



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

**Regular Meeting**

**Monday, February 22, 2016 - 3:00 PM**

**County of Ventura Government Center – Hall of Administration**

**Lower Plaza Assembly Room, 800 South Victoria Avenue, Ventura, CA 93009**

**AGENDA**

**CALL TO ORDER / ROLL CALL**

**PUBLIC COMMENT**

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

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

**CONSENT ITEMS**

**1. Minutes**

Staff: Interim Clerk of the Board

**RECOMMENDATION**

Approve minutes of regular meetings of January 25, 2016.

**2. Financials – December 2015**

Staff: Patricia Mowlavi, Chief Financial Officer

**RECOMMENDATION**

To accept the Financial Reports as presented for December of 2015.

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

## **FORMAL ITEMS**

### **3. Proposed Resolution Amending the Bylaws to Establish Commissioners' Terms of Office**

Presenter: Scott Campbell, General Counsel

#### **RECOMMENDATION**

Receive the proposed Resolution and approve the Resolution at the March 28, 2016 Commission Meeting.

### **4. Approval of Healthcare Effectiveness Data and Information Set (HEDIS) Vendor Contract**

Staff: C. Albert Reeves, M.D., Chief Medical Officer  
Kim Osajda, Quality Improvement Director

#### **RECOMMENDATION**

To accept the vendor contract as presented.

### **5. Approval of Fourth Quarter Quality Improvement Committee (QIC) Report**

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

#### **RECOMMENDATION**

To accept the QIC Report as presented.

### **6. Approval of Consultant Services for Administrative Services Only (ASO) Analysis and possible Request for Proposal (RFP)**

Staff: Ruth Watson., Chief Operations Officer

#### **RECOMMENDATION**

Approval of Consultant Services for ASO as presented.

### **7. 711 East Daily Drive Community Room Construction Contract**

Staff: Ruth Watson., Chief Operations Officer

#### **RECOMMENDATION**

To approve the construction contract as presented.

## **CLOSED SESSION**

### **8. Discussion Involving Trade Secrets**

Pursuant to Government Code Section 54956.87

Discussion will Concern: Rates of payment for health care services provided by pharmacy benefits providers.

Estimated Date for Public Disclosure of Decision on Rates and Award of Contract: February 2016.

## **RECONVENE TO REGULAR MEETING**

### **9. Pharmacy Benefits Manager (PBM) Request for Proposal (RFP) Finalist Selection**

Staff: C. Albert Reeves, M.D., Chief Medical Officer  
Anne Freese, Director of Pharmacy

#### **RECOMMENDATION**

To approve selection of PBM vendor and authorize contract for PBM Services..

## **REPORTS**

### **10. Chief Executive Officer (CEO) Update**

#### **RECOMMENDATION**

To accept the CEO Report as presented.

### **11. Compliance Update**

Staff: Brandy Armenta, Director of Compliance

#### **RECOMMENDATION**

To accept the Compliance Update as presented.

### **12. Chief Medical Officer (CMO) Update**

There is no reportable action for the CMO Update

### **13. Health Services Update**

#### RECOMMENDATION

To accept the Health Services Report as presented.

### **14. Community Outreach Summary Report**

#### RECOMMENDATION

To accept the Outreach Report as presented.

### **15. Chief Financial Officer (CFO) Update**

#### RECOMMENDATION

To accept the CFO Report as presented.

### **16. Chief Operations Officer (COO) Update**

#### RECOMMENDATION

To accept the COO Report as presented.

### **17. Chief Information and Strategy Officer (CISO) Update**

#### RECOMMENDATION

To accept the CISO Report as presented.

### **18. Human Resources Cultural Diversity Sub-Committee Update**

#### RECOMMENDATION

To accept the update as presented by General Counsel.

### **CLOSED SESSION**

### **19. CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION**

Paragraph (1) of subdivision (d) of Section 54956.9

Clinicas Del Camino Real Inc. v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan, Ventura County Superior Court Case No. 56-2014-00456149-CU-BC-VTA

## **20. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION**

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

One Case

### **COMMENTS FROM COMMISSIONERS**

### **ADJOURNMENT**

Unless otherwise determined by the Commission, the next regular meeting will be held on March 28, 2016 in the County of Ventura Government Center, Hall of Administration – Lower Plaza Assembly Room, 800 South Victoria Avenue, Ventura, CA 93009.

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) 437-5512. Notification for accommodation must be made by Friday, February 19, 2016 by 3 p.m. will enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

This agenda was posted on Friday, February 19, 2016 at 3 p.m. at the Gold Coast Health Plan Notice Board, and on the internet.



**AGENDA ITEM NO. 1**

To: Gold Coast Health Plan Commission

From: Magdalen Gutierrez-Roberts, Exec. Assistant to Ruth Watson / Interim Clerk

Date: February 22, 2016

Re: Approval of Minutes

**RECOMMENDATION:**

Staff requests that the Commission approve the regular meeting minutes of January 25, 2016.

**ATTACHMENTS:**

Regular Meeting Minutes: January 25, 2016

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

**Antonio Alatorre  
Lanyard Dial, M.D.  
Supervisor Peter Foy  
Michelle Laba, M.D.  
Gagan Pawar, M.D.**

**Shawn Atin  
Barry Fisher  
David Glycer  
Darren Lee  
Dee Pupa**

Dale Villani  
Patricia Mowlavi  
C. Albert Reeves, M.D.  
Scrymgeour

Ruth Watson  
Scott Campbell  
Melissa

**January 25, 2016**

The Commission met in regular session in the Multi-Purpose Room at the County of Ventura Government Center – Hall of Administration 800 South Victoria Avenue, Ventura, California. The meeting was called to order by Commissioner Alatorre at 3:00 p.m.

**ROLL CALL**

Present: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

Absent: Supervisor Peter Foy, David Glycer and Gagan Pawar, M.D.

Commissioner Alatorre presided.

**PLEDGE OF ALLEGIANCE**

Commissioner Alatorre led the Pledge of Allegiance.

**CONSENT ITEMS**

**1. Minutes**

**RECOMMENDATION**

Approve minutes of regular meetings of September 26, 2015, November 16, 2015 and Special meeting of October 13, 2015.

Commissioner Fischer moved to approve the recommendation. Commissioner Pupa seconded. The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Supervisor Peter Foy, David Glyer and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

## **2. Financials – October and November 2015**

### RECOMMENDATION

To accept the Financial Reports as presented for October and November of 2015.

### DISCUSSION

Commissioner Fisher moved to approve the recommendation. Commissioner Pupa seconded. The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Supervisor Peter Foy, David Glyer and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

## **3. Internal Audit Plan**

### RECOMMENDATION

To accept the Audit Plan as presented.

### DISCUSSION

The audit plan was reviewed and the Commission did not have questions.

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

The vote was as follows:



AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Supervisor Peter Foy, David Glycer and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

#### **4. Financial Audit Contract for Fiscal Year 2015 -2016**

##### **RECOMMENDATION**

To accept the appointment of Moss Adams as presented.

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

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Supervisor Peter Foy, David Glycer and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

##### **FORMAL ACTION ITEMS**

Counsel Scott Campbell requested that both formal action items No. 5 and No. 9 be reviewed and discussed at this time.

#### **5. Election of Chair and Vice Chair**

#### **9. Appointment of Executive Finance Commissioners**

Counsel Scott Campbell stated that upon reviewing the terms of Commission service, four terms were to end in March of 2016 as well as some terms for the Executive Finance Commissioners. His recommendation was to extend the terms of the Chair and Vice Chair in until the Commission seats expiring in March of 2016 have been filled in order to assure that the elected officers can serve their full terms. Counsel will present an amendment to the bylaws in order to sync Commission terms with the election of Commission officer.

Commissioner Fisher moved to approve the recommendation. Commissioner Lee seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Michelle Laba, M.D., Darren Lee, and Dee Pupa.

NOES: None.

ABSENT: Supervisor Peter Foy, David Glycer and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

## **6. Tangible Net Equity (TNE) and Working Capital Reserve Fund Policy**

Commissioner Pawar arrived at 3:11 p.m.

Commissioner Foy arrived at 3:19 p.m.

CFO Mowlavi presented the Tangible Net Equity and Working Capital Reserve Fund Policy for review and approval. This policy supports the long-term financial stability of Gold Coast Health Plan.

TNE is similar to retained earnings, fund balance or net position. TNE is calculated subtracting liabilities from assets.

The state of California requires a minimum TNE. The policy goes into detail regarding the specific calculations.

The three key elements of the policy include:

1. Establishing a minimum TNE maintenance target goal
2. Establishing and maintaining liquid reserve funds.
3. Establishing a payment protocol for delays in receipt of State Capitation Revenue.

Staff is proposing a TNE target of 500%. This is based on input from the state, consideration of economic cycles, the Plan's maturity, financial commitments, financial longevity and future business needs as well as a review of other County Organized Health Systems (COHS) TNE position.

GCHP, at \$123M, has the 2<sup>nd</sup> lowest TNE compared to other COHS (see chart). As of November, TNE is at 541% or \$9 million in excess of the 500% target.

The Plan is currently exploring various options including alternative payment strategies, such as value based payments and other opportunities in support of GCHP's mission

The Working Capital Reserve Fund supports financial stability by maintaining reserve funds to cover 3 months of medical and administrative expenses and funds for

Commission approved capital projects and other long term liabilities whose payments are projected for the current operating cycle. In the past there have been delay of payments. Commissioner Fisher asked what is longest delay, CFO Mowlavi responded that she was aware of a 3 month delay prior to the Brown administration.

Should there be delays in state capitated revenue and if the Plan's unrestricted cash proves to be inadequate to pay health care providers and vendors, liquid reserve funds will be used for two months or until the liquid reserve funds reach a level equaled to one month's projected working capital requirement. When the level of liquid reserve funds falls to one month's projected working capital requirement, management may cease payments to health care providers and vendors until such time as the State restores capitation revenue to the Plan.

Commissioner Lee questioned whether the 500% of minimum required TNE was appropriate and recommended a threshold range between 400% – 500%. Discussions continued around appropriate range. Commissioner Lee motioned to approve TNE and Working Capital Reserve Fund with TNE Target between 400% and 500% of state minimum requirement. Commissioner Fisher seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., and Dee Pupa.

NOES: None.

ABSENT: David Glycer

Commissioner Alatorre declared the motion carried.

## **7. Furniture for Office Expansion**

Ruth Watson, Chief Operations Officer stated that due to a growth in staff, the current building is out of space. There are still pending positions that have not been filled because there is nowhere to house them at present.

The pre-bid is at a government rate with three vendors approved. GCHP is requesting permission to do one source bid at a cost of \$400,000 which includes contingency. Commissioner Lee asked if the government rate is less, Ms. Watson stated that the rate is supposed to be less. Commissioner Foy stated that in one of his prior experiences the government rate was not used because it was very expensive. He asked why not go back to the other vendor. COO Watson stated the other bidder had opted out of bidding. Commissioner Foy asked what was pricing before and Ms. Watson stated lower prices but cubicles are different. Commissioner Foy asked what is government approved, Ms. Watson stated there is a different tier for government pricing, the theory is that government pricing is better and she also stated that if we delay, we put off construction. Commissioner Foy is concerned about cost. Ms. Watson stated that we are currently paying rent for space not being used. Commissioner Atin asked if the

furniture chosen was appropriate with the mission of the organization. Ms. Watson stated she wanted good ergonomics as well as furniture to last ten year. Currently the plan is to try and stay under \$400,000. The furniture at the 711 Daily building was inherited for \$1.00 on the first and second floor. Commissioner Lee stated he understood it is hard to get competitive bids.

Commissioner Lee moved to approve the request. Commissioner Dial seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D. and Dee Pupa.

NOES: None.

ABSENT: David Glycer.

Commissioner Alatorre declared the motion carried.

#### **8. State of California Contract Amendment No. A03 to Agreement No. 10-87129**

CEO Villani informed the Commission that the State has issued an amendment for abortion services at no additional impact. CEO Villani is requesting permission to sign the amendment to contract for payment of services for the Hyde Act.

Commissioner Lee moved to approve the request. Commissioner Dial seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D. and Dee Pupa.

NOES: None.

ABSTAIN: Peter Foy.

ABSENT: David Glycer.

Commissioner Alatorre declared the motion carried.

#### **10. Appointment of Commissioners to Screen Candidate for the Chief Diversity Officer**

The Commission has previously decided that a sub-committee of five people, including three Commissioners, will be selected to screen candidates for the Chief Diversity Officer position. Counsel to the Commission asked if there were three Commissioners

who would be interested in participating on the interview panel. Commissioners Atin, Lee and Alatorre volunteered. Dr. Jaime Casillas and Aaron Hinojosa will also participate. The HRCD Committee will narrow down candidates and then present to the Commission.

Commissioner Lee moved to approve the three volunteers. Commissioner Fisher seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D. and Dee Pupa.

NOES: None.

ABSENT: David Glycer.

## **REPORTS**

### **11. Chief Executive Officer Update**

Traci McGinley has resigned from her position and GCHP is now actively recruiting for a new Clerk of the Commission. Maddie Gutierrez-Roberts is currently working as interim Clerk of the Commission until the position is filled. Currently there is only one potential candidate. The Commissioners declined to participate in the process for selection of a new Clerk to the Commission. Ralph Oyaga has been hired as Executive Director of Government Relations.

Procurements for the Pharmacy Benefits Manager (PBM) and Healthcare Effectiveness Data and Information Set (HEDIS) vendors are coming to a close. The final recommendation for Executive Finance Committee will be presented to the Commission on February 22, 2016.

The Plan is currently conducting an employee survey, which consists of approximately 70 questions which include items focused on diversity. Focus groups are being evaluated and an action plan is being developed. Commissioner Foy stated he was very excited on the direction the organization is going.

Per Diem nurses – managed behavioral health cap was lifted. ASO Vendor claimed audits need Cap – so it was issued.

CEO Villani introduced Marlen Torres, Government and External Relations Manager, who gave a brief informational presentation.

- Ms. Torres highlighted that on Thursday, January 7<sup>th</sup>, Governor Brown released his proposed FY 2016-17 budget.
- The Governor's budget includes \$85.1B for the Medi-Cal program, and projects.

- Caseload-It is projected that 13.5M individuals will be enrolled in Medi-Cal by the end of the fiscal year.
- The MCO Tax budget proposes a tax reform package to extend a federally permissible managed care organization (MCO) tax. The MCO tax would be implemented for 3 years (starting in 2016). In order to implement an MCO tax a two-thirds vote in the Legislature is needed. Our trade organizations have been actively involved in discussions with the administration. Overall, it is not expected that the MCO tax will negatively impact GCHP.
- The Full-Scope Medi-Cal for Undocumented Children budget includes \$182M to provide full-scope coverage to approximately 170,000 children, under 19 years of age, starting May 1, 2016.
- Starting in 2017, the State will start assuming a 5% share of the Medi-Cal expansion population costs. The budget assumes 740M in GF cost.
- The “Medi-Cal” 2020 waiver was approved by CMS for five (5) years. Starting January 1, 2016-December 31, 2020. Total funding for the waiver is \$6.2B with a potential for additional funding in the Global Payment Program. The waiver includes the following elements:
  - Delivery system transformation and alignment incentive program for designated public hospitals and district/municipal hospitals (PRIME)
  - A Global Payment Program for designated public hospitals for services for the remaining uninsured
  - Whole Person Care Pilot Program
  - Dental Transformation Incentive Program
  - Two assessments will be conducted throughout the course of the waiver. The first is related to public hospitals. The second assessment is regarding access care for beneficiaries in Medi-Cal managed care.

CEO Villani stated Dr. Wharfield, Associate Chief Medical Officer is working with Johnson Gil on the Whole Person Care Pilot. Commissioner Alatorre asked about outreach to undocumented children. This outreach is now going on. The term undocumented has been replaced with a new term which is “Unsatisfied Documentation” status. COO Watson stated the outreach has only been done by the State not GCHP as yet.

## **12. Chief Medical Officer (CMO) Update**

Dr. Reeves stated GCHP had a booth and was a sponsor of the Senior Summit. GCHP was recognized by the Board of Supervisors with a certificate. A successful diabetes health fair was held at the Oxnard Public Library where Dr. Wharfield was a speaker. The New Diabetes Management Program was also introduced.

### **13. Health Services Update**

Year-to-date performance was reviewed and projections are increasing. There is a huge population of undetected Diabetes. Education materials and classes are offered. There has been a study showing Hispanics are twice more likely to have diabetes – the County has dashboards for comparison. Complication rates were reviewed. CEO Villani stated it is the beginning of analyzing data and creating intervention strategies to target these issues.

### **14. Chief Financial Officer (CFO) Update**

CFO Mowlavi provided status on the ACA 1202 Program is just concluding. Currently, about \$8 million remains in the program. Fiscal year to date financial highlights for the five months ending November 30, 2015 showed a \$22.8 million gain in unrestricted net assets which was driven by higher than expected growth in membership in the Adult Expansion (AE) category of aid and lower than anticipated health care and administrative costs. The Medical Loss Ratio (MLR) is targeted to be between 85 to 91 percent of revenue. Through November the MLR was 86 percent of revenue and has been increasing over the fiscal year with the month of November at 91 percent of revenue. The Administrative Cost ratio (ACR) is targeted to be between 5 and 8 percent of revenue. Through November, the ACR was at 6 percent which was favorable to the budget. This favorable variance was driven primarily by labor related savings. Tangible Net Equity (TNE) is targeted to be 500 percent of the minimum State requirement. As of November, TNE was \$123 million or 541 percent, excluding the \$7.2 million County of Ventura lines of credit.

### **15. Chief Operations Officer (COO) Update**

There is a large decrease, the first in 2 years, this indicates a 70% increase in members, but watching closely. Commissioner Foy asked if not like L.A. COO Watson stated LA Care has a different system – Challenges: has issue qualifying eligibility - members not allowed to terminate. Commissioner Foy asked when will we know, COO Watson responded end of January; expansion / membership has been added. Data needs to be reviewed.

Encounter Data Performance – GCHP is Number 1 in State; data submitted on time. The State will have an impact on the rate. GCHP got 100% in State between staff and County providers. The Call Center performance has been impacted – there are long wait times. We are currently in procurement for a consultant to evaluate the Plan's ASO model. COO Watson will present a recommendation at next Commission meeting. Commissioner Atin asked about numbers. COO Watson stated the Call Center has a large turnover. Commissioner Atin asked how many employees to answer calls, COO Watson stated approximately 24 only answer calls for GCHP. Question is: Do we

continue to outsource Call Center or do in-house? Need consultant to review strategy. Commissioner Foy stated it could be expensive; maybe look at a different call group.

## **16. Chief Information and Strategy Officer (CISO) Update**

The project portfolio consists of 42 initiatives. Since the November Commission meeting, the Plan has completed five projects.

Project Portfolio supports the approved strategic plan and reflects roughly 39k resource hours.

## **17. Human Resources Cultural Diversity Sub-Committee Update**

The job description has been finalized and posted and will now go forward with candidates. Employee Survey has 17 questions specifically related to Cultural Diversity. In addition, there will be 14 sessions for employee training. The employee hotline has been established and in the past 3 months there have been no calls or reports.

Commissioner Dial moved to approve all updates. Commissioner Fisher seconded.

The vote was as follows:

AYES: Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Barry Fisher, Peter Foy, David Glycer, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D. and Dee Pupa.

NOES: None.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

## **RECESS:**

The meeting was recessed at 4:47 p.m.

## **CLOSED SESSION**

Closed Session reconvened at 5:07

- a. Conference with Legal Counsel – Existing Litigation
- b. Conference with Legal Counsel – Anticipated Litigation

There was no reportable action.

## **ADJOURNMENT**

Closed Session was adjourned at 6:17p.m.

Minutes submitted by:  
Magdalen Gutierrez-Roberts, Interim Clerk of the Board





## **AGENDA ITEM NO. 2**

To: Gold Coast Health Plan Commission

From: Patricia Mowlavi, CFO

Date: February 22, 2016

Re: December 2015 Financials

### **SUMMARY:**

Staff is presenting the attached fiscal year to date (FYTD) December 2015 financial statements (unaudited) of Gold Coast Health Plan (Plan) for the Commission to accept and file. These financials were reviewed by the Executive / Finance Committee on February 11, 2016, where the Executive / Finance Committee recommended that the Commission accept and file these financials.

### **BACKGROUND / DISCUSSION:**

The staff has prepared the FYTD December 2015 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 months ending December 31, 2015, the Plan's gain in unrestricted net assets was approximately \$24.3 million on revenues of \$322.7 million which compares favorably to the budget of \$315.7 million. The \$17.0 million favorable variance was largely due to the continued growth in membership in the Adult Expansion (AE) category of aid. Also contributing to the variance was lower than anticipated health care and administrative costs.

Tangible Net Equity – The Plan's operating performance has increased the Tangible Net Equity (TNE) amount to approximately \$131.4 million, which is \$44.2 million better than budget. The Plan's TNE (excluding the \$7.2 million County of Ventura lines of credit) is at 550% of the State required TNE amount. The sharp rise in the TNE has been assisted, in part, by an increase in capitated arrangements which are excluded from the required TNE calculation.

Membership – December membership of 203,857 exceeded budget by 7,822 members. The increase in membership was primarily in the Adult Expansion (AE) category, which accounts for 62% of the total growth year over year.

Revenue – FYTD, net revenue was \$322.7 million or \$7.0 million favorable to budget. The positive variance was primarily due to increase in membership with higher capitation rates (Adult Expansion).

For the year, revenue includes a \$16.9 million reserve for rate reductions associated with AE. This reserve represents an expected refund, to Department of Health Care Services (DHCS), for rate overpayments (DHCS was paying at July 1, 2014 rates rather than the July 1, 2015 published rates) and the anticipated refund of revenue to achieve a medical loss ratio (MLR) of 85%, for this aid category. (The MLR is calculated by dividing health care costs by revenue.).

Health Care Costs – FYTD health care costs were \$280.6 million or \$7.4 million lower than budget. Health care costs continue to increase with December's MLR at 91.3% compared to 90.8% for November. – the month over month increase was driven by increased long term care, outpatient and pharmacy expenses. For the year, the MLR is 86.9% versus budget of 91.2%.

Some health care cost items of note include:

- Capitation – FYTD, capitation was \$48.4 million or \$11.7 million unfavorable to budget. The unfavorable variance was driven by the Enhanced Adult Expansion Capitation program, which was revised effective July 2015, as well as higher than budgeted capitated membership growth.
- Fee for Service – FYTD, total claims expense was \$223.8 million compared to a budget of \$239.2 million. While there was some movement of services between categories, the overall variance is driven by lower than expected Inpatient and Specialty Physician costs.
- Pharmacy – FYTD, overall Pharmacy expense was \$46.3 million or \$818,000 unfavorable to budget.
- Physician ACA 1202 – An ACA 1202 payment of \$524,000 was made in December.

Administrative Expenses – FYTD, administrative costs were \$17.9 million or \$2.6 million lower than budget. Savings were realized due to delays in new hires and related costs associated with personnel. These savings were somewhat offset by higher expenses in outside services, which are primarily driven by membership.

The administrative cost ratio (ACR) for FYTD is 5.5% versus 6.5% for budget. (The ACR is calculated by dividing administrative expenses by total revenue.)

Cash and Medi-Cal Receivable – At December 31, 2015, the Plan had \$408.2 million in cash and short term investments and \$62.1 million in Medi-Cal Receivable for an aggregate amount of \$470.3 million. The cash amount also included pass-through payments for AB 85 of \$1.8 million and Managed Care Organizations (MCO) tax of \$3.8 million. Excluding the impact of these amounts, the cash amount would be \$402.6 million. Note that a significant portion of the cash will be used for repayments of amounts owed to the State of California (\$235.0 million) and the County of Ventura (\$7.2 million).

Investment Portfolio – As of December 31, 2015, the value of the investments were as follows:

- Short-term Investments \$220.3 million: Cal Trust \$80.2 million; Ventura County Investment Pool \$80.1 million; LAIF CA State \$50.0 million; Bonds \$10.0 million.
- Long-term Investments (Bonds) \$19.5 million.

Short term investments in commercial paper matured in December and the redemption value of \$45.0 million is being held in a money market account to cover the recoupment of the AE overpayments scheduled by the State.

**RECOMMENDATION:**

Staff requests that the Commission accept and file the December 2015 financial statements.

