



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

2240 E. Gonzales, Suite 200, Oxnard, CA 93036  
**Monday, July 28, 2014**  
**3:00 p.m.**

**AGENDA**

**CALL TO ORDER / ROLL CALL**

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

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

**1. APPROVE MINUTES**

- [Regular Meeting of May 19, 2014](#)
- [Special Meeting of June 18, 2014](#)
- [Regular Meeting of June 23, 2014](#)

**2. CONSENT ITEMS**

- [Accept and File May Financials](#)
- [Financial Auditor 2014 Client Service and Audit Plan](#)
- [Quarterly Update to Auditor's Recommendations](#)
- [Approve Resolution Amending Personnel Rules, Regulations and Policies](#)

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.

**Ventura County Medi-Cal Managed Care Commission (VCMCC) dba  
Gold Coast Health Plan July 28, 2014 Commission Meeting Agenda (continued)**

**PLACE:** 2240 E. Gonzalez, Room 200, Oxnard, CA

**TIME:** 3:00 p.m.

- e. [Direct Staff to Conduct Conflict of Interest Biennial Review](#)
- f. [Approve Resolution Amending the Claims Procedure to Reflect Current Mailing Address](#)
- g. [Ratify Letters of Support for Grants](#)

**3. APPROVAL ITEMS**

- a. [Sponsorship Request: MICOP](#)
- b. [ACA 1202 Payment Approach](#)
- c. [Compliance Officer Report](#)
- d. [Affirming the Independent Role of the Special Investigation Ad Hoc Committee and Authorizing Actions in Furtherance Thereof](#)

**4. ACCEPT AND FILE ITEMS**

- a. [CEO Update](#)
- b. [COO Update](#)
- c. [CMO Update - Quality Improvement Committee Report 2<sup>nd</sup> Quarter 2014](#)
- d. [Health Services Update](#)

**CLOSED SESSION**

- a. **Conference with Legal Counsel-Existing Litigation Pursuant to Government Code 54956.9:** EEOC Charge No. 480-2014-02364
- b. **Closed Session Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9:** Sziklai et al. v. Ventura County Medi-Cal Managed Care Commission et al; Ventura County Superior Court, Case Number 56-2012-00428086

**COMMENTS FROM COMMISSIONERS**

**ADJOURNMENT**

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on August 25, 2014 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

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

**May 19, 2014**

*(Not official until approved)*

**CALL TO ORDER**

Legal Counsel Kierstyn Schreiner called the meeting to order at 3:00 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036 since there was currently a vacancy of the Chair and Vice Chair of the Commission.

**ELECTION OF TEMPORARY CHAIR**

There was consensus from the Commission Members that Commissioner Foy again be the temporary Chair of the meeting.

**ROLL CALL**

**COMMISSION MEMBERS IN ATTENDANCE**

**Antonio Alatorre**, Clinicas del Camino Real, Inc.

**David Araujo, MD**, Ventura County Medical Center Family Medicine Residency Program

**May Lee Berry**, Medi-Cal Beneficiary Advocate

**Lanyard Dial, MD**, Ventura County Medical Association

**Peter Foy**, Ventura County Board of Supervisors

**David Glycer**, Private Hospitals / Healthcare System

**Michelle Laba, MD**, Ventura County Medical Center Executive Committee

**Gagan Pawar, MD**, Clinicas del Camino Real, Inc. (arrived at 3:02 p.m.)

**Dee Pupa**, Ventura County Health Care Agency

**Robert Wardwell**, Private Hospitals / Healthcare System

**EXCUSED / ABSENT COMMISSION MEMBERS**

**Barry Fisher**, Ventura County Health Care Agency

**STAFF IN ATTENDANCE**

**Michael Engelhard**, Chief Executive Officer

**Nancy Kierstyn Schreiner**, Legal Counsel

**Michelle Raleigh**, Chief Financial Officer

**Traci R. McGinley**, Clerk of the Board

**Luis Aguilar**, Member Services Manager

**Brandy Armenta**, Compliance Director

**Sherri Bennett**, Network Operations Director

**Stacy Diaz**, Human Resources Director

**Mike Foord**, IT Infrastructure Manager

**Anne Freese**, Pharmacy Director

**Guillermo Gonzalez**, Government Relations Director  
**Lupe Gonzalez**, Health Educator  
**Steven Lalich**, Communications Director  
**Tami Lewis**, Operations Director  
**Melissa Scrymgeour**, Chief Information Officer  
**Lyndon Turner**, Financial Analysis Director  
**Ruth Watson**, Chief Operations Officer  
**Nancy Wharfield, MD**, Medical Director Health Services

## **PUBLIC COMMENT**

David Rodriguez, California State President of the League of United Latin American Citizens (LULAC), reviewed a letter to the Commission which stated that LULAC investigated GCHP regarding allegations of hostile work environment for people of color because LULAC had received complaints from current and former employees of GCHP. He requested the Commission table the request to approve the vacation cash-out until LULAC completes its investigation and provides information to the Commission. (The letter was provided to the Clerk of the Board for the record.)

### **1. APPROVE MINUTES**

#### **a. Regular Meeting of April 28, 2014**

Commissioner Alatorre moved to approve the Regular Meeting Minutes of April 28, 2014. Commissioner Pupa seconded. The motion carried with the following votes:

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

### **2. CONSENT ITEMS**

#### **a. March Financials**

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

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

### 3. APPROVAL ITEMS

#### a. Report and Recommendation of Executive / Finance Committee (Nominating Committee) - Election of Chair and Vice-Chair

Commissioner Glycer reported that the Nominating Committee recommended Commissioner David Araujo as Chair and Antonio Alatorre as Vice-Chair.

There being no other nominations for Chair, Commissioner Dial moved to approve David Araujo as Chair. Commissioner Berry seconded. The motion carried with the following votes:

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

As the new Chair of the Commission, Commissioner Araujo then presided over the meeting.

There being no other nominations for Vice-Chair, Commissioner Dial moved to approve Antonio Alatorre as Vice-Chair. Commissioner Berry seconded. The motion carried with the following votes:

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

#### b. Begin Process to Secure Additional Medi-Cal Funds Through an InterGovernmental Transfer (IGT)

CFO Raleigh reviewed the written report with the Commission.

Commissioner Foy moved to authorize and direct the Chief Executive Officer to provide, DHCS with a proposal to secure additional Medi-Cal Funds through an Intergovernmental Transfer (IGT), subject to review by legal counsel. Commissioner Pupa seconded. The motion carried with the following votes:

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

#### c. Resolution Amending Personnel Rules, Regulations and Policies

Stacy Diaz, Human Resources Director, reviewed the written report with the Commission.

Discussion was held separately regarding each of the four policies.

1. R-4: Dress Code (Effective May 1, 2013);
2. B-5: Vacation Buy-Back Policy (Effective April 24, 2013);
3. Bereavement Leave (Personnel Rules, Regulations and Policies Handbook - Adopted August 27, 2012 and Effective September 1, 2012); and
4. X-X: Spot Award Policy.

Commissioner Alatorre moved to table the Vacation Buy Back Policy until LULAC completes its investigation and reports its findings to the Commission. Commissioner Pawar seconded. The motion failed with the following votes:

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

Commissioner Foy moved to ratify the existing Vacation Buy Back Policy and to amend the Vacation Buy Back Policy effective July 1, 2014 that will require an employee take a minimum 40 hours during the prior 12 months before being able to cash out accrued vacation. Commissioner Pupa seconded. The motion carried with the following votes:

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

Commissioner Wardwell moved to ratify the Dress Code Policy. Commissioner Pupa seconded. The motion carried with the following votes:

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

Commissioner Berry moved to approve the amended Bereavement Leave Policy as presented. Commissioner Foy seconded. The motion carried with the following votes:

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

Legal Counsel Kierstyn Schreiner noted that an amended Resolution would come to the Commission at the next Commission Meeting.

Further discussion was held regarding the SPOT Program.

Commissioner Pupa moved to approve the SPOT program with implementation of a rating matrix and the requirement that if someone is to receive the maximum SPOT award it come before the Commission for recognition. Commissioner Foy seconded. The motion carried with the following votes:

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

**d. Adopt Amended Salary Schedule**

Human Resources Director Diaz reviewed the written report with the Commission.

Commissioner Glycer moved to adopt the amended Salary Schedule. Commissioner Foy seconded. The motion carried with the following votes:

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

**PUBLIC COMMENT** *(continued)*

Margaret Sawyer, Director of MICOP, thanked GCHP for the agreements in place that allow the families that migrate to seek medical assistance when in the different counties and communities without having to cancel and re-enroll in Medi-Cal every time. However, now that the agreements have been in place for some time some of the clinics are not aware of said agreements and the families are being turned away.

COO Watson assured the Commission that staff will reach out to the front-line of those clinics to make sure the agreements are honored.

**4. ACCEPT AND FILE ITEMS**

**a. CEO Update**

CEO Engelhard reviewed the written report with the Commission.

Commissioner Alatorre moved Accept and File the CEO Update. Commissioner Berry seconded. The motion carried with the following votes:

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

**b. COO Update**

COO Watson provided an overview of the report.

Commissioner Glycer moved to Accept and File the COO Update. Commissioner Dial seconded. The motion carried with the following votes:

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

**c. Health Services Update**

Medical Director Health Services Dr. Wharfield reviewed the written report.

Commissioner Pupa moved to Accept and File the Health Services Update. Commissioner Alatorre seconded. The motion carried with the following votes:

AYE: Alatorre, Araujo, Berry, Dial, Glycer, Laba, Pawar, Pupa and Wardwell.  
NAY: None.  
ABSTAIN: None.  
ABSENT: Fisher and Foy (was currently not in room).

**4. INFORMATIONAL ITEMS**

**a. GCHP Priorities & Initiatives for FY 2014-15 Budget Planning**

CEO Engelhard reviewed the written report with the Commission.

**b. FY 2014-15 Budget Development Process**

CFO Raleigh reviewed the written report with the Commission.

**COMMENTS FROM COMMISSIONERS**

Chair Araujo thanked the Commissioners for electing him as Chair. He requested that the meeting frequency for the Commission as well as the Executive / Finance Committee be placed on the Agenda. Chair Araujo also asked staff if there was a way to make the information for the Commission Meetings require less paper.



CIO Scrymgeour responded that she and the CEO have been looking into that matter.

Commissioners Laba and Wardwell agreed.

### **CLOSED SESSION**

Legal Counsel Kierstyn Schreiner noted that Closed Session Item a, was not needed and therefore being pulled from the Agenda.

- a. *Closed Session Conference with Legal Counsel – Anticipated Litigation Pursuant to Government Code Section 54956.9(b) - One Case*

was not needed and was therefore removed from the Agenda she then explained the purpose of the remaining Closed Session Items.

### **RECESS:**

A recess was called at 5:14 p.m. The meeting was reconvened at 5:22 p.m.

### **ADJOURN TO CLOSED SESSION**

The Commission adjourned to Closed Session at 5:22 p.m. regarding the following items:

- b. **Closed Session Pursuant to Government Code Section 54957(e)**  
Public Employee Performance Evaluation  
Title: Chief Executive Officer
- c. **Closed Session Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9:**
  - i. United States of America et al. ex re Donald Gordon, v. Gold Coast Health Plan, et al, United States District Court, Central District, Case Number: CV 11-5500-IFW (AJWx)
  - ii. Sziklai et al. v. Ventura County Medi-Cal Managed Care Commission et al; Ventura County Superior Court, Case Number 56-2012-00428086

### **RETURN TO OPEN SESSION**

The Regular Meeting reconvened at 5:50 p.m.

Legal Counsel Kierstyn Schreiner stated that Commission is having ad hoc committee comprised of Commissioner Pupa, to determine FY 2014-15 goals and performance incentives for the CEO.

### **ADJOURNMENT**

Meeting adjourned at 5:51 p.m.

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

**June 18, 2014**

*(Not official until approved)*

Notice of said meeting was duly given in the time and manner prescribed by law. Affidavit of compliance is on file in the Clerk of the Board's Office.

**CALL TO ORDER**

Chair Araujo called the meeting to order at 1:01 p.m. in the Topa Topa Room at Gold Coast Health Plan's facility located at, 711 E. Daily Drive, Suite 106, Camarillo, CA.

**ROLL CALL**

**COMMISSION MEMBERS IN ATTENDANCE**

**Antonio Alatorre**, Clinicas del Camino Real, Inc.

**David Araujo, MD**, Ventura County Medical Center Family Medicine Residency Program

**Barry Fisher**, Ventura County Health Care Agency

**David Glycer**, Private Hospitals / Healthcare System

**Gagan Pawar, MD**, Clinicas del Camino Real, Inc.

**Dee Pupa**, Ventura County Health Care Agency

**EXCUSED / ABSENT COMMISSION MEMBERS**

**Lanyard Dial, MD**, Ventura County Medical Association

**Peter Foy**, Ventura County Board of Supervisors

**Michelle Laba, MD**, Ventura County Medical Center Executive Committee

**Robert Wardwell**, Private Hospitals / Healthcare System

*Vacant*, Medi-Cal Beneficiary Advocate

**STAFF IN ATTENDANCE**

**Michael Engelhard**, Chief Executive Officer

**Nancy Kierstyn Schreiner**, Legal Counsel

**Michelle Raleigh**, Chief Financial Officer

**Traci R. McGinley**, Clerk of the Board

**Al Reeves, MD**, Chief Medical Officer

**Melissa Scrymgeour**, Chief Information Officer

**Ruth Watson**, Chief Operations Officer

**PUBLIC COMMENT**

None.

## **CLOSED SESSION**

Legal Counsel Kierstyn Schreiner explained the purpose of the Closed Session items.

## **ADJOURN TO CLOSED SESSION**

The Commission adjourned to Closed Session at 1:04 p.m. regarding the following items:

- a. **Conference with Legal Counsel Whether to Initiate Litigation Pursuant to Government Code Section 54956.9(c):** (2 cases)
- b. **Conference with Legal Counsel-Existing Litigation Pursuant to Government Code 54956.9:** EEOC Charge No. 480-2014-02058
- c. **Public Employee Discipline / Dismissal / Release Pursuant to Government Code Section 54957**
- d. **Closed Session Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9:** Sziklai et al. v. Ventura County Medi-Cal Managed Care Commission et al; Ventura County Superior Court, Case Number 56-2012-00428086
- e. **Conference with Legal Counsel - Anticipated Litigation-Significant Exposure to Litigation Pursuant to Government Code Section 54956.9(b)**

## **RETURN TO OPEN SESSION**

The Regular Meeting reconvened at 3:02 p.m.

Legal Counsel Kierstyn Schreiner stated that there was no reportable action taken in Closed Session.

## **PUBLIC COMMENT** *(continued)*

Chair Araujo noted that Public Comment is handled at the beginning of the meeting; but a request was just received. Chair Araujo reminded the Public that they may only address items on the Agenda during Special Commission Meetings.

David Rodriguez, California State President of the League of United Latin American Citizens (LULAC), advised the Commission that LULAC received a complaint from a Hispanic female alleging retaliation this year. LULAC will investigate, interview and add that to the complaint. Mr. Rodriguez closed stating that there is significant concern among the Hispanic leaders about LULAC's report, its content and the response from the Commission to date.

1. **APPROVAL ITEM**

a. **Consideration of Establishment of Ad Hoc Committee Concerning Allegations of Maltreatment of Employees and Concerns Regarding Perceived Mismanagement of Programs and Public Funding**

Chair Araujo proposed that the committee be formed with at least three members of the Commission to lead the investigation of these allegations.

Commissioner Fisher nominated Tony Alatorre and moved to create a three member ad hoc committee to review allegations of maltreatment of employees and concerns regarding perceived mismanagement of programs and public funding, and that Chair Araujo appoint the other members of the committee. Commission Pawar seconded. *(The Commission had discussion. No vote was taken on this motion.)*

After discussion Commissioner Pupa nominated Commissioner Fisher. Chair Araujo requested that Commissioner Glycer be the third member of the ad hoc committee.

Commissioner Fisher moved his restated motion to appoint a three member ad hoc committee to look into allegations of maltreatment of employees and concerns regarding perceived mismanagement of programs and public funding. The committee would be Tony Alatorre, David Glycer and Barry Fisher and this committee would be tasked with leading the investigation with the two firms that are eventually picked to assist with the investigation. Commission Pawar seconded. The motion carried with the following votes:

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

**COMMENTS FROM COMMISSIONERS**

None.

**ADJOURNMENT**

Meeting adjourned at 3:10 p.m.

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

**June 23, 2014**

*(Not official until approved)*

**CALL TO ORDER**

Chair Araujo called the meeting to order at 3:00 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036  
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

**Michelle Laba, MD**, Ventura County Medical Center Executive Committee

**Gagan Pawar, MD**, Clinicas del Camino Real, Inc. (arrived at 3:02 p.m.)

**Robert Wardwell**, Private Hospitals / Healthcare System

**EXCUSED / ABSENT COMMISSION MEMBERS**

**Peter Foy**, Ventura County Board of Supervisors

**David Glycer**, Private Hospitals / Healthcare System

**Dee Pupa**, Ventura County Health Care Agency

*Vacant*, Medi-Cal Beneficiary Advocate

**STAFF IN ATTENDANCE**

**Michael Engelhard**, Chief Executive Officer

**Nancy Kierstyn Schreiner**, Legal Counsel

**Robert Hernandez**, Legal Counsel

**Michelle Raleigh**, Chief Financial Officer

**Traci R. McGinley**, Clerk of the Board

**Brandy Armenta**, Compliance Director

**Sherri Bennett**, Network Operations Director

**Mike Foord**, IT Infrastructure Manager

**Anne Freese**, Pharmacy Director

**Guillermo Gonzalez**, Government Relations Director

**Lupe Gonzalez**, Health Educator

**Steven Lalich**, Communications Director

**Tami Lewis**, Operations Director

**Al Reeves, MD**, Chief Medical Officer

**Melissa Scrymgeour**, Chief Information Officer

**Lyndon Turner**, Financial Analysis Director

**Ruth Watson**, Chief Operations Officer  
**Nancy Wharfield, MD**, Medical Director Health Services

## **PUBLIC COMMENT**

David Rodriguez, California State President of the League of United Latin American Citizens (LULAC), read a letter to the Commission stating that a key witness on medical stress leave from GCHP received a letter from GCHP's General Counsel with questions regarding information shared with LULAC as it investigates the occurrences at GCHP. Mr. Rodriguez stated that the letter may have been sent with the intent of intimidating a core witness of the GCHP external audit that the ad hoc committee will be investigating. LULAC considers the actions by the law firm representing GCHP to be the latest in a series of strategic and rogue actions to undermine the ad hoc committee's ability to conduct a genuine and creditable audit. If the Commission does not act to prohibit the CEO and law firm from interfering with the proceedings of the ad hoc committee, this inquiry will not be conducted in the manner expected by the public and regulatory agencies that are observing and monitoring this process. LULAC strongly recommends that the Commission give serious consideration to engaging separate legal counsel for this inquiry. It is LULAC's opinion that the current counsel is clearly dedicated to representing the sole interest of CEO Engelhard and not necessarily those of the Commission. Lastly, LULAC advised the Commission that it has been contacted by representatives from California State Attorney General's Office, Medi-Cal Fraud Division and LULAC plans to meet with them later in the week. (*Letter was submitted to the Clerk of the Board.*)

May Lee Berry, immediate past member of the Commission noted that she served as a Commissioner for four (4) years. She came to the Commission not owing an allegiance to any agency or organization which allowed her to be unbiased in her decision making responsibilities. She stated that she is proud of the efforts and results of the Commission's work to meet State compliance for Medi-Cal. The structure of GCHP is capable and sound to handle an investigation with confidence. The staff can address the finding, if any, with professional resolution. As a member of the community and past Commissioner, she appealed to the Commission to support a third party investigation that is independent of LULAC and GCHP.

### **1. APPROVE MINUTES**

#### **a. Regular Meeting of May 19, 2014**

Commissioner Alatorre questioned the minutes as he and Commissioner Pawar opposed Item 3b, *Begin Process to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT)*. He also questioned the motions on 3c, *Resolution Amending Personnel Rules, Regulations and Policies; Vacation Buy Back Policy*, he believes that the motion included a requirement that employees leave a minimum balance of forty (40) hours on the books.

CEO Engelhard explained that the current Vacation Buy Back policy requires employees maintain a minimum of forty (40) hours and that it was his understanding that the motion



would add to the existing policy and require that at least forty (40) hours of vacation be used in the preceding twelve (12) months before the Vacation Buy Back could be used.

Commissioner Alatorre requested Clerk McGinley review the recording.

Approval of the Minutes was continued to the next regular Commission Meeting.

## **2. APPROVAL ITEMS**

### **a. April Financials**

CFO Raleigh reviewed the written report with the Commission.

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

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

### **b. Continue Process to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT)**

CFO Raleigh reviewed the written report with the Commission.

Commissioner Wardwell moved to authorize and direct the Chief Executive Officer to enter into agreements to secure funding for the FY 2012-13 Intergovernmental Transfer (IGT), subject to review by legal counsel. Commissioner Dial seconded. The motion carried with the following votes:

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

### **c. FY 2014-15 GCHP Operating and Capital Budgets**

CFO Raleigh reviewed the written report with the Commission.

Commissioner Dial moved to adopt the FY 2014-15 GCHP Operating and Capital Budgets. Commissioner Fisher seconded. The motion carried with the following votes:

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

### **c. Reinsurance Contract**

CFO Raleigh reviewed the written report with the Commission.

Commissioner Alatorre moved to approve OneBeacon to provide reinsurance coverage at the \$650,000 deductible level for FY 2014-15. Commissioner Laba seconded. The motion carried with the following votes:

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

**e. Executive Liability and Errors & Omissions Insurance**

CFO Raleigh reviewed the written report with the Commission.

Commissioner Fisher moved to approve utilizing the following insurance companies to provide coverage as summarized below, beginning July 1, 2014:

<b>Insurance Company</b>	<b>Policy</b>	<b>Retention</b>	<b>Coverage Limit</b>	<b>Premium</b>
RSUI	<ul style="list-style-type: none"> <li>• D&amp;O</li> <li>• EPL</li> </ul>	\$50,000 \$50,000	\$3 million each	\$103,730
Argo	Excess Coverage for D&O and EPL	N/A	\$2 million xs \$3 million (RSUI Primary Policy)	\$47,025
AIG	<ul style="list-style-type: none"> <li>• Fiduciary</li> <li>• Crime</li> </ul>	\$0 \$25,000	\$1 million each	\$6,724
Darwin	Managed Care Errors and Omissions (E&O)	\$50,000	\$3 million each per claim and in aggregate	\$43,000 <sup>1</sup>
Total				\$200,479

<sup>1</sup> Managed care E&O premium shown does not reflect surplus lines tax and fees (which is approximately 4%).

Commissioner Wardwell seconded. The motion carried with the following votes:

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

**4. ACCEPT AND FILE ITEMS**

**a. CEO Update**

CEO Engelhard reviewed the written report with the Commission and read a statement addressing comments in the LULAC report and quotes in the newspaper.

**b. COO Update**

COO Watson provided an overview of the report.

**c. Health Services Update**

Medical Director Health Services Dr. Wharfield reviewed the written report.

Commissioner Alatorre moved to Accept and File the CEO Update (including the statement of CEO Engelhard regarding LULAC), COO and Health Services Updates. Commissioner Dial seconded. The motion carried with the following votes:

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

### **CLOSED SESSION**

Legal Counsel Kierstyn Schreiner explained the purpose of the Closed Session items.

### **ADJOURN TO CLOSED SESSION**

The Commission adjourned to Closed Session at 4:49 p.m. regarding the following items:

- a. **Conference with Legal Counsel Whether to Initiate Litigation Pursuant to Government Code Section 54956.9(c):** (1 case)
- b. **Conference with Legal Counsel-Existing Litigation Pursuant to Government Code 54956.9:** EEOC Charge No. 480-2014-02058
- c. **Closed Session Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9:** Sziklai et al. v. Ventura County Medi-Cal Managed Care Commission et al; Ventura County Superior Court, Case Number 56-2012-00428086
- d. **Conference with Legal Counsel - Anticipated Litigation-Significant Exposure to Litigation Pursuant to Government Code Section 54956.9(b)**

### **RETURN TO OPEN SESSION**

The Regular Meeting reconvened at 5:58 p.m.

### **RETURN TO OPEN SESSION**

The Regular Meeting reconvened at 5:58 p.m.

Chair Araujo stated that the Commission is happy with the work CEO Engelhard and the team have done in turning the Plan and the finances around; however, they take LULAC's allegations' very seriously and that is why the Commission created an ad hoc committee comprised of Commissioners Alatorre, Fisher and Glycer to act as the investigating committee to look into these allegations. The Commission unanimously approved retaining EXTTI Inc., an independent human resource investigation firm; and Moss Adams, LLP, to conduct a forensic accounting investigation. These firms will report and

work directly with the ad hoc committee. Separate legal counsel will also be obtained to advise the committee.

Chair Araujo continued, stating that the Commission also wished to respond to the public comment made earlier in the meeting regarding the letter that was sent to an employee of the Plan. That letter was sent on the behalf of the Commission to investigate a potential HIPPA violation.

Legal Counsel Kierstyn Schreiner stated that there was nothing further to report.

### **COMMENTS FROM COMMISSIONERS**

None.

### **ADJOURNMENT**

Meeting adjourned at 6:02 p.m.

## **AGENDA ITEM 2a**

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: July 28, 2014

Re: May 2014 Financials

### **SUMMARY**

Staff is presenting the attached May 2014 financial statements of Gold Coast Health Plan (Plan) for review by the Commission. These financials were reviewed by the Executive / Finance Committee on July 10, 2014 where the Committee recommended approval of these financials to the Commission.

### **BACKGROUND / DISCUSSION**

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

### **FISCAL IMPACT**

#### **Year-To-Date Results**

On a year-to-date basis, the Plan's net income is approximately \$18.9 million compared to \$15.1 million assumed in the budget. These operating results have contributed to a Tangible Net Equity (TNE) level of approximately \$30.8 million, which exceeds both the budget of \$27.0 million (by \$3.8 million) and the State minimum required TNE amount of \$16.5 million, i.e., 84% of \$19.6 million, which is the amount needed to achieve 100% of the calculated TNE requirement) by \$14.4 million. Please note the following:

1. The Plan's TNE amount includes \$7.2 million in lines of credit with the County of Ventura.
2. On the "Financial Overview" page attached, the YTD TNE excludes the initial Affordable Care Act (ACA) 1202 funds since the Plan is continuing discussions with the State as to whether these payments to qualifying providers are considered as "pass through" funds, as assumed in the budget.

#### **May 2014 Results**

Items to note for the month include:

Membership - May membership of 148,289 exceeded budget by 13,323 members. As in the prior month, the Adult / Family and Adult Expansion (AE) categories are driving membership growth. Current membership is 23% better than at December 31, 2013 and is more than 40% better year-over-year. Consistent with the new Dual definition implemented by DHCS in April,

there was a shift in members from Dual categories to the Seniors and Persons with Disabilities (SPD) aid category.

Revenue – May net revenue was \$43.5 million which exceeded budget of \$38.3 million by \$5.2 million. On a per-member-per-month (PMPM) basis, net revenue was \$293.14 PMPM which was \$9.75 PMPM better than budget of \$283.39 PMPM. The favorable to budget revenue performance was attributed to the membership growth being greater than anticipated in total, with significantly more members than expected in higher capitation rate cells. Specific variances include:

- Adult Expansion membership exceeded budget by approximately 5,100 members, generating an additional \$3.7 million in revenue as compared with budget.
- The Adult / Family category also produced excess revenue of \$0.9 million through a positive membership variance of approximately 6,900.
- The remaining variance is due to differences in mix of the population.

Health Care Costs – Health care costs for May were \$38.8 million and were \$4.3 million more than budget. On a PMPM basis, reported health care costs were \$261.74 PMPM versus a budgeted amount of \$255.55. Causes for the variance include:

- Membership growth - Increases in membership over budget accounted for approximately \$3.4 million of the variance. Much of the membership growth occurred in a high-cost aid category (AE).
- Inpatient – Reserves were increased in May after reviewing hospital data such as census reports, utilization and authorizations. In addition, the Plan continued to hold reserves for pending possible facility claims submissions.
- LTC / SNF – Reserves were maintained for estimated rate increases pursuant to AB 1629 which relate to months prior to the system implementation of the new rates.
- Pharmacy – Pharmacy expense has risen substantially, due in part to the new Hepatitis C drug (Sovaldi) as well as through the growing Adult Expansion population. However, the increase in utilization among the new population has not achieved the rate as expected in the revised budget. The Plan has continued to include additional reserves for this expense category.

As disclosed in prior months, the current financials include an additional reserve (in the pharmacy line item) to reflect an estimated 85% MLR for overall medical expenses specific to the Adult Expansion population. Note the additional reserve still results in total expenses that are below budget for this new population, because pharmacy expenses have been less than budget. Other services will be evaluated as claims data is received. The Plan consulted with its audit firm and obtained agreement with the way the Plan is currently reporting this contract provision.

Administrative Expenses – For the month, overall operational costs were approximately \$177,000 above budget. The main cause of the variance (approximately \$102,000) was contracts driven by membership (e.g., ACS, Beacon). Legal fees also contributed to the negative variance when compared to budget; due to increased need for legal services. The negative variance to budget was partially offset by positive variances such as lower personnel costs due to timing of new hires and less use of consultants.

Cash + Medi-Cal Receivable - The total of Cash and Medi-Cal Premium Receivable balances of \$143.6 million reported as of May 31, 2014 included a MCO Tax component amounting to \$13.0 million. Excluding the impact of the tax, the total of Cash and Medi-Cal Receivable balance as of May 31, 2014 was \$130.6 million, or \$39.2 million better than the budgeted level of \$91.4 million.

Note the May State Capitation Premium Receivable was not settled in June as would normally be expected. A system conversion at The Department of Health Care Services (DHCS) has delayed the May monthly payment processing cycle. Staff has been in contact with State personnel to resolve this issue as quickly as possible.

#### **RECOMMENDATION**

Staff proposes that the Commission approve and accept the May, 2014 financial statements.

#### **CONCURRENCE**

Executive / Finance Committee, July 10, 2014

#### **Attachment**

May 2014 Financial Package



**FINANCIAL PACKAGE**  
For the month ended May 31, 2014

**TABLE OF CONTENTS**

- Financial Overview
- Membership
- Income Statement
- PMPM Income Statement by Month
- Paid Claims and IBNP Composition

**APPENDIX**

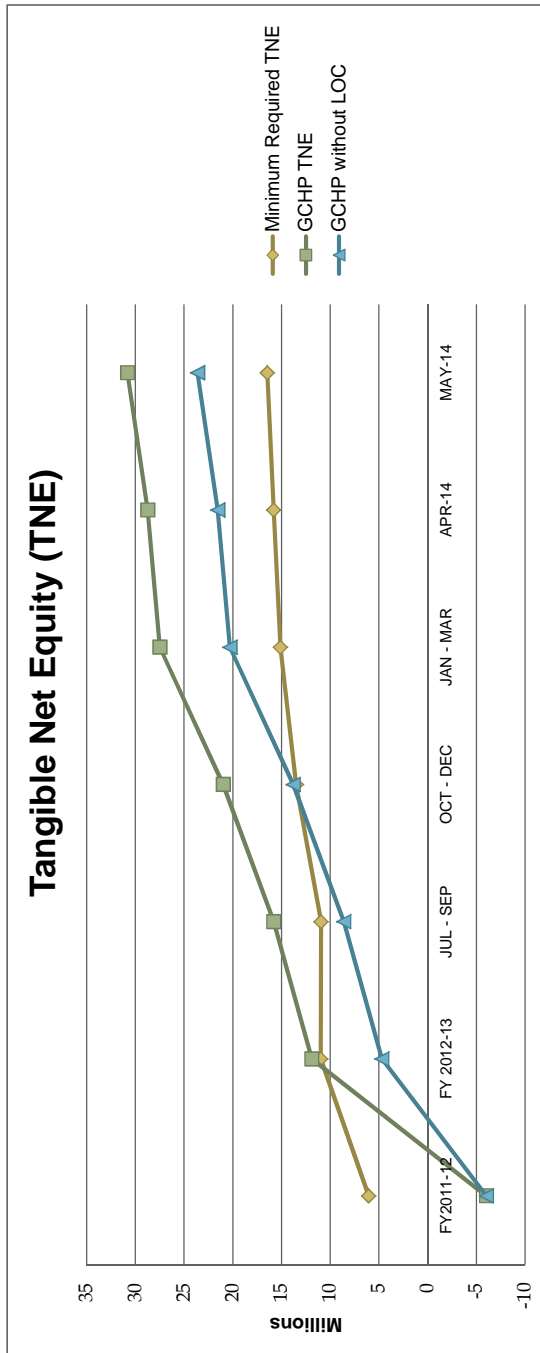
- Comparative Balance Sheet
- Cash & Medi-Cal Receivable Trend
- Statement of Cash Flows
- YTD Income Statement
- Total Expenditure Composition
- Pharmacy Cost & Utilization Trends

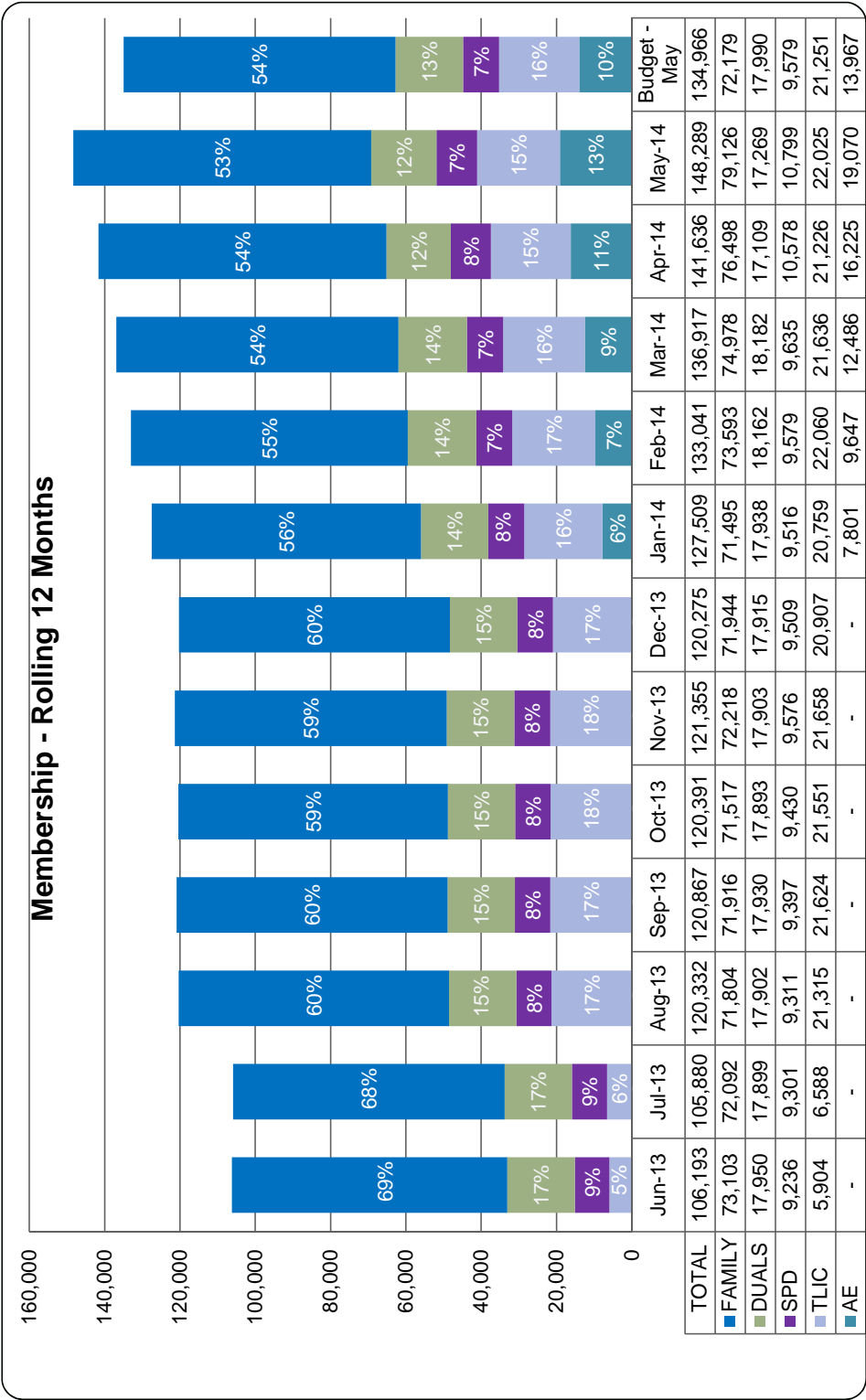


## Financial Overview

Description	AUDITED*		UNAUDITED FY 2013-14 Actual										Budget Comparison	
	FY2011-12	FY 2012-13	JUL - SEP	OCT - DEC	JAN - MAR	APR-14	MAY-14	YTD ADJUSTED**	Budget YTD	Variance Fav/(Unfav)	Variance Fav/(Unfav) %			
<b>Member Months</b>	1,258,189	1,223,895	347,079	362,021	397,467	141,636	148,289	1,396,492	1,374,745	21,747	1.6 %			
<b>Revenue</b> <i>ppm</i>	304,635,932 242.12	315,119,611 257.47	81,988,709 236.22	84,070,456 232.23	106,860,786 288.55	40,868,789 288.55	43,468,897 293.14	357,257,637 255.83	351,505,379 255.69	5,752,257 0.14	1.6 % 0.1 %			
<b>Health Care Costs</b> <i>ppm</i> % of Revenue	287,353,672 228.39 94.3%	280,382,704 229.09 89.0%	71,875,533 207.09 87.7%	72,867,512 201.28 86.7%	93,747,094 235.86 87.7%	37,065,232 261.69 90.7%	38,812,496 261.74 89.3%	314,367,867 225.11 88.0%	312,040,340 226.98 88.8%	(2,327,526) 1.87 -0.8%	(0.7)% 0.8 % -0.9%			
<b>Admin Exp</b> <i>ppm</i> % of Revenue	18,891,320 15.01 6.2%	24,013,927 19.62 7.6%	6,202,007 17.87 7.6%	6,014,475 16.61 7.2%	6,597,110 16.60 6.2%	2,563,313 18.10 6.3%	2,597,338 17.52 6.0%	23,974,244 17.17 6.7%	24,354,182 17.72 6.9%	379,938 0.55 0.2%	1.6 % 3.1 % 3.1%			
<b>Net Income</b> <i>ppm</i> % of Revenue	(1,609,063) (1.28) -0.5%	10,722,980 8.76 3.4%	3,911,169 11.27 4.8%	5,188,469 14.33 6.2%	6,516,582 16.40 6.1%	1,240,243 8.76 3.0%	2,059,063 13.89 4.7%	18,915,526 13.55 5.3%	15,110,857 10.99 4.3%	3,804,669 2.55 1.0%	25.2 % 23.2 % 23.2%			
100% TNE	16,769,368	16,138,440	16,112,437	16,056,217	17,988,276	18,817,839	19,585,761	19,585,761	18,682,754	903,008	4.8 %			
% TNE Required	36%	68%	68%	84%	84%	84%	84%	84%	84%	84%	84%			
Minimum Required TNE	6,036,972	10,974,139	10,956,457	13,487,223	15,110,152	15,806,985	16,452,040	16,452,040	15,693,513	758,526	4.8 %			
<b>GCHP TNE</b>	(6,031,881)	11,891,099	15,802,268	20,990,738	27,507,320	28,747,563	30,806,626	30,806,626	27,001,957	3,804,669	14.1 %			
TNE Excess / (Deficiency)	(12,068,853)	916,960	4,845,810	7,503,516	12,397,168	12,940,578	14,354,587	14,354,587	11,308,444	3,046,143	26.9 %			

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).  
 \*\* Adjusted results remove ACA 1202 payments (\$5.2 million) from both revenue and health care costs in order to compare to the budget (since budget assumed these funds were passed through )





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

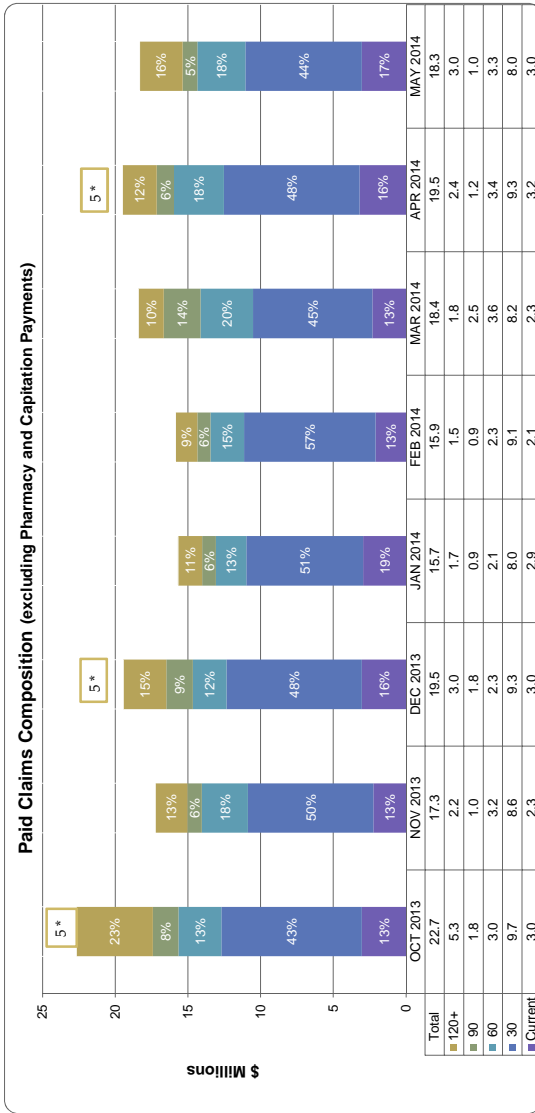
Note: Beginning in Apr '14 actual membership reflects new Duals definition as implemented by DHCS. Prior months and budget have not been restated.

