



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

2240 E. Gonzales, Suite 200, Oxnard, CA 93036  
**Monday, February 25, 2013**  
**3:00 p.m.**

**AGENDA**

**CALL TO ORDER / ROLL CALL**

**SWEAR IN OF NEW COMMISSIONER** – Peter Foy

**PUBLIC COMMENT**

1. **APPROVE MINUTES**
  - a. [Regular Meeting of January 28, 2012](#)
  
2. **ACCEPT AND FILE ITEMS**
  - a. [CEO Update](#)
  - b. [December Financials](#)
  
3. **APPROVAL ITEMS**
  - a. [County Line of Credit \(LOC\)](#)
  - b. [Intergovernmental Transfer \(IGT\)](#)
  - c. [QI Plan](#)
  
4. **CONSENT ITEMS**
  - a. [FY 2012-13 Financial Audit Contract](#)

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, 1701 LOMBARD STREET, SUITE 100, OXNARD, CA.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT 805/889-6900. 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 February 25, 2013 Commission Meeting Agenda (continued)**  
**PLACE:** 2240 E. Gonzalez, Room 200, Oxnard, CA  
**TIME:** 3:00 p.m.

**5. INFORMATIONAL ITEMS**

- a. [Utilization Management / Case Management Initiatives](#)
- b. [Provider Advisory Committee \(PAC\) Update](#)
- c. [Financial Forecast Update](#)
- d. [Healthy Families Transition to Medi-Cal](#)
- e. [Medical Management System Replacement](#)
- f. [Tatum Work Update](#)
- g. [Incurred But Not Reported \(IBNR\) Information](#)

**CLOSED SESSION**

**Closed Session Conference with Legal Counsel – Existing Litigation pursuant to Government Code Section 54956.9 Sziklai v. Gold Coast Health Plan *et al* VCSC Case No. 56-2012-00428086-CU-WT-VTA**

**Closed Session Conference with Legal Counsel – Existing Litigation pursuant to Government Code Section 54956.9 Hernandez v. Ventura County Medi-Cal Managed Care Commission-VCSC Case No. 56-2012-00427535-CU-OE-VTA**

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

Announcement from Closed Session, if any.

**COMMENTS FROM COMMISSIONERS**

**ADJOURNMENT**

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on March 25, 2013 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, 1701 LOMBARD STREET, SUITE 100, OXNARD, CA.**

**IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT 805/889-6900. 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**

**January 28, 2013**

*(Not official until approved)*

**CALL TO ORDER**

Vice-Chair Juarez called the meeting to order at 3:22 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

The Pledge of Allegiance was recited.

**ROLL CALL**

**COMMISSION MEMBERS IN ATTENDANCE**

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

**Maylee Berry**, Medi-Cal Beneficiary Advocate

**Anil Chawla, MD**, Clinicas del Camino Real, Inc.

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

**John Fankhauser, MD**, Ventura County Medical Center Executive Committee

**Robert S. Juarez**, Clinicas del Camino Real, Inc.

**Kathy Long**, Ventura County Board of Supervisors

**EXCUSED / ABSENT COMMISSION MEMBERS**

**Laurie Eberst**, Private Hospitals / Healthcare System

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

**Robert Gonzalez, MD**, Ventura County Health Care Agency

**Catherine Rodriguez**, Ventura County Medical Health System

**STAFF IN ATTENDANCE**

**Michael Engelhard**, CEO

**Nancy Kierstyn Schreiner**, Legal Counsel

**Michelle Raleigh**, CFO

**Sonia DeMarta**, Controller

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

**Charlie Cho, MD**, Chief Medical Officer

**Guillermo Gonzalez**, Government Relations Director

**Melissa Scrymgeour**, IT Director

**Julie Booth**, QI Director

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

## **PUBLIC COMMENT / CORRESPONDENCE**

Danielle Gomez, Herbay Pharmacy / Infusion Rx, explained that they provide services to patients immediately out of the hospital and work with hospitals to ensure there is no disruption in therapy. She added that they are having difficulties getting their claims paid. Several meetings had been set up to get this resolved, but most meetings were canceled at the last minute.

CEO Engelhard requested she provide her contact information to the Clerk of the Board in order to get the matter resolved.

### **1. APPROVE MINUTES**

#### **a. Regular Meeting of November 26, 2012**

Vice-Chair Juarez noted that the 1<sup>st</sup> motion of Item 4d, *Request for Additional Resources*, should be amended to read as follows:

Commissioner Juarez moved to supersede previous hiring limitations placed on the Plan's CEO and authorize hiring of up to 15 staff and come back in January to review the financial forecast, including staffing plan. Commissioner Long seconded. The motion carried. **Approved 10-0.**

Commissioner Berry moved to approve the Regular Meeting Minutes of November 26, 2012 as amended. Commissioner Chawla seconded. The motion carried. **Approved 7-0.**

### **2. ACCEPT AND FILE ITEMS**

#### **a. CEO Update**

CEO Engelhard reviewed his written report with the Commission.

#### **b. October and November Financials**

CFO Raleigh reviewed the financials and emphasized that as payments have accelerated, cash on hand has declined consistent with the faster payment of claims. Staff is monitoring cash balances on a weekly basis.

Commissioner Dial moved to accept and file the October and November Financials. Commissioner Long seconded. The motion carried. **Approved 7-0.**

#### **c. Pending Capitation Rate Issues**

CFO Raleigh reviewed the written report and noted that these pending rate items will change as the state budget changes and that the Plan will bring changes and issues back to the Commission. Staff desired to provide the Commission with an indication of the large number pending rate items at the State level.

Commissioner Long moved to accept and file Item 2a *CEO Update* and Item 2c *Pending Capitation Rate Issues*. Commissioner Dial seconded. The motion carried.  
**Approved 7-0.**

### **3. APPROVAL ITEMS**

#### **a. FY 2012-13 Revised Budget (including Financial Forecast provided to DHCS in response to CAP)**

CFO Raleigh reviewed her report. She added that all budget assumptions have been revised due to two events: 1) the financial forecast developed as part of the CAP (Corrective Action Plan) and 2) additional analysis that has been fine-tuned by staff after the financial forecast was submitted to the State on 12/11/12. She informed the Commission that the budget is conservative and realistic; a lot of time has been taken developing and analyzing the data. Staff assumed stable enrollment as well as no change in capitation rates received from the State.

Discussion was held regarding adjustments made since the prior budget was developed, such as assigning members proper aid codes. Plan staff is working with Ventura County Human Services Department to ensure that future members are coded correctly.

CFO Raleigh noted that the revised budget assumes \$8.2 million in subordinated debt commitments, the original County line-of-credit of \$2.2 million, plus \$6.0 million additional support later this year. The Plan is still in start-up mode so Administrative Expenses remain high and are assumed to stay at or near the current level as the Plan is also gearing up for health care reform.

Discussion was held with regard to how Medi-Cal expansion may also impact the Plan.

CFO Raleigh reported that 14 additional staff members are being requested and that the staffing needs have been echoed by BRG (Berkley Research Group), the State appointed monitor, as well as the State. Discussion was then held as to how many of the previously approved new positions had yet been filled.

Commissioner Dial expressed his concern that since approximately 90% of the budget is health care costs, more needs to be done to address those costs, other than just obtaining the correct aid codes. He requested "Controlling Health Care Costs" be discussed at a later meeting, but noted that he also realizes that the Plan must hire additional staff in order for this to be accomplished. CEO Engelhard added that there are initiatives related to health care cost containment and recognizes that hospital inpatient bed days and ER visits are high. Commissioner Dial indicated that those are the types of areas that the Commission would like to hear about.

Commissioner Fankhauser raised concern that the Executive Finance Committee had not reviewed the revised budget (the January meeting was cancelled due scheduling conflicts) and the Commission specifically has CFO's on the Committee for the purpose of reviewing financial matters.

Commissioner Dial moved to approve the Revised FY 2012-13 Budget as well as the 14 additional positions. Commissioner Berry seconded. The motion carried. **Approved 6-1**, with Commissioner Fankhauser voting no.

b. **FY 2011-12 Audit Results (including presentation by McGladrey LLP, Financial Statements & Report to Audit Committee)**

CFO Raleigh introduced Carrie Esler and Steve Draxler of McGladrey, who prepared the FY 2011-12 financial audit.

Carrie Esler highlighted the overview of the audit process and explained that the financial statements are the responsibility of Plan management. The auditors then reviewed the following areas: auditor's responsibility, accounting practices, management's judgments and accounting estimates, financial statement disclosures, audit adjustments and uncorrected misstatements. Their areas of concern were noted and control weaknesses reviewed.

Commissioner Dial moved to accept the financial audit. Commissioner Long seconded. The motion carried. **Approved 5-2**, with Vice-Chair Juarez and Commissioner Chawla voting no.

4. **CONSENT ITEMS**

- a. **DHCS Contract Amendment for Healthy Families**
- b. **BRG Contract Amendment Ratification**

Commissioner Dial moved to approve the Consent Items. Commissioner Long seconded. The motion carried. **Approved 7-0**.

**RECESS:**

A recess was called at 5:31 p.m. The meeting was reconvened at 5:37 p.m.

5. **INFORMATIONAL ITEMS**

- a. **Medical Management System Replacement**
- b. **Tatum Work Update**
- c. **Healthy Families Transition to Medi-Cal**
- d. **State Budget Update**
- e. **QI Report**
- f. **Real Estate Update**

There was a consensus by the Commissioners to forego staff presentations of the Informational Items as there would no longer be a quorum after 6:00 p.m. and it was essential to have a quorum for the Closed Session.

Tony Alatorre, Chief Operating Officer of Clinicas Del Camino Real, questioned why a letter he had sent via email to the Clerk of the Board earlier in the day had not been presented to the Commission. Legal Counsel Kierstyn Schreiner responded that anyone wishing to speak under Public Comment should have filled out a "Request to Speak" form so the Chair and the Clerk knew the person desired to speak. There was no indication that he desired to speak. Legal counsel explained that general correspondence is provided to the Commission when received as was his letter dated December 28, 2012, was provided to the Commission in December 2012. For written correspondence on an agenda item depending on when received will be part of the packet or delivered at the meeting. There was no indication his correspondence was for an agenda item. There was further discussion as to the Commission practice concerning public comments and adherence to the Brown Act.

### **CLOSED SESSION**

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

### **ADJOURN TO CLOSED SESSION**

The Commission adjourned to Closed Session at 5:48 p.m. regarding the following item:

**Closed Session Conference with Legal Counsel – Existing Litigation pursuant to Government Code Section 54956.9 Sziklai v. Gold Coast Health Plan et al VCSC Case No. 56-2012-00428086-CU-WT-VTA**

### **RETURN TO OPEN SESSION**

The Regular Meeting reconvened at 6:15 p.m. with Commissioners Long being absent.

Legal Counsel Kierstyn Schreiner announced that there was no reportable action.

### **COMMENTS FROM COMMISSIONERS**

None.

### **ADJOURNMENT**

Meeting adjourned at 6:17 p.m.



## **AGENDA ITEM 2a**

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, CEO

Date: February 25, 2013

Re: CEO Update

### **Staffing Update**

In January the Plan added a Compliance Specialist to our Compliance Department to ensure that GCHP complies with all appropriate standards, regulations, contractual provisions, federal waivers and laws.

In February GCHP brought on an IT Security Specialist to our IT Department to focus on GCHP's data security strategy, and to implement additional policies and procedures relating to the security and governance model.

In March our Finance Department will be having a Business Analyst join the team to provide analytical support to the finance and operations departments. Responsibilities are focused on analyzing experience and modeling changes to support the growth of the Plan.

### **Update on SPD Process**

The new Seniors and Persons with Disabilities (SPD) contract amendment is pending and the effective date from February 1, 2013 has been pushed out until the Department of Health Care Services provides a final version to the Plan for signature. The date when the Plan will receive this contract amendment is to be determined. As a result of the extensive work that is required to comply with the contract amendment requirements, GCHP Health Services Department has put a process in place to ensure that all newly enrolled SPD members receive at least 2 phone call attempts and a written communication to reach them to offer Care Management services. The process includes an extensive Health Risk Assessment to define risk level so that the appropriate level of service can be provided. Additional Care Managers have been hired to provide the needed coordination services. Through a monthly profiling process, it has been determined that GCHP receives approximately 300-400 new SPD members monthly. Bilingual Health Services Staff have been hired to ensure appropriate communication with Non-English speaking members. In addition, the GCHP language line is available to communicate with members when the appropriate language cannot provide onsite. Data collection has begun to ensure that GCHP will be ready to report on May 15th, the first tentative required reporting date.



## **Government Relations Update- January-February 2013**

### **California Association of Health Insuring Organizations (CAHIO)**

Gold Coast Health Plan's (GCHP) CEO, CFO and Director of Government Relations participated in the quarterly meeting between CAHIO and the Department of Health Care Services (DHCS). Topics discussed included: primary care physician (PCP) rate increase under the federal Affordable Care Act (ACA); SPD contract amendment for county organized health systems (COHS); outreach efforts for new Medi-Cal managed care eligibles; and other COHS-related issues and initiatives. Regarding the primary care physician rate increase under the ACA, guidance from the state is still pending as to how the rate increases will be implemented. DHCS has assured Plans that the ACA-PCP rate increase will be implemented and reimbursed retroactively to January 1, 2013.

### **Extraordinary Session of the State Legislature**

The Governor called the Legislature into special session on January 28, 2013 to consider and act upon legislation that will implement the ACA in California including expansion of eligibility under the Medi-Cal Program. Three key areas that Legislators are focusing on are:

- Changes to the Medi-Cal Program which are necessary to implement federal law, including requirements for eligibility, enrollment, and retention.
- California's Private Health Coverage market, and rules and regulations governing the individual and small group markets related to guaranteed issue of coverage, pre-existing condition exclusions, rating restrictions and other requirements necessary to conform state law to federal regulations.
- Options that allow low-cost health coverage to be provided to individuals who have incomes up to 200 percent of the federal poverty level within the California Health Benefit Exchange.

### **Medicaid Expansion**

Governor Brown has proposed two options to implement expansion of Medicaid / Medi-Cal eligibility under the ACA. One option is a state-based expansion that would use the Medi-Cal Program and managed care delivery system. The second option is a county-based expansion of Medi-Cal that would build upon the existing Low Income Health Program (LIHP). Under this option counties would maintain their current responsibilities for indigent health care services and be required to offer the statewide minimum in health benefits consistent with benefits offered through Medi-Cal. Counties could offer additional benefits, except for long-term care.

### **California State Association of Counties (CSAC) Position on County-Based Medi-Cal Expansion**

Due to network adequacy, billing, cost sharing and other legal issue concerns, the state association of counties- CSAC has taken the position that the state should continue contracting with Medi-Cal managed care plans. CSAC further believes that County human services departments should continue to administer Medi-Cal eligibility as under current law. However, CSAC would like to explore the option of a county demonstration project (or pilot) in a limited number of counties to expand their LIHP programs in lieu of the existing managed care plans.

### **Healthy Families Program Transition to Medi-Cal Managed Care**

Staff continues to participate in weekly calls with other Medi-Cal managed care plans and the Department of Health Care Services (DHCS) to discuss, identify issues and concerns with the Healthy Families Program (HFP) transition to Medi-Cal Managed Care.

Thus far it appears that there have been minimal reports of problems in phase 1a of the four-phase transition. Phase 1a includes approximately 200,000 children who are currently in a health plan that is contracted or sub-contracted by a Medi-Cal managed care plan. GCHP's Provider Relations Department is currently assessing the GCHP provider network to ensure it meets the needs of children who are transitioning to GCHP. The Ventura County Human Service Agency (HSA), reports that since the beginning of the year they are receiving and processing approximately 400 to 500 HFP applications per month. Once deemed eligible by HSA, these children will be enrolled in GCHP.

GCHP's Government Relations Director and Provider Relations Manager are meeting regularly with County HSA personnel to coordinate outreach and communication to HFP families involved in the transition to Medi-Cal managed care and GCHP.

### **Health and Human Services (HHS) Region IX**

GCHP's CEO, CFO and Director of Government Relations participated in a conference call with Herb Schultz, Director for HHS Region IX. Purpose of the call was to introduce Mr. Schultz to GCHP's new CFO and CEO as well provide an update on the Plan's progress in meeting state corrective action plan requirements.

### **GCHP Commissioner Rotation**

On Tuesday, February 12<sup>th</sup>, GCHP's Government Relations Director attended the County Board of Supervisor's meeting held in Thousand Oaks to publicly thank Supervisor Kathy Long for her service and leadership on the GCHP Commission. County Board of Supervisors Chairman, Peter Foy will assume Supervisor Long's seat on the GCHP Commission. We welcome Chairman Foy and look forward to working with him and the entire GCHP Commission.



**AGENDA ITEM 2b**

To: Gold Coast Health Plan Commissioners  
From: Michelle Raleigh, Chief Financial Officer  
Date: February 25, 2013  
RE: December, 2012 Financials

**SUMMARY:**

Staff is presenting the attached December 2012 financial statements of Gold Coast Health Plan for approval by the Commission.

**BACKGROUND / DISCUSSION:**

The Plan has prepared the December 2012 financials, including income statements, balance sheet statement, and statement of cash flows reflecting monthly and year-to-date information.

**FISCAL IMPACT:**

Not applicable.

**RECOMMENDATION:**

Staff proposes the Commission to approve the December 2012 financial statements. The Executive / Finance Committee also provided recommendation on this action during the 02/07/13 meeting.

**CONCURRENCE:**

Executive Finance Committee (02/07/13)

**ATTACHMENTS:**

December Financials

# GOLD COAST HEALTH PLAN

## SUMMARY FINANCIAL RESULTS

### SUMMARY INCOME STATEMENT THROUGH DECEMBER 31, 2012 Rolling Monthly Actual Trend

Description	Audited FY 2011-12	FY 2012-13											
		JUL	AUG	SEP	OCT	NOV	DEC	YTD					
Member Months	1,258,189	105,753	99,264	100,203	99,217	100,088	101,299	605,824					
<b>Revenue</b>	<b>304,635,932</b>	<b>23,806,175</b>	<b>24,430,512</b>	<b>24,988,448</b>	<b>25,449,011</b>	<b>25,438,394</b>	<b>25,676,263</b>	<b>149,788,804</b>					
<i>pmpm</i>	242.12	225.11	246.12	249.38	256.50	254.16	253.47	247.25					
<b>Health Care Costs</b>	<b>287,353,672</b>	<b>21,181,745</b>	<b>28,173,162</b>	<b>22,293,643</b>	<b>24,466,891</b>	<b>22,432,967</b>	<b>22,068,065</b>	<b>140,616,473</b>					
<i>pmpm</i>	228.39	200.29	283.82	222.48	246.60	224.13	217.85	232.11					
% of Revenue	94.3%	89.0%	115.3% <sup>(A)</sup>	89.2%	96.1%	88.2%	85.9%	93.9%					
<b>Admin Exp</b>	<b>18,891,320</b>	<b>1,587,586</b>	<b>1,683,028</b>	<b>1,706,253</b>	<b>1,968,888</b>	<b>2,065,315</b>	<b>2,001,876</b>	<b>11,012,946</b>					
<i>pmpm</i>	15.01	15.01	16.96	17.03	19.84	20.63	19.76	18.18					
% of Revenue	6.2%	6.7%	6.9%	6.8%	7.7%	8.1%	7.8%	7.4%					
<b>Net Income</b>	<b>(1,609,063)</b>	<b>1,036,844</b>	<b>(5,425,678)</b>	<b>988,552</b>	<b>(986,767)</b>	<b>940,112</b>	<b>1,606,322</b>	<b>(1,840,615)</b>					
<i>pmpm</i>	(1.28)	9.80	(54.66)	9.87	(9.95)	9.39	15.86	(3.04)					
% of Revenue	-0.5%	4.4%	-22.2%	4.0%	-3.9%	3.7%	6.3%	-1.2%					
100% TNE	16,769,368	14,771,512	17,167,762	16,693,841	16,827,932	16,500,637	16,308,936	16,308,936					
% TNE Required	36%	36%	36%	36%	36%	36%	52%	52%					
Required TNE	6,036,972	5,317,744	6,180,394	6,009,783	6,058,056	5,940,229	8,480,647	8,480,647					
<b>GCHP TNE</b>	<b>(6,031,881)</b>	<b>(4,995,037)</b>	<b>(10,420,715)</b>	<b>(9,432,163)</b>	<b>(10,418,930)</b>	<b>(9,478,818)</b>	<b>(5,672,496)</b>	<b>(5,672,496)</b>					

**Note:**

(A) August Health Care Costs include \$7M IBNR addition.



# Financial Statement Overview

FOR THE MONTH ENDED DECEMBER 31, 2012

## Key Drivers of Income Statement:

- **Health Care Costs** – the Plan processed \$2.7M in claims adjustments which also contributed to a lower IBNP.
- **Administrative Expenses** - have decreased due to lower general office, legal, & claims interest payments which has been partially offset by increases in salary (for new hires), mailings/postage, & consulting (e.g., Tatum, BRG, Milliman).

# Gold Coast Health Plan

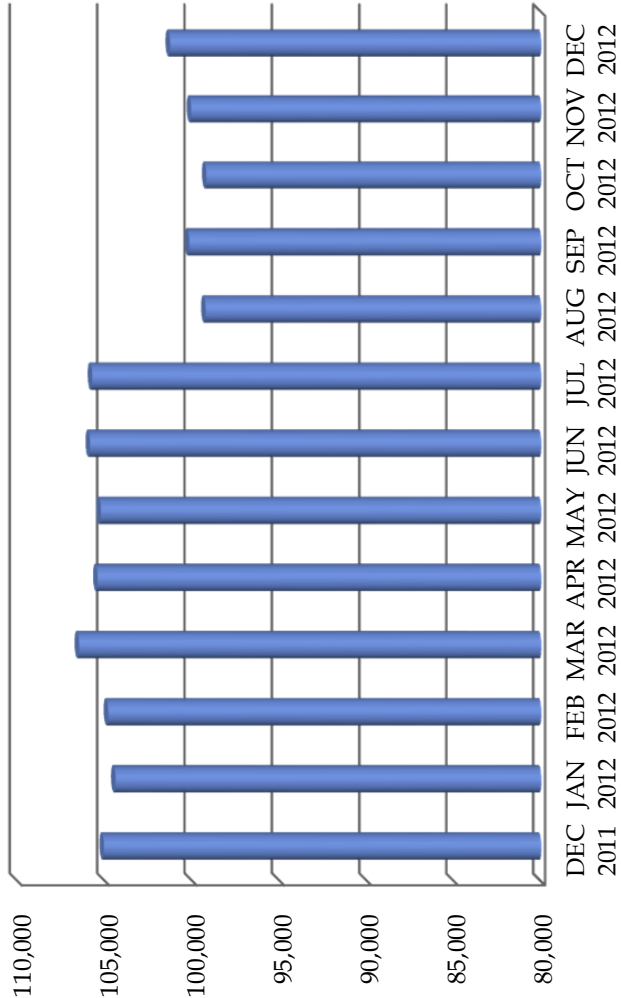
## Enrollment Dashboard

For The Month Ended December 31, 2012

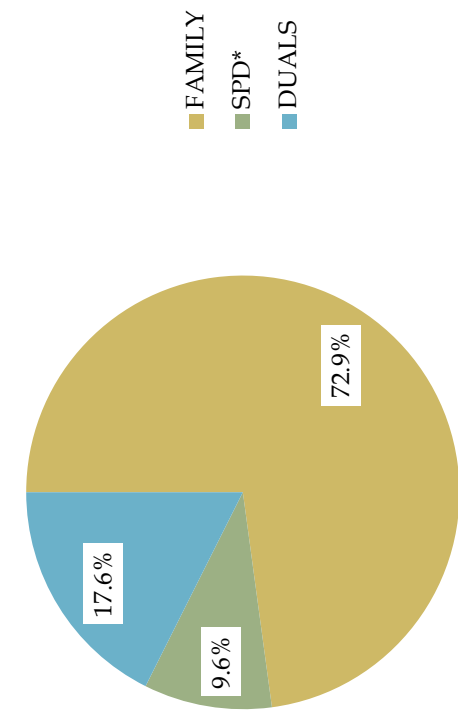
AID CATEGORY	FY 2011- 2012				FY 2012 - 2013							Dec'12 YTD	Dec'12 (% of total)
	Q1	Q2	Q3	Q4	Total YTD	Jul'12	Aug'12	Sep'12	Oct'12	Nov'12	Dec'12		
FAMILY	229,938	233,321	233,148	233,985	930,392	78,219	72,581	73,550	72,554	73,275	73,806	443,986	72.9%
SPD*	27,446	27,726	28,017	28,207	111,396	9,422	8,765	8,903	9,030	8,997	9,677	54,794	9.6%
DUALS	53,159	54,256	54,595	54,391	216,401	18,112	17,918	17,750	17,633	17,816	17,816	107,045	17.6%
<b>Total</b>	<b>310,543</b>	<b>315,303</b>	<b>315,760</b>	<b>316,583</b>	<b>1,258,189</b>	<b>105,753</b>	<b>99,264</b>	<b>100,203</b>	<b>99,217</b>	<b>100,088</b>	<b>101,299</b>	<b>605,825</b>	<b>100.0%</b>

