

Ventura County Medi-Cal Managed Care Commission (VCMCC) dba Gold Coast Health Plan Provider Advisory Committee Meeting

Date: Wednesday, August 22, 2012

Time: 4:00pm

Place: 2240 E. Gonzales Road, Suite 280, Oxnard CA 93036

AGENDA

1. Call to Order, Welcome and Roll Call
2. Public Comment/Correspondence
3. Approval of Meeting Minutes, February 9, 2012 Provider Advisory Committee Meeting
4. Introductions
5. Information Items
 - Retrospective Member Enrollment
 - Community Based Adult Services (“CBAS”)
 - Child Health and Disability Prevention Program (“CHDP”)
 - Clarification of Podiatry Benefits
 - Modification of Prior Authorizations Required
 - Transportation
 - Healthy Families Transition
 - Payment of CPT Codes Ending in “99”
 - Use of County vs. Out of County Providers
6. Augmentation of Outpatient Hospital Reimbursement

Open Discussion

Adjourn

Meeting Agenda available at <http://www.goldcoasthealthplan.org>

ADMINISTRATIVE REPORTS RELATING TO THIS AGENDA AND MATERIALS RELATED TO AN AGENDA ITEM SUBMITTED TO THE COMMITTEE AFTER DISTRIBUTION OF THE AGENDA PACKET ARE AVAILABLE FOR PUBLIC REVIEW DURING NORMAL BUSINESS HOURS AT THE OFFICE OF THE CLERK OF THE BOARD, 2220 E. GONZALES ROAD, SUITE 200, OXNARD, CA.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT 805/981-5340. REASONABLE ADVANCE NOTIFICATION OF THE NEED FOR ACCOMMODATION PRIOR TO THE MEETING (48 HOURS ADVANCE NOTICE IS PREFERABLE) WILL ENABLE US TO MAKE REASONABLE ARRANGEMENTS TO ENSURE ACCESSIBILITY TO THIS MEETING

**GOLD COAST HEALTH PLAN
PROVIDER ADVISORY COMMITTEE
MINUTES**

Date: Thursday, February 9, 2012

Location: Conference Room, Ventura County Health Care Agency
2240 E. Gonzales Rd, Suite 280, Oxnard, CA 93036

Moderator: Paul R. Roberts, Director of Provider Relations & Provider Contracting, GCHP

Members Present: Alger Brion, Clive Salmon, DPM; Mike Lurie, Mark Minnis, John Roughan, Brett Zaer, Tony Alatorre

Absent: Joyce Weckl, RN; Terrie Stanley, RN, CPHQ, MPA; John Keats, MD

Guests Present: Phil Chase, Simi Valley Care Center, Steven Krivit, Consultant, David Selman, VCMC

Staff Present: Rebecca Wright, Provider Relations Interim Manager; Lezli Stroh, Provider Relations Representative; Velma Washington, Provider Relations Assistant; Steve Lalich, Director of Communications; Earl Greenia, CEO

- I. **Call to order.** Paul Roberts called the meeting to order at 3:35pm. Introduction of GCHP staff and Committee members.
- II. **Approval of minutes.** The November 10, 2011 minutes were accepted as presented.
- III. **New business:**
 - A. Announcement that Dr. John Keats resigned to take a Medical Director position for Cigna in Phoenix, Arizona. A new candidate will be presented to the Commission for appointment.
 - B. Provider Contracting status was reviewed and a chart of network par providers and locations was presented. The plan's recent expansion initiative into Los Angeles and Santa Barbara counties was discussed. Additional hospitals were contracted for tertiary care in both counties. Providence hospitals for their four facilities in southern California and Cedars-Sinai both joined our network. Cedars-Sinai was mainly contracted for providing organ transplants to cover our increasing demand. Cedars-Sinai is also a recognized Center of Excellence facility and has nearly 400 Specialists in their affiliated medical groups. The Cottage Health System (in Santa Barbara County) contract is being finalized and will be added to the network soon. Two facilities that have been difficult to negotiate but are hopefully almost complete are the LAC+USC burn center (public side of USC Keck) and the Grossman Burn Center (Level III burn center). A lot of progress has been made in expanding the network and we should have new contracts completed in the near term.
 - C. The new VSP vendor relationship to manage Optometric services for hardware, routine refractions and lenses will be implemented March 1, 2012. Additional services will be provided by the network Optometrists that the California Board of Optometry recognizes as part of their certification under their individual licenses. GCHP's first Member Newsletter going out at the end of February will include the information in both English and Spanish to

explain the new change in routine vision care benefits. Process will be similar to the system we have with Script Care. VSP is very experienced around the country with 56 million enrollees plus their Medi-Cal experience with most of the other COHS plans. They also have great reporting capabilities (i.e. HEDIS) and can provide this service at less expense than we could do directly through GCHP. Ophthalmology physician services will continue to be provided through our direct contracts between these doctors and GCHP. Our limited Ophthalmology providers will feel some relief of the burden to provide some routine services that can be handled by Optometrists in the VSP network.

