Provider Advisory Committee (PAC)

Telephonic Regular Meeting
Executive Order N-25-20
Thursday, April 7, 2020, 7:30 a.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010
Conference Call Number: 1-805-325-7279
Conference ID: 984 339 977#

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Provider Advisory Committee (PAC) on the agenda. Persons wishing to address the Committee should complete and submit a Speaker Card.

Persons wishing to address the PAC are limited to three (3) minutes unless the Chair of the Commission extends time for good cause shown. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission.

Members of the public may call in, using the numbers above, or can submit public comments to the Committee via email by sending an email to ask@goldchp.org. If members of the public want to speak on a particular agenda item, please identify the agenda item number. Public comments submitted by email should be under 300 words.

CONSENT

1. Approval of Provider Advisory Committee (PAC) December 12, 2019 Minutes

Staff: Maddie Gutierrez, CMC – Clerk to the Commission

RECOMMENDATION: Approve the minutes.

UPDATES

2. COVID-19 Update

Staff: Margaret Tatar, Interim Chief Executive Officer
Nancy Wharfield, M.D., Chief Medical Officer

RECOMMENDATION: Receive and file the update.

3. Nurse Advice Line Program

Staff: Nancy Wharfield, Chief Medical Officer

RECOMMENDATION: Receive and file the update.

4. CalAIM Update

Staff: Marlen Torres, Director Government & Community Relations

RECOMMENDATION: Receive and file the update.

5. Quest Diagnostic Lab Contract

Staff: Steve Peiser, Senior Director Network Management

RECOMMENDATION: Receive and file the update.

6. Results of Provider Satisfaction Survey and Provider After Hours Survey

Staff: Steve Peiser, Senior Director Network Management

RECOMMENDATION: Receive and file the update.

7. Annual Network Certification

Staff: Steve Peiser, Senior Director Network Management

RECOMMENDATION: Receive and file the update.

8. Provider Dispute Resolution Process and Provider Manual Update

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Steve Peiser, Senior Director Network Management

RECOMMENDATION: Receive and file the update.

9. Financial Report, Contract Renegotiation and Savings Initiative

Staff: Kashina Bishop, Chief Financial Officer
Steve Peiser, Senior Director Network Management

RECOMMENDATION: Receive and file the update.

ROUNDTABLE/DISCUSSION

ADJOURNMENT

Unless otherwise determined by the PAC, the next meeting is scheduled for June 9, 2020 and will be held 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 Committee after distribution of the agenda packet are available for public review during normal business hours at the office of the Secretary of the Committee.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5562. Notification for accommodation must be made by the Monday prior to the meeting by 1:00 p.m. to enable GCHP to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Provider Advisory Committee

FROM: Maddie Gutierrez, CMC - Clerk to the Commission

DATE: April 7, 2020

SUBJECT: Approval of the Provider Advisory Committee (PAC) Meeting Regular Minutes of November 12, 2019.

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the November 12, 2019 Provider Advisory Committee regular meeting minutes.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
Provider Advisory Committee
November 12, 2019

CALL TO ORDER

Senior Director of Network Management, Steve Peiser, called the meeting to order at 7:33 p.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

ROLL CALL

Present: Committee members Masood Babeian, Joan Buck-Plassmeyer, David A. Fein, Will Garand. Katy Krul, Sim Mandelbaum and Pablo Velez.

Absent: Linda Baker.

1. Welcome and Opening Remarks

Staff: Steve Peiser, Senior Director of Network Management

Mr. Peiser welcomed all present and stated he had sent out some brief information on the change in leadership.

2. Gold Coast Health Plan – Change in Leadership

Staff: Melissa Scrymgeour, Chief Administrative Officer

CAO Scrymgeour stated there was a special Commission meeting on November 1, 2019. The Commission voted to not renew Mr. Villani's contract and Chief Executive Officer, Dale Villani, submitted his resignation, effective immediately. Health Management Associates will provide services as interim CEO until a permanent CEO is found. HMA will make recommendations at the November 18th commission meeting.

PUBLIC COMMENT

None.

CONSENT

3. Approval of Provider Advisory Committee (PAC) Minutes

Staff: Maddie Gutierrez, CMC, Clerk to the Commission

RECOMMENDATION: Approve the minutes.

Committee member Will Garand motioned to approve the minutes as presented.
Committee member Masood Babeian seconded.

AYES: Committee members Masood Babeian, Joan Buck-Plassmeyer, David A. Fein, Will Garand. Katy Krul, Sim Mandelbaum and Pablo Velez.

NOES: None.

ABSENT: Linda Baker.

Mr. Peiser declared the motion carried.

UPDATES

4. State Health Policy Update.

Staff: Marlen Torres, Director of Government & Community Relations.

RECOMMENDATION: Receive and file the update.

Ms. Torres stated at the last PAC meeting she provided the committee with an overview of the Proposition 56 payment concept coming from the Governor's budget. As of now, things are still in draft form. We are still waiting for final implementation and APL letters from the State. Updates will continue to be provided.

REPORTS

5. Proposed CalAIM Initiative

Staff: Marlen Torres, Director of Government & Community Relations

Ms. Torres also provided an overview of the 1115/1915B waiver proposals via PowerPoint presentation from the Department of California Health Care Services called California Advancing and Innovating Medi-Cal (CalAIM) program.

The framework establishes a foundation beyond accessing health services in traditional delivery settings. Key populations that are identified are: High Utilizers, Behavioral Health, Vulnerable children, Homelessness, Justice involved and the Aging population.

The impact to Managed Care will have a streamline approach and increase standardization across all plans. NCQA accreditation for plans, which applies to GCHP. All plans are required to be NCQA accredited by 2025. Medi-Cal managed care plans will need to develop and maintain a patient-centered population health strategy by January 1, 2021.

Enhanced Care Management In Lieu of Services (ILOS) is a new benefit and come under the health plan and will provide a whole person care approach. Provider types were reviewed. ILOS will cover various services which include, housing transition, housing deposits, short-term post hospitalization housing, recuperative care Sobering centers, etc.

DHCS is proposing to discontinue the Cal MediConnect component of the Coordinated care Initiative and begin transition to statewide managed long-term services. This will require that all Medi-Cal managed care plans to operate Dual Eligible Special Needs Plans as of January 1, 2023. Next steps guidelines were also reviewed.

Committee member Garand asked about the Prime program. Ms. Torres stated it will be going away. He also asked about the Quality Incentive Program. Ms. Torres stated it was tied to performance and not a pass thru. We are expecting a final rule within two (2) months.

Mr. Peiser stated this affects many who are present, there is a need to develop a partnership. CMO Nancy Wharfield, M.D. stated this is not just focused on hospitals. Committee member Velez asked about local planning group – who will design for Ventura County. CMO Wharfield stated it is not created yet, it is still early. Committee member Velez stated we need to be active to ensure needs are met. Ms. Torres stated stakeholder workgroups will include public information. GCHP will be involved for members and the community. Committee member Fein stated CalAIM has a website where comments and feedback can be provided. It gives an opportunity for stakeholders to give input.

6. Diabetes Prevention Program

Staff: Pauline Preciado, Director of Population Health

RECOMMENDATION: Receive and file the report.

Ms. Preciado provided a PowerPoint presentation titled GCHP Clinical and Quality Programs Updates. The presentation included the Diabetes Prevention Program (DPP), GCHP Quality Initiatives – MCAS which includes new member incentive programs and engagement program – HMS Eliza.

Ms. Preciado reviewed what the DPP was; it is a lifestyle change designed to assist Medi-Cal members with prediabetes in order to prevent or delay the onset of type 2 diabetes. She reviewed the program requirements and implementation strategy as well as the enrollment process. The program is mandated by DHCS, has 22 peer coaching session and is a yearlong program. There is a credentialing criterion for providers for them to participate.

Committee member Garand stated the hospital association launched an initiative called Communities Lifting Communities throughout Ventura County which provides screenings to identify diagnosis, food access is also coordinated, and doctors are contracted with GCHP. This is a siloed benefit for Medi-Cal members in order to assist in creating a system of care.

Quality Update /quality measures were reviewed. There will be changes done by Gov. Newsom. The minimum performance level has been increased. APL's will need to be met. There will be a focus and development of strategies. The strategies will be based on member data.

Member incentives were reviewed. GCHP has a rewards program for members. There are gift cards to members which expanded to ages 3 to 21 for well child visits. Cervical cancer screenings patients also receive a gift card from target, Amazon or Walmart. It was noted the Postpartum program will end on 12/31/2019.

There is also a member outreach campaign: HMS Elisa – this is a way to reach out to members via phone call to schedule appointments.

Mr. Velez asked what will follow up after the postpartum program ends. Ms. Preciado stated there will be a built-in system via health education which will be done in the hospital. Our staff will be working directly with hospitals. CMO Wharfield stated we need to be good stewards; we must look at lower performing measures and must shift priorities to bring those numbers up. Ms. Preciado stated the incentives are designed to reach successful numbers. GCHP has received Most Improved for two years in a row.

