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

Regular Meeting
Monday, July 23, 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 June 25, 2018.**

   Staff: Maddie Gutierrez, Clerk of the Commission

   RECOMMENDATION: Approve the minutes.

2. **Axcient Contract Extension**

   Staff: Melissa Scrymgeour, Chief Administrative Officer

   RECOMMENDATION: Approve the contract extension.

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

   Staff: Melissa Scrymgeour, Chief Administrative Officer

   RECOMMENDATION: Approve the contract extension.

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

   Staff: Ruth Watson, Chief Operating Officer

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

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

5. Chief Executive Officer (CEO) Report

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Accept and file the report.

FORMAL ACTION

6. Quality Improvement Report

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

RECOMMENDATION: Accept and file the 2018 Quality Improvement Report.

7. May Financials Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Accept and file the May Financials Report.

PRESENTATION

8. AHP Update

Staff: Ruth Watson, Chief Operating Officer
Presenter: Margaret Tatar, Managing Principal, Health Management Associates

RECOMMENDATION: Accept and file the presentation.

REPORTS

9. Chief Administrative Officer (CAO) 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.

12. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

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

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

OPEN SESSION

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on August 27, 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 Disabillties 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.

Gold Coast Health Plan
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Maddie Gutierrez, Clerk to the Commission

DATE: July 23, 2018

SUBJECT: Meeting Minutes of June 25, 2018 Regular Commission Meeting

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the June 25, 2018 Regular Commission Meeting minutes.

Ventura County Medi-Cal Managed Care Commission
(VCMMCC)
dba Gold Coast Health Plan (GCHP)
June 25, 2018 Regular Meeting Minutes

CALL TO ORDER

Commissioner Jennifer Swenson called the meeting to order at 2:05 p.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Swenson led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Shawn Atin, Narcisa Egan, Laura Espinosa (arrived at 2:07 p.m.), Debra Herwaldt, Kelly Long, Gagan Pawar, M.D., and Jennifer Swenson.

Absent: Commissioners Antonio Alatorre, Theresa Cho, M.D., Lanyard Dial, M.D., and Johnson Gill.

Due to time constraints, agenda items will be taken out of order in order to have a quorum for voting purposes. Public Comments will be done at the end of the agenda item requested.

CONSENT

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

   RECOMMENDATION: Approve the minutes.

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

   RECOMMENDATION: To continue service with TBJ Consulting.

Commissioner Long moved to approve the recommendations for Consent items 1 and 2. Commissioner Pawar seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Laura Espinosa, Debra Herwaldt, Kelly Long, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Theresa Cho, M.D., Lanyard Dial, M.D., and Johnson Gill.

Commissioner Swenson declared the motion carried.

REPORTS

3. Chief Executive Officer (CEO) Report

RECOMMENDATION: Accept and file the report.

CEO Villani reported the GCHP Annual Resource Fair was held on Saturday, June 23rd and was very successful. Guests included Supervisor John Zaragoza and Mayor-Pro-Tem, Carmen Ramirez.

CEO Villani then presented a PowerPoint presentation which highlighted the fiscal year 2018/2019 budget approach:

- Current hiring "frost"
- Reduction of health care expenditures
- Alternative Payment Methodology
- Reduction of operating costs wherever possible
- Continue to seek revenue sources

More detail will be discussed under agenda item number 5 by Chief Financial Officer Kashina Bishop.

FORMAL ACTION ITEMS

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

RECOMMENDATION: Accept the recommendation of the Executive Finance Committee and approve the fiscal year 2018-2019 budget as presented.

Chief Financial Officer Bishop noted that for the fiscal year 2018-2019 Gold Coast Health Plan faces operating losses for the third consecutive year. It was noted that the organization has maintained reserve levels consistent with the Commissions' direction although operating at a loss.

Higher medical expenditures are the primary drivers for the loss, but staff expects these medical costs will be recognized in future State capitation rates. GCHP will continue to monitor revenue as well as State policy changes that could impact revenue in the future. Staff continues to minimize expenses wherever possible. It was noted

that GCHP is investing in programs and applications needed to meet changing needs of the healthcare market. GCHP was able to decrease some medical expenses by contracting changes but it is difficult for GCHP to control some medical expenses. For example, long-term care is up 3.9% because the facility rates are set by the State and go up each year. However, membership is going through a slightly downward trend.

Administrative expenses, outside services (ASO, PBM), and salaries and benefits were reviewed. Seven new positions have been added with a net of five new positions due to two position eliminations. A receptionist was hired to take the place of the guards. Legal expenses have increased.

Commissioner Atin requested a review of staffing changes. CFO Bishop responded a PMO position had been eliminated and a FY 17/18 budgeted Executive Assistant position, Health Services added 4 positions, Compliance added one attorney position and Network Operations added a contract specialist.

Discussion was held around the FY18-19 project portfolio. Project investments are budgeted at roughly $5 million for this fiscal.

TNE as a percent required is dropping only slightly because there is an estimated decrease in the required amount.

The capital budget was reviewed – there may be improvements to two suites, so they can be rented out and in turn bring in revenue.

Commissioner Atin expressed his concern about large projects that were not reviewed in detail. CFO Bishop noted that projects would come back to the Commission for approval, this is just a budget placeholder. Commissioner Long asked if the projects would be complete by the end of the fiscal year. Chief Operating Officer, Ruth Watson, responded that the ASO project will take 18 months and therefore carry over into the next year's budget.

PUBLIC COMMENT

Danny Martinez, appearing on behalf of CA Pharmacy Association spoke on Agenda Item No. 5. Mr. Martinez stated he wanted to bring attention to the Commission on the general administration expenses and reviewed the graphs/charts with outside finance "people" to see if the graphs made sense. He mentioned the percent change for outside services and variances that occur.

Commissioner Long moved to approve the 2018-2019 Budget. Commissioner Atin seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Laura Espinosa, Debra Herwaldt, Kelly Long, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Theresa Cho, M.D., Lanyard Dial, M.D., and Johnson Gill.

Commissioner Swenson declared the motion carried.

PUBLIC COMMENT

Sunshine Mangone, appearing on behalf of Shield Healthcare stated she wanted to discuss Other Healthcare Coverage (OHC). Ms. Mangone stated she worked for Shield Healthcare which services approximately 200 GCHP members who receive incontinent products. She stated there is a 30% success rate for members receiving incontinent supplies, but it is very limited. She is asking the Commission for support in having these supplies more readily and consistently available to members.

4. April Financials Report

RECOMMENDATION: Accept and file the April financials report.

Chief Financial Officer Bishop reviewed the major components for the April fiscal year-to-date financial statements and the enrollment trends. GCHP had a net gain for the month of $16.3 million due to AB 85. Medical expenses and administrative expenses stayed very consistent with prior months. CFO Bishop also noted that DHCS notified the plans that the 16/17 capitation rates for the expansion population were rejected by CMS and the 85% MLR requirement will be added back in order for CMS to approve. GCHP will need to reserve an additional $3.8M in the May financials to reflect this change.

Commissioner Long moved to approve the recommendation. Commissioner Espinosa seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Laura Espinosa, Debra Herwaldt, Kelly Long, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Theresa Cho, M.D., Lanyard Dial, M.D., and Johnson Gill.

Commissioner Swenson declared the motion carried.

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

RECOMMENDATION: Accept the recommendation of the Executive Finance Committee and adopt the procedure outline as the Commission's policy for placing items on the agenda.

Currently there is no formal policy for determining how Commissioners place items on the agenda. General Counsel, Scott Campbell, reviewed the recommendations made by the Executive Finance Committee with the Commission.

Commissioner Espinosa moved to approve the recommendation. Commissioner Long seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Laura Espinosa, Debra Herwaldt, Kelly Long, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Theresa Cho, M.D., Lanyard Dial, M.D., and Johnson Gill.

Commissioner Swenson declared the motion carried.

PRESENTATIONS

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

RECOMMENDATION: Accept and file the presentation.

Chief Medical Officer (CMO) Nancy Wharfield, M.D. gave a PowerPoint presentation on the growing problem with high risk drugs in Ventura County. The presentation included background on the County's opioid problem and GCHP's response to the problem. Provider Opioid Tool Kit, Formulary Controls, Benefit Structure, and results were discussed.

Ashley Nettles, Program Manager for Project Safer spoke to the Commission. She stated the main goal is to reduce opioid overdoses or death. Over 200 kits have been distributed to Oxnard and Simi Valley Police departments as well as Ventura County Sheriffs' department. This has in turn saved 34 lives (since February 2014 – May 2018). Gold Coast Health Plan has contributed by providing a grant which was used to purchase kits.

Commissioner Espinosa stated this was a great program. No names have to be given in order to obtain a kit. There are 2 versions – a regular kit or a nasal spray. Training is required to use the kits.

Commissioner Pawar asked how results are monitored. Anne Freese, Pharmacy Director stated additional reporting was received from OptumRx. Guidelines were reviewed as well as patient history.

8. OptumRx Update

Jon Mahrt, Chief Operating Officer for OptumRx was present to give a verbal update on the progress of outstanding issues. Mr. Mahrt introduced his team; it included people from the Prior Authorization Department as well as those hosting an "Open Hours" for pharmacists in the area.

Mr. Mahrt provided the Commission with a handout which outlined a status report or open items, pharmacy relations and provider relations. OptumRx is working on closing out open items with GCHP. OptumRx is currently working on a plan with Anne Freese, Director of Pharmacy, to close out by end of June. Pharmacy issue is anticipated to close in November. They have developed new creative approaches such as: Open Office Hours – OptumRx has met with pharmacists and answered questions.

OptumRx is committed to full transparency. The dashboard provides insight and they are working on a faster turnaround time – distribution of prior authorization requests and how to respond when a provider calls. They also met with Dr. Pawar and Dr. Cho in their clinics to observe the daily routine and made several observations: have been made:

- How can they enhance the experience significantly
- Drug specific fact forms
- Formulary Questions

They are moving forward to launch an Electronic Prior Authorization (EPA) program which will improve the process. They will be training providers on this process, collaborating with GCHP. They will develop a systematic tracking.

Commissioner Long asked if the California Pharmacy Association had been in touch and commented that she wants to ensure their needs are met. Mr. Mahrt stated OptumRx has reached out to pharmacies and have called 10-12 pharmacies for Office Hours program. Mr. Mahrt stated the Open Office Hours have been effective.

PUBLIC COMMENT

Danny Martinez, appearing on behalf of CA Pharmacy Association spoke on Agenda Item No. 8. Mr. Martinez stated he did not receive an invitation to the Open House, only received an e-mail blast. He took a poll of the pharmacists who would be attending and received no response. Mr. Martinez stated the pharmacists are afraid. They don't want to jeopardize their contract. They are all very disheartened. It has been one year and yet there is still no resolution.

REPORTS

9. Chief Medical Officer (CMO) Update

Chief Medical Officer, Nancy Wharfield, M.D., referred to Dr. Anne Freese, Director of Pharmacy to provide an update on pharmacy issue. Dr. Freese stated OptumRx has made great progress. Almost everything has been corrected. They are now working on implementation. There is one item that will remain open until November.

Commissioner Swenson asked about 340B. Dr. Freese stated there are compliance contracts with Ventura County Medical Center (VCMC) and Clinicas Del Camino Real (CDCR). VCMC has declined to participate and CDCR will be providing an alternate proposal.

Commissioner Atin and Long expressed concern that VCMC had declined to participate.

Commissioner Swenson asked if 340B savings would be reduced if VCMC does not participate. Dr. Freese stated that this was correct.

Commissioner Pawar asked what has changed with 340B from before. Dr. Freese responded the proposed Mega Rule requirements were withdrawn. However, DHCS has published a draft APL which requires Plans to have increased oversight of 340B activities. Managed Care Plans will have more oversight responsibilities which may include auditing. GCHP incorporated these additional APL oversight and certification processes into proposed 340B contracts.

Commissioner Long asked what GCHP will do with 340B. Dr. Freese stated GCHP is awaiting a response from Clinicas Del Camino Real. Commissioner Long asked why VCMC is declining to participate in 340B. Dr. Freese stated they may have determined it is not a beneficial activity for them at this time. Commissioner Long stated she would like to understand more about this at the next commission meeting.

Commissioner Herwaldt left the meeting at 3:49 p.m.

PUBLIC COMMENT

Danny Martinez, appearing on behalf of CA Pharmacy Association spoke on Agenda Item No. 9. Mr. Martinez stated several members have asked about the corrective action plan from OptumRx. He asked if this plan was available for public disclosure and what were the list of items on the plan.

Commissioner Atin moved to accept and file agenda items 7, 8 and 9. Commissioner Long seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Laura Espinosa, Debra Herwaldt, Kelly Long, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Theresa Cho, M.D., Lanyard Dial, M.D., and Johnson Gill.

Commissioner Swenson declared the motion carried.

10. Chief Diversity Officer (CDO) Update

Interim Chief Diversity Officer, Ted Bagley, reviewed the stages of the diversity process along with the long term strategic plan. He has also been working with the Diversity Council as well as internal cases with Human Resources. Cases need to be prevented instead of waiting until they become an issue.

Interim CDO Bagley is currently working with HR on the following:

- Having difficult discussions
- Appraisal Process
- Performance Improvement
- Multicultural workplace

The organization has now moved out of reactionary processes and into planning.

Commissioner Atin agreed with CDO Bagley. It is not the number of cases being defended, instead it is the number of cases that are prevented.

CDO Bagley stated a partnership needs to be created with HR and Dale's Team. The other piece is: Community.

11. Chief Operating Officer (COO) Update

The DHCS annual audit has been completed. Many Staff, along with the Compliance team were recognized for their hard work to prepare for the audit. DHCS will issue the audit results, which will be shared with the Commission.

The development of an ASO Transformation master plan with Conduent and VBA is in process. COO Watson will have an update on the ASO at the next Commission meeting.

Americas Health Plan (AHP) and GCHP have 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.

Commissioner Pawar asked about the turn-around time for a specialist appointment. COO Watson advised that the regulatory requirement was 15 days. CMO Nancy Wharfield, M.D. stated E-Consult Services are coming in the future.

Commissioner Espinosa asked about the Call Center. COO Watson stated GCHP audits calls and service levels are reviewed. Commissioner Long asked about the quality of the call. COO Watson responded call quality is reviewed weekly by operations staff.

Commissioner Espinosa moved to accept and file agenda items 10 and 11. Commissioner Atin seconded.

AYES: Commissioners Shawn Atin, Narcisa Egan, Laura Espinosa, Debra Herwaldt, Kelly Long, Gagan Pawar, M.D., and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Theresa Cho, M.D., Lanyard Dial, M.D., and Johnson Gill.

Commissioner Swenson declared the motion carried.

CLOSED SESSION

The Commission adjourned to Closed Session at 4:11 p.m. regarding the following items in the following order:

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

The regular meeting reconvened at 4:57 p.m.

Mr. Campbell stated there was no reportable action taken.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 5:03 p.m.

Approved:

_____

Maddie Gutierrez, Clerk of the Commission

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Melissa Scrymgeour, Chief Administrative Officer

DATE: July 23, 2018

SUBJECT: Contract Extension Approval – Axcient, Inc.

SUMMARY:

In the event of a disaster, GCHP must provide alternative Information Technology (IT) infrastructure to enable continuation of mission critical business while protecting electronic personal health information (ePHI) and personal information (PI).

In January 2015, Gold Coast Health Plan (GCHP) entered into a three-year subscription agreement with Axcient, Inc. to provide disaster recovery services after an extensive RFP process. Axcient's Disaster Recovery as a Service (DRaaS) offering not only met the Plan's disaster recovery business requirements but also provided the lowest annual costs, which ranged from $76k - $172.5K annually across responding vendors. In 2017, Gartner® recognized Axcient as a visionary in the DRaaS market space.

Under the current agreement, Axcient Inc. provides GCHP with access to all backed up infrastructure and GCHP data in the event of a major incident, or declared disaster.

The initial three-year agreement terminated on July 31, 2018. GCHP will renew the contract for an additional two-year term through July 2020.

The agreement is a requirements contract, which allows GCHP to receive services at the negotiated fixed rates, and GCHP has the option to automatically renew or cancel with a thirty (30) day notice at the end of year four.

FISCAL IMPACT:

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

The total renewal amount for the two-year extension is $92,844 ($3,868.50/month for 24 months), summarized in Table 1. There is no increase in the monthly service fees with the extension.

Table 1: Axcient DRaaS Total Contract Value

Master Subscription Agreement	Amount	Period	Budgeted
Original Contract	$105,739.00	02/01/2015 - 07/31/2018	
Additional Bldg	$32,225.00	06/01/2016 - 07/31/2018	
Total Spend Years 1-3	$137,964.00		
Contract Renewal			
Years 4 & 5	**$92,844.00**	**08/01/2018 - 07/31/2020**	**Yes**
Total Projected Cumulative Spend (Yrs. 1-5)	$230,808.00		

RECOMMENDATION:

The Plan recommends the Commission approve the continuation of services with Axcient, Inc. for an additional two-year period from August 1, 2018 – July 31, 2020.

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

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Melissa Scrymgeour, Chief Administrative Officer

DATE: July 23, 2018

SUBJECT: Contract Extension Approval (SOW #7) – CIO Solutions, LP

SUMMARY:

In July 2017, Gold Coast Health Plan (GCHP) entered into a one-year service order agreement (SOW #7) with CIO Solutions to provide on-demand infrastructure engineering level services in support of "keep the lights on" infrastructure projects and approved FY17-18 enterprise initiatives requiring infrastructure engineering support.

The initial one-year agreement terminated on June 30, 2018. GCHP will renew the contract for an additional one-year term with the option to elect up to two additional one-year renewals through June 2020. The agreement is a non-requirements contract that allows GCHP to use the services ad-hoc, at the hourly rate specified. The fixed fee set forth in the agreement is $104 per hour. The agreement can be terminated for convenience at any time with a thirty (30) day notice.

A summary of year-one spend, year-two estimated spend, and the total cumulative value of the service order is included in Table 1.

Table 1: CIO Solutions SO #7 Extension and Total Projected Cumulative Spend

Period	Amount
FY 2017/2018	$74,880
FY 2018/2019	$74,880*
Total Budgeted Cumulative Spend (Yrs. 1-2)	**$149.760**
*Estimate for budget purposes only: May not spend total amount	

FISCAL IMPACT:

There is no impact to the current fiscal year, as the costs are included in the approved FY18-19 budget. The total spend last fiscal year for these services was $74,880 (713 hrs.). Based on project estimates and current workload we do not anticipate the service hours to exceed last fiscal year.

RECOMMENDATION:
GCHP recommends the Commission approve the continuation of services with CIO Solutions, LP. for an additional one-year period from July 1, 2018 – June 30, 2019.

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

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: July 23, 2018

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

SUMMARY:

The VCMMCC approved the funding associated with the ASO Core Replacement Project at the April 23, 2018 meeting. This approved funding included the associated cost of using a specialized external vendor to supplement GCHP's project related activities. GCHP has identified and is recommending approval to contract with FluidEdge Consulting Inc. in order to support these requirements.

BACKGROUND/DISCUSSION:

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

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

FISCAL IMPACT:

There isn't a requirement or commitment to procure any temporary labor services. These services will be procured ad-hoc and on a per transaction basis at pre-negotiated hourly rates. The Plan projects to spend approximately $200,000 though the contract term of July 24, 2018 until December 31, 2020 and each individual transaction is anticipated to be included in the Plan's approved fiscal year budget, which will include an annual COLA adjustment.

RECOMMENDATION:

It is the Plan's recommendation to authorize the CEO to execute a Master Agreement For Temporary Services with FluidEdge Consulting Inc. and to pre-authorize any individual transaction for these services over $100,000.

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

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: July 23, 2018

SUBJECT: Chief Executive Officer Update

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

National Update

Centers for Medicare and Medicaid (CMS) Update

Last month, the Centers for Medicare & Medicaid Services (CMS) developed its Medicaid and Children's Health Insurance Program (CHIP) Scorecard aimed at increasing public transparency about the programs' administration and outcomes. It includes three measure categories, which are adult and child core measures, state administrative measures, and federal administrative measures.

The first category uses adult and child core measures to show how states are performing in six areas. It also provides a national medium for subset measure sets, plus state-specific performance. The data examined was from 2015. The second category includes four measures around State Plan Amendments (SPA), 1915 waiver processing, state's managed care rate submission and review time, and home and community based services by states. The third category focuses on SPA and 1915 waiver processing, total managed care rate review time, CMS' managed care rate review time and submission and approval of section 1115 demonstration waivers.

Overall, California scored above the median quartile in the quality measures. As of April 2018, California has enrolled over 12 million individuals in Medicaid and CHIP — a net increase of 55.44% since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013.

Legislative Update

Last month, the House of Representatives passed a sweeping piece of legislation called H.R. 6 (the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act) to address the nation's opioid overuse epidemic. H.R. 6

incorporated dozens of previously-passed bills that would impact Medicaid, as well as Medicare and other programs, by building provider capacity, including in rural areas, providing protections for pregnant and postpartum women impacted by substance use disorders (SUD), providing a state option to expand coverage periods for justice-involved populations, expanding drug utilization review practices, and in many additional ways.

H.R. 5583, a bill to require states to annually report on certain adult health quality measures (specifically, 10 behavioral health measures) also moved out of the House of Representatives. This legislative bill builds on Congress's enactment of a requirement for states to report on the pediatric core measures set, part of the February spending bill.

H.R. 6082, the Overdose Prevention & Patient Protection Act (OPPS Act) – was passed by the House as well. If enacted, the OPPS Act would align Part 2 requirements with HIPAA privacy requirements allowing the use and disclosure of patient information for treatment, patient safety, payment, and health care operations for covered entities, including health plans operating in Medicaid, the Children's Health Insurance Program (CHIP), Dual Eligible Special Needs Plans (D-SNPs) and those offering Quality Health Plans (QHPs) in the Marketplaces. Importantly, this legislation provides enhanced privacy and security protections from any use of SUD records for initiation or substantiation of criminal, administrative, or civil charges.

The legislative bills moved on to the Senate where they will be review and voted on in their respective committees of jurisdiction.

California Legislative Update

California's Enacted FY 2018-19 Budget

On June 26, Governor Brown signed the fiscal year 2018-19 state budget. The state enjoys a budget surplus of almost $16 billion. Most of that surplus was put in rainy day funds that can be used at a future date when the state falls on hard economic times. Some of the surplus was earmarked for various one-time funding projects.

The final budget included an allocation of $1 billion in Proposition 56 funds and $1.25 billion in federal funds for supplemental payments for preventive services provided by physicians and dentists as follows:

- $500 million for payments to physicians and $210 million for payments to dentists;
- Increased rates for home health services, pediatric day health care, and pediatric free-standing subacute facilities;
- One-time funding of $6 million for qualifying Program of All-Inclusive Care for the Elderly (PACE) programs and $2 million for qualifying Community-Based Adult Services Programs;

- $220 million for educational loan repayments for physicians ($190 million) and dentists ($30 million) and establishes a loan repayment program.

Other elements of the budget include the authorization of a dental integration pilot program to be operated by the Health Plan of San Mateo.
The budget also includes $60 million in one-time funding to establish a California Health Care Cost Transparency Database to collect information on the costs of health care in order to create transparency on health care costs, and to inform policy makers, and reduce disparities and costs.

As previously reported, despite a strong push by the Democrat legislative leadership, additional funding to cover those that would be eligible for Medi-Cal coverage if not for their immigration status was not included in this year's budget. Nor did the budget include funding to restore or add benefits under the Medi-Cal program. Instead of expanding access to health care in the form of state funded universal care, the budget allocated $5 million to study the issue.

The Legislature did have some small victories, as they 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.

