Ventura County MediCal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)

Regular Meeting
Monday, January 22, 2018, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

OATH OF OFFICE

ROLL CALL

PUBLIC COMMENT

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

Persons wishing to address VCMMCC are limited to three (3) minutes. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission.

CONSENT CALENDAR

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Special Minutes of December 4, 2017

Staff: Maddie Gutierrez, Interim Clerk of the Commission

RECOMMENDATION: Approve the minutes.

2. Additional Funding Request – Service Order 1 Etonien, LLC

RECOMMENDATION

Authorize additional funds in support of ongoing internal audit requirements.

REPORTS

3. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

PRESENTATION

4. Legislative Update

Guest: Edelstein, Gilbert, Robson & Smith

RECOMMENDATION: Accept and file.

FORMAL ACTION ITEMS

5. October/November 2017 Financials

Staff: Lyndon Turner, Interim Chief Financial Officer

RECOMMENDATION: Accept and file October /November 2017 Financials report.

6. Contract Approval – Temporary Labor Services Vendors: CareNational Healthcare Service, LLC, Crossroads Staffing Inc., Healthcare Talent, Adecco USA, Inc. RJT Compuquest Inc., TEKsystems Inc.

Staff: Jean Halsell, Human Resources Executive Director

RECOMMENDATION: Authorize the Chief Executive Officer to execute a Master Agreement for temporary services for a period of three (3) years with the following vendors and to pre-authorize any individual transaction for these services over $100,000.

CareNational Healthcare Service, LLC
Crossroads Staffing Inc.
Healthcare Talent
Adecco USA, Inc.
RJT Compuquest Inc.
TEKsystems Inc.

7. Additional Funding Request – Service/Change Order 1 - MEDHOK, Inc. Professional Services

Staff: Dr. Nancy Wharfield, Chief Medical Officer

RECOMMENDATION: Authorize additional allocation of budgeted funds in support of MedHOC Inc. Medical Management System upgrade.

REPORTS

8. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.

9. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

10. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

11. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision of Section 54956.9: Five cases

12. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Scott Campbell, General Counsel and Gold Coast Health Plan Commissioners
Unrepresented employee: Chief Executive Officer

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

OPEN SESSION

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on February 26, 2018, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

Administrative Reports relating to this agenda are available at 711 East Daily Drive, Suite #106, Camarillo, California, during normal business hours and on http://goldcoasthealthplan.org. Materials related to an agenda item submitted to the Commission after distribution of the agenda packet are available for public review during normal business hours at the office of the Clerk of the Board.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5509. Notification for accommodation must be made by the Monday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, Interim Clerk to the Commission

DATE: January 22, 2018

SUBJECT: Meeting Minutes of December 4, 2017 Special Commission Meeting

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the December 4, 2017 Special Commission Meeting minutes.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
December 4, 2017 Special Meeting Minutes

CALL TO ORDER

Commissioner Darren Lee called the meeting to order at 2:04 p.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Shawn Atin, Narcisa Egan, Laura Espinosa (arrived at 2:20p.m.), Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., Catherine Rodriguez (arrived at 2:23 p.m.), and Jennifer Swenson.

Absent: Commissioners Antonio Alatorre, Lanyard Dial, M.D., and Peter Foy.

PUBLIC COMMENT

None.

CONSENT CALENDAR

2. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of October 23, 2017

RECOMMENDATION: Approve the minutes.

3. Approval of the 2018 Ventura County Medi-Cal Managed Care Commission Meeting Calendar

RECOMMENDATION: Approve the 2018 Commission meeting calendar.

Commissioner Atin moved to approve the recommendations for Consent items 2 and 3. Commissioner Swenson seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Alatorre, Dial, Espinosa, Foy and Rodriguez.

Commissioner Lee declared the motion carried.

4. Accept and File the September 2017 Year to Date Financials

RECOMMENDATION: Accept and file September 2017 Fiscal Year to Date Financials.

DISCUSSION: Commissioner Swenson requested more claims information and/or analysis and wanted more information on why the organization is over budget on healthcare costs. Lyndon Turner, Interim Chief Financial Officer (CFO) stated initiatives were currently under way. Dale Villani, Chief Executive Officer (CEO) stated the Executive Finance Committee will be meeting monthly to address healthcare costs. The next Executive Finance Committee meeting is scheduled for January 11, 2018.

5. Approval of Contact Extension and Additional Funding for Emagined Security, Managed Security Services – Service Orders No. 1 and 4

RECOMMENDATION: Authorize the Chief Executive Officer to execute (1) an amendment to Emagined Security Service Order No. 1 to extend the term from February 1, 2018 to January 31, 2020 for on-demand information security engineering and architecture services at a not-to-exceed amount of $152,000 and (2) a new Service Order No. 4 for additional managed security operations center (SOC) services for the period of January 1, 2018 to December 31, 2018 with a 12 month renewal option and a not-to-exceed amount of $178,750 for the two year period. The total amount for the two Service Orders is $330,750.

Commissioner Atin moved to approve the recommendations for Consent items 4 and 5. Commissioner Egan seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Alatorre, Dial, Espinosa, Foy and Rodriguez.

Commissioner Lee declared the motions carried.

FORMAL ACTION ITEMS

6. Quality Improvement Committee 2017 Third Quarter Report

RECOMMENDATION: Accept and file the Quality Improvement Committee 2017 Third Quarter Report.

DISCUSSION: Dr. Nancy Wharfield, Chief Medical Officer (CMO) reviewed our MBHO's (Beacon) prior year performance as well as Quality Activities that focused on child immunizations and diabetes. The National Committee of Quality Assurance (NCQA) introduced a new HEDIS measure that will require organizations to collaborate on Health Information Exchange (HIE) activities. HEDIS measures on all data and IHA improvements were noted. The dashboard on quality was highlighted and committee reports were reviewed. Commissioner Lee congratulated Dr. Wharfield on the improvements and great progress being made.

Commissioner Swenson moved to approve the recommendation. Commissioner Egan seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Alatorre, Dial, Espinosa, Foy and Rodriguez.

Commissioner Lee declared the motion carried.

7. State of California Department of Health Care Services Contracts Amendment A25 for Capitation rates for Fiscal Year 2015-16.

Chief Executive Officer Villani requested that items 7, 8 and 9 be approved all together as they are all Department of Health Care Services (DHCS) contract amendments. Amendments 7 and 8 memorialize rates which have been used to recognize revenue for fiscal years 2015-16 and 2016-17. Amendment 9 finalizes rates used for the 2014-15 Hospital Quality Assurance Fee pass-through payments.

RECOMMENDATION: Approve and authorize the Chief Executive Officer to execute Department of Health Care Services Amendment A25.

8. State of California Department of Health Care Services Contracts Amendment A26 for Capitation rates for Fiscal Year 2016-17.

RECOMMENDATION: Approve and authorize the Chief Executive Officer to execute Department of Health Care Services Amendment A26.

9. State of California Department of Health Care Services Contracts Amendment A27 for Capitation rates for Fiscal Year 2014-15.

RECOMMENDATION: Approve and authorize the Chief Executive Officer to execute Department of Health Care Services Amendment A27.

Commissioner Swenson moved to approve the recommendations for items 7, 8 and 9. Commissioner Laba seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Alatorre, Dial, Espinosa, Foy and Rodriguez.

Commissioner Lee declared the motions carried.

10. Approval of Consulting Services Agreement and Statement of Work with TBJ Consulting for Interim Chief Diversity Officer Services

RECOMMENDATION: Approve the Consulting Services Agreement and Statement of Work with TBJ Consulting for Interim Chief Diversity Officer services.

DISCUSSION: Mr. Bagley discussed his goals as the CDO and requested an amendment to his contract to add more work hours. Currently he is contracted for twenty hours per month. He is requesting an additional 16 hours per month equaling to 36 hours per month. This can be revisited at the end of ninety days.

Commissioner Lee moved to approve the recommendation to amend the contract with TBJ Consulting by increasing the scheduled work hours to thirty six (36) hours per month. Commissioner Atin seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Alatorre, Dial, Espinosa Foy and Rodriguez.

Commissioner Lee declared the motions carried.

11. Approval of Office Sublease Agreement for 711 East Daily Drive, Suite 105 and 107, Camarillo, California

RECOMMENDATION: Authorize and direct the Chief Executive Officer to execute an agreement with NAI Capital to represent Gold Coast Health Plan as the Plan's exclusive agent for sublease of Suites 105 and 107 at 711 East Daily Drive, Camarillo, California.

DISCUSSION: Ruth Watson, Chief Operating Officer explained that the Plan's need for office space has decreased as membership projections have been revised downward, while at the same time the percentage of staff teleworking has increased. Employees working on the first floor will be moved to available space on the second floor. The landlord has agreed to allow GCHP to sublet the space with the condition that they maintain final approval of the new tenants. If the space is sublet, Gold Coast Health Plan will gain a positive cash flow of $155,000 for suite 105 and $55,000 for suite 107.

Commissioner Pawar moved to approve the recommendation to sublease. Commissioner Atin seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Laura Espinosa, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Alatorre, Dial, Foy and Rodriguez.
Commissioner Lee declared the motions carried.

Commissioner Laura Espinosa arrived to the meeting at 2:20 p.m.

12. Approval to Begin Process to Secure Additional Medi-Cal funds through an Intergovernmental Transfer (IGT)

RECOMMENDATION: Authorize and direct the Chief Executive Officer to provide the Department of Health Care Services with a proposal, including information from the funding entity, to the State of California.

Commissioner Egan has been requested to recuse herself for item 12. Commissioner Catherine Rodriguez arrived to the meeting at 2:23 p.m., she was also asked to recuse herself for item 12 at 2:24 p.m.

The meeting was recessed for a short break of three minutes.

RECONVENE TO REGULAR MEETING

The Regular Meeting reconvened at 2:27 p.m.

DISCUSSION: Chief Executive Officer Villani stated the State Department of Health Care Services IGT program application/letter of interest is due by December 14, 2017. This affects Ventura County Medical Center (VCMC). This item authorizes the CEO to provide the application packet back to DHCS and move forward with the item for obtaining 2017-18 matching funds. This is typically an annual process.

Commissioner Atin asked if there were any changes in the program. Lyndon Turner, Interim Chief Financial Officer stated the funding entity (VCMC) must use the funds for covered Medi-Cal services to members and must certify and provide data directly to the State supporting the services. The funding entity is solely responsible for the credibility of the data submitted.

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

AYES: Commissioners Shawn Atin, Laura Espinosa, Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSTAIN: Commissioners Egan and Rodriguez.

ABSENT: Commissioners Alatorre, Dial, and Foy.

Commissioner Lee declared the motions carried.

Commissioners Egan and Rodriguez returned to the meeting.

PRESENTATIONS

Commissioner Pawar recused herself from the presentation due to income she receives from AHP's affiliated company, Clinicas.

1. AmericasHealth Plan (AHP) Pilot Proposal

PowerPoint handout on file.

This item is informational only. Ruth Watson, Chief Operating Officer introduced this item. At the request of the Commission, Gold Coast Health Plan has been working in partnership with AHP to develop a pilot Plan to Plan arrangement between the two entities. COO Watson gave a brief update on the Plan to Plan project Implementation and introduced Rudy Diaz, Chief Operating Officer for AmericasHealth Plan, who presented AHP's proposal.

Mr Diaz stated that AHP's goal for the Plan to Plan pilot is to create a system of healthcare coordination to provide better health care at a lower cost and to become an integrated system of care between AHP and Clinicas. Mr. Diaz reviewed the member participant recruitment strategy as well as AHP's recommendation for the patients that would be included in the selection pool.

Commissioner Atin asked GCHP staff if the new member selection which is to be a total of 5,000 would be randomly selected from Clinicas. Mr. Diaz indicated that all of the 5,000 members would be selected from the existing CDCR membership. COO Watson added that AHP will be added to GCHP's provider directory allowing new members the opportunity to choose AHP. Family members of the selected membership can choose to move to AHP if desired. It was also noted that some members may not want to be part of the pilot program.

Mr. Diaz further stated that education of the program and member choices will be presented in the members' native language and a measurement of their understanding of the decision they will make will be implemented. Member choice will include behavioral health providers. The selection process will be random. Members will benefit through a fully integrated health care system.

Commissioner Swenson asked for confirmation that the patient will have the choice to participate or not and how long is the pilot. COO Watson stated the pilot is approved for one year for a maximum allowable of 5,000 members and could be extended for up to an additional two years. Commissioner Atin asked if the state will have issues with this pilot. COO Watson stated GCHP has reached out to the state to seek guidance on what is needed for them to review and approve the Plan to Plan pilot arrangement. GCHP has also engaged Margaret Tatar. GCHP has worked with AHP and provided suggestions to AHP on what the membership proposal from AHP should include at a minimum. The membership proposal needs to come from AHP as part of any plan partner arrangement is membership enrollment. The state will review all material once submitted including the membership proposal.

Brandy Armenta, Compliance Officer added the State looks for full package submission. This includes the membership enrollment methodology, opt in and out, and the boilerplate. The material submitted is then reviewed by DHCS and they either approve or deny the request or deny the request and ask for additional information The State will not review the boilerplate submission until the GCHP DHCS contract amendment is executed. The original target date for GCHP to receive the DHCS contract amendment was September 2017, however it is still under review by CMS. DHCS has not issued a new date for release of the amendment to Plans but they are targeting spring 2018. In addition to the boilerplate, GCHP has provided feedback and suggestions to AHP on what needs to be incorporated into the proposal. GCHP and AHP legal teams are

currently reviewing terms within the boiler plate. Administrative DOFR responsibilities is another item planned for discussion. The shared goal was to get the proposal to the state before the end of the year however with GCHP not being in receipt of the final contract amendment the submission date is pending as DHCS was clear they would not review a boilerplate until the contract amendment between GCHP and DHCS was executed. Lastly the Plan do not want to compromise the integrity of the proposal therefore GCHP continues to work diligently on the DOFR, boilerplate and have engaged Milliman to assist in rate development.

Commissioner Pawar returned to the meeting at 2:55 p.m.

REPORTS

13. Chief Executive Officer (CEO) Update

Clerk of the Commission, Tracy Oehler has accepted another position and is leaving the organization at the end of the week. Maddie Gutierrez will take over duties temporarily while the organization is recruiting for the position.

CEO Vilani provided a brief update on Plan TNE, financials and work being done around increased control of healthcare costs, along with other items that will be discussed at the next Executive Finance Committee meeting scheduled for January 11, 2018.

CEO Vilani also provided an update on the Children's Health Insurance Program (CHIP) funding, which expired on September 30, 2017.