Mr. Mandelbaum asked if there are incentives for flu shots. Ms. Preciado stated there will be an outreach campaign for the flu shot. Mr. Mandelbaum asked if other counties have different initiatives which are specific to county needs. Ms. Preciado stated it was a combination: DHCS mandates needs that must be met and look at local needs in the County. CalAIM has an umbrella approach – Whole Person Care is statewide. Ms. Preciado stated plans share information and are working together based on needs and resources.

7. GCHP Contract Rate Stabilization Initiative

Staff: Steve Peiser, Sr. Director Network Management

RECOMMENDATION: Receive and file the report.

Mr. Peiser stated the Plan has faced financial challenges and the Commission is asking for a deep diver on why we've had the losses.

Rate adjustments will be done – it is not a "one size fits all", not all tolls will be used for all providers. This will not affect access to care or finance with providers.

We are currently negotiating with two hospitals – we are focusing on rate stabilization. We will need to look at strategies and need to standardize. We will need to achieve a capitated arrangement, with the exclusion of Clinicas. With a capitation agreement there will be a savings to the Plan, but there will be some impact on hospitals. Outpatient lab will be affected, chemo labs will continue in outpatient setting. There will be a consolidation of network opportunities, terminating some arrangements that are providing service outside of the County. Hospice rates will change and there will be an increase in some rate and a re-adjustment on others. We need to build up our dollar reserves in order to continue. We need to stabilize resources.

Mr. Garand asked if GCHP is contemplating with physician specialty. Mr. Peiser responded no. Mr. Garand asked what does GCHP consider DME, how is it defined. Mr. Peiser stated there is a need for further internal discussions and evaluate. Mr. Fein asked if GCHP is open to other ideas for stabilizing reserves, has the Plan reached out to providers? Mr. Peiser stated the Plan is open. We are in early stages and open to discussions. The groups need to provide information in order to work in partnership. Mr. Fein stated GCHP needs to have discussions and meetings to get information and accept input prior to finalizing. There are many ways to get to the financial goal.

ROUNDTABLE/DISCUSSION

Ms. Krul stated there was a letter from the Department of Health which stated that sub-contractors need to be Medi-Cal certified. Mr. Peiser stated some providers were terminated. There is a process in place. There is an interim letter of agreement and once certified the sub-contractor will get the agreement. Policies and procedures need to be followed.

Mr. Fein asked if narrowing the network is a priority. Mr. Peiser stated the area of focus cannot impact access. We must keep in mind what is best for the Plan. We need to pick and choose as well as set priorities. Centers of Excellence are far down the road. Mr. Fein

stated he is seeing a lot of sole sourcing outside of the County and it seems to be causing access issues. Mr. Peiser stated members come first, as well as means to enhance quality.

ADJOURNMENT

With no further items to be addressed, Mr. Pablo Velez motioned to adjourn the meeting. Mr. Will Garand seconded. The meeting was adjourned at 9:01 A.M.

Approved:

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Maddie Gutierrez, CMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Provider Advisory Committee

FROM: Margaret Tatar, Interim Chief Executive Officer
Nancy Wharfield, MD, Chief Medical Officer

DATE: April 7, 2020

SUBJECT: COVID-19 Update

COVID-19 Update

GCHP continues to respond to directives from federal, state, and local governments relating to the pandemic crisis. In addition, GCHP has redoubled its efforts to outreach to the Ventura County community we serve by proactively outreaching to members, providers, the community, and staff about the crisis.

Staff

GCHP moved to a telework environment starting on Monday, March 23, 2020, to allow the Plan to continue to serve members and keep employees (and the community) as safe as possible. While the office is closed, visitors are advised to call the Plan's call center. The call center is routing the calls accordingly.

The leadership team is sending daily emails to employees to educate, acknowledge, thank, and provide support during this time.

Members

GCHP has posted information about COVID-19 on the Plan's website, including a list of frequently asked questions and information about the new 24-hour Advice Nurse Line. Information about the hotline also was mailed to the homes of members.

The Plan's Member Services manager went on the air with two radio stations to inform members about precautions they can take to prevent getting sick with COVID-19, the symptoms to watch for, and the importance of calling their doctor first to receive medical advice. Radio ads are running on English and Spanish radio stations as well.

Providers

GCHP's website also has been updated with information for providers. It includes all communications that have been sent out to providers, along with links to resources.

- March 25: 24-Hour Advice Nurse Line for Members
  Informed providers about the launch of the Plan's hotline.

- March 20: Access to the Preauthorization Treatment Request Form
  Communicated how providers can access the Preauthorization Treatment Request Form when/if they are unable to access it through the portal.
- March 20: Issues Affecting Access to Pharmacy Services During the COVID-19 Pandemic
  This communication let providers know that we created a document with information for pharmacies and pharmacists regarding benefit status and formulary changes made to ensure necessary access for Plan members. The document contains information about:
    - Day Supply Limits and Refill-Too-Soon Edits
    - Utilization Management Edits (PA, ST, QL, AGE, etc.)
    - Reported Drugs with Limited Inventory in Ventura County
- March 19: COVID-19 Information and Resources
  Provided information on COVID-19 testing, diagnostic codes and share of cost, along with information on prescription refills and links to resources from the Centers for Disease Control and Prevention.
- March 13: COVID-19 Testing by Quest Diagnostics
  This email notified providers that testing was available through Quest and that high-risk cases should continue to be sent to Public Health.

All email communications have been posted – and will continue to be posted – to the GCHP website.

As necessary, GCHP also has been reaching out to the leaders of all major health systems individually to communicate pertinent information.

RECOMMENDATION:

Receive and file the update.

www.goldcoasthealthplan.org

AGENDA ITEM NO. 3

TO: Provider Advisory Committee

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: April 7, 2020

SUBJECT: Nurse Advice Line for Gold Coast Health Plan Members

SUMMARY:

Gold Coast Health Plan (GCHP) has partnered with Carenet, a national 24/7 Nurse Advice Line service used by many Medi-Cal Managed Care Plans to provide telephonic advice to our members. The service, which went live March 25, 2020, uses registered nurses accessing evidence-based care guidelines to provide advice to members in the language of their choice. Carenet nurses have been supplied with information about local Ventura County resources such as urgent care hours and mental health resources. Nurses can help member decide:

- If they need to go to urgent care
- Can wait to see their doctor
- Can take care of their symptoms at home
- What they should do about COVID-19 symptoms or concerns

Information about the Nurse Advice Line has been advertised through our communication channels including the GCHP website, press releases, and member mailings.

To reach the Advice Nurse Line, members can call 1-805-437-5001

The toll-free number is 1-877-431-1700.

For TTY, members can call 711.

RECOMMENDATION:

Receive and file the update.

AGENDA ITEM NO. 4

TO: Provider Advisory Committee

FROM: Marlen Torres, Director of Government & Community Affairs

DATE: April 7, 2020

SUBJECT: Cal-AIM Update

<u>Government Relations Update</u>

California Advancing and Innovating Medi-Cal (CalAIM) Update

In February, the Department of Health Care Services (DHCS) held a health plan convening primarily focusing on the Enhanced Care Management (ECM) benefit and In Lieu of Services (ILOS).

Meeting highlights are the following:

- Counties who currently have a Whole Person Care (WPC) Pilot and/or a Health Homes Program will start implementing the benefit on January 1, 2021.
- DHCS is developing an ECM and ILOS toolkit for plans and counties to use when determining how to best transition the WPC Pilot to the ECM/ILOS benefit.
  - DHCS will convene regional meetings with health plans and counties.
  - DHCS will hold informational/technical webinars and assemble strike teams for further guidance.
- In the transition plan, health plans must conduct a crosswalk of services offered under WPC to those that will be offered through ECM/ILOS and status of communication with WPC lead entity.
  - Health plans must demonstrate how it will ensure continuity of care for members receiving WPC services at the point of transition prior to reassessment. Plans will need to use risk stratification to determine the appropriate tiers/levels of care for WPC transition to ECM.
  - Health plans must have a plan for continuing partnerships and data sharing and care management systems developed and implemented under WPC.
  - Health plans must demonstrate how they are going to communicate changes to beneficiaries and ensuring continuity of care.
  - Plans must identify and assess care needs for ECM target populations and implement ILOS that are not transitioning from WPC.

- Health plans will need to indicate which ILOS they will offer beneficiaries.

DHCS also held a high-level discussion regarding rate development for this benefit. At this time, rates will be developed with the preliminary assumption that this benefit will serve approximately one percent of managed care members. Funding for the ECM benefit will be included in the capitation rates. DHCS also acknowledged health plans may need to outreach to approximately two to three percent of members in order to fully engage the targeted one percent of health plan members.

The current anticipated rate approach would be to leverage the Health Homes Program rate development structure and then modify components, factors, and assumptions to fit the final ECM program design and parameters.

Finally, per the Governor's FY 2020-2021 proposed budget, an Incentive Program will be offered statewide to all plans for the service period of January 2021 to June 2023. The purpose of the Incentive Program is to reward plan investment in ECM and ILOS implementation since ILOS will not receive capitation payments. The Incentive Program will be designed to reward plans who meet defined milestone/metrics tied to ECM/ILOS and each individual proposal by health plans must be approved by DHCS.