**CONCURRENCE:**

February 11, 2016 Executive / Finance Committee

**ATTACHMENTS:**

December 2015 Financial Package



**FINANCIAL PACKAGE**

For the month ended December 31, 2015

**TABLE OF CONTENTS**

Financial Overview

Financial Performance Dashboard

**APPENDIX**

Statement of Financial Positions

YTD Statement of Revenues, Expenses and Changes in Net Assets

Statement of Revenues, Expenses and Changes in Net Assets

Statement of Financial Positions

YTD Cash Flow

Monthly Cash Flow

Cash Trend Combined

Membership

Total Expense Composition

Paid Claims and IBNP Composition

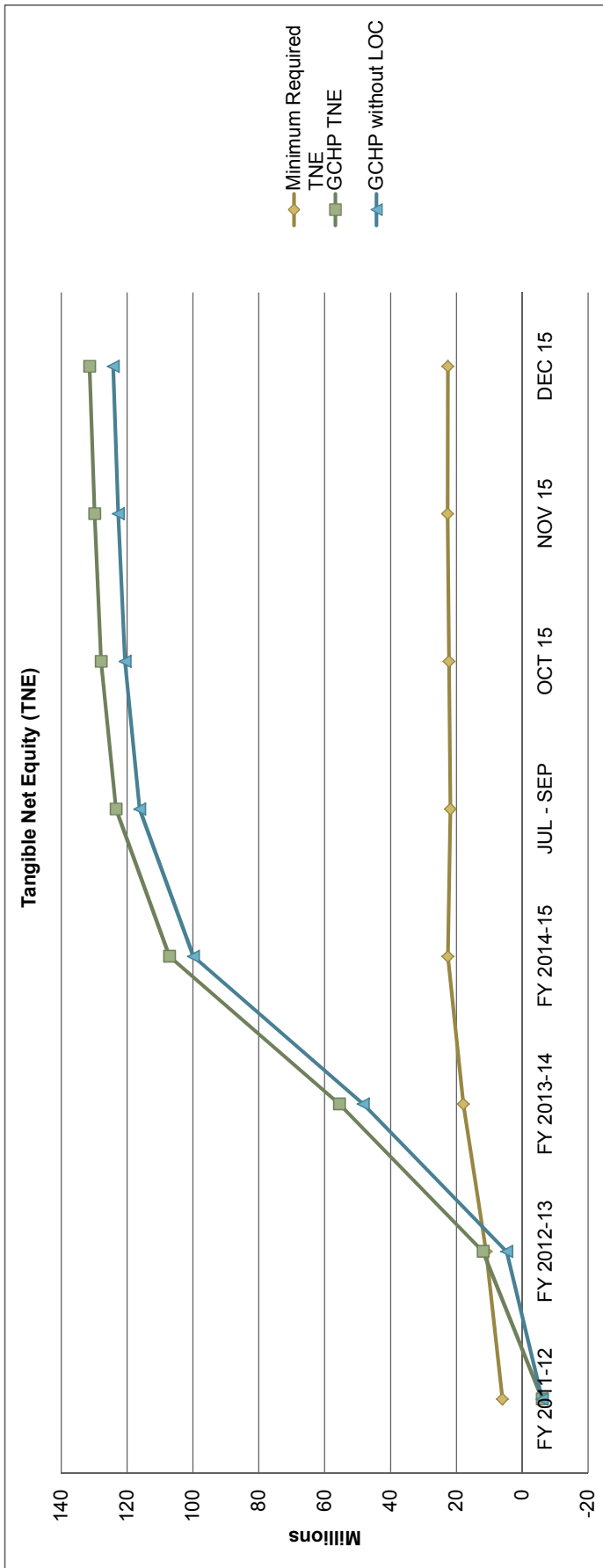
Pharmacy Cost & Utilization Trends

**GOLD COAST HEALTH PLAN  
FINANCIAL RESULTS SUMMARY**

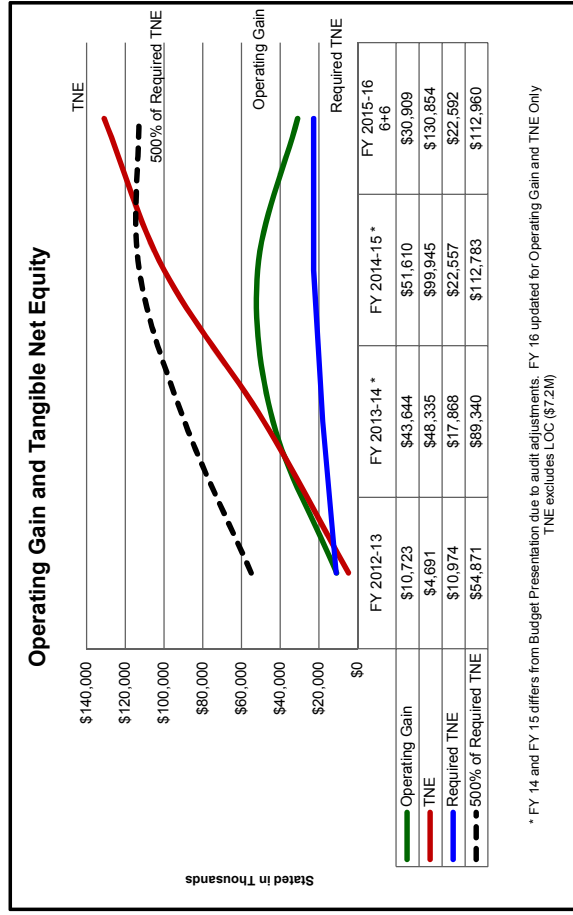
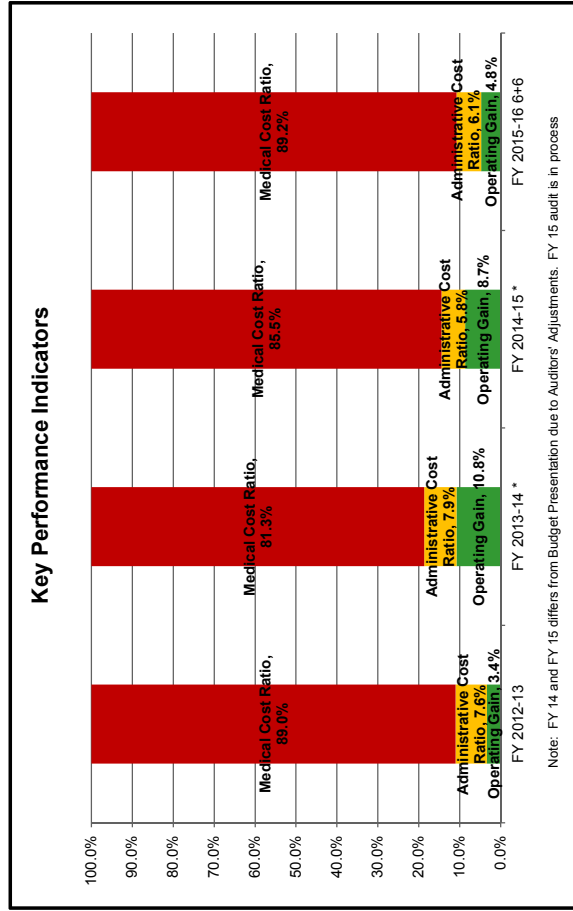
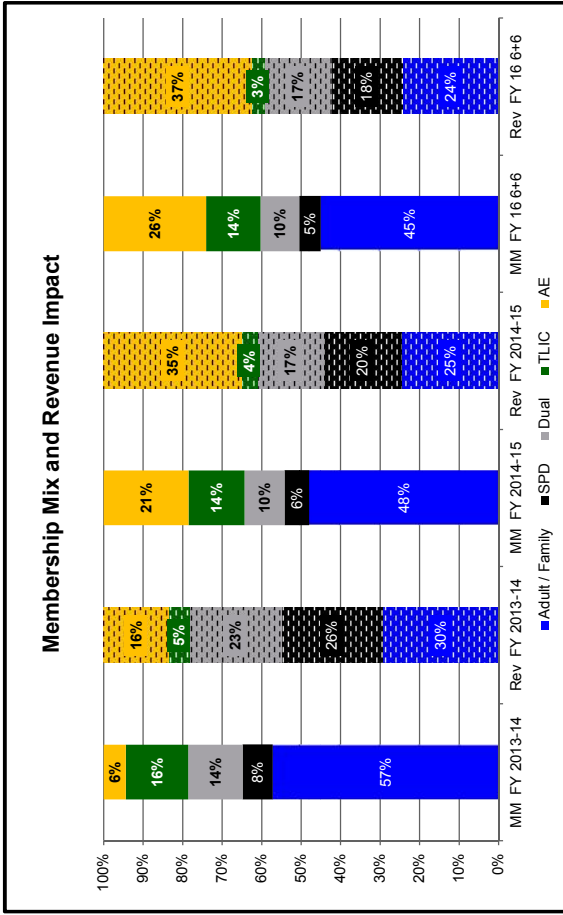
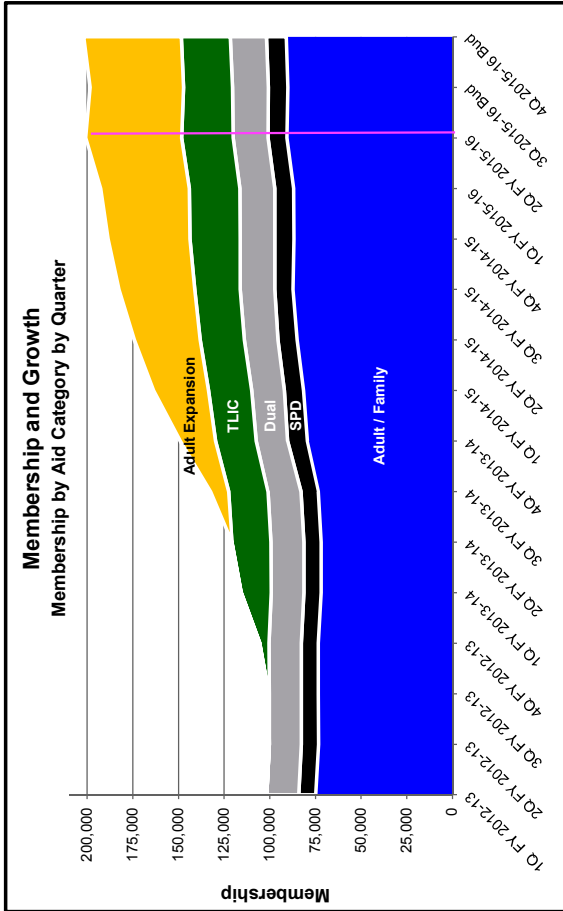
Description	FY 2015-16										Budget Comparison			
	AUDITED	AUDITED	AUDITED	AUDITED	AUDITED	JUL - SEP	OCT 15	NOV 15	DEC 15	DEC 15	DEC 15	Budget FYTD	Variance Fav / (Unfav)	Variance Fav / (Unfav)%
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2014-15					FYTD	FYTD			
<b>Member Months</b>	1,258,189	1,223,895	1,553,660	2,130,979	2,130,979	578,056	198,148	200,385	203,857	1,180,446	1,180,446	1,159,563	20,883	1.8 %
<b>Revenue</b>	304,635,932	315,119,611	402,701,476	595,607,370	595,607,370	162,960,677	52,508,015	53,274,568	53,961,656	322,704,916	322,704,916	315,695,908	7,009,008	2.2 %
<i>pppm</i>	242.12	257.47	259.20	279.50	279.50	281.91	264.99	265.86	264.70	273.38	273.38	272.25	1.12	0.4 %
<b>Health Care Costs</b>	287,353,672	280,382,704	327,305,832	509,183,268	509,183,268	137,845,237	45,086,757	48,350,456	49,274,672	280,557,122	280,557,122	287,977,651	7,420,530	2.6 %
<i>pppm</i>	228.39	229.09	210.67	238.94	238.94	238.46	227.54	241.29	241.71	237.67	237.67	248.35	10.68	4.3 %
% of Revenue	94.3%	89.0%	81.3%	85.5%	85.5%	84.6%	85.9%	90.8%	91.3%	86.9%	86.9%	91.2%	4.3 %	4.7 %
<b>Admin Exp</b>	18,891,320	24,013,927	31,751,533	34,814,049	34,814,049	8,827,059	2,951,994	2,901,309	3,182,244	17,862,605	17,862,605	20,428,652	2,566,047	12.6 %
<i>pppm</i>	15.01	19.62	20.44	16.34	16.34	15.27	14.90	14.48	15.61	15.13	15.13	17.62	2.49	14.1 %
% of Revenue	6.2%	7.6%	7.9%	5.8%	5.8%	5.4%	5.6%	5.4%	5.9%	5.5%	5.5%	6.5%	0.9 %	14.5 %
<b>Total Increase / (Decrease) in Unrestricted Net Assets</b>	(1,609,063)	10,722,980	43,644,110	51,610,053	51,610,053	16,288,381	4,469,265	2,022,803	1,504,740	24,285,190	24,285,190	7,289,605	16,995,585	233.1 %
<i>pppm</i>	(1.28)	8.76	28.09	24.22	24.22	28.18	22.56	10.09	7.38	20.57	20.57	6.29	14.29	227.3 %
% of Revenue	-0.5%	3.4%	10.8%	8.7%	8.7%	10.0%	8.5%	3.8%	2.8%	7.5%	7.5%	2.3%	5.2%	225.9 %
<b>YTD</b>	16,769,368	16,138,440	17,867,986	22,556,530	22,556,530	21,819,072	22,266,192	22,698,761	22,591,994	22,591,994	22,591,994	24,578,958	(1,986,964)	(8.1)%
% 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	22,556,530	21,819,072	22,266,192	22,698,761	22,591,994	22,591,994	22,591,994	24,578,958	(1,986,964)	(8.1)%
<b>GCHP TNE</b>	(6,031,881)	11,891,099	55,535,211	107,145,264	107,145,264	123,433,646	127,902,910	129,925,714	131,430,454	131,430,454	131,430,454	87,269,057	44,161,396	50.6 %
TNE Excess / (Deficiency)	(12,068,853)	916,960	37,667,225	84,588,734	84,588,734	101,614,573	105,636,718	107,226,953	108,838,460	108,838,460	108,838,460	62,690,100	46,148,360	73.6 %
% of Required TNE level		311%	271%	475%	475%	566%	574%	572%	582%	582%	582%	355%		
% of Required TNE level (excluding \$7.2 million LOC)				443%	443%	533%	542%	541%	550%	550%	550%	326%		

Note: TNE amount includes \$7.2 million related to the Lines of Credit (LOC) from Ventura County.

GOLD COAST HEALTH PLAN  
TANGIBLE NET EQUITY (TNE) CHART



**FINANCIAL PERFORMANCE DASHBOARD  
FOR MONTH ENDING DECEMBER 31, 2015**



\* 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)

Note: 6+6 indicates 6 months of actual results followed by 6 months of forecasts



For the month ended December 31, 2015

**APPENDIX**

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



**STATEMENT OF FINANCIAL POSITION**

	12/31/15	11/30/15	10/31/15	Audited FY 2014 - 15
<b>ASSETS</b>				
<b>Current Assets:</b>				
<b>Total Cash and Cash Equivalents</b>	\$ 187,837,453	\$ 142,007,241	\$ 113,497,885	\$ 57,218,141
<b>Total Short-Term Investments</b>	<b>220,367,591</b>	<b>260,280,302</b>	<b>260,218,693</b>	<b>165,090,357</b>
Medi-Cal Receivable	62,093,422	61,369,356	62,291,090	129,782,958
Interest Receivable	360,157	441,372	358,970	208,010
Provider Receivable	376,294	932,608	618,992	579,482
Other Receivables	174,887	172,025	172,044	979,647
<b>Total Accounts Receivable</b>	<b>63,004,760</b>	<b>62,915,360</b>	<b>63,441,096</b>	<b>131,550,096</b>
Total Prepaid Accounts	1,538,044	1,540,371	1,338,926	766,831
Total Other Current Assets	133,545	133,545	81,702	81,702
<b>Total Current Assets</b>	<b>472,881,394</b>	<b>466,876,820</b>	<b>438,578,301</b>	<b>354,707,127</b>
<b>Total Fixed Assets</b>	<b>935,810</b>	<b>956,135</b>	<b>981,894</b>	<b>1,084,113</b>
<b>Total Long-Term Investments</b>	<b>19,481,959</b>	<b>24,531,226</b>	<b>24,554,488</b>	<b>24,647,362</b>
<b>Total Assets</b>	<b>\$ 493,299,163</b>	<b>\$ 492,364,181</b>	<b>\$ 464,114,682</b>	<b>\$ 380,438,602</b>
<b>LIABILITIES &amp; NET ASSETS</b>				
<b>Current Liabilities:</b>				
Incurred But Not Reported	\$ 58,777,984	\$ 60,459,311	\$ 55,476,902	\$ 52,372,146
Claims Payable	9,502,532	11,683,971	11,320,074	13,747,426
Capitation Payable	27,603,356	29,096,440	28,417,041	34,466,106
Physician ACA 1202 Payable	10,076,883	10,600,928	10,600,928	10,965,642
AB 85 Payable	1,835,505	1,779,287	3,275,907	3,818,147
Accounts Payable	411,484	2,507,055	565,247	3,449,087
Accrued ACS	3,231,286	1,604,232	1,593,827	1,480,556
Accrued Expenses	113,717,565	106,251,563	10,094,486	6,249,194
Accrued Premium Tax	3,821,943	4,122,354	4,742,315	3,641,573
Accrued Interest Payable	94,545	90,109	84,179	70,711
Current Portion of Deferred Revenue	230,000	268,333	306,667	460,000
Accrued Payroll Expense	630,605	978,546	960,437	1,152,720
<b>Total Current Liabilities</b>	<b>229,933,687</b>	<b>229,442,130</b>	<b>127,438,011</b>	<b>131,873,310</b>
<b>Long-Term Liabilities:</b>				
DHCS - Reserve for Capitation Recoup	131,284,946	132,379,703	208,190,569	140,970,602
Other Long-term Liability-Deferred Rent	650,076	616,634	583,193	449,427
Notes Payable	7,200,000	7,200,000	7,200,000	7,200,000
<b>Total Long-Term Liabilities</b>	<b>139,135,022</b>	<b>140,196,337</b>	<b>215,973,761</b>	<b>148,620,029</b>
<b>Total Liabilities</b>	<b>369,068,709</b>	<b>369,638,467</b>	<b>343,411,772</b>	<b>280,493,338</b>
<b>Net Assets:</b>				
Beginning Net Assets	99,945,264	99,945,264	99,945,264	48,335,211
Total Increase / (Decrease in Unrestricted Net	24,285,190	22,780,450	20,757,646	51,610,053
<b>Total Net Assets</b>	<b>124,230,454</b>	<b>122,725,714</b>	<b>120,702,910</b>	<b>99,945,264</b>
<b>Total Liabilities &amp; Net Assets</b>	<b>\$ 493,299,163</b>	<b>\$ 492,364,181</b>	<b>\$ 464,114,682</b>	<b>\$ 380,438,602</b>

**FINANCIAL INDICATORS**

Current Ratio	2.06 : 1	2.03 : 1	3.44 : 1	2.69 : 1
Days Cash on Hand	233	235	233	67
Days Cash + State Capitation Rec	268	271	271	107
Days Cash + State Capitation Rec (less Tax Li	266	268	268	106

**STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS  
FOR SIX MONTHS ENDING DECEMBER 31, 2015**

	December 15 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
<b>Membership (includes retro members)</b>	1,180,446	1,159,563	20,883
<b>Revenue</b>			
Premium	\$ 352,986,936	\$ 352,630,001	\$ 356,935
Reserve for Rate Reduction	(16,915,000)	(24,233,480)	7,318,480
MCO Premium Tax	(13,898,862)	(12,930,613)	(968,249)
<b>Total Net Premium</b>	<b>322,173,075</b>	<b>315,465,908</b>	<b>6,707,167</b>
<b>Other Revenue:</b>			
Miscellaneous Income	531,841	230,000	301,841
<b>Total Other Revenue</b>	<b>531,841</b>	<b>230,000</b>	<b>301,841</b>
<b>Total Revenue</b>	<b>322,704,916</b>	<b>315,695,908</b>	<b>7,009,008</b>
<b>Medical Expenses:</b>			
<u>Capitation (PCP, Specialty, Kaiser, NEMT &amp; Vision)</u>	48,418,344	36,701,105	(11,717,239)
<u>FFS Claims Expenses:</u>			
Inpatient	51,322,238	58,755,765	7,433,527
LTC / SNF	51,342,065	54,248,518	2,906,453
Outpatient	22,268,010	18,996,278	(3,271,732)
Laboratory and Radiology	1,852,345	1,336,318	(516,027)
Emergency Room	8,325,468	7,744,112	(581,356)
Physician Specialty	20,982,144	24,908,994	3,926,850
Primary Care Physician	6,595,070	7,877,198	1,282,128
Home & Community Based Services	6,977,777	7,426,469	448,692
Applied Behavior Analysis Services	307,525	656,057	348,532
Mental Health Services	2,288,003	2,660,649	372,646
Pharmacy	46,331,092	45,513,232	(817,860)
Provider Reserve	0	3,422,366	3,422,366
Other Medical Professional	944,076	1,235,598	291,522
Other Medical Care	739	0	(739)
Other Fee For Service	3,507,382	3,589,619	82,237
Transportation	736,674	853,652	116,978
Total Claims	223,776,796	239,224,825	15,448,029
Medical & Care Management Expense	7,982,848	10,407,100	2,424,252
Reinsurance	1,050,670	1,644,621	593,951
Claims Recoveries	(671,536)	0	671,536
Sub-total	8,361,982	12,051,721	3,689,740
<b>Total Cost of Health Care</b>	<b>280,557,122</b>	<b>287,977,651</b>	<b>7,420,530</b>
<b>Contribution Margin</b>	<b>42,147,794</b>	<b>27,718,257</b>	<b>14,429,538</b>
<b>General &amp; Administrative Expenses:</b>			
Salaries and Wages	4,381,937	5,127,373	745,436
Payroll Taxes and Benefits	1,141,301	1,514,652	373,351
Travel and Training	90,497	339,329	248,832
Outside Service - ACS	9,472,748	8,968,409	(504,339)
Outside Services - Other	841,319	1,053,457	212,138
Accounting & Actuarial Services	166,738	222,000	55,263
Legal	271,273	525,000	253,727
Insurance	195,699	163,008	(32,691)
Lease Expense - Office	396,205	521,640	125,435
Consulting Services	373,250	722,884	349,634
Advertising and Promotion	48,199	31,020	(17,179)
General Office	888,762	1,367,091	478,329
Depreciation & Amortization	123,582	196,157	72,575
Printing	23,409	63,470	40,061
Shipping & Postage	39,000	67,669	28,669
Interest	177,434	128,520	(48,914)
<b>Total G &amp; A Expenses</b>	<b>18,631,355</b>	<b>21,011,679</b>	<b>2,380,324</b>
<b>Total Operating Gain / (Loss)</b>	<b>\$ 23,516,440</b>	<b>\$ 6,706,578</b>	<b>\$ 16,809,862</b>
<b>Non Operating</b>			
Revenues - Interest	792,584	600,000	192,584
Expenses - Interest	23,834	16,973	(6,861)
<b>Total Non-Operating</b>	<b>768,750</b>	<b>583,027</b>	<b>185,723</b>
<b>Total Increase / (Decrease) in Unrestricted Net Assets</b>	<b>\$ 24,285,190</b>	<b>\$ 7,289,605</b>	<b>\$ 16,995,585</b>
Net Assets, Beginning of Year	99,945,264		
Net Assets, End of Year	<u>124,230,454</u>		

**STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS**

	FY 2015-16 Monthly Trend			Current Month		
	SEP 15	OCT 15	NOV 15	DECEMBER 2015		Variance
				Actual	Budget	Fav / (Unfav)
<b>Membership (includes retro members)</b>	194,875	198,148	200,385	203,857	196,035	7,822
<b>Revenue:</b>						
Premium	\$ 61,599,815	\$ 58,478,429	\$ 59,641,624	\$ 60,609,835	\$ 60,145,833	\$ 464,002
Reserve for Rate Reduction	(1,360,000)	(4,008,000)	(4,057,000)	(4,300,000)	(4,218,049)	(81,951)
MCO Premium Tax	(2,425,493)	(2,302,588)	(2,348,389)	(2,386,513)	(2,202,157)	(184,356)
<b>Total Net Premium</b>	<b>57,814,322</b>	<b>52,167,841</b>	<b>53,236,235</b>	<b>53,923,322</b>	<b>53,725,627</b>	<b>197,695</b>
<b>Other Revenue:</b>						
Miscellaneous Income	38,333	340,175	38,333	38,333	38,334	1
<b>Total Other Revenue</b>	<b>38,333</b>	<b>340,175</b>	<b>38,333</b>	<b>38,333</b>	<b>38,334</b>	<b>1</b>
<b>Total Revenue</b>	<b>57,852,656</b>	<b>52,508,015</b>	<b>53,274,568</b>	<b>53,961,656</b>	<b>53,763,961</b>	<b>197,696</b>
<b>Medical Expenses:</b>						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	7,787,648	8,769,026	8,427,985	8,416,645	6,279,966	(2,136,679)
<b>FFS Claims Expenses:</b>						
Inpatient	8,229,483	6,591,724	9,783,188	6,939,460	10,054,336	3,114,876
LTC / SNF	7,865,679	9,041,831	8,114,443	9,457,002	9,134,556	(322,446)
Outpatient	3,102,655	3,745,058	3,888,244	4,874,113	3,237,398	(1,636,715)
Laboratory and Radiology	407,192	245,011	417,957	253,526	228,461	(25,065)
Emergency Room	1,337,763	1,377,596	1,408,873	1,384,893	1,317,400	(67,493)
Physician Specialty	3,704,106	3,323,918	3,574,803	3,527,663	4,255,032	727,369
Primary Care Physician	1,246,805	1,080,484	1,058,710	1,051,572	1,336,075	284,503
Home & Community Based Services	1,243,477	1,046,240	1,161,347	1,351,551	1,250,599	(100,952)
Applied Behavior Analysis Services	49,314	47,495	67,271	56,046	163,833	107,788
Mental Health Services	344,811	298,755	278,330	296,508	452,336	155,828
Pharmacy	7,879,357	7,939,073	7,785,843	8,641,594	7,756,982	(884,612)
<b>Provider Reserve</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>580,667</b>	<b>580,667</b>
Other Medical Professional	176,404	192,042	213,077	116,294	210,735	94,441
Other Medical Care	0	341	0	0	0	0
Other Fee For Service	570,136	604,476	554,146	786,864	608,322	(178,542)
Transportation	122,272	152,765	137,567	106,588	145,524	38,936
<b>Total Claims</b>	<b>36,279,454</b>	<b>35,682,998</b>	<b>38,443,800</b>	<b>38,843,673</b>	<b>40,732,256</b>	<b>1,888,583</b>
Medical & Care Management Expense	1,238,703	1,322,188	1,276,963	1,410,289	1,737,426	327,137
Reinsurance	276,955	(342,165)	284,242	287,084	282,241	(4,842)
Claims Recoveries	(250,030)	(345,290)	(82,534)	316,981	0	(316,981)
Sub-total	1,265,628	634,733	1,478,672	2,014,354	2,019,667	5,314
<b>Total Cost of Health Care</b>	<b>45,332,729</b>	<b>45,086,757</b>	<b>48,350,456</b>	<b>49,274,672</b>	<b>49,031,889</b>	<b>(242,783)</b>
<b>Contribution Margin</b>	<b>12,519,927</b>	<b>7,421,259</b>	<b>4,924,112</b>	<b>4,686,984</b>	<b>4,732,072</b>	<b>(45,088)</b>
<b>General &amp; Administrative Expenses:</b>						
Salaries and Wages	715,375	724,858	664,080	787,225	894,001	106,776
Payroll Taxes and Benefits	195,413	193,656	186,552	174,678	263,799	89,121
Travel and Training	18,388	19,290	16,969	12,853	38,385	25,532
Outside Service - ACS	1,578,000	1,594,863	1,642,121	1,628,393	1,515,543	(112,850)
Outside Services - Other	155,310	128,132	161,411	125,073	182,682	57,609
Accounting & Actuarial Services	5,930	25,280	17,380	78,148	25,000	(53,148)
Legal	(35,214)	(30,846)	47,671	98,593	87,500	(11,093)
Insurance	35,303	34,973	34,973	25,161	27,168	2,007
Lease Expense - Office	66,034	66,034	66,034	66,034	86,940	20,906
Consulting Services	70,228	97,990	19,345	81,081	144,517	63,436
Advertising and Promotion	8,447	0	6,116	0	0	0
General Office	120,298	158,598	126,141	183,685	166,925	(16,760)
Depreciation & Amortization	20,463	20,768	20,768	20,768	38,505	17,737
Printing	1,849	12,756	1,512	700	3,425	2,725
Shipping & Postage	883	22,202	2,938	81	3,054	2,973
Interest	17,407	28,884	33,702	49,638	21,701	(27,937)
<b>Total G &amp; A Expenses</b>	<b>2,974,114</b>	<b>3,097,438</b>	<b>3,047,714</b>	<b>3,332,111</b>	<b>3,499,145</b>	<b>167,034</b>
<b>Total Operating Gain / (Loss)</b>	<b>9,545,813</b>	<b>4,323,821</b>	<b>1,876,398</b>	<b>1,354,873</b>	<b>1,232,927</b>	<b>121,947</b>
<b>Non Operating:</b>						
Revenues - Interest	138,558	148,789	152,335	154,302	100,000	54,302
Expenses - Interest	3,247	3,344	5,930	4,436	2,939	(1,497)
<b>Total Non-Operating</b>	<b>135,311</b>	<b>145,444</b>	<b>146,405</b>	<b>149,867</b>	<b>97,061</b>	<b>52,806</b>
<b>Total Increase / (Decrease) in Unrestricted Net Assets</b>	<b>9,681,123</b>	<b>4,469,265</b>	<b>2,022,803</b>	<b>1,504,740</b>	<b>1,329,988</b>	<b>174,752</b>
<b>Full Time Employees</b>				<b>171</b>	<b>201</b>	<b>30</b>

**MPPM - STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS**

	SEP 15	OCT 15	NOV 15	DECEMBER 2015		Variance Fav / (Unfav)
				Actual	Budget	
<b>Membership (includes retro members)</b>	194,875	198,148	200,385	203,857	196,035	7,822
<b>Revenue:</b>						
Premium	316.10	295.13	297.64	297.32	306.81	(9.50)
Reserve for Rate Reduction	(6.98)	(20.23)	(20.25)	(21.09)	(21.52)	0.42
MCO Premium Tax	(12.45)	(11.62)	(11.72)	(11.71)	(11.23)	(0.47)
<b>Total Net Premium</b>	<b>296.67</b>	<b>263.28</b>	<b>265.67</b>	<b>264.52</b>	<b>274.06</b>	<b>(9.55)</b>
<b>Other Revenue:</b>						
Interest Income	0.00	0.00	0.00	0.00	0.00	0.00
Miscellaneous Income	0.20	1.72	0.19	0.19	0.20	(0.01)
<b>Total Other Revenue</b>	<b>0.20</b>	<b>1.72</b>	<b>0.19</b>	<b>0.19</b>	<b>0.20</b>	<b>(0.01)</b>
<b>Total Revenue</b>	<b>296.87</b>	<b>264.99</b>	<b>265.86</b>	<b>264.70</b>	<b>274.26</b>	<b>(9.55)</b>
<b>Medical Expenses:</b>						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	39.96	44.25	42.06	41.29	32.03	(9.25)
FFS Claims Expenses:						
Inpatient	42.23	33.27	48.82	34.04	51.29	17.25
LTC / SNF	40.36	45.63	40.49	46.39	46.60	0.21
Outpatient	15.92	18.90	19.40	23.91	16.51	(7.40)
Laboratory and Radiology	2.09	1.24	2.09	1.24	1.17	(0.08)
Emergency Room	6.86	6.95	7.03	6.79	6.72	(0.07)
Physician Specialty	19.01	16.77	17.84	17.30	21.71	4.40
Primary Care Physician	6.40	5.45	5.28	5.16	6.82	1.66
Home & Community Based Services	6.38	5.28	5.80	6.63	6.38	(0.25)
Applied Behavior Analysis Services	0.25	0.24	0.34	0.27	0.84	0.56
Mental Health Services	1.77	1.51	1.39	1.45	2.31	0.85
Pharmacy	40.43	40.07	38.85	42.39	39.57	(2.82)
Adult Expansion Reserve	0.00	0.00	0.00	0.00	0.00	0.00
Provider Reserve	0.00	0.00	0.00	0.00	2.96	2.96
Other Medical Professional	0.91	0.97	1.06	0.57	1.07	0.50
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	2.93	3.05	2.77	3.86	3.10	(0.76)
Transportation	0.63	0.77	0.69	0.52	0.74	0.22
Total Claims	186.17	180.08	191.85	190.54	207.78	17.24
Medical & Care Management Expense	6.36	6.67	6.37	6.92	8.86	1.94
Reinsurance	1.42	(1.73)	1.42	1.41	1.44	0.03
Claims Recoveries	(1.28)	(1.74)	(0.41)	1.55	0.00	(1.55)
Sub-total	6.49	3.20	7.38	9.88	10.30	0.42
<b>Total Cost of Health Care</b>	<b>232.62</b>	<b>227.54</b>	<b>241.29</b>	<b>241.71</b>	<b>250.12</b>	<b>8.41</b>
<b>Contribution Margin</b>	<b>64.25</b>	<b>37.45</b>	<b>24.57</b>	<b>22.99</b>	<b>24.14</b>	<b>(1.15)</b>
<b>General &amp; Administrative Expenses:</b>						
Salaries and Wages	3.67	3.66	3.31	3.86	4.56	0.70
Payroll Taxes and Benefits	1.00	0.98	0.93	0.86	1.35	0.49
Travel and Training	0.09	0.10	0.08	0.06	0.20	0.13
Outside Service - ACS	8.10	8.05	8.19	7.99	7.73	(0.26)
Outside Services - Other	0.80	0.65	0.81	0.61	0.93	0.32
Accounting & Actuarial Services	0.03	0.13	0.09	0.38	0.13	(0.26)
Legal	(0.18)	(0.16)	0.24	0.48	0.45	(0.04)
Insurance	0.18	0.18	0.17	0.12	0.14	0.02
Lease Expense - Office	0.34	0.33	0.33	0.32	0.44	0.12
Consulting Services	0.36	0.49	0.10	0.40	0.74	0.34
Translation Services	0.00	0.00	0.00	0.00	0.00	0.00
Advertising and Promotion	0.04	0.00	0.03	0.00	0.00	0.00
General Office	0.62	0.80	0.63	0.90	0.85	(0.05)
Depreciation & Amortization	0.11	0.10	0.10	0.10	0.20	0.09
Printing	0.01	0.06	0.01	0.00	0.02	0.01
Shipping & Postage	0.00	0.11	0.01	0.00	0.02	0.02
Interest	0.09	0.15	0.17	0.24	0.11	(0.13)
Other/ Miscellaneous Expenses	0.00	0.00	0.00	0.00	0.00	0.00
<b>Total G &amp; A Expenses</b>	<b>15.26</b>	<b>15.63</b>	<b>15.21</b>	<b>16.35</b>	<b>17.85</b>	<b>1.50</b>
<b>Total Operating Gain / (Loss)</b>	<b>48.98</b>	<b>21.82</b>	<b>9.36</b>	<b>6.65</b>	<b>6.29</b>	<b>0.36</b>
<b>Non Operating:</b>						
Revenues - Interest	0.71	0.75	0.76	0.76	0.51	0.25
Expenses - Interest	0.02	0.02	0.03	0.02	0.01	(0.01)
<b>Total Non-Operating</b>	<b>0.69</b>	<b>0.73</b>	<b>0.73</b>	<b>0.74</b>	<b>0.50</b>	<b>0.24</b>
<b>Total Increase / (Decrease) in Unrestricted Net Assets</b>	<b>49.68</b>	<b>22.56</b>	<b>10.09</b>	<b>7.38</b>	<b>6.78</b>	<b>0.60</b>

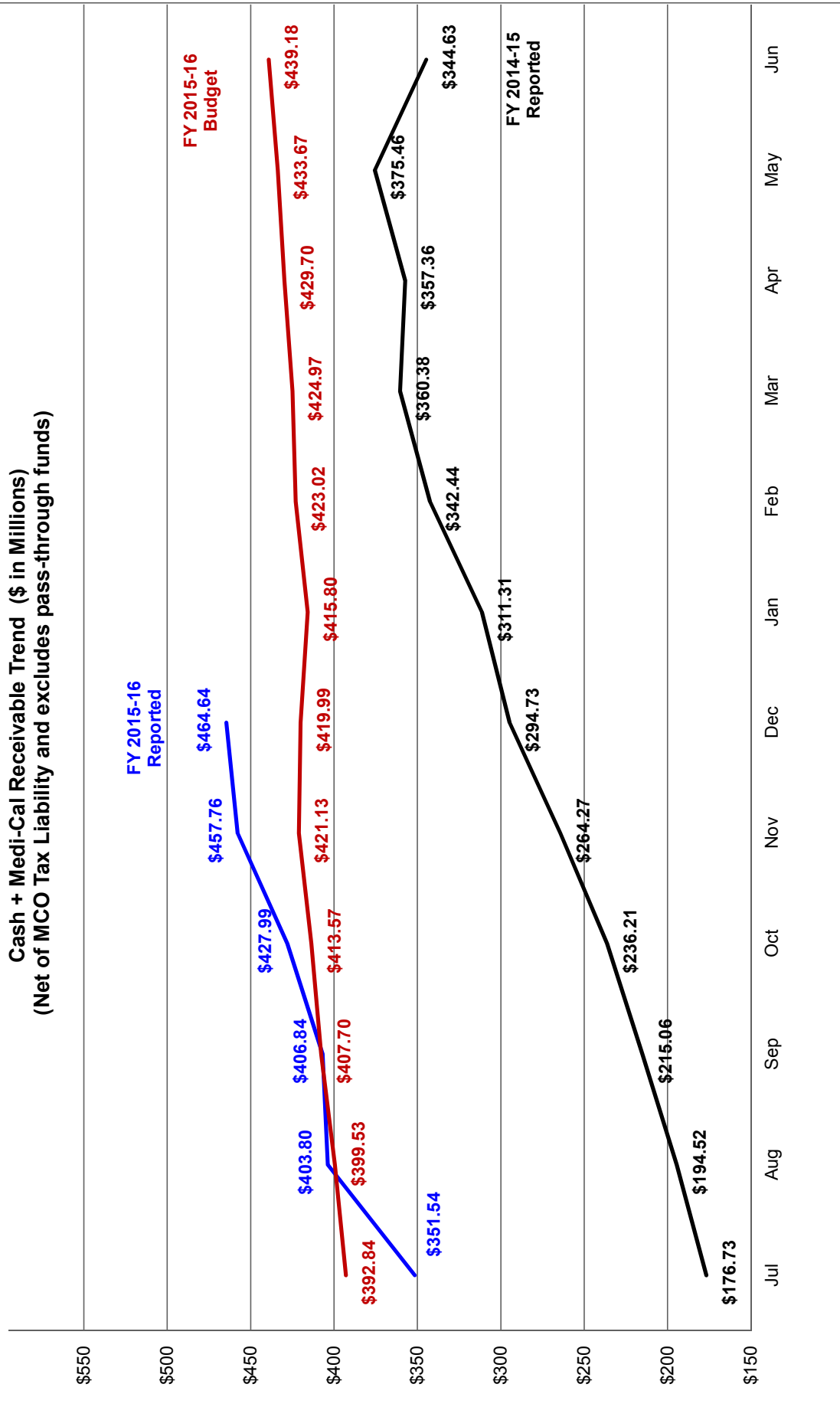
## STATEMENT OF CASH FLOWS - FYTD

	<b>DEC 15</b>
Cash Flow From Operating Activities	
Collected Premium	\$ 496,891,402
Miscellaneous Income	680,753
State Pass Through Funds	49,083,609
<u>Paid Claims</u>	
Medical & Hospital Expenses	(186,411,032)
Pharmacy	(48,293,787)
Capitation	(58,656,170)
Reinsurance of Claims	(1,671,800)
State Pass Through Funds Distributed	(27,995,630)
Paid Administration	(24,188,915)
MCO Taxes Received / (Paid)	(18,758,887)
Net Cash Provided / (Used) by Operating Activities	<b>180,679,541</b>
Cash Flow From Investing / Financing Activities	
Net Acquisition / Proceeds from Investments	(50,111,831)
Net Discount / Premium Amortization of Investments	111,831
Net Acquisition of Property / Equipment	(60,229)
Net Cash Provided / (Used) by Investing / Financing	<b>(50,060,229)</b>
<b>Net Cash Flow</b>	<b>\$ 130,619,312</b>
Cash and Cash Equivalents (Beg. of Period)	57,218,141
Cash and Cash Equivalents (End of Period)	187,837,453
	<b>\$ 130,619,312</b>
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income / (Loss)	24,285,190
Depreciation & Amortization	208,533
Net Discount / Premium Amortization of Investments	(111,831)
Decrease / (Increase) in Receivables	68,545,336
Decrease / (Increase) in Prepaids & Other Current Assets	(823,057)
(Decrease) / Increase in Payables	102,811,814
(Decrease) / Increase in Other Liabilities	(9,715,007)
Change in MCO Tax Liability	180,370
Changes in Claims and Capitation Payable	(11,107,644)
Changes in IBNR	6,405,838
	<b>180,679,541</b>
<b>Net Cash Flow from Operating Activities</b>	<b>\$ 180,679,541</b>

