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

Regular Meeting
Monday, May 21, 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

ROLL CALL

CONSENT CALENDAR

1. **Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of April 23, 2018**

   Staff: Maddie Gutierrez, Clerk of the Commission

   RECOMMENDATION: Approve the minutes.

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.

CLOSED SESSION

2. **Pharmacy Benefit Manager (PBM) Report – Excelsior Solution**
   Discussion will concern: Rates for the PBM program
   Estimated date of public disclosure: Three years from implementation of PBM contract.

3. **CONFERENCE WITH LEGAL COUNSEL- ANTICIPATED LITIGATION**
   Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: One case.

4. CONFERENCE WITH LEGAL COUNSEL-ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: Unknown number of cases.

RECONVENE TO OPEN SESSION

REPORTS

5. Chief Executive Officer (CEO) Report

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Accept and file the report.

CONSENT CALENDAR

6. MedHOK Contract Renewal

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Melissa Scrymgeour, Chief Administrative Officer

RECOMMENDATION: Approve the contract renewal.

7. Edifecs Core Renewal

Staff: Melissa Scrymgeour, Chief Administrative Officer

RECOMMENDATION: Approve the renewal.

8. Foothills Consulting Contract Resources Extension

Staff: Melissa Scrymgeour, Chief Administrative Officer

RECOMMENDATION: Approve the extension.

FORMAL ACTION

9. March Financials Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Accept and file the financials report.

REPORTS

10. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report.

11. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.

12. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATIONS
Title: Chief Executive Officer
Title: Interim Chief Diversity Officer

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OPEN SESSION

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on June 25, 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, Clerk to the Commission

DATE: May 21, 2018

SUBJECT: Meeting Minutes of April 23, 2018 Regular Commission Meeting

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the April 23, 2018 Regular Commission Meeting minutes.

Ventura County Medi-Cal Managed Care Commission
(VCMMCC)
dba Gold Coast Health Plan (GCHP)
April 23, 2018 Regular Meeting Minutes

CALL TO ORDER

Commissioner Antonio Alatorre called the meeting to order at 2:02 p.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Alatorre stated the Pledge of Allegiance would be skipped at this meeting due to the amount of items on the agenda and time constraints.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa (arrived at 2:14 p.m.), Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Absent: Commissioners Debra Herwaldt and Kelly Long.

PUBLIC COMMENT

Dr. Sandra Aldana noted a correction to the minutes of February 26, 2018. She stated the correction was her title and organization she represented. Her title change is "Member At Large". She represents the "State Council on Developmental Disabilities". Correction to the minutes has been noted.

Commissioner Laura Espinosa arrived at 2:14 p.m.

CONSENT CALENDAR

1. **Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of February 26, 2018.**

   RECOMMENDATION: Approve the minutes.

Commissioner Atin moved to accept and file Agenda Item No. 1. Commissioner Dial seconded.

Return to Agenda

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

2. **Contract Award Multi-Functional devices (Everbank Commercial Finance and Document Systems)**

   RECOMMENDATION: Approve the contract renewal.

Commissioner Dial moved to approve the contract renewal. Commissioner Atin seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

FORMAL ACTION ITEM

3. **Election of Chairperson and Vice Chairperson to serve two-year terms and appointment of Executive/Finance Committee.**

   RECOMMENDATION: 1) Elect a Commissioner to serve as Chairperson for a two-year term. 2) Elect a Commissioner to serve as Vice Chairperson for a two-year term. 3) Make appointments to the Executive/Finance Committee.

   DISCUSSION: Commissioner Laura Espinosa nominated Jennifer Swenson for Chair. Commissioner Swenson declined the nomination, she offered to serve as Vice Chair. Commissioner Atin nominated Commissioner Alatorre as Chair with a second from Commissioner Swenson.

Commissioner Atin motioned to elect Commissioner Alatorre as Chair and Commissioner Swenson as Vice-Chair. Commissioner Dial seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

Commissioner Atin nominated Commissioner Gill to participate in the Executive/Finance Committee. Commissioner Gill declined the nomination and in turn nominated Commissioner Narcisa Egan. Commissioner Dial seconded. Commissioner Dial nominated new Commissioner Debra Herwaldt. Commissioner Swenson seconded. Commissioner Pawar nominated Commissioner Laura Espinosa. Commissioner Gill seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

REPORT

4. Chief Executive Officer (CEO) Report

RECOMMENDATION: Accept and file.

CEO Villani welcomed new commissioners. He also introduced new Chief Financial Officer Kashina Bishop and thanked Lyndon Turner for serving as interim CFO. CEO Villani announced that the Association of Community Affiliated Plans (ACAP) has selected Marlen Torres, Manager of Government Affairs, for a policy analyst fellowship in Washington D.C.

CEO Villani announced that Agenda Item No. 7 - Program of All-Inclusive Care for the Elderly (PACE) was changed from a formal action item to informational.

CEO Villani provided high-level information on PACE, highlighting the positive impacts and opportunity for a PACE program in Ventura County to serve the frail, elderly population. The State has given local managed care plans "gate keeper authority" which means GCHP will be responsible to determine who receives letters of support for any PACE applications in Ventura County.

Meeting break at 2:23 p.m. due to audio difficulties.

RECONVENE TO REGULAR MEETING

The Regular Meeting reconvened at 2:34 p.m.

Commissioner Alatorre asked about DHCS' lengthy Medi-Cal re-certification process for providers, which takes several months. He requested that GCHP staff look into providing a system equivalent to the state for the certification of contracted providers within Ventura County and also Los Angeles County.

Chief Operating Officer Watson stated it had been discussed before and will determine what it takes for GCHP to do it, especially within the timeline of other projects. CEO Villani responded he understood the concerns and the team will review, but cannot at present time provide a full response. Commissioner Alatorre stated he would like for GCHP to see what it would take to bring this process in house. Brandy Armenta, Compliance Officer gave a summary of the requirements including outlining the 120-day timeframe and the option to enter into an LOA if the timeframe exceeds 120 days while the outcome is pending.

PUBLIC COMMENT

Dr. Sandra Aldana spoke on behalf of the State Council on Developmental Disabilities, which has a support position on AB2430.

PRESENTATION

5. Community Health Investments Update

RECOMMENDATION: Accept and files the report.

Karen Escalante-Dalton presented an update via PowerPoint presentation on GCHP's Community Health Investments Program, also referred to as GCHP's Grant-Making Program, established in 2017. The purpose of the program is to provide funding to external organizations that address the social determinants of health. Requests for Applications (RFA) were launched last April which identified and selected non-profit and government organizations that concentrated on three key determinants of health:

- Access to quality and affordable food
- Addressing the Built environment – where communities live i.e. housing, parks, transportation, anything that is physically outside of the clinical setting that impacts health
- Access to health – improving the ability for members to better utilize and take full advantage of their health benefits

Sixteen agencies were selected and over $1.5 million in grants was dispersed last fiscal year. Two grant awardees addressed the Commission with progress reports for the first 6-months of their grant programs. Mixteco Indigena Community Organizing Project (MICOP) Representatives Genevieve Flores-Jaro, Associate Director, and Juana Zaragoza, Mixtec Health Case Manager, shared two member success stories.

Tammy Glenn, Executive Director of Caregivers, also shared an update on their grant program, which allows approximately 500-600 seniors to continue living independently in their own homes while receiving assistance as needed. Ms. Glenn also shared information on two successful member cases.

Commissioner Dial motioned to accept Agenda Items No. 4 and 5. Commissioner Alatorre seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

FORMAL ACTION ITEMS

6. Consideration of and Action on three (3) items to extend Conduent contract for Administrative Services (ASO).

RECOMMENDATION:

1. Approve Conduent Contract extension for ASO Services – includes moving GCHP to a new Administrative Platform. Virtual Benefits Administrator (VBA).
2. Approve Conduent Contract Amendment for IT Services to augment GCHP IT resources during implementation of VBA.
3. Approve Implementation Budget for GCHP to move to a new Administrative Platform/VBA.

Ruth Watson, Chief Operating Officer provided background around the Conduent administrative services agreement. Conduent provides call center functions and claims processing, as well as fulfillment, enrollment, and encounter processing for the Plan. Included in these services is the core administrative processing system, IKA. COO Watson provided the Commission background around IKA and its limitations, particularly in processing Medi-Cal claims, and stressed the need to move to a new core platform. COO Watson discussed the extensive analysis staff conducted over the past year regarding various options to procure and implement a new system including full and partial insourcing, and going to bid for a new Administrative Services Organization (ASO). During the analysis, Conduent offered GCHP an option to extend the existing contract and implement a new core system – Virtual Benefits Administrator (VBA). Conduent selected VBA after an extensive procurement process. Under the new proposal, Conduent would absorb the bulk of implementation costs as well as provide GCHP with immediate reductions in monthly fees along with further fee reductions after implementation.

Commissioner Alatorre stated that in the past there had been issues with the Call Center and noted Spanish speaking staff was needed. COO Watson stated all new hires are bilingual. Commissioner Gill asked how the new system will benefit GCHP members. Rachel Lanser, VBA Representative stated that answers to member inquiries will be quicker and easier with the new platform. Commissioner Alatorre stated he was concerned that VBA did not have a footprint in California and referred back to the original Plan go-live issues with IKA, which impacted provider payments. COO Watson acknowledged that there were issues at go-live, while advising that both GCHP and Conduent are more established and have made significant strides in providing a high level of service to our members and providers. Commissioner Pawar asked about performance guarantees. COO Watson stated that performance guarantees are included in the current contract.

Commissioner Dial motioned to approve all three recommendations for Agenda Item No. 6. Commissioner Swenson seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: Commissioner Alatorre.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

Both Commissioners Alatorre and Pawar were recused at 3:46 P.M. from the PACE presentation and discussion due to conflict of interest.

PRESENTATION

7. Program of All-inclusive Care for the Elderly (PACE)

A PACE video was shown and the purpose of the program was explained. Dr. Si Franz, WelBe Chief Executive Officer, provided an overview of PACE programs in California. The program began approximately 40 years ago in San Francisco with the establishment of On Lok in the Chinese community. PACE addresses the care of frail seniors, providing integrated, high quality, compassionate care that allows them to "age-in-place." Most PACE participants have a four-year life expectancy but still live in their community. Participants in this program extend their life expectancy by one to three years. WelBe conducted a PACE feasibility study, which showed that Ventura County has a large need for this type of program.

Commissioner Atin asked if there were incentives for GCHP and if there was a time limit for parties to show an interest and participate. CEO Villani stated GCHP wants to be the contracted entity and will evaluate working with other organizations to also be a part of PACE. Commissioner Atin asked if bids will be solicited from others and how will other parties know GCHP is interested. COO Watson stated there is an 18-month application process. GCHP wants to apply with DHCS as a GCHP PACE Center. Partners must be selected by July 1, 2018. Commissioner Espinosa requested clarification on the policy letter issued by the DHCS. Commissioner Atin asked if there was a structure in place for other entities to join in and if those entities were interested they need to contact GCHP. The Plan indicated that further community engagement and education meetings would occur over the next thirty days.

PUBLIC COMMENT

Roberto Juarez, appearing on behalf of Clinicas del Camino Real, Inc. spoke on Agenda Item No. 7.

Mark Kovalik, appearing on behalf of Among Friends ADHC spoke on Agenda Item No. 7.

Katy Krul, appearing on behalf of Oxnard Family Circle spoke on Agenda Item No. 7 in order to learn more about the program.

Maria E. Meza, appearing on behalf of Oxnard Family Circle donated her time to Katy Krul to speak on Agenda Item No. 7.

Dr. Sandra Aldana, appearing on behalf of State Council on Developmental Disabilities spoke on Agenda Item No. 7.

Commissioners Alatorre and Pawar returned to the meeting at 4:43 p.m.

Commissioner Laura Espinosa left the meeting at 4:46 p.m.

FORMAL ACTION ITEM

8. January/February Financials Report

RECOMMENDATION: Accept and file the financials report.

CFO Bishop presented the January/February 2018 financials. The membership trend was reviewed. GCHP TNE was also compared to other Health Plans. A summary of the February 2018 Financial statements was reviewed and it was noted that the loss for the month of February 2018 was higher than the trend due to increased pharmacy expense.

Commissioner Atin motioned to approve the recommendation. Commissioner Dial seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

PRESENTATIONS

9. OPTUMRx Pharmacy Update

RECOMMENDATION: Accept and files the report.

Guest Speaker: Jon Mahrt, Chief Operating Officer, OptumRx

Mr. Mahrt addressed the Commission and acknowledged that errors had been made by OptumRx regarding pharmacy claim payments. He stated that GCHP has a pass-through contract with OptumRx and stated there were misconceptions around the issues. Specifically, there are no gag clauses or claw backs. The three payment error issues were due to human coding errors.

Mr. Mahrt gave a brief background on OptumRx. He stated that OptumRx has processed more than 1.3 million prescriptions and has delivered competitive prices. OptumRx conducted an internal audit in June 2016 around the GCHP prescription reimbursement processes and configuration. Commissioner Atin asked if the audit could be shared. Commissioner Pawar asked if there was a similar issue with other plans. Mr. Mahrt replied errors do happen. Commissioner Gill asked about impact on pharmacies and that if OptumRx made the error, why are they not bearing the cost of the error. Commissioner Alatorre asked why the error was not fixed after the first time or the second time. He stated there needs to be clear communication with the pharmacies. Mr. Mahrt stated the error was not caught early and it was a manual coding error. He agreed that communication with the pharmacies was not done effectively. Commissioner Alatorre stated it seemed pharmacies were not getting resolution. Mr. Mahrt stated he would reach out to independent pharmacies and get information needed to each for open communication.

Commissioner Pawar stated there was a concern about customer service, that phone calls for drug authorizations were time consuming, Mr. Mahrt stated he was not aware of that issue but will get facts and return with information. Commissioner Alatorre requested a check on appeals and pre-authorizations as well.

The meeting was recessed for a short break at 5:25 p.m.

Commissioner Theresa Cho, M.D. left the meeting at 5:28 p.m.

Commissioner Johnson Gill left the meeting at 5:31 p.m.

RECONVENE TO REGULAR MEETING

The Regular Meeting reconvened at 5:40 p.m.

10. Pharmacy Benefit Manager (PBM) Report – Excelsior Solutions

RECOMMENDATION: Accept and file report.

Guest Speakers: Ken Dowell, Pharmacy Analysis Board Chair
Kim Foerster, Vice President

Mr. Dowell presented the findings of the OptumRx reimbursement analysis via PowerPoint presentation. Hard copies were distributed to the public upon request.

Mr. Dowell stated issues submitted by Mr. Danny Martinez were not all answered as portions were out of scope for the initial engagement.

Mr. Dowell stated that pharmacy rates are being discussed all over the country. Management of prescription drug costs is a national issue.

Commissioner Atin stated he had three questions:

- Were independent pharmacies getting paid at a lower rate?
- Were independent pharmacies getting paid lower than chains?
- Does OptumRx pay at a lower rate than ScriptCare?

Mr. Dowell stated there had also been a review of PSAO language regarding the contract. The PSAO negotiates with the PBM and chains negotiate as well. The information on the comparison between ScriptCare and OptumRx will be presented at the next Commission meeting which is scheduled for May 21, 2018.

Commissioner Alatorre asked why OptumRx doesn't release changes in the MAC. He asked it the MAC is updated monthly or quarterly. Commissioner Swenson said the issue was that the MAC list changes, but can't be retroactive.

