Cash Elsewhere or Be Slapped With Fees

Banks are urging some of their largest customers in the U.S. to take their cash elsewhere or be slapped with fees, citing new regulations that make it onerous for them to hold certain deposits.

The banks, including J.P. Morgan Chase & Co., Citigroup Inc., HSBC Holdings PLC, Deutsche Bank AG and Bank of America Corp., have spoken privately with clients in recent months to tell them that the new regulations are making some deposits less profitable, according to people familiar with the conversations.

Full article:

<http://finance.yahoo.com/news/banks-urge-big-customers-cash-015700566.html>

How to Use Collateralization to Safeguard Public Deposits

The safety of public funds deposited with banks and other depository institutions has been a primary concern of government finance officers. Governments typically entrust depositories with millions of dollars in checking accounts, savings accounts, and certificates of deposit. Hundreds of depository institutions failed in the late 1980s and early 1990s. These bank failures highlighted the need to pay careful attention to protecting government deposits beyond the \$250,000 limit provided by the Federal Deposit Insurance Corporation (FDIC)...Although banks are more diversified and less exposed to regional economic downturns, risk of bank failure remains. A recently released GFOA publication, An Introduction to Collateralizing Public Deposits, presents concrete steps that governmental entities can take to protect their deposits in today's banking environment.

Collateralization Practices. Most states have enacted statutes that either require or permit depositories to pledge collateral securities to secure public deposits. Typically, high-quality government securities (such as U.S. Treasury obligations, federal agency securities, and municipal bonds) are pledged to protect those funds. When a collateralization program is used in conjunction with other risk-control policies and techniques, finance officers can significantly improve the safety of their deposits.

Full article:

<http://www.estoregfoa.org/StaticContent/staticpages/PI0906.htm>

Pooled Money Investment Account (PMIA)

The LAIF is part of the Pooled Money Investment Account (PMIA). The PMIA began in 1955 and oversight is provided by the Pooled Money Investment Board (PMIB) and an in-house Investment Committee. The PMIB members are the State Treasurer, Director of Finance, and State Controller.

All securities are purchased under the authority of Government Code Section 16430 and 16480.4. The State Treasurer's Office takes delivery of all securities purchased on a delivery versus payment basis using a third party custodian. All investments are purchased at market and a market valuation is conducted monthly. The enabling legislation for the LAIF is Section 16429.1 et seq. of the California Government Code.

This program offers local agencies the opportunity to participate in a major portfolio, which invests hundreds of millions of dollars, using the investment expertise of the State Treasurer's Office investment staff at no additional cost to the taxpayer. This in-house management team is comprised of civil servants who have each worked for the State Treasurer's Office for an average of 20 years

Full article:

<http://www.treasurer.ca.gov/pmia-laif/laif-program.asp>

Mutual Funds

GCHP has this option of investment but considering the size of our investments we may not use this investment vehicle unless it out performs individual investments. Contrary to GCHP's needs one of the main advantages of mutual funds is that they give small investors access to professionally managed, diversified portfolios of equities, bonds and other securities, which would be quite difficult (if not impossible) to create with a small amount of capital. Each shareholder participates proportionally in the gain or loss of the fund. Mutual fund units, or shares, are issued and can typically be purchased or redeemed as needed at the fund's current net asset value (NAV) per share, which is sometimes expressed as NAVPS.

Full article:

https://www.nyse.com/listings_directory/etf

Joint Powers Authority Pool

One example of a JPAP is the CSAC Finance Corporation and the League of California Cities which created CalTRUST to provide a convenient method for local agencies to pool their assets for investment. Recently enacted legislation authorizes local agencies

to directly invest in joint investment pools, such as CalTRUST. There is no requirement that a local agency become a JPA member.

Full article:

<http://www.caltrust.org/>

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AGENDA 2d

To: Gold Coast Health Plan Commissioners

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

Re: Provider Credentialing Policy

Date: February 23, 2015

SUMMARY:

In 2011 several separate policies were written that directed the provider credentialing process. In an effort to streamline the process, it was decided to consolidate those that are specific to provider credentialing. In addition, the updated policy reflects changes that have been adopted by the Credentialing Office, required by DHCS or required by NCQA. There are two significant changes to this new policy:

1. The Plan requires any new medical provider to be board certified or eligible. Current providers who are not board eligible will be grandfathered as plan providers.
2. Medical staff of GCHP will need to go through the Plan's credentialing process.

BACKGROUND:

There currently exists multiple policies that direct the credentialing activities of GCHP. It has been difficult for staff to identify the specific policy for a specific function and the original policies have become outdated. In order to streamline the credentialing process and update the policy to the requirements of DHCS, NCQA and to improve the quality of providers the Plan has coalesced 7 policies into 1 policy and made alterations to update the governance of credentialing.

RECOMMENDATION:

GCHP is requesting the Commission to approve the Provider Credentialing Policy presented with this request.

CONCURRENCE:

Not applicable.

Attachments:

Provider Credentialing Policy



Title: Provider Credentialing Policy	Policy Number:
Department: Quality Improvement	Effective Date:
CEO Approved:	Revised:

Purpose:

The Credentialing Program of Gold Coast Health Plan shall be comprehensive to ensure that its practitioners and providers meet the standards of professional licensure and certification. The process enables Gold Coast Health Plan to recruit and retain a quality network of practitioners and providers to serve its members and ensure ongoing access to care. It consistently and periodically assesses and evaluates a practitioner's or provider's ability to deliver quality care between credentialing and re-credentialing cycles, and it emphasizes and supports a practitioner's and provider's ability to successfully manage the health care of Plan Members in a cost-effective manner.

The Credentialing Program enables Gold Coast Health Plan to ensure that all practitioners and providers are continuously in compliance with the Centers for Medicare and Medicaid Services (CMS) requirements, the Department of Health Care Services (DHCS) or designee requirements, Gold Coast Health Plan policies and procedures, and any other applicable regulatory or accreditation entity's requirements and / or standards.

The Gold Coast Health Plan Credentialing and Recredentialing standards shall be reviewed by clinical peers that are members of the Gold Coast Health Plan's Credentials / Peer Review Committee.

Policy:

The Provider Credentialing Policy is one aspect of Gold Coast Health Plan's Quality Improvement Program. Through this policy, Gold Coast Health Plan ensures that practitioners, providers and organizational providers meet basic qualifications before delivering care to members and verifies the qualifications of said providers on an ongoing basis. In addition, this policy ensures a consistent, rigorous, and fair process for evaluating and credentialing providers.

Definitions:

American Board of Medical Specialties (ABMS): An NCQA approved source for verification of Board Certification.

American Medical Association (AMA): An NCQA approved source for verification of various MD credentials, including, but not limited to: Medical License, DEA certificate, education and training, board certification, sanction activity.

American Osteopathic Association (AOA): An NCQA approved source for verification of various DO credentials, included, but not limited to: Medical License, DEA certificate, education and training, board certification, sanction activity.

CAQH: Council for Affordable Quality Healthcare; Manages the Universal Credentialing Initiative by which a practitioner can submit a single application to one central database to

Title: Provider Credentialing Policy	Policy Number:
Department:	Effective Date:
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meet the needs of all of the health plans and Networks participating in the CAQH effort. Practitioners may easily update their information online or via fax anytime, and will confirm once each quarter that the data on file is complete and accurate. CAQH is a coalition of more than 20 of America's largest health plans and Networks and three principal health plan associations working together to help improve the healthcare experience for consumers and physicians. There is no cost for CAQH participation for the practitioners. The health plans pay a cost to access the information.

Clean Practitioner or Provider: A practitioner or provider who fully meets the standards, guidelines, and / or criteria for network participation.

CMS: Centers for Medicare and Medicaid Services headquartered in Baltimore, MD; Under the direction and oversight of the U.S. Department of Health and Human Services; Social Security Act, Titles 18,19, and 21.

Credentialing- A part of Gold Coast Health Plan's Quality Assessment and Improvement Program which verifies credentials with the issuer of the credential or other recognized monitoring organization in order to evaluate a provider's qualifications, affiliations, competency, and to monitor the quality of medical services provided.

Credentials / Peer Review Committee: Is responsible for credentialing and re-credentialing all healthcare providers and verification of a provider's professional qualifications. All credentialing and re-credentialing are performed in accordance with Gold Coast Health Plan's guidelines and standards.

Credentialing Process: Includes both the credentialing and re-credentialing of independently licensed practitioners and / or organizational providers; initial credentialing is conducted prior to a practitioner or provider being presented to the Credentialing Committee for approval; re-credentialing is conducted within three (3) years of the initial credentialing process.

Credentials Verification Organization (CVO): An organization contracted with Gold Coast Health Plan as its agent to verify primary source documentation of credentials of provider applicants wishing to join Gold Coast Health Plan's network.

Delegated Credentialing: Occurs when the credentialing functions of a managed care organization or other organization have been outsourced or contracted out to be performed by another capable organization.

Educational Commission for Foreign Medical Graduates (ECFMG): An organization that certifies providers who have graduated from a medical school in another country. ECFMG verifies each provider's diploma with the medical school prior to issuing certification.

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Facility-based Provider: A provider who renders services to Gold Coast Health Plan's members only as a result of the member being directed to a hospital, freestanding facility, or other inpatient setting. Examples of this type of provider are hospitalist, pathologists, radiologists, anesthesiologists, neonatologists, and emergency room physicians. The Facility is responsible for credentialing these providers.

Free-Standing Facilities: A health care facility that is physically, organizationally, and financially separate from a hospital and whose primary purpose is to provide immediate or short-term medical care on an outpatient basis. Examples of this type of facility include but not limited to Mammography centers, urgent care centers, surgical centers, and ambulatory. Gold Coast Health Plan assesses these facilities as Organization Providers.

Gold Coast Health Plan (GCHP): Is an independent public entity governed by the Ventura County Medi-Cal Managed Care Commission and are dedicated to serving our members. The commission is comprised of locally elected officials, Providers, hospitals, clinics, the county healthcare agency and consumer advocates. Our Member-first focus center on the delivery of exceptional service to our beneficiaries by enhancing the quality of healthcare, providing greater access and improving member's choice.

Independent Relationship: An independent relationship exists between Gold Coast Health Plan and a provider when Gold Coast Health Plan directs its members to see a specific provider or group of providers. An Independent relationship is not synonymous with an independent contract.

Locum Tenens: A Latin phrase that means "to hold the place of, to substitute for," In layman's terms, it means a temporary and / or covering practitioner.

Member: An individual residing in the Ventura County and eligible for Gold Coast Health Plan services.

National Practitioner Data Bank (NPDB): An information clearinghouse established by Title IV of Public Law 99-660 (the Health Care Quality Improvement Act of 1986), to collect and release certain information related to the professional competence and conduct of physicians, dentists, and other health care providers. The U.S. Government established the Data Bank to enhance professional review efforts by making certain information concerning medical malpractice payments and adverse actions available to eligible entities and individuals.

Nationally Recognized Accrediting Entity / Body: An organization that sets national standards specifically governing healthcare quality assurance processes, utilization review, practitioner credentialing, as well as other areas covered in this document and provides accreditation to managed care health insurance plans pursuant to national

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standards. The following entities are examples of nationally recognized accrediting entities / bodies:

- JCAHO: Joint Commission on Accreditation of Healthcare Organizations
- NCQA: National Committee for Quality Assurance; an accrediting body overseeing a variety of health plan functions and ensures quality.

Network Practitioner: Accredited and / or verified person who has entered into a contractual agreement with Gold Coast Health Plan (GCHP) to provide healthcare services to its members and follow all established plan policies and procedures.

Organizational Providers: Medical Organizational providers include: hospitals, home health agencies including infusion services providers, skilled nursing facilities, free standing surgical centers (of any type – gynecology and / or obstetrics - birthing centers, ophthalmology – laser surgery centers, urological surgery centers, cardiac surgery centers, orthopedic surgery centers, free standing hospice centers and rehabilitation facilities). Note: Inclusion of the preceding list of organizational providers in no way implies that all providers referenced are covered under the Gold Coast Health Plan benefit structure.

Primary Source Verification (PSV): The original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care practitioner / provider. Examples include medical school, graduate medical education program, and state Medical Board. Primary Source Verification may be conducted by a Credentials Verification Organization.

Quality Improvement Committee (QIC): Committee of Gold Coast Health Plan (GCHP) that is comprised of both internal and external executive leadership with oversight of GCHP quality improvement activities. Credentialing decisions are not made by the QIC, but may be reported it.

Verification File: A provider's complete credentialing application with all verification and documents gathered during the credentialing verification process, including quality improvement data furnished to Gold Coast Health Plan staff.

Type I Practitioners / Providers: Are practitioners/providers who have no issues with their Credentialing / Recredentialing File and who fully meet the standards, guidelines, and / or criteria for network participation.

Type II Practitioners / Providers: Are practitioners/providers whose Credentialing / Recredentialing file may not meet Gold Coast Health Plan standards, guidelines, criteria and require the recommendations and further review from the Credentials / Peer Review Committee. (Examples: Malpractice claims over \$30,000, Restrictions on license, etc.)

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180-Day Timeframe: To ensure that the Credentials / Peer Review Committee does not consider an applicant whose credentials may have changed since verification, Gold Coast Health Plan and its staff will adhere to strict timeframes for the credentialing process. All verifications, attestations, and information released will be less than 180 days old at the time of the credentialing decision as per NCQA standards, with the exception of those designated by NCQA as 365 (360) day time limited. For written verification, the 180- day limit begins with the date on the written verification from the entity that verified that particular credential. Unless otherwise stated, all verification timeframes in this policy are 180 days prior to the decision.

Office of the Inspector General (OIG): The Health and Human Services Office of Inspector General is responsible for excluding individuals and maintaining a sanctions list that identifies those practitioners and providers who have participated or engaged in certain impermissible, inappropriate, or illegal conduct to include, but not limited to fraudulent billing and misrepresentation of credentials. The OIG's List of Excluded Individuals and Entities (LEIE) provides information on all individuals and entities currently excluded from participation in the Medicare, Medicaid, and all other Federal health care programs.

If identified billing practices are suspected to be potentially fraudulent or abusive, the **OIG's National Hotline** should be contacted at **1-800-HHS-TIPS (1-800-447-8477)** to report the activity.

Contacting the HHS OIG Hotline:

By Phone: 1-800-HHS-TIPS (1-800-447-8477)

By Fax: 1-800-223-8164

By E-Mail: HHSTips@oig.hhs.gov

By TTY: 1-800-377-4950

By Mail:

Office of Inspector General

Department of Health and Human Services

Attn: HOTLINE

330 Independence Ave., SW

Washington, DC 20201

Centers for Medicare & Medicaid Services (CMS): Suspicions of fraud or abuse may also be reported to Medicare's Customer Service Center at **1-800- MEDICARE (1-800-633-4227)**.

Procedure:

AUTHORITY AND RESPONSIBILITY

Gold Coast Health Plan has organized the Quality Improvement Committee (QIC) to oversee all Quality Improvement Program Policies and Procedures and make

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recommendations to the full Board of Commissioners. In turn, Gold Coast Health Plan's Board of Commissioners has also delegated credentialing to Gold Coast Health Plan's Credentials / Peer Review Committee with facilitation and oversight by the Gold Coast Health Plan Chief Medical Officer. Gold Coast Health Plan's Chief Medical Officer and The Credentials / Peer Review Committee accepts the responsibility of administering the Credentialing Program and having oversight of operational activities, which include making the final decision, (i.e., approve, or denial) for all practitioners and providers regarding the suitability to provide care to Plan Members. A summary report of each Credentials / Peer Review Committee meeting will be made to the Quality Improvement Committee (QIC) and subsequently, to Gold Coast Health Plan's Board of Commissioners by the Chief Medical Officer or designee.

Each Member of the Credentials / Peer Review Committee is responsible for maintaining an objective view of Credentialing review activities.

Composition:

The Chief Medical Officer is responsible for the oversight and operation of the Credentialing Program and serves as Chairperson, or may appoint a Chairperson, with equal qualifications. The Chief Medical Officer of Gold Coast Health Plan, must review, approve, sign and date the Annual Credentialing Program each year.

The Credentials / Peer Review Committee consists of 8 voting members who serve two-year terms which may be renewed (there are no term limits). The Credentials / Peer Review committee is a peer-review body that includes participating practitioners who span a range of specialties, including primary care (i.e., family practice, internal medicine, pediatrics, general medicine, geriatrics, etc.) and specialty care. Members are nominated by the Chief Medical Officer and approved by the Board of Commissioners.

Responsibilities / Duties:

- The Chief Medical Officer is responsible for:
 1. Compliance with facility and medical records review required by DHCS;
 2. Overseeing the clinical quality of care including the review of complaints and grievances, the review and assessment of Potential Quality Issues submitted to the Quality Improvement Department and all other ongoing performance monitoring;
 3. Recommending members for the Credentials / Peer Review Committee;
 4. Referring significant quality of care issues to the Credentials / Peer Review Committee for review;
 5. Assuring the completeness of credentialing files;
 6. Coordinating and following-up on clinical quality of care recommendations by the Credentials / Peer Review and Quality Improvement Committees;
 7. Screening the list of providers to be presented to the Credentials / Peer

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Review Committee meeting to determine if any of the candidates have clinical quality of care issues that may require review by the Credentials / Peer Review Committee;

8. Classifying credentialing files as Type I (clean) or Type II (Problem);
 9. Reporting to the Quality Improvement Committee, Board of Commissioners and other appropriate authorities as required;
 10. Approving a practitioner who fully meets the established criteria as a provisional practitioner, pending Committee approval;
 11. Presenting candidates for initial credentialing and recredentialing to the Credentials / Peer Review Committee;
 12. Ensuring that proceedings of the Credentials / Peer Review Committee are recorded in the minutes of the Committee;
 13. Communicating with practitioners regarding their credentialing status; and
 14. Assuring the fairness of the credentialing process and facilitate the appeal and fair hearing process.
- The Credentials / Peer Review Committee reviews and evaluates the qualifications of each provider applying to become a contracted provider or seeking recredentialing as a contracted provider. The Credentials / Peer Review Committee has been delegated authority to:
 1. Review, and approve Type I Credentialing and Recredentialing practitioner list. Type I files will be presented to the Credentials / Peer Review Committee on a list of Type I files and presented as 1 group for approval. The CMO will sign each file and the list will be documented in the minutes of the Credentials / Peer Review Committee.
 2. Receive and review all Type II practitioners being Credentialed and Recredentialed who have been identified as problematic (e.g. Malpractice cases, licensure issues, quality concerns, missing documentation, etc.);
 3. Review the quality of care findings resulting from Gold Coast Health Plan's credentialing and quality monitoring and improvement activities;
 4. Act as the final decision maker in regards to the initial and subsequent credentialing of providers based on clinical competency and / or professional conduct;
 5. Annual Review of the Credentialing and Recredentialing policy and procedures;
 6. Establish, implement and make recommendations to policies and procedures; and
 7. Other related responsibilities.

Quorum:

A quorum (majority of voting members present) shall be satisfactory for the valid

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transaction of business by the Credentials / Peer Review Committee, which meets at least quarterly and / or as deemed necessary by the Chairperson. With the consent in writing the Credentials / Peer Review Committee may meet and take action in a forum other than a face-to-face meeting. Any action taken must be with a quorum present and all proceedings must be recorded and presented to the Committee at its next regularly scheduled meeting. Voting members include only the Committee Physicians. The Credentials / Peer Review Committee Chair votes only when there is a tie vote, in order to break a tie vote. If during a meeting, an exact Quorum is no longer met, the voting must cease.

Minutes and Reports:

1. Complete and accurate minutes will be prepared and maintained for each meeting. Minutes will reflect the name of the Committee, the date and duration of the meeting, the members present and absent, and the names of guests or other representatives. The minutes will reflect decisions and recommendations, the status of activities in progress, and the implementation status of recommendations, when appropriate. Applicable reports and substantiating data will be appended for reporting purposes. The Credentials / Peer Review Committee will be responsible for reviewing minutes for accuracy. A summary report will be submitted to the Quality Improvement Committee (QIC), which in turn reports to the Board of Commissioners.
2. For each provider discussed, the minutes will identify the specialty and a summary of the discussion regarding that provider, the Credentials / Peer Review Committee recommendation, and the rationale for recommendation.
Minutes shall be securely retained electronically and manually.

Confidentiality, Immunity and Releases Policy:

All credentialing, peer review records and proceedings are included in the quality improvement process of Gold Coast Health Plan and will be confidential in accordance with Section 1157 of the California Evidence Code. It is the policy and procedure of Gold Coast Health Plan to consider all credentialing and subsequently retained records as a result of the credentialing process as confidential. The mechanisms in effect to ensure the confidentiality of information collected in this process are as follows:

1. Gold Coast Health Plan shall hold in confidence all data and information that it acquires in the exercise of its duties and functions as a review organization as recognized under California Statutes Section 1157
2. Access to such documents will be restricted to: (1) The practitioner or provider being credentialed, pursuant to the requirements outlined in the subdivision of this policy titled "Practitioner Rights," (2) Committee Members, (3) Board Members, (4) Gold Coast Health Plan Credentialing Staff, (5) Gold Coast Health Plan's contracted Credentials Verification Organization, to conduct

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- primary source verification, and (6) Other specific individuals as designated by the Chief Medical Officer, Committee, Board and / or Gold Coast Health Plan.
3. All Credentials / Peer Review Committee members, support staff and guests will be required to sign a confidentiality of information agreement annually in order to protect the peer review function. Any breach of confidentiality may be grounds for corrective action by the Credentials / Peer Review Committee.
 4. Each Credentials / Peer Review Committee member will, in accordance with the requirements for peer review member immunity in Civil Code Section 43.7, exercise the member's duties without malice, after making a reasonable effort to obtain the facts of the matter as to which the member acts, and act in reasonable belief that the action taken by the member is warranted by the facts known to the member.
 5. All Credentials / Peer Review Committee members will comply with Gold Coast Health Plan policies for conflicts of interest.

Conflict of Interest:

All Voting Credentials / Peer Review Committee members are required to sign a Conflict of Interest agreement before becoming a member. Committee members shall reveal any associations, conflicts of interest or potential conflicts of interest with any credentialing applicant to the committee chair prior to the consideration of a candidate. No person may participate in the review and evaluation of any professional practitioner or provider with whom he / she has been in a group practice, professional corporation, partnership, corporation, or similar entity whose primary activity is the practice of medicine or where judgment may be compromised. The Chairperson of the Credentials / Peer Review Committee shall have the authority to excuse a voting member from the Credentials / Peer Review Committee in the presence of a conflict of interest.

NON DISCRIMINATORY PRACTICES

Gold Coast Health Plan conducts each Credentials / Peer Review Committee meeting in a non-discriminatory manner. No provider shall be denied privileges with Gold Coast Health Plan, have any corrective actions imposed, or have his / her privileges suspended or terminated on the basis of race, color, age, gender, marital status, sexual orientation, religious creed, ancestry, national origin, physical or mental disability, or the type of procedures or the patients in which the provider specializes.

A heterogeneous Committee will be maintained and all committee members responsible for credentialing decisions sign a statement affirming non- discrimination for credentialing decisions. Periodic audits of practitioner grievances / complaints will also be conducted to determine if there are grievances / complaints alleging discrimination.

In credentialing practitioners, Gold Coast Health Plan shall not discriminate, in terms of participation, against any practitioner, prospective or existing, who is acting within the scope of his or her license or certification under state law, solely on the basis of the class

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of license or certification.

If a practitioner is declined privileges, the reason for denial by the Credentials / Peer Review Committee shall be communicated in writing within 60 calendar days of the Committee's final decision. This prohibition does not preclude Gold Coast Health Plan from refusing to grant participation to a practitioner if there is no network need.