## STATEMENT OF CASH FLOWS - MONTHLY

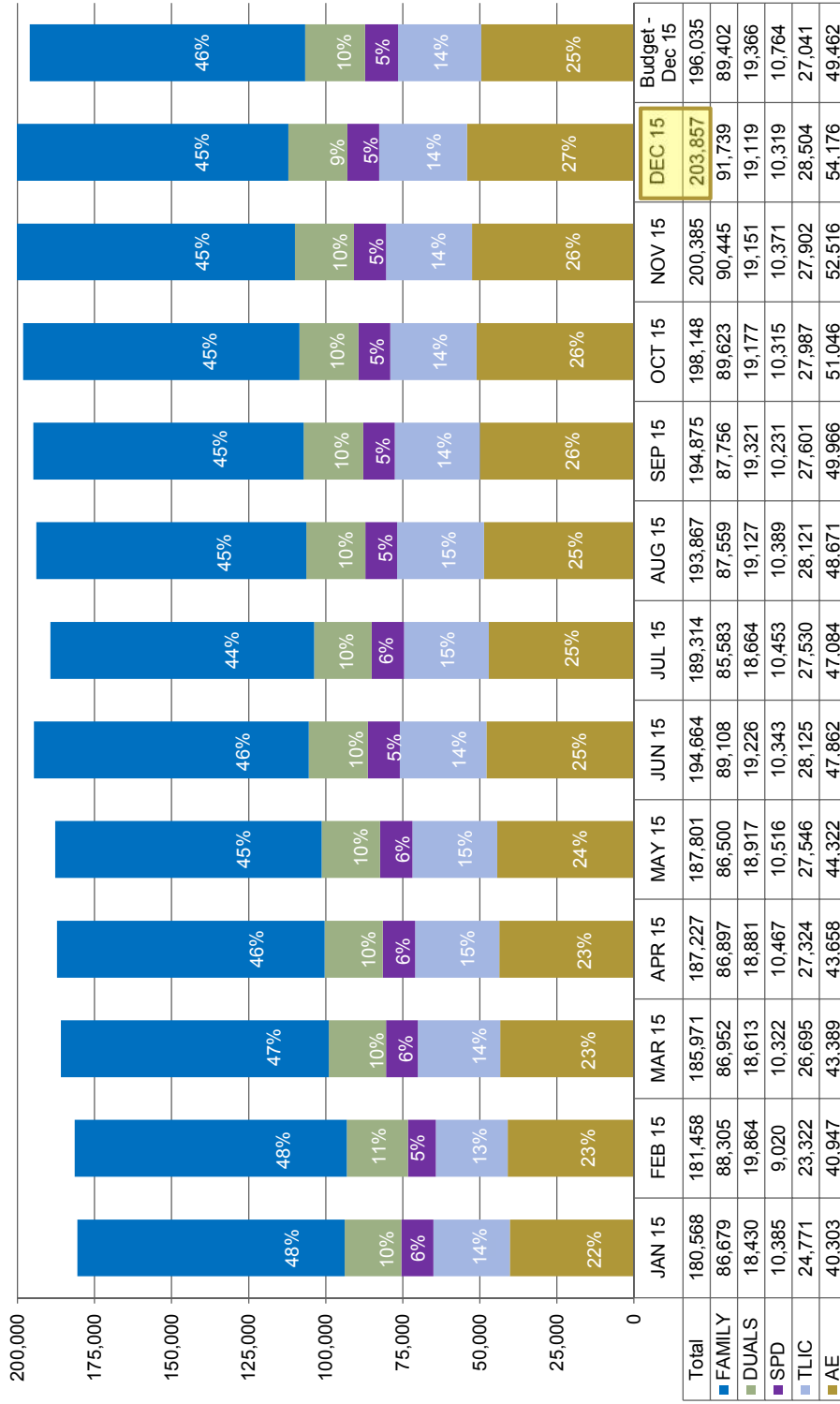
	DEC 15	NOV 15	OCT 15
Cash Flow From Operating Activities			
Collected Premium	\$ 67,706,561	\$ 76,117,540	\$ 75,884,536
Miscellaneous Income	116,280	113,988	137,805
State Pass Through Funds	1,852,286	1,796,588	17,612,139
<u>Paid Claims</u>			
Medical & Hospital Expenses	(40,122,381)	(25,481,591)	(28,454,257)
Pharmacy	(8,510,048)	(8,587,538)	(8,251,177)
Capitation	(9,971,024)	(7,839,138)	(7,599,163)
Reinsurance of Claims	(287,084)	(284,242)	(278,965)
State Pass Through Funds Distributed	(1,779,287)	(1,725,782)	(15,888,984)
Paid Administration	(5,092,623)	(1,909,868)	(6,161,977)
MCO Tax Received / (Paid)	(3,067,869)	(3,681,432)	(2,866,610)
Net Cash Provided / (Used) by Operating Activities	<b>844,813</b>	<b>28,518,525</b>	<b>24,133,346</b>
Cash Flow From Investing / Financing Activities			
Net Acquisition / Proceeds from Investments	44,961,978	(38,347)	(10,984)
Net Discount / Premium Amortization of Investments	38,022	38,347	10,984
Net Acquisition of Property / Equipment	(14,601)	(9,168)	(12,139)
Net Cash Provided / (Used) by Investing / Financing	<b>44,985,399</b>	<b>(9,168)</b>	<b>(12,139)</b>
<b>Net Cash Flow</b>	<b>\$ 45,830,212</b>	<b>\$ 28,509,357</b>	<b>\$ 24,121,207</b>
Cash and Cash Equivalents (Beg. of Period)	142,007,241	113,497,885	89,376,678
Cash and Cash Equivalents (End of Period)	187,837,453	142,007,241	113,497,885
	<b>\$ 45,830,212</b>	<b>\$ 28,509,357</b>	<b>\$ 24,121,207</b>
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	1,504,740	2,022,803	4,469,265
Net Discount / Premium Amortization of Investments	(38,022)	(38,347)	(10,984)
Depreciation & Amortization	34,927	34,927	34,927
Decrease / (Increase) in Receivables	(89,400)	525,735	2,202,780
Decrease / (Increase) in Prepays & Other Current As:	2,327	(253,289)	334,251
(Decrease) / Increase in Payables	6,186,151	96,636,709	(2,599,318)
(Decrease) / Increase in Other Liabilities	(1,099,649)	(75,815,757)	18,498,952
Change in MCO Tax Liability	(300,412)	(619,960)	695,203
Changes in Claims and Capitation Payable	(3,674,522)	1,043,296	6,487,426
Changes in IBNR	(1,681,327)	4,982,409	(5,979,156)
	<b>844,813</b>	<b>28,518,525</b>	<b>24,133,346</b>
<b>Net Cash Flow from Operating Activities</b>	<b>844,813</b>	<b>28,518,525</b>	<b>24,133,346</b>

**GOLD COAST HEALTH PLAN  
DECEMBER 2015**



**GOLD COAST HEALTH PLAN**

**Membership - Rolling 12 Month**

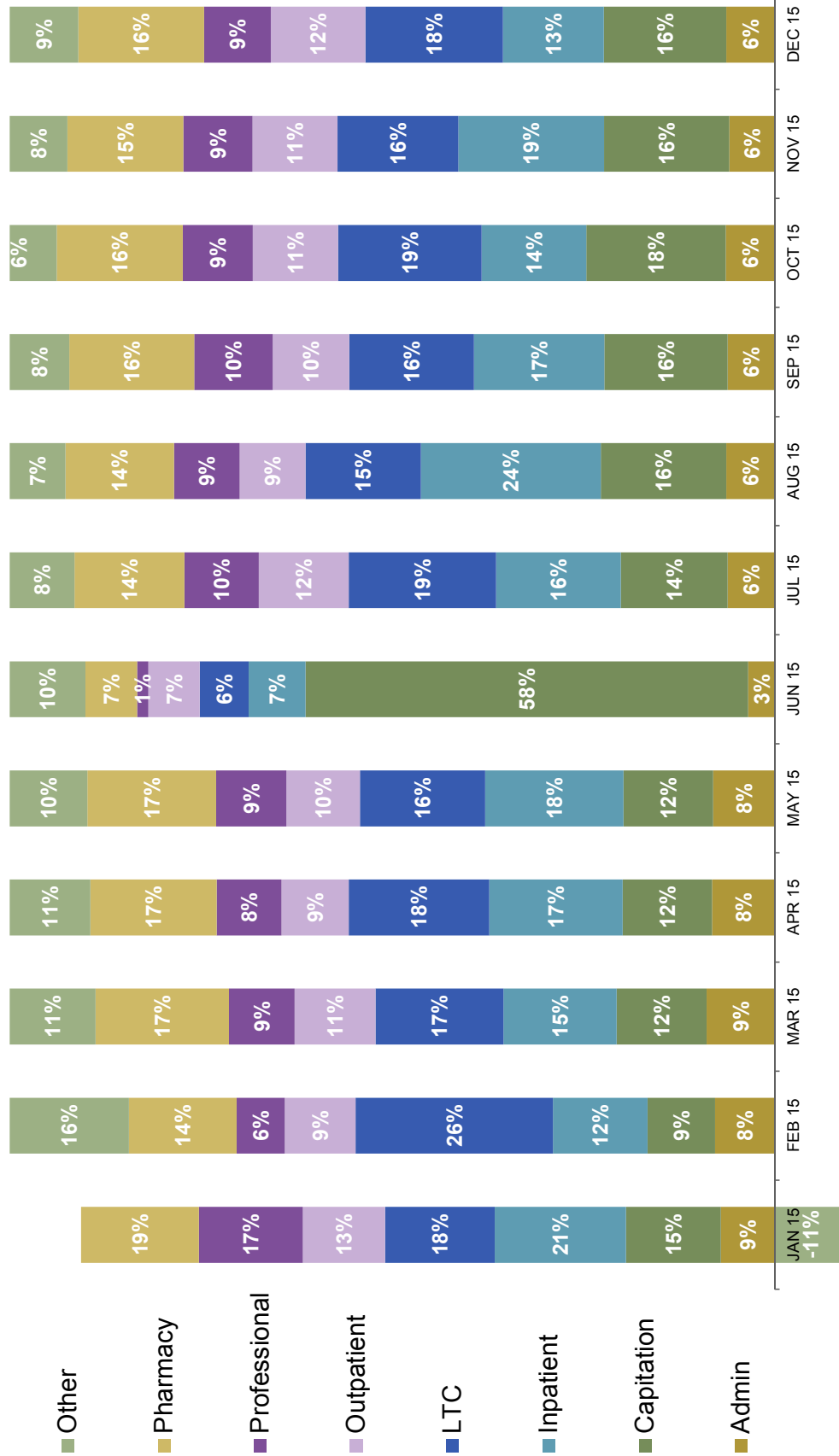


**SPD = Seniors and Persons with Disabilities    TLIC = Targeted Low Income Children    AE = Adult Expansion**



# GOLD COAST HEALTH PLAN

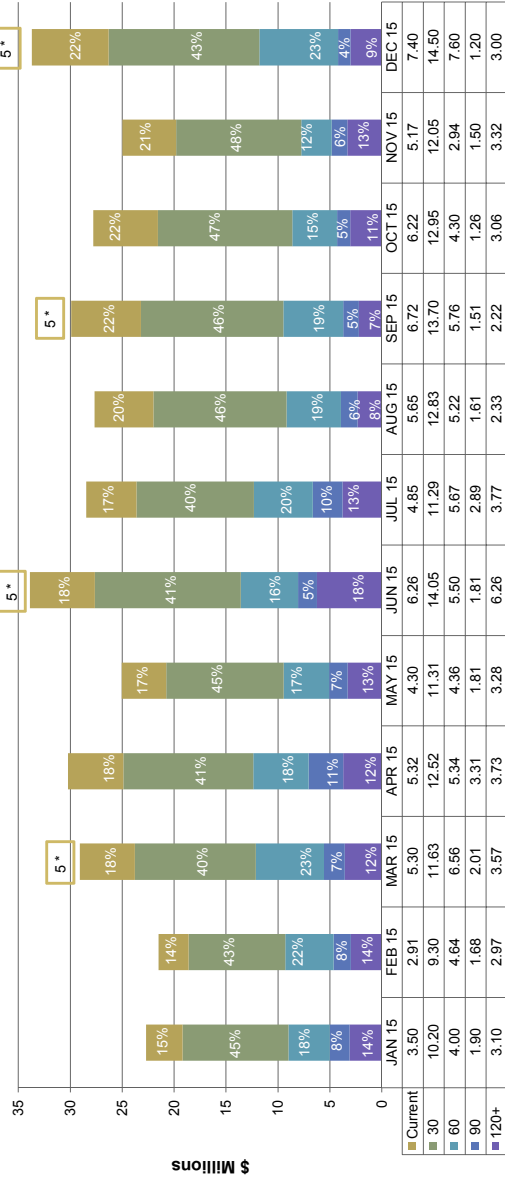
## Total Expense Composition



Note: January 15 reflects an adjustment to Adult Expansion reserve resulting in a reduction to IBNR.  
 June 15 reflects the Enhanced Adult Capitation program and reclassification of fee-for-service expense to capitation expense.

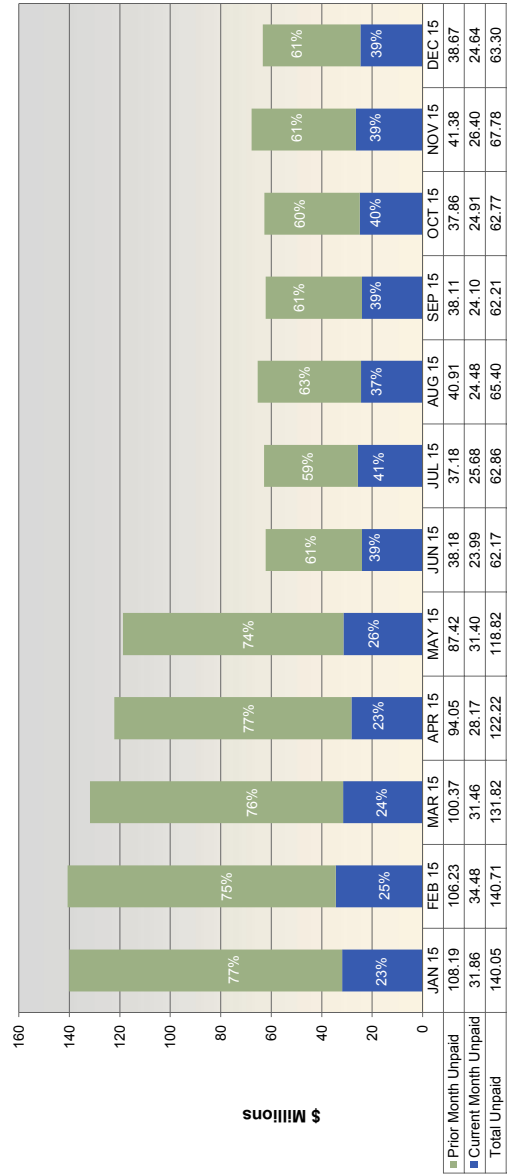
GOLD COAST HEALTH PLAN  
DECEMBER 2015

Paid Claims Composition (excluding Pharmacy and Capitation Payments)



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

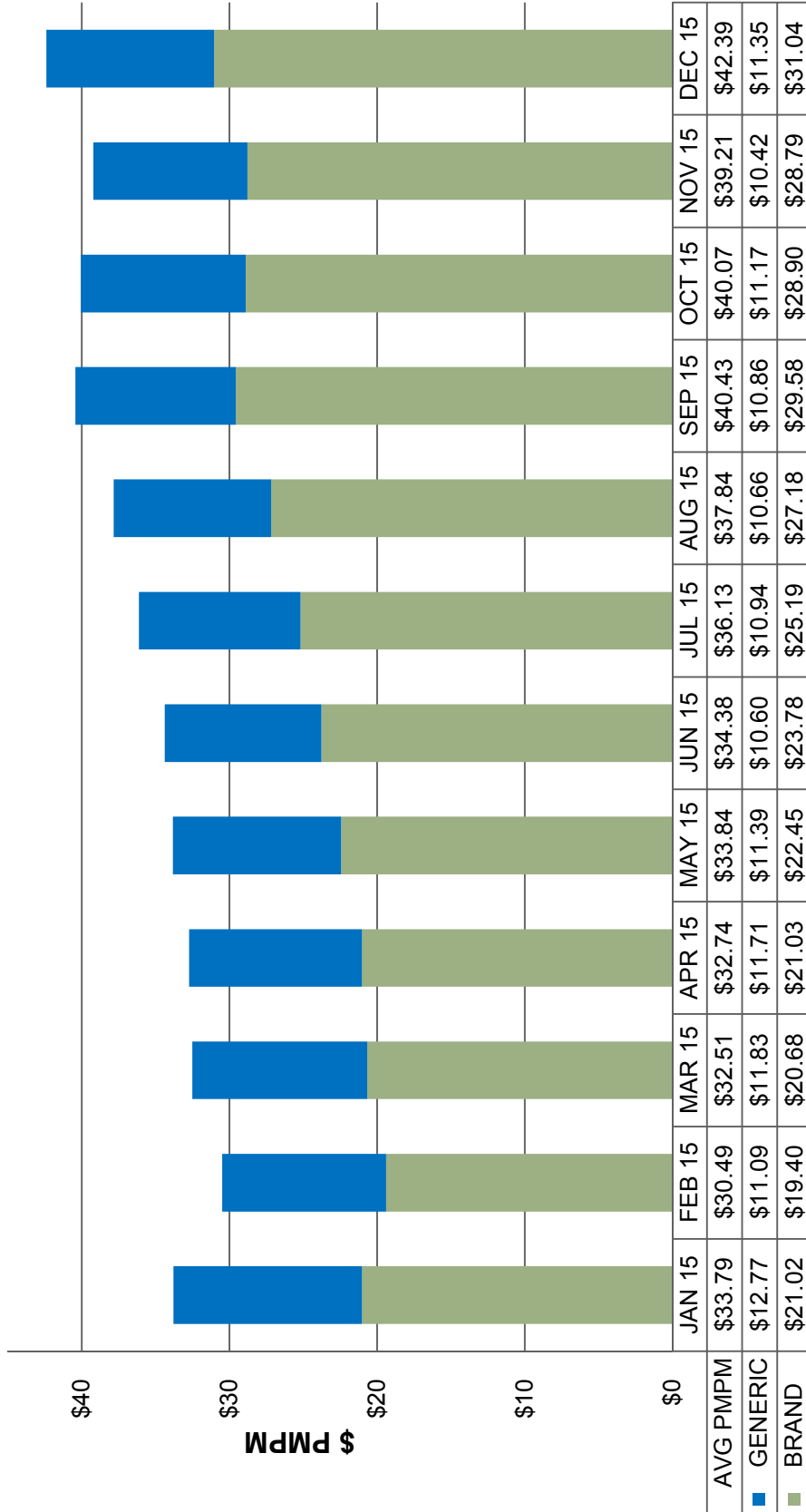
IBNP Composition (excluding Pharmacy and Capitation)



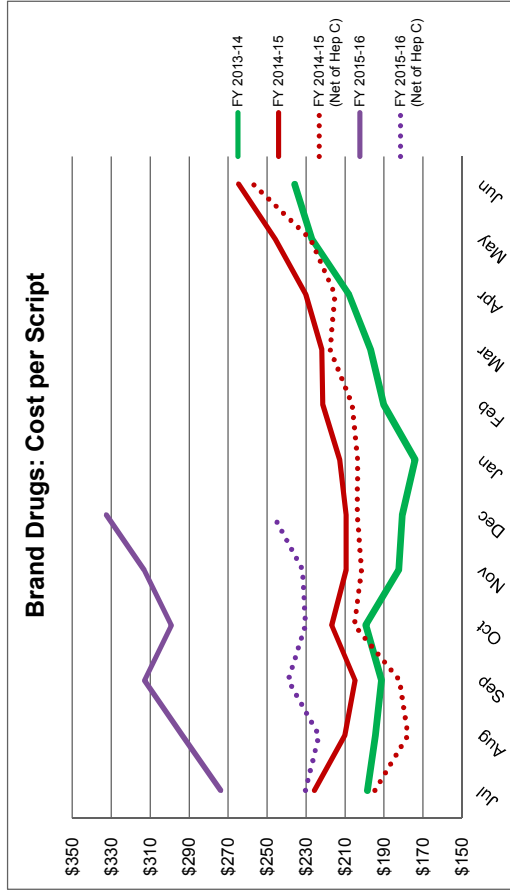
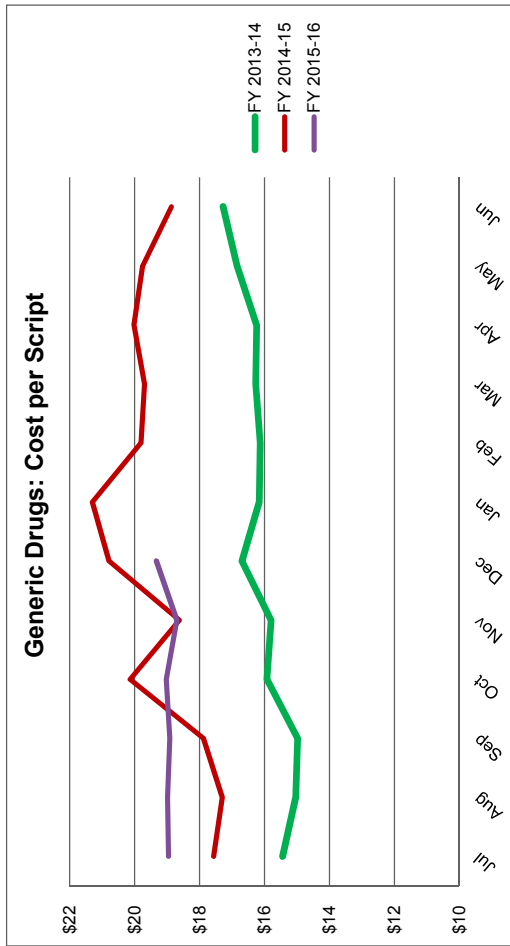
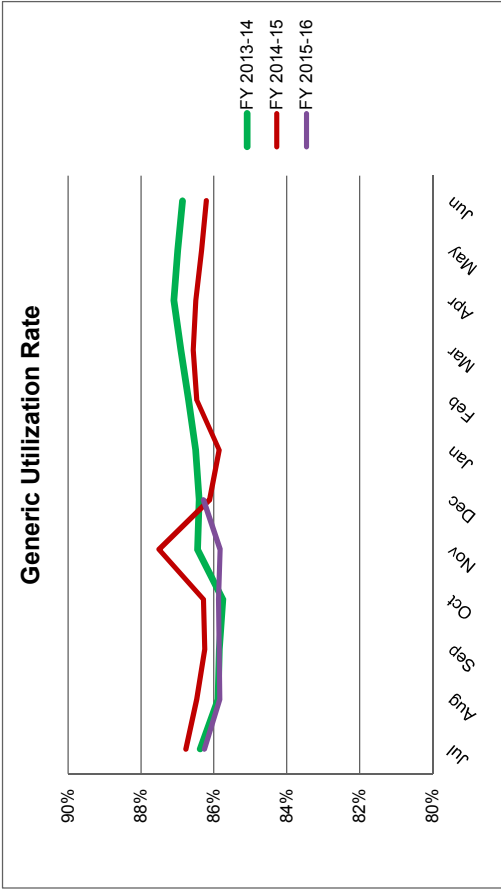
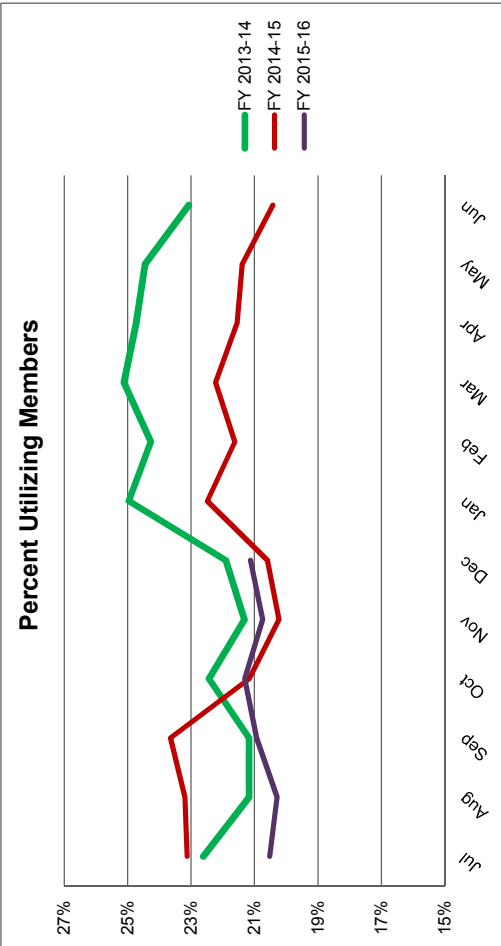
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable. June 2015 - reflects the Enhanced Adult Capitation program and reclassification of fee-for-service expense to capitation expense.

# GOLD COAST HEALTH PLAN

Pharmacy Cost Trend



**GOLD COAST HEALTH PLAN  
PHARMACY ANALYSIS**





### **AGENDA ITEM NO. 3**

**To:** Gold Coast Health Plan Commission

**From:** Scott Campbell, General Counsel

**Date:** February 22, 2016

**RE:** Receive a Resolution amending the bylaws to establish that Commissioners' terms of office begin on March 15 and to require appointment of officers and committee members every two years after a new Commission takes office.

#### **SUMMARY:**

Because the initial Commission was appointed in March 2010, the Ventura County Board of Supervisors and the Commission have always used March 15 as the date that each Commissioner's term begins. This date is not formally established in either the County Ordinance or the Commission's bylaws. This proposed Resolution would amend the bylaws to formally establish March 15 as the start of each term. The bylaws currently require appointment of officers for two-year terms, commencing on January 1. This Resolution would change the timing for the appointment of new officers so that it is consistent with the beginning of the Commissioner terms. The Commission may also make appointments to the Executive/Finance Committee. Because the officers serve as members of the committee, this Resolution clarifies that committee appointments shall occur after new officers are elected. The Resolution also amends the bylaws to streamline the process for the appointment of the Chairperson and Vice-Chairperson by eliminating the role of the Executive/Finance Committee as the Nominating Committee for those positions. The bylaws require that proposed amendments to the bylaws be presented to the Commission at least two weeks prior to adoption. Hence, the proposed bylaws are submitted now so that they Commission can adopt the amendments at the March meeting.

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

Ventura County Ordinance No. 4481, which established the Ventura County Medi-Cal Managed Care Commission, requires the Commission to establish bylaws containing procedures for the conduct of business that is not otherwise specified in the Ordinance. (Ord. 4481, as amended on October 6, 2015 is attached hereto; see section 1381-4.)

The Ordinance and the bylaws provide that each of the eight Commissioners appointed by the Board of Supervisors shall serve a four-year term, and the terms are staggered so that four Commissioners are reappointed every two years, in even-numbered years.

Neither the Ordinance nor the bylaws establish when the Commissioners' terms begin. The first Commission was appointed in March 2010, and therefore in every even-numbered year following the initial appointment, the Board of Supervisors has appointed (or re-appointed) four new Commissioners.

Under Article III, section (b), of the bylaws, the Commission must elect two officers to serve for the calendar year: a Chairperson and a Vice Chairperson. The term of each office begins on January 1 following the election.

The bylaws also establish the Executive/Finance Committee, which consists of the Chairperson, Vice Chairperson, one private hospital/healthcare representative, one Ventura County Medical Health System representative, and one Clinicas Del Camino Real representative. (See Art. IV, section (b).) If the Chairperson and/or Vice Chairperson are representatives from these agencies, then the Commission *must* appoint the other representative from that agency to serve on the Committee as well. Because the selection of a Chairperson and Vice Chairperson affect Commission's appointments to the Committee, the appointments logically should occur soon after the Chairperson and Vice Chairperson are elected.

At the Commission's January 25 regular meeting, staff presented reports to the Board to elect officers and appoint Executive/Finance Committee members, but staff noted that the composition of Commission was subject to change in March. The Commission directed staff to present an amendment to the bylaws to require that the officers and committee members be selected *after* a new Commission takes office.

This Resolution will make four changes to the bylaws: (1) Article II will be revised to clarify that the Commissioner terms begin on March 15; (2) Article III will be revised so that Officers must be elected at the first regular meeting following the appointment of Commissioners for a new term; (3) Article III will be revised so that Executive/Finance Committee appointments will be made at either the regular meeting in which new officers are elected or at the next regular meeting; and (4) Article III will be revised to remove "nominating officers" as a duty of the Executive/Finance Committee since the committee's composition will be decided after the Chairperson and Vice Chairperson take office and to streamline the appointment process.

#### **FISCAL IMPACT:**

None.

#### **RECOMMENDATION:**

Receive the proposed Resolution and approve the Resolution at the March 28, 2016 Commission meeting.

**CONCURRENCE:**

N/A.

**Attachments:**

Resolution No. \_\_\_\_\_

Ventura County Ordinance No. 4481

Gold Coast Health Plan Bylaws

**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: March 28, 2016**



**Table of Contents**

**ARTICLE I.....3**  
    **Name and Mission.....3**

**ARTICLE II.....4**  
    **Commissioners .....4**  
    **Selection and Terms of Commissioners.....5**

**ARTICLE III.....5**  
    **Officers .....5**  
    **Election.....6**  
    **Duties .....6**

**ARTICLE IV .....6**  
    **Standing Committees .....6**

**ARTICLE V .....9**  
    **Special Committees .....9**

**ARTICLE VI .....9**  
    **Meetings .....9**  
    **Conduct of Meetings..... 10**

**ARTICLE VII ..... 12**  
    **Powers and Duties ..... 12**

**ARTICLE VIII ..... 12**  
    **STAFF .....12**  
    **Chief Executive Officer..... 13**  
    **Clerk..... 13**  
    **Assistant Clerk ..... 14**

**ARTICLE IX .....14**  
    **Rules of Order .....14**

**ARTICLE X .....14**  
    **Amendments ..... 14**

**ARTICLE XI .....14**  
    **Nondiscrimination Clause..... 14**

**ARTICLE XII ..... 14**  
    **Conflict of Interest and Ethics ..... 14**

**ARTICLE XIII ..... 15**  
    **Dissolution ..... 15**

# **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 VCMCC 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 VCMCC. 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 VCMCC, 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 VCMCC 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 VCMCC by a 4/5 vote of the Board of Supervisors.

Nominations to the VCMCC 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 VCMCC 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 VCMCC 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 VCMCC shall establish two (2) committees/advisory boards, one member/consumer based and one provider based. VCMCC staff will be responsible to gather a list of potential appointments and make recommendations to the VCMCC for membership on these boards. Each of the boards shall submit a charter to the VCMCC 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 VCMCC 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)
  4. Ventura County Medical Center Health System representative
  5. Clinicas Del Camino Real representative

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 VCOMMCC 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:
  - o PCP
  - o Specialists
  - o Hospitals o LTC
  - o 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, 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 VCOMMCC members to actively participate in VCOMMCC 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 VCOMMCC at least annually.