Remainder of page intentially left blank

COMPLIANCE UPDATE:

DHCS Annual Medical Audit:

Audits and Investigation conducted the annual 2017-2018 onsite medical audit June 4, 2018 through June 15, 2018. The auditors reviewed the following areas: Utilization Management, Care Management and Care Coordination, Access and Availability, Grievance and Appeals, HIPAA, Fraud, Waste and Abuse, Delegation Oversight, Quality Improvement and Administrative Capacity. 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	**Audit Close Out Letter issued February 14, 2018
CMH	Credentialing 2018	Closed	N/A	**Audit Close Out Letter issued February 26, 2018
VCMC	Credentialing 2018	Closed	N/A	**Audit Close Out Letter issued 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	June 21, 2018
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.
***** Audit Close out Letter definition: Delegate(s) were not issued a CAP due to passing results on the annual onsite audit; therefore, the delegate receives a formal closure letter***

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

Delegate	Audit Type	Audit Month	Date CAP Issued	Date CAP Closed
VSP	QI	April	N/A	N/A
Beacon	Claims	April	May, 9, 2018	Under CAP
VTS	Transportation	May	June 7, 2018	Under CAP
City of Hope	Credentialing	June	N/A	*Audit Close Out Letter issued July 9, 2018
Children's Hospital Los Angeles	Credentialing	July	*Pending Audit Results*	
Cedars Sinai	Credentialing	July	*Pending Audit Results*	
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

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: July 23, 2018

SUBJECT: Gold Coast Health Plan Quality Improvement Report

Summary

Dr. Wharfield will present Gold Coast Health Plan's Quality Improvement Report.

GOLD COAST HEALTH PLAN
2018 QUALITY IMPROVEMENT PROGRAM

Return to Agenda
28 of 152 pages

Return to Agenda
29 of 152 pages

I. BACKGROUND

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

II. MISSION, VISION, VALUES

Mission

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

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

Vision

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

Values

The QI Program supports the organization's values of:

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

III. PURPOSE AND SCOPE

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

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

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

This foundation for a quality strategy is anchored in three linked goals of the "Triple Aim":

- Improve health
- Enhance quality of health care services, including the patient experience
- Reduce DHCS per-capita health program costs

The QI Program consists of the following elements:

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

The scope of the Quality Improvement Program will ensure the non-discriminatory quality and availability of all medically necessary, covered clinical care and services for Plan members including those with limited English proficiency, diverse cultural and ethnic backgrounds and disabilities, and regardless of race, color, national origin, creed, ancestry, religion, age, marital status, gender, health status, sexual orientation or gender identity. All covered services are required to be provided in a culturally and linguistically appropriate manner. The monitoring, evaluation and prioritization of issues reflects the population served. Provisions will be made for cultural and linguistic appropriateness based on the annual Group Needs Assessment (GNA). The scope of the QI process encompasses the following:

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

- Preventive services
- Chronic disease management
- Disease Management/Care Management/Population Health
- Prenatal care
- Family planning services
- Behavioral health care services
- Medication management
- Coordination and Continuity of Care

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

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

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

- Facility site reviews
- Credentialing of practitioners/providers
- Peer review
- Sentinel event monitoring
- PQI/PPC monitoring

- Health Education

4. A QI focus which represents

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

IV. AUTHORITY AND RESPONSIBILITY

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

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

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

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

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

1. Provider Advisory Committee
2. Member/Consumer Advisory Committee

A chart depicting the complete VCMMCC organizational structure is provided on the following pages. In addition, an organizational chart is attached depicting the key reporting relationships and discharge of QI Program activities by GCHP staff position and title. Specific roles and responsibilities are delineated in the following sections.

VCMMCC Membership

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

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

V. QI PROGRAM GOALS AND OBJECTIVES

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

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

The QI Program goals include:

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

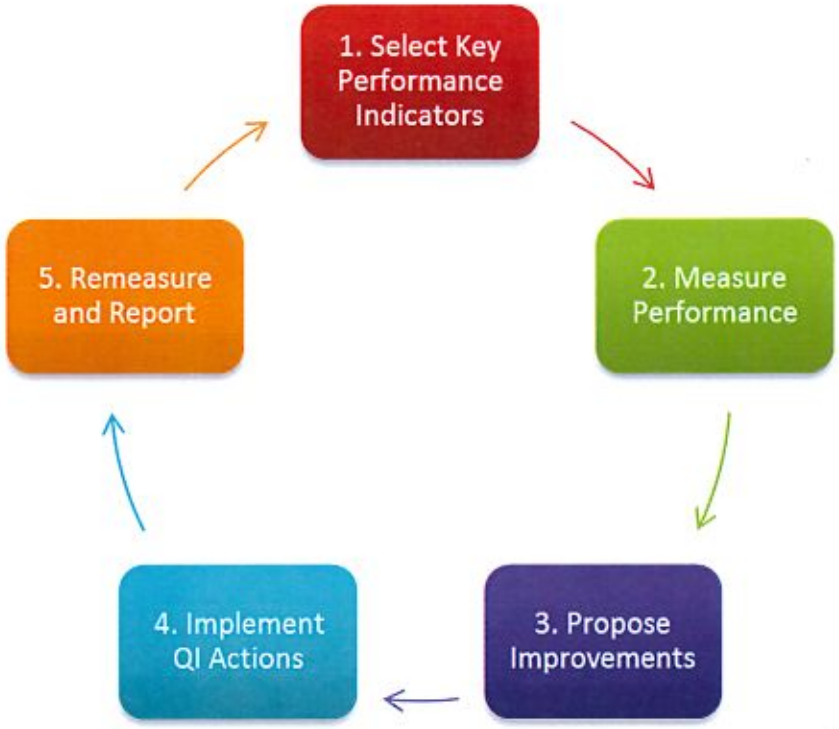
The Program Objectives include the following:

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

VI. QI PROGRAM METHODOLOGY

GCHP utilizes the Institute for Health Care Improvement (IHI) Model for Improvement. Staff is encouraged to achieve improvement continuously by using the "Rapid Cycle Small Test of Change Methodology."

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



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

The indicators may reflect the following parameters of quality:

- Structure, process, or outcome of care
- Administrative and care systems within healthcare services to include:
  - Acute and chronic condition management including disease, case management, population health activities
  - Utilization management
  - Credentialing
  - Member experience/satisfaction
  - Care and provider experience
  - Medical record review
  - Member grievances and appeals
  - Practitioner accessibility and availability

- Plan accessibility
- Member safety
- Preventive care
- Disparities in care

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

Quality initiatives are developed and implemented as indicated by data analysis for process improvements. Initiatives are reassessed on an annual basis to evaluate intervention effectiveness and compare year-to-year performance.

VII. KEY PROGRAM INITIATIVES

Case Management/Disease Management/Population Health

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

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

Members may be identified for CM/DM/Population Health through:

- member or caregiver referral
- practitioner referral
- internal GCHP departments such as Member Services/Health Education/ Utilization Management/Transition of Care Team
- referral from hospital and GCHP discharge planners
- referrals from Community agencies
- information collected from Health Risk Assessment Tools
- review of hospital and outpatient utilization patterns
- review and profiling of encounter data/pharmacy utilization data/claims and billing data

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

Utilization Management

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

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

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

Inclusion and Diversity

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

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

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

VIII. PROGRAM ORGANIZATION, OVERSIGHT AND EVALUATION

CHIEF MEDICAL OFFICER

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

The Chief Medical Officer has the overall responsibility for the clinical direction of GCHP's QI Program. The Chief Medical Officer ensures that the QI Program is adequate to monitor the full

scope of clinical services rendered, and that identified problems are resolved and corrective actions are initiated when necessary and appropriate.

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

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

MEDICAL DIRECTOR

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

DIRECTOR OF QUALITY IMPROVEMENT

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

The Director reports to the CMO and ensures that he/she is updated on any deficiencies and proposed improvement activities.

Specific roles and responsibilities include but are not limited to:

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

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

QI PROGRAM EVALUATION

A written evaluation of the QI Program is completed annually. This includes a review and revision of the QI Program Description, evaluation of the prior year's QI Work Plan, and the development of the current year's QI Work Plan to ensure ongoing performance improvement.

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

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

IX. ANNUAL WORK PLAN

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

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

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

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

- Access and Availability Studies;
- Initial Health Assessment monitoring; and
- GeoAccess Studies

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

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- Member Grievance Review
- Provider Satisfaction Survey; and

- Focus Groups

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

- HEDIS®;
- Coordination of Care Studies
- Facility Site Reviews; and
- Potential Quality Issue Investigation

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

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

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

- Credentialing and Recredentialing activities; and
- Peer Review Activities

Communication and Feedback
Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings and announcements. Providers are educated regarding quality improvement initiatives via on-site quality visits, provider newsletter, Provider Operations Bulletin and the GCHP website. Specific HEDIS® performance feedback is communicated to providers via a HEDIS® report card and listings of members who need specific services.

X. PROGRAM RESOURCES DEDICATED TO QUALITY IMPROVEMENT

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

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

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

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

Credentialing and peer review functions are supported by QI staff.

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

Responsibilities include but are not limited to the following:

- Assist in creating the annual QI Program Description
- Assist in coordination of HEDIS® data collection and analysis of results
- Work with other departments to gather information for the annual QI Evaluation
- Assist in developing activities for the annual QI Workplan
- Assist the QI Director as required
- Credential and recredential providers and facilities

OTHER QI RESOURCES

Staff from other departments will contribute to the QI process. They will continue to identify areas for improvement. Department staff will be deployed to assist in creating and implementing quality improvement initiatives.

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

- Online Member Administration Support – provider directories, health plan benefit summaries, drug formularies and claim forms
- Online Provider Resources – eligibility and benefit look-up, claims submittal, formulary information, forms
- Online Member Education and Engagement Resources – members are offered access to comprehensive clinical information in the Health Library on our website

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

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

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

- Enrollment and demographic data, including race, ethnicity and language preference data, is collected to monitor health care quality and for identifying and reducing health disparities among our patient population
- Claims data (utilization by diagnosis/procedure, provider, treatment/medications, site of care, etc.)

- Case management/ disease management/population health reports to assess support of members with complex or chronic medical and behavioral health conditions, and to evaluate coordination of care across the continuum
- Complaint and appeal data, including type of complaints, trends, and root cause analysis
- Ongoing tracking and trending of quality of care or serious reportable event data to identify patient safety issues and assess provider qualifications
- Member and provider survey data to assess satisfaction with services and operations
- Credentialing process data to measure timeliness of application processing and quality of network providers
- Network adequacy/accessibility measurement data to assess provider availability and accessibility
- HEDIS® data to assess the effectiveness of clinical care and services

XI. QUALITY COMMITTEES AND SUBCOMMITTEES

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

1. Quality Improvement Committee (QIC)

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

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

An annual QI Report is submitted to the VCMMCC addressing:

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

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

C. Opportunities for improvement.

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

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

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

QIC Objectives:

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

QIC Responsibilities:

- Facilitate data-driven indicator development for monitoring Access, Care and Service and Quality Improvement Projects interventions.
- Review quarterly committee meeting minutes, action item logs and reports regarding monitoring of health plan functions and activities. Suggest interventions or corrective actions that adhere to the rapid cycle improvement methodologies.
- Oversee the annual review, analysis and evaluation for achievement of goals and effectiveness of the QI Program, quality improvement policies and procedure and QI Work Plan for presentation.
- Recommend policy changes or implementation of new policies to GCHP's Administration and Commission.

QIC Membership:

- Chief Medical Officer (Chair)
- Medical Director
- Director of Quality Improvement
- Director of Health Education & Cultural Linguistics
- Director of Operations
- Senior Director of Network Operations
- Director of Pharmacy
- Director of Compliance
- Senior Director of Health Services
- CEO, Ex Officio
- Manager, Member Services
- Manager, Clinical Strategy Execution
- Manager, Grievance and Appeals
- External Practitioner Representatives

QIC Reporting Structure:

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

Meeting Frequency:

The QIC meets at a minimum quarterly.

2. Medical Advisory Committee (MAC)

Purpose:

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

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

Scope:

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

- Clinical and Preventive Health Care Guidelines (CPGs/PHGs)
- Provider Grievance Process
- Provider Satisfaction Issues
- Provider Access/Availability Standards
- Provider Contracting
- Provider Materials/Communications
- Clinical Programs and Service Delivery
- Utilization Management
- Pharmacy
- Quality Improvement (including clinical studies, HEDIS®/ CAHPS® Survey Outcomes)

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

Membership:

Membership is comprised of physicians representing the contracted provider community for GCHP's programs. The Chief Medical Officer will serve as Chairman and will ensure that the membership has adequate specialty representation.

Meeting Frequency:

The committee meets at a minimum on a quarterly basis.

3. Member Services Committee (MSC)

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

MSC Objectives:

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

MSC Membership:

- Manager of Member Services (Chair)
- Director of Operations
- Senior Director of Network Operations or designee
- Manager of Grievance and Appeals or designee
- Quality Improvement Representative
- Senior Director of Health Services or designee
- Director of Health Education & Cultural Linguistics or designee
- Director of Communications (Ad Hoc)
- Compliance Specialist

Meeting Frequency:

The MSC meets quarterly at a minimum.

4. Grievance and Appeals Committee (G&A)

G&A Charter:

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

G&A Objectives:

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

G&A Committee Membership:

- Manager of Grievance and Appeals (Chair)
- Sr. Grievance and Appeals Specialist
- Medical Director or designee
- Director of Network Operations or designee
- Manager of Member Services or designee
- Director of Quality Improvement or designee
- Senior Director of Health Services or designee
- Compliance Specialist
- Director of Operations
- Director of Health Education & Cultural Linguistics or designee
- Director of Pharmacy

Meeting Frequency:

The committee meets quarterly.

5. Utilization Management Committee (UMC)

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

UMC Responsibilities:

Responsibilities include but are not limited to the following:

- Annual review and approval of the UM and CM/DM/Population Health Program documents
- Review and approval of program documents addressing the needs of special populations. This includes but may not be limited to Children with Special Health Care Needs (CSHCN) and Seniors and Persons with Disabilities (SPD)
- Suggest and collaborate with other departments to address areas of patient safety. This may include but is not limited to medication safety and child safety.
- Annual adoption of preventive health criteria and medical care guidelines with guidance on how to disseminate criteria and ensure proper education of appropriate staff

- Review of the timeliness, accuracy and consistency of the application of medical policy as it is applied to medical necessity reviews
- Review utilization and case management monitors to identify opportunities for improvement
- Review data from Member Satisfaction Surveys to identify areas for improvement
- Ensure policies are in place to review, approve and disseminate UM criteria and medical policies used in review when requested
- Review, at least annually, the Inter Rater Reliability (IRR) test results of UM staff involved in decision making (RN's and MD's) and take appropriate actions for staff that fall below acceptable performance
- Interface with other GCHP committees for trends, patterns, corrective actions and outcomes of reviews

Membership:

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

Meeting Frequency:

The UMC meets quarterly at a minimum.

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

Purpose:

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

Functions:

- Ensure the Group Needs Assessment (GNA) is completed to determine a baseline for serving education and cultural /language needs.
- Work with other areas and the CMO to prioritize health education needs.
- Ensure opportunities are available to educate members on the disease process, preventive care, plan processes and all other areas essential to good member health.
- Assist providers in educating Plan members.
- Ensure written materials are at a reading level consistent with Plan membership needs and are no greater than the sixth grade reading level.
- Educate Plan staff on specific cultural barriers that might hinder the delivery of optimal health care.

Membership:

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

Meeting Frequency:

The committee meets at a minimum quarterly.

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

Purpose:

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

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

Credentialing Responsibilities:

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

Peer Review Responsibilities:

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

Membership:

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

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

Meeting Frequency:

The committee meets quarterly.

8. Pharmacy & Therapeutics (P&T) Committee

Purpose:

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

Functions:

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

Membership:

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

Meeting Frequency:

The committee meets quarterly.

XII. DELEGATION OF QUALITY IMPROVEMENT

Delegation is the formal process by which the health plan gives an external entity the authority to perform certain functions on its behalf. These functions may include quality improvement, utilization management, credentialing/recredentialing, and grievance and appeals. GCHP retains accountability for ensuring the function is being performed according to expectation and standards. GCHP will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation. GCHP will only delegate activities to entities who have demonstrated the ability to perform those duties, and who have the mechanisms in place to document the activities and produce associated reports, prior to delegation of that activity. GCHP retains the right to delegate these functions. Any delegated functions are fully described in a mutually agreed upon signed and written formal delegation agreement between the Plan and each delegated entity, and includes an effective date. All agreements clearly define GCHP's and the delegate's specific duties, responsibilities, activities, reporting requirements and identifies how GCHP will monitor and evaluate the delegate's performance. The agreement also includes the Plan's right to resume the responsibility for conducting the delegated function should the delegated entity fail to meet GCHP standards.

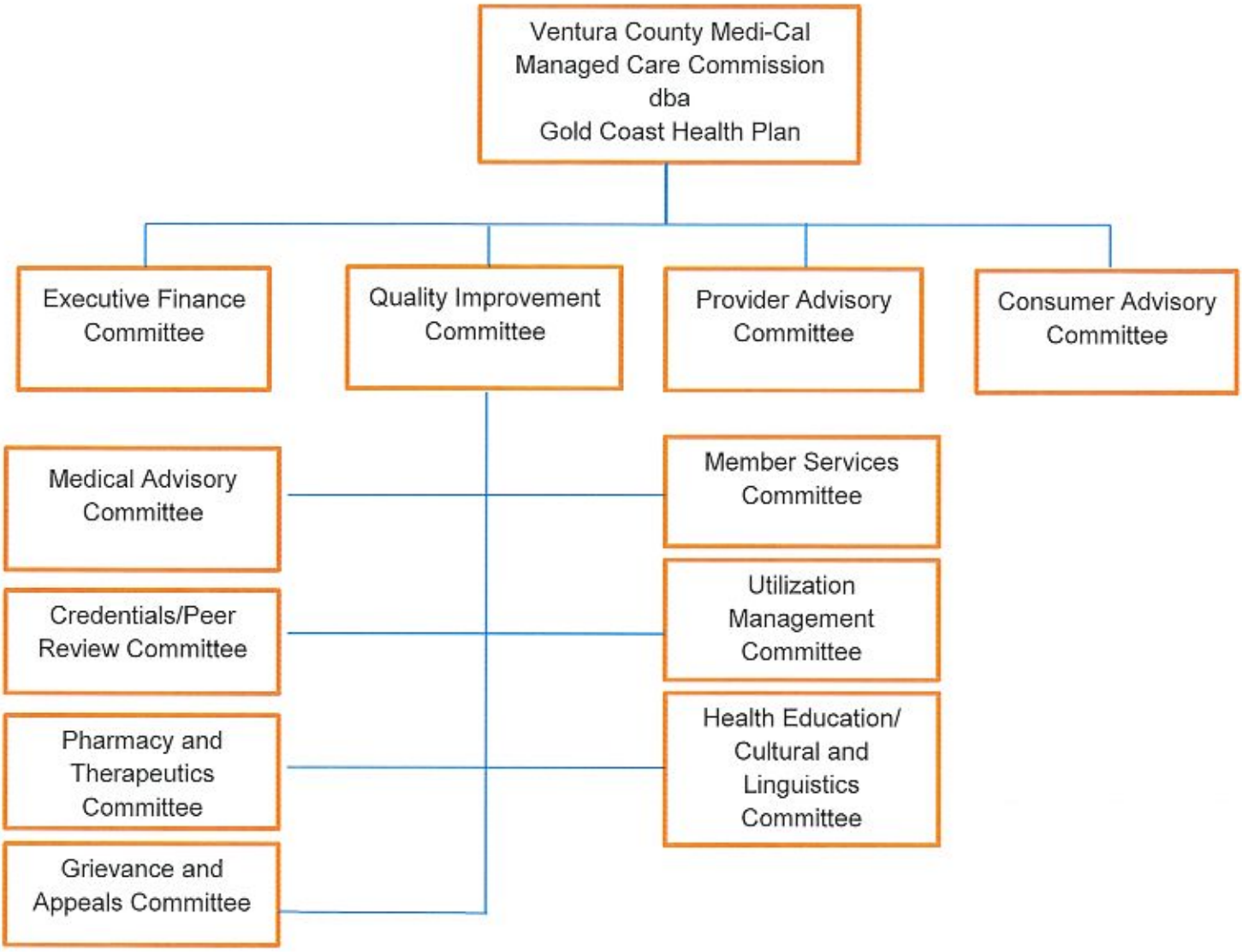
GCHP conducts ongoing oversight, evaluation and monitoring of the delegate. At a minimum, an annual audit is conducted. Corrective action plans are implemented based upon areas of non-

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

Return to Agenda
49 of 152 pages

XIII. GOLD COAST HEALTH PLAN COMMITTEE ORGANIZATIONAL CHART

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



Return to Agenda
50 of 152 pages

XIV. QUALITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2018

Dates:	
Tuesday	March 27, 2018
Tuesday	June 19, 2018
Tuesday	September 25, 2018
Tuesday	December 11, 2018
Location: Bell Canyon Conference Room	

Availability of QI Program to practitioners and members

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

REFERENCES

- Gold Coast Health Plan Quality Improvement System Policy QI-002
- Gold Coast Health Plan Utilization Management Program Description
- Gold Coast Health Plan Care Management/Disease Management/Population Health Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 13-005
- HEDIS® National Committee for Quality Assurance
- CAHPS® National Committee for Quality Assurance
- NCQA Standards and Guidelines for the Accreditation of Health Plans
- DHCS Quality Strategy
- National Quality Strategy
- Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010
- Kohn KT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press; 1999
- Title 42, Code of Federal Regulations, Section 438.240(b) (1)

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

The 2018 Quality Improvement Program Description and Work Plan were approved by the Quality Improvement Committee on June 19, 2018

The 2018 Quality Improvement Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMMCC) on XX, 2018.

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Objective: Improve Quality and Safety of Clinical Care Services					
Diabetes Clinical Practice Guideline (CPG)					
NCQA MED 2	Diabetes Clinical Practice Guideline (CPG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant CPGs Distribute if necessary	Q4 2017	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of each of the CPGs Distribute guidelines to appropriate practitioners	MAC
EVALUATION OF 2017 WORK PLAN					
RESULTS: Completed - approved at MAC 5/16/17– no substantive changes made. Showed great improvement in all of the HEDIS Measures related to diabetes, with the exception of Nephropathy. Recommend creating an action plan for conducting a causal analysis of Nephropathy rate in 2018.					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Asthma Clinical Practice Guideline (CPG)					
NCQA MED 2	Asthma Clinical Practice Guidelines (CPG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant CPGs Distribute if necessary	Q4 2017	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of each of the CPGs Distribute guidelines to appropriate practitioners	MAC
EVALUATION OF 2017 WORK PLAN					
RESULTS: Completed - approved at MAC 7/27/17– no substantive changes made. We have made improvements but are still below the MPL for Asthma Medication Ratio. The Public Health In Home Asthma Program through Ventura County Public Health targeted high emergency department utilizers with asthma-related conditions. Home visits identified triggers, increased use of asthma action plans, and provided education on correct use of controller and rescue medications. Recommendation to look at analysis of asthma medication rates and create an action plan if warranted.					
BARRIER ANALYSIS Goal Met, no barriers presently identified.					