## Income Statement Monthly Trend

	FY2013-14 Monthly Trend			Current Month		
	FEB 2014	MAR 2014	APR 2014	MAY 2014		Variance
				Actual	Budget	Fav/(Unfav)
<b>Membership (includes retro members)</b>	133,041	136,917	141,636	148,289	134,966	13,323
<b>Revenue:</b>						
Premium	\$ 37,669,204	\$ 39,652,832	\$ 42,486,972	\$ 45,197,814	\$ 40,030,224	\$ 5,167,590
Reserve for Rate Reduction	(387,418)	(440,736)	-	-	(257,732)	257,732
MCO Premium Tax	(1,451,360)	(1,529,127)	(1,672,942)	(1,779,698)	(1,576,190)	(203,508)
<b>Total Net Premium</b>	<b>35,830,427</b>	<b>37,682,970</b>	<b>40,814,030</b>	<b>43,418,115</b>	<b>38,196,302</b>	<b>5,221,813</b>
<b>Other Revenue:</b>						
Interest Income	14,272	17,728	16,425	12,448	13,210	(762)
Miscellaneous Income	37,286	38,333	38,333	38,333	38,333	-
<b>Total Other Revenue</b>	<b>51,559</b>	<b>56,061</b>	<b>54,759</b>	<b>50,782</b>	<b>51,543</b>	<b>(762)</b>
<b>Total Revenue</b>	<b>35,881,985</b>	<b>37,739,031</b>	<b>40,868,789</b>	<b>43,468,897</b>	<b>38,247,845</b>	<b>5,221,052</b>
<b>Medical Expenses:</b>						
<u>Capitation (PCP, Specialty, Kasier, NEMT &amp; Visior</u>	1,679,455	1,704,134	1,797,876	1,851,892	1,671,376	(180,516)
<u>FFS Claims Expenses:</u>						
Inpatient	5,139,891	7,940,779	9,670,256	9,002,937	7,498,934	(1,504,003)
LTC/SNF	7,988,436	7,256,361	6,106,318	8,116,213	6,067,808	(2,048,405)
Outpatient	3,057,728	2,631,325	3,845,231	3,312,183	3,418,299	106,116
Laboratory and Radiology	450,809	609,596	512,307	629,923	534,343	(95,580)
<b>Physician ACA 1202</b>	<b>104,094</b>	<b>102,189</b>	-	-	-	-
Emergency Room	871,674	975,817	1,127,040	1,093,890	1,056,758	(37,132)
Physician Specialty	1,930,722	2,433,750	2,572,332	2,306,001	2,675,372	369,370
Mental Health Services	233,276	254,043	248,532	297,327	191,921	(105,406)
Pharmacy	5,657,345	5,648,117	6,255,595	7,006,271	6,510,244	(496,027)
Other Medical Professional	192,695	218,265	200,064	224,924	189,157	(35,767)
Other Medical Care	-	3,645	331	-	-	-
Other Fee For Service	2,870,527	3,250,414	3,791,877	4,329,381	3,419,133	(910,248)
Transportation	83,111	79,919	111,272	77,615	89,403	11,788
<b>Total Claims</b>	<b>28,580,309</b>	<b>31,404,220</b>	<b>34,441,155</b>	<b>36,396,665</b>	<b>31,651,371</b>	<b>(4,745,295)</b>
Medical & Care Management Expense	774,659	828,605	896,582	921,915	961,818	39,903
Reinsurance	104,962	308,761	319,404	(120,034)	206,499	326,532
Claims Recoveries	(187,358)	(33,912)	(389,784)	(237,943)	-	237,943
Sub-total	692,263	1,103,455	826,202	563,938	1,168,316	604,379
<b>Total Cost of Health Care</b>	<b>30,952,027</b>	<b>34,211,809</b>	<b>37,065,232</b>	<b>38,812,496</b>	<b>34,491,063</b>	<b>(4,321,432)</b>
<b>Contribution Margin</b>	<b>4,929,959</b>	<b>3,527,222</b>	<b>3,803,556</b>	<b>4,656,402</b>	<b>3,756,782</b>	<b>899,620</b>
<b>General &amp; Administrative Expenses:</b>						
Salaries and Wages	577,942	584,952	585,889	662,308	682,692	20,383
Payroll Taxes and Benefits	90,406	144,143	152,089	158,128	159,084	956
Travel and Training	9,270	7,364	8,647	7,786	26,101	18,314
Outside Service - ACS	1,024,850	1,044,479	1,127,533	1,167,563	1,021,787	(145,776)
Outside Services - Other	180,177	82,663	81,293	214,869	78,084	(136,786)
Accounting & Actuarial Services	14,226	29,239	17,051	(7,071)	13,333	20,405
Legal	47,032	71,044	33,293	134,879	36,340	(98,539)
Insurance	12,477	12,120	11,990	11,949	15,095	3,146
Lease Expense - Office	28,979	28,979	226,981	63,318	64,355	1,037
Consulting Services	53,700	57,096	71,630	35,325	127,477	92,153
Translation Services	2,554	5,197	1,963	5,152	2,417	(2,735)
Advertising and Promotion	790	(790)	1,300	-	12,110	12,110
General Office	83,285	73,897	126,456	91,250	107,586	16,336
Depreciation & Amortization	7,015	7,015	14,711	15,108	49,647	34,539
Printing	862	21,503	12,008	1,312	10,496	9,184
Shipping & Postage	5,822	464	1,945	318	2,950	2,632
Interest	14,746	27,738	22,754	35,144	11,108	(24,036)
<b>Total G &amp; A Expenses</b>	<b>2,154,133</b>	<b>2,197,102</b>	<b>2,563,313</b>	<b>2,597,338</b>	<b>2,420,662</b>	<b>(176,677)</b>
<b>Net Income / (Loss)</b>	<b>\$ 2,775,825</b>	<b>\$ 1,330,120</b>	<b>\$ 1,240,243</b>	<b>\$ 2,059,063</b>	<b>\$ 1,336,120</b>	<b>\$ 722,943</b>

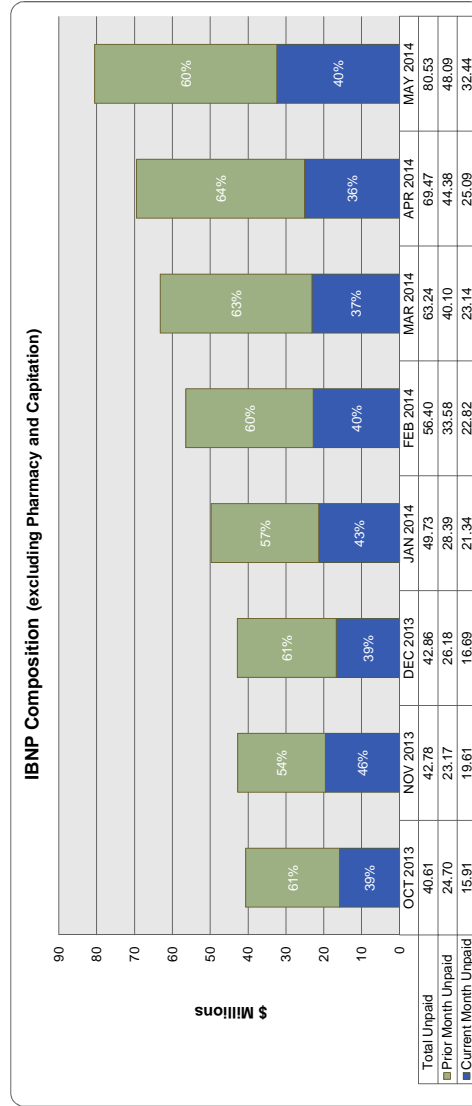
## PMPM Income Statement Comparison

	FEB 2014	MAR 2014	APR 2014	MAY 2014		Variance Fav/(Unfav)
				Actual	Budget	
<b>Membership (includes retro members)</b>	133,041	136,917	141,636	148,289	134,966	13,323
<b>Revenue:</b>						
Premium	283.14	289.61	299.97	304.80	296.59	8.20
Reserve for Rate Reduction	(2.91)	(3.22)	-	-	(1.91)	1.91
MCO Premium Tax	(10.91)	(11.17)	(11.81)	(12.00)	(11.68)	(0.32)
<b>Total Net Premium</b>	<b>269.32</b>	<b>275.22</b>	<b>288.16</b>	<b>292.79</b>	<b>283.01</b>	<b>9.79</b>
<b>Other Revenue:</b>						
Interest Income	0.11	0.13	0.12	0.08	0.10	(0.01)
Miscellaneous Income	0.28	0.28	0.27	0.26	0.28	(0.03)
<b>Total Other Revenue</b>	<b>0.39</b>	<b>0.41</b>	<b>0.39</b>	<b>0.34</b>	<b>0.51</b>	<b>(0.17)</b>
<b>Total Revenue</b>	<b>269.71</b>	<b>275.63</b>	<b>288.55</b>	<b>293.14</b>	<b>283.39</b>	<b>9.75</b>
<b>Medical Expenses:</b>						
<u>Capitation (PCP, Specialty, Kasier, NEMT &amp; Visior</u>	12.62	12.45	12.69	12.49	12.38	0.10
<u>FFS Claims Expenses:</u>						
Inpatient	38.63	58.00	68.28	60.71	55.56	(5.15)
LTC/SNF	60.04	53.00	43.11	54.73	44.96	(9.77)
Outpatient	22.98	19.22	27.15	22.34	25.33	2.99
Laboratory and Radiology	3.39	4.45	3.62	4.25	3.96	(0.29)
Physician ACA 1202	0.78	0.75	-	-	-	-
Emergency Room	6.55	7.13	7.96	7.38	7.83	0.45
Physician Specialty	14.51	17.78	18.16	15.55	19.82	4.27
Mental Health Services	1.75	1.86	1.75	2.01	1.42	(0.58)
Pharmacy	42.52	41.25	44.17	47.25	48.24	0.99
Other Medical Professional	1.45	1.59	1.41	1.52	1.40	(0.12)
Other Medical Care	-	0.03	0.00	-	-	-
Other Fee For Service	21.58	23.74	26.77	29.20	25.33	(3.86)
Transportation	0.62	0.58	0.79	0.52	0.66	0.14
<b>Total Claims</b>	<b>214.82</b>	<b>229.37</b>	<b>243.17</b>	<b>245.44</b>	<b>234.51</b>	<b>(10.93)</b>
Medical & Care Management Expense	5.82	6.05	6.33	6.22	7.13	0.91
Reinsurance	0.79	2.26	2.26	(0.81)	1.53	2.34
Claims Recoveries	(1.41)	(0.25)	(2.75)	(1.60)	-	1.60
<b>Sub-total</b>	<b>5.20</b>	<b>8.06</b>	<b>5.83</b>	<b>3.80</b>	<b>8.66</b>	<b>4.85</b>
<b>Total Cost of Health Care</b>	<b>232.65</b>	<b>249.87</b>	<b>261.69</b>	<b>261.74</b>	<b>255.55</b>	<b>(6.18)</b>
<b>Contribution Margin</b>	<b>37.06</b>	<b>25.76</b>	<b>26.85</b>	<b>31.40</b>	<b>27.83</b>	<b>3.57</b>
<b>General &amp; Administrative Expenses:</b>						
Salaries and Wages	4.34	4.27	4.14	4.47	5.06	0.59
Payroll Taxes and Benefits	0.68	1.05	1.07	1.07	1.18	0.11
Travel and Training	0.07	0.05	0.06	0.05	0.19	0.14
Outside Service - ACS	7.70	7.63	7.96	7.87	7.57	(0.30)
Outside Services - Other	1.35	0.60	0.57	1.45	0.58	(0.87)
Accounting & Actuarial Services	0.11	0.21	0.12	(0.05)	0.10	0.15
Legal	0.35	0.52	0.24	0.91	0.27	(0.64)
Insurance	0.09	0.09	0.08	0.08	0.11	0.03
Lease Expense - Office	0.22	0.21	1.60	0.43	0.48	0.05
Consulting Services	0.40	0.42	0.51	0.24	0.94	0.71
Translation Services	0.02	0.04	0.01	0.03	0.02	(0.02)
Advertising and Promotion	0.01	(0.01)	0.01	-	0.09	0.09
General Office	0.63	0.54	0.89	0.62	0.80	0.18
Depreciation & Amortization	0.05	0.05	0.10	0.10	0.37	0.27
Printing	0.01	0.16	0.08	0.01	0.08	0.07
Shipping & Postage	0.04	0.00	0.01	0.00	0.02	0.02
Interest	0.11	0.20	0.16	0.24	0.08	(0.15)
<b>Total G &amp; A Expenses</b>	<b>16.19</b>	<b>16.05</b>	<b>18.10</b>	<b>17.52</b>	<b>17.94</b>	<b>0.42</b>
<b>Net Income / (Loss)</b>	<b>20.86</b>	<b>9.71</b>	<b>8.76</b>	<b>13.89</b>	<b>9.90</b>	<b>3.99</b>



**Note: Paid Claims Composition** - reflects adjusted medical claims payment lag schedule.

\* Months Indicated with 5\* represent months for which there were 5 claim payments. For all other months, 4 claim payments were made.



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



For the month ended May 31, 2014

## **APPENDIX**

- Comparative Balance Sheet
- Cash & Medi-Cal Receivable Trend
- Statements of Cash Flow
- YTD Income Statement
- Total Expenditure Composition
- Pharmacy Cost & Utilization Trends

## Comparative Balance Sheet

	5/31/14	4/30/14	Audited FY 2012-13
<b>ASSETS</b>			
<b>Current Assets</b>			
<b>Total Cash and Cash Equivalents</b>	<b>\$ 91,842,018</b>	<b>\$ 72,576,000</b>	<b>\$ 50,817,760</b>
Medi-Cal Receivable*	51,784,771	53,513,432	11,683,076
Provider Receivable	294,941	238,327	1,161,379
Other Receivables	174,521	173,225	300,397
<b>Total Accounts Receivable</b>	<b>52,254,233</b>	<b>53,924,983</b>	<b>13,144,852</b>
Total Prepaid Accounts	490,734	529,986	324,419
Total Other Current Assets	81,719	91,719	10,000
<b>Total Current Assets</b>	<b>144,668,704</b>	<b>127,122,687</b>	<b>64,297,030</b>
<b>Total Fixed Assets</b>	<b>1,664,873</b>	<b>1,636,170</b>	<b>230,913</b>
<b>Total Assets</b>	<b>\$ 146,333,576</b>	<b>\$ 128,758,857</b>	<b>\$ 64,527,943</b>
<b>LIABILITIES &amp; FUND BALANCE</b>			
<b>Current Liabilities</b>			
Incurred But Not Reported	\$ 80,814,694	\$ 71,277,003	\$ 29,901,103
Claims Payable	8,746,221	5,259,002	9,748,676
Capitation Payable	1,485,425	1,444,901	1,002,623
Physician ACA 1202 Payable	3,222,776	3,357,133	-
AB85 Payable	595,883	590,735	-
Accrued Premium Reduction	2,096,754	2,096,754	-
Accounts Payable	1,979,072	1,430,185	1,751,419
Accrued ACS	1,145,296	1,149,054	422,138
Accrued Expenses	737,643	608,902	477,477
Accrued Premium Tax	12,996,920	11,188,973	7,337,759
Accrued Interest Payable	39,744	37,061	9,712
Current Portion of Deferred Revenue	460,000	460,000	460,000
Accrued Payroll Expense	708,187	574,926	605,937
Current Portion Of Long Term Debt	-	-	(0)
Other Current Liabilities	-	-	-
<b>Total Current Liabilities</b>	<b>115,028,617</b>	<b>99,474,627</b>	<b>\$ 51,716,843</b>
<b>Long-Term Liabilities</b>			
Deferred Revenue - Long Term Portion	498,333	536,667	920,000
Notes Payable	7,200,000	7,200,000	7,200,000
<b>Total Long-Term Liabilities</b>	<b>7,698,333</b>	<b>7,736,667</b>	<b>8,120,000</b>
<b>Total Liabilities</b>	<b>122,726,950</b>	<b>107,211,294</b>	<b>59,836,843</b>
Beginning Fund Balance	4,691,101	4,691,101	(6,031,881)
Net Income Current Year	18,915,526	16,856,462	10,722,981
<b>Total Fund Balance</b>	<b>23,606,626</b>	<b>21,547,563</b>	<b>4,691,100</b>
<b>Total Liabilities &amp; Fund Balance</b>	<b>\$ 146,333,576</b>	<b>\$ 128,758,857</b>	<b>\$ 64,527,943</b>

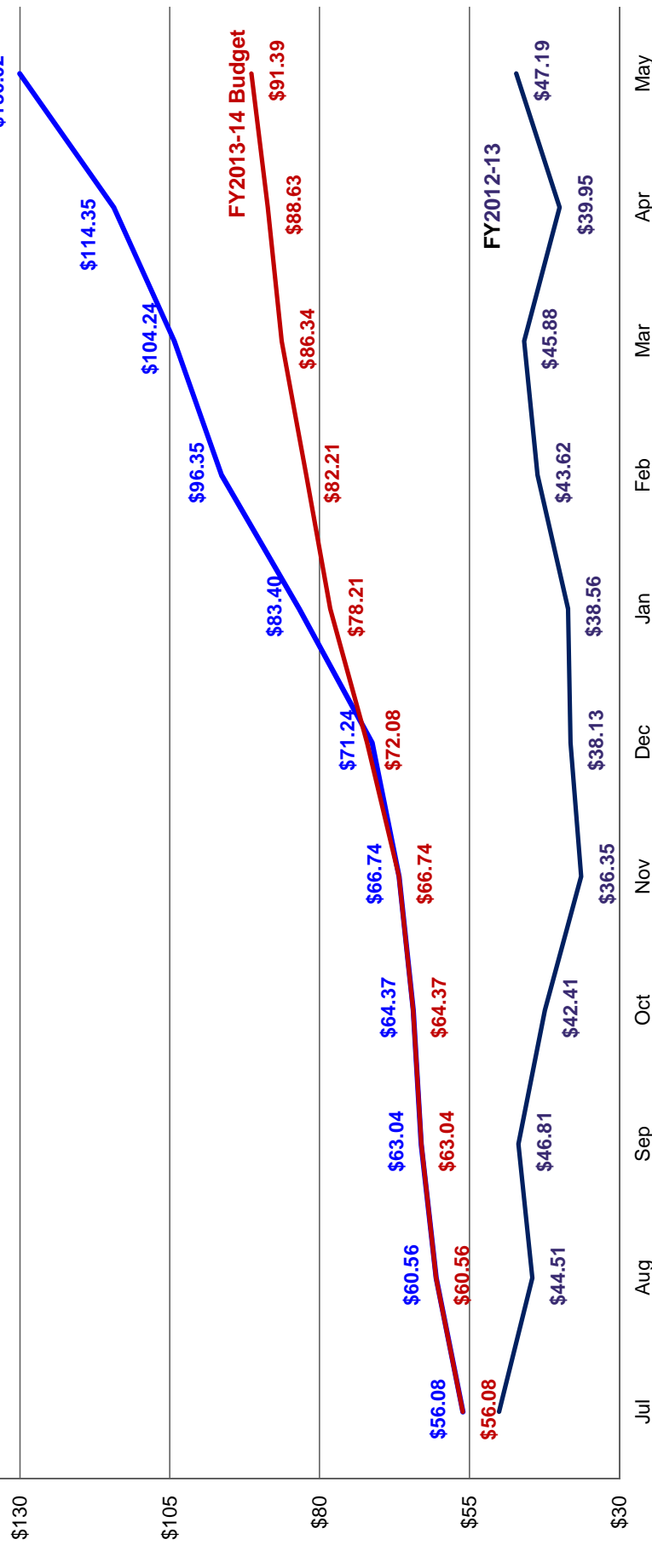
<b>FINANCIAL INDICATORS</b>			
Current Ratio	1.26 : 1	1.28 : 1	1.24 : 1
Days Cash on Hand	67	55	58
Days Cash + State Capitation Receivable	104	95	72
Days Cash + State Capitation Rec (less Tax Liab)	95	87	63

## Cash + Medi-Cal Receivable Trend (\$ in Millions)

(Net of MCO Tax Liability and excludes pass-through funds)

FY2013-14  
Reported

\$130.02





## Statement of Cash Flows - Monthly

	MAY '14	APR '14	JUN'13
<b>Cash Flow From Operating Activities</b>			
Collected Premium	\$ 47,033,424	\$ 37,650,034	\$ 52,138,834
Miscellaneous Income	12,448	16,425	8,594
State Pass Through Funds	610,463	547,636	34,346,474
<b>Paid Claims</b>			
Medical & Hospital Expenses	(18,074,838)	(22,006,605)	(17,277,826)
Pharmacy	(5,481,933)	(4,969,327)	(4,009,168)
Capitation	(1,813,549)	(1,707,411)	(1,162,302)
Reinsurance of Claims	(336,485)	(319,404)	(240,430)
State Pass Through Funds Distributed	-	(521,567)	(34,346,474)
Paid Administration	(2,609,727)	(1,271,656)	(2,616,623)
MCO Tax Received / (Paid)		(8,124,486)	829,564
<b>Net Cash Provided/ (Used) by Operating Activities</b>	<b>19,339,804</b>	<b>(706,361)</b>	<b>27,670,643</b>
<b>Cash Flow From Investing/Financing Activities</b>			
Proceeds from Line of Credit			-
Repayments on Line of Credit	-	-	-
Net Acquisition of Property/Equipment	(73,786)	(381,708)	(31,026)
<b>Net Cash Provided/(Used) by Investing/Financing</b>	<b>(73,786)</b>	<b>(381,708)</b>	<b>(31,026)</b>
<b>Net Cash Flow</b>	<b>\$ 19,266,019</b>	<b>\$ (1,088,069)</b>	<b>\$ 27,639,617</b>
Cash and Cash Equivalents (Beg. of Period)	73,664,068	73,664,068	23,068,235
Cash and Cash Equivalents (End of Period)	91,842,018	72,576,000	50,817,760
	<b>\$ 18,177,950</b>	<b>\$ (1,088,069)</b>	<b>\$ 27,749,525</b>
<b>Adjustment to Reconcile Net Income to Net Cash Flow</b>			
Net (Loss) Income	2,059,063	1,240,243	4,109,976
Loss on asset disposal	-	65,781	-
Depreciation & Amortization	45,083	44,605	11,407
Decrease/(Increase) in Receivables	1,670,751	(4,987,770)	22,788,941
Decrease/(Increase) in Prepays & Other Current Ass	49,252	300,680	769,972
(Decrease)/Increase in Payables	680,609	1,113,941	(1,578,838)
(Decrease)/Increase in Other Liabilities	(38,333)	(38,333)	(121,667)
Changes in Withhold / Risk Incentive Pool	-	-	-
Change in MCO Tax Liability	1,807,947	(6,427,510)	1,433,012
Changes in Claims and Capitation Payable	3,527,743	(2,194,076)	1,913,029
Changes in IBNR	9,537,691	10,176,079	(1,655,189)
	19,339,804	(706,361)	27,670,643
<b>Net Cash Flow from Operating Activities</b>	<b>\$ 19,339,804</b>	<b>\$ (706,361)</b>	<b>\$ 27,670,643</b>

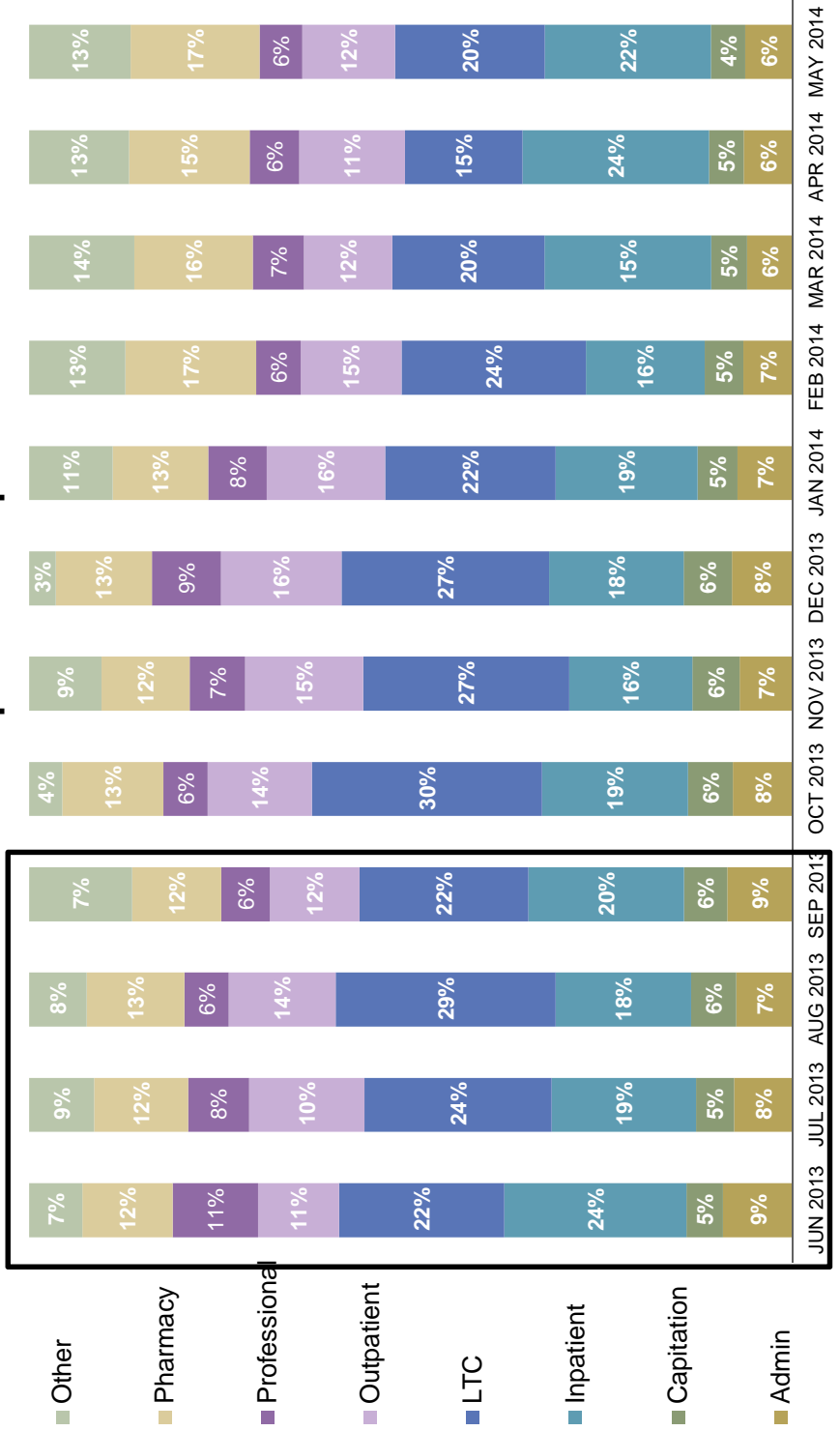
## Statement of Cash Flows - YTD

	<b>MAY 2014 YTD</b>
Cash Flow From Operating Activities	
Collected Premium	\$ 338,499,858
Miscellaneous Income	137,077
State Pass Through Funds	63,097,322
<u>Paid Claims</u>	
Medical & Hospital Expenses	(196,290,626)
Pharmacy	(43,961,142)
Capitation	(17,247,549)
Reinsurance of Claims	(3,185,182)
State Pass Through Funds Distributed	(61,216,681)
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(28,097,843)
Repay Initial Net Liabilities	-
MCO Taxes Received / (Paid)	(8,951,052)
Net Cash Provided/(Used) by Operating Activities	<b>42,784,183</b>
Cash Flow From Investing/Financing Activities	
Proceeds from Line of Credit	-
Repayments on Line of Credit	-
Net Acquisition of Property/Equipment	(1,759,925)
Net Cash Provided/(Used) by Investing/Financing	<b>(1,759,925)</b>
<b>Net Cash Flow</b>	<b>\$ 41,024,258</b>
Cash and Cash Equivalents (Beg. of Period)	50,817,760
Cash and Cash Equivalents (End of Period)	91,842,018
	<b>\$ 41,024,258</b>
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	18,915,526
Depreciation & Amortization	261,340
Decrease/(Increase) in Receivables	(39,109,381)
Decrease/(Increase) in Prepaids & Other Current Assets	(238,034)
(Decrease)/Increase in Payables	7,258,675
(Decrease)/Increase in Other Liabilities	(422,821)
Change in MCO Tax Liability	5,659,160
Loss on asset disposal	65,781
Changes in Claims and Capitation Payable	(519,653)
Changes in IBNR	50,913,591
	42,784,183
<b>Net Cash Flow from Operating Activities</b>	<b>\$ 42,784,183</b>

**Income Statement**  
**For The Eleven Months Ended May 31, 2014**

	May '14 Year-To-Date		Variance Fav/(Unfav)
	Actual	Budget	
<b>Membership (includes retro members)</b>	1,396,492	1,374,745	21,747
<b>Revenue</b>			
Premium	\$ 378,471,493	\$ 367,352,603	\$ 11,118,890
Reserve for Rate Reduction	(2,096,754)	(2,107,661)	10,907
MCO Premium Tax	(14,507,465)	(14,284,208)	(223,257)
<b>Total Net Premium</b>	<b>361,867,275</b>	<b>350,960,734</b>	<b>10,906,541</b>
<b>Other Revenue:</b>			
Interest Income	137,077	122,978	14,099
Miscellaneous Income	420,620	421,667	(1,047)
<b>Total Other Revenue</b>	<b>557,697</b>	<b>544,645</b>	<b>13,052</b>
<b>Total Revenue</b>	<b>362,424,972</b>	<b>351,505,379</b>	<b>10,919,592</b>
<b>Medical Expenses:</b>			
<u>Capitation (PCP, Specialty, Kaiser, NEMT &amp; Vision)</u>	17,777,790	17,472,729	(305,061)
<u>FFS Claims Expenses:</u>			
Inpatient	66,260,611	65,011,427	(1,249,184)
LTC/SNF	78,079,178	70,950,949	(7,128,229)
Outpatient	33,613,359	33,552,719	(60,640)
Laboratory and Radiology	3,349,627	3,322,868	(26,760)
Physician ACA 1202	5,373,618	-	(5,373,618)
Emergency Room	9,331,375	9,341,102	9,727
Physician Specialty	22,618,864	24,147,515	1,528,651
Mental Health Services	1,258,195	959,117	(299,078)
Pharmacy	47,820,475	50,380,754	2,560,279
Other Medical Professional	1,843,246	1,722,647	(120,599)
Other Medical Care	7,270	-	(7,270)
Other Fee For Service	26,794,305	25,748,742	(1,045,564)
Transportation	921,837	931,181	9,345
<b>Total Claims</b>	<b>297,271,960</b>	<b>286,069,021</b>	<b>(11,202,939)</b>
Medical & Care Management Expense	8,757,047	8,976,627	219,580
Reinsurance	(1,484,869)	(478,038)	1,006,831
Claims Recoveries	(2,786,727)	-	2,786,727
<b>Sub-total</b>	<b>4,485,451</b>	<b>8,498,589</b>	<b>4,013,139</b>
<b>Total Cost of Health Care</b>	<b>319,535,202</b>	<b>312,040,340</b>	<b>(7,494,861)</b>
<b>Contribution Margin</b>	<b>42,889,770</b>	<b>39,465,039</b>	<b>3,424,731</b>
<b>General &amp; Administrative Expenses:</b>			
Salaries and Wages	6,109,199	6,313,066	203,867
Payroll Taxes and Benefits	1,477,230	1,484,218	6,988
Travel and Training	86,668	179,133	92,465
Outside Service - ACS	11,068,085	10,794,532	(273,552)
Outside Services - Other	782,688	599,854	(182,834)
Accounting & Actuarial Services	231,307	196,613	(34,694)
Legal	741,223	470,947	(270,277)
Insurance	130,938	132,879	1,942
Lease Expense - Office	536,639	556,553	19,914
Consulting Services	1,047,352	1,392,863	345,511
Translation Services	43,165	30,810	(12,354)
Advertising and Promotion	25,369	175,019	149,650
General Office	1,014,938	1,113,466	98,528
Depreciation & Amortization	88,871	213,622	124,751
Printing	104,559	194,670	90,111
Shipping & Postage	49,192	209,709	160,517
Interest	371,041	296,228	(74,813)
Other/ Miscellaneous Expenses	65,781	-	(65,781)
<b>Total G &amp; A Expenses</b>	<b>23,974,244</b>	<b>24,354,182</b>	<b>379,938</b>
<b>Net Income / (Loss)</b>	<b>\$ 18,915,526</b>	<b>\$ 15,110,857</b>	<b>\$ 3,804,669</b>

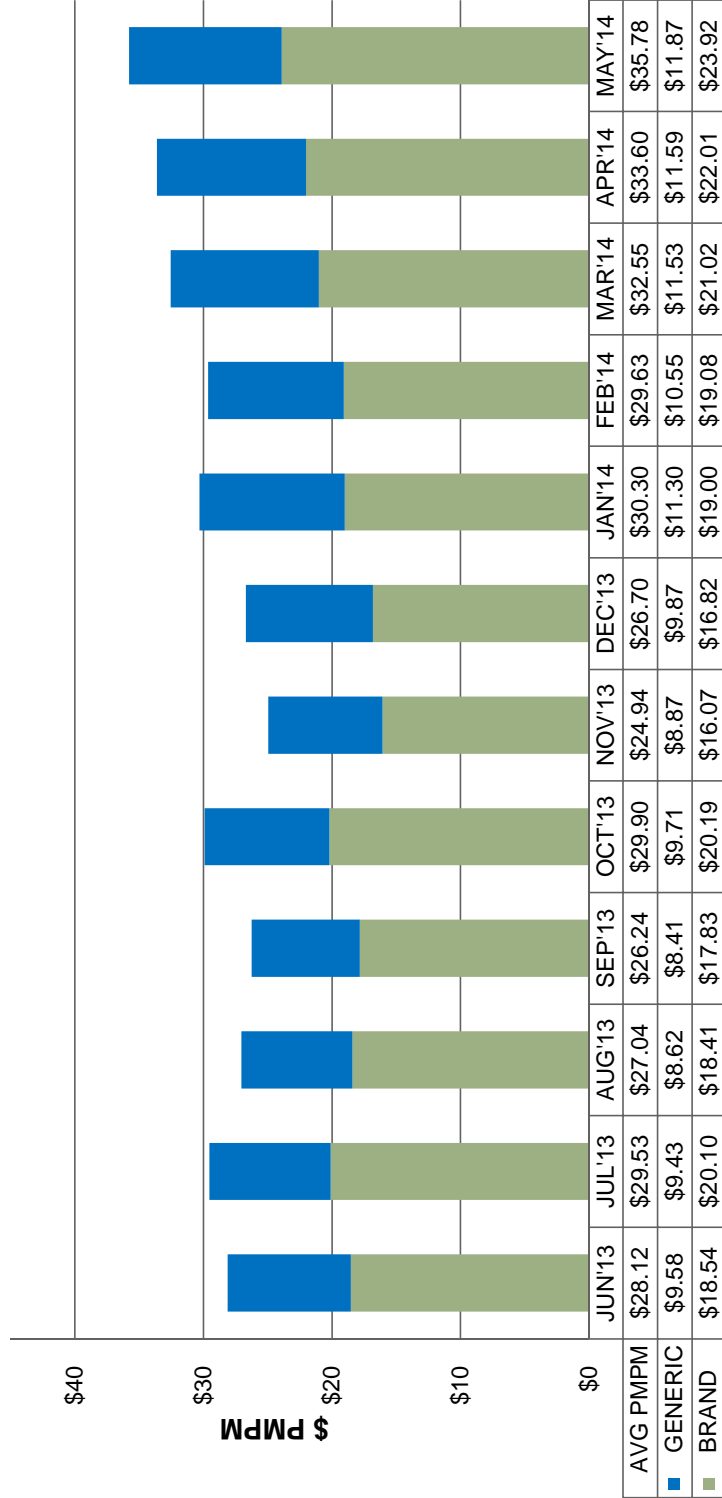
# Total Expense Composition



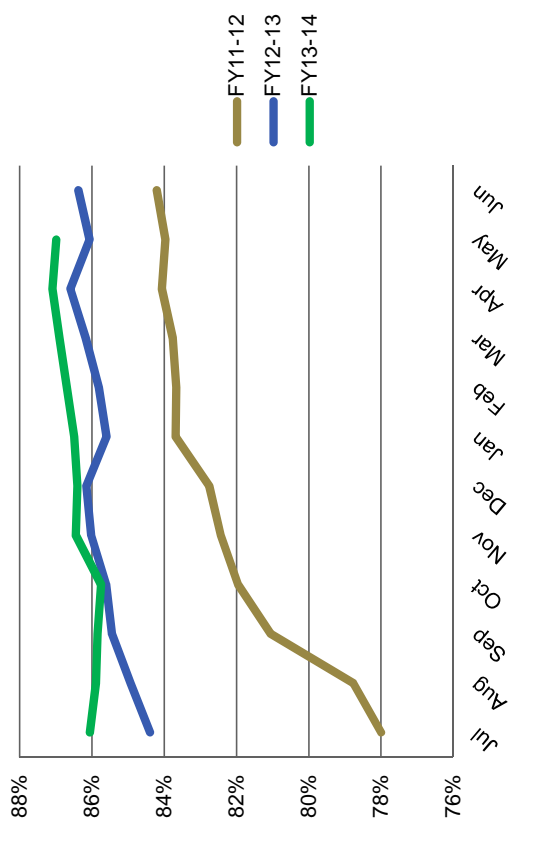
In May 2013, GCHP changed its method of distributing Health Care Costs (HCC) across categories of service. Prior months utilized an allocation methodology. The methodology was updated to utilize payment information by different categories of services. Further changes have been made with the assumption of the TLIC population and its affect on various categories of service. Therefore, the months of May - August represent the transitioning to a new methodology.

Beginning January 2014, "Other" category includes ACA 1202 physician supplement and mental health expenses.

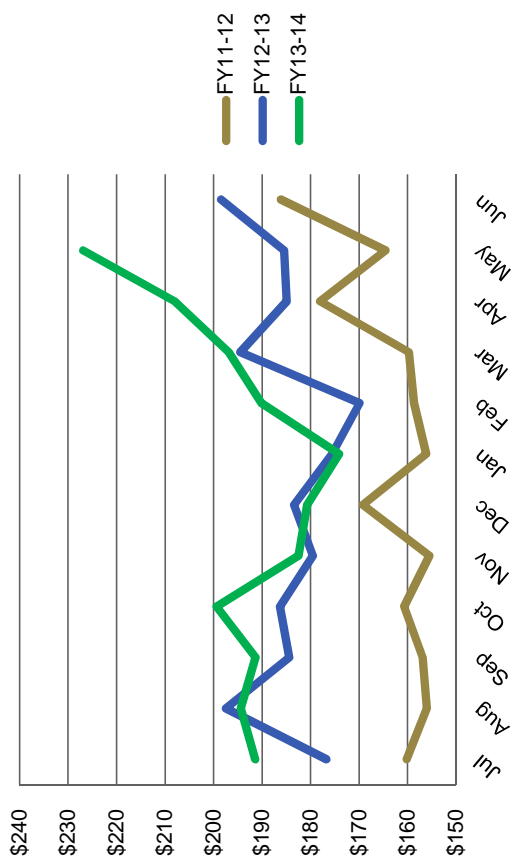
### Pharmacy Cost Trend



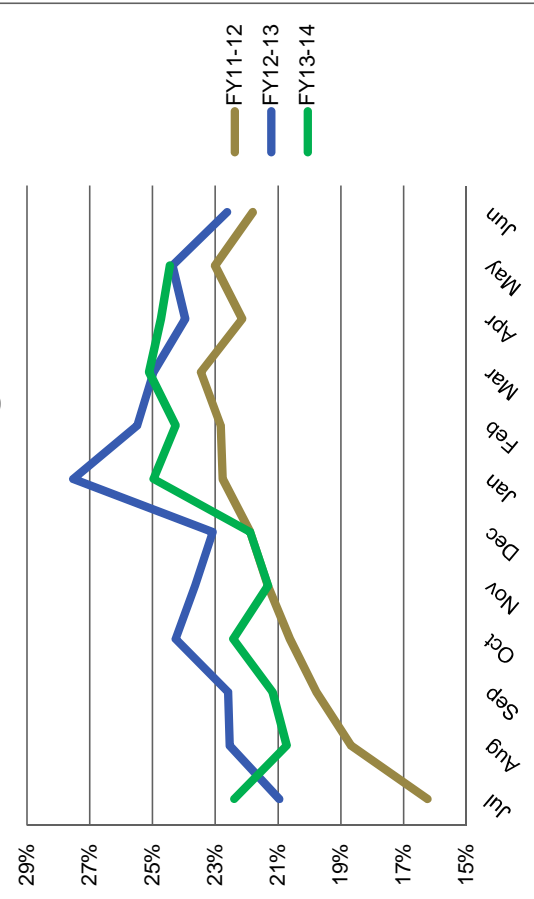
### Generic Utilization Rate



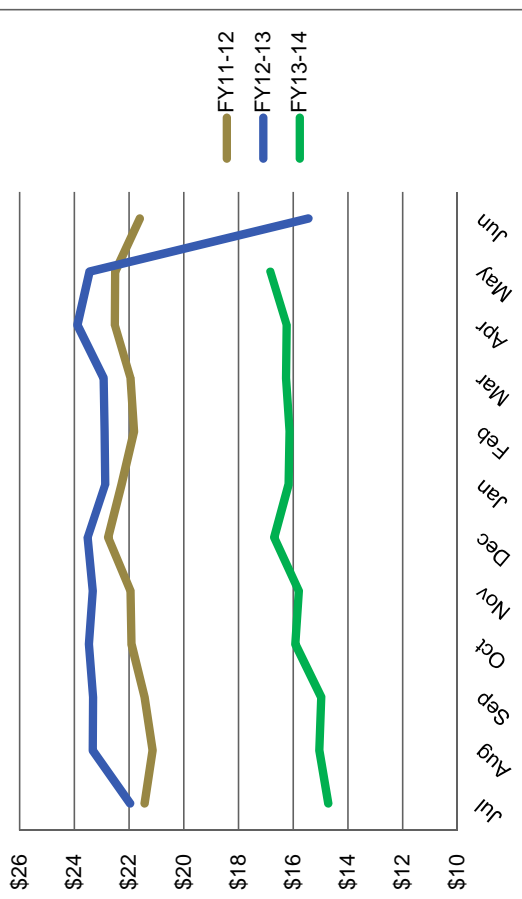
### Brand Drugs: Cost per Script



### Percent Utilizing Members



### Generic Drugs: Cost per Script



## **AGENDA ITEM 2b**

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: July 28, 2014

Re: Financial Auditor Client Service and Audit Plan

### **SUMMARY**

The Plan's financial auditors<sup>1</sup>, McGladrey LLP (McGladrey) presented the attached information at the July 7, 2014 Executive / Finance Committee. This information outlines the following items regarding the audit of the FY 2013-14 (July 1, 2013 through June 30, 2014) financial statements:

- Expectations between the Plan and McGladrey,
- McGladrey's service team,
- Key audit risks,
- Overall audit approach,
- Service deliverables,
- Timelines, and
- Other matters.

After review of the material, the Executive / Finance Committee recommended approval to the Commission of McGladrey's 2014 Client Service and Audit Plan.

### **RECOMMENDATION**

The Plan requests the Commission's approval of McGladrey's 2014 Client Service and Audit Plan.

### **CONCURRENCE**

Executive / Finance Committee – July 7, 2014

### **Attachments**

McGladrey's 2014 Client Service and Audit Plan

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<sup>1</sup> McGladrey's Partner Steve Draxler and Assurance Services Director Carrie Esler presented at the July 7, 2014 Executive / Finance Committee meeting.

# **Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan**

2014 Client Service and Audit Plan





July 10, 2014

To the Executive/Finance Committee  
Ventura County Medi-Cal Managed Care Commission  
dba Gold Coast Health Plan  
Camarillo, California

On behalf of McGladrey LLP, we are pleased to submit our 2014 client service and audit plan for Gold Coast Health Plan (GCHP). This report outlines our mutual understanding of the expectations between Gold Coast Health Plan and McGladrey LLP, our client service team, key audit risks, overall audit approach, service deliverables, timelines and other matters.

This plan has been developed to provide the Executive/Finance Committee with an overview of our plan to provide Gold Coast Health Plan with an efficient, high-quality audit that addresses key risks and business issues within the organization. It also incorporates best practices and efficiencies identified during the previous audits we have performed. This service plan will be monitored throughout the year to ensure that we meet your expectations and address key audit, business and industry risks as they arise.

We appreciate the time and resources that your team has committed to assisting us. We look forward to our meeting with you on July 10, 2014, to present this report, address any questions you may have, and discuss any other matters of interest to the Executive/Finance Committee.

