Gold Coast Health Plan℠
A Public Entity

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

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

Monday, August 24, 2015
3:00 PM

AMENDED AGENDA

CALL TO ORDER / ROLL CALL

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

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

1. APPROVE MINUTES

a. Regular Meeting of June 22, 2015

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

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

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

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba
Gold Coast Health Plan August 24, 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 PM

2. APPROVAL ITEMS

a. Department of Health Care Services (DHCS) Contract Amendments A17 and A19
b. Quality Improvement Committee Report – 2nd Quarter 2015
c. Authorization to Begin Process to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT)

3. ACCEPT AND FILE ITEMS

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

4. INFORMATIONAL ITEMS

a. Special Investigation Update

CLOSED SESSION

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

b. **Conference With Legal Counsel** – Anticipated Litigation
Significant Exposure to Litigation Pursuant to Paragraph (2) of Subdivision (d) of Section 54956.9
Number of Cases: Unknown

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

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba
Gold Coast Health Plan August 24, 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 PM

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on September 28, 2015 at County of Ventura Government Center - Hall of Administration - Lower Plaza Assembly Room, 800 S. Victoria Avenue, Ventura, CA 93009

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

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Commission Meeting Minutes
June 22, 2015
(Not official until approved)

CALL TO ORDER

Chair Araujo called the meeting to order at 3:03 p.m. Hall of Justice - Pacific Conference Room at the County of Ventura Government Center, 800 S. Victoria Avenue, Ventura, CA 93009.

The Pledge of Allegiance was recited.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE
Antonio Alatorre, Clinicas del Camino Real, Inc.
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Lanyard Dial, MD, Ventura County Medical Association
Barry Fisher, Ventura County Health Care Agency (arrived at 3:36 p.m.)
Peter Foy, Ventura County Board of Supervisors
David Glyer, Private Hospitals / Healthcare System
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Darren Lee, Private Hospitals / Healthcare System
Dee Pupa, Ventura County Health Care Agency

EXCUSED / ABSENT COMMISSION MEMBERS
Gagan Pawar, MD, Clinicas del Camino Real, Inc.
Vacant, Medi-Cal Beneficiary Advocate

STAFF IN ATTENDANCE
Dale Villani, Chief Executive Officer
Lyndon Turner, Financial Analysis Director
Traci R. McGinley, Clerk of the Board
Scott Campbell, Legal Counsel
Brandy Armenta, Compliance Director
William Freeman, Network Operations Director
Anne Freese, Pharmacy Director
Steven Lalich, Communications Director
Tami Lewis, Operations Director
Allen Maithel, Controller
Kim Osajda, Quality Improvement Director
Al Reeves, MD, Chief Medical Officer
Cathy Salenko, Legal Counsel
Melissa Scrymgeour, Chief Information Officer

Ruth Watson, Chief Operations Officer
Nancy Wharfield, MD, Associate Chief Medical Officer

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of May 18, 2015

Commissioner Foy moved to approve the Regular Meeting Minutes of May 18, 2015. Commissioner Glyer seconded. The motion carried with the following votes:

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

2. CONSENT ITEMS

a. CFO Update – April Financials

Financial Analysis Director Turner advised the Commission that McGladrey, LLP has been re-engaged to complete the FY 2013-14 audit and briefly reviewed the financials.

Commissioner Fisher arrived.

Commissioner Lee moved to approve the CFO Update - April Financials. Commissioner Pupa seconded. The motion carried with the following votes:

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

3. APPROVAL ITEMS

a. Department of Health Care Services (DHCS) Contract Amendment A16

CEO Villani provided an overview of Amendment A16 which adjusts the second half of FY 2013-14 capitation rates to provide funding for the Hospital Quality Assurance Fee (HQAF) distributions required by SB 239. These funds are a pass-through to hospitals that meet the requirements and there is no expected fiscal impact on the Plan.

Commissioner Fisher moved to authorize the CEO to executive DHCS Contract Amendment A16. Commissioner Pupa seconded. The motion carried with the following votes:

AYE:	Alatorre, Araujo, Dial, Fisher, Foy, Glyer, Laba, Lee and Pupa.

NAY: None.
ABSTAIN: None.
ABSENT: Pawar.

b. FY 2015-16 GCHP Operating and Capital Budget

Financial Analysis Director Turner provided an update to the Commission on the California Children's Services (CCS) program "Whole-Child Model" is only being implemented in specified counties at this time and Ventura has not been included.

Financial Analysis Director Turner continued, briefly reviewed the budget presentation and highlighted the following areas: Knox Keene licensing will most likely be required and will have to be budgeted once it has been confirmed. Staff had assumed the Adult Expansion (AE) rates would be reduced 15% every six months, it has now been reduced 23% for the entire year, which comes out to virtually the same. The budget includes $7 million for the Quality Initiatives or Pay-for-Performance and $5.2 million for the reinsurance policy.

Commissioner Foy asked when the Plan anticipated paying the County back on the Lines of Credit (LOCs). Financial Analysis Director Turner explained that the Plan has notified the State that it has reengaged McGladrey to complete the FY 2013-14 audit and asked to move the repayment forward, but has not received a response from the State. CEO Villani added that the Commissioners will be updated as soon as the Plan hears from the State.

Discussion was held regarding the in-patient and out-patient expenses. COO Watson explained that the Plan is trying to determine incentives that will encourage facilities to take Medi-Cal patients that no longer need to be in a regular hospital but still need care.

Commissioner Dial moved to adopt the FY 2015-16 GCHP Operating and Capital Budget. Commissioner Foy seconded. The motion carried with the following votes:

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

c. Reinsurance

COO Watson advised the Commission that the existing carrier declined to submit a quote. In reviewing the available options, an Aggregating Specific Deductible (ASD) policy appears to be the best option for the Plan. GCHP would only pay a portion of the total premium, approximately $1.47 per-member per-month (pmpm) or $3 million and holdback $23 million or $0.96 pmpm. As each claim exceeds the $650,000 deductible GCHP would allocate that expense out of that $0.96 fund, when or if that fund is exhausted the carrier picks up everything above that; however, GCHP would keep what was remaining in the fund if it had not been exhausted.

In response to questions from the Commission regarding StarLine, COO Watson explained that StarLine's price was competitive, they have been in business longer than the others, they are A rated, have good claim turn-around time and very good underwriting programs. StarLine also has the most liberal experience refund on the pay rate; they offer a claim run-in, the policy is 12 months, and each year GCHP were to renew the policy, it can carry forward the month of June into the next policy year on any claim for any member that has not yet reached the deductible. StarLine would have the option to rerate the Plan should membership increase more than 25% above the projected growth of 205,000-210,000.

Commissioner Dial moved to approve the StarLine ASD proposal. Commissioner Fisher seconded. The motion carried with the following vote:

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

d. Executive Liability and Errors & Omissions Insurance

COO Watson reviewed the options and explained that when the new legal counsel came on board they reviewed all of the insurance policy levels and suggested that this insurance be increased, it is currently only $3 million. The Plan requested quotes for $20 million, but the insurance companies will only go as high as $10 million.

Commissioner Dial moved to approve AIG / Argo for the Executive Liability policy and the AIG / Lexington for the Managed Care Errors & Omissions policy. Commissioner Fisher seconded. The motion carried with the following vote:

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

4. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Villani reported that the Plan is hopeful to have a new CFO on board by the end of July once the background check is complete.

The Plan has engaged Milliman as the consultant for the Pharmacy Benefits Manager (PBM) Request for Proposal (RFP). The RFP should be released in July and staff hopes to come to the Commission in November to award the contract.

In response to Chair Araujo, Pharmacy Director Freese confirmed that the Plan has received quite a bit of interest from other PBMs.

CEO Villani advised the Commission that a detailed report in response to the Special Investigation will be brought to the Commission in August. He added that the Plan has already put much tighter procurement procedures in place and additional training is being provided to staff.

CEO Villani noted that before the Department of Health Care Services (DHCS) will consider lifting the Corrective Action Plan (CAP), they want to see that the Plan has several years of sustained financial viability and specialty contracts have additional requirements.

Discussion was held regarding Knox Keene licensing and the costs. COO Watson explained that there would be significant staff time and would likely cost up to $1 million. She added that it would be similar to becoming accredited by the National Committee for Quality Assurance (NCQA), should the Plan decide to do that as well.

b. COO Update

COO Watson presented her report highlighting the enhanced capitation for the AE population. It will most likely be audited by the State and significant documentation supporting the program is critical. She added that the County was able to provide substantial documentation and has received their enhanced capitation. One provider has declined to participate and the Plan is now reaching out to other providers.

Commissioner Alatorre asked if the policy was the same as when it was previously provided to the Executive / Finance Committee. COO Watson explained that it was essentially the same, but is going before the Policy Review Committee and additional services are being addressed.

Commissioner Alatorre asked about the possibility of the funds having to be returned. COO Watson confirmed that GCHP has been very conservative because DHCS could audit the program and request that the funds be returned.

COO Watson noted that the Plan recently received five applications for the Provider Advisory Commission (PAC) which will be brought to the next Commission Meeting for appointment. The PAC has not met since February 2013 because the Plan was unable to obtain significant applications for the committee to have a quorum.

COO Watson concluded her report stating that membership is anticipated at 205,000 by the end of the year.

c. Health Services Update

Associate Chief Medical Officer, Dr. Wharfield, reviewed her report.

Commissioner Dial added that the Medical Advisory Board reviewed the ER visits and one member went to the ER 25-26 times per month. .He noted the Plan was making a huge effort working with local community resources to affect change. CMO Dr. Reeves reported that the ER visits have not been eliminated, but staff was able to get the visits down and that member only went to ER 3-4 times this month.

Associate Chief Medical Officer, Dr. Wharfield, noted that staff believes a large part of utilization issues are driven by either pain or mental health issues.

Chair Araujo noted that utilization seems to be driven a great deal by families as well and asked it was due to access issues. Associate Chief Medical Officer, Dr. Wharfield, responded that it is sometimes an issue with access to the PCP, but often the family may only be able to get one appointment, but multiple members of the family are ill so they utilize urgent care.

Commissioner Lee moved to accept and file the CEO, COO and Health Services Updates. Commissioner Dial seconded. The motion carried with the following votes:

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

COMMENTS FROM COMMISSIONERS

The Commissioners welcomed the new CEO Dale Villani and thanked Ruth Watson for the smooth transition.

ADJOURNMENT

Meeting adjourned at 4:39 p.m.

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AGENDA ITEM 2.a.

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, CEO

DATE: August 24, 2015

RE: Department of Health Care Services (DHCS) Contract Amendments A17 and A19

SUMMARY:

Amendment A17 - DHCS establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A17 reflects expected changes to Gold Coast Health Plan (GCHP or Plan) capitation rates for FY 2013-14.

Amendment A19 - DHCS issued a new contract amendment to Gold Coast Health Plan which incorporates the Senior and Persons with Disabilities (SPD) requirements. The SPD population has always been a population the Plan has served. The amendment outlines additional reporting requirements the Plan is responsible for reporting to DHCS on a routine basis. The Commission previously approved the SPD amendment; however it was voided by DHCS as a result of CMS review. The amendment has a newly issued amendment number and reflects the minor edits CMS requested. In addition DHCS made additional non-substantive changes which are consistent with the other COHS Plans.

BACKGROUND / DISCUSSION:

GCHP received the following contract amendments from DHCS:

- A17 - The amendment adjusts the FY 2013-14 rates to include the Intergovernmental Transfer (IGT).
- A19 - The amendment outlines additional Senior and Persons with Disabilities (SPD) reporting requirements

FISCAL IMPACT:

A17 - The revised Amendment A17 reflects increased capitation rates for the pending FY 2013-14 IGT. Once the IGT has been approved by the Centers of Medicare and Medicaid Services, the Plan will acknowledge the approximate $297,000 as revenue.

A19 - The revised Amendment A19 has no fiscal impact.

RECOMMENDATION:

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendments A17 and A19.

CONCURRENCE:

N/A

Attachments:

None

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Quality Improvement Committee Report

2nd Quarter 2015

C. Albert Reeves, MD, CMO

www.goldcoasthealthplan.org

Gold Coast Health Plan Full Scope Medicaid
HEDIS 2012 - 2013 - 2014 Rates Comparison iwth DHCS MPL

Type of Measure	HEDIS Measures and Sub-Measures	2012 Measurement Year			2013 Measurement Year			Rate Changes 2012 - 2013	2014 Measurement Year			Rate Changes 2013 - 2014
		2012 GCHP Rate	2012 Percentile	2012 DHCS MPL	2013 GCHP Rate	2013 Percentile	2013 DHCS MPL		2014 GCHP Rate	2014 Percentile	2014 DHCS MPL	
	Effectiveness of Care: Prevention and Screening Measures											
Hybrid	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**											
	BMI Percentile	42.09	25th	29.20	43.80	25th	37.96	1.71	80.05	75th	41.85	36.25
	Counseling for Nutrition	42.09	10th	42.82	43.31	10th	45.45	1.22	54.26	25th	50.00	10.95
	Counseling for Physical Activity	30.41	10th	31.63	28.71	10th	34.55	-1.70	41.85	25th	41.67	13.14
Hybrid	**Childhood Immunization Status**											
	DTaP	85.64	75th	75.74	81.27	25th	77.08	-4.37	78.59	25th	76.16	-2.68
	IPV	96.11	90th	88.19	95.13	75th	89.29	-0.98	92.65	50th	89.06	-2.48
	MMR	95.86	90th	88.81	94.89	75th	89.81	-0.97	92.65	50th	88.89	-2.24
	HiB	94.89	75th	88.86	94.89	75th	90.27	0.00	92.97	50th	89.05	-1.92
	Hepatitis B	94.89	75th	86.86	93.43	50th	87.22	-1.46	90.73	50th	86.34	-2.70
	VZV	96.35	90th	88.56	94.65	75th	89.54	-1.70	92.97	50th	88.43	-1.68
	Pneumococcal Conjugate	87.10	75th	74.94	85.16	75th	76.16	-1.94	81.15	50th	75.97	-4.01
	Combination #3	80.05	75th	64.72	75.43	50th	66.08	-4.62	69.97	25th	66.67	-5.46
Hybrid	**Immunizations for Adolescents**											
	Meningococcal	65.94	50th	53.04	63.26	25th	60.34	-2.68	68.86	25th	63.58	5.60
	Tdap/Td	84.67	50th	70.60	78.35	25th	76.66	-6.32	80.00	25th	79.86	1.65
	Combination #1	65.21	50th	50.36	60.34	25th	58.06	-4.87	63.80	25th	61.70	3.46
Hybrid	**Cervical Cancer Screening**	57.66	10th	61.81	60.58	25th	58.99	2.92	61.77	25th	54.50	1.19
	Effectiveness of Care: Respiratory Conditions Measures											
Admin	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis**	13.87	<10th	18.98	18.24	25th	17.92	4.37	21.15	25th	20.20	2.91
Admin	**Medication Management for People With Asthma** *(NR= Not Reported - Requires 2 years continuous enrollment)*											
	Medication Compliance 50% Total	NR	NA	NA	48.92	25th	44.83	NA	54.16	50th	47.88	5.24
	Medication Compliance 75% Total	NR	NA	NA	28.03	50th	22.17	NA	31.79	50th	24.55	3.76
	Effectiveness of Care: Cardiovascular Measures											
Hybrid	**Controlling High Blood Pressure**	61.56	50th	50.00	54.01	50th	50.00	-7.55	55.01	25th	48.53	1.00
	Effectiveness of Care: Diabetes Measures											
Hybrid	**Comprehensive Diabetes Care**											
	Hemoglobin A1c (HbA1c) Testing	81.75	25th	78.54	85.16	50th	79.23	3.41	90.51	75th	80.18	5.35
	**HbA1c Poor Control (>9.0%)*	56.20	10th	50.31	45.50	50th	52.58	-10.70	32.85	75th	53.76	-12.65
	HbA1c Control (<8.0%)	37.96	10th	42.09	45.50	25th	39.80	7.54	57.91	75th	38.20	12.41
	Eye Exam (Retinal) Performed	42.58	10th	45.03	45.74	25th	44.37	3.16	60.10	50th	46.25	14.36
	LDL-C Screening Performed	78.83	50th	70.34	79.56	50th	71.03	0.73	LDL NR*	NA	NA	N/A
	LDL-C Control (<100 mg/dL)	33.58	25th	28.47	28.47	25th	27.90	-5.11	LDL NR*	NA	NA	N/A
	Medical Attention for Nephropathy	79.81	50th	73.48	78.10	25th	75.00	-1.71	83.70	75th	75.67	5.60
	Blood Pressure Control (<140/90 mm Hg)	62.29	25th	54.48	61.31	50th	53.74	-0.98	63.75	50th	53.28	2.44

Gold Coast Health Plan Full Scope Medicaid
HEDIS 2012 - 2013 - 2014 Rates Comparison iwth DHCS MPL

Type of Measure	HEDIS Measures and Sub-Measures	2012 Measurement Year			2013 Measurement Year			Rate Changes 2012 - 2013	2014 Measurement Year			Rate Changes 2013 - 2014
		2012 GCHP Rate	2012 Percentile	2012 DHCS MPL	2013 GCHP Rate	2013 Percentile	2013 DHCS MPL		2014 GCHP Rate	2014 Percentile	2014 DHCS MPL	
	Effectiveness of Care: Musculoskeletal Measures											
Admin	Use of Imaging Studies for Low Back Pain	76.95	50th	72.04	77.07	50th	71.52	0.12	75.71	50th	72.15	-1.36
	Effectiveness of Care: Medication Management Measures											
Admin	Annual Monitoring for Patients on Persistent Medications											
	ACE Inhibitors or ARBs	86.73	25th	83.72	88.47	50th	84.58	1.74	82.14	<10th	85.76	-6.33
	Digoxin	88.46	25th	87.93	93.33	75th	87.50	4.87	56.25	<10th	88.89	-37.08
	Diuretics	86.28	25th	83.19	89.51	75th	83.76	3.23	83.27	10th	85.69	-6.24
	Total	82.47	25th	81.16	88.94	50th	82.41	6.47	82.30	10th	84.38	-6.64
	Access/Availability of Care Measures											
Admin	Children and Adolescents' Access to Primary Care Practitioners											
	12-24 Months	82.51	<10th	95.56	97.37	50th	95.51	14.86	95.42	10th	95.92	-1.95
	25 Months - 6 Years	63.09	<10th	86.62	86.27	10th	86.37	23.18	83.12	10th	86.07	-3.15
	7-11 Years	CAP NR*	NA	NA	82.26	<10th	87.77	NA	83.31	<10th	87.78	1.05
	12-19 Years	CAP NR*	NA	NA	79.18	<10th	86.09	NA	82.01	10th	85.83	2.83
Hybrid	Prenatal and Postpartum Care							0.00				
	Timeliness of Prenatal Care	80.78	25th	80.54	83.94	25th	79.85	3.16	85.68	50th	77.80	1.74
	Postpartum Care	63.99	25th	58.70	59.37	25th	57.91	-4.62	62.81	25th	56.18	3.44
	Utilization Measures											
Hybrid	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	61.80	10th	65.51	64.23	10th	67.40	2.43	67.11	25th	65.97	2.88
Admin	Ambulatory Care											
	Outpatient Visits/1000	317.16	AMB NA*	AMB NA*	205.78	AMB NA*	AMB NA*	-111.38	209.28	AMB NA*	AMB NA*	3.50
	ED Visits/1000	49.21	AMB NA*	AMB NA*	38.12	AMB NA*	AMB NA*	-11.09	39.21	AMB NA*	AMB NA*	1.09
	State Mandated Performance Improvement Project											
Admin	All Cause Readmission	19.17	NA	NA	13.08	NA	NA	-6.09	17.87	NA	NA	4.79

- Hybrid measures are based on a 411 sample size, of the entire eligible population for the measure, and require reviewing administrative data (claims/encounter & supplemental data) and medical records to measure performance.
- Administrative measures are based on the entire eligible population for the measure and require reviewing only administrative data (claims/encounter and supplemental data) to measure performance.
- LDL NR = the Low Density Lipoprotein sub-measures within the Comprehensive Diabetes Care measure were not reported in 2015, for the 2014 measurement year, because NCQA retired these LDL measures in 2014.
- CAP NR = The age groups 7-11 years and 12-19 years for the CAP measure were not reported in 2013, for the 2012 measurement year, because these sub-measures require two-years continuous. For the 2012 measurement year, the health plan's retrospective clinical data dated back only 18 months to July 2011.
- AMB NA = DHCS does not apply MPLs to Ambulatory Care measures.
- *HbA1c Poor Control (>9.0%) rate - a lower rate indicates better performance.

HEDIS 2014 Results

The 2014 HEDIS Survey has again shown significant improvement over the results of 2012 and 2013.

- This was particularly seen in the care of our diabetic members where we moved from the 10th percentile to the 75th percentile compared to other Medicaid Plans
- There was improvement in counseling for Nutrition and Physical Activity and Well-Child Visits in the 3rd, 4th, 5th and 6th years of life to avoid a formal corrective action plan with DHCS

HEDIS

Measures that remained below the 25th percentile included access to care of children 12 mo. to 19 years.

Improvement Plans:

- Member incentive to give $25 gift cards in a raffle to members and families who have a doctor visit in 2015
- Identify members not seen in the first 6 mo. and notify the providers that the member needs a visit
- Meet with provider groups to educate them

16

HEDIS

Measures that declined to below the 25th percentile – annual monitoring for patients on Persistent Medications

Improvement Plan:

- Evaluate the non-compliant cases – members not seen, lab tests ordered and member not compliant, tests ordered at rate over 1 yr., large number of adult expansion members not compliant
- Educate providers and members
- Identify non-compliant members in the last half of the year and notify providers and members to get the tests

HEDIS

Other ongoing HEDIS Improvement Projects:

- Diabetic Eye Exam Member Incentive
- Cervical Cancer Screening
  - non-compliant patients identified
  - notification to members and providers
- New Post Partum Member Incentive Program
- Mid-year data run of all HEDIS measures to identify non-compliant members

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Quality Improvement Projects

1. Diabetic Retinal Eye Exam QIP
    - Submitted to DHCS and approved

2. All Cause Readmission QIP
    - Revised 3 month Readmission QIP with CMH
    - Admitted high-risk members
    - Identified medication disruption and homelessness as the main causes of readmission
    - Reported to HSAG and approved
    - Project was moved to patients admitted to VCMC

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Quality Improvement Activities

Facility Site Reviews – Monitoring for Non-Compliant Providers

- GCHP is required to monitor providers for the adequacy of their offices and medical records.
- 1 practice has been intermittently non-compliant since 2013. Corrective Action Plans (CAPS) were developed.
- On April 10, 2015 a review was done and the FSR component was passed; however, there remained non-compliance with the medical record review (MRR).
- A corrective action plan was issued.
- The monitoring nurse has worked closely with this practice to keep it in the network and will resurvey in the early part of the 3rd quarter 2015.

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Quality Improvement Activities

Other Identified Quality Issues:

- Access for a specialty service identified through a grievance resulted in a member survey which verified significant delays in member access
- This was shared with the clinic administration and additional providers are being added to the clinic staff.

Quality Improvement Activities

Potential Quality Issues (PQI) Reviews

- 34 cases total to date (2nd Q)
- Cases referred from:
  - Associate Medical Director - 2
  - Health Services – 19
  - Health Education – 0
  - Grievance and Appeals – 9
  - Utilization Management – 2
  - Other - 2

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Quality Improvement Dashboard

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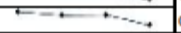
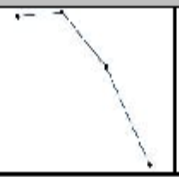
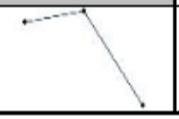
Gold Coast Health Plan HEDIS Measures -- *Quality of Care Indicators*

Legend:

Dark Green = Performance >P90 Percentile

Yellow = **Performance ≤ P50 Percentile**

Red = Performance < P25 Percentile

Measure	Description	Responsible Department	Benchmark Source	2012[1] Rate	2013[2] Rate	2014[3] Rate	P10	P25 (MPL)	P50	P75	P90 (HPL)	2015[4] Q1	Annual Trend 2012 - 2014 (Hybrid) 2012 - 2015 (Admin)	Interventions
(AAB) Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis														
AAB (Bronchitis)	The percentage of adults 18-64 years old with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or within three days after the episode start date.	Quality Improvement	HEDIS	13.87	**18.24**	**21.15**	16.87	20.20	24.33	30.45	38.66	21.83		
(AMB) Ambulatory Care														
Outpatient Visits	This measure summarizes utilization of ambulatory care.	Quality Improvement	HEDIS	317.16	**205.78**	**209.28**	259.17	314.03	353.84	404.90	467.26	40.89		Currently analyzing data.
ED Visits				49.21	**38.12**	**39.21**	39.40	52.33	64.04	74.00	82.27	10.91		
(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	**97.37**	**95.42**	93.58	95.92	96.96	97.86	98.53	71.81		Implementing member incentive program. Developing a QIA.
CAP: age 25 months - 6 years				63.09	**86.27**	**83.12**	82.16	86.07	89.08	91.73	93.58	44.89		
CAP: age 7 to 11				NR	**82.26**	**83.31**	83.57	87.78	91.15	93.50	95.19	73.84		
CAP: age 12 to 19				NR	**79.18**	**82.01**	81.57	85.83	89.98	92.17	94.42	71.75		
(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	**77.07**	**75.71**	68.22	72.15	75.29	78.57	84.03	73.25		
(MMA) Medication Management for People with Asthma														
Medication Compliance 50%: 51-64	The percentage of member 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment.	Quality Improvement	HEDIS	NR	NR	NR						NR		
Medication Compliance 50%: Total				NR	**48.92**	54.16	43.59	47.88	54.07	58.94	66.96	0.00		
Medication Compliance 75%: 51-64				NR	NR	NR						NR		
Medication Compliance 75%: Total				NR	**28.03**	31.79	20.07	24.55	30.19	35.37	43.08	0.00		

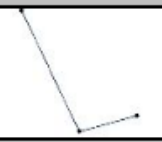
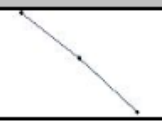
Gold Coast Health Plan HEDIS Measures -- *Quality of Care Indicators*

Legend:

Dark Green = Performance > P90 Percentile

Yellow = **Performance ≤ P50 Percentile**

Red = Performance < P25 Percentile

Measure	Description	Responsible Department	Benchmark Source	2012[1] Rate	2013[2] Rate	2014[3] Rate	P10	P25 (MPL)	P50	P75	P90 (HPL)	2015[4] Q1	Annual Trend 2012 - 2014 (Hybrid) 2012 - 2015 (Admin)	Interventions
(MPM) Annual Monitoring for Patients on Persistent Medications														
ACE Inhibitors or ARBs	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.	Quality Improvement	HEDIS	86.73	**88.47**	**82.14**	83.18	85.76	88.04	89.97	92.01	35.90		Currently analyzing data and developing a QIA.
Digoxin				88.46	**93.33**	**56.25**	86.44	88.89	91.98	94.33	95.65	0.00		
Diuretics				86.28	**89.51**	**83.27**	82.75	85.69	87.91	90.58	92.07	60.00		
(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	**60.58**	**61.77**	45.88	54.50	64.34	71.30	75.96			QI sent reminder letters to non-Compliant members and their Providers, asking them to schedule an appointment for the service.
(CBP) Controlling High Blood Pressure														
CBP	The percentage of members that that were 18-85 years of age with a dx of hypertension and adequately controlled BP (<140/90) during the measurement year.	Quality Improvement	HEDIS	61.56	**54.01**	**55.01**	43.07	48.53	56.20	63.76	69.79			Developing a QIA.
(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	**85.16**	**90.51**	77.55	80.18	83.87	87.59	91.73			
CDC: Poor A1c control (> 9.0%); lower rate is better **(Inverted rate)**				56.20	**45.50**	**32.85**[5]	30.28	36.52	44.77	53.76	60.84			
CDC: Good A1c control (< 8.0%); higher rate is better				37.96	**45.50**	**57.91**	32.60	38.20	46.17	52.89	59.37			
CDC: Diabetic Eye Exam				42.58	**45.74**	**60.10**	37.23	46.25	54.18	63.14	68.04			
CDC: LDL Testing				78.83	**79.56**									
CDC: LDL Control (<100 mg/dL)				33.58	**28.47**									
CDC: Nephropathy Monitoring				79.81	**78.10**	**83.70**	71.43	75.67	80.10	83.11	86.86			
CDC: Blood Pressure (<140/90 mm Hg)				62.29	**61.31**	**63.75**	45.54	53.28	61.31	70.07	75.18			
(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	**75.43**	**69.97**	58.70	66.67	72.33	77.78	80.86			Potentially impacted by member incentive program.

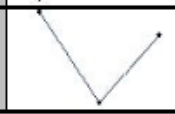
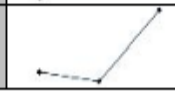
Gold Coast Health Plan HEDIS Measures -- *Quality of Care Indicators*

Legend:

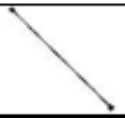
Dark Green = Performance > P90 Percentile

Yellow = **Performance ≤ P50 Percentile**

Red = Performance < P25 Percentile

Measure	Description	Responsible Department	Benchmark Source	2012[1] Rate	2013[2] Rate	2014[3] Rate	P10	P25 (MPL)	P50	P75	P90 (HPL)	2015[4] Q1	Annual Trend 2012 - 2014 (Hybrid) 2012 - 2015 (Admin)	Interventions
(IMA) Immunizations for Adolescents														
IMA	Adolescents who received one meningococcal vaccine on or between the members 11th and 13th birthday and one Tdap or Td on or between the members 10th and 13th birthdays. Combo 1	Quality Improvement	HEDIS	65.21	**60.34**	**63.80**	53.94	61.70	71.29	80.90	86.46			Potentially impacted by member incentive program.
(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	**83.94**	**85.88**	69.77	77.80	84.30	89.62	93.10			
PPC 2: Postpartum Care	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.			63.99	**59.37**	**62.81**	48.37	56.18	62.84	69.47	74.03			Implementing member incentive program. Developing a QIA.
(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	**64.23**	**67.11**	60.18	65.97	71.76	77.26	82.69			Implementing member incentive program. Developing a QIA.
(WCC) Weight Assessment for Children														
WCC: BMI %	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percetile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	Quality Improvement	HEDIS	42.09	**43.80**	**80.05**	32.18	41.85	57.40	73.72	84.46			Developing a QIA.
WCC: Nutrition				42.09	**43.31**	**54.26**	40.74	50.00	60.58	69.21	77.47			
WCC: Physical Activity				30.41	**28.71**	**41.85**	33.77	41.67	51.16	60.82	69.76			

[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] 2014 rates reflect measurement year data from January 1, 2014, through December 31, 2014.
[4] 2015 rates reflect measurement year data from January 1, 2015, through March 31, 2015.
[4] Shaded cells indicate measurements conducted only once annually (Hybrid).
[5] For the CDC-H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.

