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

Regular Meeting
Monday, September 24, 2018, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

ROLL CALL

CONSENT CALENDAR

1. **Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of August 27, 2018.**

   Staff: Maddie Gutierrez, Clerk of the Commission

   RECOMMENDATION: Approve the minutes.

2. **Community Advisory Committee (CAC) Appointments**

   Staff: Ruth Watson, Chief Operating Officer

   RECOMMENDATION: Approve the appointments to the CAC.

3. **Gartner Inc. Contract Extension**

   Staff: Melissa Scrymgeour, Chief Administrative Officer

   RECOMMENDATION: Approve the contract extension.

4. **HEDIS Year-End Gap Closure – Vendor Agreement Required**

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

   RECOMMENDATION: Approve entering into an agreement with a qualified vendor.

REPORTS

5. Chief Executive Officer (CEO) Report

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Accept and file the report.

FORMAL ACTION

6. July Financials Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Accept and file the July Financials Report.

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.

PRESENTATION

7. Enterprise Transformation Project (ETP) Update

Staff: Ruth Watson, Chief Operating Officer

RECOMMENDATION: Accept and file the presentation.

8. AmericasHealth Plan (AHP) Update

Guest Speaker: Tom Smith, Chief Executive Officer, AmericasHealth Plan

RECOMMENDATION: Accept and file the presentation. Commission to provide direction to staff.

REPORTS

9. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

10. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report. Commission to provide direction to staff.

11. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

No items for discussion.

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on October 22, 2018, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

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

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5512. Notification for accommodation must be made by the Monday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, Clerk to the Commission

DATE: September 24, 2018

SUBJECT: Meeting Minutes of August 27, 2018 Regular Commission Meeting

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the August 27, 2018 Regular Commission Meeting minutes.

Ventura County Medi-Cal Managed Care Commission
(VCMMCC)
dba Gold Coast Health Plan (GCHP)
August 27, 2018 Regular Meeting Minutes

CALL TO ORDER

Commissioner Antonio Alatorre called the meeting to order at 2:00 p.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Alatorre led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa (arrived at 2:10 p.m.), Johnson Gill, Debra Herwaldt (arrived at 2:28 p.m.) Kelly Long, Gagan Pawar, M.D., and Jennifer Swenson.

Absent: Commissioners Laura Espinosa and Debra Herwaldt at time of roll call.

PUBLIC COMMENT

None.

CONSENT CALENDAR

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

   RECOMMENDATION: Approve the minutes.

2. **MCG Health LLC - Contract Extension**

   RECOMMENDATION: Approve the contract extension.

3. **Interpreting and Translating Services – Contract Extension**

   RECOMMENDATION: Approve the contract extension.

4. **Lifesigns Sign Language Interpreter Services – Contract Extension**

RECOMMENDATION: Approve the contract extension.

5. **FluidEdge – Additional Funding Approval – Temporary Labor Agreement**

RECOMMENDATION: Approve the contract extension.

6. **June Financials Report**

RECOMMENDATION: Accept and file the June Financials Report.

Commissioner Long moved to approve the recommendations for Consent items 1 through 6. Commissioner Gill seconded.

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

NOES: None.

ABSENT: Commissioners Laura Espinosa, and Debbie Herwaldt.

Commissioner Alatorre declared the motion carried.

Commissioner Alatorre announced that he was going to change the order of the agenda due to some commissioner who have to leave early.

CLOSED SESSION

The Commission adjourned to Closed Session at 2:04 p.m. regarding the following items in the following order:

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

14. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer.

15. CONFERENCE WITH LABOR NEGOTIATORS
Agency designated representatives: Gold Coast Health Plan Commissioners unrepresented employee: Chief Executive Officer.

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

Commissioner Laura Espinosa arrived at 2:10 p.m.

Commissioner Debra Herwaldt arrived at 2:28 p.m.

OPEN SESSION

The regular meeting reconvened at 5:07 p.m.

Mr. Campbell, General Counsel, stated there was no reportable action taken.

REPORTS

7. Chief Executive Officer (CEO) Report

RECOMMENDATION: Accept and file the report.

CEO Villani provided an update on the following topics:

- Pharmacy Benefit Manager (PBM) Contract: On August 8, the State of California's Joint Legislative Audit Committee voted to approve an audit of the Plan, based on a request from Sen. Jeffery Stone, Pharm D, from Riverside County. Dr. Anne Freese attended the meeting to present on behalf of the Plan.

  The audit will focus on the following:

  1. Assessment of the role and responsibilities of state agencies as it relates to pharmacy benefits management practices and oversite.
  2. Review of the Plan's PBM RFP process and the selection of OptumRX as the PBM.
  3. Review of GCHP PBM oversight process
  4. Evaluate the process for establishing rates through a subcontractor for contracting pharmacies
  5. Review how other Medi-Cal Managed Care Plans and PBMs reimburse for pharmacy

  The State has not yet provided a timeline for the audit. The only notification GCHP has received is a document hold, which is currently in place. CEO Villani mentioned that audit committee members discussed the issue of the recent lawsuit filed by local pharmacies against OptumRx and their PSAOs and potential overlap with the audit. The State audit agency representative stated the audit work would not overlap or interfere with the lawsuit. CEO Villani stated that GCHP is not named in the lawsuit, and that the first hearing is scheduled for December 17th. Staff will provide more information as it is received.

- Transportation Vendor: Staff issued the Request for Proposal (RFP) and expects proposals by October 1st. There has been quite a bit of interest from potential vendors for this contract.

- DHCS Medical Audit: DHCS has not issued final audit results at this time. An exit conference is scheduled for Thursday, August 30th. DHCS will issue a draft CAP if there are findings and staff will share those with the Commission. GCHP performed well in the medical audit over the last couple of years. We do expect a few more findings this year as opposed last, but not many.

- Delegated Vendor Oversight: There are a number of vendors the Plan delegates functions to: vision services, transportation, etc. GCHP must monitor their performance to ensure they perform to GCHP standards. Brandy Armenta, Compliance Officer, stated there is a requirement for delegated vendors to be audited as well as reporting requirements per individual contract. We must receive timely reports and, if information is inaccurate or omitted we issue letters of non-compliance. When we are audited, we need to demonstrate to our auditors that we, in turn, are auditing our vendors as required. We identify issues and work collaboratively to close the item(s). We do not close any items until GCHP receives documentation that the deficiency was corrected. Additionally, staff conducts a focus audit to ensure deficiencies are corrected.

  Compliance Officer Armenta provided an update on the following delegated entity corrective action plans (CAP). Beacon Health is currently under a CAP, along with financial sanctions. This is the third time the Plan has imposed sanctions against Beacon for claims processing deficiencies. Commissioner Alatorre inquired as to how long Beacon had been under a CAP. Compliance Officer Armenta responded that the Plan has issued multiple CAPs for Beacon, both on the clinical and claims side. Beacon addressed the clinical issues quickly. They continue to struggle with claims processing. The Plan has issued at least six CAPs and Beacon is under a third financial sanction for claims processing. Commissioner Alatorre asked if providers are impacted. Compliance Officer Armenta stated that providers are impacted because claims are not being paid correctly. Members are being seen, but when claims are not paid properly, this could lead to an access issue. CEO Villani stated that behavioral health is a difficult area in this community. Beacon, as a delegated provider, contracts with various behavioral health organizations throughout the county. Access to behavioral health care could be better. That said, even if the Plan goes out to RFP and selects a new partner, there would likely be overlap in the provider network. Beacon advised the Plan they are moving from their Cypress center to a centralized claims processing center in Boston. The question now is when is the right time to consider looking for a new vendor? The transition to Boston needs to be smooth. If there is a problem with the conversion, then it may be time to look into an RFP.

  Compliance Officer Armenta also informed the Commission that VTS – the Plan's transportation vendor - is currently under a CAP, which will be re-evaluated in October. Additionally, Conduent has been under a CAP since 2017. The CAP remains open due to a system configuration issue that will be

addressed with the new claims system implementation. The last two issues with Conduent are due to lack of documentation and claims payment issues.

- Gold Coast Health Plan in the News: GCHP has done a lot of good work in the community which is sometimes missed. The Plan created a good news council - "Gold News Council" - with the first meeting scheduled for August 28th. This is an opportunity to talk about all the good things GCHP is doing and also find a medium to get positive information out to the community.

  CEO Villani also referenced a recent story from the California Health Foundation on the treatment of Medi-Cal patients. The story highlighted the challenges Medi-Cal patients experience in obtaining care but positively highlighted GCHP's grant and collaboration with MICOP. The Plan will continue to look at grants programs that will help in our community dependent upon our financial position.

Commissioner Long moved to accept and file the CEO Report. Commissioner Atin seconded.

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

NOES: None.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

PRESENTATIONS

8. Administrative Services Organization (ASO) Update

RECOMMENDATION: Accept and file the presentation.

Chief Operating Officer (COO) Ruth Watson provided an update on the ASO project, noting the name has changed to the Enterprise Transformation Project (ETP). A PowerPoint handout was available to the Commission, staff and public.

COO Watson emphasized that this is the largest project taken on by the Plan since go-live in July of 2011. The project is a partnering with Conduent and VBA and will transform how we conduct daily business. It is a change of both systems and processes. In addition to improved claims processing, the project will enhance customer service and improve data capture and reporting. The new system will position GCHP for the future and requires involvement across the organization. COO Watson also reviewed the project governance structure, noting the various teams' and committees' responsibilities. The 30-60-90 day timeline was also reviewed along with

the project implementation timeline, which includes the targeted "Go-Live" date. COO Watson stressed that both Conduent and VBA are aware that GCHP will not "go-live" unless the Plan is ready. We have negotiated with Conduent and VBA that if we do not go live, there will not be a major penalty. We won't go-live unless we have tested and are sure that it is right.

Commissioner Dial inquired as to whether staff had concerns with Conduent and the project due to the CAP mentioned earlier by Compliance Officer Armenta. COO Watson stated that the relationship with Compliance Officer Armenta is different than the day-to-day business relationship managed by Operations. Complaince Officer Armenta stated Conduent has been difficult to work with on the CAP process. Commissioner Dial stated he would like to see Conduent fix their compliance issues.

Commissioner Long asked about project reporting; what will be reported and how often. COO Watson stated she will report monthly on deliverables and potential risks, if any. Commissioner Long asked if the project was on track for budget. COO Watson responded that so far, GCHP is on track and that staff would include budget tracking in their reporting dashboard for the Commission.

9. Americas Health Plan (AHP) Update

COO Watson provided an update on the status of the AHP pilot, stating that GCHP has been working with AHP to develop a 5,000 member pilot per the direction of the Commission. She provided a handout of the historical timeline to the Commission, which was also available to staff the public. COO Watson reviewed the timeline with the Commission, mentioning that there have been some delays on both sides, for example due to the Plan's medical audit. AHP has developed a proposal which they will send to the State of California.

CEO Villani stated the Commission approved the pilot at the June 26, 2017 Commission meeting. The first pilot meeting with AHP was held in August of 2017. A division of financial responsibilities (DOFR) was developed and reviewed by both entities. From August 2017 thru February 2018, work on the AHP membership proposal identified the 5,000 members who would participate in the pilot. After some feedback, a second DOFR was resubmitted in April and AHP's pilot proposal was received.

Clinicas Del Camino Real (CDCR) is the parent company of Americas Health Plan and any pilot members would move from CDCR to AHP. GCHP is now waiting for something in writing from CDCR, which states they approve the 5,000 members going to the AHP pilot. The boilerplate is almost complete and will be submitted to the State within the next few weeks once completed. Compliance Officer Armenta stated this was all dependent upon them obtaining clearance from their existing counsel or getting new counsel. Compliance Officer Armenta added that AHP has changed counsel and therefore GCHP is waiting for a letter from their current counsel, which allows continued communication between both AHP and GCHP counsel. Rates for

the DOFR have been submitted to GCHP actuaries and have been approved. Draft EOC and member Identification cards were submitted as required. From GCHP's perspective the following items are outstanding:

- Finalize boilerplate
- CDCR to issue pilot proposal letter for submittal to DHCS by GCHP
- Finalize rates and DOFR

All should be ready in the next couple of weeks in order to submit to the State.

CEO Villani advised the Commission that AHP's CEO, Thomas Smith, recently met with him to discuss some changes he proposed for the pilot. Mr. Smith then addressed the Commission, reading from a letter he drafted proposing a simple standard provider agreement with GCHP in which AHP will be responsible for professional and institutional risk for the 5,000 members participating in the pilot program. Mr. Smith also provided a PowerPoint handout titled "AmericasHealth Plan & Gold Coast Health Plan Provider Agreement 2018". The handout provided bullet-point information on the provider agreement, the AHP value proposition, and patient-centered experience.

Mr. Smith presented information recently received from DHCS, which he stated can accelerate the AHP proposal, and also reviewed the pros and cons of his new proposal. This project was initially a Plan to Plan model, but information received from DHCS stated they would not approve a Plan to Plan agreement if parties involved were not fully licensed Knox Keene entities (both GCHP and AHP are not fully licensed). The current undertaking will draw resources, which are scarce, from both the Plan and AHP. Mr. Smith would like to revise this project into a simple standard provider agreement per suggested direction from DHCS. AHP will be responsible for the professional and institutional risk of the 5,000 members. Mr. Smith stated these members will receive uninterrupted care. The AHP/Clinicas partnership is a fully integrated health system which is similar to the Kaiser model. These members will have their medical history housed under one comprehensive technology platform which will provide a treatment plan which is proactive versus reactive. This will lead to patient preventative care and will reduce unnecessary acute hospitalizations. The primary objective is to maximize the patient experience and hold providers accountable, as well as provide patient resources without administrative or technical restrictions that currently exist in the system.

Commissioner Cho asked about specialty access. Mr. Smith stated there is a full comprehensive network with geo-access standards that exceed the minimum requirements. Commissioner Long asked how the pilot proposal adds value versus what is currently in place. Commissioner Swenson voiced her confusion around the proposal, stating that the project was to create a pilot Plan to Plan. How is value added with this change? Mr. Smith stated AHP received information from DHCS that they would not approve the original pilot, but would approve a provider agreement. Commissioner Atin stated he needed clarification on what Plan to Plan means and the reason for the change. Specifically, Commissioner Atin asked how success would be measured with this new approach and inquired as to whether this is a better arrangement for GCHP. Commissioner Long stated she would like to see data and

facts to understand how this new arrangement will work and then consider if it is worth the change or not.