Return to Agenda
52 of 152 pages

Gold Coast Health Plan
A Public Entity

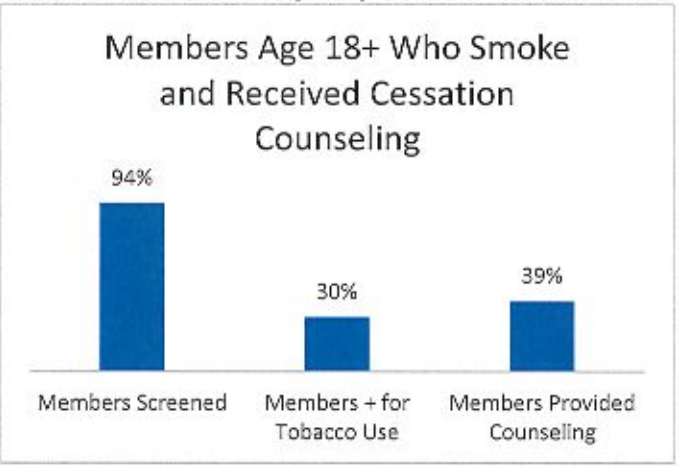
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Preventive Health Guideline (PHG)					
NCQA MED 2	Preventive Health Guideline (PHG) review and adoption at least every two years Distribution of guidelines to practitioners	Review of relevant PHGs Distribute if necessary	Q4 2017	Review and approval by Medical Advisory Committee(MAC) Annually measure performance against at least two important aspects of two PHGs Distribute guidelines to appropriate practitioners	MAC
EVALUATION OF 2017 WORK PLAN					
RESULTS: Completed - approved at MAC 7/27/17– no substantive changes made. Met the MPL on all of CIS sub-measures, with year over year improvement. Achieved the 50th percentile on all but three of Combo 3 measures. Recommendation: continue monitoring for improvement. CIS rates can be found in the HEDIS Measures section of the evaluation.					
BARRIER ANALYSIS Goal Met, no barriers presently identified					

Advance Prevention

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Smokers - Counseled to Quit					
DHCS	Increase percentage of members who smoke who report being counseled to quit in prior 6 months	90%	Q4 2017	Measure during IHA monitoring Educate providers based on results of IHA monitoring Audit and provide feedback	QI/HE
EVALUATION OF 2017 WORK PLAN					
RESULTS (Quantitative Analysis): Goal Not Met					

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation



RESULTS (Qualitative Analysis):

The 2015 CAHPS reported the percentage of members who smoke who reported being counseled to quit in the prior 6 months as NA (due to low denominator). During 2016, IHA audits of SHA forms yielded 103 members who were positive for use of tobacco products. A total of 68% were provided cessation counseling, and 32% were offered a cessation medication. The two rates were established as a baseline.

Data for smoking cessation was obtained during monthly IHA SHA medical record reviews. A total of 2940 medical records were reviewed, with 236 (8%) members age 18 or above. A total of 222 (94%) members were screened, with 66 (30%) of members positive for tobacco use. Of those members who indicated that they smoked, 39% (26 members) had evidence in the record that they were provided cessation counseling. This rate fell below the established baseline of 68%.

BARRIER ANALYSIS:

- Under-reporting of tobacco use by members.
- Missing Staying Healthy Assessments (SHA) in member medical records.
- Members who refuse counseling.
- Information Technology – EMR systems that fail to transfer data from templates to the encounter documentation.

INTERVENTIONS:

- The Basic Tobacco Intervention Skills training for medical and allied health professionals taught by Ventura County Public Health Tobacco Education & Prevention Program instructors utilizing an evidence-based approach.
- Publication of Provider Operations Bulletin regarding smoking cessation education
- Member education postcards, coasters, and resources, including 1-800-NO-BUTTS (California Smokers' Helpline)
- 1-on-1 discussions with clinic managers when submitting copies of IHA audit results regarding the focus of monitoring smoking cessation criteria.
- Provide resources to provider offices, including the Health Education Department phone number and Gold Coast Health Plan website address for sites to order smoking cessation educational materials to provide to health plan members.

NEXT STEPS:

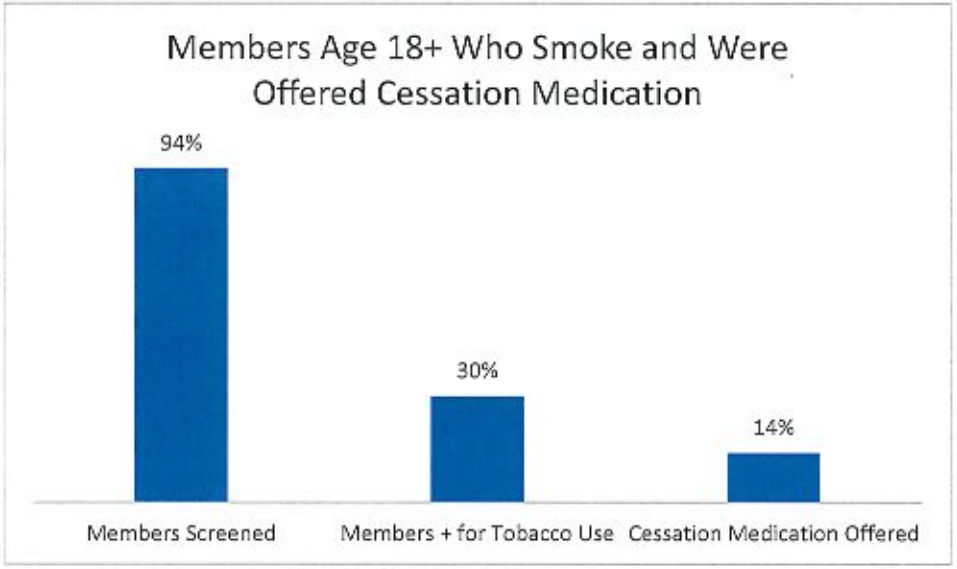
- Recommend new strategy to engage members in smoking cessation by identification of smoking members.

- Encourage providers to continue assessing for tobacco use to identify the member when they are ready for change and desire to quit smoking.
- Continue to assist provider sites with concerns, problems, and provider efforts to improve IHA SHA documentation specific to smoking cessation screening.
- During medical record reviews in EMR systems, check template sections for documentation.
- Continue to publish smoking cessation resources in the GCHP Provider Manual, including smoking cessation classes, support groups, and nicotine replacement products.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Smokers – Discussed Tobacco Cessation Medication					
DHCS	Increase percentage of members who smoke who report a provider discussed tobacco cessation medication in the prior 6 months	90%	Q4 2017	Measure during IHA monitoring Educate providers based on results of IHA monitoring Audit and provide feedback	QI

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis): Goal Not Met



2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

RESULTS (Qualitative Analysis):

The 2015 CAHPS reported the percentage of members who smoke who reported being counseled to quit in the prior 6 months as NA (due to low denominator). During 2016, IHA audits of SHA forms yielded 103 members who were positive for use of tobacco products. A total of 68% were provided cessation counseling, and 32% were offered a cessation medication. The two rates were established as a baseline.

Data for smoking cessation was obtained during monthly IHA SHA medical record reviews. A total of 2940 medical records were reviewed, with 236 (8%) members age 18 or above included in the sampling. A total of 222 (94%) members were screened, with 66 (30%) of members positive for tobacco use and 9 (14%) offered a smoking cessation medication. This rate fell below the established baseline of 32%.

BARRIER ANALYSIS:

- Providers appear to provide cessation counseling only, possibly due a knowledge deficit regarding cessation medications or cessation support resources.
- Providers may not be aware cessation medications are covered by Gold Coast Health Plan without prior authorization.
- Members may not express a readiness to quit smoking or try a cessation medication.

INTERVENTIONS:

- 1-on-1 discussions with clinic managers when submitting copies of IHA audit results regarding the focus of monitoring smoking cessation criteria.
- The Basic Tobacco Intervention Skills training for medical and allied health professionals taught by Ventura County Public Health Tobacco Education & Prevention Program instructors utilizing an evidence-based approach.
- Publication of Provider Operations Bulletin regarding smoking cessation education.

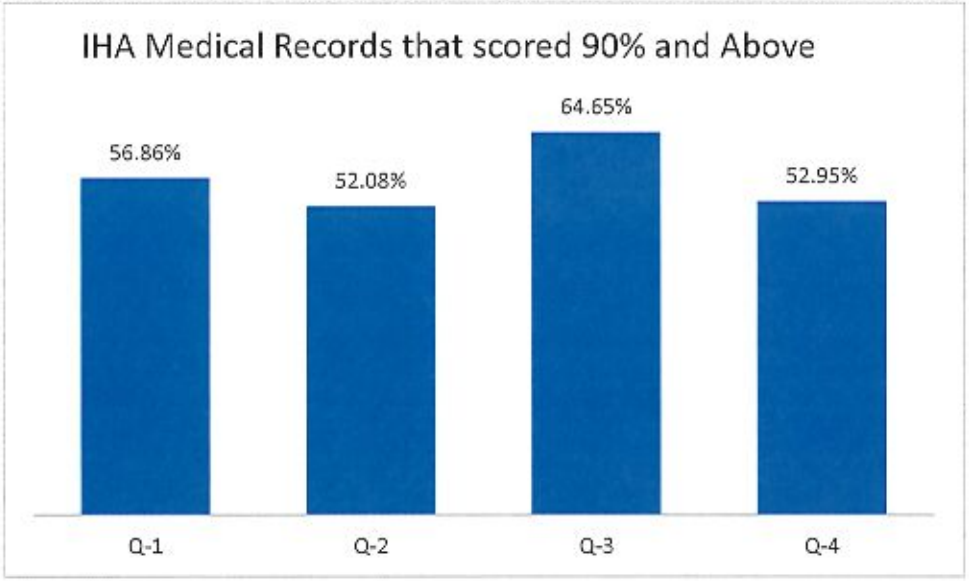
NEXT STEPS:

- Consider condensing two smoking cessation initiatives into one for next year, with new strategy to identify smoking members.
- Provide smoking cessation information, applicable ICD 10 codes, and resources to providers during 2018.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Initial Health Assessment					
DHCS	Increase rates of Initial Health Assessment (IHA)	90%	Q4 2017	Measure during medical record reviews for IHA and provide performance feedback at time of completion of record review. Educate providers of requirements and components of IHA Audit and provide feedback. Article in POB regarding requirements of IHA, including outreach requirements.	QI

RESULTS (Quantitative Analysis): Goal Not Met

Return to Agenda
66 of 152 pages



2017 Year-End Average Member Outreach Compliance per Clinic Group:

VCMC	CMH - CFH	Clinicas	Identity Med. Grp.	Dignity Health	Independent Providers	2017 Average
91%	79%	100%	84%	76%	88%	86%

RESULTS (Qualitative Analysis): Compliance for this metric is defined as having met 90% of all required IHA criteria. Graph 1 reflects the percent of records that met 90% and above of IHA required criteria. Compliance for this measure is noted in Graph 1. All quarters in 2017 fell below the 90% target.

Primary reasons for not achieving 90% on medical record audits included:

- Incomplete, unsigned, or no Staying Healthy Assessment in the medical record
- Age-appropriate preventive health screenings were missing documentation in the medical record
- Missing TB Risk Assessment
- Missing immunization status in the medical record

BARRIER ANALYSIS:

- The IHA and SHA process is lengthy - SHA form takes significant time during clinic visits in busy practices.

- Resistance to change by providers to implement steps to achieve compliance due to burdensome SHA process.
- High volume of staff turnover in clinics resulting in staff not being knowledgeable of the IHA / SHA process. Missed opportunities to offer the SHA occur.
- Reluctance to access IHA support offered by Gold Coast Health Plan Quality Improvement Department.
- Lack of resources within busy practices to devote required attention to the IHA/SHA process.
- Resistance by members to schedule an IHA visit and/or complete the SHA form.
- IHA SHA not integrated into Clinics' HER systems.

INTERVENTIONS:

- IHA and Outreach training provided to clinics by the assigned QI RN.
- Copies of each medical record review performed provided to clinics that include explanations regarding what was missing in the medical record.
- Each summary score sheet includes instruction on the requirements for a completed SHA form.
- Declines in medical record review compliance scores are reviewed with medical providers and clinic managers at the end of each monthly review.
- Continued provision of contact information of the IHA RNs in the Quality Improvement Department provided to promote outreach for answers to IHA questions or submit requests for further training.
- Ongoing telephone and e-mail support is available to providers and office staff by the QI Department IHA RN staff.
- Provider Network Operations department external representative continues to meet monthly with Quality Improvement RNs. The representative provides feedback regarding information obtained during the provider site visits as follows:
    - Any provider sites opening or closing their member panels.
    - Any provider sites terminating their contracts with Gold Coast Health Plan and/or closing their office.
    - Any provider site that is moving its location or opening an additional site that would require a new facility site review.
    - Changes in staffing and providers at provider sites.
    - Provider/clinic sites who report they are not receiving their new member name lists.
    - Any provider site with problems or questions regarding the IHA outreach logs or the Staying Healthy Assessment (SHA).
    - Provider requests for additional training on the IHA outreach logs or the SHA.

NEXT STEPS:

- Identify and share best practices with providers of strategies used by other offices that are successful in performing the IHA /SHA.
- Continue to monitor for staff turnover and offer training for new hires.
- Continue monitoring clinic site performance and provide outreach to clinics with failing or declining scores.
- Continue to educate providers and staff of the Gold Coast Health Plan IHA support resources available. Encourage requests for re-training or focused training to meet needs.
- Continue monitoring via MRR.
- Build an IHA Database to collect the results of IHA medical record reviews and perform automated tabulation of outcomes.
- Discuss IHA strategies with other COHS to gain insight on alternate processes or best practices.
- Consider adding performance monitoring of member outreach compliance by clinics to 2018 Workplan to recognize this key component of IHA efforts.

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Objective: Improve Quality and Safety of Clinical Care Services

HEDIS® Measures

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Postpartum Care					
DHCS	Postpartum Care – Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Increase rates by 5% over previous measurement year	Q4 2017	Continue Member education mailings to compliment member incentive forms HE to continue to promote incentive during outreach events Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Continue member incentive program to engage members; partner with CPSP staff at clinics and Ventura County Public Health to help promote	QI

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis): Goal Not Met.

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	Domain of Care	2015	2016	2017	2016-17 Rate Difference	Current NCQA Percentile Ranking	10th	25th	50th	75th	90th
Prenatal and Postpartum Care	Q, A, T										
Postpartum Care		59.12	65.45	**68.35**	**↑ 2.90**	**50th**	51.74	59.59	64.38	69.44	73.67

RESULTS (Qualitative Analysis): Increase was only 2.9%

HEDIS 2018 Prenatal and Postpartum Care – Postpartum Care

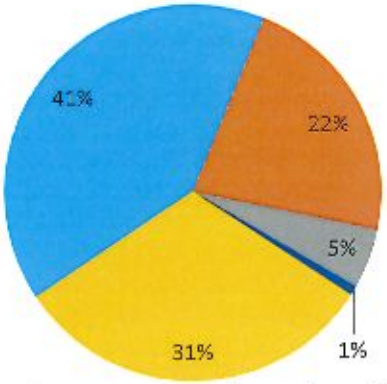
Age Band Comparison

<18 18-24 25-31 32-38 39-44

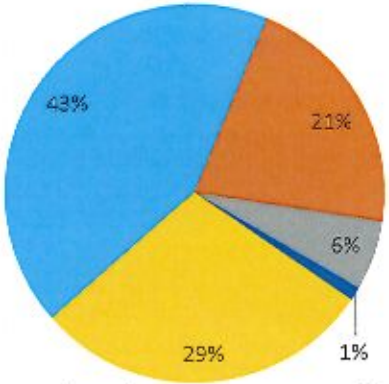
Return to Agenda
59 of 152 pages

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

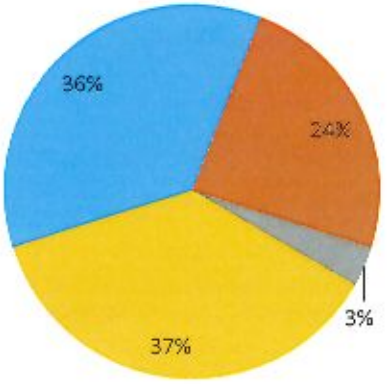
Denominator



Compliant



Non-Compliant

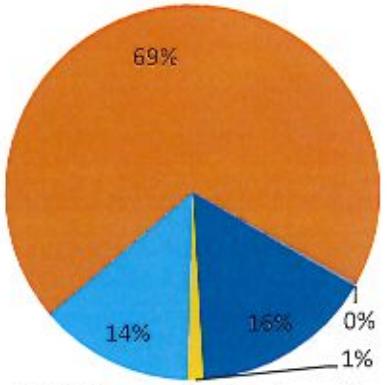


A greater percentage of members did not have did not have post partum exams across all age bands.

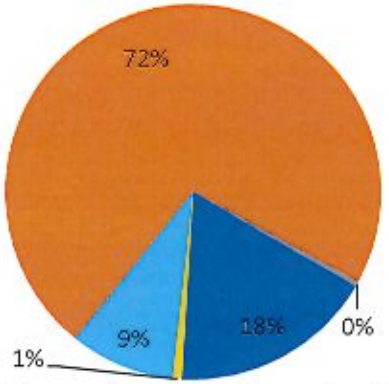
Aid Category Comparison

Adult Expansion Disabled Family Family/Adult TLIC

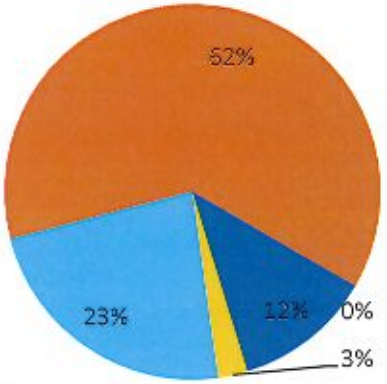
Denominator



Complaint



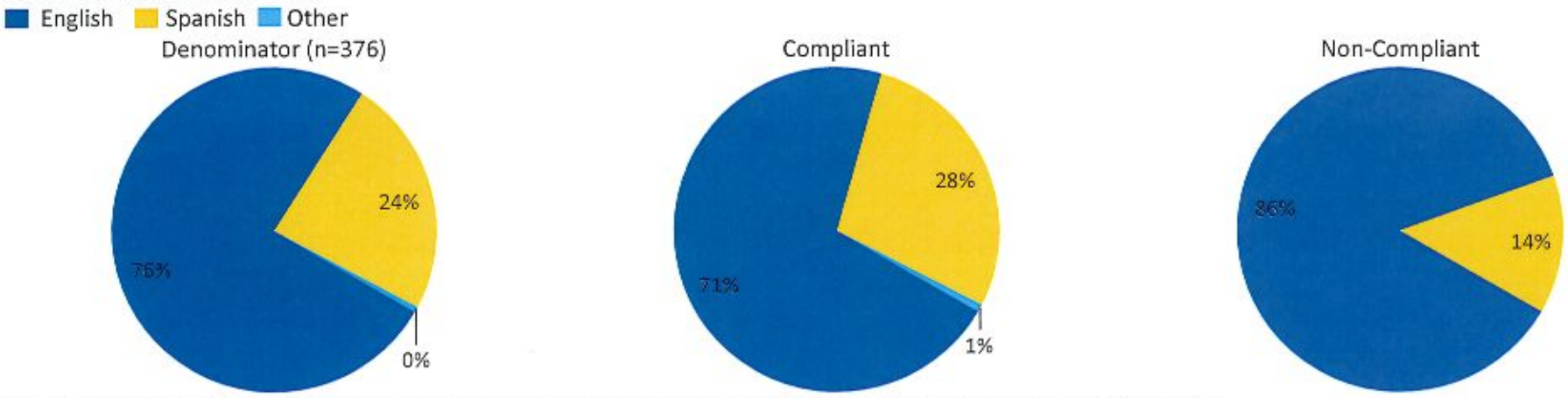
Non-Compliant



The Aid Category Family shows the greatest difference in the number of members who did not get their postpartum exam.

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Spoken Language Comparison



Our Spanish speaking members are getting their postpartum exams at a higher rate than our English speaking moms.

BARRIER ANALYSIS:
Looking at the three demographic category of Age Band, Aid Category and Spoken Language shows that we have several opportunities for improvement.

INTERVENTIONS: Since we did not meet our goal and only increased the percentage by a little less than 3%, we will continue our member incentive. We will also look at the feasibility of increasing the mailings to our members in the low-performing demographics and clinic visits to discuss the gap analysis reports. We may need to look at the data regarding pregnant members in a different way. Decision Support Services may be asked to assist in updating our reporting and analysis.

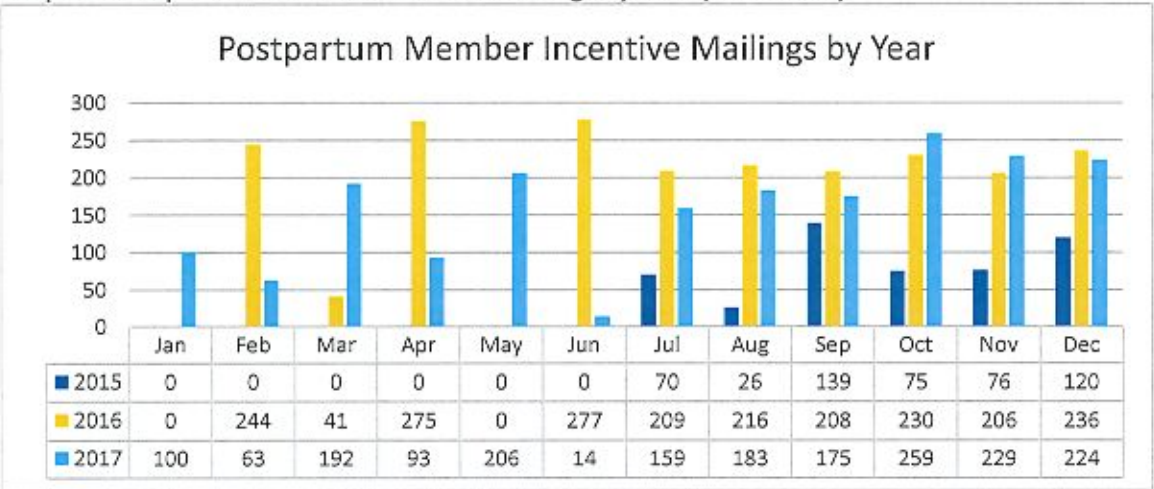
NEXT STEPS
Streamline the process used to generate the gap reports. Reach out to our partners in DSS and IT for their expertise in this matter. Consider changing goal for 2018 Work Plan to 3% improvement.

Analyze distribution of demographic indicators to identify any disparity among aid codes and language, and create an action plan as applicable.