THE CREDENTIALING PROGRAM: PRACTITIONERS

Scope of Credentialing:

The scope of the Credentialing Program is comprehensive and includes all practitioners that have an active, current and valid license, have National Provider Identification (NPI) number and are Medi-Cal participating providers or in process of becoming participants.

Practitioners who will be credentialed and reviewed on an ongoing monitoring basis include:

1. Practitioners who have an independent relationship with Gold Coast Health Plan at an outpatient setting. An independent relationship exists when Gold Coast Health Plan selects and directs its members to see a specific practitioner or group of practitioners. An independent relationship is not synonymous with an independent contract. NCQA does not require the organization to credential some practitioners with whom it holds independent contracts.
2. Practitioners who see members outside the inpatient hospital setting or outside freestanding/ ambulatory facilities.
3. Oral Surgeons who provide care under Gold Coast Health Plan medical benefits.
4. Non-physician practitioners who have an independent relationship with Gold Coast Health Plan, as defined above, and who provide care under the organization's medical benefits.
5. Hospital based practitioners who also have an independent relationship with Gold Coast Health Plan and treat members in an outpatient setting.

Types of Practitioners to be credentialed:

- Physicians (MD, DO)
- Anesthesiologists with pain-management practices
- Podiatrist (DPM)
- Chiropractors (DC)
- Oral Surgeons
- Osteopaths

Non-physician practitioners to be credentialed:

- Nurse practitioners

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- Physician Assistants (PA)
- Registered Nurse Clinical Specialists (RNCS, CNS)
- Acupuncturists
- Nurse midwives

Types of practitioner files audited (internally) during the year to ensure ongoing compliance:

Medical practitioners:

- Medical doctors (MD)
- Osteopaths (DO)
- Podiatrists (DPM)
- Anesthesiologists with pain-management practices
- Nurse Practitioners (NP, PNP, ANP)
- Physician Assistants (PA)
- Nurse midwives

Additional types of practitioners, not listed above, may also be credentialed and subject to the same policies and procedures, as those listed in this document, to ensure ongoing quality for the Gold Coast Health Plan members. However, internal file reviews may be restricted to the practitioners listed above.

Practitioners who do not need to be credentialed by Gold Coast Health Plan:

- Practitioners who practice exclusively within the inpatient setting and who provide care for Gold Coast Health Plan members only as a result of members being directed to the hospital or another inpatient setting:
 - Pathologists
 - Radiologists
 - Anesthesiologists
 - Neonatologists
 - Perinatologists
 - Emergency room physicians
 - Hospitalists
 - Telemedicine consultants
- Practitioners who practice exclusively within free-standing facilities and who provide care for Gold Coast Health Plan members only as a result of members being directed to the facility.
 - Mammography Centers
 - Urgent-Care Centers
 - Surgi-Centers

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○ Radiology Centers

- Covering practitioners (e.g., locum tenens). Locum tenens who do not have an independent relationship with the organization are outside NCQA's scope of credentialing.
- Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants)
- Rental network practitioners that are specifically for out-of-area care, and there are no incentives communicated to members; members have no obligation to seek care from rental network practitioners and may see an out-of-area practitioner.
- Telemedicine practitioners who have an independent relationship with the organization and who provide treatment services under the organization's medical benefit.

Professional Criteria:

Gold Coast Health Plan accepts professional practitioners into its network at its sole discretion based on the need for professional practitioners in certain specialties, geographic areas, or similar considerations.

Each professional practitioner must meet minimum standards for participation in Gold Coast Health Plan Network. These guidelines are intended to comply with Gold Coast Health Plan, DHCS, or its designee, NCQA, or any other applicable regulatory and / or accreditation entities where applicable.

Minimum Standards for Participation include:

- A current and valid professional license to practice in California
- Current and valid Federal DEA Certificate for practitioners with the authority to write prescriptions, as applicable for practice.
- Board certification or eligibility is a requirement for Gold Coast Health Plan Physicians requesting network participation after **ENTER EFFECTIVE DATE**. The practitioner must have relevant education (Residency) in his / her practicing specialty. New graduates must become board-certified within three (3) years of completing an approved residency or fellowship-training program in their practice area. Board certification requirements may be waived upon review of the Credentials / Peer Review Committee if the practitioner has five (5) years of verified relevant work history and / or has unrestricted, current active privileges in the specialty area. Practitioners may be "grand parented" if the practitioner was initially credentialed by Gold Coast Health Plan prior to **Enter DATE**.
- Documentation showing provider is currently participating with Medi-Cal or are in the process and / or pending participation with Medi-Cal. Please note: Providers who are in the process of applying for Medi-Cal and / or pending will need to provide Department of Health Care Services (DHCS) Letter of Interest.

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- Copy of the current Curriculum Vitae (CV) or detailed work history which must include month/year (Gaps or interruptions in work history 6 months or greater must be explained). CV or work history must cover the previous five years.
- Acceptable, current and valid malpractice insurance in the amount \$1 Million per incident and \$3 Million per aggregate per year or as determined satisfactory by the Credentials / Peer Review Committee.

Additional Requirements: CHDP, CPSP, and HIV/AIDS

- For some physician specialties there are additional credentialing requirements. For example pediatricians and family practice specialists who care for children should also be paneled by Children Health Disability Prevention Program (CHDP) to participate in the Gold Coast Health Plan network.
- Obstetricians should be paneled by Comprehensive Perinatal Services Program (CPSP).
- HIV/AIDS specialists must document that they meet certain additional education and training requirements.

HIV/AIDS Education and Training Requirements:

If the provider has been identified as an HIV/AIDS Specialist the following additional criteria will be verified prior to indicating this subspecialty in the provider listing:

- Provider is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine
- Is board certified, or has earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification or a Certificate of Added Qualification in the field of HIV Medicine
- Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
 1. In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; AND
 2. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category (1) continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV infected patients including a minimum of 5 hours related to antiretroviral therapy per year; or meets the following qualifications:
 - a) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV: AND
 - b) Has completed any of the following:
 1. In the immediately preceding 12 months has obtained board certification or

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re-certification in the field of infectious diseases from a member board of the American Board of Medical Specialties;

2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category (1) continuing medical education in the prevention of HIV infection, combined with diagnosis treatment or both, of HIV-infected patients; or
3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category (1) continuing medical education in the prevention of HIV infection combined with diagnosis.

Quality of Practice Criteria:

- Professional practitioner(s) must demonstrate acceptable office site survey and medical record keeping practices which meet DHCS or its designee, NCQA, Gold Coast Health Plan, or any other standards adopted by Gold Coast Health Plan.
- Professional practitioner(s) practice patterns must reflect a general adherence to established practice standards and protocols as adopted by Gold Coast Health Plan.
- Professional practitioner(s) must maintain satisfactory performance in the area of practice quality indicators (i.e., clinical outcomes, performance measure outcomes, member satisfaction, etc.) established by Gold Coast Health Plan.
- Gold Coast Health Plans retains the right to approve/deny new practitioners/providers based on quality issues, and to terminate individual practitioners/providers for same. Termination of individual practitioners/providers for quality of care considerations shall be supported by documented records of noncompliance with specific expectations and requirements for practitioners/providers. Gold Coast Health Plan has a prescribed system of appeals and fair hearings which must be followed.

Business Administrative Criteria:

- Professional practitioner(s) must maintain Gold Coast Health Plan access standard requirements at the majority of the ambulatory service sites where a member may be seen.
- Professional practitioner(s) area of specialty must fill a network need as determined by Gold Coast Health Plan. Gold Coast Health Plan reserves the right to deny participation, on a case-by-case basis if need does not exist for a particular specialty and if such action is deemed in the best interest of the network.
- If a practitioner is denied inclusion in the network because of a lack of a business need, it will not be considered a denial of credentialing and will not be considered a denial for a quality reason. The practitioner will not have access to the credentialing appeal or fair hearing processes.

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OB / GYN Provider PCP Delegation:

Gold Coast Health Plan determines if Obstetrician and Gynecologist (OB / GYN) providers will be considered to be added as a full service Primary Care Provider. This applies to all Obstetricians and Gynecologist (OB / GYN) providers whether they are seeking a contract with Gold Coast Health Plan, are currently contracted or they are contracted through a delegated group.

An Obstetrician and Gynecologist (OB / GYN) provider may be considered for delegation of PCP by approval of the Gold Coast Health Plan Credentials / Peer Review Committee. This decision must be made by the Gold Coast Health Plan Credentials / Peer Review committee even if the practitioner's credentialing has been done by a delegated entity. The practitioner must be able to substantiate the ability, and training in general medicine, as well as the ability to demonstrate on-going management of hypertension, diabetes, hyperlipidemia, gastrointestinal illness, cardiovascular disease, musculoskeletal disease, respiratory disease, renal disease, endocrinology and the majority of procedures outlined in the PCP scope of services.

Obstetrician and Gynecologist (OB / GYN) providers will need to attest to aforementioned criteria at a regularly scheduled meeting of the Credentials / Peer Review Committee for approval

INITIAL CREDENTIALING: PRACTITIONERS

Process and Requirements:

Gold Coast Health Plan credentials all practitioners prior to being admitted into the Gold Coast Health Plan network. The intent of the process is to validate and / or confirm credentials related to a prospective or participating practitioner by contacting the primary source of the issuing credential directly. All attestations and verification time limits, applicable in this Credentialing Program and referenced in this document, shall not exceed 180 calendar days of the Credentials / Peer Review Committee Meeting and / or Committee Decision.

Each practitioner must submit a legible and completed application on either a gold Coast Health Plan or CAQH application form. A signed and dated consent form, a signed attestation and all other required documentation as outlined below must be included in the application. The following information is obtained and verified according to the standards and utilizes sources listed under Initial Credentialing:

Application includes the following information:

- Reasons for inability to perform any essential provider functions, with or without accommodation
- Lack of present illegal drug use

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- History of loss of license and / or felony conviction
- History of loss or limitation of privileges or disciplinary actions
- Current malpractice insurance coverage
- Attestation as to the correctness and completeness of the application
- Copy of the current and valid license or license number for the participating practitioner
- Copy of the current and valid DEA/CDS Certificate, if applicable
- Copy of the medical malpractice policy face sheet, or completed liability information section on the application inclusive of policy number, effective dates of coverage, and coverage amounts.
- Copy of the board certificate and highest level of education; proof of education, training and competency in the specialty for which practitioner is seeking participation status in the Gold Coast Health Plan network.
- Copy of the current Curriculum Vitae (CV) or detailed work history which must include month/year (Gaps or interruptions in work history 6 months or greater must be explained). CV or work history must cover the previous five years.
- Documentation showing provider is currently participating with Medi-Cal or are in the process and / or pending participation with Medi-cal. Please note: Providers who are in the process of applying for Medi-Cal and / or pending will need to provide Department of Health Care Services (DHCS) Letter of Interest.
- Practitioner explanation of any adverse actions including 1) Any limitation in ability to perform the functions of the position, with or without accommodation; 2) History of loss of license and / or felony convictions; 3) History of loss or limitation of privileges or disciplinary activity; Any malpractice history, either reported or non-reported to the NPDB or other regulatory bodies.

The application will be provided to the Credentialing Coordinator of Gold Coast Health Plan. Upon receipt of the application the Credentialing staff will:

- Prepare and send a letter to the applicant reviewing the application process. Included in the letter will be a statement indicating that the applicant will have the right to review information in the file and correct erroneous information. Practitioners will have the ability to review information obtained in the credentialing process. (References, recommendations, or other peer-review protected information is excluded). The practitioner will also be informed of the process of submitting a request to review the file in writing to the Credentialing Coordinator.
- The Credentialing Coordinator or designee will also notify the Quality Improvement Office of the new application in order for the QI Office to initiate a Facility Site Review (FSR). The credentials file will be reviewed by Gold Coast Health Plan Credentialing Coordinator or designee for completeness and accuracy.

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- The FSR must be completed and satisfactory before the application will be considered complete and ready to be reviewed by the Chairman of the Credentials / Peer Review Committee.
- If the application is incomplete, the Credentialing Coordinator or designed staff will request that the applicant provide the additional missing information required. If the required information is not received within 30 calendar days, Gold Coast Health Plan Staff will inform the applicant that the application is incomplete and request the needed information. If the required information is not received within 60 calendar days of the initial receipt of the application, Gold Coast Health Plan will consider the application withdrawn. If an application has been withdrawn and the applicant wishes to apply a new application must be submitted to Gold Coast Health Plan.

Primary Source Verification:

The Gold Coast Health Plan credentialing staff, along with Gold Coast Health Plan's contracted Credentials Verification Organization (CVO), will conduct primary source verification as required by the most current and applicable CMS, DHCS or its designee, NCQA, and other Gold Coast Health Plan adopted guidelines. Gold Coast Health Plan accepts letters, telephone calls, faxes, computer printouts, and / or online viewing of information as acceptable sources of verification with appropriate reference documentation (i.e., the name of the person who provided verification, the date of the call, and the verifier's name). The information must be accurate and current.

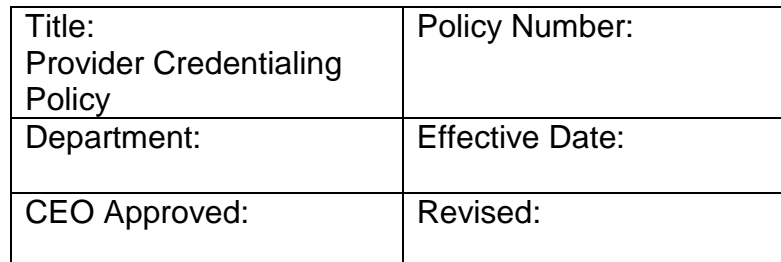
Verbal verifications documented in credentialing files are dated and signed by the credentialing staff or the CVO employee who receives the information-noting source and date. Written verifications are received in the form of letters or documented review of latest cumulative reports released by primary sources. Internet verifications may be obtained from any CMS, DHCS or its designee, NCQA, and / or Gold Coast Health Plan-approved web-site source.

To meet verification standards, all credentials must be valid at the time of the Credentials / Peer Review Committee's decision per Table VII-A below and the specific time limits as set forth by CMS, DHCS or its designee, NCQA, Gold Coast Health Plan and any other applicable regulatory and / or accreditation entities:

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Table VII-A:

Primary Source Information:	Acceptable Sources:
<p>" Credential: License " Verification Time Limit: 180 calendar days*</p> <p>Must confirm that practitioners hold a valid, current state license or certification, which must be in effect at the time of the Committee's decision; must verify licenses or certification as applicable in each state where practitioners provide care for plan members; verification <u>must come directly from the state licensing or certification agency</u>; if the plan uses the Internet to verify state licensure or certification, the Web site must be from the appropriate state licensing agency.</p> <p>Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)</p>	<p>" State Agency</p>
<p>" Credential: DEA or CDS Certificate " Verification Time Limit: 180 calendar days *</p> <p>Must be effective at the time of the credentialing decision; must be verified in each state in which the practitioner cares for plan members.</p> <p>Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)</p>	<p>" A copy of the DEA or CDS certificate " Documented visual inspection of the original certificate " Confirmation with the DEA or CDS Agency " Entry in the National Technical Information Service (NTIS) database " Entry in the American Medical Association (AMA) Physician Master File " Confirmation from the state pharmaceutical licensing agency where applicable</p>
<p>" Credential: Education and Training " Verification Time Limit: None for graduation from medical or professional school and / or completion of residency.</p> <p>The organization must verify the highest of the three levels of education and training obtained by the practitioner.</p> <ol style="list-style-type: none"> 1. Graduation from medical or professional school 2. Residency, if appropriate 3. Board certification, Required with exception of providers who were grandfathered or <p>Printout from state licensing agency's Web site: The plan may use a dated printout of the licensing agency's Web site in lieu of a letter or other written notice as long as the site states that the agency verifies education and training with primary sources and indicates that this information is current; NCQA does not require the plan to obtain written confirmation from the licensing board if there is a state statute that requires the licensing board to obtain verification of education and training directly from the institution; the plan must include a copy of the relevant state statute as proof</p> <p>Note: If a practitioner's education has not changed during the re-credentialing cycle, the previous education verification will stand and not be re-verified.</p> <p>Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)</p>	<p>Graduation from medical school : (MD, DO)</p> <p>" Medical School " AMA Physician Master File " American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. " Association of schools of the health professional, if the association performs primary source verification. At least annually, the organization must obtain written confirmation from the association that it performs primary source verification. " State licensing agency, if the state agency performs primary-source verification. At least annually, the organization must obtain written confirmation from the State-licensing agency that it performs primary source verification. " Sealed transcripts: If a practitioner submits transcripts to the organization that are in the institution's sealed envelope with an unbroken institution seal, NCQA accepts this as primary-source verification if the organization provides evidence that it inspected the contents of the envelope and confirmed that transcript shows that the practitioner completed (graduated from) the appropriate training program.</p> <p>Note: If the practitioner states that education and training were completed through the AMA's Fifth Pathway program, the organization must confirm it through primary-source verification from the AMA</p>



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** 180-Day Timeframe:* To ensure that the Credentials / Peer Review Committee does not consider an applicant whose credentials may have changed since verification, Gold Coast Health Plan and its staff will adhere to strict timeframes for the credentialing process. All verifications, attestations, and information released will be less than 180 days old at the time of the credentialing decision as per NCQA standards, with the exception of those designated by NCQA as 365 (360) day time limited. For written verification, the 180- day limit begins with the date on the written verification from the entity that verified that particular credential. Unless otherwise stated, all verification timeframes in this policy are 180 days prior to the decision.

Other Documentation required on all of some practitioners:

- Facility Site Review and Medical Record Review
- Some providers may need to satisfy CHDP, CPSP or HIV/AIDS requirements during Credentialing and Re-Credentialing. Refer to section titled “Additional Requirements”.

PROVISIONAL CREDENTIALING

Gold Coast Health Plan Chief Medical Officer or designee can on an as needed basis and when in the interest of members make practitioners available prior to completion of the entire initial credentialing process. In this case, Gold Coast Health Plan will provisionally credential practitioners who are applying to the organization for the first time. A practitioner may only be provisionally credentialed once. A practitioner must fully meet all criteria as a clean practitioner to be eligible for provisional credentialing. All required PSVs, application, and signature requirements, along with required documentation as outlined in Section

VII-A of this document will be conducted prior to presentation to the Credential/Peer review Chairperson.

Practitioners that have been provisionally credentialed will be presented to the Credentials / Peer Review Committee within the 60 calendar day period after the Credentials / Peer Review Chairperson’s approval of the provisional practitioner.

RE-CREDENTIALING: PRACTITIONERS

Gold Coast Health Plan recredentials all practitioners within three (3) years of their last credentialing or recredentialing date. The intent of the process is to identify any changes that may affect a practitioner's ability to perform the services that s / he is under contract to provide.

All application requirements detailed in Section: VII-A are applicable to the recredentialing process. All verification time frames detailed in Table: VII-A are applicable to the re-credentialing process.

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Each practitioner must complete and sign the Gold Coast Health Plan or CAQH Recredentialing Application that includes the professional questions and attestation that the information given is correct and gives Gold Coast Health Plan the right to verify the information. The following information is obtained and verified according to the standards and utilize the sources listed under Initial Credentialing:

- State licenses (unrestricted, current and valid)
- DEA/CDS certificate (if applicable)
- Additional Education, (if applicable)
- Board certification
- Hospital affiliations/status of clinical privileges
- Malpractice coverage
- Malpractice claims
- Sanction information
- Documentation showing Medi-Cal participation

The recredentialing process shall include performance-monitoring information. Sources of such information may include one or more of the following:

- Member grievances / complaints
- Member and Practitioner / Provider satisfaction surveys
- Utilization Management
- Risk Management
- Quality improvement activities, performance quality measures, quality deficiencies, and / or trending patterns
- Facility Site Review Assessment
- Medical Record Keeping Practice/Treatment Assessments

After a practitioner has been credentialed, Gold Coast Health Plan shall not prohibit or otherwise restrict any participating (or nonparticipating) practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of, a member who is a patient about:

1. The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options;
2. The risks, benefits, and consequences of treatment or non-treatment;
3. The opportunity for the individual to refuse treatment and / or express preferences about future treatment decisions.

Participating practitioners must provide information regarding treatment options, including the option of no treatment, in a culturally competent manner. They must ensure that enrollees with disabilities have effective communication regarding treatment options and /

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or decisions with participants throughout the health system.

Handling Credentialing Issues

Each provider's credentialing file is reviewed by Gold Coast Health Credentialing Coordinator for completeness and accuracy based on Credentialing Criteria prior to presentation to the Chief Medical Officer. Any file identified with exceptions or potential exceptions is referred to the Chief Medical Officer or designee, to evaluate and request additional information, as needed. If further information is needed, either the Credentialing Coordinator or Chief Medical Officer or designee will gather the additional information for the credentials file and for presentation to the Chairman of the Credentials / Peer Review Committee.

A. If any one of the following issues are identified, Credentialing staff will forward the credentialing file or active provider file to the CMO for review and if verified will be cause for immediate denial of an application or summary suspension as a provider for Gold Coast Health Plan:

- No license or a revocation of the provider's license to practice medicine in the State of California
- A sanction that disallows participation in the Medicare and Medicaid programs
- A condition that is identified that would suggest that care by the provider would present a danger to a member.
- Any verified evidence that the practitioner intentionally lied or made a misstatement on the application.
- No current malpractice coverage.

B. If any one of the following issues are identified for a practitioner who is initially applying to be a provider for Gold Coast Health Plan, the Credentialing Staff will forward the credentialing file to the CMO for review and if verified action on the application will be held until the conclusion of the legal proceedings or in the case of an unsatisfactory facility site review, the identified problems are resolved:

- A pending felony charge
- A pending criminal charge involving any criminal activity related to the practitioner's practice.
- Any pending action by the licensing board of the practitioner that could result in revocation or limitation of the practitioner's license to practice.
- Any pending criminal charge relating to a sex offense.
- An unsatisfactory Facility Site Review necessitating a Corrective Action Plan

C. If any of the following issues are identified for a practitioner who is being considered for re-credentialing the committee may temporarily extend the practitioners credentials until the practitioner has had due legal process or has had the opportunity to resolve a FSR Corrective Action Plan, or the practitioner may be suspended because of the seriousness of the accusation:

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- A pending felony charge
- A pending criminal charge involving any criminal activity relate to the practitioner's practice
- Any Pending action by the licensing board of the practitioner that could result in revocation or limitation of the practitioner's license to practice
- Any pending criminal charge relating to a sex offense.
- An unsatisfactory Facility Site Review necessitating a Corrective Action Plan.

Committee Decisions:

When a new credentials file or a recredentials file is complete it will be presented to the Credentials / Peer Review Committee as a Type I or Type II file. Type I files will be approved as a group unless a committee member wishes to discuss an individual practitioner on the Type I list. The Type II files will be considered by the Committee.

Factors to be considered by the Credentials / Peer Review Committee:

- Past history of actions taken by a licensing body
- Past history of actions taken by a medical facility
- Past history of medical malpractice claims, judgments, and / or payments
- Personal issues affecting the practitioner's ability to treat Plan Members
- Access needs of the Health Plan
- History of grievances and complaints by Plan Members – for re-credentialing
- Reviews submitted to the Credentials / Peer Review Committee by the Quality Assurance Committee as a result of the peer review process. – For re-credentialing
- Peer review issues referred to the Credentials / Peer Review Committee and verified and rated as significant PQI's.
- History of the practitioner failing to abide by the policies of the Health Plan including failing to meet the standard quality indicators such as HEDIS Metrics and access requirements – for recredentialing.
- Facility Site Review findings – for recredentialing

These factors will be taken into account as a whole for use by the Credential/Peer Review Committee in determining if a practitioner will be credentialed or re-credentialed and to determine the services that the practitioner may provide to Plan Members.