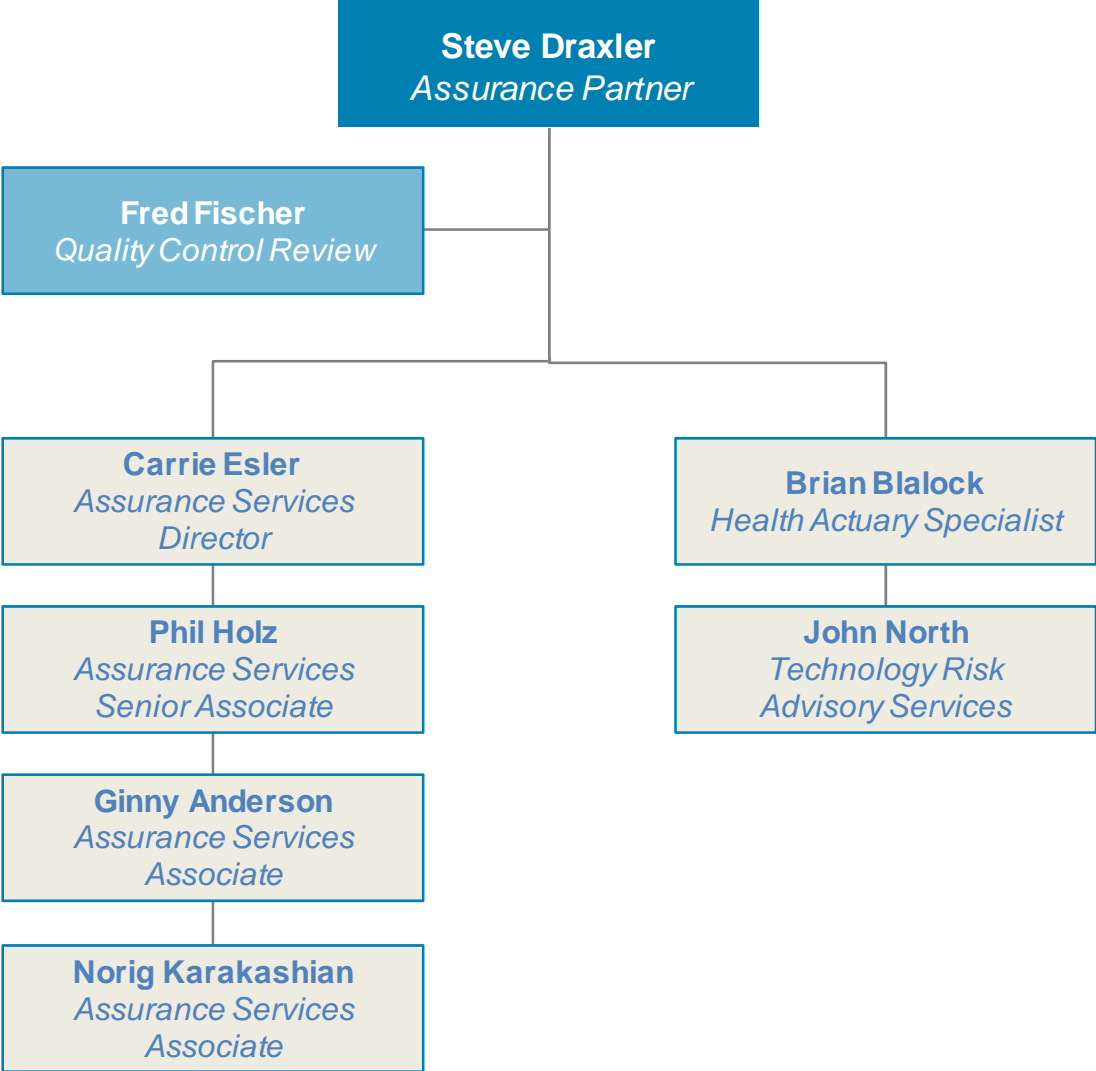
Sincerely,

A handwritten signature in black ink that reads "Steve Draxler". The signature is written in a cursive, flowing style.

Steven J. Draxler, Partner  
steve.draxler@mcgladrey.com

# The GCHP 2014 Client Service and Audit Plan

## Client Service Team



# The GCHP 2014 Client Service and Audit Plan

## Audit Scope

Auditing standards require that we plan and perform our audits to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement, whether caused by error or fraud. Based on discussions with management, we are planning to audit the financial statements and provide other services as follows:

- Financial statement audit:
  - Perform an audit at a level that allows us to express an opinion on the financial statements as a whole. The procedures are designed to be performed on specific areas of risk, using a materiality threshold calculated based upon the relevant financial metrics.
- Written communication with the Executive/Finance Committee:
  - Issue a written report summarizing the results of our audit, including all required communications under the American Institute of Certified Public Accountants' (AICPA) AU-C Section 260 (AU-C 260), *The Auditor's Communication With Those Charged With Governance*.
  - If applicable, issue a management letter providing our observations and recommendations regarding internal controls (including all material weaknesses and significant deficiencies), business and industry matters, relevant technical advice, accounting guidance, and other matters.

# The GCHP 2014 Client Service and Audit Plan

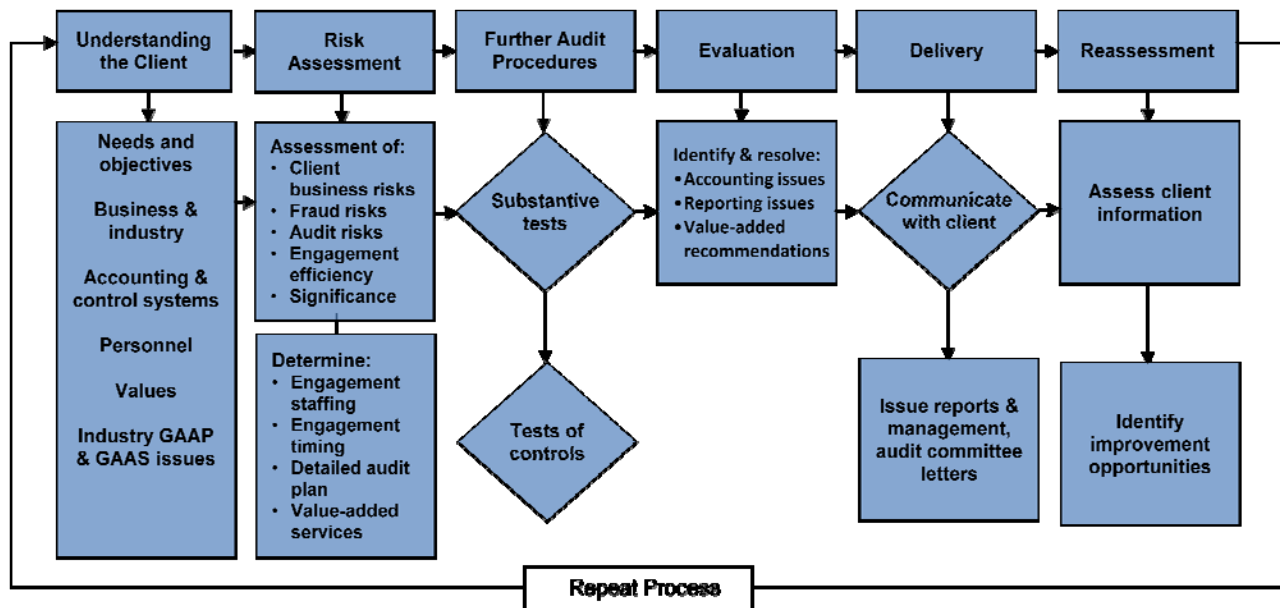
## Summary Audit Approach

### Gold Coast Health Plan

**Communication:** Effective, two-way communication between our firm and the Executive/Finance Committee is important for understanding matters related to the audit and in developing a constructive working relationship.

Your insights may assist us in understanding GCHP and its environment, in identifying appropriate sources of audit evidence, and in providing information about specific transactions or events. We will discuss with you your oversight of the effectiveness of internal control and any areas where you request additional procedures to be undertaken. We expect that you will timely communicate with us any matters you consider relevant to the audit. Such matters might include strategic decisions that may significantly affect the nature, timing and extent of audit procedures; your suspicion or detection of fraud or abuse; or any concerns you may have about the integrity or competence of senior management.

We will timely communicate to you any fraud involving senior management and other fraud that causes a material misstatement of the financial statements, illegal acts, instances of noncompliance, or abuse that come to our attention (unless they are clearly inconsequential) and disagreements with management and other serious difficulties encountered in performing the audit. We also will communicate to you and to management any significant deficiencies or material weaknesses in internal control that become known to us during the course of the audit. Other matters arising from the audit that are, in our professional judgment, significant and relevant to you in your oversight of the financial reporting process will be communicated to you in writing after the audit.



**Independence:** Independence is a cornerstone of our profession. As such, we actively monitor independence to ensure our firm and its personnel comply with applicable professional independence standards.

## The GCHP 2014 Client Service and Audit Plan

**Audit planning process:** Our audit approach places a strong emphasis on obtaining an understanding of how your business functions. On the basis of this understanding, we will perform a detailed risk assessment to design the nature, timing and extent of audit procedures. We will also review recommendations made in prior years and assess current internal control procedures.

Similar to how we have approached our past audits of GCHP, we expect to perform planning procedures through an interim date, May 31, 2014, and then create expectations for year-end. At year-end we compare our expectations to the actual results and at that point determine appropriate procedures. That timing provides the ability to continue our “no surprises” audit approach.

**Materiality:** We apply the concept of materiality both in planning and performing the audit; evaluating the effect of identified misstatements on the audit and the effect of uncorrected misstatements, if any, on the financial statements; and in forming the opinions in our reports. Our determination of materiality is a matter of professional judgment and is affected by our perception of the financial information needs of users of the financial statements. We establish performance materiality at an amount less than materiality for the financial statements as a whole to allow for the risk of misstatements that may not be detected by the audit. We use performance materiality for purposes of assessing the risks of material misstatement and determining the nature, timing and extent of further financial audit procedures. Our assessment of materiality throughout the audit will be based on both quantitative and qualitative considerations. Because of the interaction of quantitative and qualitative considerations, misstatements of a relatively small amount could have a material effect on the current financial statements as well as financial statements of future periods. We will accumulate misstatements identified during the audit, other than those that are clearly trivial. At the end of the audit, we will inform you of all individual unrecorded misstatements aggregated by us in connection with our evaluation of our audit test results.

**Internal controls:** Our audit of the financial statements will include obtaining an understanding of internal control sufficient to plan the audit and to determine the nature, timing and extent of audit procedures to be performed. An audit is not designed to provide assurance on internal control or to identify significant deficiencies or material weaknesses. Our review and understanding of GCHP's internal control is not undertaken for the purpose of expressing an opinion on the effectiveness of internal control.

# The GCHP 2014 Client Service and Audit Plan

## Areas of Audit Focus and Summary Audit Procedures

The fiscal year 2014 audit will continue to take a risk-based approach based on our understanding of the control risk assessment from results of our initial audit scoping, as well as our continuous review process. Following are the audit areas that, based on a risk assessment performed by us, we believe pose a higher risk of misstatement to the financial statements. When deemed efficient by us, tests of controls will be performed. In those areas for which we are relying on controls, as required by audit standards, we will also perform certain limited substantive and analytic tests. In those areas for which controls are not relied upon, we will perform substantive and analytic tests with more selections and a lower scope than applied when we are relying on controls. A summary of the substantive and analytic tests we plan to perform is presented below:

Risk Area	Summary Audit Procedures
Medical expenses and medical claims payable	<ul style="list-style-type: none"> <li>• Test claims adjudication process.</li> <li>• Assess adequacy of current reserving methodologies.</li> <li>• Assess independence and competence of actuaries and their methodology.</li> <li>• Test data provided to independent actuaries for accuracy and completeness.</li> <li>• Review of the actuarial firm's (engaged by management) methodologies and results by McGladrey's specialists.</li> </ul>
Capitation revenue and capitation reserve	<ul style="list-style-type: none"> <li>• Test management's calculations of capitation revenue.</li> <li>• Perform substantive tests on a selected sample, along with detailed analytical procedures.</li> <li>• Review management's methodology for allowance for uncollectibility.</li> <li>• Test cutoff.</li> <li>• Review subsequent cash receipts and credits.</li> </ul>
Premium deficiency reserve	<ul style="list-style-type: none"> <li>• Review management methodology and revenue and expense projections for determining if a premium deficiency reserve is needed.</li> </ul>
Reinsurance recoverable	<ul style="list-style-type: none"> <li>• Review management's process for calculating the reinsurance recoverable.</li> <li>• Review terms of the contract with the reinsurer.</li> <li>• Review management's methodology for allowance for uncollectibility.</li> </ul>
Internal control documentation and testing	<ul style="list-style-type: none"> <li>• Gain an understanding of internal control policies and procedures relevant to specific assertions that are likely to prevent, or detect and correct, material misstatement of financial statements.</li> <li>• Design and perform tests of controls to evaluate the operating effectiveness of those policies and procedures.</li> </ul>
Information system general computer controls	<ul style="list-style-type: none"> <li>• Assess information system controls relevant to financial reporting. Activities consist of the procedures (manual or automated) and records established to initiate, authorize, record, process and report entity transactions, events and conditions, and to maintain accountability for the related assets, liabilities and equity.</li> </ul>
Operating expenses	<ul style="list-style-type: none"> <li>• Perform analytical procedures and substantive test work to address risks.</li> </ul>
Accrued expenses	<ul style="list-style-type: none"> <li>• Test a sample of recorded balances.</li> <li>• Perform search for unrecorded liabilities.</li> <li>• Review subsequent disbursements.</li> </ul>

## The GCHP 2014 Client Service and Audit Plan

Risk Area	Summary Audit Procedures
Commitments and contingencies	<ul style="list-style-type: none"><li>• Review status of any litigation with management and legal counsel.</li><li>• Confirm with legal counsel.</li><li>• Review Commission minutes.</li><li>• Assess reasonableness of any reserve levels.</li></ul>
Unusual transactions	<ul style="list-style-type: none"><li>• Obtain an understanding of the background of the subject.</li><li>• Review available documentation.</li><li>• Test journal entries for consistency with evidence obtained.</li><li>• Test details of unique programs, including intergovernmental transfers, senate and assembly bill adjustments to rates, etc.</li></ul>
Financial statement close process, including disclosures	<ul style="list-style-type: none"><li>• Gain an understanding of the financial statement close process and read financial statements and significant disclosures.</li></ul>

# The GCHP 2014 Client Service and Audit Plan

## Use of Specialists

Gold Coast Health Plan is a complex organization. This complexity requires a level of additional specialized expertise. We have identified experts to evaluate key risk areas embedded in your business. These specialists will not only ensure we have the right resources to achieve our audit objectives, they will also be able to draw upon their best practice knowledge to identify areas of operational improvement for your business, as well as potential regulatory or compliance risks you were unaware of.

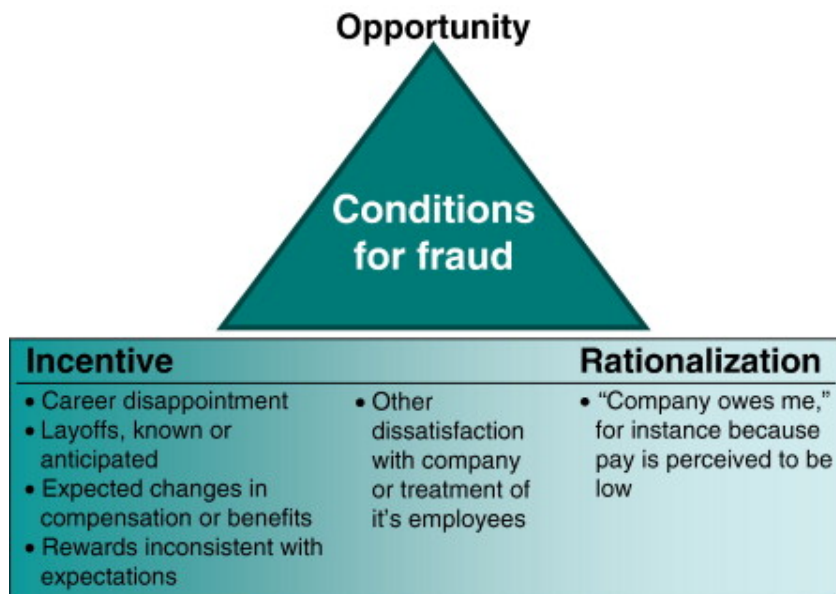
Area	Description of Services
Information technologies	Our information technologies specialists will assist with evaluating the current general computer controls implemented across GCHP.
Health actuarial	Our actuaries assist us in evaluating the methodologies utilized by the actuaries hired by management, as well as the estimated results of the actuarial calculations.



# The GCHP 2014 Client Service and Audit Plan

## Fraud Risk Considerations

Auditing standards require us to plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether caused by error or fraud. Following are the procedures designed to obtain reasonable assurance:



<b>Summary Audit Procedures</b>	
<p>Consideration of fraud in a financial statement audit</p>	<p>Assess:</p> <ul style="list-style-type: none"> <li>• Risk of misstatement due to fraudulent financial reporting or misappropriation of assets</li> <li>• Entity's risk assessment process</li> <li>• Internal audit, compliance and Executive/Finance Committee activities</li> <li>• Financial performance versus budget and prior year</li> </ul> <p>Evaluate and review:</p> <ul style="list-style-type: none"> <li>• Code of conduct/ethics policies</li> <li>• Management programs and controls to deter and detect fraud for identified risk</li> <li>• Areas more likely susceptible to fraud</li> <li>• Business rationale for significant unusual transactions</li> <li>• Management structure and any changes</li> <li>• Accounting estimates, current and retrospective, for biases</li> <li>• Revenue recognition policies and procedures</li> <li>• Inquiries of management and others within GCHP, including the Executive/Finance Committee, those outside management, and those outside the finance function</li> <li>• Journal entries and other adjustments</li> <li>• Add an element of unpredictability in audit procedures year to year</li> </ul> <p>Consider the results of the information gathered through the procedures above.</p>

# The GCHP 2014 Client Service and Audit Plan

## New Accounting Guidance and Standards

The following standard will be analyzed for applicability to Gold Coast Health Plan.

Pending Guidance	
<p>The following topics are being contemplated by various authoritative and nonauthoritative accounting standard-setting bodies.</p> <p>Based on our preliminary assessment, these topics will not have a direct impact to GCHP for 2014. We will keep you apprised of developments in these areas:</p> <ul style="list-style-type: none"> <li>• Revenue recognition</li> <li>• Accounting for leases</li> </ul>	

Effective in the Current Year	
<p>GASB Statement No. 65, <i>Items Previously Reported as Assets and Liabilities</i></p>	<p>The objective of this statement is to determine whether certain balances currently reported as assets and liabilities should continue to be reported as such or as:</p> <ul style="list-style-type: none"> <li>• Deferred outflow of resources, or</li> <li>• An outflow of resources (expense/expenditure),</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>• Deferred inflows or resources, or</li> <li>• An inflow of resources (revenue)</li> </ul> <p>This standard is expected to have little to no impact on GCHP.</p>

Effective in Future Years, Unless Optionally Adopted Early	
<p>GASB Statement No. 68, <i>Accounting and Financial Reporting for Pensions</i></p>	<p>This statement revises and establishes new financial reporting requirements for most governments that provide their employees with pension benefits. Among other requirements, Statement No. 68 requires governments providing defined benefit pensions to recognize their long-term obligations for pension benefits as a liability for the first time and calls for immediate recognition of more pension expense than is currently required.</p> <p>This standard is effective for fiscal year 2015.</p>

# The GCHP 2014 Client Service and Audit Plan

## Health Care Industry Trends

As we work with companies in the health care industry, these are some of the trends we see.

**The Affordable Care Act:** Implementation of the ACA has accelerated in 2014. As the ACA continues to roll out, the health care industry will be presented with additional opportunities and challenges.

**The increasing role of the consumer:** Consumers are becoming more price-sensitive, more discerning about the quality of care, more mobile, and exercising greater control over their health care spending. Increasingly, providers are responding to these changing dynamics.

**Affiliations and partnerships:** Providers are undertaking consolidations and building larger practices to take advantage of economies of scale. Providers are also focused on covering a wider swath of the care delivery system to manage consumer care. Integration of providers and insurers is also seeing a revival as a means to managing costs and for greater oversight of the care delivery system. Affiliations can be accomplished through forfeiture or acquisition of control of a targeted organization, or through strategic alliances that allow for affiliation without ownership. This variety of alignment of organizations is evidenced across the nation and across the spectrum of health care providers. It can allow both entities the opportunity to maintain control of their organization, while still benefiting from collaboration and affiliation.

**Venture capital:** Seeing opportunities in retail-model medicine and new technologies, capital from new sources is entering the market.

**Pricing transparency:** Employers are leading an effort to empower consumers to make better-informed choices. This will steer consumers to higher-value, lower-cost providers.

**Using technology to interact:** Many industries, such as banking, retail, insurance and real estate, have integrated technologies to interact with their customers. This trend has the potential to significantly impact how health care providers and consumers interact.

**Risk-based payment arrangements:** Outcomes-based medicine is causing a resurgence in risk-based payment arrangements. Such arrangements increase the risk to the provider, as they generally involve the provider accepting risk that previously was accepted by third-party payors.

**Big data:** The health care industry is producing an unprecedented level of data. Harnessing and analyzing data to use it for the betterment of the consumer and for a competitive advantage continues to be a challenge.

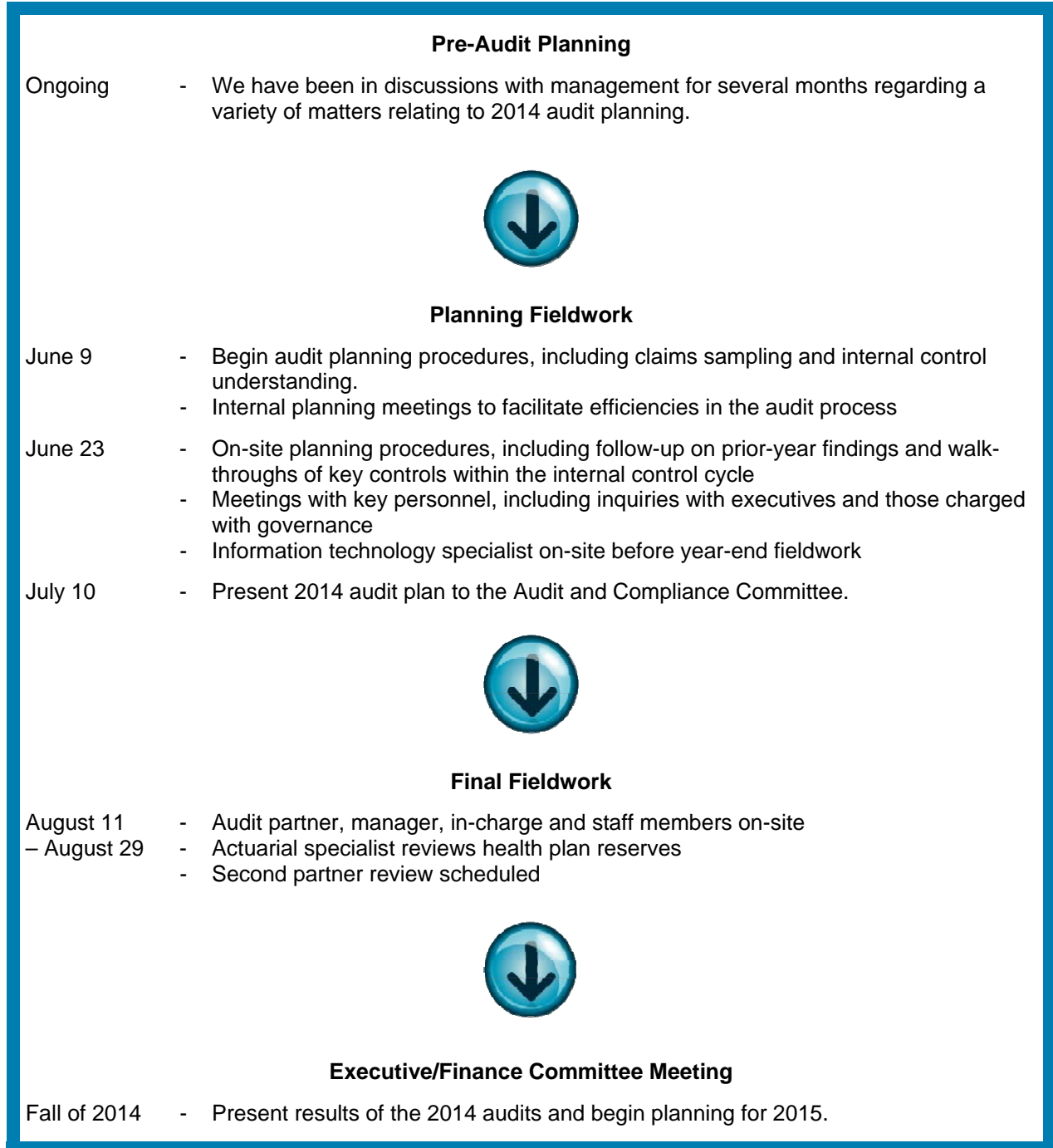
**Health care worker shortages:** It has been widely publicized that health care worker shortages are creating an increased demand for the immediate need for physicians and other workers.

**Cost containment:** Health care providers continue to focus on containing costs.

# The GCHP 2014 Client Service and Audit Plan

## Audit Calendar

The timing of our auditing procedures is coordinated with management and has been designed to match Gold Coast Health Plan's needs. Ongoing communication with our key management contacts is a key to our successful relationship and will continue throughout the process through formal and informal means.



# The GCHP 2014 Client Service and Audit Plan

## McGladrey's Peer Review Report



American Institute of CPAs  
220 Leigh Farm Road  
Durham, NC 27707-8110

December 19, 2013

Joseph Michael Adams, CPA  
McGladrey LLP  
1 S Wacker Dr Ste 800  
Chicago, IL 60606

Dear Mr. Adams:

It is my pleasure to notify you that on December 12, 2013 the National Peer Review Committee accepted the report on the most recent system peer review of your firm. The due date for your next review is October 31, 2016. This is the date by which all review documents should be completed and submitted to the administering entity.

As you know, the report had a peer review rating of pass. The Committee asked me to convey its congratulations to the firm.

Sincerely,

A handwritten signature in cursive script that reads "Betty Jo Charles".

Betty Jo Charles  
Chair, National Peer Review Committee  
nprc@aicpa.org 919 402-4502

cc: John Mark Edwardson; Andrew V. Lear

Firm Number: 10046712

Review Number 347652

Letter ID: 850189

T: 1.919.402.4502 | F: 1.919.402.4876 | nprc@aicpa.org

# The GCHP 2014 Client Service and Audit Plan



910 E. St. Louis Street, Suite 200 // P.O. Box 1190 // Springfield, MO 65801-1190  
417.865.8701 // fax 417.865.0682 // [bkd.com](http://bkd.com)

## System Review Report

To the Partners of  
McGladrey LLP  
and the National Peer Review Committee  
of the American Institute of Certified  
Public Accountants Peer Review Board

We have reviewed the system of quality control for the accounting and auditing practice of McGladrey LLP (the "firm") applicable to non-SEC issuers in effect for the year ended April 30, 2013. Our peer review was conducted in accordance with the Standards for Performing and Reporting on Peer Reviews established by the Peer Review Board of the American Institute of Certified Public Accountants. As a part of our peer review, we considered reviews by regulatory entities, if applicable, in determining the nature and extent of our procedures. The firm is responsible for designing a system of quality control and complying with it to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Our responsibility is to express an opinion on the design of the system of quality control and the firm's compliance therewith based on our review. The nature, objectives, scope, limitations of and the procedures performed in a System Review are described in the standards at [www.aicpa.org/prsummary](http://www.aicpa.org/prsummary).

As required by the standards, engagements selected for review included engagements performed under *Government Auditing Standards*, audits of employee benefit plans, audits performed under FDICIA, and audits of carrying broker-dealers, and examinations of service organizations [Service Organizations Control (SOC) 1 and 2 engagements].

In our opinion, the system of quality control for the accounting and auditing practice of McGladrey LLP applicable to non-SEC issuers in effect for the year ended April 30, 2013, has been suitably designed and complied with to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Firms can receive a rating of *pass*, *pass with deficiency(ies)* or *fail*. McGladrey LLP has received a peer review rating of *pass*.

*BKD, LLP*

December 4, 2013



## **AGENDA ITEM 2c**

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: July 28, 2014

Re: Quarterly Update to Auditor's Recommendations

### **SUMMARY**

As part of the FY 2012-13 audit performed by McGladrey LLP (McGladrey), recommendations were made as part of their report to the Executive / Finance Committee, as indicated in the following letters:

- Letter communicating deficiencies in internal controls in financial reporting
  1. Material Weaknesses (none)
  2. Significant Deficiencies
- Letter communicating comments, observations and suggestions

This quarterly status report was provided to the Executive / Finance Committee on April 3, 2014 and July 7, 2014. The status report provides an update on the Plan's progress and reflects additional progress made since the April report.

To summarize, the Plan has implemented many of the suggestions made by the auditors and is continuing to improve monitoring related activities, especially as staff has been hired.

### **RECOMMENDATION**

The Plan requests the Commission's approval of the Quarterly Update to the auditor's recommendations as part of the FY 2012-13 financial audit.

### **CONCURRENCE**

Executive / Finance Committee – July 7, 2014

### **Attachments**

Quarterly Update to Auditor's Recommendations – July 2014

# Quarterly Update to Auditor's Recommendation – July 2014

## AUDITOR'S LETTER REGARDING CONTROLS

<p><b>McGladrey Recognized Significant Deficiencies</b></p>	<p><b>Summary of McGladrey's Recommendations</b></p>	<p><b>GCHP Update April 2014</b></p>	<p><b>GCHP Update July 2014</b></p>
<p>Claims Processing</p>	<p>1. Management should continue to perform audits on the procedures performed by third-party vendors who process claims information</p>	<p>GCHP audits the third-party vendors as follows:</p> <p>A. GCHP audits vendor ACS (A division of Xerox) by performing:</p> <ul style="list-style-type: none"> <li>• A post-payment audit of all claims that were included in the 2% random sample audit that ACS performs on processed claims.</li> <li>• A pre-payment audit of all claims with a payable amount greater than \$25,000. In December 2013, GCHP updated the criteria to include all claims with a payable amount greater than \$10,000.</li> <li>• Focused audits, as needed, are done based on trends resulting from routine audit results and adjustments</li> </ul> <p>B. GCHP audits the PMB vendor (Script Care, LTD) by performing:</p> <ul style="list-style-type: none"> <li>• Daily audits of all denied and 10% of approved prior authorizations from the prior day.</li> <li>• Monthly and Quarterly random audits of pharmacy claims to ensure proper formulary processing</li> </ul> <p>NOTE – Pharmacy claims processed by Script Care will be audited for contract performance by an independent vendor by June 30, 2014.</p>	<p>COMPLETED - Audits continue as described in April. Additionally, the Director of Operations reviews all claims with a payable amount greater than \$50,000 for approval prior to payment.</p> <p>Pharmacy claim audit draft completion date was provided in early July and expected to be finalized in September, 2014.</p>



**AUDITOR'S LETTER REGARDING CONTROLS**

<b>McGladrey Recognized Significant Deficiencies</b>	<b>Summary of McGladrey's Recommendations</b>	<b>GCHP Update April 2014</b>	<b>GCHP Update July 2014</b>
Claims Processing (continued)	<p>2. Consider performing an audit, similar to a Service Organization Controls (SOC1) report</p>	<p>GCHP acknowledges the need for a SOC1 report from ACS and has defined the process and timing. The SOC1 report is expected to be complete in the first half of FY 2014-15</p>	<p>The SOC1 project is on schedule.</p>
3. Review ongoing processing policies and controls by	<ul style="list-style-type: none"> <li>• Implementing formal review process of provider contracts / fee schedules</li> <li>• Continue to review process to ensure claim payment accuracy</li> </ul>	<p>GCHP's Director of Operations is working with ACS to:</p> <ul style="list-style-type: none"> <li>• Formulate a process to validate the accuracy of provider contract and fee schedules in GCHP's core system after they have been uploaded.</li> <li>• Review all activities related to the claims processing function (claims production, adjustments quality assurance, configuration, refunds, etc.) This is one of the topics covered during a standard meeting between ACS and GCHP staff.</li> </ul>	<p>COMPLETED - Processes continued to be reviewed / improved as described in April. Additionally, an Operations Support Manager is starting on July 7, 2014, and he will have oversight of fee schedule accuracy.</p>
4. Review ongoing processing policies and controls by:	<ul style="list-style-type: none"> <li>• Continuing to monitor IT change management policies</li> </ul>	<p>The following processing policies and controls have been updated:</p> <ul style="list-style-type: none"> <li>• GCHP has implemented an internal change management policy for Plan-supported production systems. Production changes are tracked in the Connectwise helpdesk configuration changes. As GCHP introduces new systems into the production environment, they will fall under the GCHP change management policy.</li> </ul>	<p>COMPLETED - Processing policies and controls continue to be reviewed / refined as described in April.</p>

**AUDITOR'S LETTER REGARDING CONTROLS**

<b>McGladrey Recognized Significant Deficiencies</b>	<b>Summary of McGladrey's Recommendations</b>	<b>GCHP Update April 2014</b>	<b>GCHP Update July 2014</b>
<p>Claims Processing (continued)</p>	<ul style="list-style-type: none"> <li>Continue to monitor ACS's policies and procedures regarding claims processing and IT controls</li> </ul>	<ul style="list-style-type: none"> <li>Several controls were implemented in FY 2012-13 including review of ACS's process and increased auto-adjudication rate (i.e. auto adjudication increased from 33.78% to 60.44% between June 30, 2012 and June 30, 2013)</li> </ul> <p>Additionally, ACS follows a formal change management process to assure modification are reviewed by designated employees before entered into production. Production changes are tracked in a ticketing system called "Service Center". The Plan has obtained and reviewed ACS's policies for change management</p>	
<p>5.</p>	<p>Monitor the incurred but not paid (IBNP) levels monthly and incorporate estimates of reinsurance recoveries.</p>	<p>GCHP calculated IBNP estimates monthly. The Plan is evaluating the recommendation to include estimates of reinsurance recoveries within the IBNP estimate. It should be noted that the current methodology conservatively states IBNP. Also, the Plan's financial statement will reflect reinsurance recoveries of high dollar claims once payments are received from reinsurance vendor. In addition, GCHP had their actuaries (Milliman) separately calculate the IBNP estimate at November 30, 2013 and GCHP's estimate was in the range of Milliman's estimate.</p>	<p>COMPLETED - GCHP has included estimates of reinsurance recoveries into the IBNP estimates for large claims over \$500,000 (starting October, 2013). GCHP staff is currently analyzing Milliman's IBNP estimate as of April 30, 2014.</p>

**AUDITOR'S LETTER REGARDING CONTROLS**

<b>McGladrey Recognized Significant Deficiencies</b>	<b>Summary of McGladrey's Recommendations</b>	<b>GCHP Update April 2014</b>	<b>GCHP Update July 2014</b>
Claims Reserve	6. Evaluate need for premium deficiency reserves (PDR)	As GCHP updates financial projections, the Plan will continue to perform on-going evaluations regarding the need for a premium deficiency reserve (PDR). This will formally be evaluated prior to end of the fiscal year, as part of the next year's budget process	COMPLETED - The fiscal year 2014-15 budget has been approved by the Commission and based on those projections and assumptions, a PDR is not necessary for FY 2014-15. This need for a PDR will continue to be evaluated as more information is obtained from the State / other sources.
Segregation of Duties Accounting	7. Hire staff to achieve proper segregation of duties and perform monthly reconciliations	GCHP has hired a Controller and two highly qualified accountants which are allowing the Plan to implement appropriate segregation of duties and reconcile accounts monthly. The Plan is also in the process of adding a third accountant position. A Director of Finance Analysis position has been created and filled, and two additional positions providing analysis of health care expense are in the process of being filled.	In addition to staff mentioned in the April update, GCHP has hired a financial consultant who is developing a responsibilities matrix to ensure proper segregation of duties.
8.	Review Procedures to ensure proper peer review and documentation	As staff has been hired, additional documentation on procedures and peer review has improved. New procedures have been adopted and will continue to augment to support appropriate documentation of peer review.	The new financial consultant will also recommend areas in need of further documentation and / or peer review.

**AUDITOR'S LETTER REGARDING CONTROLS**

<b>McGladrey Recognized Significant Deficiencies</b>	<b>Summary of McGladrey's Recommendations</b>	<b>GCHP Update April 2014</b>	<b>GCHP Update July 2014</b>
Segregation of Duties Payroll	9. Review super-users and limit as appropriate	After a thorough review of the payroll super-users, it was determined that all super-users are appropriate.	COMPLETED - No additional update from April.
	10. Monitor supervisory approvals of payroll change	In June 2013, a process was implemented by human resource staff to review all changes made at every payroll cycle.	COMPLETED - In June 2014, the review process has been revised to coordinate reviews between human resources and finance departments.
	11. Implement a process to review changes made by super-users	Currently, GCHP finance and human resource staff are updating processes to ensure peer review of all payroll changes, including those done by super-users.	COMPLETED - No additional update from April.
Segregation of Duties - IT	12. Implement and monitor a formal review procedure of user accounts with network access and Multiview access	As of May 1, 2013, GCHP has implemented a policy for User Access Requests to track approvals and authorization for permitting new hires and removing terminations from logical and physical access to information resources, and recommended the procedures be consistently followed to ensure access is granted / termed in a timely manner. User access requests are captured and tracked in the Connectwise ticketing system.	COMPLETED - No additional update from April.

**AUDITOR'S LETTER REGARDING CONTROLS**

<b>McGladrey Recognized Significant Deficiencies</b>	<b>Summary of McGladrey's Recommendations</b>	<b>GCHP Update April 2014</b>	<b>GCHP Update July 2014</b>
Segregation of Duties IT (continued)	13. Continue to eliminate conflicting duties through IT controls and segregation of duties	<p>The Plan has performed the following regarding reducing conflicting duties:</p> <ul style="list-style-type: none"> <li>• A network user account clean-up was done in January 2013 and again in July 2013 as part of the GCHP active directory reconfiguration. As part of standard operating procedures, when a GCHP network Windows account is disabled, access to Multiview and Go-to-my-PC is subsequently restricted as the user no longer has access to the GCHP network. Go-To-My-PC access will be replaced with a secure VPN remote access solution and was implemented which included an annual review of remote user accounts</li> <li>• When an employee resigns/is terminated, the employees' manager or human resources will complete and submit a user access form with all term details. This creates a ticket to the GCHP IT Helpdesk ticket system – Connectwise. The ticket is closed once user account access is termed. In standard situation, human resources or management should submit term notices at least 5 days prior to employee leaving the Plan</li> </ul>	COMPLETED - No additional update from April.

**AUDITOR'S LETTER REGARDING CONTROLS**

<b>McGladrey Recognized Significant Deficiencies</b>	<b>Summary of McGladrey's Recommendations</b>	<b>GCHP Update April 2014</b>	<b>GCHP Update July 2014</b>
Accounts Receivable reconciliations and Allowances	14. Enhance reporting of provider accounts receivable	A review of provider receivable reports supplied by ACS Recoveries was completed. Standard, ongoing reports are utilized as part of the calculations of the provider receivable.	COMPLETED - ACS reports are delivered earlier and with improved regularity as compared with prior quarters.
15. Review accounts monthly and assess collectability	Accounts are reviewed monthly and a formulaic allowance is applied to aged balances. On an ongoing basis, GCHP is reviewing the methodology to determine what additional enhancements are appropriate.	COMPLETED - Account balances have been significantly reduced through collection efforts, thereby reducing risk (e.g. April 2014 balance of \$238,327 v. June 2013 balance of \$1,161,379)	

**AGENDA ITEM 2d**

To: Gold Coast Health Plan Commission

From: Michael Engelhard, Chief Executive Officer

Date: July 28, 2014

Re: Approve / Ratify New and / or Amended Personnel Rules, Regulations and Policies

**SUMMARY:**

The proposed New and Amendments to the adopted Personnel Rules, Regulations and Policies were presented at the May 19, 2014 Commission Meeting. The Commission approved these policies with certain revisions. The amended, adopted policies are incorporated into the Personnel Rules, Regulations and Policies Resolution.

**RECOMMENDATION**

Approve the attached Resolution which 1) ratified and amended the Workforce Attire / Dress Code effective May 2, 2012; 2) ratified the Vacation Buy-Back Policy effective April 23, 2013 and amendments to the Vacation Buy-Back Policy effective July 1, 2014; 3) amended the existing Bereavement Leave Policy effective May 19, 2014, and 4) approved the new Spot Award Policy and draft matrix for rating and scoring purposes.

**Attachment**

Proposed Amended Resolution

**RESOLUTION 2014-\_\_\_**

**A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL  
MANAGED CARE COMMISSION AMENDING  
RESOLUTION NO. 2012-001 AND THE PERSONNEL  
RULES, REGULATIONS, AND POLICIES PERTAINING  
TO: THE DRESS CODE (EFFECTIVE 05/01/2013);  
VACATION BUY-BACK POLICY (EFFECTIVE 04/23/2013)  
APPROVAL OF REVISIONS TO THE BEREAVEMENT  
LEAVE; ADOPTION OF THE SPOT AWARD POLITY AND  
ESTABLISHING A BUDGET FOR THE SPOT AWARD**

**WHEREAS**, the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan hereinafter referred to as GCHP, Plan or Employer is authorized to adopt rules and regulations for the administration of the personnel system; and

**WHEREAS**, the objectives of these Personnel Rules, Regulations and Policies hereinafter referred to as PRRPs, are to facilitate efficient and economical services to the public and to provide for an equitable system of personnel management; and

**WHEREAS**, these PRRPs set forth those procedures that ensure similar treatment for persons who apply for, are selected for, or who are employed by GCHP, and define many of the obligations, rights, privileges, and prohibitions that are placed upon all employees in the service of the Plan; and

**WHEREAS**, at the same time, within the limits of administrative feasibility, considerable latitude shall be given to Chief Executive Officer and designee in the interpretation of these rules;

**WHEREAS** the Commission adopted the Personnel Rules, Regulations, and Policies by approving Resolution No. 2012-001. These PRRPs became effective September 1, 2012.

**WHEREAS** GCHP has implemented or is proposing to implement the following policies in revision to the existing PRRPs:

**NOW, THEREFORE, BE IT RESOLVED** that the Commission desires to update the Personnel Rules, Regulations, and Policies.

**NOW, THEREFORE, BE IT RESOLVED** that the Commission of the Plan desires to update the Personnel Rules, Regulations, and Policies thereby amends Resolution No. R 2012-001 to include:

**Section 1: Dress Code Policy:** To enhance the expectations for appropriate work place attire are understood, GCHP adopted an administrative dress code policy in May 2013 which enhanced Section 8.8 of the PRRPs. The Dress Code Policy attached hereto as Exhibit "A" is hereby adopted as part of the PRRPs retroactive to May 1, 2013.



**Section 2: Vacation Buy-Back Policy:** GCHP had outlined in the PRRPs a policy of providing for a vacation cash-out policy when maximum vacation accrual limits as set forth in Section 9.4.2 of the PRRPs are reached in employment contracts. This practice is usual and limits the organization's accumulation of potentially significant financial obligations.

Section 9.4.2 of the PRRPs requires cash-out of excess accrued vacation. Therefore, GCHP adopted a vacation buy-back policy in April 2013. In adopting such a policy, GCHP recognizes that vacation is legally equivalent to "earned compensation" or more plainly, to "wages". Accrued vacation is legally protected for the employee. GCHP also recognizes that from time-to-time, employees may face certain circumstances whereby accessing accrued vacation compensation may alleviate a financial hardship or burden or other factor. Allowing employees to access accrued vacation, within the limits set forth in the attached policy, provides some flexibility for such employees. Since accrued vacation is a legal liability for the organization and is considered to be a form of "wages" to the employee, there is no net financial impact to the organization by paying out vacation accruals. This practice is also commonplace in both public agencies and commercial enterprises.

The Vacation Buy-Back Policy is hereby adopted as part of the PRRPs retroactive to April 24, 2013 and further revisions to the Vacation Buy Back Policy are adopted effective July 1, 2014 which are attached hereto as Exhibit "B-1" and "B-2" respectively.

**Section 3: Bereavement Policy:** GCHP staff requests to amend the policy to include "in-laws" as a qualifying family member for bereavement leave. Section 9.5 Bereavement Policy of the PRRPs is revised effective May 19, 2014, attached hereto as Exhibit "C".

**Section 4: Spot Award Policy:** A Spot Aware Policy is adopted and established and recommend setting an annual spot award budget of \$10,000 to begin with FY 2013-14 which is attached hereto as Exhibit "D".

**PASSED, APPROVED AND ADOPTED** by the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan at a regular meeting on the \_\_\_ day of \_\_\_\_\_, 2014 by the following vote:

**AYE:**  
**NAY:**  
**ABSTAIN:**  
**ABSENT:**

\_\_\_\_\_  
David Araujo, Chair

Attest:

\_\_\_\_\_  
Traci R. McGinley, Clerk of the Board



**Title: Dress Code**

**Original Date:** 09/01/12

**Policy #:** 8.8 of PRRP (R-4)

**Last Revision Date:** 05/23/13

**Lead Department:** Human Resources

**Effective Date:** 05/23/13

**Approved by:** CEO

**PURPOSE:**

To provide all staff members with appropriate guidelines for employee personal appearance including standards of dress, grooming, hygiene and personal cleanliness while at work, or on duty.