Commissioner Atin asked what the conclusions were from the analysis findings. Mr. Dowell responded that OptumRx's reimbursement rates are within market value.

PUBLIC COMMENT

Chris Platt spoke on Agenda Item No. 10.

Daniel Martinez, appearing on behalf of the CA Pharmacists' Association, spoke on Agenda Item No. 10. Mr. Martinez presented a flash-drive to be shown to the Commission but it was not compatible and therefore not viewed.

Carlos Varela spoke on Agenda Item No. 10.

James Leftwich spoke on Agenda Item No. 10.

Michelle Callahan spoke on Agenda Item No. 10.

Dr. Rajinder Rai spoke on Agenda Item No. 10.

Kent Miles spoke on Agenda Item No. 10.

CLOSED SESSION

The Commission adjourned to Closed Session at 6:20 p.m. regarding the following item:

11. REPORT INVOLVING TRADE SECRETS

Discussion will concern: rates for the PBM program.
Estimated date of public disclosure: Three years from implementation of PBM contract.

Commissioner Lanyard Dial, M.D. left the meeting at 7:14 p.m.

OPEN SESSION

The regular meeting reconvened at 7:17 p.m.

Mr. Campbell stated the reportable action:

Based on the information and analysis provided by Excelsior Solutions, the current rates are market rates and therefore no changes in pharmacy reimbursement are warranted at this time. GCHP staff will continue to work with OptumRx to hold it accountable to its contract and the provision of services under its contract.

The regular meeting ended at 7:21 p.m. due to lack of quorum.

Approved:

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Maddie Gutierrez, Clerk of the Commission

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: May 21, 2018

SUBJECT: Chief Executive Officer Update

SUMMARY: CEO verbal update. Government Affairs and Compliance updates are listed below.

California Legislative Update

Governor's May Budget Revise

On Friday, May 11, Governor Jerry Brown released the May Budget Revise (May Revise), which can be found at www.dof.ca.gov

The Governor highlighted the significant growth in Medi-Cal expenditures during his two terms in office and noted that total Medi-Cal spending has more than doubled since the 2011 Budget Act – growing from $45.5 billion ($14.7 billion GF) to $103.9 billion ($22.9 billion GF). Governor Brown continued to stress the need to keep overall expenditures in check given the possibility of a recession and on-going uncertainty in DC.

As a reminder, the May Revise only contains changes to the Governor's January Budget proposal. Any January budget proposal not addressed in the May Revise remains part of the Governor's overall budget request.

Items of interest for Gold Coast Health Plan include:

- **Mental Health Initiatives:** The May Revise provides additional resources to help counties decrease homelessness and reduce the number of mentally-ill individuals involved in the criminal justice system (both the county jails and state prisons, as well as those awaiting placement in state hospitals). At this point, there is no fiscal impact to GCHP. The available funding opportunities are for county behavioral health departments such as the Ventura County Behavioral Health Department.
- **Medi-Cal Health Expenditures:** Compared to the 2017 Budget Act, the Medi-Cal shortfall has grown to $830.5 million General Fund (GF) (an increase of $286.9 million since the Governor's Budget). The reason why is because of decreases in expected

drug rebates, managed care organization taxes, and increased spending through deferred claims. These overshadowed the offsets in managed care financing, the Hospital Quality Assurance Fee, and the Children's Health Insurance Program Re-authorization.

- **Proposition 56:** Proposition 56 was approved by the California voters to increase the excise tax rate on cigarettes and tobacco products. Under Prop. 56, a specified portion of the tobacco tax revenue is allocated to DHCS to increase payment to certain providers. The May Revise reflects a decrease of $51.6 million GF in Prop. 56 funds based on updated data on physician claims and revenues.
- **340B Program:** The May Revise does not include any additional changes to the already proposed changes to the 340B program beginning July 1, 2019. As expected, the May Revise includes estimated savings of $16.6 million GF annually beginning 2020-21.
- **Expanded Hepatitis C Treatment Clinical Guidelines:** The May Revise includes an additional $21.8 million GF for 2018-19 to authorize treatment for all patients ages 13 and above with Hepatitis C, regardless of liver fibrosis stage or co-morbidity, except for patients with a life expectancy of less than 12 months.

In terms of next steps, it is expected that the Department of Health Care Services will release trailer bill language shortly. The Assembly and Senate will work to finalize their budgets by the week of May 21. Any differences will go to the Budget Conference Committee for resolution and then the final budget will go to the Governor in time to meet the June 15 budget deadline.

Health Proposal Presented by Assembly Democrats

Assemblymember Joaquin Arambula (D-Fresno), chair of the Budget Subcommittee on Health and Human Services, Assemblymember Jim Wood (D-Santa Rosa), chair of the Health Committee, and Assemblymember Phil Ting (D-San Francisco), chair of the Budget Committee, announced a $1 billion investment to fund California's health care system through the Assembly's budget proposal. The budget proposal cleared the Assembly Subcommittee on Health and Human Services. The next step will be a review in the full Assembly Budget Committee.

By approving these actions prior to the May Revision—among the first major budget actions this year—Assembly Democrats are showing that improving the health care system is one of its key priorities.

The proposal includes:

- $300 million to provide enhanced premium assistance to low-income individuals and families enrolled in Covered California whose income is between 200%-400% of the federal poverty level (FPL).
- $200-250 million to establish a refundable tax credit for people with income levels between 400%-600% of the (FPL).
- $250 million to extend Medi-Cal to young adults, ages 19-25, who currently meet income-qualifications for Medi-Cal, regardless of immigration status.
- $26 million to streamline Medi-Cal eligibility and enrollment to children and pregnant women that are enrolling in the Women, Infant, and Children Nutrition Program (WIC).
- $30 million to increase Medi-Cal eligibility to 138% of the FPL for seniors and the disabled to the same income level of the Expansion population.
- $24 million to extend Transitional Medi-Cal from 6 months to 12 months.
- $50 million to establish an all-payer payments database to obtain information on payments made for health care services.
- $84 million to expand Song Brown and other OSHPD healthcare workforce programs for multiple years.
- $30 million to expand the UC Programs in Medical Education (PRIME) program over three years.

The Government Relations staff will continue tracking this new proposal and provide updates accordingly.

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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) received the Corrective Action Plan (CAP) from DHCS on March 28, 2018. The CAP identified (2) findings. The CAP submission was due April 27, 2018 and GCHP adhered to the deadline. GCHP is pending a response back from the submission.

A&I issued a letter to GCHP on April 6, 2018 requesting pre-audit information in preparation of the upcoming annual medical audit scheduled for June 4, 2018 through June 15, 2018. The pre-audit request is a significant data and document request due to A&I on April 26, 2018. GCHP submitted pre-audit material to A&I timely and continues to respond to ongoing document requests.

DHCS Contract Amendments:

The draft DHCS contract amendment has included multiple revisions based on Centers for Medicare & Medicaid Services (CMS) review. The contract amendment is still pending approval by CMS and the Plan is pending the final amendment for signature. The amendment incorporates approximately 156 Mega Reg provisions. Approximately 63 items remain TBD for the State to define and 28 items are TBD and not currently within the contract amendment. Additional provisions and requirements will be forthcoming via additional contract amendments, all plan letters, policy letters, etc. GCHP has received additional requirements from the Mega Reg via All Plan Letters and has had multiple deliverables due to DHCS to ensure compliance.

Delegation Oversight:

GCHP is required to monitor functions delegated to all entities who perform a function on behalf of the Plan. Compliance is responsible for ensuring delegated functions are performed in compliance with all applicable regulations and requirements. GCHP monitors delegates through ongoing contractual reporting/monitoring as well as conducts onsite audits. During an onsite audit if a subcontractor does not meet contractual requirements or substantial deficiencies are identified, a six-month onsite follow up audit is conducted. The audit results and report outcomes is a standard report to the GCHP Compliance Committee and Quality Improvement Committee.

The information provided below outlines recent delegation activity conducted by GCHP.

Delegate	Audit Year and Type	Audit Status	Date CAP Issued	Date CAP Closed
CDCR	Credentialing 2018	Closed	N/A	February 14, 2018
CMH	Credentialing 2018	Closed	N/A	February 26, 2018
VCMC	Credentialing 2018	Closed	N/A	February 16, 2018
USC	Credentialing 2018	Open	March 8, 2018	
VTS	Security Risk Assessment	Open	September 20, 2016	
Conduent	Claims	Open	December 28, 2017	
Kaiser	Claims	Open	February 8, 2018	
VSP	Claims	Open	March 15, 2018	
CDCR	UM	Closed	February 6,2018	March 2,2018
Beacon Health Options	UM, QI, RR, C&L	Closed	March 15, 2018	April 26, 2018

The following delegates will receive an annual onsite audit in Q2 2018 are:

Delegate	Audit Type	Audit Month	Date CAP Issued	Date CAP Closed
VSP	QI	April		
Beacon Health Options	Claims	April	**Pending	
VTS	Transportation	May		
Conduent	Claims	June		

The audit conducted on Beacon Health Options in April identified reoccurring claim processing deficiencies therefore a CAP was issued and a response is due May 30, 2018. Compliance Officer Armenta spoke with Beacon's VP of Operations and expressed concern with the following: lack of preparation for the onsite audit, reoccurring claim payment issues and lack of Beacon Health Options staff involvement during the audit. Compliance staff discussed this topic at the May 3, 2018 compliance committee meeting. Compliance Officer Armenta expressed concern to the executive team regarding the ongoing issues with Beacon and expressed the need for action to be taken. The executive team agreed to put together a workgroup to evaluate further. Pending the formation of the workgroup and next steps, compliance will apprise the commission of any action taken. GCHP current transportation

vendor VTS, was discussed at the May 3, 2018 compliance committee. The highlights of the discussion were specific to their open CAP and the recent notice of default that GCHP issued. The executive team agreed to put together a workgroup to evaluate further. Pending the formation of the workgroup and next steps, compliance will apprise the commission of any action taken.

RECOMMENDATION:

Accept and File

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AGENDA ITEM NO. 6

To: Ventura County Medi-Cal managed Care Commission

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

Date: May 21, 2018

RE: Contract Renewal with MedHOK Inc., formerly MedHOK Healthcare Solutions, LLC for the MedHOK Medical Management System (MMS)

SUMMARY:

In June 2013, after an extensive six-month long procurement process, Gold Coast Health Plan (GCHP) entered into a five-year subscription agreement with MedHOK Healthcare Solutions, LLC, for its MedHOK medical management system (MMS). MedHOK facilitates cohesive integration of GCHP's utilization management, care management, disease management, and grievance and appeals business capabilities. This enables GCHP to improve health outcomes, manage costs, and improve experience across the continuum of care and wellness.

In addition, MedHOK is vital for:

- Maintaining GCHP's compliance with continually evolving regulatory mandates
- Integrating with GCHP's core claims system and provider portal so GCHP providers have access to a more efficient online authorization request process
- Supporting reporting and analytics for monitoring Plan performance, care improvement initiatives, and external collaborations and data sharing for initiatives such as the Ventura County Whole Person Care Pilot

The initial five-year agreement terminates on June 30, 2018. GCHP negotiated renewal contract terms and pricing that extends the agreement until June 30, 2023.

FISCAL IMPACT:

The renewal amendment is a five-year contractual commitment. The Plan requires approval of $4,423,500, or $885k per year, comprised of:

- $3,918,000, or $784k per year, to renew the MMS software subscription contract for the additional five-year extension reflecting a 4% price increase as compared to GCHP's current FY 17/18 price for 200k members

- $315,000, or $63k per year, to add optional on-demand professional services in support of implementation/upgrade; regulatory and operational customizations; third-party system integrations, GCHP customized training, etc.
- $190,500, or $38k per year, to add a 4.5% contingency

Table 1: MedHOK 5-yr. Renewal Cost Summary

MedHOK Contract Years 5-10	Cumulative Yrs. 5-10	Annual
SaaS, PMPM, Training Environment	$ 3,918,000.00	$ 783,600.00
Professional Services	$ 315,000.00	$ 63,000.00
4.5% Contingency	$ 190,485.00	$ 38,097.00
Total	**$ 4,423,485.00**	**$ 884,697.00**

There is no impact to the current fiscal year as the costs are included in the approved FY17/18 budget. The annual amount for FY18/19 is included in the proposed budget plan.

The revised cumulative total of this contract is projected to be $8,010,300 for the full 10-year term beginning 6/28/2013 through 6/30/2023.

RECOMMENDATION:

The Plan recommends the Commission approve the MedHOK MMS contract extension and allow the CEO to execute the Subscription Agreement renewal amendment with MedHOK Inc. for a renewal term of five years.

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

Approved:		
Continued:		
Denied:		

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AGENDA ITEM NO. 7

To: Ventura County Medi-Cal Managed Care Commission

From: Melissa Scrymgeour, Chief Administrative Officer

Date: May 21, 2018

RE: Contract Renewal with Edifecs, Inc. for Edifecs Core Operating Rules Software

SUMMARY:

The Affordable Care Act (ACA) of 2010 established a set of operating rules to enable administrative simplification by augmenting existing HIPAA transactions to streamline information exchange across healthcare organizations. ACA Section 1104 requires all HIPAA covered entities to comply with and certify that their data and information systems meet the standards and operating rules for the following transactions: eligibility for a health plan; health care claim status, and health care electronic remittance advice (ERA) and electronic funds transfer (EFT).

CAQH CORE is an industry-wide stakeholder collaboration comprised of 140 key stakeholders committed to the development and adoption of common operating rules for administrative transactions. The Department of Health and Human Services (HHS) adopted the CAQH CORE Operating Rules to fulfill the ACA Section 1104 Federal mandate.

In June 2015, Gold Coast Health Plan (GCHP) entered into a three-year software subscription agreement with Edifecs for its Core Operating Rules solution. The Edifecs Operating Rules Solution is a hosted software as a service (SaaS) solution that bundles Operating Rules system capabilities, allowing GCHP to meet the technical requirements for eligibility, claim status and EFT/ERA transactions as mandated by HHS. GCHP's successfully implemented Edifecs and obtained CAQH CORE Phase III certification in February 2016.

The initial three-year agreement terminates on June 21, 2018. GCHP will renew the contract for an additional one-year term with the option to elect up to two additional one-year renewals through June 21, 2021.

FISCAL IMPACT:

GHCP's initial agreement included preferred pricing for the Edifecs CORE Operating Rules solution. The preferred pricing was offered to a group of local California managed care plans based on the number of participating entities. Edifecs has agreed to extend the preferred pricing agreement for up to an additional three-year period.

The estimated total three (3) year renewal costs for GCHP to continue using the Edifecs solution for HHS mandated CAQH CORE Phase III certification is shown in Table 1. Estimates include an annual 3% increase.

Table 1: Edifecs Core Operating Rules Software 3-year Renewal Summary

Year	Amount	Period
Years 4-6	$305,759.21	06/22/2018 – 06/21/2021

Table 2: Edifecs Core Operating Rules Software Projected Cumulative Spend

Year	Amount	Period
Years 1-3 Spend (Previously Approved)	$279,813.00	06/22/2015 – 06/21/2018
Years 4-6	$305,759.21	06/22/2018 – 06/21/2021
Total Projected Cumulative Spend (Yrs. 1-6)	**$585,572.21**	06/22/2015 – 06/21/2021

There is no impact to the current fiscal year as the costs are included in the approved FY17/18 budget. The annual amount for FY18/19 is included in the proposed budget plan.

RECOMMENDATION:

The Plan recommends the Commission to approve the Edifecs Core Operating Rules Software contract extension and allow the CEO to execute the revised subscription agreement with Edifecs, Inc. for a total not to exceed amount of $305,759.21 for contract years 4-6.

