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

Regular Meeting
Monday, August 27, 2018, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

ROLL CALL

CONSENT CALENDAR

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

   Staff: Maddie Gutierrez, Clerk of the Commission

   RECOMMENDATION: Approve the minutes.

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

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

   RECOMMENDATION: Approve the contract extension.

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

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

   RECOMMENDATION: Approve the contract extension.

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

   Staff: Nancy Wharfield, Chief Medical Officer

   RECOMMENDATION: Approve the contract extension.

Return to Agenda

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

Staff: Ruth Watson, Chief Operating Officer

RECOMMENDATION: Approve the contract extension.

6. **June Financials Report**

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Accept and file the June Financials Report.

PUBLIC COMMENT

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

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

REPORTS

7. **Chief Executive Officer (CEO) Report**

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Accept and file the report.

PRESENTATION

8. **Administrative Services Organization (ASO) Update**

Staff: Ruth Watson, Chief Operating Officer

RECOMMENDATION: Accept and file the presentation.

9. **Americas Health Plan (AHP) Update**

Staff: Ruth Watson, Chief Operating Officer

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

REPORTS

10. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report.

11. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

12. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

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

14. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

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

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

OPEN SESSION

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on September 24, 2018, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

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

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

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, Clerk to the Commission

DATE: August 27, 2018

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

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

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

Ventura County Medi-Cal Managed Care Commission (VCMMCC)

dba Gold Coast Health Plan (GCHP)

July 23, 2018 Regular Meeting Minutes

CALL TO ORDER

Commissioner Antonio Alatorre 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 Alatorre led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa (arrived at 2:51p.m.), Kelly Long and Jennifer Swenson.

Absent: Commissioners Lanyard Dial, M.D., Johnson Gill, Debbie Herwaldt and Gagan Pawar, M.D.

PUBLIC COMMENT

CONSENT CALENDAR

1. **Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of June 25, 2018.**

   RECOMMENDATION: Approve the minutes.

2. **Axcient Contract Extension**

   RECOMMENDATION: Approve the contract extension.

3. **Temp Staffing Labor Extension – CIO Solutions**

   RECOMMENDATION: Approve the contract extension.

4. Contract Approval – Temporary Labor Agreement – FluidEdge Consulting Inc.

RECOMMENDATION: Authorize the Chief Executive Officer (CEO) to execute a Master Agreement with FluidEdge Consulting Inc. and pre-authorize any individual transaction for these services over $100,000.

Commissioner Long moved to approve the recommendations for Consent items 1 through 4. Commissioner Atin seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Kelly Long and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Lanyard Dial, M.D., Laura Espinosa, Johnson Gill, Debbie Herwaldt and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

PUBLIC COMMENT

Kent Miles spoke on Agenda Item No. 12. Mr. Miles submitted a handout titled "How PBM's Are Driving up the Cost of Health Care in Ventura County". Mr. Miles' comments were regarding OptumRx and the information in his handout. All Commissioners and staff received a copy for their review.

REPORTS

5. Chief Executive Officer (CEO) Report

RECOMMENDATION: Accept and file the report.

CEO Villani provided an update on the following topics via a PowerPoint presentation:

- DHCS Annual Provider Network Certification: This regulatory requirement is part of the CMS Mega Rule. DHCS advised GCHP that the Plan met the provider network certification requirement and passed with no conditions.
- Prop 56 payments: Proposition 56 increased the tax rate on cigarettes and other tobacco products. The increased tax revenue would be used for additional supplemental payments to Medi-Cal providers for specific services. By the end of this fiscal year, the Plan will disperse $3.2 million in Prop 56 payments. Commissioner Alatorre asked whether this is a "pass-through" payment to providers. CEO Villani confirmed that the Prop 56 payments are pass-through payments.
- Member Texting: Last year, GCHP completed a pilot program with mPulse, a texting service vendor, to use texting for communications about preventative and office visits. Texting is an effective communications tool, however there

are specific FCC requirements around texting that must be followed. GCHP was on hold for a short period of time due to a policy limitation around member opt-in to the program. Chief Medical Officer Wharfield and her clinical team drafted a new policy document that was reviewed and approved by the Department of Healthcare Services. With this approval, GCHP will restart the texting program to assist with flu vaccine reminders, immunizations, and preventative healthcare notices.

- Medi-Cal Geographic Managed Care Model: In 2016, DHCS awarded United Healthcare (UHC) and Aetna Medi-Cal contracts in Sacramento and San Diego. These counties fall under the Medi-Cal Managed Care Geographic Model. UHC recently announced it was leaving Sacramento. Approximately 4,400 UHC members will need to be re-assigned to another Medi-Cal managed care plan. This is somewhat unusual given that DHCS is coming upon the re-compete timeframe. For geographic and 2-plan models where commercial plans are involved, DHCS runs the procurement, where they put out the RFP's and potential bidders respond.
- National and State Plan Quality Metrics: CEO Villani provided an overview of quality metrics at both the national and state level. At the national level CMS is more actively involved in Medicaid programs and has created a new Medicaid Dashboard, which is state-specific. This dashboard provides an opportunity to view how California Medi-Cal compares to other States' Medicaid programs.

  At the state level, DHCS uses a number of metrics around quality and performance. For example, Encounter Data Validation Reports. GCHP performs extremely well in this area. Beneficiary Satisfaction Surveys (CAHPS) are another metric. GCHP is at the high end of the comparison chart for member satisfaction performing significantly above the Medi-Cal average score for adults and comparable to the Medi-Cal average score for child rating.

  CEO Villani then reviewed the DHCS HEDIS Aggregated Quality Factor Scores for years 2014 – 2017. This report compares how each of the Medi-Cal plans perform on HEDIS measures. GCHP performs above the minimum performance level (MPL) for all measures. However, in 2017, although the Plan still performed above the MPL, our performance rating dropped from the previous year. This was due to data conversion issues when the Plan switched HEDIS vendors. Our State auditor – HSAG - acknowledged it was a data issue, not a quality issue and did not issue a CAP. The Plan presented this information to the QI Committee and also to the Commission in August of last year. We expect to be back on track with our scores this HEDIS reporting season.

  Commissioner Long inquired whether the Plan sets specific HEDIS performance goals. There are goals that we monitor against. Commissioner Atin asked if there is a benchmark for non-Medicaid, commercial plans. CEO Villani responded, "No", that incentives are different for private sector. Commissioner Alatorre stated that if the scores are below 40% the Plan gets capped. GCHP has been under a cap before. Brandy Armenta, Compliance

Officer, stated that if fall below the threshold there is an automatic Performance Improvement Plan as well as a Quality Improvement Plan – these are concurrently worked on in order to improve scores – it is a requirement.

CEO Villani stated the Plan has struggled in engaging both the health system providers and members to better manage care as it relates to quality metrics. There are targets GCHP can establish, and there are reporting measurements and tools we can give to providers, but we have to get members involved and providers incentivized to try to move the curve.

6. Gold Coast Health Plan Quality Improvement Report

RECOMMENDATION: Accept the report as presented.

Chief Medical Officer, Nancy Wharfield, M.D. reviewed the Annual Quality Improvement Report along with a summarized PowerPoint presentation.

Commissioner Laura Espinosa arrived to the meeting at 2:51 p.m.

CMO Wharfield stated she requests that the Commission approve the GCHP QI Program Description, the 2017 QI Work Plan Evaluation, and the 2018 QI Work Plan. The presentation information was as follows:

- Agenda Overview
- Background on what is quality, including the IHI Triple Aim
- DHCS Quality Strategy – Three linked goals and seven priorities
- GCHP's QI Program and its elements
- QI Program Description – Lists goals and objectives, methodology, key program initiatives, program organization, and oversight and evaluation. Also includes the development of the annual work plan, program resources, Quality committees and subcommittees, and delegation of quality improvement.

Dr. Wharfield reviewed the 2017 Work Plan evaluation along with 2017 notable HEDIS improvements, as well as rates in need of improvement. Improvement of the quality of non-clinical services such as the access to care, after-hours availability, provider network and provider satisfaction. Dr. Wharfield also noted improvement of patient safety and the member experience.

The 2018 Work Plan was also discussed – improvement of quality and safety of clinical services:

- Practice Guidelines
- Tobacco Cessation
- Initial Health Assessment
- Postpartum Visits
- Childhood Immunization: Combo 3
- Cervical Cancer Screening

- Child and Adolescent Access to Primary Care
- Comprehensive Diabetes Care
- Treatment of Children with Upper Respiratory Infections
- Avoidance Antibiotics in Adults with Bronchitis
- Access to Ambulatory Care

New improvement projects for 2018 were also discussed.

The 2018 work plan for improvement of member safety, assessment, member experience and organizational oversight of delegated activities were reviewed.

Commissioner Long asked if the focus on performance improvement is for those metrics where the Plan's score is less than 50%. Dr. Wharfield stated that the improvement focus is on any metrics where the Plan performs below the minimum performance level.

Dr. Wharfield stated that data is critical to the HEDIS process and that both providers and GCHP should perform ongoing data validation and raise any potential data issues quickly. HEDIS is a cycle; once the accounting period closes there are no further opportunities address data issues. For the new HEDIS season, now is the time to discover any data validation mismatch and work together to fix it so we can have the best results in the end.

Commissioner Cho asked if GCHP has a specific HEDIS data validation policy. She stated that their HEDIS report cards seem inaccurate at times. Dr. Wharfield stated there is no specific policy for GCHP but it can be something that can be worked on which can be helpful. It is in the best interest of all to ensure everything is done correctly with regard to HEDIS data collection.

Commissioner Long asked if the data validation policy is required if the Plan is moving toward a pay for performance model.

Dr. Wharfield stated that GCHP is in the process of developing policies around alternative payment methodologies. Commissioner Alatorre inquired as to how often providers receive reports on performance measures. Dr. Wharfield stated that the Plan sends performance reports every other month. Commissioner Alatorre asked if under the alternative payment model, whether the Plan would issue a CAP (corrective action plan) if the provider is not meeting minimum standards. Dr. Wharfield stated the corrective action would be to hold back full payment until the provider performs at the minimum level, with an opportunity to earn more if performing above the minimum level.

Dr. Wharfield then reviewed the 2017 preliminary HEDIS results, including rate improvements over last reporting season, rates that need improvement, and non-HEDIS activities.

Commissioner Alatorre inquired about Medi-Cal provider enrollment certification by GCHP, specifically, what it would take to perform this function in-house. CEO Villani stated the Plan made a decision not to take on this function for a number of reasons including a past deadline of January 2018 to submit an application to DHCS if plans wanted to take on this function, and that the Plan would require additional staff. COO Watson added that a new system is also needed to perform this function in-house. CEO Villani stated the only provider system that expressed interest in this was Clinicas Del Camino Real. Commissioner Alatorre stated that Medi-Cal provider enrollment certification is not a concern for Clinicas and that he would like to see the numbers (costs) to implement, adding that it was his third request for this information. He would like the Plan to provide the information at the next Commission meeting.

Dr. Wharfield then reviewed the 2019 quality goals. Commissioner Espinosa asked how the public health/education component that GCHP has with the community factors in with meeting the Plan's quality goals. Dr. Wharfield stated that staff collaborates and works with a variety of external entities such as CHDP and CCS, as well as with community service agencies and the County on Whole Person Care, all of which have similar types of goals.

Commissioner Long motioned to approve the three reports. Commissioner Swenson seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Kelly Long and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Lanyard Dial, M.D., Johnson Gill, Debbie Herwaldt and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

7. May 2018 Fiscal Year to Date Financials Report

RECOMMENDATION: Accept and file the May financials report.

Chief Financial Officer Bishop reviewed the May financials. There were several major transactions which netted a gain of $1.6 million for the month of May. The transactions were related primarily to the Adult Expansion (AE) population. Months ago, the State misclassified dual members in the AE category and overpaid the plans. The State notified plans that they would re-coup those funds. It was not much of a net impact and therefore not an issue for GCHP. The State took back approximately $9 million, which was offset by reducing the MLR amount that was accrued.

Medical expenses were approximately $5 million higher this month than the average. Inpatient costs were higher, as well as long term care and higher utilization in pharmacy. Administrative expenses continue to stay consistent and within budget. There is a gain of approximately $1.5 million fiscal year to date.

Commissioner Swenson asked what is driving the outpatient variance. CFO Bishop stated there were contract changes and lab utilization increases. CEO Villani stated that the new contract that will impact inpatient/outpatient ED rates will begin in July.

Commissioner Atin stated that neither revenue nor expenses are on budget but the revenue seemed off by 5% and that thought that it would be evenly spread. He asked why there was such a large variance on some items, such as applied behavioral health, which has an 85% variance. Commissioner Atin suggested that a brief description or explanation of big variances would be helpful to the Commission. Commissioner Long added that she would also like to see this information; the data is good but back up information should be included.

Commissioner Long motioned to approve the May financial report. Commissioner Atin seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Kelly Long and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Lanyard Dial, M.D., Johnson Gill, Debbie Herwaldt and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

8. Americas Health Plan (AHP) Update

RECOMMENDATION: Accept and file the presentation.

CEO Villani stated the update will focus on AHP contracting efforts. While significant work has been done on contract preparations by the project team, there is some communication clarity that needed to be worked out with the State. DHCS had previously advised that until the contract changes based on the CMS Mega-Rule were finalized the Plan could not move forward with any boilerplate contracts. The State has now clarified their position and provided guidance that the Plan can move forward. Another issue requiring clarification was the proper contracting vehicle. The point in question was whether AHP could be treated as a delegated medical group or a health plan. If a health plan, then the AHP pilot would fall under the State's Plan-to-Plan contracting requirements.

CEO Villani then introduced Margaret Tatar, Managing Principal for Health Management Associates. Ms. Tatar, a recognized expert in Medi-Cal, and who has worked with GCHP on the AHP pilot since mid-2017, provided an update via a PowerPoint presentation, copies of which were provided the Commission, GCHP staff and also available to the public.

Ms. Tatar presented a brief background on the AHP pilot project as it relates to GCHP's role as a County Organized Health System (COHS) and a subcontractor of DHCS. GCHP is a COHS and is exempt from licensure by the Department of Managed Health Care. GCHP is not required to be Knox-Keene licensed and is not regulated by DMHC. GCHP operates pursuant to state and federal law and is specifically contracted with the Department of Health Care Services in connection with operating the Medi-Cal program in Ventura County. GCHP must submit all sub-contracts to DHCS for approval, which includes any Plan-to-Plan or sub-contracting arrangements.

The Commission requested that GCHP work with AHP to develop a Plan-to-Plan pilot program for 5,000 Gold Coast members for a one year term with some optional extensions. GCHP and AHP management teams established perimeters for collaboration.

COO Watson stated that meetings have been facilitated between the two teams on a weekly basis. A detailed DOFR (division of financial responsibility) was created and shared with AHP. A detailed work plan was also developed. There are still some challenges on what will be covered and what will not. GCHP will continue to take the risk for pharmacy and a few other services. GCHP has engaged with DHCS on issues with the pilot in order to continue to move forward. A comparison on a specialty contract versus a pilot were reviewed. The State has sent instruction to move forward with the pilot and submit for approval.

Ms. Tatar presented a side-by-side comparison of key-model elements, which showed "current/as" with regard to the CDCR specialty contract as compared to the planned AHP pilot. DHCS must approve all sub-contracts and currently there is not a contract with AHP. Covered services were also reviewed. AHP does have a restricted Knox-Keene license. AHP will not be involved in marketing because it must have a full license for that.

Commissioner Espinosa stated that she heard that DHCS had to approve contracts but had received information contrary to this statement. She asked whether DHCS has to approve or merely review all contracts. Ms. Tatar stated that DHCS must approve ALL contracts. Compliance Officer, Brandy Armenta, informed the group that the state has specific language on approval of all contracts.

CEO Villani stated there was a letter sent by the CEO of Americas Health Plan to the Commissioners that questioned whether Plan-to-Plan contracts exist and also raised other questions around GCHP health care quality. CEO Villani felt it was

important to communicate clearly what the Plan's DHCS contract language specifies around provider contract approval.

Ms. Tatar stated that while the term, "Plan-to-Plan" might not exist in regulation, irrespective of what it is called, DHCS has to review and approve all provider sub-contracts. COO Watson stated that a Plan-to-Plan arrangement often takes full risk, whereas a delegated model does not – they take only partial risk.

Two additional elements relevant to the AHP Pilot were discussed:

1. Member Auto-Assignment Policy – GCHP currently has a commission approved member auto-assignment policy. As a safety net provider, CDCR receives member auto-assignment. There is no current provision for member auto-assignment to AHP.

Commissioner Atin stated he believed the 5,000 pilot members would come from the CDCR population. COO Watson stated that GCHP has requested documentation from AHP confirming the agreement on auto-assignment of the 5,000 CDCR members included for the first year pilot. COO Watson stated there needs to be defined criteria to determine if the pilot is a success. Commissioner Cho asked what is the advantage for the member to be part of the pilot. Ms. Tatar stated the proposal for membership and criteria streamlining, integrated care, consumer outreach and engaging members. DHCS is focused on member choice.

2. Contract rates are still outstanding - The boilerplate contract needs to be finalized and submitted to DHCS. DHCS then has 60 days to review and approve or send errors back to the Plan for correction and resubmission. The 60-day review process starts over for each resubmission cycle.

Commissioner Swenson stated she would like to see the project timeframes and task ownership on both sides, and to understand the true benefit of this pilot. COO Watson stated that the team (GCHP and AHP) must determine whether this is a delegated medical group or Plan-to-Plan arrangement. COO Watson stated most of the work is complete, but there are still some major items outstanding. A timeline can be brought back to the Commission at the next meeting.

PUBLIC COMMENT

Note: Minutes are done in "Summary form" Mr. Smith requested that his comments be noted verbatim.