**POLICY:**

Every employee represents Gold Coast Health Plan in the eyes of our Board, our members and the community-at-large. It is the policy of GCHP that employees are required to present a clean, neat, professional business appearance at all times when employees are in the workplace or representing GCHP outside of the workplace.

Our dress code is based on several factors. GCHP is a professional organization that is responsible for health care access for thousands of people. Our dress code reflects our culture of professionalism, and our respect for our mission and our fiscal responsibilities. Our actions speak loudest, but our appearance communicates as well to community leaders, providers, members and other visitors to our work place.

Our standard continues to be "Business Casual". Many examples of acceptable clothing and footwear are provided in this policy, since they are often requested by staff and help to clarify our standard.

**DEFINITIONS:**

All employees are required to adhere to these standards as part of the requirements of their employment with GCHP. Employees will be aware of, and conscientious about, the neatness and cleanliness of their apparel, and their personal hygiene while on the job.

1. **Acceptable Appearance / Attire**

Our overall standard is business professional, yet casual. Examples of acceptable attire include:

For women: Suits, blazers, dress coats, blouses, business casual shirts (such as short or long sleeved polo shirts appropriate for a business environment), dresses, skirts, pantsuits, dress slacks, business casual pants, sweaters, and capri pants. The length of capris that is acceptable is mid-calf or just below the calf. Any shorter length is considered shorts and therefore may not be worn at any time,



<b>Title: Dress Code</b>	
<b>Original Date:</b> 09/01/12	<b>Policy #:</b> 8.8 of PRRP (R-4)
<b>Last Revision Date:</b> 05/23/13	<b>Lead Department:</b> Human Resources
<b>Effective Date:</b> 05/23/13	<b>Approved by:</b> CEO

including casual Fridays. A denim skirt or blazer is acceptable if non-faded and the style is suitably professional for our business environment.

For men: Suits, sports coats, dress shirts, ties, sweaters, business casual shirts (such as short or long sleeved polo shirts appropriate for a business environment), dress slacks and business casual pants (such as Dockers).

The duties of some positions may occasionally require more professional dress than others depending upon the requirements of the job. Employees who attend both internal and external meetings, visit other professional offices, hospitals, clinics, etc., and interact with business and community representatives, must dress to present an appropriate professional business image of GCHP.

The duties of some positions may allow for the wearing of more comfortable, casual apparel due to the nature of the job requirements. When the job requires physical activity (lifting, carrying, stretching, bending, etc.) employees may wear more casual apparel such as work pants and tennis shoes to permit greater freedom of movement and safety. GCHP reserves the right to determine which job assignments meet these criteria. Ask for clarification from the manager or Human Resources department.

2. Unacceptable Appearance / Attire

Examples of unacceptable and inappropriate attire that is not in compliance with our standards include provocative attire (low cut clothing, mini skirts, etc.), oversized clothing, extremely tight clothing including spandex, leggings or other form-fitting attire, tank tops, midriff tops, crop tops, halter-neck tops and dresses, spaghetti-strap tops and dresses, sun or beach dresses, nylon jogging suits, sweats / exercise pants, sportswear and shorts of any length and / or skorts, pajamas and jeans (except casual days).

Clothing with potentially offensive words, terms, logos, pictures, cartoons, or slogans is inappropriate for our business environment and is not to be worn at any time. Clothing that exposes undergarments is also inappropriate for our business environment and is not to be worn at any time.

3. Acceptable Shoes and Footwear

Conservative, non-athletic leather walking shoes, loafers, dress boots, flats, heels, business or dress shoes, business professional sandals, and leather deck-type



<b>Title: Dress Code</b>	
<b>Original Date:</b> 09/01/12	<b>Policy #:</b> 8.8 of PRRP (R-4)
<b>Last Revision Date:</b> 05/23/13	<b>Lead Department:</b> Human Resources
<b>Effective Date:</b> 05/23/13	<b>Approved by:</b> CEO

shoes are acceptable for our business environment. Shoes are to be worn at all times while in the office. Tennis shoes may be worn on “Casual Days” only.

4. Unacceptable Shoes and Footwear

Flip flops ( thongs), slippers and non-dress boots (e.g. Uggs)

5. “Casual Day”

GCHP observes Friday as Casual Day. Employees are permitted to wear more casual and informal clothing on Fridays. Employees are still required to present a clean and neat appearance at all times as every employee continues to represent GCHP in the eyes of members and the community at large. Examples of allowable choices on dress down day include denim jeans, tee shirts and tennis shoes. As a rule of thumb, casual clothing that is acceptable attire is not appropriate for our regular Monday through Thursday standard.

Provocative attire (low cut clothing, mini skirts, etc.), oversized clothing, extremely tight clothing including spandex or other form-fitting attire, tank tops, midriff tops, crop tops, halter-neck tops and dresses, spaghetti-strap tops and dresses, sun or beach dresses, nylon jogging suits, sweats / exercise pants, sportswear and shorts of any length and / or skorts may not be worn.

Directors and managers are required to use their own discretion on Casual Day depending on their schedule for business that day. Employees who have important meetings with non-employees either on or off site on Casual Day need to consider observing the more professional standards of the regular Dress Code Policy guidelines. If there are questions, ask for clarification from the manager.

These examples are not meant to be all-inclusive, and may need to be amended from time to time as styles change.

6. Grooming and Cleanliness

All employees are expected to present themselves well groomed, with attention paid to good personal hygiene. In consideration of others, care should be taken to avoid strong, offensive odors, such as tobacco, perfumes or cologne as some employees are sensitive to the chemicals in personal care products, such as perfumes, colognes, hairspray or other hair care products and scented lotions.



<b>Title: Dress Code</b>	
<b>Original Date:</b> 09/01/12	<b>Policy #:</b> 8.8 of PRRP (R-4)
<b>Last Revision Date:</b> 05/23/13	<b>Lead Department:</b> Human Resources
<b>Effective Date:</b> 05/23/13	<b>Approved by:</b> CEO

7. Compliance

Compliance with this policy is the responsibility of every individual. Employee cooperation will make enforcement unnecessary. However, employees who fail to follow the Dress Code guidelines will be sent home and requested to return to work in compliance with the guidelines. Employees will not be compensated for time away from work.

GCHP reserves the right to determine the appropriateness of compliance with the Dress Code Policy. Continued failure to comply with this policy may result in disciplinary action, up to and including separation of employment. This policy may be revised, updated, or rescinded at any time by GCHP.

**Attachments:**

Acknowledgement of Dress Code Policy Form.

**References:**

N/A

**Revision History:**

Review Date	Revised Date	Approved By



**Gold Coast  
Health Plan<sup>SM</sup>**  
A Public Entity

**ACKNOWLEDGMENT OF DRESS CODE POLICY**

Employee Name: (Print) \_\_\_\_\_

Date: \_\_\_\_\_

I have read and understand the Dress Code Policy. I understand that if I fail to follow the Dress Code guidelines will be sent home and requested to return to work in compliance with the guidelines. I understand that I will not be compensated for time away from work.

I understand that GCHP reserves the right to determine the appropriateness of compliance with the Dress Code Policy. Continued failure to comply with this policy may result in disciplinary action, up to and including separation of employment. This policy may be revised, updated, or rescinded at any time by GCHP.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



## POLICIES AND PROCEDURES

**Title: Vacation Buy Back**

**Original Date:** 09/01/12

**Policy #:** 9.4.2 of PRRP (B-5)

**Last Revision Date:** 04/24/13

**Lead Department:** Human Resources

**Effective Date:** 04/24/13

**Approved by:** CEO

### **PURPOSE:**

To clarify Gold Coast Health Plan (GCHP) practices and policies regarding vacation time buy back. The vacation buy back is offered as an optional benefit, subject to budgetary constraints, for employees who elect to convert accrued vacation into a cash value on an annual basis.

### **POLICY:**

It is the policy of GCHP to provide employees with vacation time as a vehicle for rest and renewal. GCHP strongly encourages all eligible employees to utilize their vacation time.

However, employees may desire to access the cash payout of some of their accrued vacation. The buyback policy will be available to all employees who have accrued more than forty (40 hours of vacation).

### **DEFINITIONS:**

Eligible Employees: GCHP provides regular full- and part-time employees with vacation time.

### **PROCEDURES:**

- Employees may buy-back up to a maximum of 50% of their accrued vacation time as long as the employee maintains a minimum of forty (40) hours of vacation in their vacation account after the buy back. Payment will be made based on the employee's hourly rate.
- The request must be submitted in writing to Human Resources for approval.

### **Attachments:**

Request for Vacation Buy Back Form.

### **References:**

N/A

### **Revision History:**

Review Date	Revised Date	Approved By



**DEPARTMENT OF HUMAN RESOURCES**  
Request for Vacation Buy Back

**EMPLOYEE NAME:** \_\_\_\_\_

REQUEST DATE: \_\_\_\_\_ DEPARTMENT: N/A \_\_\_\_\_

HOURS REQUESTED: \_\_\_\_\_ PAYROLL EFFECTIVE DATE: \_\_\_\_\_

**I understand that this request is subject to HR approval and the companies Vacation Buy Back policy.**

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HUMAN RESOURCES:**

TOTAL HOURS AVAILABLE: \_\_\_\_\_ HOURS APPROVED: \_\_\_\_\_

HOURS REMAINING: \_\_\_\_\_

**Payroll Approval:** \_\_\_\_\_ **Date:** \_\_\_\_\_





## POLICIES AND PROCEDURES

**Title: Vacation Buy Back**

**Original Date:** 09/01/12

**Policy #:** 9.4.2 of PRRP (B-5)

**Last Revision Date:** 04/24/13

**Lead Department:** Human Resources

**Effective Date:** 07/01/14

**Approved by:** CEO

**PURPOSE:**

To clarify Gold Coast Health Plan (GCHP) practices and policies regarding vacation time buy back. The vacation buy back is offered as an optional benefit, subject to budgetary constraints for employees who elect to convert accrued vacation into a cash value on an annual basis.

**POLICY:**

It is the policy of GCHP to provide employees with vacation time as a vehicle for rest and renewal. GCHP strongly encourages all eligible employees to utilize their vacation time; however the buyback policy will be available to all employees who have accrued vacation in which they would like to cash out.

**DEFINITIONS:**

- Eligible Employees: GCHP provides regular full- and part-time employees with vacation time.

**PROCEDURES:**

- Employees may buy-back a maximum of 50% of their accrued vacation time.
- The request must be submitted in writing to Human Resources for approval.
- The employee must maintain a minimum of forty (40) hours of vacation remaining after the “buy back” of some of their vacation.
- In order to qualify, employees must have taken a minimum of forty (40) hours of vacation within the previous twelve (12) months of employment with GCHP.

**Attachments:**

Request for Vacation Buy Back Form.

**References:**

N/A

**Revision History:**

Review Date	Revised Date	Approved By



**DEPARTMENT OF HUMAN RESOURCES**  
Request for Vacation Buy Back

**EMPLOYEE NAME:** \_\_\_\_\_

REQUEST DATE: \_\_\_\_\_ DEPARTMENT: N/A \_\_\_\_\_

HOURS REQUESTED: \_\_\_\_\_ PAYROLL EFFECTIVE DATE: \_\_\_\_\_

**I understand that this request is subject to HR approval and the companies Vacation Buy Back policy.**

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HUMAN RESOURCES:**

TOTAL HOURS AVAILABLE: \_\_\_\_\_ HOURS APPROVED: \_\_\_\_\_

HOURS REMAINING: \_\_\_\_\_

**Payroll Approval:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Title: Bereavement Leave	Policy Number:
Department: Human Resources	Effective Date: 07/01/2014
CEO Approved:	Revised:

**Purpose:**

GCHP provides Bereavement Leave/Pay as set forth in section 9.5 of the Personnel Rules Regulations and Policies initially adopted August 27, 2012 and effective September 1, 2012 to eligible employees due to a death in their immediate family. This policy is amended as follows effective July 1, 2014.

**Policy:**

Bereavement leave is provided for Regular Full Time employees unless otherwise stipulated in an individual employment agreement Employees may take bereavement leave paid for of up to three (3) days in the event of death of any of an immediate family member. Immediate family members are defined as: as spouse, domestic partner as defined by the State of California, father, mother, grandfather, grandmother, sister, brother, son, and daughter whether related by blood, adoption or marriage.

**Definitions:**

Immediate family member for purposes of this policy is limited to the following relationships by blood, marriage, adoption or domestic partnership (Defined by the State of CA)

- Current Spouse
- Current Domestic Partner
- Parent of employee, parent of current spouse or parent of current domestic partner
- Sibling of employee, sibling of current spouse or sibling of current domestic partner
- Step-Parent or Legal Guardian
- Child of employee, child of current spouse or child of current domestic partner
- Grandparent of employee, grandparent of current spouse or grandparent of current domestic partner
- Grandchild of employee, grandchild of current spouse or grandchild of current domestic partner

**Procedure:**

- Bereavement leave must be requested at the time of the family member’s death or to attend the funeral. The employee must obtain approval from his/her supervisor if additional time off is requested. Additional time off will be paid through available Vacation accruals.
- Employees must record their bereavement hours thorough the online timecard system
- Employees must submit a time off request form to supervisor/Human Resources requesting the time
- Proof of eligibility for bereavement leave may be required



Title:	Policy Number:
Department:	Effective Date:
CEO Approved:	Revised:

- GCHP reserves the right to modify, rescind, delete or add to this policy at any time without notice

**Attachments:**

N/A

**References:**

N/A

**Revision History:**

Review Date	Revised Date	Approved By



## POLICIES AND PROCEDURES

**Title: SPOT Award Policy**

**Original Date:** 05/19/14

**Policy #:**

**Last Revision Date:** N/A

**Lead Department:** Human Resources

**Effective Date:** 05/19/14

**Approved by:** CEO

**Purpose:**

The SPOT Award is a mechanism to reward Gold Coast Health Plan (GHCP) employees for their exceptional and noteworthy contributions. SPOT Awards can also be used to acknowledge performance that is above and beyond the scope of an employee's normal duties including, but not limited to, positive customer feedback, project completion, etc.

The award will be presented to an a GCHP employee that has provided a unique service for members, created or suggested an innovation related to quality, cost or access to care or has performed an exemplary service that served as a role model or inspired other employees.

Employee SPOT awards help increase employee engagement and motivation. SPOT awards allow GCHP to recognize employee accomplishments when they happen "on the SPOT" while making the accomplishment and award more relevant and "immediate" for the employee. SPOT awards reinforce excellent performance while letting employees know that efforts are noticed and appreciated.

**Policy:**

Reward for special performance. All full-time and part-time employees are eligible, excluding Directors and C-Level Staff. Awards range from \$50-\$1,000.

**Definitions / Criteria:**

The action or accomplishment that is being recognized should be significantly beyond the scope of the employee's regular day-to-day activities and assignments. For example, the award could be for an employee who uses initiative and creativity to resolve a situation or conflict. It could also be for a one-time exceptional achievement that might not be otherwise noticed such as volunteering for extra assignments during critical times while maintaining the regular work assignment.

Criteria Guidelines:

- Performing exemplary service that serves as a role model or inspires employees
- Putting in extra hours or effort to address an issue that prevents negative business impact
- Identifying and implementing a change that results in improved quality or service to our members or providers, increases process efficiencies, and/or delivers cost savings



**Title: SPOT Award Policy**

**Original Date:** 05/19/14

**Policy #:**

**Last Revision Date:** 05/19/14

**Lead Department:** Human Resources

**Effective Date:** 05/19/14

**Approved by:** CEO

**SPOT Awards - Examples:**

To assist in developing an appropriate justification for an award, the following provides examples of awards that *describe* the accomplishment, the *way* the accomplishment was achieved and the *improvement or result* that was accomplished:

- Sue volunteered to develop a solution to late tickets. The late tickets were creating extra workload for the organization. Sue eliminated the problem, which improved our service to the customer and allowed staff to focus on more critical work assignments. This task was outside of Sue’s normal job duties that resulted in a cost savings to the organization.
- Tomas created a spreadsheet of XYZ and was able to track our usage of X. He recommended ways to be more efficient. This task was outside the scope of Tom’s regular duties, and resulted in a cost savings to the organization.

**Eligibility:**

All full and part time employees, with the exception of Directors and C-Level Staff, are eligible to receive SPOT awards. Independent contractors and temporary employees, whether contracted directly by the organization or through an agency, are not eligible to receive an award.

**Employees are only eligible for up to a maximum of \$1,500 per year**

Employees must have successfully completed ninety (90) days of employment and received a “meets expectations” or better overall rating on their most recent annual performance evaluation. Employees who have not yet received an annual performance evaluation may be eligible for an award if their manager confirms on the nomination form that they are "meeting expectations."

**Procedure:**

Awards may be presented at any time during the fiscal year and should be awarded as soon as possible after the accomplishment or event in order to provide immediate recognition to employees.

Supervisors, Managers, Directors and Chiefs, as well as peers, may nominate staff for SPOT Awards. Nominations should be submitted via the GCHP SPOT Awards Nomination form.

Nominations will be accepted throughout the fiscal year. Nominations should generally be submitted within thirty (30) days of the accomplishment (Exceptions may apply)



**Title: SPOT Award Policy**

**Original Date:** 05/19/14

**Policy #:**

**Last Revision Date:** 05/19/14

**Lead Department:** Human Resources

**Effective Date:** 05/19/14

**Approved by:** CEO

- The signatures of the supervisor and next level manager on the GCHP SPOT Nomination Form represent an endorsement of the nomination.
- Completed nomination forms should be submitted to Human Resources to review for eligibility. If the submission is approved, the nomination form is submitted to the Executive Team for review and approval.
- The final approval is made by the Executive Team for SPOT awards.
- Following the decision, the Human Resources Department notifies the nominator that the award nomination:
  - is approved
  - is denied
- If the award is approved, Human Resources will initiate a manual check request through the payroll system for the approved monetary award. The check will be grossed-up by awardee's tax rate to net the award amount. Upon receipt of the check, Human Resources will provide the award letter, certificate and check to the recipient's supervisor/manager for presentation to the employee.
- The award will be presented by the Manager/CEO and Original Nominator.

All awards are considered taxable income and will be reflected on the employee's income earning statements.

**Attachments:**

SPOT Award Nomination Form and Rating Matrix.

**References:**

N/A

**Revision History:**

Review Date	Revised Date	Approved By



**Gold Coast  
Health Plan**<sup>SM</sup>  
A Public Entity

### GCHP "SPOT" Award Matrix

Action or Accomplishment	Ranges	
Performing Exemplary Service (inspire or role model employees)		
Additional Hours Served to address an issue that prevents negative business impact		
Substantial Cost savings to GCHP		
"Big Picture" thinking		
Recycling Program Which provides Costs savings		
System / business flow process improvement		
Identifying and implementing a change that results in improved quality or service to our members or providers, increases process efficiencies, and / or delivers cost savings		
Collaboration / Team work which results in a positive financial impact		
Customer Service		

**\*\* Please Note:** The spot award evaluation matrix is presented as a draft. The Spot Award Committee will decide the final weighting to applied to individual factors.





**AGENDA ITEM 2e**

To: Gold Coast Health Plan Commission

From: Michael Engelhard, Chief Executive Officer

Date: July 28, 2014

Re: Review of Conflict of Interest Code

**SUMMARY:**

The California Government Code requires biennial review of the Conflict of Interest Code. This item is to request the Commission direct legal counsel and Clerk of the Board to review the Conflict of Interest Code and return to the Commission with recommendations for amendments, if any, to the Conflict of Interest Code for the Ventura County Medi-Cal Managed Care .

**BACKGROUND / DISCUSSION:**

Under the Political Reform Act, all public agencies are required to adopt, and amend as needed, a conflict of interest code. The Conflict of Interest Code designates positions required to file FPPC Statements of Economic Interests (Form 700), and assigns disclosure categories specifying the types of interests to be reported. The Form 700 is a public document intended to alert public officials and members of the public to the types of financial interests that may create conflicts of interests.

The Ventura County Board of Supervisors is the Plan's reviewing body therefore if an amendment to the Code is necessary, after approved by the Commission it must be provided to the Ventura County Clerk of Board and the Board of Supervisors must review and approve the revisions or request further revision. The updated Conflict of Interest Code is then not effective until approved by the Board of Supervisors.

The Commission last updated the Conflict of Interest Code in October 2012, which was originally adopted in September, 2010. The Plan has been operating under the 2012 Amended Code since August 6, 2013 when it was reviewed and approved by the Ventura County Board of Supervisors.

**RECOMMENDATION:**

That the Commission direct the Clerk of the Board and Legal Counsel to conduct a biennial review of the Plan's Conflict of Interest Code to determine if changes are required.

**CONCURRENCE**

N/A

**Attachment**

None.

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**AGENDA ITEM 2f**

To: Gold Coast Health Plan Commission  
From: Nancy Kierstyn Schreiner, Legal Counsel  
Date: July 28, 2014  
RE: Resolution Amending Claims Procedure

**SUMMARY:**

The Commission adopted the Claims Procedure by Resolution No. 2012-002 on October 22, 2014.

**RECOMMENDATION:**

Recommend approval of the attached Resolution Amending the Claim Procedure to reflect the Plan's current mailing address.

**RESOLUTION NO. R2014-\_\_\_**

**A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL  
MANAGED CARE COMMISSION AMENDING  
RESOLUTION NO. R2012-002 THEREBY UPDATING THE  
CLAIMS PROCEDURE TO REFLECT GOLD COAST  
HEALTH PLAN'S CURRENT MAILING ADDRESS**

**WHEREAS**, the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan hereinafter referred to as GCHP, is authorized to adopt rules and regulations for the processing of claims against GCHP; and

**WHEREAS**, at the October 22, 2012 Commission Meeting Resolution No. R2012-002 was approved thereby adopting rules and regulations for the processing of claims against GCHP; and

**WHEREAS**, GCHP has relocated and wishes to update the adopted Claim form and procedures to reflect the updated address.

**NOW, THEREFORE, BE IT RESOLVED** that Resolution No. R2012-002, Adopting a Claims Procedure, is hereby amended so that the Claim form is amended to reflect the current GCHP address and the procedures amended to reflect claim submittal to the current address. This amendment is, effective immediately.

**PASSED, APPROVED AND ADOPTED** by the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan at a regular meeting on the \_\_\_\_ day of \_\_\_\_\_, 2014 by the following vote:

**AYE:**  
**NAY:**  
**ABSTAIN:**  
**ABSENT:**

---

David Araujo, Chair

Attest:

---

Traci R. McGinley, Clerk of the Board

## CLAIMS PROCEDURE

For persons wishing to file a claim against the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan (GCHP), a [General Claim Form](#)\* must be completed and submitted to the Clerk of the Commission.

GCHP is prohibited from providing you with legal advice. The California Government Code beginning with Section 900 concerns claims against public entities. Please note the following:

Claims relating to causes of action for death or injury to a person or damage to personal property or growing crops must be presented to the GCHP no later than six months after the incident date.

Claims relating to any cause of action other than those for death or injury to a person or damage to personal property must be presented no later than one year after the incident date (California Government Code Section 911.2).

Once claims are received by the Clerk of the Commission, claims are referred to the Commission's Legal Counsel. The Legal Counsel conducts an investigation into the information in your claim. Your claim form is generally your only opportunity to present information you wish GCHP to consider. The Legal counsel makes a recommendation to the Commission based upon the information obtained and the laws of California.

The Commission must act within forty-five days after you submit your claim (California Government Code Section 911.6). If the Commission fails to act within forty-five days, the claim is deemed to have been denied as a matter of law (California Government Code Section 911.6).

**INSTRUCTIONS FOR FILING A CLAIM WITH VENTURA COUNTY MEDI-CAL  
MANAGED CARE COMMISSION doing business as GOLD COAST HEALTH PLAN**

The following provides specific instructions for completing each section of the Claim Form:

1. Name, Mailing Address and Telephone Number of Claimant(s).  
State full name, mailing address and telephone number of the person(s) claiming damage or injury.
  
2. Dollar Amount of Claim  
State the total amount being claimed as a result of any alleged damage or injury. If damage or injury is continuing, or is anticipated in the future, indicate by writing a plus sign “(+)” following the dollar figure.
  
3. Official Notices and Correspondence  
Provide the name and mailing address of the person to whom all correspondence should be sent, if other than the Claimant. This official contact person can be either the Claimant, or a representative of the Claimant.
  
4. When Did Damage / Injury Occur?  
State the exact month, day, year and time the incident occurred. Under state law, claims relating to causes of action for death or for injury to a Person or for damage to personal property or growing crops must be presented to GCHP no later than six months after the incident date.

If you are filing a claim beyond the six-month period, an *Application for Leave to Present a Late Claim* must also be included with your claim. An *Application for Leave to Present a Late Claim* is your written explanation of the reason(s) why the claim was not filed within the six-month period. In considering the claim, the GCHP will first decide whether or not the *Application for Leave to Present a Late Claim* should be granted or denied. (See Government Code Section 911.4 for the legally acceptable reasons a claim may be filed late).

**ONLY IF LEAVE TO PRESENT A LATE CLAIM IS GRANTED, WILL THE GCHP CONSIDER THE MERITS OF THE CLAIM.**

Claims relating to any cause of action other than those for death or injury to a person, or for damage to personal property, must be presented no later than one year after the incident date. (GOVERNMENT CODE SECTIONS 911.2 and 911.4)

5. Location of Incident  
Include the city, county and street address of occurrence.
  
6. Presenting Facts on How Incident Occurred  
Provide in FULL detail the circumstances that led up to the incident. Identify ALL FACTS which support the claim. Include the name of the agency and / or employee

that allegedly caused the damage / injury, as well as a specific identification as to any condition of public property that allegedly caused the incident.

7. Describing the Damage / Injury and How Amount of the Claim was Computed.

Provide in full detail a description of the damage / injury that allegedly resulted from the incident. Provide a breakdown of how the total amount that is being claimed was computed. Expenses incurred and / or future anticipated expenses may be declared. Attach to the claim copies of all bills, payment receipts, any photos of scene, damage, etc. **ANY CLAIMS FOR DAMAGE TO A VEHICLE MUST BE ACCOMPANIED BY TWO ESTIMATES AND PHOTO(S) OF DAMAGE.** If you need more space, please write on the back of the Claim Form or separate piece of paper.

8. Signature.

The Claim Form must be signed by the Claimant, or by the attorney or representative of the Claimant. GCHP will not accept the Claim without a proper signature. GOVERNMENT CODE SECTION 910.2 PROVIDES: "The claim must be signed by the claimant or some person on his / her behalf."

Provide all information you wish GCHP to consider. You will not be contacted for additional information. Please submit by personal delivery or mail the **original Claim Form** and supporting documentation to the Clerk of the Commission at the following address:

Gold Coast Health Plan  
Clerk of the Commission  
711 E. Daily Drive, Suite #106  
Camarillo, CA 93010-6082

ANY CLAIM PRESENTED WITH INSUFFICIENT INFORMATION WILL BE RETURNED WITH NO ACTION TAKEN BY GCHP (GOVERNMENT CODE SECTIONS 910, 910.2, 910.4, and 910.8.)

All claims will be investigated by GCHP and / or its Legal counsel. State Law allows the Commission of GCHP 45 days to respond to your claim. You will be notified in writing of the Commission's action or inaction in 45 days.

**CLAIM Against the VENTURA COUNTY MEDI-CAL MANAGED CARE  
COMMISSION doing business as GOLD COAST HEALTH PLAN**

To: Clerk of the Commission  
Gold Coast Health Plan  
711 E. Daily Drive, Suite #106  
Camarillo, CA 93010-6082  
(805) 437-5509

Pursuant to the provisions of Sections 905 and 920 of the Government Code of the State of California, demand is hereby made against Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan. In support of said claim, the following information is submitted.

1. Name, Mailing Address, Telephone Number of Claimant(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Dollar Amount of Claim: \_\_\_\_\_
3. Address to Which Official Notices and Correspondence are to be Mailed:  
\_\_\_\_\_  
\_\_\_\_\_
4. Date and Time Alleged Damage / Injury Occurred: \_\_\_\_\_
5. Location of Where Alleged Damage / Injury Occurred: \_\_\_\_\_  
\_\_\_\_\_
6. Facts on How Alleged Damage / Injury Occurred (Include Name of GCHP Employee(s) Who Caused Injury, if Known): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Describe Damage / Injury and How Amount of Claim was Computed:  
\_\_\_\_\_  
\_\_\_\_\_
8. \_\_\_\_\_  
Date  
Signature of Claimant Person Acting on Claimant's Behalf

NOTE: Provide all information you wish GCHP to consider and submit **original signed claim form** and back-up documentation if any, to address listed above. ANY CLAIM PRESENTED WITH INSUFFICIENT INFORMATION WILL BE RETURNED WITH NO ACTION TAKEN BY GCHP (GOVERNMENT CODE SECTIONS 910, 910.2, 910.4, AND 910.8).





## **AGENDA ITEM 2g**

To: Gold Coast Health Plan Commission

From: Michael Engelhard, CEO

Date: July 28, 2014

Re: Ratify Letters of Support

### **SUMMARY**

Gold Coast Health Plan (GCHP) received requests for letters of support for grants from two local organizations that serve GCHP's Membership.

GCHP received a request from the Ventura County Health Care Agency seeking a letter of support for their Health Care for the Homeless Program and from Ventura County Area Agency on Aging's (VCAAAA) seeking a letter of support for a grant focusing on subsidy-eligible population enrollment.

Due to the time restraints on submittal of the grant applications, the letters were sent out late last week

### **BACKGROUND / DISCUSSION**

GCHP delivers health care services with a Member-first focus that reflects a commitment to our Members and our Providers. This commitment includes serving Ventura County's underserved population.

Staff believes that supporting these grants fits in with the Plan's Mission: ***"To improve the health of our Members through the provision of the best possible quality health care and services."***

### **RECOMMENDATION**

Staff requests that the Commission ratify the letters to the Ventura County Health Care Agency for their Health Care for the Homeless Program and the Ventura County Area Agency on Aging's (VCAAAA) in support of their grants.

### **CONCURRENCE**

N/A

### **Attachments**

Letters of Support to the Ventura County Health Care Agency, Health Care for the Homeless Program and the Ventura County Area Agency on Aging's (VCAAAA) in support of their grants.



July 24, 2014

Michele Surber  
Program Administrator  
Health Care for the Homeless Program  
Ventura County Health Care Agency  
2323 Knoll Drive  
Ventura, CA 93003

Subject: Letter of Support and Commitment to the Health Care for the Homeless Program

Dear Ms. Surber,

Gold Coast Health Plan delivers health care services with a *Member-first focus* that reflects a commitment to our Members and our Providers. Part of this commitment is to serve the county's underserved population, which include its many homeless individuals and families who face tremendous barriers to accessing health care services. Because of this, Gold Coast Health Plan has partnered with the Ventura County Health Care Agency to serve its patients with the services the member physicians are dedicated to providing.

Gold Coast Health Plan is dedicated to continuing its coordination with the Ventura County Health Care for the Homeless Program to work jointly to benefit the Ventura County homeless population. Integrated, specialized services are the key to addressing the depth of health care needs inherent to this population. It is critical to provide a continuum of care that focuses on improved and sustained health outcomes.

Gold Coast Health Plan is committed to a strong partnership with the Health Care for the Homeless Program and the community to improve the delivery of services to the homeless population of Ventura County.

Sincerely,

Michael P. Engelhard  
Chief Executive Officer

July 24, 2014

Navigator Program Manager  
Community Relations Division  
Covered California  
1601 Exposition Boulevard  
Sacramento, CA 95814

To the Navigator Program Manager:

As the Gold Coast Health Plan (Ventura County Medi-Cal Payor) Chief Executive Officer, I am writing to express my strong support for the Ventura County Area Agency on Aging's (VCAAA) Covered California Navigator Program grant application, which focuses on subsidy-eligible population enrollment. The agency's Health Insurance Counseling and Advocacy Program (HICAP) program is widely respected and considered to be highly effective in outreach, education and enrollment related to insurance and other social services, particularly with hard-to-reach populations. Over the years the HICAP Program has crossed bridges and has made many partnerships with non-profit organizations, state and federal agencies and within their own County agencies. Ventura County Area Agency on Aging's HICAP Program Manager sits on our Consumer Board representing Senior's and people with disabilities.

Gold Coast Health Plan delivers health care services with a *Member-first focus* that reflects a commitment to our Members and our Providers. Part of this commitment is to serve the county's underserved population, which include its many homeless individuals, individuals. Families, people with disabilities who face tremendous barriers to accessing health care services. Because of this, Gold Coast Health Plan has partnered with the Ventura County Health Care Agency (Public Health), County of Ventura Human Services Agency, and County of Ventura Area Agency on aging to collaborate and to serve its patients with the services the member physicians are dedicated to providing.

Gold Coast Health Plan is dedicated to continuing its coordination with the Ventura County Area Agency on Aging Covered CA grant and their in-kind and subcontractors to work jointly to benefit the Ventura County underserved and subsidies population, Integrated, specialized services are the key to addressing the depth of health care needs inherent to this population. It is critical to provide a continuum of care that focuses on improved and sustained health outcomes.

Gold Coast Health Plan is committed to a strong partnership with the HICAP program and with Ventura County Area Agency on Aging. In improving the community to improve the delivery of services to the of Ventura County's population that need insurance through Covered CA.

Sincerely,

Michael Engelhard  
Chief Executive Officer

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## **AGENDA ITEM 3a**

To: Gold Coast Health Plan Commission

From: Lupe Gonzalez, MPH, PhD, Director of Health Education, Outreach, and Cultural Linguistic Services

Date: July 28, 2014

Re: Event Participation and / or Sponsorship Inquiries

### **SUMMARY**

Gold Coast Health Plan (GCHP) has received request from non-profit community based organizations to support local fundraising activities.

### **BACKGROUND / DISCUSSION**

GCHP is interested in taking an active role in promoting and supporting the health and well-being of the communities in which our members reside. GCHP is in the process of developing a community sponsorship program and policy that would allow GCHP to award funding to support community based agencies in their fundraising events and health promotion activities throughout the county.

Prior to the implementation of the community sponsorship program, GCHP has received a request from the Mixteco / Indigena Community Organization Project (MICOP) to sponsor their annual community fundraising event. There are three different sponsorship levels: 1) Padrino – A Patron of a Special Event at \$1,500, 2) Compadre – A table sponsor at \$750.00 and 3) Amigo – Loyal Friend level at \$500.

MICOP conducts their annual fundraising event to help fund college scholarships for low-income youth in the community, prepare and donate school backpacks with supplies for indigenous children starting school, and other activities to support the indigenous community of Ventura County.

GCHP has been an active supporter of MICOP community fundraising events since 2011. In August 2011 GCHP sponsored and staff attended the MICOP fundraising gala event celebrating their tenth anniversary. There are approximately 20,000 Mixtecs in Ventura County, and many are young families with children are members of GCHP. MICOP has several programs to promote health and wellness in the community including the Healthcare Outreach Workers Program – Promotores de Salud which is designed to increase awareness and access to medical care by providing trained

community healthcare in medical settings. Through local fundraising activities sponsored by MICOP many of their community outreach efforts would not be possible

**FISCAL IMPACT:**

Gold Coast Health Plan will sponsor the MICOP event for \$1,500. This will be paid from the existing Administrative Budget approved for FY 2014-15. No Fiscal Impact.

**RECOMMENDATION**

Staff recommends that the GCHP Commission approve a sponsorship (A Patron of a Special Event) level of \$1,500.00 to MICOP to support their Annual Night in Oaxaca, "Honoring International Day of the World's Indigenous Peoples" on August 9, 2014, at the Oxnard Performing Arts & Convention Center.

**CONCURRENCE**

N/A

**Attachments**

Event Poster

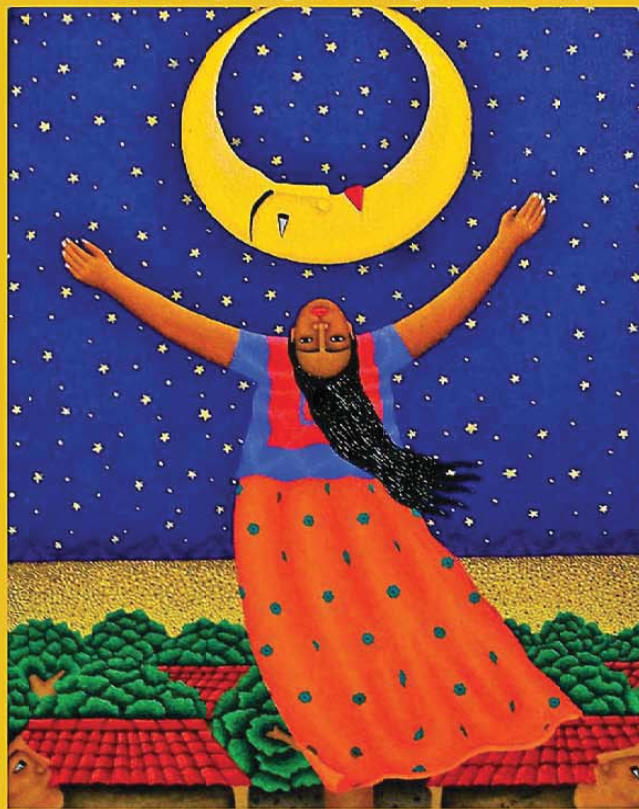
Mixteco/Indigena Community Organizing Project  
presents



# NIGHT IN AXACA

**HONORING INTERNATIONAL DAY  
OF THE WORLD'S INDIGENOUS PEOPLES**

Join us for a homemade mole dinner, chocolate tasting, dancing, and scholarship awards!  
Proceeds from the event will support building the strength and leadership of  
Ventura County's indigenous immigrant community.



Andrew Williamson  
FRESH PRODUCE



**REITER**  
AFFILIATED 76 COMPANIES



**SATURDAY~AUGUST 9, 2014~6PM**  
**OXNARD PERFORMING ARTS CENTER**  
**800 HOBSON WAY, OXNARD, CA 93030**



**FOR TICKETS & INFORMATION**

**CALL (805)483-1166**

**OR VISIT US AT**

**WWW.MIXTECO.ORG**



**Community Memorial  
Health System**

*Where Excellence Begins with Caring*



**LEAD.  
SHARE.  
IMPACT.**

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### **AGENDA ITEM 3b**

To: Gold Coast Health Plan Commission  
From: Michelle Raleigh, Chief Financial Officer  
Date: July 28, 2014  
RE: Affordable Care Act (ACA), Section 1202 Payments

#### **SUMMARY:**

Gold Coast Health Plan (GCHP or Plan) has made initial payments to qualifying physicians as required by the Affordable Care Act (ACA), Section 1202. These initial payments were made on March 27, 2014. As these initial payments were made, the State alerted the Managed Care Plans (MCPs) that a change in the calculation of these supplemental payments was necessary. Additional information has since been provided by the State allowing the Plan to make recommendations to the Commission regarding previous and future payments. Additional updates regarding ACA Section 1202 payments are provided below.

#### **BACKGROUND / DISCUSSION:**

Pursuant to the ACA, as amended by the H.R. 4872-24 Health Care and Education Reconciliation Act of 2010, Section 1202, ACA and 42 Code of Federal Regulations 447, state Medicaid agencies are required to reimburse primary care physicians with a specialty designation of family medicine, general internal medicine or pediatric medicine, at parity with Medicare payment rates (with exceptions noted below), for specified Evaluation and Management (E&M) and Vaccine Administration services for services provided during 2013 and 2014.

MCPs received a copy of a June 20, 2014 letter sent to the Center for Medicare and Medicaid Services (CMS) from the Department of Health Care Services (DHCS) regarding the increased Medicaid payment for primary care under Section 1202 of the ACA. In this letter, DHCS confirms with CMS the following:

- Payment between the MCPs and the State – DHCS will switch to CMS “Model 1” where MCPs’ capitation payments will include estimated additional payments under ACA 1202 and there will be no reconciliation. The suggestion to switch from “Model 2” came from MCPs after reviewing the detailed reconciliation process that would have been followed under “Model 2” and understanding that MCPs would possibly not be made whole through that process.

- Payments to MCPs' Delegated Providers – DHCS clarified that ACA 1202 payments would be made to sub-capitated entities as long as there is a differential between what the MCP paid to the sub-capitated entity (before any ACA 1202 payments) and the ACA 1202 Medicare rate.
- Payments based on “lesser of” language – In late March 2014, DHCS alerted MCPs that ACA 1202 payments need to also take into account the provider's reported billed charge into the calculation. Therefore, the supplemental payment would not just be based on the difference between the Medi-Cal rate paid (or rate paid to the provider under sub-capitated situations) and the effective Medicare rate, but also need to take into account the amount in the provider's billed charge field on the claim. If the billed charge was less than Medicare, the reimbursement amount would be the difference between the billed amount and the Medi-Cal rate.

MCPs raised concerns that this would reduce funds intended to be made to qualifying physicians for selected services because the “billed charge” field is sometimes populated with the Medicaid fee schedule amount. In these instances, the qualifying provider would not receive supplemental funds.

DHCS has requested exemption from this requirement for CHDP claims when providers submit a one-time attestation. This attestation will allow MCPs to pay those providers the supplemental payment rather than denying payment due to the “lesser of” requirements in federal law. DHCS believes this to be a far better approach than requiring all CHDP claims for 2013 and 2014 be resubmitted. This exemption does not apply to non-CHDP claims

Note this “lesser of” language was not reflected in the calculation of the initial payments made by the Plan in late March. The Plan followed the State-approved compliance plan in effect for that time period which did not take into account this new language due to late receipt of the information. Therefore, some payments already made by the Plan to qualifying physicians were higher than if the new “lesser of” language would have been applied. Below, the Plan provides information on the estimated amounts of these overpayments due to the methodology change.

The State will be releasing an All Plan Letter soon that will detail and clarify these changes, process, and documentation. At that time, GCHP will be prepared to continue with payments to qualifying providers as State funding is received.

Lastly, recall that DHCS has communicated that the due date for providers to attest is December 31, 2014 in order to qualify for the increased payments. Providers have received monthly notifications via the GCHP monthly Provider Operations Bulletin that have detailed

requirements and instructions pertaining to the attestation on the State site. Information has also been presented during provider town hall meetings.

**FISCAL IMPACT:**

GCHP has received an initial capitation payment of approximately \$5.2 million for services provided from January 1, 2013 to June 30, 2013. GCHP has paid qualifying physicians approximately \$2 million on March 27, 2014, for services performed during this period (to those physicians that had attested and submitted a W-9 form).

The associated estimated “overpayments” made by the Plan due to the change in methodology is approximately \$91,000 for non-CHDP claims. Note these payments were made in accordance with the State-approved compliance plan at the time. However, since the payment was made, the State clarified the calculation to include the “lesser of” language for non-CHDP claims. To be consistent across all qualifying providers for this time period, GCHP is also recommending that the Plan pay providers for services without applying the “lesser of” clause. These additional payments are expected to be approximately \$9,000, where total “overpayments” are estimated to be approximately \$100,000.

**RECOMMENDATIONS:**

GCHP is recommending to the Commission that overpayments should not be recovered from the providers and that any additional payments made for the January 1, 2013 through June 30, 2013 time period follow the same methodology for consistency. For services starting July 1, 2013, payments to providers will apply the “lesser of” clause to align with updated State guidance.

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### **AGENDA ITEM 3c**

To: Gold Coast Health Plan Commissioners  
From: Brandy Armenta, Compliance Officer / Director  
Date: July 28, 2014  
Re: Compliance Officer / Director Quarterly Report

The Compliance Committee is comprised of internal staff and external General Counsel. The Charter and Scope for the Compliance Committee includes but is not limited to:

- ensure fraud, waste & abuse and HIPAA trainings are completed,
- assist in the creation and implementation of the risk assessments,
- monitoring progress towards completion of goals identified in the compliance work plan,
- assist in the creation, implementation and monitoring of effective corrective actions for delegates, review the results of monitoring activities as described in delegation agreements to ensure delegate is meeting expectations and performing delegated functions appropriately and recommend corrective actions plans for delegates when deficiencies are identified.