DHCS is scheduled to release its final proposal in April, hold stakeholder meetings in May and submit its final draft to the Centers for Medicare and Medicaid Services (CMS) in June. However, timelines may change, stakeholders are waiting for an update from DHCS.

Local CalAIM Stakeholder and Planning Meetings

In December 2019, at the Commission Strategic Planning Retreat, staff gave an overview of the Medi-Cal Healthier California for All proposals. Staff also presented the Commission its strategy for preparing to implement the Medi-Cal Healthier California for All proposals. The Commission agreed that staff should hold meetings with external stakeholders.

In January 2020, GCHP began holding stakeholder and planning meetings. The first meeting convened the Chief Executive Officers and key leadership from all the major health systems in Ventura County. At this meeting, a general overview of the Medi-Cal Healthier California for All proposal was given. The group agreed that GCHP should engage the appropriate personnel from each health system to further discuss the current population health management initiatives across the county and how they can play a role in shaping GCHP's population health management strategy under this proposal. GCHP committed to keeping the group informed of key updates and reconvening in May for final information.

In February, GCHP sent a letter to this group outlining the CalAIM proposal updates and indicated it will hold another convening in May to present the final DHCS proposal that will be submitted to the Centers for Medicare and Medicaid Services (CMS).

GCHP staff also met with the Ventura County Health Care Agency (HCA) to discuss specifically how the current Whole Person Care Pilot is administered and how this pilot will transition into the ECM benefit under GCHP. The second meeting with leadership from the HCA was to discuss Targeted Case Management connections to the ECM benefit and Medi-Cal Healthier California for All proposal changes and how they will impact the implementation of the ECM benefit. Updates regarding the ECM benefit and ILOS were discussed at this meeting.

Once DHCS provides an update, GCHP will determine how to best proceed with local stakeholder meetings.

AGENDA ITEM NO. 5

TO: Provider Advisory Committee

FROM: Steve Peiser, Senior Director Network Management

DATE: April 7, 2020

SUBJECT: Quest Diagnostic Lab Update

RECOMMENDATION:

Receive and file the update.

AGENDA ITEM NO. 6

TO: Provider Advisory Committee

FROM: Steve Peiser, Senior Director Network Management

DATE: April 7, 2020

SUBJECT: Results of Provider Satisfaction Survey and Provider After Hours Survey

RECOMMENDATION:

Receive and file the update.

Gold Coast Health Plan
A Public Entity

Gold Coast Health Plan SPH Analytics Provider Satisfaction and Access Survey Results 2019

Integrity

Accountability

Collaboration

Trust

Respect

711 East Daily Drive, Suite 106, Camarillo, CA 93010 www.goldcoasthealthplan.org

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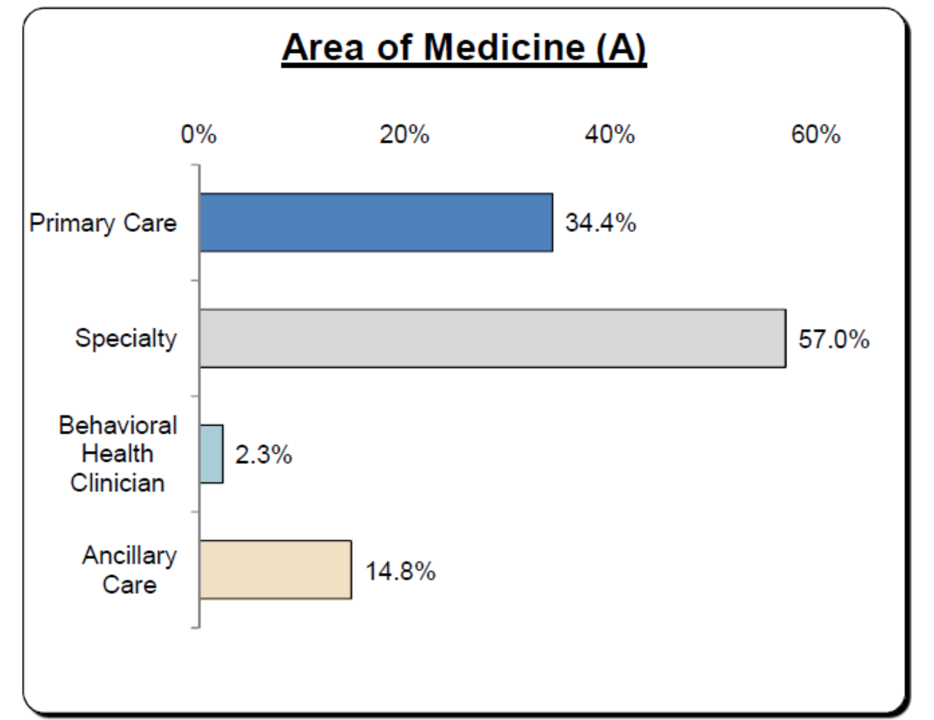
Objective

<u>Provider Satisfaction Survey-</u> Identify provider perspective of Plan on multiple organizational areas: Finance, UM/QM, Network/Coordination of Care, Pharmacy, Call Center and Provider Relations

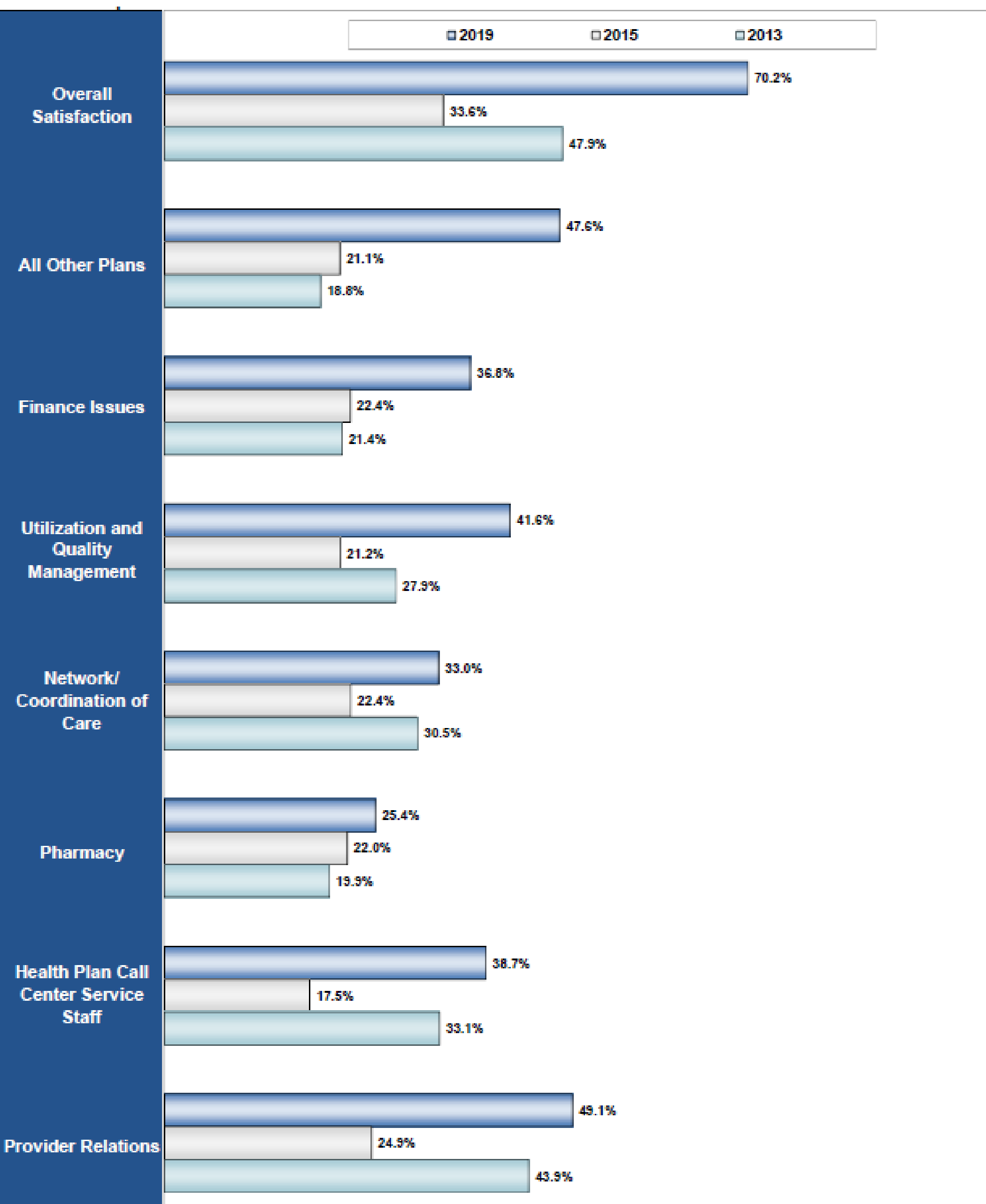
<u>Timely Access Survey</u> -To determine if provider offices are adhering to contractual obligations pertaining to DHCS Timely Access Standards.