Tom Smith, CEO of Americas Health Plan, spoke around the topic of the AHP Pilot. Mr. Smith stated that Ms. Tatar was correct on her definition of Plan-to-Plan and that he has received confirmation from outside counsel. The e-mail/memo was sent to CEO Villani and the Commission in order to have full transparency. This is essentially an IPA (independent practice association) provider agreement. AHP has three in place: one with one of the largest healthcare organizations in the world based out of the Midwest. That

deal was done in 45 days. It is a full risk deal where AHP has assumed full financial risk on a prospective basis. Mr. Smith is asking CEO Villani for the e-mail that Sarah Brooks of DHCS, sent to GCHP regarding the change in direction. Mr. Smith urges the Board to request a copy of that same e-mail. That information will give clarity and line of sight on the new direction. Mr. Smith proposes a start date of August 1, 2018 under the IPA agreement. AHP would then be classified as a provider. As a provider, AHP would become the safety net provider and the 3:1 assignment of members would go to AHP. He would like to return to Commission meeting, giving complete transparency in detail. The biggest feature of this arrangement, where AHP would assume full financial risk, is that they would assume in-patient risk. It isn't a full assumption of risk, the main difference is the contract would flow between GCHP and AHP for primary, specialty and inpatient services and some ancillary services. The DOFR is 99.9% agreed to and ready to go. This deal can be signed by end of week. Compliance Officer, Brandy Armenta can then start her delegation oversight with an undertaking that this will go forward, become effective and operational if the Commission passes the delegation oversight. Mr. Smith stated his network had the highest quality scores in Ventura County and some of the highest quality scores in the entire United States. The value proposition of not moving 5,000 lives but moving all 39,000 lives currently being handled and serviced by Clinicas would guarantee you lock in those quality scores. AHP has high 90's scores for childhood immunization rates. The focus would be on the quality scores – flow all 198,000 lives at GCHP through AHP – that is the "silver bullet". AHP would take the low quality scores below 40% and raise them. A 60% score on HEDIS is bad. All quality scores should be in the 90th percentile for all measures.

Commissioner Long advised Mr. Smith if he had further comments he could provide a letter to the Commission with specifics, which is always helpful.

Commissioner Atin motioned to approve the Agenda Items 5, 6 and 7. Commissioner Egan seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Kelly Long and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Lanyard Dial, M.D., Johnson Gill, Debbie Herwaldt and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.

CLOSED SESSION

The Commission adjourned to Closed Session at 4:56 p.m. regarding the following item:

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

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

Commissioner Alatorre recused himself during discussion of one of the cases due to conflict of interest.

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

Commissioner Theresa Cho, M.D. left the meeting at 5:20 p.m.

OPEN SESSION

The regular meeting reconvened at 6:16 p.m. Mr. Campbell stated there was no reportable action.

PUBLIC COMMENT

Daniel Martinez, appearing on behalf of the CA Pharmacists' Association spoke on Agenda Item No. 12. Mr. Martinez gave an update on continued pharmacy issues:

- One pharmacy has now closed due to OptumRx's reimbursement rate issue.
- Another pharmacy will be closing at the end of July.
- A pharmacy in Thousand Oaks where 50% of their clients are GCHP members no longer has supporting staff available. They have not been able to hire support staff since this issue with OptumRx.
- A pharmacy in Ojai has laid off an employee and reduced another employee to part-time.
- Two pharmacies in Oxnard: One has laid off an employee. 60% of their clients are GCHP members and they are in danger of closing. The second pharmacy has had to lay off three employees and a fourth will be laid off. This pharmacist has had to take out a business loan, stopped taking salary, sold their car, emptied their business account and have put their house on the market in order to stay open. They are also in danger of closing.

There is a lawsuit that has been filed against OptumRx by the independent pharmacies of Ventura County. CPHA is not part of the lawsuit but are evaluating its merits.

Mr. Martinez is asking how long it will be before something is done? What else has to happen? How many pharmacies have to close and how many people have to be laid off? The Association will be meeting with OptumRx soon to discuss issues. Mr. Martinez urges the Commission to do something because people are being affected.

Chief Operating Officer, Jon Mahrt, appeared on behalf of OptumRx to provide an update on OptumRx. Performance has been stable. Approximately 200 cases have been run per week with a turn-around time performance of 100% of the performance guarantee, which is 2 days or less. Turn-around times are within a range of 8 to 13 hours, which is expected to be the baseline for performance going forward. Approval rates are trending up from 68% to 71-76%. The experience for patients and members has improved. There have been several accomplishments which show continued investment from OptumRx.

In closing, OptumRx is not perfect but we working to clear up our errors and make adjustments as well as continue to ask for feedback.

REPORTS

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

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Kelly Long and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Lanyard Dial, M.D., Johnson Gill, Debbie Herwaldt and Gagan Pawar, M.D.

Commissioner Alatorre declared the motion carried.
The regular meeting ended at 7:19 p.m.

Approved:

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Maddie Gutierrez, CMC
Clerk to the Commission

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: August 27, 2018

SUBJECT: Contract Extension Approval – MCG Health LLC

SUMMARY:

MCG Health, LLC (MCG) licenses the Plan's evidence-based care guidelines. Use of these guidelines in our utilization management decision-making protects GCHP from risk related to inappropriate utilization, added expense, and regulatory non-compliance. MCG is fully integrated with MedHOK, the Plan's medical management system.

MCG is one of two nationally recognized care guidelines. The other is InterQual. MCG is the evidenced-based gold standard for inpatient and outpatient decisions for healthcare payers while InterQual focuses on inpatient decision making. From a market perspective, pricing for both is similar.

The Plan entered into an initial five-year agreement with MCG in September 2013 for five care guideline modules. The Plan negotiated a one-time 41% promotional discount, reflecting a $1.79 per member per year (PMPY) rate, or $335,884 MLR expense in contract year five. The Plan added two additional modules during the initial five-year contract term. To expand the scope of services and address the gap in evidence based guidelines, the plan will be adding two modules to address utilization in skilled nursing and home care.

The five-year renewal term includes the following key provisions:

- Nine MCG guideline modules to address gaps in evidence based guidelines.
- Year six PMPY of $2.74 for a reduced membership base of 154k covered lives (exclusion of delegated lives). Results in a cost increase of $85,490.73 for the first renewal year.
- Protections for membership base reduction of 10% per year, not to exceed 25% from the current baseline of 154k covered lives.
- 3.7% annual rate increase for year six.
- Annual rate increases capped at 4% for years seven through ten.

FISCAL IMPACT:

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

The total renewal amount for the five-year extension is approximately $2,282,302.92. This includes a 4% annual adjustment. For future budgeting and PO purposes, the Plan will include a $378k contingency to cover added lives over the five-year term of the license.

Table 1: MCG Total Estimated Contract Spend

Contract Term	Amount	Period	Budgeted
Initial Contract (Years 1-5) – Actual Spend	$1,416,088	9/11/2013 to 9/10/2018	Yes
Contract Extension (Years 6-10) – Projected Spend	$2,282,302.92	9/11/2018 to 9/10/2023	Yes
Total Projected Cumulative Spend (Years 1-10)	**$3,698,390.92**		

*Plan will include a $378,000 contingency to cover added lives over the five-year term of the license for budgeting and PO purposes.

RECOMMENDATION:

Gold Coast Health Plan recommends the Commission approve the continuation of services with MCG for an additional five-year period from September 11, 2018 to September 10, 2023.

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

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: August 27, 2018

SUBJECT: Contract Extension Approval – Service Order 01, Lourdes G. Campbell, Interpreting and Translating Services

SUMMARY:

Lourdes G. Campbell Interpreting and Translating, Services, ("Lourdes") provides in-person interpreting and translation services to Gold Coast Health Plan (GCHP) members and providers. The current Service Order with Lourdes commenced on November 10, 2015, and expires on October 31, 2018. This Service Order along with its master Professional Services Agreement replaced and superseded a prior Consulting Services Agreement where Lourdes had performed services since 2012. GCHP is recommending renewal of Service Order 01 for an additional twenty-four (24) month period, commencing November 01, 2018.

FISCAL IMPACT:

This Service Order 01 is a non-requirements contract which allows GCHP to use services ad-hoc at the rates specified. The Service Order can be terminated for convenience at any time with sixty (60) day notice.

The renewal amount is projected to be $40,000 per year, making the cumulative amount of the renewal $80,000.

	Amount	Period	Budgeted
Original 2 year contract term, plus a 1 year pre-negotiated renewal term	$96,800	11/10/2015 – 10/31/2018	Yes
Total YTD Spend	**$96,800**		
Estimated 2 Year Renewal Amount	$80,000	11/01/2018 – 10/31/2020	Yes
Total Cumulative Spend (Years. 1-5)	**$176,800**		

RECOMMENDATION:

Gold Coast Health Plan recommends the Commission to approve the renewal of Service Order 01 with Lourdes G. Campbell Interpreting and Translating Services for an additional twenty-four (24) month period, commencing November 1, 2018.

If the Commission desires to review this contract, it is available at Gold Coast Health Plan's Finance Department.

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AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: August 27, 2018

SUBJECT: Contract Extension Approval – Service Order 1, Lifesigns Sign Language Interpreter Services

SUMMARY:

Lifesigns Sign Language Interpreter Services, ("Lifesigns") provides telephone interpreting and video remote interpreting services to Gold Coast Health Plan's (GCHP) members and providers in over 200 different languages 24 hours, 7 days per week. The current Service Order with Lifesigns expires on October 31, 2018. GCHP is recommending renewal of this Service Order 1 for an additional twenty-four (24) month period, commencing November 01, 2018.

FISCAL IMPACT:

This Service Order 1 is a non-requirements contract which allows GCHP to use services ad-hoc at the rates specified. The Service Order can be terminated for convenience at any time with sixty (60) day notice.

The renewal amount is projected to be $36,000 per year, making the cumulative amount of the renewal $72,000.

	Amount	Period	Budgeted
Original 2 year contract term, plus a 1 year pre-negotiated renewal term	$96,000	11/10/2015 – 10/31/2018	Yes
Total YTD Spend	**$96,000**		
Estimated 2 Year Renewal Amount	$72,000	11/01/2018 – 10/31/2020	Yes
Total Cumulative Spend (Years. 1-5)	**$168,000**		

RECOMMENDATION:

Gold Coast Health Plan recommends the Commission approve the renewal of Service Order 1 with Lifesigns Sign Language Interpreter Services for an additional twenty-four (24) month period, commencing November 1, 2018.

If the Commission desires to review this contract, it is available at Gold Coast Health Plan's Finance Department.

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AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: August 27, 2018

SUBJECT: Contract Approval – Temporary Labor Agreement: FluidEdge Consulting Inc.

SUMMARY:

The Commission approved the budget for the ASO core replacement project during the April 23, 2019 Commission meeting. The approved budget includes funding for GCHP to contract with a specialized external vendor to supplement the staffing needs to successfully complete the process. GCHP has identified the specialized external vendor and resources to engage to support the project.

BACKGROUND/DISCUSSION:

Fluid Edge Consulting (FEC) assists clients with implementation, configuration and/or optimization of systems and business processes. FEC provides consultative and support resources for business operations, process design/redesign, business intelligence, information technology, and project leadership.

FEC is currently or has been contracted by other Medi-Cal COHS (San Francisco Health Plan, Cen Cal, Kern) to leverage FEC resources either to stand up or remediate their platform implementations. Outcomes have been positive and the COHS have indicated that FEC is adept at Medi-Cal and our business model and highly recommend their services.

FISCAL IMPACT:

The services will be procured ad-hoc and on a per transaction basis at pre-negotiated hourly rates. The Plan has an approved budget for the project which includes funds for these resources **during** the contract term of July 24, 2018 until December 31, 2020.

RECOMMENDATION:

Gold Coast Health Plan recommends the Commission to authorize the CEO to execute a Master Agreement for Temporary Services with FluidEdge Consulting Inc. and to pre-authorize any individual transaction for these services over $100,000.

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

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AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: August 27, 2018

SUBJECT: June 2018 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached June 2018 fiscal year-to-date (FYTD) financial statements of Gold Coast Health Plan ("Plan") for the Commission to accept and file. These financials were reviewed by the Executive / Finance Committee on August 2, 2018, and it was recommended that the Commission accept and file these financials.

BACKGROUND/DISCUSSION:

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

FISCAL IMPACT:

Financial Highlights

- For the fiscal year ended June 30, 2018, the Plan's performance is an increase in net assets of $1.1 million, which is $1.0 million less than budget. June's monthly result was a decrease in net assets of $382 thousand, or $600 thousand below budget.
- June FYTD net revenue was $723.0 million, $40.2 million higher than budget.
- Cost of health care was $677.6 million, $45.5 million higher than budget.
- The medical loss ratio was 93.7 percent of revenue, which is 1.1 percent higher than the budget.
- The administrative cost ratio was 6.8 percent, 0.5 percent lower than budget.
- June membership of 200,271 was 2,425 members lower than budget, and 1,551 lower than May's membership of 201,822.
- Tangible Net Equity was $143.4 million which represents just over two months of operating expenses in reserve and 449% of the required amount by the State.

Revenue – June FYTD net revenue was $723.0 million or $40.2 million higher than budget. Membership declines and mix reduced revenue by about $2.0 million. However,

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FINANCIAL PACKAGE
For the month ended June 2018

TABLE OF CONTENTS

- Executive Dashboard
- Statement of Financial Position
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows

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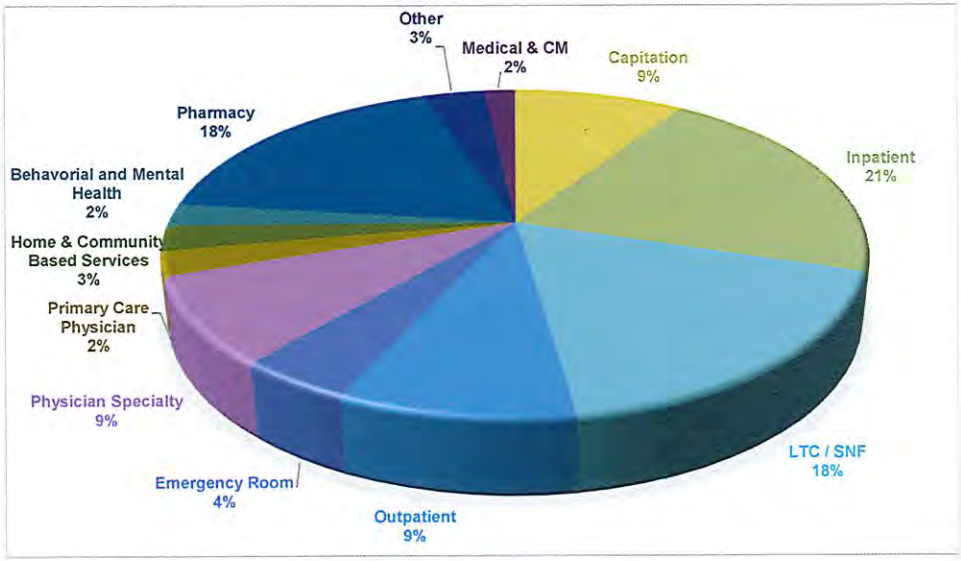
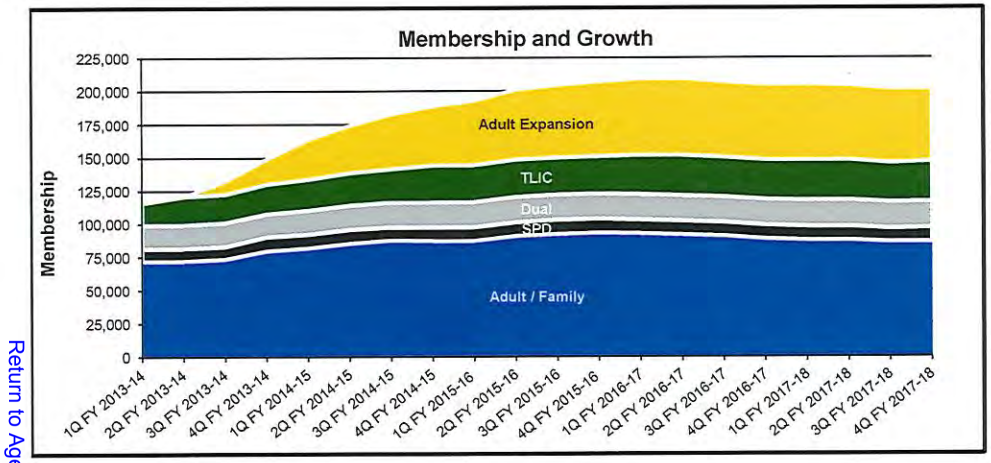
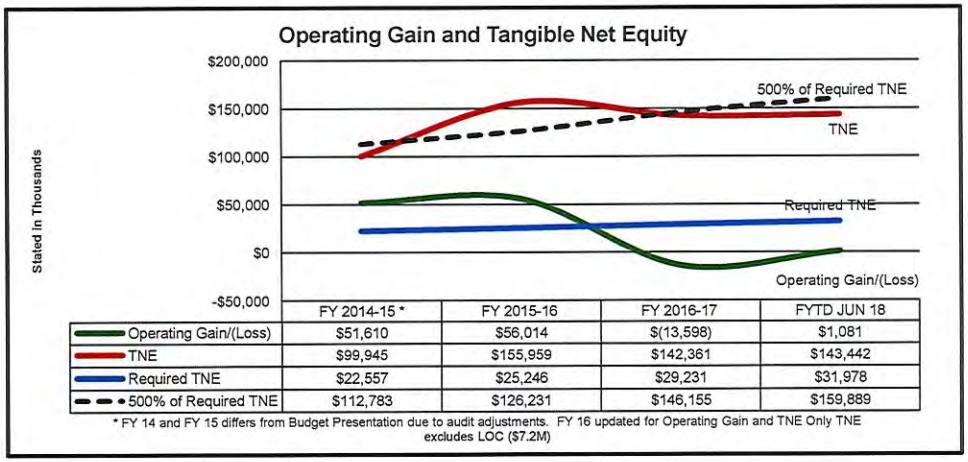
Gold Coast Health Plan