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

Approved:		
Continued:		
Denied:		

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Melissa Scrymgeour, Chief Administrative Officer

DATE: May 21, 2018

SUBJECT: Contract Extension Approval – Foothills Consulting Group

SUMMARY:

Foothills Consulting Group (Foothills) has provided information technology staff augmentation services to Gold Coast Health Plan (GCHP) since March 2017. There are currently two Foothills contractors delivering full-time senior level business systems analyst services to support delivery of GCHP's strategic and operational business-technology initiatives in the approved FY17/18 enterprise project management portfolio (EPMO). A number of these projects will continue into FY18/19 and FY19/20. Planned and proposed FY18/19 major enterprise initiatives include:

- ASO Core Claims Implementation
- Mega-Rule Compliance
- MedHOK Medical Management Systems v3.1 Enhanced Upgrade
- Provider Data Management
- Provider Contracting
- Provider Credentialing
- Windows 10 Migration
- Quest Enterprise Provider Network Analytics Implementation
- Cybersecurity Enhancement Initiatives

The two existing contractors provide additional capacity that enables the IT Business Solutions Team (applications) to perform essential day-to-day keep the lights on work. Additionally, these staff augmentation resources support break/fix and urgent IT managed work for small to medium size business technology projects.

To enable business continuity, retain existing contractor knowledge base, and mitigate disruption to EPMO enterprise initiatives, GCHP will extend the Foothills agreement for these specific two contractors for an additional 18 months, from July 1, 2018 through December 31, 2019.

FISCAL IMPACT:

Each contractor has a separate, hourly based Service Order agreement. The agreements are non-requirements contracts which allow the Plan to use services ad-hoc at the hourly rates specified.

There is no impact to the current fiscal year as these staff augmentation resources are approved in the FY17/18 budget. The annual amount for FY18/19 is included in the proposed FY18/19 EPMO budget plan.

The total renewal amount for the 18-month extension for both service orders (July 1, 2018 through December 31, 2019) is $675,000, summarized in Table 1: Foothills Service Order Extension.

Table 1: Foothills Service Order (SO) Extension

Contractor 1: Foothills SO1	Amount	Period	Budgeted
Year 2	$200,000	07/01/2018 – 06/30/2019	Yes
Year 3 (6 months)	$100,000	07/01/2019 – 12/31/2019	
Contractor 2: Foothills SO2			
Year 2	$250,000	07/01/2018 – 06/30/2019	Yes
Year 3 (6 months)	$125,000	07/01/2019 – 12/31/2019	
S01/S02 Total Extension Amount	**$675,000**	**07/01/2018 – 12/31/2019**	

Table 2: Foothills Service Orders 1 and 2 Total Projected Cumulative Spend

Service Order	Amount	Period
SO1/S02 Year 1 (Previously Approved)	$434,875	03/30/2017 – 06/30/2018 08/14/2017 – 06/30/2018
S01/S02 Year2/Year3	$675,000	07/01/2018 – 12/31/2019
Total Projected Cumulative Spend (Yrs. 1-3)	**$1,109,875**	

These agreements may be terminated for convenience at any time with a fifteen (15) day notice.

RECOMMENDATION:

The Plan recommends the Commission approve the continuation of services with Foothills Consulting Group for an additional 18-month period from July 1, 2018 – December 31, 2019 and allow the CEO to execute extensions for Service Orders 1 and 2, in the amount of $300,000 and $375,000, respectively, for a total 18-month extension not to exceed amount of $675,000.

If the Commission desires to review these contracts, they are available at GCHP's Finance Department.

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AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: May 21, 2018

SUBJECT: March 2018 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached March 2018 fiscal year-to-date (FYTD) financial statements 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 March 2018 FYTD financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

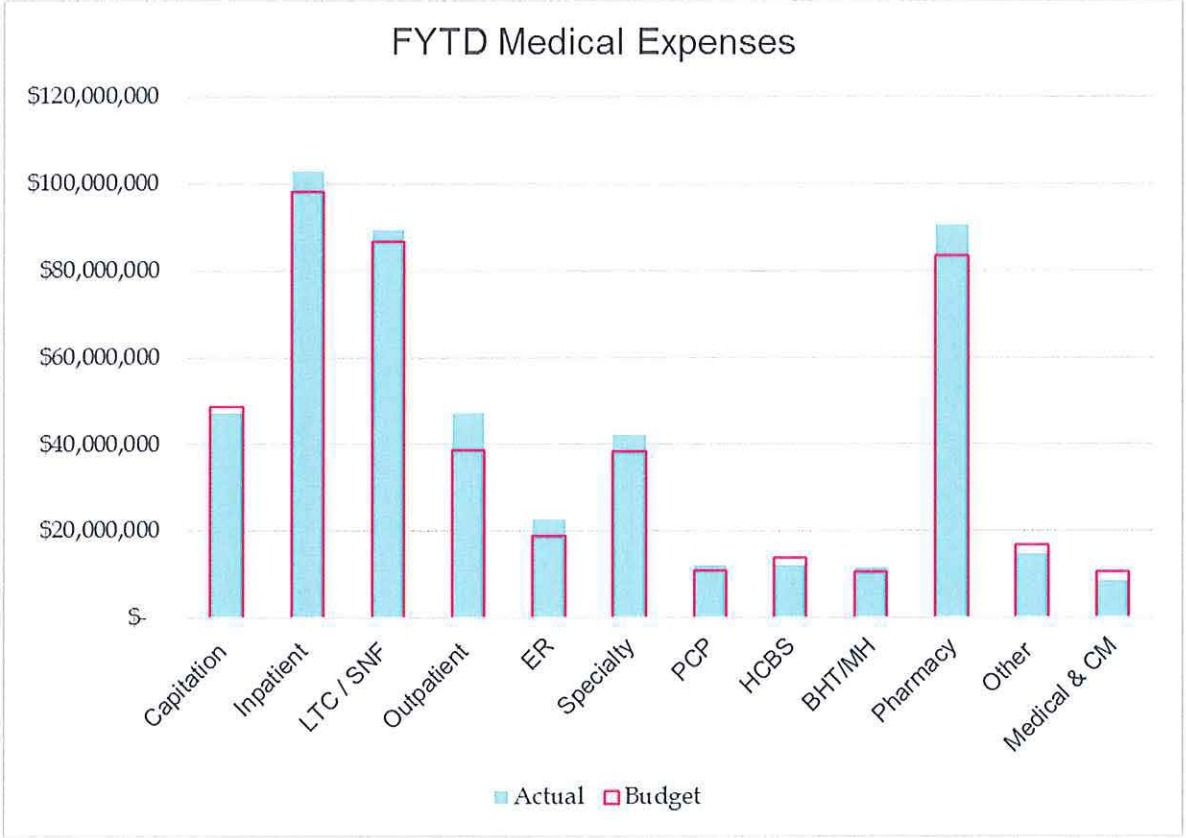
Financial Highlights

- For the nine month period ended March 31, 2018, the Plan's performance is a decrease in net assets of $16.4 million, which is $18.0 million more than budget.
- March FYTD net revenue is $518.5 million, $5.3 million higher than budget.
- Cost of health care is $501.1 million, $26.0 million higher than budget.
- The medical loss ratio is 96.6 percent of revenue, which is 4.0 percent higher than the budget.
- The administrative cost ratio is 7.1%, 0.1 percent lower than budget.
- March membership of 201,444 was 1,984 members lower than budget, and 514 lower than February's membership of 201,958.
- Tangible Net Equity is $125.9M which represents just over two months of operating expenses in reserve and 406% of the required amount by the State.

Revenue – March FYTD net revenue was $518.5 million or $5.3 million higher than budget. Membership mix contributed to the revenue increase through higher than expected Adult Expansion and Seniors and Persons with Disabilities (SPD) member-months.

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 third quarterly installment of MCO tax was paid on April 2. The next quarterly installment payment is due on July 2, 2018.

Health Care Costs – March FYTD health care costs were $501.1 million, which is $26.0 million higher than budget. Pharmacy expense decreased for the month of March due to the recognition of a $3.0 million that is estimated to be due from Optum after a year end reconciliation. The medical loss ratio (MLR) was 96.6 percent versus 92.6 percent for budget. March's health care costs and MLR were $52.2 million and 92.2 percent, respectively.



As displayed in the above graph, medical expenses are over budget in several service categories. The cause of the significant variances are as follows:

- Outpatient exceeded budget by $8.4 million (21.7%). The variance is largely the result of contract rate increases. As compared to the same period in the prior year, the average paid-per-utilization increased by 21.1%.
- Lab and Radiology exceeded the budget by $1.7 million (83.6%). Utilization increased by 6.4% and unit cost increased by 17.7% over the comparable period

last fiscal year. It was also noted that volume increased for a major lab chain as well as for a sleep disorders lab.

- Emergency Room exceeded the budget by $3.9 million (20.8%) as a result of contract rate increases. Paid-per-utilization was 26.8% above the same period last year.
- Physician Specialty and Primary Care Physician exceeded budget by 3.8 million (10.0%), and $1.3 million (11.8%), respectively. Increased volume was responsible for most of the excess. Of note, Spondylosis, intervertebral disc disorders, heart disease, respiratory infections and diseases rose significantly. In both provider categories, increases in pregnancies and deliveries were accompanied by a decrease in contraceptive and procreative management.
- Home and Community Based Services was lower than budget by $1.5 million (10.9%). The largest component, CBAS, saw modest utilization increases, but was more than offset by a decline in rates as compared to the same 9 months of the prior year. Hospice maintained steady rates, but experienced a notable decline in utilization.
- Other Fee-For-Service exceeded budget by $1.5 million (24.6%) due to a steady increase in volume.

Adult Expansion Population 85% Medical Loss Ratio – The Balance Sheet contains a $140.8 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 MLR Period 1	7/1/2015 - 6/30/2016 MLR Period 2	7/1/2016 - 6/30/2017 MLR Period 3	7/1/2017 - 3/31/2018 MLR Period 4	7/1/2017 - 3/31/2018
Total Revenue	361,237,234	293,173,426	268,060,238	223,811,457	318,560,621
Total Estimated Medical Expense	206,719,452	237,729,974	234,431,483	202,662,859	312,751,668
	57.2%	81.1%	87.5%	90.6%	98.2%
Total MLR Reserve	**118,418,494**	**22,425,065**			

Administrative Expenses – For the nine months ended March 31, administrative costs were $36.9 million or $382,000 below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 7.1 percent versus 7.3 percent for budget.

Cash and Medi-Cal Receivable – At March 31, the Plan had $349.7 million in cash and short-term investments and $82.6 million in Medi-Cal Receivables for an aggregate amount of $432.3 million. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $157.2 million.

Investment Portfolio – At March 31, 2018, the value of the investments (all short term) was $175.9 million. The portfolio included Cal Trust $51.4 million; Ventura County Investment Pool $60.5 million; LAIF CA State $64.0 million; the portfolio yielded a rate of 1.39%.

RECOMMENDATION:

Accept and file the March 2018 financial package.

CONCURRENCE:

N/A

ATTACHMENT:

March 2018 Financial Package

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FINANCIAL PACKAGE
For the month ended March, 2018

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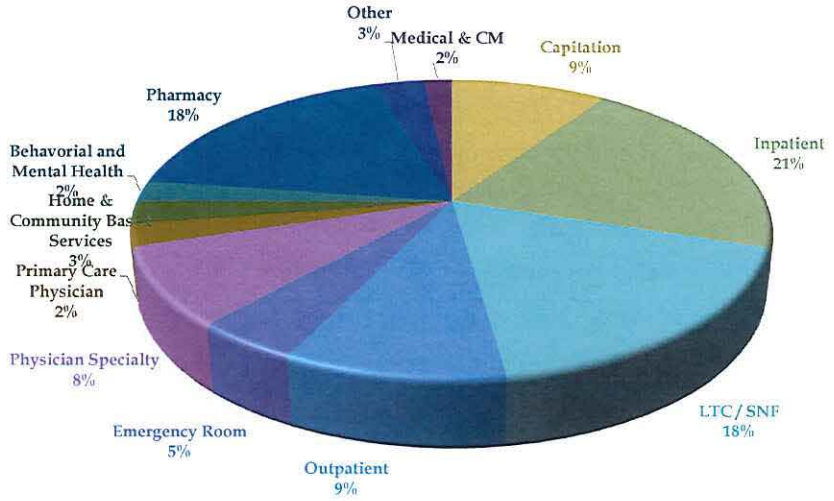
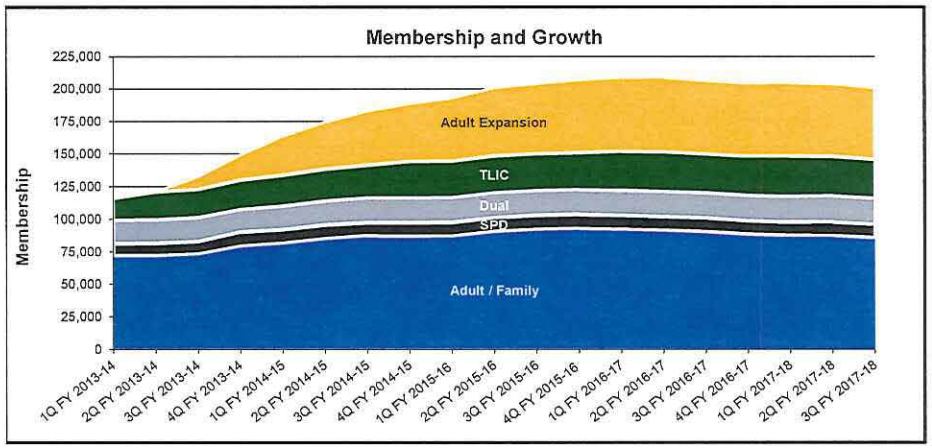
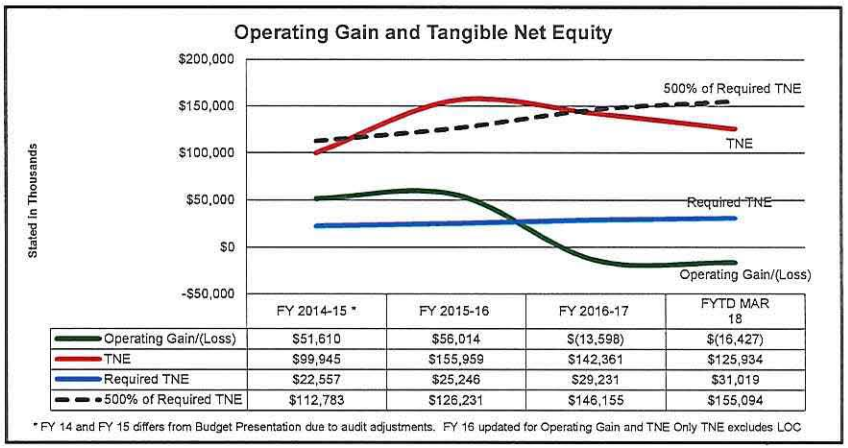
Gold Coast Health Plan