## **ARTICLE VIII**

### **STAFF**

The VCOMMCC shall employ personnel and contract for services as necessary to perform its functions. The permanent staff employed by the VCOMMCC 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 VCOMMCC. 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.

**Resolution No. 2016-\_\_**

**A RESOLUTION OF THE VENTURA COUNTY MEDICAL MANAGED CARE COMMISSION, DOING BUSINESS AS THE GOLD COAST HEALTH PLAN AMENDING THE BYLAWS TO ESTABLISH THAT COMMISSIONERS' TERMS OF OFFICE BEGIN ON MARCH 15 AND TO REQUIRE APPOINTMENT OF OFFICERS AND COMMITTEE MEMBERS PROMPTLY THEREAFTER.**

**WHEREAS**, the Ventura County Medi-Cal Managed Care Commission, doing business as the Gold Coast Health Plan ("Commission"), was initially appointed in March of 2010;

**WHEREAS**, each March of even-numbered years, the Ventura County Board of Supervisors appoints new Commissioners to serve four-year terms;

**WHEREAS**, the Commission elects a Chairman and a Vice Chairman from amongst its membership every two years;

**WHEREAS**, the Commission appoints its members to serve on the Executive/Finance Committee; and

**WHEREAS**, the Commission desires to amend the bylaws to clarify that terms of office begin in March and to establish that the selection of officers and committee members shall occur promptly thereafter.

**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 II, under the heading "**Selection and Terms of Commissioners**," the following sentence shall be added to the end of the first paragraph:

"The term of each subsequent appointment shall be deemed to commence on March 15 of the year of the appointment."

2. In Article III, under the heading "**Election**," paragraphs (a) and (b) shall be deleted in their entirety and replaced with the following:

"(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."

3. In Article IV, under the heading “**Standing Committees**,” at paragraph (b), the following shall be added to the end of subparagraph (ii):

“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.”

4. In Article IV, under the heading “**Standing Committees**” at paragraph (b), the following shall be deleted from subparagraph (iii) and the remainder of the subparagraph shall be renumbered accordingly:

~~“13. Serve as the Nominating Committee for the purpose of confirmation of candidates for Chairperson and Vice Chairperson of the VCMMCC.”~~

A copy of the Amended and Restated Bylaws with the above changes 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 28rd day of March, 2016, by the following vote:

AYE:  
NAY:  
ABSTAIN:  
ABSENT:

\_\_\_\_\_  
Chair

Attest:

\_\_\_\_\_  
Clerk of the Board



## **AGENDA ITEM NO. 4**

**To:** Gold Coast Health Plan Commission

**From:** Kim Osajda, RN, MSN, Director Quality Improvement

**Date:** February 22, 2016

**RE:** Healthcare Effectiveness Data and Information Set (HEDIS) Vendor Request For Proposal (RFP) Award Recommendation

### **SUMMARY:**

Gold Coast Health Plan (GCHP or the Plan) contracts with a HEDIS vendor in order to provide for the calculation and reporting of HEDIS measures. The contract with the current HEDIS vendor, Verisk Health, Inc., terminates on July 5, 2016. GCHP began an RFP process on October 2, 2015 to select a HEDIS vendor for the next contract term.

GCHP received responses from four (4) HEDIS vendors. The vendors were assessed for their ability to meet the RFP requirements, meet minimum qualifications, the quality of their responses, and ability to accept GCHP contract terms and pricing. Two finalists were selected and interviewed by Plan staff.

### **BACKGROUND:**

Verisk Health, Inc. was selected as the HEDIS vendor for GCHP for an initial 3 year term. Verisk provides calculation and reporting of HEDIS measures as well as medical record retrieval and abstraction services for GCHP. In the best interest of the Plan, GCHP conducted an RFP process for HEDIS services to evaluate if the incumbent or a new HEDIS vendor would be the best business partner for GCHP moving forward.

For the past four months, GCHP has conducted a detailed and thorough selection process for a HEDIS vendor, with a potential implementation date of April 1, 2016, if a new vendor is selected.

### **DISCUSSION:**

The Plan's goal is to select a HEDIS vendor that offers industry best practices, is knowledgeable in the landscape of Medicaid and can provide data to support clinical and quality initiatives to allow GCHP to further realize positive member health outcomes while maintaining fiscal responsibility.

In September, 2015, a cross functional team that included GCHP's Chief Medical Officer, the Director of Quality Improvement, the Quality Improvement Project Manager together with participation from Procurement, and Information Technology (IT) was formed to develop a strategy to proactively manage the current HEDIS vendor contract expiration date of July 5, 2016. The team agreed on a formal go-to-market strategy and issued a formal RFP on October 2, 2015 to five (5) NCQA Certified vendors.

The Plan received four (4) responsive proposals and using a fact based weighted evaluation matrix scored each proposal. Scoring was completed by Procurement, the Director of Quality Improvement, the Quality Improvement Project Manager, the Manager of IT Business Solutions, and the Senior Decision Support Services Analyst.

Each vendor was scored in eight (8) major areas: general questions, account support, implementation, data, medical record retrieval, medical record abstraction, reports, and pricing. Each section was given a weighted score.

Using the overall highest scores, the Plan developed a short list of vendors to pursue further due diligence and negotiation discussions. The selection team, through the RFP process, identified two finalists; Inovalon, Inc., and Altegra Health. Both finalists were brought in for interviews with the selection team and provided demonstrations of their HEDIS solutions to Quality Improvement and IT staff.

The table below provides a breakdown of the ranking achieved for the two finalists in those sections.

Section	Inovalon	Altegra
1. General	1	2
2. Account Support	1	2
3. Implementation	1	2
4. Data	1	2
5. Medical Record Retrieval	2	1
6. Medical Record Abstraction	2	1
7. Reports	1	2
8. Pricing	2	1

Inovalon scored highest in five (5) out of eight (8) sections of the RFP and offered the most favorable reporting capability. This represents a vendor that most closely matches its business process with the needs of GCHP in order to ensure that there is transparency and accountability within the services offered to GCHP.

While Altegra scored highest in the quantitative section of price and contract terms and conditions, the Plan feels that Inovalon provides other valuable qualitative services that are beneficial to the Plan such as:

- No use of temporary staff for medical record retrieval and abstraction

- Provider portal where providers can log in to view their reports
- Provider Quality Management module for custom reports and graphical tools
- Inovalon can accept multiple file formats including 837 and HL7
- Data Analyzer performs 1,100 data integrity and validation checks when integrating health plan data into their HEDIS software

**FISCAL IMPACT:**

Due to the selection of Inovalon, Inc., GCHP will be able to realize a projected savings of approximately \$100,596.50 over the term of the contract.

	Inovalon Projected Budget	Current Projected Budget
Year 1	\$309,693.00	\$324,713
Year 2	\$303,646.86	\$340,948
Year 3	\$309,719.80	\$357,996
Three Year Total	\$925,059.66	\$1,023,656.16
	Projected Savings	<b>\$100,596.50</b>

**RECOMMENDATION:**

It is the Plan's recommendation to move forward with Inovalon as the vendor of choice and authorize the CEO to enter into an agreement with Inovalon on behalf of the Plan to implement HEDIS services beginning April 1, 2016.

<b>Approved:</b>		
<b>Continued:</b>		
<b>Denied:</b>		



**AGENDA ITEM NO. 5**

To: Gold Coast Health Plan Commission Committee  
From: C. Albert Reeves, M.D., Chief Medical Officer  
Date: February 22, 2016  
RE: Quality Improvement Committee Report

**RECOMMENDATION:**

To accept the 2015 4<sup>th</sup> Quarter Quality Improvement Committee year-end report.



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



# Quality Improvement Committee Report

**4th Quarter 2015**

**C. Albert Reeves, MD, CMO**

[www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)

## HEDIS

### 2016 Status

- This year's HEDIS project has begun.
- It is on schedule and will be completed July 15 when our results are certified by NCQA.
- The measures remain the same as the previous year.

## Quality Improvement Projects

1. Diabetic Retinal Eye Exam Member Incentive – HEDIS
2. Cervical Cancer Screening – reminder letters – HEDIS
3. Children and Adolescents Access to Primary Care  
Providers Member Incentive – HEDIS
4. Postpartum Exam Member Incentive – HEDIS
5. Medication Management in People on Persistent  
Medications – HEDIS
6. Focus Groups – CAHPS Satisfaction Improvement

## Focus Group Survey

The CAHPS Surveys done in 2013 and 2014 indicated the areas for improvement as:

- Getting Needed Care
- Getting Care Quickly
- Customer Service

The QI Dept. developed a project to do focus groups with members to assess the experiences of the Plan's members in order to improve service and satisfaction.



Inclusion in the groups were:

- Adult members, 55 and under, over 55
  - Parents of child members
  - English speakers
  - Spanish speakers
- Group sessions were offered in English and Spanish, day time and evening and on the week-end.
- \$100 Target Gift Cards were offered for attending.
- Members were invited through phone calls.
- 78 members committed to attend, 44 actually participated (27 English and 17 Spanish speakers).

## Results:

- Members do not know the difference between the Call Center and the Plan's Member Services.
- About 25% had problems with the Call Center: dropped calls, connection times, lack of follow-up, lack of training and knowledge.
- Problems with scheduling appointments: long wait times, no same day availability, trouble getting appointments with specialists.
- Over 50% said their expectations had been met and praised the Plan.

# California Performance

## Improvement Projects (PIP)

### PIP #1 – Immunizations for Two Year Olds

This was selected by GCHP because of the effectiveness of immunizations and our HEIDS rates have met the state requirement, the rates have been decreasing.

- PIP was approved by the DHCS
- Provider collaboration is required – Las Islas Clinic was selected because of high enrollment of children
- Four Modules in each PIP, each must be approved by DHCS – Modules 1 and 2 are submitted for approval

# California Performance Improvement Projects (PIP)

## **PIP #2 – SBIRT (Screening, Brief Intervention and Referral to Treatment)**

- No mandatory topics from DHCS.
- Quality Improvement Committee has selected increased compliance with members receiving SBIRT (Screening, Brief Intervention and Referral to Treatment). This was selected because of the identification of low compliance with this required effective service to lower hazardous use of alcohol.
- The PIP proposal has been submitted to DHCS.

# Quality Improvement Activities

## Facility Site Reviews – Initial and Interim

GCHP is required to monitor providers for the adequacy of their offices, physical access and medical records.

### Initial and Periodic FSRs with PARS Completed during the 4th Quarter 2015

Initial FSRs with PARS Completed	Periodic FSRs with PARS Completed	FSR(s) with CAPS	Number of CAPS closed	Total number FSR and PARS Completed
3	1	0	0	4

### Interim FSRs performed during 4th Quarter 2015

Total number of I-FSR	Total number of I-FSR approved	Total number of critical element CAPs served	Total number of critical element CAPS completed within 10 days.	Total number of critical element CAPS <u>not</u> completed within 10 days.
20	20	0	0	0

# Quality Improvement Activities

## Initial Health Assessment Monitoring

### Fourth Quarter 2015 IHA Medical Record Reviews:

Number of Initial Facility Site Reviews:	Number of Interim Facility Site Reviews:	Number Periodic Facility Site Reviews:	Number IHA MRRs Conducted:	Number of sites with no new members during audit period	Number of sites with passing IHA score above 80%	Number of sites with score below 80%
3	20	1	28	0	23	5

# Quality Improvement Activities

## Potential Quality Issues (PQI) Reviews

- 19 cases total to date (3rd Q)
- Cases referred from:
  - Associate Medical Director - 2
  - Health Services – 20
  - Health Education – 0
  - Grievance and Appeals – 9
  - Utilization Management – 5
  - Other - 2

# Quality Improvement Dashboard



**Quality Improvement**

**Legend:**  
**Green** = Met or exceeded Benchmark  
**Red** = Did not meet Benchmark

Measure	Description	Benchmark Source	Benchmark	2014*	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend 2014 - 2015 Q2	Interventions
Facility Site Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS site audit criteria met.	DHCS/ Title 22	80%	99%	81%	93%	94%		1 provider failed FSR, CAP completed, will be on 6 month monitoring
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%		
Medical Record Quality Audit (Medi-Cal) - Scoring	The overall percentage of applicable DHCS medical record audit criteria met.	DHCS/ Title 22	80%	96%	72%	86%	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%	50%	100%	100%		
Coordination of Care	The overall percentage of applicable DHCS Care criteria met as determined by medical record audits.	NA	Tracking	100%	76%	97%	98%		

\*2014 data available for Q2, Q3, and Q4 only. No Initial or Periodic FSRs or MRRs were required during 2014 Q1

## Grievance & Appeals

Grievance & Appeals										
Legend:										
Green = Met or Exceeded Goal										
Red = Did Not Meet Goal										
Measure	Description	Compliance Source	Benchmark	2014*	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend 2014 Q2 - 2015 Q2	Interventions	
Resolution Turnaround Times (TAT) Grievances	100% TAT within 30 calendar days	GCHP		81%	42%	70%	94%			
Post Service TAR Provider Appeals Processing Time - Resolution	The percentage of provider appeals processed within 30 business days from receipt.	GCHP		100%	100%	100%	100%			
Provider Grievances: Complaint, Appeal, or Inquiry	Timely resolution of provider grievances	GCHP		NA	16%	60%	93%			
Monitoring of Complaints	Member complaints are monitored at a minimum of every six months to assess for trends/outliers	GCHP	Monitoring	NA	100%	100%	100%			
*2014 data available for Q2, Q3 and Q4 only.										

**Pharmacy**

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

Measure	Description	Responsible Department	Compliance Source	Benchmark	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend 2015	Interventions
PA Accuracy	All prior authorization requests were decided in accordance with GCHP clinical criteria.	Pharmacy	DHCS Contract	100%	97.83%	97.75%	98.50%		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 Timeliness	All prior authorization requests were completed within 1 business day.	Pharmacy	DHCS Contract	100%	99.57%	100%	100%		
Appropriate Decision Language on PA	All denied prior authorization requests contained appropriate and specific rationale for the denial	Pharmacy	DHCS Contract	100%	94.93%	97.50%	99.70%		GCHP is reviewing the denial language that is sent out and making revisions to the pre-set language as needed; this is an annual exercise and will continue going forward. Existing interventions include a second review of the language for all spelling, punctuation and grammar checks.
Annual Review of all UM Criteria	The P&T committee must review all utilization management criteria at least annually.	Pharmacy	GCHP	Met	NA	NA	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		

**Utilization Management**

**Legend:**

**Green** = Met or Exceeded Benchmark

**Red** = Did Not Meet Benchmark

**Health Services  
UM Authorization Processing Time**

Measure	Description	Responsible Department	Benchmark Source	Benchmark	2014*	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend 2014 - 2015 Q2	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	NCOA; contract, Title 22	95%	96%	100%	98%	97%		
Turn around time for expedited prior authorization	Percentage of authorizations processed within 3 days of receiving the request	Health Services	NCOA; contract, Title 22	95%	NR	100%	99%	98%		
Turn around time for post service	Percentage of decisions made within 30 calendar days of receipt of request (NCOA, contract, Title 22)	Health Services	NCOA; contract, Title 22	95%	NR	98%	97%	95%		

\*2014 data available for Q3 and Q4 only.

**Delegation Oversight : Assessment of Delegated Quality Activities**

**Legend:**

**Green** = Met or Exceeded Benchmark

**Red** = Did Not Meet Benchmark

Measure	Description	Benchmark Source	Benchmark	2014	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend 2014 - 2015 Q2	Interventions
Delegation of UM	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 5; NCOA Standard UM 15	DHCS Contract	100% <sup>1</sup>	NA	100%	NA		
Delegation of CR	Number required & percentage of current delegates assessed	Exhibit A, Attachment 4; NCOA Standard CR 9	DHCS Contract 10-87128	100% <sup>2</sup>	100%	100%	NA		
Delegation of QI	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCOA Standard QI 12	DHCS Contract	100% <sup>3</sup>	NA	NA	NA		
Delegation of RR	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 4; NCOA Standard RR 7	DHCS Contract	100% <sup>4</sup>	NA	NA	NA		
Delegation of Claims	Number required & percentage of current delegates assessed	10-87128 Exhibit A, Attachment 8	DHCS Contract	100% <sup>5</sup>	100%	100%	100%		
<p><sup>1</sup>2014 data available for Q2 and Q3 only.</p> <p><sup>2</sup>2014 data available for Q1 only.</p> <p><sup>3</sup>2014 data available for Q3 and Q4 only.</p> <p><sup>4</sup>2014 data available for Q2, Q3 and Q4 only.</p>									

**Credentials**

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

Measure	Description	Benchmark Source	Benchmark	2014*	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend 2014 - 2015 Q2	Interventions
<b>Access Indicators</b>									
Monitoring of Medicare/Medicaid sanctions	An OIG query is performed on every provider at the time of initial and re-credentialing	DHCS/ Title 22	Standard met for 100% of files presented to CPRC	100%	100%	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	NA	100%	100%	100%		
Timeliness of provider notification of credentialing decisions	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 verifications	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	100%	100%	90%	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 transition 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 for Q3 and Q4	None for Q1	None for Q2	None for Q3		

**Credentials**

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

Measure	Description	Benchmark Source	Benchmark	2014*	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend 2014 - 2015 Q2	Interventions
<b>Service Indicators</b>									
Timeliness of processing of initial applications	Initial applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	100%	90%	90%	100%		
Timeliness of processing of re-credentialing applications	Recredentialing applications will be processed within 90 days	DHCS/ Title 22	Standard met for 90% of applications received	100%	90%	100%	100%		
<b>Quality Indicators (under NMC purview)</b>									
Timeliness of Physician Recredentialing	Percent of physicians recredentialled within 36 months of the last approval date	NCOA: CR Standards	Standard met for 90% of providers	90%	90%	90%	100%		
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	NCOA: CR Standards	Standard met for 90% of providers	100%	100%	90%	100%		
*2014 data available for Q3 and Q4 only.									

**Member Services**

<b>Legend:</b> <span style="color: green;">Green</span> = Met or Exceeded Goal <span style="color: red;">Red</span> = Did Not Meet Goal									
Measure	Description	Compliance Source	Benchmark	2014	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend * 2014 - 2015 Q2	Interventions
Call Center - Aggregate Average Speed of Answer (ASA)	Average Speed to Answer (in seconds)		<= 30 seconds	11.6	30.7	9.8	148.4		Significant staffing issues started in June and continued into August, resulting in the ASA not being met in July and August. Corrective plan was initiated by Xerox and SLAs were back within goal for September.
Call Center - Aggregate Abandonment Rate	Percentage of aggregate Abandoned calls to Call Center		<= 5%	0.58%	1.47	0.57	6.9		Significant staffing issues started in June and continued into August, resulting in the Abandonment Rate not being met in July and August. Corrective plan was initiated by Xerox and SLAs were back within goal for September.
Call Center - Aggregate Call Center Call Volume	Monitored to ensure adequate staffing and identification of systemic issues.			114,678	31,393	30,369	29,563		
*Quarterly Trend for "Call Center - Aggregate Call Center Call Volume" incorporates volumn counts for 2015 quarters only.									



**Network Operation QI Dashboard - Access and Availability**

Legend:								
Green = Met or Exceeded Benchmark								
Red = Did Not Meet Benchmark								
Measure	Description	Benchmark Source	Benchmark	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend 2015	Interventions
<b>Access to Network / Availability of Practitioners</b>								
# & 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	NA	NA	Met		New mapping software has been implemented
# & 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	NA	NA	Met		
Ratio of members to physicians	1:1200	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met	Met	Met		
Ratio of members to PCPs	1:2000	DHCS, Exhibit A, Attachment 6	Standard met for 100% of members	Met	Met	Met		
Acceptable driving times and/or distances to primary care sites	30 minutes or 10 miles of member's residence	DHCS, Exhibit A, Attachment 6	Standard met for minimum 95% of members	NA	NA	Met		

**Network Operation QI Dashboard - Access and Availability**

Network Operation QI Dashboard - Access and Availability									
Legend:									
Green = Met or Exceeded Benchmark									
Red = Did Not Meet Benchmark									
Measure	Description	Benchmark Source	Benchmark	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend 2015	Interventions	
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	NA	NA			
	After-hours machine messages or service staff is in threshold languages	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members	NA	NA	NA			
	After-hours answering machine message or service includes instructions to call 911 or go to ER in the event of an emergency	DHCS, Exhibit A, Attachment 9	Standard met for 100% of members	NA	NA	NA			
Time Elapsed Standards	Urgent Care appointments for services that do not require prior authorization: within 48 hours of the request for appointment	DHCS, Exhibit A, Attachment 9	Standards met for minimum of 90% of providers	NA	NA	NA			
	Non-urgent appointments for primary care: within 10 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA	NA	NA			
	Non-urgent appointments with specialist physicians: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA	NA	NA			
	Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment	DHCS, Exhibit A, Attachment 9		NA	NA	NA			

Network Operation QI Dashboard - Access and Availability									
Legend: Green = Met or Exceeded Benchmark Red = Did Not Meet Benchmark									
Measure	Description	Benchmark Source	Benchmark	2015 Q1	2015 Q2	2015 Q3	Quarterly Trend 2015	Interventions	
Appointment Availability	Availability of appointments within CenCal Health's standards by type of encounter	DHCS, § 7.5.4	Standards met for minimum of 95% of providers	NA	NA	NA			
Provider Surveys	Measure provider satisfaction	GCHP	Satisfaction expressed in each of 6 areas for 80% of providers	NA	NA	Not Met		Preliminary findings show that providers are not satisfied with GCHP overall but we are still analyzing the data given to get more detail.	
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	Met			
Provider Visits	Number of Provider Services Representative provider visits	GCHP	Department goal = 100/quarter (400/year)	Met	Not Met	Not Met		Q3 was our busiest quarter in relation to projects. We did not meet this standard due to ICD10 implementation. Expectation is that going forward, we are back to green.	23

### Clinical Practice & Preventative Health Guidelines

**Legend:**

**Green** = Met or Exceeded Benchmark

**Red** = Did Not Meet Benchmark

Measure	Description	Responsible Department	Compliance Source	Benchmark	2014	2015
<b>Clinical Practice</b>						
Clinical Practice Guideline Adoption	Development and/or adoption of non-preventive clinical practice guidelines for the provision of acute and chronic medical services every two years.	ACMO	DHCS/ Title 22	Approval by Committee		Approved by MAC 1/29/2015
Clinical Practice Guideline Distribution	Distribution of non-preventive clinical practice guidelines for the provision of acute and chronic medical services to applicable practitioners every two years.	ACMO	DHCS/ Title 22	Distribution to Applicable Providers		Distributed to MAC 7/30/2015
<b>Preventive Services</b>						
Preventive Services Guideline Adoption	Development and/or adoption of preventive guidelines every two years.	Health Education	DHCS/ Title 22	Approval by Committee	Approved by MAC 7/24/2014	Approved by MAC 7/30/2015
Preventive Services Guideline Distribution	Distribution of preventive guidelines every two years.	Health Education	DHCS/ Title 22	Distribution to Applicable Providers		Distributed to MAC 7/30/2015

# Pharmacy and Therapeutics

## Pharmacy Benefit Manager (PBM) Oversight

Prior Authorization Statistics:

	Requests	Approved	Denied	Appeals Received	Overturned	Upheld
August 2015	1560	1303	257	19	15	4
September 2015	1642	1402	240	74	49	25
October 2015	1717	1425	292	19	18	1

Reviewed 100% of denials and 10% of approvals

- 98.5% appropriate decision
- 99.5% timely decision
- 99.7% appropriate denial language

# Pharmacy and Therapeutics

## Newly Approved Drugs and Formulary Management

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

- 9 New Drugs Reviewed
  - 5 approved, 3 were not approved, 1 pended to future date (All require a PA and have a significant clinical advantage)
- 7 Existing Drugs with new Dosage Forms Reviewed
  - 1 was approved
- 5 brand name drugs were removed due to new generics now available
  - 15 over-the-counter drugs were added per DHCS requirement

## Credentials/Peer Review

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

- The Credentialing Office continues to monitor providers for their Medical Board status.
- Provider whose license suspension case has pending for over 2 years has been given a public reprimand.
- The 2 other providers included in my last report continue to be monitored.

## Credentials/Peer Review

### Peer Review Referral

- 1 Highly rated PQI case resulted in a letter to the provider was presented.
- Case 1 – a diabetic member had a medication change that was inappropriate and resulted in illness and hospitalization. A letter to the medical director has resulted in required education of the provider and a review of supervisions of allied health professionals.



## Credentials/Peer Review

### Committee Actions

- Recredentialed - 0 providers
- Newly credentialed - 22 providers
- 1 applicant was denied credentialing due to a lack of board certification
- Credentialed - 8 facilities

# Medical Advisory

## Approved Health Plan Policies

- Custodial Care Guidelines
- Acute Inpatient Rehabilitation Guidelines
- Home Health Guideline
- Intravenous Sedation and General Anesthesia for Dental Services Guideline and Policy
  - Approved new policy that provides clear guidelines for the provider to use the least invasive procedure possible before moving to the next type of sedation.
- Zostavax Guideline - retired

## Cultural and Linguistics -3<sup>rd</sup> Quarter

### Requests for language interpreters – 748

- Requests from Staff – 596
- Requests from Providers – 152
- Increase of 200% from 2014

### Staff Bilingual Fluency Testing

- 6 new assessments
- 5 reassessments

### Sign Language Interpreter Requests – 42

- 35 fulfilled
- 6 unfulfilled
- 1 cancelled

(Almost 18% were not fulfilled – looking for additional capacity to provide this service).

# Grievance and Appeals

## Grievances Received – 3<sup>rd</sup> Quarter

Total Grievances – 274

- Administrative Grievances – 250
  - Billing – 3 (going forward this will be removed as a grievance)
  - Provider Disputes – 245
  - Quality of Service – 2
  - Clinical Grievances – 24
  - Quality of Care – 19
  - Accessibility – 4
  - Denials/Refusals (clinical appeals) – 1

## Grievance for Quality of Care (QOC)

Total Quality of Care (QOC) Grievances: 19

- Delay in care – 12
- Inappropriate provider care – 5
- Poor provider/staff attitude – 1
- Inappropriate care – 1

Accessibility: 4

- Lack of specialist availability – 2
- Transportation Issues – 2

2 QOC Grievances were referred to quality as PQI's and were reviewed and investigated.

State Fair Hearings: 1 (approved)

## Member Services

### Call Center Statistics – 3rd Quarter

- Average Calls per Month – 9,854
- Average Speed to Answer (less than 30 sec)
  - Non-compliant in July and August due to staff loss
- Abandonment Rate (less than 5%)
  - Non-compliant in July and August

The metrics were not met in July and August due to staff turn-over.

## Health Services

### Quality Improvement Projects

- California Children’s Services (CCS)/GCHP – Kaizen project of correct identification of PCP as members age out of CCS.
- Discharge Planning –Transitions of Care using MCG post-hospitalization transition needs assessment.
- Public Health and GCHP – collaboration on targeted care management.
- GCHP and CHDP collaboration to increase fluoride varnish application to children’s teeth.

## Care Management

The care management case load has increased significantly recently as a result of the Plan's Contract for Seniors and Persons with Disabilities (SPD) becoming effective August 25, 2015.

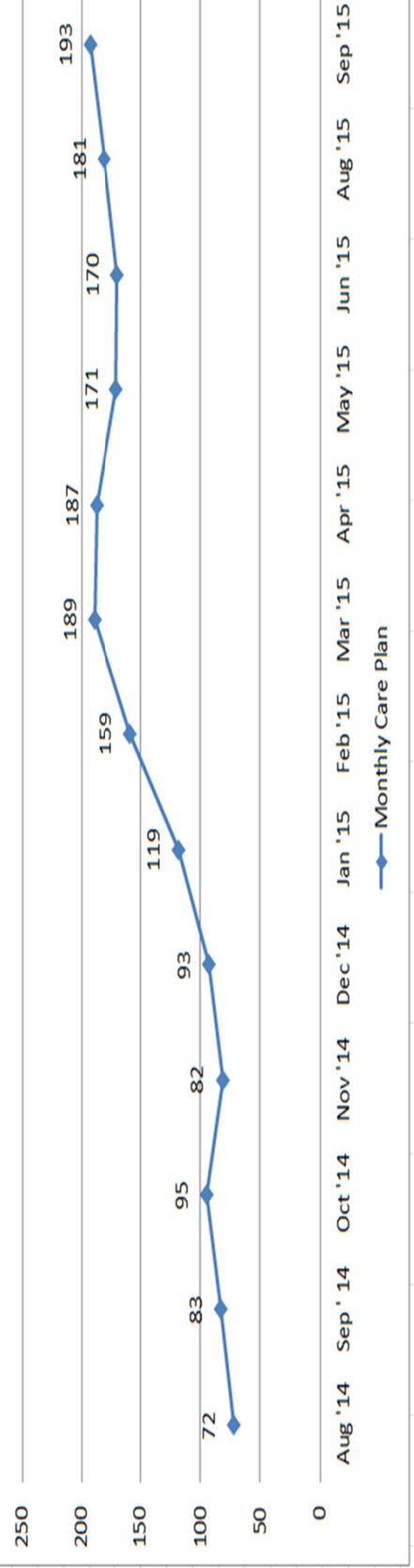
- 65 to 75 new SPD members per month
- Care Management must attempt to make contact with these new members and complete a comprehensive risk assessment survey and develop a care plan



# Care Management

2015	referrals received	Care Management	Social Worker	SPD	Other program type
		# CM referrals	# SW referrals	# of SPD referrals	
January	244	202	42		
February	297	254	43		
March	290	248	42		
April	281	245	36		
May	320	218	32	70	
June	362	245	47	70	
July	370	252	50	68	
August	289	189	35	65	
September	276	170	30	75	1
October					
November					
December					
<b>TOTAL</b>	<b>2729</b>	<b>2023</b>	<b>357</b>	<b>348</b>	

Monthly Average Care Plan



# Compliance - Delegation Oversight

All planned and required oversight audits through November 2015 have been completed.

Table 1: Audit Timeline<sup>1</sup>

Delegates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
<b>Claims</b>									Annual			
1 Specialty			6 Mo.							Annual		
2 Vision											Annual	
3 MBHO				6 Mo.								
4 Kaiser (TBD)												
<b>UM</b>												
1 Specialty						Annual						
2 MBHO											Annual	
3 NEMT												
<b>QI</b>												
1 Vision										Annual		
2 MBHO											Annual	
<b>RR</b>												
1 Vision										Annual		
2 MBHO											Annual	
<b>NEMT</b>												
1 NEMT		Complaint					6 Mo.					Annual
<b>Credentialing</b>												
1 VCMC	Annual											
2 CDCR	Annual											
3 CMH	Annual											
	<b>Legend</b>											
	Completed	In Progress	Projected									

Updated activities for the 3<sup>rd</sup> and 4<sup>th</sup> quarters were reported to the Quality Improvement Committee – those reports have been reported to the Commission in the Compliance Report.

## **AGENDA ITEM NO. 6**

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: February 22, 2016

Re: Administrative Services Organization (ASO) Consultant

### **SUMMARY:**

In August 2015, Gold Coast Health Plan (GCHP or Plan) released a Request for Proposal (RFP) for Administrative Services Organization (ASO) Consulting Services to select a vendor to assist the Plan with the evaluation of the existing ASO arrangement. Three vendors responded affirmatively to the RFP. It is the Plan's recommendation to move forward with Optimity Advisors (Optimity) as the vendor of choice and requests approval for the Chief Executive Officer (CEO) to enter into an agreement with Optimity to assist with GCHP's ASO evaluation.

### **BACKGROUND / DISCUSSION:**

Gold Coast Health Plan entered into contracts with ACS Health Administration, Inc. (ACS / Xerox) and Script Care, Ltd., (SCL) prior to Plan go-live on July 1, 2011. ACS / Xerox functions as the Plan's Administrative Services Organization (ASO), performing services such as claims processing and call center activities; SCL functions as the Plan's Pharmacy Benefits Manager (PBM). The initial five (5) year contracts for both vendors terminate June 30, 2016.

