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

Regular Meeting

Monday, April 27, 2020, 2:00 p.m.

Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

Executive Order N-25-20

Conference Call Number: 1-805-324-7279

Conference ID Number: 364 931 759#

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

OATH OF OFFICE New Commissioner: Dr. Sevet Johnson, Director of Behavioral Health, County of Ventura

ROLL CALL

PUBLIC COMMENT

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

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

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

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Regular Minutes of February 24, 2020.

Staff: Maddie Gutierrez, CMC – Clerk of the Commission

RECOMMENDATION: Approve the minutes for February 24, 2020.

UPDATES

2. Strategic Planning Update

Staff: Margaret Tatar, Interim Chief Executive Officer

RECOMMENDATION: Receive and file the update.

3. Physician Advice Module for R.N. Advice Line Update

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

RECOMMENDATION: Receive and file the update.

FORMAL ACTION

4. Adopt a Resolution to Renew Resolution No. 2020-001, to Restate and Reiterate the Declaration of a Local Emergency Related to the Outbreak of Coronavirus ("COVID-19") and Extend the Duration of Authority Empowered in the CEO to issue Emergency Regulations and Take Action

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Adopt Resolution No.2020-002 to: (1) continue and reiterate the proclamation of local emergency related to the outbreak of Coronavirus ("COVID-19") to remain effective through the duration of the Governor's State of Emergency proclamation or when the Commission terminates its Local Emergency, whichever occurs last; (2) and extend the duration of authority empowered in the CEO through May 18, 2020.

5. Election of Chairperson and Vice Chairperson to serve two-year terms and appointments to the Executive/Finance Committee.

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Staff recommends the following:

1. Elect a Commissioner to serve as Chairperson for a two-year term.
2. Elect a Commissioner to serve as Vice Chairperson for a two-year term.
3. Make any necessary appointments to the Executive/Finance Committee as follows:
   a. Chairperson (same as Commission Chair).
   b. Vice Chairperson (same as Commission Vice Chair)
   c Private Hospital Healthcare Representative (if required).
   d. Ventura County Medical Health System Representative (if required).
   e. Clinicas Del Camino Real Representative (if required).

6. Approve request regarding Program for the All-Inclusive Care for the Elderly (PACE)

Staff: Margaret Tatar, Interim Chief Executive Officer

RECOMMENDATION: Approve of letter of support for Clinicas del Camino Real (CDCR) to establish a PACE organization to serve certain designated areas of Ventura County and delegate to the interim CEO the authority to execute such letter of support.

7. Quality Improvement Committee – 2020 First Quarter Report

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Kim Timmerman, Director of Quality Improvement

RECOMMENDATION: Approve the 2020 QI Program Description and 2020 QI Work Plan as presented. Receive and file the complete report as presented.

8. Amendment to Health Management Associates (HMA) Contract

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Approve the amended HMA contract as presented.

9. February and March 2020 Financial Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Receive, approve and file both the February and March 2020 financial report.

REPORTS

10. Chief Executive Officer (CEO) Report

Staff: Margaret Tatar & Patricia Tanquary, Interim Chief Executive Officers

RECOMMENDATION: Receive and file the report.

11. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report.

12. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive 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 Number of cases: Unknown

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The document referencing the threat of litigation will be made available pursuant to Gov't Code Section 54959.9(e)(5)

15. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION

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

The document referencing the threat of litigation will be made available pursuant to Gov't Code 54959.9(e)(5).

16. LIABILITY CLAIMS

Claimant: Stephanie Reifsynder

Agency Claimed Against: Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan

17. PUBLIC EMPLOYMENT

Title Executive Director, Human Resources

18. PUBLIC EMPLOYMENT

Title: Chief Executive Officer

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held at 2:00 P.M. on May 18, 2020 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 Commission.

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 Commission to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, CMC - Clerk to the Commission

DATE: April 27, 2020

SUBJECT: Meeting Minutes of February 24, 2020 Regular Commission Meeting.

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of Minutes for the February 24, 2020 Regular Commission Meeting.

Ventura County Medi-Cal Managed Care Commission
(VCMMCC)
dba Gold Coast Health Plan (GCHP)
February 24, 2020 Regular Meeting Minutes

CALL TO ORDER

Commissioner Antonio Alatorre 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 Alatorre led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson, and Supervisor John Zaragoza.

Absent: Commissioner Fred Ashworth.

Commissioner Laura Espinosa was not present at Roll Call. Commissioner Espinosa arrived at 2:11 p.m.

Commissioner Alatorre announced it was Commissioner Lanyard Dial, M.D., last commission meeting. Commissioner Alatorre commended him for his ten (10) years of service on the Commission.

Dr. Dial stated he has worked in the system caring for Medi-Cal members. GCHP has made care better for the population. He is proud to have served on the Commission although it has been a difficult role at times.

PUBLIC COMMENT

1. Dr. Sandra Aldana thanked Dr. Dial for serving on the Commission. She also wanted to remind all that the Public Charge Rule goes into effect on this day. This will affect those seeking citizenship who receive services such as Medi-Cal, and several other public services, and encourage those to continue the use of services which are provided.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of January 27, 2020.

Staff: Maddie Gutierrez, CMC, Clerk of the Commission.

RECOMMENDATION: Approve the minutes.

Commissioner Atin motioned to approve the minutes. Commissioner Swenson seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and Supervisor John Zaragoza.

NOES: None.

ABSENT: Commissioners Fred Ashworth and Laura Espinosa.

Commissioner Alatorre declared the motion carried.

PRESENTATION

2. Employee Survey Results

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the presentation.

CDO Bagley summarized the findings of the survey. The employee survey was initiated December 2019 through the first quarter of 2020. Initially participation was low, therefore the deadline was extended. Total amount of responses equaled to 75%. All information received was anonymous.

Commissioner Laura Espinosa arrived at 2:11 p.m.

Key take aways were reviewed. 43% of staff stated they would stay with the organization. It was noted the Executive Team received low scores.

CDO Bagley stated one (1) area with less than a 50% score was: holding people accountable for their actions. He noted we need to tighten communication from the top. Most employees stated teamwork within their department was good, but not in

other areas. Less than half of the staff felt their jobs were secure and moral was good. Benefits were a strong point. Immediate supervisor ratings were high.

Strengths in the Plan were as follows:

- Opportunity to do their best daily = 73%
- Employees have what they need to do their job =75%
- Work related issues = 79%
- Managers are fair = 81%
- Employees willing to work beyond what is expected = 91%
- Benefits = 84%
- Trainings = 55%

Commissioner Pupa and Supervisor Zaragoza noted this shows employees have passion for what they do.

Areas of Improvement:

- Executive Team says one thing and does another = 75%
- Confidence in the Executive Team = 32%
- Executive Tea creates an upbeat working environment = 30%
- Safe place =32%
- Accountable = 34%
- Executive Team leads by example = 23%
- Executive Team allows freedom to express an opinion = 30%
- Executive Team shows favoritism = 77%
- Executive Team gives adequate communication = 21%

CDO Bagley stated he will review the results with each Executive Team, Leadership and all staff. Once the data is completely collected, he will develop Action Teams, represented by all aspects/levels of the organization. The Action Teams will be assigned various areas to review. How will the Commission know the issues are being fixed – there will be a report card. The Leadership needs to be fixed. We need to ask employees hard questions, then be willing to act on the issue. The report card will tell us what has been worked on.

Supervisor Zaragoza stated the survey was good and issues need to be handled. He noted managers got good scores and workers go beyond expectation, which is commendable. The report card is vital.

CDO Bagley stated there needs to be more training. People need tools to do their jobs. Supervisor Zaragoza stated all departments need to be on the same page. CDO Bagley stated there needs to be cross functional communication. Teams need to work together, and it will be easier to understand one another.

Commissioner Alatorre asked if the survey was finalized. CDO Bagley responded yes. Commissioner Alatorre stated new leadership is coming, how often will the Commission hear the report cards? CDO Bagley stated report cards will be quarterly.

Commissioner Espinosa acknowledged CDO Bagley for getting a 75% response. She also acknowledged employees for being courageous by responding to the survey. This will be an enormous asset to the organization and how the community view us as an organization. CDO Bagley stated there needs to be communication with the community.

Commissioner Atin stated this was the second survey done in the organization, he would like to see a comparison between the first survey and this one.

Commissioner Atin thanked CDO Bagley, the survey validates the thoughts of the Commission. CDO Bagley stated there are good employees and he wants to see GCHP be successful, and work together to fix issues.

Commissioner Alatorre motioned to approve the presentation. Commissioner Atin seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and Supervisor John Zaragoza.

NOES: None.

ABSENT: Commissioners Fred Ashworth.

Commissioner Alatorre declared the motion carried.

FORMAL ACTION

3. Additional Funding Request – Professional Services statemen of Work Approval for Medical Management System Integration with New Core Claims System

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

RECOMMENDATION: Authorize the CEO to execute a statement of work with MHK Inc. in an amount not to exceed $200,000 plus as a future contingency, execute any additional change orders up to an additional 10% of the total amount approved (includes prior approved amount and requested amount) for this project.

CMO Wharfield stated the payment of claims needs to improve, although fairly accurate, timeliness needs to flow. Currently we are not in standard file format.

Today, our IT team must support the non-standard file format. We need to make ETP more successful. This was not anticipated in the budget.

Commissioner Espinosa asked if $73,675 the approvals to date. CMO Wharfield responded this amount was anticipated. Commissioner Alatorre asked if the current system was not fully integrated. CMO Wharfield stated it could be faster and more accurate. Commissioner Alatorre also asked if Conduent did not give state this information three (3) years ago. CMO Wharfield stated Conduent give eligibility information but not full insight.

Commissioner Dial motioned to approve the additional funding requested. Commissioner Pawar seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and Supervisor John Zaragoza.

NOES: None.

ABSENT: Commissioners Fred Ashworth.

Commissioner Alatorre declared the motion carried.

4. Additional Funding Approval – Service Order 01, Lourdes G. Campbell, Interpreting and Translating Services

Staff: Nancy Wharfield, M.D., Chief Medical Officer
Lupe Gonzalez, Ph.D., M.P.H., Director of Health Education, Cultural and Linguistic Services

RECOMMENDATION: Staff recommends the addition of $70,000 to the existing agreement (Service Order 01) with Lourdes G. Campbell Interpreting and Translating Services

Dr. Gonzalez stated she is requesting $70,000 for interpreting services. Commissioner Alatorre asked if there was additional work. Dr. Gonzalez stated utilization has increased and there are pending invoices.

CMO Wharfield stated she is within budget but wanted to notify the Commission.

Supervisor Zaragoza motioned to approve the additional funding requested. Commissioner Espinosa seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and Supervisor John Zaragoza.

NOES: None.

ABSENT: Commissioners Fred Ashworth.

Commissioner Alatorre declared the motion carried.

5. January 2020 Financial Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Receive, approve and file the January 2020 financial report.

CMO Bishop reviewed her PowerPoint presentation where she reported a $1.9 loss for the month of January. There is a monthly variance of $3 million. She explained that we are seeing more volatility relating to high dollar cases. One provider had been billing for high-cost drugs, but that has now been corrected.

Commissioner Pawar asked if this issue would be noted in pharmacy. CFO Bishop stated it was in hospital. Steve Peiser, Sr. Director of Network Management, stated the provider was identified and payment to the provider was held until after the investigation. General Counsel, Scott Campbell stated this item will be reviewed in more detail during Closed Session.

Commissioner Swenson noted internal financial long-term care expenses are also over budget. Commissioner Pupa stated she has lots of questions, it is the same message every month. She stated when the budget is less than one dollar more ($1.00) in 2018/2019, there needs to be a closer look at expenses, there is a concern where there are increases.

CFO Bishop stated we are over budget by $7.3 million. We are seeing an overall increase to utilization. CMO Bishop is working with an HMA Representatives on a weekly basis. CEO Tatar stated a drill down will be presented at the next meeting. Commissioner Pupa stated there is an increase on expense and an increase on revenue, does that cancel out? The offset by revenue needs to be shown.

Cash investments are decreasing, and we are waiting for payment at current rates. The TNE will be bumpy for the next few months. Commissioner Pawar asked when the State will come in to watch. CEO Tatar stated when we go below 200%, we will

be on a watch list. DHCS could take steps at 180%. Commissioner Atin asked if that projection was going to happen. CFO Bishop stated if there is a one (1) month swing we could fall below 200% or we could stay above it, it is difficult to project. CEO Tatar stated there are several variables regarding cost savings. She informed the Commission there will be a drill down in areas that will impact the TNE for the next month's meeting and bring back what we need to do to stay above 200%. Commissioner Pupa also requested a comparison of budget assumptions on where we are for the first half, she sees swings. She wants to see where we are versus the budget that was approved. Commissioner Atin stated it seems odd that some months we break even, some months there is a loss, he needs to know why. CEO Tatar stated the information requested will be incorporated into the next report.

Commissioner Dial reviewed the columns for 2018 and 2019, there is a dollar change. The percentages are wrong. It shows a 50% increase, not 8%, all went up, something is wrong. All the percentages are wrong.

Commissioner Pupa stated the Commission is doing their due diligence, that is why they are asking so many questions. They don't hear quantification; the data is vague on increases. The Commission needs to know what is being done to correct the issue, they need information. Commissioner Pupa stated the Commission wants to help.

Commissioner Pupa motioned to accept and file the January financials. Commissioner Cho seconded.

Commissioner Dial noted the table presented in the report needs to be fixed.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and Supervisor John Zaragoza.

NOES: None.

ABSTAIN: Commissioner Laura Espinosa.

ABSENT: Commissioners Fred Ashworth.

Commissioner Alatorre declared the motion carried.

PUBLIC COMMENT

2. Juli Ackerman appeared on behalf of herself on the OptumRx Compounding. Ms. Ackerman is a GCHP member and is advocating for her family. Her children, and her compound medications will no longer be covered. This is an additional cost of $180.00 for her. OptumRx does not always notify pharmacies of changes. She called Member

Services and they were not aware of the change; medications will no longer be covered beginning January 2020. She has waited two (2) weeks without medications. She is requesting GCHP communicate with OptumRx. OptumRx members are not happy. CMO Wharfield stated she will reach out to the member and asked for all her information be noted on the Public Comment card.

Supervisor Zaragoza asked GCHP to investigate who else might be affected. Commissioner Alatorre asked the Commission to be notified of the outcome via email.

REPORTS

6. Chief Executive Officer (CEO) Update

Staff: Margaret Tatar & Patricia Tanquary, Interim Chief Executive Officers

RECOMMENDATION: Receive and file the update.

CEO Tanquary stated the focus in January and February has been on three (3) major activities:

- Improvement with Conduent, CAPS, and better education via provider manuals
- Working with AmericasHealth Plan (AHP) and the State
- Working with other providers

AHP and GCHP are working together focusing on what is needed for the State to get approval. A notice will go to every member with the option to switch to AHP. AHP welcome letter is being modeled after current Kaiser/GCHP letter used. Rates are also being reviewed. Both AHP and GCHP want to do the process correctly and send to DHCS by March.

CEO Tanquary stated GCHP is fixing financial, compliance, employee satisfaction issues and still comply with CalAIM. There has been good progress during the transition of Whole Person Care. CEO Tanquary has worked with the County (Barry Zimmerman) on the transition, honoring relationships without duplication.

The Governor's budget has an incentive program and we will apply for additional incentive monies which will allow for expansion of recuperative care beds. We are taking advantages of all opportunities to comply for the right dollars and the right services. We will follow up with a survey and have a joint meeting by mid-April. We expect to receive the final proposal from the State.

7. Chief Medical Officer (CMO) Update

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

RECOMMENDATION: Receive and file the update.

CMO Wharfield recently reviewed Prop. 56 funding applications with a panel. Qualified applications were sent to DHCS and they will give decision by March 18, 2020. Information will be presented to the Commission at the next meeting.

CMO Wharfield noted there is a major concern on the Corona virus but noted there have been 14,000 deaths from influenza. Point Mugu has been designated as a potential quarantine area. Supervisor Zaragoza asked if we are going to participate. CMO Wharfield replied yes. There is a meeting scheduled for the base this evening (2/24/2020) at 6:30 p.m.

CMO Wharfield stated the pharmacy carve-out continues; we will need good access to data. Commissioner Pawar asked about the SNP process. CMO Wharfield stated the transfer to SNP requires prior authorization. There are efforts through CalAIM to move members and have supervision for short term stays. Commissioner Pawar stated there is no placement. Clinicas del Camino Real (CDCR)case managers are working with GCHP / patient case managers – it is difficult to work together for placement. CMO Wharfield will meet with Commissioner Pawar to discuss the process.

8. Chief Diversity Officer (CDO) Update

Staff: Ted Bagley, Chief Diversity Officer

RECOMMENDATION: Receive and file the update.

CDO Bagley stated Dr. Lupe Gonzalez provided a cultural competency training, it was an excellent training.

There are no new investigations. He will continue to give a list of walk-in activity. CDO Bagley noted he is currently working in Human Resources and as CDO. He does plan to have more Lunch and Learns and celebrate Black History month.

Positions have been posted that are within budget. He is also currently re-writing policies on: Working from Home, Alcohol and Drug Abuse. These policies are pending approval.

Supervisor Zaragoza commended Mr. Bagley for attending the Pincard reception. The community was represented well. Mr. Bagley stated he will continue to spend time in the community.

Commissioner Alatorre motioned to accept and file the updates. Supervisor Zaragoza seconded.

Commissioner Dial noted the table presented in the report needs to be fixed.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Gagan Pawar, M.D., Dee Pupa, Jennifer Swenson and Supervisor John Zaragoza.

NOES: None.

ABSENT: Commissioners Fred Ashworth.

General Counsel Scott Campbell announced the Commission would move into Closed Session. Commissioner Alatorre requested a five (5) minute break prior to the start of the session.

Break was given at 3:47 p.m.

The Commissioner reconvened for Closed Session at 3:52 p.m.

CLOSED SESSION

9. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 549.56.9 Number of cases: Unknown

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11. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
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12. PUBLIC EMPLOYEE EVALUATION
Title: Interim Chief Executive Officer

OPEN SESSION

The regular meeting reconvened at 5:39 p.m.

General Counsel, Scott Campbell stated there was no reportable action.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

Commissioner Alatorre adjourned the meeting at 5:41 p.m.

Approved:

_____
Maddie Gutierrez, CMC
Clerk to the Commission

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Margaret Tatar, Interim Chief Executive Officer

DATE: April 27, 2020

SUBJECT: Strategic Planning Update

VERBAL PRESENTATION

RECOMMENDATION:

Receive and file the Strategic Planning Update.

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: April 27, 2020

SUBJECT: Physician Advice Module for RN Advice Line Update

Based on recent clarification of Department of Health Care Services (DHCS) requirements regarding physician linkage to RN Advice Line capabilities, Gold Coast Health Plan (GCHP) will not be pursuing a contract with Carenet, our RN Advice Line vendor, for their MD Live physician consultation module.

At the April 2, 2020 Executive Finance Committee, GCHP staff obtained Committee approval to contract with Carenet to add their physician consultation module to our services. This action was taken to comply with our understanding of DHCS mandates regarding the importance of enhancing telemedicine capabilities during the COVI-19 pandemic. Since, that time, DHCS has clarified that physician consultation services linked to an RN Advice Line are not a requirement.

While GCHP staff acknowledges that a 24/7 physician consultation service still has value for improving access and enabling social distancing, this unbudgeted contract had a projected dollar amount of approximately $450,800 for a two-year engagement.

GCHP staff will continue to monitor DHCS requirements regarding pandemic preparedness while reinforcing telemedicine capabilities in our own network. GCHP Provider Operations staff have developed telehealth guidance for Federally Qualified Health Centers (FQHCs) and non-FQHCs which is available on our website at:

http://www.goldcoasthealthplan.org/providers/welcome-providers.aspx.

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: April 27, 2020

SUBJECT: Adopt a Resolution to Renew Resolution No. 2020-001, to Restate and Reiterate the Declaration of a Local Emergency Related to the Outbreak of Coronavirus ("COVID-19") and Extend the Duration of Authority Empowered in the CEO to issue Emergency Regulations and Take Action

SUMMARY:

Adopt Resolution No.2020-002 to:

1. Continue and reiterate the declaration of Local Emergency related to the outbreak of a disease caused by the novel coronavirus ("COVID-19") and provide that the Local Emergency shall remain effective through the duration of Governor's State of Emergency proclamation or when the Ventura County Medi-Cal Managed Care Commission aka Gold Coast Health Plan ("Commission") terminates its declaration of Local Emergency, whichever occurs last; and

2. Extend the duration of authority empowered in the CEO to take those actions, measures and steps necessary to assure the health, safety and welfare of the Plan's members and staff pursuant to State law and its bylaws and continue to provide services for the benefit of Plan providers and members, to continue to remain effective through May 18, 2020.

BACKGROUND/DISCUSSION:

COVID-19, which originated in Wuhan City, Hubei Provence, China in December, 2019, has resulted in an outbreak of respiratory illness causing symptoms of fever, coughing, and shortness of breath. Reported cases of COVID-19 have ranged from very mild to severe, including illness resulting in death. Since that time, confirmed COVID-19 infections have continued to increase in California, the United States, and internationally. To combat the spread of the disease Governor Newsom declared a State of Emergency on March 4, 2020. The State of Emergency adopted pursuant to the California Emergency Services Act, put into place additional resources and made directives meant to supplement local action in dealing with the crisis.

In the short period of time following the Governor's proclamation, COVID-19 has rapidly spread through California necessitating more stringent action. On March 19, 2020, Governor Newsom issued Executive Order N-33-20 (commonly known as "Safer at Home") ordering all residents to stay at home to slow the spread of COVID-19, except as needed to maintain continuity of operation of the federal critical infrastructure sectors.

The following day, the Ventura County Health Officer issued a County-wide “Stay Well at Home”, order, requiring all County residents to stay in their places of residence subject to certain exemptions set forth in the order.

Prompted by the increase of reported cases and deaths associated with COVID-19, the Commission adopted Resolution No. 2020-001 declaring a local emergency and empowering the interim CEO with the authority to issue emergency rules and regulations to protect the health of Plan's members, staff and providers. Specifically, section (2) of Resolution No. 2020-001 describes the emergency powers delegated to the CEO which include, but are not limited to: entering into agreements on behalf of the Plan, making and implementing personnel or other decisions, to take all actions necessary to obtain Federal and State emergency assistance, and implement preventive measures to preserve Plan activities and protect the health of Plan's members, staff and providers.

Normally under Government Code Section 8630, the Commission must review the need for continuing the local emergency once every sixty (60) days until the local governing body terminates the local emergency. However, under Governor Newsom’s March 4, 2020, State of Emergency proclamation, that 60 day time period in section 8630 is waived for the duration of the statewide emergency. As such, the Plan’s local emergency proclamation will remain in effect until the Commission terminates its Local Emergency pursuant to Resolution No. 2020-001. Resolution No. 2020-001 will expire on April 27, 2020 so such authority will terminate today unless extended.

The continued spread of COVID-19 continues to present an imminent and proximate threat to Commission staff workplaces and threatens the safety and health of Commission personnel. Based on the foregoing, the Plan seeks to adopt a resolution to renew and reiterate the findings and actions in Resolution No. 2020-001 to:

1. Continue the declaration of local emergency related to the outbreak of a disease caused by the novel coronavirus (“COVID-19”) to remain effective through the duration of the Governor’s State of Emergency proclamation or when the Plan terminates its declaration of local emergency pursuant to Resolution 2020-001, whichever occurs last; and

2. Extend the duration of authority empowered in the CEO to take those actions, measures and steps necessary to assure the health, safety and welfare of the Plan’s members and staff pursuant to State law and its bylaws and continue to provide services for the benefit of Plan providers and members, to continue to remain effective through May 18, 2020.

This resolution will continue to empower the CEO with the authority to issue orders and regulations necessary to prevent the further spread of the disease and protect the health and safety of Plan members and staff and provide for authority to make decisions of how to staff the Plan during this emergency period and provide for the continuation of services for the benefit of Plan providers and members.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Adopt Resolution No.2020-002 to: (1) continue and reiterate the proclamation of local emergency related to the outbreak of Coronavirus (“COVID-19”) to remain effective through the duration of the Governor’s State of Emergency proclamation or when the Commission terminates its Local Emergency, whichever occurs last; (2) and extend the duration of authority empowered in the CEO through May 18, 2020.

CONCURRENCE:

N/A.

ATTACHMENT:

1. Resolution No.2020-002

2. Staff report adopting Resolution No. 2020-001 Declaring a Local Emergency Related to the Outbreak of Coronavirus (“COVID-19”) and Empowering the CEO with the authority to issue Emergency Regulations.(March 19, 2020).

RESOLUTION NO. 2020-002

A RESOLUTION OF THE VENTURA COUNTY MEDICAL MANAGED CARE COMMISSION, DOING BUSINESS AS THE GOLD COAST HEALTH PLAN (“COMMISSION”), TO RESTATE RESOLUTION NO. 2020-001 AND REITERATE THE DECLARATION OF A LOCAL EMERGENCY AND EXTEND THE DURATION OF AUTHORITY EMPOWERED IN THE INTERIM CHIEF EXECUTIVE OFFICER OR CHIEF EXECUTIVE OFFICER ("CEO") RELATED TO THE OUTBREAK OF CORONAVIRUS ("COVID-19")

WHEREAS, COVID-19, which originated in Wuhan City, Hubei Province, China in December 2019 has resulted in pandemic of respiratory illness affecting over 100, 000 people worldwide ;and

WHEREAS, on March 4, 2020, California Governor Newsom declared a State of Emergency to make additional resources available, formalize emergency actions already underway across multiple state agencies and departments, and help the state prepare for broader spread of COVID-19; and

WHEREAS, the increase of reported cases and deaths associated with COVID-19 prompted the County of Ventura Department of Public Health to proclaim a local health emergency; and

WHEREAS, on March 19, 2020, Governor Newsom issued Executive Order N-33-20 (commonly known as “Safer at Home”), ordering all residents to stay at home or in their place of residence to slow the spread of COVID-19, except as needed to maintain continuity of operation of the federal critical infrastructure sectors; and

WHEREAS, also on March 19, 2020, the Commission adopted Resolution No. 2020-001, proclaiming a local emergency pursuant to Government Code Sections 8630 and 8634, and empowered the CEO with the authority to issue rules and regulations to preserve Plan activities, protect the health and safety of its members staff and providers and prevent the further spread of COVID-19; and

WHEREAS, the Governor’s March 4, 2020 State of Emergency proclamation waives the Commission’s requirement under Government Code Section 8630 to review the need for continuing the local emergency once every 60 days; and

WHEREAS, in furtherance of the Governor’s Safer at Home order, the Ventura County Health Officer issued a “Stay Well at Home” order on March 20,2020, ordering all County residents to stay in their places of residence subject to exemptions set forth in the order; and

WHEREAS, on March 31, 2020, the Ventura County Health Officer amended its March 20, 2020 order to impose additional limitations on the activities of persons and entities in the County to limit the spread of COVID-19 by keeping County residents in their place or residence to the maximum extent possible; and

WHEREAS, the Center for Disease Control (“CDC”) reports that confirmed cases of COVID-19 have been confirmed in all 50 states; and

WHEREAS, COVID-19 can be spread easily through person-to-person contact, and the risk of transmission is increased when people are in close proximity; and

WHEREAS, the imminent and proximate threat of introduction of COVID-19 in Commission staff workplaces continues to threaten the safety and health of Commission personnel; and

WHEREAS, under Article VIII of the Ventura County Medi-Cal Managed Care Commission aka Gold Coast Health Plan's (the “Plan's”) bylaws, the CEO is responsible for coordinating day to day activities of the Ventura County Organized Health System, including implementing and enforcing all policies and procedures and assure compliance with all applicable federal and state laws, rules and regulations; and

WHEREAS, California Welfare and Institutions Code section 14087.53(b) provides that all rights, powers, duties, privileges, and immunities of the County of Ventura are vested in the Plan's Commission; and

WHEREAS, California Government Code section 8630 permits the Plan's Commissioners, acting with the County of Ventura's powers, to declare the existence of a local emergency to protect and preserve the public welfare of Plan's members, staff and providers when they are affected or likely to be affected by a public calamity; and

WHEREAS, California Government Code Section 8634 allows the Plan, as a local government entity, to issue orders and regulations to protect life and property if a local emergency has been declared in their jurisdiction; and

WHEREAS, a declaration of local emergency will assist in a coordinated public health response to reduce the transmission and illness severity, provide assistance to health care providers, coordinate and mitigate detriment to public services that may be disrupted from this emergency, mitigate any other effects of this emergency on the Plan and its members, staff and providers, and help the Plan recover the costs it has incurred in responding to the challenges presented by COVID-19; and

WHEREAS, the Plan is a public entity pursuant to Welfare and Institutions Code section 14087.54 and as such, the Plan may empower the CEO with the authority under sections 8630 and 8634 to issue rules and regulations to prevent the spread of COVID-19 and preserve Plan activities and protect the health and safety of its members, staff and providers; and

NOW, THEREFORE, BE IT RESOLVED, by the Ventura County Medi-Cal Managed Care Commission as follows:

Section 1. Pursuant to California Government Code sections 8630 and 8634, the Commission adopted Resolution No. 2020-001 finding a local emergency exists caused by conditions or threatened conditions of COVID-19, which constitutes extreme peril to the health and safety of Plan's members, staff and providers.

Section 2. Resolution No. 2020-001 also empowered the CEO with the authority to furnish information, to promulgate orders and regulations necessary to provide for the protection of life and property pursuant to California Government Code sections 8630 and 8634, to enter into agreements, make and implement personnel or other decisions and to take all actions necessary to obtain Federal and State emergency assistance and to implement preventive measures and other actions necessary to preserve Plan activities and protect the health of Plan's members, staff and providers, including but not limited to the following:

A. Arrange alternate "telework" accommodations to allow Plan staff to work from home or remotely, as deemed necessary by the CEO, to limit the transfer of the disease.

B. Help alleviate hardship suffered by Plan staff related to emergency conditions associated with the continued spread of the disease such as acting on near-term policies relating to sick leave for Plan staff most vulnerable to a severe case of COVID-19.

C. Address and implement expectations issued by the California Department of Health Care Services ("DHCS") and the Centers for Medicare & Medicaid Services ("CMS") regarding new obligations to combat the pandemic.

D. Coordinate with Plan staff to realign job duties, priorities, and new or revised obligations issued by DHCS and CMS.

E. Take such action as reasonable and necessary under the circumstances to ensure the continued provision of services to members while prioritizing the Plan's obligations pursuant to the agreement between DHCS and the Plan ("Medi-Cal Agreement").

F. Enter in to such agreements on behalf of the Plan as necessary or desirable, with advice of legal counsel, to carry out all actions authorized by the Commission in the Resolution.

G. Authorize the CEO to implement and take such action on behalf of the Plan as the CEO may determine to be necessary or desirable, with advice of legal counsel, to carry out all actions authorized by the Commission in this Resolution.

Section 3. In Resolution 2020-001, the Commission further ordered that:

A. The Commission approves and ratifies the actions of the CEO and the Plan's staff heretofore taken which are in conformity with the intent and purposes of these resolutions.

Section 4. Resolution No. 2020-001 shall expire on April 27, 2020.

Section 5. The Commission now seeks to renew and reiterate the powers and measures approved in Resolution No. 2020-001. Specifically, this resolution shall:

1. Continue the Commission's proclamation of local emergency to remain effective through the duration of the Governor's State of Emergency Proclamation or when the Commission terminates its proclamation of local emergency, whichever occurs later; and

2. Extend the authority granted to the CEO in Section 2 above through May 18, 2020.

Section 6. Unless renewed by the Commission, the delegation of authority empowered in the CEO, pursuant to Resolution 2020-001 shall expire on May 18, 2020.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission at a regular meeting on the 27th day of April 2020, by the following vote:

AYE:

NAY:

ABSTAIN:

ABSENT:

_____
Chair:

Attest:

_____
Clerk of Board

AGENDA ITEM NO. 1

TO: **Ventura County Medi-Cal Managed Care Commission**

FROM: **Scott Campbell, General Counsel**

DATE: **March 19, 2020**

SUBJECT: **Adopt a Resolution Declaring a Local Emergency Related to the Outbreak of Coronavirus ("COVID-19") and Empower the Interim CEO with the Authority to issue Emergency Regulations and Take Action**

SUMMARY:

Adopt a resolution declaring and a Local Emergency related to the outbreak of a disease caused by the novel coronavirus ("COVID-19") and to empower the interim Chief Executive Officer ("CEO") to take those actions, measures and steps necessary to assure the health, safety and welfare of the Ventura County Medi-Cal Managed Care Commission aka Gold Coast Health Plan's ("Plan's") members and staff pursuant to State law and its bylaws and continue to provide services for the benefit of Plan providers and members. .

BACKGROUND/DISCUSSION:

COVID-19, which originated in Wuhan City, Hubei Provence, China in December, 2019, has resulted in an outbreak of respiratory illness causing symptoms of fever, coughing, and shortness of breath. Reported cases of COVID-19 have ranged from very mild to severe, including illness resulting in death. Since that time, COVID-19 has impacted more than 150 countries, and as described in Governor Newson's March 4, 2020 State of Emergency ("State of Emergency"), and has resulted in hundreds of cases in California. The State of Emergency, adopted pursuant to the California Emergency Services Act, put into place additional resources and made directives meant to supplement local action in dealing with the crisis. The State of Emergency formalized emergency actions underway across multiple State agencies and departments that helped to prepare for the broader spread of COVID-19.

Confirmed coronavirus infections have continued to increase in California, the United States, and internationally. On March 11, 2020, the World Health Organization ("WHO") declared the coronavirus a pandemic affecting over 100,000 people worldwide. The Center for Disease Control (CDC) reports that more cases of COVID-19 are likely to be confirmed in communities across the United States, with more widespread transmission.

Also on March 12, 2020, the Ventura County Health Officer declared a local health emergency in response to (1) the continued increase of confirmed coronavirus infections in the United States; (2) in alignment with the Governor's State of Emergency and mass gatherings guidance; and (3) an increase in local costs. Amid the continued spread of the disease, the cities of

Pasadena, Long Beach, and Los Angeles have also declared a local health emergency and seven counties in northern California have adopted mandatory stay at home declarations. COVID-19 can be spread easily through person-to-person contact. The risk of transmission is increased when people are in close proximity. As a result, on March 15, 2020, federal, state and local agencies enforced strict measures to prevent the further spread of the disease:

- The CDC recommended the cancellation of postponement of all in-person gatherings of fifty (50) or more people throughout the United States, and that events of any size should be only continued if they can be carried out with adherence to guidelines for protecting vulnerable populations, hand hygiene and social distancing within confined spaces requiring attendees to be separated by six (6) feet.

- Governor Newsom issued new restrictions Statewide, calling for home isolation of everyone in California over the age of 65 and with chronic diseases and also called for the closure of bars, wineries, nightclubs, and called for social distancing in restaurants.
- .

VCMMCC Should Declare a Local Emergency and Empower the Interim CEO with the Authority to Issue Rules and Regulations to Prevent the Further Spread of the Disease and Protect the Health and Safety of VCMMCC Staff

Government Code sections 8630 and 8634 permit the Plan's Commissioners or an official designated by ordinance by the Commission, to declare a local emergency. A local emergency is defined in part as "the existence of conditions of disaster or of extreme peril to the safety of persons and property within the territorial limits" of the Plan.

The action to declare a local emergency may be taken during a Commission meeting. Normally under section 8630, the Commission must review the need for continuing the local emergency at least once every 60 days until the local governing body terminated the local emergency. However, under Governor Newsom's March 4, 2020, State of Emergency proclamation, that 60-day time period in Government code section 8630 was waived for the duration of the statewide emergency. As such, any local emergency proclamation will remain in effect until each local governing authority terminates its respective local emergency. A proclamation of local emergency powers grants the Commission, or an official designated thereby to make and issue rules and regulations on matters reasonably related to the protection of life and property as affected by such emergency.

The continued spread of COVID-19 will require critical infrastructure to address the emergency conditions related to spread of COVID-19.

Under Article VIII of Plan's bylaws, the CEO is responsible for coordinating all activities of the Ventura County Organized Health System, including implementing and enforcing all policies and procedures and assure compliance with all applicable federal and state laws, rules and regulations. The Commission is a public entity pursuant to Welfare and Institutions Code section 14087.54. Government Code sections 8630 and 8634 permit political subdivisions, including

local government agencies and public agencies, or officials designated thereby, to promulgate orders and regulations necessary to provide for the protection of life and property. As such, the Commission may empower the CEO the authority under section 8634.

The Plan seeks to adopt a resolution declaring a local emergency and empowering the interim CEO with the authority to issue orders and regulations necessary to prevent the further spread of the disease and protect the health and safety of Plan members and staff and provide for authority to make decisions of how to staff the Plan during this emergency period and provide for the continuation of services for the benefit of Plan providers and members.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Adopt Resolution No 2020- 001 Declaring a Local Emergency Related to the Outbreak of Coronavirus ("COVID-19") and Empowering the CEO with the authority to issue Emergency Regulations.

CONCURRENCE:

N/A.

ATTACHMENT:

1. Adopt Resolution No. 2020 -001 Declaring a Local Emergency Related to the Outbreak of Coronavirus ("COVID-19") and Empowering the CEO with the authority to issue Emergency Regulations.

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: April 27, 2020

SUBJECT: Election of Chairperson and Vice Chairperson to serve two-year terms and appointments to the Executive/Finance Committee

SUMMARY:

Pursuant to the bylaws, last amended on January 23, 2017, the Commission must elect from its membership a Chairperson and a Vice Chairperson to serve two-year terms. The Chairperson and Vice Chairperson also both serve on the Executive/Finance Committee. Once these officers are elected, the Commission will need to make appointments to fill the balance of the Executive/Finance Committee in accordance with the bylaws which are addressed in a separate Agenda Report.