Mr. Smith stated care cannot be managed in the hospital and that this arrangement is a fully integrated model. Patients need to be moved in and out of the hospital effectively without readmission within 30 days. Hospital readmits will be reduced. Commissioner Swenson stated she would like to see scenarios and what metrics would determine if this pilot is successful. She would like a highlight of metrics and anticipated savings, and a clear understanding of what this pilot is.

Commissioner Egan asked about the distinction between the Clinicas (CDCR) population and AHP. Mr. Smith stated the proposal is for the random selection of 5,000 members of the current population, which is comprised of a fairly large share of young moms and children but is not limited to those members. Commissioner Long stated she wants to make sure this pilot will meet the needs of the community. She asked if members can be moved without an option. Mr. Smith stated members can opt in or out of the pilot and there is no lock-in period. Compliance Officer Armenta stated that members have a choice. Commissioner Long asked what the benefit to the Gold Coast member is under this arrangement. Mr. Smith replied it would be the advantage of a totally integrated delivery model, like Kaiser. Commissioner Long stated it is a good concept but she needs more facts and numbers, she does not want to see members at risk.

CEO Villani stated the challenge is that the concept has changed several times over the last few of weeks. Last week the discussion with Mr. Smith was around an IPA model for 39,000 members for in-patient care and today, the concept has changed. What is outlined in this new letter does not look much different from what the pilot program was, it is just being called something different. If discussing a pilot, there has to be some achievable targeted metrics. CEO Villani noted that in their discussion, it was not clear about all in-patient care such as long term care, transplants or skilled nursing facilities (SNF). It seemed these were carved out of the pilot. Mr. Smith stated that the proposal was for institutional care. CEO Villani stated he had talked with Sarah Reem, Deputy Director of Planned Licensing from the Department of Managed Health Care Services, which is the regulator for AHP, (DHCS is the regulator for GCHP) and she requested the record be corrected as it pertains to a plan to plan contracts. Mr. Smith was not correct in stating that a plan to plan contract is a fabrication in the industry. Ms. Ream provided a definition of a plan to plan and made it clear that any such arrangement for AHP would require both DMHC and DHCS approval. Member choice is also important. Members get outstanding care from Clinicas (CDCR). Our HEDIS scores today include care provided at CDCR, so GCHP HEDIS scores would not change with an AHP contract. There need to be other metrics for the pilot. CEO Villani stated he supports a pilot, but there needs to be achievable outcomes such as reduced admissions, emergency room visits, or higher patient satisfaction. Mr. Villani expressed concern around moving 39,000 members to AHP given AHP's limited experience in managing large populations.

According to the DMHC dashboard, AHP has 1,291 enrollees through Q2 in 2018. A pilot with up to 5,000 members is important because it can demonstrate ability.

Commissioner Atin commented that he does not understand the approach and that if care can be improved then why doesn't Clinicas just do it? Why does it have to go under another umbrella of AHP? Commissioner Atin added that AHP is a for-profit organization, whereas Clinicas is a non-profit organization and asked how that would change the dynamics. Mr. Smith stated that if the Commissioners needed more information, he would meet with each member individually. Commissioner Atin replied that he wants the information presented at the next Commission meeting and would like it to be in laymen terms. Commissioner Swenson agreed. Mr. Smith stated he can send information in advance of the meeting.

REPORTS

10. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report.

Mr. Ted Bagley had been out of town and due to the hurricane in Hawaii, was not able to be present for the meeting. CEO Villani stated that if the Commission had questions, he would present them to Mr. Bagley.

PUBLIC COMMENT

Daniel Martinez, appearing on behalf of CA Pharmacists Association (CPhA) spoke on Agenda Item No. 11, providing a summary update on continuing pharmacy issues:

- CPhA and OptumRx met in Sacramento to discuss the various pharmacy communication issues, with emphasis on coding errors. CPhA made a recommendation that OptumRx should make the pharmacies who were negatively impacted by the errors financially whole. OptumRx has acknowledged the errors and responsibility for them.
- Mr. Martinez met with GCHP General Counsel and discussed matters related to OptumRx and how it relates to state law. Mr. Martinez noted that ultimately, GCHP is still liable.
- Mr. Martinez stated that the lawsuit (by the independent pharmacies against OptumRx and their PSAOs) was filed independently. CPhA is not a party to this lawsuit, but they are monitoring.
- Mr. Martinez stated that two pharmacies have closed, and a third is about to close at end of the month. Questions that need to be asked to both the Plan and enrollees: Are the practices going to continue to drive independent pharmacies out of business? What price will GCHP pay if there are no longer independent pharmacies left in the network?

11. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

CMO Nancy Wharfield, M.D., provided an update on three primary health topics: utilization, quality, and pharmacy.

Utilization metrics are stable, and benchmark well against the DHCS Managed Care Dashboard utilization metrics. Denial rate has remained stable between 3 and 4 %.

CMO Wharfield provided an update on HEDIS quality metrics, highlighting the Plan's improvement where 91% of the metrics (29 measures) met or exceeded the DHCS minimum performance level (MPL), and three measures (9%) fell below the desired performance level. The three measures not meeting the MPL are Asthma medication ratio (AMR), Medical attention for nephropathy (CDC-Neph), and Annual monitoring for patients on persistent medications (MPM-ACE/ARBs).

Dr. Anne Freese, Director of Pharmacy, provided an update on pharmacy. Dr. Freese reviewed the GCHP pharmacy trend for 2015/2016, 2016/2017 and 2017/2018, highlighting that the number of prescriptions have increased each year, which appears to be trending higher as members are using more medications each month. Commissioner Atin asked if this is a normal trend. Dr. Freese stated the GCHP falls in the middle – sometimes more, sometimes less – as compared to other managed care plans. Part of the increase is from pharmacy utilization for children and adults over age 65. Commissioner Dial inquired as to the reason for a drop in utilization each year after the month of May. Dr. Freese stated this is due to seasonality and that September peaks due to the return to school. Dr. Freese also provided pharmacy spend trending data around Hepatitis C drugs and dollars paid per prescription, which is trending higher due to specialty drugs on the brand side. Dr. Freese reviewed a comparison of GCHP PMPM costs and total pharmacy spend to other county organized health systems.

Commissioner Alatorre asked whether the Plan has made changes to have providers prescribe generic versus brand drugs. Dr. Freese replied that providers do typically prescribe generic drugs and that brand drugs are available to prescribe if no generic is available. On the formulary, once a generic is available, the brand is dropped and the generic is used. The Plan continuously reviews opportunities to utilize generic drugs. However, there are some brand drugs the Plan covers due to member need. As new drugs become available, there is a shift from brand to generic or generic to brand.

Dr. Freese provided an update on the OptumRx CAP. OptumRx has closed all items except for two, which are still open. The two open are related to recoupments due to

the erroneous overpayments. OptumRx extended the recoupments over a 12-cycle (6 month) period to ease pharmacy cash flow issues. In the area of call center services, there are five CAP items. Four are closed and one is still open in relation to the prior authorization process. Pharmacy network management was also reviewed. There are two network pharmacies on probation and pending action. No pharmacies have had a license revoked this year. There is also a pharmacy that had a DEA investigation, and one that is appealing termination from OptumRx. GCHP currently meets or exceeds DHCS pharmacy network standards.

Dr. Freese also provided an update on 340B, stating that GCHP put together a compliance contract outlining all the requirements for a 340B program. As reported previously, VCMC has declined the program and GCHP is currently waiting for an alternative program from Clinicas (CDCR).

PUBLIC COMMENT

Jon Mahrt, Chief Operations Officer for OptumRx, gave a brief update. OptumRx continues to make progress in meeting their performance commitments. There is a 10% increase in the prior authorization approval rate. Key areas of continued focus and improvement are:

- Striving toward going above contract commitment
- Implemented a pharmacy workflow
- Optimal provider authorization
- Continued review of pharmacy claims
- Intend to create new programs aimed at improving HEDIS measures, safety measures as well as save GCHP money
- Committed to serving the community.

12. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.

Commissioner Atin motioned to approve the Agenda Items 8, 9, 10, 11 and 12. Commissioner Espinosa seconded.

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

NOES: None.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

Commissioner Dial motioned to adjourn. Commissioner Swenson seconded.

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

NOES: None.

ABSENT: None.

Commissioner Alatorre declared the motion carried.

The regular meeting ended at 6:53 p.m.

Approved:

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Maddie Gutierrez, CMC
Clerk to the Commission

AGENDA ITEM 2

To: Ventura County Medi-Cal Managed Care Commission

From: Ruth Watson, Chief Operations Officer

Date: September 24, 2018

Re: Consumer Advisory Committee (CAC) Membership

SUMMARY:

The Consumer Advisory Committee (CAC) currently has five (5) seats up for appointment: the beneficiary member or the parent / guardian of a beneficiary member seat is currently vacant due to a resignation and needs to be filled to the unexpired term of August, 2016; the other four (4) seats are full term and expire August, 2017.

The Plan has recruited members for the vacancies on the CAC through means of advertising on the GCHP website, outreach to various organizations and recommendations from current committee members.

BACKGROUND / DISCUSSION:

Ventura County Board of Supervisor's enabling ordinance (Ordinance No. 4409, April 2010) and the California Department of Health Care Services, Medi-Cal Managed Care Division contract, required the establishment of a member / consumer based committee.

This Committee meets at least quarterly and makes recommendations, reviews policies and programs, explores issues and discusses how the Plan may fulfill its mission. The Commission originally established the Committee to be comprised of ten (10) members with two permanent seats – one (1) for the Ventura County Health Care Agency (VCHCA) and one (1) for the Ventura County Human Services Agency (VCHSA). In 2013 the Commission expanded the Committee by adding an eleventh seat which is to be held by a beneficiary member or the parent / guardian of a beneficiary member.

Each of the appointed members, with the exception of the two permanent seats, would serve a two-year term, and individuals could apply for re-appointment as there are no term limits.

The eleven (11) voting members represent a constituency served by the Plan. Committee members may include representation from the following:

- County Health Care Agency
- County Human Services Agency
- Children Welfare Services Agency

Members with:

- Chronic Medical Conditions
- Disabilities
- Special needs

Other Medi-Cal beneficiaries:

- Foster Children
- Chronic Medical Conditions
- Persons with Disabilities and Special Needs
- Seniors

GCHP received requests from 4 existing members to renew their participation on CAC:

- Frisa Herrera- Representing Foster Children
- Norma Gomez- Representing Medi-Cal Beneficiaries
- Rita Duarte-Weaver- Representing Medi-Cal Beneficiaries
- Estelle Cervantes- Representing GCHP Beneficiaries

All four members have served CAC for the past two years and are requesting that they continue to speak for the members.

One (1) CAC member is resigning his seat as his term has ended. Pedro Mendoza represents beneficiaries with Chronic Medical Conditions. Due to his work schedule and several life changes, Pedro will not be continuing.

Pablo A. Velez has requested to replace Pedro Mendoza on the CAC.

Pablo is the CEO/President/Co-Founder, Amigo Baby, Inc. (2004 to Present). Pablo has held many leadership roles in community-based organizations throughout his career. He has his Medical Doctoral Degree from Columbia where he developed several county-based services. Upon moving to the United States, he began working with special needs children, lectured in several community organizations and has created Amigo Baby, Inc. to serve the Ventura Community.

Pablo earned his MBA at UCLA and is currently seeking a Doctoral Student of Education at Johns Hopkins University.

RECOMMENDATION:

Staff requests that the Commission appoint the Consumer Advisory Committee as described above.

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Melissa Scrymgeour, Chief Administrative Officer

DATE: September 24, 2018

SUBJECT: Gartner, Inc. Contract Extension

SUMMARY:

In November 2015, Gold Coast Health Plan (GCHP) entered into a three-year subscription agreement with Gartner Information Technology Research and Industry Advisory Services. Services available with the subscription include:

- Contract review for best available terms and conditions
- RFP preparation assistance to ensure best value to the Plan
- Best practices information on all aspects of technology and technology management
- In-depth information on technology trends
- Industry and organization size benchmarking for healthcare and public sectors
- Independent product and vendor evaluations
- Technology total cost of ownership (TCO) models
- Strategies for reducing ongoing technology operating costs
- IT/organization maturity assessment

The extensive research and technical support that Gartner provides allows GCHP to save money on project development and delivery costs, determine lower cost options for providing and supporting the Plan's technology systems, benchmark our IT performance compared to similarly sized public and healthcare industry organizations, and streamline business process review and project delivery with Gartner models and methodologies.

Examples of areas where GCHP has utilized Gartner subscription services in support of the Plan's mission and strategic initiatives are:

- Provider network tools software modernization: In-depth research, personalized Gartner recommendations, and request for proposal assistance to support GCHP's need to transition from an in-house, custom solution to modern, stable and scalable solution serving as a single source of truth for provider data, incorporating contracting and credentialing.
- Technology Procurement Support: Staff has utilized Gartner's ready to use request for proposal (RFP) toolkits and industry analyst calls to prepare and review RFPs/RFIs and vendor proposals for master data management, procure-to-pay, public website and content management, provider data management, and managed security services.

- Information Security Program: Research and best-practice recommendations for developing GCHP's formal information security program and roadmap, inclusive of outsourced managed security services.
- Information Technology Continuous Service Improvement: GCHP IT performance maturity benchmarked in key areas (information security, analytics, infrastructure & operations, applications, project management, risk management). Annual re-assessment captures progress and identifies opportunities for increasing business value and efficiencies.
- Customized Analyst Interactions: GCHP regularly utilizes Gartner analyst services to support technology strategies and initiatives including our data governance and management strategy, and cloud computing architecture.

This renewal modifies the Plan's current subscription to take advantage of the County of Ventura's contract, which was awarded to Gartner in May 2003 after a competitive bidding process. The County of Ventura's contract is intended for City, County and other local government entities to receive volume pricing through a consolidated government purchasing vehicle. The transition to County pricing converts GCHP to lower pricing with a nominal savings for the renewal term ($2.6k minus a one-time $500 piggyback fee) and the potential for greater future savings with addition of expanded technical services.

The current three-year agreement terminates on November 30, 2018. GCHP will renew the contract for an additional 17-month term through April 2020, co-terming the Plan's subscription with the County of Ventura's contract renewal cycle.

FISCAL IMPACT:

There is no impact to the current fiscal year. The annual amount is included in the approved FY18/19 budget plan.

The total renewal amount for the 17-month extension is $165,500 summarized in Table 1. Renewing before October 1, 2018 ensures that GCHP locks in current County of Ventura government subscription rates and avoids an anticipated 6% ($10,000) annual increase in Gartner fees.

