Ventura County MediCal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)

Regular Meeting
Monday, February 27, 2017, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Ventura County Medi-Cal Managed Care Commission (VCMMCC) doing business as Gold Coast Health Plan (GCHP) on the agenda. Persons wishing to address VCMMCC should complete and submit a Speaker Card.

Persons wishing to address VCMMCC are limited to three (3) minutes. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission.

CONSENT CALENDAR

1. Approval of Ventura County MediCal Managed Care Commission Meeting Regular Minutes of January 23, 2017

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the minutes.

2. Appointment of Credentials/Peer Review Committee Member

Staff: Dr. Al Reeves, Chief Medical Director

RECOMMENDATION: Appoint Dr. Rob Streeter, Chief Medical Officer, St. John's Regional Medical Center and Pleasant Valley Hospital to the Credentials/Peer Review Committee.

3. Approve Professional Services Statement of Work with MedHOK, Inc.

Staff: Dr. Nancy Wharfield, Associate Chief Medical Director
Melissa Scrymgeour, Chief Information & Strategy Officer

RECOMMENDATION: Approve the professional services statement of work with MedHOK, Inc., for the implementation of a Medical Management System Platform 3.1 enhanced upgrade with a not to exceed amount of $137,500.

FORMAL ACTION ITEMS

4. December 2016 Year to Date Financials

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION: Accept and file December 2016 Fiscal Year to Date Financials.

5. Approve Resolution No. 2017-001 Amending the Bylaws to Establish Rosenberg's Rules of Order to Govern Certain Aspects of Commission Meetings and to Modify the Composition of the Executive/Finance Committee

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Approve Resolution No. 2017-001.

6. Appointment of Two Commissioners to Serve on the Executive/Finance Committee

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Appoint two Commissioners to serve on the Executive/Finance Committee.

7. Quality Improvement Committee 2016 Fourth Quarter Report

Staff: C. Albert Reeves, M.D., Chief Medical Officer

RECOMMENDATION: Accept and file the Quality Improvement Committee 2016 Fourth Quarter Report.

REPORTS

8. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

9. Chief Operations Officer (COO) Update

RECOMMENDATION: Accept and file the report.

10. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

11. Human Resources/Cultural Diversity Subcommittee Update

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

12. CONFERENCE WITH LEGAL COUNSEL – SIGNIFICANT EXPOSURE TO LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case

13. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Name of Case: Script Care v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan, Case No. 56-2017-00492349 CV-WM-VTA

14. PUBLIC EMPLOYEE APPOINTMENT
Title: Human Resources Director

15. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Diversity Officer

16. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Ventura County Medi-Cal Commission dba Gold Coast Health Plan and Scott Campbell, General Counsel
Unrepresented employee: Chief Diversity Officer and Human Resources Director

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on March 27, 2017, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

Administrative Reports relating to this agenda are available at 711 East Daily Drive, Suite #106, Camarillo, California, during normal business hours and on http://goldcoasthealthplan.org. 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.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5509. Notification for accommodation must be made by the Monday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

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

January 23, 2017 Regular Meeting Minutes

CALL TO ORDER

Commissioner Darren Lee called the meeting to order at 2:03 p.m. in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Anthony Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Peter Foy (arrived at 2:08 p.m.), Michele Laba, M.D. (arrived at 2:08 p.m.), Darren Lee, Gagan Pawar, M.D., Catherine Rodriguez, and Jennifer Swenson.

Absent: None.

OATH OF OFFICE

The Clerk of the Board administered the oath of office to Commissioner Espinosa.

PUBLIC COMMENT

None.

Scott Campbell, General Counsel, stated the Consent Calendar items are not expected to be controversial, have been previously reviewed by the Executive/Finance Committee, and unless a Commissioner requests to pull an item for individual consideration, the appropriate motion would be to approve Agenda Items Nos. 1 through 11.

CONSENT CALENDAR

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of October 24, 2016

RECOMMENDATION: Approve the minutes.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

2. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of November 9, 2016

RECOMMENDATION: Approve the minutes.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

3. Approval of Contract with SAI Global Inc. for Compliance, Governance, and Risk Software Services

RECOMMENDATION: Approve the contract with SAI Global Inc. for compliance, governance, and risk software services for five years with a not to exceed amount of $172,690.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

4. Approval of Contract with DME Consulting Group Inc. for Home Member Assessment Services

RECOMMENDATION: Approve the contract with DME Consulting Group Inc. for home member assessment services for three years with a not to exceed amount of $150,000.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

5. Approval of Contract with Milliman Inc. for Business Critical Analytics Software (MedInsight)

RECOMMENDATION: Approve the contract with Milliman Inc. for business critical analytics software (MedInsight) for four years with a not to exceed amount of $1,252,818.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

6. Approval of Contract with Coffey Communications Inc. for Custom Membership Publication Services

RECOMMENDATION: Approve the contract with Coffey Communications Inc. for custom membership publication services for three years with a not to exceed amount of $478,500.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

7. Approval of Contract with Coffey Communications Inc. for Member Fulfillment/Direct-Mailing Services

RECOMMENDATION: Approve the contract with Coffey Communications Inc. for member fulfillment/direct-mailing services for three years with a not to exceed amount of $294,000.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

8. Approval of Contract with mPulse Mobile Inc. for Member Mobile Text Messaging Services

RECOMMENDATION: Approve the contract with mPulse Inc. for member mobile text messaging services for two years with a not to exceed amount of $250,000.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

9. Appointment of Medical Advisory Committee Member and Pharmacy and Therapeutic Committee Members

RECOMMENDATION: Appoint Dr. Amita Dharawat to the Medical Advisory Committee and Drs. Janeane Moura, Joseph Cabaret, Ben Lish, and Debbie Veals to the Pharmacy and Therapeutics Committee.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

10. Appointment of Consumer Advisory Committee Beneficiary Member

RECOMMENDATION: Appoint Estelle Cervantes as the Consumer Advisory Committee Beneficiary Member.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

11. State of California Department of Health Care Services Contracts Amendment A23 Provider-Preventable Conditions and Amendment A24 Contract Term Extension to December 31, 2020

RECOMMENDATION: Ratify the Chief Executive Officer's execution of Amendment A23 and Amendment A24 to the Department of Health Care Services Contract.

Commissioner Dial moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Foy and Laba.

Commissioner Lee declared the motion carried.

Commissioners Foy and Laba arrived at 2:08 p.m.

FORMAL ACTION ITEMS

12. November 2016 Year to Date Financials

RECOMMENDATION: Accept and file the November 2016 Fiscal Year to Date Financials.

Patricia Mowlavi, Chief Financial Officer, reported for the five months ending November 20, 2016, the Plan's performance resulted in a net asset gain of $1.1 million, which was $2.5 million higher than budget; the Medical Loss Ratio (MLR) is on target at 93%; and a new report section was added showing the Adult Expansion Population MLR summary from inception to November 2016, which is currently at 84.5% and is below the required 85% resulting in the repayment of $137.5 million to the Department of Health Care Services.

Commissioner Swenson moved to approve the recommendation. Commissioner Dial seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

13. Receive Resolution No. 2017-001 Amending the Bylaws to Establish Rosenberg's Rules of Order to Govern Certain Aspects of Commission Meetings and to Modify the Composition of the Executive/Finance Committee

RECOMMENDATION: Receive the proposed Resolution and approve Resolution No. 2017-001 at the February 27, 2017 Commission meeting.

Scott Campbell, General Counsel, stated staff is proposing two changes to the Commission's Bylaws. The Bylaws require the Commission to receive the changes at one meeting and approve them at the following meeting. The first change is the adoption of *Rosenberg's Rules of Order* for the conduct of the Commission meetings when the Bylaws do not provide direction. The second change would modify the composition of the Executive/Finance Committee so it does not require two members from the same constituency and would allow any Commission member to be appointed to the Committee, provided there is at least one representative from Clinicas Del Camino Real, Ventura County Medical Center Health System, and a private hospital or healthcare entity.

Commissioner Lee received the proposed Resolution No. 2017-001.

14. Cultural Diversity Subcommittee Vacancy and Chief Diversity Officer Interview Panel Vacancy

RECOMMENDATION: Appoint a Commissioner to the Cultural Diversity Subcommittee and approve the formal appointment of Yolanda Benitez to the Chief Diversity Officer interview panel.

Mr. Campbell stated staff requests the Commission to appoint a replacement for Commissioner Lee to the Cultural Diversity Subcommittee and approve Yolanda Benitez as the LULAC representative to the Chief Diversity Officer interview panel as Dr. Jaime Casillas has resigned from the post.

Commissioner Atin moved to appoint Commissioner Espinosa to the Cultural Diversity Subcommittee. Commissioner Alatorre seconded. The motion was amended to include the approval of Ms. Benitez's appointment to the Chief Diversity Officer interview panel.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

15. Quality Improvement Committee 2016 Third Quarter Report

RECOMMENDATION: Accept and file the Quality Improvement Committee 2016 Third Quarter Report.

Albert Reeves, M.D., Chief Medical Officer, gave an update on the Quality Improvement Projects. The Performance Improvement Project (PIP) No. 1 is in conjunction with Las Islas Clinic and is currently in stage four, which is the testing of the proposed interventions: identifying members not fully immunized and to reach out to the families to schedule immunization appointments. PIP No. 2 involves increasing the utilization of standardized Child Developmental Screening Tools thereby identifying children at an early age with abnormal development so there can be an early invention. The mandated PIP must be done with a clinic partner, however the first clinic withdrew from the project and a new clinic, Sierra Vista Family Medical Clinic, has been secured and are working on stage three of the project.

There were two mandated HEDIS Improvement Projects due to the measures scoring below the minimum performance levels: cervical cancer screening and well-child examinations in the 3rd, 4th, 5th, and 6th years of life. After the barriers were identified regarding the well-child examinations, two clinics were chosen for interventions, which involved identifying members not seen from January through September, providing this information to the clinics, and having the clinics reach out to the members in order to schedule well-child examinations. The goal was to increase the rate by five percentage points. The cervical cancer screening project barriers were also identified with one clinic chosen and the developed intervention consisted of the Plan sending reminder letters followed by a phone call from the Plan's Health Navigators and assistance making appointments. The goal was to improve the rate by five percentage points.

Dr. Reeves reviewed additional quality improvement activities including the Initial Health Assessment monitoring and four facility site reviews, which all passed. A discussion occurred between the Commissioners and staff regarding the procedures when a provider fails a site review, which included implementing a corrective action plan and failure to comply would be grounds for termination.

The Compliance Delegation Oversight dashboard was reviewed and it was noted Beacon has met each benchmark though they are still on a corrective action plan. The Pharmacy and Therapeutics section involved the review of four new drugs

with three approved to be added to the formulary and one new drug being denied as the formulary placement did not provide a significant new therapy. The Credentials/Peer review reported on the monitoring of three providers on probation by the Medical Board of California (MBC); three providers with accusations, but no action taken by the MBC; and one provider arrested for issues of prescribing controlled medications with no action by the MBC and legal action is pending. Additionally, 36 new providers were approved; 20 providers were recredentialed; and three facilities were credentialed. Two peer reviews involved one case rated two for outcome and system problems and changes were instituted at the facility to prevent a recurrence; the second case involved the education of a pharmacy to prevent a recurrence. One case involved a significant issue with a provider and the quality of care and is being reviewed by an outside independent specialist.

A discussion followed between the Commissioners and staff regarding the provider network growth now having 4,787 specialty providers and 365 primary providers. This significant increase in specialty providers was primarily due to the addition of UCLA and the City of Hope to provide additional access as this has been an ongoing compliant from members. Commissioner Alatorre inquired as to whether the website has been updated to reflect the addition of specialty physicians. Ruth Watson, Chief Operating Officer, stated she would follow-up and noted one of the major projects the Plan has scheduled is to automate the database updates.

Dr. Reeves noted every five years a needs assessment is required for health plans and in September the Plan contracted with SPH Analytics to do the survey and 414 members had replied. There were 339 grievances received consisting of 306 administrative grievances and 33 clinical grievances with the top three reasons consisting of provider disputes, quality of care, and benefits. Commissioner Swenson requested the provider disputes and quality of care grievances should be monitored in order to reduce these type of grievances.

Commissioner Atin moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

16. Receive and Approve Resolution No. 2017-002 Rescinding Resolution No. 2015-007 and Adopting Personnel Rules, Regulations, and Policies and Handbook

RECOMMENDATION: Receive and Approve Resolution No. 2017-002.

Danita Fulton, Human Resources Director and Interim Chief Diversity Officer, stated the Human Resources policies and employee handbook are reviewed annually by the Human Resources Department with edit and/or changes presented to the Plan's senior leadership for review and approval prior to the Commission's review and approval. The attached policy review notes the edits or changes to each policy document with the majority of them being grammatical corrections. Highlights of the changes included a new retirement provider; vacation accrual policy update; and position recruitment procedures.

A discussion followed between the Commissioners and staff regarding Policy #4.1 Accepting Gifts and it was noted the policy does not allow employees to accept gifts of $460 or greater and is consistent with the State law.

Commissioner Atin moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Espinosa, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

It was the consensus of the Commission to hear Agenda Item No. 17 - Approval of Chief Executive Officer Employment Contract Amendment after the Reports section of the Agenda.

REPORTS

18. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

Mr, Villani provided a high level overview on the potential impact of the Affordable Care Act (ACA) Repeal and Replace noting there would probably be no significant changes occurring in 2017. Mr. Villani stated he and Government Affairs Manager Marlen Torres would be attending the ACAP Legislative Fly-in on February 7 in Washington, D.C., and on February 14, they would be attending the LHPC 3rd Annual Legislative and Agency Briefing in Sacramento.

A discussion followed between the Commissioners and staff regarding the 2012 Department of Health Care Services (DHCS) Financial Corrective Action Plan

(CAP) placed on Gold Coast Health Plan (GCHP). GCHP staff met with DHCS on December 7, 2016, to discuss the steps necessary to lift the financial CAP as there are no longer any deficiencies identified and submitted a formal written request for a timeline on December 9, 2016. A reply was received from DHCS on January 12, 2017, which acknowledged GCHP's progress on the financial CAP, but notes the Capitated Rates Development Division is actively working with GCHP to establish final guidance and a timeline to fully close the CAP. A follow-up phone call occurred between DHCS and Brandy Armenta, Compliance Officer/Director on January 20, 2017. Ms. Armenta stated due to DHCS staff turnover, the same materials have been submitted for the fourth time in the past two and half years. DHCS stated they did not have a concern with the reports received and acknowledged GCHP is not out of compliance, but as they are looking at it as group, they need to ensure everything is correct. Mr. Villani stated he believes the financial CAP will be lifted within the next three months.

Ralph Oyaga, Executive Director for Government, Regulatory and External Relations, reviewed the Alternative Resources for Community Health (ARCH) initiative including the provision of Community Health Investments (CHI), which provides monetary grants to external organizations that work to improve the health of GCHP members and Ventura County residents in general.

Mr. Oyaga introduced Karen Escalante-Dalton, an independent consultant with extensive experience in health focused grant making, to help plan and launch the CHI grant making program. Ms. Escalante-Dalton gave an update on the CHI focus on the social determinants of health and provided the status and timeline for the implementation of the program.

19. Chief Operations Officer (COO) Update

RECOMMENDATION: Accept and file the report.

Ms. Watson stated total membership is at 204,530, which is the first time in two months the Plan has experienced a loss due to the redetermination process. Staff is preparing to issue a Request for Proposal for all outsourced services provided by Xerox by the end of March.

20. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

Nancy Wharfield, M.D., Associate Chief Medical Officer, stated the 2016 inpatient utilization metrics continue to be similar to slightly improved compared to 2015. The top admitting diagnoses continue to be pregnancy and sepsis. For members admitted with a primary diagnosis of sepsis, secondary diagnoses were cancer, heart disease, liver or rental transplant, and diabetes were secondary diagnoses. Requests for outpatient service outnumbered requests for inpatient service by more than four times.

Lupe Gonzalez, Director of Health Education, Outreach, and Cultural/Linguistic Services, highlighted the community education and outreach events for October, November, and December. Fifty-seven requests were received for sign language interpreter services and a total of $12,300 was allocated to seven agencies under the sponsorship program. Dr. Donaldson from the Santa Paula Medical Clinic gave a discussion on gender identity and transgender healthcare issues for healthcare providers and staff.

Annie Freese, Pharm.D., Director of Pharmacy, gave an overview of pharmacy costs drivers: the component costs which include drug ingredients, dispensing, professional service fees, Pharmacy Benefits Manager (PBM) administrative fees, and prior authorization costs. The drivers of costs are dependent upon unit cost, utilization, mix, and traditional versus specialty. Department efficiencies included removal of ineffective PAs; enforcing payment by other health coverage, eligibility file corrections, and the development of drug utilization review standards. It was noted total costs have risen as members are utilizing more medication. Additionally, due to the new PBM contract rates there was a $1.4 million savings as of January.

A discussion followed between the Commissioners and staff regarding mandating generic drugs when possible; Commissioner Lee made the request to provide the demographics in order to do a comparison of similar plans; the impact of Hepatitis C drug costs and when treatment should occur; the reduction in the kick payments received from the State; the diabetic cost per member per month compared to the non-diabetic cost; the total percent of diabetics is 6% compared to the national rate of 7%; Commissioner Lee made the request to provide the average age for diabetics; clarification was made that the labeling is reversed on the graph titled Total Drug Spend on page 324; Commissioner Rodriguez made the request the 340B discount tracking be made monthly instead of quarterly; whether or not members can be forced to use a pharmacy that is participating in the 340B program as there is the potential for a 40% to 60% savings; and the challenges of a mail order program.

Commissioner Espinosa left at 3:55 p.m.

21. Chief Information Strategy Officer (CISO) Update

RECOMMENDATION: Accept and file the report.

Melissa Scrymgeour, Chief Information and Strategy Officer, reviewed the 2016 portfolio highlights including the OptumRX PBM implementation; completion of the Inovolan implementation for HEDIS reporting; the implementation of new software to improve capabilities and efficiencies for forecasting and budgeting; and the kick off of the procurement process for provider credentialing, contracting, and data maintenance software.

22. Human Resources/Cultural Diversity (HR/CD) Subcommittee Update

RECOMMENDATION: Accept and file the report.

Ms. Fulton stated the investigation into the September 8, 2016, allegation involving the inflatable monkey doll is complete as an outside investigator concluded there was no intent to intimidate, offend, or upset on the part of the employees who hung the monkey, the employees did not intend the display to simulate a lynching, the incident was not reported to management or Human Resources internally, and the report concluded there was insufficient evidence to support any findings or violations of the harassment prevention policy. Additionally, there have been no complaints reported or complaints received on the anonymous tip hotline since September 8, 2016. The Chief Diversity Officer (CDO) interview panel continues to score the candidates for the position with the first round of interviews scheduled for January 28, 2017, with the finalists to be forwarded to the Commission for interviews. Commissioner Atin noted it is important the report be finalized and submitted to the Commission on a quarterly basis. The Commissioners commended the Subcommittee members and Ms. Fulton on their work.

Commissioner Alatorre moved to approve the recommendation to accept and file the Report Items Nos. 18 through 20. Commissioner Foy seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Espinosa.

Commissioner Lee declared the motion carried.

FORMAL ACTION ITEMS

17. Approval of Chief Executive Officer Employment Contract Amendment

RECOMMENDATION: Approve an amendment to the employment contract with Dale Villani.

Mr. Campbell stated at two different meetings, the Commission has given two directions: one was a three-year contract and one was a 120-day contract extension, both of which Mr. Villani has approved the terms of the legal language. Staff is requesting direction from the Commission on how to proceed.

Mr. Campbell announced Closed Session Agenda Item No. 23 Public Employee Performance Evaluation and Agenda Item No. 24 Conference with Labor Negotiators with

unrepresented employee Chief Executive Officer.

CLOSED SESSION

The Commission adjourned to Closed Session at 4:16 p.m.

23. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

24. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Scott Campbell, General Counsel
Unrepresented employee: Chief Executive Officer

OPEN SESSION

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

Mr. Campbell stated Closed Session Agenda Item No. 25 Conference with Legal Counsel – Anticipated Litigation to discuss the subpoena received from the Office of Inspector General occurred and there was no reportable action taken.

25. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: Two Cases

FORMAL ACTION ITEMS

17. Approval of Chief Executive Officer Employment Contract Amendment

RECOMMENDATION: Approve an amendment to the employment contract with Dale Villani.

Mr. Campbell stated based on the Closed Session discussion, the appropriate motion would be to approve an addendum to the employment contract of Mr. Villani for three years with direction the goals to be formulated and to be agreed upon by May 31, 2017, include the removal of the financial CAP and the successful integration of the Chief Diversity Officer.

Commissioner Foy moved to approve the recommendation. Commissioner Rodriguez seconded.

AYES: Commissioners Alatorre, Atin, Dial, Egan, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Espinosa.

Commissioner Lee declared the motion carried.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 4:50 p.m.

AGENDA ITEM NO. 2

TO: Gold Coast Health Plan Commission

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

DATE: February 27, 2017

SUBJECT: Credentials/Peer Review Committee Membership

SUMMARY:

Medi-Cal Managed Care Health Plans are required by contract to have certain committees that assure the quality of care and adequate services are provided to members. The medical committees should involve licensed physicians and other licensed professionals in the process of credentialing, utilization management and pharmacy management. Due a member resignation from the Credentials/Peer Review Committee, a subcommittee of the Commission, staff is requesting to fill the vacant position on the Credentials/Peer Review Committee

BACKGROUND:

Ordinance No. 4409 of the Ventura County Board of Supervisors established Gold Coast Health Plan with certain committees. The ordinance called for a Quality Improvement Committee and other subcommittees that deal with specific medical functions of the Plan. Two years ago the commission approved the membership of the medical committees. There has recently been a resignation from the Credentials/Peer Review Committee and that seat needs replacement.

RECOMMENDATION:

GCHP is requesting the Commission's approval to add the following committee member:

1. Credentials/Peer Review Committee - Add Dr. Rob Streeter, Chief Medical Officer, St. John's Regional Medical Center and Pleasant Valley Hospital for three years.

AGENDA ITEM NO. 3

TO: Gold Coast Health Plan Commission

FROM: Dr. Nancy Wharfield, Associate Chief Medical Director
Melissa Scrymgeour, Chief Information & Strategy Officer

DATE: February 27, 2017

SUBJECT: Professional Services Statement of Work Approval – MedHOK, Inc.

SUMMARY:

MedHOK is GCHP's Medical Management System (MMS). GCHP implemented MedHOK in December 2013 to support mission critical medical management and grievance and appeals business functions. As part of the FY16/17 project portfolio, GCHP plans to upgrade the MedHOK platform, which currently consists of three software modules – Utilization Management (UM), Care Management (CM), and Grievance and Appeals (G&A). MedHOK v3.1 "Enhanced Upgrade" includes a complete re-design of the CM module, along with other enhanced features and functionality. While there are no costs for the new software, GCHP intends to utilize MedHOK professional services to meet the following business objectives:

- Successful upgrade of UM and G&A Modules with minimal business disruption
- Re-design and re-deployment of CM module
- Improved user experience and business efficiencies within CM module

MedHOK will assist GCHP in meeting these objectives by providing resources to:

- Set up and configure test, training and production environments
- Lead workflow and configuration design efforts for newly re-design CM module
- Support regression testing
- Provide end user training, including design and documentation of training materials
- Ensure all existing functionality, including letters and reports continue to work in the new software
- Support go-live and provide post-implementation warranty support.

FISCAL IMPACT:

The estimated project fees are $137,500, which includes professional services, travel and contingency. These project costs are included in the approved GCHP FY16/17 budget.

RECOMMENDATION:

It is the Plan's recommendation to approve the project budget and allow the CEO to execute the MedHOK professional services statement of work for the 3.1 "Enhanced Upgrade" implementation.

If the Commission desires to review this contract, it's available at GCHP's Finance Department.

AGENDA ITEM NO. 4

TO: Gold Coast Health Plan Commission

FROM: Patricia Mowlavi, Chief Financial Officer

DATE: February 27, 2017

SUBJECT: December 2017 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached December 2016 fiscal year-to-date (FYTD) financial statements (unaudited) of Gold Coast Health Plan ("Plan") for the Commission to accept and file. The Executive/Finance Committee did not review these financials.

BACKGROUND / DISCUSSION:

The staff has prepared the December 2016 FYTD financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Financial Highlights

Overall Performance – For the six month period ended December 31, 2016, the Plan's performance was a gain in net assets of $3.3 million which was $4.8 million higher than budget. This was driven by medical and general administrative savings.

Membership – December membership of 208,148 was below budget by 3,731 members. The Adult and Child aid categories continue to be below budget while enrollment in the Adult Expansion (AE) aid category has exceeded budget.

Revenue – December FYTD total revenue was $338.9 million or $2.7 million lower than budget related to the reserve for AE rate reduction and the MCO tax. Base revenue was $628,000 higher than budget as a result of membership mix. On a per member per month basis, total revenue was $0.20 above budget.

Health Care Benefit Costs – Through December, expenses associated with health care benefits totaled $312.4 million and represented 92.2% of revenue.

MCO Tax – As discussed in prior months' Finance Letters, the Plan MCO tax liability is pre-determined in accordance with Senate Bill X2-2 passed in October 2016. As such, the Plan's MCO tax liability for FY2017 is $84.1 million, accrued at a rate of approximately $7.0 million per month. Through December 31, 2016, $42.1 million of MCO tax has been expensed.

Adult Expansion Population 85% Medical Loss Ratio – On the Balance Sheet $138.4 million in reserve as potential Medi-Cal capitation revenue that will be recouped back to the DHCS under the terms of the MLR contract language

	Expansion Population			Classic Population
	1/1/14-6/30/15 MLR Period 1	7/1/15-6/30/16 MLR Period 2	7/1/16-12/31/16 MLR Period 3	7/1/16-12/31/16
Total Revenue	361,237,234	293,172,661	142,468,888	206,644,612
Total Estimated Medical Expense	206,719,452	237,899,253	115,022,385	197,342,216
	57.2%	81.1%	80.7%	95.5%
Total MLR Reserve	**118,168,494**	**13,101,452**	**7,150,000**	

Administrative Expenses – December FYTD administrative costs were $24.5 million or $2.8 million lower than budget. As a percentage of revenue, administrative costs (or ACR) were 7.2% versus 8.0% for budget.

Cash and Medi-Cal Receivable – At December 31, the Plan had $505.7 million in cash and short term investments and $88.9 million in Medi-Cal Receivable for an aggregate amount of $594.6 million. During the month, approximately $33.9 million in HQAF funds were paid to provider hospitals. Another $23.7 million in combined HQAF and IGT funds will be distributed to providers in January 2017 along with the next MCO Tax payment of $21.0 million. The AE overpayment due to DHCS (for incorrect rate payments and to achieve 85% MLR) totals $277.1 million. The AE repayment is expected to commence in July 2017.

Investment Portfolio – At December 31, 2016, the value of the investments was as follows:

- Short-term Investments = $283.5 million. Comprised of: Cal Trust $50.7 million; Ventura County Investment Pool $85.6 million; LAIF CA State $63.3 million; Bonds and Commercial Paper $83.9 million.
- Long-term Investments = $5.2 million (all Bonds).

RECOMMENDATION:

Staff requests that the Commission accept and file the December 2016 financial package.