The Compliance Committee has met twice in the first calendar quarter of 2014. The following items are a sample of items discussed at the meetings:

- Fraud, Waste & Abuse cases and current status of cases,
- Code of Conduct,
- Compliance Committee Charter
- Department of Justice meeting information
- Delegation Oversight audits and results
- Delegation Oversight routine monitoring
- Compliance Plan

The Compliance Committee approved Gold Coast Health Plan (hereinafter GCHP) Compliance Plan at the June 30, 2014 meeting. (The signed Compliance Plan included behind the report). Following the Compliance Committee meeting it was determined that Section 13 of the Personnel Rules state the CEO imposes discipline as opposed the Human Resources Director which was noted in the Compliance Plan approved by the Compliance Committee. Paragraph two under Enforcement and Discipline in the Compliance Plan has been updated to reflect that change and GCHP is seeking adoption of the Compliance Plan with the updated language. GCHP is required to conduct delegation oversight audits on functions which are delegated. Routine reporting from delegates to GCHP is contractually required and must be actively monitored. Delegation oversight staff is in the process of contacting each delegate to

refine reporting requirements outlined in existing contracts, providing new templates for reporting if needed, and scheduling required delegation oversight audits. An annual audit schedule for all delegates has been completed and staff is working through each audit. The delegation oversight staff has recently conducted a Utilization Management audit and the delegate audited was issued after review at the Compliance Committee a formal corrective action for areas identified as deficient. GCHP is in the process of issuing two non-compliance letters to two separate delegates for not meeting service level standards and / or not providing required reports. Delegation oversight auditing, reporting and monitoring is a requirement of GCHPs Department of Health Care Services (DHCS) contract.

On May 8, 2014 GCHP received a closure letter from DHCS for the Medical (Addendum B) corrective action plan. The Financial (Addendum A) portion of the corrective action plan remains open , however GCHP per DHCS instruction was able to terminate the State appointed monitors contract as a result of meeting requirements. .

Compliance continues to monitor and ensure all employees and temporary employees are trained on HIPAA and Fraud, Waste & Abuse. In addition, compliance & information technology staff conducts random internal audits for HIPAA and PHI issues. Results of the audits are communicated back to the Compliance Committee as well as the leadership team.

GCHP continues to meet all regulatory contract submission requirements. In addition all regulatory agency inquiries and requests are handled timely and required information is provided within the required timeframe it is requested. In closing the Compliance Committee and compliance staff is actively engaged in sustaining contract compliance.



Gold Coast Health Plan

# Compliance Plan FY 2014

Brandy Armenta  
6/27/2014

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### **Overview**

GCHP is committed to conducting its business operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations and rules pertaining to GCHP program.

As part of that commitment, GCHP has appointed a Compliance Officer and formalized its compliance activities by developing a compliance program that incorporates the fundamental elements identified by the U.S. Department of Health and Human Services, Office of the Inspector General (OIG), GCHP, and other agencies as necessary. This comprehensive approach is intended to prevent and detect violations of ethical standards, contractual obligations and applicable law with the involvement of GCHP Commission and senior staff. The Compliance Program is a continually evolving process that is modified and enhanced on an annual basis, based on compliance monitoring and new areas of risk. The Compliance Program applies to GCHP Commission, Employees and Providers.

GCHP prioritizes its commitments through a risk analysis. The Compliance Plan reflects the application of this risk analysis by focusing GCHP's limited resources in a manner that most effectively protects the Plan from fraud, waste, abuse, and other risks to GCHP, its Employees, Providers and Members.

This plan is reviewed and approved annually by GCHP Commission.

## THE COMPLIANCE PLAN

The complex laws governing GCHP and its programs are constantly evolving. This Compliance Plan establishes GCHP's principles, standards and Policies and Procedures regarding compliance with applicable laws and regulations, including those governing relationships among GCHP and regulatory agencies and Providers. The Compliance Plan is designed to ensure that GCHP's operations and the practices of its Employees, Commissioners, and Providers comply with contractual requirements, ethical standards, and applicable law.

The first part of the Compliance Plan addresses the review and implementation of contractual, legal, and regulatory obligations for GCHP's operations. GCHP has developed, and continues to develop specific Policies and Procedures relating to its business operations and compliance efforts. The balance of the Compliance Plan addresses the other elements of an effective Compliance Program including the structure and operational aspects of the Program, such as delegation of authority, training and education processes, monitoring and auditing activities, enforcement/discipline, and corrective action.

If a GCHP Employee, Provider or Commissioner has any questions about the application of this Compliance Plan, GCHP values, or GCHP Policies and Procedures, he or she can seek guidance from the Compliance Officer, or another member of the Compliance Committee. Employees, Providers and Commissioners should be generally familiar with the contractual, legal, and regulatory requirements pertinent to their job duties. All GCHP employees receive annual evaluations which include measurements of job-specific knowledge and knowledge of departmental and company policies and procedures.

This Compliance Plan does not address all of GCHP's activities and the applicable legal issues they may entail. Employees, Providers, and Commissioners should seek the guidance of their supervisor, the Compliance Officer, or GCHP Senior Leadership as applicable with respect to any other issues that may arise.

## **STANDARDS of CONDUCT**

### **CODE OF CONDUCT AND POLICIES AND PROCEDURES**

#### **Code of Conduct**

The Code of Conduct and applicable Policies and Procedures are made available to Employees and Commissioners at the time of hire or appointment, when the standards are updated, and annually thereafter. This commitment is a condition of employment and participation with GCHP.

#### **Review and Implementation of Standards**

GCHP regularly reviews its business operations against new standards imposed by applicable contractual, legal, and regulatory requirements to ensure that GCHP, its Commissioners, Employees and Providers operate under and comply with changing standards. Policies and Procedures are developed to respond to changing standards and potential risk areas identified by GCHP, the federal and state agencies. GCHP identifies risk areas by examining information collected from monitoring and auditing activities. These activities include internal reviews; external reviews of GCHP's operations by regulatory agencies; and review of GCHP's participating providers including subcontracted providers and plan(s).

#### **Compliance with Policies and Procedures**

GCHP regularly and systematically updates its Policies and Procedures to stay current with contractual, legal, and regulatory requirements. GCHP Senior Leadership and Committees meet regularly to review and approve proposed changes and additions to GCHP's Policies and Procedures. These Policies and Procedures assure that Employees perform their responsibilities in compliance with their positions and applicable law. Employees are responsible for ensuring that they comply with the Policies and Procedures relevant to job their description. Providers are responsible for complying with their contractual obligations and government regulations.

#### **Familiarity with Identified Standards**

Commissioners, Employees and Providers are trained to be familiar with the standards related to issues that are generally considered potential risk areas for managed care organizations.

## OVERSIGHT

### **Commission**

GCHP's Commission has the duty to assure that GCHP implements and monitors a Compliance Program governing GCHP's operations. The Commission receives and reviews reports from the Compliance Officer on a periodic basis.

### **Compliance Officer**

GCHP's Compliance Officer is responsible for developing and implementing Policies and Procedures and practices designed to ensure compliance with Federal and State health care program regulations.

The Compliance Officer receives periodic training in compliance procedures, has the authority to oversee and direct compliance efforts, and to report directly to the Commission. Proper execution of compliance responsibilities and promotion of adherence to the Compliance Program are factors in the annual work evaluation of the Compliance Officer.

### **The Compliance Committee**

The Compliance Committee is responsible for maintaining the Code of Conduct, subject to the ultimate authority of the Commission. GCHP maintains minutes of Compliance Committee meetings reflecting the reports made to the Compliance Committee and the Compliance Committee's decisions on issues discussed (subject to the attorney/client privilege, etc.) The Compliance Committee meets a minimum of 8 times per year. The Compliance Committee reviews compliance reports and regular reports from all departments.

### **Compliance Committee Composition**

Individuals selected for the Committee are Chiefs or department heads based upon their status as a Subject Matter Experts in the operational areas of the Health Plan.

## TRAINING

GCHP provides general and specialized trainings and education to Employees to assist them in understanding the Compliance Program, including this Compliance Plan and Policies and Procedures relevant to all staff. As a part of this process, all Employees are apprised of applicable state and federal laws, regulations, and standards of ethical conduct. Employees are also informed of the consequences of any violation of those rules or the Compliance Program.

*GCHP provides training to Commissioners, Employees, and Providers as follows:*

### **Initial and Continuing Education and Training**

New Employees receive copies of GCHP's Code of Conduct, Compliance Program and access to Policies and Procedures pertinent to that individual's job responsibilities upon commencement of their employment.

Employees may receive additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions. GCHP makes the Compliance Plan, and Compliance Policies and Procedures available to all Employees through Compliance 360. All Employees are trained annually as outlined below.

### **Ongoing Compliance Training**

At least annually, GCHP staff will be trained on three main Compliance Program topics: The GCHP Compliance Program, HIPAA Compliance, and Fraud, Waste and Abuse (FWA). Trainings may be split up into modules over the course of a calendar year.

### **Specialized Training**

Employees may receive additional training as is reasonable and necessary based on job descriptions/duties, promotions, and/or the scope of their job functions.

The Commission and Providers may be trained as necessary on how to respond appropriately to compliance inquiries and reports of potential non-compliance.

### **Commissioner Compliance Training**

New Commissioners shall receive a copy of the Compliance Plan and Code of Conduct upon their appointment to the Commission. GCHP's Compliance Department provides a general overview of the Compliance Program to all Commissioners on an annual basis.

### **Provider Compliance Training**

Providers shall receive a copy of the Code of Conduct and Provider Manual. Providers are encouraged to disseminate copies of the Code of Conduct Provider Manual to their Employees, agents, and subcontractors that furnish items or services to GCHP or its Members. Individual and Group Providers are encouraged to provide Compliance Training to their employees using tools GCHP has made available on its website or of their own design. GCHP requests copies of its sub-contracted full-service compliance programs and documentation of completed annual trainings.

In compliance with the Deficit Reduction Act of 2006, Providers will be given a copy of GCHP's False Claims Act Policy and Procedure through the Provider Manual.

### *Failure to Participate In Annual Training*

The Compliance & Human Resources Departments will make a good faith effort to ensure all Employees participate in the annual training. Employees identified as having failed to participate will be contacted to attend complete the required training as soon as possible.

### **Documentation**

The following details the documentation requirements related to the training and education program:

- All Employees must show completion of training through either an online tool, or the submission of a signed attestation
- All Employees must sign the Code of Conduct after receiving training and reviewing the document. This signature may be electronic or on paper.

### **Coordination of Training**

The Compliance Department coordinates compliance education and training programs with the Human Resources Department. The Compliance Department, unless otherwise specified by the Compliance Officer conducts Compliance Education and Training.

### **Other Education Program Communications**

- GCHP informs Commissioners, Employees and Providers of any relevant federal and state fraud alerts and policy letters, pending/new legislation reports, updates, and advisory bulletins as necessary.
- GCHP uses electronic communication and/or other forms of communication (as appropriate) to inform Employees and Providers of changes in applicable federal and state laws and regulations.
- GCHP informs Commissioners and Employees that they can obtain additional information from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer, shall be referred to the Compliance Committee.

## COMMUNICATION

The Compliance Program, including provisions of the Compliance Plan, is implemented and maintained on behalf of GCHP by the Compliance Officer and Compliance Committee as follows:

### Initial Distribution of Compliance Plan

#### Employees and Commissioners

The Compliance Plan, Code of Conduct and Policies and Procedures are made available through the Compliance 360. New Employees will receive the Compliance Plan and Code of Conduct during the onboarding process.

A copy of this Compliance Plan and Code of Conduct are distributed to Commissioners upon their appointment, and annually thereafter for review and approval. GCHP's Compliance Officer, or Clerk of the Commission, shall have responsibility to distribute and obtain a signed Code of Conduct from Commissioners annually.

### Regular Reaffirmation

GCHP requires that endorsement of the Code of Conduct and applicable policies and procedures be affirmed each calendar year as follows:

- The Code of Conduct shall be reviewed with Employees and Commissioners. Employees and Commissioners shall be advised of any changes from the prior year. Each Employee is required to review and sign a Code of Conduct annually. Each Commissioner shall also sign a Code of Conduct to acknowledge the annual review. Original signature sheets are maintained by the Compliance Department.
- The Compliance Department directly receives Employee training attestations and Code of Conduct signatures either electronically or on paper. The Clerk of the Commission receives and forwards Commissioner Code of Conduct signature pages.

### Additional Communication

The Compliance Department will:

- Inform Commissioners and Employees of any relevant fraud alerts, policy letters, pending/new legislation reports, updates, and advisory bulletins as necessary through:
  - New Staff Orientation trainings
  - Annual Compliance trainings
  - Compliance 360
  - Other venues as requested by the Compliance Officer or Compliance Committee members.

- Use electronic communications and/or other forms of communication (as appropriate) to inform Employees and Providers of changes in applicable federal and state laws and regulations through:
  - Employee bulletins (email)
  - Provider Operations Bulletins
  - The Provider Manual
  - The GCHP Website ([www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org))
  
- Inform Commissioners and Employees that they can obtain additional compliance information from the Compliance Officer. Any questions which cannot be answered by the Compliance Officer will be referred to the Compliance Committee.



## **REPORTING**

### **Disclosure, Confidentiality and Non-Retaliation**

#### **Establishment and Publication of Reporting System**

GCHP has established various avenues for the reporting fraud, waste, abuse and other misconduct. This reporting system provides several lines of “upstream” communication to ensure an effective collection of possible misconduct. Confidentiality, when requested, may be honored to the extent allowed by law.

The various means of reporting are described below:

#### *Open Door Policy*

All GCHP Employees are notified upon hire, and annually thereafter of GCHP’s open door policy. All Employees may approach their supervisor, manager, or director with any issue. GCHP Employees are encouraged to check with their supervisor, manager, or director with compliance issues, complaints, or questions. Management staff is trained to handle these situations and forward any necessary information to the Compliance Officer for review or investigation.

#### *Compliance Hotline*

GCHP has a Compliance telephone hotline (“Compliance Hotline”) for GCHP Commissioners, Employees, Providers and Members and other interested persons to report all violations or suspected violations of law and/or the Compliance Program and/or questionable or unethical conduct or practices including, without limitation.

The compliance hotline is a toll free number:

866.672.2615

Commissioners, Employees, and Providers have an affirmative duty under the Compliance Program to report all violations, suspected violations, questionable conduct or practices by a verbal or written report to GCHP via the Compliance Hotline, to a supervisor, or the Compliance Officer.

GCHP publicizes the Compliance Hotline by appropriate means of communication to Commissioners, Employees, and Providers including, but not limited to, e-mail notices, newsletters and/or posting hotline posters in prominent common areas.

The Compliance Hotline is accessible 24 hours a day, 7 days a week, excluding designated holidays (when callers are routed to a voice mail message alerting them to call back during established hours of operation).

#### **Confidentiality, Anonymous Reporting and Non-Retaliation/Non-Intimidation**

GCHP takes all reports of violations, suspected violations, questionable conduct or practices seriously.

Reports of compliance issues are treated confidentially to the extent permitted by applicable law and circumstances. For hotline reports the caller and/or author need not provide his or her name.

Communications via the Compliance Hotline or in writing are treated as privileged to the extent permitted by applicable law.

GCHP's policy prohibits any retaliatory action against a Commissioner, Employee, or Provider for making any verbal or written communication in good faith. In addition, GCHP policy prohibits any attempt to intimidate an individual reporting a compliance issue, for any reason.

### **Voluntary Disclosure and Prohibition Against Insulation**

GCHP Employees are notified annually during compliance training of GCHP's policy of voluntary disclosure. GCHP Employees are encouraged to disclose mistakes and misconduct to their supervisors, managers, directors or the Compliance Officer to prevent or deter fraud, waste, and abuse.

Although Commissioners, Employees and Providers are encouraged to report their own wrongdoing, Commissioners, Employees and Providers may not use any voluntary disclosure in an effort to insulate themselves from the consequences of their own violations or misconduct. GCHP takes violations of this reporting policy seriously and the Compliance Officer will review disciplinary and/or other corrective action for violations, as appropriate, with the Compliance Committee or General Counsel.

## **MONITORING**

Each GCHP Department is tasked with periodically monitoring and auditing their functions as the result of contractual requirements, policies and procedures, corrective actions as a result of prior audits, determinations or risk on a department or plan wide basis, or at the request of the CEO, CFO or COO.

The Compliance Department, in coordination with the Compliance Committee, is responsible for assisting in the development and maintenance of regular auditing and monitoring activities, through the use of a risk assessment approved by the Compliance Committee. The Compliance Department will be responsible for maintaining global monitoring and auditing policies and procedures as approved by the Compliance Committee.

### **Monitoring Systems**

#### Organizational Monitoring

##### Verbal and/or Written Compliance Reports

Reports of suspected or actual compliance violations, unethical conduct, Fraud, Abuse, and/or questionable conduct made by Employees in writing or verbally, formally or informally, are subject to review and investigation as provided below, in consultation with general counsel, by GCHP's Compliance Officer and/or their designee.

The Compliance Officer will work under the supervision of the Chief Executive Officer to investigate reports and initiate follow-up actions as appropriate.

#### Internal Monitoring

Department Directors regularly review internal status/progress reports to ensure compliance and efficiency in departmental activities. "Red flags" that are identified in these reports are reviewed by the Department Director and/or specially trained staff to determine if misconduct has occurred. Instances of fraud, waste, abuse, or other misconduct are investigated by the Department Director and brought before the Compliance Committee. Corrective Actions may be applied by the reviewing Department Director under the direction of the Compliance Committee. Resolution of cases identified for possible or actual fraud, waste, and abuse are reported to the Compliance Committee at the next scheduled meeting.

### **Provider Monitoring**

#### Oversight of Delegated Activities

GCHP delegates certain functions and/or processes to contracted Medical Groups and sub-contracted full-service or specialty plans who are required to meet all contractual, legal, and regulatory requirements of GCHP's Policies and Procedures and other guidelines applicable to the delegated functions. Detailed delegation agreements are executed with those Delegated Providers. Periodic reports are monitored by GCHP staff.

GCHP maintains oversight over all Delegated Providers, including but not limited to, the following delegated activities:

- Provider credentialing and re-credentialing at select facilities
- Pharmaceutical benefits and claims processing to contracted PBM
- Utilization Management
- Grievances and Appeals
- Claims payment

#### Availability of Records

GCHP and its Providers' records are available for review by regulatory agencies, or their designee. Records are maintained according to the contractual obligations specified between GCHP and the Provider, and are not kept for a period of time any shorter than mandated by applicable Federal and/or State law. Records for Medi-Cal are maintained for 7 years.

### **Audit Systems**

#### Periodic Audits

In order to comply with its regulatory and contractual requirements, GCHP conducts periodic audits of its operations. Audits may be routine or ad hoc, depending on the needs of GCHP, the Department conducting the monitoring, or pursuant to a regulatory agency request, notification or alert. Audits are based on contractual or regulatory obligations, or GCHP policy.

### **Focused Audits**

#### Compliance with Contractual Requirements

GCHP maintains contracts with and is audited by health care oversight agencies in connection with GCHP programs. Results from audits conducted by regulatory agencies will be reviewed and used to develop and modify systems to audit and monitor operations on a regular basis.

#### Government-Identified Risk Areas

The Compliance Officer or their designee monitors for specific compliance issues identified by health care agencies. This includes, but is not be limited to areas of risk identified in the OIG's Annual Work Plan, the results of audits of GCHP operations by health care oversight agencies, and Compliance Issues identified and reported to GCHP's Compliance Department.

#### Annual GCHP Monitoring and Auditing Work Plan

GCHP maintains a monitoring and auditing work plan that includes:

- Summary of internal monitoring processes
- Internal audit schedule
- Audit narrative, including:
  - Audit objectives
  - Scope and methodology
- Staff responsible for specific audits
- Strategy to monitor and audit GCHP's subcontractors
- Process for developing follow up and corrective action

The monitoring and auditing plan is modified based on a risk assessment. The risk assessment is used to determine which areas of GCHP's business may be susceptible to fraud, waste, or abuse or

non-compliance. Audit guides, experiences of other COHS plans, other resources developed by regulatory agencies and the health care industry may be used to identify high risk areas. The Compliance Department with input of the Compliance Committee prioritizes the monitoring and auditing strategy based on available resources.

Areas in GCHP's business that are found to be non-compliant will be reviewed to determine how the deficiencies should be addressed. Recommendations or Corrective Actions may be required depending on the severity of the findings.

Actions taken as a result of the work plan are tracked to evaluate the success of implementation efforts. A report on monitoring and auditing results is presented to the Compliance Committee in the quarter following the finalization of the audit report.

#### Compliance Program Annual Review

The Compliance Committee reviews the Compliance Program, including this Compliance Plan annually. The plan's functionality will be reviewed to ensure that best efforts are made to protect GCHP from fraud, waste, abuse, and other misconduct that could endanger the Plan, delivery of services, Members, Providers, and other affiliated parties.

#### External Auditing for Delegated Entities

As part of its work plan GCHP monitors and audits Delegated Entities that are involved in the administration or delivery of services to GCHP members. GCHP audits its Delegated Entities using the same auditing tools provided by regulatory agencies to ensure compliance with each program's standards. Recommendations or corrective actions are provided to the Delegated Entity upon the conclusion of each audit. Corrective actions are followed-up upon as defined/determined in the corrective action letter and at the next annual review.

#### **Audit Review**

The Compliance Officer and/or their designee submit regular reports of all monitoring, audit, and corrective action activities to the Compliance Committee. When appropriate, GCHP will provide summary reports to the appropriate health care agency (or a designee) prior to a regularly scheduled audit by that agency.

#### **Participation Status Review and Background Checks**

GCHP does not knowingly hire, contract with, or retain on its behalf, any person or entity that is currently suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs; and/or has ever been excluded from participation in Federal and/or State health care programs based on a mandatory exclusion.

Verification of a provider's eligibility to contract with GCHP is covered in Credentialing and Recredentialing policies maintained by the Provider Relations Department. Payments made by GCHP (i) to excluded persons or entities, or (ii) for items or services furnished at the medical direction or on the prescription of an excluded or suspended physician are subject to repayment/recoupment.

Employees are required to notify the Human Resources Department if, after hiring their ability to participate in federal and/or state health care programs changes. In the event GCHP discovers the status of any Employee, Volunteer or Temporary Employee no longer permits them to work for GCHP, corrective actions will be taken.

## **ENFORCEMENT**

### **Conduct Subject to Enforcement and Discipline**

Commissioners may be subject to removal, Employees to discipline up to and including termination and Providers to contract termination for non-compliance behavior, including but not limited to committing fraudulent acts.

### **Enforcement and Discipline**

GCHP maintains a “zero tolerance” policy towards any illegal conduct that impacts the operation, mission or image of GCHP. Any Employee or Provider engaging in a violation of laws or regulations (depending on the magnitude of the violation) may be terminated from employment or their contract. GCHP will accord no weight to a claim that any improper conduct was undertaken for the benefit of GCHP. Such conduct is not for GCHP’s benefit and is expressly prohibited.

GCHP maintains a policy on Employee Conduct and Work Rules which specifies unacceptable employee behavior. Employee discipline is determined by the CEO as outlined in section 13 of the Personnel rules.

In determining the appropriate discipline or corrective action for any violation of the Compliance Program or applicable law, GCHP will not take into consideration a particular person’s or entities economic benefit to the organization.

Employees and Providers should also be aware that violations of applicable laws and regulations, even unintentional, could potentially subject them or GCHP to civil, criminal or administrative sanctions and penalties. Further, violations could lead to suspension or exclusion from participation in Federal and/or State health care programs.

## REMEDATION

### **Notice of Violation or Suspected Violation**

If a Commissioner, Employee or Provider becomes aware of a violation, suspected violation or questionable or unethical conduct in violation of the Compliance Plan or applicable law, that Commissioner, Employee or Provider must notify GCHP immediately. The Commissioner, Employee, or Provider may report any violation, suspected violation, or questionable conduct to their immediate Supervisor, a Director, including the Compliance Officer by direct verbal or written report. Such reports may also be made to the Compliance Hotline.

### **Response to Notice of Violation or Suspected Violation**

Upon receipt of a report of non-compliance (whether a general compliance issue, HIPAA or FWA), the Compliance Department is responsible for review and investigation. Issues with high severity relative to compliance may be directly reported to the Compliance Officer. Issues with high severity, including that includes employee misconduct may be reported directly to the HR Director for investigation as appropriate.

The Compliance Department will work with the appropriate GCHP staff, general counsel, appropriate outside contacts to correct the compliance issue.

Reported issues are tracked by the Compliance Department for routine reporting on a quarterly basis to the Compliance Committee. Statistics on compliance issue reporting are provided to the Commission as a part of the periodic Compliance Officer report.

It is the responsibility of the Compliance Officer, or their designee to review and implement any appropriate corrective action after considering such recommendations. It is the responsibility of the HR Director or their designee to implement any disciplinary action with regard to employee misconduct.



## FRAUD

GCHP must comply with certain regulatory requirements pertaining to Fraud, Waste, and Abuse prevention. Such regulations dictate the investigative, reporting and monitoring activities related to Fraud, Waste, and Abuse prevention.

The Compliance Committee, along with the Compliance Officer is responsible for maintaining a fraud, waste, and abuse program. The program will be evaluated as an element of the Compliance Plan on an annual basis based on risks identified by the health care or regulatory agencies, and GCHP's pertinent experience.

### Fraud Detection

Fraud detection involves knowing what can go wrong, and who could do it. It also involves knowing what opportunities exist, and understanding the systems and controls designed to minimize the opportunities. Additionally, fraud detection involves knowing the symptoms or patterns of the occurrence, being on the lookout for such patterns and building programs to look for the patterns.

GCHP believes that knowing what can go wrong consists of identifying fraud indicators that warrant closer scrutiny, including the types of fraud, common fraud schemes and trends, "red-flags" and situations leading to potential fraud.

GCHP also routinely identifies trends or "global" schemes in Medicaid (Medi-Cal), Medicare or health care fraud and abuse reported in newspapers, journals, or through CMS Fraud Alerts or other means.

### *"Red Flags"*

"Red Flags" are events or circumstances that warrant further investigation and are potential indicators of fraud. GCHP reviews these examples on a periodic basis; however, some are known to naturally occur. Not all red flags result in fraud.

### Departmental Monitoring Activities

Fraud detection requires that fraud be proactively sought through a variety of means. Each department is responsible for taking proactive steps to detect fraud. GCHP exercises diligence and actively searches for possible fraudulent behavior through during the course of regular business, and as a result of fraud alerts provided by regulatory agencies via the Compliance Department. GCHP is required to conduct certain monitoring activities as a result of contractual or regulatory obligations.

Once a symptom or pattern has been identified, further research is warranted to determine whether or not there is reasonable suspicion of fraudulent behavior. Per the Plans contract with the Department of Health Care Services (DHCS) the Plan is contractually obligated to report suspicion of FWA within ten days of discovery.

### **Education and Training for Members and Providers**

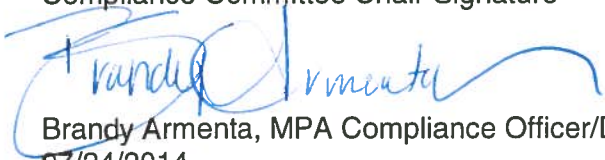
GCHP provides education on fraud prevention to its members and providers via its website, newsletters, and new member orientations. Information provided includes contact information for reporting fraud, waste, and abuse to GCHP.

**FILING SYSTEMS**

The Compliance Officer will establish and maintain a filing system (or systems) for all compliance-related documents. Records retention is handled according to GCHP's contractual and regulatory obligations. Records related to the Compliance Program, including edits to the Compliance Plan, Minutes of Committee meetings, documentation of education and similar documentation is maintained for no less than 7 years, pursuant to requirements of the Medi-Cal program.

<b>Review Date</b>	<b>Revised Date</b>	<b>Approved By</b>
<b>06/30/2014</b>		<b>Compliance Committee</b>
	<b>07/24/2014</b>	

Compliance Committee Chair Signature



Brandy Armenta, MPA Compliance Officer/Director  
07/24/2014

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### **AGENDA ITEM 3d**

To: Gold Coast Health Plan Commission

From: Barry Fisher, Special Investigation Ad Hoc Committee Chair

Date: July 28, 2014

Re: Affirming the Independent Role of the Special Investigation Ad Hoc Committee and Authorizing Actions in Furtherance Thereof

#### **SUMMARY:**

At its Special Meeting of June 18, 2014, the Commission appointed an ad hoc committee of Commission Members Fisher, Alatorre and Glycer (the Ad Hoc Committee) to, among other things, oversee the work of investigative consultants retained by the Commission to evaluate allegations contained in a report issued on May 27, 2014 by the League of United Latin American Citizens-Ventura County and amended June 12, 2014 (the LULAC Report).

Among the directives given to the Ad Hoc Committee during the June 23, 2014 Commission Meeting was to retain special counsel to advise members of the Committee on their work. The Ad Hoc Committee retained Scott H. Howard of the Howard Law Group and Joseph W. Fletcher of the Law Offices of Joseph W. Fletcher to serve as special counsel to the committee.

In reviewing steps taken by or on behalf of the Commission, special counsel has advised the Committee that it would be prudent for the Commission to affirm the independent mission of the Committee and to further expressly authorize the Committee to take certain actions on behalf of the Commission, including contracting with consultants.

On June 11, 2014 CEO Engelhard retained the accounting firm of Moss-Adams, LLP to conduct a limited financial investigation regarding various fiscal issues raised in the LULAC Report and provide that information to Commission General Counsel. On the same day, CEO Engelhard entered into a professional services agreement with EXTTI, Inc. to conduct a workplace investigation regarding allegations of racial discrimination and report the results to Commission General Counsel.

The Ad Hoc Committee requests that the Commission authorize and direct the Ad Hoc Committee to act on behalf of the Commission regarding directing the work of Moss-Adams and EXTTI and that such authority include the ability to amend and or terminate those agreements if deemed appropriate by the Ad Hoc Committee. The Ad Hoc Committee also requests it be authorized to retain additional or replacement consultants if the Ad Hoc Committee finds such to be in the best interest of the mission of the Committee.

**FISCAL IMPACT:**

The fiscal impact is unknown at this time. There is a potential of additional costs if new consultants are required.

**RECOMMENDATION:**

That the Commission take the following actions:

1. Affirm that the Ad Hoc Committee is authorized and directed to independently direct an investigation into the allegations contained in the LULAC Report;
2. Authorize the Ad Hoc Committee to enter into contracts on behalf of the Commission for special counsel and consultants which the Ad Hoc Committee deems necessary or desirable to carry out its mission. This authorization shall include amending or terminating any existing contracts for services related to the LULAC Report.

## **AGENDA ITEM 4a**

To: Gold Coast Health Plan Commission  
From: Michael Engelhard, Chief Executive Officer  
Date: July 28, 2014  
Re: CEO Update

### **HEALTH EDUCATION UPDATE**

#### **Health Education and Community Outreach Summary Report**

Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. Below is a summary of activities conducted by GCHP staff.

On Saturday, June 28, 2014, GCHP sponsored a Community Resource Fair at Del Sol Park in Oxnard. A total of 30 community organizations participated and approximately over 300 individuals and families attended the event. A total of 277 GCHP information packets and health passports were distributed and over 270 promotional items were handed out to participants during the event.

The goal of the Community Resource Fair was to increase awareness about Medi-Cal services and provide information about health care resources in the community. Participants were asked to complete an evaluation and the majority (90%) of the participants found the event to be excellent and/or very good. When participants were asked about the health screenings, the majority (88%) of the participants found the screenings to be excellent and/or very good. Approximately 34% of the respondents said they hear about the Community Resource Fair through the radio, a total of 16% said they received a flyer, 3% indicated the doctor's office, 16% said a friend, and 1% indicated they heard about the event through the newspaper.

Some highlights of the event include the following:

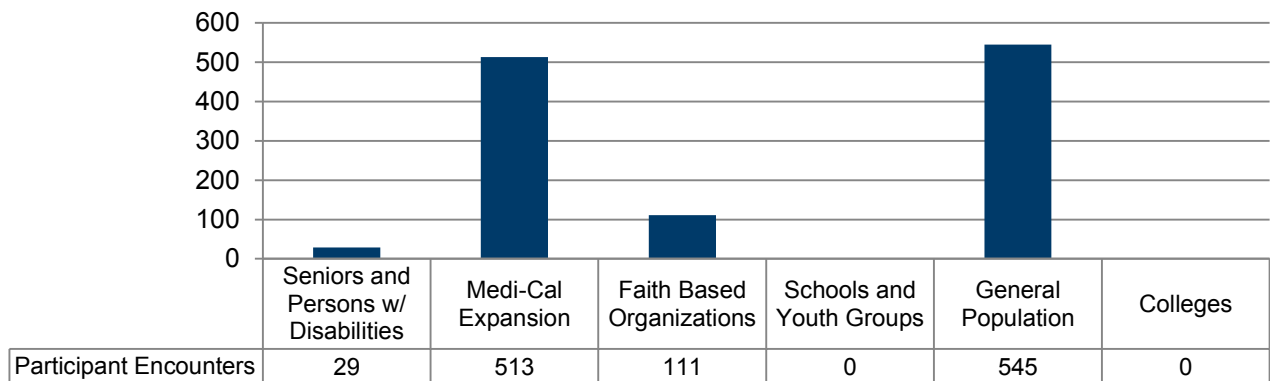
- Oxnard County Fire Department in Collaboration with Gold Cost Ambulance conducted a total of 197 CPR demonstrations.
- In collaboration with Food Share and Ventura County Public Health Department a total of 152 fresh produce bags were distributed to individuals and families.
- Ventura County Public Health Department Mobile Unit conducted approximately 100 blood pressure and glucose screenings.
- A total of 50 cholesterol screenings were administered by Clinicas del Camino Real.
- A total of 20 participants scheduled enrollment appointments with CalFresh.

- Two physical activity demonstrations were conducted by Port Hueneme Stars – Hip-Hop Dancers and Taekwondo Demonstration by Urrutia’s Twin Tigers.
- Musical Performance by Trio Amor.

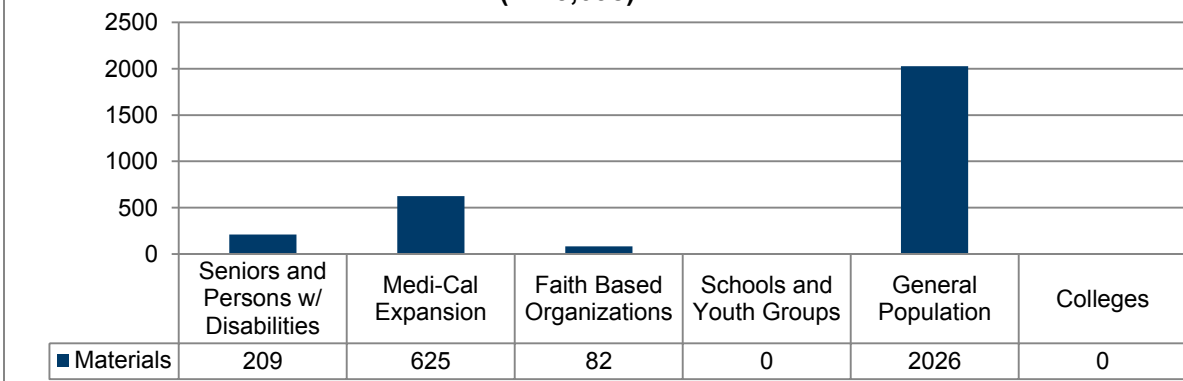
**Overall Outreach Activities**

Overall GCHP continues to reach individuals, families, and potential members through a variety of community outreach events. During the month of June GCHP staff participated in 21 community events and reached over 1,200 individuals and approximately a total 3,100 pieces of literature was distributed. Below are two charts documenting total number of encounters and materials distributed during the month of June.

**Total Participant Encounters by Category  
June 2014  
(N= 1,215)**



**Total Materials By Category  
June 2014  
(N= 3,098)**





**Activities**

Overall GCHP staff participated in 21 community outreach events/health fairs throughout the county. Below is a list of events and/or activities:

<b>Date</b>	<b>Event / Activities</b>
06/04	Member Orientation Meeting (Spanish)
06/04	Member Orientation Meeting (English)
06/04	Aprendiendo Juntos Parent Group hosted by Rainbow Connection
06/07	Santa Clara Valley Wellness Foundation Health Fair
06/10	VCMC Baby Steps Program
06/11	Member Orientation Meeting (Spanish)
06/11	Member Orientation Meeting (English)
06/11	Familias Unidas Parent Group hosted by Rainbow Connection
06/13	La Hermandad Food Distribution
06/14	Amigo Baby Inc., Annual Summer Graduation Party
06/17	Santa Paula Hospital Baby Steps Program
06/18	Westpark Community Center Monthly Food Distribution and Health Services
06/18	Ventura Area Housing Authorities Meeting
06/19	Downtown Oxnard Farmers' Market
06/19	Member Orientation Meeting (Spanish)
06/19	Member Orientation Meeting (English)
06/21	Anniversary Celebration for Santa Paula Hospital
06/22	Jornada Dominical
06/25	Member Orientation Meeting (Spanish)
06/25	Member Orientation Meeting (English)
06/28	GCHP Community Resource Fair at Del Sol Park

**GOVERNMENT AFFAIRS UPDATE**

**Hepatitis C Drug Coverage**

The Department of Health Care Services (DHCS) will develop a state supplemental drug rebate program for Medi-Cal managed care plans similar to the existing state supplemental rebate program used in fee-for-service Medi-Cal. This program is intended to help control the cost of certain categories of high-cost drugs, such as those used to treat hepatitis C, HIV / AIDS, hemophilia, and cancer.

DHCS also recently released coverage policies for Sovaldi which can be found on the DHCS website at <http://www.dhcs.ca.gov/Pages/HepatitisC.aspx>

**Behavioral Health Coverage in Medi-Cal**

As mandated by SB 870, DHCS will implement behavioral health treatment to the extent that it is required by the federal government for beneficiaries under 21 years of age. Services will be implemented only if DHCS receives federal approval to obtain federal financial participation, it

seeks state funding for the fiscal year, statutory authority is provided, and stakeholders are consulted.

Recently released federal guidance requires the provision of these services under the Early and Periodic Screening, Diagnostic, and Treatment benefits for children under age 21. Related to these requirements, DHCS will launch the Behavioral Health Forum on July 21, 2014, which is a statewide stakeholder initiative. The Forum will meet quarterly for DHCS to update stakeholders regarding policy and program issues in mental health and substance use disorder services. If you are interested in participating, you can contact [MHSUDStakeholderInput@dhcs.ca.gov](mailto:MHSUDStakeholderInput@dhcs.ca.gov)

### **Medi-Cal Enrollment and Backlog**

The California Department of Health Care Services has stated that enrollment in Medi-Cal since October 2013 has reached nearly 2.8 million. The Department expects that the total enrollment in Medi-Cal will increase from 7.9 million before implementation of the Affordable Care Act to 11.5 million in 2014-15, covering about 30 percent of the state's population. Currently, there remains a backlog of applicants who are awaiting confirmation of Medi-Cal enrollment. This backlog has decreased since the last update in May, and is now at 600,000 individuals. DHCS has provided a plan for addressing this issue with technology and administrative fixes, which predicts that the backlog will decrease to 350,000 by the end of August.

### **November Ballot Measures**

Proposition 45, a voter initiative approved for the November 2014 ballot, would give the elected Insurance Commissioner the authority to approve or deny all health insurance rate changes. California's state legislature held a joint hearing on July 2, 2014 to understand the effects the measure might have. Members of the legislature, Covered California and across the healthcare industry expressed concerns about the potential breadth of the measure, and the potential for timing issues with Covered California enrollment periods. The California Democratic Party supports this measure.

### **Legislation**

Members of the California Legislature are on summer recess and are back in their districts for the month of July. The Legislature will reconvene on August 4, 2014 and the focus during August will be in the fiscal committees. Below is a list of bills the Legislature will be voting on.

### **Chaptered Legislation**

#### **SB 857**

#### **Health Omnibus Trailer Bill**

**Summary:** SB 857 is an Omnibus Health Trailer Bill needed in order to implement the 2014-15 budget. This bill provides full scope Medi-Cal to pregnant women with incomes up to 138% FPL. It establishes the "wrap program" for women between 139% and 213% FPL which allows pregnant women to have

both Covered California coverage and Medi-Cal as a wrap pay for their premiums.

SB 857 provides statutory authority to comply with federal rules that require states to report Provider Preventable Conditions (PPCs) and prohibits Medi-Cal payment for costs of services related to PPCs.

It implements the Federal Mental Health Parity Law by requiring individuals, small group, and large health care service plan contracts to be in compliance with the federal law by January 1, 2015.

Finally, SB 857 shifts funding from the Office of Patient Advocate (OPA) to the Department of Managed Health Care (DMHC) to establish contracts with community-based organizations to provide consumer assistance.

**SB 1340**     **Health Care Coverage: Provider Contracts.**

**Summary:** This bill expands the prohibition on any provision that restricts the ability of health plans to provide cost and quality information to enrollees related to hospitals. This includes full course of treatment, prescription drugs, durable medical equipment, and other items related to treatment.

**Med-Cal Related Bills**

**AB 1552**     **Community Based Adult Services: Adult Day Health Care Centers.**

**Summary:** This bill establishes the Community-Based Adult Services (CBAS) program, as a Medi-Cal benefit. The bill would require that CBAS be provided and available at licensed Adult Day Health Care centers that are certified by the California Department of Aging as CBAS providers.

**AB 1558**     **California Health Data Organization: All-Payer Claims Database.**

**Summary:** This bill requires the University of California to establish the California Health Data Organization to create a website database that allows consumers to compare the prices paid by carriers for procedures.

**AB 1759**     **Medi-Cal Reimbursement Rates: Care: Independent Assessment.**

**Summary:** This bill requests the University of California to annually conduct an independent assessment of Medi-Cal provider reimbursement rates, access to care, and the quality of care received in the Medi-Cal program.

**AB 1771**     **Telephone Visits.**

**Summary:** This bill classifies physician telephonic and electronic patient management services as telehealth services, as defined, and therefore would require a health care service plan to cover and reimburse those services based on their complexity and time expenditure.

**AB 1868**

**Medi-Cal: Optional Benefits: Podiatric Medicine.**

**Summary:** This bill makes podiatric services a covered benefit under the Medi-Cal program. Covered benefits include all medical and surgical services provided by a podiatrist.

**AB 2325**

**Medi-Cal: CommuniCal.**

**Summary:** This bill requires DHCS to establish the Medi-Cal Patient-Centered Communication Program (CommuniCal). It would provide medical interpretation services to Medi-Cal beneficiaries who are limited English proficient (LEP).

**SB 964**

**Health Care Service Plans: Medical Surveys.**

**Summary:** This bill requires Medi-Cal only health plans under DHCS to comply with timeliness standards and reporting procedures adopted by the DMHC in cooperation with DHCS.

**SB 1005**

**Health Care Coverage: Immigration Status.**

**Summary:** This bill extends full-scope Medi-Cal eligibility to individuals who are otherwise eligible except for their immigration status. SB 1005 also creates the California Health Exchange Program for All Californians to mimic the California Health Benefit Exchange.



## **AGENDA ITEM 4b**

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: July 28, 2014

Re: COO Update

### **OPERATIONS UPDATE**

#### **ACA-Health Care Reform and Medicaid Expansion**

##### **Membership**

Enrollment continued on its monthly growth trend with the addition of 3,115 members in July, resulting in total plan membership of 159,111. July's membership added 4,696 Medi-Cal expansion members while various other Aid Codes showed a drop of 1,581 enrollees. This decrease is likely due to the impact of the re-instatement of Medi-Cal's annual re-determination requirements. Medi-Cal redetermination was suspended for the first 6 months of 2014 while counties worked through the increased volume of applications due to Medi-Cal expansion.

##### **Temporary Eligibility for Medi-Cal Pending Cases**

Members on hold pending Medi-Cal status (Aid code 8E) continued to decrease. The Plan's eligibility file includes 1,191 8E members - a decrease from June's 8E eligibility of 1,701.

##### **Total Growth**

The plan has grown by over 50,000 members between July 2013 and July 2014, a 50% increase in membership.

