AMENDED AGENDA

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

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

1. **APPROVE MINUTES**
   a. Special Meeting of September 29, 2014

2. **APPROVAL ITEMS**
   a. Affordable Care Act (ACA) Section 1202 Payments
   b. Quality Improvement Committee Report – 3rd Quarter 2014
   c. Compliance Officer Report – 3rd Quarter 2014
   d. CEO Search Firm
   e. General Counsel Support
   f. Lease Amendment / Additional Office Space

Meeting Agenda available at [http://www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)
g. 2015 Commission Meeting Calendar  

h. DHCS Contract Amendment A13

3. ACCEPT AND FILE ITEMS
   a. Special Investigation Ad Hoc Committee Report  
   b. CEO Update  
   c. August Financials  
   d. COO Update  
   e. CIO Update  
   f. Health Services Update

CLOSED SESSION

a. Closed Session Conference with Legal Counsel – Existing Litigation Pursuant to Government Code Section 54956.9  
   i. Cressena Hernandez v. Ventura County Medi-Cal Managed Care Commission et al, Ventura County Superior Court, Case Number 56-2012-00427535-CU-OE-VTA  
   ii. Clinicas Del Camino Real Inc. v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan. Ventura County Superior Court Case Number 56-2014-00456149-CU-BC-VTA

b. Conference with Legal Counsel - Anticipated Litigation Significant Exposure to Litigation Pursuant to Government Code Section 54956.9 (b). (One case)

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting of the Commission will be held on November 24, 2014 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036

Meeting Agenda available at [http://www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)

ADMINISTRATIVE REPORTS RELATING TO THIS AGENDA AND MATERIALS RELATED TO AN AGENDA ITEM SUBMITTED TO THE COMMISSION AFTER DISTRIBUTION OF THE AGENDA PACKET ARE AVAILABLE FOR PUBLIC REVIEW DURING NORMAL BUSINESS HOURS AT THE OFFICE OF THE CLERK OF THE BOARD, 711 E. DAILY DRIVE, SUITE #106, CAMARILLO, CA. 93010

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT (805) 437-5509. REASONABLE ADVANCE NOTIFICATION OF THE NEED FOR ACCOMMODATION PRIOR TO THE MEETING (48 HOURS ADVANCE NOTICE IS PREFERABLE) WILL ENABLE US TO MAKE REASONABLE ARRANGEMENTS TO ENSURE ACCESSIBILITY TO THIS MEETING.
Notice of said meeting was duly given in the time and manner prescribed by law. Affidavit of compliance is on file in the Clerk of the Board’s Office.

**CALL TO ORDER**

Chair Araujo called the meeting to order at 3:03 p.m. in Suite 200 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

**ROLL CALL**

**COMMISSION MEMBERS IN ATTENDANCE**

Antonio Alatorre, Clinicas del Camino Real, Inc.
David Araujo, MD, Ventura County Medical Center Family Medicine Residency Program
Lanyard Dial, MD, Ventura County Medical Association
Barry Fisher, Ventura County Health Care Agency
Peter Foy, Ventura County Board of Supervisors (arrived 3:41 p.m.)
David Glyer, Private Hospitals / Healthcare System
Michelle Laba, MD, Ventura County Medical Center Executive Committee
Gagan Pawar, MD, Clinicas del Camino Real, Inc.
Dee Pupa, Ventura County Health Care Agency
Robert Wardwell, Private Hospitals / Healthcare System

**EXCUSED / ABSENT COMMISSION MEMBERS**

Vacant, Medi-Cal Beneficiary Advocate

**STAFF IN ATTENDANCE**

Ruth Watson, Chief Operations Officer and Interim Chief Executive Officer
Michelle Raleigh, Chief Financial Officer
Traci R. McGinley, Clerk of the Board
Brandy Armenta, Compliance Director
Stacy Diaz, Human Resources Director
Mike Foord, IT Infrastructure Manager
Anne Freese, Pharmacy Director
Guillermo Gonzalez, Government Relations Director
Steven Lalich, Communications Director
Vickie Lemmon, Health Services Director
Tami Lewis, Operations Director
Allen Maithel, Controller
Al Reeves, MD, Chief Medical Officer
Melissa Scrymgeour, Chief Information Officer
Lyndon Turner, Financial Analysis Director
Nancy Wharfield, MD, Associate Chief Medical Officer
The Pledge of Allegiance was recited.

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

**PUBLIC COMMENT**

None.

1. **APPROVAL ITEMS**

   a. **Representation Agreement with the County of Ventura for Legal Services**

   Chair Araujo explained that the agreement would allow the Commission and the Plan to engage the County of Ventura, County Counsel's Office for legal representation services.

   Commissioner Fisher moved to approve the representation agreement with the County of Ventura County Counsel Office. Commissioner Fisher noted that county counsel John Polich was present and was the original attorney for the Commission until it was able to obtain outside counsel. Commissioner Pupa seconded.

   In response to Commissioner Dial’s question; Commissioner Fisher responded that if needed, County Counsel would be available for staff; however, GCHP staff does work with other legal firms.

   Commissioner Alatorre asked how long County Counsel’s Services would be used. Chair Araujo responded that it would be until new regular general counsel was obtained.

   The motion carried with the following votes:

   NAY: Alatorre.
   ABSTAIN: None.
   ABSENT: Foy.

   Counsel Polich then took his seat at the dais.

2. **APPROVE MINUTES**

   a. **Regular Meeting of August 25, 2014**

   Commissioner Fisher moved to approve the Meeting Minutes of August 25, 2014. Commissioner Dial seconded. The motion carried with the following votes:

   NAY: None.
   ABSTAIN: Alatorre.
   ABSENT: Foy.
1. **APPROVAL ITEMS (Continued)**

   b. **Conflict of Interest Code**
   Interim CEO Watson reviewed the written report explaining that as required, the Commission directed staff to conduct a biennial review of the Conflict of Interest Code. A number of changes were required due to new positions, revised job titles and descriptions.

   It was noted that a page was missing from the agenda item, Clerk McGinley offered to pull the information up on the computer.

   Commissioner Fisher moved to approve the Resolution updating the Conflict of Interest Code. Commissioner Dial seconded. The motion carried with the following votes:

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

   **RESOLUTION NO. R2014-002**

   A RESOLUTION OF VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION dba Gold Coast Health Plan UPDATING DESIGNATED EMPLOYEES, OFFICERS AND DISCLOSURE CATEGORY LIST FOR POLITICAL REFORM ACT AND FAIR POLITICAL PRACTICES REQUIREMENTS (CONFLICT OF INTEREST AND RESCINDING THE CONFLICT OF INTEREST CODE AMENDED PURSUANT TO RESOLUTION NO. R2012-003)

   c. **Business Property Liability Insurance Policy**
   CFO Raleigh reviewed the written report with the Commission. The current policy with Hartford Insurance expires September 30, 2014. Three companies provided quotes to the Plan’s insurance brokers, Beecher Carlson. CFO Raleigh recommended purchasing the basic Business Insurance policy with Chubb at the increased levels and the additional umbrella policy (shown below). She explained that it would provide adequate coverage for increased growth at limits no less than the current policy.

<table>
<thead>
<tr>
<th>Property</th>
<th>Chubb - Quote 2 with $2 Million Umbrella**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building</td>
<td>N/A</td>
</tr>
<tr>
<td>Business Personal Property (BPP)</td>
<td>$566,174</td>
</tr>
<tr>
<td>Electronic Data Processing (EDP)</td>
<td>$857,136</td>
</tr>
<tr>
<td>Deductible</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>General Liability</strong></td>
<td></td>
</tr>
<tr>
<td>General Aggregate</td>
<td>$4 million</td>
</tr>
<tr>
<td>Each Occurrence</td>
<td>$3 million</td>
</tr>
<tr>
<td>Advertising Injury and Personal Injury</td>
<td>$3 million</td>
</tr>
<tr>
<td>Medical Expense</td>
<td>$10,000</td>
</tr>
<tr>
<td>Damage to Rented Premises</td>
<td>$3 million</td>
</tr>
</tbody>
</table>
d. Approval of Recommended Search Firm for CEO Position

An ad hoc committee was created at the August 25, 2014 Commission for the purpose of selecting a search firm for the CEO position. The members of said ad hoc committee are Chair Araujo, Commissioner Foy and Commissioner Alatorre.

Human Resources Director Diaz reviewed the written report. Commissioner Alatorre expressed concern as to when the ad hoc committee met because he did not participate in a meeting.

HR Director Diaz responded that she had reached out to Commissioner Alatorre on several occasions via e-mail but received no response. Since Commissioner Alatorre had not been in attendance at the previous commission meeting and was volunteered for the ad hoc committee, HR Director Diaz was asked to reach out to him to see if he was able to participate. HR Director Diaz stated that since she had not heard back from Commissioner Alatorre she assumed he was not interested in serving on this ad hoc committee.

Discussion was held regarding the timeliness of the process versus scheduling another ad hoc committee meeting to review the information. Commissioners expressed the importance of ad hoc committee members reviewing the data and having discussions to determine the best firm.

Commissioner Fisher moved that the full Ad Hoc Committee reconvene within the next two weeks to agree on a firm. Commissioner Pawar seconded. The motion carried with the following votes:

NAY: Dial.
ABSTAIN: None.
ABSENT: Foy.
e. **Waive General Counsel Attorney-Client and Closed Session Privileges and Protection – Special Investigation Ad Hoc Committee Consultants**
Chair Araujo announced that the item was not being considered and was being pulled from the agenda.

3. **ACCEPT AND FILE ITEMS**

a. **Special Investigation Ad Hoc Committee Report**
Commissioner Fisher noted that Scott Howard, legal counsel for the Special Investigation Ad Hoc Committee was present should the Commission have any questions. Commissioner Fisher then reviewed the written report with the Commission, emphasizing that the investigation had expanded and expenses are expected to total between $586,000 and $636,000 approximately.

b. **CEO Update**
Interim CEO Watson presented the CEO update and announced that the Pharmacy information would not be reviewed at this time but detailed information will be going to the Commission at a later time.

Commissioner Foy arrived at 3:41 pm

c. **July Financials**
CFO Raleigh reviewed the July Financial package with the Commission. Discussion was held regarding the growth in membership. CFO Raleigh highlighted that the Tangible Net Equity (TNE) levels are at approximately 182% of the State required minimum which includes the Lines of Credit (LOC) from the County of Ventura of $7.2 million.

d. **CIO Update**
CIO Scrymgeour briefly reviewed the written CIO update and highlighted the GCHP Projects At a Glance sheet on page 3d-5.

e. **Behavioral Health Benefit for Autism Spectrum Disorder**
Associate CMO Wharfield reviewed the written report with the Commission.

f. **COO Update**
Interim CEO Watson presented the COO Update. Commissioner Alatorre asked how many members were being auto assigned. Interim CEO Watson responded that she should be able to have that information at the next Commission Meeting.

g. **Health Services Update**
Associate Medical Director Dr. Wharfield reviewed the written report.

Commissioner Pupa moved to accept and file the Special Investigation Ad Hoc Committee Report, CEO Update, July Financials, CIO Update, Behavioral Health Benefit for Autism Spectrum Disorder, COO Update and Health Services Update. Commissioner Fisher seconded. The motion carried with the following votes:
NAY: None.
ABSTAIN: None.
ABSENT: None.

CLOSED SESSION

Chair Araujo explained the purpose of the Closed Session items.

ADJOURN TO CLOSED SESSION

The Commission adjourned to Closed Session at 3:57 pm regarding the following items:

a. Public Employee Release Pursuant to Government Code Section 54954(e)

b. Public Employee Appointment Pursuant to Government Code Section 54957(b) Title: General Legal Counsel

c. Conference with Legal Counsel - Anticipated Litigation - Significant Exposure to Litigation Pursuant to Government Code Section 54956.9(b) – (One Case)

RETURN TO OPEN SESSION

The Regular Meeting reconvened at 7:30 p.m.

Chair Araujo announced that the Commission unanimously voted to release legal counsel Nancy Kierstyn Schreiner, Anderson Kill Wood & Bender, P.C., from general counsel duties. He closed stating that no additional reportable action was taken.

ADJOURNMENT

Meeting adjourned at 7:33 p.m.
AGENDA ITEM 2a

To: Gold Coast Health Plan Commission
From: Michelle Raleigh, Chief Financial Officer
Date: October 27, 2014
RE: Affordable Care Act (ACA) Section 1202 Payments

SUMMARY:
Gold Coast Health Plan (GCHP or Plan) is required to make supplemental payments to qualifying physicians as outlined in the Affordable Care Act (ACA), Section 1202. Below, GCHP provides the Commission with an update on many items related to these supplemental payments. In addition, GCHP is requesting approval to not recoup extra supplemental payments for the January 1, 2013 – June 30, 2013 time period and to process additional payments due providers for this time period using the same methodology. These extra supplemental payments were made prior to the Department of Health Care Services (DHCS) issuing final guidance.

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

The information below is summarized into two time periods to distinguish between the change in the calculation methodology based on additional DHCS guidance.

January 1, 2013 – June 30, 2013 Supplemental Payments
In early January 2014, GCHP received funding to pay out the ACA 1202 supplemental payments to qualifying physicians for services provided during the first six months of services of calendar year 2013. When the internal processing of this initial supplemental payment was complete (March 27, 2014), approximately $2.2 million was paid out according to GCHP’s compliance plan in effect at the time the payment was made.
As GCHP was making these initial payments, DHCS alerted the Managed Care Plans (MCPs) that a change in the calculation of these supplemental payments was necessary. Supplemental payments were required to be based on “lesser of” language which necessitates consideration of the provider’s reported billed charge in the calculation. This new guidance requires that supplemental payments are to be based on the difference between the

- lesser of the effective Medicare rate and the provider’s billed charge field on the claim and
- the Medi-Cal rate paid.

Therefore, if the billed charge is less than the Medicare rate, the reimbursement amount would be the difference between the billed amount and the Medi-Cal rate. The example below illustrates this extra step in the calculation:

<table>
<thead>
<tr>
<th>Table 1: ACA 1202 Supplemental Payment Calculation Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to incorporating “lesser of” language (e.g., payments made for January 1, 2013 – June 30, 2013 dates of service)</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>a) Effective Medicare Rate</td>
</tr>
<tr>
<td>b) Billed Charges</td>
</tr>
<tr>
<td>c) Medi-Cal Rate</td>
</tr>
<tr>
<td>d) “Lesser of” (a) and (b)</td>
</tr>
<tr>
<td>e) Supplemental Payment = (d) minus (c)</td>
</tr>
</tbody>
</table>

Note this “lesser of” language was not reflected in the calculation of the initial payments made by GCHP in late March 2014. GCHP followed the DHCS-approved compliance plan in effect for that time period which did not take into account this new language due to late direction from the State. Therefore, some payments already made by GCHP to qualifying physicians were higher than if the new “lesser of” language would have been applied. Following is information on the estimated amounts of these overpayments due to the methodology change.
Table 2: Estimated January 1, 2013 – June 30, 2013 Supplemental Payments

<table>
<thead>
<tr>
<th></th>
<th>(d) Total Payment</th>
<th>(e) Additional Supplemental Payments (not reflecting “lesser of” language)</th>
<th>(f) = (d) – (e) Supplemental payment incorporating “lesser of” language</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Initial Supplemental Payments made to qualifying providers</td>
<td>$2.2 million</td>
<td>$91,000(^1)</td>
<td>$2.1 million</td>
</tr>
<tr>
<td>b) Remaining Supplemental Payments to be made for this time period</td>
<td>$892,000</td>
<td>$21,000</td>
<td>$871,000</td>
</tr>
<tr>
<td>c) Total supplemental payments estimated for January 1, 2013 – June 30, 2013 (a+b)</td>
<td>$3.1 million</td>
<td>$112,000</td>
<td>$2.97 million</td>
</tr>
</tbody>
</table>

GCHP is seeking approval from the Commission to not recoup the extra supplemental payments for the January 1, 2013 – June 30, 2013 time period for the following reasons:

- Operational challenges – it would be difficult for the Plan to recoup these extra payments from the physicians (estimated to be 100+ hours of staff time, plus vendor fees).
- Financial considerations – the Plan is performing ahead of budget financially and therefore does not have a financial reason to incur the cost of recouping extra payments.
- Physician abrasion – the purpose of ACA 1202 was to build a strong and robust primary care system to achieve better access and quality outcomes. A recoupment effort would likely create physician abrasion and potentially retention issues for network physicians who already struggle with administratively burdensome regulations and low Medi-Cal reimbursement.
- Provider payment flexibility – it is within the Plan’s decision to pay physicians more than the required supplemental payment and the new DHCS ACA 1202 payment methodology gives the MCPs more flexibility with the funds (i.e., no reconciliation of

\(^1\) At the July 28, 2014 Commission meeting, additional information was requested regarding the number of physicians to whom overpayment was made and the range of dollars for these physicians. The range of overpayment to a total of 30 physicians is from $1.65 to $48,356. Majority of this overpayment was paid to four providers, two were paid a total of $76,915 and the other two were paid $8,210. The remaining 26 physicians were paid a total of approximately $5,400.
over/under-payments). The Plan would also like to treat all qualifying providers the same for this time period.

**July 1, 2013 – December 31, 2014 Supplemental Payments**

GCHP proposes that from dates of service July 1, 2013 through the end of the funding (December 31, 2014), the “lesser of language” be incorporated into the calculation of the ACA 1202 supplemental payments.

Please note that the MCPs raised concerns that the “lesser of” language would reduce funds intended to be made to qualifying physicians for selected services because the “billed charge” field is sometimes populated with the Medi-Cal fee schedule amount. In these instances, the qualifying provider would not receive supplemental funds.

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

DHCS has not yet released the final All Plan Letter (APL) with specific instructions on the calculation for CDHP services. Therefore, in the meantime, GCHP will make all supplemental payments incorporating the “lesser of” calculation for all payments. When final guidance is issued, if it is determined that additional funds can be paid (e.g., for CHDP claims), GCHP will make these payments. These payments will be made to qualifying providers as State funding is received. To date, in addition to the first six months described above, funding has been received for payments with dates of service for the August 1, 2013 – December 31, 2013 time period.

**Additional Important Information**

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

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2 Per June 20, 2014 letter sent to the Center for Medicare and Medicaid Services (CMS) from the DHCS, the State will switch to CMS “Model 1” where MCPs’ capitation payments will include estimated additional payments under ACA 1202 and there will be no reconciliation. The suggestion to switch from “Model 2” came from MCPs after reviewing the detailed reconciliation process that would have been followed under “Model 2” and understanding that MCPs would possibly not be made whole through that process.
FISCAL IMPACT:
GCHP has estimated the impact of the ACA 1202 as shown in the following table. Note this will be adjusted as membership is finalized, data is collected, and providers attest.

<table>
<thead>
<tr>
<th>Table 3: Estimated Impact of ACA 1202 Supplemental Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>a) Revenue</td>
</tr>
<tr>
<td>b) Estimated Payment Expense</td>
</tr>
<tr>
<td>c) Net Impact (a – b)</td>
</tr>
</tbody>
</table>

RECOMMENDATIONS:
GCHP is requesting the Commission’s approval to not recoup approximately $112,000 of additional supplemental payments for the January 1, 2013 – June 30, 2013 time period.