CONCURRENCE:

Not Applicable

ATTACHMENT:

December 2016 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended December 31, 2016

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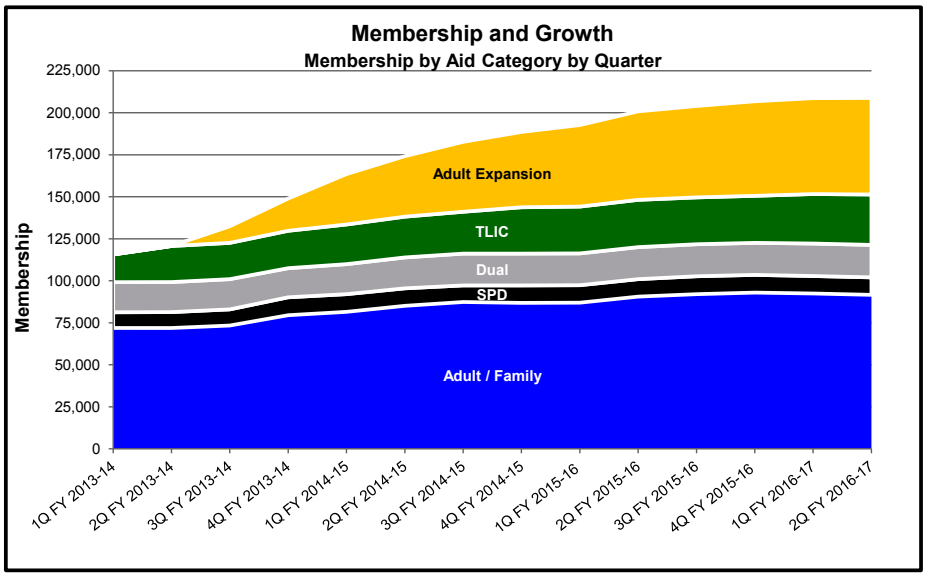
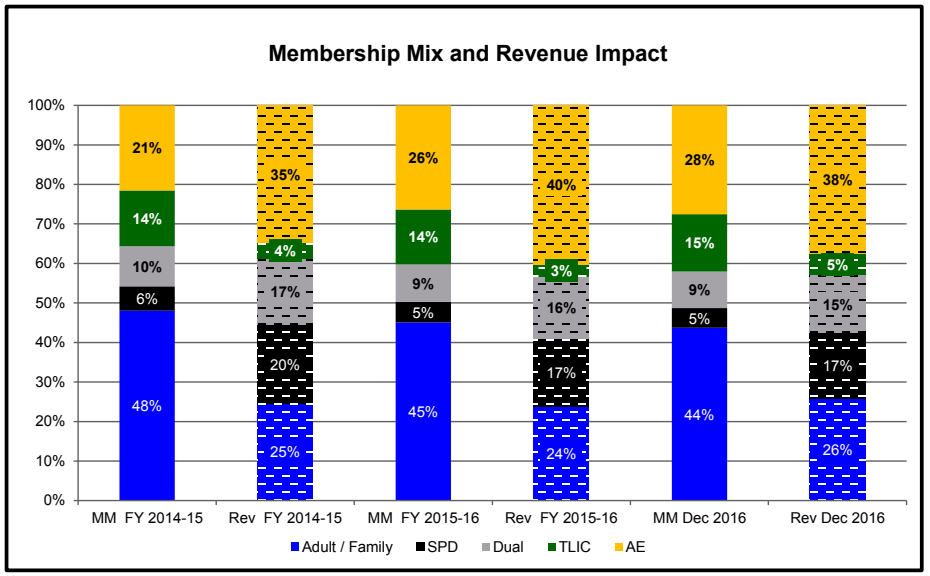
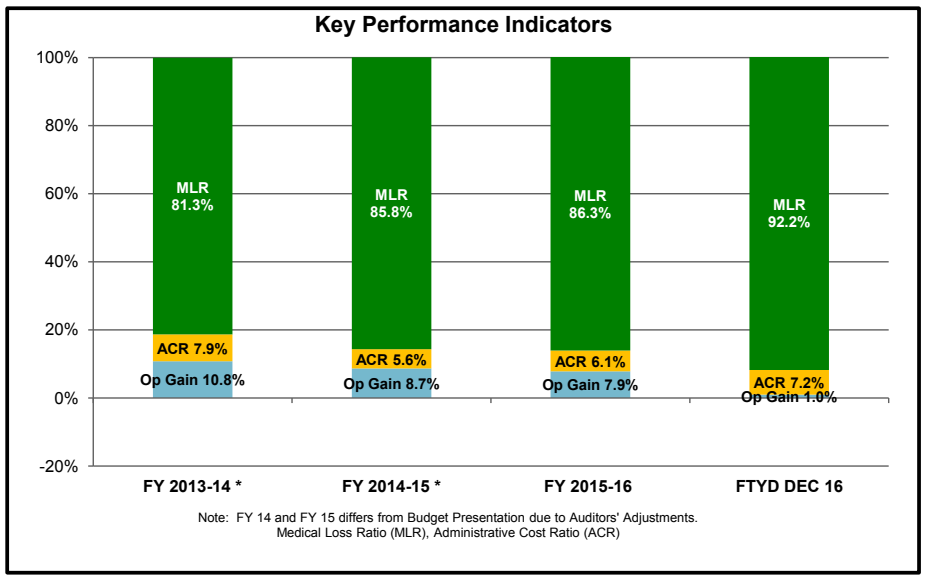
APPENDIX

Description	AUDITED FY 2011-12	AUDITED FY 2012-13	AUDITED FY 2013-14	AUDITED FY 2014-15	AUDITED FY 2015-16	FY 2016-17 JUL - SEP 16	OCT 16	NOV 16	DEC 16	OCT - DEC 16	FYTD DEC 16	Budget Comparison Budget FYTD	Variance Fav / (Unfav)
Member Months	**1,258,189**	**1,223,895**	**1,553,660**	**2,130,979**	**2,413,136**	**626,084**	**209,381**	**208,890**	**208,148**	**626,419**	**1,252,503**	**1,263,386**	(10,883)
Revenue	**304,635,932**	**315,119,611**	**402,701,476**	**595,607,370**	**675,629,602**	**148,815,746**	**50,642,097**	**83,730,577**	**55,690,409**	**190,063,083**	**338,878,829**	**341,565,941**	(2,687,112)
pmpm	*242.12*	*257.47*	*259.20*	*279.50*	*279.98*	*237.69*	*241.87*	*400.84*	*267.55*	*303.41*	*270.56*	*270.36*	0.20
Health Care Costs	**287,353,672**	**280,382,704**	**327,305,832**	**509,183,268**	**583,149,780**	**155,478,257**	**53,044,040**	**54,130,570**	**49,711,735**	**156,886,345**	**312,364,602**	**316,540,252**	4,175,650
pmpm	*228.39*	*229.09*	*210.67*	*238.94*	*241.66*	*248.33*	*253.34*	*259.13*	*238.83*	*250.45*	*249.39*	*250.55*	1.16
% of Revenue	94.3%	89.0%	81.3%	85.5%	86.3%	104.5%	104.7%	64.6%	89.3%	82.5%	92.2%	92.7%	0.50%
Admin Exp	**18,891,320**	**24,013,927**	**31,751,533**	**34,814,049**	**38,256,908**	**12,063,462**	**4,267,779**	**4,040,868**	**4,090,719**	**12,399,366**	**24,462,828**	**27,227,656**	2,764,827
pmpm	*15.01*	*19.62*	*20.44*	*16.34*	*15.85*	*19.27*	*20.38*	*19.34*	*19.65*	*19.79*	*19.53*	*21.55*	2.02
% of Revenue	6.2%	7.6%	7.9%	5.8%	5.7%	8.1%	8.4%	4.8%	7.3%	6.5%	7.2%	8.0%	0.75%
Non-Operating Revenue / (Expense)					**1,790,949**	**596,568**	**211,636**	**163,074**	**273,090**	**647,800**	**1,244,368**	**688,748**	555,620
pmpm					*0.74*	*0.95*	*1.01*	*0.78*	*1.31*	*1.03*	*0.99*	*0.55*	0.45
% of Revenue					0.3%	0.4%	0.4%	0.2%	0.5%	0.3%	0.4%	0.2%	0.17%
Total Increase / (Decrease) in Unrestricted Net Assets	**(1,609,063)**	**10,722,980**	**43,644,110**	**51,610,053**	**56,013,863**	**(18,129,405)**	**(6,458,086)**	**25,722,214**	**2,161,044**	**21,425,172**	**3,295,767**	**(1,513,218)**	4,808,985
pmpm	*(1.28)*	*8.76*	*28.09*	*24.22*	*23.21*	*(28.96)*	*(30.84)*	*123.14*	*10.38*	*34.20*	*2.63*	*(1.20)*	3.83
% of Revenue	-0.5%	3.4%	10.8%	8.7%	8.3%	-12.2%	-12.8%	30.7%	3.9%	11.3%	1.0%	-0.4%	1.42%
YTD													
100% TNE	16,769,368	16,138,440	17,867,986	22,556,530	25,246,284	26,097,131	27,172,945	27,284,463	27,075,526	27,075,526	27,075,526	27,331,953	(256,427)
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Minimum Required TNE	6,036,972	10,974,139	17,867,986	22,556,530	25,246,284	26,097,131	27,172,945	27,284,463	27,075,526	27,075,526	27,075,526	27,331,953	(256,427)
GCHP TNE	**(6,031,881)**	**11,891,099**	**55,535,211**	**107,145,264**	**155,959,127**	**137,829,722**	**131,371,635**	**157,093,849**	**159,254,894**	**159,254,894**	**159,254,894**	**151,543,938**	**7,710,956**
TNE Excess / (Deficiency)	**(12,068,853)**	**916,960**	**37,667,225**	**84,588,734**	**130,712,843**	**111,732,591**	**104,198,690**	**129,809,386**	**132,179,367**	**132,179,367**	**132,179,367**	**124,211,985**	**7,967,383**
% of Required TNE level			**311%**	**475%**	**618%**	**528%**	**483%**	**576%**	**588%**	**588%**	**588%**	**554%**	

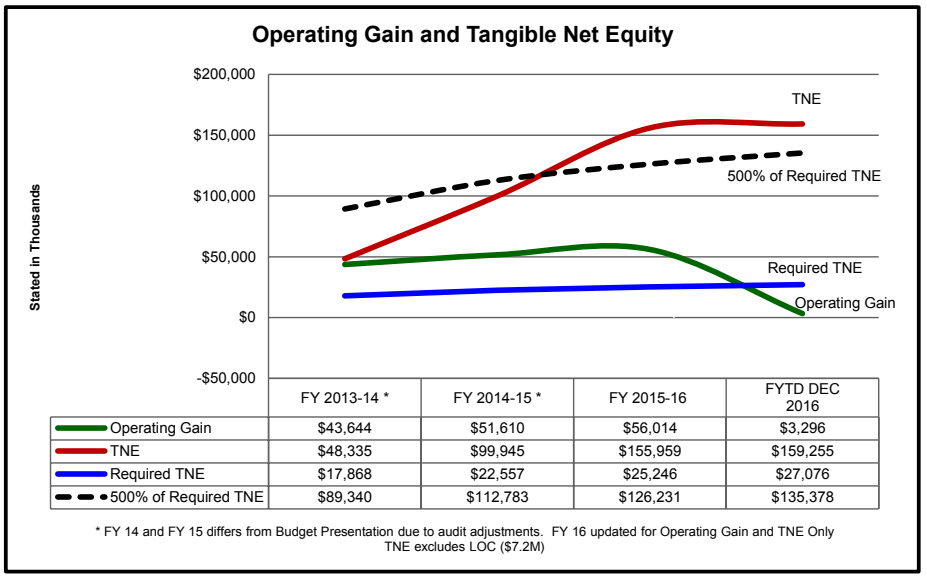
FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING December 31, 2016







Note: FY 14 and FY 15 differs from Budget Presentation due to Auditors' Adjustments.
Medical Loss Ratio (MLR), Administrative Cost Ratio (ACR)

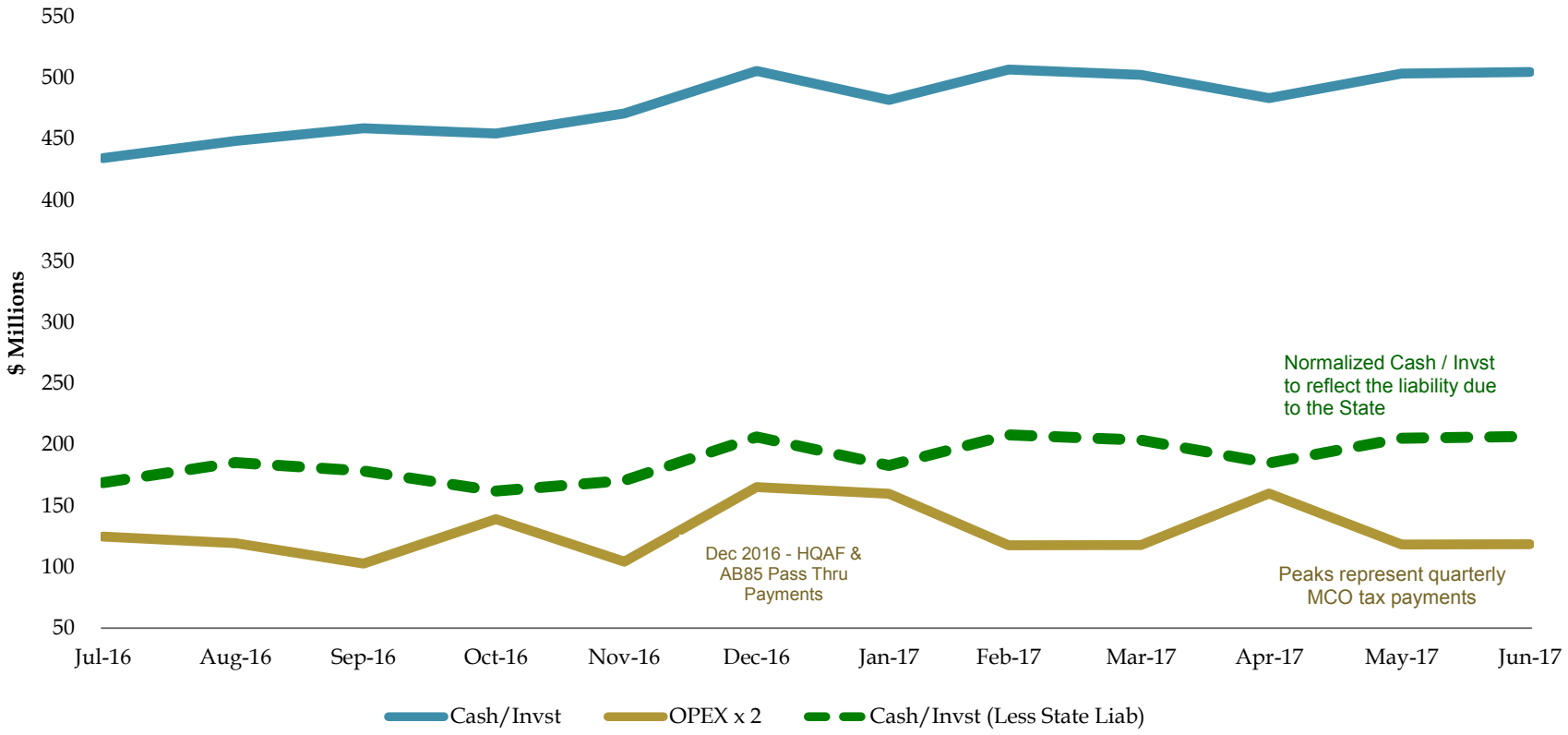


	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FYTD DEC 2016
Operating Gain	$43,644	$51,610	$56,014	$3,296
TNE	$48,335	$99,945	$155,959	$159,255
Required TNE	$17,868	$22,557	$25,246	$27,076
500% of Required TNE	$89,340	$112,783	$126,231	$135,378

* FY 14 and FY 15 differs from Budget Presentation due to audit adjustments. FY 16 updated for Operating Gain and TNE Only
TNE excludes LOC ($7.2M)

GOLD COAST HEALTH PLAN
FY 2016 - 17

Cash & Operating Expense Requirements



Dec 16 - Received and disbursed HQAF pass thru

Gold Coast Health Plan℠
A Public Entity

For the month ended December 31, 2016

APPENDIX

- Statement of Financial Position
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- YTD Cash Flow
- Monthly Cash Flow
- Membership
- Paid Claims and IBNP Composition
- Pharmacy Cost & Utilization Trends

STATEMENT OF FINANCIAL POSITION

	12/31/16	11/30/16	10/31/16
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 222,220,890**	**$ 212,517,390**	**$ 241,091,166**
Total Short-Term Investments	**283,474,863**	**258,425,655**	**213,384,150**
Medi-Cal Receivable	88,940,846	88,194,360	56,945,574
Interest Receivable	442,720	556,246	504,672
Provider Receivable	496,844	4,907,525	4,893,419
Total Accounts Receivable	**89,880,410**	**93,658,131**	**62,343,665**
Total Prepaid Accounts	1,538,489	1,834,523	1,968,938
Total Other Current Assets	133,545	133,545	133,545
Total Current Assets	**597,248,198**	**566,569,245**	**518,921,465**
Total Fixed Assets	**2,594,812**	**2,637,592**	**2,691,314**
Total Long-Term Investments	**5,201,695**	**5,219,620**	**10,251,606**
Total Assets	**$ 605,044,704**	**$ 574,426,458**	**$ 531,864,384**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 58,378,915	$ 60,125,488	$ 57,271,371
Claims Payable	16,987,914	6,252,184	6,844,936
Capitation Payable	56,929,907	56,900,134	56,743,416
Physician ACA 1202 Payable	591,696	591,696	591,696
AB 85 Payable	1,480,540	1,492,926	1,480,508
Accounts Payable	2,123,276	2,485,066	2,289,635
Accrued ACS	1,710,224	1,688,624	1,716,803
Accrued Expenses	146,023,916	134,641,385	130,341,787
Accrued Premium Tax	21,253,572	13,724,561	6,864,611
Accrued Payroll Expense	938,944	983,595	1,174,998
Total Current Liabilities	**306,418,903**	**278,885,660**	**265,319,760**
Long-Term Liabilities:			
DHCS - Reserve for Capitation Recoup	138,419,946	137,519,946	134,269,946
Other Long-term Liability-Deferred Rent	950,962	927,003	903,043
Total Long-Term Liabilities	**139,370,908**	**138,446,949**	**135,172,989**
Total Liabilities	**445,789,811**	**417,332,608**	**400,492,749**
Net Assets:			
Beginning Net Assets	155,959,127	155,959,127	155,959,127
Total Increase / (Decrease in Unrestricted Net Assets)	3,295,767	1,134,722	(24,587,491)
Total Net Assets	**159,254,894**	**157,093,849**	**131,371,635**
Total Liabilities & Net Assets	**$ 605,044,704**	**$ 574,426,458**	**$ 531,864,384**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR SIX MONTHS ENDED DECEMBER 2016

	December 2016 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	1,252,503	1,263,386	(10,883)
Revenue			
Premium	$ 384,531,075	$ 383,903,039	$ 628,036
Reserve for Rate Reduction	(3,800,000)	(1,241,866)	(2,558,134)
MCO Premium Tax	(42,119,175)	(41,095,231)	(1,023,943)
Total Net Premium	**338,611,900**	**341,565,941**	**(2,954,041)**
Other Revenue:			
Miscellaneous Income	266,929	0	266,929
Total Other Revenue	266,929	**0**	266,929
Total Revenue	**338,878,829**	**341,565,941**	**(2,687,112)**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	34,494,764	30,078,515	(4,416,249)
FFS Claims Expenses:			
Inpatient	65,701,015	63,259,093	(2,441,922)
LTC / SNF	61,280,179	57,531,051	(3,749,128)
Outpatient	24,453,027	24,540,196	87,169
Laboratory and Radiology	1,637,453	1,450,603	(186,850)
Emergency Room	9,950,310	10,774,177	823,866
Physician Specialty	26,482,924	28,574,160	2,091,236
Primary Care Physician	7,244,503	9,332,817	2,088,314
Home & Community Based Services	8,190,650	7,841,643	(349,007)
Applied Behavior Analysis Services	1,932,691	717,483	(1,215,208)
Mental Health Services	2,374,380	2,068,106	(306,274)
Pharmacy	57,668,580	58,567,390	898,811
Provider Reserve	0	6,052,812	6,052,812
Other Medical Professional	1,414,333	1,243,779	(170,553)
Other Medical Care	201,646	0	(201,646)
Other Fee For Service	4,054,218	3,786,606	(267,612)
Transportation	733,571	774,691	41,120
Total Claims	273,319,479	276,514,607	3,195,129
Medical & Care Management Expense	5,886,281	6,940,271	1,053,989
Reinsurance	120,575	3,006,859	2,886,284
Claims Recoveries	(1,456,497)	0	1,456,497
Sub-total	4,550,359	9,947,129	5,396,770
Total Cost of Health Care	**312,364,602**	**316,540,252**	**4,175,650**
Contribution Margin	**26,514,227**	**25,025,689**	**1,488,538**
General & Administrative Expenses:			
Salaries, Wages & Employee Benefits	11,263,735	11,699,220	435,485
Training, Conference & Travel	231,515	329,158	97,643
Outside Services	13,810,805	14,561,858	751,053
Professional Services	2,035,462	3,540,707	1,505,245
Occupancy, Supplies, Insurance & Others	3,007,593	4,036,984	1,029,391
ARCH/Community Grants	0	0	0
Care Management Credit	(5,886,281)	(6,940,271)	(1,053,989)
Total G & A Expenses	**24,462,828**	**27,227,656**	**2,764,827**
Total Operating Gain / (Loss)	**$ 2,051,399**	**$ (2,201,966)**	**$ 4,253,365**
Non Operating			
Revenues - Interest	1,244,368	688,748	555,620
Total Non-Operating	1,244,368	688,748	555,620
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 3,295,767**	**$ (1,513,218)**	**$ 4,808,985**
Net Assets, Beginning of Year	155,959,127		
Net Assets, End of Year	159,254,894		

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2016-17 Monthly Trend			Current Month		
	SEP 16	OCT 16	NOV 16	DECEMBER 2016 Actual	DECEMBER 2016 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	208,690	209,381	208,890	208,148	211,879	(3,731)
Revenue:						
Premium	$ 56,571,808	$ 57,442,351	$ 94,037,969	$ 63,330,543	$ 64,338,216	$ (1,007,674)
Reserve for Rate Reduction	(5,100,000)	210,000	(3,250,000)	(900,000)	(216,761)	(683,239)
MCO Premium Tax	(21,021,295)	(7,010,254)	(7,057,392)	(7,007,063)	(6,889,252)	(117,811)
Total Net Premium	**30,450,514**	**50,642,097**	**83,730,577**	**55,423,480**	**57,232,204**	**(1,808,724)**
Other Revenue:						
Miscellaneous Income	0	0	0	266,929	0	(266,929)
Total Other Revenue	0	0	0	266,929	0	(266,929)
Total Revenue	**30,450,514**	**50,642,097**	**83,730,577**	**55,690,409**	**57,232,204**	**(2,075,653)**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,038,794	5,046,179	5,203,391	5,078,661	5,042,101	(36,561)
FFS Claims Expenses:						
Inpatient	7,747,745	11,964,545	14,676,172	9,534,211	10,610,662	1,076,451
LTC / SNF	10,733,194	9,735,480	9,692,962	9,091,987	9,612,838	520,851
Outpatient	3,158,051	4,305,891	4,396,347	4,979,461	4,115,108	(864,352)
Laboratory and Radiology	291,159	228,035	556,070	146,314	243,425	97,111
Emergency Room	1,522,768	1,784,768	1,629,759	1,635,653	1,806,754	171,101
Physician Specialty	3,491,013	4,428,998	3,902,514	4,532,550	4,795,659	263,109
Primary Care Physician	1,070,439	1,003,315	1,320,692	1,326,796	1,566,058	239,262
Home & Community Based Services	1,428,204	1,576,779	1,479,249	1,302,526	1,318,471	15,945
Applied Behavior Analysis Services	455,119	348,223	394,263	274,227	119,953	(154,274)
Mental Health Services	(213,235)	551,041	209,386	456,716	346,455	(110,260)
Pharmacy	9,839,875	10,053,071	9,543,842	9,263,820	9,812,837	549,018
Provider Reserve	0	0	0	0	1,013,818	1,013,818
Other Medical Professional	221,659	268,159	249,006	230,300	208,611	(21,689)
Other Medical Care	0	234	0	200,983	0	(200,983)
Other Fee For Service	659,492	685,173	683,412	561,433	634,314	72,881
Transportation	133,842	114,936	111,824	114,725	129,696	14,971
Total Claims	40,539,327	47,048,648	48,845,497	43,651,702	46,334,660	2,682,958
Medical & Care Management Expense	967,260	1,045,143	1,020,823	1,022,900	1,178,510	155,610
Reinsurance	259,013	(4,712)	(445,809)	260,296	504,272	243,976
Claims Recoveries	(183,289)	(91,218)	(493,332)	(301,825)	0	301,825
Sub-total	1,042,985	949,213	81,682	981,371	1,682,782	701,411
Total Cost of Health Care	**46,621,107**	**53,044,040**	**54,130,570**	**49,711,735**	**53,059,542**	**3,347,808**
Contribution Margin	**(16,170,593)**	**(2,401,944)**	**29,600,008**	**5,978,674**	**4,172,661**	**1,806,013**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	1,770,149	2,009,658	1,949,253	1,960,636	2,046,815	86,179
Training, Conference & Travel	87,514	38,992	29,612	33,663	30,918	(2,744)
Outside Services	2,302,260	2,296,507	2,247,451	2,371,432	2,436,207	64,775
Professional Services	312,725	482,936	311,400	222,513	470,340	247,827
Occupancy, Supplies, Insurance & Others	478,459	484,829	523,975	525,375	651,383	126,008
Care Management Credit	(967,260)	(1,045,143)	(1,020,823)	(1,022,900)	(1,178,510)	(155,610)
Total G & A Expenses	**3,983,846**	**4,267,779**	**4,040,868**	**4,090,719**	**4,457,154**	**366,434**
Total Operating Gain / (Loss)	**(20,154,439)**	**(6,669,723)**	**25,559,140**	**1,887,955**	**(284,492)**	**2,172,447**
Non Operating:						
Revenues - Interest	190,052	211,636	163,074	273,090	75,301	197,789
Total Non-Operating	**190,052**	**211,636**	**163,074**	**273,090**	**75,301**	**197,789**
Total Increase / (Decrease) in Unrestricted Net Assets	**(19,964,387)**	**(6,458,086)**	**25,722,214**	**2,161,044**	**(209,191)**	**2,370,236**
Full Time Employees				**185**	**198**	**13**

PMPM - STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2016-17 Monthly Trend			DECEMBER 2016		Variance
	SEP 16	OCT 16	NOV 16	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	208,690	209,381	208,890	208,148	211,879	(3,731)
Revenue:						
Premium	271.08	274.34	450.18	304.26	303.66	0.60
Reserve for Rate Reduction	(24.44)	1.00	(15.56)	(4.32)	(1.02)	(3.30)
MCO Premium Tax	(100.73)	(33.48)	(33.79)	(33.66)	(32.52)	(1.15)
Total Net Premium	**145.91**	**241.87**	**400.84**	**266.27**	**270.12**	**(3.85)**
Other Revenue:						
Interest Income	0.00	0.00	0.00	0.00	0.00	0.00
Miscellaneous Income	0.00	0.00	0.00	1.28	0.00	1.28
Total Other Revenue	0.00	0.00	0.00	1.28	0.00	1.28
Total Revenue	**145.91**	**241.87**	**400.84**	**267.55**	**270.12**	**(2.57)**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	24.14	24.10	24.91	24.40	23.80	(0.60)
FFS Claims Expenses:						
Inpatient	37.13	57.14	70.26	45.80	50.08	4.27
LTC / SNF	51.43	46.50	46.40	43.68	45.37	1.69
Outpatient	15.13	20.56	21.05	23.92	19.42	(4.50)
Laboratory and Radiology	1.40	1.09	2.66	0.70	1.15	0.45
Emergency Room	7.30	8.52	7.80	7.86	8.53	0.67
Physician Specialty	16.73	21.15	18.68	21.78	22.63	0.86
Primary Care Physician	5.13	4.79	6.32	6.37	7.39	1.02
Home & Community Based Services	6.84	7.53	7.08	6.26	6.22	(0.03)
Applied Behavior Analysis Services	2.18	1.66	1.89	1.32	0.57	(0.75)
Mental Health Services	(1.02)	2.63	1.00	2.19	1.64	(0.56)
Pharmacy	47.15	48.01	45.69	44.51	46.31	1.81
Provider Reserve	0.00	0.00	0.00	0.00	4.78	4.78
Other Medical Professional	1.06	1.28	1.19	1.11	0.98	(0.12)
Other Medical Care	0.00	0.00	0.00	0.97	0.00	(0.97)
Other Fee For Service	3.16	3.27	3.27	2.70	2.99	0.30
Transportation	0.64	0.55	0.54	0.55	0.61	0.06
Total Claims	194.26	224.70	233.83	209.71	218.68	8.97
Medical & Care Management Expense	4.63	4.99	4.89	4.91	5.56	0.65
Reinsurance	1.24	(0.02)	(2.13)	1.25	2.38	1.13
Claims Recoveries	(0.88)	(0.44)	(2.36)	(1.45)	0.00	1.45
Sub-total	5.00	4.53	0.39	4.71	7.94	3.23
Total Cost of Health Care	223.40	253.34	259.13	238.83	**250.42**	**11.60**
Contribution Margin	**(77.49)**	**(11.47)**	**141.70**	**28.72**	**19.69**	**9.03**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	8.48	9.60	9.33	9.42	9.66	0.24
Training, Conference & Travel	0.42	0.19	0.14	0.16	0.15	(0.02)
Outside Services	11.03	10.97	10.76	11.39	11.50	0.11
Professional Services	1.50	2.31	1.49	1.07	2.22	1.15
Occupancy, Supplies, Insurance & Others	2.29	2.32	2.51	2.52	3.07	0.55
ARCH/Community Grants	0.00	0.00	0.00	0.00	0.00	0.00
Care Management Credit	(4.63)	(4.99)	(4.89)	(4.91)	(5.56)	(0.65)
Total G & A Expenses	19.09	20.38	19.34	19.65	21.04	1.38
Total Operating Gain / (Loss)	(96.58)	(31.85)	122.36	9.07	(1.34)	10.41
Non Operating:						
Revenues - Interest	0.91	1.01	0.78	1.31	0.36	0.96
Expenses - Interest	0.00	0.00	0.00	0.00	0.00	0.00
Total Non-Operating	0.91	1.01	0.78	1.31	0.36	0.96
Total Increase / (Decrease) in Unrestricted Net Assets	(95.67)	(30.84)	123.14	10.38	(0.99)	11.37

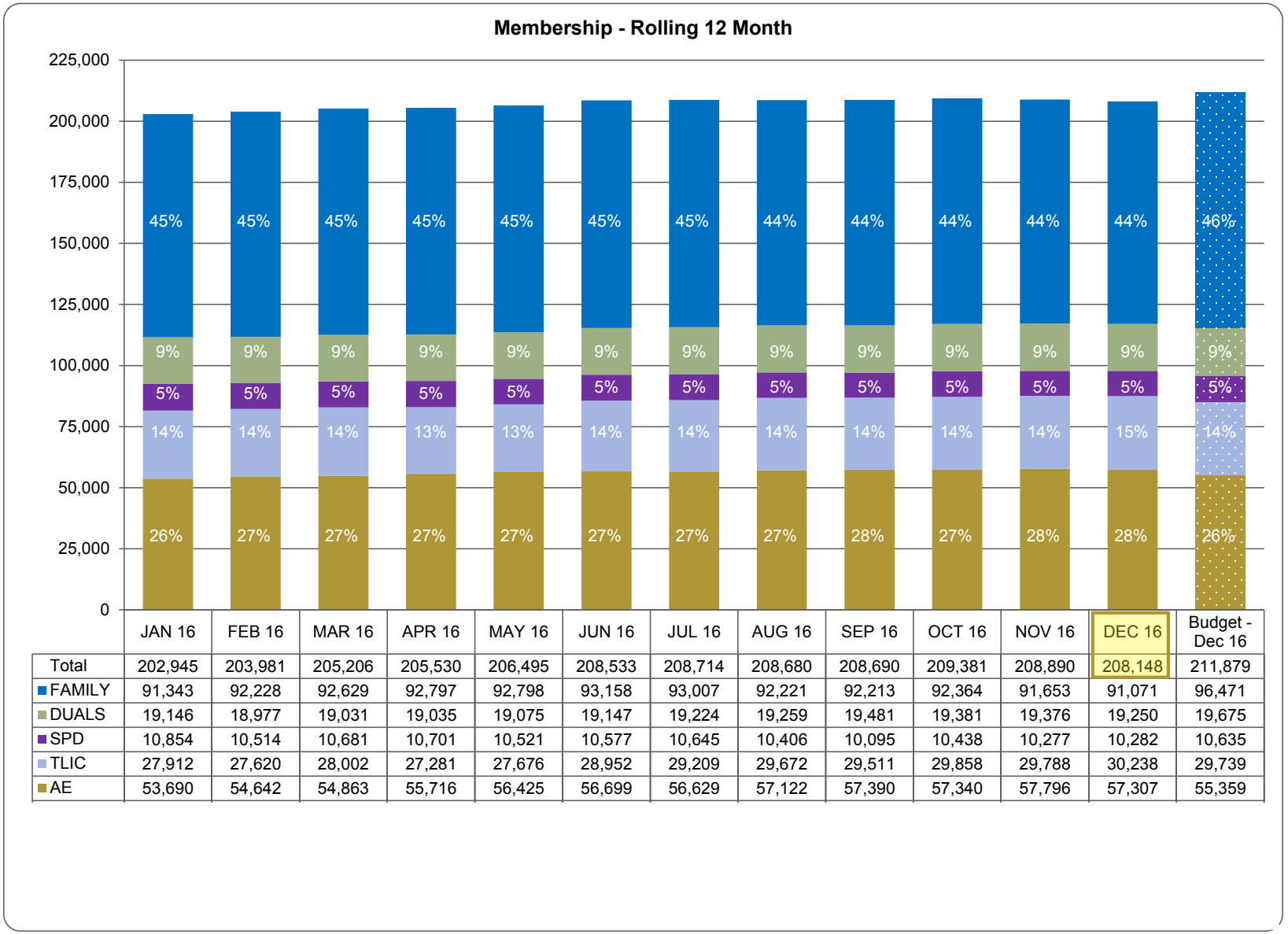
STATEMENT OF CASH FLOWS - FYTD

	DEC 16
Cash Flow From Operating Activities	
Collected Premium	$ 487,425,646
Miscellaneous Income	871,689
State Pass Through Funds	60,988,715
Paid Claims	
Medical & Hospital Expenses	(209,392,636)
Pharmacy	(60,225,660)
Capitation	(29,271,191)
Reinsurance of Claims	(1,556,861)
State Pass Through Funds Distributed	(49,135,364)
Paid Administration	(29,195,403)
MCO Taxes Received / (Paid)	(26,964,419)
Net Cash Provided / (Used) by Operating Activities	**143,544,516**
Cash Flow From Investing / Financing Activities	
Net Acquisition / Proceeds from Investments	(65,408,793)
Net Discount / Premium Amortization of Investments	373,279
Net Acquisition of Property / Equipment	(380,578)
Net Cash Provided / (Used) by Investing / Financing	**(65,416,092)**
Net Cash Flow	**$ 78,128,424**
Cash and Cash Equivalents (Beg. of Period)	144,092,466
Cash and Cash Equivalents (End of Period)	222,220,890
	$ 78,128,424
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income / (Loss)	3,295,767
Depreciation & Amortization	330,506
Net Discount / Premium Amortization of Investments	(373,279)
Decrease / (Increase) in Receivables	40,125,862
Decrease / (Increase) in Prepaids & Other Current Assets	66,637
(Decrease) / Increase in Payables	69,755,513
(Decrease) / Increase in Other Liabilities	3,943,757
Change in MCO Tax Liability	15,677,577
Changes in Claims and Capitation Payable	8,654,654
Changes in IBNR	2,067,523
	143,544,516
Net Cash Flow from Operating Activities	**$ 143,544,516**