Quality Improvement							
Legend: **Green = Met or exceeded Benchmark** **Red = Did not meet Benchmark**							
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014***	**2015 Q1**	**Quarterly Trend 2014 - 2015 Q1**	**Interventions**
Facility Site Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS site audit criteria met.	DHCS/ Title 22	80%	**99%**	**81%**		
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%**	**100%**		
Medical Record Quality Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS medical record audit criteria met.	DHCS/ Title 22	80%	**96%**	**72%**		
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%**	**50%**		
Coordination of Care	The overall percentage of applicable DHCS Coordination of Care criteria met as determined by medical record audits.	NA	Tracking	**100%**	**76%**		

*2014 data available for Q2, Q3, and Q4 only. No Initial or Periodic FSR's or MRR's were required during 2014 Q1

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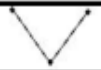
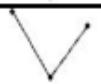
Gold Coast Health Plan DHCS QIP Measures										
Non-HEDIS Measure	Description	Responsible Department	Benchmark Source	Benchmark	2012[1] Rate	2013[2] Rate	2014 Rate	2015 Rate	Annual Trend 2012 - 2013	Interventions
All-Cause Readmissions										
SPD	DHCS Medi-Cal Managed Care Division requires that managed care plans calculate an overall Medi-Cal readmission rate, a readmission rate for the SPD population, and a readmission rate for the non-SPD population and address any disparities identified through barrier analysis with targeted interventions.	Quality Improvement	DHCS	NA	23.16	15.06	22.83			
Non-SPD			DHCS	NA	11.32	9.53	12.80			
Total (SPD and Non SPD)			DHCS	NA	19.17	13.08	17.87			

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Adult

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	2014 Benchmark	2013 HSAG	2014 TMG Mean	2014 TMG Rate	2014 TMG 25th %	2014 TMG 50th %	2014 TMG 75th %	2014 TMG 90th %	Interventions
Overall Rating of Health Plan		2014 TMG Medicaid Child Book of Business Mean and Percentiles	NA	51.2%	58.0%	51.0%	**52.6%**	57.4%	64.7%	66.5%	Monthly member access tracking survey by SPH Analytics. Plan is to conduct Focus groups.
Overall Rating of All Health Care			NA	50.7%	51.1%	49.0%	**48.0%**	50.8%	53.5%	57.7%	
Overall Rating of Personal Doctor			NA	67.9%	64.2%	71.2%	61.8%	62.9%	66.8%	**69.2%**	
Overall Rating of Specialist Seen Most Often			NA	68.8%	65.5%	68.2%	61.9%	**65.3%**	69.1%	71.8%	

Child

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	2014 Benchmark	2013 HSAG	2014 TMG Mean	2014 TMG Rate	2014 TMG 25th %	2014 TMG 50th %	2014 TMG 75th %	2014 TMG 90th %	Interventions
Overall Rating of Health Plan		2014 TMG Medicaid Child Book of Business Mean and Percentiles	NA	58.9	67.7%	60.3%	63.3%	68.0%	72.5%	74.7%	Monthly member access tracking survey by SPH Analytics. Plan is to conduct Focus groups.
Overall Rating of All Health Care			NA	54.6%	65.4%	53.5%	63.1%	65.3%	69.4%	71.0%	
Overall Rating of Personal Doctor			NA	71.0%	72.7%	67.9%	70.6%	73.0%	74.6%	76.8%	
Overall Rating of Specialist Seen Most Often			NA	67.3%	69.3%	68.2%	**65.2%**	68.9%	72.6%	76.2%	

Grievance & Appeals

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

Measure	Description	Compliance Source	Benchmark	2014*	2015 Q1	Quarterly Trend 2014 Q2 - 2015 Q1	Interventions
Resolution Turnaround Times (TAT) Grievances	100% TAT within 30 calendar days	GCHP		**81%**	**42%**		Due to the increase number of grievances we have been unable to maintain the volume of cases. Since then we have hired additional staff to accommodate the backlog.
Post Service TAR Provider Appeals Processing Time - Resolution	The percentage of provider appeals processed within 30 business days from receipt.	GCHP		**100%**	**100%**		
Provider Grievances: Complaint, Appeal, or Inquiry	Timely resolution of provider grievances	GCHP		**NA**	**16%**		Due to the increase number of grievances we have been unable to maintain the volume of cases. Since then we have hired additional staff to accommodate the backlog.
Monitoring of Complaints	Member complaints are monitored at a minimum of every six months to assess for trends/outliers	GCHP	Monitoring	**NA**	**100%**		

*2014 data available for Q2, Q3 and Q4 only.

Pharmacy							
Legend: Green = Met or Exceeded Goal Red = Did Not Meet Goal							
Measure	**Description**	**Responsible Department**	**Compliance Source**	**Benchmark**	**2015 Q1**	**Quarterly Trend**	**Interventions**
PA Accuracy	All prior authorization requests were decided in accordance with GCHP clinical criteria.	Pharmacy	DHCS Contract	100%	98%	*	Weekly meetings with the PBM to clarify criteria and expectations for the decisions. Any approvals that the plan believes should have been denied, will remain and not be overturned. Any denials that the plan believes should have been approved are overturned and the member and physician are made aware of the approval.
PA Timliness	All prior authorization requests were completed within 1 business day.	Pharmacy	DHCS Contract	100%	100%	*	
Appropriate Decision Language on PA	All denied prior authorization requests contained appropriate and specific rationale for the denial	Pharmacy	DHCS Contract	100%	95%	*	GCHP is reviewing the denial language that is sent out and making revisions to the pre-set language as needed; this is an annual exercise and will continue going forward. Existing interventions include a second review of the language for all spelling, punctuation and grammar checks.
Annual Review of all UM Criteria	The P&T committee must review all utilization management criteria at least annually.	Pharmacy	GCHP	Met	NA	*	
Review of New FDA Approved Drugs	The P&T committee must review all new FDA approved drugs and/or all drugs added to the Medi-Cal FFS Contract Drug List.	Pharmacy	DHCS Contract	Met	Met	*	

Medical Advisory Committee: *Audits, Utilization Management and Clinical Support*								
Legend: **Green = Met or Exceeded Benchmark** **Red = Did Not Meet Benchmark**								
Health Services **UM Authorization Processing Time**								
Measure	**Description**	**Responsible Department**	**Benchmark Source**	**Benchmark**	**2014***	**2015 Q1**	**Quarterly Trend 2014 Q3 - 2015 Q1**	**Interventions**
Pre-service Turnaround Request Processing Time	The % of requests processed ≤ 5 working days from receipt of information necessary to make the determination.	Health Services	DHCS/ Title 22	95%	**96%**	**99.59%**		
Concurrent Review	Combined Urgent and Standard	Health Services	DHCS/ Title 22		**NA**	**NA**		
Provider Turnaround Request Denials	Number of denied authorizations divided by total number of authorizations. (Excludes RAFs.)	Health Services	DHCS/ Title 22	Tracking	**NA**	**NA**		
Provider Turnaround Request Denials Overturned	Beginning 1/1/2010 - Number of denials overturned or modified divided by total number of appeals. Includes pre-service & post-service Auth, RAF & MRF appeals.	Health Services	DHCS/ Title 22	Tracking	**NA**	**NA**		
Clinical Utilization Management								
Inter-rater Reliability Analysis	Measurement of the consistency with which UM staff apply criteria/guidelines for determining medical necessity.	Health Services	DHCS/ Title 22	90%	**NA**	**NA**		
UM Criteria & Review								
UM Criteria Revisions	Annual review and adoption of UM criteria that are objective and based on medical evidence.	Health Services	H&S Code 1367.01, 1363.5; Title 22 53860(c)(3); DHCS:Contract 08-85212, NCQA: UM 2		**NA**	**NA**		

*2014 data available for Q3 and Q4 only.

Delegation Oversight : *Assessment of Delegated Quality Activities*							
Legend: **Green = Met or Exceeded Benchmark** **Red = Did Not Meet Benchmark**							
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014**	**2015 Q1**	**Quarterly Trend 2014 - 2015 Q1**	**Interventions**
Delegation of UM	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 5; NCQA Standard UM 15	DHCS Contract	**100%[1]**	**NA**	+	
Delegation of CR	Number required & percentage of current delegates assessed	Exhibit A, Attachment 4; NCQA Standard CR 9	DHCS Contract 10-87128	**100%[2]**	**100%**	+ +	
Delegation of QI	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard QI 12	DHCS Contract	**100%[3]**	**NA**	+	
Delegation of RR	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard RR 7	DHCS Contract	**100%[4]**	**NA**	+	
Delegation of Claims	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 8	DHCS Contract	**100%[5]**	**100%**	+ +	

[1]2014 data available for Q2 and Q3 only.

[2]2014 data available for Q1 only.

[3]2014 data available for Q3 and Q4 only.

[4]2014 data available for Q2, Q3 and Q4 only.

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Credentials

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

Measure	Description	Benchmark Source	Benchmark	2014*	2015 Q1	Quarterly Trend 2014 - 2015 Q1	Interventions
Access Indicators							
Monitoring of Medicare/Medicaid sanctions	An OIG query is performed on every provider at the time of initial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%		
Monitoring of sanctions and limitations on licensure	An Medical Board of California (MBOC) query is performed on every provider at the time of initial and re credentialing. Other state licensing boards are also queried as needed	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%		
Monitoring of Complaints	Member complaint data is considered during re-credentialing.	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	NA	NA		
Monitoring of adverse events	Quality of Care concerns are reviewed at a minimum of every 6 months and are forwarded to Credentials/Peer Review Committee (CPRC) as indicated.	DHCS/ Title 22	Biannually	NA	100%		
	HIPDB queries are performed within 180 days prior to the date of initial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%		
Timeliness of provider notification of credentialing decisions	Providers will be notified of the credentialing decision in writing within 60 days	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%		
Timeliness of verifications	All credentialing verifications are performed within 180 days (or 360 days) prior to the credentialing date, as required	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%		
# of provider terminations for quality issues	Credentials/Peer Review Committee (CPRC) denial of a credentialing application for quality issues will cause termination of the provider from the network	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	None for Q3 and Q4	None for Q1		
# 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	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	None for Q3 and Q4	None for Q1		
Service Indicators							
Timeliness of processing of initial applications	Initial applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	100%	90%		
Timeliness of processing of re-credentialing applications	Recredentialing applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	100%	90%		
Quality Indicators (under NMC purview)							
Timeliness of Physician Recredentialing	Percent of physicians recredentialed within 36 months of the last approval date	NCQA: CR Standards	Standard met for 90% of providers	90%	90%		
Continuous Monitoring of Allied Providers	Percent of allied providers' expirable elements that are current	NA	Standard met for 90% of elements	100%	100%		
Timeliness of Organization Reassessment	Percent of organizations reassessed within 36 months of the last assessment	NCQA: CR Standards	Standard met for 90% of providers	100%	100%		

*2014 data available forQ3 and Q4 only.

Member Services							
Legend: Green = Met or Exceeded Goal Red = Did Not Meet Goal							
Measure	**Description**	**Compliance Source**	**Benchmark**	**2014**	**2015 Q1**	**Quarterly Trend 2014 - 2015 Q1**	**Interventions**
Call Center - Aggregate Average Speed of Answer (ASA)	Average Speed to Answer (in seconds)		<= 30 seconds	**11.6**	**30.7**		GCHP's call center was closed for one day in February due to weather and was significantly understaffed the following day for the same reason. The ASA for February due to this one day anomaly was 64.8 seconds. The ASA for January and March were both well under 30 seconds. No intervention required.
Call Center - Aggregate Abandonment Rate	Percentage of aggregate Abandoned calls to Call Center		<= 5%	**0.58%**	**1.47**		
Call Center - Aggregate Call Center Call Volume	Monitored to ensure adequate staffing and identification of systemic issues.			114,678	31,393		

Cultural & Linguistics							
Legend: **Green = Met or Exceeded Benchmark** **Red = Did Not Meet Benchmark** NR = **Not Reported**							
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014***	**2015 Q1**	**Quarterly Trend 2014 Q3 - 2015 Q1**	**Interventions**
Cultural & linguistic requirements	Number of languages provided per the total number of languages requested through GCHP and interpretation vendors.	DHCS/Title 22	100%	**13**	**11**		
Cultural & linguistic requirements	Total number of translation requests (Excluding American Sign Language)	DHCS/Title 23	100%	**18**	**18**		
Cultural & linguistic requirements	Total number of American Sign Language interpreter requests.	DHCS/Title 24	100%	**38**	**29**		
Cultural & linguistic requirements	Total number of telephonic calls for interpreter requests.	DHCS/Title 25	100%	**309**	**497**		

*2014 data available for Q3 and Q4 only.

Network Operation QI Dashboard - Access and Availability						
Legend: **Green = Met or Exceeded Benchmark** **Red = Did Not Meet Benchmark**						
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015 Q1**	**Quarterly Trend 2015**	**Interventions**
Access to Network / Availability of Practitioners						
# & geographic distribution of PCPs	Network of PCPs located within 30 minutes or 10 miles of a member's residence to ensure each member has a PCP who is available and physically present at the service site for sufficient time to ensure access for assigned members upon member's request or when medically required and to personally manage the member on an on-going basis.	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members (per GeoAccess)	NA		
# & geographic distribution of SCPs	Adequate numbers and types of specialists within the network through staffing, contracting, or referral to accommodate members' need for specialty care.	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members (per GeoAccess)	NA		
Ratio of members to physicians	1:1200	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members (per GeoAccess)	Met		
Ratio of members to PCPs	1:2000	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members (per GeoAccess)	Met		
Acceptable driving times and/or distances to primary care sites	30 minutes or 10 miles of member's residence	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members (per GeoAccess)	NA		

Network Operation QI Dashboard - Access and Availability						
Legend: **Green = Met or Exceeded Benchmark** **Red = Did Not Meet Benchmark**						
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015 Q1**	**Quarterly Trend 2015**	**Interventions**
Access to Network / Availability of Practitioners						
After Hours Access	Providers have answering machine or service for after-hours member calls	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members	NA		
	After-hours machine messages or service staff is in threshold languages	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members	NA		
	After-hours answering machine message or service includes instructions to call 911 or go to ER in the event of an emergency	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members	NA		
Time Elapsed Standards	Urgent Care appointments for services that do not require prior authorization: within 48 hours of the request for appointment	DHCS, Exhibit A, Attachment 9	Standards met for minimum of 90% of providers	NA		
	Non-urgent appointments for primary care: within 10 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA		
	Non-urgent appointments with specialist physicians: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA		
	Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA		
Appointment Availability	Availability of appointments within CenCal Health's standards by type of encounter	DHCS, § 7.5.4	Standards met for minimum of 95% of providers	NA		

Network Operation QI Dashboard - Access and Availability						
Legend: **Green = Met or Exceeded Benchmark** **Red = Did Not Meet Benchmark**						
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015 Q1**	**Quarterly Trend 2015**	**Interventions**
Access to Network / Availability of Practitioners						
Provider Surveys	Measure provider satisfaction	GCHP	Satisfaction expressed in each of 6 areas for 80% of providers	NA		
Provider Training	Number of new PCPs / Providers receiving orientation within 10 days of contracting (Note: Provider is offered an orientation within 10 days, but may be completed within 30 days, or if provider declines training, a declination req'd)	DHCS Exhibit A, Attachment 7	100% within 10 days of contracting	Met		
Provider Visits	Number of Provider Services Representative provider visits	GCHP	Department goal = 100/quarter (400/year)	Met		
Provider Seminars	Number of seminar attendees		Adequate attendance	Met		
	Number of Provider Services Representative provider visits		Adequate # of visits to address needs	Met		
	Number of new PCPs / Providers receiving orientation within 10 days of contracting (Note: Provider is offered an orientation within 10 days, but may be completed within 30 days, or if provider declines training, a declination form is signed.)		100% within 10 days of contracting	100%		

Clinical Practice & Preventative Health Guidelines						
Legend: Green = **Met or Exceeded Benchmark** Red = **Did Not Meet Benchmark**						
Measure	**Description**	**Responsible Department**	**Compliance Source**	**Benchmark**	**2014**	**2015**
Clinical Practice						
Clinical Practice Guideline Adoption	Development and/or adoption of non-preventive clinical practice guidelines for the provision of acute and chronic medical services every two years.	ACMO	DHCS/ Title 22	Approval by Committee		**Approved by MAC 1/29/2015**
Clinical Practice Guideline Distribution	Distribution of non-preventive clinical practice guidelines for the provision or acute and chronic medical services to applicable practitioners every two years.	ACMO	DHCS/ Title 22	Distribution to Applicable Providers		
Preventive Services Guideline Adoption	Development and/or adoption of preventive guidelines every two years.	Health Education	DHCS/ Title 22	Approval by Committee	**Approved by MAC 7/24/2014**	
Preventive Services Guideline Distribution	Distribution of preventive guidelines every two years.	Health Education	DHCS/ Title 22	Distribution to Applicable Providers		

40

Pharmacy and Therapeutics

Pharmacy Benefit Manager (PBM) Oversight

41

Reviewed all denials and 10% of approvals

- 97.5% appropriate decision
- 100% timely decision
- 97.5% appropriate denial language

Pharmacy and Therapeutics

Pharmacy Inter-Rater Reliability (IRR)

42

IRR Review

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

Pharmacy and Therapeutics

Newly Approved Drugs and Formulary Management

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

- 16 drugs reviewed
- Approved 11 drugs due to significant clinical advantages
- 8 existing drugs with new dosage forms - 4 added
- 3 existing drugs requested by providers were added

43

Credentials/Peer Review

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

44

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

Credentials/Peer Review

Peer Review Referral:

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

45

Credentials/Peer Review

Committee Actions

46

- Recredentialed 10 providers
- Newly credentialed 19 providers
- Credentialed 7 facilities

Medical Advisory

Approved Health Plan Policies:

- Pediatric Preventive Services Guidelines
- Blood Lead Screening Guideline
- A new Telehealth Policy

47

Health Education and Outreach

Events:

- SBIRT Training for Providers – May 20, 2015
  - 38 GCHP Providers
  - 48 Non-contracted Providers
- Annual Community Resource Fair – June 6, 2015
  - 553 Members of the Community in attendance
  - 28 Partner Exhibitors
  - 40 GCHP Employee Volunteers

48

Cultural and Linguistics

Pacific Interpreters

- 497 requests for interpreter services
- 402 by GCHP Staff and 95 by providers
- 14 languages

American Sign Language

- 29 requests serving

49

Grievance and Appeals

Grievance and Appeals Department

1st Quarter 2015

- Administrative Grievances – 409
  - Billing - 216
  - Provider Disputes – 184
  - Other - 9
- Clinical Grievances – 41
  - Quality of Care - 25
  - Accessibility - 9
  - Provider Disputes (clinical appeals) - 3
  - Coverage - 2
  - Other - 2

50

Grievance and Appeals

Medical Appeal Cases

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

Of the quality of care cases – 11 were referred to the Quality Department as PQI's.

51

Network Planning

ICD-10 Testing

- Provider Relations is preparing to train physician offices for ICD-10 which will be starting October 1, 2015
- Town hall training held on March 29, 2015
- Additional meetings are scheduled for August 17 and August 20, 2015
- 9 New Provider Orientations have been held from January 1 through May 30, 2015
- 44 Providers Added
- 25 Providers Terminated

52

Network Planning

Quality Surveys in Planning

- Provider Satisfaction Survey to be done by SPH Analytics in the 3rd quarter 2015
- Access Survey to be done in the 3rd quarter 2015
- GeoAccess Survey
  - Purchasing the software to do this survey
  - Survey to be conducted later this year

53

Member Services

Member Services Office Inquiries 1st Quarter

- 191 Walk-Ins
- 91 Calls

Call Center Statistics – 1st Quarter

- 10,464 Average calls per month
- Average Speed to Answer (less than 30 sec)
  - Compliant in January & March
  - February – over 30 sec. due to weather issues and employees inability to get to the call center
- Abandonment Rate (less than 5%) - Compliant

54

Utilization Management

Statistics: 1st Quarter 2015

- Bed days/1000 – 211

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

- Length of Stay – 4.4 days

  (benchmark 3.6 – 4.7 days)

- Readmission Rate – 9.5%

  (benchmark managed Medi-Cal 14.5%)

55

Utilization Management

- ER visits/1000 – 494

  (benchmark managed Medi-Cal Plans 554-877)

- UM Denial Rate – 3.57%

- Authorization Turn-Around-Time Average – 99.59%

56

Utilization Management

Care Management – 1st Quarter 2015

- Over 800 new referrals

Satisfaction Surveys

- 81 Surveys offered
- 51 Surveys Completed
- 100% Overall Satisfied with Care Management Program

57

Utilization Management

Member Feedback

58

"(nurse) was wonderful, she went above and beyond. I am beyond satisfied. (Nurse) is very loving and caring; she was very good, she lifted me up when I was down. She was a godsend, I am extremely satisfied."

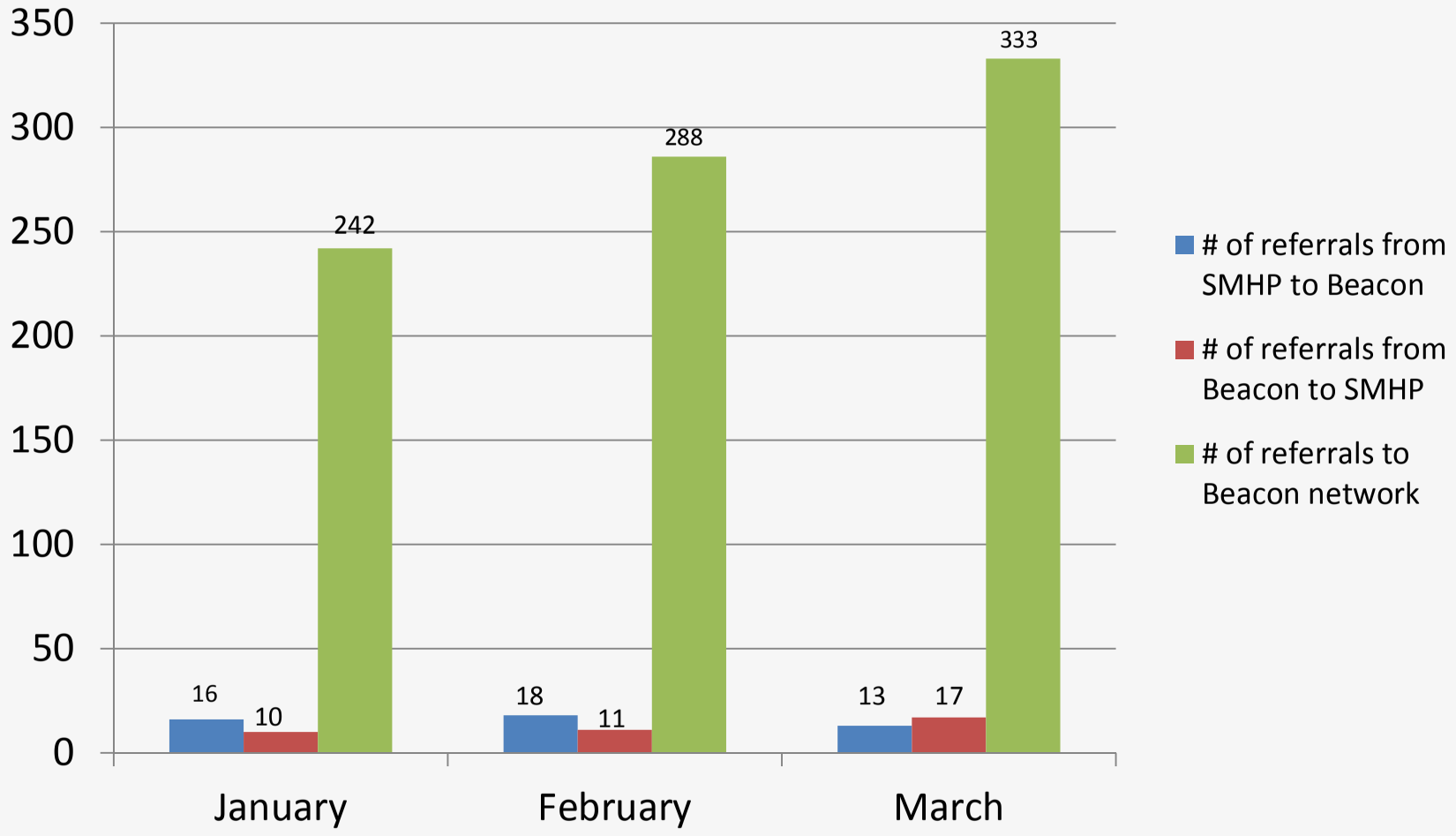
Behavioral Health Utilization

High Points:

- There is continual growth in utilization of the mental health benefit
- Beacon and Ventura Co. Behavioral Health (VCBH) collaborated in the development of a form for transitioning members between Beacon (mild to moderate) and VCBH
- Sept. 15, 2014 Applied Behavioral Analysis a treatment for Autism Spectrum Disorder became a benefit of Medi-Cal

59

Number of Referrals in the Last 3 Months



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Compliance - Delegation Oversight

- Credentialing – completed for 2015
- Other required delegation oversight for utilization management and claims are in progress and there have been corrective action plans issued
- Vision Service Plan (VSP)
  - CAP was issued to VSP on Oct. 29, 2014

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Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM 2.c.

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, CEO

DATE: August 24, 2015

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

SUMMARY:

Authorize and direct the Chief Executive Officer to submit a proposal to the California Department of Health Care Services (DHCS) to begin the process to secure additional Medi-Cal Funds through an Intergovernmental Transfer (IGT). The proposal would include a voluntary letter of interest and additional documentation from the funding entity (i.e., Ventura County Medical Center (VCMC) or other appropriate County agency).

BACKGROUND / DISCUSSION:

Intergovernmental Transfers (IGTs) are a mechanism for Medi-Cal managed care plans, counties and certain types of public hospitals to work with the State of California in order to bring federal Medicaid matching dollars to the local level.

To accomplish an IGT, a "funding entity" provides funds to the State Department of Health Care Services (DHCS). A funding entity can be counties, cities and State University teaching hospitals, or any other political subdivision of the State, as long as they meet the requirements as defined by 42 C.F.R. Section 433.50 for the funding of IGTs. The federal government then matches those funds according to a set formula. The State uses these combined funds to increase the rates it pays to the local Medi-Cal managed care plan consistent with the Plan's actuarially determined payment rates. The funding entity recoups the original outlay of funds and the federal match to those funds.

DHCS is processing a preliminary rate range IGT, which is approximately fifty-percent 50% of the estimated available IGT amounts. A subsequent Call Letter will be sent to offer the remainder of the available rate range for FY 2014-15. The amounts allocated for Rate Year 2014-15 will be one-time only and are not intended to represent a guaranteed level of funding for future years. The available IGT amounts are the nonfederal share of the differences

between Gold Coast Health Plan's capitated rates and the top of the associated actuarially sound rate range, as determined by DHCS.

As in previous IGT's, an initial transfer of funds will be required from the funding entity to DHCS. DHCS would then use a portion of these funds to leverage a federal match at the Federal Medical Assistance Percentages (FMAP) rate in effect during FY 2013-14. A portion of the funds (20%) would be paid to DHCS as an assessment fee. Subsequently, Gold Coast Health Plan (GCHP or Plan) would receive an increased capitation via a rate amendment to the Primary Agreement between GCHP and DHCS. The Plan would return the funds received via the increased capitation rate to the funding entity, after withholding amounts for MCO taxes (3.9375%) and GCHP's administrative fee (expected to be 2%).

GCHP received a letter from DHCS on August 17, 2015 (dated August 12, 2015) that required the Plan and funding entities to provide the required materials within 21 days from the date of the letter (i.e., September 2, 2015). GCHP would need to provide the State with a proposal by September 2, 2015 that would include:

- the Plan's contact person, funding entity and participation levels (i.e., expected percentage of dollars to fund) and
- the funding entity's voluntary letter of interest and some additional documentation regarding the Medi-Cal members served, scope of services, costs of services (including charges, payments and unreimbursed costs).

Terms and conditions and final funding amounts will be presented to the Commission at a later date for approval.

FISCAL IMPACT:

The impact to the Plan's FY 2015-16 revenue as a result of the preliminary rate year 2014-15 IGT is estimated to be $92,000.

RECOMMENDATION:

Subject to review by legal counsel, authorize and direct the Chief Executive Officer to provide DHCS with a proposal (including information from the funding entity) to the State of California.

CONCURRENCE:

N/A

Attachments:

None

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Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM 3.a.

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, CEO

DATE: August 24, 2015

RE: CEO Update

PLAN GENERAL UPDATES:

New CFO Onboard
Welcome to Patricia Mowlavi who has joined Gold Coast Health Plan (GCHP) from LA Care and has hit the ground running.

Core Values Project
GCHP launched an organization core values project to identify the values most important to employees and leadership. The team was comprised of volunteers from across the organization who met over several weeks and solicited input from their peers. The core values selected by this group and adopted by the management team were:

- **Integrity** - Achieving the highest quality standards of professional and ethical behavior, with transparency in all business and community interactions.
- **Accountability** - Taking responsibility for our actions and being good stewards of our resources.
- **Collaboration** - Working together to empower our GCHP community to achieve our shared goals.
- **Trust** - Building relationships through honest communication and by following through on our commitments.
- **Respect** - Embracing diversity and treating people with compassion and dignity.

Pharmacy Benefits Manager (PBM) RFP
Proposals were due by August 14, 2015 and were received from six prospective PBMs. The Plan has requested an opinion from the Fair Political Practices Commission as to whether our vendor, Milliman will be allowed to participate in the scoring using blind methodology to assist in the detailed financial analysis. The opinion is due by August 24, 2015 and scoring is scheduled to be completed by August 28, 2015. A backup vendor has been identified who did a similar analysis for LA Care. The Plan will make the final selection by October 9, 2015 and present the recommendation to the Commission on November 16, 2015.

California Association of Health Plans (CAHP) Annual Conference
GCHP staff will be attending the annual conference on October 19-21, 2015 at the JW Marriott Desert Springs Resort and Spa, Palm Desert, CA.

Gold Coast Senior Management and Commissioners Strategic Planning Even
Plans are underway for the meeting on October 13, 2015. Location TBD. Jennifer Kent, Director of the California Department of Health Care Services has accepted the invitation to participate. The meeting will focus on the GCHP 2015-16 Strategic Plan.

GOVERNMENT RELATIONS UPDATE:

On August 5, 2015 GCHP's CEO and Director of Government Affairs attended the all-plan meeting in Sacramento with the Department of Health Care Services (DHCS). The purpose of this meeting was to discuss and receive updates on issues and topics concerning the Medi-Cal program, including the following:

Behavioral Health Treatment Services Transition
On August 5, 2015 DHCS announced the delay of the transition of behavioral health treatment (BHT) services from Regional Centers to Medi-Cal managed care plans from November 1, 2015 to February 1, 2016. The transition of financial responsibility for BHT services for fee-for-service Medi-Cal beneficiaries from Regional Centers to DHCS will also be pushed back from October 1, 2015 to February 1, 2016. In late 2014 CMS issued guidance requiring states to cover BHT for children with Autism Spectrum Disorder as part of the Medi-Cal schedule of benefits.

MCO Tax
Senate and Assembly Committees held hearings on the managed care organization tax (MCO Tax) the week of August 17, 2015. A bill has been introduced in the State legislature to levy a flat tax of $7.88 per person enrolled per month in every managed care plan in California. However, no agreement has been reached between DHCS, commercial, and public health plans concerning any revenue based alternative to the MCO Tax. In the absence of an agreement on an alternative tax structure, DHCS would have to evaluate the impacts of a $1.2 billion loss in revenue for the Medi-Cal program.

Since 2005 the State has imposed variations of the MCO Tax on Medi-Cal plans to annually generate approximately $1.2 billion in federal matching funds for the Medi-Cal program. In July 2014 the Centers for Medicare and Medicaid Services (CMS) ruled that California's MCO Tax cannot be imposed exclusively on Medicaid plans, rather the MCO Tax must be applied uniformly across all health plans, both commercial and public. CMS gave California until the end of the 2016 legislative session to bring its MCO Tax structure into compliance with federal regulations or eliminate the tax altogether.

Section 1115 Waiver
DHCS continues weekly discussions with CMS to secure approval for its new 1115 waiver application dubbed 'Medi-Cal 2020' by November 1, 2015. This waiver is expected to bring in up to $20 billion in federal funds for the Medi-Cal program over a five year period. The State's existing waiver called Bridge to Reform will expire on October 31, 2015.