Please Note: A practitioner will receive one of the following designations from the Committee:

A	Approved without reservation
B	Approved with reservation (follow up within 3,6,9,12 months)
C	Not approved because of insufficient data
D	Not approved (final decision)

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ONGOING MONITORING

Gold Coast Health Plan staff monitors practitioner sanctions, grievances / complaints and quality issues between credentialing cycles and takes appropriate action(s) against practitioners when it identifies occurrences of poor quality. Gold Coast Health Plan acts on important quality and safety issues in a timely manner by reporting such occurrences at Quarterly Credentials / Peer review meetings or as needed. If an occurrence requires urgent attention, the Chief Medical Officer or designee will address it immediately; engage the Committee if necessary, and appropriate action(s) will be taken to ensure quality. If the Chief Medical Officer determines that there is an immediate danger to the provision of care by a provider; the CMO may summarily suspend for a period of 14 days. On an ongoing monitoring basis, Gold Coast Health Plan collects and takes appropriate intervention and / or action by:

Collecting and reviewing Medicare and Medicaid sanctions

- Gold Coast Health Plan staff and / or CVO will review sanction information within 30 calendar days of being posted on the OIG Report Website.

Collecting and reviewing sanctions or limitations on licensure:

- Gold Coast Health Plan staff and / or CVO will review sanction information within 30 calendar days of release. In areas where reporting entities do not publish sanction information on a set schedule, Gold Coast Health Plan and / or CVO will query for this information at least every six months.

Collecting and reviewing grievances / complaints:

- Member Complaints/Grievances: The Chief Medical Officer or designee will review a report of Member complaints/grievances quarterly and at year end. If an unusually large number of grievances, as defined in the criteria below are filed against a Provider, the Chief Medical Officer or designee will review copies of the actual grievance documentation and will make a determination as to whether the grievance materials should be submitted to the Credentials / Peer Review Committee at the next regularly scheduled meeting.

Criteria for Referral Physicians with no linked Members:

- If three or more grievances are filed against any Gold Coast Health Plan Physician with no linked Members in any given year, the practitioner will be presented to the Credentials / Peer Review Committee as noted above for their consideration

Criteria for Primary Care Physicians with linked Members:

- During any quarter, if the rate of grievances filed against any Primary Care Physician is greater than a rate of three (3) grievances per 1,200 Members months per year annualized, then the Provider will be presented to the Credentials / Peer Review Committee as noted above for their consideration. Member's complaints,

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PQI's and VQIs will also be reviewed at the time of recredentialing and issues addressed between recredentialing cycles will be part of the recredentialing review process.

Collecting and reviewing information from identified adverse events:

- Gold Coast Health Plan staff monitors for adverse events at least every six months to determine if there is evidence of poor quality that could affect the health and safety of the members. Depending on the nature of the adverse event, Gold Coast Health Plan will implement actions and / or interventions based on its policies and procedures when instances of poor quality are identified.

Medical Board of California Monitoring:

- Medical Board of California: The "Hot Sheet" website report is run monthly. This report is a summary of disciplinary matter for the Medical Board of California, the Physician Assistant Committee, Board of Podiatric Medicine, and the Board of Psychology. The practitioners on the report are matched against Gold Coast Health Plan's Provider Network Database by Credentialing Coordinator or designee. If a match is found the information is reviewed by the Chief Medical Officer or designee, and when appropriate submitted to the Credentials / Peer Review Committee for follow-up review and recommendations.
- Verify that State License Renewal occurs with no restrictions at license expiration date: Reports of expired license are run monthly by Credentialing Coordinator or designee. Staff will verify at the State licensure Board website that the license of each practitioner on the report has been renewed and is free of any sanctions or limitations. If a license is found not to have been renewed or has sanctions or limitations placed against it, the information will be reviewed by the Chief Medical Officer or designee and when appropriate submitted to Credentials / Peer Review Committee for review and recommendations.

HIV/AIDs Specialist Board Certification Status

- Verify that HIV/AIDs Specialist Board Certification status will be run monthly by Credentialing Coordinator or designee. Staff will verify at the following website that the credential is current: www.aahivm.org. If a certification has been found not to have been renewed or has sanctions or limitations placed against it, the information will be reviewed by the Chief Medical Officer or designee, and when appropriate submitted to Credentials / Peer Review Committee for review.

Potential Quality Issues (PQIs):

Refer to Potential Quality Issue Investigation and Resolution Policy

PRACTITIONER RIGHTS:

To Correct Erroneous Information

Gold Coast Health Plan's policies do not preclude practitioners' rights to review and

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correct erroneous information obtained and used to evaluate their credentialing application from outside primary sources. Such information could include, but is not limited to malpractice insurance carriers, state licensing boards, etc., with the exception of references, recommendations, or other peer-review protected information, if applicable. Gold Coast Health Plan is not required to reveal the source of information if the information was not obtained to meet organizational credentialing verification requirements or if the law prohibits disclosure.

Practitioners/Providers have the right to correct erroneous information obtained during the credentialing process within 30 calendar days by submitting in writing to the Credentialing Department any Corrections or an explanation of discrepancies by either mail, fax, or email. Practitioners/Providers are notified of this right to correct erroneous information during the credentialing process via email and / or letter. Upon receipt of notification we will document information accordingly.

Right to Review Information

Gold Coast Health Plan ensures that practitioners can access their own information obtained by Gold Coast Health Plan during the credentialing process and used to support their credentialing application. Practitioners shall be notified in writing of this right via one or more of the following methods:

- Applications
- Contracts
- Practitioner and / or Provider manuals
- Provider Newsletters
- Mail
- Email
- Fax
- Website
- Other Suitable Method analyzing

To Be Informed Of Application Status

Gold Coast Health Plan's policy is to notify a practitioner of his / her application status upon request. The process allows for phone calls, emails, letters, or faxes from practitioners. If either the credentialing staff or another department receives a request it shall be responded to within 72 hours of receipt. If another department receives a request, it will be routed to the Credentialing Department within (10) business days for follow-up and resolution by the Credentialing staff within 72 hours of initial receipt by the Credentialing Department.

The Credentialing Department staff can advise the practitioner, once key information is verified, of the following information via phone or in writing, if requested by the practitioner:

- The date the application was received

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- The status of the application – pending for additional information, etc.
- The date the application is tentatively scheduled to be presented to the Committee
- Answer any questions the practitioner may ask

Prior to disclosing any confidential practitioner information via phone, the following must be verified by the Credentialing staff and confirmed by the practitioner or designee listed on Credentialing Application (i.e. providers credentialing coordinator, office manager or any authorized person practitioner designates)

- Practitioner's full name
- Practitioner's primary office location
- Practitioner date of birth
- The name, city and state of the school the practitioner graduated

To Be Notified Of His / Her Rights

Each prospective and existing practitioner has the right to be notified of the aforementioned rights and will be notified via one of the methods listed under "Right to Review Information" described above.

FILE RETENTION

Credentialing files shall be retained for at least seven years. Credentialing files are considered protected and confidential. Each practitioner will have an electronic file in the QI directory and / or with the CVO. File cabinets containing practitioner files shall be locked and / or secured at all times. Staff utilizing practitioner files shall ensure file will be secured, as practical or business appropriate, after normal business hours.

DELEGATED CREDENTIALING:

Delegation is the formal process by which a managed care organization (MCO) such as Gold Coast Health Plan, gives another entity (e.g. an Independent Practice Association (IPA), Credentials Verification Organization (CVO), hospital, medical group, or mental health provider) the authority to perform credentialing functions on its behalf. If any functions are delegated, the MCO, i.e. Gold Coast Health Plan (i) would be responsible and accountable for assuring its members that the same standards of participation are maintained throughout its provider network; (ii) retains the right to approve, suspend, or terminate all providers and sites of care; (iii) and ensures that a consistent and equitable process is used throughout its network by requiring:

- That the delegated entity adheres to at least the same criteria policies and procedures. Gold Coast Health Plan will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation;
- A mutually agreed upon document, which may be a contract, letter, memorandum of understanding, or other document, which clearly defines the performance

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expectations for Gold Coast Health Plan and the delegated entity. This document will define Gold Coast Health Plan's and the delegate's specific duties, responsibilities, activities, reporting requirements, and identifies how Gold Coast Health Plan will monitor and evaluate the delegate's performance. This mutually agreed upon document will also specify the remedies available to Gold Coast Health Plan, including (but not limited to) revocation of the delegation if the delegate does not fulfill its obligations;

- Gold Coast Health Plan staff to audit the delegate's files on an annual basis to evaluate whether the delegated entity's activities are being conducted in accordance with Gold Coast health Plan expectations and NCQA standards. The only exception to the oversight requirements is when Gold Coast Health Plan delegates to an entity that is NCQA Certified for Credentialing or accredited by NCQA. Gold Coast Health Plan does not need to conduct an annual audit or evaluation and may assume that the delegate is carrying out responsibilities in accordance with NCQA standards;
- If monitoring reveals deficiencies in the delegate's credentialing and recredentialing processes, Gold Coast Health Plan will work with the delegate to set priorities and correct the problems. If serious problems cannot be corrected, Gold Coast Health Plan will revoke the delegation arrangement;
- That Gold Coast Health Plan retains the right, based on quality issues, to approve, to suspend or terminate providers.
- Functions performed by vendors that do not involve decision-making (i.e. data collection as may be performed by a CVO) are not delegated functions, as defined in this section.

Reporting to Medical Board of California (MBOC), National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB):

805 Reports to Medical Board of California

Actions Requiring Reports

An 805 Report is filed with the MBOC whenever any of the following actions taken by the Plan and / or its Credentials / Peer Review Committee, involving a physician, podiatrist or other allied provider become final:

1. The practitioner's application for the Gold Coast Health Plan Provider status is denied or rejected for a medical disciplinary cause or reason;
2. The practitioner's Gold Coast Health Plan Provider status is terminated or revoked for a medical disciplinary cause or reason;

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3. Restrictions are imposed or voluntarily accepted on the practitioner's authority to provide care to Gold Coast Health Plan Members for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reason;
4. The practitioner resigns or takes a leave of absence from Gold Coast Health Plan Provider status following notice of an impending investigation based on information indicating a medical disciplinary cause or reason; or
5. A summary suspension remains in effect in excess of fourteen (14) days.

Timeframe for filing an 805 Report

- a. Resignation or Leave of Absence
 - An 805 Report is filed within fifteen (15) days after the effective date of resignation or leave of absence.
- b. Denial, Termination or Restriction
 - An 805 Report is filed within fifteen (15) days after the conclusion of all of the proceedings under Gold Coast Health Plan Policy, Fair Hearing Processes for Adverse Decisions if a denial, termination or restriction results from such proceedings.
- c. Summary Suspension
 - An 805 Report is filed within fifteen (15) days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) days.

NPDB / HIPDB Reports

- a. Actions Requiring Reports.
An NPDPI / HIPDB Report is filed whenever any of the following actions, taken by the Plan-- the Credentials / Peer Review, involving a Physician, Podiatrist or other licensed clinical practitioners become final:
- b. An Action that is based on the practitioner's professional competence or professional conduct which adversely affects or could adversely affect the health or welfare of a patient when that action adversely affects the practitioner's authority to provide care to Gold Coast Health Plan Members for more than thirty (30) calendar days;
- c. Acceptance of the practitioner's surrender for restriction of authority to provide care to Gold Coast Health Plan Members while under investigation for possible



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professional incompetence or improper professional conduct or in return for not conducting an investigation or professional review action.

Timeframe for filing an NPDB / HIPDB Report

An NPDB / HIPDB Report is filed within fifteen (15) calendar days from the date the adverse action was taken or authority to provide care to Gold Coast Health Plan Members is voluntarily surrendered.

Fair Hearing Rights

Except in the event of a summary suspension in effect less than thirty one (31) calendar days or a surrender or restriction of authority to provide care to Gold Coast Health Plan Members as provided below, an NPDB / HIPDB Report is filed after the Plan Provider has had the opportunity to either waive or exhaust his / her fair Hearing rights in accordance with Gold Coast Health Plan Policy, Fair Hearing Process for Adverse Decisions.

Additional Reports

An NPDB / HIPDB Report is filed when any revision is made to a previously reported adverse action.

Attachments:

N/A

References:

National Committee for Quality Assurance "Standards and Guidelines for the Accreditation of Managed Care Organizations", Standards for Credentialing and Recredentialing, CR Standards, MMCD Policy Letter 02-03

Revision History:

Review Date	Revised Date	Approved By

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AGENDA 2e

To: Gold Coast Health Plan Commissioners

From: Lupe Gonzalez, PH.D., M.P.H.
Director of Health Education

Date: February 23, 2015

RE: Gold Coast Health Plan (GCHP) Sponsorship Policy

SUMMARY:

Gold Coast Health Plan (GCHP) is committed to supporting the public health and general welfare of the citizens of Ventura County. GCHP received a request for sponsorship by a non-profit agency, Mixteco / Indigena Community Organizing Project (MICOP), to support their annual event. Staff submitted a request to the Commission to approve a sponsorship request in the amount of \$1,500 to MICOP. The Commission approved the \$1,500 sponsorship to MICOP and asked staff to prepare a sponsorship policy for Commission approval that would allow GCHP staff to review and approve future requests.

BACKGROUND / DISCUSSION:

GCHP staff has developed the GCHP Sponsorship Policy; the purpose of which is to establish guidelines and procedures for sponsorship of external entities that serve the Medi-Cal and the medically indigent community in Ventura County.

The Sponsorship policy includes eleven (11) requirements:

- Sponsorship must be used for the promotion of the public health and general welfare of the citizens of Ventura County.
- The purpose must be compatible with the mission, vision, and policies of GCHP.
- Sponsorship may include financial and non-monetary support including letters of support, endorsements, or use of GCHP's logo.
- A yearly sponsorship budget will be included in the GCHP fiscal year budget.
- Requests for financial participation above \$5,000 shall require prior approval by the GCHP Commission.
- Sponsorship Application Forms shall be used when requests are made
- Sponsorship Applications will be reviewed by a committee.
- The Sponsorship Committee shall be comprised of the following representatives: At least three (3) members of GCHP's Executive team (CEO, CFO, COO, CMO and CIO) the Director of Health Education and the Director of Communications.

- This Ad Hoc Committee will meet on an as needed basis when the plan has received a request for sponsorship.
- Non-monetary requests for support by GCHP needing an urgent decision will be reviewed and approved by the CEO.
- Consideration for approval of sponsorship requests includes the following:
 - The sponsorship must be shown to benefit the Medi-Cal or medically indigent population of Ventura County.
 - There is the potential for such financial participation to create a positive visibility for GCHP.
 - There is the potential for such participation to create a long-term collaborative partnership between GCHP and a desired partner entity.
 - Sponsorship must not jeopardize GCHP's integrity.
- Staff will report sponsorship, endorsements, and use of GCHP's logo to the Commission no later than ninety (90) days after approval is provided.

FISCAL IMPACT:

Fiscal impact for fiscal year FY 2014-15 is projected as \$3,000. As mentioned in the summary above a \$1,500 sponsorship to MICOP has been granted and the remaining budget will be set aside should the Plan receive additional requests. The fiscal impact for FY2015-16 is pending budget review.

RECOMMENDATION:

Staff recommends Commission approval of GCHP's Sponsorship Policy as drafted.

CONCURRENCE:

None

Attachments:

Gold Coast Health Plan Sponsorship Policy and Application



Title: Gold Coast Health Plan Sponsorship	Policy Number: HE/CL-XXX
Department: Health Education	Effective Date:
CEO Approved:	Revised:

Purpose:

Gold Coast Health Plan (GCHP) is committed to supporting the public health and general welfare of the citizens of Ventura County. This document establishes the policies and procedures for Sponsorship by GCHP of external entities that particularly serve the Medi-Cal and medically indigent community.

Policy:

- A. Sponsorship must be used for the promotion of the public health and general welfare of the citizens of Ventura County
- B. Sponsorship shall be approved only if the organization and/or the purpose is compatible with the mission, vision and policies of GCHP.
- C. Sponsorship may include a financial donation, participation in an event, the donation of items that promote health and wellness, or non-monetary support including letters of support, endorsements, or the use of the GCHP logo.
- D. A yearly sponsorship budget will be included in the GCHP fiscal year budget submitted to and approved by the GCHP Commission.
- E. Requests for financial participation above five-thousand (\$5,000) dollars shall require the prior approval of the GCHP Commission.
- F. Sponsorship requests will be submitted to GCHP by the requesting entity on the GCHP Sponsorship Application Form (Attachment A).
- G. Sponsorship applications will be reviewed, approved or denied by the Sponsorship Committee comprised of at least three (3) members of GCHP's Executive team (CEO, CFO, CMO, COO and CIO) the Director of Health Education and the Director of Communications.
- H. The Sponsorship Committee will meet on an as-needed basis when the Plan has received a request for sponsorship.
- I. Non-monetary requests for support by GCHP needing an urgent decision will be reviewed and decided by the CEO.
- J. Considerations for approval of sponsorship requests by the Sponsorship Committee will be:
 - 1. The sponsorship must be shown to benefit the Medi-Cal or medically indigent population of Ventura County.
 - 2. There is the potential for such financial participation to create a positive visibility for GCHP.
 - 3. There is the potential for such participation to create a long-term collaborative partnership between GCHP and a desired partner entity.
 - 4. Sponsorship must not jeopardize GCHP's integrity.
- K. GCHP shall report any sponsorship, endorsements, use of agency logo and/or donations to the GCHP Commission no later than ninety (90) calendar days after such approval is given.



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Department: Health Education	Effective Date:
CEO Approved:	Revised:

Definitions:

Medically Indigent: Persons who do not have health insurance and who are not eligible for other health care coverage, such as Medicaid, Medicare, or private insurance.

Sponsorship: Support for an activity, event, program or project of another organization.

Procedure:**A. Sponsorship Application**

1. All requests shall be submitted to the GCHP Community Outreach Department on the GCHP Sponsorship Application Form.
2. A completed application shall include the following information:
 - a. Copy of the program or project description for which the letter of support, sponsorship or commitment is requested
 - b. Company background information and address
 - c. Project budget information
3. All requests shall be submitted at least sixty (60) days in advance of the date for which the event sponsorship is required.

B. Sponsorship Application and Review Process

1. Upon receipt of a sponsorship application, the Director of Health Education will review the application for completeness.
2. When all necessary information to review an application is available, the Director of Health Education will make the application and supporting documents available to the Sponsorship Committee, and will call a meeting of the Committee to review and make a decision on the application.
3. The Sponsorship Committee will develop the criteria for approval of sponsorship applications. Included in the criteria are the factors listed previously in the policy section as well as the potential impact to the Plan's membership and the medically indigent community. If funds are to be used for the sponsorship the criteria must include the determination that the funds will be used for the promotion of the public health and general welfare of the citizens of Ventura County.
4. The Director of Health Education will notify the requesting entity of the Plan's decision to support or deny the sponsorship request.
5. When the Plan has made a decision to sponsor an organization or event, the Director of health Education will be responsible for coordinating the commitments made by GCHP.
6. When appropriate, the Director of Health Education or the Director of Communication (as determined by the Ad Hoc Sponsorship Committee) will make the Plan's support known to GCHP members and the community.

Attachment:

GCHP Sponsorship Application Form



**Gold Coast
Health Plan**SM
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Title: Gold Coast Health Plan Sponsorship	Policy Number: HE/CL-XXX
Department: Health Education	Effective Date:
CEO Approved:	Revised:



**Gold Coast
Health Plan**SM
A Public Entity

Sponsorship Application

Organization Profile

Organization Name:		Fed Tax ID Number:	
Organization Legal Name:		Tax Exemption Status:	
Physical Address:	City:	State:	ZIP Code:
Phone:	Fax:	E-mail:	Web site:
Chief Executive:	Prefix:	E-mail:	
Event Contact Person:		Title:	
Phone:	Fax:	E-mail:	
Total Current Annual Operating Budget:		Year Organization Established:	
Organization Mission (Two (2) sentences maximum):			

Fiscal Agent Information (if different from above)

Organization Name:		Fed Tax ID Number:	
Organization Legal Name:		Tax Exemption Status:	
Physical Address:	City:	State:	ZIP Code:
Phone:	Fax:	E-mail:	Web site:
Chief Executive:	Prefix:	E-mail:	
Organization Mission (Two (2) sentences maximum):			

Event Information (In addition please attached a brief description of project/event)

Project/Event Name:		
Project/Event Location:		Project/Event Date(s):
Requested Amount:		Event/Project Budget:
Type of Event (e.g., Luncheon):		Number of Expected Attendees:
Purpose of Event:		
Items Requested (Example: 3 Footballs, Value of \$60):		
Item: _____	QTY: _____	Value \$ _____
Item: _____	QTY: _____	Value \$ _____
Item: _____	QTY: _____	Value \$ _____

References:

None



Title: Gold Coast Health Plan Sponsorship	Policy Number: HE/CL-XXX
Department: Health Education	Effective Date:
CEO Approved:	Revised:

Revision History:

Review Date	Revised Date	Approved By

AGENDA 2f

To: Gold Coast Health Plan Commissioners

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

Re: Committee Restructuring and Committee Membership

Date: February 23, 2015

SUMMARY:

Medi-Cal Managed Care Health Plans are required by contract to have certain committees that assure the quality of care and adequate services are provided to members. At the time that GCHP was being formed the Commission approved committees of the Plan. Those committees were the Consumer Advisory Committee (CAC), Provider Advisory Committee (PAC), Quality / Utilization / Peer Review Committee, Credentials Committee. A single committee comprising the duties of quality, utilization and peer review was not workable and did not meet with the requirements of DHCS. As a result, the committee structure has been altered to accommodate the realities of running the Plan and to meet the DHCS requirements. Gold Coast Health Plan Staff is requesting the Commission to approve an amended committee structure, including the dissolution of the original Quality / Utilization / Peer Review Committee. In addition, the Plan is requesting approval to add Peer Review to the Credentials Committee (Credentials / Peer Review) and approval of the membership of the new committees approved in this request by this commission.

BACKGROUND:

On April 26, 2010 Ordinance 4409 of the Ventura County Board of Supervisors established Gold Coast Health Plan with certain committees including the Consumer Advisory Committee and the Provider Advisory Committee which report to and whose members are selected by the GCHP Commission. Also established were committees required by contract with Department of Healthcare Services. A Quality / Utilization/Peer Review Committee comprised of 10 voting members was identified and also a Credentials Committee comprised of 8 members. The members of both committees were to serve for 2 years but could reapply for additional terms. The membership of these committees was to be approved by the Gold Coast Commission which was done at meetings in 2011.