CONCURRENCE:
None

Attachments:
None
Quality Improvement Department

- Internal Quality Improvement Project (QIP) – Retinal Eye Exam – see attached report to DHCS
- Readmission Quality Improvement Project - attached report to DHCS
- HEDIS Status – Improvement Plan submitted to DHCS – attached report to DHCS
- Facility Site Reviews – All reviews for Facility Site Review (FSR) and Initial Health Assessment (IHA) have been done for 2014
## GCHP HEDIS 2012 CDC_Eye Exam Rates

<table>
<thead>
<tr>
<th>Product</th>
<th>2012 Admin Numerator</th>
<th>2012 Hybrid Numerator</th>
<th>2012 Denominator</th>
<th>2012 Rate</th>
<th>2012 MPL</th>
<th>2012 MPL Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>81</td>
<td>94</td>
<td>411</td>
<td>42.58</td>
<td>45.03</td>
<td>-2.45</td>
</tr>
<tr>
<td>SPD</td>
<td>105</td>
<td>78</td>
<td>411</td>
<td>44.53</td>
<td>45.03</td>
<td>-0.50</td>
</tr>
<tr>
<td>Non-SPD</td>
<td>78</td>
<td>103</td>
<td>411</td>
<td>44.04</td>
<td>45.03</td>
<td>-0.99</td>
</tr>
</tbody>
</table>

## GCHP HEDIS 2013 CDC_Eye Exam Rates

<table>
<thead>
<tr>
<th>2013 Admin Numerator</th>
<th>2013 Hybrid Numerator</th>
<th>2013 Denominator</th>
<th>2013 Rate</th>
<th>2013 MPL</th>
<th>2013 MPL Difference</th>
<th>2012 - 2013 Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>87</td>
<td>411</td>
<td>45.74</td>
<td>44.37</td>
<td>+1.37</td>
<td>+3.16</td>
</tr>
<tr>
<td>126</td>
<td>55</td>
<td>411</td>
<td>44.04</td>
<td>44.37</td>
<td>-0.33</td>
<td>-0.49</td>
</tr>
<tr>
<td>84</td>
<td>90</td>
<td>411</td>
<td>42.34</td>
<td>44.37</td>
<td>-2.03</td>
<td>-1.70</td>
</tr>
</tbody>
</table>

SPD – Seniors and Persons with Disabilities  
MPL – Minimum Performance Level
### All-Cause Readmissions (Non-HEDIS measure)  
**HEDIS Reporting Year 2013**

<table>
<thead>
<tr>
<th>Population</th>
<th>Count of Index Stays (Denominator)</th>
<th>Count of 30-Day Readmissions (Numerator)</th>
<th>Rate</th>
<th>Lower 95% Confidence Interval</th>
<th>Upper 95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPD</td>
<td>1045</td>
<td>242</td>
<td>23.16%</td>
<td>20.55%</td>
<td>25.76%</td>
</tr>
<tr>
<td>Non-SPD</td>
<td>530</td>
<td>60</td>
<td>11.32%</td>
<td>8.53%</td>
<td>14.11%</td>
</tr>
<tr>
<td>Total (SPD and Non SPD)</td>
<td>1575</td>
<td>302</td>
<td>19.17%</td>
<td>17.20%</td>
<td>21.15%</td>
</tr>
</tbody>
</table>

### All-Cause Readmissions (Non-HEDIS measure)  
**HEDIS Reporting Year 2014**

<table>
<thead>
<tr>
<th>Population</th>
<th>Count of Index Stays (Denominator)</th>
<th>Count of 30-Day Readmissions (Numerator)</th>
<th>Rate</th>
<th>Lower 95% Confidence Interval</th>
<th>Upper 95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPD</td>
<td>883</td>
<td>133</td>
<td>15.06%</td>
<td>12.65%</td>
<td>17.48%</td>
</tr>
<tr>
<td>Non-SPD</td>
<td>493</td>
<td>47</td>
<td>9.53%</td>
<td>6.84%</td>
<td>12.23%</td>
</tr>
<tr>
<td>Total (SPD and Non SPD)</td>
<td>1376</td>
<td>180</td>
<td>13.08%</td>
<td>11.26%</td>
<td>14.90%</td>
</tr>
</tbody>
</table>

SPD – Seniors and Persons with Disabilities
Pharmacy and Therapeutics

• All new drugs approved by the FDA in the last quarter have been reviewed for addition to the formulary – 6 were added for significant clinical advantages

• A new formulary for Members with Medicare – Medi-Cal was approved

• Tobacco Cessation Requirements – added medications for smoking cessation and increased the quantity limits of medications for smoking cessation
Pharmacy and Therapeutics

PBM Oversight –

• Reviewed over 500 authorization requests
  98.5% decision appropriate
  100% timely
  85.3% denial language

• Pharmacy Inter-Rater Reliability (IRR) – 100%

• Pharmacy Use Data - Reviewed
Credentials / Peer Review Committee

- Report on actions by the Medical Board of California
  - 2 providers with recommendations to suspend their license – waiting for the required hearing to occur – their license is still valid until that time
  - 1 provider requiring training to be completed in November 2014
Credentials / Peer Review Committee

- Approved a new policy on credentialing organizational providers – compliant with National Committee for Quality Assurance Standards (NCQA)
- Credentials:
  - Re-credentialed – 19 providers
  - Newly Credentialed – 22
  - Organizational Providers - 20
Medical Advisory Committee

• Reviewed and commented on the new Potential Quality Issue (PQI) Policy, the results of the 2014 HEDIS Report, and the Provider Satisfaction Survey

• Approved a new revised Utilization Management Guideline to be used for treatment authorization – the policy now includes the use of UpToDate in addition to Milliman Care Guidelines (MCG)

• Also reviewed and approved 5 current policies
Health Education and Outreach

• 2014 – 8 Staying Healthy Assessment (SHA) trainings, 102 providers
• Screening Brief Intervention, Referral to Treatment Training (SBIRT) – Trainings will be provided by UCLA in Santa Barbara and Los Angeles – Health Education (HE) has informed & encouraged our providers to attend. GCHP is attempting to schedule a local training.
• The member incentive program for the recommended retinal screening for diabetics is going to Members soon – Members will receive 2 free movie tickets if they have the exam.
Health Education and Outreach

• In the last year the Health Navigator Program has contacted 149 high utilizers (4 or more visits per month) of the Emergency Room (ER). Many have been referred to Case Management. Those contacted have had a significant decrease in ER usage.
Cultural and Linguistics Committee

• New policy approved regarding assessment of new hires for bilingual fluency - hires of GCHP who are considered as bilingual are assessed for their competency – 2 evaluated in 2nd Quarter 2014

• Pacific Interpreters Call Volume 2nd Quarter:
  • GCHP staff – 130
  • Providers – 66
  • Languages – 11 languages
    • Most common – Spanish
    • Others - Russian, Punjabi, Hindu, Tongan-Pacific, Japanese
  • Sign Language – 38 requests
Grievance and Appeals

- Grievance and Appeals (G & A) Improvement Project:
  - Outcome – a new Grievance and Appeals Department
  - Manager selected – Stacy Luney

- 2nd Quarter G & A Statistics: Rate .08/1000
  39 grievances, 4 appeals, 8 State Fair Hearings – all met the requirements of acknowledgement letters in 5 days and closed in 30 days
Grievance and Appeals

Grievance Categories:
• 15 administrative
• 24 clinical – primary were transportation, rude Primary Care Physician (PCP), and access issues

State Fair Hearings Outcomes:
• 1 upheld the Plan
• 4 withdrawn
• 3 pended
Member Services

- Member Services Improvement Project to increase new Member participation in the New Member Orientation Meetings:
  - Expanded locations – throughout the County
  - Expanded hours – evenings and weekends
  - Included information in the new member packets
Member Services

2014 Member Orientation Attendance

<table>
<thead>
<tr>
<th>Month</th>
<th>Attendance</th>
<th>English Members</th>
<th>Spanish Members</th>
<th>County Workers</th>
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</thead>
<tbody>
<tr>
<td>January</td>
<td>2</td>
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<td>August</td>
<td>36</td>
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<td>10</td>
</tr>
<tr>
<td>September</td>
<td>43</td>
<td>23</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>
Member Services

- Call metrics:
  - 2nd Quarter Average Monthly Calls – 9718
  - Average Speed to Answer (goal less than 30 sec) - compliant
  - Abandonment Rate (goal less than 5%) - compliant
Utilization Management Committee

- Delegation Oversight – Approved the Utilization Management Program and Work Plan for both Kaiser and Clinicas del Camino Real

- UM Statistics:
  - Bed days / 1000 – 353, 264, 267
  - Length of Stay – 5.37, 4.37, 3.03
  - Readmission Rate – 14%, 11.1%, 10.5%
  - ER visits / 1000 – 494, 541, 442
Utilization Management Committee

2nd Quarter 2014

• Denial Rate (Medical Necessity): 3.08%
• Appeals: 3
  2 upheld the original decision
  1 overturned the original decision
Delegation Oversight

• Delegation oversight was reported to the Quality Improvement (QI) Committee – it is reported separately to the GCHP Commission.
## Section I – Submission Information

Complete an improvement plan (IP) form for each measure/indicator with a rate below the Minimum Performance Level (MPL) or reported as a “Not Report” (NR). Managed Care Plans (MCPs) may submit one improvement plan (IP) for all counties and all indicators in a measure group (such as Comprehensive Diabetes Control, CDC), as long as differences across counties and indicators are addressed.

### Health Plan Name: Gold Coast Health Plan

**Measure/Indicator:** Weight Assessment & Counseling for Nutrition & Physical Activity for Children and Adolescents

### Person Responsible for Implementing IP

<table>
<thead>
<tr>
<th>Name</th>
<th>Helen Chtourou, RHIT</th>
<th>Title</th>
<th>Senior Quality Improvement Project Analyst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>805-437-5592</td>
<td>Email</td>
<td><a href="mailto:hchtourou@goldchp.org">hchtourou@goldchp.org</a></td>
</tr>
</tbody>
</table>

### Medical Director Responsible for Approving IP

<table>
<thead>
<tr>
<th>Name</th>
<th>Al Reeves, MD</th>
<th>Title</th>
<th>Chief Medical Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>805-434-5611</td>
<td>Email</td>
<td><a href="mailto:areeves@goldchp.org">areeves@goldchp.org</a></td>
</tr>
</tbody>
</table>

## Section II – Measure(s) with rates below the MPL(s)

Please enter below the name of each county, the measure or indicator, the Plan 2013 measurement year (MY) Rate, DHCS MPL, and the Plan MY 2014 Target Rate for improvement. Check the appropriate boxes to indicate if the measure’s rate was below the MPL for the previous three MYs.

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventura</td>
<td>WCC_Nutrition</td>
<td>43.31</td>
<td>47.45</td>
<td>48.00</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Ventura</td>
<td>WCC_Physical Activity</td>
<td>28.71</td>
<td>34.55</td>
<td>35.00</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Description of the 1-3 highest priority barriers:

1) Three highest priority barriers:

Barrier 1: The Child Health and Disability Prevention (CHDP) well-child and well-adolescent examination periodicity schedule is not aligned with Medi-Cal and HEDIS recommendations. CHDP is a preventive program that delivers periodic health assessments and services to low income children and adolescents in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts. CHDP’s Periodicity Schedule for Health Assessment, the interval for well-child visits varies by age group: 2-3 years = 1 year interval; 4-5 years = 2 year interval; 6-8 years = 3 year interval; 9-12 years = 4 year interval; 13-16 years = 4 year intervals; 17-20 years = no interval. (Please see attached CHDP Periodicity Schedule for Health Assessment Requirements by Age Group). In addition, effective July 2003 the CHDP program became a “Gateway” to maximize the enrollment of uninsured children and youth in Medi-Cal which has increased the population of CHDP members enrolled in Gold Coast Health Plan.

Barrier 2: Parents will not schedule well-child and adolescent visits if no vaccinations are required.

Barrier 3: Physician well-care documentation is incomplete or absent, especially for documentation pertaining to counseling for nutrition and physical activity.

2) Gold Coast Health Plan did not submit an Improvement Plan (IP) for the WCC measure in 2013 because the HEDIS 2012 measurement year results were the Health Plan’s first and baseline HEDIS rate since the Health Plan initiated in July 2011. GCHP did not meet the MPL for WCC during the HEDIS Reporting Years 2013 and 2014 and no new barriers have been identified since last year.

3) A leading factor leading to ineffective intervention is the provider office’s reliance and preference in complying with the CHDP’s periodicity schedule, instead of the Medi-Cal guidelines and HEDIS specifications, due to mistaken presumption that reimbursement will not be provided if CHDP members receive annual well-care visits.

4) See attached Barrier Analysis

5) The primary lessons learned are:

a. CHDP’s Periodicity Schedule for Health Assessment and Wellness Visits conflicts with the HEDIS specifications, Gold Coast Health Plans coverage guidelines, and the American Academy of Pediatric recommended well-child visit guidelines.

b. Providers and office staff need additional training on HEDIS measure specifications, documentation, and coding.
c. Providers are very interested and engaged with improving their HEDIS rates; the health plan will send providers a 2014 mid-year Performance Feedback Report which will inform them which of the assigned members have not received well-child visits in 2014.

d. Parents schedule fewer well-child visits for children > 2 years of age. Per provider feedback, most parents will schedule well-child visits only when immunizations are needed.

6) All California Medi-Cal Managed Care Plans cover CHDP members; consequently the barrier resulting from the conflicting CHDP guidelines are applicable to all Medi-Cal plans.

7) Gold Coast Health Plan’s HEDIS 2014 rate for the Children & Adolescent Access to Primary Care Practitioners (CAP) measure reveals that children and adolescents within the WCC age group (3-17 years of age) are in the 10th NCQA national percentile for accessing a PCP. This data demonstrates that children are not accessing their PCPs as needed and the likely barriers are parental non-compliance and conflicting CHDP well-child visit guidelines.

<table>
<thead>
<tr>
<th>CAP Age Group</th>
<th>GCHP Rate</th>
<th>MPI</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-24 Months</td>
<td>97.37</td>
<td>95.51</td>
<td>25th</td>
</tr>
<tr>
<td>25 Months – 6 Years</td>
<td>86.29</td>
<td>86.37</td>
<td>10th</td>
</tr>
<tr>
<td>7-11 Years</td>
<td>82.26</td>
<td>87.77</td>
<td>10th</td>
</tr>
<tr>
<td>12-19 Years</td>
<td>79.18</td>
<td>86.09</td>
<td>10th</td>
</tr>
</tbody>
</table>

footnotes:

1 “CHDP Periodicity Schedule for Health Assessment Requirements by Age Groups”. (January 2012). California Department of Health Care Services, System of Care Division, Children Medical Services

## Section IV – Improvement Plan:

### A. Description of improvement plan:

**Intervention #1: Education on GCHP Coverage Guidelines v. CHDP Guidelines**

1. **Barriers:** Providers will not schedule CHDP members for annual child & adolescent well-care visits due to CHDP guidelines.
2. **Timelines:** 2013 - 2014
3. **Anticipated Effectiveness of New Intervention:** Increased provider education and awareness of GCHP coverage guidelines should engage providers to begin schedule annual well-child visits for CHDP members.
4. **Effectiveness of Existing Intervention:** N/A – This is a new intervention.
5. **Modifications to Existing Intervention:** After speaking with pediatric clinic groups and listening to the barriers they encounter, GCHP added education on CHDP v. GCHP guidelines to inform pediatric providers and their staff that GCHP reimburses for annual wellness exams, even though the CHDP periodicity schedule does not recommend or cover wellness exams annually.
6. **Methods for Evaluating Interventions:** Comparison of annual HEDIS rate measurement outcomes.
7. **Allocation of Resources:** QI Staff will develop and provide education to providers and their office staff through health plan newsletters, office visits, and trainings.
8. **Commitment & Accountability:** Comprehensive HEDIS training on children and adolescent wellness measures was provided to CHDP staff in April 2014, and the GCHP guidelines have been presented to the health plan’s major clinic groups and independent providers by the QI Director and CMO during site visits in June and July 2014. The QI Department will continue to provide HEDIS education to providers. Trainings will be given by QI Staff through on-site visits and webinar trainings.

**Intervention #2: Mid-Year 2014 Proactive Performance Feedback Report to Providers**

1. **Barriers:** Parents schedule child and adolescent wellness visits only when immunizations are needed.
2. **Timelines:** June – August 2014
3. **Anticipated Effectiveness of New Intervention:** The Mid-Year 2014 Performance Feedback Reports will be sent to each clinic and will list all GCHP members assigned to that clinic who have and have not had a child or adolescent wellness visit in 2014. We anticipate the report will facilitate providers to contact those members who have not had a wellness visit and schedule the annual examinations instead of relying on the members’ parents to schedule wellness visits. The benefit and intent of this report is to engage providers to proactively schedule preventative care visits with their members.
4. **Effectiveness of Existing Intervention:** N/A - This is a new intervention.
5. **Modifications to Existing Intervention:** N/A - This is a new intervention.
6. **Methods for Evaluating Intervention:** Look for any increases in well-child visits after reports are distributed to providers.
7. **Allocation of Resources:** QI Analysts and IT Analyst will work with HEDIS software vendor to complete a summer run of January through May 2014 claims/encounter data. QI staff will generate and distribute to providers the Mid-Year 2014 Performance Feedback Report.
8. **Commitment & Accountability:** QI Staff have committed to a 3-month timeline, from June to August 2014, to complete the integration of January–May 2014 claims/encounter data in the HEDIS software, complete a summer run, and distribute the letters to the clinics.
Intervention #3: HEDIS Measure Training

1) **Barriers:** HEDIS measure specifications and documentation/coding guideline trainings had never been provided to GCHP’s providers, which was previously a fee-for-service community of physicians. The QI Department is addressing provider education needs by continuing and improving the accessibility of HEDIS education. New education interventions will include HEDIS webinar training hosted by GCHP QI staff.

2) **Timelines:** 2013 and Ongoing

3) **Anticipated Effectiveness of New Intervention:** HEDIS training webinars will allow GCHP to more effectively and efficiently provide training to a larger provider audience.

4) **Effectiveness of Existing Intervention:** Existing interventions include provider education through: (1) GCHP Provider Report Cards for HEDIS 2012 and 2013 that were presented the health plan’s major clinic groups by the CMO and QI Director; (2) Provider Operation Bulletins; and (3) onsite trainings. Effectiveness of these existing interventions is demonstrated in the increase of the BMI Percentile and Counseling for Nutrition measures rate and an overall increase in the number of measures where GCHP met or exceeded the MPL.

<table>
<thead>
<tr>
<th>HEDIS Reporting Year</th>
<th>WCC_BMI</th>
<th>WCC_Counseling for Nutrition</th>
<th>WCC_Counseling for Physical Activity</th>
<th>% of Measures that Met or Exceeded the MPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>43.80</td>
<td>43.31</td>
<td>28.71</td>
<td>60%</td>
</tr>
<tr>
<td>2014</td>
<td>42.09</td>
<td>42.09</td>
<td>30.41</td>
<td>79%</td>
</tr>
</tbody>
</table>

5) **Modifications to Existing Intervention:** Modifications include establishing trainings using a new forum through online webinars, to capture a larger audience, and to provide access to recorded webinars through GCHP’s provider webpage.

