



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

2240 E. Gonzales, Suite 200, Oxnard, CA 93036
Monday, August 25, 2014
3:00 p.m.

AGENDA

CALL TO ORDER / ROLL CALL

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

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

1. APPROVE MINUTES

a. [Regular Meeting of July 28, 2014](#)

2. CONSENT ITEMS

a. [Accept and File June Financials](#)

3. APPROVAL ITEMS

a. [Resolution Reflecting Action at May 19, 2014 Meeting Amending / Revising and Ratifying Personnel Rules, Regulations and Policies for Dress Code, Vacation Buy-Back, Bereavement and SPOT Award](#)

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

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

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

**Ventura County Medi-Cal Managed Care Commission (VCMCC) dba
Gold Coast Health Plan August 25, 2014 Commission Meeting Agenda (continued)**

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

TIME: 3:00 p.m.

PAGE: Page 2 of 3

- b. [Rescind and / or Amend Vacation Buy-Back and SPOT Award Policies](#)
- c. [ACA 1202 Payment Approach](#)
- d. [DHCS Contract Amendments A01 and A12](#)
- e. [Quality Improvement Committee Report - 2nd Quarter 2014](#)
- f. [2014 QI Program and Work Plan](#)
- g. [Worker's Compensation Insurance](#)
- h. [Consumer Advisory Committee \(CAC\) Membership](#)

4. ACCEPT AND FILE ITEMS

- a. Accept Resignation of CEO
- b. [CEO Update](#)
- c. [COO Update](#)
- d. [Health Services Update](#)

5. NOTE AND FILE ITEMS

- a. Special Investigation Ad Hoc Committee Report

6. INFORMATION ITEMS

- a. [Incurred But Not Paid \(IBNP\)](#)

CLOSED SESSION

**a. Conference with Legal Counsel-Existing Litigation Pursuant to Government
Code Section 54956.9**

- (i) EEOC Charge No. 480-2014-02364
- (ii) EEOC Charge No. 480-2014-02058
- (iii) 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

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

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

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

**Ventura County Medi-Cal Managed Care Commission (VCMCC) dba
Gold Coast Health Plan August 25, 2014 Commission Meeting Agenda (continued)**

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

TIME: 3:00 p.m.

PAGE: Page 3 of 3

- b. Public Employee Appointment Pursuant to Government Code Section 54957**
Title: Chief Executive Officer-Acting / Interim Chief Executive Officer

- c. Public Employment Pursuant to Government Code Section 54957**
Title: Chief Executive Officer-Acting / Interim Chief Executive Officer

- d. Public Employee Performance Evaluation Pursuant to Government Code Section 54947:**
Title: General Counsel

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on September 22, 2014 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

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

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

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

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

July 28, 2014

(Not official until approved)

CALL TO ORDER

Chair Araujo called the meeting to order at 3:04 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE

Antonio Alatorre, Clinicas del Camino Real, Inc.
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Barry Fisher, Ventura County Health Care Agency (arrived 3:07 p.m.)
Peter Foy, Ventura County Board of Supervisors (arrived 3:07 p.m.)
David Glycer, Private Hospitals / Healthcare System
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Gagan Pawar, MD, Clinicas del Camino Real, Inc.
Dee Pupa, Ventura County Health Care Agency

EXCUSED / ABSENT COMMISSION MEMBERS

Lanyard Dial, MD, Ventura County Medical Association
Robert Wardwell, Private Hospitals / Healthcare System
Vacant, Medi-Cal Beneficiary Advocate

STAFF IN ATTENDANCE`

Michael Engelhard, Chief Executive Officer
Nancy Kierstyn Schreiner, Legal Counsel
Michelle Raleigh, Chief Financial Officer
Traci R. McGinley, Clerk of the Board
Brandy Armenta, Compliance Director
Stacy Diaz, Human Resources Director
Mike Foord, IT Infrastructure Manager
Anne Freese, Pharmacy Director
Guillermo Gonzalez, Government Relations Director
Lupe Gonzalez, Director of Health Education, Outreach, Cultural and Linguistic Services
Steven Lalich, Communications Director
Tami Lewis, Operations Director
Allen Maithel, Controller
Al Reeves, MD, Chief Medical Officer
Melissa Scrymgeour, Chief Information Officer
Lyndon Turner, Financial Analysis Director
Ruth Watson, Chief Operations Officer
Nancy Wharfield, MD, Medical Director Health Services

The Pledge of Allegiance was recited.

Language Interpreting and Translating services was provided by GCHP from Lourdes González Campbell and Associates.

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of May 19, 2014

Chair Araujo explained that due to questions regarding the May 19, 2014 Minutes at the last meeting a transcript of the agenda items and votes in question was provided.

Commissioner Foy moved to approve the Regular Meeting Minutes of May 19, 2014. Commissioner Pupa seconded. The motion carried with the following votes:

AYE: Araujo, Foy, Glycer, Laba and Pupa.
NAY: Alatorre and Pawar.
ABSTAIN: Fisher.
ABSENT: Dial and Wardwell.

b. Special Meeting of June 18, 2014

Commissioner Fisher moved to approve the Special Meeting Minutes of June 18, 2014. Commissioner Alatorre seconded. The motion carried with the following votes:

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

c. Regular Meeting of June 23, 2014

Commissioner Fisher moved to approve the Regular Meeting Minutes of June 23, 2014. Commissioner Alatorre seconded. The motion carried with the following votes:

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

2. CONSENT ITEMS

Item 2d, *Approve Resolution Amending Personnel Rules, Regulations and Policies* was pulled from the Consent Items for discussion.

a. June Financials

In response to questions about the increase in legal fees, CEO Engelhard explained that there has been a significant increase in matters requiring legal services this year related

not only to general counsel items, but items such as public records request response preparation, personnel matters, litigation defense expenses, insurance matters and provider contracting issues. He emphasized that staff is looking for ways to reduce the legal costs and clarified that multiple firms are being used for different types of matters.

b. Financial Auditor 2014 Client Service and Audit Plan

c. Quarterly Update to Auditor's Recommendations

In response to questions on the report, CFO Raleigh explained that the table provides a status update of the Plan's activities in response to the auditor's recommendations from last year.

e. Direct Staff to Conduct Conflict of Interest Biennial Review

f. Approve Resolution Amending the Claims Procedure to Reflect Current Mailing Address

g. Ratify Letters of Support for Grants

Commissioner Fisher moved to approve the Consent Items with the exception of Item 2d, which was removed from Consent Items. Commissioner Foy seconded. The motion carried with the following votes:

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

2. CONSENT ITEM – REMOVED FOR DISCUSSION

d. Approve Resolution Amending Personnel Rules, Regulations and Policies

Commissioner Fisher explained that he had not been present at the May Commission meeting and had questions on the Vacation Buy-Back and the SPOT Award. He asked why the Vacation Buy-Back policy was approved retroactively. Legal Counsel Kierstyn Schreiner explained that the Commission agreed to approve the Vacation Buy-Back policy retroactively because the policy had originally been put into place as an administrative policy and employees had already taken utilized this policy.

Commissioner Fisher asked if the Vacation Buy-Back policy could be put on hold because the Vacation Buy-Back policy is part of the outside investigation that the Special Investigation Ad Hoc Committee is overseeing.

Legal Counsel Kierstyn Schreiner explained that the resolution before the Commission reflects the action taken by the Commission on May 19, 2014. If the Commission wishes to change the policy it could be placed on the agenda at a future meeting.

Legal Counsel Kierstyn Schreiner noted that on the Bereavement Policy attachment to the Resolution should reflect an effective date of July 1, 2014.

With regard to the SPOT Award, Commissioner Fisher expressed concern about the budget amount; the County of Ventura has something similar, but with over 8,000 employees it only has an annual budget of \$500.

Commissioner Alatorre expressed concern about the September 1, 2012 date on some of the policies and had not seen or heard that date before on these policies.

Legal Counsel Kierstyn Schreiner explained that the original Personnel Policies were adopted by the Plan in August 2012, effective September 1, 2012.

Commissioner Foy moved to continue 2d, Approve Resolution Amending Personnel Rules, Regulations and Policies until the August Commission Meeting to discuss the resolution and the individual policies related to that Resolution, including the Vacation Buy-Back Policy and the SPOT Award Policy with the understanding that the CEO will suspend those two policies until further Commission Action. Commissioner Alatorre seconded. The motion carried with the following votes:

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

3. APPROVAL ITEMS

a. Sponsorship Request: MICOP

Lupe Gonzalez, Director of Health Education, Outreach, Cultural and Linguistic Services, reviewed the staff report requesting the Commission approve a \$1,500 sponsorship to the MICOP annual gala event. CEO Engelhard added that GCHP does not currently have a sponsorship policy.

Commissioner Fisher moved to approve the request for sponsorship with the condition that management present a Sponsorship Policy to the Commission for review and approval within the next three months and that the Commission will not approve any additional sponsorships until a policy is in place. Commissioner Glycer seconded. The motion carried with the following votes:

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

b. ACA 1202 Payment Approach

CFO Raleigh reviewed the report with the Commission. The initial payments were made in March, 2014 and as these payments were made the State alerted the managed care plans that a change in calculation of these supplemental payments was necessary. The

State clarified the calculation to include the “lesser of” language for non-Child Health and Disability Prevention (CHDP) claims which may have caused some providers to be overpaid based on how their original billings were submitted. Staff recommends that overpayments not be recovered from the providers and that GCHP follow the State’s methodology, including the “lesser of” language for non-CHDP claims effective July 1, 2013. The State will be providing detail and clarify these changes, processes, and documentation. At that time, GCHP will review the additional State instructions and prepare payments to qualifying providers as State funding is received.

Commissioner Foy moved to continue this item to the next Commission Meeting. Commissioner Fisher seconded. The motion carried with the following votes:

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

c. Compliance Officer Quarterly Report

Brandy Armenta, Compliance Officer, reviewed the quarterly report reflecting the Plan’s activities. After discussion, the Commission requested copies of the work plan be provided and that statistics be provided at each meeting.

Commissioner Pupa moved to approve the Compliance Report. Commissioner Foy seconded. The motion carried with the following votes:

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

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

Commissioner Fisher reviewed with the Commission that two attorneys had been retained for the Ad Hoc Committee and requested the Commission reaffirm support that this is a transparent process. Chair Araujo confirmed that the Ad Hoc Committee will report to the Commission any contracts entered into by the Ad Hoc Committee.

Commissioner Pupa moved to approve and affirm that the Special Investigation Ad Hoc Committee may enter into contracts as it deems necessary to complete the investigation. Foy seconded. The motion carried with the following votes:

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

4. ACCEPT AND FILE ITEMS

Chair Araujo announced that Item 4c, *CMO Update – Quality Improvement Committee Report 2nd Quarter 2014* is removed from the Agenda and will come before the Commission at the next meeting.

a. CEO Update

CEO Engelhard reviewed the written report.

b. COO Update

COO Watson reviewed the written report.

Commissioner Foy moved to accept and file the COO Update. Commissioner Fisher seconded. The motion carried with the following votes:

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

d. Health Services Update

Nancy Wharfield, Medical Director Health Services reviewed the written report.

Commissioner Pupa moved to accept and file the CEO and Health Services Updates. Commissioner Fisher seconded. The motion carried with the following votes:

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

COMMENTS FROM COMMISSIONERS

Commissioner Fisher commented that Guillermo Gonzalez had done a great job on the educational session done the previous week re: Advisory Group session. With regard to the Special Investigation, Commission Fisher wanted the public and employees to know that the investigation will take time but that it will be a thorough investigation into the matter.

Commissioner Pupa commended CEO Engelhard and the staff for doing great job with the additional membership that has been added to the Plan.

CLOSED SESSION

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

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 4:48 pm regarding the following items:

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

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 5:16 p.m.

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

ADJOURNMENT

Meeting adjourned at 5:17 p.m.

AGENDA ITEM 2a

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: August 25, 2014

Re: June 2014 Financials

SUMMARY

Staff is presenting the attached June 2014 financial statements of Gold Coast Health Plan (Plan) for review by the Commission. These financials were reviewed by the Executive / Finance Committee on August 7, 2014 where the Committee recommended approval of these financials to the Commission.

BACKGROUND / DISCUSSION

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

FISCAL IMPACT

Year-To-Date Results

On a year-to-date basis, the Plan's net income is approximately \$25.8 million compared to \$16.5 million assumed in the budget. These operating results have contributed to a Tangible Net Equity (TNE) level of approximately \$37.7 million, which exceeds both the budget of \$28.4 million (by \$9.3 million) and the State minimum required TNE amount of \$19.7 million (by \$18.0 million).

It should be noted that the Plan has changed the quarterly and annual TNE calculations (as of June 30, 2014) to be in alignment with State reported calculations.

Note the TNE minimum requirement is no longer being phased-in since the Plan just completed its third year of operations, which is the period of time the State phases-in the minimum TNE requirement. Please note the Plan's TNE amounts noted in the financial package include the \$7.2 million in lines of credit with the County of Ventura. Also, as of the end of the FY 2013-14, the Plan's TNE is:

- 193% of the minimum State-required TNE level and
- 156% of the minimum State-required TNE level, excluding the lines of credit of \$7.2 million.

Comparative Results Across Fiscal Years

Membership - For FY 2013-14, average monthly members were approximately 27,480 greater (or approximately 330,000 member months) than in FY 2012-13. The growth was primarily due to expansion in the Targeted Low Income Children (TLIC) and Adult Expansion (AE) member categories whose membership as a percentage of total membership rose from less than 6% at June 30, 2013 to more than 29% at June 30, 2014. The TLIC population included the children transitioning from the State's Healthy Families population in August, 2013. The AE population included the transition of the County's Low Income Health Population (LIHP) in January, 2014 and other related State expansions under the Affordable Care Act (ACA).

Revenue - This membership expansion was a significant contributor to the 30% or \$93.8 million increase in revenue for FY 2013-14 over FY 2012-13. The average revenue rate per-member-per-month (PMPM) was approximately 2% higher in the closing year, compared to FY 2012-13 as a result of the Plan enrolling a different mix of members and due to the ACA 1202 funds (i.e., funds used to pay qualifying providers rates at effective Medicare levels for specific services) received for January, 1 - June 30, 2013.

Health Care Costs - Health care costs for FY 2013-14 were 27% or \$76.3 million higher than in FY 2012-13, mostly associated with the aforementioned expansion in the TLIC and AE member categories. Also adding to health care costs were:

- The expansion of the mental health benefit provided to the Plan's members (added in connection with ACA) in January, 2014. The expense for this new service totaled \$1.5 million.
- The ACA 1202 amounts noted above have been reflected in the financials as all being paid out to providers.

The medical loss ratio (MLR) for the current year is 87% versus 89% in FY 2012-13. The MLR is calculated by dividing health care costs by total revenue and is decreased for the current year due to the revenue growth.

Administrative Expenses – Operating expenses for the closing year were approximately 10% or \$2.5 million higher than in FY 2012-13. The increases were driven primarily from:

- expenses dependent on membership (e.g. ACS, Beacon Health Strategies),
- additional personnel, and
- infrastructure costs necessary to support expanded operations.

Offsetting these operating expenses were savings achieved through less reliance on consulting services, specifically the State monitor.

The administrative cost ratio (ACR) for the year ended June 30, 2014 was 6.5% as compared to 7.6% for FY 2012-13. The ACR is calculated by dividing administrative expenses by total

revenue and the decrease for the current year versus FY 2012-13 resulted from operating efficiencies as well as revenue growth caused by expanded membership.

June 2014 Results and Comparative Results to Budget

Membership - June membership of 157,168 exceeded budget by 22,167 members. As in the prior months, the Adult / Family and AE categories are driving membership growth. Current membership is 23% better than at December 31, 2013 and is more than 48% higher year-over-year.

Revenue – June and YTD net revenue were \$46.5 and \$409.0 million, which exceeded their budgeted amounts of \$38.3 and \$390.0 million, by \$8.3 and \$19.2 million, respectively. On a PMPM basis, net revenue was \$296.03 PMPM which was \$12.87 PMPM better than budget of \$283.16 PMPM. For YTD, PMPM was \$263.22 versus \$258.14 PMPM for budget. The favorable to budget revenue performance for both June and YTD resulted from membership growth being greater than anticipated in total, with significantly more members than expected in higher capitation rate cells and the ACA 1202 payments.

Specific variances for the month of June include:

- AE membership exceeded budget by approximately 8,700 members, generating an additional \$6.5 million in revenue as compared with budget.
- The Adult / Family category also produced excess revenue of \$0.8 million through a positive membership variance of approximately 10,600.
- The remaining variance is due to differences in mix of the population.

Other notable items impacting revenue include:

- The Plan received a one-time payment in connection with implementation of Amendment #11 rates which adjusted revenue for the period January 2014 through March 2014. Upon further review of the documentation from the State, the Plan needed to adjust financials accordingly:
 - Premium - The impact of implementing these rates for the January – March time period had a net increase in revenue of \$1.2 million.
 - AB 97 Reserve for Rate Reduction - Since the Amendment #11 rates had already been reduced to reflect the AB 97 provider rate reductions, the AB 97 reserve held by the Plan for January – March time period could be released, adding approximately \$1.3 million back to revenue.
 - CBAS - Amendment #11 rates included payments for community based adult services (CBAS); rates were not paid through a separate CBAS payment as in the past. Therefore, previously recorded separate CBAS revenues were reversed resulting in reducing revenue by \$2.5 million.

Note: estimates were used for June's enrollment and associated revenue because State documentation commonly provided with the capitation check was not available in time for the month-end close.

Health Care Costs - Health care costs for June were \$37.1 million or \$2.7 million more than budget. Year-to-date health care costs were \$356.7 million compared to a budgeted \$346.5 million. On a PMPM basis, June health care costs were \$236.37 PMPM versus a budgeted amount of \$255.42. Year-to-date, actual costs were \$229.58 PMPM as compared to \$229.52 PMPM in the budget.

Causes for the June total dollar variance to budget include:

- Membership growth – Increases in membership over budget accounted for approximately \$5.6 million of negative variance. Much of the membership growth occurred in a high-cost aid category (AE).
- Capitation – Increased due to the implementation of capitation arrangements for the majority of the AE members, effective June 1. The new capitation payments, worth approximately \$0.53 million were not known during the completion of the budget.
- Inpatient – Reserves had been increased in May after reviewing hospital data such as census reports. June data suggested that inpatient census appeared to be normalizing. Consequently, approximately \$0.9 million of the reserve was released.
- LTC / SNF – Reserves of approximately \$0.4 million related to AB 1629 rate increases were added to the existing amounts in place from prior months. The Plan received additional information from the State which resulted in a better estimate of expected rate increases pursuant to AB 1629 related to months prior to the system implementation of the new rates.
- Pharmacy – Pharmacy expense has risen substantially, due in part to the new Hepatitis C drug (Sovaldi) as well as through the growing AE population. However, the increase in utilization among the new population has not achieved the rate as expected in the revised budget.
- Other Fee for Service – This category, which is a combination of five services, is greatly impacted by a high expected PMPM in the AE population. Consequently, the expenses (and related reserves) have been driven by the growth in membership.
- Reinsurance – The overall rise in health care costs was mitigated by the receipt of over \$1.2 million in recoveries. For the year, recoveries amounted to nearly \$2.5 million.

As disclosed in prior months, the current financials continue to reflect an estimated 85% MLR for overall medical expenses specific to the AE population. However, the additional reserve still results in total expenses that are below budget for this new population, because pharmacy expenses have been less than budget. Based on the 85% MLR requirement for this population, the medical expense reserve was increased by approximately \$2.0 million in June, bringing the YTD total reserve to \$8.1 million (this is reflected in the pharmacy row of the

income statement). Other services reflect a 91% MLR per the State's estimates and will be evaluated as claims data is received. The Plan consulted with its audit firm and obtained agreement with the way the Plan is increasing the reserve in response to this contract provision.

Administrative Expenses – For the month, overall operational costs were in line with budgeted expenses, with actual expenses being approximately \$132,000 more than budget. Expenses driven by membership (e.g. ACS, Beacon Health Strategies) resulted in expenses being \$183,000 more than budget. Legal expenses are also \$88,000 over budget. Savings of \$78,000 were realized from lower personnel expenses due to timing of new hires. Interest expense was favorable to budget, due to recovery from providers. For the year, operating expenses were in line with expectations and was only \$247,000 or less than 1% over budget.

Cash + Medi-Cal Receivable - The total of Cash and Medi-Cal Premium Receivable balances of \$160.0 million reported as of June 30, 2014 included a MCO Tax component amounting to \$15.0 million. Excluding the impact of the tax, the total of Cash and Medi-Cal Receivable balance as of June 30, 2014 was \$145.0 million, or \$52.0 million better than the budgeted level of \$93.0 million.

Note the State Capitation Premium Receivable for May and June was still outstanding at June 30, 2014. The May receivable was settled in July while the June receivable was received on August 1, 2014. The payment delays were caused by a system conversion at Department Health Care Services (DHCS).

Physician ACA 1202 Payable Liability – The balance for this liability at June 30, 2014 is approximately \$3.2 million and represents funds received from the State related to ACA 1202 legislation allowing for additional funding to qualifying providers. The Plan is awaiting additional guidance from the State and the Commission before distributing supplemental payments to qualifying providers. ACA 1202 medical expense also includes for a small amount to be eventually retained by the Plan to cover administration costs. Once the funds are distributed or further guidance is provided, the portion that is retained by the Plan will be recognized on the income statement.

Deferred Rent Liability – Generally, the lease payments for the new office facility increase over the lease term. According to Generally Accepted Accounting Principles (GAAP), lease expense under such lease agreements should be recorded on a straight-line basis. As such, the deferred rent balance represents the difference between what was paid and amortized using a straight-lining lease expense for the office rent. The deferred rent liability balance at June 30, 2014 is approximately \$72,000, and is included in Other Long-Term Liabilities.

Potential Post-Closing Adjustments

The Plan is aware of the following items that may adjust FY 2013-14 results through post-close adjustments:

- Revenue - Note revenue for June is based on DHCS contract amendment #11 rates which are the same rates used to compute revenue since January. Final rates for FY 2013-14 are currently being confirmed with the State. An adjustment to current year revenue will be made to reflect the new rates once the final rates are known.
- Also, as noted above, because June's enrollment data aligning with the payment received was not available in time for the month-end close, an estimate was used to compute the revenue (and Medi-Cal receivable).
- IBNP - the incurred but not paid (IBNP) liability amount is subject to review by the Plan's actuaries and external accountants and further adjustment may be necessary based on their reviews. As noted above, the Plan did not receive all appropriate documentation in time for the June close from the State. This resulted in additional estimating of the IBNP as of June 30, 2014. The Plan continues to receive inquiries from Ventura County Medical Center (VCMC) about a potential claims submission backlog that occurred when that provider transitioned to a new electronic records system. It is unclear how large the potential claims backlog continues to be and the Plan is continuing to analyze information that could impact IBNP.

RECOMMENDATION

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

CONCURRENCE

Executive / Finance Committee, August 7, 2014

Attachment

June 2014 Financial Package



FINANCIAL PACKAGE

For the month ended June 30, 2014

TABLE OF CONTENTS

- Financial Overview
- Membership
- Income Statement/PMPM Income Statement by Month
- YTD Income Statement
- Comparative Balance Sheet
- Cash & Medi-Cal Receivable Trend
- Paid Claims and IBNP

APPENDIX

- Statement of Cash Flows
- YTD Cash Flows
- Total Expenditure Composition
- Pharmacy Cost & Utilization Trends

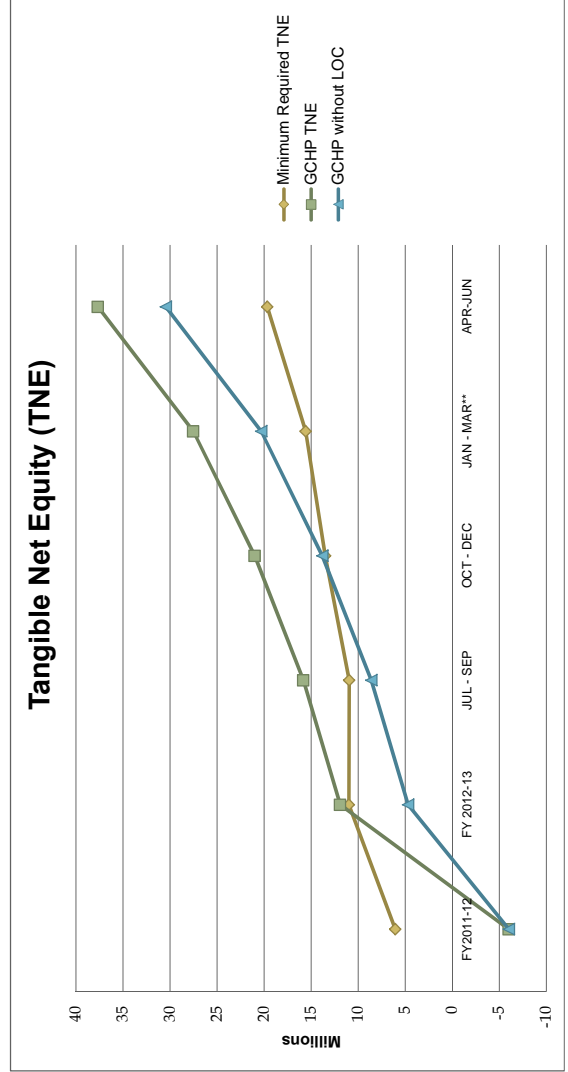
Financial Overview

Description	UNAUDITED FY 2013-14 Actual										Budget Comparison	
	AUDITED*	AUDITED*	JUL - SEP	OCT - DEC	JAN - MAR**	APR-JUN	YTD	Budget YTD	Variance Fav/(Unfav)	Variance Fav/(Unfav) %		
Member Months												
Revenue												
<i>pmpm</i>	1,258,189	1,223,895	347,079	362,021	397,467	447,093	1,553,660	1,509,746	43,914	2.9 %		
	304,635,932	315,119,611	81,988,709	84,070,466	112,028,121	130,864,339	408,951,624	389,732,567	19,219,058	4.9 %		
	242.12	257.47	236.22	232.23	281.86	292.70	263.22	258.14	5.07	2.0 %		
Health Care Costs												
<i>pmpm</i>	287,353,672	280,382,704	71,875,533	72,867,512	98,914,429	113,026,921	356,684,395	346,522,089	(10,162,306)	(2.9)%		
% of Revenue	228.39	229.09	207.09	201.28	248.86	252.80	229.99	229.52	(0.05)	(0.0)%		
	94.3%	89.0%	87.7%	86.7%	88.3%	86.4%	87.2%	88.9%	-1.7%	-1.9%		
Admin Exp												
<i>pmpm</i>	18,891,320	24,013,927	6,202,007	6,014,475	6,697,110	7,687,941	26,501,533	26,749,142	247,608	0.9 %		
% of Revenue	15.01	19.62	17.87	16.61	16.60	17.20	17.06	17.72	0.66	3.7 %		
	6.2%	7.6%	7.6%	7.2%	5.9%	5.9%	6.5%	6.9%	0.4%	5.6%		
Net Income												
<i>pmpm</i>	(1,609,063)	10,722,980	3,911,169	5,188,469	6,516,582	10,149,477	25,765,696	16,461,336	9,304,360	56.5 %		
% of Revenue	(1.28)	8.76	11.27	14.33	16.40	22.70	16.58	10.90	5.68	52.1 %		
	-0.5%	3.4%	4.8%	6.2%	5.8%	7.6%	6.3%	4.2%	2.1%	49.2%		
100% TNE	16,769,368	16,138,440	16,112,437	16,056,217	18,539,458	19,653,502	19,653,502	19,095,070	558,431	2.9 %		
% TNE Required	36%	68%	68%	84%	84%	100%	100%	100%				
Minimum Required TNE	6,036,972	10,974,139	10,956,457	13,487,223	15,573,145	19,653,502	19,653,502	19,095,070	558,431	2.9 %		
GCHP TNE	(6,031,881)	11,891,099	15,802,268	20,990,738	27,507,320	37,656,797	37,656,797	28,352,436	9,304,361	32.8 %		
TNE Excess / (Deficiency)	(12,068,853)	916,960	4,845,810	7,503,516	12,997,168	18,003,295	18,003,295	9,257,366	8,745,929	94.5 %		

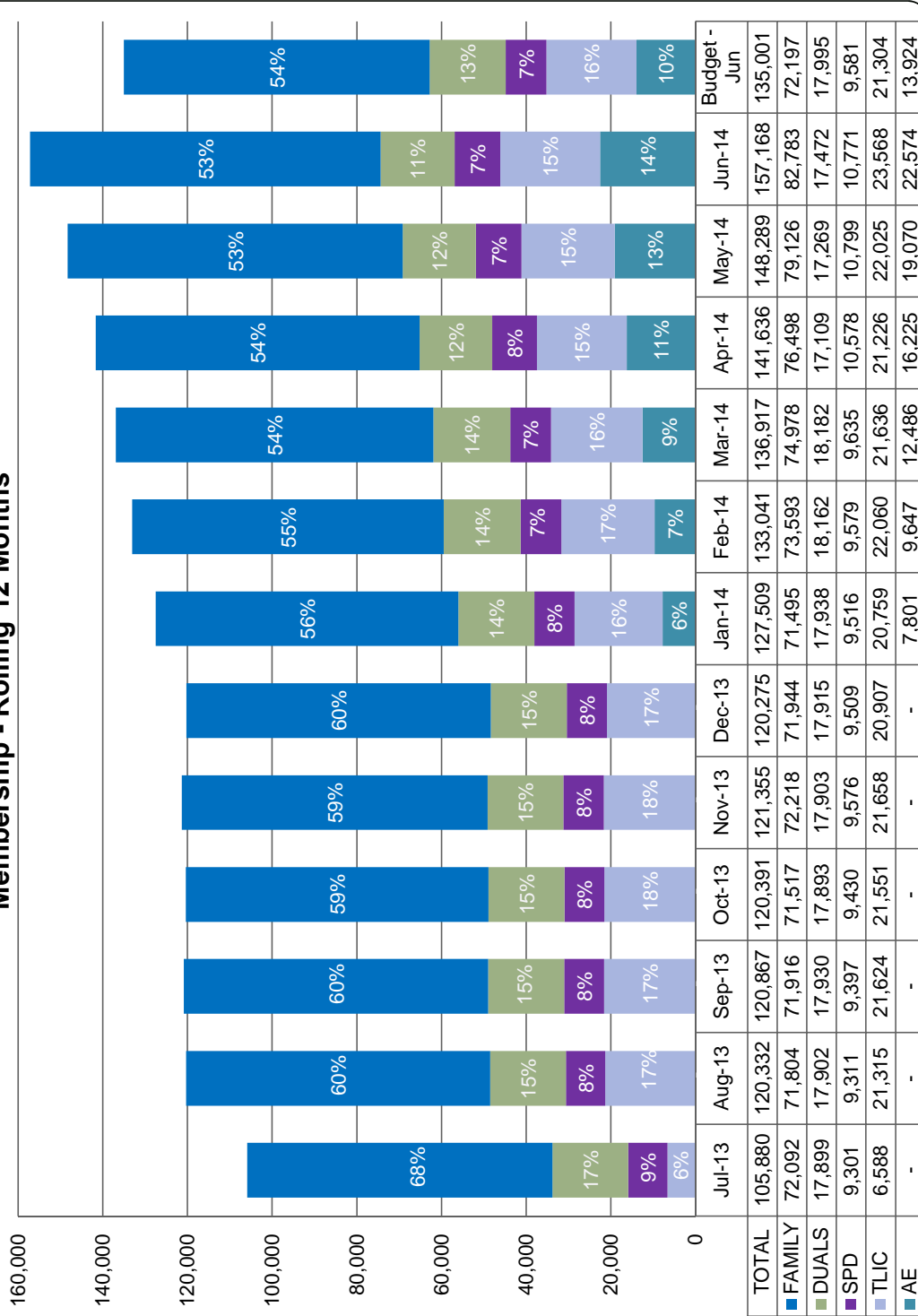
Note: TNE amount includes \$7.2 million related to the Lines of Credit (LOC) from Ventura County.