14. Compliance Update

Brandy Armenta, Compliance Officer stated the DHCS annual medical audit is forthcoming; corrective action plan was due in July to the Plan however Audits & Investigations has informed the Plan that it will not be available until January 2018. The DHCS contract amendment incorporated the majority of DHCS mega-rule as many new requirements go into effect beginning in January 2018. GCHP submitted deliverables including P&P's that were required by DHCS for the Mega-Reg draft contract amendment. Although the contract is still in draft form, GCHP was still required to submit final rule deliverables, which were submitted and approved. DHCS will issue additional deliverables to all Plans as they are currently working on additional deliverable requirements. This may possibly impact AmericasHealth Plan long term goals. The contract amendment with DHCS needs to be codified before the AHP Pilot/Plan to Plan begins.

Delegation Oversight is a large concern at the state level especially given recent events with SynerMed. DHCS issued a CAP to seven (7) Plans serving Medi-Cal who delegated functions to SynerMed. DHCS stressed the importance and requirements to Health Plans of their contractual obligation to conduct oversight. DHCS also emphasized Audits and Investigations will augment their existing audit tool specifically on delegation oversight. Gold Coast Health Plan currently delegates functions to various entities and conducts annual onsite audits. GCHP has issued CAP(s) to multiple delegates as well as imposed financial sanctions when necessary.

The security contract was approved earlier in the meeting, the Privacy Program is under the Compliance Department. Under this program compliance is responsible for member notification when there is a HIPAA breach. The majority of GCHP breaches are business associates. The Privacy Officer is working in collaboration with IT Security on a Risk Management. Approach for the organization.

15. Chief Operating Officer (COO) Update

COO Watson, stated that membership is down, with a net loss of 1,500 members. One of the reasons for this is a lack of re-determination. There has been noted movement of members out of the County and also some members have had an increase in income no longer qualifying for MediCal.

The regulatory metrics for claims have been met. Review of call center metrics were missed as a result of staff attrition at Conduent.

Results show an increase in the volume of provider grievances due to a change in the GCHP process. The Plan transitioned from accepting inquiries over the phone to a more rigorous process, requiring submittal to the plan in writing. This approach has resulted in increased volumes but has improved the Plan's ability to track and trend provider disputes giving more insight into the root cause of grievances.

COO Watson called the Commission's attention to three value based programs implemented by GCHP with Plan partners that are doing well. One is the district transition of care program which is a pilot program with Community Memorial Hospital and Camarillo Health Care District. The goal is to keep targeted population out of the Emergency Room and to avoid hospital readmissions whenever possible. The Asthma pilot program has signed an amendment which was renewed and is with Ventura County Public Health which incorporates education on asthma issues. Staff is also working with VCMC on the California 1115 waiver for public hospital redesign and incentives PRIME Program which is a five year grant with DHCS.

DISCUSSION: Commissioner Rodriguez asked about networking with UCLA. COO Watson stated that the Plan is reviewing the analytics and she will present information to the Executive Finance Committee that shows referral patterns, costs, member diagnoses, etc.

16. Internal Audit Updates: AB85 Auto-Assignment; Human resources and Payroll; and Accounts Payable

Lyndon Turner, Interim Chief Financial Officer introduced Marty Haisma and Will Oliver from Etonian.
Will Oliver presented results around the AB85 auto assignment audit that was requested by Commissioner Alatorre. A discussion followed amongst the Commissioners, staff, and Mr. Oliver around AB85 assignment logic. It was noted that based on the findings, Gold Coast Health Plan is in compliance with AB85 auto assignment requirements.

17. Chief Medical Officer (CMO) Update

Public Comment Cards were submitted under this item. There were four public speakers.

Dr. Rajindea Rai, Pharmacist – Agenda Item No. 17 spoke on Pharmacy Access Concerns.

Daniel Martinez – Agenda Item No. 17 spoke on concern around pharmacy reimbursement cuts under the new PBM.

Michelle Callahan – Agenda Item No. 17 spoke on Gold Coast Health Plan / Optum Rx and local pharmacies.

Kent Miles –Agenda Item No. 17 spoke on Pharmacy Concerns (provided a handout).

Commissioner Swenson thanked the pharmacists who spoke to the Commission and made several comments regarding pharmacy services. She stated there needs to be a safety net for patients. If the rates are lower yet the Plan is paying more in the contract there is a disconnect. Optum keeps adjusting pharmacy

rates to hit a target. Need to take a deeper look on how the contract is set up; there is a need for a platform of understanding.

Commissioner Atin suggested that a consultant needs to be hired as a third party to review how payments are done.

Anne Freese, PharmD, Director of Pharmacy, gave an implementation update and demonstrated the formula for generics. In June, July, August and part of September there was a rate error in the set up for generic drugs by Optum. There are seven weeks of claims that Optum is reversing to go back to the Plan. Another pricing error was found between August 4th – September 26th. This affected two hundred seventy four (274) pharmacies totaling an amount of $228,000.

Commissioner Lee stated his concern is MAC rates being changed. Dr. Freese stated the error is not a change. It is not retroactive. There was an implementation error. Brand pricing error was calculated incorrectly. The brand drug pricing error was discovered in late September. Dr. Freese stated the Optum team has gone back and done a complete audit of how the system was set up. Commissioner Lee stated this has been said before. Dr. Freese stated there are performance guarantees – some are quarterly, some annually. Once reprocessing is completed we will work with Finance to recalculate where we stand.

Drugs must be purchased at the 340B discount. Gold Coast Health Plan has to identify to the State that it has a 340B system in place. DHCS does a pharmacy efficiency analysis on price for generic drugs. They can decrease the rates they pay GCHP if we do not demonstrate appropriate efficiencies.

Mercer performs a retrospective review of our pharmacy costs and compares that to a market analysis. This information is shared with DHCS who can then reduce our rates if they conclude that we have overpaid. Commissioner Atin asked about consultants that can guide the Plan on the reasonableness of our set up.

Optum held meetings with various pharmacies and pharmacy representatives – they discussed the MAC appeals process to all they met with. They have also been providing written updates on their meetings with pharmacies to Gold Coast Health Plan.

Commissioner Pawar asked about the increase in prior authorization. Dr. Freese stated that rates differ in Optum versus ScriptCare. The number of prior authorizations has gone down.

Commissioner Swenson asked about a consultant. Legal Counsel Scott Campbell stated that the Commission needs to agendize to hire a consultant if the price is over $100,000 and the Commissioners requested CEO Villani get a consultant to review concerns of the pharmacists, payments, benchmark data in the marketplace to provide information to the Commission.

At the next meeting there should be an update on these concerns.

The meeting was recessed for a short break at 4:50 p.m.

RECONVENE TO REGULAR MEETING

The Regular Meeting reconvened at 5:00 p.m.

Chief Medical Officer Nancy Wharfield, M.D., continued her report. Regarding transgender care: DHCS has relaxed their position on cosmetic procedures for transgender members. Previously, these services were not a covered benefit. Currently, DHCS is following World Professional Association for Transgender Health

(WPATH) direction to decide the medical necessity of these services on a case by case basis We are currently waiting for new standards to be set.

Health Education provided a list of activities for the month of October.

Pauline Preciado, Clinical Strategy Execution Manager gave a Palliative Care update and stated it will be a benefit beginning January 1, 2018. This will improve member experience to facilitate the delivery of Palliative Care. Internal staff is working to identify eligible members who need this service. Staff will engage with DHCS as well as local community partnerships and work with local experts to address and build relationships with trusted providers. Staff is currently working to strengthen communication and will advocate at the DHCS level to obtain workshops for providers to define what Palliative care benefits will be.

18. Human Resource Compensation Plan

Jean Halsell, Human Resources Executive Director, and Steve Smith, with LTC Performance provided a presentation on the Plan's base compensation program. This information item is presented annually, per Plan bylaws. Executive Director Halsell discussed the Policy of Delineation of Authority and the requirement to present the salary range schedule on an annual basis as an information only item, which does not need approval.

The Plan conducts compensation analysis on an annual basis and makes adjustments on base compensation accordingly. All positions are reviewed as part of this process. This is in alignment with the organization's objective to recruit, motivate, and retain staff. Discussion was held amongst the Commissioners, staff, and Mr. Smith around the Plan's base compensation model with particular focus around the 60% market rate target. Legal Counsel Scott Campbell reminded the Commission that this item is only informational and is done yearly at the request of the Commission. The impact is delegated to the CEO and is part of the CEO's evaluation.

19. Chief Diversity Officer (CDO) Update

Chief Diversity Officer, Ted Bagley presented a PowerPoint presentation around his vision for the CDO program.

Commissioner Swenson moved to accept and file items 13 through 19. Commissioner Atin seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Laura Espinosa Michelle Laba, M.D., Darren Lee, Gagan Pawar, M.D., Catherine Rodriguez and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Alatorre, Dial, and Foy.

Commissioner Lee declared the motions carried.

Mr. Campbell announced there were several Closed Session items, one of which Commission Lee will recuse himself.

CLOSED SESSION

The Commission adjourned to Closed Session at 5:50 p.m. regarding the following items:

20. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITICATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 64956.9: Four Cases

21. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITICATION
Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: One Case

22. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

23. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Scott Campbell, General Counsel and Gold Coast Health Plan Commissioners
Unrepresented employee: Chief Executive Officer

OPEN SESSION

The Regular Meeting reconvened at 7:32 p.m.

Mr. Campbell stated there was no reportable action taken.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 7:41 p.m.

APPROVED:

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Maddie Gutierrez, Interim Clerk of the Commission

AGENDA ITEM NO. 2

TO: Gold Coast Health Plan Commission

FROM: Lyndon Turner, Interim Chief Financial Officer

DATE: January 22, 2018

SUBJECT: Additional Funding Request, – Service Order 1, – Etonien LLC.

SUMMARY:

Etonien LLC. is the current vendor of the Plans internal audit services. Etonien has been performing these services since July of 2015 and has consistently delivered high quality internal audits. The current agreement expires on June 30, 2018 and due to increased demand for auditing services, the agreement requires additional funding approval.

FISCAL IMPACT:

The agreement is a non-requirements contract which allows the Plan to use the services ad-hoc at the rates specified. The agreement can be terminated for convenience at any time with a fifteen (15) day notice. The rates are hourly per the identified skill set. In June of 2017, the Plan executed a one year contract renewal with Etonien and projected the annual spend to be $120,000. Due to expanded scope of the audit program, the revised projection is $190,000, or an increase of $70,000. Prior cumulative contract approval was projected to be $322,645. The revised cumulative amount of this agreement will be, $392,645.

Etonien Service Order 1	Dollars Approved and Requested	Budgeted
Prior cumulative approved amount	$322,645.00	Yes
Requested amount	$70,000.00	Yes
Revised cumulative amount	$392,645.00	Yes

RECOMMENDATION:

It is the Plan's recommendation to authorize these additional funds in support of ongoing internal audit requirements.

If the Commission desires to review this contract, it's available at GCHP's Finance Department.

AGENDA ITEM NO. 3

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, Chief Executive Officer

DATE: January 22, 2018

SUBJECT: Chief Executive Officer Update

Welcome to Supervisor Kelly Long, Ventura County District 3! Supervisor Long joins the Ventura County Managed Care Medi-Cal Commission replacing Supervisor Peter Foy who is now chair of Ventura County Board of Supervisors.

We are working on changing our current Commission Packet design in order to provide the most useful and timely information on Plan performance. You will begin seeing gradual changes at future commission meetings.

As we close calendar year 2017 and move into 2018 the Plan recognizes the significant accomplishments made by our team to improve the health and wellbeing of our members and the community. Noteworthy highlights are provided below.

Look Back - 2017 Highlights

- Removal of DHCS financial CAP
- TNE levels at commission approved range
- Disease Management texting pilot
- Hosted Opioid Policy Forum
- 30% growth in provider network; 40% growth in tertiary care hospitals
- Optum PBM Contract award and implementation
- Inovalon HEDIS vendor contract implementation
- HEDIS measures and member quality improvement results
- Launched pilot discussions with AmericasHealth Plan (AHP)
- $1.5M community health investment grants awarded to 16 local agencies
- Congresswoman Julia Brownley visit
- Strategic planning → three year plan
- Community Resource Fairs and outreach activities
- DiSC Personal Assessment tool to improve staff communication/collaboration
- Adaptive Insights, centralized budget system successfully implemented

Thomas Fires. The fires and subsequent mudslides that struck the Ventura and Santa Barbara county areas taxed the resources of our counties but not the resolve of our citizens and local governments. At Gold Coast Health Plan a number of our staff were directly impacted by the evacuations but thankfully everyone was safe. Our crisis response plan was activated and managed care rules were relaxed to allow members to receive prescription refills and oxygen tanks without prior approval. We are proud of the staff who worked to ensure members care was not disrupted even through evacuations of many of our senior members from area nursing and assisted living facilities. Our teams deployed to the Ventura County Fairgrounds evacuation center to ensure members had immediate access to physical and behavioral health support and information.

PBM Consultant Selected – Excelsior Solutions. After a formal bid process the plan selected Excelsior Solutions to conduct a review of our PBM contract. Dr. Anne Freese will present the selection process, scope of work, and timeline for the consultant during her update.

CMS Program of All-Inclusive Care for Elderly (PACE). GCHP executives are meeting on January 29, 2018 to discuss a potential PACE program and center for Ventura County. A revision by DHCS to the PACE policy is driving an increased level of interest in the PACE program across CA and with other Medi-Cal plans. The CMS PACE program is specifically designed for the frail elderly

2017/18 Financial Performance. The plan continues to focus on financial performance and trends. For the current fiscal year (through November) YTD MLR is 97% which is above budget driven primarily by a rate variance on current contracts. ACR is 6.7% which is below budget driven by GCHP management of administrative costs. Current TNE is 441% which is within plan but trending downward. Strategies are being executed to bring medical expense and TNE in line with the budget.

Look Forward 2018 – Priorities

- Fiscal integrity and responsibility
  - MLR and ACR
  - Alternative Payment Models (APMs) -> aligning incentives
- Clinical program excellence

  - Member health, prevention and wellness
  - My*Gold*Care (Palliative Care)
- Community health and engagement
  - Social determinants and population health
  - Grants and Sponsorships
- Regulatory Compliance
  - CMS Mega Rule requirements
  - Delegation oversight
- Major projects implementation
  - Conduent new core claims system (potential change)
  - Provider credentialing tools
  - Provider data management system
- Working at GCHP
  - Employee Satisfaction and Retention
  - Diversity and Inclusion
- Explore alternative revenue sources
  - Joint ventures and partnerships
  - CMS Program of All-Inclusive Care for the Elderly (PACE)

Unknowns

- Political Landscape: 2018 CA Governor's and Congressional Mid-Term Elections
- Changes to eligibility, coverage and benefits
- Financial flexibility to invest in programs and initiatives

LEGISLATIVE UPDATE:

California State Budget FY 2018-19 Proposal:

On January 10, Governor Jerry Brown released his FY 2018-19 budget proposal. Total allocation for the California Health and Human Services Agency is $155.7 billion (the Medi-Cal program accounts for 65 percent). Recent congressional Medicaid proposals have included reductions to federal funding for the Affordable Care Act expansion population, a block grant structure for Medicaid program, and capped-pre-beneficiary allotments to states; however, it is unclear if such proposals will be re-introduced this year and approved by Congress. As such, the Budget continues to reflect existing state and federal law.