Provider Satisfaction Survey

- Response Rate approximately 17.5% of practice locations



Due to anonymity of survey, GCHP is unable to identify # of providers that correlate with the volume of responders. IE-17.5% responses may account for “x” number of providers



The Plan has had SPH perform provider satisfaction surveys in 2013, 2015 and 2017.

There were 6 areas of the organization surveyed.

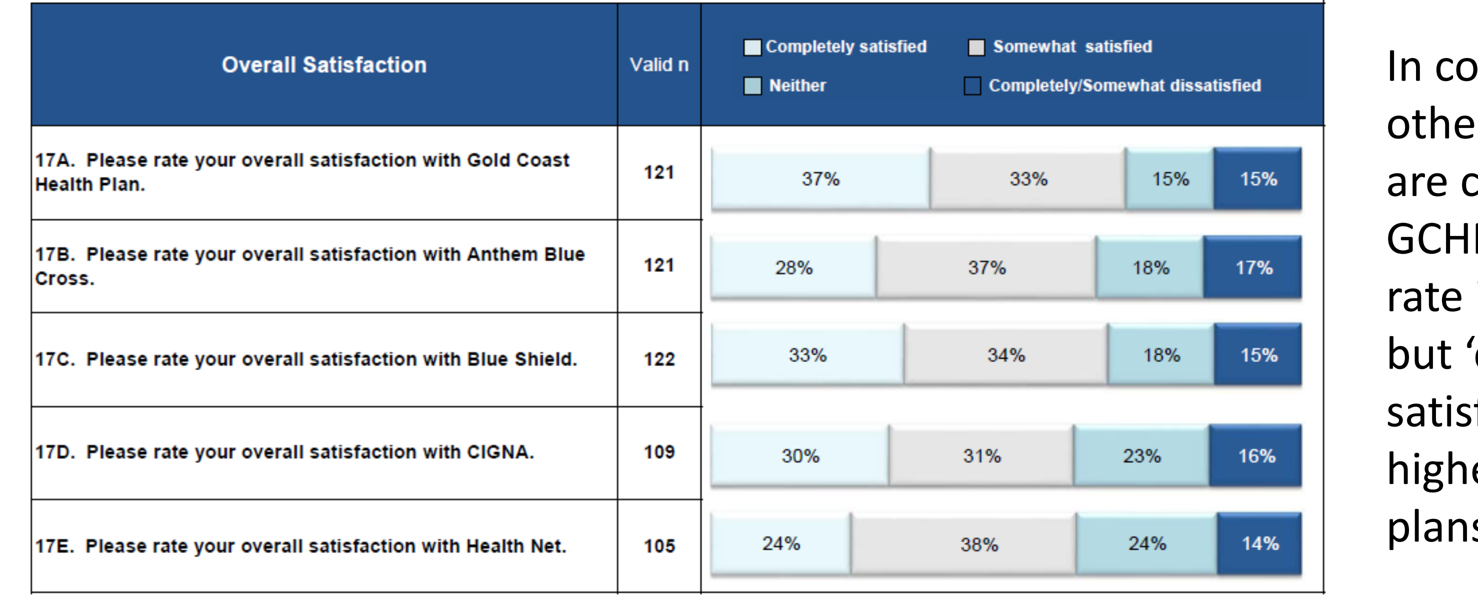
2019 has shown a significant increase in satisfaction rate in all measured areas.

Overall satisfaction for GCHP 2019 was 70.2% vs 33.6% for 2015 and 47.9% for 2013.

In comparison to all other Plans SPH has surveyed, GCHP rates for 2019 was higher.

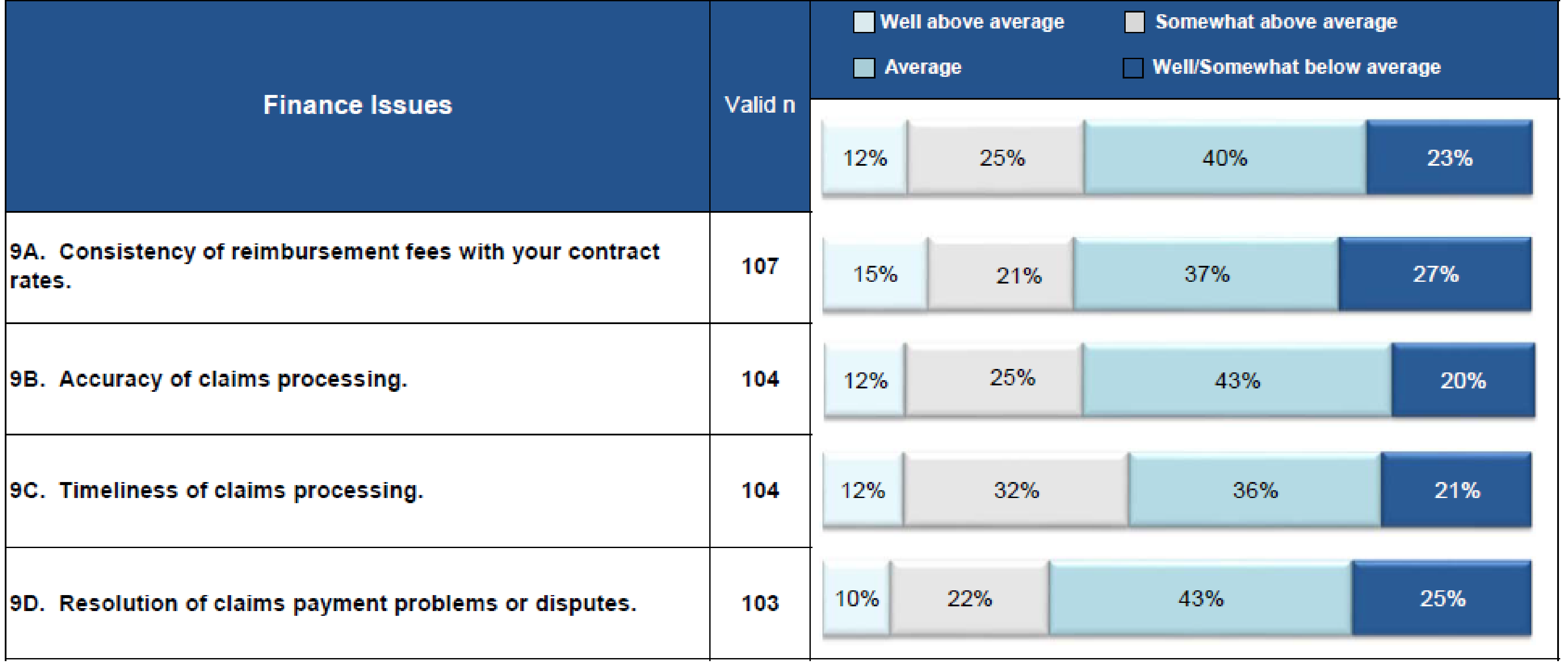
Comparative Rating	Valid n	Well above average	Somewhat above average	Average	Well/Somewhat below average
8. How would you rate Gold Coast Health Plan compared to all other health plans you contract with?	124	18%	30%	34%	19%

Overall Satisfaction segmented identifies 18% satisfaction was well above average, 30% for 'somewhat above average' and 34% for 'average.'



Overall Satisfaction	Valid n	Completely satisfied	Somewhat satisfied	Neither	Completely/Somewhat dissatisfied
17A. Please rate your overall satisfaction with Gold Coast Health Plan.	121	37%	33%	15%	15%
17B. Please rate your overall satisfaction with Anthem Blue Cross.	121	28%	37%	18%	17%
17C. Please rate your overall satisfaction with Blue Shield.	122	33%	34%	18%	15%
17D. Please rate your overall satisfaction with CIGNA.	109	30%	31%	23%	16%
17E. Please rate your overall satisfaction with Health Net.	105	24%	38%	24%	14%

In comparison to other plans providers are contracted with, GCHP dissatisfaction rate is comparable, but 'completely satisfied' rates are higher than other plans.



Overall satisfaction rate 77%

Opportunity for improvement: The main driver of dissatisfaction with the Plans finance segment revolved around reimbursement of contracted rates and provider disputes. GCHP has been in process of enhancement contract fee schedule review and the provider dispute resolution review process.

Utilization and Quality Management	Valid n	Well above average	Somewhat above average	Average	Well/Somewhat below average
10A. Access to knowledgeable UM staff.	93	18%	24%	44%	14%
10B. Procedures for obtaining pre-certification/referral/authorization information.	101	12%	23%	53%	13%
10C. Timeliness of obtaining pre-certification/referral/authorization information.	103	15%	28%	46%	12%
10D. The health plan's facilitation/support of appropriate clinical care for patients.	109	18%	25%	41%	16%
10E. Access to Case/Care Managers from this health plan.	89	16%	23%	47%	15%
10F. Degree to which the plan covers and encourages preventive care and wellness.	92	19%	24%	39%	18%

Overall satisfaction rate 86%

Opportunity for improvement: Access to case/care managers (10E) rated the highest level of dissatisfaction in the UM/QM management area, 82% approved.
Encouragement of preventative care and wellness rated the highest satisfaction rate.