Executive Dashboard as of June 30, 2018

	FY 17/18 Budget	FY 17/18 FYTD	FY 16/17 Actual	FY 15/16 Actual
Average Enrollment	203,924	202,748	207,100	201,095
Revenue	$ 279.02	$ 297.16	$ 273.72	$ 279.98
Capitation	$ 26.37	$ 25.89	$ 26.22	$ 42.27
Inpatient	$ 53.36	$ 57.34	$ 53.44	$ 46.58
LTC / SNF	$ 47.06	$ 49.72	$ 47.86	$ 43.72
Outpatient	$ 21.07	$ 25.47	$ 23.17	$ 18.29
Emergency Room	$ 10.20	$ 12.31	$ 9.07	$ 8.23
Physician Specialty	$ 20.83	$ 23.81	$ 22.55	$ 19.35
Primary Care Physician	$ 5.91	$ 6.77	$ 6.45	$ 6.11
Home & Community Based Services	$ 7.48	$ 6.87	$ 7.33	$ 6.27
Behavorial and Mental Health	$ 5.70	$ 6.35	$ 4.57	$ (0.64)
Pharmacy	$ 45.36	$ 49.76	$ 47.76	$ 41.70
Other	$ 9.09	$ 9.41	$ 6.57	$ 3.26
Medical & CM	$ 5.85	$ 4.79	$ 4.92	$ 6.52
	$ 258.28	$ 278.49	$ 259.91	$ 241.66
% of Revenue	92.6%	93.7%	95.0%	86.3%
Total Administrative Expenses	$ 49,627,225	$ 48,970,025	$ 51,176,317	$ 38,256,908
% of Revenue	7.3%	6.8%	7.5%	5.7%
TNE	$ 144,412,562	$ 143,441,983	$ 142,360,951	$ 155,959,127
Required TNE	$ 28,699,609	$ 31,977,858	$ 29,231,052	$ 25,246,284
% of Required	503%	449%	487%	618%







	FY 2014-15 *	FY 2015-16	FY 2016-17	FYTD JUN 18
Operating Gain/(Loss)	$51,610	$56,014	$(13,598)	$1,081
TNE	$99,945	$155,959	$142,361	$143,442
Required TNE	$22,557	$25,246	$29,231	$31,978
500% of Required TNE	$112,783	$126,231	$146,155	$159,889

* 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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STATEMENT OF FINANCIAL POSITION

	06/30/18	05/31/18	04/30/18
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	$ 151,227,350	$ 159,501,424	$ 171,002,203
Total Short-Term Investments	196,682,147	196,461,673	196,217,013
Medi-Cal Receivable	74,107,569	63,299,720	95,054,432
Interest Receivable	693,727	650,537	589,676
Provider Receivable	254,594	374,073	443,928
Other Receivables	1,966,502	3,808,831	3,809,386
Total Accounts Receivable	77,022,392	68,133,161	99,897,422
Total Prepaid Accounts	1,650,769	1,410,209	1,458,171
Total Other Current Assets	135,560	135,560	135,560
Total Current Assets	426,718,219	425,642,027	468,710,370
Total Fixed Assets	1,973,116	1,934,973	1,978,733
Total Assets	$ 428,691,335	$ 427,577,000	$ 470,689,103
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 45,799,697	$ 47,553,203	$ 48,795,918
Claims Payable	23,001,279	23,478,293	19,659,066
Capitation Payable	57,698,765	57,554,269	57,516,379
Physician Payable	310,852	5,263,839	4,185,159
AB 85 Payable	0	0	20,570,412
DHCS - Reserve for Capitation Recoup	124,143,559	124,143,559	140,843,559
Accounts Payable	2,910,382	1,969,200	4,617,876
Accrued ACS	1,699,348	1,709,703	1,701,053
Accrued Expenses	7,273,403	7,315,000	22,801,655
Accrued Premium Tax	20,272,257	12,826,917	5,381,576
Accrued Payroll Expense	1,130,876	926,901	1,393,012
Total Current Liabilities	284,240,419	282,740,882	327,465,664
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	1,008,932	1,012,333	1,015,733
Total Long-Term Liabilities	1,008,932	1,012,333	1,015,733
Total Liabilities	285,249,352	283,753,215	328,481,397
Net Assets:			
Beginning Net Assets	142,360,951	142,360,951	142,360,951
Total Increase / (Decrease in Unrestricted Net Assets)	1,081,032	1,462,834	(153,246)
Total Net Assets	143,441,983	143,823,785	142,207,706
Total Liabilities & Net Assets	$ 428,691,335	$ 427,577,000	$ 470,689,103
	-	-	-

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR TWELVE MONTHS ENDED JUNE 30, 2018

	June 2018	June 2018 Year-To-Date		Variance	Variance	June 2018 Year-To-Date		Variance
	Actual	Actual	Budget	Fav / (Unfav)	%	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	201,822	2,432,970	2,447,089	(14,119)	-0.58%	PMPM - FYTD		
Revenue								
Premium	$ 71,198,985	$ 841,253,929	$ 776,920,113	$ 64,333,815	8.28%	$ 345.77	$ 317.49	$ 28.28
Facility Expense AB85	0	(34,885,333)	0	$ (34,885,333)	0.00%	(14.34)	-	$ (14.34)
Reserve for Rate Reduction	-	7,126,387	0	7,126,387	0.00%	2.93	-	2.93
MCO Premium Tax	(7,445,341)	(90,520,486)	(94,121,624)	3,601,138	-3.83%	(37.21)	(38.46)	1.26
Total Net Premium	**63,753,644**	**722,974,497**	**682,798,489**	**40,176,008**	**5.88%**	**297.16**	**279.02**	**18.13**
Total Revenue	**63,753,644**	**722,974,497**	**682,798,489**	**40,176,008**	**5.88%**	**297.16**	**279.02**	**18.13**
Medical Expenses:								
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,317,338	62,995,075	64,539,832	1,544,757	2.39%	25.89	26.37	0.48
FFS Claims Expenses:								
Inpatient	11,632,142	139,511,211	130,568,432	(8,942,779)	-6.85%	57.34	53.36	(3.99)
LTC / SNF	10,565,849	120,959,177	115,153,592	(5,805,586)	-5.04%	49.72	47.06	(2.66)
Outpatient	4,631,116	61,957,283	51,562,626	(10,394,656)	-20.16%	25.47	21.07	(4.39)
Laboratory and Radiology	328,934	4,796,691	2,732,972	(2,063,719)	-75.51%	1.97	1.12	(0.85)
Directed Payments - Provider	3,305,912	3,305,912	0	(3,305,912)	0.00%	1.36	-	(1.36)
Emergency Room	2,076,945	29,954,187	24,952,748	(5,001,439)	-20.04%	12.31	10.20	(2.11)
Physician Specialty	5,424,270	57,919,961	50,982,827	(6,937,134)	-13.61%	23.81	20.83	(2.97)
Primary Care Physician	1,431,986	16,469,454	14,466,126	(2,003,327)	-13.85%	6.77	5.91	(0.86)
Home & Community Based Services	1,519,787	16,710,747	18,297,637	1,586,890	8.67%	6.87	7.48	0.61
Applied Behavior Analysis Services	776,318	8,694,696	4,664,999	(4,029,697)	-86.38%	3.57	1.91	(1.67)
Mental Health Services	907,305	6,765,968	9,287,551	2,521,583	27.15%	2.78	3.80	1.01
Pharmacy	10,066,144	121,066,190	110,990,542	(10,075,648)	-9.08%	49.76	45.36	(4.40)
Other Medical Professional	431,412	3,643,531	4,778,935	1,135,405	23.76%	1.50	1.95	0.46
Other Medical Care	4,940	34,518	0	(34,518)	0.00%	0.01	-	(0.01)
Other Fee For Service	712,513	9,515,292	7,916,112	(1,599,179)	-20.20%	3.91	3.23	(0.68)
Transportation	132,793	2,179,818	1,456,089	(723,728)	-49.70%	0.90	0.60	(0.30)
Total Claims	53,948,366	603,484,637	547,811,190	(55,673,447)	-10.16%	248.04	223.86	(24.18)
Medical & Care Management Expense	1,062,031	11,650,002	14,319,905	2,669,903	18.64%	4.79	5.85	1.06
Reinsurance	245,743	1,965,610	5,359,125	3,393,515	63.32%	0.81	2.19	1.38
Claims Recoveries	9,827	(2,539,139)	0	2,539,139		(1.04)	-	1.04
Sub-total	1,317,601	11,076,473	19,679,030	8,602,556	43.71%	4.55	8.04	3.49
Total Cost of Health Care	**60,583,306**	**677,556,186**	**632,030,052**	**(45,526,134)**	**-7.20%**	**278.49**	**258.28**	**(20.21)**
Contribution Margin	**3,170,338**	**45,418,311**	**50,768,438**	**(5,350,126)**	**-10.54%**	**18.67**	**20.75**	**(2.08)**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	2,059,967	23,093,673	23,986,027	892,353	3.72%	9.49	9.80	0.31
Training, Conference & Travel	28,162	256,103	585,439	329,336	56.25%	0.11	0.24	0.13
Outside Services	2,089,297	26,189,781	27,561,759	1,371,978	4.98%	10.76	11.26	0.50
Professional Services	264,801	3,673,851	3,436,450	(237,401)	-6.91%	1.51	1.40	(0.11)
Occupancy, Supplies, Insurance & Others	644,554	7,083,365	8,377,455	1,294,090	15.45%	2.91	3.42	0.51
ARCH/Community Grants	0	323,254	0	(323,254)	0.00%	0.13	-	(0.13)
Care Management Credit	(1,062,031)	(11,650,002)	(14,319,905)	(2,669,903)	18.64%	(4.79)	(5.85)	(1.06)
Total G & A Expenses	**4,024,751**	**48,970,025**	**49,627,225**	**657,200**	**1.32%**	**20.13**	**20.28**	**0.15**
Total Operating Gain / (Loss)	**$ (854,413)**	**$ (3,551,713)**	**$ 1,141,213**	**$ (4,692,926)**	**-411.22%**	**$ (1.46)**	**$ 0.47**	**$ (1.93)**
Non Operating								
Revenues - Interest	472,611	4,632,745	910,398	3,722,347	408.87%	1.90	0.37	1.53
Total Non-Operating	472,611	4,632,745	910,398	3,722,347	408.87%	1.90	0.37	1.53
Total Increase / (Decrease) in Unrestricted Net Assets	**$ (381,802)**	**$ 1,081,032**	**$ 2,051,611**	**$ (970,579)**	**-47.31%**	**0.44**	**0.84**	**(0.39)**

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STATEMENT OF CASH FLOWS	FYTD 17-18
Cash Flows Provided By Operating Activities	
Net Income (Loss)	$ 1,081,032
Adjustments to reconciled net income to net cash provided by operating activities	
Depreciation on fixed assets	531,819
Amortization of discounts and premium	(349,658)
Changes in Operating Assets and Liabilites	-
Accounts Receivable	50,681,998
Prepaid Expenses	1,848,228
Accounts Payable	(157,694,784)
Claims Payable	814,799
MCO Tax liablity	1,096,533
IBNR	(7,566,650)
Net Cash Provided by (Used in) Operating Activities	(109,556,683)
Cash Flow Provided By Investing Activities	
Proceeds from Restricted Cash & Other Assets	
Proceeds from Investments	215,000,000
Proceeds for Sales of Property, Plant and Equipment	-
Payments for Restricted Cash and Other Assets	-
Purchase of Investments plus Interest reinvested	(131,874,821)
Purchase of Property and Equipment	(162,869)
Net Cash (Used In) Provided by Investing Activities	82,962,310
Cash Flow Provided By Financing Activities	
None	-
Net Cash Used In Financing Activities	-
Increase/(Decrease) in Cash and Cash Equivalents	(26,594,373)
Cash and Cash Equivalents, Beginning of Period	177,821,723
Cash and Cash Equivalents, End of Period	$ 151,227,350

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AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: August 27, 2018

SUBJECT: Chief Executive Officer Update

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

Joint Legislative Audit Committee

On July 25, Gold Coast Health Plan received notification that the state of California's Joint Legislative Audit Committee (JLAC) would be voting on an audit request made by Senator Jeffery Stone, Pharm. D., from Riverside County. The hearing took place on August 8, in which Anne Freese, Pharm.D., GCHP's Director of Pharmacy, provided testimony. Ultimately, the committee voted to move forward with the audit.

The audit will principally focus on:

1. Assessment of the role and responsibilities of relevant State agencies including the Department of Health Care Services (DHCS), in overseeing GCHP responsibilities relating to its contracting Pharmacy Benefit Manager (PBM).

2. Review of GCHP's RFP process and selection of its PBM, OptumRx.

3. Review of GCHP's oversight of its PBM.

4. Evaluate whether GCHP's processes for establishing rates through its subcontractor for contracting pharmacies are reasonable and appropriate, and if not, what responsibilities, if any, fall on GCHP or its regulators to address this issue.

5. Assess how other similarly situated Medi-Cal managed care plans and their PBMs are reimbursing their contracted pharmacies for similar drugs.

At this point, it is unknown when the audit will take place. The Auditor will conduct six audits this Fall and then complete the rest of the approved audits sometime next year.

California Legislative Update

On August 6, the Legislature returned from Summer Recess to conclude their final month of work before adjourning on August 31. The first order of business is to push hundreds of bills though the Appropriations Committee process. The Appropriations Committees in each house are responsible for evaluating the fiscal impact legislative bills will have on the state. Any bill deemed to have a cost to the state of more than $150,000 is moved to the Suspense File. This low fiscal threshold means that a vast majority of bills are placed on the Suspense File. On August 16, both the Senate and Assembly Appropriations Committees held their Suspense File hearings to announce which bills would move out of committee. However, those held on the Suspense File are considered dead for the year.

The Governor's Department of Finance (DOF) provides analyses on Suspense File bills, which usually is the first-time authors learn if the Governor is likely to sign or veto their bills. Opposition from the DOF is usually not a good sign and the Appropriations Committees will often, but not always, hold these bills.

The following legislative bills moved out of committee:

- AB 2275 would require the Department of Health Care Services (DHCS) to establish a quality assessment and performance improvement program for all Medi-Cal managed care plans, which requires plans to meet a minimum performance level, effective January 1, 2021, that improves quality of care and reduces health disparities for beneficiaries. While most County Organized Health Systems (COHS), like Gold Coast Health Plan (GCHP), usually provide very good quality of care, this bill could be administratively burdensome and costly without any clear benefit to improving care. Furthermore, COHS regularly work with their local communities and DHCS to ensure enrollees receive timely quality care. The Local Health Plans of California (LHPC), of which GCHP is a member, decided to oppose AB 2275 after negotiations with the author to make the bill more manageable failed.
- AB 2299 would require DHCS to ensure that all written health education and informing materials developed by Medi-Cal managed care plans in English or translated into threshold languages are at or below the equivalent of sixth grade reading level. Additionally, health plans would also be required to conduct a one-time, targeted community review of informing materials in threshold languages for which a sixth-grade reading level cannot be determined, in order for members to ensure the cultural and linguistic appropriateness of materials in community-based settings. This measure is opposed by DHCS, which is usually a signal that the Governor could veto the bill should it make it to the Governor's desk.

The following legislative bills were held in committee:

- SB 974 would have expanded Medi-Cal coverage to individuals over the age of 65 who would otherwise qualify if not for their immigration status.
- AB 2965 would have expanded coverage to individuals up to the age of 26 who would otherwise qualify if not for their immigration status.

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COMPLIANCE UPDATE:

DHCS Annual Medical Audit:

Audits and Investigation conducted the annual 2017-2018 onsite medical audit June 4, 2018 through June 15, 2018. The auditors reviewed the following areas: Utilization Management, Care Management and Care Coordination, Access and Availability, Grievance and Appeals, HIPAA, Fraud, Waste and Abuse, Delegation Oversight, Quality Improvement and Administrative Capacity. Audits and Investigations has scheduled an exit conference with GCHP on August 30, 2018 to review the draft corrective action plan. Staff will keep the Commission apprised of the corrective action plan once finalized.

DHCS Contract Amendments:

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

Delegation Oversight:

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

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

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

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

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

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

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

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

RECOMMENDATION:
Accept and File

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AGENDA ITEM NO. 8

To: Ventura County Medi-Cal Managed Care Commission

From: Ruth Watson, Chief Operating Officer

Date: August 27, 2018

RE: Administrative Services Organization (ASO) Update

SUMMARY:

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

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AGENDA ITEM NO. 9

To: Ventura County Medi-Cal Managed Care Commission

From: Ruth Watson, Chief Operating Officer

Date: August 27, 2018

RE: Americas Health Plan (AHP) Update

SUMMARY:

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

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AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: August 27, 2018

SUBJECT: Interim Chief Diversity Officer Update

Actions:

Community Relations

- Continued community outreach efforts with an update meeting with Mike Powers, County CEO. Subject matter related to culture shift in the county, effective language translation and county diversity issues.
- Held Diversity Council meeting at GCHP with a presentation from the Mixteco Indigena Community Organization.
- Bi-weekly update meeting with Dale Villani and staff.
- Averaging three Diversity related discussions per week.
- Next Lunch-and-Learn series relates to part two of the Generation Topic - *"How to Manage a Multi-Generational Workforce".*

Case Investigations

No new cases to-date. In discussions with several employees on performance issues related to diversity subjects.