* Audited amounts reflect financial adjustments made by auditors, but exclude presentation reclassifications without P&L impact (i.e. reporting package kept the same).

**ACA 1202 payment (\$5.2 million) received from State in January was added back to revenue and health care cost in the month of January (in the June package). This is a change from prior months because the State has finalized the ACA 1202 payment methodology.



Membership - Rolling 12 Months



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

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

Income Statement Monthly Trend

	FY2013-14 Monthly Trend			Current Month		
	MAR 2014	APR 2014	MAY 2014	JUNE 2014		Variance Fav/(Unfav)
				Actual	Budget	
Membership (includes retro members)	136,917	141,636	148,289	157,168	135,001	22,167
Revenue:						
Premium	\$ 39,652,832	\$ 42,486,972	\$ 45,197,814	\$ 47,173,118	\$ 40,008,794	\$ 7,164,324
Reserve for Rate Reduction	(440,736)	-	-	1,253,837	(257,796)	1,511,634
MCO Premium Tax	(1,529,127)	(1,672,942)	(1,779,698)	(1,954,702)	(1,575,346)	(379,355)
Total Net Premium	37,682,970	40,814,030	43,418,115	46,472,254	38,175,651	8,296,602
Other Revenue:						
Interest Income	17,728	16,425	12,448	16,066	13,203	2,863
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	0
Total Other Revenue	56,061	54,759	50,782	54,399	51,536	2,863
Total Revenue	37,739,031	40,868,789	43,468,897	46,526,653	38,227,188	8,299,465
Medical Expenses:						
<u>Capitation (PCP, Specialty, Kasier, NEMT & Visior</u>	1,704,134	1,797,876	1,851,892	2,438,071	1,672,605	(765,466)
<u>FFS Claims Expenses:</u>						
Inpatient	7,940,779	9,670,256	9,002,937	6,708,899	7,492,396	783,497
LTC/SNF	7,256,361	6,106,318	8,116,213	7,439,023	6,068,491	(1,370,532)
Outpatient	2,631,325	3,845,231	3,312,183	3,062,231	3,417,512	355,281
Laboratory and Radiology	609,596	512,307	629,923	800,113	533,349	(266,764)
Physician ACA 1202	102,189	-	-	-	-	-
Emergency Room	975,817	1,127,040	1,093,890	1,514,158	1,055,816	(458,342)
Physician Specialty	2,433,750	2,572,332	2,306,001	2,046,830	2,675,808	628,978
Mental Health Services	254,043	248,532	297,327	298,328	191,969	(106,359)
Pharmacy	5,648,117	6,255,595	7,006,271	7,534,160	6,502,191	(1,031,968)
Other Medical Professional	218,265	200,064	224,924	251,042	188,935	(62,107)
Other Medical Care	3,645	331	-	387	-	(387)
Other Fee For Service	3,250,414	3,791,877	4,329,381	4,800,761	3,413,714	(1,387,048)
Transportation	79,919	111,272	77,615	142,371	89,403	(52,968)
Total Claims	31,404,220	34,441,155	36,396,665	34,598,303	31,629,583	(2,968,720)
Medical & Care Management Expense	828,605	896,582	921,915	1,363,457	973,010	(390,447)
Reinsurance	308,761	319,404	(120,034)	(934,004)	206,551	1,140,555
Claims Recoveries	(33,912)	(389,784)	(237,943)	(316,634)	-	316,634
Sub-total	1,103,455	826,202	563,938	112,819	1,179,561	1,066,742
Total Cost of Health Care	34,211,809	37,065,232	38,812,496	37,149,193	34,481,749	(2,667,444)
Contribution Margin	3,527,222	3,803,556	4,656,402	9,377,460	3,745,439	5,632,021
General & Administrative Expenses:						
Salaries and Wages	584,952	585,889	662,308	592,779	664,392	71,612
Payroll Taxes and Benefits	144,143	152,089	158,128	152,969	159,084	6,115
Travel and Training	7,364	8,647	7,786	13,484	19,138	5,654
Outside Service - ACS	1,044,479	1,127,533	1,167,563	1,179,130	1,022,033	(157,098)
Outside Services - Other	82,663	81,293	214,869	103,733	78,078	(25,655)
Accounting & Actuarial Services	29,239	17,051	(7,071)	35,136	20,833	(14,302)
Legal	71,044	33,293	134,879	124,593	36,340	(88,253)
Insurance	12,120	11,990	11,949	11,914	15,095	3,181
Lease Expense - Office	28,979	226,981	63,318	92,081	64,355	(27,726)
Consulting Services	57,096	71,630	35,325	128,446	127,977	(468)
Translation Services	5,197	1,963	5,152	4,711	2,417	(2,294)
Advertising and Promotion	(790)	1,300	-	9,010	15,596	6,586
General Office	73,897	126,456	91,250	107,081	97,180	(9,901)
Depreciation & Amortization	7,015	14,711	15,108	15,133	53,474	38,341
Printing	21,503	12,008	1,312	6,227	11,696	5,469
Shipping & Postage	464	1,945	318	237	2,950	2,713
Interest	27,738	22,754	35,144	(49,375)	4,320	53,695
Total G & A Expenses	2,197,102	2,563,313	2,597,338	2,527,289	2,394,959	(132,330)
Net Income / (Loss)	\$ 1,330,120	\$ 1,240,243	\$ 2,059,063	\$ 6,850,171	\$ 1,350,479	\$ 5,499,691

MPPM Income Statement Comparison

	MAR 2014	APR 2014	MAY 2014	JUNE 2014		Variance
				Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	136,917	141,636	148,289	157,168	135,001	22,167
Revenue:						
Premium	289.61	299.97	304.80	300.14	296.36	3.78
Reserve for Rate Reduction	(3.22)	-	-	7.98	(1.91)	9.89
MCO Premium Tax	(11.17)	(11.81)	(12.00)	(12.44)	(11.67)	(0.77)
Total Net Premium	275.22	288.16	292.79	295.69	282.78	12.90
Other Revenue:						
Interest Income	0.13	0.12	0.08	0.10	0.10	0.00
Miscellaneous Income	0.28	0.27	0.26	0.24	0.28	(0.04)
Total Other Revenue	0.41	0.39	0.34	0.35	0.51	(0.16)
Total Revenue	275.63	288.55	293.14	296.03	283.16	12.87
Medical Expenses:						
<u>Capitation (PCP, Specialty, Kasier, NEMT & Visior</u>	12.45	12.69	12.49	15.51	12.39	3.12
FFS Claims Expenses:						
Inpatient	58.00	68.28	60.71	42.69	55.50	12.81
LTC/SNF	53.00	43.11	54.73	47.33	44.95	(2.38)
Outpatient	19.22	27.15	22.34	19.48	25.31	5.83
Laboratory and Radiology	4.45	3.62	4.25	5.09	3.95	(1.14)
Physician ACA 1202	0.75	-	-	-	-	-
Emergency Room	7.13	7.96	7.38	9.63	7.82	(1.81)
Physician Specialty	17.78	18.16	15.55	13.02	19.82	6.80
Mental Health Services	1.86	1.75	2.01	1.90	1.42	(0.48)
Pharmacy	41.25	44.17	47.25	47.94	48.16	0.23
Other Medical Professional	1.59	1.41	1.52	1.60	1.40	(0.20)
Other Medical Care	0.03	0.00	-	0.00	-	(0.00)
Other Fee For Service	23.74	26.77	29.20	30.55	25.29	(5.26)
Transportation	0.58	0.79	0.52	0.91	0.66	(0.24)
Total Claims	229.37	243.17	245.44	220.14	234.29	14.16
Medical & Care Management Expense	6.05	6.33	6.22	8.68	7.21	(1.47)
Reinsurance	2.26	2.26	(0.81)	(5.94)	1.53	7.47
Claims Recoveries	(0.25)	(2.75)	(1.60)	(2.01)	-	2.01
Sub-total	8.06	5.83	3.80	0.72	8.74	8.02
Total Cost of Health Care	249.87	261.69	261.74	236.37	255.42	19.05
Contribution Margin	25.76	26.85	31.40	59.67	27.74	31.92
General & Administrative Expenses:						
Salaries and Wages	4.27	4.14	4.47	3.77	4.92	1.15
Payroll Taxes and Benefits	1.05	1.07	1.07	0.97	1.18	0.21
Travel and Training	0.05	0.06	0.05	0.09	0.14	0.06
Outside Service - ACS	7.63	7.96	7.87	7.50	7.57	0.07
Outside Services - Other	0.60	0.57	1.45	0.66	0.58	(0.08)
Accounting & Actuarial Services	0.21	0.12	(0.05)	0.22	0.15	(0.07)
Legal	0.52	0.24	0.91	0.79	0.27	(0.52)
Insurance	0.09	0.08	0.08	0.08	0.11	0.04
Lease Expense - Office	0.21	1.60	0.43	0.59	0.48	(0.11)
Consulting Services	0.42	0.51	0.24	0.82	0.95	0.13
Translation Services	0.04	0.01	0.03	0.03	0.02	(0.01)
Advertising and Promotion	(0.01)	0.01	-	0.06	0.12	0.06
General Office	0.54	0.89	0.62	0.68	0.72	0.04
Depreciation & Amortization	0.05	0.10	0.10	0.10	0.40	0.30
Printing	0.16	0.08	0.01	0.04	0.09	0.05
Shipping & Postage	0.00	0.01	0.00	0.00	0.02	0.02
Interest	0.20	0.16	0.24	(0.31)	0.03	0.35
Total G & A Expenses	16.05	18.10	17.52	16.08	17.74	1.66
Net Income / (Loss)	9.71	8.76	13.89	43.59	10.00	33.58

Income Statement
For The Twelve Months Ended June 30, 2014

	June '13 Year-To-Date	June '14 Year-To-Date		Variance
	Actual	Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	1,223,895	1,553,660	1,509,746	43,914
Revenue				
Premium	\$ 319,435,701	\$ 425,644,611	\$ 407,361,397	\$ 18,283,214
Reserve for Rate Reduction	1,914,156	(842,917)	(2,365,457)	1,522,541
MCO Premium Tax	(7,339,439)	(16,462,166)	(15,859,554)	(602,612)
Total Net Premium	314,010,417	408,339,528	389,136,385	19,203,143
Other Revenue:				
Interest Income	114,009	153,143	136,181	16,962
Miscellaneous Income	995,185	458,953	460,000	(1,047)
Total Other Revenue	1,109,194	612,096	596,181	15,915
Total Revenue	315,119,611	408,951,624	389,732,567	19,219,058
Medical Expenses:				
<u>Capitation (PCP, Specialty, Kaiser, NEMT & Vision)</u>	11,159,035	20,215,862	19,145,335	(1,070,527)
<u>FFS Claims Expenses:</u>				
Inpatient	56,836,456	72,969,510	72,503,824	(465,686)
LTC/SNF	78,149,888	85,518,201	77,019,440	(8,498,761)
Outpatient	30,804,439	36,675,590	36,970,231	294,641
Laboratory and Radiology	2,541,419	4,149,740	3,856,216	(293,524)
Physician ACA 1202	6,143,374	5,373,618	-	(5,373,618)
Emergency Room	25,758,126	10,845,533	10,396,918	(448,615)
Physician Specialty	-	24,665,694	26,823,322	2,157,628
Mental Health Services	-	1,556,523	1,151,086	(405,437)
Pharmacy	41,118,154	55,354,634	56,882,945	1,528,311
Other Medical Professional	2,884,039	2,094,288	1,911,582	(182,706)
Other Medical Care	5,713	7,657	-	(7,657)
Other Fee For Service	18,435,685	31,595,067	29,162,455	(2,432,611)
Transportation	2,625,381	1,064,208	1,020,585	(43,623)
Total Claims	265,302,675	331,870,263	317,698,604	(14,171,659)
Medical & Care Management Expense	7,557,484	10,120,504	9,949,637	(170,867)
Reinsurance	(141,858)	(2,418,872)	(271,487)	2,147,386
Claims Recoveries	(3,494,632)	(3,103,361)	-	3,103,361
Sub-total	3,920,994	4,598,270	9,678,150	5,079,880
Total Cost of Health Care	280,382,704	356,684,395	346,522,089	(10,162,306)
Contribution Margin	34,736,907	52,267,230	43,210,478	9,056,752
General & Administrative Expenses:				
Salaries and Wages	5,056,803	6,701,978	6,977,458	275,480
Payroll Taxes and Benefits	1,254,386	1,630,199	1,643,302	13,103
Travel and Training	67,666	100,152	198,271	98,119
Outside Service - ACS	10,963,938	12,247,215	11,816,565	(430,650)
Outside Service - RGS	23,674	-	-	-
Outside Services - Other	538,615	886,421	677,932	(208,488)
Accounting & Actuarial Services	406,111	266,443	217,446	(48,997)
Legal	450,167	865,816	507,287	(358,529)
Insurance	104,670	142,851	147,974	5,123
Lease Expense - Office	213,692	628,720	620,908	(7,812)
Consulting Services	3,271,648	1,175,797	1,520,840	345,043
Translation Services	22,860	47,876	33,227	(14,648)
Advertising and Promotion	10,541	34,379	190,615	156,236
General Office	996,755	1,122,019	1,210,646	88,627
Depreciation & Amortization	50,789	104,005	267,097	163,092
Printing	72,360	110,786	206,366	95,580
Shipping & Postage	58,272	49,429	212,659	163,230
Interest	450,981	321,666	300,548	(21,118)
Other/ Miscellaneous Expenses		65,781	-	(65,781)
Total G & A Expenses	24,013,927	26,501,533	26,749,142	247,608
Net Income / (Loss)	\$ 10,722,981	\$ 25,765,696	\$ 16,461,336	\$ 9,304,360

Comparative Balance Sheet

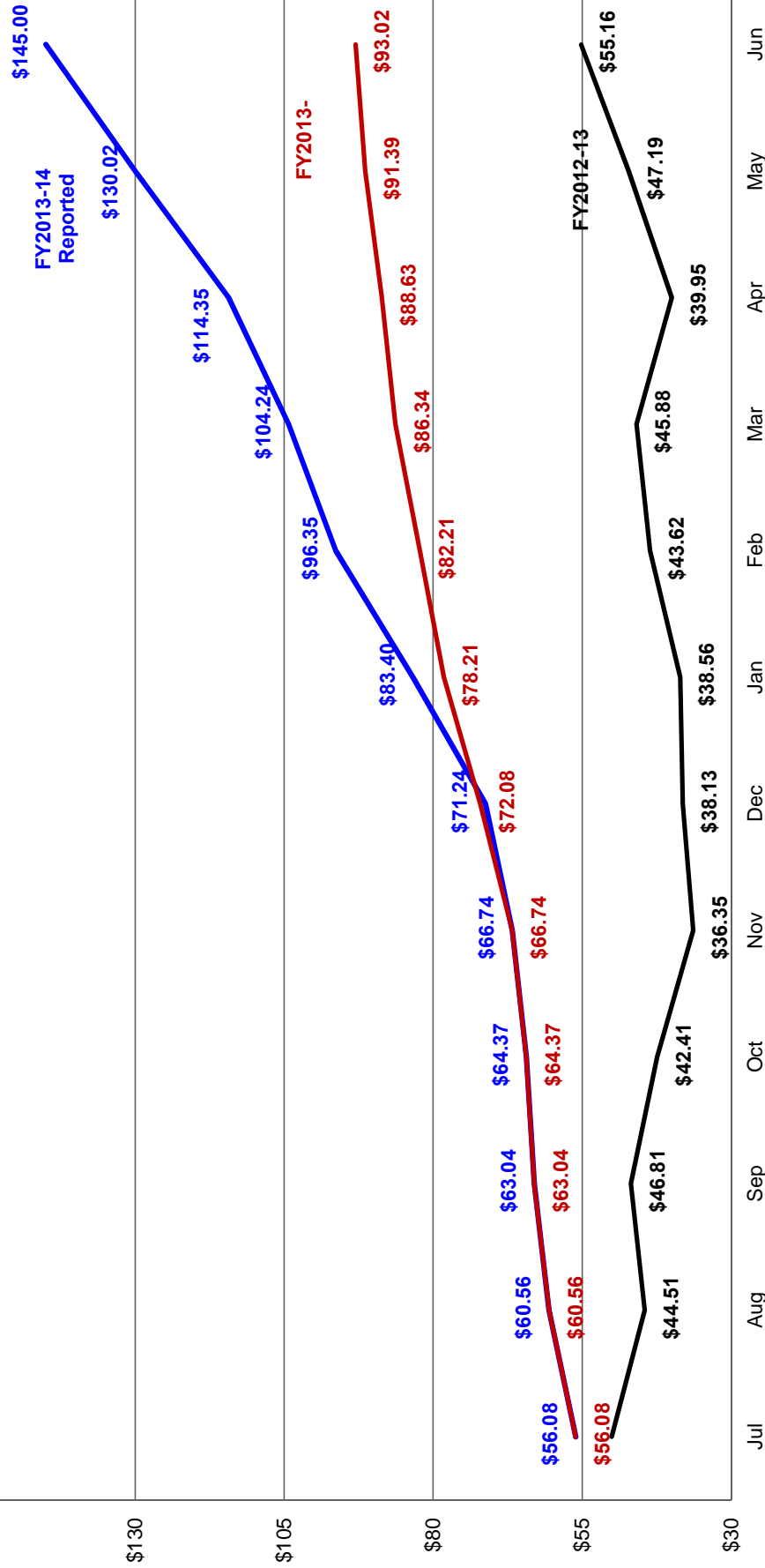
	6/30/14	5/31/14	4/30/14	Audited FY 2012-13
ASSETS				
Current Assets				
Total Cash and Cash Equivalents	\$ 60,176,698	\$ 91,842,018	\$ 72,576,000	\$ 50,817,760
Medi-Cal Receivable*	99,807,123	51,784,771	53,513,432	11,683,076
Provider Receivable	395,129	294,941	238,327	1,161,379
Other Receivables	1,458,481	174,521	173,225	300,397
Total Accounts Receivable	101,660,733	52,254,233	53,924,983	13,144,852
Total Prepaid Accounts	1,151,757	490,734	529,986	324,419
Total Other Current Assets	81,719	81,719	91,719	10,000
Total Current Assets	163,070,907	144,668,704	127,122,687	64,297,030
Total Fixed Assets	1,163,269	1,664,873	1,636,170	230,913
Total Assets	\$ 164,234,176	\$ 146,333,576	\$ 128,758,857	\$ 64,527,943
LIABILITIES & FUND BALANCE				
Current Liabilities				
Incurring But Not Reported	\$ 89,252,777	\$ 80,814,694	\$ 71,277,003	\$ 29,901,103
Claims Payable	9,482,660	8,746,221	5,259,002	9,748,676
Capitation Payable	2,054,265	1,485,425	1,444,901	1,002,623
Physician ACA 1202 Payable	3,222,776	3,222,776	3,357,133	-
AB85 Payable	1,411,679	595,883	590,735	-
Accrued Premium Reduction	842,917	2,096,754	2,096,754	-
Accounts Payable	2,875,629	1,979,072	1,430,185	1,751,419
Accrued ACS	-	1,145,296	1,149,054	422,138
Accrued Expenses	655,679	737,643	608,902	477,477
Accrued Premium Tax	14,985,060	12,996,920	11,188,973	7,337,759
Accrued Interest Payable	42,062	39,744	37,061	9,712
Current Portion of Deferred Revenue	460,000	460,000	460,000	460,000
Accrued Payroll Expense	760,032	708,187	574,926	605,937
Current Portion Of Long Term Debt	-	-	-	(0)
Other Current Liabilities	-	-	-	-
Total Current Liabilities	126,045,534	115,028,617	99,474,627	51,716,843
Long-Term Liabilities				
Other Long-term Liability	71,845	-	-	-
Deferred Revenue - Long Term Portion	460,000	498,333	536,667	920,000
Notes Payable	7,200,000	7,200,000	7,200,000	7,200,000
Total Long-Term Liabilities	7,731,845	7,698,333	7,736,667	8,120,000
Total Liabilities	133,777,380	122,726,950	107,211,294	59,836,843
Beginning Fund Balance	4,691,101	4,691,101	4,691,101	(6,031,881)
Net Income Current Year	25,765,696	18,915,526	16,856,462	10,722,981
Total Fund Balance	30,456,797	23,606,626	21,547,563	4,691,100
Total Liabilities & Fund Balance	\$ 164,234,176	\$ 146,333,576	\$ 128,758,857	\$ 64,527,943

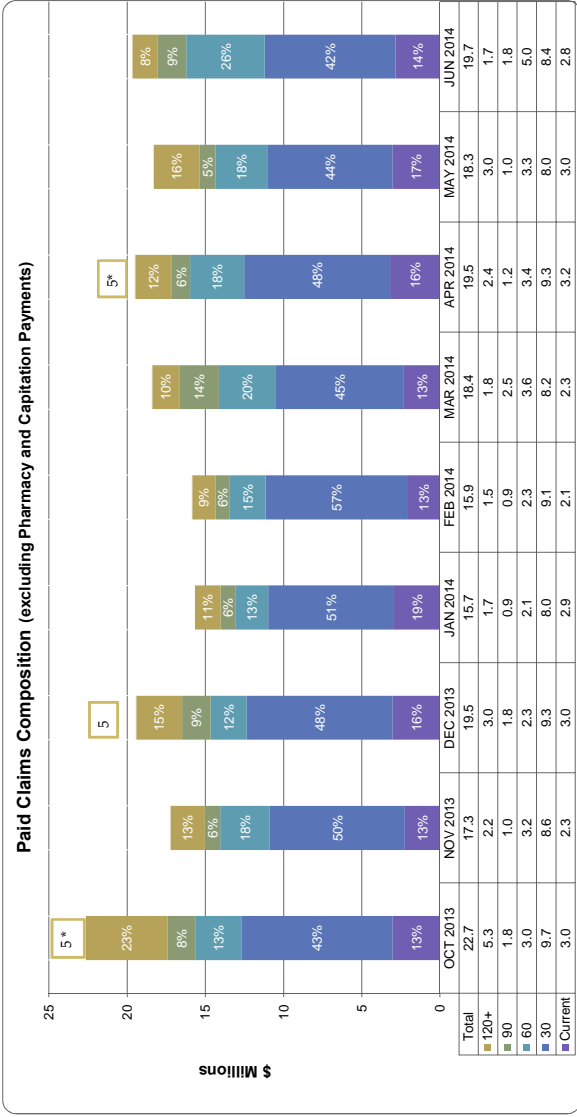
FINANCIAL INDICATORS

Current Ratio	1.29 : 1	1.26 : 1	1.28 : 1	1.24 : 1
Days Cash on Hand	46	67	55	58
Days Cash + State Capitation Receivable	121	104	95	72
Days Cash + State Capitation Rec (less Tax Liab)	110	95	87	63

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

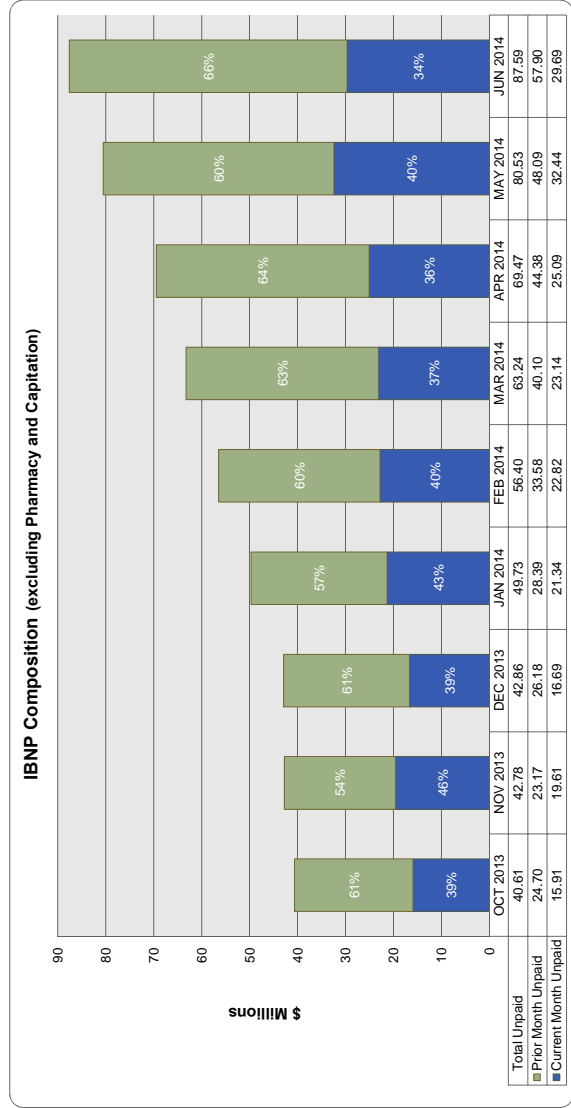
(Net of MCO Tax Liability and excludes pass-through funds)





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

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



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



For the month ended June 30, 2014

APPENDIX

- Statements of Cash Flow
- YTD Cash Flow
- Total Expenditure Composition
- Pharmacy Cost & Utilization Trends