RECOMMENDATIONS:

GCHP is requesting the Commission's approval to:

1. Formally dissolve the original Quality / Utilization / Peer Review Committee

2. Approve a Quality Improvement Committee which reports all quality matters and activities to the Commission quarterly and as needed. In addition, approve the committee membership:
 - a. Standing members:
 - Chair – Plan CMO
 - Assistant CMO
 - Department chair – Quality Improvement
 - Department chair – Member Services
 - Department chair – Network Operations
 - Department chair – Health Education, Cultural & Linguistic Services, Outreach
 - Director – Compliance
 - Director – Pharmacy
 - Director – Government Services
 - Manager – Grievance and Appeals
 - b. Two physician non-standing members to be approved by the GCHP Commission for 3 year terms. These members may roll over to additional terms with approval by the Commission. If possible one to be selected from the membership of the GCHP Board of Commissioners. Current members:
 - Gagan Pawar, M.D. - Commissioner
 - Bryan Wong, M.D. – Medical Director, VC Medical Center
3. Approve a change of the Credentials Committee to Credentials / Peer Review Committee – reviews the credentials of providers, including facilities and deals with quality issues identified through the Plan's Peer Review Process. This committee shall report to the Commission through the quarterly report of the Quality Improvement Committee.
In addition, approve the committee membership:
 - a. Standing members:
 - CMO – Chairman
 - Assistant CMO
 - b. Members approved by the GCHP Commission for 3 year terms. Members may roll-over at their request and the approval of the Commission. Current membership:
 - Stanley Frochtzwaig, M.D. FP, Medical Director, Community Memorial Hospital

- Daniel Lu, M.D., Pediatrics, Director, Mandalay Bay Women's and Children's Clinic
- Gary Proffett, M.D.
- Richard Reisman, M.D., Ob-Gyn, Medical Director, Centers for Family Health
- Guillermo Rios-Rios, Pediatrics
- Bryan Wong, M.D. FP, Medical Director, Ventura County Medical Center
- Sahin Yanik, M.D. IM, VP of Medical Affairs. St. Joh's and Pleasant Valley Hospitals

Note: Other committees required by DHCS or necessary for required quality, service and utilization functions of the Plan will be organized by the Plan Staff and report to the Quality Improvement Committee.

CONCURRENCE:

Not applicable.

Attachments:

None

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AGENDA ITEM 3b

To: Gold Coast Health Plan Commission

From: Ruth Watson, Interim CEO / Chief Operating Officer

Date: February 23, 2015

Re: CEO Update

COMPLIANCE UPDATE:

The Department of Health Care Services (DHCS) medical review audit is currently in progress. Auditors from Audits and Investigations (A&I), a division within DHCS, have been onsite at the Plan as of February 17, 2015 and will remain onsite until February 27, 2015. The medical audit review consists of Plan staff interviews and document / file reviews.

GOVERNMENT RELATIONS UPDATE:

DHCS All-Plan Meeting

On February 9, 2015 the California Department of Health Care Services (DHCS) held a meeting with Medi-Cal managed care plans to discuss a number of issues including the announcement of a new DHCS Director, the coordinated care initiative, palliative care, health homes, behavioral health therapy and other 2015 future activities related to the Medi-Cal Program.

New DHCS Director

Jennifer Kent was introduced as the newly appointed Director of DHCS. Ms. Kent previously served as executive director of GCHP's trade association Local Health Plans of California (LHPC). Ms. Kent has a strong background in working with Medi-Cal managed care plans.

Coordinated Care Initiative (CCI)

Enrollment in the state's duals demonstration project known as the Coordinated Care Initiative (CCI) remains low. A large percentage of Medicare and Medi-Cal beneficiaries have exercised their option to opt-out of the state's duals demonstration project. DHCS is working with plans and other stakeholders to increase the opt-in rate and help beneficiaries understand the Program. DHCS is developing a positive CCI publicity campaign and is looking to partner with plans to demonstrate the program's effectiveness. The California Medical Association (CMA) has adopted a neutral position on the CCI Program, but has also not encouraged their membership to support the program.

Palliative Care

Last year the Legislature passed and the Governor approved SB 1004. This legislation requires Medi-Cal managed care plans to implement and offer palliative care services. DHCS is holding a stakeholder meeting on Monday, February 23 to discuss palliative care models and options for implementing the requirements under SB 1004. DHCS is soliciting plan input and information sharing on palliative care best practices to inform the policy development process.

Health Homes

The federal Affordable Care Act (ACA) created the optional health home benefit in Medicaid to better coordinate intensive care for people with chronic conditions. California has the option to offer a health home program in Medi-Cal with 90% federal funding for eight quarters and 50% thereafter. The six care coordination services under this benefit are: comprehensive transitional care, individual and family supports, care coordination, health promotion and referral to community and social services. The target population for this benefit frequent utilizers, as well as individuals and families who are chronically homeless.

DHCS is working with plans and stakeholders on program design and reimbursement models. Implementation target date for this benefit is January 2016.

California Children's Services

The California Children's Services (CCS) carve out from Medi-Cal managed care expires at the end of 2015. The existing 1115 waiver included the development of five pilots to test pilot models for the CCS program, but to date only one pilot, in San Mateo County, has been implemented. DHCS wants to include a CCS proposal in the waiver renewal. However, the CCS workgroup is slated to conclude in July 2015 and is on a different timeline than other waiver renewal workgroups. DHCS has stated that their goal is to improve care for children in the CCS program. It is unclear how the CCS workgroup will be integrated into the waiver proposal.

The California Children's Services (CCS) program is administered as a partnership between DHCS and county health departments. The Program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions.

1115 Waiver Update

The current 'Bridge to Reform' section 1115 Medicaid waiver expires on October 31, 2015. The current waiver has provided approximately \$10 billion in federal funds to California over the five-year life of the waiver. California's Medi-Cal managed care program, CBAS program, and Coordinated Care Initiative are operated under the 1115 Waiver. DHCS expects to submit a \$17 billion federal waiver renewal proposal by early March 2015 with a target renewal implementation date of November 1, 2015. DHCS has established seven

stakeholder workgroups to receive input on the development of the waiver renewal proposal. The seven workgroups are focusing on the following specific areas that will be part of the waiver renewal:

- 1) Disproportionate Share Hospital /Safety Net Care Pool Funding Reform
- 2) Managed Care Organization and Provider Payment Reform
- 3) Delivery System Reform Incentive Program Successor
- 4) Federally Qualified Health Centers (FQHC) Payment Reforms
- 5) California Children's Services (CCS)
- 6) Housing
- 7) Workforce

State Senate Committee on Health: Hearing

On February 4, 2015 the State Senate Committee on Health held an informational hearing titled "Making Health Care Affordable: What's Driving Costs?" Several healthcare industry stakeholders testified including, DHCS Deputy Director Mari Cantwell and Amy Shin, CEO of Health Plan San Joaquin (HPSJ). Key issues repeated throughout the hearing were the following: Increased unit costs prices; increased costs of specialty drugs; increased costs of generic drugs; and transparency.

Deputy Director Cantwell testified that according to the California Health Interview Survey (CHIS), the non-elderly population enrolled in Medi-Cal is twice as likely to report poor health, have a higher prevalence of chronic disease such as diabetes, and mental health and substance abuse issues. Ms. Cantwell also testified that a large percentage of fee-for service (FFS) beneficiaries were moved into Medi-Cal managed care (MMC). Thus, MMC plans have seen an increase in costs. This may be because of pent up demand and an older population in the Medi-Cal Program.

Ms. Cantwell listed the following drivers affecting increased costs in the Medi-Cal Program:

- Plans are having a hard time negotiating rates; thus, have had to increase rates up to 10%-20% in order to build and maintain adequate provider networks
- Ms. Cantwell stated that plans have seen a significant cost increase on pharmaceutical drugs
- Approximately 11-12 cancer treatment drugs cost over \$100,000 a year per patient
- Hepatitis C drugs can cost up to \$84,000 for a twelve week treatment per beneficiary
- CMS requires that the Medicaid Program cover all FDA approved drugs

Legislative Advocacy in Washington DC

On February 11 and 12, 2015 GCHP's Director of Government Relations participated in the Association of Community Affiliated Plans' (ACAP) Legislative Advocacy "Fly- In". This event is held annually to allow ACAP-member plans to meet with Members of Congress and their staff, to discuss federal legislation and policies that impact the Medicaid/ Medi-Cal Program. GCHP staff met with the legislative aides on health for the offices of Senators Boxer and Feinstein as well as Representative Julia Brownley. Among the legislative issues discussed were: Children's Health Insurance Program (CHIP) funding extension (Federal funding for the CHIP Program sunsets in September 2015); Continuous Enrollment for Medicaid and CHIP beneficiaries; and ACA Subsidy Protection. Approximately 1.2 million low-income children and pregnant women are enrolled and receive health services through California's CHIP Programs. These programs include:

- Medicaid expansion for low-income children and pregnant women
- Optional Targeted Low Income Children's Program
- Medi-Cal Access program for Pregnant Women and Infants
- County Children's Health Initiative Matching Program

Medicaid Innovations Conference

On February 4 and February 5, 2015 GCHP's Government Relations Director along with other GCHP staff attended the Medicaid Innovations 2015 Conference held in Orlando Florida. Topics covered, among others, at this Conference were: Federal government oversight of Medicaid at the state level; innovative approaches to non-emergency transportation, home-based primary care; adding value in Medicaid managed care; and improving quality in Medicaid managed care.

Legislation

AB 72

AUTHOR: Bonta [D]

TITLE: Medi-Cal: Demonstration Project

SUMMARY:

This legislation authorizes DHCS to submit an application to the federal Centers for Medicare and Medicaid Services for a waiver to continue the state's momentum and successes achieved under the current 1115 waiver which expires in October 2015. DHCS expects to submit its new waiver application by March 2015.

AB 73

AUTHOR: Waldron [R]

TITLE: Medi-Cal: Benefits: Prescription Drugs

SUMMARY:

Declares intent of the Legislature to include specified therapeutic drug classes as a covered Medi-Cal benefit, as permitted by federal law.

- AB 187** **AUTHOR:** Bonta [D]
 TITLE: Children's Services Program: Medi-Cal: Managed Care
 SUMMARY:
 Makes technical changes to the California Children's Services Program managed care contract provisions. This bill would allow counties to continue billing for CCS covered services on a fee-for-service basis until CCS covered services are incorporated into Medi-Cal managed care contracts. Additionally this legislation would authorize pilot projects in which reimbursement for conditions eligible under the CCS program may be reimbursed on a capitated basis.
- SB 4** **AUTHOR:** Lara [D]
 TITLE: Health Care Coverage: Immigration Status
 SUMMARY:
 States the intent of the Legislature that all State residents who are eligible for Medi-Cal or a qualified health plan offered through the State Health Benefits Exchange, enroll in that coverage and obtain the care that they need. Declares the intent of the Legislature that all State residents, regardless of immigration status, have access to affordable health coverage and care.
- SB 26** **AUTHOR:** Hernandez [D]
 TITLE: Health Care Cost and Quality Database
 SUMMARY:
 States the intent of the Legislature to establish a system to provide valid, timely, and comprehensive health care performance information that is publicly available and can be used to improve the safety, appropriateness, and medical effectiveness of health care, medically effective patient-centered, timely, affordable, and equitable.
- SB 36** **AUTHOR:** Hernandez [D]
 TITLE: Medi-Cal: Demonstration Project
 SUMMARY:
 This is the companion bill AB 72. Requires DHCS to submit an application to the federal Centers for Medicare and Medicaid Services for a waiver to implement demonstration projects that continue the state's momentum and successes in innovation achieved under the current 1115 waiver.
- SB 128** **AUTHOR:** Wolk [D]
 TITLE: End of Life
 SUMMARY:
 Enacts the End of Life Option Act authorizing an adult who meets certain qualifications, and who has been determined by his or her attending

physician to be suffering from a terminal illness to make a request for medication prescribed pursuant to these provisions for the purpose of ending his or her life. Provides for no effect on a will, health care service plan or health insurance contract.

SB 137 **AUTHOR:** Hernandez [D]
 TITLE: Health care coverage: Provider Directories
 SUMMARY:
Requires health care service plans and insurers subject to regulation by the Commissioner of the Department of Managed Health Care for services at alternative rates to make a provider directory available on its Internet Web site and to update the directory weekly. Requires the Department of Managed Health Care and the Department of Insurance to develop a standard provider directory template.

SB 147 **AUTHOR:** Hernandez [D]
 TITLE: Federally Qualified Health Centers
 SUMMARY:
Requires the Department of Health Services to authorize a pilot project for federally qualified health centers that would be implemented in any county and centers willing to participate. Provides participating centers would receive capitated monthly payments for each Medi-Cal managed care enrollee assigned to the center in place of the wrap-around fee-for-service per-visit payments from the Department.

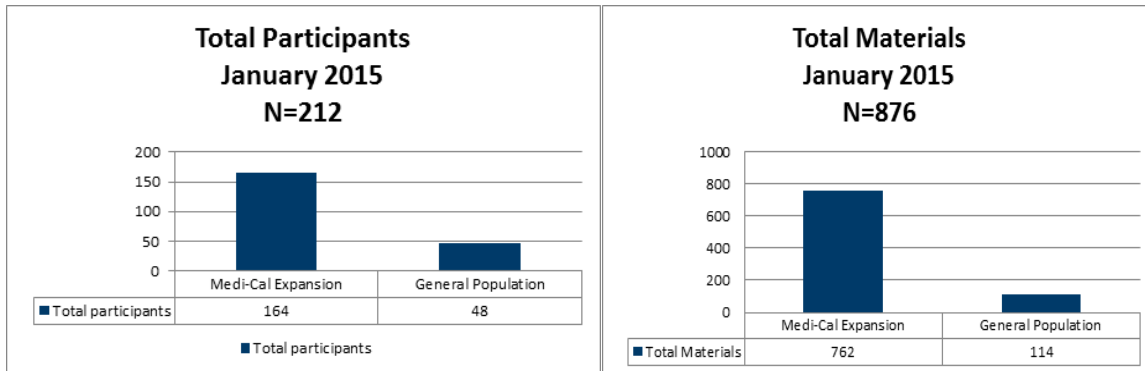
HEALTH EDUCATION AND COMMUNITY OUTREACH SUMMARY REPORT:

Gold Coast Health Plan (GCHP) participates in monthly community outreach events throughout the county. The goal of the outreach events is increase awareness of GCHP plan benefits and services. In addition, the goal is to promote healthy eating and lifestyle through the distribution of health education literature.

GCHP outreach team has prepared an outreach calendar of activities scheduled through June 2015. Outreach events and activities may also be found on the GCHP Website.

GCHP outreach team is dedicated to providing health education information to the residents of Ventura County. Through these outreach activities the team is able to provide valuable information to members as well as the general public about healthy eating and lifestyle activities to reduce chronic diseases such as diabetes. In addition to providing health education services the outreach team is able to assist individuals with information about Covered California, Medi-Cal enrollment, and variety of other services including food distribution, Cal-Fresh, and injury prevention – car seat safety.

During the month of January 2015, GCHP participated in eight (8) community outreach activities. Below is a summary report of the total number of participants reached and materials distributed during the month of January 2015.



GCHP 4th Annual Community Resource Fair

On Saturday, June 6, 2015, at Plaza Park in downtown Oxnard, GCHP will be hosting the 4th Annual Community Resource Fair. Invitation letters and registration forms will be sent to community based agencies throughout Ventura County. For more information about the community resource fair contact the GCHP Health Education Department or send an email to healtheducation@goldchp.org.



**Gold Coast
Health Plan**SM
A Public Entity

Community Outreach Schedule 2015

January

Friday, January 9, 2015

La Hermandad Food Distribution

350 "K" Street, Oxnard

Time: 10:00am – 12:30 pm

Tuesday, January 13, 2015

***Baby Steps Program hosted by Ventura
County Medical Center***

VCMC Cafeteria

3291 Loma Vista Road, Ventura

Time: 5:00pm – 6:30pm

Saturday, January 17, 2015

***Outreach Self-Management Diabetes
Program***

St. John's Regional Medical Center, Garden
Level

1600 N. Rose Ave. Oxnard

Time: 8:30am – 11:30am

Tuesday, January 20, 2015

***Baby Steps Program by Santa Paula
Hospital***

Santa Paula Hospital

825 N. 10th Street, Santa Paula

Time: **English** 5:30pm – 6:30pm

Spanish 6:30pm – 7:30pm

Wednesday, January 21, 2015

***Monthly Food Distribution Program
& Health Services***

Westpark Community Center

450 W. Harrison Avenue, Ventura

Time: 4:00pm – 5:30pm

Thursday, January 22, 2015

***Community Market Produce Giveaway
hosted by Moorpark/Simi Valley
Neighborhood for Family Learning***

612 Spring Road, Suite, 401 Moorpark

Time: 10:00am – 11:30am

Thursday, January 22, 2015

***GCHP Information Booth at the Simi Valley
Public Library***

Simi Valley Public Library

2969 Tapo Canyon, Simi Valley

Time: 10:00am – 12:00pm

Thursday, January 22, 2015

***Community Market Produce Giveaway
hosted by Moorpark/Simi Valley
Neighborhood for Family Learning***

1955 Bridge Ave, Simi Valley

Time: 1:00pm – 2:00pm

Sunday, January 25, 2015

***Jornada Dominical and Health Fair hosted
by the Oxnard Mexican Consulate***

3151 West 5th Street, Oxnard

Time: 8:00am – 2:00pm



**Gold Coast
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Community Outreach Schedule 2015

February

Tuesday, February 3, 2015

Gold Coast Health Plan Information Booth

Moorpark Family Medical Clinic
612 Spring Road, Moorpark

Friday, February 13, 2015

La Hermandad Food Distribution

350 "K" Street, Oxnard
Time: 10:00am – 12:30 pm

Thursday, February 5, 2015

Agency 101 Resource Fair

5100 Adolfo Road, Camarillo
Time: 11:30am – 4:00pm

Tuesday, February 17, 2015

Baby Steps Program by Santa Paula Hospital

Santa Paula Hospital
825 N. 10th Street, Santa Paula
Time: **English** 5:30pm – 6:30pm
Spanish 6:30pm – 7:30pm

Friday, February 6, 2015

Sharing the Harvest hosted by Santa Clara Valley Neighborhood for Learning

217 N. 10th Street, Santa Paula
Time: 9:00am – 11:00am

Wednesday, February 18, 2015

Monthly Food Distribution Program & Health Services

Westpark Community Center
450 W. Harrison Avenue, Ventura
Time: 4:00pm – 5:30pm

Friday, February 6, 2015

Sharing the Harvest hosted by Santa Clara Valley Neighborhood for Learning

1048 W. Ventura Street, Fillmore
Time: 11:30am – 1:00pm

Thursday, February 26, 2015

Community Market Produce Giveaway hosted by Moorpark/Simi Valley Neighborhood for Family Learning

612 Spring Road, Suite, 401 Moorpark
Time: 10:00am – 11:30am

Tuesday, February 10, 2015

Baby Steps Program hosted by Ventura County Medical Center

VCMC Cafeteria
3291 Loma Vista Road, Ventura
Time: 5:00pm – 6:30pm

Thursday, February 26, 2015

Community Market Produce Giveaway hosted by Moorpark/Simi Valley Neighborhood for Family Learning

1955 Bridge Ave, Simi Valley
Time: 1:00pm – 2:00pm



**Gold Coast
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Community Outreach Schedule 2015

February Continued....

Friday, February 27, 2015

***Taking it to the Teachers Mini Fair hosted
by Ventura County Transition Project***

Ventura County Office of Education

5100 Adolfo Road, Camarillo

Time: 11:30pm – 2:30pm



**Gold Coast
Health Plan**SM
A Public Entity

Community Outreach Schedule 2015

March

Tuesday, March 3, 2015

Gold Coast Health Plan Information Booth

Moorpark Family Medical Clinic
612 Spring Road, Moorpark

Friday, March 6, 2015

***Sharing the Harvest hosted by Santa Clara
Valley Neighborhood for Learning***

217 N. 10th Street, Santa Paula
Time: 9:00am – 11:00am

Tuesday, March 10, 2015

***Baby Steps Program hosted by Ventura
County Medical Center***

VCMC Cafeteria
3291 Loma Vista Road, Ventura
Time: 5:00pm – 6:30pm

Friday, March 13, 2015

***Carpe Diem Resource Faire hosted by
Ventura County Special Education Local
Plan Area***

Ventura County Office of Education
5100 Adolfo Road, Camarillo
Time: 8:00am – 4:15pm

Friday, March 13, 2015

La Hermandad Food Distribution

350 "K" Street, Oxnard
Time: 10:00am – 12:30 pm

Tuesday, March 17, 2015

***Baby Steps Program by Santa Paula
Hospital***

Santa Paula Hospital
825 N. 10th Street, Santa Paula
Time: **English** 5:30pm – 6:30pm
Spanish 6:30pm – 7:30pm

Wednesday, March 18, 2015

***Monthly Food Distribution Program
& Health Services***

Westpark Community Center
450 W. Harrison Avenue, Ventura
Time: 4:00pm – 5:30pm

Thursday, March 26, 2015

***Community Market Produce Giveaway
hosted by Moorpark/Simi Valley
Neighborhood for Family Learning***

612 Spring Road, Suite, 401 Moorpark
Time: 10:00am – 11:30am

Thursday, March 26, 2015

***Community Market Produce Giveaway
hosted by Moorpark/Simi Valley
Neighborhood for Family Learning***

1955 Bridge Ave, Simi Valley
Time: 1:00pm – 2:00pm



**Gold Coast
Health Plan**SM
A Public Entity

Community Outreach Schedule 2015

April

Friday, April 3, 2015

***Sharing the Harvest hosted by Santa Clara
Valley Neighborhood for Learning***

217 N. 10th Street, Santa Paula

Time: 9:00am – 11:00am

Friday, April 3, 2015

***Sharing the Harvest hosted by Santa Clara
Valley Neighborhood for Learning***

1048 W. Ventura Street, Fillmore

Time: 11:30am – 1:00pm

Friday, April 10, 2015

La Hermandad Food Distribution

350 "K" Street, Oxnard

Time: 10:00am – 12:30 pm

Sunday, April 12, 2015

***Jornada Dominical and Health Fair hosted
by the Oxnard Mexican Consulate***

3151 W. 5th Street, Oxnard

Time: 8:00am – 2:00pm

Tuesday, April 14, 2015

***Baby Steps Program hosted by Ventura
County Medical Center***

VCMC Cafeteria

3291 Loma Vista Road, Ventura

Time: 5:00pm – 6:30pm

Wednesday, April 15, 2015

***Monthly Food Distribution Program
& Health Services***

Westpark Community Center

450 W. Harrison Avenue, Ventura

Time: 4:00pm – 5:30pm

Tuesday, April 21, 2015

***Baby Steps Program by Santa Paula
Hospital***

Santa Paula Hospital

825 N. 10th Street, Santa Paula

Time: **English** 5:30pm – 6:30pm

Spanish 6:30pm – 7:30pm

Thursday, April 23, 2015

***Community Market Produce Giveaway
hosted by Moorpark/Simi Valley
Neighborhood for Family Learning***

612 Spring Road, Suite, 401 Moorpark

Time: 10:00am – 11:30am

Thursday, April 23, 2015

***Community Market Produce Giveaway
hosted by Moorpark/Simi Valley
Neighborhood for Family Learning***

1955 Bridge Ave, Simi Valley

Time: 1:00pm – 2:00pm



**Gold Coast
Health Plan**SM
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Community Outreach Schedule 2015

May

Friday, May 1, 2015

***Sharing the Harvest hosted by Santa Clara
Valley Neighborhood for Learning***

217 N. 10th Street, Santa Paula

Time: 9:00am – 11:00am

Saturday, May 2, 2015

***Transition Fair hosted by Ventura County
Transition Project***

Ventura County Office of Education

5100 Adolfo Road, Camarillo

Time: 9:00am – 12:00pm

Friday, April 8, 2015

La Hermandad Food Distribution

350 "K" Street, Oxnard

Time: 10:00am – 12:30 pm

Tuesday, May 12, 2015

***Baby Steps Program hosted by Ventura
County Medical Center***

VCMC Cafeteria

3291 Loma Vista Road, Ventura

Time: 5:00pm – 6:30pm

Tuesday, April 21, 2015

***Baby Steps Program by Santa Paula
Hospital***

Santa Paula Hospital

825 N. 10th Street, Santa Paula

Time: **English** 5:30pm – 6:30pm

Spanish 6:30pm – 7:30pm

Wednesday, May 20, 2015

***Monthly Food Distribution Program
& Health Services***

Westpark Community Center

450 W. Harrison Avenue, Ventura

Time: 4:00pm – 5:30pm

Thursday, May 28, 2015

***Community Market Produce Giveaway
hosted by Moorpark/Simi Valley
Neighborhood for Family Learning***

612 Spring Road, Suite, 401, Moorpark

Time: 10:00am – 11:30am

Thursday, May 28, 2015

***Community Market Produce Giveaway
hosted by Moorpark/Simi Valley
Neighborhood for Family Learning***

1955 Bridge Ave, Simi Valley

Time: 1:00pm – 2:00pm

***Saturday, May 30, 2015 (Tentative)**

Summerfest

255 W. Stanley Avenue, Ventura

Time: 9:00am – 2:00pm



**Gold Coast
Health Plan**SM
A Public Entity

Community Outreach Schedule 2015

June

Friday, June 5, 2015

Sharing the Harvest hosted by Santa Clara Valley Neighborhood for Learning

217 N. 10th Street, Santa Paula

Time: 9:00am – 11:00am

Friday, June 5, 2015

Sharing the Harvest hosted by Santa Clara Valley Neighborhood for Learning

1048 W. Ventura Street, Fillmore

Time: 11:30am – 1:00pm

Saturday, June 6, 2015

3rd Annual Gold Coast Health Plan Community Resource Fair

500 S. "B" St, Oxnard, CA 93030

Time: 9:00am – 2:00pm

Tuesday, June 9, 2015

Baby Steps Program hosted by Ventura County Medical Center

VCMC Cafeteria

3291 Loma Vista Road, Ventura

Time: 5:00pm – 6:30pm

Friday, June 12, 2015

La Hermandad Food Distribution

350 "K" Street, Oxnard

Time: 10:00am – 12:30 pm

***Saturday, June 13, 2015 (Tentative
Port Hueneme Fair**

Tuesday, June 16, 2015

Baby Steps Program by Santa Paula Hospital

Santa Paula Hospital

825 N. 10th Street, Santa Paula

Time: **English** 5:30pm – 6:30pm

Spanish 6:30pm – 7:30pm

Wednesday, June 17, 2015

Monthly Food Distribution Program & Health Services

Westpark Community Center

450 W. Harrison Avenue, Ventura

Time: 4:00pm – 5:30pm

Thursday, June 25, 2015

Community Market Produce Giveaway hosted by Moorpark/Simi Valley Neighborhood for Family Learning

612 Spring Road, Suite, 401, Moorpark

Time: 10:00am – 11:30am

Thursday, June 25, 2015

Community Market Produce Giveaway hosted by Moorpark/Simi Valley Neighborhood for Family Learning

1955 Bridge Ave, Simi Valley

Time: 1:00pm – 2:00pm

AGENDA ITEM 3c

To: Gold Coast Health Plan Commission

From: John Meazzo, Interim Chief Financial Officer

Date: February 23, 2015

Re: December 2014 Financials

SUMMARY:

Staff is presenting the attached December 2014 financial statements (unaudited) of Gold Coast Health Plan (Plan) for approval by the Commission. These financials were reviewed by the Executive - Finance Committee on February 5, 2015 where the Committee recommended approval of these financials to the Commission.