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AGENDA ITEM NO. 11

To: Ventura County Medi-Cal Managed Care Commission

From: Nancy Wharfield, MD, Chief Medical Officer

Date: August 27, 2018

RE: Chief Medical Officer Update

HEALTH SERVICES UPDATE

GCHP continues to perform well when compared to the Managed Care Medi-Cal Dashboard. Utilization metrics for CYTD 2018 are statistically similar to CY 2017.

UTILIZATION SUMMARY

BED DAYS:

Bed days/1000 members have declined by about 43%, from Plan's inception in 2011 through CY 2017. Bed days/1000 for CYTD 2018 (178) have decreased from CY 2017 (211). The proportion of bed days utilized by AE members continues to increase (47% to 49%) in a year-to-year comparison of December 2016 to December 2017.

Bed days/1000 for SPD members for CYTD 2018 (775) have decreased from CY 2017 (968). 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.

AVERAGE LENGTH OF STAY:

Average length of stay for CY2017 was 3.9. Average length of stay for CYTD 2018 is 4.2. There is no significant change in this metric.

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.

ADMITS/ 1000:

Admits/1000 for CY2017 were 53/1000 members. Admits/1000 for CYTD 2018 is 44/1000 members.

Admits/1000 SPD members are 169/1000 for CY 2017. Admits/1000 SPD members for CYTD 2018 is 140/1000.

Admits/1000 SPD 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).

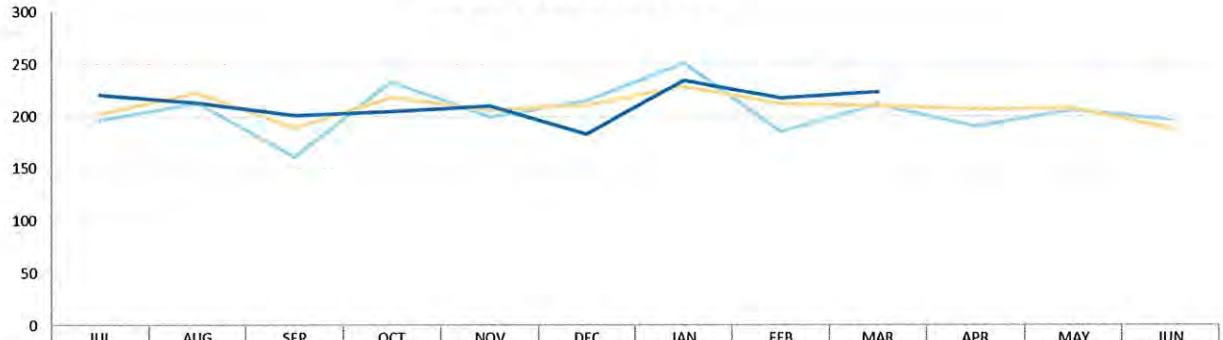
ED UTILIZATION/1000:

ED utilization/1000 members typically peaks in January or February. CYTD 2018 ED utilization/1000 members increased from CY2017 (530 v. 468), likely related to the inclusion of the peak season in CYTD and due to sequelae from the Thomas Fire in December 2017 (respiratory issues and stress). Trending utilization from April 2016-March 2017 to April 2017-March 2018, which offers a more valid comparison, there is a slight increase of ED utilization (442 v. 480). For March 2018, the Family aid code group continues to show the highest ED utilization (50%) followed by AE (31%). This utilization pattern is essentially unchanged from CY 2017.

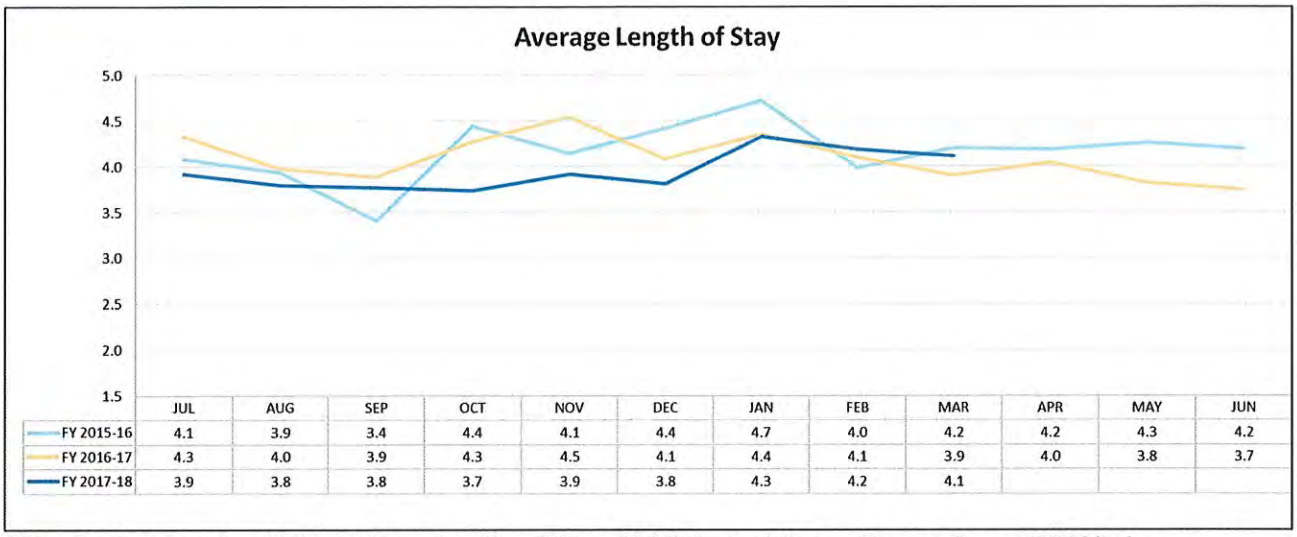
ED utilization/1000 for SPD members for CYTD 2018 has decreased from CY 2017 (671 v. 840). This trend is unexpected given the inclusion of the peak season in CYTD and will be followed. This represents approximately 8% of ED utilization.

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.

Bed Days Per 1,000



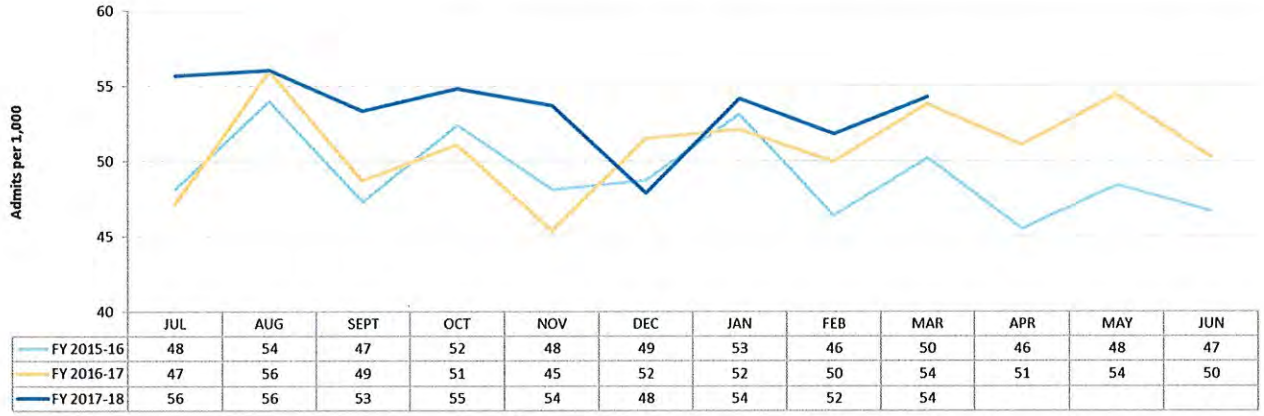
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2015-16	196	212	161	233	200	215	251	185	211	190	206	196
FY 2016-17	203	223	189	218	206	211	228	212	210	206	207	188
FY 2017-18	220	213	201	205	210	183	234	217	223			



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

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

Acute Inpatient Admissions/1000 Members

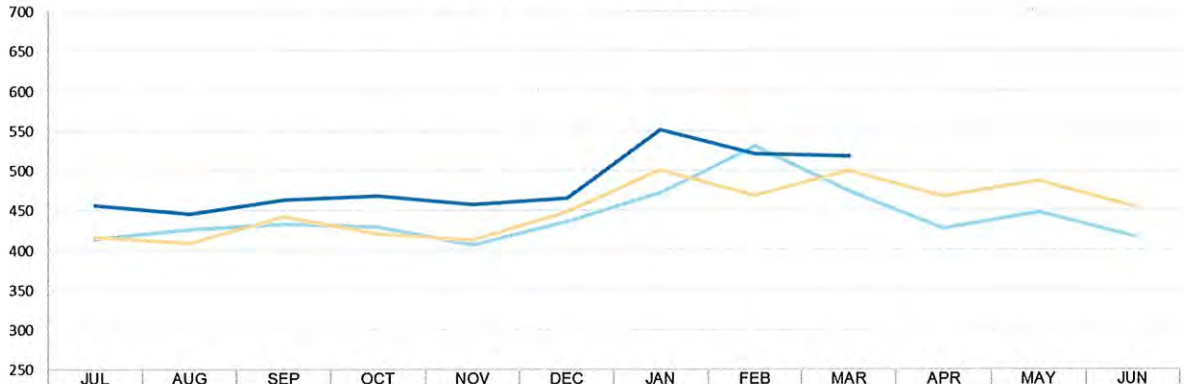


	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2015-16	48	54	47	52	48	49	53	46	50	46	48	47
FY 2016-17	47	56	49	51	45	52	52	50	54	51	54	50
FY 2017-18	56	56	53	55	54	48	54	52	54			

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

*Data from MedInsight 07/10/2018

ER Utilization Per 1,000



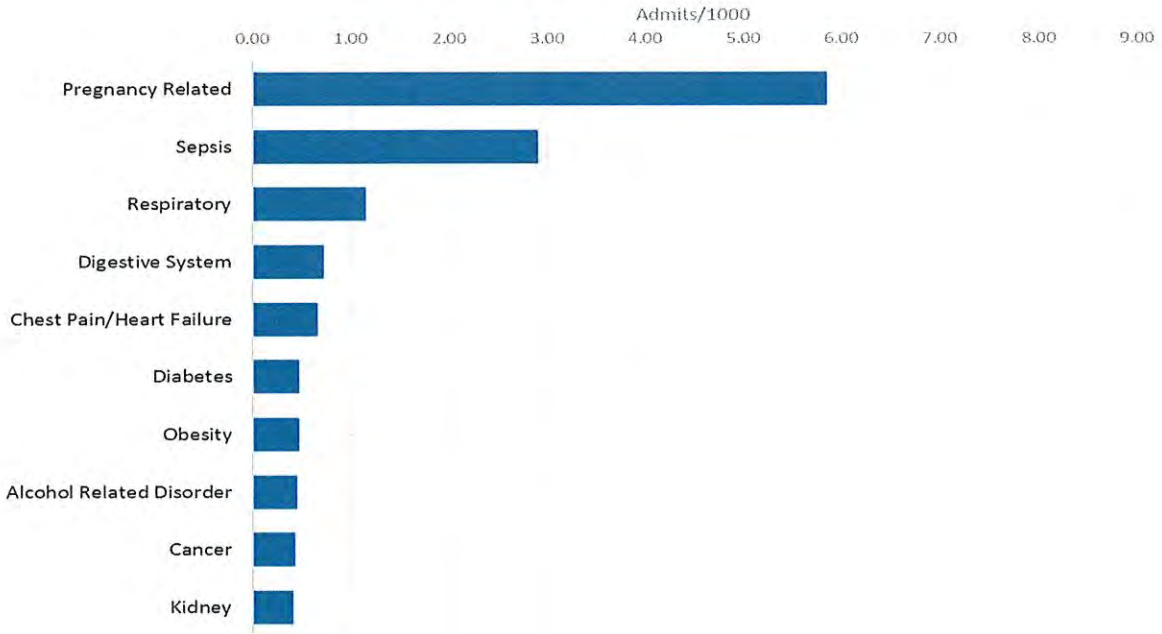
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY 2015-16	415	427	433	429	407	436	472	531	474	427	448	418
FY 2016-17	417	408	441	420	413	447	500	468	500	467	487	454
FY 2017-18	457	446	463	468	457	465	551	521	518			

*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

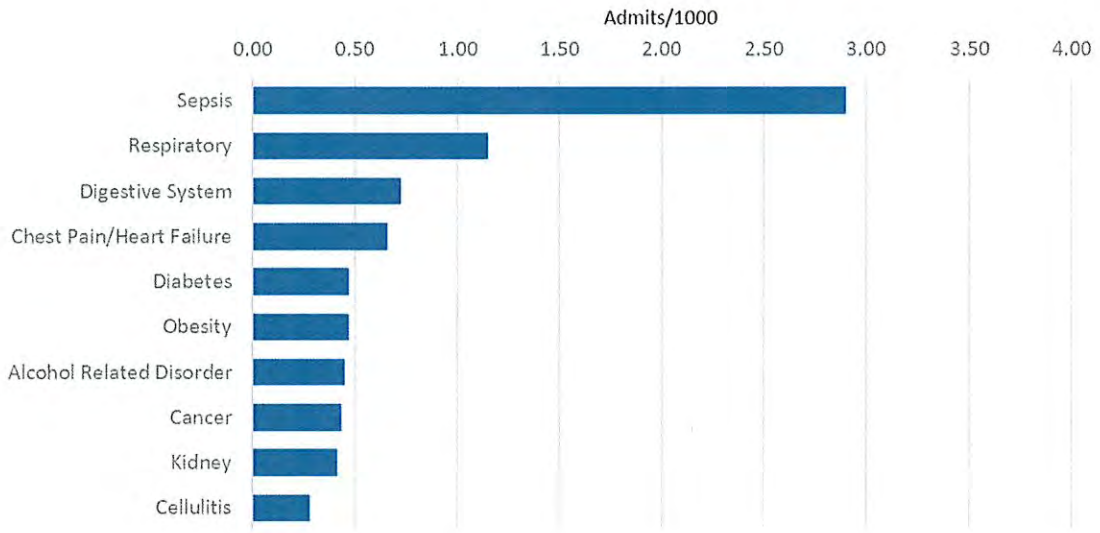
TOP ADMITTING DIAGNOSES

Pregnancy related diagnoses and sepsis continued to dominate top admitting diagnoses for CY 2017 and CYTD 2018. For members admitted with a primary diagnosis of sepsis, secondary diagnoses were cancer, heart disease, liver or renal transplant, and diabetes.

Top 10 Diagnosis Including Pregnancy
Calendar Year 2018



Top 10 Diagnoses (Excluding Pregnancy)
Calendar Year 2018

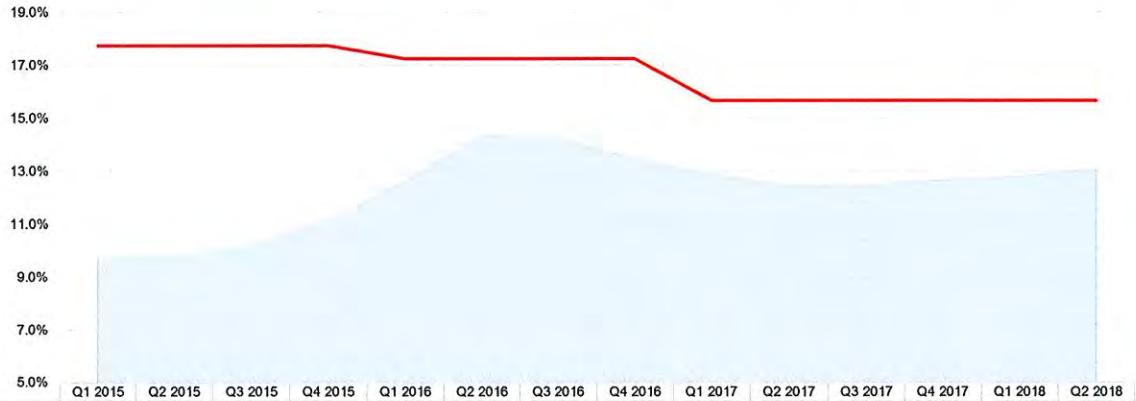


READMISSION RATE

The quarterly readmission rate has declined from a peak in Q2 of 2016 (14.3%) to an average of 13% for CYTD 2018.

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

Readmission Rate *



	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018
EBM Rate %	9.7%	9.8%	10.2%	11.1%	12.6%	14.3%	14.2%	13.5%	12.9%	12.4%	12.5%	12.7%	12.8%	13.1%
DHCS Managed Care Weighted Average	17.7%	17.7%	17.7%	17.7%	17.2%	17.2%	17.2%	17.2%	15.7%	15.7%	15.7%	15.7%	15.7%	15.7%

CLINICAL GRIEVANCES AND APPEALS

For CY 2017, there was an average of 47 grievances/quarter. The number of clinical grievances/quarter for 2nd Quarter CY 2018 has increased to 61. The increase is due in part to a State requirement that Members grieve to Managed Care Medi-Cal plan prior to filing for State Fair Hearing. For 2nd Quarter CY 2018, most grievances (79%) were characterized as quality of care issues, with access issues decreasing to 11% (22% in the 1st Quarter CY 2018) of total grievances. For the 2nd Quarter CY 2018, there are 54 appeals with 41% upheld and 28% overturned. The Plan is looking further into this increase in appeals.

QTR	Grievance Total	Appeals Total	Upheld	Partial Overturn	Overturned	Withdrawn	Dismissed
2017							
Q1	34	15	6 (40%)	-	8 (53%)	1 (7%)	-
Q2	40	17	9 (54%)	-	4 (23%)	4 (23%)	-
Q3	66	17	9 (53%)	-	6 (35%)	2 (12%)	-
Q4	46	23	13 (56%)	-	5 (22%)	5 (22%)	-
2018							
Q1*	65	28	10 (36%)	-	9 (32%)	4 (14%)	-
Q2	61	54	22 (41%)	-	15 (28%)	1 (1%)	-

*Q2 2018 total appeals includes 16 (30%) in progress.