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Network/Coordination of Care	Valid n	Well above average	Somewhat above average	Average	Well/Somewhat below average
		12%	21%	52%	15%
11A. The number of specialists in this health plan's provider network.	**113**	11%	20%	49%	20%
11B. The quality of specialists in this health plan's provider network.	**112**	12%	24%	54%	11%
11C. The timeliness of feedback/reports from specialists in this health plan's provider network.	**105**	12%	20%	52%	15%

Overall satisfaction rate 85%.

Opportunity for improvement: Satisfaction of the number of specialists in the network had the highest dissatisfaction rate. 80% of survey responded indicated an average or higher satisfaction rate.

Pharmacy	Valid n	Well above average	Somewhat above average	Average	Well/Somewhat below average
12A. Consistency of the formulary over time.	95	9%	17%	59%	16%
12B. Extent to which formulary reflects current standards of care.	96	11%	23%	54%	13%
12C. Variety of branded drugs on the formulary.	89	9%	19%	61%	10%
12D. Ease of prescribing your preferred medications within formulary guidelines.	91	7%	12%	57%	24%
12E. Availability of comparable drugs to substitute those not included in the formulary.	91	9%	15%	62%	14%
		8%	14%	60%	18%

Overall satisfaction rate 84%.

Opportunity for improvement: Highest rate of dissatisfaction based around the variety of branded drugs on the formulary.

Health Plan Call Center Service Staff	Valid n	Well above average	Somewhat above average	Average	Well/Somewhat below average
		16%	23%	48%	13%
13A. Ease of reaching health plan call center staff over the phone.	102	14%	22%	46%	19%
13B. Process of obtaining member information (eligibility, benefit coverage, co-pay amounts).	99	18%	23%	49%	9%
13C. Helpfulness of health plan call center staff in obtaining referrals for patients in your care.	97	16%	24%	46%	13%
13D. Overall satisfaction with health plan's call center service.	108	15%	23%	52%	10%

Overall satisfaction rate 87%

Opportunity for improvement: Ease of reaching health plan call center staff over the phone.

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Provider Relations	Valid n	Well above average	Somewhat above average	Average	Well/Somewhat below average
15A. Provider Relations representative's ability to answer questions and resolve problems.	57	31%	18%	43%	8%
15B. Quality of provider orientation process.	90	40%	18%	32%	11%
15C. Quality of written communications, policy bulletins, and manuals.	96	27%	21%	44%	8%

Overall satisfaction rate 92%

Opportunity for improvement: Provider relations representative's ability to answer questions and resolve problems.

Provider Access Availability Audit

Key Notes

Audit topics and appointment types: urgent care, non-urgent care, office wait time, patient call back time, physical/well-woman exams (PCP only), preventive/well-child exams (PCP only), and initial routine care visits (Specialist only).

Data collected: September and October 2019.

Plan utilized SPH for the same access audit in 2018.

Audit represents 672 total providers: 194 PCPs and 478 Specialists.

Year to Year PCP Audit Results

Audit Item		Access to Care Standard	PCP		Sig. Testing
			2019	2018	
Q2	Urgent Care - Primary Physician	Within 24 hours/ Go to urgent care	62.3%	55.0%	↔
Q2B	Urgent Care - Supplemental Physician		41.7%	66.0%	↓
Q2/ Q2B	Urgent Care - Overall Compliance		70.2%	82.1%	↓
Q3	Non-Urgent Appt. - Primary Physician	Within 10 business days	82.6%	75.8%	↔
Q3B	Non-Urgent Appt. - Supplemental Physician		76.5%	100.0%	↔
Q3/ Q3B	Non-Urgent Appt. - Overall Compliance		89.5%	99.6%	↔
Q4	Office Wait Time	45 minutes or less	86.2%	79.3%	↔
Q5	Patient Call Back Time	Within 60 minutes	62.7%	53.8%	↔
Q6	Physical/Well-Woman Exam	Within 10 business days	83.1%	88.7%	↔
Q7	Preventive/Well-Child Exam	Within 10 business days	91.7%	86.1%	↔

- The PCP scores for the following questions increased in 2019: office wait time, patient call back time, and preventive/well-child exam. These changes were not statistically significant.
- The overall compliance rate for urgent care decreased significantly among PCPs since 2018.

Note: “Sig. Testing” indicates whether or not the year-over-year change was statistically significant. A green arrow indicates a significant increase since the previous year, while a red arrow indicates a significant decrease. No arrow indicates that either the difference was not significant or significance testing is unable to be performed.

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Year to Year Specialist Audit Results

Audit Item		Access to Care Standard	Specialists		Sig. Testing
			2019	2018	
Q2	Urgent Care - Primary Physician	Within 24 hours/ Go to urgent care	50.0%	43.3%	↔
Q2B	Urgent Care - Supplemental Physician		51.1%	60.8%	↔
Q2/ Q2B	Urgent Care - Overall Compliance		60.9%	55.6%	↔
Q3	Non-Urgent Appt. - Primary Physician	Within 15 business days	85.5%	87.3%	↔
Q3B	Non-Urgent Appt. - Supplemental Physician		80.0%	69.7%	↔
Q3/ Q3B	Non-Urgent Appt. - Overall Compliance		90.7%	93.2%	↔
Q4	Office Wait Time	45 minutes or less	96.1%	93.7%	↔
Q5	Patient Call Back Time	Within 60 minutes	75.3%	63.6%	↑
Q6	Routine Care Initial Visit	Within 15 business days	70.0%	79.6%	↓

- The Specialist scores for the following questions increased in 2019: urgent care overall and office wait time. These changes were not statistically significant.
- The Specialist compliance rate for patient call back time significantly increased in 2019, while the compliance rate for a routine care initial visit significantly decreased since 2018.

Note: “Sig. Testing” indicates whether or not the year-over-year change was statistically significant. A green arrow indicates a significant increase since the previous year, while a red arrow indicates a significant decrease. No arrow indicates that either the difference was not significant or significance testing is unable to be performed.

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Q#	Audit Item	PCP				Specialist			
		Total Answering	Total Compliant	Total Non-compliant	Compliance Rate	Total Answering	Total Compliant	Total Non-compliant	Compliance Rate
Q2/Q2B	**Urgent Care - Overall Compliance**	191	134	57	**70.2%**	440	268	172	**60.9%**
Q3/Q3B	**Non-Urgent Appt. - Overall Compliance**	190	170	20	**89.5%**	463	420	43	**90.7%**
Q4	**Office Wait Time**	189	163	26	**86.2%**	460	442	18	**96.1%**
Q5	**Patient Call Back Time**	177	111	66	**62.7%**	453	341	112	**75.3%**
Q6	**Physical/Well-Woman Exam**	183	152	31	**83.1%**				
Q7	**Preventive/Well-Child Exam**	180	165	15	**91.7%**				
Q6	**Routine Care Initial Visit**					450	315	135	**70.0%**

- PCPs had the highest rates of compliance for preventive/well-child exams (91.7%) and non-urgent appointments (89.5%).
- Specialists has the highest rates of compliance for office wait time (96.1%) and non-urgent appointments (90.7%).
- Approximately seven in 10 (70.2%) PCP offices provided a compliant response for urgent care, while 60.9% of Specialist offices answered in a compliant manner for urgent care.

Note: “Total Answering” is the number of providers who answered the question with either a compliant or noncompliant response. “Total Compliant” represents the number of providers who gave a compliant response for the given question. “Total Noncompliant” represents the number of providers who answered in a noncompliant manner. “Compliance Rate” represents the percentage of provider offices that answered in a compliant manner for the given question.

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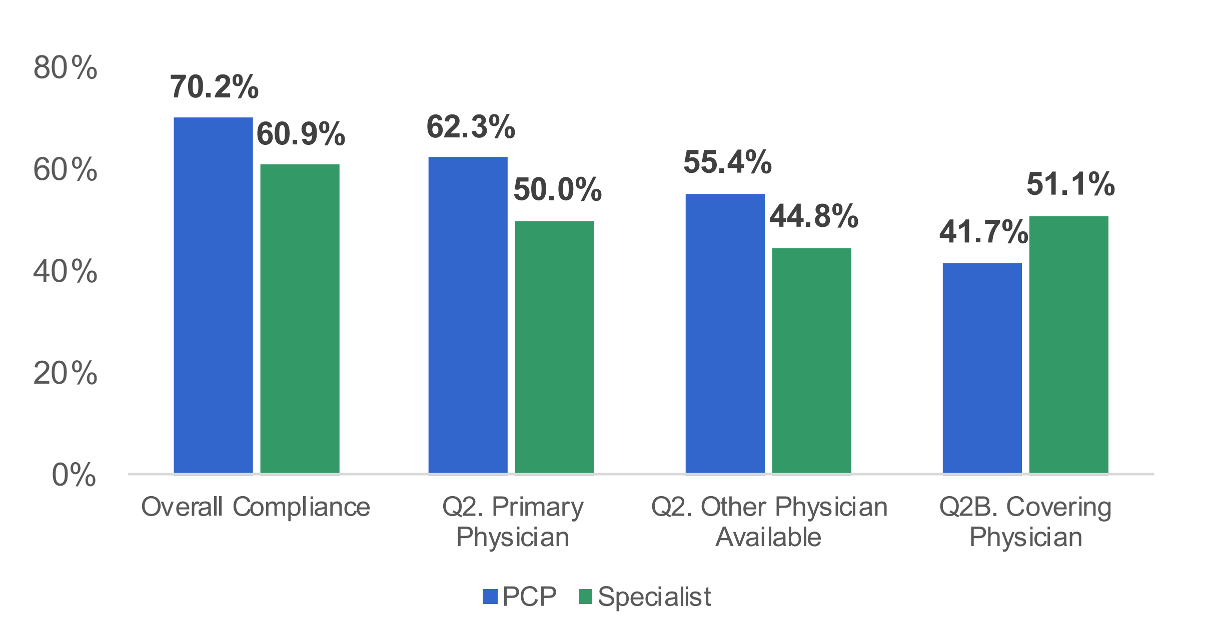
Urgent Care

