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

Regular Meeting
Monday, September 25, 2017, 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

PUBLIC COMMENT

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

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

CONSENT CALENDAR (ROLL CALL VOTE REQUIRED)

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Special Minutes of August 21, 2017

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the minutes.

2. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Special Minutes of August 30, 2017

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the minutes.

FORMAL ACTION ITEMS

3. Award of the Community Health Investments' Ad Hoc Funding to Ventura County Area Agency on Aging for the Fall Prevention Program

Presenter: Karen Escalante-Dalton, KED Consultants

RECOMMENDATION: Approve grant funding in a not-to-exceed amount of $50,000 to Ventura County Area Agency on Aging for the Fall Prevention Program.

4. June 2017 Year to Date Financials

Staff: Patricia Mowlavi, Chief Financial Officer

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

REPORTS

5. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

6. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

7. AmericasHealth Plan (AHP) Update

RECOMMENDATION: Accept and file the report.

8. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

9. Chief Diversity Officer (CDO) Update

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

10. REPORT INVOLVING TRADE SECRET
Discussion will concern: Pharmacy Benefits Manager Rates
Estimated date of disclosure: In three years, at the earliest.

OPEN SESSION

11. Pharmacy Benefits Manager (PBM) Update

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

12. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: Eleven Cases

13. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Diversity Officer

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

15. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

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

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on October 23, 2017, 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.

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

August 21, 2017 Special Meeting Minutes

CALL TO ORDER

Commissioner Darren Lee called the meeting to order at 2:03 p.m. in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Narcisa Egan, Peter Foy, Michele Laba, M.D., Darren Lee, Gagan Pawar, M.D., Catherine Rodriguez, and Jennifer Swenson.

Absent: Commissioners Lanyard Dial, M.D. and Laura Espinosa.

PUBLIC COMMENT

None.

CONSENT CALENDAR (ROLL CALL VOTE REQUIRED)

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of June 26, 2017

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the minutes.

2. Approval of Contract Extension with Mahdavi Gutta, M.D., for Pre-Service, Inpatient, Post-Service, and Appeals Cases

Staff: Nancy Wharfield, M.D., Chief Medical Officer

RECOMMENDATION: Approve a twenty-four month contract extension with Mahdavi Gutta, M.D., for pre-service, inpatient, post-service, and appeals cases for $100,800 with a not to exceed amount of $319,805.

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3. Approval of Contract Extension with Timothy Donahue, M.D., for Pre-Service, Inpatient, Post-Service, and Appeals Cases

Staff: Nancy Wharfield, M.D., Chief Medical Officer

RECOMMENDATION: Approve a twenty-four month contract extension with Timothy Donahue, M.D., for pre-service, inpatient, post-service, and appeals cases for $96,000 with a not to exceed amount of $234,420.

Commissioner Swenson moved to approve the Consent Calendar. Commissioner Atin seconded.

AYES: Commissioners Alatorre, Atin, Egan, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial and Espinosa.

Commissioner Lee declared the motion carried by a 9-0-2 roll call vote.

FORMAL ACTION ITEMS

4. May 2017 Year to Date Financials

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

Patricia Mowlavi, Chief Financial Officer, stated for the eleven-month period ending May 31, 2017, there was a decrease in net assets of $7.8 million, which was $4.9 million more than budget; the medical loss ratio (MLR) increased to 94.5%; and the cash position is on par with the liquid reserve target, which is three months of operating capital. Ms. Mowlavi noted that beginning July 2017, the State of California is beginning to recoup the Adult Expansion overpayment of $280 million and the repayment amount has been set aside under Current Liabilities.

A discussion followed between the Commissioners and staff regarding membership growth stabilizing; the current tangible net equity (TNE) being decreased to 492% generating a loss for the fiscal year; how a 95% MLR is not sustainable and the need to move towards quality and outcome based performances; and the preliminary unaudited June year end will be provided at the September Commission meeting. The main reasons for the $6 million budget gap is due to the reduction in membership, which affected the Plan in two ways: lower revenue and the Managed Care Organization (MCO) tax payments as these rates are based on the State set membership target that had a flat per member per month (PMPM) along with the long term care true up from last year.

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

AYES: Commissioners Alatorre, Atin, Egan, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial and Espinosa.

Commissioner Lee declared the motion carried.

5. Quality Improvement Committee 2017 Second Quarter Report

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

Nancy Wharfield, M.D., Chief Medical Officer, reported on the second quarter report for the Quality Improvement Committee. The Department of Health Care Services (DHCS) dashboard aggregate quality score went up by 15% over the past four years. The Initial Health Assessment monitoring needs improvement and efforts are being made including technologic solutions. The timeliness of verifications dropped to 99% due the transition from a 365-day audit cycle to a 180-day audit cycle with the expectation to be back at 100% within the next two months. Under Grievances and Appeals, turnaround times dropped due to misrouted correspondence and staffing issues both of which were identified and corrected. Access issues included there not being a system, which can track the time from when the primary care doctor makes a referral and when the patient is able to see the specialist, as well as when the primary care doctor receives the report back from the specialist and what the treatment plan is.

A discussion followed between the Commissioners and staff regarding the ratio of patients to physicians and how the current numbers meet the requirements though staff would like to make additional improvements; what the Center for Medicare and Medicaid Services (CMS) and the State will require for network adequacy with the upcoming MegaReg for better visibility; and the percentage for grievances is an artificial one as the Plan's membership does not traditionally file grievances.

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

AYES: Commissioners Alatorre, Atin, Egan, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

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ABSENT: Commissioners Dial and Espinosa.

Commissioner Lee declared the motion carried.

6. 2016 Quality Improvement Work Plan Evaluation, 2017 Quality Improvement Program Description, and 2017 Quality Improvement Work Plan

RECOMMENDATION: Approve the 2016 Quality Improvement Work Plan Evaluation, 2017 Quality Improvement Program Description, and 2017 Quality Improvement Work Plan.

Kim Osajda, Quality Improvement Director, reviewed the three documents required by DHCS to be approved annually by the Commission. The 2016 Work Plan Evaluation reflected several successes including the cervical cancer screening improvement of 3.89%, which is 6.24% above the minimum performance level (MPL); and improvement in four Healthcare Effectiveness Data and Information Set (HEDIS) measures. These measures were comprised of children and adolescent's access to primary care practitioners; well-child visits in the third, fourth, fifth, and sixth years of life; all-cause readmission; and appropriate testing for children with pharyngitis. The following HEDIS measures and sub-measures saw rate declines, some significant, compared to the previous measurement year resulting in the measures falling below the DHCS MPL: the annual monitoring for patients on persistent medications (MPM) was .54% below MPL; controlling blood pressure (CBP) was 2.02% below MPL; and three sub measures under comprehensive diabetes care were below MPL.

Staff conducted an extensive review to determine the cause of these declines including chart review, claim review, research into the HEDIS vendor systems, and the project management of the record retrieval project. The results of the analysis included providers continuing to order the tests every other year instead of once a year or members not going to the labs with no follow-up by the provider.

Quality Improvement did implement a successful improvement project consisting of provider report cards and performance feedback reports, but the implementation took longer than anticipated so staff was unable to reconcile rates until August. For the CBP, medical records existed but there was an issue with the vendor retrieving these records and had the records been provided, would have exceeded the MPL. To correct this issue, staff contacted the vendor and implemented improvement projects including mock medical record retrieval projects to ensure all the data received is correct. Another issue was with a different record retrieval company, which is no longer being used and GCHP is currently utilizing Novalon who is able to produce more data. Normally, if a Plan falls below the MPL, the DHCS would require a mandatory improvement plan. However, after discussions with staff, DHCS recognized it was a data issue and will allow GCHP to do a tri annual quality performance improvement project. It was clarified the rates are based on a random sample of 411 member records.

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A more detailed analysis is provided in the 2016 Quality Improvement Work Plan Evaluation. Changes to the program description was comprised of language changes in order to align with required DHCS wording including the addition of diabetic and asthma under disease management and the inclusion and diversity language. The only other major change was the deletion of the Network Planning Subcommittee as this information is now being captured and reported at the Quality Improvement Committee.

A discussion followed between the Commissioners and staff regarding the "two large clinic systems" referenced on page 69 of the agenda packet being Ventura County Medical Center and Clinicas del Camino Real. Report cards are being sent to the clinics on a bi-monthly basis showing their performance status along with a performance feedback report. Clarification was made regarding the insertion of the DHCS diversity and inclusion language into the program description and that the Plan is meeting all the members' needs regardless of race, color, gender, sexual identity, etc.

Ms. Osajda continued reviewing the last document, the new 2017 Quality Improvement Work Plan, which is based on the analysis of the previous work plan. Additions reflect the new National Committee for Quality Assurance (NCQA) standards, two new required quality improvement projects (health disparity and childhood immunizations for two year olds), and the standard DHCS contractual requirements.

Commissioner Pawar moved to approve the recommendation. Commissioner Alatorre seconded.

AYES: Commissioners Alatorre, Atin, Egan, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial and Espinosa.

Commissioner Lee declared the motion carried.

REPORTS

7. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

Dale Villani, Chief Executive Officer, formally introduced Dr. Wharfield as the new Chief Medical Officer and stated the recruitment has begun for a Medical Director. Vickie Lemmon, Director of Health Services, is retiring after 44 years in nursing on September 8, 2017, and noted she was instrumental in the creation of the Plan's core values. Her replacement, Kathy Neal, Senior Director of Health Services,

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joined GCHP from Central California Alliance. Melissa Scrymgeour's title has been changed to Chief Administrative Officer to reflect her expanded duties including the oversight of government affairs and external relations and the clerk of the board.

A discussion followed between the Commissioners and staff regarding the title change and pay increase for the Chief Information and Strategy Officer to reflect the duties added under the position. Concern was expressed by the Commissioners regarding the importance of transparency with respect to highly paid positions and that there is a fair and balanced process in place.

Mr. Villani stated Congresswoman Julia Brownley visited GCHP on August 11, 2017, where she had to opportunity to meet the Health Education and Membership Services teams. On July 19, 2017, GCHP hosted an appreciation event for the sixteen agencies who were the recipients of the Community Health Investment grant program.

A kickoff meeting was held on August 10, 2017, for a potential plan-to-plan pilot with AmericasHealth Plan with Ruth Watson, Chief Operating Officer, as the project lead. The biggest hurdle is the implementation of the State's MegaReg amendment, which needs to be completed prior to the Plan entering into a plan-to-plan program. Currently, the Plan is busy with projects like the ASO Request for Proposal (RFP). This RFP is a large endeavor requiring a lot of staff time and is scheduled to be released by the end of October or early November. Additionally, there are 171 MegaReg requirements in the DHCS draft contract amendment, 69 pending requirements that will come in the form of an additional amendment or a policy letter, and an additional 60 requirements that are awaiting the State to decide how they are going to conform to those requirements. With these significant projects, staff is becoming inundating and the day the day operations is being consumed with project work, it has been determined the CMS Dual Eligible Special Needs Plan (D-SNP) will be delayed for a year. Lastly, since the Plan missed three months of test files for the 274 provider network data file, there is a $25,000 monetary sanction imposed by DHCS but the corrective action plan has been removed.

The Commission unanimously agreed to recess at 3:06 p.m.

The Regular Meeting reconvened at 3:11 p.m.

8. Pharmacy Benefits Manager (PBM) Update

RECOMMENDATION: Accept and file the report.

Anne Freese, PharmD, Director of Pharmacy, stated the PBM implementation with OptumRx went live on June 1, 2017, and there are three outstanding items. The first item is the contract with the Kaiser pharmacies in relation to members who have Kaiser as a primary commercial plan or Medi-Cal coverage plan. In the prior PBM contract with Script Care, there was a contract between the PBM and Kaiser pharmacies and staff is looking to make that same contract with OptumRx. Kaiser

has reviewed the contract and requested auditing provisions to be removed, which the Plan cannot due to the DHCS contract. OptumRx is working on resolving this issue in order to execute the contract. Script Care and OptumRx are working together on the 340B program in order to develop a process so Script Care can identify the claims that qualify for 340B and provide the data to OptumRx. Script Care will be providing a proposal to GCHP for related costs. Lastly, the pharmacy reimbursement process was reviewed, which included how the PBM contracts directly with the pharmacy or a pharmacy services administrative organization (PSAO). In accordance with the DHCS contract, GCHP is required to provide members access to pharmacy services during normal business hours. In light of this, there are performance guarantees related to network access built into the OptumRx contract. At the end of July, the Plan became aware there was an error in OptumRx's coding for the maximum allowable cost (MAC) for generic drugs resulting in higher reimbursement rates for roughly two-thirds of July. The corrected reimbursement rate went into effect July 25, 2017, and once implemented there were a variety of complaints received as it affected 48 pharmacies. It was noted the State determines there is an overpayment or avoidable costs for the generic reimbursement rates, they will reduce the Plan's capitation rates up to 15%, which did occur through the previous PBM with Script Care.

A discussion followed between the Commissioners and staff regarding how each PBM has their own MAC list, and the national standard is how DHCS assesses GCHP's effectiveness of the PBM contract and pharmacy reimbursement rates, but the individual rates are in relation to the MAC list and the individual contracts between the PBM and the Plan.

Jessica Renfeldt, OptumRx's Senior Director Account Management, stated they are currently reviewing the data and the reason why this issue affected only 48 out of 300 pharmacies was due to human error and the subset of the network for the MAC was not applied.

Todd Borowski, OptumRx's Director of Industry and Network Relations, stated the pharmacies can access the appeals form through their website and will receive a response within seven days. If GCHP receives any calls from the pharmacies, they should refer them to OptumRx. In addition, there is a pharmacy help desk with an 800 number. Mr. Borowski explained how the MACs are set for generic drugs and the pharmacies' recourses are in relation to this process.

A discussion followed between the Commissioners and staff regarding how through the contract for generic drugs, the pharmacies agree to receive the lesser of either the average wholesale price minus a contracted discount, the MAC price, or the pharmacy submitted cost plus a dispensing fee. It was clarified the rates the pharmacies are being paid for GCHP are from an existing MAC list, so the pharmacies were receiving those rates prior to GCHP joining OptumRx.

Dr. Freese noted she has received eight complaints, though that number represents ten pharmacies. For each reimbursement correspondence received, she has reached out to the pharmacy by either phone or email and directed them to reach out to OptumRx through the established protocols and if contracted

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through a PSAO, to submit an appeal through their process. OptumRx has been requested to expedite and escalate any MAC appeals. Staff has completed an internal review of claims and is conducting an analysis of the data. GCHP is continuing to provide oversight on OptumRx ensuring the rates provided on GCHP's invoices are the same rates the pharmacies are receiving as well as making sure network adequacies are being adhered to per the contract terms.

There were six public speakers and one written public comment card.

Joe Hoffman expressed concern over the PBM reimbursement rates.

Hanh Platt, a representative for Medical Arts Pharmacy, expressed concern over the PBM reimbursement rates.

Carlos Varela, a representative for The Medicine Shoppe #387, expressed concern over the PBM reimbursement rates.

Alondra Arias, a representative for Hueneme Family Pharmacy, expressed concern over the PBM reimbursement rates.

Ali Kara-dish expressed concern over the PBM reimbursement rates.

Robert Andonian expressed concern over the PBM reimbursement rates.

Max Rei, a representative of All Med Drugs, submitted a speaker card expressing concern over the PBM reimbursement rates.

The Commission requested information in order to determine what the exact discrepancy is regarding the reimbursement rates as well as the cause. Scott Campbell, General Counsel, stated since the reimbursement rates are confidential, a closed session item under trade secrets will be on the October's Commission meeting in order to discuss the matter.

9. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

Ms. Watson stated in July there was a reduction in membership and in August, membership was up to 202,670 a gain of 1,767 members. Service level agreements with Conduent are being met and staff is working on process improvements with them for the length of the contract, which is two years with four successive six-month extensions. Claims denials remain within industry norms at 14.45%. The top claim denial reason is "service is included in monthly capitation per contract with provider" and the reason "services are the financial responsibility of Clinicas" is listed separately is Clinicas is the only provider GCHP has a specialty contract with. Call center volume is at 11,000 to 12,000 calls per month. There were 19 member grievances equating to .09 grievances per 1,000 members though as previously noted the member population generally do not report grievances. Key projects include the July's 274 File being successfully accepted

by the State and GCHP is in live production mode. The SB 137 Provider Directories MegaReg requirement was approved by the State on August 3, 2017. Lastly, GCHP is currently in the process of an RFP for a provider network database and credentialing system.

A discussion followed between the Commissioners and staff regarding provider grievances and that there is a strong provider dispute resolution process, which is automated and is prescribed by the State. It was noted the results of the AB 85 audit would be reported on at the next Audit Committee meeting with the date to be determined.

10. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

Dr. Wharfield stated in the standard utilization report that each of the metrics is shown by overall number with Seniors and Persons with Disabilities (SPD) broken out along with a benchmark. Numbers continue to be flat and utilization numbers have dropped since the Plan's inception. As emergency department (ED) utilization can be an access issue, focus should be placed on the real metric of avoidable ED utilization. The top admitting diagnoses distribution remains unchanged. Under Clinical Grievances and Appeals, access issues consisted of 1% for the second quarter for 2017. Information for Health Education is also provided in the report.

Dr. Freese stated there are no significant changes for the pharmacy trends with the exception of an uptick in Hepatitis C prescriptions.

Commissioner Pawar requested the Hepatitis C graph comparing the generic and brand name cost be provided in the report for the next Commission meeting.

11. Chief Administrative Officer (CAO) Update

RECOMMENDATION: Accept and file the report.

Melissa Scrymgeour, Chief Administrative Officer, stated the strategic plan has been updated to reflect the Commission's direction and feedback from the March 17, 2017, strategic planning session. It has been expanded to a three-year view that builds upon the Plan's core objectives of identifying and executing strategies to improve member access, quality of care, and improving the health and wellness of the community while maintaining financial stability. The portfolio focuses on five main areas: regulatory mandates, "lights on", security/information security, business process improvement (BPI)/technology investments, and the triple aim resulting with 15 initiatives identified.

A discussion followed between the Commissioners and staff regarding including the diversity inclusion piece in the strategic outlook as it reflects collaboration as a team and that the sponsorship programs and the strategic plan should be

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integrated. Commissioner Rodriguez requested more specific metrics in order to evaluate each initiative.

12. Chief Diversity Officer (CDO) Update

RECOMMENDATION: Accept and file the report.

The Commissioners unanimously agreed to pull Agenda Item No. 12, as Douglas Freeman was not available to present the report.

Commissioner Alatorre moved to approve the recommendation to accept and file Agenda Item Nos. 7 through 11. Commissioner Atin seconded.

AYES: Commissioners Alatorre, Atin, Egan, Foy, Laba, Lee, Pawar, Rodriguez, and Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial and Espinosa.

Commissioner Lee declared the motion carried.

Mr. Campbell announced Closed Session Item No. 13 Liability Claim from Cathy Curtis; Closed Session Item No. 14 Conference with Legal Counsel – Anticipated Litigation regarding an allegation by Andre Galvan; and Closed Session Item No. 15 – Public Employee Performance Evaluation for the Chief Diversity Officer.

CLOSED SESSION

The Commission adjourned to Closed Session at 4:46 p.m.

13. LIABILITY CLAIMS
Claimant: Cathy Curtis
Agency Claimed Against: Gold Coast Health Plan

14. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case

15. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Diversity Officer

OPEN SESSION

The Regular Meeting reconvened at 6:14 p.m.

Mr. Campbell stated the Commission denied the claim for Cathy Curtis.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 6:15 p.m.

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

August 30, 2017 Special Meeting Minutes

CALL TO ORDER

Commissioner Darren Lee called the meeting to order at 5:07 p.m. in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Peter Foy, Narcisa Egan, Laura Espinosa, Darren Lee, Catherine Rodriguez (arrived at 5:21 p.m.), and Jennifer Swenson.

Absent: Commissioners Lanyard Dial, Michele Laba, M.D., and Gagan Pawar, M.D.

PUBLIC COMMENT

None.

Mr. Campbell announced Closed Session Agenda Item No. 1 – Conference with Legal Counsel – Anticipated Litigation involving Andre Galvan; Agenda Item No. 2 – Public Employee Performance Evaluation Chief Diversity Officer; and Agenda Item No. 3 – Initiation of litigation for ten cases in which the defendants do not know the facts of the case and no further disclosure is required.

Mr. Campbell requested Commissioner Espinosa recuse herself regarding Agenda Item No. 1 due to correspondence received from the League of United Latin American Citizens (LULAC) on behalf of Mr. Galvan and she is a LULAC board member.

Commissioner Espinosa recused herself from Closed Session Agenda Item No. 1 – Conference with Legal Counsel – Anticipated Litigation involving Mr. Galvan.

CLOSED SESSION

The Commission adjourned to Closed Session at 5:14 p.m.

Commissioner Espinosa returned at 5:35 p.m.

Commissioner Rodriguez arrived at 5:21 p.m.

Commissioner Alatorre left at 6:07 p.m.

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1. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION**
   Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case

2. **PUBLIC EMPLOYEE PERFORMANCE EVALUATION**
   Title: Chief Diversity Officer

3. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION**
   Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: Ten Cases

OPEN SESSION

The Regular Meeting reconvened at 7:09 p.m.

Mr. Campbell stated there was no reportable action taken.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 7:10 p.m.

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AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Karen Escalante-Dalton, KED Consultants

DATE: September 25, 2017

SUBJECT: Community Health Investments - Ad-Hoc Funding Recommendation

SUMMARY:
This memo provides an overview of one Ad-Hoc grant recommended for funding through Gold Coast Health Plan's (GCHP) Community Health Investments. *Ad-Hoc* or *Responsive* grants are those awarded in response to requests from external organizations not related to any existing Initiative or priority area. Ad-Hoc grants must be consistent with GCHP's strategic goals, and/or provide for a specific community health need.

The Ad-Hoc grant under consideration was reviewed and scored by a 4-member Grant Review Committee. Grant reviewers met on August 8 to discuss the risks and benefits of supporting this application. The Grant Review Committee's recommendations were then presented to GCHP's Executive Leadership Team on August 15 prior to moving for final approval by the Commission. Below is an overview of the recommended grant including the organization name, the project title, a brief description of the project recommended for funding, and the grant amount recommended.

