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

Regular Meeting
Monday, June 25, 2018, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

ROLL CALL

CONSENT CALENDAR

1. **Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of April 23, 2018 and May 21, 2018.**

   Staff: Maddie Gutierrez, Clerk of the Commission

   RECOMMENDATION: Approve the minutes.

2. **TBJ Consulting – Additional Funding for Chief Diversity Officer Services**

   Staff: Scott Campbell, General Counsel

   RECOMMENDATION: To continue service with TBJ Consulting.

PUBLIC COMMENT

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

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

REPORTS

3. Chief Executive Officer (CEO) Report

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Accept and file the report.

FORMAL ACTION

4. April Financials Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: The April Financial report was reviewed and accepted by the Executive Finance Committee on June 7, 2018. The Executive Finance Committee recommends the Commission accept and file the financials report.

5. Gold Coast Health Plan Budget for Fiscal Year 2018-2019

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: The fiscal year 2018-2019 (FY2018-19) budget was reviewed and accepted by the Executive Finance Committee on June 7, 2018. The Executive Finance Committee recommends the Commission accept the Gold Coast Health Plan budget for fiscal year 2018-2019.

6. Adoption of Procedure for Adding Items to the Commission Agenda.

Staff: Scott Campbell, General Counsel.

RECOMMENDATION: The Executive Finance Committee recommends the Commission adopt the procedure outline as the Commission's policy for placing items on the agenda.

PRESENTATION

7. Gold Coast Health Plan's High Risk Drug Program

Staff: Dr. Nancy Wharfield, Chief Medical Officer

RECOMMENDATION: Accept and file the presentation.

8. OptumRx Update

Staff: Anne Freese, PharmD, Pharmacy Director

RECOMMENDATION: Accept and file the presentation.

REPORTS

9. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

10. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report.

11. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

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

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

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

OPEN SESSION

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on July 23, 2018, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

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

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

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, Clerk to the Commission

DATE: June 25, 2018

SUBJECT: Meeting Minutes of April 23, 2018 and May 21, 2018 Regular Commission Meetings

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the April 23, 2018 and May 21, 2018 Regular Commission Meetings minutes.

Ventura County Medi-Cal Managed Care Commission
(VCMMCC)
dba Gold Coast Health Plan (GCHP)
April 23, 2018 Regular Meeting Minutes

CALL TO ORDER

Commissioner Antonio Alatorre called the meeting to order at 2:02 p.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Alatorre stated the Pledge of Allegiance would be skipped at this meeting due to the amount of items on the agenda and time constraints.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa (arrived at 2:14 p.m.), Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Absent: Commissioners Debra Herwaldt and Kelly Long.

PUBLIC COMMENT

Dr. Sandra Aldana noted a correction to the minutes of February 26, 2018. She stated the correction was her title and organization she represented. Her title change is "Member At Large". She represents the "State Council on Developmental Disabilities". Correction to the minutes has been noted.

Commissioner Laura Espinosa arrived at 2:14 p.m.

CONSENT CALENDAR

1. **Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of February 26, 2018.**

   RECOMMENDATION: Approve the minutes.

Commissioner Atin moved to accept and file Agenda Item No. 1. Commissioner Dial seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

2. **Contract Award Multi-Functional devices (Everbank Commercial Finance and Document Systems)**

   RECOMMENDATION: Approve the contract renewal.

Commissioner Dial moved to approve the contract renewal. Commissioner Atin seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

FORMAL ACTION ITEM

3. **Election of Chairperson and Vice Chairperson to serve two-year terms and appointment of Executive/Finance Committee.**

   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 appointments to the Executive/Finance Committee.

   DISCUSSION: Commissioner Laura Espinosa nominated Jennifer Swenson for Chair. Commissioner Swenson declined the nomination, she offered to serve as Vice Chair. Commissioner Atin nominated Commissioner Alatorre as Chair with a second from Commissioner Swenson.

Commissioner Atin motioned to elect Commissioner Alatorre as Chair and Commissioner Swenson as Vice-Chair. Commissioner Dial seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

Commissioner Atin nominated Commissioner Gill to participate in the Executive/Finance Committee. Commissioner Gill declined the nomination and in turn nominated Commissioner Narcisa Egan. Commissioner Dial seconded. Commissioner Dial nominated new Commissioner Debra Herwaldt. Commissioner Swenson seconded. Commissioner Pawar nominated Commissioner Laura Espinosa. Commissioner Gill seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

REPORT

4. Chief Executive Officer (CEO) Report

RECOMMENDATION: Accept and file.

CEO Villani welcomed new commissioners. He also introduced new Chief Financial Officer Kashina Bishop and thanked Lyndon Turner for serving as interim CFO. CEO Villani announced that the Association of Community Affiliated Plans (ACAP) has selected Marlen Torres, Manager of Government Affairs, for a policy analyst fellowship in Washington D.C.

CEO Villani announced that Agenda Item No. 7 - Program of All-Inclusive Care for the Elderly (PACE) was changed from a formal action item to informational.

CEO Villani provided high-level information on PACE, highlighting the positive impacts and opportunity for a PACE program in Ventura County to serve the frail, elderly population. The State has given local managed care plans "gate keeper authority" which means GCHP will be responsible to determine who receives letters of support for any PACE applications in Ventura County.

Meeting break at 2:23 p.m. due to audio difficulties.

RECONVENE TO REGULAR MEETING

The Regular Meeting reconvened at 2:34 p.m.

Commissioner Alatorre asked about DHCS' lengthy Medi-Cal re-certification process for providers, which takes several months. He requested that GCHP staff look into providing a system equivalent to the state for the certification of contracted providers within Ventura County and also Los Angeles County.

Chief Operating Officer Watson stated it had been discussed before and will determine what it takes for GCHP to do it, especially within the timeline of other projects. CEO Villani responded he understood the concerns and the team will review, but cannot at present time provide a full response. Commissioner Alatorre stated he would like for GCHP to see what it would take to bring this process in house. Brandy Armenta, Compliance Officer gave a summary of the requirements including outlining the 120-day timeframe and the option to enter into an LOA if the timeframe exceeds 120 days while the outcome is pending.

PUBLIC COMMENT

Dr. Sandra Aldana spoke on behalf of the State Council on Developmental Disabilities, which has a support position on AB2430.

PRESENTATION

5. Community Health Investments Update

RECOMMENDATION: Accept and files the report.

Karen Escalante-Dalton presented an update via PowerPoint presentation on GCHP's Community Health Investments Program, also referred to as GCHP's Grant-Making Program, established in 2017. The purpose of the program is to provide funding to external organizations that address the social determinants of health. Requests for Applications (RFA) were launched last April which identified and

selected non-profit and government organizations that concentrated on three key determinants of health:

- Access to quality and affordable food
- Addressing the Built environment – where communities live i.e. housing, parks, transportation, anything that is physically outside of the clinical setting that impacts health
- Access to health – improving the ability for members to better utilize and take full advantage of their health benefits

Sixteen agencies were selected and over $1.5 million in grants was dispersed last fiscal year. Two grant awardees addressed the Commission with progress reports for the first 6-months of their grant programs. Mixteco Indigena Community Organizing Project (MICOP) Representatives Genevieve Flores-Jaro, Associate Director, and Juana Zaragoza, Mixtec Health Case Manager, shared two member success stories.

Tammy Glenn, Executive Director of Caregivers, also shared an update on their grant program, which allows approximately 500-600 seniors to continue living independently in their own homes while receiving assistance as needed. Ms. Glenn also shared information on two successful member cases.

Commissioner Dial motioned to accept Agenda Items No. 4 and 5. Commissioner Alatorre seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

FORMAL ACTION ITEMS

6. Consideration of and Action on three (3) items to extend Conduent contract for Administrative Services (ASO).

RECOMMENDATION:

1. Approve Conduent Contract extension for ASO Services – includes moving GCHP to a new Administrative Platform. Virtual Benefits Administrator (VBA).
2. Approve Conduent Contract Amendment for IT Services to augment GCHP IT resources during implementation of VBA.

3. Approve Implementation Budget for GCHP to move to a new Administrative Platform/VBA.

Ruth Watson, Chief Operating Officer provided background around the Conduent administrative services agreement. Conduent provides call center functions and claims processing, as well as fulfillment, enrollment, and encounter processing for the Plan. Included in these services is the core administrative processing system, IKA. COO Watson provided the Commission background around IKA and its limitations, particularly in processing Medi-Cal claims, and stressed the need to move to a new core platform. COO Watson discussed the extensive analysis staff conducted over the past year regarding various options to procure and implement a new system including full and partial insourcing, and going to bid for a new Administrative Services Organization (ASO). During the analysis, Conduent offered GCHP an option to extend the existing contract and implement a new core system – Virtual Benefits Administrator (VBA). Conduent selected VBA after an extensive procurement process. Under the new proposal, Conduent would absorb the bulk of implementation costs as well as provide GCHP with immediate reductions in monthly fees along with further fee reductions after implementation.

Commissioner Alatorre stated that in the past there had been issues with the Call Center and noted Spanish speaking staff was needed. COO Watson stated all new hires are bilingual. Commissioner Gill asked how the new system will benefit GCHP members. Rachel Lanser, VBA Representative stated that answers to member inquiries will be quicker and easier with the new platform. Commissioner Alatorre stated he was concerned that VBA did not have a footprint in California and referred back to the original Plan go-live issues with IKA, which impacted provider payments. COO Watson acknowledged that there were issues at go-live, while advising that both GCHP and Conduent are more established and have made significant strides in providing a high level of service to our members and providers. Commissioner Pawar asked about performance guarantees. COO Watson stated that performance guarantees are included in the current contract.

Commissioner Dial motioned to approve all three recommendations for Agenda Item No. 6. Commissioner Swenson seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: Commissioner Alatorre.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

Both Commissioners Alatorre and Pawar were recused at 3:46 P.M. from the PACE presentation and discussion due to conflict of interest.

PRESENTATION

7. Program of All-inclusive Care for the Elderly (PACE)

A PACE video was shown and the purpose of the program was explained. Dr. Si Franz, WellBe Chief Executive Officer, provided an overview of PACE programs in California. The program began approximately 40 years ago in San Francisco with the establishment of On Lok in the Chinese community. PACE addresses the care of frail seniors, providing integrated, high quality, compassionate care that allows them to "age-in-place." Most PACE participants have a four-year life expectancy but still live in their community. Participants in this program extend their life expectancy by one to three years. WellBe conducted a PACE feasibility study, which showed that Ventura County has a large need for this type of program.

Commissioner Atin asked if there were incentives for GCHP and if there was a time limit for parties to show an interest and participate. CEO Villani stated GCHP wants to be the contracted entity and will evaluate working with other organizations to also be a part of PACE. Commissioner Atin asked if bids will be solicited from others and how will other parties know GCHP is interested. COO Watson stated there is an 18-month application process. GCHP wants to apply with DHCS as a GCHP PACE Center. Partners must be selected by July 1, 2018. Commissioner Espinosa requested clarification on the policy letter issued by the DHCS. Commissioner Atin asked if there was a structure in place for other entities to join in and if those entities were interested they need to contact GCHP. The Plan indicated that further community engagement and education meetings would occur over the next thirty days.

PUBLIC COMMENT

Roberto Juarez, appearing on behalf of Clinicas Del Camino Real, Inc. spoke on Agenda Item No. 7.

Mark Kovalik, appearing on behalf of Among Friends ADHC spoke on Agenda Item No. 7.

Katy Krul, appearing on behalf of Oxnard Family Circle spoke on Agenda Item No. 7 in order to learn more about the program.

Maria E. Meza, appearing on behalf of Oxnard Family Circle donated her time to Katy Krul to speak on Agenda Item No. 7.

Dr. Sandra Aldana, appearing on behalf of State Council on Developmental Disabilities spoke on Agenda Item No. 7.

Commissioners Alatorre and Pawar returned to the meeting at 4:43 p.m.

Commissioner Laura Espinosa left the meeting at 4:46 p.m.

FORMAL ACTION ITEM

8. January/February Financials Report

RECOMMENDATION: Accept and file the financials report.

CFO Bishop presented the January/February 2018 financials. The membership trend was reviewed. GCHP TNE was also compared to other Health Plans. A summary of the February 2018 Financial statements was reviewed and it was noted that the loss for the month of February 2018 was higher than the trend due to increased pharmacy expense.

Commissioner Atin motioned to approve the recommendation. Commissioner Dial seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioners Debra Herwaldt and Kelly Long.

Commissioner Alatorre declared the motion carried.

PRESENTATIONS

9. OPTUMRx Pharmacy Update

RECOMMENDATION: Accept and files the report.

Guest Speaker: Jon Mahrt, Chief Operating Officer, OptumRx

Mr. Mahrt addressed the Commission and acknowledged that errors had been made by OptumRx regarding pharmacy claim payments. He stated that GCHP has a pass-through contract with OptumRx and stated there were misconceptions around the issues. Specifically, there are no gag clauses or claw backs. The three payment error issues were due to human coding errors.

Mr. Mahrt gave a brief background on OptumRx. He stated that OptumRx has processed more than 1.3 million prescriptions and has delivered competitive prices. OptumRx conducted an internal audit in June 2016 around the GCHP prescription reimbursement processes and configuration. Commissioner Atin asked if the audit could be shared. Commissioner Pawar asked if there was a similar issue with other plans. Mr. Mahrt replied errors do happen. Commissioner Gill asked about impact on pharmacies and that if OptumRx made the error, why are they not bearing the cost of the error. Commissioner Alatorre asked why the error was not fixed after the first time or the second time. He stated there needs to be clear communication with the pharmacies. Mr. Mahrt stated the error was not caught early and it was a manual coding error. He agreed that communication with the pharmacies was not done effectively. Commissioner Alatorre stated it seemed pharmacies were not getting resolution. Mr. Mahrt stated he would reach out to independent pharmacies and get information needed to each for open communication.

Commissioner Pawar stated there was a concern about customer service, that phone calls for drug authorizations were time consuming, Mr. Mahrt stated he was not aware of that issue but will get facts and return with information. Commissioner Alatorre requested a check on appeals and pre-authorizations as well.

The meeting was recessed for a short break at 5:25 p.m.

Commissioner Theresa Cho, M.D. left the meeting at 5:28 p.m.

Commissioner Johnson Gill left the meeting at 5:31 p.m.

RECONVENE TO REGULAR MEETING

The Regular Meeting reconvened at 5:40 p.m.

10. Pharmacy Benefit Manager (PBM) Report – Excelsior Solutions

RECOMMENDATION: Accept and file report.

Guest Speakers: Ken Dowell, Pharmacy Analysis Board Chair
Kim Foerster, Vice President

Mr. Dowell presented the findings of the OptumRx reimbursement analysis via PowerPoint presentation. Hard copies were distributed to the public upon request.

Mr. Dowell stated issues submitted by Mr. Danny Martinez were not all answered as portions were out of scope for the initial engagement.

Mr. Dowell stated that pharmacy rates are being discussed all over the country. Management of prescription drug costs is a national issue.

Commissioner Atin stated he had three questions:

- Were independent pharmacies getting paid at a lower rate?
- Were independent pharmacies getting paid lower than chains?
- Does OptumRx pay at a lower rate than ScriptCare?

Mr. Dowell stated there had also been a review of PSAO language regarding the contract. The PSAO negotiates with the PBM and chains negotiate as well. The information on the comparison between ScriptCare and OptumRx will be presented at the next Commission meeting which is scheduled for May 21, 2018.

Commissioner Alatorre asked why OptumRx doesn't release changes in the MAC. He asked it the MAC is updated monthly or quarterly. Commissioner Swenson said the issue was that the MAC list changes, but can't be retroactive.

Commissioner Atin asked what the conclusions were from the analysis findings. Mr. Dowell responded that OptumRx's reimbursement rates are within market value.

PUBLIC COMMENT

Chris Platt spoke on Agenda Item No. 10.

Daniel Martinez, appearing on behalf of the CA Pharmacists' Association, spoke on Agenda Item No. 10. Mr. Martinez presented a flash-drive to be shown to the Commission but it was not compatible and therefore not viewed.

Carlos Varela spoke on Agenda Item No. 10.

James Leftwich spoke on Agenda Item No. 10.

Michelle Callahan spoke on Agenda Item No. 10.

Dr. Rajinder Rai spoke on Agenda Item No. 10.

Kent Miles spoke on Agenda Item No. 10.

CLOSED SESSION

The Commission adjourned to Closed Session at 6:20 p.m. regarding the following item:

11. REPORT INVOLVING TRADE SECRETS

Discussion will concern: rates for the PBM program.
Estimated date of public disclosure: Three years from implementation of PBM contract.

Commissioner Lanyard Dial, M.D. left the meeting at 7:14 p.m.

OPEN SESSION

The regular meeting reconvened at 7:17 p.m.

Mr. Campbell stated the reportable action:

Based on the information and analysis provided by Excelsior Solutions, the current rates are market rates and therefore no changes in pharmacy reimbursement are warranted at this time. GCHP staff will continue to work with OptumRx to hold it accountable to its contract and the provision of services under its contract.

The regular meeting ended at 7:21 p.m. due to lack of quorum.

Approved:

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Maddie Gutierrez, Clerk of the Commission

Ventura County Medi-Cal Managed Care Commission
(VCMMCC)
dba Gold Coast Health Plan (GCHP)
May 21, 2018 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., Narcisa Egan, Laura Espinosa (arrived at 2:09 p.m.), Johnson Gill, Debra Herwaldt, Kelly Long, Gagan Pawar, M.D. (arrived at 2:07 p.m.), and Jennifer Swenson.

Absent: Commissioner Lanyard Dial, M.D.

PUBLIC COMMENT

Roberto S. Juarez, CEO, appearing on behalf of Clinicas Del Camino Real – Subject: Minutes. Mr. Juarez stated his concern for the lack of detail in the minutes of April 23, 2018. Mr. Juarez stated the individual who did a presentation was a Commissioner on the COHS for Marin County, did not have a speaker card, but was allowed to present. Clinicas Del Camino Real was the only organization who submitted a letter of intent which was the process that was supposed to be followed by the Commission. Mr. Juarez is concerned they are looking for a letter from Gold Coast so they can guarantee their investors. Mr. Juarez is concerned on the lack of transparency for people who read the minutes on-line. There is local talent in Ventura County, we have the services and skill sets and all departments necessary to do a PACE program within the county. Minutes cannot be one-sided.

Cindy Kema, Director of Operations for Conejo Valley Transit – Subject: Non-Emergency Medical Transportation for Gold Coast Members. Ms. Kema expressed her concern that there is a lack of market competition for non-emergency transportation services in the county which negatively impacts members because they do not have options.

CONSENT CALENDAR

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

   RECOMMENDATION: Approve the minutes.

The motion is amended to state the Clerk will provide a revised set of minutes to include more detailed information for all items on the agenda, including provide comments made by the speakers.

Counsel reminded the Commission that minutes are a summary, and that there are complete audio recordings of each meeting. Recordings are kept for seven years. In the new contract, recordings will be kept for ten years.

Commissioner Swenson moved to accept and file Agenda Item No. 1 with corrections. Commissioner Espinosa seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Debra Herwaldt, Gagan Pawar, M.D. and Jennifer Swenson.

NOES: None.

ABSTAIN: Commissioner Kelly Long.

ABSENT: Commissioner Lanyard Dial, M.D.

Commissioner Alatorre declared the motion carried.

PUBLIC COMMENT

Commission Chair, Antonio Alatorre read the following statement: "Mr. (Daniel) Martinez represents an association of pharmacists and is expected to speak in his representative capacity for many. Mr. Martinez will be allowed 15 minutes for his public comments rather than the usual 3 minute limit. Given the many public comments by pharmacists at prior meetings and the report received by the Commission last month, this is a unique circumstance. The Commission will otherwise continue its standard rule that each person is limited to 3 minutes of public comment, which cannot be donated or yielded to other speakers."

Daniel Martinez, appearing on behalf of the California Pharmacists Association presented a handout to the Commission.

Mr. Martinez provided a history of the PBM. He asserted that in 2014/2015 DHCS implemented a medical audit and a corrective action plan was done. A CAP was in place

and a deadline needed to be met. GCHP began a new PBM search because the ScriptCare contract was expiring on September 30, 2016. Three finalists were identified: OptumRx, ScriptCare and MagellanRx. Qualitative scoring was reviewed. Overall score showed Magellan scored highest. Mr. Martinez said that during a closed session in October 2016 the Commission awarded the contract to OptumRx. GCHP staff stated they didn't anticipate any changes to local pharmacies during the transition period.

