



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

2240 E. Gonzales, Suite 200, Oxnard, CA 93036
Monday, September 23, 2013
3:00 p.m.

AGENDA

CALL TO ORDER / ROLL CALL

PUBLIC COMMENT

1. **APPROVE MINUTES**
 - a. [Regular Meeting of August 26, 2013](#)

2. **APPROVAL ITEMS**
 - a. [Adopt 2014 Commission Meeting Calendar](#)
 - b. [Consumer Advisory Committee \(CAC\) Membership](#)
 - c. [AB 97 Implementation](#)
 - d. [ACA / Medi-Cal Mental Health Benefit Vendor Selection](#)

3. **ACCEPT AND FILE ITEMS**
 - a. [Revised Corrective Action Plan \(CAP\)](#)
 - b. [CEO Update](#)
 - c. [July Financials](#)
 - d. [CMO Update and Quarterly QI Report](#)

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 September 23, 2013 Commission Meeting Agenda (continued)**

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

TIME: 3:00 p.m.

4. INFORMATIONAL ITEMS

- a. [Consumer Advisory Committee Meeting Minutes of March 13, 2013 and June 12, 2013](#)
- b. [Provider Advisory Committee Meeting Minutes of February 12, 2013 and March 21, 2013](#)

CLOSED SESSION

1. Conference with Real Property Negotiators Pursuant to Government Code Section 54956.8

Agency designated representatives: Nancy Kierstyn Schreiner, legal counsel, Michael Engelhard, CEO, Stacy Diaz, HR Manager
Michael Slater, real estate agent of CBR

- a. **Property Owners and Subject Real Property:** Brentwood Riverpark, LLC, 2901 N. Ventura, Oxnard, CA 93036
Under Negotiation: Price and Term of Payment
- b. **Property Owners and Subject Real Property:** 711 Building LLC, 711 Daily Drive, Camarillo, CA 93010
Under Negotiation: Price and Term of Payment
- c. **Property Owners and Subject Real Property:** LBA Realty Fund II LLC, 5300 Adolfo Road, Camarillo, CA 93012
Under Negotiation: Price and Term of Payment

2. Closed Session Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9 Lucas v. Regional Government Services et al, VCSC Case No. 56-2013-00432444-CU-CE-VTA

Announcement from Closed Session, if any.

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

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**Ventura County Medi-Cal Managed Care Commission (VCOMMCC) dba
Gold Coast Health Plan September 23, 2013 Commission Meeting Agenda (continued)**
PLACE: 2240 E. Gonzalez, Room 200, Oxnard, CA
TIME: 3:00 p.m.

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on October 28, 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.

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

August 26, 2013
(Not official until approved)

CALL TO ORDER

Chair Gonzalez called the meeting to order at 3:11 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMISSION MEMBERS IN ATTENDANCE

David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
May Lee Berry, Medi-Cal Beneficiary Advocate
Anil Chawla, MD, Clinicas del Camino Real, Inc. (arrived at 3:16 p.m.)
Lanyard Dial, MD, Ventura County Medical Association
Laurie Eberst, Private Hospitals / Healthcare System
John Fankhauser, MD, Ventura County Medical Center Executive Committee
Eileen Fisler, Ventura County Health Care Agency
Peter Foy, Ventura County Board of Supervisors
Robert Gonzalez, MD, Ventura County Health Care Agency

EXCUSED / ABSENT COMMISSION MEMBERS

David Glycer, Private Hospitals / Healthcare System
Robert S. Juarez, Clinicas del Camino Real, Inc.

STAFF IN ATTENDANCE

Michael Engelhard, CEO
Nancy Kierstyn Schreiner, Legal Counsel
Michelle Raleigh, CFO
Ruth Watson, COO
Traci R. McGinley, Clerk of the Board
Charlie Cho, MD, Chief Medical Officer
Connie Harden, Member Services Project Specialist
Melissa Scrymgeour, IT Director
Nancy Wharfield, MD, Medical Director Health Services
Luis Aguilar, Member Services Manager
Brandy Armenta, Compliance Officer
Sherri Bennett, Provider Network Manager
Julie Bloom, Quality Improvement Director
Guillermo Gonzalez, Government Relations Director
Steven Lalich, Communications Manager
Jenny Palm, Health Services Director
Lyndon Turner, Finance Manager

The Pledge of Allegiance was recited.

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

SWEAR-IN OF COMMISSIONER

Eileen Fidler, Ventura County Health Care Agency, was sworn in by the Clerk of the Board as a newly appointed Commissioner of the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan.

Introductions

Stuart Busby, Chief-Capitated Rates Development Division of California Department Health Care Services (DHCS).

PUBLIC COMMENT

None.

1. APPROVE MINUTES

a. Regular Meeting of July 22, 2013

Commissioner Fankhauser moved to approve the Regular Meeting Minutes of July 22, 2013. Commissioner Foy seconded. The motion carried. **Approved 7-0.**

2. APPROVAL ITEMS

a. Workers Compensation

CFO Raleigh reviewed the written report with the Commission.

Commissioner Chawla arrived.

Commissioner Foy moved to ratify the Executive / Finance Committee's recommendation to continue the workers compensation insurance with The Hartford Company for the coverage year 2013-14. Commissioner Dial seconded. The motion carried. **Approved 8-0.**

b. Dissolution of Committees

CEO Engelhard provided an overview of the written report.

Regarding the proposed dissolution of the Compliance Committee, Commissioner Fankhauser asked if the items in the quarterly compliance report to the Commission would include issues that have already been investigated. CEO Engelhard responded yes, as well as updates on outstanding audits and reports on other compliance work in process.

Chair Gonzalez asked if the Compliance Committee was subject to the Brown Act. Legal Counsel Schreiner responded that it was created as an ad hoc committee, but if it continues to exist it would need to be designated a standing committee and would be subject to the Brown Act.

Chair Gonzalez expressed concern that issues may not come forward without a Commissioner on the Committee. He asked if there were times that reporting to the Commission would happen in a Closed Session. Legal Counsel Schreiner noted that the subject matter would be reviewed to determine if the report would be done during a Regular Meeting or in Closed Session. CEO Engelhard provided an example, if GCHP had to put a provider on a Corrective Action Plan (CAP) the report to the Commission would be that a provider was placed on a CAP, but if it was necessary to advise the Commission who that provider was that information would go into Closed Session.

Chair Gonzalez questioned how it would work if there was a complaint around an employee and who would determine what was brought forward. CEO Engelhard responded that the Compliance Officer and / or the outside legal counsel would determine what items come forward. CEO Engelhard added that legal counsel and the Compliance Officer would remain on the internal Compliance Committee and so they would monitor the activities of that Committee.

Commissioner Chawla noted that it is typical to have compliance officer reports come to the board with general topics and if something specific needed to come forward it would be in a Closed Session and added that the only reason a Commissioner was previously placed on the Committee was to ensure items were handled.

Concern was expressed about items being filtered or not coming before the Commission.

Chair Gonzalez stated that he was under the impression that the Committee would be discontinued. CEO Engelhard clarified that the issues will still be reviewed, but by a GCHP Compliance Committee composed of staff and outside legal counsel. Significant items or materials discussed at committee would then be reported quarterly to the Commission by the Compliance Officer.

Commissioner Foy moved to approve the Resolution dissolving the Audit Committee, Compensation Committee and the Compliance Committee; with the understanding that the Audit Committee functions will be handled by the Executive Finance Committee, the Compensation Committee could be assembled if needed at a future date and the ad hoc Compliance Committee would dissolve with those functions going to an internal compliance committee composed of staff and outside legal counsel which and that the Compliance Officer would then report out quarterly to the Commission. Commissioner Berry seconded. The motion carried. **Approved 7-1**, with Chair Gonzalez voting no.

RESOLUTION NO. 2013-001

A RESOLUTION OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION dba Gold Coast Health Plan DISSOLVING THE AUDIT COMMITTEE, COMPENSATION COMMITTEE AND THE COMPLIANCE COMMITTEE

c. CAC Member Appointments

Connie Harden reviewed the report with the Commission. Discussion was held regarding designation of specific seats on the Consumer Advisory Committee.

Commissioner Araujo questioned if any proposed members were Medi-Cal beneficiaries. Connie Harden responded no and added that no applications were received from beneficiaries. COO Watson added that it is very challenging to obtain beneficiary volunteers; it was even difficult with 400,000 members in Orange County.

Discussion was held as to the requirements of the seats on the Committee and what could be done to obtain beneficiaries on the Committee.

Commissioner Chawla suggested contacting GCHP Members that have spoken at Commission Meetings.

COO Watson added that there were problems in the past with beneficiaries not having transportation to the meetings.

After discussion, CEO Engelhard suggested the seats could be clarified to “represent” beneficiaries versus being a beneficiary themselves.

Chair Gonzalez requested this be agendaized for the next meeting.

Commissioner Berry moved to approve the appointments as requested and for staff to come back to the Commission with a plan to obtain a beneficiary member, suggested verbiage clarifying the designation of the Committee seats and to have an additional seat added to the Committee. Commissioner Foy seconded. The motion carried. **Approved 8-0.**

3. ACCEPT AND FILE ITEMS

a. CEO Update

CEO Engelhard reviewed the written report with the Commission.

b. CMO Update

CMO Dr. Cho reviewed the CMO Update with the Commission, discussing the pharmacy data and Health Education information. It was noted that the first two medications listed on the Top 10 Drugs by Therapeutic Class page were repeated at the end of the list.

Dr. Wharfield, Medical Director Health Services reviewed the Medical Managed Transition section of the report.

c. June Financials

CFO Raleigh reviewed the June financials and provided an overview of the material provided.

Discussion was held regarding the reasons the Administrative Expenditure category was over budget. CFO Raleigh responded that the Administrative Expenses were over in the FY2012-13 year due to excessive staff turnover resulting in the reliance on consultants and temporary workers, which are typically more expensive than hiring staff.

Commissioner Foy moved to approve the Accept and File Items as presented. Commissioner Eberst seconded. The motion carried. **Approved 8-0.**

5. INFORMATIONAL ITEMS

a. FY 2013-14 Regulatory Projects Update

IT Director Scrymgeour reviewed the report and highlighted the required current and future scheduled projects to be done by the Plan. A great many of the projects are State mandated by budget actions or driven by Federal health care reform legislation. The Plan also highlighted that it is under an existing Corrective Action Plan (CAP) and that the final Medical Audit Review CAP was expected in the coming weeks and will result in additional resource requirements at the Plan.

b. Plan-to-Plan Update

CEO Engelhard noted that at the July Commission Meeting AmericasHealth Plan (AHP) requested GCHP write a letter to the State regarding the Plan-to-Plan agreement. CEO Engelhard stated that the letter was sent explaining the history, outlining GCHP's understanding; and asking the Department of Health Care Services (DHCS) to provide guidance with regard to the Plan-to-Plan agreement. The Plan expects to receive a response which will then be shared with the Commission.

c. Medi-Cal Legislative Update

The Commissioners had no questions regarding Item 5c and the item was not reviewed during the meeting.

d. AB 97 Update

The Commissioners had no questions regarding Item 5d and the item was not reviewed during the meeting.

e. Health Care Reform Update

The Commissioners had no questions regarding Item 5e and the item was not reviewed during the meeting.

f. Healthy Families Update

COO Watson announced that the Plan's membership has grown to 118,000. Due to the Primary Care Provider (PCP) criteria GCHP put in place for the Healthy Families transition, since August 1, 2013, 76% of the transitioning members have been automatically assigned to a PCP.

Medical Director Health Services Dr. Wharfield added that GCHP placed 983 calls to members to assist in the transition and selection of their PCP; approximately 10% were reached and the outreach will continue after hours the following week.

Discussion was held regarding the criteria used to link a member with a provider and the fact that GCHP is going above and beyond Health Resources and Services Administration (HRSA) rules for assignment members to PCPs.

COMMENTS FROM COMMISSIONERS

Commissioner Eberst recognized the improvements in the operations of the Plan.

Commissioner Fankhauser noted that this was his last meeting; he will join a mission hospital in Liberia, just south of Monrovia where they have one doctor per 30,000 individuals. He added that he was honored to have been on the Commission.

ADJOURNMENT

Meeting adjourned at 5:03 p.m.

GCHP 2014 Meeting Schedule



JANUARY						
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AGENDA ITEM 2b

To: Gold Coast Health Plan Commissioners
From: Ruth Watson, COO
Date: September 23, 2013
RE: Consumer Advisory Committee - Beneficiary Member Recruitment

SUMMARY:

The Commission asked staff to develop a plan to recruit a Medi-Cal beneficiary as a member of the Consumer Advisory Committee (CAC). As a first step, the recruitment of a beneficiary member was presented to the CAC at its meeting on September 11, 2013. CAC members were asked to submit the names of any beneficiary applicants they would like to recommend. Committee members expressed concerns that beneficiaries may need special accommodations such as transportation, baby sitting and stipends to ensure that they can attend.

Recruitment efforts will be conducted specifying that this position must be a Medi-Cal beneficiary not someone representing Medi-Cal beneficiaries.

Recruitment outreach:

- CAC Members
- GCHP New Member Orientation meetings
- GCHPs Website
- Provider operations bulletins and town halls
- Community Based Organizations and activities
 - The ARC of Ventura County
 - Interface Children and Family Services
 - Tri-Counties Regional Center
 - La Hermandad
 - Project Understanding
 - Child Development Resources
 - Partnership for Safe Families & Communities
 - MICOP – Mixteco / Indigena Community Organizing Project
 - First Five Neighborhood for Learning (NFL)
 - Health Fairs and GCHP outreach presentations

Timeline:

- **September 11, 2013** – CAC Meeting - An ad hoc committee has been formed with three Committee members and GCHPs COO. This ad hoc committee will be responsible for reviewing applications and making recommendations of the selected candidate to the CAC.
- **September 16 – October 4, 2013** – CAC members will provide recommendations of possible beneficiary members to the ad hoc committee.
- **September 16 – October 7, 2013** – Letters and applications will be sent to potential candidates with the request of a two-week turn around.
- **October 18, 2013** – The ad hoc committee will meet to review the applications and select the potential candidate.
- **October 28, 2013** – A report of this plan and progress will be presented to Commission.
- **December 4, 2013** – The ad hoc committee will make their recommendation of the beneficiary **member** to the CAC for their approval.
- **January 2014** – The CAC will present the recommended beneficiary member to the Commission for approval.
- **March 2014** – The beneficiary member will be sworn into the CAC.

BACKGROUND / DISCUSSION:

The Consumer Advisory Committee (CAC) was established as a requirement of the VCMMCC enabling ordinance, DHCS and the Medi-Cal Managed Care Division. The Commission determined that the CAC would consist of two permanent seats; one for the Ventura County Health Care Agency and one for the Ventura County Human Services Agency. The other eight seats would represent the following populations: Foster Children, Medi-Cal Beneficiaries, Beneficiaries with Chronic Medical Conditions, Persons with Disabilities, Seniors, and Persons with Special Needs. The seats held by other agencies were for a two-year term. The original CAC was recruited via personal telephone calls to various agencies in the community beginning in January 2011.

When recruiting members for the upcoming term of the CAC, a search was conducted by outreach to many different agencies; recommendations of current CAC members; advertising on our website, etc. Throughout the search, no beneficiary members applied for a seat on the Committee.

RECOMMENDATION:

That the Commission:

- 1) Approve the proposed Outreach and Timeline Plan to recruit a Medi-Cal beneficiary as a member of the CAC; and
- 2) Increase the CAC to an eleven member committee, but not until such time that the Commission appoints said Medi-Cal beneficiary, thereby not causing an immediate vacant seat on the Committee.

CONCURRENCE:

N/A

Attachments:

N/A

AGENDA ITEM 2c

To: Gold Coast Health Plan Commissioners

From: Sherri Tarpchinoff Bennett, Director, Network Operations
Michelle Raleigh, Chief Financial Officer

Date: September 23, 2013

RE: Assembly Bill 97 Updates and Recommendations

SUMMARY:

The State is proceeding with implementing provider reductions for specific provider types under Assembly Bill 97 (AB 97). These reductions will result in lower capitation rates being paid to Gold Coast Health Plan (Plan) beginning October 1, 2013. Therefore, the Plan is proposing rate reductions to specific providers due to the current financial position. The Plan discussed this with the Executive / Finance Committee on August 1, 2013 and provided the Commission with a detailed background / discussion in a memo dated August 26, 2013.

BACKGROUND / DISCUSSION:

The Fiscal Year 2013-14 State budget clarified that the AB 97 provider reductions would be made retroactively for the State's fee-for-service (FFS) program. However, the reduction to managed care plans' capitation rates would be made prospectively beginning October 1, 2013.

Based on information provided by DHCS, the Plan performed an analysis quantifying the impact for specific Medi-Cal providers affected by AB 97. Pending any additional changes or clarifications provided by the State, the Plan recommends and seeks the Commission's approval regarding the following reductions in FY 2013-14:

Provider Type	Recommendation	Financial Impact (Annually)	Notes
Physician Services (PCP and Specialists) <ul style="list-style-type: none"> • Excludes Specialists • Excludes services eligible for the Affordable Care Act physician rate increase 	Not reduce rates	Minimal	<ul style="list-style-type: none"> • Impact would be minimal • Reductions would most likely involve PCP and Specialty capitation rate reductions

Provider Type	Recommendation	Financial Impact (Annually)	Notes
Emergency Transportation	Reduce rates	\$69,000	<ul style="list-style-type: none"> Providers are not contracted with the Plan and are currently reimbursed the Medi-Cal FFS rate Reduction would result in a pass-through of FFS rate less 10% Total of 87 Providers (7 in county) 10,071 Trips
Non-Emergency Transportation (NEMT)	Capitation rates already reduced	Implemented at risk (per member per month) contract with vendor reflects projected savings of \$250,000	<ul style="list-style-type: none"> Savings embedded in contract
Durable Medical Equipment (DME) & Medical Supplies	Reduce rates	\$129,000	<ul style="list-style-type: none"> DME and medical supply market saturated 143 Providers No risk to access of care Reduction would result in a pass-through of Medi-Cal FFS rate less 10%
Total		\$198,000 (proposed) + \$250,000 (currently being realized) = \$448,000	

Note:

- Due to the September 11, 2013 amendment of SB 239, there will be no rate impact for Distinct Part Sub-Acute facilities (DP-NF). The bill eliminates the Medi-Cal reimbursement rate freeze as of October 1, 2013 as it applies to DP-NF. Since Managed Care Plans were exempt from the effect of the rate cuts retroactively, SB 239 effectively reverses AB 97 cuts as it applies to DP-NFs.
- The Plan is researching whether the AB97 reductions are applicable to ICF-DD providers and will follow-up with the Commission regarding findings and analysis if necessary.

FISCAL IMPACT:

Total financial impact to the Plan would be approximately an additional \$198,000 in savings if reductions are made to rates for Emergency Transportation and DME / Medical Supply providers. Additional savings of approximately \$250,000 are currently being realized due to the Plan's reimbursement change with the NEMT vendor that went into effect July 1, 2013. It is expected that the Plan's capitation rate reduction from the implementation of the AB 97 reductions into managed care would be approximately the total amount of \$448,000, assuming the same mix of services. Therefore, the Plan expects no material net impact to operating financial results in FY 2013-14.

RECOMMENDATION:

Staff proposes that the Commission approve the proposed AB 97 implementation as described above.

CONCURRENCE:

N/A

Attachments:

None.

AGENDA ITEM 2d

To: Gold Coast Health Plan Commissioners
From: Nancy Wharfield, MD, Medical Director, Health Services
Date: September 23, 2013
RE: Procurement of Behavioral Health Vendor

SUMMARY:

Gold Coast Health Plan (GCHP) must comply with the California Department of Health Care Services (DHCS) requirement for Medi-Cal Managed Care plans to provide non-specialty mental health services based on the Essential Health Benefits requirements of the Affordable Care Act (ACA).

BACKGROUND / DISCUSSION:

Historically, the Medi-Cal Program has administered mental health services for serious emotional disturbance (specialty mental health) and treatment for substance use disorder (SUD) through county mental health plans. Care for mild behavioral illness has been delivered by primary care physicians under Medi-Cal Managed Care. This model has left a gap in coverage for mild to moderate behavioral illness that is beyond the scope of a primary care practitioner's ability and not severe enough to be covered through county specialty mental health services.

The Affordable Care Act (ACA) seeks to fill this gap by including coverage of mental health and substance use disorder as part of the ACA ten mandated Essential Health Benefits (EHB). In California, AB1 X1 and SB X1 1 were enacted into law on June 27, 2013. These bills permit non-specialty mental health services to be provided by managed care plans effective January 1, 2014.