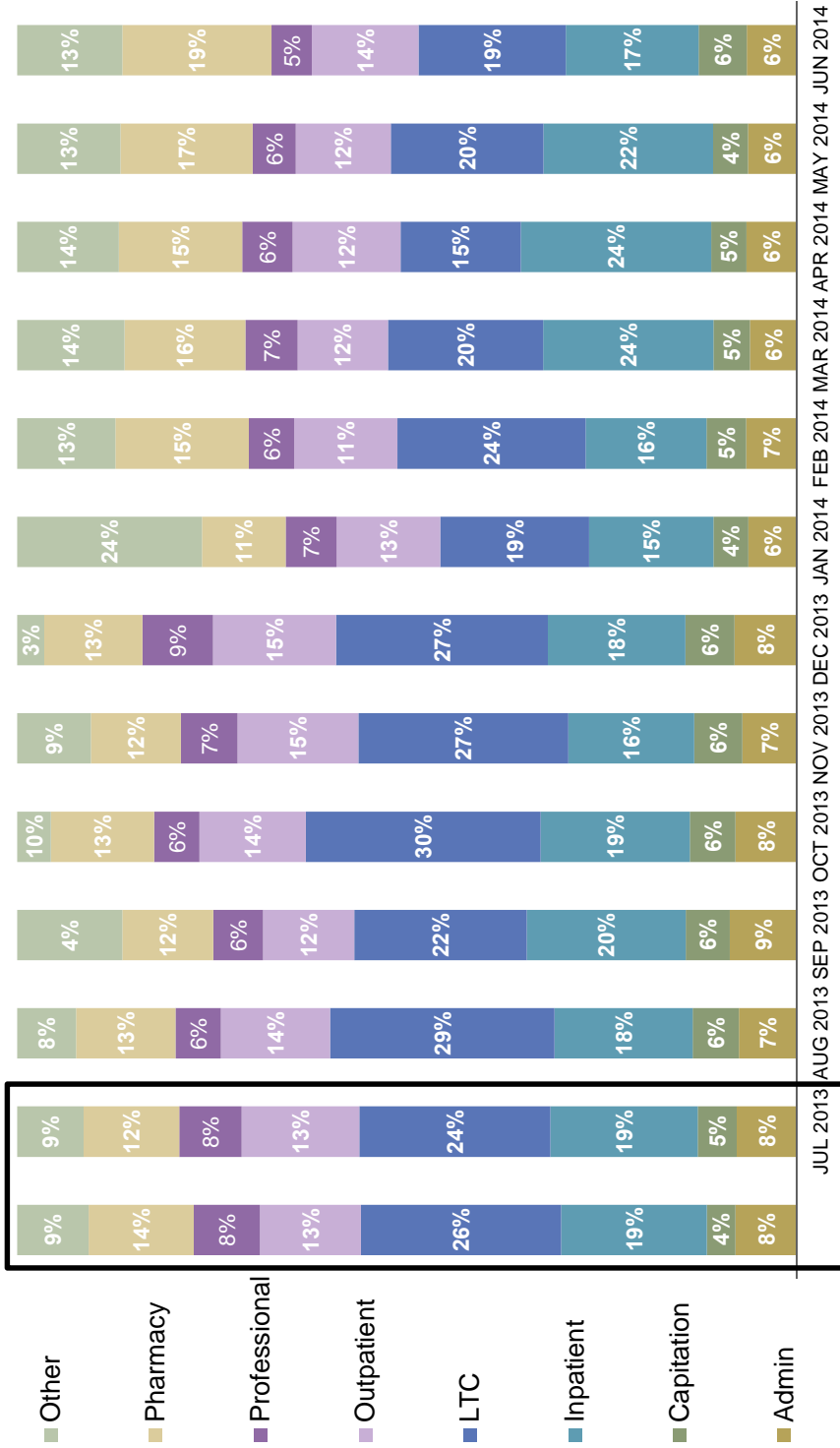
Statement of Cash Flows - Monthly

	JUNE '14	MAY '14	JUN'13
Cash Flow From Operating Activities			
Collected Premium	\$ -	\$ 47,033,424	\$ 52,138,834
Miscellaneous Income	16,066	12,448	8,594
State Pass Through Funds	-	610,463	34,346,474
<u>Paid Claims</u>			
Medical & Hospital Expenses	(19,798,531)	(18,074,838)	(17,277,826)
Pharmacy	(5,842,805)	(5,481,933)	(4,009,168)
Capitation	(1,913,772)	(1,813,549)	(1,162,302)
Reinsurance of Claims	(352,660)	(336,485)	(240,430)
State Pass Through Funds Distributed	(684,016)	-	(34,346,474)
Paid Administration	(3,093,374)	(2,609,727)	(2,616,623)
MCO Tax Received / (Paid)			829,564
Net Cash Provided/ (Used) by Operating Activities	(31,669,093)	19,339,804	27,670,643
Cash Flow From Investing/Financing Activities			
Proceeds from Line of Credit			-
Repayments on Line of Credit	-	-	-
Net Acquisition of Property/Equipment	3,774	(73,786)	(31,026)
Net Cash Provided/(Used) by Investing/Financing	3,774	(73,786)	(31,026)
Net Cash Flow	\$ (31,665,320)	\$ 19,266,019	\$ 27,639,617
Cash and Cash Equivalents (Beg. of Period)	91,842,018	72,576,000	23,068,235
Cash and Cash Equivalents (End of Period)	60,176,698	91,842,018	50,817,760
	\$ (31,665,320)	\$ 19,266,018	\$ 27,749,525
Adjustment to Reconcile Net Income to Net Cash Flow			
Net (Loss) Income	6,850,171	2,059,063	4,109,976
Loss on asset disposal	-	-	-
Depreciation & Amortization	(64,170)	45,083	11,407
Decrease/(Increase) in Receivables	(49,406,500)	1,670,751	22,788,941
Decrease/(Increase) in Prepays & Other Current As	(99,024)	49,252	769,972
(Decrease)/Increase in Payables	(714,584)	680,609	(1,578,838)
(Decrease)/Increase in Other Liabilities	33,512	(38,333)	(121,667)
Changes in Withhold / Risk Incentive Pool	-	-	-
Change in MCO Tax Liability	1,988,140	1,807,947	1,433,012
Changes in Claims and Capitation Payable	1,305,279	3,527,743	1,913,029
Changes in IBNR	8,438,082	9,537,691	(1,655,189)
	(31,669,093)	19,339,804	27,670,643
Net Cash Flow from Operating Activities	\$ (31,669,093)	\$ 19,339,804	\$ 27,670,643

Statement of Cash Flows - YTD

	<u>JUNE 2014 YTD</u>	<u>JUNE 2013 YTD</u>
Cash Flow From Operating Activities		
Collected Premium	\$ 338,499,858	\$ 336,042,267
Miscellaneous Income	153,143	114,009
State Pass Through Funds	63,097,322	34,346,474
<u>Paid Claims</u>		
Medical & Hospital Expenses	(216,089,157)	(233,904,478)
Pharmacy	(49,803,946)	(44,681,081)
Capitation	(19,161,321)	(10,411,964)
Reinsurance of Claims	(3,537,842)	(2,772,746)
State Pass Through Funds Distributed	(61,900,697)	(34,346,474)
Payment of Withhold / Risk Sharing Incentive	-	
Paid Administration	(31,191,217)	(26,392,574)
Repay Initial Net Liabilities	-	
MCO Taxes Received / (Paid)	(8,951,052)	175,900
Net Cash Provided/(Used) by Operating Activities	11,115,090	18,169,335
Cash Flow From Investing/Financing Activities		
Proceeds from Line of Credit	-	7,200,000
Repayments on Line of Credit	-	
Net Acquisition of Property/Equipment	(1,756,152)	(105,674)
Net Cash Provided/(Used) by Investing/Financing	(1,756,152)	7,094,326
Net Cash Flow	\$ 9,358,939	\$ 25,263,661
Cash and Cash Equivalents (Beg. of Period)	50,817,760	25,554,098
Cash and Cash Equivalents (End of Period)	60,176,698	50,817,760
	\$ 9,358,939	\$ 25,263,662
Adjustment to Reconcile Net Income to Net Cash Flow		
Net Income/(Loss)	25,765,696	10,722,981
Depreciation & Amortization	197,169	50,789
Decrease/(Increase) in Receivables	(88,515,881)	24,077,897
Decrease/(Increase) in Prepays & Other Current Assets	(337,057)	226,378
(Decrease)/Increase in Payables	6,544,091	265,810
(Decrease)/Increase in Other Liabilities	(389,309)	(960,000)
Change in MCO Tax Liability	7,647,300	6,734,859
Loss on asset disposal	65,781	
Changes in Claims and Capitation Payable	785,626	(239,586)
Changes in IBNR	59,351,674	(22,709,792)
	11,115,090	18,169,335
Net Cash Flow from Operating Activities	\$ 11,115,090	\$ 18,169,335

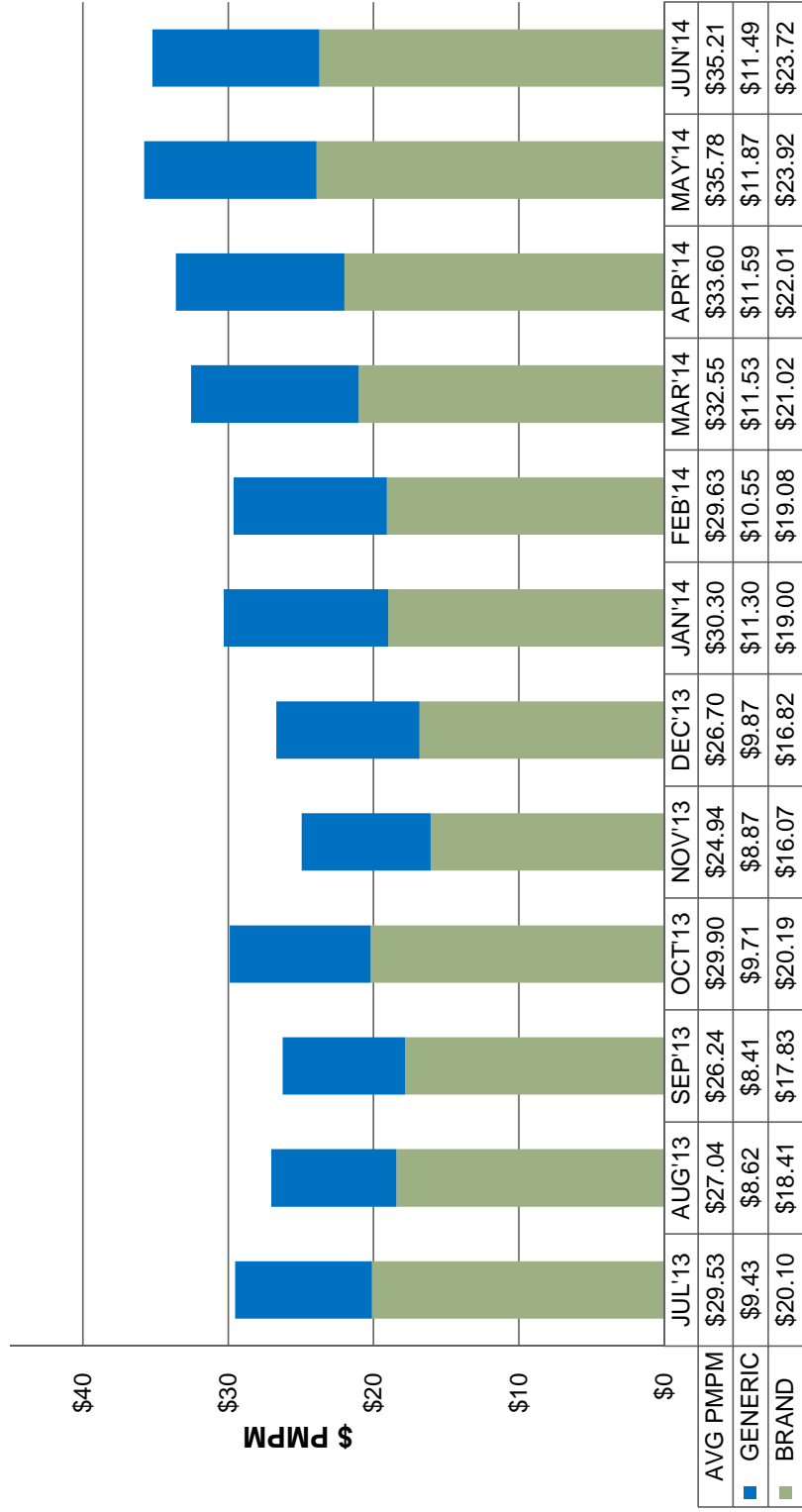
Total Expense Composition

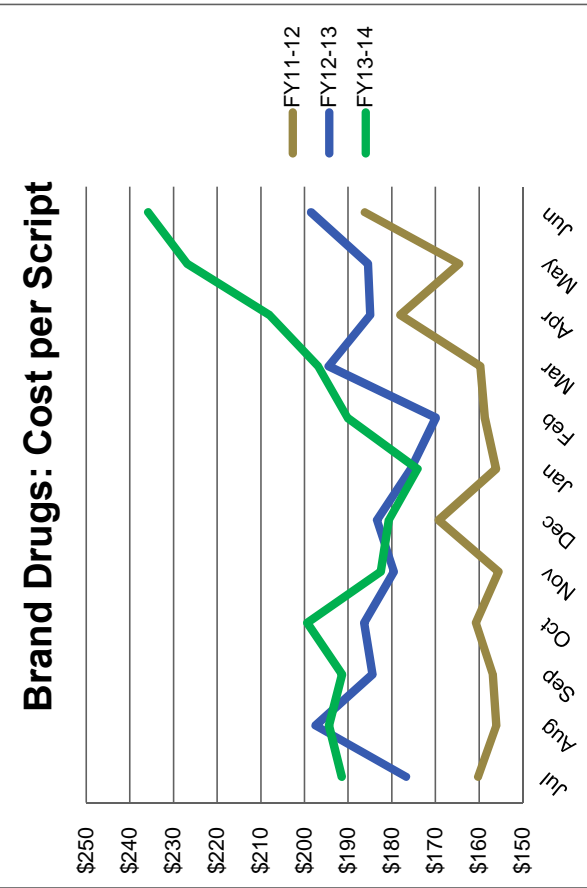
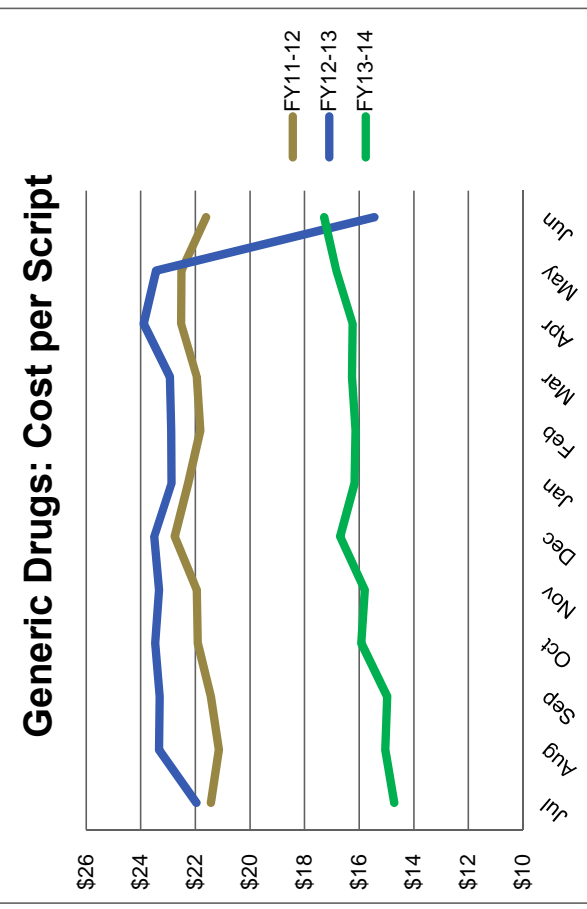
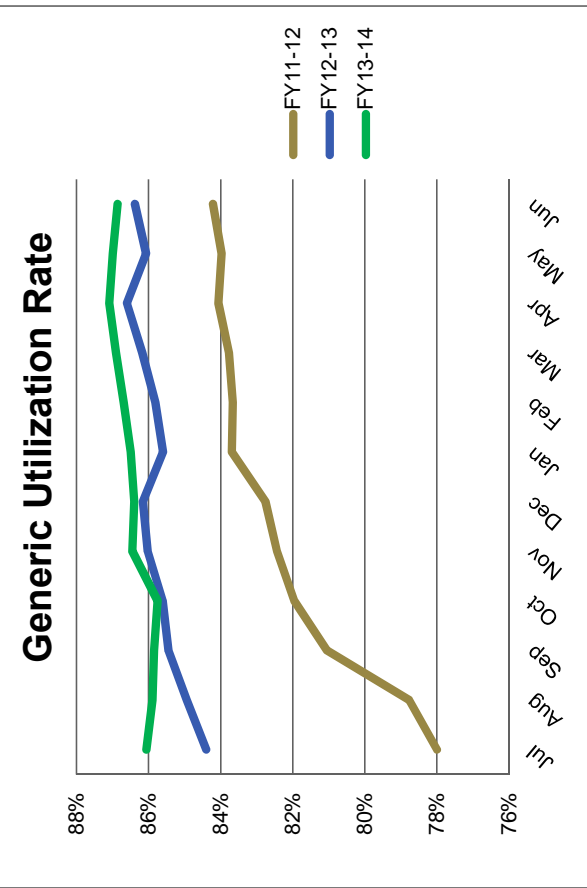
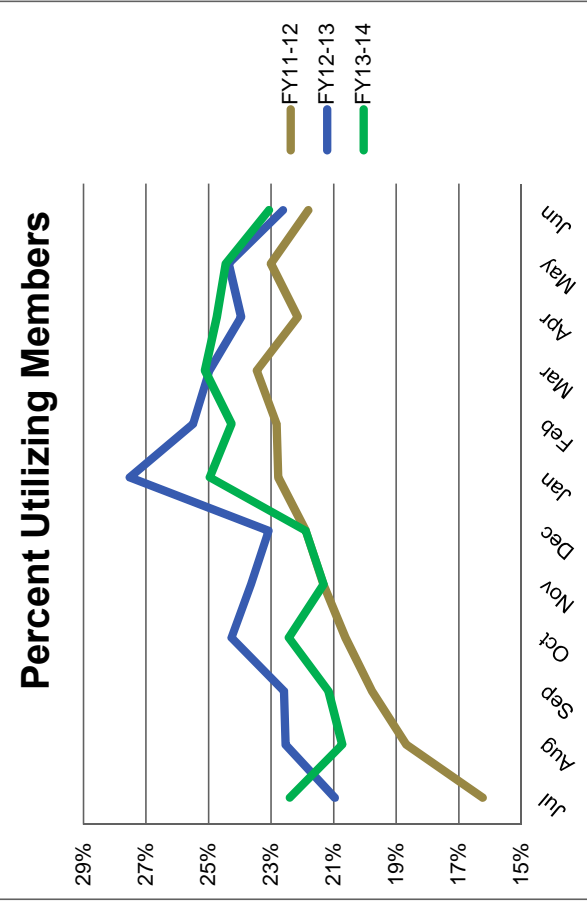


In May 2013, GCHP changed its method of distributing Health Care Costs (HCC) across categories of service. Prior months utilized an allocation methodology. The methodology was updated to utilize payment information by different categories of services. Further changes have been made with the assumption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

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

Pharmacy Cost Trend







AGENDA ITEM 3a

To: Gold Coast Health Plan Commission

From: Michael Engelhard, CEO
Stacy Diaz, Director Human Resources

Date: August 25, 2014

RE: GCHP New and Amended Personnel Rules, Regulations and Policies; Approval of Resolution

BACKGROUND:

Prior to September 1, 2012, all staff were employees of Regional Government Services (RGS) pursuant to written employment agreements with RGS and were subject to the adopted RGS personnel rules. Most staff from RGS transitioned to become Gold Coast Health Plan staff effective September 1, 2012. On August 27, 2012, the Commission, in anticipation of having its own employees, adopted Resolution No. 2012-001. This Resolution formally adopted the Plan's Personnel Rules, Regulations and Policies (Personnel Rules) with an effective date of September 1, 2012, which was when the Plan had its first employees. On June 28, 2010, the Commission adopted Policies concerning delegation of authority to the CEO and amended that Policy on November 28, 2011. The Delegation of Authority Policy, as amended in November 28, 2011, in relation to personnel, provides the CEO "authority to select, hire, evaluate, terminate and compensate all employees including the Chief Medical Officer and Chief Financial Officer." This Policy and the delegation to the CEO remains in effect.

Dress Code

Section 8.8 of the original Personnel Rules addressed the work attire for the Plan employees. The Plan, through an administration Policy R-4 adopted May 1, 2013 and effective May 23, 2013 enhanced the work attire policy to create a Dress Code for the Plan. The matrix below sets forth the original Section 8.8 language effective on September 1, 2012 and the Administrative Policy R-4 language:

At its May 19, 2014 meeting, by unanimous vote of the Commissioners present the Dress Code policy was adopted administratively by the Plan retroactively to May 1, 2013. The Dress Code language should now be added to the Personnel Rules, as part of Section 8.8. Because the original Personnel Rules were adopted by Resolution, amendments to the Personnel Rules should be reflected in a Resolution identifying any changes and the action taken by the Commission.

Original adopted Plan's Personnel Rules, Regulations and Policies	Revised Policy Effective May 23, 2013
<p>8.8 Workplace Attire: The Plan maintains a professional working environment for the benefit of its employees and the public. As public servants, each employee shall present him/herself appropriately and professionally, including but not limited to workplace attire, especially when attending off-site meetings and events. If an employee is on the job in inappropriate clothing, the immediate supervisor may require the employee to change into appropriate work wear.</p>	<p>Every employee represents Gold Coast Health Plan in the eyes of our Board, our members and the community-at-large. It is the policy of GCHP that employees are required to present a clean, neat, professional business appearance at all times when employees are in the workplace or representing GCHP outside of the workplace. Our dress code is based on several factors. GCHP is a professional organization that is responsible for health care access for thousands of people. Our dress code reflects our culture of professionalism, and our respect for our mission and our fiscal responsibilities. Our actions speak loudest, but our appearance communicates as well to community leaders, providers, members and other visitors to our work place. Our standard continues to be "Business Casual". Many examples of acceptable clothing and footwear are provided in this policy, since they are often requested by staff and help to clarify our standard.</p> <p>DEFINITIONS: All employees are required to adhere to these standards as part of the requirements of their employment with GCHP. Employees will be aware of, and conscientious about, the neatness and cleanliness of their apparel, and their personal hygiene while on the job.</p> <ol style="list-style-type: none"> 1. Acceptable Appearance / Attire: Our overall standard is business professional, yet casual. Examples of acceptable attire include: For women: Suits, blazers, dress coats, blouses, business casual shirts (such as short or long sleeved polo shirts appropriate for a business environment), dresses, skirts, pantsuits, dress slacks, business casual pants, sweaters, and capri pants. The length of capris that is acceptable is mid-calf or just below the calf. Any shorter length is considered shorts and therefore may not be worn at any time, including casual Fridays. A denim skirt or blazer is acceptable if non-faded and the style is suitably professional for our business environment. For men: Suits, sports coats, dress shirts, ties, sweaters, business casual shirts (such as short or long sleeved polo shirts appropriate for a business environment), dress slacks and business casual pants (such as Dockers). The duties of some positions may occasionally require more professional dress than others depending upon the requirements of the job. Employees who attend both internal and external meetings, visit other

Original adopted Plan's Personnel Rules, Regulations and Policies	Revised Policy Effective May 23, 2013
	<p>professional offices, hospitals, clinics, etc., and interact with business and community representatives, must dress to present an appropriate professional business image of GCHP. The duties of some positions may allow for the wearing of more comfortable, casual apparel due to the nature of the job requirements. When the job requires physical activity (lifting, carrying, stretching, bending, etc.) employees may wear more casual apparel such as work pants and tennis shoes to permit greater freedom of movement and safety. GCHP reserves the right to determine which job assignments meet these criteria. Ask for clarification from the manager or Human Resources department.</p> <ol style="list-style-type: none"> 2. Unacceptable Appearance / Attire: Examples of unacceptable and inappropriate attire that is not in compliance with our standards include provocative attire (low cut clothing, mini skirts, etc.), oversized clothing, extremely tight clothing including spandex, leggings or other form-fitting attire, tank tops, midriff tops, crop tops, halter-neck tops and dresses, spaghetti-strap tops and dresses, sun or beach dresses, nylon jogging suits, sweats / exercise pants, sportswear and shorts of any length and / or skorts, pajamas and jeans (except casual days). Clothing with potentially offensive words, terms, logos, pictures, cartoons, or slogans is inappropriate for our business environment and is not to be worn at any time. Clothing that exposes undergarments is also inappropriate for our business environment and is not to be worn at any time. 3. Acceptable Shoes and Footwear: Conservative, non-athletic leather walking shoes, loafers, dress boots, flats, heels, business or dress shoes, business professional sandals, and leather deck-type shoes are acceptable for our business environment. Shoes are to be worn at all times while in the office. Tennis shoes may be worn on "Casual Days" only. 4. Unacceptable Shoes and Footwear: Flip flops (thongs), slippers and non-dress boots (e.g. Uggs). 5. "Casual Day": GCHP observes Friday as Casual Day. Employees are permitted to wear more casual and informal clothing on Fridays. Employees are still required to present a clean and neat appearance at all times as every employee continues to represent GCHP in the eyes of members and the community at large. Examples of allowable choices on dress

Original adopted Plan's Personnel Rules, Regulations and Policies	Revised Policy Effective May 23, 2013
	<p>down day include denim jeans, tee shirts and tennis shoes. As a rule of thumb, casual clothing that is acceptable attire is not appropriate for our regular Monday through Thursday standard. Provocative attire (low cut clothing, mini skirts, etc.), oversized clothing, extremely tight clothing including spandex or other form-fitting attire, tank tops, midriff tops, crop tops, halter-neck tops and dresses, spaghetti-strap tops and dresses, sun or beach dresses, nylon jogging suits, sweats / exercise pants, sportswear and shorts of any length and / or skorts may not be worn. Directors and managers are required to use their own discretion on Casual Day depending on their schedule for business that day. Employees who have important meetings with non-employees either on or off site on Casual Day need to consider observing the more professional standards of the regular Dress Code Policy guidelines. If there are questions, ask for clarification from the manager. These examples are not meant to be all-inclusive, and may need to be amended from time to time as styles change.</p> <p>6. Grooming and Cleanliness: All employees are expected to present themselves well groomed, with attention paid to good personal hygiene. In consideration of others, care should be taken to avoid strong, offensive odors, such as tobacco, perfumes or cologne as some employees are sensitive to the chemicals in personal care products, such as perfumes, colognes, hairspray or other hair care products and scented lotions.</p> <p>7. Compliance: Compliance with this policy is the responsibility of every individual. Employee cooperation will make enforcement unnecessary. However, employees who fail to follow the Dress Code guidelines will be sent home and requested to return to work in compliance with the guidelines. Employees will not be compensated for time away from work. GCHP reserves the right to determine the appropriateness of compliance with the Dress Code Policy. Continued failure to comply with this policy may result in disciplinary action, up to and including separation of employment. This policy may be revised, updated, or rescinded at any time by GCHP.</p>

Vacation Buy-Back

Section 9.4.2 of the Personnel Rules sets forth a vacation buy-back policy when maximum vacation accrual limits have been reached. Pursuant to the Delegation of Authority Policy, the CEO approved a vacation buy-back policy for all employees effective April 24, 2013. This administrative vacation buy-back policy was Policy B-5. It was announced to all employees at an all hands meeting on April 25, 2013 that it was effective immediately. Vacation is legally equivalent to “earned compensation” or more plainly “wages.” Accrued vacation is legally protected for the employee. Employees from time-to-time may face circumstances whereby accessing accrued vacation compensation may alleviate a financial hardship or burden or other factor. Allowing employees to access accrued vacation, within the limits set forth in the policy, provides some flexibility for such employees. Because accrued vacation is a legal liability for the organization and is considered to be a form of “wages” to the employee, there is no net financial impact to the organization by paying out vacation accruals. This is also commonplace in both public agencies and commercial enterprises. Since April 24, 2013, employees have utilized the vacation buy-back policy. For example, some have used it to pay for medical procedures, some for vacation costs, and others for school tuition.

At its May 19, 2014 meeting, the Commission, unanimously by the Commissioners in attendance, approved retroactively to April 24, 2012 the administrative vacation buy-back policy.

At the May 19, 2014 Commission Meeting, there was a further amendment to the vacation buy-back policy to be effective July 1, 2014. This further amendment required effective July 1, 2014 that an employee take a minimum of 40 hours of vacation during the prior 12 months before being able to cash out accrued vacation. This further amendment was unanimously approved by the Commissioners in attendance. The matrix below sets forth the original Section 9.4.2 language effective on September 1, 2012, the Administrative Policy B-5 language which the Commission adopted retroactively to April 24, 2013, and the further amendment by the Commission on May 19, 2014.

Original adopted Plan’s Personnel Rules, Regulations and Policies	April 24, 2013	July 1, 2014 Amendment to Policy Requested by Commission
<p>9.4.2 Maximum Vacation Accrual: Employees may accrue vacation up to the maximum amount as indicated in their individual employment agreements. Excess vacation beyond the individual maximum limit will be paid at the employee’s actual hourly rate of pay at the</p>	<p>It is the policy of GCHP to provide employees with vacation time as a vehicle for rest and renewal. GCHP strongly encourages all eligible employees to utilize their vacation time. However, employees may desire to access the cash payout of some of their accrued vacation. The buyback policy</p>	<p>It is the policy of GCHP to provide employees with vacation time as a vehicle for rest and renewal. GCHP strongly encourages all eligible employees to utilize their vacation time; however the buyback policy will be available to all employees who have accrued vacation in which they would like to cash out.</p>

Original adopted Plan's Personnel Rules, Regulations and Policies	April 24, 2013	July 1, 2014 Amendment to Policy Requested by Commission
<p>payperiod ending 12/15 of each year, unless specifically pre-approved by human resources.</p>	<p>will be available to all employees who have accrued more than forty (40 hours of vacation).</p> <p>DEFINITIONS: Eligible Employees: GCHP provides regular full- and part-time employees with vacation time.</p> <p>PROCEDURES: Employees may buy-back up to a maximum of 50% of their accrued vacation time as long as the employee maintains a minimum of forty (40) hours of vacation in their vacation account after the buy back. Payment will be made based on the employee's hourly rate.</p> <p>The request must be submitted in writing to Human Resources for approval.</p>	<p>DEFINITIONS: Eligible Employees: GCHP provides regular full- and part-time employees with vacation time.</p> <p>PROCEDURES: Employees may buy-back a maximum of 50% of their accrued vacation time.</p> <p>The request must be submitted in writing to Human Resources for approval.</p> <p>The employee must maintain a minimum of forty (40) hours of vacation remaining after the "buy back" of some of their vacation.</p> <p>In order to qualify, employees must have taken a minimum of forty (40) hours of vacation within the previous twelve (12) months of employment with GCHP.</p>

Because the original Personnel Rules were adopted by Resolution, amendments to the Personnel Rules should be identified in a Resolution reflecting any changes and the action taken by the Commission. Employees have relied upon the administrative policy and the action of the Commission at its May 19, 2014 meeting.