Table 1: Gartner, Inc. Total Contract Value

Master Subscription Agreement	Amount	Period	Budgeted
Original Contract	$89,900	12/01/2015 – 12/31/2016	
Year 2	$100,308	01/01/2017 – 11/30/2017	
Year 3	$113,500	12/01/2017 – 11/30/2018	
Total Spend Years 1-3	$303,708		
Contract Renewal			
5 mo. Renewal (Co-term w/County contract)	**$47,500**	**12/01/2018 – 04/30/2019**	**Yes**
12 mo. Renewal	**$118,000**	**05/01/2019 – 04/30/2020**	**Yes**
Total Projected Cumulative Spend (4.4 Years)	$469,208		

RECOMMENDATION:

The Plan recommends the Commission approve the:

1. Transition to the County of Ventura's Gartner agreement and pricing with co-term of the renewal period to coincide with County's contract
2. Continuation of services with Gartner, Inc. by an additional 17-month period from December 1, 2018 – April 30, 2020
3. Authorize the Chief Executive Officer to execute associated renewal agreements for a 17-month renewal amount not-to-exceed added funding of $175,430 inclusive of a 6% contingency

Contracts are available for review in GCHP's Finance Department.

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: September 24, 2018

SUBJECT: HEDIS Year-End Gap Closure - Vendor Agreement Required

SUMMARY:

DHCS requires all MCP participate in quality improvement activities, which includes participation in an annual NCQA survey related to the effectiveness of care, access to care, and utilization. This survey is known as the Healthcare Effectiveness Data and Information Set (HEDIS) and is conducted at the end of each calendar year of service with results publicly reported in the Fall of the following year. The plan has the opportunity to improve results by addressing gaps in care during the 4th quarter of 2018. To that end, the Plan seeks approval to engage a HEDIS Year-End Gap Closure vendor to improve HEDIS results in the current measurement year. To accomplish this, an informal market inquiry of three qualified vendors in the Medi-Cal Managed Care market was conducted to determine the project scope/level of effort, a projected timeline and budgeted fair market pricing.

The Gap Closure program would engage approximately 47,000 adult and pediatric members in English and Spanish IVR/Live Agent telephonic outreach and appointment scheduling. The focus of effort will be on seven actionable measures where performance currently resides between the 10th and 50th percentile.

These targeted HEDIS measures are:

- Child Immunization Status (Combo 3) (CIS)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC)
- Monitoring of Persistent Medications (MPM)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Live (W34)

In order to improve HEDIS results for the current reporting cycle, the Plan will need to immediately finalize contract negotiations with a potential qualified vendor(s).

FISCAL IMPACT:

The projected dollar amount for this engagement should not exceed $175,000. There is no impact to the current fiscal year. The annual amount is included in the approved FY18/19 budget plan.

RECOMMENDATION:

In order to improve HEDIS measurements in the current measurement year, the Plan recommends the Commission approve the Plan entering into an agreement with a qualified vendor for these services in an amount not-to-exceed $175,000.

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: September 24, 2018

SUBJECT: Chief Executive Officer Update

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

GCHP LEGISLATIVE REPORT

By Don Gilbert and Trent Smith

The 2017-2018 Legislative Session came to an end at midnight, August 31. The legislative session spans two years. Bills that were not passed in the first year of the two-year session can be considered in the second year. However, bills that did not reach the Governor by August 31 are dead, although they can be reintroduced next year when a new legislative session begins.

Over the course of two years, approximately 5,600 bills were introduced. Last year, 1,189 bills were signed into law. This year, 1,562 bills reached the Governor's desk. While he has already signed or vetoed many of these bills, a majority of bills still await action by the Governor.

One of the bills passed to the Governor was AB 2275 by Assemblyman Arambula. This bill required the Department of Health Care Services (DHCS) to establish a quality assessment and performance improvement program for all Medi-Cal managed care plans. Health plans would have been required to meet a minimum performance level, effective January 1, 2021, that improved quality of care and reduced health disparities for beneficiaries.

The California Association of Health Plans (CAHP) opposed AB 2275, arguing the bill could be administratively burdensome and costly without any clear benefit to improving care. The Department of Finance also opposed the bill, as it would have required new ongoing state expenditures to create, monitor, and analyze the performance standards established in the bill. The Governor vetoed AB 2275. In his veto message he stated that the bill was duplicative and added significant costs to Medi-Cal.

The Governor will have a similar decision to make on AB 2299 by Assemblyman Kansen Chu. This bill requires DHCS to ensure that all written health education and informing materials developed by Medi-Cal managed care plans in English or translated into threshold

languages are at or below the equivalent of sixth grade reading level. This measure is also opposed by CAHP and the Department of Finance. CAHP argues that the bill includes unnecessary, repetitive, and costly steps for documents already translated by health plans. CAHP further argued that Medi-Cal managed care plans are currently required to provide health plan materials in a readability format, which means the documents are written at, or below sixth grade reading level. These requirements are contained in the contracts between health plans and DHCS.

There is a high likelihood that AB 2472 authored by Assemblyman Wood will be signed by Governor Brown. This bill requires the newly created Council on Health Care Delivery Systems to prepare a feasibility analysis of a public health insurance plan option, also known as a public option.

Previous versions of AB 2472 would have required Medi-Cal managed care plans serving counties where there are less than two plans participating in the public healthcare exchange, to negotiate with Covered California to become a new exchange plan. This provision was eventually amended out of the bill. However, the author and sponsors hope that the study required in AB 2472 will lead to solutions to provide more health care insurance options in certain underserved counties.

SB 1108, authored by Senator Hernandez, allows California to seek waivers from the federal government to increase enrollment in Medi-Cal. More significantly, SB 1108 prohibits California from requiring anyone in Medi-Cal to work in order to receive benefits. Kentucky, this year, attempted to add work requirements to the state's Medicaid program, but a judge blocked the action. SB 1108 was pursued in response to fears by some in California that the federal government could impose work requirements as a condition to be eligible for Medicaid.

Another bill attempting to preempt federal action is AB 2499 authored by Assemblyman Arambula. AB 2499 requires health plans to spend at least 80 percent of their expenditures on health care. The federal government has floated increasing the ratio insurers are allowed to spend on profits and administrative care. While it is unclear if AB 2499 or SB 1108 will prevent the federal government from imposing new Medicaid requirements, we do expect the Governor to sign both bills, if for no other reason but to send a clear political message regarding the strong principles that California holds regarding health care coverage.

AB 315 authored by Assemblyman Wood was a bill amended very late in the legislative process to impose regulations on pharmacy benefit managers (PBMs). PBMs are not regulated in a manner comparable to other health care services. Among the many changes proposed in the bill is a requirement that all PBMs register with the Department of Managed Health Care. It also requires PBMs to exercise good faith and fair dealing. More significantly, the bill requires pharmacies to disclose, upon a purchaser's request, information with respect to retail and purchase prices, as well as discounts provided by the PBM. AB 315 also establishes a pilot program in Solano and Riverside Counties prohibiting PBMs from requiring

the use of mail order to receive prescription drugs. AB 315 also creates a working group to study and consider additional changes in the prescription drug delivery network.

Regardless whether Governor Brown signs or vetoes the bill, we believe the issue of PBM reform will receive the attention of the Legislature in 2019.

GCHP in the Community:

GCHP staff is actively involved in our community. We are passionate about our mission to provide the best quality care for our members. Through our sponsorships program and participation in events, we seek to support mission-driven organizations that are similarly dedicated to serving Medi-Cal members. Here is a summary of recent community events GCHP staff has participated in along with sponsorships awarded this fiscal year.

Community Events:

- Night in Oaxaca Dinner: "Siempre Adelante"
- Santa Paula Family Health Fair sponsored by Assemblymembers Hannah Beth Jackson and Monique Limon
- K-12 Resource Fair sponsored by Assemblymember Jacqui Irwin
- Camarillo's State of the City Luncheon
- Community Action Ventura County Board Meeting – CEO Villani now a board member
- 25th Annual Fainer/Tauber MD Awards
- United Way 14th Annual Spirit Awards Gala
- Brain Injury Center of Ventura County, Evening of Magical Memories
- 2018 Ventura County Heart Walk
- Boys & Girls Club of Santa Clara Valley, Happy 50th Birthday Bash

Sponsorships:

- American Heart Association, Go Red for Women Luncheon
- American Cancer Society, Making Strides Against Breast Cancer
- Boys & Girls Club of Santa Clara Valley, BGCSV Happy 50th Birthday Bash
- VC Medical Resource Foundation, 25th Annual Fainer/Tauber MD Awards
- United Way of Ventura County, United Way 14th Annual Spirit Awards Gala
- Santa to the Sea Half Marathon
- Many Mansions, 2018 Bowls of Hope
- City of Oxnard, 2018 Multicultural Festival
- Hospice of Conejo, Festival of Trees
- Boys & Girls Club of Ventura, Leaders in Training Program
- Brain Injury Center of Ventura County, Evening of Magical Memories
- Habitat for Humanity, Hearts & Hammers Dinner and Auction
- CAREGIVERS: Volunteers Assisting the Elderly, Wearin' o' the Green Golf Tournament
- Interface Children & Family Services, Hope & Light Dinner

COMPLIANCE UPDATE:

DHCS Annual Medical Audit:

Audits and Investigation conducted the annual 2017-2018 onsite medical audit June 4, 2018 through June 15, 2018. The auditors reviewed the following areas: Utilization Management, Care Management and Care Coordination, Access and Availability, Grievance and Appeals, HIPAA, Fraud, Waste and Abuse, Delegation Oversight, Quality Improvement and Administrative Capacity. Audits and Investigations held an exit conference with GCHP on August 30, 2018 to review the draft corrective action plan. The draft audit report had findings in two categories. Staff has submitted a response and additional documentation. Staff is pending receipt of the final report and will apprise the commission of the corrective action plan once finalized.

DHCS Contract Amendments:

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

Delegation Oversight:

Gold Coast Health Plan (GCHP) is contractually required to perform oversight of all functions delegated through subcontracting arrangements. Oversight includes but is not limited to:

- Monitoring/reviewing routine submissions from subcontractors
- Conducting onsite audits
- Issuing a Corrective Action Plan (CAP) when deficiencies are identified

Delegation Audit(s) Update:
Open CAPS from previous quarters in 2018, 2017 and 2016.

Delegate	Audit Year and Type	Audit Status	Date CAP Issued	Date CAP Closed
VTS	2016 Security Risk Assessment	*Open	September 20, 2016	Under CAP
Conduent	2017 Claims	*Open	December 28, 2017	Under CAP
Delegate	**Audit Year and Type**	**Audit Status**	**Date CAP Issued**	**Date CAP Closed**
Kaiser	2017 Claims	*Open	February 8, 2018, April 23, 2018, June 20, 2018, July 27, 2018, September 12, 2018	Under CAP

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The following delegates received an annual onsite audit in Q2-Q3 2018:

Delegate	Audit Type	Audit Month	Date CAP Issued	Date CAP Closed
VSP	QI	April	N/A	N/A
Beacon	Claims	April	*May 9, 2018 August 15, 2018, September 11, 2018	Under CAP(s)
VTS	Transportation	May	June 7, 2018, September 5, 2018	Under CAP
City of Hope	Credentialing	June	N/A	Audit Close Out Letter issued July 13, 2018
Children's Hospital Los Angeles	Credentialing	July	N/A	Audit Close Out Letter issued July 30, 2018
Cedars Sinai	Credentialing	July	August 8, 2018, September 17, 2018	Under CAP
CDCR	UM-Focused	August	*N/A*	Audit Close out Letter issued August 14, 2018
CDCR	Claims-Focused	August	September 7, 2018	Under CAP
Kaiser	Claims	August	*CAP forthcoming*	
Conduent	Claims	June	*June 20, 2018 August 10, 2018, September 17, 2018	Under CAP(s)

** Denotes original CAP issued and delegate failed to perform ongoing monitoring and/or focused audit, therefore a second CAP was issued.*

Compliance will be responsible for delegation oversight of the PBM on a prospective basis. Staff is currently reviewing the contract provisions and evaluating the timeline for auditing and monitoring. The oversight will be in accordance with the established delegation oversight protocols and policies. Once the audit and ongoing monitoring is implemented, the results will be shared with the commission in the same manner as all other delegates.

The business unit, Pharmacy, will continue to be responsible for the vendor management/relationship component. The business unit will still be the primary contact with the vendor, pharmacies and applicable stakeholders.

Compliance will continue to monitor all CAP(s) in place and work with each delegate to ensure compliance is achieved and sustained. Ongoing updates will be provided to the commission.

RECOMMENDATION:

Accept and file the report.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: September 24, 2018

SUBJECT: July 2018 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached July 2018 fiscal year-to-date (FYTD) financial statements of Gold Coast Health Plan ("Plan") for the Commission to accept and file. The Executive / Finance Committee did not review these financials.