BACKGROUND/DISCUSSION:

The Commission's bylaws require that the Chairperson and Vice Chairperson be elected to a two-year term by a majority vote of its members, and that no individual serve more than two consecutive terms in either position. (*See* Bylaws, Art. III). The current Chairperson and Vice Chairperson are eligible to serve another term. The Chairperson and Vice Chairperson must be elected at the first regular meeting of the Commission after March 15th in every even-numbered year. (*See* Bylaws, Art. II). Accordingly, the Commission must now elect its officers. (*See* Bylaws, Art. III.)

The Chairperson is responsible for presiding at all meetings, executing all documents approved by the Commission, seeing that all actions of the Commission are implemented, and maintaining consultation with the Chief Executive Officer. The Vice Chairperson is responsible for performing the duties of the Chairperson in the Chairperson's absence and performing such other responsibilities as agreed upon with the Chairperson. The bylaws do not contain any specific nominating process; Staff recommends that the Commission nominate names for Chairperson (no second is needed) and then vote on each name nominated. If no majority is reached, the list of names can be reduced to the top two vote recipients until a majority is reached. The same process may then be followed for the Vice Chairperson.

The bylaws establish the five-person Executive/Finance Committee, which must consist of the Chairperson, Vice Chairperson, and three other members. The bylaws also provide that the

Executive/Finance Committee consist of at least one member from the following represented groups: a private hospital/healthcare representative, a Ventura County Medical Health System representative, and a Clinicas Del Camino Real representative. (*See* Bylaws, Art. IV, section (b)(ii).) If the Chairperson and/or Vice Chairperson is a representative from one of these agencies, then the Commission "may appoint any one of its members to fill" those open Committee positions. (*See* Bylaws, Art. IV, section (b)(ii).) Appointments to the Executive/Finance Committee must be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected, or at the next regular meeting thereafter.

The Executive/Finance Committee is an advisory committee to the Commission.

FISCAL IMPACT:

None.

RECOMMENDATION:

1. Elect a Commissioner to serve as Chairperson for a two-year term.
2. Elect a Commissioner to serve as Vice Chairperson for a two-year term.
3. Make any necessary appointments to the Executive/Finance Committee as follows:
    a. Chairperson (same as Commission Chair).
    b. Vice Chairperson (same as Commission Vice Chair)
    c Private Hospital Healthcare Representative (if required).
    d. Ventura County Medical Health System Representative (if required).
    e. Clinicas Del Camino Real Representative (if required).

CONCURRENCE:

N/A.

ATTACHMENT:

1. Gold Coast Health Plan Bylaws

AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
(dba Gold Coast Health Plan)

Approved: October 24, 2011
Amended: January 23, 2017

Table of Contents

AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM (dba Gold Coast Health Plan)

ARTICLE I

Name and Mission

The name of this Commission shall be the Ventura County Medi-Cal Managed Care Commission, hereafter referred to in these Bylaws as the VCMMCC. VCMMCC shall operate under the fictitious name, Gold Coast Health Plan.

The VCMMCC shall design and operate a program or programs, whose mission is to improve the health of its members through the provision of the best possible quality care and services. This will be accomplished by:

(a) Delivering medical care via a contracted provider network that will improve access to primary, specialty and ancillary services;

(b) Establishment of mechanisms to assure that medical care services meet appropriate quality of care standards;

(c) Incorporating a plan of service delivery and implementing reimbursement mechanisms which promote the long-term viability of a locally operated Medi-Cal managed care system and the existing participating provider networks inclusive of "Safety Net" providers herein defined as Medi-Cal disproportionate share hospitals, county clinics, federally qualified health centers, and licensed rural health clinics;

(d) Implementing a financial plan which includes the creation of a prudent reserve and which provides that if additional surplus funds accrue, they shall be used to expand access, improve benefits and augment provider reimbursement in Ventura County;

(e) Placing a high priority on prevention, education, early intervention services and case management for enrolled recipients;

(f) Ensuring that all obligations, statutory, contractual or otherwise, shall be the obligations of the VCMMCC and shall not be the obligations of the County of Ventura or the State of California; and

(g) Implementing programs and procedures to ensure a high level of member satisfaction.

ARTICLE II

Commissioners

The governing board of the VCMMCC shall consist of eleven (11) voting members ("members" or "Commissioners") who shall be legal residents of Ventura County. Members shall possess the requisite skills and knowledge necessary to design and operate a publicly managed health care delivery system.

Members of the VCMMCC shall be appointed by a majority vote of the Board of Supervisors and shall consist of the following:

(a) Physician Representatives. Three members shall be practicing physicians who serve a significant number of Medi-Cal beneficiaries in Ventura County. One shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Association, one shall be selected from a list with a minimum of three (3) nominees submitted by Clinicas Del Camino Real and one shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center Executive Committee.

(b) Private Hospital/Healthcare System Representatives. Two members shall be representatives of private hospitals and healthcare systems operating within Ventura County and shall be selected from a list with a minimum of three (3) nominees submitted by the Hospital Association of Southern California. Nominees shall be from different hospitals and healthcare systems. The two appointed members shall not be affiliated with the same hospital or healthcare system.

(c) Ventura County Medical Center Health System Representative. One member shall be a representative of the Ventura County Medical Center Health System and shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center administration.

(d) Public Representative. One member shall be a member of the Board of Supervisors, nominated and selected by the Board of Supervisors.

(e) Clinicas Del Camino Real Representative. One member shall be the chief executive officer of Clinicas del Camino Real or designee nominated by the Clinicas del Camino Real chief executive officer and approved by the Ventura County Board of Supervisors.

(f) County Official. One member shall be the Ventura County Health Care Agency Director or designee nominated by the Health Care Agency Director and approved by the Board of Supervisors.

(g) Consumer Representative. One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is

not otherwise represented on the Ventura County Medi-Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position.

(h) Ventura County Medical Center Health System Representative. One member shall be the Ventura County Medical Center Family Medicine Residency Program Director or Faculty Designee and approved by the Board of Supervisors.

Selection and Terms of Commissioners

In order to stagger terms with the intent of maintaining experienced members, in the initial cycle of appointments, the following appointees shall serve two-year terms: one of the Ventura County Medical Center Health System Representatives, the Physician Representative nominated by the Ventura County Medical Association, the Public Representative, and one Private Hospital/Healthcare System Representative. All other initial appointments and all subsequent appointments to the VCMMCC shall be for four-year terms. No member may serve more than two consecutive four-year terms. Any vacancy will be filled by the Board of Supervisors for the remainder of the unexpired term and shall maintain the balance of representation on the VCMMCC. The term of each subsequent appointment shall be deemed to commence on March 15 of the year of the appointment.

A member may resign effective on giving written notice to the Clerk of the VCMMCC, unless the notice specifies a later date for his/her resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chairperson and the Board of Supervisors. The Clerk of the VCMMC shall enter the notice in the proceedings of the Commission. The acceptance of a resignation shall not be necessary to make it effective.

A member may be removed from the VCMMCC by a 4/5 vote of the Board of Supervisors.

Nominations to the VCMMCC shall be submitted to the Ventura County Executive Office, which shall be responsible for screening nominees and presenting candidates to the Board of Supervisors.

ARTICLE III

Officers

(a) Officers of the VCMMCC shall be a Chairperson and Vice-Chairperson.

(b) The Chairperson and the Vice-Chairperson shall be elected by majority vote of the members in attendance at the first meeting of the VCMMCC to serve for the remainder of the calendar year in which the first meeting occurs. Officers subsequently elected to these offices, pursuant to the procedures outlined under “Election” below, shall serve a term of two years or until their successor(s) has/have been duly elected.

(c) No individual shall serve more than two consecutive terms in any of the elected officer positions.

Election

(a) The VCMMCC shall elect officers by majority vote of the members present.

(b) The election of officers shall be held at the first regular meeting of the VCMMCC after March 15 (or after the date upon which the Board of Supervisors appoints Commissioners for the present term if later than March 15) in every even-numbered year. The two-year terms of office shall be deemed to commence on March 15 of the year of the election, regardless of when the election actually occurs. The officers of the prior term shall continue to preside over any meetings and perform all other functions of their offices until new officers are elected.

(c) Notwithstanding the normal election process detailed in paragraphs (a) and (b) above, when circumstances warrant it, an election may be held at any time during the year. Circumstances that would warrant a special election include: one or more of the officers wishes to resign as an officer, or one or more of the officers is terminated.

Duties

(a) The Chairperson shall:

1. Preside at all meetings;

2. Execute all documents approved by the VCMMCC;

3. Be responsible to see that all actions of the VCMMCC are implemented; and

4. Maintain consultation with the Chief Executive Officer (CEO).

(b) The Vice-Chairperson shall:

1. Exercise all the responsibilities of the Chairperson in the absence of the Chairperson; and

2. In agreement with the Chairperson, perform all responsibilities mutually agreed upon.

ARTICLE IV

Standing Committees

(a) At a minimum, the VCMMCC shall establish two (2) committees/advisory boards, one member/consumer based and one provider based. VCMMCC staff will be responsible to gather a list of potential appointments and make recommendations to the VCMMCC for membership on these boards. Each of the boards shall submit a charter to the VCMMCC for approval. All meetings of standing committees shall be subject to the provisions of the Brown Act.

(b) Executive/Finance Committee.

i. Purpose. The role of the Executive/Finance Committee shall be to assist the CEO and VCMMCC accomplish its work in the most efficient and timely way. Meetings of this committee shall be at the request of the Chairperson or CEO to evaluate time sensitive matters. The Committee shall report on all of its activities to the governing board at the next regular meeting of the governing board.

ii. Membership. The Executive/Finance Committee shall be comprised of the following five (5) Commissioners:

1. Chairperson.

2. Vice-Chairperson.

3. Private hospital/healthcare system representative (to rotate between the two representatives following the representative's resignation from the committee). If the Chairperson and/or Vice-Chairperson is a private hospital/healthcare system representative, then the Commission may appoint any one of its members to fill this position.

4. Ventura County Medical Center Health System representative. If the Chairperson and/or Vice-Chairperson is a Ventura County Medical Center Health System representative, then the Commission may appoint any one of its members to fill this position.

5. Clinicas Del Camino Real representative. If the Chairperson and/or Vice-Chairperson is a Clinicas Del Camino Real representative, then the Commission may appoint any one of its members to fill this position.

The CEO and Finance Director will serve as Ex-Officio members to Co-Chair the committee.

Appointments to the Committee shall be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected or at the next regular meeting immediately thereafter. Appointments may also be made at any regular meeting where the appointment is necessitated by a resignation, termination, vacancy, special election of officers, or other event which results in the Committee lacking full membership.

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.

2. Assist the CEO in the planning or presentation of items for governing board consideration.

3. Assist the CEO or VCMMCC staff in the initial review of draft policy statements requiring governing board approval.

4. Assist the CEO in the ongoing monitoring of economic performance by focusing on budgets for pre-operational and operational periods.

5. Review proposed State contracts and rates, once actuary has reviewed and made recommendations.

6. Review proposed contracts for services over the assigned dollar value/limit of the CEO.

7. Establish basic tenets for payment-provider class and levels as related to Medi-Cal rates:

- PCP
- Specialists
- Hospitals o LTC
- Ancillary Providers

8. Recommend auto-assignment policies for beneficiaries who do not select a Primary Care Provider.

9. Review and recommend provider incentive program structure.

10. Review investment strategy and make recommendations.

11. On an annual basis, develop the CEO review process and criteria.

12. Serve as Interview Committee for CEO/CMO/CFO.

13. Assist the governing board and/or the CEO in determining the appropriate committee, if any, to best deal with questions or issues that may arise from time-to-time.
14. Develop long-term and short-term business plans for review and approval by the governing board.

15. Undertake such other activities as may be delegated from time-to-time by the governing board.

iv. Limitations on Authority. The Executive/Finance Committee shall not have the power or authority in reference to any of the following matters:

1. Adopting, amending or repealing any bylaw.

2. Making final determinations of policy.

3. Approving changes to the budget or making major structural or contractual decisions (such as adding or eliminating programs).

4. Filling vacancies or removing any Commissioner.

5. Changing the membership of, or filling vacancies in, the Executive/Finance Committee.

6. Hiring or firing of senior executives, but may make recommendations to the governing board as to their appointment, dismissal or ongoing performance.

7. Taking any action on behalf of the governing board unless expressly authorized by the governing board.

ARTICLE V

Special Committees

Members may be asked to participate on a subcommittee, task force or special project as part of their responsibilities. The VCMMCC may establish a committee(s) or advisory board(s) for any purpose that will be beneficial in accomplishing the work of the VCMMCC.

ARTICLE VI

Meetings

(a) All meetings shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code relating to meetings of local agencies ("Brown Act").

(b) A regular meeting shall be held monthly. The VCMMCC shall by resolution establish the date, time and location for the monthly meeting. A regular meeting may, for cause, be rescheduled by the Chairperson with 72 hour advance notice.

(c) Closed session items shall be noticed in compliance with Government Code section 54954.5.

(d) Special meetings may be called, consistent with the Brown Act, by the Chairperson or by a quorum of the VCMMCC. Notice of such special meeting shall conform to the Brown Act.

(e) Any meeting at which at least a quorum cannot attend, or for which there is no agenda item requiring action may be cancelled by the Chairperson with 72 hour advance notice.

(f) A quorum shall be defined as one person more than half of the appointed members of the VCMMCC. For these purposes, "appointed members" excludes unfilled positions and those vacated by resignation or removal. Unless otherwise expressly stated in these bylaws, a majority vote of members present and constituting a quorum shall be required for any VCMMCC action.

(g) After three (3) absences of any member during a fiscal year, the reasons for the absences will be reviewed by the VCMMCC and it may notify the Board of Supervisors of the absences, if it deems this action appropriate. Three or more absences from regular meetings may be cause for the VCMMCC to recommend dismissal of that member to the Board of Supervisors.

Conduct of Meetings

(a) The Chairperson shall adhere to the order of items as posted on the agenda. Modifications to the order of the agenda may be made to the extent that (on the advice of counsel) the rearrangement of the agenda items does not violate the spirit or intent of the Brown Act.

(b) All motions or amendments to motions require a second in order to be considered for action. Upon a motion and a second the item shall be open for discussion before the call for the vote.

(c) Voice votes will be made on all items as read. An abstention will not be recognized except for a legal conflict of interest. In furtherance of the foregoing, an abstention or refusal to vote (not arising from a legal conflict of interest) shall be deemed a vote with the majority of those Commissioners who do vote, except when there is a tie vote and the motion or action fails. For example, if there are 7 Commissioners present at a meeting (none of whom are subject to a legal conflict of interest), (i) a motion passes with 3 votes in favor and 4 Commissioners abstaining, (ii) a motion passes with 3 votes in favor, 2 votes against and 2 Commissioners abstaining; and (iii) a motion fails with 3 votes in favor, 3 votes against and 1 Commissioner abstaining.

(d) A call for a point of order shall have precedence over all other motions on the floor.

(e) Without objection, the Chairperson may continue or withdraw any item. In the event of an objection, a motion to continue or reset an item must be passed by a majority of the members present. A motion to continue or reset an item shall take precedence over all other motions except for a point of order.

(f) An amendment to a motion must be germane to the subject of the motion, but it may not intend an action contrary to the motion. There may be an amendment to the motion and an amendment to an amendment, but no further amendments. In the event the maker of the original motion accepts the amendment(s), the original motion shall be deemed modified. In the event the maker of the original motion does not accept the amendment(s), the amendment(s) shall be voted separately and in reverse order of proposal.

(g) Where these Bylaws do not afford an adequate procedure in the conduct of a meeting, the Chairperson may defer to the most current edition of *Rosenberg's Rules of Order*, to resolve parliamentary questions.

(h) The Chairperson shall be permitted to make motions and vote on all matters to the same extent and subject to the same limitations as other Commissioners.

ARTICLE VII

Powers and Duties

The VCMMCC is responsible for all of the activities described in Article I of these Bylaws and in its enabling ordinance. In furtherance of such responsibility, the VCMMCC shall have the following powers and duties and shall:

(a) Advise the Chief Executive Officer (CEO) and request from the CEO information it deems necessary;

(b) Conduct meetings and keep the minutes of the VCMMCC;

(c) Provide for financial oversight through various actions and methodologies such as the preparation and submission of an annual statement of financial affairs and an estimate of the amount of funding required for expenditures, approval of an annual

budget, receipt of monthly financial briefings and other appropriate action in support of its financial oversight role;

(d) Evaluate business performance and opportunity, and review and recommend strategic plans and business strategies;

(e) Establish, support and oversee the quality, service utilization, risk management and fraud and abuse programs;

(f) Encourage VCMMCC members to actively participate in VCMMCC committees as well as subcommittees;

(g) Comply with and implement all applicable federal, state and local laws, rules and regulations as they become effective;

(h) Provide for the resolution of or resolve conflict among its leaders and those under its leadership;

(i) Respect confidentiality, privacy and avoid any real or potential conflict of interest; and

(j) Receive and take appropriate action, if warranted, based upon reports presented by the CEO (or designated individual). Such reports shall be prepared and submitted to the VCMMCC at least annually.

ARTICLE VIII

STAFF

The VCMMCC shall employ personnel and contract for services as necessary to perform its functions. The permanent staff employed by the VCMMCC shall include, but not be limited to, a Chief Executive Officer (CEO), Clerk and Assistant Clerk.

Chief Executive Officer

The CEO shall have the responsibility for day to day operations, consistent with the authority conferred by the VCMMCC. The CEO is responsible for coordinating all activities of the County Organized Health System.

The CEO shall:

(a) Direct the planning, organization, and operation of all services and facilities;

(b) Direct studies of organizations, operations, functions and activities relating to economy, efficiency and improvement of services;

(c) Direct activities which fulfill all duties mandated by federal or state law, regulatory or accreditation authority, or VCMMCC board resolution, and shall bring any conflict between these laws, regulations, resolutions or policy to the attention of the VCMMCC;

(c) Appoint and supervise an executive management staff, and such other individuals as are necessary for operations. The CEO may delegate certain duties and responsibilities to these and other individuals where such delegated duties are in furtherance of the goals and objectives of the VCMMCC;

(d) Retain and appoint necessary personnel, consistent with all policies and procedures, in furtherance of the VCMMCC's powers and duties; and

(f) Implement and enforce all policies and procedures, and assure compliance with all applicable federal and state laws, rules and regulations.

Clerk

The Clerk shall:

(a) Perform the usual duties pertaining to secretaries;

(b) Cause to be kept, a full and true record of all VCMMCC meetings and of such special meetings as may be scheduled;

(c) Cause to be issued notices of regular and special meetings;

(d) Maintain a record of attendance of members and promptly report to the VCMMCC any member whose position has been vacated; and

(e) Attest to the Chair or Vice-Chair's signature on documents approved by the VCMMCC.

Assistant Clerk

The Assistant Clerk shall perform the duties of the Clerk in the Clerk's absence.

ARTICLE IX

Rules of Order

The Chairperson shall be responsible for maintaining decorum during VCMMCC meetings. All motions, comments, and questions shall be made through the Chairperson. Any decision by the Chairperson shall be considered final unless an appeal of the decision is requested and passed by a majority of the VCMMCC members present.

ARTICLE X

Amendments

(a) These Bylaws may be amended by an affirmative vote of a majority of the voting members of the VCMMCC. A full statement of a proposed amendment shall be submitted to the VCMMCC at least two weeks prior to the meeting at which the proposed amendment is scheduled to be voted upon.

(b) The Bylaws shall be reviewed annually and amendments to the Bylaws may be proposed by any VCMMCC member.

(c) Bylaws may be suspended on an ad hoc basis upon the affirmative vote of a majority of the VCMMCC members present.

ARTICLE XI

Nondiscrimination Clause

The VCMMCC or any person subject to its authority shall not discriminate against or in favor of any person because of race, gender, religion, color, national origin, age, sexual orientation or disability with regard to job application procedures, hiring, advancement, discharge, compensation, training or other terms or condition of employment of any person employed by or doing business with the VCMMCC or any person subject to its direction pursuant to federal, state or local law.

ARTICLE XII

Conflict of Interest and Ethics

VCMMCC members are subject to conflict of interest laws, including Government Code section 1090 and the 1974 Political Reform Act (Government Code section 8100 et seq.), as modified by Welfare and Institutions Code section 14087.57, and must identify and disclose any conflicts and refrain from participating in any manner in such matters in accordance with the applicable statutes**.** Members of the VCMMCC agree to adhere to all relevant standards established by state or federal law regarding ethical behavior.

ARTICLE XIII

Dissolution

Pursuant to California Welfare & Institutions Code, section 14087.54:

(a) In the event the Commissioners determine that VCMMCC may no longer function for the purposes for which it was established, at the time that VCMMCC's then existing

obligations have been satisfied or VCMMCC's assets have been exhausted, the Board of Supervisors may by ordinance terminate the VCMMCC.

(b) Prior to the termination of the VCMMCC, the Board of Supervisors shall notify the State Department of Health Care Services ("DHCS") of its intent to terminate VCMMCC. The DHCS shall conduct an audit of VCMMCC's records within 30 days of the notification to determine the liabilities and assets of VCMMCC. The DHCS shall report its findings to the Board of Supervisors within 10 days of completion of the audit. The Board of Supervisors shall prepare a plan to liquidate or otherwise dispose of the assets of VCMMCC and to pay the liabilities of VCMMCC to the extent of VCMMCC's assets, and present the plan to the DHCS within 30 days upon receipt of these findings.

(c) Upon termination of the VCMMCC by the Board of Supervisors, the County of Ventura shall manage any remaining assets of VCMMCC until superseded by a DHCS-approved plan. Any liabilities of VCMMCC shall not become obligations of the County of Ventura upon either the termination of the VCMMCC or the liquidation or disposition of VCMMCC's remaining assets.

(d) Any assets of VCMMCC shall be disposed of pursuant to provisions contained in the contract entered into between the state and VCMMCC.

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Margaret Tatar, Interim CEO

DATE: April 27, 2020

SUBJECT: Approve Request Regarding Program for the All-Inclusive Care for the Elderly (PACE)

SUMMARY:

Approve of letter of support for Clinicas to establish a PACE organization to serve certain designated areas of Ventura County and delegate to the interim CEO the authority to execute such letter of support.

BACKGROUND/DISCUSSION:

The Program of All-Inclusive Care for the Elderly (PACE) model of care provides a comprehensive medical/social service delivery system using an interdisciplinary team approach in a PACE Center that provides and coordinates all needed preventive, primary, acute and long-term care services. The PACE organization provides services to older adults who would otherwise reside in a nursing facility. The PACE model affords eligible individuals to remain independent and in their homes for as long as possible. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department of Health Care Services (DHCS), and be able to live safely in their home or community at the time of enrollment.

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016), including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part:

1. Removed the cap on the number of POs that could operate in the state, and
2. Allowed for-profit entities to become POs.

As a result of the PACE Modernization Act, DHCS has seen renewed interest in PACE and an increase in new/expansion applications to operate PACE. Accordingly, DHCS issued revised guidance to clarify its expectations regarding the PACE application process. See https://www.dhcs.ca.gov/services/ltc/Documents/PACE-Policy%20Letter-19-01.pdf. In this revised

guidance, DHCS addressed processes for review and consideration of prospective PACE organizations in County Organized Health System (COHS) Counties.

Counties that provide Medi-Cal services through a COHS, such as GCHP, are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5, et seq., provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a third-party PACE organization in a COHS county if the applicant includes a COHS's letter of support that includes the following:

1. The COHS's support for the establishment of the independent PO in the county, and;
2. The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the letter of intent submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PACE organization in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. If such independent operation of a third-party PACE organization is approved, the third-party PACE organization must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement.

GCHP has received a request for such a letter of support from Clinicas relating to its intention to establish a PACE organization that would serve certain areas of Ventura County. GCHP hereby seeks to secure Commission approval for this letter of support as the Commission, not staff, has the authority to approve such a letter.

FISCAL IMPACT:

None

RECOMMENDATION:

Approve of letter of support for Clinicas to establish a PACE organization to serve certain designated areas of Ventura County and delegate to the interim CEO the authority to execute such letter of support.

ATTACHMENT:

None

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, M.D., Chief Medical Officer
Kim Timmerman, Director of Quality Improvement

DATE: April 27, 2020

SUBJECT: Quality Improvement Committee – 2020 First Quarter Report

SUMMARY:

The Department of Health Care Services (DHCS) requires Gold Coast Health Plan (GCHP) to implement an effective quality improvement system and to ensure that the governing body routinely receives written progress reports from the Quality Improvement Committee (QIC).

The attached PPT report contains a summary of activities of the QIC and its subcommittees.

APPROVAL ITEMS:

- 2020 QI Program Description
- 2020 QI Work Plan

RECOMMENDATION:

Approve the 2020 QI Program Description and 2020 QI Work Plan as presented. Receive and file the complete report as presented.

GOLD COAST HEALTH PLAN
~~2019~~ 2020 QUALITY IMPROVEMENT PROGRAM

I. BACKGROUND

Gold Coast Health Plan is an independent public entity created by County Ordinance and authorized through Federal Legislation. The Ventura County Board of Supervisors approved implementation of a County Organized Health System (COHS) model, transitioning from fee-for-service Medi-Cal to managed care, on June 2, 2009. A year later, the board established the Ventura County Medi-Cal Managed Care Commission as an independent oversight entity, to govern and operate a single plan — Gold Coast Health Plan — to serve Ventura County's Medi-Cal population. The commission is comprised of locally elected officials, providers, hospitals, clinics, the county healthcare agency and consumer advocates.

II. MISSION, VISION, VALUES

Mission

The Quality Improvement (QI) Program is designed to support Gold Coast Health Plan's mission to improve the health of our members through the provision of high quality care and services. Our member-first focus centers on the delivery of exceptional service to our beneficiaries by enhancing the quality of health care, providing greater access, and improving member choice.

In line with that goal, Gold Coast Health Plan's Quality Improvement Program will strive to continuously improve the care and quality of service for its members in partnership with its contracted provider network, as exhibited by its dedication to the concept of measurement and re-measurement, documenting strong actions taken, and outcomes. Core values of the program include maintaining respect and diversity for members, providers and employees.

Vision

Compassionate care, accessible to all, for a healthy community.

Values

The QI Program supports the organization's values of:

- Integrity: Achieving the highest quality of standards of professional and ethical behavior, with transparency in all business and community interactions
- Accountability: Taking responsibility for our actions and being good stewards of our resources
- Collaboration: Working together to empower our GCHP community to achieve our shared goals
- Trust: Building relationships through honest communication and by following through on our commitments
- Respect: Embracing diversity and treating people with compassion and dignity

III. PURPOSE AND SCOPE

The purpose of the Gold Coast Health Plan (GCHP) Quality Improvement (QI) Program is to achieve high quality and optimal clinical outcomes in all departmental programs reflecting the State's mission to preserve and improve the health of all Californians. The QI Program provides the framework for Gold Coast to:

- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable health care and services.
- Identify and implement ongoing and innovative strategies to improve the quality, appropriateness and accessibility of member healthcare
- Implement an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services

- Facilitate organization wide integration of quality management principles
- Engagement in local community, statewide and national collaborations and initiatives aimed at improving quality of care and services.

To accomplish this, GCHP's QI Program aligns its efforts with the current version of the Department of Health Care Services (DHCS) Strategy for Quality Improvement in Health Care.

The Quality Strategy is ~~This foundation for a quality strategy is~~ anchored ~~in~~ by three linked goals ~~of the "Triple Aim"~~:

- Improve the health of all Californians
- Enhance quality, including the patient care experience, in all DHCS programs ~~of health care services, including the patient experience~~
- Reduce the Department's ~~DHCS~~ per-capita health program costs

The QI Program consists of the following elements:

A. QI Program Description
B. Annual QI Program Evaluation
C. Annual QI Work Plan
D. Quality Improvement Activities
E. QI Committee Structure
F. Policies and Procedures

The ~~scope of the~~ Quality Improvement Program will ensure that all medically necessary covered services are available and accessible to all members regardless of ~~the non-discriminatory quality and availability of all medically necessary, covered clinical care and services for Plan members including those with limited English proficiency, diverse cultural and ethnic backgrounds and disabilities, and regardless of~~ race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, ~~gender, health status,~~ sexual orientation, ~~or~~ gender identity, health status, physical or mental disability, or identification with any other persons or groups identified in Penal Code 422.56, and in a linguistically appropriate manner. ~~All covered services are required to be provided in a culturally and linguistically appropriate manner.~~ The monitoring, evaluation and prioritization of issues reflects the population served. Provisions will be made for cultural and linguistic appropriateness based on the annual Group Population Needs Assessment (~~GP~~NA).

The scope of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:

- Preventive services for children and adults
- Primary Care
- Specialty care, including behavioral health services
- Emergency services
- Inpatient services
- Ancillary services
- Chronic disease management
- Population Health/Care Management
- Prenatal/perinatal care
- Family planning services
- ~~Behavioral health care services~~
- Medication management
- Coordination and Continuity of Care

2. Quality of nonclinical services including, but not limited to:

- Accessibility
- Availability
- Member and provider satisfaction
- Grievance and appeal process
- Cultural and Linguistic Services
- Network Adequacy

3. Patient safety initiatives including, but not limited to:

- Facility site reviews/Medical record review/Physical Accessibility Review Surveys
- Credentialing of practitioners/organizational providers
- Peer review
- Sentinel event monitoring
- PQI/PPC monitoring
- Health Education
- Utilization and risk management

4. A QI focus which represents

- All care settings
- All types of services
- All demographic groups

IV. AUTHORITY AND RESPONSIBILITY

The Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) will promote, support, and have ultimate accountability, authority, and responsibility for a comprehensive and integrated Quality Improvement Program. The VCMMCC is ultimately accountable for the quality of care and services provided to members, but has delegated supervision, coordination, and operation of the program to the GCHP Chief Executive Officer and Quality Improvement Department under the supervision of the Chief Medical Officer and its Quality Improvement Committee (QIC). The Chief Medical Officer is responsible for the day-to-day oversight of the QI Program. The CMO, through the Quality Improvement Committee, will guide and oversee all activities in place to continuously monitor plan quality initiatives.

The VCMMCC's role will be to approve the overall QI Program and QI Work Plan annually, and will receive regular updates to the QI Work plan for review and comment. The VCMMCC will receive operational information through regular reports from the CMO in conjunction with the operations of its various committees as described below.

To address the scope of the Plan's QI Program goals and objectives, the structure consists of the Quality Improvement Committee (QIC) supported by seven subcommittees that meet at least quarterly:

1. Medical Advisory Committee (MAC)
2. Pharmacy & Therapeutics Committee (P&T)
3. Utilization Management Committee (UMC)
4. Health Education & Cultural Linguistics Committee (HE/CL)
5. Credentials/Peer Review Committee (C/PRC)
6. Member Services Committee (MSC)

7. Grievance & Appeals Committee (G&A)

To further support the community involvement and achieve the Plan's QI goals and objectives, the VCMMCC organized two committees reporting directly to them:

1. Provider Advisory Committee
2. Community Advisory Committee

A chart depicting the complete VCMMCC organizational structure is provided on the following pages.

Ventura County Medi-Cal Managed Care Commission (VCMMCC) Membership

GCHP is governed by the eleven (11) member VCMMCC. Commission members are appointed for two or four year terms, and member terms are staggered. The VCMMCC is comprised of locally-elected officials, providers, hospitals, clinics, the county healthcare agency and consumer advocates.

Members of the VCMMCC are appointed by a majority vote of the Board of Supervisors.

V. QI PROGRAM GOALS AND OBJECTIVES

The overall goal of the Quality Improvement Program is to improve the quality and safety of clinical care and services provided to members through GCHP's network of providers and its programs and services. Specific goals are established to support the purpose of the QI Program. All goals are reviewed annually and revised as needed. The QI Program goals are primarily identified through:

- Ongoing activities to monitor care and service delivery
- Issues identified by tracking and trending data over time
- Issues/outcomes identified in the previous year's QI Program Evaluation
- Accreditation standards, regulatory and contractual requirements ~~standards~~

The QI Program goals include:

- Develop and maintain QI resources, structure, and processes that support the organization's commitment to quality health care for our members
- Coordinate, monitor and report QI activities
- Develop effective methods for measuring the outcomes of care and services provided to members
- Identify opportunities and make improvements based on measurement, validation and interpretation of data
- Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care
- Provide culturally and linguistically appropriate services
- Measure and enhance member satisfaction with the quality of care and services provided by our network providers
- Maintain compliance with state and federal regulatory requirements
- Ensure effective credentialing and re-credentialing processes for practitioners/providers that comply with state, federal and accreditation requirements
- Ensure network adequacy and member access to primary and specialty care
- Provide oversight of delegated entities to ensure compliance with GCHP standards as well as State and Federal regulatory requirements

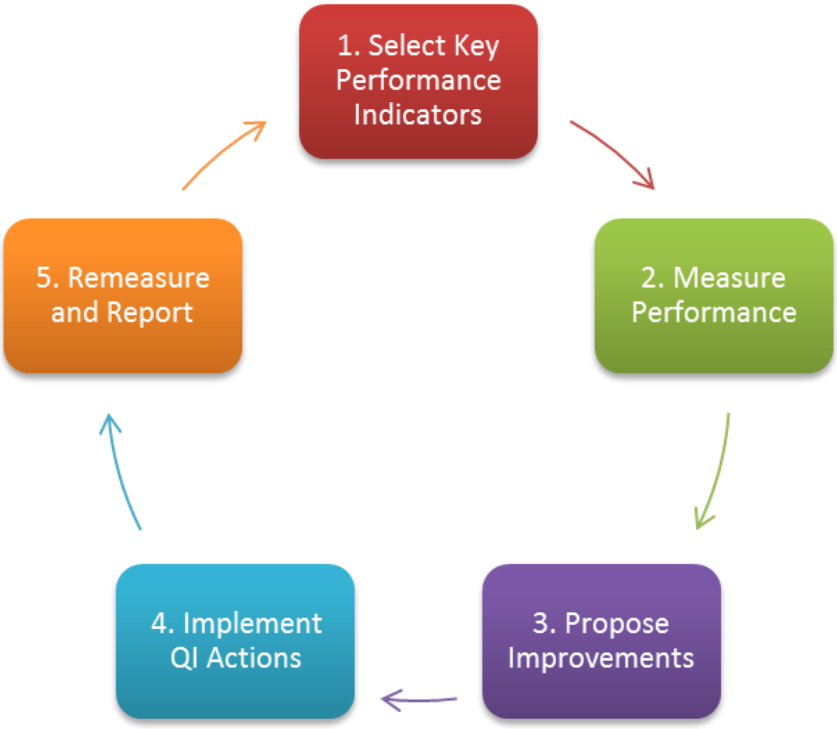
The Program Objectives include the following:

- To integrate the QI Program with other operational functions of GCHP
- To conduct an annual evaluation of the QI Program
- To establish and conduct an annual review of quality and performance improvement projects (PIPs) related to significant aspects of clinical and non-clinical services
- To identify opportunities for improvement through analysis of information collected from metrics including the Managed Care Accountability Set (MCAS)/Healthcare Effectiveness Data and Information Set (HEDIS®)/Centers for Medicare and Medicaid (CMS) Core Measures for Medicaid and utilization management patterns of care
- To encourage feedback from members and providers regarding delivery of care and services and to use the feedback to evaluate and improve the manner by which care and service are delivered

VI. QI PROGRAM METHODOLOGY

GCHP utilizes the "Plan-Do-Study-Act: (PDSA) Cycle methodology, which is an improvement process tool used by the Institute for Health Care Improvement's (IHI) Model for Improvement and adopted by the Department of Health Care Services (DHCS) as the standardized process for testing the effectiveness of interventions aimed at improving the quality of care and services. ~~Staff is encouraged to achieve improvement continuously by using the "Rapid Cycle Small Test of Change Methodology."~~ PDSA cycles focus on identifying and measuring improvement opportunities by utilizing small-scale studies to test the effectiveness of interventions that can be modified or expanded to achieve continuous improvement.

~~GCHP uses the "Plan-Do-Study-Act Cycle" (PDSA) to implement and test the effectiveness of changes. This model focuses on identifying improvement opportunities and changes, and measuring improvements. The PDSA cycle guides the test of a change to determine if the change is an improvement.~~



The QI Program is based on the latest available research in the area of quality improvement and at a minimum includes a method of monitoring, analysis, evaluation, and improvement in delivering quality care and service. The QI Program involves tracking and trending of quality indicators to ensure measures are reported, outcomes are analyzed, and goals are attained. Contractual standards, evidence-based practice guidelines, and other nationally-recognized sources (CAHPS® ~~and~~ ,HEDIS®, CMS Core Set for Medicaid) may be utilized to identify performance/metric indicators, standards, and benchmarks. Indicators are objective, measurable, and based on current knowledge and clinical experience (as applicable).

The indicators may reflect the following parameters of quality:

- Structure, process, or outcome of care
- Administrative and care systems within healthcare services to include:
    - Acute and chronic condition management including care management and population health activities
    - Utilization and risk management
    - Credentialing
    - Member experience/satisfaction
    - Care and provider experience
    - Member grievances and appeals
    - Practitioner accessibility and availability
    - Plan accessibility
    - Member safety
    - Preventive care
    - Disparities in care
    - Social determinants of heath

MCAS/HEDIS®/CMS Core Set for Medicaid measures and CAHPS® results are integrated in the QI Program~~. HEDIS® measures and methodology~~ and may be adopted as performance indicators for clinical improvement. The CAHPS® survey is utilized as one of the tools for ~~accessing~~ assessing member satisfaction.

Quality initiatives are developed and implemented as indicated by data analysis and/or medical record review for process improvements. Initiatives are reassessed on ~~an~~ a quarterly and/or annual basis to evaluate intervention effectiveness and compare ~~year-to-year~~ performance.