Executive Dashboard as of March 31, 2018

	FY 17/18 Budget	FY 17/18 FYTD	FY 16/17 Actual	FY 15/16 Actual
Average Enrollment	204,251	203,166	276,134	268,126
Revenue	$ 279.19	$ 283.56	$ 273.72	$ 279.98
Capitation	$ 26.40	$ 25.77	$ 26.22	$ 42.27
Inpatient	$ 53.41	$ 56.25	$ 53.44	$ 46.58
LTC / SNF	$ 47.10	$ 48.86	$ 47.86	$ 43.72
Outpatient	$ 21.09	$ 25.80	$ 23.17	$ 18.29
Emergency Room	$ 10.21	$ 12.40	$ 9.07	$ 8.23
Physician Specialty	$ 20.84	$ 23.06	$ 22.55	$ 19.35
Primary Care Physician	$ 5.91	$ 6.65	$ 6.45	$ 6.11
Home & Community Based Services	$ 7.46	$ 6.68	$ 7.33	$ 6.27
Behavorial and Mental Health	$ 5.71	$ 6.23	$ 4.57	$ (0.64)
Pharmacy	$ 45.42	$ 49.55	$ 47.76	$ 41.70
Other	$ 9.09	$ 8.11	$ 6.57	$ 3.26
Medical & CM	$ 5.80	$ 4.70	$ 4.92	$ 6.52
	$ 258.45	$ 274.05	$ 259.91	$ 241.66
% of Revenue	92.6%	96.6%	95.0%	86.3%
Total Administrative Expenses	$ 37,232,699	$ 36,850,904	$ 51,176,317	$ 38,256,908
% of Revenue	7.3%	7.1%	7.5%	5.7%
TNE	$ 143,928,616	$ 125,934,225	$ 142,360,951	$ 155,959,127
Required TNE	$ 29,349,405	$ 31,018,886	$ 29,231,052	$ 25,246,284
% of Required	490%	406%	487%	618%







	FY 2014-15 *	FY 2015-16	FY 2016-17	FYTD MAR 18
Operating Gain/(Loss)	$51,610	$56,014	$(13,598)	$(16,427)
TNE	$99,945	$155,959	$142,361	$125,934
Required TNE	$22,557	$25,246	$29,231	$31,019
500% of Required TNE	$112,783	$126,231	$146,155	$155,094

* 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

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STATEMENT OF FINANCIAL POSITION

	03/31/18	02/28/18
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	$ **173,830,109**	$ **135,333,059**
Total Short-Term Investments	**175,910,860**	**231,728,255**
Medi-Cal Receivable	82,529,212	65,673,363
Interest Receivable	545,164	524,135
Provider Receivable	491,649	419,135
Other Receivables	6,903,910	1,503,719
Total Accounts Receivable	**90,469,934**	**68,120,352**
Total Prepaid Accounts	1,673,963	1,882,622
Total Other Current Assets	135,560	135,560
Total Current Assets	**442,020,427**	**437,199,849**
Total Fixed Assets	**1,962,221**	**1,999,377**
Total Assets	$ **443,982,648**	$ **439,199,226**
LIABILITIES & NET ASSETS		
Current Liabilities:		
Incurred But Not Reported	$ 48,190,749	$ 48,075,136
Claims Payable	24,194,830	26,800,598
Capitation Payable	57,430,870	57,408,696
DHCS - Reserve for Capitation Recoup	140,843,559	140,843,559
Accounts Payable	609,164	1,456,986
Accrued ACS	1,723,169	1,745,110
Accrued Expenses	22,437,361	22,639,052
Accrued Premium Tax	20,272,257	12,826,917
Accrued Payroll Expense	1,327,330	1,150,696
Total Current Liabilities	**317,029,290**	**312,946,749**
Long-Term Liabilities:		
Other Long-term Liability-Deferred Rent	1,019,133	1,019,406
Total Long-Term Liabilities	**1,019,133**	**1,019,406**
Total Liabilities	**318,048,423**	**313,966,155**
Net Assets:		
Beginning Net Assets	142,360,951	142,360,951
Total Increase / (Decrease in Unrestricted Net Assets)	(16,426,726)	(17,127,881)
Total Net Assets	**125,934,225**	**125,233,071**
Total Liabilities & Net Assets	$ **443,982,648**	$ **439,199,226**
	-	-

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STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR NINE MONTHS ENDED March 31, 2018

	MARCH 2018 Actual	March 2018 Year-To-Date Actual	March 2018 Year-To-Date Budget	Variance Fav / (Unfav)	Variance %
Membership (includes retro members)	201,444	1,828,496	1,838,258	(9,762)	-0.53%
Revenue					
Premium	$ 64,112,861	$ 610,556,541	$ 583,923,255	$ 26,633,286	4.56%
Facility Expense AB85	0	(14,314,921)	0	(14,314,921)	0.00%
Reserve for Rate Reduction	-	(9,573,613)	0	(9,573,613)	0.00%
MCO Premium Tax	(7,445,341)	(68,184,463)	(70,704,346)	2,519,883	-3.56%
Total Net Premium	**56,667,520**	**518,483,544**	**513,218,909**	**5,264,635**	**1.03%**
Total Revenue	**56,667,520**	**518,483,544**	**513,218,909**	**5,264,635**	**1.03%**
Medical Expenses:					
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,220,308	47,113,842	48,539,178	1,425,336	2.94%
FFS Claims Expenses:					
Inpatient	13,457,055	102,855,115	98,190,327	(4,664,788)	-4.75%
LTC / SNF	10,463,375	89,346,127	86,579,928	(2,766,198)	-3.19%
Outpatient	6,244,155	47,170,550	38,760,888	(8,409,662)	-21.70%
Laboratory and Radiology	434,234	3,771,734	2,054,137	(1,717,597)	-83.62%
Emergency Room	2,487,580	22,667,995	18,765,847	(3,902,148)	-20.79%
Physician Specialty	4,713,170	42,166,163	38,318,334	(3,847,829)	-10.04%
Primary Care Physician	1,297,074	12,150,975	10,872,784	(1,278,192)	-11.76%
Home & Community Based Services	1,316,384	12,212,578	13,708,258	1,495,680	10.91%
Applied Behavior Analysis Services	754,433	6,213,164	3,505,737	(2,707,427)	-77.23%
Mental Health Services	846,627	5,175,564	6,984,802	1,809,238	25.90%
Pharmacy	3,713,606	90,610,113	83,498,045	(7,112,068)	-8.52%
Other Medical Professional	326,060	2,596,833	3,590,853	994,020	27.68%
Other Medical Care	2,470	26,059	0	(26,059)	0.00%
Other Fee For Service	830,469	7,412,122	5,947,959	(1,464,162)	-24.62%
Transportation	161,182	1,668,309	1,095,740	(572,569)	-52.25%
Total Claims	47,047,874	446,043,400	411,873,638	(34,169,762)	-8.30%
Medical & Care Management Expense	1,004,592	8,586,457	10,664,235	2,077,778	19.48%
Reinsurance	(616,425)	1,395,904	4,025,785	2,629,881	65.33%
Claims Recoveries	(435,238)	(2,039,998)	0	2,039,998	0.00%
Sub-total	(47,071)	7,942,363	14,690,020	6,747,657	45.93%
Total Cost of Health Care	**52,221,112**	**501,099,606**	**475,102,837**	**(25,996,769)**	**-5.47%**
Contribution Margin	**4,446,409**	**17,383,938**	**38,116,072**	**(20,732,134)**	**-54.39%**
General & Administrative Expenses:					
Salaries, Wages & Employee Benefits	1,967,490	17,182,839	17,911,801	728,962	4.07%
Training, Conference & Travel	14,444	187,149	487,692	300,543	61.63%
Outside Services	2,170,367	19,733,649	20,703,544	969,895	4.68%
Professional Services	314,751	2,808,308	2,580,801	(227,508)	-8.82%
Occupancy, Supplies, Insurance & Others	586,680	5,202,162	6,213,097	1,010,934	16.27%
ARCH/Community Grants	0	323,254	0	(323,254)	0.00%
Care Management Credit	(1,004,592)	(8,586,457)	(10,664,235)	(2,077,778)	19.48%
Total G & A Expenses	**4,049,140**	**36,850,904**	**37,232,699**	**381,795**	**1.03%**
Total Operating Gain / (Loss)	**$ 397,269**	**$ (19,466,966)**	**$ 883,373**	**$ (20,350,339)**	**-2303.71%**
Non Operating					
Revenues - Interest	303,886	3,040,240	684,292	2,355,948	344.29%
Total Non-Operating	303,886	3,040,240	684,292	2,355,948	344.29%
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 701,155**	**$ (16,426,726)**	**$ 1,567,665**	**$ (17,994,391)**	**-1147.85%**
Net Assets, Beginning of Year		142,360,951			
Net Assets, End of Current Period		125,934,225			

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STATEMENT OF CASH FLOWS	FYTD 17-18
Cash Flows Provided By Operating Activities	
Net Income (Loss)	$ (16,426,726)
Adjustments to reconciled net income to net cash provided by operating activities	
Depreciation on fixed assets	400,207
Amortization of discounts and premium	(251,011)
Changes in Operating Assets and Liabilites	-
Accounts Receivable	37,234,456
Prepaid Expenses	1,825,034
Accounts Payable	(127,901,569)
Claims Payable	1,429,603
MCO Tax liablity	1,096,533
IBNR	(5,175,598)
Net Cash Provided by Operating Activities	(107,769,072)
Cash Flow Provided By Investing Activities	
Proceeds from Restricted Cash & Other Assets	
Proceeds from Investments	205,000,000
Proceeds for Sales of Property, Plant and Equipment	-
Payments for Restricted Cash and Other Assets	-
Purchase of Investments plus Interest reinvested	(101,202,180)
Purchase of Property and Equipment	(20,362)
Net Cash (Used In) Provided by Investing Activities	103,777,458
Cash Flow Provided By Financing Activities	
None	-
Net Cash Used In Financing Activities	-
Increase/(Decrease) in Cash and Cash Equivalents	(3,991,614)
Cash and Cash Equivalents, Beginning of Period	177,821,723
Cash and Cash Equivalents, End of Period	$ 173,830,109

Return to Agenda

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AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: May 21, 2018

SUBJECT: Interim Chief Diversity Officer Update

Community Relations –

- Continued my community outreach efforts with meetings with the N.A.A.C.P leadership; attended the "Advancing Civil Rights in Challenging Times" Leadership Brunch sponsored by LULAC. Attended a session Facilitated by the Ventura Veterans Foundation involving re-establishing the Veterans Court after the retirement of one of its greatest supporters and founder Judge Coleen Toy White.
- Attended Diversity symposium in Thousand Oaks to see what other companies are doing in the area of Diversity and Inclusion.
- Continue to attend management meetings to answer any questions centered on Diversity and Inclusion.
- Met with perspective Diversity Council members to answer questions related to the charter of the group. Held first Diversity Council meeting on May 10, 2018.
- Met with the head of the Amgen Diversity Council to possibly facilitate a meeting between the two groups.
- Currently reviewing several videos that will be the subject of future "Lunch and Learn series" related to empowerment, implicit Bias(pre-set attitude), and unconscious bias in the workplace.

Development of Diversity Strategic Plan

- Diversity and Inclusion Strategic Plan has been completed and a draft copy was included in your binder from the April meeting. I had ask that you review the draft and share any suggestions or comments before document is finalized. The document was also reviewed by GCHP's senior team.

TRAINING PLAN

The first training of managers was scheduled and completed on March 29 referencing ***Performance Management.*** The training was facilitated by Cynthia Germano from BBK. Future sessions and training topics will be included in my report.

Case Investigations

No new cases to-date. HR is currently working on a response to the attorney of an employee whose job was eliminated. More to come if it becomes a formal case.

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Diversity/Inclusion Council

Marlen Torres

Vicky Connaughton

Rodney Waiters

Sarah Palomino

Marlin Wiley

Ritchie Nojadera

Susan Enriquez

Shannon Robledo

Brittany Hyland

Chris Martinez

James Markas

Return to Agenda

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AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: May 21, 2018

SUBJECT: Chief Operating Officer Update

Executive Summary

ASO Transformation Project – GCHP and Conduent have executed a contract to extend ASO services and to implement a new Administrative Platform with Virtual Benefits Administrator (VBA) as approved by the Commission at the April 23, 2018 Commission Meeting. The first joint Executive and Stakeholder kick off meetings were held on May 15, 2018 at GCHP. Project related materials that will be used to manage and track deliverables throughout the life of the project were reviewed. Additionally, both parties are working together to develop a comprehensive project Plan to ensure the project's success. Requirements gathering will begin on June 7, 2018.

Americas Health Plan (AHP) Pilot – Representatives from GCHP and AHP have met over the last several weeks and have made significant progress reviewing and documenting the roles and responsibilities for each entity in preparation of implementation of the Plan to Plan contract. As GCHP prepares for the Department of Health Care Services (DHCS) audit scheduled for June, the teams have agreed to work on deliverables and exchange documents for review. We will reconvene following the audit and begin the sub-group meetings and deliverables.

Coordination of Benefits Agreement (COBA) Project – The Coordination of Benefits Agreement (COBA) project has passed the testing phase with CMS. The project start date was May 14, 2018 with the first live file scheduled to deliver to GCHP on May 21, 2018.

Contracting - GCHP's contracting team continues to work on developing new contracts, renegotiating contracts up for renewal and assessing the network to ensure access to members in geographically strategic areas.

The contracting team is currently negotiating 2 hospital contracts that will introduce Alternative Payment Models designed to incentivize providers to deliver high-quality cost-effective care.

Network Operations Regulatory Initiatives -

- Provider Directory (SB137) - This bill regulates Provider Directory data requirements as well as the frequency of updates and a data validation process. This regulation is part of the new "mega-regs" and represents a significant increase in requirements and administrative effort for Medi-Cal Plans. Final efforts for print and fulfillment are in process and it is expected that the Plan will meet this regulatory requirement.

- Network Certification – Beginning July 1, 2018, all Medi-Cal managed care plans (MCPs) will be required to submit annual network certifications in addition to continuing requirements for reporting significant changes to their networks. MCPs must confirm that their networks will meet the anticipated needs of their service areas. This means that plans must maintain a provider network adequate to serve their service areas. For county-organized health systems, DHCS requires network capacity adequate to serve 100% of the Plan's eligible beneficiaries in the service area. MCPs must also meet FTE provider-to-beneficiary ratios of 1 FTE PCP to every 2000 beneficiaries, and 1 FTE network physician to every 1200 beneficiaries. GCHP exceeds this requirement.

  Effective July 1, 2018, DHCS has also established time and distance standards based on county population density. These standards apply to primary and specialty care for adults and children, OB/GYN services, hospitals, pharmacy, and mental health services. Primary care and mental health outpatient services should be offered within 10 business days of request, while specialty care appointments should be offered within 15 business days of request. Primary care, hospital, and pharmacy sites must be located within 10 miles or 30 minutes of a beneficiary's residence regardless of county; time and distance standards vary by county density designation.

  Policies and procedures relating to this APL have been created for submittal to DHCS. To meet these requirements it was an "all hands on deck" process to review current processes and workflows. Significant meetings and time were allocated to looking at our methodologies, which in turn impacted other key priorities to meet this regulatory timeline.

- Provider Data Submission - 274 file – This regulatory requirement provides further specification for a Plan's Provider Network Data Reporting. Data from these submissions are used for beneficiary enrollment, to assist in determining network adequacy and meeting state and federal reporting requirements. GCHP continues to meet state submission timeframes and expectations for this requirement. This process remains ongoing between DHCS and all Plans. This was another "all hands on deck" requirement for the Plan. Multiple departments within the Plan were involved in

developing new field enhancements and calculations involving FTE calculations around network adequacy.

