Gold Coast Health Plan
A Public Entity

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

Regular Meeting
Monday, February 26, 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

PUBLIC COMMENT

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

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

CONSENT CALENDAR

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of January 22, 2018

Staff: Maddie Gutierrez, Interim Clerk of the Commission

RECOMMENDATION: Approve the minutes.

REPORTS

2. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

PRESENTATION

3. Pharmacy Benefit Manager (PBM) Update – Excelsior Solutions

Guest Speaker: Kim Foerster, Vice President and Ken Dowell, Pharmacy Analytics Board Chair – Excelsior Solutions

RECOMMENDATION: Accept and file.

FORMAL ACTION ITEMS

4. December 2017/January 2018 Financials

Staff: Lyndon Turner, Interim Chief Financial Officer

RECOMMENDATION: Accept and file the Financials report.

5. Intergovernmental Transfer (IGT) Report

Staff: Lyndon Turner, Interim Chief Financial Officer

RECOMMENDATION: Authorize and direct the Chief Executive Officer to execute the Health Plan Provider Agreement with the County of Ventura to secure additional AB85 funding.

REPORTS

6. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.

7. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

8. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

9. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

10. PUBLIC EMPLOYEE APPOINTMENT
Title: Chief Diversity Officer

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

OPEN SESSION

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

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

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

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

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, Interim Clerk to the Commission

DATE: February 26, 2018

SUBJECT: Meeting Minutes of January 22, 2018 Regular Commission Meeting

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the January 22, 2018 Regular Commission Meeting minutes.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
January 22, 2018 Regular Meeting Minutes

CALL TO ORDER

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

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa (arrived at 2:18p.m.), Michelle Laba, M.D., Darren Lee, Kelly Long (arrived at 2:12 p.m.) Gagan Pawar, M.D., Catherine Rodriguez (arrived at 2:23 p.m.), and Jennifer Swenson (arrived at 2:39 p.m.)

Absent: Commissioner Peter Foy.

OATH OF OFFICE

Kelly Long, Ventura County (VC) Board of Supervisors, was welcomed and pledged her oath of office. She will now sit on the Commission, replacing (VC) Board of Supervisor Peter Foy.

Commissioner Espinosa arrived at 2:18 p.m.

PUBLIC COMMENT

April Miles, appearing on behalf of OMAC Pharmacy provided a handout from DHCS regarding Fee-for-Service pharmacy reimbursement changes-Related to Agenda Item No. 9.

Kent Miles, spoke on Agenda Item No. 9 and provided a handout – CISION article on Optum Rx.

Danny Martinez, appearing on behalf of CA Pharmacy Association – spoke on Agenda Item No. 9.

CONSENT CALENDAR

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

   RECOMMENDATION: Approve the minutes.

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

   RECOMMENDATION: Authorize additional funds in support of ongoing internal audit requirements.

Commissioner Long moved to approve the recommendations for Consent items 1 and 2. Commissioner Alatorre seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Michelle Laba, M.D., Darren Lee, Kelly Long, and Gagan Pawar, M.D.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Rodriguez and Swenson.

Commissioner Lee declared the motion carried.

REPORTS

3. **Chief Executive Officer (CEO) Update**

   RECOMMENDATION: Accept and file the report.

   CEO Villani on behalf of GCHP welcomed Supervisor Long to the Commission. CEO Villani stated that as this is the first meeting of 2018, he would like to review highlights from 2017.

   - DHCS lifted the financial cap,
   - Growth in the provider network,
   - Implementation of two large vendor contracts: OptumRx for PBM and Inovolan for HEDIS,
   - Kicked off Plan to plan pilot discussions with Americas Health Plan,

- Held a variety of resource fairs held throughout the community.

GCHP staff provided substantial support to members and our community during the recent Thomas Fires. This included ensuring members clinical needs and medications were met. Health Education and Community Outreach staff worked at the VC fairgrounds and assisted with member needs as did Beacon for behavioral health support.

Commissioner Rodriguez arrived at 2:23 p.m.

GCHP selected Excelsior Solutions as the PBM external consultant through an informal bid process. Dr. Freese will provide additional detail around the PBM consultant analysis during her PBM report.

The Plan is exploring the possibility of a Program for All-Inclusive Care for the Elderly (PACE) center. GCHP is in early stages of research, but wanted to keep the Commission informed. If this is a potentially viable opportunity, it will be brought back for future discussion.

GCHP priorities for 2018 are focused around the continuation of providing quality care to our members, ensuring fiscal integrity, clinical program excellence, community health and engagement, regulatory compliance, project implementation, employee satisfaction, and developing alternative revenue sources.

Commissioner Lee asked about pharmacy issues. Dr. Anne Freese, Pharmacy Director stated under Agenda Item No. 9 she has included her prepared pharmacy report. She provided updates on the status of the Kaiser LOA and 340B contracts. The Kaiser LOA is waiting for final signatures and GCHP will be reaching out to 340B eligible covered entities in order to follow the new OptumRx process.

Excelsior Solutions has been selected as the PBM consultant to do a market check on the reimbursement through OptumRx. Discussion was held regarding what the consultant will assess and the timeline. Excelsior will present at both the February and March meetings with the full analysis expected at the March meeting. The analysis will include both a local and national review. Additionally, due to concerns raised from the public comments regarding MAC list availability, Dr. Freese will look further into the availability and process to access the list from OptumRx.

Commissioner Swenson arrived at 2:39 p.m.

PUBLIC COMMENT CONT'D.

Dr. Rajindea Rai spoke on Agenda Item No. 9.

Commissioner Lee directed Dr. Freese to get information on the MAC list; where it can be found and how often it changes.

PRESENTATION

4. Legislative Update

RECOMMENDATION: Accept and file the presentation.

Guest Speakers: Don Gilbert and Trent Smith of Edelstein, Gilbert, Robson & Smith

Mr. Gilbert and Mr. Smith provided a summary of State legislative initiatives and priorities. This is the second year of a two-year legislative session and the last year of Governor Brown's tenure.

Legislature convened on January 3rd, and a number of bills were introduced. The introduction deadline is February 16th. All bills are read and forwarded to GCHP management team if there is potential for impact.

Mr. Smith stated the Governor released the State budget on January 10th, which currently has a $19 billion surplus. The Governor is being cautious with spending due to uncertainty at the federal level. Currently the proposed budget allows for all Medi-Cal funding to remain the same. There is some new money from Prop 56 which will be provided for new physician payments as well as new dental payments.

Medi-Cal spending in the last 6-7 years has shown a growth average of 6%. Currently there is growth of 11%, which equates to not only enrollment growth, but also increased healthcare costs. The governor is proposing the 340B program be discontinued within Medi-Cal as this funding was intended to provide drugs for the uninsured only. Anticipate that federally qualified health clinics and public hospitals will oppose, as they rely on this funding program.

Commissioner Alatorre asked about the CHIP funding share percentage by the state. Mr. Smith stated it will continue to be an 80/20 split between Federal and State.

Commissioner Dial moved to accept and file items 3 and 4. Commissioner Long seconded.

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

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

FORMAL ACTION ITEMS

5. October / November 2017 Financials

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

DISCUSSION: The Executive Finance Committee meeting was not held as scheduled due to a lack of quorum, but members of the committee were met with individually and information was provided. At the end of November there were 202,000 members, but a decline is expected in subsequent months. TNE was also reviewed and was reported at 441% of required. Year-to-date income statement was reviewed. Health care costs are currently approximately $35 million over budget. Mr. Turner stated the overage included $14 million paid to the County through AB85, designed to support public hospitals systems. October revenue was also higher due to the related funding of the AB85 payment. Administration expenses are below budget and there is a tight rein on administrative expenses. Training and travel have been limited. There has been tighter management of projects and only doing mandatory, regulatory projects that must be complete. Commissioner Rodriguez asked about facility expense.

A discussion of the OptumRx pharmacy contract followed. Dr. Freese stated Optum paid incorrect rates at the beginning of the contract term. Gold Coast Health Plan reached out to Optum after seven months, which has resulted in rate adjustments going forward. Invoice credits have been issued to address inaccurate MAC list implementation. On a second issue, name brand drugs were paid at an incorrect rate – those rates are still being paid back to GCHP. Pricing adjustments were made in December and more are expected in order to meet the pricing guarantees. Commissioner Lee asked about the contractual term in respect to meeting performance guarantees. Dr. Freese stated at end of the contract year plus a 90-day leeway, expected by August.

Commissioner Swenson asked where GCHP anticipates ending the fiscal year. A PowerPoint update of the TNE projection was presented. Revenue rates were also

discussed. Rates are determined by State actuaries, which use the Plan's data to project forward. GCHP has complied with all data requests and has had discussions with the State to further explain Plan cost data. State is under pressure due to the initial generous rates for Adult Expansion. Nevertheless, in the most recent year GCHP obtained a rate increase.

Commissioner Lee asked if GCHP knew that provider rate increases would throw off the budget, why would the contract increases be granted? COO Watson stated the Plan was told to spend down the TNE and this was an effort to do so. Mr. Turner stated that an increase in contract rates was included in the budget, but due to the timing of the negotiations vis-à-vis the budget preparation, final rates were not available in time. COO Watson stated that on five separate occasions GCHP thought it had a contract with the County, but presentation to the Board of Supervisors for approval was continuously delayed.

CEO Villiani stated that GCHP is aware of when a contract rate changes as well as aware of the impact of that change. The Plan now needs to review hospital rates. Staff is currently in discussion with the County to determine how to meet Plan obligations with the County and at the same time pay what would be a reasonable rate. The Plan also needs to put in place provider incentives. COO Watson stated GCHP wants to move towards Value Based Contracts and is in the midst of developing more Value Based Programs. In order to do this, base rates must be reduced. Commissioner Swenson stated that one of the benefits in working with the grant programs was it was an additional method to reduce TNE.

UCLA was mentioned as an example of a beneficial re-contracting. This facility was out of network so GCHP brought it into the network at a more favorable rate. Transplant and Oncology are very expensive. Commissioner Long stated she would like to see the breakdown in utilization. COO Watson stated the conversations cannot go deep due to contract confidentiality issues. The Plan works to divert inpatient costs to outpatient. Commissioner Swenson stated the utilization and cost PowerPoint is very helpful and asked to include year-to-date pmpm data to help see if in-line. Commissioner Egan stated higher costs seem to be related more to non-acute care. Commissioner Egan stated pharmacy is also a big part of costs.

Commissioner Long asked what the goal is for TNE. Mr. Turner stated 400 to 500%. Commissioner Long stated the chart on TNE is below 500%. COO Watson stated the Commission wanted the TNE below 500%. Legal Counsel Campbell stated that in the Strategic Plan from last March, TNE was to be lowered. Commissioner Lee confirmed TNE was then at 550 or 575% and wanted it lower – between 400 to 500%. CEO Villani stated a major contract had expired with the County. This provided GCHP the opportunity to follow the TNE strategy by contracting for one year at rates that would reduce TNE,

and then re-negotiate the contract. COO Watson added over 80,000 members seek care with the county.

Due to the direction of the discussion, further dialogue would need to be held for Closed Session.

Commissioner Lee moved to accept and file Agenda Item No. 5. Commissioner Alatorre seconded.

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

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

The meeting was recessed for a short break at 4:23 p.m.

RECONVENE TO REGULAR MEETING

The Regular Meeting reconvened at 4:31p.m.

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

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

DISCUSSION: Commissioner Lee clarified that these are temporary staffing contracts that may or may not exceed $1.25 million, which locks in rates for temporary staff as needed. Commissioner Dial asked if the intent was to spend the full amount. Jean Halsell, Executive Director of Human Resources, responded the $1.25 million is a projection of temporary staff spending. She does not foresee going over the $1.25 million not to exceed amount, but it depends on the number of active projects driving staffing needs. General Counsel Campbell stated that it is better to get pre-authorization now

instead of waiting until the Plan reaches the $100k threshold for CEO contract signing authority for each temporary staff resource.

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

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

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

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

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

DISCUSSION: None.

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

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

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

REPORTS

8. Chief Operating Officer (COO) Report

COO Watson advised that GCHP membership in January dropped to 197,000. This a consistent trend across the state as most of California's public plans have experienced a decrease in membership. California's stronger economy may be a factor. GCHP has reached out to the County Human Services Agency (HAS) for more data to determine why the significant drop.

All service level agreements have been met in claims. Standard operational statistics are also good. Lexington Kentucky, where our Call Center is located, had an ice storm and it impacted our numbers due to snow days. There is an issue with mailroom process which can affect the process of a grievance. There is a five day turn around requirement by the state – if mail is not sorted properly it can take longer than five days to get to us. There is a process improvement project to help fix this issue.

GCHP has contracted with Conduent to provide administrative services to the Plan since 2011. As the Plan's Administrative Services Organization (ASO) Conduent provides claim and encounter processing, Call Center services and the Plan's core transaction systems. With the approval of this Commission GCHP extended the Conduent contract for two years with the intent to evaluate options to bring ASO services in-house or continue to outsource all or portions of the services currently out sourced. Optimity was engaged to work with staff on this initiative. . A thorough analysis indicated potential costs of $20 to $50 million to bring these services in-house, depending on which services were chosen. In addition to purchasing a new system, the plan requirements would include hiring additional staff, finding and acquiring space and a significant expansion of the IT team. While staff prepared a comprehensive RFP to identify potential new vendors, and Conduent presented a proposal that will improve plan functionality and service levels. The proposal included a decrease in current costs at implementation and through the life of the contract. Conduent conducted a thorough search and identified Virtual Benefit Administration (VBA) as a system that had the capability of filling in GCHP's service gaps and meeting the Plan's needs for the future. Staff will present their recommendation for approval at the February Commission meeting.

The Plan has continued to meet with Americas Health Plan (AHP) through the end of the year. AHP CEO, Enrique DeLaGarza is no longer with AHP. A meeting is being set up to discuss next steps. COO Watson reminded the Commission that GCHP has not received the new contract from the State of California and we have been informed by DHCS that we are prohibited from submitting the AHP proposal until our contract is approved. Brandy Armenta, Director of Compliance, stated the contract is still under CMS review and final approval has not been granted.

9. Chief Medical Officer (CMO) Report

Dr. Nancy Wharfield, Chief Medical Officer stated Dr. Freese's report was the CMO report and she has already given that information to the Commission earlier in the meeting.

10. Chief Diversity Officer (CDO) Report

Ted Bagley, Interim Chief Diversity Officer (CDO) provided an update on CDO activities during his first month. His primary focus has been on foundation building, both internally and externally within the community and establishing credibility. He has also begun to work with legal for a way to find quick solutions. Interim CDO Bagley has spent time with Commissioners as well as GCHP staff in order to establish a direction and vision. Mr. Bagley also met with several community leaders: LULAC, NAACP, California State University Channel Islands and the Gold Coast Veterans Foundation. CDO Bagley plans to develop a strategic plan for diversity and inclusion. Commissioner Long asked Mr. Bagley about his thoughts on whether the CDO position should report into Human Resources rather than be a separate position to the Commission. Mr. Bagley stated that over a period of time, the CDO should be a position at Gold Coast Health Plan. Commissioner Long asked if the implementation should be sooner than later and what would be most beneficial to GCHP. Mr. Bagley stated the advantage of having the structure as it is now helps him to develop and define the function of the position. He is working toward that. Commissioner Espinosa noted her observation of changes already and asked to include Commission input for the diversity strategic plan. Mr. Bagley stated he wants to involve the Commission and will make sure they are part of the implementation. Commissioner Espinosa stated she would not rush to have a Diversity Officer in H.R.; she does not believe the organization is ready.

Chief Administrative Officer Scrymgeour stated the annual commission strategic planning session is scheduled for March 15th. The diversity strategy could be included as a topic in that meeting.

Commissioner Dial moved to approve Agenda Items 8, 9, and 10. Commissioner Atin seconded.

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

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

CLOSED SESSION

The Commission adjourned to Closed Session at 4:57 p.m. regarding the following items in the following order:

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

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

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

Various Commissioners (Commissioners Espinosa, Lee, Pawar and Alatorre) were recused during the discussion of cases which could be a potential conflict of interest.

OPEN SESSION

The regular meeting reconvened at 6:40 p.m.

Mr. Campbell stated there was no reportable action taken.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 6:47 p.m.

Approved:

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Maddie Gutierrez, Interim Clerk of the Commission

AGENDA ITEM NO. 2

TO: Gold Coast Health Plan Commission

FROM: Dale Villani, Chief Executive Officer

DATE: February 26, 2018

SUBJECT: Chief Executive Officer Update

VCMMCC Commissioner Changes

The Board of Supervisors will be voting on several new commissioner positions at the February 27 meeting.
Leaving:

- Darren Lee, Dignity CEO
- Michelle Laba, MD, Ventura County
- Catherine Rodriguez, Ventura County

The following reappointments (pending Board of Supervisors approval):

- Antonio Alatorre, Clinicas
- Gagan Pawar, MD, Clinicas
- Shawn Atin, Ventura County

New Commissioners being appointed (pending Board of Supervisors approval):

- Johnson Gill, Ventura County
- Theresa Cho, MD, Ventura County
- HASC Nominee (TBD)

DHCS Annual Medical Audit

Audits and Investigations (A&I) conducted the annual onsite medical audit during the weeks of June 5, 2017 through June 16, 2017. Gold Coast Health Plan (GCHP) received the draft report in which A&I identified three findings. The three findings were similar and were all specifically related to medical record documentation. The audit results exemplify the commitment by GCHP staff to ensure sustained contract compliance and program excellence!

GCHP CFO Interviews

On February 9, 2018 interviews were conducted for three potential candidates for the vacant CFO position. The interview panel was comprised of one member of the Board of Commissioners, members of GCHP Executive Staff and the CFO from CenCal Health Plan. The Plan continues to interview other potential candidates.

FOOD Share CAN-Tree Wrap Up Party

On February 8, 2018 GCHP CEO Villani was invited to speak at the wrap up party event. The 6th Annual CAN-tree Drive raised over 200,000 lbs of food to continue to feed our community. FOOD Share received a $150,000 grant from GCHP to provide healthy food distributions, nutrition education, and healthy recipe taste testing throughout Ventura County to improve the health and reduce hunger among food insecure clients including GCHP.