VII. KEY PROGRAM INITIATIVES

Population Health/Care Management

The Population Health (PH) Framework is an interdisciplinary structure that utilizes data from across the healthcare continuum to support and align GCHP's efforts to achieve positive health outcomes for defined populations.

It is a practical and customizable method that is designed to guide and organize Care Management in its effort to guide education and develop programs in order to best meet the needs of the GHCP community. Integration into the Population Health framework will allow Care Management to plan effective engagement strategies, improve existing programs, and demonstrate the results of resource investments. The framework encourages an approach to integrate continuous evaluation and improvement into routine program operations.

The organization collects, integrates, and assesses member data to identify target populations. Data sources may include:

1. Medical and/or behavioral claims/encounters
2. Pharmacy Claims
3. Utilization Management
4. HIF/MET
5. Laboratory Results
6. Health Appraisal results
7. Electronic Health Records
8. Advanced data sources may include, but are not limited to:
   - Regional immunization registries (CAIR Registries)
   - Integrated data warehouses between providers, practitioners, and the organizations

These data sources will be evaluated to develop actionable interventions to meet the care needs of targeted populations.

~~GCHP Population Health (PH)/Care management (CM) Programs are a collaborative process that assess, develop, plan, implement, coordinate, monitor, and evaluate the options and services needed to meet the member's health and human service needs and is characterized by advocacy, communication and resource management. Through telephonic interaction with the member, the member's significant other(s) and providers, the GCHP staff collects and analyzes data about the actual and potential care needs for the purpose of developing an individualized care plan. The goal of the PH/CM program is to simultaneously promote the member's wellness, autonomy, and appropriate use of services and financial resources. These programs strive to empower members to exercise their options and access the services appropriate to meet their individual health needs to promote quality outcomes. The PH/CM Programs adhere to the Triple Aim by striving to improve the health and health outcomes of GCHP members by empowering members to take control of their~~

~~health.~~

~~GCHP's Population Health Program uses a population health approach with a patient-centered medical home model to improve the clinical and quality management outcomes of our members with chronic conditions. GCHP's Population Health Programs, which include Asthma, Diabetes, and Pre-Diabetes, are developed from evidence-based clinical practice guidelines. These conditions were selected based upon common chronic conditions experienced by GCHP members.~~

~~Members may be identified for Population Health/Care Management through:~~
- ~~member or caregiver referral~~
- ~~practitioner referral~~
- ~~HIF/MET with an identified relative health risk, such as diabetes, pre-diabetes, or asthma~~
- ~~internal GCHP departments such as Member Services/Health Education/Utilization Management/Transition of Care Team~~
- ~~referral from hospital and GCHP discharge planners~~
- ~~referrals from Community agencies~~
- ~~information collected from Health Risk Assessment Tools~~
- ~~review of hospital and outpatient utilization patterns~~
- ~~review and profiling of encounter data/pharmacy utilization data/claims and billing data~~

For additional information, refer to the Population Health/Care Management Program Description.

Utilization Management

GCHP's Utilization Management (UM) Program is integrated with the QI Program to ensure continuous quality improvement. The UM Program is designed to ensure that medically appropriate services are provided to all GCHP members of the Plan through a comprehensive framework that assures the provision of high quality, cost effective, medically appropriate healthcare services in compliance with the benefit coverage and in accordance with regulatory and accreditation requirements. The UM Program Description defines how UM decisions are made by appropriately trained individuals in a fair and consistent manner. The Utilization Management Program functions ultimately under the direction of the Associate Chief Medical Officer ~~Medical Director~~ or his/her designee, who is fully involved in the UM Program implementation. The UM Program Description is approved by the UMC and the program evaluation is reported to the QIC.

UM/CM staff will assist providers in making referrals to and in locating necessary carved-out and linked services. The UM Program includes continuous quality improvement process which are coordinated with QI Program activities as appropriate. The UM and QI Committees work together to collaborate on and resolve cross-related issues.

For additional information, refer to the Utilization Management Program Description.

Inclusion and Diversity

GCHP assigns members to PCPs, without regard to race, color, ethnicity, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or gender identity. All contracted providers are expected to render services to members they have accepted assignment for or have agreed to accept referrals. They may not refuse services to any member based on the criteria above. GCHP follows up on all grievances alleging discrimination and takes

appropriate action.

To ensure that members have access to covered services that are delivered in a manner that meets their needs, GCHP conducts the following activities:

- Review of member complaints and grievances
- Provision of language assistance services to assist providers to provide linguistically appropriate medical care to Limited English Proficient members
- Conducting a Group Population Needs Assessment as defined by DHCS ~~every 5 years~~
- Provision of a Cultural Competency Training Program for both providers and GCHP staff
- Conducting surveys of members to determine if culture and language needs are met by providers
- Provision of a Seniors and Persons with Disabilities (SPD) Cultural Sensitivity Training for providers and staff
- Assessment of provider linguistic capabilities
- Assessment of GCHP staff language capabilities

VIII. PROGRAM ORGANIZATION, OVERSIGHT AND EVALUATION

CHIEF MEDICAL OFFICER

The Chief Executive Officer has appointed the Chief Medical Officer (CMO) as the designated physician to support the QI Program by providing day to day oversight and management of quality improvement activities.

The CMO has the overall responsibility for the clinical direction of GCHP's QI Program. The CMO ensures that the QI Program is adequate to monitor the full scope of clinical services rendered, and that identified problems are resolved and corrective actions are initiated when necessary and appropriate.

The Chief Medical Officer serves on the following committees: QIC, C/PRC, P&T, UM, and MAC. The Chief Medical Officer works directly with all GCHP department heads and executive team members to achieve the goals of the QI Program. Further, as Chief Medical Officer and a member of the Quality Improvement Committee, the CMO annually oversees the approval of the clinical appropriateness of the Quality Improvement Program.

The Chief Medical Officer reports to the Chief Executive Officer. The Chief Medical Officer's job description also specifies that the Chief Medical Officer has the ability and responsibility to inform the Chief Executive Officer, and if necessary the Commission, if at any time the Chief Medical Officer believes his/her clinical decision-making ability is being adversely hindered by administrative or fiscal consideration.

ASSOCIATE CHIEF MEDICAL OFFICER ~~DIRECTOR~~

The Associate Chief Medical Officer ~~Director~~ assists in the functions of the Health Services Department by collaborating with the Chief Medical Officer, Health Services Staff, Quality Improvement Department, Grievance and Appeals Department, and other GCHP staff. This collaboration allows the Associate Chief Medical Officer ~~Director~~ to oversee and carry out utilization management decisions, resolve clinical complaints and appeals and monitor clinical quality improvement programs. Key performance and quality of care indicators and criteria are established and reported to the QIC by the Associate Chief Medical Officer~~Director~~. The Associate Chief Medical Officer ~~Director~~ also serves on committees as directed by the CMO including the QIC, C/PRC, P&T, UMC and MAC.

DIRECTOR OF QUALITY IMPROVEMENT

The QI Director is responsible for working with sub-committee chairs and appropriate departments to ensure all quality monitors, analysis and improvement initiatives are in place. The Director works with the QIC, subcommittees and leadership to educate all health plan staff on the importance and role in quality improvement, communication, analysis and reporting. The Director is a mentor for all department heads and works with them to implement processes that will create both efficient and quality services.

The Director reports to the Sr. Director of Population Health ~~Executive Director of Health Services~~, who collaborate to ensure that the CMO is updated on any deficiencies and proposed improvement activities.

Specific roles and responsibilities of the QI Director include but are not limited to:

- Ensuring that the annual Quality Improvement description and Work Plan are created and reviewed by all appropriate areas
- Working with all appropriate departments in the creation of the annual QI Evaluation and analysis of results
- Ensuring QIC approval of all QI documents annually
- Guiding the collection of MCAS/HEDIS®/CMS Core Set for Medicaid data as mandated by contractual requirement and assisting in the development of activities to improve care
- Ensuring that appropriate principles of data collection and analysis are used by all departments when looking for improvement opportunities
- Providing educational opportunities for QI staff and other staff members key to improving care and service to better target improvement initiatives

The QI Director oversees staff consisting of an adequate number of Registered Nurses with the requirement to fulfill QI responsibilities, and other staff that includes a QI Manager, QI Project Manager(s), ~~Senior~~ Quality Improvement Data ~~HEDIS®~~ Analysts, ~~QI Data Analyst,~~ and Credentialing/ ~~Coordinator and~~ QI Specialists.

QI PROGRAM EVALUATION

A written evaluation of the QI Program is completed annually. This annual report includes a comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to the results of performance measures, outcomes/findings from Performance Improvement Projects (PIPs), consumer and provider satisfaction, and the quality review of services rendered. The analysis includes a review and revision of the QI Program Description, evaluation of the prior year's QI Work Plan, and the development of the current year's QI Work Plan to ensure ongoing performance improvement.

The evaluation is reviewed and approved by the QIC and VCMMCC and includes at least the following:

- A description of completed and ongoing QI activities that addresses quality and safety of clinical care provided to GCHP members, including trended measures and an analysis of barriers to success.
- A description of completed and ongoing QI activities that address service quality and the experience of care for GCHP members, including trended measures and an analysis of barriers to success.
- Analysis and evaluation of the overall effectiveness of the QI Program (QI committee structure, ~~communication,~~ QI program resources, practitioner participation and leadership involvement), including progress toward influencing network-wide safe clinical practices and addressing the cultural and linguistic needs of GCHP members.

- Recommendation for restructure or changes to the QI Program for the subsequent year to make it more effective.

IX. ANNUAL WORK PLAN

The Annual QI Work Plan serves as the roadmap for the QI Program and lists measurable objectives for key indicators and includes interventions to improve performance. The QI Work Plan is developed largely from recommendations from the annual QI Program Evaluation. Areas of significant focus include partially resolved and unresolved activities from the previous year, and newly identified focus areas for the coming year. These activities include clinical and service improvement activities that have the greatest potential impact on quality of care, service and patient safety. The Work Plan also reflects the contractual requirements of GCHP.

At a minimum, the QI Work Plan includes a clear description of the monitoring and improvement activities and objectives, the specific timeframe and responsible parties for conducting the activities and monitoring of previously identified issues. Activities and outcomes are compared to predetermined goals/target improvement metrics. Improvement activities identified during the year and other changes may be made to the QI Work Plan as presented to the QIC and VCMMCC for approval on an ongoing basis. The QIC oversees the prioritization and implementation of clinical and non-clinical Work Plan initiatives. The QI Work Plan is assessed and updated at a minimum, semi-annually, and is included as part of the Annual QI Program Evaluation.

GCHP views this as a living document that reflects ongoing progress on QI activities and a tool to focus improvement efforts throughout the year and evaluate progress against the objectives. This continuous quality improvement effort will help GCHP achieve its mission to improve the health and well-being of the people of Ventura County by providing access to high quality medical services.

Quality Improvement activities that measure and monitor access to care include the following:

- Access and Availability Studies
- Initial Health Assessment monitoring
- GeoAccess Studies
- Network Adequacy

Quality Improvement activities that measure and monitor provider and member satisfaction include the following:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Member Grievance Review
- Provider Satisfaction Surveys
- Focus Groups

Quality Improvement activities that evaluate preventive and chronic care as well as coordination, collaboration and patient safety include the following:

- MCAS/HEDIS®/CMS Core Set for Medicaid
- Coordination of Care Studies
- Facility Site Reviews
- Potential Quality Issue Investigation

Quality Improvement activities that evaluate GCHP's ability to serve a culturally and linguistically diverse membership may include but is not limited to the following:

- Annual provider language study

- Annual cultural and linguistic study
- Ongoing monitoring of interpreter service and use
- Ongoing monitoring of grievances
- Focus groups to determine how to meet needs of diverse members

Quality Improvement activities that evaluate GCHP's quality of care include the following:

- Credentialing and Recredentialing activities
- Peer Review Activities
- Delegation Oversight

Communication and Feedback

Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings, website content and announcements. Providers are educated regarding quality improvement initiatives via on-site quality visits, provider update memos, Provider Operations Bulletin and the GCHP website. ~~Specific~~ Reporting of specific MCAS/HEDIS®/CMS Core Set for Medicaid measures ~~performance feedback~~ is communicated to providers via an annual ~~HEDIS®~~ report card and periodic progress reports of projected rates including listings of members who need specific clinical services ("gap reports.").

X. PROGRAM RESOURCES DEDICATED TO QUALITY IMPROVEMENT

QI Program Resources - Multidisciplinary Staff

Resources for the QI Program come from various department staff in addition to the leadership roles described in the Program Oversight section of this document.

Support for improvement initiatives related to population health/care management, utilization/risk management and other clinical process improvement measures and outcomes is provided by Health Services and QI staff.

Quality initiatives related to service including member satisfaction and those related to complaints and appeals are supported by Member Services and Grievance and Appeals staff.

Quality initiatives related to provider network and provider communication is supported by Provider Network Operations staff.

Credentialing and peer review functions are supported by QI staff.

The quality improvement staff assists the Director in assessing data for improvement opportunities. They work with other departments to assist in planning and implementing activities that will improve care or service.

Responsibilities of multidisciplinary staff include but are not limited to the following:

- Assist in creating the annual QI Program Description
- Assist in coordination of MCAS/HEDIS®/CMS Core Set for Medicaid data collection and analysis of results
- Work with other departments to gather information for the annual QI Evaluation
- Collaborate in developing activities for the annual QI Work Plan
- Identify areas for improvement and assist in implementing quality improvement initiatives
- Assist the QI Director in achieving the goals of the QI Program

QI Program Resources - Program and Tools
GCHP has dedicated resources to the acquisition of programs and tools that promote high quality services for our members. These include but are not limited to:

- Online Member Administration Support – provider directories, health plan benefit summaries, drug formularies and claim forms
- Online Provider Resources – eligibility and benefit look-up, claims submittal, formulary information, forms
- Online Member Education and Engagement Resources – members are offered access to comprehensive clinical information in the Health Library on our website
- Online Data for performance metrics – providers have access to Inovalon's INDICES® dashboards that offer visualization and customization capabilities that enable measurement of performance against benchmarks and identification of gaps in care

QI Tools, Resources and Sources of Data
GCHP utilizes tools and resources that provide standards, benchmarks, guidelines, best practices, and measurement and evaluation methodologies to assist in guiding our improvement strategies. These resources include:

- *National initiatives and measurement sets* such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Healthcare Effectiveness Data and Information Set (HEDIS®), Centers for Medicare and Medicaid (CMS) Core Set for Medicaid, Quality Compass
- *Government issued laws, regulations and guidance* including those from DHCS, CMS, the U.S. Preventive Services Taskforce (USPSTF), and National Institutes of Health (NIH)
- *Healthcare Quality Improvement Organizations* such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), and the Agency for Healthcare Research and Quality (AHRQ), Health Services Advisory Group (HSAG)
- *The Guide to Community Preventive Services (The Community Guide);* a collection of evidence-based findings of the Community Preventive Services Task Force established by the U.S. Department of Health and Human Services (DHHS)

QI Program Resources- Data, Information and Analytics Support
GCHP's QI Program monitors and evaluates performance and information from many different sources throughout the organization including but not limited to:

- Enrollment and demographic data, including race, ethnicity and language preference data, is collected to monitor health care quality and for identifying and reducing health disparities among our patient population
- Claims data (utilization by diagnosis/procedure, provider, treatment/medications, site of care, etc.)
- Population health/care management reports to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the continuum
- Complaint and appeal data, including type of complaints, trends, and root cause analysis
- Ongoing tracking and trending of quality of care or serious reportable event data to identify patient safety issues and assess provider qualifications
- Member and provider survey data to assess satisfaction with services and operations
- Credentialing process data to measure timeliness of application processing and quality of network providers
- Network adequacy/accessibility measurement data to assess provider availability and accessibility

- MCAS/HEDIS®/CMS Core Set for Medicaid data to assess the effectiveness of clinical care and services

XI. QUALITY COMMITTEES AND SUBCOMMITTEES

Committee minutes will be recorded at each meeting and will reflect key discussion points, recommended policy decisions, analysis and evaluation of QI activities, needed actions, planned activities, responsible person, and follow up. Minutes record the practitioner and health plan staff attendance and participation. Minutes will be produced within a reasonable timeframe, at a minimum, within one month or by the date of the next meeting. Minutes will be reviewed and approved by the originating committee and will be signed and dated within the same reasonable timeframe. Committee meeting minutes shall be submitted to DHCS quarterly, or as requested.

i. Quality Improvement Committee (QIC)

The QIC is the principal organizational unit that will have delegated authority to monitor, evaluate and report to the VCMMCC on all component elements of the GCHP Quality Improvement program. The Committee shall have a minimum of 8 voting members and be chaired by the GCHP Chief Medical Officer (CMO) and facilitated by the Director, Quality Improvement. Membership will consist of the chairs of the 7 QI Subcommittees and at least one Commissioner and at least one practicing physician in the community. The Committee shall meet at least quarterly. Ad hoc committees, however, will meet on an as needed basis. The Committee will critically examine and make recommendations on all quality functions of GCHP described in this program and by California and Federal regulatory authorities as appropriate.

It is the responsibility of the QIC and its subcommittees to assure that QI activities encompass the entire range of services provided and include all demographic groups, care settings, and types of service. The committee reviews recommendations from the Plan committees and makes recommendations on their implementation. The VCMMCC is updated quarterly or as frequently to demonstrate follow-up on all findings and required action by the Chair of the QIC or designee via a report which may include QIC minutes, information packet, data dashboard, or other communication mechanism. All of the Plan's Committees are required to maintain confidentiality and avoid conflict of interest.

An annual QI Report is submitted to the VCMMCC addressing:

A. Quality improvement activities such as:
   i. Utilization Reports
   ii. Review of the quality of services rendered
   iii. MCAS/HEDIS®/CMS Core Set for Medicaid results
   iv. Quality Improvement Projects and initiatives - status and/or results
   v. Satisfaction Survey Results
   vi. Collaborative initiatives - status and/or results

B. Success in improving patient care and outcomes, and provider performance.

C. Opportunities for improvement.

D. Overall effectiveness of quality monitoring and review activities or specific areas that require remedial action as indicated in the annual report issued by the state's EQRO.

E. Effectiveness in performing quality management functions and achieving goals and objectives through quality monitoring programs will be measured and reported.

F. Presentation of the QI Plan including recommendations for revision identified as a result of the review.

QIC Objectives:

- Ensure communication process is in place to adequately track ~~action items and~~ work plan and QI activities and enable horizontal and lateral communication as well as closing the loop when issues are resolved.
- Ensure QIC members can have a candid discussion about barriers to achieving quality goals and objectives, and to facilitate the removal of such barriers.

QIC Responsibilities:

- Oversees the annual review, analysis and evaluation for achievement of goals and effectiveness of the Quality Improvement Program, Quality Improvement Work Plan, and quality improvement policies and procedures.
- Makes recommendations for implementation of interventions or corrective actions based on results of quality improvement activities.
- Facilitates data-driven indicator review and development for monitoring key quality management activities, including but not limited to: MCAS/HEDIS®, Access/Availability, Performance Improvement Projects, Service/Clinical Quality measures, Health Service metrics, Credentialing performance, and Delegation Oversight.
- Reviews recommendations from the Plan committees, which may include quarterly committee meeting minutes, action item logs and reports regarding monitoring of health plan functions and activities, and makes recommendations on their implementation.
- ~~Facilitate data-driven indicator development for monitoring Access, Care and Service and Quality Improvement Projects interventions.~~
- ~~Review quarterly committee meeting minutes, action item logs and reports regarding monitoring of health plan functions and activities. Suggest interventions or corrective actions that adhere to the rapid cycle improvement methodologies.~~
- ~~Oversee the annual review, analysis and evaluation for achievement of goals and effectiveness of the QI Program, quality improvement policies and procedures and QI Work Plan .~~
- ~~Recommend policy changes or implementation of new policies to GCHP's Administration and Commission.~~

QIC Membership:

- Chief Medical Officer (Chair)
- Associate Chief Medical Officer ~~Director~~
- Director of Quality Improvement
- Director of Health Education & Cultural Linguistics
- ~~Director of Operations~~
- ~~Senior~~ Sr. Director of Network Operations
- Director of Pharmacy
- Director of Compliance
- Compliance Officer
- ~~Executive Director of Health Services~~Director of Care Management
- Director of Utilization Management
- CEO, Ex Officio
- Sr. Director~~,~~ of Population Health
- Manager, Member Services
- Manager, Grievance and Appeals

- External Practitioner Representatives
- Commissioner

QIC Reporting Structure:

The QIC reports to the VCMMCC. The Chair of the QIC ensures that quarterly reports are submitted to the VCMMCC.

Meeting Frequency:

The QIC meets at a minimum quarterly.

ii. Medical Advisory Committee (MAC)

Purpose:

The purpose of the MAC is to provide feedback and advice to the health plan on any aspect of health plan policy or operations affecting network providers or members. Through MAC, GCHP seeks input/guidance to foster discussion of matters including, but not limited to the following:

- The delivery of medical care to the plan's membership
- Issues of concern to the physician community
- Quality of care updates and/or concerns
- GCHP clinical programs to ensure optimal effectiveness for members and providers
- Local medical care practices that may affect health plan operations

Scope:

The Committee scope may include, but is not limited to, the following data/activities/processes:

- Clinical and Preventive Health Care Guidelines (CPGs/PHGs)
- Provider Grievance Process
- Provider Satisfaction Issues
- Provider Access/Availability Standards
- Provider Contracting
- Provider Materials/Communications
- Clinical Programs and Service Delivery
- Utilization Management
- Pharmacy
- Quality Improvement (including clinical studies, MCAS/HEDIS®/CMS Core Set Medicaid/ CAHPS® ~~S~~survey o~~O~~utcomes)

Feedback from the MAC is relayed to the QIC as well as other QI committees and/or departments where data may be relevant to process improvements. Practitioner feedback may be utilized in a variety of ways, including but not limited to: help improve outcomes, assess/revise policies and procedures, and/or modify program offerings.

Membership:

Membership is comprised of physicians representing the contracted provider community for GCHP's programs. The Chief Medical Officer will serve as Chair~~man~~ and will ensure that the membership has adequate specialty representation. Efforts are made to rotate membership every two years; however, in order to ensure continuity of committee activity, membership may be extended.

Meeting Frequency:

The committee meets at a minimum on a quarterly basis.

iii. Member Services Committee (MSC)

The MSC oversees those processes that assist members in navigating GCHP's system. This committee provides oversight of service indicators, analyzes results, and suggests the implementation of actions to correct or improve service levels. Through monitoring of appropriate indicators, the MSC will identify areas of opportunity to improve processes and implement interventions.

MSC Objectives:

- Ensure GCHP members have an understanding of their health care system and know how to obtain care and services when they need them.
- Ensure GCHP members will have their concerns resolved quickly and effectively and have the right to voice complaints or concerns without fear of discrimination.
- Ensure GCHP members can trust that the confidentiality of their information will be respected and maintained.
- ~~Ensure members have access to information on languages spoken in physician offices to better aid them in the selection of a primary care physician.~~
- Have access to appropriate language interpreter services at no charge when receiving medical care.
- Ensure GCHP members can reach the Member Services Department quickly and be confident in the information they receive.
- Utilize the CAHPS® survey to identify service indicators for improvement.
- Ensure GCHP's Member Rights and Responsibilities policy is distributed to members and providers.
- Ensure that GCHP's member materials are developed in a culturally-appropriate format.
- Interface with other GCHP committees to improve service delivery to members.

MSC Membership:

- Manager of Member Services (Chair)
- ~~Director of Operations~~ Chief Administrative Officer or designee
- ~~Senior~~ Sr. Director of Network Operations or designee
- Director Government & Community Relations
- Manager of Grievance and Appeals or designee
- Quality Improvement Representative
- ~~Executive~~ Director of Care Management ~~Health Services~~ or designee
- Director of Health Education & Cultural Linguistics or designee
- Manager of Public Relations ~~Director of Communications (Ad Hoc)~~
- Director of Compliance or designee

Meeting Frequency:

The MSC meets quarterly at a minimum.

iv. Grievance and Appeals Committee (G&A)

G&A Charter:

The Grievance and Appeal Committee monitors expressions of dissatisfaction from members and providers. Information gathered is used to improve the delivery of service and care to Gold Coast Health Plan members.

G&A Committee Objectives:

- Review and respond to all ~~(~~member and provider~~)~~ grievances timely
- Review issues for patterns which may require process changes
- Review all grievances and appeals that may affect the quality of care delivered to members
- Ensure all GCHP departments are educated on the appropriate process for communicating member and provider grievances and/or appeals to the correct area for resolution
- Ensure that issues needing intervention are reviewed and routed to the appropriate area for discussion and intervention

G&A Committee Membership:

- Manager of Grievance and Appeals (Chair)
- Senior Grievance and Appeals Specialist
- Associate Chief Medical Officer ~~Director~~ or designee
- ~~Senior~~ Sr. Director of Network Operations or designee
- Manager of Member Services or designee
- Director of Quality Improvement or designee
- ~~Executive Director of Health Services or designee~~
- Director of Care Management
- Director of Utilization Management
- Director of Compliance or designee
- ~~Director of Operations~~
- Director of Health Education & Cultural Linguistics or designee
- Director of Pharmacy or designee

Meeting Frequency:

The committee meets quarterly.

v. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) oversees the implementation of the UM Program and promotes the optimal utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multi-disciplinary and monitors continuity and coordination of care as well as under- and over-utilization. The committee is charged with reviewing and approving clinical policies, clinical initiatives and programs before implementation. It is responsible for annually providing input on GCHP's clinical strategies, such as clinical guidelines, utilization management criteria, population health/care management protocols, and the implementation of new medical technologies. The UMC is established as a standing sub-committee of the QI Committee, and reports to the QIC quarterly.

UMC Responsibilities:

Responsibilities include but are not limited to the following:

- Annual review and approval of the UM and Population Health/Care Management Program documents.
- Review and approval of program documents addressing the needs of special populations. This includes but may not be limited to Children with Special Health Care Needs (CSHCN) and Seniors and Persons with Disabilities (SPD).
- Suggest and collaborate with other departments to address areas of patient safety. This may include but is not limited to medication safety and child safety.
- Annual adoption of preventive health criteria and medical care guidelines with guidance on how to disseminate criteria and ensure proper education of appropriate staff.
- Review of the timeliness, accuracy and consistency of the application of medical policy as it is applied to medical necessity reviews.
- Review utilization and case management monitors to identify opportunities for improvement.
- Review data from Member Satisfaction Surveys to identify areas for improvement.
- Ensure policies are in place to review, approve and disseminate UM criteria and medical policies used in review when requested.
- Review, at least annually, the Inter Rater Reliability (IRR) test results of UM staff involved in decision making (RN's and MD's) and take appropriate actions for staff that fall below acceptable performance.
- Interface with other GCHP committees for trends, patterns, corrective actions and outcomes of reviews.

Membership:

- Associate Chief Medical Officer ~~Director~~ (Chair)
- Chief Medical Officer
- ~~Executive Director, Health Services~~
- Director of Care Management
- Director of Utilization Management
- Manager of Care Management
- ~~Manager of CM/DM/Children's Services~~
- Manager~~s~~ of Utilization Management
- Director of Pharmacy
- Physician Reviewers
- Compliance Designee
- Director of Quality Improvement

Meeting Frequency:

The UMC meets quarterly at a minimum.

vi. Health Education & Cultural Linguistics Committee (HE/CL)

Purpose:

The purpose of the HE/CL committee is to assess the health education, cultural and language needs of the Plan population. The committee will be responsible to ensure materials of all types are available in languages other than English to appropriately accommodate members with Limited English Proficiency (LEP) skills. The HE/CL Committee will review data to assist GCHP staff and providers to better understand unique characteristics of the varied population. The committee will assist in developing cultural sensitivity trainings and ensure that those that serve the population are appropriately trained.

Functions:

- Ensure that members have access to appropriate health education materials.
- Ensure that Providers have access to health education services and materials.
- Ensure that Providers and Plan staff deliver culturally and linguistically (C&L) appropriate healthcare services to GCHP's diverse membership.
- Ensure that Providers and staff receive trainings on cultural competency, language assistance, Seniors and Persons with Disabilities (SPD) and/or diversity trainings.
- Ensure that all members – regardless of race, color, region, national origin, gender, gender identity, disability or language capabilities have equal access to quality healthcare.
- Ensure that GCHP implements C&L requirements set by Department of Health Care Services (DHCS).
- Ensure the ~~Group~~ Population Needs Assessment (~~G~~PNA) is completed to determine a baseline for serving education and cultural ~~-~~/language needs.
- Collaborate and work with GCHP's Health Services, Quality Improvement and other departments to ensure ~~-~~health education, cultural and linguistic services needs are addressed.
- Ensure opportunities are available to educate members on the disease process, preventive care, plan processes and all other areas essential to good member health.
- Assist providers in educating Plan members and promote positive health outcomes.
- Ensure that all written information materials comply with the ~~readably~~ readability and suitability requirements set by the Department of Health Care Services. The member informing materials shall be at a sixth grade or lower and ~~. It should also~~ be consistent with the Plan's membership needs.
- Educate Plan staff on specific cultural barriers that might hinder the delivery of optimal health care.

Membership:

- Director of Health Education & Cultural Linguistic Services (Chair)
- Chief Medical Officer or designee
- ~~Executive Director of Health Services or designee~~
- Sr. Director of Population Health
- Director of Care Management
- ~~Managers of Population Health/Care Management or designees~~
- ~~Director~~ Manager of Communications or designee
- Manager of Member Services or designee
- ~~Senior~~ Sr. Director of Network Operations or designee
- Director of Quality Improvement or designee
- Cultural and Linguistic Specialist
- Health Navigator /Health Navigator Lead

Meeting Frequency:

The committee meets at a minimum quarterly.

vii. Credentials/Peer Review Committee (C/PRC)

Purpose:

The Credentials/Peer Review Committee provides guidance and peer input into GCHP's ~~provider~~ credentialing and practitioner peer review process.

The C/PRC fulfills the credentialing and peer review functions as follows:

Credentialing Responsibilities:

- Provide guidance and comments on GCHP's practitioner/provider credentialing process
- Review and make decisions for initial credentialing and re-credentialing for participation in GCHP's provider network
- Review the practitioner and provider credentialing policies annually and make recommendations for changes, as appropriate

Peer Review Responsibilities:

- Review results of provider profiling when available and suggest methods to feed information back to network providers
- Review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns and determine corrective action when necessary

Membership:

- Chief Medical Officer (Chair)
- Seven to nine (7-9) physicians

To assure due process in the performance of peer review investigations, the Chief Medical Officer shall appoint other physician consultants, as necessary, to obtain relevant clinical expertise and representation by an appropriate mix of physician types and specialties.

Meeting Frequency:

The committee meets quarterly.

viii. Pharmacy & Therapeutics (P&T) Committee

Purpose:

The P&T Committee serves as the oversight committee to GCHP for the development and implementation of a plan-wide medication management program. The P&T Committee is for the development of a formulary to ensure optimal efficacy, safety, and cost-effectiveness of drug therapy.

Functions:

- Maintenance of a drug formulary based on an objective evaluation of efficacy, safety and cost-effectiveness of medications that is reviewed and updated at least quarterly
- Assess, review and determine formulary status for all new drugs approved by the FDA and all drugs added to the Medi-Cal Fee For Service List of Contract Drugs
- Review and approve all matters pertaining to the use of medication, including development of prescribing guidelines and protocols and procedures to promote high quality and cost-effective drug therapy
- Provide oversight of the prior authorization process to ensure that medications are reviewed consistently according to the approved guidelines
- Review and evaluation of analyses including but not limited to population demographics, morbidities, health risks, and provider-specific and plan-wide utilization patterns for enrolled members
- Review any other issues related to pharmacy quality and usage

Membership:

- Chief Medical Officer (Chair)
- PBM representative
- Director of Pharmacy Services, or pharmacist designee
- Physicians and representatives of a variety of clinical specialties

Meeting Frequency:

The committee meets quarterly.

XII. DELEGATION OF QUALITY IMPROVEMENT

Delegation is the formal process by which the health plan gives an external entity the authority to perform certain functions on its behalf. These functions may include quality improvement, utilization management, credentialing/recredentialing, and grievance and appeals. GCHP retains accountability for ensuring the function is being performed according to expectations and standards set forth by DHCS and GCHP.

GCHP will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation. GCHP will only delegate activities to entities who have demonstrated the ability to perform those duties, and who have the mechanisms in place to document the activities and produce associated reports, prior to delegation of that activity. GCHP retains the right to delegate these functions.

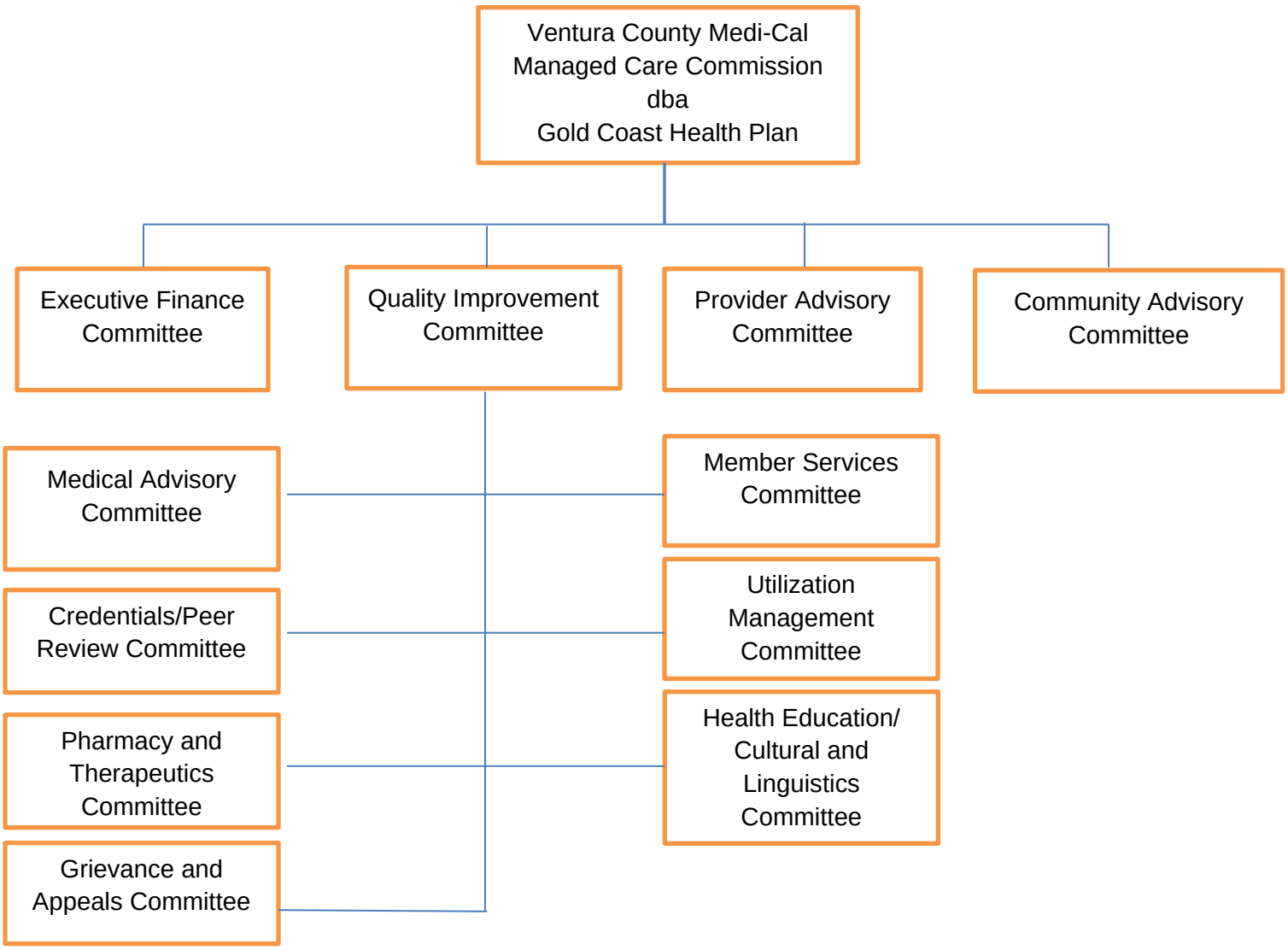
Any delegated functions are fully described in a mutually agreed upon signed and written formal delegation agreement between the Plan and each delegated entity~~,~~ and includes an effective date. All agreements clearly define GCHP's and the delegate's specific duties, responsibilities, activities, reporting requirements and identifies how GCHP will monitor and evaluate the delegate's performance. The agreement also includes the Plan's right to resume the responsibility for conducting the delegated function should the delegated entity fail to meet GCHP standards.

GCHP conducts ongoing oversight, evaluation and monitoring of the delegate. At a minimum, an annual audit is conducted using an audit tool that is based upon current NCQA, DHCS and GCHP standards and modified on an as-needed basis. In the event any deficiencies are identified through the oversight process, c~~C~~orrective action plans are implemented based upon areas of non-compliance. If the delegate is unable to correct or does not comply with the corrective action plan within the required timeframe, GCHP will take action that may include imposing sanctions, de-delegation of the delegated function or termination of the contract or agreement. Focused audits may be performed to verify deficiencies have been corrected or if a quality issue is identified. Audit results and outcomes of corrective action plans are reported to QIC.

Delegated entities are required to submit at least semi-annual reports to GCHP according to the reporting schedule specified in the delegation agreement. ~~Audit results and outcomes of corrective action plans are reported to QIC.~~

XIII. GOLD COAST HEALTH PLAN COMMITTEE ORGANIZATIONAL CHART

The following organizational chart shows the key GCHP committees that advise the Ventura County Medi-Cal Managed Care Commission and their reporting relationships:



XIV. QUALITY COMMITTEE MEETINGS FOR CALENDAR YEAR ~~2019~~2020

Dates:	
Tuesday	**~~March 26, 2019~~ March 24, 2020**
Tuesday	**~~June 18, 2019~~ June 16, 2020**
Tuesday	**~~September 24, 2019~~ September 22, 2020**
Tuesday	**~~December 10, 2019~~ December 8, 2020**
Location: Bell Canyon Conference Room	

Availability of QI Program to practitioners and members

The QI Program is available on GCHP's website at www.goldcoasthealthplan.org. Printed copies are available upon request.