COMMUNITY HEALTH INVESTMENTS AD-HOC FUNDING RECOMMENDATIONS			
Agency Name	**Project Name**	**Project Description**	**Amount Rec.**
Ventura County Area Agency on Aging	**Fall Prevention Program**	To prevent falls among seniors, including monolingual Spanish-speaking, socioeconomically disadvantaged GCHP members in Oxnard and Camarillo by providing home visits, home modifications, linkages to social services, health navigation with primary care physicians, and evidence-based exercise classes. The project goal is to decrease recidivist falls from the current rate of 19% to 4% among project participants, resulting in significant healthcare cost reductions.	$50,000
Total Recommended for Approval			**$50,000**

FISCAL IMPACT:

The cost to award the proposed grant funds for one-year is $50,000 to be disbursed in two payments of $25,000.

RECOMMENDATION:

Staff hereby recommends that the Commission approve funding in a not to exceed amount of $50,000 to the Ventura County Area on Aging for the Fall Prevention Program.

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Patricia Mowlavi, Chief Financial Officer

DATE: September 25, 2017

SUBJECT: June 2017 Fiscal Year to Date Financials

SUMMARY:

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

BACKGROUND/DISCUSSION:

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

FISCAL IMPACT:

Financial Highlights

Overall Performance – For the full fiscal year or twelve-month period ended June 30, 2017, the Plan's performance was a decrease in net assets of $13.6 million, which was $10.5 million higher than budget. Cost of health care was higher than budget by $8.7 million driven by higher contracted rates. The medical loss ratio increased to 94.5 percent of revenue, which was 2.0 percent higher than the budget. Administrative savings were realized through lower than projected administrative expenses – most notably those expenses related to projects and those whose variability are determined by membership levels.

Membership – June's membership of 203,990 was 10,738 members below budget. For FYTD, membership is 2,485,202 or 59,634 below budget.

Revenue – For the fiscal year, net revenue was $680.3 million or $7.3 million below budget due to the aforementioned below budget membership. On a PMPM basis, revenue was $3.55 PMPM above budget due to membership mix, with higher than expected Adult Expansion membership.

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 FY2017 is $84.5 million, accrued at a rate of approximately $7.0 million per month. The last quarterly installment of MCO tax for the fiscal year was be paid on July 6, 2017.

Health Care Costs – Health care costs for the fiscal year were $645.9 million or $8.7 million higher than budget. The medical loss ratio (MLR) was 94.5% versus 92.5% for budget.

Adult Expansion Population 85% Medical Loss Ratio – The Balance Sheet contains a $131.3 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	7/1/2016 - 6/30/2017
Total Revenue	361,237,234	293,173,426	268,060,238	408,478,360
Total Estimated Medical Expense	206,719,452	237,729,974	234,431,483	411,499,792
	57.2%	81.1%	87.5%	100.7%
Total MLR Reserve	**118,168,494**	**13,101,452**		

Administrative Expenses – For the fiscal year ended June 30, administrative costs were $51.2 million or $3.4 million below budget. As a percentage of revenue, administrative costs (or ACR) were 7.5% versus 7.9% for budget.

Cash and Medi-Cal Receivable – At June 30, the Plan had $457.3 million in cash and short-term investments and $126.4 million in Medi-Cal Receivable for an aggregate amount of $583.6 million. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $280.2 million. The Plan anticipates AE repayment to commence in sometime during second quarter in FY 2018. As consistent with prior fiscal years, the State has delayed the May and June capitation payments until August.

Investment Portfolio – At June 30, 2017, the value of the investments (all short term) was $279.5 million. The portfolio included Cal Trust $51.0 million; Ventura County Investment Pool $85.9 million; LAIF CA State $63.5 million; Bonds and Commercial Paper $79.1 million.

RECOMMENDATION:

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

CONCURRENCE:

N/A

ATTACHMENT:

June 2017 Financial Package

FINANCIAL PACKAGE
For the month ended June 30, 2017

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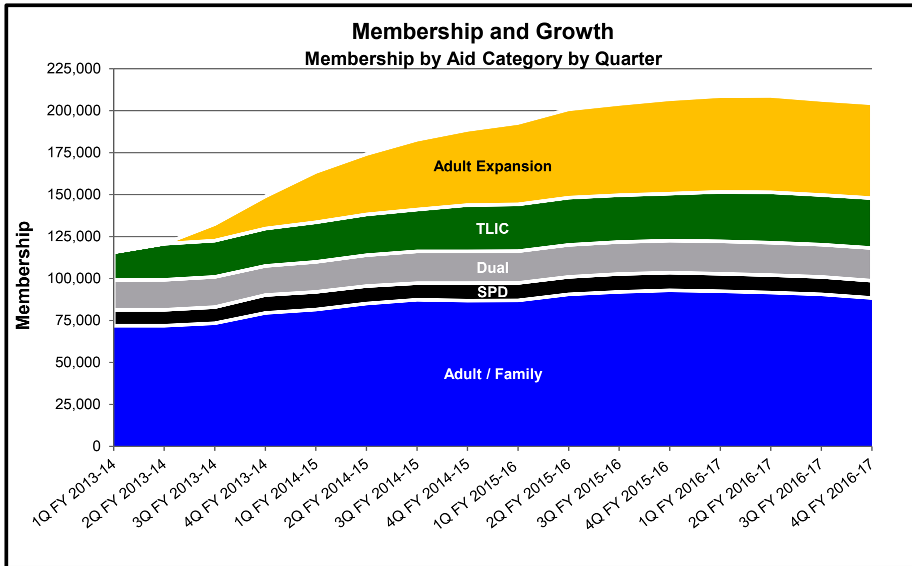
- Financial Performance Dashboard
- Cash and Operating Expense Requirements

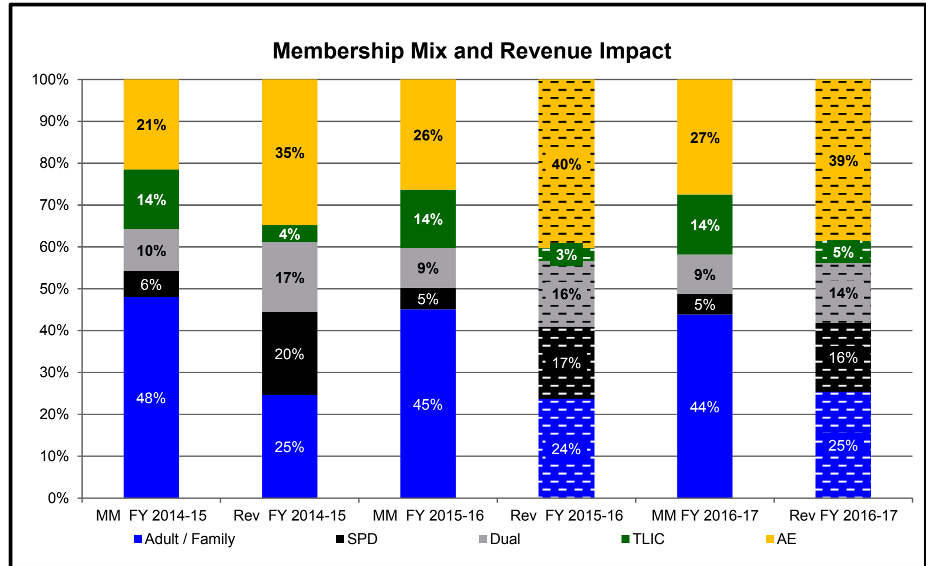
APPENDIX

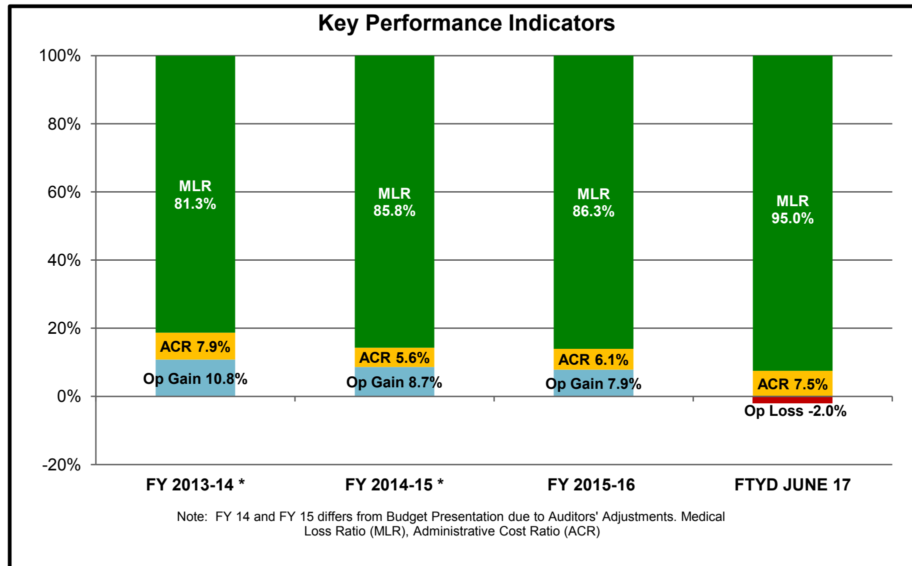
- Statement of Financial Positions
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows
- Membership
- Paid Claims and IBNP Composition

Description	AUDITED FY 2014-15	AUDITED FY 2015-16	FY 2016-17 JUL - SEP 16	OCT - DEC 16	JAN - MAR 17	APR - JUN 17	FYTD JUN 17	Budget Comparison Budget FYTD	Variance Fav / (Unfav)
Member Months	**2,130,979**	**2,413,136**	**626,084**	**626,419**	**619,463**	**613,236**	**2,485,202**	**2,544,836**	(59,634)
Revenue	**595,607,370**	**675,629,602**	**148,815,746**	**190,063,083**	**175,648,323**	**165,728,127**	**680,255,278**	**687,543,830**	(7,288,551)
pmpm	*279.50*	*279.98*	*237.69*	*303.41*	*283.55*	*270.25*	*273.72*	*270.17*	3.55
Health Care Costs	**509,183,268**	**583,149,780**	**155,478,257**	**156,886,345**	**161,064,037**	**172,502,637**	**645,931,276**	**637,185,946**	(8,745,329)
pmpm	*238.94*	*241.66*	*248.33*	*250.45*	*260.01*	*281.30*	*259.91*	*250.38*	(9.53)
% of Revenue	85.5%	86.3%	104.5%	82.5%	91.7%	104.1%	94.5%	92.5%	-1.97%
Admin Exp	**34,814,049**	**38,256,908**	**12,063,462**	**12,399,366**	**12,325,129**	**14,388,360**	**51,176,317**	**54,539,066**	3,362,749
pmpm	*16.34*	*15.85*	*19.27*	*19.79*	*19.90*	*23.46*	*20.59*	*21.43*	0.84
% of Revenue	5.8%	5.7%	8.1%	6.5%	7.0%	8.7%	7.5%	7.9%	0.43%
Non-Operating Revenue / (Expense)		**1,790,949**	**596,568**	**647,800**	**1,004,824**	**1,004,947**	**3,254,139**	**1,068,017**	2,186,122
pmpm		*0.74*	*0.95*	*1.03*	*1.62*	*1.64*	*1.31*	*0.42*	0.89
% of Revenue		0.3%	0.4%	0.3%	0.6%	0.6%	0.5%	0.2%	0.32%
Total Increase / (Decrease) in Unrestricted Net Assets	**51,610,053**	**56,013,863**	**(18,129,405)**	**21,425,172**	**3,263,981**	**(20,157,923)**	**(13,598,175)**	**(3,113,166)**	(10,485,010)
pmpm	*24.22*	*23.21*	*(28.96)*	*34.20*	*5.27*	*(32.87)*	*(5.47)*	*(1.22)*	(4.25)
% of Revenue	8.7%	8.3%	-12.2%	11.3%	1.9%	-12.2%	-2.0%	-0.5%	-1.54%
YTD									
100% TNE	22,556,530	25,246,284	26,097,131	27,075,526	27,709,401	29,231,052	29,231,052	29,290,529	(59,478)
% TNE Required	100%	100%	100%	100%	100%	100%	100%	100%	
Minimum Required TNE	22,556,530	25,246,284	26,097,131	27,075,526	27,709,401	29,231,052	29,231,051.72	29,290,529	(59,478)
GCHP TNE	**107,145,264**	**155,959,127**	**137,829,722**	**159,254,894**	**162,518,875**	**142,360,951**	**142,360,951**	**149,943,990**	**(7,583,039)**
TNE Excess / (Deficiency)	**84,588,734**	**130,712,843**	**111,732,591**	**132,179,367**	**134,809,474**	**113,129,900**	**113,129,900**	**120,653,461**	**(7,523,561)**
% of Required TNE level	**475%**	**618%**	**528%**	**588%**	**587%**	**487%**	**487%**	**512%**	

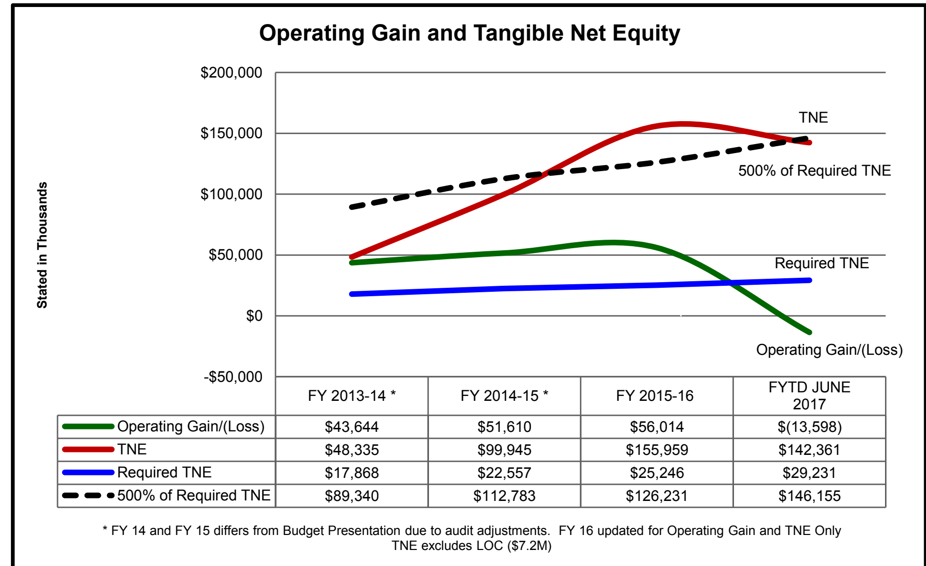
FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING JUNE 30, 2017







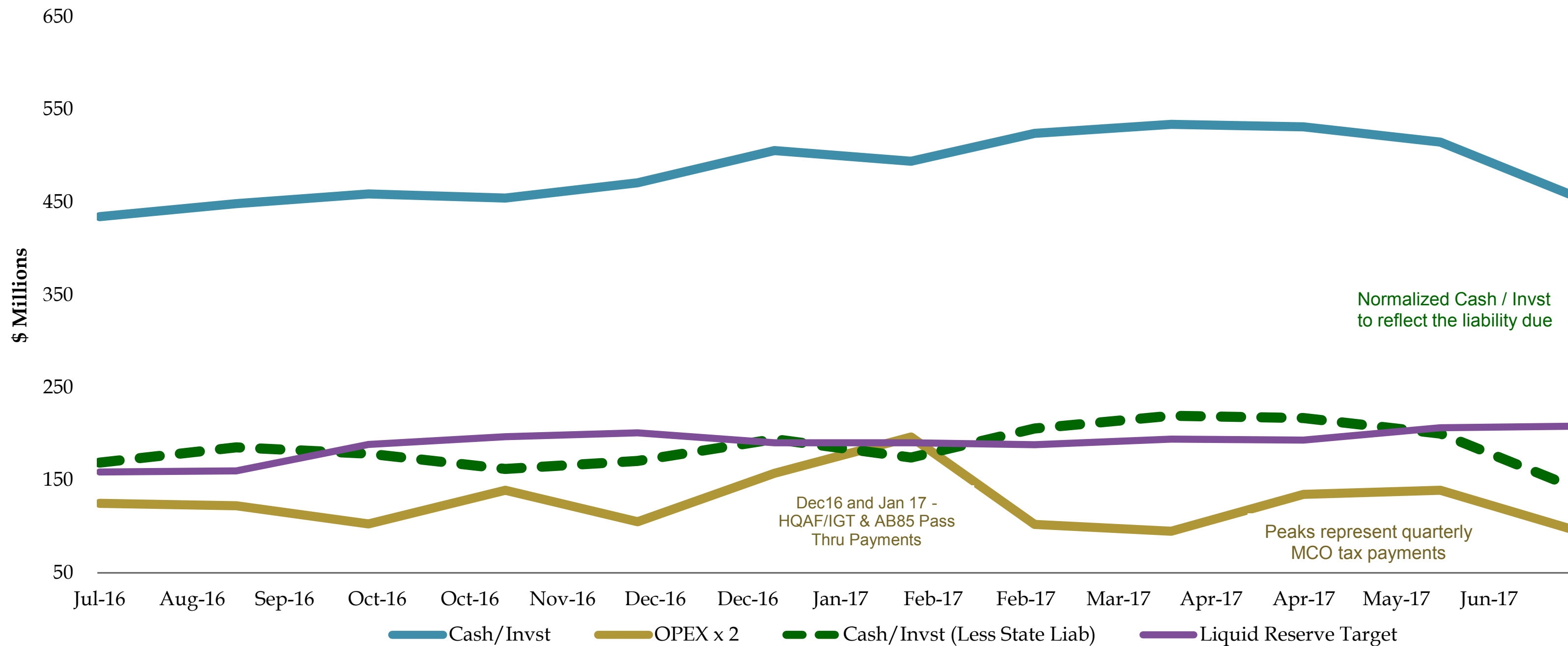
Note: FY 14 and FY 15 differs from Budget Presentation due to Auditors' Adjustments. Medical Loss Ratio (MLR), Administrative Cost Ratio (ACR)



	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FYTD JUNE 2017
Operating Gain/(Loss)	$43,644	$51,610	$56,014	$(13,598)
TNE	$48,335	$99,945	$155,959	$142,361
Required TNE	$17,868	$22,557	$25,246	$29,231
500% of Required TNE	$89,340	$112,783	$126,231	$146,155

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

Back to Agenda


GOLD COAST HEALTH PLAN
FY 2016 - 17
Cash & Operating Expense Requirements
650
550
450
350
250
150
50
$ Millions
Normalized Cash / Invst
to reflect the liability due
Dec16 and Jan 17 -
HQAF/IGT & AB85 Pass
Thru Payments
Peaks represent quarterly
MCO tax payments
Jul-16
Aug-16
Sep-16
Oct-16
Oct-16
Nov-16
Dec-16
Dec-16
Jan-17
Feb-17
Feb-17
Mar-17
Apr-17
Apr-17
May-17
Jun-17
Cash/Invst
OPEX x 2
Cash/Invst (Less State Liab)
Liquid Reserve Target
Dec 16 and Jan 17 - Received and disbursed HQAF and IGT pass thru
Jun 17 - Capitation revenue receipt deferred until August 17

For the month ended June 30, 2017

APPENDIX

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

STATEMENT OF FINANCIAL POSITION

	06/30/17	05/31/17	04/30/17
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 177,821,723**	**$ 235,633,348**	**$ 252,321,190**
Total Short-Term Investments	**279,457,668**	**279,295,844**	**279,137,218**
Medi-Cal Receivable	126,360,679	65,412,833	59,897,643
Interest Receivable	521,185	593,285	532,839
Provider Receivable	822,526	585,831	655,718
Total Accounts Receivable	**127,704,390**	**66,591,949**	**61,086,200**
Total Prepaid Accounts	3,498,997	2,003,556	1,423,907
Total Other Current Assets	135,560	133,545	133,545
Total Current Assets	**588,618,339**	**583,658,242**	**594,102,059**
Total Fixed Assets	**2,342,066**	**2,256,975**	**2,417,225**
Total Assets	**$ 590,960,405**	**$ 585,915,217**	**$ 596,519,284**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 53,366,347	$ 54,406,013	$ 59,143,280
Claims Payable	16,129,092	16,032,342	16,146,292
Capitation Payable	57,303,049	57,113,252	57,092,423
Physician ACA 1202 Payable	0	591,696	591,696
AB 85 Payable	0	1,458,214	1,461,995
DHCS - Reserve for Capitation Recoup	131,269,946	131,269,946	131,269,946
Accounts Payable	2,870,882	3,441,721	2,882,782
Accrued ACS	1,670,932	1,668,431	1,669,857
Accrued Expenses	162,787,944	155,989,637	155,346,947
Accrued Premium Tax	21,061,415	13,727,855	6,507,001
Accrued Payroll Expense	1,118,259	1,083,361	1,361,309
Total Current Liabilities	**447,577,866**	**436,782,470**	**433,473,527**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	1,021,588	1,021,861	1,022,133
Total Long-Term Liabilities	**1,021,588**	**1,021,861**	**1,022,133**
Total Liabilities	**448,599,454**	**437,804,330**	**434,495,661**
Net Assets:			
Beginning Net Assets	155,959,127	155,959,127	155,959,127
Total Increase / (Decrease in Unrestricted Net Assets)	(13,598,175)	(7,848,240)	6,064,497
Total Net Assets	**142,360,951**	**148,110,887**	**162,023,623**
Total Liabilities & Net Assets	**$ 590,960,405**	**$ 585,915,217**	**$ 596,519,284**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR TWELVE MONTHS ENDED JUNE 30, 2017