Bereavement

Section 9.5 of the Personnel Rules sets forth the Bereavement Policy. There was a desire to grant bereavement leave to include in-laws of current spouses or domestic partners. The matrix below sets forth the original Section 9.5 language effective on September 1, 2012 and the amendments to bereavement leave approved by the Commission at its May 19, 2014 meeting:

<p>Original adopted Plan's Personnel Rules, Regulations and Policies</p>	<p>Policy Revised and approved by Commission May 19, 2014</p>
<p>9.5 Bereavement Leave: Bereavement leave is provided for employees as defined in their individual employment agreements. Unless otherwise stipulated in an individual employment agreement, employees may take bereavement leave of up to 24 hours in the event of death of any of an immediate family member. Immediate family members are defined as: as spouse, domestic partner as defined by the State of California, father, mother, grandfather, grandmother, sister, brother, son, and daughter.</p>	<p>Bereavement leave is provided for Regular Full Time employees unless otherwise stipulated in an individual employment agreement. Employees may take bereavement leave paid for of up to three (3) days in the event of death of any of an immediate family member.</p> <p>Immediate family members are defined as: as spouse, domestic partner as defined by the State of California, father, mother, grandfather, grandmother, sister, brother, son, and daughter whether related by blood, adoption or marriage.</p> <p>DEFINITIONS: Immediate family member for purposes of this policy is limited to the following relationships by blood, marriage, adoption or domestic partnership (Defined by the State of CA):</p> <ul style="list-style-type: none"> • Current Spouse • Current Domestic Partner • Parent of employee, parent of current spouse or parent of current domestic partner • Sibling of employee, sibling of current spouse or sibling of current domestic partner • Step-Parent or Legal Guardian • Child of employee, child of current spouse or child of current domestic partner • Grandparent of employee, grandparent of current spouse or grandparent of current domestic partner • Grandchild of employee, grandchild of current spouse or grandchild of current domestic partner <p>PROCEDURES: Bereavement leave must be requested at the time of the family member's death or to attend the funeral. The employee must obtain approval from his / her supervisor if additional time off is requested. Additional time off will be paid through available Vacation accruals.</p> <p>Employees must record their bereavement hours thorough the online timecard system</p>

Original adopted Plan's Personnel Rules, Regulations and Policies	Policy Revised and approved by Commission May 19, 2014
	<p>Employees must submit a time off request form to supervisor / Human Resources requesting the time</p> <p>Proof of eligibility for bereavement leave may be required</p>

Because the language of Section 9.5 was amended unanimously by the Commissioners in attendance at the May 19, 2014 Commission Meeting it should be reflected in a Resolution identifying any amendments and changes to the adopted Personnel Rules.

“SPOT” Award

A “SPOT” Award policy was also presented to the Commission at its May 19, 2014 meeting. This was an entirely new policy. There was a question about whether such a policy conformed with the statutes and regulations prohibiting gifts of public funds. Legal counsel researched this issue and determined that, properly drafted and administered, a “SPOT” Award program does not run afoul of the prohibitions on gifts of public funds. In fact, there are other public entities within the State of California that have adopted these policies. The recommendation of legal counsel was to keep the awards low, place annual caps on the amount each employee is eligible to receive, and make sure that awards were given for actions above and beyond the employee’s regular scope of work.

The following is the language of the “SPOT” Award approved by the Commission at the May 19, 2014 Meeting. The Commission included in its approval that the award include an implementation rating matrix and that the awardee come before the Commission should they receive the maximum SPOT Award.

Policy approved by Commission May 19, 2014
<p>Reward for special performance. All full-time and part-time employees are eligible, excluding Directors and C Level Staff. Awards range from \$50-\$1,000.</p> <p>DEFINITIONS: The action or accomplishment that is being recognized should be significantly beyond the scope of the employee’s regular day-to-day activities and assignments. For example, the award could be for an employee who uses initiative and creativity to resolve a situation or conflict. It could also be for a one-time exceptional achievement that might not be otherwise noticed such as volunteering for extra assignments during critical times while maintaining the regular work assignment.</p>

Policy approved by Commission May 19, 2014

Criteria Guidelines:

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

Awards - Examples:

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

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

ELIGIBILITY:

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

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

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

PROCEDURES:

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

Supervisors, Managers, Directors and Chiefs, as well as peers, may nominate staff for “SPOT” Awards.

Nominations should be submitted via the GCHP “SPOT” Awards.

Policy approved by Commission May 19, 2014

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

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

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

GCHP “SPOT” Award Matrix

Action or Accomplishment	Ranges	
	Minimum	Maximum
Performing Exemplary Service (inspire or role model employees)	\$ 50.00	\$ 500.00
Additional Hours Served to address an issue that prevents negative business impact	\$ 50.00	\$ 500.00
Substantial Cost savings to GCHP	\$100.00	\$1,000.00
"Big Picture" thinking	\$ 50.00	\$ 500.00
Recycling Program Which provides Costs savings	\$ 50.00	\$ 500.00
System / business flow process improvement	\$100.00	\$1,000.00
Identifying and implementing a change that results in improved quality or service to our members or providers, increases process efficiencies, and / or delivers cost savings	\$ 50.00	\$1,000.00
Collaboration / Team work which results in a positive financial impact	\$ 50.00	\$1,000.00

GCHP "SPOT" Award Matrix		
Action or Accomplishment	Ranges Minimum - Maximum	
Customer Service	\$ 50.00	\$ 300.00
<p>** Please Note: The "SPOT" Award evaluation matrix is presented as a draft with example ranges.</p> <p>The "SPOT" Award Committee will decide the final weighting to applied to individual factors.</p> <p>The "SPOT" Award Committee may decide to revise the factors at a later date as conditions and goals of the organization change with time.</p>		

A copy of the memorandum from legal counsel dated May 13, 2014 to staff regarding analysis of "SPOT" Award is attached.

RECOMMENDATION:

Because the original Personnel Rules were adopted by Resolution, amendments to the Personnel Rules should be reflected in a Resolution identifying any new policies and the action taken by the Commission.

A copy of the approved minutes for the May 19, 2014 Commission meeting are attached which reflects the action of the Commission. The Resolution, which reflects all the actions taken at the Commission meeting on May 19, 2014, is also attached. The Commission should adopt the attached Resolution which reflects its actions of May 19, 2014. Please note that employees have undertaken actions based upon the Commission's actions at its May 19, 2014 meeting. The actions by employees in reliance on these policies should be taken into consideration by the Commission for any future actions.

Should the Commission desire to further revise, amend or rescind any of the Personnel Rules or its prior actions it should take such action at its August meeting and adopt a Resolution reflecting the action taken at its August meeting. A separate agenda item is provided for such discussion by the Commission.

CONCURRENCE:

N/A

Attachments:

Memorandum from legal counsel re: analysis of "SPOT" Award
Resolution Amending Personnel Rules, Regulations and Policies

MEMORANDUM

By E-mail

To: Michael Engelhard
Stacy Diaz

From: Nancy Kierstyn Schreiner
Robert Hernandez

C/M: GCHP - General

Date: May 13, 2014

Re: Proposed Spot Award Program

INTRODUCTION

The purpose of this memo is to evaluate Gold Coast Health Plan's proposed "Spot Award" program and identify potential issues or concerns. Overall, the proposed plan likely complies with applicable laws regarding prohibitions on gifts of public funds; however, the authorities are not entirely clear on the issue. We would advise some small changes to the proposed plan, such as a lower top-end limit on the cash value of the awards, and per-employee limits on both the number of awards received and the total cash value of awards received in a fiscal year.

DISCUSSION

The California Constitution prohibits gifts of public funds. Specifically, the Constitution prohibits additional payment for work that has already been performed or additional payment for work that an employee is already contracted to do. Spot award programs, though apparently allowable, must be tailored to avoid crossing the line into prohibited gifts.

We are aware of no clear authority that identifies what are appropriate limitations or restrictions on the type of spot awards GCHP is proposing. Generally, the California constitution and various statutes and regulations prohibit public entities from making gift of public funds. For example, paying a public employee or contractor a bonus for work already performed would in many instances be an improper gift of public funds because in such a situation, the public entity would be getting nothing of value in return for the bonus: the work was already done. Nevertheless, it is less clear how

Anderson Kill

incentive programs should be treated, and spot award programs have been implemented by other public entities.

For example, Lawrence Berkeley National Laboratory (affiliated with the University of California) has a spot award program and safety spot award program. Under the safety spot award program, employees may receive awards of \$25, \$50, \$75, \$100, \$150, \$250, or \$500, with no employee able to receive more than \$1500 in any fiscal year. It is unclear why these particular limits were chosen, but they do not appear to be out of line with the amounts given by private employers. Further, as far as we are aware, LBNL was not required by any statute or regulation to select the cash award amounts that it did.

The University of California itself publishes some guidelines that indicate that its spot awards should be limited to \$75.¹ The policy also emphasizes that employee recognition awards should be infrequent and such awards should be limited to no more than three per year per employee.

Under the GCHP spot bonus program, the proposed awards range from \$50 to \$1000. These numbers are slightly higher than the amounts set out above in the two examples. We suggest a lower top-end amount for GCHP's awards so that the awards are less likely to raise suspicion or cross the line into a prohibited gift of public funds. Further, and for the same reasons, we suggest that the GCHP spot award program contain both a total amount limit per person and a total number of awards limit per person.

GCHP's proposed plan should also include language to indicate clearly that the intent of the awards is not to provide money to employees for work they have already performed, or were already required to perform, but instead are intended to reward employees for going above and beyond their required job duties. Awards that fit into the latter category are not "gifts." For example, there is a case in which L.A. County social workers went on strike, but some social workers stayed on the job during the strike, taking on additional work. At the conclusion of the strike, the County paid a bonus to the employees who stayed on. It was determined that this did not violate the prohibition against gifts of public funds because the employees were doing more than their regular jobs. (*Social Workers Union v. County of Los Angeles* (1969) 270 Cal. App. 2d 65.)

In another case, it was determined that a payment is not a gift of public funds if it is used for a public purpose. (*Sturgeon v. County of Los Angeles* (2008) 167 Cal. App. 4th 630.) There, the issue was this: Los Angeles Superior Court judges were state employees, with their salaries being set by the state legislature. However, the County of Los Angeles treated them like County employees and paid some additional

¹ See <http://policy.ucop.edu/doc/3420353/BFB-G-41>.

Anderson Kill

amount of money (up to 19% of a judges salary) into the “MegaFlex Cafeteria Spending Account.” A taxpayer-plaintiff argued, among other things, that this was a prohibited gift of public funds. The court determined that the extra money was used for a public purpose, the purpose being the recruitment and retention of judges to serve in Los Angeles County.

The GCHP, is outlined, may comply with the requirements of the Constitution, however it could still be strengthened. The “Definitions/Criteria” section of the proposed plan states: “The action or accomplishment that is being recognized should be significantly beyond the scope of the employee’s regular day-to-day activities and assignments.” If adhered to, this is precisely the type of requirement that would help the plan steer clear of the prohibition on gifts of public funds. This point should be emphasized in the examples provided to make it entirely clear that the purpose of the awards program is to provide recognition for accomplishments above and beyond regular work assignments.

The first example listed in the proposed program states::

Sue volunteered to develop a solution to late tickets. The late tickets were creating extra workload for the organization. Sue eliminated the problem, which improved our service to the customer and allowed staff to focus on more critical work assignments.

This example could be strengthened to emphasize that the project Sue undertook was beyond her normal job duties. If the actions taken by Sue were merely part of her regular job description, an award for such activity may well be an improper gift.

The second example states:

Tomas created a spreadsheet of XYZ and was able to track our usage of X. He recommended ways to be more efficient. This task was outside the scope of Tom’s regular duties, and resulted in a cost savings to the organization.

This example is much stronger than the first. It indicates that Tomas saved the organization money, and that the task was outside the scope of his regular duties. When an organization recognizes a cost savings from an employee’s actions, it is much less likely that a bonus payment can be classified as an improper gift because the organization has received some benefit for the payment above and beyond what it expects from the employee as part of the employee’s assigned job duties.

Not stated in the cases, but implicit in the entire concept, is that the amount of the award should not exceed the value of the work performed for the public

entity. Otherwise the award may be perceived to be a wasteful gift. Making such an assessment on a case by case basis must necessarily involve some discretion, but keeping the awards small and infrequent should prevent the awards from actually crossing the line and becoming improper gifts, and should also eliminate the perception of the same.

RECOMMENDATIONS

The proposed spot award program is may be compliant as is, but we suggest the following modifications to eliminate most doubt:

1. Revise the policy to put dollar per year and awards per year limits on each employee;
2. Revise the examples to indicate clearly that the awards are given for performance beyond the scope of normal job duties; and
3. Review the higher end of the proposed awards to make sure that any awards made to employees do not exceed the value of the benefit received by the Plan.

RESOLUTION 2014-____

A RESOLUTION OF THE VENTURA COUNTY MEDICAL MANAGED CARE COMMISSION AMENDING RESOLUTION NO. 2012-001 AND THE PERSONNEL RULES, REGULATIONS, AND POLICIES PERTAINING TO: THE DRESS CODE; VACATION BUY-BACK POLICY APPROVAL OF AMENDMENTS TO THE BEREAVEMENT LEAVE; AND ADOPTION OF THE SPOT AWARD POLICY AND ESTABLISHING A BUDGET FOR THE SPOT AWARD

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

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

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

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

WHEREAS the Commission adopted the Personnel Rules, Regulations, and Policies by approving Resolution No. 2012-001 on August 27, 2012. These PRRPs became effective September 1, 2012.

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

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

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

Section 1: Dress Code Policy: To enhance the expectations for appropriate work place attire are understood, GCHP adopted an administrative dress code policy in May 2013 which enhanced Section 8.8 of the PRRPs. The Dress Code Policy attached hereto as Exhibit "A" is hereby adopted as part of the PRRPs retroactive to May 1, 2013, with an effective date of May 23, 2013.

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

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

The Vacation Buy-Back Policy is hereby adopted as part of the PRRPs retroactive to April 24, 2013 and further revisions to the Vacation Buy Back Policy are adopted effective July 1, 2014 which are attached hereto as Exhibit "B1" and "B2" respectively.

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

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


PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan at a regular meeting on the 19th day of May, 2014 by the following vote:

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

David Araujo, Chair

Attest:

Traci R. McGinley, Clerk of the Board

 Gold Coast Health Plan <small>A Public Entity</small>	POLICIES AND PROCEDURES
Policy #: 8.8 of PRRP (R-4)	Lead Department: Human Resources
Title: Dress Code	
Original Date: 09/01/12	Last Revision Date: 05/01/13
Approved by: CEO 05/01/13 and Commission 05/19/14	
Effective Date: 05/23/13	

PURPOSE:

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

POLICY:

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

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

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

Definitions:


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

1. Acceptable Appearance / Attire

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

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

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

 Gold Coast Health Plan <small>A Public Entity</small>	POLICIES AND PROCEDURES
Policy #: 8.8 of PRRP (R-4)	Lead Department: Human Resources
Title: Dress Code	
Original Date: 09/01/12	Last Revision Date: 05/01/13
Approved by: CEO 05/01/13 and Commission 05/19/14	
Effective Date: 05/23/13	

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

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

2. Unacceptable Appearance / Attire

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

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

3. Acceptable Shoes and Footwear


Conservative, non-athletic leather walking shoes, loafers, dress boots, flats, heels, business or dress shoes, business professional sandals, and leather deck-type shoes are acceptable for our business environment. Shoes are to be worn at all times while in the office. Tennis shoes may be worn on "Casual Days" only.

4. Unacceptable Shoes and Footwear

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

5. "Casual Day"

GCHP observes Friday as Casual Day. Employees are permitted to wear more casual and informal clothing on Fridays. Employees are still required to present a clean and neat appearance at all times as every employee continues to represent GCHP in the eyes of members and the community at large. Examples of allowable choices on dress down day

 Gold Coast Health Plan <small>A Public Entity</small>	POLICIES AND PROCEDURES
Policy #: 8.8 of PRRP (R-4)	Lead Department: Human Resources
Title: Dress Code	
Original Date: 09/01/12	Last Revision Date: 05/01/13
Approved by: CEO 05/01/13 and Commission 05/19/14	
Effective Date: 05/23/13	

include denim jeans, tee shirts and tennis shoes. As a rule of thumb, casual clothing that is acceptable attire is not appropriate for our regular Monday through Thursday standard.

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

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

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


6. Grooming and Cleanliness

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

7. Compliance

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

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

 Gold Coast Health Plan <small>A Public Entity</small>	POLICIES AND PROCEDURES
Policy #: 8.8 of PRRP (R-4)	Lead Department: Human Resources
Title: Dress Code	
Original Date: 09/01/12	Last Revision Date: 05/01/13
Approved by: CEO 05/01/13 and Commission 05/19/14	
Effective Date: 05/23/13	



ACKNOWLEDGMENT OF DRESS CODE POLICY

Employee Name: (Print) _____


Date: _____

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

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

Employee Signature

Date

 Gold Coast Health Plan <small>A Public Entity</small>	POLICIES AND PROCEDURES
Policy #: 9.4.2 of PRRP (B-5)	Lead Department: Human Resources
Title: Vacation Buy Back	
Original Date: 09/01/12	Last Revision Date:04/24/13
Approved by: CEO 04/24/13 and Commission 05/19/14	
Effective Date: 04/24/13	

I. PURPOSE:

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

II. POLICY:

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

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


III. DEFINITIONS:

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

IV. PROCEDURES:

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

Exhibit "B-1"

 Gold Coast Health Plan <small>A Public Entity</small>	POLICIES AND PROCEDURES
Policy #: 9.4.2 of PRRP (B-5)	Lead Department: Human Resources
Title: Vacation Buy Back	
Original Date: 09/01/12	Last Revision Date: 05/19/14
Approved by: Commission	
Effective Date: 07/01/14	

I. PURPOSE:

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

II. POLICY:


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

III. DEFINITIONS:

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

IV. PROCEDURES:

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

 Gold Coast Health Plan <small>A Public Entity</small>	POLICIES AND PROCEDURES
Policy #: 9.5 of PRRP	Lead Department: Human Resources
Title: Bereavement	
Original Date: 09/01/12	Last Revision Date: 05/19/14
Approved by: Commission	
Effective Date: 05/19/14	

Purpose:

GCHP provides Bereavement Leave / Pay as set forth in section 9.5 of the Personnel Rules Regulations and Policies initially adopted August 27, 2012 and effective September 1, 2012 to eligible employees due to a death in their immediate family. This policy is amended as follows effective May 19, 2014.

Policy:

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


Definitions:

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

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

Procedure:

- Bereavement leave must be requested at the time of the family member's death or to attend the funeral. The employee must obtain approval from his / her supervisor if additional time off is requested. Additional time off will be paid through available Vacation accruals.

 Gold Coast Health Plan <small>A Public Entity</small>	POLICIES AND PROCEDURES
Policy #: 9.5 of PRRP	Lead Department: Human Resources
Title: Bereavement	
Original Date: 09/01/12	Last Revision Date: 05/19/14
Approved by: Commission	
Effective Date: 05/19/14	

- Employees must record their bereavement hours through the online timecard system
- Employees must submit a time off request form to supervisor / Human Resources requesting the time
- Proof of eligibility for bereavement leave may be required
- GCHP reserves the right to modify, rescind, delete or add to this policy at any time without notice

Attachments:

N/A

References:

N/A

AGENDA ITEM 3b

To: Gold Coast Health Plan Commission

From: Michael Engelhard, CEO
Stacy Diaz, Director Human Resources

Date: August 25, 2014

RE: Consideration of rescission and / or amendments to Vacation Buy-Back and “SPOT” Award Policies

BACKGROUND:

The Commission at its July 28, 2014 meeting requested that consideration or rescission and / or amendments to the Vacation Buy-Back Policy and “SPOT” Award Policies be placed on the agenda for the August meeting. The Commission also requested the CEO to exercise his administrative authority to stay use of vacation buy-back and the “SPOT” award, until such time as the Commission could consider further action. Such administrative authority was exercised and conveyed to the employees.

The adopted Commission Bylaws recognize Robert’s Rules of Order. Pursuant to Robert’s Rules of Order Motions for reconsideration must be made during the same meeting the original motion was voted on and approved. By contrast Motions to rescind or amend may be made at a future meeting. Robert’s Rules Subpart 7 of Section 35 provides for Motions to rescind or amend as follows:

In the assembly, except when applied to a constitution, bylaws, or special rule of order:
Require (a) a two-thirds vote, (b) a majority vote when notice of intent to make the motion, stating the complete substance of the proposed change has been given at the previous meeting with a quarterly time interval or in the call of the present meeting, or (c) a vote of a majority of the entire membership-anyone will suffice.

A copy of the relevant section of Robert’s Rules is attached. Where the Rules refer to an “assembly,” they mean simply the governing body or voting group that is meeting.

Since the Commissions’ desire at its last meeting was to have this matter on an agenda for discussion and the exact desired actions were not detailed at the last meeting nor were the exact substance of the proposed changes, pursuant to Robert’s Rules, any action at the August Commission Meeting must be approved by a two-thirds vote. GCHP is not a membership organization with a Board of Directors so the option (c) under the Rules is not an option. Option (b) is not available because the motion to rescind was not noticed or complete substance set forth at the previous meeting.

At its May 19, 2014 meeting, by unanimous vote of the Commissioners present the Commission took the following actions

Vacation Buy-Back

Section 9.4.2 of the Personnel Rules sets forth a Vacation Buy-Back policy when maximum vacation accrual limits have been reached. Pursuant to the Delegation of Authority Policy, the CEO approved a Vacation Buy-Back policy for all employees effective April 24, 2013. This Administrative Vacation Buy-Back policy was Policy B-5. It was announced to all employees at an all hands meeting on April 25, 2013 that it was effective immediately.

At its May 19, 2014 meeting, the Commission, unanimously by the Commissioners in attendance, approved retroactively to April 24, 2012 the administrative Vacation Buy-Back policy.

At the same Commission meeting, there was a further amendment to the Vacation Buy-Back policy to be effective July 1, 2014. This further amendment required effective July 1, 2014 that an employee take a minimum of 40 hours of vacation during the prior 12 months before being able to cash out accrued vacation. This further amendment was unanimously approved by the Commissioners in attendance. The matrix below sets forth the original Section 9.4.2 language effective on September 1, 2012, the Administrative Policy B-5 language which the Commission adopted retroactively to April 24, 2013, and the further amendment by the Commission on May 19, 2014.

Original adopted Plan's Personnel Rules, Regulations and Policies	April 24, 2013	July 1, 2014 Amendment to policy requested by Commission
<p>9.4.2 Maximum Vacation Accrual: Employees may accrue vacation up to the maximum amount as indicated in their individual employment agreements. Excess vacation beyond the individual maximum limit will be paid at the employee's actual hourly rate of pay at the pay period ending 12/15 of each year, unless specifically pre-approved by human resources.</p>	<p>It is the policy of GCHP to provide employees with vacation time as a vehicle for rest and renewal. GCHP strongly encourages all eligible employees to utilize their vacation time. However, employees may desire to access the cash payout of some of their accrued vacation. The buyback policy will be available to all employees who have accrued more than forty (40) hours of vacation).</p> <p>DEFINITIONS: Eligible Employees: GCHP provides regular full- and part-time employees with vacation time.</p> <p>PROCEDURES:</p> <ul style="list-style-type: none"> • Employees may buy-back up to a maximum of 50% of their accrued vacation time as long as the employee maintains a minimum of forty (40) hours of vacation in their vacation account after the buy back. 	<p>It is the policy of GCHP to provide employees with vacation time as a vehicle for rest and renewal. GCHP strongly encourages all eligible employees to utilize their vacation time; however the buyback policy will be available to all employees who have accrued vacation in which they would like to cash out.</p> <p>DEFINITIONS: Eligible Employees: GCHP provides regular full- and part-time employees with vacation time.</p> <p>PROCEDURES:</p> <ul style="list-style-type: none"> • Employees may buy-back a maximum of 50% of their accrued vacation time. • The request must be submitted in writing to Human Resources for approval. • The employee must maintain a minimum of forty (40) hours of vacation remaining after the

Original adopted Plan's Personnel Rules, Regulations and Policies	April 24, 2013	July 1, 2014 Amendment to policy requested by Commission
	<p>Payment will be made based on the employee's hourly rate.</p> <p>The request must be submitted in writing to Human Resources for approval.</p>	<p>"buy back" of some of their vacation.</p> <p>In order to qualify, employees must have taken a minimum of forty (40) hours of vacation within the previous twelve (12) months of employment with GCHP.</p>

"SPOT" Award

A "SPOT" Award policy was also presented to the Commission at its May 19, 2014 meeting. This was an entirely new policy. There was a question about whether such a policy conformed with the statutes and regulations prohibiting gifts of public funds. Legal counsel researched this issue and determined that, properly drafted and administered, a "SPOT" award program does not run afoul of the prohibitions on gifts of public funds. In fact, there are other public entities within the State of California that have adopted these policies. The recommendation of legal counsel was to keep the awards low, place annual caps on the amount each employee is eligible to receive, and make sure that awards were given for actions above and beyond the employee's regular scope of work.

The following is the language of the "SPOT" award approved by the Commission at the May 19, 2014 meeting. The Commission included in its approval that the it program include an implementation rating matrix and that awardees receiving the maximum amount come before the Commission.

Policy Approved by Commission May 19, 2014
<p>Reward for special performance. All full-time and part-time employees are eligible, excluding Directors and C-Level Staff. Awards range from \$50-\$1,000.</p> <p>DEFINITIONS: The action or accomplishment that is being recognized should be significantly beyond the scope of the employee's regular day-to-day activities and assignments. For example, the award could be for an employee who uses initiative and creativity to resolve a situation or conflict. It could also be for a one-time exceptional achievement that might not be otherwise noticed such as volunteering for extra assignments during critical times while maintaining the regular work assignment.</p> <p>Criteria Guidelines:</p> <ul style="list-style-type: none"> • Performing exemplary service that serves as a role model or inspires employees • Putting in extra hours or effort to address an issue that prevents negative business impact • Identifying and implementing a change that results in improved quality or service to our members or providers, increases process efficiencies, and/or delivers cost savings "SPOT" <p>Awards - Examples: To assist in developing an appropriate justification for an award, the following provides examples of awards that <i>describe</i> the accomplishment, the <i>way</i> the accomplishment was achieved and the <i>improvement or result</i> that was accomplished:</p> <ul style="list-style-type: none"> • Sue volunteered to develop a solution to late tickets. The late tickets were creating extra workload for the organization. Sue eliminated the problem, which improved our service to the customer and allowed staff to focus on more critical work assignments. This task was outside of Sue's normal job duties that resulted in a

Policy Approved by Commission May 19, 2014

cost savings to the organization.

- Tomas created a spreadsheet of XYZ and was able to track our usage of X. He recommended ways to be more efficient. This task was outside the scope of Tom's regular duties, and resulted in a cost savings to the organization.

ELIGIBILITY:

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

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

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

PROCEDURES:

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

Supervisors, Managers, Directors and Chiefs, as well as peers, may nominate staff for "SPOT" Awards.

Nominations should be submitted via the GCHP "SPOT" Awards.

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

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

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

GCHP "SPOT" Award Matrix		
Action or Accomplishment	Ranges	
	Minimum	Maximum
Performing Exemplary Service (inspire or role model employees)	\$ 50.00	\$ 500.00
Additional Hours Served to address an issue that prevents negative business impact	\$ 50.00	\$ 500.00

GCHP "SPOT" Award Matrix		
Action or Accomplishment	Ranges	
	Minimum	Maximum
Substantial Cost savings to GCHP	\$100.00	\$1,000.00
"Big Picture" thinking	\$ 50.00	\$ 500.00
Recycling Program Which provides Costs savings	\$ 50.00	\$ 500.00
System / business flow process improvement	\$100.00	\$1,000.00
Identifying and implementing a change that results in improved quality or service to our members or providers, increases process efficiencies, and/or delivers cost savings	\$ 50.00	\$1,000.00
Collaboration / Team work which results in a positive financial impact	\$ 50.00	\$1,000.00
Customer Service	\$ 50.00	\$ 300.00
<p>** Please Note: The "SPOT" award evaluation matrix is presented as a draft with example ranges. The "SPOT" Award Committee will decide the final weighting to applied to individual factors. The "SPOT" Award Committee may decide to revise the factors at a later date as conditions and goals of the organization change with time.</p>		

RECOMMENDATION:

Should the Commission desire to further revise, amend or rescind its prior actions it should take such action via a two-thirds vote at its August meeting and adopt a Resolution reflecting the action taken at its August meeting.

CONCURRENCE:

N/A.

Attachments:

Relevant Section of Robert's Rules and Memorandum from legal counsel dated May 13, 2014 to staff regarding analysis of "SPOT" Award.