Conducting dual RFP processes, awarding contracts and the potential of two (2) new vendor implementations occurring simultaneously introduced significant financial, operational, business process and resource capacity risk to the Plan. In November 2014, staff recommended and received Commission approval to extend the contract with ACS / Xerox for a period of one (1) year, commencing July 1, 2016, with an option for two additional yearly renewals and to send the PBM contract out to bid. Staff also committed to evaluate the existing ASO arrangement to determine if administrative services should continue to be outsourced, brought in-house or some combination of the two. Based on the scope and complexity of the current ACS / Xerox contract, the Plan requires outside consulting services to assist with the evaluation.

The ASO contract is a strategic arrangement supporting Plan administrative operations. Under the ASO arrangement, ACS / Xerox provides core administrative functions on behalf of the Plan. These functions include:

- Claims Processing – Mailroom, Scanning / Optical Character Recognition (OCR), Electronic Data Interchange (EDI), Workflow automation / Contact tracking, System configuration, Claim adjudication, Claim Adjustments, Claim dispute resolution, Claim payment recovery (through Xerox Recovery Services)
- Call Center – Member and provider calls
- Fulfillment – Member materials (Member Handbook, ID cards, Provider Directory, Ad hoc mailings)
- Encounter Data Submission to DHCS
- Standard and Ad Hoc Reporting
- Systems Support and Configuration (Core Administration Processing System (IKA), IVR, ACD, Scanning & Workflow, Provider Portal, Contact Tracking)
- Staffing to support all services

The Scope of Work to be completed by Optimity includes:

- Lead an assessment of GCHP's current ASO vendor to determine if current performance is in line with contract terms
  - Review current contract for gaps and perform a risk analysis
  - Compare vendor performance to industry benchmarks and leading practice metrics
- Provide GCHP with insight into third party vendors that provide technology and/or ASO offerings for managed care entities (Medicaid, Medicare, dual eligibles)
- Meet with internal GCHP stakeholders to gather concerns around current performance issues and future-state opportunities for inclusion in future vended or internal administrative systems
- Synthesize all research, analysis and findings into a cohesive vendor assessment report
- Create a recommendation(s) document that supports the path-forward decision to continue current vended arrangements or move to a partial/full internalization of operations functions
- Manage future RFP process(es) including development of RFP documents and draft contract(s)

### **FISCAL IMPACT:**

The Plan is still negotiating final contract terms with the selected vendor, Optimity. The work is expected to commence in FY 2015-16 and be completed in FY 2016-17, spreading the cost of the engagement over two budget years. The FY 2015-16 budget has \$250,000 allocated for these consulting services, allowing for GCHP to begin the evaluation once the contract is fully executed. Staff estimates the total Plan impact to be between \$300,000 and \$375,000 this estimate includes consultant travel expenses. All travel expenses will be approved by GCHP and will adhere to the Plan's travel policy.

**RECOMMENDATION:**

Subject to review by legal counsel, authorize and direct the Chief Executive Officer to execute an agreement with the selected ASO Consulting Services vendor, Optimity.

**CONCURRENCE:**

None

**ATTACHMENTS:**

None

## **AGENDA ITEM NO. 7**

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: February 22, 2016

Re: 711 Daily Drive Community Room Construction Contract

### **SUMMARY:**

On October 29, 2015 at a Special Meeting the Commission approved the Plan's recommendation for space expansion to 770 Paseo Camarillo. This expansion plan also included the buildout of a large meeting room on the first floor at the Plan's current location at 711 E. Daily Drive in Camarillo. On January 21, 2016, GCHP issued a formal Request For Proposal (RFP) to three landlord approved and recommended construction contractors. GCHP received one responsive proposal on the required due date of February 4, 2016 and is recommending the award to this responsive bidder, Staples Construction Company, Inc. (Staples)

Staff proposes furnishing this meeting room for 100 occupants will be done through BKM Office Environments. BKM is a local, contracted, preferred supplier chosen through a competitive bid process using a pre-negotiated contract rate as approved in the January 25, 2016 Commission Meeting.

### **BACKGROUND / DISCUSSION:**

Significant membership growth and additional regulatory requirements has driven increased staffing to meet service demands. As a result, Gold Coast Health Plan's (GCHP's) existing office space has reached full capacity. On October 29, 2015 at a Special Meeting the Commission approved the Plan's recommendation to lease and build out an expansion space at 770 Paseo Camarillo. This project also included a phase 2 initiative for construction of a large meeting room at the Plan's current location on Daily Drive.

The first phase of the project is nearing completion with a projected move-in date of April 18, 2016. The relocation of 55 staff members to the expansion location will free up space allowing GCHP to move forward with phase 2 of its expansion project. This phase entails constructing and furnishing a large meeting room on the ground floor of the Plan's current location at 711 Daily Drive. This large meeting room will be used for Commission meetings, staff training, staff meetings and community events.

## **FISCAL IMPACT:**

The Plan is still negotiating final contract terms with the selected vendor, Staples Construction Company, Inc. The work is expected to commence in April, 2016 and be completed before the end of the fiscal year on June 30, 2016. Costs for this project are included in the FY15-16 budget approved by the Commission on June 22, 2015 and total \$298,000.00. Total costs for Phase 2 are inclusive of:

- Fixed bid construction contract from Staples - \$203,000
- 10% contingency factor - \$20,000
- Furniture allowance - \$75,000

## **RECOMMENDATION:**

Subject to review by legal counsel, authorize and direct the Chief Executive Officer to execute an agreement with Staples Construction Company, Inc.

Staff also recommends an additional spend of \$75,000 with BKM Office Environments, to furnish the meeting room at 711 E Daily Drive.

## **CONCURRENCE:**

None

## **Attachments:**

None



**AGENDA ITEM NO. 8**

To: Gold Coast Health Plan Commission

From: Scott Campbell, General Counsel

Date: February 22, 2016

Re: Closed Session

**Discussion Involving Trade Secrets**

Pursuant to Government Code Section 54956.87

Discussion will Concern: Rates of payment for health care services provided by pharmacy benefits providers.

Estimated Date for Public Disclosure of Decision on Rates and Award of Contract:  
February 2016.





## **AGENDA ITEM NO. 9**

To: Ventura County Medi-Cal Managed Care Commission  
From: Anne Freese, PharmD, Director of Pharmacy  
Date: February 22, 2016  
RE: PBM RFP Award Recommendation

### **SUMMARY:**

Gold Coast Health Plan (GCHP or the Plan) contracts with a Pharmacy Benefits Manager (PBM) in order to provide pharmacy benefit services to its members. The contract with the current PBM, Script Care LTD. (SCL), terminates on September 30, 2016. GCHP began an RFP process on November 6, 2015 to select a PBM for the next contract term.

GCHP received responses from ten PBMs. The PBMs were assessed for their ability to meet the RFP requirements, meet minimum qualifications, the quality of their responses, ability to accept GCHP contract terms and pricing. Three finalists were selected and interviewed by Plan staff. At this time, Plan staff is making a recommendation on final selection.

### **BACKGROUND:**

SCL was selected as the PBM for GCHP in 2010 for an initial 5 year term beginning on the plan go live date. SCL provides a full suite of PBM services including prescription claim adjudication, pharmacy network access, and utilization management (UM) services for GCHP. In the best interest of the Plan, GCHP conducted an RFP process to select the best business partner moving forward.

For the past four months, GCHP has conducted a detailed and thorough selection process for a PBM, with a potential implementation date of October 1, 2016, if a new PBM is selected.

### **DISCUSSION:**

The Plan's goal is to select a PBM that shares GCHP's philosophy and will work collaboratively to continuously improve our members' customer service experience, health status and cost-effective solutions related to pharmacy benefits. Further, GCHP is seeking a PBM with industry best practices, is knowledgeable in the landscape of Medicaid and Medicare pharmacy benefits, and has the clinical and quality initiatives to allow GCHP to further realize positive member health outcomes while maintaining fiscal responsibility.

GCHP's Chief Medical Officer, Assistant Chief Medical Officer and Director of Pharmacy made up the core selection team and subject matter expertise was provided from all of the following departments: compliance, finance, information technology, information security and operations.

The selection team, through the RFP process, identified three finalists: Magellan Rx Management, Inc. (MRx), OptumRx, and SCL. All three finalists were brought in for interviews with the selection team. Based upon the interviews and their RFP responses, the 3 finalists were given one final opportunity to review their bids and provide a best and final offer (BAFO).

Each vendor was assessed in 3 major areas: technical questions, contract terms and conditions and statement of work review, and pricing. The technical questions were divided into 14 sections.

Anne Freese will provide a powerpoint presentation showing the ranking of each finalist for all sections assessed using a ranking system of 1-2-3 with number 1 being the best. The highest rank in each section is highlighted in yellow for ease of identification.

#### **FISCAL IMPACT:**

Through the RFP process, GCHP assessed the vendors on the following financial areas: pricing (overall drug price and administrative fees), performance guarantees, and maximum allowable costs (MAC) for generic drugs.

Although overall drug pricing and administrative fees are integral to the ability of the plan to be responsible fiscal stewards, generic drug pricing is reviewed on an annual basis by the California Department of Health Care Services (DHCS) and the plan receives a penalty in the form of reduced pharmacy rates by an equal percentage of what DHCS considers to be an overpayment. By assigning points specifically to each vendor on the health and ability of the vendor to reduce generic pricing, this puts GCHP in the most favorable position for future DHCS efficiency reviews.

#### **RECOMMENDATION:**

Magellan Rx Management, Inc. is the preferred vendor, scoring highest in 14 out of 18 sections of the RFP and offered the most favorable pricing terms to GCHP in the form of the lowest all-inclusive administrative fee, lowest overall pricing and most favorable MAC drug pricing. This represents a vendor that most closely matches its business practices with the needs of GCHP in order to ensure that there is transparency and accountability within the services offered to GCHP.

It is the Plan Staff's recommendation to move forward with MRx as the vendor of choice. Staff is asking for the Ventura County Medi-Cal Managed Care Commission to approve the finalist selection.



# Gold Coast Health Plan

## PBM RFP Finalists Ranking Comparison

Anne Freese, PharmD, Director of Pharmacy

[www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)



# Capability Review

[www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)

# Section Rankings

	Script Care	OptumRx	MagellanRx
<b>General</b>	2	3	1
<b>Definition of Discounts</b>	2	3	1
<b>Rebates</b>	1	2	1
<b>Formulary</b>	3	2	1
<b>Account Management and Imp.</b>	2	3	1
<b>Auditing And Quality Assurance</b>	3	2	1
<b>Coverage and Contractual Issues</b>	2	3	1
<b>Network Access Details</b>	2	2	1

# Section Rankings

	Script Care	OptumRx	MagellanRx
Eligibility	2	3	1
System and Support	2	3	1
Data Reporting	1	2	2
Member Services	2	1	1
Specialty Pharmacy	3	2	1
Drug Utilization Review	3	1	2
Review of Contract Terms and Conditions and Statement of Work	1	2	2



# Pricing Review

[www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)

# Pricing Rankings

	Script Care	OptumRx	MagellanRx
Pricing	3	2	1
MAC Analysis	2	2	1
Performance Guarantees	1	2	2





## **AGENDA ITEM NO. 10**

To: Gold Coast Health Plan Commission  
From: Dale Villani, Chief Executive Officer  
Date: February 22, 2016  
RE: CEO Update

### **Ventura County Medi-Cal Managed Care Commission Changes**

Gold Coast Health Plan (GCHP) expresses our sincere appreciation to Mr. David Glycer, Chief Financial Officer, Community Memorial Health System, for his role as Commissioner since his initial appointment in March 2012. Mr. Glycer's term ends in March 2016 and the Hospital Association of Southern California has nominated Jennifer Swenson, President and CEO of Simi Valley Hospital as his replacement. The Ventura County Board of Supervisors are scheduled to approve Ms. Swenson's nomination to the Commission at their March 8 meeting. Mr. Glycer's dedication and commitment to the GCHP and the Medi-Cal beneficiaries of Ventura County are noteworthy. We wish him continued success.

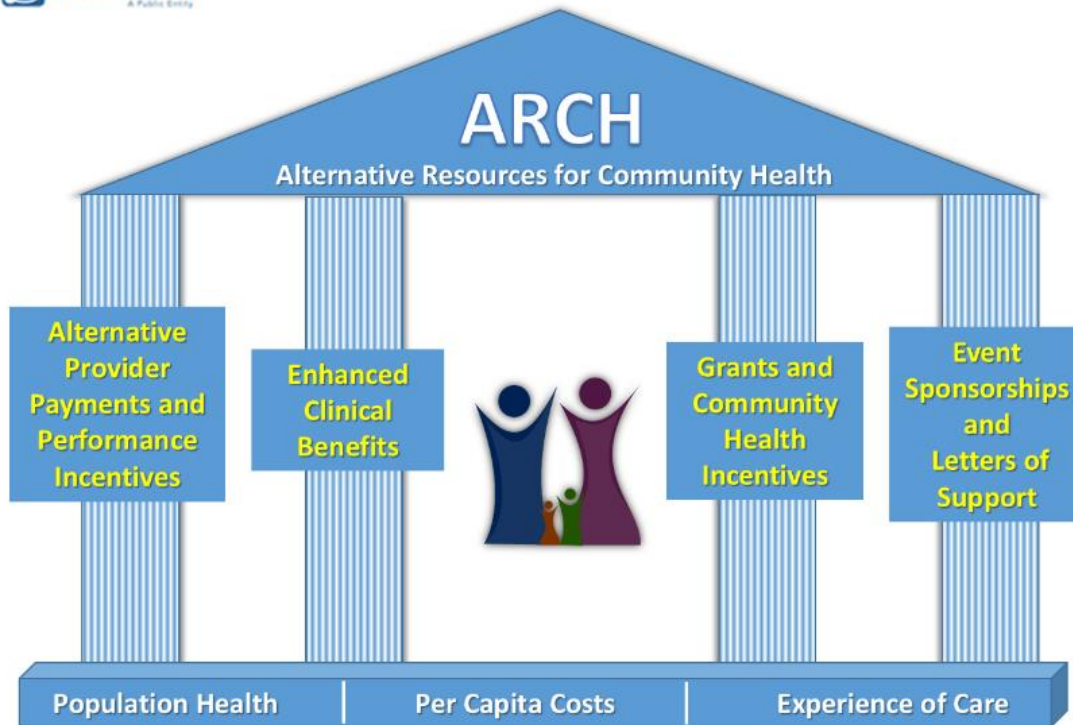
### **Employee Survey**

The Plan has received the final results for the 2015 Employee Survey. The survey was conducted by an independent research firm called Amplitude Research. Of the 177 employees, responses were provided by 132 employees for a completion rate of 75%. While we are still reviewing the full survey results, the initial findings are very positive with over 81% of employees Satisfied or Very Satisfied with their job. Over 56% of employees "Definitely Would" recommend working at Gold Coast Health Plan to a friend. We will bring a detailed presentation of the full findings to the March 28 Commission.

### **Alternative Resources for Community Health (ARCH)**

The Plan is enhancing investments in the Ventura health care and social services community through a new initiative known as Alternative Resources for Community Health (ARCH). The program builds upon the foundation of the Triple Aim (Improved Population Health, Lower Per Capita Costs, and an Improved Experience of Care). The four pillars of ARCH are: 1) Alternative reimbursement models and incentives to providers with the goal of improving population health; 2) Enhanced clinical services, based on evidence based medicine, and not typically reimbursed by Medi-Cal; 3) investing in community initiatives which improve health care or access to care for Medi-Cal and community members, and; 4) Sponsoring events and

activities which benefit the Ventura County community. The Plan will invest and allocate dollars annually towards this initiative.



**GOVERNMENT RELATIONS UPDATE:**

**Legislative Advocacy in Washington, DC**

On February 9 and 10, Gold Coast Health Plan’s (GCHP) Chief Operations Officer and Manager of Government and External Relations participated in the Association of Community Affiliated Plans’ (ACAP) Legislative Advocacy “Fly-In”. This event is held annually to allow ACAP member plans to meet with Members of Congress and their staff to discuss federal legislation and policies that impact the Medicaid/Medi-Cal program. GCHP staff met with health legislative aides for the offices of Senators Barbara Boxer and Dianne Feinstein as well as Representatives Lois Capps and Julia Brownley.

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 CMS. Topics discussed were integration of mental and physical health, long term care, and continued oversight of the Medicaid program.

## Managed Care Organization (MCO) Tax

On Tuesday, February 8, Senator Hernandez introduced Senate Bill 2X-15 regarding the Medi-Cal Managed Care Organization Tax. The bill would impose a three year MCO tax on health plans with different taxing tiers based on enrollment. SB 2X-15 would also reduce the amount of the Corporate and Gross Premium taxes that certain health plans are required to pay for three years.

The taxing tiers are based on Medi-Cal enrollment, non-Medi-Cal enrollment and a special tier for Kaiser (see below). The tax would generate a total of \$1.3 billion dollars and \$1.1 billion would be used to fund the Medi-Cal program.

<b>Medi-Cal</b>	<b>Cumulative Enrollment</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>
<b>Tier 1</b>	0-2 million	\$40	\$42.50	\$45
<b>Tier 2</b>	2-4 million	\$19	\$20.25	\$21
<b>Tier 3</b>	4 million +	\$1	\$1	\$1
<b>Other</b>		<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>
<b>Tier 1</b>	0-4 million	\$7.50	\$8	\$8.50
<b>Tier 2</b>	4-8 million	\$2.50	\$3	\$3.50
<b>Tier 3</b>	8 million +	\$1	\$1	\$1
<b>AHCSP (Kaiser)</b>		<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>
<b>Tier 1</b>	0-8 million	\$2	\$2.25	\$2.50

Under this model, GCHP would be taxed under tier one of the Medi-Cal program tiers. The proposed MCO tax will not have a negative impact on GCHP.

The California Association of Health Plans (CAHP) and the Local Health Plans of California (LHPC) are in support of the tax. The local health plans believe that the Department of Health Care Services (DHCS) has devised a new MCO tax model that is fair and meets federal requirements.

In order to implement the MCO tax a two-thirds vote in the Legislature is needed. Additionally, DHCS will need to seek approval from the Centers for Medicare and Medicaid to implement the MCO tax.

## Introduced Legislation Related to Medi-Cal

Below is a list of Medi-Cal related bills that have been introduced in the current legislative

**AB 1696** **Medi-Cal: Tobacco Cessation Services Summary:** AB 1696 would require tobacco cessation services to include all intervention recommendations, as

periodically updated, assigned a grade A or B by the United States Preventive Services Task Force, and, at a minimum, 4 quit attempts per year. The bill would also require, tobacco cessation services to include at least 4 counseling sessions per quit attempt and a 12-week treatment regimen of any medication approved by the federal Food and Drug Administration for tobacco cessation.

**AB 1795**     **Health Care Programs: Cancer**

**Summary:** AB 1795 would delete the existing definition for “period of coverage” and mandate that cancer treatment services be for the duration of treatment for an individual diagnosed with breast cancer or cervical cancer, or who is diagnosed with a reoccurrence of breast cancer or cervical cancer, as long as the individual continues to meet all other eligibility requirements. The bill would require the department to provide breast cancer screening and diagnostic services to individuals of any age who are symptomatic and to individuals who are 40 years of age or older, who meet the other eligibility requirements.

**AB 1831**     **Health Care Coverage: Prescription Drugs: Refills**

**Summary:** AB 1831 would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, that provides coverage for prescription drug benefits to allow for early refills of covered topical ophthalmic products at 70% of the predicted days of use.

**ABX2-20**     **Medi-Cal: Managed Care Organization Tax**

**Summary:** ABX2-20 would impose a three year MCO tax on health plans with different taxing tiers based on enrollment.

**SB 960**     **Medi-Cal: telehealth: reproductive health care**

**Summary:** SB 960 would allow that, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for "reproductive health care provided by store and forward." The bill would define that term to mean an asynchronous transmission of medical information to be reviewed at a later time by a physician, nurse practitioner, certified nurse midwife, licensed midwife, physician assistant, or registered nurse at a distant site, where the provider at the distant site reviews the medical information without the patient being present in real time, as defined and as specified.

**SBX2-15**     **Medi-Cal: Managed Care Organization Tax**

**Summary:** SBX2-15 would impose a three year MCO tax on health plans with different taxing tiers based on enrollment.

**RECOMMENDATION:**

To accept the report as presented by CEO Villani.



**AGENDA ITEM NO. 11**

To: Gold Coast Health Plan Commissioners  
From: Brandy Armenta, Compliance Officer / Director  
Date: February 22, 2016  
Re: Compliance Update

Gold Coast Health Plan (GCHP) had auditors from Audits & Investigations (A&I) a division within the Department of Health Care Services (DHCS) onsite from February 17- February 25 2015. The purpose of the onsite audit is to perform the annual medical audit which includes but is not limited to: interviewing staff & providers, file reviews and evaluating plan policies & processes. The review period of the audit was December 1, 2013 through November 30, 2014. The Plan is working with DHCS on deficiencies identified in the draft report and the final report is slated to be released at a future date.

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

Compliance continues to monitor and ensure all employees and temporary employees are trained and retrained on HIPAA and Fraud, Waste & Abuse. Compliance staff has revised and created new HIPAA privacy policies and procedures. Compliance staff has developed a comprehensive privacy program. A privacy work plan is in the process of being implemented for 2016, and staff is working on all facets of the work plan to ensure goals are achieved.

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. With the transition of ABA services on February 1, 2016 additional weekly and daily reporting has been required.

GCHP compliance committee continues to meet in accordance with the compliance committee charter. The delegate who was under a corrective action plan and financial sanction withhold was lifted in January 2016. The delegate continues to be monitored closely however has met the requirements outlined in the CAP. The committee reviewed the 2016 delegation audit schedule which also includes internal departments. The committee reviewed the annual report on the delegate's contractual reporting obligations. Compliance staff monitors contractual reporting from delegates and issues letters of non-compliance when the report is: not received, information is omitted and or if inaccurate data is provided. The committee also reviewed the

scores from the last internal HIPAA privacy desk audit conducted at the Plan by compliance staff.

The Plan is required to conduct oversight audits on functions which the Plan delegates. Below is a grid which outlines recent delegation oversight audit activities:

<b>Delegate</b>	<b>Onsite Audit (Clinical)</b>	<b>CAP Issued (Clinical)</b>	<b>CAP Closed (Clinical)</b>	<b>Onsite Audit (Non-Clinical)</b>	<b>CAP Issued (Non-Clinical)</b>	<b>CAP Closed (Non-Clinical)</b>
<i>Vision</i>	10/19-10/21 2015	11/20/2015	01/08/2016	10/19-10/21 2015	11/10/2015	CAP #2 Response Due 02/29/2016
<i>NEMT</i>				12/01-12/04 2015	12/14/2015	01/04/2016
<i>MBHO</i>	11/16-11/18 2015	12/23/2015	CAP response received 01/13/2016 <b>Pending Closure</b>	11/16-11/18 2015	12/04/2015	01/22/2016
<i>Specialty Contract</i>	06/09-6/10 2015	07/13 2015	11/13 2015	09/28-09/29 2015	10/06/2015	10/26/2015
<i>ASO</i>	N/A	N/A	N/A	01/06-01/08 2016	01/20/2016	CAP response due 03/02/2016

The Plan currently delegates credentialing to three entities: Ventura County Medical Center (VCMC), Clinicas del Camino Real (CDCR), and Community Memorial Health System (CMH).

<b>Credentialing</b>	<b>VCMC</b>	<b>CDCR</b>	<b>CMH</b>
<b>Onsite Audit</b>	January 29, 2016	January 27, 2016	January 25, 2016
<b>CAP Issued</b>	N/A	N/A	January 23, 2016
<b>CAP Closed</b>	N/A *Close out letter sent February 3, 2016	N/A *Close out letter sent February 10, 2016	Open

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
<b>Hotline</b> A confidential telephone and web-based process to collect information compliance, ethics, and FWA	9												9
<b>Hotline Referral *FWA</b>	0												0
<b>Hotline Referral *FWA</b>	0												0
<b>Hotline Referral</b>	9												9
<b>Hotline Referral</b>	0												0
<b>Hotline Referral</b>	0												0
<b>Delegation Oversight</b> 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	8												8
	62												62
	4												4
<b>Delegation Oversight</b>	0												0
<b>Delegation Oversight</b>	2												2
<b>Audits</b> External regulatory entities evaluate GCHP compliance with contractual obligations.	0												0
	0												0
	0												0
	0												0
	0												0
	0												0
<b>Fraud, Waste &amp; Abuse</b> 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.	9												9
	0												0
	9												9
	0												0
	0												0
<b>HIPAA</b>	1												1

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	1												1
	0												0
	0												0
	0												0
<b>Training Sessions</b>													
Staff are informed of the GCHIP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	20												20
	6												6
	6												6
	2												2
	6												6
<b>Code of Conduct</b>													
<b>HIPAA (Individual Training)</b>													
<b>HIPAA (Department Training)</b>													
	0												0

\*\* Reporting Requirements are defined by functions delegated and contract terms. Revised contracts, amendments or new requirements from 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.





**AGENDA ITEM NO. 12**

To: Gold Coast Health Plan Commission  
From: C. Albert Reeves, Chief Medical Officer  
Date: February 22, 2016  
RE: CMO Update

**RECOMMENDATION:**

There is no reportable action for the CMO Update.

**AGENDA ITEM NO. 13**

To: Gold Coast Health Plan Commission  
 From: Nancy Wharfield, Associate CMO  
 Date: February 22, 2016  
 RE: Health Services 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 YTD 2015 are slightly improved compared with CY 2014. Emergency Department (ED) utilization / 1000 members is essentially unchanged (459 ER visits / 1000 members) compared to CY 2014 (463 visits / 1000 members).

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.

<b>Utilization Per 1000</b>		
	<b>2014</b>	<b>2015 YTD (Jan – Oct)</b>
<b>Inpatient</b>		
Bed days/1000	225	207
Admits/1000	51	49
Average LOS	4.4	4.3
<b>ED Utilization</b>		
ED Cases / 1000	463	459

\* Data from MedInsight 1/29/16. Data excludes Duals, LTC and SNF.

Total Volume		
	2014 Total	2015 YTD (Jan – Oct)
<b>Inpatient</b>		
Bed days	30,474	29,129
Admissions	6,926	6,856
<b>ED Utilization</b>		
ED Cases	62,828	64,398

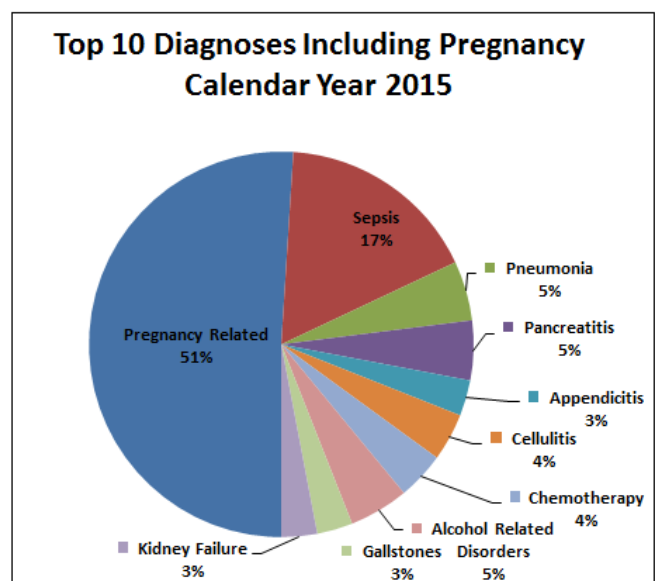
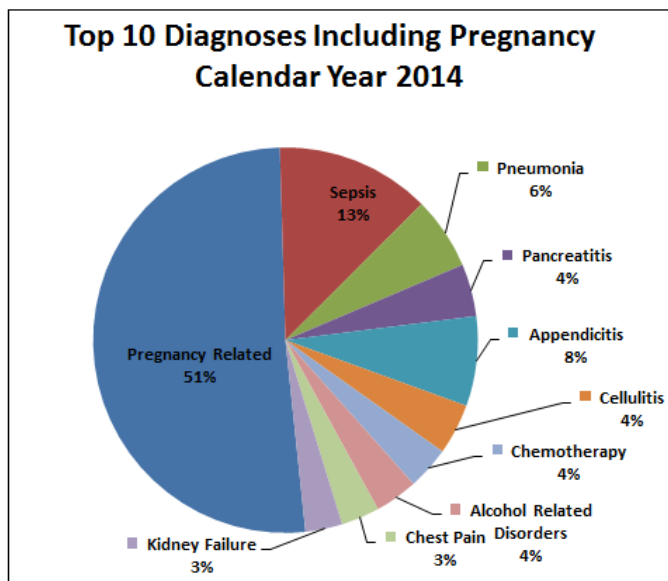
\* Data from MedInsight 1/29/16. Data excludes Duals, LTC and SNF.

Monthly Averages		
	2014	2015 YTD (Jan – Oct)
<b>Inpatient</b>		
Bed days	2,540	2,913
Admissions	577	686
<b>ED Utilization</b>		
ED Cases	5,236	6,440

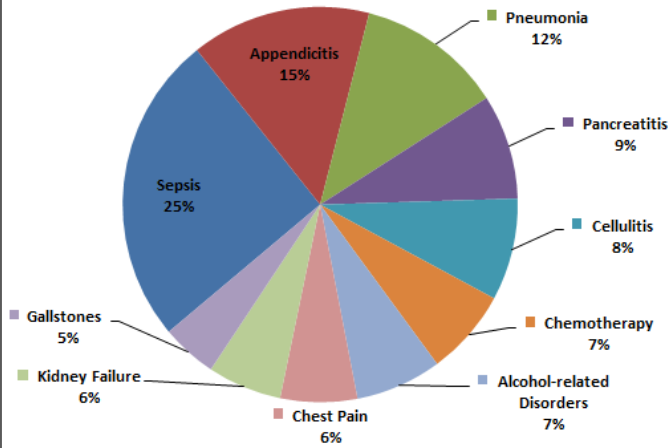
\* Data from MedInsight 1/29/16. Data excludes Duals, LTC and SNF.

### Top Admitting Diagnoses

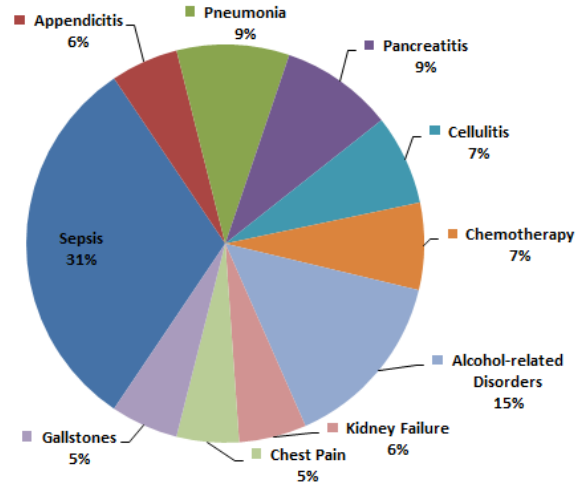
Pregnancy related diagnoses overshadow all other admitting diagnoses for CY 2014 and YTD CY 2015. Pneumonia and sepsis were also top diagnoses for CY 2014 and YTD 2015. When pregnancy is excluded, sepsis, alcohol-related disorders, pneumonia, and pancreatitis are the leading diagnoses for both CY 2014 and YTD 2015.