	JUNE 2017 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	2,485,202	2,544,836	(59,634)
Revenue			
Premium	$ 761,021,942	$ 772,781,471	$ (11,759,529)
Reserve for Rate Reduction	3,350,000	(2,486,692)	5,836,692
MCO Premium Tax	(84,483,344)	(82,750,950)	(1,732,394)
Total Net Premium	**679,888,598**	**687,543,830**	**(7,655,231)**
Other Revenue:			
Miscellaneous Income	366,680	0	366,680
Total Other Revenue	366,680	**0**	366,680
Total Revenue	**680,255,278**	**687,543,830**	**(7,288,551)**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	65,154,983	60,551,307	(4,603,676)
FFS Claims Expenses:			
Inpatient	132,800,947	127,445,672	(5,355,276)
LTC / SNF	118,933,150	115,404,197	(3,528,953)
Outpatient	57,585,161	49,439,909	(8,145,252)
Laboratory and Radiology	3,461,006	2,924,064	(536,942)
Emergency Room	22,532,374	21,698,530	(833,844)
Physician Specialty	56,050,291	57,612,315	1,562,024
Primary Care Physician	16,020,932	18,811,666	2,790,734
Home & Community Based Services	18,221,793	15,856,017	(2,365,775)
Applied Behavior Analysis Services	5,427,331	1,439,956	(3,987,375)
Mental Health Services	5,936,378	4,160,506	(1,775,872)
Pharmacy	118,705,452	117,847,604	(857,848)
Provider Reserve	349,507	12,173,607	11,824,100
Other Medical Professional	3,170,882	2,506,437	(664,445)
Other Medical Care	201,880	0	(201,880)
Other Fee For Service	8,425,088	7,619,022	(806,066)
Transportation	1,930,850	1,557,316	(373,534)
Total Claims	570,123,402	556,496,816	(13,626,586)
Medical & Care Management Expense	12,226,174	14,081,114	1,854,940
Reinsurance	1,199,049	6,056,710	4,857,660
Claims Recoveries	(2,772,332)	0	2,772,332
Sub-total	10,652,891	20,137,824	9,484,932
Total Cost of Health Care	**645,931,276**	**637,185,946**	**(8,745,329)**
Contribution Margin	**34,324,003**	**50,357,883**	**(16,033,881)**
General & Administrative Expenses:			
Salaries, Wages & Employee Benefits	22,655,305	24,176,999	1,521,694
Training, Conference & Travel	414,140	553,175	139,035
Outside Services	27,618,547	29,297,444	1,678,897
Professional Services	4,481,764	6,149,897	1,668,132
Occupancy, Supplies, Insurance & Others	7,029,744	8,442,665	1,412,921
ARCH/Community Grants	1,202,990	0	(1,202,990)
Care Management Credit	(12,226,174)	(14,081,114)	(1,854,940)
Total G & A Expenses	**51,176,317**	**54,539,066**	**3,362,749**
Total Operating Gain / (Loss)	**$ (16,852,314)**	**$ (4,181,183)**	**$ (12,671,132)**
Non Operating			
Revenues - Interest	3,254,139	1,068,017	2,186,122
Total Non-Operating	3,254,139	1,068,017	2,186,122
Total Increase / (Decrease) in Unrestricted Net Assets	**$ (13,598,175)**	**$ (3,113,166)**	**$ (10,485,010)**
Net Assets, Beginning of Year	155,959,127		
Net Assets, End of Current Period	142,360,951		

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2016-17 Monthly Trend			Current Month		
	Mar 17	Apr 17	May 17	JUNE 2017 Actual	JUNE 2017 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	205,829	205,106	204,140	203,990	214,728	(10,738)
Revenue:						
Premium	$ 62,813,120	$ 62,371,164	$ 62,297,031	$ 62,406,054	$ 65,141,205	$ (2,735,151)
Reserve for Rate Reduction	4,000,000	0	0	0	(221,226)	221,226
MCO Premium Tax	(7,006,094)	(7,006,180)	(7,006,391)	(7,333,552)	(6,979,630)	(353,922)
Total Net Premium	**59,807,026**	**55,364,984**	**55,290,640**	**55,072,502**	**57,940,349**	**(2,867,847)**
Total Revenue	**59,807,026**	**55,364,984**	**55,290,640**	**55,072,502**	**57,940,349**	**(2,867,847)**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,227,526	4,925,418	5,109,110	5,296,649	5,103,750	(192,899)
FFS Claims Expenses:						
Inpatient	12,784,974	11,425,679	14,792,275	8,603,936	10,757,522	2,153,586
LTC / SNF	9,891,367	8,511,453	11,760,337	10,552,442	9,667,930	(884,512)
Outpatient	4,028,914	4,851,932	9,266,158	3,812,264	4,173,822	361,558
Laboratory and Radiology	312,311	355,908	406,545	211,239	247,045	35,806
Emergency Room	2,177,348	1,909,550	2,087,934	2,211,124	1,830,224	(380,900)
Physician Specialty	4,747,630	4,820,252	6,295,447	4,741,892	4,869,770	127,879
Primary Care Physician	1,175,549	1,690,721	1,543,446	1,708,898	1,589,178	(119,720)
Home & Community Based Services	1,459,004	1,471,628	1,476,855	1,475,139	1,347,962	(127,177)
Applied Behavior Analysis Services	621,128	467,688	706,081	684,387	120,720	(563,668)
Mental Health Services	542,188	412,599	(1,019,269)	697,153	350,299	(346,854)
Pharmacy	10,301,143	9,184,491	10,141,893	12,698,077	9,926,216	(2,771,861)
Provider Reserve	166,667	0	82,840	0	1,024,423	1,024,423
Other Medical Professional	293,662	295,072	336,526	368,748	211,727	(157,021)
Other Medical Care	0	0	0	0	0	0
Other Fee For Service	601,990	785,269	758,238	842,709	641,772	(200,938)
Transportation	91,625	240,721	216,162	391,072	130,944	(260,129)
Total Claims	49,195,501	46,422,962	58,851,468	49,369,463	46,889,554	(2,479,910)
Medical & Care Management Expense	1,066,266	907,107	1,131,145	1,113,973	1,183,395	69,422
Reinsurance	256,032	254,509	(88,325)	252,147	511,053	258,906
Claims Recoveries	(263,948)	(349,428)	(21,421)	(672,140)	0	672,140
Sub-total	1,058,350	812,188	1,021,399	693,979	1,694,448	1,000,468
Total Cost of Health Care	**55,481,377**	**52,160,568**	**64,981,977**	**55,360,092**	**53,687,752**	**(1,672,340)**
Contribution Margin	**4,325,650**	**3,204,416**	**(9,691,336)**	**(287,590)**	**4,252,597**	**(4,540,187)**
General & Administrative Expenses:				(287,590)		
Salaries, Wages & Employee Benefits	1,982,336	1,667,223	2,047,525	1,949,388	2,077,982	128,595
Training, Conference & Travel	28,317	20,403	44,185	26,061	42,176	16,115
Outside Services	2,353,686	2,324,945	2,307,093	2,276,567	2,470,810	194,242
Professional Services	438,247	431,279	584,945	587,108	438,340	(148,768)
Occupancy, Supplies, Insurance & Others	613,892	493,222	719,478	858,173	676,788	(181,385)
ARCH/Community Grants	0	0	0	1,202,990	0	(1,202,990)
Care Management Credit	(1,066,266)	(907,107)	(1,131,145)	(1,113,973)	(1,183,395)	(69,422)
Total G & A Expenses	**4,350,212**	**4,029,965**	**4,572,081**	**5,786,313**	**4,522,701**	**(1,263,613)**
Total Operating Gain / (Loss)	**(24,562)**	**(825,549)**	**(14,263,418)**	**(6,073,903)**	**(270,104)**	**(5,803,800)**
Non Operating:						
Revenues - Interest	343,025	330,298	350,681	323,968	62,046	261,922
Total Non-Operating	**343,025**	**330,298**	**350,681**	**323,968**	**62,046**	**261,922**
Total Increase / (Decrease) in Unrestricted Net Assets	**318,463**	**(495,251)**	**(13,912,736)**	**(5,749,936)**	**(208,058)**	**(5,541,878)**
Full Time Employees				**186**	**200**	**14**

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

	FY 2016-17 Monthly Trend			JUNE 2017		Variance
	Mar 17	Apr 17	May 17	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	205,829	205,106	204,140	203,990	214,728	(10,738)
Revenue:						
Premium	305.17	304.09	305.17	305.93	303.37	2.56
Reserve for Rate Reduction	19.43	0.00	0.00	0.00	(1.03)	1.03
MCO Premium Tax	(34.04)	(34.16)	(34.32)	(35.95)	(32.50)	(3.45)
Total Net Premium	**290.57**	**269.93**	**270.85**	**269.98**	**269.83**	**0.15**
Total Revenue	**290.57**	**269.93**	**270.85**	**269.98**	**269.83**	**0.15**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	25.40	24.01	25.03	25.97	23.77	(2.20)
FFS Claims Expenses:						
Inpatient	62.11	55.71	72.46	42.18	50.10	7.92
LTC / SNF	48.06	41.50	57.61	51.73	45.02	(6.71)
Outpatient	19.57	23.66	45.39	18.69	19.44	0.75
Laboratory and Radiology	1.52	1.74	1.99	1.04	1.15	0.11
Emergency Room	10.58	9.31	10.23	10.84	8.52	(2.32)
Physician Specialty	23.07	23.50	30.84	23.25	22.68	(0.57)
Primary Care Physician	5.71	8.24	7.56	8.38	7.40	(0.98)
Home & Community Based Services	7.09	7.17	7.23	7.23	6.28	(0.95)
Applied Behavior Analysis Services	3.02	2.28	3.46	3.36	0.56	(2.79)
Mental Health Services	2.63	2.01	(4.99)	3.42	1.63	(1.79)
Pharmacy	50.05	44.78	49.68	62.25	46.23	(16.02)
Provider Reserve	0.81	0.00	0.41	0.00	4.77	4.77
Other Medical Professional	1.43	1.44	1.65	1.81	0.99	(0.82)
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	2.92	3.83	3.71	4.13	2.99	(1.14)
Transportation	0.45	1.17	1.06	1.92	0.61	(1.31)
Total Claims	239.01	226.34	288.29	242.02	218.37	(23.65)
Medical & Care Management Expense	5.18	4.42	5.54	5.46	5.51	0.05
Reinsurance	1.24	1.24	(0.43)	1.24	2.38	1.14
Claims Recoveries	(1.28)	(1.70)	(0.10)	(3.29)	0.00	3.29
Sub-total	5.14	3.96	5.00	3.40	7.89	4.49
Total Cost of Health Care	269.55	254.31	318.32	271.39	**250.03**	**(21.36)**
Contribution Margin	**21.02**	**15.62**	**(47.47)**	**(1.41)**	**19.80**	**(21.21)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	9.63	8.13	10.03	9.56	9.68	0.12
Training, Conference & Travel	0.14	0.10	0.22	0.13	0.20	0.07
Outside Services	11.44	11.34	11.30	11.16	11.51	0.35
Professional Services	2.13	2.10	2.87	2.88	2.04	(0.84)
Occupancy, Supplies, Insurance & Others	2.98	2.40	3.52	4.21	3.15	(1.06)
Care Management Credit	(5.18)	(4.42)	(5.54)	(5.46)	(5.51)	(0.05)
Total G & A Expenses	21.14	19.65	22.40	28.37	21.06	(7.30)
Total Operating Gain / (Loss)	(0.12)	(4.02)	(69.87)	(29.78)	(1.26)	(28.52)
Non Operating:						
Revenues - Interest	1.67	1.61	1.72	1.59	0.29	1.30
Total Non-Operating	1.67	1.61	1.72	1.59	0.29	1.30
Total Increase / (Decrease) in Unrestricted Net Assets	1.55	(2.41)	(68.15)	(28.19)	(0.97)	(27.22)

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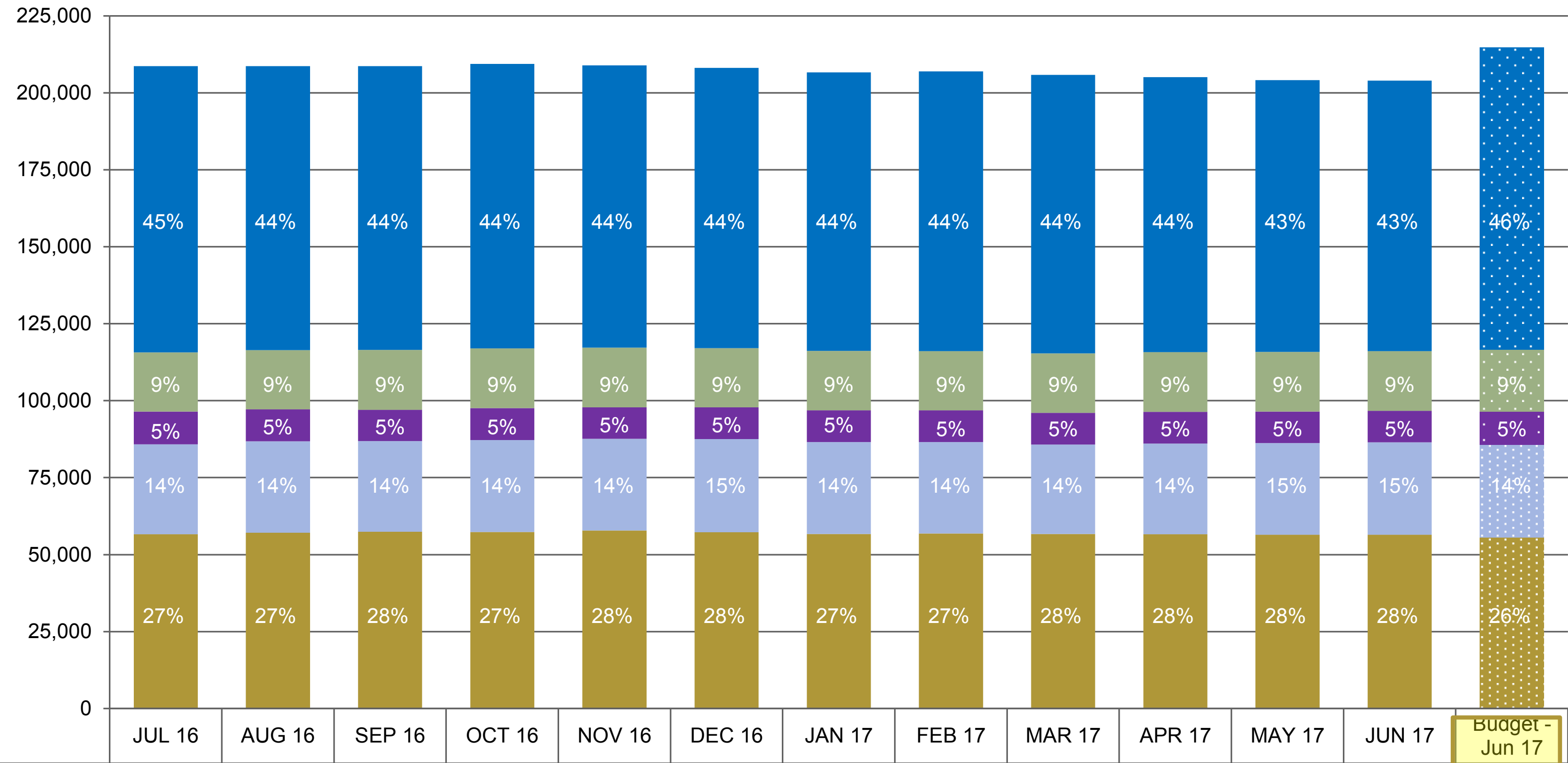
STATEMENT OF CASH FLOWS	APR 17	MAY 17	JUN 17	FYTD
Cash Flows Provided By Operating Activities				
Net Income (Loss)	(495,251)	(13,912,736)	(5,749,936)	(13,598,175)
Adjustments to reconciled net income to net cash provided by operating activities				-
Depreciation on fixed assets	44,777	29,082	42,197	586,692
Amortization of discounts and premium	(29,586)	(30,899)	(30,929)	(122,367)
Changes in Operating Assets and Liabilites				-
Accounts Receivable	6,205,223	(5,505,749)	(61,112,441)	2,301,882
Prepaid Expenses	257,979	(579,649)	(1,497,456)	(1,895,886)
Accounts Payable	(833,853)	918,201	4,214,684	82,199,318
Claims Payable	2,218,979	(93,120)	286,546	8,168,973
MCO Tax liablity	(14,012,903)	7,220,855	7,333,559	15,485,419
IBNR	4,024,297	(4,737,267)	(1,039,666)	(2,945,045)
Net Cash Provided by Operating Activities	(2,620,336)	(16,691,283)	(57,553,442)	90,180,810
Cash Flow Provided By Investing Activities				
Proceeds from Restricted Cash & Other Assets				-
Proceeds from Investments	20,000,000			95,000,000
Proceeds for Sales of Property, Plant and Equipment				-
Payments for Restricted Cash and Other Assets				-
Purchase of Investments	(40,147,814)	(127,727)	(130,894)	(151,067,536)
Purchase of Property and Equipment	-	131,168	(127,288)	(384,018)
Net Cash (Used In) Provided by Investing Activities	(20,147,814)	3,441	(258,183)	(56,451,554)
Cash Flow Provided By Financing Activities				
None				-
Net Cash Used In Financing Activities	-	-	-	-
Increase/(Decrease) in Cash and Cash Equivalents	(22,768,151)	(16,687,842)	(57,811,624)	33,729,257
Cash and Cash Equivalents, Beginning of Period	275,089,340	252,321,190	235,633,348	144,092,466
Cash and Cash Equivalents, End of Period	252,321,190	235,633,348	177,821,723	177,821,723

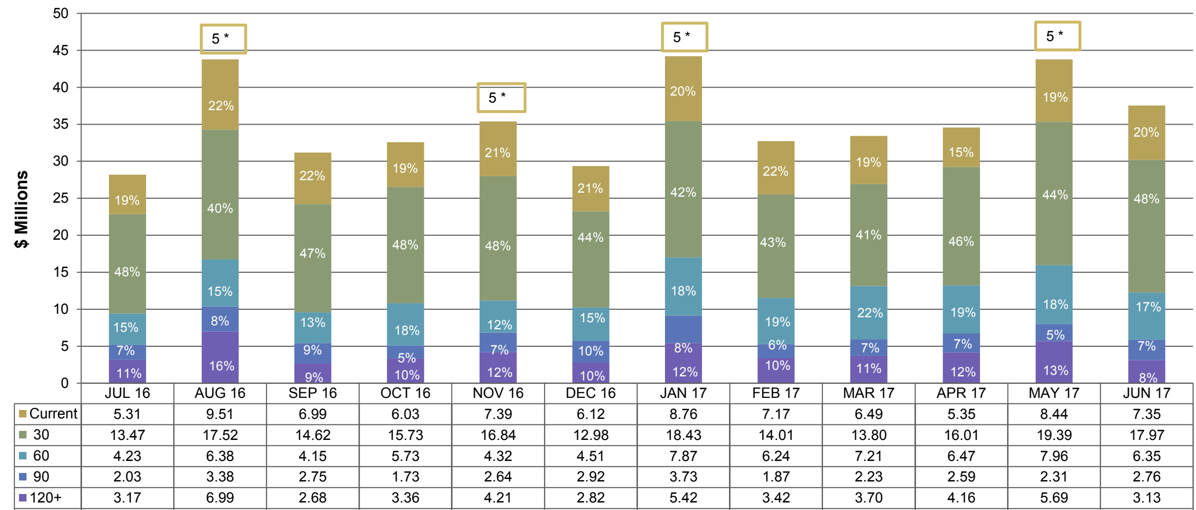
GOLD COAST HEALTH PLAN



	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17	Budget - Jun 17
Total	208,714	208,680	208,690	209,381	208,890	208,148	206,664	206,970	205,829	205,106	204,140	203,990	214,728
FAMILY	93,007	92,221	92,213	92,364	91,653	91,071	90,477	90,911	90,456	89,311	88,281	87,925	98,118
DUALS	19,224	19,259	19,481	19,381	19,376	19,250	19,352	19,213	19,329	19,401	19,375	19,321	20,071
SPD	10,645	10,406	10,095	10,438	10,277	10,282	10,246	10,321	10,326	10,319	10,219	10,236	10,765
TLIC	29,209	29,672	29,511	29,858	29,788	30,238	29,858	29,682	29,038	29,495	29,831	30,047	30,181
AE	56,629	57,122	57,390	57,340	57,796	57,307	56,731	56,843	56,680	56,580	56,434	56,461	55,593

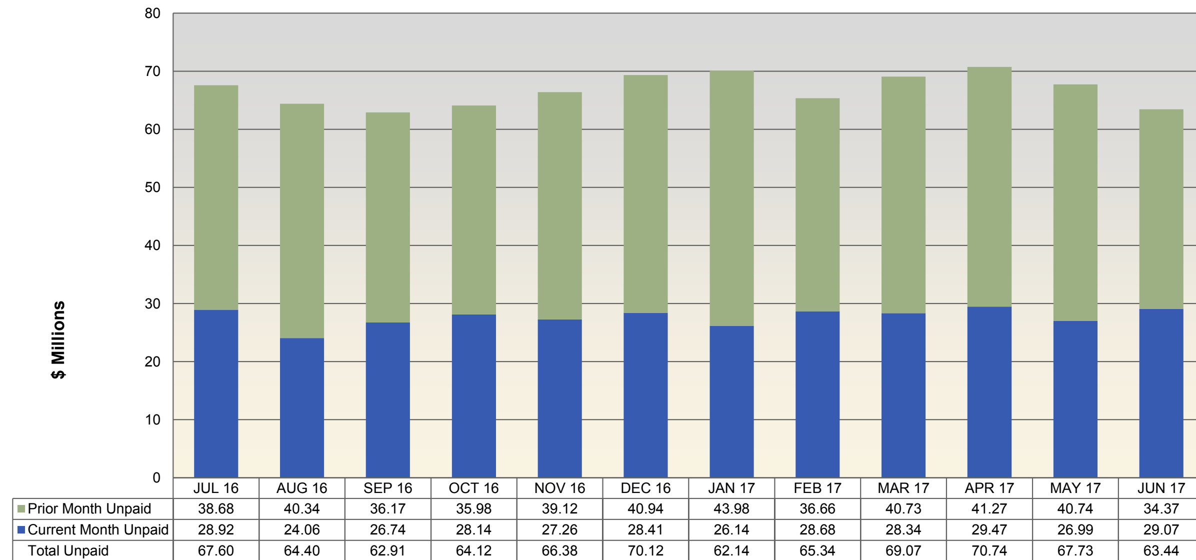
SPD = Seniors and Persons with Disabilities **TLIC = Targeted Low Income Children** **AE = Adult Expansion**

GOLD COAST HEALTH PLAN
JUNE 2017



	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17
Current	5.31	9.51	6.99	6.03	7.39	6.12	8.76	7.17	6.49	5.35	8.44	7.35
30	13.47	17.52	14.62	15.73	16.84	12.98	18.43	14.01	13.80	16.01	19.39	17.97
60	4.23	6.38	4.15	5.73	4.32	4.51	7.87	6.24	7.21	6.47	7.96	6.35
90	2.03	3.38	2.75	1.73	2.64	2.92	3.73	1.87	2.23	2.59	2.31	2.76
120+	3.17	6.99	2.68	3.36	4.21	2.82	5.42	3.42	3.70	4.16	5.69	3.13

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



	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17
Prior Month Unpaid	38.68	40.34	36.17	35.98	39.12	40.94	43.98	36.66	40.73	41.27	40.74	34.37
Current Month Unpaid	28.92	24.06	26.74	28.14	27.26	28.41	26.14	28.68	28.34	29.47	26.99	29.07
Total Unpaid	67.60	64.40	62.91	64.12	66.38	70.12	62.14	65.34	69.07	70.74	67.73	63.44

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

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: September 25, 2017

SUBJECT: Chief Executive Officer Update

PLAN HIGHLIGHTS

Plan continues to carefully monitor DHCS rate and membership changes as well as the impact of increased hospital expenses against FY 17/18 budget. Staff activities are focused on the implementation of regulatory initiatives such as Palliative Care, Non-Medical Transportation (NMT), and the new risk stratification tool Health Information Form/Member Evaluation Tool (HIF-MET). Additionally, the team continues to make progress on the AHP Plan-to-Plan Pilot.