#### **JUNE OPERATIONS REPORTS ATTACHED:**

##### **June 2014 Operations Summary**

**Claims Inventory** – ended the month with an inventory of 32,461 which equates to Days Receipt on Hand (DROH) of 6 days. Claim receipts from January through June are as follows:

- January – 91,130
- February – 90,048

- March – 109,857
- April – 110,855
- May – 108,312
- June – 116,474 (this is approximately a 28% increase since January 2014)

**Claims TAT** – the regulatory requirement of processing 90% of clean claims within 30 calendar days was not met in June. Claim receipts were the highest they have been since the addition of new membership. The results for June were 85.3%. The Plan worked with Xerox to develop an inventory reduction plan and as a result, on July 9, 2014, we were once again over 90% and back in compliance.

**Claims Processing Accuracy** – financial accuracy in June fell short of GCHP’s goal of 98%; the financial accuracy for the month was 90.37%. Two claims processors each had a large dollar error which negatively impacted the results; both of those individuals are no longer with the company. Additionally, Xerox is revising the pre-payment audit in order to identify additional high dollar claims before the claims are finalized. Procedural accuracy exceeded the goal in June.

**Call Volume** – call volume increased by 6% in June (almost 10,000 calls!). The 6-month call volume average for July 2013 – December 2013 was 7,286 calls per month. The 6-month average for January 2014 – June 2014 was 9,237 and represents a 27% increase in calls.

**Average Speed to Answer** – we continue to significantly exceed the goal of answering calls within 30 seconds or less. The combined results for June were 6.6 seconds.

**Abandonment Rate** – the abandonment rate continues to exceed Plan standards. The goal is that 5% or less of the calls received by the Plan are abandoned; we have remained below 1% for 11 of the last 12 months.

**Average Call Length** – the combined result of 6.09 minutes met the goal of 7 minutes or less. All categories (member, provider, Spanish) were under 7 minutes in June.

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

- 35C to 837 Encounter Data Transition (regulatory requirement)
- Encounter Data Improvement Project (improve the quality of the data sent to DHCS in order to meet new quality measures established by the State beginning January 2015)
- Grievance and Appeals Improvement Project
- ICD-10 Readiness (regulatory requirement)
- Member Orientation Meetings (now including Saturday meetings)

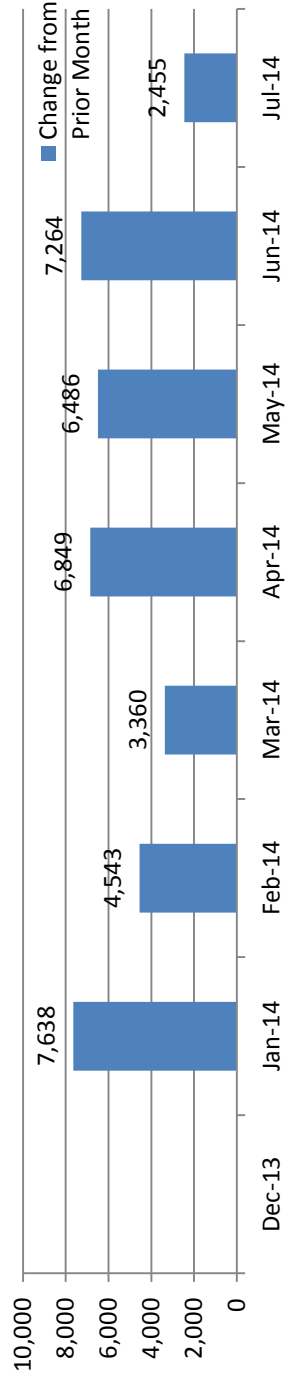
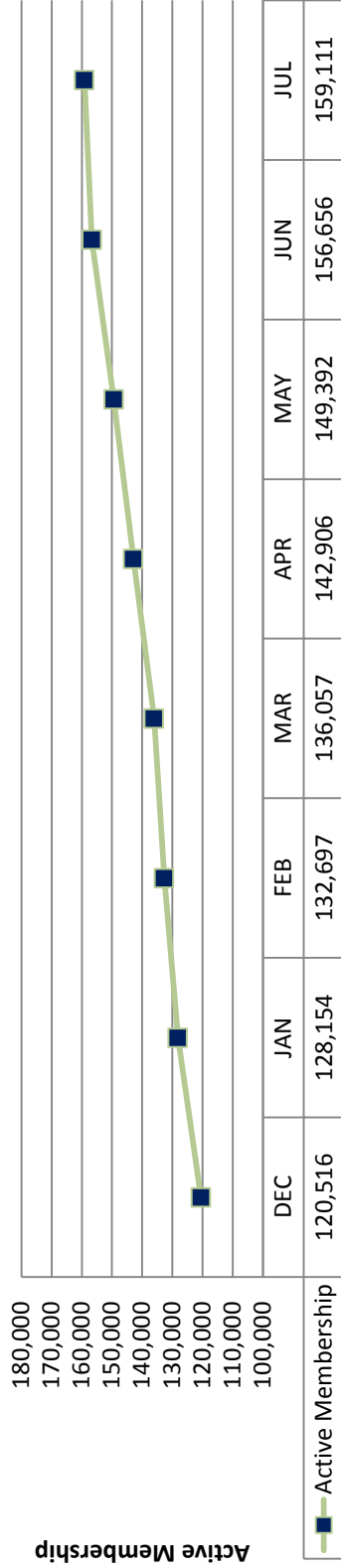
- 2014 Member Handbook (submitted to DHCS on June 3, 2014 for approval)
- Crossover Claims
- Plan Selection (PCP selection during sign-up via Covered California; information matched once Medi-Cal beneficiary becomes a GCHP member)



# GCHP Membership

July 2014 Total Membership – 159,111  
January through July membership growth – 38,595

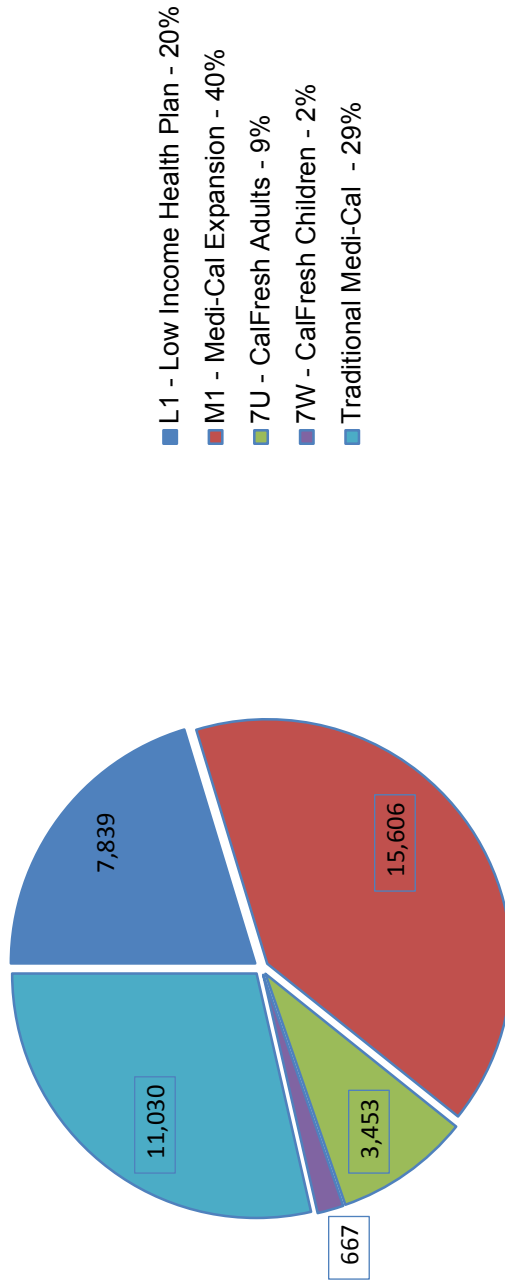
## GCHP Membership Increase January - July 2014





# New Membership

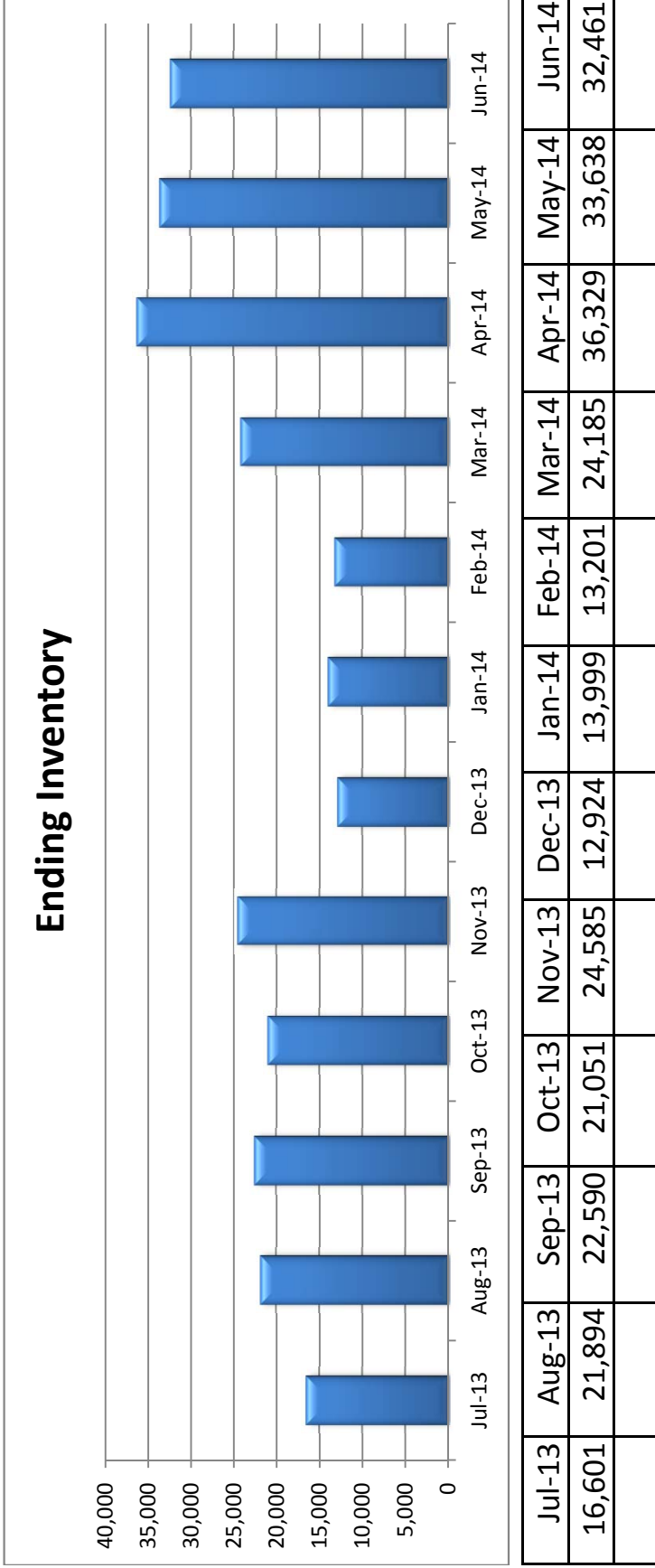
## GCHP New Membership Breakdown



**Note: GCHP Pended eligibility (not shown) – 1,191 (down 528 from June)**

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

# Claims Inventory Summary



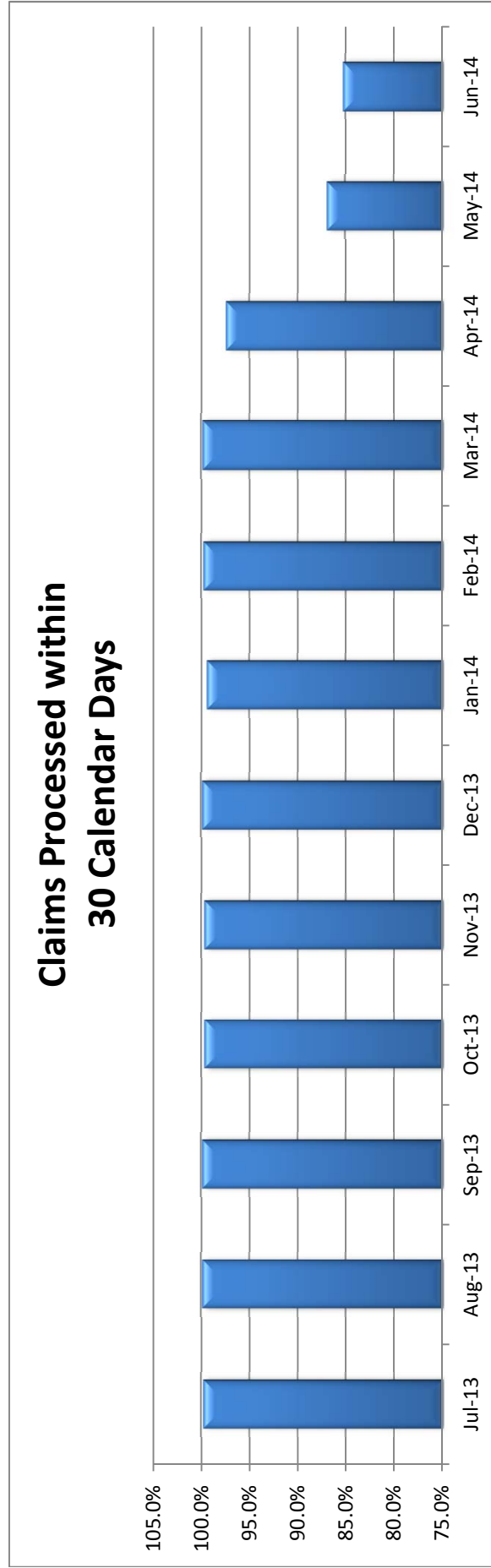
Goal: 23,250 or less (based on membership as of June 1, 2014). Anticipate moving to a Days Receipt on Hand (DROH) methodology as of July 1, 2014.

Note 1: November 2013 increase was due to a bulk submission of claims from VCMC on 11/22/13 that artificially inflated the inventory for two weeks. More than 70% had previously been submitted and were denied as duplicates; an additional 20% were denied for various reasons.

Note 2: June 2014 ending inventory continues to reflect increased membership. Daily claim receipts continued to average ~5,550 per day in June. New staff hired by Xerox to handle the increased claims volume have completed training and are beginning to make an impact.

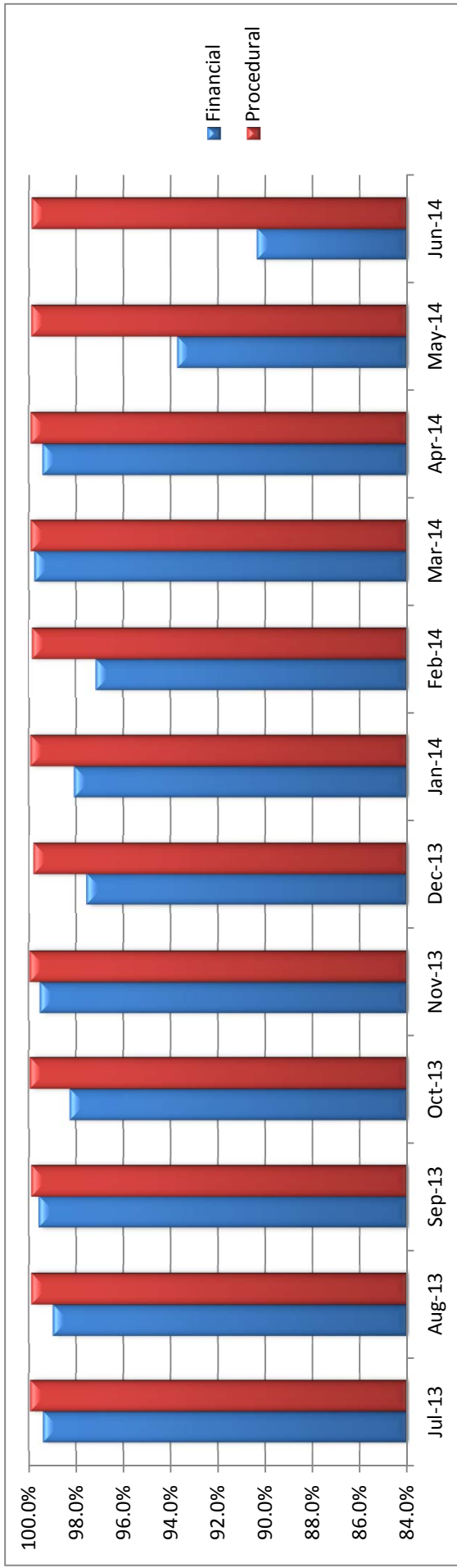
# Claims Processing Turnaround Time

Jun-14	1-30 Days		31-45 Days		46-60 Days		Over 60 Days		Total Claims
	#	%	#	%	#	%	#	%	
Clean Claims	91,417	85.3	15,528	14.49	213	0.2	16	0.01	107,174
Contested Claims	1,945	74.12	664	25.3	15	0.57	0	0	2,624
Total Claims	93,362	85.03	16,192	14.75	228	0.21	16	0.01	109,798



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

# Claims Processing Accuracy



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Financial	99.4%	99.0%	99.59%	98.27%	99.54%	97.56%	98.10%	97.16%	99.77%	99.43%	93.74%	90.37%
Procedural	99.95%	99.9%	99.9%	99.96%	99.97%	99.79%	99.94%	99.85%	99.93%	99.93%	99.91%	99.89%

**Goal:**  
**Financial - 98% or higher**  
**Procedural - 97% or higher**

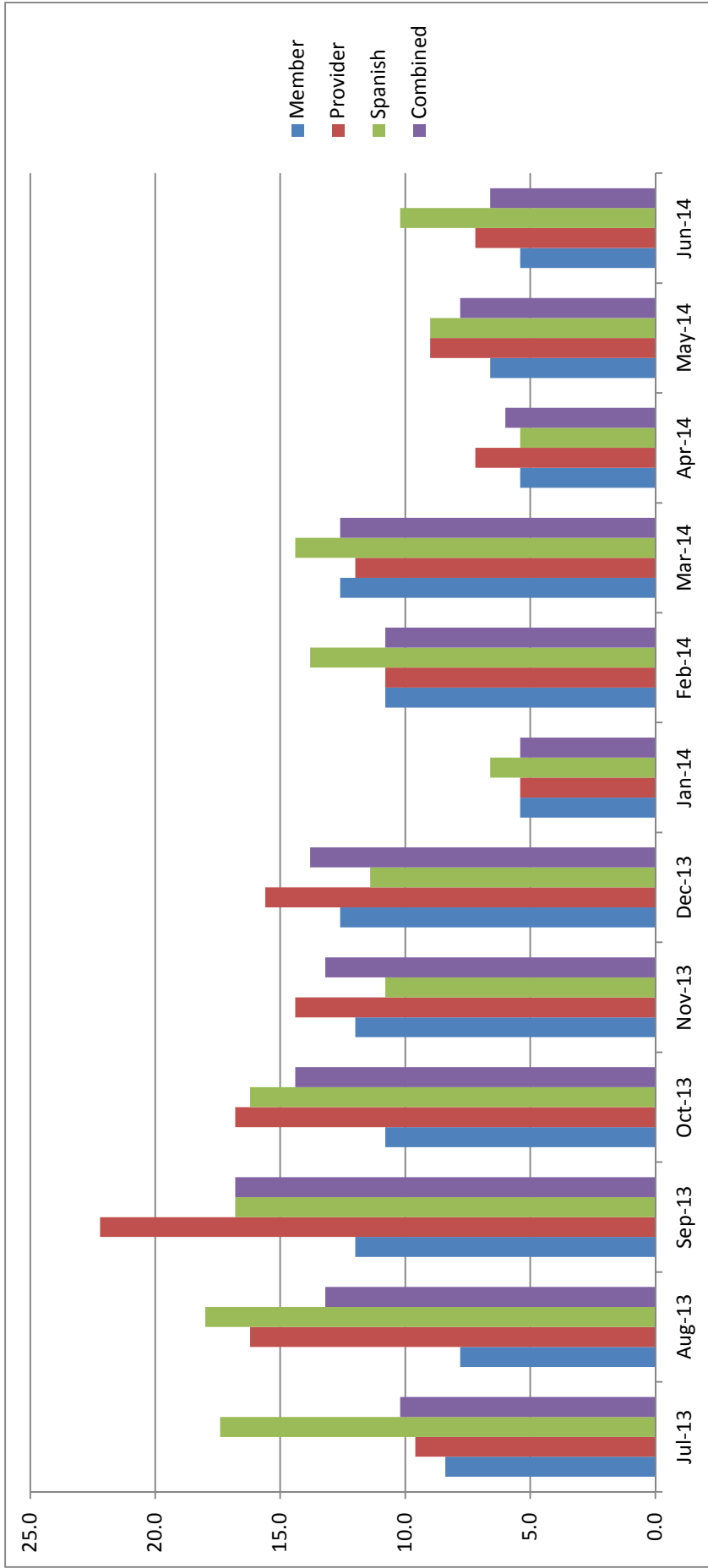
# Xerox Call Center Volume



4b-9

	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Member	2,562	3,639	3,276	3,185	2,439	2,354	4,143	4,339	4,365	4,408	4,354	4,631
Provider	3,596	3,556	3,190	4,155	2,881	2,877	3,491	3,282	3,534	4,430	4,153	4,354
Spanish	748	1,734	1,055	1,082	724	664	986	1,123	1,004	933	897	996
Total	6,906	8,929	7,521	8,422	6,044	5,895	8,620	8,744	8,903	9,771	9,404	9,981

# Xerox Call Center Average Speed to Answer (in seconds)

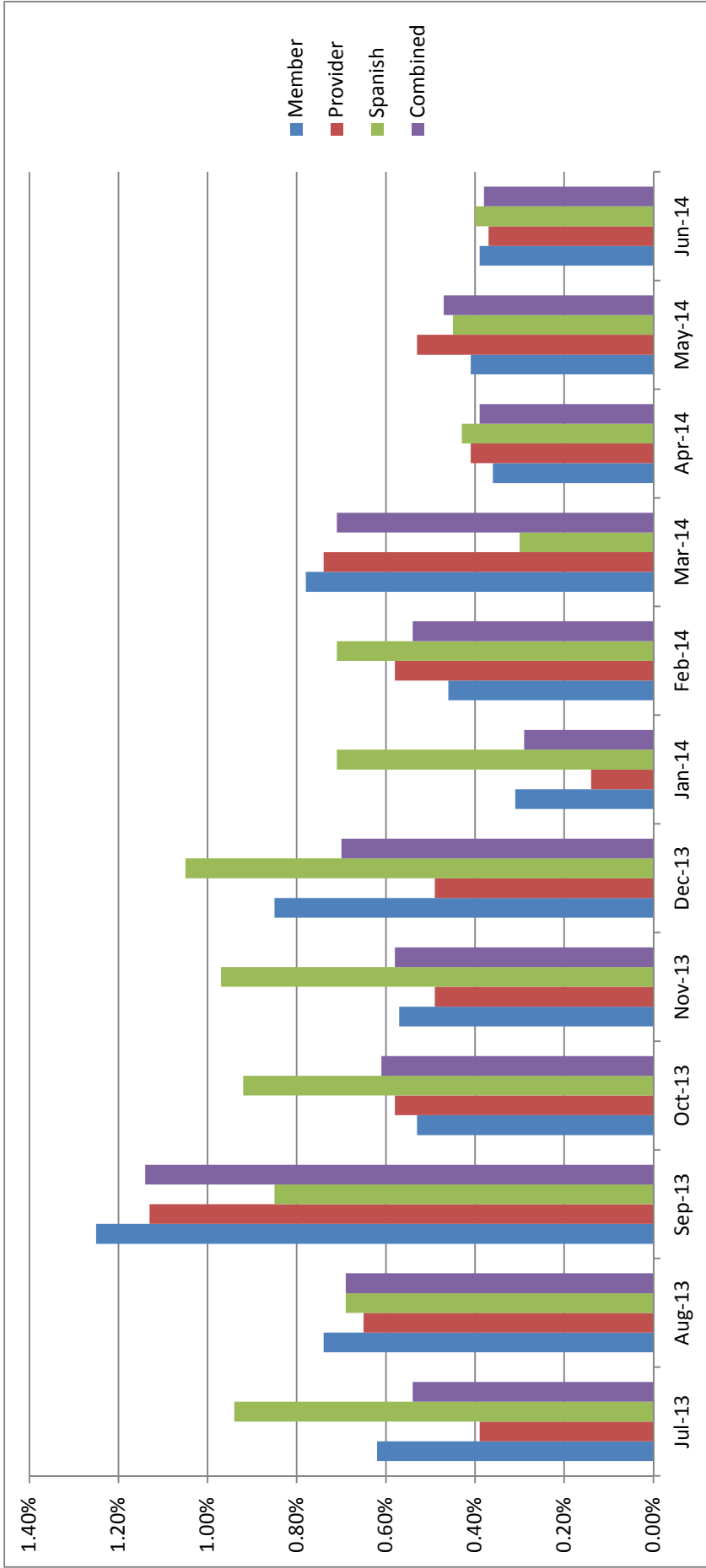


4b-10

	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Member	8.4	7.8	12.0	10.8	12.0	12.6	5.4	10.8	12.6	5.4	6.6	5.4
Provider	9.6	16.2	22.2	16.8	14.4	15.6	5.4	10.8	12.0	7.2	9.0	7.2
Spanish	17.4	18.0	16.8	16.2	10.8	11.4	6.6	13.8	14.4	5.4	9.0	10.2
Combined	10.2	13.2	16.8	14.4	13.2	13.8	5.4	10.8	12.6	6.0	7.8	6.6

**GOAL: 30 seconds or less**

# Xerox Call Center Abandonment Rate

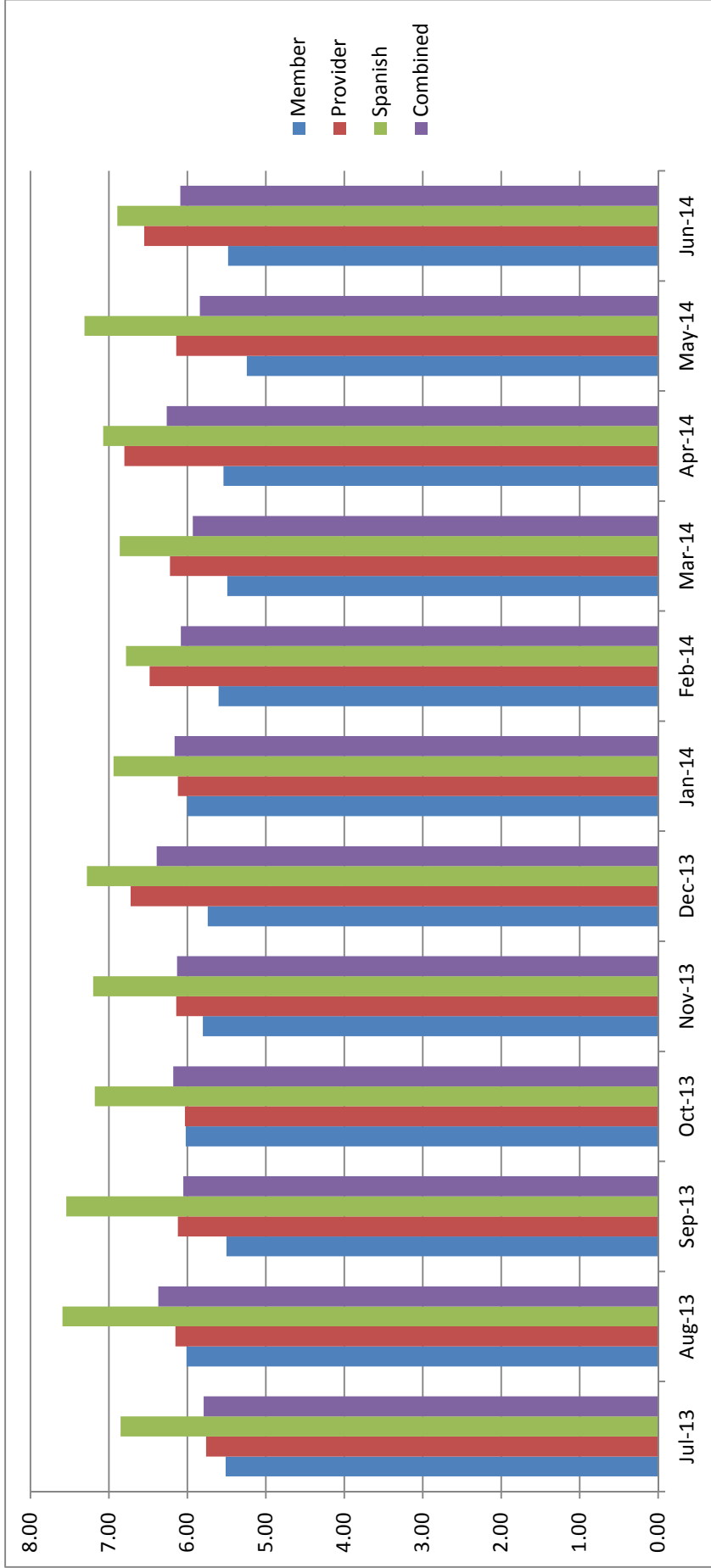


4b-11

	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Member	0.62%	0.74%	1.25%	0.53%	0.57%	0.85%	0.31%	0.46%	0.78%	0.36%	0.41%	0.39%
Provider	0.39%	0.65%	1.13%	0.58%	0.49%	0.49%	0.14%	0.58%	0.74%	0.41%	0.53%	0.37%
Spanish	0.94%	0.69%	0.85%	0.92%	0.97%	1.05%	0.71%	0.71%	0.30%	0.43%	0.45%	0.40%
Combined	0.54%	0.69%	1.14%	0.61%	0.58%	0.70%	0.29%	0.54%	0.71%	0.39%	0.47%	0.38%

**GOAL: 5% or less**

# Xerox Call Center Average Call Length (in minutes)



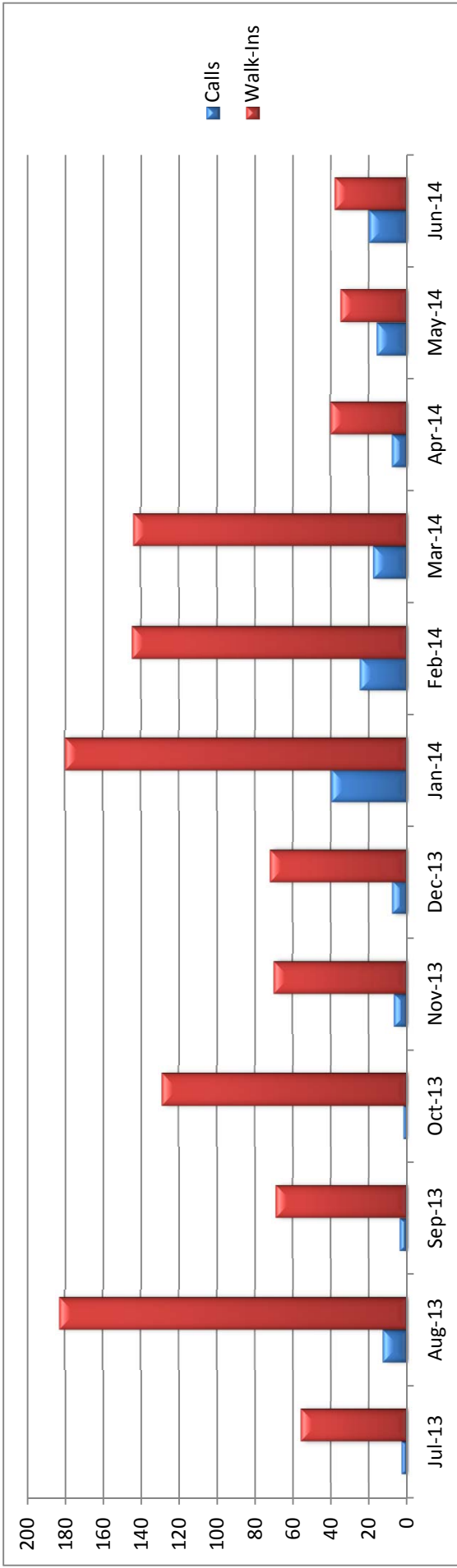
4b-12

	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Member	5.51	6.01	5.50	6.02	5.80	5.74	6.00	5.60	5.49	5.54	5.24	5.48
Provider	5.76	6.15	6.12	6.03	6.14	6.72	6.12	6.48	6.22	6.80	6.14	6.55
Spanish	6.85	7.59	7.54	7.18	7.20	7.28	6.94	6.78	6.86	7.07	7.31	6.89
Combined	5.79	6.37	6.05	6.18	6.13	6.39	6.16	6.08	5.93	6.26	5.84	6.09

**GOAL: 7 minutes or less**



# Oxnard/Camarillo Member Services Activity



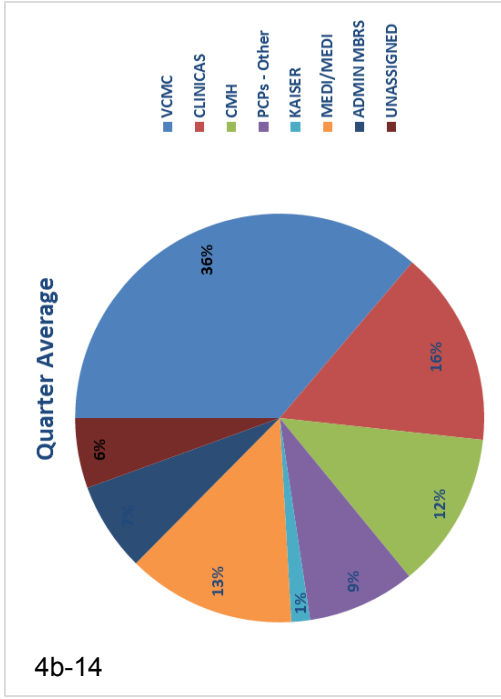
	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Calls	3	13	4	2	7	8	40	25	18	8	16	20
Walk-Ins	56	183	69	129	70	72	180	145	144	40	35	38

Note: August 2013 walk-in increase due to Healthy Families transition; October 2013 increase not directly associated with one issue; January, February and March 2014 increase due to LHP transition and Medi-Cal Expansion.



# PCP / Member Assignment Report

The graphs below consolidate the total number of members assigned by PCP grouping.

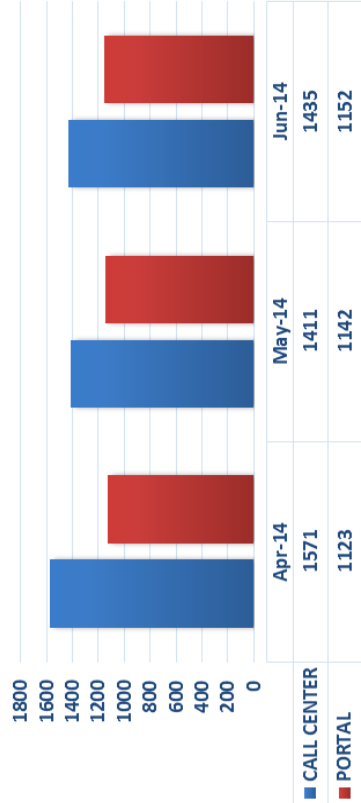


\*UNASSIGNED includes Share of Cost, Newly Eligible and Other Insurance

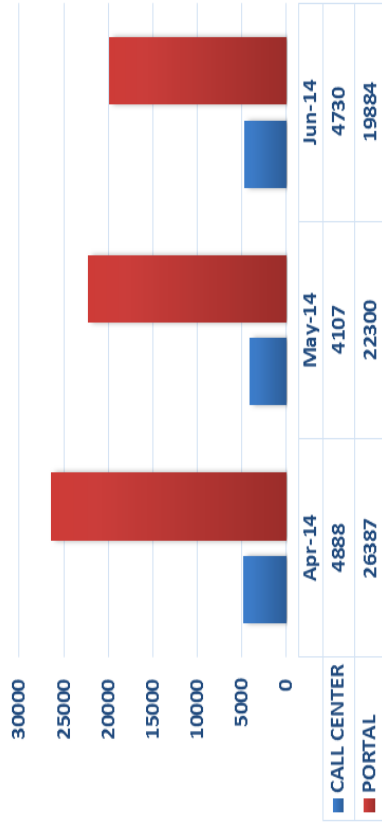


# Provider Portal / Call Center Usage

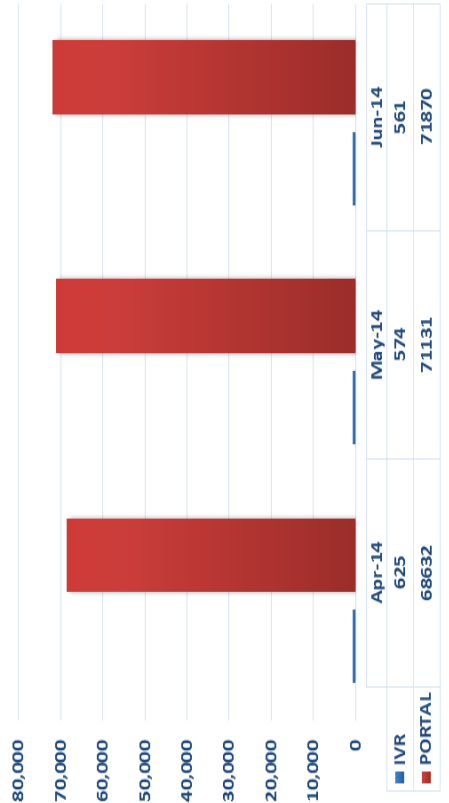
Authorization Request/Inquiries



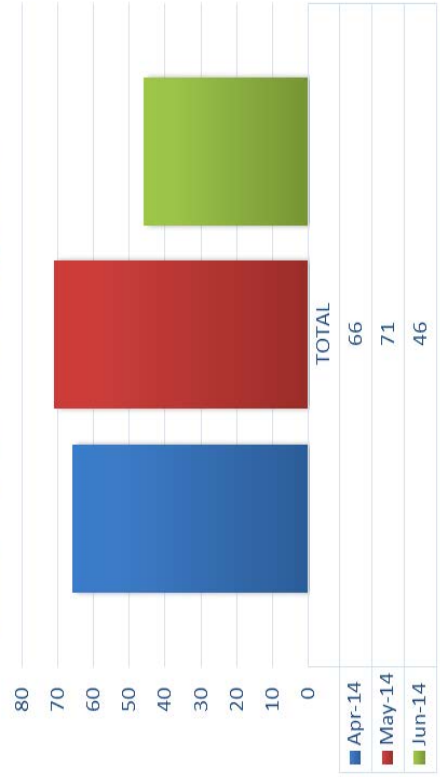
Claim Inquiries



Member Eligibility Inquires



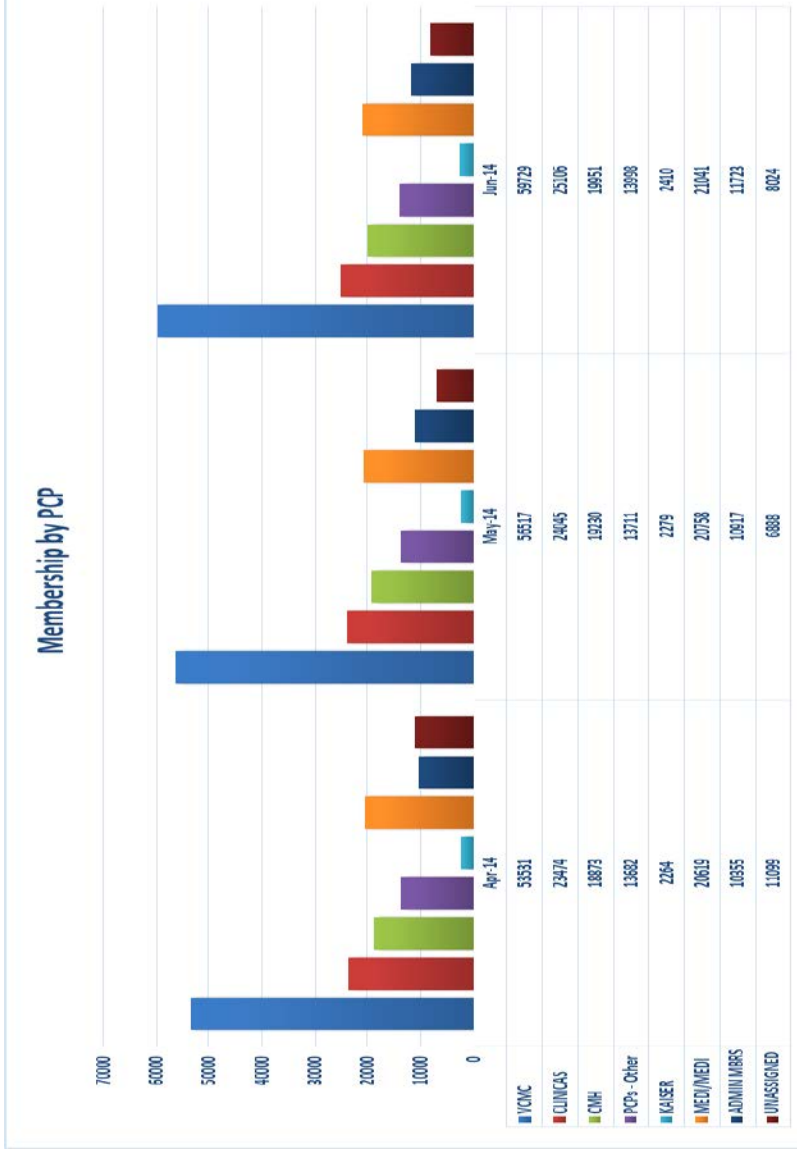
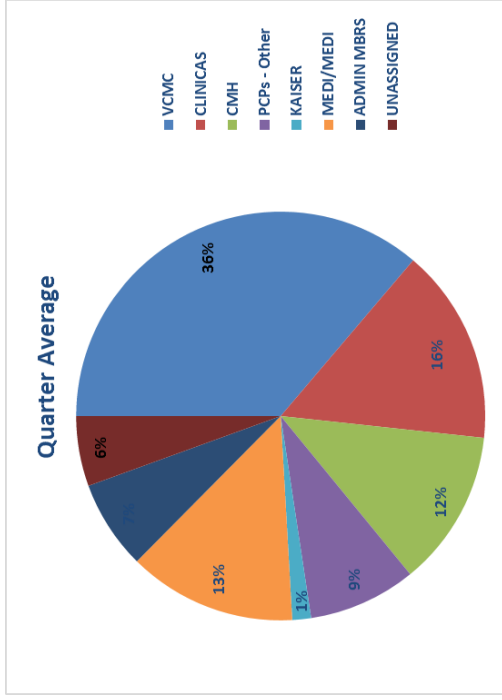
Provider Portal New Registration





# PCP / Member Assignment Report

The graphs below consolidate the total number of members assigned by PCP grouping.