Operations Dashboard

Membership

Membership continues to remain below 200,000 for 2018. January's enrollment was 197,609 which is within 100 members of May's enrollment. Adult Expansion also remains flat between January (52,745 members) and May (52,681 members).

Based on the current economy and the time of year, we can expect enrollment to remain at this level.

Operations Dashboard Monthly Volumes- May 2018	
	Volume
Membership:	
Total	**197,529**
May Loss	**-6,468**
May Add	**4,244**
Gain/Loss (net)	**259**
AB-85: (new)	
VCMC	**534**
Remaining Providers	**544**
VCMC Target	**65,765**
VCMC % of Target	**43.23%**

AB 85 Auto Assignment- GCHP assigned 534 new members to VCMC, while the remaining 544 new members were assigned to providers in compliance with the VCMMCC Auto Assignment policy (MS-005) for May. VCMC has 28,430 Adult Expansion (AE) members assigned as of May 1, 2018. VCMC's target enrollment, as established by DHCS, is 65,765 and is currently at 43.23% of the target.

Operations Dashboard

Encounter Data

Encounter data fluctuates month over month depending on provider submissions and services. The error rates are consistent month over month by provider type. The most common error types submitted involve members not effective on date of service, coding errors and duplicate submissions.

GCHP encounter data continues to reflect 100% submission rates on the quarterly and annual DHCS scorecards indicating that the data submitted is clean and useable by the state.

Operations Dashboard Monthly Volumes- April 2018 Total Encounters Submitted: 409,266		
Encounter Type	**Errors**	**% of Errors**
Professional	1,988	1.8%
Institutional	438	0.7%
Pharmacy	274	0.1%
Total	**2,700**	**0.7%**

- **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.

Claims

Annually, Conduent processes approximately 2,300,000 claims for GCHP. This does not include the volume of encounters received by GCHP. Claim submission continues to edge upward since January. January's claim count was 205,967 which is 11,216 claims lower than April. The average daily receipt in January was 7,852 claims which is 1,677 claims per day lower than April.

Operations Dashboard Monthly Claims Volumes- January- April 2018				
		Month		
	April	March	Feb	Jan
Total	**217,183**	215,953	188,639	205,967
Daily Average Receipt	**9,529**	9,816	9,432	9,362
Days Receipt on Hand	**4**	3.12	2.85	2.61

Conduent is measured on claim performance by three industry-standard metrics (Service Level Agreements (SLAs)). Conduent continues to meet and exceed these metrics month over month. We also continue to review processes and performance through audit and quality goals and initiatives.

Operations Dashboard Key Performance Metrics- January- April 2018					
	Benchmark		**Month**		
		April	March	Feb	Jan
Turn Around Time	90.00%	**97.70%**	95.62%	95.45%	99.76%
Financial Accuracy	98.00%	**99.00%**	99.74%	99.92%	99.77%
Procedural Accuracy	97.00%	**99.00%**	99.99%	99.74%	99.65%

Call Center

Call Center metrics continue to demonstrate fluidity due to call volumes and talk times remaining high. Particularly, talk times for both provider and member calls remain in the 9 to 10 minute time frame. Typically, member calls have less talk times than provider calls. Conduent and GCHP actively address opportunities to reduce talk times, increase consistency with staffing and look to innovate the workflows.

Conduent is measured on call center performance by three industry-standard metrics (Service Level Agreements (SLAs)). Conduent has struggled with Average Speed to Answer for several months due to attrition (voluntary and involuntary), new employees coming onto the program and illness (January). Conduent continues to seek out new employees to backfill for attrition/performance issues. Currently there are 2 new hire classes beginning or scheduled within the next 4 weeks.

As a result of Conduent's efforts the Call Center has met or exceeded all service metrics in April. Additionally, Conduent is in the process of upgrading the Call Center Supervisor position to a Manager to further improve program outcomes..

Operations Dashboard Call Volume- January-April 2018				
	April	March	Feb	Jan
Call Volume (# of calls)	**12,587**	12,719	10,968	12,548

Operations Dashboard Key Performance Metrics- January- April 2018					
	Benchmark	**April**	March	Feb	Jan
Avg. Speed To Answer	30 Seconds	**22**	40.8*	27.8	50.4*
Abandonment Rate	5.00%	**1.05%**	2.13%	1.57%	2.24%
Call Quality Scores	95.00%	**97.56%**	96.73%	96.90%	96.70%

**ASA spike due to attrition, new employees being hired and illness*

Grievance and Appeals

Grievance and Appeals (G&A) is measured in a 2-month lookback due to the time allowed to process the request (45 days).

G&A has seen a small increase since January consistent with the claims volume increase. GCHP overall G&As per thousand remain low and similar to other COHS plans.

DHCS measures G&A performance against 2 metrics for each category (2 for Grievance, 2 for Appeals). The metrics are timeliness of acknowledgement and timeliness of resolution. The metrics are significantly rigid (100%) and GCHP continues to look at ways to improve the process to meet each metric at 100%.

Of note in January and February, GCHP did receive an influx of unfounded requests due to one provider having a system error. GCHP did respond to all 9,000 requests, however the metrics were impacted by this issue.

Operations Dashboard Monthly Volumes- January-March 2018			
	March	February	January
G&A Volume:			
Clinical	**11**	8	6
Upheld	**4**	3	4
Overturned	**5**	4	1
Withdrawn	**2**	1	1
Provider	**150**	154	180
Member	**29**	33	22
Grievances/ 1,000	**0.15**	0.17	0.11
Quality of Care (reasons)	**17**	29	4
State Fair Hearings	**0**	0	3
Denied			1
Dismissed			1
Withdrawn			1

Operations Dashboard Monthly Volumes by Issue Type–January-March 2018			
Grievance (Issue Type):	**March**	Feb	Jan
Accessibility	**4**	8	4
Benefits/Coverage	**1**	1	1
Billings	**4**	2	6
Denial/Refusals	**1**	1	4
Quality of Care	**17**	18	4
Quality of Service	**2**	1	2
Referral	**0**	1	1

Operations Dashboard Key Performance Metrics January-March 2018				
	Benchmark	**March**	Feb	Jan
Grievance Acknowledgement	100.00%	**91.00%**	87.00%	96.00%
Appeal Acknowledgement	100.00%	**100.00%**	100.00%	100.00%
Grievance Resolution	100.00%	**100.00%**	99.00%	96.00%
Appeal Resolution	100.00%	**100.00%**	100.00%	100.00%

A. PROVIDER ADDS AND TERMINATIONS May 2018

ADDITIONS:

- Key specialty areas recruited include: Pulmonology, GI, OB, and Ophthalmology
- Recruitment of 1 urgent care center.
- Recruitment of 1 Congregate Living facility. Key in assisting hospitals upon discharge with hard to place members.

PROVIDER TYPE	# PROVIDER ADDS May2018	TOTAL PROVIDER ADDS July 2017-May2018	TOTAL NETWORK PROVIDERS
Hospital	**0**	**11**	**33**
-Acute Care	0	0	19
-LTAC	0	10	9
-Tertiary	0	1	5
Providers	**96**	**1,152**	**6,397**
-PCP's & Midlevels	4	60	441
-Specialists	61	1,042	5,615
-Hospitalists	31	50	341
Ancillary	**2**	**11**	**388**
-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	1	33
-OT/PT/ST	0	6	83
-Radiology/Imaging	0	0	29
Pharmacy	**1**	**7**	**838**
SNF/LTC/CLF	**1**	**8**	**8**
Behavioral Health	**0**	**39**	**327**

B. TERMINATIONS:

- 3 providers resigned from City of Hope Medical Foundation. No significant impact to network.
- 2 providers (1-Family Practioner (FP) & 1 Nurse Practioner (NP)) terminated from CDCR. No reason for termination from group provided. No impact to network.
- 1 FNP (Family Nurse Practioner) from CMH terminated. No reason for termination from group noted. No impact to network.
- 1 NP from Identity Medical Group terminated from group. No reason given for termination. No impact to network

PROVIDER TYPE	# PROVIDER TERMS May 2017	TOTAL PROVIDER TERMS July 2017- May 2017	COMMENTS
Hospital	**0**	**0**	---
-Acute Care	0	0	---
-LTAC	0	0	---
-Tertiary	0	0	---
Providers	**7**	**147**	---
-PCP's & Midlevels	4	44	No major impact
-Specialists	3	82	No major impact
-Hospitalists	0	24	No major impact
Ancillary	**6**	**11**	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	1	1	No major impact
-Radiology/Imaging	5	5	No major impact
Pharmacy	**0**	**21**	No major impact. Terms result of wrong Pharmacy submissions by Optum
SNF/LTC/CLF	**0**	**0**	---
Behavioral Health	**0**	**17**	---

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: May 21, 2018

SUBJECT: Chief Medical Officer Update

QUALITY IMPROVEMENT REPORT

The Department of Health Care Services (DHCS) requires Gold Coast Health Plan (GCHP) to implement an effective quality improvement system and to ensure that the governing body routinely receives written progress reports from the Quality Improvement Committee (QIC). This report contains a summary of activities of the QIC and its subcommittees.

QUALITY IMPROVEMENT ACTIVITIES

HEDIS

Data collection for Measurement Year (MY) 2017/Reporting Year (RY) 2018 is currently in the final phases. The scheduled end date for data collection is early May 2018. Final certified rates to be available in June/July 2018.

A number of process changes were implemented in an effort to positively impact HEDIS rates:

- Production of complete claims, encounter and supplemental data submission to maximize administrative positive hits (this included new lab data not utilized in prior years)
- Pursuit of medical records began 6 weeks earlier than prior year
- BAA with VCMC was executed to allow remote EHR access to HEDIS vendor (Inovalon)
- Remote access to Clinicas EMR obtained for GCHP Clinical Staff for the HEDIS season
- GCHP Clinical Staff over-read of 100% of records (compliant and non-compliant) to validate vendor review process/accuracy and find opportunities for secondary pursuit

HEDIS COMPLIANCE AUDIT

- Health Services Advisory Group (HSAG) completed an onsite HEDIS Compliance Audit on March 5, 2018. The purpose of the audit was to validate the HEDIS data collected and reported by the Plan and to verify compliance with HEDIS production process specifications.
- The HSAG auditor commended GCHP for the level of knowledge, active involvement, and expertise demonstrated by staff from key areas (QI, IT, Operations, Claims, Pharmacy, Network Operations). No high risk issues were identified in closing remarks.
- Formal audit report received March 19, 2018.

2018 ENCOUNTER DATA VALIDATION (EDV) STUDY

- HSAG is conducting an EDV study on behalf of DHCS to evaluate encounter data completeness and accuracy through review of a sample of 411 randomly-selected medical records.
- HSAG is requiring 40% of sample cases by 4/9/2018, and 90% of sample cases by 5/11/18.
- GCHP met the submission deadline.

PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

Child Immunizations PIP

Childhood Immunizations (CIS-Combo 3) is a required topic for those MCPs that performed below the minimum performance level (MPL), or below the statewide Medi-Cal managed care average with declining performance on CIS-Combo 3 in Reporting Year (RY 2017). CIS-Combo 3 measures the percentage of children 2 years of age who had four DTaP, three IPV, one MMR, three HIB, three HepB, one VZV, and four PCV vaccinations.

Module 4: Plan-Do-Study-Act for Each Intervention

- In Process
- The following departments and clinic are currently collaborating on developing an intervention to increase child immunizations in children < 2 years of age who are enrolled in Gold Coast Health Plan:
    - Quality Improvement
    - Health Education/Cultural Linguistics
    - Mandalay Bay Women's and Children's Medical Group

Health Disparity PIP: CDC HbA1c > 9.0 in non-English speaking Hispanics/Latinos

DHCS requires MCPs to conduct a performance improvement project on an identified health disparity. The QI department performed an analysis for the Comprehensive Diabetes Care sub measure HbA1c >9% to determine if any disparity existed. The analysis indicated that there is a significant disparity in HbA1c >9% rates across the Hispanic or Latino groups. Further analysis revealed a significant disparity in HbA1c >9% in the English and Non-English speaking subgroup.

Module 4: Plan-Do-Study-Act for Each Intervention

- In Process
- The following departments and clinic are currently collaborating on developing an intervention to reduce HbA1c > 9.0 in non-English speaking Hispanics/Latinos who have diabetes and are enrolled at Gold Coast Health Plan.
    - Quality Improvement
    - Las Islas Family Medical Group

IMPROVEMENT PROJECTS (IPS)

Annual Monitoring for Patients on Persistent Medications (MPM)

The Annual Monitoring for Patients on Persistent Medications (MPM) measure determines compliance with annual lab screenings by looking for code data (CPT and LOINC codes) found in administrative data (claims, encounter and lab data).

For PDSA 1, the effectiveness of HEDIS® clinic report cards was tested with two Clinicas del Camino Real (CDCR) clinics: Oxnard and Simi Valley. The following two reports were distributed to help the clinics monitor their performance metrics and perform outreach to their patients:

(1) report cards with each clinic's current HEDIS rates
(2) performance feedback reports listing members needing services, including medication monitoring labs

The goal of increasing the MPM rates by 10% at both clinics was surpassed.

The studied revealed that over 30% of labs marked as non-compliant on GCHP's Performance Feedback Report were not due to incomplete labs but due to missing lab data not collected by GCHP. This high volume of missing data will decrease the effectiveness, validity and reliability of the Performance Feedback Report, and continue to result in under-reported HEDIS data.

For PDSA 2, GCHP will study a new data-driven intervention. Since the two clinics studied in MPM PDSA 1 are part of a clinic system that exclusively uses Quest Diagnostics for processing labs, the Quality Improvement, Decision Support Services and Information Technology departments will collaborate on implementing and testing the effectiveness of a data validation process on the monthly lab data submitted from Quest Diagnostics. The "Plan" portion of PDSA 2 was submitted to DHCS on January 31, 2018 and the intervention will be tested March 1, 2018 to May 31, 2018.

Controlling High Blood Pressure, Comprehensive Diabetes Care – Blood Pressure Control

The Quality Improvement Department has completed and submitted to DHCS two of the three Continuous Quality Improvement (CQI) summary reports.

Reporting Period: July 1, 2017 to August 30, 2017
Submitted to DHCS: September 15, 2017
Improvement Activities:

1. Bi-monthly performance feedback (gap analysis) reports including members in the CBP and CDC-BP measures to enable clinics to identify which members need to have their blood pressure monitored.

2. CDC letter: QI and DM departments collaborated on developing a member letter that (1) reminds members to get their annual diabetic screenings and (2) promote the Diabetes Disease Management program.
   CBP letter: QI and HE departments collaborated on developing the member letter that (1) reminds members to get the annual BP screening and (2) educates the member on monitoring and controlling BP.