CMS Program of All-Inclusive Care for Elderly (PACE)

The Plan continues to evaluate options for contracting with CMS for a PACE program in Ventura County. We are also considering options for partnering with other organizations in the establishment of a program. Clinicas del Camino Real, Inc submitted a written request to GCHP for approval of their own Clinicas PACE program which we are considering as part of our overall strategy. We will provide more information at the March commission meeting on our recommended PACE strategy. Per DHCS Policy Letter 17-03, DHCS will only consider the operation of a third party PACE organization in a COHS county if the applicant includes a COHS' letter of support.

Excelsior Solutions

Excelsior Solutions is the PBM consultant hired by GCHP and will be presenting separately. Their final report will be presented to the March 26, 2018 commission meeting.

2017/18 Financial Performance

The Plan continues to monitor overall financial performance for the fiscal year. Through December 2017 the medical loss ratio is 96.9% versus budget of 92.6%. The administrative expense ratio is 6.7% versus 7.3% budget. TNE is at 433% of required amount and within approved guidelines. Contract negotiations are currently underway to address unsustainable rates including contingency plans in case negotiations do not result in an agreement.

Alternative Payment Methodologies (APMs)

The Ventura County Board of Supervisors will be voting on February 27 to approve an amendment to the primary care physician's agreement. The amendment will reduce the capitation payment by $0.04 per member per month, effective March 1, 2018. These

additional dollars will be retained in an incentive pool to reward improvements in members HbA1C scores. Other measures across all provider organizations will be rolled out as the plan moves toward value based reimbursement models.

LEGISLATIVE UPDATE:

Congressional Budget Deal

Last week, Congress passed a budget deal that will extend the Children's Health Insurance Program (CHIP) an extra four years of funding—bringing the previous six-year extension to a full decade. The extra extension will save the federal government $6 billion, according to the Congressional Budget Office, because of the coverage it offers for children who would otherwise need to be subsidized on the health exchanges.

Other health-related provisions include:

- Delays the Medicaid Disproportionate Shared Hospital (DSH) cuts by 2 years
- Requires states to count lottery winnings greater than $80,000 as income for Medicaid eligibility
- Requires that, if a Medicaid beneficiary has another source of health care coverage, that source pays (to the extent of its liability) before Medicaid does
- Permanently reauthorizes Special Needs Plans (SNPs)

In Ventura County, extending CHIP will keep approximately 30,000 children insured through Gold Coast Health Plan (GCHP).

White House Proposed Budget for 2019

On Monday, February 12, President Trump released his proposed 2019 budget. Health care programs received major scrutiny, including the largest chunk of savings from repealing and replacing the Affordable Care Act (ACA) — $675 billion, according to the budget documents.

The budget includes $1.4 trillion in reductions to Medicaid, repeal of exchange subsidies after two years and $1.2 trillion in spending increases in the form of "market-based" grants to states. The White House fiscal budget would reduce approximately $199 billion in funding over ten years for the Medicaid-eligible population.

The likelihood of Congress adopting this proposed budget in the current political climate is unlikely, especially in an election year.

California Legislative Update

The Assembly Select Committee on Universal Healthcare held two informational hearings last week. The first hearing focused on implementation barriers to universal coverage. Scott Graves, Director of Research at the California Budget and Policy Center, testified that achieving a single payer health care system would require significant tax increases. He noted that a tax increase of over $100 billion would be needed to help finance a single-payer system. Graves also noted that key provisions of the state Constitution constrain the Legislature's ability to raise taxes and dedicate proceeds to universal health coverage.
The second hearing, focused on proposals by various parties to achieve universal coverage. Health Access, a consumer advocacy group, presented a list of policy options that may manifest into legislation this year. These policy ideas include adjustments to the Medical Loss Ratio, public utility style regulation of health care and prices (New York state has already adopted a similar model to curve pharmacy costs), and limits on mergers and acquisitions. When asked about creating a state-based individual mandate to backfill the loss of the effective federal mandate, Anthony Wright from Health Access, stated that it might work in California depending on how it is enforced.

Committee Co-Chair Dr. Jim Wood noted that additional hearings could be held if needed. The committee is working with the University of California to release its recommendations on how to proceed toward a universal healthcare strategy in a few months.

For additional information on state policy initiatives, see the attached report from GCHP's lobbyists.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

Gold Coast Health Plan Legislative Report
By Don Gilbert and Trent Smith
February 9, 2018

While the Legislature has returned to Sacramento to begin the second year of its two-year session, it remains relatively quiet for the time being. It can best be described as the calm before the storm. The deadline to introduce new bills is February 16. Newly introduced bills are trickling in, but a vast majority will be introduced between February 12 and 16. In fact, if past years are any indication, close to one thousand bills could be introduced during the deadline week.

While the Legislature waits for the flood of new bills, the Senate and Assembly Health Committees have been holding joint hearings to study the concept of universal health care. The hearings have been very lively, with supporters of universal health care packing the hearing room and providing very colorful testimony. It is unlikely that a universal health care bill will pass this year. However, we expect bills will be introduced in the coming weeks that propose expanding healthcare to unserved populations. For example, SB 974 (Lara) was recently introduced. This bill proposes expanding Medi-Cal eligibility to adult undocumented immigrants.

In addition, we believe a bill will be introduced to allow individuals who do not meet the current financial criteria required for Medi-Cal eligibility to purchase Medi-Cal coverage by paying premiums to Medi-Cal managed care plans. This proposal was debated briefly in one of the joint health committee hearings on universal health care. The debate focused on the good job that public Medi-Cal managed care plans do in providing quality care to their enrollees. Thus, some have advocated for expanding the role of public Medi-Cal managed care plans to include private pay members. Obviously, we will be very involved if a bill such as this is introduced.

Another issue that is generating a lot of interest among legislators is prescription opioid abuse. There have been several informational hearings on the issue and many bills will be introduced in an attempt to combat the over subscribing and abuse of prescription opioids. We expect a bill will be introduced to require physicians to prescribe all drugs electronically to the pharmacy, rather than allowing paper prescriptions. While electronic prescribing is a common practice among many physicians, experts still believe that paper prescriptions are still a source of fraud and abuse.

Bills will also be introduced to limit the initial quantity of prescription opioids. One bill, AB 1998 (Rodriguez), has already been introduced and proposes to limit, to three days, the initial prescription of opioids. However, a physician would be able to use their professional judgement to write a prescription for a greater amount as long as justification is included in the patient's medical file. We also understand a similar bill will be introduced to establish the initial prescription limit to seven days.

With a $19 billion state budget surplus, we are also expecting the introduction of bills that will increase Medi-Cal benefits or expand Medi-Cal eligibility in some manner. For example, AB 1785 (Nazarian) has already been introduced to exclude 529 college savings accounts from being considered as part of the income and asset test used to determine Medi-Cal eligibility.

A bill focused on addressing both opioid abuse and Medi-Cal reimbursement is AB 1963 (Waldron). This measure would increase Medi-Cal reimbursement for medications and treatments used to address opioid addiction.

We will continue to monitor the debate on the Governor's proposal to restrict 340B Drug Reimbursement within the Medi-Cal program. Budget hearings to review this proposal will begin in March.

COMPLIANCE **UPDATE:**

DHCS Annual Medical Audit

Audits and Investigations (A&I) conducted the annual onsite medical audit from June 5, 2017 through June 16, 2017. Gold Coast Health Plan (GCHP) received the draft report in which A&I identified (3) three findings. The three findings were similar and were all specifically relative to medical records. Providers sampled did not indicate in the medical chart referrals and follow up from referrals, within medical records for services such as CCS and Behavioral Health. The audit results exemplify the commitment by GCHP staff to ensure sustained contract compliance.

DHCS Contract Amendments & Regulatory Updates

The draft DHCS Final Rule contract amendment (version 3) was sent to Plans on January 22, 2018. The amendment is still pending CMS approval. The Plan is in anticipation of receiving the final amendment for signature. The amendment incorporates approximately 156 Mega Reg provisions. Approximately 63 items remained TBD for the State to define and 28 items are TBD and not in the contract amendment. The Department of Health Care Services (DHCS) has published several All Plan Letters incorporating final rule provisions. Staff is actively working on deliverables associated with the All Plan Letters. GCHP was required to submit Final Rule (Mega Reg) deliverables to DHCS based on the draft contract amendment in May 2017. Additional provisions and requirements will be forthcoming via additional contract amendments, All Plan Letters, policy letters etc.

The Compliance Committee met on February 1, 2018 and approved an updated Compliance Committee Charter that reflects changes based on the final rule amendment and incorporated additional leadership committee members. The committee reviewed delegation oversight activities, GCHP privacy program and work plan, fraud waste and abuse cases, and required compliance trainings including AB1234, fraud waste and abuse and HIPAA.

Delegation Oversight

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

Audits Conducted in Q4 2017 & Beginning of Q1 2018

Delegate Name	Audit Type	Audit Date	Status
Beacon Health Options	Clinical; QI, UM, RR	February 2018	Open
Conduent	2017 Annual Claims	April 2017	Open
CHLA	2017 Credentialing	November 2017	Closed
Clinicas del Camino Real, Inc.	2017 Annual Claims	November 2017	Closed
	2018 Credentialing	January 2018	Closed
	Clinical; UM	January 2018	Open
Vision Service Plan	2017 Claims	December 2017	Open
Kaiser	2017 Annual Claims	December 2017 & January 2018	Open
USC	Credentialing	February 2018	Open

***Open:** Audit is completed and results are in process or GCHP issued a CAP and a response is pending.

AGENDA ITEM NO. 3

To: Ventura County Medi-Cal Managed Care Commission

From: Anne Freese, PharmD, Director of Pharmacy

Date: February 26, 2018

RE: Excelsior Solutions

SUMMARY:

Kim Foerster, Vice President, and Ken Dowell, Chair Pharmacy Analytics Board, from Excelsior Solutions will give a verbal presentation to the commission.

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Lyndon Turner, Interim Chief Financial Officer

DATE: February 26, 2018

SUBJECT: December 2017 Fiscal Year to Date Financials

SUMMARY:

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

BACKGROUND/DISCUSSION:

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

FISCAL IMPACT:

Financial Highlights

Overall Performance – For the six month period ended December 31, 2017, the Plan's performance was a decrease in net assets of $11 million, which was $11.9 million higher than budget. Results also included the effect of AB85 Cost Balance revenue and payments, which benefited net assets by $2.8 million. Cost of health care was higher than budget by $34 million, which was driven by higher contracted rates. The medical loss ratio increased to 96.9 percent of revenue, which was 4.3 percent higher than the budget. Administrative savings were realized through lower than projected administrative expenses. The administrative cost ratio was 0.06 percent lower than budget.

Membership – December membership of 204,403 was 306 members higher than budget.

Revenue – December FYTD net revenue was $362.7 million or $19.9 million higher than budget. On a PMPM basis, revenue was $16.65 PMPM above budget due to membership mix, with higher than expected Adult Expansion membership. FYTD net revenue also included AB85 Cost Balance revenue of $17.1 million.

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

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

Health Care Costs – December FYTD health care costs were $351.4 million or $34 million higher than budget. The medical loss ratio (MLR) was 96.9 percent versus 92.6 percent for budget. Health Care Costs also included AB85 Cost Balance payments of $14.3 million. Without the effect of the AB85 payments and associated revenue, the MLR would have been 97.5 percent.

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

	Expansion Population				Classic Population
	1/1/2014 - 6/30/2015 MLR Period 1	7/1/2015 - 6/30/2016 MLR Period 2	7/1/2016 - 6/30/2017 MLR Period 3	7/1/2016 - 12/31/17 MLR Period 4	7/1/2016 - 12/31/17
Total Revenue	361,237,234	293,173,426	268,060,238	159,713,830	213,739,813
Total Estimated Medical Expense	206,719,452	237,729,974	234,431,483	142,647,464	208,901,086
	57.2%	81.1%	87.5%	89.3%	97.7%
Total MLR Reserve	**118,418,494**	**23,601,452**			

Administrative Expenses – For the fiscal year ended December 31, administrative costs were $24.3 million or $744,000 below budget. As a percentage of revenue, administrative costs (or ACR) were 6.7 percent versus 7.3 percent for budget.

Cash and Medi-Cal Receivable – At December 31, the Plan had $409.9 million in cash and short-term investments and $62.1 million in Medi-Cal Receivable for an aggregate amount of $472 million. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $187.9 million. For the fiscal year-to-date through December, the State has recouped a total of $106.2 million related to AE rate overpayment.

Investment Portfolio – At December 31, 2017, the value of the investments (all short term) was $231.2 million. The portfolio included Cal Trust $51.2 million; Ventura County Investment Pool $86.3 million; LAIF CA State $63.8 million; Bonds and Commercial Paper $30 million, and the portfolio yielded a rate of 1.23%.

RECOMMENDATION:

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

CONCURRENCE:

N/A

ATTACHMENT:

December 2017 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended December 31, 2017

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Description	AUDITED	AUDITED	FY 2017-18					Budget Comparison	
	FY 2015-16	FY 2016-17	JUL - SEP 17	Oct-17	Nov-17	Dec-17	FYTD DEC 17	Budget FYTD	Variance Fav / (Unfav)
Member Months	**2,413,136**	**2,485,202**	**613,774**	**204,538**	**202,667**	**204,403**	**1,225,382**	**1,227,291**	(1,909)
Revenue	**675,629,602**	**680,255,278**	**173,265,018**	**74,757,460**	**57,038,772**	**57,642,394**	**362,703,644**	**342,830,341**	19,873,302
pmpm	*279.98*	*273.72*	*282.29*	*365.49*	*281.44*	*282.00*	*295.99*	*279.34*	16.65
Health Care Costs	**583,149,780**	**645,931,276**	**168,295,943**	**72,669,165**	**54,812,607**	**55,624,784**	**351,402,499**	**317,353,853**	(34,048,646)
pmpm	*241.66*	*259.91*	*274.20*	*355.28*	*270.46*	*272.13*	*286.77*	*258.58*	(28.19)
% of Revenue	86.3%	95.0%	97.1%	97.2%	96.1%	96.5%	96.9%	92.6%	-4.3%
Admin Exp	**38,256,908**	**51,176,317**	**12,381,259**	**4,073,448**	**3,842,595**	**3,975,794**	**24,273,096**	**25,017,415**	744,318
pmpm	*15.85*	*20.59*	*20.17*	*19.92*	*18.96*	*19.45*	*19.81*	*20.38*	0.58
% of Revenue	5.7%	7.5%	7.1%	5.4%	6.7%	6.9%	6.7%	7.3%	0.6%
Non-Operating Revenue / (Expense)	**1,790,949**	**3,254,139**	**913,559**	**379,051**	**371,031**	**334,948**	**1,998,590**	**457,107**	1,541,483
pmpm	*0.74*	*1.31*	*1.49*	*1.85*	*1.83*	*1.64*	*1.63*	*0.37*	1.26
% of Revenue	0.3%	0.5%	-0.5%	-0.5%	-0.7%	-0.6%	-0.6%	-0.1%	-0.4%
Total Increase / (Decrease) in Unrestricted Net Assets	**56,013,863**	**(13,598,175)**	**(6,498,625)**	**(1,606,101)**	**(1,245,399)**	**(1,623,236)**	**(10,973,362)**	**916,181**	(11,889,543)
pmpm	*23.21*	*(5.47)*	*(10.59)*	*(7.85)*	*(6.15)*	*(7.94)*	*(8.96)*	*0.75*	(9.70)
% of Revenue	8.3%	2.0%	-3.8%	-2.1%	-2.2%	-2.8%	-3.0%	0.3%	3.3%
YTD									
100% TNE	25,246,284	29,231,052	29,888,218	30,584,422	30,176,111	30,344,434	30,344,434	29,512,538	831,896
% TNE Required	100%	100%	100%	100%	100%	100%	100%	100%	
Minimum Required TNE	25,246,284	29,231,052	29,888,218	30,584,422	30,176,111	30,344,434	30,344,434	29,512,538	831,896
GCHP TNE	**155,959,127**	**142,360,951**	**135,862,326**	**134,256,225**	**133,010,826**	**131,387,590**	**131,387,590**	**143,277,132**	(11,889,542)
TNE Excess / (Deficiency)	**130,712,843**	**113,129,900**	**105,974,109**	**103,671,803**	**102,834,716**	**101,043,156**	**101,043,156**	**113,764,594**	(12,721,438)
% of Required TNE level	**618%**	**487%**	**455%**	**439%**	**441%**	**433%**	**433%**	**485%**	

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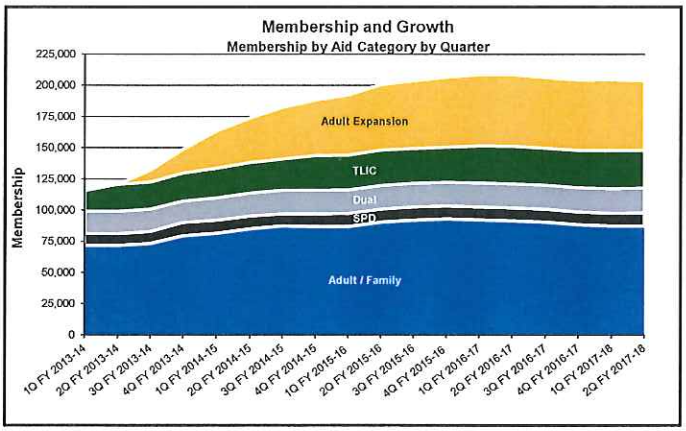
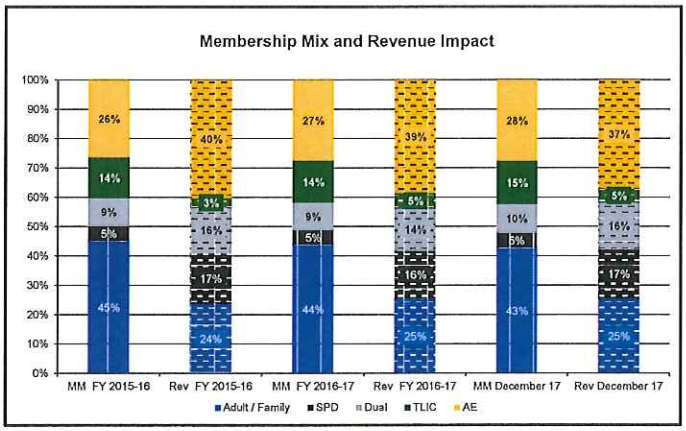
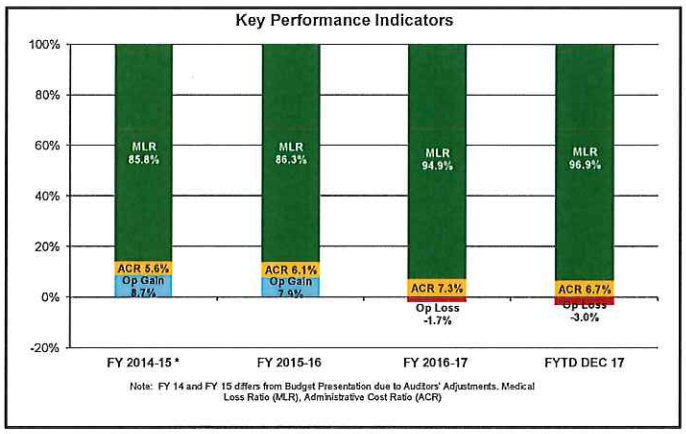
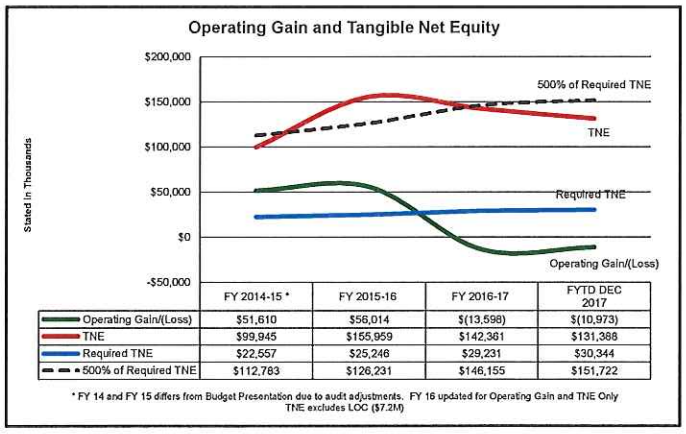
FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING DECEMBER 31, 2017