The Budget reflects an 88 percent federal share in CHIP funding until December 2017, and 65 percent as of January 1, 2018. The May revision will, at a minimum, include savings of approximately $150 million General Fund (GF) to reflect temporary federal funding authorized, in late December 2017, after the Budget was finalized.

Estimated revenues due to Proposition 56 are $1.3 billion. The Budget allocates $649.9 million in 2018-19, an increase of $232.8 million, for supplemental payments and rate increases based on those approved in the 2017 budget package. Of the increased amount, approximately $163 million is for physician payments and $70 million is for dental payments.

It is projected that the Medi-Cal program will cover nearly 13.5 million Californians in 2018-19.

Significant adjustments are as follows:

- The Budget reflects increase in expenditures of approximately $543.7 million GF. The increase is due to retroactive payments of drug rebates to the federal government and a higher estimate of Medi-Cal managed care rates.
- The state's cost-sharing ratio for the optional Medi-Cal expansion population will increase to 6 percent this year. Costs in 2018-19 are projected to be $22.9 billion (1.6 billion GF) for the 3.9 million Californians in the optional Medi-Cal expansion.
- The Budget proposes to restrict the use of federal 340B Drug Pricing reimbursements within the Medi-Cal program, effective July 1, 2019.

Children's Health Insurance Program (CHIP) Reauthorization:

The Children's Health Insurance Program (CHIP) expired on September 30, 2017. States continued to operate their programs with leftover CHIP allotment funds from fiscal year 2017. Additionally, before the December recess, Congress approved $2.85 billion in CHIP funding as part of the short-term spending bill that expires on January 19, 2018.

Congress still has to complete multiple steps to extend funding. The House has already passed a bill that would extend federal CHIP funding for five years, providing states the funding necessary to support coverage, which was over $14 billion in 2016. The Senate Finance Committee also moved legislation out of committee to extend funding for five years. Final legislation still requires passage by the full Senate, resolution of any differences between the House and Senate bills, and signature by the President.

One factor contributing to delay of continued progress to pass the five-year extension has been difficulty reaching agreement on how to offset the federal costs to extend coverage. Despite the temporary funding granted by the short-term spending bill, some states will start running out of money after January 19. In California; however, it is expected that funds will be available at least until March 2018.

In their latest analysis, the Congressional Budget Office found that a 10-year reauthorization would save the federal government $6 billion over the next decade. The development has

led to some Democrats now calling for more than a five-year reauthorization of the program, which some Republicans are also considering.

COMPLIANCE UPDATE:

DHCS Annual Medical Audit:

Audits and Investigations (A&I) conducted the annual onsite medical audit during the weeks of June 5, 2017 through June 16, 2017. Gold Coast Health Plan (GCHP) is anticipating a draft report which A&I has confirmed for a release of the report in January 2018.Staff will keep the commission apprised as GCHP receives information.

DHCS Contract Amendments:

The draft DHCS contract amendment (version 2) was sent to Plans in April of 2017. The amendment is still under review by CMS and the Plan is pending the final amendment for signature. The amendment incorporates approximately 156 Mega Reg provisions. Approximately 63 items remained TBD for the State to define and 28 items are TBD and not in the contract amendment. Additional provisions and requirements will be forthcoming via additional contract amendments, all plan letters, policy letters etc. GCHP was required to submit Final Rule (Mega Reg) deliverables to DHCS based on the draft contract amendment in May 2017.

Delegation Oversight:

Upcoming Audits Conducted CY 2018
The table below illustrates upcoming audits for January and open audits.

Delegate Name	Audit Type	Audit Date	Status
Conduent	2017 Annual Claims	April 2017	Open
Clinicas del Camino Real, Inc.	2017 Annual Claims	Novembe r 2017	Open
	2018 Credentialing	January 2018	Pending
	***Clinical: UM	Decembe r 2017 Moved to January 2018	Pending

Vision Service Plan	2017 Annual Claims	December 2017	Open
Ventura County Medical Center	2018 Credentialing	January 2018	Pending
Kaiser Health Plan	2017 Claims	December 2017 & January 2018	Open
Community Memorial Health System	2018 Credentialing	January 2018	Pending

***Pending:** Audit(s) scheduled for a future date and pre-audit letter and material sent.

****Open:** Audit is completed and results are in process.

**** CDCR Audit originally scheduled in December 2017, audit date changed due to the Thomas fire, the audit scheduled is January 2018.*

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Marlen Torres, Government Affairs and External Relations Manager

DATE: January 22, 2018

SUBJECT: January 2018 Legislative Update

RECOMMENDATION:

Accept and file.

Legislative Update
January 22, 2018

The Legislature returned from its recess on January 3, 2018. While legislators were in their districts the last several months, there was no shortage of news and intrigue in Sacramento. Since the Legislature adjourned in September, two Assemblymen have resigned their seats due to allegations of sexual harassment. Another Assemblyman resigned due to health reasons.

Meanwhile, the Senate has hired an outside law firm to investigate allegations of sexual harassment against two Senators. One of those Senators was asked by Leadership to take a leave of absence while the investigation concludes. He initially refused, but was eventually convinced to temporarily step aside when support in his own caucus began to erode. He has vowed to return on February 1, 2018 but Capitol insiders believe the results of the investigation will lead to his resignation or a vote to expel him.

The issue of sexual harassment and how the Legislature handles complaints and investigations has been the subject of at least one legislative hearing. More hearings on the subject are scheduled in January. The issue of sexual harassment will cast a dark cloud over the Legislature this year and could impact the debate on many larger unrelated policy issues. There are also rumors that more legislators will be accused of sexual harassment in the coming weeks and months, which will heighten the debate further.

2018 is the second year of the two-year Legislative Session. Bills introduced last year that failed to make it out of the first policy committee must be heard and passed out of their house of origin by the end of January. So far, there are no bills pending from last year that are of interest to Gold Coast Health Plan (GCHP), but we are monitoring these bills in case they are amended.

The deadline to introduce new bills for 2018 is February 16, 2018. At this point, there are no rumors of any major bills that could impact GCHP. However, we will be on the lookout for any legislation requiring County Organized Health Systems (COHS) to obtain a Knox Keene License, as patient advocates in Sacramento continue to push this issue.

We are also participating in discussions with health committee consultants regarding their interest in getting more health plans to participate in Covered California. They have a particular interest in getting more COHS to participate in the healthcare exchange. However, their primary focus is in underserved counties. Ventura County does not appear to be of concern to the consultants at this time.

Governor Brown released his final Proposed Budget on January 10. He is proposing a $190 billion budget with a general fund surplus of over $19 billion. In presenting the Budget,

Governor Brown urged caution despite the abundance of surplus revenue. In what has become
something of an annual warning, Governor Brown emphasized the fact that the current general fund surplus is still smaller than the general fund deficit at the height of the recession, and that 50 percent of income tax revenue comes from the volatile earnings of the top one percent of income earners. As has been the case in previous years, the Governor's Budget emphasizes saving in the State's rainy-day fund, reduction of state liabilities, and investment in the Governor's championed school funding formula.

It remains to be seen how the Legislature will react to this budget. Last month, the Chair of the Assembly Budget Committee released his own blueprint of the State Budget. In a noticeable departure from the Governor's proposal, the blueprint opted to use some of the surplus revenue to support ongoing state funding for healthcare, education, and welfare benefits. While reinvesting in these programs has been a long-term priority for Democrats in the Legislature, the Governor has a well-established track record of success on the Budget.

There were not many health care related proposals included in the Governor's proposal. Rather, the Governor urged caution when it comes to healthcare spending. Specifically, he warned that there is great uncertainty surrounding federal funding to support the health and human service program. There is no shortage of rumors coming out of Washington D.C. concerning how Congress could reduce federal funding for the Affordable Care Act (ACA) and Medicaid. At this point, the Governor's Budget reflects no changes in federal funding, but he warns that there are any number of scenarios where federal actions can blow a hole in the State Budget.

The Budget Proposal highlights the fact that Proposition 56, the voter approved increase in tobacco taxes, is expected to generate $649.9 million for supplemental medical provider payments and rate increases. $163 million will be allocated for physician payments and $70 million is earmarked for dental payments. The Governor also warns that the success of the supplemental payments in increasing the number of Medi-Cal providers, consistent with the intent of the initiative, will be closely monitored and measured. If necessary, the Governor will work with the Legislature to modify expenditures to achieve better outcomes as intended by the initiative. Another $69.4 million of Proposition 56 funds will be allocated to support new growth in the Medi-Cal program. Finally, $64.5 million in Proposition 56 funds will be used for rate increases for home health providers that provide medically necessary in-home services to
children and adults in the fee-for-service system. These rate increases will begin on July 1, 2018.

Overall, Medi-Cal costs continue to grow. Since 2012-13, General Fund spending to support the Medi-Cal program has grown approximately six percent annually to $20.1 billion in 2017-18. Spending increases are attributed to a combination of higher health care cost inflation, program expansion, and caseload growth. In the current budget year, General Fund

spending for Medi-Cal is projected to increase 11 percent, or $543.7 million, bringing the projected total to $21.6
billion. The increase is attributed primarily to retroactive payments of drug rebates to the federal government and a higher estimate of Medi-Cal managed care costs.

The only potentially controversial healthcare proposal in the Governor's Budget is a call to restrict 340B Drug Reimbursement within Medi-Cal starting July 1, 2019. The State claims the 340B program was designed to serve the uninsured, not Medi-Cal recipients. By shifting these drug purchases to the traditional pharmacy purchasing structure, the State hopes to gain more revenue in the form of rebates from drug companies. However, many clinics and hospitals rely on the 340B program to provide low cost drugs to their patients. The budget summary did not provide any projected State Budget savings generated by discounting the use of the 340B program within Medi-Cal. It is likely that this proposal will be opposed by the hospitals, clinics, and some patient groups.

The Legislature is required to pass a State Budget by June 15 in time for the start of the new fiscal year, which begins July 1. The budget committees will soon begin holding hearings to consider various elements of the Governor's Proposed Budget. However, very little action will take place until after the Governor releases the May Revise, which reflects updated budget revenue generated from April tax returns.

Throughout 2017 we closely followed the debate in Congress as to whether the ACA would be repealed or modified. Like today, there was a great concern that state funding for Medicaid services would be substantially reduced. This fear created a black cloud over the healthcare budget and policy debates in Sacramento. The Governor's January Budget proposal assumed there would be no change in federal funding, but it was still difficult to ignore the possibility that Congress could act to abolish or amend the ACA.

Among the many healthcare bills introduced in 2017 was SB 17 by Senator Hernandez. SB 17 was one of the most heavily lobbied bills in 2017. This measure requires drug manufacturers to notify specified purchasers in writing at least 90 days prior to the planned effective date, if it is increasing a drug price by more than 16 percent over a two year period. The bill also requires health plans and insurers that report rate information through the existing large and small group rate review process to also report specified information related to prescription drug pricing to the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI). These agencies would then be required to prepare a consumer-friendly report that demonstrates the overall impact of drug costs on healthcare premiums.

SB 17 was supported by labor unions and commercial health plans that are concerned with the high costs of prescription drugs and the impact they have on the overall rising costs of healthcare. The bill was strongly opposed by pharmaceutical manufacturers. Negotiations

and heavy lobbying took place all year long. Eventually, the bill passed to the Governor's desk with bipartisan support in the last days of the session.

Another bill of interest was SB 538 by Senator Monning which prohibited various contract provisions between hospitals and health plans. According to the author, his bill sought to prohibit anti-competitive contract provisions that dominant hospital systems impose on health plans to maintain market power and to inflate prices charged to consumers, workers, and employers. The bill was supported by a unique coalition of health plans, businesses, and labor unions. Hospitals opposed the bill. SB 538 passed out of the Senate but did not receive a hearing in the Assembly Health Committee. SB 538 may be pursued further in 2018.

Meanwhile, health plans and public hospitals negotiated for most of the year on a new financing mechanism required under federal regulations. The final agreement was amended into SB 171 by Senator Hernandez. The bill also establishes a medical loss ratio (MLR) of 85 percent for Medi-Cal managed care plans and requires a plan to remit any profits in excess of 15 percent. This matter will not impact COHS, as they all currently exceed this standard.

AB 205 by Assemblyman Wood was amended with language needed to comply with additional federal guidelines, including new time and distance standards to ensure network adequacy. This bill also includes new standards for plan grievances and appeals. Both bills were signed into law by the Governor.

Another bill of interest was SB 323 by Senator Mitchell, which authorizes a federally qualified health center (FQHC) or rural health clinic (RHC) to enroll as a Drug Medi-Cal (DMC) certified provider and receive reimbursement for such services. It also allows a FQHC and RHC to contract with one or more mental health plans (MHP) that contract with DHCS to provide specialty mental health (SMH) services to Medi-Cal beneficiaries. SB 323 had no opposition and received unanimous support. The Governor signed SB 323 into law.

We also watched closely AB 275 by Assemblyman Wood. The bill requires that before closing or changing its level of service, a long-term healthcare facility must provide 60 days' notice to the affected residents or their guardians and 60-day written notice to the State Long-Term Care Ombudsman. AB 275 was introduced in response to the unexpected closure of long-term care facilities on the North Coast last year. Governor Brown signed AB 275 into law earlier this year.

A bill that arose late in the session was AB 1250 by Assemblyman Jones-Sawyer. This bill prohibits a county from contracting for personal services currently or customarily performed by county employees except in narrow circumstances. The bill is sponsored by public employee labor unions and is intended to prevent counties from contracting out services just for the purpose of saving money. Counties are vigorously opposing the bill. AB 1250 is drafted so broadly that public health plans became concerned that it could jeopardize many of their service contracts with providers. While we doubt this is the intent of the bill, the

concern was heightened in the last policy committee when the author took an amendment to exclude Santa

Clara Health Plan. He took this amendment to gain the vote of a Senator from Santa Clara. Public health plans became concerned that if AB 1250 specifically excludes Santa Clara then other public health plans must be impacted by the bill. Negotiations continued until the last few days of session, but ultimately the bill stalled in the Senate. We expect that it will come back for further consideration in 2018.

Early in the year we followed closely SB 202 by Senator Dodd. This measure proposed increasing the personal needs allowance amount from $35 to $80 per month for Medi-Cal enrollees receiving care in a nursing facility or a Program of All-Inclusive Care for the Elderly (PACE) organization. Unfortunately, this bill was held in the Senate Appropriations Committee because of the potential cost to the State.

Another bill we monitored in 2017 was AB 1372 by Assemblyman Levine. This bill would permit a certified crisis stabilization unit (CSU) to provide medically necessary crisis stabilization services to individuals beyond the 24-hour limit currently in law when an individual needs inpatient psychiatric care or outpatient care and there is no bed placement readily available. The sponsors, the County Behavioral Health Directors Association of California, argued that CSUs provide a location for individuals undergoing a mental health crisis to receive short-term treatment. During an individual's time in a CSU, staff provide supportive care and attempt to secure referrals for appropriate long-term or inpatient care. The current 24-hour limitation at these facilities binds the hands of behavioral health workers, often forcing them to stop care for their patients. AB 1372 would help reduce unnecessary emergency room visits by granting CSUs more time to be able to find appropriate and effective care for their patients.