Analysis of Member Outreach Activities: 2017 Postpartum Member Incentive Evaluation

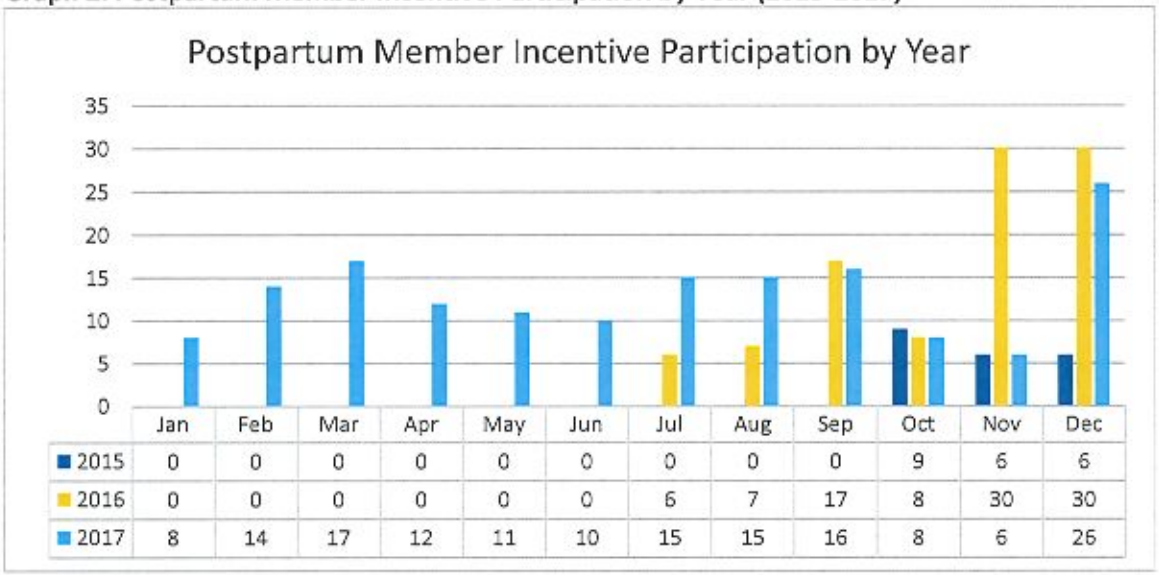
Quantitative Analysis

Graph 1: Postpartum Member Incentive Mailings by Year (2015-2017)



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2015	0	0	0	0	0	0	70	26	139	75	76	120
2016	0	244	41	275	0	277	209	216	208	230	206	236
2017	100	63	192	93	206	14	159	183	175	259	229	224

Graph 2: Postpartum Member Incentive Participation by Year (2015-2017)



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2015	0	0	0	0	0	0	0	0	0	9	6	6
2016	0	0	0	0	0	0	6	7	17	8	30	30
2017	8	14	17	12	11	10	15	15	16	8	6	26

Return to Agenda
62 of 152 pages

2017 Postpartum Member Incentive Evaluation
Qualitative Analysis
Successes
Member Comprehension of Program Criteria

- In 2017, 100% (158/158) of the postpartum member incentives returned were completed correctly per the program criteria indicating the member incentive was easy to understand.

Increase Member Participation in 2017

- Graph 2 shows that, compared to 2015 and 2016, participation increased in 2017 and from 2016 to 2017, there was a 61% increase in participation in 2017.

Barriers
Low Member Participation

- Despite the participation increase in 2017, Graph 2 shows the overall participation was still low with only 158 forms returned.

Next Steps
Although we did not meet our goal of increasing postpartum exam by 5% over the previous measurement year, we will continue the member incentive since member engagement increased in 2017. Additional mechanisms to publicize the member incentive program will be explored, including but not limited to provider office visits and Joint Operations Meetings.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Childhood Immunizations					
DHCS	Childhood Immunization Status Combo 3 – Percentage of two year old children who receive a specific group of vaccines (DTap, IV, MMR, HiB, HepB, VZV and PCV) on or before their 2nd birthday	Increase rates by 5% over previous measurement year	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Educate Providers on trending of rates via Provider Update	QI

Return to Agenda
63 of 152 pages

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis) Goal Met. Rate increased 5.57% over previous year.

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	Domain of Care	2015	2016	2017	2016-17 Rate Difference	Current NCQA Percentile Ranking	10th	25th	50th	75th	90th
Effectiveness of Care: Prevention and Screening											
Childhood Immunization Status	Q, A, T										
Combination #3		75.43	64.96	70.53	↑ 5.57	25th	58.05	65.25	71.58	75.91	79.32

Rate increased 5.57% over previous year.
BARRIER ANALYSIS: Goal met, no barrier analysis needed.

INTERVENTIONS: Please see notes regarding the Childhood Immunization PIP.
NEXT STEPS: Please see notes regarding the Childhood Immunization PIP.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Adolescent Immunizations					
DHCS	Immunizations for Adolescents (Combo 2) – percentage of adolescents 13 years of age who received a meningococcal vaccine on or between the member's 11th and 13th birthday and Tdap or Td on or between the member's 10th and 13th birthdays and at least two HPV vaccines on or between the member's 9th and 13th birthdays.	Increase rates by 5% over previous measurement year	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports	QI

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis): Goal Met. We increased the rate by 11.5% over the 2016 rate.

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	Domain of Care	2015	2016	2017	2016-17 Rate Difference	Current NCQA Percentile Ranking	10th	25th	50th	75th	90th
Effectiveness of Care: Prevention and Screening											
Immunizations for Adolescents	Q, A, T										
Combination #2		NR	22.08	33.58	↑ **11.50**	90th	12.27	15.87	19.79	24.62	30.39

RESULTS (Qualitative Analysis): We increased the rate by 11.5% over the 2016 rate.

BARRIER ANALYSIS: Goal met, no barrier analysis needed.
INTERVENTIONS: NA
NEXT STEPS: Consider discontinuing this Work Plan item in 2018. Focus efforts on other high-priority measures.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Children and Adolescent Access to Primary Care (CAP)					
DHCS	Children and Adolescents' Access to Primary Care Practitioners – percentage of members 12 months – 19 years of age who had a visit with a PCP	Meet or exceed DHCS MPL	Q4 2017	CAP P4P Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports	QI Network Operations QI

EVALUATION OF 2017 WORK PLAN

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

RESULTS (Quantitative Analysis): Goal not met

HEDIS Measure/Data Element	Domain of Care	2015	2016	2017	2016-17 Rate Difference	Current NCQA Percentile Ranking	2017 NCQA Percentile Ranking 10th	25th	50th	75th	90th
Access/Availability of Care											
Children and Adolescents' Access to Primary Care Practitioners	A										
12-24 Months		94.65	93.86	95.05	↑ 1.19	25th	90.66	93.27	95.70	97.09	97.9
25 Months - 6 Years		84.87	85.52	84.72	↓ 0.80	10th	80.67	84.94	87.87	90.76	93.2
7-11 Years		85.62	84.54	86.12	↑ 1.58	10th	83.39	87.58	90.77	93.51	96.1
12-19 Years		84.14	82.32	83.69	↑ 1.37	10th	81.72	85.65	89.52	92.45	94.7

RESULTS (Qualitative Analysis): DHCS MPL was met for one out of four sub-measures (12-24 months). While the MPL was not met for the other 3 sub-measures, we did increase our rates slightly as noted in the table above. The MPL was missed by a range of .22% to 2% (look at age band analysis).

BARRIER ANALYSIS:

- Ability to obtain robust and complete administrative data
- Administrative data lags
- Limited P4P initiative does not impact full GCHP provider network

INTERVENTIONS:

- CAP P4P incentive for one clinic
- Provide provider performance feedback by means of 2016 HEDIS report cards
- Bi-monthly prospective HEDIS report cards and performance feedback reports
- Member incentive campaign for well child visits (7-11 years; 3-6 years)

NEXT STEPS:

- Further evaluate 2017 performance to identify improvement opportunities
- Conduct deep dive analysis on administrative data to determine causes for low performance
- Consider expanding CAP P4P to other clinics
- Provide provider performance feedback by means of 2017 HEDIS report cards
- Bi-monthly prospective HEDIS report cards and performance feedback reports
- Evaluate member campaign and make changes based on SWOT
- Streamline the process used to generate the gap reports. Reach out to our partners in DSS and IT for their expertise in this matter.

Return to Agenda
66 of 152 pages

Analysis of 2017 Member Outreach Activities

1. Well-Child Member Incentive for 7 to 11 Year Old Children

Study Period: 11/1/16 to 04/30/17

Prediction: We had predicted that revising the well-child member incentive, with a guaranteed $15.00 gift card for completing a well-child exam would increase member participation in the member incentive program.

Goal: The goal was to increase well-child exam in this age group exams by 5% by April 30, 2017.

Quantitative Analysis:

Since we received completed member incentive flyers from children and adolescents outside of the 7 to 11-year age group, we based our analysis of member participation on all returned forms for all age groups. A total of 7,679 well-child letters were mailed but only 147 forms were returned. After reviewing the returned forms, only 134 forms show the members had a valid well-child exam. These results caused only a 1.75% increase in well-child exams.

7 – 11 Year Old Well-Child Member Incentive Activity

	2017
Member Incentives Mailed	**3060**
Total Forms Returned	64
No Visit	6
Not Child	
Not Member	
Valid	58
Total Valid Forms Returned by Age	
12-24 months	
25 months - 6 years	8
7 - 11 years	49
12-19 years	1
Participation Rate	1.75%

Return to Agenda
67 of 152 pages

Qualitative Analysis:

- **Increased Member Engagement**
  A guaranteed gift card increased member engagement with participating in the well-child member incentive program compared to the previous well-child raffle member incentive program.
- **Member Comprehension of Member Incentive Requirements**
  The member incentive flyer for the first mailing in November did not specify the 7-11-year-old age requirement. Although this initial mailing was sent only to households with 7 to 11-year-old children, 20 of the 56 valid forms returned in 2016 were for children outside the 7 to 11-year age range. The member incentive flyer was corrected for the second mailing, but 9 of the 49 returned forms in 2017 were still outside the specific age range. A total of 29 forms returned were outside the age requirements, but the health plan accepted these and awarded the $15 gift card since the members completed a well-child exam.

Barrier Analysis:

- Low member participation in incentive program

Next Steps:

We adopted the $15.00 gift card member incentive, but revised it to target only 3 to 6 year old children in order to improve both the CAP rate for the 25 month – 6 Year old group and the Well-Child Exam in the 3rd, 4th, 5th, and 6th Years of Life (W34) measure.

2. Well-Child Member Incentive for 3 to 6 Year Old Children

Study Period: 02/21/17 to 12/31/17

Prediction: The revised member incentive, which guarantees a $15.00 gift card if a well-child exam is completed, will increase member engagement in participating in the well-child incentive program.

Goal: By December 31, 2017 increase the administrative rate of well-child exams for 3 to 6 years old children, who have full-scope Medi-Cal benefits in Ventura County, by 5% over the previous measurement year from 66% (2016 MY) to 71% (2017 MY goal).

Quantitative Analysis:

A total of 14,322 member incentive flyers were mailed to households with 3 to 6 year old children who had no well-child exams. Only 280 valid member incentive forms were returned which equates to a 1.75% participation rate.

3 - 6 Year Old Well-Child Member Incentive Activity

	2017
Member Incentives Mailed	14,322
Total Forms Returned	287
Total Valid Forms Returned	280

Return to Agenda
68 of 152 pages

Participation Rate	2.00%

Qualitative Analysis:

- **Member Comprehensive of Program Criteria**
  - 97.6% (280/287) of the well-child member incentives returned were completed correctly per the program criteria indicating the member incentive was easy to understand
  - Only 2.4% (7/287) of the forms returned that did not meet the program and these members were not eligible for an incentive
    - Reason for disqualification: no evidence of a well-child exam in 2017

Barrier Analysis

- **Member Outreach Activities**
  - **Bi-Annual Mailers Addressed to Household and Not Child**
    To reduce mail costs through our distribution vendor, the member incentive letters were not addressed to each child but to each household that had a 3-6-year-old child missing a well-child exam in 2017. The combined mail queries in February and August of 2017 produced a total count of 16,793 children needed well-child exams. However, the mail list was reduced from 16,793 to 14,322 to send the letters to unique household addresses. Consequently, 2,471 households had more than one child needing a well-child exam, but the mailer contained only one member incentive.
    Reducing the mailed list to household resulted in only a 15% reduction in mailers. For the 2018 measurement year, we may consider addressing the letters to each child to test if this may increase parent/child engagement in the member incentive program.

  - **Timing and frequency of Member Mailings**
    Parents may need recurring reminders throughout the year, to remind them to schedule their child's annual wellness exam. Currently, we scheduled only two annual member mailings.

- **Administrative Data Lags**
  - GCHP's timeframe for accepting claims submissions is one year from the date of service, which does not incentivize providers to submit claims as soon as services are completed and this results in claims lags.
  -

Next Steps:

We surpassed our goal of increasing the W34 rate by 5% over the previous measurement year from 66.18% (2016 MY) to 71.18% (2017 MY goal). The final 2017 MY rate is 75.47, which is a 9.29% increase which raised the W34 rate to the 50th NCQA percentile ranking. Recommend re-evaluating incentive campaign.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Counseling for Nutrition and Physical Activity (WCC)					
DHCS	Counseling for Nutrition and Physical Activity for Children and Adolescents – percentage of members 3-17 years of age who	Meet or exceed DHCS MPL	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports	QI

Return to Agenda
69 of 152 pages

had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling			Provider Operations Bulletin article Meet with clinics to discuss rates	

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis): Goal Met

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	Domain of Care	2015	2016	2017	2016-17 Rate Difference	Current NCQA Percentile Ranking	10th	25th	50th	75th	90th
Effectiveness of Care: Prevention and Screening											
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Q										
Counseling for Nutrition		55.99	54.50	79.56	↑ **25.06**	75th	42.92	51.8	62.65	70.88	79.5
Counseling for Physical Activity		49.88	48.66	74.94	↑ **26.28**	75th	35.90	45.1	55.38	63.47	71.6

RESULTS (Qualitative Analysis): Our rate has been increased by at least 25% for both sub-measures.

BARRIER ANALYSIS: Goal met, no barrier analysis needed.

INTERVENTIONS:

- Provide provider performance feedback by means of 2016 HEDIS report cards
- Bi-monthly prospective HEDIS report cards and performance feedback reports
- Member incentive campaign for well child visits (7-11 years; 3-6 years)

NEXT STEPS:

- Continue Well Child Member Incentive for 3-6 year old.
- Consider discontinuing this Work Plan item in 2018. Focus efforts on other high-priority measures.

Return to Agenda
70 of 152 pages

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Objective: Improve Quality and Safety of Clinical Care Services

Over/Under Utilization

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Appropriate Testing for Children with Pharyngitis					
DHCS	Appropriate Testing for Children with Pharyngitis - percentage of children 2 – 18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic **and received a group A strep test.**	Meet or exceed NCQA 25th percentile	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis) : Goal Not Met

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2015**	**2016**	**2017**	**2016-17 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Effectiveness of Care: Respiratory Conditions											
Appropriate Testing for Children with Pharyngitis (CWP)	Q	51.46	59.46	60.46	↑ 1.00	10th	59.70	67.15	75.21	82.90	88.00

RESULTS (Qualitative Analysis):

HEDIS 2018 Appropriate Testing for Children with Pharyngitis

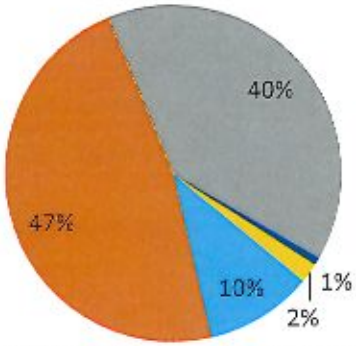
Aid Category Comparison

Adult Expansion Disabled Family Family/Adult TLIC

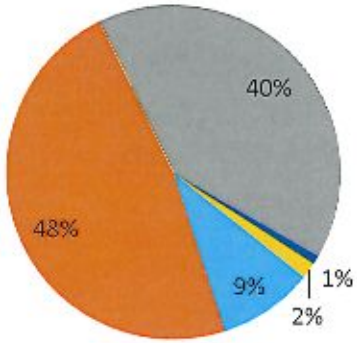
Return to Agenda
71 of 152 pages

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

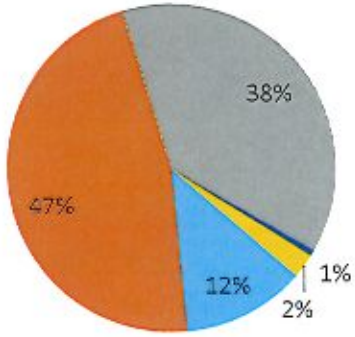
Denominator



Compliant



Non-Compliant

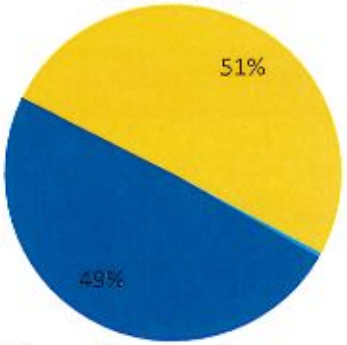


Family Aid Category is has more non-compliant members than compliant.

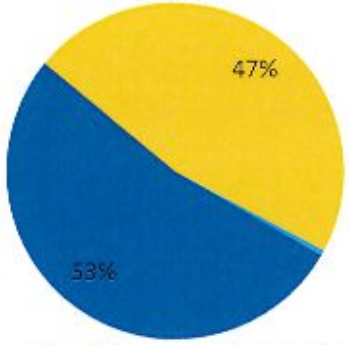
Spoken Language Comparison

English Spanish

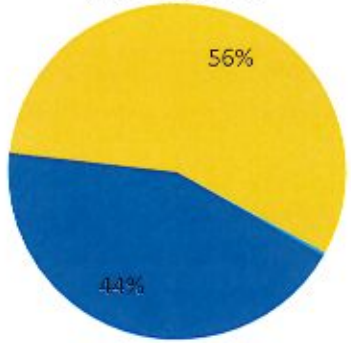
Denominator



Compliant



Non-Compliant

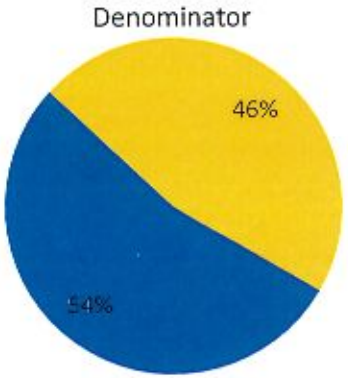


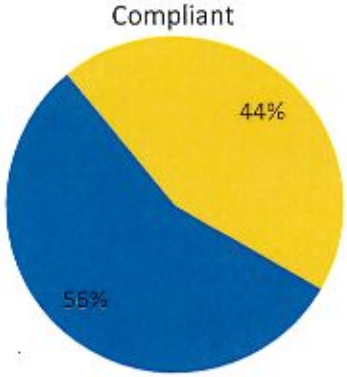
English speaking members are getting more strep testing than Spanish speaking members.

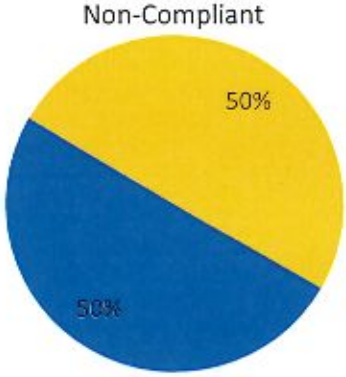
Gender Comparison

Female Male

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation







Females are receiving more proper tests for pharyngitis that males

BARRIER ANALYSIS: Family Aid Category has more non-compliant members than compliant. Family/Adult and TLIC had higher numbers of compliance. English speaking members are more are getting more strep testing than Spanish speaking members. Members speaking other languages were such a low number they didn't appear in the chart. Females are receiving more testing for pharyngitis than males.
Resources did not permit Academic Detailing.

INTERVENTIONS:

- This is a provider education issue and additional analysis will be done to determine how our clinics or clinic systems are performing. This information will be utilized to guide our educational efforts.
- Revise the provider report cards and gap reporting process, reach out to our partners in DSS and IT for their expertise.

NEXT STEPS:

- This is a non-reported measure, consider replacing with higher priority measure.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Appropriate Treatment for Children with Upper Respiratory Infection					
DHCS	Appropriate Treatment for Children with Upper Respiratory Infection - percentage of children 3 months – 18 years of age who were diagnosed with an upper respiratory infection (URI) and	Meet or exceed NCQA 90th Percentile	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI

Return to Agenda
73 of 152 pages

were not dispensed an antibiotic prescription.			

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis) : Goal not met

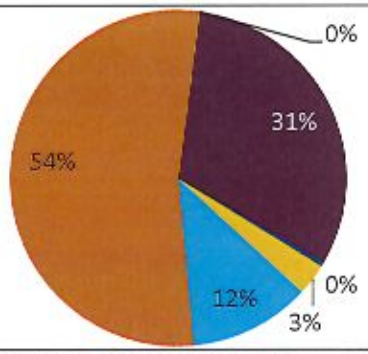
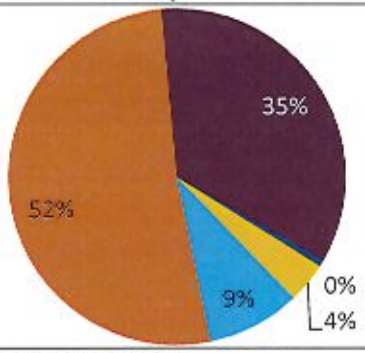
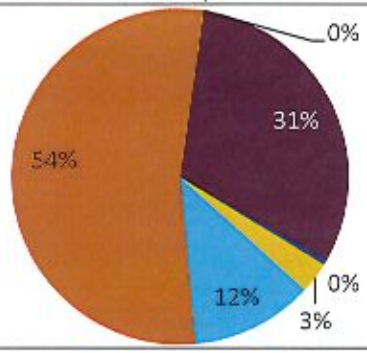
							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	Domain of Care	2015	2016	2017	2016-17 Rate Difference	Current NCQA Percentile Ranking	10th	25th	50th	75th	90th
Effectiveness of Care: Overuse/Appropriateness											
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Q	94.82	94.80	95.40	↑ 0.60	75th	77.78	86.38	89.67	93.54	95.98

RESULTS (Qualitative Analysis):

HEDIS 2018 Appropriate Treatment for Children with Upper Respiratory Infection (URI)

Aid Category Comparison

Adult Expansion Disabled Family Family/Adult Not Contracted TLIC

Denominator	Compliant	Non-Compliant
		

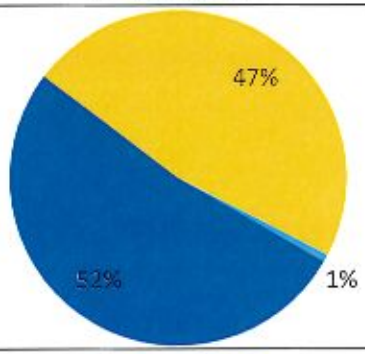
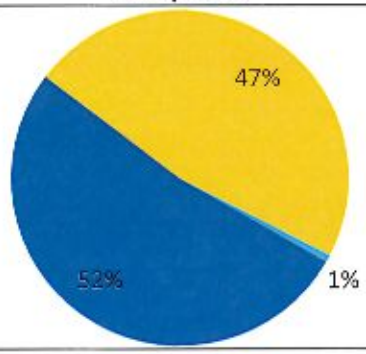
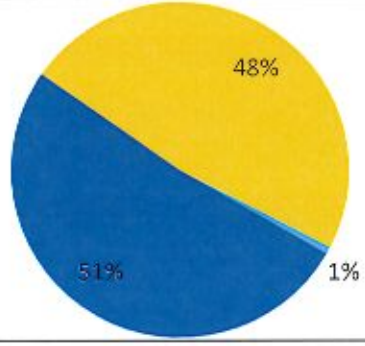
TLIC and Disabled has less non-compliance that compliance for this measure.

Return to Agenda
74 of 152 pages

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Language Spoken Comparison

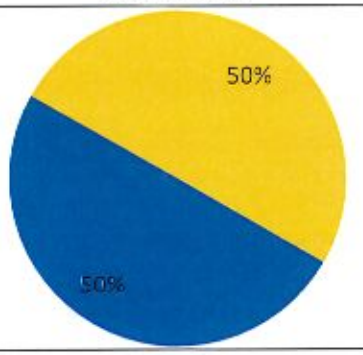
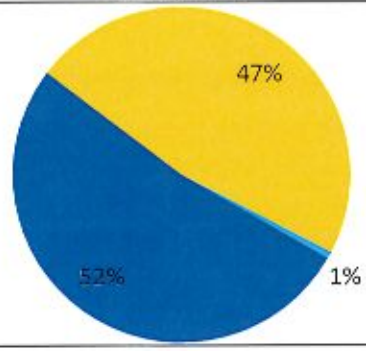
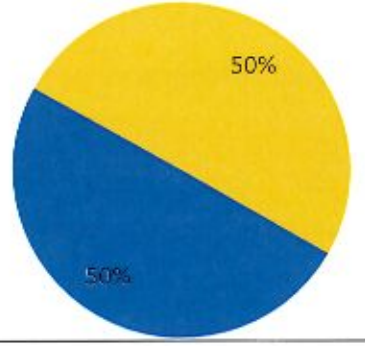
English Spanish Other

Denominator	Compliant	Non Compliant
		

Spanish speakers were given more antibiotics for URI than English Speakers.