	FY 2014-15 *	FY 2015-16	FY 2016-17	FYTD DEC 2017
Operating Gain/(Loss)	$51,610	$56,014	$(13,598)	$(10,973)
TNE	$99,945	$155,959	$142,361	$131,388
Required TNE	$22,557	$25,246	$29,231	$30,344
500% of Required TNE	$112,783	$126,231	$146,155	$151,722

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

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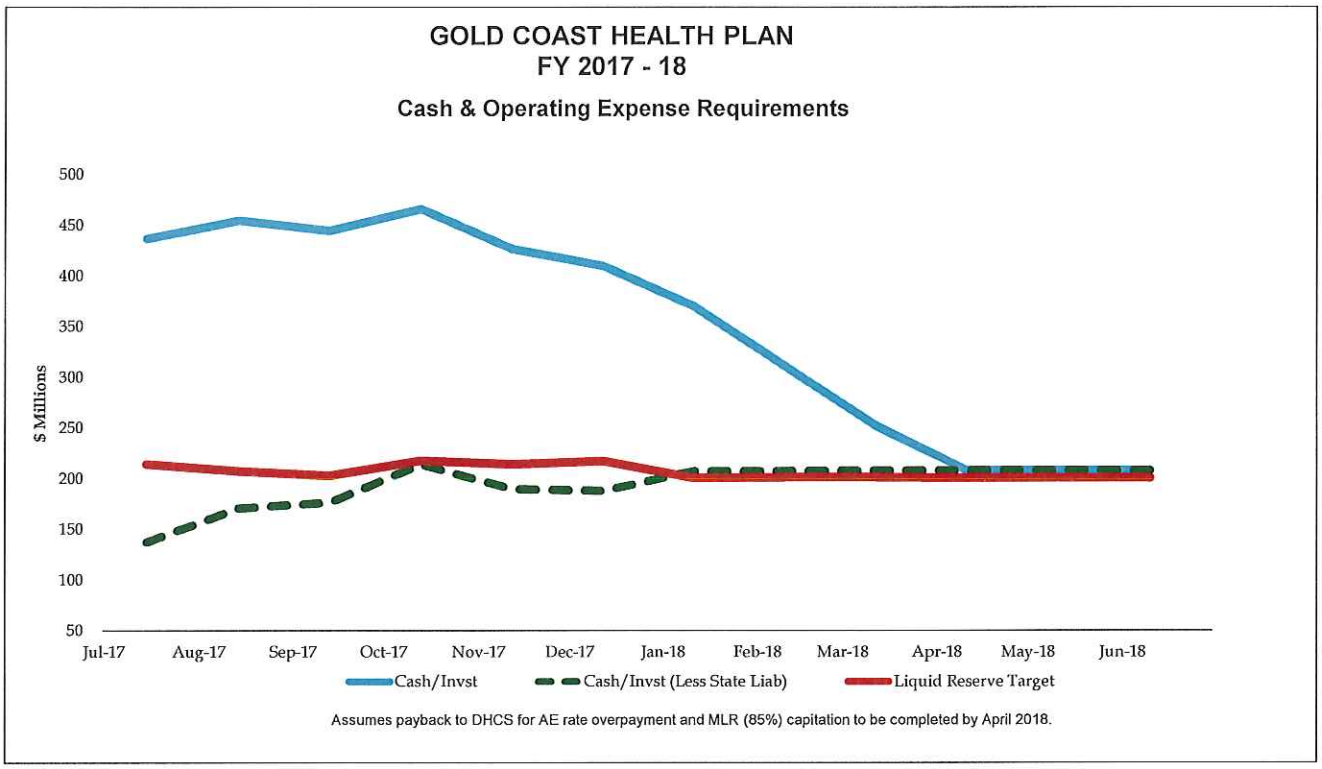

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Gold Coast Health Plan℠
A Public Entity

For the month ended December 31, 2017

APPENDIX

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

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STATEMENT OF FINANCIAL POSITION

	12/31/17	11/30/17	10/31/17
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	$ **178,672,343**	$ **190,572,563**	$ **230,002,639**
Total Short-Term Investments	**231,223,903**	**236,164,814**	**236,051,645**
Medi-Cal Receivable	62,059,112	59,013,523	57,388,453
Interest Receivable	474,424	576,773	490,150
Provider Receivable	490,133	490,091	570,999
Other Receivables	1,500,000	1,500,000	1,500,000
Total Accounts Receivable	**64,523,669**	**61,580,387**	**59,949,601**
Total Prepaid Accounts	1,520,085	1,604,421	1,665,727
Total Other Current Assets	135,560	135,560	135,560
Total Current Assets	**476,075,561**	**490,057,745**	**527,805,173**
Total Fixed Assets	**2,089,355**	**2,127,863**	**2,172,200**
Total Assets	$ **478,164,916**	$ **492,185,608**	$ **529,977,373**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 51,879,606	$ 49,824,137	$ 59,796,861
Claims Payable	17,934,796	23,392,054	26,952,345
Capitation Payable	57,375,799	57,335,118	57,348,334
AB 85 Payable	0	0	14,314,921
DHCS - Reserve for Capitation Recoup	142,019,946	142,019,946	142,019,946
Accounts Payable	405,286	2,280,817	2,708,446
Accrued ACS	1,678,706	1,651,499	1,685,026
Accrued Expenses	49,812,370	64,416,257	79,311,619
Accrued Premium Tax	23,706,812	16,261,471	9,036,636
Accrued Payroll Expense	944,054	973,259	1,526,518
Total Current Liabilities	**345,757,375**	**358,154,558**	**394,700,651**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	1,019,951	1,020,224	1,020,497
Total Long-Term Liabilities	**1,019,951**	**1,020,224**	**1,020,497**
Total Liabilities	**346,777,326**	**359,174,782**	**395,721,148**
Net Assets:			
Beginning Net Assets	142,360,951	142,360,951	142,360,951
Total Increase / (Decrease in Unrestricted Net Assets)	(10,973,362)	(9,350,125)	(8,104,726)
Total Net Assets	**131,387,590**	**133,010,826**	**134,256,225**
Total Liabilities & Net Assets	$ **478,164,916**	$ **492,185,608**	$ **529,977,373**

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STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR SIX MONTHS ENDED DECEMBER 31, 2017

	December 2017 Year-To-Date		Variance	December 2017 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	1,225,382	1,227,291	(1,909)		PMPM - FYTD	
Revenue						
Premium	$ 418,125,696	$ 390,035,254	$ 28,090,443	$ 341.22	$ 317.80	$ 23.42
Reserve for Rate Reduction	(10,750,000)	0	(10,750,000)	(8.77)	-	(8.77)
MCO Premium Tax	(44,672,053)	(47,204,912)	2,532,859	(36.46)	(38.46)	2.01
Total Net Premium	**362,703,644**	**342,830,341**	**19,873,302**	**295.99**	**279.34**	**16.65**
Total Revenue	**362,703,644**	**342,830,341**	**19,873,302**	**295.99**	**279.34**	**16.65**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	31,383,182	32,446,854	1,063,672	25.61	26.44	0.83
FFS Claims Expenses:						
Inpatient	68,507,293	65,627,625	(2,879,668)	55.91	53.47	(2.43)
LTC / SNF	59,428,428	57,844,078	(1,584,350)	48.50	47.13	(1.37)
Outpatient	29,841,614	25,895,753	(3,945,861)	24.35	21.10	(3.25)
Laboratory and Radiology	2,790,257	1,372,168	(1,418,089)	2.28	1.12	(1.16)
Emergency Room	15,435,135	12,543,283	(2,891,852)	12.60	10.22	(2.38)
Physician Specialty	27,779,130	25,595,245	(2,183,886)	22.67	20.86	(1.81)
Primary Care Physician	8,392,016	7,262,859	(1,129,156)	6.85	5.92	(0.93)
Home & Community Based Services	7,995,458	9,124,304	1,128,846	6.52	7.43	0.91
Applied Behavior Analysis Services	3,687,285	2,341,816	(1,345,470)	3.01	1.91	(1.10)
Mental Health Services	3,286,973	4,668,889	1,381,915	2.68	3.80	1.12
Facility Expense AB85	14,314,921	0	(14,314,921)	11.68	-	(11.68)
Pharmacy	64,510,621	55,829,764	(8,680,857)	52.65	45.49	(7.16)
Other Medical Professional	1,731,317	2,397,911	666,594	1.41	1.95	0.54
Other Medical Care	17,157	0	(17,157)	0.01	-	(0.01)
Other Fee For Service	5,143,218	3,971,577	(1,171,641)	4.20	3.24	(0.96)
Transportation	1,178,092	732,877	(445,214)	0.96	0.60	(0.36)
Total Claims	314,038,916	275,208,148	(38,830,768)	256.28	224.24	(32.04)
Medical & Care Management Expense	5,511,804	7,011,083	1,499,279	4.50	5.71	1.21
Reinsurance	1,513,645	2,687,767	1,174,122	1.24	2.19	0.95
Claims Recoveries	(1,045,048)	0	1,045,048	(0.85)	-	0.85
Sub-total	5,980,401	9,698,851	3,718,450	4.88	7.90	3.02
Total Cost of Health Care	**351,402,499**	**317,353,853**	**(34,048,646)**	**286.77**	**258.58**	**(28.19)**
Contribution Margin	**11,301,145**	**25,476,488**	**(14,175,344)**	**9.22**	**20.76**	**44.84**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	11,179,057	11,925,450	746,393	9.12	9.72	0.59
Training, Conference & Travel	118,866	363,599	244,733	0.10	0.30	0.20
Outside Services	12,968,986	13,822,259	853,273	10.58	11.26	0.68
Professional Services	1,747,626	1,740,151	(7,476)	1.43	1.42	(0.01)
Occupancy, Supplies, Insurance & Others	3,472,111	4,177,039	704,928	2.83	3.40	0.57
ARCH/Community Grants	298,254	0	(298,254)	0.24	-	(0.24)
Care Management Credit	(5,511,804)	(7,011,083)	(1,499,279)	(4.50)	(5.71)	(1.21)
Total G & A Expenses	**24,273,096**	**25,017,415**	**744,318**	**19.81**	**20.38**	**0.58**
Total Operating Gain / (Loss)	**$ (12,971,951)**	**$ 459,074**	**$ (13,431,025)**	**$ (10.59)**	**$ 0.37**	**$ (10.96)**
Non Operating						
Revenues - Interest	1,998,590	457,107	1,541,483	1.63	0.37	1.26
Total Non-Operating	1,998,590	457,107	1,541,483	1.63	0.37	1.26
Total Increase / (Decrease) in Unrestricted Net Assets	**$ (10,973,362)**	**$ 916,181**	**$ (11,889,543)**	**(8.96)**	**0.75**	**(9.70)**
Net Assets, Beginning of Year	142,360,951					
Net Assets, End of Current Period	131,387,590					

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STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2017-18 Monthly Trend			Current Month		
	Sep 17	Oct 17	Nov 17	DECEMBER 2017 Actual	DECEMBER 2017 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	205,695	204,538	202,667	204,403	204,097	306
Revenue:						
Premium	$ 65,515,904	$ 92,952,801	$ 64,484,113	$ 65,087,735	$ 64,814,021	$ 273,714
Reserve for Rate Reduction	0	(10,750,000)	0	0	0	0
MCO Premium Tax	(7,445,348)	(7,445,341)	(7,445,341)	(7,445,341)	(7,850,119)	404,779
Total Net Premium	**58,070,555**	**74,757,460**	**57,038,772**	**57,642,394**	**56,963,901**	**678,493**
Total Revenue	**58,070,555**	**74,757,460**	**57,038,772**	**57,642,394**	**56,963,901**	**678,493**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,195,341	5,366,499	5,227,460	5,234,149	5,384,095	149,946
FFS Claims Expenses:						
Inpatient	8,207,433	11,632,587	12,494,725	12,655,214	10,893,684	(1,761,530)
LTC / SNF	9,284,303	9,603,109	8,808,642	11,015,363	9,610,157	(1,405,206)
Outpatient	4,754,839	5,713,292	5,508,393	4,802,540	4,301,804	(500,736)
Laboratory and Radiology	322,764	768,075	401,544	515,260	227,984	(287,276)
Emergency Room	3,095,278	2,747,716	2,342,990	2,151,239	2,081,830	(69,408)
Physician Specialty	4,415,312	5,180,091	4,507,849	4,486,463	4,253,282	(233,182)
Primary Care Physician	1,815,495	1,434,420	1,480,044	957,226	1,206,782	249,556
Home & Community Based Services	1,489,103	1,333,942	1,529,513	1,491,381	1,525,872	34,492
Applied Behavior Analysis Services	597,717	448,868	784,599	470,711	389,012	(81,700)
Mental Health Services	480,327	637,050	581,836	496,304	774,818	278,514
Facility Expense AB85	0	14,314,921	0	0	0	0
Pharmacy	10,672,826	10,826,820	8,972,076	9,365,918	9,260,879	(105,039)
Other Medical Professional	266,673	351,173	313,076	218,914	398,649	179,735
Other Medical Care	0	6,757	0	4,160	0	(4,160)
Other Fee For Service	811,715	923,020	896,590	749,390	660,433	(88,956)
Transportation	174,290	308,692	172,707	127,120	121,501	(5,619)
Total Claims	46,388,074	66,230,534	48,794,585	49,507,201	45,706,687	(3,800,514)
Medical & Care Management Expense	945,798	913,362	950,184	823,748	1,149,661	325,913
Reinsurance	253,422	253,413	252,801	250,746	446,972	196,227
Claims Recoveries	(175,499)	(94,644)	(412,425)	(191,059)	0	191,059
Sub-total	1,023,721	1,072,131	790,561	883,435	1,596,633	713,199
Total Cost of Health Care	**52,607,136**	**72,669,165**	**54,812,607**	**55,624,784**	**52,687,415**	**(2,937,369)**
Contribution Margin	**5,463,419**	**2,088,295**	**2,226,165**	**2,017,609**	**4,276,486**	**(2,258,877)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	1,898,872	1,874,076	1,895,317	1,778,120	2,021,649	243,529
Training, Conference & Travel	23,568	29,532	12,926	9,486	35,326	25,840
Outside Services	2,179,263	2,226,128	2,194,591	2,071,996	2,298,591	226,595
Professional Services	335,641	286,718	186,051	237,704	280,208	42,504
Occupancy, Supplies, Insurance & Others	526,862	570,355	503,894	702,236	599,996	(102,241)
ARCH/Community Grants	0	0	0	0	0	0
Care Management Credit	(945,798)	(913,362)	(950,184)	(823,748)	(1,149,661)	(325,913)
Total G & A Expenses	**4,018,408**	**4,073,448**	**3,842,595**	**3,975,794**	**4,086,109**	**110,315**
Total Operating Gain / (Loss)	**1,445,011**	**(1,985,152)**	**(1,616,430)**	**(1,958,185)**	**190,377**	**(2,148,562)**
Non Operating:						
Revenues - Interest	328,847	379,051	371,031	334,948	75,952	258,996
Total Non-Operating	**328,847**	**379,051**	**371,031**	**334,948**	**75,952**	**258,996**
Total Increase / (Decrease) in Unrestricted Net Assets	**1,773,858**	**(1,606,101)**	**(1,245,399)**	**(1,623,236)**	**266,329**	**(1,889,565)**
Full Time Employees				**183**	**191**	**8**