DHCS has decided to use the existing county system to administer specialty mental health and substance use disorder treatment. Non-specialty mental health services will be covered by Medi-Cal managed care plans. Enhanced SUD benefits will be administered by county alcohol and drug programs under Drug Medi-Cal. DHCS is working with stakeholders and drafting contract amendments for plans at this time. GCHP anticipates that contract and policy updates will be shared with the plans in early October 2013. DHCS has shared the following information on benefit changes:

1. Addition of non-specialty mental health services
 - individual and group mental health evaluation and treatment (psychotherapy)

- psychological testing when clinically indicated to evaluate a mental health condition
 - outpatient services for monitoring of drug therapy
 - psychiatric consultation
 - expansion of Drug Medi-Cal (DMC) outpatient, residential and inpatient detoxification care to include all Medi-Cal members (beyond the current pregnant/postpartum restrictions)
2. Addition of SUD benefits
- -inpatient detoxification
 - -screening and brief intervention (SBI)

IMPLEMENTATION ISSUES

Gold Coast Health Plan will need to proceed quickly to implement this new benefit by the target implementation date of January 1, 2014. In order to accomplish this, GCHP has solicited information from 3 managed behavioral health organizations with Medi-Cal experience in the area of mental health benefits management (Beacon Health Solutions, Optum, and The Holman Group). GCHP is currently evaluating the capacity of these vendors for network development, capability to comply with Medi-Cal regulatory requirements, utilization and care management, technology, claims payment and cost.

It will take approximately 90 days to integrate a behavioral health managed care system. In order to meet the January 1, 2014 deadline mandated by the ACA, staff is requesting approval for urgent procurement of a contract with a behavioral health vendor to help administer the new mental health benefit.

FISCAL IMPACT

DHCS is still finalizing the benefit parameters, business rules and rates. Staff anticipates that the recommended action to provide these Medi-Cal mental health services will result in revenue neutrality to the Plan. In other words, staff expects that capitation rates the Plan receives from DHCS through an upcoming contract amendment will be in an amount equivalent to the expected cost of benefits and administration.

RECOMMENDATION:

Authorize the CEO, with the assistance of legal counsel, to enter into a contract with a vendor selected through an emergency procurement process for the provision of Medi-Cal mental health services, as defined by the Department of Health Care Services, effective January 1, 2014.

CONCURRENCE:

N/A

Attachments:

None.

AGENDA ITEM 3a

To: Gold Coast Health Plan Commissioners
 From: Michael Engelhard, Chief Executive Officer
 Date: September 23, 2013
 RE: Revised Corrective Action Plan

SUMMARY:

On September 18, 2013, the State of California’s Department of Health Care Services (DHCS or “Department”) transmitted a revised Corrective Action Plan (CAP) to Gold Coast Health Plan (GCHP or “Plan”). This revised CAP (letter attached) incorporates revisions to the original Financial CAP of October 4, 2012 and a new Medical CAP. The Medical CAP is a result of findings from the Medical Audit Review conducted by the Department in December 2012 for the period of November 1, 2011 - October 31, 2012. Staff, under the CEO’s direction, is working aggressively to address all the issues raised in the revised CAP.

BACKGROUND / DISCUSSION:

On October 22, 2012, staff brought forward a description of the October 4, 2012 Corrective Action Plan. This CAP contained items in eight key areas, one of which was the Department’s concern about the Plan’s TNE level. Staff has addressed the majority of the issues put forth in the original CAP; the most significant remaining issue is the level of the Plan’s TNE relative to the State’s TNE requirement.

The Plan remains below the State’s TNE requirement, but has made significant progress towards that goal since the original CAP was issued. The table below illustrates the Plan’s gains in this area.

	October 31, 2012 ("Required" is 38% of TNE Calculation)	June 30, 2013 ("Required" is 68% of TNE Calculation)	Change
Required TNE	\$ 6,058,056	\$10,975,958	\$ 4,917,902
Reported TNE	(\$10,418,930)	\$ 7,736,261	\$18,155,191
Excess / (Deficit)	(\$16,476,986)	(\$ 3,239,696)	\$13,237,290

It should be noted that \$7.2 million of the Plan’s improvement in reported TNE was a result of the County of Ventura providing lines of credit in support of the Plan. Despite this improvement in TNE, the plan remains below the required phased-in TNE level. Moreover, while the Plan has made significant improvement in its TNE position, the TNE requirements in the 2013-14 fiscal year will increase. The phased-in TNE requirement will grow to

approximately \$13.5 million at December 32, 2013, or 84% of the approximately \$16 million full TNE level, which the Plan will need to achieve by June 30, 2014. The Department is committed to ensuring the Plan stays focused on reaching its required TNE level of approximately \$16 million at June 30, 2014. The Plan shares this commitment to achieving full TNE compliance by June 30, 2014.

The “medical” part of the CAP emanates from the Department’s Medical Review Audit conducted in December 2012. The results of the audit work by DHCS was finalized and sent to GCHP on June 11, 2013 requiring GCHP to submit a Corrective Action Plan (CAP) and respond to any deficiencies documented in that audit report within 30 days. GCHP submitted its proposed CAP to DHCS on July 8, 2013. The new CAP received by GCHP on September 18, 2013 incorporates GCHP’s responses. GCHP has 30 days from September 18, 2013 to provide a response that includes information on how a finding has been resolved and supporting documentation, and for those that remain outstanding the plan of action and timeframe for remedy.

CONCURRENCE:

N/A

Attachments:

DHCS Consolidated Corrective Action Plan for GCHP dated September 18, 2013.



TOBY DOUGLAS
Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

September 18, 2013

Michael Engelhard, CEO
Dr. Robert Gonzalez, Chair
Gold Coast Health Plan and Commission
2220 East Gonzales Road, Suite 200
Oxnard, CA 93036

RECEIVED

SEP 19 2013

GOLD COAST HEALTH PLAN

Subject: Consolidated Corrective Action Plan for Gold Coast Health Plan

Dear Mr. Engelhard and Dr. Gonzalez:

Thank you for your letter addressed to the Department of Health Care Services (DHCS) Director, Toby Douglas, dated August 6, 2013. The Director's Office referred your letter to me for response. DHCS values its partnership with Gold Coast Health Plan (GCHP) in providing for the health care needs of California's Medi-Cal population. DHCS is eager to solidify this partnership through expeditious resolution of the outstanding elements in GCHP's two Corrective Action Plans (CAPs).

On October 4, 2012, a CAP was established to address the plan's financial condition and critical contract compliance issues in the areas of staffing, claims processing, financial controls, and having an MIS system capable of performing the functions required pursuant to your contract with DHCS. Compliance with these core health plan functions is critical to the success of GCHP. While GCHP has made some progress on this CAP, critical elements remain outstanding.

In December 2012, DHCS conducted a medical audit of GCHP. On June 7, 2013, DHCS notified GCHP that a CAP must be submitted to address significant deficiencies identified during the medical audit. While GCHP has made some progress with the 110 audit findings, critical elements remain outstanding.

In the August 6, 2013 letter, you share your rationale for advancing GCHP's proposed plan-to-plan contract with Americas Health Plan (AHP), a wholly owned subsidiary of Clinicas Del Camino (CDCR). To that end, you represent that GCHP is operationally capable of moving forward. Further, you conclude that the "crux of the matter" is whether finalizing the plan-to-plan will jeopardize GCHP's progress in addressing outstanding CAP issues and creating financial or other instability. Respectfully, we disagree with your assessment and conclusions.

We believe that plan management needs to devote all of its time and resources to the expeditious closure of the two outstanding CAPs under which you are operating. It is imperative that DHCS see demonstrable progress on these CAPs and be assured that the Board and management team are fully aware of the seriousness of GCHP's situation. Accordingly, DHCS is hereby consolidating your two CAPs into one overall CAP (attached as addendum A and B) with clearly identified timelines and milestones that must be achieved by GCHP. Only when GCHP has satisfied the outstanding CAPs will DHCS entertain your proposed plan-to-plan. Delegation of risk to another health plan is a serious matter, as are the delegation of oversight and management and financial controls that must be in place to ensure successful oversight of your delivery system. We are confident that you and your Board will agree with our assessment.

As you know, DHCS has the authority to take actions for noncompliance with contract requirements and failure to meet the objectives set forth in your consolidated CAP. Such actions include, but are not limited to, imposition of sanctions upon GCHP, assessment of damages, installation of temporary management, or termination of the contract for cause. DHCS, of course, continues to believe that GCHP will meet the obligations set forth in the consolidated CAP and serve Ventura County as an effective managed care organization.

Please sign and date acknowledging receipt of this CAP letter and return to DHCS within seven working days from the date of this letter. Additionally, please provide a response to the financial CAP in accordance with the due dates prescribed in addendum A and provide a response to the medical CAP, addendum B, within 30 days from the date of this letter. CRDD will oversee the financial CAP and the Medi-Cal Managed Care Division will oversee the medical CAP. Please direct your correspondence to Sarah Brooks, Chief, Plan Monitoring and Medical Policy Branch via email at: sarah.brooks@dhcs.ca.gov and copy Calvin Oshiro, Chief, Financial Audit and Reviews Section at: calvin.oshiro@dhcs.ca.gov.

Michael Engelhard, CEO
Gold Coast Health Plan

Date

Sincerely,



Jane Ogle
Deputy Director
Health Care Delivery Systems

Enclosure

cc: Please See Next Page

Page 3

cc: Toby Douglas, Director
Department of Health Care Services
MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Mari Cantwell
Chief Deputy Director
Department of Health Care Services
Health Care Financing, MS 4050
P.O. Box 997413
Sacramento, CA 95899-7413

Stuart Busby, Chief
Department of Health Care Services
Capitated Rates Development Division, MS 4413
P.O. Box 997413
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Margaret Tatar, Chief
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P.O. Box 997413
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Capitated Rates Development Division
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AGENDA ITEM 3b

To: Gold Coast Health Plan Commissioners

From: Michael Engelhard, CEO

Date: September 23, 2013

Re: CEO Update

COMPLIANCE & DELEGATION OVERSIGHT ACTIVITIES UPDATE

The Compliance Department (“Compliance”) has added an additional compliance specialist to the team. The new associate’s primary focus will be on delegation oversight activities.

Compliance staff activities include:

- Attending Department of Justice quarterly fraud meetings.
- Attending a one day conference in Sacramento in October 2013, hosted by Department of Health Care Service with a topic of “Prescription Drug Diversion Symposium”.
- Training of GCHP staff on Fraud, Waste and Abuse. To date, 78 employees have attended the training and 7 employees are scheduled for the September 23, 2013 training.
- Leading mandatory quarterly training for all new associates on fraud waste and abuse.

Compliance has received 10 reports on the compliance / fraud hotline for 2013 as of September 1, 2013. To date, 1 case has been referred to DHCS Program Integrity Unit, 4 reports have been sent to Gold Coast Health Plan’s Grievance & Appeals staff, 4 reports have been sent to Gold Coast Health Plan’s member services staff and 1 case was sent to DHCS third party liability division.

Health Plans often work together and educate each other on trends and law enforcement agencies with a focus on fraud. An investigator at another Plan was gracious enough to provide us with information relative to a new unit formed in Ventura County called the Ventura County Interagency Pharmaceutical Crimes Unit. According to a June 11, 2013 press release, this special unit can be described as follows:

In accordance with the HIPAA Omnibus rule, Compliance has completed the revision of the notice of privacy practices and the notice is currently posted on Gold Coast Health Plan’s website in English and Spanish. In addition and in accordance with the rule, members will receive a copy of the new notice of privacy practices via mail this month. Compliance staff is working in collaboration with IT staff to revise HIPAA privacy and security policies and procedures.

Compliance continues to work with department heads on the initial medical audit findings. The goal and intent is to ensure ongoing monitoring, sustained compliance and follow up on commitments made by Plan staff. The Plan is in anticipation of receipt of an updated corrective action plan.

Compliance submits all regulatory submissions, material review request and is the liaison with DHCS on any issues. While many regulatory submissions are quarterly, questions, material review and addressing questions / issues occur on a daily basis. The Plan is current with all regulatory submissions.

Delegation Oversight continues to ramp up GCHP's regulatory oversight requirements / functions. Delegation Oversight activities include:

- Training New Team Associate
- Delegation Oversight Committee Participation
- Quality Improvement Committee Participation
- Credentialing Committee Participation
- Compliance Committee Participation
- Delegation Oversight Policy and Procedure Review/Creation
- JOC Participation with contracted, delegated providers
- Readiness Assessment Tool for Plan-to-Plan Implementation
- Plan Partner (Kaiser) Document Review
- Delegated Credentialing Audit Preparation
 - Documentation Request
 - Industry Collaboration Effort (ICE) Audit Tool Review
 - Schedule on-site audit
- Specialty Contract Audit Preparation:
 - Documentation Request
 - ICE Audit Tool Review
 - Schedule on-site audit
- OIG Sanction Monitoring
 - Network
 - Employees
 - Vendors
- Delegation Oversight New Quarterly Monitoring Tools
- ICE Delegation Oversight Credentialing and UM & CM Workgroup Participation
- Ongoing Monitoring for NEMT vendor – Internal workgroup

AFFORDABLE CARE ACT (ACA)

Increased Medicaid Payment for Primary Care Physicians

GCHP has developed and submitted a required compliance plan to DHCS reflecting how additional payments will be made to attested providers and qualifying services per ACA Section. The draft compliance plan was distributed to the Provider Advisory Committee (PAC) on August 20, 2013 for review and comment. There were no comments or suggestions received from the PAC. The compliance plan was submitted to DHCS on September 5, 2013, prior to the September 30, 2013 deadline.

IGT FUNDS

The FY2011-12 intergovernmental transfer (IGT) funds were received from the Department of Health Care Services (DHCS) on August 28, 2013. As planned, GCHP retained funds for both the MCO related taxes and the administrative fee. The remaining balance was paid to the provider on September 6, 2013 within the 30 days from receipt of funds requirement.

HEALTHY FAMILIES (HF) UPDATE

After months of preparation, planning and partnership with the previous HF plans, GCHP received 14,076 new members; the HF population is now called Targeted Low Income Children (TLIC). Phases 1 & 2 of the HF transition targeted plans that had both a Commercial (HF) and a Medi-Cal line of business, thus making the lift and sweep between lines of business and contracted PCP's a fairly straight forward process. Phase 3 was the first in the transition in which the "existing plan" did not have a both lines of business and the members would be moved to a new plan as well as being new Medi-Cal members. The expectation was that this Phase would experience a greater disruption in continuity of care. For GCHP the transition went very smoothly.

Membership & PCP Assignment

- Of the 14,076 new members, GCHP was able to immediately assign 10,185 to their existing in network PCP.
- This left 3,891 members who had previously been with an out of network PCP and needed to select a new in-network PCP.
 - Since August 1, 2013, GCHP has worked diligently to reach as many of these unassigned members as possible.
 - The Call Center staff was increased and the hours of operation were extended into the evening hours.
 - Outbound & inbound member calls and the PCP Selection forms returned by the members have resulted in the assignment of almost 1,600 transitioned members to an in-network PCP.
 - Of the initial population of members transferred, GCHP has assigned 83.7% of the membership transitioned to a PCP.

Pre-Authorizations

- Almost 800 authorizations for care transitioned with these members.

- Of these, 254 were for Mental and Behavioral Health services no longer covered under Medi-Cal.
 - GCHP Health Services staff called all these members advising them of the changes in benefits.
 - GCHP Provider Relations team called as many providers as they could (contact information was not provided by previous plans making this an onerous task)
- The remaining 550+ authorizations were for Medical and/ or Surgical care
 - Where preauthorization was required, GCHP partnered with the members and providers to get the services authorized.

Prescriptions

- GCHP worked with Script Care to institute a 60 day grandfathering program for off-formulary medications with reports to Providers alerting them of the requirement to change to a formulary medication and to work with the members to get this accomplished.

Continuity of Care

Since August 1, 2013, 12 cases have been opened and resolved.

Phase III Transition of Healthy Families Program Transition to Medi-Cal

On September 16, 2013 the Department of Health Care Services (DHCS) released its monthly monitoring report, as required by the State Legislature, on the HFP transition to Medi-Cal for the period covering August 1 through August 31, 2013. As of August 31, 2013, a total of 719,410 children have transitioned into Medi-Cal which include approximately 20,000 children who reside in Ventura County. Also included in the total number of children who transitioned into Medi-Cal statewide were 10,700 AIM-linked infants under 250% FPL. All remaining AIM-linked infants from 251-300% FPL will transition to Medi-Cal in Phase 4b that begins on November 1, 2014. The full report may be accessed at:

<http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx>

Healthy Families Transition Outreach

GCHP staff continues to conduct new member orientations in English and Spanish, and reach out to families via telephone to assist them and answer questions as well as to ensure a smooth transition to GCHP. During the month of July and early August GCHP ran radio announcements in English and Spanish to raise awareness concerning the transition to Medi-Cal managed care.

GOVERNMENT AFFAIRS UPDATE

Affordable Care Act and Medicaid Expansion

On Tuesday September 17, 2013 Gold Coast Health Plan's (GCHP) CEO, Michael Engelhard participated in a joint presentation with the Ventura County Human Service Agency (HSA) and the Ventura County Health Care Plan to County Board of Supervisors. In summary, County

Supervisors received an update on outreach efforts by GCHP and its community partners to inform residents of Medicaid expansion under the Affordable Care Act (ACA). Supervisors also received an update on the August 1st transition of approximately 20,000 children that were enrolled in the Healthy Families Program (HFP) to GCHP and Medi-Cal managed care.

Integration of Mental Health Benefits Into Medi-Cal Managed Care

Beginning January 1, 2014 all health plans, including those in Medi-Cal managed care, will be required to offer mental health and substance use disorder services. As defined by DHCS, these services include:

- Individual and group mental health evaluation and treatment
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory drugs
- Supplies and supplements
- Psychiatric consultation to non-specialty benefits

GCHP's Director of Health Services and Provider Relations are working to ensure network adequacy and meet the administrative and procedural changes that must be completed by January 1, 2014 to meet the demand for the above mentioned services. Additionally GCHP staff is participating in weekly calls with DHCS and Plans to receive guidance for the successful integration of mental health and substance use disorder services into the Medi-Cal schedule of benefits.

End of State Legislative Session

On Thursday, September 12, 2013 state lawmakers adjourned and completed the 2013 legislative session. Lawmakers passed a number of bills aimed at making technical changes to the Medi-Cal Program and enable implementation of the Affordable Care Act in California.

Per state constitution the Governor has until October 15th to either sign or veto bills or they become law by default. The following is a list of legislation related to the Medi-Cal Program as well as Medi-Cal related bills that were either approved or await signature from the Governor.

Medi-Cal Related Bills Signed by the Governor

SB 126 Health Care Coverage: Pervasive Developmental Disorder or Autism

This bill requires health care service plan contracts and health insurance policies to provide benefits for specified conditions, including coverage for behavioral health treatment, as defined, for pervasive developmental disorder or autism, except as specified. This bill would extend the operation of these provisions until January 1, 2017.

SB 138 Confidentiality of Medical Information

This bill declares the intent of the Legislature to incorporate HIPAA standards into state law and to clarify standards for protecting the confidentiality of medical information in insurance

transactions. The bill would define additional terms in connection with maintaining the confidentiality of this information, including a "confidential communications request" which an insured or a subscriber or enrollee under a health care plan, may submit for the purpose of specifying the method for transmitting medical information communications.

Medi-Cal-Related Bills Pending Governor Signature

AB 411 Medi-Cal: Performance Measures

This bill would require, DHCS to stratify all patient-specific Healthcare Effectiveness Data and Information Set (HEDIS) measures, or their External Accountability Set performance measure equivalent, by certain characteristics, including geographic area and primary language. It would also require DHCS to publicly report this analysis on the DHCS web site.

SB 239 Medi-Cal: Hospitals: Quality Assurance Fee

This bill would, subject to federal approval, impose a hospital quality assurance fee, as specified, on certain general acute care hospitals from January 1, 2014, through December 31, 2015, to be deposited into the Hospital Quality Assurance Revenue Fund. Subject to federal approval, this bill requires that moneys in the Hospital Quality Assurance Revenue Fund be continuously appropriated and available only for certain purposes, including paying for health care coverage for children, and making supplemental payments for certain services to private hospitals and increased capitation payments to Medi-Cal managed care plans.

The bill would also require the payment of direct grants to designated and non-designated public hospitals in support of health care expenditures funded by the quality assurance fee.

SB 494 Health Care Providers

This bill would, until January 1, 2019, require a health care plan to ensure that there is at least one full-time equivalent primary care physician for every 2,000 enrollees. This bill would authorize the assignment of up to an additional 1,000 enrollees, as specified, to a primary care physician for each full-time equivalent non-physician medical practitioner supervised by that physician.

SB 639 Health Care Coverage

This bill would prohibit the medical deductible under a small employer health care service plan contract or health insurance policy offered, sold, or renewed on or after January 1, 2014, from exceeding \$2,000 in the case of a plan contract or policy covering a single individual, or \$4,000 in all other cases.

AGENDA ITEM 3c

To: Gold Coast Health Plan Commission

From: Michelle Raleigh, Chief Financial Officer

Date: September 23, 2013

Re: July, 2013 Financials (Unaudited)

SUMMARY:

Staff is presenting the attached July, 2013 financial statements (unaudited) of Gold Coast Health Plan (Plan) for review and acceptance by the Commission. The Executive / Finance Committee meeting scheduled for September 5th was cancelled, so staff will review the July financial package in detail during the September 23rd Commission meeting.

BACKGROUND / DISCUSSION:

The Plan has prepared the July 2013 financial package (unaudited), including balance sheets, income statements and statements of cash flows reflecting July.