BACKGROUND/DISCUSSION:

The staff has prepared the July 2018 FYTD financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Financial Highlights

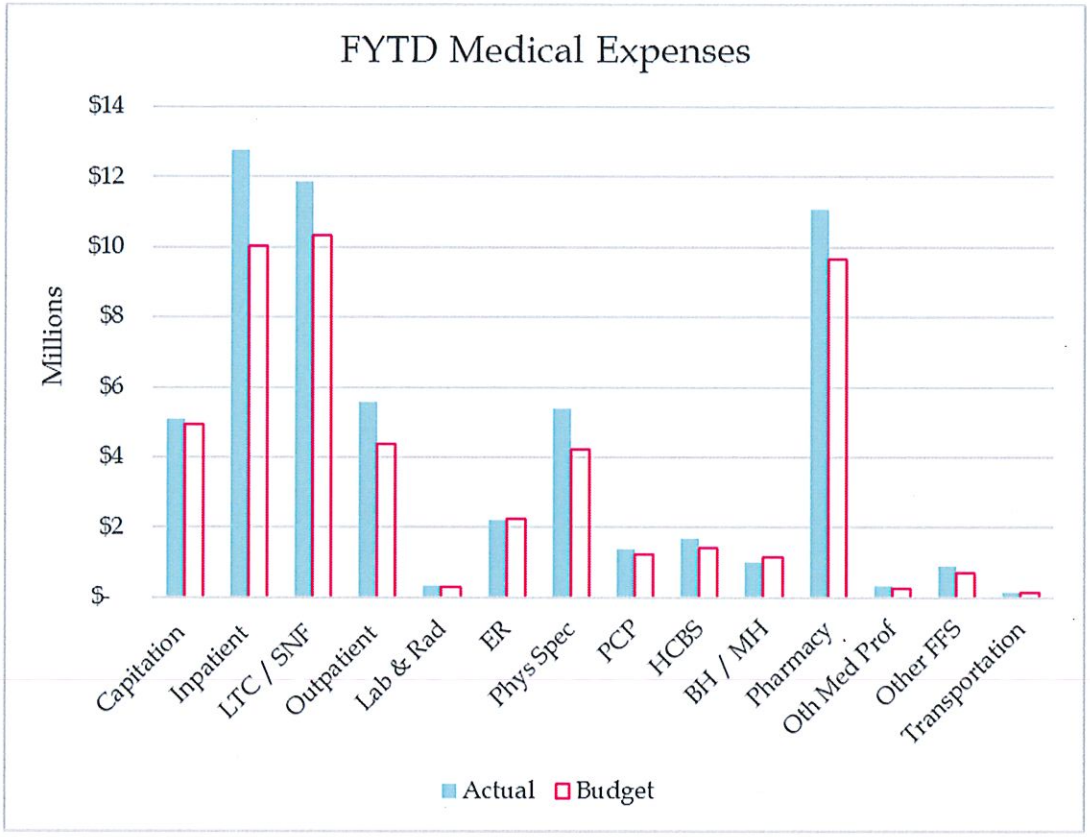
- For the fiscal year ended July 31, 2018, the Plan's performance is increase in net assets of $48.5 thousand, which is $1.4 million less than budget.
- July FYTD net revenue was $59.7 million, $1.4 million higher than budget.
- Cost of health care was $56.3 million, $4.0 million higher than budget.
- The medical loss ratio was 94.4 percent of revenue, which is 4.6 percent higher than the budget.
- The administrative cost ratio was 6.2 percent, 1.0 percent lower than budget.
- July membership of 200,314 was 1,888 members lower than budget, and 43 higher than June's membership of 200,271.
- Tangible Net Equity was $133.1 million which represents just over two months of operating expenses in reserve and 407% of the required amount by the State.

Revenue – July FYTD net revenue was $59.7 million or $1.4 million higher than budget.

July's results also include approximately $809 thousand of additional revenue recognized through recent funding of the Proposition 56 directed payments. In spite of the membership shortfall of 1,888, the change in membership mix contributed and additional $208 thousand in revenue.

MCO Tax – MCO tax is a pre-determined liability in accordance with Senate Bill X2-2, passed in October 2016. The Plan's MCO tax liability for FY 2019 is $94.5 million, accrued at a rate of approximately $7.9 million per month. The fourth and final quarterly installment of MCO tax was paid on July 2. The total tax has not yet been funded by the state.

Health Care Costs – July FYTD health care costs were $56.3 million, which was $4.0 million higher than budget. The medical loss ratio (MLR) was 94.4 percent versus 89.8 percent for budget.



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

- Inpatient exceeded budget by $918 thousand (9.17%). While the average per diem rate decreased in July, General utilization, as seen in paid claims, increased by 17%. The most notable aid category experiencing utilization increases was the SPD Duals. Notable diagnoses, as compared to the prior six-month averages, occurred in Central Nervous System Infections, Endocrine Disorders, Pulmonary Disorders and Paralysis. These categories accounted for $801 thousand in excess of the average in paid claims.

- Outpatient exceeded budget by 1.1 million (24.6%). As compared to the prior six-month average, increases were seen in Dialysis Centers ($124 thousand), Hematology/Oncology Clinics ($354 thousand), Outpatient Surgery ($126 thousand) and Cancer Outpatient Pharmacy at out of area facilities ($219 thousand).
- Physician Specialty exceeded budget by $1.1 million (25.1%). The high dollar-volume diagnoses in Physician Specialty were Medications and Infusions, Anesthesia, Physical Therapy and Other Diagnostic Services. Overall, July paid claims included a 29% increase in utilization. Some of the increase was due to timing of billing by providers.
- Pharmacy exceeded budget by $1.4 million (14.9%). As compared to the prior six months, volume decreased 15% while unit cost increased 12.8%. The July per-member per-month for Pharmacy was $55.27.

Adult Expansion Population 85% Medical Loss Ratio – The Balance Sheet contains a $124.1 million reserve for return of potential Medi-Cal capitation revenue to the DHCS under the terms of the MLR contract language.

Administrative Expenses – For the fiscal year ended July 31, administrative costs were $3.7 million or $894 thousand below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 6.2 percent versus 7.2 percent for budget.

Cash and Medi-Cal Receivable – At July 31, the Plan had $268.9 million in cash and short-term investments and $141.2 million in Medi-Cal Receivables. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totaled $124.1 million.

Investment Portfolio – At July 31, 2018, the value of the investments (all short term) was $177.2 million. The portfolio included Cal Trust $51.8 million; Ventura County Investment Pool $50.9 million; LAIF CA State $64.6 million; commercial paper $1.0 million; the portfolio yielded a rate of 1.95%.

RECOMMENDATION:

Staff requests that the Commission accept and file the July 2018 financial package.

ATTACHMENT:

July 2018 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended July 2018

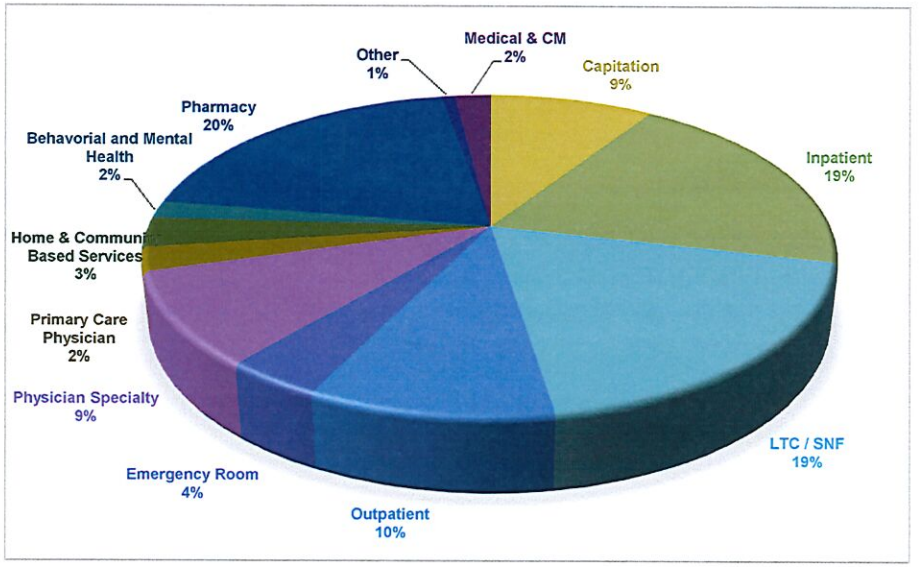
TABLE OF CONTENTS

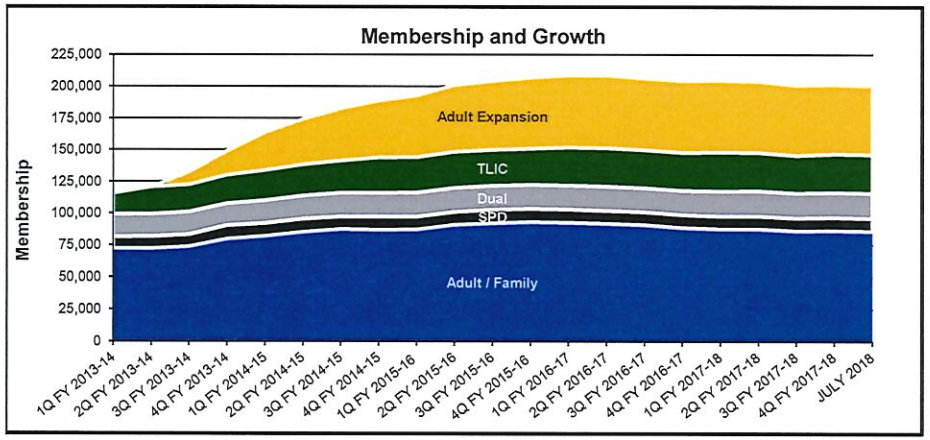
Return to Agenda

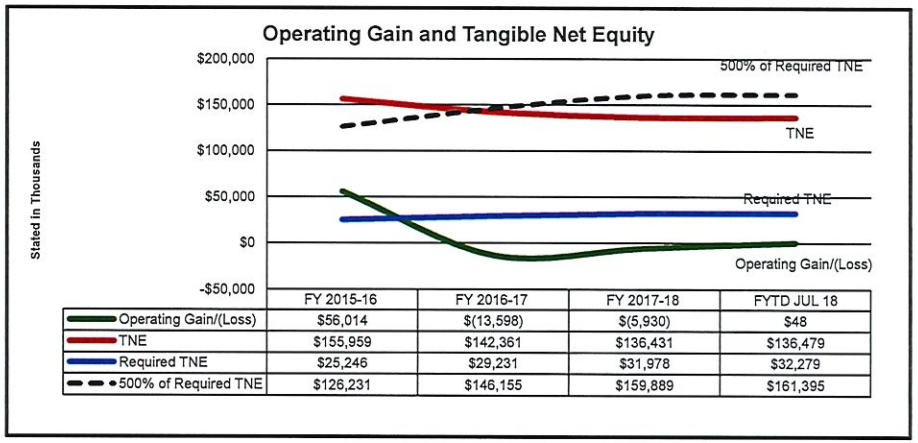
Gold Coast Health Plan

Executive Dashboard as of July 31, 2018

	FYTD 18/19 Budget	FYTD 18/19 Actual	FY 17/18 Actual	FY 16/17 Actual
Average Enrollment	202,202	200,314	202,748	207,100
Revenue	$ 288.34	$ 297.87	$ 296.95	$ 273.72
Capitation	$ 24.34	$ 25.38	$ 25.89	$ 26.22
Inpatient	$ 49.51	$ 54.55	$ 58.22	$ 53.44
LTC / SNF	$ 51.03	$ 53.24	$ 50.82	$ 47.86
Outpatient	$ 21.58	$ 27.14	$ 25.68	$ 23.17
Emergency Room	$ 11.03	$ 10.83	$ 12.76	$ 9.07
Physician Specialty	$ 20.83	$ 26.31	$ 23.78	$ 22.55
Primary Care Physician	$ 6.11	$ 6.69	$ 6.77	$ 6.45
Home & Community Based Services	$ 7.10	$ 8.33	$ 6.87	$ 7.33
Behavorial and Mental Health	$ 5.64	$ 4.92	$ 6.35	$ 4.57
Pharmacy	$ 47.66	$ 55.27	$ 49.76	$ 47.76
Other	$ 8.08	$ 2.09	$ 9.46	$ 6.57
Medical & CM	$ 5.99	$ 5.60	$ 4.79	$ 4.92
	$ 258.91	$ 280.36	$ 281.15	$ 259.91
% of Revenue	89.8%	94.1%	94.7%	95.0%
Total Administrative Expenses	$ 4,594,684	$ 3,700,580	$ 49,015,352	$ 51,176,317
% of Revenue	7.2%	6.2%	6.8%	7.5%
TNE	$ 130,197,664	$ 133,059,371	$ 136,430,829	$ 142,360,951
Required TNE	$ 29,779,906	$ 32,278,973	$ 32,236,738	$ 29,231,052
% of Required	437%	412%	423%	487%







	FY 2015-16	FY 2016-17	FY 2017-18	FYTD JUL 18
Operating Gain/(Loss)	$56,014	$(13,598)	$(5,930)	$48
TNE	$155,959	$142,361	$136,431	$136,479
Required TNE	$25,246	$29,231	$31,978	$32,279
500% of Required TNE	$126,231	$146,155	$159,889	$161,395

Return to Agenda

STATEMENT OF FINANCIAL POSITION

	07/30/18	06/30/18	05/31/18
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	$ 91,642,461	$ 151,302,531	$ 159,501,424
Total Short-Term Investments	177,247,086	196,682,147	196,461,673
Medi-Cal Receivable	141,198,589	74,172,090	63,299,720
Interest Receivable	431,763	693,727	650,537
Provider Receivable	402,530	254,594	374,073
Other Receivables	1,287,555	466,502	3,808,831
Total Accounts Receivable	143,320,437	75,586,914	68,133,161
Total Prepaid Accounts	2,023,609	1,731,189	1,410,209
Total Other Current Assets	135,560	135,560	135,560
Total Current Assets	414,369,154	425,438,341	425,642,027
Total Fixed Assets	1,974,286	1,973,116	1,934,973
Total Assets	$ 416,343,440	$ 427,411,457	$ 427,577,000
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 58,805,456	$ 49,219,643	$ 47,553,203
Claims Payable	22,073,016	27,923,669	23,478,293
Capitation Payable	57,516,729	57,698,765	57,554,269
Physician Payable	0	310,852	5,263,839
DHCS - Reserve for Capitation Recoup	124,143,559	124,143,559	124,143,559
Accounts Payable	1,215,320	2,910,382	1,969,200
Accrued ACS	3,372,726	1,699,348	1,709,703
Accrued Expenses	7,842,267	7,977,865	7,315,000
Accrued Premium Tax	5,811,650	20,272,257	12,826,917
Accrued Payroll Expense	1,199,975	1,130,876	926,901
Total Current Liabilities	282,170,383	293,287,217	282,740,882
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	1,113,686	1,113,357	1,012,333
Total Long-Term Liabilities	1,113,686	1,113,357	1,012,333
Total Liabilities	283,284,069	294,400,574	283,753,215
Net Assets:			
Beginning Net Assets	133,010,883	142,360,951	142,360,951
Total Increase / (Decrease in Unrestricted Net Assets)	48,488	(9,350,069)	1,462,834
Total Net Assets	133,059,371	133,010,883	143,823,785
Total Liabilities & Net Assets	$ 416,343,440	$ 427,411,457	$ 427,577,000

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR ONE MONTH ENDED JULY 31, 2018