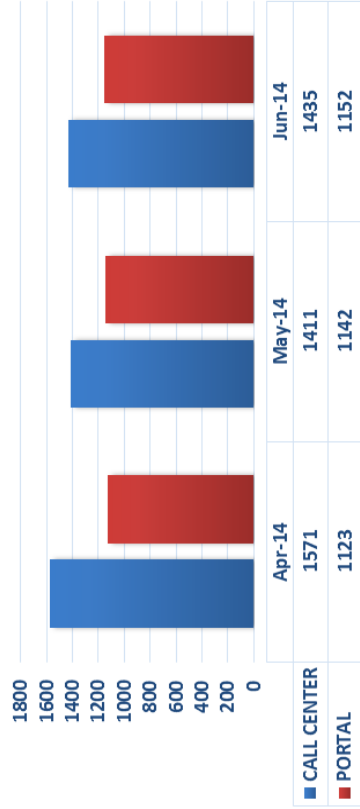


\*UNASSIGNED includes Share of Cost, Newly Eligible and Other Insurance

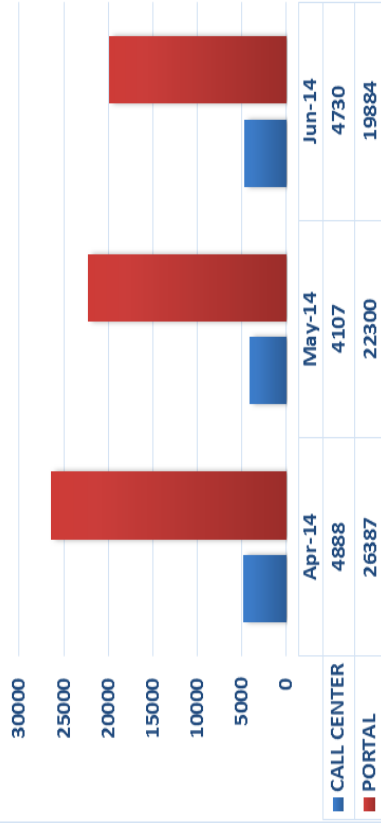


# Provider Portal / Call Center Usage

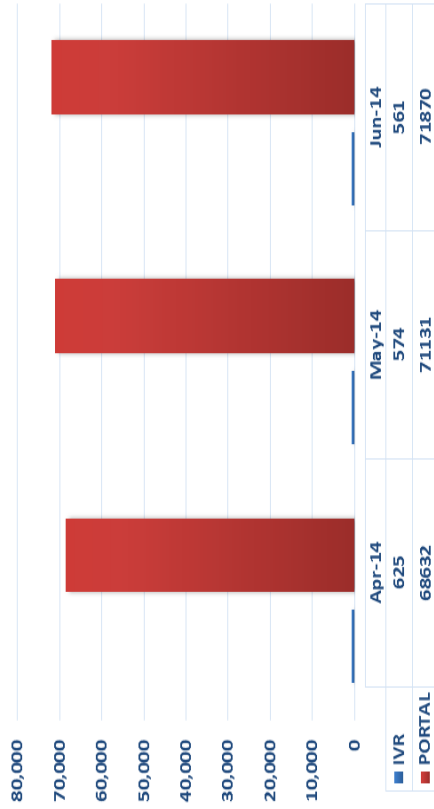
### Authorization Request/Inquiries



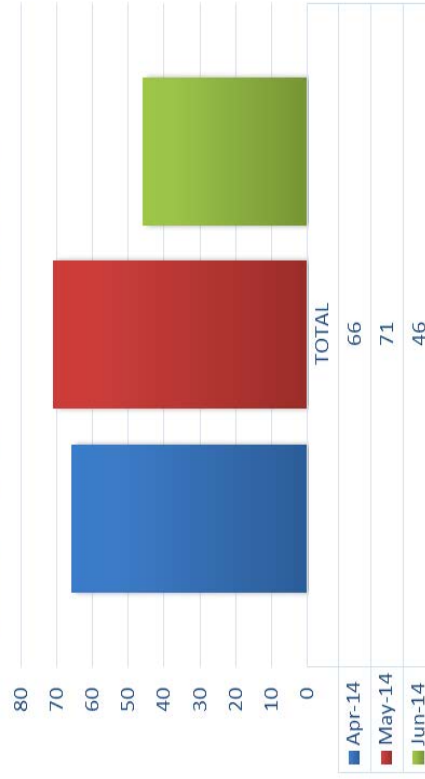
### Claim Inquiries



### Member Eligibility Inquires



### Provider Portal New Registration



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## **AGENDA ITEM 4c**

To: Gold Coast Health Plan Commission Committee

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

Date: July 28, 2014

Re: CMO Update - Quality Improvement Committee Report 2<sup>nd</sup> Quarter 2014

### **SUMMARY**

The Quality Improvement (QI) Committee of Gold Coast Health Plan (GCHP) met on June 24, 2014. The proceedings and reports are as follows.

### **BACKGROUND / DISCUSSION**

#### **A. Approvals**

1. Approved the 2014 Quality Improvement Plan (Included)
2. Approved the 2014 Quality Improvement Work Plan (Included)
3. Approved a new Policy for Potential Quality Issues (PQI's) – this is a process used for the Plan to receive reports of quality issues, evaluate those issues, rate the seriousness of the issue, use the data in the credentialing process and refer serious issues to the Credentials / Peer Review Committee.

#### **B. Old Business**

1. Association for Community Affiliated Plans (ACAP) Substance Abuse Collaborative – ER Initiative – a program to contact Members who are seeking treatment of chronic pain syndromes at emergency departments more than 4 times per month. The Navigator Program has shown a decrease in ER utilization of those Members who have been contacted. This program has received recognition by ACAP and an article was written about the program on the ACAP Website.
2. Behavioral Health Program – There continues to be collaboration between Beacon, County Behavioral Health and GCHP There are regular monthly meetings. Processes have been set up to prevent Members from being lost between the 2 providers of behavioral health.
3. Medical Management Corrective Action Plan (CAP) – The Medical Management CAP was closed out by the Department of Health Care Services (DHCS) on May 8, 2014.

#### **C. New Business**

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – this survey was commissioned by DHCS and was done by Health Services Advisory

Group (HSAG). The survey was done in 2013 on Members enrolled between July and December 2012. The sample size was 1350 adults and 1650 children.

Out of a maximum of five stars, the Adult Survey Results were as follows:

Health Plan: 2 out of 5 stars  
All Health Care: 3 out of 5 stars  
Personal Doctor: 5 out of 5 stars  
Specialist Seen: 5 out of 5 stars  
Getting Needed Care: 3 out of 5 stars  
Getting Care Quickly: 1 out of 5 stars  
How Well Doctors Communicate: 3 out of 5 stars  
Customer Service: 3 out of 5 stars

Out of a maximum of five stars, the Child Survey Results are as follows:

Health Plan: 1 out of 5 stars  
All Health Care: 1 out of 5 stars  
Personal Doctor: 3 out of 5 stars  
Specialist Seen: 2 out of 5 stars  
Getting Needed Care: 1 out of 5 stars  
Getting Care Quickly: 1 out of 5 stars  
How Well Doctors Communicate: 1 out of 5 stars  
Customer Service: 1 out of 5 stars

It was noted that this study was done on Members in the last half of 2012 when the Plan had difficulties. It has also been noted that this report does not allow the Plan to assess differences in providers with regard to access and performance. The Plan has contracted to do another survey in the next few months to give a timely evaluation of member satisfaction and will allow the Plan to assess differences in service by provider groups.

1. Internal Quality Improvement Project – Retinal Eye Exam for diabetics – this was a project to improve Healthcare Effectiveness Data and Information Set (HEDIS) Scores on this HEDIS Measure. The Plan passed the Minimum Performance Level (MPL) for the 2014 HEDIS Survey.
2. Readmission Quality Improvement Project – this is a quality project to identify Members discharged from the hospital with Chronic Obstructive Pulmonary Disease (COPD) and Chronic Heart Failure (CHF). The member is contacted immediately after discharge to inquire if the member received their discharge medications, have a follow-up appointment. The project has identified barriers to the Members getting follow-up appointments. The Plan has worked with VCMC and a discharge follow-up clinic has been instituted for patients who are not able to get appointments with their doctor in the recommended time period.



### 3. Facility Site Review (FSR) / IHA Monitoring –

- Terry Wagemann, RN has received her State certification as a FSR Master Trainer.
- The State had done FSR Reviews and found problems with some facilities. There was a CAP. All items have been corrected and the CAP is closed.
- The Plan is required to do site reviews every 3 years. Since the Plan is just 3 years old most offices needed to have site reviews done before their 3 year anniversary. 69 sites have been reviewed and 2 were still in process.
- Physical Accessibility Review Survey – this is to be done on high volume specialists. GCHP identified 17 high volume specialists. Site reviews are to be done within 12-36 months. So far 12 of the 17 have been done and the provider's sites passed.
- HEDIS 2014 – Healthcare Effectiveness Data and Information Set – the preliminary HEDIS Results for 2014 have been received and approved by HSAG. At the time of the QI Meeting the Plan was waiting for approval from the National Committee for Quality Assurance (NCQA). Subsequently that approval has been received. Of the 29 measures the Plan met the Minimal Performance Level (MPL) on 23 of the 29 measures. We did not meet them for 6 measures. This was an improvement from 2013 when the Plan did not meet the MPL for 10 measures. The QI Dept. has developed an improvement plan for 2015 and has already instituted measures to meet those measures that did not meet the MPL in 2014.

### D. QI Subcommittee Reports

#### 1. Pharmacy and Therapeutics Committee

- Committee reviewed 69 new drugs approved by the FDA 27 were added to the pharmacy formulary because they added an advantage or new treatment over what is currently available
- Stricter Guidelines for Sovaldi were approved. These are consistent with the guidelines recently provided by the DHCS.
- PBM oversight – Anne Freese director of pharmacy identified pharmacy credentialing deficiencies. A Corrective Action Plan was issued to the PBM. The problems were corrected and the CAP was closed.
- Oversight of the PBM's coverage determination process - reviews all denied cases daily and reviews 10% of all approved cases. Jan – April 2014 over 1400 cases were reviewed. Most decisions are appropriate. There are problems with language in the determination letters and Ms. Freese continues to work with the PBM to correct these problems.
- Inter-Rater Reliability (IRR) assessment – the pharmacists make decisions on cases reviewed by another pharmacist to check for consistency in determinations. The score of the 3 pharmacists making decisions by the Script Care Pharmacists is 100%.

- Pharmacy spend – the committee was presented the statistics on total spend, high cost drugs, high cost diagnoses, PMPM costs.
2. Credentials / Peer Review Committee (C / PRC)
    - 2 physicians who are credentialed by the committee have been identified as having action taken by the Medical Board of California. One (1) provider has received a reprimand and was required to receive training. That requirement has been completed and the provider is in good standing. The Medical Board has recommended suspension of the 2<sup>nd</sup> provider's medical license. The provider has the right to a hearing. Until that time the provider has a valid license to practice medicine and the status will be monitored.
    - The committee discussed requiring board certification for new providers. The committee was in favor of this requirement and this will be considered to be added to the credentialing policy.
    - 107 providers were considered by the committee for initial credentialing or recredentialing. All were approved. 2 were approved for a limited time period due to needed completion of educational activities required by the Medical Board for 1 provider, and for the completion of a malpractice case for another provider.
    - Credentialing has been transferred internally from the Provider Relations Department to the Quality Department of Gold Coast Health Plan.
  3. Medical Advisory Committee – MAC received updates on behavioral health, MedHok, SHA/SBIRT surveys, Sovaldi, UM, CAHPS Survey, and the Provider Report Card.
  4. Health Education / Cultural Linguistics Committee (HECLC)
    - The Health Education Department has been providing education to offices for the State Required Staying Healthy Assessment (SHA)
    - There are translation challenges for providers to do the SHA on their Mixteco Members. Health Education is working with providers to make the process easier
    - A Resource Fair is planned for June 28, 2014.
    - The department is working with cultural and linguistic training for newly hired Plan Staff.
    - Tri-County Glad did an employee training on working with the deaf community.
  5. Grievance and Appeals
    - A Grievance and Appeals Department has been established and the manager position has been posted.
    - There will be a process to connect grievance to the Quality Improvement Department.
    - Grievance and appeal numbers for 1<sup>st</sup> quarter 2013 and 2014 (See charts).
    - Grievances per 1000 Members = 0.08.
  6. Network Planning Committee
    - Provider relations representatives are now assigned by areas rather than by clinic.

- Provider Satisfaction Survey – conducted by the Myers Group. Surveyed 216 locations with 750 providers. 153 responses. Loyalty analysis – 72.9% were indifferent, 20.6% loyal, 6.5% defection.
7. Member Services
- Member orientations are being held throughout the county in English and Spanish. Attendance is low and the Plan is looking for ways to increase attendance.
  - Call Center metrics – 1<sup>st</sup> quarter 8600 – 8900 calls per month. The call center met all metrics. Average Speed to Answer – goal is less than 30 sec. – met Abandonment Rate – goal is 5% or less – we are well below that
8. Utilization Management –
- See Attached graphs
  - Denial Rate 1<sup>st</sup> Quarter 2014 = 4%
  - TAR turnaround times – went to 86% with the new membership (should be 90% or better). this has now been corrected and is back above 90%.
  - Inter-Rater Reliability Scores - all physician reviewers passed. All nurses are being tested.

## **RECOMMENDATION**

That the Commission accept the CMO Update which includes the quarterly Quality Improvement Report.

## **CONCURRENCE**

N/A

## **Attachments**

2014 QI Program

2014 QI Work Plan

Grievance & Appeals Graphs

Utilization Management Graphs

# **GOLD COAST HEALTH PLAN 2014 QUALITY IMPROVEMENT PROGRAM**

July 3, 2014 FINAL

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## I. MISSION AND PURPOSE

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

### **Purpose:**

The purpose of the Gold Coast Health Plan (GCHP) Quality Improvement (QI) Program is to achieve high quality and optimal clinical outcomes in all departmental programs reflecting the State mission to preserve and improve the health of all Californians. To accomplish this GCHP’s QI Program aligns its efforts with the current versions of the DHCS Strategy for Quality Improvement in Health Care and the Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) on Site Reviews which include but are not limited to:

- annually report performance measurement results,
- produce improvement plans for poor performance,
- participate in the administration of a consumer satisfaction survey, and
- conduct ongoing quality improvement projects (QIPs).

In addition to these regulatory requirements, GCHP will align its policy and procedure for its QI Program to be consistent with the States adoption of the National Quality Strategy as a foundation. This foundation for a quality strategy is anchored in three linked goals also referred to as the Institute for Healthcare Improvement’s (IHI) Triple Aim, seven priorities and ten principles. They are as follows:

### **The Triple Aim**

1. Better Care—Improve the overall quality, by making health care more patient-centered, accessible, and safe;
2. Healthy People/Healthy Communities—Improve the health of the United States population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care; and
3. Affordable Care—Reduce the cost of quality health care for individuals, families, employers, and government.

### **Seven Priorities**

1. Improve patient safety
2. Deliver effective, efficient, affordable care
3. Engage persons and families in their health
4. Enhance communication and coordination of care
5. Advance prevention
6. Foster healthy communities
7. Eliminate health disparities

### **Ten Principles**

1. Person-centeredness and family engagement, including understanding and valuing patient preferences, will guide all strategies, goals, and health care improvement efforts;
2. Specific health considerations will be addressed for patients of all ages, backgrounds, health needs, care locations, and sources of coverage; Eliminating disparities in care—including but not limited to those based on race, color, national origin, gender, age, disability, language, health literacy, sexual orientation and gender identity, source of payment, socioeconomic status, and geography—will be an integral part of all strategies, goals and health care improvement efforts;
4. Attention will be paid to aligning the efforts of the public and private sectors;

5. Quality improvement will be driven by supporting innovation, evaluating efforts around the country, rapid-cycle learning, and disseminating evidence about what works;
6. Consistent national standards will be promoted, while maintaining support for local, community, and state-level activities that are responsive to local circumstances;
7. Primary care will become a bigger focus, with special attention towards the challenges faced by vulnerable populations, including children, older adults, and those with multiple health conditions;
8. Coordination among primary care, behavioral health, other specialty clinicians and health systems will be enhanced to ensure that these systems treat the ~~w~~whole person;”
9. Integration of care delivery with community and public health planning will be promoted; and
10. Providing patients, providers, and payers with the clear information they need to make choices that are right for them, will be encouraged.

**Accountability:**

The Ventura County Medi-Cal Managed Care Commission (VCMCMCC) will promote, support, and have ultimate accountability, authority, and responsibility for a comprehensive and integrated Quality Improvement (QI) Program. The VCMCMCC is ultimately accountable for the quality of care and services provided to Members but will delegate supervision, coordination, and operation of the program to the Chief Executive Officer and Quality Improvement Department under the supervision of the Chief Medical Officer and its QI Committee. The Board will approve the overall QI Plan, Work Plan and QI annual report; the CMO will be responsible for the day-to-day oversight of the QI Program. The Board will receive operational information through reports from the CMO and/or the Health Services Department in conjunction with the operations of its various Committees as described below.

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

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

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

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

**II. SCOPE, GOALS & OBJECTIVES**

The scope of the Quality Improvement Program will include the non-discriminatory quality and

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

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

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

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

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

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

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

4. A QI focus which represents

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

The goal of the QIP is to develop and implement systematic methodologies to monitor and evaluate processes using data to drive decisions and rapid cycle improvement to resolve identified problem. GCHP's Quality Improvement Committee oversees the monitors established by GCHP's committees. Each QI subcommittee tracks its performance indicators a continuous focus on



the Plan's operational and clinical priorities for improvement and reports out to the QIC. This constitutes the QI Work Plan which is a separate document.

The QI Program encompasses the following goals and objectives but is not limited to them.

- Analyzing sufficient amounts of data needed for statistical significance in order to reliably identify opportunities for improvement that are high risk, high volume, high cost, and/or problem prone and consistent with the State quality strategy listed in the seven priorities.
- Measuring and reporting indicators addressing clinical diagnosis or disease categories after identification for the purpose of quality assurance and/or improvement
- Prioritize indicator selection based on incidence and prevalence of disease or condition utilizing high risk and problem prone triggers and also considering data stratification such as setting, pharmaceuticals, member aid code, member age, provider, clinic, etc., to target intervention efforts.
- Completion of External Accountable Set Performance Measures such as HEDIS, HEDIS audits, reporting and follow-up.
- Compliance with Regulatory Minimum Performance Standards and/or analysis of barriers and targeted interventions, as needed
- Monitoring and acting on under/over utilization of services including but not limited to: *Frequency of Selected Procedures; Inpatient Utilization: General Hospital/Acute Care* – including utilization of acute inpatient services in various categories; and *Ambulatory Care - including Outpatient Visits and Emergency Department Visits sub measures.*
- Participation and reporting of the DHCS administered Consumer Assessment of Healthcare Providers and Systems (CAHPS®)2 surveys to assess member satisfaction with MCPs and additional customized survey questions, if any to assess specific problems and/or special populations. This survey is currently conducted every 2 years.
- Participating in the DHCS-led statewide collaborative (SWC) Quality Improvement Project and conduct an internal QIP consistent with Title 42, Code of Federal Regulations, Section 438.240(b) (1), requires that QIPs be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.”
- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Reporting and analyzing complaint/grievance data as well as other surveys or data
- Facility Site Review surveys to assess compliance with patient safety standards, medical record review standards and accessibility
- Promoting Preventative Care Guideline (PCG) compliance for chronic and acute care
- Report of physician credentialing
- Report of Provider Network Services, analysis of gaps and interventions to close gaps
- Promotion of Practices Guidelines integration with community standards
- Reporting Utilization Management including trend analysis (See UM Plan)
- Health Education Programs and Results
- Cultural and Linguistics Programs
- Reporting of Pharmacy utilization data, particularly for the identification of quality improvement efforts

- Reporting of access and availability data and Initial Health Assessment (IHA)/Staying Healthy Assessment (SHA) monitoring
- Reporting of Delegation Oversight activities which may include specialty contracts, vendor contracts, pharmacy benefit management, etc.,
- Conducting bi-directional communication as needed with all QI Committee subcommittees and with Medical, Provider, Consumer and the Board of Commissioners to report findings, activities and outcomes and act on recommendations.
- Request approval for QI Plan and QI Work Plan including goals and objective from the Board of Commissioners annually.
- Provide quarterly progress reports to the Board of Commissioners that include but are not limited to: actions taken including requests, progress in meeting goals and objective and improvements made.
- Comply with all regulatory requirements.

### **III. VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (VCMCC) AS GOVERNING BODY: INTERNAL DELEGATION OF QUALITY ACTIVITIES**

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

#### *Membership*

GCHP is governed by an eleven (11) member Ventura County Medi-Cal Managed Care Commission (VCMCC). Commission members are appointed for two or four year terms, and member terms are staggered.

Members of the VCMCC are appointed by a majority vote of the Board of Supervisors and consist of the following:

- Three members shall be practicing physicians who serve a significant number of Medi-Cal beneficiaries in Ventura County. One shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Association, one shall be selected from a list with a minimum of three (3) nominees submitted by Clinicas Del Camino Real and one shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center Executive Committee; (Physician Representatives)
- Two members shall be representatives of private hospitals and healthcare systems operating within Ventura County and shall be selected from a list with a minimum of three (3) nominees submitted by the Hospital Association of Southern California. Nominees shall be from different hospitals and healthcare systems. The two appointed members shall not be affiliated with the same hospital or healthcare system; (Private Hospital/Healthcare System Representatives)

- One member shall be a representative of the Ventura County Medical Center Health System and shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center administration; (Ventura County Medical Center Health System Representative)
- One member shall be a member of the Board of Supervisors, nominated and selected by the Board; (Public Representative)
- One member shall be the chief executive officer of Clinicas del Camino Real or designee nominated by the Clinicas del Camino Real chief executive officer and approved by the Ventura County Board of Supervisors; (Clinicas Del Camino Real Representative)
- One member shall be the Ventura County Health Care Agency Director or designee nominated by the Health Care Agency Director and approved by the Board of Supervisors; (County Official)
- One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is not otherwise represented on the Ventura County Medi-Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position; (Consumer Representative)
- One member shall be the Ventura County Medical Center Family Medicine Residency Program Director or Faculty Designee and approved by the Board of Supervisors. (Ventura County Medical Center Health System Representative)

There are two Committees which report to the VCMMCC. These committees are the:

- Provider Advisory Committee
- Consumer Advisory Committee

Information discussed in these two committees which is relevant to the delivery of quality service health care to plan members, is communicated to the appropriate Plan committee for discussions and action. The committees' function and membership are described below.

### **Consumer Advisory Committee (CAC)**

*Purpose:*

The CAC provides member and community input to GCHP's policies and operations. The CAC reviews and comments on GCHP proposed policies and actions that may affect plan members.

*Function:*

- Provide input for service enhancements upon review of trends of member dissatisfaction

- Review and provide input regarding Member Rights and Responsibilities, member communication and educational materials.
- Review and provide feedback on the cultural appropriateness of material for limited English proficient (LEP) members.
- Make recommendations regarding possible changes to enhance the member experience with GCHP.

*Membership:*

The Member Services Manager is responsible for membership recruitment, retention and coordination of meetings and agendas. The Chief Operating Officer serves as the Chairman and is a non-voting member of the Committee. Membership consists of eleven (11) individuals who represent community and consumer interests including a GCHP beneficiary. Members may not directly earn their income from the provision of medical services. Each of the appointed members serves a one or two-year term. Individuals may apply for re- appointment if desired, as there are no term limits.

The eleven (11) voting members represent various constituencies who serve or are part of the Medi-Cal population

Committee members may include representation from the following:

- County Health Care Agency
- County Human Services Agency
- Children Welfare Services Agency
- Members with Chronic Medical Conditions
- Members with Disabilities/Special needs Members
- Seniors
- Other Medi-Cal beneficiaries

*Meeting Frequency:*

The committee meets quarterly at a minimum.

**Provider Advisory Committee**

*Purpose:*

The Provider Advisory Committee (PAC) is a venue for providers to give input on GCHP's policies and operations.

*Function:*

The roll of the PAC is to consider and analyze situations of concern and bring its recommendations to the Commission for its consideration.

Feedback from the PAC is relayed to the appropriate GCHP committee or department for any necessary action.

*Membership:*

Membership is comprised of five or more physician or non-physician members as well as a maximum of two pharmacists representing the contracted provider community for GCHP's programs. In addition, non-voting members consist of the Manager of Provider Network, who serves as the Chair person and other GCHP staff relevant to the discussion of issues of concern

*Meeting Frequency:*

The committee meets at a minimum on a quarterly basis.

## **V. QUALITY COMMITTEES**

### **1. Quality Improvement Committee (QIC)**

*QIC Charter*

The QIC is the principal organizational unit that will have delegated authority to monitor, evaluate and report to the Ventura County Medi-Cal Managed Care Commission on all component elements of the GCHP's Quality Improvement System outlined in this Plan. The Committee shall have a minimum of 8 voting members and be chaired by the by the GCHP Chief Medical Officer (CMO) and facilitated by the Director, Quality Improvement. Membership will consist of the chairs of the 8 QI Subcommittee and at least 2 Commissioners of which at least 1 will be a practicing physician in the community. The Committee shall meet at least quarterly. Ad hoc committees, however, will meet on an as-needed basis. The Committee will critically examine and make recommendations on all quality functions of GHCP described in this policy and by California and Federal regulatory authorities as appropriate.

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

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

- A. Quality improvement activities such as:
  - i. Utilization Reports
  - ii. Review of the quality of services rendered
  - iii. HEDIS results
  - iv. Quality Improvement Projects – status and/or results
  - v. Satisfaction Survey Results
  - vi. Collaborative initiatives – status and/or results
- B. Success in improving patient care, and outcomes, and provider performance.
- C. Opportunities for improvement.
- D. Overall effectiveness of quality monitoring and review activities or specific areas that require remedial action as indicated in the annual report issued by the state’s EQRO.
- E. Effectiveness in performing quality management functions and achieving goals and objectives through quality monitoring programs will be measured and reported.
- F. Presentation of the QI Plan including recommendations for revision identified as a result of the Review.

*QIC Objectives*

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

*QIC Responsibilities:*

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

*QIC Membership:*

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

*QIC Reporting Structure:*

The QIC reports to the Ventura County Medi-Cal Managed Care Commission. The Chair of the QIC ensures that quarterly reports are submitted to the VCCMMC.

*Meeting frequency:*

The QIC meets at a minimum quarterly.

## **2. Medical Advisory Committee (MAC)**

*Purpose:*

The purpose of the MAC is to:

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

*Function:*

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

- Clinical Care Guidelines
- Preventive Care Guidelines
- Provider Grievance Process
- Provider Satisfaction Issues
- Provider Materials
- Quality Improvement activities
- Provider Access standards
- Provider contracting issues
- Clinical Service Delivery
- Utilization Data
- HEDIS measures

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

*Membership:*

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

*Meeting Frequency*

The committee meets at a minimum on a quarterly basis.

### **3. Member Services Committee (MSC)**

*MSC Charter*

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

*MSC Objectives*

Ensure GCHP members have an understanding of their health care system and know how to obtain care and services when they need them.

- Ensure GCHP members will have their concerns resolved quickly and



effectively and have the right to voice complaints or concerns without fear of discrimination.

- Ensure GCHP members can trust that the confidentiality of their information will be respected and maintained.
- Ensure members have access to information on languages spoken in physician offices to better aid them in the selection of a primary care physician.
- Have access to appropriate language interpreter services at no charge when receiving medical care
- Ensure GCHP members can reach the Member Services Department quickly and be confident in the information they receive.
- Utilize the CAHP survey to identify service indicators for improvement.
- Ensure GCHP's Member Rights and Responsibilities policy is distributed to members and providers.
- Ensure that GCHP's member materials are developed in a culturally appropriate format.
- Interface with other GCHP committees to improve service delivery to members.

#### *MSC Membership*

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

*Meeting Frequency:*

The MSC meets quarterly at a minimum.

#### **4. Grievance and Appeals Committee**

*G&A Charter*

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

*G&A Objectives*

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

*G&A committee Membership*

- Medical Director, Health Services (Chair)
- Manager of Grievance and Appeals
- Grievance and Appeals Coordinator
- Manager of Member Services or Designee
- Quality Improvement Director or Designee
- Director of Health Services or Designee
- Compliance Specialist

*Meeting Frequency:*

The Committee meets quarterly.

#### **5. Network Planning Committee (NPC)**

*NPC Charter:*

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

*NPC Objectives:*

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

- Ensure that provider network meets DHCS standards and that there is adequate capacity to meet member needs.

*NPC Membership:*

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

*Meeting Frequency:*

The committee meets at a minimum quarterly

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

*Committee Charter:*

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

*UM/CM Responsibilities*

Responsibilities include but are not limited to the following:

- Annual Review and approval of the UM and CM Program Documents
- Review and approval of program documents addressing the needs of special populations. This includes but may not be limited to Children with Special Health Care Needs (CSHCN) and Seniors and Persons with Disabilities (SPD)

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

*Membership:*

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

- Chief Medical Officer

*Meeting Frequency:*

The UM/CM Committee meets quarterly at a minimum.

## **7. HEALTH EDUCATION/CULTURAL LINGUISTICS COMMITTEE (HE/CL)**

*Purpose:*

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

*Functions:*

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

*Membership:*

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

*Meeting Frequency:*

The committee meets at a minimum quarterly

**8. Credentials Committee (CC)**

*Purpose:*

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

*Functions:*

*Credentialing Responsibilities:*

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

*Peer Review Responsibilities:*

- Review results of provider profiling when available and suggest

methods to feed information back to network providers

- Review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns and determine corrective action when necessary.

*Membership:*

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

*Meeting Frequency:*

The committee meets quarterly.

## **9. Pharmacy & Therapeutics (P&T) Committee**

*Purpose:*

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

*Function:*

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



- Any other issues related to pharmacy quality and usage.

*Membership:*

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

*Meeting Frequency:*

The committee meets quarterly.

#### **IV. RESOURCES DEDICATED TO QUALITY IMPROVEMENT**

##### **CHIEF MEDICAL OFFICER**

*Responsibilities:*

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

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

*Reporting Responsibility:*

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

##### **DIRECTOR OF QUALITY IMPROVEMENT**

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

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

Specific roles and responsibilities include but are not limited to:

- Ensuring that the annual Quality Improvement plan and work plan are created and reviewed by all appropriate areas
- Working with all appropriate departments in the creation of the annual QI review and analysis of results
- Ensuring QIC approval of all QI document annually
- Guiding the collection of HEDIS data as mandated by contractual requirement and assisting in the development of activities to improve care
- Ensuring that appropriate principles of data collection and analysis are used by all departments when looking for improvement opportunities
- Providing educational opportunities for QI staff and other staff members key to improving care and service to better target improvement initiative

#### QUALITY IMPROVEMENT STAFF

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

Responsibilities include but are not limited to the following:

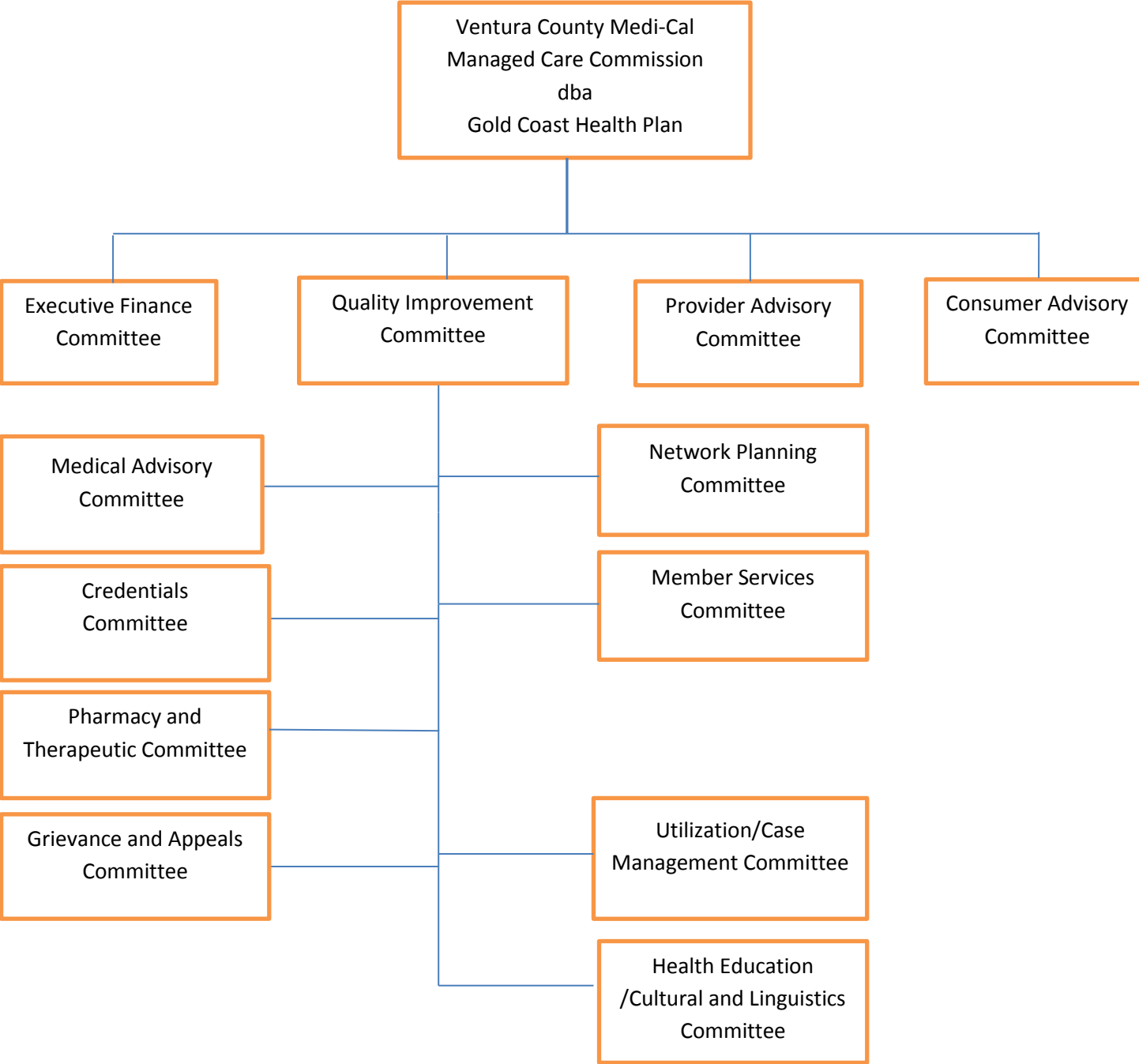
- Assist in creating the annual QI Plan document
- Assist in coordination of HEDIS data collection and analysis of results
- Work with other departments to gather information for the annual QI Review
- Assist in developing activities for the annual QI work plan
- Assist the QI Director as required

#### OTHER QI RESOURCES

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

# GOLD COAST HEALTH PLAN COMMITTEE ORGANIZATIONAL CHART

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



## **X. QUALITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2014**

**Tuesday, February 25, 2014**

**Tuesday, June 24, 2014**

**Tuesday, September 23, 2014**

**Tuesday, December 16, 2014**

**Location – TBD**

### **AVAILABILITY OF QIP TO PRACTITIONERS AND MEMBERS**

The QIP is available on GCHP's website at [www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org). Printed copies are available upon request.

### **REFERENCES**

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

### **UTILIZATION MANAGEMENT AND CARE MANAGEMENT PROGRAM DESCRIPTION IN A SEPARATE DOCUMENT**

**The Quality Improvement Plan was approved by the Quality Improvement Committee on 6/24/2014.**



**2014 Quality Improvement Work Plan**

**The Quality Improvement Department is responsible for the monitoring and enhancement of quality improvement processes to ensure the delivery of quality customer service and access to high quality medical services for GCHP members.**

**Objective #1: HEDIS**

*GCHP must comply with the DHCS requirements for reporting performance measurement results.*

Process/ Objectives	Key Tasks	TIMELINE		Lead Staff	Monitoring/Status of Milestones and Evaluation
		Start	End		
1. HEDIS – Healthcare Effectiveness Data and Information Set.  External Accountability Set (EAS) is a DHCS requirement. HEDIS complies with the EAS requirement. HEDIS measures which must adhere to the most current HEDIS reporting year specifications and to DHCS specified timelines based on “All Facility Letter”.	2013 Data for 2014 Measures	02/14	05/14		The HEDIS 2014 Reporting for 2013 data was submitted on 6/13/14.
	1. Edit and submit HEDIS Roadmap.	11/13	01/14		
	2. Submit test run	11/14	12/14		
	3. Submit production run	11/14	01/14		
	4. Record Retrieval	02/14	03/14		
	5. Record Abstraction	03/14	05/14		
	6. Admin Refresh	02/14	04/14		
	7. HEDIS HSAG Audit	03/14	-----		
	8. HEDIS Submission	05/14	06/14		
9. Summer Run	06/14	07/14			

**Objective #2: Satisfaction Surveys**

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

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
<p>1. <i>Consumer Satisfaction Survey (State Requirement)</i></p> <p>The EQRO – External Quality Review Organization (HSAG) is responsible for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey biennially in compliance with NCQA and AHRQ requirements. The CAHPS® surveys a sample of Medi-Cal managed care members in English and Spanish and covers services provided to adults and children.</p>	<p>First CAHPS Audit will be 2015 for 2014 data.</p> <p>Educate providers</p>	<p>Jan 2014</p>	<p>2014</p>		
<p>2. Provider Satisfaction Surveys</p> <p>GCHP will assume responsibility to conduct and for the monitoring, oversight and reporting the required mechanisms to assure provider satisfaction.</p>	<p>Must ensure that information and documentation provided by GCHP is reviewed at appropriate levels: must demonstrate this review and discussion of information in committee with any applicable interventions.</p>	<p>Jan 2014</p>			
<p>3. Access to Care Survey</p>	<p>Discuss survey at QIC and document</p>	<p>Jan 2014</p>			

**Objective #3 – QIP’s**

**Quality Improvement Projects - Plans are required to conduct ongoing quality improvement projects (QIPs).**

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
<p><i>1a Quality and Performance Improvement Program Requirements for 2012 External Statewide QIP</i></p>	<p>External Statewide QIP – Hospital Readmissions</p> <ul style="list-style-type: none"> <li>• Participate in ongoing statewide organized meetings.</li> <li>• Document “all” steps in the process</li> <li>• Submitted baseline historical data to HSAG</li> <li>• Submitted barrier analysis and interventions to HSAG 1/31/2012 and 09/30/2013.</li> <li>• Submit analysis of intervention</li> </ul>	<p>Jan 2014</p>	<p>Sept 2014</p>		
<p><i>1b Internal QIP</i></p>	<ul style="list-style-type: none"> <li>• Internal QIP – Increase Retinal eye exams for diabetic patients</li> <li>• Submitted internal QIP to DHCS for approval on 7/31/2013 and 09/30/2013.</li> </ul>	<p>Jan 2014</p>	<p>Sept 2014</p>		<p>HEDIS MPL met for diabetic retinal eye exam 6/13/14.</p>



**Objective #4: UM Monitoring**

*Plans are required to report utilization data for selected HEDIS® Use of Services measures through the contracted EQRO. DHCS medical and nurse consultants facilitate discussions of utilization data monitoring results at the quarterly Medical Directors meetings.*

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
UM Monitoring Over Utilization Under Utilization Appropriate Utilization	Utilization measures reported quarterly with monthly data points to UM Committee, QIC and Commission report card indicators reported bi-annually to UM Committee, QIC and Clinic Directors	Jan 2014	Dec 2014		

**Objective #5: Committees**

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

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
1. Quality Improvement Committee Develop, implement quality Program Plan outlining structure, scope, criteria, and processes of all QI functions	<ul style="list-style-type: none"> <li>• QI Plan Approval</li> <li>• QI Plan Approval</li> <li>• QI Annual P&amp;P Review</li> <li>• QI Plan Review</li> <li>• QI Work Plan Review</li> <li>• QI Plan Assessment</li> </ul>	Jan 2014  October 2014  October 2014 December 2014	June 2014		The Quality Improvement Plan and the Quality Improvement Work Plan were approved at the Quality Improvement Committee on 6/24/14.

<p>2. Member Services Committee</p>	<ul style="list-style-type: none"> <li>• Committee Meetings</li> <li>• Action Plans</li> <li>• Call Center Measures</li> <li>• Annual Review</li> </ul>	<p>Jan 2014</p>	<p>Dec 2014</p>		
<p>3. Network Management Committee</p>	<ul style="list-style-type: none"> <li>• Committee Meetings</li> <li>• Action Plans</li> <li>• Annual Review</li> </ul>	<p>Jan 2014</p>	<p>Dec 2014</p>		
<p>4. Grievances &amp; Appeals Committee</p>	<ul style="list-style-type: none"> <li>• Committee Meetings</li> <li>• Action Plans</li> <li>• G&amp;A Measures</li> <li>• Annual Review</li> </ul>	<p>Jan 2014</p>	<p>Dec 2014</p>		
<p>5. Health Education/Cultural Linguistics Committee</p>	<ul style="list-style-type: none"> <li>• Committee Meetings</li> <li>• Action Plans</li> <li>• ED Navigator Program Review</li> <li>• Annual Review</li> </ul>	<p>Jan 2014</p>	<p>Dec 2014</p>		
<p>6. Medical Advisory Committee (MAC)</p>	<ul style="list-style-type: none"> <li>• Committee Meetings</li> <li>• Action Plans</li> <li>• Annual Review</li> </ul>	<p>Jan 2014</p>	<p>Dec 2014</p>		
<p>7. Pharmacy &amp; Therapeutic Committee (P&amp;T)</p>	<ul style="list-style-type: none"> <li>• Review of New Drugs</li> <li>• Annual Formulary Review</li> <li>• PBM Oversight</li> <li>• Review of Policies Affecting Access to Prescription Drugs</li> </ul>	<p>Jan 2014</p>	<p>Dec 2014</p>		

8. Credentials/Peer Review Committee	<ul style="list-style-type: none"> <li>• Committee Meetings</li> <li>• Actions Plans</li> <li>• Annual Review</li> </ul>	Jan 2014	Dec 2014		
9. UM Committee	<ul style="list-style-type: none"> <li>• Committee Meetings</li> <li>• Actions Plans</li> <li>• Annual Review</li> </ul>	Jan 2014	Dec 2014		

**Objective #6: Facility Site Reviews**

***GCHP must conduct site reviews on all primary care provider sites.***

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
Facility Site Reviews (FSR) <b>Site Review Reports</b> <ul style="list-style-type: none"> <li>• Plan nurse reviewers conduct the initial and tri-annual full scope reviews. Plan reviewers use the DHCS Full Scope Site Review Survey and Medical Record Review Survey forms to ensure that all contracting plans and subcontracting entities use DHCS survey standards, review criteria and scoring methodology.</li> </ul>	<ul style="list-style-type: none"> <li>• Submit 2014 bi-annual report to DHCS</li> <li>• Submit 2014 bi-annual report to DHCS</li> <li>• Develop procedures for entering data into FSR database and submission of data to DHCS</li> <li>• Certify FSR Nurse as Master Trainer</li> </ul>	Jan 2014	Dec 2014		

<p>PARS – Physical Accessibility Site Reviews</p>	<ul style="list-style-type: none"> <li>• P&amp;P written for PARS</li> <li>• Specialist Provider Volume Annual Review due 1/31/2014</li> </ul>	<p>Jan 2014</p>	<p>Dec 2014</p>		
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**Objective #7: Quality Measurement and Improvement**

*GCHP is required to have an ongoing program for quality assessment and performance improvement of the services provided to enrollees. Quality measurement and improvement standards include clinical practice guidelines, quality assessment and performance improvement program and health information systems.*

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures/ Status Milestones
		Start	End		
<p>Clinical Practice Guidelines</p>	<p>Approve at MAC. Disseminate Guidelines to Providers</p>	<p>Jan 2014</p>	<p>Dec 2014</p>		<p>Newly adopted Clinical Practice Guidelines are announced in the Provider Newsletter and/or on the Provider Update page of the website.</p>

<p>Disease Management Program</p> <p>Selection of Chronic Disease states pertinent to its membership.</p>	<p>Identify chronic disease for GCHP population disease management.</p>	<p>Jan 2014</p>	<p>Dec 2014</p>	<p>The two major disease categories identified for 2014 and approved at the February QIC meeting are Diabetes and Asthma</p>
<p>Member/Provider Communication Plan</p>	<p>Develop materials and mechanism to communicate to Providers and Members</p> <p>Use Website</p>	<p>Jan 2014</p>	<p>Dec 2014</p>	<p>Members and providers receive a newsletter 3 times per year. The newsletters are posted on the website.</p>

The Quality Improvement Work Plan was approved at the Quality Improvement Committee Meeting on 6/24/2014.