STATEMENT OF CASH FLOWS - MONTHLY

	DEC 16	NOV 16	OCT 16
Cash Flow From Operating Activities			
Collected Premium	$ 72,918,701	$ 67,346,446	$ 71,859,110
Miscellaneous Income	258,997	103,527	34,529
State Pass Through Funds	51,098,178	1,480,308	1,482,137
Paid Claims			
Medical & Hospital Expenses	(30,164,283)	(36,727,345)	(35,550,674)
Pharmacy	(10,041,457)	(10,259,026)	(10,214,616)
Capitation	(5,049,668)	(4,886,047)	(4,877,725)
Reinsurance of Claims	(260,296)	(259,610)	(258,964)
State Pass Through Funds Distributed	(39,401,630)	(1,480,508)	(1,482,258)
Paid Administration	(4,629,360)	(3,742,401)	(4,576,541)
MCO Tax Received / (Paid)	(3,145)	(196,518)	(21,018,984)
Net Cash Provided / (Used) by Operating Activities	**34,726,037**	**11,378,825**	**(4,603,987)**
Cash Flow From Investing / Financing Activities			
Net Acquisition / Proceeds from Investments	(25,031,282)	(40,009,520)	(177,707)
Net Discount / Premium Amortization of Investments	14,093	59,547	177,707
Net Acquisition of Property / Equipment	(5,348)	(2,629)	8,606
Net Cash Provided / (Used) by Investing / Financing	**(25,022,538)**	**(39,952,601)**	**8,606**
Net Cash Flow	**$ 9,703,500**	**$ (28,573,776)**	**$ (4,595,381)**
Cash and Cash Equivalents (Beg. of Period)	212,517,390	241,091,166	245,686,547
Cash and Cash Equivalents (End of Period)	222,220,890	212,517,390	241,091,166
	$ 9,703,500	**$ (28,573,776)**	**$ (4,595,381)**
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	2,161,044	25,722,214	(6,458,086)
Net Discount / Premium Amortization of Investments	(14,093)	(59,547)	(177,707)
Depreciation & Amortization	48,128	56,350	56,350
Decrease / (Increase) in Receivables	3,777,721	(31,314,466)	3,661,463
Decrease / (Increase) in Prepaids & Other Current Ass	296,035	134,415	(144,140)
(Decrease) / Increase in Payables	10,985,302	4,287,866	11,434,754
(Decrease) / Increase in Other Liabilities	923,960	3,273,960	(186,041)
Change in MCO Tax Liability	7,529,011	6,859,950	(14,009,434)
Changes in Claims and Capitation Payable	10,765,503	(436,034)	(1,779,737)
Changes in IBNR	(1,746,573)	2,854,117	2,998,591
	34,726,037	11,378,825	(4,603,987)
Net Cash Flow from Operating Activities	**34,726,037**	**11,378,825**	**(4,603,987)**

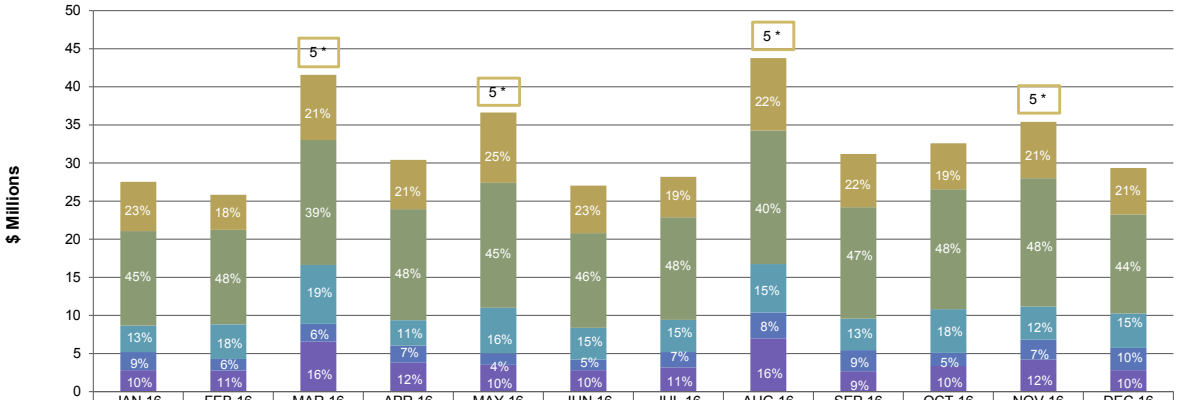
GOLD COAST HEALTH PLAN



	JAN 16	FEB 16	MAR 16	APR 16	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	Budget - Dec 16
Total	202,945	203,981	205,206	205,530	206,495	208,533	208,714	208,680	208,690	209,381	208,890	208,148	211,879
FAMILY	91,343	92,228	92,629	92,797	92,798	93,158	93,007	92,221	92,213	92,364	91,653	91,071	96,471
DUALS	19,146	18,977	19,031	19,035	19,075	19,147	19,224	19,259	19,481	19,381	19,376	19,250	19,675
SPD	10,854	10,514	10,681	10,701	10,521	10,577	10,645	10,406	10,095	10,438	10,277	10,282	10,635
TLIC	27,912	27,620	28,002	27,281	27,676	28,952	29,209	29,672	29,511	29,858	29,788	30,238	29,739
AE	53,690	54,642	54,863	55,716	56,425	56,699	56,629	57,122	57,390	57,340	57,796	57,307	55,359

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

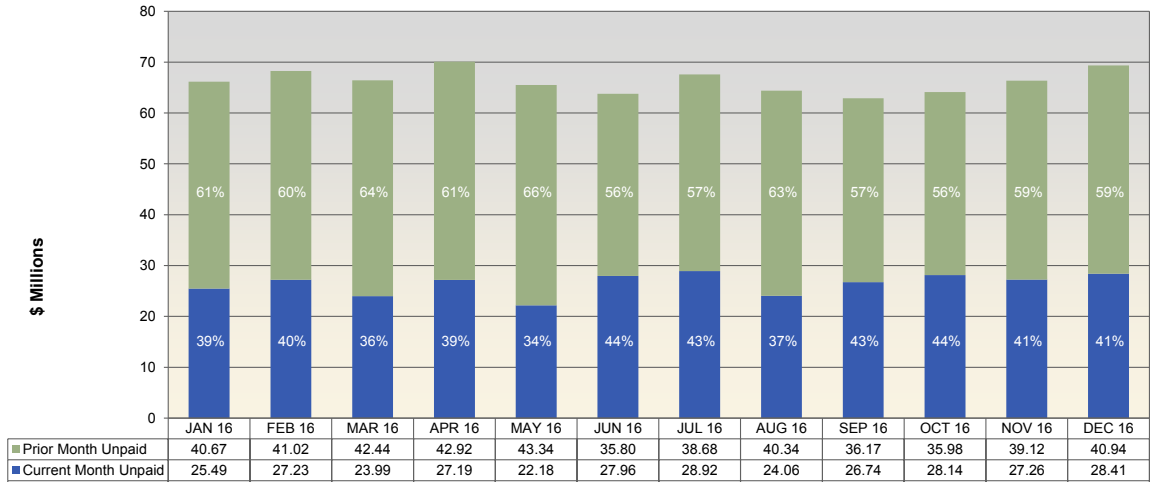
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	JAN 16	FEB 16	MAR 16	APR 16	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16
Current	6.47	4.61	8.56	6.46	9.24	6.24	5.31	9.51	6.99	6.03	7.39	6.12
30	12.40	12.40	16.40	14.57	16.40	12.42	13.47	17.52	14.62	15.73	16.84	12.98
60	3.45	4.54	7.73	3.34	5.95	4.18	4.23	6.38	4.15	5.73	4.32	4.51
90	2.38	1.50	2.33	2.24	1.51	1.38	2.03	3.38	2.75	1.73	2.64	2.92
120+	2.82	2.78	6.56	3.80	3.52	2.81	3.17	6.99	2.68	3.36	4.21	2.82

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

IBNP Composition (excluding Pharmacy and Capitation)

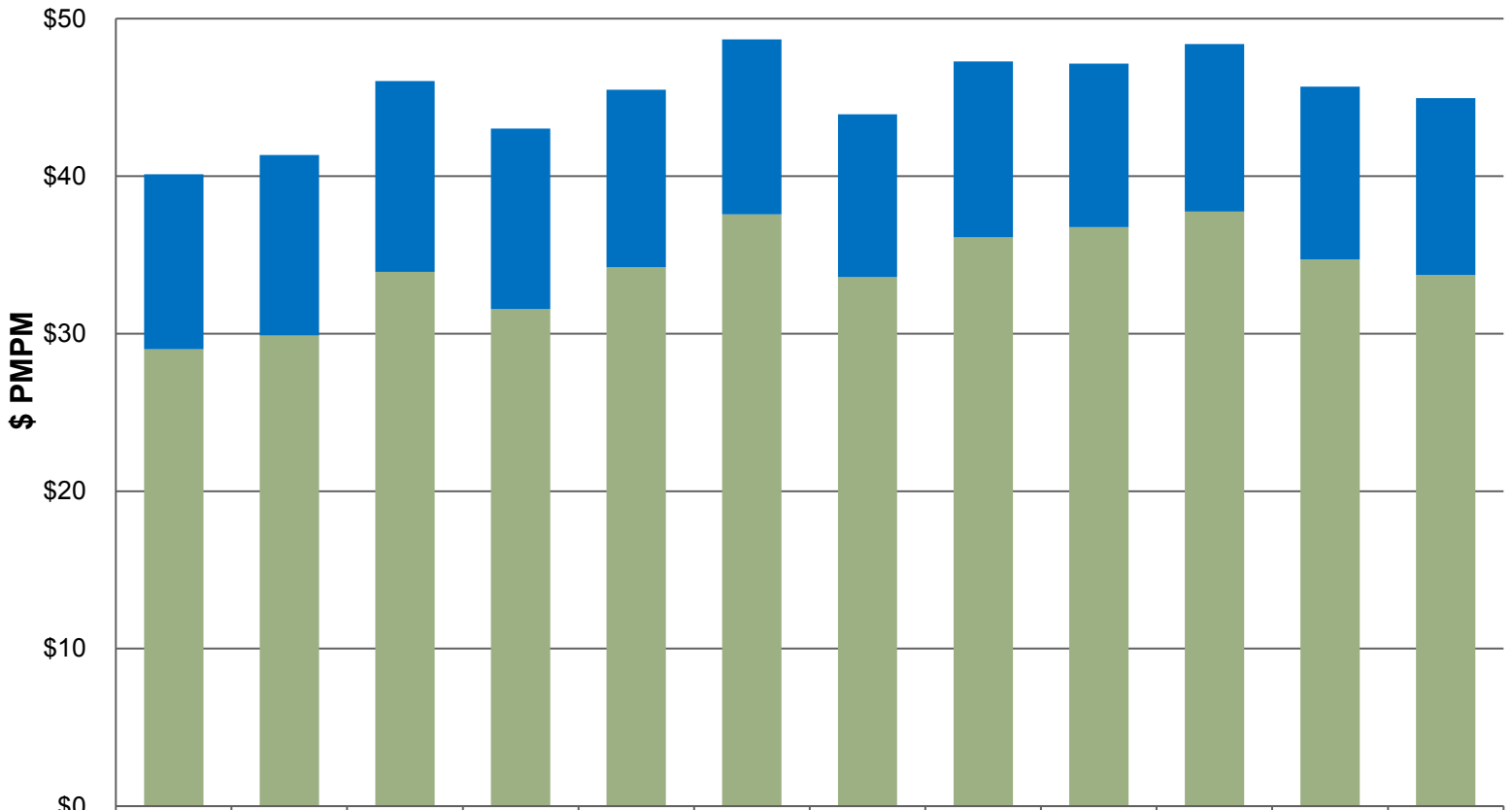


	JAN 16	FEB 16	MAR 16	APR 16	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16
Prior Month Unpaid	40.67	41.02	42.44	42.92	43.34	35.80	38.68	40.34	36.17	35.98	39.12	40.94
Current Month Unpaid	25.49	27.23	23.99	27.19	22.18	27.96	28.92	24.06	26.74	28.14	27.26	28.41

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

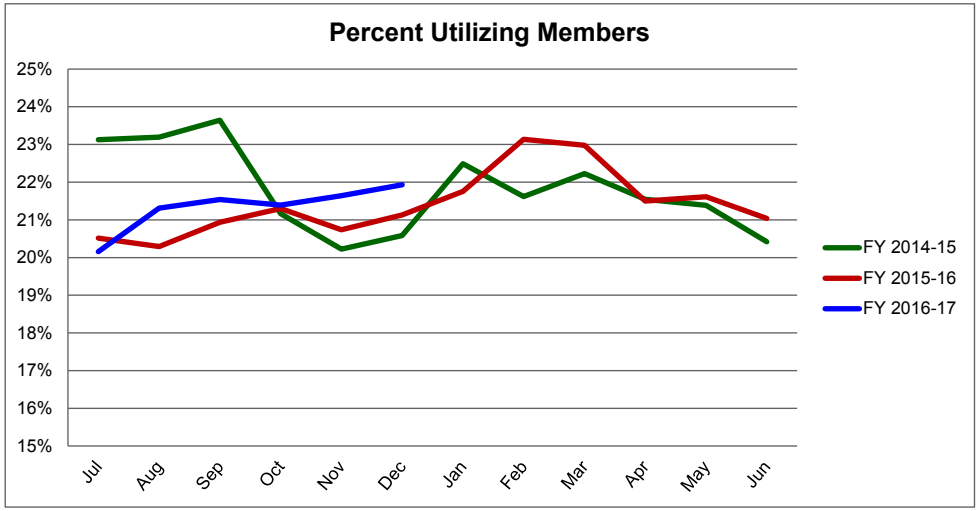
GOLD COAST HEALTH PLAN

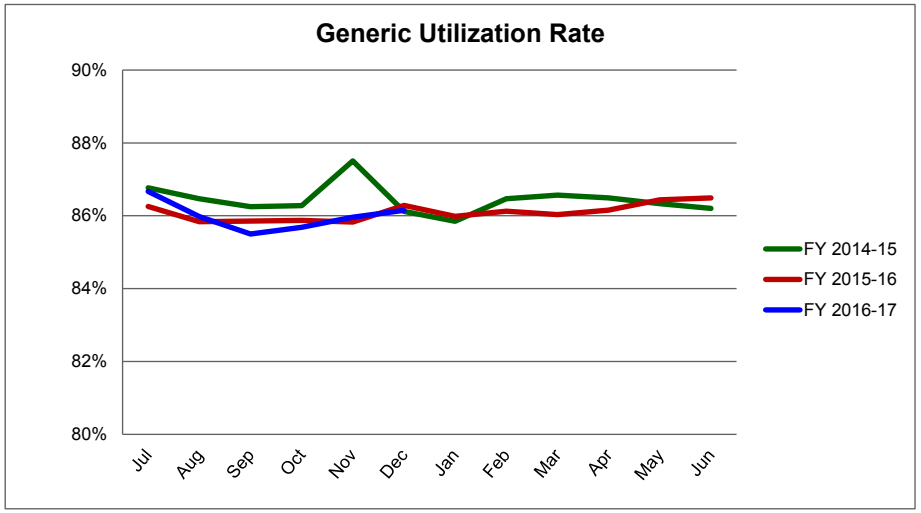
Pharmacy Cost Trend



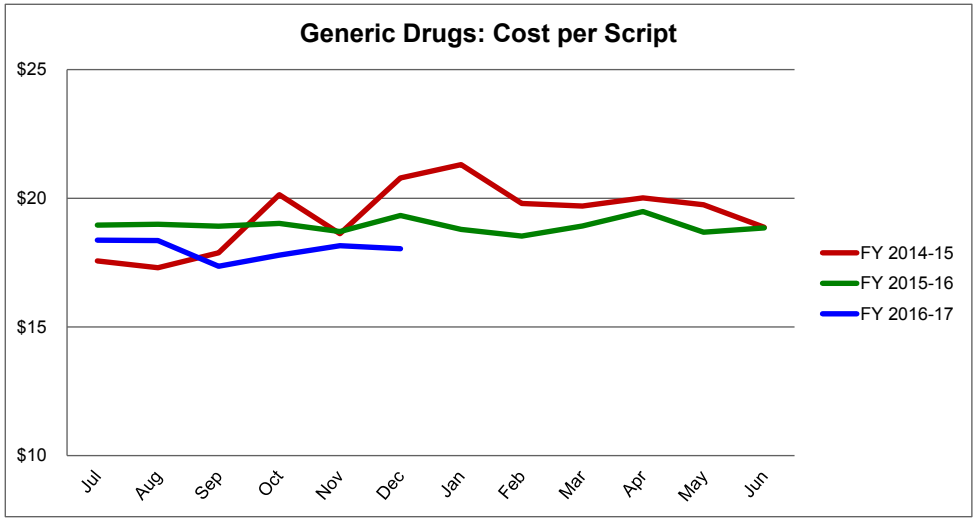
	JAN 16	FEB 16	MAR 16	APR 16	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16
AVG PMPM	$40.11	$41.33	$46.03	$43.01	$45.48	$48.67	$43.93	$47.28	$47.15	$48.38	$45.69	$44.95
GENERIC	$11.11	$11.45	$12.11	$11.47	$11.26	$11.09	$10.34	$11.17	$10.39	$10.64	$10.97	$11.23
BRAND	$29.00	$29.88	$33.92	$31.55	$34.22	$37.58	$33.59	$36.11	$36.77	$37.74	$34.71	$33.73

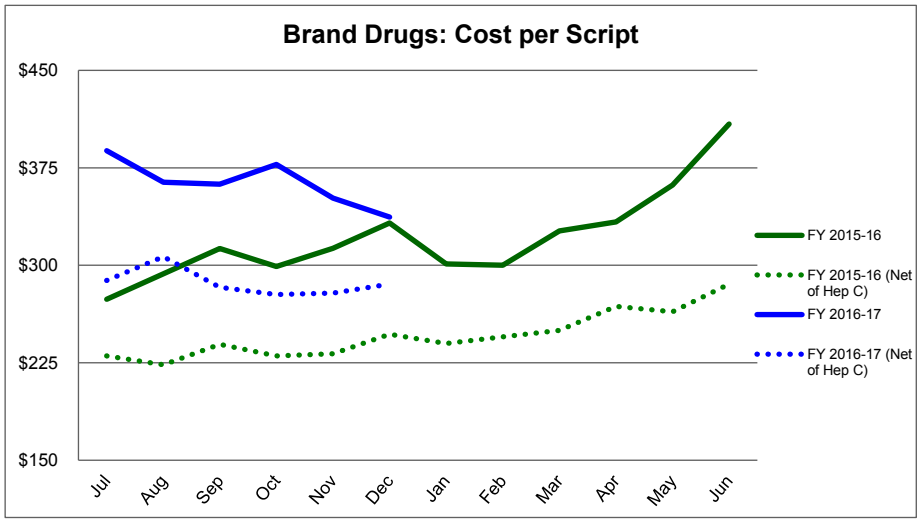
GOLD COAST HEALTH PLAN
PHARMACY ANALYSIS





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





AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: February 27, 2017

SUBJECT: Approve Resolution No. 2017-001 Amending the Bylaws to Establish *Rosenberg's Rules of Order* to Govern Certain Aspects of Commission Meetings and to Modify the Composition of the Executive/Finance Committee

SUMMARY:

Article X of the Ventura County Medi-Cal Managed Care Commission's ("Commission's") Bylaws provides that a full statement of any proposed amendment be presented to the Commission at least two weeks prior to the meeting at which the amendment is voted on. At the Commission's January meeting, staff presented a full statement of two proposed amendments to the Bylaws. The Commission reviewed the proposed amendments and directed staff to bring the item for final approval at this meeting.

The first amendment adopts *Rosenberg's Rules of Order* for the conduct of Commission meetings, except where the bylaws provide other rules of conduct. The second amendment modifies the composition of the Executive/Finance Committee so that it does not require two members from the same constituency. The Bylaws currently limit who can serve on the Committee, and the change would allow any Commission member to be appointed to the Committee, provided that there is at least one representative from Clinicas Del Camino Real, Ventura County Medical Center Health System, and a private hospital or healthcare entity.

BACKGROUND/DISCUSSION:

Article X of the Commission's Bylaws requires that the Commission review the Bylaws annually. At its recent strategic planning session, the Commission discussed the Bylaws and staff recommended two changes.

First, staff proposed to adopt *Rosenberg's Rules of Order* to govern the procedure of Commission meetings where procedures are not established by the Bylaws. Currently, Article VI references *Robert's Rules of Order* for the conduct of Commission meetings. *Robert's Rules* is the classic model for parliamentary procedures, but it can be cumbersome and unwieldy for a smaller board, such as the Commission. *Rosenberg's Rules* is derived from and similar to *Robert's Rules*, but is more simplified. It is designed to be utilized in local government

proceedings. The more streamlined procedures in *Rosenberg's Rules* will be easier to apply and more efficient for the Commission. A copy of *Rosenberg's Rules* is attached.

Second, at the request of a Commissioner, staff is proposing a change to the composition of the Executive/Finance Committee, which currently consists of (1) the Chairperson, (2) the Vice-Chairperson, (3) a private hospital/healthcare representative, (4) a representative of Clinicas Del Camino Real, and (5) a representative of Ventura County Medical Center Health System. Article IV of the Bylaws provides that if the Chairperson or Vice-Chairperson is from one of the three constituencies, then the other representative from that constituency must also serve on the Commission. For example, because Commissioner Alatorre serves as Vice-Chairperson, Commissioner Pawar *must* serve on the Commission.

The proposed amendment will modify the Bylaws so that if the Chairperson or Vice-Chairperson is a representative of one of these three specific constituencies, then the Commission could appoint *any* Commission member to fill the Committee position. For example, since Commissioner Alatorre serves as Vice-Chairperson and represents Clinicas, the Commission will be able to appoint any member to fill the Committee position currently reserved for Clinicas.

FISCAL IMPACT:

There is no fiscal impact.

RECOMMENDATION:

Approve Resolution No. 2017-01 amending the Bylaws.

CONCURRENCE:

N/A

ATTACHMENTS:

Resolution No. 2017-001
Gold Coast Health Plan Bylaws
Rosenberg's Rules of Order

RESOLUTION NO. 2017-001

A RESOLUTION OF THE VENTURA COUNTY MEDICAL MANAGED CARE COMMISSION, DOING BUSINESS AS THE GOLD COAST HEALTH PLAN AMENDING THE BYLAWS TO ESTABLISH THAT ROSENBERG'S RULES OF ORDER SHALL BE THE COMMISSION'S RULES OF PROCEDURE AND TO CHANGE THE COMPOSITION OF THE EXECUTIVE/FINANCE COMMITTEE

WHEREAS, the Ventura County Medi-Cal Managed Care Commission, doing business as the Gold Coast Health Plan ("Commission"), has adopted Amended and Restated Bylaws for the Operation of the Ventura County Organized Health System ("Bylaws"); and

WHEREAS, under Article IV(b) of the Bylaws, the Executive/Finance Committee consists of the Chairperson, the Vice-Chairperson, a private hospital/healthcare representative, a representative of Clinicas Del Camino Real, and a representative of Ventura County Medical Center Health System;

WHEREAS, Article IV(b) provides that if a representative of one of the identified constituencies serves as Chairperson or Vice-Chairperson, then the other representative of that constituency must serve on the Committee; and

WHEREAS, the Commission desires to amend Article IV(b) of the Bylaws so that if the Chairperson or Vice-Chairperson is a representative of one of the identified constituencies, the Commission may appoint any member of the Commission to serve on the Committee; and

WHEREAS, under Article VI of the Bylaws, the Commission has adopted *Robert's Rules of Order* to govern the procedure of Commission meetings; and

WHEREAS, the Commission desires to amend Article VI of the Bylaws, so that *Rosenberg's Rules of Order* shall govern the procedure of Commission meetings.

NOW THEREFORE BE IT RESOLVED, that the Bylaws for the Operation of the Ventura County Organized Health System shall be amended as follows:

1. In Article IV, under the heading "Standing Committees," paragraph (b), subparagraph ii, shall be amended to read as follows (additions are underlined; deletions are shown in strikethrough):

   "ii. <u>Membership</u>. The Executive/Finance Committee shall be comprised of the following five (5) Commissioners:

      1. Chairperson.

2. Vice-Chairperson.

3. Private hospital/healthcare system representative (to rotate between the two representatives following the representative's resignation from the committee). If the Chairperson and/or Vice-Chairperson is a private hospital/healthcare system representative, then the Commission may appoint any one of its members to fill this position.

4. Ventura County Medical Center Health System representative. If the Chairperson and/or Vice-Chairperson is a Ventura County Medical Center Health System representative, then the Commission may appoint any one of its members to fill this position.

5. Clinicas Del Camino Real representative. If the Chairperson and/or Vice-Chairperson is a Clinicas Del Camino Real representative, then the Commission may appoint any one of its members to fill this position."

The CEO and Finance Director will serve as Ex-Officio members to Co-Chair the committee.

~~If the private hospital/healthcare system representative, the Ventura County Medical Center Health System representative and/or the Clinicas Del Camino Real representative are also the Chairperson and/or Vice-Chairperson of the governing board, then, the other Commissioner who is a representative of the same constituency or organization as the Commissioner serving as Chairperson or Vice-Chairperson shall be appointed to the Executive/Finance Committee to fill that reserved seat. For example, if the Ventura County Medical Center Health System representative and the Clinicas Del Camino Real representative are also the Chairperson and Vice-Chairperson, respectively, of the governing board, then, the other Ventura County Medical Center Health System representative and the physician representative nominated by Clinicas Del Camino Real shall be appointed to fill the respective designated seat on the Executive/Finance Committee.~~

Appointments to the Committee shall be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected or at the next regular meeting immediately thereafter. Appointments may also be made at any regular meeting where the appointment is necessitated by a resignation, termination, vacancy, special election of officers, or other event which results in the Committee lacking full membership.

2. In Article VI, under the heading “Conduct of Meeting,” paragraph (g) shall be amended as follows:

   “(g) Where these Bylaws do not afford an adequate procedure in the conduct of a meeting, the Chairperson may defer to the most current edition of ~~Robert’s Rules of Order~~ *Rosenberg’s Rules of Order*, to resolve parliamentary questions.”

3. A copy of the Amended and Restated Bylaws with the above changes shown in redline is attached as Exhibit “A.”

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission doing business as the Gold Coast Health Plan at a regular meeting on the 27th day of February, 2017, by the following vote:

AYE:
NAY:
ABSTAIN:
ABSENT:

_____
Chair

Attest:

_____
Clerk of the Board

AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
(dba Gold Coast Health Plan)

Approved: October 24, 2011
Amended: ~~April 25, 2016~~January 23, 2017

Table of Contents

AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM (dba Gold Coast Health Plan)

ARTICLE I

Name and Mission

The name of this Commission shall be the Ventura County Medi-Cal Managed Care Commission, hereafter referred to in these Bylaws as the VCMMCC. VCMMCC shall operate under the fictitious name, Gold Coast Health Plan.

The VCMMCC shall design and operate a program or programs, whose mission is to improve the health of its members through the provision of the best possible quality care and services. This will be accomplished by:

(a) Delivering medical care via a contracted provider network that will improve access to primary, specialty and ancillary services;

(b) Establishment of mechanisms to assure that medical care services meet appropriate quality of care standards;

(c) Incorporating a plan of service delivery and implementing reimbursement mechanisms which promote the long-term viability of a locally operated Medi-Cal managed care system and the existing participating provider networks inclusive of "Safety Net" providers herein defined as Medi-Cal disproportionate share hospitals, county clinics, federally qualified health centers, and licensed rural health clinics;

(d) Implementing a financial plan which includes the creation of a prudent reserve and which provides that if additional surplus funds accrue, they shall be used to expand access, improve benefits and augment provider reimbursement in Ventura County;

(e) Placing a high priority on prevention, education, early intervention services and case management for enrolled recipients;

(f) Ensuring that all obligations, statutory, contractual or otherwise, shall be the obligations of the VCMMCC and shall not be the obligations of the County of Ventura or the State of California; and

(g) Implementing programs and procedures to ensure a high level of member satisfaction.