Gender Comparison

Female Male

Denominator	Compliant	Numerator
		

Females were slightly more compliant than males for this measure.

BARRIER ANALYSIS: Aid Categories TLIC and Disabled performed better that the other Aid Categories, English speakers performed better than Spanish speakers and females better than males.

Resources did not permit Academic Detailing.

Return to Agenda
75 of 152 pages

INTERVENTIONS:

- This is a provider education issue and additional analysis will be done to determine how our clinics or clinic systems are performing. This information will be utilized to guide our educational efforts.

NEXT STEPS: Recommend evaluation of program and continue monitoring.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)					
DHCS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis - percentage of adults 18 – 64 years of age with a diagnosis of acute bronchitis **who were not dispensed** an antibiotic prescription.	Meet or exceed NCQA 50th Percentile	Q4 2017	Provide provider performance feedback by means of 2016 HEDIS report cards Provider Operations Bulletin article Meet with clinics to discuss rates Academic detailing	QI

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis): Goal Met

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2015**	**2016**	**2017**	**2016-17 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	**Q**	25.58	29.27	32.75	**↑ 3.48**	50th	21.69	24.91	28.70	33.74	39.53

RESULTS (Qualitative Analysis): A 3.48 % increase in our rate enabled achievement of the 50th percentile.

BARRIER ANALYSIS: Goal met, no barrier analysis needed.

INTERVENTIONS: N/A

NEXT STEPS: Consider evaluation of program and continue monitoring.

Return to Agenda
76 of 152 pages

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Ambulatory Care (AMB)					
DHCS	Ambulatory Care- Summarizes Utilization of Ambulatory Care Outpatient Visits – per 1,000 Member Months	Meet Medi-Cal Managed Care Performance Dashboard Rate	Q4 2017	Adult and child member letters for appointment reminders/engage members to see their PCP Meet with clinics to discuss results of clinic rates	QI

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis): Goal Partially Met

							2017 NCQA Percentile Ranking				
HEDIS Measure/Data Element	**Domain of Care**	**2015**	**2016**	**2017**	**2016-17 Rate Difference**	**Current NCQA Percentile Ranking**	10th	25th	50th	75th	90th
Utilization											
Ambulatory Care		Visits/1000	Visits/1000	Visits/1000							
Outpatient Visits		246.05	252.22	271.06	↑ **18.84**	N/A					
ED Visits		41.05	38.79	41.21	↑ **2.42**	N/A					

RESULTS (Qualitative Analysis): Current DHCS Dashboard rate for Outpatient Visits at 90% is 473.7/1000 and our rate, while it is up nearly 19% falls far short of the goal. Conversely, while the ED Visits are also up from last year, and they are below the DCHS Dashboard rate of 52.3/1000.

BARRIER ANALYSIS:

- Further evaluate 2017 performance to identify improvement opportunities

NEXT STEPS: Recommend creating action plan from evaluation of performance to improve OP visits.

Objective: Improve Quality and Safety of Clinical Care Services

Quality Improvement Projects

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
PIP					
DHCS	Child Immunization PIP: Increase the Rate of Combo 3 Immunizations Administered	By June 30, 2019, increase the rate of Combo 3	June 30, 2019	This is a two-year performance improvement project (PIP) health plan/clinic collaborative between GCHP's Quality Improvement (QI) and Health Education/Cultural Linguistics (HE/CL)	QI

Return to Agenda
77 of 152 pages

	On/Before the 2nd Birthday for Children Enrolled at Mandalay Bay Women's and Children's Medical Group	immunizations administered on/before the 2nd birthday for children enrolled at Mandalay Bay Women's and Children's Medical Group from 73.64% to 83.64%.		Departments and Ventura County Medical Center's Mandalay Bay Women's and Children's Medical Group. This project requires the submission of five PIP modules to the Department of Health Care Services (DHCS) and to Health Services Advisory Group (HSAG), which is the Quality Improvement Organization contracted with DHCS to oversee the two-year PIP projects.	

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

For the 2017-2019 PIP cycle, DHCS required all Medi-Cal managed care to implement a child immunization status (CIS) PIP if the health plan's 2016 measurement year (MY) CIS Combo 3 rate was below the minimum performance level (MPL) or below the statewide Medi-Cal managed care average. GCHP's 2016 MY Combo 3 rate (64.96) was slightly above the MPL (64.3), but below the statewide Medi-Cal managed care average (73.84) published in the June 2017 *California Department of Health Care Services Medi-Cal Children's Health Dashboard*, which caused the QI Department to implement a new CIS PIP.

In June 2017, the QI Department completed a detailed analysis of the HEDIS 2016 MY data to determine possible causes for the CIS Combo 3 rate decline and this analysis included reviewing annual rate trends, immunization utilization, clinical data sources that impacted the rates (e.g. claims, supplemental), changes in eligible population, and access to PCP. The following issues were identified:

- There are missed opportunities for administering immunizations during the PCP visits.
- There is no significant disparity in child immunizations between the four ethnic groups represented in the data: (1) Hispanic/Latinos, (2) Non-Hispanic/Non-Latinos, (3) Declined, (4) Unknown.
- There is an inverse relationship with compliance rates and immunizations that require three or more doses = immunizations with higher does requirements → lower rates.
- The compliance rates for DTaP and Pneumococcal are lower than the rest of the immunizations measured because the 4th dose is not administered before the child's 2nd birthday.
- A focused review on VCMC clinics showed there is a high rate of children receiving the 4th dose of DTaP and Pneumococcal between their 2nd and 3rd birthday.

RESULTS (Qualitative Analysis)

Based on the analysis completed in June 2017, it appears that the reduced CIS Combo 3 rates is mostly attributed to children not receiving all required immunizations due to the following process issues:

- Missed immunizations during clinic visits
- Immunizations administered after 2 years of age
- Higher dose immunizations (DtaP and PCV) incomplete

BARRIER ANALYSIS

In November 2017, the QI and HE/CL Departments met with Mandalay Bay Women's and Children's Medical Group to identify additional clinical, behavioral and technical drivers that may be contributing to reported decrease in child immunizations.

- Parent/guardian perception that child immunizations are not important.
- Parent/guardian is unaware of what vaccinations their child needs and/or have been administered.

- Provider does not routinely check the child's immunization status at each clinic visit
- Provider access.
- Parent access.

These drivers were included in the Key Driver Diagram section of Module 1 which was submitted to DHCS and HSAG on November 15, 2017.

NEXT STEPS

The QI and HE/CL Departments will continue to collaborate with Mandalay Bay Women's and Children's Medical Group on completing the activities to implement a health plan/clinic coordinated telephonic outreach program to schedule child immunization appointments for children < 2 years of age who have not completed all their required child immunizations. The planned testing period for this intervention is September 1, 2018 to June 30, 2019.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Healthcare Disparity PIP					
DHCS	Health Disparity PIP: Decrease the Rate of HbA1c > 9.0 in Non-English-Speaking Hispanic/Latino Members with Diabetes Who Are Enrolled at Las Islas Family Medical Group	By June 30, 2019, decrease the rate of HbA1c > 9.0 among adults, 18-75 years of age, non-English speaking Hispanic/Latinos member with diabetes who are enrolled at Las Islas Family Medical Group from 70.39% to 59.20%.	June 30, 2019	This is a two-year performance improvement project (PIP) health plan/clinic collaborative between GCHP's Quality Improvement (QI) Department and Ventura County Medical Center's Las Islas Family Medical Group. This project requires the submission of five PIP modules to the Department of Health Care Services (DHCS) and to Health Services Advisory Group (HSAG), which is the Quality Improvement Organization contracted with DHCS to oversee the two-year PIP projects.	QI

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

For the 2017-2019 PIP cycle, DHCS required all Medi-Cal managed care health plans to select a PIP topic focused on improving a disparity in care. In November 2017, the Quality Improvement Department completed a disparity analysis on low-performing measures reported in 2017, to identify any disparities in care among Gold Coast Health Plan members. A statistical analysis using p-values was used to look for disparities among gender, race, language, and ethnicity. The final results showed a higher prevalence of uncontrolled HbA1c (>9.0) in diabetic members who were non-English speaking Hispanics and Latinos. Tables 1 and 2 shows a summary of the results of the statistical analysis and a detailed summary is documented in Module 1 which was submitted to DHCS and HSAG on November 15, 2017.

Return to Agenda
79 of 152 pages

Table 1: Disparity results of language for CDC - HbA1C > 9

	Administrative Data		Hybrid Data	
Language	English	Non-English	English	Non-English
Numerator	2451	1858	130	88
Denominator	3225	2332	242	157
Rate	0.753	0.7967	0.537	0.561
P-Value	The Z-Score is -3.828. The p-value is 0.00012. The result is significant at p <0.05.		The Z-Score is -0.4704. The p-value is 0.63836. The result is not significant at p <0.05.	

Table 2: Disparity results of language for CDC- HbA1C > 9 within Hispanic/Latino group

	Administrative Data within Hispanic or Latino Diabetic Patients	
Language	English	Non-English
Numerator	829	1333
Denominator	1086	1672
Rate	0.7634	0.7972
P-Value	The Z-Score is -2.1071. The p-value is 0.03486. The result is significant at p <0.05.	

RESULTS (Qualitative Analysis)

Discussions with the clinic partner, Las Islas Family Medical Clinic, revealed that a significant process issue in the clinic setting that is contributing to the higher rate of uncontrolled HbA1c in this population is difficulty with getting the diabetic patient into the clinic to get the lab tests. Since the HEDIS specifications for the Comprehensive Diabetes Care measure places a member with no HbA1c test during into the HbA1c > 9.0 category, an intervention that increases the administration of HbA1c tests may reduce the HbA1c > 9.0 rate in non-English speaking Hispanics and Latinos because these members will have a lab reading that may be < 8.0 or they will receive the necessary treatment to reduce it.

BARRIER ANALYSIS

In November 2017, the QI Department met with Las Islas Family Medical Group to identify clinical, behavioral and technical drivers that may be contributing to reported increase in uncontrolled HbA1c among this subset of members.

- Language barriers
- Cultural barriers
- Data management and reporting
- Lack of member knowledge on how to manage diabetes
- Members are non-compliant with treatment plans and doctor's orders
- Lack and/or missing lab data for the health plan to validate the completion of an HbA1c test and the results
- Provider awareness

These drivers were included in the Key Driver Diagram section of Module 1 which was submitted to DHCS and HSAG on November 15, 2017.

Return to Agenda
80 of 152 pages

NEXT STEPS

The QI Department will continue to collaborate with Las Islas Family Medical Clinic on selecting, implementing and testing an intervention to decrease the prevalence of uncontrolled HbA1c in non-English speaking Hispanics and Latinos diagnosed with diabetes.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
IP: Annual Monitoring for Patients on Persistent Medications					
DHCS	IP: Annual Monitoring for Patients on Persistent Medication	Meet or exceed DHCS MPL	Q4 2017	Provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Educate providers via Provider Update Audit and feedback	QI

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

PDSA 1 Study Period: 09/01/17 – 11/30/17

Pre-Intervention Analysis:

After the MPM 2016 measurement year (MY) rates were finalized on May 15, 2017, staff from the Quality Improvement (QI) Department reviewed the medical records of the non-compliant members assigned to the MPM measure who did not have lab monitoring for ACE/ARBs and/or diuretics, to determine why no lab monitoring was completed during the measurement year. The primary barrier identified was that healthcare providers were ordering labs every other year.

Intervention:

We tested the effectiveness of HEDIS clinic reports to inform providers which members did have labs.

Goal:

By November 30, 2017, increase the MPM rate of two high-volume/low-performing clinics by 10% points.

Post-Intervention Analysis:

We exceeded our 10%-point goal for each clinic and 100% of the labs ordered were completed at both clinics during the three-month study period.

RESULTS (Qualitative Analysis)

The QI RN did not receive any specific feedback from the clinic on how they utilized the performance feedback reports. However, the results of the medical record reviews show that at both clinics, 100% of the labs ordered were completed. Based on these stats and the significant increase in the MPM rates for both clinics, we can deduce that the performance feedback reports were effective with helping to increase the number of labs completed.

BARRIER ANALYSIS

- Missing administrative lab data: the results of the medical record reviews showed that >30% of the non-compliant members on the HEDIS report cards had labs before the intervention which indicates data deficiencies that the HEDIS software did not have the administrative data to validate the labs were complete.
- Missing lab orders: the results of the medical records reviews also showed that there was still a large number of labs not ordered by a physician during the study period which indicates.

NEXT STEPS

The purpose for the PDSA improvement project was to increase GCHP's MPM rate to meet or exceed the DCHS minimum performance level (MPL) which equates to the NCQA 25th percentile. The table below shows that all three MPM rates increased for the 2017 MY but the MPM ACE/ARB sub-measure did not meet the 2017 MPL. The QI Department will continue study this measure and implement interventions to improve performance.

MPM Rate Analysis

MPM Measures	2016 MY Rate	2017 MY Rate	2017 DHCS MPL	2016-2017 MY Rate Change	Goal Status
ACE/Arbs	85.09	85.48	85.93	+ 0.39	Did Not Meet MPL
Diuretics	85.14	86.54	85.52	+ 1.40	Met MPL
Total	84.95	85.85	85.58	+ 0.90	Met MPL

Return to Agenda
82 of 152 pages

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
IP: Comprehensive Diabetes Care – Blood Pressure Control					
DHCS	IP: Comprehensive Diabetes Care • Blood Pressure Control	Meet or exceed DHCS MPL	Q4 2017	Ensure aggressive management of medical records retrieval of HEDIS vendor Member educational mailing with health education materials	QI

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

Between June 1, 2017 and November 30, 2017, the Quality Improvement applied the following quality improvement activities to increase the Comprehensive Diabetes Care blood pressure sub-measure:

1. Generate provider gap reports with CBP and CDC-BP measure indicators.
2. Member outreach to educate members on monitoring their blood pressure.
3. Retrospective analysis of gaps in the 2016 MY medical record retrieval, abstraction, and overread process.
4. Coordinate HEDIS vendor's remote access to VCMC's EMR.
5. Provider chase flag logic reconfiguration.
6. Provider education on CBP and CDC-BP measures.

The table below shows that the CDC-BP 2017 MY rate increased 17.28 percentage points achieving a score of 65.94 which ranks at the 50th percentile.

CDC-BP Rate Analysis

Blood Pressure Measures	2016 MY Rate	2017 MY Rate	2017 DHCS MPL	2016-2017 MY Rate Change	Goal Status
CDC-BP	48.66	65.94	52.70	+17.28	Exceeded MPL

RESULTS (Qualitative Analysis)

Reinstated improvement activities from prior year that were previously part of the HEDIS workflow.

BARRIER ANALYSIS

The CDC-BP measure uses only medical record data to evaluate the blood pressure compliance status for the random sample of diabetic members pulled into the annual Comprehensive Diabetes Care measure. Access to medical records is key to ensuring each member's clinic history is completely reviewed in order to report the most accurate CDC-BP rate. After the CDC-BP 2016 measurement year (MY) rates were finalized on May 15, 2017, staff from the Quality Improvement (QI) Department reviewed the medical records of the non-compliant members with uncontrolled hypertension to determine the cause for the increased in diabetic members with uncontrolled hypertension. The following barriers were identified in 2017, and corrected in the improvement activities as listed below:

Return to Agenda
83 of 152 pages

- The HEDIS vendor contracted with a 3rd party retrieval vendor (CIOX) that had a separate reporting software that was not integrated with the HEDIS vendor's software which also affected the accuracy and timeliness of retrieval status reports.
- No overreads of non-compliant records by GCHP staff caused missed opportunities for secondary pursuit to find compliant records.
- The provider data in the medical record chase files were not carefully reviewed to remove specialties and locations that are not chased.
- Limited provider education on NCQA's definition of "Adequately Control BP" in the CBP and CDC-BP HEDIS specifications.
- Final chase review was completed incorrectly in 2017.
- GCHP - HEDIS Timeline was not maintained in 2017.
- Limited oversight of the HEDIS vendor's record retrieval, abstraction and overread process in 2017.

NEXT STEPS

The QI Department will continue to practice the QI activities implemented in 2016-2017 to ensure the continuous oversight and monitoring of internal and external activities related to HEDIS data collection and reporting. Continue monitoring.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
IP: Comprehensive Diabetes Care					
DHCS	IP: Comprehensive Diabetes Care • HbA1c Adequate Control (<8.0%) • HbA1c Poor Control (>9.0%)	Meet or exceed DHCS MPL	Q4 2017	Ensure aggressive management of medical records retrieval of HEDIS vendor Collaborate with DM program to close care gaps and provide health coaching Bi-monthly prospective HEDIS report cards and performance feedback reports Member educational mailing	QI

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

This one-year improvement project transitioned to the two-year disparity PIP.

RESULTS (Qualitative Analysis)

This one-year improvement project transitioned to the two-year disparity PIP.

BARRIER ANALYSIS

This one-year improvement project transitioned to the two-year disparity PIP.

NEXT STEPS

This one-year improvement project transitioned to the two-year disparity PIP.

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
IP: Controlling Blood Pressure					
DHCS	IP: Controlling Blood Pressure	Meet or exceed DHCS MPL	Q4 2017	Ensure aggressive management of medical records retrieval of HEDIS vendor Member educational mailing with health education materials	

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

Between June 1, 2017 and November 30, 2017, the Quality Improvement applied the following quality improvement activities to increase the Comprehensive Diabetes Care blood pressure sub-measure:

1. Generate provider gap reports with CBP and CDC-BP measure indicators.
2. Member outreach to educate members on monitoring their blood pressure.
3. Retrospective analysis of gaps in the 2016 MY medical record retrieval, abstraction, and overread process.
4. Coordinate HEDIS vendor's remote access to VCMC's EMR.
5. Provider chase flag logic reconfiguration.
6. Provider education on CBP and CDC-BP measures.

The table below shows that the CBP 2017 MY rate increased 9.49 percentage points achieving a score of 54.50 which ranks at the 25th percentile.

CBP Rate Analysis

Blood Pressure Measure	2016 MY Rate	2017 MY Rate	2017 DHCS MPL	2016-2017 MY Rate Change	Goal Status
CBP	45.01	54.50	47.69	+ 9.49	Met MPL

RESULTS (Qualitative Analysis)

Reinstated improvement activities from prior year that were previously part of the HEDIS workflow.

BARRIER ANALYSIS

The CBP measure uses only medical record data to evaluate the blood pressure compliance status for the random sample of hypertensive members pulled into the annual Controlling Blood Pressure measure. Access to medical records is key to ensuring each member's clinic history is completely reviewed in order to report the most accurate CBP rate. After the CBP 2016 measurement year (MY) rate were finalized on May 15, 2017, staff from the Quality Improvement (QI) Department reviewed the medical records of the non-compliant members with uncontrolled hypertension to determine the cause for the increased in hypertensive members with uncontrolled hypertension. The following barriers were identified in 2017, which were addressed in 2017 and 2018 and corrected in the improvement activities listed in the previous page:

- The HEDIS vendor contracted with a 3rd party retrieval vendor (CIOX) that had a separate reporting software that was not integrated with the HEDIS vendor's software which also affected the accuracy and timeliness of retrieval status reports.

- No overreads of non-compliant records by GCHP staff caused missed opportunities for secondary pursuit to find compliant records.
- The provider data in the medical record chase files were not carefully reviewed to remove specialties and locations that are not chased.
- Limited provider education on NCQA's definition of "Adequately Control BP" in the CBP and CDC-BP HEDIS specifications.
- Final chase review was completed incorrectly in 2017.
- GCHP - HEDIS Timeline was not maintained in 2017.
- Limited oversight of the HEDIS vendor's record retrieval, abstraction and overread process in 2017.

NEXT STEPS

The QI Department will continue to practice the QI activities implemented in 2016-2017 to ensure the continuous oversight and monitoring of internal and external activities related to HEDIS data collection and reporting. Continue monitoring.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Opioid Use Improvement Strategy					
GCHP	Opioid Use Improvement Strategy	Develop strategy	Q4 2017	Formulary Edits Provider education	Pharmacy

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

Formulary Edits:

The following 'soft edits' were developed for implementation of 1/1/2018:

- Concurrent Use Prenatal Edit
- Concurrent Use Benzodiazepine Edit
- DEA Verification
- Cummulative Daily Acetaminophen Dose > 4000mg
- High Dose Opioid Edit

Provider Education:

The following resources were packaged into a Provider Opioid Toolkit and was provided to all PCPs and other providers who may prescribe opioids. Over 500 kits were distributed and a presentation was made to the 3 major clinics contacted with GCHP regarding the availability and utility of the information in the toolkits.

Practice Resources

1. Opioid Risk Tool (ORT)
2. PHQ-9 Health Assessment
3. CAGE-AID (Alcohol/Drug Screening Tool)
4. Sample Pain Contract
5. Urine Drug Testing Tool

Return to Agenda
86 of 152 pages

6. Poster on Alternative Treatments (CDC Doc)
7. Dose Tapering Guide
8. BH Flyer on Pain Mgmt Resources
9. SUD Clinic List

Clinical Resources

1. GCHP Opioid Prescribing Guidelines
2. CDC Guideline App Flyer
3. CDC Guidelines Poster
4. Medical Board of California Press Release on Opioid Guidelines
5. Turn The Tide Poster
6. CURES 2.0 Flyer
7. MMWR Article on Naloxone Distribution Effects

RESULTS (Qualitative Analysis): Planning was conducted in 2017 to be measured in 2018.

BARRIER ANALYSIS

The "soft edits" will trigger a reject at the pharmacy which may be overridden at the point of sale by the dispensing pharmacist. This has the potential to lower expected results due to 'auto' overriding of the edit by the pharmacists without providing an intervention.

The toolkit needs to be in a readily available fashion on a website for easy access by the physicians.

NEXT STEPS

Next steps are as follows:

1. Consider changing the "soft edits" to "hard edits" that requires the providers to submit a prior authorization with documentation of medical necessity.
2. Develop a webpage on the GCHP website for the provider toolkit

Objective: Improve Quality of Nonclinical Services

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Access to Care					
NCQA NET 2 DHCS	**Primary Care Access** Members are offered: • Non-urgent primary care within 10 business days of request • Urgent care within 48 hours	Standards met for minimum of 90% of providers	Q4 2017	Monitor performance and complaints relating to appointments Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met Conduct survey	Network Operations Grievances and Appeals

	Specialty Care Access Members are offered: • Non-urgent specialty care appointment within 15 business days • Non-urgent ancillary services within 15 business days				

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis): Survey was not conducted in Q42017

RESULTS (Qualitative Analysis)

Network Ops: The Provider Appointment Availability Survey was not repeated in Q4 2017 due to the need for reconsiderations around the survey format and further working with the survey Vendor. However, results taken from 2016 were shared with PCP's and in-area Specialists by way of Joint Operation Meetings (JOM's), Orientations and routine site visits to ensure understanding and improve future scores.

Primary Care access prior survey results

1. Non-Urgent primary care within 10 days of request: 90.2% Met criteria 5.9% increase from 2015/16
2. Urgent care within 24 hours: 100%. Met criteria. However, it is important to keep in mind that this number is based on the DMHC standard of 48 hrs.

Specialty Care Access:

1. Non-urgent specialty care appointment within 15 business days: 51.6% Did not meet standard
2. Non-urgent ancillary services within 15 business days 76.5% did not meet standard, 4% reduction 2015/16

Efforts were initiated to identify these specialty providers and discuss findings and alternatives. Network Operations department undertook an aggressive strategy to enhance the specialty network concentrating on key specialty areas where there were limited providers and access were impacted. The results of this effort have resulted in a threefold increase in network specialists.