\* SPD = Seniors and Persons with Disabilities

### Membership

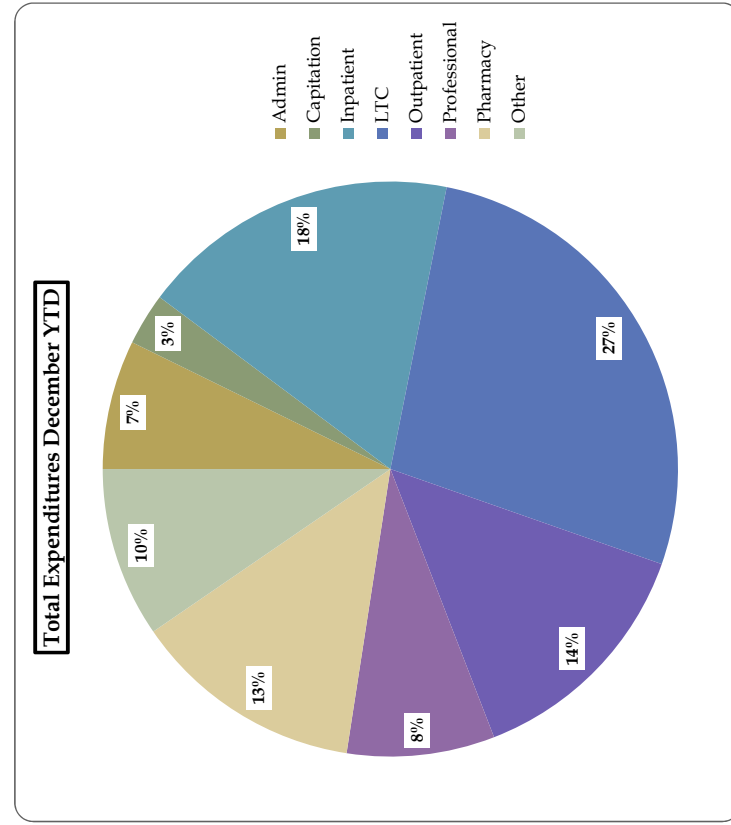
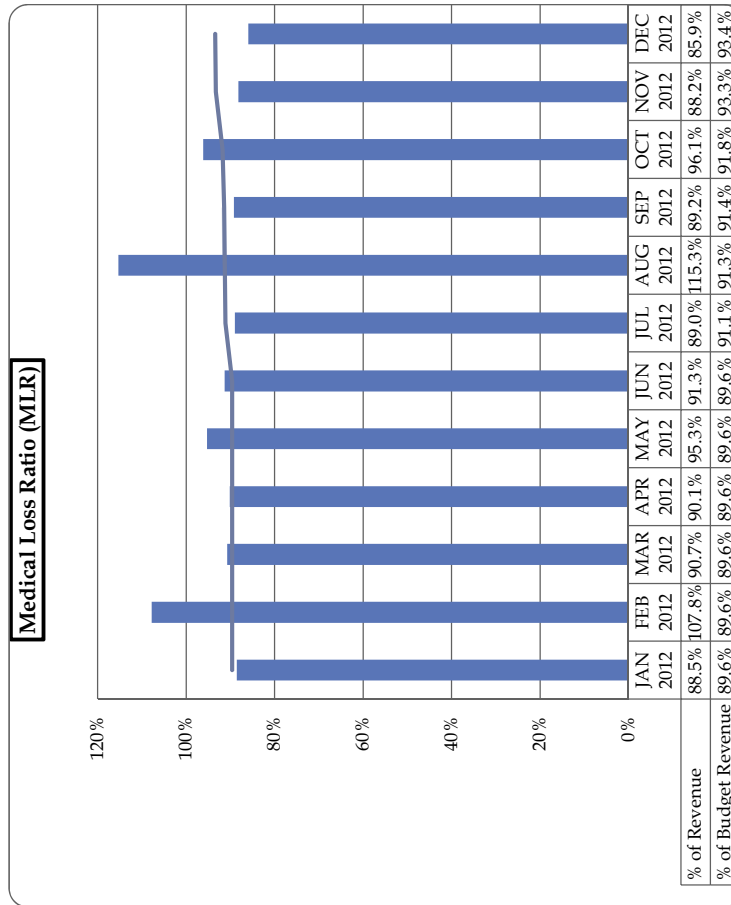


### Membership Percentage of Total December YTD



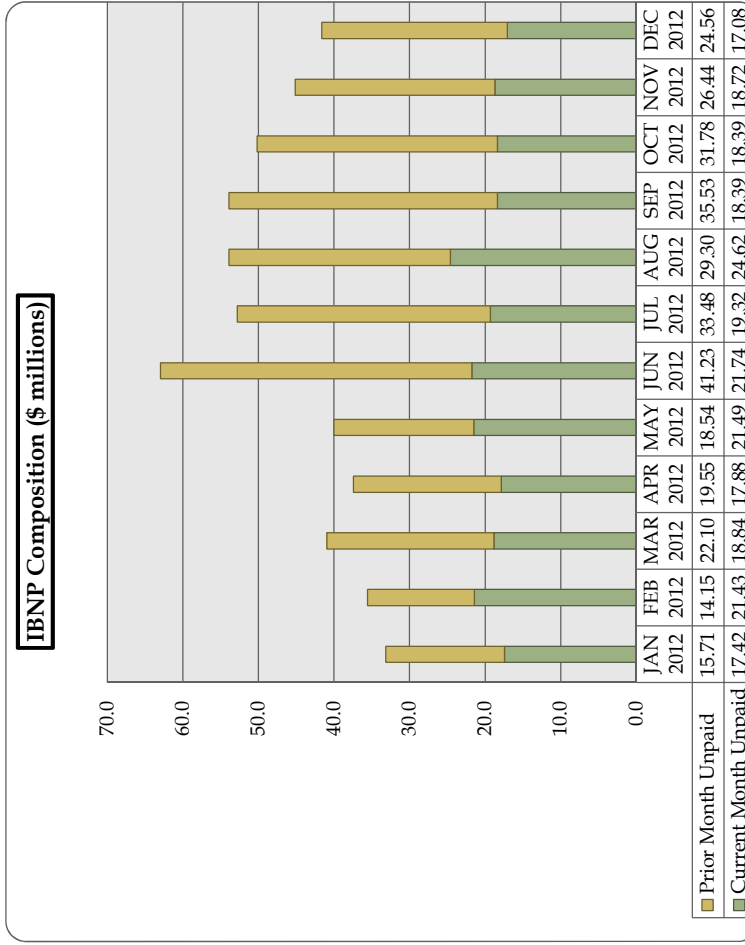
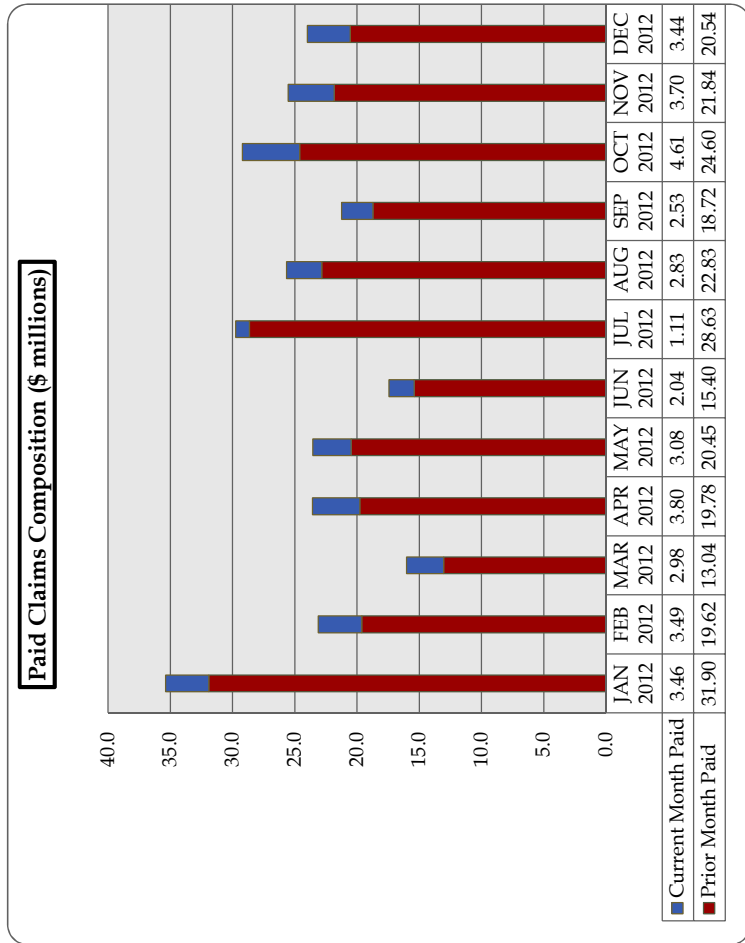
# Gold Coast Health Plan

Medical Cost Trend Through December 31, 2012



# Gold Coast Health Plan

Medical Cost Trend Through December 31, 2012



**Note:**

1. Paid Claims Composition chart- per adjusted medical claims payment lag schedule and pharmacy reports.
2. IBNP Composition chart- reflects updated medical cost reserve calculation (e.g., calculation of current month incurred claims less current month paid, plus prior month liability less prior paid in current month). Total reserve ties to the IBNR and Claims Payable balance on the Balance Sheet.



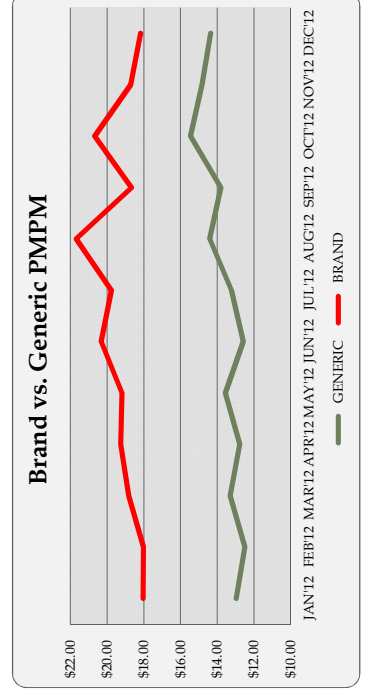
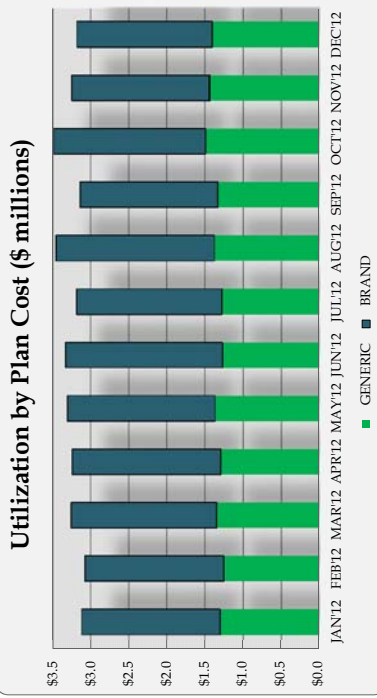
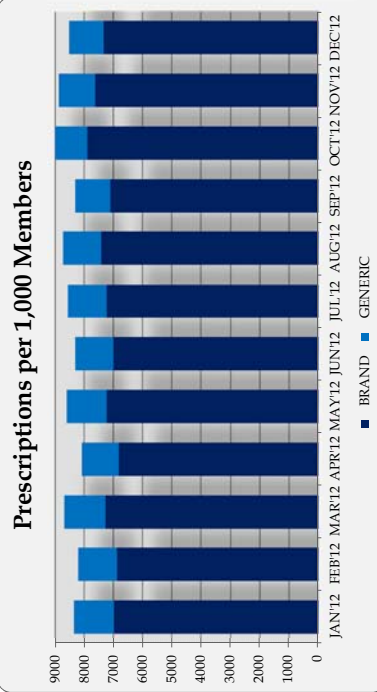
**Gold Coast Health Plan**

Script Care Plan Utilization and Cost Trend  
For The Month Ended December 31, 2012

	JAN'12	FEB'12	MAR'12	APR'12	MAY'12	JUN'12	JUL'12	AUG'12	SEP'12	OCT'12	NOV'12	DEC'12
<b>Membership</b>	100,636	100,768	101,439	101,272	101,041	101,207	96,540	95,797	96,669	96,447	96,907	97,745
<b>Utilization</b>	23,775	23,926	24,981	23,349	24,216	23,089	22,167	22,373	22,638	24,071	23,659	23,378
% (enrollment)	<b>23.6%</b>	<b>23.7%</b>	<b>24.6%</b>	<b>23.1%</b>	<b>24.0%</b>	<b>22.8%</b>	<b>23.0%</b>	<b>23.4%</b>	<b>23.4%</b>	<b>25.0%</b>	<b>24.4%</b>	<b>23.9%</b>
<b>Number Of Claims Paid</b>												
BRAND	11,421	11,267	11,903	10,888	11,617	11,052	10,757	10,499	9,743	10,685	10,013	9,596
GENERIC	58,588	57,714	61,435	57,443	60,861	58,950	58,183	59,204	57,199	63,537	61,625	59,720
Total	70,009	68,981	73,338	68,331	72,478	70,002	68,940	69,703	66,942	74,222	71,638	69,316
BRAND % of all claims	<b>16.3%</b>	<b>16.3%</b>	<b>16.2%</b>	<b>15.9%</b>	<b>16.0%</b>	<b>15.8%</b>	<b>15.6%</b>	<b>15.1%</b>	<b>14.6%</b>	<b>14.4%</b>	<b>14.0%</b>	<b>13.8%</b>
GENERIC % all claims	<b>83.7%</b>	<b>83.7%</b>	<b>83.8%</b>	<b>84.1%</b>	<b>84.0%</b>	<b>84.2%</b>	<b>84.4%</b>	<b>84.9%</b>	<b>85.4%</b>	<b>85.6%</b>	<b>86.0%</b>	<b>86.2%</b>
<b>Plan Cost</b>												
BRAND	1,815,536	1,816,430	1,908,982	1,951,084	1,939,849	2,066,168	1,908,700	2,077,303	1,804,984	1,994,454	1,813,487	1,776,242
GENERIC	1,304,658	1,259,202	1,348,636	1,283,842	1,370,173	1,273,925	1,277,492	1,380,952	1,333,405	1,491,109	1,437,940	1,404,164
Total	\$ 3,120,194	\$ 3,075,632	\$ 3,257,618	\$ 3,244,925	\$ 3,309,822	\$ 3,330,093	\$ 3,186,191	\$ 3,458,255	\$ 3,138,389	\$ 3,485,563	\$ 3,251,427	\$ 3,180,407
Brand pmpm	\$18.04	\$18.03	\$18.82	\$19.27	\$19.20	\$20.32	\$19.77	\$21.68	\$18.67	\$20.68	\$18.71	\$18.17
Generic pmpm	\$12.96	\$12.50	\$13.30	\$12.78	\$13.56	\$12.59	\$13.23	\$14.42	\$13.79	\$15.46	\$14.84	\$14.37
Total pmpm	\$31.00	\$30.52	\$32.11	\$32.04	\$32.76	\$32.90	\$33.00	\$36.10	\$32.47	\$36.14	\$33.55	\$32.54
BRAND % total cost	<b>58.2%</b>	<b>59.1%</b>	<b>58.6%</b>	<b>60.1%</b>	<b>58.6%</b>	<b>61.7%</b>	<b>59.9%</b>	<b>60.1%</b>	<b>57.5%</b>	<b>57.2%</b>	<b>55.8%</b>	<b>55.8%</b>
GENERIC % total cost	<b>41.8%</b>	<b>40.9%</b>	<b>41.4%</b>	<b>39.9%</b>	<b>41.4%</b>	<b>38.3%</b>	<b>40.1%</b>	<b>39.9%</b>	<b>42.5%</b>	<b>42.8%</b>	<b>44.2%</b>	<b>44.2%</b>
avg. claim cost (Brand)	\$158.96	\$161.22	\$160.38	\$179.20	\$166.97	\$186.04	\$177.44	\$197.86	\$185.26	\$186.66	\$181.11	\$185.10
avg. claim cost (Generic)	\$22.27	\$21.82	\$21.95	\$22.52	\$22.51	\$21.61	\$21.96	\$23.33	\$23.31	\$23.47	\$23.33	\$23.51

Note:

The actual claims paid and cost obtained from Script Care, Ltd.



**Gold Coast Health Plan**  
 Comparative Balance Sheet  
 December 31, 2012

	12/31/12	11/30/12	6/30/12
<b>ASSETS</b>			
<b>Current Assets</b>			
<b>Total Cash and Cash Equivalents</b>	<b>\$ 13,304,588</b>	<b>\$ 36,352,153</b>	<b>\$ 25,554,098</b>
Medi-Cal Receivable	25,430,325	-	28,534,938
Provider Receivable	3,846,142	3,709,193	6,539,541
Other Receivables	198,400	1,503,174	2,148,270
<b>Total Accounts Receivable</b>	<b>29,476,868</b>	<b>5,212,367</b>	<b>37,222,748</b>
Total Prepaid Accounts	1,077,780	1,082,002	185,797
Total Other Current Assets	205,810	1,172,982	375,000
<b>Total Current Assets</b>	<b>\$ 44,065,045</b>	<b>\$ 43,819,505</b>	<b>\$ 63,337,644</b>
<b>Total Fixed Assets</b>	<b>160,278</b>	<b>163,831</b>	<b>176,028</b>
<b>Total Assets</b>	<b>\$ 44,225,323</b>	<b>\$ 43,983,336</b>	<b>\$ 63,513,672</b>
<b>LIABILITIES &amp; FUND BALANCE</b>			
<b>Current Liabilities</b>			
Incurred But Not Reported	\$ 34,800,130	\$ 36,644,957	\$ 52,610,898
Claims Payable	6,834,979	8,512,814	10,357,609
Capitation Payable	917,020	907,950	633,276
Accrued Premium Reduction	2,579,492	2,779,176	1,914,157
Accounts Payable	1,762,278	2,018,804	845,045
Accrued ACS	-	-	200,000
Accrued Expenses	200,000	200,000	-
Accrued Premium Tax	604,458	37	602,900
Current Portion of Deferred Revenue	460,000	460,000	460,000
Accrued Payroll Expense	297,795	416,748	-
Current Portion Of Long Term Debt	291,667	333,333	500,000
<b>Total Current Liabilities</b>	<b>\$ 48,747,819</b>	<b>\$ 52,273,820</b>	<b>\$ 68,123,886</b>
<b>Long-Term Liabilities</b>			
Other Long-term Liability	-	-	41,667
Deferred Revenue - Long Term Portion	1,150,000	1,188,333	1,380,000
Notes Payable	2,200,000	-	-
<b>Total Long-Term Liabilities</b>	<b>3,350,000</b>	<b>1,188,333</b>	<b>1,421,667</b>
<b>Total Liabilities</b>	<b>\$ 52,097,819</b>	<b>\$ 53,462,153</b>	<b>\$ 69,545,553</b>
Beginning Fund Balance	(6,031,881)	(6,031,881)	(4,422,819)
Net Income Current Year	(1,840,615)	(3,446,936)	(1,609,062)
<b>Total Fund Balance</b>	<b>(7,872,496)</b>	<b>(9,478,817)</b>	<b>(6,031,881)</b>
<b>Total Liabilities &amp; Fund Balance</b>	<b>\$ 44,225,323</b>	<b>\$ 43,983,336</b>	<b>\$ 63,513,672</b>

# Financial Statement Overview

FOR THE MONTH ENDED DECEMBER 31, 2012

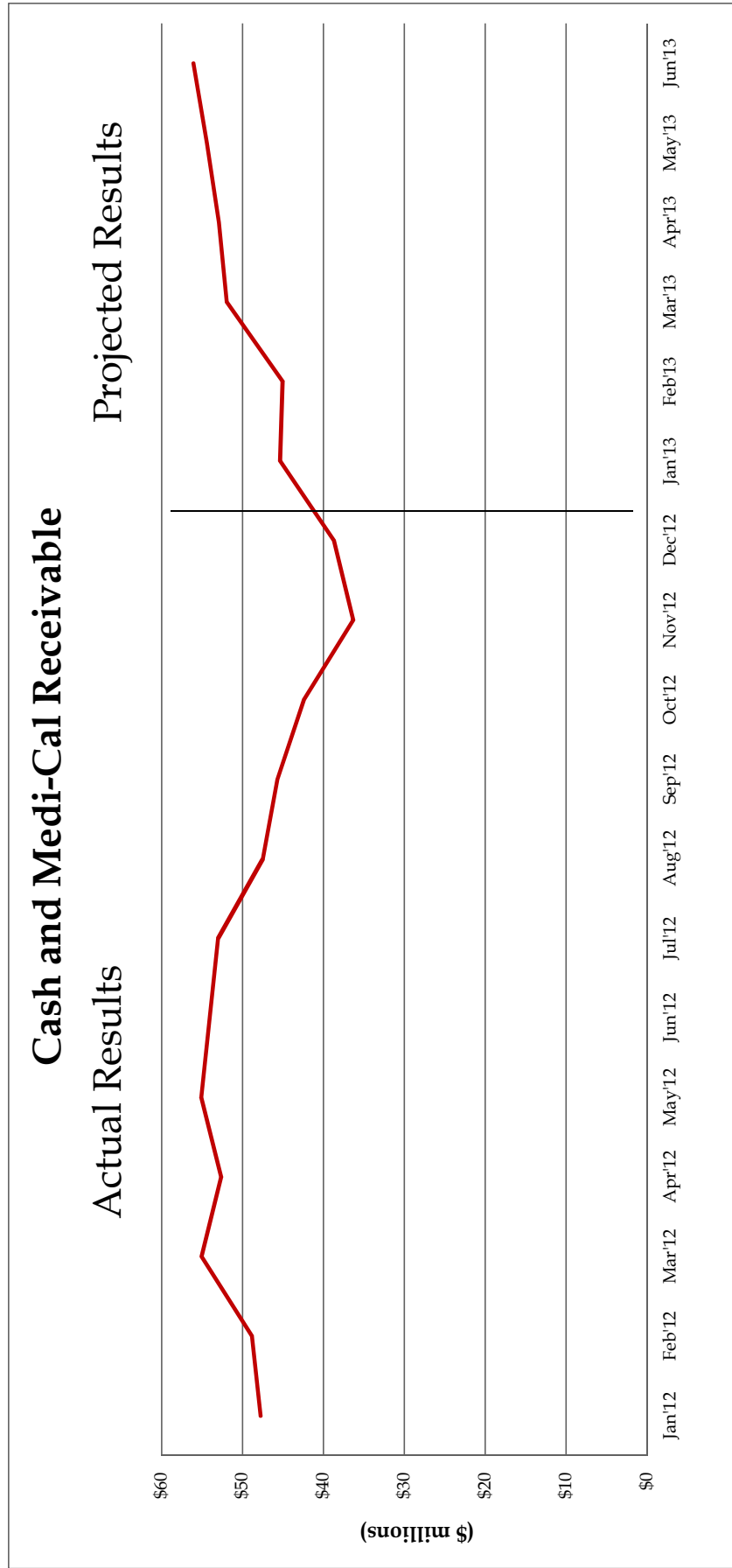


## Key Driver of Balance Sheet:

- **Cash & Medi-Cal Receivable** – reflects draw of \$2.2 million on line of credit.
- **Other Receivable** – reduction in December reflects the receipt of reinsurance recoveries.
- **Other Current Assets** – December reduction reflects a refund from the State for MCO taxes paid.
- **IBNP (Incurred But Not Paid = Incurred But Not Reported + Claims Payable)** – decreased due to continued acceleration and stabilizing of claims payments.
- **Accrued Premium Tax** - refund for MCO tax exceeded what was anticipated, resulting in liability to the State.
- **Accrued Payroll Expense** - transition to in-house payroll and benefits processing completed in December, reflecting normal operations.
- **Notes Payable** - as mentioned above, the Plan drew the \$2.2 million on a line of credit with the County of Ventura.