Staff is currently assessing the impact of these initiatives, specifically around the GCHP enterprise project portfolio. As GCHP diverts resources to work on these new initiatives, projects initially prioritized (regulatory, lights-on) and planned for FY 17/18 are falling behind or have a delayed start.

GCHP IN THE COMMUNITY

In alignment with our collaborative community partner objective and enhanced communication strategies, GCHP launched a branded content initiative with the Ventura County Star in March 2017. The initiative highlights the Plan’s strategic partnerships and collaborations with community partners. Since launch, GCHP published 27 original articles, which garnered nearly 11,000 total visits with more than 2,300 readership hours on VCStar.com.

Plan staff also participated in the following community functions in August and September:

- MICOP Night in Oaxaca 2017: Nuestras Estrellas - August 5, 2017
- Annual David Fainer, MD and Leo Tauber, MD Awards – August 17, 2017
- United Way Ventura County Spirit Awards August 26, 2017
- Ventura County Housing Trust Fund Annual Event - September 21, 2017

LEGISLATIVE UPDATES

<u>All-Plan CEO Meeting</u>

On September 6, 2017 the Department of Health Care Services (DHCS) held its quarterly All-Plan CEO meeting. The following topics were discussed:

- **Managed Care Final Rule (Mega Rule):** Starting in 2018, a number of requirements will take effect. For example, the annual network certification will be expanded from what is currently conducted. DHCS expressed it wants to make the requirements as streamlined as possible. The contract amendment is currently under review by CMS. ***GCHP is pending the release of the final rule contract amendment that incorporates approximately 156 items of the Mega Rule requirements. GCHP has submitted final rule deliverables to DHCS. Final Rule deliverables submitted by GCHP to DHCS were approved. GCHP is in anticipation of additional deliverables once additional requirements are codified.*

- **Palliative Care**: DHCS is pending the Governor signature of SB 294. Once Plans have the required policies and procedures by DHCS in place, they will receive one-time grants of up to $50,000 for provider network development, data analysis, and other palliative care program development costs. DHCS has created a checklist of deliverables, including policies and procedures, and has engaged Cal State San Marcos to provide provider training on palliative care.

- **Non-Medical Transportation (NMT):** On July 1, 2017, NMT became an expanded benefit for all members and is no longer limited to those receiving EPSDT services. The scope of the requirements will expand as of October 1, 2017, in which Plans are required to provide NMT to services not covered under Medi-Cal, i.e. dental appointments.

- **Proposition 56 Payments:** DHCS has proposed supplemental payments for physician services pertaining to a small group of procedure codes in both the Medi-Cal fee for-service (FFS) and Medi-Cal managed care delivery systems. DHCS would like a process that is simpler than the ACA 1202 payments, and is working with CMS on the proposed methodology.

- **Children's Health Insurance Program (CHIP) Re-Authorization:** The current federal appropriation runs out at the end of September and many states will exhaust their allotment of federal money later this year or early next year. CMS has authorized funding CHIP through Dec 2017 while Congress works on the legislation. The program is for children in families that make too much to qualify for Medi-Cal, but not enough to afford other coverage. Even if CHIP funding is not re-authorized, 900,000 children in California would continue to be covered under Medicaid through 2019 based on the Maintenance of Effort (MOE) requirements under the Affordable Care Act (ACA).

- **PACE Guidance:** Under new guidance, all PACE applications must go through an initial review process by DHCS in order to move forward with submission to the Centers for

Medicare and Medicaid Services (CMS) via the web-based Health Plan Management System (HPMS). It is important to note that in counties that provide Medi-Cal services through a County Organized Health System (COHS), DHCS will only consider the operation of a third party in a COHS county if the applicant includes a COHS' letter of support.

- **Mental Health Parity:** Draft APL's were sent out for stakeholder review and feedback. Changes to screening and training requirements were clarified within the draft APL. Contract changes are required to be submitted to CMS by October 2, 2017, so Plans will have a short review period for the proposed contract amendment language.

The next meeting will take place in December 2017.

Fall Prevention

The Ventura County Board of Supervisors proclaimed the week of September 22-28 as Fall Prevention Awareness Week in Ventura County. GCHP, as approved by the commission, is providing a grant to the Ventura County Area Agency on Aging for their Fall Prevention Program.

Per Dr. Thomas K. Duncan, the Ventura County Medical Center's Trauma Medical Director, each year one in three persons over the age of sixty-five, require medical attention due to a fall. The average cost of hospitalization is $37,000-$75,000. In response, the Ventura County Fall Prevention Coalition has put in place a number of evidence-based programs to educate individuals on fall prevention.

National Update

Legislative Advocacy in Washington, DC

On September 12-13, 2017, Gold Coast Health Plan's (GCHP) Manager of Government Relations participated in the Association of Community Affiliated Plans' (ACAP) Legislative Advocacy "Fly-In". This event is held tri-annually to allow ACAP member plans to meet with members of Congress and their staff to discuss federal legislation and policies that affect the Medicaid/Medi-Cal program. GCHP staff met with health legislative aides from the offices of Senators Dianne Feinstein and Kamala Harris as well as Representatives Julia Brownley and Steve Knight. The main discussion topic was on the preservation of the Children's Health Insurance Program (CHIP). Funding for this program is set to expire on September 30. Gold Coast Health Plan provides coverage to approximately 30,000 children under CHIP in Ventura County.

Latest Efforts to Repeal and Replace the Affordable Care Act

On Wednesday, September 13, 2017 the latest attempt to repeal and replace the Affordable Care Act, known as the Graham-Cassidy proposal, was announced. According to Health Affairs, the main federal Medicaid funding reduction provisions included in the new proposal are:

- A one-year elimination of federal funding for all Medicaid-covered services furnished by Planned Parenthood.
- An end to federal funding of retroactive Medicaid eligibility, a basic safety-net feature of the program since 1965 that enables states and health care providers to cover the cost of health care for catastrophically ill people who were eligible but not enrolled at the time they experienced a high-cost event, whether illness or injury; and,
- A permanent one-third reduction (phased in between FY 2021 and FY 2026) in the amount of matching funds for the traditional program that states can generate through lawful provider taxes.

Graham-Cassidy allows states to impose work requirements on traditional adults whose eligibility is tied to poverty. The proposal would allow states to secure savings by reverting to a more frequent (semi-annual) eligibility redetermination process. The proposal would allow states to elect to run a portion of their traditional Medicaid programs as a block grant, with more freedom to eliminate eligibility groups whose coverage is now mandatory, eliminate mandatory benefits, and make other changes that reduce Medicaid spending by withdrawing assistance.

Regarding the Medicaid Expansion population, this version would eliminate the expansion group at the end of December 2019. After this date, states would no longer have an option to extend Medicaid to all low-income working-age adults, even at a reduced federal funding rate, as was the case with the Better Care Reconciliation Act (BCRA).

The proponents of the proposal have until September 30, 2017 to move legislation out of the Senate. The Congressional Budget Office (CBO) stated it will conduct a partial review of the proposal which will include, whether the legislation would reduce on-budget deficits by at least as much as was estimated for H.R. 1628, the American Health Care Act; whether Titles I and II in the legislation would each save at least $1 billion; and whether the bill would increase on-budget deficits in the long term. CBO will provide as much qualitative information as possible about the effects of the legislation

The Government Relations team will continue to closely track this proposal and provide you updates as needed.

State Legislative Summary

The last day of the legislative cycle was on Friday, September 15, 2017. The State Legislature sent a number of health related bills to the Governor’s desk (for a complete listing please refer to the legislative bills table). Governor Brown has until October 15, 2017 to sign or veto bills presented to him.

Next month, Government Relations staff will have a complete analysis on the Legislative bills related to Medi-Cal, which were signed or vetoed by Governor Brown.

Gold Coast Health Plan
A Public Entity

Gold Coast Health Plan's Priority Tracking Legislative Bills Table

BILL NUMBER	SUMMARY	STATUS
AB 205 (Wood)	**Medi-Cal: Medi-Cal Managed Care Plans** Mega Reg provisions for network requirements, EQRO, grievance, and State Fair Hearing.	9/15/17: Senate amendments concurred in. To Engrossing and Enrolling.
AB 391 (Chiu)	**Medi-Cal: Asthma Preventive Services** Would require DHCS to seek an amendment to its Medicaid state plan to include qualified asthma preventive service providers.	9/13/17: Senate amendments concurred in. To Engrossing and Enrolling
AB 428 (Ridley-Thomas)	**Brown Act; Quorum for local plan meetings** Would continue to allow a quorum where health authority members call in to meeting, provided other requirements are met.	7/31/17: Approved by the Governor.
AB 447 (Gray)	**Medi-Cal: Covered benefits: glucose monitors** Would add continuous glucose monitors that are medically necessary as a Medi-Cal benefit.	9/18/17: Enrolled and presented to the Governor at 4 p.m.
AB 1074 (Maienschein)	**Health Care Coverage: Autism** Revises 'behavioral health treatment' services to modify current supervisorial requirements.	9/13/17: Enrolled and presented to the Governor at 4 p.m.
AB 1092 (Cooley)	**Medi-Cal Eyeglasses** Restores eyeglass coverage of one pair every two years to ages 21 older.	6/15/17: Referred to Senate Health and Appropriations Committees
AB 1316 (Quirk)	**Public Health: Childhood Lead Poisoning: Prevention** Would require the standard of care to be that all children be screened for blood lead levels.	9/11/17: Senate amendments concurred in. To Engrossing and Enrolling.

Gold Coast Health Plan
A Public Entity

Gold Coast Health Plan's Priority Tracking Legislative Bills Table

BILL NUMBER	SUMMARY	STATUS
AB 1534 (Nazarian)	**HIV Specialists** Requires every health care service plan contract that is issued, amended, or renewed on or after January 1, 2018 to permit an HIV specialist to be an eligible primary care provider, if the provider requests primary care provider status and meets the health care service plan's eligibility criteria for all specialists seeking primary care provider status.	9/5/17: Ordered to inactive file at the request of Senator Atkins.
SB 171 (Hernandez)	**Medi-Cal: Medi-Cal Managed Care Plans** Mega Reg provisions for MLR and directed payments to public hospitals.	9/15/17: Ordered to engrossing and enrolling
SB 199 (Hernandez)	**Health Care Cost, Quality Database** This bill requires the California Health and Human Services Agency (CHHSA) to convene an advisory committee to make recommendations related to a statewide health care cost, quality, and equity atlas.	9/1/17: September 1 hearing: Held in committee and under submission
SB 223 (Atkins)	**Health Care Language Assistance Services** Would require specified documents be translated into threshold languages identified by the needs assessment. Would also require written notice be made available in the top 15 languages spoken by limited-English-proficient individuals.	9/14/17: Ordered to engrossing and enrolling

SB 743 (Hernandez)	**Family Planning Providers** This bill prohibits Medi-Cal managed care plans from restricting an enrollee's choice of a family planning services provider, even if they are out-of-network, and requires Medi-Cal managed care plans to reimburse out-of-network providers at the applicable fee-for-service rate.	9/14/17: Ordered to engrossing and enrolling.

COMPLIANCE UPDATE

Audits and Investigations (A&I) conducted the annual onsite medical audit during the weeks of June 5–16, 2017. GCHP anticipates a draft report from A&I, tentatively slated for September 2017. Staff will apprise the Commission of updates as GCHP receives further information.

GCHP conducted an audit of Conduent the week of April 24-27, 2017, and issued a subsequent CAP on June 16, 2017. GCHP has received three responses from Conduent; however, the CAP remains open until Conduent corrects all deficiencies.

Beacon Health Strategies (Beacon), the Plan's MBHO, successfully fulfilled their obligations under the CAP, which was tied to previously imposed financial sanctions. Beacon is under a secondary CAP based on the last annual audit and is close to closure of the CAP. Vision Service Plan's (VSP) CAP was closed September 21, 2017. GCHP delegation oversight staff works with each delegate on achieving compliance to address the deficiencies identified and ultimately close out the CAPs issued.

The GCHP Compliance Committee met on September 21, 2017 and reviewed the following:

- Delegate compliance rate on reporting,
- Non-compliance letters issued CAP status,
- Upcoming audit schedule,
- Fraud, waste & abuse cases,
- Privacy breaches and,
- Internal audits.

The committee will review the compliance program and code of conduct at the next compliance committee.

GCHP's Compliance Officer attended and presented at the National Association of Latino HealthCare Executive (NALHE) 2017 Annual Leadership Summit 2017, held in Los Angeles September 13-15, 2017.

The compliance dashboard is attached for reference and includes information on but is not limited to staff trainings, fraud referrals, HIPAA breaches, and delegate audits.

Gold Coast Health Plan
A Public Entity

COMPLIANCE REPORT 2017

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
Hotline A confidential telephone and web-based process to collect info on compliance, ethics, and FWA	Referrals *one referral can be sent to multiple referral agencies*	5	1	7	14	9	13	16	8					73
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0	0	0	3	1	0	0	0					4
Hotline Referral *FWA	Department of Justice	0	0	0	0	0	0	0	0					0
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	5	1	7	11	8	13	16	8					69
Hotline Referral	External Agency (i.e. HSA)	0	0	0	0	0	0	0	0					0
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	0	0	0	0	0	0	0	0					0
Delegation Oversight The committee's function is to ensure that delegated activities of subcontracted entities are in compliance with standards set forth from GCHP contract with DHCS and all applicable regulations	Delegated Entities	8	8	8	8	8	8	8	8					8
	Reporting Requirements Reviewed **	71	83	68	81	75	73	85	70					606
	Audits conducted	5	1	0	1	0	0	0	0					7
Delegation Oversight	Letters of Non-Compliance	0	0	1	0	0	0	0	0					1
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	0	1	1	1	0	0	0	0					3
Audits External regulatory entities evaluate GCHP compliance with contractual obligations.	Total	0	0	0	0	0	0	0	0					0
	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	0	0	0	0	0	0	0	0					0
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0	0	0	0	0	0	0	0					0
	HEDIS Compliance Audit (HSAG)	0	0	0	0	0	0	0	0					0
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2012*	0	0	0	0	0	0	0	0					0
	DHCS Medical Audit	0	0	0	0	0	1	0	0					1
Fraud, Waste & Abuse The Fraud Waste and Abuse Prevention process is intended to prevent, detect, investigate, report and resolve suspected and /or actual FWA in GCHP daily operations and interactions, whether internal or external.	Total Investigations	5	1	0	14	8	13	16	8					65
	Investigations of Providers	0	0	0	1	0	0	3	0					4
	Investigations of Members	5	1	0	1	5	13	10	3					38
	Investigations of Other Entities	0	0	0	1	4	0	2	5					12
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0	0	0	0	0	0	0	0					0

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Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
HIPAA	Referrals	6	2	4	2	3	2	5	0					24
Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	State Notification	6	2	4	2	3	2	5	0					24
	Federal Notification	0	3	0	0	0	0	0	0					3
	Member Notification	2	0	0	0	0	1	1	0					4
	HIPAA Internal Audits Conducted	0	0	1	0	0	0	1	0					2
Training	**Training Sessions**	12	12	6	9	9	12	12	6					78
Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Fraud, Waste & Abuse Prevention (Individual Training)	2	2	0	1	1	2	2	0					10
	Fraud, Waste & Abuse Prevention (Member Orientations)	6	6	6	6	6	6	6	6					48
	Code of Conduct	2	2	0	1	1	2	2	0					10
	HIPAA (Individual Training)	2	2	0	1	1	2	2	0					10
	HIPAA (Department Training)	0	0	0	0	0	0	0	0					0

** Reporting Requirements are defined by functions delegated and contract terms. Revised contracts, amendments or new requirements form DHCS may require additional requirements from subcontractors as a result the number is fluid
** Audits- Please note multiple audits have been conducted on the Plan, however many occurred in 2012 and 2013 and will be visible on the annual comparison dashboard
** This report is intended to provide a high level overview of certain components of the compliance department and does not include/reflect functions the department is responsible for on a daily basis.
^ The large aggregates for the month of November and December represent the yearly training of full time employees and new coming Commissioners.

VENTURA COUNTY STAR

HOME NEWS SPORTS BUSINESS OPINION ENTERTAINMENT LIFESTYLE OBITUARIES insider USA TODAY JOBS

Gold Coast Health Plan

Story From Gold Coast Health Plan

STORY FROM GOLD COAST HEALTH PLAN

Celebrates with MICOP at Night in Oaxaca Event

Read Story Steven Lalich for Gold Coast Health Plan

Integrity - Accountability - Collaboration - Trust - Respect

Gold Coast Health Plan's member-first focus centers on the delivery of exceptional service to our beneficiaries by enhancing the quality of health care, providing greater access and improving member choice.

To learn more about GCHP, call 1.888.301.1228

HEADLINES

STORY FROM GOLD COAST HEALTH PLAN — Immunizations: Grown-ups need them, too

STORY FROM GOLD COAST HEALTH PLAN — Breastfeeding: Nature's Formula

STORY FROM GOLD COAST HEALTH PLAN — American Diabetes Association offers FREE diabetes prevention camp in Oxnard for at-risk youth

STORY FROM GOLD COAST HEALTH PLAN — World Hepatitis Day: The fight to eliminate viral hepatitis

Habitat for Humanity Awarded $75,000 Grant from Gold Coast Health Plan Just in Time for Oxnard Groundbreaking

California Health Report: Health Plans for Over 2 Million Californians Don't Follow Consumer Protection Law

More than 2 million Californians in 21 counties are enrolled in health plans that are out of compliance with the Knox-Keene Act, which requires insurers to provide patients with timely access to doctors.(Guzik)

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: September 25, 2017

SUBJECT: Chief Operating Officer Update

OPERATIONS UPDATE

Membership Update

As of September 1, 2017, Gold Coast Health Plan's (GCHP's) total membership was 202,630. The Plan experienced a net loss of 40 members over the previous month. We attribute the loss to the following potential impacts:

- Lack of redeterminations;
- Movement of members out of the county;
- Increases to income rendering member ineligible for plan participation.

AB 85 Auto Assignment- State Assembly Bill 85 (AB 85) requires that the Plan assign 50% of new Adult Expansion (AE) members who have not chosen a PCP within 30-days of enrollment to the County Public Hospital System, VCMC. In the month of September, GCHP assigned 510 members to VCMC, while the remaining 500 members were assigned to providers in compliance with the VCMMCC Auto Assignment policy. VCMC has 30,939 AE members assigned as of September 1, 2017. VCMC's target enrollment, as established by DHCS, is 65,765 and is currently at 47.04% of the target.

Monthly Adult Expansion (AE) Membership Lookback (by aid code)

	L1	M1	7U	7W	7S	Total
Sep 17	432	56,042	32	7	84	56,597
Aug 17	447	56,028	58	14	87	56,634
Jul 17	464	55,407	80	30	94	56,075
Jun 17	484	55,462	83	31	91	56,151
May 17	505	55,331	92	35	113	56,076
Apr 17	520	55,333	94	44	163	56,154
Mar 17	560	55,539	100	48	210	56,457
Feb 17	590	55,667	113	55	243	56,668
Jan 17	646	55,551	141	50	203	56,591
Dec 16	695	55,820	521	123	240	57,399
Nov 16	770	55,567	1,057	216	314	57,924
Oct 16	919	55,103	1,227	254	374	57,877

Member Orientation Meetings
Eighty-seven (87) total members (67 English, 20 Spanish) attended Member Orientation meetings between January and August 2017. Of the 85 members, 54 indicated they learned about the meeting through the informational flyer included in each new member packet.
Other methods of notification included:

- Website
- TCRC
- HSA

Claims Update
Claims Inventory represents the number of claim received during the month. Claims Inventory for August is 206,314. This equates to a Days Receipt on Hand (DROH) of 4.0 days in August compared to a DROH maximum goal of 5 days. August is reflecting a slight increase in DROH over the previous month. GCHP received an average of 8,970 claims per day in August.

Monthly Claims Receipts

Month	Total Monthly Claims Received	Average Daily Claims Receipts
August 2017	206,314	8,970
July 2017	167,905	8,395
June 2017	183,581	8,345
May 2017	200,595	9,118
April 2017	164,613	8,231
March 2017	208,407	9,061
February 2017	171,343	9,018
January 2017	168,660	8,433
December 2016	190,686	9,080
November 2016	170,209	8,510
October 2016	209,638	9,983
September 2016	159,446	7,593
August 2016	180,049	7,828

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

- **Claims Turnaround Time (TAT) -** The number of days needed to process a claim from date of receipt to date of determination. The target is determination of 90% of original clean claims processed within 30 calendar days of receipt.

- **Financial Claims Processing Accuracy-** Percentage of correct payments against the total payments made in a month. The target is ≥ 98%
- **Procedural Claims Processing Accuracy-** The number of claims without any procedural errors (non-financial) against the total number of claims processed. The target is ≥ 97%.

Conduent met all SLAs for the month of August.

Monthly Claims SLA Performance

Month: August		
Service Level Agreement	**Expected Outcome**	**Actual Outcome**
Claim Turnaround Time	90%	97.69%
Financial Claims Processing Accuracy	98%	99.14%
Procedural Claim Processing Accuracy	97%	99.71%

Claims Denials remain at 14.32% of total volume in July, which is within industry expectations.

Top Claims Denial Reasons

- Service is included in Monthly Capitation per contract with provider
- Duplicate line item
- Primary Carrier EOB Required
- Charges incurred after term date
- Denied base on system edit
- Services are the financial responsibility of Clinicas

<u>Encounter Update</u>

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

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

Monthly Encounter Data

Month: August			
Encounter Type	**Submitted**	**Errors**	**% of Errors**
Professional	144,313	3,539	2.5%
Institutional	65,755	647	1.0%
Pharmacy	137,415	154	.01%
Total	**347,483**	**4,340**	**1.2%**

Reasons for the errors include:

- Not Valid code
- Duplicate encounter
- No Medi-Cal eligibility
- Procedure date
- Admission date

Note: SLAs do not apply to encounter data.