AB 1372 was supported by several counties. However, this bill received late opposition from the Department of Health Care Services (DHCS) and the California Association of Hospitals. As a result, the bill was not brought up for a final vote. Further negotiations will take place in 2018.

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Lyndon Turner, Interim Chief Financial Officer

DATE: January 22, 2018

SUBJECT: October and November 2017 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached November 2017 fiscal year-to-date (FYTD) financial statements (unaudited) of Gold Coast Health Plan ("Plan") for the Commission to accept and file. The Executive / Finance Committee did not review these financials.

BACKGROUND/DISCUSSION:

The staff has prepared the November 2017 FYTD financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Financial Highlights

Overall Performance – For the five month period ended November 30, 2017, the Plan's performance was a decrease in net assets of $9.4 million, which was $10 million higher than budget. Cost of health care was higher than budget by $31.1 million, primarily driven by higher contracted rates. The medical loss ratio increased to 97.0 percent of revenue, which was 4.4 percent higher than the budget. Administrative savings were realized through lower than projected administrative expenses. The administrative cost ratio was 0.07 percent lower than budget.

Membership – November membership of 202,667 was 1,631 members lower than budget, and 1,871 lower than October's membership of 204,538

Revenue – November FYTD net revenue was $305.1 million or $19.2 million higher than budget, On a PMPM basis, revenue was $19.41 PMPM above budget due to membership mix, with higher than expected Adult Expansion membership. October's net revenue was $74.8 million, and included AB 85 cost balance revenue.

MCO Tax – MCO tax is a pre-determined liability in accordance with Senate Bill X2-2 passed in October 2016. The Plan's MCO tax liability for FY 2018 is $89.3 million,

accrued at a rate of approximately $7.4 million per month. The second quarterly installment of MCO tax for the fiscal year is scheduled for payment in January 2018.

Health Care Costs – November FYTD health care costs were $295.8 million or $31.1 million higher than budget. The medical loss ratio (MLR) was 97 percent versus 92.6 percent for budget. October's health care costs and MLR were $72.7 million and 97.2 percent, respectively. October's results included a special AB 85 cost balance payment of $14.3 million.

Adult Expansion Population 85% Medical Loss Ratio – The Balance Sheet contains a $142 million reserve for return of potential Medi-Cal capitation revenue to the DHCS under the terms of the MLR contract language.

	Expansion Population				Classic Population
	1/1/2014 - 6/30/2015	7/1/2015 - 6/30/2016	7/1/2016 - 6/30/2017	7/1/2016 - 11/30/17	7/1/2016 - 11/30/17
	MLR Period 1	MLR Period 2	MLR Period 3	MLR Period 4	
Total Revenue	361,237,234	293,173,426	268,060,238	137,747,403	178,063,847
Total Estimated Medical Expense	206,719,452	237,729,974	234,431,483	122,251,501	173,526,213
	57.2%	81.1%	87.5%	88.8%	97.5%
Total MLR Reserve	**118,168,494**	**23,851,452**			

Administrative Expenses – For the fiscal year ended November 30, administrative costs were $20.3 million or $634 thousand below budget. As a percentage of revenue, administrative costs (or ACR) were 6.7 percent versus 7.3 percent for budget. October's administrative costs and ACR were $4.1 million and 5.4 percent, respectively.

Cash and Medi-Cal Receivable – At November 30, the Plan had $426.7 million in cash and short-term investments and $59 million in Medi-Cal Receivable for an aggregate amount of $485.8 million. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $202.8 million. For the fiscal year ended November, the State has recouped a total of $91.3 million related to AE rate overpayment.

Investment Portfolio – At November 30, 2017, the value of the investments (all short term) was $236.2 million. The portfolio included Cal Trust $51.2 million; Ventura County Investment Pool $86.2 million; LAIF CA State $63.8 million; Bonds and Commercial Paper $35 million.

RECOMMENDATION:

Staff requests that the Commission accept and file the November 2017 financial package.

CONCURRENCE:

N/A

ATTACHMENT:

November 2017 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended November 30, 2017

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Description	AUDITED FY 2015-16	AUDITED FY 2016-17	FY 2017-18 JUL - SEP 17	Oct-17	Nov-17	FYTD NOV 17	Budget Comparison Budget FYTD	Variance Fav / (Unfav)
Member Months	**2,413,136**	**2,485,202**	**613,774**	**204,538**	**202,667**	**1,020,979**	**1,023,194**	(2,215)
Revenue	**675,629,602**	**680,255,278**	**173,265,018**	**74,757,460**	**57,038,772**	**305,061,250**	**285,866,440**	19,194,810
pmpm	*279.98*	*273.72*	*282.29*	*365.49*	*281.44*	*298.79*	*279.39*	19.41
Health Care Costs	**583,149,780**	**645,931,276**	**168,295,943**	**72,669,165**	**54,812,607**	**295,777,714**	**264,666,438**	(31,111,276)
pmpm	*241.66*	*259.91*	*274.20*	*355.28*	*270.46*	*289.70*	*258.67*	(31.03)
% of Revenue	86.3%	95.0%	97.1%	97.2%	96.1%	97.0%	92.6%	-4.4%
Admin Exp	**38,256,908**	**51,176,317**	**12,381,259**	**4,073,448**	**3,842,595**	**20,297,302**	**20,931,306**	634,003
pmpm	*15.85*	*20.59*	*20.17*	*19.92*	*18.96*	*19.88*	*20.46*	0.58
% of Revenue	5.7%	7.5%	7.1%	5.4%	6.7%	6.7%	7.3%	0.7%
Non-Operating Revenue / (Expense)	**1,790,949**	**3,254,139**	**913,559**	**379,051**	**371,031**	**1,663,641**	**381,155**	1,282,486
pmpm	*0.74*	*1.31*	*1.49*	*1.85*	*1.83*	*1.63*	*0.37*	1.26
% of Revenue	0.3%	0.5%	-0.5%	-0.5%	-0.7%	-0.5%	-0.1%	-0.4%
Total Increase / (Decrease) in Unrestricted Net Assets	**56,013,863**	**(13,598,175)**	**(6,498,625)**	**(1,606,101)**	**(1,245,399)**	**(9,350,125)**	**649,852**	(9,999,977)
pmpm	*23.21*	*(5.47)*	*(10.59)*	*(7.85)*	*(6.15)*	*(9.16)*	*0.64*	(9.79)
% of Revenue	8.3%	2.0%	-3.8%	-2.1%	-2.2%	-3.1%	0.2%	3.3%
YTD								
100% TNE	25,246,284	29,231,052	29,888,218	32,302,213	30,176,111	30,176,111	29,511,872	664,239
% TNE Required	100%	100%	100%	100%	100%	100%	100%	
Minimum Required TNE	25,246,284	29,231,052	29,888,218	32,302,213	30,176,111	30,176,111	29,511,872	664,239
GCHP TNE	**155,959,127**	**142,360,951**	**135,862,326**	**134,256,225**	**133,010,826**	**133,010,826**	**143,010,803**	(9,999,977)
TNE Excess / (Deficiency)	**130,712,843**	**113,129,900**	**105,974,109**	**101,954,012**	**102,834,716**	**102,834,716**	**113,498,932**	(10,664,216)
% of Required TNE level	**618%**	**487%**	**455%**	**416%**	**441%**	**441%**	**485%**	

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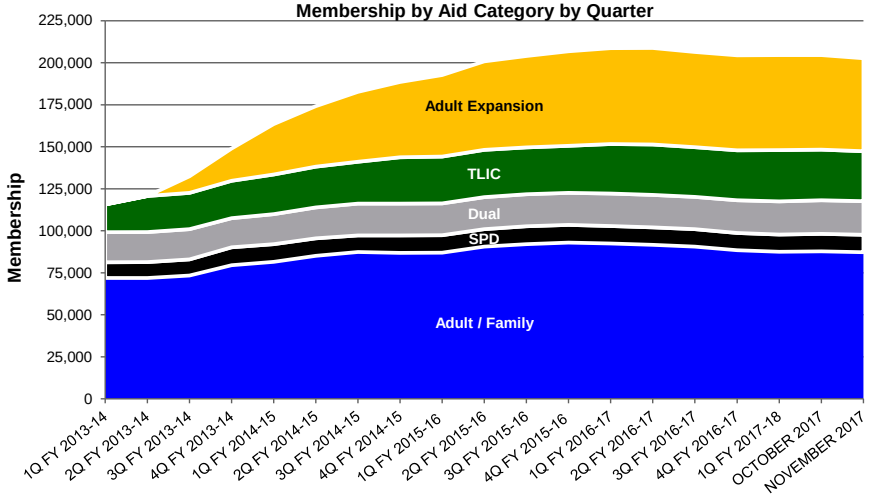
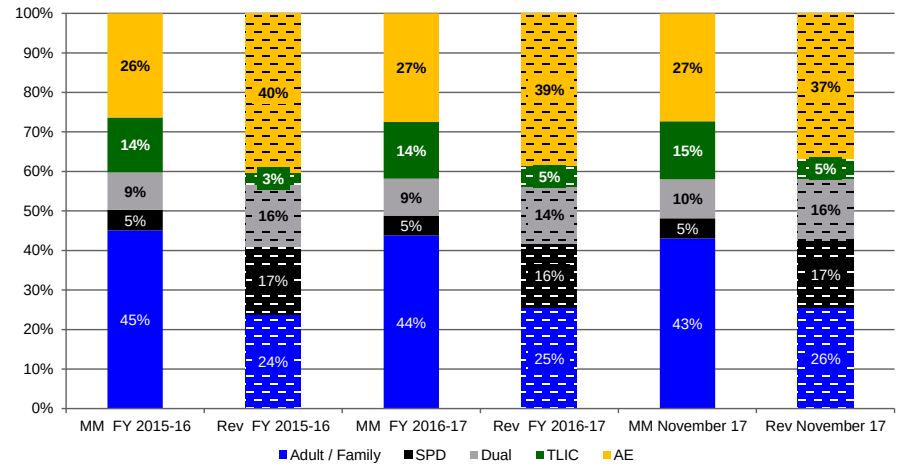
FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING NOVEMBER 30, 2017

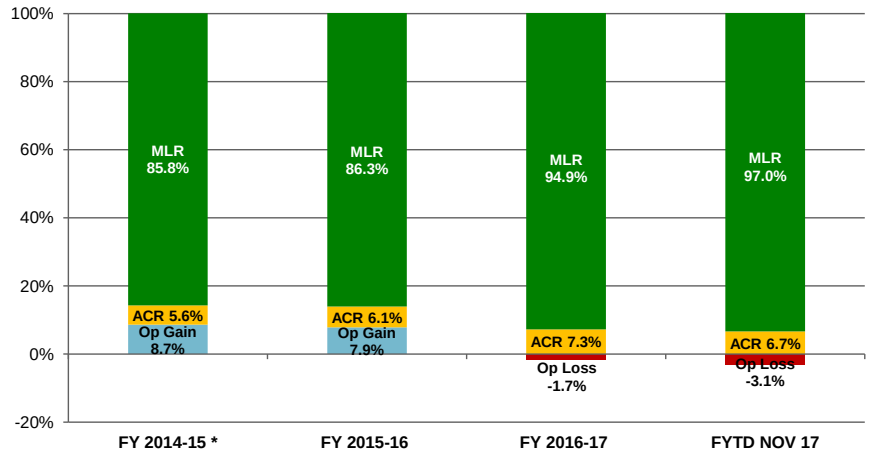
Membership and Growth
Membership by Aid Category by Quarter



Membership Mix and Revenue Impact

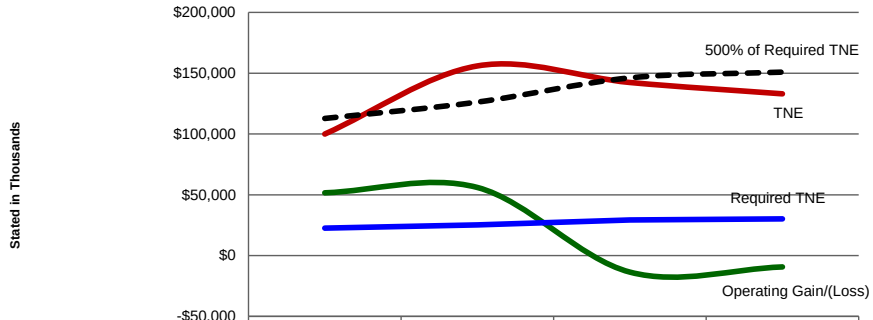


Key Performance Indicators



Note: FY 14 and FY 15 differs from Budget Presentation due to Auditors' Adjustments. Medical Loss Ratio (MLR), Administrative Cost Ratio (ACR)

Operating Gain and Tangible Net Equity



	FY 2014-15 *	FY 2015-16	FY 2016-17	FYTD NOV 2017
Operating Gain/(Loss)	$51,610	$56,014	$(13,598)	$(9,350)
TNE	$99,945	$155,959	$142,361	$133,011
Required TNE	$22,557	$25,246	$29,231	$30,176
500% of Required TNE	$112,783	$126,231	$146,155	$150,881

* FY 14 and FY 15 differs from Budget Presentation due to audit adjustments. FY 16 updated for Operating Gain and TNE Only
TNE excludes LOC ($7.2M)