BARRIER ANALYSIS

Network Ops conducted surveys via ICE in 2016/17 and discovered many challenges such as standards based upon DMHC standards, participation of 30 various (Commercial, Medicare, Medicaid) health plans delayed results plus results were convoluted. Thus for 2017/18 we partnered with SPH Analytics which provided us one-to-one interaction and involvement in ensuring standards were based off DHCS.

NEXT STEPS

A Provider Appointment Availability Survey is currently in progress, it began June 1, 2018. Network Operations anticipates receiving the results report package in Q3 2018. Consider action plan based on results.

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
After Hours Availability					
DHCS	After Hours Availability • Members are able to reach a provider after hours	Standards met for 90 % of providers	Q4 2017 Q3 2017	Monitor performance and complaints relating to after-hours availability Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met Conduct survey	Network Operations Grievances and Appeals

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis): Survey was not conducted in Q42017

RESULTS (Qualitative Analysis)

Network Ops: The Provider After Hours Survey was not repeated in Q4 2017 however, results taken from 2016/17 were shared with PCP's and in-area Specialists by way of Joint Operation Meetings (JOM's), Orientations and routine site visits to ensure understanding and improve future scores.

954 PCP/Specialist Providers surveyed. Over all approximately 18% of the surveyed providers did not meet After-Hours standards.

Person or type of recording equipment reached after hours;

- Recording or Auto Attendant: 72.2% met the after-hours standards
- Live Person: 70.7%
    - The PCP portion yielded 74.7% met the after-hours standards
        - 25.3% did not meet standards
    - For Specialists 82.7%
        - 17.3% did not meet standards

No grievances were received related to after-hours availability.

BARRIER ANALYSIS

N/A – Q42017

NEXT STEPS

Provider After Hours Survey currently in progress, began June 1, 2018. Network Operations anticipates the results report package in Q3 2018. Consider action plan based on results.

Return to Agenda
89 of 152 pages

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Availability of Practitioners					
NCQA NET 1 DHCS	Availability of Practitioners	Ratios: 1 PCP 1:2000 Total Physicians 1: 1200 Physician Supervision to Non-Physician Practitioner Ratio Nurse Practitioners 1:4 Physician Assistants 1:4 Network maintained PCP located within 30 minutes or 10 miles	Q4 2017	Conduct bi-annual ratio analysis and annual Quest Analytics analysis for primary care and high volume specialties Identify gaps and implement corrective action plan Monitor progress towards action plans to maintain or improve GeoAccess standards Report bi-annual ratio analysis and annual GeoAccess findings to QIC	Network Operations

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

- Ratio of Members to PCPs 1:796
  - With the inclusion of CHLA, COH and UCLA we far exceeded the standard which dropped the ratio.
- Ratio of Members to Total Physicians 1:43
- Network maintained 99.9% of members within 30 minutes or 10 miles to PCP
- Nurse Practitioners to PCP Physicians 1:2
- Physician Assistants to PCP Physicians 1:3
- All Mid-levels to Total Physicians 1:4

RESULTS (Qualitative Analysis)

Availability of PCP practitioners continues to maintain within standards as well as specialists. Growth in high-volume specialties were targeted in the last year and all standards met within the quarter including Mid-levels to Total Physicians.

BARRIER ANALYSIS None

NEXT STEPS: Continue to monitor and access standards in accordance with the new Network certification APL, which takes into account ratios based on actual FTE's.

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Objective: Improve Quality of Nonclinical Services

Practitioner Availability: Cultural Needs & Preferences

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Availability of Practitioners					
NCQA NET 1 DHCS	Practitioner Availability: Cultural and Linguistics Needs & Preferences: Assess the cultural, ethnic and linguistic needs of our members	Complete Annual Assessment	Q4 2017	Analyze the demographic needs of our members to identify opportunities for improvement	Member Services Network Operations

EVALUATION OF 2017 WORK PLAN

RESULTS (Qualitative Analysis)

Availability of PCP practitioners continues to maintain within standards as well as specialists. Growth in high-volume specialties were targeted in the last year and all standards met within the quarter including Mid-levels to Total Physicians. See charts on following pages.

BARIER ANALYSIS: None

NEXT STEPS: Continue to monitor

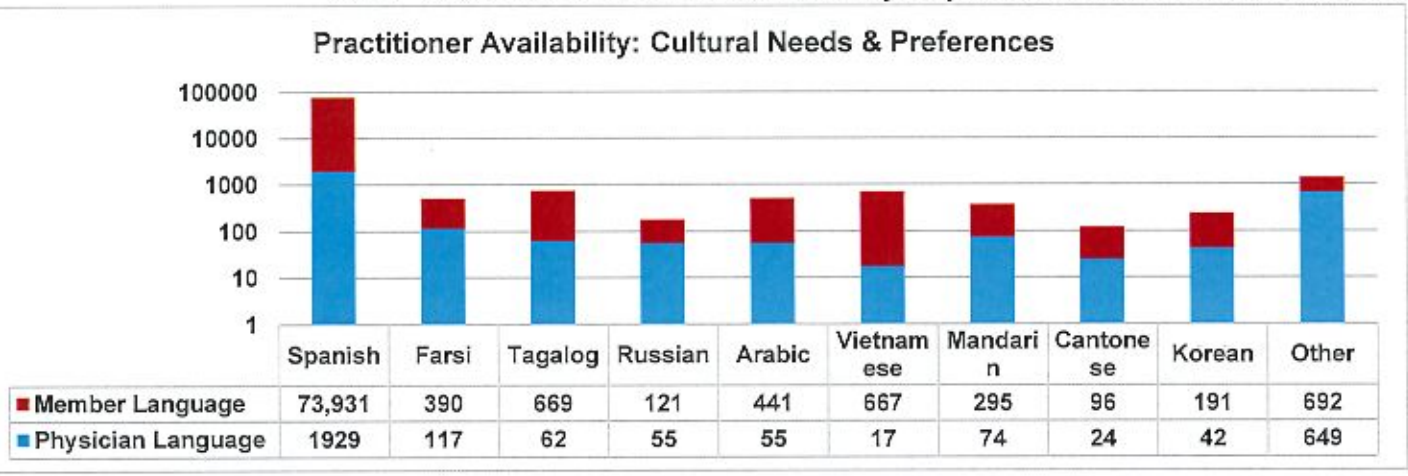
RESULTS (Qualitative Analysis)

MbrDataElement	ETHNICITY	M_ETHNICITY	MbrCount
Ethnicity	American Indian/Alaskan Native	Alaskan Native or American Indian	500
Ethnicity	Asian/Pacific Islander	Asian Indian	687
Ethnicity	Asian/Pacific Islander	Asian or Pacific Islander	1413
Ethnicity	Asian/Pacific Islander	Cambodian	112
Ethnicity	Asian/Pacific Islander	Chinese	836
Ethnicity	Asian/Pacific Islander	Filipino	3057
Ethnicity	Asian/Pacific Islander	Guamanian	46
Ethnicity	Asian/Pacific Islander	Hawaiian	274
Ethnicity	Asian/Pacific Islander	Japanese	222
Ethnicity	Asian/Pacific Islander	Korean	449
Ethnicity	Asian/Pacific Islander	Laotian	66
Ethnicity	Asian/Pacific Islander	Samoan	145
Ethnicity	Asian/Pacific Islander	Vietnamese	1241
Ethnicity	Black/African American	Black	3361
Ethnicity	Caucasian/White	White	48660
Ethnicity	Hispanic/Latino	Hispanic	118114
Ethnicity	Not Available/Unknown	Not Available/Unknown	8955
Ethnicity	Other	Amerasian	258
Ethnicity	Other	Other	15744
Total			**204140**

MbrDataElement	M_PRIMARY_LANGUAGE	Primary_Spoken_Language	MbrCount
Language	American Sign Language (ASL)	American Sign Language (ASL)	56
Language	Arabic	Arabic	441
Language	Armenian	Armenian	68
Language	Cambodian	Cambodian	53
Language	Cantonese	Cantonese	96
Language	English	English	124977

Return to Agenda
92 of 152 pages

Language	Farsi	Farsi	390
Language	French	French	1
Language	Hebrew	Hebrew	5
Language	Hmong	Hmong	9
Language	Ilocano	Ilocano	11
Language	Italian	Italian	9
Language	Japanese	Japanese	29
Language	Korean	Korean	191
Language	Lao	Lao	3
Language	Mandarin	Mandarin	295
Language	No response, client declined to state	Not Available/Unknown	14
Language	No Valid Data Reported (MEDS generated)	Not Available/Unknown	1626
Language	Other Chinese Languages	Other Chinese Languages	132
Language	Other Non-English	Other Non-English	268
Language	Other Sign Language	Other Sign Language	3
Language	Polish	Polish	3
Language	Portuguese	Portuguese	5
Language	Russian	Russian	121
Language	Samoan	Samoan	11
Language	Spanish	Spanish	73931
Language	Tagalog	Tagalog	699
Language	Thai	Thai	21
Language	Turkish	Turkish	5
Language	Vietnamese	Vietnamese	667
Total			**204140**



	Spanish	Farsi	Tagalog	Russian	Arabic	Vietnamese	Mandarin	Cantonese	Korean	Other
Member Language	73,931	390	669	121	441	667	295	96	191	692
Physician Language	1929	117	62	55	55	17	74	24	42	649

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Provider Network					
NCQA NET 1 DHCS	Assess the provider network and adjust the availability of providers within the network, if necessary, to meet membership needs and preferences	Complete Annual Assessment	Q4 2017	Monitor how effectively the practitioner network meets the needs and preferences of our members	Network Operations

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

New contracted provider groups by end year 2017 = 47

New Physicians/Professionals added into the network by end year 2017 = 1264

RESULTS (Qualitative Analysis)

With the use of various reports (e.g. State of PNO, GeoAccess) we assess the types of services being rendered as well as geographical mapping from members' residence to determine any gaps in the network. In addition, we worked with the UM committee on identifying network development opportunities.

BARRIER ANALYSIS

None

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

NEXT STEPS: Continue and expand upon our current focus and reporting capabilities to determine network and member needs. Also seek the support and input from our health services department to determine member needs and preferences. Collaborate with DSS, QI Credentialing, Member Services, Health Ed/Cultural & Linguistics, and other key departments to work out the methodology for such reporting

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Provider Satisfaction Survey					
	Provider Satisfaction Survey	Complete Survey	Q4 2017	Analyze results and identify opportunities for improvement Develop and implement interventions as needed to improve rates	Network Operations

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

The Provider Satisfaction Survey was placed on hold by leadership as the prior survey had significant challenges both in terms of number of physicians who participated in the survey as well as conflicting results and the inability to gain specific insight as there was no reference for provider comments. The initial survey did not meet our needs and it was determined by leadership that we look at the value of creating our own survey. After much debate it was decided to create a list of key needs and expectations and work with the vendor on a more tailored approach. This survey was further placed on hold due to competing strategic and state regulatory reporting priorities. We have prioritized moving forward on a Provider Satisfaction Survey To commence by no later than the 2nd qtr. of FY 2019.

RESULTS (Qualitative Analysis): None

BARRIER ANALYSIS: Discussed above in quantitative results

NEXT STEPS: Complete survey by 2nd qtr. of FY 2019

Objective: Improve Patient Safety

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Facility Site Reviews					
DHCS	Complete Initial and Tri-annual Facility Site Reviews Complete Interim Reviews	100%	Year End 2017	Monitor FSR database Submit bi-annual reports to DHCS	FSR Nurse QI

Return to Agenda
95 of 152 pages

EVALUATION OF 2017 WORK PLAN					
RESULTS (Quantitative Analysis): Goal Met					
RESULTS (Qualitative Analysis): All site reviews completed for 2017 and bi-annual reports submitted to DHCS.					
BARRIER ANALYSIS: Goal Met, no barriers presently identified.					
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Physical Accessibility Site Reviews					
DHCS	Complete Physical Accessibility Site Reviews	100%	Year End 2017	Compile reports for high volume/ancillary specialists Submit report to State Complete PARs for new provider sites	FSR Nurse QI
EVALUATION OF 2017 WORK PLAN					
RESULTS (Quantitative Analysis): Goal Met					
RESULTS (Qualitative Analysis): All PARs completed for 2017. Reports completed and submitted to DHCS.					
BARRIER ANALYSIS: Goal Met, no barriers presently identified.					
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Safe Clinical Practice					
NCQA MED 4 DHCS	Improve Safe Clinical Practice	Tracking	Ongoing	Monitor site visit results from practitioner credentialing Monitor member complaints involving clinical quality of care concerns (safety)	Credentialing/ Peer Review Grievances and Appeals
EVALUATION OF 2017 WORK PLAN					
RESULTS (Quantitative Analysis): Goal Met					
RESULTS (Qualitative Analysis): No site visits were conducted in 2017 as no grievances were submitted to QI that would trigger a site visit.					
BARRIER ANALYSIS: Goal Met, no barriers presently identified. **NEXT STEPS:** Grievances will continue to monitor member complaints involving clinical quality of care concerns (safety). QI will ensure site visits are completed within 30 days as needed.					

Return to Agenda
96 of 152 pages

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Objective: Member Experience: CAHPS, Complaints/Grievances TBD					
Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Complaints and Grievances/Call Center Monitoring					
NCQA QI 4 DHCS	Conduct annual assessment of complaints and grievances. Conduct Six Month Member Access and Satisfaction Survey results to identify opportunities for improvement	Increase rates by 5% over previous year : Your Overall Appointment Experience Adult: 2015 - 68.6% Child: 2015 – 57.9% Ease of Accessing Care Adult: 2015 - 85.9% Child: 2015 - 89.1%	Q4 2017 July to Dec 2017	Provider Interventions: • Review 2016 Member Access and Satisfaction Survey final results with clinics • Provider access survey Q2 2016; follow up with providers not meeting standards Conduct Six Month Member Access and Satisfaction Survey Provide results to Network Operations	Network Operations QI
	Call Center Monitoring	ASA: 30 seconds or less Abandonment Rate : 5% or less		Monitor complaints and grievances Customer Service Interventions: • Monitor results/reports of after call survey performed by call center; follow up if issues identified • Monitor Average Speed of Answer (ASA and Abandonment Rate	Grievances and Appeals Member Services

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

Call Center Average Speed of Answer (ASA) and Abandonment Rate:

Results of the call center show an increase of 35 seconds for the ASA in 2017 (51 seconds), in comparison to the 16 seconds ASA in 2016. The abandonment rate also shows an increase of 1.60% for 2017 (2.49%) in comparison to 0.89% abandonment rate in 2016.

Monitor Complaints and Grievances:

The grievance data for 2016 shows 156 grievances received and in 2017, there were 217 grievances received. In comparison, this equates to an increase of about 39%.

Return to Agenda
97 of 152 pages

RESULTS (Qualitative Analysis)

Call Center After Call Survey, IVR satisfaction:

Results of the survey show an 8.4 % improvement on the satisfaction of using the IVRS. In 2017, 5.5% of the callers expressed their dissatisfaction with the IVRS in comparison to 6% in 2016.

Monitor Complaints and Grievances:

The results from the previous year show that the increase is related increase in membership.

BARRIER ANALYSIS

BARRIERS CALL CENTER:

The Conduent call center experienced attritions throughout the year due to agent performance and attendance. The call center has also found challenges with recruiting new talent due to competition with other companies in the area that are offering higher wages.

CALL CENTER NEXT STEPS

The Conduent call center will be working with the University of Kentucky to search and recruit part time employees in an effort to hire new representatives quickly. The call center will also be recruiting for a supervisor position at the Arizona call center and is planning to add additional representatives at that location. The call center is planning to staff up to 27 representatives.

BARRIERS COMPLAINTS AND GRIEVANCES:

At this time, no barriers were identified.

COMPLAINTS AND GRIEVANCES NEXT STEPS:

Continue to track all complaints and grievances for possible trending to communicate to all departments to identify process improvement opportunities.

Objective: Health Plan Quality

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
QIPD, Program Evaluation, Workplan					
NCQA QI 1 DHCS	•Update QI Program Description •Complete 2015 QI Program Evaluation •Develop and Implement 2016 QI Program Work Plan	100%	June 2017	1. Review and revise annual QI Program Description, Work Plan and Evaluation 2. Obtain approval of 2016 QI Program and Work Plan and Evaluation of 2015 QI Program 3. Evaluate the adequacy of resources, committee structure, practitioner participation and leadership involvement in the QI Program in order to restructure or change the QI Program for subsequent year as necessary	Chief Medical Officer QI Director Quality Improvement Committee

Return to Agenda
98 of 152 pages

Gold Coast Health Plan
A Public Entity

2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

EVALUATION OF 2017 WORK PLAN
RESULTS (Quantitative Analysis): Goal met.
RESULTS (Qualitative Analysis): The QI Program Description, Work Plan, and Work Plan Evaluation were approved at QIC on June 20, 2017 and at the Ventura County Medi-Cal Managed Care Commission meeting on August 21, 2017.
BARRIER ANALYSIS: No barriers presently identified. **NEXT STEPS:** Develop and implement 2018 QI Program Description and QI Work Plan based upon evaluation of 2017 activities. Consider removing these tasks from the QI Work Plan as these are regularly monitored and reported.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring/Improvement Activities	Responsible Department/ Committee
Delegation					
NCQA CR 8, QI 10, UM 13, RR 5 DHCS	Completion of Delegation Oversight Delegated Activities • Credentialing • QI • UM • Members' Rights • Claims	100%	Q4 2017	1. Complete audits 2. Issue CAPs as applicable 3. Follow-up on CAPs as applicable 4. Report to Compliance Committee and QIC	Compliance

EVALUATION OF 2017 WORK PLAN
RESULTS (Quantitative Analysis) Goal Met
RESULTS (Qualitative Analysis) Delegation oversight audits were completed.
BARRIER ANALYSIS Goal met, no barriers presently identified. **NEXT STEPS** Continue delegation oversight activities timely.

Gold Coast Health Plan℠
A Public Entity

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services			**Objective Met:**		
Required by: NCQA MED 2			**Target Completion Date:** Q4 2018		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Diabetes Clinical Practice Guideline (CPG) review and adoption at least every two years	Review and approval by Medical Advisory Committee (MAC) Distribute guidelines to appropriate practitioners	Health Services MAC	MAC Approval Timely distribution	1/1/2018	12/31/2018
Asthma Clinical Practice Guidelines (CPG) review and adoption at least every two years	Review and approval by Medical Advisory Committee (MAC) Distribute guidelines to appropriate practitioners	Health Services MAC	MAC Approval Timely distribution	1/1/2018	12/31/2018
Preventive Health Guideline (PHG) review and adoption at least every two years	Define, review and approval by Medical Advisory Committee (MAC) Distribute guidelines to appropriate practitioners Align PHG with Provider Handbook and applicable policies	Health Services MAC Quality	MAC Approval Timely distribution Updates completed	1/1/2018	12/31/2018
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services		Objective Met:			
Required by: DHCS		**Target Completion Date:** Q4 2018			
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
	Advance Prevention				
Increase awareness of benefits of tobacco cessation in member population identified as smoking	Research mechanisms to identify smokers (e.g. upon enrollment and/or within existing member population) Create and implement campaign for members and providers Quarterly measurement of tobacco cessation medication dispensing Create system to monitor provider performance regarding offering interventions	Health Ed Health Ed/Provider Operations Pharmacy Health Ed/QI	50% of identified smokers receive intervention		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services	Objective Met:
Required by: DHCS	**Target Completion Date:** Q4 2018

Advance Prevention

Goals	Activities	Responsible Party	Metrics	Start Date	End Date
Increase rates of Initial Health Assessment (IHA) completion by provider sites	Evaluate current system of monitoring for IHA Educate providers regarding requirements and components of IHA Audit providers and provide feedback Establish mechanism to monitor provider compliance with new member outreach Create and implement campaign to increase provider awareness of requirements	QI Health Ed	Increase rate of IHA completion by 5% compared to CY17	1/1/2018	12/31/2018

Evaluation/Analysis of Intervention(s):

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services			Objective Met:		
Required by: DHCS			**Target Completion Date:** Q4 2018		
HEDIS® Measures					
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Postpartum Care – Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Re-evaluate effectiveness of the PP intervention and member incentives program. Analyze demographic results for potential disparity; create action plan to address if present. Provide provider performance feedback by means of 2017 HEDIS report cards Develop and implement member campaign regarding value of timely postpartum visit	QI Health Education	Increase rates by 3% over previous measurement year		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services				Objective Met:	
Required by: DHCS				**Target Completion Date:** Q4 2018	
HEDIS® Measures					
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Childhood Immunization Status Combo 3 ➢ Percentage of two year old children who receive required vaccines (DTaP, IPV, MMR, HiB, HepB, VZV and PCV) on or before their 2nd birthday	Provide provider performance feedback by means of 2017 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Create and implement provider and member education campaigns	QI Health Ed	Increase rates by 3% over previous measurement year		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services			Objective Met:		
Required by: DHCS			**Target Completion Date:** Q4 2018		
HEDIS® Measures					
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Cervical Cancer Screening	Evaluate 2017 performance to identify opportunities Create and implement provider and member awareness campaign Bi-monthly prospective HEDIS report cards and performance feedback reports	QI Health Ed	Increase rates by 5% over previous measurement year		
Evaluation/Analysis of Intervention(s):					

Gold Coast Health Plan℠
A Public Entity

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services	**Objective Met:**
Required by: DHCS	**Target Completion Date:** Q4 2018

HEDIS® Measures

Goals	Activities	Responsible Party	Metrics	Start Date	End Date
Children and Adolescents' Access to Primary Care Practitioners – percentage of members 12 months – 19 years of age who had a visit with a PCP	Evaluate 2017 performance to identify opportunities Consider expanding CAP P4P Provide provider performance feedback by means of 2017 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Evaluate member campaign and make changes based on SWOT	QI Health Education	Improve 5% over prior year performance		

Evaluation/Analysis of Intervention(s):

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services			Objective Met:		
Required by: DHCS			**Target Completion Date:** Q4 2018		
HEDIS® Measures					
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Comprehensive Diabetes Care ➢ Improve rate of medical attention for nephropathy in diabetic members (screening or monitoring or evidence of nephropathy)	Evaluate 2017 performance for opportunities Provide provider performance feedback by means of 2017 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Create and implement member and provider awareness campaigns	QI Health Ed	Improve 3% over prior year results		
Evaluation/Analysis of Intervention(s):					

Gold Coast Health Plan℠
A Public Entity

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2018		
Over/Under Utilization					
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Appropriate Treatment for Children with Upper Respiratory Infection - percentage of children 3 months – 18 years of age who were diagnosed with an upper respiratory infection (URI) and **were not dispensed** an antibiotic prescription.	Provide provider performance feedback by means of 2017 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Create and implement member and provider campaigns	QI Health Education	Improve 5% compared to prior year performance		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services			**Objective Met:**		
Required by: DHCS			**Target Completion Date:** Q4 2018		
Over/Under Utilization					
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis - percentage of adults 18 – 64 years of age with a diagnosis of acute bronchitis **who were not dispensed** an antibiotic prescription.	Evaluate 2017 performance for opportunities. Provide provider performance feedback by means of 2017 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Create and implement member and provider campaigns	QI Health Education	Improve 5% compared to prior year performance		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services				Objective Met:	
Required by: DHCS				**Target Completion Date:** Q4 2018	
Over/Under Utilization					
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Access to Ambulatory Care ➢ Utilization of Ambulatory Care Outpatient Visits per 1,000 Member Months	Evaluate 2017 results to identify opportunities Create and implement action plan to improve metric	QI/Claims/ Provider Operations	Meet Medi-Cal Managed Care Performance Dashboard Rate		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services	Objective Met:
Required by: DHCS	**Target Completion Date:** Q4 2018