Key concepts in the Medi-Cal 2020 waiver include: delivery system and payment transformation; targeted case management through health homes; shared savings and workforce development e.g. financial incentives to enhance workforce capacity to serve Medi-Cal beneficiaries.

CMS Proposed Managed Care Regulations
August 1, 2015 CMS approved California State Plan Amendment 14-0021-MM1 which provides full scope medical benefits to all new pregnant women applicants whose incomes are at or below 138% of the federal poverty level (FPL).

On July 24, 2015 the State submitted its comment letter to CMS on proposed new regulations for the Medicaid program. DHCS comments focused on the following key areas of the proposed regulation change:

- CMS proposes that states certify and enroll all Medi-Cal providers through the fee-for service system. The State letter urged CMS to allow plans the flexibility to use their own enrollment procedures and processes.
- CMS proposed restriction on the use of rate ranges and certification of individual rates. The State letter urged CMS to allow states flexibility to use rate ranges for reimbursement purposes.

CMS is expected to issue final regulations by mid-2016.

California Children Services Redesign
On June 11, 2015, DHCS put forth their Whole Child proposal for the redesign of the California Children Services program (CCS). The CCS program provides medical care and case management to children with specialty health care needs who meet certain eligibility requirements.

The existing CCS program will sunset on October 31, 2015. Under DHCS' Whole Child Delivery Model, the CCS carve out for non-participating plans, including GCHP, would be extended until 2019. The remaining five of six County Organized Health Systems and up to four Two Plan model counties would be responsible for providing the health care of children in the CCS program. While DHCS has established advisory and technical workgroups to solicit input and support of their proposal, the Department does not believe it needs statutory authority to implement its redesign proposal for the CCS program.

Medi-Cal Coverage for Undocumented Immigrant Children
The 2015-16 California budget allocated $40 million in State General Funds to provide full-scope Medi-Cal coverage to undocumented eligible individuals under age 19 no sooner than. The California Department of Finance estimates an annual cost of this expansion to be $132 million. Approximately 170,000 undocumented immigrant children are eligible for full-scope coverage.

LEGISLATIVE UPDATE
The State Legislature reconvened from its summer recess on August 17, 2015 and is in the first year of a two-year session. Governor Brown has also called for a special session of the Legislature to address two issues: 1) the MCO Tax and funding for the Medi-Cal program; and 2) transportation infrastructure. Special sessions of the Legislature do not have a time limit and can be conducted concurrently with the regular session of the Legislature.

August 28, 2015 is the last day for fiscal committees to meet and report bills to the floor of each legislative chamber. September 11, 2015 is the last day for each house to pass bills. October 11, 2015 is the last day for the Governor to sign or veto bills passed by Legislature on or before September 11, 2015. Bills on the Governor's desk that are not signed or vetoed become law by default.

There are several pending legislative proposals of significance to Gold Coast Health Plan and the Medi-Cal program that are worth noting. These include a bill, SB 260 that would require county organized health systems (COHS) to obtain a Knox Keen license. Another bill, AB 1231, proposes to add nonmedical transportation (NMT) as a Medi-Cal benefit for a beneficiary to obtain covered specialty care services, if those services are more than 60 minutes or 30 miles from the beneficiary's place of residence.

Other proposed Medi-Cal legislation pending in the State legislature:

AB 187 (Bonta) California Children's Services (CCS) program.
This bill would extend the prohibition against CCS Services being incorporated into a Medi-Cal manged care contract through January 2017. This bill is supported by the the California Children's Hospital Association and a number of advocacy groups.

SB 260 (Monning) Knox Keene Licensing of County Organized Health System (COHS) Plans
Currently COHS plans, including Gold Coast Health Plan, are exempt from requirements to obtain Knox-Keene licensure. Initially COHS were exempted because they were limited to a Medi-Cal only product line and were not engaged in competition for other lines of business. With exception of Gold Coast Health Plan, all other remaining COHS have since obtained a

Knox-Keene license for non-Medi-Cal lines of business.

As proposed, SB 260, would require Gold Coast Health Plan to file for initial Knox Keen licensure with the Department of Managed Health Care (DMHC) in order to obtain a Knox-Keene license. However, COHS plans that already have a Knox-Keene license for non-Medi-Cal products would be required to file a "material modification" to their existing licenses to add their respective health plan and services as new products. According to DMHC, material modification filings and review are similar to that of initial licensure filings, but take less time in part because DMHC has already reviewed certain information about the plan that is on file with the plan's other licensed product(s).

- **Licensure Fees.** Plans licensed under the Knox-Keene Act are required to pay fees to DMHC to support the costs and expenses associated with their licensure and regulation, and also to support DMHC's Office of the Patient Advocate (OPA) which assists and collects data from State health care consumer assistance call centers in order to enable consumers to access services for which they are eligible. For the 2015-16 fiscal year, full-service plans are required to pay a fee of $1.54 per covered life. Based on GCHP's current enrollment of 192,683 members, GCHP's annual Knox Keen licensure fees to DMHC would be approximately $296,731. This does not include administrative or staffing costs.

- **Proposed Implementation Timeline.** The Assembly Health Committee has recommend a January 1, 2017 implementation date for the four COHS that must file material modifications and a July 1, 2017 implementation date for GCHP which must file an initial licensure application. According to Committee staff these timeframes will grant COHS time to prepare to submit the licensure filings with DMHC and for DMHC to complete its review in order to grant licensure.

- **Status.** On July 7, SB 260 passed out of the Assembly Health Committee on a 12-5 vote. The bill is now in the Assembly Appropriations Committee pending a fiscal review and hearing set for August 19.

AB 1231 (Perez) Non-Medical Transportation (NMT)
Assembly bill 1231 (AB 1231) proposes to add non-medical transportation as a Medi-Cal benefit for a beneficiary to obtain covered specialty care Medi-Cal services, if those services are more than 60 minutes or 30 miles from the beneficiary's place of residence.

- **Fiscal Impact.** According to the Assembly Appropriations Committee, potential annual costs to health plans for this service may be in the range of $1 to $2 million in Medi-Cal managed care. Due to data limitations this estimate is fairly rough, it

assumes a small percentage of rural Medi-Cal enrollees receive transportation services each year for a single specialty visit and is based on a cost of $50 to $100 per transport. However, the actual cost of mandating NMT as a covered benefit in Medi-Cal will depend on several factors, which are subject to significant uncertainty and change.

- **Status.** On June 18, AB 1231 passed out of the Assembly Health Committee on a 9-0 vote. It is scheduled to be heard by the Assembly Appropriations Committee on August 17, 2015.

See Attached Legislative Bills Table.

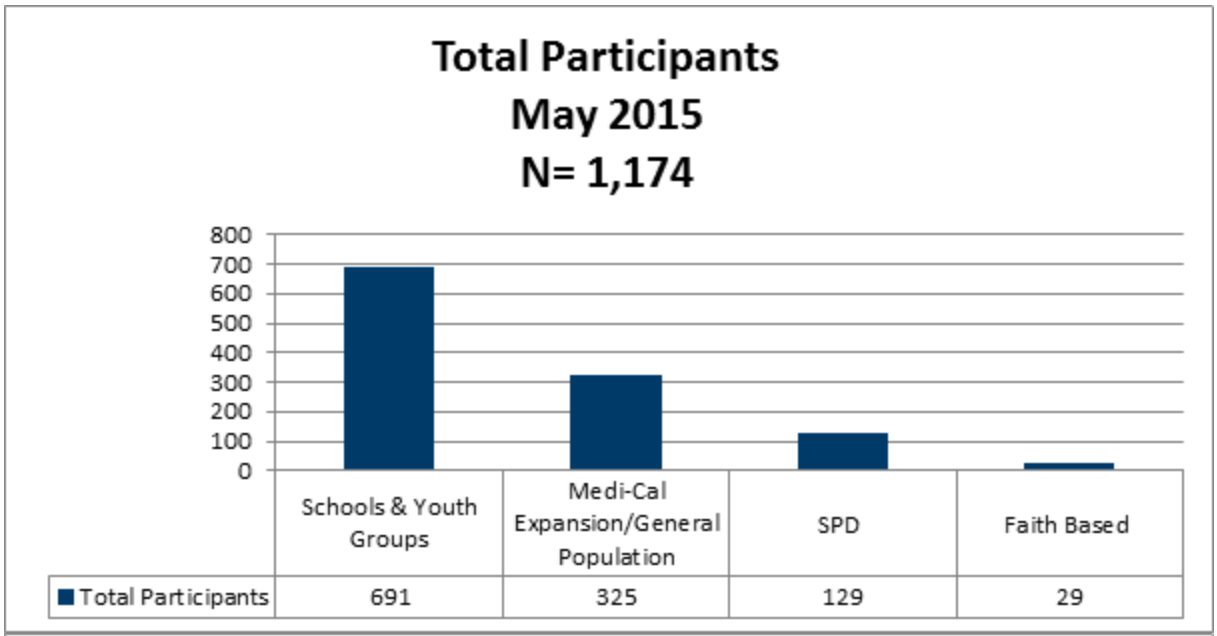
HEALTH EDUCATION AND COMMUNITY OUTREACH UPDATE:

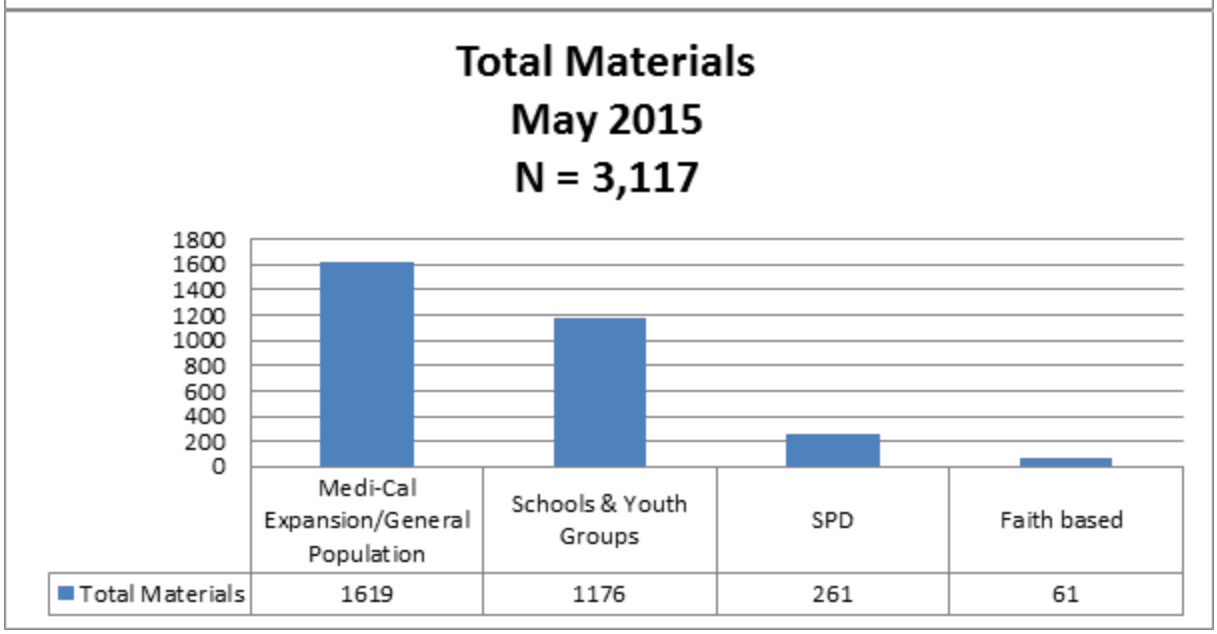
Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. The health education and outreach team conducted the following activities during the months of May, June and July.

Outreach Events – May 2015

During the month of May, GCHP's health education and outreach team participated in 15 different community based resource and health fairs. The team also participated in food distribution events held throughout various locations in the county. A total of 1,174 individuals were reached and approximately 3,100 education materials were distributed to various groups and organizations.

The majority (59%) of individuals reached were from school and youth groups. While 52% of the educational materials distributed were to adults under the Medi-Cal expansion / General population category. Below are two charts that highlight the total number of participants reached and materials distributed during the month of May.





Outreach Events – June 2015

During the month of June, staff participated in 10 community outreach events throughout the county. A total of 1,096 individuals were reached and approximately 3,938 education materials were distributed to various groups and organizations during outreach events.

4th Annual Community Resource Fair

On Saturday, June 6, 2015 GCHP held its annual Community Resource Fair at Plaza Park in downtown Oxnard. Twenty-eight (28) community organizations and four (4) GCHP

Departments (i.e., Health Education, Member Services, Care Management, and Pharmacy) participated in the community resource fair. Approximately 553 individuals and families attended the event.

The community resource fair featured health screening by Dignity Health, St. John's Hospital, Ventura County Public Health Department, and Clinicas del Camino Real. Free health screenings included anemia checks, blood pressure, glucose, Body Mass Index (BMI) and vision test. Additionally, participants were able to view the Tobacco Bus of Horrors, participate in CPR training, and view the Mobile Crash Unit sponsored by the Oxnard Police Department. Other youth and family activities included Zumba for Kids, martial arts demonstration, and table display of resources from various agencies throughout the county.

A total of 105 individuals were screened for abnormal glucose levels, high blood pressure, body mass index (BMI) and high hemoglobin levels by Dignity Health. Of the 105 individuals screened, 54 individuals had abnormal results and were referred to their primary care provider (PCP) for additional follow-up.
GCHP received certificates of appreciation and recognition from several distinguished elected officials including:

- Ventura County Supervisor John C. Zaragoza
- Mayor of Oxnard Tim Flynn
- Field Representative for Congresswoman Julia Brownley, Sandra Delgado
- Field Representative for Assembly Member Jacqui Irwin, Johnny Garcia Vasquez.

Outreach Events – July 2015
During the month of July, staff participated in 15 community outreach events throughout the county. A total of 710 individuals were reached and approximately 3,378 education materials were distributed to various groups and organizations during outreach events.

Of the 15 community outreach events, GCHP participated in five (5) new community outreach events:

- July 18, 2015 - Camarillo Farmers Market
- July 19, 2015 – Santa Clara Chapel hosted by Dignity Health St. John's
- July 24, 2015 – Summer BBQ hosted by Project Access Resource Centers – Housing Unit for Low-Income Families.
- July 24 & 25, 2015 – Homeless Veterans hosted by Ventura County Stand Down CA Army National Guard Armory
- July 25, 2015 – Health Fair and Hope hosted by Simi Covenant and Nueva Esperanza Community Church

GCHP's Sponsorship Committee reviewed a total of eight sponsorship applications. Of the

eight sponsorship applications four were funded, two received approval for letters of support, and two were denied sponsorship funding.

The following organizations and / or events were funded:

- **Senior Summit 2015 – County Supervisors Linda Parks:** The Sponsorship Committee awarded $1000 (Yellow Brick Road Level) to the Senior Summit 2015 Conference. The efforts made by Supervisor Linda Parks, will help advance the health and wellbeing of Ventura County's growing senior community. The Senior Summit is a half-day conference and free to all participants. The funding awarded will help pay for lunch and transportation services.

- **Camarillo Hospice**: The Sponsorship Committee awarded $1000 (Serrano Sponsor) to the 7th Annual Chili Cook-off and Music Festival. The committee was impressed by the efforts made by the Camarillo Hospice organization which is staffed by volunteers dedicated to serving the residents of Ventura County's with various supports groups. The funds raised from this festival will provide free services including comfort, support and counseling to individuals facing a life-limiting illness and/or grieving the loss of a loved one and education on end-of-life issues.

- **City of Oxnard**: The Sponsorship Committee awarded $350 (Copper Sponsor Level) to the City of Oxnard's 20th Annual Multicultural Festival to support and celebrate diversity and cultural understanding within the local community.

- **Ventura County Military Collaborative (VCMilC):** The Sponsorship Committee awarded VCMilC with the sponsorship level of $500 (2 Star Event Level). The Sponsorship Committee was impressed by the efforts made by this organization to advance the health and wellbeing of Ventura County's Military and Veteran community. The 4th Annual Military and Veteran Expo will host a community resource fair and will have representatives from the following service areas: job and career centers, mental health services, legal assistance, and family activities.

GCHP Sponsorship Committee approved the following agencies with requests for letters of support:

- **Ventura County Area Agency on Aging (VCAAA)**: VCAAA's proposal is seeking federal funding to implement an expanded evidence-based fall prevention program. GCHP is committed to exploring innovative funding arrangements to support evidence-based fall prevention programs.

- **Livingston Memorial Visiting Nurse Association (LMVNA):** LMVNA's, proposal is seeking funding through the Dignity Health / St. John's Collaborative grant for a

diabetes education program. GCHP is proud to support the efforts by LMVNA to reduce the number of those diagnosed with diabetes. The diabetes education program is designed to work with GCHP providers including Clinicas del Camino Real in offering bilingual diabetes education services.

COMPLIANCE UPDATE:

Gold Coast Health Plan (GCHP) had auditors from Audits & Investigations (A&I) a division within the Department of Health Care Services (DHCS) from February 17- February 25, 2015. The purpose of the onsite is to conduct the annual medical audit which includes: interviewing staff, review files and processes. The review period of the audit was December 1, 2013 through November 30, 2014. The plan was slated to receive the draft report on April 13, 2015 however A&I issued the draft report on July 8, 2015. The draft report was in conjunction with the exit conference between: A&I, DHCS and GCHP staff on July 8, 2015. The Plan had 15 calendar days to provide additional material to demonstrate compliance and or additional clarification information. A&I will review the material and issue a final CAP late August or beginning of September 2015.

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

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

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

GCHP compliance committee continues to meet on a monthly basis. At the last meeting the compliance committee voted to apply financial sanctions on one of the Plans delegates for lack of response to a CAP issued. The delegate did respond after the sanction letter was received, however the CAP is not closed for lack of compliance on certain areas and the delegate is still under financial sanctions. The Plan is committed to holding all delegates accountable.

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

A six month follow up audit was conducted on May 4, 2015 specific to claims processing on our mental health behavioral organization MBHO. A CAP was issued on May 14, 2015 and remains open. A routine annual audit on utilization management audit was conducted on the specialty contract delegate on June 9, 2015. A CAP has been issued to the delegate. A six month follow up audit was conducted on the NEMT delegate on July 27 & 28, 2015. A CAP was issued on August 4, 2015 and closed.

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

See Attached Compliance Update Table.

Legislative Bills

Bill	Summary	Potential Impact to GCHP
SB 260: Medi-Cal: County Organized Health Systems. **Status:** Passed 12-5 by Assembly Health Committee on July 8, 2015. Referred to Assembly Appropriations Committee. **Impact: High**	Requires County Organized Health Services (COHS) plans to become fully Knox Keene licensed within 18 months of enactment.	Subjects GCHP to all current and proposed laws / regulations under the Knox Keene Act and the Department of Managed Health Care. Undetermined staffing and administrative costs.
SB 4: Health Care Coverage: Immigration Status. **Status:** Passed 10-6 by Assembly Health Committee on July 14, 2015. Referred to Assembly Appropriations Committee. **Impact: High**	Provides Medi-Cal coverage to all eligible children regardless of immigration status. Requires Department of Health Care Services (DHCS) to transition children with limited-scope Medi-Cal to full-scope Medi-Cal within 30 days after the implementation date.	The FY 2015-16 state budget includes full-scope Medi-Cal coverage for all eligible children regardless of immigration status up to age 19. GCHP enrollment is expected to increase.
SB 36: Medi-Cal: demonstration project**.** **Status:** Passed 18-0 by Assembly Health Committee to Assembly Appropriations Committee on July 15, 2015. **Impact: High**	Requires DHCS to submit a section 1115 waiver renewal. The existing waiver is set to expire on October 31, 2015. The proposed waiver is expected to bring between $15-$20 billion to Medi-Cal over a five year period.	There are additional pilot demonstration programs in the waiver that GCHP could participate in such as health homes and workforce development pilot programs.
SB 137: Health Care Coverage: Provider Directories. **Status:** Passed 17-2 by the Assembly Health Committee on July 4, 2015. Referred to Assembly Appropriations Committee **Impact: High**	Requires the online provider directory to be updated at least weekly. The directory must meet or exceed 97% accuracy.	Requires GCHP to update its online provider directory on a weekly basis. GCHP would submit at least quarterly a report to DHCS demonstrating its provider directory is up to date with at least a 97 percent accuracy.
AB 1162: Medi-Cal: Tobacco Cessation. **Status:** Passed 8-0 by Senate Health Committee on July 15, 2015. Referred to Senate Appropriations Committee. **Impact: Medium**	Includes at a minimum four quit attempts per year with no required break between attempts, requires at least four tobacco cessation counseling session per quit attempt, and a 90 day treatment regime of any medication approved by the FDA including over-the-counter medication. At least one prescription medication and all over-the-counter medications shall be available without prior authorization.	GCHP currently follows the DHCS policy guidance put forth in September 2014. AB 1162 would require GCHP to cover the additional proposed benefits described in the bill summary section.

Legislative Bills

Bill	Summary	Potential Impact to GCHP
AB 1231: Medi-Cal: Non-medical Transportation. **Status:** Passed 9-0 by the Senate Committee on Health on June 18, 2015. Referred to the Senate Committee on Appropriations. **Impact: Medium**	Adds to the schedule of benefits non-medical transportation services for covered specialty care, if those services are more than 60 minutes or 30 miles from the beneficiary's place of residency.	Potential annual costs to health plans for this service may be significant. However, the actual cost of mandating Non-medical Transportation (NMT) as a covered benefit in Medi-Cal will depend on several factors, including the number of members requiring specialty services which are subject to uncertainty and change.
AB 1299: Specialty Mental Health Services: Foster Children. **Status:** Senate Appropriations Committee. **Impact: Medium to High**	Requires that foster youth placed outside their county of original jurisdiction are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program standards and requirements.	GCHP would be required to cover mild to moderate mental health conditions. GCHP may see a flux in membership.
SB 614: Medi-Cal: mental health services: peer, parent, and family support specialist certification. **Status:** Passed 18-0 by the Assembly Health Committee on July 15, 2015. Referred to the Assembly Appropriations Committee. **Impact:** Unknown	Requires DHCS to establish a program for certifying peer and family support specialists (PFSS) and seek federal waivers or state plan amendments to implement the certification program.	Uncertain impact on Medi-Cal managed care plans that provide mental health services to Medi-Cal beneficiaries when the mental illness is not severe.
AB 187: Medi-Cal managed care: California Children's Services Program. **Status:** Passed 8-0 by Senate Health Committee on July 8, 2015. Referred to Senate Appropriations Committee. **Impact: Low**	Extends the carve-out of California Children's Services (CCS) services from Medi-Cal managed care until January 1, 2017.	CCS services would be carved out from GCHP until January 2017.

Legislative Bills

Bill	Summary	Potential Impact to GCHP
AB 366: Medi-Cal Annual Access Monitoring Report. **Status:** Passed 9-0 by the Senate Appropriations Committee on July 16, 2015. Referred to the Senate Appropriations Committee. **Impact:** **Low**	Requires DHCS, by March 15, 2016, and annually thereafter by February 1st, to submit to the Legislature, and post on DHCS' website a Medi-Cal access monitoring report providing an assessment of access to care in Medi-Cal. DHCS would be required to hold a public meeting to present the access monitoring report annually.	Minimal impact to GCHP.
AB 1018: Medi-Cal: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). **Status:** Referred to Senate Appropriations Committee. **Impact:** **Low**	Requires DHCS and the Department of Education to convene a joint task force to examine the delivery of mental health services to children eligible for EPSDT. The taskforce is required to submit a report to the Legislature on key findings and recommendations.	At this time the impact is unknown.
AB 1117: Medi-Cal Vaccination Rates. **Status:** Senate Appropriations Committee. **Impact:** Unknown	Establishes a pilot program in Medi-Cal to reward Medi-Cal managed care organizations and providers for vaccinating children younger than two years of age.	No impact to GCHP if it does not participate in the pilot project.
SB 33: Medi-Cal: Estate Recovery. **Status:** Held in the Assembly Appropriations Committee. **Impact:** **Low**	Limits the Medi-Cal estate recovery to only those services required to be covered under the federal Medicaid law. Would eliminate estate recovery against the estate of a surviving spouse of a deceased Medi-Cal beneficiary.	No Impact to GCHP.
SB 586: California Children's Services Program. **Status:** Held in Assembly Committee on Health. **Impact:** **Low**	Requires DHCS to enter into contracts with one or more Kids Integrated Delivery System (KIDS) to provide CCS and Medi-Cal services to eligible children. Makes permanent, the CCS "carve-out" of services from Medi-Cal managed care.	Would permanently "carve-out" CCS services from GCHP.

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COMPLIANCE REPORT 2015

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

^^

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Training	**Training Sessions**	12	4	9	3	12	151	39					
Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Fraud, Waste & Abuse Prevention	4	1	3	1	4	73	19					
	Fraud, Waste & Abuse Prevention (Member Orientations)	0	1	0	0	0	0	0					
	Code of Conduct	4	1	3	1	4	5	1					
	HIPAA (Individual Training)	4	1	3	1	4	73	19					
	HIPAA (Department Training)	0	0	0	0	0	0	0					

** Reporting Requirements are defined by functions delegated and contract terms. Revised contracts, amendments or new requirements form DHCS may require additional requirements from subcontractors as a result the number is fluid
** Audits- Please note multiple audits have been conducted on the Plan, however many occurred in 2012 and 2013 and will be visible on the annual comparison dashboard
** This report is intended to provide a high level overview of certain components of the compliance department and does not include/reflect functions the department is responsible for on a daily basis.
^^Training Sessions: 5 new employees, along with 68 yearly training.

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AGENDA ITEM 3.b.

TO: Gold Coast Health Plan Commission

FROM: Patricia Mowlavi, CFO

DATE: August 24, 2015

RE: CFO Update - May 2015 Financials

SUMMARY:

Staff is presenting the attached May 2015 financial statements (unaudited) of Gold Coast Health Plan (Plan) for the Commission to accept and file. These financials were reviewed by the Executive / Finance Committee on July 9, 2015 where the Committee recommended that the Commission accept and file these financials.

BACKGROUND / DISCUSSION:

The staff has prepared the May 2015 financial package, including statement of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Highlights of Year-To-Date Financial Results:

On a year-to-date basis through May, the Plan's gain in unrestricted net asset was approximately $69.1 million compared to the $15.2 million budget. These operating results contributed to a Tangible Net Equity (TNE) level of approximately $108.9 million, which exceeded both the budget of $47.5 million by $61.4 million and the State minimum required TNE amount of $22.2 million by $86.7 million. As in prior reports, the Plan's TNE amount includes $7.2 million County of Ventura lines of credit (LOC). The May TNE was 490% of the State required TNE, and 10% below the average 6 County Organized Health Systems of 500%.

Highlights of May Financial Results:

Membership – May membership of 187,801 increased by 574 over the prior month, and exceeded budget by 22,498 members. The majority of the growth was in the Adult Expansion (AE) category, accounting for approximately 68% of the positive variance in membership.

Revenue – May net revenue was $44.5 million or $7.4 million below the budgeted amount of $51.9 million. The variance was primarily due to a $13.7 million revenue reduction related to the AE claims reserve reduction mentioned below. The revenue reduction was necessary to maintain a medical loss ratio (MLR) of 85% for this aid group. On a Per-Member Per-Month (PMPM) basis, net premium revenue was $237.15, or $77.10 under the budget of $314.26.

Health Care Costs –May health care costs were $34.5 million or $13.0 million below budget. On a PMPM basis, reported health care cost for May was $183.68 compared to a budgeted amount of $287.16. The positive variance was largely due to the release of certain claims reserves connected to the Adult Expansion population. Other highlights include:

- Capitation – Higher than budget by $1.6 million, due to higher than anticipated members being covered by capitated providers and a recent increase in provider rates. Also included were Adult Expansion members (565 in May 2015) recently designated as covered by the Kaiser capitation agreement, but not contemplated in the FY 2014-15 budget.
- Fee for Service – All Fee for Service in aggregate was $28.5 million which was $14.8 million better than budget of $43.3 million. Excluding the AE population, most categories of service experienced lower than budget variance with the exception of Outpatient and Emergency Room. As a group, net Fee for Service claims for the traditional populations were better than budget by $1.7 million
- LTC / SNF – New AB1629 rates were published by the Department of Health Care Services (DHCS) in late January. However, a later announcement by DHCS indicated that the rates contained errors and delayed final processing until the rates were corrected. Plan continues to accrue an estimated increase, and the final payment is now expected at the end of June.
- Pharmacy – Lower than expected utilization in the AE category, again contributed to savings of approximately $3.8 million. However, AE Pharmacy costs were somewhat higher in May. On a PMPM basis, May AE Pharmacy was $56.31 compared to $50.62 in April. We anticipate continued positive variance versus budget for the AE population.
- Adult Expansion Reserve – Approximately $1.1 million related to June 2014 services was released pursuant to the planned IBNP alignment methodology disclosed in prior

months. Additional reserves of $8.2 million were released or avoided by continued step-wise reduction of book-to-budget rates. The release and avoidance of these reserves affected most categories of service.

In January 2015 the Plan initiated a prudent and measured convergence strategy which will gradually move AE claims reserves from the State rate methodology (85% of capitation revenue) to the traditional Incurred But Not Reported (IBNR) model. A proxy of similar Aid categories was used for the AE population to develop model completion factors. These modeled completion factor percentages were applied to AE claims data as an alternate method of claims development. Based on this analysis claims aged one year or more were deemed complete or nearly complete and excess reserves were released. In addition, the budget rates for the near months (less than one year old) will be systematically reduced to avoid adding new reserves while maintaining the 85% MLR.

Administrative Expenses - For the month of May, overall operational costs were $3.0 million or $75,000 over budget. Higher than budgeted legal fees and outside services were offset by positive variance due to lower personnel and related personnel expenses. The following were the primary contributors to the large variances:

- Outside Services (ACS / Xerox and Beacon Health Strategies) – over budget by $100,000 due to expanded membership.
- Legal Fees – over budget by $35,000 due to continued legal services and ongoing services associated with the investigation being overseen by the Special Investigation Ad Hoc Committee. Year to date legal expenses of $2.34 million exceeded the budget by $2.0 million.
- General Office –over budget by $30,000 due to expenses related to recruitment and equipment for new hires.

Cash + Medi-Cal Receivable – The total of Cash and Medi-Cal Premium Receivable balances of $377.1 million reported as of May 31, 2015. This total includes pass-through payments for AB 85 of $5.4 million. Excluding the impact of the pass through amount, the total of Cash and Medi-Cal Receivable balance as of May 31, 2015 was $372.0 million or $207.0 million better than the budgeted level of $164.5 million.

Investment Portfolio – No new securities transactions were initiated during the month. As of May 31, 2015, the value the investments are as follows:

- Short-term Investments $205.0 million: Cal Trust $75.0 million; Ventura County Investment Pool $80.0 million; Commercial paper and bonds $50.0 million.
- Long-term Investments (Bonds) $25.0 million.

RECOMMENDATION:

Staff requests that the Commission accept and file the (unaudited) May 2015 financial package.

CONCURRENCE:

July 9, 2015 Executive / Finance Committee.