**Top 10 Diagnoses Excluding Pregnancy  
Calendar Year 2014**



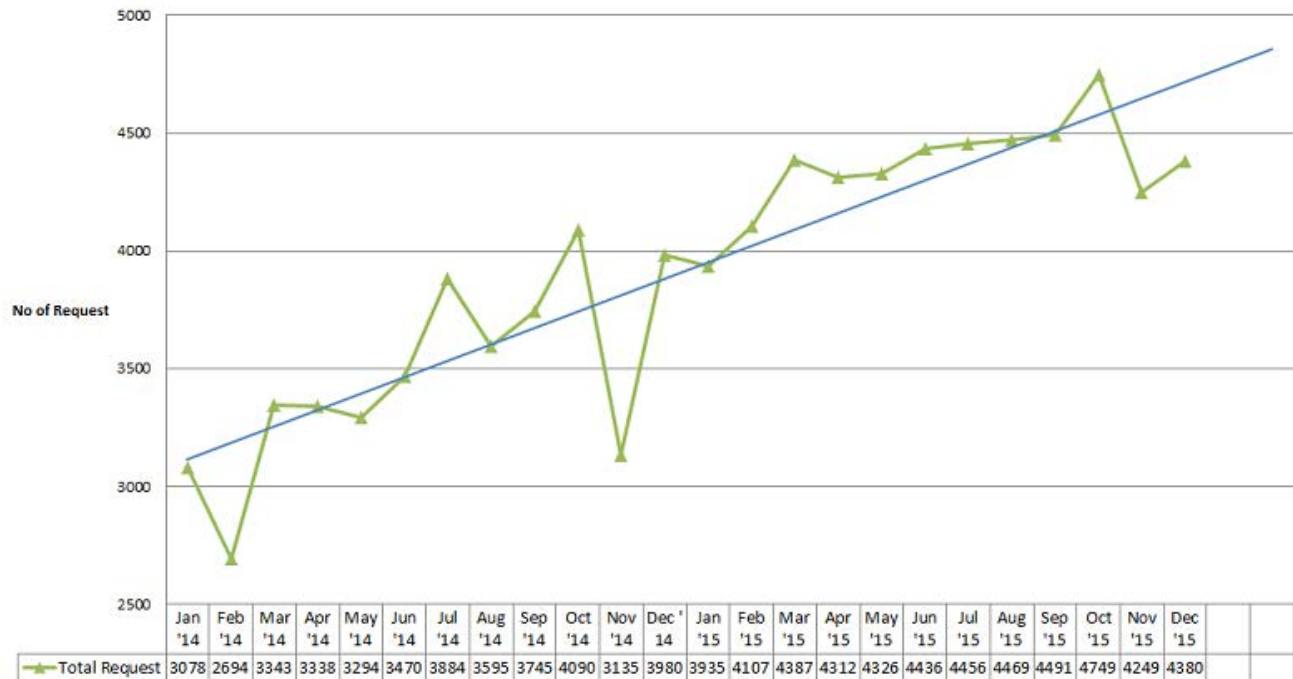
**Top 10 Diagnoses Excluding Pregnancy  
Calendar Year 2015**

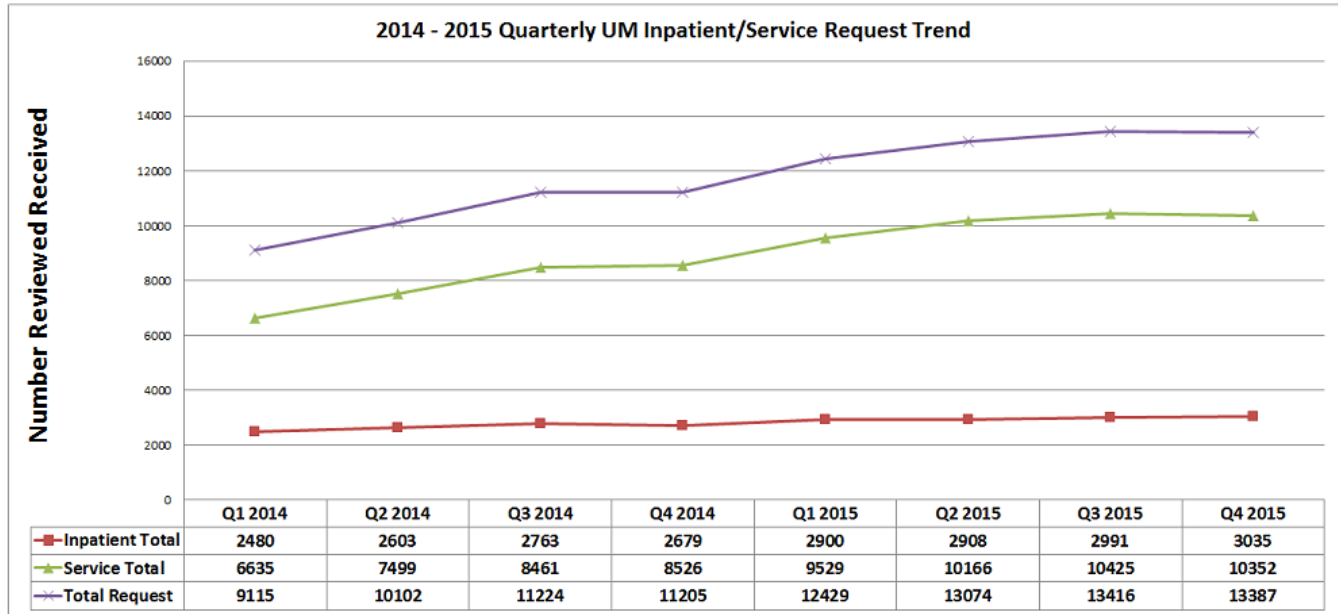


**Authorization Requests**

Requests for outpatient service continue to outnumber requests for inpatient service. Outpatient service requests for YTD CY 2015 were 214 / 1000 members compared to 213 /1000 members for CY 2014. Requests for inpatient service for YTD 2015 are 62 / 1000 members compared to 71 / 1000 members for CY 2014.

**Monthly Total Request Trend**



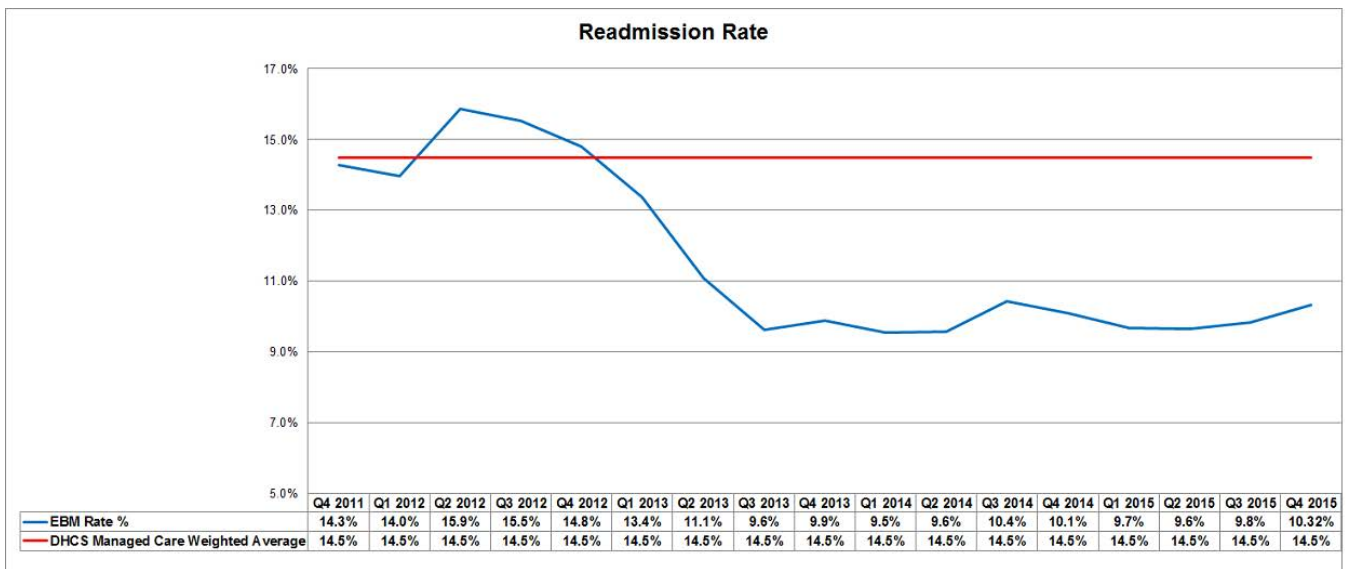


Increase comparison from 2014 Quarter to 2015 Quarter in Percentage

	Q1	Q2	Q3	Q4
Inpatient Request	16.94%	11.72%	8.25%	13.29%
Service Request	43.62%	35.56%	23.21%	21.42%
Total Request	36.36%	29.42%	19.53%	19.47%

## Readmission Rate

The readmission rate has remained between 9.5% and 10.5% since the 3rd quarter of 2013. Benchmark: The weighted average for the HEDIS 2013 All Cause Readmission Rate from the February 2014 Medi-Cal Managed Care Performance Dashboard is approximately 14.5%.



\*Evidence Based Measurement (EBM) rate to be restated as of 3 quarters prior to reporting quarter.

### Clinical Grievances and Appeals

For CY 2014, the average number of clinical grievances/quarter was 30. For CY 2015, the average number of clinical grievances/quarter was 32. There was an average of 9 appeals/quarter for both CY 2014 and CY 2015.

Benchmark: For Q3 2015, 79% of all GCHP grievances were about quality issues and 17% were about access. The September 17, 2015 Medi-Cal Managed Care Performance Dashboard reports 38 % of Q1 2015 grievances statewide were about quality issues and 16% were about access.

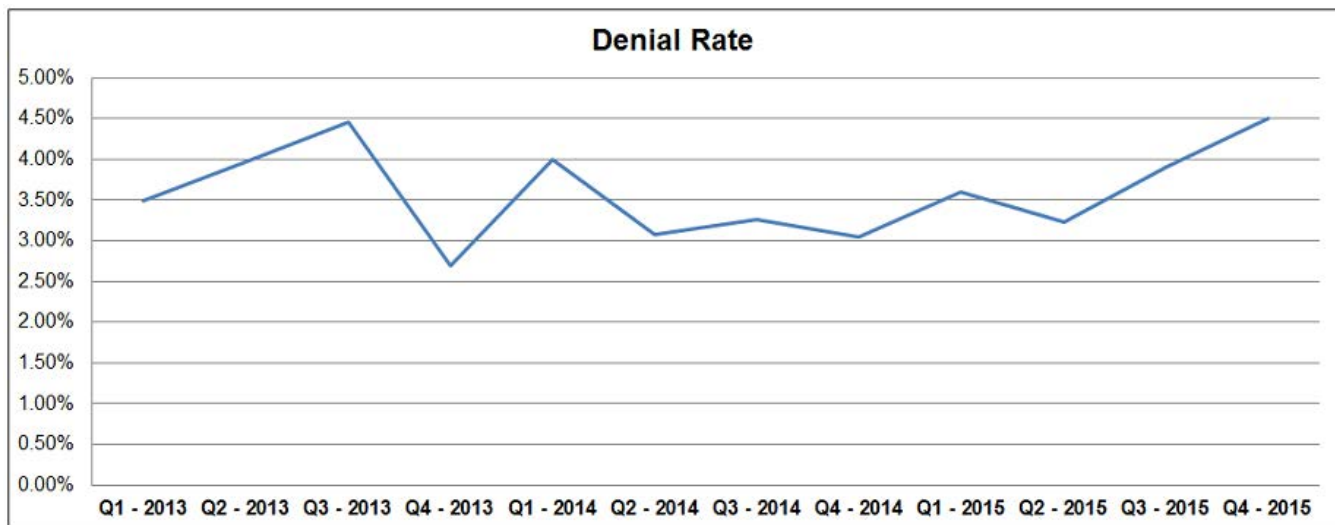
#### Clinical Grievances & Appeals

Quarter	Grievance Total	Appeals Total	Upheld	Partial Overturn	Overtured	Withdrawn
<b>2015</b>						
Q1	41	4	1 (25%)	-	3 (75%)	-
Q2	34	6	3 (50%)	-	3 (50%)	-
Q3	24	8	4 (50%)	-	4 (50%)	-
Q4	29	19	11 (58%)	-	5 (26%)	3 (16%)

### Denial Rate

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

The average denial rate for calendar year 2013 was 3.66% and for 2014 was 3.34%. The average denial for CY 2015 YTD was 3.8%.



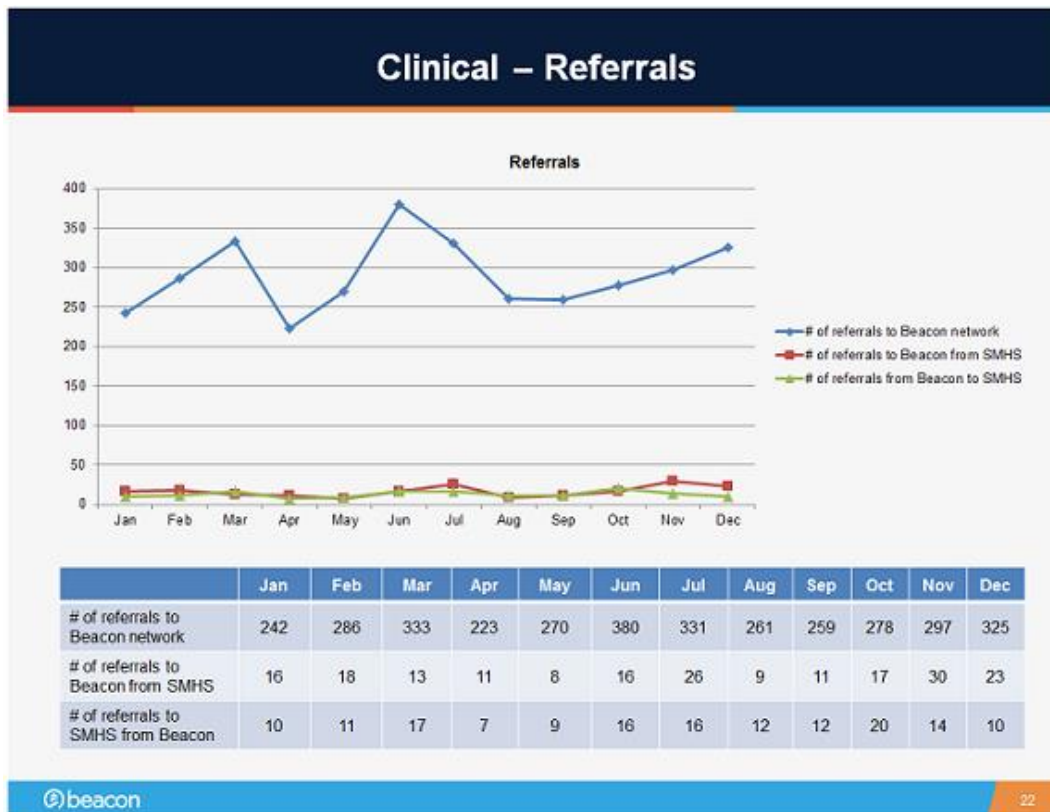
## Behavioral Health Spotlight

On January 1, 2014, under the Affordable Care Act, Medi-Cal managed care plans became responsible for the delivery of care for mild to moderate mental health problems.

The prevalence of depressive and anxiety disorders in primary care settings is high. Between 10% and 20% of adults in any given year will visit their primary care physician during an episode of mental illness (although frequently not because of the episode). Depression and anxiety disorders contribute to the majority of those visits. If unrecognized and undiagnosed, depression and anxiety disorders contribute to high medical utilization in the primary care setting. Twenty-four percent of high utilizers (the top 10%) have been found to suffer from major depression and 22% from an anxiety disorder.

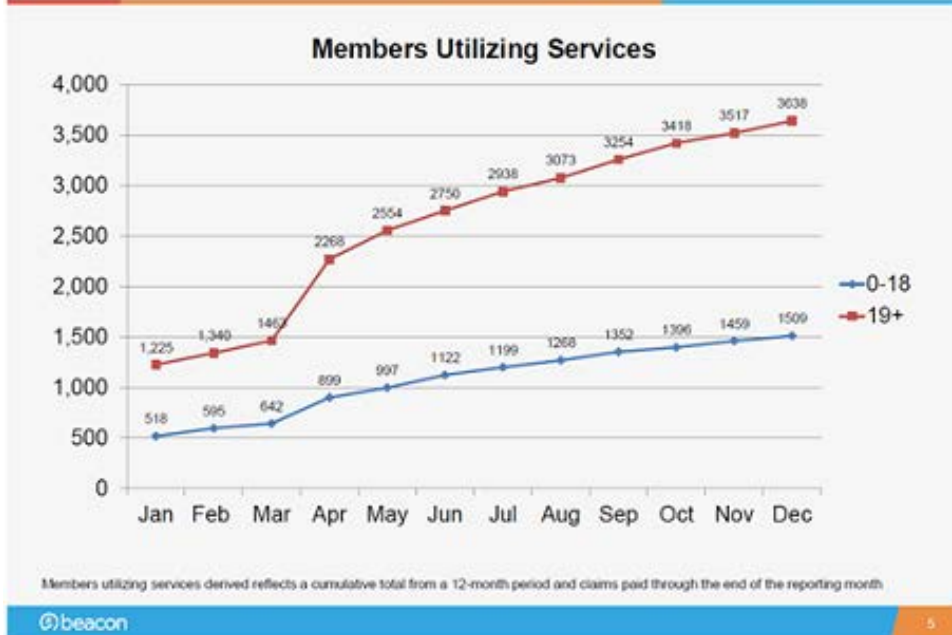
In primary care, presenting complaints for behavioral problems are more likely to be somatic than psychological. Back pain, chest pain, shortness of breath, heart palpitations, problems with sleep or appetite, and fatigue are among the most frequent presenting symptoms. Many people with mental illnesses do not receive treatment. More than 60% of adults with mild to moderate mental health problems do not receive outpatient care or medication treatment to address their condition.

For CY 2015, there was an average of just over 300 new referrals/ month for mild to moderate mental health care. Most referrals come from PCPs or GCHP Care Managers. About 5% come from Ventura County Behavioral Health.



By the end of CY 2015, about 5000 members/month were receiving mental health care. Over 70% of members receiving this care are adults. While this represents over a 1000% increase from CY 2014, care for mild to moderate mental health problems is still underutilized.

### MH Services Utilization by Age Band, 2015



### Utilization Comparison Year to Year





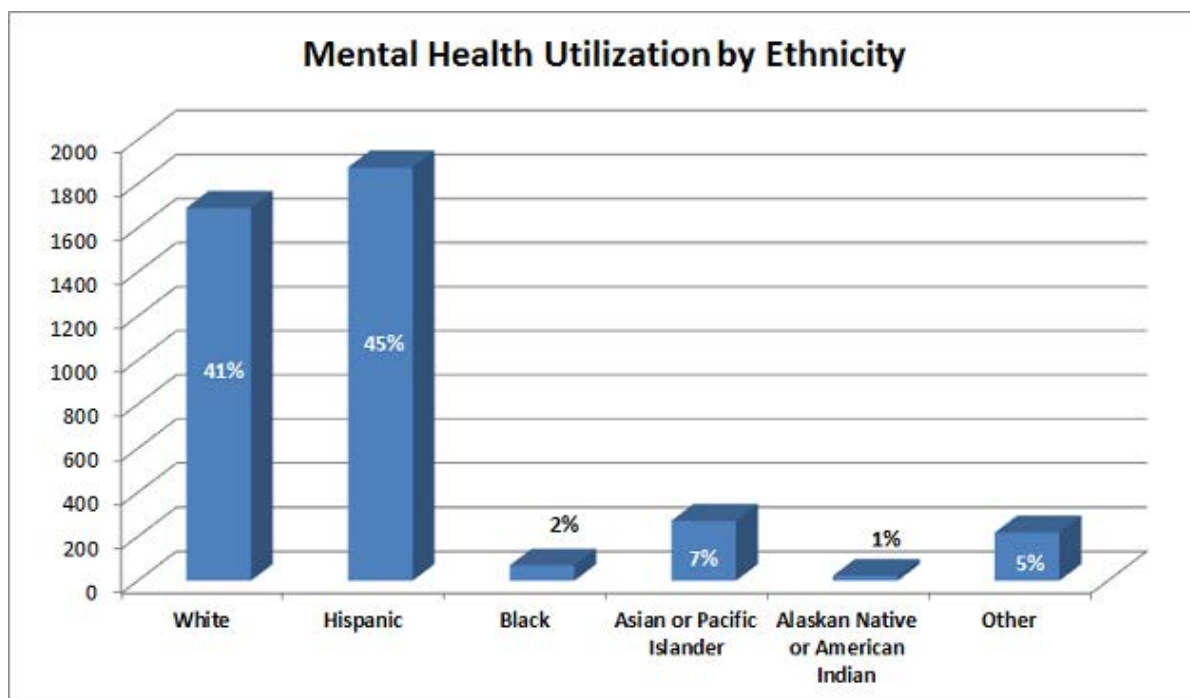
Top diagnoses for adults were depression and anxiety. For children, top diagnoses were adjustment disorder and ADHD.

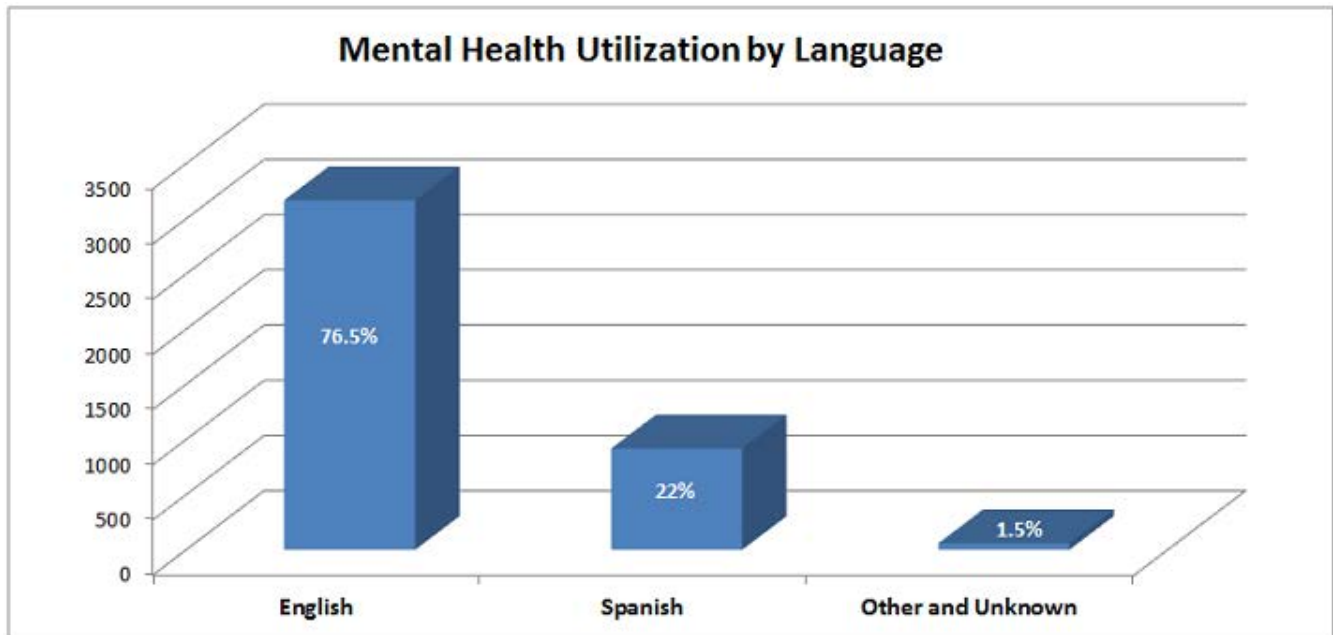
Top Diagnoses of Mental Health Service Utilizers	
Children 0-18	Adults 19+
Adjustment Disorder, Mixed	Major Depressive Disorder
ADHD	Anxiety Disorder, NOS
Anxiety Disorder, NOS	Adjustment Disorder
Generalized Anxiety Disorder	PTSD
PTSD	Generalized Anxiety Disorder

Reporting period July 1 to September 30, 2015

beacon

For the first half of CY 2015, slightly more Hispanics than Whites utilized mental health services. Almost three and a half times as many members who stated English was their language preference used mental health services as those identifying Spanish as their preferred language.







**AGENDA ITEM NO. 14**

To: Gold Coast Health Plan Commission

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

Date: February 22, 2016

RE: Community Outreach Summary Report – January 2016

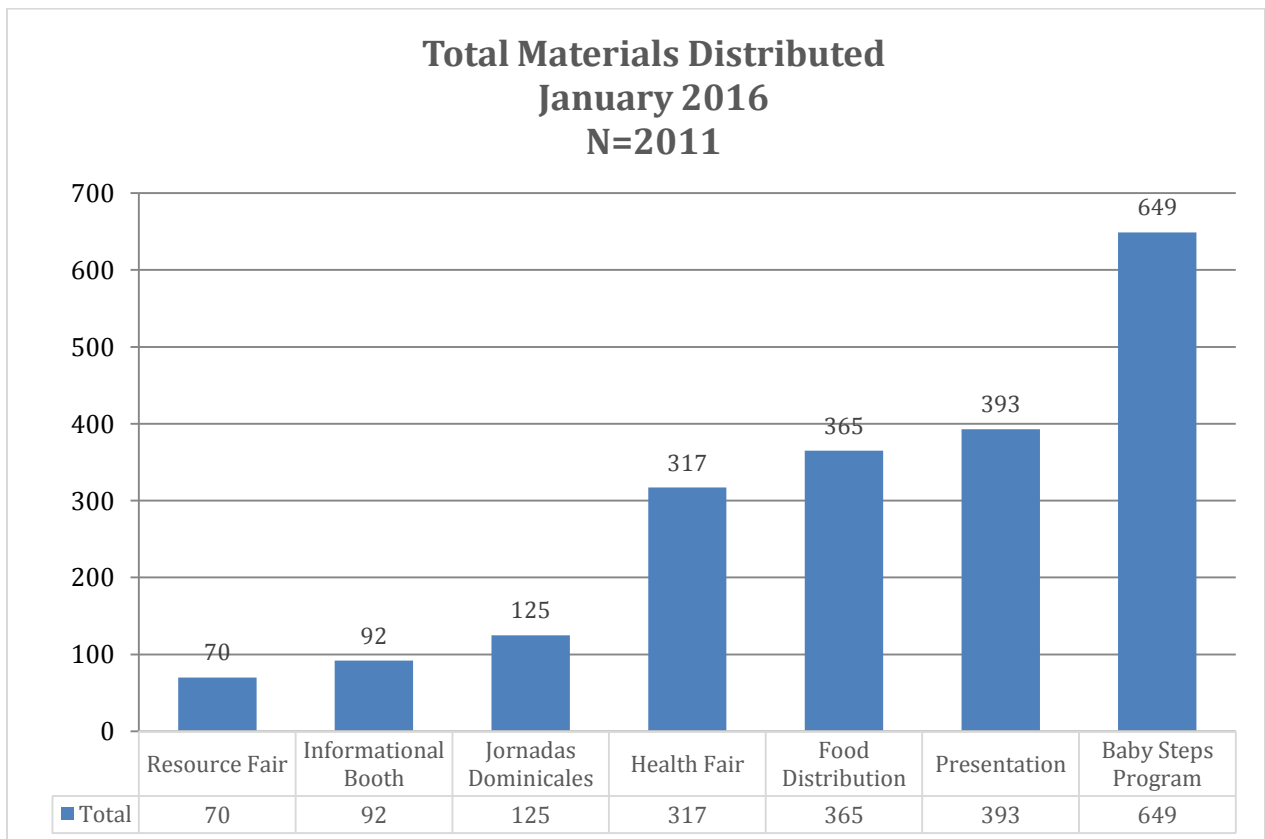
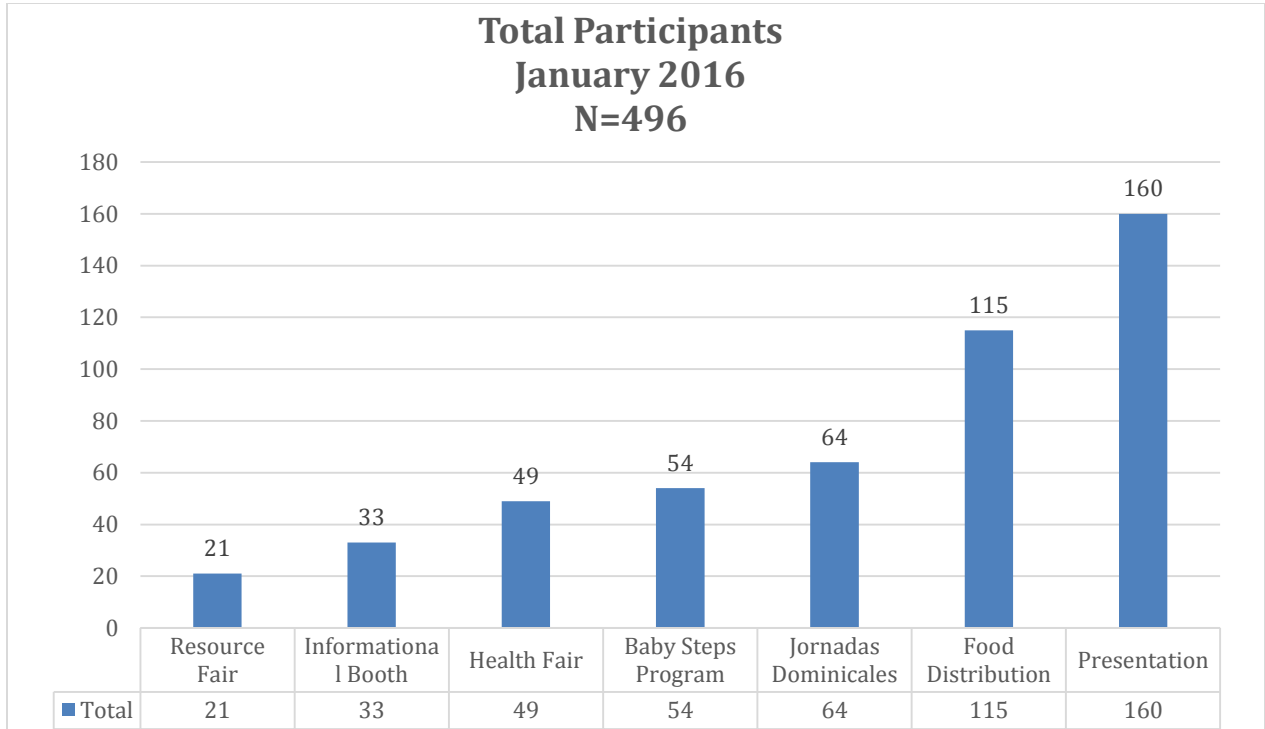
**SUMMARY:**

Gold Coast Health Plan (GCHP) participates 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.

Below is a summary of activities conducted during the month of January 2016.

**Outreach Activities – January 2016**

GCHP participated in 10 community health education and outreach events. The majority of individuals who participated were from events that focused on reaching the general population and low-income families. A total of 496 participants were reached and 2,011 health information materials were distributed. Below are two charts that highlight the total number of participants reached and materials distributed in January.



### **Upcoming Outreach Events**

February 27, 2016 – GCHP will host a community education workshop on the prevention of heart disease and hypertension. The workshop will be located at the Oxnard Public Library and will be from 1:00 PM – 3:30 PM. Several community partners will be available to answer questions related to heart disease. In addition, participants will receive free health screenings.

May 14, 2016 – GCHP will host the 5<sup>th</sup> Annual Community Resource Fair to be held at Plaza Park in Oxnard, CA. The event will host over 30 community based agencies offering a series of health screenings and free resources.



## **AGENDA ITEM NO. 15**

To: Gold Coast Health Plan Commission  
From: Patricia Mowlavi, Chief Financial Officer  
Date: February 22, 2016  
Re: CFO Update

### Overall Financial Performance

For the six months ended December 31, 2015, the Plan's gain in unrestricted net assets was \$24.3 million and was favorable to budget by \$17.0 million. The favorable variance was largely due to higher than expected growth in membership in the Adult Expansion (AE) category of aid. Also contributing to the variance was lower than anticipated health care and administrative costs.

### Membership

Fiscal year 2015-16 membership continued to grow but at a flatter rate compared to the rapid growth seen over the past two fiscal years with the AE and Targeted Low Income Children (TLIC) transition. In the near future, we are looking forward to the addition of 2,900 children with limited scope coverage to join the Plan in May 2016 with full benefits.

### Membership Mix and Revenue

As of December, the Family aid category comprised the majority of membership at 45 percent followed by AE which grew to 26 percent of total membership. From a revenue standpoint, AE contributed the majority of revenue followed by the Family aid category.

### Key Performance Indicators

The Medical Loss Ratio (MLR) is targeted to be between 85 and 91 percent of revenue. Through December the MLR was 87 percent of revenue and has been increasing over the fiscal year with the month of December at 91 percent of revenue. The Administrative Cost Ratio (ACR) is targeted to be between 5 and 8 percent of revenue. Through December, the ACR was at 5.5 percent which was favorable to the budget. This favorable variance was driven primarily by labor related savings.