ARTICLE II

Commissioners

The governing board of the VCMMCC shall consist of eleven (11) voting members ("members" or "Commissioners") who shall be legal residents of Ventura County. Members shall possess the requisite skills and knowledge necessary to design and operate a publicly managed health care delivery system.

Members of the VCMMCC shall be appointed by a majority vote of the Board of Supervisors and shall consist of the following:

(a) Physician Representatives. 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.

(b) Private Hospital/Healthcare System 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.

(c) Ventura County Medical Center Health System Representative. 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.

(d) Public Representative. One member shall be a member of the Board of Supervisors, nominated and selected by the Board of Supervisors.

(e) Clinicas Del Camino Real 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.

(f) County Official. 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.

(g) Consumer Representative. 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.

(h) Ventura County Medical Center Health System 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.

Selection and Terms of Commissioners

In order to stagger terms with the intent of maintaining experienced members, in the initial cycle of appointments, the following appointees shall serve two-year terms: one of the Ventura County Medical Center Health System Representatives, the Physician Representative nominated by the Ventura County Medical Association, the Public Representative, and one Private Hospital/Healthcare System Representative. All other initial appointments and all subsequent appointments to the VCMMCC shall be for four-year terms. No member may serve more than two consecutive four-year terms. Any vacancy will be filled by the Board of Supervisors for the remainder of the unexpired term and shall maintain the balance of representation on the VCMMCC. The term of each subsequent appointment shall be deemed to commence on March 15 of the year of the appointment.

A member may resign effective on giving written notice to the Clerk of the VCMMCC, unless the notice specifies a later date for his/her resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chairperson and the Board of Supervisors. The Clerk of the VCMMC shall enter the notice in the proceedings of the Commission. The acceptance of a resignation shall not be necessary to make it effective.

A member may be removed from the VCMMCC by a 4/5 vote of the Board of Supervisors.

Nominations to the VCMMCC shall be submitted to the Ventura County Executive Office, which shall be responsible for screening nominees and presenting candidates to the Board of Supervisors.

ARTICLE III

Officers

(a) Officers of the VCMMCC shall be a Chairperson and Vice-Chairperson.

(b) The Chairperson and the Vice-Chairperson shall be elected by majority vote of the members in attendance at the first meeting of the VCMMCC to serve for the remainder of the calendar year in which the first meeting occurs. Officers subsequently elected to these offices, pursuant to the procedures outlined under “Election” below, shall serve a term of two years or until their successor(s) has/have been duly elected.

(c) No individual shall serve more than two consecutive terms in any of the elected officer positions.

Election

(a) The VCMMCC shall elect officers by majority vote of the members present.

(b) The election of officers shall be held at the first regular meeting of the VCMMCC after March 15 (or after the date upon which the Board of Supervisors appoints Commissioners for the present term if later than March 15) in every even-numbered year. The two-year terms of office shall be deemed to commence on March 15 of the year of the election, regardless of when the election actually occurs. The officers of the prior term shall continue to preside over any meetings and perform all other functions of their offices until new officers are elected.

(c) Notwithstanding the normal election process detailed in paragraphs (a) and (b) above, when circumstances warrant it, an election may be held at any time during the year. Circumstances that would warrant a special election include: one or more of the officers wishes to resign as an officer, or one or more of the officers is terminated.

Duties

(a) The Chairperson shall:

1. Preside at all meetings;

2. Execute all documents approved by the VCMMCC;

3. Be responsible to see that all actions of the VCMMCC are implemented; and

4. Maintain consultation with the Chief Executive Officer (CEO).

(b) The Vice-Chairperson shall:

1. Exercise all the responsibilities of the Chairperson in the absence of the Chairperson; and

2. In agreement with the Chairperson, perform all responsibilities mutually agreed upon.

ARTICLE IV

Standing Committees

(a) At a minimum, the VCMMCC shall establish two (2) committees/advisory boards, one member/consumer based and one provider based. VCMMCC staff will be responsible to gather a list of potential appointments and make recommendations to the VCMMCC for membership on these boards. Each of the boards shall submit a charter to the VCMMCC for approval. All meetings of standing committees shall be subject to the provisions of the Brown Act.

(b) Executive/Finance Committee.

i. Purpose. The role of the Executive/Finance Committee shall be to assist the CEO and VCMMCC accomplish its work in the most efficient and timely way. Meetings of this committee shall be at the request of the Chairperson or CEO to evaluate time sensitive matters. The Committee shall report on all of its activities to the governing board at the next regular meeting of the governing board.

ii. Membership. The Executive/Finance Committee shall be comprised of the following five (5) Commissioners:

1. Chairperson.
2. Vice-Chairperson.
3. Private hospital/healthcare system representative (to rotate between the two representatives following the representative's resignation from the committee). If the Chairperson and/or Vice-Chairperson is a private hospital/healthcare system representative, then the Commission may appoint any one of its members to fill this position.
4. Ventura County Medical Center Health System representative. If the Chairperson and/or Vice-Chairperson is a Ventura County Medical Center Health System representative, then the Commission may appoint any one of its members to fill this position.
5. Clinicas Del Camino Real representative. If the Chairperson and/or Vice-Chairperson is a Clinicas Del Camino Real representative, then the Commission may appoint any one of its members to fill this position.

The CEO and Finance Director will serve as Ex-Officio members to Co-Chair the committee.

~~If the private hospital/healthcare system representative, the Ventura County Medical Center Health System representative and/or the Clinicas Del Camino Real representative are also the Chairperson and/or Vice-Chairperson of the governing board, then, the other Commissioner who is a representative of the same constituency or organization as the Commissioner serving as Chairperson or Vice-Chairperson shall be appointed to the Executive/Finance Committee to fill that reserved seat. For example, if the Ventura County Medical Center Health System representative and the Clinicas Del Camino Real representative are also the Chairperson and Vice-Chairperson, respectively, of the governing board, then, the other Ventura County Medical Center Health System representative and the physician representative nominated by Clinicas Del Camino Real shall be appointed to fill the respective designated seat on the Executive/Finance Committee.~~

Appointments to the Committee shall be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected or at the next regular meeting immediately thereafter. Appointments may also be made at any regular meeting where the appointment is necessitated by a resignation, termination, vacancy, special election of officers, or other event which results in the Committee lacking full membership.

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.

2. Assist the CEO in the planning or presentation of items for governing board consideration.

3. Assist the CEO or VCMMCC staff in the initial review of draft policy statements requiring governing board approval.

4. Assist the CEO in the ongoing monitoring of economic performance by focusing on budgets for pre-operational and operational periods.

5. Review proposed State contracts and rates, once actuary has reviewed and made recommendations.

6. Review proposed contracts for services over the assigned dollar value/limit of the CEO.

7. Establish basic tenets for payment-provider class and levels as related to Medi-Cal rates:

- PCP
- Specialists
- Hospitals o LTC
- Ancillary Providers

8. Recommend auto-assignment policies for beneficiaries who do not select a Primary Care Provider.

9. Review and recommend provider incentive program structure.

10. Review investment strategy and make recommendations.

11. On an annual basis, develop the CEO review process and criteria.

12. Serve as Interview Committee for CEO/CMO/CFO.

13. Assist the governing board and/or the CEO in determining the appropriate committee, if any, to best deal with questions or issues that may arise from time-to-time.
14. Develop long-term and short-term business plans for review and approval by the governing board.

15. Undertake such other activities as may be delegated from time-to-time by the governing board.

iv. Limitations on Authority. The Executive/Finance Committee shall not have the power or authority in reference to any of the following matters:

1. Adopting, amending or repealing any bylaw.

2. Making final determinations of policy.

3. Approving changes to the budget or making major structural or contractual decisions (such as adding or eliminating programs).

4. Filling vacancies or removing any Commissioner.

5. Changing the membership of, or filling vacancies in, the Executive/Finance Committee.

6. Hiring or firing of senior executives, but may make recommendations to the governing board as to their appointment, dismissal or ongoing performance.

7. Taking any action on behalf of the governing board unless expressly authorized by the governing board.

ARTICLE V

Special Committees

Members may be asked to participate on a subcommittee, task force or special project as part of their responsibilities. The VCMMCC may establish a committee(s) or advisory board(s) for any purpose that will be beneficial in accomplishing the work of the VCMMCC.

ARTICLE VI

Meetings

(a) All meetings shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code relating to meetings of local agencies ("Brown Act").

(b) A regular meeting shall be held monthly. The VCMMCC shall by resolution establish the date, time and location for the monthly meeting. A regular meeting may, for cause, be rescheduled by the Chairperson with 72 hour advance notice.

(c) Closed session items shall be noticed in compliance with Government Code section 54954.5.

(d) Special meetings may be called, consistent with the Brown Act, by the Chairperson or by a quorum of the VCMMCC. Notice of such special meeting shall conform to the Brown Act.

(e) Any meeting at which at least a quorum cannot attend, or for which there is no agenda item requiring action may be cancelled by the Chairperson with 72 hour advance notice.

(f) A quorum shall be defined as one person more than half of the appointed members of the VCMMCC. For these purposes, "appointed members" excludes unfilled positions and those vacated by resignation or removal. Unless otherwise expressly stated in these bylaws, a majority vote of members present and constituting a quorum shall be required for any VCMMCC action.

(g) After three (3) absences of any member during a fiscal year, the reasons for the absences will be reviewed by the VCMMCC and it may notify the Board of Supervisors of the absences, if it deems this action appropriate. Three or more absences from regular meetings may be cause for the VCMMCC to recommend dismissal of that member to the Board of Supervisors.

Conduct of Meetings

(a) The Chairperson shall adhere to the order of items as posted on the agenda. Modifications to the order of the agenda may be made to the extent that (on the advice

of counsel) the rearrangement of the agenda items does not violate the spirit or intent of the Brown Act.

(b) All motions or amendments to motions require a second in order to be considered for action. Upon a motion and a second the item shall be open for discussion before the call for the vote.

(c) Voice votes will be made on all items as read. An abstention will not be recognized except for a legal conflict of interest. In furtherance of the foregoing, an abstention or refusal to vote (not arising from a legal conflict of interest) shall be deemed a vote with the majority of those Commissioners who do vote, except when there is a tie vote and the motion or action fails. For example, if there are 7 Commissioners present at a meeting (none of whom are subject to a legal conflict of interest), (i) a motion passes with 3 votes in favor and 4 Commissioners abstaining, (ii) a motion passes with 3 votes in favor, 2 votes against and 2 Commissioners abstaining; and (iii) a motion fails with 3 votes in favor, 3 votes against and 1 Commissioner abstaining.

(d) A call for a point of order shall have precedence over all other motions on the floor.

(e) Without objection, the Chairperson may continue or withdraw any item. In the event of an objection, a motion to continue or reset an item must be passed by a majority of the members present. A motion to continue or reset an item shall take precedence over all other motions except for a point of order.

(f) An amendment to a motion must be germane to the subject of the motion, but it may not intend an action contrary to the motion. There may be an amendment to the motion and an amendment to an amendment, but no further amendments. In the event the maker of the original motion accepts the amendment(s), the original motion shall be deemed modified. In the event the maker of the original motion does not accept the amendment(s), the amendment(s) shall be voted separately and in reverse order of proposal.

(g) Where these Bylaws do not afford an adequate procedure in the conduct of a meeting, the Chairperson may defer to the most current edition of ~~Robert's Rules of Order~~*Rosenberg's Rules of Order*, to resolve parliamentary questions.

(h) The Chairperson shall be permitted to make motions and vote on all matters to the same extent and subject to the same limitations as other Commissioners.

ARTICLE VII

Powers and Duties

The VCMMCC is responsible for all of the activities described in Article I of these Bylaws and in its enabling ordinance. In furtherance of such responsibility, the VCMMCC shall have the following powers and duties and shall:

(a) Advise the Chief Executive Officer (CEO) and request from the CEO information it deems necessary;

(b) Conduct meetings and keep the minutes of the VCMMCC;

(c) Provide for financial oversight through various actions and methodologies such as the preparation and submission of an annual statement of financial affairs and an estimate of the amount of funding required for expenditures, approval of an annual budget, receipt of monthly financial briefings and other appropriate action in support of its financial oversight role;

(d) Evaluate business performance and opportunity, and review and recommend strategic plans and business strategies;

(e) Establish, support and oversee the quality, service utilization, risk management and fraud and abuse programs;

(f) Encourage VCMMCC members to actively participate in VCMMCC committees as well as subcommittees;

(g) Comply with and implement all applicable federal, state and local laws, rules and regulations as they become effective;

(h) Provide for the resolution of or resolve conflict among its leaders and those under its leadership;

(i) Respect confidentiality, privacy and avoid any real or potential conflict of interest; and

(j) Receive and take appropriate action, if warranted, based upon reports presented by the CEO (or designated individual). Such reports shall be prepared and submitted to the VCMMCC at least annually.

ARTICLE VIII

STAFF

The VCMMCC shall employ personnel and contract for services as necessary to perform its functions. The permanent staff employed by the VCMMCC shall include, but not be limited to, a Chief Executive Officer (CEO), Clerk and Assistant Clerk.

Chief Executive Officer

The CEO shall have the responsibility for day to day operations, consistent with the authority conferred by the VCMMCC. The CEO is responsible for coordinating all activities of the County Organized Health System.

The CEO shall:

(a) Direct the planning, organization, and operation of all services and facilities;

(b) Direct studies of organizations, operations, functions and activities relating to economy, efficiency and improvement of services;

(c) Direct activities which fulfill all duties mandated by federal or state law, regulatory or accreditation authority, or VCMMCC board resolution, and shall bring any conflict between these laws, regulations, resolutions or policy to the attention of the VCMMCC;

(c) Appoint and supervise an executive management staff, and such other individuals as are necessary for operations. The CEO may delegate certain duties and responsibilities to these and other individuals where such delegated duties are in furtherance of the goals and objectives of the VCMMCC;

(d) Retain and appoint necessary personnel, consistent with all policies and procedures, in furtherance of the VCMMCC's powers and duties; and

(f) Implement and enforce all policies and procedures, and assure compliance with all applicable federal and state laws, rules and regulations.

Clerk

The Clerk shall:

(a) Perform the usual duties pertaining to secretaries;

(b) Cause to be kept, a full and true record of all VCMMCC meetings and of such special meetings as may be scheduled;

(c) Cause to be issued notices of regular and special meetings;

(d) Maintain a record of attendance of members and promptly report to the VCMMCC any member whose position has been vacated; and

(e) Attest to the Chair or Vice-Chair's signature on documents approved by the VCMMCC.

Assistant Clerk

The Assistant Clerk shall perform the duties of the Clerk in the Clerk's absence.

ARTICLE IX

Rules of Order

The Chairperson shall be responsible for maintaining decorum during VCMMCC meetings. All motions, comments, and questions shall be made through the Chairperson. Any decision by the Chairperson shall be considered final unless an appeal of the decision is requested and passed by a majority of the VCMMCC members present.

ARTICLE X

Amendments

(a) These Bylaws may be amended by an affirmative vote of a majority of the voting members of the VCMMCC. A full statement of a proposed amendment shall be submitted to the VCMMCC at least two weeks prior to the meeting at which the proposed amendment is scheduled to be voted upon.

(b) The Bylaws shall be reviewed annually and amendments to the Bylaws may be proposed by any VCMMCC member.

(c) Bylaws may be suspended on an ad hoc basis upon the affirmative vote of a majority of the VCMMCC members present.

ARTICLE XI

Nondiscrimination Clause

The VCMMCC or any person subject to its authority shall not discriminate against or in favor of any person because of race, gender, religion, color, national origin, age, sexual orientation or disability with regard to job application procedures, hiring, advancement, discharge, compensation, training or other terms or condition of employment of any person employed by or doing business with the VCMMCC or any person subject to its direction pursuant to federal, state or local law.

ARTICLE XII

Conflict of Interest and Ethics

VCMMCC members are subject to conflict of interest laws, including Government Code section 1090 and the 1974 Political Reform Act (Government Code section 8100 et seq.), as modified by Welfare and Institutions Code section 14087.57, and must identify and disclose any conflicts and refrain from participating in any manner in such matters in accordance with the applicable statutes**.** Members of the VCMMCC agree to adhere to all relevant standards established by state or federal law regarding ethical behavior.

ARTICLE XIII

Dissolution

Pursuant to California Welfare & Institutions Code, section 14087.54:

(a) In the event the Commissioners determine that VCMMCC may no longer function for the purposes for which it was established, at the time that VCMMCC's then existing obligations have been satisfied or VCMMCC's assets have been exhausted, the Board of Supervisors may by ordinance terminate the VCMMCC.

(b) Prior to the termination of the VCMMCC, the Board of Supervisors shall notify the State Department of Health Care Services ("DHCS") of its intent to terminate VCMMCC. The DHCS shall conduct an audit of VCMMCC's records within 30 days of the notification to determine the liabilities and assets of VCMMCC. The DHCS shall report its findings to the Board of Supervisors within 10 days of completion of the audit. The Board of Supervisors shall prepare a plan to liquidate or otherwise dispose of the assets of VCMMCC and to pay the liabilities of VCMMCC to the extent of VCMMCC's assets, and present the plan to the DHCS within 30 days upon receipt of these findings.

(c) Upon termination of the VCMMCC by the Board of Supervisors, the County of Ventura shall manage any remaining assets of VCMMCC until superseded by a DHCS-approved plan. Any liabilities of VCMMCC shall not become obligations of the County of Ventura upon either the termination of the VCMMCC or the liquidation or disposition of VCMMCC's remaining assets.

(d) Any assets of VCMMCC shall be disposed of pursuant to provisions contained in the contract entered into between the state and VCMMCC.

Rosenberg's Rules of Order

REVISED 2011

Simple Rules of Parliamentary Procedure for the 21st Century

By Judge Dave Rosenberg

LEAGUE® OF CALIFORNIA CITIES

MISSION AND CORE BELIEFS

To expand and protect local control for cities through education and advocacy to enhance the quality of life for all Californians.

VISION

To be recognized and respected as the leading advocate for the common interests of California's cities.

About the League of California Cities

Established in 1898, the League of California Cities is a member organization that represents California's incorporated cities. The League strives to protect the local authority and automony of city government and help California's cities effectively serve their residents. In addition to advocating on cities' behalf at the state capitol, the League provides its members with professional development programs and information resources, conducts education conferences and research, and publishes Western City magazine.

About the Author

Dave Rosenberg is a Superior Court Judge in Yolo County. He has served as presiding judge of his court, and as presiding judge of the Superior Court Appellate Division. He also has served as chair of the Trial Court Presiding Judges Advisory Committee (the committee composed of all 58 California presiding judges) and as an advisory member of the California Judicial Council. Prior to his appointment to the bench, Rosenberg was member of the Yolo County Board of Supervisors, where he served two terms as chair. Rosenberg also served on the Davis City Council, including two terms as mayor. He has served on the senior staff of two governors, and worked for 19 years in private law practice. Rosenberg has served as a member and chair of numerous state, regional and local boards. Rosenberg chaired the California State Lottery Commission, the California Victim Compensation and Government Claims Board, the Yolo-Solano Air Quality Management District, the Yolo County Economic Development Commission, and the Yolo County Criminal Justice Cabinet. For many years, he has taught classes on parliamentary procedure and has served as parliamentarian for large and small bodies.

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Introduction

The rules of procedure at meetings should be simple enough for most people to understand. Unfortunately, that has not always been the case. Virtually all clubs, associations, boards, councils and bodies follow a set of rules — *Robert's Rules of Order* — which are embodied in a small, but complex, book. Virtually no one I know has actually read this book cover to cover. Worse yet, the book was written for another time and for another purpose. If one is chairing or running a parliament, then *Robert's Rules of Order* is a dandy and quite useful handbook for procedure in that complex setting. On the other hand, if one is running a meeting of say, a five-member body with a few members of the public in attendance, a simplified version of the rules of parliamentary procedure is in order.

Hence, the birth of *Rosenberg's Rules of Order*.

What follows is my version of the rules of parliamentary procedure, based on my decades of experience chairing meetings in state and local government. These rules have been simplified for the smaller bodies we chair or in which we participate, slimmed down for the 21st Century, yet retaining the basic tenets of order to which we have grown accustomed. Interestingly enough, *Rosenberg's Rules* has found a welcoming audience. Hundreds of cities, counties, special districts, committees, boards, commissions, neighborhood associations and private corporations and companies have adopted *Rosenberg's Rules* in lieu of *Robert's Rules* because they have found them practical, logical, simple, easy to learn and user friendly.

This treatise on modern parliamentary procedure is built on a foundation supported by the following four pillars:

1. **Rules should establish order.** The first purpose of rules of parliamentary procedure is to establish a framework for the orderly conduct of meetings.
2. **Rules should be clear.** Simple rules lead to wider understanding and participation. Complex rules create two classes: those who understand and participate; and those who do not fully understand and do not fully participate.
3. **Rules should be user friendly.** That is, the rules must be simple enough that the public is invited into the body and feels that it has participated in the process.
4. **Rules should enforce the will of the majority while protecting the rights of the minority.** The ultimate purpose of rules of procedure is to encourage discussion and to facilitate decision making by the body. In a democracy, majority rules. The rules must enable the majority to express itself and fashion a result, while permitting the minority to also express itself, but not dominate, while fully participating in the process.

Establishing a Quorum

The starting point for a meeting is the establishment of a quorum. A quorum is defined as the minimum number of members of the body who must be present at a meeting for business to be legally transacted. The default rule is that a quorum is one more than half the body. For example, in a five-member body a quorum is three. When the body has three members present, it can legally transact business. If the body has less than a quorum of members present, it cannot legally transact business. And even if the body has a quorum to begin the meeting, the body can lose the quorum during the meeting when a member departs (or even when a member leaves the dais). When that occurs the body loses its ability to transact business until and unless a quorum is reestablished.

The default rule, identified above, however, gives way to a specific rule of the body that establishes a quorum. For example, the rules of a particular five-member body may indicate that a quorum is four members for that particular body. The body must follow the rules it has established for its quorum. In the absence of such a specific rule, the quorum is one more than half the members of the body.

The Role of the Chair

While all members of the body should know and understand the rules of parliamentary procedure, it is the chair of the body who is charged with applying the rules of conduct of the meeting. The chair should be well versed in those rules. For all intents and purposes, the chair makes the final ruling on the rules every time the chair states an action. In fact, all decisions by the chair are final unless overruled by the body itself.

Since the chair runs the conduct of the meeting, it is usual courtesy for the chair to play a less active role in the debate and discussion than other members of the body. This does not mean that the chair should not participate in the debate or discussion. To the contrary, as a member of the body, the chair has the full right to participate in the debate, discussion and decision-making of the body. What the chair should do, however, is strive to be the last to speak at the discussion and debate stage. The chair should not make or second a motion unless the chair is convinced that no other member of the body will do so at that point in time.

The Basic Format for an Agenda Item Discussion

Formal meetings normally have a written, often published agenda. Informal meetings may have only an oral or understood agenda. In either case, the meeting is governed by the agenda and the agenda constitutes the body's agreed-upon roadmap for the meeting. Each agenda item can be handled by the chair in the following basic format:

First, the chair should clearly announce the agenda item number and should clearly state what the agenda item subject is. The chair should then announce the format (which follows) that will be followed in considering the agenda item.

Second, following that agenda format, the chair should invite the appropriate person or persons to report on the item, including any recommendation that they might have. The appropriate person or persons may be the chair, a member of the body, a staff person, or a committee chair charged with providing input on the agenda item.

Third, the chair should ask members of the body if they have any technical questions of clarification. At this point, members of the body may ask clarifying questions to the person or persons who reported on the item, and that person or persons should be given time to respond.

Fourth, the chair should invite public comments, or if appropriate at a formal meeting, should open the public meeting for public input. If numerous members of the public indicate a desire to speak to the subject, the chair may limit the time of public speakers. At the conclusion of the public comments, the chair should announce that public input has concluded (or the public hearing, as the case may be, is closed).

Fifth, the chair should invite a motion. The chair should announce the name of the member of the body who makes the motion.

Sixth, the chair should determine if any member of the body wishes to second the motion. The chair should announce the name of the member of the body who seconds the motion. It is normally good practice for a motion to require a second before proceeding to ensure that it is not just one member of the body who is interested in a particular approach. However, a second is not an absolute requirement, and the chair can proceed with consideration and vote on a motion even when there is no second. This is a matter left to the discretion of the chair.

Seventh, if the motion is made and seconded, the chair should make sure everyone understands the motion.

This is done in one of three ways:

1. The chair can ask the maker of the motion to repeat it;
2. The chair can repeat the motion; or
3. The chair can ask the secretary or the clerk of the body to repeat the motion.

Eighth, the chair should now invite discussion of the motion by the body. If there is no desired discussion, or after the discussion has ended, the chair should announce that the body will vote on the motion. If there has been no discussion or very brief discussion, then the vote on the motion should proceed immediately and there is no need to repeat the motion. If there has been substantial discussion, then it is normally best to make sure everyone understands the motion by repeating it.

Ninth, the chair takes a vote. Simply asking for the "ayes" and then asking for the "nays" normally does this. If members of the body do not vote, then they "abstain." Unless the rules of the body provide otherwise (or unless a super majority is required as delineated later in these rules), then a simple majority (as defined in law or the rules of the body as delineated later in these rules) determines whether the motion passes or is defeated.

Tenth, the chair should announce the result of the vote and what action (if any) the body has taken. In announcing the result, the chair should indicate the names of the members of the body, if any, who voted in the minority on the motion. This announcement might take the following form: "The motion passes by a vote of 3-2, with Smith and Jones dissenting. We have passed the motion requiring a 10-day notice for all future meetings of this body."

Motions in General

Motions are the vehicles for decision making by a body. It is usually best to have a motion before the body prior to commencing discussion of an agenda item. This helps the body focus.

Motions are made in a simple two-step process. First, the chair should recognize the member of the body. Second, the member of the body makes a motion by preceding the member's desired approach with the words "I move … "

A typical motion might be: "I move that we give a 10-day notice in the future for all our meetings."

The chair usually initiates the motion in one of three ways:

1. **Inviting the members of the body to make a motion,** for example, "A motion at this time would be in order."
2. **Suggesting a motion to the members of the body,** "A motion would be in order that we give a 10-day notice in the future for all our meetings."
3. **Making the motion.** As noted, the chair has every right as a member of the body to make a motion, but should normally do so only if the chair wishes to make a motion on an item but is convinced that no other member of the body is willing to step forward to do so at a particular time.

The Three Basic Motions

There are three motions that are the most common and recur often at meetings:

The basic motion. The basic motion is the one that puts forward a decision for the body's consideration. A basic motion might be: "I move that we create a five-member committee to plan and put on our annual fundraiser."

The motion to amend. If a member wants to change a basic motion that is before the body, they would move to amend it. A motion to amend might be: "I move that we amend the motion to have a 10-member committee." A motion to amend takes the basic motion that is before the body and seeks to change it in some way.

The substitute motion. If a member wants to completely do away with the basic motion that is before the body, and put a new motion before the body, they would move a substitute motion. A substitute motion might be: "I move a substitute motion that we cancel the annual fundraiser this year."

"Motions to amend" and "substitute motions" are often confused, but they are quite different, and their effect (if passed) is quite different. A motion to amend seeks to retain the basic motion on the floor, but modify it in some way. A substitute motion seeks to throw out the basic motion on the floor, and substitute a new and different motion for it. The decision as to whether a motion is really a "motion to amend" or a "substitute motion" is left to the chair. So if a member makes what that member calls a "motion to amend," but the chair determines that it is really a "substitute motion," then the chair's designation governs.

A "friendly amendment" is a practical parliamentary tool that is simple, informal, saves time and avoids bogging a meeting down with numerous formal motions. It works in the following way: In the discussion on a pending motion, it may appear that a change to the motion is desirable or may win support for the motion from some members. When that happens, a member who has the floor may simply say, "I want to suggest a friendly amendment to the motion." The member suggests the friendly amendment, and if the maker and the person who seconded the motion pending on the floor accepts the friendly amendment, that now becomes the pending motion on the floor. If either the maker or the person who seconded rejects the proposed friendly amendment, then the proposer can formally move to amend.

Multiple Motions Before the Body

There can be up to three motions on the floor at the same time. The chair can reject a fourth motion until the chair has dealt with the three that are on the floor and has resolved them. This rule has practical value. More than three motions on the floor at any given time is confusing and unwieldy for almost everyone, including the chair.

When there are two or three motions on the floor (after motions and seconds) at the same time, the vote should proceed *first* on the *last* motion that is made. For example, assume the first motion is a basic "motion to have a five-member committee to plan and put on our annual fundraiser." During the discussion of this motion, a member might make a second motion to "amend the main motion to have a 10-member committee, not a five-member committee to plan and put on our annual fundraiser." And perhaps, during that discussion, a member makes yet a third motion as a "substitute motion that we not have an annual fundraiser this year." The proper procedure would be as follows:

First, the chair would deal with the *third* (the last) motion on the floor, the substitute motion. After discussion and debate, a vote would be taken first on the third motion. If the substitute motion *passed*, it would be a substitute for the basic motion and would eliminate it. The first motion would be moot, as would the second motion (which sought to amend the first motion), and the action on the agenda item would be completed on the passage by the body of the third motion (the substitute motion). No vote would be taken on the first or second motions.

Second, if the substitute motion *failed*, the chair would then deal with the second (now the last) motion on the floor, the motion to amend. The discussion and debate would focus strictly on the amendment (should the committee be five or 10 members). If the motion to amend *passed*, the chair would then move to consider the main motion (the first motion) as *amended*. If the motion to amend *failed,* the chair would then move to consider the main motion (the first motion) in its original format, not amended.

Third, the chair would now deal with the first motion that was placed on the floor. The original motion would either be in its original format (five-member committee), or if *amended*, would be in its amended format (10-member committee). The question on the floor for discussion and decision would be whether a committee should plan and put on the annual fundraiser.

To Debate or Not to Debate

The basic rule of motions is that they are subject to discussion and debate. Accordingly, basic motions, motions to amend, and substitute motions are all eligible, each in their turn, for full discussion before and by the body. The debate can continue as long as members of the body wish to discuss an item, subject to the decision of the chair that it is time to move on and take action.

There are exceptions to the general rule of free and open debate on motions. The exceptions all apply when there is a desire of the body to move on. The following motions are not debatable (that is, when the following motions are made and seconded, the chair must immediately call for a vote of the body without debate on the motion):

Motion to adjourn. This motion, if passed, requires the body to immediately adjourn to its next regularly scheduled meeting. It requires a simple majority vote.

Motion to recess. This motion, if passed, requires the body to immediately take a recess. Normally, the chair determines the length of the recess which may be a few minutes or an hour. It requires a simple majority vote.