Quality Improvement Projects

Goals	Activities	Responsible Party	Metrics	Start Date	End Date
Health Disparity PIP: Decrease the Rate of HbA1c > 9.0 in Non-English-Speaking Hispanic/Latino Members with Diabetes Who Are Enrolled at Las Islas Family Medical Group	Two-year performance improvement project (PIP) - health plan/clinic collaborative between GCHP QI and Ventura County Medical Center's Las Islas Family Medical Group. • Submit Modules as directed by DHCS/HSAG for approval • Report updates/results to QIC	QI	By June 30, 2019, decrease the rate of HbA1c > 9.0 among adults, 18-75 years of age, non-English speaking Hispanic/Latinos member with diabetes who are enrolled at Las Islas Family Medical Group from 70.39% to 59.20%.	1/1/2018	12/31/2018

Evaluation/Analysis of Intervention(s):

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services	Objective Met:
Required by: DHCS	**Target Completion Date:** Q4 2018

Quality Improvement Projects

Goals	Activities	Responsible Party	Metrics	Start Date	End Date
Child Immunization PIP: Increase the Rate of Combo 3 Immunizations Administered On/Before the 2nd Birthday for Children Enrolled at Mandalay Bay Women's and Children's Medical Group	Two-year performance improvement project (PIP) - health plan/clinic collaborative between GCHP QI and Health Education/Cultural Linguistics (HE/CL) Departments and Ventura County Medical Center's Mandalay Bay Women's and Children's Medical Group. • Submit Modules as directed by DHCS/HSAG for approval • Report updates/results to QIC	QI	By June 30, 2019, increase the rate of Combo 3 immunizations administered on/before the 2nd birthday for children enrolled at Mandalay Bay Women's and Children's Medical Group from 73.64% to 83.64%.	1/1/2018	12/31/2018

Evaluation/Analysis of Intervention(s):

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services	**Objective Met:**
Required by: DHCS	**Target Completion Date:** Q4 2018

Quality Improvement Projects

Goals	Activities	Responsible Party	Metrics	Start Date	End Date
IP: Annual Monitoring for Patients on Persistent Medication	Provider performance feedback by means of 2017 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Educate providers via Provider Update Conduct audit and provide feedback	QI	Meet or exceed DHCS MPL		

Evaluation/Analysis of Intervention(s):

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services	Objective Met:
Required by: DHCS	**Target Completion Date:** Q4 2018

Quality Improvement Projects

Goals	Activities	Responsible Party	Metrics	Start Date	End Date
IP: Comprehensive Diabetes Care ➢ Blood Pressure Control	Ensure aggressive management of medical records retrieval of HEDIS vendor Member educational mailing with health education materials	QI Health Education	Meet or exceed DHCS MPL		

Evaluation/Analysis of Intervention(s):

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services	Objective Met:
Required by: DHCS	**Target Completion Date:** Q4 2018

Quality Improvement Projects

Goals	Activities	Responsible Party	Metrics	Start Date	End Date
IP: Controlling Blood Pressure	Ensure aggressive management of medical records retrieval of HEDIS vendor Member educational mailing with health education materials	QI Health Education	Meet or exceed DHCS MPL	1/1/2018	05/31/2018

Evaluation/Analysis of Intervention(s):

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services	Objective Met:
Required by: DHCS	**Target Completion Date:** Q4 2018

Quality Improvement Projects

Goals	Activities	Responsible Party	Metrics	Start Date	End Date
IP: Asthma Medication Ratio	Perform barrier analysis to determine factors that contributed to the AMR rate decrease in 2017. Implement and test intervention to improve the AMR rate.	QI	Meet or exceed DHCS MPL	1/1/2018	12/31/2018

Evaluation/Analysis of Intervention(s):

Return to Agenda
116 of 152 pages

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #1: Improve Quality and Safety of Clinical Care Services	Objective Met:
Required by: DHCS	**Target Completion Date:** Q4 2018

Quality Improvement Projects

Goals	Activities	Responsible Party	Metrics	Start Date	End Date
Reduction in potential unsafe opioid prescriptions including the following: • Reduction in number of users above 90 mg MEDD • Reduction in total number of opioids users Reduction in number of users concurrently using with benzodiazepines and prenatal vitamins	1. Formulary Edits • Implementation of soft edits • Potential for hard edit development 2. Provider education • Development and release of GCHP opioid use webpage for provider resources	Pharmacy	Reduce 5% from prior year metrics		

Evaluation/Analysis of Intervention(s):

Gold Coast Health Plan℠
A Public Entity

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #2: Improve Quality of Nonclinical Services			**Objective Met:**		
Required by: NCQA NET 2; DHCS			**Target Completion Date:** Q4 2018		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Primary Care Access Members are offered: • Non-urgent primary care within 10 business days of request • Urgent care within 24 hours **Specialty Care Access** Members are offered: • Non-urgent specialty care appointment within 15 business days • Non-urgent ancillary services within 15 business days	Conduct survey and evaluate results Monitor performance and complaints relating to appointments Develop and implement corrective action plans when timely access standards not met Report quarterly performance to QIC	Network Operations G&A Network Operations	Standards met for minimum of 90% of providers	06/01/18	08/31/18
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #2: Improve Quality of Nonclinical Services		Objective Met:			
Required by: NCQA NET 2; DHCS		**Target Completion Date:** Q4 2018			
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
After Hours Availability • Members are able to reach a provider after hours	Conduct survey and evaluate results. Monitor performance and complaints relating to after-hours availability Develop and implement corrective action plans when timely access standards not met Report quarterly performance to QIC	Network Operations Grievances and Appeals	Standards met for 90 % of providers		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #2: Improve Quality of Nonclinical Services		Objective Met:			
Required by: NCQA NET 1; DHCS		**Target Completion Date:** Q4 2018			
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Network Adequacy as demonstrated by availability of practitioners	Conduct bi-annual ratio analysis and annual Quest Analytics analysis for primary care and high-volume specialties Identify gaps and implement corrective action plan Monitor progress toward action plans to maintain or improve GeoAccess standards Develop process for network certification process (with ratios) for implementation by 3/31/19 Report bi-annual ratio analysis and annual GeoAccess findings to QIC	Network Operations	Ratios: 1 PCP 1:2000 Total Physicians 1: 1200 Physician Supervision to Non-Physician Practitioner Ratio Nurse Practitioners 1:4 Physician Assistants 1:4 Network maintained PCP located within 30 minutes or 10 miles. Network maintained DHCS core specialists located within 60 minutes or 30 miles. Hospitals 30 minutes or 15 miles.		

Evaluation/Analysis of Intervention(s):

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #2: Improve Quality of Nonclinical Services		Objective Met:			
Required by: GCHP Internal Activity		**Target Completion Date:** Q4 2018			
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Provider Satisfaction Survey	Analyze 2017 results and identify opportunities for improvement Develop and implement interventions as needed to improve rates Prepare for 1Q19 provider survey	Network Operations	Development and implementation of action plan to improve		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #2: Improve Quality of Nonclinical Services				Objective Met:	
Required by: NCQA NET 1; DHCS				**Target Completion Date:** Q4 2018	
Practitioner Availability: Cultural Needs & Preferences					
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Practitioner Availability - Cultural and Linguistics Needs & Preferences ➢ Adequate resources to address the cultural, ethnic and linguistic needs of our members	Evaluate the demographic needs of members and identify opportunities for improvement Create and implement an action plan to address areas for improvement	Network Operations Health Education	Development and implementation of action plan to improve		
Evaluation/Analysis of Intervention(s):					

Gold Coast Health Plan℠
A Public Entity

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #3: Improve Member Safety			**Objective Met:**		
Required by: DHCS; NCQA MED 4			**Target Completion Date:** Q4 2018		
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Compliance with facility site reviews (FSR)	Review FSR database regularly to maintain scheduled visits Complete Initial, Interim, and Tri-annual Facility Site Reviews timely Issue CAPs as needed to facilitate clinic compliance improvement Submit bi-annual reports to DHCS	QI	100% on time		
Complete Physical Accessibility Review (PAR)	Compile reports for high volume/ancillary specialists Complete PARs for new provider sites Submit report to DHCS	QI	100% on time		
Monitor Clinic for safety practices	Monitor FSR site visit results from deficiencies, track and trend Monitor member complaints and PQIs involving clinical quality of care concerns (safety) Issue CAP(s) and track improvements as needed	QI Grievances and Appeals	Evaluate tracking system, improve if needed		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #4: Assess and Improve Member Experience				Objective Met:	
Required by: NCQA QI 4; DHCS				**Target Completion Date:** Q4 2018	
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Assess Member Access and Satisfaction Conduct annual assessment of complaints and grievances.	Review and evaluate 2017 Member Access and Satisfaction Survey Identify opportunities for improvement Create and implement action plan for improvement Continue to monitor complaints and grievances	Network Operations QI Grievances and Appeals	Development and implementation of action plan to improve		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #4: Assess and Improve Member Experience		Objective Met:			
Required by: NCQA QI 4; DHCS		**Target Completion Date:** Q4 2018			
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Call Center Monitoring	Customer Service Interventions: • Monitor results/reports of after call survey performed by call center; follow up if issues identified • Monitor Average Speed of Answer (ASA and Abandonment Rate)	Member Services	ASA: 30 seconds or less Abandonment Rate: 5% or less		
Evaluation/Analysis of Intervention(s):					

2018 Gold Coast Health Plan
Quality Improvement Work Plan

Objective #5: Ensure organizational oversight of delegated activities				**Objective Met:**	
Required by: NCQA CR 8; QI 7; UM 13; RR 5; DHCS				**Target Completion Date:**	
Goals	**Activities**	**Responsible Party**	**Metrics**	**Start Date**	**End Date**
Completion of Delegation Oversight Delegated Activities • Credentialing • QI • UM • Members' Rights • Claims	1. Complete audits 2. Issue CAPs as applicable 3. Follow-up on CAPs as applicable 4. Report to Compliance Committee and QIC	Compliance	100%	1/1/2018	12/31/2018
Evaluation/Analysis of Intervention(s):					

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: July 23, 2018

SUBJECT: May 2018 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached May 2018 fiscal year-to-date (FYTD) financial statements of Gold Coast Health Plan ("Plan") for the Commission to accept and file. The Executive / Finance Committee did not review these financials.

BACKGROUND/DISCUSSION:

The staff has prepared the May 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

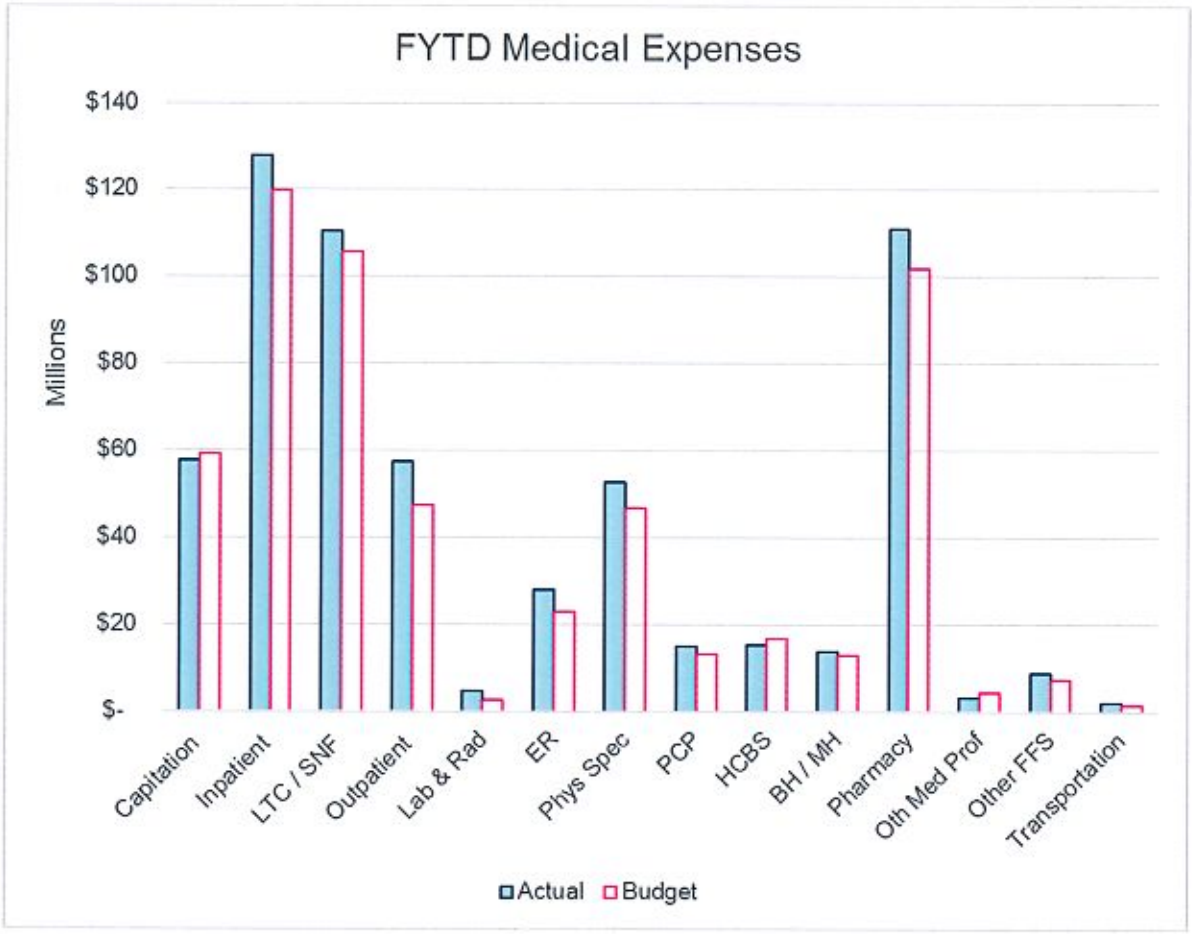
- There was a net gain of $1.6 million for the month of May 2018. For the eleven month period ended May 31, 2018, the Plan's performance is an increase in net assets of $1.5 million, which is $371 thousand below budget.
- May FYTD net revenue is $659.2 million, $32.9 million higher than budget.
- Cost of health care is $617.0 million, $37.1 million higher than budget.
- The medical loss ratio is 93.6%, which is 1.0 percent higher than the budget.
- The administrative cost ratio is 6.8%, 0.5 percent lower than budget.
- May membership of 201,822 was 1,124 members lower than budget and 559 lower than April's membership of 202,381.
- Tangible Net Equity is $143.8 million, which represents just over two months of operating expenses in reserve and 458% of the required amount by the state.

Revenue – May FYTD net revenue was $659.2 million or $32.9 million higher than budget. Revenue for the month of May contained three significant unusual items. Approximately $9.0 million of revenue was recouped by the state through a multi-year retroactive reclassification of Adult Expansion (AE) members as Dual Seniors and Persons with Disabilities (SPD), which carry a lower rate. However, the reduction in AE revenue and other factors made it possible for the Plan to release approximately $20.5 million of the

revenue reserve associated with the 85% Medical Loss Ratio (MLR) requirement. May results also include a revenue reserve of approximately $3.8 million as a result of the state's recent announcement that fiscal year 2016-17 would also be subject to the 85% MLR requirement. Membership mix in May contributed a $1.4 million revenue increase through higher than expected AE and 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 fourth quarterly installment of MCO tax was paid on July 2. The MCO tax remains unfunded.

Health Care Costs – May FYTD health care costs were $617.0 million, which is $37.1 million higher than budget. The medical loss ratio was 93.6 percent versus 92.6 percent for budget. May's health care costs and MLR were $61.1 million and 92.2 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:

- Inpatient exceeded budget by $8.1 million (6.8%). The variance is largely the result of contract rate increases. May's Inpatient costs also contain high-dollar claims roughly double the typical amount, adding approximately $3.0 million to the monthly variance.
- Outpatient was over budget by $10.0 million or 21.2%. Unit cost increased by 24.5% over the comparable period last fiscal year, while utilization increased only 1.5%
- Lab and Radiology exceeded the budget by $2.0 million (78.2%). However, May's costs, at $297 thousand, were approximately 29% lower than the recent trend.
- Emergency Room exceeded the budget by $5.0 million (21.8%) as a result of contract rate increases. Paid-per-utilization was 28.6% above the same period last year, while utilization increased 0.2%.
- Physician Specialty exceeded budget by 5.7 million (12.3%). The high dollar-volume diagnoses are diseases of the circulatory system, musculoskeletal system, nervous system, complications of pregnancy and neoplasms. These five categories comprise nearly 50% of total specialty services.
- Primary Care Physician exceed budget by $1.8 million (13.3%). The heaviest utilization and expenditures occurred in standard office visits, consultation and standard diagnostics.
- Home and Community Based Services was lower than budget by $1.6 million (9.4%). The largest component, CBAS, experienced flat utilization, but this was accompanied by minor rate decreases as compared to the same 11 months of the prior year. Hospice has maintained steady utilization during the current fiscal year, but is about 20% below the level experienced in the prior year.
- Pharmacy exceeded budget by $9.2 million (9.0%). Utilization is 8.1% more than the comparable prior period. May's cost per prescription was only 0.9% more than the average during the prior year.
- Other Medical Professional was under budget by $1.2 million (26.7%). A large portion of this category is related to eye care, audiology 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 $1.5 million (21.2%) due to a slow but steady increase in volume. The largest expenditures in this category are medical supplies, DME and hearing devices.

Adult Expansion Population 85% Medical Loss Ratio – The Balance Sheet contains a $124.1 million reserve for return of potential Medi-Cal capitation revenue to the DHCS under the terms of the MLR contract language. As previously mentioned, the balance of the reserve was reduced due to AE member reclassification, retroactive to the inception of the AE population, and related analysis of the MLR report submitted to DHCS.

Administrative Expenses – For the eleven months ended May 31, administrative costs were $44.9 million or $598 thousand below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 6.8 percent versus 7.3 percent for budget.

Cash and Medi-Cal Receivable – At May 31, the Plan had $356.0 million in cash and short-term investments and $63.3 million in Medi-Cal Receivables. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $126.3 million.

Investment Portfolio – At May 31, 2018, the value of the investments (all short term) was $196.5 million. The portfolio included Cal Trust $51.6 million; Ventura County Investment Pool $60.6 million; LAIF CA State $64.3 million; commercial paper $20.0 million; the portfolio yielded a rate of 1.70%.

RECOMMENDATION:

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

CONCURRENCE:

N/A

ATTACHMENT:

May 2018 Financial Package

Gold Coast Health Plan℠
A Public Entity

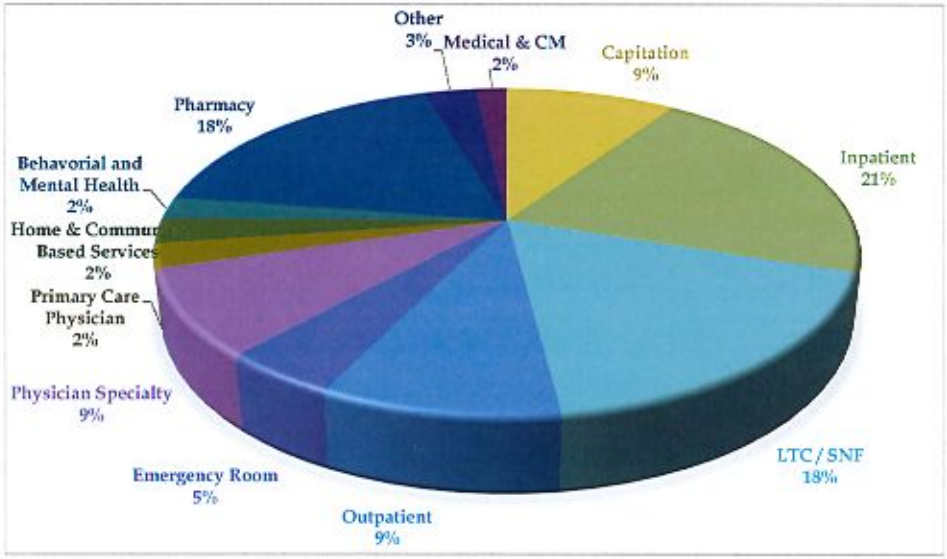
FINANCIAL PACKAGE
For the month ended May 2018

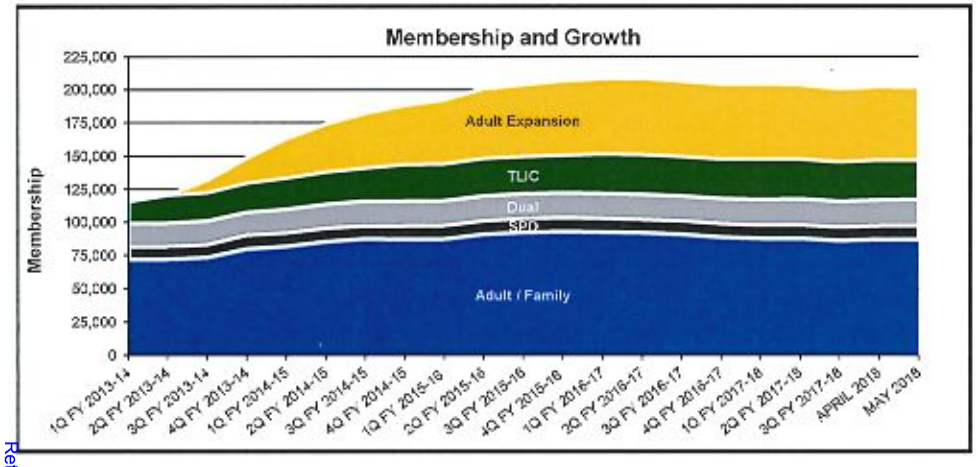
TABLE OF CONTENTS

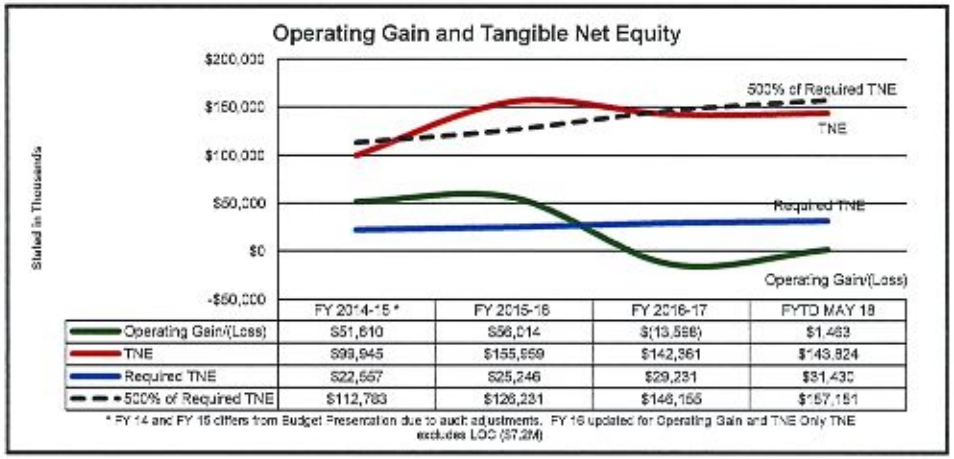
Gold Coast Health Plan

Executive Dashboard as of May 31, 2018

	FY 17/18 Budget	FY 17/18 FYTD	FY 16/17 Actual	FY 15/16 Actual
Average Enrollment	224,439	202,973	207,100	201,095
Revenue	$ 279.08	$ 295.26	$ 273.72	$ 279.98
Capitation	$ 26.38	$ 25.83	$ 26.22	$ 42.27
Inpatient	$ 53.38	$ 57.28	$ 53.44	$ 46.58
LTC / SNF	$ 47.07	$ 49.44	$ 47.86	$ 43.72
Outpatient	$ 21.08	$ 25.68	$ 23.17	$ 18.29
Emergency Room	$ 10.20	$ 12.49	$ 9.07	$ 8.23
Physician Specialty	$ 20.84	$ 23.51	$ 22.55	$ 19.35
Primary Care Physician	$ 5.91	$ 6.74	$ 6.45	$ 6.11
Home & Community Based Services	$ 7.47	$ 6.80	$ 7.33	$ 6.27
Behavorial and Mental Health	$ 5.70	$ 6.17	$ 4.57	$ (0.64)
Pharmacy	$ 45.38	$ 49.72	$ 47.76	$ 41.70
Other	$ 9.09	$ 7.94	$ 6.57	$ 3.26
Medical & CM	$ 5.84	$ 4.74	$ 4.92	$ 6.52
	$ 258.34	$ 276.33	$ 259.91	$ 241.66
% of Revenue	92.6%	93.6%	95.0%	86.3%
Total Administrative Expenses	$ 45,543,002	$ 44,945,274	$ 51,176,317	$ 38,256,908
% of Revenue	7.3%	6.8%	7.5%	5.7%
TNE	$ 144,194,540	$ 143,823,785	$ 142,360,951	$ 155,959,127
Required TNE	$ 28,699,641	$ 31,430,219	$ 29,231,052	$ 25,246,284
% of Required	502%	458%	487%	618%