Attachments:

May 2015 Financial Package

Gold Coast Health Plan℠
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FINANCIAL PACKAGE
For the month ended May 31, 2015

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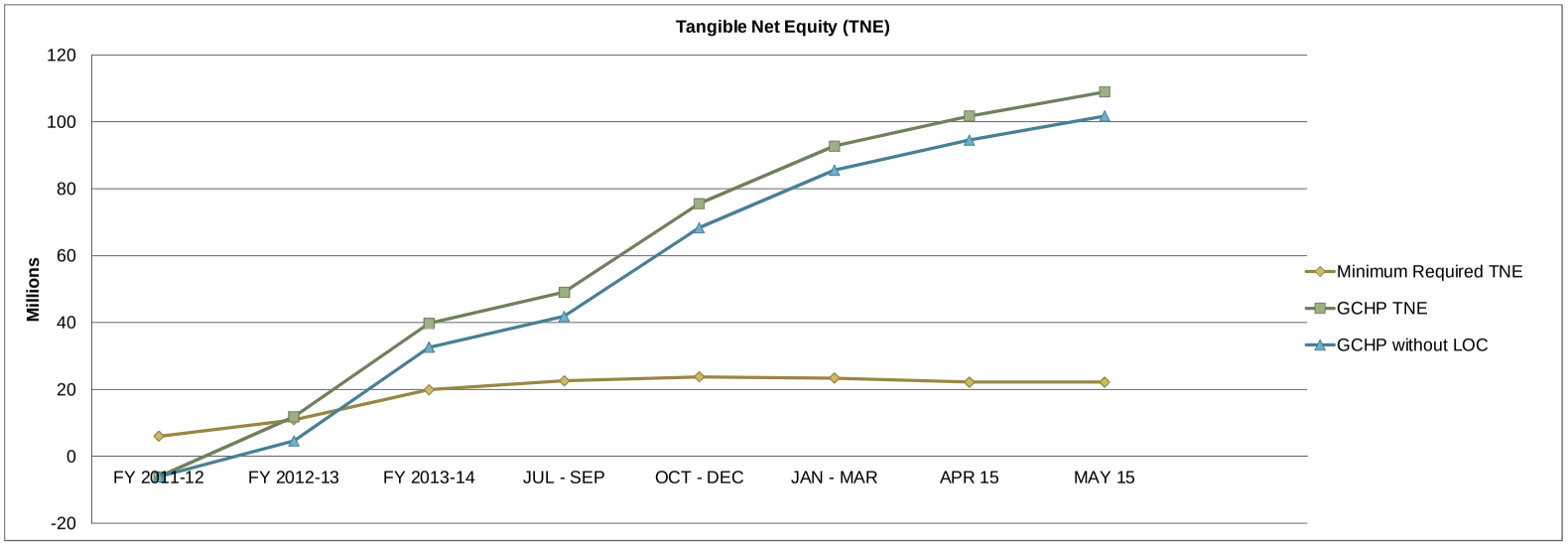
APPENDIX

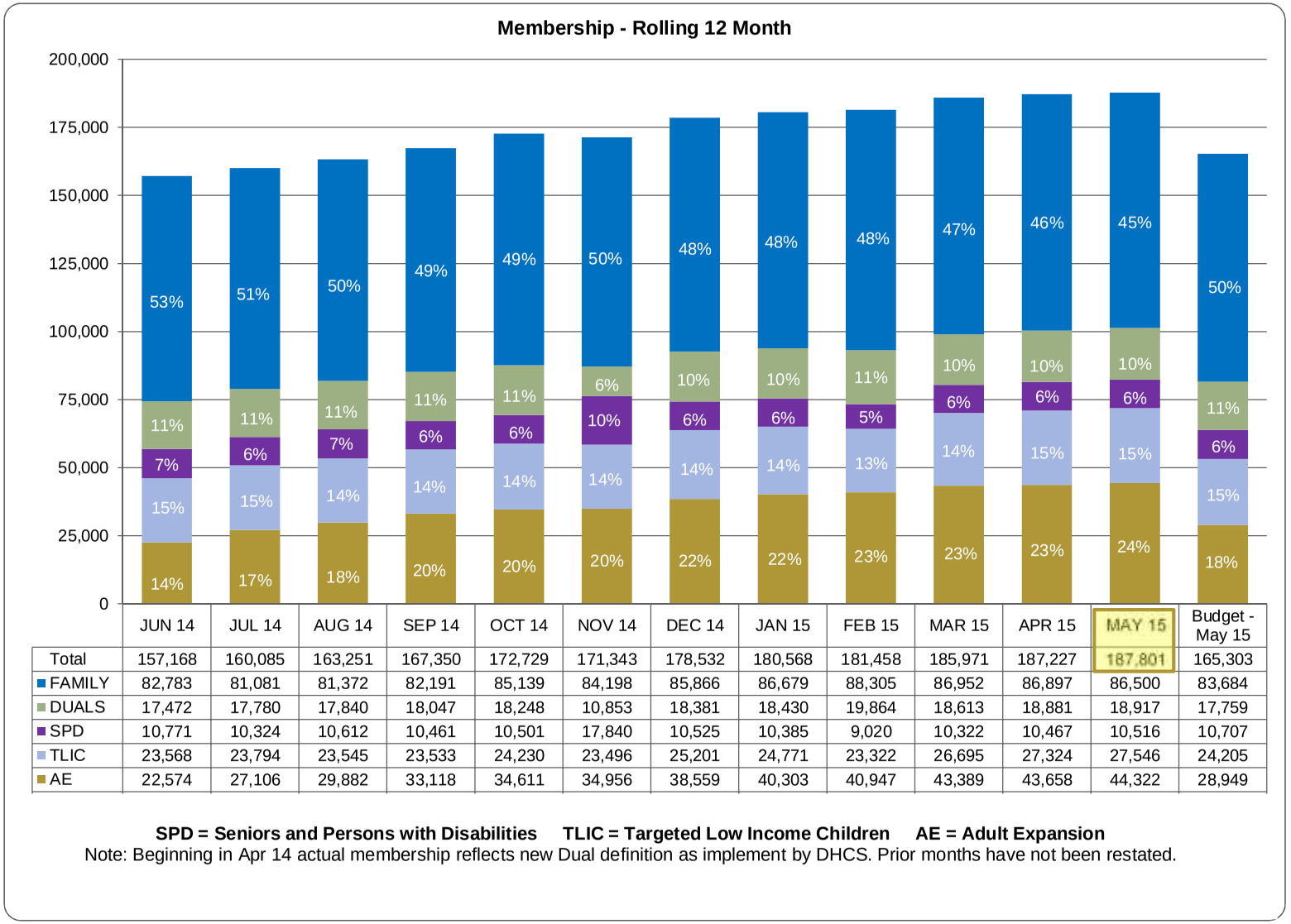
GOLD COAST HEALTH PLAN
Financial Results Summary

Description	AUDITED* FY 2011-12	AUDITED* FY 2012-13	UNAUDITED FY 2013-14	FY 2014-15 JUL - SEP	FY 2014-15 OCT - DEC	FY 2014-15 JAN - MAR	FY 2014-15 APR 15	FY 2014-15 MAY 15	Budget Comparison Budget May 15	Budget Comparison Variance Fav / (Unfav)	Budget Comparison Variance Fav / (Unfav)%
Member Months	**1,258,189**	**1,223,895**	**1,553,660**	**490,686**	**522,604**	**547,997**	**187,227**	**187,801**	**165,303**	22,498	13.6 %
Revenue	**304,635,932**	**315,119,611**	**423,995,809**	**158,761,380**	**142,036,566**	**123,095,167**	**46,117,588**	**44,688,649**	**52,003,666**	(7,315,017)	(14.1)%
pmpm	*242.12*	*257.47*	*272.90*	*323.55*	*271.79*	*224.63*	*246.32*	*237.96*	*314.60*	(76.64)	(24.4)%
Health Care Costs	**287,353,672**	**280,382,704**	**369,321,385**	**141,486,486**	**106,577,061**	**96,973,428**	**34,081,837**	**34,495,572**	**47,468,554**	12,972,982	27.3 %
pmpm	*228.39*	*229.09*	*237.71*	*288.34*	*203.93*	*176.96*	*182.03*	*183.68*	*287.16*	103.48	36.0 %
% of Revenue	94.3%	89.0%	87.1%	89.1%	75.0%	78.8%	73.9%	77.2%	91.3%	14.1%	15.4 %
Admin Exp	**18,891,320**	**24,013,927**	**26,751,533**	**7,994,304**	**8,969,982**	**8,943,041**	**3,051,574**	**3,019,621**	**2,942,354**	(77,267)	(2.6)%
pmpm	*15.01*	*19.62*	*17.22*	*16.29*	*17.16*	*16.32*	*16.30*	*16.08*	*17.80*	1.72	9.7 %
% of Revenue	6.2%	7.6%	6.3%	5.0%	6.3%	7.3%	6.6%	6.8%	5.7%	(1.1)%	(19.4)%
Total Increase / (Decrease) in Unrestricted Net Assets	**(1,609,063)**	**10,722,980**	**27,922,891**	**9,280,590**	**26,489,523**	**17,178,698**	**8,984,176**	**7,173,456**	**1,592,758**	5,580,698	350.4 %
pmpm	*(1.28)*	*8.76*	*17.97*	*18.91*	*50.69*	*31.35*	*47.99*	*38.20*	*9.64*	28.56	296.4 %
% of Revenue	-0.5%	3.4%	6.6%	5.8%	18.6%	14.0%	19.5%	16.1%	3.1%	13.0%	424.1 %
YTD											
100% TNE	16,769,368	16,138,440	19,964,221	22,600,707	23,789,982	23,415,058	22,201,719	22,242,684	26,409,624	(4,166,940)	(15.8)%
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%		
Minimum Required TNE	6,036,972	10,974,139	19,964,221	22,600,707	23,789,982	23,415,058	22,201,719	22,242,684	26,409,624	(4,166,940)	(15.8)%
GCHP TNE	**(6,031,881)**	**11,891,099**	**39,813,991**	**49,094,581**	**75,584,104**	**92,762,801**	**101,746,977**	**108,920,434**	47,518,666	**61,401,768**	**129.2 %**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**19,849,770**	**26,493,874**	**51,794,122**	**69,347,744**	**79,545,259**	**86,677,750**	**21,109,042**	**65,568,708**	**310.6 %**
% of Required TNE level			**199%**	**217%**	**318%**	**396%**	**458%**	**490%**	**180%**		
% of Required TNE level (excluding $7.2 million LOC)			**163%**	**185%**	**287%**	**365%**	**426%**	**457%**	**153%**		

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



GOLD COAST HEALTH PLAN



	JUN 14	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	Budget - May 15
Total	157,168	160,085	163,251	167,350	172,729	171,343	178,532	180,568	181,458	185,971	187,227	187,801	165,303
FAMILY	82,783	81,081	81,372	82,191	85,139	84,198	85,866	86,679	88,305	86,952	86,897	86,500	83,684
DUALS	17,472	17,780	17,840	18,047	18,248	10,853	18,381	18,430	19,864	18,613	18,881	18,917	17,759
SPD	10,771	10,324	10,612	10,461	10,501	17,840	10,525	10,385	9,020	10,322	10,467	10,516	10,707
TLIC	23,568	23,794	23,545	23,533	24,230	23,496	25,201	24,771	23,322	26,695	27,324	27,546	24,205
AE	22,574	27,106	29,882	33,118	34,611	34,956	38,559	40,303	40,947	43,389	43,658	44,322	28,949

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

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

Statement of Financial Position

	05/31/15	04/30/15	Unaudited FY 2013-14
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 107,850,902**	**$ 156,092,662**	**$ 60,176,698**
Total Short-Term Investments	**205,076,483**	**205,047,085**	**0**
Medi-Cal Receivable	64,200,793	3,591,487	114,632,056
Interest Receivable	287,272	204,622	0
Provider Receivable	591,258	585,800	395,129
Other Receivables	172,194	171,605	1,821,475
Total Accounts Receivable	**65,251,517**	**4,553,514**	**116,848,660**
Total Prepaid Accounts	823,387	1,006,954	994,278
Total Other Current Assets	81,702	81,702	81,719
Total Current Assets	**379,083,991**	**366,781,916**	**178,101,355**
Total Fixed Assets	**1,086,020**	**1,089,289**	**1,163,269**
Total Long-Term Investments	**24,670,537**	**24,693,694**	**0**
Total Assets	**$ 404,840,547**	**$ 392,564,899**	**$ 179,264,625**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 108,186,896	$ 114,772,998	$ 92,710,021
Claims Payable	14,281,478	11,070,028	9,482,660
Capitation Payable	6,923,232	6,352,189	2,054,265
Physician ACA 1202 Payable	11,160,498	11,160,498	12,765,516
AB 85 Payable	5,374,040	6,915,742	1,245,284
Accounts Payable	648,141	2,047,893	2,875,709
Accrued ACS	2,811,440	1,428,930	0
Accrued Expenses	1,139,852	1,350,385	748,120
Accrued Premium Tax	(31,063)	4,131,904	15,775,120
Accrued Interest Payable	67,968	66,047	42,062
Current Portion of Deferred Revenue	460,000	460,000	460,000
Accrued Payroll Expense	942,711	789,471	760,032
Total Current Liabilities	**151,965,193**	**160,546,086**	**138,918,788**
Long-Term Liabilities:			
DHCS - Reserve for Capitation Recoup	143,500,602	129,815,278	0
Other Long-term Liability-Deferred Rent	415,985	379,891	71,845
Deferred Revenue - Long Term Portion	38,333	76,667	460,000
Notes Payable	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	**151,154,920**	**137,471,836**	**7,731,845**
Total Liabilities	**303,120,113**	**298,017,922**	**146,650,634**
Net Assets:			
Beginning Net Assets	32,613,991	32,613,991	4,691,101
Total Increase / (Decrease in Unrestricted Net Assets)	69,106,443	61,932,986	27,922,890
Total Net Assets	**101,720,434**	**94,546,977**	**32,613,991**
Total Liabilities & Net Assets	**$ 404,840,547**	**$ 392,564,899**	**$ 179,264,625**

FINANCIAL INDICATORS			
Current Ratio	2.49 : 1	2.28 : 1	1.28 : 1
Days Cash on Hand	250	292	34
Days Cash + State Capitation Rec	302	295	100
Days Cash + State Capitation Rec (less Tax Liab)	302	291	91

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2014-15 Monthly Trend			Current Month		
	FEB 15	MAR 15	APR 15	MAY 15		Variance
				Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	181,458	185,971	187,227	187,801	165,303	22,498
Revenue:						
Premium	$ 60,901,975	$ 59,433,011	$ 60,117,248	$ 60,609,305	$ 54,076,760	$ 6,532,545
Reserve for Rate Reduction	(13,980,481)	(14,663,168)	(12,032,264)	(13,685,324)	0	(13,685,324)
MCO Premium Tax	(1,913,763)	(4,806,046)	(2,083,799)	(2,386,510)	(2,129,272)	(257,237)
Total Net Premium	**45,007,731**	**39,963,798**	**46,001,185**	**44,537,471**	**51,947,488**	**(7,410,016)**
Other Revenue:						
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	(0)
Total Other Revenue	38,333	38,333	38,333	38,333	38,333	(0)
Total Revenue	**45,046,064**	**40,002,131**	**46,039,519**	**44,575,805**	**51,985,821**	**(7,410,017)**
Medical Expenses:						
Capitation (PCP, Specialty, Kasier, NEMT & Vision)	3,459,155	4,052,943	4,334,304	4,406,664	2,855,040	(1,551,623)
FFS Claims Expenses:						
Inpatient	4,843,204	5,097,394	6,477,031	6,776,899	10,753,709	3,976,810
LTC / SNF	10,126,507	5,762,933	6,819,386	6,139,754	7,607,916	1,468,162
Outpatient	2,533,435	2,281,965	2,230,932	2,355,940	2,814,194	458,254
Laboratory and Radiology	46,028	162,651	11,628	196,578	870,607	674,028
Physician ACA 1202	3,134,914	0	0	0	0	0
Emergency Room	1,042,118	1,194,168	1,010,132	1,052,564	1,668,571	616,007
Physician Specialty	1,791,663	2,021,708	2,379,637	2,605,488	3,448,201	842,713
Primary Care Physician	673,648	934,447	774,095	830,822	2,780,566	1,949,744
Home & Community Based Services	775,691	956,829	812,703	698,217	836,499	138,282
Applied Behavior Analysis Services	8,265	11,165	14,727	20,429	0	(20,429)
Mental Health Services	415,979	678,589	684,279	697,231	781,616	84,386
Pharmacy	5,532,105	6,006,966	6,129,485	6,312,066	10,115,951	3,803,886
Other Medical Professional	111,261	151,825	74,024	150,919	291,323	140,403
Other Medical Care	0	0	341	0	0	0
Other Fee For Service	250,180	660,972	641,698	627,872	971,115	343,243
Transportation	75,730	(50,918)	108,496	65,367	344,326	278,959
Total Claims	31,360,727	25,870,693	28,168,594	28,530,146	43,284,593	14,754,447
Medical & Care Management Expense	1,016,692	1,079,869	1,087,702	1,112,867	1,127,251	14,384
Reinsurance	502,015	480,408	492,016	535,763	201,670	(334,093)
Claims Recoveries	(177,502)	(100,289)	(778)	(89,868)	0	89,868
Sub-total	1,341,205	1,459,988	1,578,939	1,558,762	1,328,920	(229,842)
Total Cost of Health Care	**36,161,087**	**31,383,625**	**34,081,837**	**34,495,572**	**47,468,554**	**12,972,982**
Contribution Margin	**8,884,977**	**8,618,506**	**11,957,681**	**10,080,233**	**4,517,267**	**5,562,966**
General & Administrative Expenses:						
Salaries and Wages	711,273	736,114	683,270	840,098	863,507	23,409
Payroll Taxes and Benefits	189,329	195,625	192,640	197,312	239,130	41,819
Travel and Training	10,869	8,984	11,020	14,277	21,194	6,917
Outside Service - ACS	1,349,555	1,447,875	1,398,128	1,327,673	1,240,306	(87,367)
Outside Services - Other	151,651	153,238	235,597	164,778	152,369	(12,409)
Accounting & Actuarial Services	14,585	5,415	10,000	10,000	25,000	15,000
Legal	289,180	188,244	226,134	68,274	33,333	(34,941)
Insurance	33,940	32,538	39,441	38,039	14,583	(23,456)
Lease Expense - Office	64,785	65,957	65,957	68,687	64,354	(4,333)
Consulting Services	12,475	37,106	22,212	93,310	91,816	(1,494)
Translation Services	3,990	5,466	8,166	4,909	7,083	2,174
Advertising and Promotion	2,057	1,178	1,041	7,060	31,129	24,069
General Office	182,426	131,637	72,685	120,899	90,920	(29,979)
Depreciation & Amortization	16,530	18,111	19,444	19,444	31,913	12,469
Printing	1,089	365	21,226	19,038	9,375	(9,663)
Shipping & Postage	22,696	25,648	187	13,128	11,342	(1,786)
Interest	9,641	15,268	41,678	10,774	15,000	4,226
Total G & A Expenses	**3,066,071**	**3,068,769**	**3,048,826**	**3,017,700**	**2,942,354**	**(75,346)**
Total Operating Gain / (Loss)	**5,818,906**	**5,549,737**	**8,908,856**	**7,062,533**	**1,574,913**	**5,487,620**
Non Operating:						
Revenues - Interest	46,762	40,314	78,069	112,844	17,845	94,999
Expenses - Interest	3,115	2,528	2,749	1,921	0	(1,921)
Total Non-Operating	**43,647**	**37,785**	**75,320**	**110,923**	**17,845**	**93,078**
Total Increase / (Decrease) in Unrestricted Net Assets	**5,862,553**	**5,587,523**	**8,984,176**	**7,173,456**	**1,592,758**	**5,580,698**
Full Time Employees				**152**	**169**	**17**

PMPM Statement of Revenues, Expenses and Changes in Net Assets

	FEB 15	MAR 15	APR 15	MAY 15 Actual	MAY 15 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	181,458	185,971	187,227	187,801	165,303	22,498
Revenue:						
Premium	335.63	319.58	321.09	322.73	327.14	(4.41)
Reserve for Rate Reduction	(77.05)	(78.85)	(64.27)	(72.87)	0.00	(72.87)
MCO Premium Tax	(10.55)	(25.84)	(11.13)	(12.71)	(12.88)	0.17
Total Net Premium	**248.03**	**214.89**	**245.70**	**237.15**	**314.26**	**(77.10)**
Other Revenue:						
Interest Income	0.00	0.00	0.00	0.00	0.00	0.00
Miscellaneous Income	0.21	0.21	0.20	0.20	0.23	(0.03)
Total Other Revenue	0.21	0.21	0.20	0.20	0.23	(0.03)
Total Revenue	**248.25**	**215.10**	**245.90**	**237.36**	**314.49**	**(77.13)**
Medical Expenses:						
Capitation (PCP, Specialty, Kasier, NEMT & Vision)	19.06	21.79	23.15	23.46	17.27	(6.19)
FFS Claims Expenses:						
Inpatient	26.69	27.41	34.59	36.09	65.05	28.97
LTC / SNF	55.81	30.99	36.42	32.69	46.02	13.33
Outpatient	13.96	12.27	11.92	12.54	17.02	4.48
Laboratory and Radiology	0.25	0.87	0.06	1.05	5.27	4.22
Physician ACA 1202	17.28	0.00	0.00	0.00	0.00	0.00
Emergency Room	5.74	6.42	5.40	5.60	10.09	4.49
Physician Specialty	9.87	10.87	12.71	13.87	20.86	6.99
Primary Care Physician	3.71	5.02	4.13	4.42	16.82	12.40
Home & Community Based Services	4.27	5.15	4.34	3.72	5.06	1.34
Applied Behavior Analysis Services	0.05	0.06	0.08	0.11	0.00	(0.11)
Mental Health Services	2.29	3.65	3.65	3.71	4.73	1.02
Pharmacy	30.49	32.30	32.74	33.61	61.20	27.59
Adult Expansion Reserve	0.00	0.00	0.00	0.00	0.00	0.00
Provider Reserve	0.00	0.00	0.00	0.00	0.00	0.00
Other Medical Professional	0.61	0.82	0.40	0.80	1.76	0.96
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	1.38	3.55	3.43	3.34	5.87	2.53
Transportation	0.42	(0.27)	0.58	0.35	2.08	1.73
Total Claims	172.83	139.11	150.45	151.92	261.85	109.93
Medical & Care Management Expense	5.60	5.81	5.81	5.93	6.82	0.89
Reinsurance	2.77	2.58	2.63	2.85	1.22	(1.63)
Claims Recoveries	(0.98)	(0.54)	(0.00)	(0.48)	0.00	0.48
Sub-total	7.39	7.85	8.43	8.30	8.04	(0.26)
Total Cost of Health Care	199.28	168.76	182.03	183.68	**287.16**	**103.48**
Contribution Margin	**48.96**	**46.34**	**63.87**	**53.68**	**27.33**	**26.35**
General & Administrative Expenses:						
Salaries and Wages	3.92	3.96	3.65	4.47	5.22	0.75
Payroll Taxes and Benefits	1.04	1.05	1.03	1.05	1.45	0.40
Travel and Training	0.06	0.05	0.06	0.08	0.13	0.05
Outside Service - ACS	7.44	7.79	7.47	7.07	7.50	0.43
Outside Service - CQS	0.00	0.00	0.00	0.00	0.00	0.00
Outside Service - RGS	0.00	0.00	0.00	0.00	0.00	0.00
Outside Service - Script Care	0.00	0.00	0.00	0.00	0.00	0.00
Outside Services - Other	0.84	0.82	1.26	0.88	0.92	0.04
Accounting & Actuarial Services	0.08	0.03	0.05	0.05	0.15	0.10
Legal	1.59	1.01	1.21	0.36	0.20	(0.16)
Insurance	0.19	0.17	0.21	0.20	0.09	(0.11)
Lease Expense - Office	0.36	0.35	0.35	0.37	0.39	0.02
Consulting Services	0.07	0.20	0.12	0.50	0.56	0.06
Translation Services	0.02	0.03	0.04	0.03	0.04	0.02
Advertising and Promotion	0.01	0.01	0.01	0.04	0.19	0.15
General Office	1.01	0.71	0.39	0.64	0.55	(0.09)
Depreciation & Amortization	0.09	0.10	0.10	0.10	0.19	0.09
Printing	0.01	0.00	0.11	0.10	0.06	(0.04)
Shipping & Postage	0.13	0.14	0.00	0.07	0.07	(0.00)
Interest	0.05	0.08	0.22	0.06	0.09	0.03
Other/ Miscellaneous Expenses	0.00	0.00	0.00	0.00	0.00	0.00
Total G & A Expenses	16.90	16.50	16.28	16.07	17.80	1.73
Total Operating Gain / (Loss)	32.07	29.84	47.58	37.61	9.53	28.08
Non Operating:						
Revenues - Interest	0.26	0.22	0.42	0.60	0.11	0.49
Expenses - Interest	0.02	0.01	0.01	0.01	0.00	(0.01)
Total Non-Operating	0.24	0.20	0.40	0.59	0.11	0.48
Total Increase / (Decrease) in Unrestricted Net Assets	32.31	30.05	47.99	38.20	9.64	28.56

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
For Eleven Months Ended May 31, 2015

	MAY 15 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	1,936,315	1,775,796	160,519
Revenue			
Premium	$ 655,676,321	$ 565,247,301	$ 90,429,020
Reserve for Rate Reduction	(116,899,946)	0	(116,899,946)
MCO Premium Tax	(25,053,122)	(22,256,612)	(2,796,510)
Total Net Premium	**513,723,253**	**542,990,688**	**(29,267,436)**
Other Revenue:			
Miscellaneous Income	451,985	421,663	30,322
Total Other Revenue	451,985	**421,663**	30,322
Total Revenue	**514,175,237**	**543,412,351**	**(29,237,114)**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	37,977,576	30,129,788	(7,847,788)
FFS Claims Expenses:			
Inpatient	81,932,007	111,288,250	29,356,244
LTC / SNF	88,647,478	82,930,504	(5,716,974)
Outpatient	28,667,575	29,355,182	687,607
Laboratory and Radiology	5,076,964	8,650,276	3,573,312
Physician ACA 1202	8,077,096	0	(8,077,096)
Emergency Room	13,556,560	17,228,204	3,671,644
Physician Specialty	29,774,753	36,181,802	6,407,049
Primary Care Physician	19,091,633	28,336,029	9,244,396
Home & Community Based Services	13,103,176	9,187,098	(3,916,078)
Applied Behavior Analysis Services	55,509	0	(55,509)
Mental Health Services	6,639,445	8,302,920	1,663,475
Pharmacy	62,397,743	103,634,594	41,236,851
Adult Expansion Reserve	(8,100,000)	0	8,100,000
Other Medical Professional	2,148,863	2,997,049	848,187
Other Medical Care	1,097	0	(1,097)
Other Fee For Service	7,794,116	10,326,363	2,532,247
Transportation	2,209,489	3,476,018	1,266,529
Total Claims	361,073,501	451,894,289	90,820,788
Medical & Care Management Expense	11,397,645	11,883,365	485,720
Reinsurance	4,142,248	2,166,471	(1,975,777)
Claims Recoveries	(976,586)	0	976,586
Sub-total	14,563,307	14,049,836	(513,470)
Total Cost of Health Care	**413,614,384**	**496,073,914**	**82,459,530**
Contribution Margin	**100,560,853**	**47,338,437**	**53,222,416**
General & Administrative Expenses:			
Salaries and Wages	7,662,065	9,118,113	1,456,047
Payroll Taxes and Benefits	2,156,741	2,446,656	289,915
Travel and Training	119,942	241,348	121,405
Outside Service - ACS	14,689,346	13,340,059	(1,349,286)
Outside Services - Other	1,581,882	1,568,099	(13,783)
Accounting & Actuarial Services	154,641	275,000	120,359
Legal	2,341,846	366,666	(1,975,180)
Insurance	266,879	160,417	(106,463)
Lease Expense - Office	712,422	707,894	(4,528)
Consulting Services	390,771	1,346,515	955,744
Translation Services	53,605	77,913	24,308
Advertising and Promotion	26,529	257,969	231,440
General Office	1,172,286	1,548,251	375,965
Depreciation & Amortization	185,168	278,393	93,225
Printing	103,454	200,797	97,343
Shipping & Postage	109,077	189,938	80,861
Interest	198,883	165,000	(33,883)
Total G & A Expenses	**31,925,538**	**32,289,028**	**363,489**
Total Operating Gain / (Loss)	**$ 68,635,315**	**$ 15,049,410**	**$ 53,585,905**
Non Operating			
Revenues - Interest	524,113	186,532	337,581
Expenses - Interest	52,985	0	(52,985)
Total Non-Operating	471,128	186,532	284,596
Total Increase / (Decrease) in Unrestricted Net Assets	$ 69,106,443	$ 15,235,941	$ 53,870,501
Net Assets, Beginning of Year	32,613,991		
Net Assets, End of Year	101,720,434		

Statement of Cash Flows - Monthly

	MAY 15	APR 15	MAR 15
Cash Flow From Operating Activities			
Collected Premium	$ -	$ 66,932,156	$ 134,811,271
Miscellaneous Income	112,844	78,069	40,314
State Pass Through Funds	-	2,139,715	4,383,049
Paid Claims			
Medical & Hospital Expenses	(25,562,731)	(30,629,285)	(35,848,764)
Pharmacy	(6,784,343)	(6,410,487)	(5,781,444)
Capitation	(3,835,620)	(3,767,160)	(3,141,517)
Reinsurance of Claims	(535,763)	(529,803)	(480,408)
State Pass Through Funds Distributed	(1,541,703)	(1,532,177)	(1,446,016)
Paid Administration	(3,508,393)	(1,737,229)	(4,795,844)
MCO Tax Received / (Paid)	(6,549,477)	(1,651,004)	(3,383,516)
Net Cash Provided / (Used) by Operating Activities	**(48,205,186)**	**22,892,795**	**84,357,126**
Cash Flow From Investing / Financing Activities			
Net Acquisition of Investments	(6,241)	(179,737,508)	(50,003,271)
Net Acquisition of Property / Equipment	(30,333)	(24,727)	(18,626)
Net Cash Provided / (Used) by Investing / Financing	**(36,574)**	**(179,762,235)**	**(50,021,897)**
Net Cash Flow	**$ (48,241,760)**	**$ (156,869,440)**	**$ 34,335,229**
Cash and Cash Equivalents (Beg. of Period)	156,092,662	312,962,102	278,626,873
Cash and Cash Equivalents (End of Period)	107,850,902	156,092,662	312,962,102
	$ (48,241,760)	**$ (156,869,440)**	**$ 34,335,229**
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	7,173,456	8,984,176	5,587,523
Depreciation & Amortization	33,602	33,602	32,269
Decrease / (Increase) in Receivables	(60,698,003)	(70,360)	63,478,378
Decrease / (Increase) in Prepaids & Other Current Assets	183,567	(127,154)	106,964
(Decrease) / Increase in Payables	(1,614,317)	2,337,526	(6,751,516)
(Decrease) / Increase in Other Liabilities	13,683,085	18,939,718	27,713,537
Change in MCO Tax Liability	(4,162,967)	800,379	2,313,260
Changes in Claims and Capitation Payable	3,782,493	1,159,564	138,152
Changes in IBNR	(6,586,102)	(9,164,657)	(8,261,441)
	(48,205,186)	22,892,795	84,357,126
Net Cash Flow from Operating Activities	**(48,205,186)**	**22,892,795**	**84,357,126**