Motion to fix the time to adjourn. This motion, if passed, requires the body to adjourn the meeting at the specific time set in the motion. For example, the motion might be: "I move we adjourn this meeting at midnight." It requires a simple majority vote.

Motion to table. This motion, if passed, requires discussion of the agenda item to be halted and the agenda item to be placed on "hold." The motion can contain a specific time in which the item can come back to the body. "I move we table this item until our regular meeting in October." Or the motion can contain no specific time for the return of the item, in which case a motion to take the item off the table and bring it back to the body will have to be taken at a future meeting. A motion to table an item (or to bring it back to the body) requires a simple majority vote.

Motion to limit debate. The most common form of this motion is to say, "I move the previous question" or "I move the question" or "I call the question" or sometimes someone simply shouts out "question." As a practical matter, when a member calls out one of these phrases, the chair can expedite matters by treating it as a "request" rather than as a formal motion. The chair can simply inquire of the body, "any further discussion?" If no one wishes to have further discussion, then the chair can go right to the pending motion that is on the floor. However, if even one person wishes to discuss the pending motion further, then at that point, the chair should treat the call for the "question" as a formal motion, and proceed to it.

When a member of the body makes such a motion ("I move the previous question"), the member is really saying: "I've had enough debate. Let's get on with the vote." When such a motion is made, the chair should ask for a second, stop debate, and vote on the motion to limit debate. The motion to limit debate requires a two-thirds vote of the body.

NOTE: A motion to limit debate could include a time limit. For example: "I move we limit debate on this agenda item to 15 minutes." Even in this format, the motion to limit debate requires a two-thirds vote of the body. A similar motion is a *motion to object to consideration of an item.* This motion is not debatable, and if passed, precludes the body from even considering an item on the agenda. It also requires a two-thirds vote.

Majority and Super Majority Votes

In a democracy, a simple majority vote determines a question. A tie vote means the motion fails. So in a seven-member body, a vote of 4-3 passes the motion. A vote of 3-3 with one abstention means the motion fails. If one member is absent and the vote is 3-3, the motion still fails.

All motions require a simple majority, but there are a few exceptions. The exceptions come up when the body is taking an action which effectively cuts off the ability of a minority of the body to take an action or discuss an item. These extraordinary motions require a two-thirds majority (a super majority) to pass:

Motion to limit debate. Whether a member says, "I move the previous question," or "I move the question," or "I call the question," or "I move to limit debate," it all amounts to an attempt to cut off the ability of the minority to discuss an item, and it requires a two-thirds vote to pass.

Motion to close nominations. When choosing officers of the body (such as the chair), nominations are in order either from a nominating committee or from the floor of the body. A motion to close nominations effectively cuts off the right of the minority to nominate officers and it requires a two-thirds vote to pass.

Motion to object to the consideration of a question. Normally, such a motion is unnecessary since the objectionable item can be tabled or defeated straight up. However, when members of a body do not even want an item on the agenda to be considered, then such a motion is in order. It is not debatable, and it requires a two-thirds vote to pass.

Motion to suspend the rules. This motion is debatable, but requires a two-thirds vote to pass. If the body has its own rules of order, conduct or procedure, this motion allows the body to suspend the rules for a particular purpose. For example, the body (a private club) might have a rule prohibiting the attendance at meetings by non-club members. A motion to suspend the rules would be in order to allow a non-club member to attend a meeting of the club on a particular date or on a particular agenda item.

Counting Votes

The matter of counting votes starts simple, but can become complicated.

Usually, it's pretty easy to determine whether a particular motion passed or whether it was defeated. If a simple majority vote is needed to pass a motion, then one vote more than 50 percent of the body is required. For example, in a five-member body, if the vote is three in favor and two opposed, the motion passes. If it is two in favor and three opposed, the motion is defeated.

If a two-thirds majority vote is needed to pass a motion, then how many affirmative votes are required? The simple rule of thumb is to count the "no" votes and double that count to determine how many "yes" votes are needed to pass a particular motion. For example, in a seven-member body, if two members vote "no" then the "yes" vote of at least four members is required to achieve a two-thirds majority vote to pass the motion.

What about tie votes? In the event of a tie, the motion always fails since an affirmative vote is required to pass any motion. For example, in a five-member body, if the vote is two in favor and two opposed, with one member absent, the motion is defeated.

Vote counting starts to become complicated when members vote "abstain" or in the case of a written ballot, cast a blank (or unreadable) ballot. Do these votes count, and if so, how does one count them? The starting point is always to check the statutes.

In California, for example, for an action of a board of supervisors to be valid and binding, the action must be approved by a majority of the board. (California Government Code Section 25005.) Typically, this means three of the five members of the board must vote affirmatively in favor of the action. A vote of 2-1 would not be sufficient. A vote of 3-0 with two abstentions would be sufficient. In general law cities in

California, as another example, resolutions or orders for the payment of money and all ordinances require a recorded vote of the total members of the city council. (California Government Code Section 36936.) Cities with charters may prescribe their own vote requirements. Local elected officials are always well-advised to consult with their local agency counsel on how state law may affect the vote count.

After consulting state statutes, step number two is to check the rules of the body. If the rules of the body say that you count votes of "those present" then you treat abstentions one way. However, if the rules of the body say that you count the votes of those "present and voting," then you treat abstentions a different way. And if the rules of the body are silent on the subject, then the general rule of thumb (and default rule) is that you count all votes that are "present and voting."

Accordingly, under the "present and voting" system, you would **NOT** count abstention votes on the motion. Members who abstain are counted for purposes of determining quorum (they are "present"), but you treat the abstention votes on the motion as if they did not exist (they are not "voting"). On the other hand, if the rules of the body specifically say that you count votes of those "present" then you **DO** count abstention votes both in establishing the quorum and on the motion. In this event, the abstention votes act just like "no" votes.

How does this work in practice?
Here are a few examples.

Assume that a five-member city council is voting on a motion that requires a simple majority vote to pass, and assume further that the body has no specific rule on counting votes. Accordingly, the default rule kicks in and we count all votes of members that are "present and voting." If the vote on the motion is 3-2, the motion passes. If the motion is 2-2 with one abstention, the motion fails.

Assume a five-member city council voting on a motion that requires a two-thirds majority vote to pass, and further assume that the body has no specific rule on counting votes. Again, the default rule applies. If the vote is 3-2, the motion fails for lack of a two-thirds majority. If the vote is 4-1, the motion passes with a clear two-thirds majority. A vote of three "yes," one "no" and one "abstain" also results in passage of the motion. Once again, the abstention is counted only for the purpose of determining quorum, but on the actual vote on the motion, it is as if the abstention vote never existed — so an effective 3-1 vote is clearly a two-thirds majority vote.

Now, change the scenario slightly. Assume the same five-member city council voting on a motion that requires a two-thirds majority vote to pass, but now assume that the body **DOES** have a specific rule requiring a two-thirds vote of members "present." Under this specific rule, we must count the members present not only for quorum but also for the motion. In this scenario, any abstention has the same force and effect as if it were a "no" vote. Accordingly, if the votes were three "yes," one "no" and one "abstain," then the motion fails. The abstention in this case is treated like a "no" vote and effective vote of 3-2 is not enough to pass two-thirds majority muster.

Now, exactly how does a member cast an "abstention" vote? Any time a member votes "abstain" or says, "I abstain," that is an abstention. However, if a member votes "present" that is also treated as an abstention (the member is essentially saying, "Count me for purposes of a quorum, but my vote on the issue is abstain.") In fact, any manifestation of intention not to vote either "yes" or "no" on the pending motion may be treated by the chair as an abstention. If written ballots are cast, a blank or unreadable ballot is counted as an abstention as well.

Can a member vote "absent" or "count me as absent?" Interesting question. The ruling on this is up to the chair. The better approach is for the chair to count this as if the member had left his/her chair and is actually "absent." That, of course, affects the quorum. However, the chair may also treat this as a vote to abstain, particularly if the person does not actually leave the dais.

The Motion to Reconsider

There is a special and unique motion that requires a bit of explanation all by itself; the motion to reconsider. A tenet of parliamentary procedure is finality. After vigorous discussion, debate and a vote, there must be some closure to the issue. And so, after a vote is taken, the matter is deemed closed, subject only to reopening if a proper motion to consider is made and passed.

A motion to reconsider requires a majority vote to pass like other garden-variety motions, but there are two special rules that apply only to the motion to reconsider.

First, is the matter of timing. A motion to reconsider must be made at the meeting where the item was first voted upon. A motion to reconsider made at a later time is untimely. (The body, however, can always vote to suspend the rules and, by a two-thirds majority, allow a motion to reconsider to be made at another time.)

Second, a motion to reconsider may be made only by certain members of the body. Accordingly, a motion to reconsider may be made only by a member who voted in the majority on the original motion. If such a member has a change of heart, he or she may make the motion to reconsider (any other member of the body — including a member who voted in the minority on the original motion — may second the motion). If a member who voted in the minority seeks to make the motion to reconsider, it must be ruled out of order. The purpose of this rule is finality. If a member of minority could make a motion to reconsider, then the item could be brought back to the body again and again, which would defeat the purpose of finality.

If the motion to reconsider passes, then the original matter is back before the body, and a new original motion is in order. The matter may be discussed and debated as if it were on the floor for the first time.

Courtesy and Decorum

The rules of order are meant to create an atmosphere where the members of the body and the members of the public can attend to business efficiently, fairly and with full participation. At the same time, it is up to the chair and the members of the body to maintain common courtesy and decorum. Unless the setting is very informal, it is always best for only one person at a time to have the floor, and it is always best for every speaker to be first recognized by the chair before proceeding to speak.

The chair should always ensure that debate and discussion of an agenda item focuses on the item and the policy in question, not the personalities of the members of the body. Debate on policy is healthy, debate on personalities is not. The chair has the right to cut off discussion that is too personal, is too loud, or is too crude.

Debate and discussion should be focused, but free and open. In the interest of time, the chair may, however, limit the time allotted to speakers, including members of the body.

Can a member of the body interrupt the speaker? The general rule is "no." There are, however, exceptions. A speaker may be interrupted for the following reasons:

Privilege. The proper interruption would be, "point of privilege." The chair would then ask the interrupter to "state your point." Appropriate points of privilege relate to anything that would interfere with the normal comfort of the meeting. For example, the room may be too hot or too cold, or a blowing fan might interfere with a person's ability to hear.

Order. The proper interruption would be, "point of order." Again, the chair would ask the interrupter to "state your point." Appropriate points of order relate to anything that would not be considered appropriate conduct of the meeting. For example, if the chair moved on to a vote on a motion that permits debate without allowing that discussion or debate.

Appeal. If the chair makes a ruling that a member of the body disagrees with, that member may appeal the ruling of the chair. If the motion is seconded, and after debate, if it passes by a simple majority vote, then the ruling of the chair is deemed reversed.

Call for orders of the day. This is simply another way of saying, "return to the agenda." If a member believes that the body has drifted from the agreed-upon agenda, such a call may be made. It does not require a vote, and when the chair discovers that the agenda has not been followed, the chair simply reminds the body to return to the agenda item properly before them. If the chair fails to do so, the chair's determination may be appealed.

Withdraw a motion. During debate and discussion of a motion, the maker of the motion on the floor, at any time, may interrupt a speaker to withdraw his or her motion from the floor. The motion is immediately deemed withdrawn, although the chair may ask the person who seconded the motion if he or she wishes to make the motion, and any other member may make the motion if properly recognized.

Special Notes About Public Input

The rules outlined above will help make meetings very public-friendly. But in addition, and particularly for the chair, it is wise to remember three special rules that apply to each agenda item:

Rule One: Tell the public what the body will be doing.

Rule Two: Keep the public informed while the body is doing it.

Rule Three: When the body has acted, tell the public what the body did.

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AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: February 27, 2017

SUBJECT: Appointment of Two Commissioners to Serve on the Executive/Finance Committee

SUMMARY:

If the Commission approves a resolution modifying the composition of the Executive/Finance Committee, then the Commission will be able to appoint two new committee members. Commissioner Pawar was automatically assigned to the Committee under the prior Bylaws but has expressed an interest in allowing another Commissioner to serve instead. The Commission may elect to appoint a different member. Additionally, Commission Swenson was automatically assigned a position.

BACKGROUND/DISCUSSION:

Article X of the Commission's Bylaws requires that the Commission review the Bylaws annually. At its recent strategic planning session, the Commission discussed the Bylaws and staff recommended two changes. These changes were presented to the Commission for initial review in January and have been presented for final approval at this meeting.

One of the proposed amendments to the Bylaws will change to the composition of the Executive/Finance Committee. The Committee consists of (1) the Chairperson, (2) the Vice-Chairperson, (3) a private hospital/healthcare representative, (4) a representative of Clinicas Del Camino Real, and (5) a representative of Ventura County Medical Center Health System. Article IV of the Bylaws used to require that if the Chairperson or Vice-Chairperson is from one of the three constituencies, then the other representative from that constituency must also serve on the Commission. Therefore, because Commissioner Alatorre serves as Vice-Chairperson, Commissioner Pawar was automatically assigned to serve on the Committee. Commissioner Pawar requested that the rule be modified so that another Commissioner could serve in her place. Additionally, because Commissioner Lee serves a Chairperson, Commissioner Swenson is automatically assigned to serve on the Committee.

The proposed amendment will modify the Bylaws so that if the Chairperson or Vice-Chairperson is a representative of one of these three specific constituencies, then the Commission could appoint *any* Commission member to fill the Committee position. Therefore, if the Commissioner

approves the amendment to the Bylaws, the Commission will be able to appoint any member to fill the Committee position currently reserved for Clinicas and the private hospitals, since they are already represented on the Committee.

Because automatic assignments are no longer necessary if the amendment is approved, the Commission as a whole should reconsider the assignments. The Commission may take action to appoint any one of the Commissioners to serve on the Committee seats currently held by Commissioners Pawar and Swenson.

FISCAL IMPACT:

There is no fiscal impact.

RECOMMENDATION:

Appoint two Commissioners to serve on the Executive/Finance Committee.

CONCURRENCE:

N/A.

ATTACHMENTS:

None.

AGENDA ITEM NO. 7

TO: Gold Coast Health Plan Commission

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

DATE: February 27, 2017

SUBJECT: Quality Improvement Committee Report

RECOMMENDATION:

To accept and file the 2016 Fourth Quarter Quality Improvement Committee Report.

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Quality Improvement Committee Report

4th Quarter 2016

Commission Meeting February 27, 2017

C. Albert Reeves, MD, CMO

Integrity
Accountability
Collaboration
Trust
Respect

Quality Improvement

Quality Improvement										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2014***	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2014 - 2016 Q3**	**Interventions**
Facility Site Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS site audit criteria met.	DHCS/ Title 22	80%	**99%**	**92%**	**99%**	**99%**	**98%**		
Facility Site Audit (Medi-Cal) - Compliance	The percentage of providers that passed facility audits without or following completion of a corrective action plan.	DHCS/ Title 22	NA	**100%**	**100%**	**100%**	**100%**	**100%**		
Medical Record Quality Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS medical record audit criteria met.	DHCS/ Title 22	80%	**96%**	**88%**	**93%**	**95%**	**93%**		
Medical Record Quality Audit (Medi-Cal) - Compliance	The percentage of providers that passed medical record audits without or following completion of a corrective action plan.	DHCS/ Title 22	NA	**100%**	**88%**	**100%**	**100%**	**100%**		
Coordination of Care	The overall percentage of applicable DHCS Coordination of Care criteria met as determined by medical record audits.	NA	Tracking	**100%**	**93%**	**98%**	**98%**	**100%**		

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

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GCHP Improvement Projects

1. Performance Improvement Project (PIP) #1 – Childhood Immunizations – 2 year olds

- Project is ongoing at Las Islas Family Medical Clinic.
- Currently in stage 4 – testing the proposed interventions which are to identify members not fully immunized, and reach out to the families to schedule appointments for the immunizations.
- Status as of October 2016 – Rate 87.18% (goal 77.66%)

  89.74% of calls result in an appointment

  77.78% of appointments are kept

GCHP Improvement Projects

2. Performance Improvement Project (PIP) #2 – increase the utilization of standardized Child Developmental Screening Tools Project.

- Now working with Sierra Vista Family Medical Clinic for this project.
- PIP Modules 1 & 2 have been sent to HSAG for approval.

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2016 HEDIS Improvement Projects

Mandated HEDIS Improvement Projects due to the measures scoring below the minimum performance level (MPL). These 2 improvement projects continue in order to improve the rates for 2016 and test interventions.

1. Well-Child Exams in the 3rd, 4th, 5th and 6th Years of Life
2. Cervical Cancer Screening

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Other Quality Improvement Activities

1. Initial Health Assessment (IHA) Monitoring – an IHA is to be done on any new member within 120 days of enrollment in GCHP. DHCS expects the Plan to monitor for compliance.

   The GCHP goal is 90% compliance.

   129 sites surveyed – 84 (65%) above 90%, and 45 (35%) below. Primary reasons for failing the IHA monitoring are absent or incomplete Staying Healthy Assessment and missing TB Risk Assessment. Clinics received counseling regarding the reasons for failure – including a copy of the audit form and explanation, clinic staff training, 1 on 1 training of new staff.

Other Quality Improvement Activities

2. Facility Site Reviews – new providers are reviewed at time of contracting, and existing primary care providers are reviewed every 3 years.

   6 new sites were reviewed – 4 passed initially and 2 received CAP's. Both CAP's were closed; therefore, all were completed.

   1 interim site review and passed.

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Compliance Delegation Oversight

Delegation Oversight : *Assessment of Delegated Quality Activities*									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2015 - 2016 Q1**	**Interventions**
Delegation of UM	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 5; NCQA Standard UM 15	DHCS Contract	**100%**[5]	**100%**	**100%**	**NA**		
Delegation of CR	Number required & percentage of current delegates assessed	Exhibit A, Attachment 4; NCQA Standard CR 9	DHCS Contract 10-87128	**100%**[6]	**100%**	**NA**	**NA**		
Delegation of QI	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard QI 12	DHCS Contract	**100%**[7]	**NA**	**NA**	**NA**		
Delegation of RR	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCQA Standard RR 7	DHCS Contract	**100%**[7]	**NA**	**NA**	**NA**		
Delegation of Claims	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 8	DHCS Contract	**100%**	**NA**	**100%**	**100%**		

[5]2015 data available for Q2 and Q4 only.

[6]2015 data available for Q1 and Q2 only.

[7]2015 data available for Q1 and Q4 only.

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Delegation Oversight

1. Beacon Health Strategies – May 2016 audit of claims identified deficiencies – continue to work to close a corrective action plan (CAP).
2. Vision Service Plan (VSP) May 2016 audit of claims identified deficiencies – continuing to work with VSP to close a CAP.
3. Ventura Transit System (VTS) – an audit identified IT security deficiencies. A CAP was issued on September 20, 2016 and a remediation plan was received for compliance within 180 days.

Delegation Oversight

4. Clinicas Del Camino Real (CDCR) – a claims audit in October 2016 identified minor deficiencies for the specialty services. CDCR is working on correcting the deficiencies.

Pharmacy

Pharmacy										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Measure	**Description**	**Responsible Department**	**Compliance Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2015-2016 Q1**	**Interventions**
PA Accuracy	All prior authorization requests were decided in accordance with GCHP clinical criteria.	Pharmacy	DHCS Contract	99%	98%	**97.67%**	**98.21%**	**100%**		Weekly meetings with the PBM to clarify criteria and expectations for the decisions. Any approvals that the plan believes should have been denied, will remain and not be overturned. Any denials that the plan believes should have been approved are overturned and the member and physician are made aware of the approval.
PA Timliness	All prior authorization requests were completed within 1 business day.	Pharmacy	DHCS Contract	99%	98%	**100.00%**	**100%**	**100%**		
Appropriate Decision Language on PA	All denied prior authorization requests contained appropriate and specific rationale for the denial	Pharmacy	DHCS Contract	99%	98%	**99.86%**	**99.89%**	**99%**		GCHP is reviewing the denial language that is sent out and making revisions to the pre-set language as needed; this is an annual exercise and will continue going forward. Existing interventions include a second review of the language for all spelling, punctuation and grammar checks.
Annual Review of all UM Criteria	The P&T committee must review all utilization management criteria at least annually.	Pharmacy	GCHP	Met	Met	**N/A**	**Met**	**Met**		
Review of New FDA Approved Drugs	The P&T committee must review all new FDA approved drugs and/or all drugs added to the Medi-Cal FFS Contract Drug List.	Pharmacy	DHCS Contract	Met	Met	**Met**	**Met**	**Met**		

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Pharmacy and Therapeutics

Newly Approved Drugs and Formulary Management

15 New Drugs or new drug combinations were reviewed:

- 4 approved to be added to the formulary because they provide significant clinical advantages.
- 11 drugs were denied formulary placement as not providing a significantly new therapy.

Opiate Safety Program

Approved a Drug requested by a provider – Nucynta

This drug is a synthetic opiate medication with significantly less addicting potential but good pain relieving properties. It is more expensive than many other available opiate medications, but the committee felt that the advantage of less addiction potential was worth the difference in cost.

Opiate Safety Program

- Methadone 40 mg. (used for pain) was removed from the formulary due to more potential for harm.
- Added a requirement for a prior authorization for alprazolam when used in combination with an opiate due to an increased chance of harm.
- OxyContin was removed from the formulary because of the risk for abuse.

Hepatitis C Drugs

- Zepatier and Epclusa – these are relatively new drugs on the market to treat Hepatitis C. These drugs are less expensive than the drugs which were previously on the market, and in many instances they are equally as effective. These drugs were designated as the drugs of choice for many treatments for Hepatitis C. The State has lowered the kick-payment, and by requiring the drugs to be used, we will ensure that the Plan's costs for these treatments are covered in our state reimbursement.

Credentials/Peer Review

Credentials									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2015-2016 Q3**	**Interventions**
Access Indicators									
Monitoring of Medicare/Medicaid sanctions	An OIG query is performed on every provider at the time of intitial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%	100%		
Monitoring of sanctions and limitations on licensure	An Medical Board of California (MBOC) query is performed on every provider at the time of initial and re-credentialing. Other state licensing boards are also queried as needed	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%	100%		
Monitoring of Complaints	Member complaint data is considered during re-credentialing.	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	NA	NA	NA	NA		
Monitoring of adverse events	Quality of Care concerns are reviewed at a minimum of every 6 months and are forwarded to Credentials/Peer Review Committee (CPRC) as indicated.	DHCS/ Title 22	Biannually	100%	100%	100%	100%		
	HIPDB queries are performed within 180 days prior to the date of initial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%	100%		
Timeliness of provider notification of credentialing decisions	Providers will be notified of the credentialing decision in writing within 60 days	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	100%	100%		
Timeliness of verifications	All credentialing verifications are performed within 180 days prior to the credentialing date, as required	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	98%	96%	97%	100%		GCHP Compliance changed the audit tool used by Credentialing from NCQA to ICE which requires audits within 180 days instead of the historical 365 days. Any historical files that were previously on a 365 day audit cycle will transistion to a 180 days audit and be caught up over the next 2 quarters.
# of provider terminations for quality issues	Credentials/Peer Review Committee (CPRC) denial of a credentialing application for quality issues will cause termination of the provider from the network	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	None	None	None	None		
Timeliness of processing of initial applications	Initial applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	93%	96%	95%	97%		
Timeliness of processing of re-credentialing applications	Recredentialing applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	95%	95%	94%	96%		

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Credentials/Peer Review

Credentials									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2015-2016 Q3**	**Interventions**
Quality Indicators (under NMC purview)									
Timeliness of Physician Recredentialing	Percent of physicians recredentialed within 36 months of the last approval date	NCQA: CR Standards	Standard met for 90% of providers	**93%**	**91%**	**92%**	**98%**		
Continuous Monitoring of Allied Providers	Percent of allied providers' expirable elements that are current	NA	Standard met for 90% of elements	**100%**	**100%**	**100%**	**100%**		
Timeliness of Organization Reassessment	Percent of organizations reassessed within 36 months of the last assessment	NCQA: CR Standards	Standard met for 90% of providers	**98%**	**96%**	**95%**	**96%**		

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Credentials/Peer Review

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

- Reported on monitoring of 3 providers on probation by the Medical Board of California (MBC).
- Reported on 3 providers with accusations, but no action taken by the MBC.
- Reported on the status of 1 provider arrested for issues of prescribing controlled medications. The provider has no actions by the MBC and the legal action is pending.

Credentials/Peer Review

Credentialing

- 31 new providers were approved
- 6 providers were recredentialed
- 5 facilities credentialed

- 4 new PQI's were submitted for review. 4 cases were closed and trended.
- All cases reviewed and rated low and trended.
- 1 case previously reviewed and rated 3 with quality of care concerns was reviewed in follow-up after obtaining additional information and a response from the provider. The provider was notified that after review by peers in his specialty that the care was below the standard of care and there will be ongoing review of the provider's cases.
  - The same provider had irregularities in documentation identified and there will also be ongoing review of his documentation.

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Cultural and Linguistics

Cultural & Linguistics (C&L)								
Legend:								
Met or exceeded Benchmark								
Did not meet Benchmark								
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2016**	**Interventions**
Sign Language Services	Percent of sign language services fulfilled	DHCS/Title 22	100%	79%[1]	79%	96%[2]		

[1] 2016 Q1 Rate corrected due to calculation error

[2] 2016 Q3 Rate includes requests that were cancelled and fulfilled after appointment was rescheduled

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Health Education, Cultural Linguistic Services

Group Needs Assessment Project

Completed October 17, 2016 – received 417 valid responses, 218 English speakers and 199 Spanish speakers.

Key Recommendations:

- Increase Well-Child visits for children between the ages of 3-6.
- Increase provider education about improving access and preventive services.
- Childhood obesity – increase health education program to reduce childhood obesity.
- Increase provider and member education regarding language assistance services including how to access an interpreter when visiting a provider.

Health Education, Cultural Linguistic Services

- Quality Improvement projects for HEDIS Measures – Postpartum Visit Promotion and Cervical Cancer Screening Promotion – reaching out to members who are non-compliant.
- Translation services – 769 requests for translation – 323 by providers and 409 by staff, 37 by others.
- Major outreach event – Diabetes 4th annual Community Fair.
- In planning – Cultural Competency Training for Health Care Providers on gender identity and transgender health on January 9, 2017.

Grievance and Appeals

Grievance & Appeals									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Compliance Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2015-2016 Q3**	**Interventions**
Resolution Turnaround Times (TAT) Grievances	100% TAT within 30 calendar days	GCHP		76%	100%	99%	99%		
Post Service TAR Provider Appeals Processing Time - Resolution	The percentage of provider appeals processed within 30 business days from receipt.	GCHP		100%	100%	94%	100%		
Provider Grievances: Complaint, Appeal, or Inquiry	Timely resolution of provider grievances	GCHP		66%	100%	98%	99%		
Monitoring of Complaints	Member complaints are monitored at a minimum of every six months to assess for trends/outliers	GCHP	Monitoring	100%	100%	100%	100%		

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Grievance and Appeals

Grievances Received – 3rd Quarter 2016

Total Grievances – 439 (324 in 2015)

- 406 Administrative Grievances – Top 3 are - 395 provider disputes, 28 quality of care disputes, 6 quality of service.
- 33 Clinical – Top 3 are – 28 quality of care (none serious on review), Denials/Refusals – 2 , Accessibility -2

Clinical Appeals – 24 cases: 7 upheld, 12 overturned, 5 pending

State Fair Hearings – cases: 5 – 3 denied, 2 withdrawn

Quality Workgroup Reviews – 0

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Grievance and Appeals

Pharmacy: 125 appeals

- 92 overturned
- 33 upheld

Kaiser: 19 cases

- 3 appeals
- 6 grievances
- 10 complaints

Beacon: 7 grievances

- 6 not substantiated
- 1 substantiated

Member Services

Call Center Statistics – 3rd Quarter 2016

Member Services									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Compliance Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2015 - 2016 Q3**	**Interventions**
Call Center - Aggregate Average Speed of Answer (ASA)	Average Speed to Answer (in seconds)		<= 30 seconds	**57.5**	**79.0**	**12.0**	**8.0**		
Call Center - Aggregate Abandonment Rate	Percentage of aggregate Abandoned calls to Call Center		<= 5%	**16.7%**	**3.50%**	**0.30%**	**0.40%**		
Call Center - Aggregate Call Center Call Volume	Monitored to ensure adequate staffing and identification of systemic issues.			117,039	29,820	30,084	31,003		

Member Services

- Interactive Voice Response (IVR) optimization is completed and has been successful.
- Explanation of Benefits (EOB) Initiative – for the services of home health, skilled nursing, physical/occupational therapy and DME an EOB will be sent to the member indicating the services and charges and instructions on what to do if it is inaccurate. This is to identify fraud, waste and abuse.
- Call metrics – average speed to answer, and abandonment rate goals were met.