6) **Methods for Evaluating Intervention:** Attendance of live webinars and recordings will be tracked quarterly.

7) **Allocation of Resources:** QI staff will work with the health plan’s Communication Department to implement GoToMeeting web-based live interactive and recorded webinars trainings.

8) **Commitment & Accountability:** Education is an effective intervention for improving HEDIS rates because providers and their staff will increase their awareness of the HEDIS metric specifications and the quality of care documentation and coding guidelines that are measured. GCHP is committed to providing continued education to providers through provider education articles published in the Provider Operations Bulletin, coordinating with Health Education to provider education to members through Member Newsletters and Health Fairs, site visits, and creating new enhanced and more accessible education through live and recorded webinars.

Intervention #4: GCHP Provider Report Cards

1) **Barriers:** Providers cannot develop strategies for improving their HEDIS rates if they do not know their HEDIS scores.

2) **Timelines:** Summer 2013; Summer 2014

3) **Anticipated Effectiveness of New Intervention:** Providers will become more engaged in scheduling preventative wellness exams if their HEDIS rates for the WCC measure is low.

4) **Effectiveness of Existing Intervention:** The Annual GCHP Provider Report Cards were initiated in the summer of 2013 to report each clinic’s HEDIS rates. Due to the providers’ increased provider awareness of the W34 measurement specification guidelines and the measurement outcomes, there was a slight increase in the reported rates for two of the three elements of the WCC measure.
Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

<table>
<thead>
<tr>
<th>HEDIS Reporting Year</th>
<th>WCC_BMI</th>
<th>WCC_Counseling for Nutrition</th>
<th>WCC_Counseling for Physical Activity</th>
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<tbody>
<tr>
<td>2013</td>
<td>43.80</td>
<td>43.31</td>
<td>28.71</td>
</tr>
<tr>
<td>2014</td>
<td>42.09</td>
<td>42.09</td>
<td>30.41</td>
</tr>
</tbody>
</table>

5) **Modifications to Existing Intervention**: No modification.

6) **Methods for Evaluating Interventions**: Comparison of annual HEDIS rate measurement outcomes.

7) **Allocation of Resources**: Using the HEDIS software, QI Staff generated the Provider Report Cards and the CMO and QI Director met with each clinic’s administrator to present and discuss the outcomes presented in the HEDIS Provider Report Cards.

8) **Commitment & Accountability**: The QI staff created the Provider Report Cards in June 2014 and the Chief Medical Officer and QI Director meet with the clinic physicians and administrators to present the HEDIS result in July 2014.

---

**B. SMART objective (See PDSA Cycle worksheet):**

SMART Objective: By September 30, 2014, increase the percent of child and adolescent wellness visits by creating the HEDIS 2014 Provider Report Cards to report to providers how their clinics performed in 2013. Reporting these scores will motivate providers who performed poorly on the WCC measure to develop strategies to increase their rates.
Section V – Improvement Plan Grid: Enter interventions to address each of the 1 to 3 high-priority barriers. Interventions should be measurable and include the following description: what, where, when, how, and to whom. If multiple interventions are planned, list interventions in order of effectiveness and/or highest priority (e.g., directly addresses the barrier, best practice, etc.) and include the county/counties where the intervention will be conducted. Do not include planning activities. Enter the targeted barrier for each intervention. If it is an existing intervention, check “yes,” and indicate the duration of existing intervention prior to the implementation of the new timeline, i.e., number of weeks, months. Enter the implementation timeline for new and existing interventions, i.e., start and end date. Enter the name of the person(s) and department responsible for the implementation and evaluation of each intervention.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Targeted (High-Priority)</th>
<th>Targeted</th>
<th>Existing Intervention</th>
<th>Duration of Existing</th>
<th>Timeline for Implementation</th>
<th>Responsible Person and</th>
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## Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

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<th>No</th>
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<th>Department</th>
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<tr>
<td>Education on GCHP coverage guidelines v. CHDP guidelines</td>
<td>Providers</td>
<td>Ventura</td>
<td>☐</td>
<td>☒</td>
<td>Ongoing</td>
<td>Complete</td>
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<tr>
<td>Mid-Year 2014 Performance Feedback Report</td>
<td>Providers</td>
<td>Ventura</td>
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<td>☒</td>
<td>3 months</td>
<td>3 months</td>
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<tr>
<td>HEDIS Measure Training</td>
<td>Providers</td>
<td>Ventura</td>
<td>☒</td>
<td>☒</td>
<td>Ongoing</td>
<td>3 months</td>
</tr>
<tr>
<td>GCHP Provider Report Cards</td>
<td>Providers</td>
<td>Ventura</td>
<td>☒</td>
<td>☒</td>
<td>2 months</td>
<td>2 months</td>
</tr>
</tbody>
</table>
Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

**Section I – Submission Information:** Complete an improvement plan (IP) form for each measure/indicator with a rate below the Minimum Performance Level (MPL) or reported as a “Not Report” (NR). Managed Care Plans (MCPs) may submit one improvement plan (IP) for all counties and all indicators in a measure group (such as Comprehensive Diabetes Control, CDC), as long as differences across counties and indicators are addressed.

**Health Plan Name:** Gold Coast Health Plan  
**Measure/indicator:** Well-Child Visit in the 3 rd, 4 th, 5 th, and 6 th Years of Life

**Person Responsible for Implementing IP**  
**Name:** Helen Chtourou, RHIT  
**Title:** Senior Quality Improvement Project Analyst  
**Phone:** 805-437-5592  
**Email:** hchtourou@goldchp.org

**Medical Director Responsible for Approving IP**  
**Name:** Al Reeves, MD  
**Title:** Chief Medical Officer  
**Phone:** 805-437-5611  
**Email:** areeves@goldchp.org

**Section II – Measure(s) with rates below the MPL(s):** Please enter below the name of each county, the measure or indicator, the Plan 2013 measurement year (MY) Rate, DHCS MPL, and the Plan MY 2014 Target Rate for improvement. Check the appropriate boxes to indicate if the measure’s rate was below the MPL for the previous three MYs.

<table>
<thead>
<tr>
<th></th>
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</tr>
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<tbody>
<tr>
<td>Ventura</td>
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<td>64.23</td>
<td>67.40</td>
<td>MPL</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Description of the 1-3 highest priority barriers:

1) Three highest priority barriers:

**Barrier 1:** The Child Health and Disability Prevention (CHDP) well-child examination periodicity is not aligned with Medi-Cal and HEDIS recommendations. CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts. Per CHDP’s Periodicity Schedule for Health Assessment, the interval for well-child visits varies by age group: 2-3 years = 1 year interval; 4-5 years = 2 year interval; 6-8 years = 3 year interval. (Please see attached CHDP Periodicity Schedule for Health Assessment Requirements by Age Group). In addition, effective July 2003 the CHDP program became a “Gateway” to maximize the enrollment of uninsured children and youth in Medi-Cal which has increased the population of CHDP members enrolled in Gold Coast Health Plan.

**Barrier 2:** Parents will not schedule well-child visits if no vaccination is required.

**Barrier 3:** Physician well-child visit documentation is incomplete or absent, especially for documentation pertaining to developmental history, health education and anticipatory guidance.

1) Gold Coast Health Plan did not submit an Improvement Plan (IP) for the W34 measure in 2013 because the HEDIS 2012 measurement year results were the Health Plan’s first and baseline HEDIS rate since the Health Plan initiated in July 2011. GCHP did not meet the MPL for W34 during the HEDIS Reporting Years 2013 and 2014, and no new barriers have been identified since last year.

2) A leading factor leading to ineffective intervention is the provider office’s reliance and preference in complying with the CHDP’s periodicity schedule, instead of the Medi-Cal guidelines and HEDIS specifications, due to mistaken presumption that reimbursement will not be provided if CHDP members receive annual well-care visits.

3) See attached Barrier Analysis

4) The primary lessons learned are:
   a. CHDP’s Periodicity Schedule for Health Assessment and Wellness Visits conflicts with the HEDIS specifications, Gold Coast Health Plans coverage guidelines, and the American Academy of Pediatric recommended well-child visit guidelines.
b. Providers and office staff need additional training on HEDIS measure specifications, documentation, and coding.

c. Providers are very interested and engaged with improving their HEDIS rates; the health plan will send providers a 2014 mid-year Performance Feedback Report which will inform them which of the assigned members have not received well-child visits in 2014.

d. Parents schedule fewer well-child visits for children > 2 years of age. Per provider feedback, most parents will schedule well-child visits only when immunizations are needed.

6) All California Medi-Cal Managed Care Plans cover CHDP members; consequently the barrier resulting from the conflicting CHDP guidelines are applicable to all Medi-Cal plans.

7) Gold Coast Health Plan’s HEDIS 2014 rate for the Children & Adolescent Access to Primary Care Practitioners (CAP) measure reveals that children within the W34 age group (3-6 years of age) are in the 10th NCQA national percentile for accessing a PCP. GCHPs scored 86.29 which is below the DHCS MPL rate 86.37. This data demonstrates that children are not accessing their PCPs as needed and the likely barriers are parental non-compliance and conflicting CHDP well-child visit guidelines.

<table>
<thead>
<tr>
<th>CAP Age Group</th>
<th>GCHP Rate</th>
<th>MPL</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-24 Months</td>
<td>97.37</td>
<td>95.51</td>
<td>25th</td>
</tr>
<tr>
<td>25 Months – 6 Years</td>
<td>86.29</td>
<td>86.37</td>
<td>10th</td>
</tr>
<tr>
<td>7-11 Years</td>
<td>82.26</td>
<td>87.77</td>
<td>10th</td>
</tr>
<tr>
<td>12-19 Years</td>
<td>79.18</td>
<td>86.09</td>
<td>10th</td>
</tr>
</tbody>
</table>
### Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>W34 Measure</th>
<th>% of Measures that Met or Exceeded the MPL</th>
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</thead>
<tbody>
<tr>
<td>2013</td>
<td>61.80</td>
<td>60%</td>
</tr>
<tr>
<td>2014</td>
<td>64.23</td>
<td>79%</td>
</tr>
</tbody>
</table>

**Foot Notes**

## Section IV – Improvement Plan:

### A. Description of improvement plan:

**Intervention #1: Education on GCHP Coverage Guidelines v. CHDP Guidelines**

1) **Barriers:** Providers will not schedule CHDP members for annual well-child visits due to CHDP guidelines.

2) **Timelines:** 2013 - 2014

3) **Anticipated Effectiveness of New Intervention:** Increased provider education and awareness of GCHP coverage guidelines should engage providers to begin schedule annual well-child visits for CHDP members.

4) **Effectiveness of Existing Intervention:** N/A – This is a new intervention.

5) **Modifications to Existing Intervention:** After speaking with pediatric clinic groups and listening to the barriers they encounter, GCHP added education on CHDP v. GCHP guidelines to inform pediatric providers and their staff that GCHP reimburses for annual well-child exams, even though the CHDP periodicity schedule does not recommend or cover well-child exams annually.

6) **Methods for Evaluating Interventions:** Comparison of annual HEDIS rate measurement outcomes.

7) **Allocation of Resources:** QI Staff will develop and provide education to providers and their office staff through health plan newsletters, office visits, and trainings.

8) **Commitment & Accountability:** Comprehensive HEDIS training on well-child care measures was provided to CHDP staff in April 2014, and the GCHP guidelines have been presented to the health plan’s major clinic groups and independent providers by the QI Director and CMO during site visits in June and July 2014. The QI Department will continue to provide HEDIS education to providers. Trainings will be given by QI Staff through on-site visits and webinar trainings.

**Intervention #2: Mid-Year 2014 Proactive Performance Feedback Report to Providers**

1) **Barriers:** Parents schedule well-child visits only when immunizations are needed.

2) **Timelines:** June – August 2014

3) **Anticipated Effectiveness of New Intervention:** The Mid-Year 2014 Performance Feedback Reports will be sent to each clinic and will list all GCHP members assigned to that clinic who have and have not had a well-child visit in 2014. We anticipate the report will facilitate providers to contact those members who have not had a well-child visit and schedule the annual examinations members instead of relying on the members’ parents to schedule wellness visits. The benefit and intent of this report is to engage providers to proactively schedule preventative care visits with their members.

4) **Effectiveness of Existing Intervention:** N/A - This is a new intervention.

5) **Modifications to Existing Intervention:** N/A - This is a new intervention.

6) **Methods for Evaluating Intervention:** Look for any increases in well-child visits after reports are distributed to providers.

7) **Allocation of Resources:** QI Analysts and IT Analyst will work with HEDIS software vendor to complete a summer run of January through May 2014 claims/encounter data. QI staff will generate and distribute to providers the Mid-Year 2014 Performance Feedback Report.

8) **Commitment & Accountability:** QI Staff have committed to a 3-month timeline, from June to August 2014, to complete the integration of January –May 2014 claims/encounter data in the HEDIS software, complete a summer run, and distribute the letters to the clinics.
Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Intervention #3: HEDIS Measure Training

1) **Barriers:** HEDIS measure specifications and documentation/coding guideline trainings had never been provided to GCHP’s providers, which was previously a fee-for-service community of physicians. The QI Department is addressing provider education needs by continuing and improving the accessibility of HEDIS education. New education interventions will include HEDIS webinar training hosted by GCHP QI staff.

2) **Timelines:** 2013 and Ongoing

3) **Anticipated Effectiveness of New Intervention:** HEDIS training webinars will allow GCHP to more effectively and efficiently provide training to a larger provider audience.

4) **Effectiveness of Existing Intervention:** Existing interventions include provider education through: (1) GCHP Provider Report Cards for HEDIS 2012 and 2013 that were presented the health plan’s major clinic groups by the CMO and QI Director; (2) Provider Operation Bulletins; and (3) onsite trainings. Effectiveness of these existing interventions is demonstrated in the increase of the W34 measure rate and an overall increase in the number of measures where GCHP met or exceeded the MPL. HEDIS

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>W34 Measure</th>
<th>% of Measures that Met or Exceeded the MPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>61.80</td>
<td>60%</td>
</tr>
<tr>
<td>2014</td>
<td>64.23</td>
<td>79%</td>
</tr>
</tbody>
</table>

5) **Modifications to Existing Intervention:** Modifications include establishing trainings using a new forum through online webinars, to capture a larger audience, and to provide access to recorded webinars through GCHP provider webpage.

6) **Methods for Evaluating Intervention:** Attendance of live webinars and recordings will be tracked quarterly.

7) **Allocation of Resources:** QI staff will work with the health plan’s Communication Department to implement GoToMeeting web-based live interactive and recorded webinars trainings.

8) **Commitment & Accountability:** Education is an effective intervention for improving HEDIS rates because providers and their staff will increase their awareness of the HEDIS metric specifications and the quality of care documentation and coding guidelines that are measured. GCHP is committed to providing continued education to providers through provider education articles published in the Provider Operations Bulletin, coordinating with Health Education to provider education to members through Member Newsletters and Health Fairs, site visits, and creating new enhanced and more accessible education through live and recorded webinars.

Intervention #4: GCHP Provider Report Cards

1) **Barriers:** Providers cannot develop strategies for improving their HEDIS rates if they do not know their HEDIS scores.

2) **Timelines:** Summer 2013; Summer 2014

3) **Anticipated Effectiveness of New Intervention:** Providers will become more engaged in scheduling well-child exam if their HEDIS rates for the W34 measure is low.

4) **Effectiveness of Existing Intervention:** The Annual GCHP Provider Report Cards were initiated in the summer of 2013 to reports each clinic’s HEDIS rates. Due to the providers’ increased provider awareness of the W34 measurement specification guidelines and the measurement outcomes, there was a slight increase in the reported rates for W34: 61.80% (HEDIS 2013) to 64.23 (HEDIS 2014).

5) **Modifications to Existing Intervention:** No modification.

6) **Methods for Evaluating Interventions:** Comparison of annual HEDIS rate measurement outcomes.

7) **Allocation of Resources:** Using the HEDIS software, QI Staff generated the Provider Report Cards and the CMO and QI Director met with each clinic’s administrator to
Improvement Plan (IP) for Reporting Year 2014 (Measurement Year 2013)

Section V – Improvement Plan Grid: Enter interventions to address each of the 1 to 3 high-priority barriers. Interventions should be measurable and include the following description: what, where, when, how, and to whom. If multiple interventions are planned, list interventions in order of effectiveness and/or highest priority (e.g., directly addresses the barrier, best practice, etc.) and include the county/counties where the intervention will be conducted. Do not include planning activities. Enter the targeted barrier for each intervention. If it is an existing intervention, check “yes,” and indicate the duration of existing intervention prior to the implementation of the new timeline, i.e., number of weeks, months. Enter the implementation timeline for new and existing interventions, i.e., start and end date. Enter the name of the person(s) and department responsible for the implementation and evaluation of each intervention.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Targeted (High-Priority)</th>
<th>Targeted</th>
<th>Existing Intervention</th>
<th>Duration of Existing</th>
<th>Timeline for Implementation</th>
<th>Responsible Person and</th>
</tr>
</thead>
</table>

Commitment & Accountability: The QI staff created the Provider Report Cards in June 2014 and the Chief Medical Officer and QI Director meet with the clinic physicians and administrators to present the HEDIS result in July 2014.