In June 2017 OptumRx goes live. In August the first coding error occurred. In December 2017 a second coding error occurs and the Commission brings in an independent consultant to review concerns of pharmacists, payments and benchmark data. In March 2018 a third coding error occurred and a fourth coding error is found in payments made between the dates of February 6-27th. Several examples of underpaid claims were provided in the handout.

Mr. Martinez proposed options for solutions to this issue: 1) Do nothing. 2) Execute a 90-day termination and initiate a new RFP with original terms. 3) Renegotiate the existing contract with OptumRx which would include a full pass-through contract, retroactive payments to pharmacies who had money taken due to human error, remove the exemption of mail-order and specialty claims from pass through and transparent pricing, remove language that allows OptumRx to unilaterally make pricing modifications. He requested the Commission agendize the pharmacy issue and take action at the next Commission meeting scheduled for June.

Dr. Rajinder Rai, Pharmacist - spoke regarding the PBM. Dr. Rai stated she met with Mike Powers, CEO of Ventura County after the May Commission meeting and he was the one who suggested to present today's information before the Commission to come up with a solution to alleviate the on-going problems with OptumRx. She has also met with many legislators at various levels (local, state and federal). Dr. Rai referred to the report Mr. Martinez gave earlier. Dr. Rai ended by stating the Commission will be part of the problem or part of the solution.

CLOSED SESSION

The Commission adjourned to Closed Session at 3:00 p.m. regarding the following items:

2. **Pharmacy Benefit Manager (PBM) Report – Excelsior Solutions**
   Discussion will concern: rates for the PBM program.
   Estimated date of public disclosure: three years from implementation of PBM contract.

3. **Conference with Legal Counsel – Anticipated Litigation**
   Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9
   One case.

4. **Conference with Legal Counsel – Anticipated Litigation**
   Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: Unknown number of cases.

Commissioner Jennifer Swenson left the meeting at 4:23 p.m.

RECONVENE TO OPEN SESSION

The regular meeting reconvened at 5:06 p.m.

General Counsel Rich Egger stated there was no reportable action taken.

REPORTS

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

   RECOMMENDATION: Accept and file.

   CEO Villani reviewed the Governor's budget and stated there was a potential impact on membership. Items of interest for GCHP are:

   - Mental Health initiatives aimed at reducing the number of mentally-ill in the criminal justice system and decreasing homelessness,
   - Medi-Cal health expenditures
   - .

Some proposals could provide increased coverage for seniors and extend Medi-Cal benefits for undocumented youth. The Plan will continue to track these proposals and provide updates to the Commission.

Additional updates:

- Launch of the Administrative Services Organization (ASO) project.

- Delegated vendor oversight – GCHP works with many vendors and the Plan's Compliance and Delegation Oversite team looks at overall performance. OptumRx is under a corrective action plan. The Plan will continue to provide updates on OptumRx's performance. Beacon Health Options (BHO) is the Plan's behavioral health provider. BHO provides great clinical care and services, but struggles with administrative functions around claims processing. GCHP put BHO on a CAP There is also a concern with Ventura Transit System (VTS) and GCHP will move forward with a Request for Proposal (RFP). Brandy Armenta, Compliance Officer stated the CAP was not yet issued but will be in June. A corrective action plan will be issued, once issued it can be discussed further.

DHCS will conduct the Plan's annual medical audit between the dates of June 4 through June 15, 2018. Staff anticipates the audit team will concentrate around delegation oversight. Staff will provide updates to the Commission at the June meeting.

The Commission was given information on the PACE Program at the last Commission meeting held on April 23, 2018. PACE is a Medi-Care program and it brings opportunity bring in new service, new benefits and new monies to the County. Both the CEO and COO met with a number of Adult Day Care Center directors for their input and to understand any concerns. Some expressed concern as to how a PACE program would impact their centers. CEO Villani explained that a PACE Center has specific requirements that must be met. For example, there must be a centralized location where various services are provided and it must coordinate with providers. Clinicas Del Camino Real has stated they are interested in a PACE program. Gold Coast Health Plan also has an interest in this program. Staff will gather more information and present at the June Commission meeting.

Commissioner Atin asked what the Plan staff anticipated bringing back in June regarding the PACE program. Specifically, Commissioner Atin motioned that GCHP staff bring analysis back for the Commission to: 1) make a decision as to whether to move forward if there is interest and, 2) determine the process for moving forward with a PACE program.

Commissioner Long expressed concern that Commission discussion about PACE is primarily focused around contracts. What is missing from the discussion is patient care, which is the ultimate goal. She asked staff to provide information around who is being targeted, what services are needed, and how this will be successful for the community.

Commissioner Atin amended his motion: There will be additional discussion for this program and analysis presented to the Commission in order to determine if PACE will move forward, and if it does, the process for moving forward. Commissioner Espinosa seconded

Commissioner Gill stated the County requested he explore the possibility of a PACE program administered by the VC HCA. He indicated they are looking at internal assets and it is still to be determined if it could be done in partnership or alone.

Commissioner Alatorre stated that at the last Commission meeting he asked how many letters of intent had been received and he had been told several. He requested clarification. COO Watson stated there is no formal letter of intent, there are letters of support. CEO Villani clarified that he was asked who he had spoken with about a PACE program and he responded there were two: The Institute on Aging and WellBe. Commissioner Alatorre stated he specifically asked how many letters of intent were submitted and he was told one.

Commissioner Atin repeated the amended his motion: There will be additional discussion for this program and analysis presented to the Commission in order for the Commission to determine if the process will move forward, if it does, the Commission will determine how the PACE will be processed. Once there is a decision, the Commission will direct GCHP CEO Villani to follow the DHCS rule which states GCHP will have to decide who they will receive the letters of support based on the analysis.

Commissioner Espinosa seconded the amended motion.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Debra Herwaldt, Kelly Long, Gagan Pawar and Jennifer Swenson.
NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Lanyard Dial, M.D.

Commissioner Alatorre declared the motion carried.

Commissioner Atin motioned to accept and file the CEO Report. Commissioner Espinosa seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Debra Herwaldt, Kelly Long, Gagan Pawar and Jennifer Swenson.
NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Lanyard Dial, M.D.

Commissioner Alatorre declared the motion carried.

CONSENT CALENDAR

6. MedHOK Contract Renewal

RECOMMENDATION: Approve the contract renewal.

7. Edifecs Core Renewal

RECOMMENDATION: Approve the contract renewal.

8. Foot Hills Consulting Contract Resources Extension

RECOMMENDATION: Approve the extension

Commissioner Long motioned to accept Consent Items Nos. 6, 7, 8. Commissioner Pawar seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Debra Herwaldt, Kelly Long, Gagan Pawar and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Lanyard Dial, M.D.

Commissioner Alatorre declared the motion carried.

FORMAL ACTION

9. March Financials Report

RECOMMENDATION: Accept and file.

CFO Bishop gave a brief overview of the capitation rates, and the methodology for which they are established. GCHP is operating at a loss and this could continue through next fiscal year. Initial financial projections indicate that GCHP could see an increase in capitation revenue for FY 19/20which would allow for the potential to build back up reserves.

Commissioner Espinosa asked about Adult Expansion – will it expire with ACA. COO Watson responded they will still have benefits but the money changes.

CFO Bishop also reviewed the membership trend. In January, February and March the trend was lower but it has increased for the month of April. At the end of March, there was a net gain of just over $700,000 due to receivable for pharmacy performance guarantee. Fiscal year to date there is a loss of 16.4 million.

CEO Villani wanted to clarify that in the past, for financial reserves, we had too much money sitting idle. The Commission requested that we use these reserves for the community, therefore, a one-time grants program in the amount of $1.5 million and also increased the reimbursement rate on several of our big contracts. We are now recalibrating and working through for next year. We are more thoughtful on contract rates.

Commissioner Egan asked about the impact of facility expense AB85 and rate reduction? CFO Bishop replied we received the revenue from the State and it is then distributed out as directed by the State and Hospital Association. Commissioner Egan asked if this was part of the cost. CFO Bishop stated it is a pass-through and is not built into the standard process for establishing capitation rates.

Commissioner Alatorre asked about the pharmacy line item – why is it $3 million if we are averaging $9 - $10 million? CFO Bishop stated this was due to performance guarantee. Lyndon Turner, Senior Director of Finance, stated we learned about significant adjustments consolidated into net credit.

Commissioner Long motioned to accept and file the March financials report. Commissioner Alatorre seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Debra Herwaldt, Kelly Long, Gagan Pawar and Jennifer Swenson.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Lanyard Dial, M.D.

Commissioner Alatorre declared the motion carried.

Commissioner Alatorre left the meeting at 5:52 p.m. Commissioner Pawar took over Chairing the meeting.

REPORTS

10. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report.

CDO Bagley stated the Diversity Council has held meetings. The long-term Strategic Plan was reviewed. Both Commissioners Atin and Espinosa had comments and they were reviewed. The next step is to ensure the Strategic Plan is in step with the business. Leader Training has started and a Performance Management training was held in March. There will continue to be more trainings for Managers.

CDO Bagley stated there are currently no open cases.

Mr. Bagley stated he would like to establish relationships within GCHP as well as in the community. If you have credibility, if your brand is strong then people will let you know when there are issues and they can be solved. CDO Bagley plans to have the

GCHP Diversity Council meet with other councils in other organizations. He will get best practices from other organizations.

Commissioner Espinosa asked about the timeline for the permanent CDO. CDO Bagley stated he had been asked about his availability. In September/October GCHP will begin looking for a permanent CDO.

Commissioner Espinosa noted the focus was on employees, but what about PACE? Or Beacon? CDO Bagley stated he needs to start with foundation and will develop more phases. He is trying to establish an all-inclusive network. Commissioner Atin thanked Mr. Bagley for putting structures in place. Commissioner Espinosa stated she would like to see the diversity Council work on community grants. Mr. Bagley stated he will look into partnership for community grants.

Commissioner Espinosa asked how the Diversity Council measures success. Mr. Bagley replied the council has set up a diversity chart and he has begun to train the council.

Commissioner Long motioned to accept and file. Commissioner Atin seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Debra Herwaldt, Kelly Long, and Gagan Pawar.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Antonio Alatorre, Lanyard Dial, M.D. and Jennifer Swenson.

Commissioner Pawar declared the motion carried.

11. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.

Chief Operating Officer Ruth Watson stated her report would be brief. She stated the ASO kick-off has begun. There have been several meetings with Americas Health Plan (AHP) over the past few weeks and the teams will work on deliverables and reconvene after the DHCS audit scheduled for June 4th through the 15th is completed.

All operational metrics are being met with one exception. Grievance and Appeals turn-around time continues to be an issue. This metric has a standard of 100% and when documents are mis-directed or submitted to other departments the team's ability to meet this metric is impacted. Grievance and Appeal continues to work to educate

other departments to insure that grievance and appeals are forwarded immediately for processing.

Commissioner Long motioned to accept and file. Commissioner Espinosa seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Debra Herwaldt, Kelly Long, and Gagan Pawar.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Antonio Alatorre, Lanyard Dial, M.D. and Jennifer Swenson.

Commissioner Pawar declared the motion carried.

12. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

Chief Medical Officer (CMO) Dr. Nancy Wharfield stated HEDIS evaluation is going toward "All data". The organization is trying to hit HEDIS marks and there is a chart review when the marks are not hit. Codes must be completed in the system.

Quality analysis is becoming more about quality of data for future. The HEDIS overlaps with the quality audit. The final analysis report will be presented soon. Utilization review was summarized and is getting "tight and flat." Quarterly performance improvement is presented. Dr. Cho stated there is a struggle inputting codes due to time constraints. Dr. Anne Freese gave the pharmacy report – standard graphs were reviewed. OptumRx has been informed they are on a corrective action plan for 12 items. Six of the items are almost complete and corrected. OptumRx submitted their improvement plan. Commissioner Long stated she expected monthly updates. CEO Villani state GCHP needs to balance contract issues and concentrate on HEDIS. Commissioner Long stated there is a need to create better outcomes. Commissioner Pawar asked about dollars paid for prescriptions. Dr. Freese replied that brand prescriptions are always an increase in cost and every year in July we will see an increase.

Commissioner Long motioned to accept and file. Commissioner Espinosa seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Narcisa Egan, Laura Espinosa, Johnson Gill, Debra Herwaldt, Kelly Long, and Gagan Pawar.

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Antonio Alatorre, Lanyard Dial, M.D. and Jennifer Swenson.

Commissioner Pawar declared the motion carried.

CLOSED SESSION

The Commission adjourned to Closed Session at 6:22 p.m. regarding the following items:

13. Public Employee Performance Evaluations
Title: Interim Chief Diversity Officer
Title: Chief Executive Officer

Commissioner Long left the meeting at 6:49 p.m.

RECONVENE TO OPEN SESSION

The regular meeting reconvened at 6:53 p.m.

General Counsel Rich Egger stated there was no reportable action taken.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 7:03 p.m.

Approved:

_____

Maddie Gutierrez, Clerk of the Commission

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AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: June 25, 2018

SUBJECT: TBJ Consulting – Additional Funding for Chief Diversity Officer Services

SUMMARY:

In November of 2017, the Plan contracted with TBJ Consulting for provision of services related to the Chief Diversity Officer position. The Statement of Work in the services agreement anticipated that TBJ Consulting would spend only 32 hours a month working on diversity-related concerns, complaints, and investigations. Importantly, at the onset of services, TBJ Consulting indicated its concern that additional hours might be necessary because of continued scrutiny from certain community groups, as well as the scope of ongoing employee concerns. Recall that the Chief Diversity Officer position was anticipated to be full time. In order to effectively address Statement of Work, and in order to address increased utilization, the projected spend through the contract period ending November 30, 2018 is now projected at approximately $225,000, or an average of 72 hours per month.

TBJ Consulting has stated that the significant increase was required to address necessary community outreach, plan implementation, and diversity training, as well as continued investigative and complaint-resolution services. At the onset of services, TBJ Consulting was required to engage in significant community outreach, coordinating with community groups that had received complaints from employees. While the Plan is familiar with public concerns expressed by LULAC, TBJ Consulting was also required to coordinate and reach out to the NAACP, the California Labor Commissioner, and various educational institutions. Further, as services ramped up, TBJ Consulting developed and implemented a Diversity and Inclusion Strategic Plan and a Diversity and Inclusion Council. Similarly, TBJ Consulting put in significant work coordinating with and supporting the Plan's executive and human resources teams and implementing diversity-related training, such as the "Lunch and Learn" diversity series. In addition to these community-relations, ramp-up activities, and training services, TBJ Consulting continued to engage employee concerns. A confidential log of individual employee cases is maintained by TBJ Consulting.

FISCAL IMPACT:

The agreement is a non-requirements contract which allows the Plan to use the services *ad hoc*, at the hourly rate specified. The fixed fee set forth in the agreement is currently $250.00 per hour "as planned". The agreement can be terminated for convenience at any time with a fourteen (14) day notice. The Plan has spent $105,000 through May. The remaining six (6) months of work, however, is projected to be an additional $120,000, making the cumulative amount of this agreement $225,000.

RECOMMENDATION:

It is the Plan's recommendation to continue service with TBJ Consulting.

If the Commission desires to review this contract, it's available at GCHP's Finance Department.

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: June 25, 2018

SUBJECT: Chief Executive Officer Update

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

National Legislative Update

Affordable Care Act (ACA)

On June 7, the Department of Justice said it would not defend the law against a legal challenge filed by Texas and 19 other states; instead, the Justice Department wants to overturn key Obamacare provisions. The lawsuit filed earlier this year claims that Congress' decision to eliminate Obamacare's individual mandate penalty means the whole health law should be ruled invalid. However, the Justice Department says that the ACA's Medicaid coverage provisions could be kept unlike provisions that protect people with pre-existing conditions, or who are older and sicker.

Legal experts see a long and winding road for the case with the prospects for success of the underlying suit unlikely.

Opioid Legislation

On June 12, the Senate Finance Committee approved its draft legislation to address the opioid crisis, the same day that the House began voting on dozens of its own opioid-related bills.

The bipartisan committee package combines 22 bills recently introduced by committee members. It includes provisions that would expand telehealth access for addiction treatment, remove lifetime limits under Medicaid for Medication Assisted Treatment for substance use disorder, and support treatment through family-focused residential programs. It would also require that health care professionals use electronic prescribing for Medicare-covered drugs for certain controlled substances. The bill would cost $162 million over 10 years, according to a preliminary committee estimate.

The committee adopted by voice vote an amendment by Senator Sherrod Brown (D-Ohio) that would amend the 2016 opioid-related law known as the Comprehensive Addiction and

Recovery Act. It would change a section of that law designed to prevent prescription drug abuse among at-risk people in Medicare health or drug plans. The amendment would allow them to appeal more quickly if they're considered at risk and are forced to use a limited number of prescribers and pharmacies.

The House is voting the week of June 11 on 26 opioid bills previously advanced by the House Energy and Commerce Committee. These bills are unlikely to be contentious, though additional bills scheduled for debate later in the week may face opposition from some Democrats.

California Legislative Update

California State Budget

On June 8, the joint Budget Conference Committee completed its work and the final budget will be voted on by the Legislature by June 15. Legislative leadership called for more spending to expand health care services; however, the final budget deal includes only minor increases in health care spending. There was no allocation to provide health care for adult undocumented immigrants. Nor did the budget include funding to restore or add benefits under the Medi-Cal Program. Instead of expanding access to health care, as Democrats advocated, the budget will only allocate $5 million to study the issue.

The Legislature also rejected the Governor's proposal to eliminate the 340B Pharmaceutical Program. Negotiations continue between the clinics, public hospitals, health plans, and the Department of Health Care Services (DHCS) on language to require new reporting requirements intended to bring more transparency to the program.

A complete budget report will be given at next month's Commission meeting.

Legislative Bills

The Legislature met its May 31, "House of Origin", deadline. This means that all Assembly bills must pass the Assembly Chamber and Senate bills must pass the Senate Chamber in order to continue moving along the process. Due to this deadline, the Legislature convened for three consecutive days on the Floor of each house to discuss and vote on the hundreds of bills before them.

Legislative bills of interest, authored by Assemblymember Joaquin Arambula (D- Fresno), include AB 2965, which would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages who are otherwise eligible for those benefits if not for their immigration status. AB 2965 moved out of the Assembly and is awaiting to be heard in the Senate Health Committee. Another bill of interest is AB 2275, this measure requires the Department of Health Care Services (DHCS) to establish a Quality Assessment and Performance Improvement program for all Medi-Cal Managed Care (MCMC) plans, through which the MCMC plans, commencing

January 1, 2021, would be required to meet a minimum performance level. The MCMC plans would be required to meet the performance targets to receive specified financial incentives. AB 2275 is currently in the Senate Health Committee.

Finally, AB 2430 would increase income eligibility in the Aged, Blind and Disabled Federal Poverty Level Program from 100% of the federal poverty level (FPL) to 138% of the FPL making this population eligible for Medi-Cal full benefits without a share of cost, moved out of the Assembly and is currently in the Senate Appropriations Committee.

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COMPLIANCE UPDATE:

DHCS Annual Medical Audit:

Audits and Investigations (A&I) conducted the annual 2016-2017 onsite medical audit during the weeks of June 5, 2017 through June 16, 2017. Gold Coast Health Plan (GCHP) received the Corrective Action Plan (CAP) from DHCS on March 28, 2018. The CAP identified (2) findings. The CAP submission was due April 27, 2018 and DHCS issued a closure letter on May 24, 2018.

Audits and Investigation conducted the annual 2017-2018 onsite medical audit June 4, 2018 through June 15, 2018. The auditors reviewed the following areas: Utilization Management, Care Management and Care Coordination, Access and Availability, Grievance and Appeals, HIPAA, Fraud, Waste and Abuse, Delegation Oversight, Quality Improvement and Administrative Capacity. Staff will provide ongoing updates to the commission once received by A&I.

DHCS Contract Amendments:

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

Delegation Oversight:

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

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

Delegation Audit(s) Update:

Delegate	Audit Year and Type	Audit Status	Date CAP Issued	Date CAP Closed
CDCR	Credentialing 2018	Closed	N/A	February 14, 2018
CMH	Credentialing 2018	Closed	N/A	February 26, 2018
VCMC	Credentialing 2018	Closed	N/A	February 16, 2018
USC	Credentialing 2018	Closed	March 8, 2018	May 17, 2018
VTS	Security Risk Assessment	*Open	September 20, 2016	Under CAP
Conduent	Claims	*Open	December 28, 2017	Under CAP
Kaiser	Claims	*Open	February 8, 2018	Under CAP
VSP	Claims	*Open	March 15, 2018	Under CAP
CDCR	UM	Closed	February 6,2018	March 2,2018
Beacon	UM, QI, RR, C&L	Closed	March 15, 2018	April 26, 2018

Audit Status Open: Audits are closed when the CAP is closed.