Statement of Cash Flows - YTD

	MAY 15
Cash Flow From Operating Activities	
Collected Premium	$ 735,416,586
Miscellaneous Income	524,112
State Pass Through Funds	51,814,653
Paid Claims	
Medical & Hospital Expenses	(278,957,905)
Pharmacy	(66,725,051)
Capitation	(33,126,434)
Reinsurance of Claims	(5,475,375)
State Pass Through Funds Distributed	(47,893,558)
Paid Administration	(34,602,997)
MCO Taxes Received / (Paid)	(43,289,146)
Net Cash Provided / (Used) by Operating Activities	**277,684,885**
Cash Flow From Investing / Financing Activities	
Net Acquisition of Investments	(229,747,020)
Net Acquisition of Property / Equipment	(263,661)
Net Cash Provided / (Used) by Investing / Financing	**(230,010,681)**
Net Cash Flow	**$ 47,674,204**
Cash and Cash Equivalents (Beg. of Period)	60,176,698
Cash and Cash Equivalents (End of Period)	107,850,902
	$ 47,674,204
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income / (Loss)	69,106,443
Depreciation & Amortization	340,911
Decrease / (Increase) in Receivables	51,597,143
Decrease / (Increase) in Prepaids & Other Current Assets	170,908
(Decrease) / Increase in Payables	3,707,927
(Decrease) / Increase in Other Liabilities	143,423,075
Change in MCO Tax Liability	(15,806,183)
Changes in Claims and Capitation Payable	9,667,786
Changes in IBNR	15,476,875
	277,684,885
Net Cash Flow from Operating Activities	**$ 277,684,885**

Gold Coast Health Plan℠
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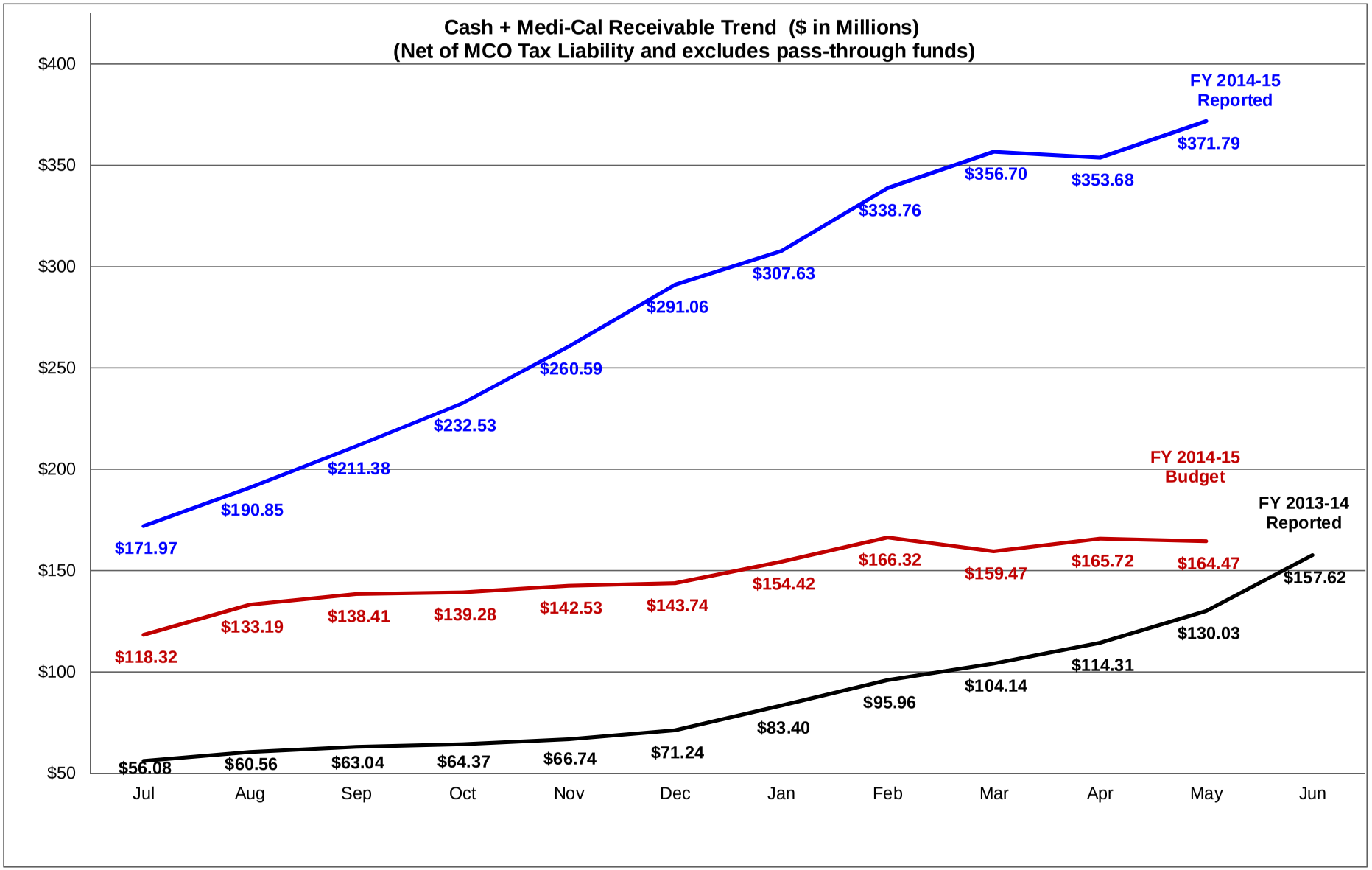
For the month ended May 31, 2015

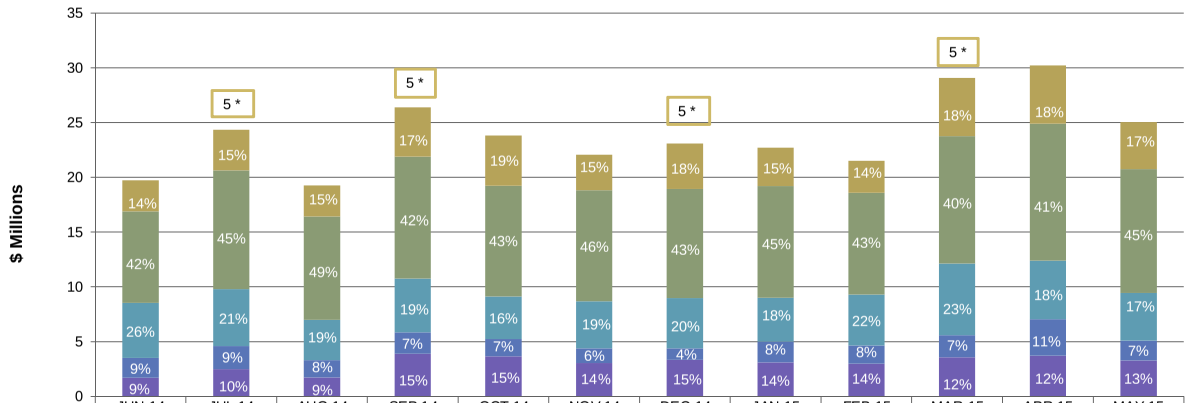
APPENDIX

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

GOLD COAST HEALTH PLAN
MAY 15



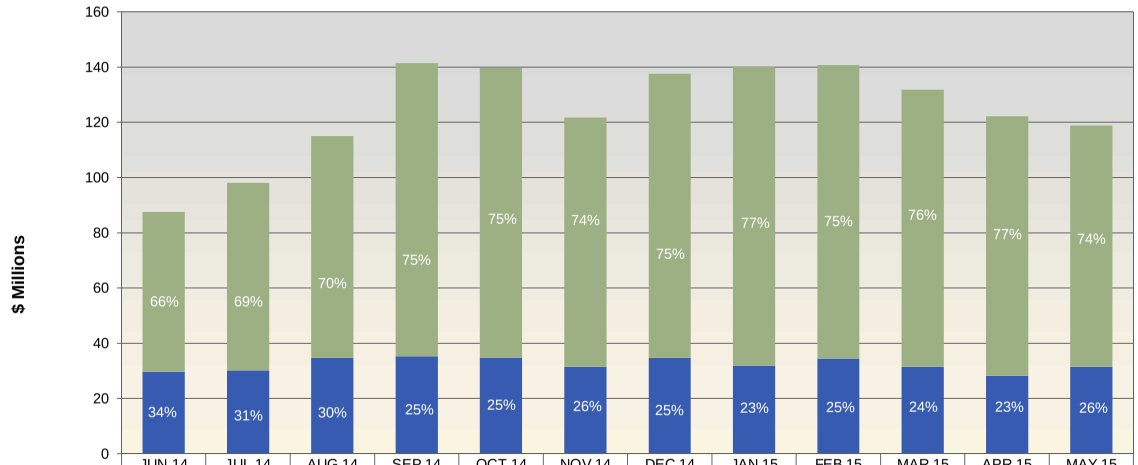
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	JUN 14	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15
Current	2.84	3.70	2.85	4.50	4.57	3.25	4.14	3.50	2.91	5.30	5.32	4.30
30	8.35	10.85	9.42	11.15	10.13	10.15	9.96	10.20	9.30	11.63	12.52	11.31
60	5.04	5.20	3.69	4.90	3.89	4.29	4.61	4.00	4.64	6.56	5.34	4.36
90	1.80	2.10	1.58	1.95	1.56	1.35	1.03	1.90	1.68	2.01	3.31	1.81
120+	1.70	2.50	1.73	3.90	3.66	3.05	3.35	3.10	2.97	3.57	3.73	3.28

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.

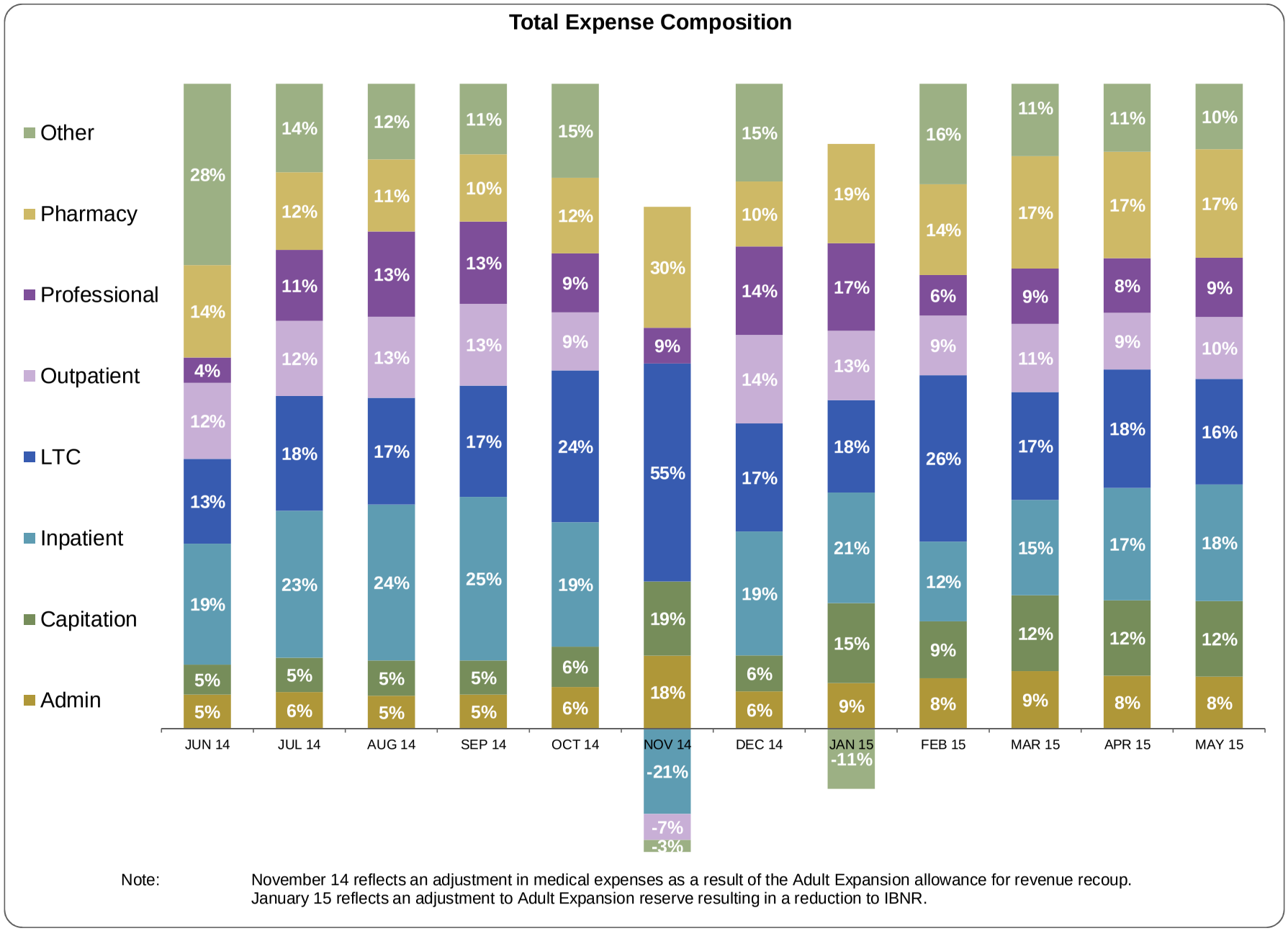
IBNP Composition (excluding Pharmacy and Capitation)



	JUN 14	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15
Prior Month Unpaid	57.90	67.93	80.29	106.07	104.95	90.22	102.84	108.19	106.23	100.37	94.05	87.42
Current Month Unpaid	29.69	30.14	34.67	35.33	34.78	31.45	34.71	31.86	34.48	31.46	28.17	31.40
Total Unpaid	87.59	98.06	114.96	141.40	139.73	121.67	137.55	140.05	140.71	131.82	122.22	118.82

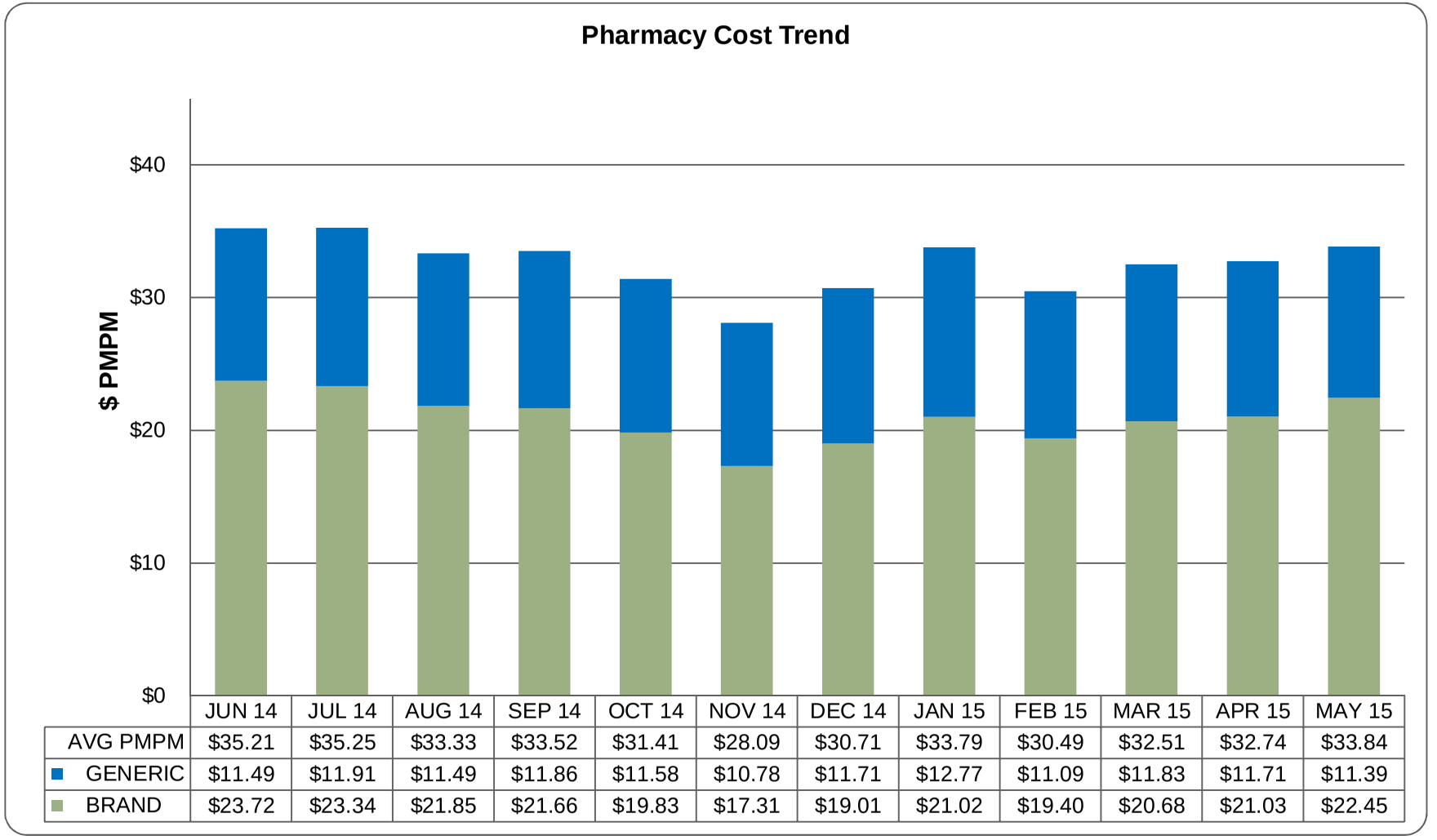
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

GOLD COAST HEALTH PLAN



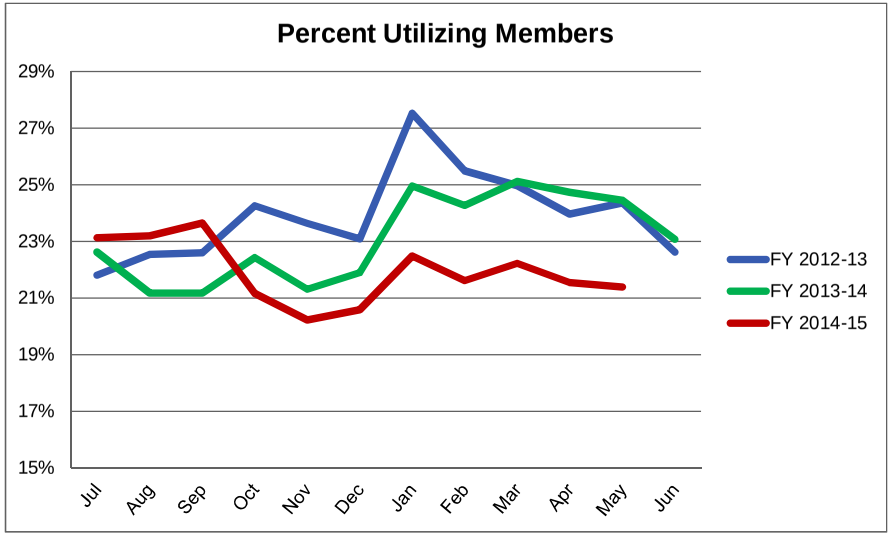
Note: November 14 reflects an adjustment in medical expenses as a result of the Adult Expansion allowance for revenue recoup.
January 15 reflects an adjustment to Adult Expansion reserve resulting in a reduction to IBNR.

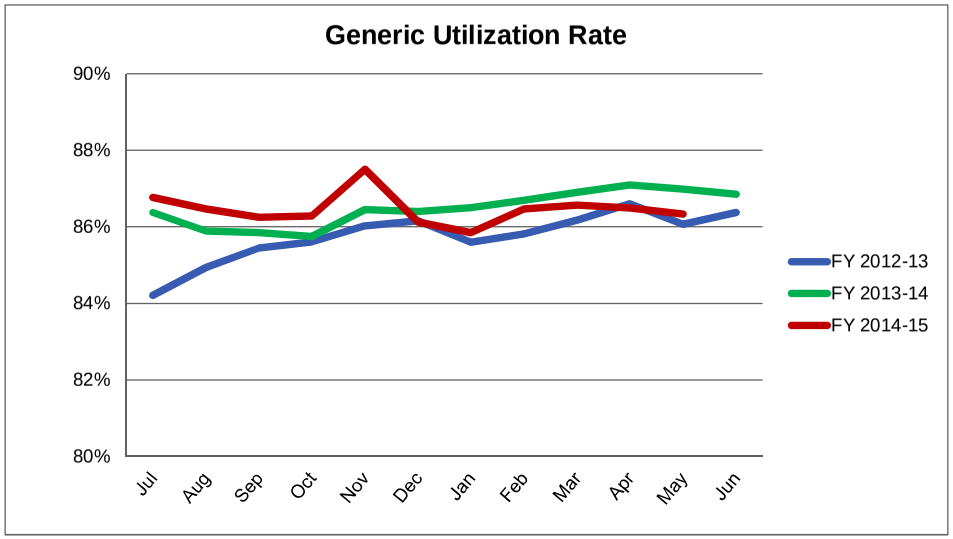
GOLD COAST HEALTH PLAN



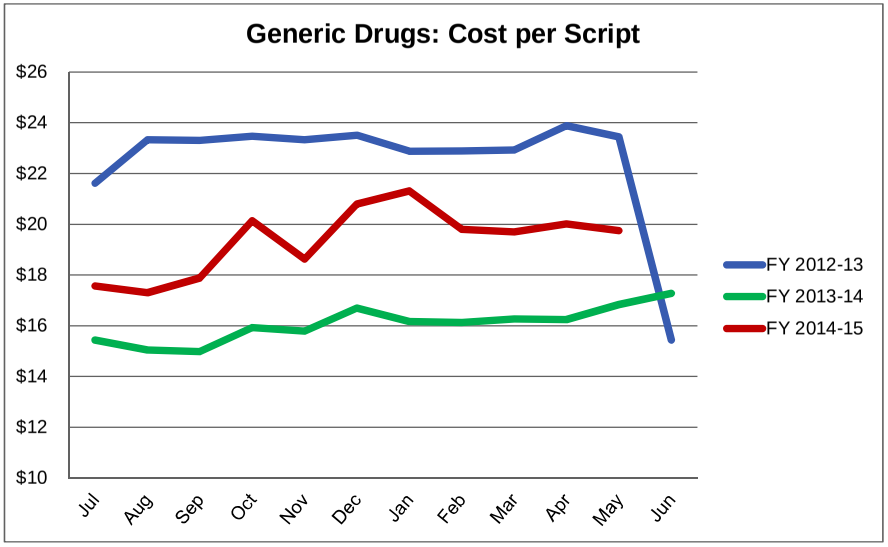
	JUN 14	JUL 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15
AVG PMPM	$35.21	$35.25	$33.33	$33.52	$31.41	$28.09	$30.71	$33.79	$30.49	$32.51	$32.74	$33.84
GENERIC	$11.49	$11.91	$11.49	$11.86	$11.58	$10.78	$11.71	$12.77	$11.09	$11.83	$11.71	$11.39
BRAND	$23.72	$23.34	$21.85	$21.66	$19.83	$17.31	$19.01	$21.02	$19.40	$20.68	$21.03	$22.45

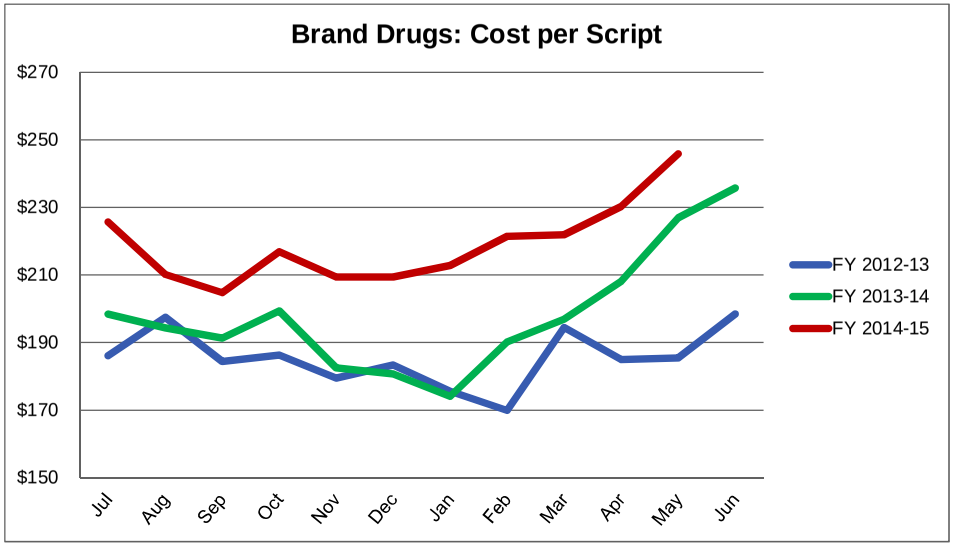
GOLD COAST HEALTH PLAN
Pharmacy Analysis





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





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Gold Coast Health Plan℠
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AGENDA ITEM 3.c.

TO: Gold Coast Health Plan Commission

FROM: Ruth Watson, COO

DATE: August 24, 2015

RE: COO Update

OPERATIONS UPDATE

Space Expansion – Significant membership growth and additional regulatory requirements has driven increased staffing to meet service demands. As a result, GCHP's existing office space will soon be at capacity. In May, staff advised the Commission of the Plan's intent to work with our broker to identify available space for expansion of 10,000 to 20,000 square feet. Projected costs for office expansion are included in the FY 2015-16 approved budget.

This additional square footage is intended to accommodate 40-50 staff over the near term and, if necessary in the future, another 40 to 50 people in 2 to 4 years. This expansion will also include space for a large multi-purpose room that can be used for commission meetings, community meetings, training rooms and all-staff meetings. The Plan is in the process of issuing an RFP for three properties that exist in our Camarillo campus. At the same time, staff is also working with a space planner to "restack" the current footprint in order to maximize the Plan's use of the existing space. Once a property is selected, the final proposal will be presented to the Commission for approval

Membership Update – August 2015

Gold Coast Health Plan (GCHP) added 1,520 members in July and 2,462 members in August. GCHP has crossed the 190,000 threshold and now has a total membership of 191,783 as of August 1, 2015. GCHP's membership has increased by 73,271 or 61.8% since January 2014. The cumulative new membership since January 1, 2014 is summarized as follows:

Aid Code	# of New Members
L1 – Low Income Health Plan (LIHP)	3,039
M1 – Adult Expansion	42,465
7U – CalFresh Adults	2,766
7W – CalFresh Children	746
7S – Parents of 7Ws	380

Traditional Medi-Cal	23,875
Total New Membership 1/1/14 – 8/1/15	73,271

Total members assigned to the M1 aid code increased in both July (40,948) and August (42,465). All other Medi-Cal Expansion aid codes, with the exception of 7S, decreased either due to re-determination into other aid codes or loss of coverage. GCHP had 59 potential new members transitioning from Covered CA as of August 1, 2015; 53 were identified as new to GCHP on the August eligibility file from DHCS.

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

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

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

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

AB 85 Capacity Tracking – VCMC has a total of 28,245 Adult Expansion members assigned to them as of August 2015. VCMC's target enrollment is 65,765 and is currently at 42.9% of the enrollment target.

June 2015 Operations Summary

Claims Inventory – ended June with an inventory of 33,228; this equates to Days Receipt on Hand (DROH) of 4.2 compared to a DROH goal of 5. GCHP received approximately 7,800 claims per day in June which is ~2,500 more claims per day than received in June 2014. Monthly claim receipts from July 2014 through June 2015 are as follows:

Month	Total Claims Received	Receipts per Day
June 2015	171,806	7,809
May 2015	160,992	8,050
April 2015	146,198	6,645
March 2015	152,948	6,952
February 2015	130,559	6,528
January 2015	127,517	6,376
December 2014	128,087	6,099
November 2014	111,182	6,177
October 2014	134,274	5,838
September 2014	119,233	5,678
August 2014	108,695	5,176
July 2014	117,136	5,324

Claims Turnaround Time (TAT) – the regulatory requirement of processing 90% of clean claims within 30 calendar days was met in June with a result of 97.9%.

Claims Processing Accuracy – the financial accuracy goal of 98% or higher was met in June with a result of 99.94% and procedural accuracy exceeded the goal of 97% in June at 99.99%.

Call Volume – call volume exceeded 10,000 calls during June; the number of calls received in June was 10,404. The 12-month average is 10,085 calls per month.

Average Speed to Answer (ASA) – Although the ASA increased during the month, the combined result (Member, Provider and Spanish lines) for June still met the Service Level Agreement (SLA) goal of 30 seconds or less with a result of 16.2 seconds.

Abandonment Rate – the abandonment rate continued to meet SLA expectations. June's

combined result was 0.96% compared to a goal of 5% or less.

Average Call Length – the combined result of 7.94 minutes in June was above the goal of 7.0 minutes.

Grievance and Appeals – GCHP received 96 member grievances and 30 provider grievances (related to claim payment disputes) during June. The number of member grievances received per 1,000 members was 0.51; excluding the balance billing issues this number would drop to 0.08. GCHP removed Balance Billing as a grievance type as of July 1, 2015, which is consistent with the other COHS.

Type of Member Grievances	Number of Grievances
Accessibility – Lack of PCP Availability	3
Balance Billing	79
Benefits/Coverage	1
Denial/Refusals	2
Quality of Care	8
Quality of Service	3

There were three clinical appeals in June; two were denied for untimely filing and one was withdrawn. One State Fair Hearing was approved in favor of the member in June.

Member Orientation Meetings – GCHP Member Services continues to offer three (3) Member Orientation meetings, in both English and Spanish, each month in various locations throughout the county. A total of 127 members (97 English, 30 Spanish) plus 17 County Employees/Others attended meetings in the first six month of 2015 compared with a total of 28 during the same time period in 2014. GCHP continues to include an informational flyer in each new member packet to make members aware of this opportunity to learn more about GCHP and their Medi-Cal benefits.

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

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

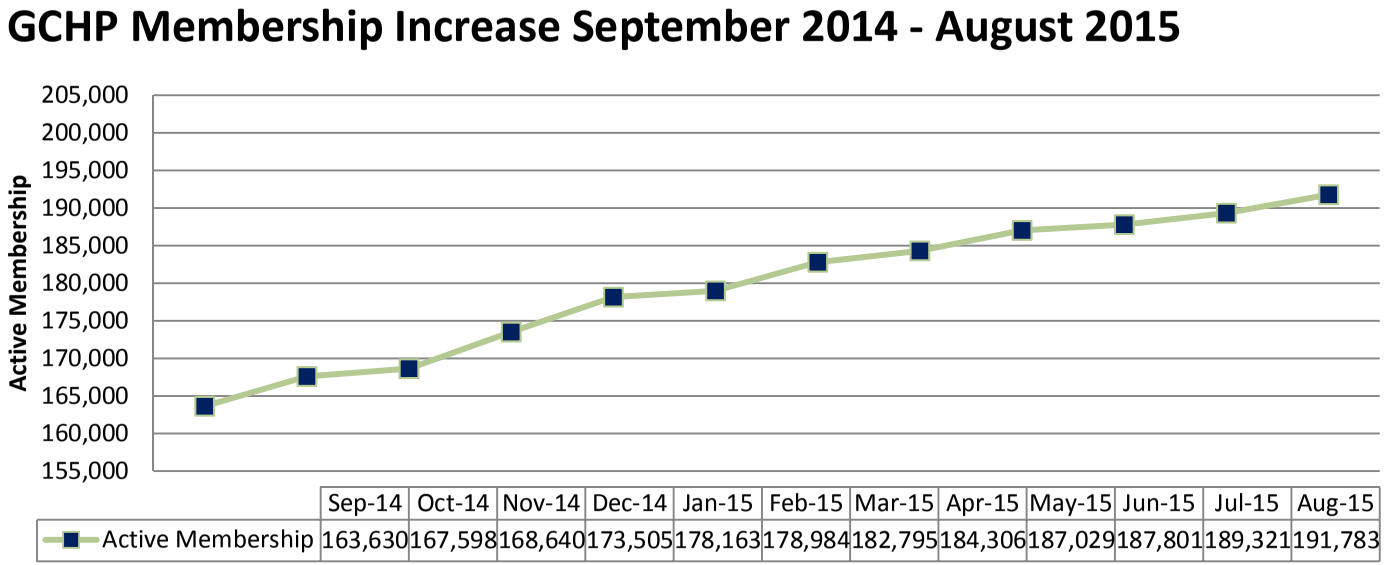
- Business Continuity Plan (BCP) – the BCP project has been completed; the

Emergency Management Team (EMT), Mission Critical departments and back-ups have received training.