FISCAL IMPACT:

Highlights of financials include:

The Plan's overall performance for the month exceeded budget. Net income for the month was approximately \$1.3 million compared to \$0.8 million for budget. Performance was favorably impacted by an increase in revenue of approximately \$0.4 million over budget resulting from higher capitation rates paid to the Plan and by lower than expected administrative expenses which contributed approximately \$0.1 million to net income. Impacting performance were slightly higher health care costs of approximately \$0.1 million greater than budgeted.

The month's positive net income contributed to a significant improvement in the Plan's Tangible Net Equity (TNE). As a result, July TNE is \$9.0 million versus budgeted TNE of \$8.0 million. Required TNE for July was \$10.9 million (68% of \$16.0 million).

Other items to note include:

Membership - The Plan's July membership was 105,880 and exceeded budget by approximately 900. Membership mix for July, compared with budget, increases occurred mainly in TLIC with smaller gains in certain Dual categories.

Revenue - Total revenue for the month was \$26.7 million and is in line with budget at \$26.3 million. On a per member per month (PMPM) basis, revenue was \$251.99 PMPM or \$1.89 PMPM better than budget. The slight differences between actual and budgeted membership is due to enrollment mix,.

Health Care Costs – As with revenue, health care costs were in line with budget. Although July's health care costs of \$23.4 million were slightly more than that budgeted by \$0.1 million, the actual PMPM health care cost of \$221.29 was \$0.61 PMPM favorable to budget because membership exceeded budget.

Administrative Expenses - Overall operational costs were \$0.1 million or \$1.55 PMPM lower than anticipated. Impacting expenses were the following:

- Savings from lower than projected fees associated with continued supported provided by ACS.
- Timing of certain expenditures with some expected expenditures pushed into the future (e.g., Xerox SOC-1 audit).
- Savings were offset by higher than projected personnel costs caused by timing of new hires.

Cash + Medi-Cal Receivable - the Plan continues to monitor its cash balance and is continuing with cash management programs that began in February 2013. The total of Cash and Medi-Cal Premium Receivable balances of \$59.5 million exceeded the budget of \$54.7 million by \$4.8 million, or 9%.

RECOMMENDATION:

Staff proposes that the Plan's Commission approve and accept the July, 2013 financial package.

CONCURRENCE:

N/A

Attachments:

July, 2013 Financial Package



FINANCIAL PACKAGE
For the month ended July 31, 2013

TABLE OF CONTENTS

- Financial Overview
- Membership
- Total Expenditure Composition
- Paid Claims and IBNP Composition
- Pharmacy Cost & Utilization Trends
- Cash & Medi-Cal Receivable Trend
- Income Statement by Month

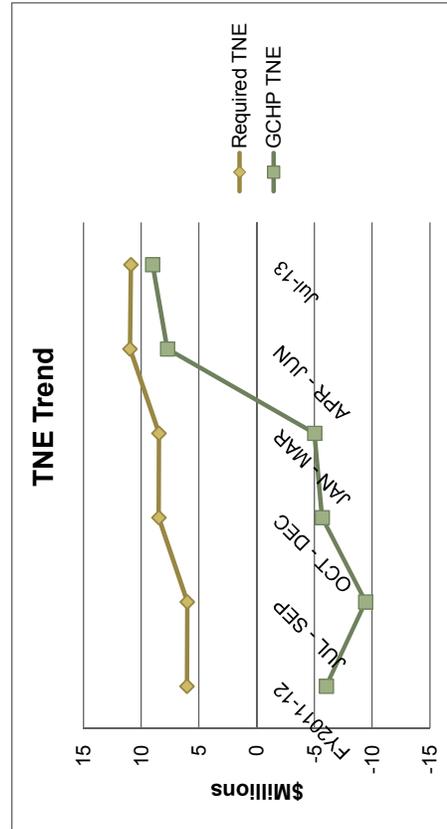
APPENDIX

- Comparative Balance Sheet
- Statement of Cash Flows

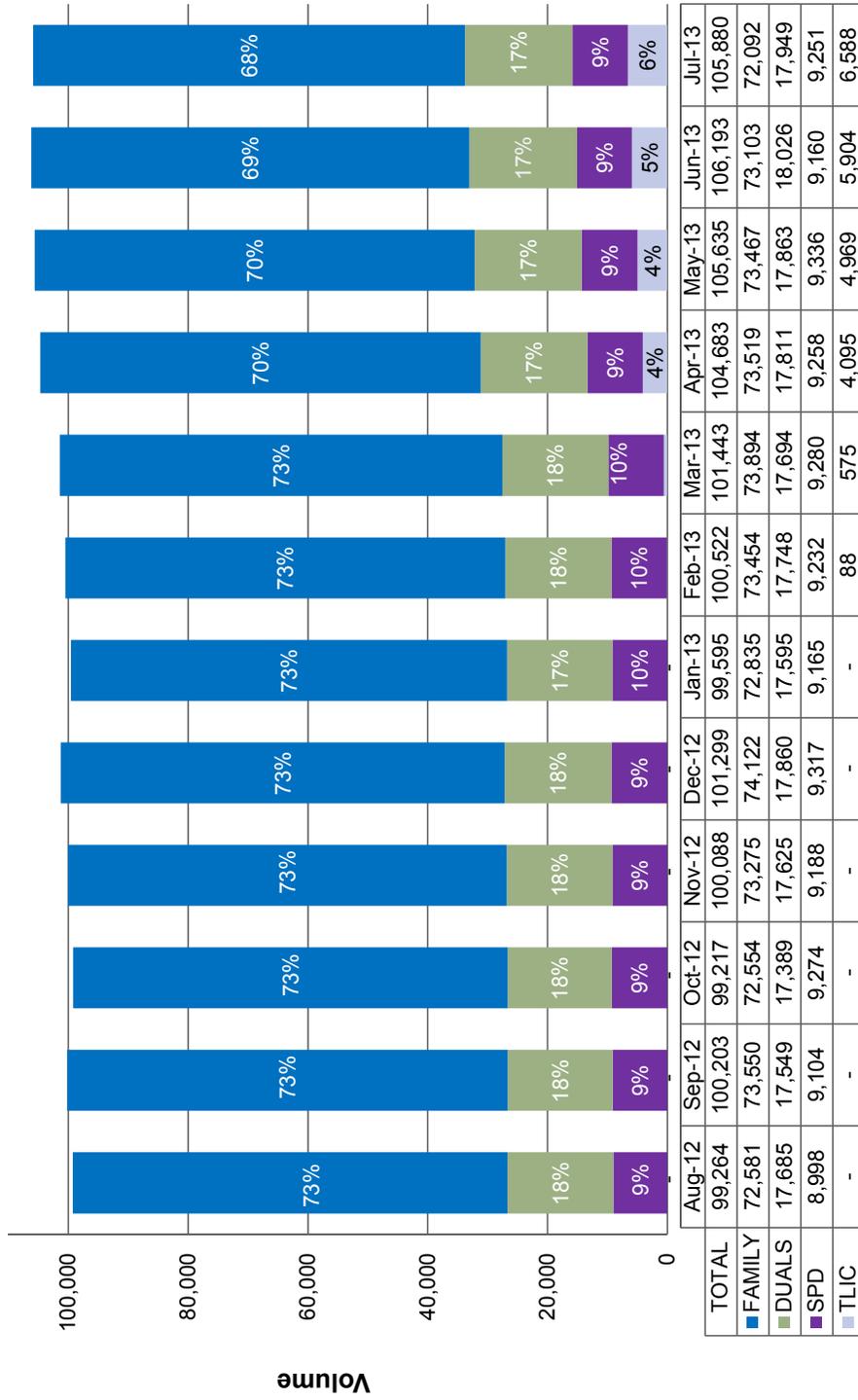
Financial Overview

Description	UNAUDITED FY 2012-13 Actual and JUL 2013											
	AUDITED	JUL - SEP	OCT - DEC	JAN - MAR	APR - JUN	Jul-13	Budget YTD	Variance Fav/(Unfav)	Variance Fav/(Unfav) %			
Member Months		305,220	300,604	301,560	316,511	105,880	104,961	919	0.9 %			
Revenue		73,225,136	76,563,668	76,414,965	84,827,867	26,680,808	26,251,364	429,444	1.6 %			
<i>pmpm</i>		239.91	254.70	253.40	268.01	251.99	250.11	1.89	0.8 %			
Health Care Costs		71,648,550	68,967,923	69,698,937	70,134,156	23,429,811	23,290,215	(139,597)	(0.6)%			
<i>pmpm</i>		234.74	229.43	231.13	221.59	221.29	221.89	0.61	0.3 %			
% of Revenue	94.3%	97.8%	90.1%	91.2%	82.7%	87.8%	88.7%					
Admin Exp		4,976,867	6,036,079	6,049,617	6,951,364	1,968,367	2,114,031	145,663	6.9 %			
<i>pmpm</i>		16.31	20.08	20.06	21.96	18.59	20.14	1.55	7.7 %			
% of Revenue	6.2%	6.8%	7.9%	7.9%	8.2%	7.4%	8.1%					
Net Income		(3,400,282)	1,559,667	666,411	7,742,347	1,282,629	847,119	435,510	(51.4)%			
<i>pmpm</i>		(11.14)	5.19	2.21	24.46	12.11	8.07	4.04	(50.1)%			
% of Revenue	-0.5%	-4.6%	2.0%	0.9%	9.1%	4.8%	3.2%					
100% TNE		16,693,841	16,308,936	16,264,038	16,141,114	16,003,415	16,266,238	(262,822)	(1.6)%			
Required TNE		6,009,972	8,480,647	8,457,300	10,975,968	10,882,323	11,061,042	(178,719)	(1.6)%			
GCHP TNE		(9,432,163)	(5,672,496)	(5,006,086)	7,736,261	9,018,891	8,016,909	1,001,982	12.5 %			
TNE Excess / (Deficiency)		(15,441,946)	(14,153,143)	(13,463,355)	(3,239,696)	(1,863,432)	(3,044,133)	1,180,701	38.8 %			

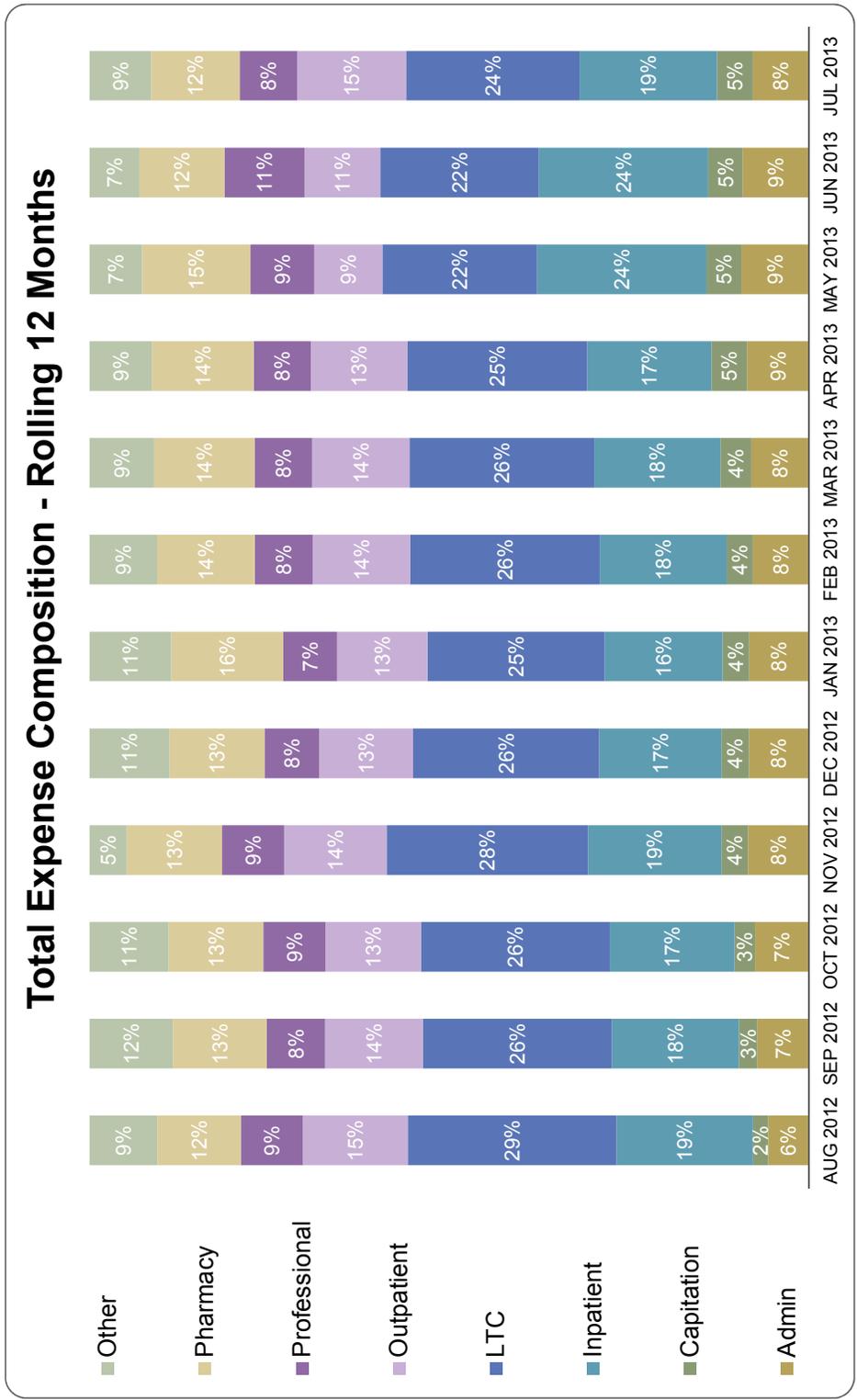
Note: Jul-Sep- Health Care Costs include \$7M IBNR addition.



Membership - Rolling 12 Months

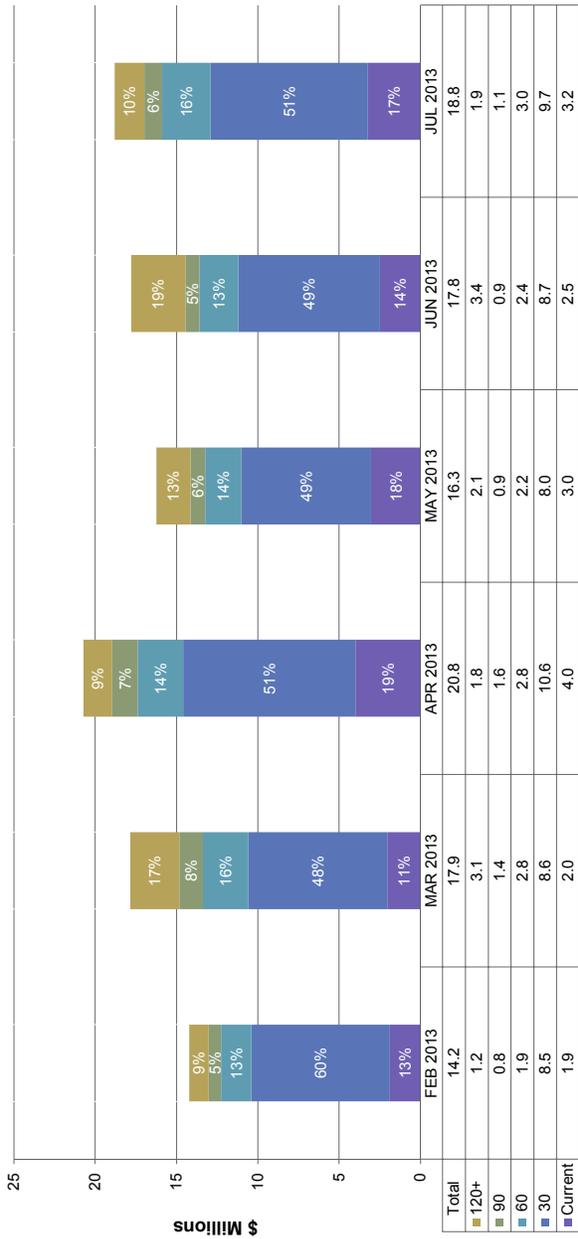


SPD = Seniors and Persons with Disabilities
 TLIC = Targeted Low Income Children



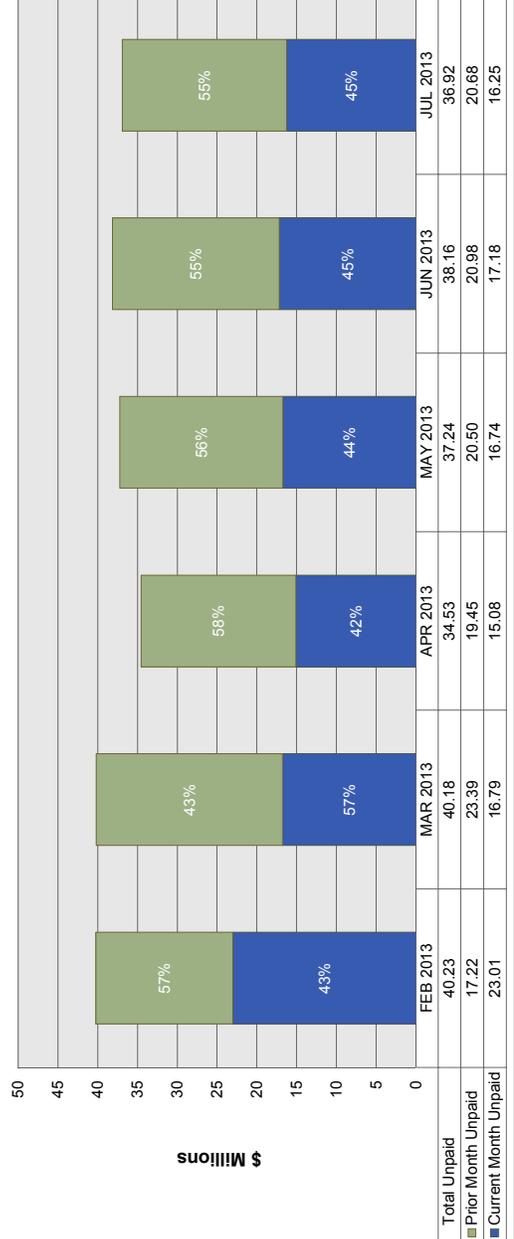
In May, GCHP changed its method of distributing Health Care Costs (HCC) across categories of service. Prior months utilized an allocation methodology. The methodology was updated to utilize payment information by different categories of services. This change will more accurately reflect true HCC, as it is based on actual claims payments rather than estimates.

Paid Claims Composition (excluding Pharmacy and Capitation Payments)



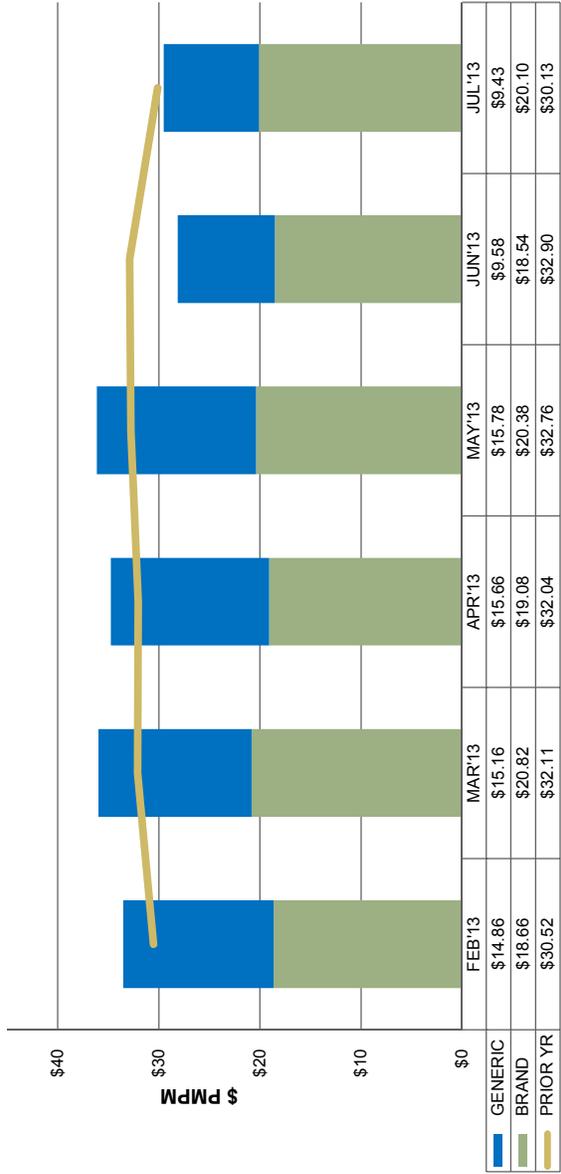
Note: Paid Claims Composition - reflects adjusted medical claims payment lag schedule.