**Gold Coast Health Plan**  
Cash and Medi-Cal Receivable Trend

Actual 2012												Budget 2013					
Jan'12	Feb'12	Mar'12	Apr'12	May'12	Jun'12	Jul'12	Aug'12	Sep'12	Oct'12	Nov'12	Dec'12	Jan'13	Feb'13	Mar'13	Apr'13	May'13	Jun'13
\$ 47.79	\$ 48.85	\$55.09	\$ 52.67	\$55.12	\$54.08	\$ 53.05	\$47.51	\$ 45.70	\$42.41	\$36.35	\$ 38.73	\$45.36	\$ 45.04	\$51.98	\$52.94	\$54.43	\$ 56.07



**Gold Coast Health Plan**  
**Statement of Cash Flows**  
**Month Ended December 31, 2012**

	<u>DEC'12</u>
Cash Flow From Operating Activities	
Collected Premium	\$ -
Miscellaneous Income	7,899
<u>Paid Claims</u>	
Medical & Hospital Expenses	(21,362,731)
Pharmacy	(1,843,831)
Capitation	(907,950)
Reinsurance of Claims	(667,195)
Reinsurance Recoveries	
Payment of Withhold / Risk Sharing Incentive	
Paid Administration	(2,248,058)
Repay Initial Net Liabilities	
MCO Taxes Expense	1,774,300
Net Cash Provided/ (Used) by Operating Activities	<b>(25,247,565)</b>
Cash Flow From Investing/Financing Activities	
Proceeds from Line of Credit	2,200,000
Repayments on Line of Credit	-
Net Acquisition of Property/Equipment	-
Net Cash Provided/(Used) by Investing/Financing	<b>2,200,000</b>
<b>Net Cash Flow</b>	<b><u>\$ (23,047,565)</u></b>
Cash and Cash Equivalents (Beg. of Period)	36,352,153
Cash and Cash Equivalents (End of Period)	13,304,588
	<b><u>\$ (23,047,565)</u></b>
Adjustment to Reconcile Net Income to Net Cash Flow	
Net (Loss) Income	1,606,322
Depreciation & Amortization	3,554
Decrease/(Increase) in Receivables	(24,264,500)
Decrease/(Increase) in Prepaids & Other Current Assets	971,395
(Decrease)/Increase in Payables	(575,163)
(Decrease)/Increase in Other Liabilities	(80,000)
Change in MCO Tax Liability	604,422
Changes in Claims and Capitation Payable	(1,668,765)
Changes in IBNR	(1,844,828)
	<u>(25,247,565)</u>
<b>Net Cash Flow from Operating Activities</b>	<b><u>\$ (25,247,565)</u></b>

**Gold Coast Health Plan**  
**Statement of Cash Flows**  
Six Months Ended December 31, 2012

	<u>DEC '12 YTD</u>
Cash Flow From Operating Activities	
Collected Premium	\$ 153,256,917
Miscellaneous Income	73,394
<u>Paid Claims</u>	
Medical & Hospital Expenses	(130,048,429)
Pharmacy	(19,670,021)
Capitation	(4,164,085)
Reinsurance of Claims	(1,617,125)
Reinsurance Recoveries	-
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(12,274,675)
Repay Initial Net Liabilities	-
MCO Taxes Expense	-
Net Cash Provided/(Used) by Operating Activities	<b>(14,444,023)</b>
Cash Flow From Investing/Financing Activities	
Proceeds from Line of Credit	2,200,000
Repayments on Line of Credit	-
Net Acquisition of Property/Equipment	(5,487)
Net Cash Provided/(Used) by Investing/Financing	<b>2,194,513</b>
<b>Net Cash Flow</b>	<b><u>\$ (12,249,510)</u></b>
Cash and Cash Equivalents (Beg. of Period)	25,554,098
Cash and Cash Equivalents (End of Period)	13,304,588
	<b><u>\$ (12,249,510)</u></b>
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	(1,840,615)
Depreciation & Amortization	21,238
Decrease/(Increase) in Receivables	7,745,881
Decrease/(Increase) in Prepaids & Other Current Assets	(722,793)
(Decrease)/Increase in Payables	1,880,363
(Decrease)/Increase in Other Liabilities	(480,000)
Change in MCO Tax Liability	1,558
Changes in Claims and Capitation Payable	(3,238,886)
Changes in IBNR	(17,810,768)
	<u>(14,444,023)</u>
<b>Net Cash Flow from Operating Activities</b>	<b><u>\$ (14,444,023)</u></b>

GOLD COAST HEALTH PLAN  
FINANCIAL INDICATORS

	<u>12/31/12</u>	<u>11/30/12</u>	<u>6/30/12</u>
Current Ratio	90.4%	83.8%	93.0%
Days Cash on Hand	17	45	30
Days Cash + State Capitation Receivable	48	45	64
Operating Margin	6.3%	3.7%	-0.5%
Medical Loss Ratio	85.9%	88.2%	94.3%



## APPENDIX



**Gold Coast Health Plan**  
**Income Statement Comparison**  
For The Period Ended December 31, 2012

	2012 Actual Monthly Trend			December 2012		
	Sep	Oct	Nov	Month-To-Date		Variance
				Actual	Budget	Fav/(Unfav)
<b>Membership</b>	96,669	96,447	96,907	97,745	96,495	1,250
<b>Revenue:</b>						
Premium	\$ 23,459,154	\$ 25,524,694	\$ 25,519,637	\$ 25,759,968	\$ 25,733,880	\$ 26,088
Reserve for Rate Reduction	894,648	(126,771)	(128,543)	(129,959)	(126,943)	(3,016)
MCO Premium Tax	584,793	(635)	(37)	21	(772)	793
<b>Total Net Premium</b>	<b>24,938,595</b>	<b>25,397,288</b>	<b>25,391,057</b>	<b>25,630,030</b>	<b>25,606,165</b>	<b>23,865</b>
<b>Other Revenue:</b>						
Interest Income	11,519	13,390	9,004	7,899	15,440	(7,541)
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	0
<b>Total Other Revenue</b>	<b>49,853</b>	<b>51,724</b>	<b>47,337</b>	<b>46,233</b>	<b>53,773</b>	<b>(7,540)</b>
<b>Total Revenue</b>	<b>24,988,448</b>	<b>25,449,011</b>	<b>25,438,394</b>	<b>25,676,263</b>	<b>25,659,938</b>	<b>16,325</b>
<b>Medical Expenses:</b>						
<u>Capitation</u>	620,832	755,447	907,950	917,020	945,701	28,681
<u>Incurred Claims:</u>						
Inpatient	4,249,910	4,592,634	4,542,801	4,093,335	4,479,419	386,084
LTC/SNF	6,291,550	6,933,988	6,858,363	6,228,689	6,932,642	703,953
Outpatient	2,561,831	2,750,021	2,735,387	2,458,657	2,835,129	376,472
Laboratory and Radiology	215,187	231,690	229,447	206,113	233,715	27,602
Emergency Room Facility Services	497,489	533,516	529,753	474,523	538,643	64,120
Physician Specialty Services	1,940,550	2,280,039	2,111,295	1,838,999	1,908,199	69,200
Pharmacy	3,138,389	3,485,563	3,251,427	3,180,407	3,133,998	(46,409)
Other Medical Professional	274,599	288,240	288,957	332,271	255,563	(76,708)
Other Medical Care Expenses	627	606	-	732	-	(732)
Other Fee For Service Expense	1,459,626	1,589,710	1,570,885	1,426,578	1,565,159	138,581
Transportation	284,846	308,025	306,198	275,536	303,736	28,200
Total Claims	20,914,605	22,994,031	22,424,513	20,515,839	22,186,204	1,670,365
Medical & Care Management Expense	534,999	556,393	587,293	560,329	599,938	39,609
Reinsurance	223,207	225,239	224,722	225,793	233,477	7,684
Claims Recoveries	-	(64,218)	(1,711,511)	(150,917)	-	150,917
Sub-total	758,206	717,413	(899,496)	635,205	<b>833,415</b>	198,210
<b>Total Cost of Health Care</b>	<b>22,293,643</b>	<b>24,466,891</b>	<b>22,432,967</b>	<b>22,068,065</b>	<b>23,965,320</b>	<b>1,897,255</b>
<b>Contribution Margin</b>	<b>2,694,805</b>	<b>982,120</b>	<b>3,005,427</b>	<b>3,608,198</b>	<b>1,694,618</b>	<b>1,913,580</b>
<b>General &amp; Administrative Expenses:</b>						
Salaries and Wages	268,413	388,828	323,624	354,451	307,499	(46,952)
Payroll Taxes and Benefits	64,735	62,808	72,886	88,331	108,017	19,686
Total Travel and Training	11,156	6,690	5,784	2,996	4,893	1,897
Outside Service - ACS	942,882	890,492	1,052,244	916,305	929,597	13,292
Outside Service - RGS	-	245	-	-	0	-
Outside Services - Other	109,202	104,166	17,311	44,810	24,564	(20,246)
Accounting & Actuarial Services	9,818	85,290	44,311	37,529	5,000	(32,529)
Legal Expense	42,522	12,196	67,921	41,114	32,350	(8,764)
Insurance	10,766	10,792	11,846	9,245	10,792	1,547
Lease Expense - Office	11,869	18,289	15,879	15,977	16,630	653
Consulting Services Expense	112,076	191,975	330,613	379,747	357,897	(21,850)
Translation Services	819	2,812	590	4,101	765	(3,336)
Advertising and Promotion Expense	-	3,150	-	2,645	2,500	(145)
General Office Expenses	56,656	84,636	78,657	48,327	44,926	(3,401)
Depreciation & Amortization Expense	6,958	3,554	3,561	3,554	3,741	187
Printing Expense	1,727	2,538	1,670	1,276	1,871	595
Shipping & Postage Expense	230	21	606	21,825	475	(21,350)
Interest Exp	56,424	100,407	37,812	29,643	5,700	(23,943)
<b>Total G &amp; A Expenses</b>	<b>1,706,253</b>	<b>1,968,888</b>	<b>2,065,315</b>	<b>2,001,876</b>	<b>1,857,217</b>	<b>(144,659)</b>
<b>Net Income / (Loss)</b>	<b>\$ 988,552</b>	<b>\$ (986,767)</b>	<b>\$ 940,112</b>	<b>\$ 1,606,322</b>	<b>\$ (162,599)</b>	<b>\$ 1,768,921</b>

**Gold Coast Health Plan**  
**PMPM Income Statement Comparison**  
**For The Period Ended December 31, 2012**

	2012 Actual Monthly Trend			Nov'12 Month-To-Date		Variance
	Sep	Oct	Nov	Actual	Budget	Fav/(Unfav)
<b>Members (Member/Months)</b>	96,669	96,447	96,907	97,745	96,495	1,250
<b>Revenue:</b>						
Premium	240.00	261.14	261.08	263.54	266.69	(3.14)
Reserve for Rate Reduction	9.15	(1.30)	(1.32)	(1.33)	(1.32)	(0.01)
MCO Premium Tax	5.98	(0.01)	(0.00)	0.00	(0.01)	0.01
<b>Total Net Premium</b>	<b>255.14</b>	<b>259.83</b>	<b>259.77</b>	<b>262.21</b>	<b>265.36</b>	<b>(3.15)</b>
<b>Other Revenue:</b>						
Interest Income	0.12	0.14	0.09	0.08	0.16	(0.08)
Miscellaneous Income	0.39	0.39	0.39	0.39	0.40	(0.01)
<b>Total Other Revenue</b>	<b>0.51</b>	<b>0.53</b>	<b>0.48</b>	<b>0.47</b>	<b>0.53</b>	<b>(0.06)</b>
<b>Total Revenue</b>	<b>255.65</b>	<b>260.36</b>	<b>260.25</b>	<b>262.69</b>	<b>265.92</b>	<b>(3.23)</b>
<b>Medical Expenses:</b>						
<u>Capitation</u>	6.35	7.73	9.29	9.38	9.80	(0.42)
<u>Incurred Claims:</u>						
Inpatient	43.48	46.99	46.48	41.88	46.42	(4.54)
LTC/SNF	64.37	70.94	70.17	63.72	71.84	(8.12)
Outpatient	26.21	28.13	27.98	25.15	29.38	(4.23)
Laboratory and Radiology	2.20	2.37	2.35	2.11	2.42	(0.31)
Emergency Room Facility Services	5.09	5.46	5.42	4.85	5.58	(0.73)
Physician Specialty Services	19.85	23.33	21.60	18.81	19.78	(0.96)
Pharmacy	32.11	35.66	33.26	32.54	32.48	0.06
Other Medical Professional	2.81	2.95	2.96	3.40	2.65	0.75
Other Medical Care Expenses	0.01	0.01	-	0.01	-	0.01
Other Fee For Service Expense	14.93	16.26	16.07	14.59	16.22	(1.63)
Transportation FFS	2.91	3.15	3.13	2.82	3.15	(0.33)
Total Claims	213.97	235.25	229.42	209.89	229.92	(20.03)
Medical & Care Management	5.47	5.69	6.01	5.73	6.22	(0.48)
Reinsurance	2.28	2.30	2.30	2.31	2.42	(0.11)
Claims Recoveries	-	(0.66)	(17.51)	(1.54)	-	(1.54)
Sub-total	7.76	7.34	(9.20)	6.50	8.23	(1.74)
<b>Total Cost of Health Care</b>	<b>230.62</b>	<b>253.68</b>	<b>231.49</b>	<b>225.77</b>	<b>248.36</b>	<b>(22.59)</b>
<b>Contribution Margin</b>	<b>27.88</b>	<b>10.18</b>	<b>31.01</b>	<b>36.91</b>	<b>17.56</b>	<b>19.35</b>
<b>Administrative Expenses</b>						
Salaries and Wages	2.75	3.98	3.31	3.63	3.19	0.44
Payroll Taxes and Benefits	0.66	0.64	0.75	0.90	1.12	(0.22)
Total Travel and Training	0.11	0.07	0.06	0.03	0.05	(0.02)
Outside Service - ACS	9.65	9.11	10.77	9.37	9.63	(0.26)
Outside Services - Other	1.12	1.07	0.18	0.46	0.25	0.20
Accounting & Actuarial Services	0.10	0.87	0.45	0.38	0.05	0.33
Legal Expense	0.44	0.12	0.69	0.42	0.34	0.09
Insurance	0.11	0.11	0.12	0.09	0.11	(0.02)
Lease Expense -Office	0.12	0.19	0.16	0.16	0.17	(0.01)
Consulting Services Expense	1.15	1.96	3.38	3.89	3.71	0.18
Translation Services	0.01	0.03	0.01	0.04	0.01	0.03
Advertising and Promotion Expense	-	0.03	-	0.03	0.03	0.00
General Office Expenses	0.58	0.87	0.80	0.49	0.47	0.03
Depreciation & Amortization Expense	0.07	0.04	0.04	0.04	0.04	(0.00)
Printing Expense	0.02	0.03	0.02	0.01	0.02	(0.01)
Shipping & Postage Expense	0.00	0.00	0.01	0.22	0.00	0.22
Interest Exp	0.58	1.03	0.39	0.30	0.06	0.24
<b>Total Administrative Expenses</b>	<b>17.46</b>	<b>20.14</b>	<b>21.13</b>	<b>20.48</b>	<b>19.25</b>	<b>1.23</b>
<b>Net Income / (Loss)</b>	<b>10.11</b>	<b>(10.10)</b>	<b>9.62</b>	<b>16.43</b>	<b>(1.69)</b>	<b>18.12</b>

**Gold Coast Health Plan**  
**Income Statement Comparison**  
For The Six Months Ended December 31, 2012

	Dec'12 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
<b>Membership</b>	580,105	578,419	1,686
<b>Revenue:</b>			
Premium	\$ 150,152,305	\$ 150,336,484	\$ (184,179)
Reserve for Rate Reduction	(665,337)	(660,702)	(4,634)
MCO Premium Tax	(1,558)	(3,086)	1,528
<b>Total Net Premium</b>	<b>149,485,410</b>	<b>149,672,695</b>	<b>(187,285)</b>
<b>Other Revenue:</b>			
Interest Income	73,394	87,369	(13,975)
Miscellaneous Income	230,000	230,000	(0)
<b>Total Other Revenue</b>	<b>303,394</b>	<b>317,369</b>	<b>(13,975)</b>
<b>Total Revenue</b>	<b>149,788,804</b>	<b>149,990,064</b>	<b>(201,261)</b>
<b>Medical Expenses:</b>			
<u>Capitation</u>	4,447,828	4,514,035	66,207
<u>Incurred Claims:</u>			
Inpatient	27,204,449	27,526,215	321,766
LTC/SNF	41,271,134	42,049,585	778,452
Outpatient	16,341,614	16,817,137	475,522
Laboratory and Radiology	1,372,309	1,404,133	31,824
Emergency Room Facility Services	3,164,852	3,237,735	72,882
Physician Specialty Services	12,603,769	12,469,476	(134,292)
Pharmacy	19,700,232	19,535,662	(164,570)
Other Medical Professional	1,793,022	1,682,861	(110,161)
Other Medical Care Expenses	4,311	-	(4,311)
Other Fee For Service Expense	9,435,805	9,571,982	136,177
Transportation	1,830,109	1,855,792	25,683
Total Claims	134,721,606	136,150,578	1,428,972
Medical & Care Management Expense	3,296,895	3,335,215	38,319
Reinsurance	1,348,893	28,955	(1,319,938)
Claims Recoveries	(3,198,751)	-	3,198,751
Sub-total	1,447,038	3,364,170	1,917,132
<b>Total Cost of Health Care</b>	<b>140,616,473</b>	<b>144,028,784</b>	<b>3,412,311</b>
<b>Contribution Margin</b>	<b>9,172,331</b>	<b>5,961,281</b>	<b>3,211,050</b>
<b>General &amp; Administrative Expenses:</b>			
Salaries and Wages	1,955,200	1,945,825	(9,375)
Payroll Taxes and Benefits	552,980	528,889	(24,091)
Total Travel and Training	35,074	32,282	(2,792)
Outside Service - ACS	5,522,963	5,421,917	(101,046)
Outside Service - RGS	23,674	23,674	0
Outside Services - Other	296,837	278,774	(18,063)
Accounting & Actuarial Services	195,067	133,228	(61,839)
Legal Expense	181,821	137,486	(44,335)
Insurance	49,497	49,990	493
Lease Expense - Office	85,752	87,156	1,404
Consulting Services Expense	1,261,457	1,306,624	(45,167)
Translation Services	9,427	6,265	(3,162)
Advertising and Promotion Expense	9,295	9,150	(145)
General Office Expenses	403,373	364,917	(38,456)
Depreciation & Amortization Expense	21,238	21,498	260
Printing Expense	32,135	40,523	8,388
Shipping & Postage Expense	38,789	19,567	(19,222)
Interest Exp	338,366	281,676	(56,690)
<b>Total G &amp; A Expenses</b>	<b>11,012,946</b>	<b>10,689,441</b>	<b>(323,505)</b>
<b>Net Income / (Loss)</b>	<b>\$ (1,840,615)</b>	<b>\$ (4,728,160)</b>	<b>\$ 3,534,555</b>



### **AGENDA ITEM 3a**

To: Gold Coast Health Plan Commissioners  
From: Michael Engelhard, Chief Executive Officer  
Date: February 28, 2013  
RE: County Line Of Credit (LOC) Support

#### **SUMMARY:**

In the event an agreement is needed and can be reached with the County of Ventura and pending appropriate County approvals, this action requests the authorize the Chief Executive Officer to enter into an LOC contract with the County of Ventura.

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

In October 2012, Gold Coast Health Plan received a corrective action plan (CAP) from DHCS. A key finding in the CAP was GCHP was deficient in meeting its TNE requirements. The Department expressed concerns about GCHP's ability to meet the required 100% TNE level prior to the June 30, 2014 target date.

As part of the Plan's response to the CAP in addressing the TNE deficiency, the Plan submitted a financial forecast indicating steps the Plan will take to improve its financial operations and become TNE compliant on or before June 30, 2014.

Included in the financial forecast to address the Plan's existing TNE deficiency, the forecast assumes an additional temporary capital contribution from the County of Ventura. The County had previously committed \$2.2 million in the form of a subordinated debt Line of Credit on May 10, 2011. As part of the plan to fix the Plan's TNE shortfall, GCHP drew down the entire \$2.2 million in December 2012.

It is anticipated that the terms of the new LOC would be similar to those of the original LOC. The amount of the additional County support is to be determined. The Plan will repay the County both LOC's in accordance to the terms of each agreement and once the Plan has achieved TNE sufficiency and stability

As of December 31, 2012, GCHP reported having a TNE deficiency of \$13,654,721 (per statutory Orange Blank filings).

**FISCAL IMPACT:**

The interest rate on the LOC is not known at this time. The primary fiscal impact will be an improvement in the Plan's TNE position relative to its state contract requirements.

**RECOMMENDATION:**

Authorize the CEO to enter into a Letter of Credit contract with the County of Ventura to partially address the Plan's TNE contractual requirements.

**CONCURRENCE:**

N/A.

**Attachments:**

None.

### **AGENDA ITEM 3b**

To: Gold Coast Health Plan Commission

From: Michael Engelhard, Chief Executive Officer

Date: February 25, 2013

RE: Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT)

#### **SUMMARY:**

Authorize and direct the Chief Executive Officer to enter into the necessary agreements with the Ventura County Medical Center (VCMC) or other appropriate County agency and the California Department of Health Care Services (DHCS) to secure additional Medi-Cal Funds through an Intergovernmental Transfer (IGT)

#### **BACKGROUND:**

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

To accomplish an IGT, a County, or a taxing authority such as a district hospital, provides funds to the State Department of Health Care Services (DHCS). The federal government then matches those funds according to a set formula. The State uses these combined funds to increase the rates it pays to the local Medi-Cal managed care plan consistent with the Plan's actuarially determined payment rates. The funding entity recoups the original outlay of funds and the federal match to those funds.

#### **DISCUSSION:**

The proposed IGT would involve an initial transfer of funds from the funding entity to DHCS. The DHCS would then use these funds to leverage a federal match at the Federal Medical Assistance Percentages (FMAP) rate in effect during Fiscal Year 2011-12.

Subsequently, Gold Coast Health Plan would receive an increased capitation via a rate amendment to the Primary Agreement between Gold Coast Health Plan and DHCS. Gold Coast Health Plan would return the original funds to the funding entity. In the case of this initial IGT, the federal match portion would remain for a period of time with GCHP.

Subject to CMS and DHCS approval, these funds could be used to partially address GCHP's regulatory TNE deficit. Ensuring the financial viability and stability of GCHP is consistent with the State of California's desire to use managed care as a means to increase access to care, establish coordinated systems of care and medical homes, and to control costs.

If the use of the federal match towards TNE is not approved by DHCS or CMS then these funds would be fully returned to the funding entity.

Subject to DHCS and CMS approval, the implementation of the IGT involves the following three (3) agreements. GCHP would be party to the second and third agreements listed:

1. Agreement between the funding entity and DHCS for the transfer of funds from the funding entity to DHCS;
2. Agreement between Gold Coast Health Plan and the funding entity;
3. Amendment to Primary Agreement with DHCS. This amendment will consist of a rate amendment to account for the increased capitation payment resulting from the IGT between funding entity and DHCS.

DHCS has established templates for these agreements and does not allow revision except in specific areas noted on the templates. The revised agreements would require review and approval by County Counsel and GCHP legal counsel.

**FISCAL IMPACT:**

The fiscal impact is not known at this time. The Plan is waiting for additional analysis from DHCS on the potential size of the IGT funds that would be available to GCHP.

Although the agreement term is one year, there is a potential for renewal in future years.

**RECOMMENDATION:**

1. Subject to review by legal counsel, authorize and direct the Chief Executive Officer to execute an agreement to implement an IGT among the funding entity, GCHP, and the State of California; and,
2. Subject to review by legal counsel, authorize and direct the Chief Executive Officer to Execute an Amendment to the Primary Agreement between DHCS and Gold Coast Health Plan.

**RATIONALE FOR RECOMMENDATION:**

As proposed, the IGT could result in a significant increase in capital to Gold Coast Health Plan to address the Plan's existing TNE deficit.

**CONCURRENCE:**

N/A.

**Attachments:**

None.



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

# 2012 Quality Improvement Annual Report

Charles Cho, MD  
Chief Medical Officer

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





# Mission of GCHP

## Quality Improvement (QI) Program

- To improve the health and well-being of the people of Ventura County by providing access to high quality medical services.
- To achieve that goal, the QI Program will strive to continuously improve the care and quality of service for its members in partnership with its contracted quality provider network.

# The practice of best quality medicine is the most cost effective.

Who are the quality providers?

- Good diagnosticians make correct diagnoses
- They practice quality medicine producing the best outcome in patient care
- They avoid unnecessary tests, procedures and referrals.
- Quality medical practice is most cost effective – which is our objective in managing patient care

# QI Program promotes & adheres to these principles:

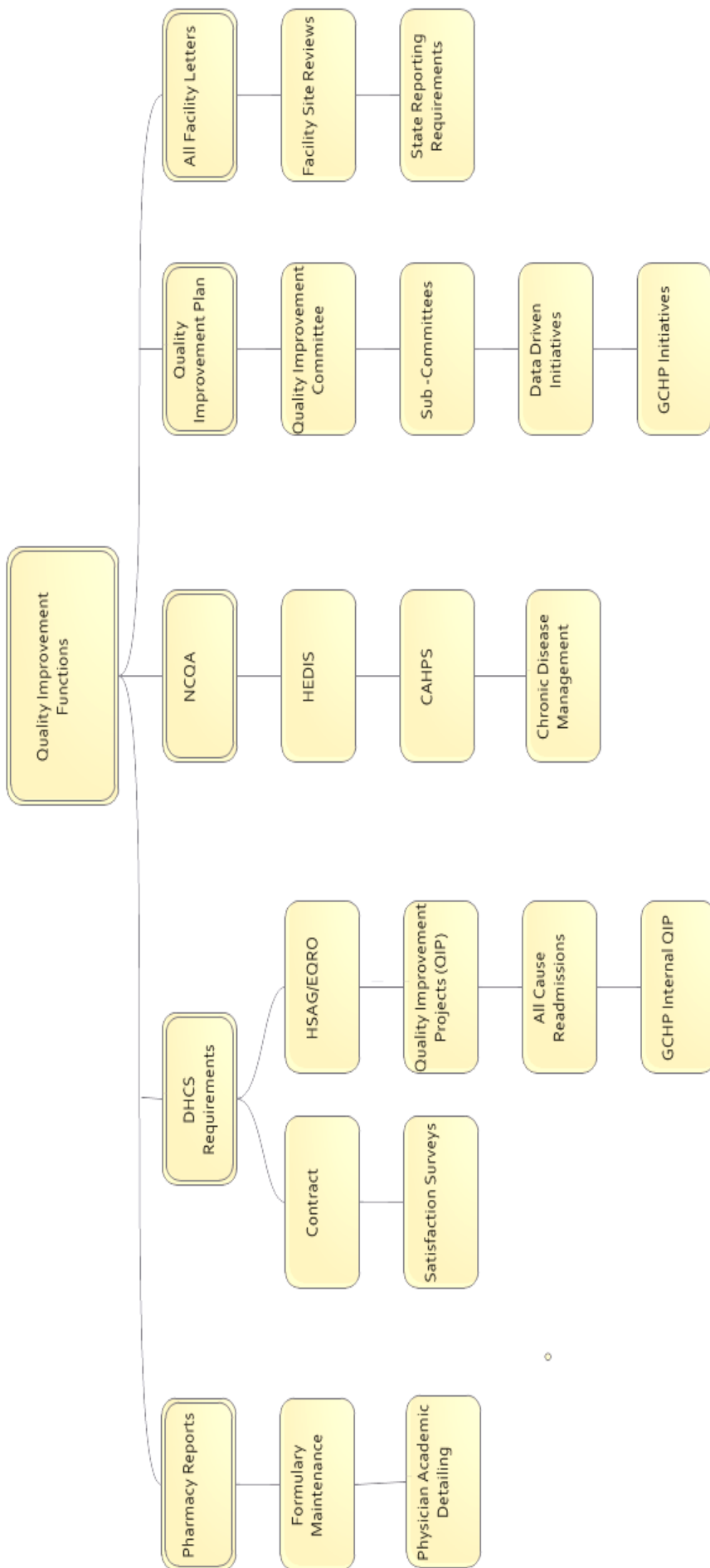
- Health Plan's duty is to provide proper tools
- Policies and procedures that are user friendly and yet least onerous for providers to participate. Classic example: Direct referral system, which provides ready access to care
  - good quality medical practice
- Satisfied physicians take care of their patients with enthusiasm which results in good outcome for their patients providing best quality care

# Quality Improvement Department

had a delayed start due to other pressing need of priorities in going live

- QI Director, Julie Booth, hired in April of 2012.
- A credible staff has been assembled.
- State report deadlines have all been met
- Is prepared to tackle huge tasks.

# GCHP QI Functional Chart



QI FUNCTIONS

# QIC Accomplishments and Activities

- Facility Site Reviews completed.
- First HEDIS submission in process.
- Participation in State's Readmission Rates Improvement Project .