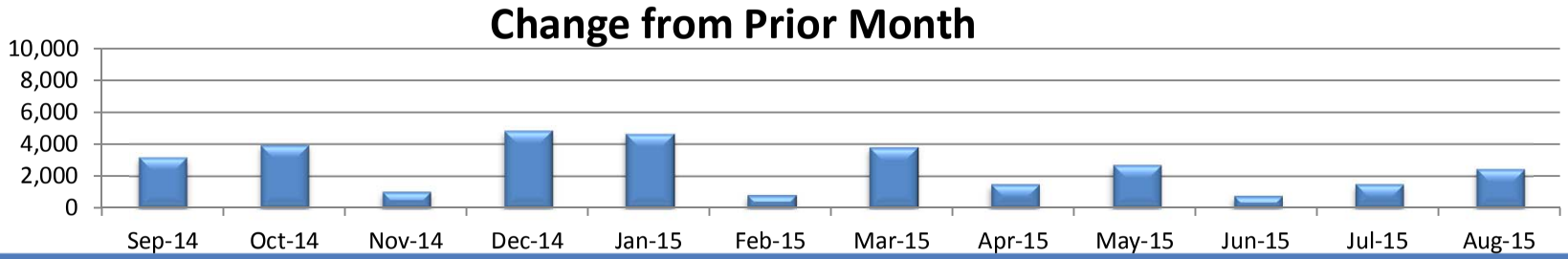
- ICD-10 Readiness – work continues towards implementation of the new code set which is effective for dates of service on or after October 1, 2015. Testing is currently underway following upgrades to ika and iCES. GCHP conducted two provider training sessions on August 17th and 20th to assist providers in their preparation and readiness for the transition to ICD-10.
- Member Handbook – the 2015-16 Member Handbook was implemented into production beginning with July 2015 new members.
- ASO Consultant Services RFP – the RFP for consultant services to assist in the evaluation of GCHP's ASO arrangement has been released.

GCHP Membership

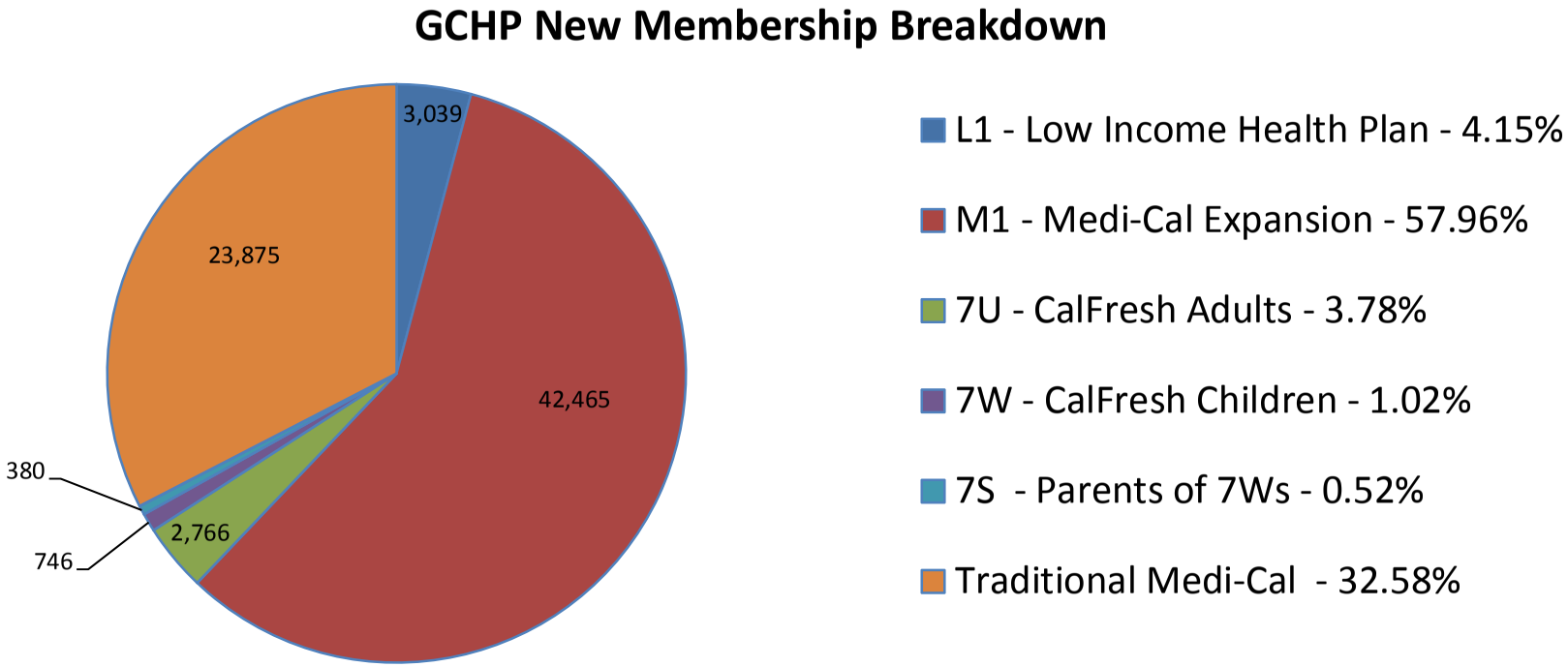
Total Membership as of August 1, 2015 – 191,783
New Members Added Since January 2014 – 73,271



	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Active Membership	163,630	167,598	168,640	173,505	178,163	178,984	182,795	184,306	187,029	187,801	189,321	191,783



Membership Growth



Note: GCHP Pended eligibility (not shown) – 911 (decreased 276 from July)

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

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

	Aug-15		Jul-15		Jun-15		May-15		Apr-15		Mar-15	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
AB85 Eligible	**1,159**		**1,312**		**1,519**		**1,489**		**2,342**		**1,609**	
VCMC	869	74.98%	984	75.00%	1,139	74.98%	1,116	74.95%	1,756	74.98%	1,206	74.95%
Balance	290	25.02%	328	25.00%	380	25.02%	373	25.05%	586	25.02%	403	25.05%
Regular Eligible	**1,023**		**891**		**1,455**		**1,620**		**1,420**		**1,277**	
Regular + AB85 Balance	**1,313**		**1,219**		**1,835**		**1,993**		**2,006**		**1,680**	
Clinicas	265	20.18%	372	30.52%	458	24.96%	508	25.49%	513	25.57%	421	25.06%
CMH	138	10.51%	156	12.80%	203	11.06%	233	11.69%	236	11.76%	193	11.49%
Independent	30	2.28%	29	2.38%	55	3.00%	53	2.66%	65	3.24%	37	2.20%
VCMC	880	67.02%	662	54.31%	1,119	60.98%	1,199	60.16%	1,192	59.42%	1,029	61.25%
Total Assigned	**2,182**		**2,203**		**2,974**		**3,109**		**3,762**		**2,886**	
Clinicas	265	12.14%	372	16.89%	458	15.40%	508	16.34%	513	13.64%	421	14.59%
CMH	138	6.32%	156	7.08%	203	6.83%	233	7.49%	236	6.27%	193	6.69%
Independent	30	1.37%	29	1.32%	55	1.85%	53	1.70%	65	1.73%	37	1.28%
VCMC	1,749	80.16%	1,646	74.72%	2,258	75.92%	2,315	74.46%	2,948	78.36%	2,235	77.44%

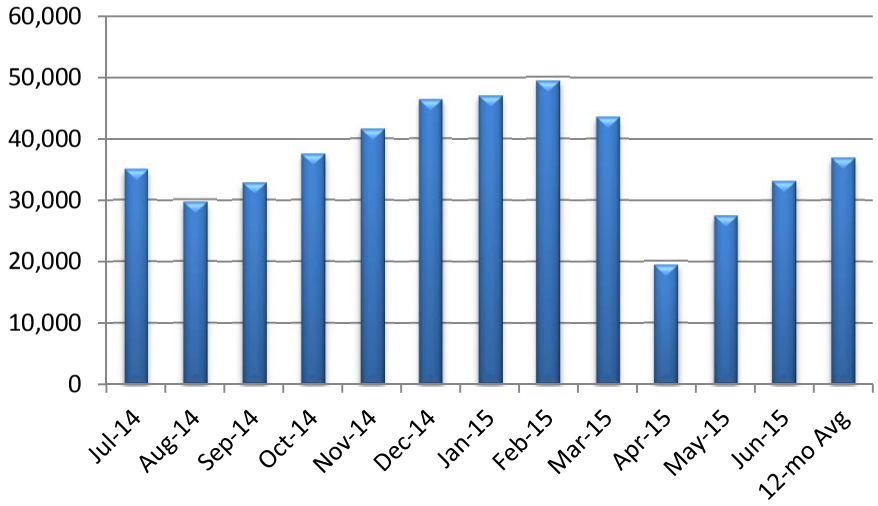
Auto Assignment Process

- 75% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85
- The remaining 25% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others
- The County's overall auto assignment results will be higher than 75% since they receive 75% of the AE members plus a 3:1 ratio of all other unassigned members
- VCMC's target enrollment is 65,765
  - VCMC has 28,245 assigned Adult Expansion members as of August 1, 2015 and is currently at 42.9% of capacity

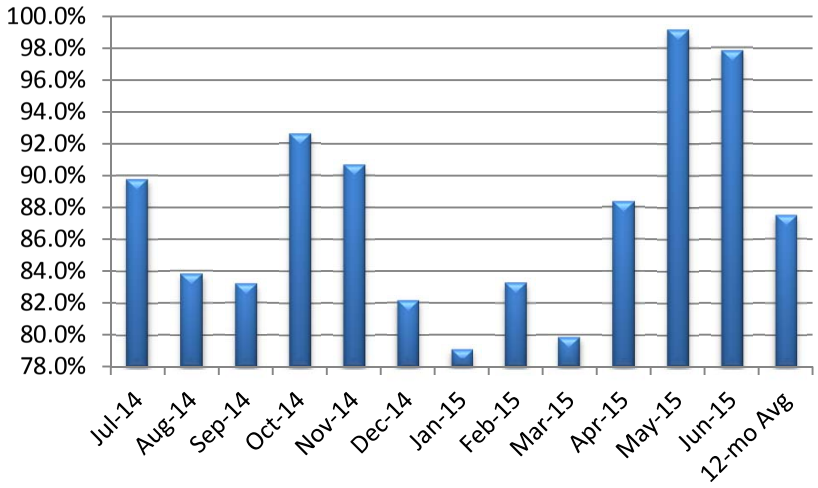
GCHP Claims Metrics – June 2015

- The 30 Day Turnaround Time (TAT) remained in compliance at 97.9%
- Ending Inventory increased by ~5,600 claims from May but was still below the Days Receipt on Hand (DROH) goal of 5 days. DROH for June was 4.2.
- Service Level Agreements for Financial Accuracy (99.94%) and Procedural Accuracy (99.99%) were both met in June.

Ending Inventory

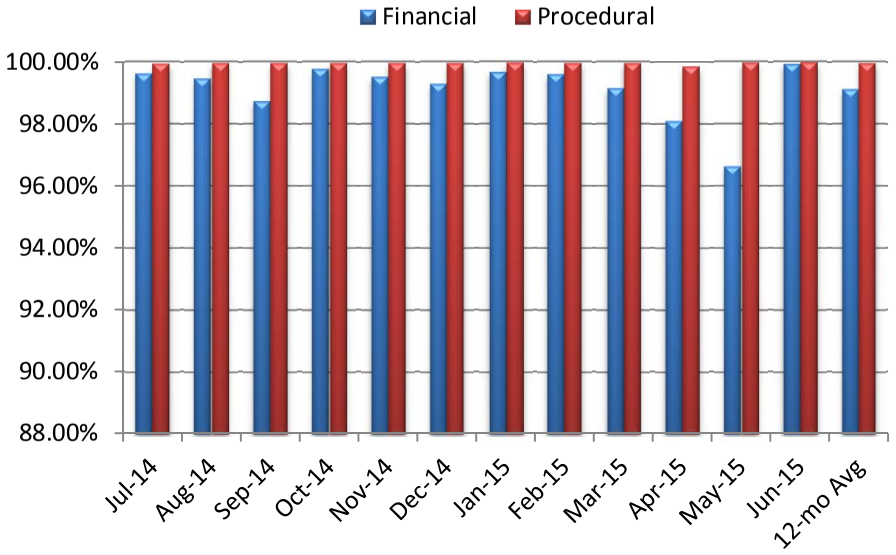


Clean Claims Processed within 30 Calendar Days



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

Financial and Procedural Accuracy

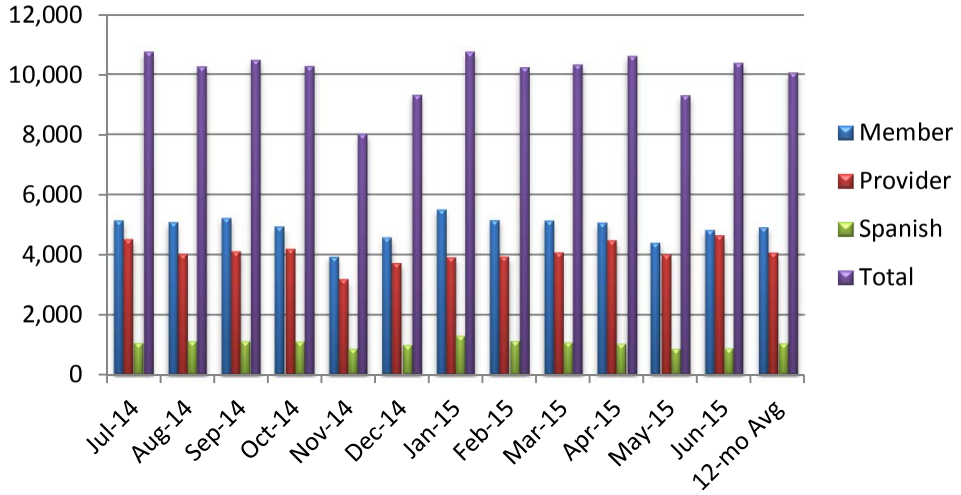


Financial Accuracy – 98% or higher
Procedural Accuracy – 97% or higher

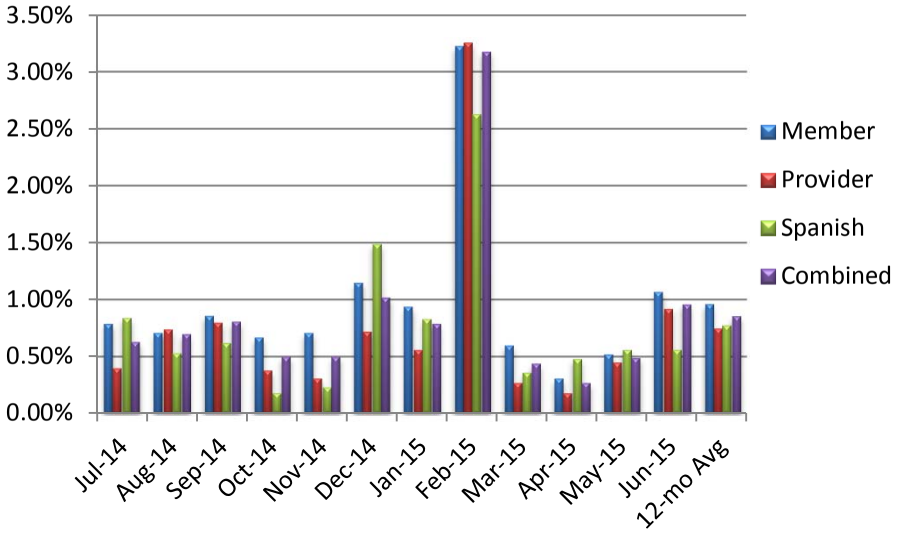
GCHP Call Center Metrics – June 2015

- Call volume increased in June; GCHP received 10,404 calls during the month
- ASA (16.2 seconds) and Abandonment Rate (0.96%) both increased during June but were still within goal

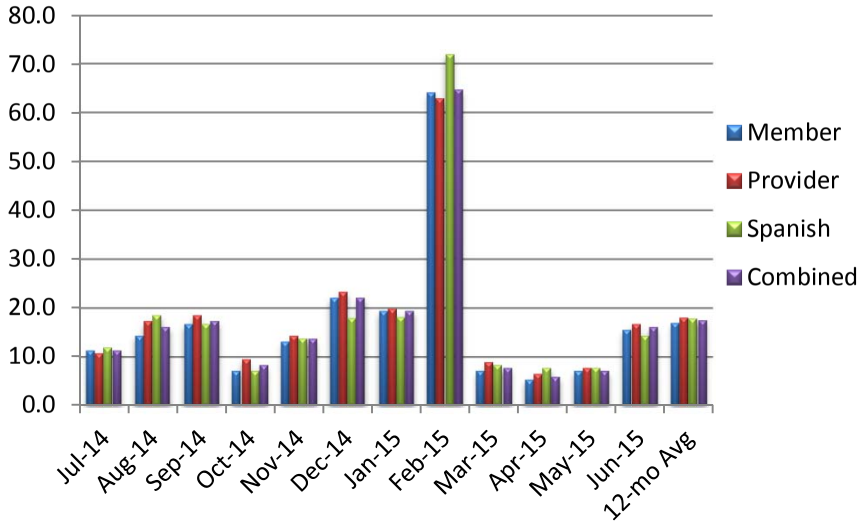
Call Center Volume



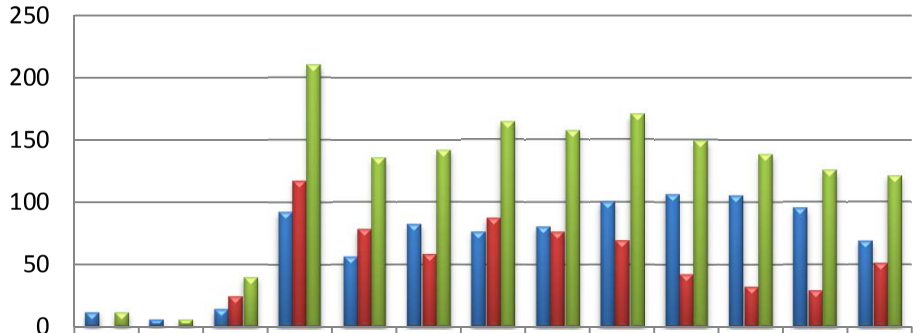
Abandonment Rate
(goal of 5% or less)



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



Total Grievances per Month

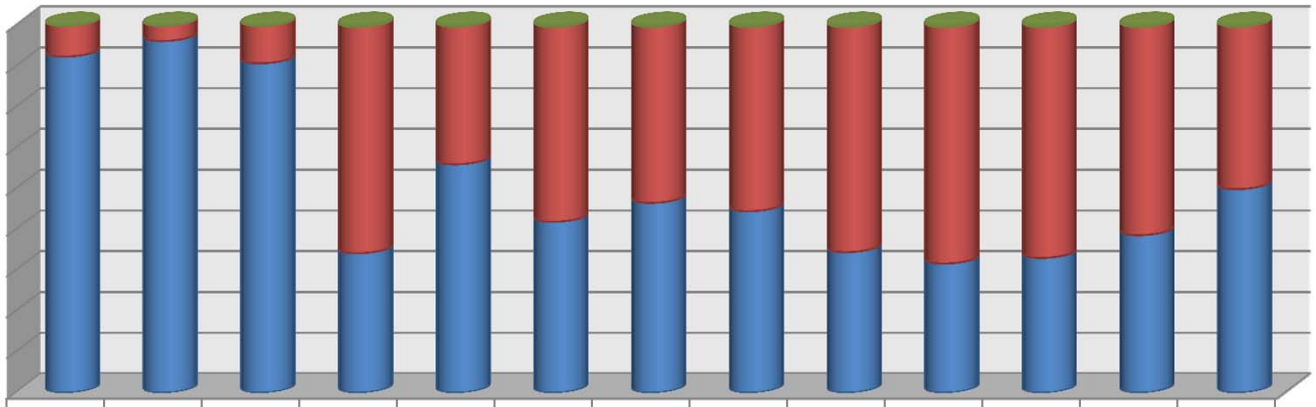


	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	12-mo Avg
Member	12	6	15	93	57	83	77	81	101	107	106	96	69
Provider	0	0	25	118	79	59	88	77	70	43	33	30	52
Combined	12	6	40	211	136	142	165	158	171	150	139	126	121

GCHP Grievance & Appeals Metrics – June 2015

- GCHP received a total of 126 grievances in June; the majority of the member grievances resulted from providers who were balance billing the member
- GCHP received 0.51 member grievances per 1,000 members in June; excluding balance billing the results would be 0.08
  - Balance billing was removed as a grievance type as of 7/1/15

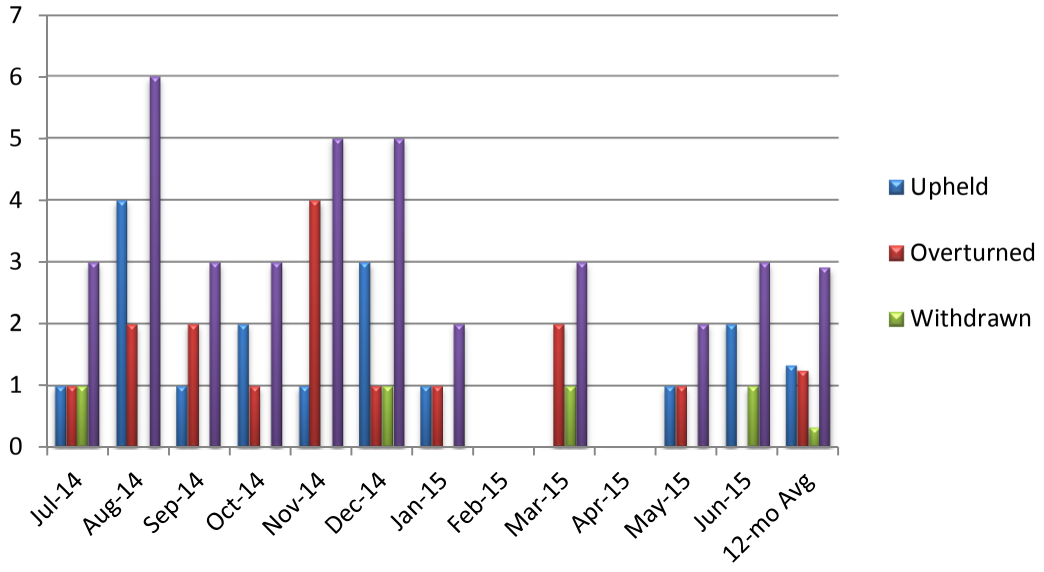
Member Grievances per 1000 Members



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	12-mo Avg
# of Grievance per 1000 Members	0.08	0.04	0.09	0.55	0.34	0.48	0.43	0.45	0.55	0.58	0.57	0.51	0.39
Total Member Grievances Filed	12	6	15	93	57	83	77	81	101	107	106	96	70
Membership Count	159,111	160,427	163,630	167,598	168,640	173,505	178,163	178,984	182,795	184,306	187,029	187,801	174,332

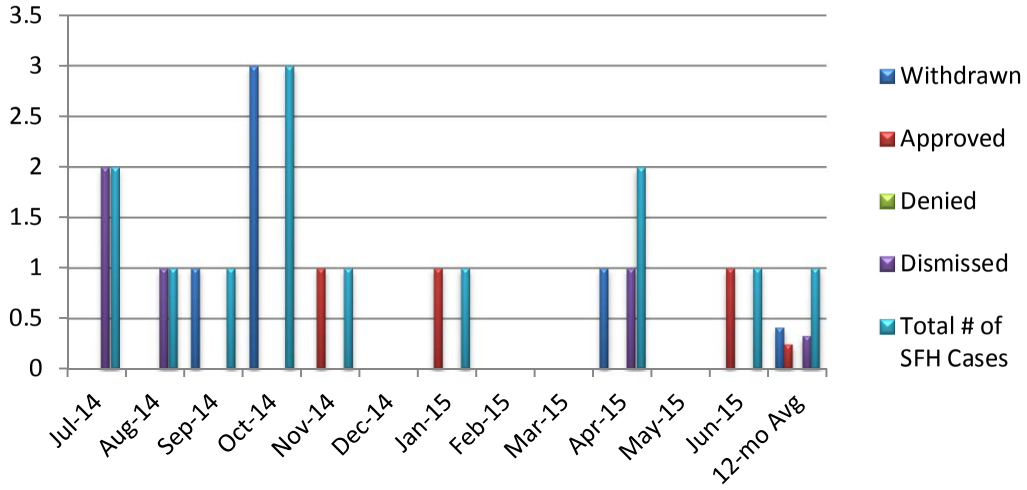
GCHP Grievance & Appeals Metrics – June 2015

Clinical Appeals



- GCHP resolved three clinical appeals in June; two were upheld and one was withdrawn

State Fair Hearings



- One State Fair Hearing was approved in favor of the member during the month of June

Gold Coast Health Plan℠
A Public Entity

AGENDA ITEM 3.d.

TO: Gold Coast Health Plan Commission

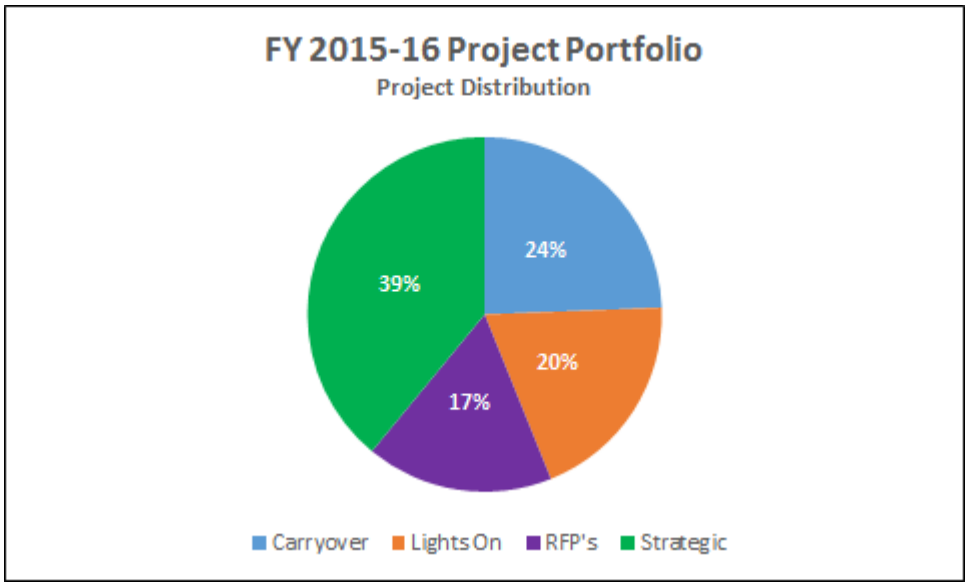
FROM: Melissa Scrymgeour, CIO

DATE: August 24, 2015

RE: CIO Update

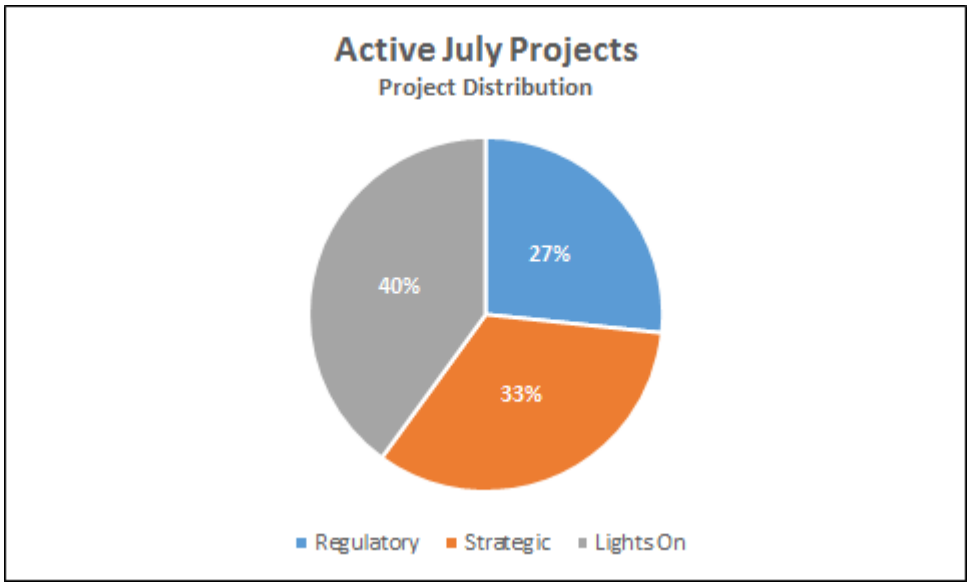
Project Management Office (PMO)
The FY 2015-16 Project Portfolio consists of the following approved initiatives for the upcoming fiscal year:

- Ten (10) active carryover projects from FY 2014-15.
- Seven (7) Requests for Proposals (RFP) for new systems, services, and/or strategic consulting support.
- Eight (8) "Lights On" projects, including software and server upgrades, as well as office expansion and reconfiguration.
- Sixteen (16) projects supporting GCHP strategic tenants around quality, provider network maintenance, member, provider and community engagement, communications, finance, administrative services, and technology and analytics.



PMO Project Activity Highlights through July 2015:

- Closed Business Continuity Planning (BCP).
- Closed Crossover Claims.
- SharePoint RFP: RFP effort complete and final vendor selected. The Plan expects to execute the contract with ShareSquared by the end of August 2015. The total contract cost is less than $100,000. The Plan will kick off implementation in September.
- CORE-HIPAA/ACA Administrative Simplification Rules: Executed contract with Edifecs on June 30, 2015 and kicked off the project.
- The overall health of the active portfolio projects has been challenged by resource availability, both GCHP and Xerox. Large regulatory projects are competing for the same resources. Recent GCHP staffing increases have helped mitigate this risk on the Plan side. ACS is actively working to address their current resource capacity constraints.
    - Two Projects, PDMO and ACS Extract Optimization were put on hold to mitigate resource issues. The PMO is reevaluating timeline to move projects back to active status and reestablish project baseline.