REFERENCES

- Gold Coast Health Plan Quality Improvement Committee Charter
- Gold Coast Health Plan ~~Quality Improvement System~~ Policy QI-002: Quality and Performance Improvement Requirements
- Gold Coast Health Plan Utilization Management Program Description
- Gold Coast Health Plan Population Health ~~Program~~/Care Management Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 19-017: Quality and Performance Improvement Requirements ~~13-005~~
- GCHP DHCS Contract 10-87128, Exhibit A, Attachment 4
- HEDIS® - Healthcare Effectiveness Data and Information Set - a registered trademark of the National Committee for Quality Assurance (NCQA)~~.~~
- CAHPS® - Consumer Assessment of Healthcare Providers and Systems - a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
- NCQA Standards and Guidelines for the Accreditation of Health Plans
- DHCS ~~Quality~~ Strategy for Quality Improvement in Health Care, March 2018
- National Quality Strategy, Agency for Healthcare Research and Quality (AHRQ)
- Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010
- Kohn KT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press; 1999
- Title 42, Code of Federal Regulations, Section 438.240 Quality Assessment and Performance Improvement Program ~~(b) (1)~~

UTILIZATION MANAGEMENT AND POPULATION HEALTH/CARE MANAGEMENT PROGRAM DESCRIPTIONS CONTAINED IN SEPARATE DOCUMENTS.

The ~~2019~~ 2020 Quality Improvement Program Description and Work Plan were approved by the Quality Improvement Committee on ~~March 26, 2019~~ March 24, 2020.

The ~~2019~~ 2020 Quality Improvement Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMMCC) on ~~May 20, 2019~~Month Day, 2020.

Gold Coast Health Plan℠
A Public Entity

2020 QI Work Plan

Quality Improvement Department
GOLD COAST HEALTH PLAN

Return to Agenda

Return to Agenda

Objective #1: Improve Quality and Safety of Clinical Care Services

Practice Guidelines

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: Practice Guidelines** **Topic: Practice Guidelines**			**Objective Met:**		
Required by: NCQA Standard MED 2			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Review and adoption of evidence-based Diabetes Clinical Practice Guideline (CPG) at least every two years.	Review and approval by Medical Advisory Committee (MAC)	Health Services	MAC Approval	01/01/20	12/31/20
	Distribute guidelines to appropriate practitioners, upon request		Timely distribution		
Review and adoption of evidence-based Asthma Clinical Practice Guidelines (CPG) at least every two years.	Review and approval by Medical Advisory Committee (MAC)	Health Services	MAC Approval		
	Distribute guidelines to appropriate practitioners, upon request		Timely distribution		
Review and adoption of Preventive Health Guideline (PHG) at least every two years.	Define, review and seek approval by Medical Advisory Committee (MAC)	Health Services	MAC Approval		
	Distribute guidelines to appropriate practitioners		Timely distribution		
	Ensure alignment of PHG with Provider Manual and applicable policies	QI	Updates completed		
Evaluation/Analysis of Interventions:					

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Advance Prevention: Tobacco Cessation

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: Advance Prevention** **Topic: Tobacco Cessation**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase awareness of benefits of tobacco cessation in member population identified as smoking.	Utilize DHCS methodology to identify smokers via monthly data pulls.	QI	50% of identified smokers receive intervention.	01/01/20	12/31/20
	Create and implement education campaigns for members and providers.	Health Education/ Provider Operations		01/01/20	12/31/20
	Measure and report tobacco cessation medication dispensing and cessation counseling quarterly.	DSS/QI/Pharm		01/01/20	12/31/20
	Create system to monitor provider performance for offering tobacco cessation interventions.	QI/DSS		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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Advance Prevention: Initial Health Assessment

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: Advance Prevention** **Topic: Initial Health Assessment**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase rates of Initial Health Assessment (IHA)/Individual Health Education Behavior Assessment (IHEBA) completion by provider sites.	Educate providers regarding requirements and components of IHA.	QI	Increase rate of IHA completion by 5% compared to CY19.	01/01/20	12/31/20
	Audit providers and provide feedback on opportunities for improvement.			01/01/20	12/31/20
	Monitor and report provider compliance with outreach to new members to schedule IHA appointments. Follow up on deficient sites.			01/01/20	12/31/20
	Create and implement campaigns to increase provider awareness of requirements; member awareness of IHA offering.	HE/ PNO/QI/MS		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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Advance Prevention: ACE

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: Advance Prevention** **Topic: Adverse Childhood Experiences (ACE)**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Evaluate the percentage of full-scope Medi-Cal GCHP members (pediatrics and adults) who are screened for adverse childhood experiences (ACE) using a standardized screening tool.	Evaluate baseline utilization and identify barriers, opportunities for improvement and provider collaborations.	QI	Establish baseline and monitoring process.	01/01/20	12/31/20
	Create and implement provider and member education campaigns.	HE/PNO/QI/MS		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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Advance Prevention: LCS

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: Advance Prevention** **Topic: Lead Screening in Children (LCS)**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase the percentage of children who had one or more capillary or venous lead blood test for lead poisoning by their 2nd birthday.	Evaluate improved data capture with single source lab provider (Quest Diagnostics).	QI/IT	Increase administrative rate by 2%.	01/01/20	12/31/20
	Explore partnerships with Help Me Grow/First 5 to educate clinics on best practices.	QI/HE		01/01/20	12/31/20
	Utilize Initial Health Assessment and medical record reviews to identify barriers and opportunities for improvement.	QI		01/01/20	12/31/20
	Create and implement provider and member awareness campaigns.	HE/ PNO/QI/MS		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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MCAS Measures: AMR

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: MCAS Measures** **Topic: Asthma Medication Ratio (AMR)**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase the percentage of members, 5-64 years of age with a diagnosis of persistent asthma, who had a ≥ 0.50 ratio of controller medications to total asthma medications during the measurement year.	Evaluate MY2019 performance to identify opportunities for improvement and develop interventions.	QI	Increase rates by 3% over previous measurement year.	01/01/20	12/31/20
	Provide clinics/providers with the annual 2019 MY MCAS rate reports.	QI		01/01/20	12/31/20
	Provide clinics/providers with the prospective 2020 MY MCAS rate and member gap reports.	QI/Inovalon		01/01/20	12/31/20
	Conduct asthma outreach campaigns including educational IVR calls and text messages, followed by gap closure campaign.	QI/HMS Eliza		01/01/20	12/31/20
	Based on identified individuals diagnosed with asthma, develop program to conduct follow up education (i.e. home and office visits).	HE/QI		01/01/20	12/31/20
	Provider Incentive Program with VCMC	QI, PNO		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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MCAS Measures: AWC

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: MCAS Measures** **Topic: Adolescent Well Care (AWC)**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase percentage of adolescents, 12 to 21 years of age, who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year.	Evaluate effectiveness of the well care member incentive program and identify program changes/enhancements, as applicable.	QI	Meet or exceed DHCS MPL (50th percentile).	01/01/20	12/31/20
	Evaluate 2019 MY outcomes for barriers, improvement opportunities and provider collaborations.	QI		01/01/20	12/31/20
	Provide clinics/providers with the annual 2019 MY MCAS rate reports.	QI		01/01/20	12/31/20
	Provide clinics/providers with the prospective 2020 MY MCAS rate and member gap reports.	QI/Inovalon		01/01/20	12/31/20
	Evaluate data improvement activities related to provider specialty mapping.	QI		01/01/20	12/31/20
	Conduct gap closure campaign for members identified as missing a well care visit.	QI/HMS Eliza		01/01/20	12/31/20
	Create and implement provider and member awareness campaigns.	HE/ PNO/QI/MS		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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Objective #1: Improve Quality and Safety of Clinical Care Services Section: MCAS Measures Topic: Adolescent Well Care (AWC)	Objective Met:

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MCAS Measures: CCS

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: MCAS Measures** **Topic: Cervical Cancer Screening (CCS)**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase percentage of women 21-64 years of age who were screened for cervical cancer.	Evaluate effectiveness of the CCS member incentive program and identify program changes/enhancements, as applicable.	QI	Increase rates by 3% over previous measurement year.	01/01/20	12/31/20
	Provide clinics/providers with the annual 2019 MY MCAS rate reports.	QI		01/01/20	12/31/20
	Provide clinics/providers with the prospective 2020 MY MCAS rate and member gap reports.	QI/Inovalon		01/01/20	12/31/20
	Evaluate improved data capture with single source lab provider (Quest Diagnostics).	QI/IT		01/01/20	12/31/20
	Conduct gap closure campaign for members identified as missing cervical cancer screening	QI/HMS Eliza		01/01/20	12/31/20
	Create and implement provider and member awareness campaign	HE/PNO/QI/MS		01/01/20	12/31/20

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Objective #1: Improve Quality and Safety of Clinical Care Services Section: MCAS Measures Topic: Cervical Cancer Screening (CCS)			Objective Met:		
	Provider Incentive Program with VCMC	QI/PNO		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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MCAS Measures: CHL

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: MCAS Measures** **Topic: Chlamydia Screening in Women (CHL)**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase the percentage of women, 16-24 years of age, who were identified as sexually active and who had at least one chlamydia screening during the measurement year.	Provide clinics/providers with the annual 2019 MY MCAS rate reports.	QI	Meet or exceed DHCS MPL (50th percentile).	01/01/20	12/31/20
	Provide clinics/providers with the prospective 2020 MY MCAS rate and member gap reports.	QI/Inovalon		01/01/20	12/31/20
	Evaluate improved data capture with single source lab provider (Quest Diagnostics).	QI/IT		01/01/20	12/31/20
	Conduct gap closure campaign for members identified as missing chlamydia screening	QI/HMS Eliza		01/01/20	12/31/20
	Create and implement provider and member education campaigns	HE/PNO/QI/MS		01/01/20	12/31/20
	Provider Incentive Program with VCMC	QI/PNO		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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MCAS Measures: CIS Combo 10

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: MCAS Measures** **Topic: Childhood Immunization Status (CIS) Combo 10**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase the percentage of two-year-old children who received all required Combo 10 vaccines (DTaP, PCV, HiB, IPV, Hep A, Hep B, ROTA, MMR, VZV, and Flu) on or before their 2nd birthday.	Provide clinics/providers with the annual 2019 MY MCAS rate reports.	QI	Meet or exceed DHCS MPL (50th percentile).	01/01/20	12/31/20
	Provide clinics/providers with the prospective 2020 MY MCAS rate and member gap reports.	QI/Inovalon		01/01/20	12/31/20
	Explore partnerships with VCPH/VCOE/community agencies to educate clinics on CoCASA reporting and/or best practices	QI/HE		01/01/20	12/31/20
	Conduct gap closure campaign for members identified as missing immunizations before their 2nd birthday	QI/HMS Eliza		01/01/20	12/31/20
	Create and implement provider and member education campaigns	HE/PNO/QI/MS		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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MCAS Measures: DEV

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: MCAS Measures** **Topic: Developmental Screening in the First Three Years of Life (DEV)**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding, or on, their first, second or third birthday.	Provide clinics/providers with the annual 2019 MY MCAS rate reports.	QI	Establish baseline and monitoring process.	01/01/20	12/31/20
	Provide clinics/providers with the prospective 2020 MY MCAS rate and member gap reports.	QI/Inovalon		01/01/20	12/31/20
	Explore partnerships with Help Me Grow/First 5 to educate clinics on best practices	QI/HE		01/01/20	12/31/20
	Evaluate baseline utilization and identify barriers, opportunities for improvement and provider collaborations	QI		01/01/20	12/31/20
	Create and implement provider and member education campaigns	HE/PNO/QI/MS		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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MCAS Measures: W15

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: MCAS Measures** **Topic: Well-Child Visits in the Frist 15 Months of Life (W15)**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase the percentage of children, who turned 15 months old during the measurement year, and had six or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life.	Provide clinics/providers with the annual 2019 MY MCAS rate reports.	QI	Meet or exceed DHCS MPL (50th percentile).	01/01/20	12/31/20
	Provide clinics/providers with the prospective 2020 MY MCAS rate and member gap reports.	QI/Inovalon		01/01/20	12/31/20
	Evaluate MY2019 performance to identify opportunities for improvement and develop interventions.	QI		01/01/20	12/31/20
	Conduct well-baby outreach campaign including educational IVR calls and text messages, followed by gap closure campaign	QI/HMS Eliza		01/01/20	12/31/20
	Evaluate data improvement activities related to provider specialty mapping.	QI/IT		01/01/20	12/31/20
	Create and implement provider and member education campaigns.	HE/PNO/QI/MS		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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MCAS Measures: W34

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: MCAS Measures** **Topic: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q42020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Increase the percentage of members, 3-6 years of age, who had one or more well-child visits with a primary care practitioner (PCP) during the measurement year.	Provide clinics/providers with the annual 2019 MY MCAS rate reports.	QI	Increase rate by 2% over previous measurement year.	01/01/20	12/31/20
	Provide clinics/providers with the prospective 2020 MY MCAS rate and member gap reports.	QI/Inovalon		01/01/20	12/31/20
	Evaluate MY2019 performance to identify opportunities for improvement and develop interventions.	QI		01/01/20	12/31/20
	Conduct outreach campaign including educational IVR calls and text messages, followed by gap closure campaign.	QI/HMS Eliza		01/01/20	12/31/20
	Evaluate data improvement activities related to provider specialty mapping.	QI/IT		01/01/20	12/31/20
	Evaluate effectiveness of the well care member incentive program and identify program changes/enhancements, as applicable	QI		01/01/20	12/31/20
	Create and implement provider and member education campaigns.	HE/PNO/QI/MS		01/01/20	12/31/20

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Objective #1: Improve Quality and Safety of Clinical Care Services Section: MCAS Measures Topic: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)			Objective Met:		
	Provider Incentive Program with VCMC	QI/PNO		01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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Quality Improvement Projects: AWC PIP

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: Quality Improvement Projects** **Topic: Adolescent Well Care(AWC) Performance Improvement Project (PIP)**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2019		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
AWC PIP: Increase the rate of adolescent well care exams for adolescents, 12 to 21 years of age, who are enrolled at Community Memorial Health Center for Family Health (CMH CFH) Airport Marina Clinic.	Two-year performance improvement project (PIP): health plan/clinic collaborative between GCHP's Quality Improvement Department and CMH CFH Airport Marina Clinic. • Submit Modules as directed by DHCS/HSAG for approval • Report updates/results to QIC	QI	By June 30, 2021, increase the percentage of adolescent well care exams among 12 to 21-year-old Gold Coast Health Plan members assigned to CMH Centers for Family Health Airport Marina Clinic, from 39.26% to 54.26%.	07/01/19	06/30/20
Evaluation/Analysis of Interventions:					

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Quality Improvement Projects: CCS Disparity PIP

Objective #1: Improve Quality and Safety of Clinical Care Services **Section: Quality Improvement Projects** **Topic: Cervical Cancer Screening (CCS) Disparity (Performance Improvement Project) PIP**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2019		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Health Disparity CCS PIP: Increase the rate of cervical cancer exams for women, 21 to 64 years of age, who live in Area 5 (Oxnard/Port Hueneme) and are enrolled at Ventura County Medical Center's Magnolia Family Medical Clinic.	Two-year performance improvement project (PIP): health plan/clinic collaborative between GCHP's Quality Improvement Department and Magnolia Family Medical Clinic. • Submit Modules as directed by DHCS/HSAG for approval • Report updates/results to QIC	QI	By June 30, 2021, increase the percentage of cervical cancer screening among 21 to 64-year-old female members of Gold Coast Health Plan who are assigned to Magnolia Family Medical Clinic in Oxnard, California, from 46.75% to 60.65%.	07/01/19	06/30/21
Evaluation/Analysis of Interventions:					

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Objective 2: Improve Quality of Nonclinical Services

Cultural & Linguistic Needs & Preferences

Objective #2: Improve Quality and Safety of Non - Clinical Services **Section: Cultural & Linguistic Needs and Preferences** **Topic: Practitioner Availability**			**Objective Met:**		
Required by: NCQA NET 1; DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Practitioner Availability - Cultural and Linguistics Needs & Preferences • Ensure adequate resources to address the cultural, ethnic and linguistic needs of our members	Evaluate the demographic needs of members and identify opportunities for improvement. Create and implement an action plan to address areas for improvement, as needed.	PNO/HE	Development and implementation of action plan to improve.	01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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Primary and Specialty Care Access

Objective #2: Improve Quality of Nonclinical Services **Section: Primary & Specialty Care Access** **Topic: Primary & Specialty Care Access**			**Objective Met:**		
Required by: NCQA NET 2; DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Primary Care Access Members are offered: • Non-urgent primary care within 10 business days of request • Urgent care within 24 hours **Specialty Care Access** Members are offered: • Non-urgent specialty care appointment within 15 business days • Non-urgent ancillary services within 15 business days	Conduct survey and evaluate results	PNO	Standards met for minimum of 90% of providers.	01/01/20	12/31/20
	Develop and implement corrective action plans when timely access standards not met	PNO			
	Report quarterly performance to QIC	PNO			
	Monitor complaints relating to the member access for appointments and/or referrals,	G&A			
Evaluation/Analysis of Interventions:					

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After Hours Availability

Objective #2: Improve Quality of Nonclinical Services **Section: After Hours Availability** **Topic: After Hours Availability**			**Objective Met:**		
Required by: NCQA NET 2; DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
After Hours Availability • Members are able to reach a provider after hours	Conduct survey and evaluate results.	PNO	Standards met for minimum of 90% of providers.	01/01/20	12/31/20
	Develop and implement corrective action plans when timely access standards not met.	PNO			
	Report quarterly performance to QIC.	PNO			
	Monitor complaints relating to after-hours availability to ensure that it is communicated for trending and improvement opportunities.	G & A			
Evaluation/Analysis of Interventions:					

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Network Adequacy

Objective #2: Improve Quality of Nonclinical Services **Section: Network Adequacy** **Topic: Network Adequacy**			**Objective Met:**		
Required by: NCQA NET 1; DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Assess and Improve Network Adequacy as demonstrated by availability of practitioners.	Conduct bi-annual ratio analysis and annual Quest Analytics analysis for primary care and high-volume specialties	PNO	Ratios: 1 PCP 1:2000 Total Physicians 1: 1200	01/01/20	12/31/20
	Identify gaps and implement corrective action plan(s).		Physician Supervision to Non-Physician Practitioner Ratios: Nurse Practitioners 1:4 Physician Assistants 1:4		
	Monitor progress toward action plans to maintain or improve GeoAccess standards: Network maintained PCPs.		Network maintained PCP located within 10 miles or 30 minutes from members residence.		
	Monitor progress toward action plans to maintain or improve GeoAccess standards: Network maintained DHCS Core Specialists.		Network maintained DHCS Core specialists located within 30 miles or 60 minutes from members residence.		
	Develop process for network certification (with ratios).		Develop process for network certification (with ratios).		
	Report bi-annual ratio analysis and annual GeoAccess findings to QIC.		Hospitals 15 miles or 30 minutes from members residence		
Evaluation/Analysis of Interventions:					

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Provider Satisfaction

Objective #2: Improve Quality of Nonclinical Services **Section: Provider Satisfaction** **Topic: Provider Satisfaction Survey**			**Objective Met:**		
Required by: GCHP Internal Activity			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Provider Satisfaction Survey	Analyze results and identify opportunities for improvement.	PNO	Development and implementation of action plan to improve.	01/01/20	12/31/20
	Develop and implement interventions as needed to improve rates.				
Evaluation/Analysis of Interventions:					

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Objective 3: Improve Member Safety

Facility Site Monitoring

Objective #3: Improve Member Safety **Section: Facility Site Monitoring** **Topic: Facility Site Monitoring**			**Objective Met:**		
Required by: DHCS; NCQA MED 3			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Maintain Compliance with Facility Site Review (FSR) Requirements	Review FSR database regularly to maintain scheduled visits.	QI	100% on time	01/01/20	12/31/20
	Complete and document Initial, Interim, and Tri-annual Facility Site Reviews timely.				
	Issue and monitor corrective action plans (CAPs) as needed to facilitate clinic compliance and improvement on identified deficiencies.				
	Submit bi-annual reports to DHCS: • 07/30/20 (Jan – June) • 12/31/20 (July – December)				
Complete Physical Accessibility Reviews (PAR)	Compile report for high volume/ancillary specialist visits for Seniors and Persons with Disabilities (SPD) population.	QI	100% on time	01/01/20	12/31/20
	Submit PARS report to DHCS (by 01/31/20)				
	Complete and document PARs for identified provider sites.				
Conduct Facility Site Monitoring to Ensure Safety Practices	Monitor FSR results and deficiencies; track and trend.	QI	100% on time	01/01/20	12/31/20
	Monitor member complaints/grievances and potential quality issues (PQIs) involving quality of care/safety concerns.	G&A/QI			
	Issue CAPS and track improvements as needed				
Evaluation/Analysis of Interventions:					

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Credentialing/Recredentialing

Objective #3: Improve Member Safety **Section: Credentialing/Recredentialing** **Topic: Credentialing/Recredentialing**			**Objective Met:**		
Required by: DHCS, NCQA CR Standards			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Implement a well-defined credentialing and recredentialing process for evaluating and selecting practitioners/providers to provide care to members.	Perform timely verification of all required credentialing elements to ensure current, accurate and complete files for credentialing decisions.	QI	100% on time	01/01/20	12/31/20
	Perform ongoing monitoring of sanctions and adverse events.				
	Perform timely recredentialing (within 36 months of last approval date).				
Evaluation/Analysis of Interventions:					

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Pharmacy

Objective #3: Improve Member Safety **Section: Pharmacy** **Topic: Reduction in Potential Unsafe Opioid Prescriptions**			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Achieve reduction in potential unsafe opioid prescriptions including the following: • Reduction in number of users above 90 mg MEDD • Reduction in total number of opioid users • Reduction in total number of opioid users concurrently using antipsychotics	1. POS Soft Edits for Opioid Doses Above 90 mg MEDD 2. Retrospective Review and Provider Intervention Related to Concurrent Use of Antipsychotics and Opioids	Pharmacy	Reduce 2% from prior year metrics.	01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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Objective 4: Assess and Improve Member Experience

Member Access & Satisfaction

Objective #4: Assess and Improve Member Experience **Section: Member Access & Satisfaction** **Topic: Member Access & Satisfaction**			**Objective Met:**		
Required by: NCQA QI 4; DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Assess Member Access and Satisfaction	Identify opportunities for improvement based on data analysis	QI/MS/G&A/PNO	Development and implementation of action plan to improve.	01/01/20	12/31/20
Assess Member Complaints and Grievances	Conduct annual assessment of complaints and grievances	G&A			
	Identify opportunities for improvement				
	Create and implement action plan for improvement				
Evaluation/Analysis of Interventions:					

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Call Center Monitoring

Objective #4: Assess and Improve Member Experience **Section: Call Center Monitoring** **Topic: Call Center Monitoring**			**Objective Met:**		
Required by: NCQA QI 4; DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Call Center Monitoring	Member Services Telephone Access Analysis • Monitor Average Speed of Answer (ASA) • Monitor Abandonment Rate • Phone Quality Results	Member Services	ASA: 30 seconds or less Abandonment Rate: 5% or less Phone Quality Results: ≥ 95%	01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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Objective 5: Ensure Organizational Oversight of Delegated Activities

Delegation Oversight

Objective #5: Ensure organizational oversight of delegated activities **Section: Delegation Oversight** **Topic: Delegation Oversight of Delegated Activities**			**Objective Met:**		
Required by: NCQA CR 8; QI 5; UM 13; ME 1; DHCS			**Target Completion Date:** Q4 2020		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Completion of Delegation Oversight Delegated Activities: • Credentialing • Quality Improvement • Utilization Management • Members' Rights • Claims	1. Complete audits 2. Issue CAPs as applicable 3. Follow-up on CAPs as applicable 4. Report to Compliance Committee, QIC, and C/PRC	Compliance	100%	01/01/20	12/31/20
Evaluation/Analysis of Interventions:					

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Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

Quality Improvement Committee Report – Q1 2020

Kimberly Timmerman, MHA, CPHQ
Director, Quality Improvement
April 27, 2020

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Quality Improvement Update

- 2020 QI Program Description Updates/Revisions
- 2020 QI Work Plan Updates
- HMS Eliza - Member Outreach Campaigns
- COVID-19 Impacts on Quality Improvement Activities
- Strategy Update

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2020 QI Program Description Updates/Revisions

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Substantive Revisions/Updates
Added reference to Managed Care Accountability Set (MCAS) and CMS Core Set for Medicaid (in addition to HEDIS®)
Updated new roles, titles, reporting relationships and committee representation throughout document to reflect: • Associate Chief Medical Officer • Director of Care Management • Director of Utilization Management • Sr. Director Population Health & Equity
Revised Population Health/Care Management section (by PH/CM business owners)
Aligned QIC Responsibilities with QIC Charter
Delegation of Quality Improvement – enhanced to include actions taken if delegate unable to correct or does not comply with the corrective action plan
Updated content to align with requirements of current GCHP DHCS Contract 10-87128, Exhibit A, Attachment 4
Updated references section

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2020 QI Work Plan Updates

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Objective 1: Improve Quality and Safety of Clinical Care Services

Metrics Added in 2020	Rationale
Childhood Immunization Status – Combo 10	Metric added to DHCS MCAS
Chlamydia Screening	Low Rate; Metric added to DHCS MCAS
Adolescent Well Care*	Low Rate; Metric added to DHCS MCAS
Well Child Visits in the First 15 Months of Life*	Low Rate; Metric added to DHCS MCAS
Developmental Screening	Low Rate; Metric added to DHCS MCAS
Lead Screening in Children	DHCS Statewide Medi-Cal Initiative
Adverse Childhood Experiences Screening (ACES)	DHCS Statewide Medi-Cal Initiative
Adolescent Well Care PIP	New 2019-2021 PIP Cycle
Cervical Cancer Screening Disparity PIP	New 2019-2021 PIP Cycle

*Added in June 2019 after DCHS release of MCAS measures

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Objective 1: Improve Quality and Safety of Clinical Care Services (continued)

Metrics Retained in 2020 Work Plan from 2019	Rationale
Tobacco Cessation	DHCS Monitoring Requirement
Initial Health Assessment (IHA)	DHCS Monitoring Requirement
Asthma Medication Ratio	Low rate; MCAS/HEDIS Measure
Cervical Cancer Screening	Low rate; MCAS/HEDIS Measure
Well Care Exam in the 3rd, 4th, 5th, and 6th Years of Life	Low rate; MCAS/HEDIS Measure

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Objective 1: Improve Quality and Safety of Clinical Care Services (continued)

Metrics Retired in 2020	Rationale
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Removed from DHCS MCAS
Children and Adolescents' Access to Primary Care Practitioners	Removed from DHCS MCAS
Improve Use of Imaging Studies for Low Back Pain	Removed from DHCS MCAS
Childhood Immunization Status – Combo 3	Replaced by Combo 10
Prenatal and Postpartum Care	PPC-Postpartum Rate in 90th Percentile
Annual Monitoring for Patients on Persistent Medications Improvement Project (IP)	2018-2019 IP Cycle Ended
Asthma Medication Ratio Improvement Project (IP)	2018-2019 IP Cycle Ended
Comprehensive Diabetes Care – Medical Attention for Nephropathy Improvement Project (IP)	2018-2019 IP Cycle Ended
Comprehensive Diabetes Care – HbA1c > 9.0 Disparity PIP	2017-2019 PIP Cycle Ended
Childhood Immunization Stats – Combo 3 PIP	2017-2019 PIP Cycle Ended

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Objective 2: Improve Quality of Nonclinical Services

2020 Metrics	Status
Cultural & Linguistic Needs and Preferences: Practitioner Availability Primary & Specialty Care Access After Hours Availability Network Adequacy Provider Satisfaction	No substantive changes

Objective 3: Improve Member Safety

2020 Metrics	Status
Facility Site Monitoring Credentialing/Recredentialing	No substantive changes
Pharmacy: Reduction in Potential Unsafe Opioid Prescriptions	• Removed: Reduction in number of users concurrently using benzodiazepines and prenatal vitamins • Added: Reduction in total number of opioid users concurrently using antipsychotics

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Objective 4: Assess and Improve Member Experience

2020 Metrics	Status
Member Access & Satisfaction	No substantive changes
Call Center Monitoring	Metric Section: • Added: Phone Quality Results ≥ 95%

Objective 5: Ensure Organizational Oversight of Delegated Activities

2020 Metrics	Status
Delegation Oversight of Delegated Activities	No Changes

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Eliza Member Outreach: Educational Campaigns

Status Update:

- ***LAUNCHED*** Antidepressant Medication Adherence – AMM (IVR)
  - Targets members 18 years of age and older who are prescribed antidepressant medication and had a diagnosis of major depression
  - First calls 1/21/2020, Follow-up in 60 days
  - Members get three sets of calls in 2020
  - 523 unique calls, 79% Reachable, 30% Reached (within standard benchmarks)
- ***PENDING DHCS APPROVAL + MONITORING TIMING BASED ON COVID-19 PRIORITIES***
  - Well Baby – W15, CIS, CAP (IVR/SMS)
  - Well Child – CAP, AWC, IMA, W34 (IVR/SMS)
  - Adult Preventive – BCS, CCS, CHL (IVR/SMS)
  - Condition Management – CDC HbA1c (IVR/SMS)
  - Asthma Medication Adherence – AMR (IVR/SMS)

Member barriers captured in IVR responses and forwarded to GCHP Care Management team for follow-up.

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HMS-Eliza Member Outreach Campaigns - Next Steps

- Await final phase of DHCS follow up review/approval of texting initiative/scripts
- Continue AMM Educational IVR Program - Monitor progress/ effectiveness
- Launch Asthma Medication Adherence (AMR) and Comprehensive Diabetes Care (CDC-HbA1c) pending SMS approval by DHCS
  - Both programs will utilize IVR and text messaging
- Assess timing of remaining outreach/interventions based COVID-19 status
- Future state: Evaluate combining effort with DHCS Preventive Care Outreach requirement to achieve efficiencies (timing TBD pending COVID-19 status)

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COVID-19 Impacts on Quality Improvement Activities

- **Facility Site Reviews (FSRs)**
  - DHCS allowing for a delay of FSRs in 30-day increments
  - GCHP required to notify DHCS about requested extensions

- **Initial Health Assessments (IHA) and Staying Healthy Assessment (SHA) Medical Record Audit**
  - DHCS has recognized that healthcare providers may need to delay or cancel routine/non-urgent care
  - The QI team will not be auditing medical records for IHA/SHA compliance until further notice

- **HMS Eliza Telephonic Outreach for Preventive Care Gaps**
  - The preventive gaps in care member outreach IVR calls will be postponed
  - The Antidepressant Medication Management outreach will continue
  - Additional outreach campaigns are pending for Asthma and HbA1c, to encourage management of chronic conditions during quarantine

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COVID-19 Impacts on Quality Improvement Activities

- **Member Incentive Programs: Well-Care and Cervical Cancer Screening**
  - Incentive programs remain available
  - Decreased participation anticipated as providers prioritize COVID-19 care and pause non-urgent preventive care services
  - Delays in processing member gift cards for qualifying visits

- **MCAS/HEDIS Data Collection**
  - Challenges with record collection at non-EMR sites
  - Awaiting DHCS guidance on expectations for MPL achievement
  - NCQA has announced option to use RY 2019 hybrid rates where appropriate

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Quality Strategy Update

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HEDIS®/MCAS Data Collection in Process

- Project close scheduled for 5/4/20
- Final audited rates to be available July 2020

Gaps in Care Outreach/Educational Campaigns

- Educational campaigns (IVR/texting) – chronic conditions/preventive care

Member Incentives

- Well Care Visits Ages 3-21
- Cervical Cancer Screening

Inovalon HEDIS® Software

- Platform Upgrade - Completed
- INDICES Data Visualization/Provider Portal – Go Live Q1-Q2 2020
    - Provider Training Plan under development

Performance Improvement Projects (PIPs): 2019-2021

- Health Equity – Cervical Cancer Screening
- Adolescent Well Care Visits

QI Collaboration Meeting Kick Off – Held 2/26/20

- Next meeting TBD June/July 2020

Recommendation:

Approve the 2020 QI Program Description and 2020 QI Work Plan

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AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: April 27,2020

SUBJECT: Approve a rate revision to the Agreement ("Agreement") with Health Management Associates ("HMA") for the period from March 1, 2020, to June 15, 202.

SUMMARY:

Approve of Rate Reduction for the HMA contract to serve as Interim CEO from March 1- June 15, 2020.

BACKGROUND/DISCUSSION:

At the November 2019, meeting, the Gold Coast Health Plan ("GCHP") Commission ("Commission") appointed Health Management Associates ("HMA") as interim Chief Executive Officer ("CEO") of GCHP.

Since the interim appointment, the global COVID-19 pandemic has necessitated a move to telework for GCHP staff; increased member, provider, and external communications; resulted in daily reporting to the Department of Health Care Services (DHCS); and disrupted or delayed certain planned activities. For example, GCHP had developed a two-year strategic plan that reflected DHCS' vision for its next waiver, CalAIM, which it must revisit as a result of the pandemic and State budget implications from the anticipated recession that the country now faces.

Based upon the emergence of the pandemic and its implications for the State Budget, Medi-Cal, and GCHP, HMA and GCHP have negotiated an additional 10% discount for HMA rates for the period of March 1, 2020, through June 15, 2020. The parties assume June 15, 2020, as the termination date of this agreement based upon the anticipated selection of a new CEO by June 1, 2020, and onboarding of the new CEO by the interim management for the period of June 1 through June 15.

FISCAL IMPACT:

GCHP will realize an additional reduction of 10% from current rates for the period of March 1, 2020, to June 15, 2020.

Comparison of HMA 10% Reduced Rates

Current Professional Hourly Rates	Proposed Professional Hourly Rates
• Managing Principal $385--$450	• Managing Principal $346--$405
• Principal $360--$390	• Principal $324- $351
• Senior Consultant $310	• Senior Consultant $279
• Consultant $210	• Consultant $189
• Research Assistant $160	• Research Assistant $144
• Clerical and Staff Support $95	• Clerical and Staff Support $85

RECOMMENDATION:

Staff recommends that the Commission approve this contract extension with the recommended rates for the period March 1, 2020, through June 15, 2020.

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: April 27, 2020

SUBJECT: February 2020 and March 2020 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached February 2020 and March 2020 fiscal year-to-date (FYTD) financial statements of Gold Coast Health Plan ("Plan") for the Commission to review and approve.

BACKGROUND/DISCUSSION:

The staff has prepared the unaudited February 2020 and March 2020 FYTD financial package, including statements of financial position, statement of revenues and expenses, changes in net assets, and statement of cash flows.

Financial Overview:

The Plan experienced losses last fiscal year in the amount of $56 million, and while the decline in Tangible Net Equity (TNE) has stabilized, we continue to be in a vulnerable position with excess reserves $39.7 million which is 221% of the regulatory required amount. While mindful of the financial position, the Plan remains committed to its mission to provide quality health care to its members. The importance of ensuring we can continue to be a resource to members and providers has never been more important than now, with the onset of the COVID-19 pandemic. While there are variables beyond our control which impact the Plan, we remain focused on areas we can control which include continual process improvements, strong internal controls, and fair and transparent contract negotiations with providers. In the Finance department specifically, we are focused on the following priorities:

1. Accurate reporting and strong documentation. We recently implemented a cloud-based software, FloQast, which will improve the management of the month-end close, eliminate manual processes, and guarantee we are audit-ready every month.
2. Improving the timeline for the financial statement close to allow us to report on a timely basis and ensure adequate time for analysis.

3. Implementing a conservative budget approach which is flexible to reflect the financial implications of changes to membership and unforeseen changes to the Plan.
4. Enhancing the financial forecasting process.
5. Tracking of COVID-19 related expenses for potential reimbursement that the Plan may qualify for under grant or relief programs available from the Federal Emergency Management Agency.