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

	FY 2017-18 Monthly Trend			DECEMBER 2017		Variance
	Sep 17	Oct 17	Nov 17	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	205,695	204,538	202,667	204,403	204,097	306
Revenue:						
Premium	318.51	454.45	318.18	318.43	317.56	0.86
MCO Premium Tax	(36.20)	(36.40)	(36.74)	(36.42)	(38.46)	2.04
Total Net Premium	**282.31**	**365.49**	**281.44**	**282.00**	**279.10**	**2.90**
Total Revenue	**282.31**	**365.49**	**281.44**	**282.00**	**279.10**	**2.90**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	25.26	26.24	25.79	25.61	26.38	0.77
FFS Claims Expenses:						
Inpatient	39.90	56.87	61.65	61.91	53.38	(8.54)
LTC / SNF	45.14	46.95	43.46	53.89	47.09	(6.80)
Outpatient	23.12	27.93	27.18	23.50	21.08	(2.42)
Laboratory and Radiology	1.57	3.76	1.98	2.52	1.12	(1.40)
Physician ACA 1202	0.00	0.00	0.00	0.00	0.00	0.00
Emergency Room	15.05	13.43	11.56	10.52	10.20	(0.32)
Physician Specialty	21.47	25.33	22.24	21.95	20.84	(1.11)
Primary Care Physician	8.83	7.01	7.30	4.68	5.91	1.23
Home & Community Based Services	7.24	6.52	7.55	7.30	7.48	0.18
Applied Behavior Analysis Services	2.91	2.19	3.87	2.30	1.91	(0.40)
Mental Health Services	2.34	3.11	2.87	2.43	3.80	1.37
Pharmacy	51.89	52.93	44.27	45.82	45.37	(0.45)
Provider Reserve	0.00	0.00	0.00	0.00	0.00	0.00
Other Medical Professional	1.30	1.72	1.54	1.07	1.95	0.88
Other Medical Care	0.00	0.03	0.00	0.02	0.00	(0.02)
Other Fee For Service	3.95	4.51	4.42	3.67	3.24	(0.43)
Transportation	0.85	1.51	0.85	0.62	0.60	(0.03)
Total Claims	225.52	323.81	240.76	242.20	223.95	(18.26)
Medical & Care Management Expense	4.60	4.47	4.69	4.03	5.63	1.60
Reinsurance	1.23	1.24	1.25	1.23	2.19	0.96
Claims Recoveries	(0.85)	(0.46)	(2.03)	(0.93)	0.00	0.93
Sub-total	4.98	5.24	3.90	4.32	7.82	3.50
Total Cost of Health Care	255.75	355.28	270.46	272.13	**258.15**	**(13.98)**
Contribution Margin	**26.56**	**10.21**	**10.98**	**9.87**	**20.95**	**(11.08)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	9.23	9.16	9.35	8.70	9.91	1.21
Training, Conference & Travel	0.11	0.14	0.06	0.05	0.17	0.13
Outside Services	10.59	10.88	10.83	10.14	11.26	1.13
Professional Services	1.63	1.40	0.92	1.16	1.37	0.21
Occupancy, Supplies, Insurance & Others	2.56	2.79	2.49	3.44	2.94	(0.50)
ARCH/Community Grants	0.00	0.00	0.00	0.00	0.00	0.00
Care Management Credit	(4.60)	(4.47)	(4.69)	(4.03)	(5.63)	(1.60)
Total G & A Expenses	19.54	19.92	18.96	19.45	20.02	0.57
Total Operating Gain / (Loss)	7.03	(9.71)	(7.98)	(9.58)	0.93	(10.51)
Non Operating:						
Revenues - Interest	1.60	1.85	1.83	1.64	0.37	1.27
Total Non-Operating	1.60	1.85	1.83	1.64	0.37	1.27
Total Increase / (Decrease) in Unrestricted Net Assets	8.62	(7.85)	(6.15)	(7.94)	1.30	(9.25)

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STATEMENT OF CASH FLOWS	Oct 17	Nov 17	Dec 17	FYTD 17-18
Cash Flows Provided By Operating Activities				
Net Income (Loss)	(1,606,101)	(1,245,399)	(1,623,236)	(10,973,362)
Adjustments to reconciled net income to net cash provided by operating activities				
Depreciation on fixed assets	44,337	44,337	44,398	266,351
Amortization of discounts and premium	(1,449)	(16,909)	(186,589)	(282,196)
Changes in Operating Assets and Liabilites				-
Accounts Receivable	34,870,655	(1,630,786)	(2,943,282)	63,180,721
Prepaid Expenses	(51,346)	61,307	84,336	1,978,912
Accounts Payable	(7,191,110)	(30,224,970)	(16,481,689)	(99,980,971)
Claims Payable	3,300,274	(3,573,507)	(5,416,578)	(4,885,503)
MCO Tax liablity	(11,456,128)	7,224,835	7,445,341	4,531,087
IBNR	3,451,153	(9,972,724)	2,055,469	(1,486,741)
Net Cash Provided by Operating Activities	21,360,284	(39,333,816)	(17,021,830)	(47,651,701)
Cash Flow Provided By Investing Activities				
Proceeds from Restricted Cash & Other Assets				
Proceeds from Investments	45,000,000		35,000,000	149,000,000
Proceeds for Sales of Property, Plant and Equipment				-
Payments for Restricted Cash and Other Assets	-			-
Purchase of Investments	(30,153,687)	(96,261)	(29,872,500)	(100,484,039)
Purchase of Property and Equipment	-		(5,890)	(13,640)
Net Cash (Used In) Provided by Investing Activities	14,846,313	(96,261)	5,121,610	48,502,321
Cash Flow Provided By Financing Activities				
None	-	-	-	-
Net Cash Used In Financing Activities	-	-	-	-
Increase/(Decrease) in Cash and Cash Equivalents	36,206,598	(39,430,076)	(11,900,220)	850,620
Cash and Cash Equivalents, Beginning of Period	193,796,041	230,002,639	190,572,563	177,821,723
Cash and Cash Equivalents, End of Period	230,002,639	190,572,563	178,672,343	178,672,343

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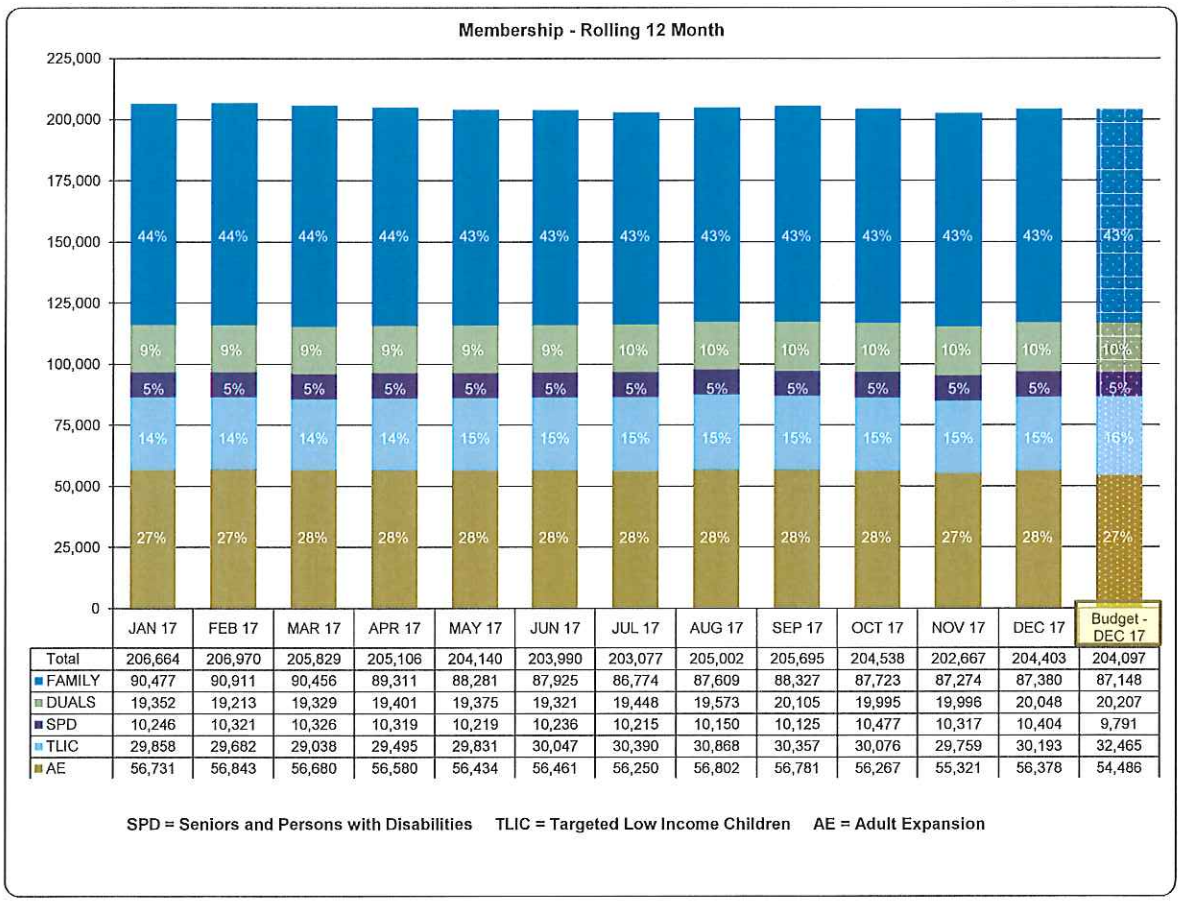
GOLD COAST HEALTH PLAN



	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17	JUL 17	AUG 17	SEP 17	OCT 17	NOV 17	DEC 17	Budget - DEC 17
Total	206,664	206,970	205,829	205,106	204,140	203,990	203,077	205,002	205,695	204,538	202,667	204,403	204,097
FAMILY	90,477	90,911	90,456	89,311	88,281	87,925	86,774	87,609	88,327	87,723	87,274	87,380	87,148
DUALS	19,352	19,213	19,329	19,401	19,375	19,321	19,448	19,573	20,105	19,995	19,996	20,048	20,207
SPD	10,246	10,321	10,326	10,319	10,219	10,236	10,215	10,150	10,125	10,477	10,317	10,404	9,791
TLIC	29,858	29,682	29,038	29,495	29,831	30,047	30,390	30,868	30,357	30,076	29,759	30,193	32,465
AE	56,731	56,843	56,680	56,580	56,434	56,461	56,250	56,802	56,781	56,267	55,321	56,378	54,486

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

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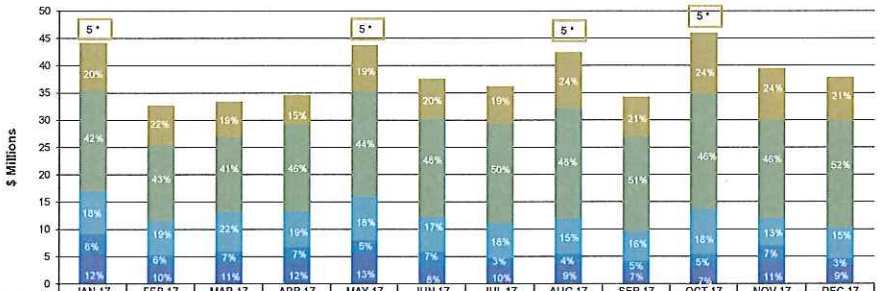
GOLD COAST HEALTH PLAN
DECEMBER 2017

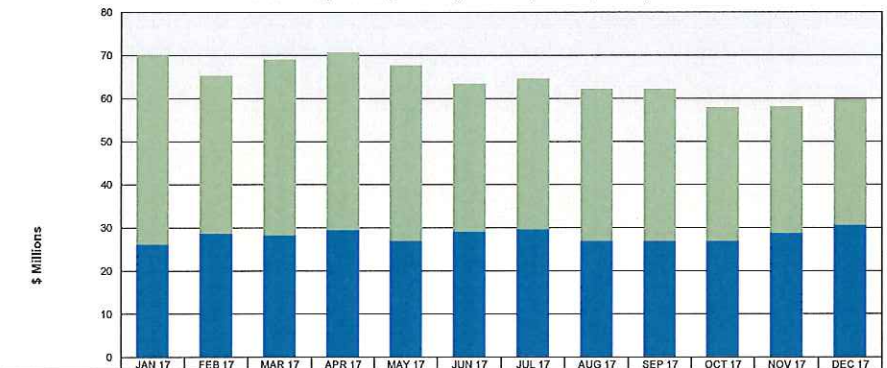
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17	JUL 17	AUG 17	SEP 17	OCT 17	NOV 17	DEC 17
Current	8.76	7.17	6.49	5.35	8.44	7.35	6.89	10.23	7.37	11.19	9.47	7.95
30	18.43	14.01	13.80	16.01	19.39	17.97	18.24	20.24	17.35	21.23	18.00	19.65
60	7.87	6.24	7.21	6.47	7.96	6.35	6.40	6.53	5.42	8.14	5.06	5.69
90	3.73	1.87	2.23	2.59	2.31	2.76	1.19	1.50	1.71	2.27	2.79	1.25
120+	5.42	3.42	3.70	4.16	5.69	3.13	3.49	3.95	2.45	3.19	4.19	3.31

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

IBNP Composition (excluding Pharmacy and Capitation)



	JAN 17	FEB 17	MAR 17	APR 17	MAY 17	JUN 17	JUL 17	AUG 17	SEP 17	OCT 17	NOV 17	DEC 17
Prior Month Unpaid	43.98	36.66	40.73	41.27	40.74	34.37	35.01	35.32	35.32	31.13	29.42	29.23
Current Month Unpaid	26.14	28.68	28.34	29.47	26.99	29.07	29.65	26.89	26.89	26.87	28.73	30.58
Total Unpaid	62.14	65.34	69.07	70.74	67.73	63.44	64.65	62.21	62.21	58.00	58.15	59.81

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

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AGENDA ITEM NO. 5

To: Gold Coast Health Plan Commission

From: Dale Villani, Chief Executive Officer

Date: February 26, 2018

RE: FY2016-17 AB85 Cost Balance Medi-Cal Funds through an Intergovernmental Transfer

SUMMARY:

Authorize and direct the Chief Executive Officer to execute the Health Plan Provider Agreement between Gold Coast Health Plan and the County of Ventura to secure additional FY2016-17 funding for Optional Medi-Cal Expansion members under Assembly Bill 85.

BACKGROUND:

Intergovernmental Transfers (IGTs) are a mechanism for Medi-Cal managed care plans, counties and certain types of public hospitals to work with the State of California to bring additional funding, including federal Medicaid matching dollars, to the local level.

To accomplish an IGT, a "funding entity" provides funds to the State Department of Health Care Services (DHCS). A funding entity can be counties, cities and State University teaching hospitals, or any other political subdivision of the State, as long as they meet the requirements as defined by 42 C.F.R. Section 433, Subpart B for the funding of IGTs. The federal government then matches those funds according to a set formula. The State uses these combined funds to increase the rates it pays to the local Medi-Cal managed care plan consistent with the Plan's actuarially determined payment rates. The funding entity recoups the original outlay of funds and the federal match to those funds.

Assembly Bill 85 (Chapter 24, Statutes of 2013) also provides for voluntary Intergovernmental Transfers (IGT) to support payments to Medi-Cal managed care plans under Welfare and Institutions (W&I) Code, sections 14199.2 and 14301.5. These programs allow for IGTs to provide a portion of the non-federal share of the risk-based payments to managed care health plans as described in W&I Code, section 14199.2(e)(1) and 14301.5(b)(4).

DISCUSSION:

On February 9th, DHCS communicated directly with the funding entity to secure a non-binding commitment letter, a draft IGT agreement and a draft Health Plan Provider Agreement. The proposed IGT is a mechanism to provide a portion of the AB85 "Cost Balance" payments to the

local funding entity for reimbursement of Optional Medi-Cal Expansion expenditures for FY2016-17. The total amount had been previously estimated by DHCS actuaries and communicated to the Plan during July, 2017. The final IGT is expected to contain amounts for the Cost Balance payment as well as minor capitation rate adjustments for the period of July 1, 2016 through June 30, 2017. The local government's non-federal share contribution is expected to be approximately 5%.

Once the required documents are reviewed and approved by DHCS, Gold Coast Health Plan (GCHP or Plan) would execute the Health Plan Provider Agreement. The Plan would then receive an increased capitation via a rate amendment to the Primary Agreement between GCHP and DHCS. The Plan would return the funds received to the funding entity. The Plan is precluded from charging an administrative fee on this particular IGT.

FISCAL IMPACT:

There is no impact to the Plan's FY2017-18 revenue.

RECOMMENDATION:

Authorize and direct the Chief Executive Officer to execute the Health Plan Provider Agreement with the County of Ventura to secure additional AB85 funding.

CONCURRENCE:

N/A.

Attachments:

None.

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: February 26, 2018

SUBJECT: Chief Operating Officer Update

OPERATIONS UPDATE

Membership Update

Gold Coast Health Plan's (GCHP's) total membership effective February 1, 2018 is 198,130, Membership continues to churn as the Plan added 4,098 newly effective or reinstated members, while 3,463 members terminated. The result was a net increase of 635 members over the previous month.

AB 85 Auto Assignment- GCHP assigned 625 new members to VCMC, while the remaining 626 new members were assigned to providers in compliance with the VCMMCC Auto Assignment policy (MS-005) for February. VCMC has 28,848 AE members assigned as of February 1, 2018. VCMC's target enrollment, as established by DHCS, is 65,765 and is currently at 43.87% of the target.

Operations Dashboard Monthly Volumes- February 2018	
	Volume
Membership:	
Total	**198,130**
Gain/Loss	**635**
AB-85: (new)	
VCMC	**625**
Remaining Providers	**626**
VCMC Target	**67,765**
VCMC % of Target	**43.87%**

Claims Update

Claims Inventory Results - Claims Inventory for January is 205,967 averaging 9,362 claims received per day. This equates to a Days Receipt on Hand (DROH) of 2.61 days in January compared to a DROH maximum goal of 5 days.

Operations Dashboard Monthly Volumes- January 2018	
	Volume
Claim Volume:	
Total	**205,967**
Daily Average Receipt	**9,362**

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

Conduent met all three (3) SLAs in the month of January 2018.

Operations Dashboard Key Performance Metrics (January 2018)		
	Actual	Benchmark
Claims Processing:		
Turn Around Time	95.45%	90.00%
Financial Accuracy	99.92%	98.00%
Procedural Accuracy	99.74%	97.00%

Encounter Update

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

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

Operations Dashboard Monthly Volumes- January 2018		
Encounter Type	**Errors**	**% of Errors**
Professional	1,988	1.90%
Institutional	438	0.70%
Pharmacy	311	0.20%
Total	**2,737**	**0.80%**

Reasons for the errors include:

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

Call Center Update

Call Center Volume – Conduent received 12,548 calls from GCHP members and providers in the month of January. This is an increase in call volume of 2,863 calls over December.

Operations Dashboard Monthly Volumes- January 2018	
	Volume
Call Volume	12,548 calls

Call Center Performance - GCHP has three (3) SLAs that measure Conduent's call center efficacy on a monthly basis. Conduent met two (2) of the three (3) SLAs in the month of January 2018.

Operations Dashboard Key Performance Metrics (January 2018)		
	Actual	Benchmark
Call Center:		
Average Speed To Answer	50.40 sec	30 sec
Abandonment Rate	2.24%	5.00%
Call Quality Scores	96.70%	95.00%

Average Speed to Answer was not met due to illness absences within the call center team.