Call Center Update

Call Center Results – Conduent is responsible for taking level one calls from members and providers. The volumes reported reflect only Conduent call data. Additional calls are taken by the GCHP member services team, which includes calls routed from Conduent, considered escalated or second level calls, calls from providers and members directly to the GCHP member services team and any calls to members or providers who request a call back from the GCHP member services team. Conduent has three (3) call queues: provider, member (English), member (Spanish).

GCHP monitors and reports on two (2) specific areas that help identify the Conduent Call Center work effort:

- **Call Volume** – Call volume measures the number of calls taken in a month's time. August call volume was 10,310, a decrease from previous month.

- **Average Call Length** – Call length measures the amount of time a call center representative spends on a call with a member or provider. Call length is a function of the call type and may be shorter or longer depending on the type of call and type of caller. GCHP measures the average call length only as an indicator of how long the call center representatives are spending with our callers. August average call length was 6.65 minutes per call.

GCHP currently has three (3) SLAs that measure Conduent's call center efficacy on a monthly basis. Conduent met all three (3) targets in the month of August.

- **Average Speed to Answer (ASA) –** The number of seconds a caller waits in a queue until the call is answered by a call center representative.
  - Target – <u><</u>30 seconds
- **Abandonment Rate –** Abandonment rate measures the percentage of calls disconnected by a caller prior to the call being answered by a Customer Service Representative.
  - Target - ≤ 5%.
- **Call Center Call Quality** – Conduent and GCHP staff work collaboratively to calibrate selected calls each week and use a standardized scoring tool to measure the percentage of calls answered accurately.
  - Target - 95% or higher.

Monthly SLA Performance

Month August		
Service Level Agreement	**Expected Outcome**	**Actual Outcome**
Average Speed To Answer	≤30 seconds	41.14 sec
Abandonment Rate	≤5%	1.94%
Call Center Call Quality	≥95%	95.02%

Average Speed to Answer exceeded 30 seconds in the month of August. Conduent expressed a decrease is staff through attrition during this period. Conduent had already hired additional staff in anticipation of the attrition who are not trained and taking member and provider calls. Conduent believes they have adequately addressed the internal issues that lead to missing the SLA in August.

<u>Grievance and Appeals Update</u>

Conduent is responsible for responding to level one Provider Dispute Resolution (PDR) requests when providers disagree with the manner in which a claim was processed. GCHP manages all first level member appeals should a member submit an issue regarding a claim payment or denial, provider access or any other situation the member has experienced. Should the member or provider choose to continue to a second level action, those requests are resolved by GCHP. The Grievance and Appeals team at GCHP also processes any clinical appeals in conjunction with the GCHP Health Services team.

GCHP received six (6) clinical appeals for the month of July. Two (2) of the clinical appeals were upheld, two (2) appeals were overturned and two (2) of the appeals were withdrawn. During July, GCHP attended five (5) State Fair Hearing cases. Two (2) were withdrawn, one (1) was approved, one (1) was denied and one (1) was dismissed.

GCHP received 29 member grievances and 172 PDRs in the month of July. Member grievances equate to 0.14 grievances per 1,000 members, which remains consistent month over month.

Monthly Member Grievances

Month of July	
Type of Member Grievances	**Number of Grievances**
Accessibility	2
Benefits	1
Billings	1
Denials/Refusals	1
Eligibility	1
Quality of Care	16
Quality of Service	7
Total Member Grievances	**29**

Note: G&A results are reported 2 months in arrears

GCHP received 16 Quality of Care member grievances, which consisted of the following issues:

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

Monthly Claims Receipts

Month	Total Monthly Claims Received	Average Daily Claims Receipts
July 2016	166,955	8,347
June 2016	177,246	8,057
May 2016	157,434	7,497
April 2016	162,287	7,728
March 2016	193,881	8,429
February 2016	176,656	8,833
January 2016	154,770	8,146
December 2015	170,897	7,768
November 2015	142,247	7,902
October 2015	156,109	7,095
September 2015	164,510	7,834
August 2015	152,840	7,278
July 2015	162,237	7,374

Gold Coast Health Plan

Weekly Claims Processing Dashobard

May 3, 2017 - Aug 30, 2017

	05/03/17	05/10/17	05/17/17	05/24/17	05/31/17	06/07/17	06/14/17	06/21/17	06/28/17	07/05/17	07/12/17	07/19/17	07/26/17	08/02/17	08/09/17	08/16/17	08/23/17	08/30/17
Corrective Action Plan Tracking																		
CAP Reference																		
3c - Percentage of Claims Denied (1)	13.02%	14.41%	14.42%	13.20%	11.19%	14.86%	12.70%	14.76%	14.02%	12.07%	14.99%	12.08%	12.64%	11.85%	13.14%	12.64%	15.25%	16.44%
3e - Number of Claim Adjustments (2)	2,579	899	1,565	903	94	848	951	1,001	810	586	1,000	1,041	1,035	942	1,028	1,411	1,375	1,110
3f - Number of Claims Processing FTEs (3)	48	48	47	47	47	47	46	46	45	44	44	44	43	43	43	42	42	41
3g - Auto Adjudication Rate (4)	56.76%	48.00%	55.05%	51.43%	52.83%	48.32%	52.26%	46.16%	48.75%	50.56%	40.10%	57.45%	52.78%	55.12%	53.40%	49.71%	53.04%	50.83%
3g - Auto Adjudication Rate including Autobot (4)	69.49%	59.86%	67.92%	64.82%	67.49%	61.52%	65.76%	63.75%	64.32%	69.23%	58.20%	71.53%	68.65%	67.80%	66.86%	73.62%	68.91%	63.76%
4a - Number of Items in ACS Refund Check Queue (5)	141	71	32	47	81	78	61	17	33	33	69	8	27	0	0	6	11	0
4a - Number of Items in ACS Refund Check Queue > 20 Days TAT (	79	31	0	0	19	41	0	0	0	3	1	0	0	0	0	1	0	0
4a - Number of Items in Non-Indexed Refund Check Queue (5)	14	71	59	47	19	27	25	53	50	25	37	55	43	37	65	89	62	118
Claim Receipts																		
Total Claim Receipts	49,841	45,293	44,028	42,548	41,394	42,137	43,970	42,595	42,085	35,511	39,366	42,239	40,343	42,283	55,122	40,934	41,920	41,661
Average Claims Receipts (6)	8,136	8,272	8,375	8,524	9,086	8,663	8,505	8,502	8,505	8,539	8,208	7,978	7,960	7,873	8,212	8,999	8,934	9,013
Mailroom Inventory on Hand																		
Items in EDGE to be worked (8)	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
Claims with Front-end Errors (9)	1,950	1,075	1,252	934	814	1,148	846	558	932	412	571	757	865	722	1,046	544	546	667
IKA Inventory on Hand																		
Pended Inventory	35,602	32,794	34,474	34,425	33,964	30,735	31,490	26,263	23,317	22,783	22,572	24,178	25,789	29,663	39,049	34,965	36,069	33,222
Working Inventory (10)	**37,561**	**33,878**	**35,735**	**35,368**	**34,787**	**31,892**	**32,345**	**26,830**	**24,258**	**23,204**	**23,152**	**24,944**	**26,663**	**30,394**	**40,104**	**35,518**	**36,624**	**33,898**
Claims Ready to Pay (11)	4,532	6,091	5,972	4,817	5,326	6,201	5,165	5,067	3,808	1,284	7,216	4,229	5,001	2,626	6,209	3,653	3,624	3,220
Current Inventory	**42,093**	**39,969**	**41,707**	**40,185**	**40,113**	**38,093**	**37,510**	**31,897**	**28,066**	**24,488**	**30,368**	**29,173**	**31,664**	**33,020**	**46,313**	**39,171**	**40,248**	**37,118**
DROH Working Inventory (10, 12)	4.6	4.1	4.3	4.1	3.8	3.7	3.8	3.2	2.9	2.7	2.8	3.1	3.3	3.9	4.9	3.9	4.1	3.8
DROH Current Inventory (12)	5.2	4.8	5.0	4.7	4.4	4.4	4.4	3.8	3.3	2.9	3.7	3.7	4.0	4.2	5.6	4.4	4.5	4.1
Clean Claims Aging (7)																		
31 to 60 Days	1,912	2,694	2,530	2,160	2,182	1,221	1,177	1,733	1,358	1,032	1,045	1,056	992	983	1,005	1,035	1,086	1,184
61 to 90 Days	40	41	9	0	0	993	992	993	0	0	0	0	0	0	0	0	3	2
90+ Days	7	3	7	5	5	6	3	5	6	1	1	0	1	1	1	1	2	2
Total Clean Claims Aged > 30 Days	**1959**	**2738**	**2546**	**2165**	**2187**	**2220**	**2172**	**2731**	**1364**	**1033**	**1046**	**1056**	**993**	**984**	**1006**	**1036**	**1091**	**1188**
Contested Claims Aging (7)																		
0 to 30 Days	358	554	979	654	667	623	699	1468	1506	451	330	323	343	415	419	290	264	289
31 to 60 Days	32	23	16	13	42	7	10	84	67	8	2	10	9	4	2	4	9	6
61 to 90 Days	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
90+ Days	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Aging of Total Contested Claims	**391**	**578**	**996**	**668**	**710**	**631**	**710**	**1554**	**1574**	**460**	**333**	**334**	**353**	**420**	**422**	**295**	**274**	**296**
Productivity																		
EDI Claims Rejected	0	1	0	20	11	0	0	0	0	1	0	1	0	0	0	0	0	0
Deleted Claims (13)	745	958	1,119	906	912	893	909	867	965	897	700	885	1,061	1,174	1,033	978	818	946
Denied Claims	6,355	6,421	6,081	5,968	4,537	6,358	5,359	6,539	5,822	5,092	5,175	5,065	4,845	4,786	5,276	5,990	6,228	7,138
Allowed Claims	42,468	38,125	36,089	39,239	36,001	36,429	36,828	37,769	35,701	37,082	29,348	36,860	33,497	35,589	34,875	41,413	34,622	36,273
Actual Weekly Production (14)	48,823	44,546	42,170	45,207	40,538	42,787	42,187	44,308	41,523	42,174	34,523	41,925	38,342	40,375	40,151	47,403	40,850	43,411
Total Weekly Production (15)	**49,568**	**45,505**	**43,289**	**46,133**	**41,461**	**43,680**	**43,096**	**45,175**	**42,488**	**43,072**	**35,223**	**42,811**	**39,403**	**41,549**	**41,184**	**48,381**	**41,668**	**44,357**
Average Daily Production (16)	8,527	8,860	8,932	9,138	9,313	8,858	8,732	8,677	8,683	8,646	8,446	8,400	8,138	8,085	8,016	8,197	8,497	8,570
DWOH Working Inventory (10, 17)	4.4	3.8	4.0	3.9	3.7	3.6	3.7	3.1	2.8	2.7	2.7	3.0	3.3	3.8	5.0	4.3	4.3	4.0
DWOH Current Inventory (17)	4.9	4.5	4.7	4.4	4.3	4.3	4.3	3.7	3.2	2.8	3.6	3.5	3.9	4.1	5.8	4.8	4.7	4.3

Notes:

(1) Percentage of Claims Denied is calculated as the number of Denied claims divided by Actual Weekly Production (total denied and allowed claims for the week).

Gold Coast Health Plan
Weekly Claims Processing Dashobard
May 3, 2017 - Aug 30, 2017

(2) Number of Claims Payment Adjustments processed in the ika claims system as reported by Xerox on the claims Financial Transaction Summary Report.
(3) Number of Xerox claims processing FTEs as reported in the Roster Report provided by Xerox.
(4) Auto Adjudication Rate calculated from "Inventory Tracking to Date" using week to date productivity totals as of Wednesday of each week.
Auto Adjudication Rate including Autobot includes claims processed with Autobot, which allows for systematic processing of claims.
(5) Number of Items in Refund Queue reflects the number reported by Xerox in the "Queue Aging Report" as of Wednesday of each week.
(6) Average Claims Receipts is calculated as the number of receipts in the past four weeks divided by 20 days.
(7) Reflects the aging reported by Xerox on the "Claims Aging Report" as of Wednesday of each week.
(8) Count of items still in EDGE process that have not been loaded into KWIK or ika.
(9) Includes claims that need additional research to determine whether or not they can be loaded into ika.
(10) Working inventory includes mailroom inventory on hand and pending claims inventory. It does not include claims that have been adjudicated and have a status of ready to pay.
(11) Claims Ready to Pay have been adjudicated and are ready for payment stream.
(12) Days Receipt on Hand (DROH) is calculated as the Working/Current Inventory divided by the Average Claim Receipts.
(13) Deleted claims have been replaced by a new claim. Deleted claims are still in ika; however, the status has been changed to deleted so the new claim can be worked.
(14) Actual Weekly Production is the total number of Denied and Allowed claims.
(15) Total Weekly Production includes Deleted, Denied and Allowed claims.
(16) Average Daily Production is calculated as the total production in the past four weeks divided by 20 days.
(17) Days Work on Hand (DWOH) is calculated as the Working/Current Inventory divided by the Average Daily Production.

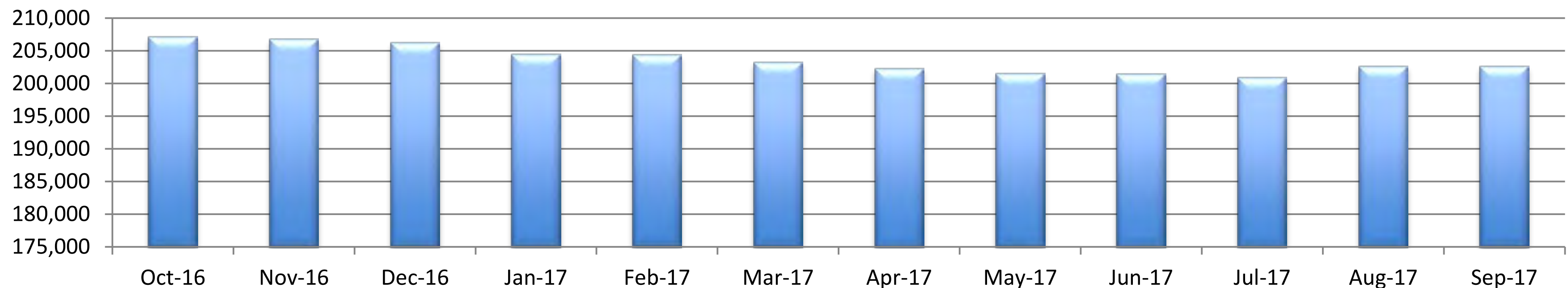
Sources: Claims Financial Transaction Summary Report, GCHP Inventory Tracking to Date, Claims Aging Report, Queue Aging Report, Xerox Roster Report

Gold Coast Health Plan℠
A Public Entity

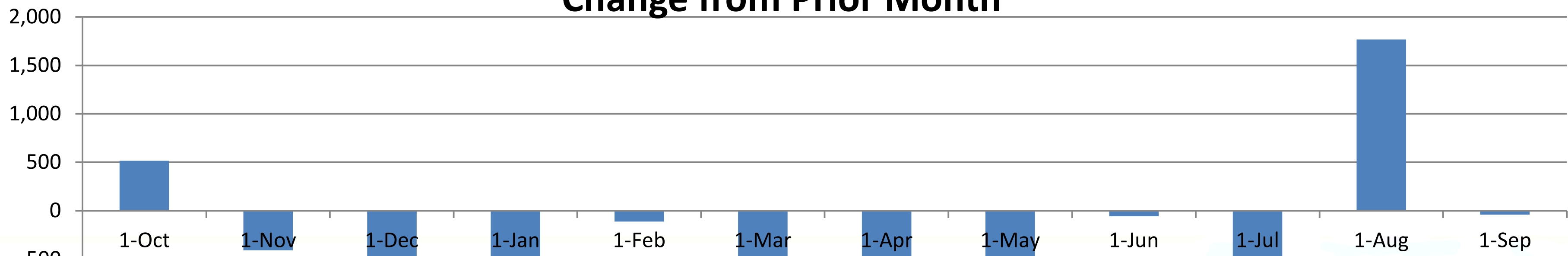
GCHP Membership

Total Membership as of Sept 1, 2017 – 202,630

*New Members Added Since January 2014 – 84,118

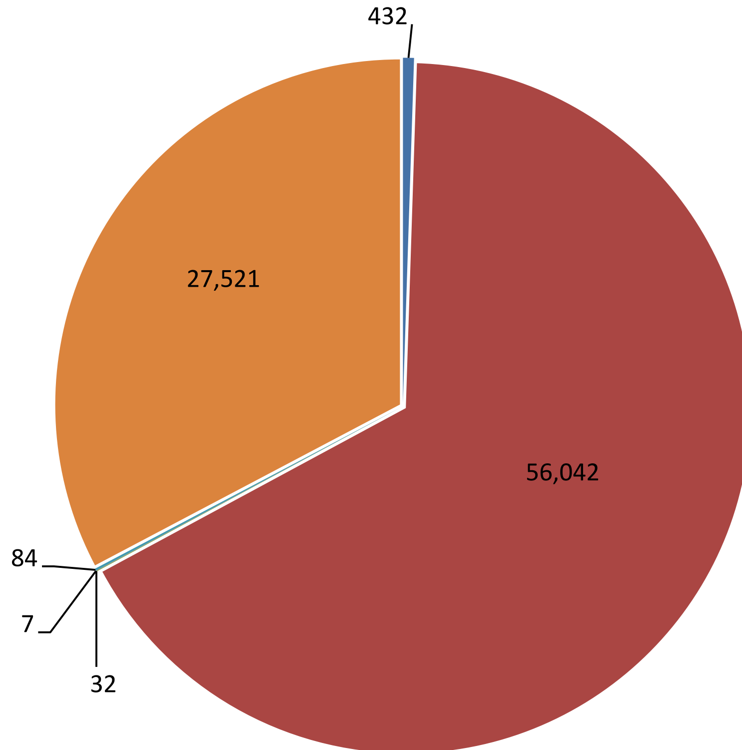


	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Active Membershi	207,188	206,780	206,252	204,529	204,417	203,243	202,338	201,514	201,455	200,903	202,670	202,630



Membership Growth

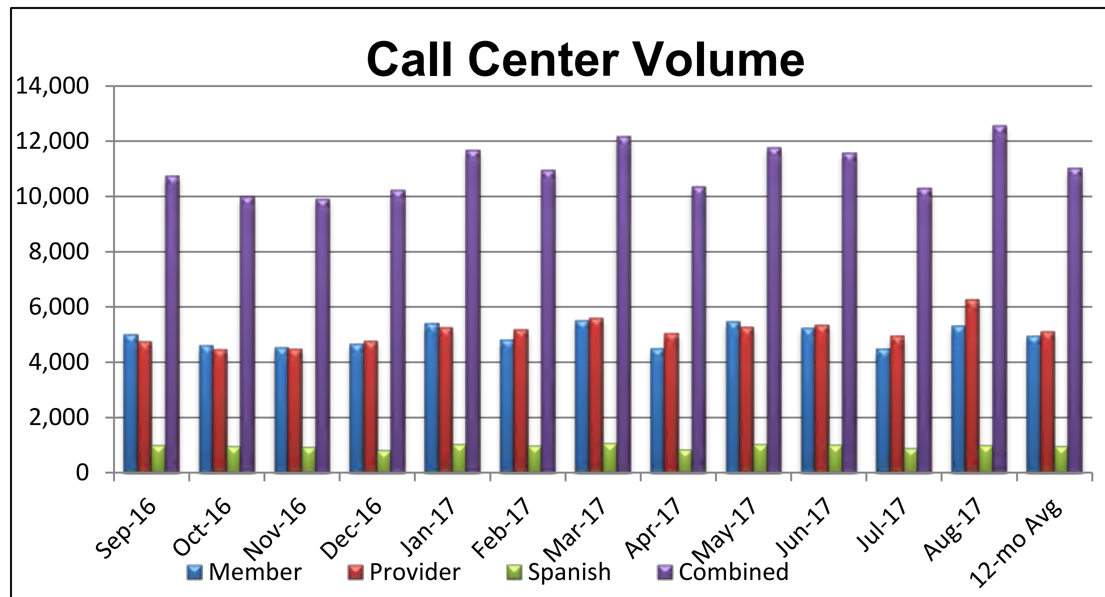
GCHP New Membership Breakdown

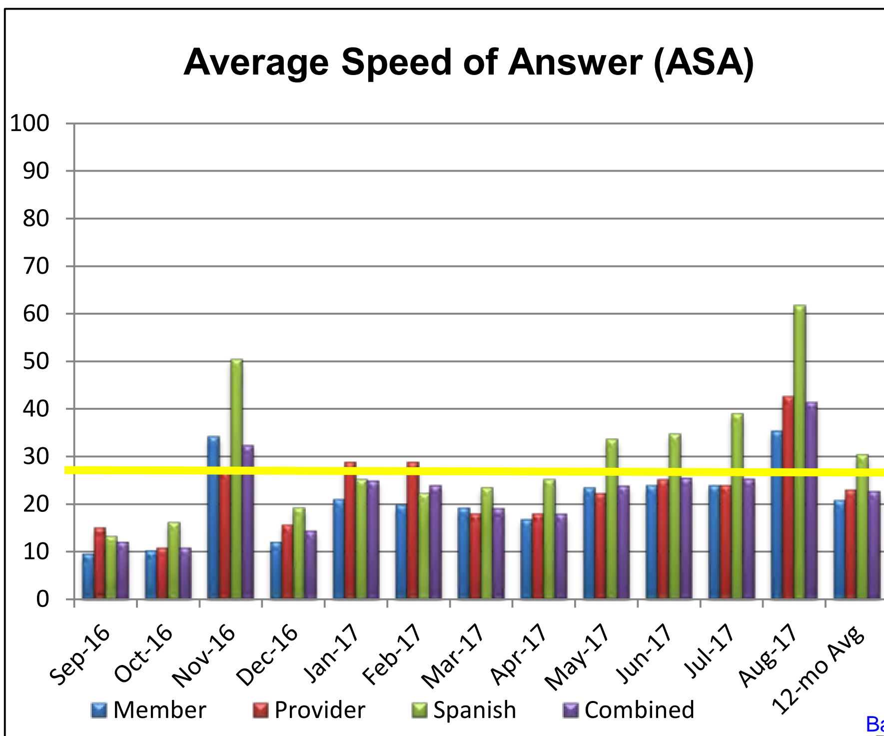


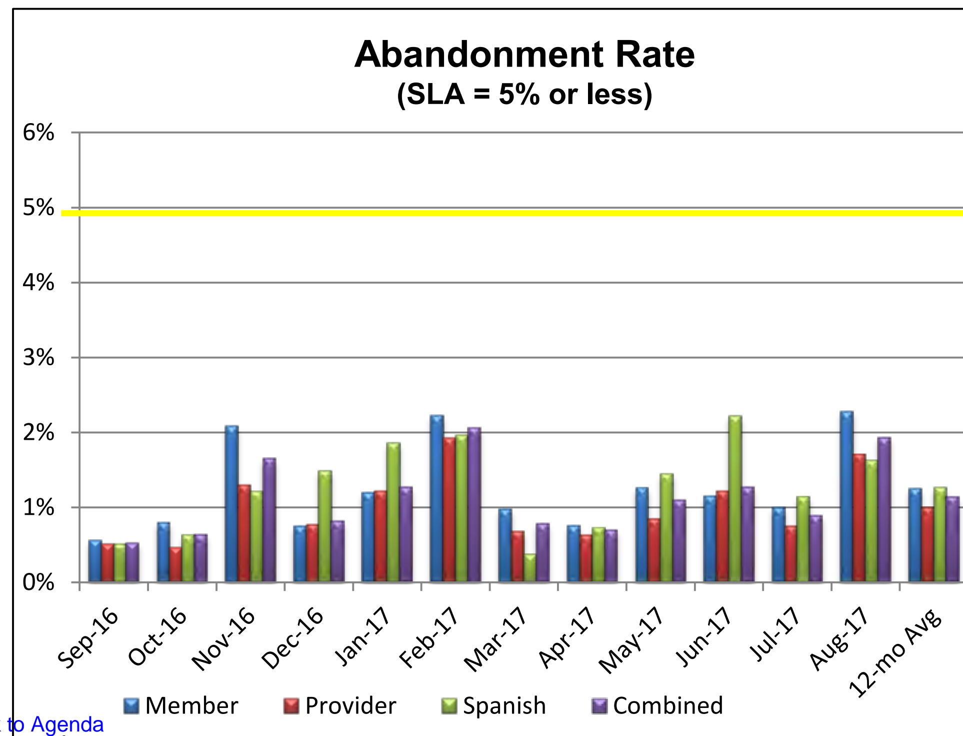
- L1 - Low Income Health Plan - 0.51%
- M1 - Medi-Cal Expansion - 66.62%
- 7U - CalFresh Adults - 0.04%
- 7W - CalFresh Children - 0.01%
- 7S - Parents of 7Ws - 0.10%
- Traditional Medi-Cal - 32.72%