	July 2018 Actual	July 2018 Year-To-Date Actual	July 2018 Year-To-Date Budget	Variance Fav / (Unfav)	Variance %	July 2018 Year-To-Date Actual	July 2018 Year-To-Date Budget	Variance Fav / (Unfav)
Membership (includes retro members)	200,314	200,314	202,202	(1,888)	-0.93%	PMPM - FYTD		
Revenue								
Premium	67,543,850	67,543,850	65,987,163	1,556,687	2.36%	$ 337.19	$ 326.34	$ 10.85
MCO Premium Tax	(7,875,415)	(7,875,415)	(7,683,682)	(191,733)	2.50%	(39.32)	(38.00)	(1.32)
Total Net Premium	**59,668,435**	**59,668,435**	**58,303,481**	**1,364,954**	**2.34%**	**297.87**	**288.34**	**9.53**
Total Revenue	**59,668,435**	**59,668,435**	**58,303,481**	**1,364,954**	**2.34%**	**297.87**	**288.34**	**9.53**
Medical Expenses:								
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,084,051	5,084,051	4,920,626	(163,425)	-3.32%	25.38	24.34	(1.05)
FFS Claims Expenses:								
Inpatient	10,927,980	10,927,980	10,010,094	(917,886)	-9.17%	54.55	49.51	(5.05)
LTC / SNF	10,664,422	10,664,422	10,318,968	(345,454)	-3.35%	53.24	51.03	(2.21)
Outpatient	5,436,279	5,436,279	4,363,801	(1,072,478)	-24.58%	27.14	21.58	(5.56)
Laboratory and Radiology	331,866	331,866	277,237	(54,629)	-19.70%	1.66	1.37	(0.29)
Emergency Room	2,170,057	2,170,057	2,230,974	60,917	2.73%	10.83	11.03	0.20
Physician Specialty	5,270,415	5,270,415	4,212,508	(1,057,908)	-25.11%	26.31	20.83	(5.48)
Primary Care Physician	1,340,460	1,340,460	1,236,232	(104,228)	-8.43%	6.69	6.11	(0.58)
Home & Community Based Services	1,668,253	1,668,253	1,436,376	(231,878)	-16.14%	8.33	7.10	(1.22)
Applied Behavior Analysis Services	696,211	696,211	609,363	(86,848)	-14.25%	3.48	3.01	(0.46)
Mental Health Services	289,930	289,930	530,953	241,023	45.39%	1.45	2.63	1.18
Pharmacy	11,072,343	11,072,343	9,635,979	(1,436,363)	-14.91%	55.27	47.66	(7.62)
Provider Reserve	189,685	189,685	-	(189,685)	0.00%	0.95	-	(0.95)
Other Medical Professional	311,930	311,930	252,571	(59,359)	-23.50%	1.56	1.25	(0.31)
Other Medical Care	2,730	2,730	-	(2,730)	0.00%	0.01	-	(0.01)
Other Fee For Service	893,789	893,789	712,138	(181,651)	-25.51%	4.46	3.52	(0.94)
Transportation	144,525	144,525	135,680	(8,845)	-6.52%	0.72	0.67	(0.05)
Total Claims	51,420,837	51,420,837	45,962,874	(5,457,963)	-11.87%	256.70	227.31	(29.39)
Medical & Care Management Expense	1,121,530	1,121,530	1,211,383	89,853	7.42%	5.60	5.99	0.39
Reinsurance	(1,035,363)	(1,035,363)	256,763	1,292,126	503.24%	(5.17)	1.27	6.44
Claims Recoveries	(241,416)	(241,416)	-	241,416	0.00%	(1.21)	-	1.21
Sub-total	(155,250)	(155,250)	1,468,146	1,623,396	110.57%	(0.78)	7.26	8.04
Total Cost of Health Care	**56,349,638**	**56,349,638**	**52,351,646**	**(3,997,992)**	**-7.64%**	**281.31**	**258.91**	**(22.40)**
Contribution Margin	**3,318,796**	**3,318,796**	**5,951,834**	**(2,633,038)**	**-44.24%**	**16.57**	**29.44**	**(12.87)**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	1,921,502	1,921,502	1,919,229	(2,273)	-0.12%	9.59	9.49	(0.10)
Training, Conference & Travel	23,838	23,838	47,442	23,604	49.75%	0.12	0.23	0.12
Outside Services	2,102,512	2,102,512	2,259,767	157,256	6.96%	10.50	11.18	0.68
Professional Services	195,614	195,614	272,641	77,027	28.25%	0.98	1.35	0.37
Occupancy, Supplies, Insurance & Others	578,644	578,644	922,944	344,300	37.30%	2.89	4.56	1.68
Care Management Credit	(1,121,530)	(1,121,530)	(1,211,383)	(89,853)	7.42%	(5.60)	(5.99)	(0.39)
G&A Expenses	3,700,580	3,700,580	4,210,641	510,060	12.11%	18.47	20.82	2.35
Project Portfolio	-	-	384,043	384,043	100.00%	-	1.90	1.90
Total G&A Expenses	**3,700,580**	**3,700,580**	**4,594,684**	**894,104**	**19.46%**	**18.47**	**22.72**	**4.25**
Total Operating Gain / (Loss)	**(381,784)**	**(381,784)**	**1,357,151**	**(1,738,935)**	**-128.13%**	**$ (1.91)**	**$ 6.71**	**$ (8.62)**
Non Operating								
Revenues - Interest	430,272	430,272	77,738	352,534	453.49%	2.15	0.38	1.76
Total Non-Operating	430,272	430,272	77,738	352,534	453.49%	2.15	0.38	1.76
Total Increase / (Decrease) in Unrestricted Net Assets	**48,488**	**48,488**	**1,434,889**	**(1,386,401)**	**-96.62%**	**0.24**	**7.10**	**(6.85)**

Return to Agenda

STATEMENT OF CASH FLOWS	June 18	July 18	FYTD 17-18
Cash Flows Provided By Operating Activities			
Net Income (Loss)	(7,392,956)	48,488	$ 48,488
Adjustments to reconciled net income to net cash provided by operating activities			
Depreciation on fixed assets	44,091	44,183	44,183
Amortization of discounts and premium	(30,119)	(18,514)	(18,514)
Changes in Operating Assets and Liabilites			-
Accounts Receivable	(7,453,752)	(67,733,524)	(67,733,524)
Prepaid Expenses	(320,980)	(292,420)	(292,420)
Accounts Payable	1,898,693	101,830	101,830
Claims Payable	(363,115)	(6,343,540)	(6,343,540)
MCO Tax liablity	7,445,341	(14,460,607)	(14,460,607)
IBNR	(1,753,505)	9,585,813	9,585,813
Net Cash Provided by (Used in) Operating Activities	(7,926,303)	(79,068,291)	(79,068,291)
Cash Flow Provided By Investing Activities			
Proceeds from Restricted Cash & Other Assets			
Proceeds from Investments	10,000,000	20,000,000	20,000,000
Purchase of Investments plus Interest reinvested	(10,190,355)	(546,425)	(546,425)
Purchase of Property and Equipment	(82,234)	(45,353)	(45,353)
Net Cash (Used In) Provided by Investing Activities	(272,589)	19,408,222	19,408,222
Increase/(Decrease) in Cash and Cash Equivalents	(8,198,892)	(59,660,070)	(59,660,070)
Cash and Cash Equivalents, Beginning of Period	159,501,423	151,302,531	151,302,531
Cash and Cash Equivalents, End of Period	151,302,531	91,642,461	$ 91,642,461

AGENDA ITEM NO. 7

To: Ventura County Medi-Cal Managed Care Commission

From: Ruth Watson, Chief Operating Officer

Date: September 24, 2018

RE: Enterprise Transformation Project (ETP) Update

SUMMARY:

Ruth Watson, Chief Operating Officer will give a verbal presentation to the Commission.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 8

To: Ventura County Medi-Cal Managed Care Commission

From: Tom Smith, Chief Executive Officer – AmericasHealth Plan

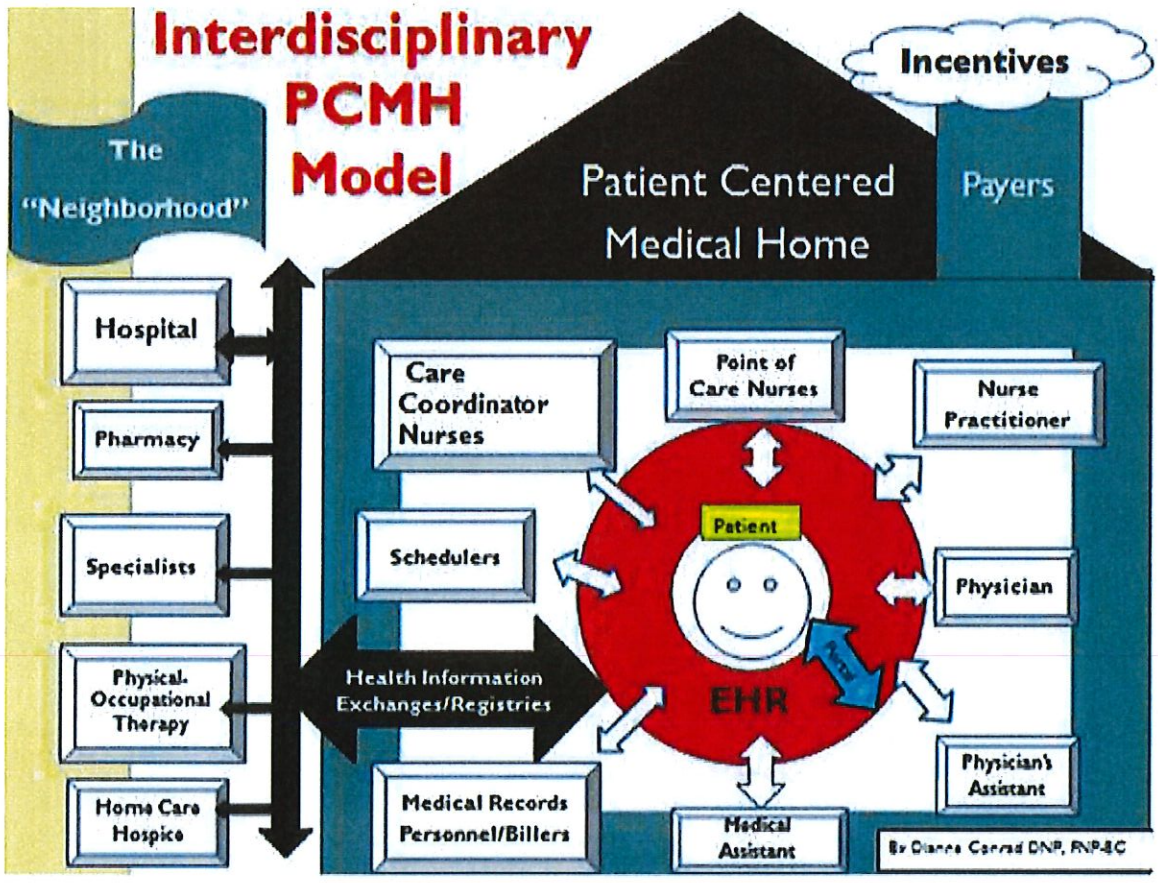
Date: September 24, 2018

RE: AmericasHealth Plan (AHP) Presentation

SUMMARY:

Tom Smith, AmericasHealth Plan Chief Executive Officer will give opening remarks for the AHP presentation to the Commission.

Beverly Gibbs and Linda Baker, AHP Medical Management Executives, will assist in the presentation.


Interdisciplinary
PCMH
Model
The
"Neighborhood"
Patient Centered
Medical Home
Incentives
Payers
Hospital
Pharmacy
Specialists
Physical-
Occupational
Therapy
Home Care
Hospice
Care
Coordinator
Nurses
Point of
Care Nurses
Nurse
Practitioner
Schedulers
Patient
Physician
Health Information
Exchanges/Registries
EHR
Physician's
Assistant
Medical Records
Personnel/Billers
Medical
Assistant

Patient-Centered
Primary Care
COLLABORATIVE

Why the Medical Home Works: A Framework

Feature	Definition	Sample Strategies	Potential Impacts
Patient-Centered	**Supports patients and families** to manage & organize their care and participate as **fully informed partners** in health system transformation at the **practice, community, & policy** levels	• **Dedicated staff help patients navigate system** and create care plans • **Focus on strong, trusting relationships** with physicians & care team, open communication about decisions and health status • Compassionate and culturally sensitive care	Patients are more likely to seek the right care, in the right place, and at the right time
Comprehensive	**A team of care providers** is wholly accountable for patient's **physical and mental health** care needs – includes prevention and wellness, acute care, chronic care	• Care team focuses on '**whole person**' and **population health** • Primary care could **co-locate** with behavioral and/or oral health, vision, OB/GYN, pharmacy • Special attention is paid to **chronic disease** and complex patients	Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated
Coordinated	Ensures care is **organized across all elements** of broader health care system, including specialty care, hospitals, home health care, community services & supports, & public health	• Care is **documented and communicated** across providers and institutions, including patients, specialists, hospitals, home health, and public health/social supports • Communication and connectedness is enhanced by **health information technology**	Providers are less likely to order duplicate tests, labs, or procedures
Accessible	Delivers **consumer-friendly services** with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations	• More efficient appointment systems offer **same-day or 24/7 access** to care team • Use of **e-communications and telemedicine** provide alternatives for face-to-face visits and allow for after hours care	Better management of chronic diseases and other illness improves health outcomes
Committed to quality and safety	Demonstrates commitment to quality improvement through use of **health IT** and other tools to ensure patients and families make informed decisions	• **EHRs, clinical decision support, medication management** improve treatment & diagnosis. • Clinicians/staff monitor **quality improvement goals** and use data to track populations and their quality and cost outcomes	Focus on wellness and prevention reduces incidence / severity of chronic disease and illness
			Cost savings result from: • Appropriate use of medicine • Fewer avoidable ER visits, hospitalizations, & readmissions

Return to Agenda

AGENDA ITEM NO. 9

To: Ventura County Medi-Cal Managed Care Commission

From: Nancy Wharfield, MD, Chief Medical Officer

Date: September 24, 2018

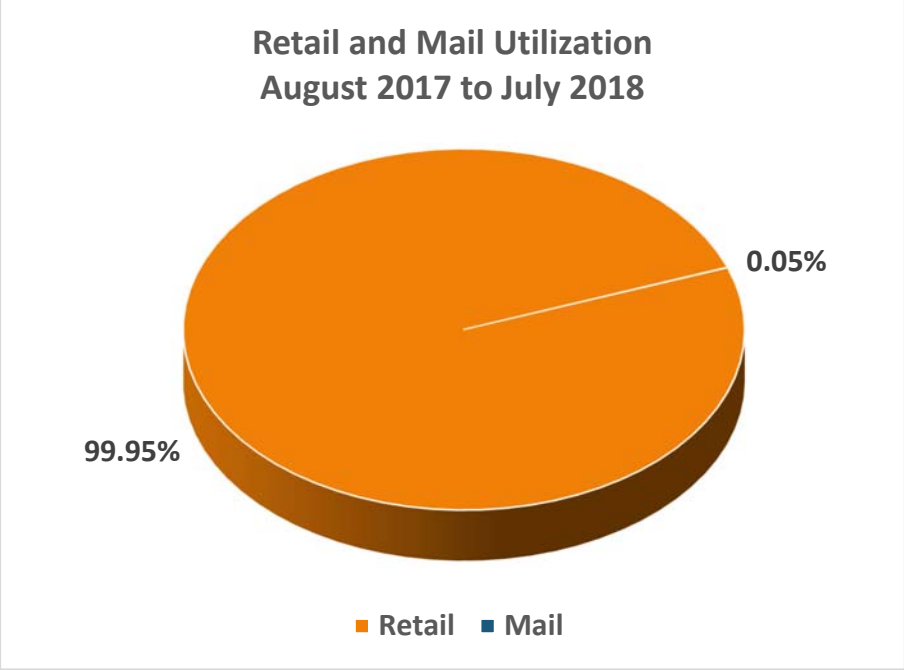
RE: Chief Medical Officer Update

OptumRx Updates

California Pharmacists Association Proposed Contract Considerations

- Move towards a fully transparent and pass through contract. Currently GCHP's contract with OptumRx is transparent and pass through with the following exceptions:

    - *Mail order and Specialty drugs*
      Although utilization of mail order can lead to significant savings for a payer, it is not highly utilized by Medi-Cal Plans due to the mobile nature of the population we serve. Mail order utilization for GCHP is minimal with 0.05% of all prescriptions from August 2017 to July 2018 being filled by OptumRx's mail order pharmacy representing about 0.0003 % of pharmacy cost (less than $4K per month).