Access to Care Standard: Within 24 hours/Patient will be seen today as a walk in or work in/Same day appointment/Go to an urgent care center

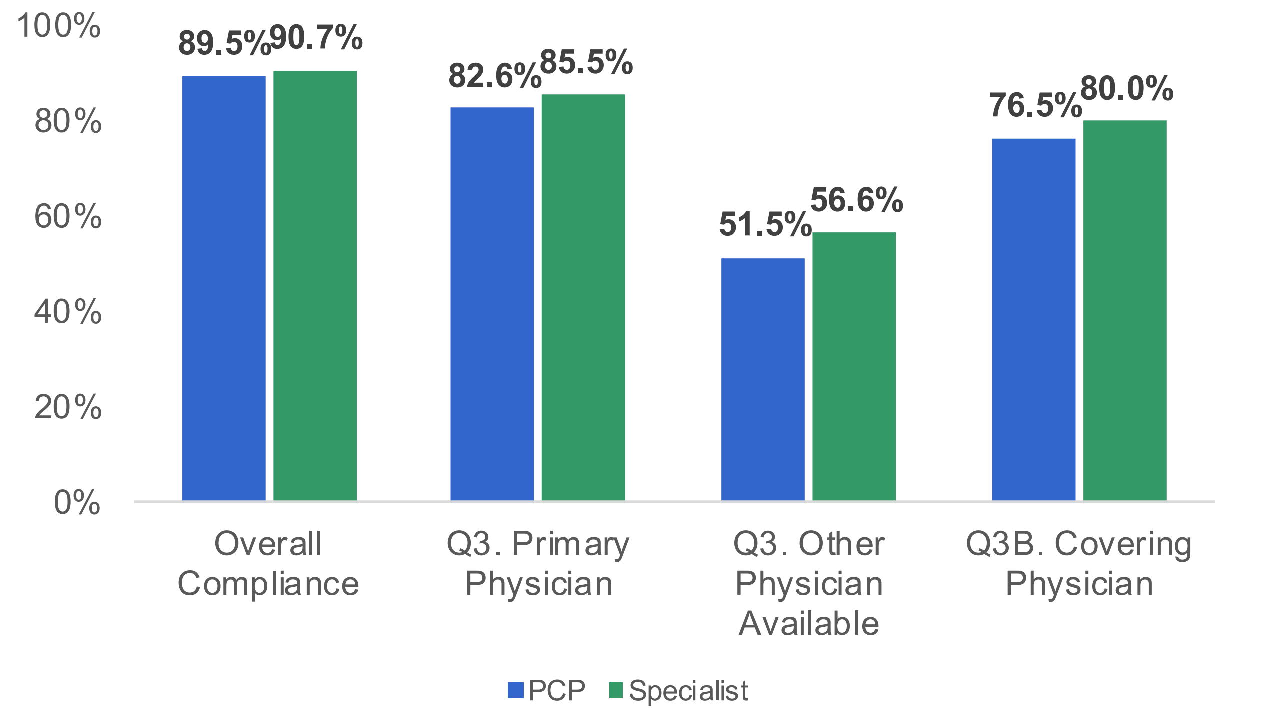


Overall, PCPs had a higher rate of compliance (70.2%) for providing urgent care in comparison to Specialists (60.9%).

Approximately six in 10 PCP offices and half of Specialist offices answered in a compliant manner when the office was asked about urgent care availability for the primary physician being audited.

Non-Urgent Appointment

Access to Care Standard: Within 10 business days (PCP)/Within 15 business days (Specialist)/Patient will be seen today as a walk in or work in/Same day appointment



PCP and Specialist offices had very similar compliance rates when asked how soon a patient could be seen for a non-urgent care appointment for a patient enrolled in Gold Coast Health Plan (89.5% and 90.7%, respectively).

When asked about the primary physician being audited, 82.6% of PCPs and 85.5% of Specialists answered in a compliant manner for non-urgent care appointments

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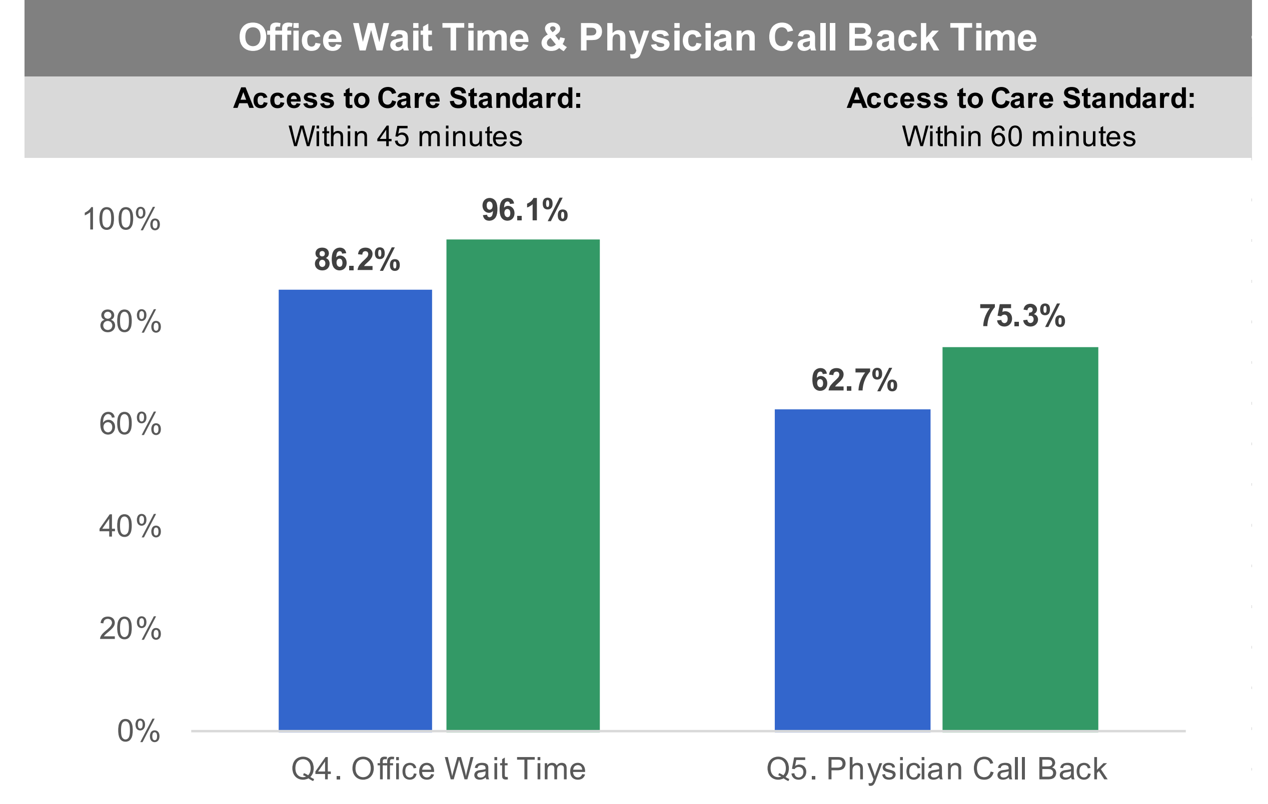

When asked how long a patient waits in the waiting room on average before being taken to the exam room, 86.2% of PCP offices said that patients are usually seen within 45 minutes. Specialist offices had a higher rate of compliance (96.1%) for the average office wait time.

More Specialists were compliant (75.3%) than PCPs (62.7%) when stating how long it takes for a medical professional to call a patient back if someone is not immediately available to assist a patient that believes they need immediate but not emergency care.