Organizational Expense and Risk Management Strategies

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

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

2. Tighten controls on Administrative Expense:
   a. Open Position Justification – implementation of enhanced documentation requirement for new or open positions prior to hiring approval to fill open positions (regardless of budget status). The documentation must include details and metrics on the impact to workload in addition to any compliance or financial risks of not hiring the position; and
      Tracking the root cause of claims interest and implementing processes to reduce. *Potential Savings - $500,000 annually*

3. Continuous attention to, and enhancement of, the Provider Network Contracting strategy:
   a. Implementation of a preferred provider agreement with Quest, resulting in reduced contract rates and an estimated annual savings of $3.4 million; and
   b. Contract re-negotiations with hospitals which moved stop loss provisions from first to second dollar, improved language related to high cost drugs, transition of percentage of charge reimbursement to contract rates based on the Medi-Cal fee schedule, and limits to annual increase of chargemaster.
      Potential Savings - $3 million annually

4. Enhance Claims Management:
   a. Implementation of contract with Health Management Systems, which will improve identification of claim overpayments and will allow the Plan to obtain recovery dollars for coordination of benefits for both medical and pharmacy expenses (e*stimated potential savings - $1-2 million annually);*
   b. Contract language – tracking areas in which improvement in contract language would prevent errors leading to settlements and interest;

c. Identification of inconsistencies in claims handling to reduce expenses; and
d. Improvement of the Provider Dispute Resolution (PDR) turn-around time to reduce abrasion and costs.*

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

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

**** indicates new initiative.***

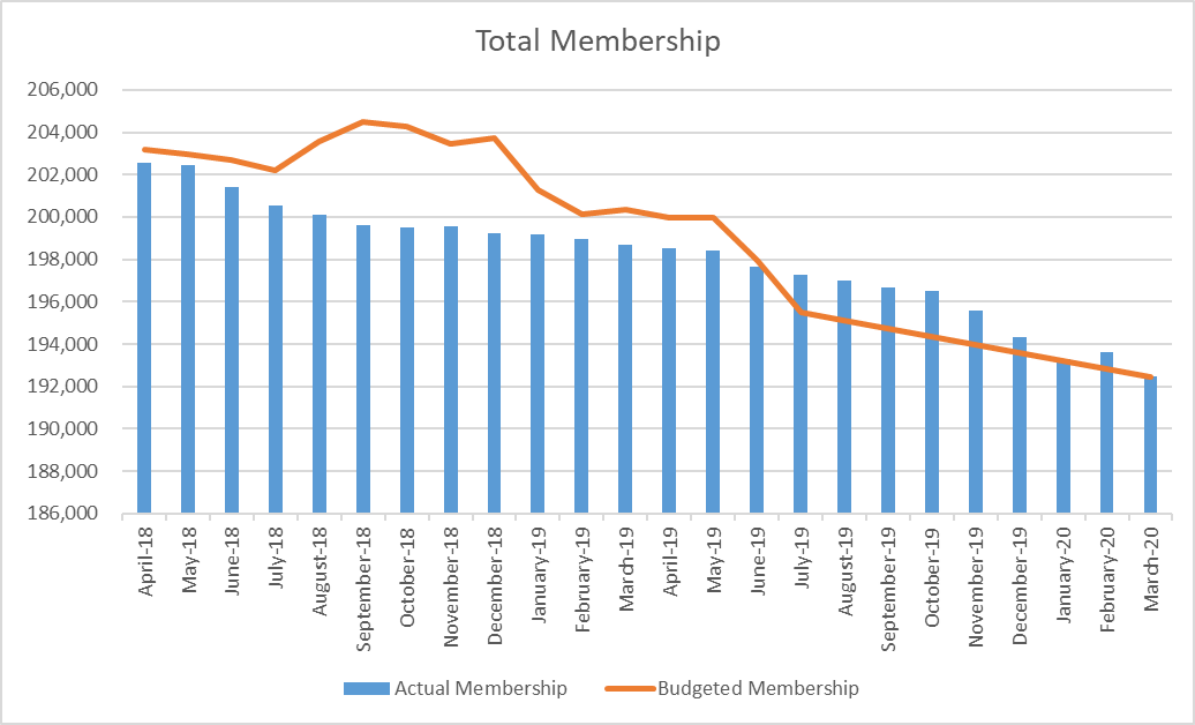
Financial Report:

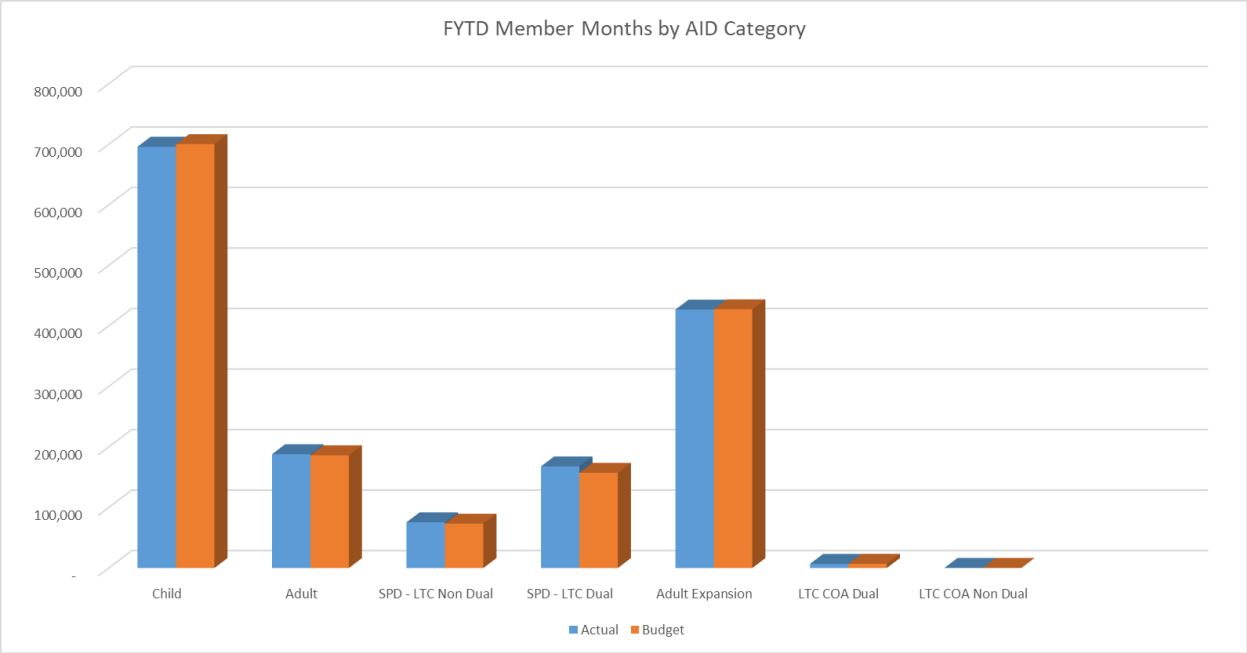
The TNE is $72.6 million; this is 221% of the regulatory required amount, an excess of $39.7 million, The budgeted year end TNE was 280% of the required, and an excess of $60.2 million.

For the months of February 2020 and March 2020, the Plan is reporting net gains of $283,289 and $213,914 respectively.

March 2020 FYTD Highlights

1. Net loss of $3.0 million; a $3.6 million unfavorable year-to-date budget variance.
2. FYTD net revenue is $612.7 million, $28.9 million higher than budget.
3. FYTD Cost of health care is $579.6 million, $39.5 million higher than budget.
4. The medical loss ratio is 94.6% of revenue, which is 2.1% higher than the budget.
5. The administrative cost ratio is 6.2%, 1.3% lower than budget and the actual spend is $6.2 million below budget.
6. Current membership for March is 192,476, which is slightly less than budget but will increase with retroactivity. Member months for the year are at 1,756,777 which 1% greater than budget.
7. Tangible Net Equity is $72.6 million which represents approximately 32 days of operating expenses in reserve and 221% of the required amount by the State.





Revenue

Net Premium revenue is over budget by $28.9 million and 5%. The budget variance is being driven by the following:

1. The aggregate membership is over budget by 1%. Due to the widespread economic impact of COVID-19 there is a resulting rise in unemployment and the

Plan is projecting a growth in membership and will continue to monitor changes in unemployment. For reference, below is historical data that reflects changes in Medi-Cal enrollment following a recession.

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

[1] Source: Department of Health Care Services (DHCS), Research and Analytic Studies Division (RASD), *Medi-Cal Statistical Brief, August 2015*

[2] This increase could also include changes in eligibility so this may not reflect a direct link to the recessionary growth only.

2. Case mix is contributing to both higher revenue and expenses. For example, the number of members in the Child AID category is under budget while the membership in the Seniors and Persons with Disability (SPD) AID categories are over budget. Due to disparities in cost for members in the various AID categories, that Plan is paid a higher capitation rate for those members in the SPD AID category.

3. Due to the increasing risk of the current population in FY19-20, GCHP received revised draft capitation rates from the State which were 1.7% higher than budgeted.

4. Due to increased utilization, supplemental payments for Behavioral Health services are $4.0 million higher than budgeted.

5. Capitation revenue attributable to Proposition 56 and Ground Emergency Transportation Payment (GEMT) are over budget by $7.1 million due to updated rates for the additional programs explained below:

In 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. A portion of this revenue is allocated to DHCS for use as the nonfederal share of health care expenditures. The initial Proposition 56 directed payment was implemented for dates of service in FY 2017-18 with additional amounts being paid to providers with encounter data related to certain CPT codes.

The program was expanded for dates of service beginning July 1, 2019 to include supplemental payments for specified family planning codes and a value-based payment program which requires additional payments for qualifying services related to prenatal/postpartum care, early childhood visits, chronic disease management, and behavioral health integration. The program was further expanded for dates of service beginning January 1, 2020 for developmental screening services and adverse childhood event screening services.

The Plan has continued to make payments under Proposition 56 related to the continued physician services and we will process payments for the new programs once the final All Plan Letters are issued and the Plan receives the appropriate funding from DHCS.

GEMT is a Quality Assurance Fee program which provides for an enhanced reimbursement rate for emergency medical transports by non-contracted providers.

Health Care Costs

FYTD Health care costs are $579.6 million; this equates to a $39.5 million and 7% unfavorable budget variance. In addition, this is an increase of $40.0 million from the prior year.

Notable variances from the budget are as follows:

1. Membership is over budget by 1% which will impact the anticipated medical expenses. This is offset by increased capitation revenue from the State.

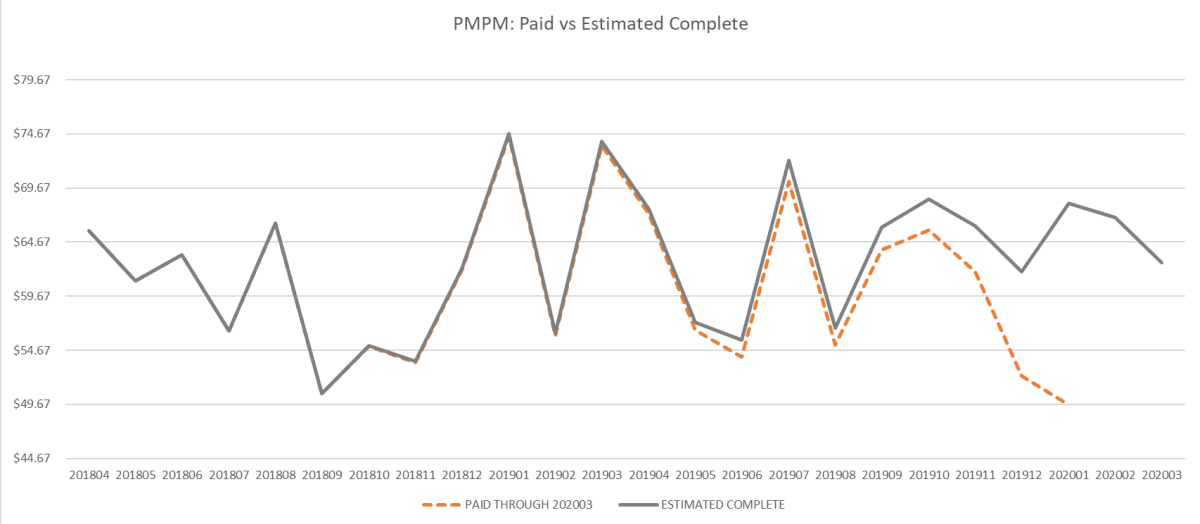
2. Case mix is contributing to both higher revenue and expense, as noted in the Revenue section.

3. The State validated the assertion that as the membership has declined for the current fiscal year, it is the healthier population that is disenrolling which is increasing the overall per member per month costs of the remaining membership. The State gave us an additional 1.7% in the capitation rates to offset this increased expense.

4. Directed payments (for Proposition 56) are over budget by $9.3 million. GCHP is accruing a directed payment expense equal to 100% of the current year revenue attributable to Proposition 56. Approximately $7.1 million of the variance is due to

updated rates from the State. The additional variance is driven by prior year changes in estimate.

5. Inpatient hospital costs are over budget by $10.9 million. Overall, there has been more volatility with high dollar claims. The AID categories with the most significant increases from budget are Adult and Adult Expansion. Acute inpatient admissions per 1,000 members has increased from 54.87 in FY 18-19 to 58.21 in FY 19-20, a 4% increase, and the average cost per admit has increased approximately 5%.



Top 10 Diagnosis - Total Paid	CY 2018	CY 2019	$ Change	% Change
Bacterial infection	$ 20,672,438	$ 21,905,168	$ 1,232,729	6%
Diseases of the heart	$ 7,686,213	$ 8,440,298	$ 754,085	10%
Complications mainly related to pregnan	$ 6,618,730	$ 7,291,445	$ 672,715	10%
Cerebrovascular disease	$ 6,978,965	$ 5,807,967	$ (1,170,998)	-17%
Complications	$ 6,398,625	$ 6,372,159	$ (26,466)	0%
Cancer of lymphatic and hematopoietic t	$ 7,308,956	$ 3,825,545	$ (3,483,411)	-48%
Indications for care in pregnancy; labor;	$ 4,234,013	$ 4,555,715	$ 321,702	8%
Alcohol-related disorders	$ 3,154,103	$ 5,402,008	$ 2,247,905	71%
Hypertension	$ 2,681,458	$ 4,951,212	$ 2,269,754	85%
Fractures	$ 3,472,043	$ 3,688,738	$ 216,695	6%
TOTAL PAID - ALL DIAGNOSIS	$ 139,379,405	$ 153,176,694	$ 13,797,289	10%

6. Outpatient expense is under budget by $2.7 million. There has been a significant decrease in costs due to a hematology oncology clinic which was terminated from the network and an effort to improve contract language which better defines high cost drugs. Costs associated with drugs provided at a facility are categorized to

the facility category of service. The magnitude of the budget variance has decreased in the past couple of months due to claims payments with dates of service back to early 2019.

7. Physician Specialty is over budget by $7.5 million. The primary drivers continue to be dermatology, physical therapy, orthopedic surgery, and physical medicine and rehabilitation. As previously noted, dermatology is beginning to decrease due to a provider termination in November. The increase in physical therapy is primarily related to services being provided to children with developmental disabilities. These children were previously cared for by the Tri-Counties Regional Center but under revisions in Medi-Cal rules these services were transitioned to the Plan. The increase in orthopedic surgery is the result of the Plan's effort to increase access as there had previously been a shortage of orthopedic providers. Physician specialty costs is an area of focus for the Expense and Utilization workgroup.

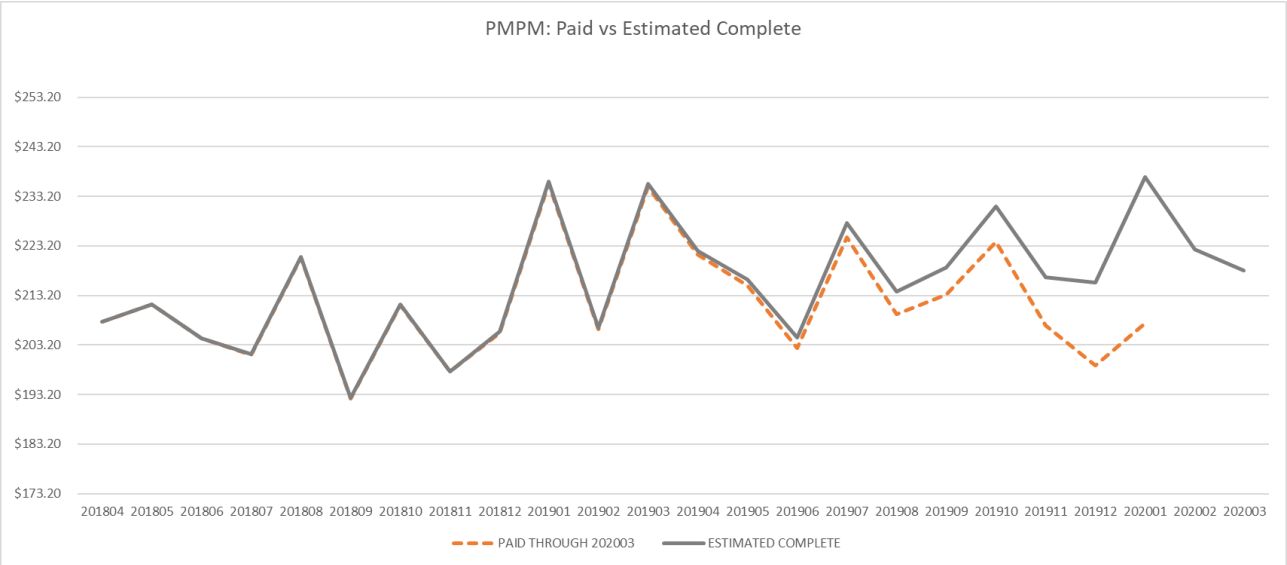
Provider Type	CY 2018	CY 2019	$ Change	% Change
Dermatology	$ 1,626,344	$ 2,722,562	$ 1,096,218	67%
Physical therapist (independently practicing)	$ 2,303,711	$ 3,201,385	$ 897,674	39%
Orthopedic surgery	$ 936,054	$ 1,431,638	$ 495,584	53%
Anesthesiology	$ 4,714,151	$ 5,043,780	$ 329,629	7%
Ophthalmology	$ 2,069,421	$ 2,355,453	$ 286,032	14%
Pathology	$ 1,559,488	$ 1,805,471	$ 245,984	16%
Internal medicine	$ 2,277,397	$ 2,520,296	$ 242,899	11%
Medical oncology	$ 357,969	$ 593,228	$ 235,259	66%
Physician assistant	$ 125,826	$ 335,065	$ 209,239	166%
Pulmonary disease	$ 385,079	$ 583,995	$ 198,915	52%

8. Behavioral and mental health is over budget by $3.7 million. Utilization increased significantly in 2019 with behavioral health benefits for being extended to members that do not have an autism diagnosis. The budget is $8.16 per member per month and the average expense in FY 19-20 $9.95 per member per month, an annualized increase of approximately $3.2 million. The increased cost is offset by supplemental payments from the State for Behavioral Health treatment which is over budget by $4.0 million.

9. Primary Care Physician is over budget by $3.2 million (31%). This is due to a classification issue with the non-PBM pharmacy expenses within the budget. Non-PBM pharmacy expense was budgeted under pharmacy but the expense is being reflected in the Primary Care Physician line item. If properly classified, the budget variance would be $1.1 million (9%). This will be corrected in the coming year's budget process.

10. Pharmacy expense is over budget by $3.8 million and 4% due to increases in both utilization and unit costs (6% excluding the non-PBM pharmacy portion).

11. Total fee for service health care costs excluding capitation and pharmacy, and considering date of service, are over budget by $9.65 PMPM (5%).



Note: Medical expenses are calculated through a predictive model which examines the timing of claims receipt and claims payments. It is referred to as "Incurred But Not Paid" (IBNP) and is a liability on the balance sheet. On the balance sheet, this calculation is a combination of the Incurred But Not Reported and Claims Payable. The total liability is the difference between the estimated costs (the orange line above) and the paid amounts (in grey above).

12. The Plan is closely monitoring for data that would provide information on the potential impact of COVID-19 on medical expenses, both in relation to this current fiscal year and in providing a meaningful projection for next fiscal year in the budget process.

Administrative Expenses

For the fiscal year to date through March, administrative costs were $37.7 million and $6.2 million below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 6.2% versus 7.5% for budget.

The administrative expenses are currently running below amounts allocated to administration in the capitation revenue from the State. In addition, the ratio is comparable to other local initiative health plans.

Cash and Short-Term Investment Portfolio

At March 31st, the Plan had $81.2 million in cash and short-term investments. The investment portfolio included Ventura County Investment Pool $42.6 million; LAIF CA State $200,000; the portfolio yielded a rate of 2.2%.

Medi-Cal Receivable

At March 31st, the Plan had $211.4 million in Medi-Cal Receivables due from the DHCS.

RECOMMENDATION:

Staff recommends that the Commission approve the February 2020 and March 2020 financial package.

ATTACHMENT:

February 2020 and March 2020 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended March 31, 2020

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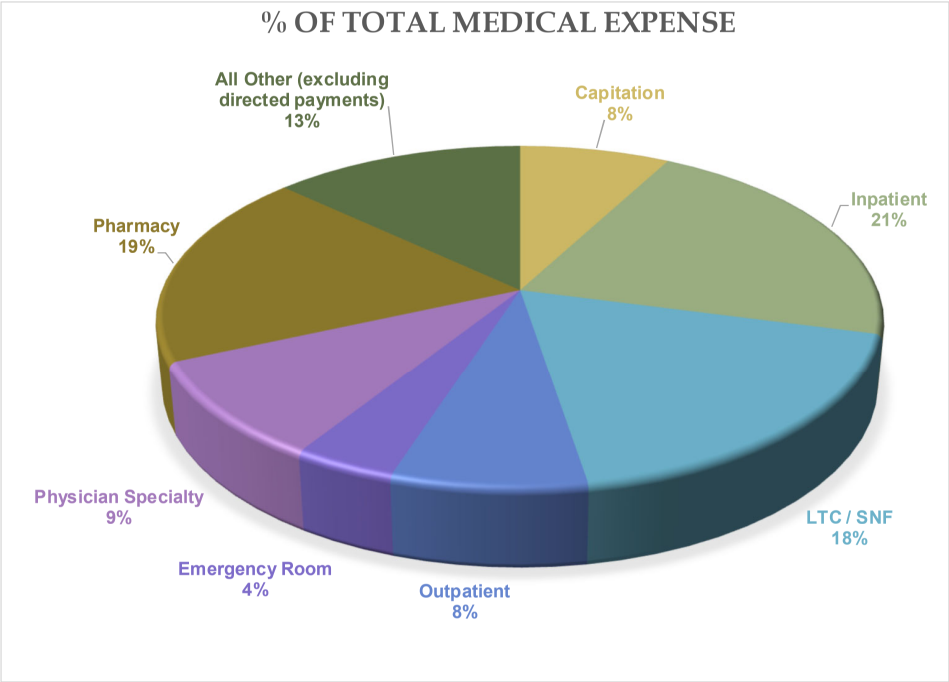
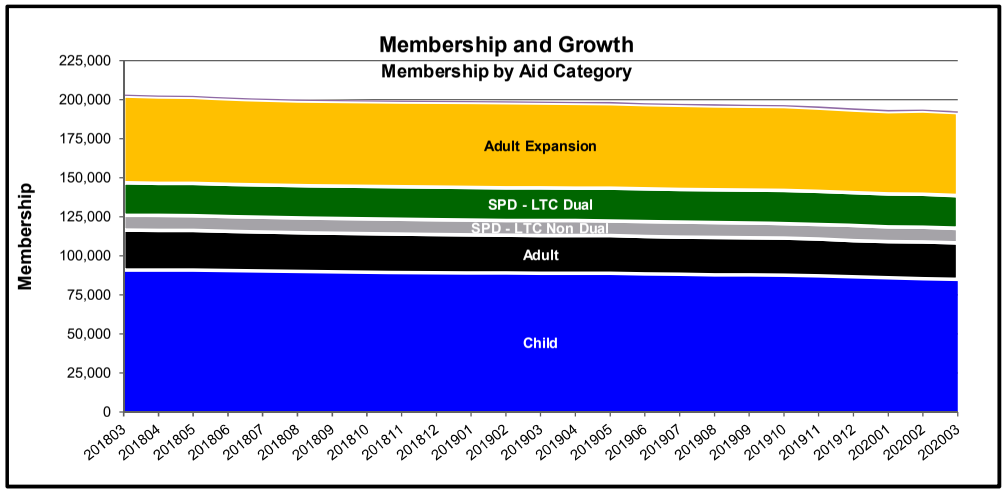
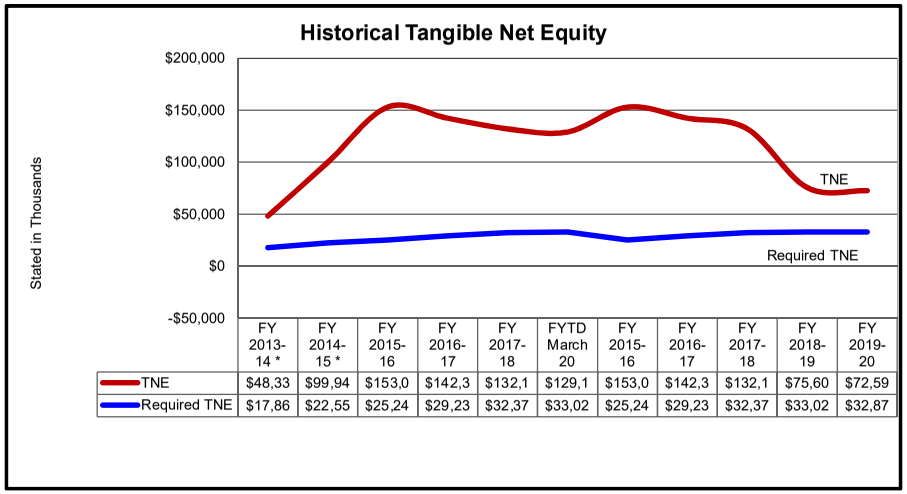
Gold Coast Health Plan

Executive Dashboard as of March 31, 2020

	FYTD 19/20 Budget	FYTD 19/20 Actual	FY 18/19 Actual	FY 17/18 Actual
Average Enrollment	193,982	195,197	198,140	202,748
PMPM Revenue	$ 334.44	$ 348.79	$ 299.23	$ 284.60
Medical Expenses				
Capitation	$ 26.53	$ 24.77	$ 23.90	$ 13.90
Inpatient	$ 61.62	$ 67.41	$ 62.09	$ 58.98
LTC / SNF	$ 57.22	$ 58.10	$ 56.06	$ 51.30
Outpatient	$ 25.68	$ 24.00	$ 25.88	$ 25.74
Emergency Room	$ 11.91	$ 12.67	$ 12.14	$ 12.77
Physician Specialty	$ 25.50	$ 29.64	$ 26.71	$ 23.82
Pharmacy	$ 57.08	$ 58.88	$ 56.60	$ 49.76
All Other *(excluding directed payments)*	$ 36.09	$ 41.46	$ 38.20	$ 32.93
Total Per Member Per Month	$ 301.62	$ 316.92	$ 301.58	$ 269.21
Medical Loss Ratio	92.5%	94.6%	102.0%	95.1%
Total Administrative Expenses	$ 43,919,771	$ 37,690,542	$ 46,655,880	$ 49,015,352
% of Revenue	7.5%	6.2%	6.6%	7.1%
TNE	$ 93,700,000	$ 72,598,903	$ 75,604,948	$ 132,115,371
Required TNE	$ 33,464,286	$ 32,869,733	$ 32,382,791	$ 32,373,536
% of Required	280%	221%	233%	408%







	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FY 2016-17	FY 2017-18	FYTD March 20	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
TNE	$48,33	$99,94	$153,0	$142,3	$132,1	$129,1	$153,0	$142,3	$132,1	$75,60	$72,59
Required TNE	$17,86	$22,55	$25,24	$29,23	$32,37	$33,02	$25,24	$29,23	$32,37	$33,02	$32,87

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STATEMENT OF FINANCIAL POSITION

	03/31/20	02/29/20	01/31/20
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**38,393,376**	**$ 46,955,465**	**$ 23,564,253**
Total Short-Term Investments	**42,824,558**	**42,711,634**	**42,711,621**
Medi-Cal Receivable	211,381,138	196,277,857	177,981,340
Interest Receivable	356,509	394,467	350,024
Provider Receivable	292,569	315,573	368,005
Other Receivables	11,329,670	7,825,513	7,825,511
Total Accounts Receivable	**223,359,885**	**204,813,409**	**186,524,879**
Total Prepaid Accounts	2,239,310	2,253,125	2,220,558
Total Other Current Assets	153,789	153,789	237,891
Total Current Assets	**306,970,918**	**296,887,422**	**255,259,202**
Total Fixed Assets	**1,720,750**	**1,673,700**	**1,714,571**
Total Assets	**$ 308,691,668**	**$ 298,561,122**	**$ 256,973,774**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 54,510,478	$ 56,573,529	$ 51,525,911
Claims Payable	8,092,540	13,069,982	13,008,329
Capitation Payable	21,569,403	24,263,273	26,299,794
Physician Payable	14,404,132	13,455,283	12,058,364
DHCS - Reserve for Capitation Recoup	5,257,358	5,257,358	5,257,358
Accounts Payable	2,453,052	2,216,914	843,995
Accrued ACS	1,641,884	1,775,084	1,520,143
Accrued Provider Reserve	727,999	236,542	21,776
Accrued Pharmacy	19,216,469	11,549,603	12,672,329
Accrued Expenses	30,730,302	28,695,351	753,789
Accrued Premium Tax	74,088,244	65,946,399	57,744,672
Accrued Payroll Expense	2,305,733	2,038,757	2,064,671
Total Current Liabilities	**234,997,594**	**225,078,075**	**183,771,130**
Long-Term Liabilities:			
Other Long-term Liability-Deferred Rent	1,095,171	1,098,058	1,100,945
Total Long-Term Liabilities	**1,095,171**	**1,098,058**	**1,100,945**
Total Liabilities	**236,092,765**	**226,176,133**	**184,872,075**
Net Assets:			
Beginning Net Assets	75,604,948	75,604,947.77	75,604,948
Total Increase / (Decrease in Unrestricted Net Assets)	(3,006,045)	(3,219,959)	(3,503,248)
Total Net Assets	**72,598,903**	**72,384,989**	**72,101,700**
Total Liabilities & Net Assets	**$ 308,691,668**	**$ 298,561,122**	**$ 256,973,774**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR MONTH ENDED March 31, 2020

	Feb 2020	March 2020	March 2020 Year-To-Date		Variance	Variance	March 2020 Year-To-Date		Variance
	Actual	Actual	Actual	Budget	Fav / (Unfav)	%	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	193,603	192,476	1,756,777	1,745,836	10,941	1%	**PMPM - FYTD**		
Revenue									
Premium	76,981,123	$ 73,575,738	$ 686,286,666	$ 583,880,098	$ 102,406,568	18%	$ 390.65	$ 334.44	$ 56.21
Reserve for Cap Requirements	-	-	539,983	-	539,983	0%	0.31	-	0.31
MCO Premium Tax	(8,201,727)	(8,141,845)	(74,088,244)	-	(74,088,244)	0%	(42.17)	-	(42.17)
Total Net Premium	**68,779,397**	**65,433,893**	**612,738,405**	**583,880,098**	**28,858,307**	**5%**	**348.79**	**334.44**	**14.34**
Other Revenue:									
Miscellaneous Income	-	-	10,589	-	10,589	0%	0.01	-	0.01
Total Other Revenue	-	-	10,589	-	10,589	0%	0.01	-	0.01
Total Revenue	**68,779,397**	**65,433,893**	**612,748,994**	**583,880,098**	**28,868,896**	**5%**	**348.79**	**334.44**	**14.35**
Medical Expenses:									
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	3,127,158	1,677,571	43,508,301	46,310,201	2,801,901	6%	24.77	26.53	1.76
FFS Claims Expenses:									
Inpatient	15,369,109	12,506,762	118,420,418	107,577,054	(10,843,364)	-10%	67.41	61.62	(5.79)
LTC / SNF	11,089,364	11,808,212	102,068,104	99,895,492	(2,172,612)	-2%	58.10	57.22	(0.88)
Outpatient	5,342,615	6,246,323	42,156,255	44,837,103	2,680,849	6%	24.00	25.68	1.69
Laboratory and Radiology	168,636	1,010,996	4,291,832	2,981,032	(1,310,800)	-44%	2.44	1.71	(0.74)
Directed Payments - Provider	2,706,027	2,318,705	22,854,819	13,516,070	(9,338,749)	-69%	13.01	7.74	(5.27)
Emergency Room	2,706,365	2,462,016	22,257,524	20,793,732	(1,463,791)	-7%	12.67	11.91	(0.76)
Physician Specialty	4,998,330	5,097,489	52,073,671	44,518,776	(7,554,895)	-17%	29.64	25.50	(4.14)
Primary Care Physician	1,427,574	1,592,289	13,361,358	10,209,405	(3,151,953)	-31%	7.61	5.85	(1.76)
Home & Community Based Services	1,270,530	1,173,926	13,016,318	14,075,649	1,059,331	8%	7.41	8.06	0.65
Applied Behavioral Analysis/Mental Health Servic	1,811,650	1,732,995	17,972,800	14,240,011	(3,732,789)	-26%	10.23	8.16	(2.07)
Pharmacy	11,362,888	10,729,413	103,439,308	99,647,724	(3,791,584)	-4%	58.88	57.08	(1.80)
Provider Reserve	214,767	468,807	409,669	1,353,185	943,516	70%	0.23	0.78	0.54
Other Medical Professional	504,689	169,594	3,095,523	2,851,210	(244,313)	-9%	1.76	1.63	(0.13)
Other Medical Care	1,950	-	29,761	-	(29,761)	0%	0.02	-	(0.02)
Other Fee For Service	871,558	815,691	7,883,454	6,985,841	(897,613)	-13%	4.49	4.00	(0.49)
Transportation	186,327	998	1,219,170	1,267,176	48,006	4%	0.69	0.73	0.03
Total Claims	60,032,379	58,134,216	524,549,984	484,749,462	(39,800,522)	-8%	298.59	277.66	(20.93)
Medical & Care Management Expense	1,131,300	1,111,701	10,751,151	12,074,733	1,323,582	11%	6.12	6.92	0.80
Reinsurance	86,563	278,852	2,098,090	716,503	(1,381,587)	-193%	1.19	0.41	(0.78)
Claims Recoveries/Budget Reduction	(246,374)	(43,636)	(1,299,050)	(3,750,000)	(2,450,950)	65%	(0.74)	(2.15)	(1.41)
Sub-total	971,489	1,346,916	11,550,191	9,041,236	(2,508,955)	-28%	6.57	5.18	(1.40)
Total Cost of Health Care	**64,131,026**	**61,158,703**	**579,608,475**	**540,100,899**	**(39,507,576)**	**-7%**	**329.93**	**309.37**	**(20.56)**
Contribution Margin	**4,648,371**	**4,275,189**	**33,140,519**	**43,779,199**	**(10,638,680)**	**-24%**	**18.86**	**25.08**	**(6.22)**
General & Administrative Expenses:									
Salaries, Wages & Employee Benefits	1,740,245	1,975,396	19,038,271	20,384,717	1,346,446	7%	10.84	11.68	0.84
Training, Conference & Travel	21,558	2,020	170,910	483,867	312,957	65%	0.10	0.28	0.18
Outside Services	2,486,002	2,080,458	18,892,119	20,257,165	1,365,046	7%	10.75	11.60	0.85
Professional Services	418,446	469,599	2,969,097	2,572,230	(396,867)	-15%	1.69	1.47	(0.22)
Occupancy, Supplies, Insurance & Others	764,499	579,029	6,128,060	6,833,623	705,563	10%	3.49	3.91	0.43
Care Management Reclass to Medical	(1,131,300)	(1,111,701)	(10,751,151)	(12,074,733)	(1,323,582)	11%	(6.12)	(6.92)	(0.80)
G&A Expenses	4,299,450	3,994,802	36,447,307	38,456,869	2,009,562	5%	20.75	22.03	1.28
Project Portfolio	156,899	186,279	1,243,235	5,462,902	4,219,666	77%	0.71	3.13	2.42
Total G&A Expenses	**4,456,349**	**4,181,080**	**37,690,542**	**43,919,771**	**6,229,228**	**14%**	**21.45**	**25.16**	**3.70**
Total Operating Gain / (Loss)	**192,022**	**94,109**	**(4,550,023)**	**(140,572)**	**(4,409,451)**	**3137%**	**(2.60)**	**(0.08)**	**(2.52)**
Non Operating									
Revenues - Interest	91,268	119,805	1,543,978	778,507	765,471	98%	0.88	0.45	0.43
Total Non-Operating	91,268	119,805	1,543,978	778,507	765,471	98%	0.88	0.45	0.43
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 283,289**	**$ 213,914**	**$ (3,006,045)**	**$ 637,935**	**$ (3,643,980)**	**-571%**	**$ (1.72)**	**$ 0.37**	**$ (2.08)**

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FYTD PMPM BUDGET TO ACTUAL ANALYSIS - FEE FOR SERVICE BY AID CATEGORY

	Adult				Child				Adult Expansion			
	Budget	Actual	Variance	%	Budget	Actual	Variance	%	Budget	Actual	Variance	%
Inpatient	$ 117.34	$ 134.35	$ 17.01	14%	$ 7.60	$ 5.78	$ (1.82)	-24%	$ 97.75	$ 118.47	$ 20.72	21%
Outpatient	42.23	42.94	0.71	2%	4.69	4.19	(0.50)	-11%	40.44	36.83	(3.61)	-9%
ER	16.73	17.44	0.71	4%	9.46	10.15	0.69	7%	15.48	16.36	0.88	6%
LTC	4.36	11.45	7.09	163%	0.33	0.26	(0.07)	-21%	20.99	21.76	0.77	4%
PCP	9.70	10.35	0.65	7%	5.95	6.49	0.54	9%	6.91	7.60	0.69	10%
Specialty	47.33	55.02	7.69	16%	6.07	6.81	0.74	12%	40.60	46.70	6.10	15%
Pharmacy	79.23	93.83	14.60	18%	12.94	11.71	(1.23)	-10%	99.26	109.35	10.09	10%
Mental Health/ABA	5.06	5.61	0.55	11%	7.19	8.86	1.67	23%	4.97	5.68	0.71	14%
All Other	11.16	12.36	1.20	11%	1.94	2.11	0.17	9%	13.38	13.49	0.11	1%
Total	$ 333.14	$ 383.35	$ 50.21	15%	$ 56.17	$ 56.36	$ 0.19	0%	$ 339.78	$ 376.24	$ 36.46	11%
FYTD Member Months	209,136	211,843	2,707	1%	787,252	782,202	(5,050)	-1%	480,461	480,220	(241)	0%

	Seniors and Persons with Disabilities (SPD)				SPD - Dual				Long Term Care (LTC)			
	Budget	Actual	Variance	%	Budget	Actual	Variance	%	Budget	Actual	Variance	%
Inpatient	$ 316.42	$ 249.48	$ (66.94)	-21%	$ 18.37	$ 18.42	$ 0.05	0%	$ 627.90	$ 1,003.63	$ 375.73	60%
Outpatient	105.41	93.70	(11.71)	-11%	19.78	19.28	(0.50)	-3%	274.05	198.79	(75.26)	-27%
ER	25.15	26.88	1.73	7%	1.74	1.84	0.10	6%	10.46	12.20	1.74	17%
LTC	162.64	136.74	(25.90)	-16%	91.96	86.29	(5.67)	-6%	7,432.23	7,637.47	205.24	3%
PCP	16.39	18.73	2.34	14%	4.58	4.50	(0.08)	-2%	9.22	4.42	(4.80)	-52%
Specialty	83.04	89.40	6.36	8%	17.24	20.21	2.97	17%	172.15	227.64	55.49	32%
Pharmacy	267.46	301.70	34.24	13%	6.06	6.70	0.64	11%	224.42	270.24	45.82	20%
Mental Health/ABA	59.90	74.23	14.33	24%	1.00	1.25	0.25	25%	0.68	3.00	2.32	341%
All Other	82.63	78.08	(4.55)	-6%	56.16	58.78	2.62	5%	135.92	562.30	426.38	314%
Total	$ 1,119.04	$ 1,068.94	$ (50.10)	-4%	$ 216.89	$ 217.27	$ 0.38	0%	$ 8,887.03	$ 9,919.69	$ 1,032.66	12%
FYTD Member Months	82,482	85,036	2,554	3%	176,921	189,459	12,538	7%	225	330	105	47%

	LTC - Dual			
	Budget	Actual	Variance	%
Inpatient	$ 46.38	$ 33.57	$ (12.81)	-28%
Outpatient	14.36	9.61	(4.75)	-33%
ER	1.83	0.31	(1.52)	-83%
LTC	7,314.95	7,321.74	6.79	0%
PCP	0.96	0.26	(0.70)	-73%
Specialty	13.52	7.96	(5.56)	-41%
Pharmacy	1.30	0.37	(0.93)	-72%
Mental Health/ABA	0.25	0.70	0.45	180%
All Other	132.42	145.17	12.75	10%
Total	$ 7,525.97	$ 7,519.69	$ (6.28)	0%
FYTD Member Months	7,830	7,687	(143)	-2%

FFS expenses budgeted based on CY 2018 PMPM data, with the following trend assumptions:

Inpatient - 1% annual trend and known contractual changes.
ER - 1.5% annual trend and known contractual changes.
LTC - 3% estimated fee schedule change
Specialty Physician - 1% estimated fee schedule change
Mental Health/ABA - 6% annual increase due to utilization.
Pharmacy - 3% overall annual increase.
Home and Community Based Services - 2% annualized increase due to utilization.