IBNP Composition (excluding Pharmacy and Capitation)

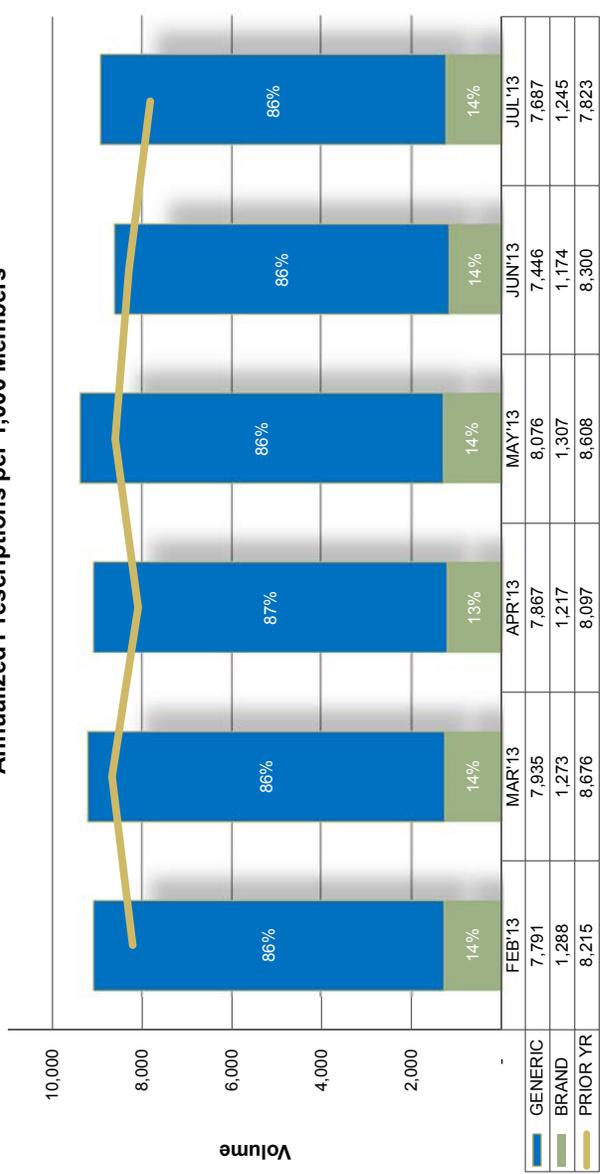


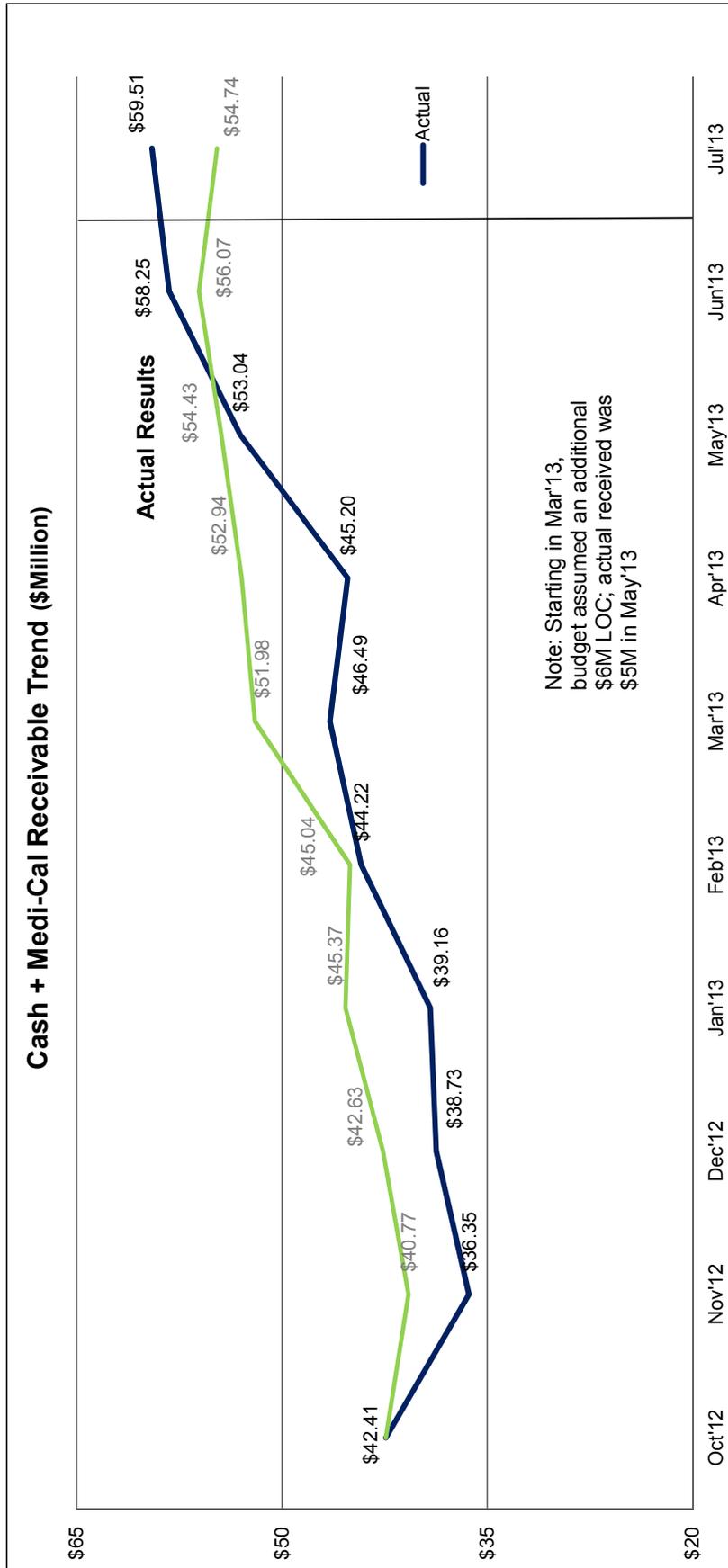
Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

Pharmacy Cost Trend



Annualized Prescriptions per 1,000 Members





Income Statement Monthly Trend

	2013 Actual Monthly Trend			Current Month		
	APR 2013	MAY 2013	JUN 2013	JUL 2013		Variance
				Actual	Budget	Fav/(Unfav)
Membership (includes retro members)	104,683	105,635	106,193	105,880	104,961	919
Revenue:						
Premium	\$ 26,032,054	\$ 26,048,832	\$ 29,108,295	\$ 27,686,491	\$ 26,334,269	\$ 1,352,222
Reserve for Rate Reduction	1,785,047	-	1,180,078	-	(129,138)	129,138
MCO Premium Tax	-	-	-	(1,053,211)	-	(1,053,211)
Total Net Premium	27,817,101	26,048,832	30,288,373	26,633,279	26,205,131	428,148
Other Revenue:						
Interest Income	7,579	7,203	8,594	9,195	7,900	1,295
Miscellaneous Income	38,333	573,518	38,333	38,333	38,333	0
Total Other Revenue	45,912	580,721	46,927	47,529	46,233	1,295
Total Revenue	27,863,013	26,629,553	30,335,300	26,680,808	26,251,364	429,444
Medical Expenses:						
<u>Capitation (PCP, Specialty, NEMT & Visic</u>	1,274,651	1,226,446	1,254,306	1,270,073	1,273,004	2,931
<u>Incurred Claims:</u>						
Inpatient	4,422,556	5,955,342	6,185,239	4,850,263	5,791,379	941,116
LTC/SNF	6,404,450	5,438,652	5,774,127	6,128,764	5,536,866	(591,898)
Outpatient	2,682,417	1,803,363	2,132,380	2,882,860	1,943,468	(939,392)
Laboratory and Radiology	225,582	158,267	126,783	222,454	143,937	(78,517)
Emergency Room Facility Services	521,965	430,333	506,334	745,797	476,947	(268,850)
Physician Specialty Services	2,026,032	2,245,622	2,929,617	2,033,957	2,630,016	596,059
Pharmacy	3,626,289	3,819,028	3,092,352	3,126,910	3,019,499	(107,411)
Other Medical Professional	216,345	83,856	84,601	169,903	81,636	(88,267)
Other Medical Care Expenses	-	-	755	-	-	-
Other Fee For Service Expense	1,489,453	1,497,072	1,524,389	1,137,610	1,464,853	327,243
Transportation	73,499	71,310	60,991	40,124	66,918	26,794
Total Claims	21,688,588	21,502,845	22,417,569	21,338,642	21,155,520	(183,122)
Medical & Care Management Expe	894,013	722,529	732,777	742,126	701,100	(41,026)
Reinsurance	26,355	70,711	(368,913)	259,745	160,590	(99,154)
Claims Recoveries	(484,211)	(610,167)	(213,342)	(180,775)	-	180,775
Sub-total	436,157	183,072	150,522	821,096	861,691	40,595
Total Cost of Health Care	23,399,396	22,912,363	23,822,397	23,429,811	23,290,215	(139,597)
Contribution Margin	4,463,617	3,717,190	6,512,903	3,250,997	2,961,150	289,847
General & Administrative Expenses:						
Salaries and Wages	464,103	600,314	731,003	562,828	475,310	(87,518)
Payroll Taxes and Benefits	113,969	108,592	199,544	123,309	122,355	(954)
Total Travel and Training	5,140	13,746	2,712	3,630	17,168	13,538
Outside Service - ACS	892,178	945,040	924,744	852,085	929,263	77,179
Outside Services - Other	99,755	31,920	26,808	16,447	77,725	61,278
Accounting & Actuarial Services	33,046	51,270	61,489	44,003	88,333	44,331
Legal Expense	37,957	46,299	80,775	57,931	30,400	(27,531)
Insurance	9,245	10,516	7,677	11,838	10,792	(1,046)
Lease Expense - Office	26,080	25,980	7,937	25,980	25,980	-
Consulting Services Expense	286,436	443,743	229,676	172,165	183,638	11,473
Translation Services	1,125	4,610	3,672	4,878	3,317	(1,561)
Advertising and Promotion Expense	-	1,050	-	4,080	14,960	10,880
General Office Expenses	171,615	71,628	83,271	63,357	100,355	36,998
Depreciation & Amortization Expense	3,836	3,648	11,407	5,235	6,614	1,379
Printing Expense	5,445	3,672	12,974	2,628	5,180	2,552
Shipping & Postage Expense	10,933	179	2,120	41	13,525	13,484
Interest Exp	24,186	1,180	17,120	17,933	9,115	(8,818)
Total G & A Expenses	2,185,050	2,363,386	2,402,927	1,968,367	2,114,031	145,663
Net Income / (Loss)	\$ 2,278,567	\$ 1,353,803	\$ 4,109,976	\$ 1,282,629	\$ 847,119	\$ 435,510

PMPM Income Statement Comparison

	2013 Actual Monthly Trend			Jul'13 Month-To-Date		Variance
	APR 2013	MAY 2013	JUN 2013	Actual	Budget	Fav/(Unfav)
Members (Member/Months)	101,741	105,635	106,193	105,880	104,961	919
Revenue:						
Premium	255.87	246.59	275.56	261.49	250.90	10.59
Reserve for Rate Reduction	17.55	-	11.17	-	(1.23)	1.23
MCO Premium Tax	-	-	-	(9.95)	-	(9.95)
Total Net Premium	262.72	246.02	286.06	251.54	249.67	1.88
Other Revenue:						
Interest Income	0.07	0.07	0.08	0.09	0.08	0.01
Miscellaneous Income	0.38	5.43	0.36	0.36	0.37	(0.00)
Total Other Revenue	0.43	5.48	0.44	0.45	0.46	(0.01)
Total Revenue	263.16	251.51	287.17	251.99	250.11	1.89
Medical Expenses:						
<u>Capitation</u>	12.53	11.61	11.87	12.00	12.13	(0.13)
<u>Incurred Claims:</u>						
Inpatient	43.47	56.38	58.55	45.81	55.18	9.37
LTC/SNF	62.95	51.49	54.66	57.88	52.75	(5.13)
Outpatient	26.37	17.07	20.19	27.23	18.52	(8.71)
Laboratory and Radiology	2.22	1.50	1.20	2.10	1.37	(0.73)
Emergency Room Facility Services	5.13	4.07	4.79	7.04	4.54	(2.50)
Physician Specialty Services	19.91	21.26	27.73	19.21	25.06	5.85
Pharmacy	35.64	36.15	29.27	29.53	28.77	(0.76)
Other Medical Professional	2.13	0.79	0.80	1.60	0.78	(0.83)
Other Medical Care Expenses	-	-	0.01	-	-	-
Other Fee For Service Expense	14.64	14.17	14.43	10.74	13.96	3.21
Transportation FFS	0.72	0.68	0.58	0.38	0.64	0.26
Total Claims	204.84	203.09	211.73	201.54	201.56	0.02
Medical & Care Management	8.79	6.84	6.94	7.01	6.68	(0.33)
Reinsurance	0.26	0.67	(3.49)	2.45	1.53	(0.92)
Claims Recoveries	(4.76)	(5.78)	(2.02)	(1.71)	-	1.71
Sub-total	4.12	1.73	1.42	7.75	8.51	0.76
Total Cost of Health Care	223.53	216.90	224.33	221.29	221.89	0.61
Contribution Margin	42.64	35.19	61.33	30.70	28.21	2.49
Administrative Expenses						
Salaries and Wages	4.56	5.68	6.88	5.32	4.53	(0.79)
Payroll Taxes and Benefits	1.12	1.03	1.88	1.16	1.17	0.00
Total Travel and Training	0.05	0.13	0.03	0.03	0.16	0.13
Outside Service - ACS	8.77	8.95	8.71	8.05	8.85	0.81
Outside Services - Other	0.98	0.30	0.25	0.16	0.74	0.59
Accounting & Actuarial Services	0.32	0.49	0.58	0.42	0.84	0.43
Legal Expense	0.37	0.44	0.76	0.55	0.29	(0.26)
Insurance	0.09	0.10	0.07	0.11	0.10	(0.01)
Lease Expense -Office	0.26	0.25	0.07	0.25	0.25	0.00
Consulting Services Expense	2.82	4.20	2.16	1.63	1.75	0.12
Translation Services	0.01	0.04	0.03	0.05	0.03	(0.01)
Advertising and Promotion Expense	-	0.01	-	0.04	0.14	0.10
General Office Expenses	1.69	0.68	0.78	0.60	0.96	0.36
Depreciation & Amortization Expense	0.04	0.03	0.12	0.05	0.06	0.01
Printing Expense	0.05	0.03	0.02	0.02	0.05	0.02
Shipping & Postage Expense	0.11	0.00	0.16	0.00	0.13	0.13
Interest Exp	0.24	0.01	-	0.17	0.09	(0.08)
Total Administrative Expenses	20.64	22.32	22.63	18.59	20.14	1.55
Net Income / (Loss)	21.52	12.79	38.70	12.11	8.07	4.04



APPENDIX

- Comparative Balance Sheet
- Monthly Statement of Cash Flows

Comparative Balance Sheet

	7/31/13	6/30/13	Audited FY 2011-12
ASSETS			
Current Assets			
Total Cash and Cash Equivalents	\$ 24,277,962	\$ 50,707,852	\$ 25,554,098
Medi-Cal Receivable	35,230,747	7,543,835	28,534,938
Provider Receivable	914,174	1,161,379	6,539,541
Other Receivables	195,116	300,397	2,148,270
Total Accounts Receivable	36,340,038	9,005,611	37,222,748
Total Prepaid Accounts	1,226,549	351,145	185,797
Total Other Current Assets	10,000	10,000	375,000
Total Current Assets	\$ 61,854,548	\$ 60,074,607	\$ 63,337,644
Total Fixed Assets	236,494	230,913	176,028
Total Assets	\$ 62,091,042	\$ 60,305,520	\$ 63,513,672
LIABILITIES & FUND BALANCE			
Current Liabilities			
Incurred But Not Reported	\$ 33,171,805	\$ 29,901,103	\$ 52,610,895
Claims Payable	5,648,707	9,748,676	10,357,609
Capitation Payable	1,015,278	1,002,623	633,276
Accrued Premium Reduction	-	-	1,914,157
Accounts Payable	2,000,411	1,693,432	886,715
Accrued ACS	1,191,571	422,138	200,000
Accrued Expenses	522,166	477,477	-
Accrued Premium Tax	7,513,140	7,286,494	602,900
Accrued Interest Payable	12,869	9,712	-
Current Portion of Deferred Revenue	460,000	460,000	460,000
Accrued Payroll Expense	654,538	605,937	-
Current Portion Of Long Term Debt	-	41,667	500,000
Total Current Liabilities	\$ 52,190,484	\$ 51,649,258	\$ 68,165,553
Long-Term Liabilities			
Other Long-term Liability	-	-	-
Deferred Revenue - Long Term Portion	881,667	920,000	1,380,000
Notes Payable	7,200,000	7,200,000	-
Total Long-Term Liabilities	8,081,667	8,120,000	1,380,000
Total Liabilities	\$ 60,272,151	\$ 59,769,258	\$ 69,545,553
Beginning Fund Balance	536,262	(6,031,881)	(4,422,819)
Net Income Current Year	1,282,629	6,568,143	(1,609,062)
Total Fund Balance	1,818,891	536,262	(6,031,881)
Total Liabilities & Fund Balance	\$ 62,091,042	\$ 60,305,520	\$ 63,513,672

FINANCIAL INDICATORS

Current Ratio	1.19 : 1	1.16 : 1	0.93 : 1
Days Cash on Hand	29	27	30
Days Cash + State Capitation Receivable	70	63	64

Statement of Cash Flows - Monthly

	JUL'13	JUN'13
Cash Flow From Operating Activities		
Collected Premium	\$ -	\$ 52,138,834
Miscellaneous Income	9,195	8,594
HQAF Funds Received	-	34,346,474
<u>Paid Claims</u>		
Medical & Hospital Expenses	(18,926,200)	(17,277,826)
Pharmacy	(2,994,857)	(4,009,168)
Capitation	(1,257,418)	(1,162,302)
Reinsurance of Claims	(259,745)	(240,430)
HQAF Funds Distributed	-	(34,346,474)
Paid Administration	(2,163,484)	(2,616,623)
MCO Tax Received / (Paid)	(826,566)	829,564
Net Cash Provided/ (Used) by Operating Activities	(26,419,075)	27,670,643
Cash Flow From Investing/Financing Activities		
Proceeds from Line of Credit	-	-
Repayments on Line of Credit	-	-
Net Acquisition of Property/Equipment	(10,815)	(31,026)
Net Cash Provided/(Used) by Investing/Financing	(10,815)	(31,026)
Net Cash Flow	\$(26,429,890)	\$ 27,639,617
Cash and Cash Equivalents (Beg. of Period)	50,707,852	23,068,235
Cash and Cash Equivalents (End of Period)	24,277,962	50,707,852
	\$(26,429,890)	\$ 27,639,617
Adjustment to Reconcile Net Income to Net Cash Flow		
Net (Loss) Income	1,282,629	4,109,976
Depreciation & Amortization	5,235	11,407
Decrease/(Increase) in Receivables	(27,334,427)	22,788,941
Decrease/(Increase) in Prepaids & Other Current Assets	(875,404)	769,972
(Decrease)/Increase in Payables	1,172,860	(1,578,838)
(Decrease)/Increase in Other Liabilities	(80,000)	(121,667)
Change in MCO Tax Liability	226,645	1,433,012
Changes in Claims and Capitation Payable	(4,087,314)	1,913,029
Changes in IBNR	3,270,701	(1,655,189)
	(26,419,075)	27,670,643
Net Cash Flow from Operating Activities	\$(26,419,075)	\$ 27,670,643



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



CMO Update and Quality Improvement Quarterly Report

September 2013

Charles Cho, MD

Chief Medical Officer

www.goldcoasthealthplan.org

GOLD COAST HEALTH PLAN 2013 QUALITY IMPROVEMENT PROGRAM

- III. VENTURA COUNTY MEDI-CAL
MANAGED CARE COMMISSION will
receive quarterly updates to the QI Work
Plan for review and comment.

QI Dashboard

- Dashboard Definition: A tool that will tell you at a glance the health of an organization
- Dashboard consist of selected measures from various subcommittees including
 - HEDIS measures
 - Special projects and
 - Requests from the Board



GCHP QI Dashboard

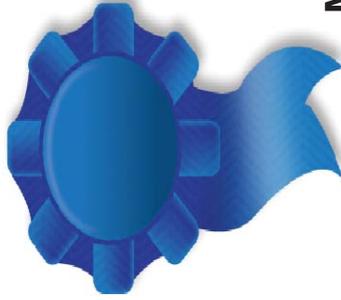
September 2013

QI Dashboard Measures

- HEDIS Measures
- Pharmacy Measures
- PCP Volume
- IHA Monitoring
- Urgent Care Volume
- ED Measures
- Hospital Average LOS
- Readmissions
- Health Education Measures
- G & A Volume
- Call Center Measures
- Medicare Enrollment

HEDIS 2013 Reporting of 2012 Data

- Based on first year of data submissions by GCHP
- Feedback from HSAG was positive about GHCP's first year performance and processes



Well Done!