Audit Item		Access to Care Standard	PCP		Sig. Testing
			2019	2018	
Reached a Recording/Auto-Attendant					
Q2	**Emergency Instructions and Advice Provided**	Recording intercepted by live person/Hang up, dial 911, go to ER/Press # or stay on the line to be connected to provider or nurse or to speak to after-hours service rep. or operator/Provides number for physician or nurse	**100.0%**	**100.0%**	↔
Q3	**Instructions Provided in Spanish**	Yes/Recording intercepted by a live person	**93.2%**	**100.0%**	↔
Reached a Live Person					
Q4	**Put on Hold**	No	**84.4%**	**99.5%**	↔
Q5	**Emergency Instructions and Advice Provided**	Hang up, dial 911, go to ER/Connect caller to provider or nurse/Take caller information and give to doctor or nurse/Nurse must triage/This is the provider	**90.7%**	**97.6%**	↓

- 100% of PCP offices were compliant in adhering to the Gold Coast access to care standard for providing emergency instructions.
- In comparison to 2018 (100%), slightly fewer PCP offices' recordings had the option to listen to the recording in Spanish in 2019 (93.2%).
- Fewer provider offices were compliant in providing emergency instructions and advice when a live person was reached, as the compliance rate among PCPs decreased from 97.6% in 2018 to 90.7% in 2019. This change was statistically significant.

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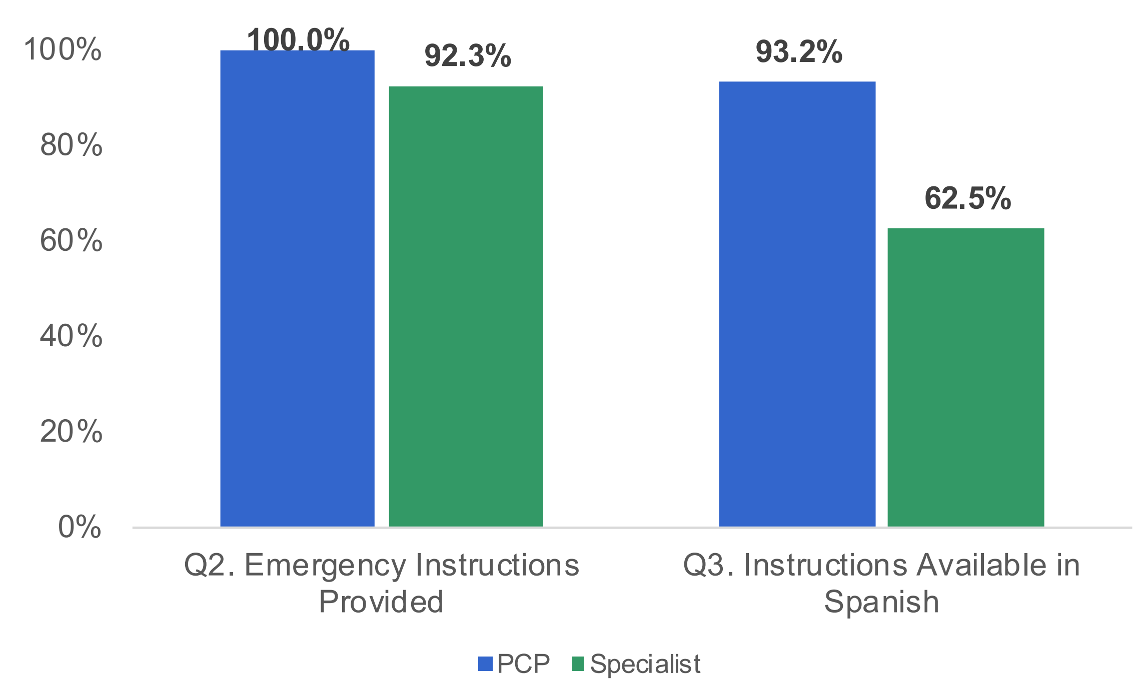
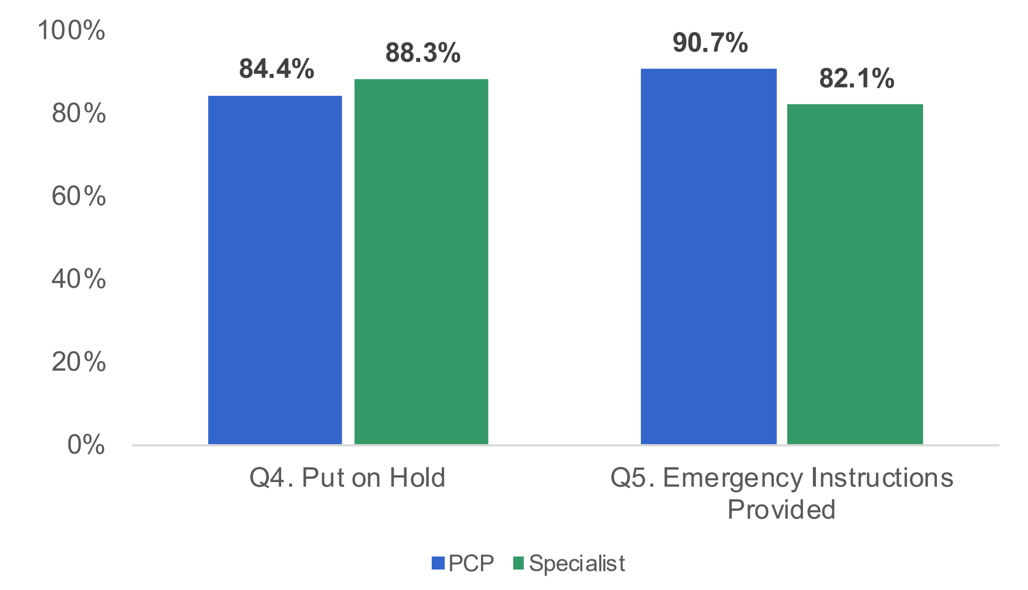


92.3% of Specialist offices' recordings were compliant per Gold Coast's access to care standards.

PCP offices had a higher rate of compliance (93.2%) in comparison to Specialist offices (62.5%) with regard to providing the option to listen to the after-hours recording in Spanish.



Slightly more Specialist offices (88.3%) put the caller on hold in comparison to PCP offices (84.4%).

When the live person was asked what they would tell a patient calling with an emergency situation, more PCP offices (90.7%) than Specialist offices (82.1%) provided a compliant response.

Overall lessons learned and opportunities for improvement:

Provider Satisfaction

- Increased provider outreach to respond to survey
- Collaborative Contract Rate auditing between Vendor and Plan
- Enhanced PGR process
- Continued review for provider network needs
- Enhancement to call center staff processes to minimize provider abrasion

Provider Access Audit

- Provider education
- Provider Outreach: Provider Operations Bulletin, Provider Manual, Provider relations, Provider site visits

AGENDA ITEM NO. 7

TO: Provider Advisory Committee

FROM: Steve Peiser, Senior Director Network Management

DATE: April 7, 2020

SUBJECT: Annual Network Certification

RECOMMENDATION:

Receive and file the update.

AGENDA ITEM NO. 8

TO: Provider Advisory Committee

FROM: Nancy Wharfield, MD, Chief Medical Officer
Steve Peiser, Senior Director Network Management

DATE: April 7, 2020

SUBJECT: Provider Dispute Resolution Process and Provider Manual Update

RECOMMENDATION:

Receive and file the update.

AGENDA ITEM NO. 9

TO: Provider Advisory Committee

FROM: Kashina Bishop, Chief Financial Officer
Steve Peiser, Sr. Director, Network Management

DATE: April 7, 2020

SUBJECT: Financial Report, Contract Renegotiation and Savings Initiative

FYTD Financial Highlights

1. Gold Coast Health Plan (GCHP) is reporting a fiscal year to date (FYTD) net loss of $3.2 million, which is generally attributable to the following:

2. February FYTD net revenue is $547.3 million. This reflects a $27.9 million and 5% favorable budget variance, and a $64.0 increase over last year. Significant impacts to revenue are as follows:
   a. The aggregate membership is over budget by 1%. Due to the widespread economic impact of COVID-19, which is resulting in a rise in unemployment, the Plan is projecting a growth in membership. Staff will continue to monitor changes in unemployment. Below is historical data which reflects changes in Medi-Cal enrollment following a recession.

Years Spanned (Total # of Months During Economic Recession)[1]	Start Date of Economic Recession	End Date of Economic Recession	Year-over-year change in Medi-Cal Enrollment[2]
1970 (11)	January 1970	November 1970	22.6%
1973-1975 (16)	December 1973	March 1975	-2.2% 3.9% 9.1%
1980 (6)	February 1980	July 1980	4.8%
1981-1982 (16)	August 1981	November 1982	3.9% -1.4%
1990-1991 (8)	August 1990	March 1991	13.1% 16.6%
2001 (8)	April 2001	November 2001	8.2%
2008-2009 (18)	January 2008	June 2009	2.5% 5.3%

[1] Source: Department of Health Care Services (DHCS), Research and Analytic Studies Division (RASD), *Medi-Cal Statistical Brief, August 2015*
[2] This increase could also include changes in eligibility so this may not reflect a direct link to the recessionary growth only.

b. Case mix is contributing to both higher revenue and expense; for example, the number of members in the Child AID category is under budget while the membership in the Seniors and Persons with Disability (SPD) AID categories are over budget. Due to disparities in cost for members in the various AID categories, that Plan is paid a higher capitation rate for those members in the SPD AID category.
c. Due to increasing risk of the population, GCHP received revised FY 19-20 draft capitation rates from the State which were 1.7% higher than budgeted.