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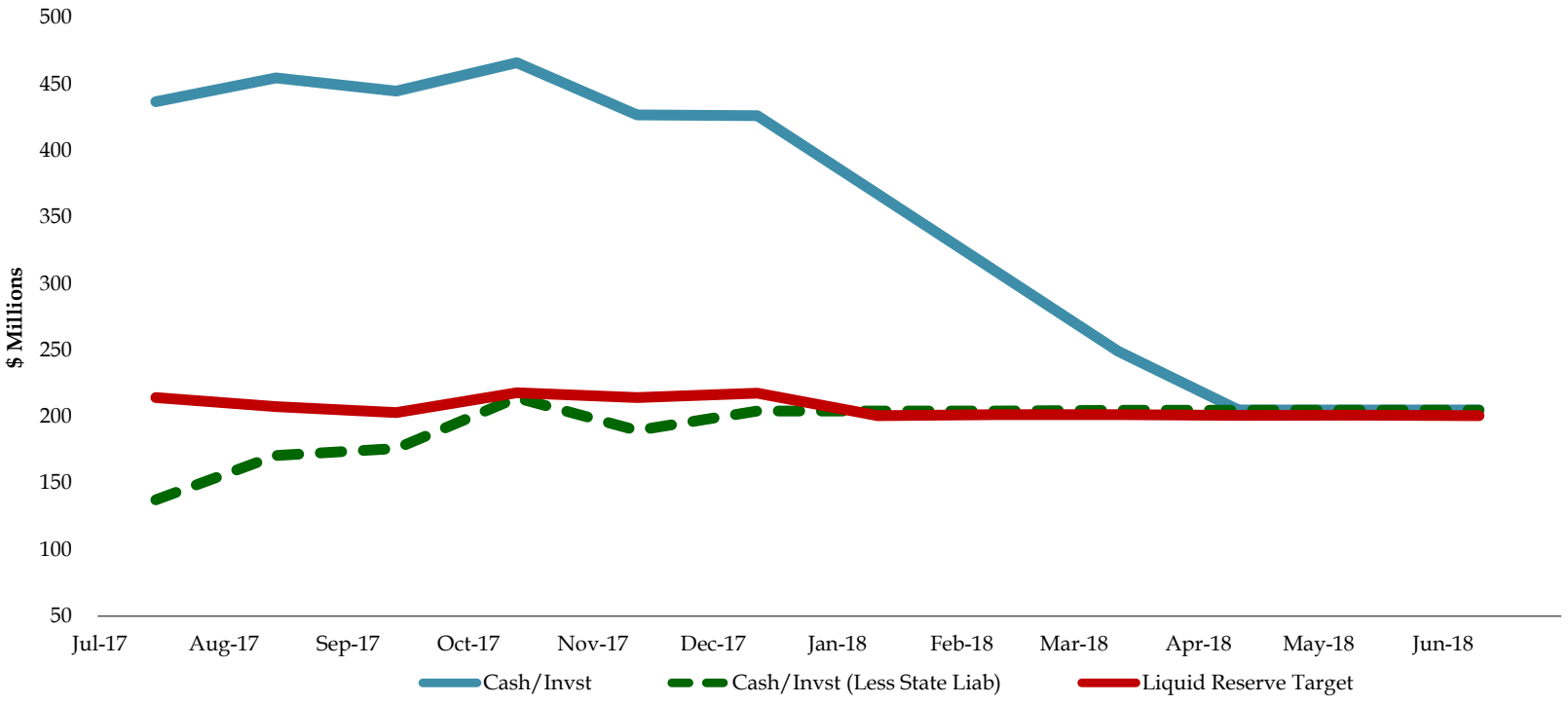
GOLD COAST HEALTH PLAN
FY 2017 - 18

Cash & Operating Expense Requirements



Assumes payback to DHCS for AE rate overpayment and MLR (85%) capitation to be completed by April 2018.

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Gold Coast Health Plan℠
A Public Entity

For the month ended November 30, 2017

APPENDIX

- Statement of Financial Position
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows
- Membership
- Paid Claims and IBNP Composition

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STATEMENT OF FINANCIAL POSITION

	11/30/17	10/31/17	09/30/17
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 190,572,563**	**$ 230,002,639**	**$ 193,796,041**
Total Short-Term Investments	**236,164,814**	**236,051,645**	**250,896,509**
Medi-Cal Receivable	59,013,523	57,388,453	92,245,791
Interest Receivable	576,773	490,150	516,998
Provider Receivable	490,091	570,999	557,467
Other Receivables	1,500,000	1,500,000	1,500,000
Total Accounts Receivable	**61,580,387**	**59,949,601**	**94,820,256**
Total Prepaid Accounts	1,604,421	1,665,727	1,614,382
Total Other Current Assets	135,560	135,560	135,560
Total Current Assets	**490,057,745**	**527,805,173**	**541,262,749**
Total Fixed Assets	**2,127,863**	**2,172,200**	**2,216,537**
Total Assets	**$ 492,185,608**	**$ 529,977,373**	**$ 543,479,286**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 49,824,137	$ 59,796,861	$ 56,345,708
Claims Payable	23,392,054	26,952,345	23,839,533
Capitation Payable	57,335,118	57,348,334	57,160,872
AB 85 Payable	0	14,314,921	0
DHCS - Reserve for Capitation Recoup	142,019,946	142,019,946	131,269,946
Accounts Payable	2,280,817	2,708,446	2,268,304
Accrued ACS	1,651,499	1,685,026	1,688,638
Accrued Expenses	64,416,257	79,311,619	112,140,057
Accrued Premium Tax	16,261,471	9,036,636	20,492,764
Accrued Payroll Expense	973,259	1,526,518	1,390,368
Total Current Liabilities	**358,154,558**	**394,700,651**	**406,596,190**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	1,020,224	1,020,497	1,020,770
Total Long-Term Liabilities	**1,020,224**	**1,020,497**	**1,020,770**
Total Liabilities	**359,174,782**	**395,721,148**	**407,616,960**
Net Assets:			
Beginning Net Assets	142,360,951	142,360,951	142,360,951
Total Increase / (Decrease in Unrestricted Net Assets)	(9,350,125)	(8,104,726)	(6,498,625)
Total Net Assets	**133,010,826**	**134,256,225**	**135,862,326**
Total Liabilities & Net Assets	**$ 492,185,608**	**$ 529,977,373**	**$ 543,479,286**

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STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR FIVE MONTHS ENDED NOVEMBER 30, 2017

	November 2017 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	1,020,979	1,023,194	(2,215)
Revenue			
Premium	$ 353,037,962	$ 325,221,233	$ 27,816,729
Reserve for Rate Reduction	$ (10,750,000)	0	(10,750,000)
MCO Premium Tax	(37,226,712)	(39,354,793)	2,128,081
Total Net Premium	**305,061,250**	**285,866,440**	**19,194,810**
Total Revenue	**305,061,250**	**285,866,440**	**19,194,810**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	26,149,033	27,062,759	913,726
FFS Claims Expenses:			
Inpatient	55,852,079	54,733,940	(1,118,138)
LTC / SNF	48,413,066	48,233,922	(179,144)
Outpatient	25,039,075	21,593,949	(3,445,125)
Laboratory and Radiology	2,274,997	1,144,183	(1,130,814)
Emergency Room	13,283,896	10,461,452	(2,822,444)
Physician Specialty	23,292,667	21,341,963	(1,950,704)
Primary Care Physician	7,434,790	6,056,078	(1,378,713)
Home & Community Based Services	6,504,077	7,598,432	1,094,354
Applied Behavior Analysis Services	3,216,574	1,952,804	(1,263,770)
Mental Health Services	2,790,669	3,894,071	1,103,401
Facility Expense AB85	14,314,921	0	(14,314,921)
Pharmacy	55,144,703	46,568,885	(8,575,818)
Other Medical Professional	1,512,403	1,999,261	486,858
Other Medical Care	12,997	0	(12,997)
Other Fee For Service	4,393,829	3,311,144	(1,082,685)
Transportation	1,050,972	611,376	(439,595)
Total Claims	264,531,715	229,501,461	(35,030,254)
Medical & Care Management Expense	4,688,056	5,861,422	1,173,366
Reinsurance	1,262,899	2,240,795	977,896
Claims Recoveries	(853,989)	0	853,989
Sub-total	5,096,966	8,102,217	3,005,251
Total Cost of Health Care	**295,777,714**	**264,666,438**	**(31,111,276)**
Contribution Margin	**9,283,536**	**21,200,002**	**(11,916,467)**
General & Administrative Expenses:			
Salaries, Wages & Employee Benefits	9,400,938	9,903,802	502,864
Training, Conference & Travel	109,379	328,273	218,894
Outside Services	10,896,990	11,523,668	626,678
Professional Services	1,509,922	1,459,942	(49,980)
Occupancy, Supplies, Insurance & Others	2,769,875	3,577,043	807,168
ARCH/Community Grants	298,254	0	(298,254)
Care Management Credit	(4,688,056)	(5,861,422)	(1,173,366)
Total G & A Expenses	**20,297,302**	**20,931,306**	**634,003**
Total Operating Gain / (Loss)	**$ (11,013,767)**	**$ 268,697**	**$ (11,282,464)**
Non Operating			
Revenues - Interest	1,663,641	381,155	1,282,486
Total Non-Operating	1,663,641	381,155	1,282,486
Total Increase / (Decrease) in Unrestricted Net Assets	**$ (9,350,125)**	**$ 649,852**	**$ (9,999,977)**
Net Assets, Beginning of Year	142,360,951		
Net Assets, End of Current Period	133,010,826		

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STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2017-18 Monthly Trend			Current Month		
	Aug 17	Sep 17	Oct 17	NOVEMBER 2017 Actual	NOVEMBER 2017 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	205,002	205,695	204,538	202,667	204,298	(1,631)
Revenue:						
Premium	$ 65,078,872	$ 65,515,904	$ 92,952,801	$ 64,484,113	$ 64,888,345	$ (404,233)
Reserve for Rate Reduction	0	0	(10,750,000)	0	0	0
MCO Premium Tax	(7,445,341)	(7,445,348)	(7,445,341)	(7,445,341)	(7,857,850)	412,510
Total Net Premium	**57,633,531**	**58,070,555**	**74,757,460**	**57,038,772**	**57,030,495**	**8,277**
Total Revenue	**57,633,531**	**58,070,555**	**74,757,460**	**57,038,772**	**57,030,495**	**8,277**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,162,964	5,195,341	5,366,499	5,227,460	5,393,841	166,381
FFS Claims Expenses:						
Inpatient	11,586,395	8,207,433	11,632,587	12,494,725	10,912,305	(1,582,420)
LTC / SNF	10,114,354	9,284,303	9,603,109	8,808,642	9,615,201	806,559
Outpatient	5,607,078	4,754,839	5,713,292	5,508,393	4,307,701	(1,200,692)
Laboratory and Radiology	350,157	322,764	768,075	401,544	228,288	(173,256)
Emergency Room	3,020,035	3,095,278	2,747,716	2,342,990	2,085,501	(257,489)
Physician Specialty	4,665,076	4,415,312	5,180,091	4,507,849	4,258,699	(249,150)
Primary Care Physician	1,302,571	1,815,495	1,434,420	1,480,044	1,208,394	(271,650)
Home & Community Based Services	1,072,894	1,489,103	1,333,942	1,529,513	1,524,306	(5,207)
Applied Behavior Analysis Services	757,729	597,717	448,868	784,599	389,527	(395,073)
Mental Health Services	426,848	480,327	637,050	581,836	776,206	194,370
Facility Expense AB85	0	0	14,314,921	0	0	0
Pharmacy	11,428,152	10,672,826	10,826,820	8,972,076	9,278,888	306,812
Other Medical Professional	294,355	266,673	351,173	313,076	399,097	86,021
Other Medical Care	6,240	0	6,757	0	0	0
Other Fee For Service	960,938	811,715	923,020	896,590	661,092	(235,498)
Transportation	247,980	174,290	308,692	172,707	121,765	(50,942)
Total Claims	51,840,803	46,388,074	66,230,534	48,794,585	45,766,970	(3,027,615)
Medical & Care Management Expense	1,015,943	945,798	913,362	950,184	1,149,544	199,360
Reinsurance	251,278	253,422	253,413	252,801	447,413	194,611
Claims Recoveries	(187,798)	(175,499)	(94,644)	(412,425)	0	412,425
Sub-total	1,079,423	1,023,721	1,072,131	790,561	1,596,957	806,396
Total Cost of Health Care	**58,083,191**	**52,607,136**	**72,669,165**	**54,812,607**	**52,757,768**	**(2,054,838)**
Contribution Margin	**(449,660)**	**5,463,419**	**2,088,295**	**2,226,165**	**4,272,727**	**(2,046,561)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	1,986,761	1,898,872	1,874,076	1,895,317	2,005,292	109,974
Training, Conference & Travel	20,631	23,568	29,532	12,926	47,309	34,383
Outside Services	2,197,098	2,179,263	2,226,128	2,194,591	2,300,813	106,223
Professional Services	391,965	335,641	286,718	186,051	280,233	94,182
Occupancy, Supplies, Insurance & Others	535,444	526,862	570,355	503,894	612,798	108,903
ARCH/Community Grants	0	0	0	0	0	0
Care Management Credit	(1,015,943)	(945,798)	(913,362)	(950,184)	(1,149,544)	(199,360)
Total G & A Expenses	**4,115,955**	**4,018,408**	**4,073,448**	**3,842,595**	**4,096,901**	**254,305**
Total Operating Gain / (Loss)	**(4,565,615)**	**1,445,011**	**(1,985,152)**	**(1,616,430)**	**175,826**	**(1,792,256)**
Non Operating:						
Revenues - Interest	282,279	328,847	379,051	371,031	76,041	294,991
Total Non-Operating	**282,279**	**328,847**	**379,051**	**371,031**	**76,041**	**294,991**
Total Increase / (Decrease) in Unrestricted Net Assets	**(4,283,336)**	**1,773,858**	**(1,606,101)**	**(1,245,399)**	**251,866**	**(1,497,265)**
Full Time Employees				**182**	**189**	**7**

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PMPM - STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

				NOVEMBER 2017		Variance
	Aug 17	Sep 17	Oct 17	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	205,002	205,695	204,538	202,667	204,298	(1,631)
Revenue:						
Premium	317.45	318.51	454.45	318.18	317.62	0.56
MCO Premium Tax	(36.32)	(36.20)	(36.40)	(36.74)	(38.46)	1.73
Total Net Premium	**281.14**	**282.31**	**365.49**	**281.44**	**279.15**	**2.29**
Total Revenue	**281.14**	**282.31**	**365.49**	**281.44**	**279.15**	**2.29**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	25.18	25.26	26.24	25.79	26.40	0.61
FFS Claims Expenses:						
Inpatient	56.52	39.90	56.87	61.65	53.41	(8.24)
LTC / SNF	49.34	45.14	46.95	43.46	47.06	3.60
Outpatient	27.35	23.12	27.93	27.18	21.09	(6.09)
Laboratory and Radiology	1.71	1.57	3.76	1.98	1.12	(0.86)
Physician ACA 1202	0.00	0.00	0.00	0.00	0.00	0.00
Emergency Room	14.73	15.05	13.43	11.56	10.21	(1.35)
Physician Specialty	22.76	21.47	25.33	22.24	20.85	(1.40)
Primary Care Physician	6.35	8.83	7.01	7.30	5.91	(1.39)
Home & Community Based Services	5.23	7.24	6.52	7.55	7.46	(0.09)
Applied Behavior Analysis Services	3.70	2.91	2.19	3.87	1.91	(1.96)
Mental Health Services	2.08	2.34	3.11	2.87	3.80	0.93
Pharmacy	55.75	51.89	52.93	44.27	45.42	1.15
Provider Reserve	0.00	0.00	0.00	0.00	0.00	0.00
Other Medical Professional	1.44	1.30	1.72	1.54	1.95	0.41
Other Medical Care	0.03	0.00	0.03	0.00	0.00	0.00
Other Fee For Service	4.69	3.95	4.51	4.42	3.24	(1.19)
Transportation	1.21	0.85	1.51	0.85	0.60	(0.26)
Total Claims	252.88	225.52	323.81	240.76	224.02	(16.74)
Medical & Care Management Expense	4.96	4.60	4.47	4.69	5.63	0.94
Reinsurance	1.23	1.23	1.24	1.25	2.19	0.94
Claims Recoveries	(0.92)	(0.85)	(0.46)	(2.03)	0.00	2.03
Sub-total	5.27	4.98	5.24	3.90	7.82	3.92
Total Cost of Health Care	283.33	255.75	355.28	270.46	**258.24**	**(12.22)**
Contribution Margin	**(2.19)**	**26.56**	**10.21**	**10.98**	**20.91**	**(9.93)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	9.69	9.23	9.16	9.35	9.82	0.46
Training, Conference & Travel	0.10	0.11	0.14	0.06	0.23	0.17
Outside Services	10.72	10.59	10.88	10.83	11.26	0.43
Professional Services	1.91	1.63	1.40	0.92	1.37	0.45
Occupancy, Supplies, Insurance & Others	2.61	2.56	2.79	2.49	3.00	0.51
ARCH/Community Grants	0.00	0.00	0.00	0.00	0.00	0.00
Care Management Credit	(4.96)	(4.60)	(4.47)	(4.69)	(5.63)	(0.94)
Total G & A Expenses	20.08	19.54	19.92	18.96	20.05	1.09
Total Operating Gain / (Loss)	(22.27)	7.03	(9.71)	(7.98)	0.86	(8.84)
Non Operating:						
Revenues - Interest	1.38	1.60	1.85	1.83	0.37	1.46
Total Non-Operating	1.38	1.60	1.85	1.83	0.37	1.46
Total Increase / (Decrease) in Unrestricted Net Assets	(20.89)	8.62	(7.85)	(6.15)	1.23	(7.38)