## QIC Activities (continued)

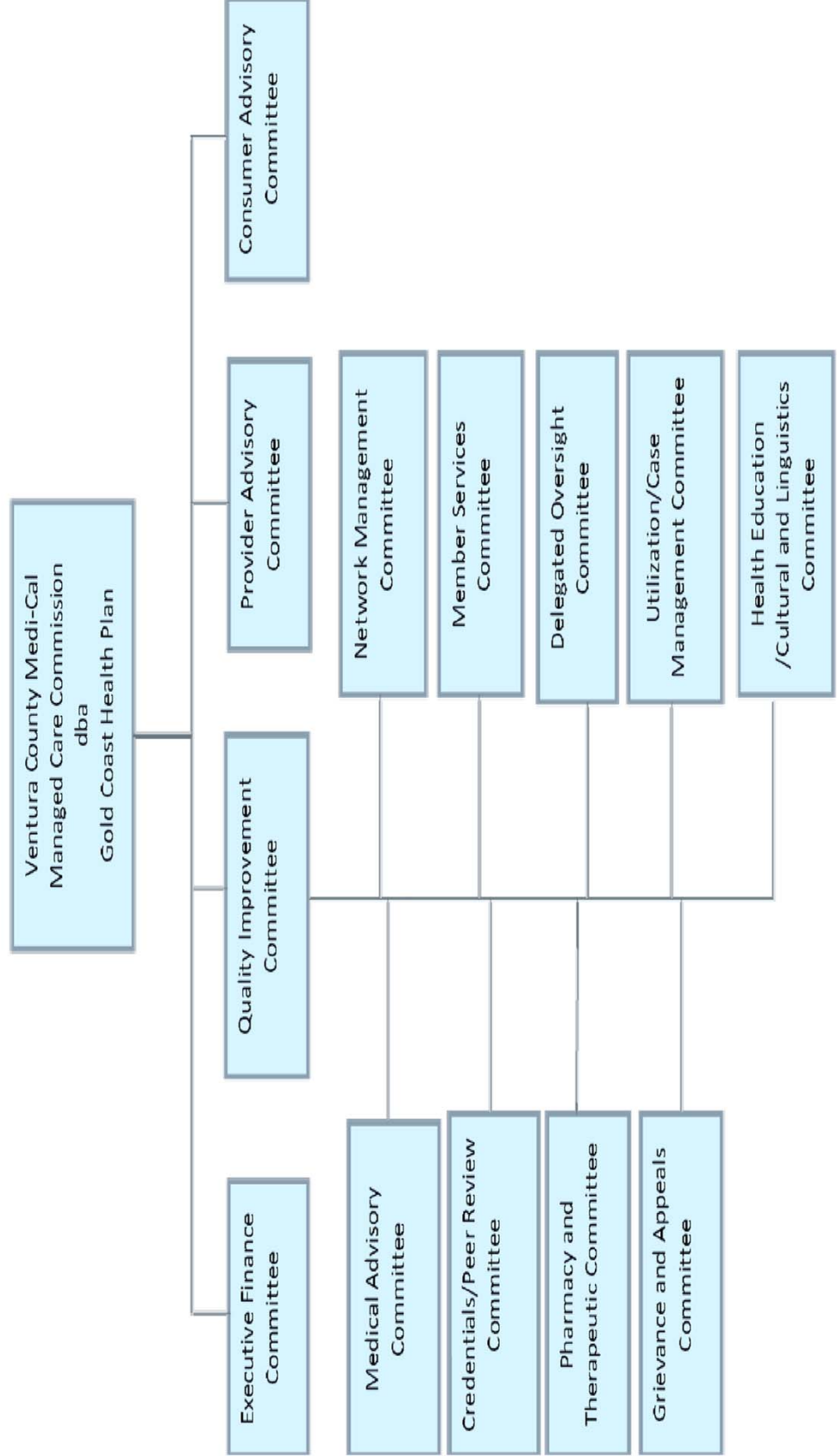
- Our other QI measures in process include:
  - Improvement in smoking cessation
  - Improvement of pain management – currently looking at low back pain for our first pain management initiative
  - Improvement in appropriate utilization of emergency room and urgent care
  - Improvement in patient education
  - Improvement in provider education; particularly HEDIS measures

## QI Plan Committees

- QI Committee (QIC) is chaired by the CMO
- And has 9 sub-committees



# QI Plan Committees



# Quality Improvement Plan Sub-Committees

Chair – Charles Cho, M.D.

- Pharmacy & Therapeutics (P&T) Committee
- Credentials and Peer Review Committee
- Medical Advisory Committee

# Pharmacy & Therapeutics (P&T) Committee Accomplishments

One of the most robust and successful activities at GCHP

## Ingredients for Success

- 1) 14 members representing most all specialties having drug expertise in their respective field
- 2) The formulary was the key for success - user friendly

## (P&T) Committee Accomplishments

(continued)

- 3) The generic drug use percentage is at 85%
  - top among COHS
- 4) Timely and reliable reports by Script Care pointing to the areas of interest such as the top 15 most expensive drugs
- 5) At the same time a good number of new drugs were added when appropriate

## (P&T) Committee Accomplishments

(continued)

- 6) Quarterly Pharmacy Newsletters
  - Informative and educational
- Efforts to keep expenses at \$31.00 pmpm or less
  - or within 14% of total budget -
    - that is the industry average

# Credentials and Peer Review Committee Accomplishments

- 8 physician members
- Most members are Medical Directors of hospitals or major clinics, who have been involved in credentialing processes.
- This made the operation of this committee smooth and efficient, adding quality providers to the network.

# Medical Advisory Committee (MAC)

## Accomplishments

- 14 members representing various disciplines of medicine
- The primary function: to analyze, advise, recommend & make policy decisions on all matters pertaining to medical management.
- Topics in 2012 included:
  - Utilization management prior authorization list
  - HEDIS practice guidelines
  - Nutritional supplements
  - Bariatric surgery
  - Telemedicine

# Quality Improvement Plan

## Sub-Committees (continued)

- Nancy Wharfield, MD; Medical Director,  
Health Services chairs
  - Utilization Management/Case Management  
(UM/CM) Committee
  - Grievance & Appeals Committee



# Utilization Management (UM) and Case Management (CM) Committee

- Some UM reports are now available:
  - Hospital Days/1000 is 384.3, which is higher than other COHS.
  - Average length of hospital stay is 5.13 days.
  - Top ER diagnosis is URI.
  - About half of ER visits are children ages 0-19.
- As reports begin to emerge, the data will need to be validated, after which they can be utilized for decision making

## UM / CM Committee

(continued)

- During the last 6 months the Department added more staff for case management
- Need for more C/M staff is anticipated
- Beginning 10/1/12, transition of nearly 1,000 Adult Day Health Care Center members into CBAS was successfully carried out

# Grievances & Appeals (G&A) Committee

- Dr. Wharfield was recently named Chair
- In the process of establishing trend reports such as for member services vs clinical grievances.

# Quality Improvement Plan

## Sub-Committees (continued)

- Member Services Committee
  - Chair - Andre Galvan; Manager, Member Services
- Network Management Committee
  - Chair - Sherri Bennett; Manager, Provider Network
- Delegation Oversight Committee
  - Robert Franco; Project Manager, Delegation Oversight
- Education and Cultural Linguistics Committee
  - Chair – Lupe Gonzalez, PhD; Manager, Health Education, Cultural Linguistics & Disease Management

# Any questions?



## Gold Coast Health Plan Annual Quality Improvement Committee Report

The mission and purpose of the Gold Coast Health Plan Quality Improvement Program 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, the GCHP QI Program will strive to continuously improve the care and quality of service for its members in partnership with its contracted provider network.

The Quality Improvement ((QI) Program involves all aspects of GCHP operations and is therefore organized to include virtually all of the departments, as shown on the Organization Chart.

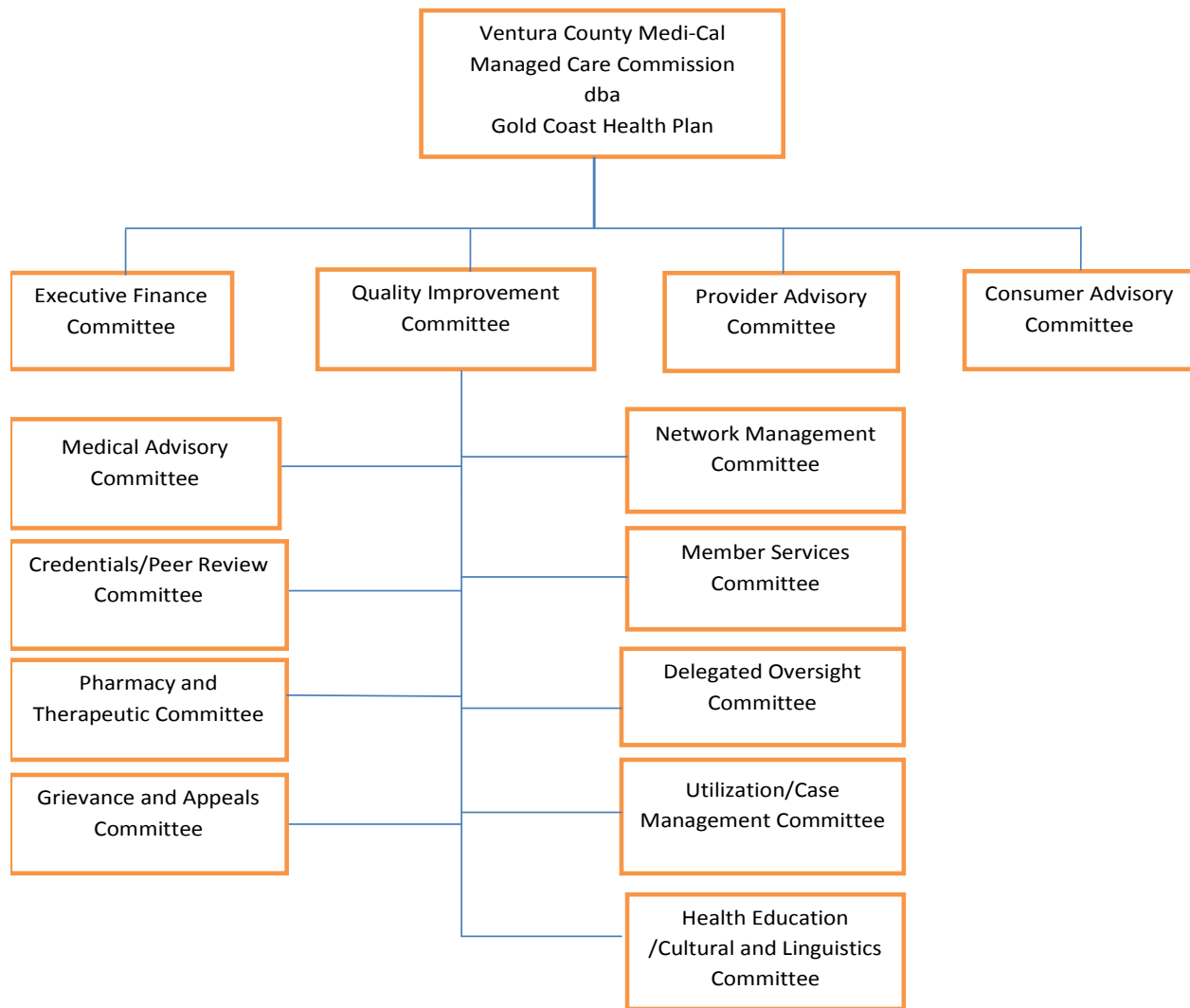
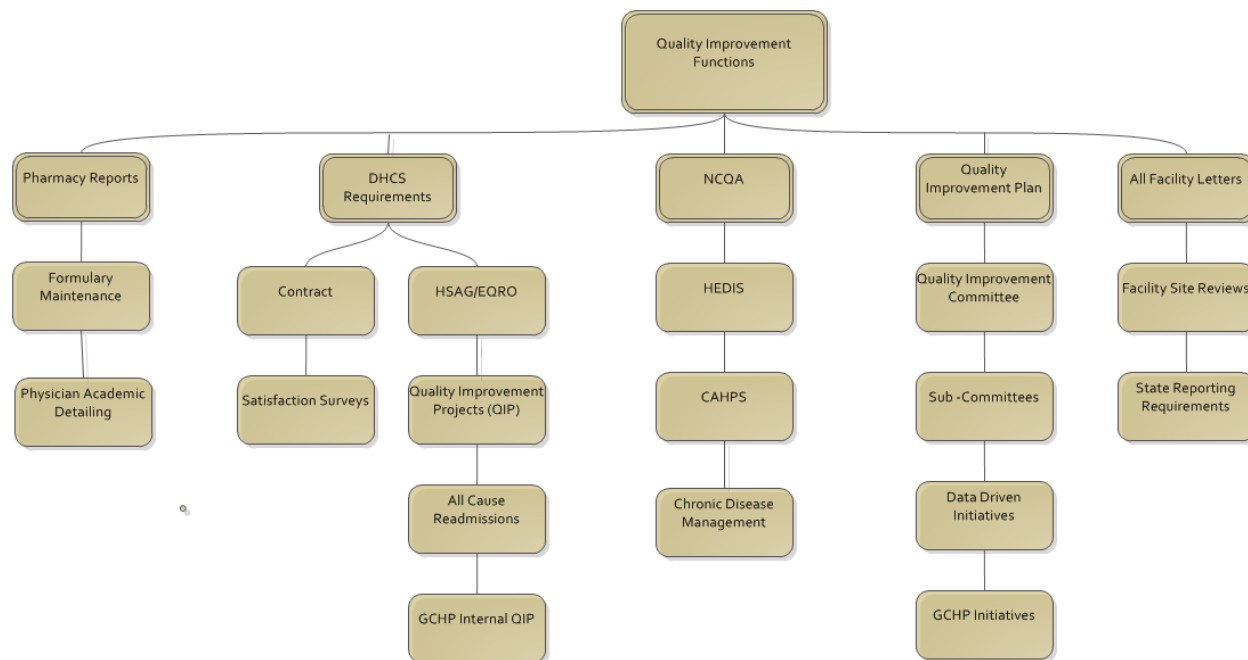


Chart from QI Plan (attached) Page 25

The Quality Improvement Department had a rather late start, due to recruitment difficulty in filling the position of its Director. Julie Booth came on board in April of 2012 and has organized the Department (see functional chart below) well with all the key staff employed in their respective positions.



#### QI FUNCTIONS

The following will briefly report on each of the committees. More detailed information is also available in its last Committee meeting minutes of 12/14/12, which is attached.

- 1) **Quality Improvement Committee:** Their activities and accomplishment include:
  - a) Adoption of revised QI Plan at its last Committee meeting of 12/14/13. (see attached) Facility Site Review surveys are up to date. A Site Review Nurse is in process of receiving her certification.
  - b) An upcoming major project in process is the mandated HEDIS measures for 2013, which will tell us how well our provider network is doing in delivering care for our members.
  - c) Currently, we are participating on the State's mandated quality improvement project (QIP) to decrease hospital readmissions.
  - d) Currently, the Department is participating in QI measures that include:
    - Smoking cessation in support of P & T and Health Education Committees.
    - Improvement in patient education.
    - Improvement in provider education, particularly HEDIS measures.
    - Improvement in reporting quality improvement measures using statistical process control.
    - Validation of data used for quality reporting.
- 2) **Pharmacy and Therapeutic (P & T) Committee:** 14 members, representing most all specialties. They render expertise in their respective field of drug uses. The pharmacy program has been one of the most robust and successful activities at GCHP. The success can be attributable to following:
  - The formulary was structured to include sufficient choices for all therapeutic categories. In addition, special attention was paid to make it user friendly so that each physician can readily select the effective and most cost effective drugs among available choices.

- Its expenses have been kept at less than \$31.00/PMPM for the last 18 months of our operation. This is at or less than average when compared with five other COHS, which have been in operation for many more years.
  - The generic drug use percentage has been consistently excellent now at 85%. This is the top among CHOS. I attribute this remarkable feat to well-educated and sophisticated physicians in GCHP network, who know how to select the most cost effective drugs among available options listed on the formulary.
  - The key to this good utilization control of drugs is due to excellent and timely reports that Script Care, our PBM, has been providing to us from very beginning of our operation This enabled our management team and the P & T Committee to review and evaluate the main areas of interest such as the top 15 most expensive drugs. Many expensive drugs are well worth spending when their use saves lives while preventing more costly hospitalizations. However, we have been able to identify several \$1 million dollars per year drugs that were no better in clinical efficacy than much cheaper drugs of same class that the P & T Committee was able to delete from the formulary. Again, this was possible mainly because of the excellent reports pointing to the areas that needed actions on.
  - At the same time GCHP has also been adding a good number of new drugs to the formulary, when appropriate. Providing broad spectrum of necessary drugs is a quality issue, which has not been compromised at GCHP.
  - I believe the success of this department can be measured in one way; that is there has rarely been any provider complaint concerning restrictions placed on certain drugs requiring prior authorizations. This would indicate that these restrictions have been reasonable and fair to them.
  - In addition, there has been good communication with providers through the quarterly Pharmacy Newsletters informing them of pertinent items of interest. These have been not only informative but also educational.
- 3) Credentials Committee: 8 physician members. Most of them are either medical directors of hospitals or major clinics, who have been involved in credentialing processes. This made the operation of this committee smooth and efficient adding quality providers to the network. This group has credentialed all the network physicians carefully reviewing each file for quality of care and service.
- 4) Medical Advisory Committee: 14 members, representing various discipline of medicine. The primary function of this committee is to advise, recommend and make policy decisions on all matters pertaining to utilization management. This Committee has worked on approving the prior authorization list, HEDIS measurement guidelines for patient care and documentation, and most recently, is discussing telemedicine, to name a few examples.
- 5) Utilization and Management Committee:
- The focus of the Utilization and Management (UM)/Case Management (CM) has been on staffing and developing processes. During the last 6 months the Department hired 3 dedicated case managers (one with CCS expertise), 2 nurses (one dedicated to transplants) and one social worker with a strong dialysis background. Future CM focus will be for chronic disease management and medication issues. This will necessitate additional staffs.
  - Some UM reports from Milliman are now available: Hospital Days/1000 is 384.3, which is higher than other COHS. Average length of stay is 5.13 days. Top ER diagnosis is URI. About half of ER visits are children ages 0-19. Now that these reports began to emerge, the committee and the Health Services will need to validate the data, after which they can be utilized for UM/CM purposes.
  - Beginning 10/1/12 the Health Services had accomplished a smooth transition of about 800 of the 1200 formally Adult Day Health Care Center members into the new CBAS program. These are mostly feeble and elderly members at high risk, and good case management is essential for preventing bad health outcome.



- 6) Member Services Committee:
  - This Committee reported that the membership data trend report showed a drop in membership in August 2012 due to the State discontinuing the practice of providing retroactive enrollments.
  - The Member Services now routinely tracks the Call Center benchmark goals such as abandonment rates, which is a quality issue. The QIC at its last meeting on 12/14/12 suggested categorizing calls by type/trend/resolution.
- 7) Grievance & Appeals Committee:
  - In the process of establishing trend reports.
- 8) Network Management Committee:
  - In the process of reviewing all provider contracts.
- 9) Delegation Oversight Committee:
  - Delegated Credentialing oversight audit was conducted recently at Clinicas del Camino Real and Community Memorial Hospital. Both passed satisfactorily. GCHP did not have to audit VCMC, as audit results from ICE were used.
- 10) Health Education/Cultural Linguistics Committee:
  - During the months of May and June 2012 GCHP conducted a Group Needs Assessment (GNA) to assess the health education, cultural and linguistic needs of our members. A state approved survey was mailed to a random sample of 10,000 Medi-Cal members, returning 1,362 survey for a 13% response rate. Following were helpful response data:
    - a. To the question of which health topics they wanted to learn more, the top 5 were as follows: Healthy eating (44.0%), Cholesterol or heart health (34.4%), Healthy teeth (33.4%), Diabetes (31.9%), and Exercise (30.2%). On the basis of this, the GCHP Member Newsletter to be mailed in late January of 2013 contains a subject on Cholesterol.
    - b. To the question of how they prefer to get health information from your health plan, overwhelming 78.8% preferred the health information mailed to their homes. The next two methods were through health plan website (10.7%) and email (7.9%).
    - c. For cultural and linguistic services, 52% preferred English and 42% preferred Spanish.
  - This Department is participating in the Quit Smoking program in conjunction with the P & T Committee efforts. Taking advantage of DHCS grant allowing \$20 gift card as an incentive, they are preparing literature to inform patients about this program.
  - Developing health education classes and sponsoring education events. City of Ventura and Housing Authority are providing community room for GCHP to provide education classes to the community which will include educating members on a) GCHP benefits, b) PCP selection, and c) Preventive Care. Ventura County Public Health Agency and St. John's Hospital are participating.

**Action Item**

Board approval of QI Plan

**Quality Improvement Committee**  
**Report to the Board of Commissioners**  
**4<sup>th</sup> Qtr 2012**

**Quality Improvement Committee (QIC):**

1. GCHP is in the process of setting up for the abstraction of the HEDIS measurement data for our first submission. HEDIS vendors are now in place. QI is working with IT to export the claims data to the vendor based on HEDIS specifications. We will also be working with physician offices should a medical record be needed.
2. The Delegation Oversight (DO) Program is in the process of setting up its program for Utilization Review as well as other aspects of DO.
3. A Facility Site Review Nurse was hired and is in training to become what is referred to as a "Master Trainer." A process is also being set up to manage the ongoing facility site reviews (FSR), medical record reviews (MRR) and physical accessibility review survey (PARS).
4. The State mandated Quality Improvement Project (QIP) to avoid readmissions to the acute hospital for Seniors and Persons with Disabilities (SPD) population has been underway. After intense discussion of barriers that need to be overcome to avoid readmission, the consensus recommendation was to focus on the barrier of education at discharge, particularly with medication self-administration. The next step will be to develop improvement interventions which will be discussed at a future meeting.
5. The Quality Improvement Plan was finalized for 2013. There are nine QIC subcommittees as follows.

**Member Services Committee**

1. The Membership Data Trend report showed a drop in membership in August 2012 to due to the State discontinuing the practice of providing retroactive enrollments.

**Grievances & Appeals Committee**

1. Dr. Wharfield will be chairing the G& A Committee in the future.
2. Dr. Fankhauser asked to see more detail in G&A report such as type of G&A.
3. Reports will be developed and presented.

**Network Management Committee**

1. Sherri Bennett's new title was announced: Provider Network Manager over Provider Relations and Contracts.
2. The current physician network system is robust and will begin focus on what new providers GCHP needs to be added to the network.
3. A contracting focus will be on finding cost effective ways of providing services, such as infusion therapy, to members.
4. It was confirmed that GCHP will not need to credential and contract with hospital clinical staff such as radiologists because NCQA doesn't require health plans to credential these types of providers; however, radiologists at free standing facilities will continue to be credentialed and Nurse Practitioners.

### **Delegation Oversight Committee**

1. Reviewed and updated two policies: (1) Utilization Management and (2) Credentialing and Re-credentialing at the Delegation Oversight Committee and will send policies to the State for approval.
2. Clinicas del Camino Real and Community Memorial Hospital both passed their credentialing audits and the results were reviewed at the Delegation Oversight Committee. It was noted the audit results from ICE were used for Ventura County Medical Center so GCHP did not have to audit VCMC.

### **Utilization Management (UM)/Case Management (CM) Committee**

1. UM/CM focus has been on staffing and developing processes. Case Management has hired 3 dedicated Case Managers (one with CCS expertise), two nurses (one dedicated to transplants) and one social worker with a strong dialysis background.
2. With recent data UM/CM can begin to be proactive vs. reactive. Utilization Management reports from Milliman are now available. Hospital days per 1,000 are 384.3. Other COHS show a little lower. Average LOS inpatient stay is 5.13 days. Top ER diagnosis is URI. About half of the ER visits are children ages 0 – 19. Access may be one of the reasons for the high URI ER visits.
3. The future focus for Case Management is chronic disease management and medication issues.

### **Health Education/Cultural Linguistics Committee**

1. Cultural linguistic services are being tracked by a form to track translation services and accuracy of translations to patients.
2. Group Needs Assessment is pending state approval. 52% preferred English and 42% preferred Spanish. 60% of patients under age 20, 25% of patients ages 21-64 and 14% of patients over age 65.
3. Health Education developing health education classes and sponsoring education events. City of Ventura and Housing Authority are providing community rooms for GCHP to provide education classes to the community which will include educating members on 1) GCHP benefits, 2) PCP selection, and 3) Preventive Care. The Public Health Agency, County of Ventura, and Saint John's are participating.
4. The Quit Smoking program will be implemented by the first quarter in 2013. DHCS and DPH met with Dr. Cho and GCHP's Clinical Pharmacist regarding receipt of a special grant, which GCHP P & T and the HE/CL Committees fully intend to utilize for the Quit Smoking program. A \$20.00 gift card is provided but patient must ask for it and GCHP is preparing literature to inform patients.

### **Credentialing/Peer Review Committee**

1. Physician participation is good with 6 out of 8 physician committee members attending the last meeting.
2. At last Committee meeting, 14 out of 15 new physicians had their credentialing packets approved to join GCHP network. The application for one OB/GYN is pending.

### **Pharmacy & Therapeutics (P&T) Committee**

1. Physician participation is good with 10 out of 14 physician committee members attending the last meeting.
2. Total cost for the last 6 month period of the report was almost 20 million compared to previous period which was 18.5 million. One of the reasons for the increase was due to one drug for a hemophiliac patient which cost ½ to 1 million.
3. Generic use 84.5%; October 2011 – March 2012 saw a 1.41% increase in generic utilization. GCHP physicians prescribe more generic drugs than other COHS. Plan cost increased 6.6% period over period and prescription volume increase 3.1%.
4. Total cost per prescription increased by \$1.57 to \$47.19.
5. Single source brands accounted for 15% of volume for 58% of cost.
6. Specialty drugs account for 22% of total cost.
7. 3827 diabetics on meds, 5620 on testing supplies for 18.6% drug spend. \$131.31 in costs for diabetics compared to \$12.34 for non-diabetics. The number of diabetics is low compared to State and National averages. However, due to GCHP significantly higher population between 0-20, the figure may accurate and is in the process of being validated via ICD9 coding.
8. Drug utilization reviews are conducted each meeting. For example, Singular was the top drug for expenses costing nearly \$1 million for the year. However, it was widely used inappropriately especially for acute asthma, when this drug is not the first line of therapy. There has been intensive physician education on proper prescribing of Singular and its costs; and the use is dropping. In addition, GCHP is working on ways to identify patients who are high utilizers of anti-asthmatics and providing patients education.
9. Dr. Cho and the clinical pharmacist are routinely analyzing the top 15 drugs at its weekly meeting to find ways to be cost effective and to be sure of proper use of drugs. Physician profiles and academic detailing are planned for next year.
10. The CMO notes that drugs are expensive, but hospitalization is more expensive and there needs to be a balance. There are many experts on the P/T Committee that provide suggestions. A review of specialty drugs is underway for next year.