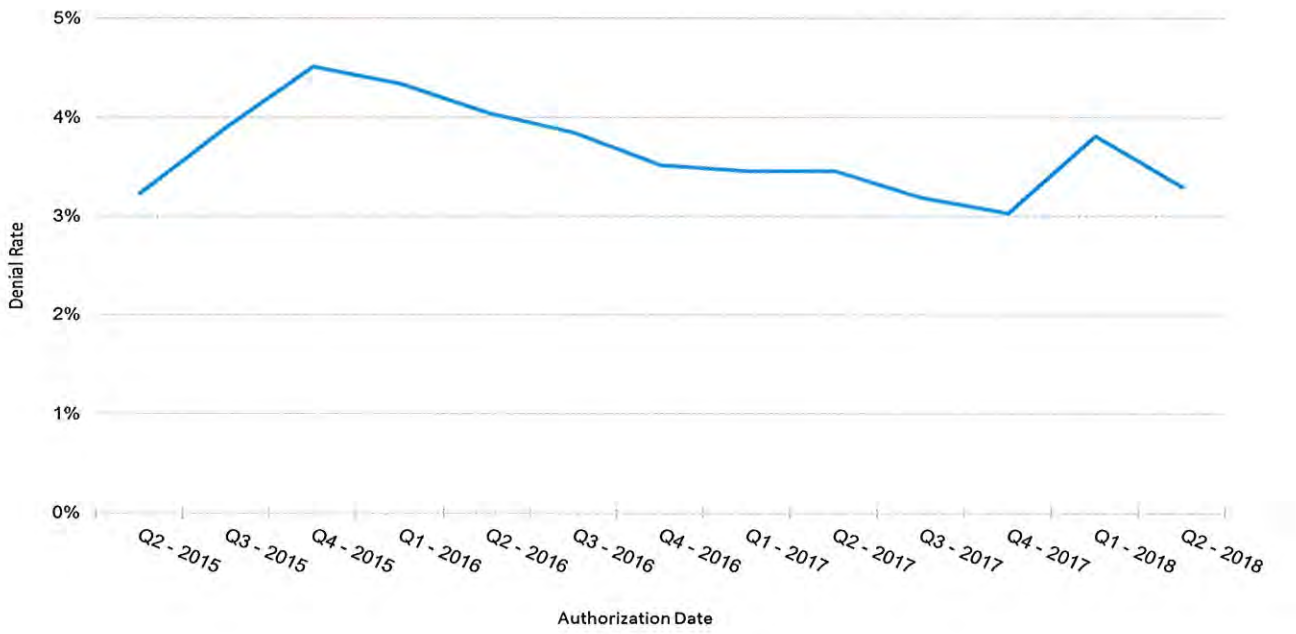
Grievance benchmark: DHCS tracks grievances by type. In Q3 2017, the DHCS grievance average was 60% for quality of care and 14% for access issues.

DENIAL RATE

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

The denial rate has ranged between 2.7% and 4.5% since 2013. The average denial rate for CY 2016 was 3.9% and for CY 2017 is 3.3%. The average for CYTD 2018 is 3.6%.

Denial Rate Trend



Of note, 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 inpatient calculations, and it is important to note that there is variability of reporting of Administrative Days among managed care plans. Dual eligible members, Skilled Nursing Facility (SNF), and Long Term Care (LTC) data is not included in this presentation.

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MY 2017 HEDIS Performance Update

August 27, 2018

Integrity

Accountability

Collaboration

Trust

Respect

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HEDIS Performance Highlights

- 80% of HEDIS measures improved in measurement year (MY) 2017 compared to the prior year
- Of HEDIS® measures reported in DHCS Aggregate Quality Score
  - ➢29 measures (91%) of metrics met or exceeded NCQA 25th percentile (DHCS MPL)
  - ➢3 measures (9%) fell below the desired performance level

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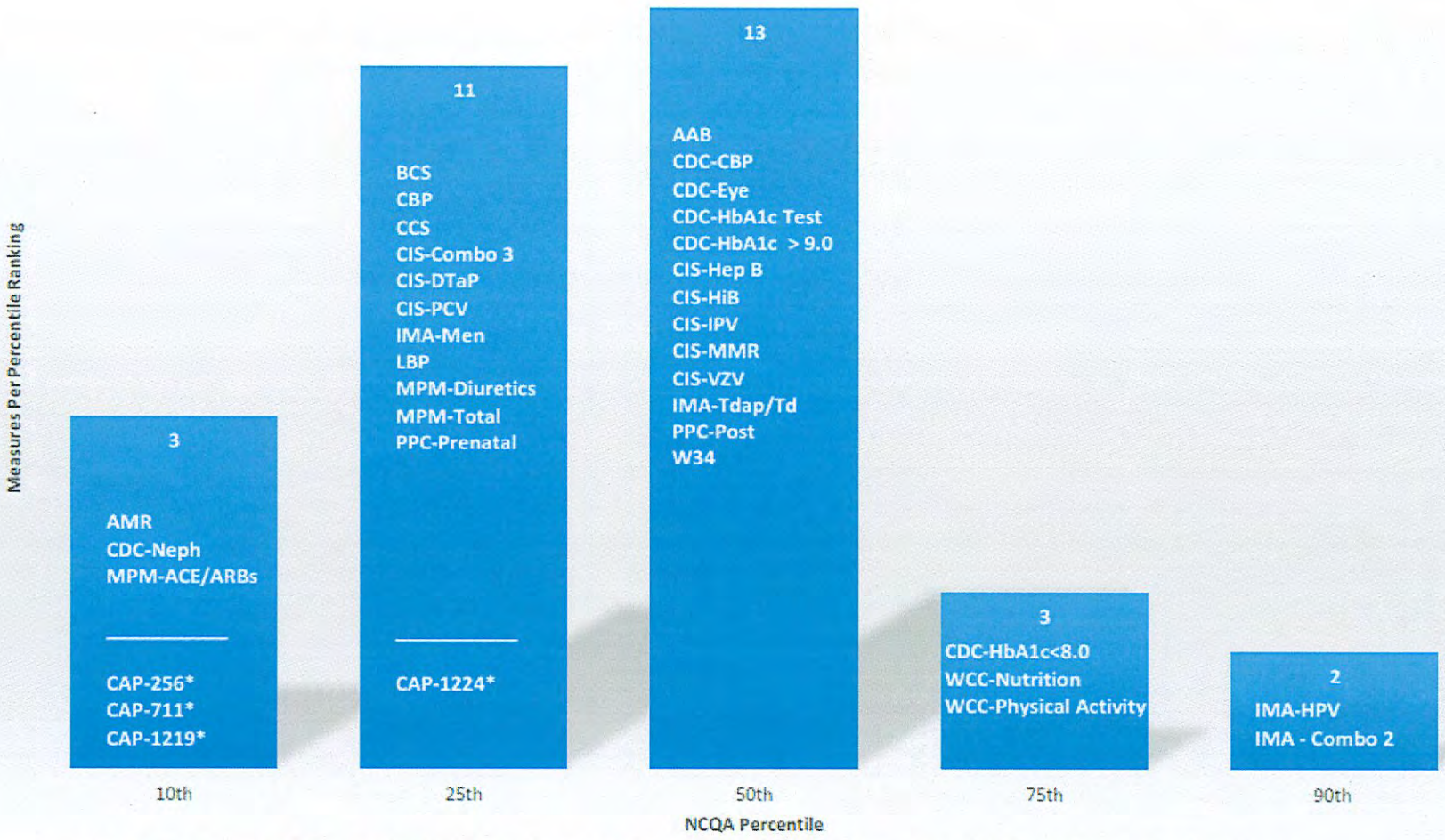
2017 Measurement Year (MY)HEDIS Performance by NCQA Percentile Ranking



* For these measures, the Department of Health Care Services (DHCS) does not hold managed care plans (MCPs) accoutable to meet the minimum performance (MPL) which equates to the 25th percentile ranking. Percentile rankings are determined by the National Committee for Quality Assurance (NCQA).

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NCQA Rank	HEDIS Measure Abbreviation	HEDIS Measure Name	Measure Defintion
10th Percentile			
1	AMR	Asthma Medication Ration	The percentage of 5 - 64 year old members with persistent asthma that had a ratio of controller medications to total asthma medications of ≥ 50%.
2	CDC-Neph	Comprehensive Diabetes Care	The percentage of 18-75 year old members with diabetes that were screened for nephropathy.
3	MPM-ACE/ARBS	Annual Monitoring for Patients on Persistent Medications	The percentage of members ≥ 18 years of age who received at least 180 treatment days of ACE/ARBs and at least one therapeutic monitoring event.
Not Held to MPL	*CAP-256**	*Children and Adolescents' Access to PCP*	*The percentage of 25 month to 6 year old members who had visit with a PCP.*
Not Held to MPL	*CAP-711**	*Children and Adolescents' Access to PCP*	*The percentage of 7 - 11 year old members who had visit with a PCP.*
Not Held to MPL	*CAP-1219**	*Children and Adolescents' Access to PCP*	*The percentage of 12-19 year old members who had visit with a PCP.*
25th Percentile			
1	BCS	Breast Cancer Screening	The percentage of 50-74 year old women who received a mammogram to screen for breast cancer.
2	CBP	Controlling Blood Pressure	The percentage of 18-85 year old members diagnosed with hypertension who had adequately controlled blood pressure.
3	CCS	Cervical Cancer Screening	The percentage of 21-64 year old women who were screened for cervical cancer.
4	CIS-Combo 3	Child Immunization Status	The percentage of 2 year old children who had the following immunizations by their 2nd birthday: 4 DTaP, 3 IPV, 1 MMR, 3 HiB,3 HepB, 1 VZV, and 4 PCV.
5	CIS-DTaP	Child Immunization Status	The percentage of 2 year old children who had 4 DtaP vaccines by their 2nd birthday.
6	CIS-PCV	Child Immunization Status	The percentage of 2 year old children who had 4 PCV vaccines by their 2nd birthday.
7	IMA-Men	Immunizations for Adolescents	The percentage of 13 years members who had 1 meningococcal conjugate vaccine between their 11th and 13th birthday.
8	LBP	Use of Imaging Studies for Low Back Pain	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study within 28 days of the diagnosis.
9	MPM-Diuretics	Annual Monitoring for Patients on Persistent Medications	The percentage of members ≥ 18 years of age and older who received at least 180 treatment days of diuretics and at least one therapeutic monitoring event.
10	MPM-Total	Annual Monitoring for Patients on Persistent Medications	The percentage of members ≥ 18 years of age who received at least 180 treatment days of ACE/ARBs and/or diuretics and at least one therapeutic monitoring event.
11	PPC-Prenatal	Prenatal and Postpartum Care	The percentage of women with livebirth deliveries who had a prenatal exam during the first trimester or within 42 days of enrollment in the health plan.
Not Held to MPL	*CAP-1224**	*Children and Adolescents' Access to PCP*	*The percentage of 12 - 24 month old members who had visit with a PCP.*

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NCQA Rank	HEDIS Measure Abbreviation	HEDIS Measure Name	Measure Defintion
50th Percentile			
1	AAB	Avoidance of Antibiotic Treatment in Adults with Acture Bronchitis	The percentage of 18–64 members with acute bronchitis who were not dispensed an antibiotic prescription within 30 days prior to or 7 days following the date of the diagnosis.
2	CDC-CBP	Comprehensive Diabetes Care	The percentage of 18-75 year old members with diabetes that had adequately controlled blood pressure.
3	CDC-Eye	Comprehensive Diabetes Care	The percentage of 18-75 year old members with diabetes that had an annual retinal eye exam.
4	CDC-HbA1c Test	Comprehensive Diabetes Care	The percentage of 18-75 year old members with diabetes that had an HbA1c test.
5	CDC-HbA1c>9.0	Comprehensive Diabetes Care	The percentage of 18-75 year old members with diabetes that had HbA1c > 9.0.
6	CIS-Hep B	Child Immunization Status	The percentage of 2 year old children who had 3 Hep B vaccines by their 2nd birthday.
7	CIS-HiB	Child Immunization Status	The percentage of 2 year old children who had 3 HiB vaccines by their 2nd birthday.
8	CIS-IPV	Child Immunization Status	The percentage of 2 year old children who had 3 IPV vaccines by their 2nd birthday.
9	CIS-MMR	Child Immunization Status	The percentage of 2 year old children who had 1 MMR vaccine by their 2nd birthday.
10	CIS-VZV	Child Immunization Status	The percentage of 2 year old children who had 4 PCV vaccines by their 2nd birthday.
11	IMA-Tdap/Td	Immunizations for Adolescents	The percentage of adolescents 13 years of age who had 1 Tdap vaccine between their 10th and 13th birthday.
12	PPC-Post	Prenatal and Postpartum Care	The percentage of women with livebirth deliveries who had a postpartum exam within 21 – 56 days after delivery.
13	W34	Well-Child Visit in the 3rd, 4th, 5th, and 6th Years of Life	The percentage of children 3–6 years of age who had a well-child exam with a PCP.
75th Percentile			
1	CDC-HbA1c<8.0	Comprehensive Diabetes Care	The percentage of 18-75 year old members with diabetes that had HbA1c < 8.0.
2	WCC-Nutrition	Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents	The percentage of 3-17 members who were counseled for nutrition.
3	WCC-Physical Activity	Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents	The percentage of 3-17 members who were counseled for physical activity.
90th Percentile			
1	IMA-HPV	Immunizations for Adolescents	The percentage of 13 year old members who had 1 HPV vaccine between their 9 th and 13th birthday.
2	IMA - Combo 2	Immunizations for Adolescents	The percentage of 13 year old members who had all of the following vaccines between their 9th and 13th birthday: 1 HPV, 1 Tdap, 1 Meningococcal conjugate.

* For these measures, the Department of Health Care Services (DHCS) does not hold managed care plans (MCPs) accoutable to meet the minimum performance (MPL) which equates to the 25th percentile ranking. Percentile rankings are determined by the National Committee for Quality Assuranc (NCQA).

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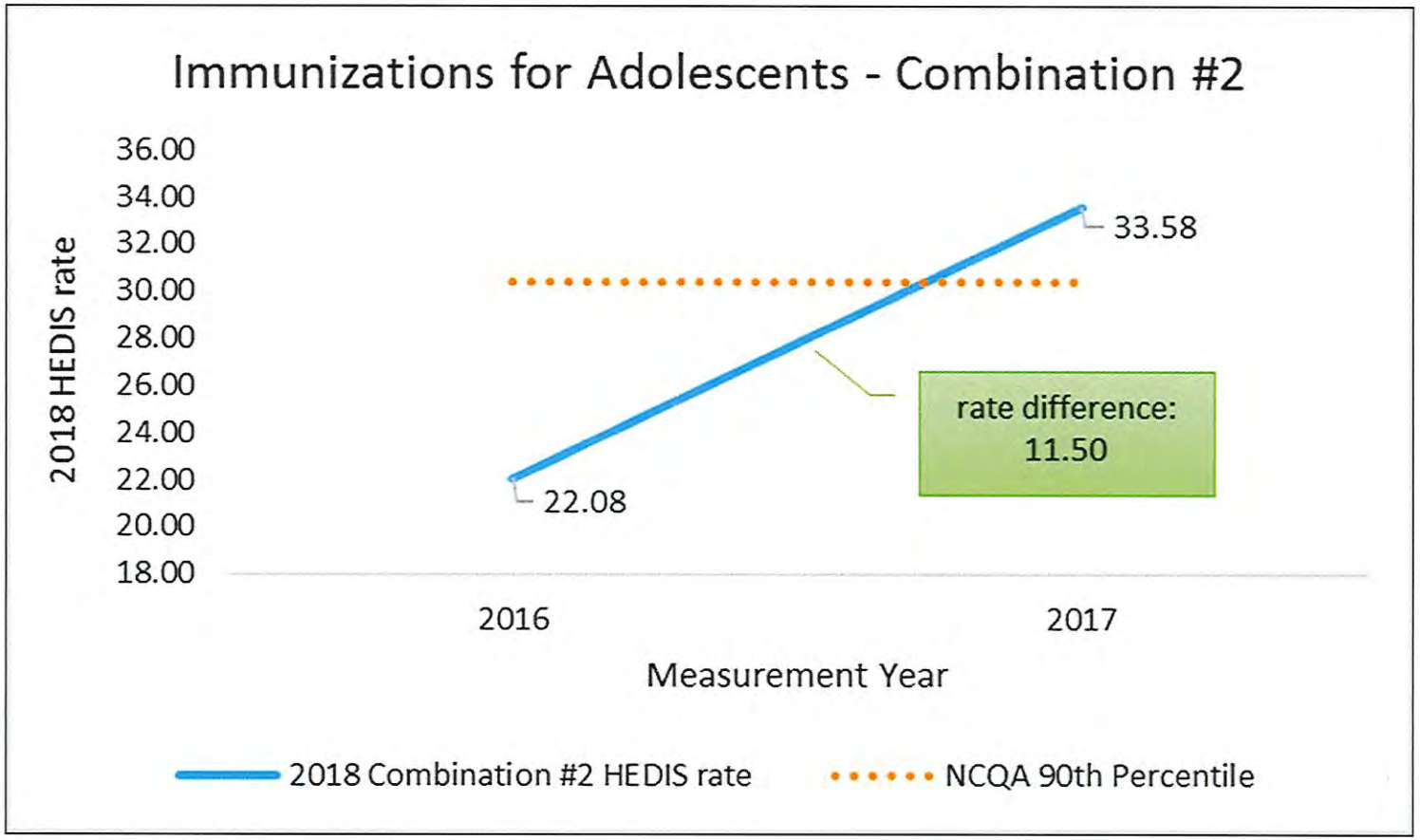
MY 2017 HEDIS Improvements (>90th percentile)



