

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

August 21, 2017 Special Meeting Minutes

CALL TO ORDER

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

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

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

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

PUBLIC COMMENT

None.

CONSENT CALENDAR (ROLL CALL VOTE REQUIRED)

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

Staff: Tracy Oehler, Clerk of the Board

RECOMMENDATION: Approve the minutes.

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

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

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

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

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

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

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

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

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial and Espinosa.

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

FORMAL ACTION ITEMS

4. May 2017 Year to Date Financials

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

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

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

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

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

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial and Espinosa.

Commissioner Lee declared the motion carried.

5. Quality Improvement Committee 2017 Second Quarter Report

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

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

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

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

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

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial and Espinosa.

Commissioner Lee declared the motion carried.

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

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

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

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

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

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

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

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

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

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

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial and Espinosa.

Commissioner Lee declared the motion carried.

REPORTS

7. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

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

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

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

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

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

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

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

8. Pharmacy Benefits Manager (PBM) Update

RECOMMENDATION: Accept and file the report.

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

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

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

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

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

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

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

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

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

Joe Hoffman expressed concern over the PBM reimbursement rates.

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

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

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

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

Robert Andonian expressed concern over the PBM reimbursement rates.

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

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

9. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

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

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

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

10. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

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

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

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

11. Chief Administrative Officer (CAO) Update

RECOMMENDATION: Accept and file the report.

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

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

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

12. Chief Diversity Officer (CDO) Update

RECOMMENDATION: Accept and file the report.

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

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

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

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Dial and Espinosa.

Commissioner Lee declared the motion carried.

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

CLOSED SESSION

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

13. LIABILITY CLAIMS

Claimant: Cathy Curtis

Agency Claimed Against: Gold Coast Health Plan

14. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION

Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One Case

15. PUBLIC EMPLOYEE PERFORMANCE EVALUATION

Title: Chief Diversity Officer

OPEN SESSION

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

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

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

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

APPROVED:



Tracy J. Oehler, Clerk of the Board