BACKGROUND / DISCUSSION:

The Plan staff prepared the December 2014 financial package, including balance sheet, statement of cash flows and income statements.

FISCAL IMPACT:

Highlights of Year-To-Date Financial Results:

On a year-to-date basis through December, the Plan's net income was approximately \$35.8 million compared to the \$9.8 million budget. These operating results have contributed to a Tangible Net Equity (TNE) level of approximately \$75.6 million, which exceeded both the budget of \$40.5 million by \$35.1 million and the State minimum required TNE amount of \$23.8 million by \$51.8million. As in prior reports, the Plan's TNE amount includes \$7.2 million County of Ventura lines of credit. The December TNE was 318% of the state required TNE, but 182% below the average of 6 County Organized Health Systems of 500%.

Highlights of December Financial Results:

Membership – December membership of 178,532 exceeded budget by 18,643 members. The majority of the growth was in the Adult Expansion (AE) category, where membership was 14,574 higher than budget. This accounts for approximately 78% of the total growth in membership.

Revenue – December net revenue was \$59.6 million or \$11.3 million better than the budgeted amount of \$48.3 million. The positive variance was primarily due to growth in membership with higher capitation rates (Adult Expansion). An adjustment of \$7.2 million was recorded as a reserve in anticipation of a reduction to rate in the Adult Expansion (AE) category. On a PMPM basis, revenue was \$333.63, which was \$31.71 better than the budget of \$301.92.

Health Care Costs - Health care costs for December were \$50.9 million or approximately \$7.2 million above budget. On a PMPM basis, reported health care costs for December were \$285.37 compared to a budgeted amount of \$273.63. The variance is due to AE membership

increases which again exceeded budget and accounted for \$10.0 million of the difference. This was offset by favorable AE cost variances of \$2.8 million. December costs have been aligned with the new AE rate sheet developed by DHCS. Other variances include:

- Physician ACA 1202 – An estimated \$4.9 million was recorded to recognize the final segment of the calendar year 2014 physician increases under the Affordable Care Act.
- Pharmacy – Lower than expected utilization in the AE category, again contributed to savings of approximately \$3.4 million.
- Adult Expansion Reserve – A previously recorded \$3.5 million reserve was reversed to achieve the 85% medical loss ratio (MLR) for this population using the new lower rates as published by DHCS. As disclosed in prior months, the current financials continue to reflect a targeted 85% MLR for overall medical expenses specific to the AE population as suggested by the Affordable Care Act's risk corridor.
- The approximate reserve recorded to increase the actual claims and IBNR to the 85% based upon DHCS' expected claims cost is approximately \$38 million. The additional claims expense reserve is anticipated to gradually decrease through June of 2015 as a result of:
 - Increases in capitation, hospital rate increases (per diem and outpatient augmentation) and FFS rates
 - AE member utilization of services in the 3 months ending Dec 31, 2014 was 1400% greater than the 3 months ending March 31, 2014
 - Provider incentives and other programs being instituted by the Plan which will increase AE utilization.
- The effect of a \$38 million reduction in reserves for claims expense would be accompanied by a reduction of \$44.7 million in revenues, resulting in a corresponding payable to the state. Similar to the adjustment in November, the net effect to the Plan would be a \$6.7 million decrease in profits.
- Staff will continue to review paid claims data in connection with the year-end reconciliation of the estimated claims expense to actual paid claims and IBNR reserves. Our reserve methodology may be amended, if necessary, under guidance from our audit and actuary firms.
- Outpatient and Inpatient – Higher than budgeted utilization was noted in the Disabled aid category and resulted in a negative variance of \$0.6 million. However, it was also noted that Inpatient services for the Disabled category produced a positive \$1.3 million variance, suggesting that more services were shifted to outpatient facilities.
- LTC / SNF – Significantly higher costs were noted in the LTC Dual aid category. An unfavorable variance of \$0.9 million was driven by a 50% increase in billed days. The bulk of the increase was related to higher than trend November days billed in December.

Administrative Expenses – For the month of December, overall operational costs were \$3.1 million or \$370,000 over budget. Higher than budgeted legal fees and outside services were offset by positive variance due to lower personnel and associated expenses. The following were the primary contributors to the large variances:

- Outside Services (ACS and Beacon) – over budget by \$169,000 due to growth in membership.
- Legal Fees – over budget by \$346,000 due to continued legal services and ongoing services for the investigation. Year to date legal expenses of \$1.4 million exceeded the budget by \$1.3 million.
- Consulting – under budget by \$78,000 due to increase use of in-house services for budgeted projects.

Cash + Medi-Cal Receivable – The total of Cash and Medi-Cal Premium Receivable balances of \$295 million reported as of December 31, 2014. This total includes pass-through payments for MCO tax of \$3.8 million. Excluding the impact of the pass through amount, the total of Cash and Medi-Cal Receivable balance as of December 31, 2014 was \$291 million or \$147.3 million better than the budgeted level of \$143.7 million

Investments–The funds deposited at Rabobank have increased in excess of \$215 million. The Plan’s executive staff with the opinion of Best, Best and Krieger, LLP, the Plan’s general counsel, has agreed to open two additional bank accounts. Reducing funds in one bank will mitigate the obvious risks. Also, banks now prefer to maintain client’s balances to fit the bank’s financial needs. Rabobank is following this trend with the recent announcement that funds in excess of \$50 million will now earn 0.05%, significantly less than the usual rate of 0.22%.

Exhibit 1(1) in part 3 (following the Investment Policy) addresses this subject. The accounts will be opened at banks that are approved California Government Depositories. See Depository requirements and guidelines on Exhibit 1(2). The first bank account is being opened at Bank of the West. This bank is a subsidiary of a European bank, BNP Paribas, the fourth largest bank globally. BNP Paribas Securities Services has been present in the US for over 25 years. We will choose one more bank from two now being evaluated. Additional information was requested on three investment options posted in the investment policy “2 partial investments reference schedule” page 12. The explanation of these investment options are available on: Exhibit 1(3) PMIA; (4) Mutual Funds; (5) Joint Powers Authority Pool.

RECOMMENDATION

Staff requests that the Committee approve the December 2014 financial packages.

CONCURRENCE

N/A

Attachments

December, 2014 Financial Package



FINANCIAL PACKAGE

For the month ended December 31, 2014

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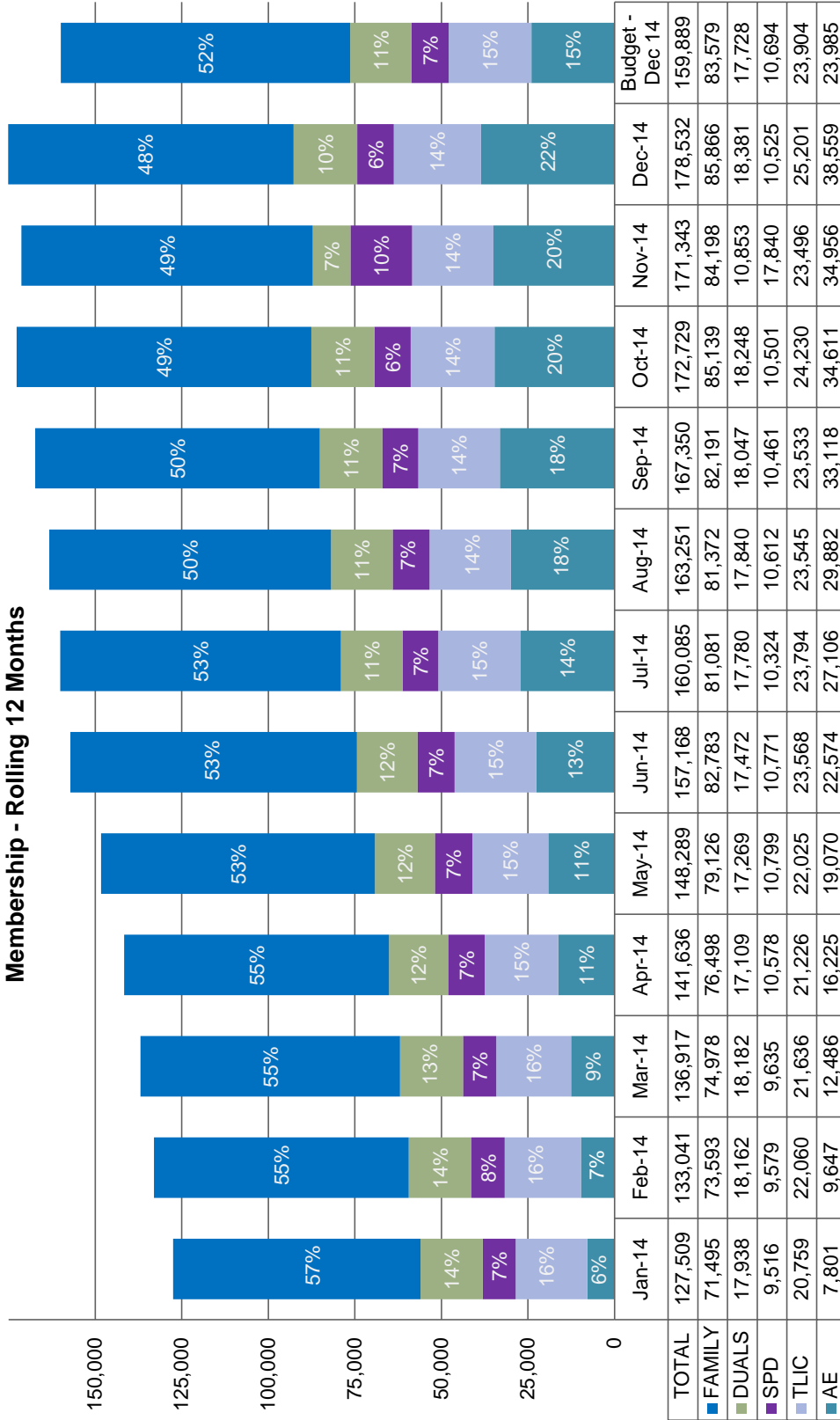
- Cash Trend Combined
- Paid Claims and IBNP Composition
- Total Expenditure Composition
- Pharmacy Cost & Utilization Trends

GOLD COAST HEALTH PLAN
Financial Results Summary

Description	AUDITED*		FY 2014 - 15				Budget Comparison	
	FY2011-12	FY 2012-13	UNAUDITED	JUL - SEP	OCT 2014	NOV 2014	DEC 2014	DEC 2014
Member Months	1,258,189	1,223,895	1,553,660	490,686	172,729	171,343	178,532	
Revenue								
pppm	304,635,932	315,119,611	423,995,809	158,761,380	56,934,456	25,538,171	59,563,938	
pppm	242.12	257.47	272.90	323.55	329.62	149.05	333.63	
Health Care Costs								
pppm	287,353,672	280,382,704	369,321,385	141,486,486	42,774,442	12,855,002	50,947,617	
% of Revenue	228.39	229.09	237.71	288.34	247.64	75.02	285.37	
	94.3%	89.0%	87.1%	89.1%	75.1%	50.3%	85.5%	
Admin Exp								
pppm	18,891,320	24,013,927	26,751,533	7,994,304	2,954,018	2,883,649	3,132,315	
% of Revenue	15.01	19.62	17.22	16.29	17.10	16.83	17.54	
	6.2%	7.6%	6.3%	5.0%	5.2%	11.3%	5.3%	
Net Income								
pppm	(1,609,063)	10,722,980	27,922,891	9,280,590	11,205,997	9,799,520	5,484,006	
% of Revenue	(1.28)	8.76	17.97	18.91	64.88	57.19	30.72	
	-0.5%	3.4%	6.6%	5.8%	19.7%	38.4%	9.2%	
YTD								
100% TNE	16,769,368	16,138,440	19,964,221	22,600,707	24,668,181	21,069,622	23,789,982	
% TNE Required	36%	68%	100%	100%	100%	100%	100%	
Minimum Required TNE	6,036,972	10,974,139	19,964,221	22,600,707	24,668,181	21,069,622	23,789,982	
GCHP TNE	(6,031,881)	11,891,099	39,813,991	49,094,581	60,300,578	70,100,097	75,584,104	
TNE Excess / (Deficiency)	(12,068,853)	916,960	19,849,770	26,493,874	35,632,397	49,030,475	51,794,122	
% of Required TNE level			199%	217%	244%	333%	318%	
% of Required TNE level (excluding \$7.2 million LOC)			163%	185%	215%	299%	287%	
Budget								
Dec 2014								
Budget				490,686	172,729	171,343	178,532	
Variance Fav/(Unfav)				323.55	329.62	149.05	333.63	
Variance Fav/(Unfav) %				89.1%	75.1%	50.3%	85.5%	
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GOLD COAST HEALTH PLAN

Membership - Rolling 12 Months



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

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

Comparative Balance Sheet

	12/31/14	11/30/14	10/31/14
ASSETS			
Current Assets			
Total Cash and Cash Equivalents	\$ 215,731,716	\$ 183,224,078	\$ 164,976,610
Medi-Cal Receivable*	79,164,402	86,747,896	75,437,421
Provider Receivable	739,377	1,067,444	748,596
Other Receivables	169,825	172,938	171,902
Total Accounts Receivable	80,073,603	87,988,278	76,357,918
Total Prepaid Accounts	1,037,280	1,135,545	1,258,445
Total Other Current Assets	81,702	79,079	79,079
Total Current Assets	296,924,300	272,426,981	242,672,052
Total Fixed Assets	1,049,670	1,080,359	1,110,800
Total Assets	\$ 297,973,971	\$ 273,507,340	\$ 243,782,853
LIABILITIES & FUND BALANCE			
Current Liabilities			
Incurred But Not Reported	\$ 140,562,535	\$ 128,769,325	\$ 145,918,067
Claims Payable	8,196,446	7,010,225	8,565,735
Capitation Payable	2,567,438	2,499,232	2,443,391
Physician ACA 1202 Payable	14,235,884	12,765,516	12,765,516
AB85 Payable	-	1,234,422	-
DHCS - Reserve for Capitation Recoup	43,976,489	36,753,996	-
Accounts Payable	3,253,329	1,805,393	1,690,595
Accrued ACS	1,430,991	1,331,496	1,331,053
Accrued Expenses	2,749,516	1,337,668	1,082,568
Accrued Premium Tax	3,839,632	8,145,887	7,883,262
Accrued Interest Payable	56,448	54,703	52,028
Current Portion of Deferred Revenue	460,000	460,000	460,000
Accrued Payroll Expense	555,013	728,952	775,348
Total Current Liabilities	221,883,723	202,896,815	182,967,564
Long-Term Liabilities			
Other Long-term Liability-Deferred Rent	276,144	242,094	208,044
Deferred Revenue - Long Term Portion	230,000	268,333	306,667
Notes Payable	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	7,706,144	7,710,427	7,714,711
Total Liabilities	229,589,867	210,607,242	190,682,275
Beginning Fund Balance	32,613,991	32,613,991	32,613,991
Net Income Current Year	35,770,113	30,286,106	20,486,587
Total Fund Balance	68,384,104	62,900,097	53,100,578
Total Liabilities & Fund Balance	\$ 297,973,971	\$ 273,507,340	\$ 243,782,853

FINANCIAL INDICATORS

Current Ratio	1.34 : 1	1.34 : 1	1.33 : 1
Days Cash on Hand	120	349	108
Days Cash + State Capitation Rec	164	515	158
Days Cash + State Capitation Rec (less Tax Liab)	161	499	153

Statement of Cash Flows - Monthly

	DEC 14	NOV 14	OCT 14
Cash Flow From Operating Activities			
Collected Premium	\$ 76,497,908	\$ 53,468,516	\$ 214,139
Miscellaneous Income	47,435	37,734	42,429
State Pass Through Funds	1,619,462	1,272,300	-
<u>Paid Claims</u>			
Medical & Hospital Expenses	(26,863,207)	(22,348,925)	(23,375,027)
Pharmacy	(5,297,236)	(5,828,747)	(6,006,120)
Capitation	(2,939,560)	(2,907,935)	(2,902,464)
Reinsurance of Claims	(476,754)	(471,741)	(460,248)
State Pass Through Funds Distributed	(1,234,422)	(1,147,874)	(25,173,527)
Paid Administration	(3,518,102)	(1,487,467)	(3,309,178)
MCO Tax Received / (Paid)	(5,327,887)	(2,338,145)	(5,536,013)
Net Cash Provided/ (Used) by Operating Activities	32,507,638	18,247,716	(66,506,008)
Cash Flow From Investing/Financing Activities			
Proceeds from Line of Credit	-	-	-
Repayments on Line of Credit	-	(248)	(2,518)
Net Acquisition of Property/Equipment	-	(248)	(2,518)
Net Cash Provided/(Used) by Investing/Financing	-	(248)	(2,518)
Net Cash Flow	\$ 32,507,638	\$ 18,247,468	\$ (66,508,526)
Cash and Cash Equivalents (Beg. of Period)	183,224,078	164,976,610	231,485,135
Cash and Cash Equivalents (End of Period)	215,731,716	183,224,078	164,976,610
	\$ 32,507,638	\$ 18,247,468	\$ (66,508,526)
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	5,484,006	9,799,520	2,205,997
Depreciation & Amortization	30,689	30,689	30,600
Decrease/(Increase) in Receivables	7,914,675	(11,630,360)	(60,251,822)
Decrease/(Increase) in Prepaids & Other Current Assets	95,643	122,900	(86,831)
(Decrease)/Increase in Payables	10,245,526	38,315,038	(15,061,438)
(Decrease)/Increase in Other Liabilities	(4,284)	(4,284)	(4,284)
Change in MCO Tax Liability	(4,306,255)	262,625	(3,191,544)
Changes in Claims and Capitation Payable	1,254,427	(1,499,669)	1,668,398
Changes in IBNR	11,793,211	(17,148,743)	8,184,917
	32,507,638	18,247,716	(66,506,008)
Net Cash Flow from Operating Activities	\$ 32,507,638	\$ 18,247,716	\$ (66,506,008)

Statement of Cash Flows - YTD

	DEC 14
Cash Flow From Operating Activities	
Collected Premium	\$ 392,534,725
Miscellaneous Income	197,847
State Pass Through Funds	33,242,938
<u>Paid Claims</u>	
Medical & Hospital Expenses	(142,028,420)
Pharmacy	(34,881,783)
Capitation	(16,316,111)
Reinsurance of Claims	(2,939,591)
State Pass Through Funds Distributed	(30,860,629)
Paid Administration	(18,205,765)
Repay Initial Net Liabilities	-
MCO Taxes Received / (Paid)	(25,121,732)
Net Cash Provided/(Used) by Operating Activities	155,621,479
Cash Flow From Investing/Financing Activities	
Proceeds from Line of Credit	-
Repayments on Line of Credit	-
Net Acquisition of Property/Equipment	(66,462)
Net Cash Provided/(Used) by Investing/Financing	(66,462)
Net Cash Flow	\$ 155,555,018
Cash and Cash Equivalents (Beg. of Period)	60,176,698
Cash and Cash Equivalents (End of Period)	215,731,716
	\$ 155,555,018
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	35,770,113
Depreciation & Amortization	180,060
Decrease/(Increase) in Receivables	36,775,057
Decrease/(Increase) in Prepaids & Other Current Assets	(42,984)
(Decrease)/Increase in Payables	47,820,949
(Decrease)/Increase in Other Liabilities	(25,702)
Change in MCO Tax Liability	(11,935,488)
Changes in Claims and Capitation Payable	(773,041)
Changes in IBNR	47,852,515
	155,621,479
Net Cash Flow from Operating Activities	\$ 155,621,479