Network Operations

Network Operation QI Dashboard - Access and Availability									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2015 - 2016 Q1**	**Interventions**
Access to Network / Availability of Practitioners									
# & geographic distribution of PCPs	Network of PCPs located within 30 minutes or 10 miles of a member's residence to ensure each member has a PCP who is available and physically present at the service site for sufficient time to ensure access for assigned members upon member's request or when medically required and to personally manage the member on an on-going basis.	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	Met	**Met**		**99.9%**		
# & geographic distribution of SCPs	Adequate numbers and types of specialists within the network through staffing, contracting, or referral to accommodate members' need for specialty care.	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	Met	**Met**		**99.6%**		
Ratio of members to physicians	1:1200	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met	**Met**		**1:193**		
Ratio of members to PCPs	1:2000	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met	**Met**		**1:867**		

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Network Operations

Network Operation QI Dashboard - Access and Availability									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2015 - 2016 Q1**	**Interventions**
Access to Network / Availability of Practitioners									
Acceptable driving times and/or distances to primary care sites	30 minutes or 10 miles of member's residence	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	Met	**Met**		**Met**		
After Hours Access	Providers have answering machine or service for after-hours member calls	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members		NA				In process of working with a vendor to start getting this data
	After-hours machine messages or service staff is in threshold languages	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members		NA				In process of working with a vendor to start getting this data
	After-hours answering machine message or service includes instructions to call 911 or go to ER in the event of an emergency	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members	NA	NA				In process of working with a vendor to start getting this data
Time Elapsed Standards	Urgent Care appointments for services that do not require prior authorization: within 48 hours of the request for appointment	DHCS, Exhibit A, Attachment 9	Standards met for minimum of 90% of providers	NA	**Not Met**				Currently working with a vendor to repeat Provider Appt & Availability Survey.
	Non-urgent appointments for primary care: within 10 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA	**Not Met**				Currently working with vendor to repeat Provider Appt & Availability Survey
	Non-urgent appointments with specialist physicians: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA	**Not Met**				Currently working with vendor to repeat Provider Appt & Availability Survey
	Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA	**Not Met**				Currently working with vendor to repeat Provider Appt & Availability Survey

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Network Operations

Network Operation QI Dashboard - Access and Availability									
Legend:									
Met or exceeded Benchmark									
Did not meet Benchmark									
Measure	**Description**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2015 - 2016 Q1**	**Interventions**
Access to Network / Availability of Practitioners									
Appointment Availability	Availability of appointments within GCHP's standards by type of encounter	DHCS, § 7.5.4	Standards met for minimum of 95% of providers	NA	**Not Met**				Currently working with vendor to repeat Provider Appt & Availability Survey
Provider Surveys	Measure provider satisfaction	GCHP	Satisfaction expressed in each of 6 areas for 80% of providers	**Not Met**	NA				
Provider Training	Number of new PCPs / Providers receiving orientation within 10 days of contracting (Note: Provider is offered an orientation within 10 days, but may be completed within 30 days, or if provider declines training, a declination req'd)	DHCS Exhibit A, Attachment 7	100% within 10 days of contracting	Met	**Met**	**100%**	**100%**		
Provider Visits	Number of Provider Services Representative provider visits	GCHP	Department goal = 100/quarter (400/year)	Met	**Met**	**167**	**121**		

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Network Operations

Access Metrics:

- PCP – 1 per 580 members (standard 1:2000)
- Geography 99.9% of members travel 1.5 mi to receive PCP care (standard 30 min or 10 mi)

Specialists:

- Geography 99.7% travel 1.2 mi to see a specialist
- (standard is 10 mi)

Network Operations

Newly added providers:

Hospitals – 8 including 3 acute care, 3 long term acute care and 2 tertiary

Physicians and groups – 28 anesthesia, 7 burn,

6 cardiology, 4 GI, 5 OB

Ancillary – 2 ambulatory surgery centers, audiology, hospice, Palliative care, 2 PT/OT , 2 Pulm rehab

SNF/LTC – 4 providers

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Health Services

Utilization Management Committee

Utilization Management										
Legend:										
Met or exceeded Benchmark										
Did not meet Benchmark										
Health Services										
UM Authorization Processing Time										
Measure	**Description**	**Responsible Department**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2016 Q3**	**Quarterly Trend 2015- 2016 Q1**	**Interventions**
Turn around time for standard prior authorization	Percentage of requests processed ≤ 5 working days from receipt of information necessary to make the determination.	Health Services	NCQA; contract, Title 22	95%	**98.10%**	**98.12%**	**98.05%**	**98.35%**	-	
Turn around time for expedited prior authorization	Percentage of authorizations processed within 3 days of receiving the request	Health Services	NCQA; contract, Title 22	95%	**98.66%**	**98.70%**	**98.26%**	**98.10%**	-	
Turn around time for post service	Percentage of decisions made within 30 calendar days of receipt of request (NCQA, contract, Title 22)	Health Services	NCQA; contract, Title 22	95%	**96.78%**	**97.26%**	**95.12%**	**100.00%**	-	

Care Management Workload										
Measure	**Description**	**Responsible Department**	**Benchmark Source**	**Benchmark**	**2015**	**2016 Q1**	**2016 Q2**	**2015 Q3**	**Quarterly Trend 2016 Q1 -Q3**	**Interventions**
Total Careplans Opened	Number of care plans opened during specific reporting period. (excludes DM, Health Ed, Health Nav)	Health Services	N/A	N/A	309	301	326	298.0	-	
Total Careplans Closed	Number of care plans closed during specific reporting period. (excludes DM, Health Ed, Health Nav)	Health Services	N/A	N/A	293	270	282	288.0	-	
Average Careplans in Case Load	Average number of careplans active during specific reporting period (CM only)	Health Services	N/A	N/A	175	198	241	250.0	-	

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Utilization Management

- Turn around times meet or exceed goals and State requirements, except Post Service Requests at 94% - an action plan is in place to correct this. (this is due to coordination with CCS)
- Disease management – review for ethnic disparity – 56% are Spanish Speakers (total population of Spanish Speaking diabetics is 37%). There does not appear to be a disparity.
- Utilization measures – Hospital admits, hospital days, ER visits, appeals, and denials remain in the same ranges.
- Dental anesthesia – the State required an audit of 25 IV sedation cases for dental procedures - this revealed a significant increase from a specific anesthesiologist – this is being reviewed further.

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AGENDA ITEM NO. 8

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, Chief Executive Officer

DATE: February 27, 2017

SUBJECT: Chief Executive Officer Update

LEGISLATIVE ADVOCACY IN WASHINGTON, DC AND SACRAMENTO

The Government Relations staff at Gold Coast Health Plan (GCHP) has been closely tracking the latest proposal presented by the Republican leadership regarding repealing and replacing the Affordable Care Act (ACA).

Last week, House Republicans released a proposal that considers changing the Medicaid program from its current federal matching system to a state choice of per capita allotment or block grant approach (based on Speaker Paul Ryan's "A Better Way" proposal) as part of the Affordable Care Act (ACA) Repeal Reconciliation package. This is particularly concerning for health plans that will be relied upon to continue providing care for Medicaid enrollees under such a system.

The Association of Community Affiliated Plans (ACAP) has been actively advocating for Plans and discussing the potential impact such a proposal would have on Local Plans. Thus, ACAP hosted a legislative advocacy day where Plans met with Congressional representatives to discuss the impact of repealing and replacing the ACA.

On February 7 and 8, GCHP's Chief Executive Officer (CEO) and Government Relations staff participated in ACAP's Legislative Advocacy "Fly-In". This event is held annually to allow ACAP member plans to meet with members of Congress and their staff to discuss federal legislation and policies that impact the Medicaid/Medi-Cal program. GCHP staff met with Congresswoman Julia Brownley and legislative staff from Congress

Members Steve Knight and Salud Carbajal. GCHP staff provided updated information on the Plan and discussed the potential impacts of changes to the ACA on Ventura County.

The ACAP “Fly-In” also provided the opportunity for health plans to learn about health policy initiatives/trends occurring at a national level. ACAP hosted a Health Policy Seminar that included speakers from the House Energy & Commerce Committee and the Centers for Medicare and Medicaid Services (CMS). Topics discussed were the potential impact to health plans regarding the ACA’s Repeal and Replace Republican proposal, long term care, and the Medicaid reform.

On February 14, the Local Health Plans of California (LHPC) held their yearly Legislative Briefing. Local health plans took the opportunity to discuss with legislative staff a number of initiatives Plans have executed to care for their members as well as the potential impact of repealing and replacing the ACA will have in local communities. GCHP’s CEO and Government Relations staff met with Assembly Members Jacqui Irwin, Monique Limon, and California Senator Hannah-Beth Jackson.

COMPLIANCE UPDATE

Gold Coast Health Plan (GCHP) was notified on February 7, 2017 that the Medical Audit corrective action plan (CAP) issued in November 1, 2016 has been closed. On February 8 2017, Audits and Investigations (A&I) notified GCHP that the annual onsite Medical Audit would take place April 24, 2017 through May 5, 2017. Staff is currently compiling pre-audit document material that is due to A&I no later than March 8, 2017. Compliance staff will keep the commission apprised of the audit.

On February 17, 2017, the Department of Health Care Services (DHCS) lifted the Financial CAP that GCHP had been under since October 2012.

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

GCHP compliance staff completed three credentialing audits during the month of January 2017. An audit was conducted on Xerox and results are currently in process of being compiled. An audit on our MBHO for Quality Improvement, Utilization Management and Member Rights and Responsibilities occurred February 20, 21 2017 and results are in review. GCHP MBHO remains under a CAP, for claims processing and financial sanctions are currently in place. GCHP Vision provider is also under a CAP. GCHP delegation oversight staff is working with each delegate on achieving compliance to address the deficiencies identified and ultimately close out the CAPs issued.

The compliance dashboard is attached for reference and includes information on but is not limited to staff trainings, fraud referrals, HIPAA breaches, delegate audits.

COMPLIANCE REPORT 2016

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
Hotline A confidential telephone and web-based process to collect info on compliance, ethics, and FWA	Referrals *one referral can be sent to multiple referral agencies*	0												0
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0												0
Hotline Referral *FWA	Department of Justice	0												0
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	5												5
Hotline Referral	External Agency (i.e. HSA)	0												0
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	0												0
Delegation Oversight	Delegated Entities	8												8
The committee's function is to ensure that delegated activities of subcontracted entities are in compliance with standards set forth from GCHP contract with DHCS and all applicable regulations	Reporting Requirements Reviewed **	71												71
	Audits conducted	2												2
Delegation Oversight	Letters of Non-Compliance	0												0
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	0												0
Audits	Total	0												0
External regulatory entities evaluate GCHP compliance with contractual obligations.	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	0												0
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0												0
	HEDIS Compliance Audit (HSAG)	0												0
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2012*	0												0
	DHCS Medical Audit	0												0
Fraud, Waste & Abuse	Total Investigations	5												5
The Fraud Waste and Abuse Prevention process is intended to prevent, detect, investigate, report and resolve suspected and /or actual FWA in GCHP daily operations and interactions, whether internal or external.	Investigations of Providers	0												0
	Investigations of Members	5												5
	Investigations of Other Entities	0												0
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0												0

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
HIPAA	Referrals	6												6
Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	State Notification	6												6
	Federal Notification	0												0
	Member Notification	2												2
	HIPAA Internal Audits Conducted	0												0
Training	**Training Sessions**	12												12
Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Fraud, Waste & Abuse Prevention (Individual Training)	2												2
	Fraud, Waste & Abuse Prevention (Member Orientations)	6												6
	Code of Conduct	2												2
	HIPAA (Individual Training)	2												2
	HIPAA (Department Training)	0												0

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

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

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

^ The large aggregates for the month of November and December represent the yearly training of full time employees and new coming Commissioners.

AGENDA ITEM NO. 9

TO: Gold Coast Health Plan Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: February 14, 2017

SUBJECT: COO Update

OPERATIONS UPDATE

Membership Summary– February 2017

As of February 1, 2016, Gold Coast Health Plan's (GCHP's) total membership is 204,417. The Plan experienced a loss of 112 members from January 2017 through February 2017. The cumulative total for new membership is summarized as follows:

Aid Code	# of New Members
L1 – Low Income Health Plan (LIHP)	590
M1 – Adult Expansion	55,667
7U – CalFresh Adults	113
7W – CalFresh Children	55
7S – Parents of 7Ws	243
Traditional Medi-Cal	29,237
Total New Membership 1/1/14 – 2/1/17	85,905

Adult Expansion Membership (Aid Code M1) slightly increased in February following a slight drop off in January which is consistent with a new plan year. M1 members represent 64.80% of GCHP's new membership since January 1, 2016.

	L1	M1	7U	7W	7S
Feb 17	590	55,667	113	55	243
Jan 17	646	55,551	141	50	203
	L1	**M1**	**7U**	**7W**	**7S**
Dec 16	695	55,820	521	123	240
Nov 16	770	55,567	1,057	216	314
Oct 16	919	55,103	1,227	254	374
Sep 16	1,015	54,740	1,370	280	336
Aug 16	1,162	54,237	1,470	307	361
Jul 16	1,261	53,767	1,593	346	397
Jun 16	1,349	53,864	1,703	386	424
May 16	1,407	52,898	1,820	433	478
Apr 16	1,596	51,769	1,910	462	549
Mar 16	1,800	50,648	2,015	510	620
Feb 16	1,873	50,185	2,110	549	579
Jan 16	1,953	49,653	2,205	608	736

AB 85 Capacity Tracking – VCMC has a target enrollment of 65,765 Adult Expansion Members. The current membership with VCMC is 30,385 as of February 2017, which accounts for 46.20% of their enrollment target.

Operations Summary – December 2017

Claims Inventory for December 2016 a total of 190,686 claims were received with an average of 9,080 claims received per day and a Days Receipt on Hand (DROH) of 3.73 days. This equated to 35,554 claims in inventory with 21 business days in the month. The target DROH is a maximum of 5 days. Monthly claim receipts from July 2015 through December 2016 are:

Month	Total Claims Received	Receipts per Day
December 2016	190,686	9,080
November 2016	170,209	8,510
October 2016	209,638	9,983
September 2016	159,446	7,593
August 2016	180,049	7,828
July 2016	166,955	8,347
June 2016	177,246	8,057
May 2016	157,434	7,497
April 2016	162,287	7,728
March 2016	193,881	8,429
February 2016	176,656	8,833
January 2016	154,770	8,146
December 2015	170,897	7,768
November 2015	142,247	7,902
October 2015	156,109	7,095
September 2015	164,510	7,834
August 2015	152,840	7,278
July 2015	162,237	7,374

Claims Processing Results – Conduent reported that all Claims Service Level Agreements (SLAs) areas were met or exceeded in December 2016. SLAs reported are listed below:

- **Claims Turnaround Time (TAT)** for December 2016 was 97.9% of clean claims processed within 30 calendar days and 100% of unclean claims were processed within 60 calendar days. The regulatory requirement of processing clean claims is 90% of within 30 calendar days of receipt.
- **Financial Claims Processing Accuracy** for December 2016 was 99.72%. The contractual requirement for financial accuracy is ≥ 98%.
- **Procedural Claims Processing Accuracy** for December 2016 was 99.99%. The contractual requirement for procedural accuracy is ≥ 97%.

Call Center Results – Conduent has hired an internal call center subject matter expert who is working with GCHP management to improve call center results. The Conduent and GCHP teams

are currently working together to review the call center training materials and to expand and improve the new hire training curriculum and staffing requirements. All statistics listed below reflect a combination of all call center line types (provider, member, Spanish and English)

- **Call Volume for** December 2016 was 10,233 calls, which is slightly higher than previous months.
- **Call Volume 12-month Average** for the past rolling 12-month period was 10,051 calls per month.
- **Average Speed to Answer (ASA)** for December 2016 was 14.3 seconds. The contractual requirement for average speed to answer is ≤ 30 seconds.
- **Abandonment Rate** for December 2016 was 0.82%. The contractual requirement for abandonment rate is ≤ 5%.
- **Average Call Length** for December 2016 was 6.57 minutes per call. We have continued to see a reduction in call length which is expected when training is improved.
- **Call Center Phone Quality** – for December 2016 was 94.9%. The contractual requirement for call center phone quality is 95% or higher.

Grievance and Appeals received 7 member grievances and 118 provider claim payment grievances during November. The 12 member grievances equate to 0.03 grievances per 1,000 members.

Type of Member Grievances	Number of Grievances
Quality of Care	9
Quality of Service	4
Billing	2
Denials/Refusals	1
Total Member Grievances	**16**

There were 9 clinical appeals in December; 2 were upheld, 6 overturned and 1 was withdrawn. There was 1 State Fair Hearing case in December and it was withdrawn.

Member Orientation Meetings
A total of 150 members (91 English, 30 Spanish) have attended Member Orientation meetings from January 2016 through December 2016. Of the 150 members, 66 indicated they learned about the meeting as a result of the informational flyer included in each new member packet.

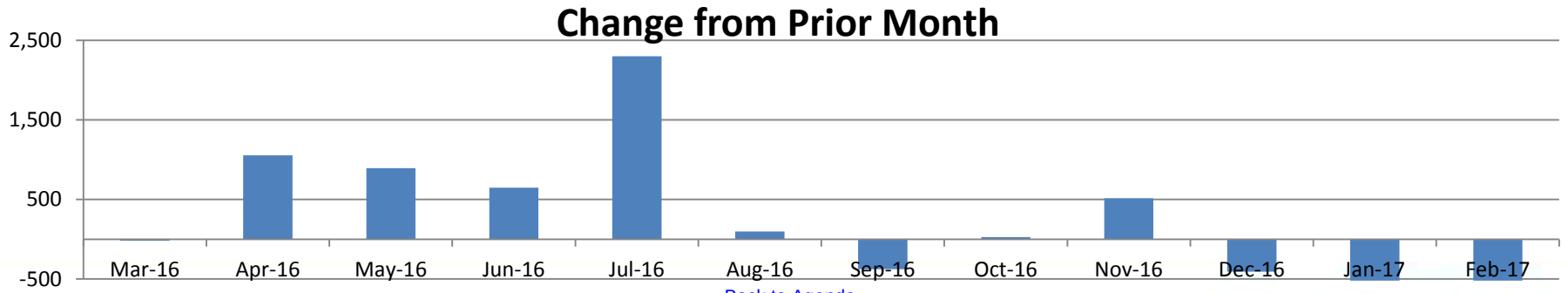
Conduent Contract Extension/New Contract Negotiation
The existing Administrative Services contract with Conduent has been extended through April 30, 2017. GCHP's procurement team is working with Conduent to extend the contract beyond April 2017, while we pursue an RFP strategy. This will provide GCHP with data regarding the market value of the Conduent contract and better line of site to the options and costs in the general market place. Once GCHP has secured the RFPs from all vendors, the procurement team will assess and evaluate the options and provide a recommendation on how to proceed with vendor selection.

GCHP Membership

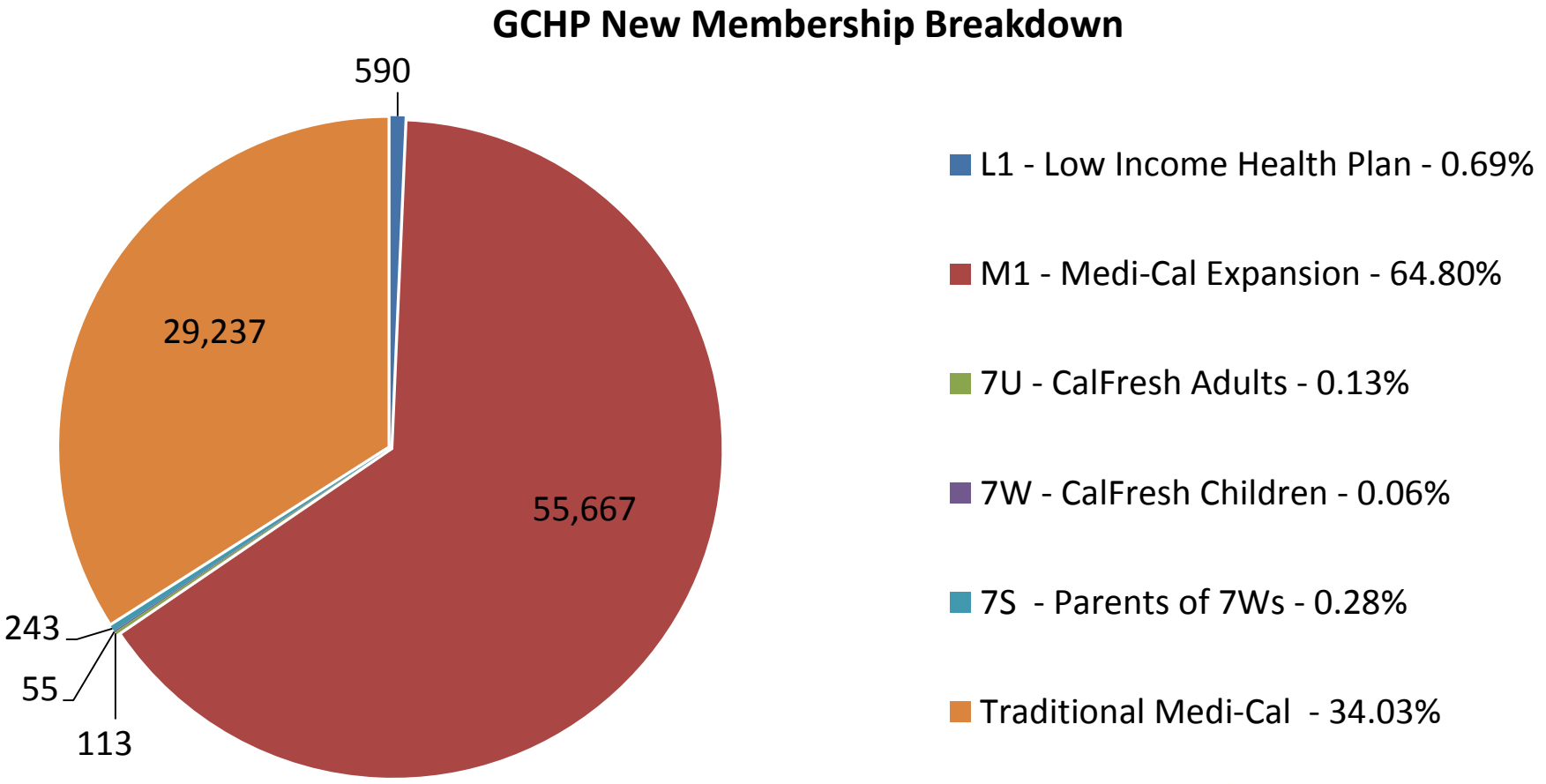
Total Membership as of February 1, 2017 – 204,417

*New Members Added Since January 2014 – 85,905

	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Active Membership	203,075	203,969	204,619	206,920	207,019	206,644	206,672	207,188	206,780	206,252	204,529	204,417



Membership Growth



GCHP Membership Churn Summary

	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Membership from Prior Month	202,037	202,019	203,075	203,969	204,619	206,920	207,019	206,644	206,672	207,188	206,780	206,252	204,529
Prior Month Members Inactive in Current Month	6,139	6,078	5,723	5,642	5,584	5,881	6,182	6,083	5,575	6,866	6,054	8,733	6,682
Sub-total	195,898	195,941	197,352	198,327	199,035	201,039	200,837	200,561	201,097	200,322	200,726	197,519	197,847
Percentage of Inactive Members from Prior Month	3.04%	3.01%	2.82%	2.77%	2.73%	2.84%	2.99%	2.94%	2.70%	3.31%	2.93%	4.23%	3.27%
Current Month New Members	4,215	5,059	4,742	4,368	6,316	4,378	3,916	4,256	4,193	4,533	3,809	5,165	4,118
Sub-total	200,113	201,000	202,094	202,695	205,351	205,417	204,753	204,817	205,290	204,855	204,535	202,684	201,965
Percentage of New Members Reflected in Current Membership	2.09%	2.49%	2.32%	2.13%	3.05%	2.11%	1.90%	2.06%	2.02%	2.19%	1.85%	2.53%	2.01%
Retroactive Member Additions	1,906	2,075	1,875	1,924	1,569	1,602	1,891	1,855	1,898	1,855	1,717	1,845	2,452
Active Current Month Membership	**202,019**	**203,075**	**203,969**	**204,619**	**206,920**	**207,019**	**206,644**	**206,672**	**207,188**	**206,780**	**206,252**	**204,529**	**204,417**
Percentage of Retroactive Members Reflected in Current Membership	0.94%	1.02%	0.92%	0.94%	0.76%	0.77%	0.92%	0.90%	0.92%	0.90%	0.83%	0.90%	1.20%

GCHP Auto Assignment by PCP/Clinic as of February 1, 2017

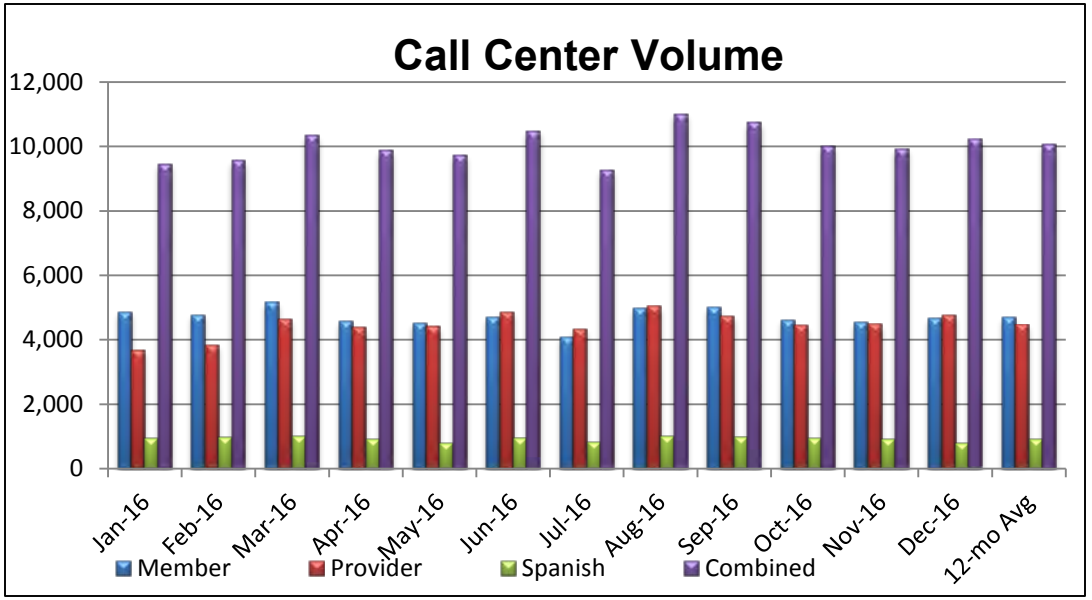
	Feb-17		Jan-17		Dec-16		Nov-16		Oct-16		Sep-16	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
AB85 Eligible	**1357**		**1,000**		**1,030**		**1,003**		**919**		**979**	
VCMC	678	49.96%	499	49.90%	772	74.95%	752	74.98%	689	74.97%	734	74.97%
Balance	679	50.04%	499	49.90%	258	25.05%	251	25.02%	230	25.03%	245	25.03%
Regular Eligible	**1,102**		**888**		**1,161**		**1,262**		**935**		**989**	
Regular + AB85 Balance	**1,781**		**1,387**		**1,419**		**1,513**		**1,165**		**1,234**	
Clinicas	396	22.23%	314	22.64%	358	25.23%	365	24.12%	284	24.38%	293	23.74%
CMH	225	12.63%	170	12.26%	185	13.04%	178	11.76%	149	12.79%	149	12.07%
Independent	33	1.85%	32	2.31%	38	2.68%	25	1.65%	27	2.32%	21	1.70%
VCMC	1127	63.28%	871	62.80%	838	59.06%	945	62.46%	705	60.52%	771	62.48%
Total Assigned	**2,459**		**1,888**		**2,191**		**2,265**		**1,854**		**1,968**	
Clinicas	396	16.10%	314	16.63%	358	16.34%	365	16.11%	284	15.32%	293	14.89%
CMH	225	9.15%	170	9.00%	185	8.44%	178	7.86%	149	8.04%	149	7.57%
Independent	33	1.34%	32	1.69%	38	1.73%	25	1.10%	27	1.46%	21	1.07%
VCMC	1,805	73.40%	1,370	72.56%	1,610	73.48%	1,697	74.92%	1,394	75.19%	1,505	76.47%

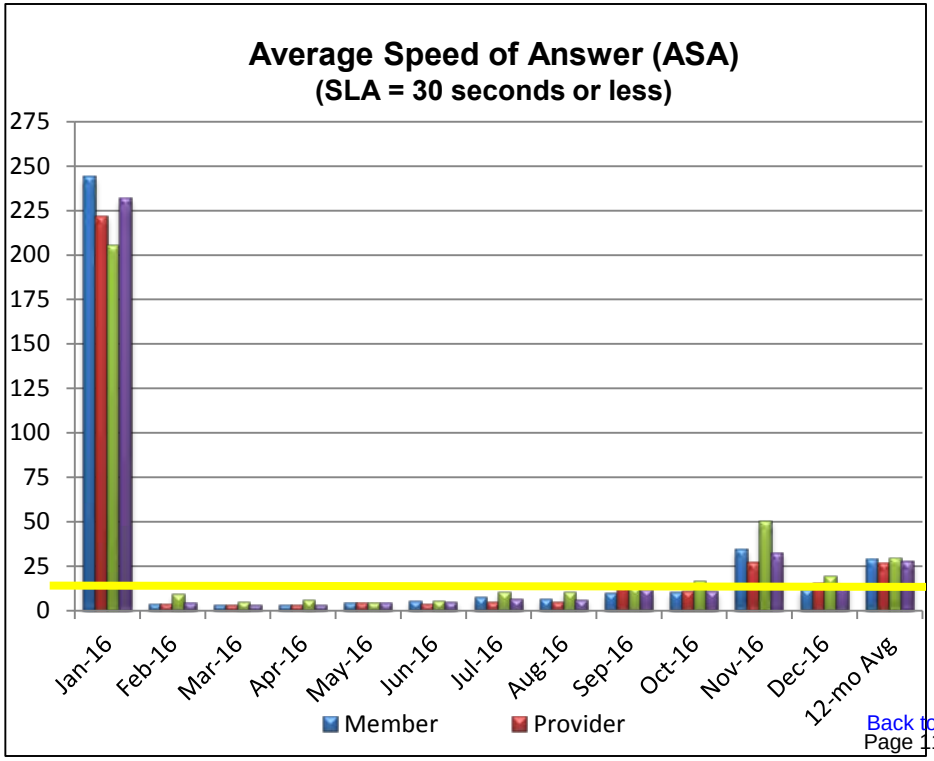
Auto Assignment Process

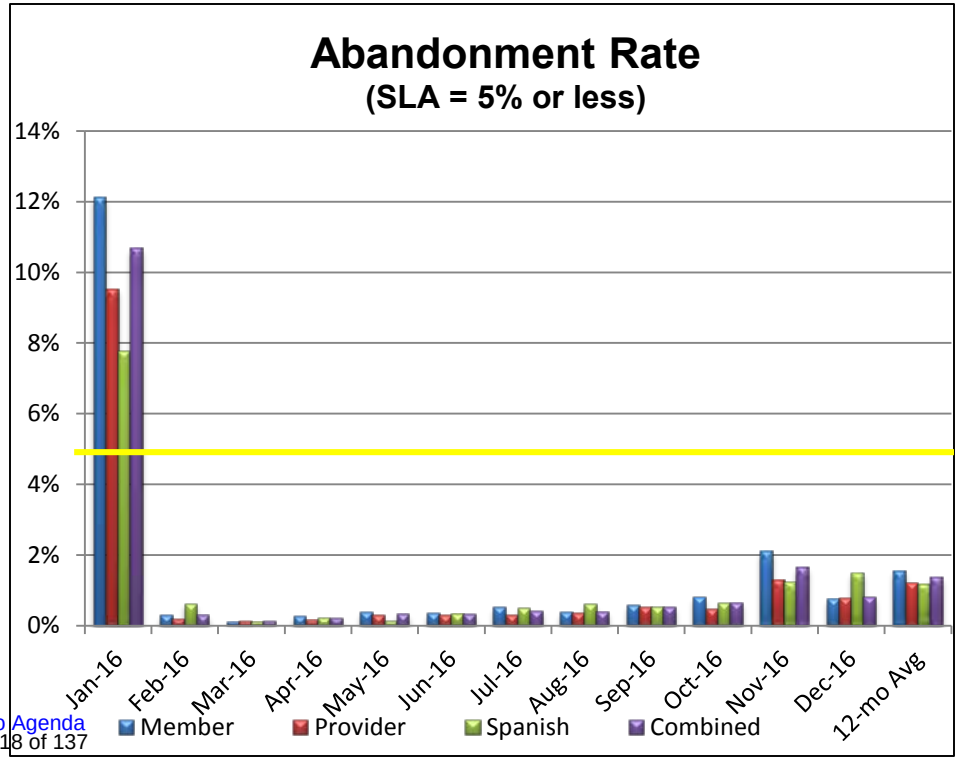
- 75% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85
- The remaining 25% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others
- The County's overall auto assignment results will be higher than 75% since they receive 75% of the AE members plus a 3:1 ratio of all other unassigned members
- VCMC's target enrollment is 65,765
  - VCMC has 30,385 assigned Adult Expansion members as of February 1, 2017 and is currently at 46.20% of capacity