B. SMART objective (See PDSA Cycle worksheet):

SMART Objective: By September 30, 2014, increase the percent of children well-child visits by creating the HEDIS 2014 Provider Report Cards to report to providers how their clinics performed in 2013. Reporting these scores will motivate providers who performed poorly on the W34 measure to develop strategies to increase their rates.
<table>
<thead>
<tr>
<th>Education on GCHP coverage guidelines v. CHDP guidelines</th>
<th>Providers</th>
<th>Ventura</th>
<th>No</th>
<th>2 months</th>
<th>Ongoing</th>
<th>Complete</th>
<th>Quality Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-Year 2014 Performance Feedback Reports</td>
<td>Providers</td>
<td>Ventura</td>
<td>No</td>
<td>3 months</td>
<td>3 Months</td>
<td>Quality Improvement</td>
<td></td>
</tr>
<tr>
<td>HEDIS Measure Trainings</td>
<td>Providers</td>
<td>Ventura</td>
<td>No</td>
<td>2 months</td>
<td>2 Months</td>
<td>Quality Improvement</td>
<td></td>
</tr>
<tr>
<td>GCHP Provider Report Cards</td>
<td>Providers</td>
<td>Ventura</td>
<td>No</td>
<td>2 months</td>
<td>2 Months</td>
<td>Quality Improvement</td>
<td></td>
</tr>
</tbody>
</table>
Updated Quality Improvement Work Plan

For Information Only and Not Approval
2014 Quality Improvement Work Plan

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

Objective #1: HEDIS

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

<table>
<thead>
<tr>
<th>Process/Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Monitoring/Status of Milestones and Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HEDIS – Healthcare Effectiveness Data and Information Set.</td>
<td>2013 Data for 2014 Measures</td>
<td>02/14</td>
<td>05/14</td>
<td>The HEDIS 2014 Reporting for 2013 data was submitted on 06/13/14</td>
</tr>
</tbody>
</table>
Objective #2: Satisfaction Surveys

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

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>Evaluation Measures/Status Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumer Satisfaction Survey</td>
<td>First CAHPS Audit will be 2015 for 2014</td>
<td>Jan 2014, End Dec 2014</td>
</tr>
<tr>
<td></td>
<td>The EQRO – External Quality Review Organization (HSAG) is responsible for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey biennially in compliance with NCQA and AHRQ requirements. The CAHPS® surveys a sample of Medi-Cal managed care members in English and Spanish and covers services provided to adults and children. GCHP will add CAHPS survey for 2014, and every year thereafter.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Educate providers</td>
<td></td>
</tr>
<tr>
<td>2. Provider Satisfaction Surveys</td>
<td>Must ensure that information and documentation provided by GCHP is reviewed at appropriate levels; must demonstrate this review and discussion of information in committee with any applicable interventions.</td>
<td>Reported to MAC Committee, and QI Committee.</td>
</tr>
<tr>
<td></td>
<td>GCHP will assume responsibility to conduct and for the monitoring, oversight and reporting the required mechanisms to assure provider satisfaction.</td>
<td></td>
</tr>
<tr>
<td>3. Access to Care Survey</td>
<td>Discuss survey at QIC and document</td>
<td>Jan 2014</td>
</tr>
</tbody>
</table>
### Objective #3 – QIP’s

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

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
</table>
| **1a Quality and Performance Improvement Program Requirements for 2012**<br>**External Statewide QIP** | External Statewide QIP – Hospital Readmissions  
- Participate in ongoing statewide organized meetings.  
- Document “all” steps in the process  
- Submitted baseline historical data to HSAG  
- Submitted barrier analysis and interventions to HSAG 1/31/2012 and 09/30/2013.  
- Submit analysis of intervention | Jan 2014  
Sept 2014  
Ongoing |  | Going forward will be “All Cause” Readmissions. |
| **1b Internal QIP** | Internal QIP – Increase Retinal eye exams for diabetic patients  
- Submitted internal QIP to DHCS for approval on 7/31/2013 and 09/30/2013. | Jan 2014  
Ongoing |  | HEDIS MPL met for diabetic retinal eye exam 06/13/14.  
Objective #4: UM Monitoring

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

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>UM Monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Over Utilization Under Utilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Utilization measures reported quarterly with monthly data points to UM Committee, QIC and Commission report card indicators reported bi-annually to UM Committee, QIC and Clinic Directors</td>
<td>Jan 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec 2014</td>
<td></td>
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</tr>
</tbody>
</table>

Objective #5: Committees

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

*Committees to develop Dashboard reporting for 2014.

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Quality Improvement Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Develop, implement quality Program Plan outlining structure, scope, criteria, and processes of all QI functions | • QI Plan Assessment  
• QI Plan Review  
• QI Work Plan  
• Annual P&P Review  
• Revise PQI Policies and Procedures | Jan 2014               |            | The Quality Improvement Plan and the Quality Improvement Work Plan were approved at the Quality Improvement Committee on 06/24/14. QI workplan to be evaluated regularly and amended appropriately. |
<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Monthly Activities</th>
<th>Jan 2014</th>
<th>Dec 2014</th>
</tr>
</thead>
</table>
| 2. Member Services Committee                        | Committee Meetings  
Action Plans  
Call Center Measures  
Annual Review                                           |          |          |
| 3. Network Management Committee                     | Committee Meetings  
Action Plans  
Annual Review                                                 | Jan 2014 | Dec 2014 |
| 4. Grievances & Appeals Committee                   | Committee Meetings  
Action Plans  
G&A Measures  
Annual Review                                   | Jan 2014 | Dec 2014 |
| 5. Health Education/Cultural Linguistics Committee  | Committee Meetings  
Action Plans  
ED Navigator Program Review  
Annual Review                       | Jan 2014 | Dec 2014 |
| 6. Medical Advisory Committee (MAC)                 | Committee Meetings  
Action Plans  
Annual Review  
Approve & Review Medical P&Ps                               | Jan 2014 | Dec 2014 |
| 7. Pharmacy & Therapeutic Committee (P&T)           | Review of New Drugs  
Annual Formulary Review  
PBM Oversight  
Review of Policies Affecting Access to Prescription Drugs  
Review quantity limits  
Review prior auth's.  
Objective #6: Facility Site Reviews

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

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Submit 2014 bi-annual report to DHCS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop procedures for entering data into FSR database and submission of data to DHCS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Certify FSR Nurse as Master Trainer</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Complete required FSR, PAR, IHA.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop FSR Database</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Begin training for QI RN as Master Trainer</td>
<td></td>
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</tbody>
</table>

Site Review Reports:
- Plan nurse reviewers conduct the initial and tri-annual full scope reviews. Plan reviewers use the DHCS Full Scope Site Review Survey and Medical Record Review Survey forms to ensure that all contracting plans and subcontracting entities use DHCS survey standards, review criteria and scoring methodology.
Objective #7: Quality Measurement and Improvement

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

<table>
<thead>
<tr>
<th>Process Objectives</th>
<th>Key Tasks</th>
<th>TIMELINE</th>
<th>Lead Staff</th>
<th>Evaluation Measures/ Status Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Practice Guidelines</td>
<td>• Approve at MAC.</td>
<td>Jan 2014</td>
<td>Staff</td>
<td>Newly adopted Clinical Practice Guidelines are announced in the Provider Newsletter and/or on the website.</td>
</tr>
<tr>
<td></td>
<td>• Disseminate Guidelines to Providers</td>
<td>Dec 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diabetes Guidelines to be presented at MAC.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease Management Program</td>
<td>• Identify chronic disease for GCHP population disease management.</td>
<td>Jan 2014</td>
<td>Staff</td>
<td>The two major disease categories identified for 2014 and approved at the February QIC meeting are Diabetes and Asthma.</td>
</tr>
<tr>
<td>Selection of Chronic Disease states pertinent to</td>
<td>• Diabetes Guidelines to be presented at MAC.</td>
<td>Dec 2014</td>
<td></td>
<td>Roadmap and framework for diabetes in process.</td>
</tr>
<tr>
<td>its membership.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Member/Provider Communication Plan | • Develop materials and mechanisms to communicate to Providers and Members  
• Use Website  
• Create email address & link on website for HEDIS questions.  
• HEDIS report card | Jan 2014 | Dec 2014 | Members and providers receive a newsletter 3 times per year. The newsletters are posted on the website. |
AGENDA ITEM 2c

To: Gold Coast Health Plan Commissioners
From: Brandy Armenta, Compliance Officer / Director
Date: October 27, 2014
Re: Compliance Officer / Director Quarterly Report

The Compliance Committee is comprised of internal staff and external General Counsel. The Charter and Scope for the Compliance Committee includes but is not limited to:

- Ensure fraud, waste and abuse and HIPAA trainings are completed,
- Assist in the creation and implementation of the risk assessments,
- Monitoring progress towards completion of goals identified in the compliance work plan,
- Assist in the creation, implementation and monitoring of effective corrective actions for delegates, review the results of monitoring activities as described in delegation agreements to ensure delegate is meeting expectations and performing delegated functions appropriately and recommend corrective actions plans for delegates when deficiencies are identified.

The Compliance Committee has met during the third calendar quarter of 2014. The following items are a sample of items discussed at the meetings:

- Fraud, waste and abuse cases and current status of cases,
- Code of conduct,
- Compliance Committee charter
- Department of justice meeting information
- Delegation oversight audits and results
- Delegation oversight routine monitoring
- Compliance plan

GCHP is required to conduct delegation oversight audits on functions which are delegated. Routine reporting from delegates to the Plan is contractually required and must be actively monitored. Reporting statistics from delegates can be found in the compliance dashboard. An annual audit schedule was created and staff is working through each audit. The delegation oversight staff has conducted the following audits:

- Credentialing
- Specialty Contract
The last audit for calendar year 2014 will be on the Plans transportation vendor. The audit is slated for November 2014.

The Plan received additional information from the Department of Health Care Services (DHCS) on October 1, 2014 relative to oversight auditing requirements for Kaiser. Once a final determination is confirmed by DHCS the Plan will align activities to ensure compliance. Given the active ongoing discussions relative to oversight specific to Kaiser the Plan has elected to move the onsite audit planned for November 2014 to January 2015. The Plan anticipates final resolution by DHCS soon and the Plan will conform to DHCS policy.

The Plan has issued the following corrective action plans (CAP) in 2014:

- Credentialing (3) *
- Specialty Contract (2)
- MBHO (2)
- Vision (Audit results are in review official CAP has not been issued)

* denotes CAP(s) have been closed; all others are at various stages of the CAP process.

The Plan continues to monitor delegates through contractual required reporting. Reports are reviewed and when deficiencies are identified the Plan issues letters of non-compliance. This process is monitored, tracked and reported to the compliance committee. In addition the aggregate information is provided to the commission on the compliance dashboard.

The DHCS CAP, Financial (Addendum A) remains open, however GCHP, per DHCS instruction, was able to terminate the State appointed monitors contract as a result of continuously meeting CAP requirements. The Plan continues to submit items on a monthly basis as required by the CAP.

Compliance continues to monitor and ensure all employees and temporary employees are trained and retrained on HIPAA and Fraud, Waste and Abuse. In addition, compliance and information technology staff conducts random internal audits for HIPAA and PHI issues. Results of the audits are communicated back to the Compliance Committee as well as the leadership team.

As a component of commissioner compliance training, compliance staff will be working with commissioners in the next month for HIPAA and FWA training. The training is web based which will allow commissioner’s flexibility in completely training requirements. An assigned due date will be Included in the access information for each training topic.
GCHP continues to meet all regulatory contract submission requirements. In addition all regulatory agency inquiries and requests are handled timely and required information is provided within the timeframe requested. In closing the Compliance Committee and compliance staff is actively engaged in sustained contract compliance.
## COMPLIANCE REPORT 2014

### Hotline

<table>
<thead>
<tr>
<th>Category</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>2</td>
<td>6</td>
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<td>6</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

Referrals: *one referral can be sent to multiple agencies*  
*FWA* - Federal Intellectual Property Act

### Hotline Referral

<table>
<thead>
<tr>
<th>Category</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
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<td>Referrals</td>
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<td>0</td>
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<td>0</td>
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</tr>
</tbody>
</table>

### Delegation Oversight

- **Obligated Entities**  
  | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |

- **Reporting/Requirements Reviewed**  
  | 8 | 9 | 21 | 24 | 21 | 16 | 26 | 34 | 22 |

- **Audits Conducted**  
  | 3 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |

- **Letters of Non-Compliance**  
  | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 3 |

### Audits

<table>
<thead>
<tr>
<th>Category</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<tbody>
<tr>
<td>Total</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>

**Medical Use of Data Evaluation performed by DHCS via Interagency agreement with DHCS:**  
| 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

DHCS Facility Site Review & Medical Record Review **Audit was conducted in 2013**:  
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

HEDS Compliance Audit (HSA):  
| 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |

DHCS Member Rights and Program Integrity Monitoring Review **Review was conducted in 2012**  
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

DHCS Medical Audit **Audit was conducted in 2012**:  
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### Fraud, Waste & Abuse

- **Total Investigations**  
  | 5 | 9 | 6 | 2 | 6 | 2 | 6 | 4 | 8 |

- **Investigations of Providers**  
  | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 |

- **Investigations of Members**  
  | 5 | 9 | 5 | 2 | 6 | 1 | 5 | 0 | 8 |

- **Investigations of Other Entities**  
  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

- **Fulfillment of DHCS/DOJ/other agency/claim/claim report Requests**  
  | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |

- **Fraud, Waste, & Abuse Prevention**  
  | 22 | 4 | 63 | 36 | 6 | 4 | 8 | 8 | 5 |

### HIPAA

- **HIPAA Internal Audits Conducted**  
  | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |

### Training

- **Training Sessions**  
  | 24 | 4 | 1 | 9 | 5 | 5 | 73 | 7 | 5 |

**August - Numbers may change as the month has not ended**  
**Reporting Requirement are defined by functions delegated and contract terms. Revised contract, amendments or new requirements form DHCS may require additional requirements from subcontractors as a result the number is fluid**  
**Audits: Please note multiple audits have been conducted on the Plan, however many occurred in 2012 and 2013 as such it is a fairly accurate representation of what has occurred.**  
**This report is intended to provide a high level overview of certain components of the compliance department and does not include/reflect functions the department is responsible for on a daily basis.**
AGENDA ITEM 2d

To: Gold Coast Health Plan Commission

From: Stacy Diaz, Director Human Resources

Date: October 27, 2014

RE: Executive Search Firm Selection for Chief Executive Officer

SUMMARY:
In August 2014, Gold Coast Health Plan began the Request for Proposal (RFP) process to select an executive search firm to manage the recruitment of a Chief Executive Officer for the Plan. It is the Plan’s recommendation to move forward with Witt / Kieffer as the firm of choice and that the Commission authorize Gold Coast Health Plan (GCHP) to enter into an agreement with Witt / Kieffer to conduct the recruitment process for the Chief Executive Officer position.

BACKGROUND:
In August 2014, after the announcement of resignation of Chief Executive Officer, Michael Engelhard; Gold Coast Health Plan (GCHP) was asked to identify and retain an executive search firm to manage the recruitment of a new Chief Executive Officer for GCHP.

DISCUSSION:
GCHP issued a Request for Proposal (RFP) for the recruitment of Chief Executive Officer of the Plan. The RFP was sent to five (5) executive search firms, per the request of the Commission.

An Ad Hoc Committee was formed to review and discuss the proposals. The Ad Hoc Committee met on Monday, October 6, 2014 to review and discuss all options. After review and discussion, the staff and Ad Hoc Committee have recommended Witt / Kieffer for the executive search in attaining a new Chief Executive Officer. The recommendation is based on the following:

- References
- Company Overview / Experience
  - Voted top “10” in the nation
  - Years of Experience
  - Experience with Private Sectors/ Healthcare
  - Staff Qualifications
• Witt / Kieffer is currently conducting Chief Executive Officer Search in CA for another Plan
• Candidate Guarantee

FISCAL IMPACT:
Professional fees for this search assignment are one-third of the positions projected total compensation, minimum fee of $85,000. Additional fees would include out-of-pocket expenses for staff / candidate travel accommodations, advertising, education verification and any other related expenses.

RECOMMENDATION:
Witt / Kieffer is the preferred executive firm, providing the Plan with proven expertise in executive searches throughout the Nation.

The Ad Hoc Committee concludes that Witt / Kieffer strikes the best balance of industry experience and proven placement of executives.

It is the Ad Hoc Committee’s recommendation to move forward with Witt / Kieffer as the executive search firm to manage the recruitment for Chief Executive Officer.

CONCURRENCE:
N/A

Attachments:
None
AGENDA ITEM 2e

To: Gold Coast Health Plan Commission
From: Ruth Watson, Interim CEO
Date: October 29, 2014
RE: General Counsel Support

SUMMARY
At the September 29, 2014 Special Commission meeting the Commission made the
decision to replace the current General Counsel. The Commission delegated contract
negotiation and selection of the final candidate to interim CEO, Watson.

After conducting additional review of the firm’s qualifications and experience and
comparison of negotiated fees, staff is recommending Best, Best and Krieger (BB&K) as
the best candidate to represent the Commission and the Plan as General Counsel. GCHP
is requesting approval for the Interim CEO to enter into a contract for General Counsel
Legal Services with BB&K.

FISCAL IMPACT
Upon concluding negotiations with BB&K, there will be a rate increase in hourly fees of
approximately 7%.

RECOMMENDATION
Staff proposes that the Commission approve and accept the staff’s recommendation that
BB&K is the best qualified firm to provide General Counsel Legal Services for the
Commission and the Plan and authorize Interim CEO, Watson to enter into an agreement
with BB&K for no less than 12 months.

CONCURRENCE
N/A

Attachments
None
AGENDA ITEM 2f

To: Gold Coast Health Plan Commission

From: Ruth Watson, Interim Chief Executive Officer

Date: October 27, 2014

RE: Lease Amendment / Additional Office Space

SUMMARY:
In November 2013 Gold Coast Health Plan (GCHP) signed a lease agreement at our new facility located at 711 E. Daily Drive, Camarillo, CA; with a relocation date of April 7, 2014. During the initial lease agreement a few suites were occupied with other tenants and were not immediately available to GCHP. The Plan had requested the Right of First Refusal (ROFR) when the additional space became available. In September 2014, GCHP was informed that an additional suite will be available mid-January of 2015. The space is approximately 1,023 usable and 1,150 rentable square feet. When combined with current space leased, GCHP’s total premises will consist of 34,767 rentable square feet. It is the Plan’s recommendation to move forward with the additional space expansion and request the Commission to authorize the Plan’s CEO to enter into an agreement with the current landlord to lease the additional space.

BACKGROUND:
Last year when finalizing the lease for the new GCHP location, staff was aware of the potential need for additional space as membership was projected to grow, so staff requested the ROFR for additional leased space in the building should it become available. During our first six months of occupancy, the Plan has experienced a 39% increase in enrollment, which far exceeds projections for membership growth due to Medi-Cal expansion. This accelerated growth has stretched the capacity of our current space. Staff has been added to serve the needs of this new population.

As GCHP staff researches longer-term options to address the space challenges (i.e., teleworking and restacking the existing workspace), the Plan was informed in September that an additional suite, located between two of GCHP’s existing leased suites would be available mid-January of 2015. Membership growth, as well as new services and regulatory requirements, will likely continue to drive an increase in Plan staffing. Leasing an office suite, contiguous to our existing space and expanding the overall square footage available will assist GCHP in meeting its immediate and future space needs.
FISCAL IMPACT:
The initial Base Rent is $1.80 per rentable square foot per month (the same as the rate in the existing gross lease) or $2,070.00 per month in additional rent. The existing lease will be amended to ensure that the lease for both spaces co-terminate at the same time and all contract terms are the same for both spaces. The lease terms would reflect the current lease to include janitorial and utility expenses. Additional costs estimated at $50,000 to include office furniture, security access, equipment, cabling and networking fees.

RECOMMENDATION:
It is recommended that the Commission authorize the Plan to move forward with the lease expansion.

CONCURRENCE:
N/A

Attachments:
None
## GCHP 2015 Meeting Schedule

Meetings begin at 3:00 p.m.

Proposed October 27, 2014

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AGENDA ITEM 2h

To: Gold Coast Health Plan Commission

From: Ruth Watson, CEO

Date: October 27, 2014

Re: DHCS Contract Amendment A13

SUMMARY

The State of California Department of Health Care Services (DHCS) establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A13 reflects expected changes to Gold Coast Health Plan (GCHP or Plan) capitation rates for FY2013-14.