Income Statement Monthly Trend

	FY2014-15 Monthly Trend*			Current Month		
	SEP 14	OCT 14	NOV 14	DEC 14		Variance
				Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	167,350	172,729	171,343	178,532	159,889	18,643
Revenue:						
Premium	\$ 59,992,380	\$ 59,184,067	\$ 64,766,272	\$ 67,600,543	\$ 50,196,163	\$ 17,404,380
Reserve for Rate Reduction	-	-	(36,753,996)	(7,222,493)	-	(7,222,493)
MCO Premium Tax	(2,362,200)	(2,330,373)	(2,550,172)	(930,197)	(1,976,474)	1,046,277
Total Net Premium	57,630,180	56,853,694	25,462,104	59,447,852	48,219,689	11,228,163
Other Revenue:						
Interest Income	30,121	42,429	37,734	47,435	16,565	30,870
Miscellaneous Income	38,333	38,333	38,333	68,651	38,333	30,318
Total Other Revenue	68,454	80,762	76,067	116,086	54,898	61,189
Total Revenue	57,698,634	56,934,456	25,538,171	59,563,938	48,274,586	11,289,352
Medical Expenses:						
<u>Capitation (PCP, Specialty, Kasier, NEMT & Vision)</u>	2,796,518	2,864,387	2,932,938	3,004,545	2,690,068	(314,476)
<u>FFS Claims Expenses:</u>						
Inpatient	13,423,203	8,820,600	(3,366,301)	10,389,370	9,834,314	(555,056)
LTC/SNF	9,147,787	10,759,562	8,603,699	9,058,853	7,510,868	(1,547,985)
Outpatient	3,693,295	2,405,528	154,989	4,421,489	2,604,346	(1,817,143)
Laboratory and Radiology	1,191,252	533,829	(658,499)	1,239,938	748,601	(491,337)
Physician ACA 1202	-	-	-	4,942,182	-	(4,942,182)
Emergency Room	1,818,198	1,181,015	(526,608)	1,773,425	1,521,022	(252,403)
Physician Specialty	3,527,267	2,156,736	1,150,877	4,232,969	3,219,336	(1,013,633)
Primary Care Physician	3,230,565	2,026,593	263,568	3,187,156	2,485,097	(702,059)
Home & Community Based Services	1,729,152	1,106,600	1,315,061	1,429,964	835,189	(594,775)
Applied Behavior Analysis Services	-	-	-	392	-	(392)
Mental Health Services	670,802	710,363	464,368	642,434	743,505	101,071
Pharmacy	5,525,771	5,358,792	4,772,776	5,436,966	8,807,462	3,370,496
Adult Expansion Reserve	-	2,500,000	-	(3,500,000)	-	3,500,000
Other Medical Professional	340,253	196,706	(64,226)	409,206	264,091	(145,116)
Other Medical Care	331	-	-	38	-	(38)
Other Fee For Service	1,328,749	1,333,514	(3,254,779)	1,744,277	924,584	(819,693)
Transportation	379,458	82,729	58,244	792,920	303,302	(489,618)
Total Claims	46,006,084	39,172,566	8,913,169	46,201,577	39,801,717	(6,399,860)
Medical & Care Management Expense	1,024,517	1,029,183	911,817	1,075,547	1,063,992	(11,555)
Reinsurance	449,539	460,248	471,741	(206,923)	195,065	401,988
Claims Recoveries	(128,569)	(751,942)	(374,663)	872,871	-	(872,871)
Sub-total	1,345,487	737,488	1,008,895	1,741,495	1,259,057	(482,438)
Total Cost of Health Care	50,148,088	42,774,442	12,855,002	50,947,617	43,750,843	(7,196,774)
Contribution Margin	7,550,545	14,160,015	12,683,169	8,616,322	4,523,744	4,092,578
General & Administrative Expenses:						
Salaries and Wages	690,867	712,605	587,651	724,287	807,593	83,306
Payroll Taxes and Benefits	192,767	185,805	151,578	265,074	216,586	(48,488)
Travel and Training	12,543	19,428	8,957	9,763	13,734	3,972
Outside Service - ACS	1,278,018	1,332,236	1,331,496	1,370,254	1,201,706	(168,549)
Outside Services - Other	123,714	136,260	136,226	143,598	120,773	(22,825)
Accounting & Actuarial Services	15,037	10,990	37,386	10,000	25,000	15,000
Legal	202,842	249,708	355,504	378,862	33,334	(345,528)
Insurance	7,186	17,151	16,863	18,265	14,583	(3,682)
Lease Expense - Office	63,588	63,318	63,048	63,318	64,354	1,036
Consulting Services	56,353	43,960	5,420	9,194	87,654	78,460
Translation Services	5,882	4,208	10,895	401	7,083	6,682
Advertising and Promotion	-	100	5,684	147	5,839	5,692
General Office	116,147	77,828	125,251	87,687	95,988	8,301
Depreciation & Amortization	16,534	16,441	16,530	16,530	25,930	9,400
Printing	26,864	3,123	739	-	24,077	24,077
Shipping & Postage	1,681	1,249	1,362	17,239	2,632	(14,607)
Interest	(7,319)	79,607	29,060	17,695	15,000	(2,695)
Total G & A Expenses	2,802,703	2,954,018	2,883,649	3,132,315	2,761,867	(370,448)
Net Income / (Loss)	\$ 4,747,842	\$ 11,205,997	\$ 9,799,520	\$ 5,484,006	\$ 1,761,877	\$ 3,722,130
Full time employees				143	165	22

PMPM Income Statement Comparison

	SEP 14	OCT 14	NOV 14	DEC 14		Variance
				Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	167,350	172,729	171,343	178,532	159,889	18,643
Revenue:						
Premium	358.48	342.64	377.99	378.65	313.94	64.70
Reserve for Rate Reduction	-	-	(214.51)	(40.45)	-	(40.45)
MCO Premium Tax	(14.12)	(13.49)	(14.88)	(5.21)	(12.36)	7.15
Total Net Premium	344.37	329.15	148.60	332.98	301.58	31.40
Other Revenue:						
Interest Income	0.18	0.25	0.22	0.27	0.10	0.16
Miscellaneous Income	0.23	0.22	0.22	0.38	0.24	0.14
Total Other Revenue	0.41	0.47	0.44	0.65	0.34	0.31
Total Revenue	344.78	329.62	149.05	333.63	301.92	31.71
Medical Expenses:						
<u>Capitation (PCP, Specialty, Kasier, NEMT & Vision)</u>	16.71	16.58	17.12	16.83	16.82	(0.00)
<u>FFS Claims Expenses:</u>						
Inpatient	80.21	51.07	(19.65)	58.19	61.51	3.31
LTC/SNF	54.66	62.29	50.21	50.74	46.98	(3.77)
Outpatient	22.07	13.93	0.90	24.77	16.29	(8.48)
Laboratory and Radiology	7.12	3.09	(3.84)	6.95	4.68	(2.26)
Physician ACA 1202	-	-	-	27.68	-	(27.68)
Emergency Room	10.86	6.84	(3.07)	9.93	9.51	(0.42)
Physician Specialty	21.08	12.49	6.72	23.71	20.13	(3.58)
Primary Care Physician	19.30	11.73	1.54	17.85	15.54	(2.31)
Home & Community Based Services	10.33	6.41	7.68	8.01	5.22	(2.79)
Applied Behavior Analysis Services	-	-	-	0.00	-	(0.00)
Mental Health Services	4.01	4.11	2.71	3.60	4.65	1.05
Pharmacy	33.02	31.02	27.86	30.45	55.08	24.63
Adult Expansion Reserve	-	14.47	-	(19.60)	-	19.60
Other Medical Professional	2.03	1.14	(0.37)	2.29	1.65	(0.64)
Other Medical Care	0.00	-	-	0.00	-	(0.00)
Other Fee For Service	7.94	7.72	(19.00)	9.77	5.78	(3.99)
Transportation	2.27	0.48	0.34	4.44	1.90	(2.54)
Total Claims	274.91	226.79	52.02	258.79	248.93	(9.85)
Medical & Care Management Expense	6.12	5.96	5.32	6.02	6.65	0.63
Reinsurance	2.69	2.66	2.75	(1.16)	1.22	2.38
Claims Recoveries	(0.77)	(4.35)	(2.19)	4.89	-	(4.89)
Sub-total	8.04	4.27	5.89	9.75	7.87	(1.88)
Total Cost of Health Care	299.66	247.64	75.02	285.37	273.63	(11.74)
Contribution Margin	45.12	81.98	74.02	48.26	28.29	(19.97)
Memo: exclusive of adjustment						
General & Administrative Expenses:						
Salaries and Wages	4.13	4.13	3.43	4.06	5.05	0.99
Payroll Taxes and Benefits	1.15	1.08	0.88	1.48	1.35	(0.13)
Travel and Training	0.07	0.11	0.05	0.05	0.09	0.03
Outside Service - ACS	7.64	7.71	7.77	7.68	7.52	(0.16)
Outside Services - Other	0.74	0.79	0.80	0.80	0.76	(0.05)
Accounting & Actuarial Services	0.09	0.06	0.22	0.06	0.16	0.10
Legal	1.21	1.45	2.07	2.12	0.21	(1.91)
Insurance	0.04	0.10	0.10	0.10	0.09	(0.01)
Lease Expense - Office	0.38	0.37	0.37	0.35	0.40	0.05
Consulting Services	0.34	0.25	0.03	0.05	0.55	0.50
Translation Services	0.04	0.02	0.06	0.00	0.04	0.04
Advertising and Promotion	-	0.00	0.03	0.00	0.04	0.04
General Office	0.69	0.45	0.73	0.49	0.60	0.11
Depreciation & Amortization	0.10	0.10	0.10	0.09	0.16	0.07
Printing	0.16	0.02	0.00	-	0.15	0.15
Shipping & Postage	0.01	0.01	0.01	0.10	0.02	(0.08)
Interest	(0.04)	0.46	0.17	0.10	0.09	(0.01)
Total G & A Expenses	16.75	17.10	16.83	17.54	17.27	(0.27)
Net Income / (Loss)	28.37	64.88	57.19	30.72	11.02	19.70

Income Statement
For Six Months Ended December 31, 2014

	Dec 14 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	1,013,290	953,916	59,374
Revenue			
Premium	\$ 356,626,880	\$ 297,867,492	\$ 58,759,387
Reserve for Rate Reduction	(43,976,489)	-	(43,976,489)
MCO Premium Tax	(12,310,609)	(11,728,533)	(582,077)
Total Net Premium	300,339,781	286,138,960	14,200,821
Other Revenue:			
Interest Income	197,847	98,296	99,551
Miscellaneous Income	260,318	229,998	30,320
Total Other Revenue	458,165	328,294	129,871
Total Revenue	300,797,946	286,467,254	14,330,692
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	16,811,349	15,988,354	(822,995)
FFS Claims Expenses:			
Inpatient	51,939,472	58,226,372	6,286,901
LTC/SNF	54,130,181	44,975,705	(9,154,477)
Outpatient	17,162,503	15,446,494	(1,716,009)
Laboratory and Radiology	4,252,165	4,389,968	137,803
Physician ACA 1202	4,942,182	-	(4,942,182)
Emergency Room	7,509,567	8,999,565	1,489,998
Physician Specialty	17,984,105	19,118,627	1,134,522
Primary Care Physician	13,483,011	14,660,187	1,177,176
Home & Community Based Services	8,170,660	5,007,220	(3,163,440)
Applied Behavior Analysis Services	392	-	(392)
Mental Health Services	3,272,762	4,425,798	1,153,036
Pharmacy	32,315,284	51,416,839	19,101,554
Other Medical Professional	1,490,741	1,561,399	70,658
Other Medical Care	369	-	(369)
Other Fee For Service	5,176,024	5,507,144	331,120
Transportation	1,803,998	1,785,596	(18,402)
Total Claims	223,633,416	235,520,913	11,887,498
Medical & Care Management Expense	6,041,648	6,304,191	262,544
Reinsurance	1,690,086	1,163,778	(526,308)
Claims Recoveries	(112,951)	-	112,951
Sub-total	7,618,783	7,467,970	(150,813)
Total Cost of Health Care	248,063,547	258,977,237	10,913,690
Contribution Margin	52,734,399	27,490,017	25,244,382
General & Administrative Expenses:			
Salaries and Wages	4,017,912	4,871,564	853,652
Payroll Taxes and Benefits	1,169,809	1,267,749	97,940
Travel and Training	70,060	163,114	93,054
Outside Service - ACS	7,823,209	7,171,588	(651,622)
Outside Services - Other	736,187	823,933	87,746
Accounting & Actuarial Services	104,641	225,000	120,359
Legal	1,400,737	200,000	(1,200,737)
Insurance	106,058	87,500	(18,558)
Lease Expense - Office	379,906	386,124	6,218
Consulting Services	213,234	799,932	586,698
Translation Services	26,949	42,498	15,549
Advertising and Promotion	9,955	81,904	71,949
General Office	579,095	1,099,159	520,064
Depreciation & Amortization	95,110	136,073	40,963
Printing	40,250	124,422	84,172
Shipping & Postage	45,331	75,678	30,347
Interest	145,844	90,000	(55,844)
Total G & A Expenses	16,964,287	17,646,238	681,951
Net Income / (Loss)	\$ 35,770,113	\$ 9,843,780	\$ 25,926,333

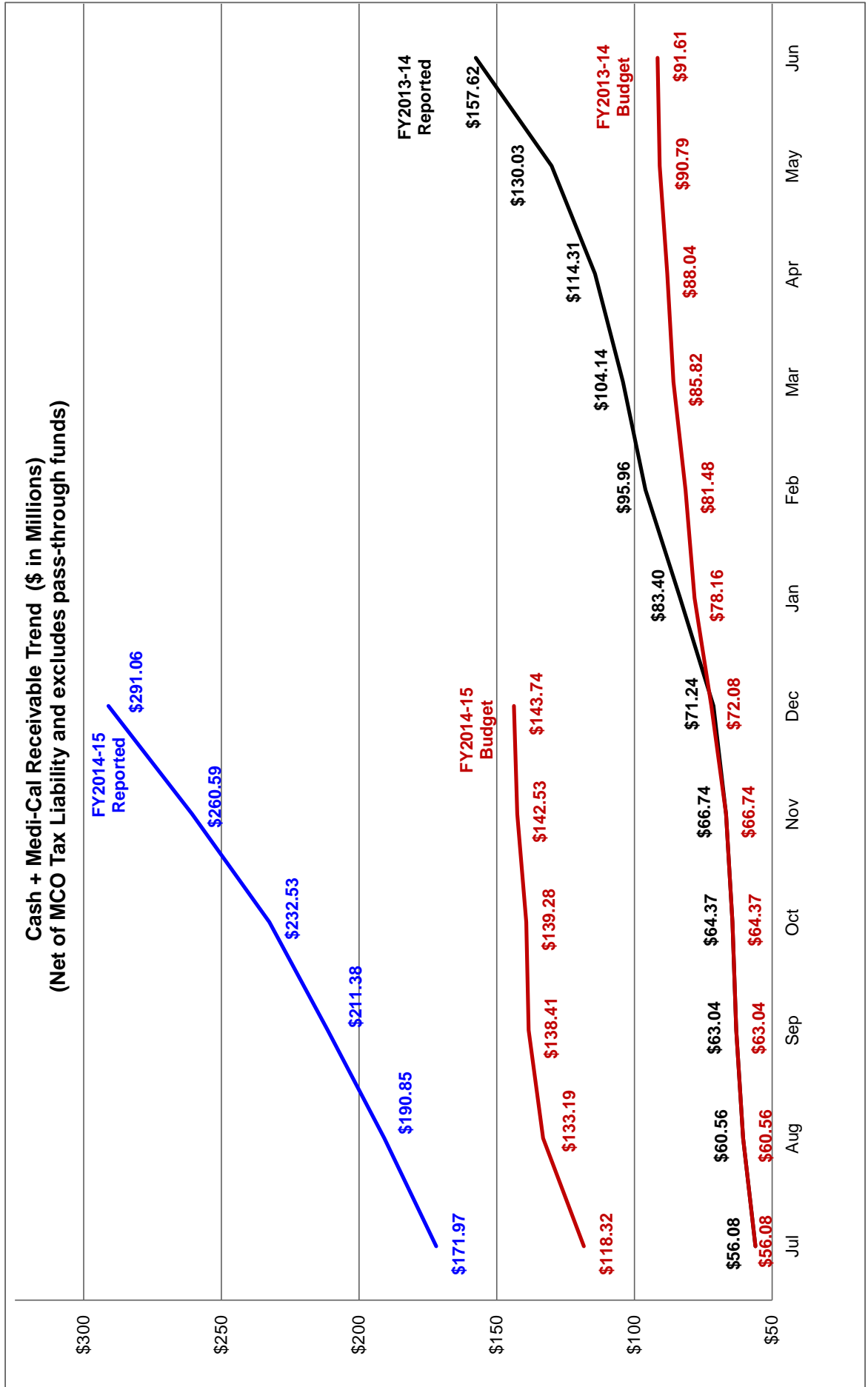


For the month ended December 31, 2014

APPENDIX

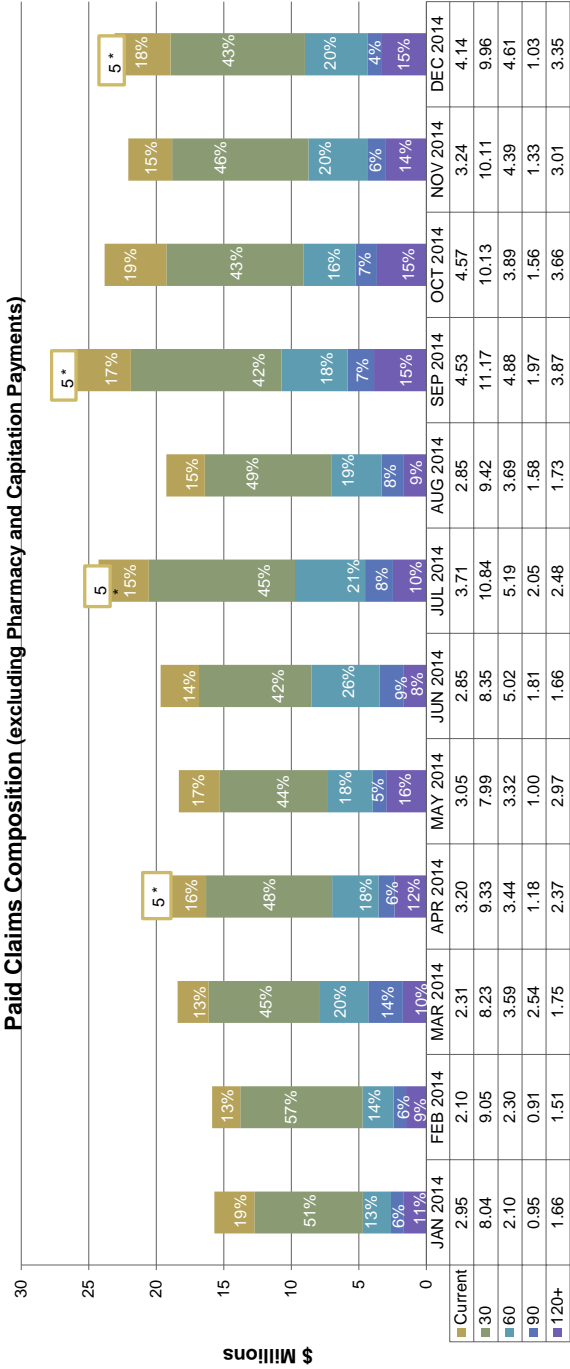
- Cash Trend Combined
- Paid Claims and IBNP Composition
- Total Expenditure Composition
- Pharmacy Cost & Utilization Trends

**GOLD COAST HEALTH PLAN
DEC 14**



GOLD COAST HEALTH PLAN DEC 14

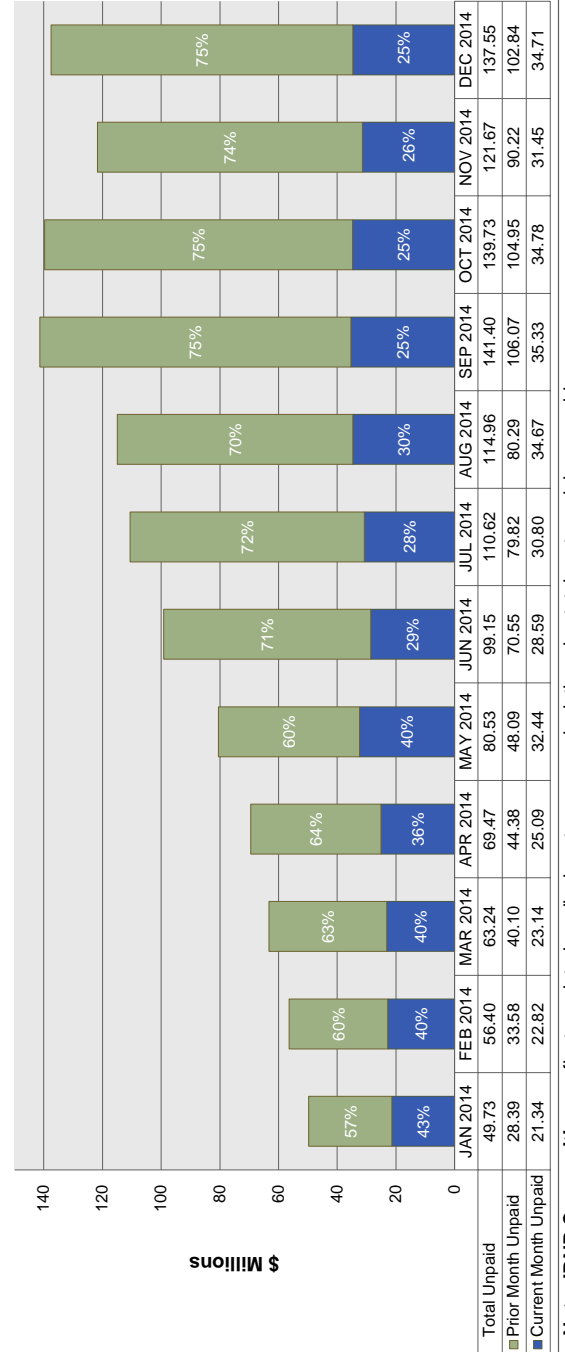
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



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.