§35. RESCIND; AMEND SOMETHING PREVIOUSLY ADOPTED 1

By means of the motions to *Rescind* and to *Amend Something Previously Adopted*—which are two forms of one incidental main motion governed by identical rules—the assembly can change an action previously taken or ordered. *Rescind*—also known as *Repeal* or *Annul*—is the motion by which a previous action or order can be canceled or countermanded. The effect of *Rescind* is to strike out an entire main motion, resolution, order, or rule that has been adopted at some previous time. *Amend Something Previously Adopted* is the motion that can be used if it is desired to change only a part of the text, or to substitute a different version. 10 15

Standard Descriptive Characteristics

The motions to *Rescind* and to *Amend Something Previously Adopted*: 20

1. Take precedence over nothing, and can therefore be moved only when no other motion is pending. *Previous notice* (pp. 121–24) of intent to offer one of these motions at the next meeting can be given while another question is pending, however—provided that it does not interrupt a speaker (see Standard Characteristic 7). These motions yield to subsidiary, privileged, and incidental motions. 25
2. Can be applied to anything (e.g., bylaw, rule, policy, decision, or choice) which has continuing force and effect and which was made or created at any time or times as the result of the *adoption* of one or more main motions. (However, see below for actions that cannot be rescinded or amended.) All of the subsidiary motions can be applied to the motions to *Rescind* and to *Amend Something Previously Adopted*. 30 35

- 1 3. Are out of order when another has the floor; but previous
notice of intent to offer one of these motions at the next
meeting can be given after another member has been as-
signed the floor, provided that he has not begun to speak.
- 5 4. Must be seconded.
5. Are debatable; debate can go into the merits of the ques-
tion which it is proposed to rescind or amend.
6. Are amendable, by the processes of primary and second-
ary amendment in any of the forms discussed in 12,
10 as applicable to the particular case. Thus, a motion to
Rescind can be amended, for example, by substituting for
it a motion to amend what is proposed to be rescinded.
But if a motion to *Rescind* or to *Amend Something Previ-
ously Adopted* is amended so that the change proposed by
15 the amended motion then exceeds the scope of a previous
notice that was given, the effect of the previous notice is
destroyed and the motion can no longer be adopted by a
majority vote (see Standard Characteristic 7). When these
motions *require* previous notice (as may be the case with
20 respect to a motion to rescind or amend a provision of
the bylaws or a special rule of order), such a motion can-
not be amended so as to make the proposed change
greater than that for which notice has been given.
- 25 7. In an assembly, except when applied to a constitution, by-
laws, or special rules of order, require (a) a two-thirds
vote, (b) a majority vote when notice of intent to make
the motion, stating the complete substance of the pro-
posed change, has been given at the previous meeting
within a quarterly time interval or in the call of the present
30 meeting, or (c) a vote of a majority of the entire mem-
bership—any one of which will suffice. The same vote is
required for the assembly to rescind or amend an action
taken by subordinate bodies, such as some executive
boards, empowered to act on behalf of the assembly. In a
35 committee, these motions require a two-thirds vote unless
all committee members who voted for the motion to be

rescinded or amended are present or have received ample notice, in which case they require a majority vote. A motion to rescind or amend provisions of a constitution or bylaws is subject to the requirements for amendment as contained in the constitution or bylaws (see 56, 57). If the bylaws or governing instrument contains no provision relating to amendment, a motion to rescind or amend applied to a constitution or to bylaws is subject to the same voting requirement as to rescind or amend special rules of order—that is, it requires (a) previous notice as described above *and* a two-thirds vote or (b) a vote of a majority of the entire membership.

8. A negative vote on these motions can be reconsidered, but not an affirmative vote.

Further Rules and Explanation

RIGHT OF ANY MEMBER TO MAKE THE MOTIONS, WITHOUT TIME LIMIT. In contrast to the case of the motion to *Reconsider*, there is no time limit on making these motions after the adoption of the measure to which they are applied, and they can be moved by any member, regardless of how he voted on the original question. When previous notice has been given, it is usual to wait for the member who gave notice of these motions to move them; but if he does not, any member can do so.

PROPOSED AMENDMENTS BEYOND THE SCOPE OF THE NOTICE. As noted in Standard Descriptive Characteristic 6 above, when previous notice is a *requirement* for the adoption of a motion to rescind or amend something previously adopted, no subsidiary motion to amend is in order that proposes a change greater than that for which notice was given. This is always the case, for example, when the bylaws of an organization require previous notice for their amendment, which they should do (pp. 580–82). It will also

1 be the case, as a practical matter, whenever a majority of the
entire membership is not in attendance at the time the vote
is taken on a motion to rescind or amend a provision of the
constitution or bylaws, or a special rule of order. In either of
5 the situations described above, no subsidiary motion to
amend is in order that proposes a change going beyond the
scope of the notice which was given, for the reason that adop-
tion of such a motion will destroy the effect of the notice,
and the motion is thus tantamount to a motion to *Postpone*
10 *Indefinitely*.

ACTIONS THAT CANNOT BE RESCINDED OR
AMENDED. The motions to *Rescind* and to *Amend Some-*
thing Previously Adopted are not in order under the following
15 circumstances:

- a) When it has previously been moved to reconsider the vote
on the main motion, and the question can be reached by
calling up the motion to *Reconsider* (37).
- 20 b) When something has been done, as a result of the vote
on the main motion, that is impossible to undo. (The un-
executed part of an order, however, can be rescinded or
amended.)
- 25 c) When a resignation has been acted upon, or a person has
been elected to or expelled from membership or office,
and the person was present or has been officially notified
of the action. (The only way to reverse an expulsion is to
follow whatever procedure is prescribed by the bylaws for
admission or reinstatement. For the case of an election, see
30 pp. 653–54 regarding removal of a person from office.)

Form and Example

When previous notice has been given, the motions to
35 *Rescind* or to *Amend Something Previously Adopted* may be
made as follows:

MEMBER A (obtaining the floor): In accordance with notice given at the last meeting, I move to rescind the resolution that authorized additional landscaping of the grounds. [Or "... to amend the resolution ... by adding ..."] (Second.) 1

In such a case, a majority vote is sufficient. 5

When no notice of the motion to *Rescind* or to *Amend Something Previously Adopted* has been given, the motions may be made as follows: 10

MEMBER A (obtaining the floor): I move to rescind the motion relating to ... adopted at the May meeting. [Or "... to amend the motion ... by inserting ..."] (Second.)

Without previous notice, the motion requires a two-thirds vote or a majority of the entire membership for its adoption. 15

In a great many instances, the motion or resolution originally adopted is not referred to, and only the bylaw, rule, or policy to be rescinded or amended is mentioned. For example: 20

MEMBER A (obtaining the floor): In accordance with the notice given in the call of this meeting, I move to amend Article V, Section 3 of the bylaws by striking out subparagraph (c) thereof. (Second.) 25

To offer an amendment to change one form of the motion into the other:

If the motion was made "to amend the motion relating to ... adopted at the May meeting ... by inserting ...": 30

MEMBER A (obtaining the floor): I move to substitute for the pending motion the following: "To rescind the motion relating to ... adopted at the May meeting."

If the motion was made "To rescind the resolution that authorized additional landscaping of the grounds.": 35

1 MEMBERA (obtaining the floor): I move to substitute for the pending
 motion the following: "To amend the resolution that authorized addi-
 tional landscaping of the grounds by adding 'at a cost not to exceed
 \$100,000.'"

5

Rescind and Expunge from the Minutes

On extremely rare occasions when it is desired not only
 to rescind action but also to express the strongest disapproval,
 10 a member may move to *Rescind and Expunge from the
 Minutes* (or *the Record*). Adoption of this motion requires an
 affirmative vote of a majority of the entire membership, and
 may be inadvisable unless the support is even greater. Even a
 unanimous vote at a meeting is insufficient if that vote is not
 15 a majority of the entire membership. If such a motion is
 adopted, the secretary, in the presence of the assembly, draws
 a single line through or around the offending words in the
 minutes, and writes across them the words, "Rescinded and
 Ordered Expunged," with the date and his signature. In the
 20 recorded minutes the words that are expunged must not be
 blotted or cut out so that they cannot be read, since this
 would make it impossible to verify whether more was ex-
 punged than ordered. In any published record of the pro-
 ceedings, the expunged material is omitted. Rather than
 25 expunging, it is usually better to rescind the previous action
 and then, if advisable, to adopt a resolution condemning the
 action which has been rescinded.

30 §36. DISCHARGE A COMMITTEE

By means of the motion to *Discharge a Committee* from
 further consideration of a question or subject, the assembly
 can take the matter out of a committee's hands* after refer-

*Or a committee can take it out of a subcommittee's hands.

**Ventura County Medi-Cal Managed Care Commission
(VCOMMCC) dba Gold Coast Health Plan (GCHP)
Commission Meeting Minutes
May 19, 2014**

CALL TO ORDER

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

ELECTION OF TEMPORARY CHAIR

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

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE

Antonio Alatorre, Clinicas del Camino Real, Inc.
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
May Lee Berry, Medi-Cal Beneficiary Advocate
Lanyard Dial, MD, Ventura County Medical Association
Peter Foy, Ventura County Board of Supervisors
David Glycer, Private Hospitals / Healthcare System
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Gagan Pawar, MD, Clinicas del Camino Real, Inc. (arrived at 3:02 p.m.)
Dee Pupa, Ventura County Health Care Agency
Robert Wardwell, Private Hospitals / Healthcare System

EXCUSED / ABSENT COMMISSION MEMBERS

Barry Fisher, Ventura County Health Care Agency

STAFF IN ATTENDANCE

Michael Engelhard, Chief Executive Officer
Nancy Kierstyn Schreiner, Legal Counsel
Michelle Raleigh, Chief Financial Officer
Traci R. McGinley, Clerk of the Board
Luis Aguilar, Member Services Manager
Brandy Armenta, Compliance Director
Sherri Bennett, Network Operations Director
Stacy Diaz, Human Resources Director
Mike Foord, IT Infrastructure Manager
Anne Freese, Pharmacy Director
Guillermo Gonzalez, Government Relations Director

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

PUBLIC COMMENT

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

1. APPROVE MINUTES

a. Regular Meeting of April 28, 2014

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

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

2. CONSENT ITEMS

a. March Financials

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

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

3. APPROVAL ITEMS

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

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

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

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

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

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

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

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

CFO Raleigh reviewed the written report with the Commission.

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

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

c. Resolution Amending Personnel Rules, Regulations and Policies

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

Discussion was held separately regarding each of the four policies.

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

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

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

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

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

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

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

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

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

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

Further discussion was held regarding the SPOT Program.

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

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

d. Adopt Amended Salary Schedule

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

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

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

PUBLIC COMMENT (continued)

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

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

4. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Engelhard reviewed the written report with the Commission.

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

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

b. COO Update

COO Watson provided an overview of the report.

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

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

c. Health Services Update

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

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

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

4. INFORMATIONAL ITEMS

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

CEO Engelhard reviewed the written report with the Commission.

b. FY 2014-15 Budget Development Process

CFO Raleigh reviewed the written report with the Commission.

COMMENTS FROM COMMISSIONERS

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

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

Commissioners Laba and Wardwell agreed.

CLOSED SESSION

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

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

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

RECESS:

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

ADJOURN TO CLOSED SESSION

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

- b. Closed Session Pursuant to Government Code Section 54957(e)**
Public Employee Performance Evaluation
Title: Chief Executive Officer

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

RETURN TO OPEN SESSION

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

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

ADJOURNMENT

Meeting adjourned at 5:51 p.m.

APPROVED:



Traci R. McGinley, MMC, Clerk of the Board



AGENDA ITEM 3c

To: Gold Coast Health Plan Commission
From: Michelle Raleigh, Chief Financial Officer
Date: August 25, 2014
RE: Affordable Care Act (ACA), Section 1202 Payments

SUMMARY:

Gold Coast Health Plan (GCHP or Plan) has made initial payments to qualifying physicians as required by the Affordable Care Act (ACA), Section 1202. These initial payments were made on March 27, 2014. As these initial payments were made, the State alerted the Managed Care Plans (MCPs) that a change in the calculation of these supplemental payments was necessary.

This item was continued from the July 28, 2014 Commission Meeting.

RECOMMENDATION:

The Plan has not received guidance from the California Department of Health Care Services (DHCS) in the form of an All-Plan Letter.

Therefore, there is no recommended action at this time. This item should be continued to a future Commission meeting after DHCS has provided detailed guidance to the Plan.

BACKGROUND / DISCUSSION:

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

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

- Payment between the MCPs and the State – DHCS will switch to CMS “Model 1” where MCPs’ capitation payments will include estimated additional payments under ACA 1202 and there will be no reconciliation. The suggestion to switch from “Model 2” came from MCPs after reviewing the detailed reconciliation process that would have been followed under “Model 2” and understanding that MCPs would possibly not be made whole through that process.
- Payments to MCPs’ Delegated Providers – DHCS clarified that ACA 1202 payments would be made to sub-capitated entities as long as there is a differential between what the MCP paid to the sub-capitated entity (before any ACA 1202 payments) and the ACA 1202 Medicare rate.
- Payments based on “lesser of” language – In late March 2014, DHCS alerted MCPs that ACA 1202 payments need to also take into account the provider’s reported billed charge into the calculation. Therefore, the supplemental payment would not just be based on the difference between the Medi-Cal rate paid (or rate paid to the provider under sub-capitated situations) and the effective Medicare rate, but also need to take into account the amount in the provider’s billed charge field on the claim. If the billed charge was less than Medicare, the reimbursement amount would be the difference between the billed amount and the Medi-Cal rate.

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

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

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

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

Lastly, recall that DHCS has communicated that the due date for providers to attest is December 31, 2014 in order to qualify for the increased payments. Providers have received monthly notifications via the GCHP monthly Provider Operations Bulletin that have detailed requirements and instructions pertaining to the attestation on the State site. Information has also been presented during provider town hall meetings.

At the July 28, 2014 Commission meeting, additional information was requested regarding the number of physicians to whom overpayment was made and the range of dollars for these physicians. The range of overpayment to a total of 30 physicians is from \$1.65 to \$48,356. Majority of this overpayment was paid to four providers, two were paid a total of \$76,915 and the other two were paid \$8,210. The remaining 26 physicians were paid a total of approximately \$5,400.

FISCAL IMPACT:

None at this time since no action is recommended.

CONCURRENCE:

N/A.

Attachments:

None.



AGENDA ITEM 3d

To: Gold Coast Health Plan Commission
From: Michael Engelhard, CEO
Date: August 25, 2014
Re: State of California Contract Amendments A01 and A12

SUMMARY:

The State of California Department of Health Care Services (DHCS) establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A01 is a replacement to the current Amendment A01 and reflects an update to the Adult / Family Hyde supplemental capitation rate. Amendment A12 reflects changes to GCHP capitation rates due to the FY 2012-13 Intergovernmental Transfer (IGT).

BACKGROUND / DISCUSSION:

Gold Coast Health Plan (GCHP or Plan) received the following contract amendments from the DHCS on August 11, 2014:

- A01 – This a replacement to the current Amendment 01 and updates the Adult / Family Hyde capitation rates back to July 1, 2011. The Hyde capitation rates are paid to GCHP for non-Federally covered abortions.
- A12 - The amendment adjusts the FY 2012-13 rates to include the Intergovernmental Transfer (IGT).
- Both amendments extend the contract term from April 30, 2015 to December 31, 2015.

FISCAL IMPACT:

The updated Amendment A01 capitation rates were known by the Plan and have been received through quarterly payments. Accordingly, there is no fiscal impact.

The revised Amendment A12 reflects increased capitation rates for the pending FY 2012-13 IGT. Once the IGT has been approved by the Centers of Medicare and Medicaid Services, the Plan will acknowledge the approximate \$532,000 as revenue.

RECOMMENDATION:

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendments A01 and A12.

CONCURRENCE:

N/A.

Attachments:

None.



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



Quality Improvement Committee Highlights

Monday August 25, 2014

**C. Albert Reeves, M.D.
Chief Medical Officer**

www.goldcoasthealthplan.org



Quality Improvement Department

www.goldcoasthealthplan.org

Consumer Assessment of Healthcare Providers and Systems (CAHPS Survey)

- Commissioned by DHCS
- Performed by Health Services Advisory Group (HSAG)
- Performed in 2013 on members enrolled between July and Dec. 2012
- 1350 adults and 1650 children

Adult Results: (0-5 stars)

- Health Plan - 2 stars
- All Health Care – 3 stars
- Personal Doctor – 5 stars
- Specialist Doctors Seen – 5 stars
- Getting Needed Care – 3 stars
- Getting Care Quickly – 1 star
- How Well Doctors Communicate – 3 stars
- Customer Service – 3 stars

Child Results: (1-5 stars)

- Health Plan – 1 star
- All Health Care – 1 star
- Personal Doctor – 3 stars
- Specialist Doctors seen – 2 stars
- Getting Needed Care – 1 star
- Getting Care Quickly – 1 star
- How Well Doctors Communicate – 1 star
- Customer Service – 1 star

The CAHPS Survey was done in 2013 based on members from 2012. This was done at a time when the Plan was new and experiencing challenges.

Issues:

- Survey access data did not allow the Plan to identify specific provider issues.
- Poor evaluation by children the reasons are unclear.
- Customer Service data is old.

Action: Gold Coast Health Plan (GCHP) has contracted for another survey to be done in 2014 to compare results and identify specific provider access problems and provide a more timely evaluation.

HEDIS 2014

- 29 Quality Measures selected by DHCS
- DHCS expects plans to reach a Minimum Performance Level (MPL) – 25th percentile for Medicaid Plans.

Gold Coast Results:	<u>2013</u>	<u>2014</u>
Met	19	23
Did Not Meet	10	6

Improved Measures Reaching MPL

- Cervical Cancer Screening
- Appropriate Antibiotic Treatment of Bronchitis
- HbA1c (diabetic) <8%
- Retinal Eye Exam for Diabetics

Measures Not Meeting MPL

Counseling Children for Nutrition

Counseling Children for Physical Activity

Children 12 – 24 Mo. Access to Primary Care

Children 25 mo. – 6 yrs. Access to Primary Care

Children 7 – 11 yrs. Access to Primary Care

Adolescents 12 – 19 yrs. Access to Primary Care

Strategies for Improvement

The Quality Improvement Dept. has identified barriers for compliance and developed strategies to improve the Plan's results including:

- Meeting with providers to discuss results and provide education.
- Webinars for providers.
- Collect mid-year data and inform providers of members needing visits and tests.

Other Quality Improvement Department Activities

- Internal Quality Improvement Project – Retinal Eye Exam for Diabetics – passed the HEDIS MPL for this HEDIS Measure.
- Readmission Quality Improvement Project – readmissions are down significantly.
- Facility Site Reviews (FSR) – closed the State CAP on FSR’s, completed 35 of 45 FSR’s for every 3 year re-credentialing.
- FSR RN, Terry Wagemann, became a State Certified FSR Master Trainer.

Pharmacy & Therapeutics Committee

- Reviewed 69 new drugs approved by FDA and approved 27 for addition to the formulary.
- Approved stricter approval guidelines for Sovaldi.
- PBM Oversight – identified credentialing deficiencies, issued a Corrective Action Plan to the PBM, re-audited the PBM and closed the CAP.
- Inter-rater Reliability Assessment – 3 pharmacists for ScriptCare checked for appropriateness and consistency of authorization decisions – 100%.

Credentials/Peer Review Committee

- Reviewed the status of 2 providers receiving actions by the California Medical Board.
- Discussed instituting a Board Certification Requirement for Credentialing.
- 107 providers were reviewed for credentialing or re-credentialing (done every 3 years). All were approved including 2 providers approved for a limited time:
 - 1 for completion of required training
 - 1 for completion of a malpractice case

Health Education/ Cultural Linguistics Committee

The Health Navigator Program:

- Identifies frequent ER Utilizers.
- Contacts the member.
- Counsels and refers to PCP or Case Management.
- Members are tracked.
- Program has successfully lowered number of ER Visits.

This program received recognition by ACAP on their website.

Grievance & Appeals Committee

A Grievance and Appeals Dept. has been established and the manager position filled.

First Quarter 2014 statistics include 40 Grievances (0.08 per 1000 members):

- 5 access to specialty care
- 2 for DME
- 2 eligibility issues
- 3 long wait times
- 7 PCP office rude
- 2 poor customer service
- 9 quality of care
- 10 UM denial appeals

Grievance & Appeals Committee (con't)

10 Appeals:

- 1 decided in favor of member
- 6 upheld
- 3 were pending

State Fair Hearing Report:

- 1 case held from Q4 2013 – member withdrew 1/3/2014.
- 1 case filed Q1 2014 – member disputing resolution of grievance – held to Q2 2014 - withdrew 4/7/2014.

Network Planning Committee

Provider Satisfaction Survey presented: 216 locations surveyed with 750 providers and received 153 responses.

Results:

- Finance/Claims Issues: 68% satisfied, 32% dissatisfied.
- Utilization and Quality Management: 83% satisfied, 17% dissatisfied.
- Network/Coordination of Care: 84% satisfied, 16% dissatisfied.
- Pharmacy: 77% satisfied, 23% dissatisfied.
- Call Center: 84% satisfied, 16% dissatisfied.
- Provider Relations: 83% satisfied, 17% dissatisfied.

Member Services Committee

Member orientations are being held throughout the county in English and Spanish, week-days, evenings and on Saturdays.

Call Center Metrics:

- Q1 2014 had 8,600 – 8,900 calls per month

The Call Center met all metrics for:

- Average Speed to Answer (goal less than 30 sec.)
- Abandonment Rate (goal is 5% or less)

Utilization Management Committee

Fourth Quarter 2013 statistics include:

- Bed Days per 1000: 210 (Includes Admin. Days)
(2011 - 337, 2012 - 357)
- Average Length of Stay: 4.7
(2011 - 4.8, 2012 - 4.5)
- Readmission Rate: 9.9%
(2011 - 14.3%, 2012 - 14.8%)
- ER Utilization per 1000: 374
(2011 - 439, 2012 - 514)

Utilization Management Committee (con't)

- Authorization Requests Q1 2014: 15,792
(Q1 2013: 14,369)
- Denial Rate Q1 2014: 4%
- Appeals: 5
 - 1 approved for member
 - 4 denied for member

GOLD COAST HEALTH PLAN 2014 QUALITY IMPROVEMENT PROGRAM

July 3, 2014 FINAL

I.	Mission and Purpose	3
II.	Scope, Goals & Objectives	4
III.	Ventura County Medi-Cal Managed Care Commission as Governing Body	
i.	Consumer Advisory Committee	7
ii.	Provider Advisory Committee	8
IV.	Quality Committees	
I.	Quality Improvement Committee	9
II.	Medical Advisory Committee	11
III.	Member Services Committee	12
IV.	Grievance and Appeals Committee	13
V.	Network Planning Committee	14
VI.	Utilization Management/Case Management Committee	17
VII.	Health Education/Cultural Linguistics Committee	19
VIII.	Credentials Committee	20
IX.	Pharmacy and Therapeutics Committee	21
V.	Resources Dedicated to Quality Improvement	22
A.	Chief Medical Officer	

B. Director Quality Improvement

C. Quality Improvement Staff

VI.	Committee Organizational Chart	25
VII.	Quality Committee Meetings for Calendar Year	26

I. MISSION AND PURPOSE

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

Purpose:

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

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

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

The Triple Aim

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

Seven Priorities

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

Ten Principles

1. Person-centeredness and family engagement, including understanding and valuing patient preferences, will guide all strategies, goals, and health care improvement efforts;
2. Specific health considerations will be addressed for patients of all ages, backgrounds, health needs, care locations, and sources of coverage; Eliminating disparities in care—including but not limited to those based on race, color, national origin, gender, age, disability, language, health

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

Accountability:

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

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

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

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

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

II. SCOPE, GOALS & OBJECTIVES

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

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

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

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

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

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

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

4. A QI focus which represents

- All care settings
- All types of services

- All demographic groups

The *goal* of the QIP is to develop and implement systematic methodologies to monitor and evaluate processes using data to drive decisions and rapid cycle improvement to resolve identified problem. GCHP's Quality Improvement Committee oversees the monitors established by GCHP's committees. Each QI subcommittee tracks its performance indicators a continuous focus on the Plan's operational and clinical priorities for improvement and reports out to the QIC. This constitutes the QI Work Plan which is a separate document.

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

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

- Promotion of Practices Guidelines integration with community standards
- Reporting Utilization Management including trend analysis (See UM Plan)
- Health Education Programs and Results
- Cultural and Linguistics Programs
- Reporting of Pharmacy utilization data, particularly for the identification of quality improvement efforts
- Reporting of access and availability data and Initial Health Assessment (IHA)/Staying Healthy Assessment (SHA) monitoring
- Reporting of Delegation Oversight activities which may include specialty contracts, vendor contracts, pharmacy benefit management, etc.,
- Conducting bi-directional communication as needed with all QI Committee subcommittees and with Medical, Provider, Consumer and the Board of Commissioners to report findings, activities and outcomes and act on recommendations.
- Request approval for QI Plan and QI Work Plan including goals and objective from the Board of Commissioners annually.
- Provide quarterly progress reports to the Board of Commissioners that include but are not limited to: actions taken including requests, progress in meeting goals and objective and improvements made.
- Comply with all regulatory requirements.

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

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

Membership

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

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

- Three members shall be practicing physicians who serve a significant number of Medi-Cal beneficiaries in Ventura County. One shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Association, one shall be selected from a list with a minimum of three (3) nominees submitted by Clinicas Del Camino Real and one shall be selected from a list with a minimum of three (3)

nominees submitted by the Ventura County Medical Center Executive Committee;
(Physician Representatives)

- Two members shall be representatives of private hospitals and healthcare systems operating within Ventura County and shall be selected from a list with a minimum of three (3) nominees submitted by the Hospital Association of Southern California. Nominees shall be from different hospitals and healthcare systems. The two appointed members shall not be affiliated with the same hospital or healthcare system; (Private Hospital/Healthcare System Representatives)
- One member shall be a representative of the Ventura County Medical Center Health System and shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center administration; (Ventura County Medical Center Health System Representative)
- One member shall be a member of the Board of Supervisors, nominated and selected by the Board; (Public Representative)
- One member shall be the chief executive officer of Clinicas del Camino Real or designee nominated by the Clinicas del Camino Real chief executive officer and approved by the Ventura County Board of Supervisors; (Clinicas Del Camino Real Representative)
- One member shall be the Ventura County Health Care Agency Director or designee nominated by the Health Care Agency Director and approved by the Board of Supervisors; (County Official)
- One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is not otherwise represented on the Ventura County Medi-Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position; (Consumer Representative)
- One member shall be the Ventura County Medical Center Family Medicine Residency Program Director or Faculty Designee and approved by the Board of Supervisors. (Ventura County Medical Center Health System Representative)

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

- Provider Advisory Committee
- Consumer Advisory Committee

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

Consumer Advisory Committee (CAC)

Purpose:

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

Function:

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

Membership:

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

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

Committee members may include representation from the following:

- County Health Care Agency
- County Human Services Agency
- Children Welfare Services Agency

- Members with Chronic Medical Conditions
- Members with Disabilities/Special needs Members
- Seniors
- Other Medi-Cal beneficiaries

Meeting Frequency:

The committee meets quarterly at a minimum.

Provider Advisory Committee

Purpose:

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

Function:

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

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

Membership:

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

Meeting Frequency:

The committee meets at a minimum on a quarterly basis.

V. QUALITY COMMITTEES

1. Quality Improvement Committee (QIC)

QIC Charter

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

functions of GHCP described in this policy and by California and Federal regulatory authorities as appropriate.

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

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

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

QIC Objectives

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

QIC Responsibilities:

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

QIC Membership:

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

QIC Reporting Structure:

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

Meeting frequency:

The QIC meets at a minimum quarterly.

2. Medical Advisory Committee (MAC)

Purpose:

The purpose of the MAC is to:

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

Function:

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

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

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

Membership:

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

Meeting Frequency

The committee meets at a minimum on a quarterly basis.

3. Member Services Committee (MSC)

MSC Charter

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

MSC Objectives

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

- Ensure GCHP members will have their concerns resolved quickly and effectively and have the right to voice complaints or concerns without fear of discrimination.
- Ensure GCHP members can trust that the confidentiality of their information will be respected and maintained.
- Ensure members have access to information on languages spoken in physician offices to better aid them in the selection of a primary care physician.
- Have access to appropriate language interpreter services at no charge when receiving medical care
- Ensure GCHP members can reach the Member Services Department quickly and be confident in the information they receive.
- Utilize the CAHP survey to identify service indicators for improvement.
- Ensure GCHP's Member Rights and Responsibilities policy is distributed to members and providers.
- Ensure that GCHP's member materials are developed in a culturally appropriate format.

- Interface with other GCHP committees to improve service delivery to members.

MSC Membership

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

Meeting Frequency:

The MSC meets quarterly at a minimum.

4. Grievance and Appeals Committee

G&A Charter

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

G&A Objectives

- Review and respond to all grievances timely and in writing
- Review issues for patterns which may require process changes
- Review all grievances and appeals that may affect the quality of care delivered to members

- Ensure all GCHP departments are educated on the appropriate process for communicating member grievances and appeals to the correct area for resolution
- Ensure that issues needing intervention are routed to the appropriate area for discussion and intervention

G&A committee Membership

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

Meeting Frequency:

The Committee meets quarterly.

5. Network Planning Committee (NPC)

NPC Charter:

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

NPC Objectives:

- Ensure GCHP providers have an understanding of the health plan and health network and know how to obtain services they need for their patients.
- Ensure GCHP providers will have their concerns resolved quickly and effectively, and have the right to voice complaints or concerns without fear of termination.
- Ensure GCHP providers have access to accurate and timely

eligibility information to ensure prompt medical care to members.

- Ensure GCHP providers have access to appropriate language assistance, including interpreter services, to ensure prompt medical care for their patients.
- Ensure GCHP providers can reach Provider Services, Health Services, Member Services, and Claims departments quickly and be confident in the information they receive.
- Maintain a reporting calendar that delineates reports to be submitted for the committee's review, the reporting frequency, and the months that reports are due.
- Evaluate overall effectiveness of applicable service, quality, and improvement activities to identify areas of improvement for services rendered to GCHP providers.
- Develop, maintain, and disseminate GCHP's provider materials in alignment with the health plan's strategic goals for provider education and satisfaction.
- Oversee the resulting data from provider satisfaction surveys, inquiries, complaints, appeals, PCP requests for member reassignment, and terminations to identify areas of opportunity for improvement in services to GCHP providers.
- Ensure that provider network meets DHCS standards and that there is adequate capacity to meet member needs.