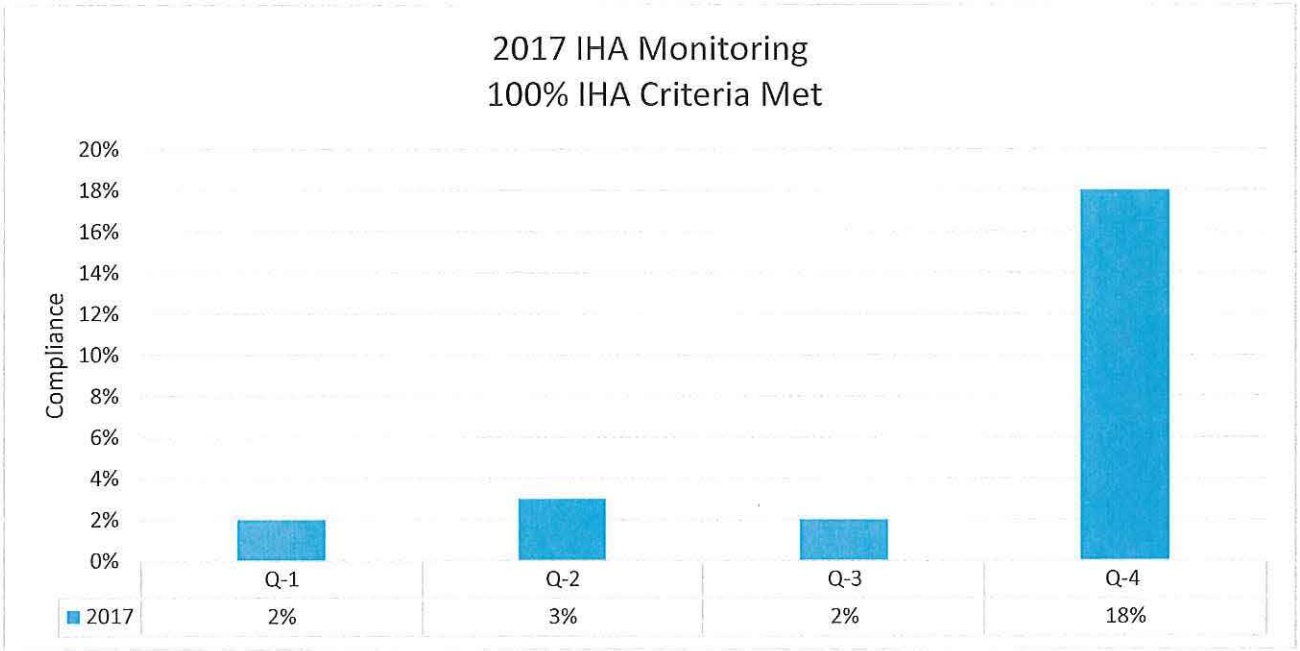
Reporting Period: September 1, 2017 to November 30, 2017
Submitted to DHCS: January 11, 2018
Improvement Activities:

1. To avoid the third-party retrieval vendor obstacle encountered in 2017, Gold Coast Health Plan collaborated with VCMC to grant GCHP's HEDIS retrieval/abstraction vendor (Inovalon) remote access to VCMC's electronic medical record (EMR) system.
2. To correct the provider chase flag issue, the QI Department reviewed the provider file and applied the following criteria to determine each provider's chase flag (Yes/No) status: (1) location (2) provider specialty and (3) non-existing "dummy" PCPs. Only providers within Ventura County that provide clinical care related to the HEDIS measures were assigned a "Yes" chase flag.
3. In the October 2017 edition of the Provider Operations Bulletin, the QI Department published an educational article titled "HEDIS Performance Measures That Evaluate Adequate Control of Blood Pressure." The article presented: (1) definition of the CBP and CDC measures; (2) an overview of GCHP's 2013-2016 MY rates for the CBP and CDC-CBP measures; (3) criteria for collecting blood pressure readings for HEDIS reporting; and (4) tips to improve the blood pressure measures.

IHA MONITORING (IHA)

An IHA must be completed within 120 days of enrollment with GCHP. On a monthly basis, the QI Department conducts medical record reviews on a random sample of members. The medical record review occurs during the month immediately following the 120-day IHA expiration period.

	Total Medical Records Reviewed	Number of Medical Records scored 100%	Number of Medical Records scored 90%-99%	Number of Medical Records scored 89% and below
Q-1	846	16 (2%)	481	345
Q-2	697	22 (3%)	363	312
Q-3	727	16 (2%)	470	241
Q-4	695	125 (18%)	368	202



Primary reasons for not achieving 100% on medical record audits:

- Incomplete, unsigned, or no Staying Healthy Assessment (SHA) in the medical record
- Age-appropriate preventive health screenings were missing documentation in the medical record

Included in the IHA medical record review is monitoring of provider interventions when a member indicates a high-risk answer on the SHA form. The inclusion of monitoring for risk factor follow up began in February 2017 during 1st quarter 2017.

IHA and Risk Factor Interventions - 4th Quarter 2017:

- 4 providers offices received IHA and Outreach training:
    - VCMC Academic Family Medical Center – Ventura
    - CMH Premiere Health Center – Santa Paula
    - Dignity Health Medical Group – Call Center – Camarillo
    - CMH Midtown Medical Specialties – Ventura
- Copies of each medical record review performed includes explanations in a comment column explaining to the provider what was missing in the medical record and interventions that were missing for marked high-risk answers.
- Each summary score sheet includes instruction on the requirements for a completed SHA form.
- Declines in medical record review compliance scores are reviewed with medical providers and clinic managers at the end of each monthly review.
- Continued provision of contact information of the IHA RNs in the Quality Improvement Department is provided to promote medical providers to reach out for answers to IHA questions or submit requests for further training.
- Ongoing telephone and e-mail support is available to providers and office staff by the QI Department IHA RN staff.
- Provider Network Operations department external representative continues to meet monthly with Quality Improvement RNs. The representative provides feedback regarding information obtained during the provider site visits as follows:
    - Any provider sites opening or closing their member panels.
    - Any provider sites terminating their contracts with Gold Coast Health Plan and/or closing their office.
    - Any provider site that is moving its location or opening an additional site that would require a new facility site review.
    - Changes in staffing and providers at provider sites.
    - Provider/clinic sites who report they are not receiving their new member name lists.
    - Any provider site with problems or questions regarding the IHA outreach logs or the Staying Healthy Assessment (SHA).
    - Provider requests for additional training on the IHA outreach logs or the SHA.

FACILITY SITE REVIEW

Three (3) initial FSRs and 0 periodic FSRs with up-to-date PARS were conducted in the fourth quarter of 2017. Two (2) Interim-FSRs were conducted in the fourth quarter of 2017.

2017 Year End:

Initial and Periodic FSRs with PARS Completed during 2017

Initial FSRs with PARS Completed	Periodic FSRs with PARS Completed	FSR(s) with CAPS	Number of CAPS closed	Total number FSR and PARS Completed
7	55	2	2	62

Interim FSRs performed during 2017

Total number of I-FSR	Total number of I-FSR approved	Total number of critical element CAPs served	Total number of critical element CAPS completed within 10 days	Total number of critical element CAPS **not** completed within 10 days
5	5	0	NA	NA

SMOKING CESSATION

Department of Health Care Services (DHCS) All Plan letter (APL) 16-014 outlines information regarding requirements for comprehensive tobacco cessation services. Medi-Cal Managed Care Plans (MCPs) are to identify tobacco users and track data on tobacco cessation interventions. Data for smoking cessation is obtained during monthly IHA SHA medical record reviews.

2017 Year End Total Compliance		
Total # members (+) for tobacco use	Total # members cessation counseling provided	Total # members smoking cessation medication Offered
66	29 (44%)	10 (15%)
Goal	68%	32%

Interventions during 4th Quarter 2017:

- Continued monitoring of smoking cessation documentation during IHA SHA medical record reviews in 4th quarter 2017.
- 1-on-1 discussions with clinic managers when submitting copies of IHA audit results regarding the focus of monitoring smoking cessation criteria.
- Provided names, phone numbers, and e-mail contact information of the IHA nurses in the Gold Coast Health Plan Quality Improvement Department as resources for questions and concerns regarding smoking cessation activities.
- Provided the Health Education Department phone number and Gold Coast Health Plan website address to access and order smoking cessation educational materials to provide to health plan members.
- Continued to assist provider sites with concerns, problems, and provider efforts to improve IHA SHA documentation specific to smoking cessation screening.

ALCOHOL MISUSE SCREENING AND COUNSELING IN PRIMARY CARE

Department of Health Care Services (DHCS) requires that Medi-Cal managed health care plans (MCPs) provide Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care

(AMSC) for MCP members ages 18 and older who misuse alcohol. Monitoring of AMSC implementation is obtained during monthly IHA SHA medical record reviews.

4th Quarter 2017

In the 4th quarter, the total number of records reviewed (695) yielded 39 members over age 18. Of the 39 members, 5 were found to be positive for alcohol use.

The 5 members found positive for alcohol use had no documentation of Audit or Audit –C assessment in their medical records and only 1 member received counseling. None of the 5 members were referred to the county program for alcohol use disorders.

2017 Year End Total (Q-2 through Q-4)

Total medical records reviewed	# Records over age 18 years	# members positive for alcohol use	# records with AUDIT OR AUDIT-C in MR	# members who received counseling	# members referred to Ventura County ETOH Program
2116	116 (5.5%)	7 (6%)	0 (0%)	4 (57%)	0 (0%)

Interventions during 4th Quarter 2017:

- Monitoring of AMSC documentation during IHA SHA medical record reviews in 4TH quarter 2017.
- One-on-one discussions with clinic managers when submitting copies of IHA audit results regarding the focus of monitoring for alcohol use.
- Provided names, phone numbers, and e-mail contact information of the IHA nurses in the Gold Coast Health Plan Quality Improvement Department as resources for questions and concerns regarding the SHA, the AMSC, and validated expanded alcohol screening questionnaires: Audit / Audit C screenings.
- Provided the Health Education Department phone number and Gold Coast Health Plan website address to access alcohol treatment referral information for members.
- Continued to assist provider sites with concerns, problems, and provider efforts to improve IHA SHA documentation specific to the SHA form and AMSC evaluations.

CREDENTIALS/PEER REVIEW

- Monitoring of Medical Board of California actions
  - Reviewed the status of 7 contracted providers with either Medical Board of California actions or legal actions by the court.
  - 1 provider with a legal case is scheduled for a court date on 4/17/18.

- Credentialing
  - 57 new providers were approved
  - 36 providers were recredentialed; one provider was pended until further information is received; one provider was administratively denied
  - 13 facilities were credentialed

- Peer Review
  - 2 new PQI cases
    - 1 is complete and closed
    - 1 remaining open requiring a response from the provider, open in medical record pursuit or review phase

HEALTH SERVICES UPDATE

Utilization patterns, top admitting diagnoses, and the aid code groups of utilizing populations are similar to prior months and benchmark well against DHCS Managed Care Dashboard data. Bed days/1000 members and admissions/1000 members are essentially unchanged from prior reports. The average length of stay in the last half of CY 2017 decreased by about 7% compared to the last half of CY 2016. Emergency room utilization/1000 members showed an increase of about 7% in the last half of CY 2017 compared to the last half of CY 2016. The Ventura County Thomas Fire and flu season contributed to the increase in emergency room utilization.

UTILIZATION SUMMARY

Inpatient utilization metrics for CY 2017 are similar to CY 2016.

BED DAYS:

Bed days/1000 members have declined by about 43%, from Plan's inception in 2011 through CY 2016. Bed days/1000 for CY 2017 (211) remains unchanged from CY 2016 (210). The proportion of bed days utilized by AE members continues to increase (47% to 49%) in a year-to-year comparison of December 2016 to December 2017.

Bed days/1000 for SPD members for CY 2017 are also similar to CY 2016 (968 v. 1006). While the rate of bed days for SPD members is high, it does not have a strong effect on the overall plan rate of bed days per 1,000 members because SPD is such a small portion of our membership (5%).

Bed days/1000 benchmark: While there is no Medi-Cal Managed Care Dashboard report of bed days/1000 members, review of available published data from other managed care plans averages 238/1000 members. There is variability of reporting of Administrative Days among managed care plans.

AVERAGE LENGTH OF STAY:

Average length of stay for CY2016 was 4.2. Average length of stay for CY 2017 is 3.9.

Average length of stay benchmark: While there is no Medi-Cal Managed Care Dashboard report of bed days/1000 members, review of available published data from other managed care plans averages 5. There is variability in reporting of Administrative Days among managed care plans.

ADMITS/ 1000:

Admits/1000 for CY2016 were 50/1000 members. Admits/1000 for CY 2017 are 53/1000 members.

Admits/1000 SPD members are 169 for CY 2017.

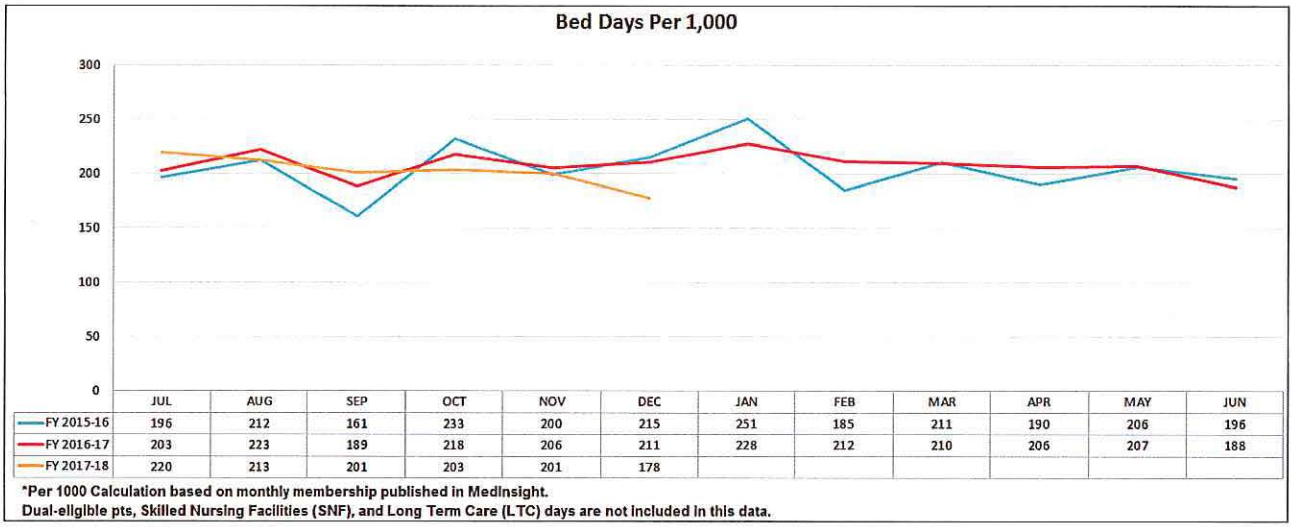
Admits/1000 benchmark: The DHCS average for admits/1000 members is 54. The DHCS average admits/1000 for SPD members is 458. This variation between GCHP and DCHS may be explained by the relative youth of GCHP SPD members versus DHCS SPD members. (Only 33% of GCHP SPD members are age 40 – 64 years versus 42% for the DHCS SPD population).

ED UTILIZATION/1000:

ED utilization/1000 members typically peaks in January or February. CY 2017 ED utilization/1000 members increased from CY2016 (468 v. 443). For December 2017, the Family aid code group continues to show the highest ED utilization (49%) followed by AE (34%). This utilization pattern is essentially unchanged from CY 2016.

ED utilization/1000 for SPD members for CY 2017 is also increased from CY 2016 (849 v. 802). This represents approximately 9% of ED utilization.