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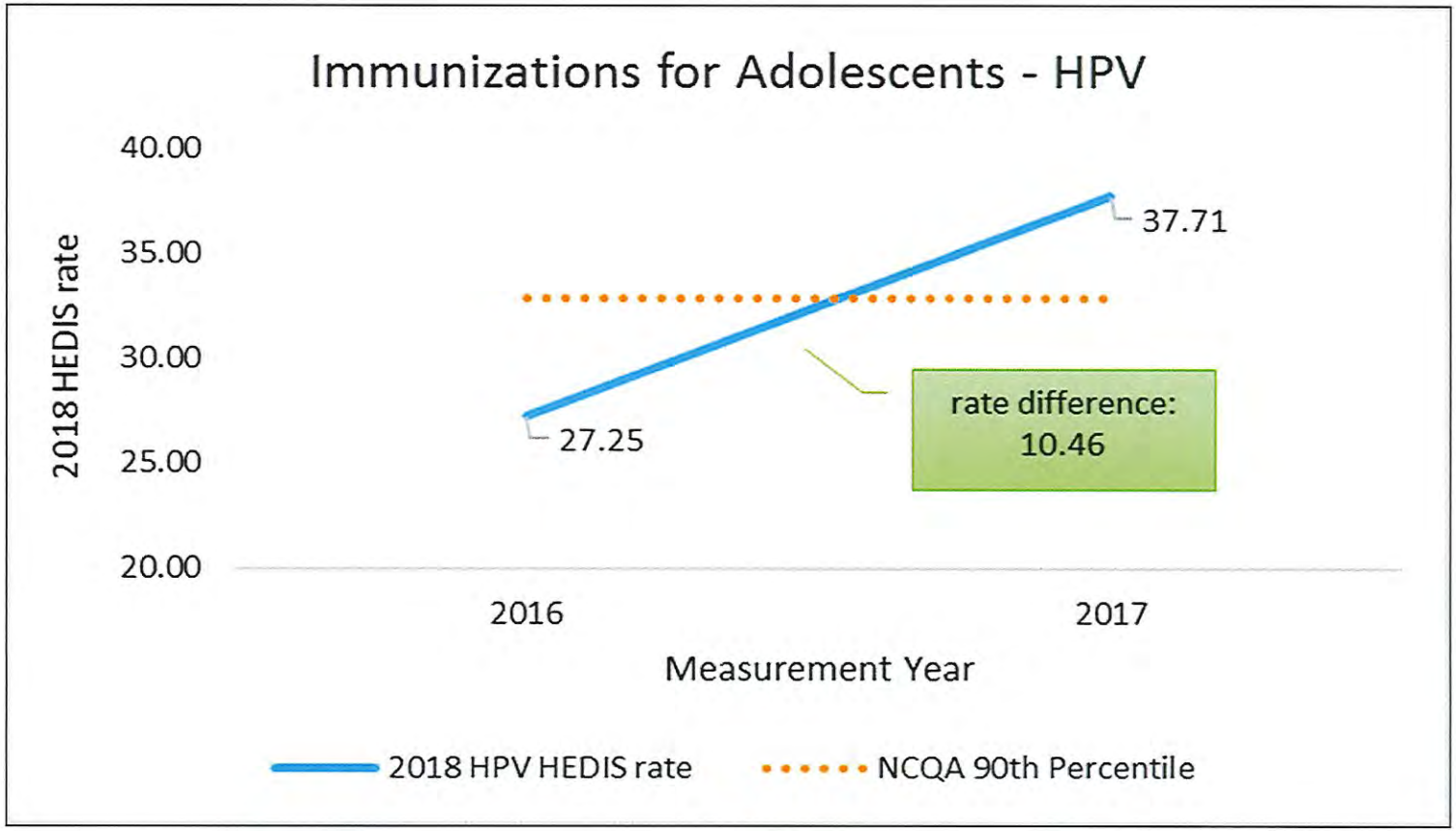
MY 2017 HEDIS Improvements (>90th percentile)



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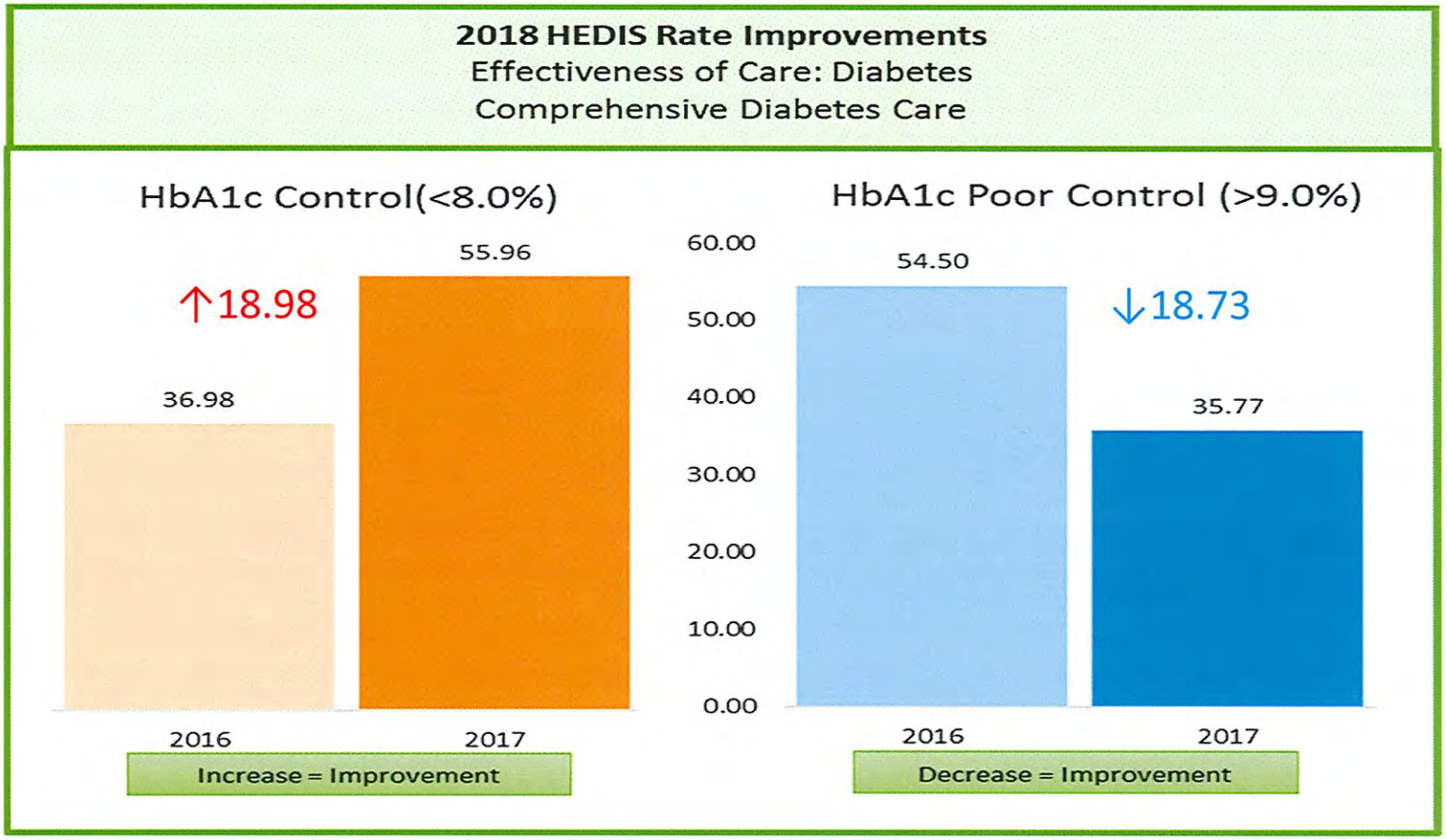
Notable HEDIS Improvements



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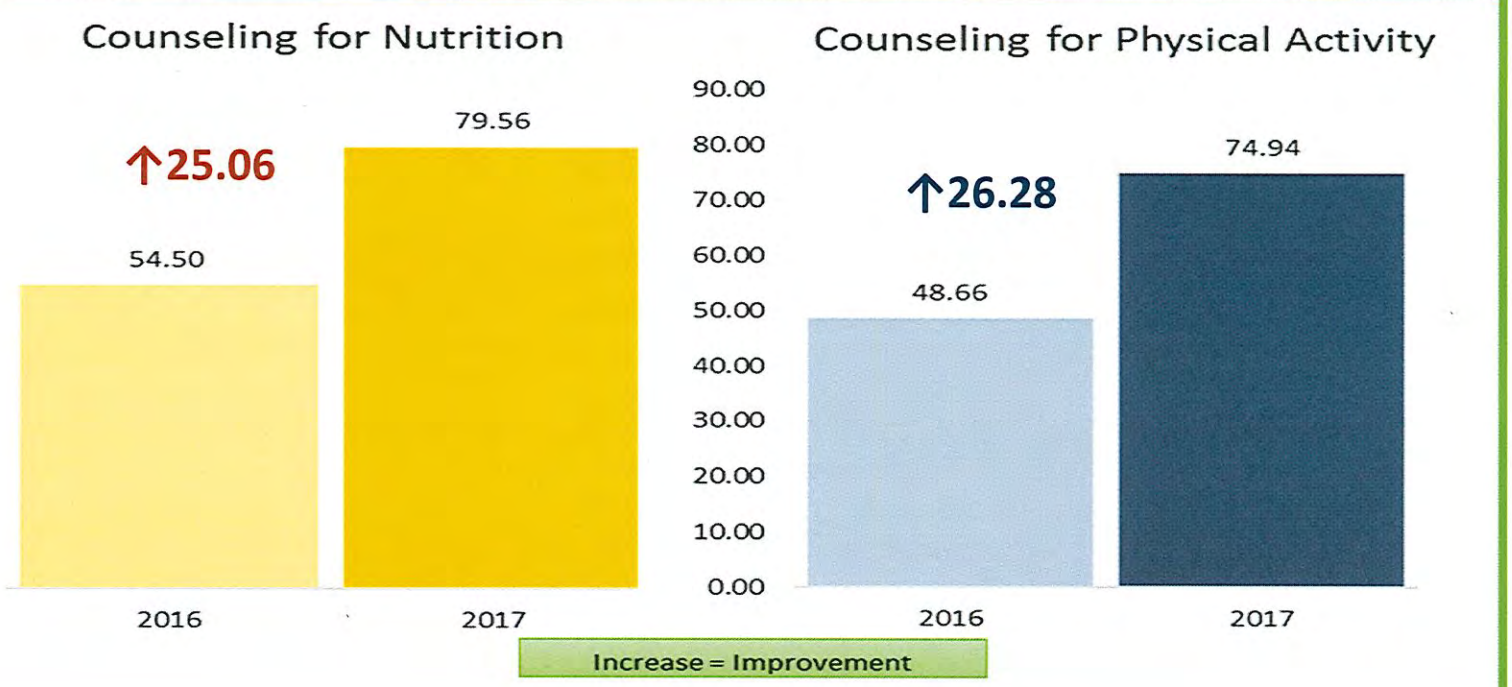
Notable HEDIS Improvements

2018 HEDIS Rate Improvements
Effectiveness of Care: Prevention and Screening
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents



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Rates in Need of Improvement

2018 HEDIS rates currently in NCQA 10th Percentile

HEDIS Measure/Data Element	Rate	NCQA Percentile Rankings 25th	50th
Effectiveness of Care: Respiratory Conditions			
Asthma Medication Ratio			
Medication Compliance 75% Total	**54.41**	55.33	62.19
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care			
Medical Attention for Nephropathy	**88.08**	88.56	90.27
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications			
ACE Inhibitors or ARBs	**85.48**	85.93	87.84
Access/Availability of Care			
Children and Adolescents' Access to Primary Care Practitioners			
25 Months - 6 Years	**84.72**	84.94	87.87
7-11 Years	**86.12**	87.58	90.77
12-19 Years	**83.69**	85.65	89.52
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)	**60.46**	67.15	75.21

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In Progress…

- Produce Clinic-Level MY 2017 HEDIS Report Cards
- Assess Clinic-Level performance to identify high/low performers
- Debrief with HEDIS vendor and HSAG auditor on improvement strategies
- Conduct barrier analysis on low-performing measures to identify target opportunities
- Explore interventions – member/provider focused, data capture, Medicaid plan best practices

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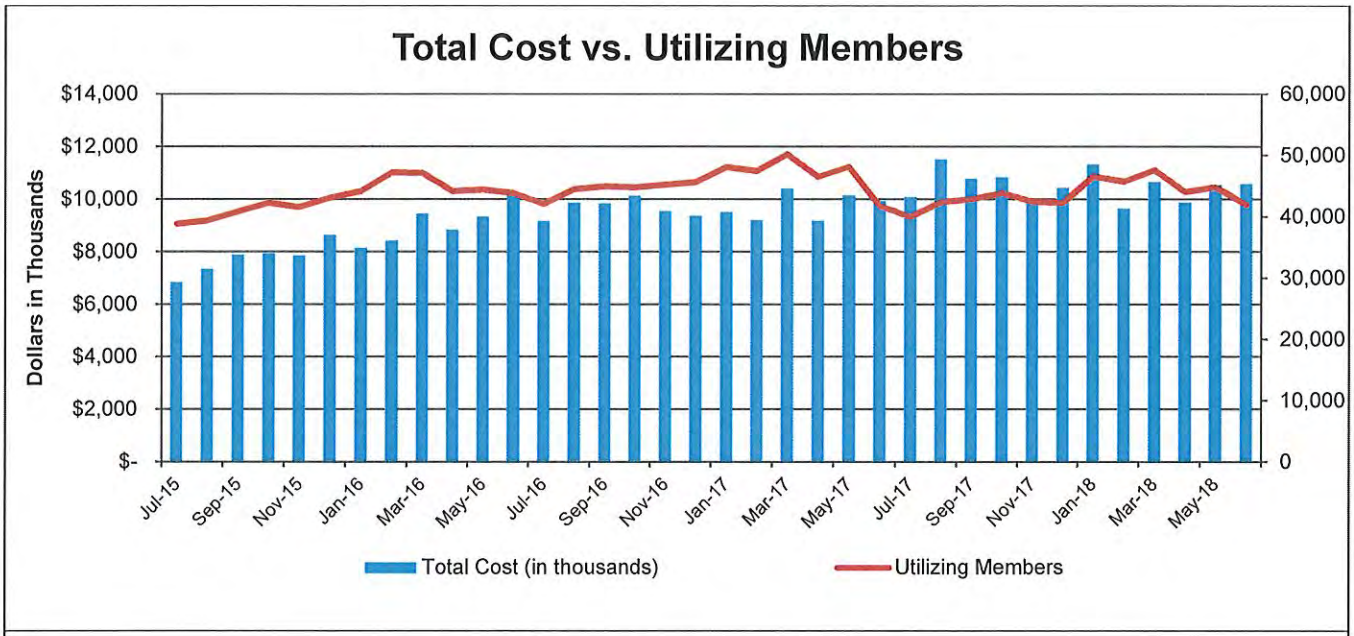
Pharmacy Benefit Performance and Trends

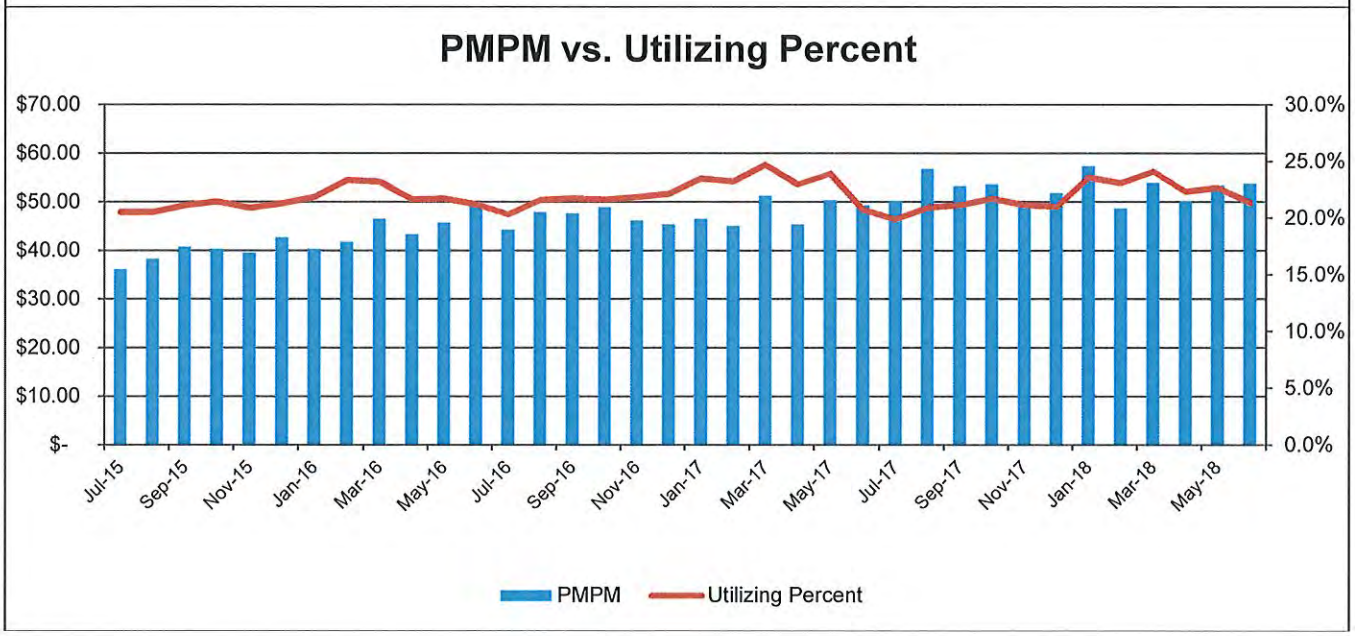
SUMMARY:

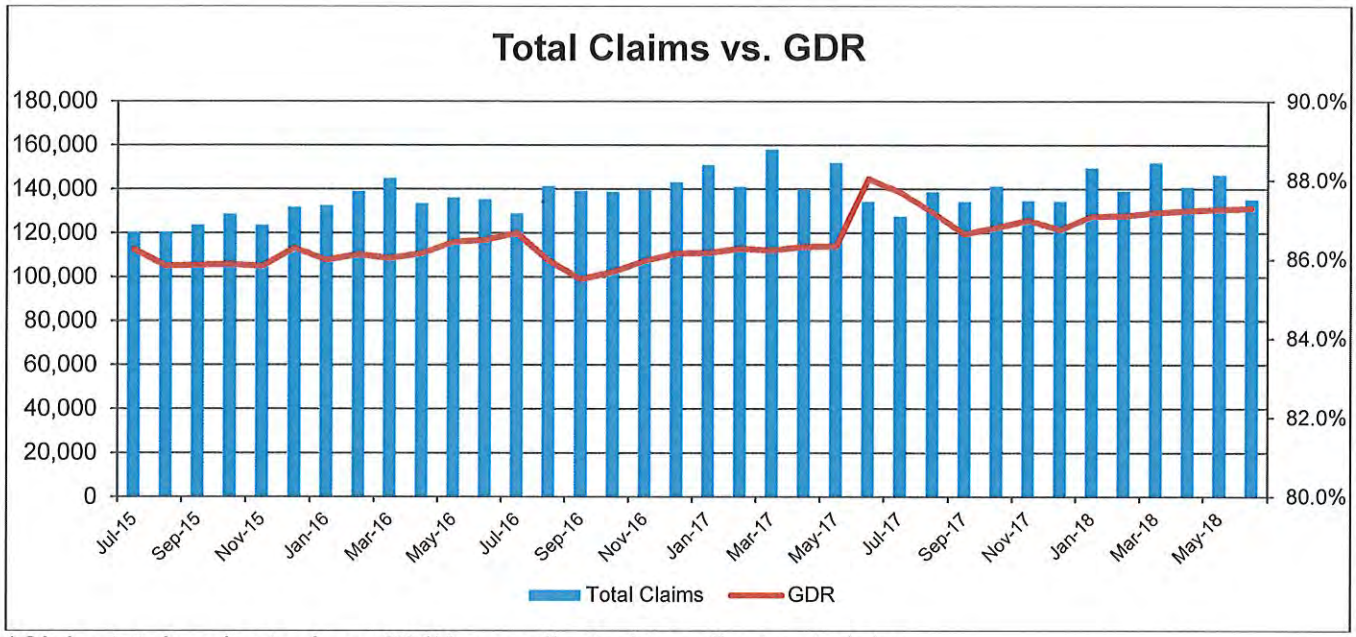
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of June 2018. Although minor changes may occur to the data going forward due to the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

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

PHARMACY COST TRENDS:

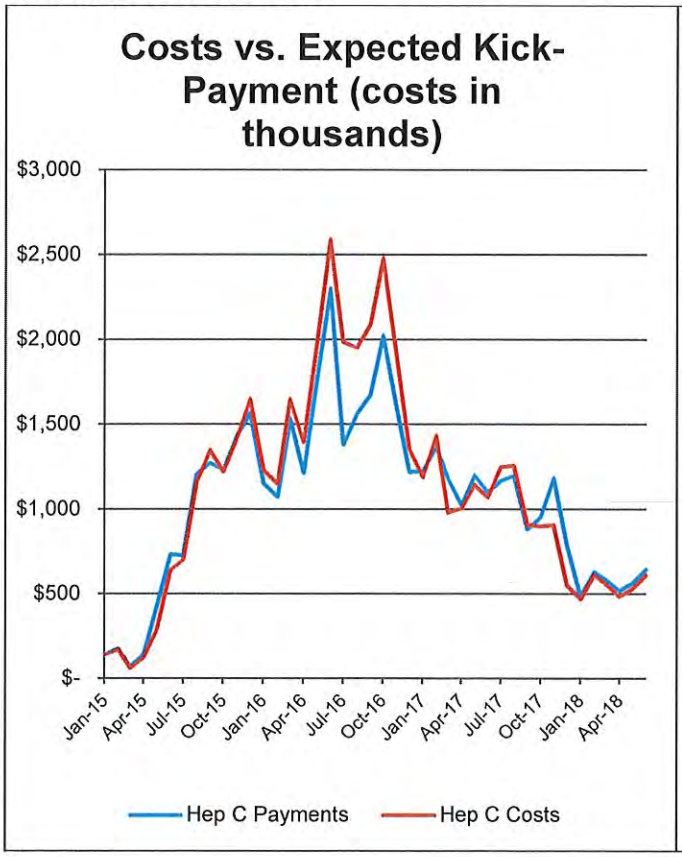


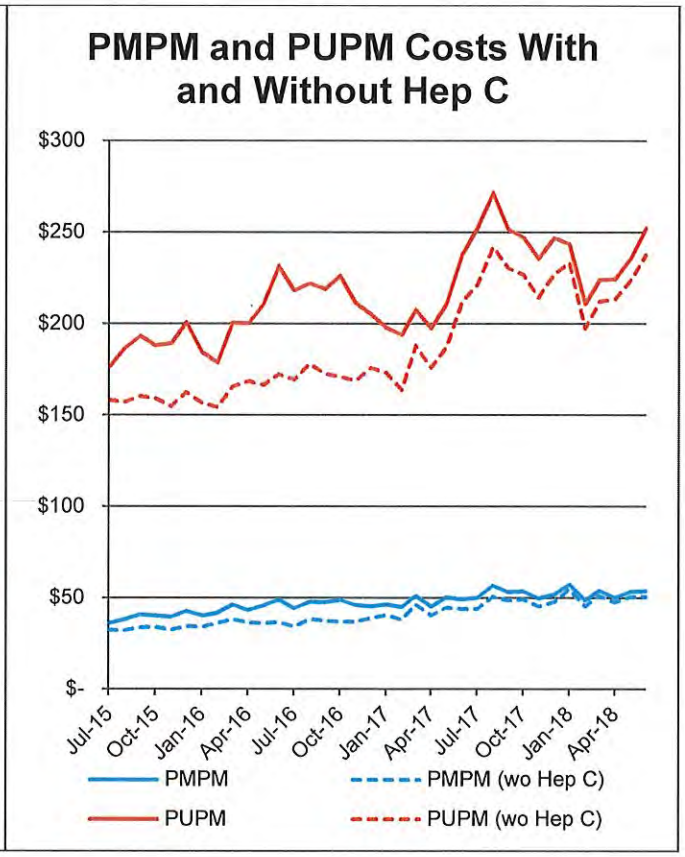




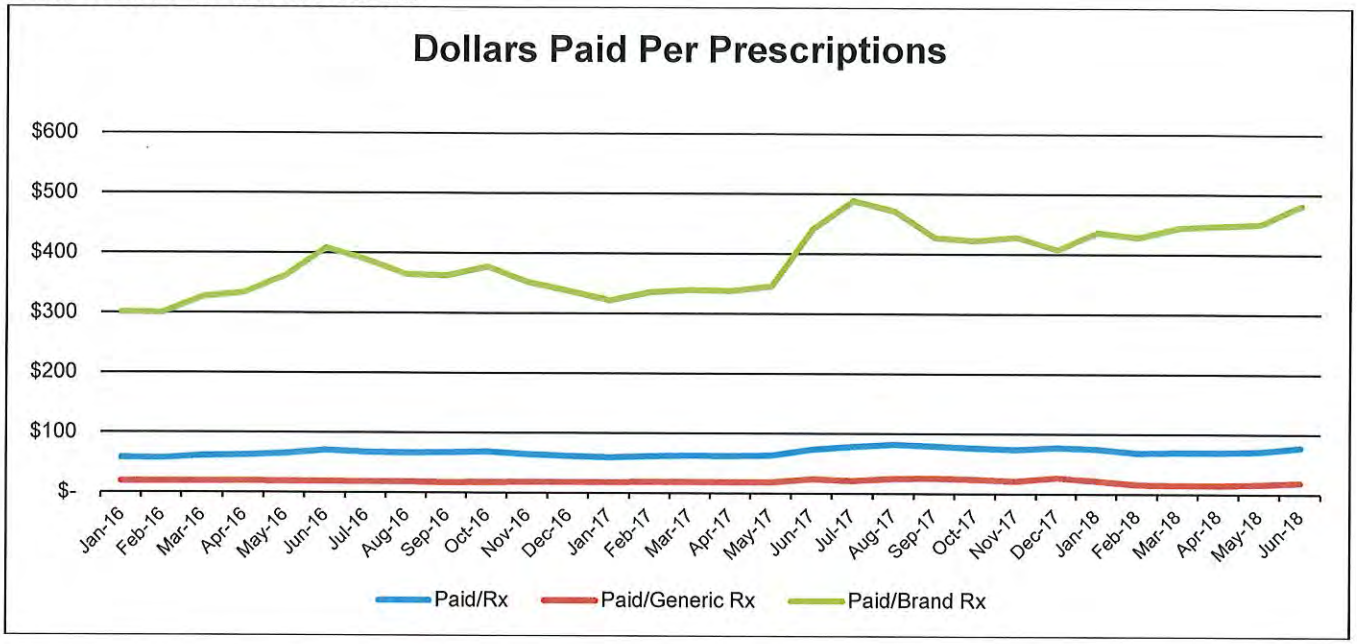
*Claim totals prior to June 2017 are adjusted to reflect net claims.

HEPATITIS C FOCUS:

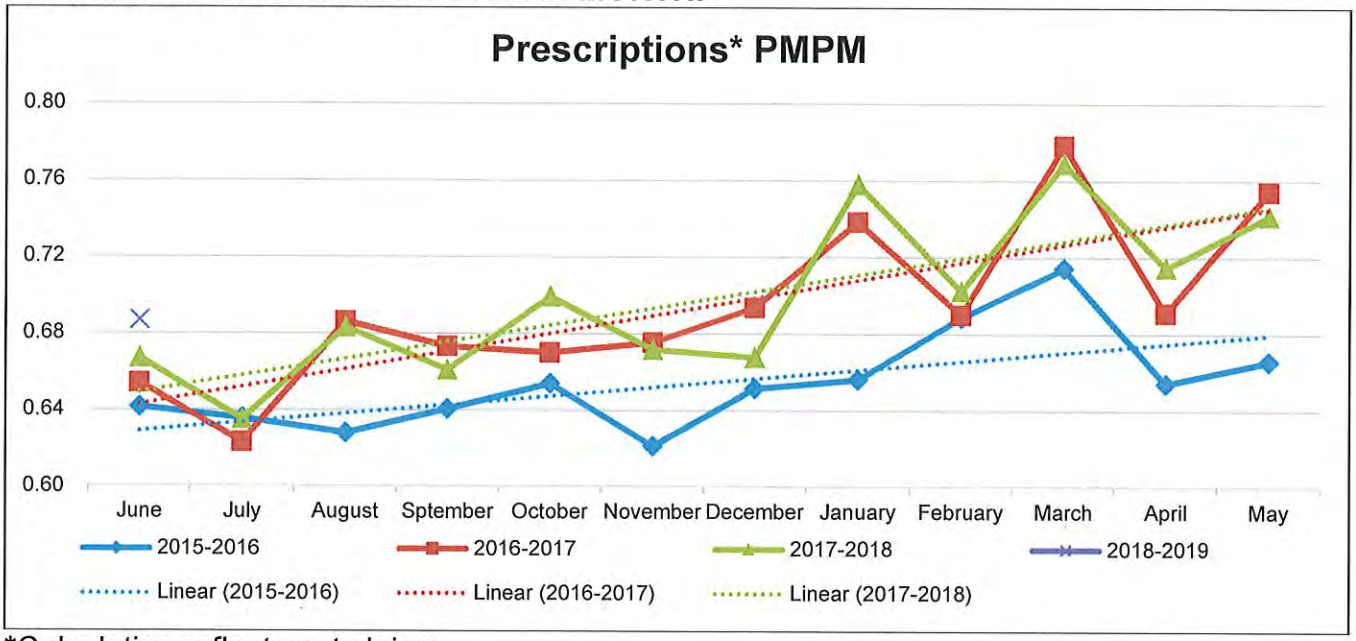




PAID PER PRESCRIPTION:

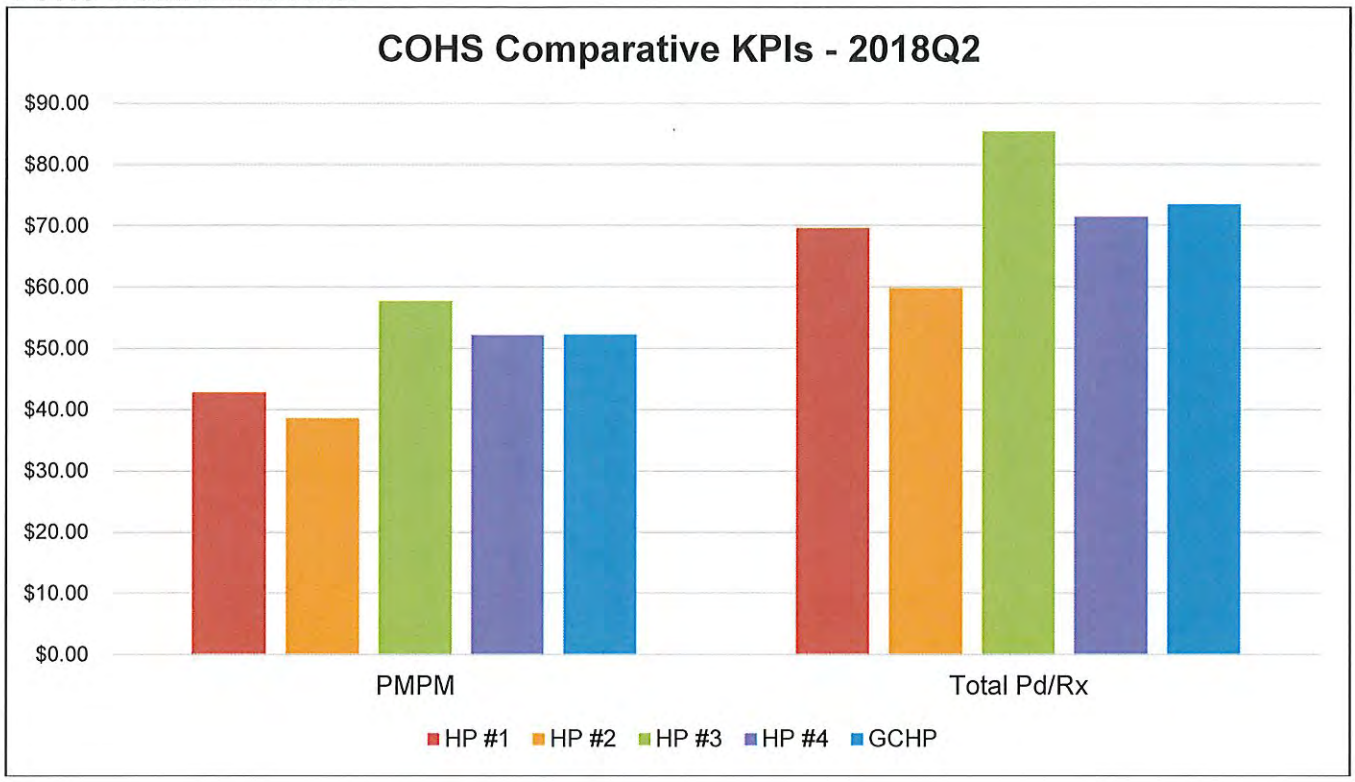


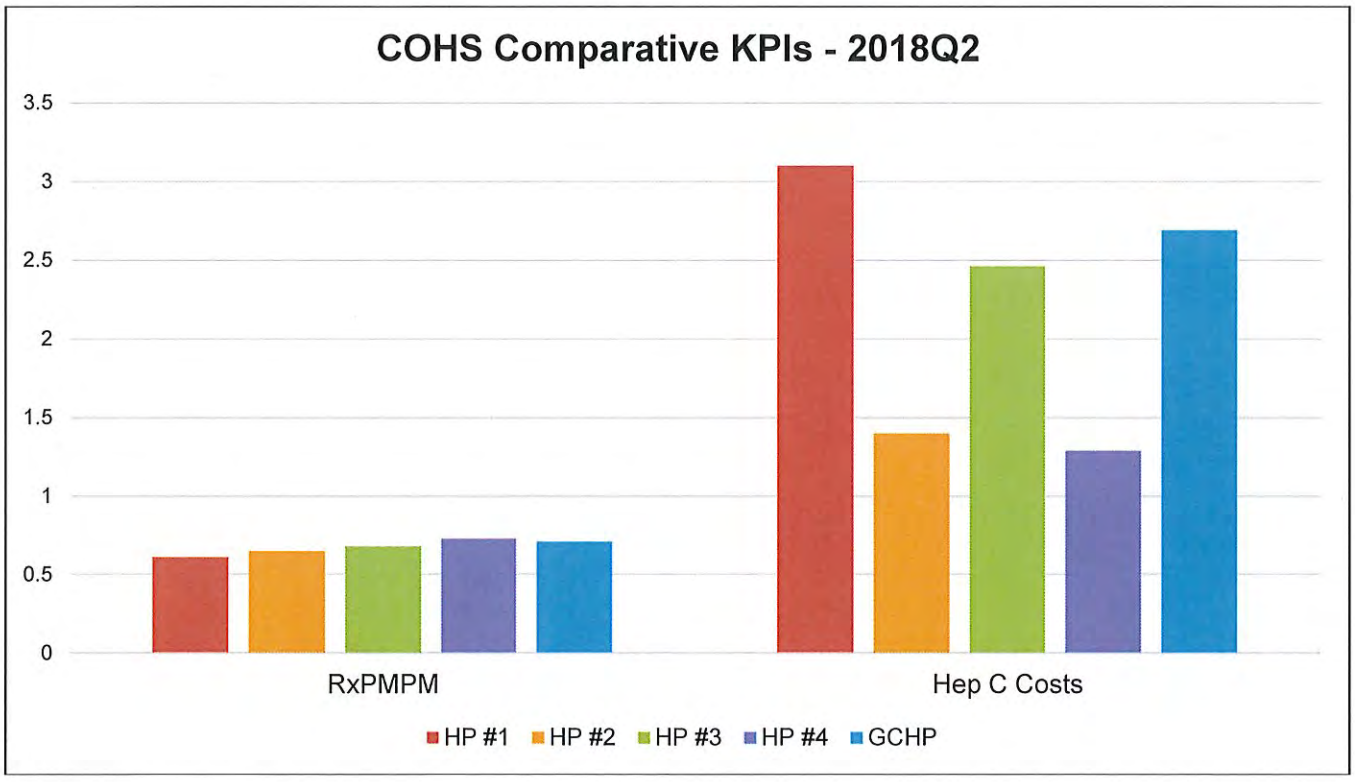
PRESCRIPTIONS PER MEMBER PER MONTH:



*Calculation reflects net claims.