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

Delegate	Audit Type	Audit Month	Date CAP Issued	Date CAP Closed
VSP	QI	April	N/A	N/A
Beacon	Claims	April	May, 9, 2018	Under CAP
VTS	Transportation	May	June 7, 2018	Under CAP
City of Hope	Credentialing	June	*Pending results from Audit	
Conduent	Claims	June	May 25, 2018 notification sent for failure to provide files timely, onsite audit cancelled as a result. CAP issued June 20, 2018	Under CAP

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

RECOMMENDATION:

Accept and File

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: June 25, 2018

SUBJECT: April 2018 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached April 2018 fiscal year-to-date (FYTD) financial statements of Gold Coast Health Plan ("Plan") to the Commission for approval. The Executive / Finance Committee has reviewed the financials and has recommended approval.

BACKGROUND/DISCUSSION:

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

FISCAL IMPACT:

Financial Highlights

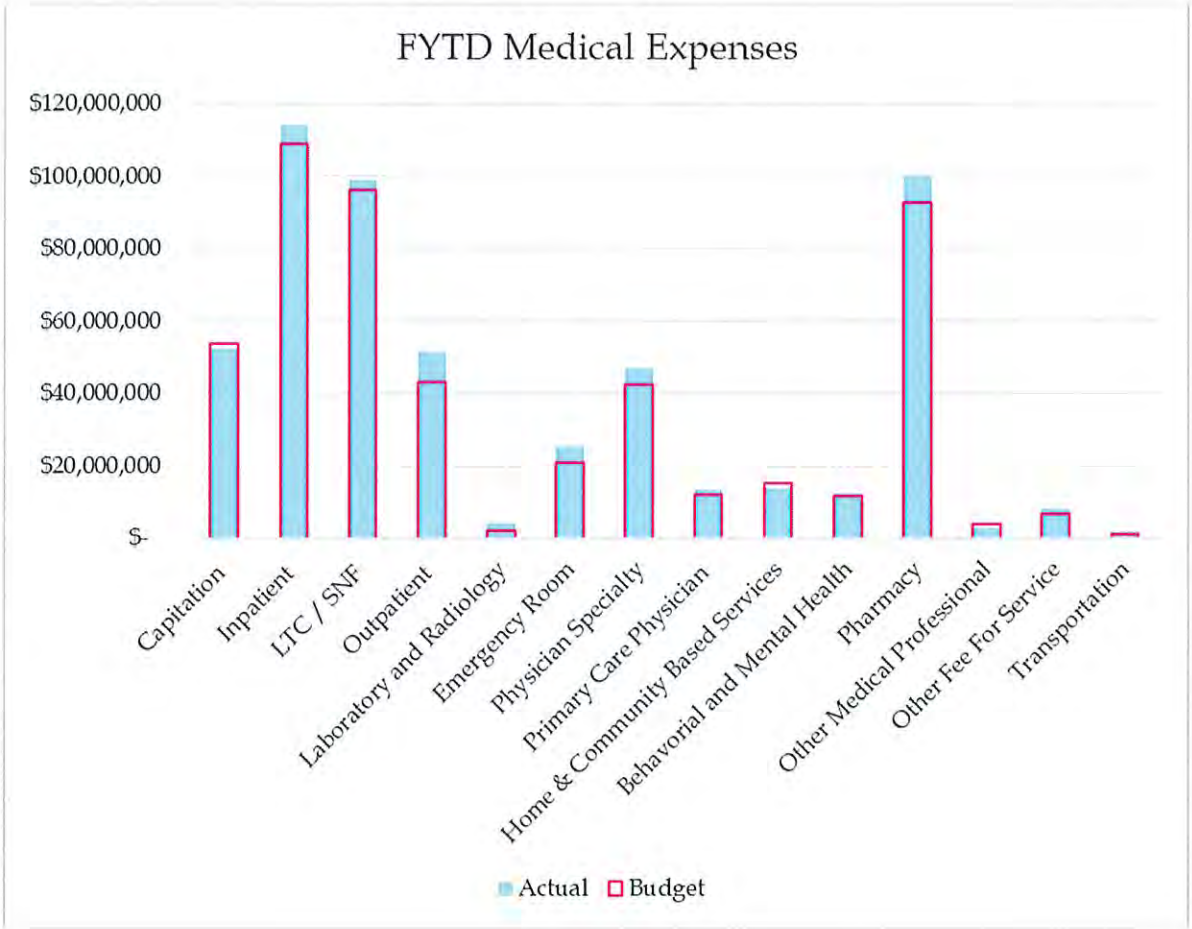
- For the ten month period ended April 30, 2018, the Plan's performance is a decrease in net assets of $153 thousand, which is $2.0 million more than budget.
- April FYTD net revenue is $593.0 million, $23.1 million higher than budget.
- Cost of health care is $555.9 million, $28.4 million higher than budget.
- The medical loss ratio is 93.8 percent of revenue, which is 1.2 percent higher than the budget.
- The administrative cost ratio is 6.9%, 0.4 percent lower than budget.
- April membership of 202,381 was 808 members lower than budget, but 937 higher than March's membership of 201,444.
- Tangible Net Equity is $142.2 million which represents just over two months of operating expenses in reserve and 429% of the required amount by the State.

Revenue – April FYTD net revenue was $593.0 million or $23.1 million higher than budget. Approximately $4.7 million of additional revenue was generated by retroactivity and associated rate adjustments. April's results also include approximately $12.9 million of additional net revenue generated by the AB85 Cost Balance payment due to the County Designated Public Hospital. The revenue associated with AB 85 Cost Balance is an actuarial amount calculated at the State, while the expense component is based on actual cost data submitted by the hospital. The Department of Health Care Services has recently announced that CMS will apply the Adult Expansion (AE) risk corridor requirements to FY2016-17. As a result, it may be necessary to record a reserve of approximately $4.0 million to meet the requirement, thereby reducing this

revenue. Membership mix also contributed to the revenue increase through higher than expected AE and Seniors and Persons with Disabilities (SPD) member-months.

MCO Tax – MCO tax is a pre-determined liability in accordance with Senate Bill X2-2, passed in October 2016. The Plan's MCO tax liability for FY 2018 is $89.3 million, accrued at a rate of approximately $7.4 million per month. The third quarterly installment of MCO tax was paid on April 2. The next quarterly installment payment is due on July 2, 2018.

Health Care Costs – April FYTD health care costs were $555.9 million, which is $28.4 million higher than budget. The medical loss ratio (MLR) was 93.8 percent versus 92.6 percent for budget. April's health care costs and MLR were $54.8 million and 73.6 percent, respectively.



As displayed in the above graph, medical expenses are over budget in several service categories. The cause of the significant variances are as follows:

- Outpatient exceeded budget by $8.6 million (19.9%). The variance is mainly the result of contract rate increases. As compared to the same ten-month period in the prior year, the average paid-per-utilization increased by 23.5%, while utilization increased by only 0.5%.
- Lab and Radiology exceeded the budget by $1.9 million (82.9%). Utilization increased by 17.8% and unit cost increased by 18.4% over the comparable period last fiscal year.

High volume was noted for a major lab chain, a sleep disorders lab and a reproductive testing specialty lab.

- Emergency Room exceeded the budget by $4.5 million (21.8%) as a result of contract rate increases. Paid-per-utilization was 28.5% above the same period last year, while utilization increased 3.0%.
- Physician Specialty and Primary Care Physician exceeded budget by 4.4 million (10.4%) the high dollar-volume specialty types are Diagnostic Evaluation and Consultation, Radiology and Imaging Diagnostics and Anesthesia, with these three categories comprising nearly 58% of the total specialty services.
- Primary Care Physician exceed budget by $1.5 million (12.2%). The heaviest utilization occurred in standard office visits, and Primary Care display noticeable seasonal tendencies. Spikes in office visits were noted in the winter months.
- Home and Community Based Services was lower than budget by $1.5 million (9.5%). The largest component, CBAS, experienced flat utilization, but this was accompanied by minor rate decreases as compared to the same 10 months of the prior year. Hospice maintained steady rates, but experienced a notable decline in utilization.
- Other Medical Professional was under budget by $1.1 million (27.0%). A large portion of this category is related to eye care and physical therapy. While utilization and unit cost are gently rising, the increases are lower than anticipated in the budget.
- Other Fee-For-Service exceeded budget by $1.4 million (21.9%) due to a slow but steady increase in volume. To a large extent, this category is driven by medical supplies and DME.

Adult Expansion Population 85% Medical Loss Ratio – The Balance Sheet contains a $140.8 million reserve for return of potential Medi-Cal capitation revenue to the DHCS under the terms of the MLR contract language.

	Expansion Population				Classic Population
	1/1/2014 - 6/30/2015 MLR Period 1	7/1/2015 - 6/30/2016 MLR Period 2	7/1/2016 - 6/30/2017 MLR Period 3	7/1/2017 - 4/30/2018 MLR Period 4	7/1/2017 - 4/30/2018
Total Revenue	361,237,234	293,173,426	268,060,238	247,538,414	356,624,139
Total Estimated Medical Expense	206,719,452	237,729,974	234,431,483	220,673,072	349,538,479
	57.2%	81.1%	87.5%	89.1%	98.0%
Total MLR Reserve	**118,418,494**	**22,425,065**			

Administrative Expenses – For the ten months ended April 30, administrative costs were $40.8 million or $471,000 below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 6.9 percent versus 7.2 percent for budget.

Cash and Medi-Cal Receivable – At April 30, the Plan had $367.2 million in cash and short-term investments and $95.1 million in Medi-Cal Receivables. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $157.2 million.

Investment Portfolio – At April 30, 2018, the value of the investments (all short term) was $196.2 million. The portfolio included Cal Trust $51.5 million; Ventura County Investment Pool $60.5 million; LAIF CA State $64.3 million; commercial paper $19.9 million; the portfolio yielded a rate of 1.54%.

RECOMMENDATION:

Staff requests that the Commission accept and file the April 2018 financial package.

CONCURRENCE:

N/A

ATTACHMENT:

April 2018 Financial Package

Gold Coast Health Plan℠
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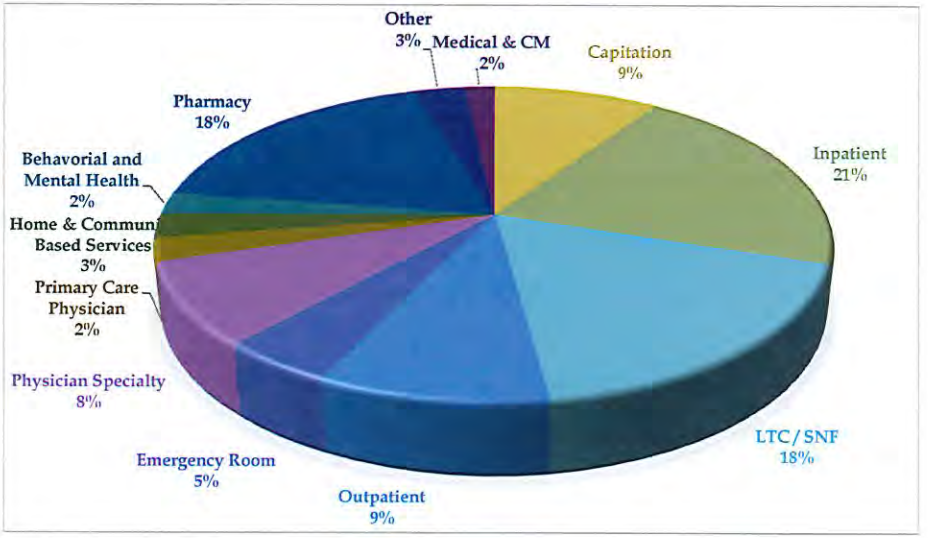
FINANCIAL PACKAGE
For the month ended April, 2018

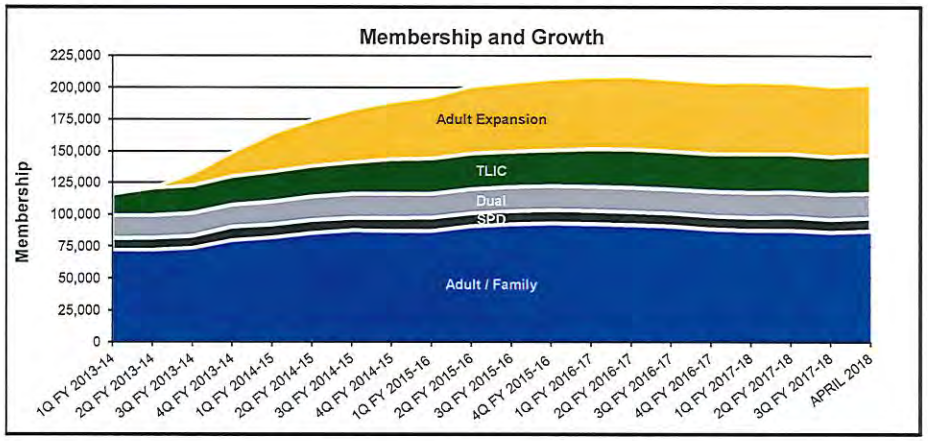
TABLE OF CONTENTS

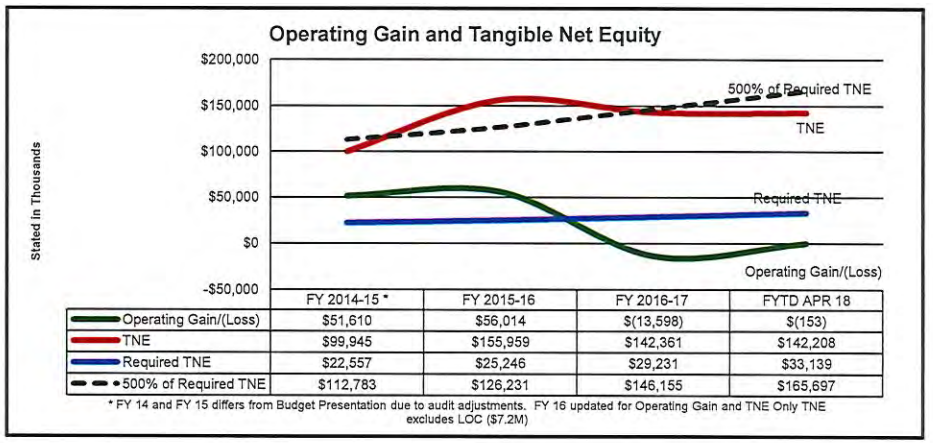
Gold Coast Health Plan

Executive Dashboard as of April 30, 2018

	FY 17/18 Budget	FY 17/18 FYTD	FY 16/17 Actual	FY 15/16 Actual
Average Enrollment	204,145	203,088	207,100	201,095
Revenue	$ 279.14	$ 291.97	$ 273.72	$ 279.98
Capitation	$ 26.39	$ 25.81	$ 26.22	$ 42.27
Inpatient	$ 53.40	$ 56.28	$ 53.44	$ 46.58
LTC / SNF	$ 47.09	$ 48.80	$ 47.86	$ 43.72
Outpatient	$ 21.08	$ 25.41	$ 23.17	$ 18.29
Emergency Room	$ 10.20	$ 12.49	$ 9.07	$ 8.23
Physician Specialty	$ 20.84	$ 23.13	$ 22.55	$ 19.35
Primary Care Physician	$ 5.91	$ 6.67	$ 6.45	$ 6.11
Home & Community Based Services	$ 7.46	$ 6.79	$ 7.33	$ 6.27
Behavorial and Mental Health	$ 5.71	$ 6.08	$ 4.57	$ (0.64)
Pharmacy	$ 45.40	$ 49.46	$ 47.76	$ 41.70
Other	$ 9.09	$ 8.13	$ 6.57	$ 3.26
Medical & CM	$ 5.82	$ 4.68	$ 4.92	$ 6.52
	$ 258.40	$ 273.72	$ 259.91	$ 241.66
% of Revenue	92.6%	93.8%	95.0%	86.3%
Total Administrative Expenses	$ 41,286,249	$ 40,814,901	$ 51,176,317	$ 38,256,908
% of Revenue	7.2%	6.9%	7.5%	5.7%
TNE	$ 144,160,152	$ 142,207,706	$ 142,360,951	$ 155,959,127
Required TNE	$ 28,710,631	$ 33,139,410	$ 29,231,052	$ 25,246,284
% of Required	502%	429%	487%	618%







	FY 2014-15 *	FY 2015-16	FY 2016-17	FYTD APR 18
Operating Gain/(Loss)	$51,610	$56,014	$(13,598)	$(153)
TNE	$99,945	$155,959	$142,361	$142,208
Required TNE	$22,557	$25,246	$29,231	$33,139
500% of Required TNE	$112,783	$126,231	$146,155	$165,697

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

Return to Agenda

STATEMENT OF FINANCIAL POSITION

	04/30/18	03/31/18
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	$ 171,002,203	$ 173,830,109
Total Short-Term Investments	196,217,013	175,910,860
Medi-Cal Receivable	95,054,432	82,529,212
Interest Receivable	589,676	545,164
Provider Receivable	443,928	491,649
Other Receivables	3,809,386	6,903,910
Total Accounts Receivable	99,897,422	90,469,934
Total Prepaid Accounts	1,458,171	1,673,963
Total Other Current Assets	135,560	135,560
Total Current Assets	468,710,370	442,020,427
Total Fixed Assets	1,978,733	1,962,221
Total Assets	$ 470,689,102.75	$ 443,982,648
LIABILITIES & NET ASSETS		
Current Liabilities:		
Incurred But Not Reported	$ 48,795,918	$ 48,190,749
Claims Payable	19,659,066	24,194,830
Capitation Payable	57,516,379	57,430,870
Physician Payable	4,185,159	0
AB 85 Payable	20,570,412	0
DHCS - Reserve for Capitation Recoup	140,843,559	140,843,559
Accounts Payable	4,617,876	609,164
Accrued ACS	1,701,053	1,723,169
Accrued Expenses	22,801,655	22,437,361
Accrued Premium Tax	5,381,576	20,272,257
Accrued Payroll Expense	1,393,012	1,327,330
Total Current Liabilities	327,465,664	317,029,290
Long-Term Liabilities:		
Other Long-term Liability-Deferred Rent	1,015,733	1,019,133
Total Long-Term Liabilities	1,015,733	1,019,133
Total Liabilities	328,481,397	318,048,423
Net Assets:		
Beginning Net Assets	142,360,951	142,360,951
Total Increase / (Decrease in Unrestricted Net Assets)	(153,246)	(16,426,726)
Total Net Assets	142,207,706	125,934,225
Total Liabilities & Net Assets	$ 470,689,102.75	$ 443,982,648
	-	-

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR TEN MONTHS ENDED APRIL 30, 2018