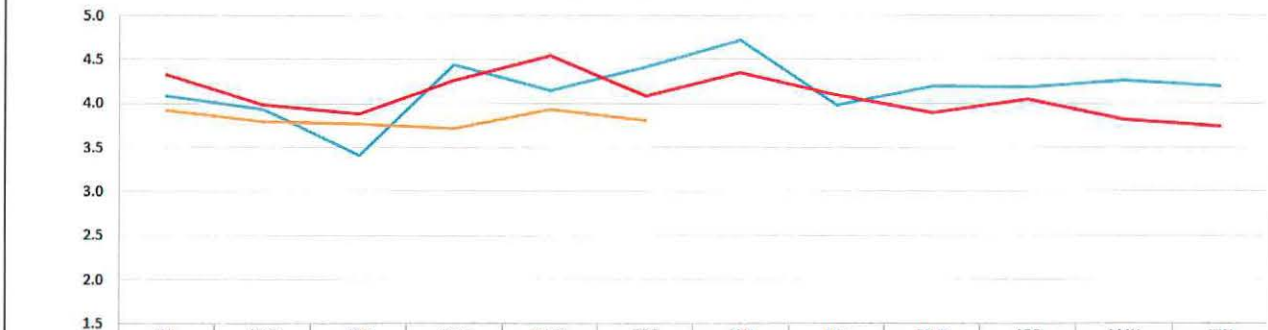
ED utilization benchmark: The HEDIS mean for managed Medicaid plans for ED utilization/1000 members is 587. The March 2017 Medi-Cal Managed Care Performance Dashboard reported average SPD ED utilization to be 1065/1000 members.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2015-16	196	212	161	233	200	215	251	185	211	190	206	196
FY 2016-17	203	223	189	218	206	211	228	212	210	206	207	188
FY 2017-18	220	213	201	203	201	178						

*Per 1000 Calculation based on monthly membership published in MedInsight.
Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

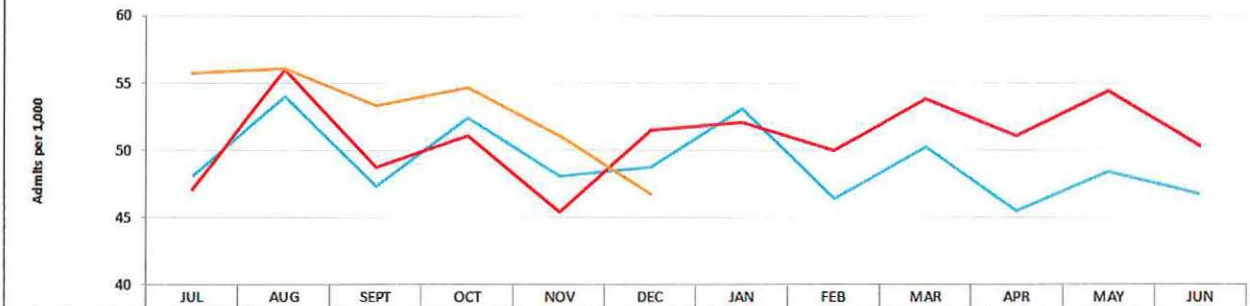
Average Length of Stay



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2015-16	4.1	3.9	3.4	4.4	4.1	4.4	4.7	4.0	4.2	4.2	4.3	4.2
FY 2016-17	4.3	4.0	3.9	4.3	4.5	4.1	4.4	4.1	3.9	4.0	3.8	3.7
FY 2017-18	3.9	3.8	3.8	3.7	3.9	3.8						

*Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

Acute Inpatient Admissions/1000 Members

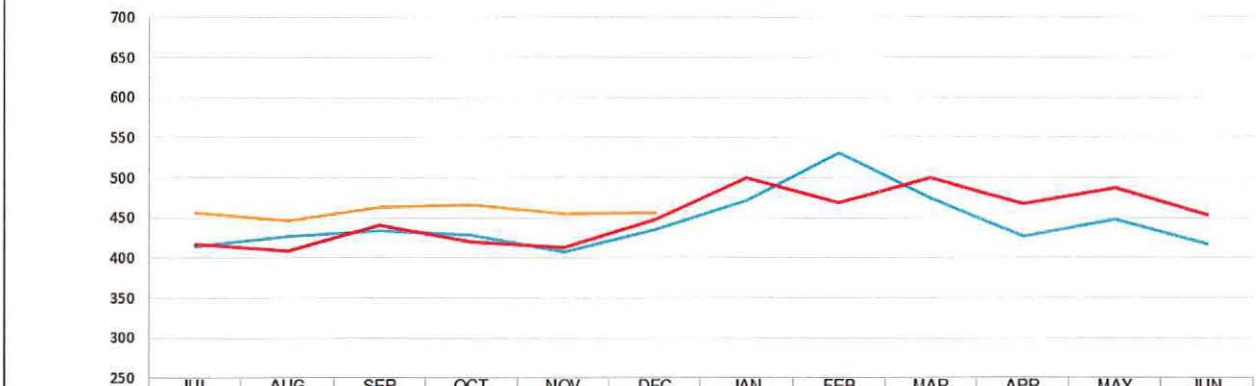


	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2015-16	48	54	47	52	48	49	53	46	50	46	48	47
FY 2016-17	47	56	49	51	45	52	52	50	54	51	54	50
FY 2017-18	56	56	53	55	51	47						

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

*Data from MedInsight 04/10/2018

ER Utilization Per 1,000



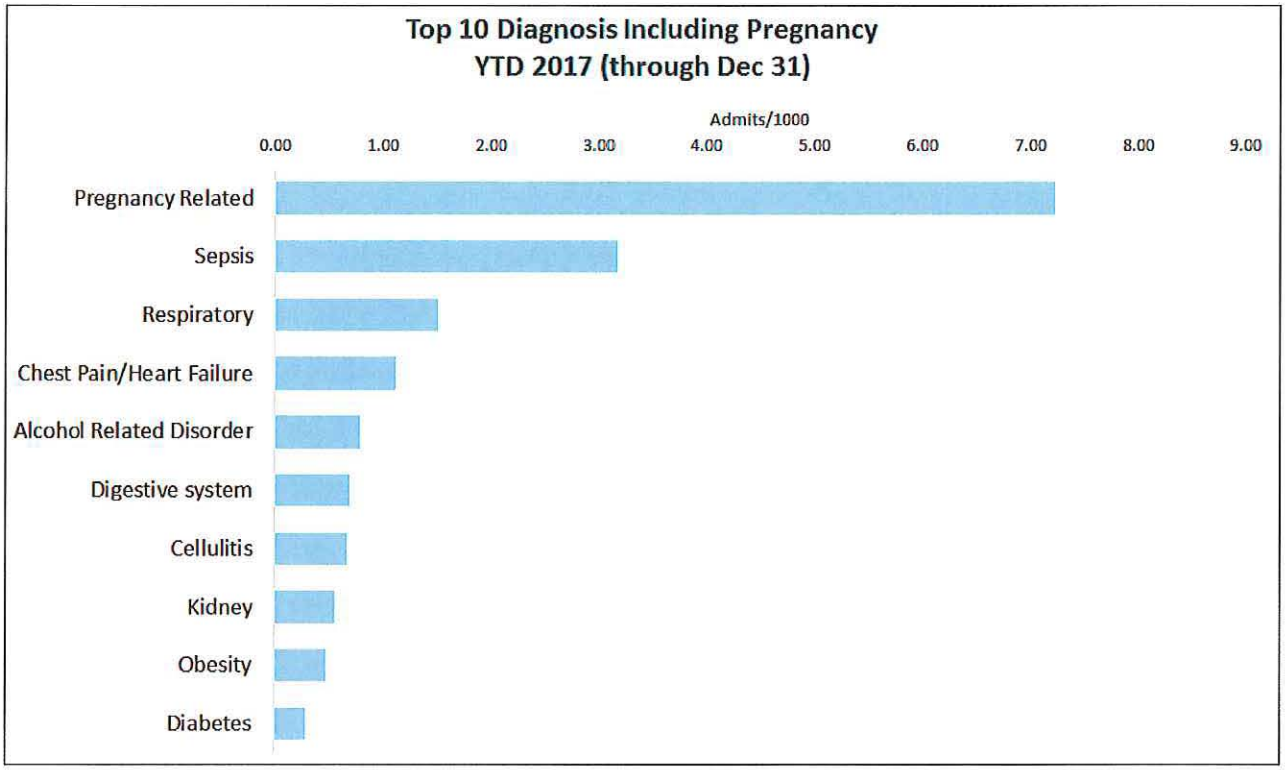
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2015-16	415	427	433	429	407	436	472	531	474	427	448	418
FY 2016-17	417	408	441	420	413	447	500	468	500	467	487	454
FY 2017-18	457	446	463	467	455	456						

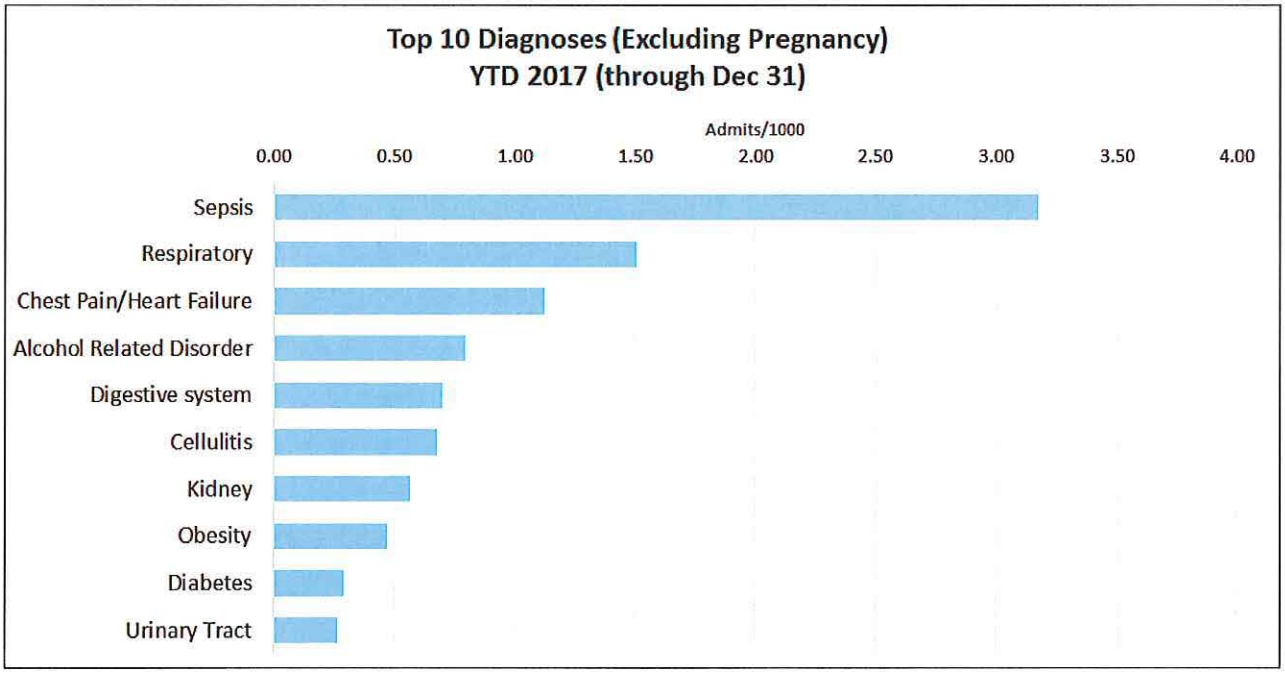
*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts are not included in this data.

*ER Utilization calculated on visits without an IP admit

TOP ADMITTING DIAGNOSES

Pregnancy related diagnoses and sepsis continued to dominate top admitting diagnoses for CY 2016 and CYTD 2017. For members admitted with a primary diagnosis of sepsis, secondary diagnoses were cancer, heart disease, liver or renal transplant, and diabetes.

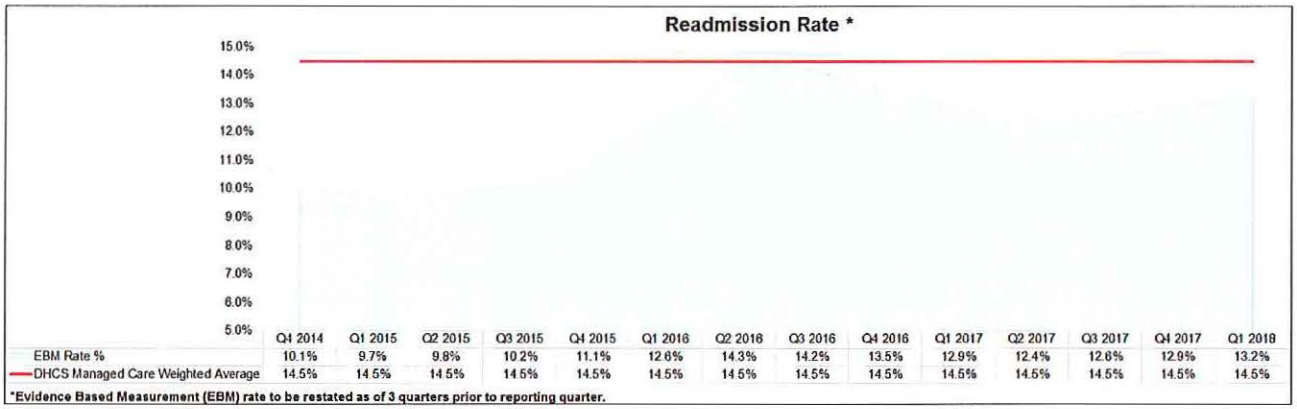




READMISSION RATE

The quarterly readmission rate has declined from a recent peak in Q2 of 2016 (14.3%) to an average of 12.7% for CY 2017.

Readmission rate benchmark: The DHCS Managed Care weighted average for readmission is 14.5%.



CLINICAL GRIEVANCES AND APPEALS

For CY 2017, there was an average of 47 grievances/quarter. The number of clinical grievances for Q1 2018 is 65. For CYTD 2018, most grievances (62%) were characterized as quality of care issues, with access issues accounting for 22% of total grievances.

QTR	Grievance Total	Appeals Total	Upheld	Partial Overturn	Overturned	Withdrawn	Dismissed
2017							
Q1	34	15	6 (40%)	-	8 (53%)	1 (7%)	-
Q2	40	17	9 (54%)	-	4 (23%)	4 (23%)	-
Q3	66	17	9 (53%)	-	6 (35%)	2 (12%)	-
Q4	46	23	13 (56%)	-	5 (22%)	5 (22%)	-
2018							
Q1*	65	28	10 (36%)	-	9 (32%)	4 (14%)	-

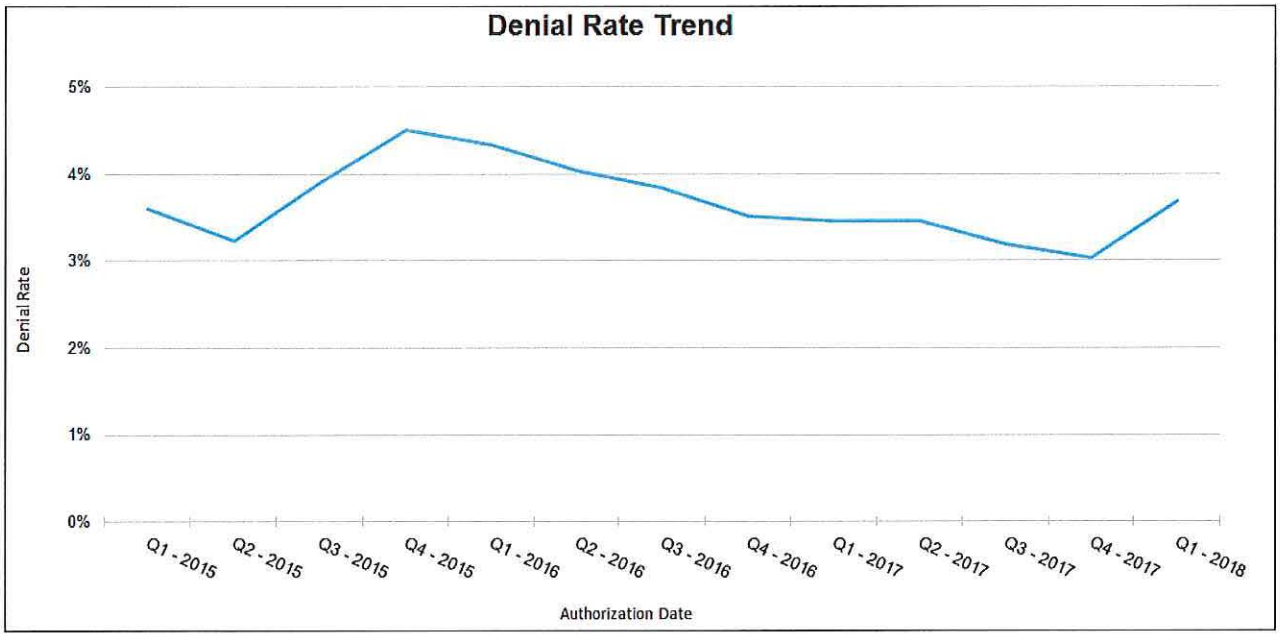
*Q1 2018 total appeals includes 5 (18%) in progress.