COHS COMPARISONS:





PBM OVERSIGHT:

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

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

Number of Items	Items Open	Items Pending Closure	Items Closed
14	4	4	10

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

Number of Items	Items Open	Items Pending Closure	Items Closed
5	2	2	3

NETWORK MANAGEMENT:

Access:

DHCS Required Access Standards:

- 100% of all members must have access to a pharmacy within 10 miles or 30 minutes

OptumRx – GCHP Contract Requirements:

- Urban – 1 pharmacy within 3 miles for 99% of membership
- Suburban – 1 pharmacy within 5 miles for 95% of membership
- Rural – 1 pharmacy within 5 miles for 90% of membership

GCHP Current Access Assessment:

- GCHP Pharmacy Network meets the DHCS Access Standards (Certified by DHCS)
- GCHP Pharmacy Network meets the OptumRx-GCHP Contracted Access Standards
- Average Distance to Pharmacy
    - Urban: 0.5 miles
    - Suburban: 0.6 miles
    - Rural: 1.0 miles
    - Independent to Chain: Less than 5 miles
        - Less than a mile: 62%

    - 1 mile: 6%
    - 1 mile to 2 miles: 15%
    - 2 miles: 4%
    - More than 2 miles: 13%
- Pharmacy Comparison: June-Dec 2017 compared to Jan-July 2018
    - Total prescription volume increased by 5.59%
    - Independent pharmacy volume increased by 2.97%
- Ventura County Network by City (As of 8/1/2018)

City	Number of Pharmacies	Independent	Chain
Camarillo	15	Yes	Yes
Fillmore	2	No*	Yes
Moorpark	3	Yes	Yes
Newbury Park	8	Yes	Yes
Oak Park	2	Yes	Yes
Ojai	6	Yes	Yes
Oxnard	20	Yes	Yes
Port Hueneme	2	Yes	Yes
Santa Paula	3	Yes	Yes
Simi Valley	22	Yes	Yes
Thousand Oaks	25	Yes	Yes
Ventura	22	Yes	Yes
West Hills	15	Yes	Yes

*The independent pharmacy in Fillmore was sold to CVS.

Monitoring:

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

*One pharmacy listed in multiple categories.

340B DRUG DISCOUNT PROGRAM

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

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

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

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: August 27, 2018

SUBJECT: Chief Operating Officer Update

Executive Summary

ASO Transformation Project – Conduent spent two weeks on site between July 30, 2018 and August 10, 2018. During that time, the groups accomplished several key tasks including completion of the scope of work document, the initiation and planning milestones of the project plan, the shared responsibility document (the RACI), and the preparation of two presentations for the Executive Steering Committee (ESC) and the Governance Committee.

The ESC met on August 7, 2018 and reviewed the documents developed by the core team. The core team then presented the document to the Governance team on August 9, 2018. The result was approval by the Governance team and approval to proceed.

The ESC will meet bi-weekly and the Governance team, monthly, with the purpose of status updates and resolution of issues that cannot be solved at the core group level.

Membership - GCHP membership for August 2018 is 195,814 with a net gain of 59 members. In the month of August, GCHP gained 3,590 new members and lost 5,697 with 2,166 retro add members. Adult Expansion remained flat with August members at 52,417 versus January members at 52,745. This trend in membership is not expected to change while the California economy continues to perform well with statewide unemployment rates at a long-term low.

Operations Dashboard

Membership

Operations Dashboard Monthly Volumes- August 2018	Volume
Membership:	
Total	**195,814**
July Loss	**-6,216**
July Add	**3,192**
Retroactivity	**2,166**
Gain/Loss (net)	**59**
AB-85: (new)	
VCMC	**355**
Remaining Providers	**355**
VCMC Target	**65,765**
VCMC % of Target	**42.14%**

AB 85 Auto Assignment- GCHP assigned 355 new members to VCMC, while the remaining 355 new members were assigned to providers in compliance with the VCMMCC Auto Assignment policy (MS-005) for August. VCMC has 27,711 Adult Expansion (AE) members assigned as of August 1, 2018. VCMC's target enrollment, as established by DHCS, is 65,765 and is currently at 42.14% of the target.

Operations Dashboard

Encounter Data

Encounter data fluctuates month over month depending on provider submissions and services. Error rates are consistently low. Common error types submitted involve members not effective on date of service, coding errors and duplicate submissions.

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

Operations Dashboard Monthly Volumes- Aug 2018 Total Encounters Submitted: 459,068		
Encounter Type	**Errors**	**% of Errors**
Professional	3,563	2.5%
Institutional	1,098	1.7%
Pharmacy	392	0.2%
Total	**5,053**	**1.1%**

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

Claims

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

Service Level Agreements (SLA)

Operations Dashboard Monthly Claims Volumes- April - July 2018				
	Month			
	July	**June**	May	April
Total	**191833**	**208,412**	215,166	217,183
Daily Average Receipt	**8719**	**9924**	9,780	9,529
Days Receipt on Hand	**5**	**6**	4	3.79

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

Operations Dashboard Key Performance Metrics- April - July 2018					
	Benchmark		Month		
		July	June	May	April
Turn Around Time	90.00%	99.40%	98.66%	99.08%	97.70%
Financial Accuracy	98.00%	99.38%	99.16%	99.30%	99.00%
Procedural Accuracy	97.00%	99.38%	99.25%	99.91%	99.00%

Call Center

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

Conduent is measured on call center performance by three industry-standard metrics (Service Level Agreements (SLAs)). Call volume for July increased over June by 8%. Conduent met SLAs despite the increase to volume.

Operations Dashboard Call Volume- April-July 2018				
	July	June	May	April
Call Volume (# of calls)	**12,923**	**11,916**	12,183	12,455

Operations Dashboard Key Performance Metrics- April - July 2018					
	Benchmark	July	June	May	April
Avg. Speed To Answer	30 Seconds	**27.0**	**20.4**	90.6	22
Abandonment Rate	5.00%	**1.32%**	**1.02%**	4.73%	1.05%
Call Quality Scores	95.00%	**96.2%**	**97.24%**	96.7%	97.56%

Grievance and Appeals

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

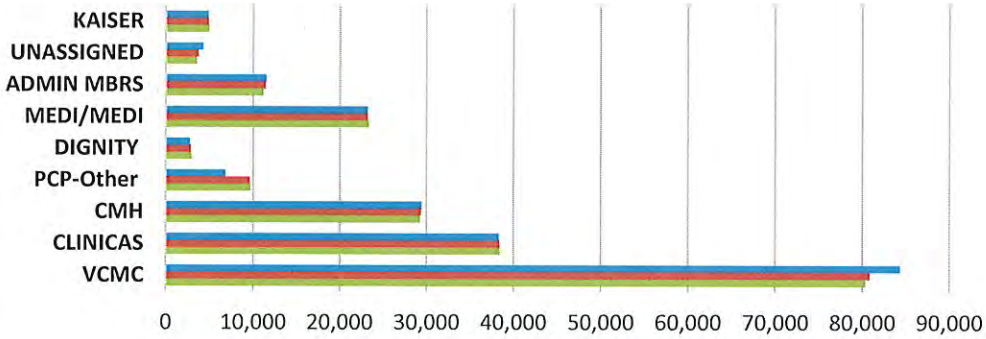
DHCS measures G&A performance against 2 metrics for each category (2 for Grievance, 2 for Appeals). The metrics are timeliness of acknowledgement and timeliness of resolution. The metrics are significantly rigid (100%) and GCHP continues to look at ways to improve the process to meet each metric at 100%.

Operations Dashboard Monthly Volumes - April - June 2018			
	June	**May**	April
G&A Volume:			
Clinical	**25**	**9**	20
Upheld	**20**	**4**	10
Overturned	**4**	**5**	9
Withdrawn	**1**	**0**	1
Provider	**117**	**147**	108
Member	**18**	**27**	34
Grievances/ 1,000	**0.09**	**0.14**	0.17
Quality of Care	**18**	**16**	20
State Fair Hearings	**1**	**0**	1
Denied	**1**		1
Dismissed			0
Withdrawn			0

Operations Dashboard Monthly Volumes by Issue Type - April - June 2018			
Grievance (Issue Type):	**June**	**May**	**Apr**
Accessibility	**2**	**3**	**3**
Benefits/Coverage	**0**	**1**	**1**
Billings	**1**	**3**	**4**
Denial/Refusals	**0**	**1**	**1**
Quality of Care	**13**	**16**	**20**
Quality of Service	**2**	**2**	**5**
Referral	**0**	**1**	**0**

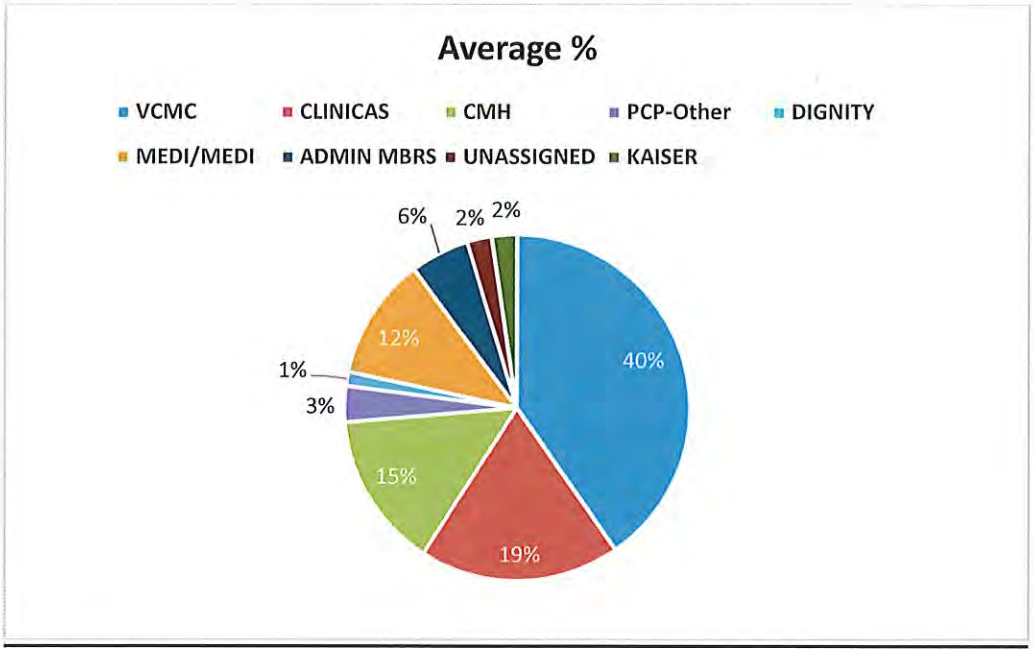
Operations Dashboard Key Performance Metrics April - June 2018				
	Benchmark	June	May	April
Grievance Acknowledgement	100.00%	**96**	**85%**	97%
Appeal Acknowledgement	100.00%	**100**	**89%**	100%
Grievance Resolution	100.00%	**99**	**98%**	95%
Appeal Resolution	100.00%	**100**	**100%**	100%

MEMBER PCP ASSIGNMENTS



	VCMC	CLINICAS	CMH	PCP-Other	DIGNITY	MEDI/MEDI	ADMIN MBRS	UNASSIGNED	KAISER
May-18	84,343	38,310	29,405	6,819	2,776	23,202	11,544	4,290	4,816
Jun-18	80,874	38,415	29,356	9,648	2,864	23,232	11,423	3,741	4,881
Jul-18	80,432	38,449	29,218	9,722	2,953	23,318	11,161	3,533	4,937

% Distribution of Membership By Provider and Member Type



PROVIDER ADDS AND TERMINATIONS JULY 2018

ADDITIONS:

- 38 specialists added via Children's Hospital Medical Group
- 12 specialists added via City of Hope Medical Foundation
- 1 PCP added via CMH Centers for Family Health (Airport Marina)
- 1 Mid-levels added via Moorpark Family Clinic
- 1 Midlevel and 5 Specialists added via Adult and Pediatric Urgent Care
- 1 Hospitalists added via Hospitalist Medicine Physicians of California
- 1 specialist added via Anacapa Surgical Associates
- 4 Radiology specialists added via 4 different imaging centers

PROVIDER TYPE	# PROVIDER ADDS July 2018	TOTAL PROVIDER ADDS July 2018-July 2018	TOTAL NETWORK PROVIDERS
Hospital	**0**	**0**	**33**
-Acute Care	0	0	19
-LTAC	0	0	9
-Tertiary	0	0	5
Providers	**64**	**64**	**6,511**
-PCP's & Midlevels	2	2	445
-Specialists	60	60	5,723
-Hospitalists	2	2	343
Ancillary	**0**	**0**	**388**
-ASC	0	0	8
-CBAS	0	0	6
-DME	0	0	108
-Home Health	0	0	33
-Hospice	0	0	21
-Laboratory	0	0	67
-Optometry	0	0	33
-OT/PT/ST	0	0	83
-Radiology/Imaging	0	0	29
Pharmacy	**0**	**0**	**838**
SNF/LTC/CLF	**0**	**0**	**8**
Behavioral Health	**4**	**4**	**368**

3. **TERMINATIONS:**

- 17 specialist providers terminated from City of Hope Medical Foundation resigned from the group. GCHP did not receive notice prior to this termination. This is not unusual for large academic affiliated medical groups as providers (residents/fellows/visiting professors) train and subsequently move on when their training is complete if not offered an attending academic position with the group.
- 21 pediatric sub-specialists terminated from Children's Hospital LA Medical Group and no prior notice received. This is not unusual for large academic affiliated medical groups as providers (residents/fellows/visiting professors) train and subsequently move on when their training is complete if not offered an attending academic position with the group. No network access impact.
- The remaining 9 other provider terminations are as follows and have no significant impact on the network itself or member access.
    - 6 VCMC providers: 3-PCP, 1- Pediatric Specialist Endocrinology), 2-Mid-level. No network access impact. There are 445 PCP's and mid-levels contracted within the County. There are 2 additional pediatric endocrinologists contracted in the County.
    - 1 Cardio-Thoracic Surgery Specialist, Out-of-County. No network access impact
    - 1 Pediatric PCP affiliated with Salida del Sol Family Health Center. Provider retired. No network access impact as there are 44 pediatric PCP's contracted within the County.
    - 1 Speech Pathology Provider- no network access impact. There are 19 additional speech pathology providers contracted in the County.

PROVIDER TYPE	# PROVIDER TERMS July 2018	TOTAL PROVIDER TERMS July 2018- July 2018	COMMENTS
Hospital	**0**	**0**	---
-Acute Care	0	0	---
-LTAC	0	0	---
-Tertiary	0	0	---
Providers	**47**	**47**	---
-PCP's & Midlevels	6	6	No major impact
-Specialists	40	40	No major impact
-Hospitalists	0	0	No major impact
Ancillary	**1**	**1**	No major impact
-ASC	0	0	No major impact
-CBAS	0	0	---
-DME	0	0	No major impact
-Home Health	0	0	---
-Hospice	0	0	No major impact
-Laboratory	0	0	---
-Optometry	0	0	---
-OT/PT/ST	1	0	No major impact
-Radiology/Imaging	0	0	No major impact
Pharmacy	**0**	**0**	No major impact. Terms result of wrong Pharmacy submissions by Optum
SNF/LTC/CLF	**0**	**0**	---
Behavioral Health	**0**	**0**	---

4. CONTRACTING INITIATIVES

A. Enhanced Access:
- Added 1 acupuncturist
- Added 1 hearing aid DME specialist
- Finalizing agreement with Pediatric General Surgeon
- Finalizing Agreement with subacute and specialty care for pediatric and adult traumatic brain injury rehabilitation, and patients with medically complex injuries and neuromuscular or congenital anomalies.
- Added 1 GI provider with Interim Letter of Agreement (provider awaiting response from DHCS for Medi-Cal licensing).
- Standardized Hospice network rates, facilitating smoother network operations processes and claims payment

B. Provider Network:
- Finalizing contract amendment and rate schedule with Dignity Health.
- In negotiations with Simi Valley hospital on contract renewal.
- Finalized Amendment to UCLA Agreement reflecting charge master adjustments.
- Finalizing direct transplant services agreement with UCLA, which will reduce transplant costs associated with transplant rental networks.
- Conducted VCMC Joint Operations Meeting.
- Conducted Apria Joint Operations Meeting.

C. Regulatory Initiatives: no activity at this time