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

1. Physician participation is good with 9 out of 14 physician committee members attending the last meeting.
2. Committee members reviewed diabetes and smoking cessation practice guidelines based on HEDIS requirements. Other guidelines reviewed were enteral nutrition, and ultrasound use.
3. Dr. Wharfield is tracking high volume ED patients so that GCHP can assist them with their care. She is working on developing a similar model as CMH's Intensive Care Program.
4. A subcommittee of the MAC was established to create a prior authorization form to include clearance of contraindications Zostavax injection.

# **GOLD COAST HEALTH PLAN 2013 QUALITY IMPROVEMENT PROGRAM**

12/18/12 Final Draft

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 Management Committee	14
VI.	Delegation Oversight Committee	16
VII.	Utilization Management/Case Management Committee	17
VIII.	Health Education/Cultural Linguistics Committee	19
IX.	Credentialing Committee	20
X.	Pharmacy and Therapeutics Committee	21

V.	Resources Dedicated to Quality Improvement	22
	A. Chief Medical Officer	
	B. Director Quality Improvement	
	C. Quality Improvement Specialists	
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. GCHP’s quality program is centralized at the Plan under the Chief Medical Officer and is not delegated to any other entities.

**Accountability:**

The Quality Improvement Committee chaired by the Chief Medical Officer is accountable for:

1. Assigning responsibility for monitoring and evaluating activities.
2. Delineating the scope of quality of care, quality of service, and patient safety provided by the organization.
3. Identifying important aspects of quality of care, quality of service, and patient safety provided by the organization.
4. Using measurable indicators to routinely and systematically monitor aspects of care, service and safety based on current knowledge or proven industry methodologies.
5. Identifying comparable benchmarks and/or thresholds and goals for meaningful, industry- standard, performance indicators.
6. Monitoring the important aspects of quality of care, quality of service, and patient safety, by collecting and organizing data for each indicator.
7. Evaluating quality of care and service when benchmarks and/or goals are reached, or when measurements fall outside thresholds, and identify opportunities to improve or correct problems.
8. Identifying barriers to improvement that are directly associated with continued improvement and mitigating barriers and resolving identified problems.
9. Designing relevant, strong and timely interventions and taking action to improve or correct identified problems.



10. Evaluating the effectiveness of those actions using comparable measurements.
11. Communicating results to the relevant committees, individuals, departments and to appropriate committees, GCHP's executive leadership and Commission.
12. Re-evaluating performance at appropriate intervals using comparable measurements; assessing performance relative to benchmarks, thresholds and/or goals; and identifying remaining barriers. Based on findings, implementing new and/or improved interventions as necessary.
13. Continuing the QI cycle as warranted.

This document describes how this general approach to quality monitoring and improvement is achieved at GCHP. This is accomplished through a description of the QIP's scope, goals and objectives, a narrative description of the quality committee structure, concluding with tables of organization showing reporting relationships, membership, a yearly meeting calendar and GCHP's policy concerning the availability of QI documents. To ensure appropriate resources to support the quality function, an organization-wide Work Plan (separate document) is annually developed in congruence with the QIP and GCHP's Strategic Plan. To ensure successful performance of the QIP, GCHP's leadership is responsible to set appropriate goals and objectives for staff and those involved in the QI process.

## **II. SCOPE, GOALS & OBJECTIVES**

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
- Availability

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 ensure the objective and systematic monitoring, evaluation and pursuit of opportunities to improve, and resolve identified problems.

GCHP's Quality Improvement Committee oversees the monitors established by GCHP's committees. Performance indicators are tracked to maintain a continuous focus on the Plan's operational and clinical priorities for improvement.

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

The Ventura County Medi-Cal Managed Care Commission (VCMACC) 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, VCMACC will receive quarterly updates to the QI Work plan for review and comment.

#### *Membership*

GCHP is governed by an eleven (11) member Ventura County Medi-Cal Managed Care

Commission (VCMCC). Commission members are appointed for two or four year terms, and member terms are staggered.

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

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

- One member shall be the Ventura County Medical Center Family Medicine Residency Program Director or Faculty Designee and approved by the Board of Supervisors. (Ventura County Medical Center Health System Representative)

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

- Provider Advisory Committee
- Consumer Advisory Committee

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

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

#### *Purpose:*

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

#### *Function:*

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

#### *Membership:*

The Member Services Manager is responsible for membership recruitment, retention and coordination of meetings and agendas. The Member Services Manager serves as the Chairman and is a non-voting member of the Committee. Membership consists of 10 individuals who represent community and consumer interests. Members may not directly earn their income from the provision of medical services. Each of the appointed members serves a two-year term. Individuals may apply for re- appointment if desired, as there are no term limits.

The ten voting members represent various constituencies who serve 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
- Disabilities
- Special needs
- Seniors
- Other Medical 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 responsible for the monitoring and enhancement of organization-wide quality improvement processes to ensure the delivery of quality customer service and access to high quality medical services. It is accountable to the Ventura County Medi-Cal Managed Care Commission. It is the responsibility of the QIC 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 policy recommendations from the all Plan committees and makes recommendations on their implementation. The Ventura County Medi-Cal Managed Care Commission is updated via the QIC minutes, at least, quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The QIC continually strives for excellence and quality in health care delivery and service to GCHP's members, providers, internal customers and the community by pursuing meaningful and measurable activities to improve and perfect processes, outcomes, and satisfaction. Committee minutes are maintained and submitted to VCMMCC quarterly. GCHP ensures that the rules of confidentiality are maintained in quality improvement discussions. An annual quality improvement report is submitted to VCMMCC which includes a comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements, including but not limited to, the collection of aggregate data on utilization, review of HEDIS measures, outcomes/findings from Quality Improvement Projects (QIP's) and member/provider satisfaction survey results and actions.

*QIC Objectives*

- Ensure quality committees have access to timely information to ensure prompt implementation of quality improvement

initiatives.

- 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:*

- Recommend policy changes or implementation of new policies to GCHP's Administration and Commission.
- Ensure indicators established for monitoring Access, Care and Service and Quality Improvement Projects are appropriate and will lead to improvement
- Review quarterly committee reports regarding monitoring of health plan functions and activities. Suggest interventions or corrective actions to ensure follow-up when indicated.
- Oversee the development and annual review of the QIP, quality improvement activities (QIAs) and projects, Quality improvement Work Plan, and Work Plan Evaluation.
- Oversee the annual analysis and evaluation of the effectiveness of quality improvement activities, and achievement of Work Plan goals.

*QIC Membership:*

- Chief Medical Officer
- VCMCC Commissioners
- Director of Quality Improvement
- Manager, Health Education and Cultural Linguistics
- Director of Government Relations
- Director of Health Services
- Manager of Member Services
- Quality Improvement Staff
- Medical Director, Health Services
- Manager of Provider Network Manager
- Project Manager, Delegation Oversight

- 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, 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.
- Review service indicators and data from Member Satisfaction Surveys to identify areas for improvement in services rendered to GCHP members.
- 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*

- Manager of Member Services (Chair)
- Manager of Provider Network
- Member/Grievance Coordinator
- Sr. Quality Improvement Project Manager
- Director of Health Services
- Manager of Health Education & Cultural Linguistics
- Manager 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)
- 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 Management Committee (NMC)**

### *NMC 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.

### *NMC 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.

*NMC Membership:*

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

- Manager, Health Education and Cultural Linguistics

*Meeting Frequency:*

The committee meets at a minimum quarterly

## **6. Delegation Oversight Committee (DOC)**

*DOC Charter*

The Delegation Oversight Committee (DOC) is responsible for developing and overseeing agreements between GCHP and its delegated entities. The National Committee for Quality Assurance (NCQA) defines delegation as: “a formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed appropriately. An organization is ultimately accountable for all functions performed within its purview, whether performed by the MCO itself, by a delegate or by any sub delegates”.

The DOC reviews pre-delegation assessments, draft delegation agreements, and oversee delegated functions for quality and other regulatory compliance. If opportunities for improvement are identified through the oversight process, the DOC may implement interventions or recommend corrective actions for the delegate.

*DOC Objectives:*

- Monitor the ability of delegates to perform delegated functions.
- Ensure delegation agreements clearly delineate the responsibilities of both the delegate and the delegator.
- Review the results of monitoring activities as described in the delegation agreement to ensure delegate is meeting expectations and performing delegated functions appropriately.
- Recommend corrective actions as needed when opportunities for improvement are identified.
- Recommend that delegation agreements be terminated if delegate is unable or unwilling to meet expectations despite appropriate interventions or requests for corrective actions.

- Review delegates' reports to ensure compliance with delegation agreements and identify potential areas for improvement.
- Evaluate overall effectiveness of delegation arrangements.
- Oversee the appropriate development and administration of relevant policies and procedures and delegation agreements, including periodic review and revision.

*DOC Membership:*

- QI Project Manager, Delegation Oversight (Chair)
- QI Project Manager, Credentialing
- Sr. Quality Improvement Project Manager
- QI Project Manager, Facility Site Review Nurse
- Manager of Member Services
- Manager of Claims
- CFO or designee
- Manager, Utilization Management
- Manager of Health Education/Cultural Linguistic
- Ad hoc members as needed

*Meeting Frequency:*

The committee meets at a minimum quarterly.

**7. 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 of Quality Improvement
- Manager, Health Education and Cultural Linguistics
- Chief Medical Officer

*Meeting Frequency:*

The UM/CM Committee meets quarterly at a minimum.

## **8. 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.

*Membership:*

- Manager of Health Education, Cultural and Linguistic Services (Chair)
- Director of Health Services or designee
- Manager of Communications or designee
- Manager of Member Services or designee
- Manager of Provider Network
- Quality Improvement Representative

*Meeting Frequency:*

The committee meets at a minimum quarterly

**9. Credentials/Peer Review (C/PR) Committee**

*Purpose:*

The Credentials/Peer Review 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 recredentialing 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. The Medical Director, Health Services will be an ad hoc member with a vote to the committee.

*Meeting Frequency:*

The committee meets quarterly.

## **10. Pharmacy & Therapeutics (P&T) Committee**

*Purpose:*

The P&T Committee serves as the advisory committee to GCHP for the development and implementation of a plan-wide medication management program. The P&T Committee is responsible to provide guidance on 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.
- Serve in an advisory capacity to GCHP for all matters pertaining to the use of medication, including development of prescribing guidelines, protocols and procedures to promote high quality and cost-effective drug therapy.
- 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. Medical Director, Health Services is an ad hoc committee member with a vote.

*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, C/PR, 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 for ensuring all quality monitors; appropriate analysis and improvement initiative are in place. The Director ensures that all health plan staff is educated on the importance of quality and how each staff member plays a

role in the quality improvement process. The Director is a mentor for all department heads and works with them to implement processes that will create both efficient and quality service.

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 SPECIALIST (S)

The quality improvement specialists assist 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:

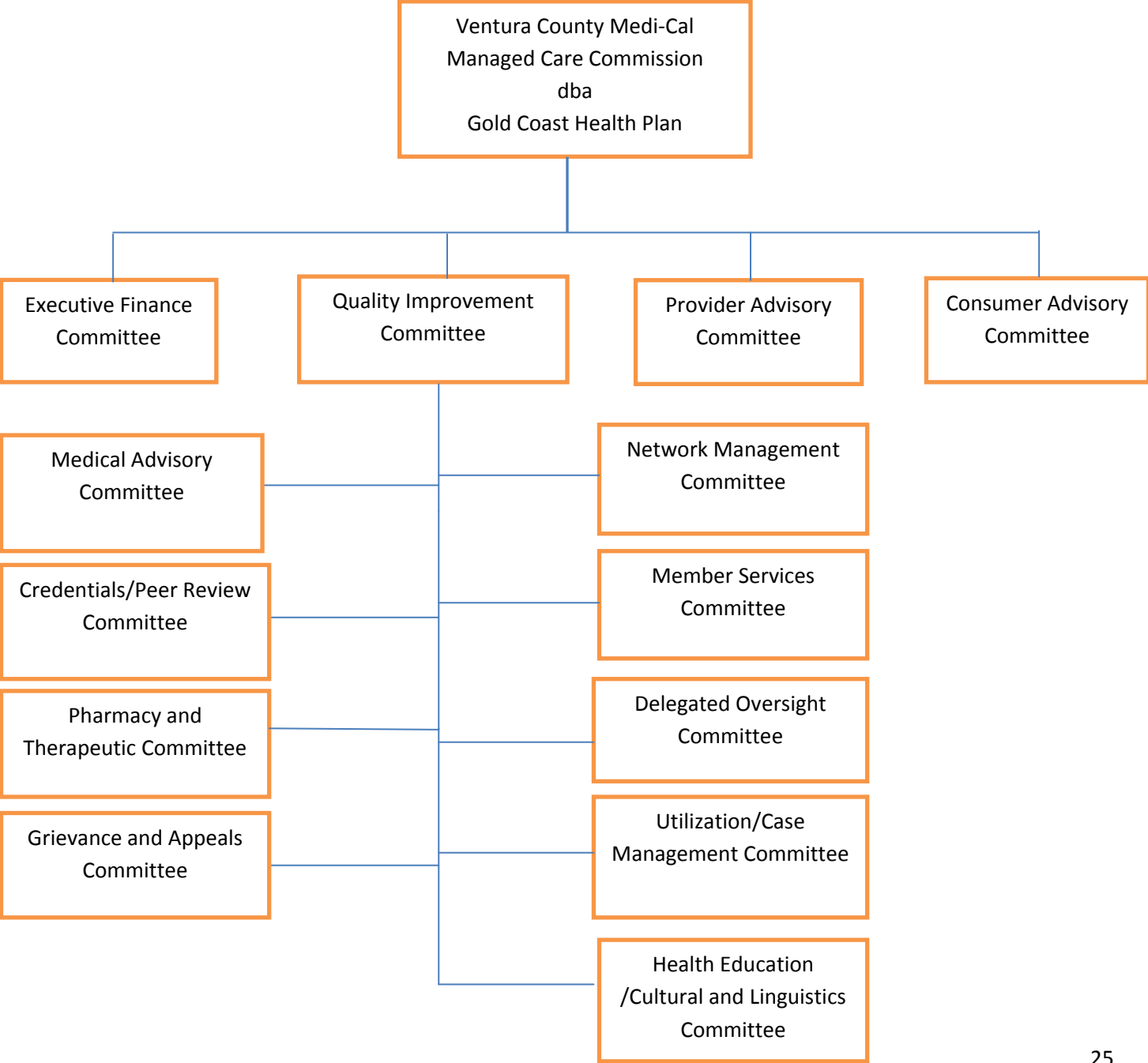
- Assist in creating the annual QI Program document
- Assist in coordination of HEDIS data collection and analysis of results
- Work with other departments to gather information for the annual QI Review
- Assist in developing activities for the annual QI work plan
- Assist the QI Director as required

## 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. All GCHP staff will be educated on their role in the QI process.

## 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 2013**

**Thursday February 7, 2013**

**Thursday May 2, 2013**

**Thurs day August 1, 2013**

**Thurs day November 7, 2013**

## **AVAILABILITY OF QIP TO PRACTITIONERS AND MEMBERS**

The QIP is available on GCHP's website at [www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org). Printed copies are available upon request.

## **UTILIZATION MANAGEMENT PROGRAM DESCRIPTION (INCORPORATED AS A SEPARATE DOCUMENT)**

Ventura County Medi-Cal Managed Care Commission (VCMMCC)  
dba

Gold Coast Health Plan (GCHP) Quality Improvement Committee (QIC) Meeting Minutes

Date: Friday, December 14, 2012

Time: 9:00am – 10:30am

Place: 2240 E. Gonzales Road, Suite 280, Oxnard, CA 93036

**Call to Order**

Dr. Charles Cho – Chief Medical Officer called the meeting to order at 9:03am, in Suite 280, Ventura County Public Health Building located in 2240 E. Gonzales Road, Suite 280, Oxnard, CA 93036.

**Members in Attendance**

Dr. Charles Cho – Chief Medical Officer, Michael Engelhard, Chief Executive Officer, Laurie Eberst – Commissioner, John Fankhauser, MD – Commissioner, Julie Booth – Director Quality Improvement, Susan Tweedy – Senior QI Project Manager, Doris De La Huerta – FSR Nurse, Helen Chtourou – HEDIS Project Manager, Robert Franco – Delegation Oversight Project Manager, Andre Galvan – Manger Member Services, Lupe Gonzalez – Manager of Health Education & Disease Management & Cultural Linguistics, Guillermo Gonzales – Director Government Affairs, Jennifer Palm – Director Health Services, - Sherrie Bennett – Provider Network Manager,

**Other Staff in Attendance**

Steve Lalich – Manager of Communications and Connie Harden – Member Services Project Specialist.

**Absent/Excused**

Nancy Wharfield, MD, - Medical Director Health Services

**Approval of QIC meeting minutes**

Approval of the Minutes of September 28, 2012 with one revision under the section “Grievance & Appeals (G&A) Committee”. The word “up” was changed to “down”. A motion by Laurie Eberst to approve the minutes and seconded by Jenny Palm. Everyone was in favor of adopting the minutes with one revision.

**Introductions**

2013 QI Plan Review & Approve.....Dr. Cho



Editorial changes were made to the QI Plan for 2013. Medical Director, Health Services is now the Chair for the Grievance and Appeals Committee and the UM/CM Committee. QI Director was added as a member to the Network Management Committee and the title of the Chair was changed to Provider Network Manager. The Medical Director, Health Services was added as an ad hoc committee member with a vote to the Pharmacy & Therapeutics Committee. Jenny Palm requested on the behalf of the Medical Director, Health Services changes to the UM Committee membership structure which included having one UM Nurse (on a rotating basis), one CM Nurse (on a rotating basis), adding the UM Manager, Case Manager and the Quality Improvement Director to the Committee. A request was made to remove other clinical staff from the UM/CM Committee. Dr. Fankhauser motioned for the changes to be accepted and Laurie Eberst seconded the motion. Michael Engelhardt recommended we adopt the Plan as amended and the QI Plan would be sent out to the Committee members for further review and revisions brought to the next QI Committee meeting.

Dr. Cho also commented that QI activities had been delayed because we did not have enough reporting information, plus a QI director had just been hired recently. Julie Booth has really organized the department and the department is now ready to initiate all QI activities. QI is required to report quarterly to the Commission. Now that there is a full working committee, QI can begin reporting to the Commission both quarterly and annually.

Readmission Quality Improvement Project (QIP).....Susan Tweedy

GCHP is required to participate in the State-Wide Quality Improvement Project (QIP) concerning “All-Cause Readmissions”. The logic map/barrier analysis diagram from HSAG (State EQRO) was reported to the Committee. The barrier analysis is a diagram developed by HSAG from their perspective as to possible reasons for high readmission rates for SPD members. The goal is to apply the barrier analysis to GCHP’s SPD membership and submit GCHP’s version of the barrier analysis to the State by January 31, 2013. GCHP is only required to pick one possible intervention to improve readmission rates. The barrier analysis document will be discussed at the Medical Advisory Committee and was brought to the QI Committee for informational purposes only.

GCHP is also required to develop an internal Quality Improvement Project (QIP). DHCS has approved a delay for GCHP in implementing a QIP until the Plan knows their HEDIS measure results in June 2013.

HEDIS Status/Verisk Contract/Benchmarks.....Helen Chtourou/Susan Tweedy

Over the last few months QI has been collecting member data from internal and external systems and testing the integration of all the data into Verisk’s software in preparation for the HEDIS reviews next year. Verisk is an NCQA approved HEDIS software vendor and GCHP will be using their HEDIS performance suite to audit, review, and submit GCHP’s 2012 HEDIS results next year. NCQA’s 2013 HEDIS Data Submission Timeline was distributed to the QI Committee.

Facility Site Review.....Doris De La Huerta

Dr. Cho introduced Doris de la Huerta as the new Facility Site Review Nurse. Doris reported out on her training schedule to become certified as the GCHP Facility Site Review Nurse and the list of items completed within the Facility Site Review function from July 1, 2012 through December 31, 2012.

- Facility Site Review initial training completed through Health Net.
- FSR training scheduled with CenCal Certified Site Review Nurse.
- Submission of semi-annual July 1, 2012 through December 31, 2012 Facility Site Review and Medical Record Review results to DHCS.
- High Volume Ancillary/Specialist Provider Sampling Methodology developed, submitted and approved by DHCS.
- All PCP Physical Accessibility Review Surveys (PARS) Completed.
- All High Volume Ancillary/Specialist Provider PARS Completed.
- Inter-rater reliability (IRR) completed for PARS
- Annual review and submission of any changes to the High Volume Ancillary/Specialist list under review and will be reported to DHCS by 1/31/2013.
- FSR, MRR & PARS Policy Updated

**QI Subcommittee Reports**

Member Services Committee.....Andre Galvan

Andre reviewed the Members Services reports. The Membership Data Trend report showed a drop in membership in August 2012 to due to the State discontinuing the practice of providing retroactive enrollments. QI Committee members inquired if the Call Center Report has been compared to other COHS and if calls were trended by type of call. Andre confirmed that the results of the Call Center Report have not been compared to other COHS and calls have not been trended by type. Michael Engelhard stated that Cal Optima did not trend calls by type either. Dr. Fankhauser stated benchmarks and trends are part of quality. Michael confirmed that benchmark goals such as abandonment rates are listed on the Call Center Report. QI Committee member suggested categorizing calls by type/trend/resolution. Sherri will ask IKA to categorize calls by type in KWIK system. Dr. Fankhauser noted there was only one month with high abandonment rate for the Spanish calls, which Andre stated was a staffing issue. Dr. Fankhauser commended that there was no large variation in Spanish vs. English calls.

Grievances & Appeals Committee.....Andre Galvan

Dr. Wharfield will be chairing the G& A Committee in the future. Andre presented the Grievances and Appeals report. Andre confirmed that they are not using a vendor to track G&A stats, but using an in-house system. Dr. Cho requested to correct and clarify a statement in the September 28, 2012 QI Committee minutes for statement to read “15 G&A current quarter in June vs. 21 in prior quarter” to reflect the decrease in G&A. Dr. Fankhauser asked to see more detail in G&A report such as type of G&A and also stated report shows too few complaints. QI Committee member wanted to know if report showed complaints regarding scheduling

appointments and Andre replied this would be under the “Access to Care” category in the report. QI Committee members agreed that type Access to Care grievances were important to know because it affects quality of care.

Network Management Committee.....Sherri Bennett  
Sherri announced her new position as Provider Network Manager over Provider Relations and Contracts. Stated that current physician network system is robust and will begin focus on what new providers GCHP need to be added to the network. Also focus on finding cost effective ways of providing services, such as infusion therapy, to members.  
Sherri confirmed that GCHP will not need to credential and contract with hospital clinical staff such as radiologist because NCQA doesn’t require health plans to credential these types of providers; however, Nurse Practitioners will need to be credentialed.

Delegation Oversight Committee.....Robert Franco  
Reviewed and updated two policies: (1) Utilization Management and (2) Credentialing and Re-credentialing at the Delegation Oversight Committee and will send polices to the State for approval. The results of the audit with Clinicas del Camino Real and Community Memorial Hospital were reviewed at the Delegation Oversight Committee, which passed. It was noted the audit results from ICE were used for Ventura County Medical Center so GCHP did not have to audit VCMC.

Utilization Management (UM)/Case Management (CM) Committee.....Dr. Nancy Wharfield/Jennifer Palm

Dr. Wharfield was not present and Jennifer Palm presented on her behalf. UM/CM focus has been on staffing and developing processes. With recent data UM/CM can begin to be proactive vs. reactive. Case Management has hired 3 dedicated Case Managers (one with CCS expertise), two nurses (one dedicated to transplants) and one social worker with a strong dialysis background. With the most recent CBAS transition, Case management was able to have a couple of members attend out of area CBAS facilities for language/cultural match. The future focus for Case Management is chronic disease management and medication issues. Utilization Management reports from Milliman now available. Hospital days per 1,000 are 384.3. Other COHS show a little lower. Average LOS inpatient stay is 5.13 days. Top ER diagnosis is URI. About half of the ER visits are children ages 0 – 19. Access may be one of the reasons for the high URI ER visits.

Health Education/Cultural Linguistics Committee.....Lupe Gonzalez  
Cultural linguistic services are being tracked by a form to track translation services and accuracy of translations to patients. Group Needs Assessment is pending state approval. 52% preferred English and 42% preferred Spanish. 60% of patients under age 20, 25% of patients ages 21-64 and 14% of patients over age 65. The top five diagnoses from ACS were 1) Respiratory 2) Acute Respiratory 3) General 4) Diabetes and 5) Abdominal/Pelvic Pain. Since there is no HEDIS data this year, will report next year. Dr. Fankhauser stated list of diagnoses are not very specific and

Lupe stated that ASC collapses the diagnoses, however, she hopes to provide greater specificity with future data runs.

Health Education developing health education classes and sponsoring education events. City of Ventura and Housing authority are providing community room for GCHP to provide education classes to the community which will include educating members on 1) GCHP benefits, 2) PCP selection, and 3) Preventive Care. The Public Health Agency, County of Ventura, and Saint John's are participating.

The Quit Smoking program will be implemented by the first quarter in 2013. DHCS and DPH met with Dr. Cho and GCHP's Clinical Pharmacist regarding the Quit Smoking program. Dr. Cho stated that statistics show 1 in 5 patients who participate in smoking cessation programs have better outcome. QI Committee member asked about incentives for the program. A \$20.00 gift card is provided but patient must ask for it and GCHP is preparing literature to inform patients. Dr. Cho emphasized the importance of the program to prevent future diseases and that the State has helped by providing the drugs.

Credentialing/Peer Review Committee.....Dr. Charles Cho  
Physician participation is good and 6 out of 8 committee members attended the last meeting. At last Committee meeting approved 14 new physicians to join GCHP network, but did not pass an OB/GYN. The application for the OB/GYN is pending.