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STATEMENT OF CASH FLOWS	Sept 17	Oct 17	Nov 17	FYTD 17-18
Cash Flows Provided By Operating Activities				
Net Income (Loss)	1,773,858	(1,606,101)	(1,245,399)	(9,350,125)
Adjustments to reconciled net income to net cash provided by operating activities				
Depreciation on fixed assets	44,337	44,337	44,337	221,954
Amortization of discounts and premium	(22,098)	(1,449)	(16,909)	(95,607)
Changes in Operating Assets and Liabilites				-
Accounts Receivable	2,538,883	34,870,655	(1,630,786)	66,124,003
Prepaid Expenses	279,261	(51,346)	61,307	1,894,576
Accounts Payable	(21,970,428)	(7,191,110)	(30,224,970)	(83,499,282)
Claims Payable	(4,365,366)	3,300,274	(3,573,507)	531,075
MCO Tax liablity	7,445,348	(11,456,128)	7,224,835	(2,914,254)
IBNR	4,272,130	3,451,153	(9,972,724)	(3,542,210)
Net Cash Provided by Operating Activities	(10,004,074)	21,360,284	(39,333,816)	(30,629,871)
Cash Flow Provided By Investing Activities				
Proceeds from Restricted Cash & Other Assets				
Proceeds from Investments	-	-		69,000,000
Proceeds for Sales of Property, Plant and Equipment		45,000,000		45,000,000
Payments for Restricted Cash and Other Assets		-		-
Purchase of Investments	(143,607)	(30,153,687)	(96,261)	(70,611,539)
Purchase of Property and Equipment		-		(7,750)
Net Cash (Used In) Provided by Investing Activities	(143,607)	14,846,313	(96,261)	43,380,711
Cash Flow Provided By Financing Activities				
None	-	-	-	-
Net Cash Used In Financing Activities	-	-	-	-
Increase/(Decrease) in Cash and Cash Equivalents	(10,147,681)	36,206,598	(39,430,076)	12,750,840
Cash and Cash Equivalents, Beginning of Period	203,943,722	193,796,041	230,002,639	177,821,723
Cash and Cash Equivalents, End of Period	193,796,041	230,002,639	190,572,563	190,572,563
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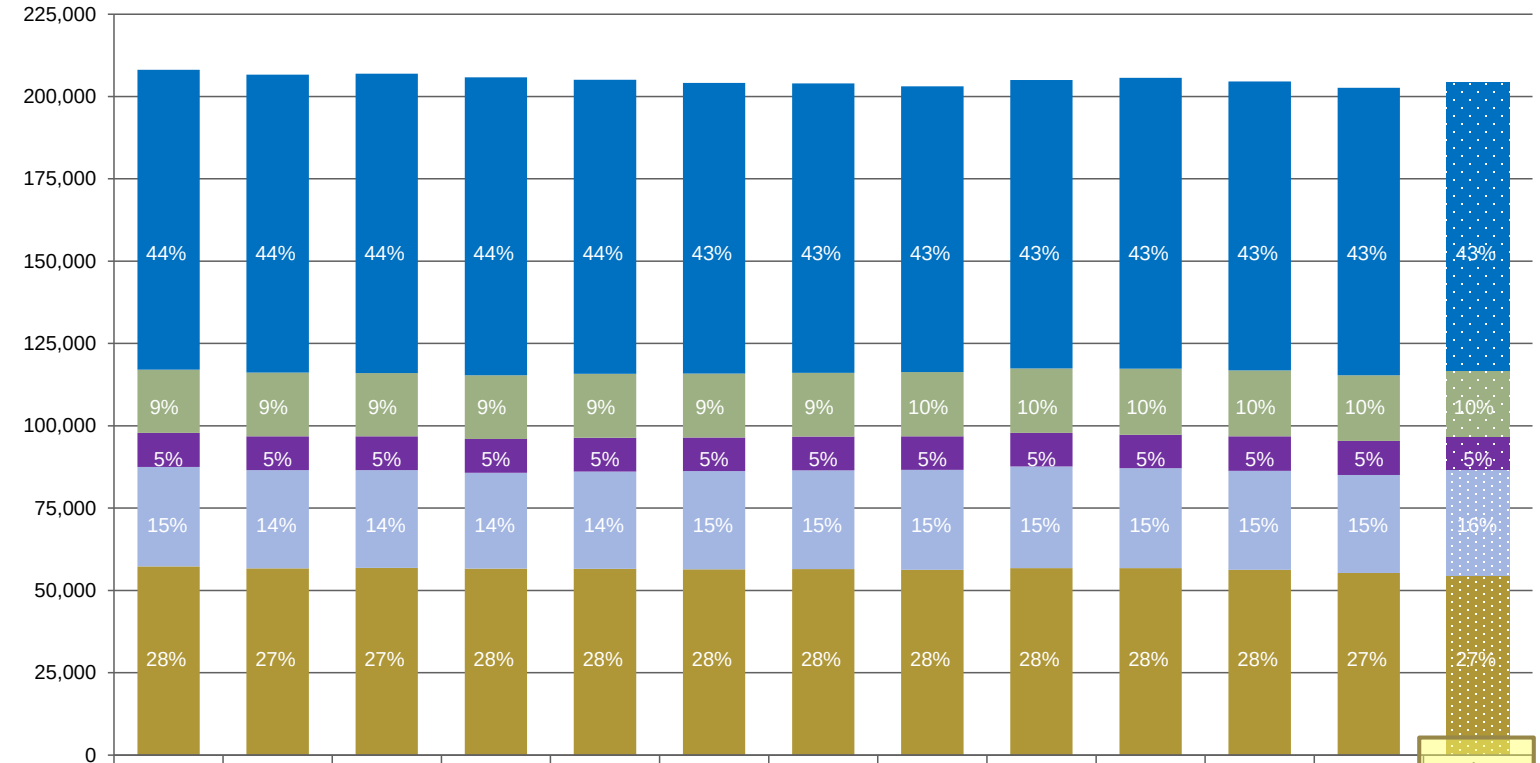
GOLD COAST HEALTH PLAN

Membership - Rolling 12 Month



	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17	JUL 17	AUG 17	SEP 17	OCT 17	NOV 17	Budget - Nov 17
Total	208,148	206,664	206,970	205,829	205,106	204,140	203,990	203,077	205,002	205,695	204,538	202,667	204,298
FAMILY	91,071	90,477	90,911	90,456	89,311	88,281	87,925	86,774	87,609	88,327	87,723	87,274	87,445
DUALS	19,250	19,352	19,213	19,329	19,401	19,375	19,321	19,448	19,573	20,105	19,995	19,996	20,165
SPD	10,282	10,246	10,321	10,326	10,319	10,219	10,236	10,215	10,150	10,125	10,477	10,317	9,816
TLIC	30,238	29,858	29,682	29,038	29,495	29,831	30,047	30,390	30,868	30,357	30,076	29,759	32,218
AE	57,307	56,731	56,843	56,680	56,580	56,434	56,461	56,250	56,802	56,781	56,267	55,321	54,654

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

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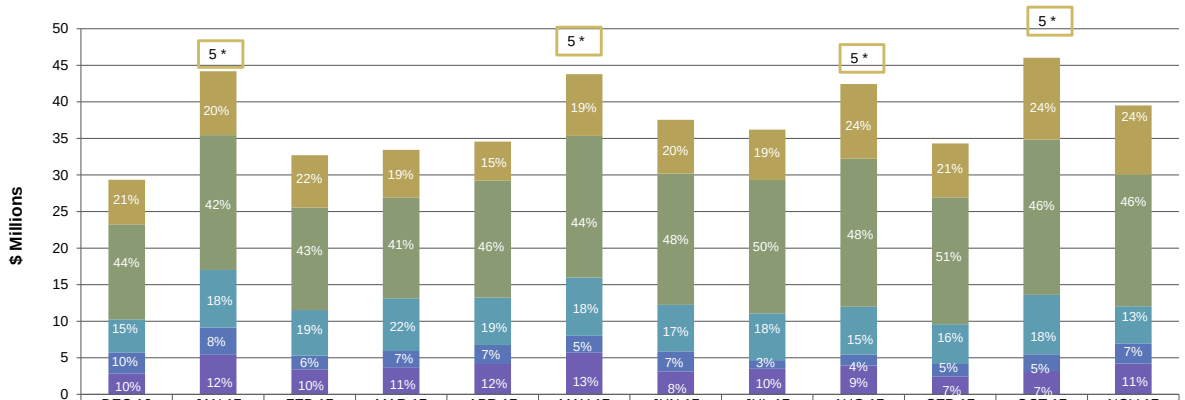
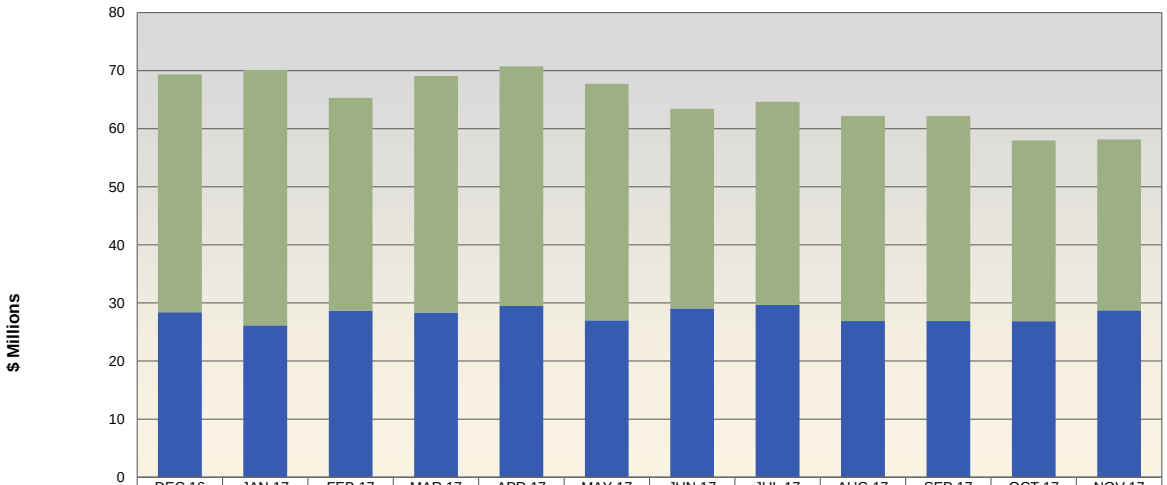
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17	JUL 17	AUG 17	SEP 17	OCT 17	NOV 17
Current	6.12	8.76	7.17	6.49	5.35	8.44	7.35	6.89	10.23	7.37	11.19	9.47
30	12.98	18.43	14.01	13.80	16.01	19.39	17.97	18.24	20.24	17.35	21.23	18.00
60	4.51	7.87	6.24	7.21	6.47	7.96	6.35	6.40	6.53	5.42	8.14	5.06
90	2.92	3.73	1.87	2.23	2.59	2.31	2.76	1.19	1.50	1.71	2.27	2.79
120+	2.82	5.42	3.42	3.70	4.16	5.69	3.13	3.49	3.95	2.45	3.19	4.19

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

IBNP Composition (excluding Pharmacy and Capitation)



	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17	JUL 17	AUG 17	SEP 17	OCT 17	NOV 17
Prior Month Unpaid	40.94	43.98	36.66	40.73	41.27	40.74	34.37	35.01	35.32	35.32	31.13	29.42
Current Month Unpaid	28.41	26.14	28.68	28.34	29.47	26.99	29.07	29.65	26.89	26.89	26.87	28.73
Total Unpaid	70.12	62.14	65.34	69.07	70.74	67.73	63.44	64.65	62.21	62.21	58.00	58.15

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

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AGENDA ITEM NO. 6

TO: Gold Coast Health Plan Commission

FROM: Jean Halsell, Executive Director, Human Resources, Human Resources

DATE: January 22, 2018

SUBJECT: Contract Approval – Temporary Labor Services Vendors: CareNational Healthcare Service, LLC, Crossroads Staffing Inc., Healthcare Talent, Adecco USA, Inc., RJT Compuquest Inc., TEKsystems Inc.

SUMMARY:

GCHP utilizes temporary services to augment full time staff during times of increased workload. Temporary help is a flexible, cost effective way to manage peak business requirements without hiring full time, long-term employees. In order to manage the process, increase our ability to acquire staff quickly and meet the business needs efficiently and cost effectively, GCHP solicited the marketplace for temporary labor services. GCHP is recommending awarding three-year contracts to several vendors for multiple disciplines utilized frequently, based on fair and open market competition.

BACKGROUND/DISCUSSION:

Leveraging the enterprise temporary labor spend, a cross functional team developed a sourcing strategy that allowed GCHP to go to the marketplace to bid on one or more sub-categories of temporary labor.

GCHP issued a formal Request For Proposal, (RFP) for clerical, medical and information technology skill sets and received twenty, (20) formal proposals from temporary labor vendors in the marketplace.

Using qualitative and quantitative evaluation factors, each proposal was scored against pre-determined factors to develop a short list of vendors for each subcategory. The Plan then finalized contractual negotiations with the each of the following short listed vendors.