3. FYTD Health care costs are $518.4 million; this equates to a $38.0 million and 8% unfavorable budget variance. In addition, this is an increase of $46.0 million from the prior year. The medical loss ratio is 94.7% of revenue, which is 2.2% higher than the budget. We attribute this to the following:
   a. Membership is over budget by 1% which will impact the anticipated medical expenses. This is offset by increased capitation revenue from the State.
   b. Case mix is contributing to both higher revenue and expense, as noted above.
   c. The State validated the assertion that as the membership declines, it is the healthier population that are disenrolled, increasing the overall per member per month costs of the remaining membership. If membership increases as a result of COVID-19, we will anticipate this trend to reverse.
   d. Due to the overall increase in acuity of the members, acute inpatient admissions per 1,000 members has increased from 54.87 in FY 18-19 to 58.21 in FY 19-20, a 4% increase, and the average cost per admit has increased approximately 5%.
   e. There has been a significant decrease in outpatient costs in part due to an effort to improve contract language which better defines high cost drugs. Costs associated with drugs provided at a facility are categorized to the facility category of service.
   f. Physician Specialty costs have continued to increase. The primary drivers are dermatology, physical therapy, orthopedic surgery, and physical medicine and rehabilitation. Dermatology is beginning to decrease due to a provider termination in November. The increase in Physical therapy is primarily related to services being provided to children, which is a key niche area of which there is key expertise regarding children with developmental disabilities. These children where previously cared for in the Tri-Counties Regional Center, but under revisions in Medi-Cal rules these services were transitioned to the Plan. The increase in orthopedic surgery is due to an effort to increase access, as there had been a shortage of providers. Physician specialty costs is an area of focus for the Expense and Utilization workgroup.

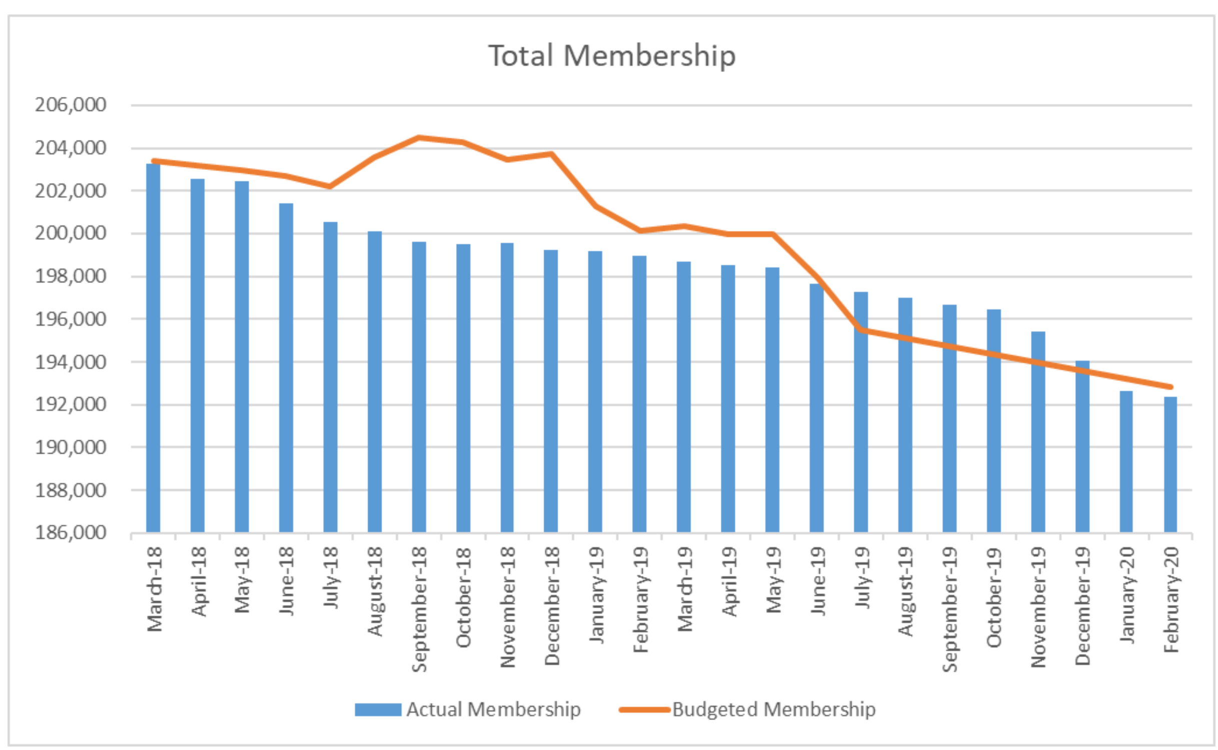
Provider Type	CY 2018	CY 2019	$ Change	% Change
Dermatology	1,626,344	2,721,700	1,095,356	67%
Physical therapist (independently practicing)	2,301,912	3,162,441	860,529	37%
Orthopedic surgery	935,301	1,398,204	462,903	49%
Physical medicine and rehabilitation	1,314,557	1,741,807	427,250	33%
Hematology/oncology	646,794	982,876	336,082	52%
Pathology	1,549,106	1,770,815	221,710	14%
Physician assistant	125,643	322,688	197,045	157%
Internal medicine	2,272,675	2,466,482	193,807	9%
Ophthalmology	2,068,660	2,259,015	190,355	9%
Pulmonary disease	376,401	566,243	189,842	50%

g. Behavioral and mental health utilization increased significantly in 2019 with behavioral health benefits being extended to members that do not have an autism diagnosis. The increased cost is offset by supplemental payments from the State.
h. Pharmacy expense is over budget by $4.0 million and 5% due to increases in both utilization and unit costs. On a per member per month basis, pharmacy costs have increased 5% from the prior year fiscal year.

4. The administrative cost ratio is 6.1%, compared to a budget of 7.5%. This is comparable to other local health plan.

5. Tangible Net Equity is $72.4 million which represents approximately 32 days of operating expenses in reserve and 219% of the required amount by the State.

6. Current membership for February is 192,346, although it will increase with retroactivity. Member months for the year are at 1,561,834 which 1% greater than budget.



Expense and Risk Management Strategies

The Plan is specifically and aggressively engaged in a variety of activities aimed at tightening internal controls, minimizing further reductions to TNE, and mitigating potential risk areas that could have an adverse financial impact on the Plan. We are working to:

1. Improve Reporting for DHCS Rate Development Template and Supplemental Data Requests:
   a. A team-based, organizational-wide approach to all State submissions which ensures completeness, accuracy, and maximizes potential revenue.

2. Tighten controls on Administrative Expense:
   a. Open Position Justification – enhanced documentation requirement for new or open positions prior to approval, regardless of budget status. The documentation must include details and metrics on the change to workload and compliance or financial risks of not hiring the position; and
   b. Tracking the root cause of claims interest and implementing processes to reduce.

3. Continuous attention to, and enhancement of, Provider Network Contracting:
   a. Implementation of a preferred provider agreement with Quest, resulting in reduced contract rates and an estimated annual savings of $3.4 million; and

b. Contract re-negotiations with hospitals which moved stop loss provisions from first to second dollar, improved language related to high cost drugs, transition of percentage of charge reimbursement to contract rates based on the Medi-Cal fee schedule, and limits to annual increase of chargemaster.

4. Enhance Claims Management:
   a. Implementation of contract with Health Management Systems, which will improve identification of claim overpayments and will allow the Plan to obtain recovery dollars for coordination of benefits, including pharmacy expenses.
   b. Contract language – tracking areas in which improvement in contract language would prevent errors leading to settlements and interest.
   c. Identification of inconsistencies in claims handling to reduce expenses; and
   d. Ongoing improvement of the Provider Dispute Resolution (PDR) turnaround time to reduce abrasion and costs.

5. Enhance Utilization Management:
   a. Nurse advice hotline which will direct members to the appropriate level of care and potentially divert from the ER.
   b. CCS deferral identification, and review of ED claims for payment by CCS.
   c. Risk assessment of new members through the Health Information Form and the Member Evaluation Tool which encourages connection to the appropriate level of care.
   d. Admin day reduction and transition of care efforts.
   e. Over and under-utilization studies.

6. Re-constitute the Expense and Utilization Workgroup – a cross functional workgroup that identifies utilization and cost variances, and research root cause to determine if any areas are actionable. Current area of focus is as follows:
   a. Understanding disparities in maternity length of stay between systems.
   b. Aligning internal reporting with RDT logic.
   c. Researching various cost variances.

RECOMMENDATION:

Staff requests that the PAC accept and file the Financial Update.

CONTRACT RATE ADJUSTMENT PROJECTIONS FY2019-20

SAVINGS

LOCAL HOSPITALS
$2.4M

TERTIARY HOSPITALS
$1.34M

CAPITATION INITIATIVE
$3.4M

PENDING
TERTIARY HOSPITALS
$2M

TOTAL ESTIMATED SAVINGS
$9.14M

EXPENSES

CONTRACTUAL
ADJUSTMENTS
$1.5M

QUALITY IMPROVEMENT
PROGRAM
$1.15M

PENDING
SETTLEMENT
$1.6M

TOTAL ESTIMATED EXPENSES
$4.25M

TOTAL NET SAVINGS
$4.89M