Pharmacy & Therapeutics (P&T) Committee.....Dr. Charles Cho  
Physician participation is good and 10 out of 14 physicians attended the last P&T committee meeting. Reviewed formulary and statistics on how much GCHP is spending on drugs. One drug for a hemophiliac patient cost ½ to 1 million. GCHP physicians prescribe more generic drugs than other COHS and 87.5% of prescribed drugs are generic. Dr. Cho credits Dr. Fankhauser for teaching physicians to prescribe generic drugs. Dr. Cho noted that Singulair is one of the top drugs for asthma, but not good for acute asthma or rhinitis and there has been education on proper prescribing on Singulair. QI Committee member suggested flagging patients who are high utilizers of anti-asthmatics and providing education and that it can also be seasonal. Diabetes medications results in 18.6% of drug cost expenditures. There are only 4,000 diabetes members in the health plan because most of the GCHP members are younger. No complaints in use of diabetic drugs and they are lifesaving drugs, but will work on patient behavior and education. Dr. Cho has also noted that he and Scriptcare's Clinical Pharmacist are analyzing the top 15 drugs. Dr. Cho stated he will profile physicians and provide Academic detailing next year. Dr. Cho also notes that drugs are expensive, but hospitalization is more expensive and there needs to be a balance. There are many experts on the P/T Committee that provide suggestions. The Committee will be reviewing infusion therapy, a specialty drug that is very expensive. Will also work on reducing costs of drugs by providing education to providers on administering drugs

in office vs. administered by Scriptcare because GCHP pays for drugs administered in the providers' offices.

Medical Advisory (MAC) Committee.....Dr. Charles Cho  
Committee members reviewed diabetes and smoking cessation practice guidelines based on HEDIS requirements.

Dr. Wharfield is tracking high volume ED patients. She is working on developing a similar model as CMH's Intensive Care Program.

Dr. Wharfield researched published guidelines and spoke to community physicians concerning the use of enteral nutrition such as Ensure, Pediasure and Nephro. The intent is to not exclude people but to use appropriately. Appears to be more parent driven. Some use indicates that it doesn't seem medically appropriate. Other alternatives such as Carnation Breakfast meals can be used.

Ultrasound over utilization in only one are: perinatology study. Guidelines have been established.

Dr. Cho received approval from MAC Committee to require prior authorization before administering Zostavax vaccine for shingles/Herpes Zoster. Dr. Fankhauser asked to refer to evidence based measures and standards/benchmarks for arriving at this decision. Dr. Cho confirmed that MAC had looked at the ACIP guidelines and research regarding effectiveness of the Zostavax. Dr. Cho's decision to require a prior authorization for the administration of the Zostavax vaccine because the vaccine is 1) 57% effective, 2) a high risk for complications with immunocompromised patients, and 3) it is expensive. Dr. Cho commented that a vaccine should have 80% or greater effectiveness to be cost effective. A subcommittee of the MAC was established to create a prior authorization form to include clearance of contraindications.

**Adjournment**

Dr. Cho adjourned the meeting at 10:45am. Next QI meeting will be scheduled on February 7, 2013.

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

Charles Cho, M, D., Chair

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

**Quality Improvement Committee Meeting**  
Thursday, February 7, 2013

**Call to Order**

Dr. Charles Cho – Chief Medical Officer called the meeting to order at 3:04pm, in Suite 280, Ventura County Public Health Building located in 2240 E. Gonzales Road, Suite 280, Oxnard, CA 93036.

**Members in Attendance**

Dr. Charles Cho – Chief Medical Officer, Laurie Eberst – Commissioner, John Fankhauser, MD – Commissioner, Nancy Wharfield, MD, - Medical Director Health Services, Julie Booth – Director Quality Improvement, Susan Tweedy – Senior QI Project Manager, Doris De La Huerta – FSR Nurse, Helen Chtourou – HEDIS Project Manager, Robert Franco – Delegation Oversight Project Manager, Andre Galvan – Manger Member Services, Lupe Gonzalez – Manager of Health Education & Disease Management & Cultural Linguistics, Guillermo Gonzalez – Director Government Affairs, Jennifer Palm – Director Health Services, - Sherrie Bennett – Provider Network Manager.

**Other Staff in Attendance**

Cassie Undlin, Interim Chief Operating Officer

**Absent/Excused**

Michael Engelhard, Chief Executive Officer

**Approval of QIC meeting minutes**

Approval of the Minutes of December 14, 2012. No revisions or additions. A motion by Lupe Gonzalez to approve the minutes and seconded by John Fankhauser, MD. Everyone was in favor of adopting the minutes.

**CMO Report**

Dr. Cho presented the Annual CMO QI Report for 2012 to the Committee members. The intent is to re-emphasize the importance of Quality Improvement (QI) and to garner support from the Committee and that it is a cooperative and collaborative process. To be what is best for all areas and each department. QI is not only a must but it is mandated by the State and it is a good thing to do for managed care. The best quality medicine is the most cost effective. That is what managed care is about to do the best job and saving money. So it is the best thing to do for members who are the recipients of good quality care and good health outcomes and for our health plan because of the cost effective care. We are the beneficiaries of saving money. There is a Mission Statement which was approved by the State and it states “to improve the health and well-being of the people of Ventura County by providing access to high quality medical services.” The QI program is to continuously improve the care and provide services “in partnership with its contracted quality provider network.” We need to keep emphasizing this and this will then result in high quality care and saving money.

Who are the quality providers? We all know we need good diagnosticians to make correct diagnoses, practice quality medicine, and produce the best outcomes. They avoid unnecessary tests and procedures, and know when to refer and not to refer patients for consultations. Good quality care is having good quality doctors.

The health plan has the responsibility to provide proper tools for these quality doctors. The policies and procedures need to be user friendly. With so many HMO's coming in with their policies and procedures the provider offices are getting bogged down. When GCHP first started, we needed to make it easy for the doctors. We have to trust that Doctors are doing a good job, by making the "Direct Referral Policy" without requiring prior authorization, trusting that they know when to refer. In many other HMO situations they require prior authorizations resulting in delay of medical care. GCHP has received very good feedback from providers because of this policy. We have not lost anything and satisfied physicians take care of their patients with more enthusiasm. Good for patient care.

The QI program was almost delayed a year because of other priorities to get the Plan going live. Further delay had occurred with difficulty in recruiting a suitable QI Director. When Julie Booth, Director was hired April 2012 it was almost a year later than was originally planned. Julie quickly assembled a credible staff and met all State reporting deadlines.

In reviewing the GCHP QI Functional Chart there are three functional columns that are directly related to regulatory requirements. The three are DHCS QIP, HEDIS and All Plan Letter requirements. The other two areas are Pharmacy Oversight with a \$40 million dollar plus budget and that is a big task. Finally there are nine sub-committees under QI. The QI process is a collaborative effort and Dr. Cho encouraged the Committee members to submit ideas to QI. Again QI is a collaborative effort with all of the subcommittees working closely together with the QI Department.

Three of the committees are chaired by Dr. Cho and he gave an overview of these committees. Dr. Cho emphasized that membership of the committees are pulled from the best of the providers in the Community. There is overlap of providers in the Committees because of their expertise and are the best ones for the Committees and they can serve on both.

#### Pharmacy and Therapeutics:

The most important function of the P&T is the review of the formularies. They have worked on designing a formulary. The formulary was designed to be user friendly and that can best serve the needs of the members. The goal is to have a formulary where there are choices for the doctors to choose from and choose the right drug that is cost effective. Designed for the doctor to think about the medicine for a certain disease and the doctor can go to that category for that therapeutic brand of medicine. He will see the drug that he was thinking of prescribing but he will also see four or five other drugs. He can compare. Without this type of system the provider would have prescribed what he was thinking of at the beginning. When he sees these he can see the differences and he can see the different columns and see what is cheaper and the dosages. By providing this kind of formulary we are providing the doctor a selection and he doesn't have to go to something else. He doesn't have to choose one; he can consult the formulary and choose the one that is the best medicine for that condition and most cost effective. This process has been working.

The generic percentage use is in the low 80s when the plan first started. That number has moved up to about 85% which is among the best in the industry. A fantastic increase without having to push the providers, they made the choices themselves.

ScriptCare has been very good from the very start of the Plan by providing the Plan valuable reports. We can see the top 15 drugs. If the medicine is good for that patients care, whether it is expensive or not, the provider should use it. We should not necessarily restrict expensive medicine. In looking at the top 15, a couple of times expensive medicines were prescribed but they are not any better than the less expensive. P&T committee then would eliminate the higher cost drug without any problem because the less expensive medicine is just as good. P&T also adds medicines, if appropriate, when a request is made by a provider. The request is reviewed and added if meritorious. The pharmacy newsletter is also sent out to all providers which is informative and educational. This quarter the newsletter covered drug adherence problems, 50% of patient problems related to patient not sticking to the medicine regimen. Example of eliminating a drug is Ventolin. They are the same drug, and ProAir was eliminated because of the expense. Proair four times more expensive and it has ethanol in it which may cause allergy. Taken to the Committee and removed. The formulary and the newsletter are both important factors in educating the doctors. Our efforts should be to do our best and not always focus on the cost.

Credentials Committee

There are eight physicians on the Credentials Committee: three are CMO's of the biggest hospitals; two doctors are Medical Directors of the biggest Clinics and one leading physician from Clinicas, the Medical Director from SeaView IPA and a leading doctor from Oxnard. These doctors have been involved in Credentialing before and it made it easier for the Plan and they have been doing a very good job operationally.

#### Medical Advisory Committee (MAC)

MAC has 14 physician members. MAC was a little hampered for a while because of lack of data. But, data is becoming available. There are physicians on MAC and most are teachers and top in their specialty in the community. Their function is to analyze reports, advise, recommend and make policies.

In addition to these three Committees, there are two committees under Dr. Wharfield: Utilization Management Committee and Grievance and Appeals Committee. We are starting to see preliminary reports of hospital stays and length of stay. These reports become very important to the UM Committee and to MAC for developing new policies and for identifying issues for improvement. Beginning 10/1/12 they have done a great job transitioning nearly 1,000 Adult Day Health Care Center members into CBAS. GCHP is adding a number of staff in Utilization Management. Investing in the proper personnel is necessary, and a good case manager will easily pay off 5 to 10 times of the investment, as an example.

The remaining subcommittees include:

Membership Sub-Committee is chaired by Andre Galvan. The Call Center benchmarks are of great interest to the Commission. A question at the last Commission meeting was the number of dropped calls for providers. The number still is not that high. Network Management is managed by Sherri Bennett. Robert Franco has Delegation Oversight and the three delegated groups all passed their audits. Health Education/Cultural Linguistics (HE/CL) is responsible for educating the members and the Plan can do a good job educating the members then the Plan can be popular and change behaviors. Lupe Gonzalez, Chair of HE/CL, presented to the Commission the survey and it showed what the members were interested in. The top five health topics of interest to members are healthy eating, cholesterol or heart health, healthy teeth, diabetes and exercise. Using this Survey as the guide the last member newsletter sent in January contains a topic on cholesterol. Also, the survey showed that 80% wanted information obtained through mail. 52% preferred in English while 42% preferred Spanish. Lupe is always out in the



community and one of the good things is that she recently met with the City of Ventura Housing authority and now has a nice room to provide education classes, to educate on benefits, PCP selection, etc.

### **QI Subcommittee Reports**

#### **Credentialing/Peer Review Committee**

The Committee met in November and the minutes were presented at the December 14, 2012 QI Committee meeting.

#### **Pharmacy & Therapeutics Committee**

Financials were already presented in the 2012 QI annual review. The next meeting is in two weeks and the pharmacist is bringing eight pages of drugs that need discussion for either deletion or requiring prior authorization. A lot of work is going on with P&T. January financial reported increase in ppm to 36.00 largely attributable to flu epidemic. Use of Tamiflu and Zithromax contributed to nearly \$100,000. Also, one case of Hemophilic drug use was \$145,000.

#### **Medical Advisory Committee**

The MAC meeting was held January 17, 2013. ER usage was discussed in the MAC. There are some high utilizers. The Zostavax for herpes roster shingles vaccine is very expensive. 60 and older are recommended to have this vaccine. A similar vaccine pneumovax is also recommended but it is inexpensive. Zostavax because it is expensive and only about 60% effective with some complications and there are contraindications, the Committee decided to keep it on the prior authorization list. Diabetic population is relatively low in our Plan and right now only 4% of the diabetic population is on drugs. Less than half of what we expected. The reason for the low number may be related to the fact that 60% of our population is under the age of 21. We continue to monitor the number. SeaView IPA is doing a tremendous job of discharge planning and saving a lot of money. A discussion ensued and Dr. Cho noted that according to Dr. Proffett the Medical Director of SeaView IPA, they have reduced the ER visits by 46% thru this discharge planning process and similar % of decreases in readmissions. Dr. Fankhauser inquired as to whether Sea View IPA was going to give GCHP their plan for reducing ER visits. Dr. Cho has been discussing this with Dr. Profett and has connected Dr. Wharfield with him for detailed follow-up. Julie Booth submitted the Readmission Data for the Statewide Quality Improvement Project (QIP) for SPD's and Non-SPD's. The readmissions rate was 14% to 15%. The data is being validated per Dr. Cho's request. Telemedicine was also discussed. This would apply to patients who need a referral to a specialist. There would be a video or telephone conference for consultation. We would like to get into telemedicine. VCMC is doing it and we are seeing how we as a plan can accommodate it. UCLA is connecting with VCMC via a grant.

#### **Member Services Committee**

Andre reviewed the minutes from the Member Services Committee meeting held on January 17, 2013. Highlighted issues are balance billing issues the number one identified issue from the call center and member walk-ins. Andre presented the document showing the overall membership snapshot and all the membership for December 2012. The report is broken out between Family, SPD and Duals and Family is the largest population. Dr. Fankhauser wanted to know what happened in July enrollment. Andre explained that is when the State stopped retro-disenrollment.

Call Center Statistics were discussed and it was mentioned that Dr. Araujo a Commissioner, noted at the Board meeting that almost 50% of the calls were by providers calling. Dr. Araujo was concerned about the abandonment rate. Andre explained the average standard is 5%. GCHP rate is still below the average. Call Center is tracking the Spanish abandonment rate and the numbers are coming down due to increased staffing and looking when most of the calls are coming in and having the appropriate Spanish speaking staff. Dr. Cho asked if they know why there was a blip in July. Andre explained that it was due to staffing issues. Cassie commented that the call center didn't have dedicated Spanish speaking staff. Dr. Fankhauser commented how terrific it was to see the calls going down for the Spanish speaking members and terrific work on the call centers part.

Andre presented the Member Services Committee 2013 initiatives and the analysis. The first initiative is to analyze provider calls and why are they 50% of the total calls and second initiative is analyzing balance billing issues for members. Will start doing a deep dive analysis on how to resolve these issues. First, we need to look at the reasons why. Dr. Fankhauser commented that providers have a hard time accessing the website because providers don't have their tax id number. The providers at VCMC bill under the Counties tax ID number and they don't have that number when they access the website, either the Provider web portal or the call center. Cassie remarked that she appreciated the comment by Dr. Fankhauser and will look into that. Andre stated they don't know the real reasons at this time for the high volume of calls. What they expect to happen with the QI initiative is to decrease provider calls and increase provider satisfaction. The second initiative is the balance billing issue; working together with provider relations and claims to identify possible solutions.

### **Grievance and Appeals Committee**

Dr. Wharfield discussed the grievance and appeals and the overarching idea is that this is a culture shift in the County to have Managed Care and that people normally don't know they have a PCP and they don't realize that they have a grievances and appeals process. The number of overall grievances for the Plan is very low.

#### Appeals

The total number of appeals for 2012 was 22. The compliance standard for responding to appeals is 30 days and the turnaround time (TAT) was good, two were out of compliance and it brought the percentage number to 91%, but the absolute number of non-compliant TAT was grievances was only 2. The Plan would like to maintain that number and improve on it. Through Member Services there is an enhanced process for tracking the appeals and believe that it is going compliance TAT will improve.

#### Grievances

Total grievances for the Plan in 2012 were 68. Looking at benchmark data that is available and doing a comparison, the grievance rate was 6.8 grievances/10,000 members. A benchmark example from MRMIB, showed a report of 900,000 members showing rates of 57 grievances/10,000 members. Our numbers are very low in comparison. So the question is whether everyone's care is perfect out there or the other possibility is that members don't understand the process. What we would like to do is enhance the capture of what these issues are. Education for all the departments to encourage people how to file a formal grievance if they are identifying a member complaint will begin. For example; Dr. Wharfield shared that she had picked up a grievance today just doing regular work. She was trying to deal with an issue and invited the member to file a grievance so it could be logged and tracked. Cassie mentioned they need to reinforce with ACS to do this as well. Dr. Wharfield stated that one of the departments they want

to work with is the Call Center. Dr. Cho commented that when the Plan first began they thought there were a lot of grievances because members were more familiar with the fee for service system and didn't like managed care. Jenny commented that at the beginning members were assigned to the wrong PCP and getting flooded with calls and there were system issues and some pharmacy related issues as well. Dr. Fankhauser asked if there is a phone number on their card as to who to call for grievances or a customer service phone number. Cassie said yes there is a phone number and the Plan is working on the website too, to make sure the information is available and clear. Lupe mentioned that the phone number and a description of the process are in the member handbook for filing a grievance both locally and through the State. A complaint cannot be filed as a grievance unless the member requests it.

There is also a mechanism for tracking grievance turnaround time. There are three types of letters that are sent out: acknowledgement, resolution and extension letters. Each of the letters has a different TAT time frame that needs to be met and we are 91% compliant with the 5 day turnaround time for the acknowledgement letters, the resolution letters are not so compliant and the TAT is at 69%. Improving compliance will be a focus and there is a tracking system in place. Just knowing the number does not tell the entire story. Compliance is already improving.

### **Network Management Committee**

Sherri Bennett discussed that she had recently acquired the role as Network Manager and has responsibility for Contracting, Provider Relations and Credentialing. She is looking at a different structure for the department to be a more provider friendly group. The department is staffing up and recently added two external provider relations representatives, one internal provider relations representative to handle phone calls. The external representatives will have time to be in the provider offices, educating the providers on the types of programs the Plan has to offer and asking the providers to offer these programs to the members. Two contract coordinators were hired. One will oversee the credentialing area and comes from Children's LA. She is very knowledgeable and knows a lot about contracting with providers and hospitals and knows the credentialing requirements. One person was promoted from Health Services and will oversee the provider database and the provider directory functions.

The department created a strategic plan and the whole team has taken part and it has been a fun exercise and the department can see where they are going and their accomplishments. In future meetings Network Management will present initiatives such as cleaning up the provider data bases.

The next goal will be a provider network audit. In the past month had to submit to the State provider updates. A one week extension was requested and the updates are due on February 8, 2013. During this process it was discovered there are issues in the way that data is being stored and not so much the data entry. The access data base has issues and moving forward on how to store the data and looking at Cactus or a different data base that has more restrictions on it and less vulnerable to changes. We will be going through our database, provider by provider and when it is cleaned up putting it into another database. Provider relations is working hard to validate the provider rosters coming in. Want to get monthly updates, quarterly was not sufficient and it was found that providers moved around or no longer in the area.

Other initiatives, provider reps will do site visits. We are copying what some of the other COHS are doing. Network Management was able to contact and meet some of the staff at the other COHS who shared how they track their provider visits. For example criteria for provider visits would be based on if a provider has 1,000 plus members the offices would get 4 visits a year. Trying to quantify the number of visits but

also based on the provider's needs. Dr. Fankhauser inquired as to what the visit would look like, would they schedule a time with the provider or just drop by. Sherri said it depends on the provider office but the Plan has to have something to offer prior to the visit. One of the offerings could be information, something good that is happening at Gold Coast. The current Provider Bulletin email blast doesn't get into the hands of the people who do the work and want to make sure the Providers know what is really going on at GCHP. Information provided at these visits could include, policies and procedures, and validating information such as appointment availability, routine vs. sick, what time allotments do they need. Network Management is also standardizing processes and tracking every piece of correspondence sent to the providers and they are being loaded into the KWIK system.

The final initiative is provider satisfaction surveys that are being developed and will be sent out to the providers. The surveys will be sent to both the PCP's and Specialists. A decision is being made as to internally handle the survey process or hire an external vendor. The external vendors are expensive. Cen Cal shared their survey tool and we may utilize that and do it ourselves. There is also an access to care survey. There will be a couple of types of access surveys. One will be after hours to see what the provider phone system says, and making sure the standard is met and the second is blind calls to the provider offices during the day. May hire an outside vendor or hire a couple of temporary staff to do it. They will also check available appointment times, special needs, etc. The department is making strides. Dr. Cho wanted to know there are State requirements for the survey. Sherri mentioned that there are annual requirements. A survey has not been done yet and the goal is to do it the second quarter of this year. Dr. Fankhauser commented that Network Management had done great work.

### **Delegation Oversight (DO)**

DO is continuing oversight of the delegated credentialing entities. The delegate's will be providing monthly Network updates beginning Jan 2013. Moving towards monthly updates and on the 15<sup>th</sup> of each month will receive those updates. On the DO graph it also indicates the type of specialty for each provider who was added or termed. DO is working closely with Provider Relations to ensure the updates are incorporated into our database and will translate into our network and directory.

DO is also working with Ventura Transit System (VTS) which is the new Non-Emergency Transportation provider. DO has conducted a readiness assessment and identified some minor issues that the vendor is addressing. There will be monthly monitoring for the first year to ensure compliance to the contractual agreements.

An onsite visit is being scheduled to monitor the Clinicas Specialty Contract. The purpose of the onsite visit is to ensure all the contractually required reporting is being captured and DO is also working with ACS to acquire the reported encounter data from Clinicas.

Finally, the Plan to Plan contracts are coming up and GCHP is working with an outside vendor to create a readiness tool and conduct the initial readiness reviews. In addition to the readiness tool, the vendor is creating an ongoing monitoring tool that will be utilized for the annual plan to plan audits.

428 physicians were credentialed by our three delegated organizations.

DO is now expanding from just credentialing with our goal to create a dashboard and identify milestones. It is an evolving process. Discussion ensued and Dr. Cho requested further details on ICE. Robert

explained that ICE is a collaboration of health plans and they have developed a template for delegation oversight and we use their tool. The tool is used for annual delegation oversight. We go onsite for each of the facilities.

### **Health Education/Cultural Linguistics Committee (HE/CL)**

The first year HE/CL focused on the department structure. The goal was to develop a health education department and unit as well as ensuring providers and members have access to culturally and linguistically appropriate materials. Dr. Cho covered some of the topics that were surveyed last year; These topics will continue to occur as a theme in the member newsletters. Lupe Gonzalez showed a sample of the newsletter sent out a couple of weeks ago. The newsletter went out to 45,000 unique household members. The newsletter is one way to disseminate health education materials. This year we are following the National Public Health Calendar and health promotion. This newsletter issue focused on the following:

- cholesterol,
- controlling blood pressure,
- four ways to measure blood pressure,
- information on diabetes,
- colon cancer screening,
- knowing the risks and signs of a heart attack,
- differentiated between genders because there are different heart attack signs for men and women,
- women's health that focused on pap smears and the importance of getting the test.

It is a bi-lingual newsletter and it goes out on a tri-annual basis. We are in the planning phases of the next issue. We are looking at a variety of issues based on the population. We have a diverse population and looking at Seniors and Children and making the newsletter friendly and specific to the members. One of the things that will be incorporated is a calendar of diabetes education, zumba classes, health activities and dental programs that are offered through community resources. Members will be able to tear it out and have a resource available in both English and Spanish. It is a self-management, self-referral process where they call directly. For example, if they are interested in a diabetes class they can call St. John's. Our goal is making it easy as possible for members to self-refer.

In the QI Committee packet there are two work plans. There are two plans because the two areas of HE/CL are unique and different and yet they do overlap. Health Education does cross over to member services and provider relations as well as the general community. In regards to the health topics we will continue to focus with provider relations in providing providers contact information for Cultural Linguistic services. The Plan is using the train the trainer model. We are training the provider relations staff to show the materials for telephonic interpreters, ASL interpreters and Mixteco interpreters to the provider offices. When provider relations go out they will have a packet of Cultural Linguistic materials available to give to the provider. Free of charge, so that our members who have diversity have access to those services. Each of the providers is given an ID badge along with provider access code that they can apply to their badge and questions that they need to ask directly. Recently gave VCMC over 200 cultural/linguistics materials for their center. We are currently working with CBAS centers, working with CMH and all the other providers. HE/CL is developing a spreadsheet to tally the number of contacts that we have and materials that are provided. Also this year looking at tracking the number of telephonic interpreters and total number of interpreters used internally and by the providers including the number of minutes used as well as cost. We will be focusing on cultural sensitivity training which is one of our

mandates. We are looking at bringing in individuals to meet with our staff as well as our providers. One training is already scheduled for March 2013. Pacific Interpreter's stresses the importance of having culturally linguistically sensitive staff and so they do a work shop on how to access an interpreter and sensitivity training for seniors. Last year the sensitivity training was put on the website so providers could access it. This year we are tracking it because that's a mandate and are to see if our providers are actually utilizing the website for training purposes and hands on training for seniors and individuals with disabilities. Partnering with community based agencies to help us.

Another initiative is addressing women's health issues; breast feeding and pre-natal care and working closely with WICK ensuring that the women who deliver have resources and information on breast feeding and lactation promotion. Big demand for general health information classes in the community. Continue to partner with local partners such as St. John's and the County, City of Ventura and other agencies as well.

The second work plan is one of the health education initiatives promoted by Dr. Wharfield, Jenny and Dr. Cho: the high use of ER utilization by our members. The three objectives are that we hope to move forward and establish an internal task force, identify the utilization and identify partnerships with local hospitals to reduce ER utilization. This is a draft and just beginning to develop a task force and come up with strategies for reducing ER visits. HE/CL contacted other health plans to see what they have done to reduce utilization. One thing they have done is utilize the health navigator model. We are looking at putting together strategies of working with our members directly and putting together policies when they are discharged from an ER such as 1.) Connect them with their PCP for follow up visits, instead of going back to the ER; and 2.) Increasing knowledge and education of the Medical Home and appropriate ER use. We will be proposing this plan to finance committee and senior management for staffing.

Lupe presented a prototype of a smoking brochure. It is in the process of being reviewed and going through the Communication department for outline. We are collecting feedback and will be sent to Dr. Fankhauser for his comments. Lupe already created a resource guide that focuses on the State's help line, support groups and community resources. We will be developing future brochures on different topics.

### **Utilization Management Committee (UM)**

Dr. Wharfield summarized the Utilization Management report. The main expenses are for the health plan are hospital days and average length of stay and ER utilization and readmission days. For our hospital days for average length of stay (ALOS), excludes SNF and LTC and there is going to be a lag until all the claims data is in. An NIH data report for 2011 shows the mean ALOS for all hospitals was 4.6. We are not at that number but we are not so far off for a new organization. Our largest utilizer VCMC shows their self-published rate is 4.9 ALOS. When we look at our claims data VCMC is at 4.07. There are two issues. Is VCMC doing better than they think they are or is there validation through the claims data? There are a lot of numbers that feed into the ALOS and they need to be analyzed before reporting final numbers.