GCHP Call Center Metrics – Aug 2017

- Call volume remained above 10,000 during the month; GCHP received 12,560 calls during August
- Service Level Agreements (SLA) for ASA (41.4 seconds vs the contractual requirement of ≤ 30 seconds) and Abandonment Rate (1.94% vs the contractual requirement of ≤ 5%) ASA was not met for August and Abandonment Rate was met for August



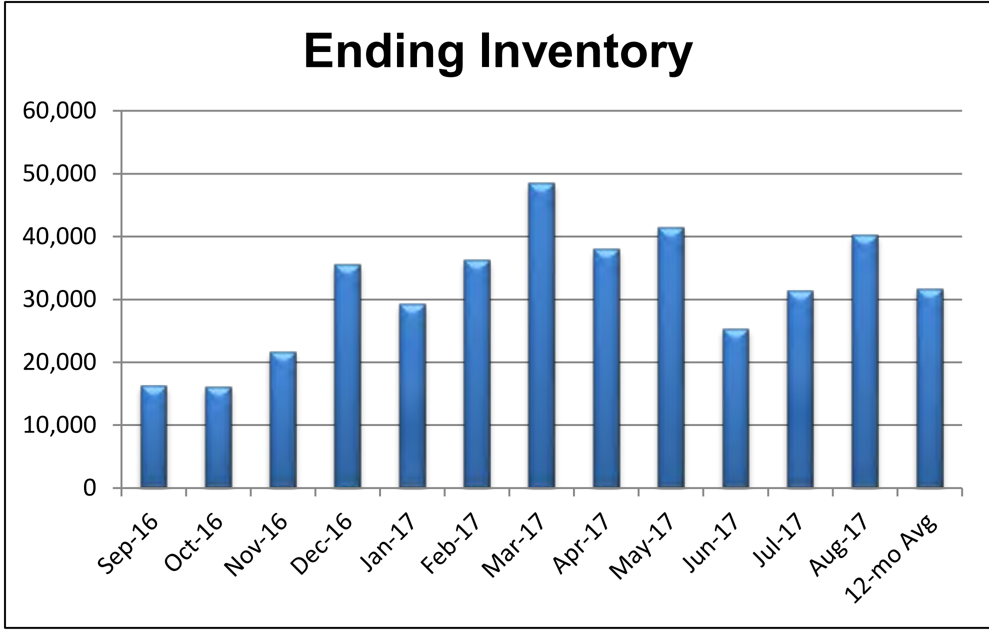


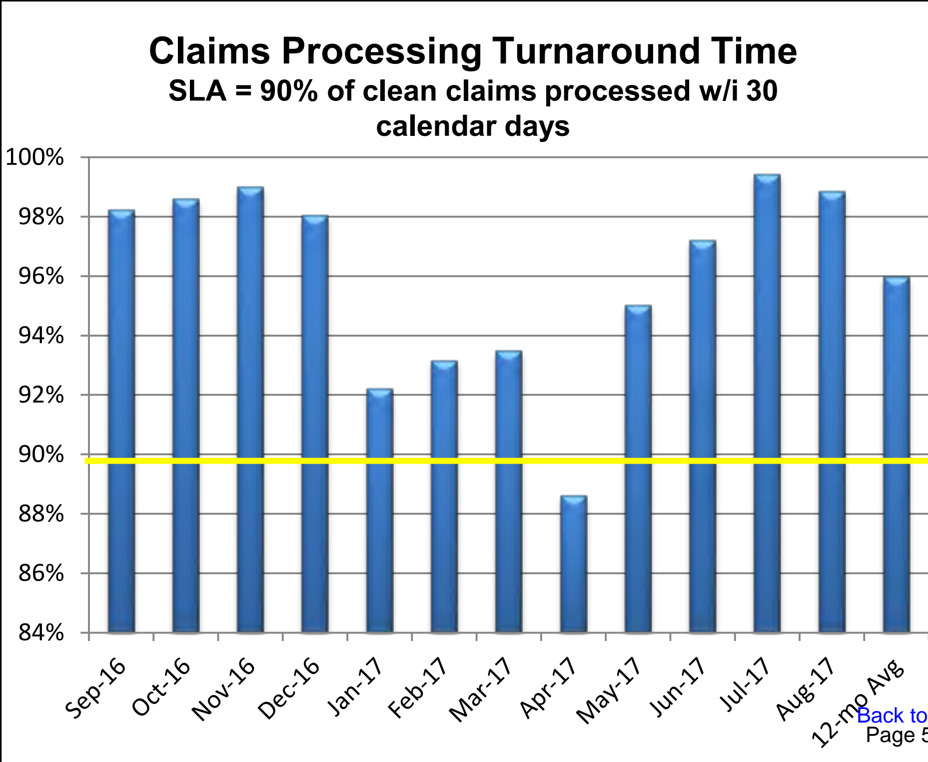


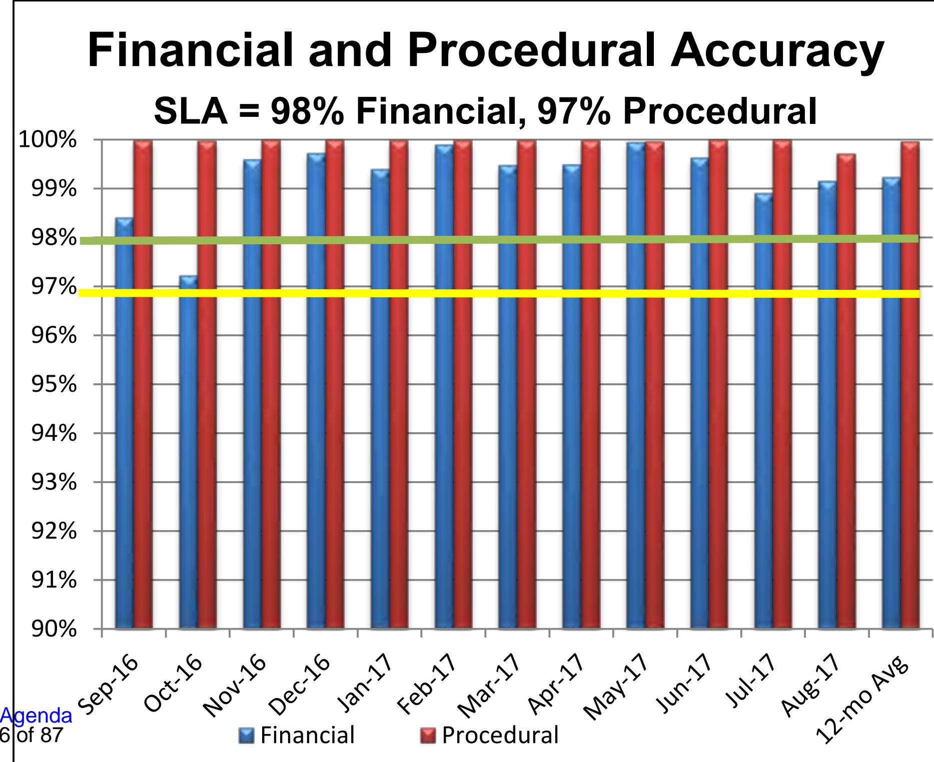
Back to Agenda

GCHP Claims Metrics – August 2017

- The 30 Day Turnaround Time (TAT) was compliant with the expected service level. 98.85% of clean claims were processed timely with the minimum requirement at 90%.
- Ending Inventory was 40,220 which equates to a Days Receipt on Hand (DROH) of 4.0 days vs a target DROH ≤ 5 days
- Service Level Agreements (SLAs) for Financial Accuracy (99.14%) and Procedural Accuracy (99.71%) were both met in August

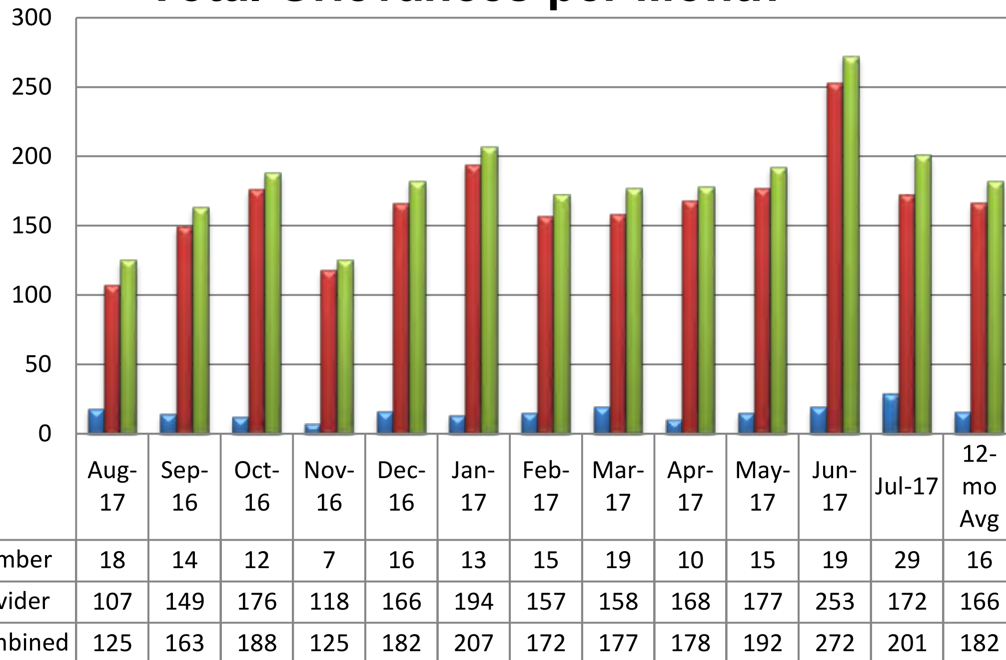




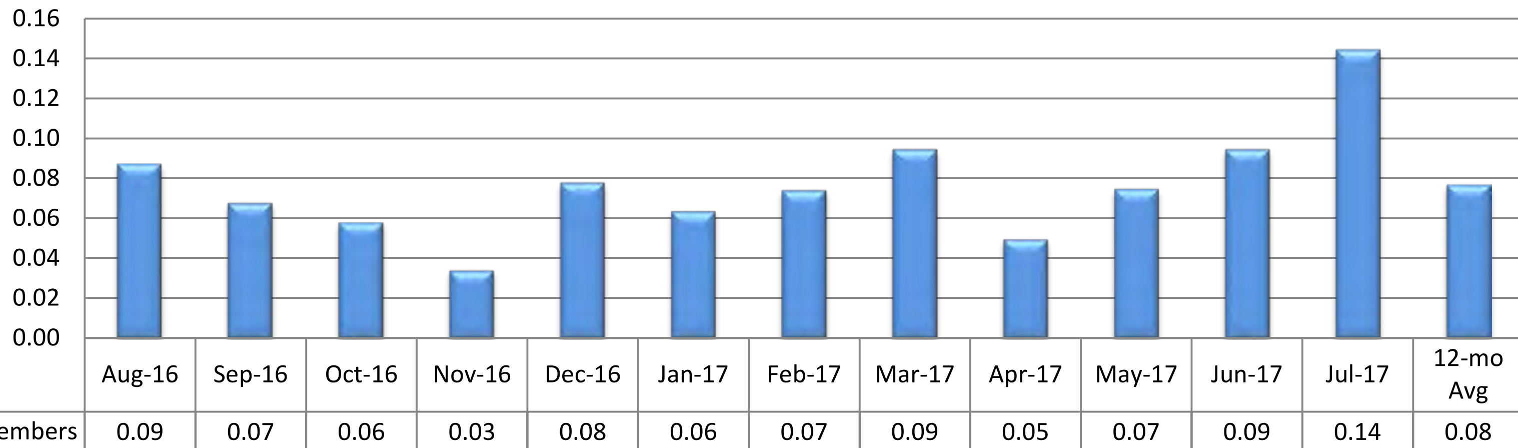


GCHP Grievance & Appeals Metrics – July2017

- GCHP received 29 member grievances (0.14 grievances per 1,000 members) and 172 provider grievances during July 2017
- GCHP's 12-month average for total grievances is 182
  - 16 member grievances per month
  - 166 provider grievances per month

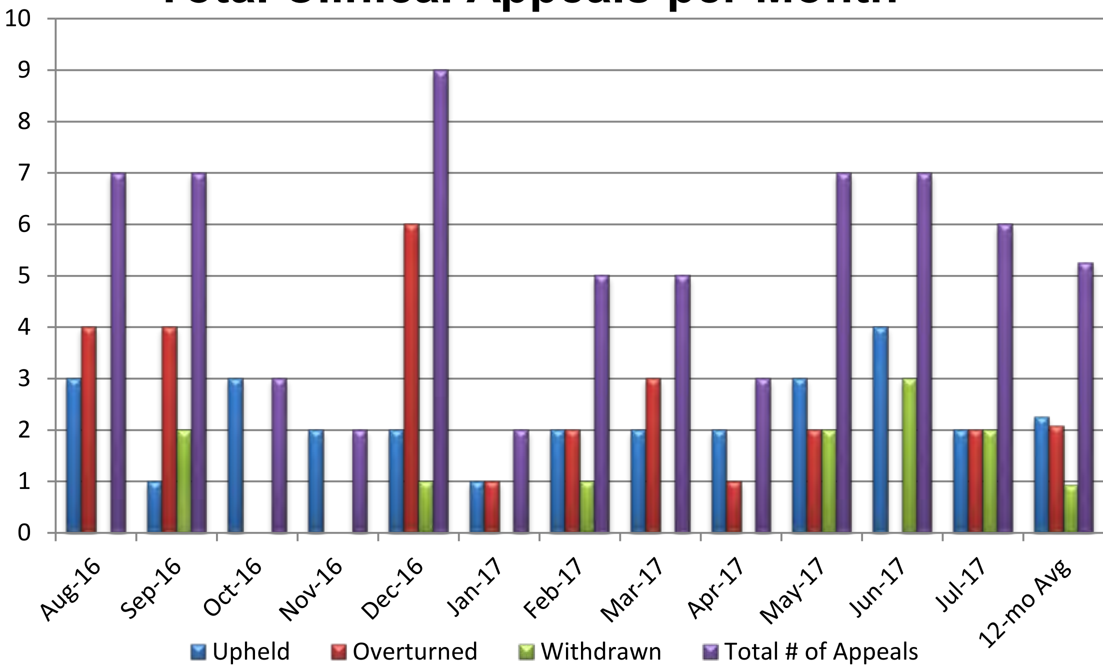


	Aug-17	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	12-mo Avg
Member	18	14	12	7	16	13	15	19	10	15	19	29	16
Provider	107	149	176	118	166	194	157	158	168	177	253	172	166
Combined	125	163	188	125	182	207	172	177	178	192	272	201	182



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	12-mo Avg
# of Grievance per 1000 Members	0.09	0.07	0.06	0.03	0.08	0.06	0.07	0.09	0.05	0.07	0.09	0.14	0.08

	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	12-mo Avg
Membership Count	206,644	206,672	207,188	206,780	206,252	204,529	203,243	201,514	202,338	201,514	201,455	200,903	204,086
Total Member Grievances Filed	18	14	12	7	16	13	15	19	10	15	19	29	16
# of Grievance per 1000 Members	0.09	0.07	0.06	0.03	0.08	0.06	0.07	0.09	0.05	0.07	0.09	0.14	0.08



GCHP Grievance & Appeals Metrics – July 2017

- GCHP had 6 clinical appeals in July; 2 Upheld, 2 Overturned and 2 Withdrawn
- TAT for grievance acknowledgement was non-compliant at 64% due to misrouted correspondence
- TAT for grievance resolution was non-compliant at 98%
- TAT for appeal acknowledgement and resolution were compliant at 100%.
- 5 State Fair Hearings were reported in July 2017, 2 were Withdrawn, 1 Denied, 1 Approved, and 1 Dismissed

G&A Acknowledgement and Resolution TAT

SLA = Acknowledgement - 100% w/i 5 days, Resolution - 100% w/i 30 days

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 12-mo Avg

Grievance Acknowledgement Grievance Resolution Appeal Acknowledgement Appeal Resolution

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Membership Update – September 2017

Gold Coast Health Plan (GCHP) had a decrease of 40 members this month which continues to indicate membership growth is beginning to stabilize. GCHP's membership as of September 1, 2017 is 202,630 and had a decrease by 84,118 (70.98%) since the beginning of Medi-Cal Expansion in January 2014. The cumulative new membership since January 1, 2014 is summarized as follows:

Aid Code	# of New Members
L1 – Low Income Health Plan (LIHP)	432
M1 – Adult Expansion	56,042
7U – CalFresh Adults	32
7W – CalFresh Children	7
7S – Parents of 7Ws	84
Traditional Medi-Cal	27,521
Total New Membership 1/1/14 – 9/1/17	84,118

Adult Expansion membership (aid code M1) decreased from the previous month after a slight increased since the start of Medi-Cal Expansion. M1 members represent 66.62% of GCHP's new membership since January 1, 2014.