Specialty medications represent high cost, high touch therapies for patients with complex diseases like cancer or multiple sclerosis. Medications often require special handling like refrigeration and may be injectable or infused.
Specialty medications filled at OptumRx's specialty pharmacy, BriovaRx, represent 22% of GCHP's specialty volume. The other 78% of specialty medications are filled by GCHP's network of local pharmacies.

GCHP proposed removing the exception of mail order and specialty pharmacy services from transparent/pass through status to OptumRx. OptumRx response is pending. Cost savings analysis is in process.
NOTE: Even without full transparency/pass through status on specialty drugs, shifting more business to OptumRx specialty pharmacy services would result in significant savings to the plan.

- *Remove pass through exception on rebates not obtained through OptumRx*
  Currently all rebates are obtained through OptumRx so 100% pass through of rebates is being accomplished. This suggestion will not result in any changes to the current process. OptumRx has agreed explicitly state this in a contract amendment and language is anticipated this month.

- Remove unilateral pricing changes by OptumRx for AWP benchmarking changes, membership changes.
  Language that addresses changes for industry wide pricing methodology changes or significant membership changes are necessary within the contract for protection of both GCHP and OptumRx. However, OptumRx has agreed to strike the language allowing OptumRx to make unilateral changes and is proposing language to allow for mutual agreement of new terms. Proposed language is anticipated this month.

- Add language of certification against remuneration
  OptumRx has agreed to this and proposed contract amendment language is anticipated this month.
  NOTE: This language already exists but is located in a pricing exhibit not available to the public. This action will add the certification against remuneration statement to an amendment which will be available to the public.

<u>Improving the Provider Experience</u>

A number of efforts are underway to explore ways to improve the provider experience:

- Lean 6 Sigma Black Belt
  - OptumRx has assigned a lean 6 sigma black belt to examine the GCHP prior authorization process

- Provider specific reporting
- Provider survey in development
- GCHP observation inside clinics
    - GCHP is exploring the feasibility of hiring extra pharmacy staff to support this effort
- Standardized appeal form in development
- Technology solution
    - e-Prescribing already in place
    - Feasibility of PreCheck My Script currently under exploration

Improving the Member Experience

- OptumRx member survey
    - OptumRx conducted a member satisfaction survey which found 93% of respondents giving positive feedback (average 4.2/5 points). Interpretation is limited by small sample size.
- Post Rx fill telephonic satisfaction survey
- Adherence module
    - OptumRx is providing GCHP with credit to launch a 3-pronged industry leading adherence program. The program addresses the following scenarios:
        1. New to Therapy letter – member letter mailed after first fill
        2. Late to Refill IVR Reminder – IVR call to member on late refill that transfer member to last filling pharmacy to refill their prescription
        3. Review for Low Adherence – Provider and Member letters; IVR outreach to members

MAC Audit

GCHP is engaging an independent audit firm to review OptumRx MAC performance.

Clinical Modules

To begin on October 1, 2018:

- Retrospective Drug Utilization Review (RDUR)
    - Provider intervention program that makes recommendations to drug therapy to align with clinical practice guidelines
    - Modules:
        1. Gaps in Care:
           Will address HEDIS Asthma Medication Ratio (AMR) measure
        2. Safe & Appropriate Utilization
- Opioid Risk Management – Retrospective Provider Intervention

    - Prescriber fax detailing recommended changes in therapy to align with CDC prescribing guidelines
- Opioid Risk Management - Intensive Case Management
    - Prescriber intervention and member lock-in program

Vendor Oversight

Compliance will begin to include PBM oversight reporting in upcoming reports.

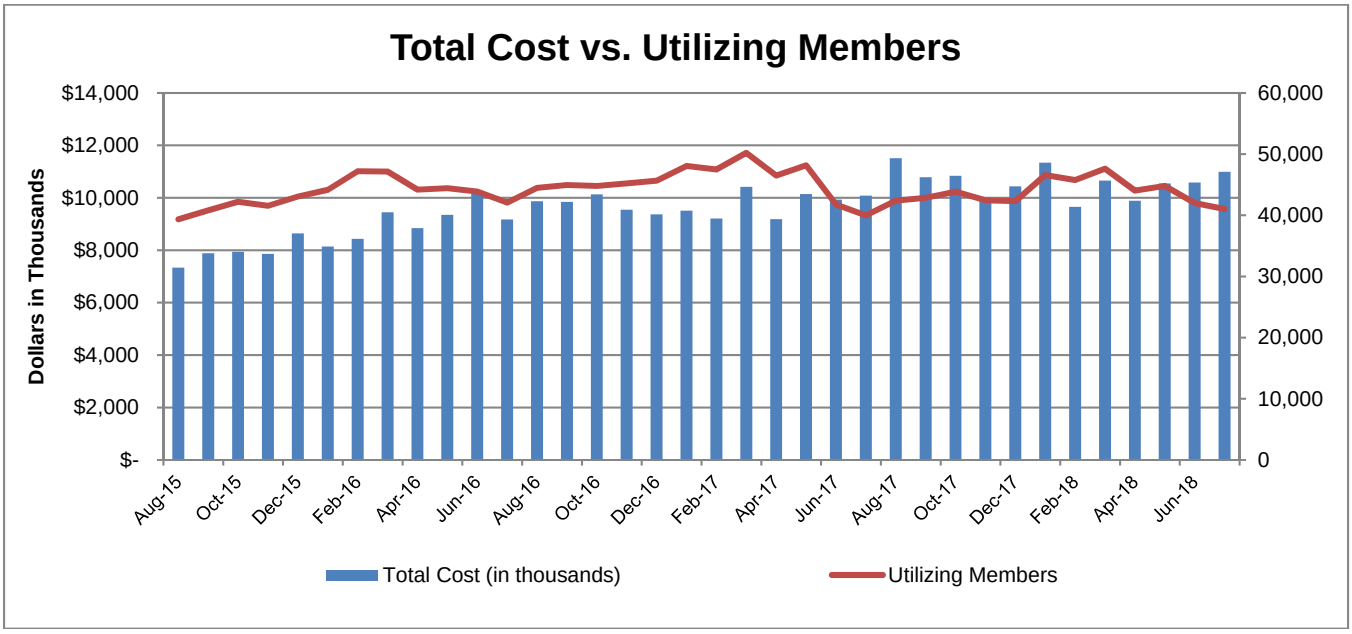
Pharmacy Benefit Performance and Trends

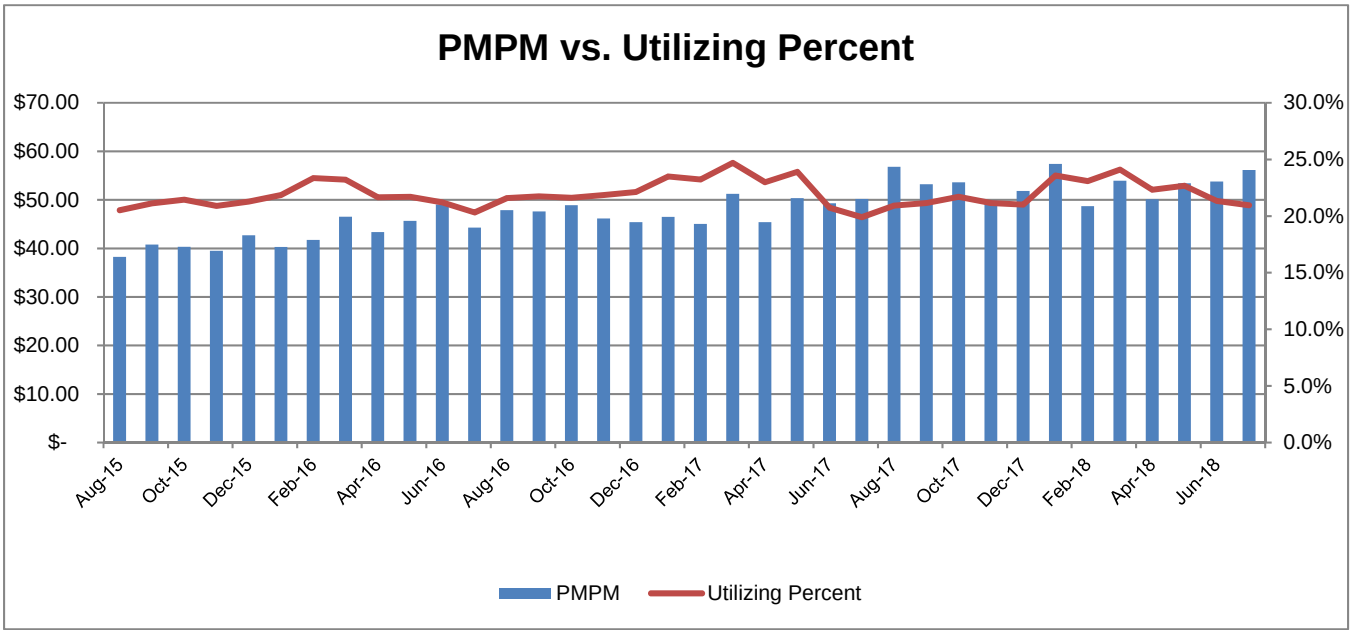
SUMMARY:

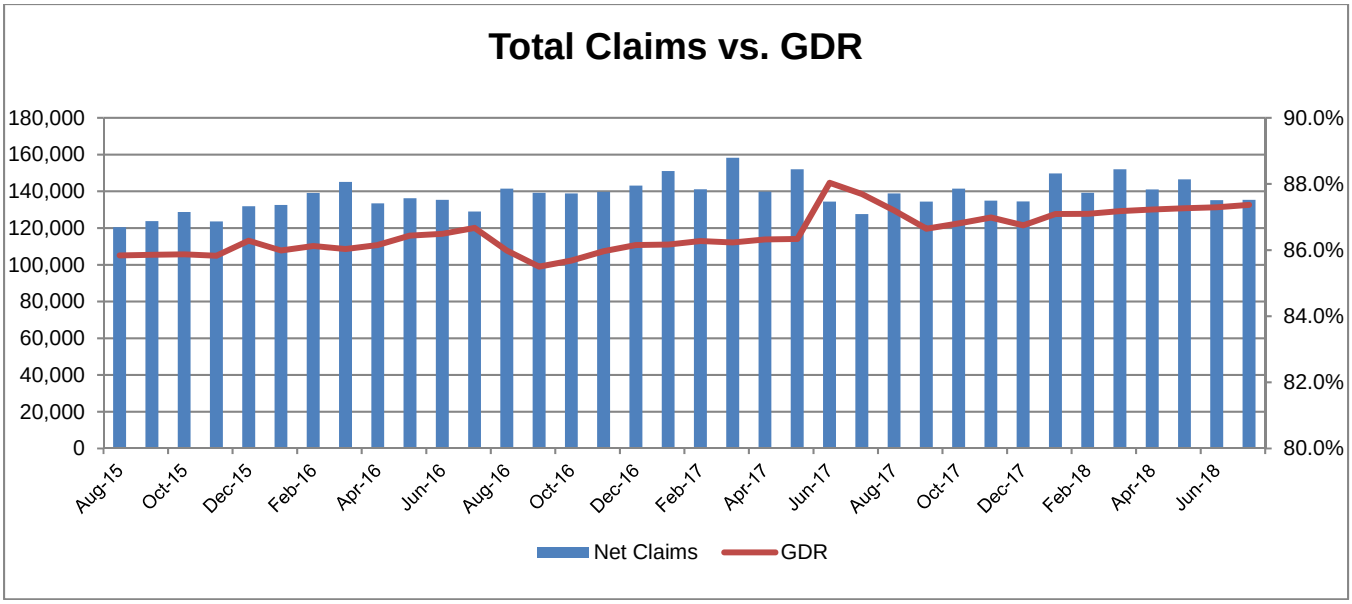
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of July 2018. Although minor changes may occur to the data going forward due to the potential of claim adjustments from audits and/or member reimbursement requests, the data is generally considered complete due to point of sale processing of pharmacy data.