Grievance and Appeals (G&A) Update

GCHP received eight (8) clinical appeals for the month of December. Four (4) were Upheld, three (3) Overturned and one (1) Withdrawn. During December, there were three (3) State Fair Hearings; two (2) were Denied and one (1) was withdrawn.

GCHP received 15 member grievances and 105 provider grievances in the month of December. Member grievances equate to 0.07 grievances per 1,000 members, a slight increase from the previous month.

Operations Dashboard Monthly Volumes- December 2017	
Grievances (Issue Type):	**Volume**
Denials/Refusals	6
Quality of Care	7
Quality of Service	2

GCHP received seven (7) Quality of Care member grievances, which consisted of the following issues:

- Inappropriate provider care

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

Operations Dashboard Key Performance Metrics (December 2017)		
	Actual	Benchmark
Grievance and Appeals:		
Grievance Acknowledgement	72.00%	100.00%
Appeal Acknowledgement	100.00%	100.00%
Grievance Resolution	71.00%	100.00%
Appeal Resolution	100.00%	100.00%

Grievance Resolution dropped in the month of February due to the receipt of over 9,000 requests from one physician billing service on behalf of 4 of their client provider practices. GCHP attempted to contact the groups to determine the cause of the high volume of requests with no response. The Plan received an email from the billing service on 1/29/2018 indicating that they experienced a technical error with their system which generated the multiple

requests, unfortunately they were not able to identify which requests were valid requiring the plan to review and process each request. Despite the G&A team working substantial overtime this significant increase in volume resulted in the Plan missing the timeliness requirement.

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

- ASO Transformation Project- GCHP is undertaking a significant project to determine the best next steps for transforming our processes and technology. Conduent, our current partner, has performed a national search to find a new technology that is Medicaid/Medi-Cal based with the ability to expand and grow as GCHP's business grows. GCHP hosted Conduent and the system vendor in our office on February 5th and 6th, 2018, to continue discussions pertaining to the system functionality and project requirements. GCHP came away with a realistic vision of the capabilities and resources required to continue with this solution.
- Implementation of the "Coordination of Benefits Agreement (COBA)" project, which provides direct COB information from CMS to GCHP to process dual claims effectively, continues to be a focus. We anticipate a live date of March 15, 2018.
- The 2018 HEDIS audit continues to a focus for operations collaboratively with Compliance and QI. The HEDIS audit will take place on March 5, 2018.
- Operations is currently working with Provider Relations on the new All Plan Letter (APL) 18-XXX which will compare the 274 file with the provider data base. This APL is not final, however the file is due to the state by March 15, 2018.

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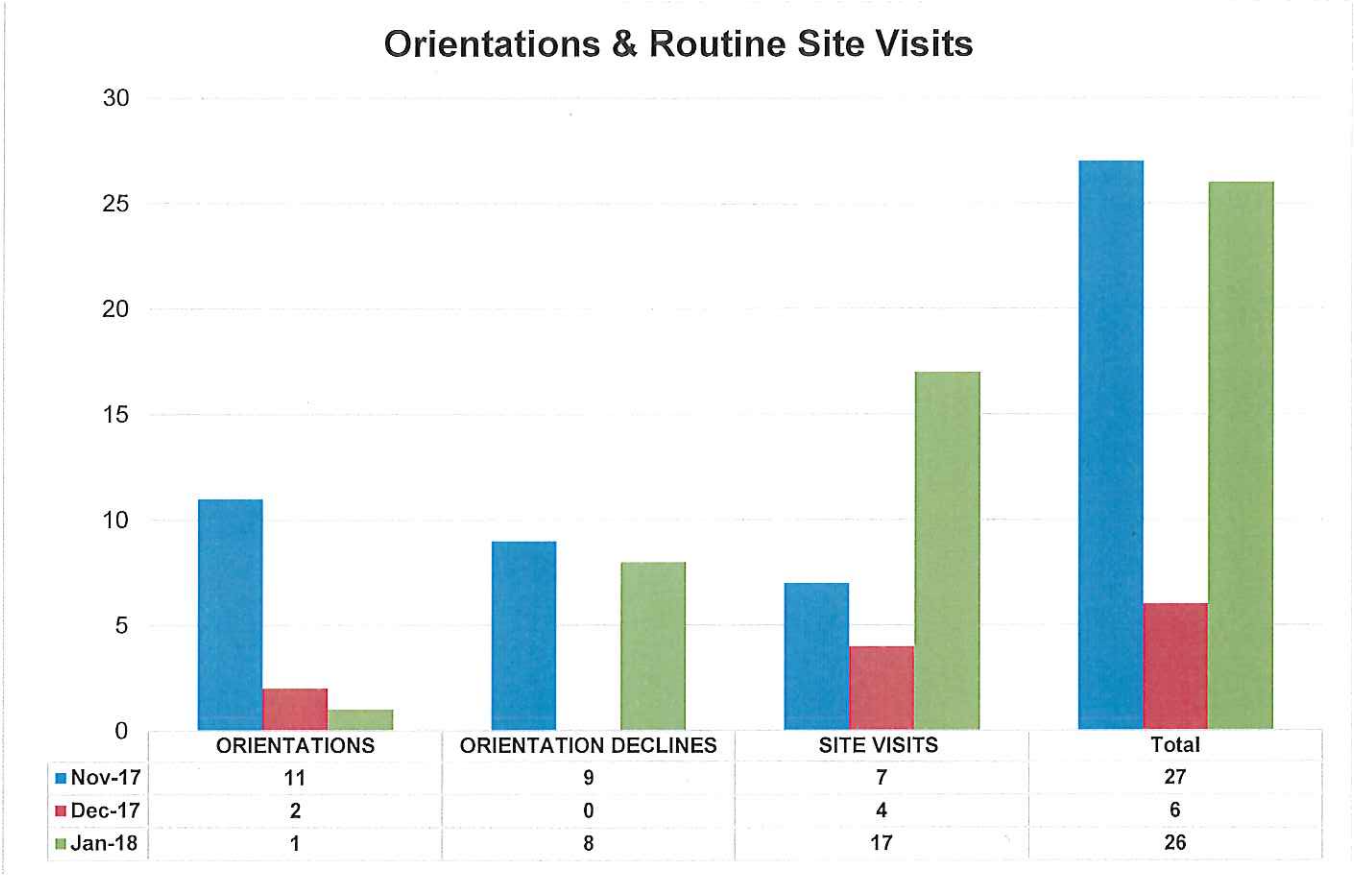
NETWORK UPDATE JANUARY 2018

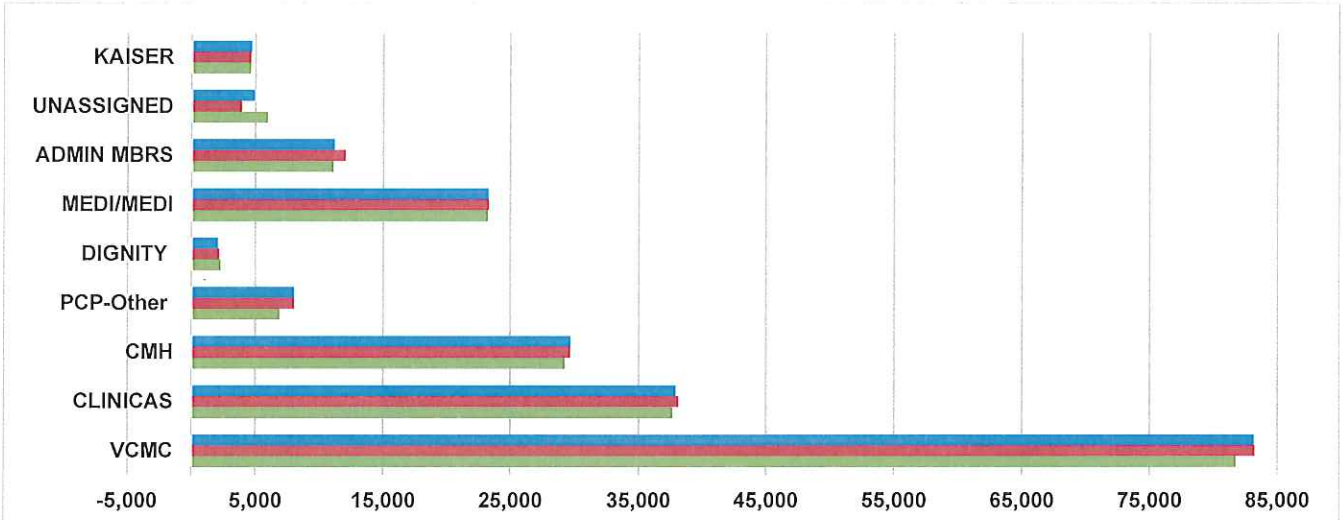
A. PROVIDER SITE VISIT RESULTS



	ORIENTATIONS	ORIENTATION DECLINES	SITE VISITS	Total
Nov-17	11	9	7	27
Dec-17	2	0	4	6
Jan-18	1	8	17	26

- Orientations: 14 new provider orientations were conducted by GCHP Provider Relations Staff.
- 17 Physicians declined orientation due to joining an established contracted group with GCHP. Established groups such as delegated providers have participated in previous orientations; they are familiar with GCHP policies and procedures and capability to perform the orientation function.
- Site Visits: 28 provider site visits were completed. The figure is up 27.3%. The goal for the Provider Relations team is to complete 20 site visits per month. Despite the increase in site visits, overall these site visits remain down due to competing priorities resulting from increased regulatory compliance activities.

B. MEMBER PCP ASSIGNMENTS:



	VCMC	CLINICAS	CMH	PCP-Other	DIGNITY	MEDI/MEDI	ADMIN MBRS	UNASSIGNED	KAISER
Nov-17	83,168	37,942	29,673	8,028	2,071	23,259	11,167	4,926	4,693
Dec-17	83,259	38,165	29,683	8,073	2,200	23,307	12,048	3,941	4,651
Jan-18	81,777	37,682	29,237	6,898	2,293	23,197	11,100	5,938	4,624

Unassigned members are Newly Eligible/Enrolled

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

C. KEY PROJECTS:

- **MANAGED CARE PROVIDER DATA IMPROVEMENT PROJECT (MCPDIP) 274-UPDATE:** All requirements met.

- **SB 137 PROVIDER DIRECTORIES:** All requirements met.

➢ **APL-18-005 (formerly 18-XXX) NETWORK CERTIFICATION REQUIREMENTS**

- Received final draft APL 18-005 from DHCS on 02/20/18.
- APL 18-XXX addresses new standards for all Medi-Cal Managed Care Plans regarding new Annual Network certification, other network reporting requirements and associated network adequacy standards.
- The implementation of this new APL requires
  - Reprioritization of existing projects and resource analysis needed
  - Requirements development
  - Testing, approval and implementation
  - Revision to Policies and Procedures
- Full compliance and submission of Network Certification report due March 15, 2018.

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PROVIDER ADDS AND TERMINATIONS JANUARY 2018

A. ADDITIONS:

PROVIDER TYPE	# PROVIDER ADDS JAN 2018	TOTAL PROVIDER ADDS July 2017-January 2018	TOTAL NETWORK PROVIDERS
Hospital	**0**	**11**	**33**
-Acute Care	0	0	19
-LTAC	0	10	9
-Tertiary	0	1	5
Providers	**48**	**749**	**6,004**
-PCP's & Midlevels	7	54	435
-Specialists	179	869	5452
-Hospitalists	7	19	310
Ancillary	**0**	**0**	**455**
-ASC	0	0	8
-CBAS	0	0	6
-DME	0	2	108
-Home Health	0	0	33
-Hospice	0	2	21
-Laboratory	0	0	67
-Optometry	0	0	32
-OT/PT/ST	0	2	79
-Radiology/Imaging		0	29
Pharmacy	**1**	**4**	**835**
SNF/LTC/CLF	**0**	**0**	**76**
Behavioral Health	**21**	**38**	**326**

B. TERMINATIONS:

PROVIDER TYPE	# PROVIDER TERMS Jan 2017	TOTAL PROVIDER TERMS July 2017- January 2017	COMMENTS
Hospital	**0**	**0**	---
-Acute Care	0	0	---
-LTAC	0	0	---
-Tertiary	0	0	---
Providers	**12**	**102**	---
-PCP's & Midlevels	9	36	No major impact
-Specialists	26	69	No major impact
-Hospitalists	4	24	No major impact
Ancillary	**0**	**5**	No major impact
-ASC	0	1	No major impact
-CBAS	0	0	---
-DME	0	3	No major impact
-Home Health	0	0	---
-Hospice	0	1	No major impact
-Laboratory	0	0	---
-Optometry	0	0	---
-OT/PT/ST	0	0	---
-Radiology/Imaging	0	0	---
Pharmacy	**0**	**21**	No major impact. Terms result of wrong Pharmacy submissions by Optum
SNF/LTC/CLF	**0**	**0**	---
Behavioral Health	**6**	**17**	No major impact

D. CONTRACTING INITIATIVES:

- Initiated re-contracting efforts with two major tertiary centers whose agreements are legacy contracts and driving higher costs compared to other like facilities. **UPDATE: Negotiations still in process. Potentially evaluating termination of one contracted out of county tertiary provider due to high costs.**

- Finalizing full direct transplant services contract relationship with one tertiary facility to be effective March 1, 2018

- Initiated re-negotiation discussions with an in-county hospital facility whose agreement will terminate effective 7/1//2018. **UPDATE: Continue to review and discuss negotiation terms with this provider.**

- Evaluating laboratory services capitation contract that will serve to reduce outpatient clinical and anatomical lab costs. **UPDATE: We have received one proposal from a laboratory provider and awaiting a second proposal**.

- Working with Ventura County Medical Center (VCMC) to establish a contract under PRIME Alternative Payment Methodology Initiative. Focus on HEDIS Diabetes HbA1C > 9% screenings and reductions to achieve 10% improvement in their aggregate clinic HEDIS scores in this area. **UPDATE: Completed and to be submitted to the County Board of Supervisors for approval in March.**

- Initiating access, provider satisfaction and provider after hour surveys in Mid-March through April.

- Finalized a provider specialty services agreement and separate ASC contract with a major in-county orthopedic practice.

AGENDA ITEM NO. 7

TO: Gold Coast Health Plan Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: February 26, 2018

SUBJECT: Chief Medical Officer Update

HEALTH SERVICES UPDATE

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

UTILIZATION SUMMARY

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

BED DAYS:

Bed days/1000 members have declined by about 43%, from Plan's inception in 2011 through CY 2016. Bed days/1000 for CYTD 2017 are unchanged from CY2016 (210). The proportion of bed days utilized by AE members increased slightly (41% to 46%) in a year-to-year comparison of September 2016 to September 2017.

Bed days/1000 for SPD members for CYTD 2017 are also similar to CY 2016 (999 v. 1006). While the rate of bed days for SPD members is high, it does not have a strong effect on the overall plan rate of bed days per 1,000 members because SPD is such a small portion of our membership (5%).

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

AVERAGE LENGTH OF STAY:

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

Average length of stay benchmark: While there is no Medi-Cal Managed Care Dashboard report of bed days/1000 members, review of available published data from other managed

care plans averages 5. There is variability in reporting of Administrative Days among managed care plans.

ADMITS/ 1000:

Admits/1000 for CY2016 were 50/1000 members. Admits/1000 for CYTD2017 are 53/1000 members.

Admits/1000 SPD members are 191 for CYTD 2017.

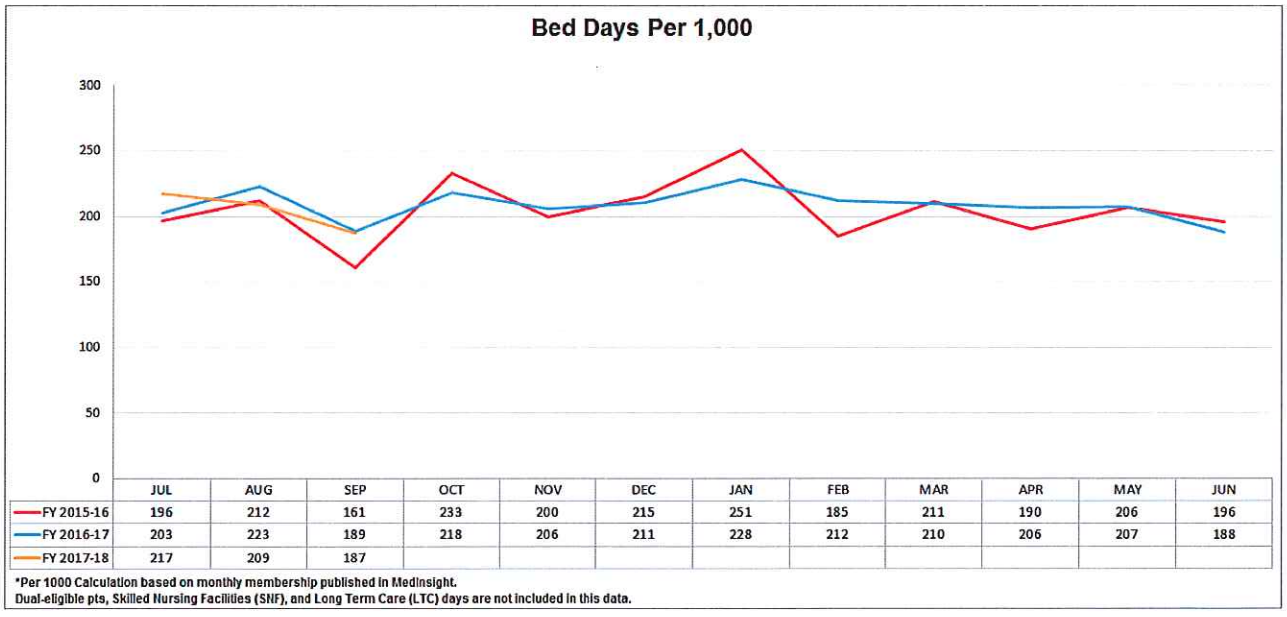
Admits/1000 benchmark: The DHCS average for admits/1000 members is 54. The DHCS average admits/1000 for SPD members is 458. This variation between GCHP and DCHS may be explained by the relative youth of GCHP SPD members versus DHCS SPD members. (Only 33% of GCHP SPD members are age 40 – 64 years versus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

ED UTILIZATION/1000:

ED utilization/1000 members typically peaks in January or February. CYTD 2017 ED utilization/1000 members increased from CY2016 (474 v. 447). For September 2017, the Family aid code group continues to show the highest ED utilization (47%) followed by AE (35%). This utilization pattern is essentially unchanged from CY 2016.