15

Measures

Met Minimum Performance Level (MPL) or Better

Opportunities

for Improvement (OFI's)

10

Measures

Did Not Meet the Minimum Performance Level
(the 25th Percentile)



HEDIS Measure/Data Element	GCHP 2012 Rate	DHCS MPL	GCHP National Percentile
<i>Effectiveness of Care: Prevention and Screening</i>			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
<i>BMI Percentile</i>	42.09	29.20	25th
<i>Counseling for Nutrition</i>	42.09	42.82	10th
<i>Counseling for Physical Activity</i>	30.41	31.63	10th
Childhood Immunization Status			
<i>Combination #3</i>	80.05	64.72	75th
Immunizations for Adolescents			
<i>Combination #1</i>	65.21	50.36	50th
Cervical Cancer Screening	57.66	61.81	10th

HEDIS Measure/Data Element	GCHP 2012 Rate	DHCS MPL	GCHP National Percentile
<i>Effectiveness of Care</i>			
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	13.87	18.98	< 10th
Controlling High Blood Pressure	61.56	50.00	50th
Use of Imaging Studies for Low Back Pain	76.95	72.04	50th
Annual Monitoring for Patients on Persistent Medications	82.47	81.16	25th

HEDIS Measure/Data Element	GCHP 2012 Rate	DHCS MPL	GCHP National Percentile
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care			
<i>Hemoglobin A1c (HbA1c) Testing</i>	81.75	78.54	25th
<i>HbA1c Poor Control (>9.0%)</i>	56.20	34.33	75th
<i>HbA1c Control (<8.0%)</i>	37.96	42.09	10th
<i>Eye Exam (Retinal) Performed</i>	42.58	45.03	10th
<i>LDL-C Screening Performed</i>	78.83	70.34	50th
<i>LDL-C Control (<100 mg/dL)</i>	33.58	28.47	25th
<i>Medical Attention for Nephropathy</i>	79.81	73.48	50th
<i>Blood Pressure Control (<140/90 mm Hg)</i>	62.29	54.48	25th

HEDIS Measure/Data Element	GCHP 2012 Rate	DHCS MPL	GCHP National Percentile
Access/Availability of Care			
Children and Adolescents' Access to Primary Care Practitioners			
12-24 Months	82.51	95.56	< 10th
25 Months - 6 Years	63.09	86.62	< 10th
Prenatal and Postpartum Care			
<i>Timeliness of Prenatal Care</i>	80.78	80.54	25th
<i>Postpartum Care</i>	63.99	58.70	25th
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	61.80	65.51	10th
Ambulatory Care			
AMB - AMB OP Visit/1000	317.16	301.57	25th
AMB - AMB ER Visit/1000	49.21	52.45	10th

GCHP – Top 10 Drugs by Rx's

Aug-13		
Drug	# Scripts	Amount Paid
HYDROCO/APAP	2918	\$29,159.18
METFORMIN	1817	\$6,274.87
OMEPRAZOLE	1708	\$10,554.97
IBUPROFEN	1614	\$5,310.91
VENTOLIN HFA	1580	\$61,382.10
LEVOTHYROXIN	1416	\$6,369.76
LISINOPRIL	1371	\$3,639.49
AMOXICILLIN	1278	\$7,883.93
LORATADINE	1171	\$5,044.89
GABAPENTIN	1127	\$19,583.33

GCHP – Top 10 Drugs by Dollar

Aug-13			
Drug	# Scripts	Amount Paid	
ADVAIR DISKU	433	\$96,412.03	
LANTUS	544	\$93,928.65	
BENEFIX	1	\$93,225.60	
REVLIMID	7	\$68,793.83	
VENTOLIN HFA	1580	\$61,382.10	
NEULASTA	13	\$54,449.59	
DIVALPROEX	474	\$49,398.22	
METHYLPHENID	394	\$48,981.64	
HUMIRA PEN	14	\$43,523.45	
GLEEVEC	5	\$43,182.94	

Benefix is as hemophilia factor drug

GCHP – Top 10 Therapeutic Class

Aug-13		
Therapeutic Class	Claim Count	Amount Paid
Antiasthmatic	3632	\$303,770.37
Antidiabetic	4376	\$291,669.59
Antineoplastics	342	\$233,082.54
Stimulants/Anti-Obesity Anorexiant	1268	\$193,946.66
Anticonvulsant	4432	\$188,450.94
Analgesics-Anti-Inflammatory	3520	\$159,384.91
Assorted Classes	193	\$131,514.57
Dermatological	3029	\$129,670.24
Analgesics-Narcotic	5060	\$122,570.47
Misc. Endocrine	597	\$103,588.90

Specialty Drugs by Dollar Amount

April – June 2013

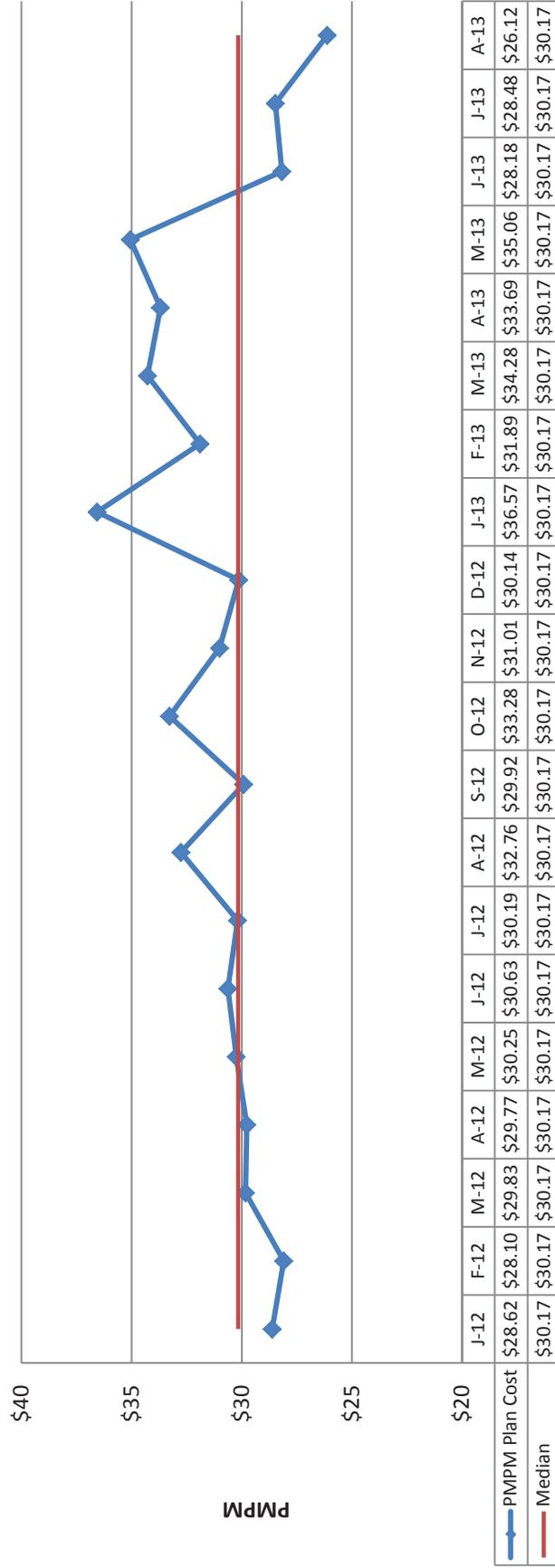
Specialty Drug	Amount Paid	Rx's
NEULASTA INJ 6MG/0.6M	212,775.19	53
REVLIMID CAP 10MG	119,222.77	12
ENBREL SRCLK INJ 50MG/ML	113,259.78	49
GLEEVEC TAB 400MG	112,359.54	13
HUMIRA PEN KIT 40MG/0.8	111,036.59	43
COPAXONE KIT 20MG/ML	104,916.01	22
INCIVEK TAB 375MG	102,748.36	5
XELODA TAB 500MG	87,823.28	37
ENBREL INJ 50MG/ML	71,888.01	31
CARIMUNE NF INJ 6GM	60,558.27	3

Specialty Drug Expenses

April – June 2013

	Number RX	Number of Rx/mo	% of Total Rx	Total Expenses	Expense/mo	% of Total
Specialty Drug	268	89	0.11%	\$1,096,584	\$365,528	10.40%
Total Drug Expenses	238,127	79,375		\$10,537,669	\$3,512,556	

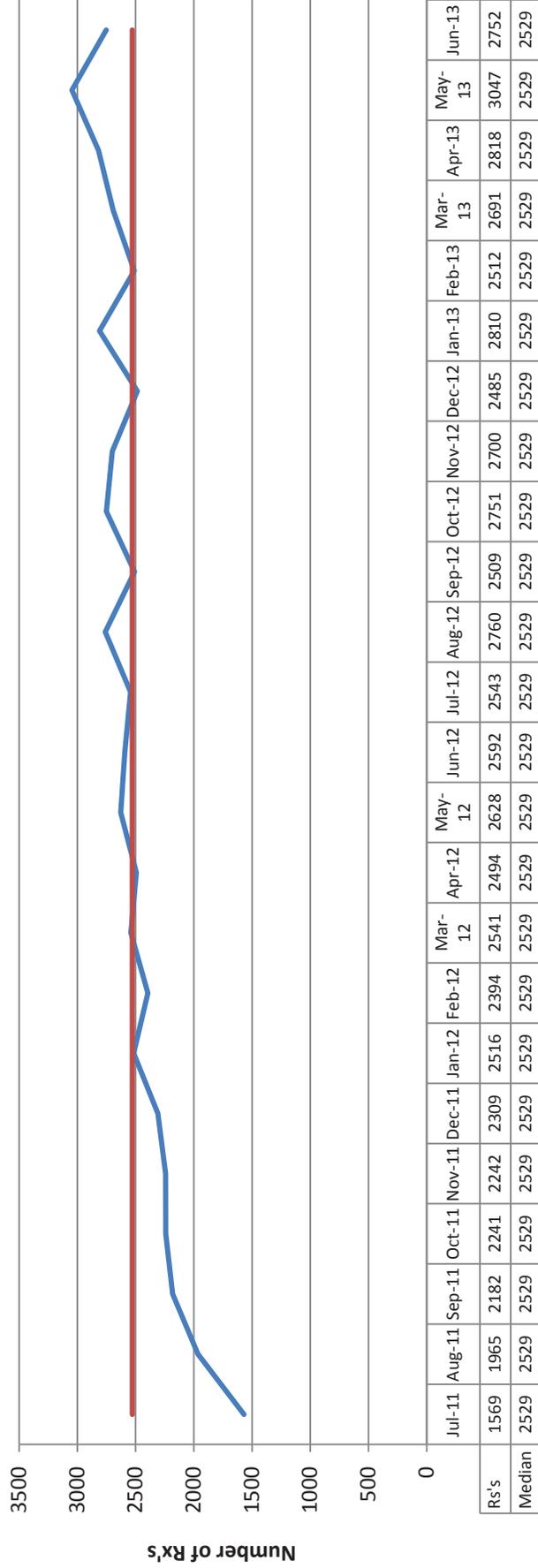
GCHP Pharmacy - Per Member Per Month Cost



- These PMPM costs are based on Script Care enrollment data and therefore may not tie to pharmacy PMPMs reported in the monthly financial report
- June and July reductions due to implementation of new pricing for generic drugs
- The PMPM reduction in August is due to the addition of more than 14,000 former Healthy Families lives, with lower average drug utilization

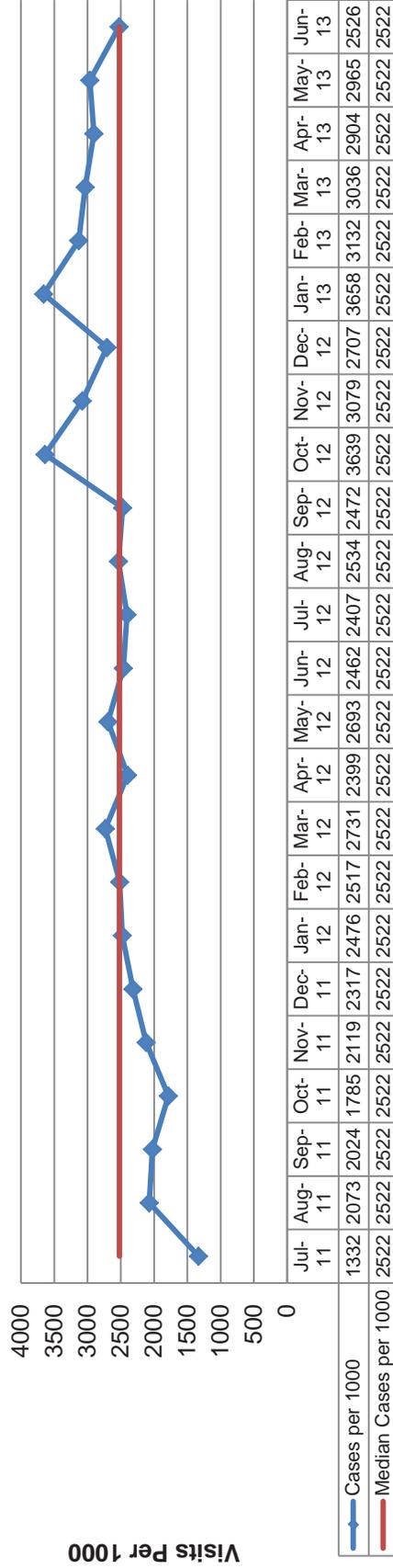
Board Request

Hydrocodone Rx's by Month



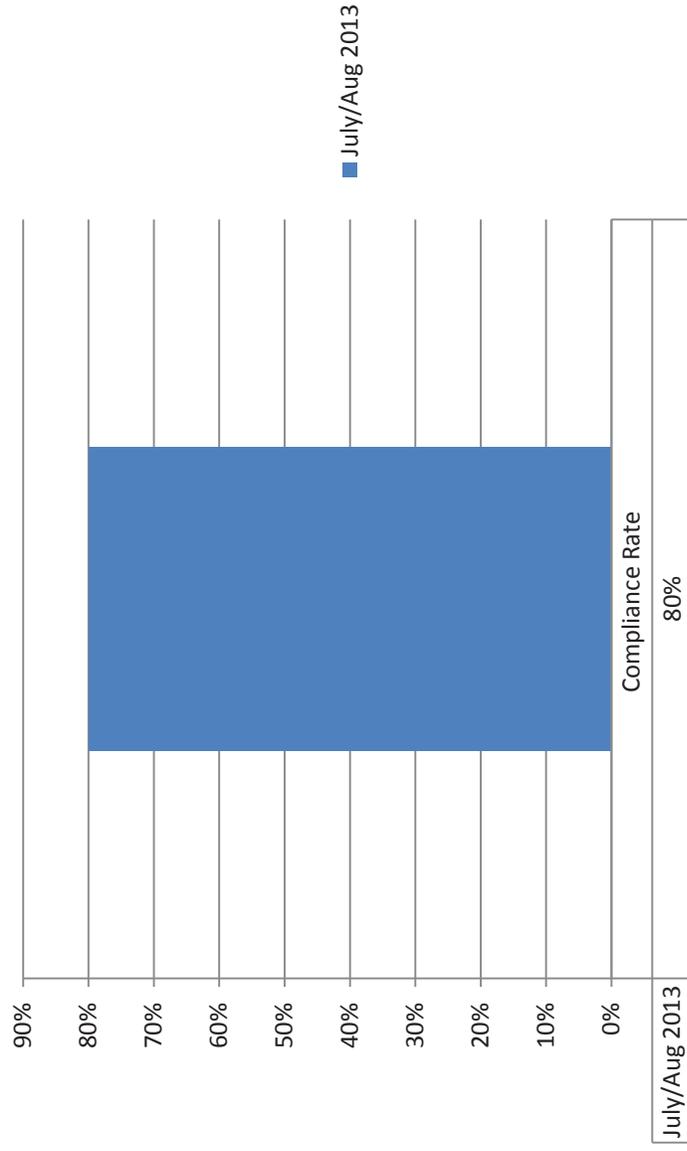
No statistically significant trend yet. Hydrocodone use will be monitored closely by the Plan for any changes in utilization and for existing usage.

Monthly PCP Visits Per 1000



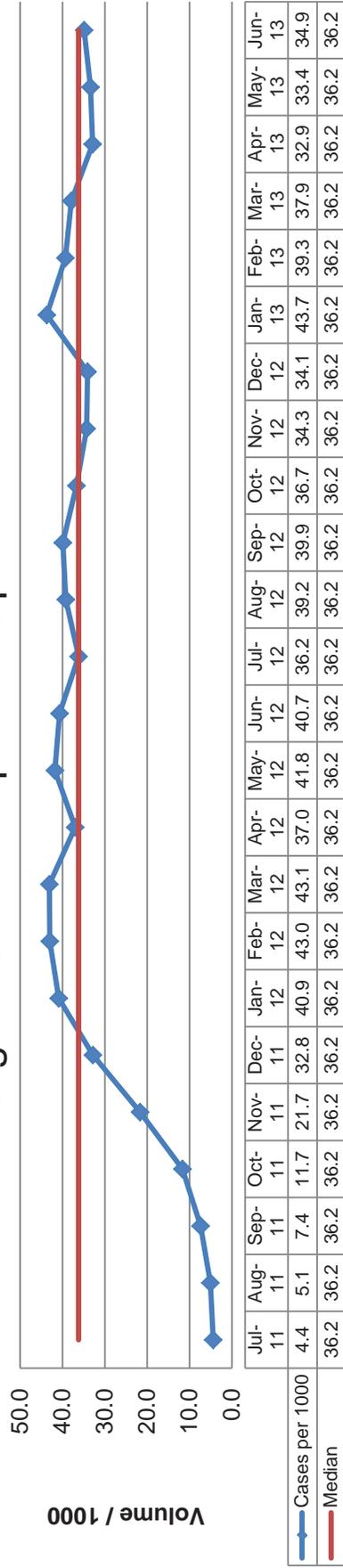
PCP Visits Top 10 ICD9 Diagnosis	
ICD9 Diagnosis Desc 1	Cases per 1000
V202 - ROUTIN CHILD HEALTH EXAM	236
4659 - ACUTE URI NOS	142
V221 - SUPERVIS OTH NORMAL PREG	66
25000 - DMII WO CMP NT ST UNCNTR	58
462 - ACUTE PHARYNGITIS	39
49390 - ASTHMA NOS	38
3829 - OTITIS MEDIA NOS	37
4019 - HYPERTENSION NOS	34
4779 - ALLERGIC RHINITIS NOS	28
78060 - FEVER NOS	27
V7231 - ROUTINE GYN EXAMINATION	27
7862 - COUGH	27

Initial Health Assessment (IHA) Completion Rate

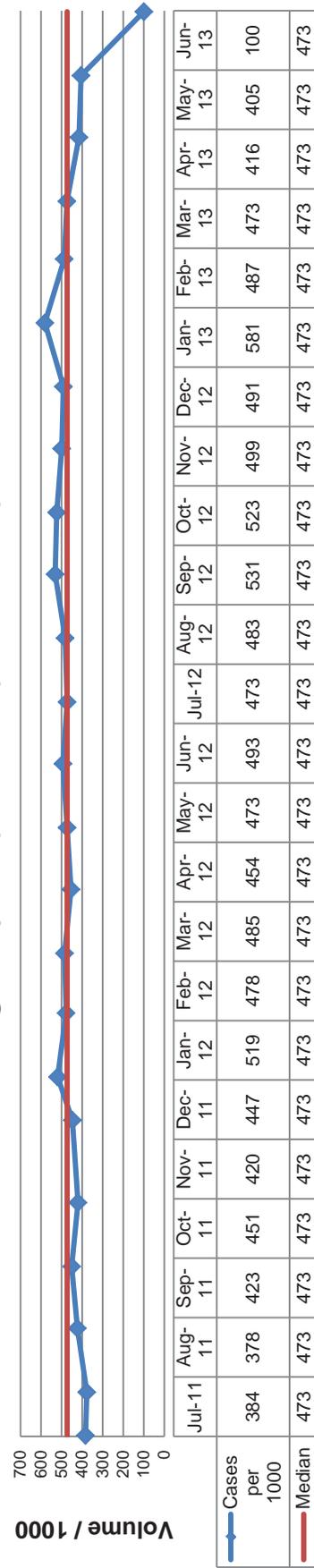


IHA must be completed within 120 days for new patients

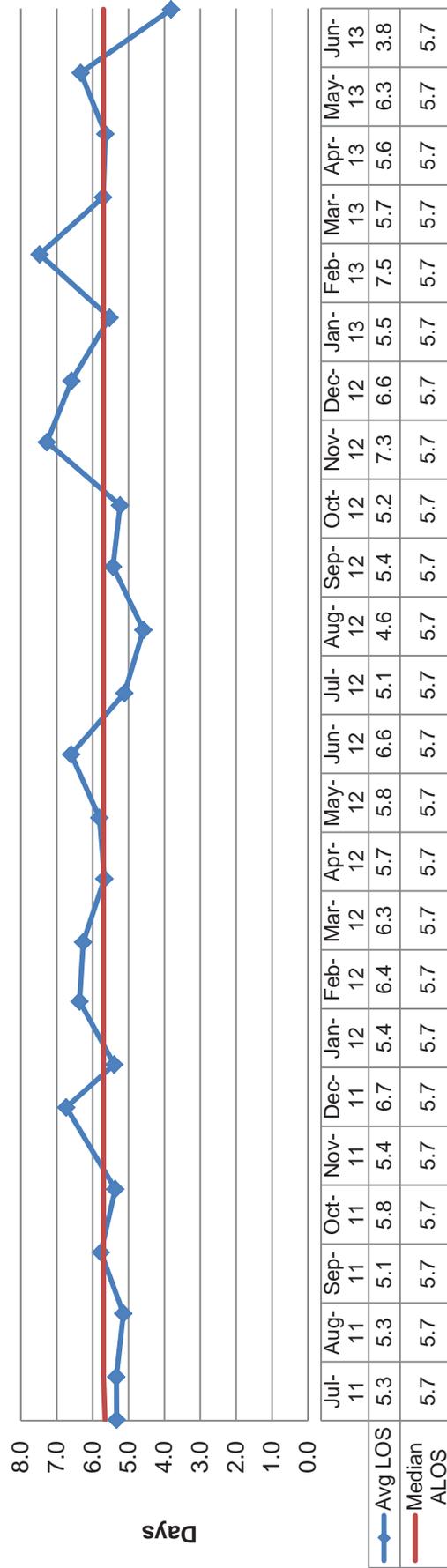
All Urgent Care Visit per 1000 per Month