BACKGROUND / DISCUSSION

GCHP received a contract amendment from the DHCS on October 7, 2014 which updated the Plan’s FY2013-14 capitation rates for the traditional Medi-Cal population (i.e., not the Adult Expansion or the Targeted Low Income Children populations) as follows:

- Rate period from July 1, 2013 to December 31, 2013
  - Increases monthly capitation rates to compensate the Plan for Community Based Adult Services (CBAS) funds that will no longer be paid through separate kick payments
  - Includes AB97 provider rate reductions for Medi-Cal only (non-Dual) populations
  - Includes second half of CY2013 Affordable Care Act Section 1202 funds to be paid to qualifying providers performing specific services
  - Includes funds for the Hospital Quality Assurance Fee (HQAF) program pursuant to SB335 to be paid to specific hospitals identified by the California Hospital Association

- Rate period commencing January 1, 2014
  - Increases monthly capitation rates to compensate the Plan for CBAS funds that will no longer be paid through separate kick payments
Includes AB97 provider rate reductions for Medi-Cal only (non-Dual) populations
Includes funding of new Mental Health benefit expansion, effective January 1, 2014

FISCAL IMPACT

Amendment A13 confirms that the Plan will eventually be paid the rates that were previously communicated as final by DHCS. This information was communicated by DHCS via updated rate packages received after the close of FY2013-14. These rates were identified by GCHP management as post-closing (fiscal year) adjustments and will be reflected in the audited financials. This amendment is expected to increase revenue by approximately $8.3 million for FY2013-14. Note this includes $5.0 million of expected ACA 1202 funds for the 7/1/13-12/31/13 time period. Reflecting these rates will also allow the Plan to reverse the AB97 reserves recorded last fiscal year.

The HQAF is a pass-through item with no fiscal impact.

RECOMMENDATION

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendment A13.

CONCURRENCE

N/A

Attachments
None
AGENDA ITEM 3b

To: Gold Coast Health Plan Commission
From: Ruth Watson, Interim CEO / Chief Operating Officer
Date: October 27, 2014
Re: CEO Update

GOVERNMENT RELATIONS UPDATE

Community Based Adult Services Program
Currently the Community Adult Service Program (CBAS) is authorized under an approved waiver by the federal government that expires at the end of October 2014. The California Department of Health Care Services (DHCS) submitted an amendment to the section 1115 waiver to the Center for Medicare & Medicaid Services (CMS), to extend the CBAS Program through October 31, 2015. Enhanced case management services were not included in the new DHCS - proposed waiver amendment.

In late September Governor Brown vetoed legislation (AB 1552), that would have codified the CBAS Program as a permanent Medi-Cal benefit.

Medi-Cal Managed Care Plans As Medicaid Certified Application Counselors
In early 2014 Gold Coast Health Plan submitted an application to participate in Covered California’s Certified Application Counselor Program (CAC). The objective of the CAC Program is to provide information and assistance to consumers regarding Covered California and to help facilitate enrollment in Medi-Cal. Covered California will be responsible for designating, certifying and training Medi-Cal Certified Application Counselors participating in the CAC program. Medi-Cal CACs may perform the following duties:

• Provide information to individuals and all members of the public about the full range of options and insurance affordability programs for which they may be eligible for including Medi-Cal

• Assist individuals to apply for coverage through Covered California and for other health insurance affordability programs including Medi-Cal

Staff can either participate in the 3.5 day training or take the on-line self-training modules at their own pace and the certification exam can be taken at any time. Certified
Application Counselors will be required to undergo background checks, which will be paid for by the participating Plan. Access to CalHEERS will be granted to CACs once the individual passes the exam and clears the background check.

In addition to the required training, Covered California requires that participating plans enter into an MOU for plans to be eligible to serve as enrollers for Covered California and Medi-Cal.

**Reimbursement Rates for BHT/ABA Services**

DHCS is in the process of developing reimbursement rates for behavioral health treatment (BHT) and applied behavioral analysis (ABA) benefits in the Medi-Cal Program. DHCS is also seeking an 1115 Demonstration Waiver for the Substance Use Disorder (SUD) and Drug Medi-Cal (DMC) Program.

DHCS has asked the California Association of Health Plans (CAHP) to reach out to health plans, particularly those that have implemented behavioral health benefits commercially, to assist DHCS in their rate development. DHCS is specifically requesting that those health plans willing to provide the state information on their provider rates do so using the attached table. DHCS has indicated that once rates are developed plans will be reimbursed retroactively for providing these services to September 15, 2014.

**GCHP- DHCS 2013-2014 Contract Amendment**

On October 7, 2014 GCHP received an amendment to its contract with DHCS. The purpose of this amendment is to adjust the 2013-2014 capitation rates and other payment provisions. A detailed memo will be provided to GCHP Commissioners explaining the changes.

**GCHP Behavioral Health Policy Forum**

On October 14, 2014 GCHP held a behavioral health policy forum. Attendees included representatives from Ventura County elected officials, community based organizations and stakeholders. Discussion focused on behavioral health policy and implementation of the behavioral health benefit in the Medi-Cal Program. The intent of this policy forum and future forums is to strengthen the partnership between GCHP and its community partners and stakeholders.

**Denti-Cal Subcommittees**

Three Legislative Subcommittees have been created for the purpose of addressing administrative barriers, triaging protocols, and increasing the provider pool for dental services for individuals with special needs. A commercial health plan, Sutter Health, previously announced they could no longer provide anesthesia services for dental care due to increased costs.
Legislation
Below is a list of Medi-Cal related bills that were either approved or vetoed by the Governor.

**AB 1552**  Community Based Adult Services
**Summary:** Requires Community-Based Adult Services to be provided as a Medi-Cal benefit.  **Vetoed.**

**AB 2325**  Medi-Cal: Communi-Cal.
**Summary:** Requires DHCS to establish a program to provide and reimburse for medical interpretation services provided to Medi-Cal enrollees with limited English proficiency.  **Vetoed**

**AB 2418**  Health care coverage: prescription drugs: refills.
**Summary:** Requires health plan contracts and health insurance policies to allow for synchronization of prescription refills.  **Vetoed**

**SB 508**  Medi-Cal: eligibility.
**Summary:** Establishes income eligibility thresholds pursuant with MAGI standards. Extends Medi-Cal benefits to former foster care youth up to 21 years of age.  **Approved**

**SB 964**  Health care coverage.
**Summary:** Increases ongoing oversight of health plans, with a focus on ensuring compliance of plans with existing health care access standards in the Medi-Cal managed care and individual markets. Requires Medi-Cal MCPs to be subject to routine medical surveys by the DMHC.  **Approved**

**SB 1002**  Medi-Cal: redetermination.
**Summary:** Requires counties to begin a new 12 month eligibility period for Medi-Cal when approving or certifying an individual’s eligibility for CalFresh benefits in order to align Medi-Cal and CalFresh eligibility periods.

**SB 1004**  Health care: palliative care.
**Summary:** Makes palliative care a Medi-Cal benefit that is cost neutral to the General Fund.

**SB 1053**  Health care coverage: contraceptives.
**Summary:** Requires health plans to cover a variety of Food and Drug Administration (FDA) approved contraceptive drugs, devices, counseling, follow-up services, and voluntary sterilization procedures. Requires utilization controls for family planning services for Medi-Cal MCPs to be subject to cost-sharing requirements.

**SB 1124**  Medi-Cal: estate recovery.
**Summary:** Limits recovery from the estate of a deceased Medi-Cal beneficiary, to only those costs for health care services the estate is required to cover under federal law.
**SB 1341**  Medi-Cal: Statewide Automated Welfare System (SAWS).

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

**SB 1457**  Medical care: electronic treatment authorization requests.

**Summary:** Requires requests for authorization for treatment services in the Medi-Cal Program to be submitted in an electronic format determined by DHCS via DHCS’ website or other electronic means designated by DHCS.

**NON-EMERGENCY MEDICAL TRANSPORTATION**

Non-emergency Medical Transportation (NEMT) is a Medi-Cal benefit providing transportation to covered Medi-Cal services when the member's medical and physical condition does not allow that member to travel by means of private or public conveyance.

In October 2012, Gold Coast Health Plan (GCHP or Plan) conducted a Request for Proposal (RFP) for NEMT. The objective was to contract with a transportation provider that would assume risk for and manage all NEMT benefits for eligible GCHP members in an effort to improve utilization, streamline and improve the NEMT process, and reduce Plan costs. As a result of the detailed RFP Process Ventura Transit System (VTS) was awarded the contract and began to provide NEMT services for Plan members on February 1, 2013.

At the November 24, 2014 Commission Meeting staff will present a report on the utilization, cost effectiveness and quality of NEMT provided by VTS.

**HEALTH EDUCATION AND COMMUNITY OUTREACH SUMMARY REPORT**

**Summary**
Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. Below is a summary of activities conducted by GCHP staff.

**September 2014 Outreach Activities**
Overall GCHP continues to reach individuals, families, and potential members through a variety of community outreach events. During the month of September GCHP staff participated in 14 community events and reached over 1,500 individuals, providing approximately 2,200 pieces of literature. Staff continues to hand out materials related to
the Affordable Care Act (ACA) and continues to reach potential individuals eligible for Medi-Cal through the ACA Medi-Cal expansion program.

Below are two charts documenting the total number of materials distributed and encounters during the month of September.
Year-to-Date Total Number of Encounters
The total number encounters reached from January 2014 – September 2014 is roughly 8,300 individuals. Information regarding GCHP and the Medi-Cal Expansion Program continues to increase.

Upcoming Health Education Activities
GCHP Health Education Department will be hosting a series of Health Education Workshops throughout the county beginning in October. Each month the theme will be in conjunction with the national public health observances calendar.

October is Breast Cancer Awareness Month - GCHP will host four Breast Cancer Awareness Workshops, speakers will focus on prevention, early detection, and treatment. GCHP will be partnering with local school districts, Ventura County Health Care Agency, Public Health Department, California’s Every Woman Counts, and Community Memorial Hospital, Center for Family Health.

November is Diabetes Awareness Month – GCHP will host two Diabetes Awareness Workshops, speakers will focus on diabetes prevention and information about maintaining a healthy lifestyle. As part of the Diabetes Awareness Campaign, GCHP will be partnering with Ventura County Health Care Agency, Clinicas del Camino Real, Ventura County Human Service Agency, Community Action, MICOP and Covered California.

GCHP will host a Community Resource Fair in honor of Diabetes Awareness Month. The event will be held on Saturday, November 8, 2014, at the Oxnard Public Library from 10 a.m. to 12 p.m. The Community Resource Fair will feature guest speakers, free health screenings, resource booths, and demonstrations on how to use a glucose meter. For more information contact the Health Education Department at healtheducation@goldchp.org.

Two (2) Free Movie Tickets with Your Eye Exam
As an incentive to increase retinal eye exams among members diagnosed with diabetes mellitus, GCHP implemented a member incentive program. Members who complete their eye exam before December 31, 2014, will receive two (2) free movie tickets if they:

1. Make an appointment to get the eye exam test
2. Mail the signed and completed form in the enclosed stamped self-addressed envelope

Once the form is returned to GCHP, Health Education staff will verify the information to ensure that the criteria has been met; once criteria has been met movie theater tickets will be mailed to the member.
AGENDA ITEM 3c

To: Gold Coast Health Plan Commission
From: Michelle Raleigh, Chief Financial Officer
Date: October 27, 2014
Re: August 2014 Financials

SUMMARY
Staff is presenting the attached August 2014 financial statements (unaudited) of Gold Coast Health Plan (GCHP or Plan) for approval. The Executive / Finance Committee did not meet in October to review the August financial package.

BACKGROUND / DISCUSSION
The Plan’s staff has prepared the August 2014 financial package, including balance sheet, income statements and statements of cash flows.

FISCAL IMPACT

Highlights of YTD Financials
The Plan’s overall performance for the month exceeded budget. On a year-to-date (YTD) basis, the Plan’s net income for the month was approximately $4.9 million compared to $3.1 million assumed in the budget. These operating results have contributed to a Tangible Net Equity (TNE) level of approximately $42.6 million, which exceeds both the budget of $35.4 million (by $7.2 million) and the State minimum required TNE amount of $22 million (by $20.6 million).

Please note the Plan’s TNE amounts noted in the financial package include the $7.2 million in lines of credit with the County of Ventura. Also, as of the end of the August 2014, the Plan’s TNE is:
- 194% of the minimum State-required TNE level and
- 161% of the minimum State-required TNE level, excluding the lines of credit of $7.2 million
Highlights of August Financials

Membership - August membership of 163,251 exceeded budget by 4,801 members. The majority of membership growth is in Adult Expansion (AE) category, where membership was 6,978 higher than budget. In the Adult / Family category, membership was 2,123 below budgeted estimates. Current membership is 36% higher than at December 31, 2013 and year-over-year.

Revenue – August total revenue is $51.4 million, which exceeded the budgeted amount of $47.4 million, by $4 million. On a per-member-per-month (PMPM) basis, total revenue was $315.15 PMPM which was $15.85 PMPM better than budget of $299.30 PMPM. The favorable results were driven by membership growth being greater than anticipated in total, with significantly more members than expected in higher capitation rate cells.

For the new fiscal year, DHCS contract amendment 11 rates were adjusted for known policy changes including:

• Blood factor drugs – effective July 1, 2014, these drugs will not be the responsibility of the managed care plans and the rates have been reduced by $7.38 PMPM for Aged / Disabled and $3.76 PMPM for AE.
• Mental health – effective July 1, 2014, the State will increase the mental health portion of the capitation rates by an average $2.96 PMPM to reflect estimated phase-in of the expanded benefit that begun on January 1, 2014.

Note additional revenue was not accrued for the supplemental payment for the treatment of Hepatitis C, since the State’s methodology and amount was not available at the time of the August close.

Health Care Costs – Total cost of health care for August was $46.1 million or $3.2 million more than budget. On a PMPM basis, August health care costs were $282.42 PMPM or $11.76 PMPM more than the budgeted amount of $270.66 PMPM.

Primary causes for the August total dollar variance to budget include:

• Membership - Increases in AE membership of nearly 7,000 over budget accounted for approximately $3.3 million of negative variance.
• Inpatient – Several hospitals reported claims with dates of service extending back to April and beyond, causing a negative variance of $0.6 million.
• LTC / SNF – The Plan continues to hold reserves related to AB 1629 rate increases (required for the Plan to pass down to certain providers) for August 2013 that have not been paid out since the funds have not been received by the State. An amount of $0.3 million was added in anticipation of new AB 1629 rates effective August 2014, bringing the total LTC rate reserve to $1.7 million.
Pharmacy – The increase in utilization among the new AE population has not achieved the rate as expected in the budget, contributing a positive variance of $4.7 million. These savings have been partially offset due to increases in other costs such as Solvaldi, resulting in a net favorable variance of $3.1 million.

In addition, in the course of the annual review by external actuaries, the Plan incorporated the following recommendations including:

- Adding a reserve of approximately $2.4 million to increase the probability that the Plan’s booked liability is sufficient to pay the claims. Note approximately half of this amount would have been previously classified under the AE reserve.
- Including approximately $0.1 million to cover costs of processing claims beyond a six-month run-out period in the event of termination of Plan’s claim processor. This Plan responsibility was recently clarified in a proposed contract amendment with the Plan’s claims processor. This expense was included in the inpatient cost category since it is assumed that claims falling into this category would be expected to be mainly Inpatient claims.

The expenses for the AE population are still uncertain and for August, are estimated to be at more than an 85% medical loss ratio (MLR), therefore there is no additional reserve in the “Adult Expansion Reserve” category on the income statement. Note that for the AE population:

- Medical expenses continue to be estimated from State rate packages (which reflect a 91% MLR) and will be evaluated as claims data is received, and
- Pharmacy expenses have been less than budget.

Note that the Plan continues to hold reserves (as shown on the IBNP portion of the Balance Sheet) of approximately $9 million to date in estimated liability due to the AE MLR requirement.

Administrative Expenses – For the month of August, overall operational costs were approximately $420,000 lower than budgeted expenses. The following primary factors contributed to this lower than expected expense:

- Lower personnel (e.g., Salaries and Wages) expenses due to delays in hiring staff,
- Lower Consulting services due to delays in utilizing resources associated with new projects, and
- Lower General Office expense due to reclassifying the amortized software license expense (of Milliman Care Guidelines and MedHok) to health care expense.

Cash + Medi-Cal Receivable - The total of Cash and Medi-Cal Premium Receivable balances of $189 million reported as of August 31, 2014 included a MCO Tax
component amounting to $11.3 million. Excluding the impact of the tax and pass-through amounts to providers, the total of Cash and Medi-Cal Receivable balance as of August 31, 2014 was $176.6 million, or $43.6 million better than the budgeted level of $133.0 million.

RECOMMENDATION
Staff proposes that the Plan’s Commission approve and accept the August, 2014 financial statements.