Regarding hospital days the focus is on continued stay review process and improving that process. Hard work is being done with the CSO nurses to make sure they understand how to apply the Milliman Guidelines we use to review the patient. We are focusing both on their review of the cases and anticipating the discharge needs at the beginning of the hospital stay. Hiring a discharge planner will be a huge asset.

The other initiative we will have is to work with the UR departments to improve communication. A lot of going back and forth between the two organizations occurs and a decision needs to be made to either deny or try and get the right information. We need to closely monitoring the level of service. Is the patient in the DOU because the need or because there isn't a bed available. Are they really at intermediate level of care? Regarding comparison to bench marks. We have formally committed to reducing the bed days by half a day this year and we will do trending month to month. Dr. Fankhauser noted that based on 2012 data looks like first half of the year was worse than the second half of the year. Dr. Wharfield said the last drop in the few months of the year is does not demonstrate all the paid claims yes so not all data is available yet.

ER concerns are that we have people who use the ER multiple times and don't use their PCP. We think that patient education is going to be an important thrust and in addition we will try and contact those members directly for education. The little sample we have done, if you call somebody up about something in the past they can't recall. We want to partner with the ER's to get more real-time data. We want to talk to those members right when they come out of the ER. That's when we are going to get the most impact, getting them the follow up appointment they need. The medicines they need, essentially doing ER discharge planning. Dr. Fankhauser inquired how you would capture that information. Dr. Wharfield said there are some models in other cities where you get real time ER data. We are probably not going to get the day they are in the ER but we may be able to get it right after. The ER's know their census and they know who they saw but we need to enhance our partnership so we can get the information. Just as in good discharge planning like the SeaView model it requires immediate attention at the time of discharge and/or at the time of ER discharge. Long term there may be a role for a nurse advice line and we are continuing to discuss this. Will our members utilize it? If they are not understanding the concept of a medical home and having a PCP would they engage in a nurse advice line?

On readmission rates, there are no great bench marks. All 30 day readmission rates is a new initiative. Looking at data from 2011, All Cause readmission rates are 18%. We may not be doing so bad. We have to compare ourselves to the other COHS. The data will be available in June and we will have real benchmarks.

How will we approach, who will we select? Can't look at every single discharge. Selection criteria that we will be using are you somebody who is readmitted a lot (3 or more readmissions) are you socially isolated, NICU discharges and also anybody with multiple discharge needs including poly pharmacy. The discharge planner we are hiring is going to be key on targeting this. Concurrent stay nurses, new urgent discharge line for the DME and infusion companies so we can get the work done. The big thing that SeaView is doing is "eyes on the ground". Many organizations approach this process by making phone calls to members, it is probably a poor substitute for going into a home and seeing what is really occurring. What SeaView does is they have Nurse Practitioners who in a way have a private practice and they go out and assess if they see someone who has CHF they can order LASIK, will do the medication, and facilitate the follow up appointment. GCHP is not a care giver and we cannot hire nurse practitioners to go out and provide medical care. GCHP can approach that kind of activity through home health care. We will pick up the home health care at the time of discharge and then we will determine through them what we think the visit should be. Should the member be seen for example: 3 times a week for the next 3 weeks, then once a month or quarterly, whatever it needs to be? Dr. Wharfield did go out and look and see if there were organizations we can hire and do that kind of work and there are not any. Home Health agency is going to be a first step for us and how to create that service level. The readmissions rates we found were 17% to 18%.

Dr. Cho commented as far as bench marks go, comparing to our peers in California is more appropriate than comparing with National rates, and based on our demographics, for an example, Cen Cal has 27 years of data that are very reliable and reproducible. Our demographics are similar and Dr. Cho will ask them for their bench marks. The hospital days are more important than LOS, and Dr. Cho noted that the hospital days went down from 380 days to 325 days within the last 3 years and recently Cen Cal's readmission rates went down because of special programs. Better to use their bench marks than National Rates. Dr. Fankhauser commented that Inpatient utilization by top billing providers, St. John's Pleasant Valley Hospital has an unusual long rate. Is it because they have a rehab and everyone agreed that was the reason because they have a sub-acute. Dr. Wharfield noted this data pull is new for us and trying to not include LTC data. Dr. Fankhauser noted that if you compare the local hospitals, and VCMC who has a disproportionate number of oncology patients and the numbers could be skewed. Dr. Cho commented that you don't want a low number and find that it isn't achievable.

### **Approval Items**

#### **Quality Improvement Plan**

Dr. Cho said it had been looked at the last meeting. The requirement is that it does need to be reviewed the first quarter of the year. The only correction Dr. Cho had was to include Dr. Wharfield on the Medical Advisor Committee. With that correction a motion to adopt was taken. Sherri made the first motion and Dr. Fankhauser seconded it. All voted in favor. The QI Plan can now go to the Commission for approval.

### **Discussion Items**

#### **Readmission Quality Improvement Project (QIP)**

Julie Booth provided an update on the Statewide QIP – the readmission project that the State has mandated has to do with stratifying the data in a certain way. These readmission rates differ only slightly from the Plan's All Cause Readmission rates from what Dr. Wharfield showed. The specifications are different by excluding OB/GYN and requiring continuous enrollment of 120 days and no one under the age of 21. The data was reviewed line by line and confirmed each patient was an actual readmission. The patient had to be in the plan and not in and out. The readmission rate is 14% opposed to 18% for All Plan. Dr. Cho commented that the number is expected to be higher if it included the high risk patients. The State claims that when they run SPD's the readmissions rate is 20%. The State wants that number lowered. We stratify between SPD and non-SPD. A barrier analysis, fishbone diagram was designed based on QI Committee input and we made a decision to focus on the patient being readmitted and tie it into Dr. Wharfield's initiative and provide education and follow up after discharge. The State mandated Interventions includes hiring two additional staff which was the idea at the time but in further discussion with Dr. Wharfield and Dr. Cho the Home Health option may be a better solution.

#### **Facility Site Review**

The Physical Accessibility Review Survey (PARS) we have completed show only 6% of provider offices have medical equipment available but in reality the specific question is there an "exam table that automatically changes height" for the patient. Statewide most provider offices with the exception of VCMC have not been passing that one question. It has to be a certain kind of exam table. The PARS evaluate the offices if they are limited or have basic access. Dr. Wharfield commented that the basic means they don't have a ramp, parking accessibility, etc. The PARS for High volume specialists went into effect in November 2012. Most access was fine. Braille or signage was different for each facility.



## **HEDIS Status**

Julie Booth gave an overview of the Medical Advisory Committed (MAC) presentation. The minimum performance level (MPL) a ratio, must be achieved or we will get a corrective action plan. The High Performance Level (HPL) would be a wonderful level to reach. Some of the measures are administrative and calculated off of claims data and if it is a hybrid measure it is calculated on both claims and chart review. We will have an opportunity to look at the chart for the hybrid measures. Dr. Fankhauser commented that the health plan could help with these measures by actually prompting the patient on cervical cancer screening, adolescent well care visits, etc. The COHS comparison was shown and it shows the rates for all the COHS for 2012. These will be the bench marks when we do have results. Dr. Fankhauser noted we need to figure out what Cen Cal and Central Alliance are doing right. They have a lot of HPL's. We have visited Central Alliance and on calls with the COHS on what they are doing to get their numbers up but a lot of it has to do with claims coding. Also, has to do with the provider practice. Dr. Wharfield noted that most of these are positive measures. On the avoidance of antibiotic treatment in adults with acute bronchitis, how is that counted? Is it counted by the diagnosis and noted there was no antibiotic therapy? Julie commented that is it strictly based on claims data and a look at the diagnosis without an antibiotic. No chart review is performed. Julie noted that diabetes poor control is also an inverse measure. One of our measures was presented and GCHP is at 93% for kids who have access to care for the 12 to 24 month age range. This is based on test data only. The providers are going to get an email shortly about HEDIS giving them basic information and it is in the provider bulletin and discussed at meetings.

## **Operations Update**

Cassie Undlin noted that she is reporting in her role as COO on quality initiatives in the operations area. She also wanted to propose the establishment of a Quality Operations Committee that would report to the QI Committee. Cassie reported out on the Auto Adjudication Project which is in collaboration with Xerox. One of the issues on the State Corrective Action Plan (CAP) was that the auto adjudication rate is extremely low and the concern is that having too many manual processes increases the error rate. The Plan was mandated by the State to increase the rate 60% by the end of December. The Plan did not make 60% in December and she did not think we could since it was an unreasonably high number, but headway was made and the goal as a project is to hit 60% by the end of June. We do believe it is an important issue and so working collaboratively with Xerox and looking at requiring manual intervention.

All pending claims were studied and looked at the highest categories to focus on first. One of the categories as lay people is to make a match between the treating provider and the provider of record and the EDI electronic information that comes to Xerox from providers. The number one priority is implementing a claims editing system that will help. Other issues are changes in how systems are set up and programming changes and LTC. The system is designed for a hospital system and claims. The way LTC bills are submitted they have a different end date; hospitals are the date of discharge. LTC billing cuts off at the last day and that last day had to be manually added in.

Manual Data entry was tried to simulate an EDI claim coming in. Found that there were processes that needed to be remapped so they would look just like an EDI claim. Another issue is coordination of benefits. Have to make sure to coordinate with the EOB. But, fully anticipate that one of our over payment issues is around not getting the EOB's from the providers. What we did was assess what all the things we thought were important to improve the auto adjudication rate. We looked at what was pending

and prioritized the issues that were an easy fix. What we have seen is an increase in auto adjudication to approximately 23%. At the end of the year the auto adjudication was around 35%. In February there will be changes going into effect and expect to see an increase mapping on data entry. This is a Six Sigma project and meets all the project parameters. Dr. Cho had a question as to whether auto adjudication will increase provider satisfaction. Cassie stated there is still a lot of work to do, but yes because of fewer errors, provider satisfaction should increase.

#### Inventory

Inventory processes are a QI process and we need to reduce the number of pends and look at turnaround time for claims payment. Looking at exceeding the State requirements on TAT. We are required by the State to meet 15,000 claims inventory at a certain point in time. It was met a one point in time and now we are going up and down. The state wants to make sure we can keep on track and keep inventory at a low number. It will rise at some point. Currently at a 98% of 30 days and our requirement is 90%.

#### Quality Operations Committee

Cassie requested the forming of a formal committee that pulls all the operational committees together to discuss what they are doing, but the other committees would still be their own committees. Try to make it more of an operational focus on process improvement.

Any further comments? There were none.

#### **Adjournment**

Dr. Cho adjourned the meeting at 4:59pm. Next QI meeting will be scheduled on May 2, 2013.

Submitted by Julie Booth

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

Charles Cho, M, D., Chair



## **AGENDA ITEM 4a**

To: Gold Coast Health Plan Commissioners  
From: Michelle Raleigh, Chief Financial Officer  
Date: February 25, 2013  
RE: FY 2012-13 Financial Audit Contract

### **SUMMARY:**

Staff is proposing to utilize McGladrey LLP (McGladrey) to perform the Plan's FY 2012-13 financial audit. The Plan's Executive / Finance Committee also recommended this action during the 02/07/13 meeting.

### **BACKGROUND / DISCUSSION:**

The Plan's contract with DHCS requires an annual audit be performed on the Plan's financial statements. This also provides confidence to the community and the Commission that the Plan's financial condition is accurately represented. To meet these needs, the Plan hires a firm qualified to perform this annual financial audit.

In 2011, the Plan solicited a Request for Proposal (RFP) for auditing services and selected McGladrey after a thorough review and evaluation process. McGladrey has performed the financial audits for the Plan's first two years (i.e., year ending 06/30/11 and 06/30/12). During the course of these audits, McGladrey has gained an understanding of the Plan staff, operations, and finances.

The Executive Finance Committee is recommending that the Plan use McGladrey for a third year. This recommendation is being made for several reasons, including:

- McGladrey has been working with the Plan since start-up and will be able to leverage relationships and experience, and
- The audit pre-work for the FY 2012-13 year will start in March, which makes issuing and scoring an RFP and finalizing a contract very difficult in that timeframe.

McGladrey has provided an updated engagement letter with a quote that matches previous fee projections. The Plan's Audit Committee Chair will need to sign the engagement letter, along with the Plan's CEO and CFO.

The Plan anticipates issuing an RFP and proceeding with a new procurement after the FY 2012-13 audit is complete.

**FISCAL IMPACT:**

McGladrey's quote to perform the FY 2012-13 financial audit is \$97,000. The FY 2011-12 financial audit was \$95,000.

**RECOMMENDATION:**

Staff proposes to utilize McGladrey for the FY 2012-13 audit and seeks the Commission's recommendation. The Executive / Finance Committee also provided recommendation on this action during the 02/07/13 meeting.

**CONCURRENCE:**

Executive / Finance Committee (02/07/13)

**ATTACHMENTS:**

None.



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

# Utilization And Care Management

February 25, 2013



## Table of Contents

Utilization Management (UM) Process.....	4
Care Management (CM) Process.....	5
UM/CM Focus for 2013.....	6
Inpatient Hospitalization.....	7
Enhanced Continued Stay Review (CSR).....	9
Enhanced Discharge Planning.....	10
Home Health Follow-up.....	11
Readmission Rate.....	14
Emergency Room Utilization.....	15

## Introduction to UM/CM

The role of Utilization Management (UM) and Care Management (CM) is to deliver the right care, at the right time, in the right setting.

## Utilization Management Process

- Nurse Specialists
  - ✓ Prior Authorization
  - ✓ Continued Stay Review
  - ✓ Discharge Planner
- Outcomes
  - ✓ Authorization
  - ✓ Denial
    - Peer to Peer
    - Appeal
- Review Criteria
  - ✓ Milliman Care Guidelines-national evidence-based standards
  - ✓ Specialty review in field of expertise



## Care Management Process

- RNs and social worker
- 1:1 facilitation of care for selected members
- Personalized care plan
- Engage support of family, primary care physician
- Conference calls
- Education about disease process

## UM/CM FOCUS FOR 2013

Inpatient Hospital  
Utilization

Readmission  
Rate

Emergency  
Room Utilization

## INPATIENT HOSPITALIZATION

Where we are:

	Sept 2011 – Aug 2012	Jan 2012 – Dec 2012
Bed days/1000	410	348
Average length of stay	4.94	4.81

## Areas of Focus for Inpatient Hospital Utilization

- Enhanced Continued Stay Review
- Enhanced Discharge Plan
- Home Health Follow-up

## ENHANCED CONTINUED STAY REVIEW

- Improved application of Milliman Care Guidelines
- Improved communication with hospitals
- Early anticipation of discharge needs

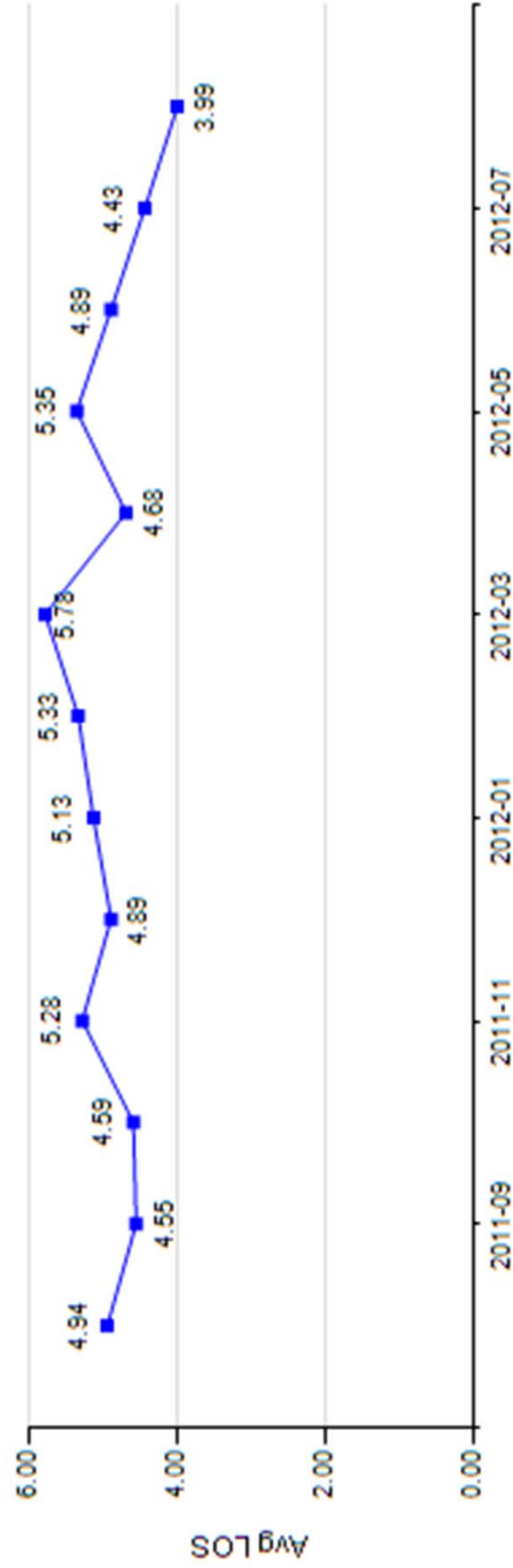
## ENHANCED DISCHARGE PLAN

- Dedicated Discharge Planner hired
- Bridges CSR to CM
- Urgent discharge phone line
- Home Health follow-up
  - In-home evaluation and care plan

## HOME HEALTH FOLLOW-UP

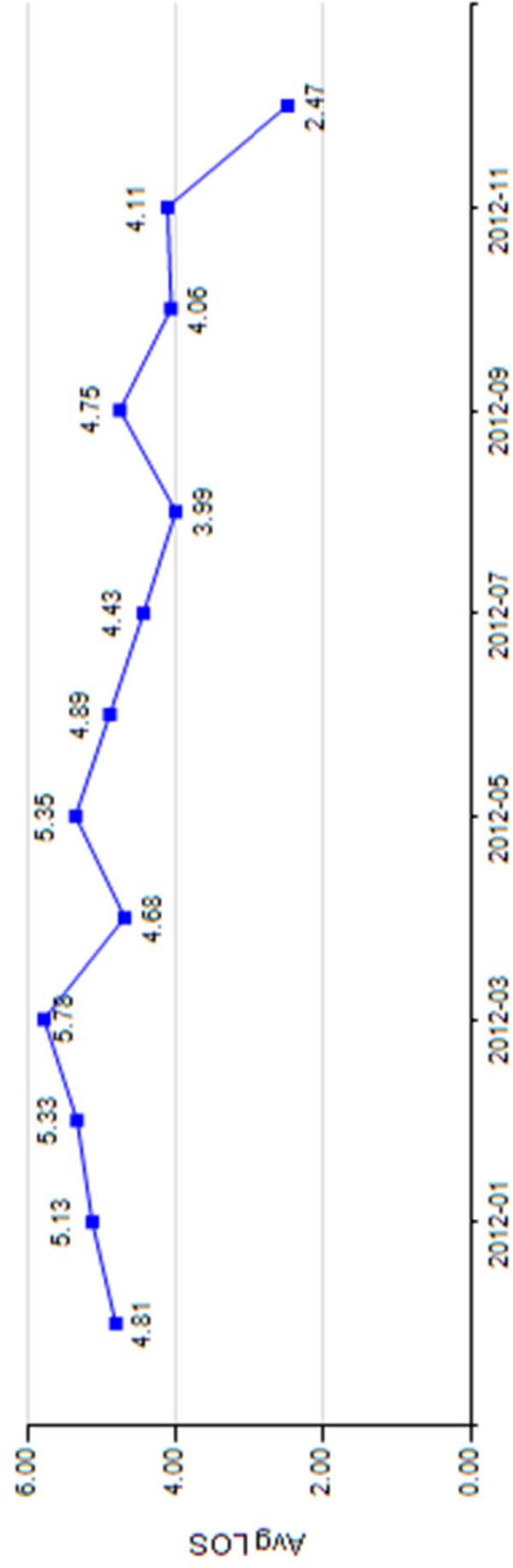
- In-home evaluation for medically fragile patients with multiple or complex discharge needs
  - NICU
  - Polypharmacy
  - Social isolation
  - History of multiple admissions

## Inpatient Utilization Summary September 2011 through August 2012





## Inpatient Utilization Summary January 2012 through December 2012



## READMISSION RATE

### Where we are

- September 2011 through December 2012 - 15.34%

### Definition

- Readmission for any reason within 30 days

### Focus

- Discharge Planning
- Follow up on completion of discharge needs
- Home visits
- Case management referral

## Emergency Room Utilization

- Where we are
- Total ER visits September 2011 through August 2012 - 47,651

Focus

- Member education
  - What is an emergency?
  - Do you know your PCP?
  - Do you know your PCP's Urgent Care hours?
  - Review of ER Discharge Plan with Health Navigator
- Flyer, web, and newsletter
- 24 hour nurse advice line
- Overutilizers/Avoidable ER visits
- Partner with ER for real time encounter information

## Top Emergency Room Diagnoses

- Respiratory tract infection
- Abdominal pain
- Sprain
- Skin Infection
- Headache
- Ear infection
- Back pain
- Urinary tract infection
- Chest pain
- Nausea and vomiting
- Asthma
- Allergic reaction
- Virus
- Tooth and jaw pain
- Diabetes



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



# Provider Advisory Committee Meeting

**February 12, 2013**

**Sherri Tarpchinoff Bennett  
Provider Network Manager**

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



# Primary Care Payment Increase

## ACA Section 1202 Implementation

## Overview

- Section 1202 of the Affordable Care Act increases payments to the Medicare equivalent for specified services for qualified providers.
- Final rule was published in Federal Register November 6, 2012
- For CY2013 and CY2014, States must pay Medicare rates for specified primary care services.
- Guidance continues to be provided regarding:
  - An updated 2013 Medicare Physician Fee Schedule
  - Statewide rates
  - Managed care rate methodology
- The increased payments are retroactive to January 1, 2013 for both FFS Medi-Cal and Managed Care.

## Eligible Providers

- **According to the final rule, physicians must meet the following rules:**
  - Board certification in family medicine, internal medicine and/or pediatric medicine. (OB/GYN and Emergency physicians are not categorically eligible), or
  - Board certified in a subspecialty related to one of the listed specialties, or
  - At least 60 percent of billed services to Medi-Cal must fall within the E&M or vaccine administrative codes covered by the regulation
  - Nurse Practitioners and other physician extenders are eligible if the work under the direct supervision of a qualified physician.
  - Providers must be enrolled in Medi-Cal

***\*\*Services provided by Federally Qualified Health Centers ,Rural Health Clinics , and health department/clinic are not qualified but will continue to receive their PPS Rate.***



## Eligible Providers

- The recognized boards are:
  - American Board of Medical Specialties – [www.abms.org](http://www.abms.org)
  - American Osteopathic Association- [www.osteopathic.org](http://www.osteopathic.org)
  - American Board of Physician Specialties – [www.abps.org](http://www.abps.org)

*\*A listing of qualified subspecialties is available at each web site.*

## Eligible Providers

- Physician's must "self-attest" their eligibility
- Once the self attestation mechanism is developed by DHCS, there will be an established timeframe for providers to attest and those who self-attest during that timeframe will receive payments retro-active to January 1, 2013.
- Physicians cannot receive additional payments until they self-attest.

## Services and Fee Schedule

- E&M Codes 99201 – 99499 and their successor codes.
- Vaccine administrative codes 90460, 90461, and 90471-90474 and their successor codes.
- Codes that are not covered by Medi-Cal are not eligible for the increase.
- The increase does not apply to services provided to beneficiaries dually eligible for Medicare and Medi-Cal.
- CMS will provide equivalent rates to codes that are not covered by Medicare.

# Claims Payment / Methodology

It is up to DHCS to develop a payment methodology to MCOs for CMS approval – they have until March 31, 2013 to do so.

## Three Models have been proposed:

### Model 1: Full risk prospective capitation

- The State would calculate a capitation rate based on the enhanced rates and pay MCPs prospectively with no reconciliation

### Model 2: Prospective capitation with risk-sharing that incorporates retrospective reconciliation

- The State would pay the pay the MCP prospectively, but would reconcile retrospectively.

### Model 3: Non-risk reconciled payments for enhanced rates

- MCPs summarize actual encounter data to calculate the total payment owed to eligible providers and submit to State for payment.

# Claims Payment / Methodology

- Increased rates must be passed on to the rendering provider
  - this includes salaried physicians.
  - Payment directly to rendering provider?
  - Payment to group and the group reports back to the MCP that 100% of the money was distributed to rendering provider?
- Reconciliation must take place at least quarterly.
- Plans are not required to pay enhanced payments until they receive funding from DHCS (estimate June/July 2013)
- Retroactive payments are not subject to timely filing requirements.

## Claims Payment / Methodology

- It is important for providers (*especially capitated providers*) to submit claims with all encounter information – without this information, GCHP will not be able to adequately identify claims that are eligible for retro-active payment.

# QUESTIONS



# Financial Forecast – Update as of 2/25/13

Table below provides a status update of the Plan’s progress towards implementing initiatives reflected in the Financial Forecast provided to the State of 12/11/12. Overall, results expected to be more favorable than forecast.