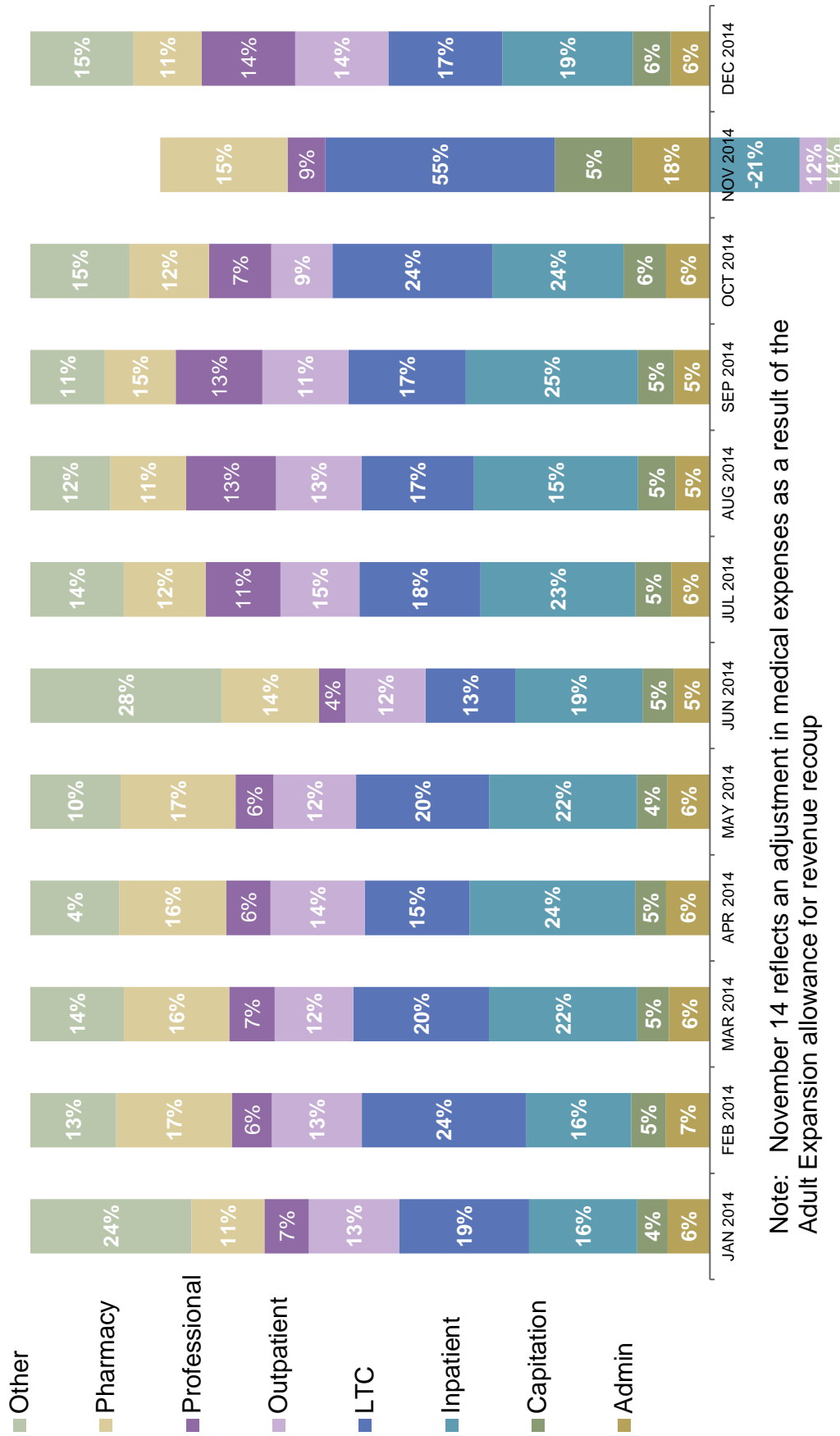
IBNP Composition (excluding Pharmacy and Capitation)



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

GOLD COAST HEALTH PLAN

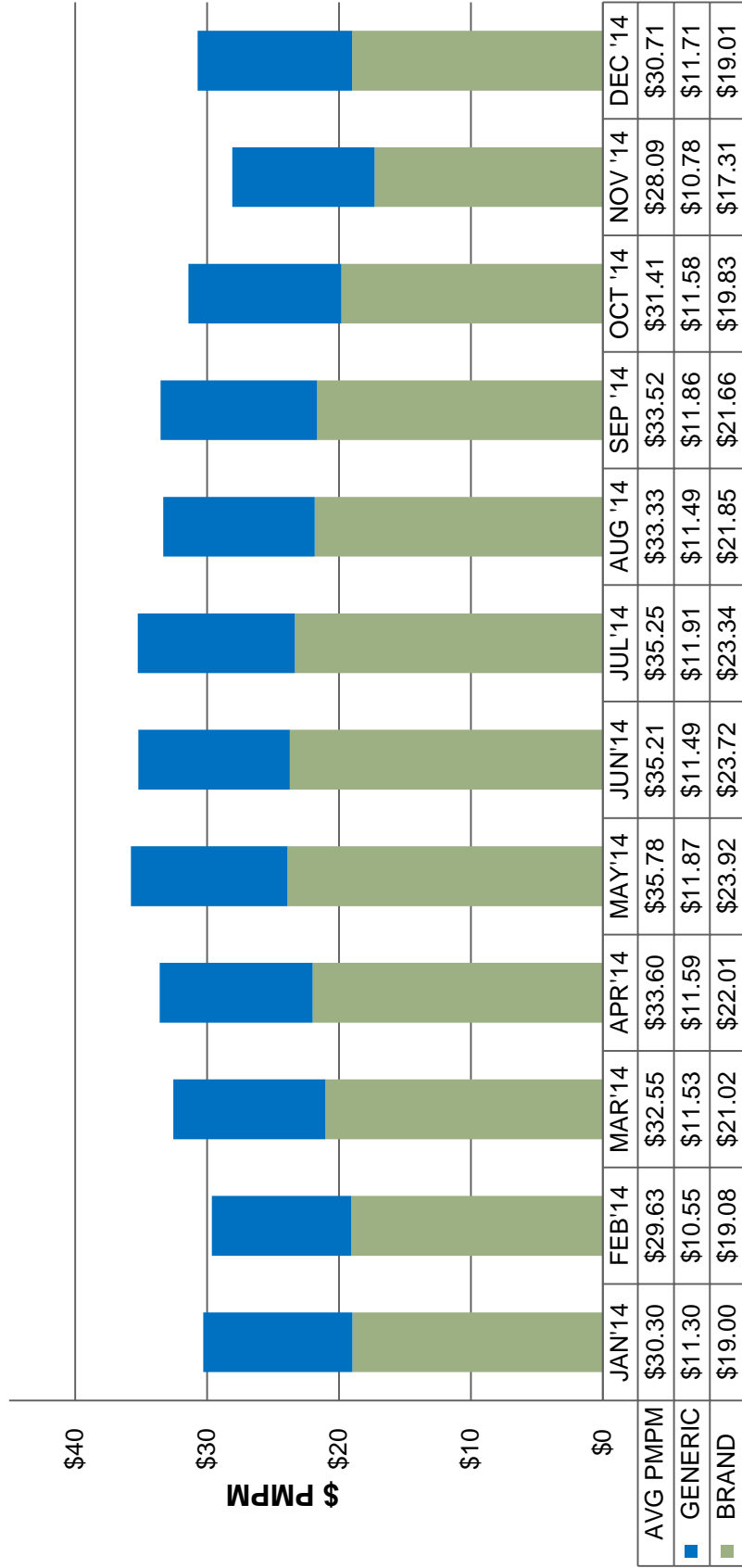
Total Expense Composition



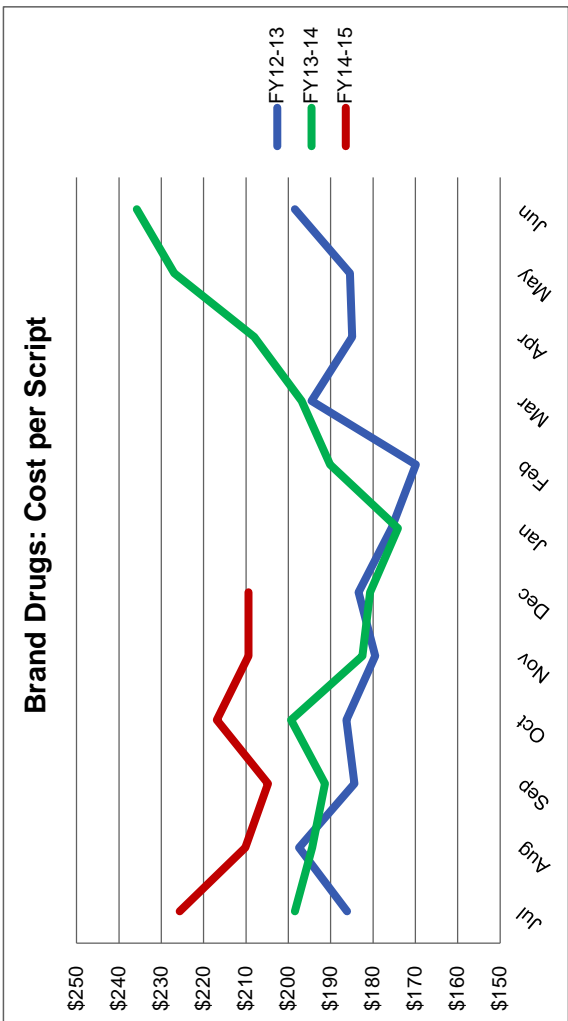
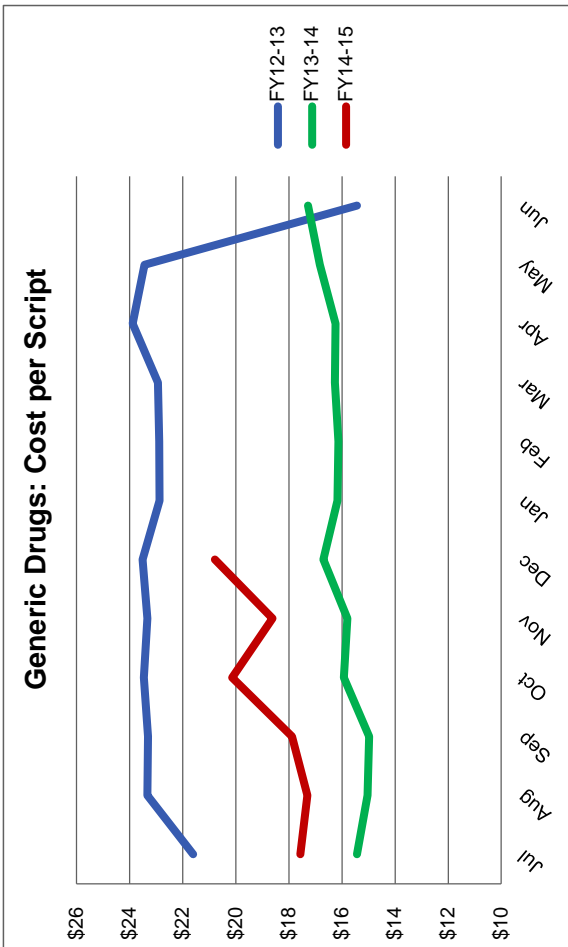
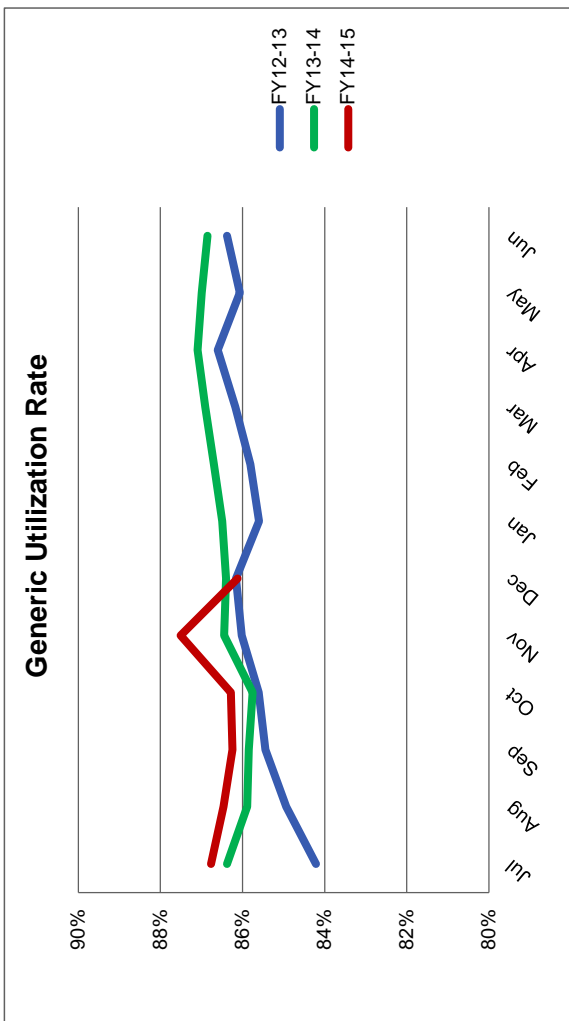
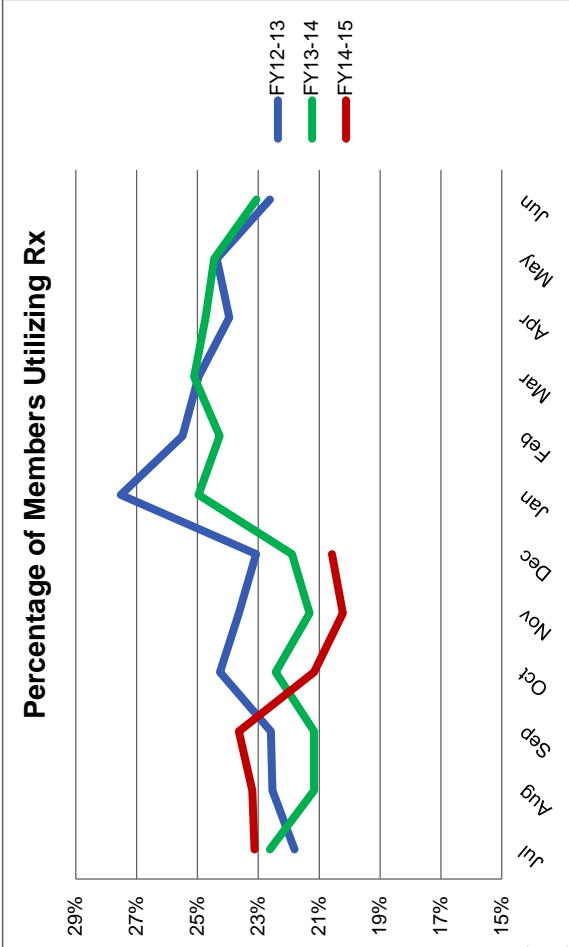
Note: November 14 reflects an adjustment in medical expenses as a result of the Adult Expansion allowance for revenue recoup

GOLD COAST HEALTH PLAN

Pharmacy Cost Trend



GOLD COAST HEALTH PLAN
Pharmacy Analysis



AGENDA ITEM 3d

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: February 23, 2015

Re: COO Update

OPERATIONS UPDATE:

Membership Update

Gold Coast Health Plan (GCHP) experienced a modest increase of 821 members in February, bringing our total membership to 178,984 as of February 1, 2015. This represents an increase of 60,472 in the past fourteen months. The cumulative new membership since January 1, 2014 is summarized as follows:

L1 (Low Income Health Plan) – 6,128
M1 (Adult Expansion) – 31,203
7U (CalFresh Adults) – 3,342
7W (CalFresh Children) – 872
7S (Parents of 7Ws) – 442
Traditional Medi-Cal – 18,485

M1 membership continues on an upward climb. GCHP was originally expecting to see increases in the 7W and 7S aid code categories due to the transition of Covered CA members to Medi-Cal. DHCS indicated that we had a potential of 2,196 members transitioning in January; however, one-third of those members were not included on our January eligibility file and another one-third were already existing GCHP members with an effective date prior to January 1, 2015. GCHP eventually added 486 members in January who transitioned from Covered CA. GCHP added an additional 24 members who transitioned from Covered CA in February.

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

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

	15-Jan	15-Feb	15-Mar	15-Apr	15-May	15-Jun
L1	6,508	6,128	0	0	0	0
M1	30,107	31,203	0	0	0	0
7U	3,390	3,342	0	0	0	0
7W	872	872	0	0	0	0
7S	478	442	0	0	0	0

Member Orientation Meetings – GCHP Member Services started off 2015 with a solid turnout for Member Orientation meetings conducted during the month. A total of 34 members and 9 County Employees/Others attended a meeting during January.

Comments/feedback from a recent Orientation meeting included:

- Members are really impressed with the coverage and the services they are eligible for as a GCHP member.
- Members are very thankful to GCHP for conducting these presentations.
 - Two ladies who have been with us since early last year said “everyone needs this information whether you are new to the plan or not.”

Full Scope Medi-Cal Coverage for Pregnant Women – Medi-Cal is expanding coverage for pregnant women beginning July 1, 2015. Eligible pregnant women with incomes above 60 percent of the Federal Poverty Level (FPL) up to and including 138 percent of the FPL are eligible for full-scope Medi-Cal coverage and will be required to choose a Managed Care Plan (MCP) unless an exemption applies. Prior to the expansion of eligibility, full-scope Medi-Cal coverage only extended to pregnant women from 0% up to and including 60% FPL.

These newly enrolled women will maintain their full scope benefits throughout their pregnancy until the last day of the month in which the 60th day lands after the end of the pregnancy. Before that point, they will undergo an eligibility redetermination and be placed into the appropriate aid code. This transition to MCPs of an estimated 11,000 pregnant women is a one-time shift of existing limited scope members into full-scope Medi-Cal coverage. Thereafter, pregnant women with incomes 0% up to and including 138% of the FPL will be eligible for full scope Medi-Cal and will be enrolled in MCPs.

Medi-Cal will send notices to fee-for-service members beginning July 1, 2015 with coverage commencing September 1, 2015.

January 2015 Operations Summary:

Claims Inventory – ended January with an inventory of 47,084; this equates to Days Receipt on Hand (DROH) of 7. GCHP is now receiving more than 6,000 claims per day. Monthly claim receipts from February 2014 through January 2015 are as follows:

Month	Total Claims Received	Receipts per Day
February	90,048	4,739
March	109,857	5,231
April	110,855	5,039
May	108,312	5,158
June	116,474	5,546
July	117,136	5,324
August	108,695	5,176
September	119,233	5,678
October	134,274	5,838
November	111,182	6,177
December	128,087	6,099
January	127,517	6,376

Claims TAT – the regulatory requirement of processing 90% of clean claims within 30 calendar days was not met in January (79.1%). TAT has been impacted by the increased volume of claims which is a direct result of increased membership. Xerox is adding 10 additional claims processors in response to the higher than anticipated membership and subsequent claims volume. The Inventory Reduction Plan is being monitored closely and compliance is projected by the end of March.

Claims Processing Accuracy – financial accuracy remained above goal in January at 99.68%. Procedural accuracy also exceeded the goal for January at 99.98%.

Call Volume – call volume returned to pre-holiday levels; the number of calls received in January was 10,777.

Average Speed to Answer (ASA) – GCHP continued to exceed the goal of answering calls within 30 seconds or less. The combined results (Member, Provider and Spanish lines) for January were 19.5 seconds.

Abandonment Rate – the abandonment rate continued to remain exceedingly low. The goal is 5% or less of the calls received being abandoned; January's results were 0.79%.

Average Call Length – the combined result of 7.35 minutes in January was slightly above the goal of 7.0 minutes.

AB 85 Capacity Tracking – VCMC has a total of 23,293 Adult Expansion members assigned to them as of January 2015. VCMC's target enrollment is 65,765 so they are currently at 35% of their enrollment target.

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

- 35C to 837 Encounter Data Transition – GCHP is now submitting production data to the State in the new 837 format. Quality results have been good.
- Encounter Data Improvement Project (EDIP) – improve the quality of the data sent to DHCS in order to meet new quality measures established by the State beginning January 2015.
- ICD-10 Readiness – work continues towards implementation of the new code set which is effective for dates of service on or after October 1, 2015.
- Crossover Claims – implementation is underway. Providers will not have to submit paper claims with Medicare Explanation of Benefits for dates of service on or after April 1, 2015.
- Plan Selection – PCP selection during sign-up via Covered California; information matched once Medi-Cal beneficiary becomes a GCHP member. DHCS has indicated that non-COHS plans are currently the focus with a go-live no earlier than May 2015. Implementation for COHS plans would follow shortly thereafter.

AGENDA ITEM 3e

To: Gold Coast Health Plan Commission

From: Melissa Scrymgeour, Chief Information Officer

Date: February 23, 2015

Re: CIO Update

Project Management Office (PMO)

As of February 23, 2015, the GCHP project portfolio consists of 13 “active” projects:

February 2015 PMO Project Activity Highlights:

- Closed Member Satisfaction Survey
- Kicked off Pharmacy Benefit Manager (PBM) Consultant RFP
- Kicked off Provider Contracts and Capitation Rebasing Evaluation (Phase 2)

March 2015 PMO Planned Project Activity:

- Close Provider Contracts and Capitation Rebasing Evaluation (Phase 1)
- Close MedHOK SPD and ACG-Risk Stratification projects
- Close Non-Emergent Medical Transportation (NEMT) Phase 1
- Kick off ACA Core Administrative Simplification Rules (CORE)
- Kick off Business Continuity Planning (BCP)
- Kick off MedInsight Upgrade

FY2014-15 GCHP Projects:

- **ICD-10 Readiness (Phase 1 & Phase 2):** Transition all systems and providers from ICD-9 to ICD-10 by the revised Center for Medicaid and Medicare Services (CMS) mandated date of 10/15/2015.
- **Disease Management (DM) Program (Roadmap & Program):** Contractually required. Introduce formal DM program to better manage health outcomes for targeted member population. The initial Diabetes program will benefit roughly 10k members and help build a model for other diseases (CHF, COPD, and Prenatal).

- **Member Satisfaction:** Gauge and measure member satisfaction with GCHP, as requested by the Commission.
- **Xerox/ACS Service Organization Control (SOC) Audit:** Recommended by Plan financial auditor.
- **Encounter Data Improvement Project (EDIP):** Contractual requirement for State EDIP initiative. The State requires managed care plans to submit complete, accurate, timely and reasonable encounter data in a HIPAA compliant file format.
- **Delegation & Oversight Framework:** Institute standard delegation and oversight requirements, policies, and procedures for establishing provider contracts.
- **Business Continuity Planning (RFP & Implementation):** Contractual requirement to draft plan for critical business process resumption in the event of an emergency.
- **IT Disaster Recovery Planning:** Contractual requirement to draft plan for data and system recovery in the event of an emergency for business critical functions.
- **Crossover Claims:** Further optimizes claims processing accuracy and efficiencies to appropriately handle claims where a portion is covered by Medicare.
- **Operationalize Information Security Program** – Required to ensure ongoing HIPAA and HITECH (Health Information Technology for Economic and Clinical Health Act-2009) compliance.
- **Social Media Policy & Roadmap:** Establish a communication strategy via social media platforms to members, providers and the general community.
- **ACA Core Administrative Simplification Rules (CORE):** Regulatory requirement to utilize standard electronic transaction sets as defined under the Affordable Care Act.
- **HR Flexible Work Program-Telework Policy:** Implement initiatives to attract and retain staff. Under consideration are a telework strategy, employee recognition, and flexible work schedules.
- **Pharmacy Benefits Manager (PBM) Implementation:** Consulting Vendor for RFP creation, RFP and possible implementation of new PBM.
- **MedHOK ACG-Risk Stratification:** Implement MedHOK ACG module for member risk stratification. Supports the GCHP disease management program.

- **Provider Contracts & Capitation Rebasing Evaluation 9 (Phase 1 & Phase 2):** Evaluation of provider capitation rates.
- **MedInsight Upgrade:** Upgrade of the existing Milliman MedInsight Business Intelligence (BI) Tool; moving from and on premise to hosted solution.
- **Provider Portal Evaluation:** Evaluate provider portal solutions in effort to streamline provider online experience for eligibility and claim inquiries, and authorization requests. Supports Plan “valued and trusted partner” strategy.
- **MedHOK SPD:** Implement MedHOK functional enhancements to meet State SPD assessment and reporting requirements.
- **MedHOK MMS Post Implementation:** Implement system fixes to resolve MedHOK post-implementation issues.
- **ICES / IKA Upgrades:** Software version upgrade for core administration processing and claims editing systems.
- **ACS Data Warehouse Extract Optimization:** Implement improvements to the nightly IKA data extract process for GCHP reporting.
- **Non-Emergent Medical Transportation (NEMT)-(Phase 1 & Phase 2):** Modify non-emergent medical transportation processes to ensure sustained regulatory and contractual compliance. Analyze and evaluate alternatives to existing benefit.
- **Behavioral Health Benefit for Autism Spectrum Disorder (ABA)-(Phase 1 & Phase 2):** Regulatory requirement to introduce Applied Behavioral Analysis (ABA) as a treatment for Autism Spectrum Disorder (ASD) effective September 15, 2014.