Vendor	Clerical	Medical	Information Technology
CareNational Healthcare Service, LLC	X		
Crossroads Staffing Inc.	X	X	
Healthcare Talent			X
Adecco USA, Inc	X	X	X
RJT Compuquest Inc.	X	X	X
TEKsystems Inc.			X

FISCAL IMPACT:

There isn't a requirement or commitment to procure any temporary labor services. These services will be procured ad-hoc and on a per transaction basis at pre-negotiated hourly rates. The Plan projects to spend approximately $1.25M annually in temporary labor services and each individual transaction is anticipated to be included in the Plan's approved fiscal year budget, which will include an annual COLA adjustment.

RECOMMENDATION:

It is the Plan's recommendation to authorize the CEO to execute a Master Agreement For Temporary Services for a period of 3 years with the following vendors and to pre-authorize any individual transaction for these services over $100,000.

CareNational Healthcare Service, LLC
Crossroads Staffing Inc.
Healthcare Talent
Adecco USA, Inc.
RJT Compuquest Inc.
TEKsystems Inc.

If the Commission desires to review these contracts, they are available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 7

TO: Gold Coast Health Plan Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer
Melissa Scrymgeour, Chief Administrative Officer

DATE: January 22, 2018

SUBJECT: Additional Funding Request –Professional Services Statement of Work Approval – MedHOK, Inc.

SUMMARY:

MedHOK is GCHP's Medical Management System (MMS). GCHP is currently working on a project to upgrade the MedHOK MMS platform, which consists of three software modules – Utilization Management (UM), Care Management (CM), and Grievance and Appeals (G&A). In February 2017, the Commission approved the Plan's recommendation for the initial project budget, authorizing the CEO to execute the MedHOK professional services statement of work for estimated project costs of $137,500.

Unplanned regulatory initiatives and staffing constraints have extended the project schedule, therefore requiring additional funding to be allocated for project completion. It is important to note that these additional funds are included in the approved FY17/18 budget.

The Plan recommends the Commission approve allocation of the additional funds required to complete the project.

Summary of MedHOK professional services for the MedHOK v3.1 "Enhanced Upgrade":

- Set up and configure test, training and production environments
- Lead workflow and configuration design efforts for newly re-design CM module
- Support regression testing
- Provide end user training, including design and documentation of training materials, including train the trainer activities to increase efficiency of GCHP employees and have less reliance on MedHOK training support in the future.
- Ensure all existing functionality, including letters and reports continue to work in the new software
- Support go-live and provide post-implementation warranty support.

FISCAL IMPACT:

An additional $54,000 for professional services plus, as a contingency, an additional 20% of the total amount approved for the upgrade is required for project completion. These additional amounts are included in the FY17-18 budget, therefore fiscal impact is budget neutral.

MedHOK SOW	Dollars Approved and Requested	Budgeted
Prior Approved Amount	$137,500	Yes
Change Order 1 Requested Approval Amount	$54,000	Yes
20% Future Contingency	$38,300	Yes

RECOMMENDATION:

It is the Plan's recommendation to authorize the CEO to execute a change order/amendment with MedHOK Inc. in the amount of $54,000, plus as a future contingency, execute any additional change orders up to an additional 20% of the total amount approved (includes prior approved amount and requested amount) for this project.

If the Commission desires to review this contract, it's available at GCHP's Finance Department.

Approved:		
Continued:		
Denied:		

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: 1-22-2018

SUBJECT: Chief Operating Officer Update

OPERATIONS UPDATE

Membership Update

As of January 1, 2018, Gold Coast Health Plan's (GCHP's) total membership is 197,495. The Plan experienced the largest membership decrease in the past 12 months, 9,189 members. The Plan had a total new membership of 5808 leaving a net loss of 3,881 members over the previous month.

GCHP is working with the County to determine the cause of this significant disenrollment from the plan. We expect that redeterminations, a better economy and people leaving the county will drive the decrease.

AB 85 Auto Assignment- GCHP assigned 451 new members to VCMC, while the remaining 451 new members were assigned to providers in compliance with the VCMMCC Auto Assignment policy (MS-005) for January. VCMC has 28,795 AE members assigned as of January 1, 2018. VCMC's target enrollment, as established by DHCS, is 65,765 and is currently at 43.78% of the target.

Operations Dashboard Monthly Volumes- January 2018	
	Volume
Membership:	
Total	**197,495**
Gain/Loss	**<3881>**
AB-85	
VCMC	**451**
Remaining Providers	**451**
VCMC Target	**67,765**
VCMC % of Target	**43.78%**

Claims Update

Claims Inventory Results - Claims Inventory for December is 157,043 averaging 7,852 claims received per day. This equates to a Days Receipt on Hand (DROH) of 2.98 days in December compared to a DROH maximum goal of 5 days.

Operations Dashboard Monthly Volumes- December 2017	
	Volume
Claim Volume	
Total	**157,043**
Daily Average Receipt	**7,852**

Claims Processing Results – GCHP has three (3) several Service Level Agreements (SLAs) in place with Conduent to ensure that claims processed meet the minimum state and generally accepted service levels for claim processing.

Conduent met all three (3) SLAs in the month of December 2017.

Operations Dashboard Key Performance Metrics (December 2017)		
	Actual	Benchmark
Claims Processing:		
Turn Around Time	99.76%	90.00%
Financial Accuracy	99.77%	98.00%
Procedural Accuracy	99.65%	97.00%

Encounter Update

Encounter Data Quality Summary– GCHP collects monthly encounter data, which we submit to DHCS. These data determine, in part, the rates GCHP receives from the state to manage member care. GCHP measures three (3) aspects of encounter data on a monthly and quarterly basis:

- **Submitted** – the total number of encounter records submitted to GCHP each month.
- **Errors** – the total number of encounters submitted with invalid data such as formatting, errors, utilization of out of date coding or missing data.
- **Percent of Errors** – the number of errors divided by the total number of encounters submitted.

Operations Dashboard Monthly Volumes- December 2017		
Encounter Type	**Errors**	**% of Errors**
Professional	3,201	2.10%
Institutional	741	0.90%
Pharmacy	316	0.20%
Total	**4,258**	**1.10%**

Reasons for the errors include:

- Not Valid code
- Duplicate encounter
- No Medi-Cal eligibility

Call Center Update

Call Center Volume – Conduent received 9,685 calls from GCHP members and providers in the month of December. This is a decrease in call volume from November of 2,498 call. December is the first month call volume is under 10,000 calls in a month since January 2017.

Operations Dashboard Monthly Volumes- December 2017	
	Volume
Call Volume	9,685 calls

Call Center Performance - GCHP has three (3) SLAs that measure Conduent's call center efficacy on a monthly basis. Conduent met all three (3) SLAs in the month of December 2017.

Operations Dashboard Key Performance Metrics (December 2017)		
	Actual	Benchmark
Call Center:		
Average Speed To Answer	19.49 sec	30 sec
Abandonment Rate	0.87%	5.00%
Call Quality Scores	95.67%	95.00%

Grievance and Appeals Update

GCHP received eight (8) clinical appeals for the month of November. Six (6) were Upheld, two (2) Overturned. During November, one (1) State Fair Hearing case was reported and dismissed.

GCHP received 13 member grievances and 146 provider grievances in the month of November. Member grievances equate to 0.06 grievances per 1,000 members, a slight decrease from the previous month.

Operations Dashboard Monthly Volumes- November 2017	
	Volume
Grievance and Appeals (Issue Type):	
Billing	2
Quality of Care	10
Quality of Service	1

GCHP received 10 Quality of Care member grievances, which consisted of the following issues:

- Delay of Care
- Poor provider/staff attitude
- Inappropriate provider care

GCHP measures the response times for several Grievance and Appeals Categories. The response times for November are:

Operations Dashboard Key Performance Metrics (November 2017)		
	Actual	Benchmark
Grievance and Appeals:		
Grievance Acknowledgement	70.00%	100.00%
Appeal Acknowledgement	99.00%	100.00%
Grievance Resolution	100.00%	100.00%
Appeal Resolution	100.00%	100.00%

The mailroom process can affect the performance of the Grievance Acknowledgement rate. We are actively working to resolve any delays due to our standard mailroom process.

Noteworthy Activities - Operations continues to lead or participate in the following projects:

- ASO Transformation Project- GCHP is undertaking a significant project to determine the best next steps for transforming our processes and technology. Conduent, our current partner, has performed a national search to find a new technology that is Medicaid/Medi-Cal based with the ability to expand and grow as GCHP's business grows. The system Conduent has selected, developed by Virtual Benefit Administrators (VBA), has robust system configuration that will allow GCHP to manage various provider contracting methods, payment types, and member-specific requirements. Conduent has presented GCHP with a proposal for which we are assessing the merits to determine if the technology meets the needs of our organization. If this proposal does not meet our needs, we will pursue an RFP. This project will be a multi-year project requiring significant internal resources.
- Implementation of the "Coordination of Benefits Agreement (COBA)" project, which provides direct COB information from CMS to GCHP to process dual claims effectively, continues to be a focus.
- Operations continues to work cross-departmentally to launch the new My Gold Care palliative care program.
- The 2018 HEDIS audit continues to a focus for operations collaboratively with Compliance and QI.
- Operations continues to meet the state requirements for submission of the 274-provider file by the 10th of each month successfully.

NETWORK UPDATE DECEMBER 2017

A. KEY PROJECTS:

➢ **MANAGED CARE PROVIDER DATA IMPROVEMENT PROJECT (MCPDIP) 274-UPDATE**

- GCHP is submitting monthly files timely to the state. GCHP continues to meet changing regulatory requirements for this initiative.

➢ **SB 137 PROVIDER DIRECTORIES**

- GCHP is **one month ahead of schedule** in meeting production requirements.
- GCHP will be in full compliance with the Final Rule Amendment, which is expected to be signed this month.

- **APL-18-XXX- NETWORK CERTIFICATION REQUIREMENTS**

  - Received new draft APL 18-XXX from DHCS on 12/28/17.

  - With new standards for all Medi-Cal Managed Care Plans regarding new Annual Network certification, other network reporting requirements and associated network adequacy standards.

  - The implementation of this new APL requires
    - Reprioritization of existing projects and resource analysis needed
    - Gap analysis
    - Requirements development
    - Testing, approval and implementation
    - Revision to Policies and Procedures

  - Full compliance and submission of Network Certification report is due March 15, 2018.

- **APL-17-019 Provider Credentialing and Enrollment**
  - On 11/4/2017 DHCS issued new responsibilities for the Medi-Cal Managed Care Plans regarding the screening and enrollment of all network providers.

PROVIDER ADDS AND TERMINATIONS DECEMBER 2017

A. ADDITIONS:

PROVIDER TYPE	# PROVIDER ADDS DEC 2017	TOTAL PROVIDER ADDS July-Dec 2017	TOTAL NETWORK PROVIDERS
Hospital	**0**	**11**	**33**
-Acute Care	0	0	19
-LTAC	0	10	9
-Tertiary	0	1	5
Providers	**48**	**749**	**6,004**
-PCP's & Midlevels	5	47	428
-Specialists	43	690	5273
-Hospitalists	0	12	303
Ancillary	**0**	**0**	**455**
-ASC	0	0	8
-CBAS	0	0	6
-DME	0	2	108
-Home Health	0	0	33
-Hospice	0	2	21
-Laboratory	0	0	67
-Optometry	0	0	32
-OT/PT/ST	0	2	79
-Radiology/Imaging		0	29
Pharmacy	**3**	**3**	**834**
SNF/LTC/CLF	**0**	**0**	**76**
Behavioral Health	**21**	**38**	**326**

B. TERMINATIONS:

PROVIDER TYPE	# PROVIDER TERMS DEC 2017	TOTAL PROVIDER TERMS July-Dec 2017	COMMENTS
Hospital	**0**	**0**	---
-Acute Care	0	0	---
-LTAC	0	0	---
-Tertiary	0	0	---
Providers	**12**	**102**	---
-PCP's & Midlevels	2	29	No major impact
-Specialists	6	49	No major impact
-Hospitalists	4	24	No major impact
Ancillary	**0**	**5**	No major impact
-ASC	0	1	No major impact
-CBAS	0	0	---
-DME	0	3	No major impact
-Home Health	0	0	---
-Hospice	0	1	No major impact
-Laboratory	0	0	---
-Optometry	0	0	---
-OT/PT/ST	0	0	---
-Radiology/Imaging	0	0	---
Pharmacy	**0**	**21**	No major impact. Terms result of wrong Pharmacy submissions by Optum
SNF/LTC/CLF	**0**	**0**	---
Behavioral Health	**6**	**17**	No major impact

- Working with VCMC on establishing a contract under PRIME Alternative Payment Methodology Initiative. Focus on HEDIS Diabetes HbA1C > 9% screenings and reductions to achieve 10% improvement in their aggregate clinic HEDIS scores in this area.

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: January 22, 2018

SUBJECT: Chief Medical Officer Update

PHARMACY BENEFIT PERFORMANCE AND TRENDS

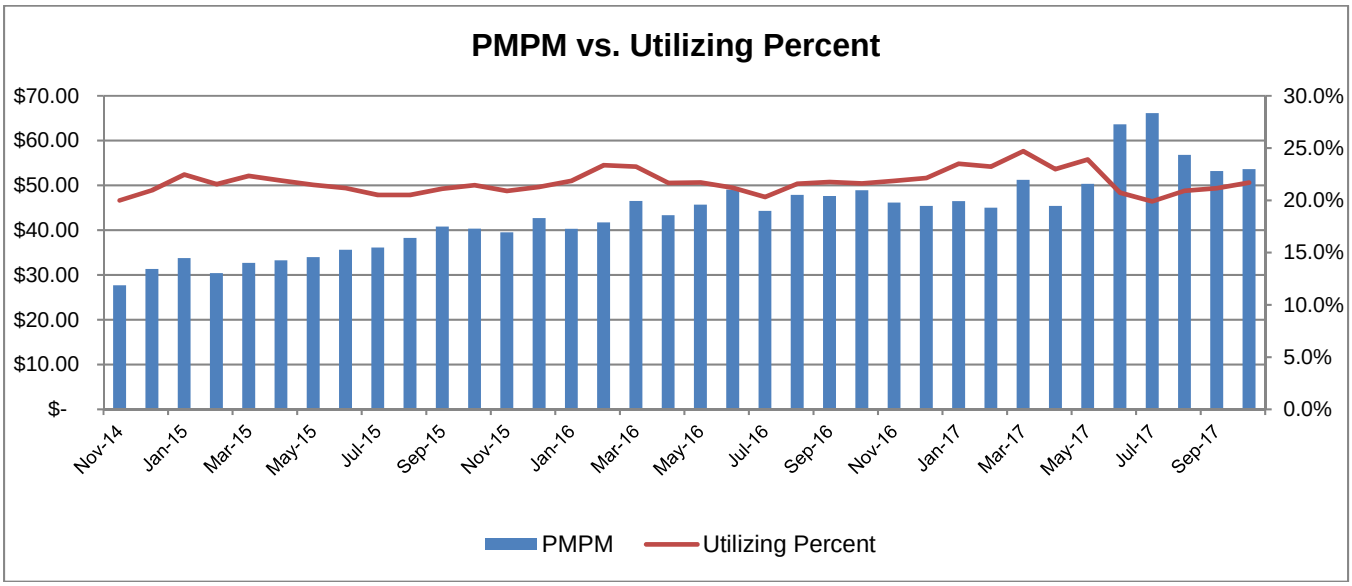
SUMMARY:
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of October 2017. Although minor changes may occur to the data going forward due to the potential of claim adjustments from audits and/or member reimbursement requests, the data is generally considered complete due to point of sale processing of pharmacy data.