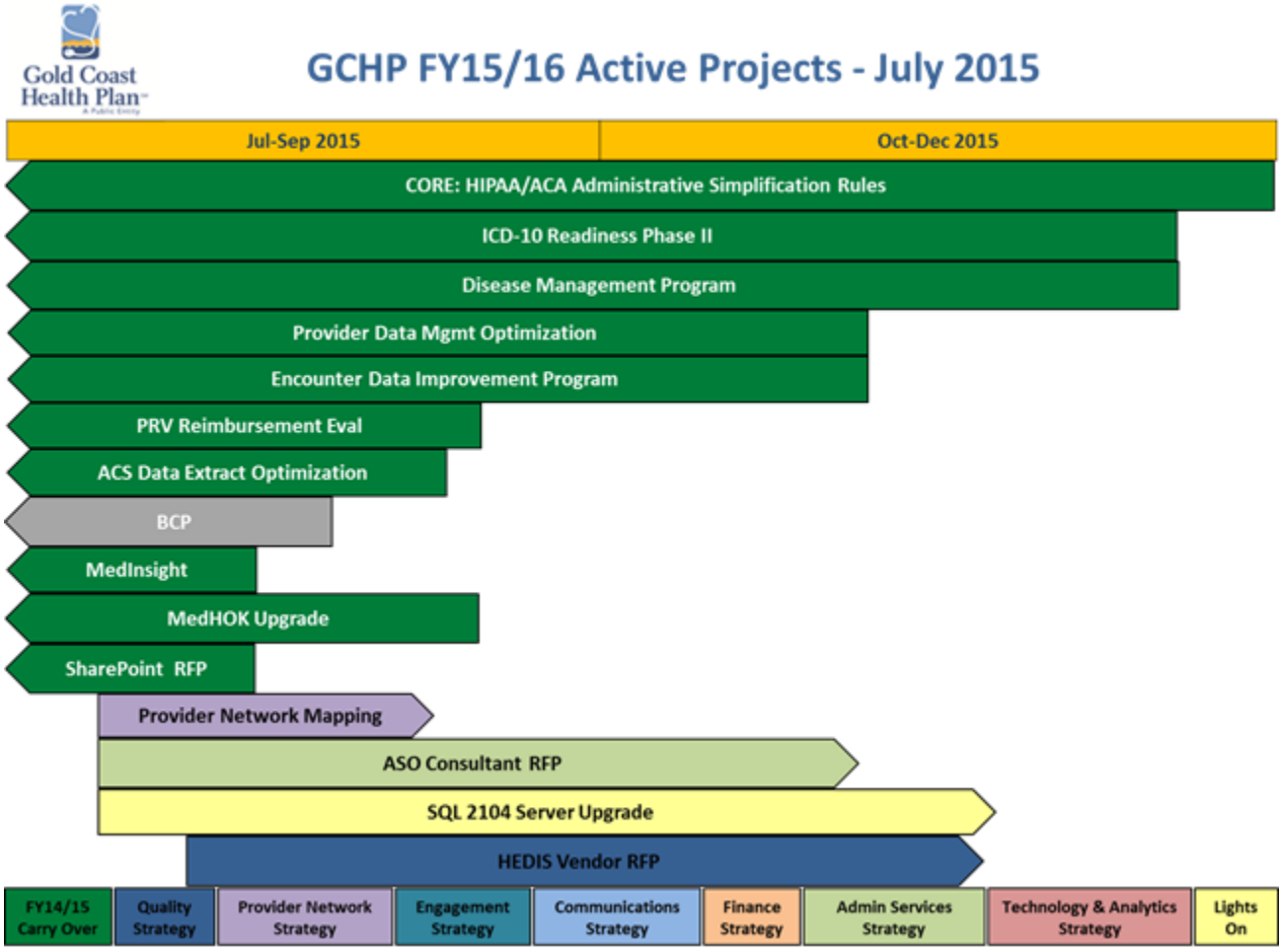
Upcoming PMO Portfolio Activity:

- ICD-10 Readiness Phase II: Begin ICD-10 Testing phase. Testing efforts will continue until go live on October 1, 2015.
- Provider Network Mapping Tool: Execute vendor software contract. Install software and conduct training.
- CORE-HIPAA/ACA Administrative Simplification Rules: Begin development and

testing phases targeting November 2015.

- MedInsight Upgrade: Complete user acceptance testing, user training, run parallel processing through August and close the project.
- Complete contracting with SharePoint implementation vendor and close RFP.
- MedHOK Upgrade: Conduct user acceptance and regression testing in preparation for rollout in August.
- Kickoff RFP Initiatives for the following:

    - Administrative Services Organization (ASO) RFP Consultant
    - Health Effectiveness Data and Information Sets (HEDIS) Solution

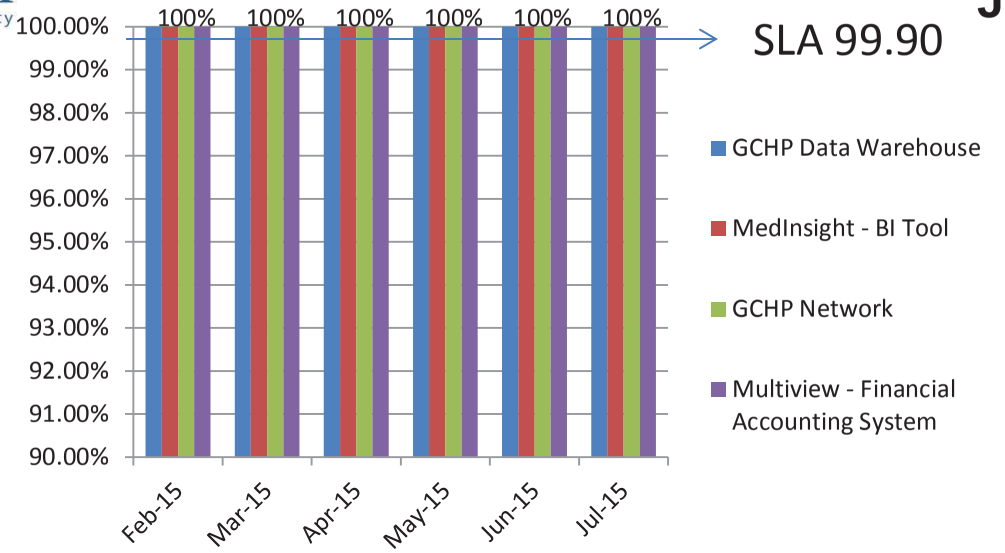


FY 2015-16 GCHP Projects:

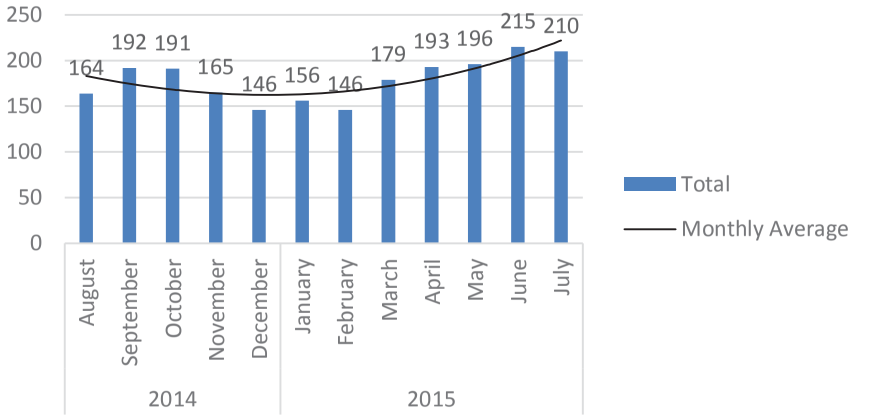
- **Healthcare Effectiveness Data and Information Set (HEDIS) Vendor Request for Proposal (RFP) and Implementation:** RFP and possible implementation of new HEDIS solution.
- **Care Gaps Implementation:** Implement Care Gaps module for member care coordination.
- **Provider Network Mapping:** Implement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

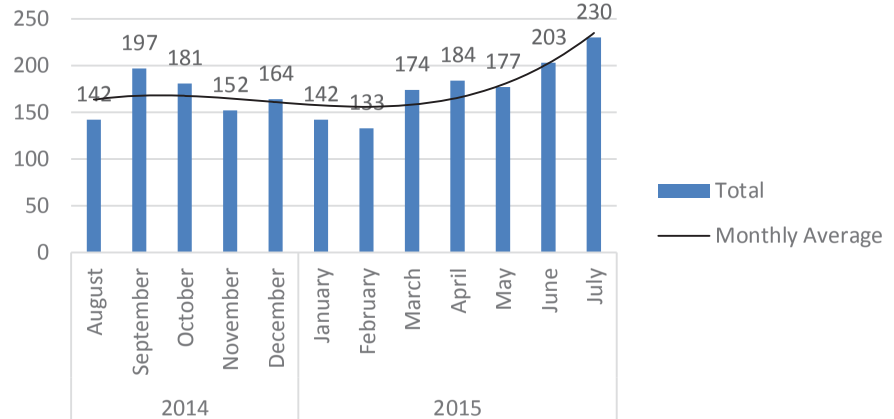
- **Office Expansion and Reconfiguration:** Office expansion project which will include the reconfiguration of the current location, in addition to acquiring new office space to accommodate growth and future expansion.
- **Microsoft SQL 2014 Upgrade:** Version upgrade and landscape redesign of GCHP SQL server environment.
- **Multiview Upgrade:** Software version upgrade for Multiview financial system.
- **Microsoft Office 2013 Upgrade:** Upgrade all employee machines to Microsoft Office 2013.
- **Ika/ICES Upgrade:** Software version upgrade for Xerox/ACS core administration processing and claims editing systems.
- **MedHOK Upgrade:** Software version upgrade for MedHOK medical management system.
- **MedInsight Upgrade:** Software version upgrade for MedInsight Business Intelligence (BI) tool; includes transition to hosted solution.

GCHP IT Metrics – July 2015

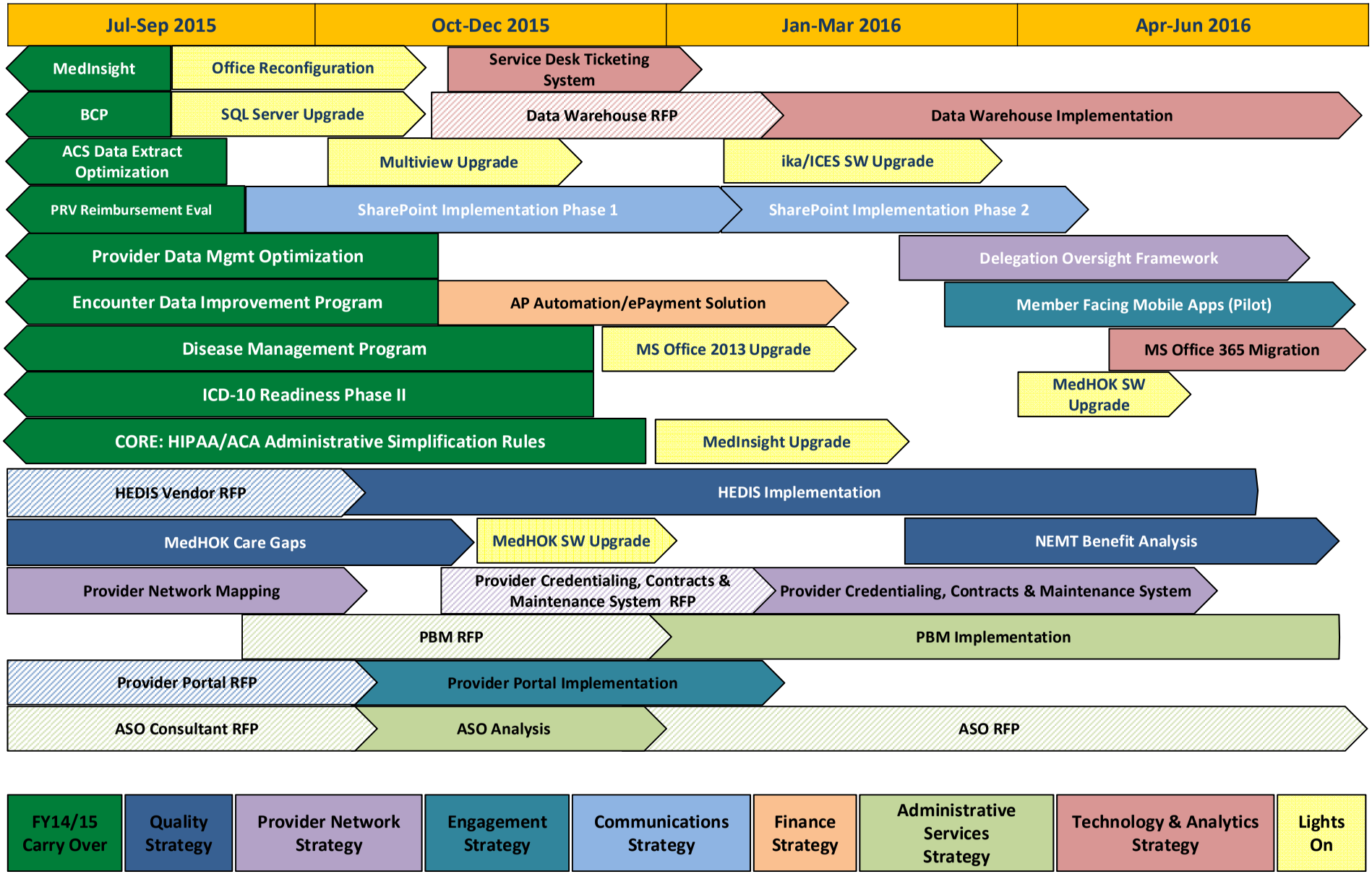


GCHP Helpdesk Service Ticket Trending





GCHP FY 2015-16 Project Portfolio



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AGENDA ITEM 4.e.

TO: Gold Coast Health Plan Commission

FROM: Dr. Nancy Wharfield, Associate Chief Medical Officer

DATE: August 24, 2015

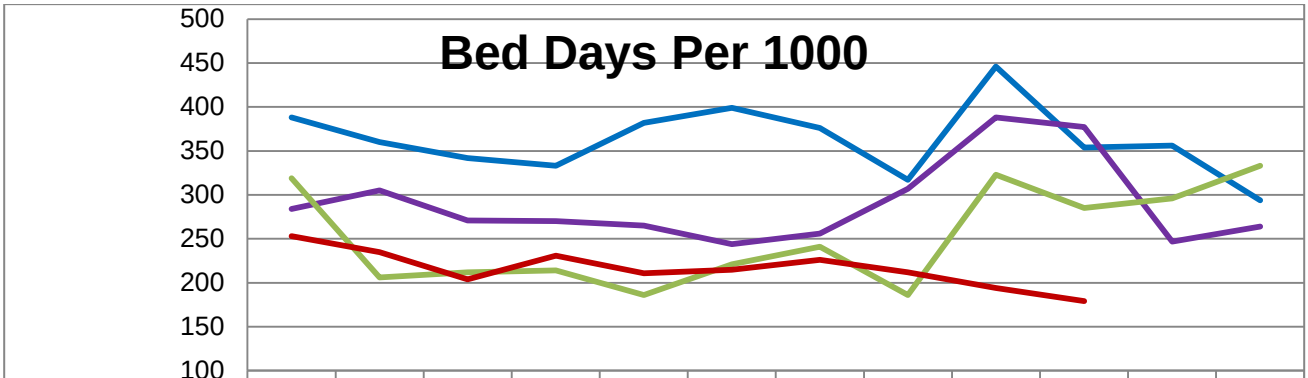
RE: Health Services Update

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.

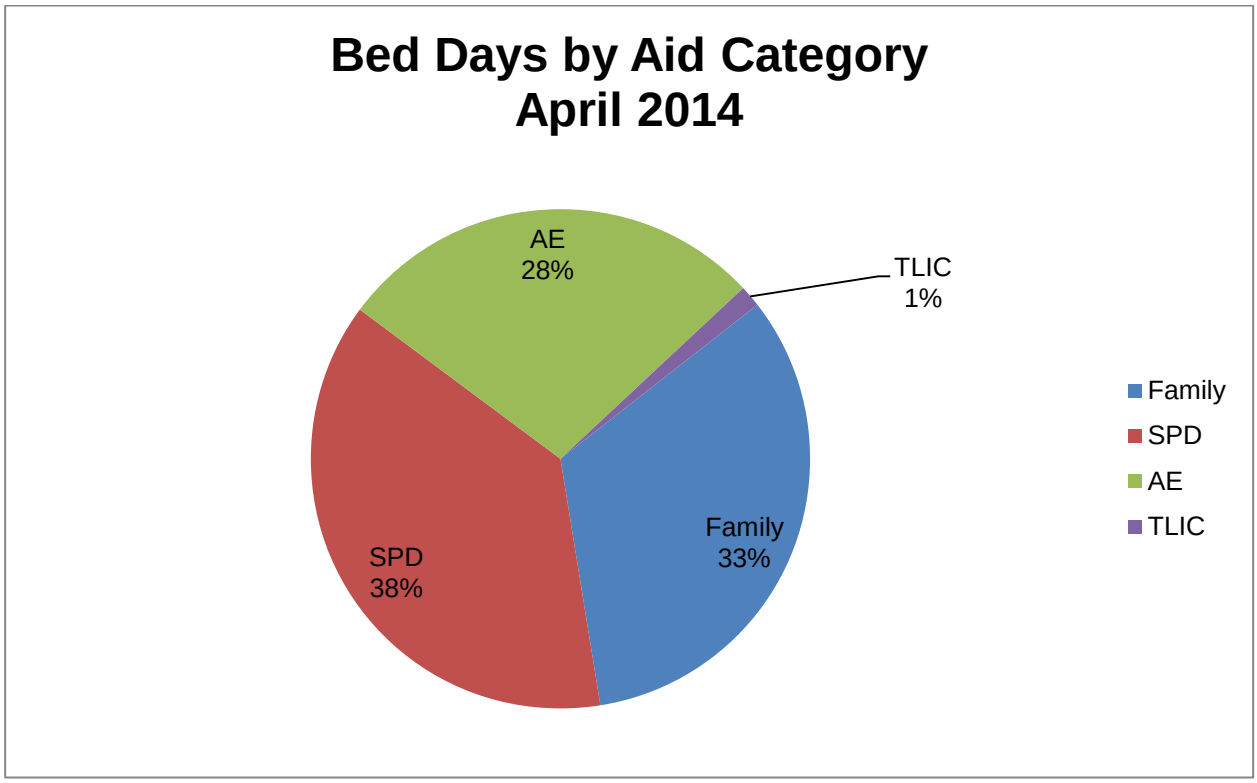
Bed Days/1000 Members

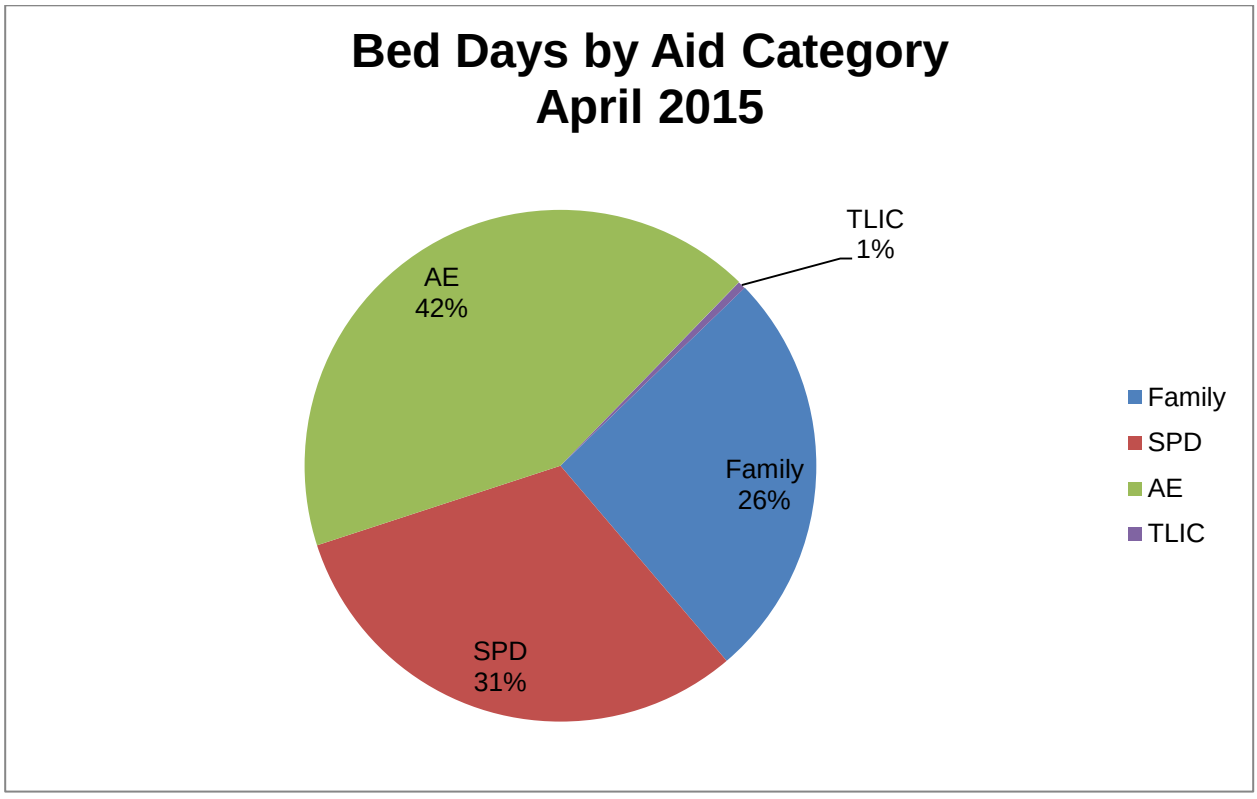
Bed days/1000 members for FY 2014-15 declined from summer through fall and winter and average 216 for FY YTD. A March peak in bed days/1000 members seen in other years of operation has not been reproduced in 2015. The percent of bed days utilized by AE members increased 1.5 times from March 2014 compared to March 2015.

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



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2011-12	388	360	342	333	382	399	376	317	446	354	356	294
FY 2012-13	284	305	271	270	265	244	256	307	388	377	247	264
FY 2013-14	319	206	212	214	186	221	241	186	323	285	296	333
FY 2014-15	253	235	204	231	211	215	226	212	194	179		

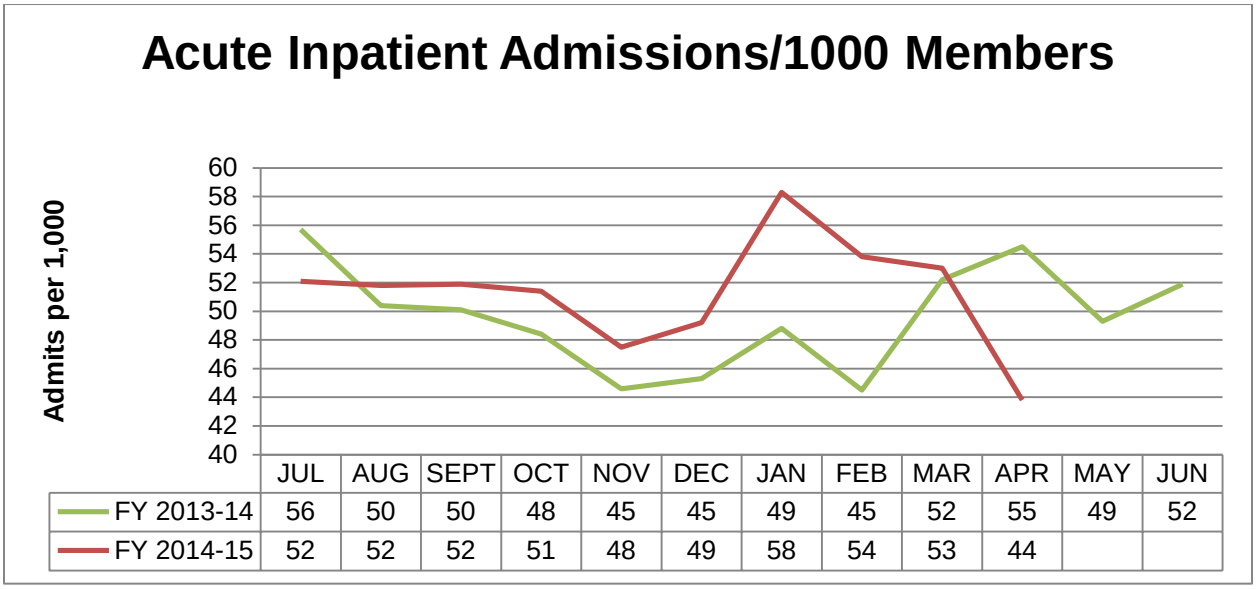

Bed Days by Aid Category
April 2014
AE
28%
TLIC
1%
Family
33%
SPD
38%
Family
SPD
AE
TLIC


Bed Days by Aid Category
April 2015
TLIC
1%
AE
42%
Family
26%
SPD
31%
Family
SPD
AE
TLIC

Inpatient Admissions/1000 Members

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

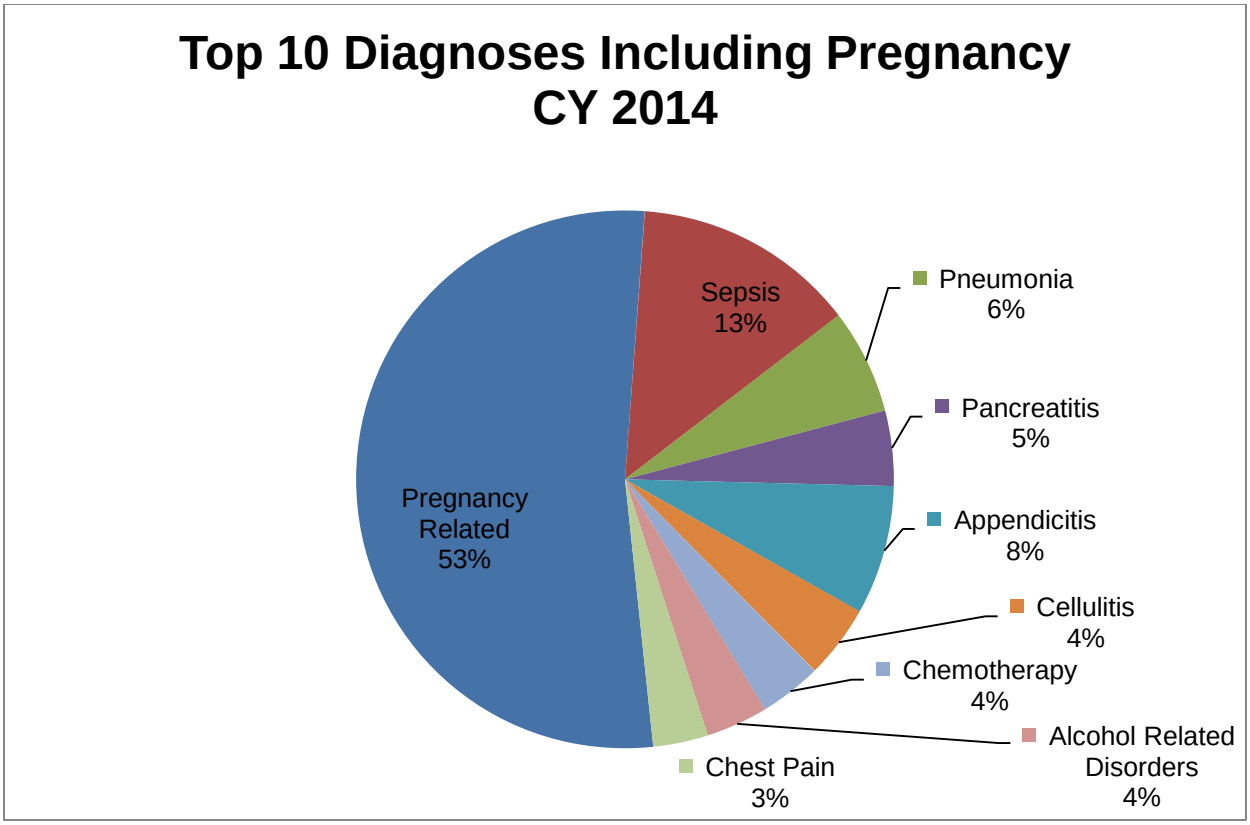
Benchmark: Reports of inpatient hospital admissions/1000 members from available published managed care plan data range from 68-71.