Gold Coast
Health Plan™
A Public Entity

2/2015: GCHP Projects

“At a Glance”

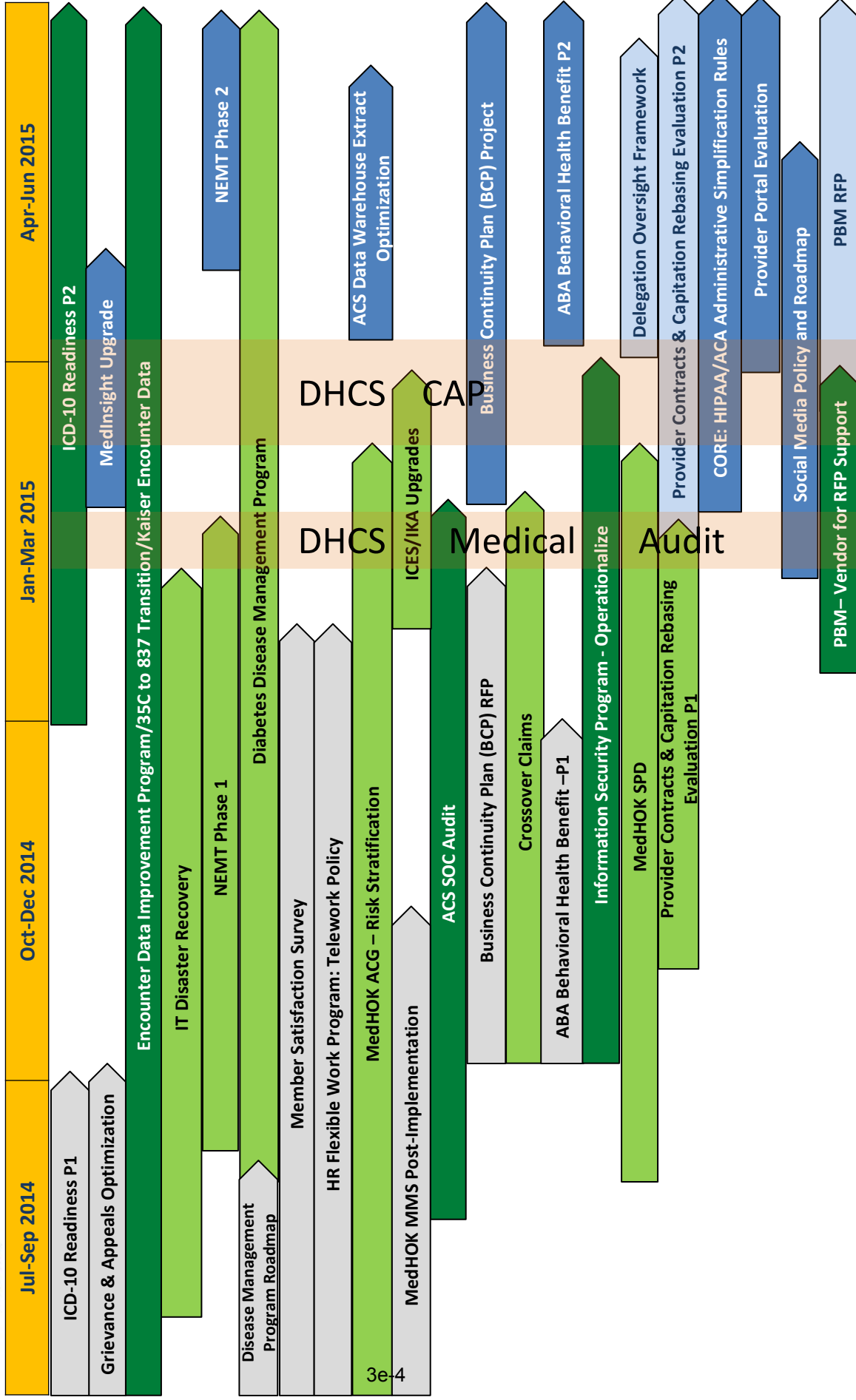
LEGEND:

GREEN- Active Projects (Lighter GREEN reflects Project Extensions)

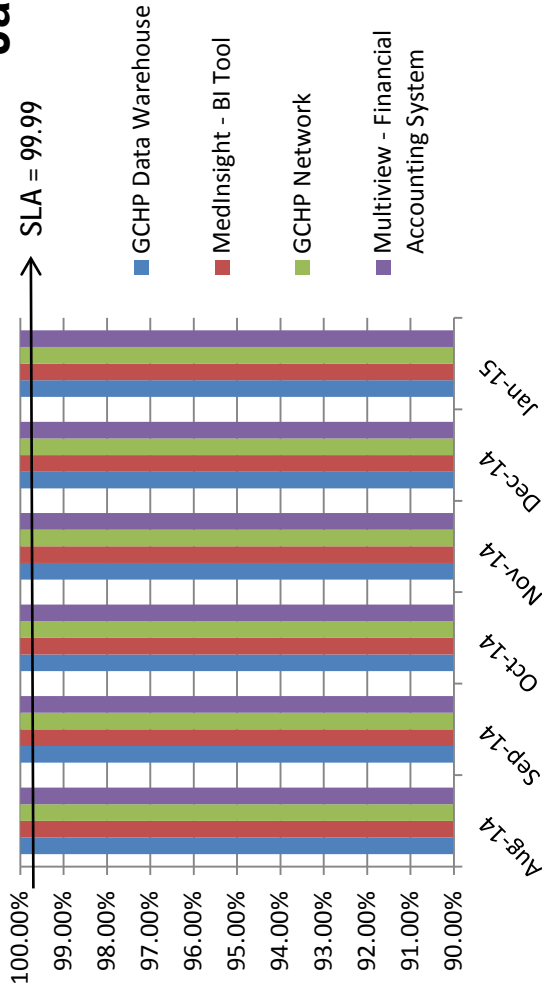
BLUE –Approved FY14/15 Projects

Dark BLUE-Delayed Start

GREY-Closed



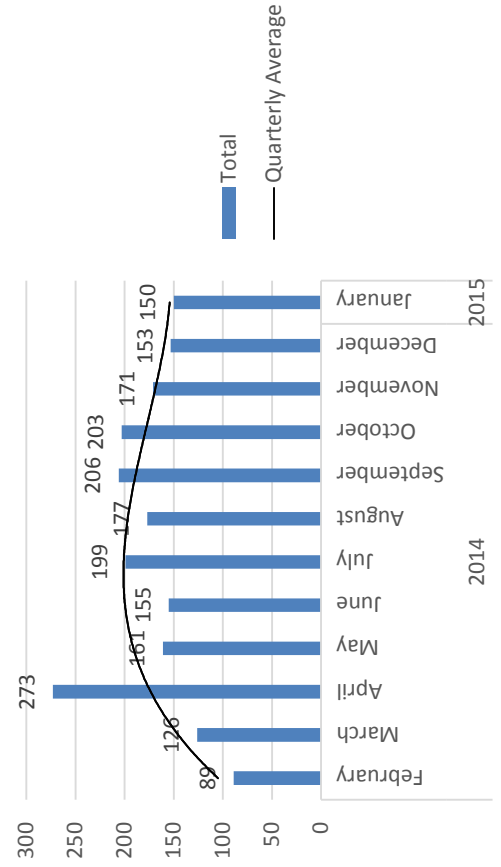
GCHP IT Metrics – January 2015



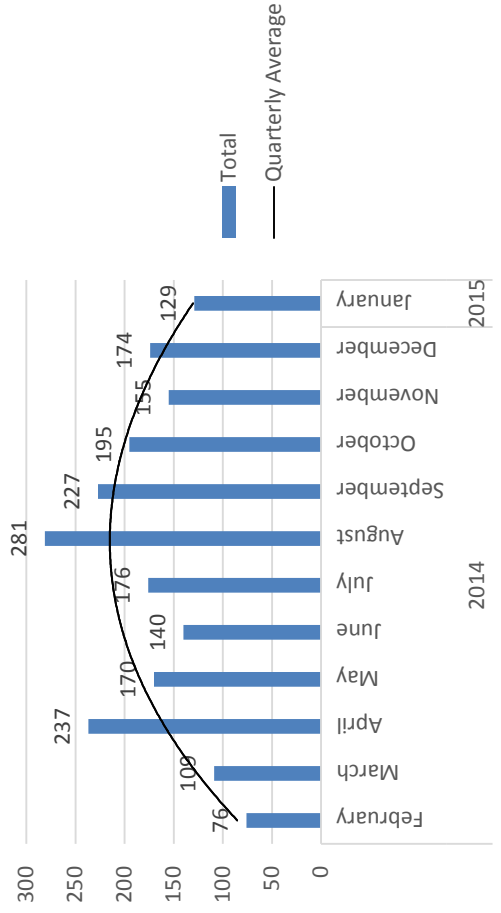
3e-5

GCHP Helpdesk Service Ticket Trending

Total Tickets Entered per Month



Total Tickets Closed per Month



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AGENDA ITEM 3f

To: Gold Coast Health Plan Commission

From: Dr. Nancy Wharfield, Associate Chief Medical Officer

Date: February 23, 2015

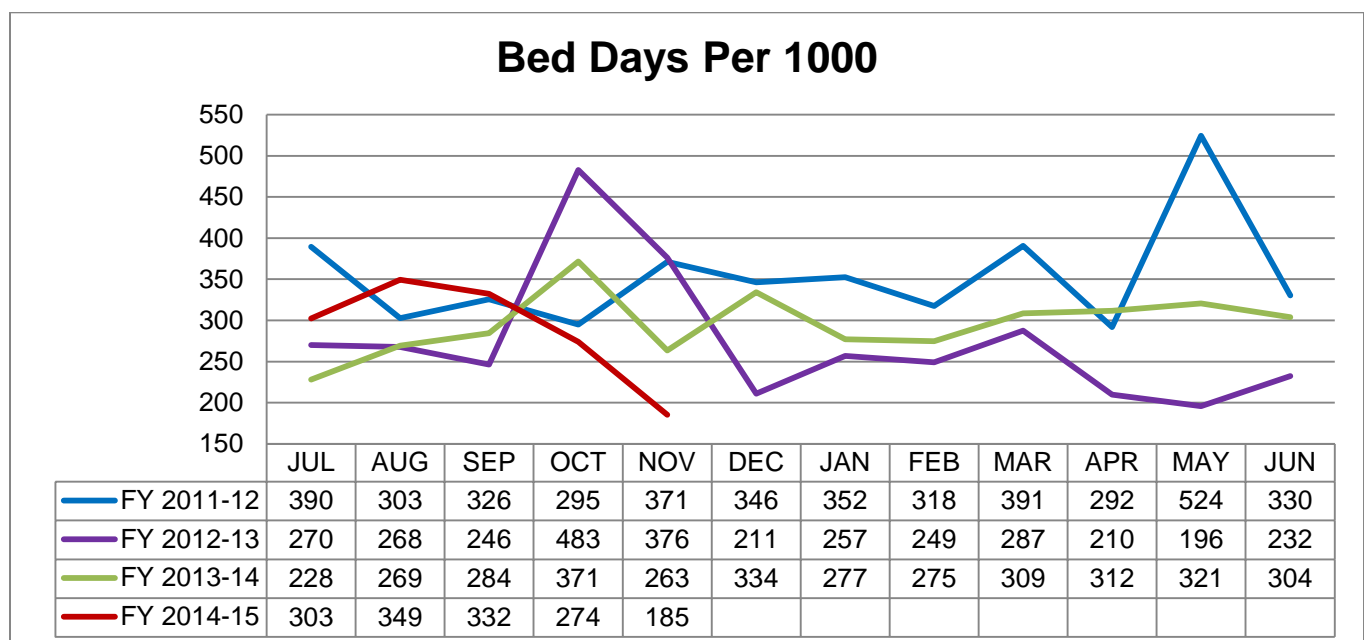
Re: Health Services Update

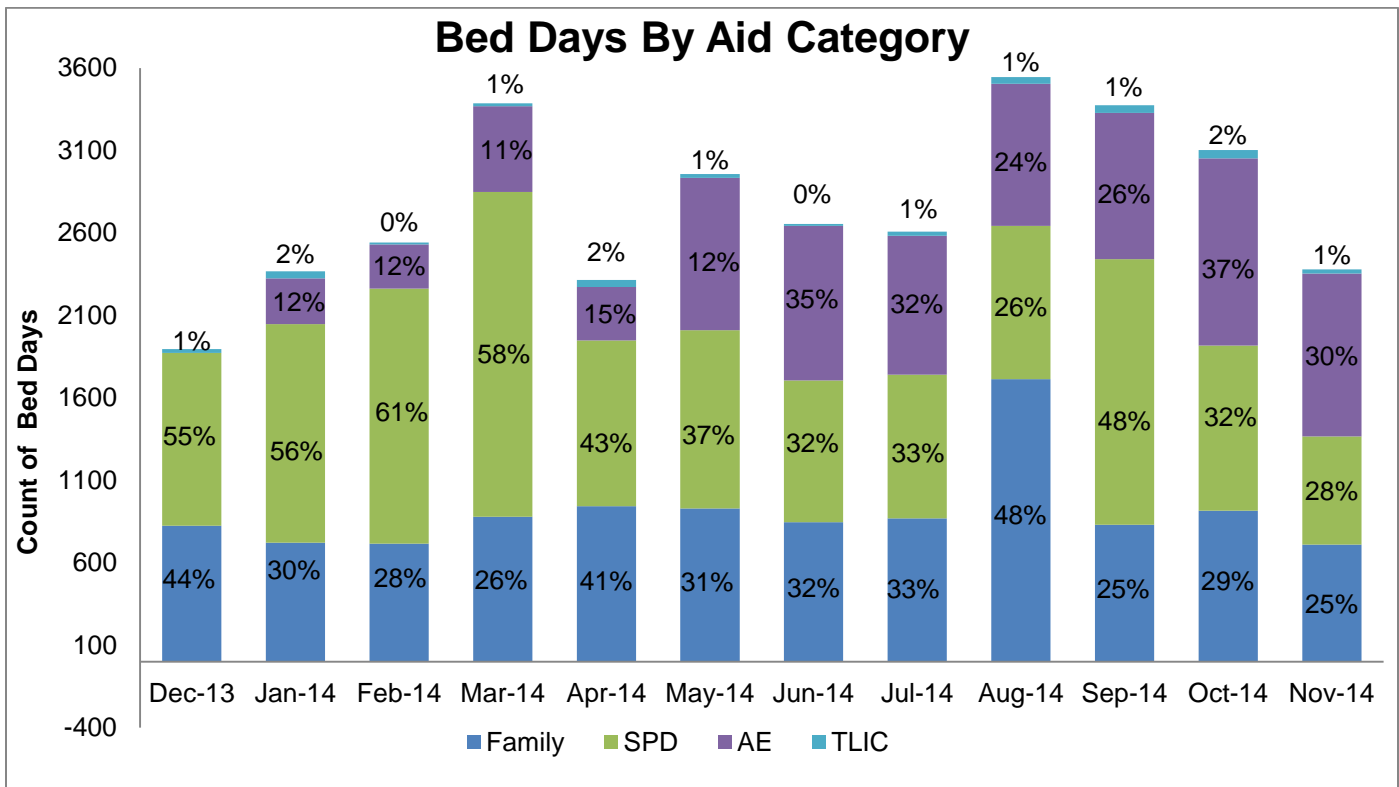
Utilization data in the Health Services monthly update to the Commission is based on paid claims compiled by date of service and is lagged by 3 months to allow for partial run out of claims data. Claims data is complete at approximately 6 months. While incomplete, a 3 month lagged snapshot allows us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

Inpatient Utilization

Bed days/1000 members for FY 2014-15 declined from summer to fall. Adult Expansion members showed a slightly higher percentage of bed days than SPD and Family aid code groups.

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

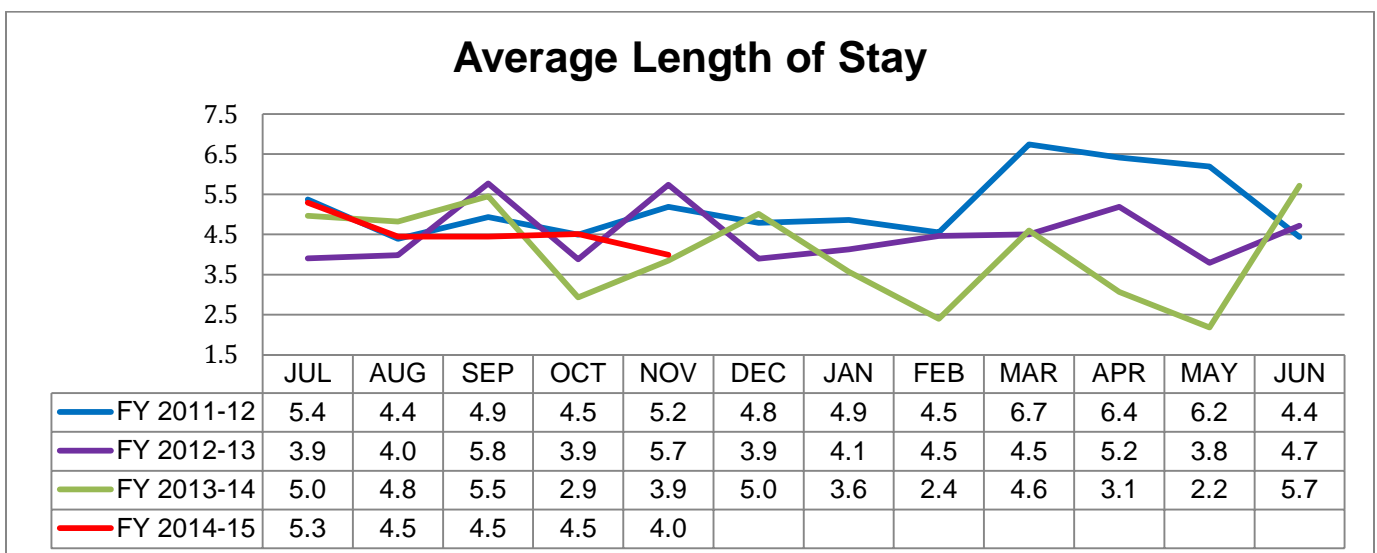




Average Length of Stay

Average length of stay for FY 2014-15 year to date is the same as FY 2013-14 (4.6).

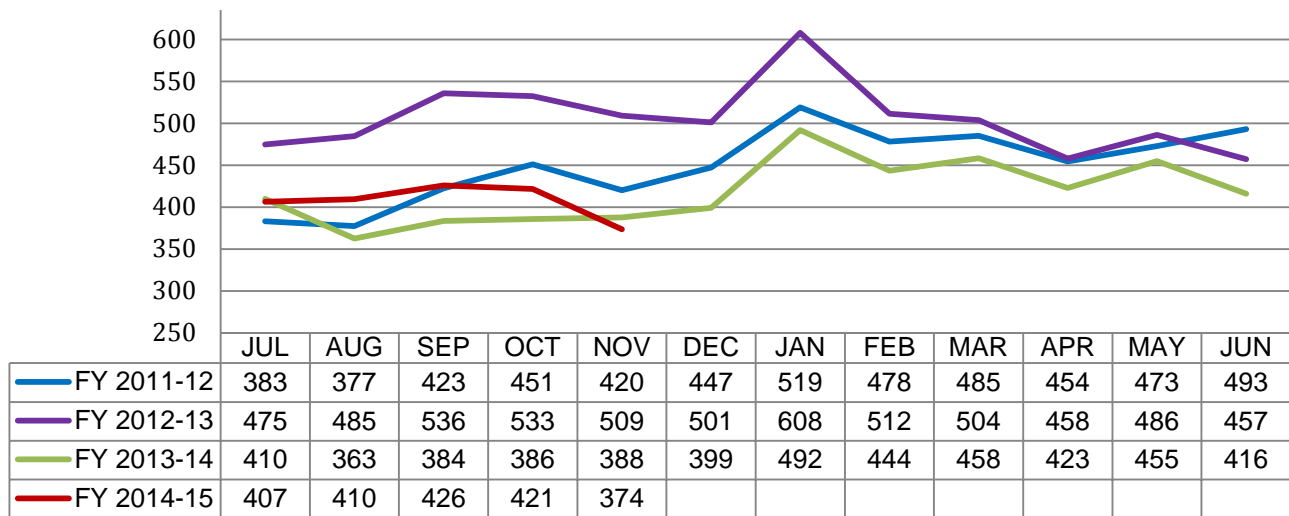
Benchmark: Average length of stay from available published data from other managed care plans range from 3.6 – 4.7. There is variability in reporting of Administrative days among managed care plans.



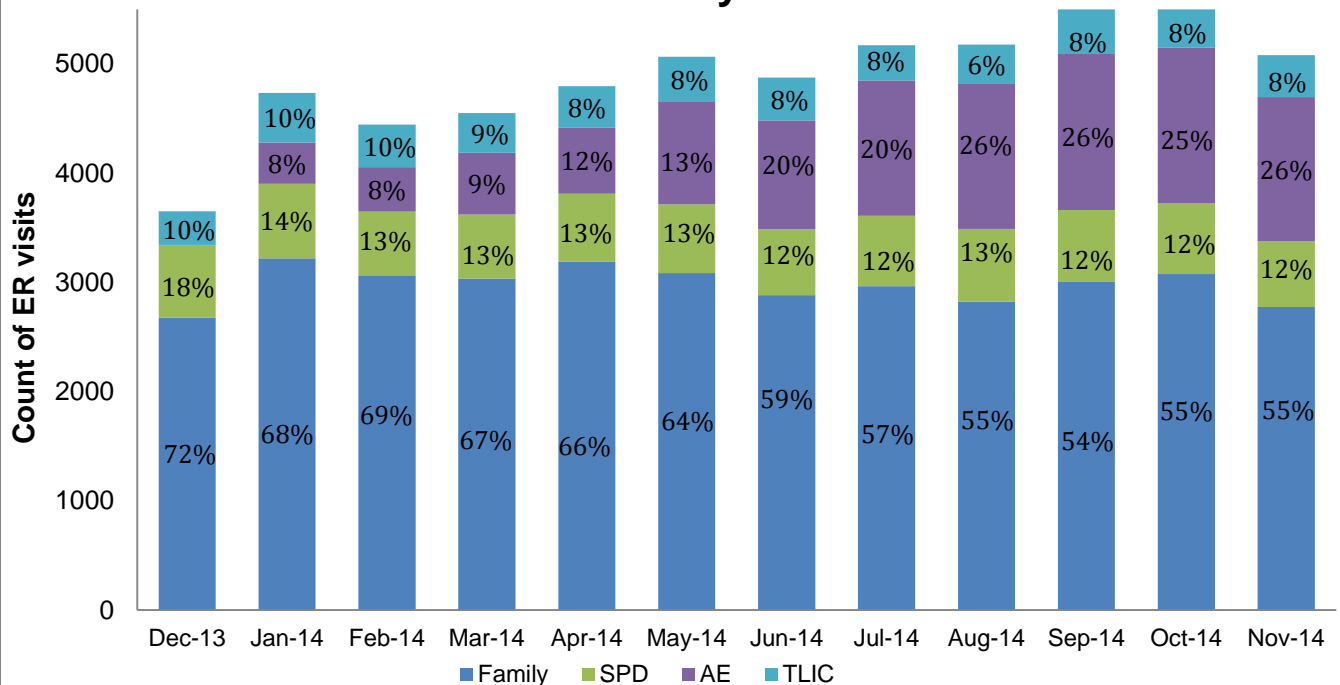
ER Utilization

ER utilization for FY 2014-15 averages just over 400 (407) and is slightly higher than the average for the same period in FY 2013-14 (387). The highest percentage of ER utilization is by Family aid code group members followed by the AE group.

ER Utilization Per 1000



ER Utilization by Aid Code



Authorization Requests

Requests for outpatient service continue to outnumber requests for inpatient service. The rise in requests for outpatient service has declined and has remained at 200/1000 members or below for November 2014 through January 2015. Requests for inpatient service have reached a plateau between 50 – 75 requests/1000 members since May 2014.

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