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STATEMENT OF CASH FLOWS	Feb 2020	Mar-20	FYTD 19-20
Cash Flows Provided By Operating Activities			
Net Income (Loss)	283,289	$ 213,914	$ (3,006,045)
Adjustments to reconciled net income to net cash provided by operating activities			
Depreciation on fixed assets	40,872	43,462	335,393
Amortization of discounts and premium	-	-	-
Changes in Operating Assets and Liabilites			-
Accounts Receivable	(18,288,530)	(18,546,476)	(143,600,682)
Prepaid Expenses	51,534	13,816	(195,239)
Accrued Expense and Accounts Payable	28,632,662	10,560,302	20,859,527
Claims Payable	(577,948)	(6,722,464)	(1,927,123)
MCO Tax liablity	8,201,727	8,141,845	50,461,998
IBNR	5,047,618	(2,063,051)	2,752,566
Net Cash Provided by (Used in) Operating Activities	23,391,224	(8,358,652)	(74,319,605)
Cash Flow Provided By Investing Activities			
Proceeds from Restricted Cash & Other Assets			
Proceeds from Investments	-	-	4,970,286
Purchase of Investments plus Interest reinvested	(13)	(112,924)	(833,245)
Purchase of Property and Equipment	-	(90,513)	(388,373)
Net Cash (Used In) Provided by Investing Activities	(13)	(203,437)	3,748,668
Increase/(Decrease) in Cash and Cash Equivalents	23,391,211	(8,562,089)	(70,570,937)
Cash and Cash Equivalents, Beginning of Period	23,564,253	46,955,465	108,964,313
Cash and Cash Equivalents, End of Period	46,955,465	38,393,375.64	38,393,376

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Margaret Tatar, Interim Chief Executive Officer

DATE: April 27, 2020

SUBJECT: Chief Executive Officer Report

CEO SUMMARY: Verbal Update.

Government and Community Relations Update

Congressional Legislative Package in Response to COVID-19
Over the last month, Congress passed three COVID-19 funding packages via a phased approach. Below are the major highlights from each package:

- Phase I: The Coronavirus Preparedness and Response Supplemental Appropriations Act was enacted into law on March 6 and provided $8.3 billion in emergency funding to treat and prevent the spread of COVID-19 through ensuring vaccines developed to fight the coronavirus are affordable, additionally impacted small businesses can qualify for Small Business Administration Economic Injury Disaster Loans, and Medicare recipients can consult with their providers by telephone or teleconference.

- Phase II: The Families First Coronavirus Response Act, became law on March 18. This act provided for a $100 billion package that includes provisions for paid sick leave, free coronavirus testing, expanded food assistance, and additional unemployment benefits.

- Phase III: The Coronavirus Aid, Relief, and Economic Security (CARES) Act was enacted on March 27. The CARES Act provides an estimated $2 trillion stimulus package to battle the harmful effects of the COVID-19 pandemic. Some of the major components of the CARES Act include:

    - Creates a $150 billion Coronavirus Relief Fund for state, local and tribal governments.

    - $30 billion for an Education Stabilization Fund for states, school districts and institutions of higher education for costs related to the coronavirus.

    - $45 billion for the Disaster Relief Fund for the immediate needs of state, local, tribal and territorial governments to protect citizens and help them respond and recover from the overwhelming effects of COVID-19.

- $4.3 billion, through the Centers for Disease Control and Prevention (CDC), to support federal, state and local public health agencies to prevent, prepare for and respond to the coronavirus.

- Expanding unemployment insurance from three to four months and provides temporary unemployment compensation of $600 per week.

- $1,200 direct payments to many Americans and $500 for each dependent child.

On April 21, the U.S. Senate approved a roughly $484 billion deal that includes increasing funds for a popular small business loan program that ran out of money last week as businesses scrambled for a lifeline during the coronavirus pandemic. The bill includes $310 billion for the now-depleted Paycheck Protection Program. The House isn't expected to take up the measure until April 23.

The federal stimulus will provide considerable help to California. However, given the magnitude of the impact that the COVID-19 crisis will have on the state's economy, additional relief is needed. On April 8, Governor Newsom wrote to House Speaker, Nancy Pelosi, asking for $1 trillion in direct and flexible relief be provided to states and local governments in the next federal stimulus bill.

California Legislative Update

Earlier this month, the Senate Pro Tempore, Toni Atkins, and Assembly Speaker, Anthony Rendon, indicated that each house is in the process of finalizing preparations to hold informational hearings, in the coming weeks, focusing on the state's COVID-19 spending. The Senate Pro Tempore announced the creation of a special committee on California's COVID-19 emergency response. The Special Committee on Pandemic Emergency Response, a bipartisan committee of 11 senators (one of them being our own Senator Hannah-Beth Jackson), has been tasked with reviewing the state's response to the COVID-19 health crisis – what has gone right and what could be improved. The committee will also make recommendations for future preparedness if the coronavirus returns later in the year or if the state faces a subsequent pandemic.

In addition, Assemblymember Phil Ting, the Chair of the Assembly Budget Committee, confirmed the state will adopt a "workload budget" to meet the June 15 constitutional deadline to adopt a budget. Normally, budget subcommittees would already be meeting to consider proposals for new spending from the Administration. In a letter to his colleagues, Assemblymember Ting confirmed that the June budget would include no new spending that was not related to the state's response to COVID-19, wildfire prevention, and homelessness.

Assemblymember Ting went on to explain that once the extended July 15 filing deadline for personal income taxes passes, the Governor and the Legislature will have a reliable understanding of the state's revenue shortfall and will then revisit the budget in an August Revision. As of now, rough estimates predict that the state could lose anywhere from $8 to $20 billion of revenue due to economic turmoil caused by COVID-19. Reflecting this,

Assemblymember Ting warned that the state would likely need to consider sizeable ongoing reductions to major programs in August.

While the state is facing a financial challenge, it does so with roughly $19.2 billion in reserves. Much of this money could be appropriated when the Legislature adopts its June budget. As we noted, the CARES Act is expected to provide $25 billion to California which includes payments to the state, local governments, and direct payments to individuals and businesses. The state will receive $8.4 billion of this from the Corona Virus Relief Fund for healthcare response actions.

For a further breakdown of the CARES Act funding see the section below.

Special Senate Budget and Fiscal Review Subcommittee on COVID-19 Response

On April 16, the Special Senate Budget and Fiscal Review Subcommittee on COVID-19 Response held an informational hearing. The hearing focused on how the money appropriated by the Legislature was being used by the Governor. Senators also asked questions regarding the impact of the current recession and how the Administration was positioning itself to deal with the economic downturn. Experts from the Legislative Analyst's Office (LAO), the California Department of Finance, and the California Budget and Policy Center testified and provided great insight.

From a budget perspective, the following actions were taken by the Legislature:

- The Legislature pass SB 89, which appropriated up to $1 billion for any purpose related to the March 4 proclamation of a state emergency related to COVID-19.

- The Governor transferred $1.3 billion to the Disaster Response Emergency Operations Account (DREOA), bringing its balance to $1.4 billion. The DREOA is the source of funds that the Administration uses to quickly respond to emergencies. This account is within the Special Fund for Economic Emergencies.

- Through the Executive Order in which the Governor announced the DREOA transfer, he stipulated that he would utilize these funds and any other legally available state funds to help address the COVID-19 emergency. Making it clear that, if needed, the Governor will use emergency powers to spend above the current balance of the DREOA.

The LAO made it clear that due to job loss and abrupt halting of economic activity, California has entered an economic recession. The LAO then provided two plausible recession scenarios:

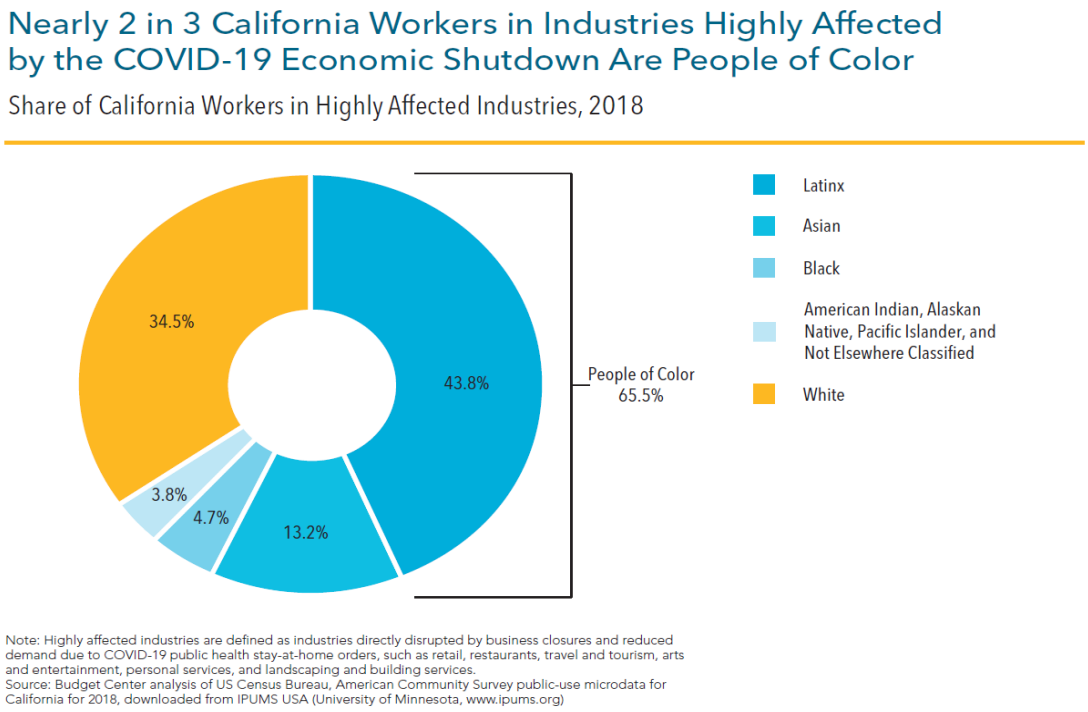
- This recession could occur in a U-Shape. Meaning it would have sharp downturn with depressed level of activity persisting for some period, followed by a pronounced recovery. This was depicted as a best-case scenario.

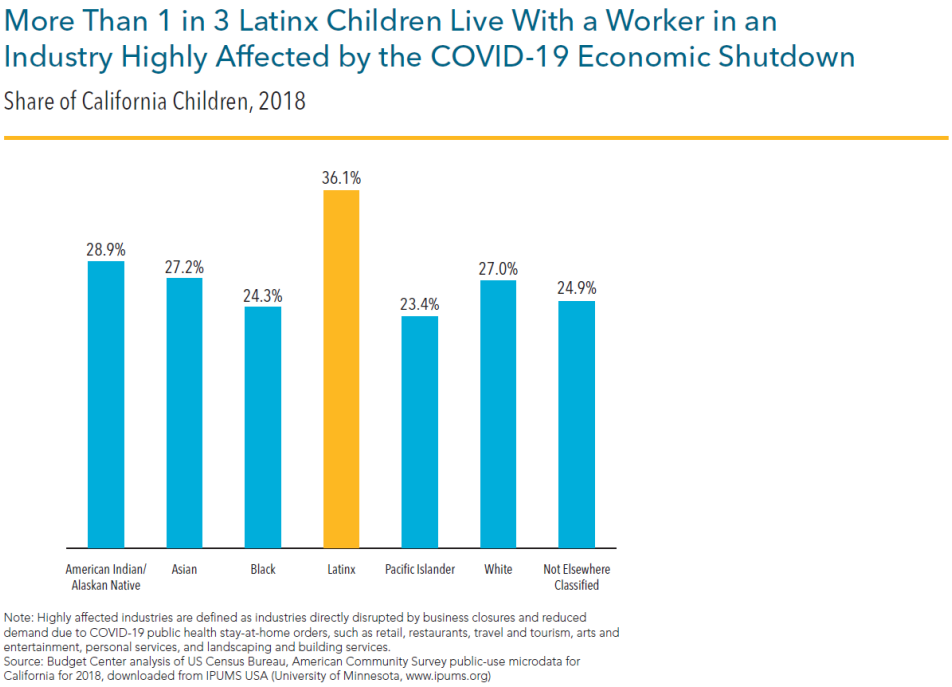
- This recession could also occur in an L-Shape. Meaning it would have a sharp downturn, slow resolution to the virus, and inadequate federal fiscal stimulus leading to a protracted recession with high unemployment rates. This was the worst of the two scenarios.

Per the LAO, which shape the recovery takes depended on the trajectory of the virus itself. According to the Department of Finance, the recession predictions made last year accounted for about $70 billion loss in revenue over a three-year period with an estimated unemployment rate of 9%. The 2008 recession accounted for an unemployment rate of about 12%. This recession is expected to supersede the 2008 unemployment rate.

In order to minimize budget cuts to vital programs, the LAO reminded the Legislature that the State can: (1) take loans from other special funds, (2) use deferrals – essentially shifting payments to a later date, (3) shift funds from one program to another, and (4) ask for assistance from the Federal Government. Federal assistance will be key for California to mitigate the impacts of the recession.

Finally, the California Budget and Policy Center, highlighted how the hardest hit in this recession will be California workers with less education, people of color and immigrants. See the graphs below for further information.





This was the first of several hearings that will take place as the final budget is passed by June 15. More information to come once the May Revise is released in the coming weeks.

Community Relations Update

Gold Coast Health Plan (GCHP) in the Community

In the last month, GCHP awarded sponsorships to the following organizations:

- **Turning Point Foundation:** A sponsorship was awarded to their annual fundraising event, “2020 Mardi Gras Party & Fundraiser.” GCHP’s sponsorship will directly fund the homeless housing program.
- **Soroptimist International of Oxnard:** A sponsorship was awarded to their annual fundraising event, “Stop Human Trafficking and Sexual Slavery.” Proceeds of the event will support victims with programs for social and economic empowerment.
- **Diversity Collective Ventura County:** A sponsorship was awarded to their annual fundraising event, “AIDS Walk Ventura County.” Proceeds of the event will support HIV and AIDS education and prevention programs.
- **Secure Beginnings:** A sponsorship was awarded to the “Free Diaper Bank.” GCHP’s sponsorship will directly fund diapers and wipes for children in Ventura County. The organization reported an increase in community participation since the start of COVID-19 pandemic due to unemployment.

- **Students for Eco-Education and Agriculture (SEEAG):** A sponsorship was awarded to their "Ventura County Child Wellness Initiative." Proceeds will support a county-wide nutrition program for children as well as distance learning during the COVID-19 pandemic.
- **Food Share:** A sponsorship of $5,000 was awarded to Food Share in response to the COVID-19 pandemic. Addressing food insecurity during the COVID-19 pandemic has become a focal point with the Governor and his Administration, state elected officials, and communities across the state including Ventura County.

  In response to the pandemic, Food Share has set up pop-up pantries across the county. Ventura County residents facing food insecurity are able to pick up a box of non-perishable foods and one or two bags of produce at the pop-up pantries. Food Share is currently serving 75,000 individuals on a monthly basis. In addition, Food Share is building 55,000 emergency food boxes with enough groceries to feed a family of four for three days.

  The $5,000 sponsorship will buy 263 boxes of food that will feed more than 1,000 individuals in our community.

In addition, individual GCHP staff members have contributed to many COVID-related causes, including contributions of hundreds of hand moisturizers for the brave clinicians risking their lives to care for patients suffering from COVID-19.

Collaborative Meetings and Conferences

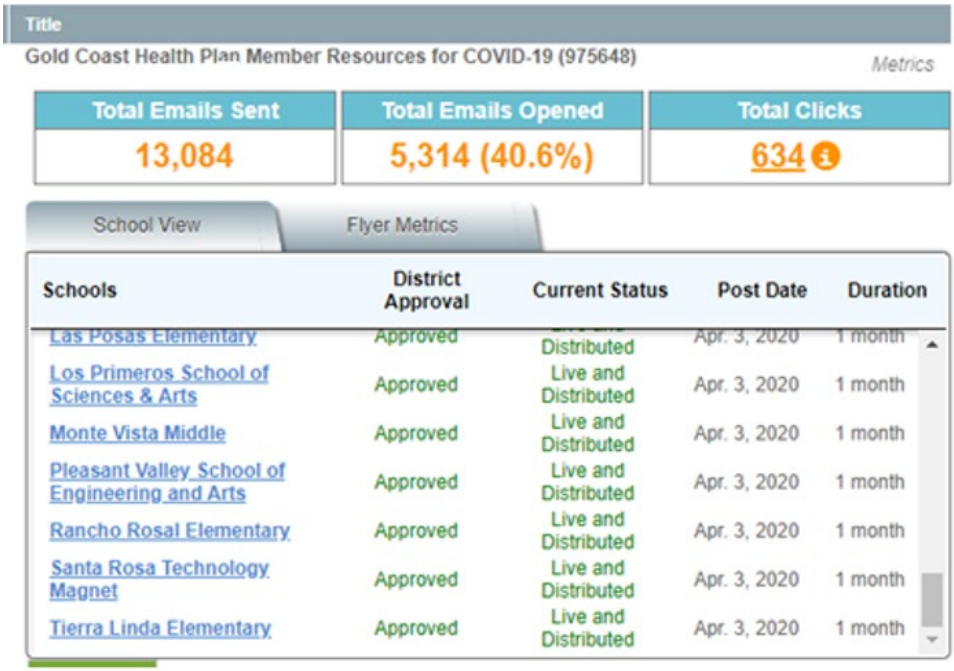
Below is a table highlighting participation in community events such as Tele-Townhalls, network and coalition meetings.

Title	***Host***
Southwinds Collaborative Meeting	Southwinds Neighborhood Council
Oxnard Navigation Center Community Town Hall	City of Oxnard
Community Conversation on Aging Santa Paula	Ventura County Area Agency on Aging & City of Santa Paula
Ventura County Networking Meeting	Dignity Health
Outreach Coordinator Meeting	Oxnard Police Department
Circle of Care	One Step a la Vez
SEEAG Collaborative Meeting	Students for Eco-Education and Agriculture
Building Healthy Communities	Ventura County Office of Education
COVID-19 Teleconference Town Hall: Support for Workers	Assemblymember Monique Limón, Senator Hannah Beth Jackson and Congressman Salud Carbajal
COVID-19 Teleconference Town Hall: Support for Older Adults, Their Families, and Caregivers	Assemblymember Monique Limón, Senator Hannah Beth Jackson and Congressman Salud Carbajal

COVID-19 Community Engagement Efforts

The Community Relations team is working with community partners to provide the community with GCHP resources. More than 100 community-based organizations received GCHP's member FAQs and Covid-19 Member Resources flyer. Partners, such as the Ventura County Health Care Agency, Community Action of Ventura County and MICOP, shared the information via their social media. In addition, the team used the Oxnard and Pleasant Valley school districts' information distribution application, "Peachjar," to send the flyer out to parents.

Below you can see the metrics of member resources for COVID-19 distribution at various school sites.



Title

Gold Coast Health Plan Member Resources for COVID-19 (975648)

Metrics

Total Emails Sent	Total Emails Opened	Total Clicks
13,084	5,314 (40.6%)	634

School View | Flyer Metrics

Schools	District Approval	Current Status	Post Date	Duration
Las Posas Elementary	Approved	Distributed	Apr. 3, 2020	1 month
Los Primeros School of Sciences & Arts	Approved	Live and Distributed	Apr. 3, 2020	1 month
Monte Vista Middle	Approved	Live and Distributed	Apr. 3, 2020	1 month
Pleasant Valley School of Engineering and Arts	Approved	Live and Distributed	Apr. 3, 2020	1 month
Rancho Rosal Elementary	Approved	Live and Distributed	Apr. 3, 2020	1 month
Santa Rosa Technology Magnet	Approved	Live and Distributed	Apr. 3, 2020	1 month
Tierra Linda Elementary	Approved	Live and Distributed	Apr. 3, 2020	1 month

Farmworker Community

GCHP is working with vulnerable populations, like the farmworker community, to provide support through education, resources, and accessibility to health care services. The Community Relations team partnered with the Ventura County Farmworker Resource Program, Reiter Affiliated Companies, and Good Farms to inform and distribute GCHP's COVID-19 Member Resources flyer. Grower companies distributed the flyer along with paychecks. The Farmworker Resource Program shared the flyer on their social media platforms and distributed it during outreach efforts. In addition, the team is targeting communities with high farmworker populations, such as the Southwinds neighborhood in Oxnard. During the food distribution in the neighborhood, residents will be provided with GCHP resource materials.

The Homeless Population

In previous months, the Community Relations team was joining the Ventura County Health Care Agency's Backpack Medicine team. The team was focused on connecting GCHP members with important resources and information about GCHP's benefits. Even though staff is not going out with the Backpack Medicine team due to the stay-at-home order, they continue to share information so it can relayed those experiencing homelessness.

Community Action of Ventura County also is providing information on GCHP's resources to those experiencing homelessness that they serve.

The Nursing Home Eligible Population

GCHP is pleased to have had the opportunity to work with the providers of Community-Based Adult Services (CBAS) in Ventura County and the state Department of Health Care Services (DHCS) to modify the CBAS benefit so GCHP's most vulnerable members could continue to receive services. The goal was to keep the 900 GCHP members who are currently receiving CBAS services in their homes and out of nursing homes. GCHP's effort to modify the CBAS benefit has led to DHCS' adoption of thepolicy statewide. GCHPis grateful to the local CBAS community for this important collaboration.

Future Efforts in Response to COVID-19

In collaboration with GCHP's Decision Support Services team, the cities with the highest density of members were identified:

MEMCITY	Total
Oxnard	80,025
Simi Valley	12,402
Santa Paula	11,988

The Community Relations team is working on developing strategies to engage members – especially those who are vulnerable – in these cities. The team is forming partnerships with community-based organizations to assist with these efforts. More information will be shared at the May Commission meeting.

Compliance Update

DHCS Annual Medical Audit

The DHCS Audits and Investigation (A&I) team conducted the annual medical audit on June 3-7, 2019. GCHP staff received the final report from A&I on September 13. GCHP submitted its Corrective Action Plan (CAP) responses to DHCS on October 14 and they are currently under review. GCHP's goal is to resolve the findings in a timely manner. GCHP will continue to keep the commission apprised.

Due to the COVID-19 pandemic, GCHP has requested that this year's medical audit be moved from June to August. A&I has acknowledged the request and will be reaching out to GCHP as the August date approaches.

Joint Legislative Audit Committee (JLAC) Audit

As previously reported, JLAC released its final audit report on August 15. The report had two recommendations:

1) To ensure that the public clearly understands the commission's decisions, the commission should report its' reasoning for awarding contracts or the legal basis, if any, for choosing not to do so.

2) To ensure that it addresses any significant performance issues by its' contractors in a timely manner, Gold Coast should establish a process to immediately require contractors to take necessary corrective action to resolve issues and ensure that they do not recur.

GCHP is required to respond in 60 days, again in six months, and for the final time in one year, about the steps it took to implement the recommendations that are within statutory authority. Per JLAC's direction, the response included timelines and specifies who the responsible party is for implementing the recommendations. GCHP submitted the response to JLAC on October 14 with both items classified as partially implemented.

1. For item one, a policy and procedure tailored towards the commission was approved at the October 28 Commission meeting.

2. For item two, a policy and procedure specific to Pharmacy Benefit Manager oversight was submitted to JLAC for review. Concurrently the policy was also submitted to DHCS for review and approval as it encompasses elements of GCHP's DHCS contract requirements. Once approved by DHCS, JLAC will consider it implemented. GCHP will continue to update the commission on this item.

   April 2020 – On April 1, GCHP received confirmation that the corrective action is fully implemented and the audit is closed.

DHCS Contract Amendments

The draft DHCS contract amendment has included multiple revisions based on review by the Centers for Medicare and Medicaid Services (CMS) review. The amendment is still pending approval by CMS. GCHP is awaiting the final amendment for signature. 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. GCHP is audited by DHCS in accordance with those standards.

January 2020 – On January 13, following the Commission's approval, GCHP submitted the signed contract amendment to DHCS. GCHP is awaiting the final signed contract amendment from DHCS. GCHP will update the Commission on the status.

February 2020 – There is no new information. GCHP will update the Commission when new information is available.

April 2020 – There is no new information. GCHP will update the Commission when new information is available.

Delegation Oversight

Delegate	Audit Year/Type	Audit Status	Date CAP Issued	Date CAP Closed	Notes
Conduent	2017 Annual Claims Audit	Open	12/28/2017		Issue will not be resolved until new claims platform conversion
Kaiser	2018 Annual Claims Audit	Closed	9/23/2018	05/24/2019	
Conduent	2018 Annual Claims Audit	Open	6/20/2018	Under CAP	Pending ongoing monitoring
Beacon Health Options	2018 Annual Claims Audit	Closed	6/26/2018	11/14/2019	
Beacon Health Options	2018 6 month Claims (focused) Audit	Closed	11/21/2018	11/14/2019	

Clinicas del Camino Real, Inc.	2018 Annual Claims Audit	Closed	12/28/2018	02/18/2020	
Cedars	2019 Annual Credentialing	Closed	7/11/2019	11/27/2019	
Children's Hospital	2019 Annual Credentialing	Closed	7/16/2019	10/29/2019	
City of Hope	2019 Annual Credentialing	Closed	6/10/2019	10/29/2019	
Optum	2019 Annual Audit (C&L, FWA, HIPAA, UM, Credentialing)	Closed	3/4/2019	12/11/2019	
Kaiser	2019 Annual Claims Audit	Open	9/23/2019	Under CAP	
Beacon Health Options	2019 Annual Call Center Audit	Open	5/23/2019	Under CAP	
VTS	2019 Annual Call Center Audit	Open	4/26/2019	Under CAP	
CDCR	2019 Concurrent UM Quarterly Audit	Closed	8/29/2019	N/A (CAP not issued)	
Beacon Health Options	2019 Concurrent UM Quarterly Audit	Closed	10/11/2019	11/15/2019	
VSP	2019 Annual Claims Audit	Open	10/29/2019	Under CAP	
Conduent	2019 Call Center Audit	Open	1/14/2020	Under CAP	
Conduent	2019 Annual Claims Audit	Open	Pending	Pending	
VTS	2019 Annual Transportation Audit	Open	1/17/2020	Pending	

GCHP is contractually required to perform oversight of all functions delegated through subcontracting arrangements. Oversight includes, but is not limited to:

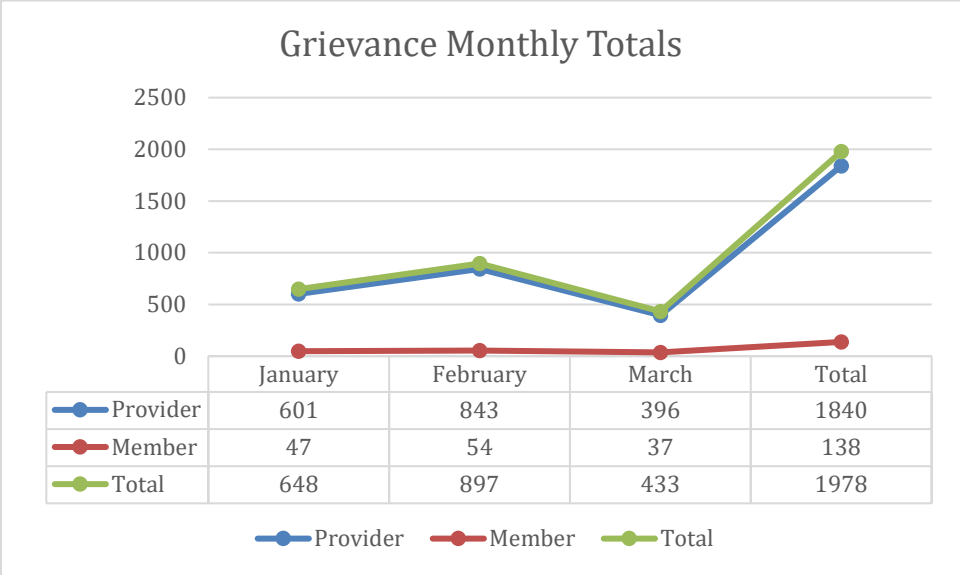
- Monitoring / reviewing routine submissions from subcontractors
- Conducting onsite audits
- Issuing a CAP when deficiencies are identified

**Ongoing monitoring denotes delegate is not making progress on a CAP issued and/or audit results were unsatisfactory and GCHP is required to monitor the delegate closely as it is a risk to GCHP when delegates are unable to comply.*

Compliance will continue to monitor all CAPs. GCHP's goal is to ensure compliance is achieved and sustained by its delegates. It is a DHCS requirement for GCHP to hold all delegates accountable. The oversight activities conducted by GCHP are evaluated during the annual DHCS medical audit. DHCS auditors review GCHP's policies and procedures, audit tools, audit methodology, and audits conducted and corrective plans issued by GCHP during the audit period. DHCS continues to emphasize the high level of responsibility plans have in oversight of delegates.

Grievance and Appeals

Grievance First Quarter Monthly Totals:



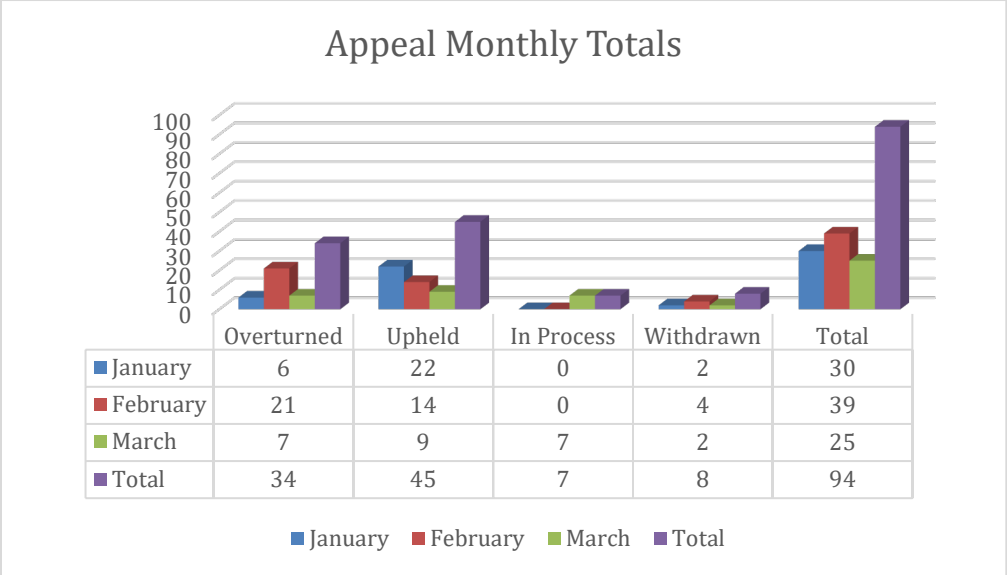
	January	February	March	Total
Provider	601	843	396	1840
Member	47	54	37	138
Total	648	897	433	1978

In the first quarter of 2019, GCHP received a total of 71 member grievances reported. The member grievance analysis showed a significant increase in the first quarter of 2020, with 138 cases. The top three categories were quality of care, transportation and billing.

In the first quarter of 2019, there were a total of 644 provider grievances. In the first quarter of 2020, there is a significant increase, with 1,840 cases. The top categories included claims appeal, claims payment, and claims billing dispute. The increase is due in part to a one provider requesting an additional review of its claims.

Overall, the Grievance and Appeals results show a continuous increase in the cases being received from year-to-year. The growth in member grievances is warranted to ensure GCHP is capturing the experiences of members as they navigate the system. This information is useful to GCHP in order to make the necessary changes for improvement.

Clinical Appeal Monthly Yearly Comparison



	Overturned	Upheld	In Process	Withdrawn	Total
January	6	22	0	2	30
February	21	14	0	4	39
March	7	9	7	2	25
Total	34	45	7	8	94

In the first quarter of 2020, Grievance and Appeals received 94 clinical appeals, which is comparable to last year's total of 100. Of the 94 clinical appeals, 34 were overturned, 45 were upheld, and eight were withdrawn.

COVID-19 Information

Grievance and Appeals received a directive from DHCS (it came from CMS initially), that requires health plans to advise all members that they have an additional 120 days to file a state hearing during the COVID-19 pandemic. Grievance and Appeals has prepared verbiage to add to all Notice of Appeals Resolution (NAR) letters to inform members of the temporary change.

AmericasHealth Plan

Gold Coast Health Plan (GCHP) has reviewed all DHCS requirements for submission of the Plan-to-Plan Proposal with AmericasHealth Plan (AHP). The submission packet for DHCS includes a revised Plan-to-Plan Proposal from GCHP that incorporates the state's requirements for the possible enrollment of all members. It also includes a revised Boilerplate Agreement which meets the state's requirements and follows new guidance that was issued after the document's previous submission in August.

GCHP rewrote the Plan-to-Plan Proposal, Boilerplate Agreement and respective Division of Responsibilities documents. GCHP and AHP leadership have been meeting weekly for more than a month. As of today, both entities agree on all document revisions.

GCHP will present the revised documents to the Commission for approval prior to submitting them to DHCS for final approval. If DHCS makes any changes, the Commission and AHP will have to approve those changes.

Network Operations

- **COVID-19 Provider Network Outreach**
  Since the inception of the COVID-19 pandemic, GCHP has expanded its outreach efforts to providers. GCHP is reaching out at least twice a week by email and phone to determine closures and/or other impacts due to Covid-19 for reporting to DHCS. The providers include:

    - Hospitals
    - SNF & LTC
    - CBAS Centers
    - Home Health / Hospice / Palliative Care
    - Congregate Living Facilities

  GCHP has developed and implemented a Provider Communications Workgroup to ensure a formalized and organized strategy for assessment and prioritization of provider communications regarding COVID-19 regulatory and operational updates. Multiple updates have been sent to the following providers (in addition to those listed above):

    - Urgent Care
    - PCP: non-clinic affiliated
    - Pharmacy Infusion
    - Laboratory
    - Radiology
    - Physical Therapy / Occupational Therapy / Speech Thearpy
    - Audiology & Hearing Aids
    - DME

➢ **CBAS DURING COVID-19: A Case Study for GCHP and Provider Collaboration**

- During the initial stages of the COVID-19 pandemic, GCHP reached out to its CBAS center providers to discuss their operational impacts and how they were addressing the care needs of GCHP's members.

- Through a collaborative process with GCHP, the centers continued with their operations despite unknown reimbursement parameters and service guidelines. They shifted resources and focused on providing services in homes. These services include:

    - Social work case management and monitoring, inclusive of the use of telephonic / telehealth services
    - Meal preparation and delivery
    - Home visits
    - Pharmacy/Rx support and facilitation of access to and delivery of medications
    - Transportation for medical care

- With the input and support of CBAS providers, GCHP was able to develop an amendment to its CBAS agreements, setting forth the terms for providing services during the COVID-19 pandemic. The amendment was approved by DHCS. The contract amendment reflected the same guidance from DHCS and the Department of Aging that was identified in their recent guidance to CBAS providers. In this regard, GCHP was ahead of the curve and in line with the final guidance issued by these two regulatory agencies.

- GCHP also developed a specific reporting mechanism that allows CBAS centers to document the services they have provided from March 16 to now. This form is in current use and will be used for tracking and further regulatory reporting purposes.

- As GCHP continues to monitor the services being provided by CBAS centers, GCHP will continue to inform the Commission of the progress being made during this pandemic.

➢ **PCP - Member Assignment - Refer to Attachment A**

➢ **Regulatory:**

In Process:

- Annual Network Certification (ANC) submission date has been extended as a result of the Covid-19 pandemic. The new date is April 20. GCHP expects a timely submission.