Abbreviation Key:
PMPM: Per member per month
PUPM: Per utilizer per month
GDR: Generic dispensing rate
COHS: County Organized Health System
KPI: Key Performance indicators
RxPMPM: Prescriptions per member per month

PHARMACY COST TRENDS:

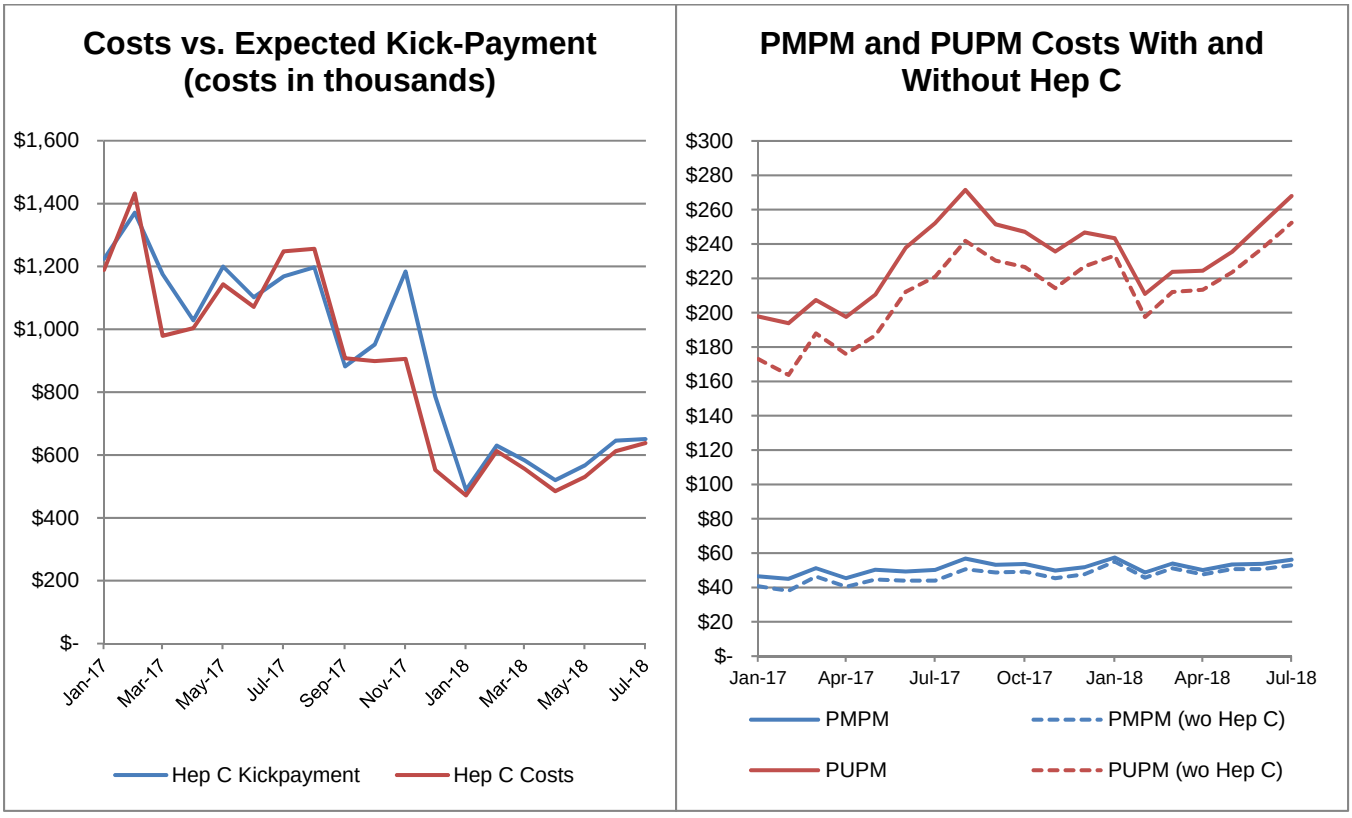




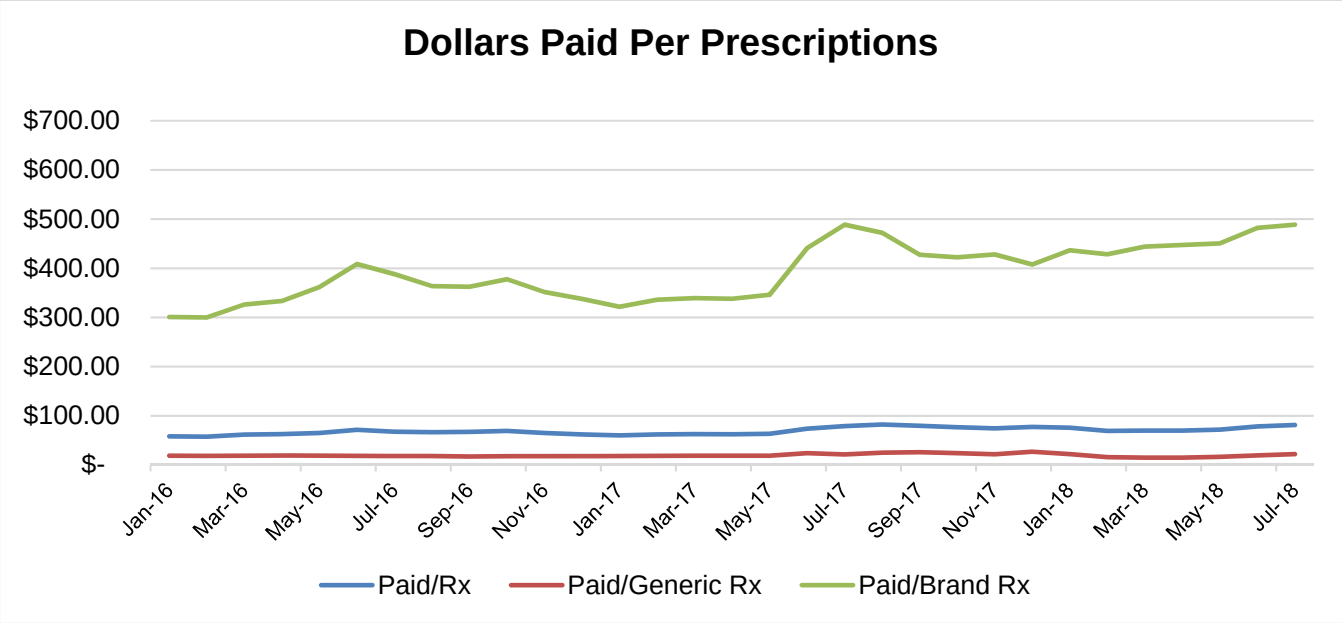


*Claim totals prior to June 2017 are adjusted to reflect net claims.

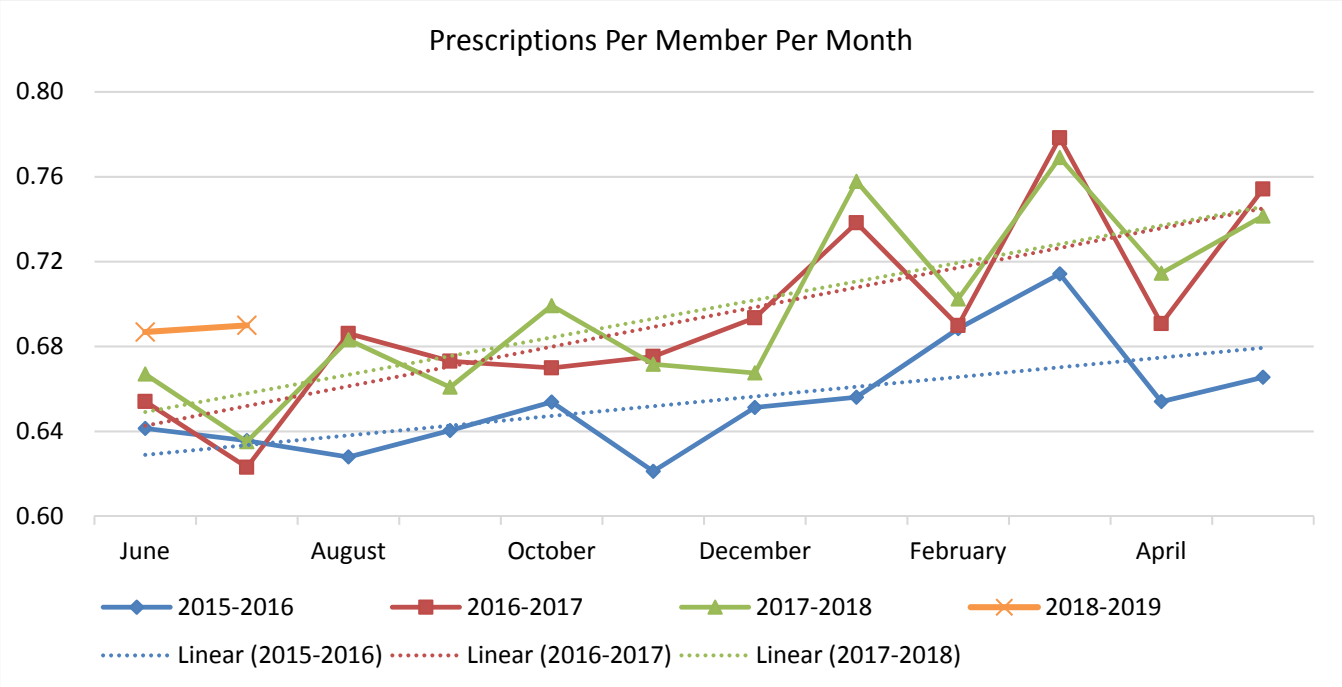
HEPATITIS C FOCUS:



PAID PER PRESCRIPTION:

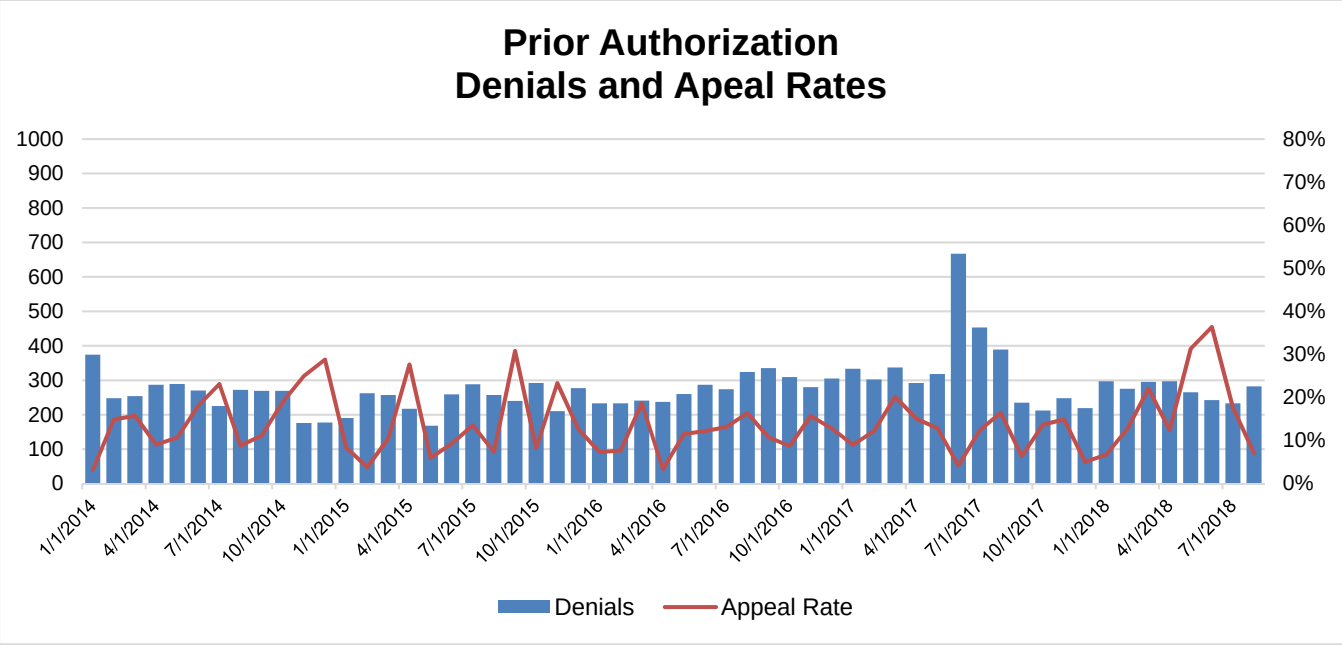


PRESCRIPTIONS PER MEMBER PER MONTH:



*Calculation reflects net claims.

PRIOR AUTHORIZATION STATISTICS:



PBM OVERSIGHT:

The Pharmacy Benefit Manager (PBM), OptumRx (ORx), is delegated to perform several functions for Gold Coast Health Plan (GCHP). The pharmacy department is responsible for ensuring that all delegated functions are occurring properly according to industry standards, in accordance with GCHP policies and procedures, and as required under the terms of the OptumRX-GCHP agreement.

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

Number of Items	Items Open	Items Pending Closure	Items Closed
14	2	2	12

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

Number of Items	Items Open	Items Pending Closure	Items Closed
5	1	1	4

Monitoring:

Issue Type	Number of Pharmacies
CA Board of Pharmacy Disciplinary Actions – Pending	2
CA Board of Pharmacy Disciplinary Actions – License Revoked	0
CA Board of Pharmacy Disciplinary Actions – Probation	2
OptumRx Audits – Appeal Pending	1*
DEA Investigations	1*

*One pharmacy listed in multiple categories.

340B DRUG DISCOUNT PROGRAM

The Covered Entities (CE) that were previously sharing the drug discount with GCHP received new compliance contracts in accordance with DHCS MCP draft compliance standards in late January or early February. GCHP staff with each entity. Below are the status of each:

1. Ventura County Medical Center (VCMC) has informed GCHP that it will not continue an outpatient, contract pharmacy based, 340B discount sharing program with GCHP.

2. Clinicas del Camino Real (CDCR) has indicated that it would provide an alternative arrangement to GCHP, but GCHP has not yet received that proposal.

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: September 24, 2018

SUBJECT: Interim Chief Diversity Officer Update

Actions:

Community Relations

- Attended Diversity symposium in the Los Angeles area with a focus on attracting and retaining diverse talent in the general area and attracting more business to California. Symposium also covered legal initiatives around diversity.
- Bi-weekly update meeting with Dale Villani and Staff.
- Donated time to The Veterans Foundation to assist in resume writing and effective interview techniques.
- Attended Board meetings with the Gold Coast Veterans Foundation and The California State University at Channel Island.
- Scheduled a joint diversity meeting with Amgen Pharmaceuticals to share best practices. Meeting scheduled for early October.
- Key areas of concern during diversity discussions: 1) FMLA excessive use and Performance against goals issues.

Grievance Activity

- Had 7 diversity related discussions during the month of August.
- Met with 3 managers to coach in conducting difficult discussions with employees.
- Held Diversity Council meeting at GCHP with a focus on attendance and terminations. The focus is primarily to look at trends to identify any adverse impact areas.
- Currently investigating 2 internal diversity concerns.

Case Investigations

No new cases to-date. Several in the investigatory stage. All related to job performance.

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: September 24, 2018

SUBJECT: Chief Operating Officer (COO) Update

Executive Summary

Enterprise Transformation Project (ETP) – The GCHP, Conduent and VBA teams have continued to work collaboratively to meet our project goals and timelines.