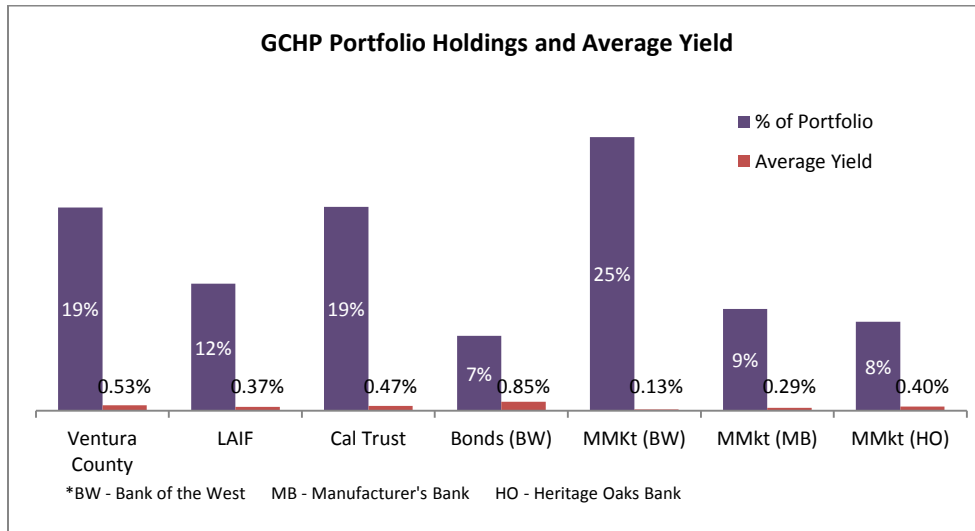
Tangible Net Equity (TNE)

TNE is targeted to be 500 percent of the State requirement. As of December, TNE was \$124 million or 550 percent, excluding the \$7.2 million County of Ventura lines of credit.

Investment Portfolio

The value of the investments as of December was \$239 million. In December, \$45 million of commercial paper matured which coincides with the scheduled recoupment of the approximately \$103.8 million (at December 31, 2015) in AE rate overpayments, which will be paid back to the state. There is an additional \$131.3 million due back to the state to achieve the required minimum 85 percent MLR for Adult Expansion. This currently appears as a long term liability. The current MLR for Adult Expansion without the MLR adjustment is 75%.

The investment holdings including money market and the respective yields are shown in the graph below.



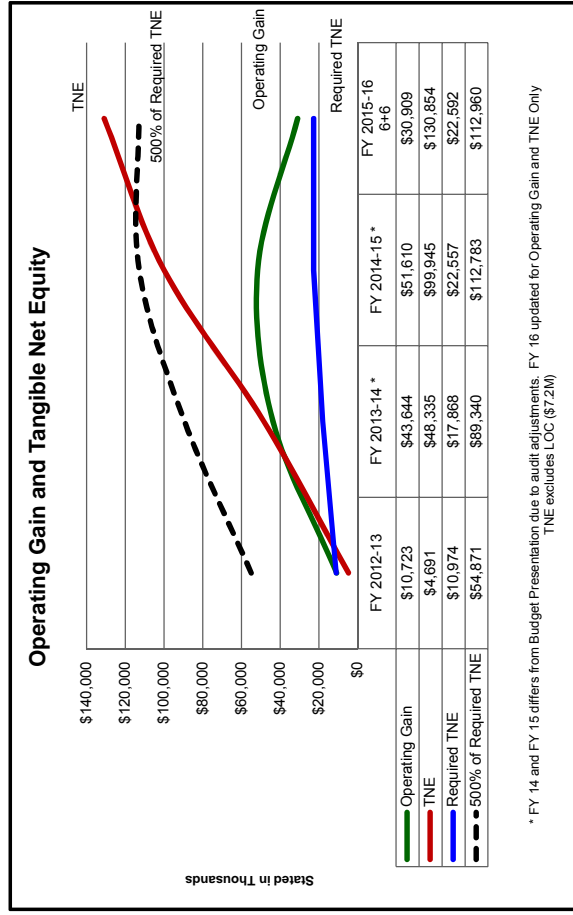
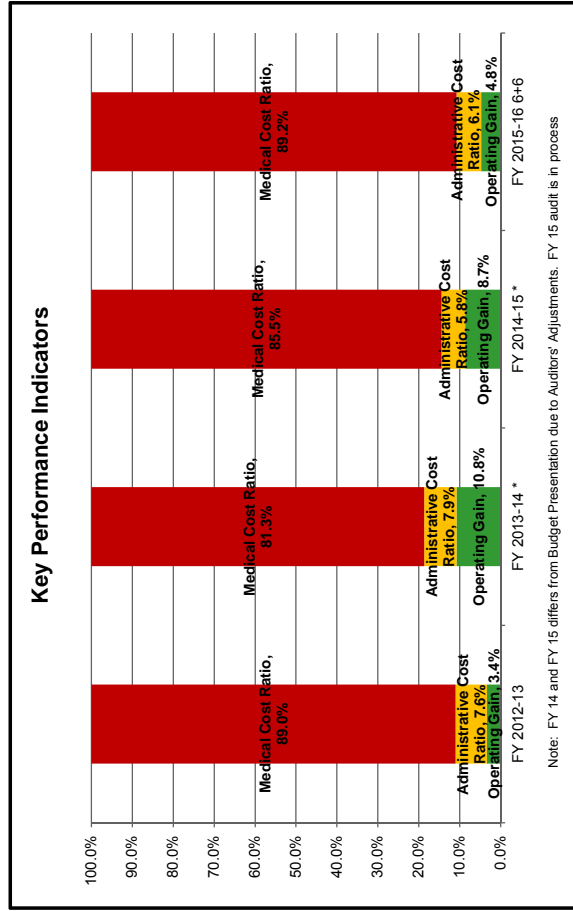
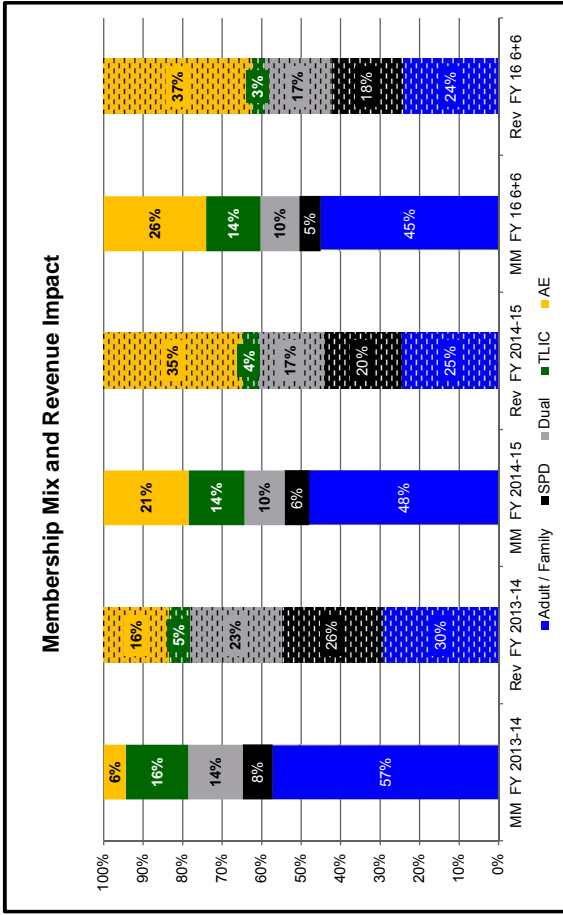
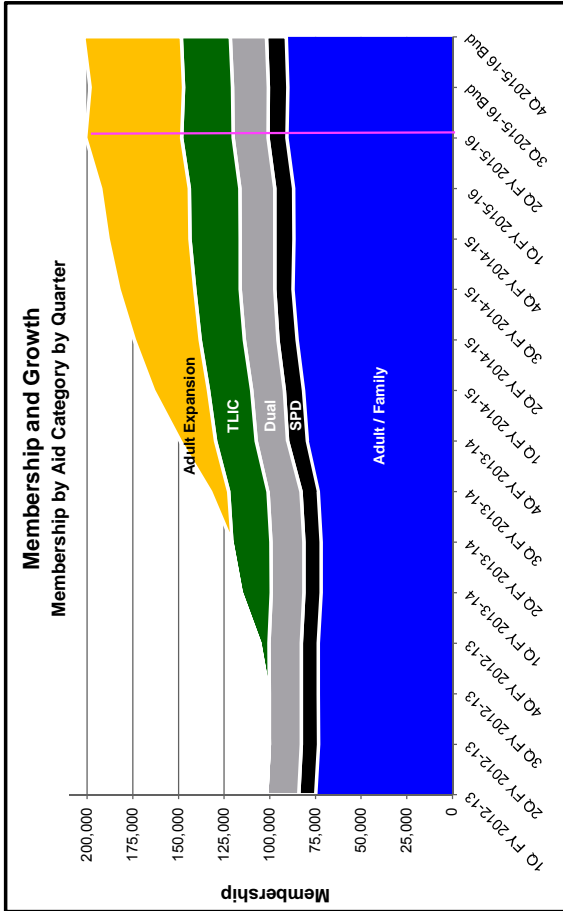
**GOLD COAST HEALTH PLAN  
FINANCIAL RESULTS SUMMARY**

Description	FY 2015-16										Budget Comparison	
	AUDITED	AUDITED	AUDITED	AUDITED	JUL - SEP	OCT 15	NOV 15	DEC 15	DEC 15	Budget FYTD	Variance Fav / (Unfav)	Variance Fav / (Unfav)%
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15					FYTD			
<b>Member Months</b>	1,258,189	1,223,895	1,553,660	2,130,979	578,056	198,148	200,385	203,857	1,180,446	1,159,563	20,883	1.8 %
<b>Revenue</b>	304,635,932	315,119,611	402,701,476	595,607,370	162,960,677	52,508,015	53,274,568	53,961,656	322,704,916	315,695,908	7,009,008	2.2 %
<i>pppm</i>	242.12	257.47	259.20	279.50	281.91	264.99	265.86	264.70	273.38	272.25	1.12	0.4 %
<b>Health Care Costs</b>	287,353,672	280,382,704	327,305,832	509,183,268	137,845,237	45,086,757	48,350,456	49,274,672	280,557,122	287,977,651	7,420,530	2.6 %
<i>pppm</i>	228.39	229.09	210.67	238.94	238.46	227.54	241.29	241.71	237.67	248.35	10.68	4.3 %
% of Revenue	94.3%	89.0%	81.3%	85.5%	84.6%	85.9%	90.8%	91.3%	86.9%	91.2%	4.3 %	4.7 %
<b>Admin Exp</b>	18,891,320	24,013,927	31,751,533	34,814,049	8,827,059	2,951,994	2,901,309	3,182,244	17,862,605	20,428,652	2,566,047	12.6 %
<i>pppm</i>	15.01	19.62	20.44	16.34	15.27	14.90	14.48	15.61	15.13	17.62	2.49	14.1 %
% of Revenue	6.2%	7.6%	7.9%	5.8%	5.4%	5.6%	5.4%	5.9%	5.5%	6.5%	0.9 %	14.5 %
<b>Total Increase / (Decrease) in Unrestricted Net Assets</b>	(1,609,063)	10,722,980	43,644,110	51,610,053	16,288,381	4,469,265	2,022,803	1,504,740	24,285,190	7,289,605	16,995,585	233.1 %
<i>pppm</i>	(1.28)	8.76	28.09	24.22	28.18	22.56	10.09	7.38	20.57	6.29	14.29	227.3 %
% of Revenue	-0.5%	3.4%	10.8%	8.7%	10.0%	8.5%	3.8%	2.8%	7.5%	2.3%	5.2%	225.9 %
<b>YTD</b>	16,769,368	16,138,440	17,867,986	22,556,530	21,819,072	22,266,192	22,698,761	22,591,994	22,591,994	24,578,958	(1,986,964)	(8.1)%
% TNE Required	36%	68%	100%	100%	100%	100%	100%	100%	100%	100%		
Minimum Required TNE	6,036,972	10,974,139	17,867,986	22,556,530	21,819,072	22,266,192	22,698,761	22,591,994	22,591,994	24,578,958	(1,986,964)	(8.1)%
<b>GCHP TNE</b>	(6,031,881)	11,891,099	55,535,211	107,145,264	123,433,646	127,902,910	129,925,714	131,430,454	131,430,454	87,269,057	44,161,396	50.6 %
TNE Excess / (Deficiency)	(12,068,853)	916,960	37,667,225	84,588,734	101,614,573	105,636,718	107,226,953	108,838,460	108,838,460	62,690,100	46,148,360	73.6 %
% of Required TNE level			311%	475%	566%	574%	572%	582%	582%	355%		
% of Required TNE level (excluding \$7.2 million LOC)			271%	443%	533%	542%	541%	550%	550%	326%		

Note: TNE amount includes \$7.2 million related to the Lines of Credit (LOC) from Ventura County.



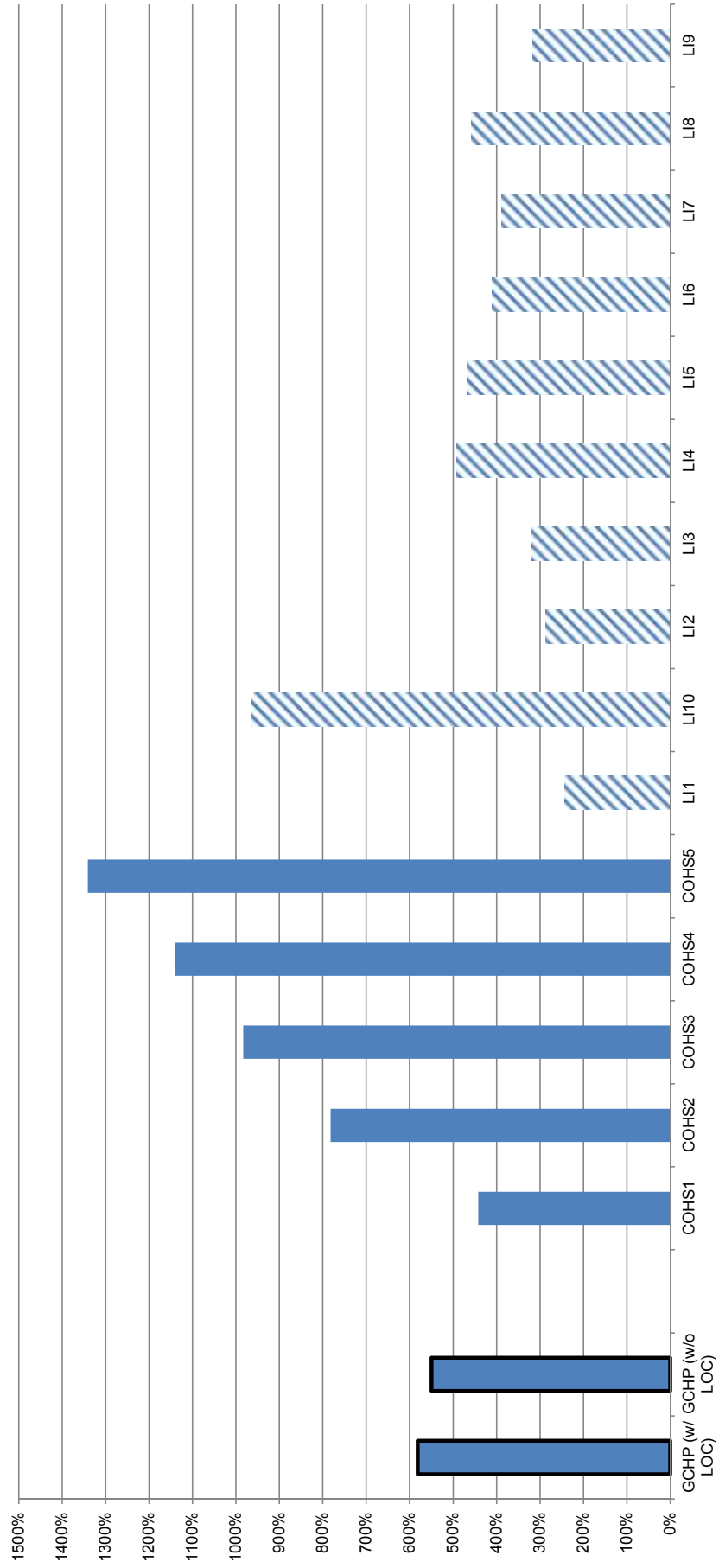
**FINANCIAL PERFORMANCE DASHBOARD  
FOR MONTH ENDING DECEMBER 31, 2015**



\* 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)

Note: 6+6 indicates 6 months of actual results followed by 6 months of forecasts

**% TNE to Required - Public Plans**  
**TNE for All Plans Except GCHP as of Most Recent Quarter - September 30, 2015**  
**GCHP TNE as of December 31, 2015**  
**(Source: DHCS Medi-Cal Managed Care Dashboard)**



**AGENDA ITEM NO. 16**

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: February 22, 2016

Re: COO Update

**OPERATIONS UPDATE**

**Membership Update – February 2016**

Gold Coast Health Plan (GCHP) had a minimal decrease in membership this month; the net decrease from January was 18. As of February 1, 2016, GCHP has a membership of 202,019. Even with the minimal decrease, GCHP’s membership has increased by 83,507 since January 2014, which represents a 70.46% increase in two years. Approximately 25% of GCHP’s total membership consists of Adult Expansion (M1) members. The cumulative new membership since January 1, 2014 is summarized as follows:

<b>Aid Code</b>	<b># of New Members</b>
L1 – Low Income Health Plan (LIHP)	1,873
M1 – Adult Expansion	50,185
7U – CalFresh Adults	2,110
7W – CalFresh Children	549
7S – Parents of 7Ws	579
Traditional Medi-Cal	28,211
<b>Total New Membership 1/1/14 – 2/1/16</b>	<b>83,507</b>

The number of members assigned to the M1 aid code continues to increase; all other Medi-Cal Expansion aid codes decreased in February. GCHP had 218 new members that transitioned from Covered CA as of February 1, 2016.

	<b>L1</b>	<b>M1</b>	<b>7U</b>	<b>7W</b>	<b>7S</b>
Feb 16	1,873	50,185	2,110	549	579
Jan 16	1,953	49,653	2,205	608	736

	L1	M1	7U	7W	7S
Dec 15	2,129	49,456	2,285	573	287
Nov 15	2,298	47,527	2,395	628	354
Oct 15	2,515	46,138	2,525	682	354
Sep 15	2,698	44,260	2,654	733	360
Aug 15	3,039	42,465	2,766	746	380
Jul 15	3,218	40,948	2,918	770	355
Jun 15	3,413	39,283	2,986	781	353
May 15	3,908	37,519	3,083	813	379
Apr 15	4,102	35,582	3,162	831	381
Mar 15	4,965	34,350	3,236	856	396
Feb 15	6,128	31,203	3,342	872	442
Jan 15	6,508	30,107	3,390	872	478

	L1	M1	7U	7W	7S
Dec 14	6,972	27,176	3,204	589	15
Nov 14	7,289	24,060	3,254	599	14
Oct 14	7,443	23,569	3,312	296	11
Sep 14	7,568	21,944	3,368	606	5
Aug 14	7,726	18,585	3,400	624	4
Jul 14	7,839	15,606	3,453	667	4
Jun 14	7,975	10,910	3,515	691	3
May 14	8,118	7,279	3,680	714	0
Apr 14	8,134	4,514	3,584	684	0
Mar 14	8,154	2,482	1,741	0	0
Feb 14	8,083	1,550	0	0	0
Jan 14	7,618	183	0	0	0

**AB 85 Capacity Tracking** – VCMC has a total of 30,672 Adult Expansion members assigned to them as of February 2016. VCMC's target enrollment is 65,765 and is currently at 46.6% of the enrollment target.

### **December 2015 Operations Summary**

**Claims Inventory** – ended December with an inventory of 20,253; this equates to Days Receipt on Hand (DROH) of 2.6 days compared to a DROH maximum goal of 5 days. GCHP received approximately 7,800 claims per day in December. Monthly claim receipts from January 2015 through December 2015 are as follows:

Month	Total Claims Received	Receipts per Day
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
June 2015	171,806	7,809
May 2015	160,992	8,050
April 2015	146,198	6,645
March 2015	152,948	6,952
February 2015	130,559	6,528
January 2015	127,517	6,376

**Claims Turnaround Time (TAT)** – the regulatory requirement of processing 90% of clean claims within 30 calendar days was met in December with a result of 99.5%.

**Claims Processing Accuracy** – the financial accuracy goal of 98% or higher was met in December with a result of 99.92%; procedural accuracy exceeded the goal of 97% in December at 99.98%.

**Call Volume** – call volume increased in December but remained below 10,000 calls for the fifth straight month; the number of calls received in December was 8,382. The 12-month average is 9,763 calls per month.

**Average Speed to Answer (ASA)** – as discussed at the November Commission meeting, the Xerox call center experienced staffing issues towards the end of December which resulted in missing the Service Level Agreement (SLA) of answering calls in 30 seconds or less. The combined ASA result (Member, Provider and Spanish lines) for December was 86.89 seconds. Xerox was placed on a Corrective Action Plan in January. Xerox is back in compliance as of February.

**Abandonment Rate** – staffing issues also impacted the Abandonment Rate in December but the combined result of 4.26% was still under the goal of 5% or less. The Abandonment Rate is well below 5% as of February.

**Average Call Length** – the combined result of 7.11 minutes in December is approaching the goal of 7.0 minutes. Xerox is actively working with the call center agents to improve call handling time.

**Call Center Phone Quality** – call quality for December was 95.9% versus a goal of 95%.

**Grievance and Appeals** – GCHP received 14 member grievances and 101 provider grievances (related to claim payment disputes) during December. The number of member grievances received per 1,000 members was 0.07.

Type of Member Grievances	Number of Grievances
Quality of Care	7
Benefits and Coverages	2
Eligibility	2
Denials/Refusals	1
Accessibility – Transportation Issue	1
Quality of Service	1
<b>Total Member Grievances</b>	<b>14</b>

There were five clinical appeals in December; three were upheld, one was overturned and one was withdrawn. There were three State Fair Hearing cases in December; one was approved, one was denied and one was dismissed.

**Member Orientation Meetings** – A total of 171 members (132 English, 39 Spanish) plus 25 County Employees/Others attended Member Orientation meetings in 2015. GCHP continues to include an informational flyer in each new member packet to make members aware of this opportunity to learn more about GCHP and their Medi-Cal benefits. We are also exploring the option of adding an informational message to the IVR that would be played during hold times to promote these meetings.

**Behavioral Health Treatment (BHT) Transition** – The transition of BHT services from the regional centers to managed care plans began February 1, 2016. GCHP members currently receiving BHT services at the regional center will be transitioned over a six-month period based on month of birth. GCHP is required to send 60-day and 30-day notices to all transitioning members and has sent out the following notices:

Transition Month	60-Day Notices Sent	30-Day Notices Sent
February 2016 (Jan & Feb birth month)	12/1/15	1/1/16
March 2016 (Mar & Apr birth month)	1/1/16	2/1/16
April 2016 (May & Jun birth month)	2/1/16	

Members who were scheduled to transition on February 1, 2016, but for whom the managed care plans did not receive treatment information from the regional centers, did not transition and will continue to receive their treatment at the regional centers until March 1, 2016. These members will transition at that time if the managed care plans have received treatment information in order to safely transition the member.

**Noteworthy Activities** – Additional projects/activities that Operations continues to lead or be involved in:

- **ASO Consultant Services Evaluation** – Operations will be the primary contact for the consultant vendor during the engagement.
- **Knox-Keene Licensure** – Operations will support Compliance in this activity.
- **IVR Optimization** – GCHP will focus on improving the customer experience for both members and providers through improved messaging and consolidation of prompts. The target date to have these changes implemented is 4/30/16.

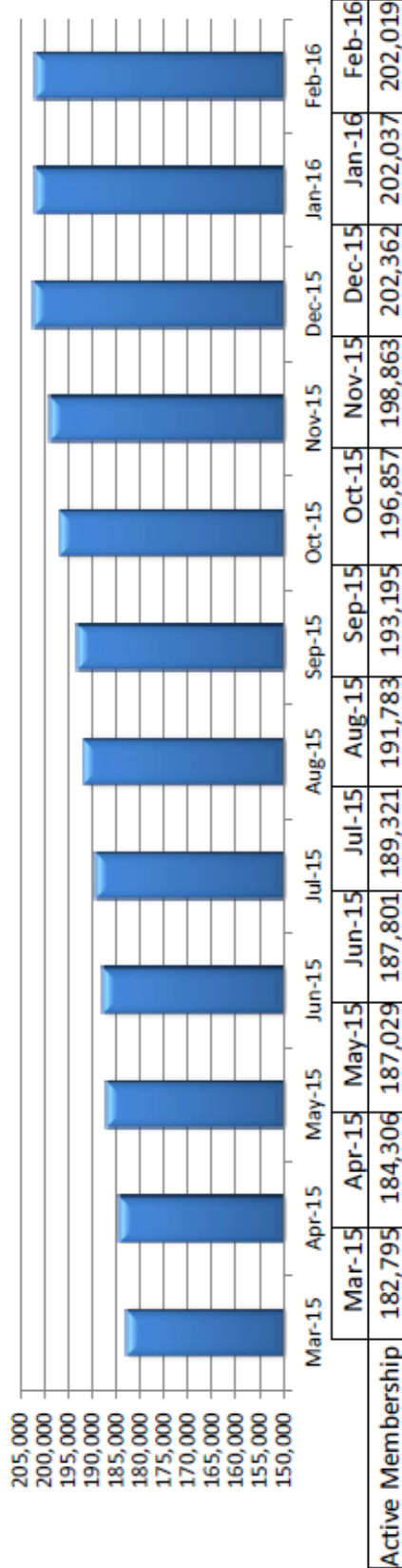


# GCHP Membership

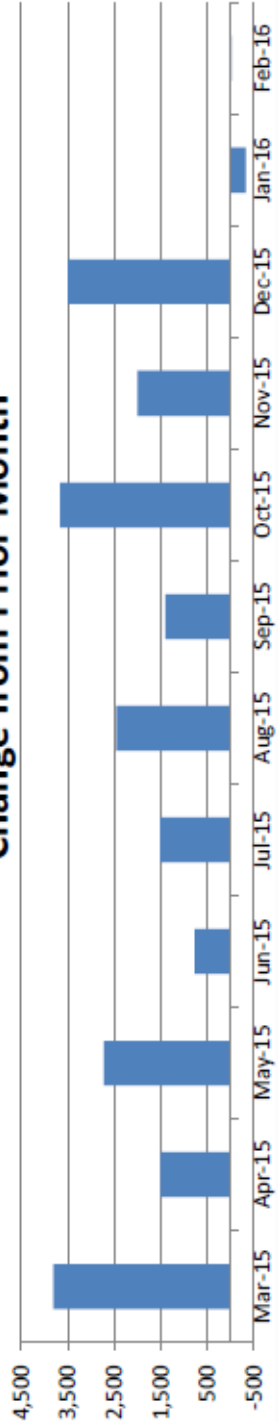
Total Membership as of February 1, 2016 – 202,019

\*New Members Added Since January 2014 – 83,507

**GCHP Membership Trend March 2015 - February 2016**



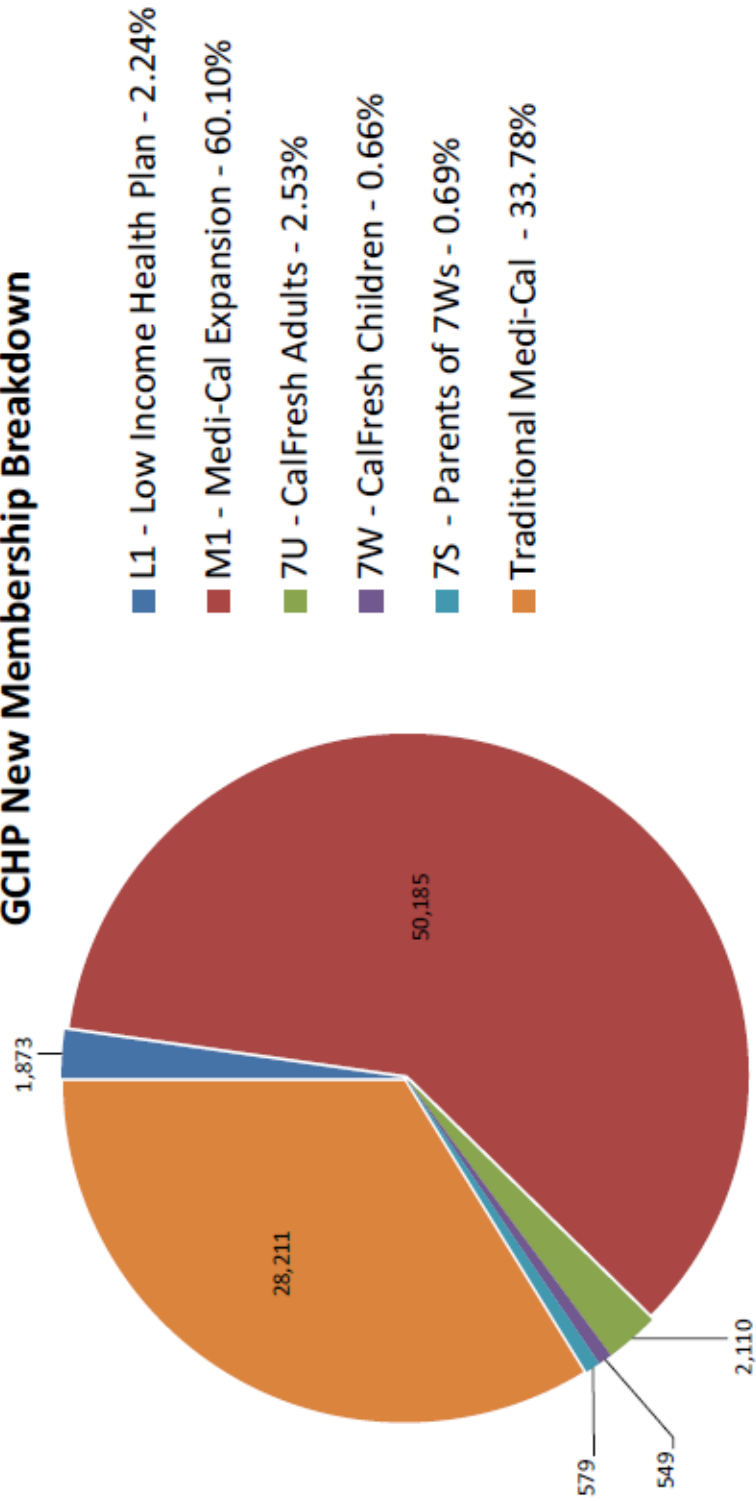
## Change from Prior Month





# Membership Growth

**GCHP New Membership Breakdown**



## GCHP Membership Churn Summary – FY 2015-16

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
<b>Membership from Prior Month</b>	187,801	189,321	191,783	193,185	196,857	198,863	202,362	202,037
<b>Prior Month Members Inactive in Current Month</b>	5,352	4,448	5,280	3,371	4,141	3,236	6,906	6,139
<b>Sub-total</b>	182,449	184,873	186,503	189,814	192,716	195,627	195,456	195,898
<b>Percentage of Inactive Members from Prior Month</b>	2.85%	2.35%	2.75%	1.74%	2.10%	1.63%	3.41%	3.04%
<b>Current Month New Members</b>	5,068	5,241	5,383	5,503	5,015	5,454	5,794	4,215
<b>Sub-total</b>	187,517	190,114	191,886	195,317	197,731	201,081	201,250	200,113
<b>Percentage of New Members Reflected in Current Membership</b>	2.68%	2.73%	2.79%	2.80%	2.52%	2.70%	2.87%	2.09%
<b>Retroactive Member Additions</b>	1,804	1,669	1,299	1,540	1,132	1,281	787	1,906
<b>Active Current Month Membership</b>	<b>189,321</b>	<b>191,783</b>	<b>193,185</b>	<b>196,857</b>	<b>198,863</b>	<b>202,362</b>	<b>202,037</b>	<b>202,019</b>
<b>Percentage of Retroactive Members Reflected in Current Membership</b>	0.95%	0.87%	0.67%	0.78%	0.57%	0.63%	0.39%	0.94%