CONCURRENCE
N/A

Attachment
August 2014 Financial Package
FINANCIAL PACKAGE
For the month ended August 31, 2014

TABLE OF CONTENTS

• Financial Overview
• Membership
• Income Statement
• Balance Sheet

APPENDIX

• Cash Trend Combined
• Paid Claims & IBNP
• YTD Income Statement
• Monthly Cash Flow
• YTD Cash Flow
• Total Expenditure Composition
## Financial Overview

### Description

**AUDITED**

<table>
<thead>
<tr>
<th>Description</th>
<th>FY2011-12</th>
<th>FY 2012-13</th>
<th>AUDITED* UNAUDITED FY 2013-14 Actual</th>
<th>FY 2014-15</th>
<th>Budget</th>
<th>Variance</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>1,258,189</td>
<td>1,223,895</td>
<td>347,079</td>
<td>382,021</td>
<td>397,467</td>
<td>447,093</td>
<td>160,085</td>
</tr>
<tr>
<td>Revenue</td>
<td>304,635,932</td>
<td>315,119,611</td>
<td>81,988,709</td>
<td>84,070,456</td>
<td>112,028,121</td>
<td>130,864,339</td>
<td>49,614,139</td>
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<tr>
<td>ppm</td>
<td>242.12</td>
<td>257.47</td>
<td>236.22</td>
<td>232.23</td>
<td>281.86</td>
<td>309.92</td>
<td>315.15</td>
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<td>Health Care Costs</td>
<td>287,353,672</td>
<td>280,382,704</td>
<td>71,875,533</td>
<td>72,867,512</td>
<td>98,914,429</td>
<td>113,026,921</td>
<td>44,870,662</td>
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<td>207.09</td>
<td>201.28</td>
<td>248.86</td>
<td>252.80</td>
<td>282.92</td>
</tr>
<tr>
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<td>94.3%</td>
<td>89.0%</td>
<td>87.7%</td>
<td>86.7%</td>
<td>88.3%</td>
<td>86.4%</td>
<td>90.4%</td>
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<tr>
<td>Admin Exp</td>
<td>18,891,320</td>
<td>24,013,927</td>
<td>6,202,007</td>
<td>6,014,475</td>
<td>6,597,110</td>
<td>7,687,941</td>
<td>2,719,481</td>
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<tr>
<td>ppm</td>
<td>15.01</td>
<td>19.62</td>
<td>17.87</td>
<td>16.61</td>
<td>17.20</td>
<td>15.14</td>
<td>16.06</td>
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<td>% of Revenue</td>
<td>6.2%</td>
<td>7.6%</td>
<td>7.6%</td>
<td>7.2%</td>
<td>5.9%</td>
<td>5.5%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Net Income</td>
<td>(1,609,063)</td>
<td>10,722,980</td>
<td>3,911,169</td>
<td>5,188,469</td>
<td>6,516,582</td>
<td>10,149,477</td>
<td>2,023,996</td>
</tr>
<tr>
<td>ppm</td>
<td>(1.28)</td>
<td>8.76</td>
<td>11.27</td>
<td>14.33</td>
<td>16.40</td>
<td>22.70</td>
<td>12.64</td>
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<tr>
<td>% of Revenue</td>
<td>-0.5%</td>
<td>3.4%</td>
<td>4.8%</td>
<td>6.2%</td>
<td>5.8%</td>
<td>7.8%</td>
<td>4.1%</td>
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<tr>
<td>100% TNE</td>
<td>16,769,368</td>
<td>16,138,440</td>
<td>16,112,437</td>
<td>16,056,217</td>
<td>18,539,458</td>
<td>19,653,502</td>
<td>21,822,933</td>
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<tr>
<td>% TNE Required</td>
<td>36%</td>
<td>68%</td>
<td>68%</td>
<td>64%</td>
<td>84%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Minimum Required TNE</td>
<td>6,036,972</td>
<td>10,974,139</td>
<td>10,965,457</td>
<td>13,487,223</td>
<td>15,573,145</td>
<td>19,653,502</td>
<td>21,822,933</td>
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<tr>
<td>GCHP TNE</td>
<td>(6,031,884)</td>
<td>11,411,099</td>
<td>14,502,268</td>
<td>20,990,738</td>
<td>27,507,320</td>
<td>37,656,797</td>
<td>39,480,792</td>
</tr>
<tr>
<td>TNE Excess / (Deficiency)</td>
<td>(12,068,852)</td>
<td>916,960</td>
<td>4,845,810</td>
<td>7,503,516</td>
<td>12,397,168</td>
<td>18,003,295</td>
<td>17,857,799</td>
</tr>
</tbody>
</table>

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

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

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

### Tangible Net Equity (TNE)

- **Minimum Required TNE**
- **GCHP TNE**
- **GCHP without LOC**

![Tangible Net Equity (TNE)](chart.png)
SPD = Seniors and Persons with Disabilities  
TLIC = Targeted Low Income Children  
AE = Adult Expansion

Note: Beginning in Apr '14 actual membership reflects new Duals definition as implemented by DHCS. Prior months have not been restated.
### Income Statement Monthly Trend

**FY2014-15 Monthly Trend**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAY 2014</td>
<td>148,289</td>
<td>157,168</td>
<td>160,085</td>
</tr>
<tr>
<td>JUN 2014</td>
<td>148,289</td>
<td>157,168</td>
<td>160,085</td>
</tr>
<tr>
<td>JUL 2014</td>
<td>148,289</td>
<td>157,168</td>
<td>160,085</td>
</tr>
<tr>
<td>AUGUST 2014</td>
<td>163,251</td>
<td>158,450</td>
<td>4,801</td>
</tr>
</tbody>
</table>

#### Revenue:

- **Membership** (includes retro members)
  - MAY 2014: 148,289
  - JUN 2014: 157,168
  - JUL 2014: 160,085
  - AUGUST 2014: 163,251

#### Other Revenue:

- **Interest Income**
  - MAY 2014: 12,448
  - JUN 2014: 16,066
  - JUL 2014: 14,142
  - AUGUST 2014: 25,986

#### Total Revenue

- MAY 2014: 43,418,115
- JUN 2014: 46,472,254
- JUL 2014: 49,561,663
- AUGUST 2014: 51,384,288

#### Medical Expenses:

- **Capitation** (PCP, Specialty, Kasier, NEMT & Vision)
  - MAY 2014: 11,741,392
  - JUN 2014: 16,677,164
  - JUL 2014: 16,321,675
  - AUGUST 2014: 17,807,862

#### Sub-total

- MAY 2014: 36,396,665
- JUN 2014: 34,598,303
- JUL 2014: 41,612,325
- AUGUST 2014: 41,727,695

#### Total Costs of Health Care

- MAY 2014: 38,812,496
- JUN 2014: 37,149,193
- JUL 2014: 44,870,662
- AUGUST 2014: 46,104,742

#### Contribution Margin

- MAY 2014: 4,656,402
- JUN 2014: 9,377,460
- JUL 2014: 4,743,477
- AUGUST 2014: 5,343,866

#### General & Administrative Expenses:

- **Salaries and Wages**
  - MAY 2014: 662,308
  - JUN 2014: 592,779
  - JUL 2014: 677,265
  - AUGUST 2014: 725,299

#### Sub-total

- MAY 2014: 2,597,338
- JUN 2014: 2,527,289
- JUL 2014: 2,719,481
- AUGUST 2014: 2,472,120

#### Net Income / (Loss)

- MAY 2014: $2,059,063
- JUN 2014: $6,850,171
- JUL 2014: $2,023,996
- AUGUST 2014: $2,871,746

#### Full time employees

- MAY 2014: 136
- JUN 2014: 156
- JUL 2014: 20
- AUGUST 2014: 136

---

**FY2013-14 Monthly Trend**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAY 2014</td>
<td>148,289</td>
<td>157,168</td>
<td>160,085</td>
</tr>
<tr>
<td>JUN 2014</td>
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<td>157,168</td>
<td>160,085</td>
</tr>
<tr>
<td>JUL 2014</td>
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<td>160,085</td>
</tr>
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<td>AUGUST 2014</td>
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<td>158,450</td>
<td>4,801</td>
</tr>
</tbody>
</table>

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- JUN 2014: 156
- JUL 2014: 20
- AUGUST 2014: 136
### August 2014 PMPM Income Statement Comparison

<table>
<thead>
<tr>
<th></th>
<th>May 2014</th>
<th>Jun 2014</th>
<th>Jul 2014</th>
<th>Actual Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Membership (includes retro members)</strong></td>
<td>148,289</td>
<td>157,168</td>
<td>160,085</td>
<td>163,251</td>
<td>158,450</td>
</tr>
<tr>
<td><strong>Revenue:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Premium</td>
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<td>7.98</td>
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<td>-</td>
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<td>(12.44)</td>
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<td>MCO Premium Tax</td>
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<td>(12.44)</td>
<td>(12.74)</td>
<td>(12.86)</td>
<td>(12.25)</td>
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<td><strong>Total Net Premium</strong></td>
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<td>0.24</td>
<td>0.23</td>
<td>0.24</td>
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<td>0.33</td>
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<td>299.30</td>
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<tr>
<td>Inpatient</td>
<td>60.71</td>
<td>42.69</td>
<td>68.28</td>
<td>71.92</td>
<td>60.76</td>
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<tr>
<td>LTC/SNF</td>
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<td>47.33</td>
<td>53.27</td>
<td>49.20</td>
<td>47.23</td>
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<tr>
<td>Emergency Room</td>
<td>7.38</td>
<td>9.63</td>
<td>8.70</td>
<td>11.46</td>
<td>9.39</td>
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<td>Physician Specialty</td>
<td>15.55</td>
<td>13.02</td>
<td>21.61</td>
<td>21.17</td>
<td>19.99</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>-</td>
<td>-</td>
<td>11.35</td>
<td>18.12</td>
<td>15.26</td>
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<tr>
<td>Home &amp; Community Based Services</td>
<td>-</td>
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<td>7.44</td>
<td>8.56</td>
<td>5.26</td>
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<tr>
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<td>1.20</td>
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<td>4.63</td>
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<td>Pharmacy</td>
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<td>47.94</td>
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<td>53.72</td>
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<td>220.14</td>
<td>259.94</td>
<td>255.60</td>
<td>246.19</td>
</tr>
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<td><strong>Other Medical Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>60.71</td>
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<td>68.28</td>
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<td>15.26</td>
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<td>-</td>
<td>-</td>
<td>7.44</td>
<td>8.56</td>
<td>5.26</td>
</tr>
<tr>
<td>Mental Health Services</td>
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<td>1.90</td>
<td>1.20</td>
<td>3.63</td>
<td>4.63</td>
</tr>
<tr>
<td>Pharmacy</td>
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<td>47.94</td>
<td>36.10</td>
<td>33.33</td>
<td>53.72</td>
</tr>
<tr>
<td><strong>Total Other Medical Expenses</strong></td>
<td>245.44</td>
<td>220.14</td>
<td>259.94</td>
<td>255.60</td>
<td>246.19</td>
</tr>
<tr>
<td><strong>Total Claims</strong></td>
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<td>220.14</td>
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<td>255.60</td>
<td>246.19</td>
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<tr>
<td><strong>Total Cost of Health Care</strong></td>
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<td>236.37</td>
<td>280.29</td>
<td>282.42</td>
<td>270.66</td>
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<tr>
<td><strong>Contribution Margin</strong></td>
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<td>59.67</td>
<td>29.63</td>
<td>32.73</td>
<td>28.65</td>
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<td><strong>General &amp; Administrative Expenses:</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Salaries and Wages</td>
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<td>3.77</td>
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<td>0.14</td>
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<td>Lease Expense - Office</td>
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<td>0.39</td>
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<tr>
<td>Consulting Services</td>
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<td>0.02</td>
<td>0.02</td>
<td>0.04</td>
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<tr>
<td>Advertising and Promotion</td>
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<td>0.03</td>
<td>-</td>
<td>0.08</td>
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<td>0.61</td>
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<tr>
<td>Depreciation &amp; Amortization</td>
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<tr>
<td>Printing</td>
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<td>0.01</td>
<td>0.05</td>
<td>0.08</td>
</tr>
<tr>
<td>Shipping &amp; Postage</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.14</td>
<td>0.13</td>
</tr>
<tr>
<td>Interest</td>
<td>0.24</td>
<td>(0.31)</td>
<td>0.12</td>
<td>0.05</td>
<td>0.09</td>
</tr>
<tr>
<td><strong>Total G &amp; A Expenses</strong></td>
<td>17.52</td>
<td>16.08</td>
<td>16.99</td>
<td>15.14</td>
<td>18.25</td>
</tr>
<tr>
<td><strong>Net Income / (Loss)</strong></td>
<td>13.89</td>
<td>43.59</td>
<td>12.64</td>
<td>17.59</td>
<td>10.39</td>
</tr>
</tbody>
</table>
### Comparative Balance Sheet

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cash and Cash Equivalents</td>
<td>$124,801,815</td>
<td>$61,568,613</td>
<td>$60,176,698</td>
<td>$50,817,760</td>
</tr>
<tr>
<td>Medi-Cal Receivable</td>
<td>64,217,509</td>
<td>106,497,750</td>
<td>99,807,123</td>
<td>11,683,076</td>
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<tr>
<td>Provider Receivable</td>
<td>471,036</td>
<td>451,665</td>
<td>395,129</td>
<td>1,161,279</td>
</tr>
<tr>
<td>Other Receivables</td>
<td>173,540</td>
<td>534,822</td>
<td>1,458,481</td>
<td>300,397</td>
</tr>
<tr>
<td>Total Accounts Receivable</td>
<td>64,802,086</td>
<td>107,484,237</td>
<td>101,660,733</td>
<td>13,144,852</td>
</tr>
<tr>
<td>Total Prepaid Accounts</td>
<td>1,073,641</td>
<td>1,172,196</td>
<td>1,151,757</td>
<td>324,419</td>
</tr>
<tr>
<td>Total Other Current Assets</td>
<td>79,079</td>
<td>79,079</td>
<td>81,719</td>
<td>10,000</td>
</tr>
<tr>
<td>Total Current Assets</td>
<td>190,756,622</td>
<td>170,304,125</td>
<td>163,070,907</td>
<td>64,297,030</td>
</tr>
<tr>
<td>Total Fixed Assets</td>
<td>1,162,985</td>
<td>1,173,456</td>
<td>1,163,269</td>
<td>230,913</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$191,919,606</td>
<td>$171,477,581</td>
<td>$164,234,176</td>
<td>$64,527,943</td>
</tr>
<tr>
<td><strong>LIABILITIES &amp; FUND BALANCE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incurred But Not Reported</td>
<td>$117,199,839</td>
<td>$102,120,547</td>
<td>$89,252,777</td>
<td>$29,901,103</td>
</tr>
<tr>
<td>Claims Payable</td>
<td>9,737,671</td>
<td>8,427,358</td>
<td>9,482,660</td>
<td>9,748,676</td>
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<tr>
<td>Capitation Payable</td>
<td>2,253,578</td>
<td>2,142,484</td>
<td>2,054,265</td>
<td>1,002,623</td>
</tr>
<tr>
<td>Physician ACA 1202 Payable</td>
<td>3,222,776</td>
<td>3,222,776</td>
<td>3,222,776</td>
<td>-</td>
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<tr>
<td>AB85 Payable</td>
<td>1,079,935</td>
<td>979,634</td>
<td>1,411,679</td>
<td>-</td>
</tr>
<tr>
<td>Accrued Premium Reduction</td>
<td>842,917</td>
<td>842,917</td>
<td>842,917</td>
<td>-</td>
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<tr>
<td>Accounts Payable</td>
<td>247,671</td>
<td>1,420,993</td>
<td>2,675,629</td>
<td>1,751,419</td>
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<tr>
<td>Accrued ACS</td>
<td>1,246,022</td>
<td>1,204,802</td>
<td>-</td>
<td>422,138</td>
</tr>
<tr>
<td>Accrued Expenses</td>
<td>674,925</td>
<td>695,771</td>
<td>655,679</td>
<td>477,477</td>
</tr>
<tr>
<td>Accrued Premium Tax</td>
<td>11,292,429</td>
<td>9,149,250</td>
<td>14,985,060</td>
<td>7,337,759</td>
</tr>
<tr>
<td>Accrued Interest Payable</td>
<td>47,215</td>
<td>44,662</td>
<td>42,062</td>
<td>9,712</td>
</tr>
<tr>
<td>Current Portion of Deferred Revenue</td>
<td>460,000</td>
<td>460,000</td>
<td>460,000</td>
<td>460,000</td>
</tr>
<tr>
<td>Accrued Payroll Expense</td>
<td>596,812</td>
<td>558,034</td>
<td>760,032</td>
<td>605,937</td>
</tr>
<tr>
<td>Current Portion Of Long Term Debt</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Current Liabilities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Current Liabilities</td>
<td>148,843,790</td>
<td>131,269,227</td>
<td>126,045,534</td>
<td>51,716,843</td>
</tr>
<tr>
<td>Long-Term Liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Long-term Liability-Deferred Rent</td>
<td>139,945</td>
<td>105,896</td>
<td>71,845</td>
<td>-</td>
</tr>
<tr>
<td>Deferred Revenue - Long Term Portion</td>
<td>383,333</td>
<td>421,667</td>
<td>460,000</td>
<td>920,000</td>
</tr>
<tr>
<td>Notes Payable</td>
<td>7,200,000</td>
<td>7,200,000</td>
<td>7,200,000</td>
<td>7,200,000</td>
</tr>
<tr>
<td>Total Long-Term Liabilities</td>
<td>7,723,278</td>
<td>7,727,562</td>
<td>7,731,845</td>
<td>8,120,000</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>156,567,068</td>
<td>138,996,789</td>
<td>133,777,380</td>
<td>59,836,843</td>
</tr>
<tr>
<td>Beginning Fund Balance</td>
<td>30,456,797</td>
<td>30,456,797</td>
<td>4,691,101</td>
<td>(6,031,881)</td>
</tr>
<tr>
<td>Net Income Current Year</td>
<td>4,895,742</td>
<td>2,023,996</td>
<td>28,785,896</td>
<td>10,722,981</td>
</tr>
<tr>
<td><strong>Total Fund Balance</strong></td>
<td>35,352,539</td>
<td>32,480,792</td>
<td>30,456,797</td>
<td>4,691,100</td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Fund Balance</strong></td>
<td>$191,919,606</td>
<td>$171,477,581</td>
<td>$164,234,176</td>
<td>$64,527,943</td>
</tr>
</tbody>
</table>

### Financial Indicators

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Current Ratio</td>
<td>1.28 : 1</td>
<td>1.3 : 1</td>
<td>1.29 : 1</td>
<td>1.24 : 1</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>77</td>
<td>39</td>
<td>46</td>
<td>58</td>
</tr>
<tr>
<td>Days Cash + State Capitation Receivable</td>
<td>117</td>
<td>106</td>
<td>121</td>
<td>72</td>
</tr>
<tr>
<td>Days Cash + State Capitation Rec (less Tax Liab)</td>
<td>110</td>
<td>100</td>
<td>110</td>
<td>63</td>
</tr>
</tbody>
</table>
APPENDIX

- Cash Trend combined
- Paid Claims & IBNP composition
- Monthly Cash Flow
- YTD Cash Flow
- Income Statement YTD
- Total Expenditure Composition
- Pharmacy Cost & Utilization Trends
Cash + Medi-Cal Receivable Trend ($ in Millions)
(Net of MCO Tax Liability and excludes pass-through funds)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$143.59</td>
<td>$176.65</td>
<td>$176.65</td>
<td>$176.65</td>
</tr>
<tr>
<td>$130.03</td>
<td>$157.94</td>
<td>$157.94</td>
<td>$157.94</td>
</tr>
<tr>
<td>$114.31</td>
<td>$133.02</td>
<td>$133.02</td>
<td>$133.02</td>
</tr>
<tr>
<td>$104.14</td>
<td>$118.32</td>
<td>$118.32</td>
<td>$118.32</td>
</tr>
<tr>
<td>$95.96</td>
<td>$95.96</td>
<td>$95.96</td>
<td>$95.96</td>
</tr>
<tr>
<td>$83.40</td>
<td>$83.40</td>
<td>$83.40</td>
<td>$83.40</td>
</tr>
<tr>
<td>$71.24</td>
<td>$66.74</td>
<td>$66.74</td>
<td>$66.74</td>
</tr>
<tr>
<td>$66.08</td>
<td>$66.08</td>
<td>$66.08</td>
<td>$66.08</td>
</tr>
<tr>
<td>$63.04</td>
<td>$63.04</td>
<td>$63.04</td>
<td>$63.04</td>
</tr>
<tr>
<td>$56.08</td>
<td>$56.08</td>
<td>$56.08</td>
<td>$56.08</td>
</tr>
</tbody>
</table>
For Reporting Period:

<table>
<thead>
<tr>
<th>Month</th>
<th>09/2012</th>
<th>10/2012</th>
<th>11/2012</th>
<th>12/2012</th>
<th>01/2013</th>
<th>02/2013</th>
<th>03/2013</th>
<th>04/2013</th>
<th>05/2013</th>
<th>06/2013</th>
<th>07/2013</th>
<th>08/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Unpaid</td>
<td>22.2</td>
<td>43.3</td>
<td>16.9</td>
<td>17.3</td>
<td>22.2</td>
<td>13.7</td>
<td>16.9</td>
<td>17.3</td>
<td>22.2</td>
<td>13.7</td>
<td>16.9</td>
<td>17.3</td>
</tr>
<tr>
<td>Prior Month Unpaid</td>
<td>13.8</td>
<td>23.5</td>
<td>8.9</td>
<td>13.6</td>
<td>23.5</td>
<td>8.9</td>
<td>13.6</td>
<td>23.5</td>
<td>8.9</td>
<td>13.6</td>
<td>23.5</td>
<td>8.9</td>
</tr>
<tr>
<td>Current Month Unpaid</td>
<td>8.4</td>
<td>4.8</td>
<td>8.0</td>
<td>8.7</td>
<td>4.8</td>
<td>8.0</td>
<td>8.7</td>
<td>4.8</td>
<td>8.0</td>
<td>8.7</td>
<td>4.8</td>
<td>8.0</td>
</tr>
</tbody>
</table>