	L1	M1	7U	7W	7S
Sept 17	432	56,042	32	7	84
Aug 17	447	56,028	58	14	87
Jul 17	464	55,407	80	30	94
Jun 17	484	55,462	83	31	91
May 17	505	55,331	91	35	113
Apr 17	520	55,333	94	44	163
Mar 17	560	55,539	100	48	210
Feb 17	590	55,667	113	55	243
Jan 17	646	55,551	141	50	203
Dec 16	695	55,820	521	123	240
Nov 16	770	55,567	1,057	216	314
Oct 16	919	55,103	1,227	254	374
Sep 16	1,015	54,740	1,370	280	336
Aug 16	1,162	54,237	1,470	307	361

GCHP Auto Assignment by PCP/Clinic as of July 1, 2017

	Sep-17		Aug-17		Jul-17		Jun-17		May-17		Apr-17	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
AB85 Eligible	1021		1039		1155		1293		**1290**		**1518**	
VCMC	510	49.95%	519	49.95%	577	49.96%	646	49.96%	645	50.00%	759	50.00%
Balance	511	50.05%	520	50.05%	578	50.04%	647	50.04%	645	50.00%	759	50.00%
Regular Eligible	**1,074**		**903**		**1,073**		**883**		**983**		**1,567**	
Regular + AB85 Balance	**1,585**		**1,423**		**1,651**		**1,530**		**1,628**		**2,326**	
Clinicas	414	26.12%	384	26.99%	367	22.23%	347	22.68%	384	23.59%	552	23.73%
CMH	203	12.81%	172	12.09%	217	13.14%	203	13.27%	194	11.92%	299	12.85%
Independent	33	2.08%	27	1.90%	45	2.73%	45	2.94%	34	2.09%	57	2.45%
VCMC	935	58.99%	840	59.03%	1022	61.90%	935	61.11%	1016	62.41%	1418	60.96%
Total Assigned	**2,095**		**1,942**		**2,228**		**2,176**		**2,273**		**3,085**	
Clinicas	414	19.76%	384	19.77%	367	16.47%	347	15.95%	384	16.89%	552	17.89%
CMH	203	9.69%	172	8.86%	217	9.74%	203	9.33%	194	8.53%	299	9.69%
Independent	33	1.58%	27	1.39%	45	2.02%	45	2.07%	34	1.50%	57	1.85%
VCMC	1445	68.97%	1359	69.98%	1599	71.77%	1581	72.66%	1661	73.08%	2,177	70.57%

Auto Assignment Process

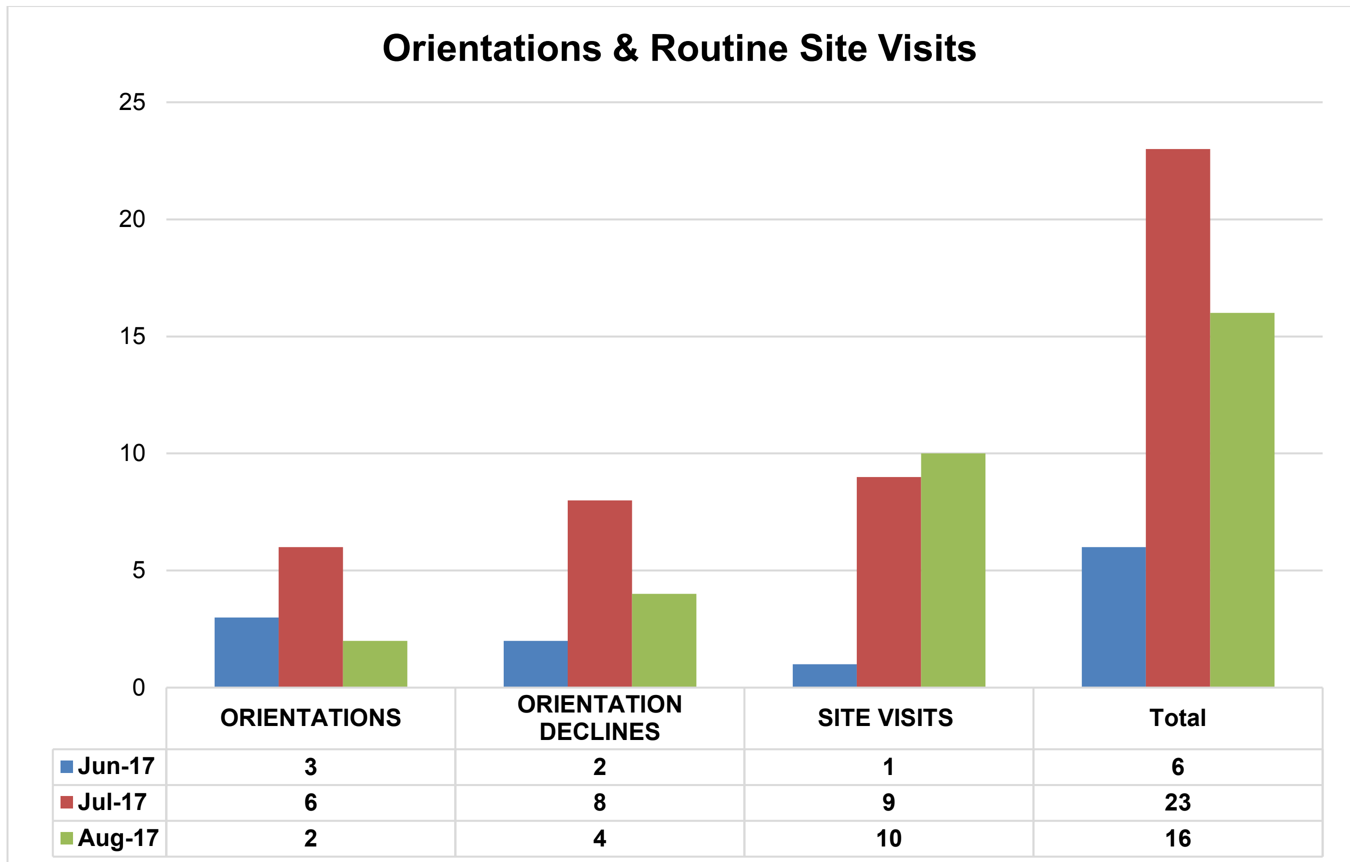
- 47% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85
- The remaining 53% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others
- The County's overall auto assignment results will be higher than 50% since they receive 50% of the AE members plus a 3:1 ratio of all other unassigned members
- VCMC's target enrollment is 65,765
  - VCMC has 30,939 assigned Adult Expansion members as of Sept 1, 2017 and is currently at 47.04% of capacity

GCHP Membership Churn Summary

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Membership from Prior Month	206,672	207,188	206,780	206,252	204,529	204,417	203,244	202,404	202,204	202,219	201,767	203,623
Prior Month Members Inactive in Current Month	5,575	6,866	6,054	8,733	6,682	7,555	8,028	7,399	6,475	6,078	4,595	5,641
Sub-total	201,097	200,322	200,726	197,519	197,847	196,862	195,216	195,005	195,729	196,141	197,172	197,982
Percentage of Inactive Members from Prior Month	2.70%	3.31%	2.93%	4.23%	3.27%	3.70%	3.95%	3.66%	3.20%	3.01%	2.28%	2.77%
Current Month New Members	4,193	4,533	3,809	5,165	4,118	4,088	4,587	4,371	4,237	3,691	4,455	4,371
Sub-total	205,290	204,855	204,535	202,684	201,965	200,950	199,803	199,376	199,966	199,832	201,627	202,353
Percentage of New Members Reflected in Current Membership	2.02%	2.19%	1.85%	2.53%	2.01%	2.01%	2.27%	2.16%	2.10%	1.83%	2.19%	2.15%
Retroactive Member Additions	1,898	1,855	1,717	1,845	2,452	2,294	2,601	2,828	2,253	1,935	1,996	1,388
Active Current Month Membership	**207,188**	**206,780**	**206,252**	**204,529**	**204,417**	**203,244**	**202,404**	**202,204**	**202,219**	**201,767**	**203,623**	**203,741**
Percentage of Retroactive Members Reflected in Current Membership	0.92%	0.90%	0.83%	0.90%	1.20%	1.13%	1.29%	1.40%	1.11%	0.96%	0.98%	0.68%

NETWORK UPDATE AUGUST 2017

A. PROVIDER SITE VISIT RESULTS



	ORIENTATIONS	ORIENTATION DECLINES	SITE VISITS	Total
Jun-17	3	2	1	6
Jul-17	6	8	9	23
Aug-17	2	4	10	16

- Orientations: 11 new provider orientations were conducted by GCHP Provider Relations Staff over the last 3 months. This figure is up approximately 42% due to staffing re-allocation of resources, which were previously dominated by the MCPDIP 274 project.

- 14 Physicians declined orientation during this reporting period due to their joining an established contracted group with GCHP. Established groups such as delegated providers have participated in previous orientations; they are familiar with GCHP policies and procedures and have the staff and capability to perform the orientation function on their own.

- Site Visits: 20 provider site visits were completed by Network Operations-Provider Relations staff. The goal for the Provider Relations team is to complete 20 site visits per Provider Relations Specialists per month i.e., 40 visits per month. These figures are down for this 3-month period due to two factors: loss of a Provider Relations Specialist and final efforts to complete the 274 and Provider Directory submissions to the State.

B. KEY PROJECTS:

1. MANAGED CARE PROVIDER DATA IMPROVEMENT PROJECT (MCPDIP) 274- UPDATE

- GCHP is submitting monthly files timely to the state.
- The monthly files received by the State have been accepted and approved upon each submission.

2. SB 137 PROVIDER DIRECTORIES

- Our provider directory was approved based on the requirements of our DHCS contract and the mega regulation requirements.
- Final Rule deliverable #8: Re: Minimum 12 font throughout the directory and 18-font tag line – **DHCS approved draft with changes on 08/03.**
- Completed action plan for remaining FR #8 deliverables Re: Obtaining after hour call hours and URL information.

3. PROVIDER NETWORK DATA BASE & CREDENTIALING SYSTEM RFP

- Received RFP responses from three vendors.
- Finalized scoring of RFP's.
- Setting up demonstration visits with Vendors.

C. PROVIDER ADDS & TERMINATIONS- August 1, 2017-September 14, 2017

Provider Adds: 40

- **Hospitals: 10**
  - LTAC: 10
- **Providers**: **18**
  - PCPs & Mid-levels: 6
  - Specialists 10
  - Hospitalists: 2
- **Ancillary: 12**
  - DME: 2
  - Hospice: 1
  - Occupational Therapy: 1
  - Physical Therapy: 5
  - Radiology: 1

Provider Terms: 19

- DME: 1 — **Impact:** None. 42 DME providers contracted.
- Hospice: 1 — **Impact:** None. 16 Hospice providers contracted.
- PCP's and Mid-Levels: 7 — **Impact:** Small. Terms mainly due to provider clean-up Under 274. 168 FP's, 47 peds and 35 IM PCP's remain actively contracted. # excludes mid-levels.
- Optometry: 1 — **Impact:** None: provider re-located
- Radiology: 2 — **Impact:** None: Terms due to provider clean-up under 274.
- Specialists: 5 — **Impact:** None: Terms due to provider clean-up and Physicians re-locating.
- Speech Pathology: 2 — **Impact:** None: Terms due to provider clean-up under 274.

D. VALUE BASED INITIATIVES:

- Camarillo Health Care District Transition of Care Program: Program initiated 8/1/2017

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AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: September 25, 2017

SUBJECT: AmericasHealth Plan Update

711 East Daily Drive, Suite 106, Camarillo, CA 93010-6082 | Member Services: 888-301-1228 | Administration: 805-437-5500 | Fax: 805-437-5132

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Update on GCHP-AHP Pilot Program

Monday, September 25, 2017

Ruth Watson, COO

Integrity

Accountability

Collaboration

Trust

Respect

Back to Agenda

Overview

1. Progress on GCHP – AHP Pilot Program

2. AHP's Proposal for Pilot Membership
    a. Confirm common understanding of AHP Pilot
    b. Anticipate formal request from AHP on membership
    c. Address policy implications for Commission

3. Next Steps for GCHP – AHP Pilot Program

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Progress to Date

- Launched Pilot Program Collaboration on August 10, 2017
  - ➢ Established parameters for the collaboration
  - ➢ Identified leads for the collaboration
  - ➢ Created a 'relationship map' for key players to ensure smooth collaboration

Executive Committee Co-Chairs	GCHP Lead	AHP Lead
CEO	Dale Villani	Enrique de la Garza. M.D.
Steering Committee members	**Title**	
Ruth Watson, Chair	COO-GCHP	
Enrique de la Garza, M.D.	CEO-AHP	
Rudy Diaz	COO-AHP	
Sonia DeMarta	CFO- AHP	
Anita Guevin	Compliance Officer-AHP	
James Ward	Executive Network Consultant - AHP	
David Cruz	Communications + Government Relations Director - AHP	
Amy Slade	Exec. Asst to CEO & Project Manager - AHP	
Dale Villani	CEO-GCHP	
Lyndon Turner	Director of Financial Analysis – GCHP	
Brandy Armenta	Compliance Officer - GCHP	
Steve Pieser	Senior Director of Network Operations - GCHP	
Margaret Tatar	Managing Principal, Health Management – consultant	
Maddie Gutierrez	Exec. Asst. to COO - GCHP	
Patricia Mowlavi	CFO - GCHP	
Nancy Warfield	CMO -GCHP	
Corry Keenan	Manager- Project Management	
Working Groups	**GCHP Lead and Members**	**AHP Lead and Members**
Operations	Ruth Watson, COO and Steve Pieser	Rudy Diaz, COO, and James Ward
Finance/rates/encounters	Patricia Mowlavi or Lyndon Turner	Sonia DeMarta and Rudy Diaz
Compliance	Brandy Armenta	Anita Guevin
Medical/Clinical/UM/quality	Nancy Wharfield	Norman Kato, M.D. & Beverly Gibbs, RN
Communications	TBD	David Cruz
Functional Focus Areas	**GCHP Lead and Members**	**AHP Lead and Members**
DOFR	Ruth Watson, Steve Peiser, Patricia Mowlavi and/or Lyndon Turner	Rudy Diaz, James Ward, and Sonia DeMarta
Contract Terms	Brandy Armenta	Anita Guevin
Outcomes and quality	Nancy Wharfield	Beverly Gibbs, RN
Communications	TBD	David Cruz

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Progress to Date: GCHP Has

1. Facilitated weekly meetings of the GCHP-AHP Pilot Program leads
2. Engaged with DHCS on its required approvals
3. Shared the relevant boilerplate contract with AHP
4. Prepared a detailed workplan and shared with AHP for comments
5. Created a detailed DOFR and shared that with AHP for comments
6. Dedicated *significant* leadership resources to the Pilot Program
7. Planned for needed Budget adjustments for Pilot Program activities
8. Adjusted GCHP staff workloads to accommodate this Pilot Program
9. Made the GCHP-AHP Pilot Program a clear priority for staff
10. Engaged with DHCS on membership issues on behalf of AHP

AHP's Proposal – General

1. General pilot parameters are as follows:
   a. Risk-based contract with specific carve outs;
   b. Three-year contract with option years for years 2 and 3 based on performance as agreed to by both parties;
   c. Enrollment will be capped at 5,000 members in year 1.

2. AHP's pilot membership request:
   a. AHP requests a block transfer of GCHP members;
   b. AHP will submit a formal request by September 30 for:
      i. The specific source of GCHP membership it is requesting;
      ii. The specific method for identifying such GCHP membership.

3. Policy Implications for Commission:
   a. Commission will have to change Commission policy MS-005; and
   b. Commission will have to approve the member movement from the current approach to the proposed new Pilot.

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AHP’s Membership Goals: Policy implications

In anticipation of AHP’s request, GCHP and Commission must:

1. Require certain GCHP Members to be ‘block transferred’ to AHP;
2. Secure DHCS approval for the block transfer, which shall include:
    a. Confirmation that members will maintain their choice;
    b. Specific information on the benefits to impacted Members;
    c. Specific information on the Member impact;
3. Identify the category(ies) of Members who will be block-transferred;
4. Change MS-005, as necessary, to:
    a. Identify Members who will no longer be subject to auto-assignment if the Commission decides to block transfer such Members to AHP;
    b. Identify the changes for Administrative Members if the Commission decides to block transfer Administrative Members to AHP;
5. Require Members who are transferred to select a PCP;
6. Confirm members will have the right to choose and leave the Pilot;
7. Determine the period for which this policy change is in effect.

***NOTE**: If we transfer Administrative Members, Commission needs to confirm that:

1. Those Administrative Members would have ‘choice’;
2. Could seek to leave AHP and return to GCHP; and
3. If so, they would be returned to Administrative Member status.

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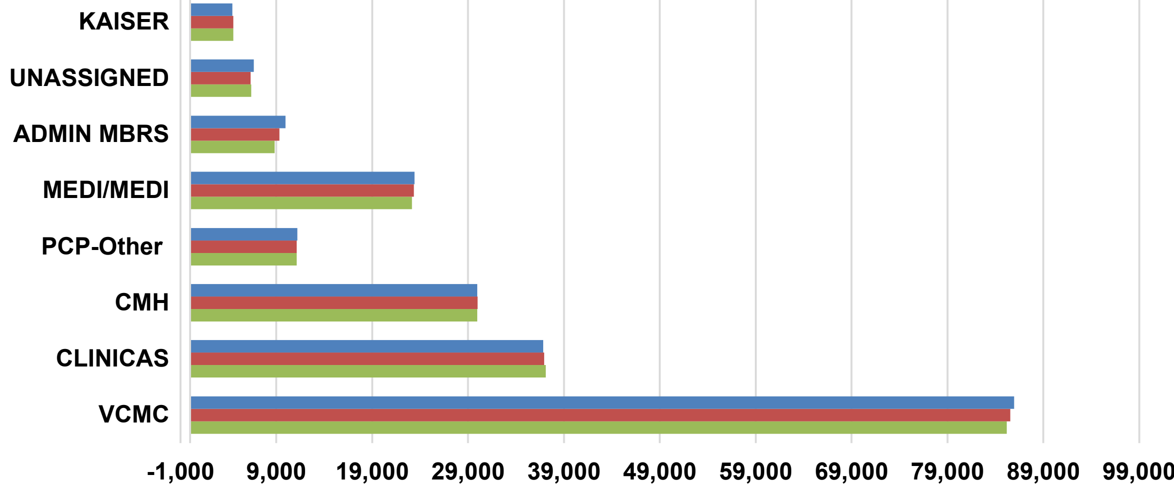
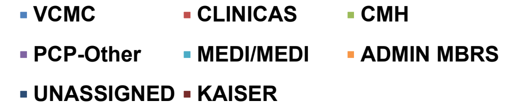
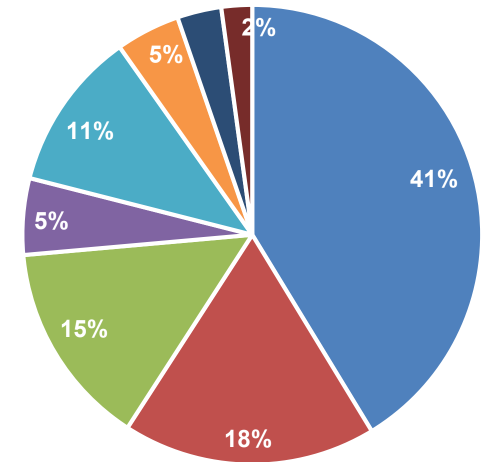
GCHP Membership and Assignments



	VCMC	CLINICAS	CMH	PCP-Other	MEDI/MEDI	ADMIN MBRS	UNASSIGNED	KAISER
Mar-17	85,959	36,832	29,942	11,196	23,425	9,938	6,639	4,422
Apr-17	85,556	36,947	29,984	11,117	23,327	9,333	6,304	4,499
May-17	85,197	37,115	29,939	11,109	23,133	8,826	6,385	4,525

Average %





- Unassigned members are Newly Eligible/Enrolled
- Administrative Member(s)
  - Share of Cost (SOC): Has Medi-Cal with a Share of Cost requirement.
  - Long-Term Care (LTC): Resides in a skilled or intermediate-care nursing facility and has been assigned an LTC Aid Code.
  - Out of Area: Resides outside GCHP's service area but whose Medi-Cal case remains in Ventura County.
  - Other Health Coverage: Has other health insurance that is primary to their Medi-Cal coverage; this includes Members with both Medi-Cal and commercial insurance. Medi-Cal is the payer of last resort; therefore GCHP Members with other coverage must access care through their primary insurance.

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Next Steps – short term

1. Clarify all aspects of AHP's request for membership:
   a. Identify the GCHP Members AHP is requesting
   b. Confirm Member choice to leave the pilot
   c. Establish the period within which AHP shall grow its membership
   d. Establish rationale for block transfer from the Member's perspective for DHCS
2. Seek and secure Commission approval for the necessary policy change in October
3. Submit the block transfer request to DHCS for approval
4. Continue to conduct the GCHP-AHP Pilot Program meetings
5. Continue to update the Commission on critical policy and other emerging issues
6. Secure AHP comments on the workplan
7. Secure AHP comments on the DOFR
8. Secure AHP comments and input on the boilerplate
9. Prepare and report to Commission on Budget adjustments for Pilot

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Questions

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AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: September 25, 2017

SUBJECT: Chief Medical Officer Update

COMMUNITY OUTREACH UPDATE

Summary

Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. The health education and outreach team maintains a positive presence in the community by working with various county public health departments, community based organizations, schools, senior centers, faith-based centers and social service agencies.

Outreach Events. Below is a list of activities during the month of August:

August 2017	List of Activities
8/4/2017	Sharing the Harvest hosted by Santa Clara Valley Neighborhood for Learning, Santa Paula
8/4/2017	Community Resource Fair Kindergarten Round Up hosted by Moorpark/Simi Neighborhood for Learning (NfL) and Gold Coast Health Plan
8/5/2017	Amigo Baby Summer Party hosted by Amigo Baby, Inc., Oxnard College Park
8/8/2017	Baby Steps Program hosted by Ventura County Medical Center, Ventura
8/12/2017	3rd Annual K-12 Resource Fair “Transitions to the Future” hosted by Office of Assemblymember Jacqui Irwin, Oxnard
8/13/2017	National Health Week Center Health Fair hosted by Clinicas Del Sol Park, Oxnard
8/15/2017	Baby Steps Program hosted by Santa Paula Hospital, Santa Paula
8/16/2017	Westpark Community Center Monthly Food Distribution Program & Health Services, Ventura
8/17/2017	Gold Coast Health Plan Information Booth at the Consulate of Mexico, Oxnard
8/19/2017	Ventura County Pride Festival hosted by the Diversity Collective Ventura County, Ventura
8/24/2017	Community Market Produce Giveaway hosted by Moorpark Neighborhood for Family Learning, Moorpark
8/24/2017	Community Market Produce Giveaway hosted by Simi Valley Neighborhood for Family Learning, Simi Valley
8/24/2017	11th Annual Farmworker Informational Fair, America’s Job Center of CA, Oxnard

Health Education

The Health Education Department Smoking Prevention Program focuses on providing materials and brochures to members and speaking to them about the harms of all tobacco products, not just cigarettes. The materials are available at resource fairs and workshops that GCHP attends throughout Ventura County. The Health Education Department also works directly with members to provide tobacco cessation materials and program coordination. As part of our Smoking Prevention Program, the Health Education Department will be mailing information on the California Smokers' Helpline to members who have been identified as tobacco users. The informational postcard will guide them to the state program.

The department also has a brochure to guide members to hospital and public health smoking cessation programs. The brochure also directs members to telephonic smoking cessation programs, and members can speak to GCHP directly for questions regarding any of these services.

Samples of some of the smoking prevention materials that Health Education provides to members are shown below:

The Health Education Department continues to educate members throughout the community on various health topics. During the month of August, the Health Education Department conducted workshops on diabetes, eye health, healthy living, cataract awareness, nutrition and physical activity. GCHP health navigators will call members after an event if they have completed a health education referral and are active GCHP members.

Upcoming Community Events:

- Saturday, September 23rd: 6th Annual Strengthening Our Families Workshops hosted by Oxnard School District, Oxnard
- Saturday, September 23rd: Day for Kids, hosted by Boys and Girls Clubs of Greater Oxnard and Port Hueneme, Ventura

- Saturday, September 23rd: Day for Kids, hosted by Boys and Girls Clubs of Greater Ventura
- Wednesday, September 27th: Current School Community Resource Fair, hosted by Current School, Oxnard

Cultural and Linguistic Services

GCHP Health Education Department, Cultural Linguistic Services coordinates interpreting and translation services for members. GCHP offers interpreting services at no cost and in over 200 languages, including sign language. GCHP monitors requests for interpreting and translation services daily. Below are the totals for the month of August:

A) Telephonic Interpreting Services
   - A total of 313 requests for telephonic interpreting services for August.

B) Sign Language Interpreter Services
   - A total of 57 request for sign language interpreting services for August.

C) In-Person Interpreter Services
   - A total of 8 requests for in-person interpreting services for August.

D) Translation Services
   - A total of 3 requests for translation services for August.

Sponsorship Program

A total of $3,100 was allocated to four agency/organizations under the GCHP Sponsorship Program during the month of August. The fiscal year-to-date (YTD) total is $43,200. Below is a summary of the programs and funding approved.