# GCHP Auto Assignment by PCP/Clinic as of February 1, 2016

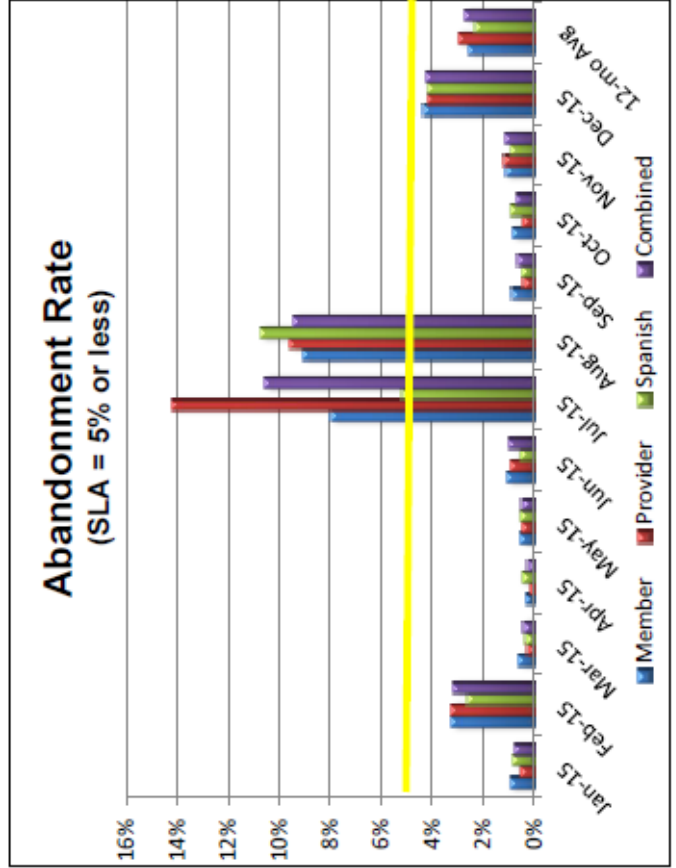
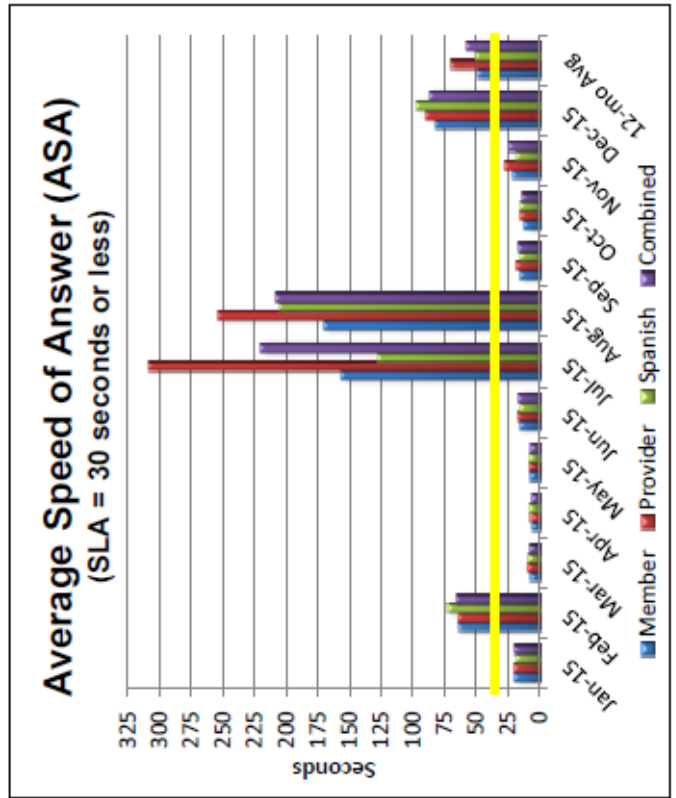
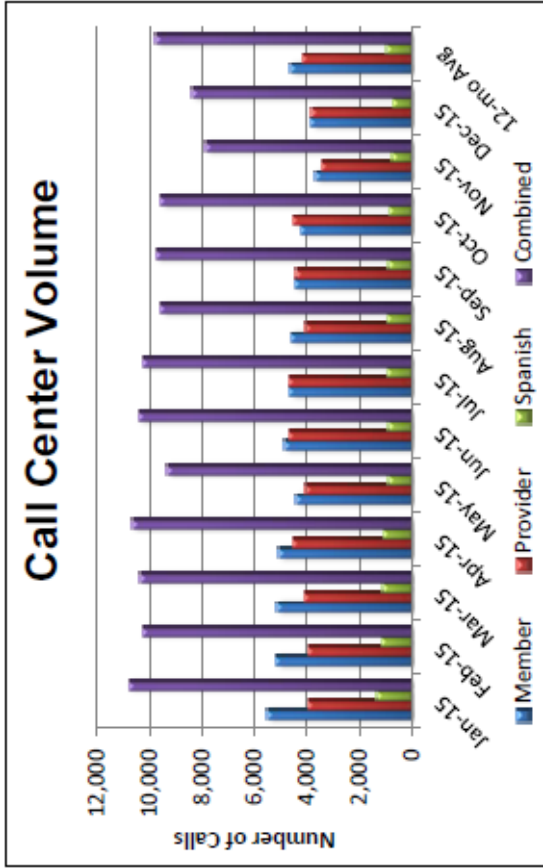
	Feb-16		Jan-16		Dec-15		Nov-15		Oct-15		Sep-15	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
<b>AB85 Eligible</b>	<b>1,591</b>		<b>1,292</b>		<b>1,066</b>		<b>1,075</b>		<b>996</b>		<b>1,350</b>	
VCMC	1,193	74.98%	969	75.00%	799	74.95%	806	74.98%	747	75.00%	1,012	74.96%
Balance	398	25.02%	323	25.00%	267	25.05%	269	25.02%	249	25.00%	338	25.04%
<b>Regular Eligible</b>	<b>1,250</b>		<b>944</b>		<b>1,051</b>		<b>1,008</b>		<b>1,011</b>		<b>1,141</b>	
<b>Regular + AB85 Balance</b>	<b>1,648</b>		<b>1,267</b>		<b>1,318</b>		<b>1,277</b>		<b>1,260</b>		<b>1,479</b>	
Clinicas	305	18.51%	251	19.81%	269	20.41%	268	20.99%	259	20.56%	275	18.59%
CMH	193	11.71%	144	11.37%	142	10.77%	176	13.78%	144	11.43%	161	10.89%
Independent	34	2.06%	23	1.82%	39	2.96%	26	2.04%	38	3.02%	46	3.11%
VCMC	1,116	67.72%	849	67.01%	868	65.86%	807	63.19%	819	65.00%	997	67.41%
<b>Total Assigned</b>	<b>2,841</b>		<b>2,236</b>		<b>2,117</b>		<b>2,083</b>		<b>2,007</b>		<b>2,491</b>	
Clinicas	305	10.74%	251	11.23%	269	12.71%	268	12.87%	259	12.90%	275	11.04%
CMH	193	6.79%	144	6.44%	142	6.71%	176	8.45%	144	7.17%	161	6.46%
Independent	34	1.20%	23	1.03%	39	1.84%	26	1.25%	38	1.89%	46	1.85%
VCMC	2,309	81.27%	1,818	81.31%	1,667	78.74%	1,613	77.44%	1,566	78.03%	2,009	80.65%

## 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 30,672 assigned Adult Expansion members as of February 1, 2016 and is currently at 46.6% of capacity

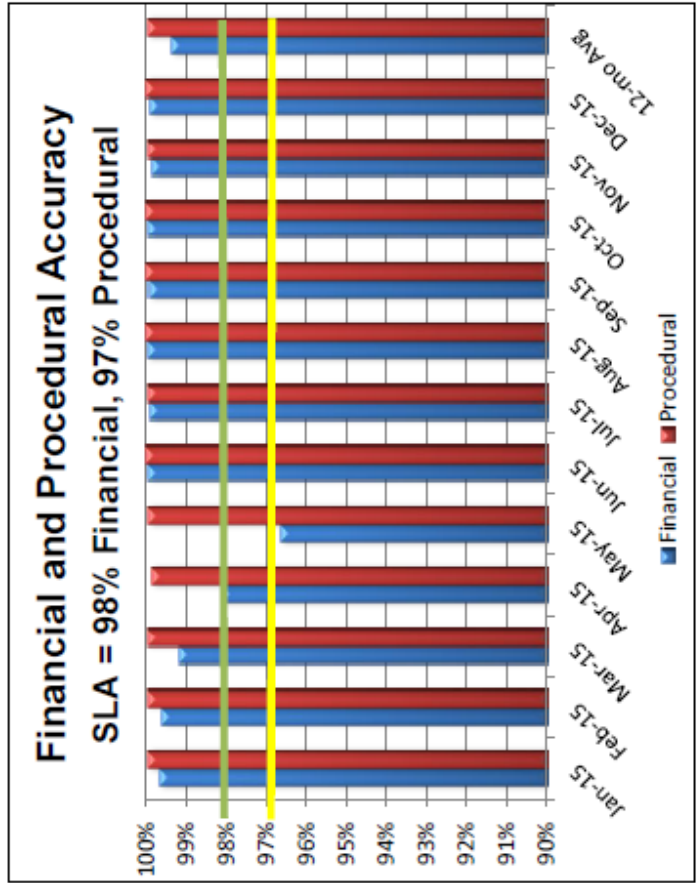
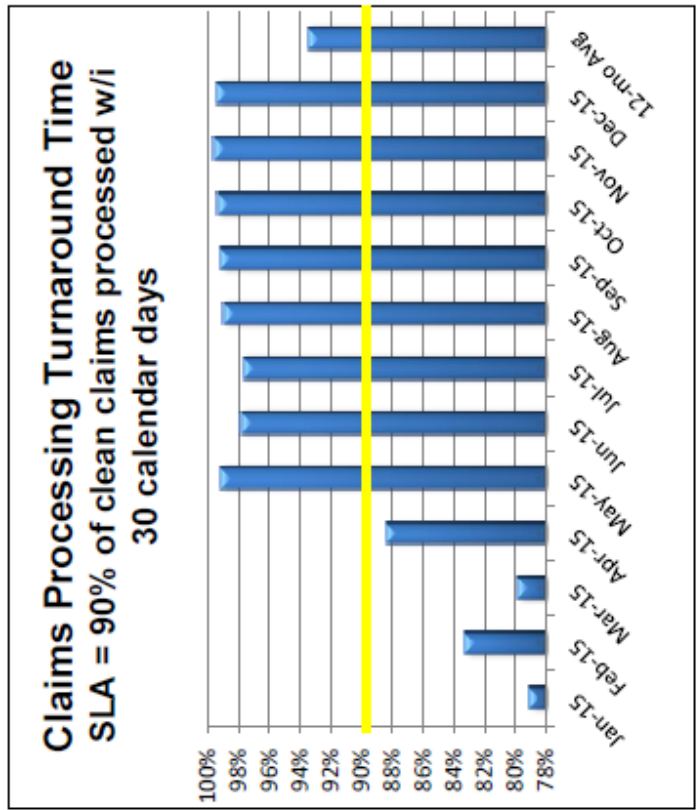
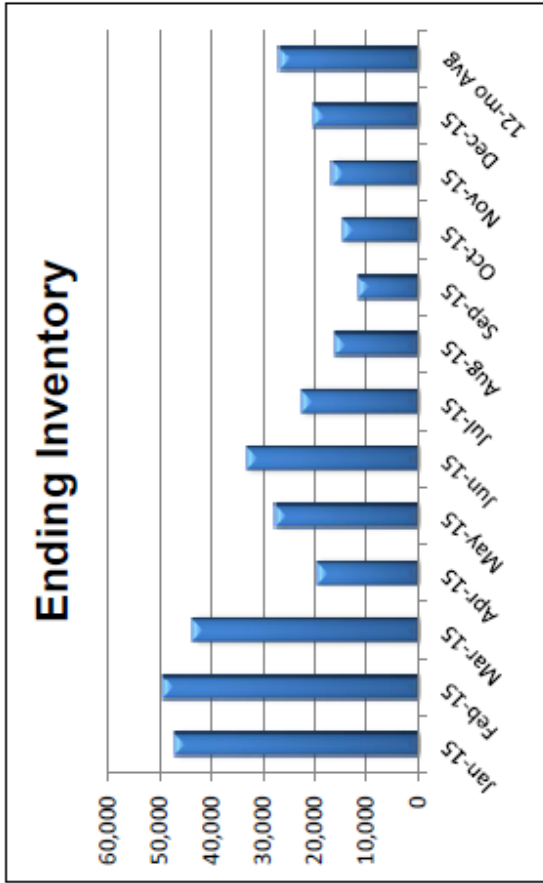
## GCHP Call Center Metrics – December 2015

- Call volume increased slightly in December but still remained below 10,000; GCHP received 8,382 calls during the month
- The Service Level Agreement (SLA) for ASA was not met (86.89 seconds) in December due to staffing issues
- The Abandonment Rate was also impacted by staffing issues and increased in December but the SLA was still met (4.26%)

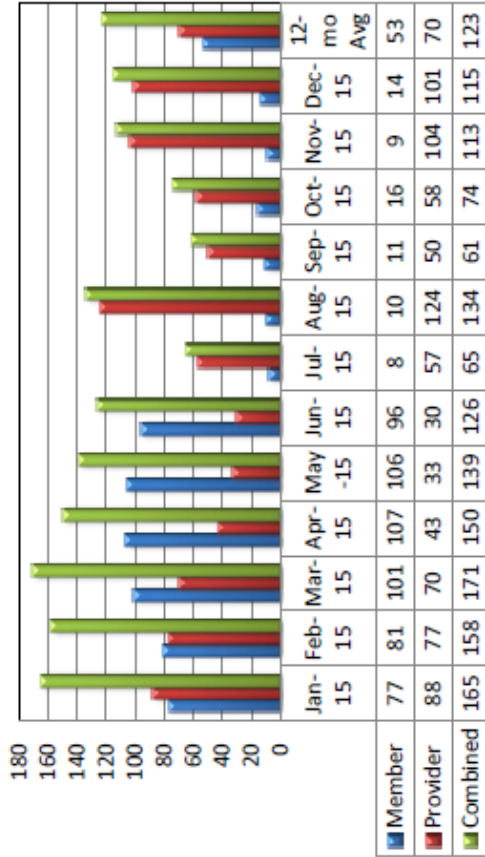


## GCHP Claims Metrics – December 2015

- The 30 Day Turnaround Time (TAT) remained in compliance at 99.5%
- Ending Inventory was 20,253 which equates to a Days Receipt on Hand (DROH) of 2.6 days vs a DROH maximum goal of 5 days
- Service Level Agreements for Financial Accuracy (99.92%) and Procedural Accuracy (99.99%) were both met in December



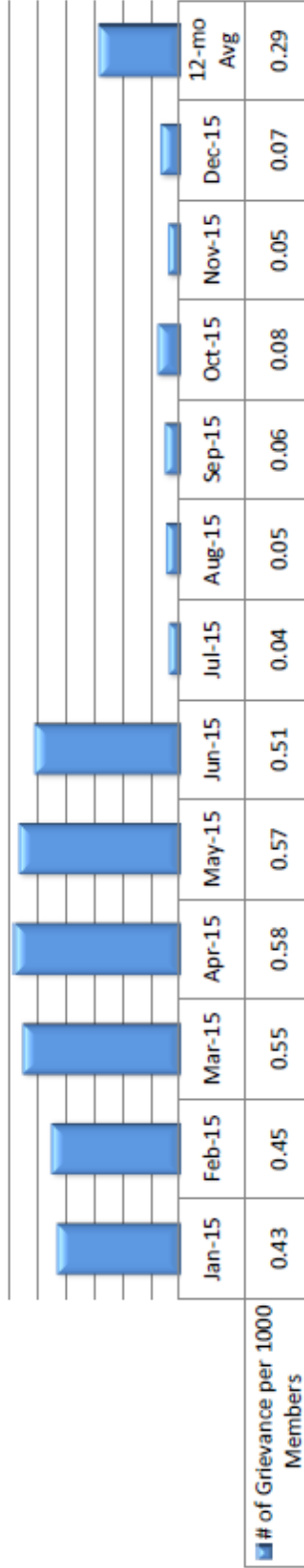
## Total Grievances per Month



## GCHP Grievance & Appeals Metrics – December 2015

- GCHP received 14 member grievances (0.07 grievances per 1,000 members) and 101 provider grievances during December
- GCHP's 12-month average for total grievances is 123 but is skewed due to the inclusion of balance billing in member grievances until July 2015

## Member Grievances per 1000 Members

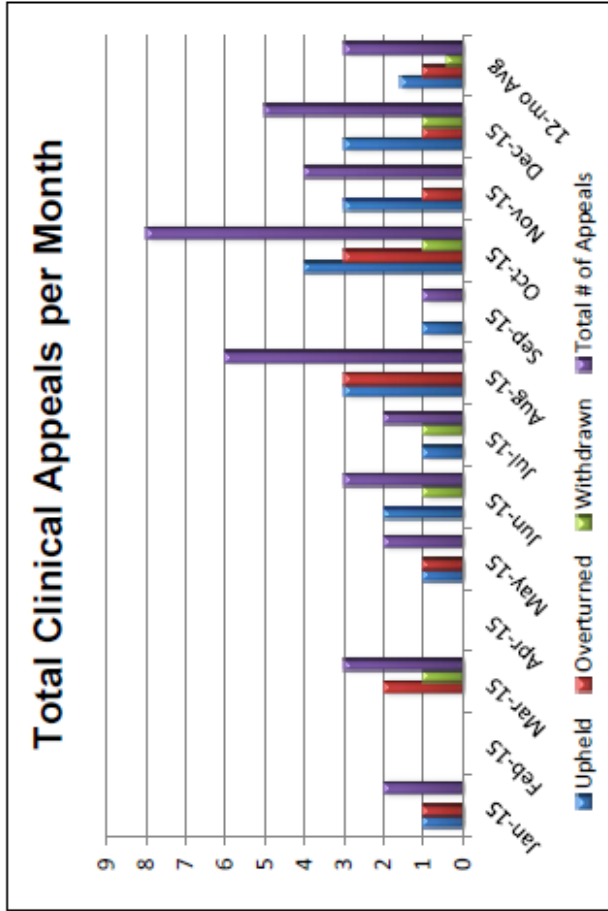


Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	12-mo Avg
178,163	178,984	182,795	184,306	187,029	187,801	189,321	193,185	196,857	196,857	198,863	202,362	189,710
77	81	101	107	106	96	8	10	11	16	9	14	53
0.43	0.45	0.55	0.58	0.57	0.51	0.04	0.05	0.06	0.08	0.05	0.07	0.29

\* Balance billing removed as a grievance type as of July 2015

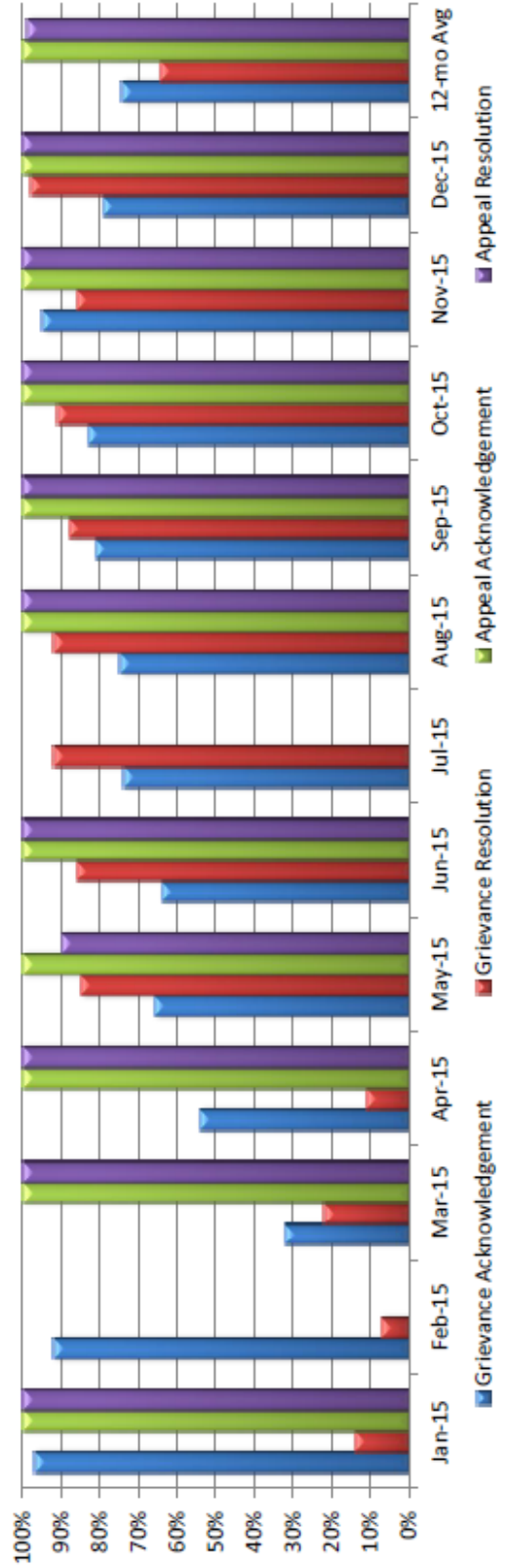
## GCHP Grievance & Appeals Metrics – December 2015

- GCHP resolved 5 clinical appeals in December; 3 were upheld, 1 was overturned and 1 was withdrawn
- GCHP's 12-month average for clinical appeals is 3
- TAT for grievance acknowledgements was not met (% decreased from prior month due to staffing issues)
- TATs for appeal acknowledgement and resolution were met during the month



## G&A Acknowledgement and Resolution TAT

SLA = Acknowledgement - 100% w/i 5 days, Resolution - 100% w/i 30 days





**AGENDA ITEM NO. 17**

To: Gold Coast Health Plan Commission  
 From: Melissa Scrymgeour, CISO  
 Date: February 22, 2016  
 RE: CISO Update

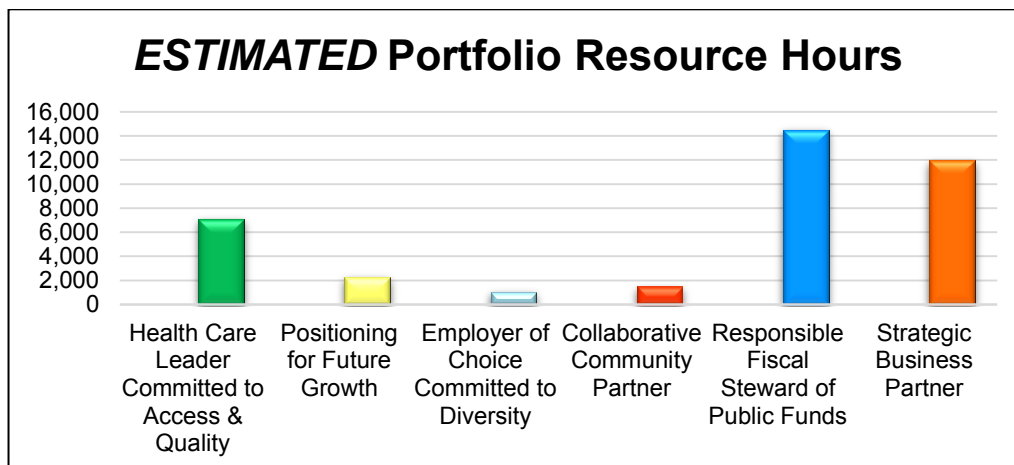
**Project Management Office (PMO)**

**PMO Project Activity Highlights through January 2016**

- Obtained CAQH Committee on Operating Rules for Information Exchange (CORE®) certification and closed project.
- Kicked off Provider Data Management Optimization (PDMO) Program

**Upcoming PMO Portfolio Activity:**

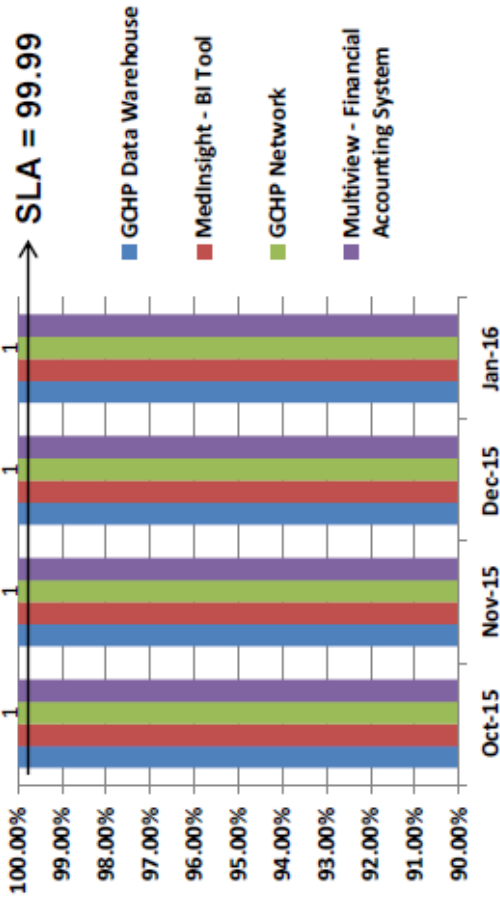
- Planning and kick off for the following projects:
  - Potential HEDIS Implementation
  - Potential PBM Implementation
  - ASO Analysis
  - Enterprise Data Warehouse
- Close SQL 2014 Upgrade
- Close SharePoint Phase I
- Close Benefits Analysis Committee (BAC) / Benefits Analysis Subcommittee (BASC)



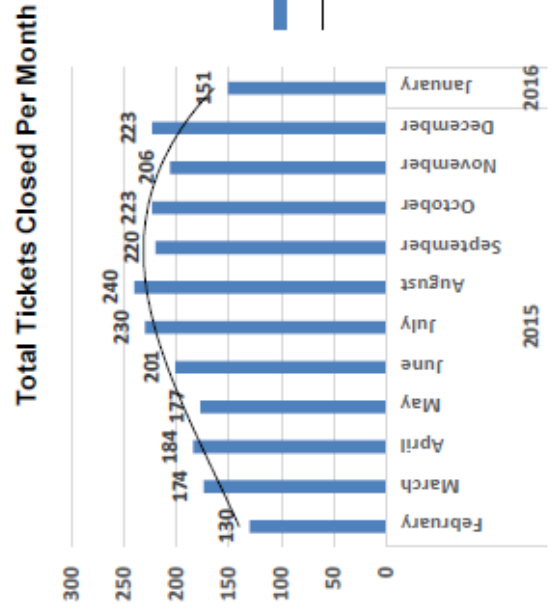
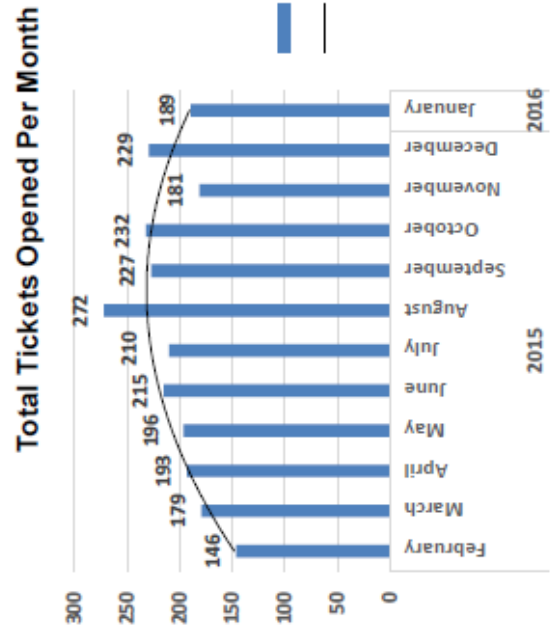


As reported during the January 2016 Commission meeting, the current project portfolio consists of roughly 39k resource hours. The PMO is currently evaluating Project Portfolio Management (PPM) tools to provide capacity and demand planning, and resource management functionality to assist in the evaluation and prioritization of the portfolio. The PPM tool will provide improved visibility into resource capacity and help to identify additional staffing needs to successfully deliver the strategic portfolio.

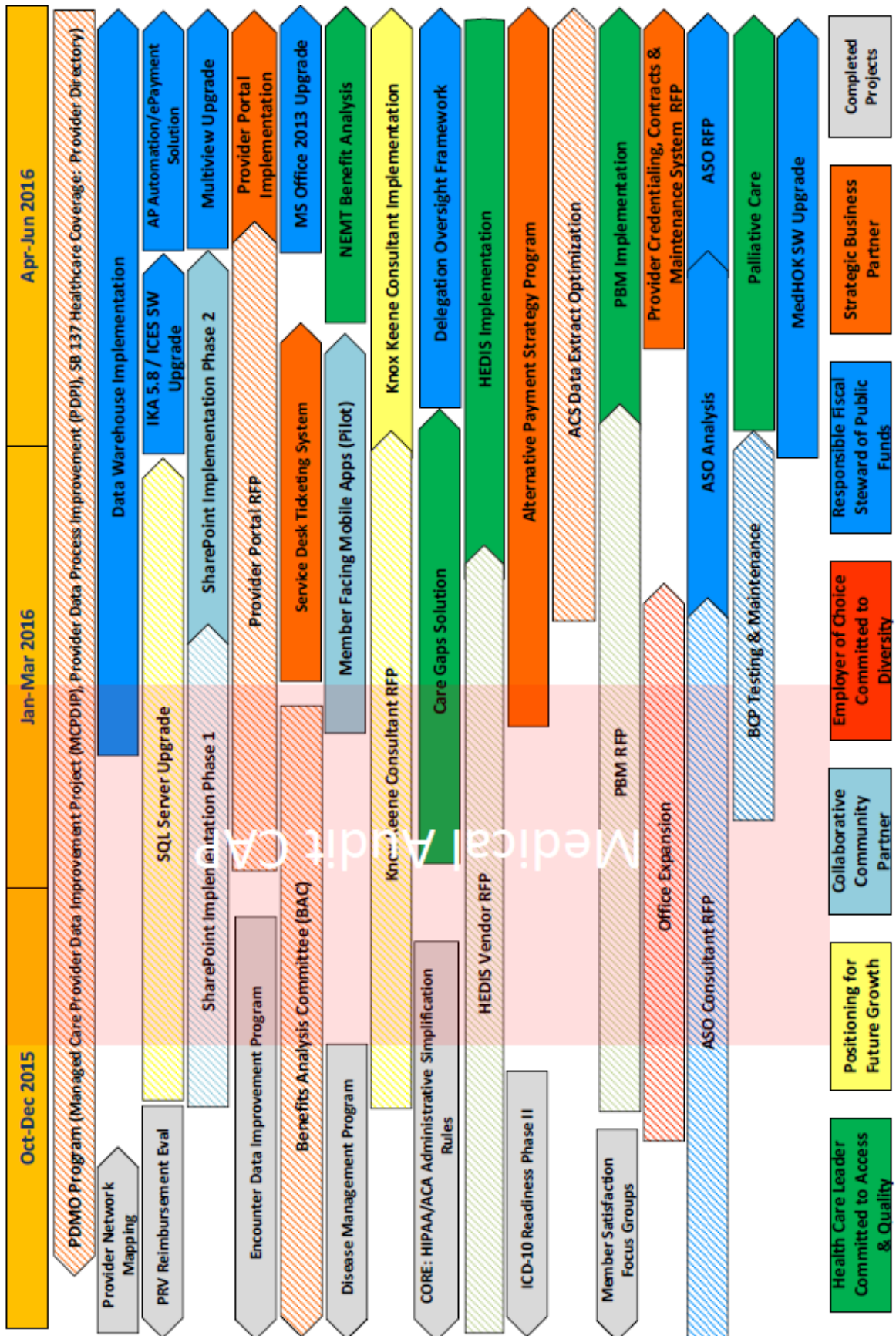
## GCHP IT Metrics – January 2016



## GCHP Helpdesk Service Ticket Trending



# GCHP FY 2015-16 Project Portfolio (Reforecast)





**AGENDA ITEM NO. 18**

To: Gold Coast Health Plan Commission  
From: Scott Campbell, General Counsel  
Date: February 22, 2016  
RE: Human Resources Cultural Diversity Sub-Committee Update

**RECOMMENDATION:**

To accept the oral report as presented by the General Counsel.