ED utilization/1000 for SPD members for CYTD 2017 is also increased from CY 2016 (861 v. 802). This represents approximately 9% of ED utilization.

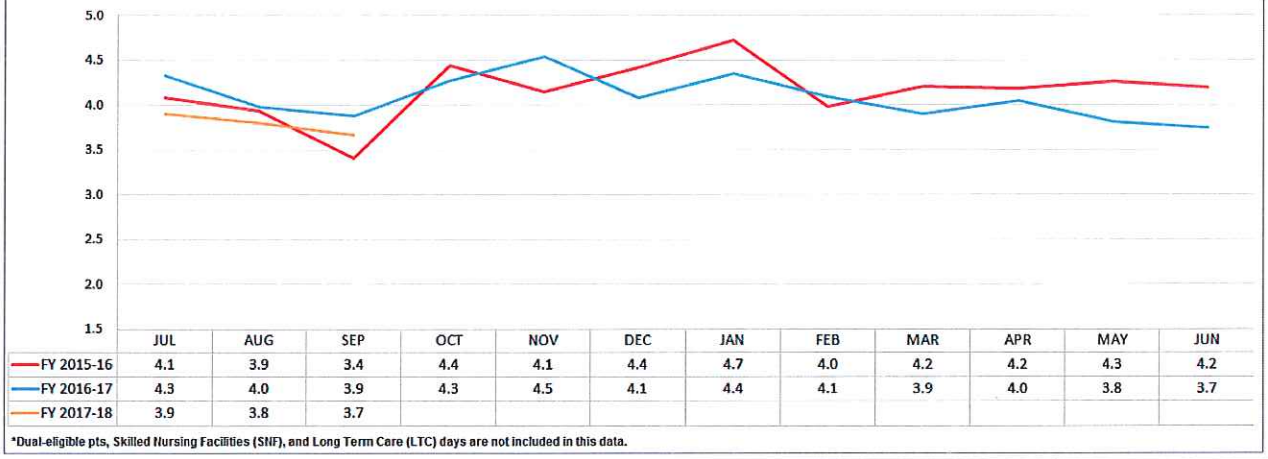
ED utilization benchmark: The HEDIS mean for managed Medicaid plans for ED utilization/1000 members is 587. The March 2017 Medi-Cal Managed Care Performance Dashboard reported average SPD ED utilization to be 1065/1000 members.



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2015-16	196	212	161	233	200	215	251	185	211	190	206	196
FY 2016-17	203	223	189	218	206	211	228	212	210	206	207	188
FY 2017-18	217	209	187									

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

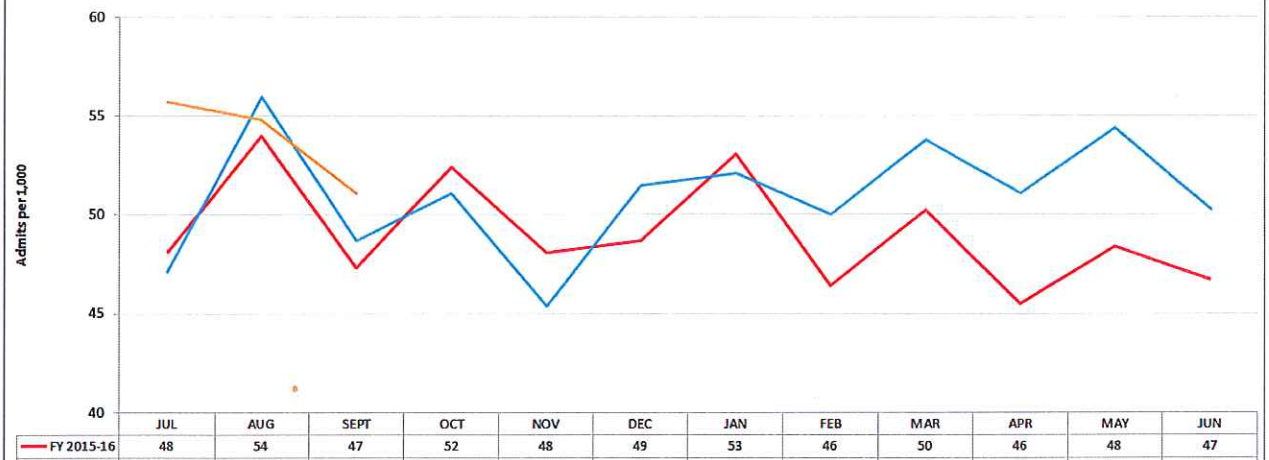
Average Length of Stay



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

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

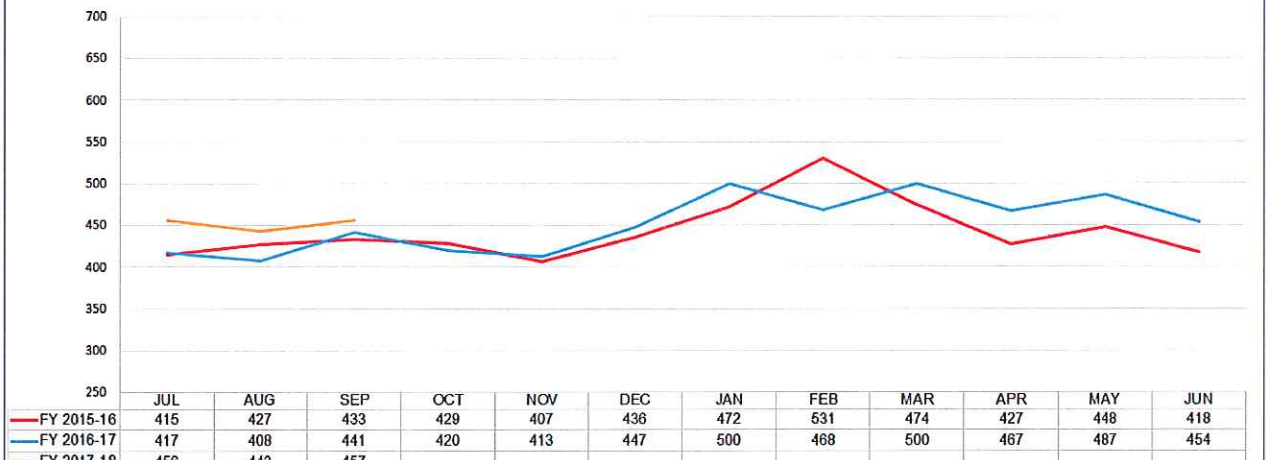
Acute Inpatient Admissions/1000 Members



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

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts and Long Term Care (LTC) days are not included in this data.
* Data from MedInsight 3/22/16

ER Utilization Per 1,000

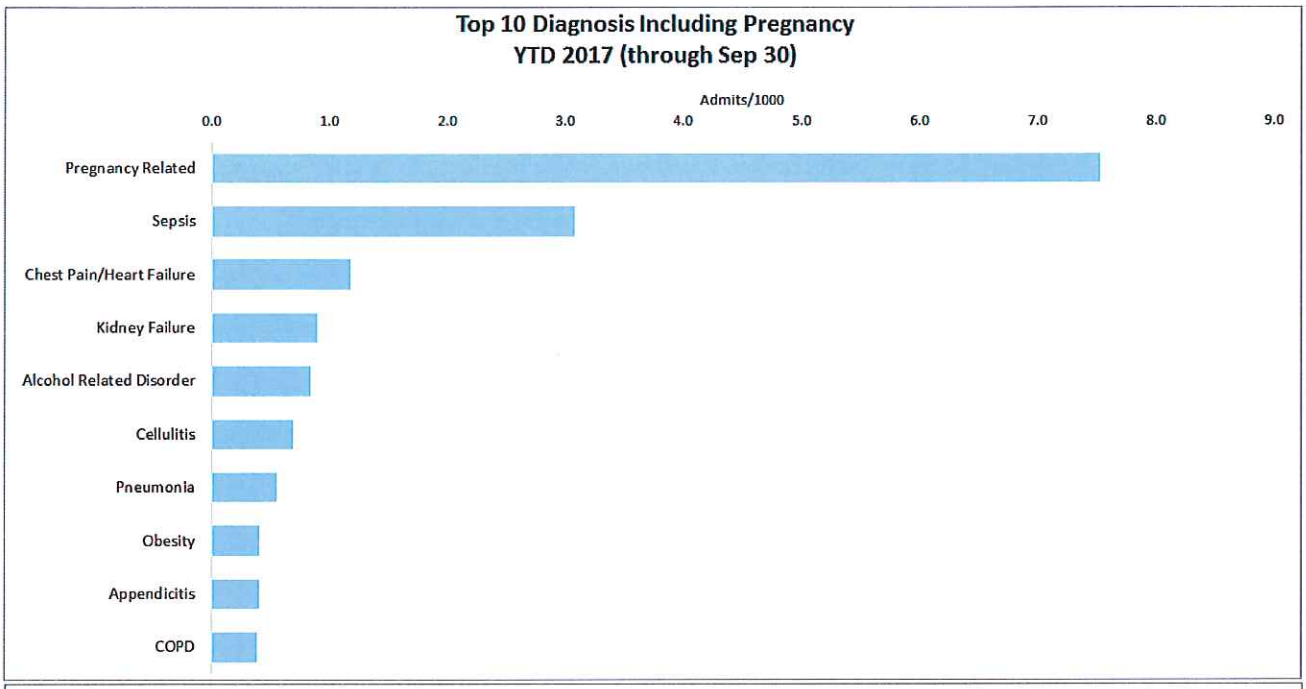


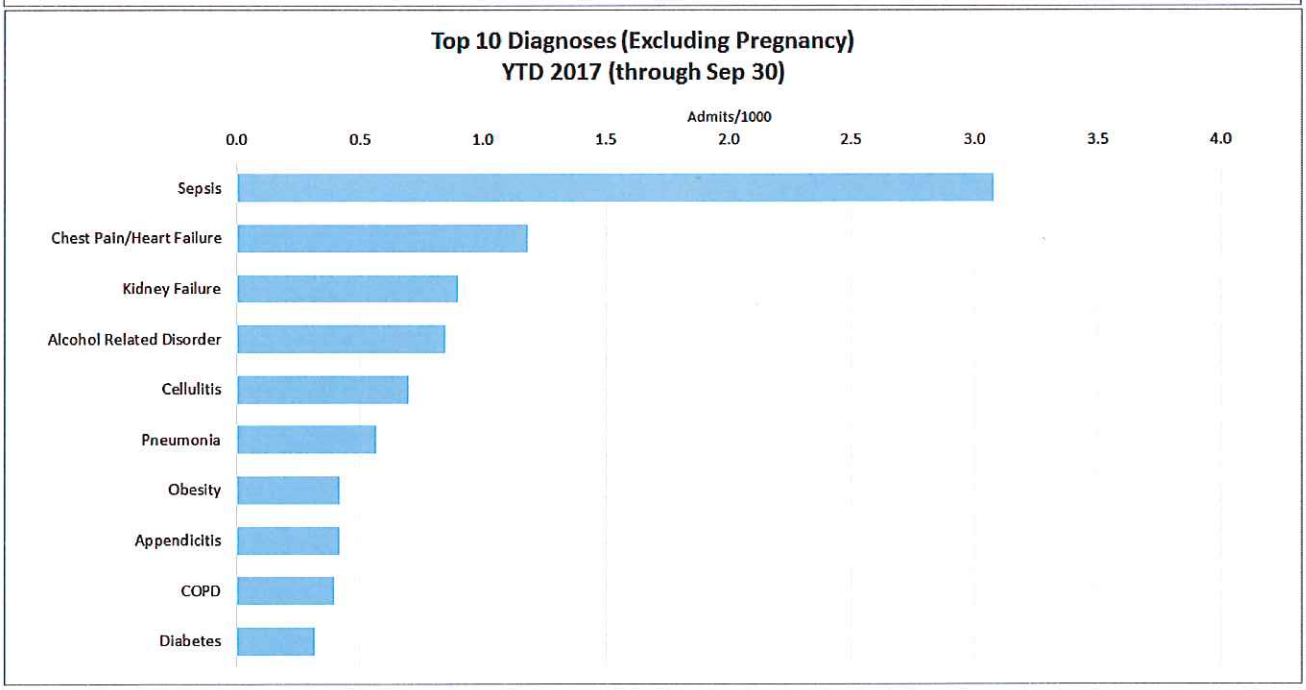
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2015-16	415	427	433	429	407	436	472	531	474	427	448	418
FY 2016-17	417	408	441	420	413	447	500	468	500	467	487	454
FY 2017-18	456	443	457									

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts are not included in this data.
*ER Utilization calculated on visits without an IP admit

TOP ADMITTING DIAGNOSES

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

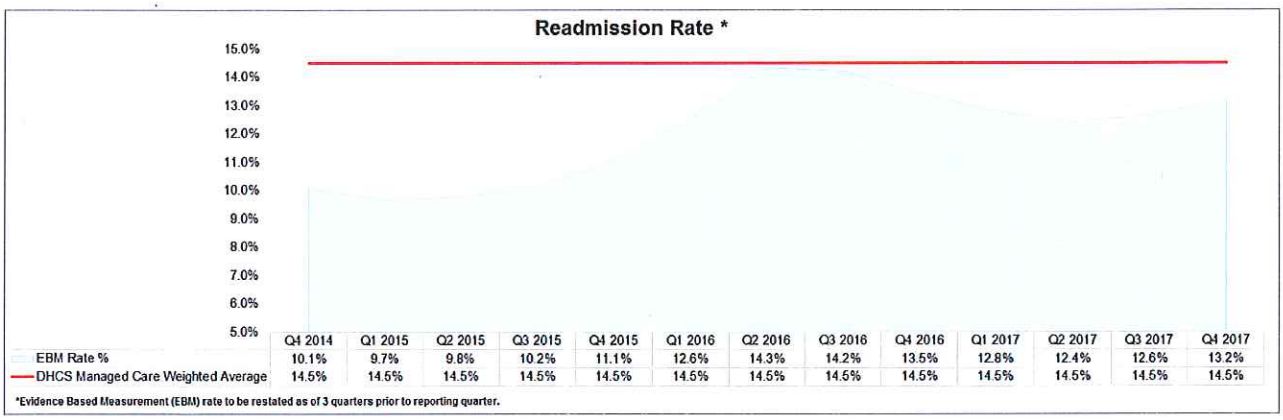




READMISSION RATE

The quarterly readmission rate has declined from a recent peak in Q2 of 2016 (14.3%) to an average of 12.8% for CYTD 2017.

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



	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017
EBM Rate %	10.1%	9.7%	9.8%	10.2%	11.1%	12.6%	14.3%	14.2%	13.5%	12.8%	12.4%	12.6%	13.2%
DHCS Managed Care Weighted Average	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%	14.5%

*Evidence Based Measurement (EBM) rate to be restated as of 3 quarters prior to reporting quarter.

CLINICAL GRIEVANCES AND APPEALS

For CY 2016, there were an average of 30 grievances/ quarter. The average number of clinical grievances/quarter for CY 2017 has increased to 47. For CY 2017, most grievances (77%) were characterized as quality of care issues, with access issues comprising 5% of total grievances.

QTR	Grievance Total	Appeals Total	Upheld	Partial Overturn	Overturned	Withdrawn	Dismissed
2016							
Q1	26	9	3 (34%)	-	4 (44%)	1 (11%)	1 (11%)
Q2	32	9	7 (78%)	-	2 (22%)	-	-
Q3	33	24	7 (29%)	-	14 (58%)	1 (5%)	-
Q4	27	21*	7 (33%)	-	6 (29%)	1 (5%)	-
2017							
Q1	34	15	6 (40%)	-	8 (53%)	1 (7%)	-
Q2	40	17	9 (54%)	-	4 (23%)	4 (23%)	-
Q3	66	17	9 (53%)	-	6 (35%)	2 (12%)	-
Q4	46	23	13 (56%)	-	5 (22%)	5 (22%)	-

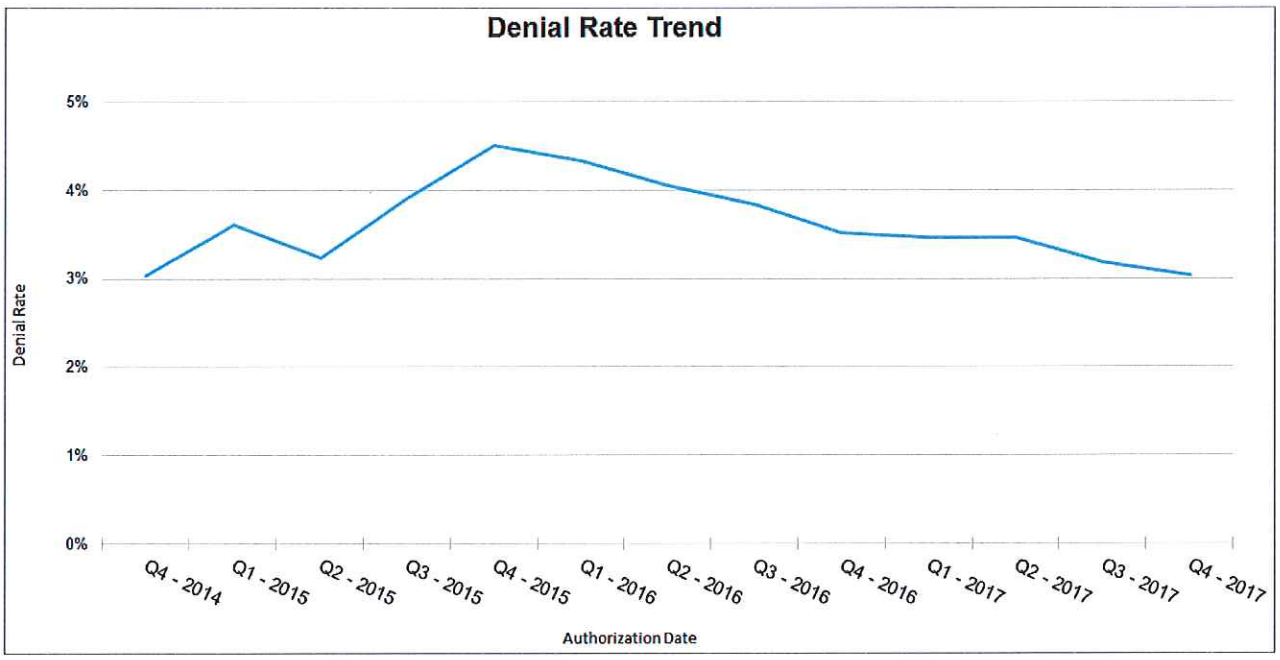
*Q4 2016 total appeals includes 7 (33%) in progress.