	April 2018	April 2018 Year-To-Date		Variance	Variance	April 2018 Year-To-Date		Variance
	Actual	Actual	Budget	Fav / (Unfav)	%	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	202,381	2,030,877	2,041,447	(10,570)	-0.52%	PMPM - FYTD		
Revenue								
Premium	$ 102,483,285	$ 713,039,826	$ 648,359,242	$ 64,680,583	9.98%	$ 351.10	$ 317.60	$ 33.50
Facility Expense AB85	(20,570,412)	(34,885,333)	0	$ (34,885,333)	0.00%	(17.18)	-	$ (17.18)
Reserve for Rate Reduction	-	(9,573,613)	0	(9,573,613)	0.00%	(4.71)	-	(4.71)
MCO Premium Tax	(7,445,341)	(75,629,804)	(78,519,542)	2,889,738	-3.68%	(37.24)	(38.46)	1.22
Total Net Premium	**74,467,532**	**592,951,076**	**569,839,701**	**23,111,375**	**4.06%**	**291.97**	**279.14**	**12.83**
Total Revenue	**74,467,532**	**592,951,076**	**569,839,701**	**23,111,375**	**4.06%**	**291.97**	**279.14**	**12.83**
Medical Expenses:								
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,305,910	52,419,753	53,883,003	1,463,251	2.72%	25.81	26.39	0.58
FFS Claims Expenses:								
Inpatient	11,434,948	114,290,062	109,003,815	(5,286,248)	-4.85%	56.28	53.40	(2.88)
LTC / SNF	9,753,858	99,099,984	96,125,627	(2,974,358)	-3.09%	48.80	47.09	(1.71)
Outpatient	4,428,710	51,599,260	43,035,244	(8,564,016)	-19.90%	25.41	21.08	(4.33)
Laboratory and Radiology	399,494	4,171,227	2,280,769	(1,890,458)	-82.89%	2.05	1.12	(0.94)
Emergency Room	2,707,428	25,375,423	20,832,170	(4,543,253)	-21.81%	12.49	10.20	(2.29)
Physician Specialty	4,808,831	46,974,994	42,546,451	(4,428,543)	-10.41%	23.13	20.84	(2.29)
Primary Care Physician	1,387,750	13,538,725	12,072,452	(1,466,273)	-12.15%	6.67	5.91	(0.75)
Home & Community Based Services	1,573,606	13,786,184	15,237,687	1,451,502	9.53%	6.79	7.46	0.68
Applied Behavior Analysis Services	801,425	7,014,589	3,892,674	(3,121,915)	-80.20%	3.45	1.91	(1.55)
Mental Health Services	162,950	5,338,514	7,753,855	2,415,340	31.15%	2.63	3.80	1.17
Pharmacy	9,834,469	100,444,582	92,681,798	(7,762,784)	-8.38%	49.46	45.40	(4.06)
Other Medical Professional	312,559	2,909,393	3,987,437	1,078,045	27.04%	1.43	1.95	0.52
Other Medical Care	0	26,059	0	(26,059)	0.00%	0.01	-	(0.01)
Other Fee For Service	638,154	8,050,276	6,604,969	(1,445,307)	-21.88%	3.96	3.24	(0.73)
Transportation	229,059	1,897,368	1,216,137	(681,231)	-56.02%	0.93	0.60	(0.34)
Total Claims	48,473,241	494,516,641	457,271,084	(37,245,557)	-8.15%	243.50	223.99	(19.51)
Medical & Care Management Expense	909,840	9,496,297	11,889,181	2,392,884	20.13%	4.68	5.82	1.15
Reinsurance	246,810	1,642,714	4,470,769	2,828,055	63.26%	0.81	2.19	1.38
Claims Recoveries	(138,777)	(2,178,775)	0	2,178,775		(1.07)	-	1.07
Sub-total	1,017,873	8,960,236	16,359,950	7,399,714	45.23%	4.41	8.01	3.60
Total Cost of Health Care	**54,797,024**	**555,896,630**	**527,514,037**	**(28,382,592)**	**-5.38%**	**273.72**	**258.40**	**(15.32)**
Contribution Margin	**19,670,508**	**37,054,446**	**42,325,664**	**(5,271,217)**	**-12.45%**	**18.25**	**20.73**	**(2.49)**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	1,797,815	18,980,654	19,881,936	901,282	4.53%	9.35	9.74	0.39
Training, Conference & Travel	15,721	202,869	514,363	311,494	60.56%	0.10	0.25	0.15
Outside Services	2,161,164	21,894,813	22,992,244	1,097,431	4.77%	10.78	11.26	0.48
Professional Services	298,808	3,107,116	2,861,009	(246,107)	-8.60%	1.53	1.40	(0.13)
Occupancy, Supplies, Insurance & Others	600,330	5,802,492	6,925,878	1,123,386	16.22%	2.86	3.39	0.54
ARCH/Community Grants	0	323,254	0	(323,254)	0.00%	0.16	-	(0.16)
Care Management Credit	(909,840)	(9,496,297)	(11,889,181)	(2,392,884)	20.13%	(4.68)	(5.82)	(1.15)
Total G & A Expenses	**3,963,998**	**40,814,901**	**41,286,249**	**471,348**	**1.14%**	**20.10**	**20.22**	**0.13**
Total Operating Gain / (Loss)	**$ 15,706,511**	**$ (3,760,455)**	**$ 1,039,414**	**$ (4,799,870)**	**-461.79%**	**$ (1.85)**	**$ 0.51**	**$ (2.36)**
Non Operating								
Revenues - Interest	566,969	3,607,209	759,786	2,847,423	374.77%	1.78	0.37	1.40
Total Non-Operating	566,969	3,607,209	759,786	2,847,423	374.77%	1.78	0.37	1.40
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 16,273,480**	**$ (153,246)**	**$ 1,799,201**	**$ (1,952,447)**	**-108.52%**	**(0.08)**	**0.88**	**(0.96)**

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STATEMENT OF CASH FLOWS	FYTD 17-18
Cash Flows Provided By Operating Activities	
Net Income (Loss)	$ (153,246)
Adjustments to reconciled net income to net cash provided by operating activities	
Depreciation on fixed assets	443,968
Amortization of discounts and premium	(283,505)
Changes in Operating Assets and Liabilites	-
Accounts Receivable	27,806,968
Prepaid Expenses	2,040,826
Accounts Payable	(102,917,985)
Claims Payable	1,164,507
MCO Tax liablity	(13,794,149)
IBNR	(4,570,429)
Net Cash Provided by Operating Activities	(90,263,046)
Cash Flow Provided By Investing Activities	
Proceeds from Restricted Cash & Other Assets	
Proceeds from Investments	205,000,000
Proceeds for Sales of Property, Plant and Equipment	-
Payments for Restricted Cash and Other Assets	-
Purchase of Investments plus Interest reinvested	(121,475,840)
Purchase of Property and Equipment	(80,635)
Net Cash (Used In) Provided by Investing Activities	83,443,525
Cash Flow Provided By Financing Activities	
None	-
Net Cash Used In Financing Activities	-
Increase/(Decrease) in Cash and Cash Equivalents	(6,819,521)
Cash and Cash Equivalents, Beginning of Period	177,821,723
Cash and Cash Equivalents, End of Period	$ 171,002,203

Gold Coast Health Plan℠
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www.goldcoasthealthplan.org

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: June 25, 2018

SUBJECT: Fiscal Year 2018-2019 Operating and Capital Budgets

SUMMARY:

Staff is presenting the Fiscal Year 2018-2019 Operating and Capital Budgets of Gold Coast Health Plan (GCHP) to the Commission. Staff presented an overview of these budgets to the Executive/Finance Committee on June 7, 2018.

The Executive/Finance Committee reviewed and recommends the approval of the Fiscal Year 2018-2019 budgets as presented.

RECOMMENDATION:

Staff requests that the Ventura County Medi-Cal Managed Care Commission approve the Fiscal Year 2018-2019 Operating and Capital Budgets.

Integrity • Accountability • Collaboration • Trust • Respect

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FY 2018-19 OPERATING AND CAPITAL BUDGETS

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

Executive Budget Summary

Overview

In looking forward to fiscal year 2018-19, Gold Coast Health Plan faces the fiscal challenge of operating at a loss for the third consecutive year while needing to move forward in achieving some of the objectives set forth in the Strategic Plan. Despite operating at a loss, the plan is adequately reserved to cover operating losses at this level through the budget period and maintain reserve levels consistent with the Commission direction.

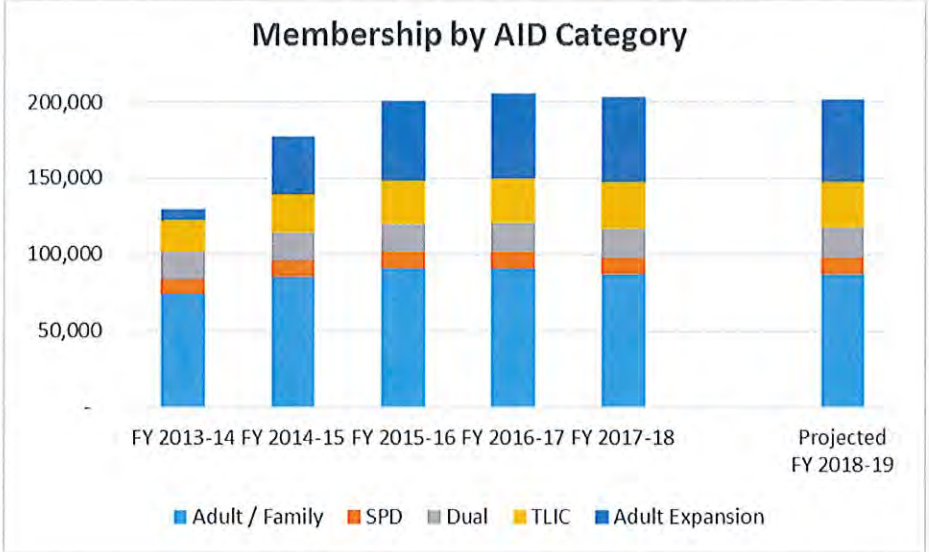
The basis for the continued operating losses has been higher than anticipated medical expenditures. Staff expects that these medical costs will be fully recognized in the capitation rates received from the State in FY 2019-20, but will need to continually monitor the forecasted revenue and for changes in State policy and activities that can impact future revenue.

While Gold Coast staff looked to minimize expenses where possible, it was also very important to be realistic in establishing the assumptions and expectations for this next fiscal year. The plan is moving beyond its initial startup phase and is now investing in programs and applications needed to meet the changing needs of the health care marketplace, including new CMS and Mega-rule requirements. A major initiative in the plans evolution is the implementation of improved claim and call system platforms; this will temporarily require a significant resource allocation to support the project work.

This document outlines the fiscal year 2018-19 operating and capital budgets and major associated assumptions.

Membership

Membership is projected at an average of 201,774, slightly less than the average membership experienced in FY 2017-18. This is based on a downward trend in the past several months of the year.

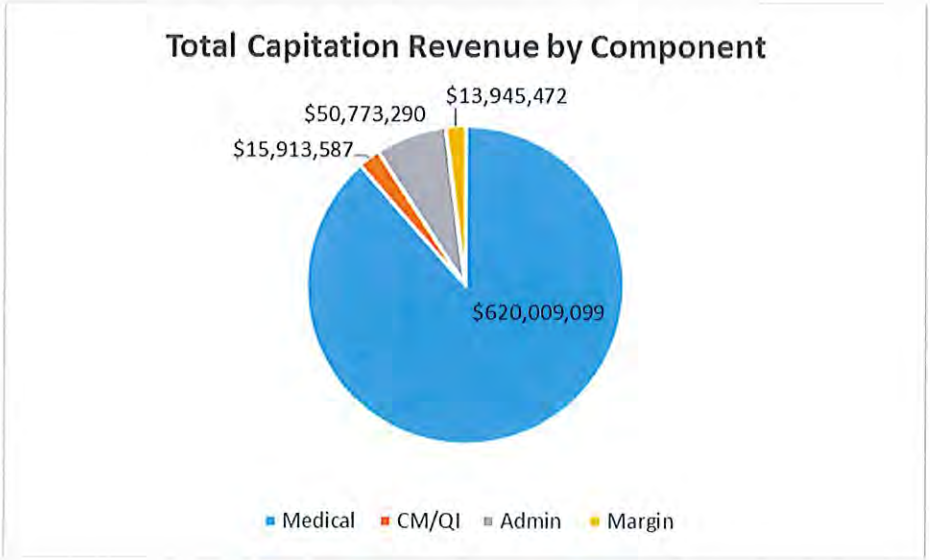


Revenue

Total revenue in the budget is projected at $700,641,448 ($289.37 pmpm) based on draft capitation rates received from the State. On a pmpm basis, this is an approximate 3.5% increase in the base capitation rates from FY 2017-18.

Base Capitation	$	684,428,849
Hep C Supplemental	$	7,813,049
BHT Supplemental	$	8,399,550
	$	700,641,448

The capitation rates from the State were established based on medical expenditures in calendar year 2016, with applied trend factors, credibility adjustments and program changes. Components were then applied for administrative expenses and an operating margin.



Medical Expenses

The medical expense budget is $660,036,879 and is developed by calculating pmpm costs by aid category and provider type, and then incorporating anticipated changes as a result of utilization patterns, market trends and changes in provider reimbursement rates forecasted to occur during the budget year. Gold Coast is projecting a slight decrease in medical expenses on a pmpm basis, but as noted in the following table, a slight increase to the MLR is expected. The apparent increase in the MLR is due the use of FYTD financial statements as of April 2018 as a comparative base period. FYTD 2017-18 results include the unusual net revenue impact of AB85. The FY 2018-19 budget does not include revenue projections associated with AB85, which produces a slightly higher MLR. Excluding the effect of the AB85 revenue, the FYTD 2017-18 MLR would be 96.5% and the projected 2018-19 MLR would show an improvement of 2.3%.

FY 2018-19 MEDICAL EXPENSE BUDGET					
	FY 2017-18 as of April 2018 PMPM	Projected FY 2018-19 PMPM	Projected FY 2017-18 Total Dollar	Projected FY 2018-19 Total Dollar	Percent Change
Capitation - PCP Expense	$ 25.81	$ 24.33	$ 62,903,703	$ 58,917,897	-6%
Fee For Service					
Inpatient FFS Expense	$ 56.28	$ 52.29	$137,148,075	$126,619,650	-8%
Outpatient FFS Expense	25.41	23.42	61,919,112	56,697,917	-8%
LTC/SNF Expense	48.80	51.50	118,919,981	124,702,072	5%
ER Facility Services FFS	12.49	11.07	30,450,507	26,802,115	-12%
Physician Specialty Services FFS	23.13	22.62	56,369,993	54,762,191	-3%
Transportation FFS	0.93	0.73	2,276,842	1,761,996	-23%
Other Fee For Service Expense	3.96	3.82	9,660,331	9,242,505	-4%
Primary Care Physician FFS	6.67	6.64	16,246,470	16,080,487	-1%
Applied Behavioral Analysis Svcs	3.45	3.03	8,417,507	7,348,428	-13%
Mental Health Services	2.63	2.63	6,406,217	6,376,003	0%
Pharmacy Expense FFS	49.46	53.18	120,533,498	128,757,593	7%
Other Medical Professional	1.43	1.40	3,491,271	3,397,445	-3%
Home & Community Based Svcs	6.79	7.02	16,543,421	16,991,005	3%
Laboratory and Radiology Expense	2.05	1.44	5,005,473	3,494,585	-30%
Other Medical Care Expenses	0.01	(0.00)	31,271	-	-100%
Sub-total	$ 243.50	$ 240.79	$593,419,969	$583,033,992	-2%
Reinsurance-Net	$ 0.81	$ 1.27	$ 1,971,257	$ 3,074,064	56%
Refunds & Recoveries	$ (1.07)	$ -	$ (2,614,530)	$ -	-100%
Care Management	$ 4.68	$ 6.20	$ 11,395,557	$ 15,010,927	32%
Total Medical Expenses	$ 273.72	$ 272.60	$667,075,956	$660,036,879	-1%
MLR	**93.8%**	**94.2%**	**95.0%**	**94.2%**	

The major assumptions impacting the projected medical expenses are as follows:

- Reductions in capitation for an FQHC provider to assist in strategic retention of funding.
- Contracting changes mitigating expenses associated with inpatient, outpatient, emergency room, physician specialty, laboratory and radiology.
- An assumed increase of 3.9% for LTC/SNF expenses associated with annual increases based on State established facility rates.
- A projected increase of 3.5% in pharmacy expenses associated with drug unit cost trends and utilization factors.
- Applied Behavioral Analysis is expected to moderate as the utilizing population is further assimilated into normalized treatment patterns.

Note: Care management expenses are outlined in the General and Administrative budget.

General and Administrative Expenses

The 2018-19 general and administrative budget is $48,826,075, excluding those expenses associated with major projects. This is 7% of estimated revenue and within the amount allocated in the capitation rates for administrative expenses which is a total of $50,773,920.

The budget was developed at a department level and is based on a review of FY 2017-18 actual expenditures with changes based on certain assumptions and expectations for FY 2018-19. Gold Coast has developed a new cost center to track and outline large projects such as the ASO transition.

The following table outlines general and administrative budget and includes a comparison to the initial budget (adopted in June 2017) for 2017-18, as well as a projection on the actual expenditures to be incurred during the current fiscal year 2017-18.

FY 2018-19 GENERAL AND ADMINISTRATIVE EXPENSES					
	FY 2017-18 Projected Actual	FY 2017-18 Budget	FY 2018-19 Budget	Change Budget to Budget	Percent Change
Salary Expense	$ 16,776,306	$ 17,242,854	$ 18,310,154	$1,067,300	6%
Temp Labor	1,086,985	1,173,029	745,788	(427,241)	-36%
Taxes and Benefits	5,191,894	5,578,704	5,832,110	253,406	5%
Training, Conference, and Travel	340,684	585,439	585,341	(98)	0%
Outside Services - ACS	19,788,511	19,380,945	19,728,000	347,055	2%
Outside Services - PBM Admin	3,050,844	3,884,669	2,950,044	(934,625)	-24%
Outside Services - Other	3,876,204	4,296,145	4,111,519	(184,626)	-4%
Accounting & Actuarial Services	372,088	311,000	204,072	(106,928)	-34%
Legal	1,693,398	1,250,000	1,500,000	250,000	20%
Consulting Services	1,178,183	1,534,150	1,101,846	(432,304)	-28%
Translation Services	132,429	100,000	163,456	63,456	63%
Committee/Advisory	11,550	16,300	21,450	5,150	32%
Employee Recruitment	218,890	225,000	218,422	(6,578)	-3%
Lease	1,445,832	1,431,823	1,440,136	8,313	1%
Depreciation & Amortization	555,749	623,694	495,691	(128,003)	-21%
Non-Capital - Furniture & Equipment	125,845	254,602	181,451	(73,151)	-29%
Office & Operating Supplies	163,804	216,960	166,828	(50,132)	-23%
Shipping & Postage	111,984	101,800	218,363	116,563	115%
Printing	97,637	123,550	275,828	152,278	123%
Software Licenses	2,669,773	3,610,551	3,518,361	(92,190)	-3%
Repairs & Maintenance	94,589	110,000	94,841	(15,159)	-14%
Telephone/Internet	150,155	108,960	174,672	65,712	60%
Advertising and promotion	287,914	388,060	296,357	(91,703)	-24%
Insurance	527,986	578,400	600,000	21,600	4%
Interest	531,117	480,000	540,000	60,000	13%
Professional dues, fees, and licenses	274,388	285,854	311,984	26,130	9%
Subscriptions and publications	23,139	40,200	26,397	(13,803)	-34%
Bank Service Fees	23,399	23,000	23,891	891	4%
ARCH/Community Grants	323,254	-	-	-	#DIV/0!
Care Management	(12,650,455)	(15,010,345)	(15,010,927)	(582)	0%
Total General and Administrative	$ 48,474,075	$ 48,945,345	$ 48,826,075	$ (119,270)	0%
% Admin to Revenue	**7.0%**	**7.3%**	**7.0%**		
Project Portfolio	$ -	$ -	$ 5,045,262	$5,045,262	#DIV/0!
Total G&A (including Projects)	$ 48,474,075	$ 48,945,345	$ 53,871,337	$4,925,992	10%
% to Revenue	**7.0%**	**7.3%**	**7.7%**		

Salary Expense

Salary expense includes a merit pool equal to 3% of total salaries, and a 6% vacancy factor. Also impacting the salary expense are the addition of new positions. The below table represents budgeted positions by department in comparison with the FY 2017-18 budget.

	Budgeted Positions		
	FY 17/18	FY 18/19	Change
Diversity	2	1	-1
Executive	10	9	-1
Human Resources	6	6	0
Compliance	9	11	2
Operations	2	2	0
Appeals & Grievance	5	5	0
Operations Support Services	5	5	0
Member Services	6	7	1
Claims	7	7	0
Facilities	3	3	0
Network Operations	9	10	1
Communications	2	2	0
Accounting/Financial Planning & Analysis	11	11	0
Decision Support Services	6	6	0
PMO	5	4	-1
Information Technology	2	2	0
Infrastructure	4	5	1
Solution Services	10	9	-1
Government Relations	1	1	0
Quality	10	10	0
Pharmacy	2	2	0
Health Services/Health Education	80	84	4
	197	202	5

The new positions, net of transfers and re-purposing, are as follows:

Attorney (Compliance) – this cost is offset by a savings in external legal expense.

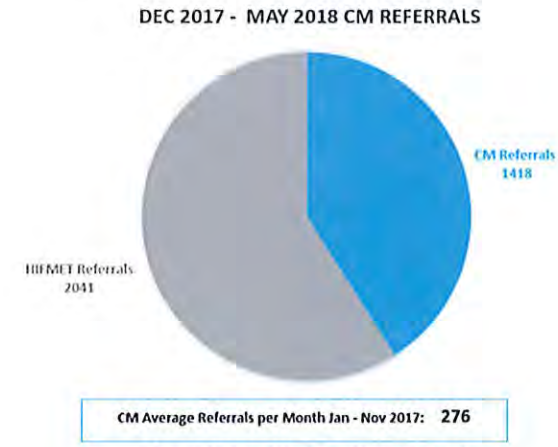
Receptionist (Member Services) – this cost was offset by a reduction of the use of guards at the front desk.