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

Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.
### Statement of Cash Flows - Monthly

<table>
<thead>
<tr>
<th></th>
<th>AUG '14</th>
<th>JULY '14</th>
<th>JUNE '14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flow From Operating Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collected Premium</td>
<td>$94,832,281</td>
<td>$45,212,063</td>
<td>$0</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>25,986</td>
<td>14,142</td>
<td>16,066</td>
</tr>
<tr>
<td>State Pass Through Funds</td>
<td>1,882,392</td>
<td>717,413</td>
<td>-</td>
</tr>
<tr>
<td><strong>Paid Claims</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Hospital Expenses</td>
<td>(19,339,369)</td>
<td>(23,318,973)</td>
<td>(19,798,531)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>(6,254,420)</td>
<td>(5,751,973)</td>
<td>(5,842,805)</td>
</tr>
<tr>
<td>Capitation</td>
<td>(2,557,362)</td>
<td>(2,464,945)</td>
<td>(1,913,772)</td>
</tr>
<tr>
<td>Reinsurance of Claims</td>
<td>(444,200)</td>
<td>(637,110)</td>
<td>(352,660)</td>
</tr>
<tr>
<td>State Pass Through Funds</td>
<td>(2,224,871)</td>
<td>-</td>
<td>(684,016)</td>
</tr>
<tr>
<td>Paid Administration</td>
<td>(2,668,390)</td>
<td>(4,432,355)</td>
<td>(3,093,374)</td>
</tr>
<tr>
<td>MCO Tax Received / (Paid)</td>
<td>-</td>
<td>(7,908,088)</td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash Provided/ (Used) by Operating Activities</strong></td>
<td>63,252,047</td>
<td>1,430,176</td>
<td>(31,669,093)</td>
</tr>
</tbody>
</table>

|                                |          |          |          |
| **Cash Flow From Investing/Financing Activities** |          |          |          |
| Proceeds from Line of Credit   | -        | -        | -        |
| Repayments on Line of Credit   | -        | -        | -        |
| Net Acquisition of Property/Equipment | (18,845) | (38,262) | 3,774    |
| **Net Cash Provided/(Used) by Investing/Financing** | (18,845) | (38,262) | 3,774    |

|                                |          |          |          |
| **Net Cash Flow**              | $63,233,203 | $1,391,914 | $(31,665,320) |

|                                |          |          |          |
| **Cash and Cash Equivalents (Beg. of Period)** | 61,568,613 | 60,176,698 | 91,842,018 |
| **Cash and Cash Equivalents (End of Period)** | 124,801,815 | 61,568,613 | 60,176,698 |
| **Net Cash Flow from Operating Activities** | $63,252,047 | $1,430,176 | $(31,669,093) |

|                                |          |          |          |
| **Adjustment to Reconcile Net Income to Net Cash Flow** |          |          |          |
| Net (Loss) Income              | 2,871,746 | 2,023,996 | 6,850,171 |
| Loss on asset disposal         | -        | -        | -        |
| Depreciation & Amortization    | 29,316   | 28,075   | (64,170) |
| Decrease/(Increase) in Receivables | 42,682,152 | (5,823,505) | (49,406,500) |
| Decrease/(Increase) in Prepads & Other Current Assets | 98,554 | (17,799) | (99,024) |
| (Decrease)/Increase in Payables | (1,699,316) | (841,185) | (714,584) |
| (Decrease)/Increase in Other Liabilities | (4,284) | (4,284) | 33,512 |
| Changes in Withhold / Risk Incentive Pool | - | - | - |
| Change in MCO Tax Liability    | 2,143,179 | (5,835,810) | 1,988,140 |
| Changes in Claims and Capitation Payable | 1,421,408 | (967,083) | 1,305,279 |
| Changes in IBNR               | 15,079,291 | 12,867,771 | 8,438,082 |
| **Net Cash Flow from Operating Activities** | $63,252,047 | $1,430,176 | $(31,669,093) |
## Income Statement

For Two Month Ended August 31, 2014

<table>
<thead>
<tr>
<th></th>
<th>August '14 Year-To-Date</th>
<th>Variance</th>
<th>Favi/(Unfav)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership (includes retro members)</td>
<td>323,336</td>
<td>316,548</td>
<td>6,788</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td>$ 105,083,619 $ 98,433,254</td>
<td>$ 6,650,365</td>
<td></td>
</tr>
<tr>
<td>Reserve for Rate Reduction</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>MCO Premium Tax</td>
<td>(4,137,668) (3,875,809)</td>
<td>(261,858)</td>
<td></td>
</tr>
<tr>
<td>Total Net Premium</td>
<td>100,945,951 94,557,444</td>
<td>6,388,507</td>
<td></td>
</tr>
<tr>
<td>Other Revenue:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Income</td>
<td>40,129</td>
<td>32,483</td>
<td>7,646</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>76,667</td>
<td>76,666</td>
<td>1</td>
</tr>
<tr>
<td>Total Other Revenue</td>
<td>116,795</td>
<td>109,149</td>
<td>7,647</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>101,062,747</td>
<td>94,666,593</td>
<td>6,396,153</td>
</tr>
<tr>
<td>Medical Expenses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitation (PCP, Specialty, Kaiser, NEMT &amp; )</td>
<td>5,212,961</td>
<td>5,289,635</td>
<td>76,674</td>
</tr>
<tr>
<td>FFS Claims Expenses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>22,672,600 19,205,577</td>
<td>(3,467,023)</td>
<td></td>
</tr>
<tr>
<td>LTC/SNF</td>
<td>16,560,280 14,972,709</td>
<td>(1,587,572)</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>6,487,202 5,102,025</td>
<td>(1,385,177)</td>
<td></td>
</tr>
<tr>
<td>Laboratory and Radiology</td>
<td>1,945,645</td>
<td>1,436,832</td>
<td>(508,814)</td>
</tr>
<tr>
<td>Physician ACA 1202</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>3,263,537 2,966,814</td>
<td>(296,723)</td>
<td></td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>6,916,257 6,321,384</td>
<td>(594,873)</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>4,775,130 4,821,411</td>
<td>(46,281)</td>
<td></td>
</tr>
<tr>
<td>Home &amp; Community Based Services</td>
<td>2,589,883</td>
<td>1,668,029</td>
<td>(921,854)</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>784,794 1,466,037</td>
<td>681,243</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>11,220,979 16,941,166</td>
<td>5,720,187</td>
<td></td>
</tr>
<tr>
<td>Other Medical Professional</td>
<td>608,801</td>
<td>514,431</td>
<td>(94,371)</td>
</tr>
<tr>
<td>Other Medical Care</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other Fee For Service</td>
<td>4,024,263 1,825,237</td>
<td>(2,199,026)</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>490,647</td>
<td>586,284</td>
<td>95,637</td>
</tr>
<tr>
<td>Total Claims</td>
<td>83,340,020 77,927,935</td>
<td>(5,412,085)</td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Care Management Expense</td>
<td>2,000,584</td>
<td>2,076,806</td>
<td>76,221</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>515,481</td>
<td>386,189</td>
<td>(129,292)</td>
</tr>
<tr>
<td>Claims Recoveries</td>
<td>(93,642)</td>
<td>-</td>
<td>93,642</td>
</tr>
<tr>
<td>Sub-total</td>
<td>2,422,423</td>
<td>2,462,994</td>
<td>40,572</td>
</tr>
<tr>
<td>Total Cost of Health Care</td>
<td>90,975,404</td>
<td>85,580,564</td>
<td>(5,394,840)</td>
</tr>
<tr>
<td>Contribution Margin</td>
<td>10,087,343</td>
<td>9,086,029</td>
<td>1,001,314</td>
</tr>
<tr>
<td>General &amp; Administrative Expenses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and Wages</td>
<td>1,302,502</td>
<td>1,610,006</td>
<td>307,504</td>
</tr>
<tr>
<td>Payroll Taxes and Benefits</td>
<td>374,584</td>
<td>408,120</td>
<td>33,535</td>
</tr>
<tr>
<td>Travel and Training</td>
<td>19,151</td>
<td>42,495</td>
<td>23,344</td>
</tr>
<tr>
<td>Outside Service - ACS</td>
<td>2,511,204</td>
<td>2,380,376</td>
<td>(130,829)</td>
</tr>
<tr>
<td>Outside Service - RGS</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Outside Services - Other</td>
<td>196,390</td>
<td>243,195</td>
<td>(46,806)</td>
</tr>
<tr>
<td>Accounting &amp; Actuarial Services</td>
<td>31,228</td>
<td>90,000</td>
<td>58,773</td>
</tr>
<tr>
<td>Legal</td>
<td>213,821</td>
<td>66,666</td>
<td>(147,155)</td>
</tr>
<tr>
<td>Insurance</td>
<td>46,592</td>
<td>29,167</td>
<td>(17,425)</td>
</tr>
<tr>
<td>Lease Expense - Office</td>
<td>126,635</td>
<td>128,708</td>
<td>2,073</td>
</tr>
<tr>
<td>Consulting Services</td>
<td>98,307</td>
<td>309,602</td>
<td>211,295</td>
</tr>
<tr>
<td>Translation Services</td>
<td>5,563</td>
<td>14,166</td>
<td>8,603</td>
</tr>
<tr>
<td>Advertising and Promotion</td>
<td>4,024</td>
<td>25,968</td>
<td>21,944</td>
</tr>
<tr>
<td>General Office</td>
<td>172,401</td>
<td>534,898</td>
<td>362,497</td>
</tr>
<tr>
<td>Depreciation &amp; Amortization</td>
<td>29,074</td>
<td>36,031</td>
<td>6,956</td>
</tr>
<tr>
<td>Printing</td>
<td>9,523</td>
<td>42,540</td>
<td>33,017</td>
</tr>
<tr>
<td>Shipping &amp; Postage</td>
<td>23,800</td>
<td>32,684</td>
<td>8,884</td>
</tr>
<tr>
<td>Interest</td>
<td>26,800</td>
<td>30,000</td>
<td>3,200</td>
</tr>
<tr>
<td>Other/ Miscellaneous Expenses</td>
<td>5,191,601</td>
<td>6,024,622</td>
<td>833,021</td>
</tr>
<tr>
<td>Total G &amp; A Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Income / (Loss)</td>
<td>$ 4,895,742 $ 3,061,407</td>
<td>$ 1,834,334</td>
<td></td>
</tr>
</tbody>
</table>
## Statement of Cash Flows - YTD

### AUG 2014 YTD

**Cash Flow From Operating Activities**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collected Premium</td>
<td>$140,044,345</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>40,129</td>
</tr>
<tr>
<td>State Pass Through Funds</td>
<td>2,599,805</td>
</tr>
</tbody>
</table>

**Paid Claims**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Hospital Expenses</td>
<td>(42,658,341)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>(12,006,394)</td>
</tr>
<tr>
<td>Capitation</td>
<td>(5,022,306)</td>
</tr>
<tr>
<td>Reinsurance of Claims</td>
<td>(1,081,309)</td>
</tr>
<tr>
<td>State Pass Through Funds Distributed</td>
<td>(2,224,871)</td>
</tr>
<tr>
<td>Payment of Withhold / Risk Sharing Incentive</td>
<td>-</td>
</tr>
<tr>
<td>Paid Administration</td>
<td>(7,100,745)</td>
</tr>
<tr>
<td>Repay Initial Net Liabilities</td>
<td>-</td>
</tr>
<tr>
<td>MCO Taxes Received / (Paid)</td>
<td>(7,908,088)</td>
</tr>
</tbody>
</table>

**Net Cash Provided/(Used) by Operating Activities**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>64,682,224</td>
</tr>
</tbody>
</table>

**Cash Flow From Investing/Financing Activities**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proceeds from Line of Credit</td>
<td>-</td>
</tr>
<tr>
<td>Repayments on Line of Credit</td>
<td>-</td>
</tr>
<tr>
<td>Net Acquisition of Property/Equipment</td>
<td>(57,107)</td>
</tr>
</tbody>
</table>

**Net Cash Provided/(Used) by Investing/Financing**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(57,107)</td>
</tr>
</tbody>
</table>

**Net Cash Flow**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$64,625,117</td>
</tr>
</tbody>
</table>

**Cash and Cash Equivalents (Beg. of Period)**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>61,568,613</td>
</tr>
</tbody>
</table>

**Cash and Cash Equivalents (End of Period)**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>124,801,815</td>
</tr>
</tbody>
</table>

**Net**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$63,233,203</td>
</tr>
</tbody>
</table>

**Adjustment to Reconcile Net Income to Net Cash Flow**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Income/(Loss)</td>
<td>4,895,742</td>
</tr>
<tr>
<td>Depreciation &amp; Amortization</td>
<td>57,391</td>
</tr>
<tr>
<td>Decrease/(Increase) in Receivables</td>
<td>36,858,647</td>
</tr>
<tr>
<td>Decrease/(Increase) in Prepays &amp; Other Current Assets</td>
<td>80,755</td>
</tr>
<tr>
<td>(Decrease)/Increase in Payables</td>
<td>(1,910,500)</td>
</tr>
<tr>
<td>(Decrease)/Increase in Other Liabilities</td>
<td>(8,567)</td>
</tr>
<tr>
<td>Change in MCO Tax Liability</td>
<td>(3,692,631)</td>
</tr>
<tr>
<td>Loss on asset disposal</td>
<td>-</td>
</tr>
<tr>
<td>Changes in Claims and Capitation Payable</td>
<td>454,325</td>
</tr>
<tr>
<td>Changes in IBNR</td>
<td>27,947,062</td>
</tr>
</tbody>
</table>

**Net Cash Flow from Operating Activities**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$64,682,224</td>
</tr>
</tbody>
</table>
For the month ended February 28, 2014
Beginning January 2014, "Other" category includes ACA 1202 physician supplement and mental health expenses.

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

Beginning January 2014, "Other" category includes ACA 1202 physician supplement and mental health expenses.
For the month ended February 28, 2014

<table>
<thead>
<tr>
<th>Month</th>
<th>AVG PMPM</th>
<th>GENERIC</th>
<th>BRAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEP'13</td>
<td>$26.24</td>
<td>$8.41</td>
<td>$17.83</td>
</tr>
<tr>
<td>OCT'13</td>
<td>$29.90</td>
<td>$9.71</td>
<td>$20.19</td>
</tr>
<tr>
<td>NOV'13</td>
<td>$24.94</td>
<td>$8.87</td>
<td>$16.82</td>
</tr>
<tr>
<td>DEC'13</td>
<td>$26.70</td>
<td>$9.87</td>
<td>$17.83</td>
</tr>
<tr>
<td>JAN'14</td>
<td>$30.30</td>
<td>$10.55</td>
<td>$22.01</td>
</tr>
<tr>
<td>FEB'14</td>
<td>$32.55</td>
<td>$11.53</td>
<td>$23.34</td>
</tr>
<tr>
<td>MAR'14</td>
<td>$35.78</td>
<td>$11.87</td>
<td>$20.19</td>
</tr>
<tr>
<td>APR'14</td>
<td>$35.25</td>
<td>$11.49</td>
<td>$19.00</td>
</tr>
<tr>
<td>MAY'14</td>
<td>$35.25</td>
<td>$11.49</td>
<td>$19.08</td>
</tr>
<tr>
<td>JUN'14</td>
<td>$35.21</td>
<td>$11.49</td>
<td>$21.02</td>
</tr>
<tr>
<td>JUL'14</td>
<td>$35.1</td>
<td>$11.49</td>
<td>$21.02</td>
</tr>
<tr>
<td>AUG'14</td>
<td>$33.33</td>
<td>$11.49</td>
<td>$21.85</td>
</tr>
</tbody>
</table>

Pharmacy Cost Trend
AGENDA ITEM 3d

To: Gold Coast Health Plan Commission

From: Ruth Watson, Chief Operating Officer

Date: October 27, 2014

Re: COO Update

OPERATIONS UPDATE

Membership

Gold Coast Health Plan continued to see growth on the October Enrollment file, adding 4,238 members to the Plan. GCHP’s membership as of October 1, 2014 is 167,598, which represents an increase of 47,086 members (approximately 39%) since January 1, 2014. The cumulative new membership since January 1st is summarized as follows:

L1 (Low Income Health Plan) – 7,443
M1 (Adult Expansion) – 23,569
7U (CalFresh Adults) – 3,312
7W (CalFresh Children) – 296
Traditional Medi-Cal – 12,466

Members with Traditional aid codes accounted for the majority of October’s growth, adding 3,104 new members. Membership in all Medi-Cal Expansion aid codes, with the exception of M1, continued to decrease in October:

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1</td>
<td>7,618</td>
<td>8,083</td>
<td>8,154</td>
<td>8,134</td>
<td>8,118</td>
<td>7,975</td>
<td>7,839</td>
<td>7,726</td>
<td>7,568</td>
<td>7,443</td>
</tr>
<tr>
<td>M1</td>
<td>183</td>
<td>1,550</td>
<td>2,482</td>
<td>4,514</td>
<td>7,279</td>
<td>10,910</td>
<td>15,606</td>
<td>18,585</td>
<td>21,944</td>
<td>23,569</td>
</tr>
<tr>
<td>7U</td>
<td>0</td>
<td>0</td>
<td>1,741</td>
<td>3,584</td>
<td>3,680</td>
<td>3,515</td>
<td>3,453</td>
<td>3,400</td>
<td>3,368</td>
<td>3,312</td>
</tr>
<tr>
<td>7W</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>684</td>
<td>714</td>
<td>691</td>
<td>667</td>
<td>624</td>
<td>606</td>
<td>296</td>
</tr>
</tbody>
</table>

Member Orientation Meetings – the GCHP Member Services department has worked to increase the attendance of members at Member Orientation Meetings. Meetings are now held in multiple locations throughout the county and include Saturday and evening sessions. The most significant impact has been the inclusion of meeting information in new member packets. A total of 28 members attended meetings during the first six month of
2014. We started including the informational flyer in member packets beginning July 2014 and 98 members have attended orientation meetings during July, August and September.

**September 2014 Operations Summary**

**Claims Inventory** – ended the month with an inventory of 32,872 claims; this equates to Days Receipt on Hand (DROH) of 7 days. We received approximately 10,500 more claims in September than the prior month. Claim receipts from January through September are as follows:

- January - 91,130
- February - 90,048
- March - 109,857
- April - 110,855
- May - 108,312
- June - 116,474
- July - 117,136
- August - 108,695
- September - 119,233

**Claims TAT** – the regulatory requirement of processing 90% of clean claims within 30 calendar days was not met in September. The results for September were 83.2%; Xerox is on track to meet this metric for October.

**Claims Processing Accuracy** – financial accuracy remained on goal in September with results coming in at 98.74%. Procedural accuracy also exceeded the goal in August at 99.97%.