Grievance benchmark: DHCS tracks grievances by type. In Q2 2017, the DHCS grievance average was 38% for quality of care and 11% for access issues.

DENIAL RATE

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

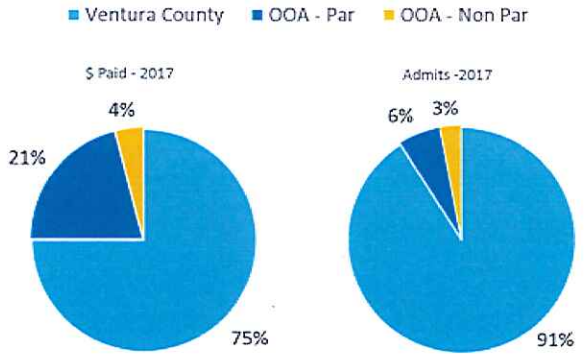
The denial rate has ranged between 2.7% and 4.5% since 2013. The average denial rate for CY 2016 was 3.9% and for CYTD 2017 is 3.3%.



Out of Area Hospital costs and utilization are not increasing.

People admitted to these hospitals are our sickest members who need specialized treatment available at specific facilities

Low Volume/High Risk/High Cost



September 2017

OOA Admits have risk scores 17x higher than general membership

- Top Chronic Conditions are: Renal Failure, Active Cancer, Heart or Liver Transplants

OOA Hospitals make up 21% of Inpatient $ Paid (CY 2017)

- $ Paid showing gradual decrease over the last 24 months
- Average of $2.5M per month (incurred) to OOA hospitals

OOA Hospitals make up 9% of Inpatient Admits (CY 2017)

- % of admits to par facilities has increased
- Average of 65 admits per month (duals+non duals) to OOA hospitals

HEALTH EDUCATION, CULTURAL AND LINGUISTIC SERVICES UPDATE

With the new calendar year, the Department has begun to refine community outreach and health education by focusing on the member and member outcomes. In January, 152 members were engaged by staff through attendance at educational opportunities, direct mailings of health materials, and HIF follow ups. Cervical Health Awareness classes were the most frequently attended educational opportunity in January.

PHARMACY BENEFIT PERFORMANCE AND TRENDS

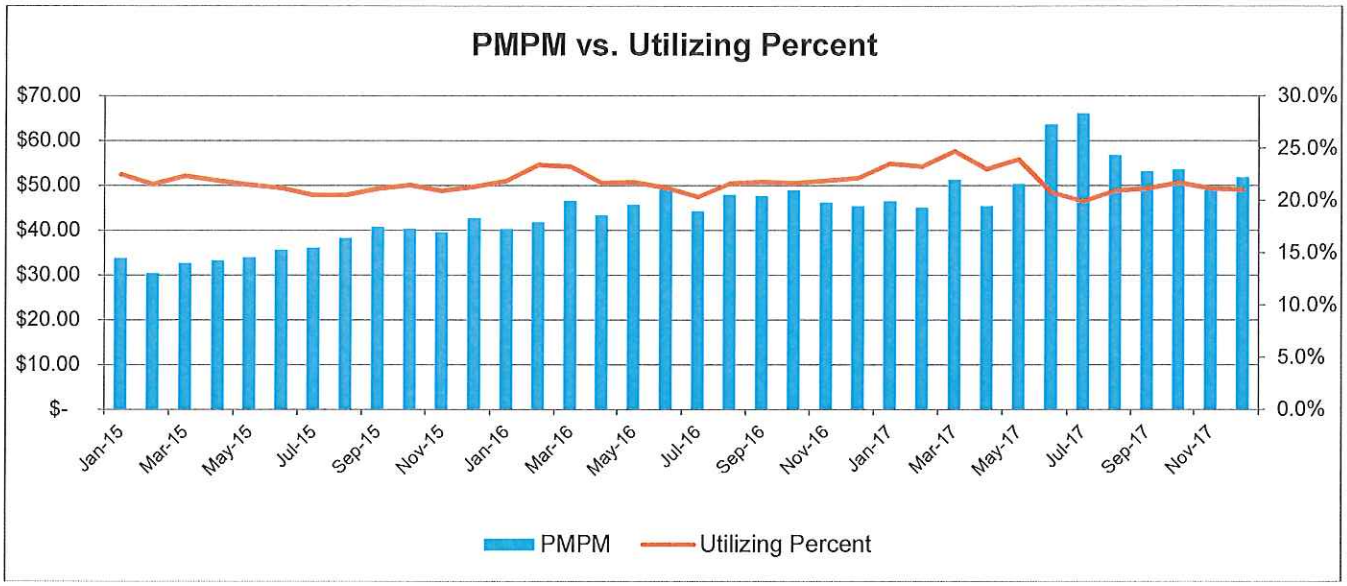
SUMMARY:
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of October 2017. Although minor changes may occur to the data going forward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

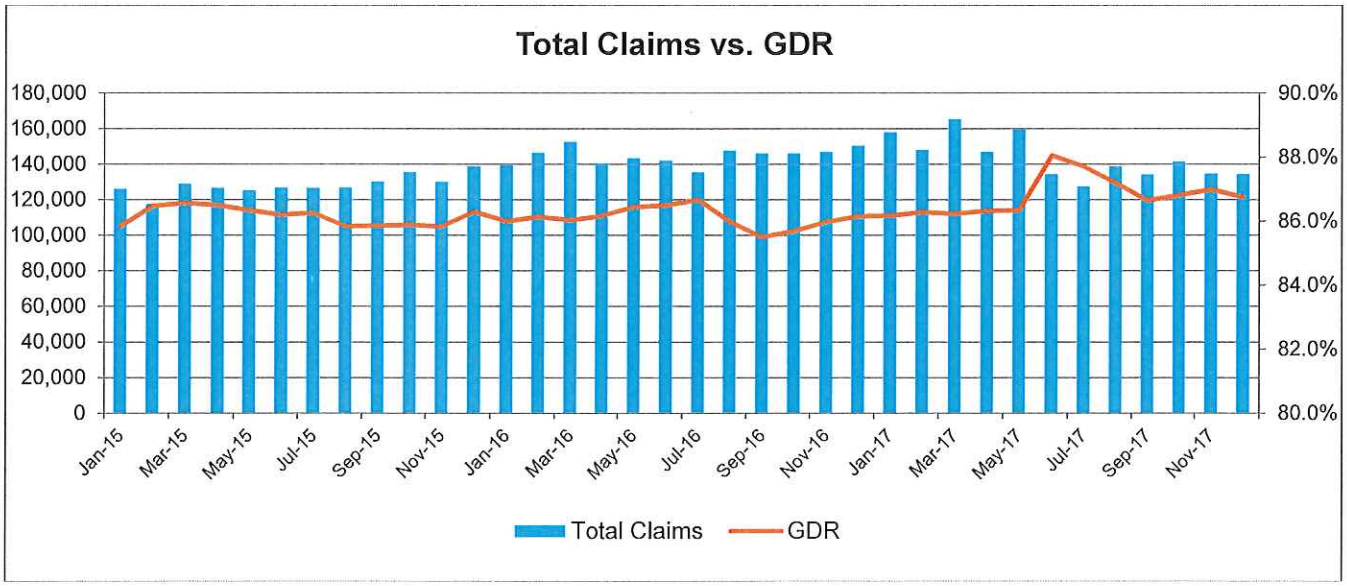
Verbal updates will be provided on the following items:

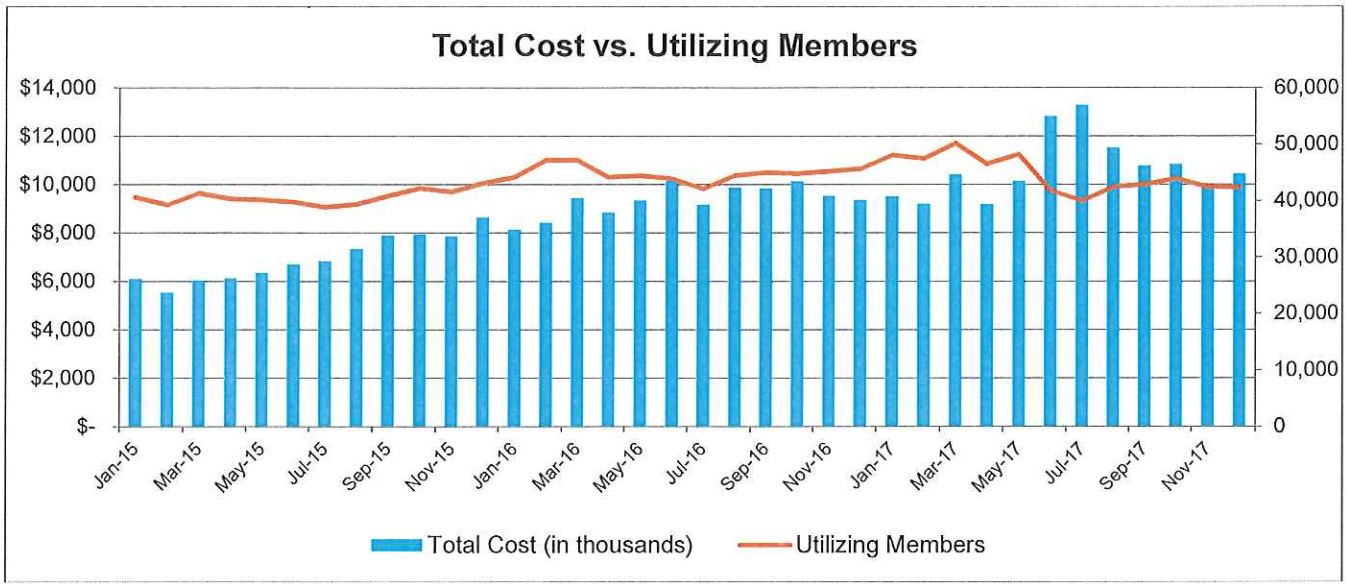
- Kaiser pharmacies
- 340B eligible drugs claims
- Pharmacy reimbursement
- Pharmacy consultant

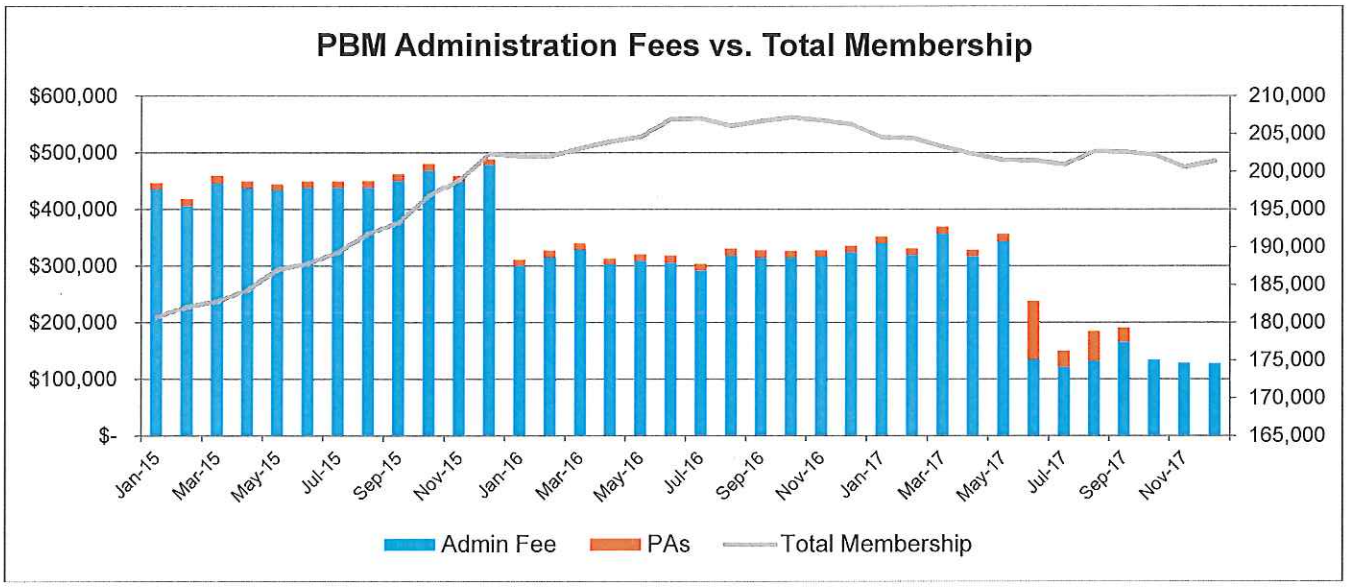
Abbreviation Key:
PMPM: Per member per month
PUPM: Per utilizer per month
GDR: Generic dispensing rate
PA: Prior authorization

PHARMACY COST TRENDS:

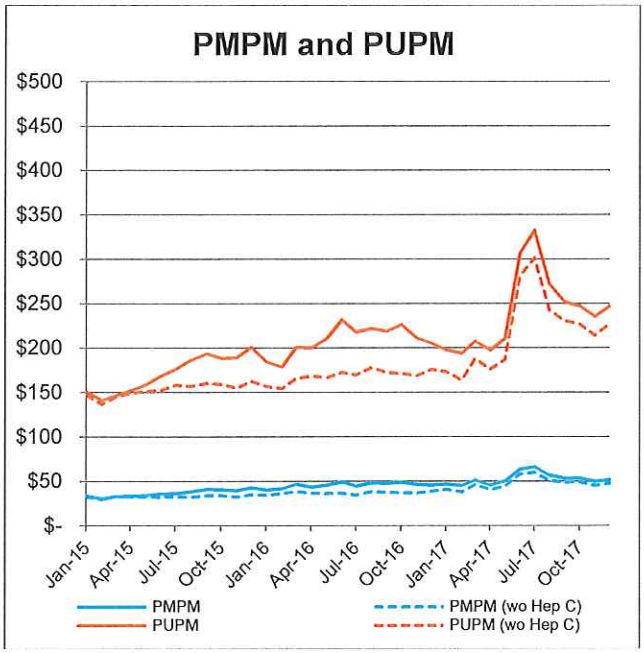


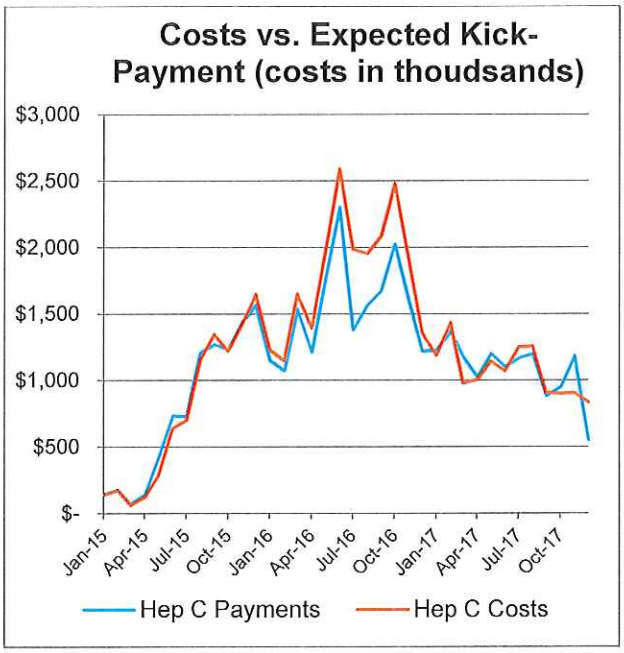



Total Cost vs. Utilizing Members
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
60,000
50,000
40,000
30,000
20,000
10,000
0
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Total Cost (in thousands)
Utilizing Members


PBM Administration Fees vs. Total Membership
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
210,000
205,000
200,000
195,000
190,000
185,000
180,000
175,000
170,000
165,000
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Admin Fee
PAs
Total Membership

HEPATITIS C FOCUS:





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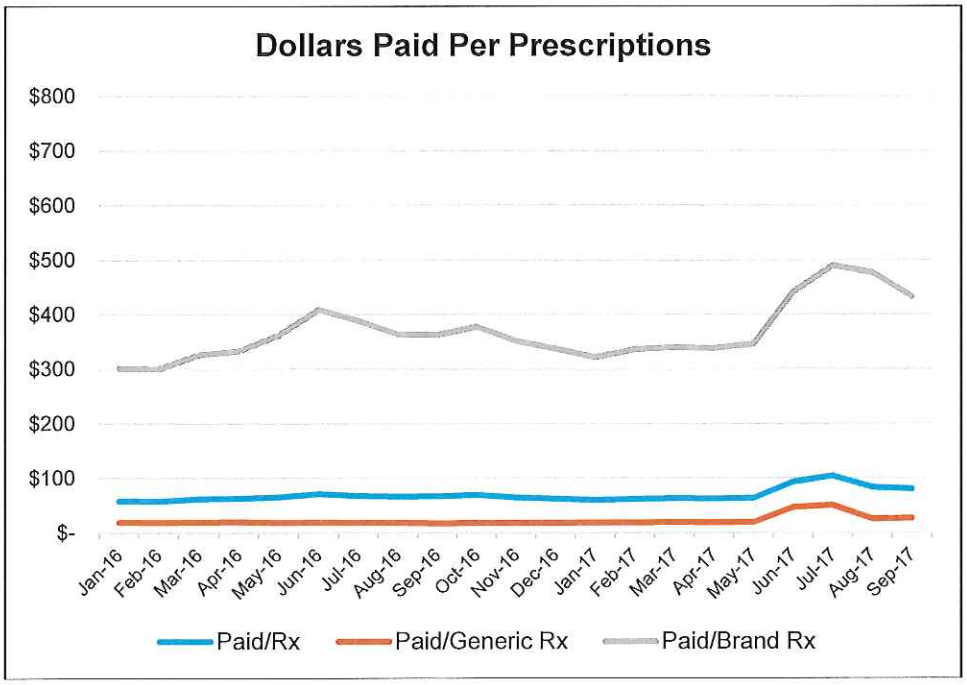
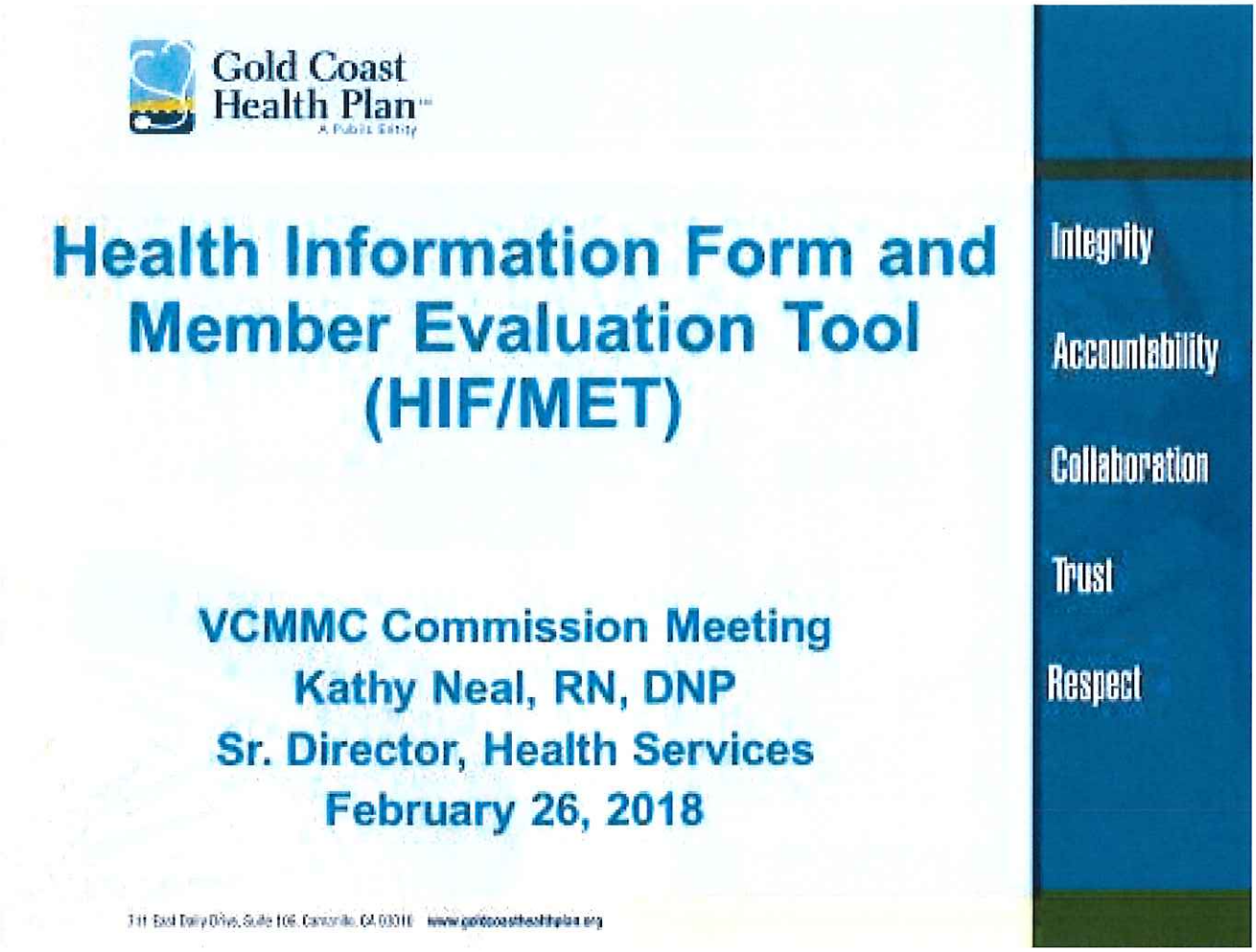


HEALTH INFORMATION FORM AND MEMBER EVALUATION TOOL (HIF/MET) UPDATE



PURPOSE:

- What is HIF/MET
- Why is HIF/MET being implemented
- How is HIF/MET administered
- Review early results

WHAT IS HIF/MET:

- HIF is a standardized structured dichotomous survey that new members complete
- English and Spanish
- HIF collects data related to:
  - Need to see MD within next 60 days
  - Number prescription meds taken
  - Mental Health conditions
  - Recent hospitalizations and ED visits
  - ADL status
  - DME use
  - Presence of any chronic conditions
- MET is the process to identify significant medical needs from the collected data

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

HEALTH INFORMATION FORM

You are receiving this form because you are enrolled in Gold Coast Health Plan, your Medi-Cal provider. Your plan will use this form to make sure you get needed care.

Please fill in the circle with black or blue pen for the answers that apply to you. Complete one form for each person in your family who is enrolled in Gold Coast Health Plan.

If you have questions, please call Gold Coast Health Plan, toll free at **1-888-301-1228** (or TTY dial **1-888-310-7347**) Monday through Friday, between 8:00 a.m. and 5:00 p.m.

Please return completed form in the enclosed YELLOW return envelope or mail to:

Gold Coast Health Plan
P.O. Box 9153
Oxnard, CA 93031-9826

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Name:_____ Date of Birth:_____ GCHP/ BIC ID#_____

1. Do you need to see a doctor within the next 60 days? ○ Yes ○ No
2. Do you take 3 or more prescription medicines each day? ○ Yes ○ No
3. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia? ○ Yes ○ No
4. Have you been to the emergency room two or more times in the last 12 months? ○ Yes ○ No
5. Have you been admitted to the hospital in the last 12 months? ○ Yes ○ No
6. Have you needed help with personal care, such as bathing, getting dressed, or changing bandages in the last 6 months? ○ Yes ○ No
7. Are you using medical equipment or supplies, such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags? ○ Yes ○ No
8. Do you have a condition that limits your activities or what you can do? ○ Yes ○ No
9. Are you pregnant? ○ Yes ○ No

   9a. *If Yes, are you currently seeing a doctor for this pregnancy?* ○ Yes ○ No

10. Do you see a doctor regularly for a chronic medical condition? ○ Yes ○ No

    10a. *If Yes, fill in all that apply:*

○ a. Asthma	○ b. Cancer	○ c. Cystic Fibrosis	○ d. Diabetes
○ e. Heart Problems	○ f. Hepatitis	○ g. High Blood Pressure	○ h. HIV or AIDS
○ i. Kidney Disease	○ j. Seizures	○ k. Sickle Cell Anemia	○ l. Tuberculosis

○ m. Other:_____

I understand that this information will be disclosed to Gold Coast Health Plan.

Signature:_____ Date:_____

If not signed by beneficiary, specify relationship: Parent of minor Guardian Other representative

CONFIDENTIAL

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

Gold Coast Health Plan
A Public Entity

www.goldcoasthealthplan.org

FORMULARIO DE INFORMACIÓN SOBRE LA SALUD

Usted está recibiendo este formulario porque está inscrito en Gold Coast Health Plan, su proveedor de Medi-Cal. Su plan usará este formulario para asegurarse de que reciba la atención necesaria.

Por favor, rellene el círculo con tinta negra o azul junto a las respuestas que le apliquen a usted. Complete un formulario para cada persona de su familia que esté inscrita en Gold Coast Health Plan.

Si tiene preguntas, por favor llame a Gold Coast Health Plan, llame gratis al **1-888-301-1228** de lunes a viernes, entre las 8:00 a.m. y las 5:00 p.m. Los usuarios de TTY deberán marcar **1-888-310-7347**

Devuelva el formulario completado en el sobre AMARILLO adjunto o por correo a:

Gold Coast Health Plan
P.O. Box 9153
Oxnard, CA 93031-9826

El llenar este formulario es voluntario. No se le negará la atención en base a sus respuestas confidenciales.

Nombre:_____ Fecha de nacimiento:_____ # de ID de GCHP/ # de BIC_____

1.	¿Necesita ver a un médico dentro de los próximos 60 días?	O Sí	O No
2.	¿Toma 3 o más medicamentos al día?	O Sí	O No
3.	¿Ve usted regularmente a un doctor por un trastorno mental como depresión, trastorno bipolar, o esquizofrenia?	O Sí	O No
4.	¿Ha estado en una sala de emergencia dos o más veces en los últimos 12 meses?	O Sí	O No
5.	¿Ha ingresado al hospital en los últimos 12 meses?	O Sí	O No
6.	Ha necesitado ayuda con el cuidado personal, como bañarse, vestirse, o cambiar vendajes en los últimos 6 meses?	O Sí	O No
7.	¿Está usando equipo médico o suministros, como cama de hospital, silla de ruedas, andador, oxígeno o bolsas de ostomía?	O Sí	O No
8.	¿Usted tiene una condición que limita sus actividades o lo que puede hacer?	O Sí	O No
9.	¿Está embarazada?	O Sí	O No
	9a. *De contestar Sí, ¿está actualmente viendo a un doctor para este embarazo?*	O Sí	O No
10.	¿Ve a un doctor con regularidad para una condición médica crónica?	O Sí	O No

10a. *De contestar Sí, llene todo lo que sea aplicable:*

O a. Asma	O b. Cáncer	O c. Fibrosis quística	O d. Diabetes
O e. Problemas cardiacos	O f. Hepatitis	O g. Presión arterial alta	O h. VIH o SIDA
O i. Enfermedad renal	O j. Convulsiones	O k. Anemia falciforme	O l. Tuberculosis

O m. Otro:_____

Entiendo que esta información será compartida a Gold Coast Health Plan.

Firma: _____ Fecha: _____

Si no está firmado por el beneficiario, especificar la relación: Padre de menor Tutor Otro representante

CONFIDENCIAL

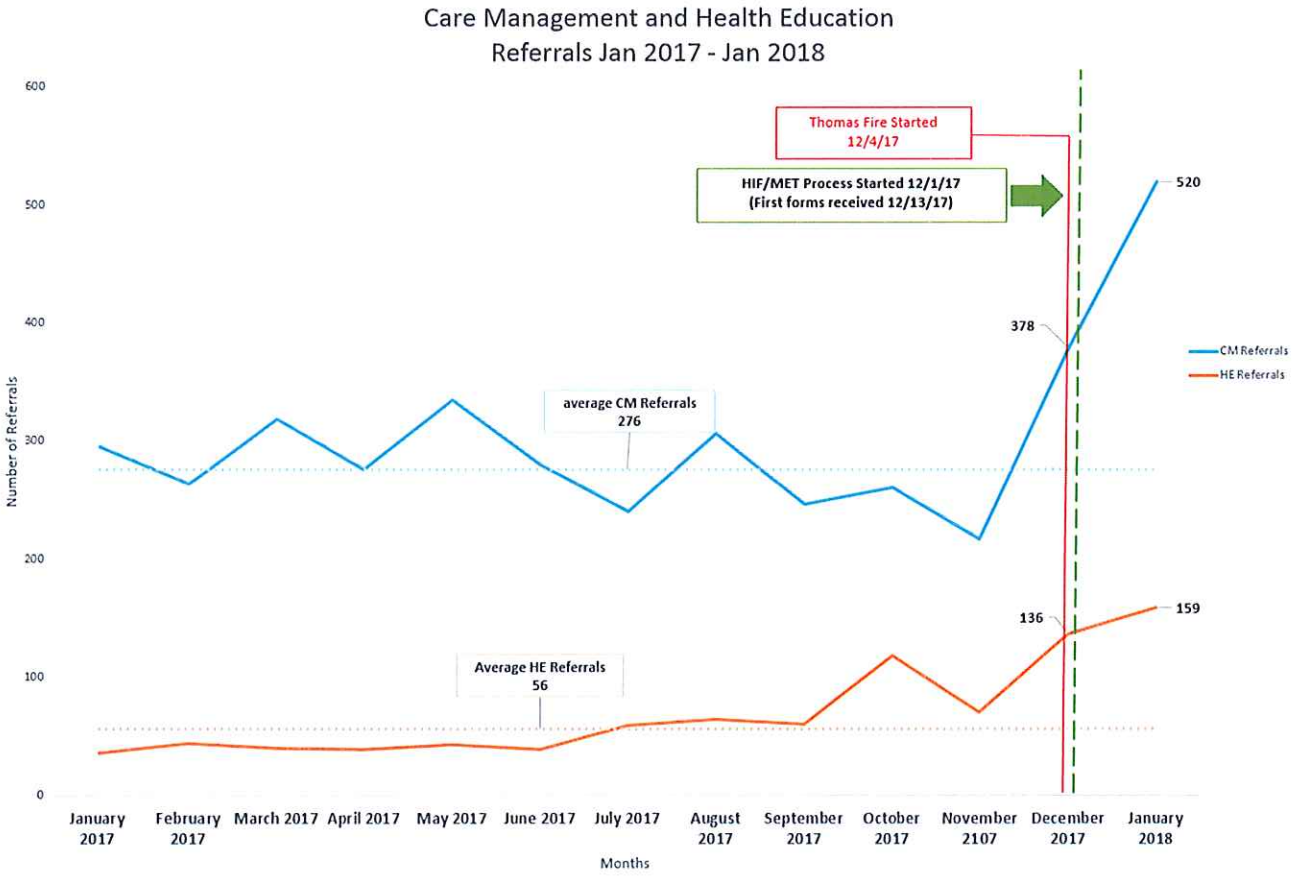
711 East Daily Drive, Suite 106, Camarillo, CA 93010-6082 | Servicios para los Miembros: 888-301-1228 | Administración: 805-437-5500 | Fax: 805-437-5132

WHY IS HIF/MET BEING IMPLEMENTED:

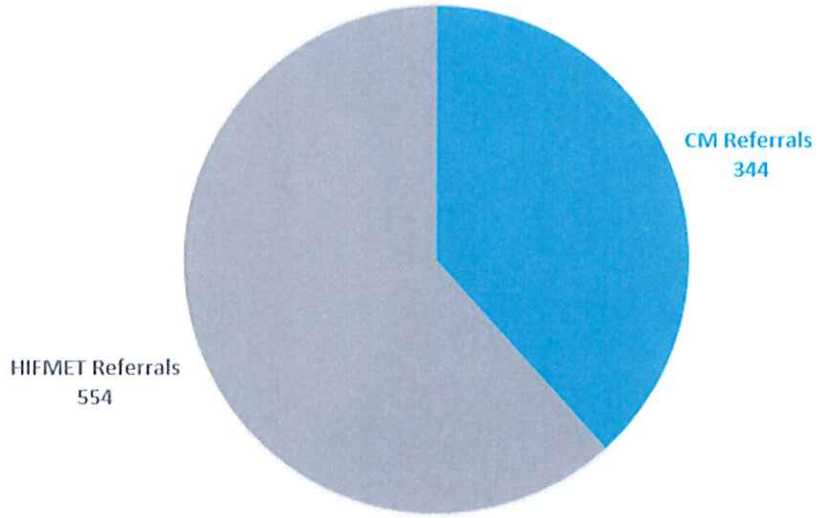
- Done over phone with SPDs since 2013
- To meet DHCS compliance with CMS Mega Regs
- Help identify newly enrolled members who may need expedited services

ADMINISTRATION OF HIF/MET:

- HIF sent in new member packets that are mailed by the 7th of each month
- Each member will receive two "robo-calls" approximately the 17th and the 30th of the month
- Member asked to complete and return in color coded, stamped envelope
- CM will review each HIF and triage to PCP, Health Education, Care Coordination, and Complex Case Management as needed.

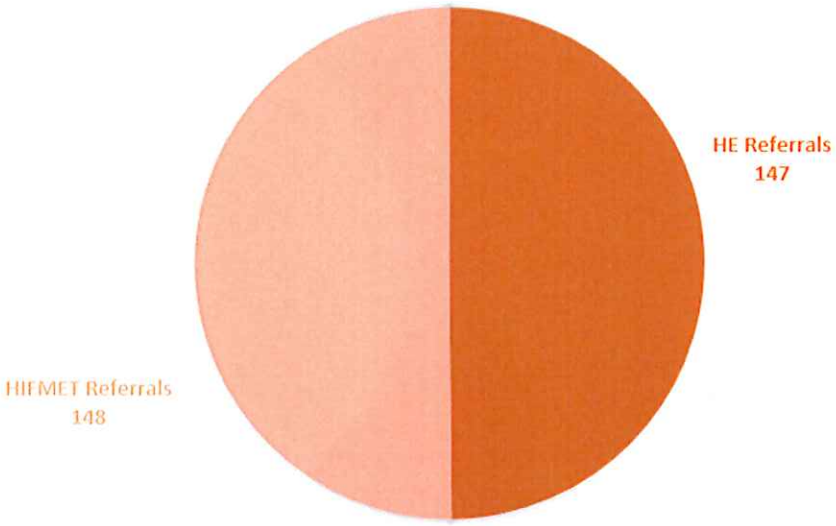


DEC 2017 & JAN 2018 CM REFERRALS



CM Average Referrals per Month Jan - Nov 2017: 276

DEC 2017 & JAN 2018 HE REFERRALS



HE Average Referrals per month Jan - Nov 2017: 56

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: February 26, 2018

SUBJECT: Chief Diversity Officer Update

Actions:

Community Relations – As a part of my continuing community relations efforts, met with Mike Powers, Ventura County Chief Executive Officer for the purpose of sharing my diversity philosophy and the current climate assessment at Gold Coast Healthy Plan. I continue to meet with groups within the GCHP family to understand how they see the environment and what can be done to correct issues as they are identified. Jean and I met with Shawn Atin to review and update him on the status of current outstanding cases. Attended several diversity symposiums in the community to see what other companies are doing related to Diversity and Inclusion. To my knowledge, there are no new cases since ones that were reviewed with the commission in January.

Development of Diversity Strategic Plan

Plan will include mission, vision, council development, charter for the council, membership roles and responsibilities as well as meeting schedule. The group with be diverse and cross leveled.

Training Plan

In partnering with HR and Legal, develop a training plan for everyone in a key leadership role. Jean Halsell and I have been in contact with legal representatives for the purpose of delivering a training module related to:

- Proper documentation
- Having difficult discussions
- Effective appraisal delivery

It is our plan to have these sessions completed over the next quarter.

Diversity Council

In process of developing a diversity council made up of key elements of the GCHP organizational structure. The council will address:

- Educational needs
- Internal and external Communications
- Community Activities
- Symposiums on Diversity and Inclusion
- Mentorship
- Affinity networks (Phase 2)
- Data Trends

Next Commission meeting (March)

- Strategic Plan complete but not ready for group discussion until the March meeting. Working with GCHP's overall strategic plan for consistency of purpose.