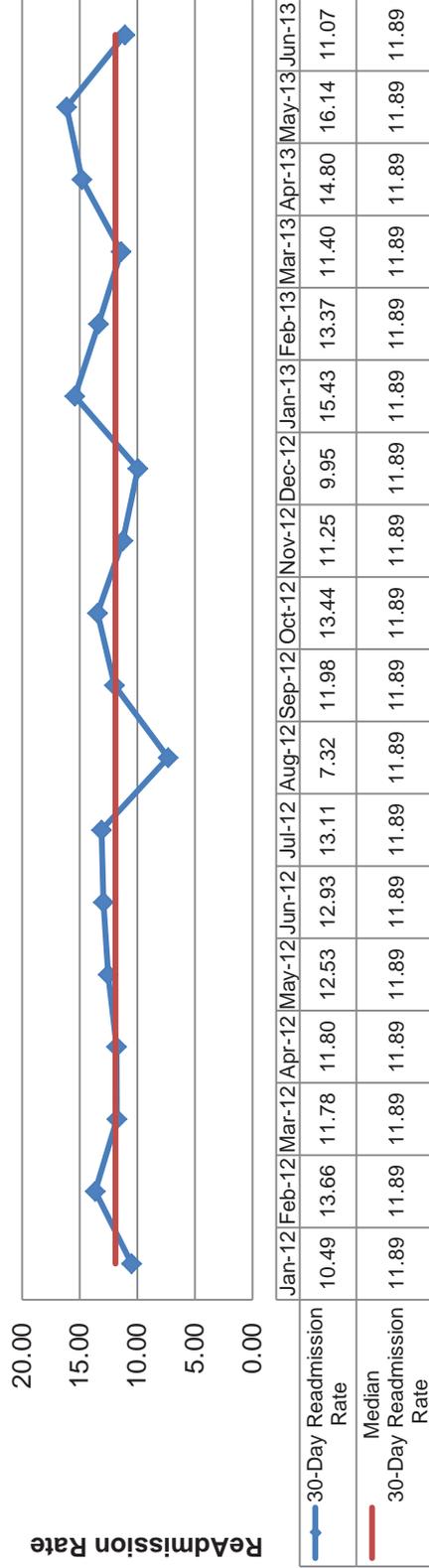
All Emergency Dept Visit per 1000 per Month



All Members Acute Inpatient Avg LOS



Monthly 30-Day Re-Admission Rate



Source: MedInSight Home > Operational Report > Hospital Care Services > Inpatient Acute Admissions and ReAdmissions

A hospital's readmission rate is calculated by dividing the total number of patients readmitted within thirty days of discharge by the total number of hospital admissions.

Parameters: SPD and Non SPD; Age 21 and Over; Filtered Non Maternity related Diagnosis; LTCs are excluded.

Median is based on 2012 data.

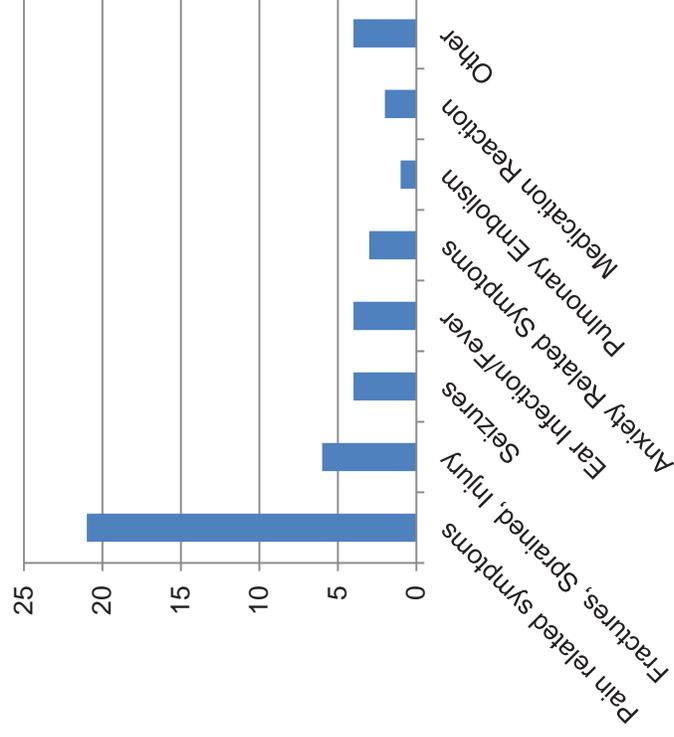
ER Health Navigator Program

Goal: To reduce avoidable ER visits and refer members back to their PCP.

Summary of Interventions

- A total of 315 members were phoned.
- Of the 315 members, a total of **269 or (85%)** were unable to reach by phone (wrong #, etc.) and/or were identified as being out of county residents.
- Of the 315 members, a total of **46 (14.6%)** were contacted.

Total # of ER Visits



ER Health Navigator Program

Preliminary findings of the total 46 cases that received the Intervention

- A total of 46 Members received an intervention call by the Health Navigator
- Of the 46 cases a total of 35 were reported as a non-avoidable ER visit
 - 24 cases reported visiting the ER for Pain Management and pain related symptoms (i.e., appendix, migraines, stomach pain, lower back pain, chest pain, etc.) .
 - Individuals with chronic pain are referred to Case Management
 - 7 cases reported fractures and/or sprained injuries
 - 4 cases reported visiting the ER for Seizures
- A total of 8 cases were reported as avoidable ER visits
 - 8 cases were identified as avoidable visits (ie., x-ray only, anxiety, gastritis, and fever)
- A total of 3 declined/refused to provide information

Health Education Referral Update

The majority of the referrals are from the CM Team

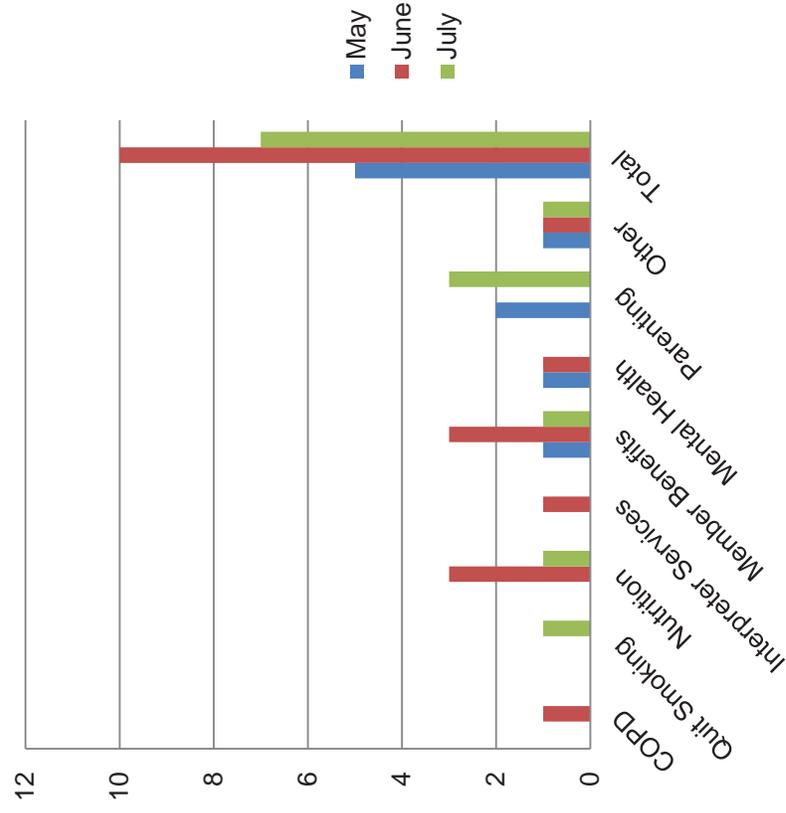
Nutrition education continues to be the most requested service

Health Education staff also assisted members with social supportive services including: food bank, charity, etc.

Health Ed. Staff also assisted with educating members about their benefits. Members are referred back to Member Services for more information.

Increase in parenting and pregnancy related health education information.

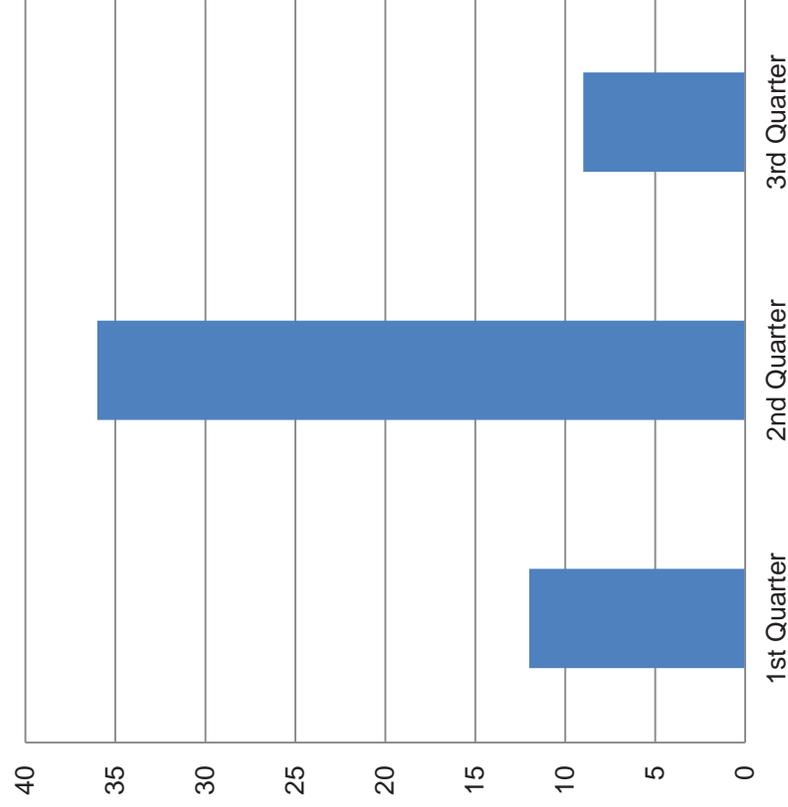
Health Education Referral
May - July 2013



ASL Interpreter Requests

ASL Interpreter Request Quarterly Report 2013

- **A total of 57 ASL (American Sign Language) Interpreter Request Forms were completed (for first 3 quarters)**
- **A total of 16 ASL Interpreter Request Forms were received for a Specialty Centers or for a VSP Provider.**
- **A total of 41 requests for an Interpreter came from Network Providers.**



C & L Materials to Providers

Based on request for Cultural and Linguistic (C&L) materials by Providers. The increase in request is due to:

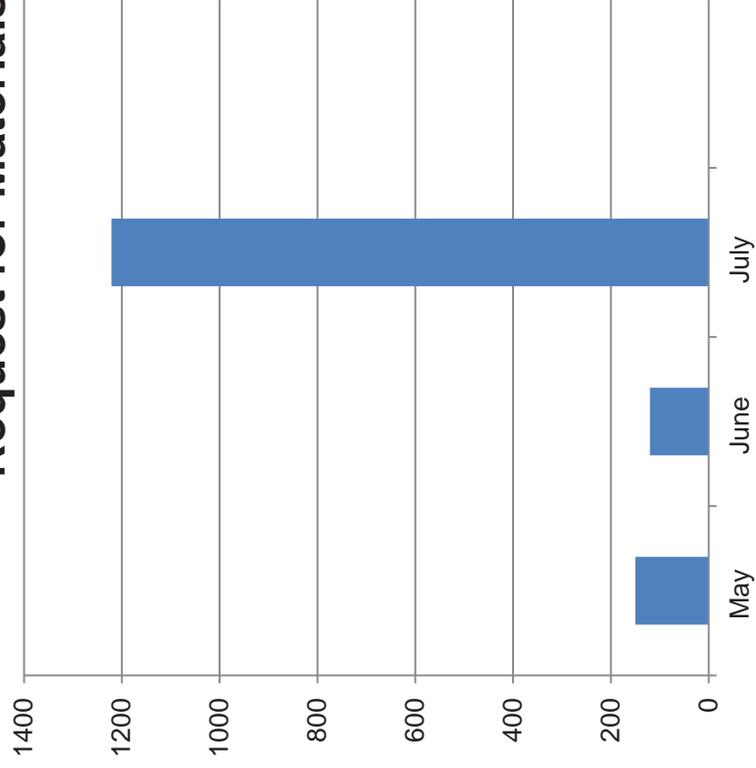
An increase in requests during the month of July

An increase in Provider outreach and education

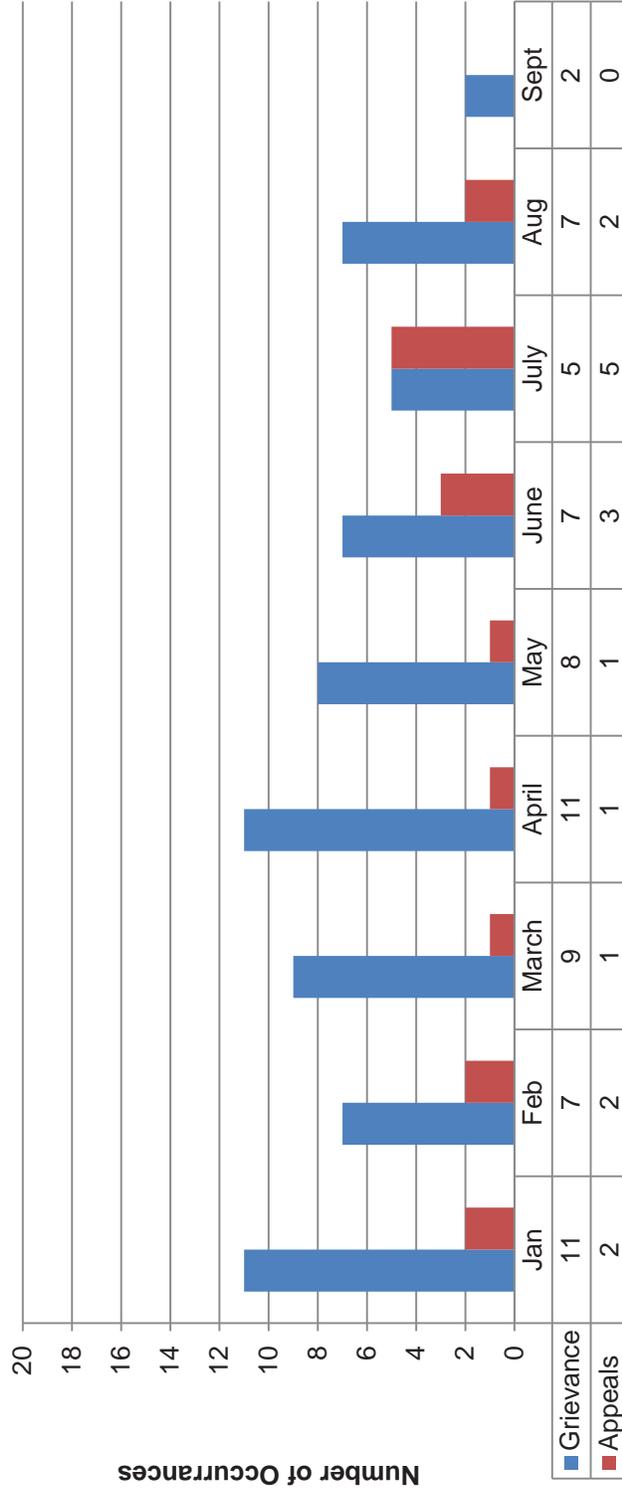
An increase in Provider Town Hall meetings by Provider Relations

All new Providers receive a packet of materials on how to request an interpreter and how to order materials.