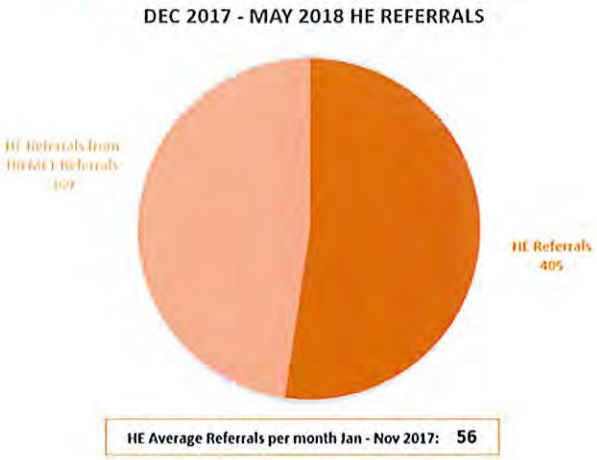
Contract Specialist (Network Operations) – this position was added during FY 2017-18 in order to deliver more consistent and standardized contracts, and assist in the contracting efforts to develop a more robust and cost effective provider network.

Care Management Coordinator (Health Services) – This position is needed due to the increase in care coordination requests. Since December 2017, there has been a 215% increase in CM referrals created by the new process related to the Health Information Forms/Member Evaluation Tools (HIF/MET). Staff anticipates that the expense of this position will be offset by a reduction in utilization by new members served in the HIF/MET process.

Case/Care Management, Social Worker (Health Services) – The HIF/MET process has increased the Social Determinants of Health (SDH) needs. A second position is needed to address SDH and connect to community resources to reduce overall emergency and inpatient utilization.

RN Case/Care Management (Health Services) – RNs are facilitating care coordination and complex case management of existing and new populations which will, over time, have a positive effect on reducing utilization. This workload has increased significantly due to the HIF/MET referrals.





RN Utilization Management (Health Services) – this position is necessary to ensure right care, right time, right place for members while maintaining compliance with mandated turn-around times set by DHCS.

Note: Although the budget reflects new positions, management is continuing to operate with a soft hiring freeze, and assessing the functional needs of the organization as positions are vacated.

Temp Labor
The reduction is related to the hiring of staff positions where the work has been deemed to be ongoing and a net savings for the work can be achieved.

Outside Services – PBM
Savings will be achieved through the favorable administrative fee structure in the OptumRx contract. As compared to the previous PBM contract, these fees are approximately 25% lower.

Accounting & Actuarial Services
The decrease in accounting and actuarial expense is related to limiting the use of a consultant to perform internal audit functions.

Legal
The increased amount is based on actual expenditures for FY 2017-18 which was higher than budget due to some significant cases. The amount was reduced from actual expenditures based on the hiring of an in house attorney.

Consulting
Decrease primarily due to classification of project portfolio.

Translation
The increased amount is based on utilization of these services which has been highly encouraged by the Health Education department.

Depreciation and Amortization/Non-Capital Furniture and Equipment
The decreased cost is due to the transfer of costs to the Project Portfolio cost center.

Shipping & Postage/Printing
The increase is due to a regulatory requirement to update materials with additional taglines and the mailing of Evidence of Coverage.

Telephone/Internet
Increase due to additional bandwidth and electronic communication enhancements.

Interest

The interest expense was increased to be more reflective of recent experience. During FY 2017-18, there were a significant number contracts loaded in the system retroactively requiring claims reprocessing and corresponding interest assessments. Due to process improvements implemented, staff anticipates this will not occur to the same extent in FY 2018-19, but was conservative in establishing the budget.

ARCH/Community Grants

Due to the budgeted loss, Gold Coast did not include this in the proposed FY 2018-19 budget. If the financial situation changes or funds become available, this will be a high priority for the organization as these both support the mission and strategic plan.

Gold Coast Health Plan FY 2018-19 Project Portfolio	FY 2018-19 Expense		FY 2018-19 Capital	**
ASO Transformation	$ 3,614,645		$ 50,000	
MedHOK Upgrade	126,000	*		
AHP Plan to Plan	TBD			
Visitor Management	16,500			
	$ 3,757,145		$ 50,000	
FY 2018-19 Project Initiatives				
Keep the Lights On "KTLO" & Information Security				
IT Infrastructure Business Continuity Implementation	$ 83,000		$ 156,000	
Internet Service Provider (ISP Redundancy)	87,000			
Windows 10 Migration	338,100			
Internet Access Security Enhancements (CyberData Breach)	80,000			
	$ 588,100		$ 156,000	
Strategic Technology Investments				
Quest Analytics Enterprise Implementation	$ 118,667		$ 26,000	
Provider Credentialing, Contracting and Data Management	707,350		219,450	
	$ 826,017		$ 245,450	
Triple AIM				
ADT - Real Time ED Utilization	$ 300,000	*	$ -	
eConsult	300,000	*	-	
	$ 600,000		$ -	
Total Project Cost (excluding care management)	$ 5,045,262		$ 451,450	

*** included in care management.**

**** depreciation included under FY 2018-19 expense column.**

FY 2018-19 Project Initiatives

KTLO & Information Security

These projects are important to continually improve business operations; address cybersecurity risks, and ensure business continuity in case of an emergency or disaster.

Strategic Technology Investments

These are critical to improve business efficiencies and the organization's ability to address expanded State and Federal provider network and credentialing regulatory requirements as mandated in the CMS MegaRule. These also mitigate the risk of a financial penalty that could be assessed for non-compliance.

Triple AIM

Health information technology to ensure best care and access for our underserved population.

Interest Income

Total interest income is budgeted at $934,189. This amount is significantly less than the FY 2017-18 actual amount which is $3.6 million through April 2018. Staff estimated a substantial reduction in cash and investments due to the payment of amounts due to the State for the adult expansion 85% MLR requirement. In addition, of the remaining cash and investments, it was assumed that more amounts would be in cash and money markets with lower yields.

Capital Budget

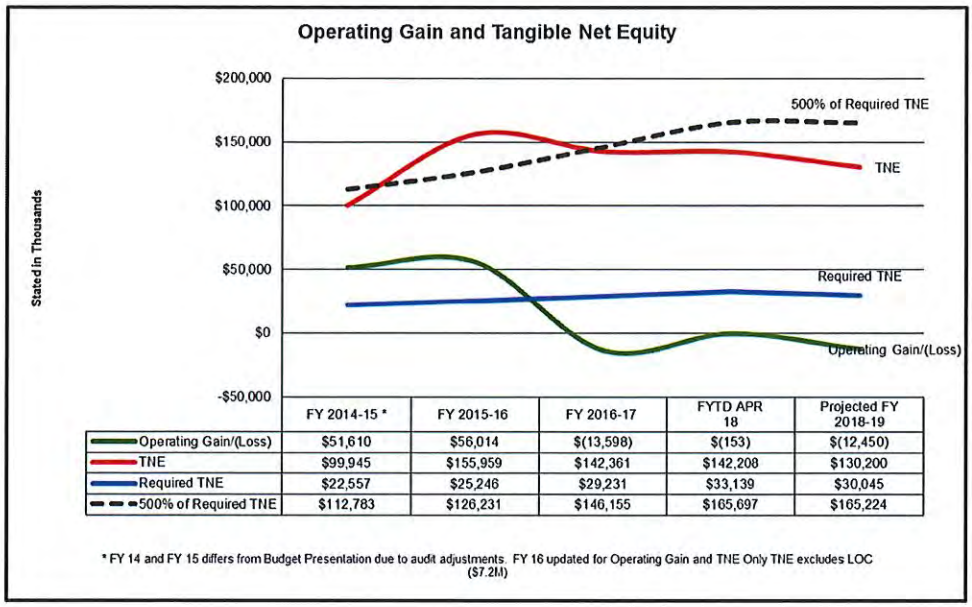
The total budget for capital expenditures, excluding those included in the project portfolio, are $353,000. Of that amount, $225,000 is related to potential needed improvements in in order to lease out the vacant suites in the 711 building.

GOLD COAST HEALTH PLAN FY 2018-19 OPERATING BUDGET		
Program Revenue	$	700,641,448
Medical Expenses	$	660,036,879
MLR		94.2%
Gross Margin	$	40,604,569
General & Administrative Expenses	$	48,826,075
Admin %		7.0%
Project Portfolio	$	5,045,262
Interest Income	$	934,189
Net Loss	$	(12,332,579)

GOLD COAST HEALTH PLAN FY 2018-19 CAPITAL BUDGET			
Asset Category	Description		Amount ($)
Leasehold Improvements	Office and cubical Repair | Reconfiguration 711	$	48,000
Leasehold Improvements	Cubical reconfiguration to accommodate PHI compliance 770 s		27,000
Leasehold Improvements	Door swipes 711 | 770		18,000
Leasehold Improvements	Suite 105 | 107 Construction		225,000
Leasehold Improvements	Community Room Upgrade		35,000
		$	353,000

Projected Tangible Net Equity (TNE)

The TNE is projected to be at $130.2 million or 433% of the State required amount. This is within the Plan's policy of a minimum of 400% to 500% of the State required amount.



	FY 2014-15 *	FY 2015-16	FY 2016-17	FYTD APR 18	Projected FY 2018-19
Operating Gain/(Loss)	$51,610	$56,014	$(13,598)	$(153)	$(12,450)
TNE	$99,945	$155,959	$142,361	$142,208	$130,200
Required TNE	$22,557	$25,246	$29,231	$33,139	$30,045
500% of Required TNE	$112,783	$126,231	$146,155	$165,697	$165,224

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

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: June 25, 2018

SUBJECT: Adoption of Procedure for Adding Items to the Commission Agenda

SUMMARY:

The Ralph M. Brown Act prohibits local agency boards from taking action or deliberating on any items that are not contained on a properly noticed agenda. The Brown Act, however, does not establish procedures for preparing an agenda, and each agency follows its own policy as to how board members may place items on the agenda. For example, some agencies only allow the chair to add items, some agencies allow any board member to add items, some agencies require that only the board as a whole can add items, and some agencies adopt other procedures.

The Commission currently does not have a formal policy for determining how Commissioners may place items on the Commission's agenda for each meeting. The agenda is generally prepared by Gold Coast Health Plan staff, but the bylaws are silent on this issue. The Commissioners have asked to consider a more formal policy and referred the issue to the Executive Finance Committee for a recommendation.

The Executive Finance Committee recommends the following policy:

1. Any Commissioner, including the Chair and Vice Chair, may request that an item be placed on an agenda. The request shall be made by e-mail, and the e-mail shall also be sent to the Chair, Vice Chair and the CEO. Those three shall determine whether the item should be placed on a future agenda.

2. Alternatively, at the appropriate time during a regular Commission meeting, Commissioners may make a request to that an item be added to a future agenda. The Chair, Vice Chair and CEO will consult each other and determine whether the item should be placed on a future agenda.

The Commission may approve the Committee's recommendation or it may consider modifications or alternatives to the recommended procedure. The Commission may also choose to maintain the status quo and elect not to have a formal policy. In adopting any agenda policy, the Committee should bear in mind that in order to place items on the agenda, requests must be given to staff with sufficient time to research and prepare the agenda packet.

RECOMMENDATION:

The Executive Finance Committee recommends that the Commission adopt the procedure outlined above as the Commission's policy for placing items on the agenda.

ATTACHMENTS:

Draft Agenda Approval Policy

Title: Agenda Approval Policy

Purpose

The purpose of the agenda approval policy is to establish a mechanism for Commissioners to request that items be placed on the agenda in an orderly and efficient manner.

Policy

1. Any Commissioner, including the Chair and Vice Chair, may request that an item be placed on an agenda. The request shall be made by e-mail, and the e-mail shall also be sent to the Chair, Vice Chair and the CEO. Those three shall determine whether the item should be placed on a future agenda.

2. Alternatively, at the appropriate time during a regular Commission meeting, Commissioners may make a request to that an item be added to a future agenda. The Chair, Vice Chair and CEO will consult each other and determine whether the item should be placed on a future agenda.

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www.goldcoasthealthplan.org

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: June 25, 2018

SUBJECT: Gold Coast Health Plan Approach to High Risk Drugs

Summary

Dr. Wharfield will present Gold Coast Health Plan's Approach to High Risk Drugs.

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Gold Coast Health Plan Approach to High Risk Drugs

Nancy Wharfield, MD, CMO

June 25, 2018

Integrity

Accountability

Collaboration

Trust

Respect

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

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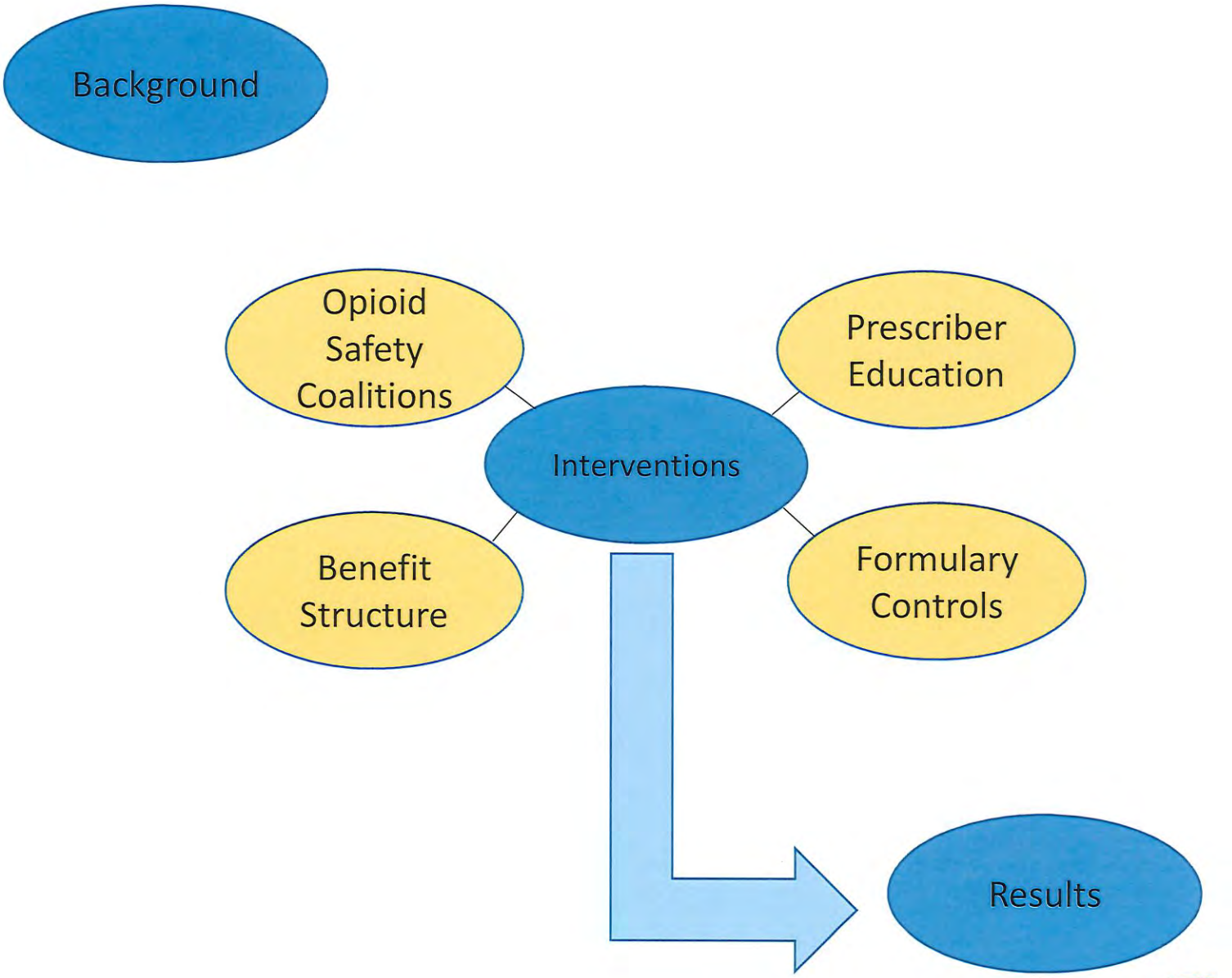

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Background

- Opioid overdose deaths
  - ✓Increased 4x since 1999
  - ✓Almost 100 people/year in Ventura County
- Naloxone antidote administration
  - ✓Increased 45% from 2012 to 2017
  - ✓Ages 21 – 30
  - ✓Male predominance
  - ✓Oxnard and Ventura

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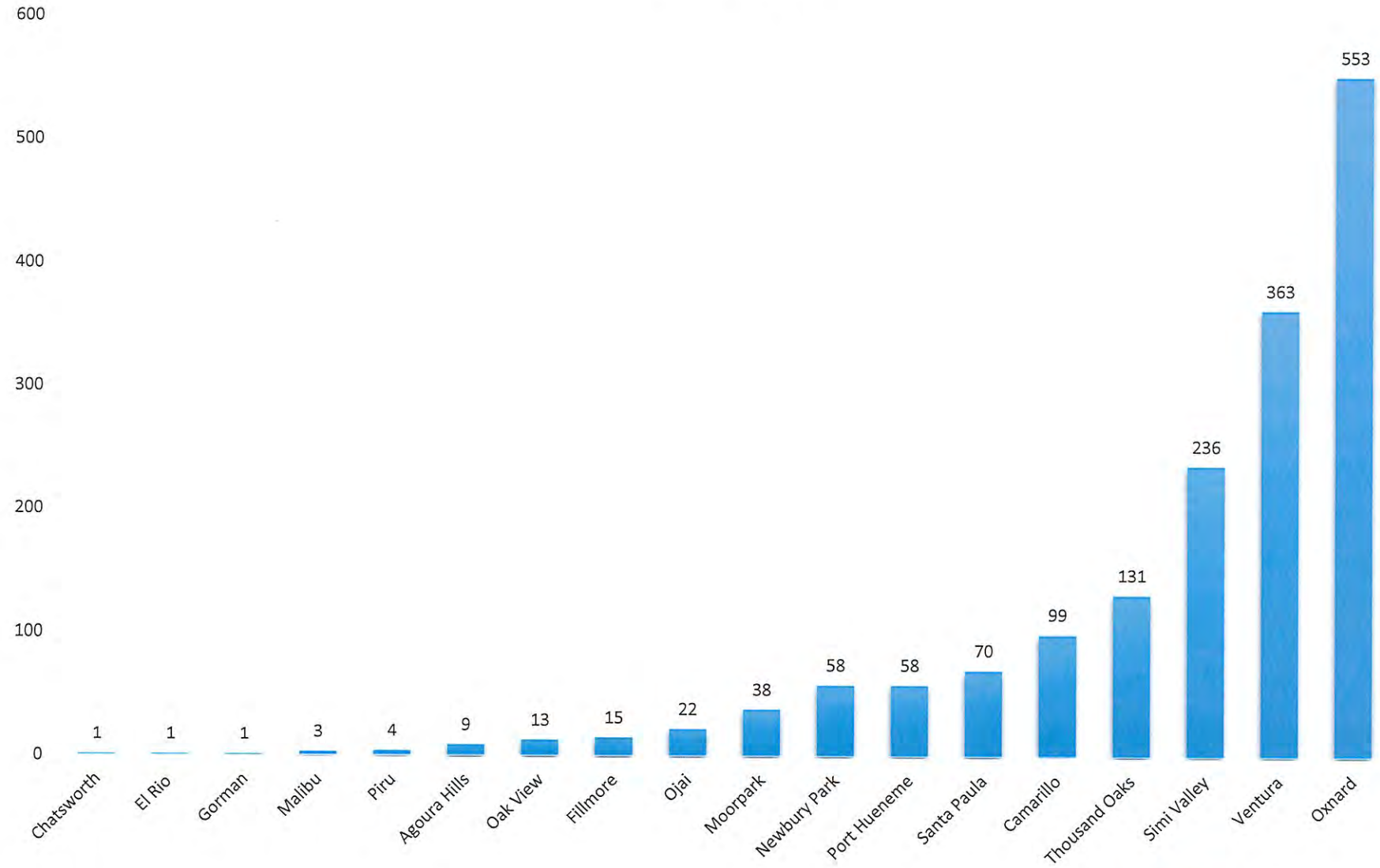
Cases of Naloxone Administration, by City
1February, 2012 – *31Aug, 2017*
n = 1689