NPC Membership:

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

Meeting Frequency:

The committee meets at a minimum quarterly

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

Committee Charter:

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

UM/CM Responsibilities

Responsibilities include but are not limited to the following:

- Annual Review and approval of the UM and CM Program Documents
- Review and approval of program documents addressing the needs of special populations. This includes but may not be limited to Children with Special Health Care Needs (CSHCN) and Seniors and Persons with Disabilities (SPD)
- Suggest and collaborate with other departments to address areas of patient safety. This may include but is not limited to medication safety and child safety.
- Annual adoption of preventive health criteria and medical care guidelines with guidance on how to disseminate criteria and ensure proper education of appropriate staff.
- Review of the timeliness, accuracy and consistency of the application of medical policy as it is applied to medical necessity reviews
- Review utilization and case management monitors to identify opportunities for improvement.
- Review data from Member Satisfaction Surveys to identify areas for

improvement.

- Ensure policies are in place to review, approve and disseminate UM criteria and medical policies used in review when requested.
- Review at least, annually the Inter Rater Reliability Test results of UM staff involved in decision-making (RN's and MD's) and take appropriate actions for staff that fall below acceptable mark.
- Interfaces with other GCHP committees for trends, patterns, corrective actions and outcomes of reviews.

Membership:

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

Meeting Frequency:

The UM/CM Committee meets quarterly at a minimum.

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

Purpose:

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

Functions:

- Ensure the Group Needs Assessment (GNA) is completed to determine a baseline for serving education and cultural /language needs.
- Work with other areas and the CMO to prioritize health education needs.
- Ensure opportunities are available to educate members on disease process, preventive care, plan processes and all other areas essential to good member health.
- Assist providers in educating Plan members.
- Ensure written materials are at a reading level consistent with Plan membership needs and are no greater than the sixth grade reading level.
- Educate Plan staff on specific cultural barriers that might hinder the delivery of optimal health care.
- As needed, the Health Education, Cultural and Linguistic Committee will meet separately to review specific program goals and objectives. Members for the Health Education Committee will consist of the same membership as the Cultural and Linguistic Committee with expectation of

Membership:

- Director, Health Education & Cultural Linguistics (Chair)
- Chief Medical Officer
- Medical Director
- Director of Health Services or designee
- Manager of Case Management or designee
- Director of Communications
- Manager of Member Services or designee

- Director of Network Operations or designee
- Quality Improvement Representative
- Cultural and Linguistic Specialist
- Health Education Specialist

Meeting Frequency:

The committee meets at a minimum quarterly

8. Credentials Committee (CC)

Purpose:

The Credentials Committee provides guidance and peer input into GCHP's provider credentialing and practitioner peer review process.

Functions:

Credentialing Responsibilities:

- Provide guidance and comments on GCHP's provider credentialing process.
- Review and make decisions for initial credentialing and re-credentialing for participation in GCHP's provider network.
- Review the provider credentialing policy annually and make recommendations for change

Peer Review Responsibilities:

- Review results of provider profiling when available and suggest methods to feed information back to network providers
- Review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns and determine corrective action when necessary.

Membership:

The Committee will consist of seven to nine (7-9) physicians and the CMO who will be the chairperson. To assure due process in the performance of

peer review investigations, the Chief Medical Officer shall appoint other physician consultants as necessary to obtain relevant clinical expertise and representation by an appropriate mix of physician types and specialties.

Meeting Frequency:

The committee meets quarterly.

9. Pharmacy & Therapeutics (P&T) Committee

Purpose:

The P&T Committee serves as the oversight committee to GCHP for the development and implementation of a plan-wide medication management program. The P&T Committee is for the development of a formulary to ensure optimal efficacy, safety, and cost- effectiveness of drug therapy.

Function:

- Maintenance of a drug formulary based on an objective evaluation of efficacy, safety and cost-effectiveness of medications that is reviewed and updated at least quarterly.
- Assess, review and determine formulary status for all new drugs approved by the FDA and all drugs added to the Medi-Cal Fee For Service List of Contract Drugs
- Review and approve all matters pertaining to the use of medication, including development of prescribing guidelines and protocols and procedures to promote high quality and cost-effective drug therapy.
- Provide oversight of the prior authorization process to ensure that medications are reviewed consistently according to the approved guidelines
- Review and evaluation of analyses including but not limited to population demographics, morbidities, health risks, and provider-specific and plan-wide utilization patterns for enrolled members.
- Any other issues related to pharmacy quality and usage.

Membership:

The P&T Committee members include but are not limited to GCHP's Chief Medical Officer (Chair), PBM representative, GCHP's Director of Pharmacy Services, physicians, and representatives of a variety of clinical specialties.

Meeting Frequency:

The committee meets quarterly.

IV. RESOURCES DEDICATED TO QUALITY IMPROVEMENT

CHIEF MEDICAL OFFICER

Responsibilities:

The Chief Medical Officer has the overall responsibility for the clinical direction of GCHP's QIP. The Chief Medical Officer ensures that the QIP is adequate to monitor the full scope of clinical services rendered, and that identified problems are resolved and corrective actions are initiated when necessary and appropriate.

The Chief Medical Officer serves on the QIC, CC, P&T, UM/CM, NMC and MAC Committees. The Chief Medical Officer works directly with all GCHP department heads and executive team members. Further, as Chief Medical Officer and a member of the Quality Improvement Committee, the Chief Medical Officer annually oversees the approval of the clinical appropriateness of the Quality Improvement Program.

Reporting Responsibility:

The Chief Medical Officer reports to and is supervised by the Chief Executive Officer. The Chief Medical Officer's job description also specifies that the Chief Medical Officer has the ability and responsibility to inform the Chief Executive Officer, and if necessary the Commission, if at any time the Chief Medical Officer believes his/her clinical decision-making ability is being adversely hindered by administrative or fiscal consideration.

DIRECTOR OF QUALITY IMPROVEMENT

The QI Director is responsible working with sub-committee chairs and appropriate departments to ensure all quality monitors; analysis and improvement initiatives are in place. The Director works with the QIC, subcommittees and leadership to educate all health plan staff on the importance and role in quality improvement, communication, analysis and reporting. The Director is a mentor for all department heads and works with them to implement processes that will create both efficient and quality services.

The Director reports to the CMO and ensures that he/she is updated on any deficiencies and proposed improvement activities.

Specific roles and responsibilities include but are not limited to:

- Ensuring that the annual Quality Improvement plan and work plan are created and reviewed by all appropriate areas
- Working with all appropriate departments in the creation of the annual QI review and analysis of results

- Ensuring QIC approval of all QI document annually
- Guiding the collection of HEDIS data as mandated by contractual requirement and assisting in the development of activities to improve care
- Ensuring that appropriate principles of data collection and analysis are used by all departments when looking for improvement opportunities
- Providing educational opportunities for QI staff and other staff members key to improving care and service to better target improvement initiative

QUALITY IMPROVEMENT STAFF

The quality improvement staff assists the director in assessing data for improvement opportunities. They work with other departments to assist in planning and implementing activities that will improve care or service.

Responsibilities include but are not limited to the following:

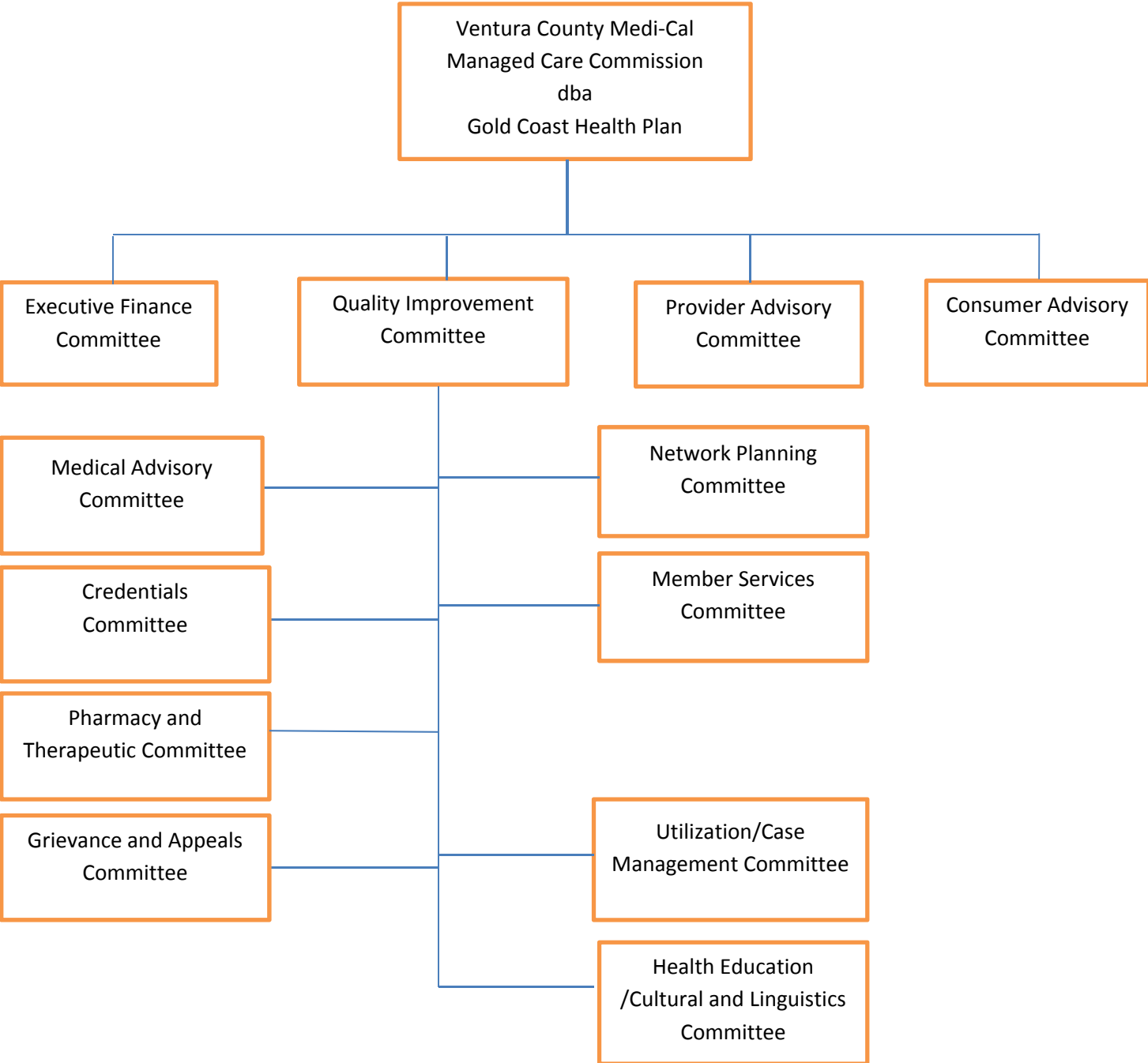
- Assist in creating the annual QI Plan document
- Assist in coordination of HEDIS data collection and analysis of results
- Work with other departments to gather information for the annual QI Review
- Assist in developing activities for the annual QI work plan
- Assist the QI Director as required

OTHER QI RESOURCES

Staff from other departments will contribute to the QI process. They will continue to identify areas for improvement. Department staff will be deployed to assist in creating and implementing quality improvement initiatives.

GOLD COAST HEALTH PLAN COMMITTEE ORGANIZATIONAL CHART

The following organizational chart shows the key GCHP committees that advise the Ventura County Medi-Cal Managed Care Commission and their reporting relationships:



X. QUALITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2014

Tuesday, February 25, 2014

Tuesday, June 24, 2014

Tuesday, September 23, 2014

Tuesday, December 16, 2014

Location – TBD

AVAILABILITY OF QIP TO PRACTITIONERS AND MEMBERS

The QIP is available on GCHP's website at www.goldcoasthealthplan.org. Printed copies are available upon request.

REFERENCES

- Gold Coast Health Plan Quality Improvement System Policy and Procedure 4A
- Gold Coast Health Plan Utilization Management Program Description
- Gold Coast Health Plan Care Management Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 13-005.
- HEDIS® National Committee for Quality Assurance.
- DHCS Quality Strategy
- National Quality Strategy
- Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010.
- Kohn KT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 1999.
- The Quality Improvement and Assessment (QIA) Guide for Medi-Cal MCPs
- The QIA Guide = available on the DHCS website at:
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>.
- Title 42, Code of Federal Regulations, Section 438.240(b) (1).
- Gold Coast Health Plan Policies and Procedures as they apply

UTILIZATION MANAGEMENT AND CARE MANAGEMENT PROGRAM DESCRIPTION IN A SEPARATE DOCUMENT

The Quality Improvement Plan was approved by the Quality Improvement Committee on 6/24/2014.



Updated on: 06/16/14

2014 Quality Improvement Work Plan

The Quality Improvement Department is responsible for the monitoring and enhancement of quality improvement processes to ensure the delivery of quality customer service and access to high quality medical services for GCHP Members.

Objective #1: HEDIS

GCHP must comply with the DHCS requirements for reporting performance measurement results.

Process / Objectives	Key Tasks	TIMELINE		Lead Staff	Monitoring / Status of Milestones and Evaluation
		Start	End		
<p>1. HEDIS – Healthcare Effectiveness Data and Information Set.</p> <p>External Accountability Set (EAS) is a DHCS requirement. HEDIS complies with the EAS requirement. HEDIS measures which must adhere to the most current HEDIS reporting year specifications and to DHCS specified timelines based on “All Facility Letter”.</p>	<p>2013 Data for 2014 Measures</p> <ol style="list-style-type: none"> Edit and submit HEDIS Roadmap. Submit test run Submit production run Record Retrieval Record Abstraction Admin Refresh HEDIS HSAG Audit HEDIS Submission Summer Run 	<p>02/14</p> <p>11/13</p> <p>11/14</p> <p>11/14</p> <p>02/14</p> <p>03/14</p> <p>02/14</p> <p>03/14</p> <p>05/14</p> <p>06/14</p>	<p>05/14</p> <p>01/14</p> <p>12/14</p> <p>01/14</p> <p>03/14</p> <p>05/14</p> <p>04/14</p> <p>-----</p> <p>06/14</p> <p>07/14</p>		<p>The HEDIS 2014 Reporting for 2013 data was submitted on 06/13/14.</p>

Objective #2: Satisfaction Surveys

GCHP must comply with the DHCS requirements for reporting Satisfaction Survey Results.

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures / Status Milestones
		Start	End		
<p>1. <i>Consumer Satisfaction Survey (State Requirement)</i></p> <p>The EQRO – External Quality Review Organization (HSAG) is responsible for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey biennially in compliance with NCQA and AHRQ requirements. The CAHPS® surveys a sample of Medi-Cal managed care members in English and Spanish and covers services provided to adults and children.</p>	<p>First CAHPS Audit will be 2015 for 2014 data.</p> <p>Educate Providers</p>	01/14	01/14		
<p>2. <i>Provider Satisfaction Surveys</i></p> <p>GCHP will assume responsibility to conduct and for the monitoring, oversight and reporting the required mechanisms to assure Provider satisfaction.</p>	<p>Must ensure that information and documentation provided by GCHP is reviewed at appropriate levels: must demonstrate this review and discussion of information in committee with any applicable interventions.</p>	01/14			
<p>3. <i>Access to Care Survey</i></p>	<p>Discuss survey at QIC and document</p>	01/14			

Objective #3 – QIP’s

Quality Improvement Projects - Plans are required to conduct ongoing quality improvement projects (QIPS).

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures / Status Milestones
		Start	End		
<p>1a Quality and Performance Improvement Program Requirements for 2012 External Statewide QIP</p>	<p>External Statewide QIP – Hospital Readmissions</p> <ul style="list-style-type: none"> • Participate in ongoing statewide organized meetings. • Document “all” steps in the process • Submitted baseline historical data to HSAG • Submitted barrier analysis and interventions to HSAG 1/31/12 and 09/30/13. • Submit analysis of intervention 	01/14	09/14		
<p>1b Internal QIP</p>	<ul style="list-style-type: none"> • Internal QIP – Increase Retinal eye exams for diabetic patients • Submitted internal QIP to DHCS for approval on 07/31/13 and 09/30/13. 	01/14	09/14		<p>HEDIS MPL met for diabetic retinal eye exam 06/13/14.</p>

Objective #4: UM Monitoring

Plans are required to report utilization data for selected HEDIS® Use of Services measures through the contracted EQRO. DHCS medical and nurse consultants facilitate discussions of utilization data monitoring results at the quarterly Medical Directors meetings.

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures / Status Milestones
		Start	End		
UM Monitoring Over Utilization Under Utilization Appropriate Utilization	Utilization measures reported quarterly with monthly data points to UM Committee, QIC and Commission report card indicators reported bi-annually to UM Committee, QIC and Clinic Directors	01/14	12/14		

Objective #5: Committees

GCHP shall maintain a system of accountability which includes the participation of the governing body of the health plan's organization, the designation of a quality improvement committee with oversight and performance responsibility.

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures / Status Milestones
		Start	End		
1. Quality Improvement Committee Develop, implement quality Program Plan outlining structure, scope, criteria, and processes of all QI functions	<ul style="list-style-type: none"> • QI Plan Approval • QI Plan Approval • QI Annual P&P Review • QI Plan Review • QI Work Plan Review • QI Plan Assessment 	01/14 10/14 12/14	06/14		The Quality Improvement Plan and the Quality Improvement Work Plan were approved at the Quality Improvement Committee on 6/24/14.

2. Member Services Committee	<ul style="list-style-type: none"> • Committee Meetings • Action Plans • Call Center Measures • Annual Review 	01/14	12/14		
3. Network Management Committee	<ul style="list-style-type: none"> • Committee Meetings • Action Plans • Annual Review 	01/14	12/14		
4. Grievances & Appeals Committee	<ul style="list-style-type: none"> • Committee Meetings • Action Plans • G&A Measures • Annual Review 	01/14	12/14		
5. Health Education/Cultural Linguistics Committee	<ul style="list-style-type: none"> • Committee Meetings • Action Plans • ED Navigator Program Review • Annual Review 	01/14	12/14		
6. Medical Advisory Committee (MAC)	<ul style="list-style-type: none"> • Committee Meetings • Action Plans • Annual Review 	01/14	12/14		
7. Pharmacy & Therapeutic Committee (P&T)	<ul style="list-style-type: none"> • Review of New Drugs • Annual Formulary Review • PBM Oversight • Review of Policies Affecting Access to Prescription Drugs 	01/14	12/14		
8. Credentials/Peer Review Committee	<ul style="list-style-type: none"> • Committee Meetings • Actions Plans • Annual Review 	01/14	12/14		
9. UM Committee	<ul style="list-style-type: none"> • Committee Meetings • Actions Plans • Annual Review 	01/14	12/14		

Objective #6: Facility Site Reviews

GCHP must conduct site reviews on all primary care Provider sites.

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures / Status Milestones
		Start	End		
<p>Facility Site Reviews (FSR)</p> <p><i>Site Review Reports</i></p> <ul style="list-style-type: none"> Plan nurse reviewers conduct the initial and tri-annual full scope reviews. Plan reviewers use the DHCS Full Scope Site Review Survey and Medical Record Review Survey forms to ensure that all contracting plans and subcontracting entities use DHCS survey standards, review criteria and scoring methodology. 	<ul style="list-style-type: none"> Submit 2014 bi-annual report to DHCS Submit 2014 bi-annual report to DHCS Develop procedures for entering data into FSR database and submission of data to DHCS Certify FSR Nurse as Master Trainer 	01/14	12/14		
<p>PARS – Physical Accessibility Site Reviews</p>	<ul style="list-style-type: none"> P&P written for PARS Specialist Provider Volume Annual Review due 01/31/14 	01/14	12/14		

Objective #7: Quality Measurement and Improvement

GCHP is required to have an ongoing program for quality assessment and performance improvement of the services provided to enrollees. Quality measurement and improvement standards include clinical practice guidelines, quality assessment and performance improvement program and health information systems.

Process Objectives	Key Tasks	TIMELINE		Lead Staff	Evaluation Measures / Status Milestones
		Start	End		
Clinical Practice Guidelines	Approve at MAC. Disseminate Guidelines to Providers	01/14	12/14		Newly adopted Clinical Practice Guidelines are announced in the Provider Newsletter and/or on the Provider Update page of the website.
Disease Management Program Selection of Chronic Disease states pertinent to its membership.	Identify chronic disease for GCHP population disease management.	01/14	12/14		The two major disease categories identified for 2014 and approved at the February QIC meeting are Diabetes and Asthma
Member / Provider Communication Plan	Develop materials and mechanism to communicate to Providers and Members Use Website	01/14	12/14		Members and Providers receive a newsletter 3 times per year. The newsletters are posted on the website.

The Quality Improvement Work Plan was approved at the Quality Improvement Committee Meeting on 06/24/14.

AGENDA ITEM 3g

To: Gold Coast Health Plan Commissioners
 From: Michelle Raleigh, Chief Financial Officer
 Date: August 25, 2014
 Re: Workers Compensation Contract

SUMMARY:

Gold Coast Health Plan's (GCHP) contract with The Hartford for workers compensation coverage expires on August 31, 2014. The Plan's insurance broker, Beecher Carlson Insurance Services, LLC (Beecher Carlson), has prepared a proposal of options for coverage year (CY) 2014-15. GCHP staff is requesting the Commission to authorize the Plan to continue workers compensation insurance coverage through The Hartford.

BACKGROUND / DISCUSSION:

GCHP began utilizing The Hartford to provide workers compensation coverage on September 1, 2012 when it terminated its agreement with Regional Government Services for human resources and payroll services.

The Hartford's annual contract expires on August 31, 2014. Therefore, Plan staff requested that Beecher Carlson, obtain bids from workers compensation carriers. Bids were obtained from two carriers with premium information summarized below.

	Projected Payroll Expense \$9,875,476		Estimated Payroll Expense \$14,385,814*	
Average Head Count	109		165	
Coverage Period	09/01/13 - 08/31/14		09/01/14 - 08/31/15	
	The Hartford	The Hartford	State Fund	
Cost				
Estimated Annual Premium	\$ 84,870	\$ 115,355	\$	129,993
Base Rate (per \$100 in payroll)	\$ 0.86	\$ 0.80	\$	0.90
Coverage				
Bodily Injury by Accident-Each Accident	\$ 1,000,000	\$ 1,000,000	\$	1,000,000
Bodily Injury by Accident-Policy Limit	\$ 1,000,000	\$ 1,000,000	\$	1,000,000
Bodily Injury by Disease-Each Employee	\$ 1,000,000	\$ 1,000,000	\$	1,000,000

* Estimated payroll expenses for FY 2014-15.

The Plan recommends continuing coverage with The Hartford because:

- They offer a lower premium rate (\$0.80 vs. \$0.90 per \$100) payroll for the equivalent coverage level and
- It is administratively simpler to continue coverage with an existing carrier.

FISCAL IMPACT:

Premiums will increase by approximately \$30,485 (\$115,355 versus \$84,870) for CY 2014-15 when compared to CY 2013-14, driven by higher payroll expenses due to higher staffing levels at the Plan, partially offset by a lower premium rate than last year (\$0.80 per \$100 of payroll versus \$0.86 per \$100 of payroll expense).

RECOMMENDATION:

Staff requests the Commission to authorize the Plan to continue the workers compensation insurance with The Hartford Company for CY 2014-15.

CONCURRENCE:

N/A

Attachments:

N/A



AGENDA ITEM 3h

To: Gold Coast Health Plan Commissioners
From: Ruth Watson, Chief Operations Officer
Date: August 25, 2014
Re: Consumer Advisory Committee (CAC) Membership

SUMMARY:

The Consumer Advisory Committee (CAC) currently has five (5) seats up for appointment: one (1) seat is vacant due to a resignation and needs to be filled to the unexpired term of August, 2015; the other four (4) seats are full term and expire August, 2016.

The Plan has recruited members for the vacancies on the CAC through means of advertising on the GCHP website, outreach to various organizations and recommendations from current board members.

BACKGROUND / DISCUSSION:

Ventura County Board of Supervisor's enabling ordinance (Ordinance No. 4409, April 2010) and the California Department of Health Care Services, Medi-Cal Managed Care Division, required the establishment of a member / consumer based committee. This Committee meets at least quarterly and makes recommendations, reviews policies and programs, explores issues and discusses how the Plan may fulfill its mission. The Commission established the Committee size as ten (10) members with two permanent seats - one for the Ventura County Health Care Agency (VCHCA) and one for the Ventura County Human Services Agency. When the first two-year term ended in June 2013, a new Committee of ten (10) was recruited and then seated. Terms were then staggered to avoid having to replace the entire Committee every two years. The Commission expanded the CAC last year by adding an eleventh seat to be held by a beneficiary member or the parent / guardian of a beneficiary member.

Each of the appointed members, with the exception of the two permanent seats, would serve a two-year term, and individuals could apply for re-appointment as there are no term limits.

The eleven (11) voting members represent a constituency served by the Plan. Committee members may include representation from the following:

- County Health Care Agency
- County Human Services Agency
- Children Welfare Services Agency

Members with:

- Chronic Medical Conditions
- Disabilities
- Special needs

Other Medi-Cal beneficiaries:

- Foster Children
- Chronic Medical Conditions
- Persons with Disabilities and Special Needs
- Seniors

Five current members of the CAC have requested to remain on the Committee. Following is a brief biography on those members along with the seat they hold:

Foster Children

Frisa Herrera has been employed at Casa Pacifica since March 1999, as both the Clinic Administrator and Medi-Cal biller. Casa Pacifica serves abused, neglected, and severely emotionally disturbed children and adolescents from the tri-county regions of Southern California. Frisa has a unique understanding and familiarity with the needs of foster children. She is deeply committed to serve the needs of foster children and it is her stated goal to, “be the voice for the foster community in Ventura County.”

Medi-Cal Beneficiaries

Norma Gomez has worked as an interpreter, educator, and case manager with the Mixteco Indigena Community Organization Project (MICOP) in Oxnard since 2000. As an educator to the Mixteco Community, she leads workshops and group activities to provide information on nutrition, health, and parenting. She also provides case management and conducts follow-up home visits with the Mixteco Community. She assists Mixteco residents with completing applications for disability, unemployment, school, Medi-Cal, Food Stamps, passport applications, etc. Norma facilitates “Aprendiendo con Mama y Papa” (Learning with Mother and Father) educational workshops for Mixteco and Latino migrant farm worker children.

Medi-Cal Beneficiaries

Rita Duarte-Weaver has been working for the Ventura County Public Health Department for the last 14 years. As part of her employment, she has conducted regular outreach on Medi-Cal and Health Care for Kids programs for the last eleven years. Rita has extensive knowledge of Medi-Cal and how to assist our population.

Beneficiaries with Chronic Medical Conditions

Pedro Mendoza is employed by the Tri-Counties Regional Center as the Benefits Coordinator. He is currently working in building relationships with community resources to work together to best serve the families at Tri-Counties. Pedro assists families with SSI, IHSS, Medi-Cal and issues they may have with services. Pedro works with the Area Board 9, Consumers Rights Advocates and Family Resource Centers to put on seminar for the families he serves.

Beneficiary Member or Parent / Guardian of Beneficiary Member

Michelle Gerardi served an internship at the HSA Ventura, Veterans Services as a Client Intake office assistant. She has worked for HELP of Ojai in the Community Assistance Program as a Case Management Aid.

GCHP received one application to fill the unexpired term of the seat currently held by an individual designated as Persons with Disabilities.

Persons with Disabilities

Paula Johnson is currently employed with The ARC of Ventura County as the Director of Clinical Services. She has many years working with individuals and families of adults with developmental disabilities. Her educational background includes a Master's Degree in Education and a Bachelor's Degree in Behavioral Psychology.

RECOMMENDATION:

Staff requests that the Commission appoint the Consumer Advisory Committee as described above.

CONCURRENCE:

N/A

Attachments:

N/A

AGENDA ITEM 4b

To: Gold Coast Health Plan Commission
From: Michael Engelhard, Chief Executive Officer
Date: August 25, 2014
Re: CEO Update

FINANCE UPDATE

Department of Health Care Services (DHCS) Rates Meeting

DHCS held a quarterly All Plan Rate meeting on August 14, 2014. Many rates issues were discussed such as:

1. FY 2014-15 Rate Development Process,
2. ACA Operational Expansion Rate Adjustments scheduled for July 1, 2014; October 1, 2014; and January 1, 2015,
3. Hepatitis C Supplemental payment methodology, and
4. Schedule of rates in queue for CMS approvals

The plans anticipate additional guidance on the first three items from the State.

COMPLIANCE UPDATE

The Compliance Department has included in this month's Commission packet three documents: The 2014 Monthly Compliance Dashboard, 2014 Delegation Oversight Audit Work Plan and the 2014 Compliance Work Plan. The goal is to provide the Commission visibility into compliance activities on a monthly basis to augment the quarterly Compliance Committee Report.

The Plan's Compliance Officer and Compliance Specialist attended the Department of Justice quarterly Program Integrity meeting in Los Angeles on August 19, 2014. Compliance staff continues to be an active participant in these meetings as it provides a venue to learn about emerging fraud trends.

Delegation oversight staff is actively auditing contracted subcontractors and is on target with the audit schedule. Routine review / monitoring of contractual required reports from our delegates is an ongoing process. Preparation for upcoming scheduled audits as well as monitoring existing corrective actions plans issued by the Plan is also in process.