Grievance benchmark: DHCS tracks grievances by type. In Q3 2017, the DHCS grievance average was 60% for quality of care and 14% for access issues.

DENIAL RATE

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

The denial rate has ranged between 2.7% and 4.5% since 2013. The average denial rate for CY 2016 was 3.9% and for CY 2017 is 3.3%.



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

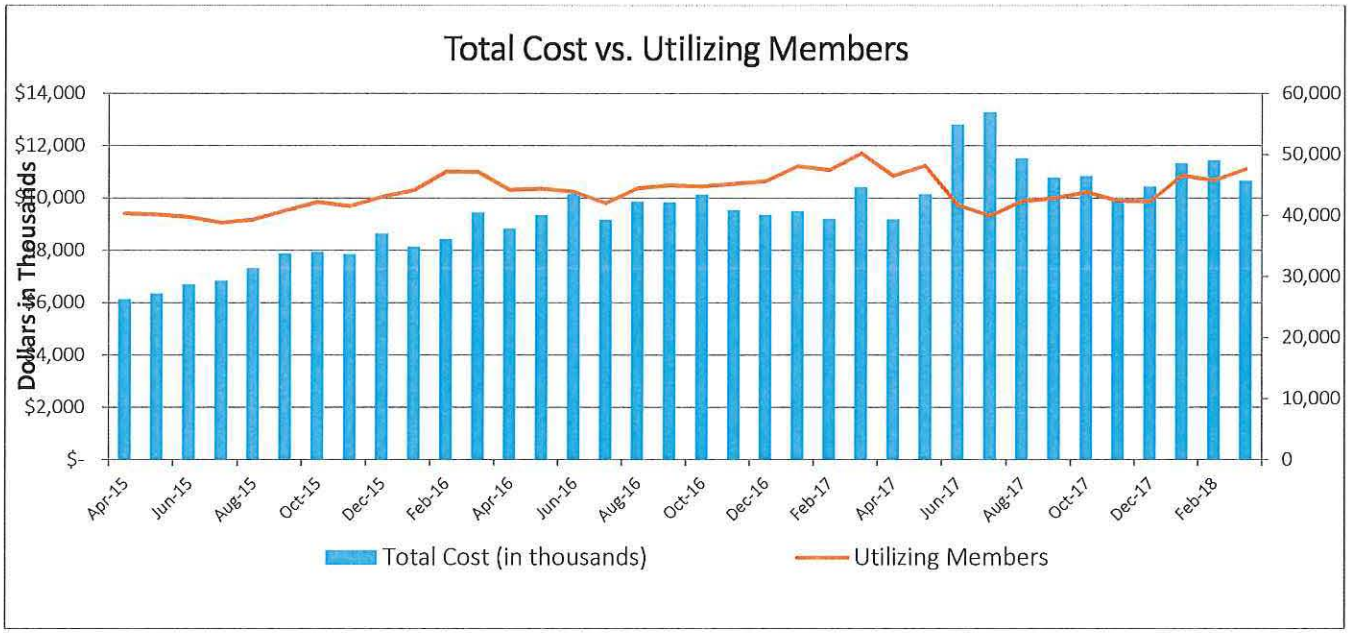
PHARMACY BENEFIT PERFORMANCE AND TRENDS

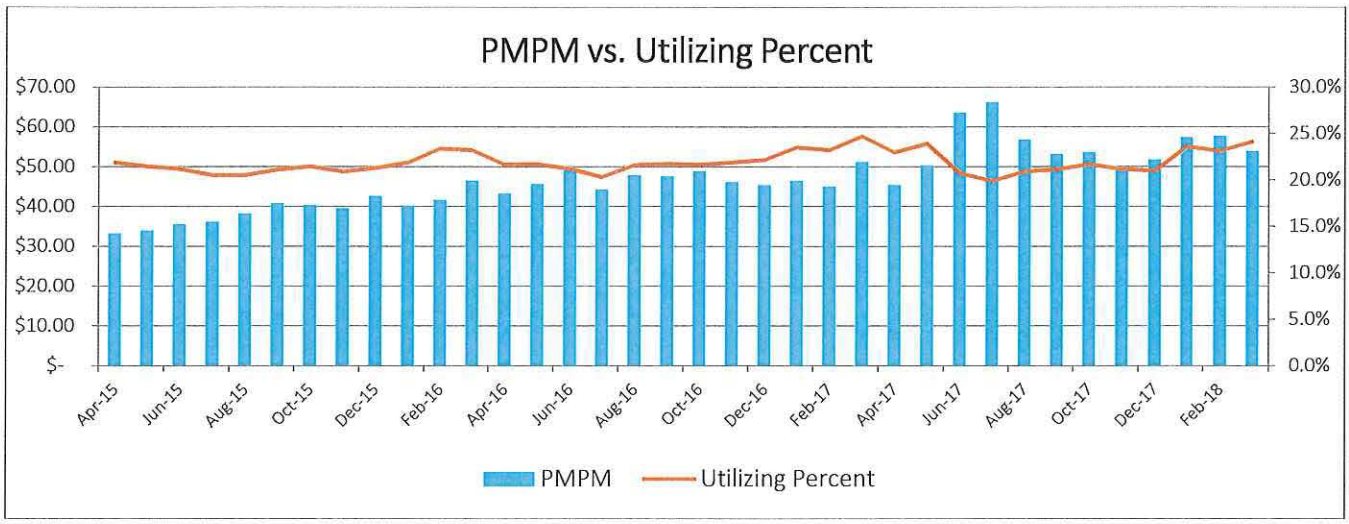
SUMMARY:

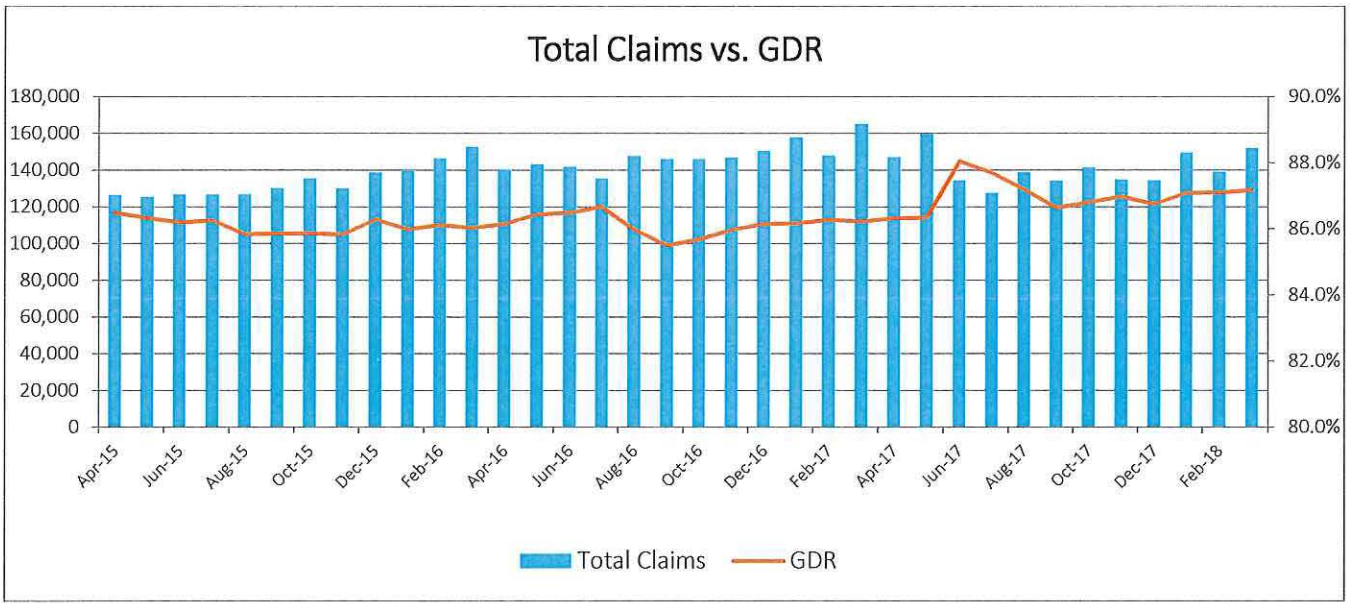
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of October 2017. Although minor changes may occur to the data going forward due to the 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.

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

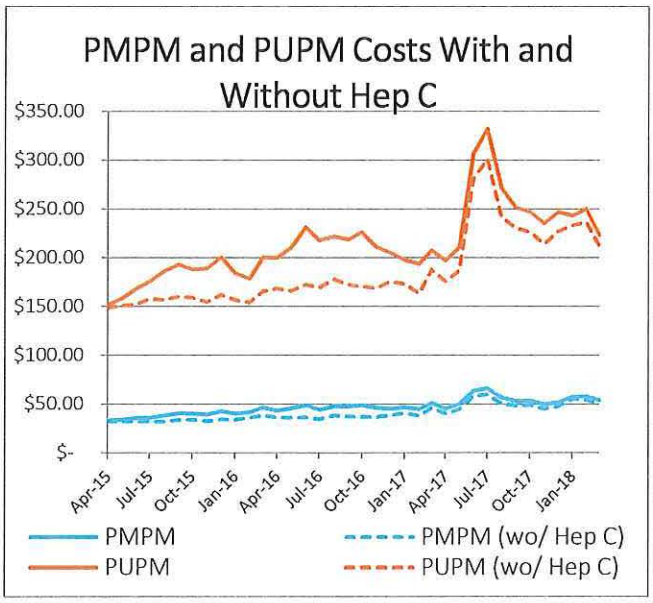
PHARMACY COST TRENDS:

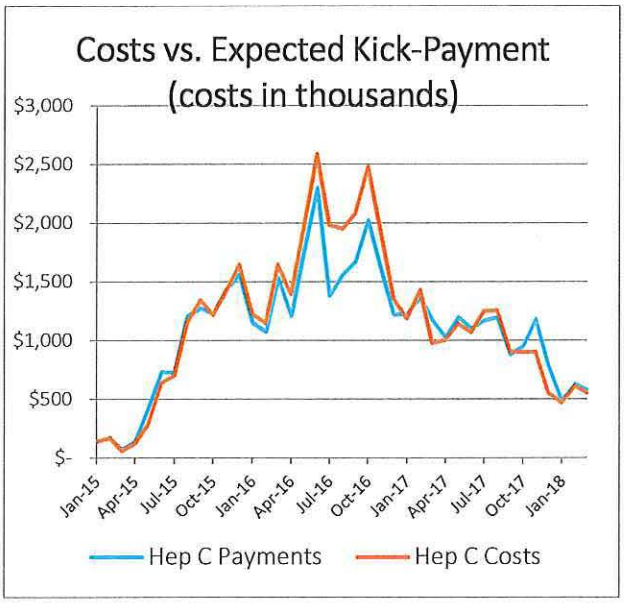



PMPM vs. Utilizing Percent
$70.00
$60.00
$50.00
$40.00
$30.00
$20.00
$10.00
$-
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17
Jun-17
Aug-17
Oct-17
Dec-17
Feb-18
PMPM
Utilizing Percent

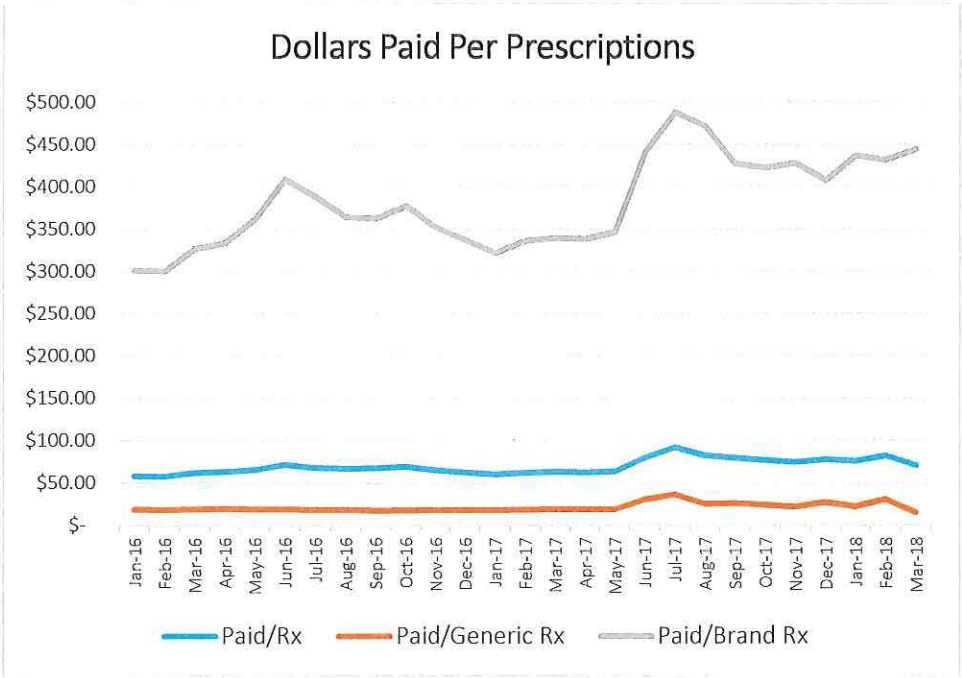

Total Claims vs. GDR
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
90.0%
88.0%
86.0%
84.0%
82.0%
80.0%
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17
Jun-17
Aug-17
Oct-17
Dec-17
Feb-18
Total Claims
GDR

HEPATITIS C FOCUS:





PAID PER PERSCRIPTION:



PBM OVERSIGHT:

The Pharmacy Benefit Manager (PBM), OptumRx (ORx), is delegated to perform several functions for Gold Coast Health Plan (GCHP). The pharmacy department is responsible for ensuring that all delegated functions are occurring properly according to industry standards,

in accordance with GCHP policies and procedures, and as required under the terms of the OptumRX-GCHP agreement.

As part of GCHP's oversight, GCHP has placed OptumRx on a corrective action plan (CAP) to improve its performance under the terms of the agreement. Below is a table outlining the elements of the CAP:

Number of Items	Items Open	Items Pending Closure	Items Closed
12	12	6	0

Additionally, GCHP has directed OptumRx to development an improvement plan focused on the services provided via the telephonic call center. Below is a table outlining the elements of that improvement plan:

Number of Items	Items Open	Items Pending Closure	Items Closed
5	5	0	0