*Source: VC EMS

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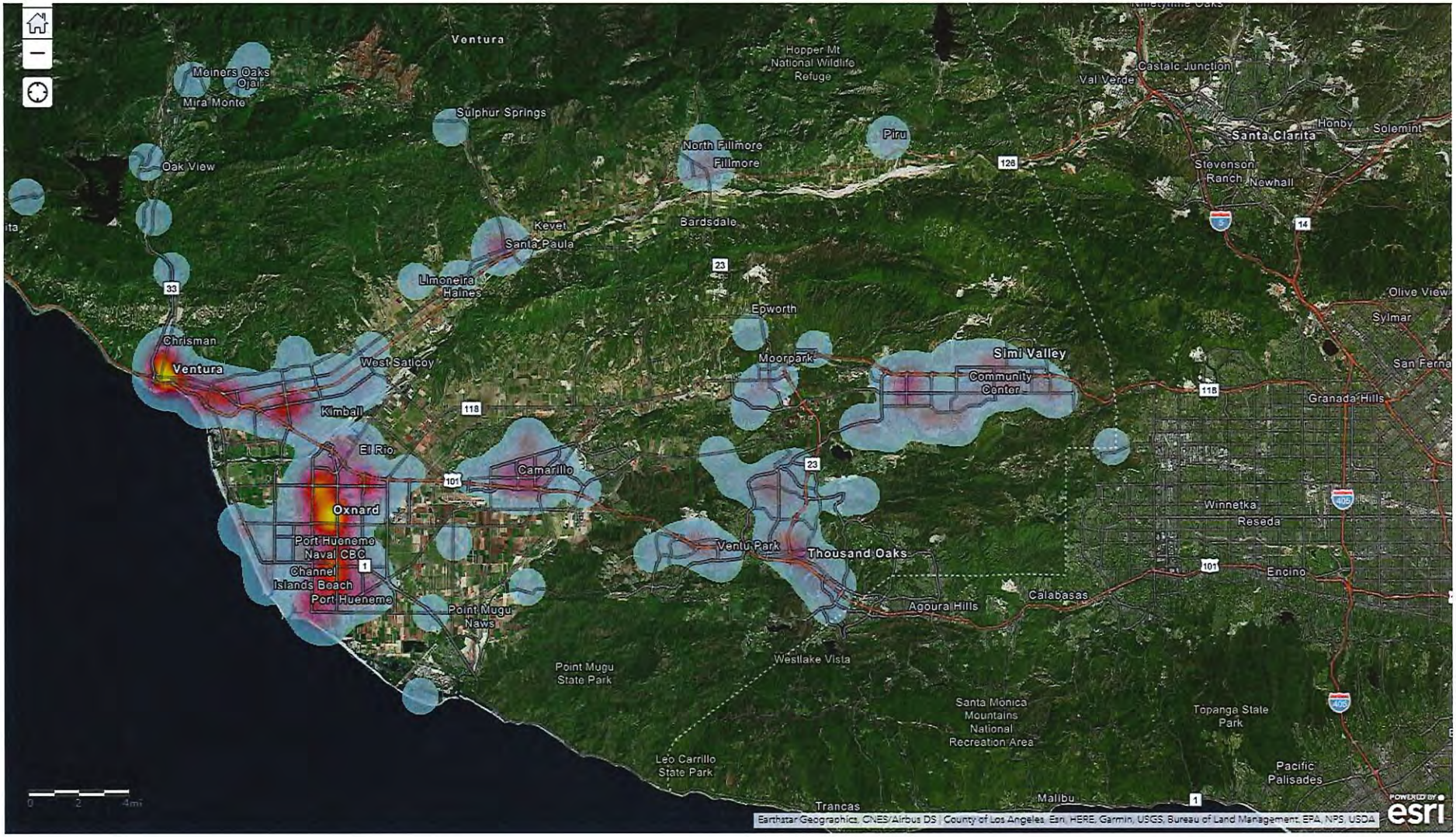
Heat Map – Countywide
Prehospital Naloxone Administration
CY 2017



*Source: VC EMS

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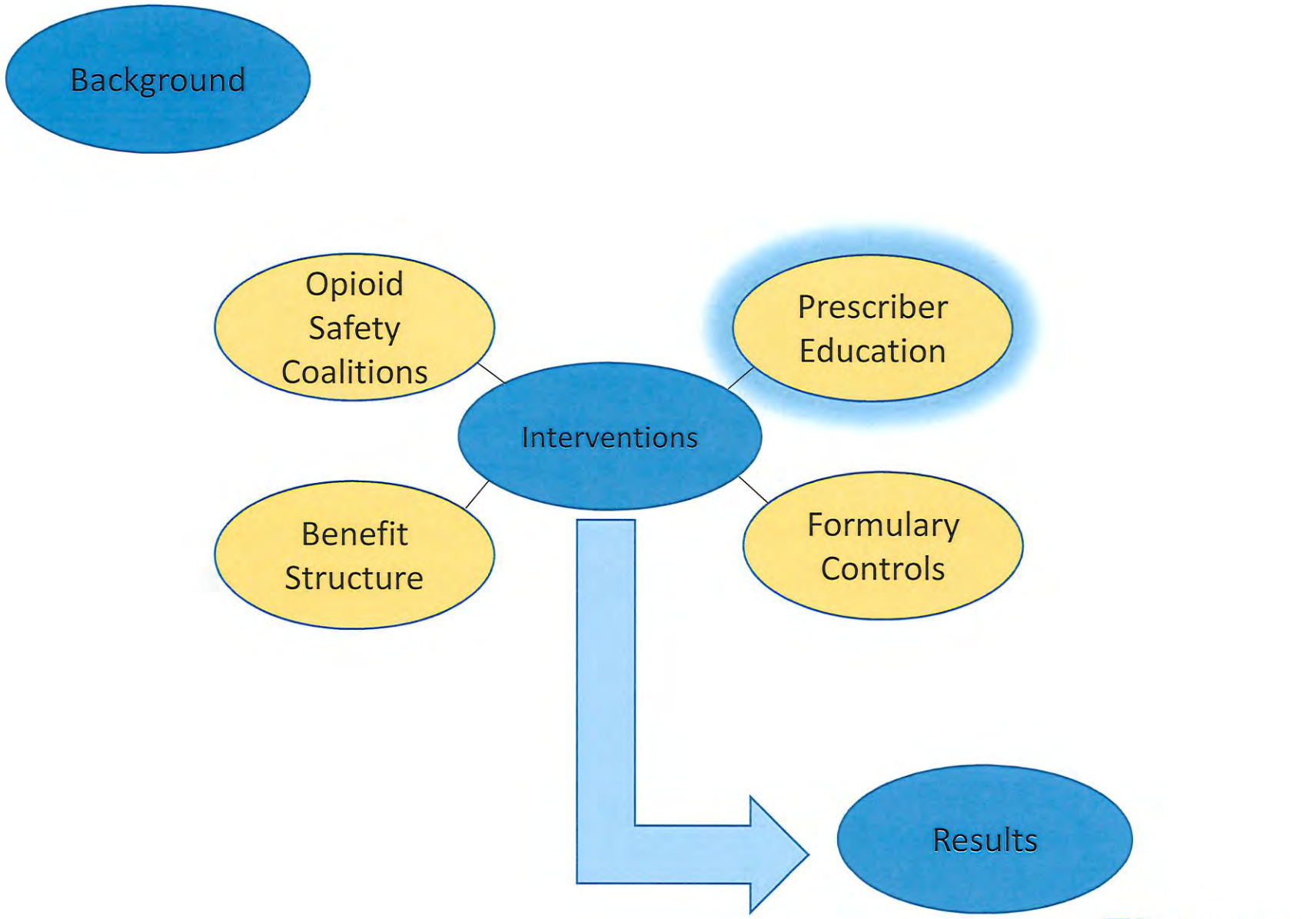

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Prescriber Education

- Opioid Tool Kit 2017
  - ✓CDC and CA Medical Board Guidelines
  - ✓Information on the Controlled Substance Utilization, Review and Evaluation System (CURES)
  - ✓GCHP Clinical Guidelines
  - ✓Practice Resources
    - Sample Pain Contract
    - Alcohol Screening Questionnaire
    - Urine Drug Screen Information

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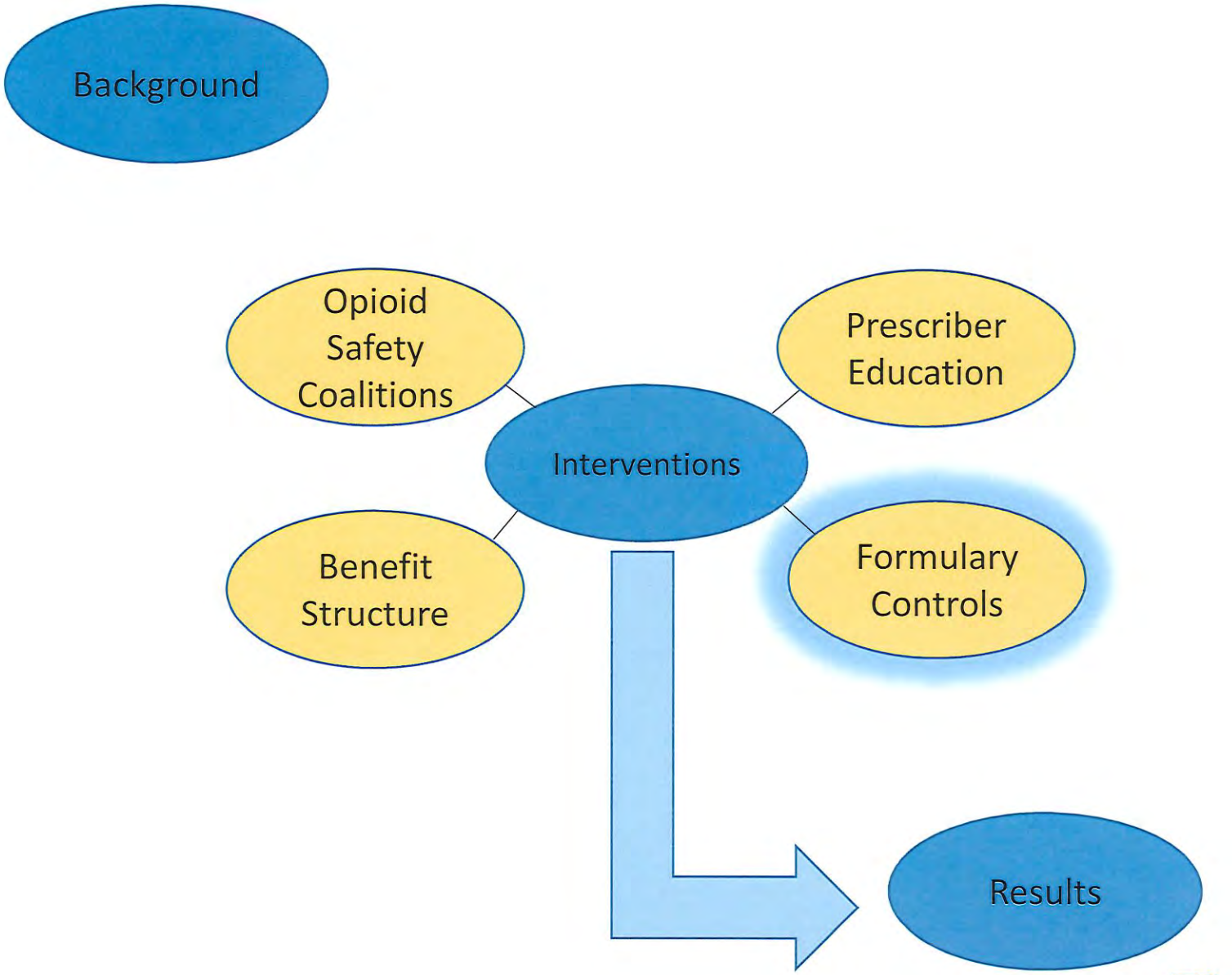

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Formulary Controls

- Dose Limits
  - ✓All Rx >90 MEDD require intervention by a pharmacist
  - ✓Quantity Limits with enforced ratios for all opioids
- Avoidance of early refills
  - ✓Refill limits
  - ✓Early refill requires Director of Pharmacy approval
- Avoidance of high dose formulation
  - ✓High dose methadone removed from formulary
- Avoidance of high risk medication
  - ✓ Oxycontin removed from formulary
  - ✓Alprazolam (Xanax) and carisoprodol (Soma) require authorization
- Combination therapy
  - ✓Concurrent therapy with prenatals or benzodiapines require intervention by a pharmacy

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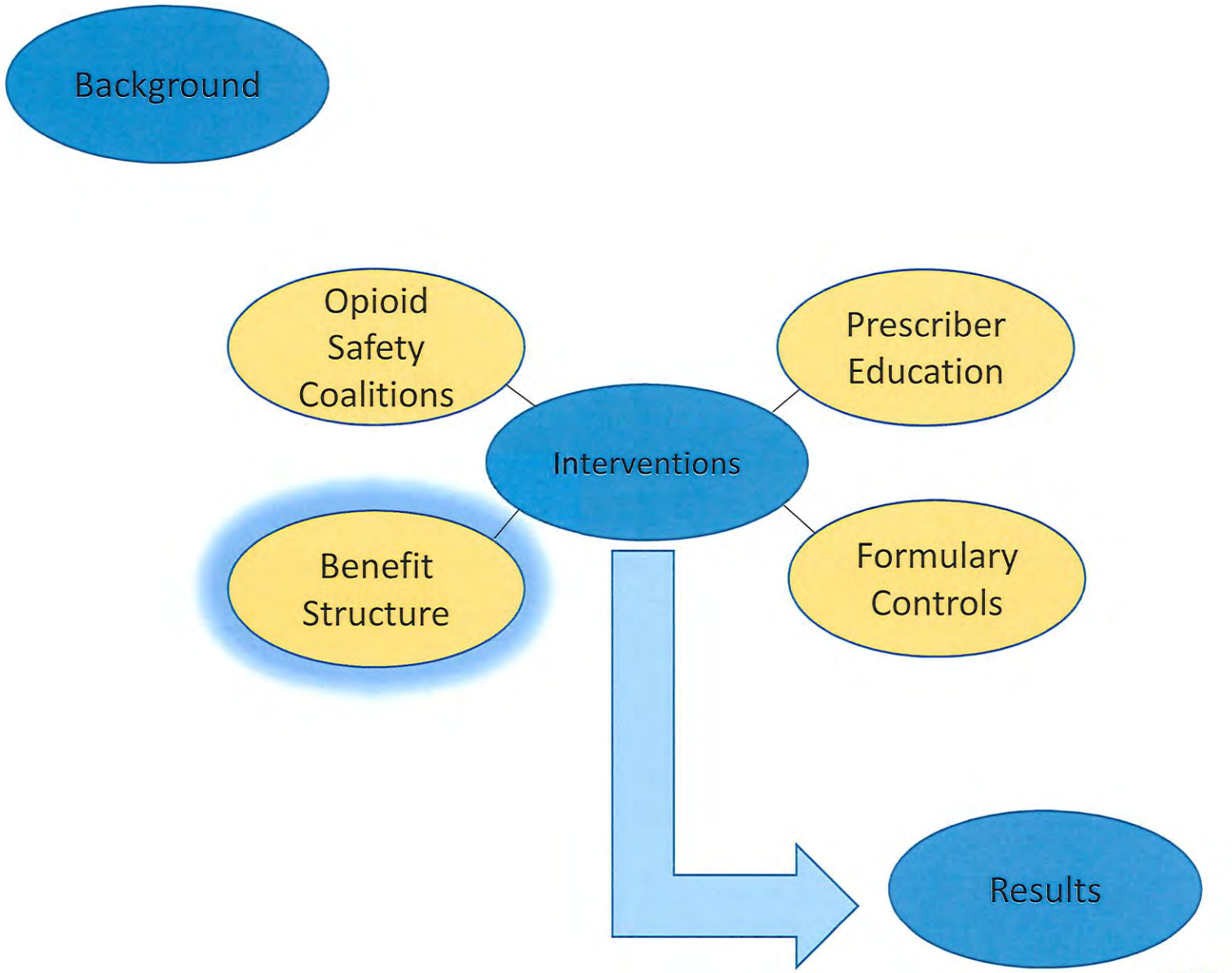

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Benefit Structure

- Chiropractic Services
- Acupuncture

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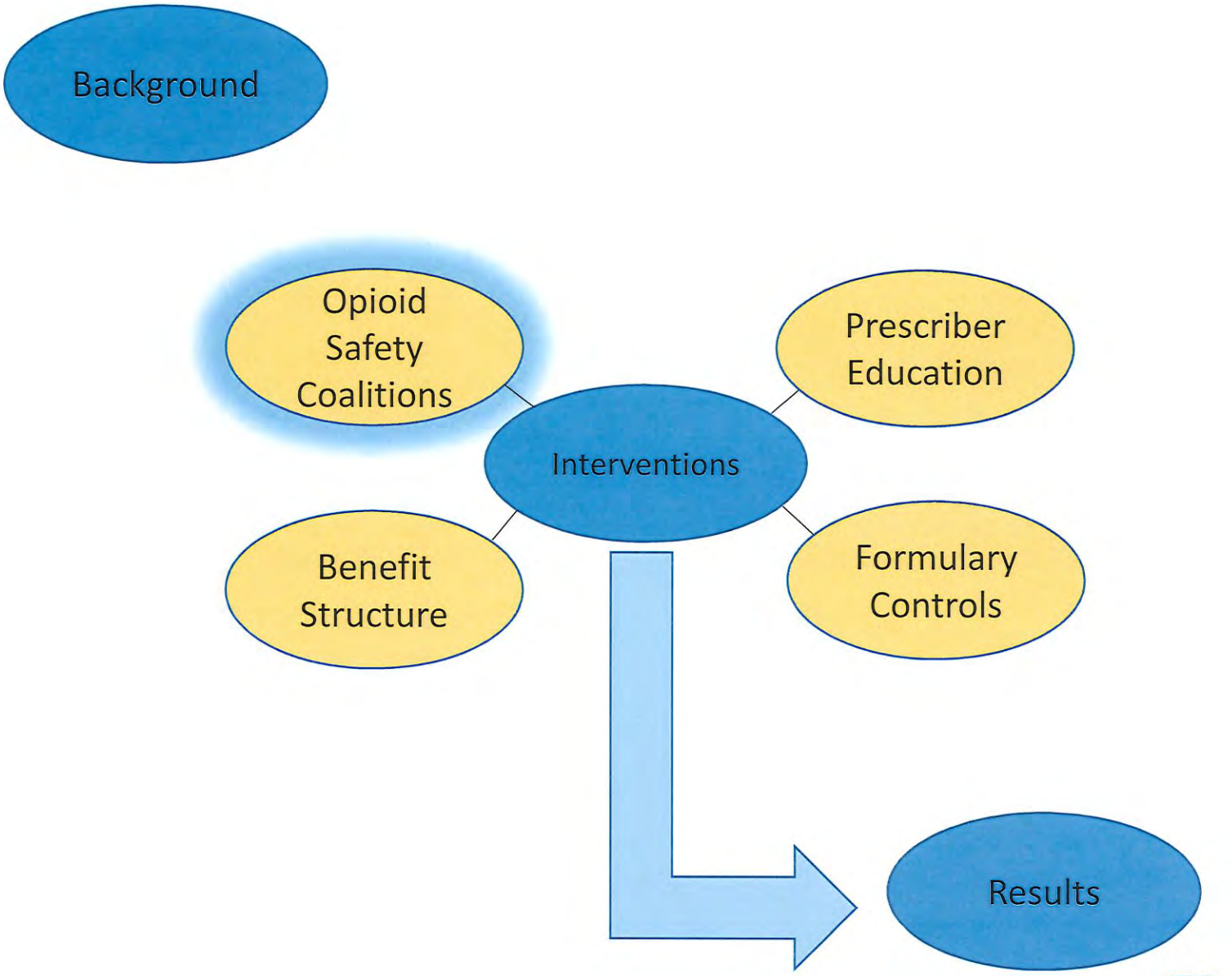

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Opioid Safety Coalitions

- Ventura County Rx Abuse and Heroin Workgroup

http://venturacountylimits.org/resource_documents/Reducing-Rx-Saving-Lives-FNL.pdf