- Subcontractor ANC provider fulfillment is a new requirement by DHCS. The due date is April 20. GCHP expects timely delivery.

Completed:

- The quarterly DHCS Timely Access submission was sent on time.
- The January 2020 Provider Directory was approved by DHCS. GCHP is gearing up to distribute the directory to new members.

➢ **Provider Contracting Update:**

- **Medical Cost Reduction Contract Strategy: Refer to CFO Report**

- **New Contracts:**

  - S & K Health Services, Inc., dba Infinity Adult Day Health Care Center
  - CBAS center in Westlake Village
  - DME Consulting, Inc.: Provides outreach to members to determine mobility issues and potential needs of durable medical equipment (DME).
  - Rikk Lynn, dba Pimple Popper, MD, Inc.: Dermatologist in Ventura; contract to be effective upon credentialing.
  - Shilpa Jindani Inc.: Family medicine primary care provider (PCP) in Newbury Park; contract to be effective upon credentialing.

- **Amendments:**

  - National Seating and Mobility Inc.: Additional location in Goleta.
  - Ventura Orthopedic Medical Group Inc.: Addition of two providers to the interim Letter of Agreement (LOA).
  - Two Trees Physical Therapy and Wellness: Addition of two new therapists to the interim LOA.
  - Antulio B Aroche Jr. DO APC: Additional location in Camarillo.
  - Premier Diagnostics Inc.: Addition of CPT codes and reimbursement for DME supplies.
  - Amended all Hospice Provider Agreements according to the current Medi-Cal Hospice Services Rate.

- **Interim LOA:**

  - Ventura Care Partners, APC: Interim LOA in place for provider to continue providing palliative care services to GCHP's members while pending credentialing.
  - Hospitalist Medicine Physicians of California: Interim LOA in place for hospitalists to continue seeing GCHP's members while pending credentialing.

- **Member-Specific LOA:**

  Provider contracting has worked on 29 LOAs during this time period. Of those that are fully executed, we have the following:

  - 22 Amigo Baby LOAs
  - Two Accredo Health Group LOAs
  - The Surgery Group of Los Angeles: LOA to cover an office consultation for a GCHP transgender member to discuss a potential gender transformation surgery.
  - Two Congregate Living Facility LOA extensions for members that have either been out-of-area or difficult to place and required skilled nursing care
    - Burbank Congregate Living Center
    - MIH Project A, LLC
  - Two LOAs for a GCHP member in subacute care that requires bedside hemodialysis.

- **BetterDoctor**:

  Network Operations continues to meet weekly with Quest Analytics to ensure that the process continues to move smoothly.

  Network continues to verify the demographic information obtained from BetterDoctor. The following reviews were performed:

  - 3,909 provider lines reviewed
  - 278 provider records were audited to ensure the providers were loaded accurately in PNDB and IKA (GCHP's claims system).

<u>BetterDoctor Report – Contracting</u>

12 provider records were reviewed on the BetterDoctor Report for potential terminations.

➢ **Provider Contracting and Credentialing Management System (PCCM)**

This major system initiative will replace both Network Operations and Credentialing's legacy provider network data base. The project was kicked off in April 2019. Regularly scheduled bi-weekly meetings are being held to maximize data conversion and efficiency.

Project health is **RED** due to the following:

- Extension of the timeline to complete iteration 7 data mapping, data conversion and crosswalks. The extension is required to support the accuracy of the converted data. Iteration 7 conversion was expected to be delivered on March 20, was extended to April 10, and was extended again to April 22.

- The September go-live date is impacted. Project re-planning is in process.
- Validation of converted data is < 5%.
- Pending metrics confirming data conversion pass / fail percentages.
- Resource constraints as a result of competing production and project priorities.

PCCM Items Currently In Progress:

- Development of data conversion testing metrics (dashboard)
- Development of iteration 7 test scripts
- Review of the production printed directory process and expectations for the go forward process with eVIPs
- Mapping review and clean-up of iterations 1-8
- PNDB data clean up
- Interface development
- Monthly vs. Quarterly provider roster analysis

➢ **Provider Additions:**

March 2020 Provider Additions: 36 Total

23 in-area providers

Provider Type	Additions
CBAS	1
Mid-level	2
Pharmacy	1
Primary Care Provider	1
Specialist	16
Specialist- Hospitalist	2

12 out-of-area providers

Provider Type	Terms
Hospitalist	1
Specialist	11

March 2020 Provider Terminations – 16 Total

7 in-area providers

Provider Type	Terms
Midlevel	3
Specialist	3
Specialist- Hospitalist	1

9 out-of-area providers

Provider Type	Terms
Specialist	9

These provider terminations have no impact on member access and availability. The specialist terminations are primarily associated with tertiary adult and pediatric academic medical centers, where interns, residents, and fellows have finished with their clinical rotations.

- **Provider Manual Update:** Project completed and draft manual submitted to DHCS for approval.

- **Provider Satisfaction / Provider Access Survey: Completed-** Refer to Attachment B for further details

  - **Provider Satisfaction Survey**:

    SPH completed the survey and submitted a summary to GCHP. 1,000 providers were surveyed and the response rate was a dismal 17%. Network Operations is evaluating opportunities for greater provider engagement to increase the number of survey respondents.

    - **Key Results:**

      - Significant increase in overall satisfaction from 2013 (47.9%) to 2015 (33.6%) to 2019 (70.2%)
      - Increases in all departmental categorizations: Finance (77%), UM/QM (86%), Network (85%), Pharmacy (84%), Customer Service (87%) and Provider Relations (92%).

  - **Provider Access Audit**:

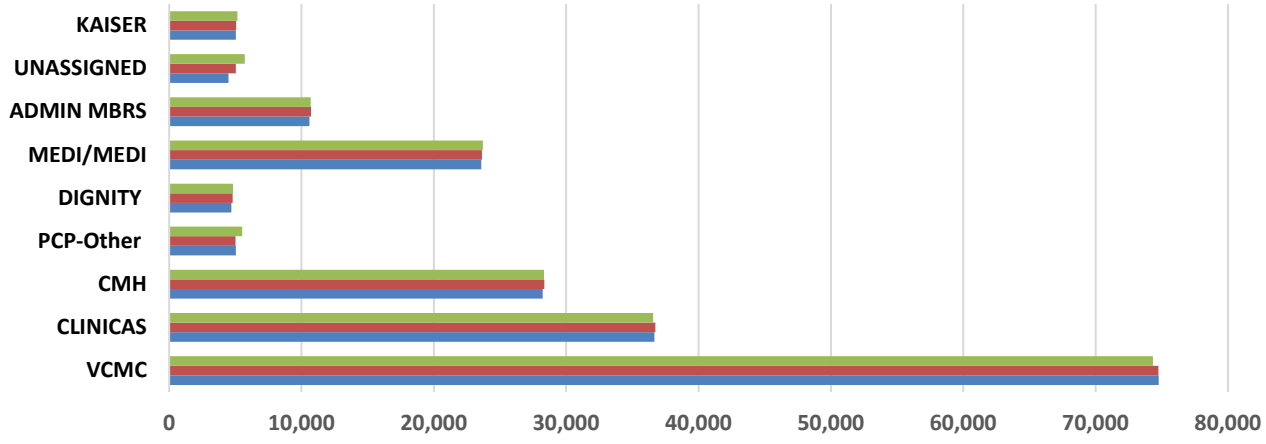
    SPH completed its audit and submitted a summary to GCHP. Network Operations will be working with GCHP's PCP and specialty providers to address deficits and to improve annual scores.

    - **Key Results**:

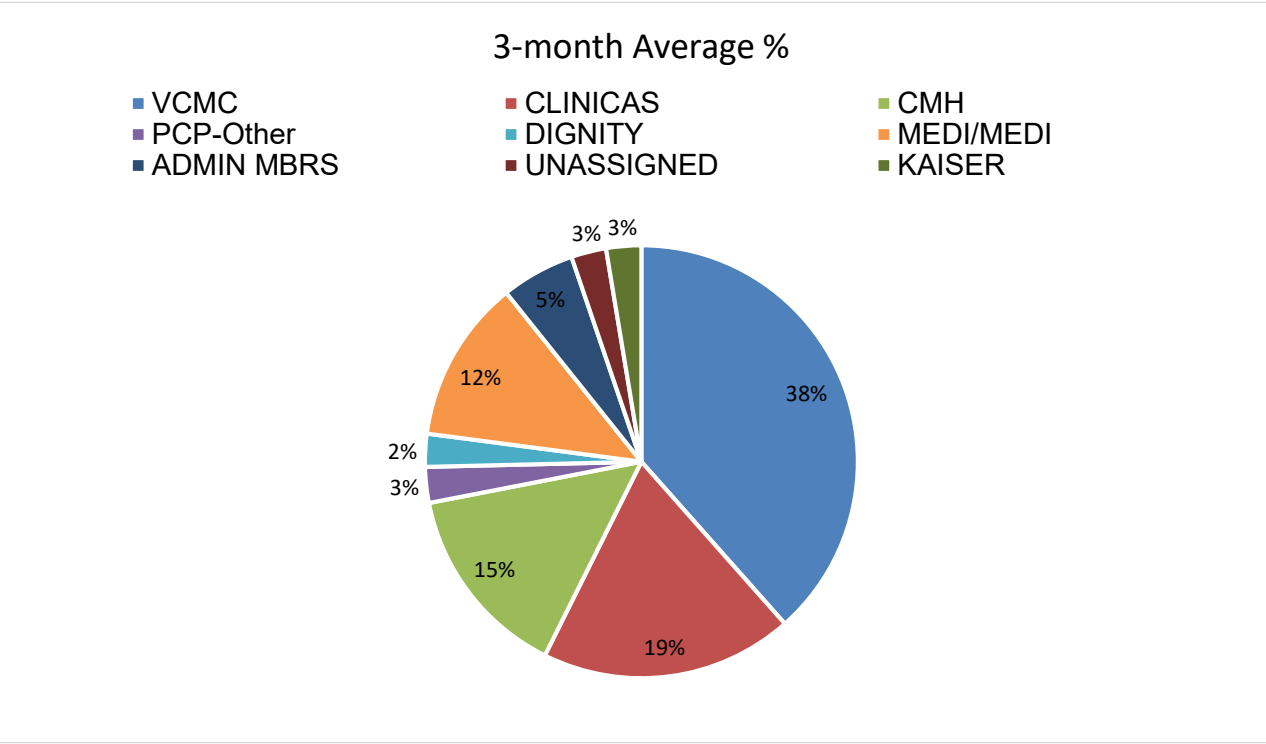
      - **PCP 2019 vs 2018**:
        - Decrease in urgent care (within 24 hours) accessibility (82.1% down to 70.2%)
        - Decrease in non-urgent care(within 10 business days) accessibility (99.6% down to 89.5%)
        - Increase audit rate in office wait time and patient call back time

      - **Specialist 2019 vs 2018:**
        - Increase in urgent care accessibility (55.6% up to 60.9%)
        - Decrease in non-urgent care accessibility (93.2% down to 90.7%)
        - Decrease in routine initial visit accessibility (79.6% down to 70%)
        - Increase audit rate in office wait time and patient call back time

ATTACHMENT A- PCP Assignments

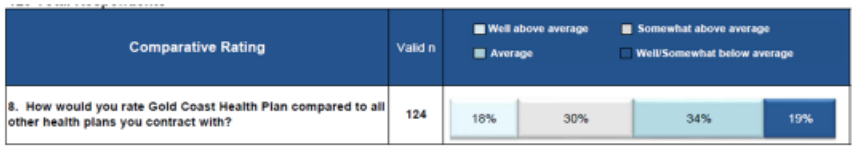


	VCMC	CLINICAS	CMH	PCP-Other	DIGNITY	MEDI/MEDI	ADMIN MBRS	UNASSIGNED	KAISER
Mar-20	74,328	36,557	28,333	5,511	4,817	23,698	10,700	5,705	5,160
Feb-20	74,751	36,729	28,337	5,019	4,793	23,633	10,716	5,028	5,055
Jan-20	74,759	36,665	28,223	5,033	4,694	23,576	10,605	4,476	5,032

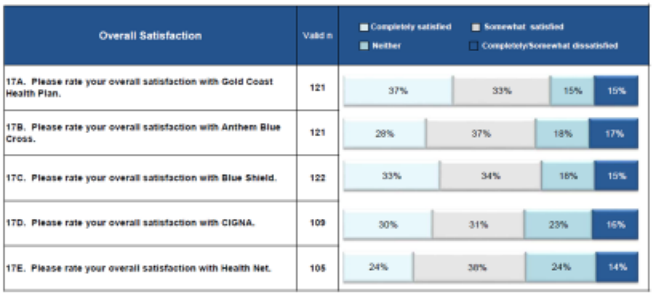


ATTACHMENT B- PROVIDER SATISFACTION SURVEY RESULTS

OVERALL RATING



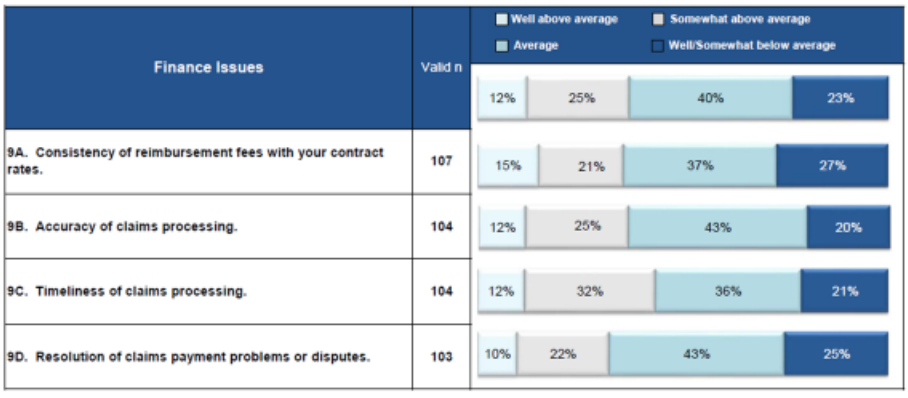
Overall Satisfaction segmented identifies 18% satisfaction was well above average, 30% for 'somewhat above average' and 34% for 'average.'



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

Gold Coast Health Plan

FINANCE RATING

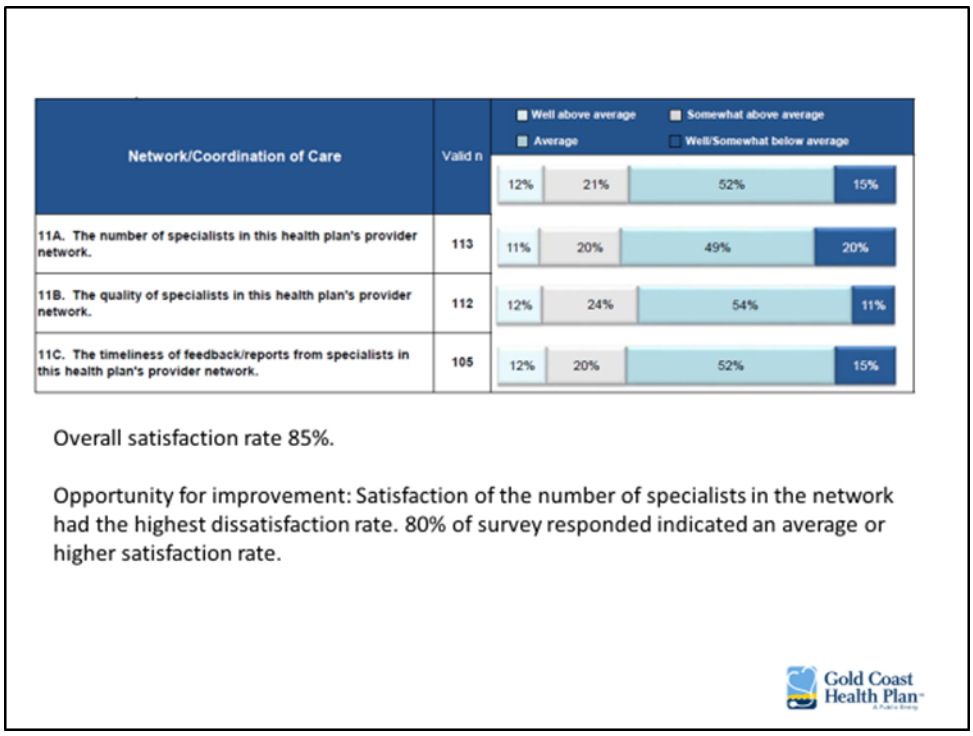


Overall satisfaction rate 77%

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

Gold Coast Health Plan

NETWORK/COORDINATION OF CARE RATING



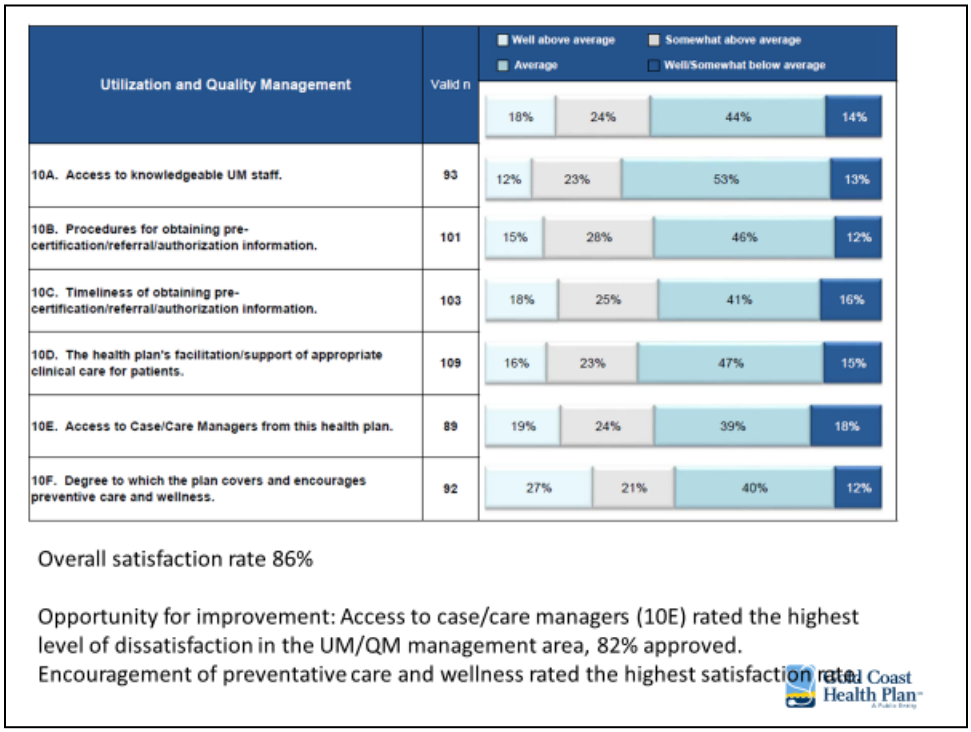
Network/Coordination of Care	Valid n	Well above average	Somewhat above average	Average	Well/Somewhat below average
11A. The number of specialists in this health plan's provider network.	113	12%	21%	52%	15%
11B. The quality of specialists in this health plan's provider network.	112	11%	20%	49%	20%
11C.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

Overall satisfaction rate 85%.

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

Gold Coast Health Plan

UTILIZATION MANAGEMENT



Utilization and Quality Management	Valid n	Well above average	Somewhat above average	Average	Well/Somewhat below average
		18%	24%	44%	14%
10A. Access to knowledgeable UM staff.	93	12%	23%	53%	13%
10B. Procedures for obtaining pre-certification/referral/authorization information.	101	15%	28%	46%	12%
10C. Timeliness of obtaining pre-certification/referral/authorization information.	103	18%	25%	41%	16%
10D. The health plan's facilitation/support of appropriate clinical care for patients.	109	16%	23%	47%	15%
10E. Access to Case/Care Managers from this health plan.	89	19%	24%	39%	18%
10F. Degree to which the plan covers and encourages preventive care and wellness.	92	27%	21%	40%	12%

Overall satisfaction rate 86%

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

Gold Coast Health Plan

PHARMACY RATING

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

Overall satisfaction rate 84%.

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

Gold Coast Health Plan

HEALTH PLAN CALL CENTER RATING

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

Overall satisfaction rate 87%

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

Gold Coast Health Plan

PROVIDER RELATIONS

Provider Relations	Valid n	Well above average	Somewhat above average	Average	Well/Somewhat below average
15A. Provider Relations representative's ability to answer questions and resolve problems.	57	31%	18%	43%	8%
15B. Quality of provider orientation process.	90	40%	18%	32%	11%
15C. Quality of written communications, policy bulletins, and manuals.	96	27%	21%	44%	8%
		26%	16%	53%	5%

Overall satisfaction rate 92%

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

Gold Coast Health Plan

Year to Year PCP Audit Results

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

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

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

Gold Coast Health Plan

Year to Year Specialist Audit Results

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

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

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

Gold Coast Health Plan

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

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

Gold Coast Health Plan

RECOMMENDATION:

Recive and file the report.

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

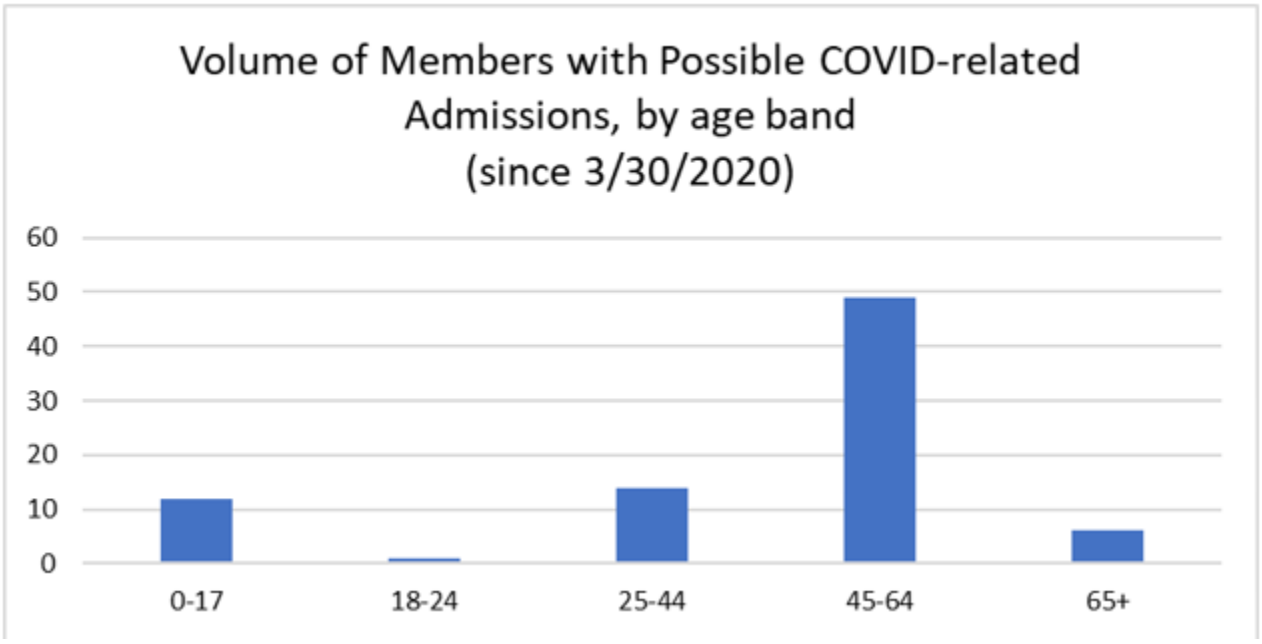
FROM: Nancy Wharfield, Chief Medical Officer

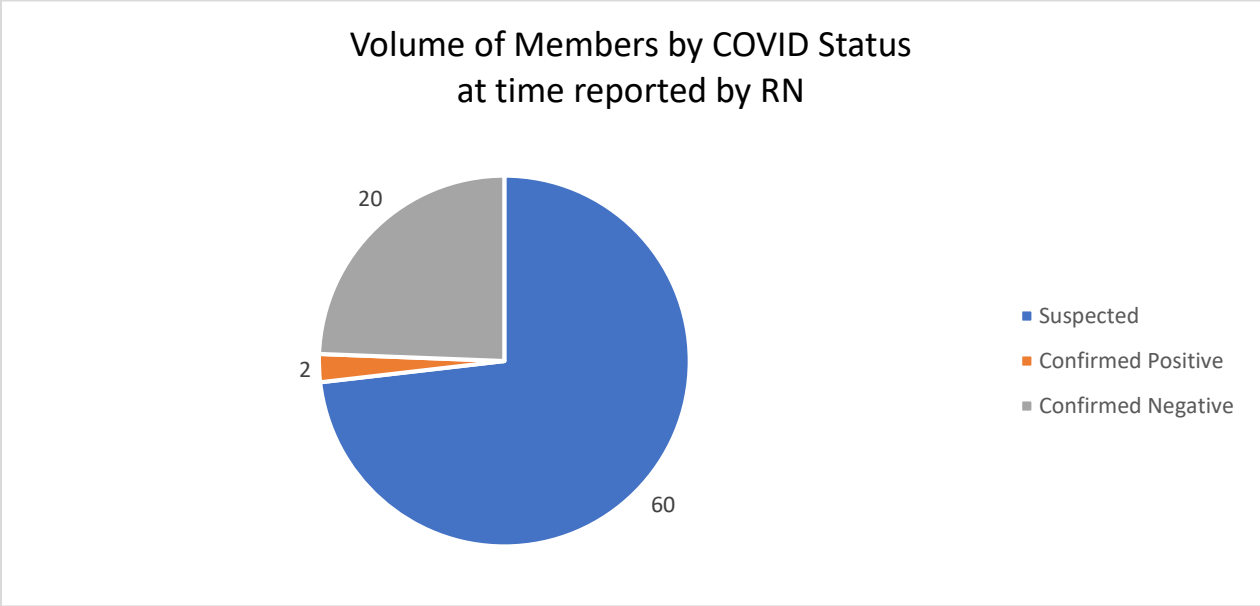
DATE: April 27, 2020

SUBJECT: Chief Medical Officer Report

COVID-19 Update

Gold Coast Health Plan (GCHP) has been reporting COVID-19 related hospital admissions to Department of Health Care Services (DHCS) daily. As of 4/16/2020, there have been 82 GCHP members with COVID-19 related admissions. The greatest number of COVID-19 related admissions are in the 45-64 age group followed by 25-44 and 0-17. Only 2 cases were confirmed positive and 20 were confirmed negative. Results on the remaining 60 members are pending. Most cases were admitted through the emergency department.



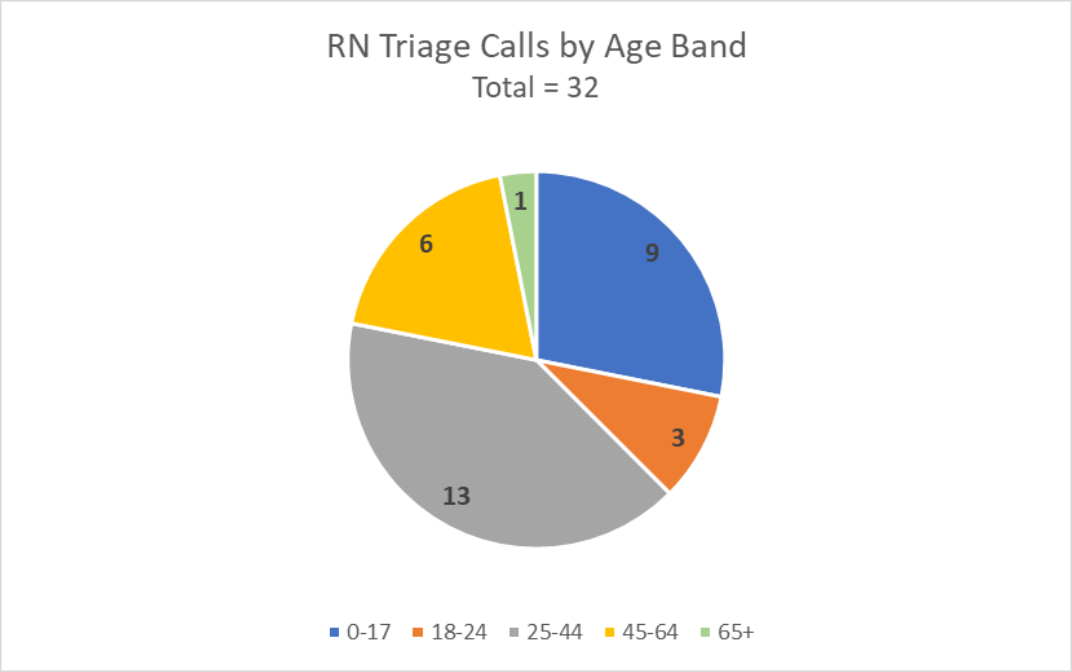


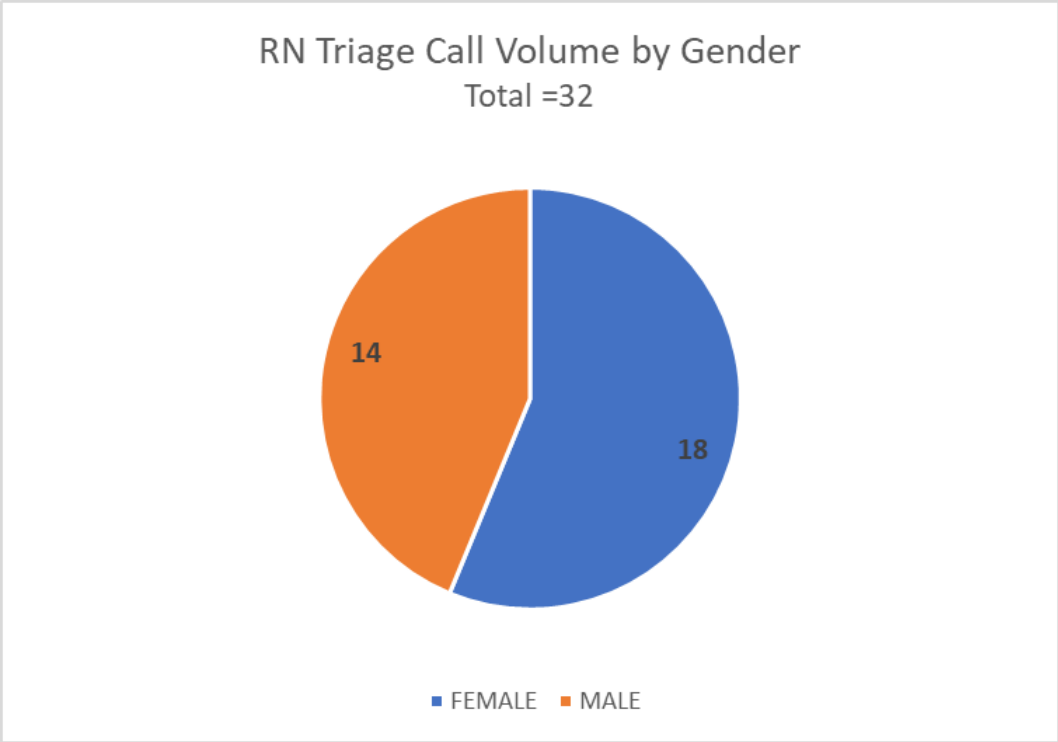
GCHP staff are strategizing to reach out to our most vulnerable members to ensure that they are receiving appropriate care during the pandemic. We are using a combination of robocalls and direct calls out to identified members. Our Care Management and Health Education teams have reached out to several at-risk populations to offer support, including over 300 members receiving home health services and CBAS members whose centers have recently closed. As a result, we have been able to address access issues, promote telehealth services and our 24/7 Nurse Advice Line, and link members to needed resources throughout the county. Members have expressed themes of stress around food and housing insecurity, financial insecurity due to job loss, social isolation and fear of COVID-19, and anxiety about not being able to see their doctors.

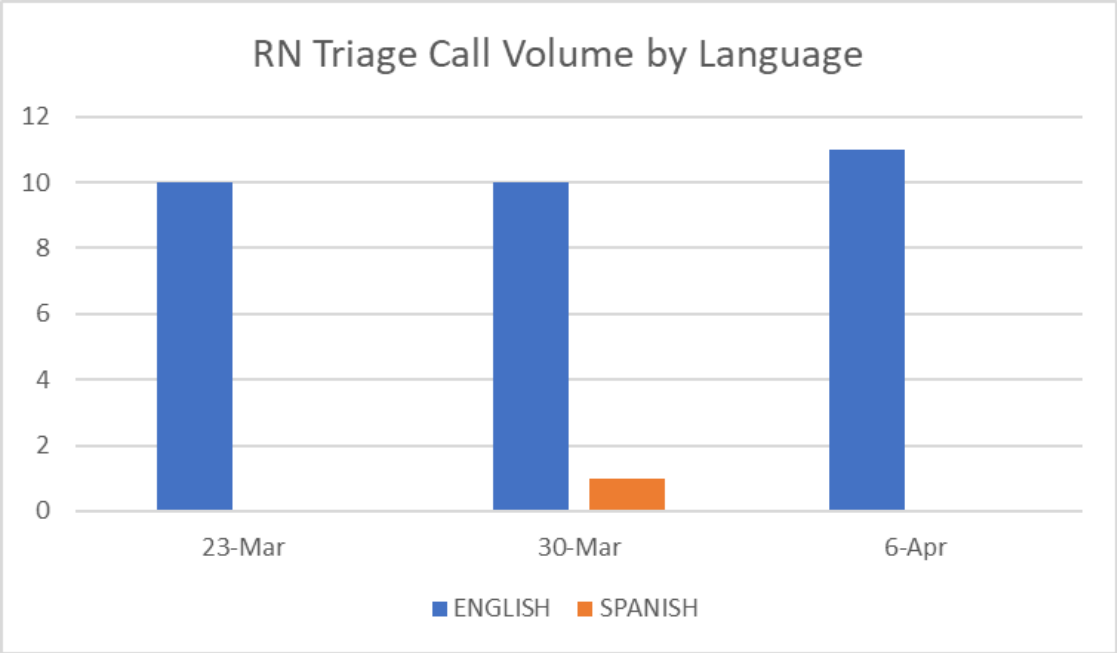
Nurse Advice Line Update

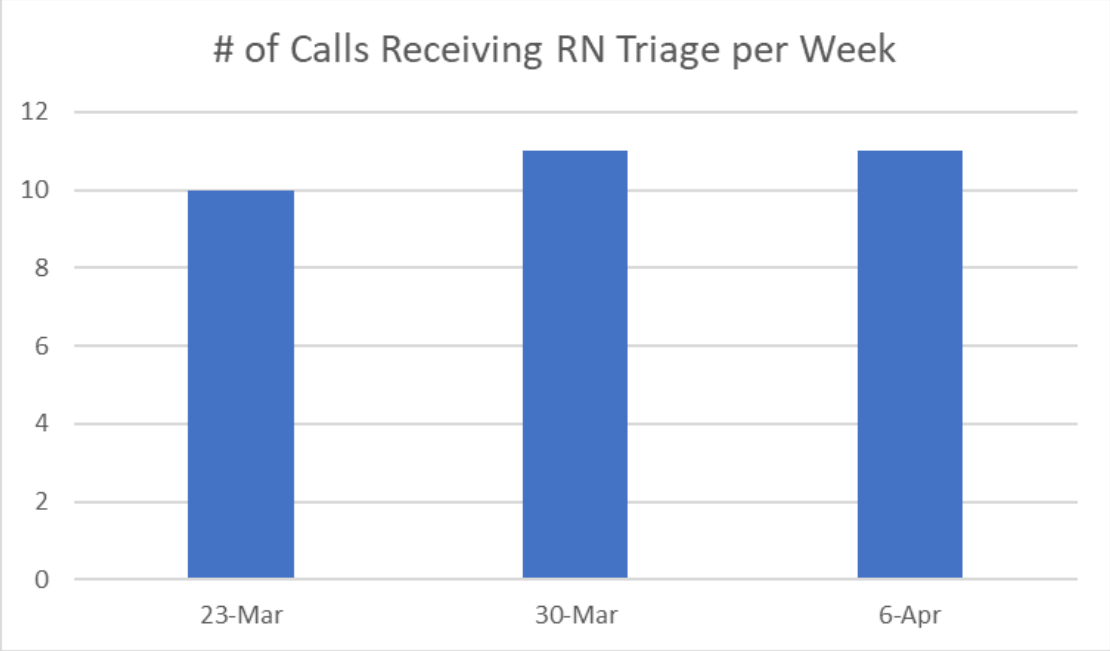
GCHP has averaged about 10 calls/week in the 3 weeks the Carenet RN Advice line has been active for a total of 32 calls. There were slightly more calls from women than men and there was only 1 call from a Spanish-speaking member. Most calls were in the 25-44 age group followed by 0-17 and 45-64. About a third of the callers had concerns that could possibly be COVID related (URI/flu-like symptoms/cough) but only 2 members directly expressed concern about COVID symptoms or exposures. A variety of other health concerns were expressed including chest pain, abdominal pain, rash, hearing change, nausea and numbness and tingling. Three calls resulted in EMS 911 activation, 2 led to emergency room recommendations, and there were 8 members who were advised on self-care at home. There was 1 poison control referral. The remainder of callers had recommendations to follow-up with their providers in days to weeks.

The call volume is low enough that the GCHP Care Management team is able to follow up with all callers to ensure that concerns were addressed adequately. About a third of callers were referred into a formal Care Management program.