Cultural and Linguistic Services Request for Materials

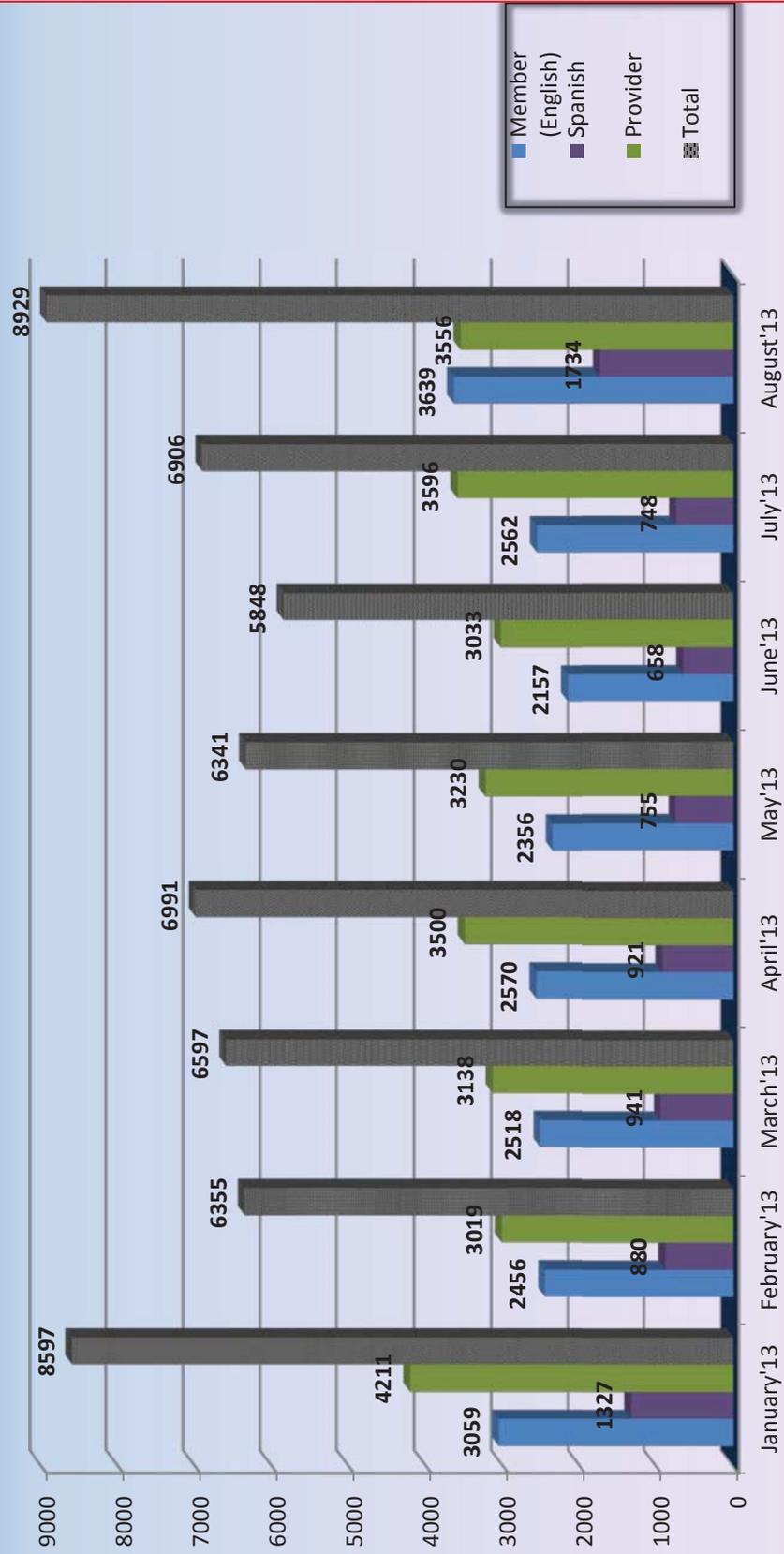


Member Grievance and Appeals 2013



Grievance: Average 7/month
Appeal: Average 2/month

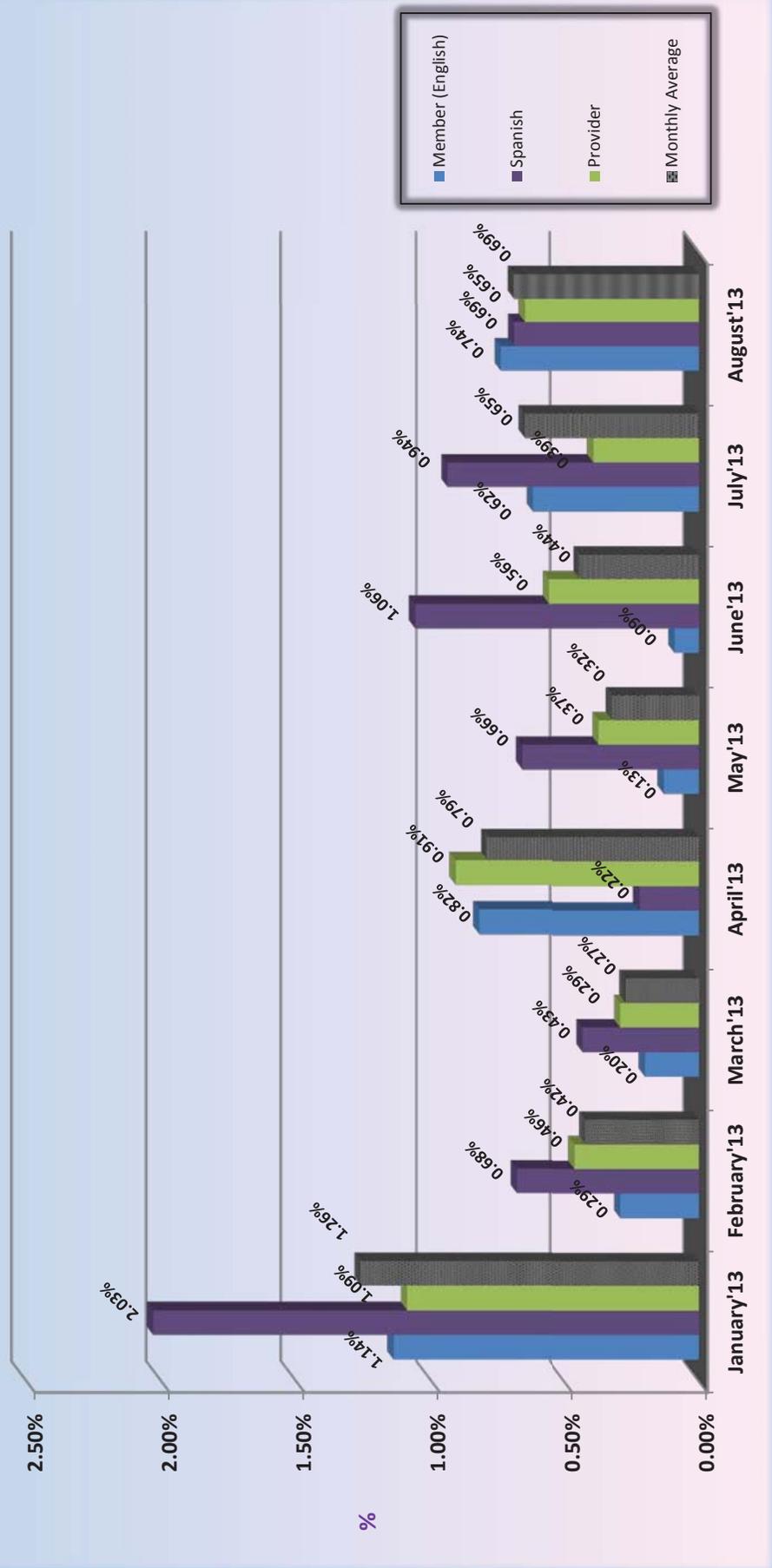
Total Monthly Calls by Queue



Average Speed of Answer Goal ≤ 30 seconds



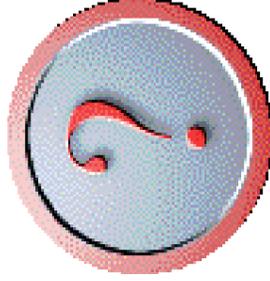
Abandonment Rate Goal ≤ 5%



**Medicare Part A - Monthly Conversions -
Tracking Log**

Month	New	Cumulative
Apr-2013	36	36
May-2013	22	58
Jun-2013	47	105
Jul-2013	34	139
Aug-2013	183	322

Any Comments and Questions?



AGENDA ITEM 3d

To: Gold Coast Health Plan Commissioners
From: Charles Cho, Chief Medical Officer
Date: September 23, 2013
RE: CMO Update - Substance Abuse Collaborative

The Association for Community Affiliated Plans (ACAP) recently announced that it would convene a collaborative of ACAP-member plans to provide support for strategies to address substance abuse.

The collaborative will focus its efforts on prescription drug abuse, which has increased in recent years: the number of drug overdoses grew every year between 1999 and 2010. Of the more than 38,000 overdoses reported in 2010; nearly 60 percent involved prescription or over-the-counter drugs, 3 in 4 of which involved opioids such as hydrocodone, oxycodone or methadone. In 2010, more than 16,500 deaths from opioid overdoses were reported—more than a fourfold increase from 1999.

The collaborative will initially involve ACAP-member Safety Net Health Plans. Gold Coast Health Plan applied and was accepted for participation. Each participating plan will dedicate a team of three to five staff—including medical directors, quality staff, pharmacy directors and substance abuse specialists—to the project. Gold Coast Health Plan's core team will consist of Julie Booth, Quality Improvement Director; Dr. Charles Cho, Chief Medical Officer and Richard Kleinberger, Clinical Pharmacist.

The collaborative will conclude around April 2015 with a symposium for all 58 ACAP-member health plans to learn from the collaborative participants about their action plans, results and lessons learned followed by a publication for review by all interested parties.

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

Quality Improvement Committee Meeting
Thursday, May 30, 2013

Call to Order

Dr. Charles Cho – Chief Medical Officer called the meeting to order at 3:08pm, in Suite 280, Ventura County Public Health Building located in 2240 E. Gonzales Road, Suite 280, Oxnard, CA 93036.

Members in Attendance

Charles Cho, MD – Chief Medical Officer, Laurie Eberst – Commissioner, John Fankhauser, MD – Commissioner, Anil Chawla, MD – Commissioner, Nancy Wharfield, MD – Medical Director Health Services, Julie Booth – Director Quality Improvement, Susan Tweedy – Senior Quality Improvement Project Manager, Robert Franco – Delegation Oversight Project Manager, Luis Aguilar – Manager Member Services, Lupe Gonzalez – Manager Health Education/Cultural Linguistics, Jennifer Palm – Director Health Services, Cassie Undlin – Interim Chief Operating Officer

Other Staff in Attendance

Kathleen Garner – Provider Network Representative
Sonji Lopez – Grievance & Appeals Coordinator
Connie Harden – Member Services Project Specialist
Doris De La Huerta – FSR Nurse
Lupe Harrion – Quality Improvement Administrative Coordinator

Absent/Excused

Michael Engelhard – Chief Executive Officer
Guillermo Gonzalez – Director Government Affairs
Sherri Bennett – Manager Provider Contracting

Introductions

Dr. Cho welcomed everyone to the meeting and introduced Dr. Anil Chawla Commissioner as a new member to the Quality Improvement Committee. Round table introductions followed.

Approval of QIC meeting minutes

Approval of the Minutes of February 7, 2013. No revisions or additions. A motion by Dr. Wharfield to approve the minutes and seconded by Julie Booth. A vote was taken and all were in favor of adopting the minutes.

CMO Report

Dr. Cho stated that although the Quality Improvement Program was delayed almost a year because of other priorities, the Program is currently doing very well. Recently, the QI department completed the HEDIS audit of collecting and abstracting data. This process involved the retrieval and abstraction of almost 4,000 medical records in order to meet MMCD requirements.

QI Director Update

On February 25, 2013, Dr. Cho presented the Quality Improvement Plan including the QI Work Plan to the Ventura County Medical Managed Care Commission dba Gold Coast Health Plan for their approval. He provided the Commission the same presentation that was presented at Quality Improvement Committee (QIC) on February 7, 2013. The QI Plan was unanimously approved by the Commission.

The Quality Improvement Department reports to the "Commission" on a monthly basis. However, the Quality Improvement Committee will provide a formal report to the Commission quarterly which will include but not be limited to:

- Quality Improvement (QI) Findings
- Direct operational modifications to the QI systems, as needed
- Reports of acceptable quality care across the continuum
- Plans population and medical need metrics to assist with quality improvement prioritization
- HEDIS baseline data
- HEDIS performance improvement projects
- Sustainability of performance improvement interventions as evidenced by data

The QI Department has been using the Ishikawa diagram (also called Fishbone Diagrams, Fault Tree Analysis or Cause-and-Effect Diagrams) that show the causes of a specific event as the tool for a barrier analysis as required by the State mandated Quality Improvement Project specifications. This tool assists in identifying potential factors causing an overall effect. Each cause or reason for imperfection is a source of variation. Causes are usually grouped into major categories to identify these sources of variation. An example of our most recent barrier analysis using the fishbone diagram was used for the All Cause Readmissions Statewide QIP presented at the December 14, 2012 QIC meeting.

Although the fishbone diagram is only one of several tools that can be utilized for barrier analysis, it is the model currently used by the Department of Health Care Services for the State mandated quality improvement project. Accepting this model will not preclude GCHP from using another tool should one be deemed more appropriate for a project however, we would like approval of the fishbone diagram as the organizational model. Also presented were educational materials on how to conduct a barrier analysis. Plans will be made to disseminate the material to all staff.

QI Subcommittee Reports

Pharmacy & Therapeutics Committee (P&T)

Dr. Cho reported on the information from the last P&T meeting held on May 16, 2013, however minutes from that meeting are not yet available. The most important function of the P&T is the review of the formularies and recommended changes to the formulary. Each recommended change is thoroughly reviewed, discussed, modified and approved by the committee. The committee makes sure any unnecessary drugs are omitted and necessary drugs are added and that those that are in the formulary have proper restrictions, allowances and prior authorizations, including necessary step therapy, etc. The P&T raised concerns about the ppm costs starting to go up in April 2012. An overview of the April 2012 Top 12 Drugs by Rx, Top 12 Drugs by Dollar and Top 12 Drugs by Therapeutic Class showed an increase in brand named drugs for cancer treatment. Overall the formulary is being used very well in promoting generic brands when appropriate. A review of Prior Authorizations (PA) showed approximately 5,000 PA's were received from December 2012 to April 2013. Ninety-one percent of the PA's were approved and nine percent denied. Twenty-one percent of the denials went through the appeal process.

Credentialing/Peer Review Committee

Dr. Cho gave an overview of the Committee minutes from the March 21, 2013 meeting. Twelve provider applications were reviewed at the March 21, 2013 meeting. The Committee reviewed and approved all twelve applications. The sanction list from the California Medical Board was also reviewed. The eight provider members on the Committee are all experts in their field. Dr. Fankhauser noted his name was spelled wrong in the minutes and his name will be corrected.

Medical Advisory Committee (MAC)

Dr. Cho reported the MAC has started to review and add new policies. Recently MAC presented a policy for defining the uses for Telemedicine. A discussion ensued and Dr. Chawla inquired as to whether GCHP would, for example, pay for the doctors using Telemedicine who worked at UCLA? Dr. Cho answered that currently the UCLA providers are paid through a UCLA grant. Dr. Fankhauser asked how we would do the credentialing of the doctors using Telemedicine? The details on credentialing need to be worked out requiring discussion and approval. Dr. Wharfield explained that the details of the Telemedicine policy for GCHP still need to be finalized. At this time, MAC is merely bringing forward the concept of making Telemedicine.

Member Services Committee (MSC)

Luis Aguilar reviewed the minutes from the Member Services Committee meeting held on April 18, 2013. The Plan received feedback from the members of the Consumer Advisory Committee. An action item list of 13 issues was created from the feedback of which 70% have been completed. A multi-department Balance Billing process was implemented which includes the Claims, Call Center and Member Services areas. This new process helps resolve issues for our members and increased the turnaround time to address and resolve issues. Since implementing this process issues have dropped by 50%. In the call center, the average speed to answer a phone call has improved since March 2013.

Grievance and Appeals Committee (G&A)

Dr. Wharfield discussed that G&A has been working on data management and clarification of processes. She reviewed the types of grievances received in the first quarter. The highest volume grievance category is quality of care issues and there were a total of 26 grievances. There had been concern that our grievance numbers were low. Members don't want to go on record that they made a complaint about service. We continue to get the word out to the members that it's their right to file a grievance if they need to and it's helpful to GCHP in order to improve our services. By gender male and female members were equal in filing grievances and mainly English-speaking members were the ones to file.

By contract we're required to address appeals within 45 days but internally we aim for a 30 day turnaround time. In the first quarter, six out of 30 appeals were beyond 30 days but not more than 45 days. Acknowledgement letters are going out within 5 days and Resolution letters are going out within 30 days and there were no letters that were out of compliance.

Network Management Committee (NMC)

Kathleen Garner stated since the first quarter we have two termed primary care providers, thirteen newly added PCP providers, four termed specialists and five newly added specialists. There are sixteen newly added Pharmacy providers. A discussion ensued concerning the availability of a 24 hour pharmacy in Ventura County. Kathleen will find out and let Dr. Cho know the exact location of 24 hour pharmacies in the County.

The Provider Directory Production Schedule shows when the next update will be done. Julie encouraged everyone to keep and report up-to-date contact information for providers. Dr. Fankhauser asked if the

provider directory is online and how easily accessible is it to members to find a provider. Kathleen explained that the online directory is available, and very easy to utilize.

Delegation Oversight (DO)

During April 30th Delegation Oversight Committee Meeting a draft policy and procedure was introduced for the delegation oversight activities which will encompass some of the plan to plan activities specifically surrounding the Healthy Families/Kaiser members.

The Plan has contracted with Provencio Advisory Services (PAS) to assist with the design of the Delegation Oversight Program. Over the past month, PAS has met with most of our internal leadership to gauge their interaction with the delegated groups. PAS is completing their interviews with the delegated groups, which will complete the first phase of their assessment. We are expecting the report for PAS regarding their recommendations in early July.

The Delegated provider sanction list was reviewed. The DO is monitoring the Medical Board's decision of any providers on the sanction list. Dr. Fankhauser and Commissioner Eberst made the recommendation that the "Notes" section of the Sanctions Report be removed and not available for public record.

The other report is regarding VTS Call Statistics. We are working with the vendor to create a report for our next DO meeting to capture the encounter data based on a recommendation from the committee members.

DO is also working with Vendor Management to establish our working relationship with the remainder of the delegated entities. Specifically Xerox, the call center, claims processing, Script Care our Pharmacy Benefits Manager and VSP our vision vendor. The scope of DO is continuing to grow and we are working to establish clearly documented roles and responsibilities.

Health Education/Cultural Linguistics Committee (HE/CL)

Lupe Gonzalez reported on the HE/CL minutes from the January 29, 2013 meeting. Cultural Linguistics (CL) has worked on quantifying the number of translation and interpreter requests. The data was presented and reviewed. January through April has seen a steady increase in requests for translation services. The health plan contracts with Lucas-Campbell for our written translations and with Life Signs for all our ASL interpreter services.

HE/CL is working collaboratively with Provider Relations on two initiatives; during the provider site visit the provider has the opportunity to review available educational materials and complete a request form and provider relations forwards the form immediately to HE/CL for processing. The second initiative is Town Hall Meetings with the providers and educational and interpreter services are discussed.

Total number of materials distributed to providers including posters, brochures, ID badges, etc. is about 1200 pieces. Commissioner Eberst asked if we were happy with our translation services because she can recommend another service if we are interested. Lupe said she would follow-up with the Commissioner on that recommendation.

The Health Education referral form is available on our website for members to self-refer for Health Education (HE) services. Dr. Fankhauser asked if 100% of the requests for referrals are granted? He also explained that with the thousands of diabetics in the community, do the members know this form exists and are there any other triggers that would prompt the HE program? Lupe stated there are no other triggers; so far we've only had 22 requests. Dr. Fankhauser suggested the number is low because

providers don't know the form exists. Lupe said HE would focus on a campaign to continue working with the providers specifically around available HE services.

HE is going to work with the Public Health Department and some of their initiatives on Healthy Communities, the Tobacco Program and also on physical education and fitness programs. Dr. Fankhauser asked if we would be able to support the increase in requests for educational materials? Lupe reported that two additional staff had been added and a budget request for 2 additional staff is awaiting approval.

HE is developing a Diabetes Education Directory. HE is working with community partners to see what types of services are available to all of our members, in both English and Spanish. Dr. Chawla asked if the HE referral service is class based or if it is one on one education. Lupe said she first contacts the health educator at the referring provider to see what would be appropriate for the diabetic member.

Prenatal Care and Breastfeeding is an initiative, based on the stages of the pregnancy and provides parenting advice, offered in a quick read format. We are also working with VCMC and First Five to provide New Parent Kits.

HE is partnering with WIC. Because of the transition of Healthy Families to MediCal, it has increased the eligibility of families for WIC and they are looking for partners to promote the WIC services for members. Lupe presented a draft of a newsletter which will go out to our members in mid-June focusing on summer events, balance billing information, the transition of Healthy Families, information on staying fit and healthy as a family and information on immunizations. HE met with 14 different agencies collaborating services regarding oral care, working with City of Ventura on Health Education and similar classes with City of Oxnard Housing. We're looking at a possible Memorandum of Understanding with Food Share to work on doing some support on health education topics around nutrition with that population.

Utilization Management Committee (UMC)

Dr. Wharfield provided an update on UM activities. The selection of a new medical management system has been narrowed down to two choices. The new system will improve our functionality and reporting capabilities.

A discharge manager has been hired. Our cost savings goal is to improve the quality of care relative to inpatient hospital utilization while decreasing the overall inpatient spending. Numbers are improving but in order to improve them more will require collaboration with the facilities. We are excited to have access to medical records at some of the facilities and we're still working on getting census data, etc. Dr. Wharfield shared that based on a comparison from other plans we're definitely in range of meeting reasonable targets. Dr. Fankhauser asked if we know where the best use of the money should be spent, to which Dr. Wharfield answered discharge planning is critical for us and having accurate information about the member has been difficult. Placement is also critical but there are no beds to place patients. Dr. Chawla asked if we are notified when a patient gets admitted to the hospital. Jenny Palm answered, yes, we currently receive a daily census that is emailed or faxed to us.

Dr. Wharfield presented a chart of the Top 20 Inpatient Diagnoses by ICD9 listed in order of expense. She asked the Commissioners to assist in collaborating with us more on providing patient contact information from the hospital. We're working on the highest utilizers and we think it will be more beneficial if we do it in real time. If we could call patients who have non-urgent reasons for going to the ER, it will do two things: it will allow us real time education opportunity and to encourage follow up visits with their primary care provider. We're finding that we can't reach these members because we don't have good

phone numbers. Commissioner Eberst stated St. John's Hospital has 24-hour on-site emergency room case managers. Kay Duncan is the Director of Case Managers and she would be the key person to speak with to get the ER case managers to have them make this part of their routine. She asked how we've gotten around HIPAA with this issue. Jenny Palm stated if the patient is our member then we are HIPAA compliant. Dr. Fankhauser stated that VCMC is converting from an old system that could only provide partial information for the patient. He offered that better information will be available from VCMC after 30 days when they've switched to their new system.

Approval Items

Quality Improvement Project Summary Form

Julie Booth presented for approval the Quality Improvement Projects Summary Form. This is a draft form to test for 2 months, finalize it in the 3rd month and have it ready for the next QIC meeting. It is based on the State of California Quality Improvement Project Form which is 25 pages long which we have consolidated to 2 pages. We will provide training on how to use this form. This form will be used for various purposes, it may be used here, it might be used to report on something to the Commission or it might be used to report something to another committee. A sample was provided to show what the form looks like filled out. One on one and "Lunch and Learn" education will be provided in the future. A motion to accept the form was made by Commissioner Eberst, a second motion was made by Dr. Fankhauser. All voted in favor and the motion was passed.

Adoption of a Model for Barrier Analysis

Julie also sought approval of the Fishbone Diagram as our barrier analysis. This model is based on the State's model. A motion to accept this model was made by Dr. Fankhauser, a second motion was made by Dr. Wharfield. All voted in favor and the motion was passed.

Discussion Items

Readmission Quality Improvement Project (QIP)

Dr. Wharfield stated the model we'd like to follow is a CMS Care Transition model to select people who are at high risk for readmission. This would include someone who has a history of readmissions or has a social situation that qualifies them. The goal is to meet them in the hospital prior to discharge and introduce them to the idea that someone will be visiting them at home. A home health visit nurse would conduct an assessment to include medicine reconciliation, make sure they understand when their follow up appointment is and that they go to their appointment. If it was necessary in certain circumstances to provide additional visits, the nurse will give us that feedback, and then follow up calls will be done every week as needed. It would be helpful to have a blanket authorization that would go to the home health agency. Dr. Fankhauser asked how we will decide which patient needs follow up services? Dr. Wharfield explained the patient would need to qualify based on a pre-determined selection criteria. If it looks like a patient will have trouble or is high-risk, then we would consider them. An example would be a new mom of NICU babies who doesn't know how to handle the needs of these babies. Dr. Fankhauser stated that this is a large undertaking and having a case manager from GCHP would be a good idea. Dr. Wharfield is going to meet with Dr. Araujo and the discharge planners to see how this process can be implemented. Dr. Chawla asked if the discharge planners are RN's, Jenny replied affirmatively.