Agency/Organization	Approved Award Amount	Event/Org Summary
Ventura County District Attorney: Family Justice Center Strategic Planning Event	$500	An interactive discussion on the development and implementation of a Family Justice Center in Ventura County where collaborative, coordinated service providers work together to provide a safe, welcoming environment for victims of domestic violence, sexual assault, child abuse, human trafficking, and elder abuse.
Alzheimer's Assn - 2017 Oxnard Walk to End Alzheimer's	$1,000	Fundraiser to raise awareness about Alzheimer's and the support available through the Association.
Boys & Girls Club of Greater Oxnard and Port Hueneme	$1,000	"Day for Kids" celebrates and honors America's children; educates adults on the importance of meaningful time with them; and to engage in healthy lifestyles.
California Juvenile Justice Initiative	$600	The National Center for Youth Law is a non-profit law firm that helps low-income children achieve their potential by transforming the public agencies that serve them.

PHARMACY BENEFIT PERFORMANCE AND TRENDS

SUMMARY:

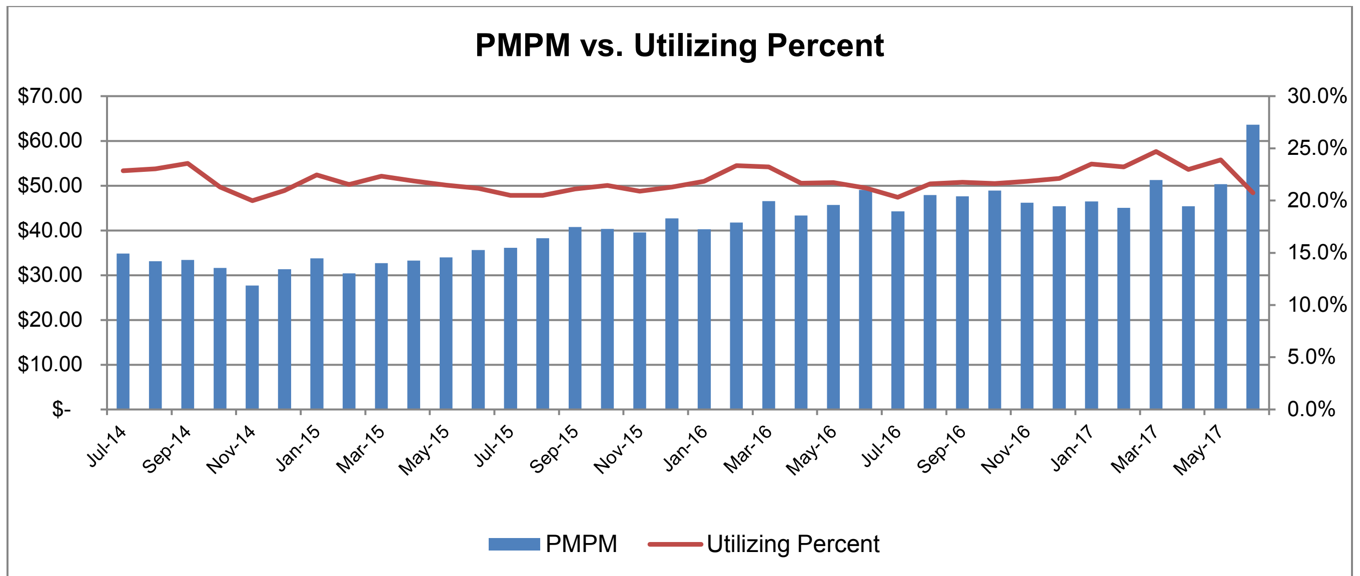
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of June 2017. Although minor changes may occur to the data going forward due to the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

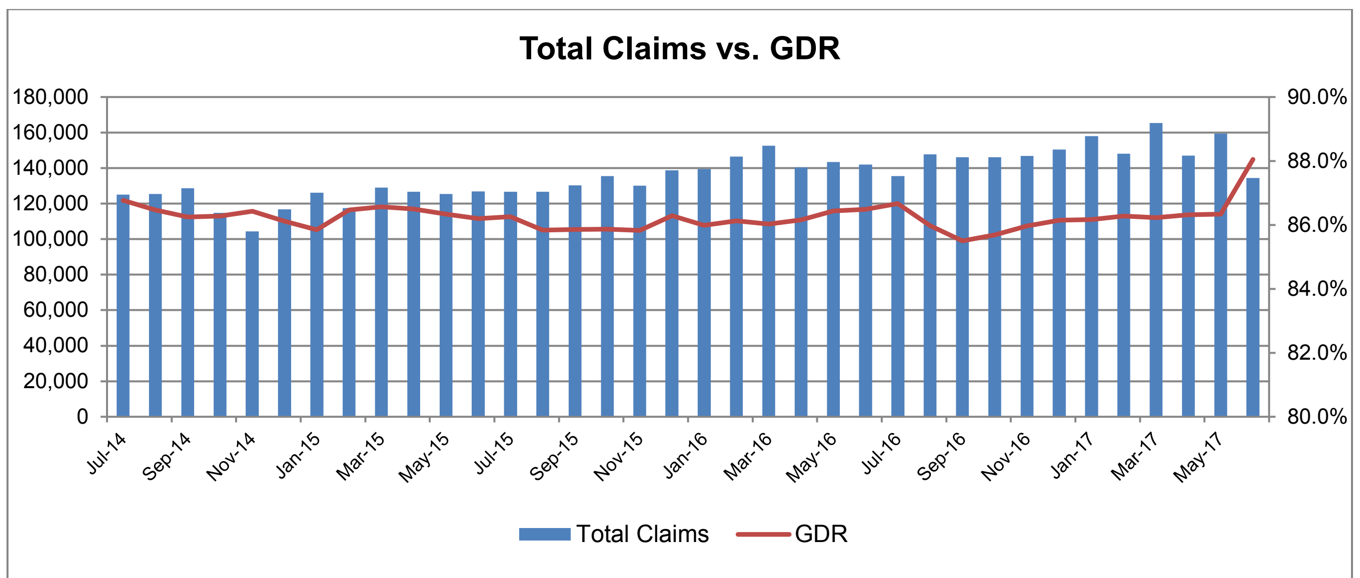
GCHP has seen a slight membership drop in 2017, while utilization has generally remained flat. Slight cost declines occurred in November and December 2016, however costs increased again in January, March, and May 2017. The biggest change to note is the increase in costs in June 2017, which is attributed to the new PBM, OptumRx. Additional information regarding the increases seen in June will be provided verbally.

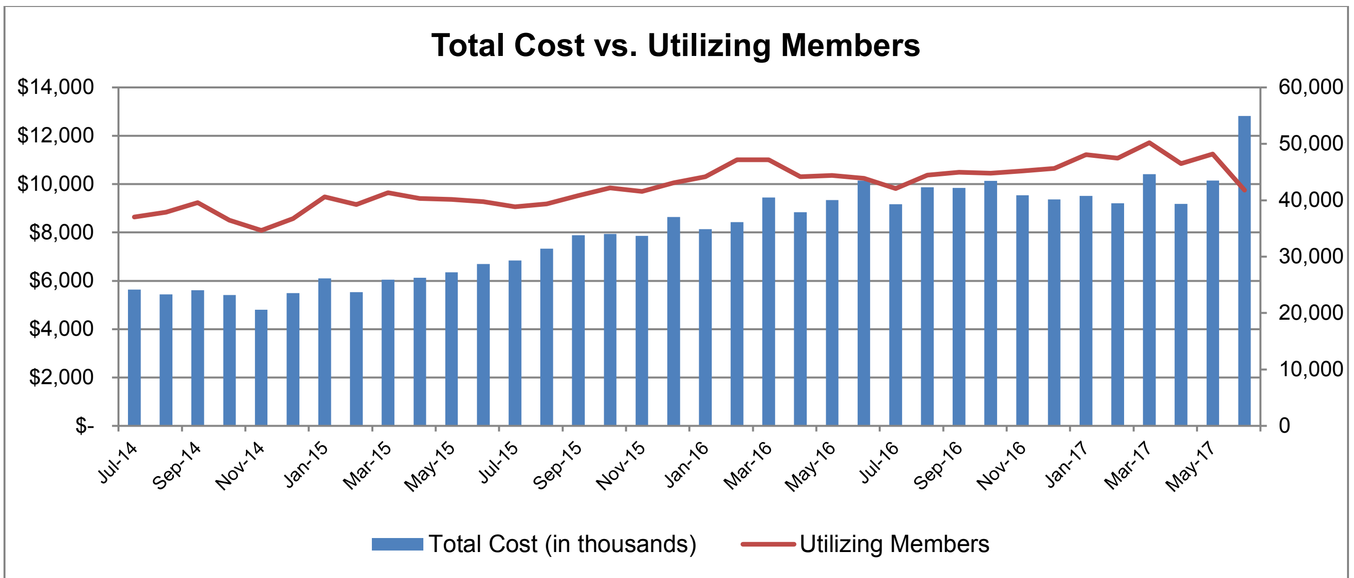
Hepatitis C continues to be a major driver of pharmacy costs though cost has decreased since the peak in May 2016. Formulary changes and the implementation of preferred products to align with DHCS kick payment utilization and cost assumptions have resulted in the Plan estimating to recoup all costs related to Hepatitis C from March 2017 through May 2017. A new hepatitis C drug was released which has a much lower cost than all available agents. Due to this drug, the DHCS kickpayment is greatly reduced for FY 17-18. In response to this, GCHP has aligned its formulary status of hepatitis C agents with the DHCS usage assumption.

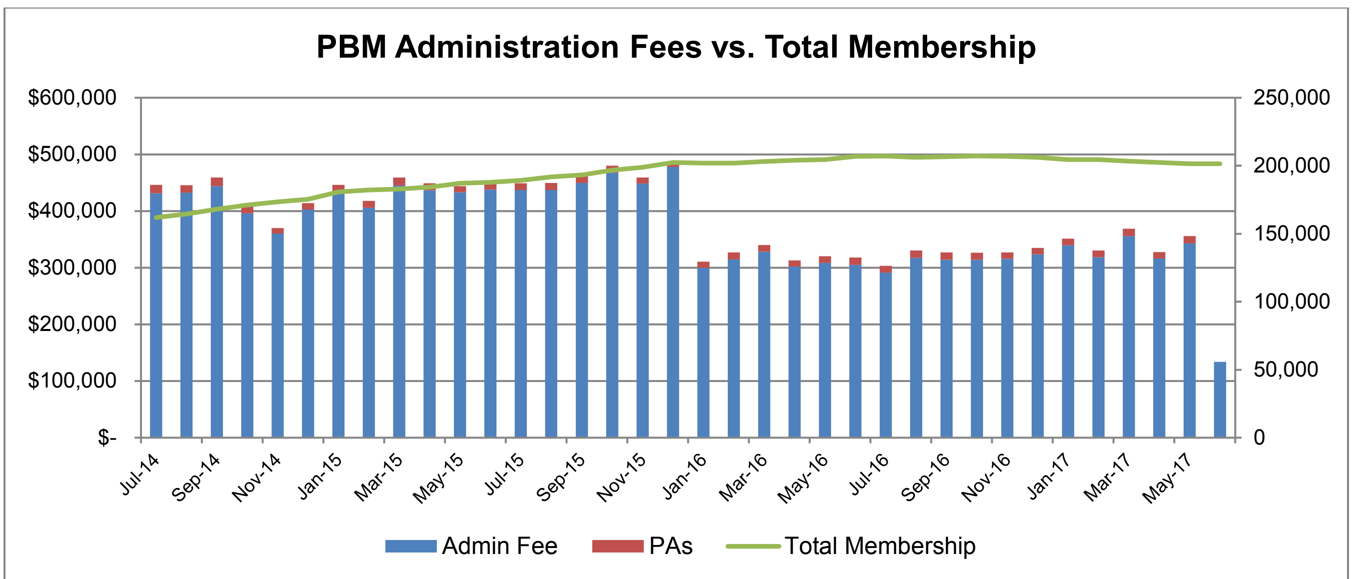
Abbreviation Key:
PMPM: Per member per month
PUPM: Per utilizer per month
GDR: Generic dispensing rate
PA: Prior authorization

PHARMACY COST TRENDS:

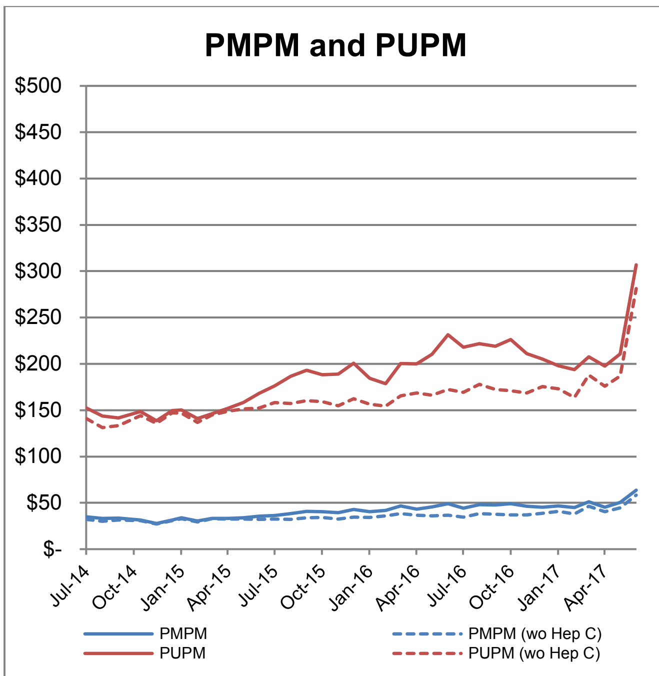


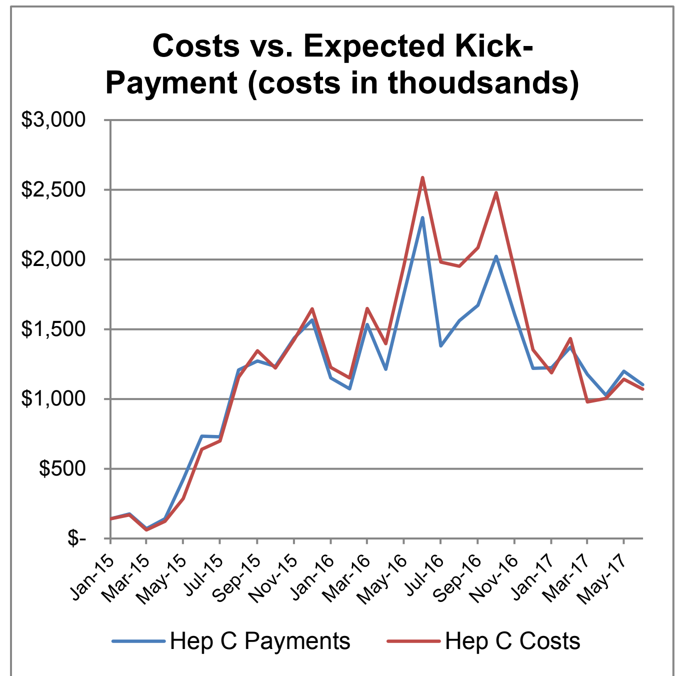



Total Cost vs. Utilizing Members
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
60,000
50,000
40,000
30,000
20,000
10,000
0
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Total Cost (in thousands)
Utilizing Members


PBM Administration Fees vs. Total Membership
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
250,000
200,000
150,000
100,000
50,000
0
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Admin Fee
PAs
Total Membership

HEPATITIS C FOCUS:





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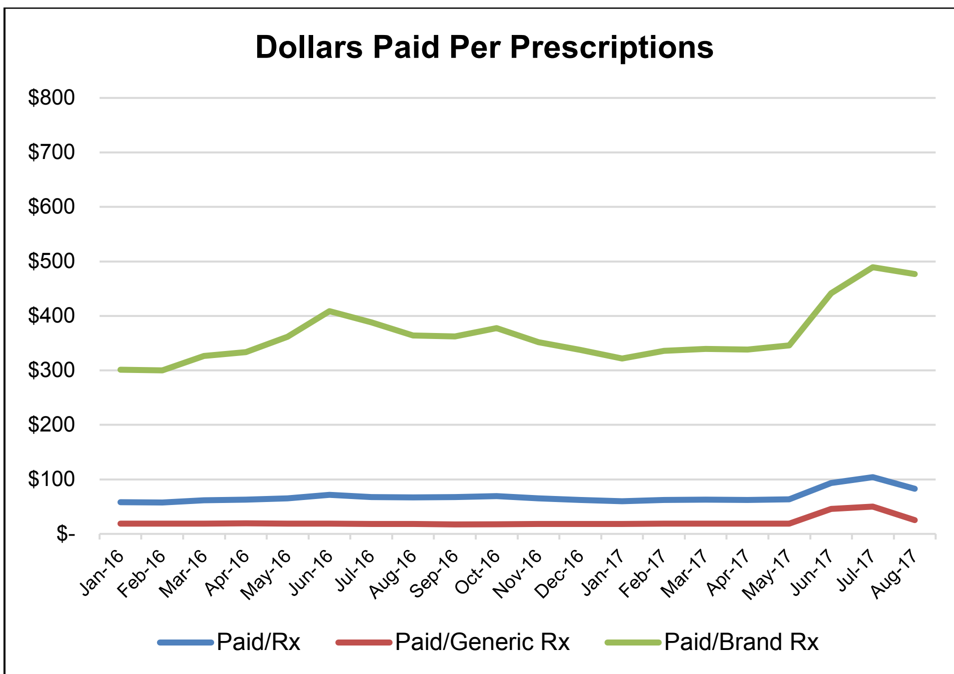

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Joseph Ortiz, Diversity Counsel

DATE: September 25, 2017

SUBJECT: Chief Diversity Officer Update

APRIL 2017- JUNE 2017
DIVERSITY AND INCLUSION QUARTERLY REPORT:

THE GOLD COAST HEALTH PLAN
CHIEF DIVERSITY OFFICER UPDATE

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APRIL TO JUNE 2017 DIVERSITY AND INCLUSION QUARTERLY REPORT

I.
INTRODUCTION & FACTUAL SUMMARY

As the Commission will recall, the last report was issued April 10, 2017, upon the hiring of Douglas Freeman as Gold Coast Health Plan's Chief Diversity Officer ("CDO"). This report will cover the time period from April 10, 2017 to the present.

On April 10, 2017, Mr. Freeman was hired as the CDO pursuant to Section 1382 of Ordinance 4481, which calls for the creation of a CDO to oversee the GCHP Cultural Diversity Program. On April 19, 2017, with the assistance of diversity counsel, Mr. Freeman presented a 2015-2017 Diversity and Inclusion Review to the Commission. That report outlined the establishment of the Diversity Program at GCHP, the establishment of the Diversity Subcommittee, the implementation of an Anonymous Hotline, and the creation and hiring of the CDO position.

Upon the hiring of Mr. Freeman, he began an assessment of GCHP data to identify any diversity-related disparities in various workforce metrics. This process is still underway. Further, Mr. Freeman began a process of meeting with internal stakeholders at GCHP. From May through July of 2017, Mr. Freeman made various contacts and issued a number of significant diversity-related sponsorship checks on or about July 23, 2017. These sponsorships were intended to raise GCHP's diversity profile and to provide some concrete deliverables, including survey assessments and data calculators. Mr. Freeman also reviewed and made suggestions for changes to GCHP policy and procedures to accommodate the new Diversity Program. Finally, on or about August 15, 2017, Mr. Freeman guided GCHP through a GCHP Pilot *Foundations of Diversity and Inclusion* training program. Unfortunately, Mr. Freeman elected to voluntarily end his brief tenure with GCHP as of September 8, 2017, after a mere five months of employment.

II.
APRIL 2017-JUNE 2017 CHIEF DIVERSITY OFFICER ACTION POINTS

April 10, 2017	CDO Commences Employment. Douglas Freeman commences role as GCHP CDO.
April 19, 2017	Commission Meets CDO. CDO attends his first Commission meeting and presents a review of Diversity related activities from inception of the program through the CDO's hiring.

May 22, 2017	Commission Presented with a Diversity Strategy. Based on internal data collection, the CDO presents a diversity strategy. The Commission seeks greater clarification about proposed budget expenditures.
June 26, 2017	Code of Conduct Review. The CDO reviews GCHP various ethics and anti-harassment policies with an eye toward revising to accommodate the new Diversity Program.
July 23, 2017	Diversity Sponsorships: The CDO utilizes spending authority to provide significant sponsorship support to diversity-related events and programs. Sponsorships include procurement of tools, including survey assessments and data calculators.
August 15, 2017	Diversity Training: The CDO leads GCHP employees through *Foundations of Diversity and Inclusion* training.
September 8, 2017	Departure of Douglas Freeman: Mr. Freeman voluntarily ends his tenure as CDO, a mere five months into his term.

III.
SUMMARY OF CHIEF DIVERSITY OFFICER REPORTS

[Per *Brown Act* personnel matters must be handled confidentially. Best practices are to limit distribution of unproven allegations in order to (1) limit concerns of retaliatory behavior; (2) protect confidentiality of disciplinary files and investigations; (3) limit the coordination of testimony; and (4) protect against allegations of defamation against the Plan.]

Issue No.	Policy Category/ Issue	Submitted/ Status
Sensitivity Concerns:		
N/A	N/A	N/A
Hotline Matters (not Harassment related):		
N/A	N/A	N/A

Harassment Allegations:*

.00201	Retaliation: Allegation of retaliatory conduct	05-02-17/Unsubstantiated
.00202	Bullying Alleged bullying	05-29-2017/Unsubstantiated

* Note that this list categorizes all issues, including but not limited to discrimination, harassment, and retaliation, that touch on a protected category as a "Harassment Allegation." Inclusion on this list is not an indicator that the allegations have merit. Further note: The allegation report is as provided by Mr. Freeman to Diversity Counsel.

DATED: September 13, 2017

GOLD COAST HEALTH PLAN
DIVERSITY COUNSEL

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Anne Freese, PharmD, Director of Pharmacy

DATE: September 25, 2017

SUBJECT: Implementation of New PBM: OptumRx

SUMMARY:

Gold Coast Health Plan (GCHP or the Plan) contracts with a Pharmacy Benefits Manager (PBM) in order to provide pharmacy benefit services to its members. The commission entered into a new contract with OptumRx (ORx) to be the PBM effective June 1, 2017.

BACKGROUND:

GCHP worked diligently with ORx on plan specifications to build out GHCP's pharmacy benefit within ORx's systems. This has been a detailed, complex and arduous process to ensure that the benefit is built to the same specifications as with the prior PBM.

DISCUSSION:

ORx's claim system went live for GCHP on June 1. At that time, GCHP and ORx conducted daily check-in calls to verify reports of identify issues and ensure that the benefit and systems were working properly. Through August 31, OptumRx has paid over 400,000 prescriptions claims for GCHP members.

There are several outstanding issues and verbal updates will be provided on the following items:

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