- GCHP/VCBH Opioid Policy Summit May 2017

https://www.goldcoasthealthplan.org/about-us/government-affairs.aspx

- Project SAFER Grant

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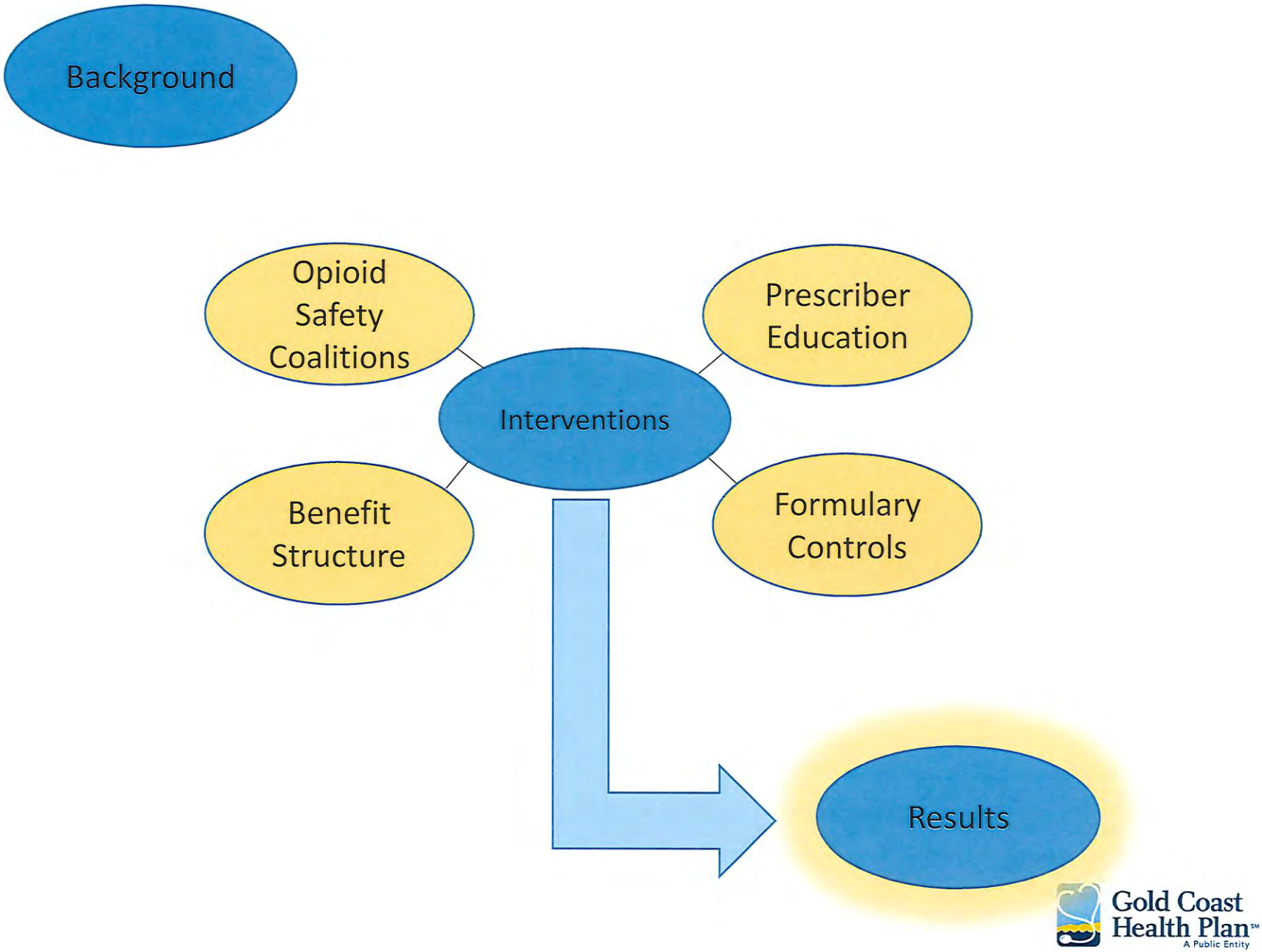

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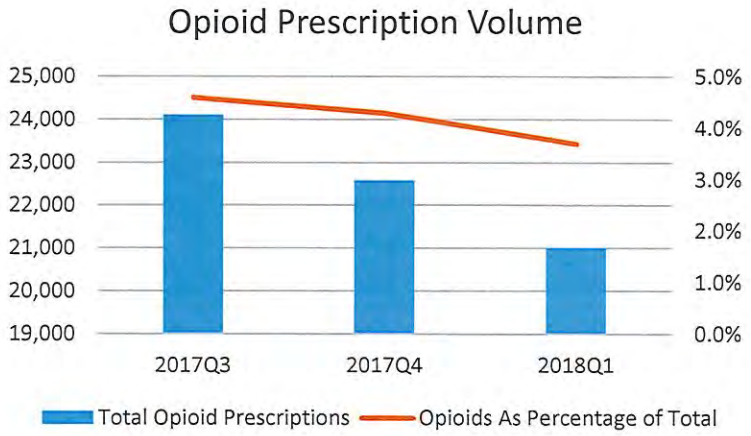
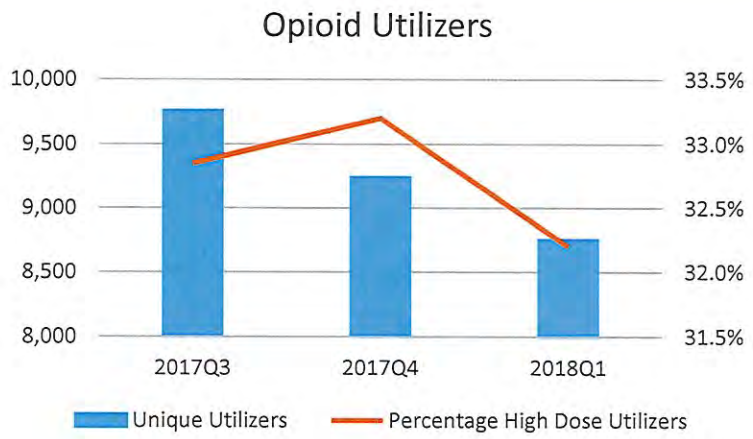
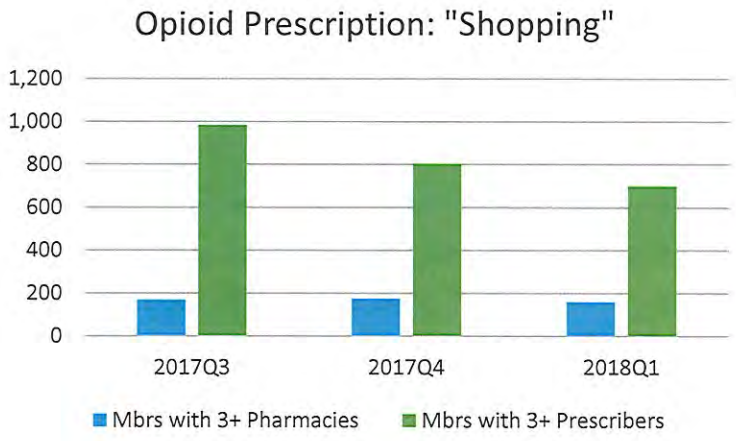
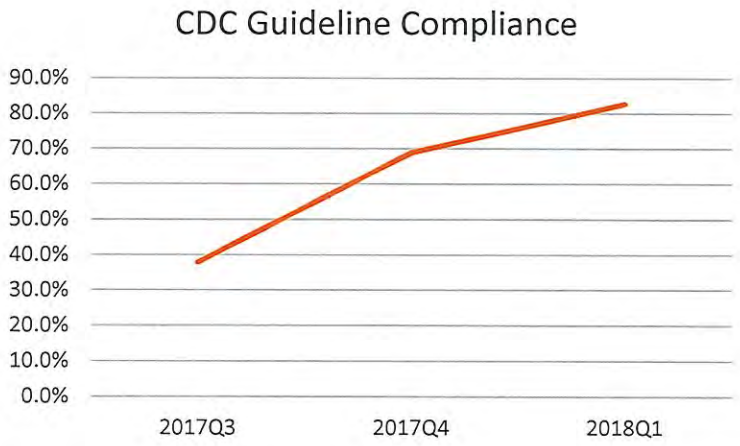
Results









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AGENDA ITEM NO. 8

To: Ventura County Medi-Cal Managed Care Commission

From: Anne Freese, PharmD, Director of Pharmacy

Date: June 25, 2018

RE: OptumRx – Follow Up and Progress

SUMMARY:

Jon Mahrt, Chief Operating Officer for OptumRx will give a verbal presentation to the Commission.

AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: June 25, 2018

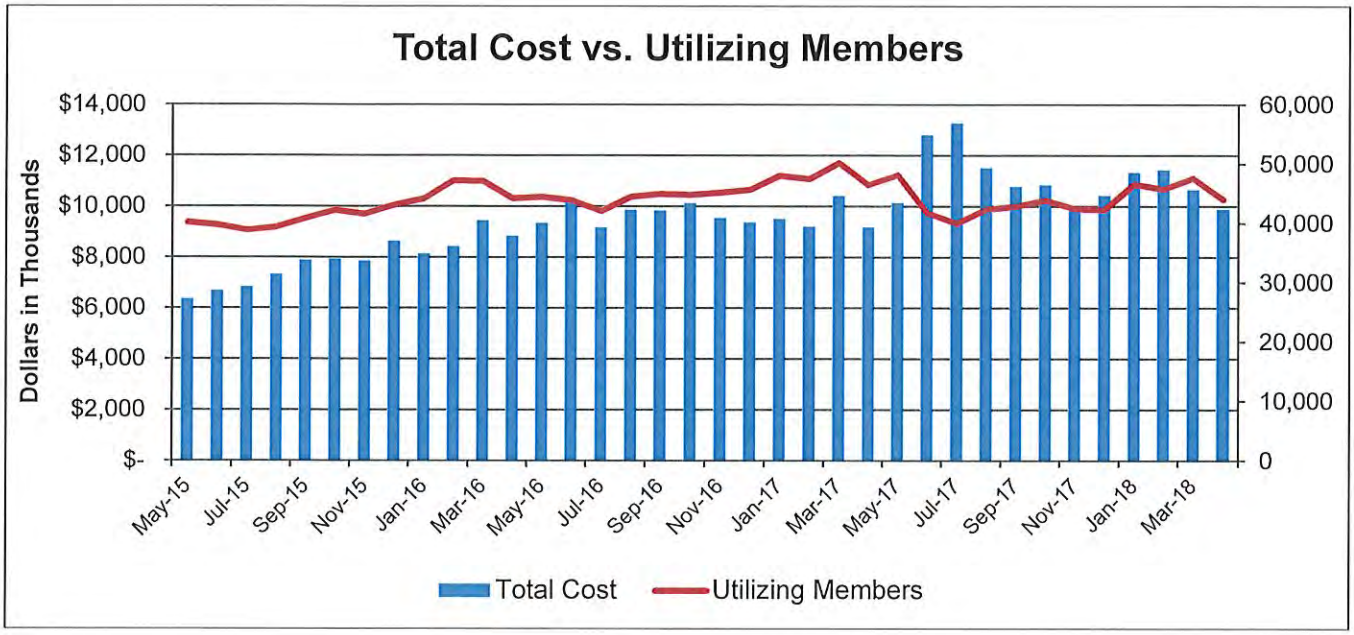
SUBJECT: Chief Medical Officer Update

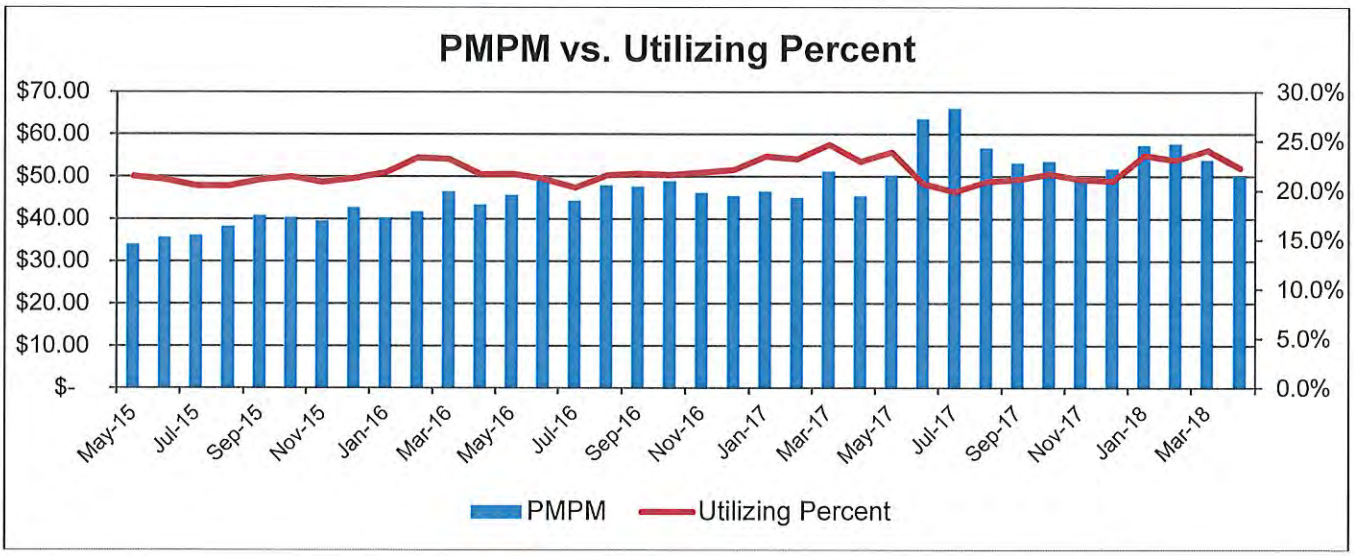
Pharmacy Benefit Performance and Trends

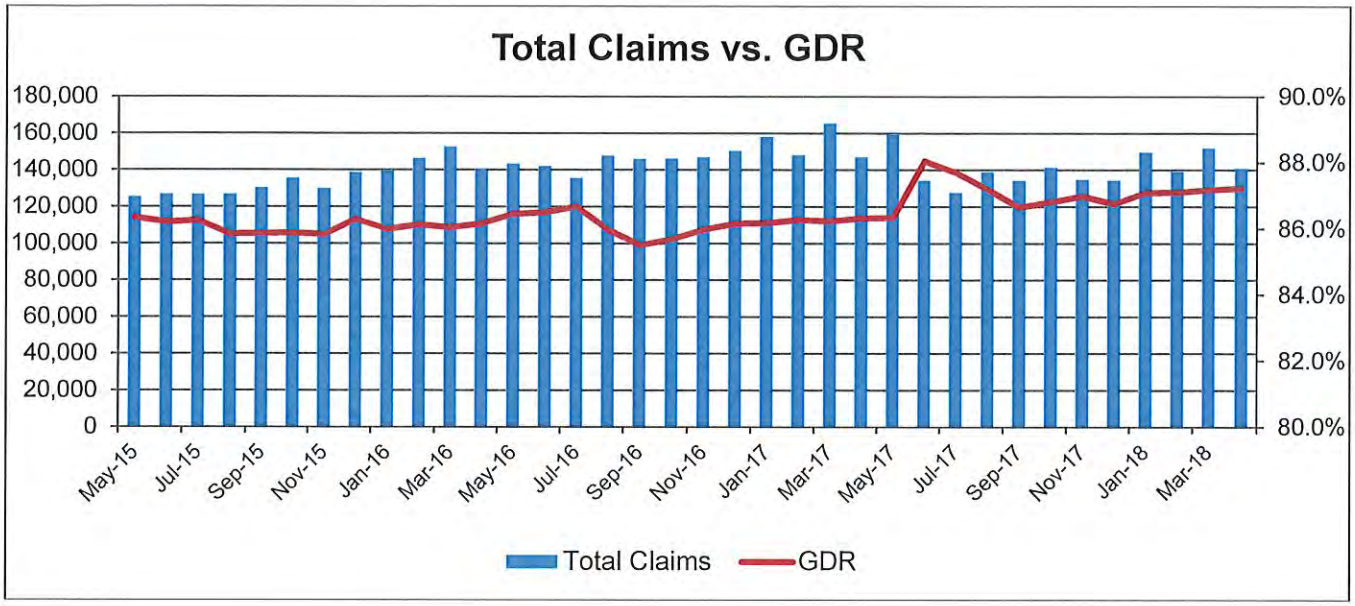
SUMMARY:
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of April 2018. Although minor changes may occur to the data going forward due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

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

PHARMACY COST TRENDS:







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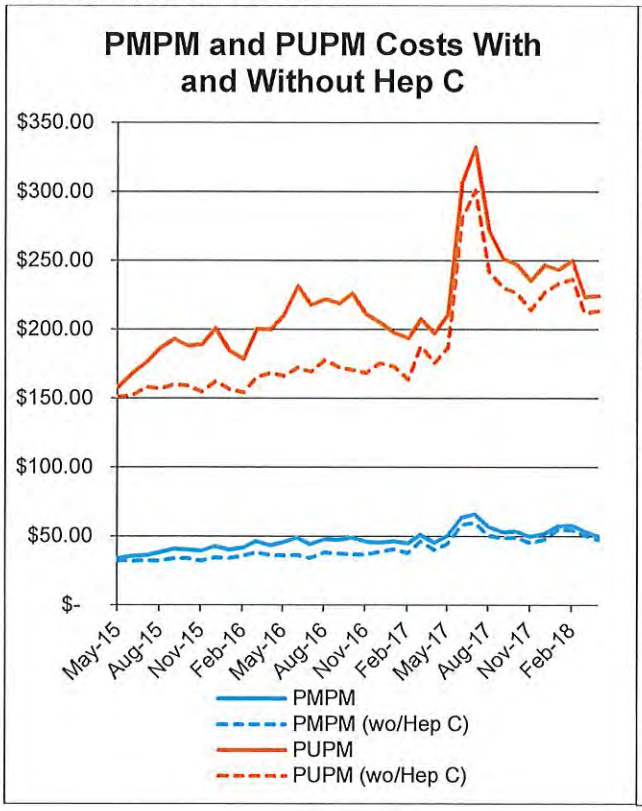

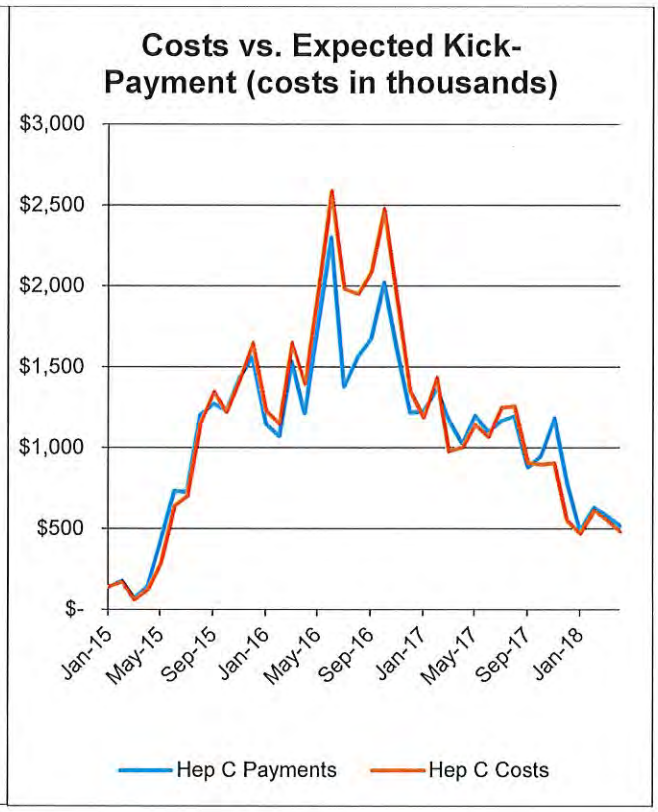

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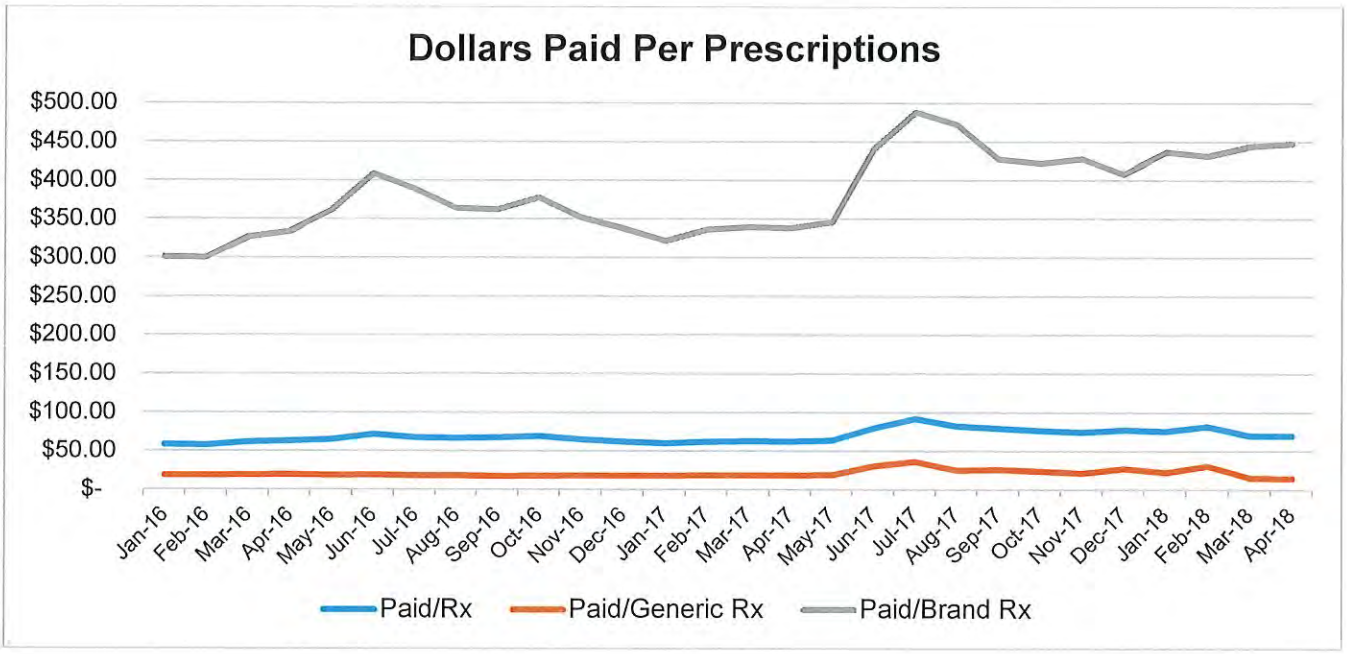


PBM OVERSIGHT:

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

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

Number of Items	Items Open	Items Pending Closure	Items Closed
14	12	7	1

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

Number of Items	Items Open	Items Pending Closure	Items Closed
5	4	1	1

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: June 25, 2018

SUBJECT: Interim Chief Diversity Officer Update

STAFF REPORT

Ladies and Gentlemen,

Initially we were shooting from the hip on time required to do the Chief Diversity Officer's position correctly. This is a full time job that I am doing in 2-3 days per week depending on business need. As I stated in prior meetings with you, to do this job correctly, it takes community relationship building and the building of credibility in the workplace.