The project plan was scheduled to be "baselined" by September 7, 2018, meaning that the project plan has been completed with major milestones, gates, resources and timing documented, enabling the reporting of project and budget health to the Governance Team, the GCHP Executive Committee and the Commission.

The project plan was not baselined as planned. The delay was communicated to the GCHP Executive Committee and Governance Team during the second week of September. The delay and baselining of plan has not impacted key deliverables. The project team identified a mitigation plan and executed that plan during the second and third weeks of September to absorb the delays and continue with plan development. Progress on document gathering and inventory, internal GCHP requirements and identification of areas of change continue to move forward in preparation for the requirements gathering activities scheduled to begin in October. This major project continues to be on track and is within the Commission approved budget.

Membership - GCHP membership for September 2018 is 195,356 with a net loss of 458 members. In the month of September, GCHP gained 3,516 new members and lost 5,817 with 1,843 retro add members. Adult Expansion remain flat with September members at 52,393 versus January members at 52,745. We have discussed this trend with HSA for their input. They do not see any forthcoming changes to this pattern in the near future.

Operations Dashboard

Membership

Operations Dashboard Monthly Volumes- September 2018	
	Volume
Membership:	
Total	**195,356**
September Loss	**-5,817**
September Add	**3,516**
Retroactivity	**1,843**
Gain/Loss	**-458**
AB-85: (new)	
VCMC	**355**
Remaining Providers	**355**
VCMC Target	**65,765**
VCMC % of Target	**41.89%**

AB 85 Auto Assignment- GCHP assigned 355 new members to VCMC, while the remaining 355 new members were assigned to providers in compliance with the VCMMCC Auto Assignment policy (MS-005) for September. VCMC has 27,550 Adult Expansion (AE) members assigned as of September 1, 2018. VCMC's target enrollment, as established by DHCS, is 65,765 and is currently at 41.89% of the target.

Encounter Data

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

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

Operations Dashboard Monthly Volumes- September 2018 Total Encounters Submitted: 345,727		
Encounter Type	**Errors**	**% of Errors**
Professional	3,272	2.6%
Institutional	994	1.3%
Pharmacy	208	0.1%
Total	**4,266**	**2.1%**

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

Claims

Annually, Conduent processes approximately 2,500,000 claims for GCHP. This does not include the volume of encounters received by GCHP. August claim submission is higher than July by 16,579, a significant drop in claims for July. Claims cycles would anticipate an increase to claims with the end of summer/beginning of fall.

Operations Dashboard Monthly Claims Volumes- May - August 2018				
		Month		
	August	July	June	May
Total	**208,001**	191,833	208,412	215,166
Daily Average Receipt	**9,455**	8719	9924	9,780
Days Receipt on Hand	**5**	5	6	4

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

Operations Dashboard Key Performance Metrics- May - August 2018					
	Benchmark		Month		
		August	July	June	May
Turn Around Time	90.00%	94.05%	99.40%	98.66%	99.08%
Financial Accuracy	98.00%	99.28%	99.38%	99.16%	99.30%
Procedural Accuracy	97.00%	99.94%	99.38%	99.25%	99.91%

Call Center

Call center metrics continue to demonstrate fluidity due to call volumes and talk times remaining high. Particularly, talk times for provider and member calls remain similar where we would typically see member talk time lower than provider talk times. Conduent and GCHP actively address opportunities to reduce talk times, increase consistency with staffing and look to innovate the workflows.

Conduent is measured on call center performance by three industry-standard metrics (Service Level Agreements (SLAs)). Call volume for August decreased over July by 2%.

Conduent continues to struggle with attrition in the call center. The geographical area is home to several health plan call centers which are currently hiring staff at premium rates to support upcoming open enrollment. Conduent has taken several steps to mitigate the attrition including staffing through agencies, improved pay models to retain employees and temporary back fill of open positions through temporary agencies.

Operations Dashboard Call Volume- May - August 2018				
	August	July	June	May
Call Volume (# of calls)	**12,670**	12,923	11,916	12,183

Operations Dashboard Key Performance Metrics- May - August 2018					
	Benchmark	August	July	June	May
Avg. Speed To Answer	30 Seconds	**94.8**	27.0	20.4	90.6
Abandonment Rate	5.00%	**4.66%**	1.32%	1.02%	4.73%
Call Quality Scores	95.00%	**96.0%**	96.2%	97.24%	96.7%

Grievance and Appeals

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

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

June metrics are demonstrating a drop over May statistics. May appears to be an outlier for submissions to G&A.

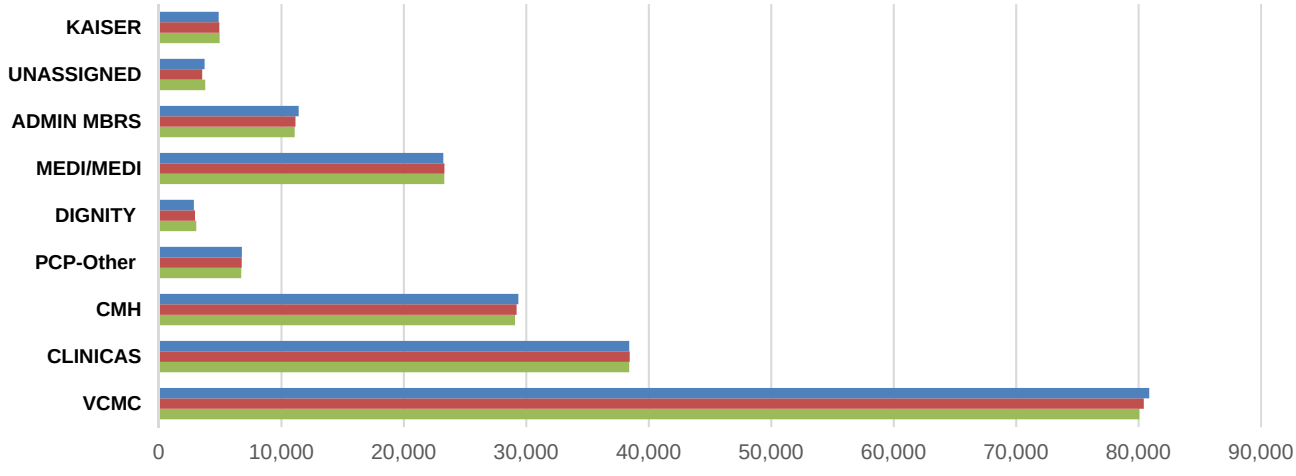
Operations Dashboard
Monthly Volumes - May- July 2018

	July	June	May
G&A Volume:			
Clinical	**22**	**25**	**9**
Upheld	**13**	**20**	**4**
Overturned	**7**	**4**	**5**
Withdrawn	**2**	**1**	**0**
Provider	**148**	**117**	**147**
Member	**24**	**18**	**27**
Grievances/ 1,000	**0.12**	**0.09**	**0.14**
Quality of Care	**12**	**18**	**16**
State Fair Hearings	**2**	**1**	**0**
Denied	**2**	**1**	**0**
Dismissed	**0**	**0**	**0**
Withdrawn	**0**	**0**	**0**

Operations Dashboard Monthly Volumes by Issue Type - May - July 2018			
Grievance (Issue Type):	July	June	May
Accessibility	6	2	3
Benefits/Coverage	2	0	1
Billings	3	1	3
Denial/Refusals	0	0	1
Quality of Care	12	13	16
Quality of Service	1	2	2
Referral	0	0	1

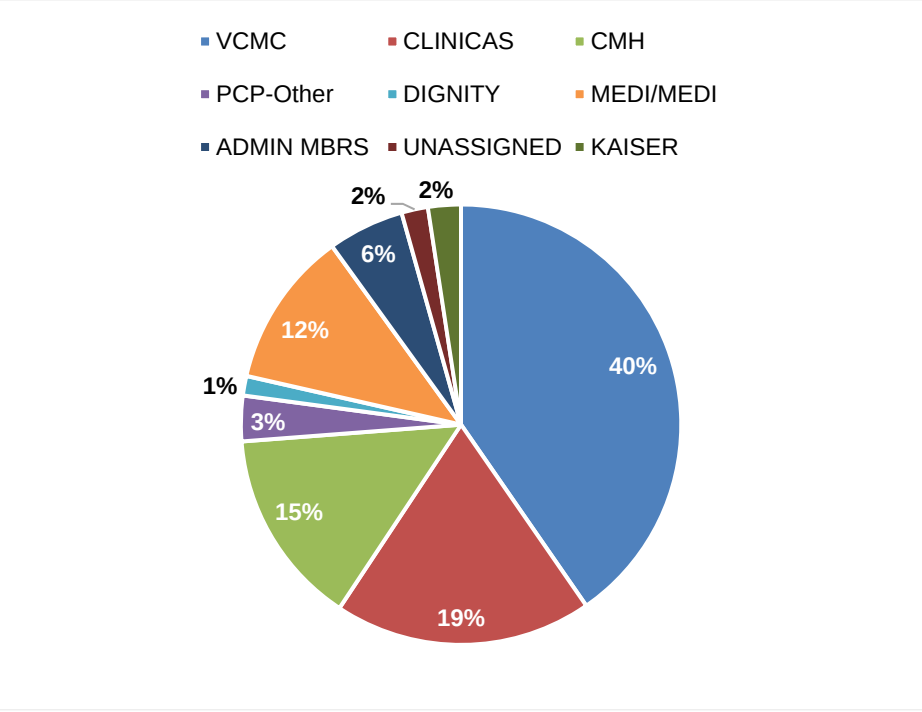
PROVIDER NETWORK OPERATION REPORT

1. MEMBER PCP ASSIGNMENTS



	VCMC	CLINICAS	CMH	PCP-Other	DIGNITY	MEDI/MEDI	ADMIN MBRS	UNASSIGNED	KAISER
Jun-18	80,874	38,415	29,356	6,784	2,864	23,232	11,423	3,741	4,881
Jul-18	80,432	38,449	29,218	6,769	2,953	23,318	11,161	3,533	4,937
Aug-18	80,055	38,404	29,075	6,727	3,051	23,305	11,088	3,787	4,966

% Distribution of Membership By Provider and Member Type



2. PROVIDER ADDS AND TERMINATIONS JULY 2018

ADDITIONS:

- 16 specialists added via Children's Hospital Medical Group
- 9 specialists added via City of Hope Medical Foundation
- 12 specialists added via Cedars-Sinai Medical Foundation
- 8 Specialists added via VCMC
- 3 specialists (Urgent Care) added Adventist Health Physicians Network
- 3 Pharmacy's added: 2 in Fillmore, 1 in Ojai
- 2 specialist added via USC Care Medical Group
- 1 Specialist added via Dignity Health Medical Group
- 1 PCP added via Dignity Health Medical Group
- 1 Mid-level added via Fillmore Family Medical Group
- 1 Hospitalists added via VCMC

PROVIDER TYPE	# PROVIDER ADDS August 2018	TOTAL PROVIDER ADDS July 2018-June 2019	TOTAL NETWORK PROVIDERS
Hospital	**0**	**0**	**33**
-Acute Care	0	0	19
-LTAC	0	0	9
-Tertiary	0	0	5
Providers	**54**	**118**	**6,565**
-PCP's & Midlevels	2	4	447
-Specialists	51	111	5,773
-Hospitalists	1	3	344
Ancillary	**0**	**0**	**388**
-ASC	0	0	8
-CBAS	0	0	6
-DME	0	0	108
-Home Health	0	0	33
-Hospice	0	0	21
-Laboratory	0	0	67
-Optometry	0	0	33
-OT/PT/ST	0	0	83
-Radiology/Imaging	0	0	29
Pharmacy	**3**	**3**	**841**
SNF/LTC/CLF	**0**	**0**	**85**
Behavioral Health	**0**	**4**	**385**

3. TERMINATIONS:

- o 3 specialist providers terminated from City of Hope Medical Foundation due to provider resignations.with no notice given to GCHP. This is not unusual for large academic affiliated medical groups as providers (residents/fellows/visiting professors) train and subsequently move on when their training is complete if not offered an attending academic position with the group. There is no resulting impact to network access.
- o The remaining 9 other provider terminations are as follows and have no significant impact on the network itself or member access.

    - 8 VCMC providers: 5-PCP (FP), 2- Specialists, 1- Radiologist. No access impact. There are 447 PCP's and mid-levels contracted within the County.
    - 1 Hospitalist associated with Ventura Anesthesia Medical Group

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PROVIDER TYPE	# PROVIDER TERMS July 2018	TOTAL PROVIDER TERMS July 2018- June 2019	COMMENTS
Hospital	**0**	**0**	---
-Acute Care	0	0	---
-LTAC	0	0	---
-Tertiary	0	0	---
Providers	**47**	**47**	---
-PCP's & Midlevels	5	11	No major impact
-Specialists	6	46	No major impact
-Hospitalists	1	1	No major impact
Ancillary	**0**	**1**	No major impact
-ASC	0	0	No major impact
-CBAS	0	0	---
-DME	0	0	No major impact
-Home Health	0	0	---
-Hospice	0	0	No major impact
-Laboratory	0	0	---
-Optometry	0	0	---
-OT/PT/ST	0	1	No major impact
-Radiology/Imaging	0	0	No major impact
Pharmacy	**0**	**0**	---
SNF/LTC/CLF	**0**	**0**	---
Behavioral Health	**0**	**0**	---

4. CONTRACTING INITIATIVES

A. Enhanced Access:

- Added 1 acupuncturist
- Added 1 hearing aid DME specialist
- Finalizing agreement with a Pathology Group
- Finalizing agreement with Orthopedic Surgery Center in Thousand Oaks.
- Finalizing Agreement with Orthopedic Surgery Group who will provide services in Oxnard and Simi Valley.
- Finalizing Interim Letter of Agreement with Physical Therapy group adding a new location with four additional therapists (provider awaiting response from DHCS for Medi-Cal licensing).

- Finalizing Interim Letter of Agreement with Retinal Specialist (provider awaiting response from DHCS for Medi-Cal licensing).

B. Provider Network:
- Finalized contract amendment, rate schedule and Settlement with Dignity Health.
- In negotiations with Simi Valley hospital on contract renewal.
- Added Clinicas La Colonia clinic location
- Finalizing direct transplant services agreement with UCLA, which will reduce transplant costs associated with transplant rental networks.
- Finalized Infusion Therapy for supplies
- Finalized Amendment for DME provider.

C. Regulatory Initiatives: no activity at this time
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