GOVERNMENT RELATIONS UPDATE

Medi-Cal Waiver Renewal Process Begins

State health officials started the process to renew California's federal 1115 Medicaid waiver. The Bridge to Reform waiver included many of the state's delivery and payment reforms associated with the ACA, including the expansion of Medi-Cal eligibility to include Californians up to 138% of the federal poverty level.

The current waiver is due to expire in October 2015. The new 1115 waiver will focus on transforming the delivery system and payment reform.

New concepts have been proposed by DHCS. For example, DHCS is seeking systems reform to improve care and ensure sustainability of the program. Incentive programs will focus on care coordination across the system including providers and Medi-Cal managed care plans.

DHCS is also proposing to reform the payment system for Federally Qualified Health Centers (FQHCs).

California Children's Services Program

The California Children's Services (CCS) program will be included in the new 1115 Medicaid waiver. DHCS will conduct a stakeholder process to determine how to improve access to health care for children and youth with special health care needs. The first CCS stakeholder meeting is anticipated to occur September 2014.

DHCS is interested in making changes in the CCS program aimed at improving care delivery, quality, and reducing costs.

Applied Behavior Analysis (ABA) Therapy is now a Medi-Cal Covered Benefit

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) issued an informational bulletin to clarify Medicaid coverage of services to children with autism. While the CMS bulletin did not specifically state that Applied Behavioral Analysis (ABA) or behavioral health therapy (BHT) must be provided, the bulletin stated that such services may be provided to children and beneficiaries under the age of twenty-one through the Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT).

On August 5, 2014, the state Department of Health Care Services (DHCS) announced that ABA therapy will be a covered Medi-Cal benefit for beneficiaries under the age of twenty-one on a retroactive basis to July 7, 2014. The DHCS announcement concerning ABA therapy has raised a number of questions and issues for Medi-Cal plans and their members.

DHCS and the Medi-Cal managed care plans are continuing to work together to determine the best process to implement this benefit.



Managed Care Organization (MCO) Tax

On Tuesday, July 25, 2014 CMS issued a letter to all state Medicaid directors regarding health care-related taxes. Currently, states are allowed to charge MCO taxes. CMS is concerned that such taxes are not consistent with applicable statutory and regulatory requirements.

DHCS is reviewing CMS guidance and affirms CMS cannot make policy changes via a policy letter. Any changes to the MCO tax in California will need to be done by the end of the next Legislative session, which is in two years.

Legislation

Friday, August 15, 2014 was the last day for fiscal committees to meet and report bills to their respective Legislative Floors. Both the Senate and Assembly Appropriations Committees approved a number of Medi-Cal related bills. Below is the list of bills that will be voted on by the Legislature.

AB 1310

Medi-Cal: telehealth.

Summary: Prohibits DHCS from requiring a health care provider licensed to practice in California to be located in California in order to provide telehealth services to Medi-Cal beneficiaries.

AB 1552

Community-Based Adult Services: Adult Day Health Care Centers.

Summary: Requires Community-Based Adult Services to be provided as a Medi-Cal benefit.

AB 2325

Medi-Cal: CommuniCal.

Summary: Requires DHCS to establish a program to provide and reimburse for medical interpretation services provided to Medi-Cal enrollees with limited English proficiency.

SB 18

Medi-Cal Renewal.

Summary: Requires DHCS to accept private foundation money as a nonfederal share of costs for outreaching activities for Medi-Cal renewals. SB 18 requires DHCS to seek federal matching funds.

SB 508

Medi-Cal: Eligibility.

Summary: SB 508 codifies numerous Medi-Cal eligibility requirements related to the implementation of the ACA. Specifies in statute the Medi-Cal income eligibility thresholds currently in use for various eligibility groups including children, whose income is determined based on Modified Adjusted Gross Income (MAGI). Clarifies the state's eligibility rules for Former Foster Youth (FFY) to allow specified FFY Medi-Cal eligibility up to age 26.

SB 964

Health Care Coverage.

Summary: SB 964 increases ongoing oversight of health plans, with a focus on ensuring compliance of plans with existing health care access standards in the Medi-Cal managed care and individual markets. Requires Medi-Cal managed care plans to be subject to routine medical surveys by the Department of Managed Health Care (DMHC).

SB 1002

Medi-Cal: Redetermination.

Summary: Requires counties to begin a new 12-month eligibility period for Medi-Cal when approving or certifying an individual's eligibility for CalFresh benefits in order to align Medi-Cal and CalFresh eligibility periods.

SB 1004

Health Care: Palliative Care.

Summary: Makes palliative care a Medi-Cal benefit that is cost neutral to the General Fund.

SB 1124

Medi-Cal: Estate Recovery.

SB 1124 limits recovery from the estate of a deceased Medi-Cal beneficiary to those costs for health care services the estate is required to cover under federal law.

SB 1176

Health Care Coverage: Cost Sharing: Monitoring.

Summary: Requires a health care service plan or health insurer that provides coverage for essential health benefits to monitor the accrual of out-of-pocket (OOP) costs toward the annual OOP limit. Requires plans to reimburse enrollees who exceed the maximum OOP limits.

SB 1341

Medi-Cal: Statewide Automated Welfare System (SAWS).

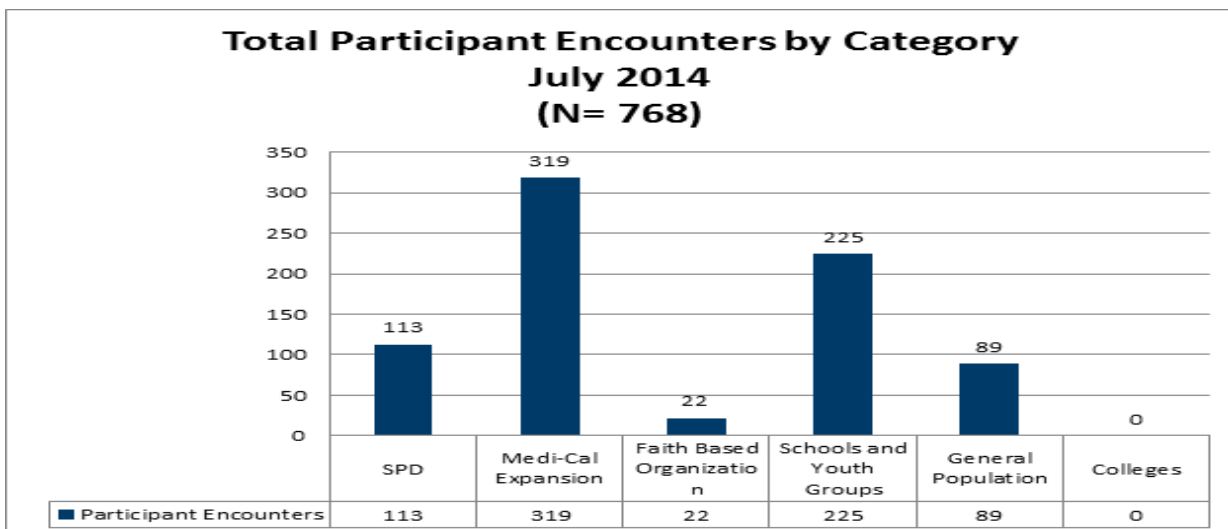
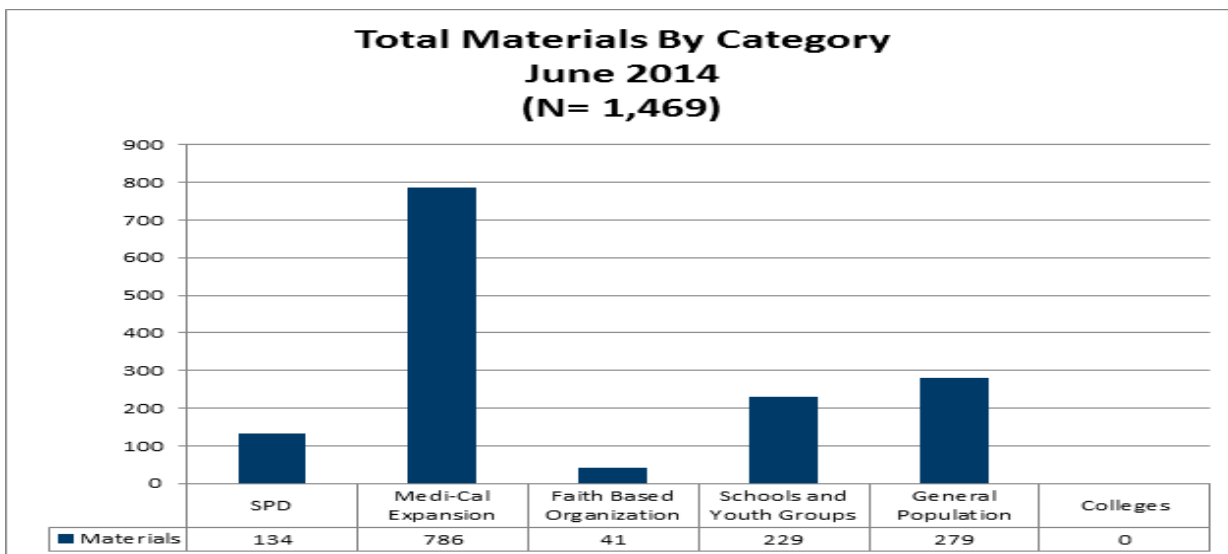
Summary: Requires SAWS to be the system of record for Medi-Cal and to contain all Medi-Cal eligibility rules and case management functionality. Effective January 1, 2016, SAWS shall be used to generate all consumer notifications related to Medi-Cal, and CalHEERS may be used to generate notices to consumers related to the premium tax credit program.

HEALTH EDUCATION AND COMMUNITY OUTREACH SUMMARY REPORT

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

Overall Outreach Activities

GCHP continues to contact individuals, families, and potential members through a variety of community outreach events. During the month of July, GCHP staff participated in 12 community events, reached over 700 individuals and distributed approximately 1,500 pieces of literature. Below are two charts documenting total number of materials distributed and encounters during the month of July. Staff continues to hand out materials related to the Affordable Care Act (ACA) and continued to reach potential individuals eligible for Medi-Cal through the ACA Medi-Cal expansion category.



Activities

GCHP staff participated in 12 community outreach events/health fairs throughout the county. During the month of July staff participated in a faith based event and reached 22 families. The majority of all outreach encounters are within outreach activities that reach potential individuals eligible for Medi-Cal through the Medi-Cal expansion program.

The total number of individuals encountered from January 2014 – July 2014 is roughly 5,600. Outreach activities during the month of July accounts for 12% of the total number encounters reported to date. On average, the GCHP outreach team participates in 16 community events monthly; July was slightly lower than the previous months due to the limited number of events held during the month of July and limited staffing. Below is a list of events and/or activities held during the month of July:

Date	Event/Activities
07/08	VCMC Baby Steps Program
07/09	The Bridge Food Pantry
07/11	La Hermandad Food Distribution
07/15	Santa Paula Hospital Baby Steps Program
07/16	Food Distribution Program & Health Services
07/17	Downtown Oxnard Farmers Market
07/18	Family Health and Safety Expo
07/19	Fruit and Veggie Fest
07/19	Churches Helping Communities Build Bridges
07/20	Jornada Dominical and Health Fair
07/23	The Bridge Food Pantry
07/26	“Day at the Park” Summer Family Picnic

Upcoming Outreach Activities

Below is a list of upcoming community outreach events and network partnership meetings:

Date	Event/Activities
08/08	La Hermandad Food Distribution
08/09	Back 2 Schools Bash
08/09	Night in Oaxaca
08/12	VCMC Baby Steps
08/14	Downtown Oxnard Farmers Market
08/16	National Health Center Week
08/16	Das Williams Family Health Fair
08/16	Fun in the Sun
08/17	Jornada Dominical
08/17	St. John’s Health Fair
08/19	SPH Baby Steps

08/20	Westpark Food Distribution
08/22	Simi Valley Farmers Market
08/28	First5 - Produce Giveaway in Moorpark
08/28	First5 - Produce Giveaway in Simi Valley

COMPLIANCE REPORT 2014

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Hotline A confidential telephone and web-based process to collect info on compliance, ethics, and FWA	5	9	6	2	6	2	6	1				
Hotline Referral *FWA Department of Health Care Services Program Integrity Unit / A&I	0	0	0	0	0	0	2	0				
Hotline Referral *FWA Department of Justice	0	0	0	0	0	0	1	0				
Hotline Referral Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	1	5	5	2	6	2	3	1				
Hotline Referral External Agency (i.e. HSA)	2	2	0	0	0	0	0	0				
Hotline Referral Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	2	2	1	0	0	0	1	0				
Delegation Oversight 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	8	8	8	8	8	8				
	8	9	21	24	21	16	26	12* as of 08/11/14				
	3	0	0	0	1	0	0	1				
	0	0	0	0	0	0	1	*1 in Process				
Delegation Oversight Letters of Non-Compliance	0	0	0	0	0	0	1					
Delegation Oversight Corrective Action Plan(s) Issued to Delegates	3	0	0	0	0	0	1	0				
Audits External regulatory entities evaluate GCHP compliance with contractual obligations.	1	0	1	0	0	0	0	0				
	1	0	0	0	0	0	0	0				
	0	0	0	0	0	0	0	0				
	0	0	1	0	0	0	0	0				
	0	0	0	0	0	0	0	0				
	0	0	0	0	0	0	0	0				
	0	0	0	0	0	0	0	0				
	0	0	0	0	0	0	0	0				
Fraud, Waste & Abuse 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.	5	9	6	2	6	2	6	0				
	0	0	1	0	0	1	1	0				
	5	9	5	2	6	1	5	0				
	0	0	0	0	0	0	0	0				
	0	1	1	0	1	0	1	0				
HIPAA Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	0	3	0	1	1	2	1	0				
	0	3	0	1	1	2	1	0				
	0	0	0	0	0	0	0	0				
	0	1	0	0	0	0	0	0				
	0	0	0	0	1	0	0	1				
Training Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	49	11	71	44	21	27	96	18				
	22	4	63	26	6	4	8	8				
	2	2	2	2	4	4	4	0				
	1	1	5	7	5	7	8	3				
	24	4	1	9	5	5	73	7				
	0	0	0	0	1	3	3	0				

** August - Numbers may change as the month has not ended

** 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.



Audit Work Plan 2014-2015

Process / Objectives	Key Tasks	TIMELINE		Status Update	Lead Staff
		Start	End		
Policies and Procedures (P&P)	Delegation Oversight – Subcontractors P&P				
	Sanctions P&P	Sep-13	Mar-14	Approved	D. Becerra
D.O. Medical CAP	Contract Performances	Dec-13	Jun-14	Closed	D. Becerra
	Engagement Letter (30 days response back)				
	Medical Group 1				
Credentialing Audits	Medical Group 2				
	Medical Group 3	Dec-13	Mar-14	Closed	D. Becerra
	Engagement Letter (30 days response back)				
Specialty Contract Audit	UM				K. Osajda
	Claims				D. Becerra / A. Vargas
	Engagement Letter (30 days response back)	Apr-14	Ongoing	In Progress	K. Osajda
Vision	QI				K. Osajda
	RR				K. Osajda
	Claims	Sep-14	TBD	Pending	K. Osajda
	Engagement Letter (30 days response back)				A. Vargas
NEMT	Drivers information				
	Title 22 Compliance	Dec-14	TBD	Pending	A. Vargas / A. Galvan
	Transportation book Log				
MBHO	Engagement Letter (30 days response back)				
	Claims				K. Osajda
	UM				A. Vargas
	RR				K. Osajda
Plan Partner	QI	Aug-14	TBD	Pending	K. Osajda
	Engagement Letter (30 days response back)				K. Osajda
	Claims				A. Vargas
	UM				K. Osajda
Plan Partner	RR				K. Osajda
	QI	Oct-14	TBD	Pending	K. Osajda
	Engagement Letter (30 days response back)				

* NCQA Fully Accredited/Certified in Credentialing therefore no Credentialing Audit is required per GCHP-DHCS Contract



Compliance Work Plan 2014-2015

Process / Objectives	Key Tasks	TIMELINE		Status Update	Lead Staff
		Start	End		
Compliance Training	HIPPA	2013	Ongoing	Current	B.Armenta C.Martinez
	FWA				
	Compliance Program Code of Conduct				
Board Compliance Training	Contract Compliance	Sep-14	Oct-14	Pending	B.Armenta
Regulatory Compliance	Audit Submissions	N/A	Ongoing	Current	B.Armenta
	Regulatory Contract Submissions				
	Regulatory Agency Submissions				
Contract Compliance	Contract Assessments	Apr-14	Ongoing	In Progress	B.Armenta/ D.Becerra
	P&P Review				
	ACA Requirement Review				
HIPPA Privacy	Internal Review	Oct-14	Nov-14	Pending	B.Armenta C.Martinez
	Revise Privacy P&P				
	BAA Review *				
Fraud, Waste and Abuse	Annual Review of Notice of Privacy Practices	Oct-14	TBD	Pending	
	Annual Review of Release of Information Form				
	Process Improvement				
Corrective Action Plan	Fraud Detection	2013	*Medical CAP Closed 05/08/2014	In Progress	B.Armenta
	Revise templates				
	Revise JAMS				
External Audit	Medical CAP	Ad Hoc	Ad Hoc	Ad Hoc	B.Armenta
	Financial CAP				
	Pre-Audit Request Submissions				
	Onsite Preparation				
	Ongoing Follow up				
	Internal Coordination				

*BAA Review is ongoing and all historic BAA are required to be updated prior to September

AGENDA ITEM 4c

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: August 25, 2014

Re: COO Update

OPERATIONS UPDATE

Membership

Gold Coast Health Plan experienced moderate growth on the August Enrollment file, adding 1,316 members to the Plan. Although the membership increase was much smaller than the preceding months, it did bring GCHP to another significant milestone, exceeding an enrollment mark of 160,000 members. GCHP's membership as of August 1, 2014 is 160,427, which represents an increase of 39,915 members since January 1, 2014 (approximately 33% growth). The cumulative new membership since January 1st is summarized as follows:

L1 (Low Income Health Plan) – 7,839
M1 (Adult Expansion) – 15,606
7U (CalFresh Adults) – 3,453
7W (CalFresh Children) – 667
Traditional Medi-Cal – 11,030

GCHP continues to see growth in the Adult Expansion category (M1), adding an additional 2,979 members in August. We are starting to see the impact to eligibility redeterminations, which were put on hold from January to June, as members are moving from transitional aid codes to traditional aid codes. One example of this would be the LIHP transition members, where eligibility was reported as 7,975 in June and is now 7,726 in August.

July 2014 Operations Summary

Claims Inventory – ended the month with an inventory of 35,089 which equates to Days Receipts on Hand (DROH) of 7 days. Claim receipts from January through July are as follows:

- January – 91,130
- February – 90,048
- March – 109,857

- April – 110,855
- May – 108,312
- June – 116,474
- July – 117,136 (this is approximately a 28.5% increase since January 2014)

Claims Turn Around Time (TAT) – the regulatory requirement of processing 90% of clean claims within 30 calendar days was not met in July; however, there was significant improvement in this metric from the previous two months. Claim receipts have continued to increase which is reflective of our new membership. The results for July were 89.8%, which was only .2% short of the goal.

Claims Processing Accuracy – financial accuracy was back on goal in July with results coming in at 99.63%. Procedural accuracy also exceeded the goal in July.

Call Volume – call volume hit the 10,000 call mark in July! The 6-month call volume average for July 2013 – December 2013 was 7,286 calls per month. The 7-month average for January 2014 – July 2014 was 9,457 and represents a 30% increase in calls.

Average Speed to Answer – we continue to significantly exceed the goal of answering calls within 30 seconds or less. The combined results for July were 11.4 seconds.

Abandonment Rate – the abandonment rate continues to remain exceedingly low. The goal is 5% or less of the calls received being abandoned; we have remained below 1% for 10 months in a row.

Average Call Length – the combined result of 6.25 minutes in July met the goal of 7 minutes or less although the provider calls were slightly over 7 minutes (7.11).

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

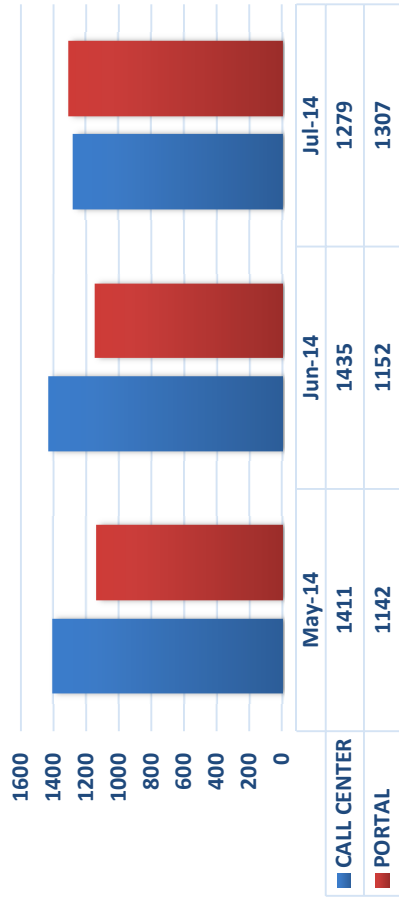
- 35C to 837 Encounter Data Transition – Regulatory requirement effective October 1, 2014)
- Encounter Data Improvement Project – Improve the quality of the data sent to Department of Health Care Services (DHCS) in order to meet new quality measures established by the State beginning January 2015
- Grievance and Appeals Improvement Project – Go live set for October 1, 2014
- ICD-10 Readiness – Regulatory requirement to implement new code set effective October 1, 2015
- Member Orientation Meetings – Meeting flyers included in new member packets have generated increased attendance at meetings

- 2014 Member Handbook – Approved by default as of August 4, 2014; target use beginning with September new member packets
- Crossover Claims – Project initiation the fourth quarter of 2014
- Plan Selection – PCP selection during sign-up via Covered California; information matched once Medi-Cal beneficiary becomes a GCHP member (postponed by State; implementation to occur no sooner than December 1, 2014).

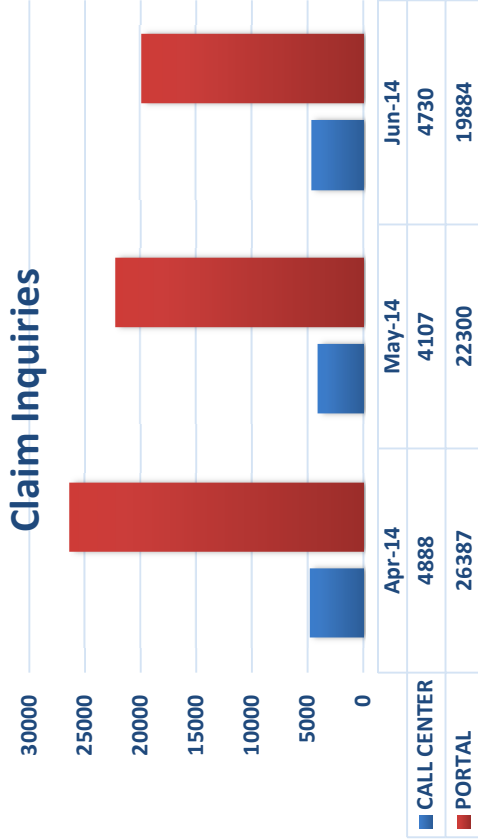
JULY OPERATIONS REPORTS ATTACHED:

PCP Member Assignment Report

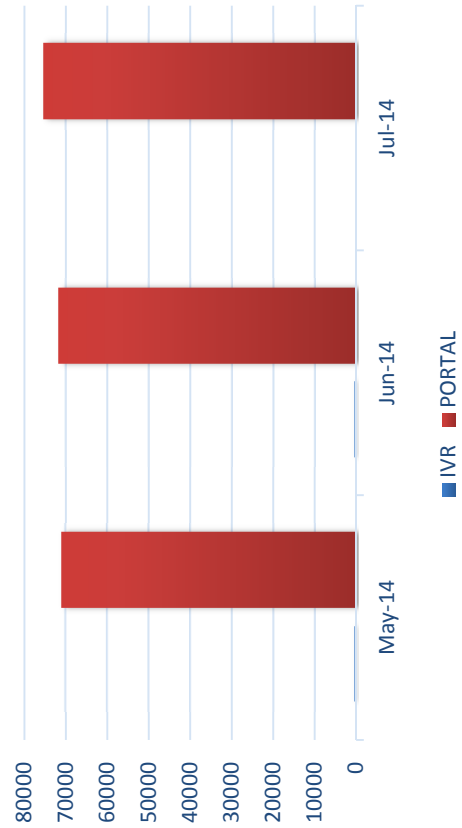
Authorization Request/Inquiries



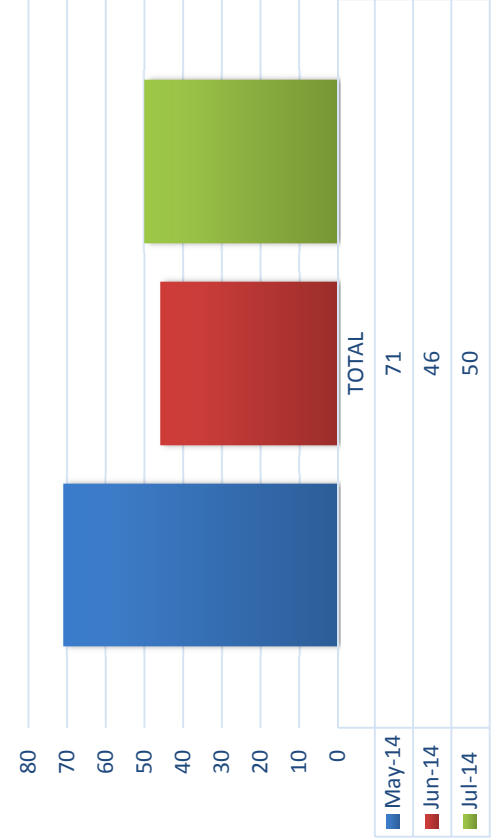
Claim Inquiries



Provider Eligibility Inquiries

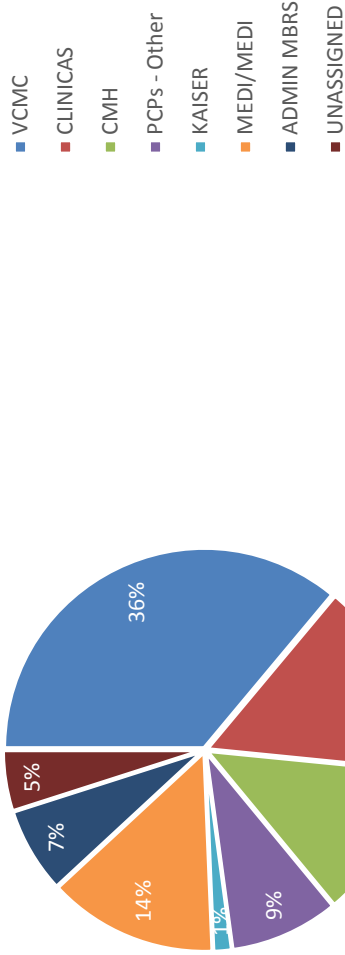


Provider Portal New Registration

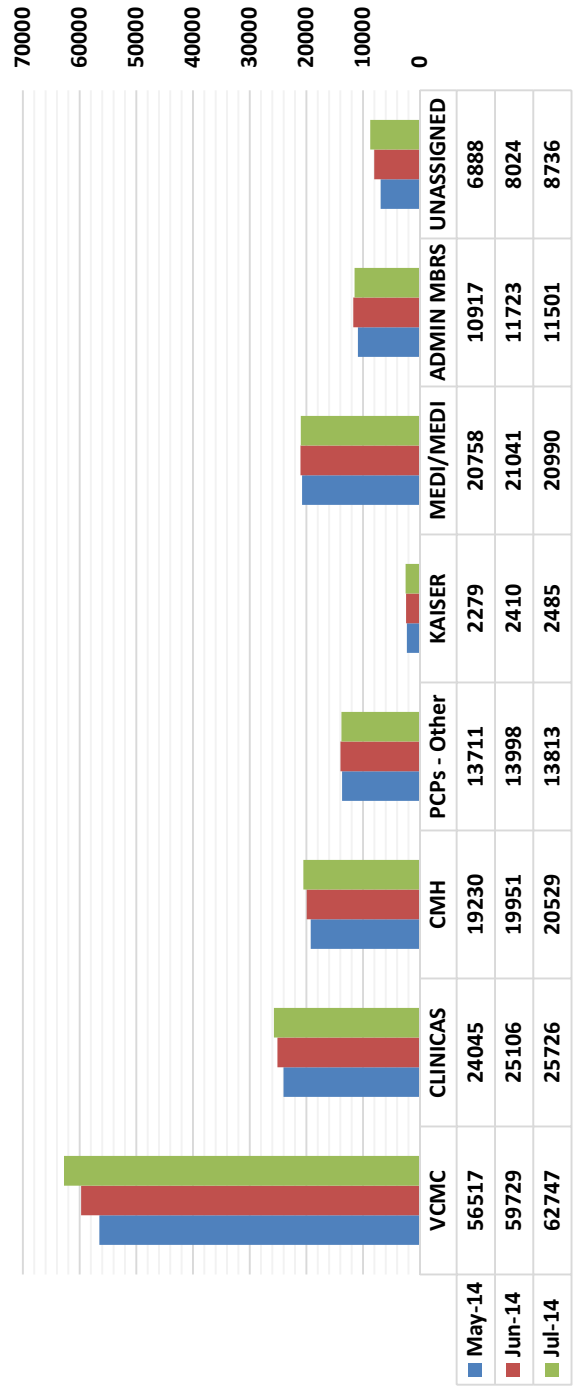


Provider Portal/Call Center Usage

Membership by PCP Quarterly Average



Membership by PCP





AGENDA ITEM 4d

To: Gold Coast Health Plan Commission

From: Dr. Nancy Wharfield, Associate Chief Medical Officer

Date: August 25, 2014

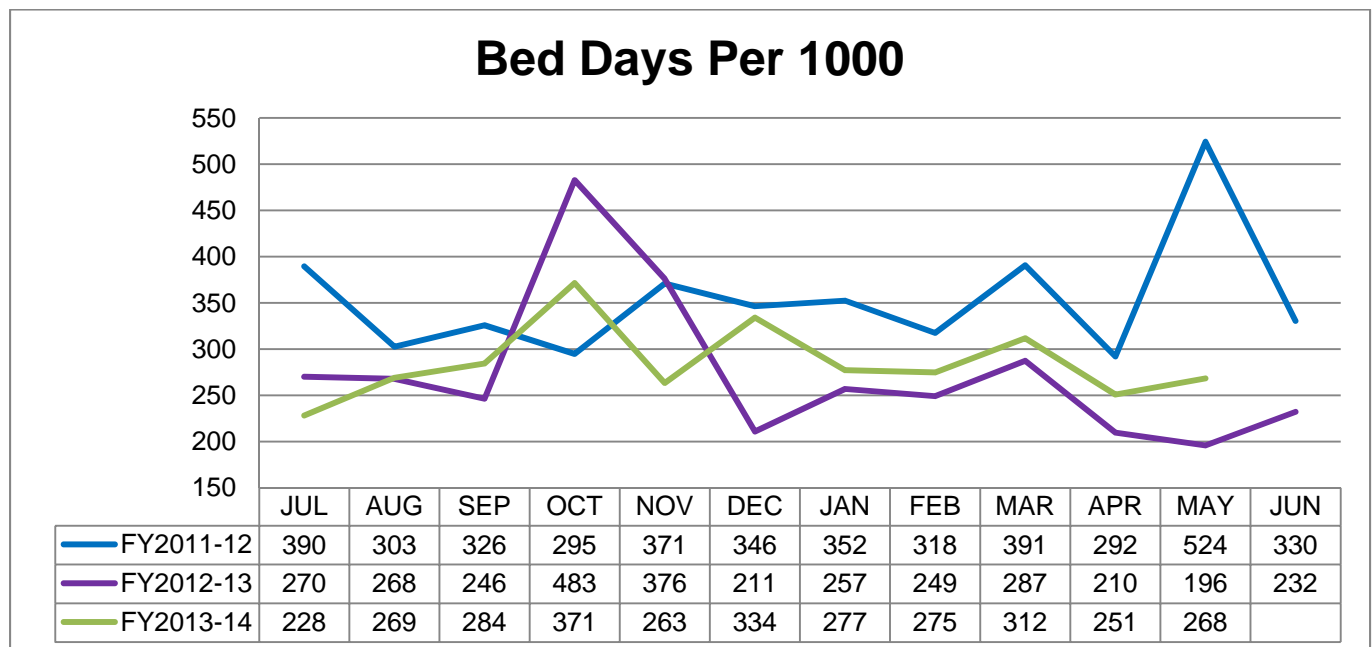
Re: Health Services Update

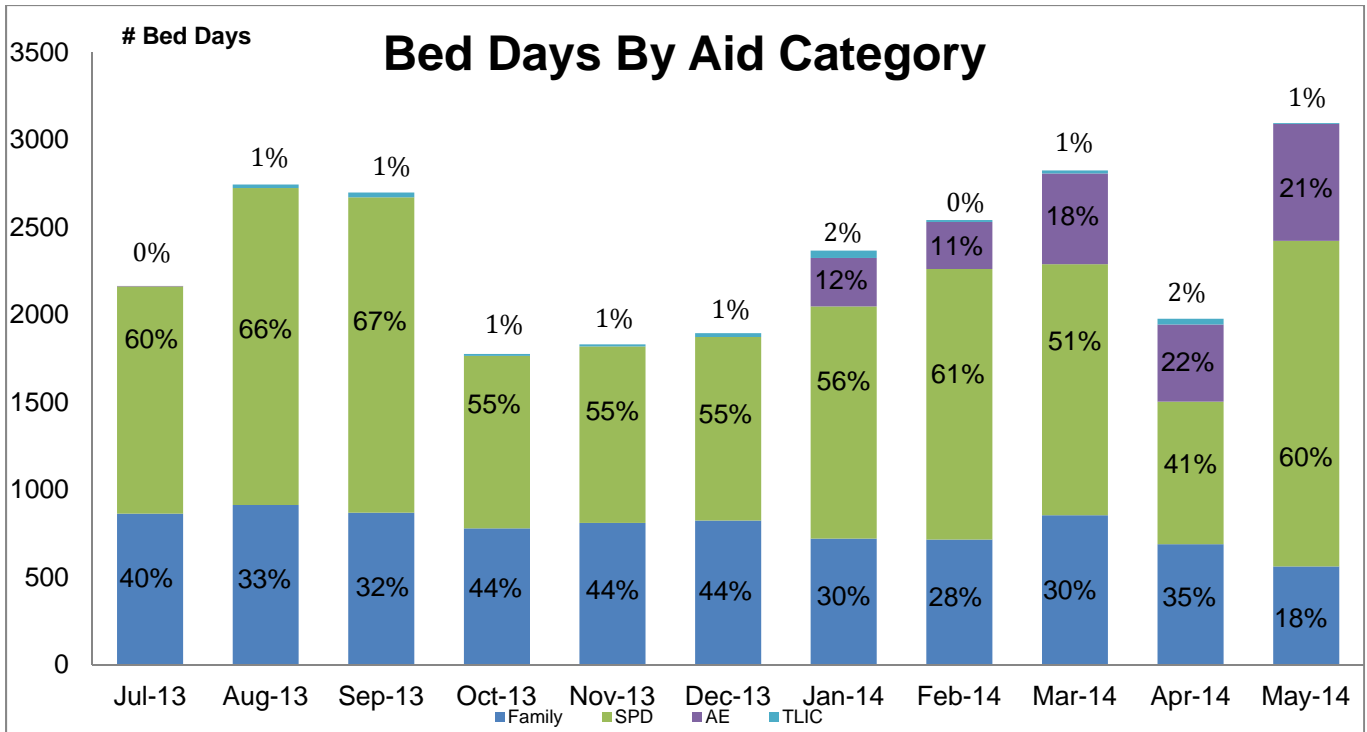
Utilization data in the Health Services monthly update to the Commission is based on paid claims compiled by date of service and is lagged by 3 months to allow for partial run out of claims data. Claims data are complete at approximately 6 months. While incomplete, a 3 month lagged snapshot allows us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

Inpatient Utilization

Peaks in March are demonstrated each year of operation. Bed days by aid code category show that SPD members have the highest percent of inpatient utilization.

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

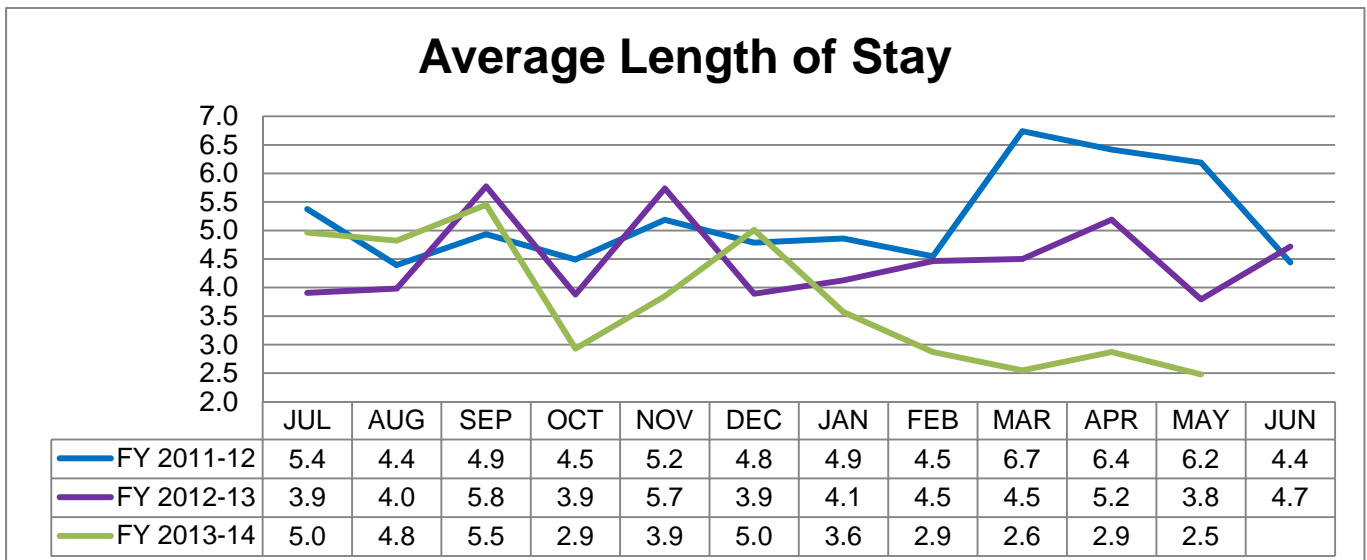




Average Length of Stay

Average length of stay remains low compared to prior years since January 2014 and below 3 since February 2014.

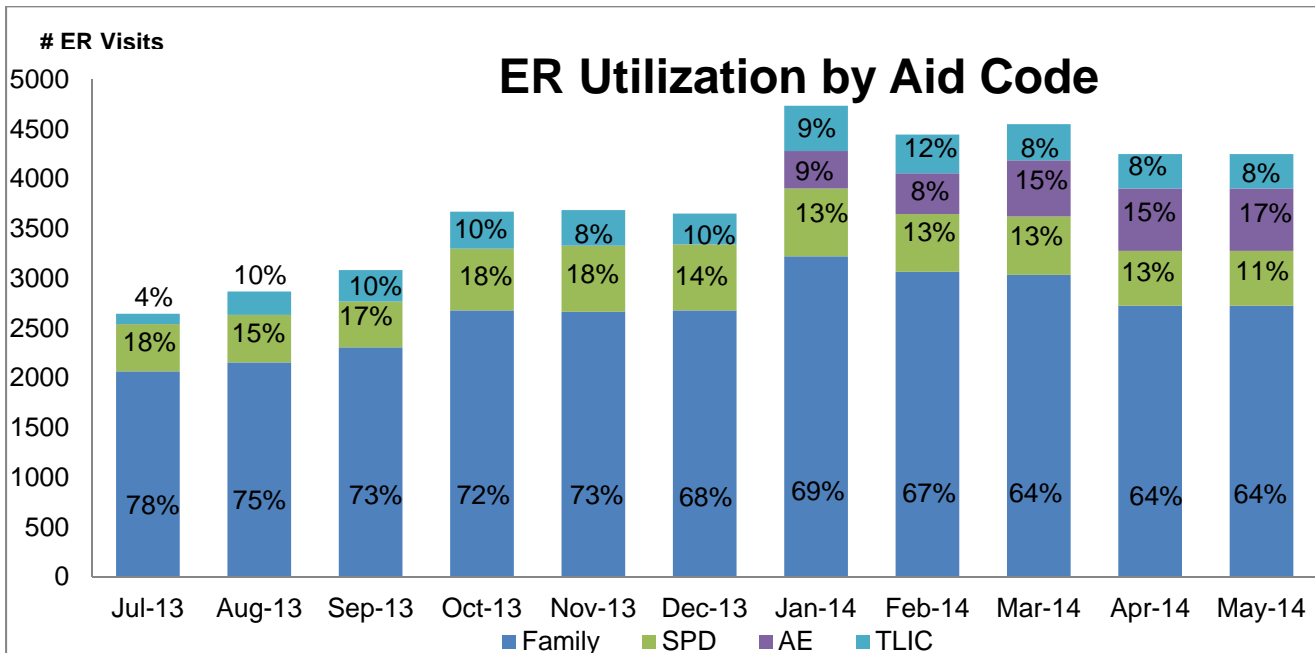
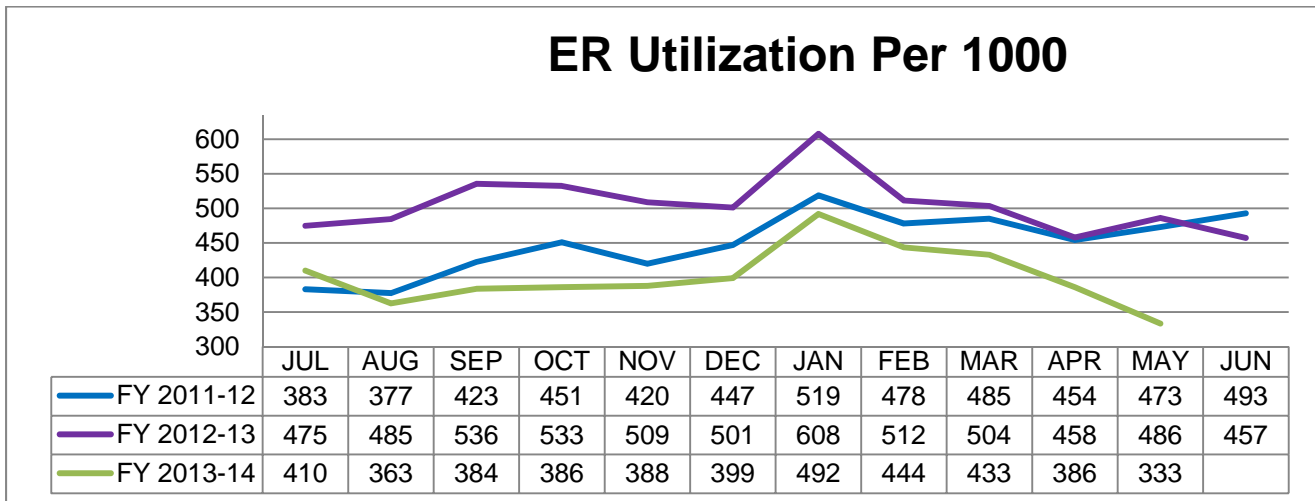
Benchmark: Average length of stay from available published data from other managed care plans range from 3.6 – 4.1. There is variability in reporting of Administrative Days among managed care plans.



ER Utilization

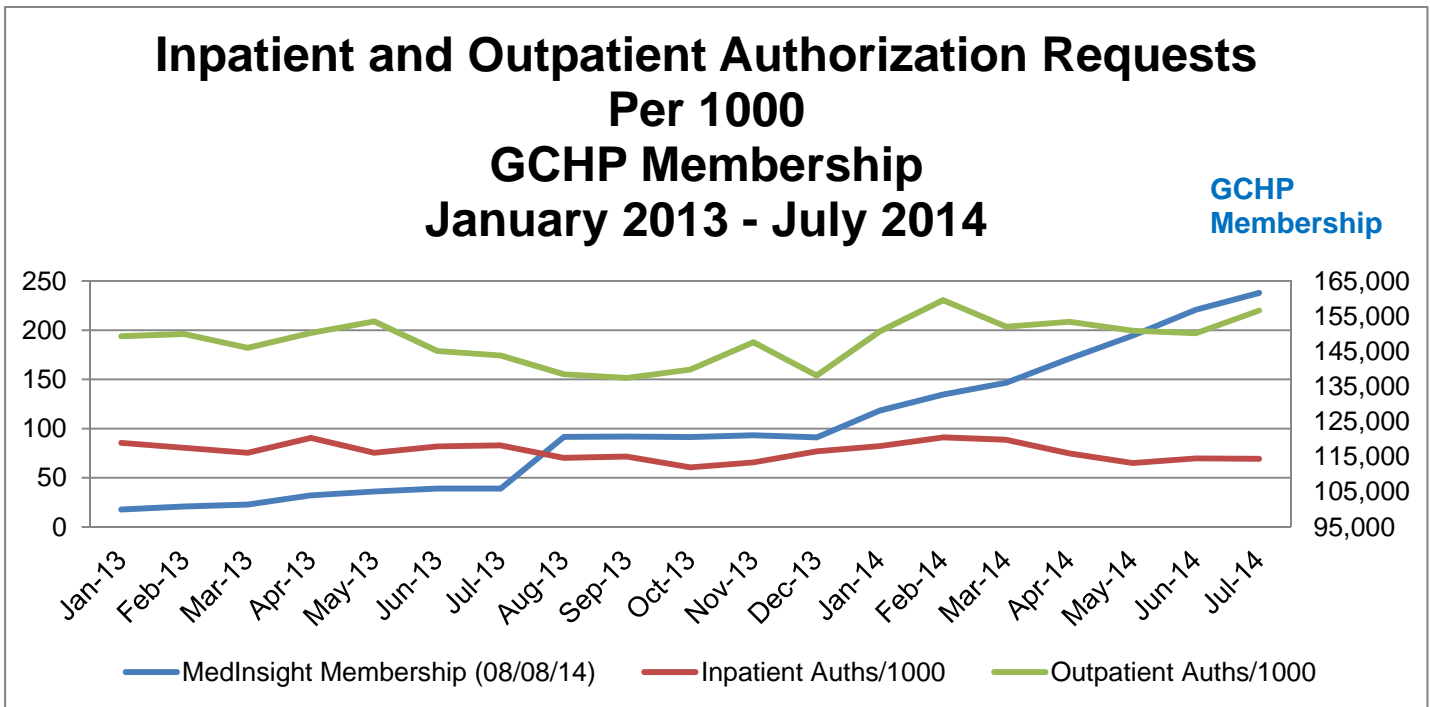
ER utilization for FY 2013-14 remains lower than prior years and mirrors a general decline in utilization from winter to spring for all years. The Family aid code group members showed the highest percent of ER utilization. For the period May 1, 2013 through April 30, 2014, 7% of ER utilization occurred outside of Ventura County.

Benchmark: ER Utilization / 1000 members from available published data from other managed care plans range from 554 – 877. For July 2013 through May 2014, Gold Coast Health Plan average utilization / 1000 member months (including Duals) is 32 compared with the 2013 DCHS Managed Care Dashboard report of about 40-60 ER visits / 1000 member months.

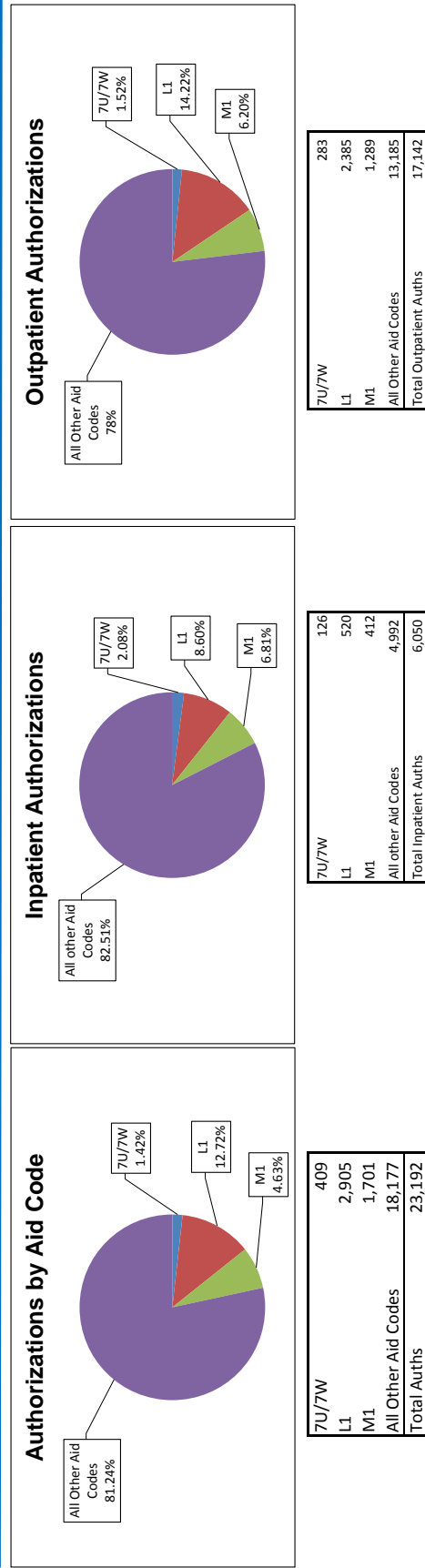


Authorization Requests

Requests for outpatient service continue to outnumber requests for inpatient service. Outpatient service requests / 1000 members remains at 200 or above since January 2014. Requests for inpatient service declined from March 2014 to April 2014 and have plateaued at below 75 / 1000 members for the last 3 months. Among Medi-Cal expansion members new to Gold Coast Health Plan since January 1, 2014, service requests for L1 members continue to predominate.



Gold Coast Health Plan Authorizations by Aid Code January - August 2014



Data Source: MedHOK Authorizations by Aid Code Query on 08/08/2014



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



Health Care Cost Reserves

**Michelle Raleigh, CFO
August 25, 2014**



Gold Coast
Health PlanSM
A Public Entity



Agenda

- Background
- Definitions
- Payment Lag
- Reserve Calculation Methods
- GCHP's Approved Method
 - History
 - Part I
 - Part II
 - Example
- Closing Comments

Background

- Health Care Cost Reserves (Reserves) are estimates of costs necessary for the Plan to analyze financial status and produce financial statements
- Reserves are calculated by the Plan and periodically reviewed by independent actuaries and annually reviewed by independent auditors
- Reserves are an important driver of financial results since a high percentage (e.g., 85-90%) of current month's medical expenses are estimated
- Reserves are the largest liability on the Plan's Balance Sheet (typical for managed care plans)
- Note – this is an update of the presentation made to the Executive / Finance Committee on February 7, 2013 and the Commission on February 25, 2013

Definitions

Incurred But Not Reported (IBNR): costs associated with a health care service that has been provided but for which the health plan has not received the claim (i.e., claim not yet reported)

Definitions

Incurring But Not Paid (IBNP): total health care cost reserve. IBNP is the sum total of all claim reserve pieces:

$$\text{IBNP} = \text{IBNR} + \text{Claims Payable}$$

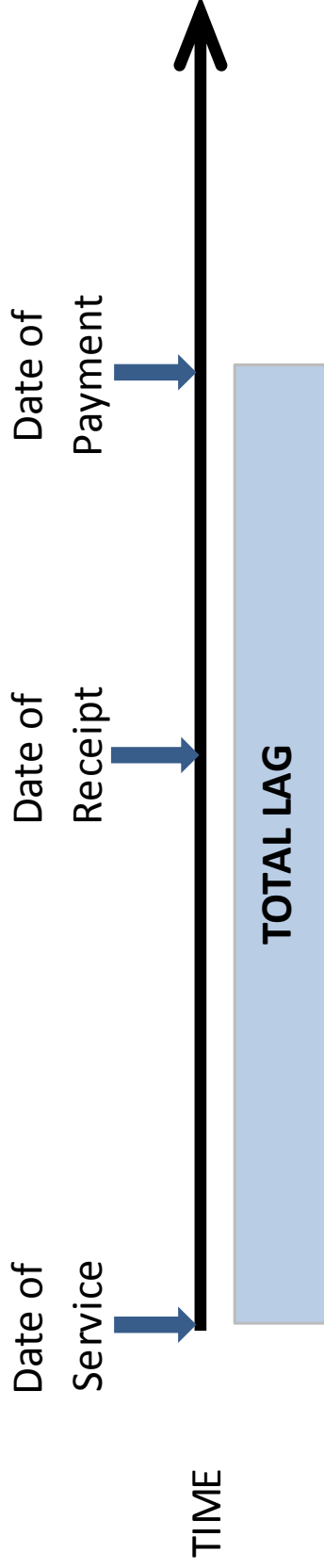
- IBNR = claims that have not yet been received
 - Claims Payable = claims received, in various stages of processing, but not yet paid (per ACS reports)
- GCHP provides both IBNR and Claims Payable amounts on the Balance Sheet

Definitions, Continued

Incurred Date: date on which services were rendered by a provider (i.e., date of service)

Lag: The time between the incurred date of a claim and the date on which a claim payment is made

Claim Payment Lag



Different claim types or provider types can have varying lengths of lag. The lag to payment may be spread out over several months. For example:

- Hospital Inpatient Claims – lag is 6 months on average
- PCP Claims – lag is 4 months on average
- Lab / Radiology Claims – lag is 5 months on average

Reserve Calculation Methods

- Most methods rely on sufficient and stable historical experience, sorted by certain claims / provider types and varying populations
- One method or a combination of different methods can be used to estimate total reserves, depending on circumstances (e.g., new populations)
- Reserve estimates need to take into account many variables including but not limited to:
 - rate of claims processing and reporting
 - changes in reimbursement of payment
 - high-cost or “shock” claims

Reserve Calculation Methods

- Method A: Completion Factor Method:

Using claims payment history, estimate the proportion of claims incurred in a given period and paid in that and any given succeeding period (i.e., the “completion factor” is the portion that is paid divided by the estimated total incurred amount).

- Example: cumulative paid claims for December services are \$200 and are estimated to be 78% “complete” through the end of May (i.e., 5 months later)
- Results in \$56 ($\$200 / 0.78$) that is estimated to be unpaid

Reserve Calculation Methods

- Method B: PMPM Method:

Using claims payment history, calculate a per-member per-month (PMPM) estimate.

 - Example: claims paid in a particular month were \$15 PMPM where historical average PMPM is \$20
 - Results in \$5 that is estimated to be unpaid
- Other methods exist (e.g., Average \$ / claim, Bornhuetter-Ferguson)
- GCHP's reserve calculation is based on hybrid approach, and varies by population

GCHP's IBNP Method - History

- Current GCHP methodology was agreed upon by several parties as of June 30, 2012:
 - GCHP staff and outside actuaries (Milliman),
 - Department of Health Care Services (DHCS) actuaries, and
 - Berkeley Research Group (BRG, State Monitor).
- As of June 30, 2013, the reserve was approved by the above parties, in addition to the independent auditors and their actuaries. No adjustment was made to the reserve through the audit process.
- Since June 30, 2013, independent actuaries (Milliman) review GCHP reserves at least semi-annually and are in the process of completing their review of the reserve as of June 30, 2014
- Currently, GCHP develops reserves by claim / provider type and is expanding methodology to develop reserves also by major population group

GCHP's IBNP Method – Part I

- Traditional Medi-Cal Population Reserve Calculation:
 1. Completion factors are used for more complete months (if lag is calculated to be over 80% complete),
 2. PMPM estimates are used for more incomplete months, and
 3. Other indicators are reviewed and incorporated as necessary, such as:
 - High dollar claims and estimated reinsurance recoveries,
 - Off-system special claims payments,
 - Retroactive rates adjustments due to providers,
 - Hospital census trends, and
 - Medical management authorizations for inpatient and outpatient trends.

GCHP's IBNP Method – Part II

- Newer Populations (i.e., TLIC and Adult Expansion) Reserve Calculation:
 1. PMPM cost estimates provided by State are used, and
 2. As with traditional populations, other indicators are reviewed and incorporated as necessary such as:
 - High dollar claims and estimated reinsurance recoveries,
 - Off-system special claims payments,
 - Retroactive rates adjustments due to providers,
 - Hospital census trends, and
 - Medical management authorizations for inpatient and outpatient trends.

GCHP's IBNP Method – Part II

- Newer Populations (i.e., TLIC and Adult Expansion) Reserve Calculation, continued:
 - Currently, GCHP is working with outside actuaries to determine appropriate updates to the TLIC reserve, as this population has been with GCHP for 1 year.
 - Currently, expenses estimated to be under the 85% medical loss ratio (MLR) for the Adult Expansion population are included as an additional part of the IBNP (per guidance from auditors)

Reserve Calculation Example

	A		B		C		D		E		F = E - A	
	Amount Paid	Completion Factor	PMPM	Method (A/B)	Estimated Incurred	IBNP						
Jan	21,149,595	99.5%	193.24	A	21,255,875	106,279						
Feb	20,373,692	98.8%	179.32	A	20,621,632	247,941						
Mar	19,750,777	95.8%	187.38	A	20,611,477	860,700						
Apr	19,931,003	94.3%	192.22	A	21,144,161	1,213,158						
May	17,909,539	92.3%	181.41	A	19,410,488	1,500,949						
Jun	17,748,956	89.9%	179.54	A	19,749,565	2,000,609						
Jul	16,918,573	86.3%	181.58	A	19,610,221	2,691,648						
Aug	16,725,480	80.5%	188.88	A	20,776,748	4,051,268						
Sep	16,895,141	77.0%	190.00	B	20,900,000	4,004,859						
Oct	13,718,712	62.4%	190.00	B	20,710,000	6,991,288						
Nov	9,216,947	43.8%	190.00	B	20,615,000	11,398,053						
Dec	845,753	5.2%	190.00	B	21,090,000	20,244,247						
TOTAL	191,184,168				246,495,167	55,310,999						

Reserve example calculated is a hybrid of Method A (completion factor) and Method B (PMPM – shown in yellow highlight).



GCHP's Reserve Components as of June 30, 2014 (unaudited)

Claims Payable	\$ 9,482,660
Traditional Medi-Cal Population IBNR	43,040,293
TLIC IBNR	8,407,128
Adult Expansion IBNR	29,705,355
Adult Expansion 85% MLR Addition	8,100,000
TOTAL IBNP	\$98,735,436

Closing Comments

- Accumulation of more data is bringing better predictability and accuracy to the calculation.
- Operational improvements in claims processing are smoothing out payment patterns, adding to accuracy.
- Data mining and more sophisticated reporting is bringing more granularity to the analysis.
- The Plan is constantly refining and improving the method. New staff with specific expertise adds credibility to the process.