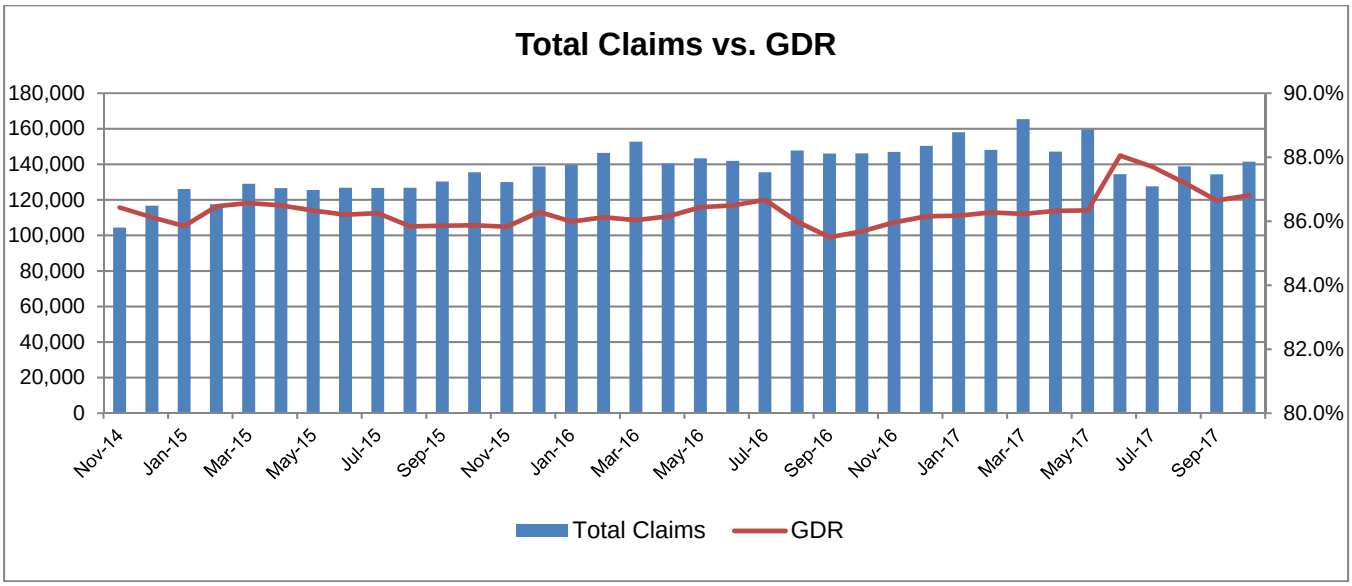
Verbal updates will be provided on the following items:

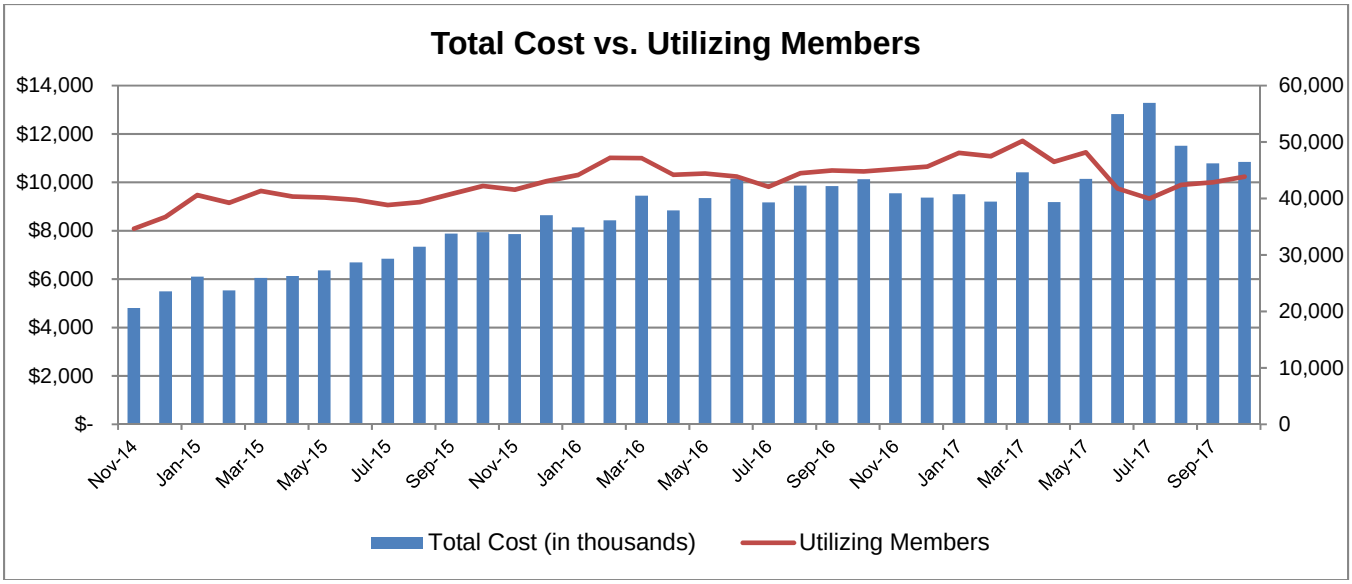
- Kaiser pharmacies
- 340B eligible drugs claims
- Pharmacy reimbursement
- Pharmacy consultant

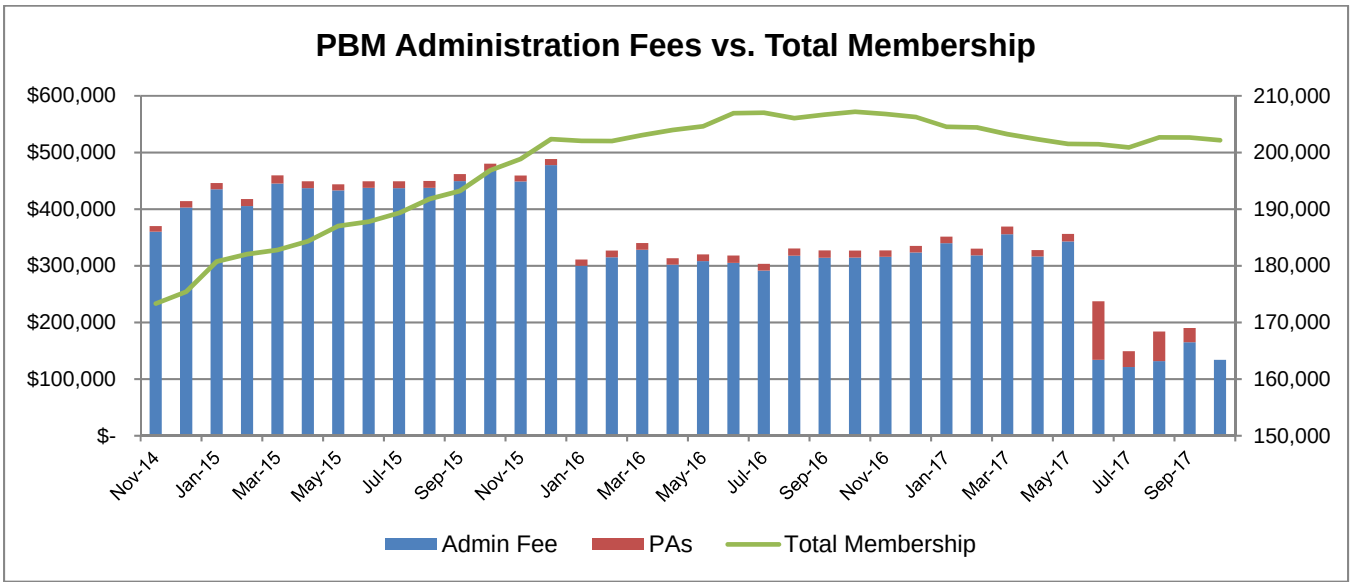
Abbreviation Key:
PMPM: Per member per month
PUPM: Per utilizer per month
GDR: Generic dispensing rate
PA: Prior authorization

PHARMACY COST TRENDS:

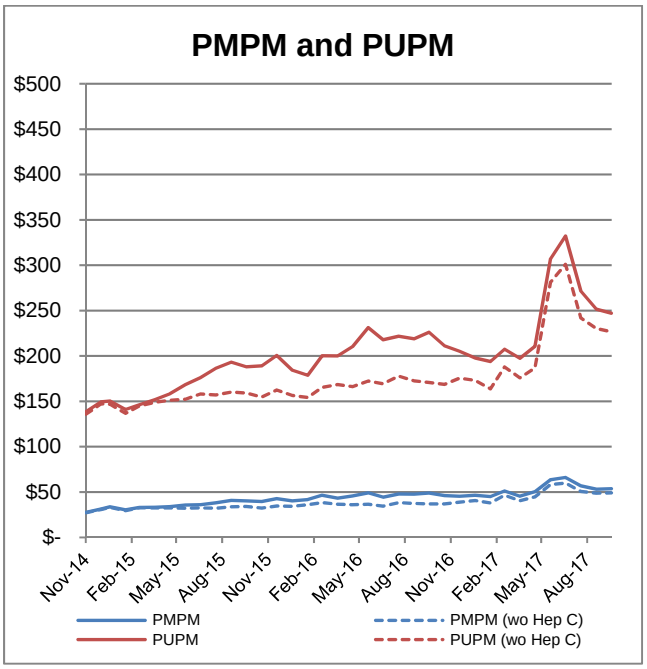


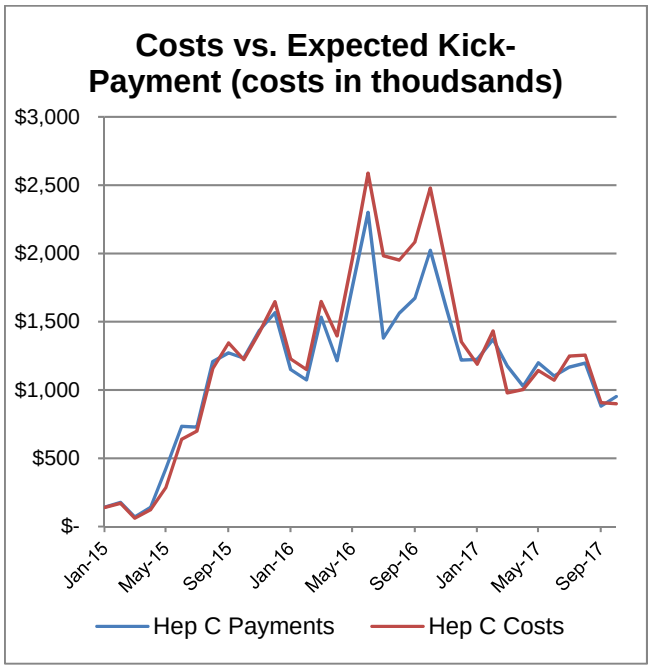



Total Cost vs. Utilizing Members
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
60,000
50,000
40,000
30,000
20,000
10,000
0
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Total Cost (in thousands)
Utilizing Members


PBM Administration Fees vs. Total Membership
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
210,000
200,000
190,000
180,000
170,000
160,000
150,000
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Admin Fee
PAs
Total Membership

HEPATITIS C FOCUS:





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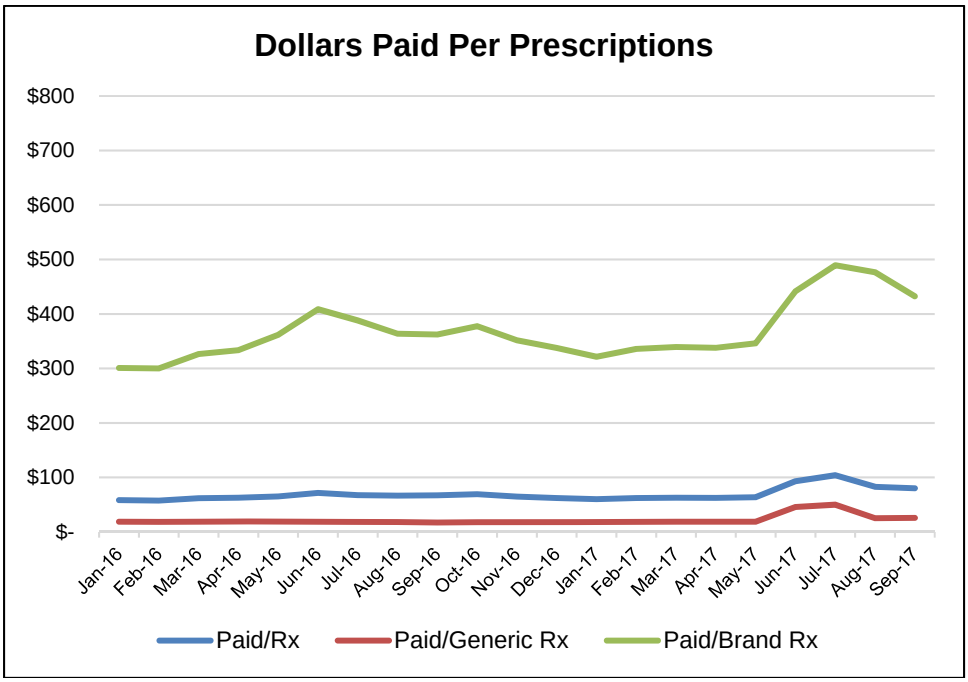

AGENDA ITEM NO.10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: January 22, 2018

SUBJECT: Interim Chief Diversity Officer Update

Community Relations

Met with several members of the commission to discuss direction and diversity philosophy. Key directions includes but are not limited to partnering with current internal GCHP staff to create positive diversity environment with an outcome target of reduced litigation, and a more trained and participative leadership team. Also met with each of the senior GCHP Leadership team to discuss diversity concerns, training and development and how we work together going forward.

- Retention
- Decreased turnover costs
- Positive working environment
- Productive workplace
- Team development

Met with leaders from LULAC, NAACP, California State University Channel Islands, and the Gold Coast Veterans Foundation to establish our presence in the community and develop dialogue for future reference.

Development of Diversity Strategic Plan

Plan will include mission, vision, council development, charter for the council, membership roles and responsibilities and meeting schedule.

Training Plan

In partnering with HR and Legal, develop a training plan for everyone in a key leadership role.

- Proper documentation
- Having difficult discussions
- Effective appraisal delivery

Case Investigations

Accumulated data related to active cases within GCHP in preparation for effective response to requesting agencies. All data was submitted to legal for final response to requesting agencies.

Next Commission Meeting (February)

- Formal presentation of Diversity Strategic Plan