RN Triage Call Volume by Language
12
10
8
6
4
2
0
23-Mar
30-Mar
6-Apr
ENGLISH
SPANISH


# of Calls Receiving RN Triage per Week
12
10
8
6
4
2
0
23-Mar
30-Mar
6-Apr

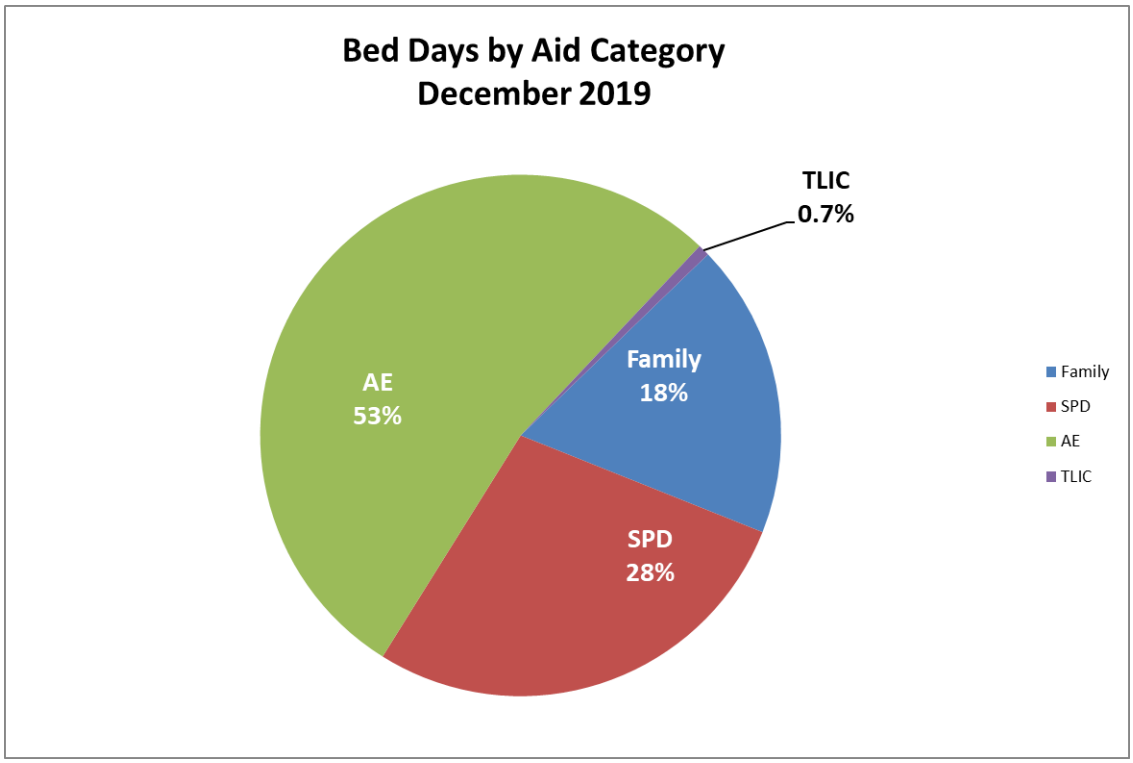
Utilization Update

BED DAYS

Bed days/1000 members increased by 4% from 2018 to 2019 (226 to 235). The 2019 CY Q1 seasonal peak seen in winter was larger than prior years.

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.

Approximately half of bed days are utilized by Adult Expansion (AE) members (53%), followed by Seniors and Persons with Disabilities (SPD) (28%) and Family aid code groups (18%). Low income children (TLIC) utilization is less than 1% (0.7%).



AVERAGE LENGTH OF STAY (ALOS)

Average length of stay for 2019 was similar to 2018 (4.1 to 4.2).

Average length of stay benchmark: While there is no Medi-Cal Managed Care Dashboard report of ALOS, review of available published data from other managed care plans averages 5.

Administrative day ALOS: The average length of stay for administrative, or placement days, has declined over a 2-year period from 2017 through 2019 by 28% (6 to 4.3). For the same period, the quarterly number of approved administrative days was reduced by nearly half. This is due to increased Transition of Care team focus, relationships with facility utilization review departments, and contracting for increased skilled nursing facility bed availability which includes congregate facilities.

ADMITS/1000 MEMBERS

Admissions/1000 members increased by 5.7% from 2018 to 2019 (53.82 to 56.88). This reflects the 2019 CY Q1 seasonal peak which was higher than prior years.

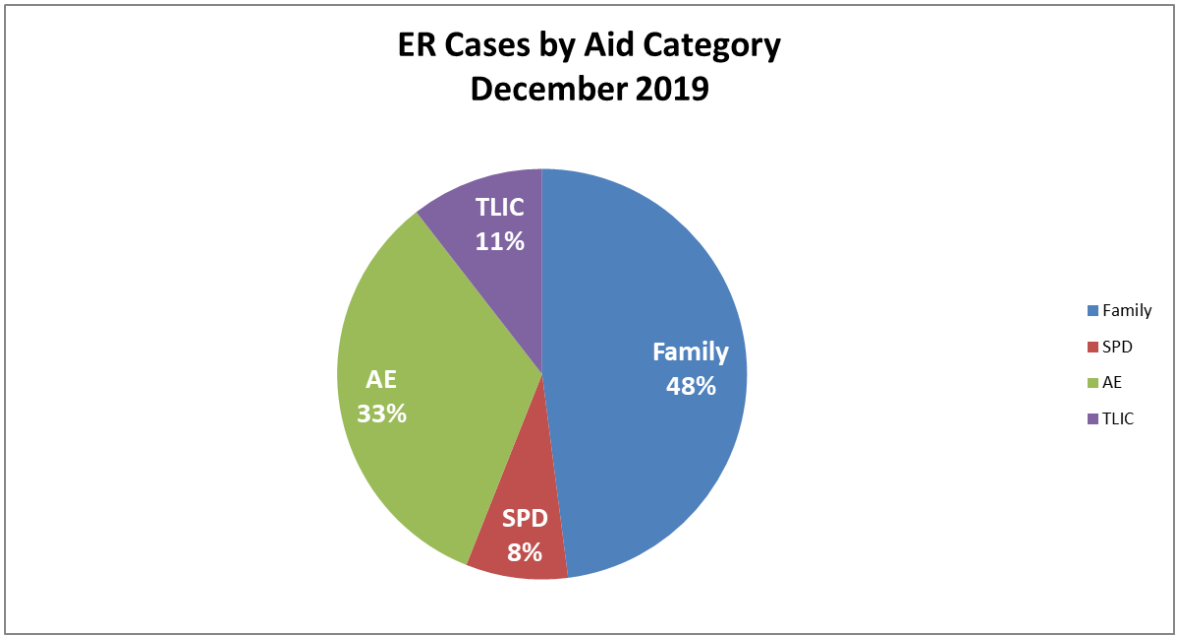
Medi-Cal managed care plans are noting a marked decrease in inpatient authorization requests due to COVID-19. GCHP inpatient authorization request show a 12% decrease for CY Q1 compared to CY Q1 2019.

Admits/1000 members benchmark: The Medi-Cal plan average is 55/1000 members.

ED UTILIZATION/1000 MEMBERS

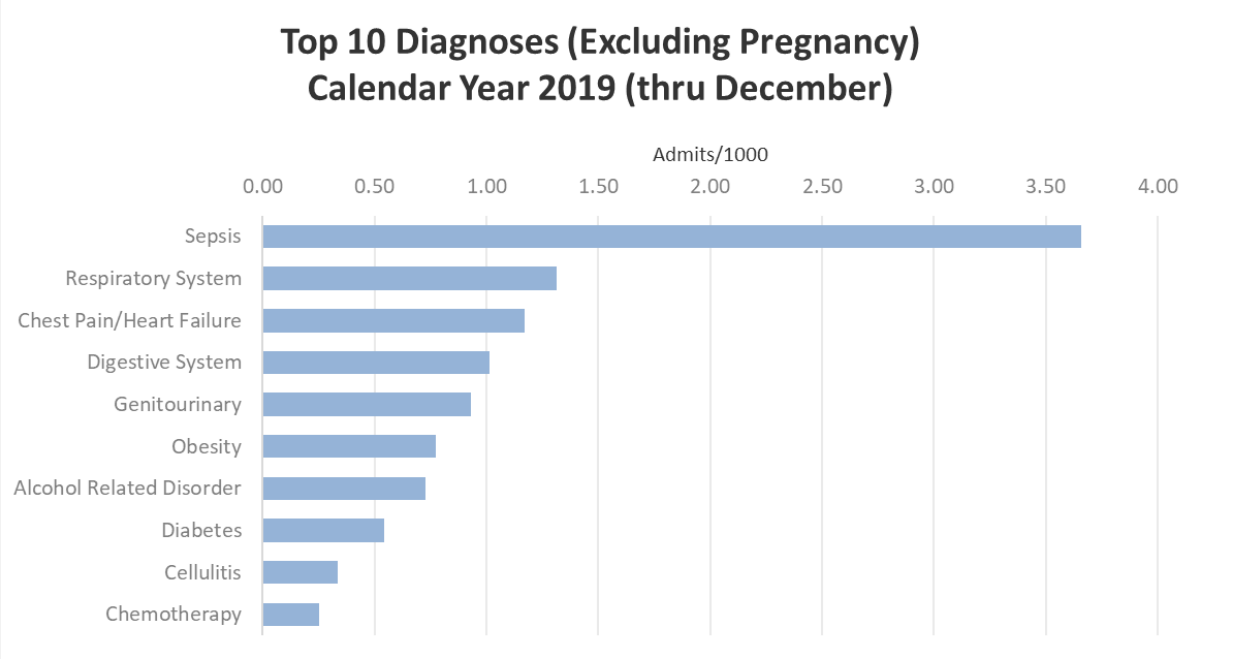
ED utilization/1000 members increased by 4.7% from 2018 to 2019 (472 to 494).
ED utilization benchmark: The HEDIS mean for managed Medicaid plans for ED utilization/1000 members is 587.

The Family aid code group represents nearly half of ED visits (48%) followed by Adult Expansion (33%), TLIC (11%) and SPD (8%).



TOP ADMITTING DIAGNOSES

Pregnancy/childbirth continues to be our top admitting diagnosis category. When pregnancy is excluded, the top admitting diagnoses continue to be sepsis, followed by respiratory, cardiac, gastrointestinal, genitourinary, obesity, alcohol, diabetes, cellulitis, and chemotherapy.



READMISSION RATE

The quarterly readmission rate for 2019 was 14.8%.

Readmission rate benchmark: The DHCS Medi-Cal readmission rate is 15.8%.

Pharmacy Hot Topic Items

Medi-Cal Rx
The California Department of Health Care Services (DHCS) will be carving out all prescription benefits from the Managed Care Plans (MCP) as of January 1, 2021 under a new program called Medi-Cal Rx. Upon implementation, all retail prescription claims will be submitted directly to the state via its PBM. DHCS has announced ongoing stakeholder and technical workgroups along with monthly Managed Care Plan updates. Gold Coast Health Plan will continue to work with advocacy groups, other MCPs and DHCS in order to facilitate the implementation of the carve out and will continue to bring information as it becomes available to this group.

CA State Auditor: GCHP Audit Findings
GCHP was audited by the CA State Auditor to assess GCHP's award of its PBM contract to OptumRx, Inc., and its subsequent monitoring of OptumRx. GCHP developed 2 policies to address the findings in the audit and responded to the auditor with draft versions of the policies in the required 60-day timeframe. GCHP submitted its 6-month response to the audit findings on February 14th stating that the draft policies have been formally adopted and approved by the VCMMCC and the California Department of Health Care Services. GCHP was informed that upon receipt of the 6-month update, GCHP's response is considered complete and no further action is necessary.

COVID-19
As part of its response to the COVID-19 pandemic, GCHP has made significant, temporary changes to the pharmacy benefit to ensure member access to pharmacy services while ensuring the principles of social distancing and shelter-in-place:

- Refill Too Soon Edit: GCHP temporarily lifted the refill too edit to allow pharmacies to fill chronic, maintenance medications early
- 90 Day Supply: Allow any chronic, maintenance medication to be filled for up to 90 days at a time
- Out of Network Pharmacies: Allow out of network pharmacies to fill medications for member if related to COVID-19 and being unable to access a network pharmacy
- Formulary Overrides: Allow overrides of up to 90 days for medications impacted by COVID-19

All of these changes have the potential to increase costs to GCHP. Further information will be provided on the impact of these changes and the potential for reimbursement.

Pharmacy Benefit Cost Trends

Gold Coast Health Plan's (GCHP) pharmacy trend shows in overall price increase of 18.16% from March 2019 to March 2020. Pharmacy trend is impacted by unit cost increases, utilization, and the drug mix. Pharmacy costs are predicted to experience double digit increases (>10%) each year from now until 2025. GCHP's trends are in-line with state and national data that is also experiencing significant increases in pharmacy costs. Impact from COVID-19 is expect to increased costs further.

Factor	National Trend	GCHP Trend
Unit Cost	• Price inflation is a top contributor, outpacing utilization growth 4:1. • Average price increase per drug was 10.5% in the first half of 2019. 	• Unit cost increased 2.5% from 2018Q4 to 2019Q4. Unit cost changes from 2019Q1 to 2020Q1 should be available in May. 
Utilization	• The number of prescriptions increased 21% from 2014 to 2017. 	• RxPMPM increased 3.2% from March 2019 to March 2020. • 29.1% of GCHP's members have 3 or more disease categories 
Drug Mix	• 59 new drug approval in 2018 – new all-time record high, 28% increase from 2017. • Pharma TV ad spending increased to $3.73B in 2018. • Specialty drugs are expected to be nearly 50% of total drug spend by 2022 	• Specialty drugs account for ~40% of GCHP's total drug spend. GCHP's Specialty users have increased 30% from 2017 to 2019. 

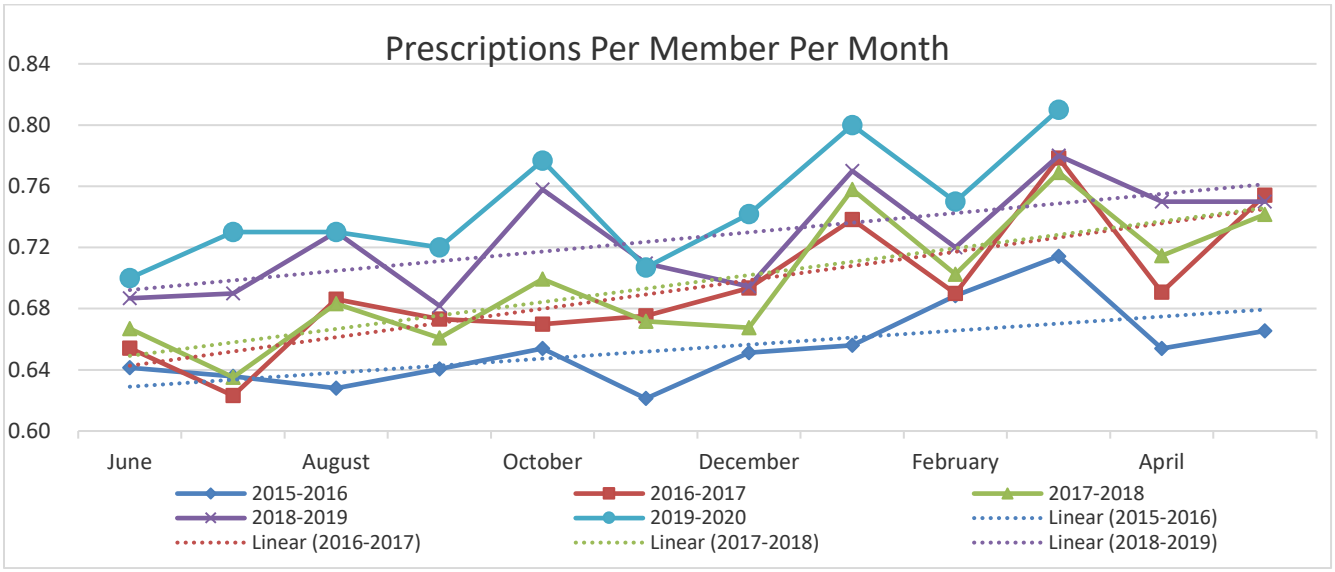
GCHP Annual Trend Data

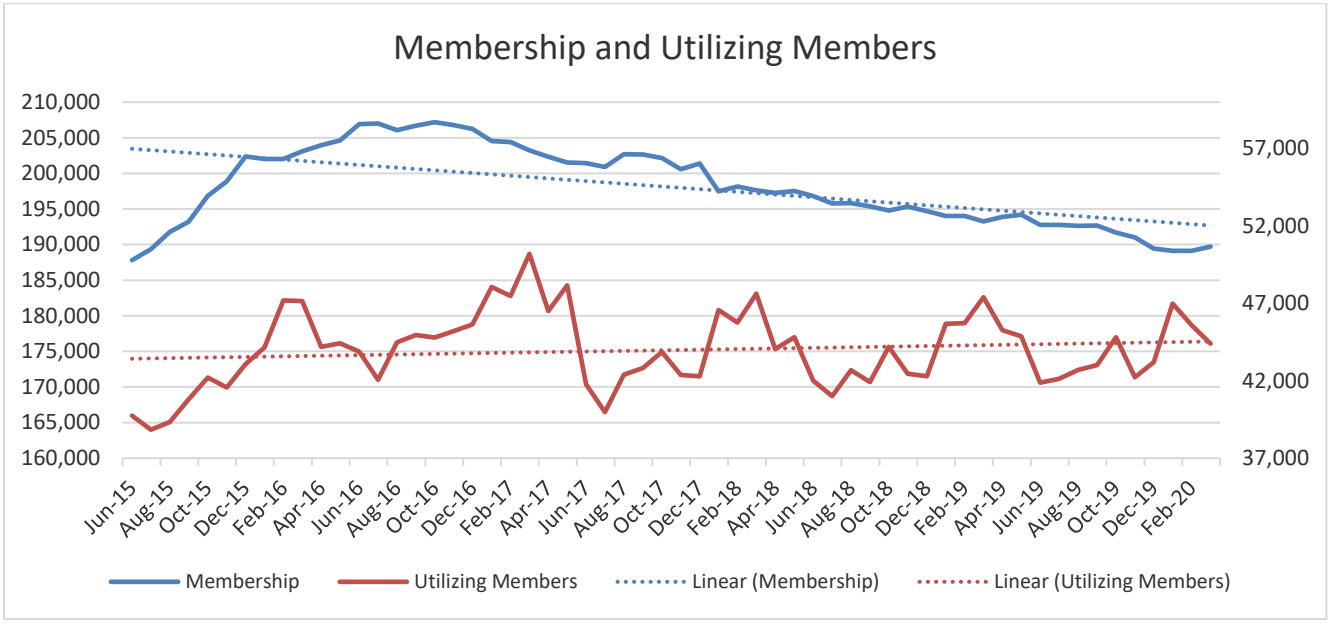
Unit Cost Trends

OptumRx reported that GCHP's unit cost trends from 2018Q4 to 2019Q4 was a 2.5% increase in unit cost. Note that the greatest price changes generally occur in the first quarter of the year.

Utilization Trends:

GCHP's utilization is increasing as demonstrated by the number of members using prescriptions and the number of prescriptions each member is using while GCHP's total membership continues to decline.


Prescriptions Per Member Per Month
0.84
0.80
0.76
0.72
0.68
0.64
0.60
June
August
October
December
February
April
2015-2016
2016-2017
2017-2018
2018-2019
2019-2020
Linear (2015-2016)
Linear (2016-2017)
Linear (2017-2018)
Linear (2018-2019)


Membership and Utilizing Members
210,000
205,000
200,000
195,000
190,000
185,000
180,000
175,000
170,000
165,000
160,000
57,000
52,000
47,000
42,000
37,000
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
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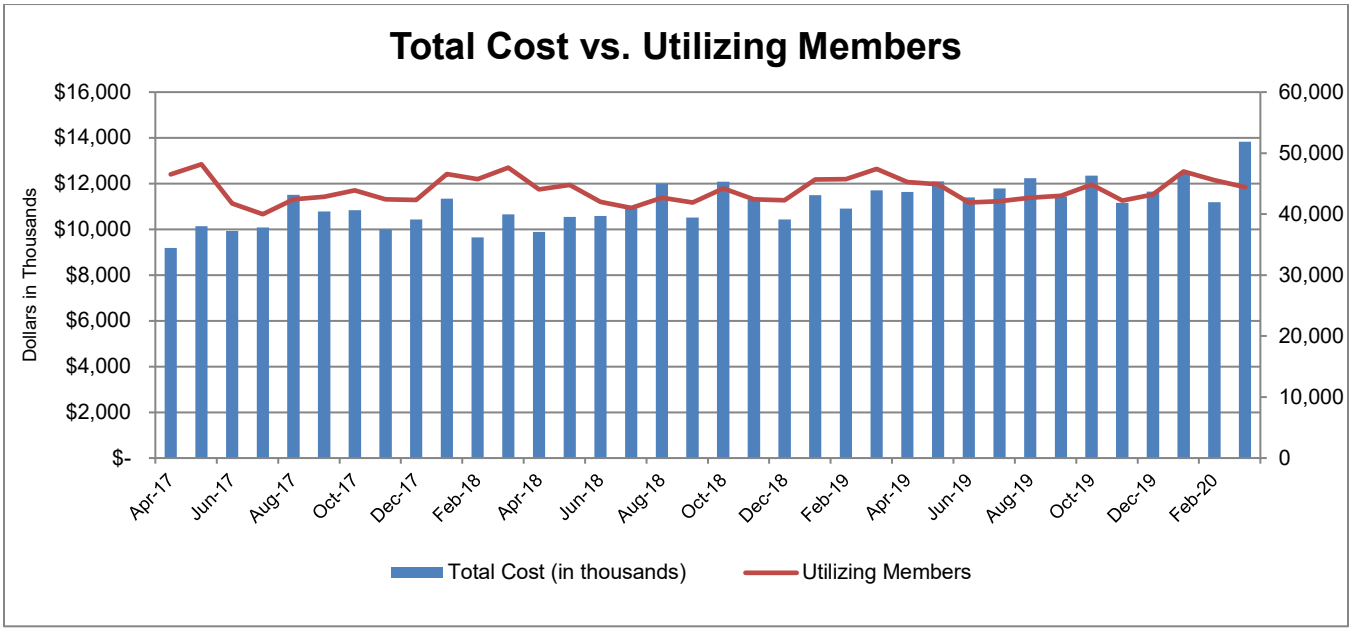
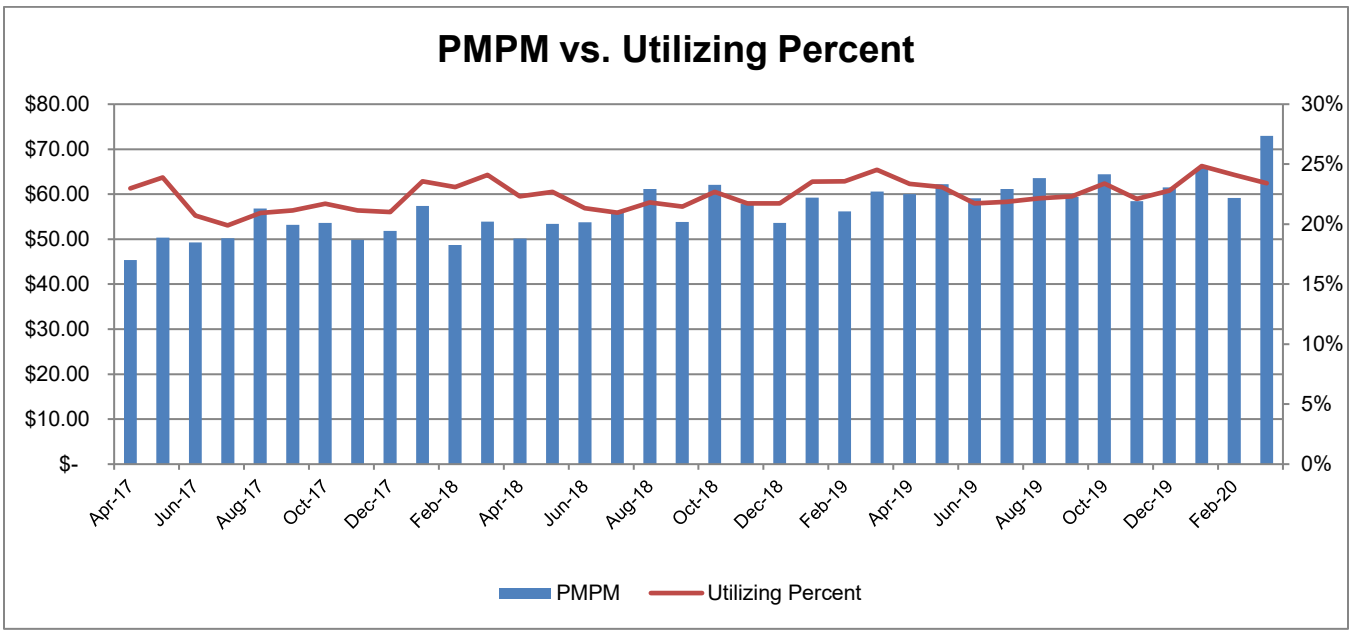
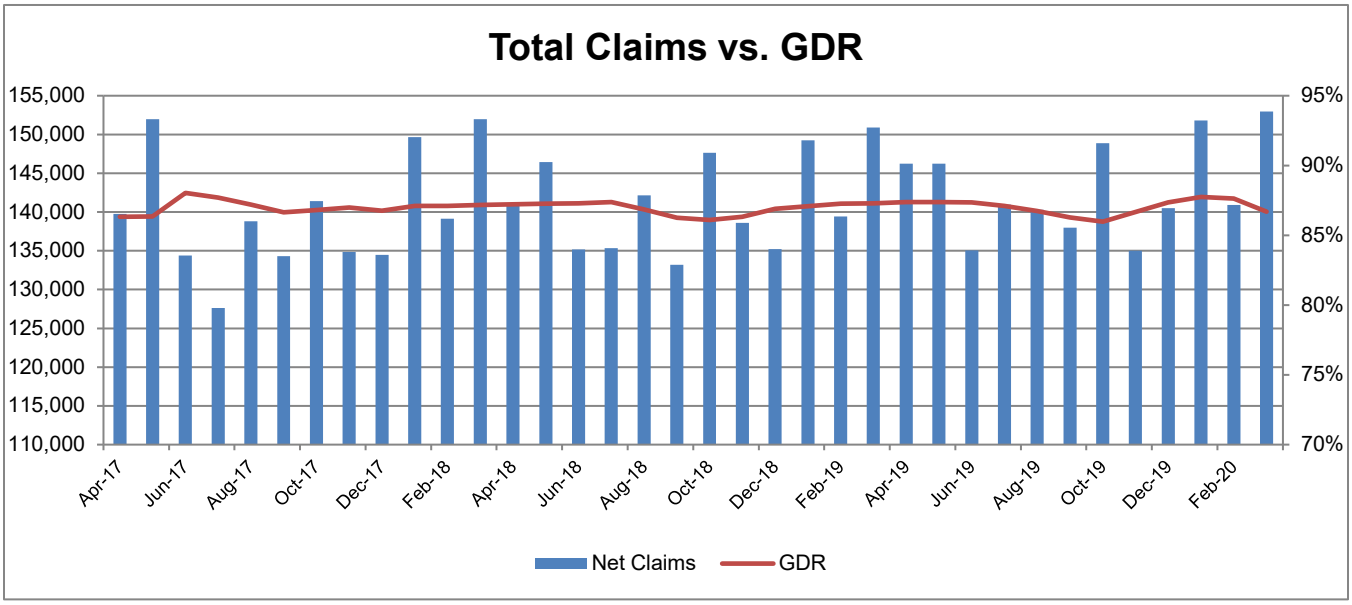
Aug-18
Oct-18
Dec-18
Feb-19
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Membership
Utilizing Members
Linear (Membership)
Linear (Utilizing Members)

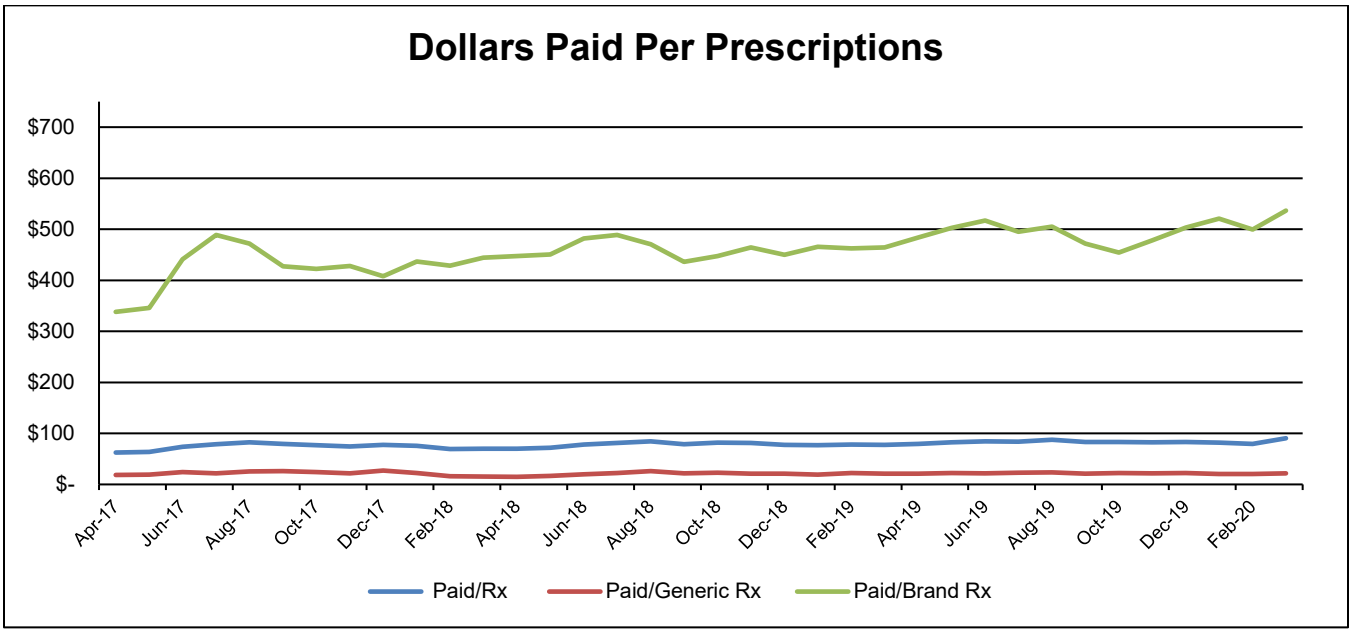
Pharmacy Monthly Cost Trends:





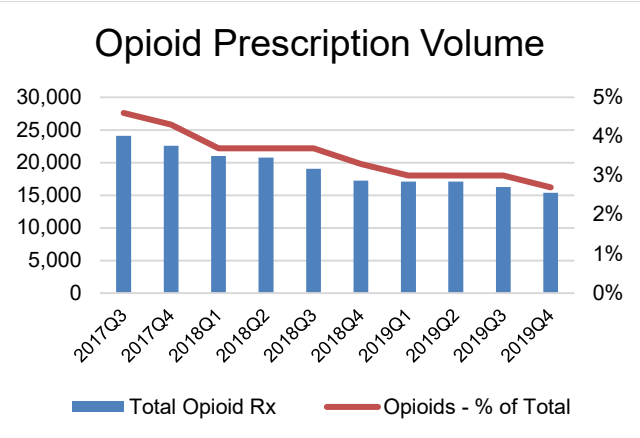


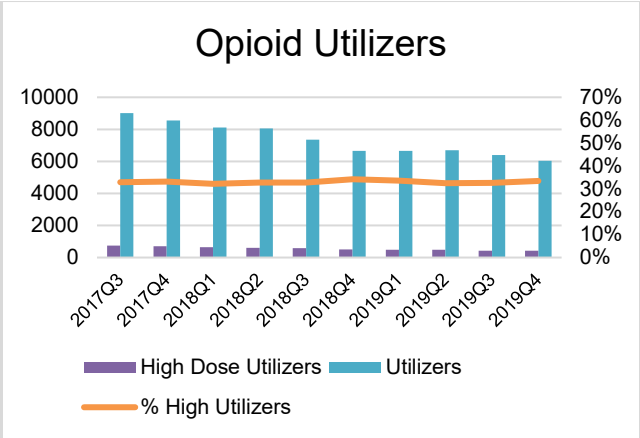
*Claim totals prior to June 2017 are adjusted to reflect net claims.

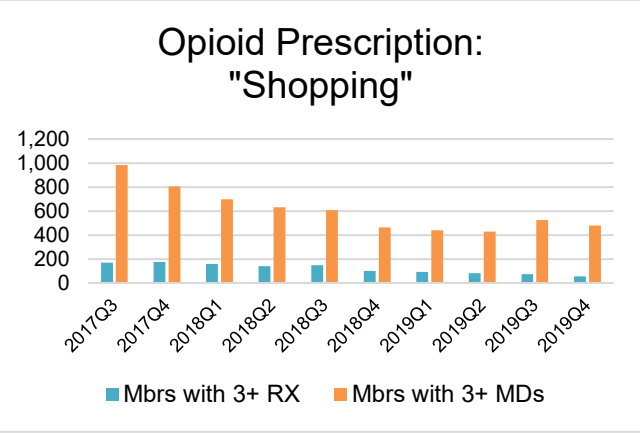


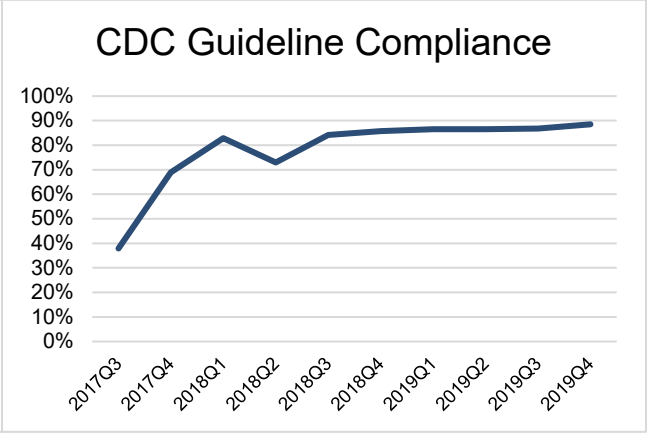
Pharmacy Opioid Utilization Statistics

GCHP continues to monitor the opioid utilization of its members and below are graphs showing some general stats that are often used to track and compare utilization. In general, GCHP continues to see a positive trend toward less prescriptions and lower doses of opioids for the membership.









Definitions and Notes:
High Dose Utilizers: utilizers using greater than 90 mg MEDD
High Utilizers: utilizers filling greater than 3 prescriptions in 120 days
Prescribers are identified by unique NPIs and not office locations

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 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 August 2019. 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.

References:

1. https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/?_sf_s=drug+spending#item-contribution-to-growth-in-drug-spending-by-growth-driver_2017
2. https://arstechnica.com/science/2019/07/big-pharma-raising-drug-prices-even-more-in-2019-3400-hikes-as-high-as-879/
3. US Food and Drug Administration. "2018 New Drug Therapy Approvals."
4. https://www.fiercepharma.com/marketing/another-record-year-for-pharma-tv-ads-spending-tops-3-7-billion-2018
5. https://www.kff.org/medicaid/issue-brief/utilization-and-spending-trends-in-medicaid-outpatient-prescription-drugs/

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: April 27, 2020

SUBJECT: Chief Diversity Officer Report

Monthly Actions:

Community Relations/Diversity

- Attended diversity panel discussion at Oxnard College.
- Employee Survey completed and task teams developed to address concerns.
- Attended African American Youth Leadership symposium In Los Angeles.
- One (1) internal investigations on Leadership capability.
- Met with Diversity Committee to plan activities for the coming Fiscal year.

Case Investigations

- There were two internal investigations (one ending in termination).
- There were no new grievances through the hotline. One old case still with the insurance lawyers.
- Met with one employee work group to explain policy related to job posting.

Office Visit Activity

- Four career discussions
- One mentor/mentee visit
- Three policy related concerns
- Five supervisor consultations

HR Resource Activities

- Posted five positions during the month: Microsoft 365 Solutions Architect, Temp position for Provider Relations, One IT Developer, LVN PT, Executive Director, Strategy and External Affairs. All are within budget.
- Completed policies related to Tele-commuting, excellent co-sponsor by BBK
- Resignations: Two key losses
- Completed the re-write of three policies**:** (1) Alcohol and Drug Abuse (2) Remote Work Assignments (3) Emergency Administration Policy (4) Tele-commuting (which was co-developed with BBK).

- In process rewrites: (1) Employment of Relatives (2) Reduction in Force Policy.
- Shared survey data with the Commission.
- Currently all employees of GCHP are in a work-from-home status.
- Families First Coronavirus Response Act (FFCRA) Policy completed.

Facilities

- Donated 40 N95 masks to the county through Mike Power's office. Masks were distributed to first responders.

BEST BEST & KRIEGER LLP
ATTORNEYS AT LAW

Memorandum

To: Gold Coast Commissioners **File No.:** 65172.00000

From: Scott Haskell Campbell

Date: April 27, 2020

Re: Closed Session Memo

Gold Coast Health Plan has received correspondence from an employee seeking a severance package. All other information is protected by Government Code Section 6254(c) and employee personnel and privacy protections.

cc: Margaret Tatar

BEST BEST & KRIEGER LLP
ATTORNEYS AT LAW

Memorandum

To: Gold Coast Commissioners **File No.:** 65172.00000

From: Scott Haskell Campbell

Date: April 27, 2020

Re: Closed Session Memo

On October 22, 2019, American Medical Response (on behalf of itself and its affiliated entities, including Gold Coast Ambulance) made a demand to Gold Coast Health Plan for ground emergency medical transportation (GEMT) services provided between July 1, 2018, and approximately September 30, 2019. American Medical Response argues that these fees are authorized by Senate Bill 523, which established a GEMT quality assurance program funded by provider fees to support an increase in Medi-Cal fee for service rates and created a retroactive add-on to the Medi-Cal fee-for-service rate. American Medical Response has threatened litigation concerning this demand.

cc: Margaret Tatar