Provider Relations Site Visits

Kat Garner gave an overview of their policy and procedures on Site Visits and the process and how often they would be meeting with our providers.

Facility Site Review

Susan Tweedy provided an update of the Facility Site Reviews. She explained the difference between the Provider Relations Site Visit and the Facility Site Reviews. The Provider Relations site visit is more of an educational visit once the provider is contracted with our organization. The Facility Site Review is required to be done by a certified FSR nurse or a Master Trainer as designated by Department of Health Care Services (DHCS). They audit a primary care site who wants to be contracted by the organization and then a medical record review process is done at a later date.

In March 2013 the Medical Monitoring Unit (MMU) of the DHCS notified Gold Coast Health Plan they would be conducting a random full-scope Facility Site Review (FSR) and Medical Record Review (MRR) of twenty-nine (29) GCHP primary care sites from April 9-11, 2013. A list of the 29 sites was received from MMU and each of the sites were notified in advanced and provided an opportunity for individual review/education of the audit process.

In April 2013, upon their arrival, the auditors selected twenty (20) sites from the list of 29 primary care sites for auditing. Four teams of two Nurse Evaluators from the MMU of DHCS completed the Facility Site Reviews and Medical Record Review audits. Official results of the audit have not been received from the MMU.

A nurse auditor from the MMU evaluated Doris De La Huerta, RN, BSN, CCM and approved her certification as a Master Trainer for Gold Coast Health Plan.

HEDIS Status

The Healthcare Effectiveness Data Information Set (HEDIS) reporting year used data from January 1, 2012 through December 31, 2012. Our measurement year is 2013. Stratification was required to identify SPD vs. NON-SPD population. We're still going through the process. Our results don't get locked into the State's system until June 17, 2013. We have been going through incremental audits at every stage of the process. We have successfully passed through all of the hurdles with their stamp of approval. In terms of actual data outcomes, we will not receive results until September or October 2013. We know internally some idea of how we're doing. We've received compliments from the State that as a first year plan we're doing very well. We are looking forward to sharing the actual results with the Committee when we receive them.

Operations Update

Jenny Palm presented for Cassie Undlin. Part of our corrective action plan with the State was to increase claim Auto Adjudication to 60%, this week we jumped up to 67%. A lot of work was done to reach this rate and we're working to maintain it. The down trend data on the provided chart was due to a hold on claims.

Provider Satisfaction Survey

Kat Garner indicated that the contract for administering the provider satisfaction survey has been narrowed down to two final candidates. A final decision still needs to be made.

Additional Comments

Dr. Cho expressed his appreciation to the Commissioners for their time and participation at these meetings. He also explained that the future QIC meetings need to be rescheduled due to a conflict with the Executive Finance Meeting

Adjournment

Dr. Cho adjourned the meeting at 5:00pm. Next QI meeting will be scheduled on a date to be determined.

Submitted by Julie Booth

Approved by: Charles Cho Date: 8-13-13

Charles Cho, M, D., Chair

**Ventura County Medi-Cal Managed Care Commission
(VCMCC) dba Gold Coast Health Plan
Consumer Advisory Committee Minutes
March 13, 2013**

CALL TO ORDER

Cassie Undlin, Interim Chief Operating Officer, called the meeting to order at 5:00 p.m. in Suite 200 located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMITTEE MEMBERS IN ATTENDANCE

Joseph Buchroeder
Edie Brown
Norma Gomez
Frisa Herrera
Ruben Juarez
Katharine Raley
Linda Smith

EXCUSED / ABSENT COMMITTEE MEMBERS

Robert Dennis
Julianna Fjeld
Curtis Updike

COMMITTEE STAFF IN ATTENDANCE

Cassie Undlin, Chair, Interim Chief Operating Officer
Luis Aguilar, Member Services Manager
Sonji Lopez, Grievance and Appeals Assistant
Blanca Robles, Member Services Eligibility Specialist
Connie Harden, Member Services Project Specialist
Paula Cabral, Administrative Assistant

OTHER STAFF IN ATTENDANCE

Brandy Armenta, Compliance Officer / Manager
David Bacerra, Outreach Coordinator
Sonia DeMarta, Controller
Robert Franco, Compliance Project Manager - Delegation Oversight
Kathleen Garner, Provider Relations Representative
Steve Lalich, Communications Manager
Chris Martinez, Compliance Specialist
Maureen Ndu, Contracts Coordinator
Jennifer Palm, Director, Health Services

Velma Washington, Provider Relations Representative
Nancy Wharfield, MD, Medical Director Health Services

OTHERS IN ATTENDANCE

Christina Montero of Tri County GLAD - on behalf of Julianna Fjeld
Norma Cahue of County Human Services Agency - on behalf of Curtis Updike

Language Interpreting and Translating services provided by Gold Coast Health Plan from Lourdes González Campbell and Associates.

PUBLIC COMMENT / CORRESPONDENCE

None

1. APPROVAL OF MINUTES – DECEMBER 5, 2012

Connie Harden, Member Services, noted that corrections were needed on the first page; Julie Fjeld should be Julianna Fjeld, Lupe Gonzalez, Health Educator should be corrected to Lupe Gonzalez, PhD., M.P.H. Manager of Health Education and Disease Management; and the minutes should reflect that Brandy Armenta, Compliance Officer / Manager was in attendance. Committee Member Brown moved to approve the minutes as corrected, Committee Member Herrera seconded. The motion carried. Approved 6-0.

The Pledge of Allegiance was recited.

Steve Lalich noted on page two of the minutes that social media was not active at this time and requested the minutes be amended: “Additionally, we utilize social media although Facebook and Twitter are not active at this time; YouTube is available and will be a good tool for the Plan.” should read as follows: “Additionally, GCHP utilizes YouTube as social media because Facebook and Twitter are not active at this time; but would be a good tool for the Plan.”

Committee Member Juarez moved to amend the minutes as reflected and Committee Member Herrera seconded. The motion carried. Approved 6-0.

2. GOALS AND OBJECTIVES

Committee Member Juarez moved to approve the goals and objectives and Committee Member Linda Smith seconded. The motion carried. Approved 6-0.

3. INFORMATIONAL ITEMS

a. Welcome

Dr. Nancy Wharfield, Medical Director Health Services, stated that she has met with each of the Committee Members. She stated that Gold Coast Health Plan (GCHP) wants the meetings to be interactive and needs involvement and feedback from the Committee Members. GCHP is working towards a culture change for our Members as well as for our Providers in Ventura County. Our goal is to give our Members the quality health care they deserve and for our Providers to understand the care that is needed for our Members.

Committee Member Brown asked if GCHP is monitoring the timeframe for a Member to be referred from a PCP to a specialist. Dr. Wharfield said at this time GCHP does not have the ability to monitor that at this time. Director of Health Services Palm, noted that the state standard in the contract is two weeks to see a specialist. Director Palm added that sometimes the wait is a little longer but GCHP strives to be within the State's timeframe. Dr. Wharfield stated that GCHP prefers to keep Members in network and in the area; however, for services that are not available, GCHP does have tertiary care which would require prior authorization.

Committee Member Raley asked who should be contacted at GCHP regarding specific problems and have the ability to reply within eight hours. Chair Undlin replied that the first call should be directed to Member Services.

Committee Member Juarez related how some Members select a PCP but do not immediately establish care; therefore, when they do go to the PCP, are told they are not accepting new patients. They want to change their Provider but do not have a current PCP directory. There is frustration among the Members because they are calling the 888 number (with the call center in another state) and are told they are not in the system and then they contact Committee Member Juarez. This needs to change. Manager Lalich will follow up with Committee Member Juarez.

Committee Member Raley asked if the Committee had access to the CEO; Chair Undlin replied yes and urged the Committee to let GCHP know the issues that need to be addressed and expressed that the Committee's contribution is very much appreciated.

b. Pre-Authorization Overview

Dr. Wharfield presented a brief overview of certain services requiring prior-authorization. If a denial is received, a letter is sent to the requesting Provider and the Members. The Provider then has the opportunity to call directly and speak "peer to peer" with the reviewing physician and if information is missing, it can be changed and the decision can be reversed. On a more formal basis, if the Member wants to appeal a decision, another physician can review the case.

Dr. Wharfield noted that in regards to grievances, GCHP needs help to encourage Members to file grievances. If GCHP receives grievances, GCHP can track and fine-tune the different problems. Committee Member Raley asked if they could advocate for the Members as many do not have transportation or cell phones or cell phones with limited minutes and a Member will not waste their minutes calling the 888 number. Dr. Wharfield stated that a formal release may be required to advocate for a Member, but it is possible.

c. CBAS

Jenny Palm, Director of Health Services, stated that GCHP currently has about 600 Members receiving Community Based Adult Services (CBAS) and that GCHP works closely with the centers. Director Palm asked if there were any questions or issues that the Committee was receiving from Members or if anything is unclear about the services CBAS offers. To which there were no responses.

d. Sensitive Services

Dr. Wharfield explained that sensitive services are related to pregnancy, family planning, pregnancy testing, and HIV testing or sexually transmitted diseases. Members have the option of going to an in-network Provider or out of network Provider (in or out of Ventura County) as long as it is a Medi-Cal Provider, and GCHP will pay for the services. This includes minors down to the age of 12; they can receive these services without receiving parental consent. If needed, GCHP will assist the Members in locating a Provider out of county.

Committee Member Herrera asked if the Providers are informed about this because there is a concern some Providers may feel if the Member is not assigned to them they will not be reimbursed for services. Dr. Wharfield stated that the directive is “any willing Medi-Cal Provider.” Some Providers may not be aware of this requirement; if there is an issue, the Members can contact GCHP and GCHP will inform the Provider and reassure them that they will be paid. Director Palm added that this is an area in which GCHP needs to educate the Providers, as well as ensuring the patient’s privacy is being protected when sending billing information to the home.

e. PCP Access

Dr. Wharfield said that when someone becomes a GCHP Member they have thirty (30) days to choose a Provider or be auto assigned. Dr. Wharfield said that this is an area that needs to be discussed further and is part of Provider education. Our Members also need to be educated about our policies and the importance of establishing a medical home so that the PCP can become familiar with them.

Committee Member Juarez said that the community clinic will accept these patients if needed. Committee Member Herrera asked about foster children that may be placed in a group home and are not seeing their PCP within the required first 120 days. Dr. Wharfield said if the Members are not showing up for their initial visit, GCHP needs to push the Providers to contact them.

Manager Lalich noted that GCHP has gone out into the community along with materials going out to the Members stating they must select a PCP within 30 days, establish a relationship within 120 days and that they have the right to switch PCP’s the following month. There was a discussion as to the many reasons Members do not establish a relationship with their PCP and ways to correct the problem.

Committee Member Herrera said that there is a concern with foster youth receiving their prescriptions. Foster youth are initially covered under the State Medi-Cal system for the first month and then are switched over to GCHP; however, sometimes the child is pulled

and placed in a group home. The pharmacies are filling the prescriptions, but there is a big difference with how they are paid. The State covers name brands and GCHP covers generic (\$20 vs. \$200). GCHP needs to know how this can be avoided. Chair Undlin stated that this needs to be addressed and will respond to Committee Member Herrera.

f. Transportation Vendor

The President of Ventura Transit Systems (VTS), Masood Babaeian, stated that VTS services began on February 1, 2013. They are averaging 5,000 trips per month; 1,000 Members are using the service on a regular basis. Services are not denied if they meet medical criteria.

Committee Member Gomez stated that she has a family who is having problems with transportation services. Their child requires a hearing device and needs to go to a Provider in Westlake Village. She has spoken to Guillermo Gonzalez but she has not heard back from him. Committee Member Gomez was unaware of the transportation vendor. Masood Babaeian suggested that Committee Member Gomez contact his office. It was noted that VTS will provide some out of the area transportation. Committee Member Raley asked if transportation was available for seniors (Medi-Medi). Teresa Howarth is in charge of transportation and can be reached at 1-855-628-7433.

A break was provided at 6:05 pm.

The meeting reconvened at 6:30 pm.

g. ACE

Chair Undlin stated that the ACE Program is for adults ages 21-64 who do not qualify for Medi-Cal. Chair Undlin said that the Low Income Health Plan (LIHP) is part of the waiver the State has with CMS. They are looking at individuals in the 100-138% range of the federal poverty level (FPL). This is being reviewed as part of the Governor's budget. Part of the population (139% to 200% FPL) will go into the Exchange. There was a discussion regarding the different programs going into effect. Chair Undlin said it should be discussed further at the next meeting.

John Buchroeder left the meeting at 6:40 pm.

h. HEALTHY FAMILIES

Steve Lalich stated that GCHP is in Phase III of the Healthy Families Program that is transitioning into Medi-Cal beginning August 1, 2013. GCHP is going to try to mirror the outreach campaign GCHP did originally and leverage our relationships with most of our Providers (VCMC, Clinicas, CMH) to get into their clinic systems to reach the patient population about this change.

In order to get this information out, GCHP plans to get involved with some community activities that will be held and host some other events. Committee Member Juarez is involved in some school based outreach programs and would like to have our new Outreach Coordinator, David Becerra, participate in those. Depending on our budget, GCHP is proposing to do some paid media events (radio / television) to announce these

changes to coincide the August 1, 2013 date. GCHP plans to revise our website homepage with a thumbnail with information for our Members and Providers. Everything is still being reviewed and GCHP really needs the committee's feedback. Committee Member Juarez has been working with the Healthy Families Program for 15 years and gave an overview of the program and the impact it has had in our community. Information is also on the Healthy Families website.

Manager Lalich said that the next newsletter will be sent in mid-July and will include Healthy Families information. The newsletters are also on the GCHP website. Committee Member Raley asked that the senior community be included in these newsletters regarding upcoming Medicare changes and other issues related to seniors. Chair Undlin would like feedback on the newsletter.

i. Balance Billing

Luis Aguilar, Member Services Manager, stated that GCHP is receiving calls from Members regarding bills they are receiving from Providers. GCHP currently has an internal work group that includes Provider Relations, Claims and Member Services. GCHP is working on a work flow to train the Call Center on how to handle calls from Members with bills. Provider education has been given.

Committee Member Juarez discussed a problem about Members who get referred from their PCP to another doctor, but then receive a bill and a notice stating that they are not a contracted provider. The Members come into the Healthy Families offices with a collection letter and need help resolving the situation.

Committee Member Raley spoke about a serious problem occurring with ambulance billing. Medicare is being improperly billed and then the bills are being sent to the client. The ALJ is involved and this may go the Grand Jury or class action suits may be filed.

Connie Harden, Member Services, stated that there needs to be Member education and if the Members don't report the problems GCHP can't correct the problem. Connie stated that GCHP needs copies of the bills to assist Members. Chair Undlin said that GCHP will be working on these issues.

j. Call Center Reporting

Luis Aguilar reviewed the Call Center reports. The Spanish and English calls are being answered in a timely manner and within the guidelines provided.

Christina Montera of Tri-County GLAD, speaking on behalf of Julianna Fjeld stated that Committee Member Fjeld would like the Call Center to refer to the deaf population as "*deaf and hard of hearing*" not hearing impaired.

OTHER

Committee Member Smith reported receiving a new member packet for her daughter when her daughter has been a GCHP member since July 2011, with no break in service. She questioned why GCHP is sending a new packet and card. She also questioned the receipt of a 2011 Provider Directory asking if that is that the most current

Provider Directory? Other members also reported members' receipt of multiple ID cards. Luis Aguilar will follow up.

Chair Undlin stated that before the next meeting, a reminder will be sent with a request for topics to be discussed.

The meeting was adjourned at 7:30 pm.

**Ventura County Medi-Cal Managed Care Commission
(VCMCC) dba Gold Coast Health Plan
Consumer Advisory Committee Minutes
June 12, 2013**

Due to a lack of quorum, the Ventura County Medi-Cal Managed Care Commission Consumer Advisory Committee Meeting scheduled to begin at 5:00 p.m. was cancelled.

**Ventura County Medi-Cal Managed Care Commission
(VCMCC) dba Gold Coast Health Plan (GCHP)
Provider Advisory Committee Meeting Minutes
February 12, 2013**

CALL TO ORDER

Provider Network Manager Sherri Bennett called the meeting to order at 3:45 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMITTEE MEMBERS PRESENT

Antonio Alatorre, Clinicas del Camino Real, Inc.

Kimberly Bridges, RN, BSN, Centers for Family Health, Community Memorial Health System

Alger Brion, Maywood Acres SNF

Mark Minnis, Livingston Memorial VNA Home Health & Hospice

Clive Salmon, DPM, Podiatrist

Joyce Weckl, RN, Certified Nurse Midwife

EXCUSED / ABSENT COMMITTEE MEMBERS

C. Albert Reeves, MD, Ventura County Health Care Plan

John Roughan, Simi Valley Hospital & Health Care Services

Brett Zaer, Superior Mobility

Joan Araujo, VCMC Ambulatory Care Administrator

STAFF IN ATTENDANCE

Michael Engelhard, CEO

Debbie Rieger, Interim IT Director

Dr. Charles Cho, Chief Medical Officer

Jenny Palm, Health Services Director

Sherri Bennett, Provider Network Manager

Traci R. McGinley, Clerk of the Board

PUBLIC COMMENT

None.

1. **APPROVE MINUTES – August 22, 2012**

Committee Member Minnis moved to approve the Meeting Minutes of August 22, 2012. Committee Member Brion seconded the motion. The motion carried. **Approved 6-0.**

2. **INTRODUCTIONS**

Staff and Committee Members were introduced.

3. **INFORMATION ITEMS**

a. **Corrective Action Plan**

CEO Engelhard reported that Gold Coast Health Plan (GCHP) received a Corrective Action Plan (CAP). Department of Health Care Services' (DHCS) primary concerns are regarding areas in operations that need improvement: The IBNR, claims inventory / processing, refunds, leadership / staffing, and financing.

CEO Engelhard highlighted some of the areas, stating that the claims processing has been progressively attacked and the number of claims have been drastically reduced. Claims processing turn around needs to be improved. The TNE is the biggest concern, but the State also wishes the Plan to identify additional cost savings through utilization measures. The last piece of the CAP is the submission of encounter data; as there has been formatting issues. GCHP has responded to these issues and believes the Plan is showing great progress and is becoming stable.

Discussion was held regarding the Plan working with a recovery vendor and how that process will work with the Providers.

b. **Ventura Transportation System**

Provider Network Manager Bennett advised the Committee Members on the RFP process completed by GCHP. The Plan now has a full risk contract with the vendor for transportation services. Members must contact the vendor and then the vendor is required to follow the guidelines.

c. **ACA PCP Rate Increase**

Provider Network Manager Bennett reviewed the presentation with the Committee and noted that the Plan is waiting for additional guidance from the State on some of the items, as well as the fee schedule. It will be imperative that Providers provide encounter information as the Plan will be required to reconcile with the Providers quarterly.

Committee Member Weckl asked about Nurse Practitioner services to which Provider Network Manager Bennett responded that she would research those services and provide the information to Committee Member Weckl.

d. Healthy Families Plan Transition

Provider Network Manager Bennett advised that effective January 2013 they are individuals are no longer enrolled into "Healthy Families" and by the end of the year it will be fully phased in. Eligibility will be determined by Human Services and benefits will mirror Medi-Cal Services.

Committee Member Alatorre raised concern that GCHP is only recognizing Ventura County Mental Health for mental health services, but it should be any Medi-Cal provider such as Clinicas.

Discussion was held regarding the contracting and the phase-in period for continuity of care.

Provider Network Manager Bennett advised the Committee that the Plan is setting up meetings with the Networks to discuss the issues and the contracts. GCHP will be doing 90, 60 and 30-Day notices as well as media outreach. The desire is to have minimal or no disruption in coverage.

COMMENTS FROM COMMITTEE MEMBERS

Committee Member Alatorre noted that VSP treats large groups differently than small groups. Interim COO Undlin was to check into the situation, but Clinicas has not heard back regarding this issue. Provider Network Manager Bennett noted that she would check into the matter.

CMO Cho responded that he was not aware of the issues with VSP, but will work with Committee Member Alatorre to work through the issues.

Committee Member Minnis raised concerns regarding services for home health and office visits and asked if there is written documentation. Health Services Director Palm responded that all Home Health services require authorization. Committee Member Minnis stressed that there were certain visits that were allowed. Health Services Director Palm noted that the information is on the website and she would provide the information to him.

ADJOURNMENT

Meeting adjourned at 4:40 p.m.

APPROVED:



Sherril Tarpchinoff Bennett, Provider Network Manager

**Ventura County Medi-Cal Managed Care Commission
(VCMCC) dba Gold Coast Health Plan (GCHP)
Provider Advisory Committee Meeting Minutes
Tuesday, May 21, 2013**

Due to a lack of quorum, the Ventura County Medi-Cal Managed Care Commission Provider Advisory Committee Meeting scheduled to begin at 3:30 p.m. was cancelled.

APPROVED:



Sherri Tarpchinoff Bennett, Provider Network Manager