Areas	Number of Initiatives	Status Update
Correct coding of members	2	<ul style="list-style-type: none"> <li>Both initiatives (i.e., correct coding of LTC and Medicare members) are underway and on track;               <ul style="list-style-type: none"> <li>LTC-confirmed 32 of 40 historical members converted; an additional 24 are pending from HSA;</li> <li>Part A-anticipating results of Part A conversions with the February Enrollment file at the end of the month.</li> </ul> </li> <li>Strategies being implemented to ensure ongoing conversions</li> </ul>
Collecting and processing overpayments, coordinating benefit payments, enhancing claims payment edits, and collecting from reinsurance vendor	8	<ul style="list-style-type: none"> <li>Half of the initiatives have been sent to the vendor for recovery processing, the other half are being analyzed and quantified. Anticipating recoveries beginning in March. Examples of recoveries includes, but not be limited to:               <ul style="list-style-type: none"> <li>Overpayments (e.g., paid at the incorrect rate, denied claims, duplicate claim payments)</li> <li>Voluntary refunds (i.e., provider refund checks)</li> <li>Credit Balance Letters (e.g., refund checks related to GCHP Hospital Credit Balance Letter)</li> <li>Other recoveries (e.g., reinsurance of high dollar claims identified)</li> <li>Coordination of Benefits (e.g., using cross-over Medicare payments to determine COB)</li> </ul> </li> <li>Coordinating with vendor to review and refine our combined work flow process to ensure we are aligned.</li> <li>Strategies being developed to identify future claims processing issues and implement changes quickly</li> </ul>
Provider re-contracting	4	<ul style="list-style-type: none"> <li>Non-emergent medical transportation full-risk contract implemented on schedule (2/1/13).</li> <li>Additional provider re-contracting discussions are underway; finalizing the schedule with remaining providers.</li> </ul>
Enhanced utilization and case management	3	<ul style="list-style-type: none"> <li>Strategies defined and on track to implement</li> <li>Currently reviewing reports to monitor progress</li> <li>Additional information to be provided at 2/25 Commission meeting</li> </ul>
Managing administrative budget & TNE requirements	2	<ul style="list-style-type: none"> <li>Defining process to monitor budget monthly in coordination with all departments</li> <li>Working with the County to determine approval and timing of additional funding</li> </ul>



GCHP Financial Forecast Status Update  
Results through: December 31, 2012

This document provides a status update to Gold Coast Health Plan's (GCHP or Plan) financial forecast provided the Department of Health Care Services (DHCS) on December 11, 2012. The financial forecast was provided in response to the Corrective Action Plan (CAP) Amendment and projects revenue and expenses through 6/30/14. This status update compares actual financial results to the financial forecast and highlights major differences.

This update compares actual activities to those estimated in the financial forecast for both November and December of 2012 (the financial forecast included actual results through October, 2012). These two months are summarized in tables below.

**November 2012**

<b>Highlights of Major Differences between Financial Forecast and Actual Financial Results</b>				
<b>Financial Statement Category</b>	<b>A. Financial Forecast</b>	<b>B. Actual</b>	<b>C. Difference (A-B)</b>	<b>Comments</b>
Revenue	\$25.7M	\$25.4M	(\$0.2M)	Differences due to: <ul style="list-style-type: none"> <li>• CBAS members below forecast</li> <li>• membership mix</li> </ul>
Health Care Costs	\$24.1M	\$22.4M	\$1.7M	Differences due to: <ul style="list-style-type: none"> <li>• Reinsurance recoveries of \$1.3M received in November (vs. expected in January)</li> <li>• Lower reserve estimates*</li> </ul>
Administrative Costs	\$1.8M	\$2.1M	(\$0.3M)	Differences due to higher expenses in: <ul style="list-style-type: none"> <li>• consulting services</li> <li>• ACS claims processing fees</li> </ul>
Net Income	(\$0.2M)	\$0.9M	\$1.1M	

**December 2012**

<b>Highlights of Major Differences between Financial Forecast and Actual Financial Results</b>				
<b>Financial Statement Item</b>	<b>A. Financial Forecast</b>	<b>B. Actual</b>	<b>C. Difference (A-B)</b>	<b>Comments</b>
Revenue	\$25.7M	\$25.7M	\$0.0	N/A
Health Care Costs	\$24.1M	\$22.1M	\$2.0	Differences due to lower reserve estimates*
Administrative Costs	\$1.8M	\$2.0M	(\$0.2M)	Differences due to: <ul style="list-style-type: none"> <li>• Timing of new hires</li> <li>• Timing of vendor work</li> </ul>
Net Income	(\$0.2M)	\$1.6M	\$1.8M	

\* Note – reserve estimates are reviewed by State Monitor (BRG) each month.

Also important to note that as of the end of December, 2012:

- Line of Credit - Initial line of credit of \$2.2 million that was expected in December 2012, was received in December.
- TNE – phase-in requirement has increased to 52% of the 100% level as of 12/31/12 per the State’s TNE phase-in schedule (i.e., at \$7,982,225 per Orange Blank submitted to State). The Plan’s TNE at 12/31/12 was a negative \$5,672,496, resulting in a deficit of \$13,654,721. This deficit is smaller than expected in the financial forecast (i.e., \$17,436,735) due to better than expected operating results in November and December.



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

# Healthy Families Program Transition to Medi-Cal



# Overview

- I. State Mandate**
- II. Transition Timeline**
- III. Expected Changes**
- IV. Continuity of Care**
- V. Member Notification & Outreach**

## **State Mandate**

- **Assembly Bill (AB) 1494**
- **Healthy Families Program (HFP)  
Transition to Medi-Cal Managed Care**

## Transition Timeline

- **Four Phases Over A One Year Period**
  - **From January to September**
  - **Gold Coast Health Plan – Phase III**
- August 1, 2013**

## HFP Transition to Medi-Cal

- HFP Enrollment in Ventura County
 

▶ Anthem Blue Cross-EPO	43	0.2%
▶ Anthem Blue Cross-HMO	5, 876	29.0%
▶ Kaiser Permanente	3, 185	15.7%
▶ Ventura County Health Plan	<u>11, 162</u>	55.1%
Total	20,266	

Source: MRMIB- December 2012

# Transitions By County

- Phase Ia- Approx. 411,654 children total in Phase Ia & Ib, Ic. January 1, 2013: Alameda, Riverside, San Bernardino, San Francisco, Santa Clara, Orange, San Mateo, and San Diego.
- Phase Ib- March 1, 2013: Contra Costa, Fresno, Kern, Kings, Madera, Tulare, Sacramento, San Diego (Health Net), Napa, Solano, Sonoma, Yolo, Monterey, Santa Cruz, Santa Barbara, and San Luis Obispo
- Phase Ic- April 1, 2013 children in a Health Net plan in the counties of: Kern, Los Angeles, Tulare, Sacramento, San Diego, San Joaquin, and Stanislaus
- Phase II- April 1, 2013. Approx. 261,060 children who are in a HFP subcontracted plan will transition to a Medi-Cal managed care plan.
- Phase III- August 1, 2013. Approx. 152,602 children not in a contracted or subcontracted Medi-Cal managed care plan will transition to a Medi-Cal managed care plan. GCHP is in Phase III.
- Phase IV- September 1, 2013. Approx. 42,753 children who reside in a county that does not Medi-Cal managed care will receive services on a fee-for-service basis.



## Expected Changes

- Aid Codes
- Premiums/Family Incomes
- Eligibility Coordinated Through Ventura County Human Services Agency

# Continuity of Care

- **Network Adequacy**
- **Member Assistance**
- **Information**

# Member Notification & Outreach

- State Scheduled Mailing of Notices
- Communication & Outreach Effort to Members
- Member Assistance
- Information

## Assistance & Service

- HSA Enrollment Assistance 1 805 385-9363
- GCHP Member Services 1 888 301-1228
- TDD/TTY Line 1 888 310-7347
- State HFP Member Line 1 886 848-9166
- Websites: [www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)



# Gold Coast Health Plan's Mission

To Improve the Health of Our Members  
Through the Provision of the Best Possible  
Quality Care and Services

Contact GCHP  
888-301-1228  
[www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)



# Questions ?

## **AGENDA ITEM 5e**

To: Gold Coast Health Plan Commission

From: Michael Engelhard, Chief Executive Officer  
Melissa Scrymgeour, Director, IT

Date: February 25, 2013

RE: GCHP Medical Management System Replacement

### **SUMMARY:**

Currently, Gold Coast Health Plan (GCHP) utilizes ICMS as its Medical Management System (MMS) to coordinate authorization of medical services for our eligible member population. ACS, our managed services provider, has informed GCHP that the ICMS system is not ICD-10 compliant and will be sunset June 2013. Consequently, GCHP must select, install and implement a new ICD-10 compliant MMS by 10/01/2014, in accordance with the CMS mandated ICD-10 deadline. ACS has committed to continued support of ICMS until GCHP has implemented the replacement MMS solution.

### **BACKGROUND:**

When GCHP was formed, the Plan entered into an agreement with ACS, a division of Xerox Corp., to provide the core systems, staff, operations, and application development support to process and administer membership, claims, and customer service. The original ACS proposal did not account for a MMS solution. GCHP entered into a subsequent agreement for ACS to provide a medical management system (titled "ICMS"). As part of this additional agreement, ACS would also provide nurses to GCHP as part of staffing the medical management function.

### **DISCUSSION**

ACS does not plan to remediate ICMS for ICD-10 compliance and as such, has instructed GCHP to select a replacement MMS. ACS initially stated they would support ICMS through the end of June 2013, but has since extended support while GCHP implements the replacement system solution. Xerox conducted its own RFI / RFP process and has entered into a preferred partnership with CH Mack as a replacement solution to ICMS. However, Xerox has recommended that GCHP conduct its own selection process, and even if CH Mack is selected as the system, recommended that GCHP negotiate a separate licensing agreement.

GCHP intends to select and implement the replacement MMS by the end of calendar year 2013 in preparation for expected membership growth beginning January 2014, due to the ACA expansion. GCHP will follow an expedited RFI / RFP (Request for Information / Request for Proposal) process for system selection and has engaged an independent consultant with extensive experience in MMS selections, whose sole focus is to manage the selection process.

Between 01/01/13-03/31/13, we plan to identify, evaluate, and select a medical management system, including, but not limited to the following tasks:

- Survey of potential vendors using a rapid RFI process
- Secondary vendor screening (if needed)
- Create tailored requirements and scoring tools for finalist presentations
- Create key scenarios for final vendors to prepare for finalist presentations
- Coordinate and facilitate vendor presentations
- Conduct vendor references and site visits
- Create final system recommendation based on overall vendor scores

In early January, GCHP issued a MMS solicitation of interest to ten vendors, all of whom have active customers currently using their MMS solution. Upon execution of our non-disclosure agreement (NDA), nine vendors were issued the RFI and provided responses by the deadline of 02/15/2013. One vendor withdrew from the selection process. Our next steps are to review the RFI responses and narrow the list down to no more than four vendors who will receive and complete the RFP.

As part of the RFI / RFP process, we will utilize key selection criteria, taking into consideration multiple factors, including:

- Business functionality / usability
- Cost
- Technology Platform (system needs to grow with GCHP)
- Ability to meet aggressive project deadline (12/31/13)
- Vendor experience (solution expertise)

**FISCAL IMPACT:**

The cost of retaining the system selection consultant is approximately \$20,000, whose work will be conducted over the course of 90 days. The cost to issue and evaluate the RFI / RFP will be absorbed by in-house staff. The cost of the new system will be brought to the Commission when more concrete information is available.



**STAFF ACTION:**

Staff will move forward with the RFI / RFP process for a medical management system replacement – target vendor selection and contract execution by 04/30/2013, and system implementation by 12/31/2013.

**CONCURRENCE:**

N/A.

**Attachments:**

None.



# Gold Coast Health Plan<sup>SM</sup>

A Public Entity

February 25, 2013

**Tatum Team**

Cassie Undlin  
Debbie Rieger  
Laurel Kiichli

## Tatum Status Update

Tatum is concentrating on five primary areas for their engagement:

- Project Management – providing oversight on key initiatives.
- Staff Evaluation and Development – improving departmental cohesiveness through development of policies and procedures, making staffing recommendations and restructuring where needed.
- Operational Optimization – assessing the “as is” state of current operations, and recommending and/or developing tools to further enhance operations.
- System Optimization and Configuration – working with internal and external resources to enhance and further automate key processes.
- Transitioning – transferring work to GCHP staff with appropriate amount of training and documentation

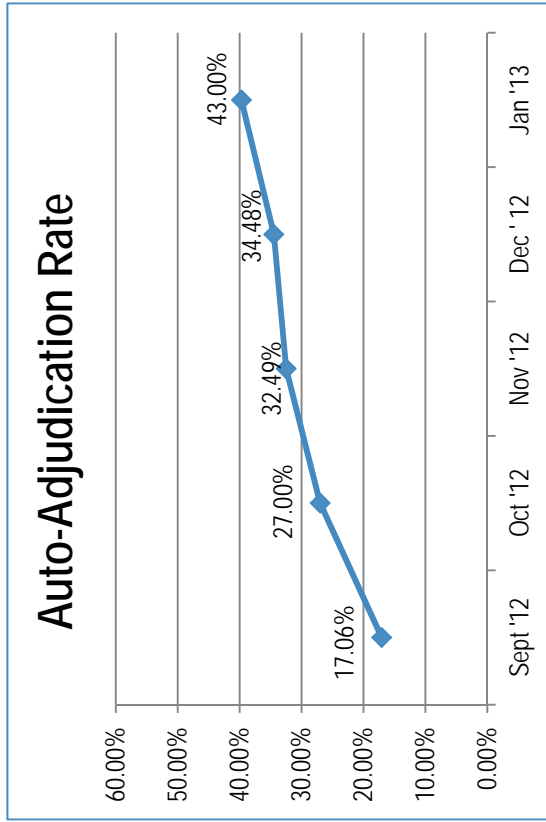
## Tatum Key Member and Provider Benefits

- **Membership Services**
  - Restructured call center to separate member and provider calls to improve service levels
  - Analysis of Aid Codes, resulting in increased revenue
- **Network Management**
  - Implemented monthly provider operations bulletin
  - Evaluated and implemented pricing policies resulting in reducing inventory, improving turnaround time, and cost savings
- **Long Term Care**
  - Review and implement changes in Long Term Care claims processing, improving accuracy of payments
  - Implement contracting strategy focused on level of care, to improve the member experience
- **ikaSystems review**
  - Phase 1 of the systems review completed and implemented, changes that result in improvements in accuracy and efficiency
  - Implemented weekly meeting with ikaSystems and Xerox
- **Better tools for Medical Management**
  - Implement Health Plan Tools software that will allow us to evaluate and score the health risk of SPD and other high risk members

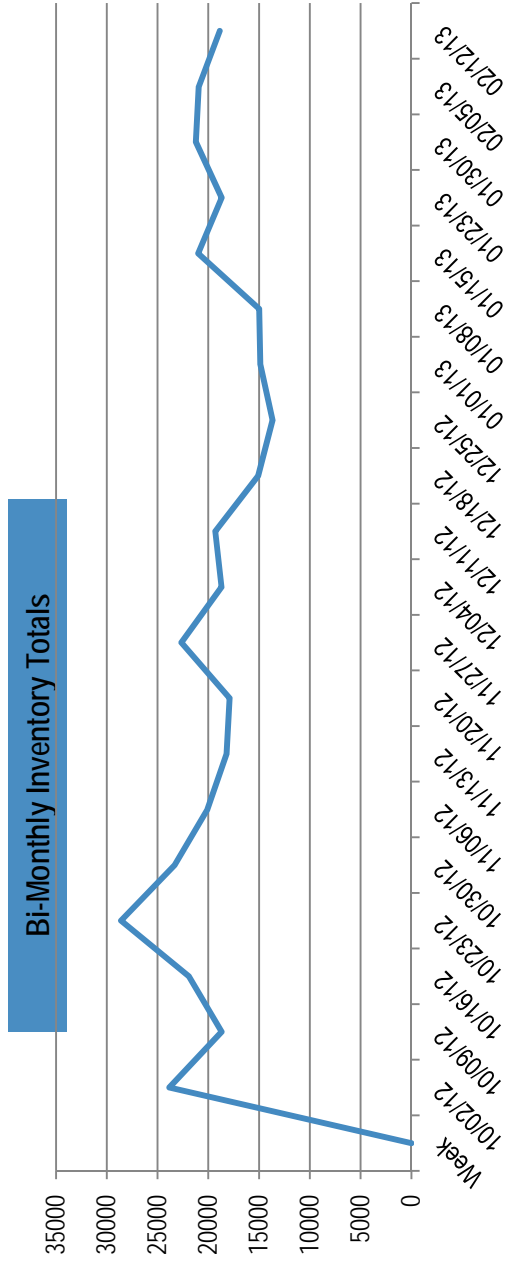
## Tatum Key Accomplishments

- Reduced claims backlog from a high of 55,000 to 15,000
- Increased auto adjudication rate from 22% to 43%.
- Improved turnaround time for paid claims within 30 days from 63% to 99%
- Reduced unprocessed refund inventory from 1110 to 48. Currently maintaining <20 day turnaround time.
- Restructured Provider Contracting and Services Department
- Improved internal communications, through the Operations Committee
- Renegotiated Xerox nursing contract, resulting in an annual savings of \$400,000
- Recovery Services implemented with calls and mailings started February 11, 2013, with anticipated returns starting in early March
- State requirements 3.A and 3.B AIRS and 35 C through January 2012 completed and submitted
- QI/HSAG encounter questionnaire submitted
- IKA 5.3 upgrade to Xerox for testing
- Finalized interest policy based on legal review

## Operational Optimization – Claims Stats:



Auto Adjudicate Target:  
 30% by December 31, 2012  
 60% by June 30, 2013



The following slides track the progress on each of these initiatives. Below is the description of the various colors and comments that are utilized on the tracking tool.

GHCP Tatum Update	
Key	Description
●	Green - We are on track to deliver committed scope by committed deadline with committed resources/funding.
●	Yellow - We are not on track to deliver committed scope by committed deadline with committed resources/funding, but we have a plan to get back to green.
●	Red - We are not on track and we need a plan to get the project back on track.
	Grayed out: not started
Trans	Transitioned to GCHP staff
Comp	Task completed

## Project Management

GHCP Tatum Update						
Scope	Category	Sub-category	Jan 27	Feb 3	Feb 10	Feb 17
			Project Management	Specialty Contract		●
	Plan to Plan tool kit		●	●	●	●
	Enrollment issues	Long Term Care aid code	●	●	●	●
		Medicare Part A coverage	●	●	●	●
		Administrative Members	●	●	●	●
	Long Term Care		●	●	●	●



## Staff / Evaluation Development

GHCP Tatum Update						
Scope	Category	Sub-category	Jan 27	Feb 3	Feb 10	Feb 17
			Staff Evaluation/ Development	IT	IT leader, transition to IT Director	●
		Restructure IT Department	Trans	Trans	Trans	Trans
		Develop Reporting Team	Trans	Trans	Trans	Trans
		Provider Relations Restructure	●	●	●	●
	Provider Relations	Improve Provider Collaboration	●	●	●	●
		Provider Contract Development	●	●	●	●
	Member Services	Member resolution focus	●	●	●	●
		Grievance & Appeals				
	Claims	Claims auditing	●	●	●	●
		Provider Claims Disputes Re-design	●	●	●	●
	Interdepartmental communications	Operations Committee	●	●	●	●
		Reports Committee	●	●	Trans	●
	Vendor Management	Vendor Contract Manager	●	●	●	●

## Operational Optimization

GHCP Tatum Update						
Scope	Category	Sub-category	Jan 27	Feb 3	Feb 10	Feb 17
			Operational Optimization			
	Claims Processing	Claims process improvement	●	●	●	●
		TAT, Inventory	●	●	●	●
		Interest Policy	●	●	●	●
		Auto Adjudication improvement	●	●	●	●
	Provider Contracting	Non-emergency medical transport	●	●	●	●
		RN Rate Reductions	●	●	●	●
	Vendor Management	ACS monitoring	●	●	●	●
		Improve Service Level and Key Performance measures	●	●	●	●
	Financial Recovery Project	Revenue generation/cost avoidance/cost savings	●	●	●	●

## System Optimization and Configuration

GHCP Tatum Update						
Scope	Category	Sub-category	Jan 27	Feb 3	Feb 10	Feb 17
			System Optimization and Configuration	Health Plan Tools		●
	Milliman		Trans	Trans	Trans	Trans
	ICES		●	●	●	●
	System Configuration	IKA set up	●	●	●	●
	Work Flow Management	Enhance use of tool	●	●	●	●

The ultimate goal is to successfully transition the activities performed or overseen by Tatum staff to internal or external sources managed by GCHP

GHCP Tatum Update						
Scope	Category	Sub-category	Jan 27	Feb 3	Feb 10	Feb 17
			Transition activities	IT Director		●
	COO					
	Claims Pricing		●	●	●	●
	Provider Contracting		●	●	●	●
	Milliman		Trans	Trans	Trans	Trans
	ACS contract development		●	●	●	●



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



# Health Care Cost Reserves (IBNR Primer)

Presentation to the Commission

02/25/13

# Agenda

- ✓ Background
- ✓ Definitions
- ✓ Payment Lag
- ✓ Reserve Calculation Methods
- ✓ GCHP's Approved Method
- ✓ Closing Comments

## Background

- ✓ Reserves are an important driver of financial results since a high percentage of current month expenses are estimated
- ✓ Several adjustments were made to GCHP's reserves in initial months due to:
  - Low estimates of costs
  - Unsteady payment patterns

## Definitions

Incurred But Not Reported or “IBNR”: costs associated with a medical service that has been provided but for which the health plan has not received the claim.

*Estimating IBNR is a critical element to understanding the financial condition of a managed care organization.*



# Definitions

Incurring but not paid or “IBNP”: total health care claim reserve. IBNP is the sum total of all claim reserve pieces:

IBNP = IBNR + Claims Payable

- IBNR = “incurred but not reported”, indicating claims that have not yet been reported
- Claims Payable = claims that have been reported, but not yet paid

## Definitions, Continued

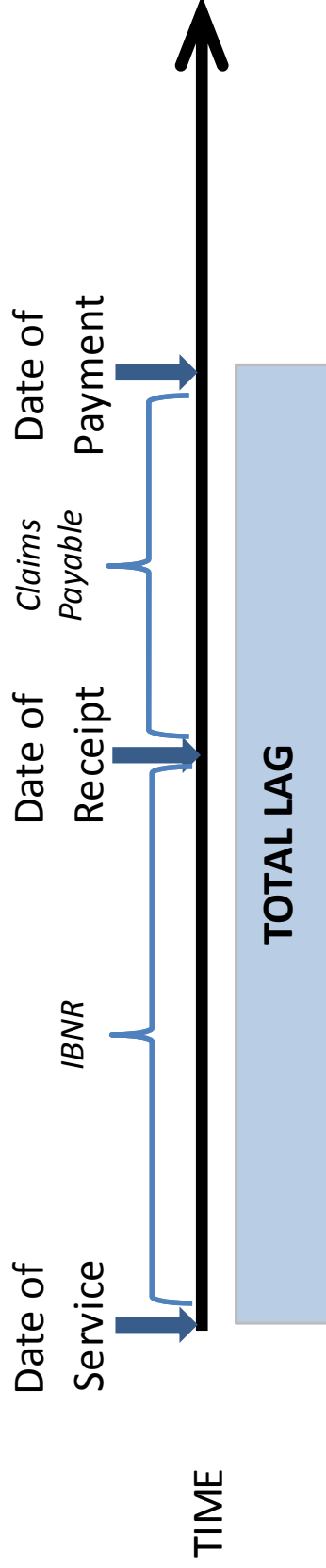
Incurred Date: date on which services were rendered by a provider (i.e., date of service).

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

*Refer to next page for graphical presentation.*



# Payment Lag



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

# Lag Table Example

Date of Service	Date of Payment												TOTAL
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Jan	923,059	4,233,919	4,829,502	1,273,204	1,113,770	3,192,642	2,364,088	1,279,815	717,782	417,793	420,044	383,978	21,149,595
Feb	-	999,823	6,274,883	2,316,046	1,736,761	3,254,568	2,021,743	1,176,328	678,735	780,142	767,831	366,832	20,373,692
Mar	-	-	1,397,532	4,512,884	3,922,282	3,560,257	2,793,200	1,363,037	606,155	617,506	688,943	288,981	19,750,777
Apr	-	-	-	1,024,082	6,326,170	4,375,672	4,147,823	1,696,868	353,478	873,339	782,647	350,923	19,931,003
May	-	-	-	-	1,011,075	6,857,354	5,888,952	1,752,470	949,295	670,858	523,503	256,032	17,909,539
Jun	-	-	-	-	-	1,555,036	9,478,844	3,223,023	795,408	1,370,287	885,310	441,047	17,748,956
Jul	-	-	-	-	-	-	2,125,423	8,826,274	1,981,392	1,707,152	1,753,106	525,227	16,918,573
Aug	-	-	-	-	-	-	-	2,151,398	6,043,639	5,790,057	1,825,998	914,387	16,725,480
Sep	-	-	-	-	-	-	-	-	1,411,754	9,257,351	4,032,817	2,193,219	16,895,141
Oct	-	-	-	-	-	-	-	-	-	2,714,771	7,940,549	3,063,393	13,718,712
Nov	-	-	-	-	-	-	-	-	-	-	1,987,314	7,229,633	9,216,947
Dec	-	-	-	-	-	-	-	-	-	-	-	845,753	845,753
<b>SUM</b>	923,059	5,233,742	12,501,917	9,126,216	14,110,059	22,795,529	28,820,074	21,469,214	13,537,637	24,199,253	21,608,063	16,859,406	191,184,168

**Completion Factor Example:** for claims with date of service in January, payments through October are 96% complete (amounts shaded in green), assuming fully paid in December (total of first row).

*Several months may elapse before all claims have been completed. Lag tables help to identify payment patterns and are used to estimate remaining claims liabilities.*

## Reserve Calculation Methods

- Most methods rely on sufficient and stable historical data sorted by certain claims/provider types and varying populations.
- Actuaries review results from multiple methods and can estimate reserves using a hybrid of methodologies.
- Reserve estimates need to take into account many variables including but not limited to:
  - *rate of claims processing and reporting*
  - *high-cost or “shock” claims*

# Reserve Calculation Methods

- Method A: Completion Factor Method: proportion of claims incurred in a given period and paid in that and any given succeeding period (i.e., ratio is the “completion factor”).
  - Example: claims incurred in December are \$200 and are 78% complete by the end of May, resulting in \$56 that has not be paid
- Method B: PMPM Method: A per-member per-month (PMPM) estimate is calculated from historical data.
  - Example: claims paid in a particular month were \$15 PMPM where historical average PMPM is \$20, resulting in \$5 that has not been paid
- Other methods exist

# Reserve Calculation Example

	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
<b>TOTAL</b>	<b>191,184,168</b>				<b>246,495,167</b>	<b>55,310,999</b>

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

## GCHP's Approved Method

- Claims reserve based on hybrid approach:
  - Completion factors used for more complete months (usually over 70 or 80 percent complete).
  - PMPM estimates used for more incomplete months.
- Adjustments made to capture true cost of medical expenses (e.g., reinsurance recoveries, adjustments)
- Future enhancements to include separate analysis of:
  - high dollar claims
  - by claim/provider type
  - By population group



## Closing Comments

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