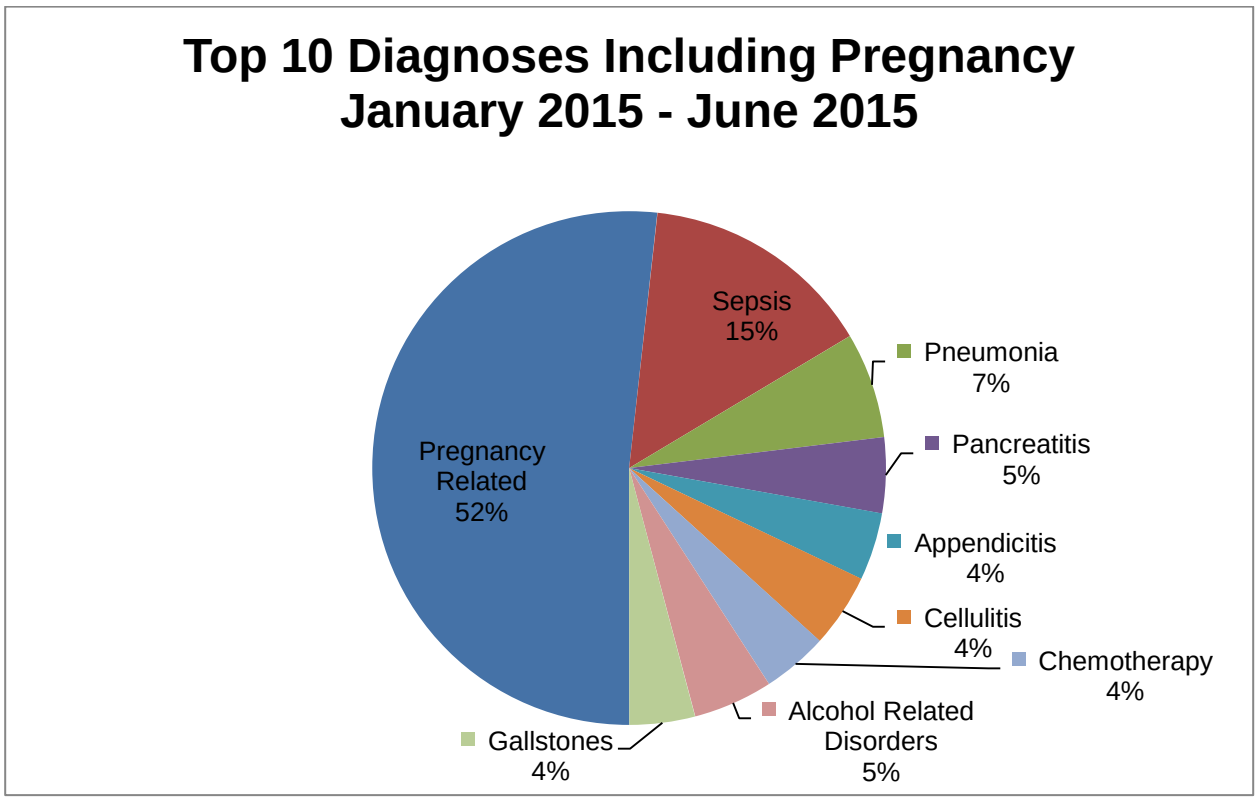


	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2013-14	56	50	50	48	45	45	49	45	52	55	49	52
FY 2014-15	52	52	52	51	48	49	58	54	53	44		

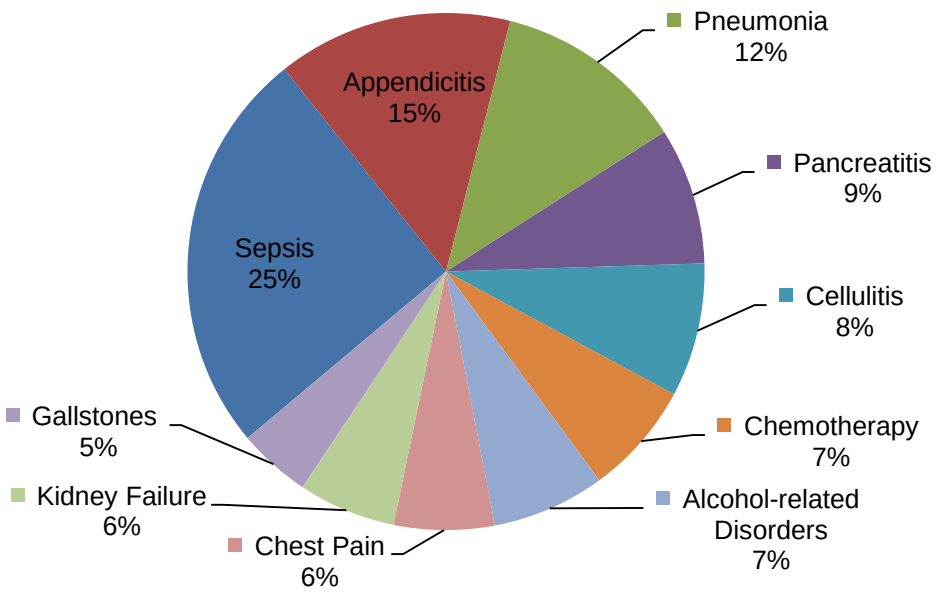
Top Admitting Diagnoses

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

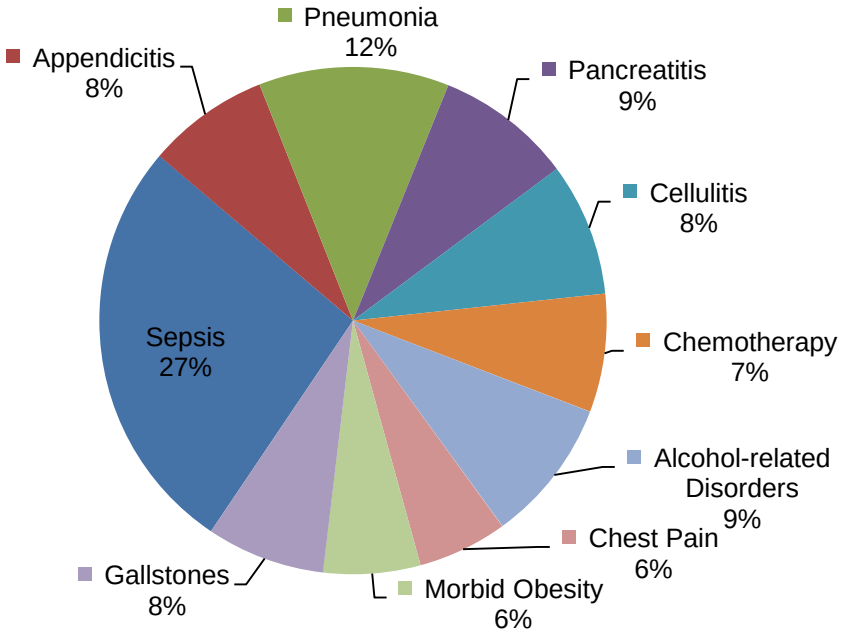

Top 10 Diagnoses Including Pregnancy
CY 2014
Sepsis
13%
Pneumonia
6%
Pancreatitis
5%
Appendicitis
8%
Cellulitis
4%
Chemotherapy
4%
Alcohol Related
Disorders
4%
Chest Pain
3%
Pregnancy
Related
53%


Top 10 Diagnoses Including Pregnancy
January 2015 - June 2015
Sepsis
15%
Pneumonia
7%
Pancreatitis
5%
Appendicitis
4%
Cellulitis
4%
Chemotherapy
4%
Alcohol Related
Disorders
5%
Gallstones
4%
Pregnancy
Related
52%

Top 10 Diagnoses Excluding Pregnancy Calendar Year 2014



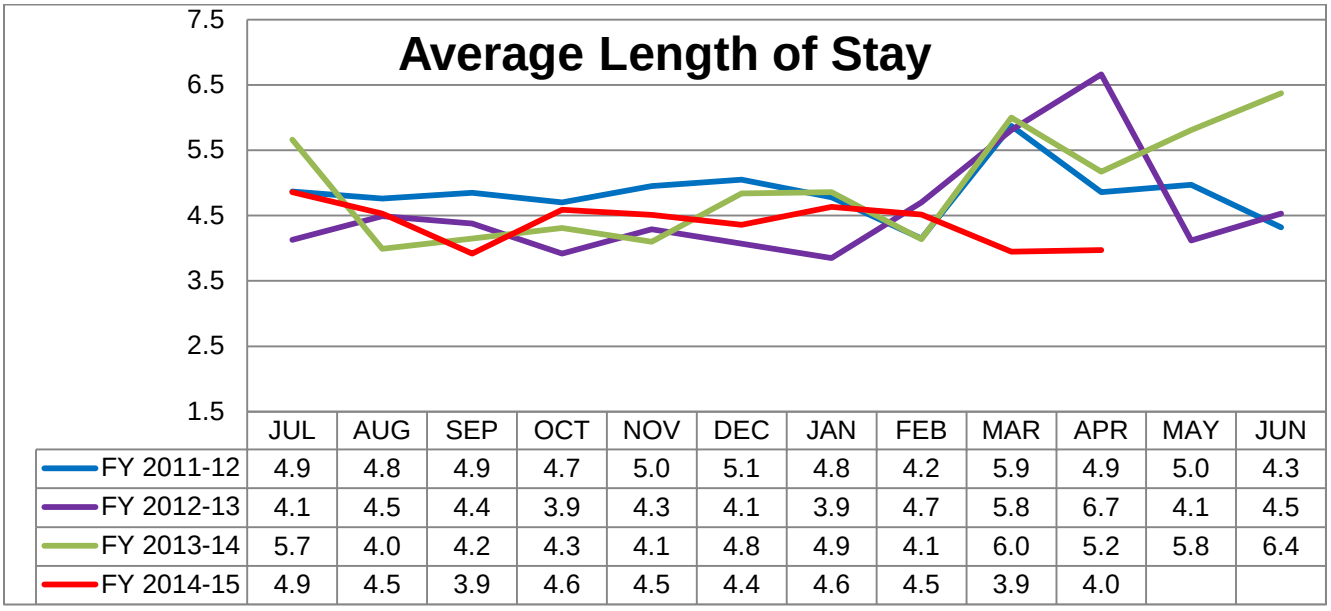
Top 10 Diagnoses Excluding Pregnancy January 2015 - June 2015



Average Length of Stay

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

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



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

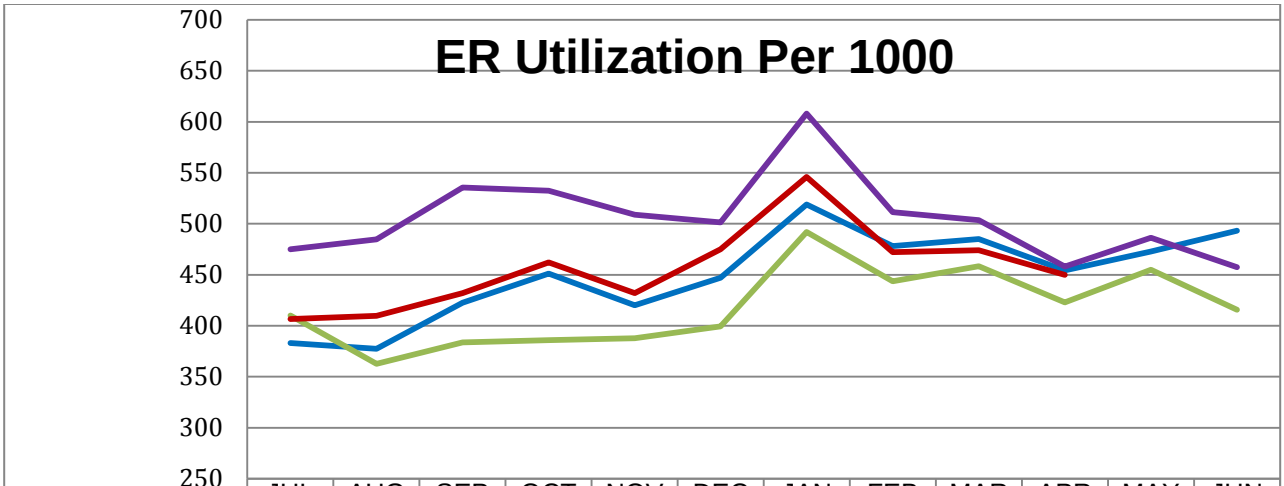
ER Utilization

ER utilization declined from the seasonal January peak seen each year of operation. ER utilization for FY 2014-15 YTD averages 456 visits/1000 members and is higher than the average for the same period in FY 2013-14 (414). Average ER visits/1000 members for CY 2014 was 442. The percent of ER utilization by AE members approximately doubled in April 2015 compared to April 2014.

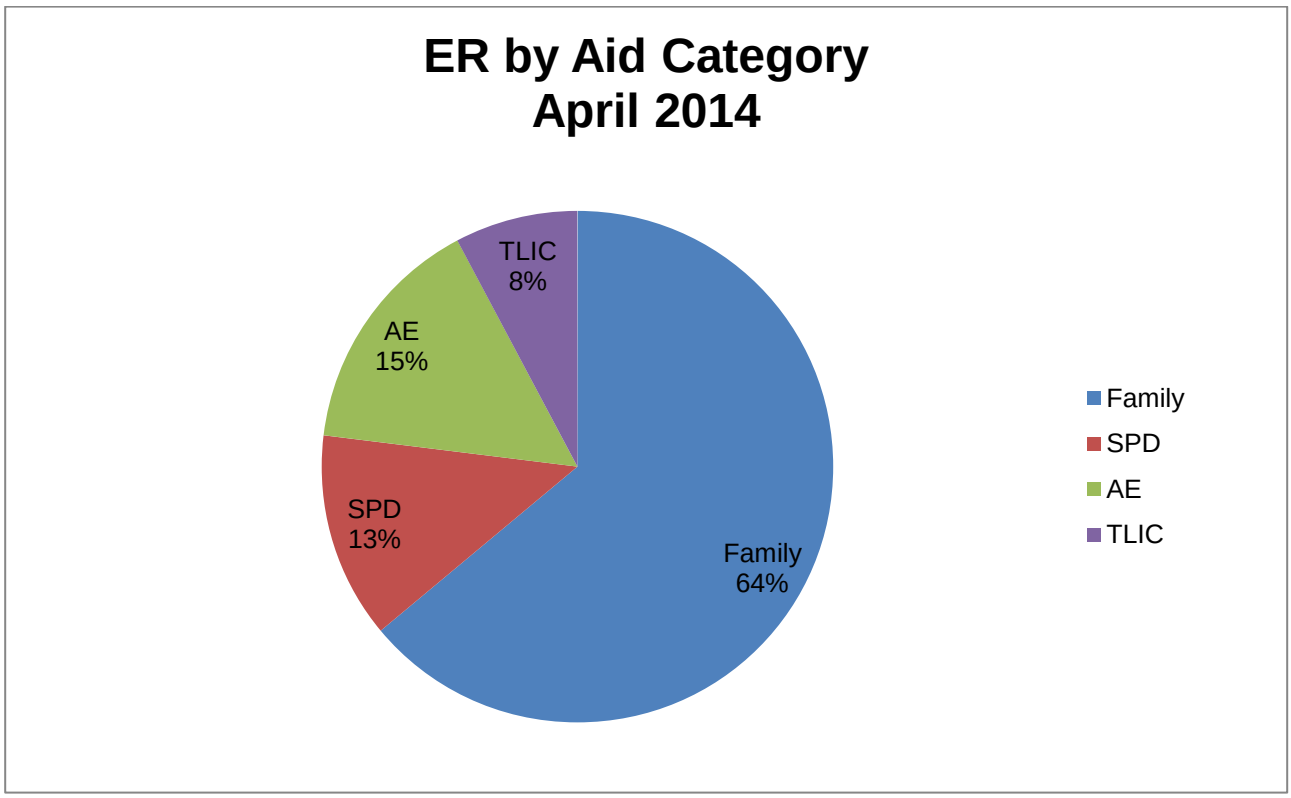
Benchmark: ER utilization/1000 members from available published data from other managed care plans ranges from 554-877.

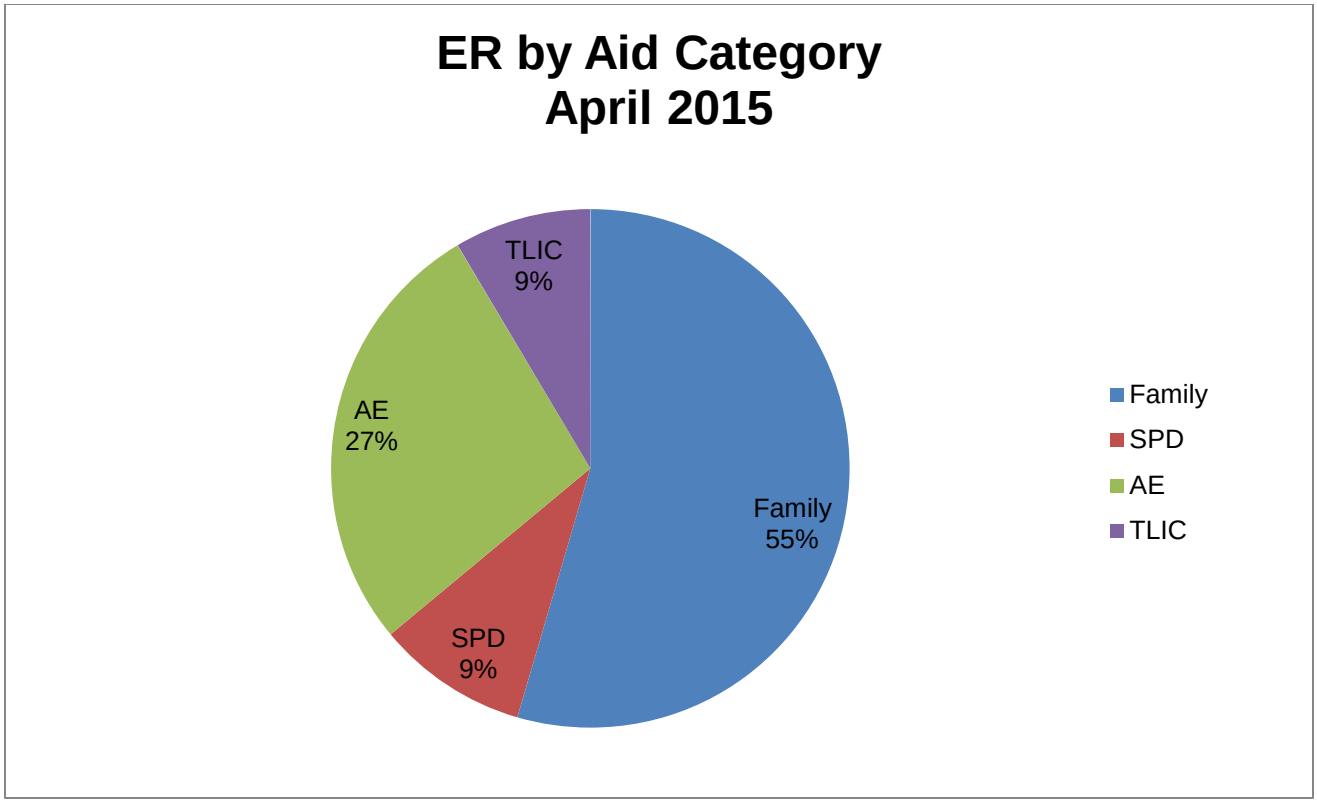
The June 16, 2015 DHCS Medi-Cal Managed Care Performance Dashboard reported 39 ***ER visits/1000 member months*** statewide for all managed care plans in FY 2013-14. GCHP ***ER utilization/1000 member months*** for the same period was also 39.

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



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2011-12	383	377	423	451	420	447	519	478	485	454	473	493
FY 2012-13	475	485	536	533	509	501	608	512	504	458	486	457
FY 2013-14	410	363	384	386	388	399	492	444	458	423	455	416
FY 2014-15	407	410	432	462	432	475	546	472	474	450		

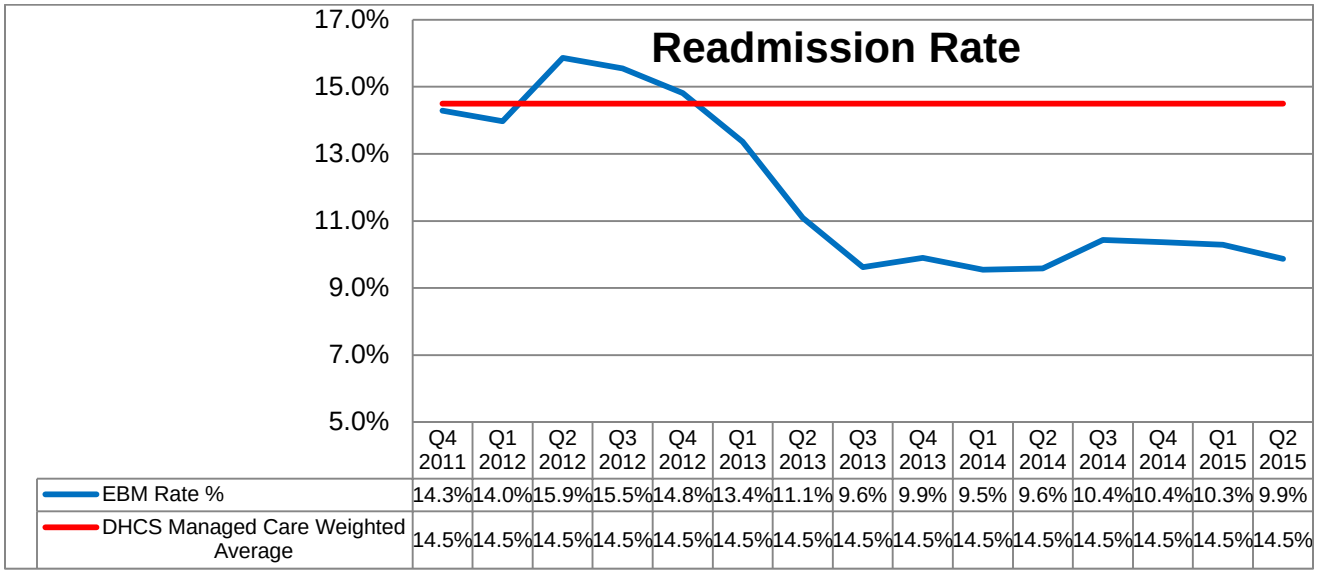




Readmission Rate

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

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

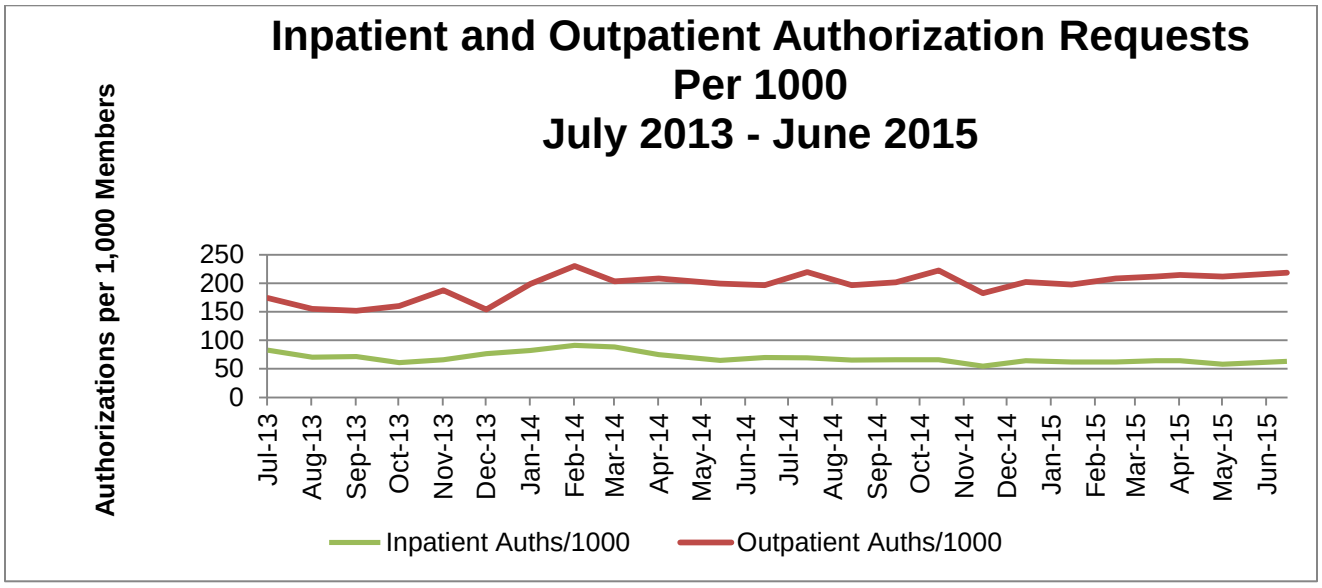


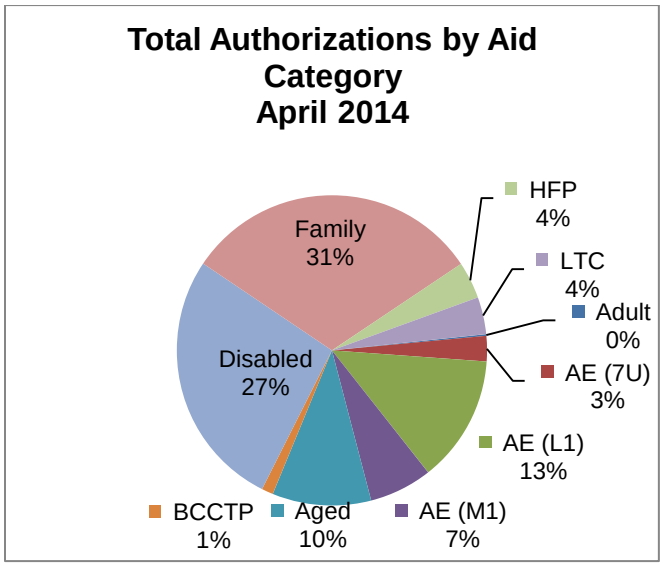
	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015
EBM Rate %	14.3%	14.0%	15.9%	15.5%	14.8%	13.4%	11.1%	9.6%	9.9%	9.5%	9.6%	10.4%	10.4%	10.3%	9.9%
DHCS Managed Care Weighted Average	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%

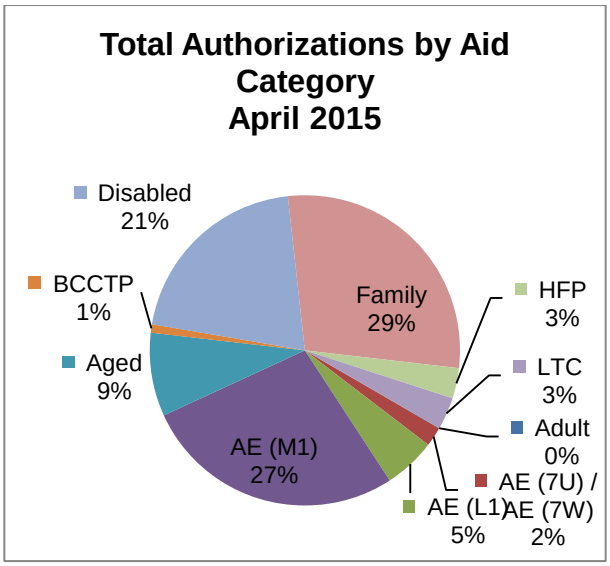
Authorization Requests

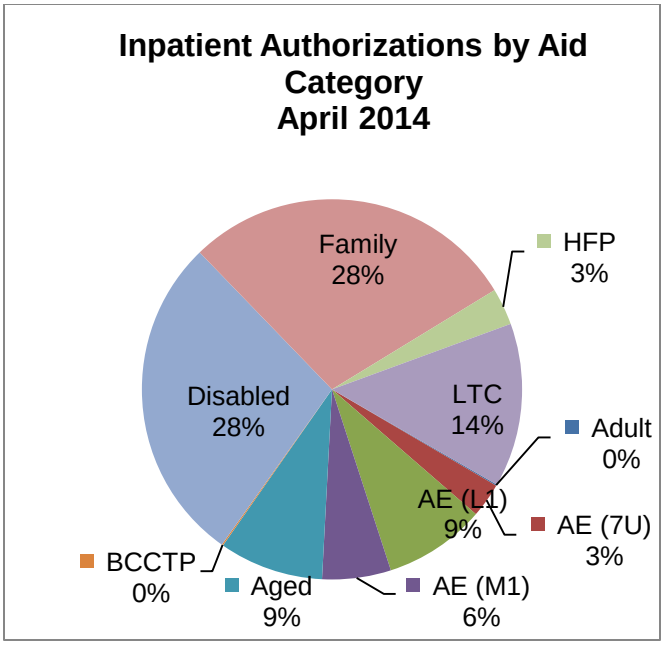
Requests for outpatient service continue to outnumber requests for inpatient service. Outpatient service requests have increased since January 2015 and reached a plateau at about 214 requests/1000 members since March 2015. Requests for inpatient service have declined from a peak in February 2014 and average 62 requests/1000 members for CY 2014.

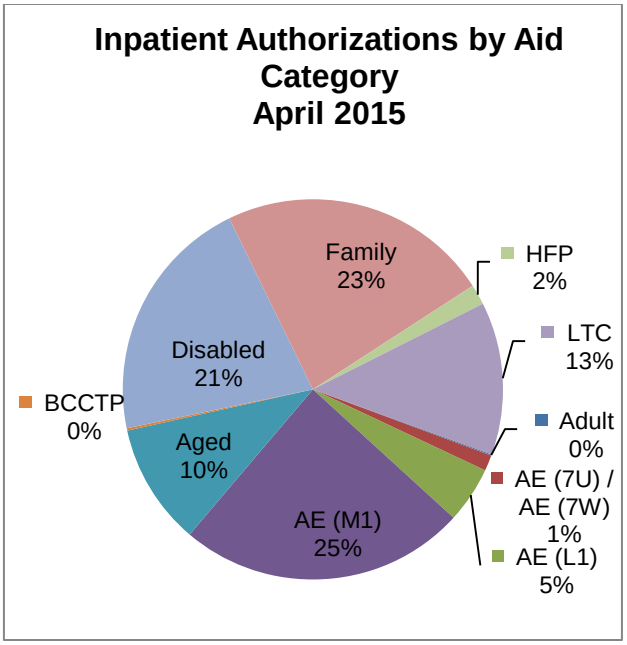
In April 2015, AE members accounted for 34% of all service requests and represented 23% of GCHP membership. Within the AE group, requests for service by M1 members approximately quadrupled from April 2014 to April 2015.

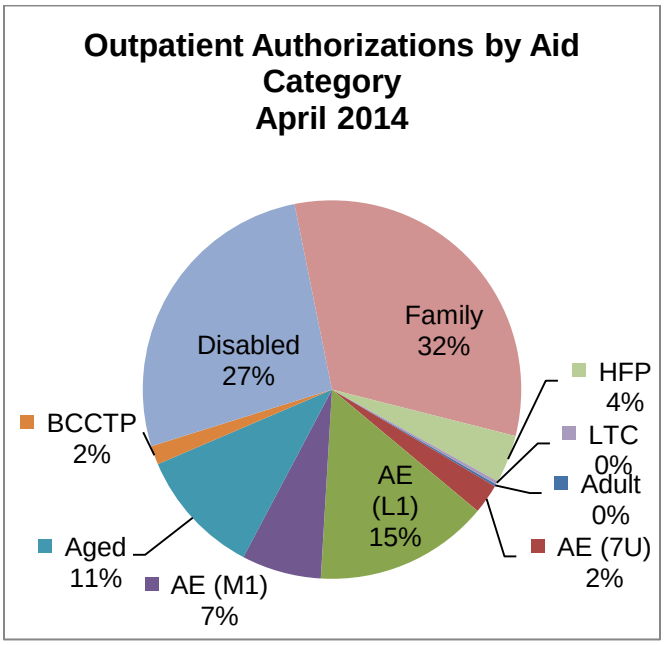


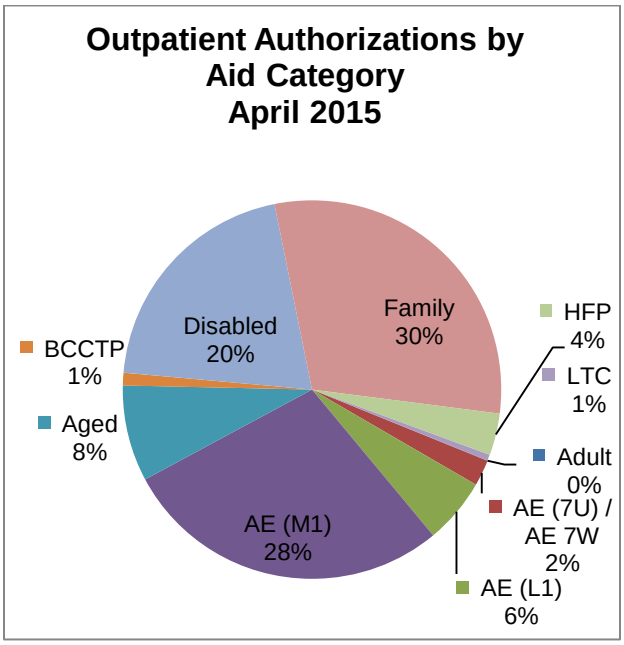





Inpatient Authorizations by Aid Category
April 2014
Family 28%
HFP 3%
Disabled 28%
LTC 14%
Adult 0%
AE (L1) 9%
AE (7U) 3%
BCCTP 0%
Aged 9%
AE (M1) 6%


Inpatient Authorizations by Aid Category
April 2015
Family 23%
HFP 2%
Disabled 21%
LTC 13%
BCCTP 0%
Adult 0%
Aged 10%
AE (7U) / AE (7W) 1%
AE (M1) 25%
AE (L1) 5%


Outpatient Authorizations by Aid Category
April 2014
Disabled 27%
Family 32%
HFP 4%
BCCTP 2%
LTC 0%
AE (L1) 15%
Adult 0%
Aged 11%
AE (7U) 2%
AE (M1) 7%


Outpatient Authorizations by Aid Category
April 2015
Disabled 20%
Family 30%
HFP 4%
BCCTP 1%
LTC 1%
Aged 8%
Adult 0%
AE (7U) / AE 7W 2%
AE (M1) 28%
AE (L1) 6%

Clinical Grievances and Appeals

For CY 2014, the average number of clinical grievances/quarter was 30. For CY 2015 YTD, the average number of clinical grievances/quarter is 38.

Benchmark: For Q2 2015, 57% of all GCHP grievances were about quality issues and 9.5% were about access. The June 16, 2015 Medi-Cal Managed Care Dashboard reports 46 % of Q4 2014 grievances statewide were about quality issues and 20% were about access.

Clinical Grievances

	2014	2015
Q1	**22**	**41**
Q2	**34**	**34**
Q3	**32**	
Q4	**31**	

For CY 2014, the average number of appeals/quarter was 9. For CY YTD 2015, there are 5 appeals/quarter on average.

Appeals

Quarter	Total	Upheld	Partial Overturn	Overturned
2014				
Q1	**10**	**8 (80%)**	**-**	**2 (20%)**
Q2	**3**	**2 (67%)**	**-**	**1 (33%)**
Q3	**10**	**6 (60%)**	**-**	**4 (40%)**
Q4	**12**	**5 (42%)**	**1 (8%)**	**6 (50%)**
2015				
Q1	**4**	**1 (25%)**		**3 (75%)**
Q2	**6**	**3 (50%)**		**3 (50%)**

Denial Rate

Denial rate is calculated by dividing all not medically necessary denials by all requests for service. Denials for duplicate requests, member ineligibility, rescinded requests, other health coverage, or CCS approved case are not included in this calculation.

The average denial rate for calendar year 2013 was 3.66% and for 2014 was 3.34%. The average denial for CY 2015 YTD is 3.14%.