GCHP Call Center Metrics – December 2016

- Call volume increased above 10,000 during the month; GCHP received 10,233 calls during December
- Service Level Agreements (SLA) for ASA (14.3 seconds vs the contractual requirement of ≤ 30 seconds) and Abandonment Rate (0.82% vs the contractual requirement of ≤ 5%) ASA and Abandonment Rate were met for December

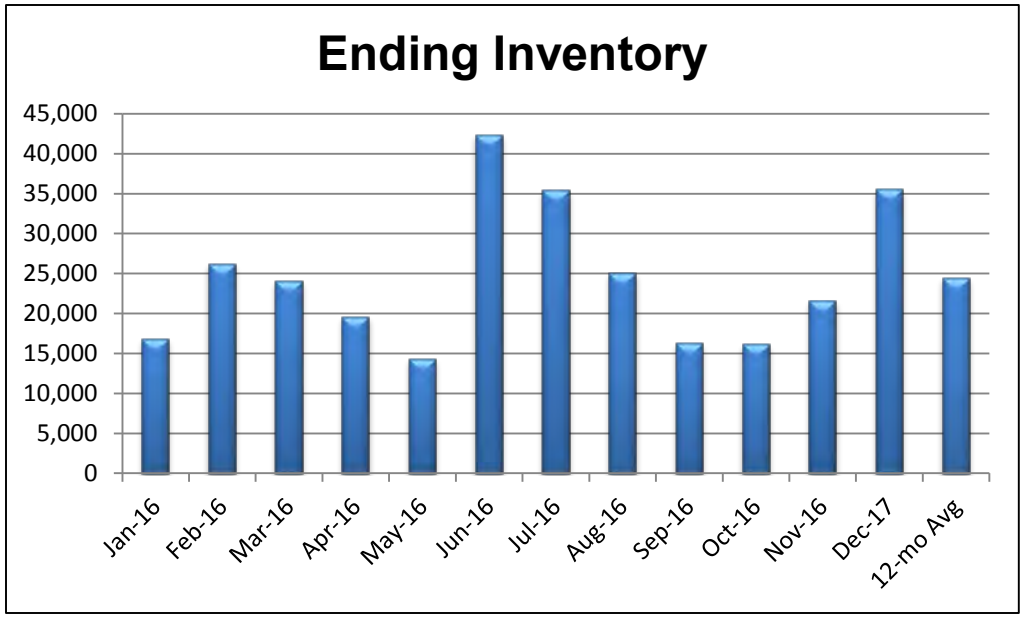


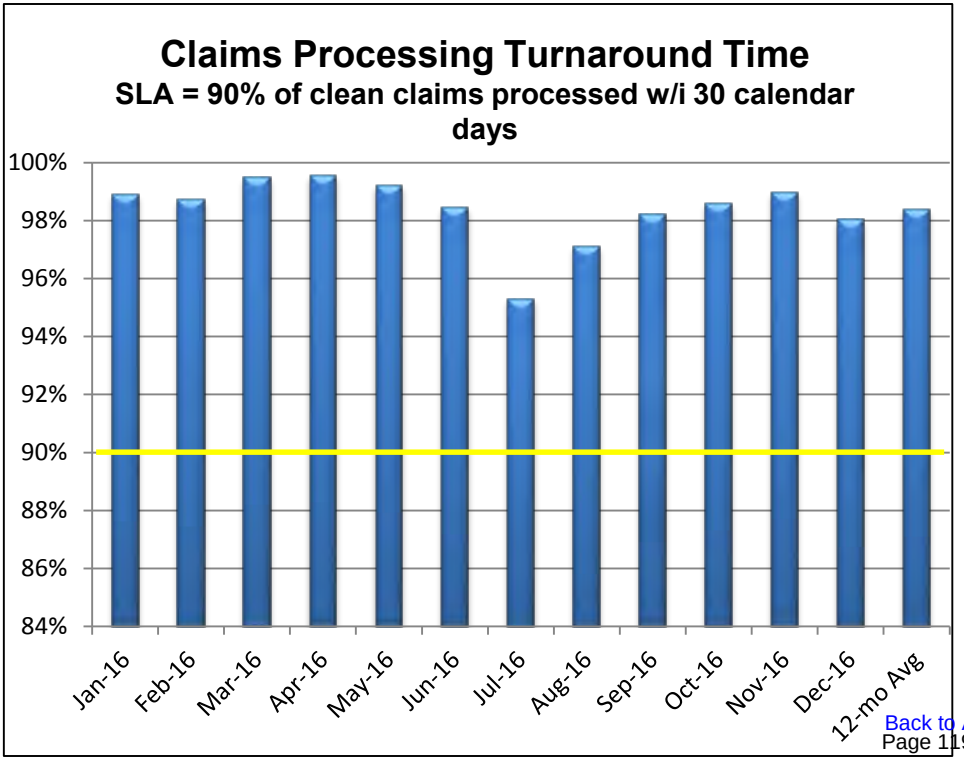


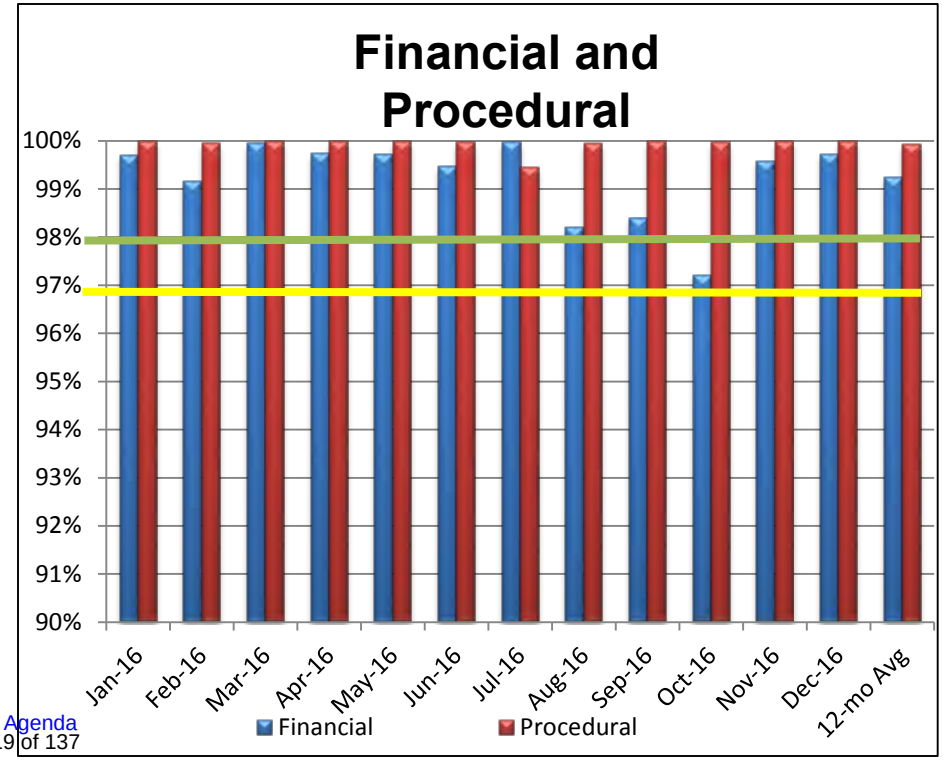


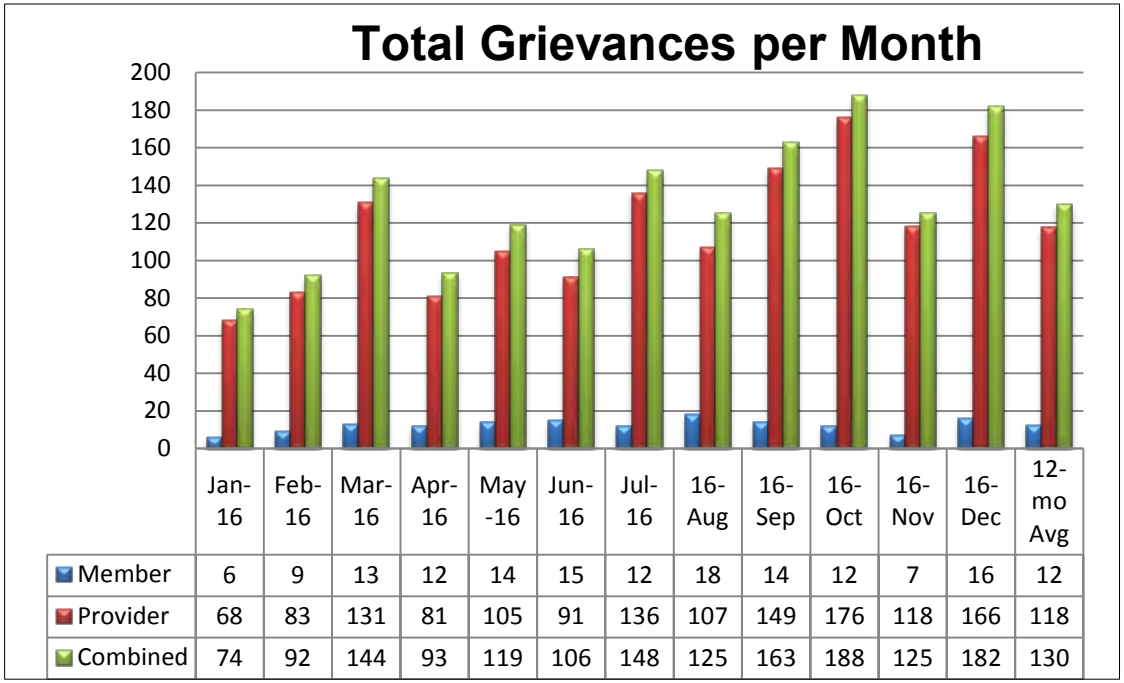
GCHP Claims Metrics – December 2016

- The 30 Day Turnaround Time (TAT) remained in compliance at 97.04% for clean claims and 100% for the unclean claims
- Ending Inventory was 35,554 which equates to a Days Receipt on Hand (DROH) of 3.73 days vs a target DROH ≤ 5 days
- Service Level Agreements (SLAs) for Financial Accuracy (99.72%) and Procedural Accuracy (99.99%) were both met in December







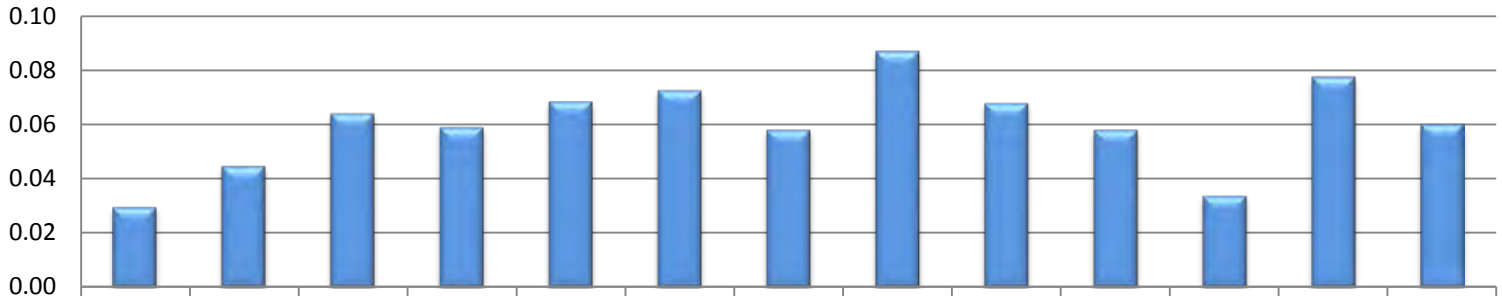


	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	12-mo Avg
Member	6	9	13	12	14	15	12	18	14	12	7	16	12
Provider	68	83	131	81	105	91	136	107	149	176	118	166	118
Combined	74	92	144	93	119	106	148	125	163	188	125	182	130

GCHP Grievance & Appeals Metrics – Dec. 2016

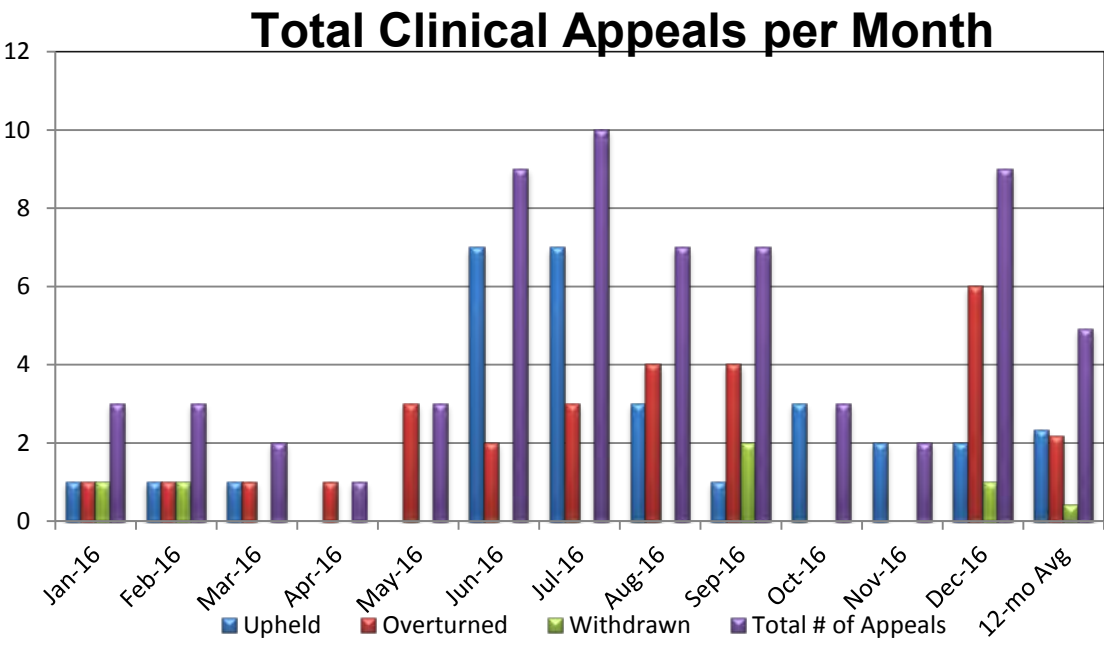
- GCHP received 16 member grievances (0.08 grievances per 1,000 members) and 166 provider grievances during December 2016
- GCHP's 12-month average for total grievances is 130
  - 12 member grievances per month
  - 118 provider grievances per month

Member Grievance per 1000 Members



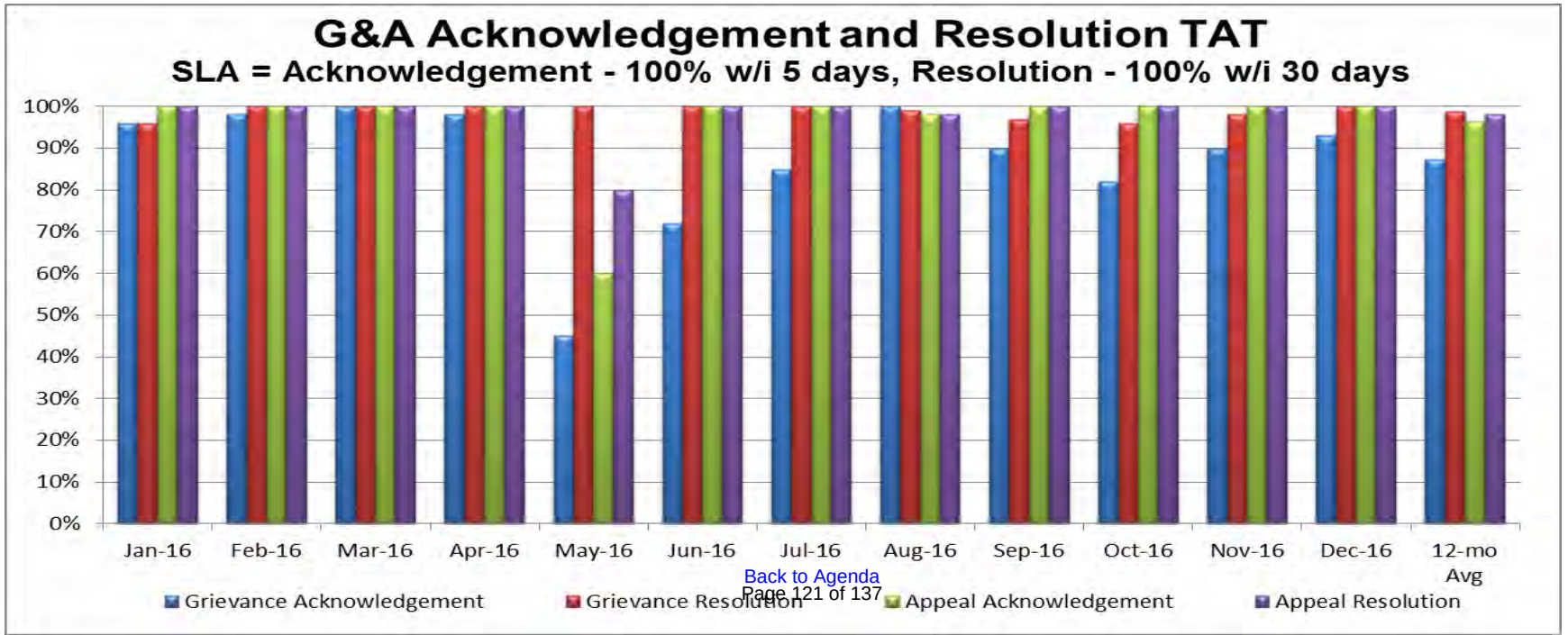
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	12-mo Avg
# of Grievance per 1000 Members	0.03	0.04	0.06	0.06	0.07	0.07	0.06	0.09	0.07	0.06	0.03	0.08	0.06

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	12-mo Avg
Membership Count	202,037	202,019	203,075	203,969	204,619	206,920	207,019	206,644	206,672	207,188	206,780	206,252	205,266
Total Member Grievances Filed	6	9	13	12	14	15	12	18	14	12	7	16	12
# of Grievance per 1000 Members	0.03	0.04	0.06	0.06	0.07	0.07	0.06	0.09	0.07	0.06	0.03	0.08	0.06



GCHP Grievance & Appeals Metrics – December 2016

- GCHP had 9 clinical appeals in Nov; 2 upheld, 6 overturned and 1 withdrawn
- TAT for grievance acknowledgement was non-compliant at 93%
- GCHP continues to monitor and review the processes for ways of improving the results
- TAT for grievance resolution was compliant at 100%
- TAT for appeal acknowledgement and resolution was compliant at 100%.
- 1 State Fair Hearings in Dec., it was withdrawn by the member



Gold Coast Health Plan℠
A Public Entity

Network Operations Dashboard

January 2017

Integrity

Accountability

Collaboration

Trust

Respect

PROVIDER NETWORK GROWTH FYE 2016 3rd Qtr January Ending- FY 2017 3rd Qtr January Ending

FY 2016 3rd Qtr Ending January		FY 2017 3rd Qtr Ending January
356	Total # of Primary Care Providers	397 (360)
2,821	Total # of Specialty Physicians	6,578 (4,787)
HOSPITALS		HOSPITALS
304	Total # of Behavioral Health Providers	352 (348)
241	Total # of Pharmacy Providers	235 (235)
385	Total # of All Other Providers (Home Health, Ancillaries, SNF's, CBAS, LTAC's)	452 (392)

FY 2016		FY 2017
11	Acute Care	**16**
3	Tertiary Care	**5**

- UCLA- 1,851
- USC Care- 395
- CHLA- 234
- City of Hope- 238

Numbers in **( )** denote figures ending December 2016

Gold Coast Health Plan℠ A Public Entity

CONTRACT & ACCESS IMPROVEMENT
2nd Qtr ENDING FY 2017

STATUS	Hospitals	Physicians/ Medical Groups	Ancillary/ Outpatient	SNF/LTC
Pending	➢ **1 Facilities** - Tertiary	➢ **2 Provider Groups** - Specialty - ENT 5 - Neuro-Surgery 8	➢ **1 Facilities/Providers** - None at this time	None at this time
Outreach	➢ **1 Facility** - Acute Care/Rehab	➢ **7 Provider Groups** - Multi-Specialty 58 - Primary Care-IM, FP 43 - Pediatrics (2 groups) 7 - GI 4 - Orthopedics 18	➢ **4 Facilities/Providers** - Acupuncture Services 22 - Bio-Reference Lab 1 - Nutritional Services 11 - Mobile Diagnostic X-ray 1	None at this time

Numbers in RED represent total number of providers in each category

Gold Coast Health Plan℠
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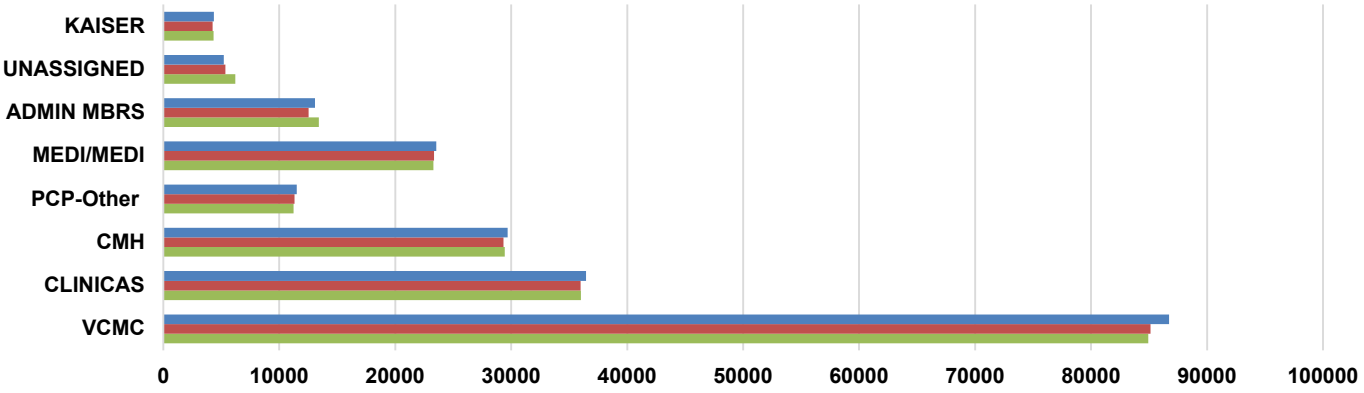
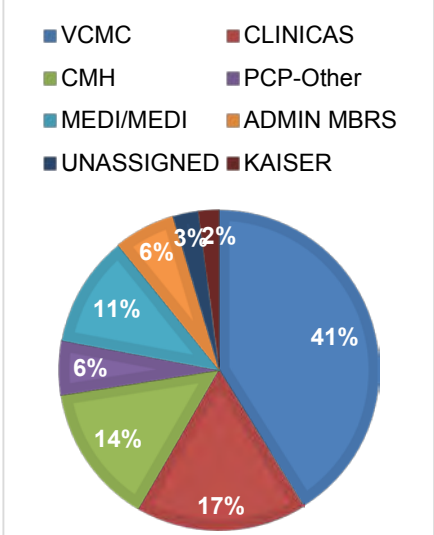
Member PCP Assignments



	VCMC	CLINICAS	CMH	PCP-Other	MEDI/MEDI	ADMIN MBRS	UNASSIGNED	KAISER
Nov-16	86718	36444	29689	11501	23532	13080	5228	4370
Dec-16	85142	35973	29321	11321	23343	12531	5367	4257
Jan-17	84943	36021	29438	11229	23291	13409	6216	4337



- Unassigned members are Newly Eligible/Enrolled
- Administrative Member(s)
  - Share of Cost (SOC): a Member who has Medi-Cal with a Share of Cost requirement.
  - Long-Term Care (LTC): A Member who is residing in a skilled or intermediate-care nursing facility and has been assigned an LTC Aid Code.
  - Out of Area: A Member who resides outside GCHP's service area but whose Medi-Cal case remains in Ventura County.
  - Other Health Coverage: A Member who has other health insurance that is primary to their Medi-Cal coverage; this includes Members with both Medi-Cal and commercial insurance. Medi-Cal is the payer of last resort; therefore GCHP Members with other coverage must access care through their primary insurance.

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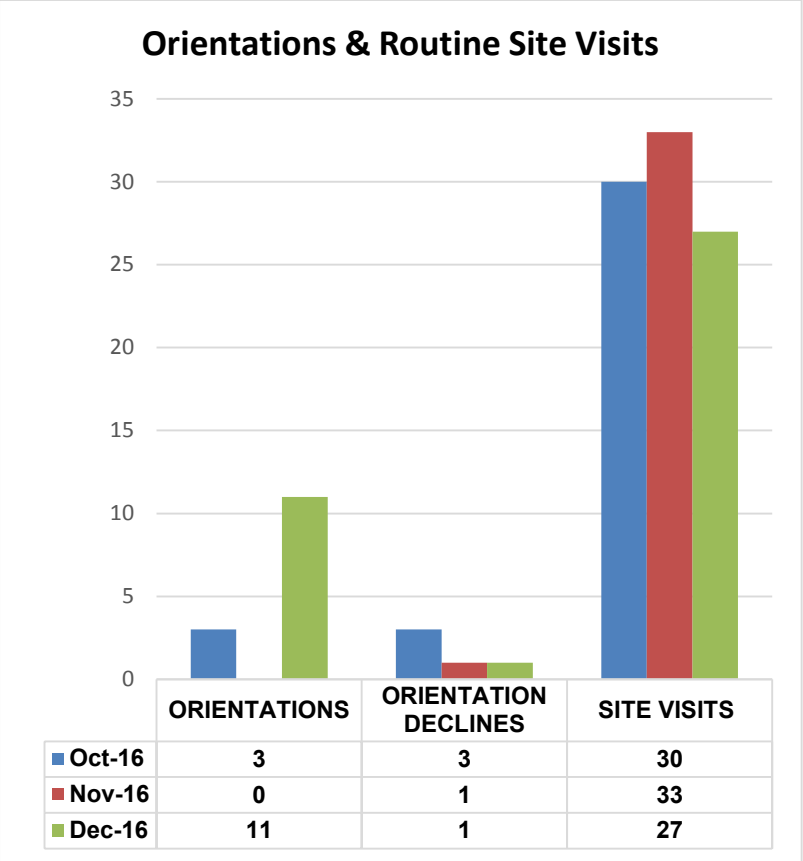
Provider Site Visits and Orientations

Provider Relations Representatives perform Orientations with newly GCHP contracted Providers and routinely visit provider offices. These visits create opportunities for providers to ask questions and for the representatives to deliver current information and materials. Visits may be pre-scheduled at the providers request to discuss specific issues or concerns and may include representation from other GCHP business areas.

Delegated groups are responsible to provide Orientation with new providers within ten (10) days of the providers effective date of hire.

A total of 5 physician's declined Orientation in Q4 due to joining an established contracted group with GCHP. Established groups participated in previous Orientations therefore are familiar with GCHP policies and procedures.



	ORIENTATIONS	ORIENTATION DECLINES	SITE VISITS
Oct-16	3	3	30
Nov-16	0	1	33
Dec-16	11	1	27

Gold Coast Health Plan℠ A Public Entity

AGENDA ITEM NO. 10

TO: Gold Coast Health Plan Commission

FROM: C. Albert Reeves, Chief Medical Officer

DATE: February 27, 2017

SUBJECT: Chief Medical Officer Update

HEALTH SERVICES UPDATE

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

UTILIZATION SUMMARY

Inpatient utilization metrics for CYTD 2016 continue to be similar to slightly improved compared with CY 2015.

Bed days/1000 for CYTD 2016 (through October) show 4.5% decrease compared to CY 2015. Adult Expansion members utilized the greatest number of bed days (41%) followed by SPD (35%) and Family members (24%).

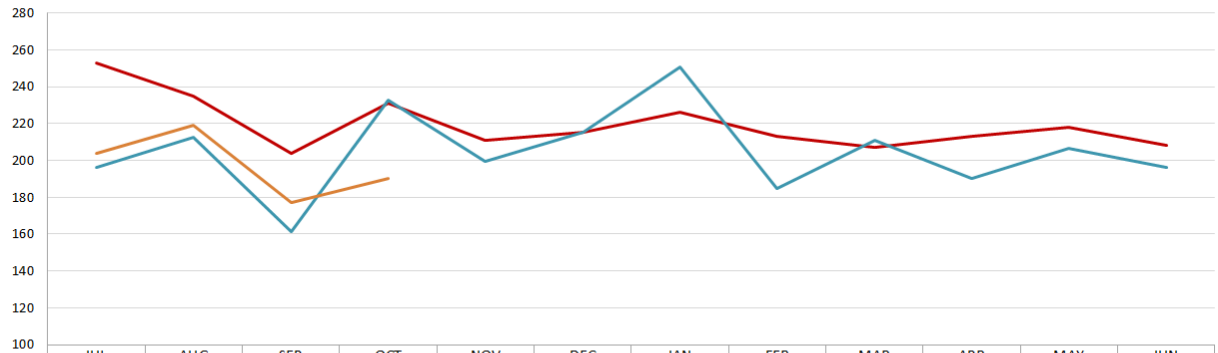
Average length of stay for CYTD 2016 (4.2) is similar to CY2015 (4.3).

Admits/1000 decreased about 3% from CY 2015 to CYTD 2016 (51 TO 49).

ED utilization/1000 decreased by 3% from CY 2015 to CYTD 2016. The family aid code group continues to utilize about half of all ED visits (48%) followed by AE members at 33%.

Benchmark: The September 17, 2015 DHCS Medi-Cal Managed Care Performance Dashboard reported 36 ER visits / 1000 member months statewide for all managed care plans for October 2013 – September 2014. GCHP ER utilization / 1000 member months for the same period was 38.