My primary days to work at Gold Coast are Wednesdays and Thursdays. Other days that I work are based on the needs of the business such as luncheons, commission meetings and other community initiatives which are required to establish credibility in the position. That being said, I think what's been done has been successful to this point. I am working a two day schedule on a position, if done correctly, is a full time position. Some would ask, what are you doing when there are no open cases? Well, I am glad that you asked. I committed to the Plan as well as to the Commission that I would put into place a foundation for Diversity and Inclusion before leaving. Here is how that is being done:

Stage One

1. Community meetings with organizations that are receivers of complaints from employees such as LULAC, NAACP, Labor Board, Veterans, Universities, etc.
2. Development and implementation of the Diversity and Inclusion Strategic Plan – An abundance of research and time, both at work and home, that is not totally charged to the budget.
3. No charges to budget for mileage to and from work or community meetings related to the position.
4. Setting up of Diversity and Inclusion Council to include developing charter and selection of members.
5. Working internal cases with HR to prevent external charges (daily maintenance).
6. Visits to other Diversity networks such as Amgen, Girl Scouts/Boy Scouts, Dole Foods, Ford, County diversity network and Northrop Grumman.

7. Coaching and counselling of Dale's senior team in support of Jean and the HR team.
8. 1:1 meetings with individual employees mostly related to career development or diversity concerns. A log is kept, in the event someone needs to view the activity.
9. Management training on key issues such as documentation, having difficult discussions, attendance, etc.
10. Development of Lunch and Learn series to address issues of a diverse nature and to assist HR in their areas of responsibility.

Stage Two

1. Supplier Diversity – a proactive business program which encourages the use of minority-owned, women owned, veteran, owned, LGBT-owned Service disabled veteran owned, historically underutilized business and Small Business Administration (SBA)-defined small business concerns as suppliers.
2. CDO reporting status to Gold Coast (2 years)
3. Diversity symposium – The bringing together of Diversity leaders in the area to share best practices.
4. Affinity Networks – Networks open to all employees offering training, education programs, networking opportunities, conferences and community cultural recognition events. It also allows for cultural sharing of ideas and concerns in a safe and non-judgmental environment.

Summary

Many issues never see the light of day because of the efforts of HR and diversity involvement. If there is a feeling from the Commission that the hours are unacceptable, I can strictly become a person who just does investigations. If that is the case, we are agreeing to a defensive posture which won't solve the issues of the past. My approach is proactive and preparing for difficult time in the time of peace. If that is not the direction the Commission approves of, please advise.

Ted Bagley
Chief Diversity Officer

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: June 25, 2018

SUBJECT: Chief Operating Officer Update

Executive Summary

Department of Healthcare Services (DHCS) Annual Audit – GCHP Operations and Network Operations Departments participated in the Annual DHCS audit from June 4 – 15, 2018 in our offices. DHCS will issues results shortly and we will provide a status at that time.

ASO Transformation Project – GCHP and Conduent continue to work on the initial steps of forming the work plan for the project. Conduent and GCHP participated in a virtual meeting for several hours over 3 days to finalize documents and establish work groups. Conduent has continued to work behind the scenes with VBA on structure of the system.

Americas Health Plan (AHP) Pilot – Representatives from GCHP and AHP agreed to suspend meetings until June 20, 2018 so GCHP staff could focus on the DHCS Audit. The new focus is on setting up the work groups for individual functional areas. The meetings begin on June 26, 2018. AHP and GCHP agreed to submit documents to the State for review of the plan to plan agreement. A response from the State can take up to 60 days during which time work activities will continue between GCHP and AHP.

Contracting - GCHP's contracting team continues to work on developing new contracts, renegotiating contracts up for renewal and assessing the network to ensure access to members in geographically strategic areas.

The contracting team is currently negotiating 2 major hospital contracts that will introduce Alternative Payment Models designed to incentivize providers to deliver high-quality cost-effective care.

Network Operations Regulatory Initiatives -

- Provider Directory (SB137) - This bill regulates Provider Directory data requirements as well as the frequency of updates and a data validation process. This regulation is part of the new "mega-regs" and represents a significant increase in requirements and

administrative effort for Medi-Cal Plans. Final efforts for print and fulfillment are in process and it is expected that the Plan will meet this regulatory requirement.

- Network Certification – Beginning July 1, 2018, all Medi-Cal managed care plans (MCPs) will be required to submit annual network certifications in addition to continuing requirements for reporting significant changes to their networks. MCPs must confirm that their networks will meet the anticipated needs of their service areas. This means that plans must maintain a provider network adequate to serve their service areas. For county-organized health systems, DHCS requires network capacity adequate to serve 100% of the Plan's eligible beneficiaries in the service area. MCPs must also meet FTE provider-to-beneficiary ratios of 1 FTE PCP to every 2000 beneficiaries, and 1 FTE network physician to every 1200 beneficiaries. GCHP exceeds this requirement.

  Effective July 1, 2018, DHCS has also established time and distance standards based on county population density. These standards apply to primary and specialty care for adults and children, OB/GYN services, hospitals, pharmacy, and mental health services. Primary care and mental health outpatient services should be offered within 10 business days of request, while specialty care appointments should be offered within 15 business days of request. Primary care, hospital, and pharmacy sites must be located within 10 miles or 30 minutes of a beneficiary's residence regardless of county; time and distance standards vary by county density designation.

- Provider Data Submission - 274 file – This regulatory requirement provides further specification for a Plan's Provider Network Data Reporting. Data from these submissions are used for beneficiary enrollment, to assist in determining network adequacy and meeting state and federal reporting requirements. GCHP continues to meet state submission timeframes and expectations for this requirement. This process remains ongoing between DHCS and all Plans. This was another "all hands on deck" requirement for the Plan. Multiple departments within the Plan were involved in developing new field enhancements and calculations involving FTE calculations around network adequacy.

Operations Dashboard

Membership

Membership continues to remain below 200,000 for 2018. June's enrollment remains consistent with the previous months. Based on the current economy and the time of year, we can expect enrollment to remain at this level.

Operations Dashboard Monthly Volumes- June 2018	
	Volume
Membership:	
Total	**196,794**
June Loss	**-6,417**
June Add	**3,470**
Retro Activity	**2212**
Gain/Loss (net)	**-735**
AB-85: (new)	
VCMC	**457**
Remaining Providers	**456**
VCMC Target	**65,765**
VCMC % of Target	**42.75%**

AB 85 Auto Assignment- GCHP assigned 457 new members to VCMC, while the remaining 456 new members were assigned to providers in compliance with the VCMMCC Auto Assignment policy (MS-005) for June. VCMC has 28,118 Adult Expansion (AE) members assigned as of June 1, 2018. VCMC's target enrollment, as established by DHCS as part of AB85, is 65,765 and is currently at 42.75% of the target.

Operations Dashboard

Encounter Data

Encounter data fluctuates month over month depending on provider submissions and services. The error rates are consistent month over month by provider type. The most common error types submitted involve members not effective on date of service, coding errors and duplicate submissions.

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

Operations Dashboard Monthly Volumes- May 2018 Total Encounters Submitted: 437,011		
Encounter Type	**Errors**	**% of Errors**
Professional	2,129	1.6%
Institutional	431	0.6%
Pharmacy	259	0.1%
Total	**2,819**	**0.6%**

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

Claims

Annually, Conduent processes approximately 2,300,000 claims for GCHP. This does not include the volume of encounters received by GCHP. Claim submission slightly edged downward for May. April's claim count was 217,183 which is 2,017 claims higher than May. The average daily receipt in May was 9,780 claims which is 251 claims per day higher than April.

Operations Dashboard
Monthly Claims Volumes- February- May 2018

	Month			
	May	April	March	Feb
Total	**215,166**	217,183	215,953	188,639
Daily Average Receipt	**9,780**	9,529	9,816	9,432
Days Receipt on Hand	**4**	3.79	3.12	2.85

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

Operations Dashboard
Key Performance Metrics-February - May 2018

	Benchmark	**Month**			
		May	April	March	Feb
Turn Around Time	90.00%	**99.08%**	97.70%	95.62%	95.45%
Financial Accuracy	98.00%	**99.30%**	99.00%	99.74%	99.92%
Procedural Accuracy	97.00%	**99.91%**	99.00%	99.99%	99.74%

Call Center

Call center metrics continue to demonstrate fluidity due to high call volumes and talk times - talk times for both provider and member calls remain in the 9 to 10 minute time frame. Member calls generally take less time than provider inquiries which often involve multiple

members and claims. Conduent and GCHP continue to collaboratively address opportunities to reduce talk times, improve call accuracy, iaddress staffing issues by hiring in advance of attrition and work together to innovate call processes and workflows.

Operations Dashboard Call Volume- February-May 2018				
	May	**April**	March	Feb
Call Volume (# of calls)	**12,183**	**12,455**	12,719	10,968

Operations Dashboard Key Performance Metrics- February-May 2018					
	Benchmark	**May**	April	March	Feb
Avg. Speed To Answer	30 Seconds	**90.6**	22	40.8*	27.8
Abandonment Rate	5.00%	**4.73%**	1.05%	2.13%	1.57%
Call Quality Scores	95.00%	**96.7%**	97.56%	96.73%	96.90%
**ASA spike due to attrition, new employees being hired and illness*					

Grievance and Appeals

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

G&A continues to show a decline in provider inquiries reducing the overall volume. GCHP overall G&A's per thousand remain low and similar to other COHS plans.
DHCS measures G&A performance against 2 metrics for each category (2 for Grievance, 2 for Appeals). The metrics are timeliness of acknowledgement and timeliness of resolution. The performance metric of 100%, remains a challenge as even one day delay on one grievance or appeal will cause the metric to be missed. GCHP continues to review timeliness delays to determine root cause and identify ways to improve the process to meet each metric at 100%.

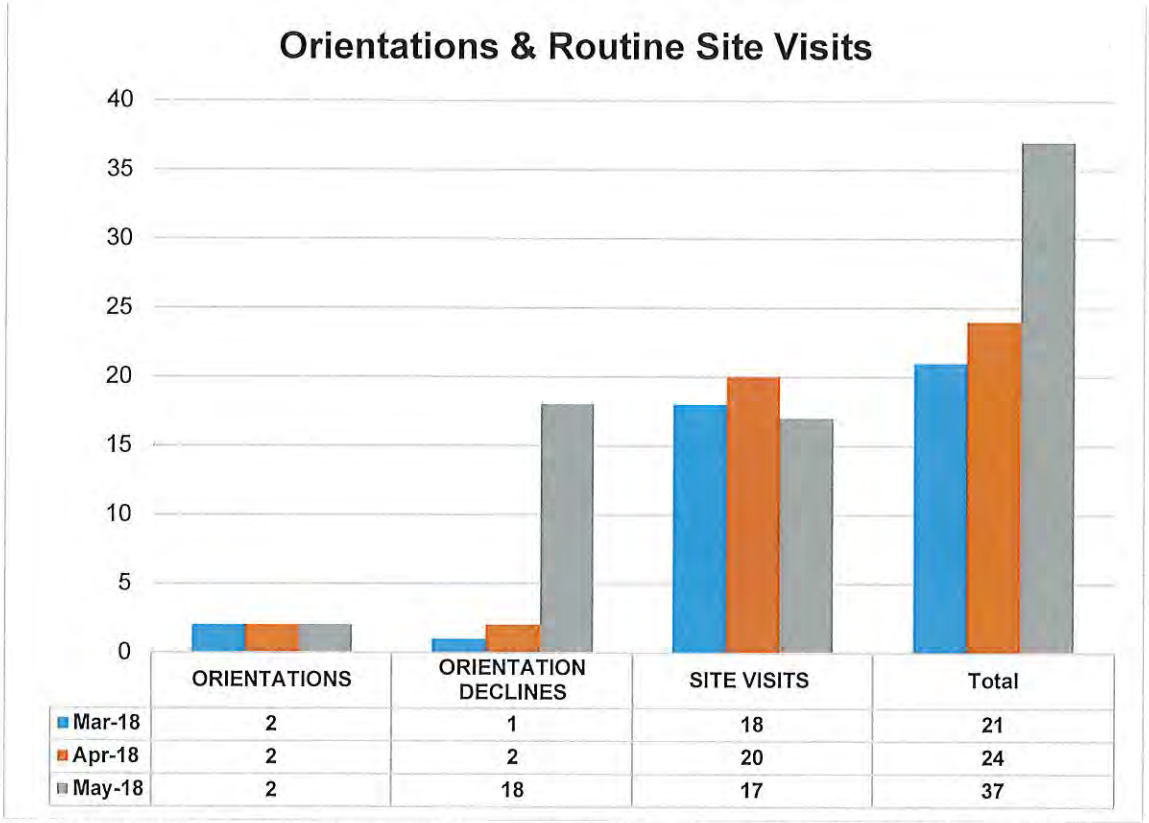
Operations Dashboard Monthly Volumes- February - April 2018			
	April	**March**	February
G&A Volume:			
Clinical	**20**	**11**	8
Upheld	**10**	**4**	3
Overturned	**9**	**5**	4
Withdrawn	**1**	**2**	1
Provider	**108**	**121**	154
Member	**34**	**29**	33
Grievances/ 1,000	**0.17**	**0.15**	0.17
Quality of Care (reasons)	**20**	**17**	29
State Fair Hearings	**1**	**0**	0
Denied	**1**		
Dismissed	**0**		
Withdrawn	**0**		

Operations Dashboard Monthly Volumes by Issue Type–February - April 2018			
Grievance (Issue Type):	**Apr**	Mar	Feb
Accessibility	**3**	4	8
Benefits/Coverage	**1**	1	1
Billings	**4**	4	2
Denial/Refusals	**1**	1	1
Quality of Care	**20**	17	18
Quality of Service	**5**	2	1
Referral	**0**	0	1

Operations Dashboard Key Performance Metrics February - April 2018				
	Benchmark	**April**	March	Feb
Grievance Acknowledgement	100.00%	**97%**	91.00%	87.00%
Appeal Acknowledgement	100.00%	**100%**	100.00%	100.00%
Grievance Resolution	100.00%	**95%**	100.00%	99.00%
Appeal Resolution	100.00%	**100%**	100.00%	100.00%

Network Operations Dashboard

A. PROVIDER SITE VISIT RESULTS



	ORIENTATIONS	ORIENTATION DECLINES	SITE VISITS	Total
Mar-18	2	1	18	21
Apr-18	2	2	20	24
May-18	2	18	17	37

- Orientations: 6 new provider orientations were conducted by GCHP Provider Relations Staff over the last 3 months.

- 21 Physicians declined orientation during this reporting period due to their joining an established contracted group with GCHP. Established groups such as delegated providers have participated in previous orientations; they are familiar with GCHP policies and procedures and have the staff and capability to perform the orientation function on their own. Network Operations staff insures consistency of training through their regularly scheduled provider site visits.

- Site Visits: 55 provider site visits were completed by Network Operations-Provider Relations staff over the last 3 month period. The figure is up 27.3% compared to the previous 3 month period. The goal for the Provider Relations team is to complete 20 site visits per Provider Relations Specialists per month i.e., 40 visits per month. Despite the increase in site visits, overall these site visits are slightly down due to

competing priorities resulting from increased regulatory compliance activities and DHCS Audit preparation (May/June).

B. PROVIDER ADDITIONS AND TERMINATIONS JUNE 2018

ADDITIONS:

- Key specialty areas recruited include: Dermatology and Ophthalmology

PROVIDER TYPE	# PROVIDER ADDS June 2018	TOTAL PROVIDER ADDS July 2017-June 2018	TOTAL NETWORK PROVIDERS
Hospital	**0**	**11**	**33**
-Acute Care	0	0	19
-LTAC	0	10	9
-Tertiary	0	1	5
Providers	**8**	**1,160**	**6,405**
-PCP's & Midlevels	0	60	441
-Specialists	8	1,050	5,623
-Hospitalists	0	50	341
Ancillary	**2**	**11**	**388**
-ASC	0	0	8
-CBAS	0	0	6
-DME	0	2	108
-Home Health	0	0	33
-Hospice	0	2	21
-Laboratory	0	0	67
-Optometry	0	1	33
-OT/PT/ST	0	6	83
-Radiology/Imaging	0	0	29
Pharmacy	**1**	**7**	**838**
SNF/LTC/CLF	**1**	**8**	**8**
Behavioral Health	**0**	**39**	**327**

C. TERMINATIONS:

- 1 Midlevel and 5 specialist providers terminated from City of Hope Medical Foundation all due to provider resignationsfrom the group.
- 7 pediatric sub-specialists terminated from Children's Hospital LA Medical Group. Providers terminated from the group without prior notice to the Plan.

This is not an unusual practice for large academic affiliated medical groups as providers (residents/fellows/visiting professors) train and subsequently move on when their training is complete if not offered an attending academic position with the group.

- The remaining 4 other provider terminations are individual single terms that have no significant impact on the network itself or member access.

PROVIDER TYPE	# PROVIDER TERMS June 2017	TOTAL PROVIDER TERMS July 2017- June 2017	COMMENTS
Hospital	**0**	**0**	---
-Acute Care	0	0	---
-LTAC	0	0	---
-Tertiary	0	0	---
Providers	**17**	**167**	---
-PCP's & Midlevels	3	47	No major impact
-Specialists	13	95	No major impact
-Hospitalists	1	25	No major impact
Ancillary	**6**	**11**	No major impact
-ASC	0	1	No major impact
-CBAS	0	0	---
-DME	0	3	No major impact
-Home Health	0	0	---
-Hospice	0	1	No major impact
-Laboratory	0	0	---
-Optometry	0	0	---
-OT/PT/ST	1	1	No major impact
-Radiology/Imaging	5	5	No major impact
Pharmacy	**0**	**21**	No major impact. Terms result of wrong Pharmacy submissions by Optum
SNF/LTC/CLF	**0**	**0**	---
Behavioral Health	**0**	**17**	---