**Call Volume** – call volume continues to increase and remained above 10,000 for the third straight month. GCHP received 10,508 calls in the month of September.

**Average Speed to Answer** – we continue to exceed the goal of answering calls within 30 seconds or less. The combined results for September were 17.4 seconds.

**Abandonment Rate** – the abandonment rate continues to remain exceedingly low. The goal is 5% or less of the calls received being abandoned; we have remained below 1% for 12 consecutive months.

**Average Call Length** – the combined result of 6.63 minutes in September met the goal of 7 minutes or less although the provider and Spanish calls were slightly over 7 minutes during month.
Noteworthy Activities – Operations continues to lead or be involved in the following projects:

- 35C to 837 Encounter Data Transition – DHCS continued to maintain an effective date of October 1, 2014 for this project even though the State has not completed testing with any plans statewide. DHCS will allow plans to submit in the old format until November 12, 2014. GCHP has moved successfully through all phases of testing to date and anticipates moving into production in November.
- Encounter Data Improvement Project (EDIP) – improve the quality of the data sent to DHCS in order to meet new quality measures established by the State beginning January 2015.
- Grievance and Appeals Improvement Project – the Grievance & Appeals Department officially launched on October 1, 2014 and marked the occasion with an Open House so GCHP employees could visit the department and learn more about Grievance & Appeals.
- ICD-10 Readiness – regulatory requirement to implement new code set effective October 1, 2015.
- Crossover Claims – preliminary project work commenced August 2014.
- Plan Selection – PCP selection during sign-up via Covered California; information matched once Medi-Cal beneficiary becomes a GCHP member. DHCS has canceled the monthly conference calls with the COHS and is currently focusing on non-COHS plans.
GCHP Claims Metrics – September 2014

- 30 Day Turnaround Time was not met during September but is trending towards goal in October
- Ending Inventory equals 7 Days Receipt on Hand (DROH) compared to goal of 5 days
- Financial and Procedural Accuracy both exceeded required Service Levels

Ending Inventory

Clean Claims Processed within 30 Calendar Days

Financial & Procedural Accuracy

Regulatory requirement – 90% of clean claims must be processed within 30 calendar days

Financial Accuracy – 98% or higher
Procedural Accuracy – 97% or higher
GCHP Call Center Metrics – September 2014

- Call volume exceeded 10,000 for the third month in a row
- Abandonment rate and ASA remain well within goal

Abandonment Rate
(goal is 5% of less)

Average Speed of Answer (ASA)
(goal is 30 seconds or less)
GCHP Membership allocation – September 2014

- Membership counts by PCP as of first day of each month.
- Unassigned members are Newly Eligible/Enrolled
- ADMIN members count is the remainder after deducting those with Medicare Coverage but includes those with SOC and OHI.
## GCHP Auto Assignment by PCP/Clinic as of October 1, 2014

<table>
<thead>
<tr>
<th></th>
<th>Oct-14</th>
<th>Sep-14</th>
<th>Aug-14</th>
<th>Jul-14</th>
<th>Jun-14</th>
<th>May-14</th>
<th>Apr-14</th>
<th>Mar-14</th>
<th>Feb-14</th>
<th>Jan-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
<td>Count</td>
</tr>
<tr>
<td>A85 Eligible</td>
<td>2,494</td>
<td>2,729</td>
<td>3,647</td>
<td>2,775</td>
<td>2,250</td>
<td>2,253</td>
<td>2,198</td>
<td>2,316</td>
<td>376</td>
<td></td>
</tr>
<tr>
<td>VCMC</td>
<td>1,870</td>
<td>74.98%</td>
<td>2,044</td>
<td>74.98%</td>
<td>2,765</td>
<td>74.99%</td>
<td>2,081</td>
<td>74.99%</td>
<td>1,948</td>
<td>75.00%</td>
</tr>
<tr>
<td>Balance</td>
<td>624</td>
<td>25.02%</td>
<td>682</td>
<td>25.02%</td>
<td>922</td>
<td>25.03%</td>
<td>694</td>
<td>25.04%</td>
<td>634</td>
<td>25.04%</td>
</tr>
<tr>
<td>Regular Eligible</td>
<td>1,631</td>
<td>2,192</td>
<td>1,698</td>
<td>2,012</td>
<td>1,584</td>
<td>1,726</td>
<td>1,456</td>
<td>1,516</td>
<td>911</td>
<td>998</td>
</tr>
<tr>
<td>Regular + A85 Balance</td>
<td>2,255</td>
<td>2,874</td>
<td>2,620</td>
<td>3,106</td>
<td>2,147</td>
<td>1,796</td>
<td>2,106</td>
<td>1,404</td>
<td>911</td>
<td>998</td>
</tr>
<tr>
<td>Clinicas</td>
<td>529</td>
<td>23.46%</td>
<td>666</td>
<td>23.17%</td>
<td>610</td>
<td>23.28%</td>
<td>649</td>
<td>23.28%</td>
<td>481</td>
<td>22.04%</td>
</tr>
<tr>
<td>CMH</td>
<td>326</td>
<td>13.15%</td>
<td>314</td>
<td>10.93%</td>
<td>42</td>
<td>1.40%</td>
<td>45</td>
<td>1.40%</td>
<td>184</td>
<td>7.68%</td>
</tr>
<tr>
<td>Independent</td>
<td>57</td>
<td>2.53%</td>
<td>69</td>
<td>2.40%</td>
<td>52</td>
<td>1.98%</td>
<td>64</td>
<td>2.25%</td>
<td>53</td>
<td>2.52%</td>
</tr>
<tr>
<td>VCMC</td>
<td>1,408</td>
<td>62.44%</td>
<td>1,825</td>
<td>63.50%</td>
<td>2,163</td>
<td>67.47%</td>
<td>1,388</td>
<td>65.91%</td>
<td>775</td>
<td>67.47%</td>
</tr>
<tr>
<td>Total Assigned</td>
<td>4,125</td>
<td>4,915</td>
<td>5,385</td>
<td>5,287</td>
<td>5,834</td>
<td>5,054</td>
<td>4,054</td>
<td>3,236</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinicas</td>
<td>529</td>
<td>12.82%</td>
<td>666</td>
<td>13.54%</td>
<td>610</td>
<td>11.33%</td>
<td>649</td>
<td>12.48%</td>
<td>481</td>
<td>11.86%</td>
</tr>
<tr>
<td>CMH</td>
<td>261</td>
<td>6.33%</td>
<td>314</td>
<td>6.38%</td>
<td>282</td>
<td>5.24%</td>
<td>300</td>
<td>5.24%</td>
<td>184</td>
<td>4.54%</td>
</tr>
<tr>
<td>Independent</td>
<td>57</td>
<td>1.38%</td>
<td>69</td>
<td>1.40%</td>
<td>52</td>
<td>0.97%</td>
<td>64</td>
<td>1.21%</td>
<td>53</td>
<td>1.31%</td>
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<tr>
<td>VCMC</td>
<td>3,278</td>
<td>79.47%</td>
<td>3,865</td>
<td>78.67%</td>
<td>4,441</td>
<td>82.47%</td>
<td>4,244</td>
<td>82.77%</td>
<td>3,336</td>
<td>82.99%</td>
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</table>

### Auto Assignment Process

- 75% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85.
- The remaining 25% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others.
- The County's overall auto assignment results will be higher than 75% since they receive 75% of the AE members plus a 3:1 ratio of all other unassigned members.
- AB85 assignment began in March 2014 for members eligible in January 2014.
AGENDA ITEM 3e

To: Gold Coast Health Plan Commission

From: Melissa Scrymgeour, Chief Information Officer

Date: October 27, 2014

Re: CIO Update

Infrastructure and Systems

As reported during the September 29, 2014 Commission Meeting, GCHP has experienced a number of post-implementation issues with the MedHOK Medical Management (MMS) system that have prevented the Plan from recognizing the full benefits of the solution. GCHP Health Services Staff is able to use MedHOK to perform standard functions around utilization and case management, ensuring members receive timely and medically necessary medical. A task force comprised of GCHP business, IT and MedHOK resources is actively working through a prioritized list of remaining open issues. The most recent changes were implemented the last week of September. Two additional releases are scheduled over the next four to six weeks to address the remaining issues.

In addition to the production support activities listed above, the team continues to make progress on several MedHOK related project activities:

- MedHOK ACG Module Implementation - The ACG risk stratification tool will be useful in the development and build out of the GCHP Disease Management program.
- MedHOK SPD Enhancements - System changes required to meet State requirements for assessing, tracking and reporting case management needs for the GCHP SPD member population.
- GCHP Grievance and Appeals (G&A) Optimization - Enhancements to the G&A module were successfully implemented on October 1, 2014.

Project Management Office (PMO)

The GCHP Project Portfolio as of October 2014 consists of 26 projects either in active or planned status. Here is a summary of the accomplishments for October:
• “Grievance and Appeals Improvement Project” went live on October 1, and is currently in post-implementation monitoring, with a target to close in November.
• Closed “Disease Management Program Roadmap” project.
• Closed “ICD-10 Readiness” project.

At this time, 45% of the portfolio supports regulatory and contractual requirements and the remaining 55% are strategic or “lights on” in nature.

FY 2014-15 GCHP Projects:

• **ICD-10 Readiness**: Transition all systems and providers from ICD-9 to ICD-10 by the revised Center for Medicaid and Medicare Services (CMS) mandated date of October 15, 2015.

• **Disease Management (DM) Program**: Contractually required. Introduce formal DM program to better manage health outcomes for targeted member population. The initial Diabetes program will benefit roughly 10,000 Members and help build a model for other diseases (CHF, COPD, and Prenatal).

• **Member Satisfaction**: Gauge and measure member satisfaction with GCHP, as requested by the Commission.

• **Grievance & Appeals Optimization**: Enhance grievance and appeals processes to ensure sustained regulatory and contractual compliance.

• **Xerox / ACS Service Organization Control (SOC) Audit**: Recommended by Plan financial auditor.

• **Encounter Data Improvement Project (EDIP)**: Contractual requirement for State EDIP initiative. The State requires managed care plans to submit complete, accurate, timely and reasonable encounter data in a HIPAA compliant file format.

• **Delegation & Oversight Framework**: Institute standard delegation and oversight requirements, policies, and procedures for establishing provider contracts.

• **Business Continuity Planning**: Contractual requirement to draft plan for critical business process resumption in event of emergency.

• **Disaster Recovery Planning**: Contractual requirement to draft plan for data and system recovery in event of emergency for business critical functions.
• **Crossover Claims:** Further optimizes claims processing accuracy and efficiencies to appropriately handle claims where a portion is covered by Medicare.

• **Operationalize Information Security Program** – Required to ensure ongoing HIPAA and HITECH (Health Information Technology for Economic and Clinical Health Act-2009) compliance.

• **Social Media Policy & Roadmap:** Establish a communication strategy via social media platforms to members, providers and the general community.

• **ACA Core Administrative Simplification Rules (CORE):** Regulatory requirement to utilize standard electronic transaction sets as defined under the Affordable Care Act.

• **HR Flexible Work Program:** Implement initiatives to attract and retain staff. Under consideration are a telework strategy, employee recognition, and flexible work schedules

• **ASO or PBM RFP:** Vendor evaluation and RFP for Xerox / ACS (ASO) or Scriptcare (PBM). Both contracts expire in June 2016.

• **MedHOK ACG-Risk Stratification:** Implement MedHOK ACG module for member risk stratification.

• **Provider Contracts & Capitation Rebasing Evaluation:** Evaluation of provider capitation rates.

• **MedHOK Provider Portal:** Implement MedHOK provider portal to streamline provider online experience for eligibility and claim inquiries, and authorization requests. Supports Plan “valued and trusted partner” strategy.

• **Provider Credentialing System (PCS) RFP & Implementation:** Selection and procurement of provider data and credentialing management software.

• **MedHOK SPD**: Implement MedHOK functional enhancements to meet State SPD assessment and reporting requirements.

• **MedHOK MMS Post Implementation**: Implement system fixes to resolve MedHOK post-implementation issues.

• **ICES / IKA Upgrades**: Software version upgrade for claims processing system.
• **Data Warehouse Extract Optimization**: Implement improvements to the nightly IKA data extract process for GCHP reporting.

• **Non-Emergent Medical Transportation (NEMT)**: Modify non-emergent medical transportation processes to ensure sustained regulatory and contractual compliance. Analyze and evaluate alternatives to existing benefit.

• **Behavioral Health Benefit for Autism Spectrum Disorder**: Regulatory requirement to introduce Applied Behavioral Analysis (ABA) as a treatment for Autism Spectrum Disorder (ASD) effective September 15, 2014.

*Reflects “New” projects added since the May 19, 2014 Commission meeting.*
GCHP Helpdesk Service Ticket Trending

GCHP IT Metrics – September 2014

SLA = 99.99%

- GCHP Data Warehouse
- MedInsight - BI Tool
- GCHP Network
- Multiview - Financial Accounting System

GCHP Helpdesk Service Ticket Trending

Total Tickets Entered per Month

- January: 136
- February: 89
- March: 126
- April: 273
- May: 161
- June: 155
- July: 199
- August: 177
- September: 206

Total Tickets Closed per Month

- January: 144
- February: 76
- March: 109
- April: 237
- May: 170
- June: 140
- July: 176
- August: 281
- September: 233
### 10/2014: GCHP Projects “At a Glance”

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<td>ICD-10 Readiness Phase I</td>
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<td>ICD-10 Readiness Phase 2</td>
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<td>Grievance &amp; Appeals Optimization</td>
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<td>Encounter Data Improvement Program/35C to 837 Transition/Kaiser Encounter Data</td>
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<td>IT Disaster Recovery</td>
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<td>NEMT Phase 1</td>
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<td>NEMT Phase 2</td>
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<td>Diabetes Disease Management Program</td>
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<td>Member Satisfaction Survey</td>
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<td>HR Flexible Work Program: Telework Policy</td>
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<td>ACS Data Warehouse-Extract Optimization</td>
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<td>MedHOK ACG – Risk Stratification</td>
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<td>MedHOK MMS Post-Implementation</td>
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<td>ACS SOC Audit</td>
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<td>Delegation Oversight Framework</td>
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<td>Information Security Program - Operationalize</td>
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<td>MedHOK SPD</td>
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<td>CORE: HIPAA/ACA Administrative Simplification Rules</td>
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<td>Provider Contracts &amp; Capitation Rebasing Evaluation</td>
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<td>ICES/IKA Upgrades</td>
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<td>Provider Portal - MedHOK</td>
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<td>Social Media Policy and Roadmap</td>
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<td>ASO (Xerox/ACS) – Vendor for RFP Support</td>
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<td>PBM (Scriptcare) – Vendor for RFP Support</td>
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<td>PBM RFP</td>
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**LEGEND:**
- GREEN - Active Projects (Lighter GREEN reflects Project Delays/Extensions)
- BLUE – Proposed FY14/15 Projects
- Dark BLUE-Delayed Start
10/2014: GCHP Projects “At a Glance”

LEGEND:
GREEN – Active Projects (Lighter GREEN reflects Project Delays/Extensions)
BLUE – Proposed FY14/15 Projects
Dark BLUE-Delayed Start

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<td>Provider Credentialing &amp; Contracts System RFP (Propose moving to FY15/16)</td>
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<td>ACS SOC Audit</td>
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<td>PBM (Scriptcare) – Vendor for RFP Support</td>
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<td>PBM RFP</td>
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AGENDA ITEM 3f

To:           Gold Coast Health Plan Commission

From: Dr. Nancy Wharfield, Associate Chief Medical Officer

Date: October 27, 2014

Re: Health Services Update

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

**Inpatient Utilization**

Bed days/1000 members remains under 300 and Family, SPD, and AE aid code categories each account for about 1/3 of bed day utilization for July 2014.

Benchmark: Reports of bed days/1000 members from available published data from other managed care plans range from 161 – 890/1000 members. There is variability of reporting of Administrative Days among managed care plans.
**Average Length of Stay**

Average length of stay remains low compared to prior years and at 3.1 or below since April 2014.

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

ER Utilization remains low compared to prior years and seasonal variation with a peak in late spring followed by decline in utilization in summer continues. Family aid code group members continue to show the highest percentage of ER utilization.

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

ER Utilization Per 1000

ER Utilization by Aid Code
Readmission Rate

Readmission rate has remained between 9.6% and 10.7% for the past 5 quarters.

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

Authorization Requests

Requests for outpatient service continue to outnumber requests for inpatient service. Outpatient requests for service/1000 members peaked in February 2014 and July 2014. Requests for inpatient service have reached a plateau at 75/1000 members or below for the last 6 months.

Among Medi-Cal expansion members new to Gold Coast Health Plan since January 1, 2014, outpatient services requests for L1 members continue to predominate.
Inpatient and Outpatient Authorization Requests Per 1000
GCHP Membership
January 2013 - September 2014

GCHP Membership

Inpatient Auths/1000
Outpatient Auths/1000

MedInsight Membership (10/14/2014)

[Chart showing trends in inpatient and outpatient authorization requests per 1000 GCHP membership over the specified period, with lines representing MedInsight membership and authorization requests, and the y-axis indicating authorization requests ranging from 0 to 250.]
Gold Coast Health Plan Authorizations by Aid Code
January - September 2014

**Authorizations by Aid Code**
- 7U/7W: 633
- L1: 3,650
- M1: 2,879
- All Other Aid Codes: 23,376
- Total Auths: 30,538

**Inpatient Authorizations**
- 7U/7W: 186
- L1: 676
- M1: 654
- All other Aid Codes: 6,351
- Total Inpatient Auths: 7,867

**Outpatient Authorizations**
- 7U/7W: 447
- L1: 2,974
- M1: 2,225
- All Other Aid Codes: 17,025
- Total Outpatient Auths: 22,671

Data Source: MedHOK Authorizations by Aid Code Query on 10/02/2014
Grievance and Appeals

The number of grievances for Q3 2014 is essentially unchanged from Q2 2014. Grievances/1000 member months remains low and comparable to the incidence of grievances reported by other COHS on the DHCS Managed Care Dashboard.

### Grievances

<table>
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<tr>
<th>Quarter</th>
<th>Total Number</th>
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<tbody>
<tr>
<td>Q4 2013</td>
<td>28</td>
</tr>
<tr>
<td>Q1 2014</td>
<td>22</td>
</tr>
<tr>
<td>Q2 2014</td>
<td>34</td>
</tr>
<tr>
<td>Q3 2014</td>
<td>32</td>
</tr>
</tbody>
</table>

### Appeals

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total</th>
<th>Upheld</th>
<th>Overturned</th>
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<tbody>
<tr>
<td>Q4 2013</td>
<td>1</td>
<td>1 (100%)</td>
<td>0</td>
</tr>
<tr>
<td>Q1 2014</td>
<td>10</td>
<td>8 (80%)</td>
<td>2 (20%)</td>
</tr>
<tr>
<td>Q2 2014</td>
<td>3</td>
<td>2 (67%)</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Q3 2014</td>
<td>10</td>
<td>6 (60%)</td>
<td>4 (40%)</td>
</tr>
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</table>

### Denial Rate

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

Average denial rate for 2013 was 3.66% and for Q1 – Q3 of 2014 is 3.45%.