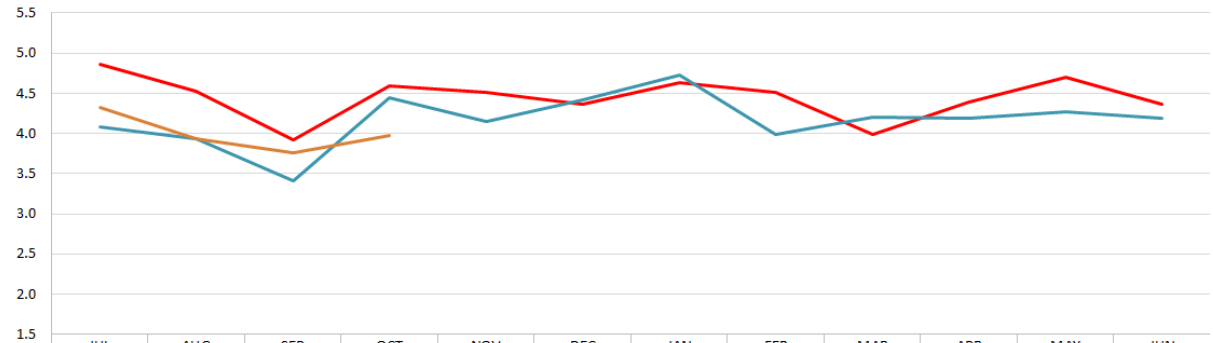
Bed Days Per 1,000



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	253	235	204	231	211	215	226	213	207	213	218	208
FY 2015-16	196	212	161	233	200	215	251	185	211	190	206	196
FY 2016-17	204	219	177	190								

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

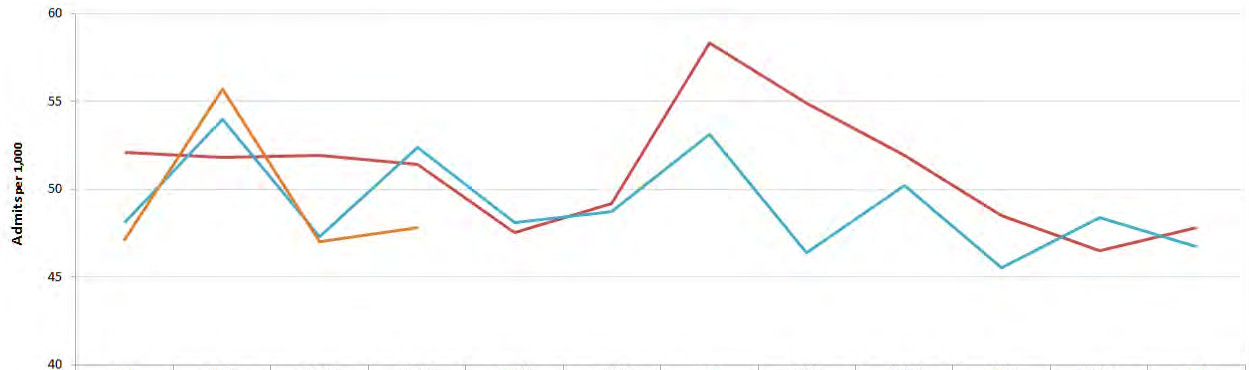
Average Length of Stay



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	4.9	4.5	3.9	4.6	4.5	4.4	4.6	4.5	4.0	4.4	4.7	4.4
FY 2015-16	4.1	3.9	3.4	4.4	4.1	4.4	4.7	4.0	4.2	4.2	4.3	4.2
FY 2016-17	4.3	3.9	3.8	4.0								

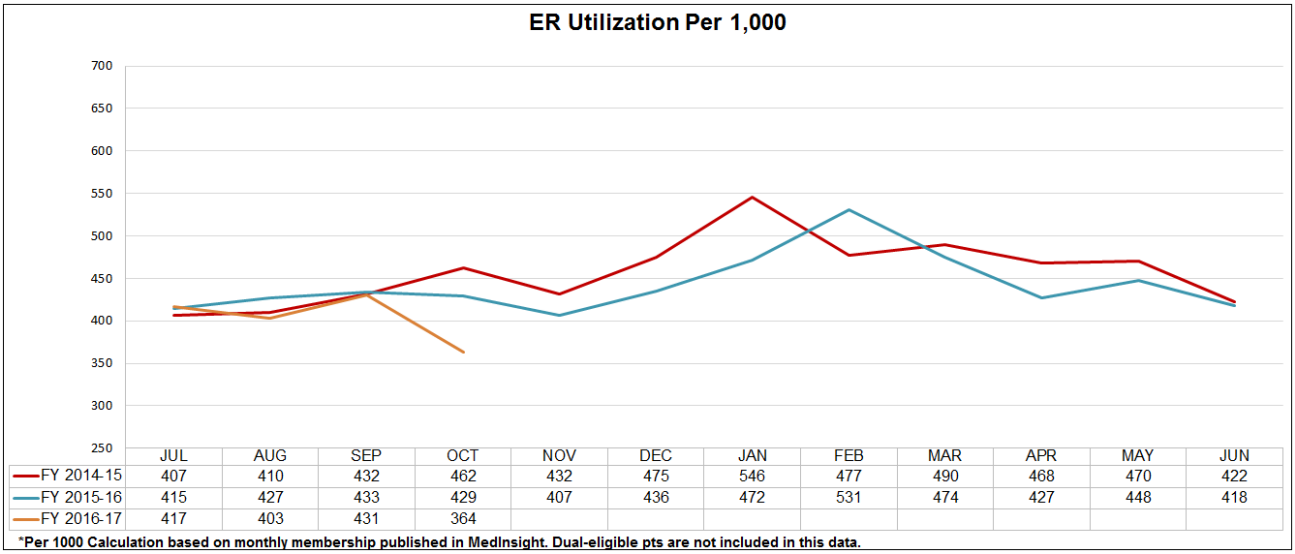
*Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

Acute Inpatient Admissions/1000 Members



	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	52	52	52	51	48	49	58	55	52	49	47	48
FY 2015-16	48	54	47	52	48	49	53	46	50	46	48	47
FY 2016-17	47	56	47	48								

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.
*Data from MedInsight 01/07/2017

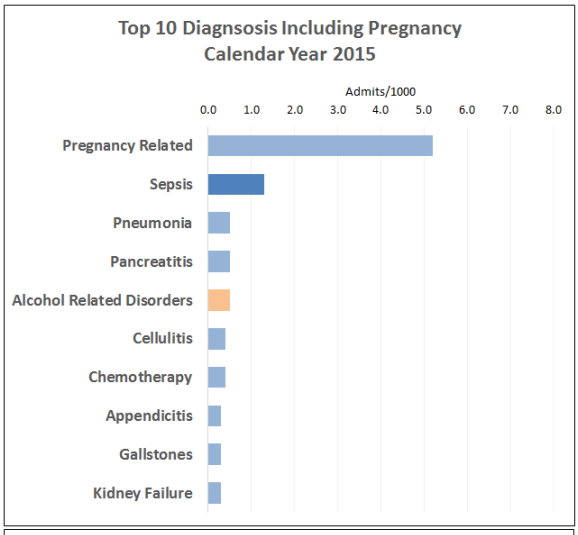


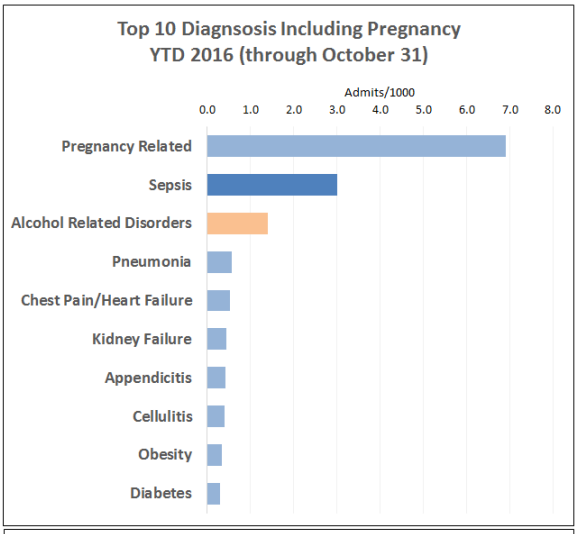
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2014-15	407	410	432	462	432	475	546	477	490	468	470	422
FY 2015-16	415	427	433	429	407	436	472	531	474	427	448	418
FY 2016-17	417	403	431	364								

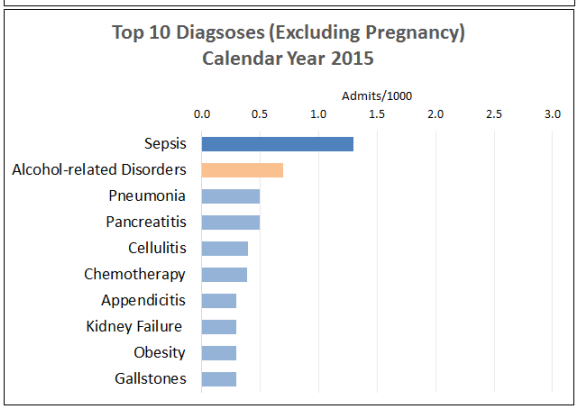
*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts are not included in this data.

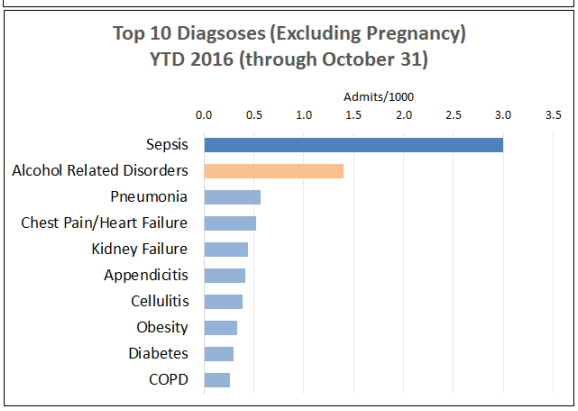
TOP ADMITTING DIAGNOSES

Pregnancy related diagnoses and sepsis continue to dominate top admitting diagnoses for CY 2016. For members admitted with a primary diagnosis of sepsis, secondary diagnoses were cancer, heart disease, liver or renal transplant, and diabetes were secondary diagnoses.



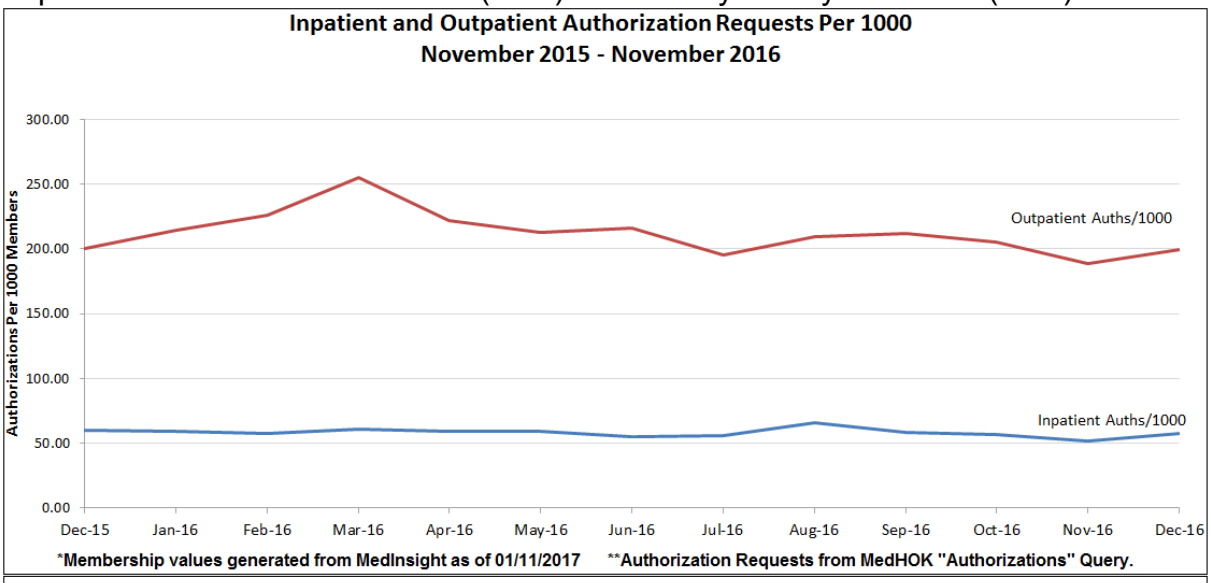


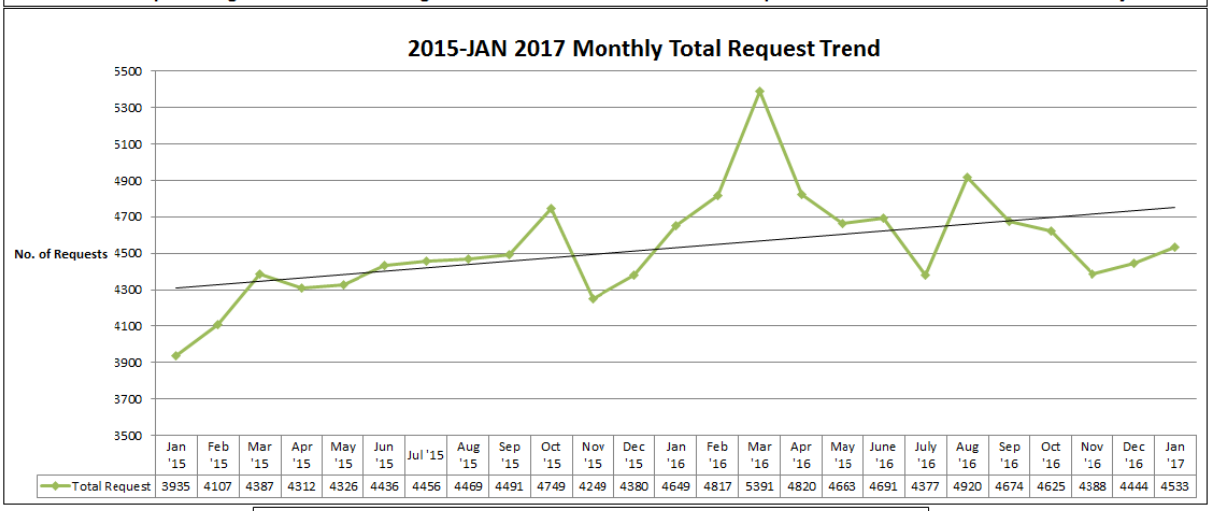


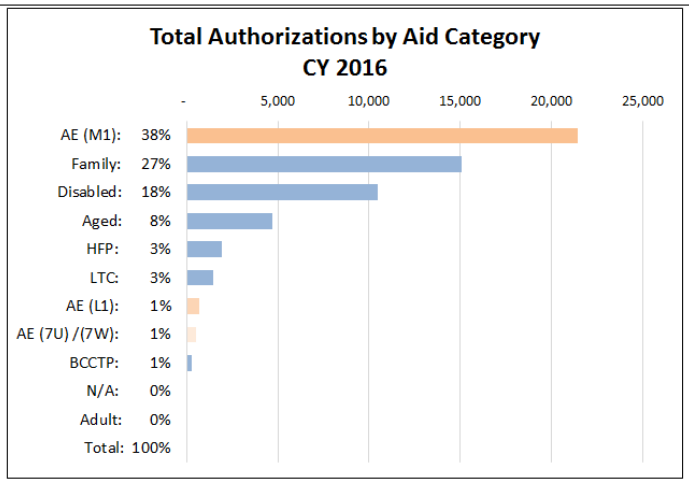


AUTHORIZATION REQUESTS

For CY2016, requests for outpatient service outnumber requests for inpatient service by about 4 times. Requests for outpatient service have declined to 213 requests/1000 members in CY 2016 from a peak of 255/1000 in March of 2016. Most outpatient service requests are for AE M1 members (38%) followed by Family members (27%).



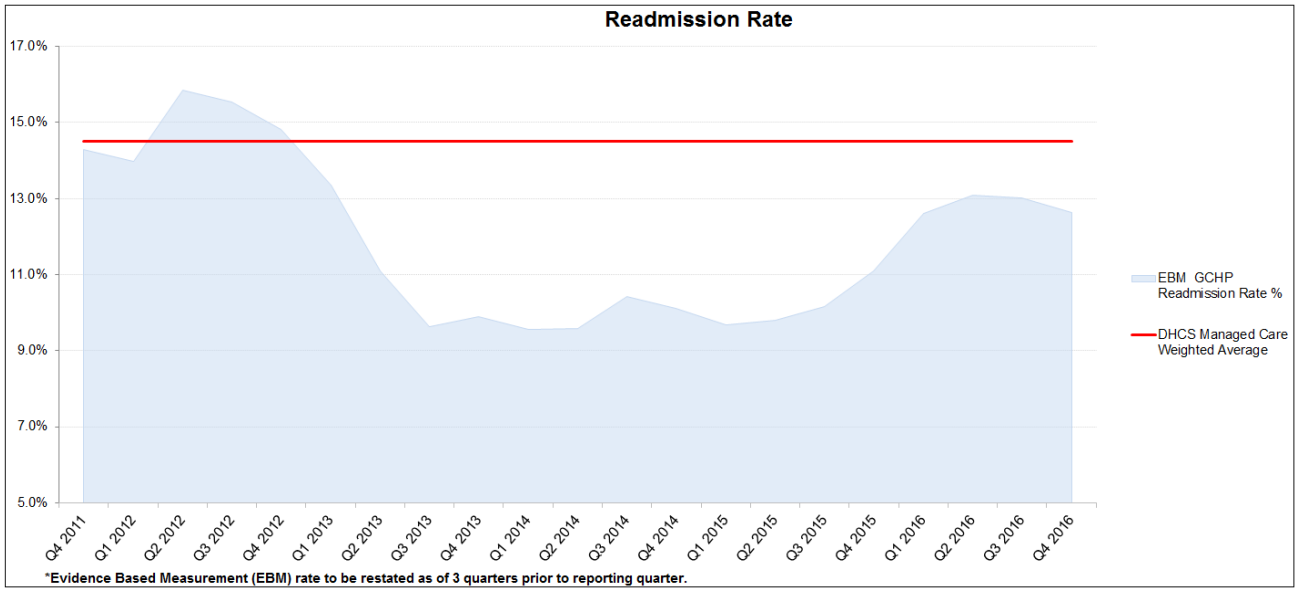




Readmission Rate

The readmission rate has remained between 9.5% and 13% since 2013.

Benchmark: The weighted average for the HEDIS 2013 All Cause Readmission Rate from the February 2014 Medi-Cal Managed Care Performance Dashboard is approximately 14.5%.



Clinical Grievances and Appeals

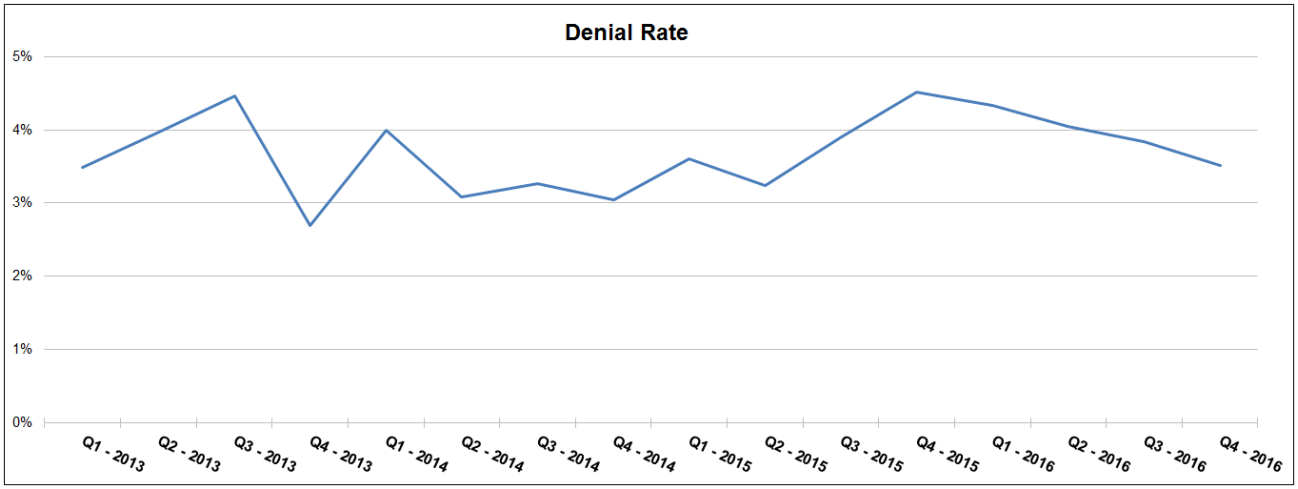
For CY2016, there were an average of 30 grievances/ quarter compared with 32 grievances/quarter for CY2015. Most grievances (85%) were characterized as quality of care issues. Only 2% of grievances were characterized as access issues.

QTR	Grievance Total	Appeals Total	Upheld	Partial Overturn	Overturned	Withdrawn	Dismissed
2016							
Q1	26	9	3 (34%)	-	4 (44%)	1 (11%)	1 (11%)
Q2	32	9	7 (78%)	-	2 (22%)	-	-
Q3	33	24	7 (29%)	-	14 (58%)	1 (5%)	-
Q4	27	21	7 (33%)	-	6 (29%)	1 (5%)	-

Denial Rate

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

The denial rate has ranged between 2.7% and 4.5% since 2013. The average denial rate for CY 2015 was 3.8% and for CY 2016 was 3.9%.



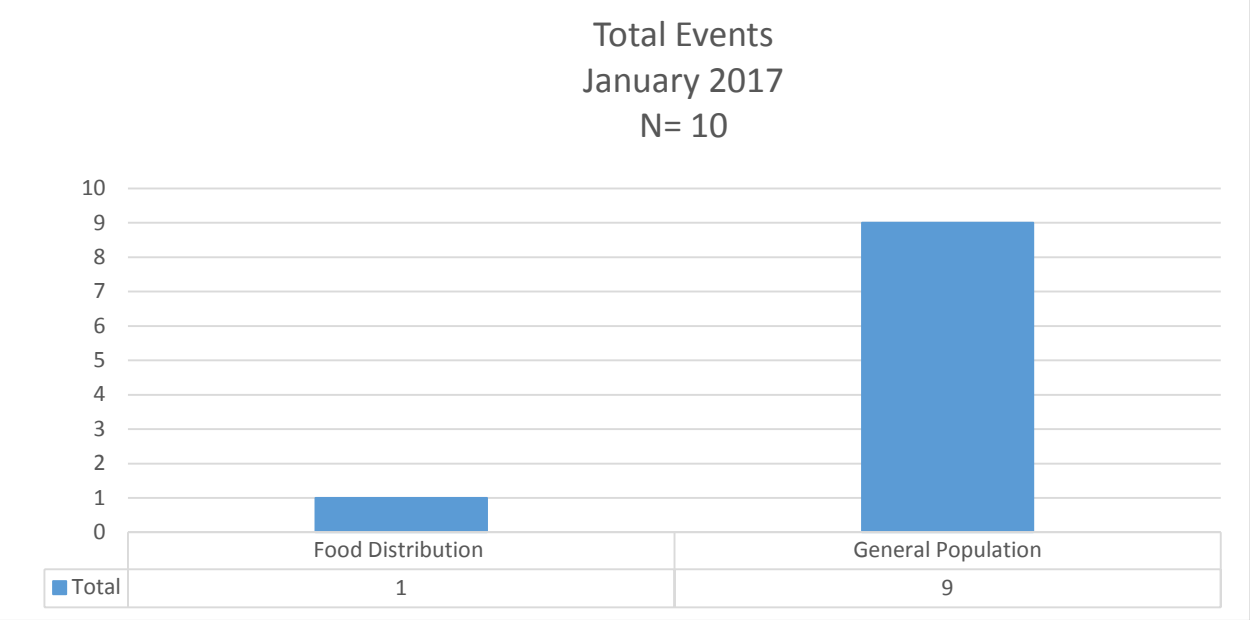
COMMUNITY OUTREACH SUMMARY REPORT – JANUARY 2017

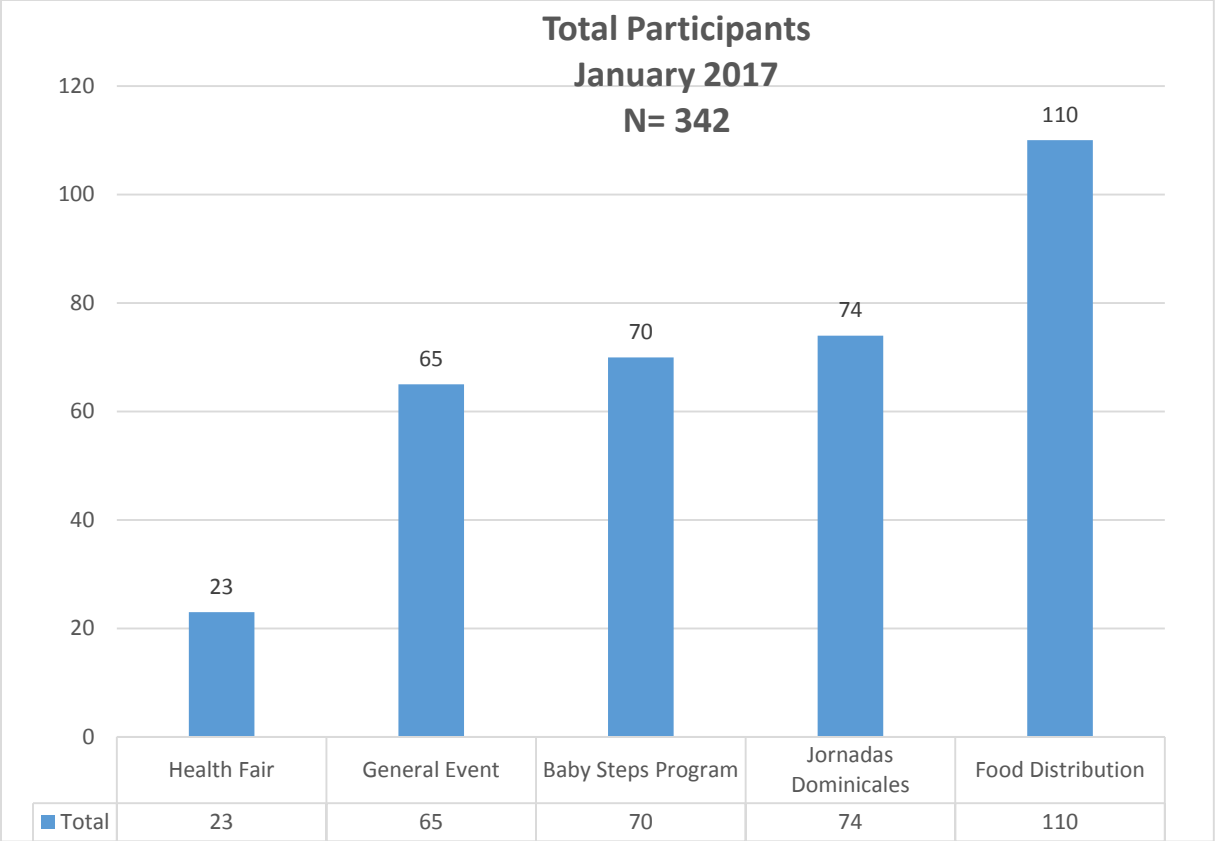
Summary

Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. The health education and outreach team maintains a positive presence in the community by working with various county public health departments, community based organizations, schools, senior centers, faith-based centers and social service agencies.

Outreach Activities

Below are the charts that highlight the total number of events and participants for the month of January.





Outreach Events

Below is a summary of activities during the month of January.

Date	Event
1/6/2017	Sharing the Harvest hosted by Santa Clara Valley Neighborhood for Family Learning, Santa Paula
1/10/2017	Baby Steps Program hosted by Ventura County Medical Center, Ventura
1/17/2017	Baby Steps Program hosted by Santa Paula Hospital
1/18/2017	Westpark Community Center Monthly Food Distribution Program & Health Services, Ventura
1/22/2017	Jornada Dominical and Health Fair hosted by Consulate of Mexico in Oxnard
1/25/2017	Agency 101 hosted by Ventura County Children's System of Care, Camarillo
1/26/2017	Community Market Produce Giveaway hosted by Moorpark Neighborhood for Family Learning
1/26/2017	Community Market Produce Giveaway hosted by Simi Valley Neighborhood for Family Learning
1/26/2017	GCHP Healthy Living and Cervical Health Awareness Month, Our Lady of Guadalupe Parish, Oxnard
1/28/2017	GCHP Cervical Health Awareness Month, Oxnard Public Library

For information about community outreach events and/or health education classes, please refer to the GCHP website community calendar. Events are listed in English and Spanish.

Cervical Health Awareness Month

January was Cervical Health Awareness Month. Approximately 12,000 women in the United States are diagnosed with cervical cancer (CDC Website 2017). Cervical cancer continues to be the second most common type of cancer among women, second only to breast cancer. Cervical cancer is one of the most treatable cancers, if found early.

In honor of National Cervical Health Awareness Month, GCHP Health Education Department hosted a community health education workshop and health fair on the prevention of cervical cancer. The health fair was held at the Oxnard Public Library on Saturday, January 28, 2017, below is the flyer in English and Spanish.

Cultural and Linguistic Services

GCHP Health Education Department coordinates interpreting and translation services for members. GCHP offers interpreting services at no cost and in over 200 languages, including sign language. GCHP monitors requests for interpreting services monthly, below are the totals for the month of January:

A) Telephonic Interpreting Services
- A total of 274 requests for telephonic interpreting services

B) Sign Language Interpreter Services
- A total of 14 requests for sign language

Sponsorships Requests

A total of $5,000 was allocated to three organizations under the sponsorship program during the month of January. Below is a summary of the programs and funding approved.

Agency/Organization	Approved Award Amount	Event/Org Summary
Oxnard Panthers Youth Football/Cheer	$2500	Non-profit youth football and cheerleading organization that promotes student-athletes to enhance their skills and positive reinforcement for low-income families in our local community.
Casa Pacifica for Children & Families	$1500	Provides hope and help for abused, neglected, or at-risk children and their families; and its vision is to lead the services sector in promoting healthy outcomes for children and families.
For The Troops	$1000	Military Tribute Gala honoring all veterans; featuring our Iraq war veterans. 10 Year Celebration.

AGENDA ITEM NO. 11

TO: Gold Coast Health Plan Commission

FROM: Scott Campbell, General Counsel

DATE: February 27, 2017

SUBJECT: Human Resources/Cultural Diversity Subcommittee Update

VERBAL PRESENTATION