Gold Coast Health Plan  
1st Quarter 2014 Grievance Log and Quarterly Grievance Report

**Total Issue Types of Grievances Received**

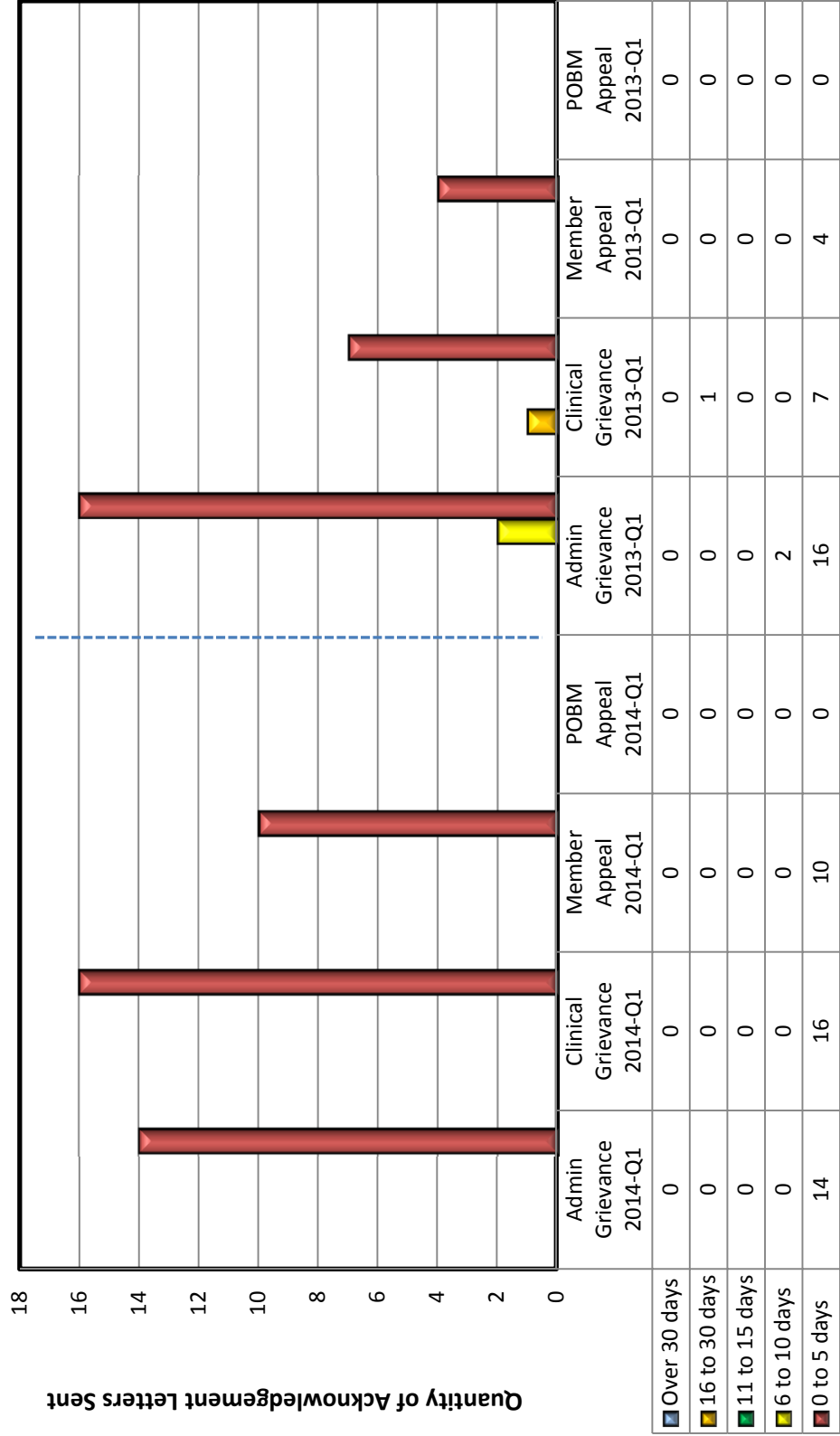
**Issue Types of Grievances**

Quarter	Year	Product	Types of Grievances	Count
1	2014	Medi-Cal	Access to Care - PCP	
			Access to Care - Specialitst	5
			Appearance of office	
			Appointment Availability	
			Claim Issue	
			DME	2
			Eligibility Issues	2
			Infection Control	
			Long Wait Time	3
			Member hasn't received ID cards	
			Out-of-Network Related	
			Patient Death	
			PCP Change	
			PCP Rude, Staff Rude	7
			Pharmacy Issues	
			Physical Accessibility Related	
			Poor Customer Service	2
			Provider Issues	
			Quality of Care Issue	9
			Readmission	
			Transportation	
			UM Process (appeals)	10
			Wrong Diagnosis	
			<b>Total</b>	<b>40</b>

**Resolution Favor: Appeal - Denials**

Quarter	Year	Product	Resolution Favor	Count
1	2014	Medi-Cal	In Favor of Member	1
			Not in Favor of Member	6
			Pending	3
			<b>Total</b>	<b>10</b>

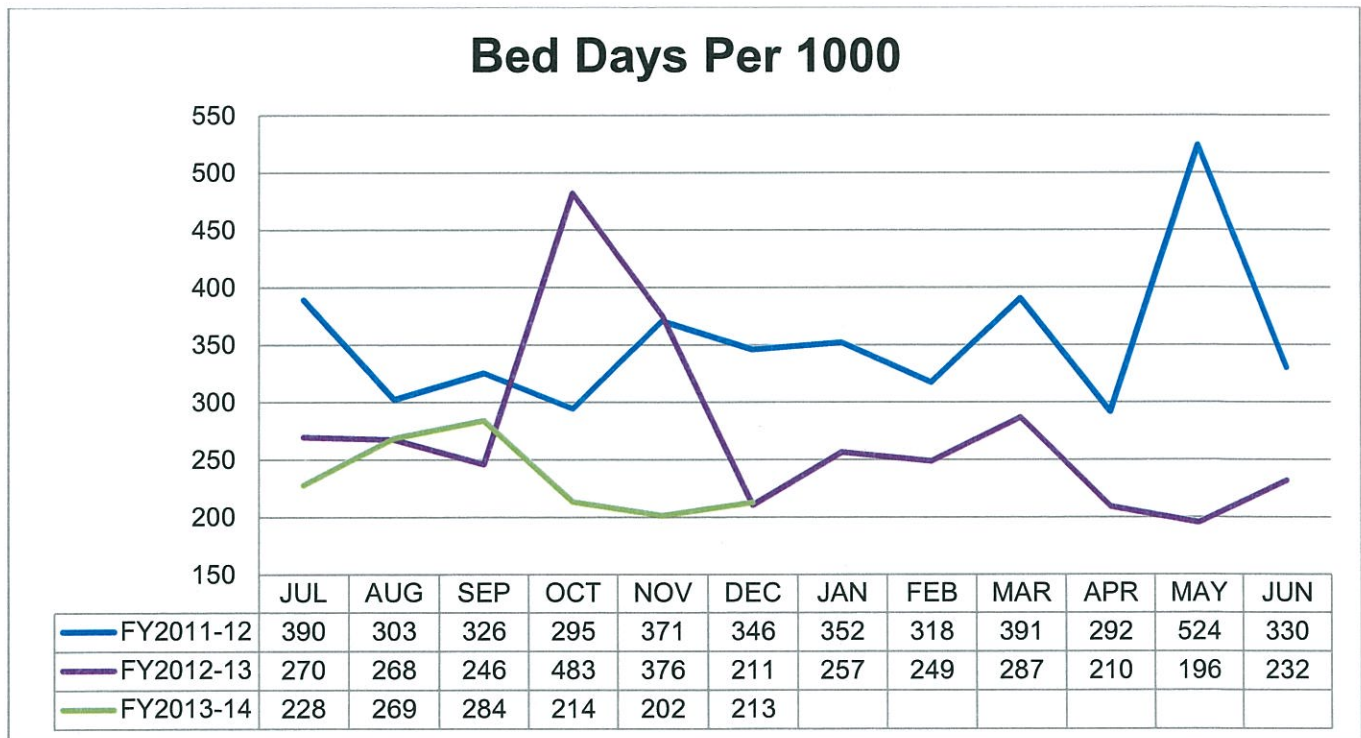
## Gold Coast Health Plan TAT for Acknowledgement Letters – 1<sup>st</sup> Qtr 2014



## Inpatient Utilization

Acute inpatient days/1000 members continued below 225 for Q4 of 2013.

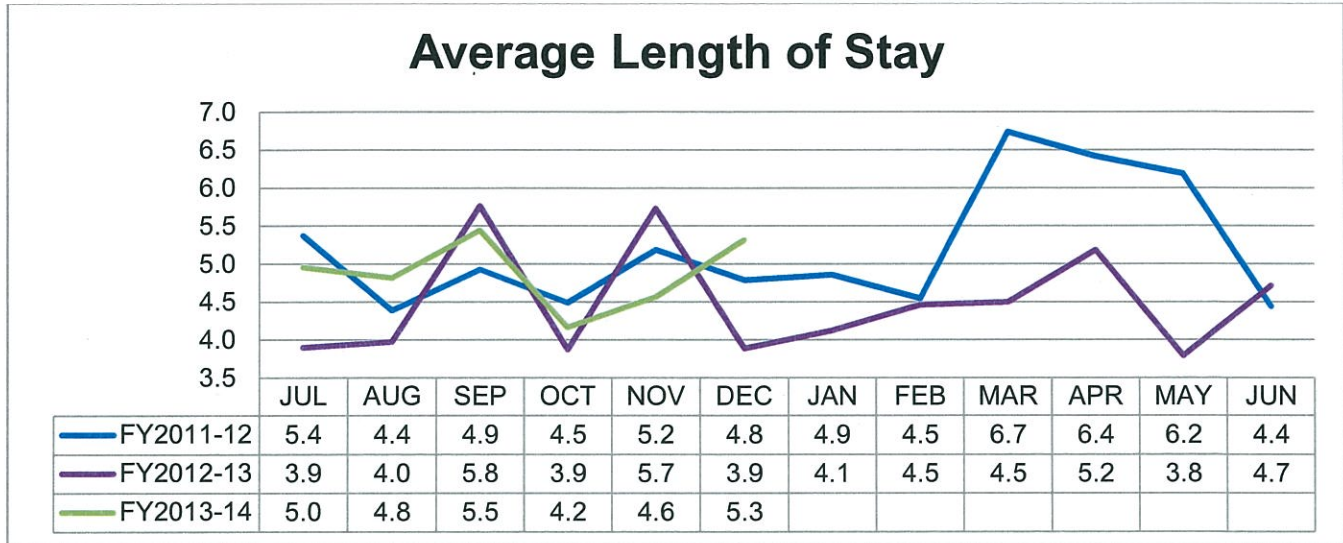
Inpatient days/1000 members and average length of stay calculations are based on paid claims and are lagged by 3 months to allow for adequate run out of claims data. Administrative days are included in these calculations. Dual eligible members, SNF, and LTC data are not included in this data.





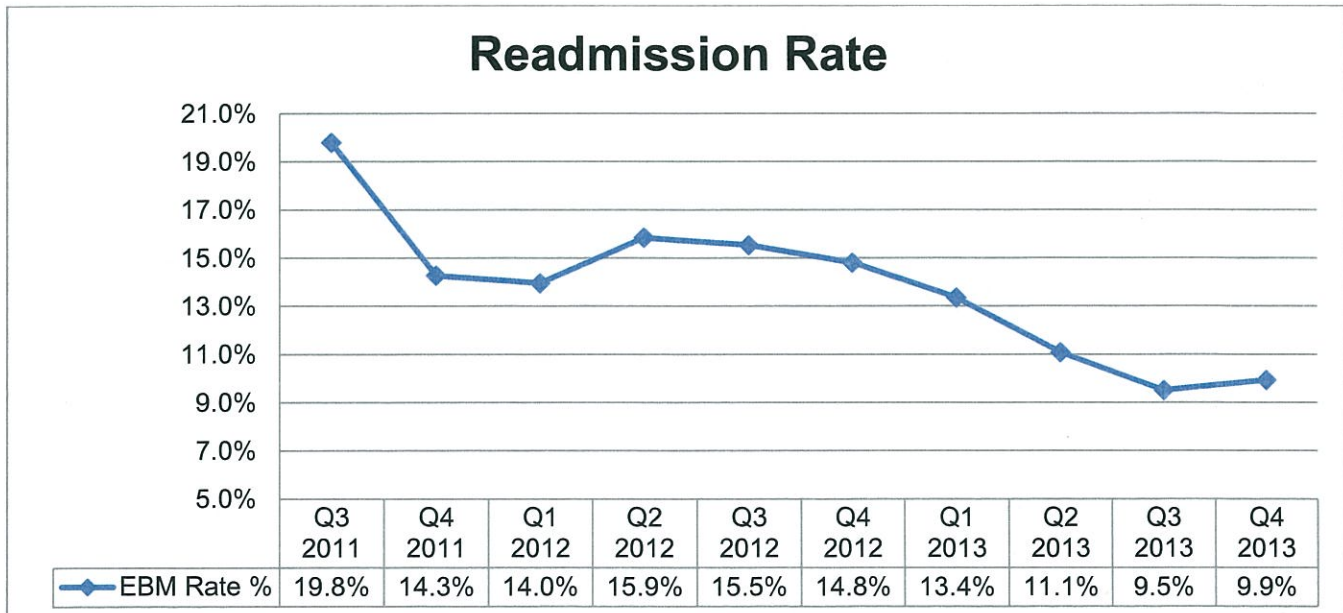
### Average Length of Stay

Average length of stay has shown an increase since October 2013 and mirrors prior peaks seen in September and November of 2013.



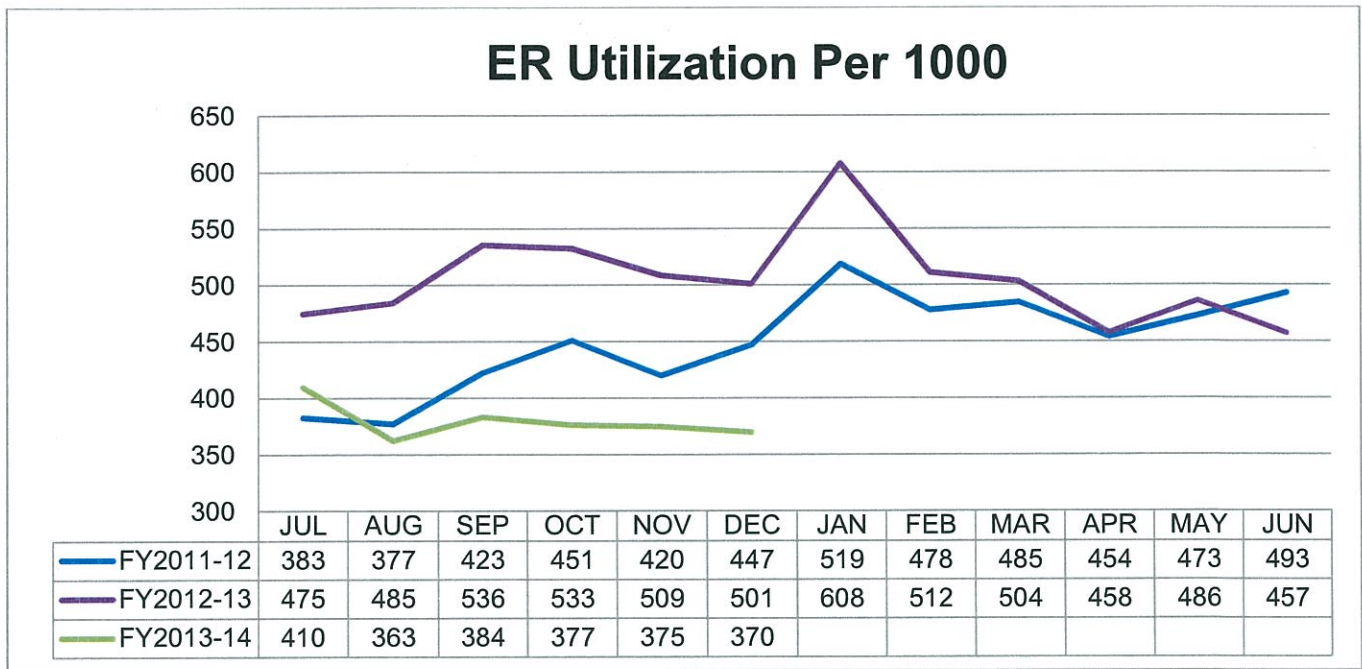
### Readmission rate

The 30 day readmission rate is slightly increased from Q3 2013 to Q4 2013. To further our Transition of Care efforts, an On-Site Discharge Nurse began work at VCMC the week of April 21, 2014. We anticipate that this initiative will help prevent unnecessary readmissions but may also contribute to a decreased length of stay and reduction of bed days as well.



## ER Utilization

ER utilization remains below 400 visits/member since August 2013. The year-to-year comparison for December 2013 to December 2014 showed a 26% decrease. Health Educators and Care Managers continue to reach out to our highest utilizing members. Gold Coast Health Plan is putting processes in place to notify providers about high utilizers assigned to them.



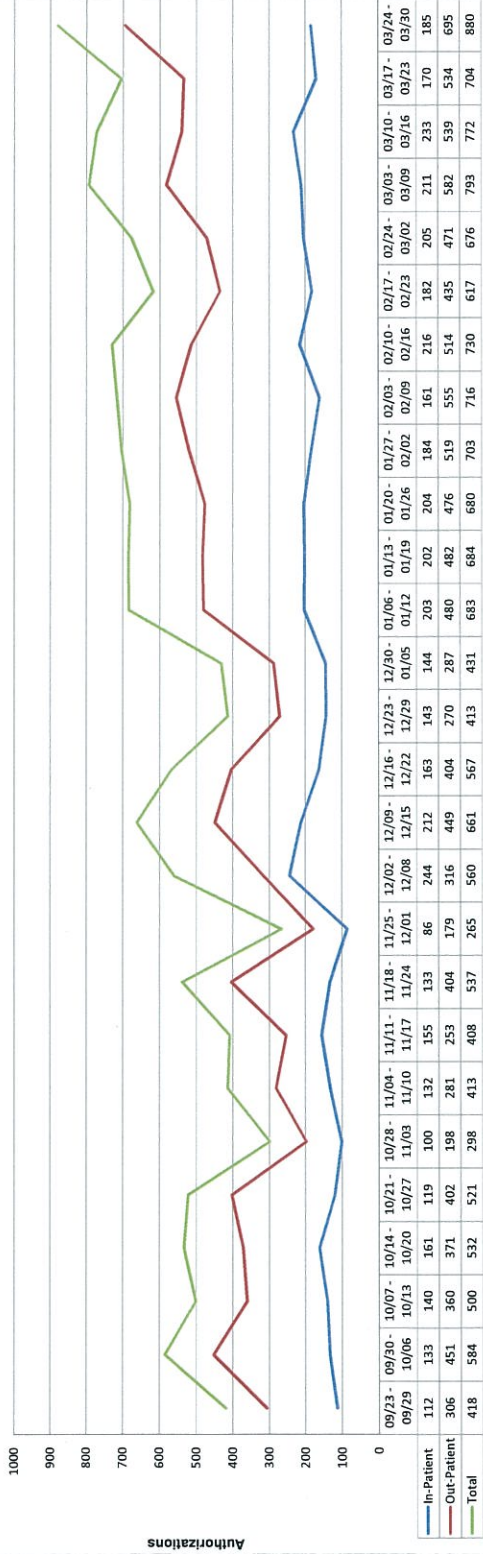
## Authorization Requests

Requests for inpatient and outpatient services increased by approximately 44% from Q4 2013 to Q1 2014. During this same period, membership increased by approximately 16%. This may be the result of increased need for services for members who have not previously had health care coverage. Health Services staffing has been increased to accommodate this increased demand. Our average denial rate for Q1 2013 – Q1 2013 is 3.7%.

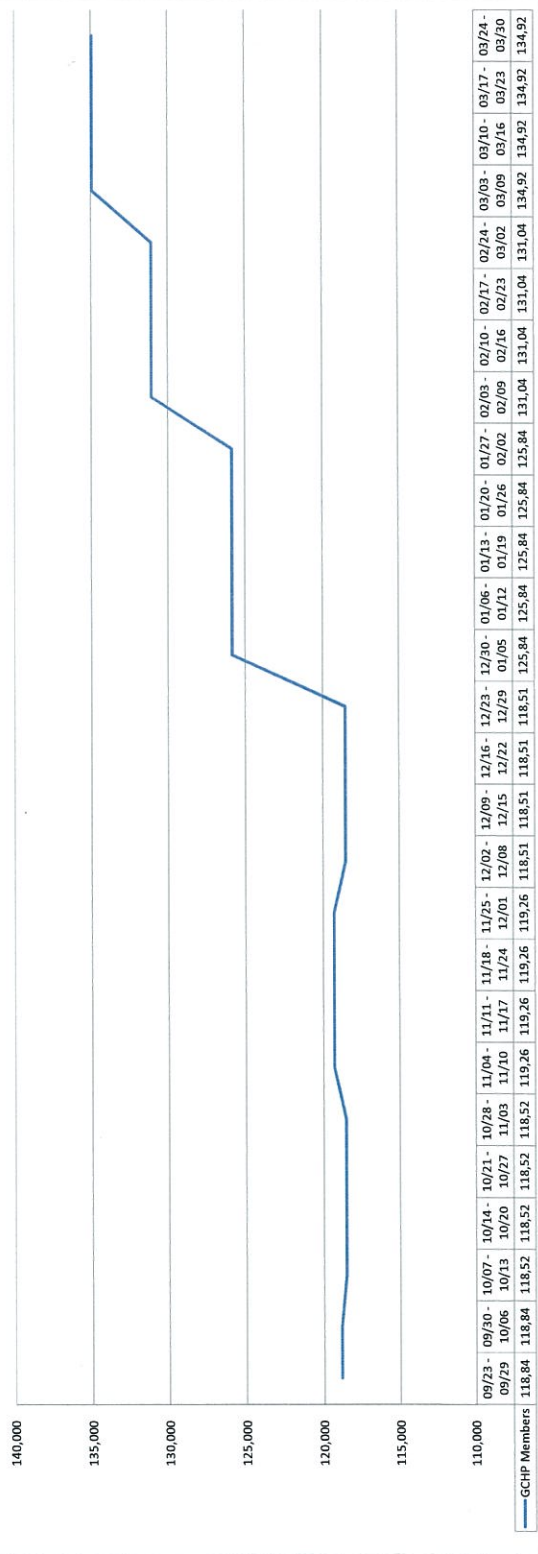
**Weekly Authorizations  
09/23/2013 - 03/30/2014**

Report Run Date: 04/09/2014

**Weekly Authorizations (09/23/2013 - 03/30/2014)**



**GCHP Members**



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**AGENDA ITEM 4d**

To: Gold Coast Health Plan Commission

From: Dr. Nancy Wharfield, Associate Chief Medical Officer

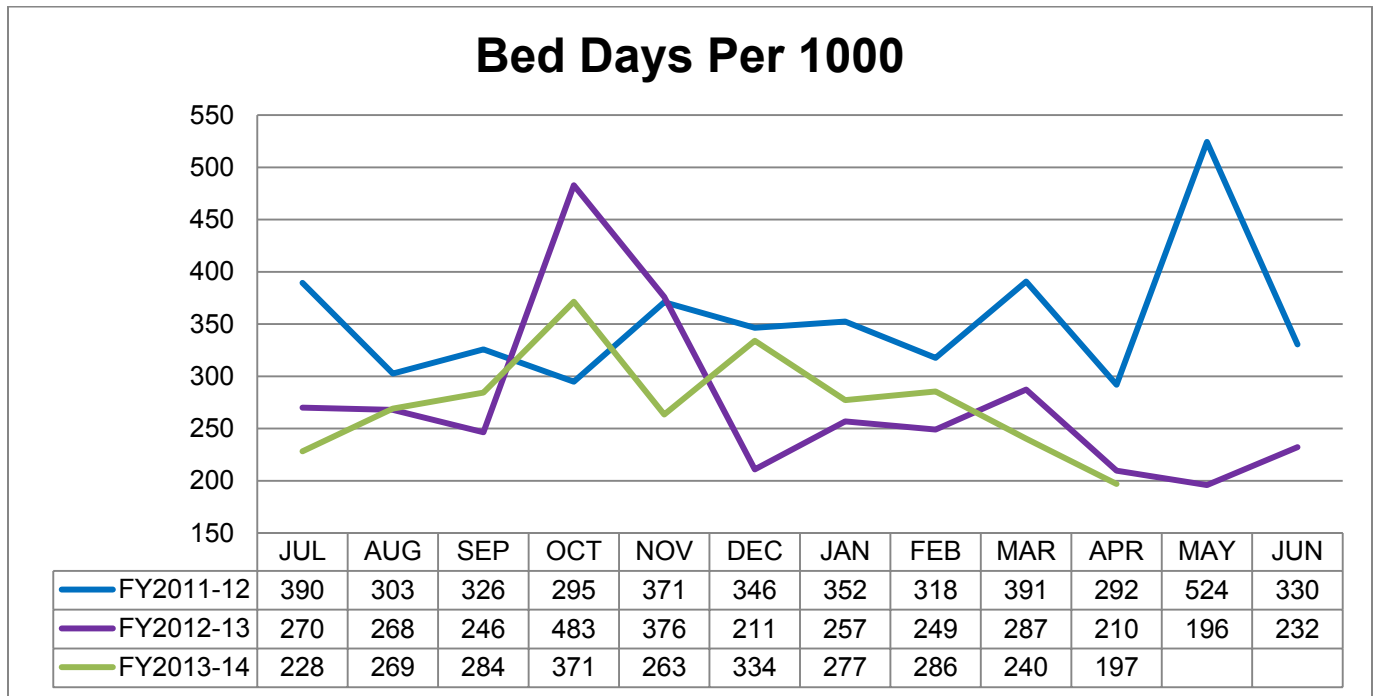
Date: July 28, 2014

Re: Health Services Update

**Inpatient Utilization**

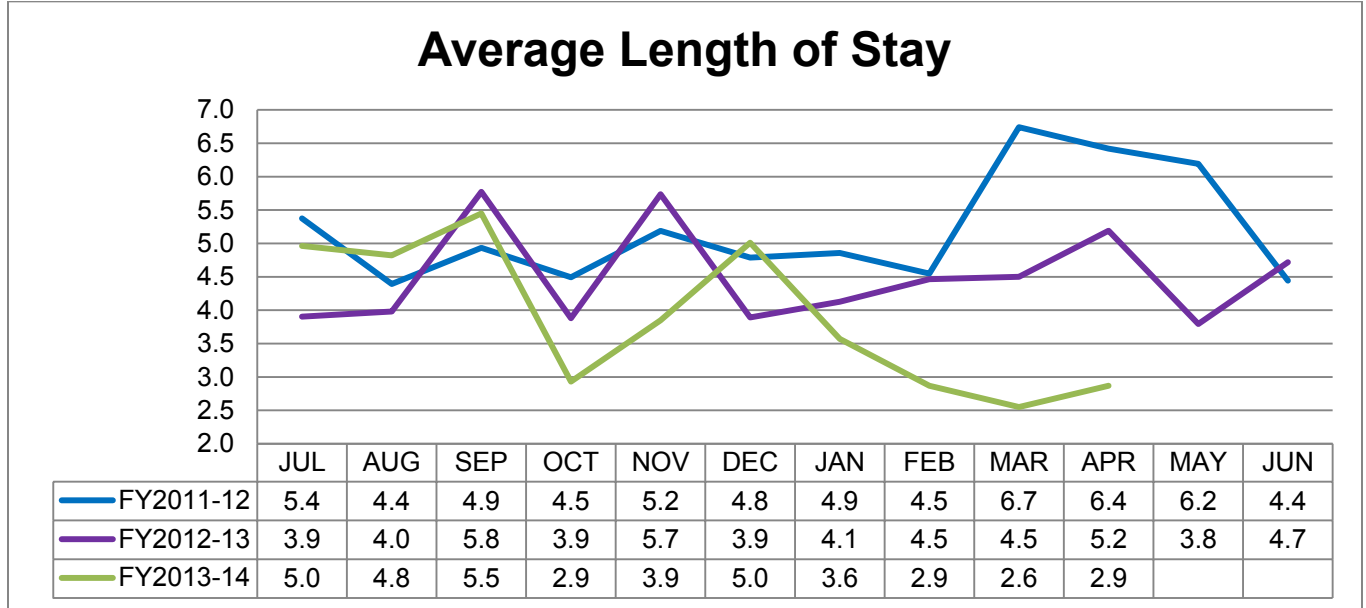
For FY 2013 – 2014, acute inpatient days/1000 members mirror the decline in bed days from winter to spring seen in prior years.

Inpatient days / 1000 members and average length of stay calculations are based on paid claims and are lagged by 3 months to allow for adequate run out of claims data. Administrative days are included in these calculations. Dual eligible members, SNF, and LTC data are not included in this data.



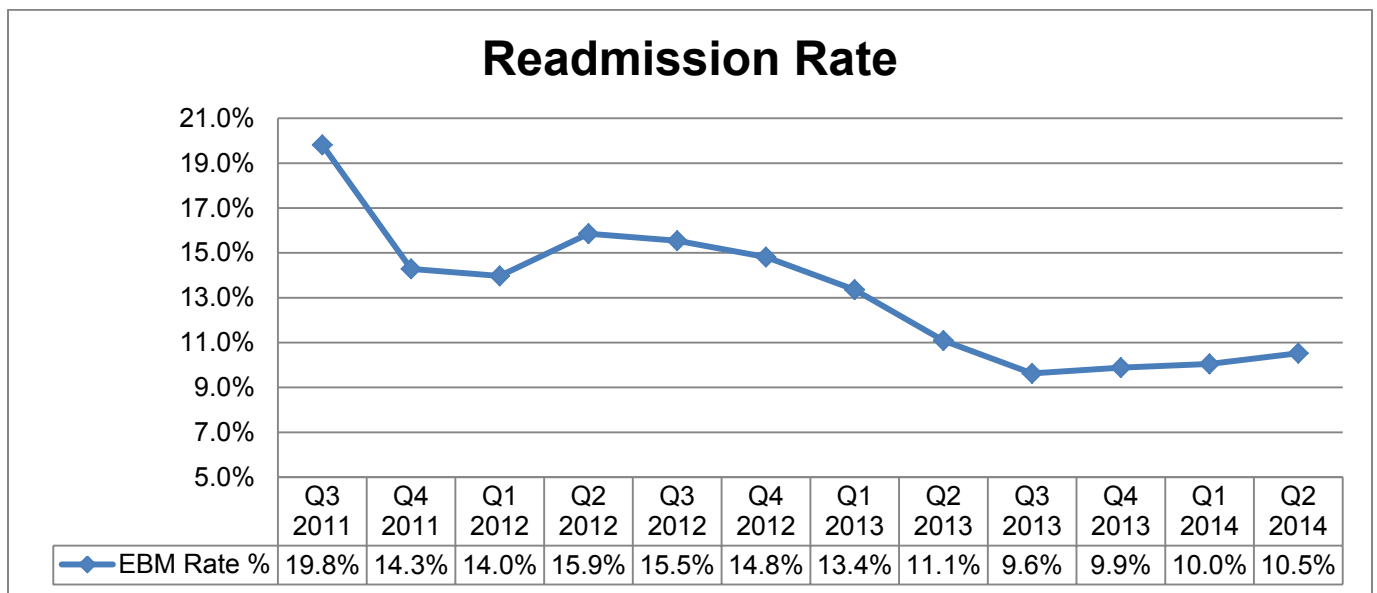
### Average Length of Stay

Average length of stay remains low compared to prior years since January 2014.



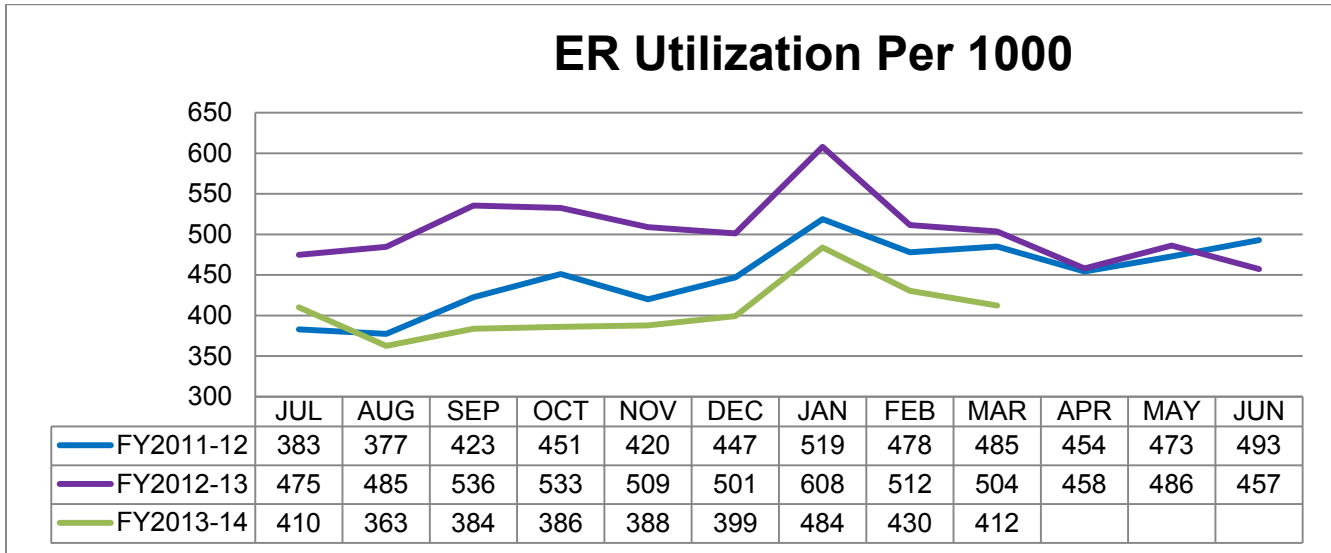
### Readmission Rate

The 30 day all cause readmission rate has plateaued at about 10% for 2013 fourth quarter through the second quarter of 2014.



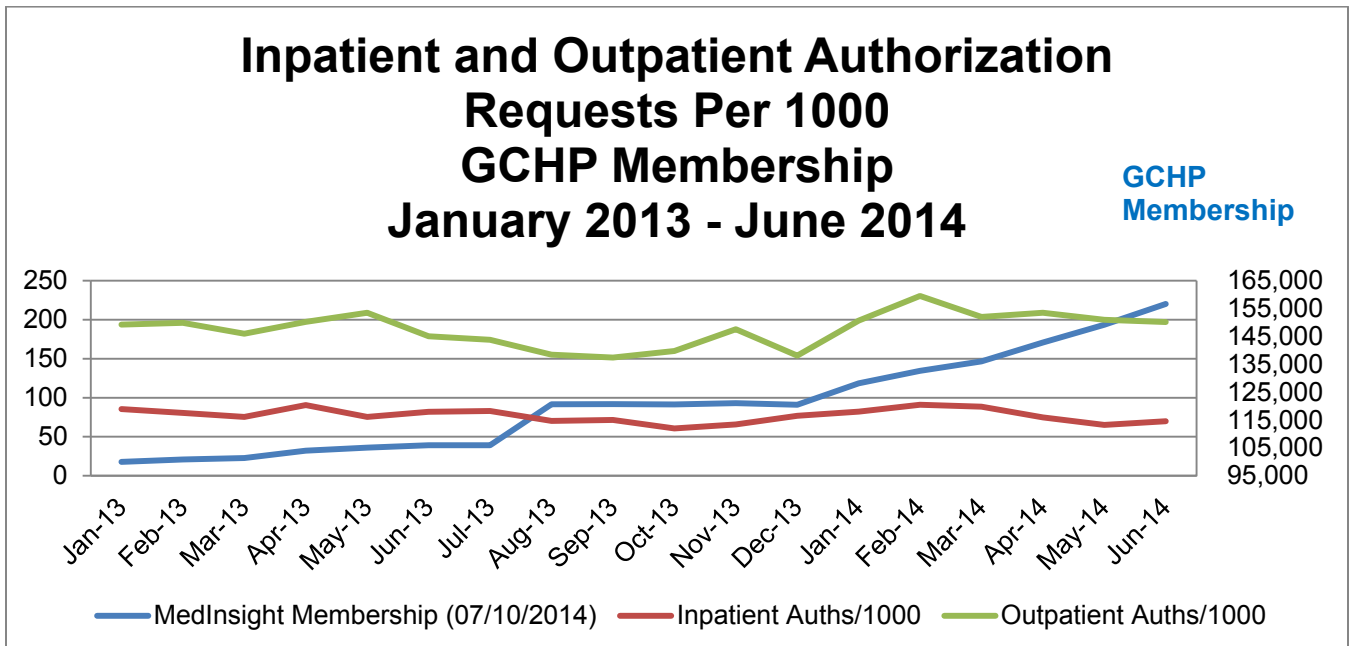
**ER Utilization**

ER utilization for FY 2013-2014 remains lower than prior years and mirrors a general decline in utilization from winter to spring seen for all years.

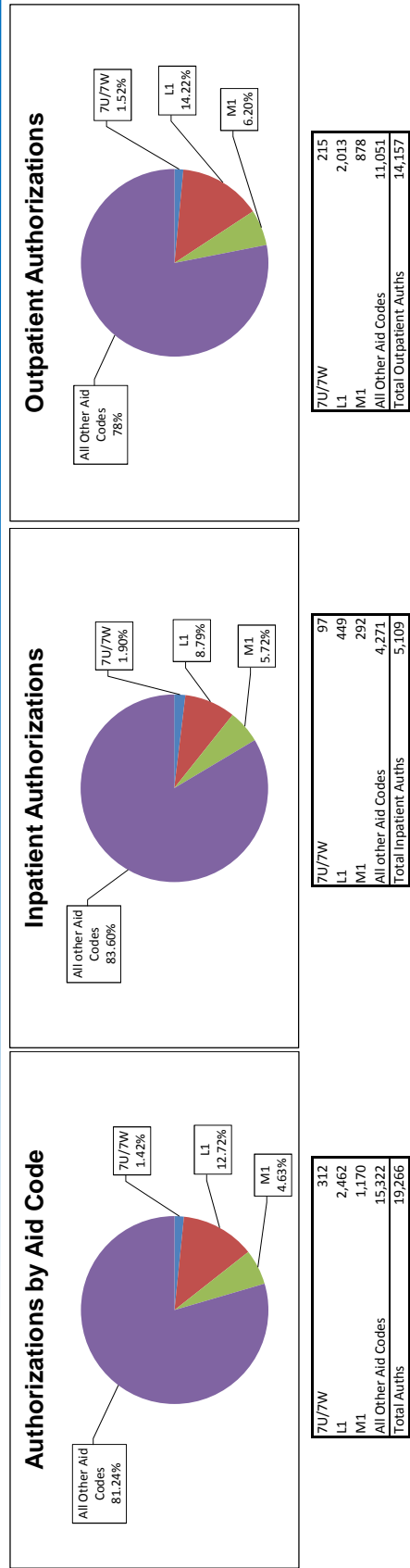


**Authorization Requests**

Requests for outpatient service continue to outnumber requests for inpatient service. Requests for both types of service peaked in February 2014. Among the Medi-Cal expansion members new to Gold Coast Health Plan since January 1, 2014, service requests for L1 members continue to predominate.



## Gold Coast Health Plan Authorizations by Aid Code January - June 2014



Data Source: MedHOK Authorizations by Aid Code Query on 07/03/2014



### Grievance and Appeals

The number of grievances increased slightly in the second quarter of 2014. Grievances / 1000 member months remains low and comparable to the incidence of grievances reported by other COHS on the DHCS Managed Care Dashboard.

#### Grievances

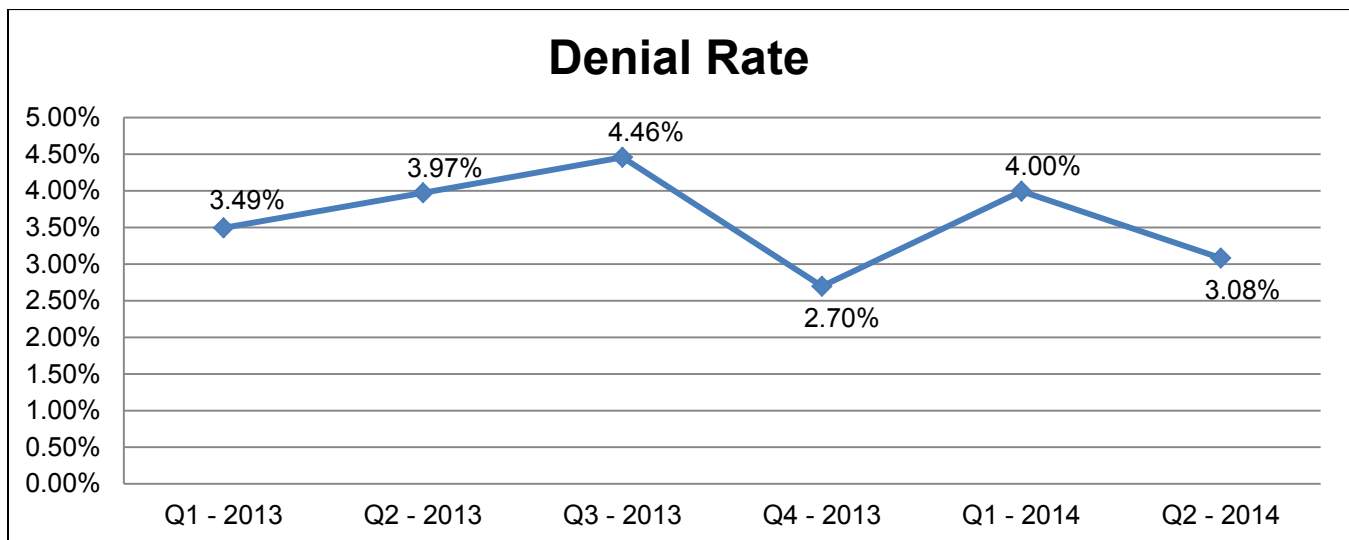
Total Number	
Q4 2013	28
Q1 2014	29
Q2 2014	39

#### Appeals

Quarter	Total	Upheld	Overtured
Q4 2013	1	1 (100%)	0
Q1 2014	5	1 (20%)	4 (80%)
Q2 2014	3	2 (67%)	1 (33%)

### 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.



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## **AGENDA ITEM 4e**

To: Gold Coast Health Plan Commission

From: Barry Fisher, Special Investigation Ad Hoc Committee Chair

Date: July 28, 2014

Re: Affirming the Independent Role of the Special Investigation Ad Hoc Committee and Authorizing Actions in Furtherance Thereof

### **SUMMARY:**

At its Special Meeting of June 18, 2014, the Commission appointed an ad hoc committee of Commission Members Fisher, Alatorre and Glycer (the Ad Hoc Committee) to, among other things, oversee the work of investigative consultants retained by the Commission to evaluate allegations contained in a report issued on May 27, 2014 by the League of United Latin American Citizens-Ventura County and amended June 12, 2014 (the LULAC Report).

Among the directives given to the Ad Hoc Committee during the June 23, 2014 Commission Meeting was to retain special counsel to advise members of the Committee on their work. The Ad Hoc Committee retained Scott H. Howard of the Howard Law Group and Joseph W. Fletcher of the Law Offices of Joseph W. Fletcher to serve as special counsel to the committee.

In reviewing steps taken by or on behalf of the Commission, special counsel has advised the Committee that it would be prudent for the Commission to affirm the independent mission of the Committee and to further expressly authorize the Committee to take certain actions on behalf of the Commission, including contracting with consultants.

On June 11, 2014 CEO Engelhard retained the accounting firm of Moss-Adams, LLP to conduct a limited financial investigation regarding various fiscal issues raised in the LULAC Report and provide that information to Commission General Counsel. On the same day, CEO Engelhard entered into a professional services agreement with EXTTI, Inc. to conduct a workplace investigation regarding allegations of racial discrimination and report the results to Commission General Counsel.

The Ad Hoc Committee requests that the Commission authorize and direct the Ad Hoc Committee to act on behalf of the Commission regarding directing the work of Moss-Adams and EXTTI and that such authority include the ability to amend and or terminate those agreements if deemed appropriate by the Ad Hoc Committee. The Ad Hoc Committee also requests it be authorized to retain additional or replacement consultants if the Ad Hoc Committee finds such to be in the best interest of the mission of the Committee.

**FISCAL IMPACT:**

The fiscal impact is unknown at this time. There is a potential of additional costs if new consultants are required.

**RECOMMENDATION:**

That the Commission take the following actions:

1. Affirm that the Ad Hoc Committee is authorized and directed to independently direct an investigation into the allegations contained in the LULAC Report;
2. Authorize the Ad Hoc Committee to enter into contracts on behalf of the Commission for special counsel and consultants which the Ad Hoc Committee deems necessary or desirable to carry out its mission. This authorization shall include amending or terminating any existing contracts for services related to the LULAC Report.