- D. A discussion was held on the use of out-of-network (or “non-par”) providers and in-network provider responsibilities when making referrals. Mr. Roberts explained some of the needs and scenarios that might require GCHP network providers to refer our Members to out of county providers. It was noted that many Members were being treated at non-contracted facilities in the beginning of GCHP going live and our Health Services Department spent a lot of hours transferring cases to contracted facilities once the Members were stabilized. Recognizing that some in-county providers were referring to non-contracted facilities out of habit or lack of understanding of GCHP requirements, a letter was sent by Dr. Cho in November to remind providers not to refer Members outside of the county for procedures without prior authorization from the Plan. A flowchart was created to show participating providers how to make referrals to all par providers with a Direct Referral form plus how they must request prior auth (with a special form) from the Plan for making referrals to either non-par providers or those who were contracted outside of Ventura County. Mr. Roberts reviewed the chart with the Committee and noted that this will be presented in the upcoming In-Service Outreach Sessions for GCHP Providers which will begin February 15th and continue through March 9th. Letters advising Providers about the sessions, locations and times were sent this week. All materials to be presented during these sessions will also be available on-line for those providers and staff who cannot attend. The sessions will comprise a 20 minute PowerPoint with a Q&A following the presentation. Provider Directories, the newly revised Provider Manual will be previewed and various tip sheets and FAQ documents and user guides will also be distributed.
- E. Provider, Alger Brion, commended Kathleen Garner for her ongoing assistance in their billing, pharmacy and resident eligibility issues. A lot of details still need to be worked out with billing, pharmacy and patient care. Script Care has been able to resolve the pharmacy issue, but, there are other financial and business items that yet need to be resolved. It was pointed out that these Committee sessions are more general in nature but a face-to-face meeting may be necessary as a follow-up to these concerns. Staff will be notified to contact Mr. Brion to pursue these issues.
- IV. **New Study Topics:** Opportunity for Providers to identify issues as take-aways for Plan staff and management to research and present findings and recommendations to the CEO and Board.
1. Nursing facility billing issues. All submitted items are not staying with initial claims submissions. Mistakes in losing or misplacing attachments in the mailroom are creating duplicate work and is making provider cash flow difficult. GCHP is currently working with providers and claims to fix this problem. Reminded providers about enrollment with EDI to avoid submitting paper claims that could assist in avoiding this error in the short term.
 2. Inconsistency in payments is affecting cash flow. Providers identified issues such as they are not sure when the checks are going to be cut; the claims billed are not what is paid back. Claims billed for the same date of service are not paid at the same time or overpaid because of duplicate submissions. Providers are reimbursing through hard

- checks for claims that were incorrectly paid. Duplicate submissions were a common reason for several overpayments to providers. Mr. Roberts noted that we recently had meetings with providers and their trade group to review this situation. He was not sure of current status but if Mr. Chase would send him an email he would be pleased to either respond directly or escalate it to the proper Plan officials.
3. Formal response to appeals is not being received timely, within 15 days, or not at all. Mr. Roughan, Simi Valley Hospital, noted that the hospital has submitted several hundred claims appeals but none have been acknowledged. Some constitute single items while others were grouped into common appeals. Some complaints from Members have also been submitted with no response. Mr. Roberts noted that he was unaware of this problem and he will determine status and provide a written response to Mr. Roughan.
 4. Crossover claims from Medi-Medi are an issue for some providers. Paper submissions of EOBs from Medicare as primary carrier are being sent to Gold Coast by providers due to electronic crossover from Medi-Cal not currently being available. Mr. Roberts noted that is an item on our "to-do" list and we hope to soon implement automatic electronic crossover of claims from Medicare to Gold Coast without requiring the provider to obtain the EOB and submit that with their claims to GCHP. However, he pointed out that the list of items to be attacked is quite lengthy and at present he cannot indicate exactly when this task might be completed.
 5. Share of Cost not being recognized and the gross rate is being paid instead of the net rate. GCHP does not track SOC and this is an issue that must be addressed between Member and provider at the time of service. It is the provider's responsibility to clear the SOC with the state so that the proper claims information comes to the Plan for adjudication and payment.
- V. **Presentation:** Mike Lurie and his guest consultant, Steve Krivit, discussed potential capitation scenarios for GCHP to consider in adopting for the Plan's PCPs. Background from Mike Lurie: Community Memorial is a two hospital system with 10 clinics, some specialty and primary. At inception of the contracting process, one of the things that was disappointing to the providers was the capitation rate. Mr. Lurie expressed that he is not a fan of capitation in managed care. He is concerned that the low rate could cause providers to turn patients away. He understands the concept, but, does not like it. The capitation payment strategy adopted by the Plan could have been more sophisticated. For example, there could have been separate capitation payments based on age and sex in addition to the aid category. Some Members will utilize PCP services at a greater rate than the \$8.38 will cover. Mr. Lurie and Mr. Krivit provided a summary of samples of what other COHS Plans are doing in this area that are more sophisticated even without historical data that they recognize GCHP does not have at this point in time.

Background of Steve Krivit: Self-employed consultant who has worked with Medi-Cal managed programs such as CenCal and Santa Clara Family Health Plan. Mike Lurie asked Steve to review the charts on how other COHS pays their PCPs. A brief survey was conducted to look at four methods of reimbursement using capitation and the strengths and weaknesses of each method. It was suggested that GCHP develop cap rates that are adjusted for eligibility categories plus add age and gender categories. They recommend we look for a more sophisticated method of utilizing capitation financing. Examples from other COHS go beyond the aid category, age and gender criteria. They add incentives to providers. Some plans which use incentive driven capitation have been in business a long time and can build their experience into their rates. GCHP could build factors like those into

their rates. There are also some plans that are using FFS. Strength of using FFS provides a closer detail of the services provided to Members. Underreporting could occur with capitation since there is no incentive to produce a claim that will go unpaid. Having a paper trail of claims could provide assurances to the regulators in terms of documenting encounters and such. The presentation summary indicated 4 different ways that claims are being paid. Hopefully, this could serve to assist GCHP in reviewing and revising its capitation formulae and incentives in the health care delivery system it uses to compensate its Primary Care Providers.

Response: Paul explained that GCHP is encouraging providers to participate in generating ideas on how to best provide financial incentives. He stated we are a public benefit organization and we have no profit motives to make and keep money for management or shareholders. He also noted that from day one it has been our stated intent for the long term to have some sort of provider incentive compensation program (like P4P, “pay for performance”) but that it would not be available at start-up. We all knew it would take time to collect the information needed to make a sound decision in this area. The first order of business was to generate a surplus of savings over budget in order to have the funds to share with providers. Being new and not knowing how things would turn out it would not be wise to implement such a program without knowing if there were funds to finance it. Second, we had to collect the utilization and cost data that would be necessary to devise a prudent program. He also noted that the historical record is clear that FFS compensation has a tendency for providers to over-utilize whereas capitation generates incentives for providers to underutilize. With only 8 months of experience at present and all the issues identified with our claims processing systems, GCHP does not enough data to implement any kind of program right now. In addition, it was concluded that the State financial structure of payments forced GCHP to be fiscally conservative because of budget constraints. Clearly, age and sex adjustments could create a higher capitation rate for some and lower the rate for others. GCHP feels that it is too soon to make changes when we are not yet stable in our current operations. Co-pays and rate reductions are also on the table which had to be considered in year one. We just determined that GCHP’s impact will be a 2.19% reduction in capitation amounts from the state. We are not going to collect these amounts from providers retroactively for 2011 and have not yet decided what we will do on a going forward basis for 2012. The scene is constantly changing such as the Feds ruling against the potential state-mandated co-pays, so, the picture isn’t completely clear but is a bit less hazy. The first adjustment that could be made is age and sex. Good performance would be next. Long term strategy will begin in year 3 according to Earl Greenia. GCHP does not have access to the data that would be needed for those types of incentives yet. The idea is to stabilize in year one, analyze in year two and implement incentives if there is a surplus. It is possible that previous paid claims data from the state could be used to help implement incentives and make age and sex adjustments.

VI. **Round table:**

1. Question by Phil Chase about the Plan’s reserves and suggested that GCHP keep in mind the budget shortfalls in the fall. Provider wrote a bill for prompt payment and sent it to Speaker Boehner. Suggestion that GCHP try to anticipate state budget problems and keep reserves available for budget impasses. Many providers cannot withstand the financial hit to their cash flow if the state reaches an impasse like it has in previous years.
2. Is there a mechanism for tracking out-of-county referrals that could have been done in county? How do we know how many dollars are spent outside of the county?

- VII. **Next meeting:** The problem of scheduled meeting dates was discussed. Our meetings happen to coincide with other key Plan meetings that are held on the second Thursday of the month they are scheduled. It was asked if there would be a problem with anyone if our meeting date was moved from the 2nd to the 3rd Thursday of the month in which quarterly meetings are to be held? No member expressed a concern with this suggestion. So, the next meeting was scheduled for the third Thursday in May on the 17th.
- VIII. **Meeting adjournment:** The meeting adjourned at 4:38pm.

Minutes Recorded and Submitted by Lezli Stroh, Provider Relations Representative
Date: February 23, 2012