	FY 2014-15 *	FY 2015-16	FY 2016-17	FYTD MAY 18
Operating Gain/(Loss)	$51,610	$56,014	$(13,588)	$1,483
TNE	$99,945	$155,959	$142,361	$143,824
Required TNE	$22,557	$25,246	$29,231	$31,430
500% of Required TNE	$112,783	$126,231	$146,155	$157,151

* 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)

STATEMENT OF FINANCIAL POSITION

	05/31/18	04/30/18
ASSETS		
Current Assets:		
Total Cash and Cash Equivalents	**$ 159,501,424**	**$ 171,002,203**
Total Short-Term Investments	**196,461,673**	**196,217,013**
Medi-Cal Receivable	63,299,720	95,054,432
Interest Receivable	650,537	589,676
Provider Receivable	374,073	443,928
Other Receivables	3,808,831	3,809,386
Total Accounts Receivable	**68,133,161**	**99,897,422**
Total Prepaid Accounts	1,410,209	1,458,171
Total Other Current Assets	135,560	135,560
Total Current Assets	**425,642,027**	**468,710,370**
Total Fixed Assets	**1,934,973**	**1,978,733**
Total Assets	**$ 427,577,000**	**$ 470,689,103**
LIABILITIES & NET ASSETS		
Current Liabilities:		
Incurred But Not Reported	$ 47,553,203	$ 48,795,918
Claims Payable	23,478,293	19,659,066
Capitation Payable	57,554,269	57,516,379
Physician Payable	5,263,839	4,185,159
AB 85 Payable	0	20,570,412
DHCS - Reserve for Capitation Recoup	124,143,559	140,843,559
Accounts Payable	1,969,200	4,617,876
Accrued ACS	1,709,703	1,701,053
Accrued Expenses	7,315,000	22,801,655
Accrued Premium Tax	12,826,917	5,381,576
Accrued Payroll Expense	926,901	1,393,012
Total Current Liabilities	**282,740,882**	**327,465,664**
Long-Term Liabilities:		
Other Long-term Liability-Deferred Rent	1,012,333	1,015,733
Total Long-Term Liabilities	**1,012,333**	**1,015,733**
Total Liabilities	**283,753,215**	**328,481,397**
Net Assets:		
Beginning Net Assets	142,360,951	142,360,951
Total Increase / (Decrease in Unrestricted Net Assets)	1,462,834	(153,246)
Total Net Assets	**143,823,785**	**142,207,706**
Total Liabilities & Net Assets	**$ 427,577,000**	**$ 470,689,103**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR ELEVEN MONTHS ENDED MAY 31, 2018

	May 2018 Actual	May 2018 Year-To-Date Actual	May 2018 Year-To-Date Budget	Variance Fav / (Unfav)	Variance %	May 2018 Year-To-Date PMPM - FYTD Actual	PMPM - FYTD Budget	Variance Fav / (Unfav)
Membership (includes retro members)	201,822	2,232,699	2,244,393	(11,694)	-0.52%			
Revenue								
Premium	$ 57,015,118	$ 770,054,943	$ 712,690,244	$ 57,364,700	8.05%	$ 344.90	$ 317.54	$ 27.36
Facility Expense AB85	0	(34,885,333)	0	$ (34,885,333)	0.00%	(15.62)	-	$ (15.62)
Reserve for Rate Reduction	16,700,000	7,126,387	0	7,126,387	0.00%	3.19	-	3.19
MCO Premium Tax	(7,445,341)	(83,075,145)	(86,325,390)	3,250,245	-3.77%	(37.21)	(38.46)	1.25
Total Net Premium	**66,269,777**	**659,220,853**	**626,364,853**	**32,856,000**	**5.25%**	**295.26**	**279.08**	**16.18**
Total Revenue	**66,269,777**	**659,220,853**	**626,364,853**	**32,856,000**	**5.25%**	**295.26**	**279.08**	**16.18**
Medical Expenses:								
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,257,985	57,677,737	59,216,594	1,538,856	2.60%	25.83	26.38	0.55
FFS Claims Expenses:								
Inpatient	13,589,006	127,879,068	119,796,616	(8,082,452)	-6.75%	57.28	53.38	(3.90)
LTC / SNF	11,293,344	110,393,328	105,648,229	(4,745,100)	-4.49%	49.44	47.07	(2.37)
Outpatient	5,726,907	57,326,167	47,302,539	(10,023,627)	-21.19%	25.68	21.08	(4.60)
Laboratory and Radiology	296,530	4,467,758	2,507,050	(1,960,708)	-78.21%	2.00	1.12	(0.88)
Emergency Room	2,501,820	27,877,242	22,894,487	(4,982,755)	-21.76%	12.49	10.20	(2.29)
Physician Specialty	5,520,697	52,495,691	46,767,998	(5,727,693)	-12.25%	23.51	20.84	(2.67)
Primary Care Physician	1,498,743	15,037,468	13,270,247	(1,767,221)	-13.32%	6.74	5.91	(0.82)
Home & Community Based Services	1,404,775	15,190,960	16,767,516	1,576,555	9.40%	6.80	7.47	0.67
Applied Behavior Analysis Services	903,789	7,918,378	4,279,097	(3,639,282)	-85.05%	3.55	1.91	(1.64)
Mental Health Services	520,149	5,858,663	6,521,443	2,662,780	31.25%	2.62	3.80	1.17
Pharmacy	10,555,464	111,000,046	101,845,031	(9,154,015)	-8.99%	49.72	45.38	(4.34)
Other Medical Professional	302,726	3,212,119	4,383,470	1,171,352	26.72%	1.44	1.95	0.51
Other Medical Care	3,519	29,578	0	(29,578)	0.00%	0.01	-	(0.01)
Other Fee For Service	752,503	8,802,779	7,261,024	(1,541,754)	-21.23%	3.94	3.24	(0.71)
Transportation	149,657	2,047,025	1,336,254	(710,770)	-53.19%	0.92	0.60	(0.32)
Total Claims	55,019,630	549,536,271	502,582,002	(46,954,269)	-9.34%	246.13	223.93	(22.20)
Medical & Care Management Expense	1,091,674	10,587,971	13,109,599	2,521,628	19.23%	4.74	5.84	1.10
Reinsurance	77,153	1,719,887	4,915,221	3,195,354	65.01%	0.77	2.19	1.42
Claims Recoveries	(370,190)	(2,548,966)	0	2,548,966		(1.14)	-	1.14
Sub-total	798,636	9,758,872	18,024,820	8,265,948	45.86%	4.37	8.03	3.66
Total Cost of Health Care	**61,076,250**	**616,972,880**	**579,823,416**	**(37,149,464)**	**-6.41%**	**276.33**	**258.34**	**(17.99)**
Contribution Margin	**5,193,527**	**42,247,973**	**46,541,438**	**(4,293,465)**	**-9.23%**	**18.92**	**20.74**	**(1.81)**
General & Administrative Expenses:								
Salaries, Wages & Employee Benefits	2,053,052	21,033,706	21,939,949	906,243	4.13%	9.42	9.78	0.35
Training, Conference & Travel	25,072	227,941	548,543	320,602	58.45%	0.10	0.24	0.14
Outside Services	2,205,671	24,100,484	25,278,337	1,177,853	4.66%	10.79	11.26	0.47
Professional Services	301,934	3,409,049	3,177,076	(231,973)	-7.30%	1.53	1.42	(0.11)
Occupancy, Supplies, Insurance & Others	536,318	6,438,810	7,708,696	1,269,886	16.47%	2.88	3.43	0.55
ARCH/Community Grants	0	323,254	0	(323,254)	0.00%	0.14	-	(0.14)
Care Management Credit	(1,091,674)	(10,587,971)	(13,109,599)	(2,521,628)	19.23%	(4.74)	(5.84)	(1.10)
Total G & A Expenses	**4,130,373**	**44,945,274**	**45,543,002**	**597,728**	**1.31%**	**20.13**	**20.29**	**0.16**
Total Operating Gain / (Loss)	**$ 1,063,154**	**$ (2,697,301)**	**$ 998,436**	**$ (3,695,737)**	**-370.15%**	**$ (1.21)**	**$ 0.44**	**$ (1.65)**
Non Operating								
Revenues - Interest	552,925	4,160,134	835,153	3,324,981	398.13%	1.86	0.37	1.49
Total Non-Operating	552,925	4,160,134	835,153	3,324,981	398.13%	1.86	0.37	1.49
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 1,616,080**	**$ 1,462,834**	**$ 1,833,589**	**$ (370,755)**	**-20.22%**	**0.66**	**0.82**	**(0.16)**

Return to Agenda
135 of 152 pages

STATEMENT OF CASH FLOWS	FYTD 17-18
Cash Flows Provided By Operating Activities	
Net Income (Loss)	$ 1,462,834
Adjustments to reconciled net income to net cash provided by operating activities	
Depreciation on fixed assets	487,728
Amortization of discounts and premium	(319,538)
Changes in Operating Assets and Liabilites	-
Accounts Receivable	59,571,229
Prepaid Expenses	2,088,788
Accounts Payable	(158,784,590)
Claims Payable	6,100,303
MCO Tax liablity	(6,348,808)
IBNR	(5,813,144)
Net Cash Provided by (Used in) Operating Activities	(101,555,199)
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	(121,684,466)
Purchase of Property and Equipment	(80,635)
Net Cash (Used In) Provided by Investing Activities	83,234,899
Cash Flow Provided By Financing Activities	
None	-
Net Cash Used In Financing Activities	-
Increase/(Decrease) in Cash and Cash Equivalents	(18,320,300)
Cash and Cash Equivalents, Beginning of Period	177,821,723
Cash and Cash Equivalents, End of Period	$ 159,501,424

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 8

To: Ventura County Medi-Cal Managed Care Commission

From: Ruth Watson, Chief Operating Officer

Date: July 23, 2018

RE: Americas Health Plan (AHP) Update

SUMMARY:

Ruth Watson, Chief Operating Officer and Margaret Tatar, Managing Principal, Health Management Associates will give a verbal presentation to the Commission.

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

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 9

To: Ventura County Medi-Cal Managed Care Commission

From: Melissa Scrymgeour, Chief Administrative Officer

Date: July 23, 2018

RE: Chief Administrative Officer (CAO) Report

SUMMARY:

Melissa Scrymgeour, Chief Administrative Officer will give a verbal presentation to the Commission.

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Interim Chief Diversity Officer

DATE: July 23, 2018

SUBJECT: Interim Chief Diversity Officer Update

Actions:

Community Relations

- Continued my community outreach efforts with meetings with one of the recent LULAC appointees, Mr. Rick Castaniero. Discussion centered on creating a working relationship to solve problems versus the current adversarial relationship.
- Held Lunch and Learn seminar on **"Generation Impact"** to organization.
- Continue to attend management meetings to answer any questions centered on Diversity and Inclusion.
- Completed primary responsibility listing with Diversity and Inclusion Council.
- Reviewed Council's direction and involvement with executive team.
- Bi-weekly update meeting with Dale Vallini.
- Visited CSUCI nursing program with GCHP's nursing leadership team.
- Currently serving on two (2) community boards at CSUCI and the Gold Coast Veterans Foundation.

Developed Competency Model for Diversity

- In review with Diversity Council before implementation.
- Developing foundational workbook to effectively hand off to next CDO.

Case Investigations

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

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: July 23, 2018

SUBJECT: Chief Operating Officer (COO) Update

Executive Summary

ASO Transformation Project – GCHP and Conduent continue to work through the first three phases (initiation, planning and execution) of the implementation. Conduent was on site July 10-13 2018 during which time we completed several key documents and established high level tasks in the project plan. Our first governance meeting will be held at GCHP on August 9, 2018 at which time we will present our documents to the governance committee. GCHP has participated in several introductory meeting with Conduent and VBA where VBA is gathering information on the current system set up as part of requirements gathering.

Operations Dashboard

Membership

Membership continues to remain below 200,000 for July 2018. January's enrollment was 197,609. July is 1854 members lower. Adult Expansion also remains flat between January (52,745 members) and July (52,383 members). Retroactivity for July shows a gain of 1,985 member for 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- July 2018	
	Volume
Membership:	
Total	**195,755**
July Loss	**-6,216**
July Add	**3,192**
July Retroactivity	**1,985**
Gain/Loss (net)	**-1,039**
AB-85: (new)	
VCMC	**398**
Remaining Providers	**397**
VCMC Target	**65,765**
VCMC % of Target	**42.20%**

AB 85 Auto Assignment- GCHP assigned 398 new members to VCMC, while the remaining 397 new members were assigned to providers in compliance with the VCMMCC Auto Assignment policy (MS-005) for July. VCMC has 27,753 Adult Expansion (AE) members assigned as of July 1, 2018. VCMC's target enrollment, as established by DHCS, is 65,765 and is currently at 42.20% 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- June 2018 Total Encounters Submitted: 388,691		
Encounter Type	**Errors**	**% of Errors**
Professional	2,845	2.0%
Institutional	568	0.6%
Pharmacy	613	0.4%
Total	**4,026**	**1.0%**

- **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. June claim submission is lower than May by 6,754, a significant drop in claims for June. We expect that claim counts will increase towards the end of the summer which is a typical claim cycle. The average daily receipt in June was 9,924 which is slightly higher than May.

Operations Dashboard Monthly Claims Volumes- March - June 2018				
		Month		
	June	May	April	March
Total	**208,412**	215,166	217,183	215,953
Daily Average Receipt	**9924**	9,780	9,529	9,816
Days Receipt on Hand	**6**	4	3.79	3.12

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- March - June 2018					
	Benchmark		Month		
		June	May	April	March
Turn Around Time	90.00%	91.92%	99.08%	97.70%	95.62%
Financial Accuracy	98.00%	99.16%	99.30%	99.00%	99.74%
Procedural Accuracy	97.00%	99.25%	99.91%	99.00%	99.99%

Call Center

Call Center metrics continue to demonstrate fluidity due to call volumes and talk times remaining high. Particularly, talk times for both provider and member calls remain in the 9 to 10 minute time frame. Typically, member calls have less talk times than provider calls. Conduent and GCHP actively address opportunities to reduce talk times, increase consistency with staffing and look to innovate the workflows.
Conduent is measured on call center performance by three industry-standard metrics (Service Level Agreements (SLAs)). Conduent has struggled with Average Speed to Answer throughout the past several months, however was under the SLA for average Speed to Answer for June.

Operations Dashboard Call Volume- March-June 2018				
	June	May	April	March
Call Volume (# of calls)	**11,916**	12,183	12,455	12,719

Operations Dashboard Key Performance Metrics- March - June 2018					
	Benchmark	June	May	April	March
Avg. Speed To Answer	30 Seconds	**20.4**	90.6	22	40.8*
Abandonment Rate	5.00%	**1.02%**	4.73%	1.05%	2.13%
Call Quality Scores	95.00%	**97.24%**	96.7%	97.56%	96.73%
**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).

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

Operations Dashboard
Monthly Volumes- March - May 2018

	May	April	March
G&A Volume:			
Clinical	**9**	20	11
Upheld	**4**	10	4
Overturned	**5**	9	5
Withdrawn	**0**	1	2
Provider	**147**	108	121
Member	**27**	34	29
Grievances/ 1,000	**0.14**	0.17	0.15
Quality of Care (reasons)	**16**	20	17
State Fair Hearings	**0**	1	0
Denied		1	
Dismissed		0	
Withdrawn		0	

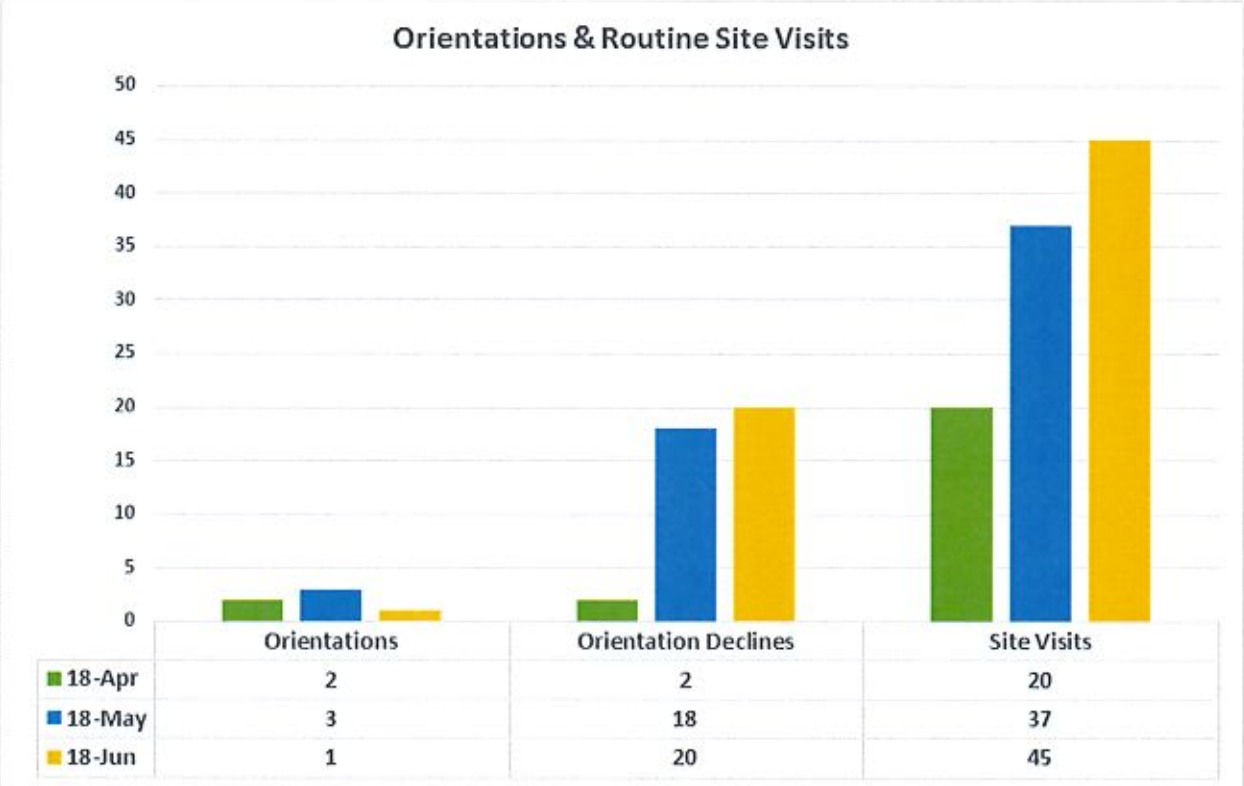
Operations Dashboard
Monthly Volumes by Issue Type– March - May 2018

Grievance (Issue Type):	May	Apr	Mar
Accessibility	**3**	**3**	4
Benefits/Coverage	**1**	**1**	1
Billings	**3**	**4**	4
Denial/Refusals	**1**	**1**	1
Quality of Care	**16**	**20**	17
Quality of Service	**2**	**5**	2
Referral	**1**	**0**	0

Operations Dashboard Key Performance Metrics February - April 2018				
	Benchmark	**May**	April	March
Grievance Acknowledgement	100.00%	**85%**	97%	91.00%
Appeal Acknowledgement	100.00%	**98%**	100%	100.00%
Grievance Resolution	100.00%	**89%**	95%	100.00%
Appeal Resolution	100.00%	**100%**	100%	100.00%

PROVIDER NETWORK OPERATION REPORT

1. Provider Orientations and Routine Site Visits



- Orientations: 6 new provider orientations were conducted by GCHP Provider Relations Staff over the last 3 months. This figure has remained constant over the last two reporting periods.

- 40 Physicians declined orientation during this reporting period due to their joining an established contracted group with GCHP. This was a significant increase from the previous reporting period with the increase exclusively associated with large Radiology Medical Groups, who have historically declined orientation as they are familiar with GCHP policies and procedures and have the staff and capability to perform the orientation function on their own.

- Site Visits: 102 provider site visits were completed by Network Operations- Provider Relations staff. This represents a 53% increase in provider site visits compared to the previous reporting period. The goal for the Provider Relations team is to complete 20 site visits per Provider Relations Specialists per month. A total of 40 visits per month. This figure was exceeded for the month of June 2018 as the Provider relations Team is now at full staffing levels and reprioritization of tasks.

2. PROVIDER ADDS AND TERMINATIONS JUNE 2018

ADDITIONS:

- 40 specialists added via Children's Hospital Medical Group
- 2 Mid-levels added via Moorpark Family Clinic and Adult and Pediatric Urgent Care

PROVIDER TYPE	# PROVIDER ADDS June 2018	TOTAL PROVIDER ADDS June2017-July 2018	TOTAL NETWORK PROVIDERS
Hospital	**0**	**11**	**33**
-Acute Care	0	0	19
-LTAC	0	10	9
-Tertiary	0	1	5
Providers	**42**	**1,202**	**6,447**
-PCP's & Midlevels	2	62	443
-Specialists	40	1,090	5,663
-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	**4**	**89**	**377**

3. **TERMINATIONS:**

- 1 Midlevel and 5 specialist providers terminated from City of Hope Medical Foundation. All reasons for these terminations was that provider resigned from the group. No network access impact
- 2 Mid-levels and 10 pediatric sub-specialists terminated from Children's Hospital LA Medical Group. Providers terminated from group and no prior notice received. This is not unusual for large academic affiliated medical groups as providers (residents/fellows/visiting professors) train and subsequently move on when their training is complete if not offered an attending academic position with the group. No network access impact.
- The remaining 6 other provider terminations are as follows and have no significant impact on the network itself or member access.

  - 1 PT provider- No Network access impact
  - 4 VCMC providers: 2-PCP, 1- Pediatric Specialist, 1- Mid-level. No network access impact.
  - 1 Cardio-Thoracic Surgery Specialist, Out-of-County. No network access impact

PROVIDER TYPE	# PROVIDER TERMS June 2018	TOTAL PROVIDER TERMS July 2017- June 2018	COMMENTS
Hospital	**0**	**0**	---
-Acute Care	0	0	---
-LTAC	0	0	---
-Tertiary	0	0	---
Providers	**23**	**190**	---
-PCP's & Midlevels	5	52	No major impact
-Specialists	18	113	No major impact
-Hospitalists	0	25	No major impact
Ancillary	**1**	**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	2	No major impact
-Radiology/Imaging	0	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	**3**	**20**	---

4. CONTRACTING INITIATIVES

A. Enhanced Access:
- Finalized Agreement with new Congregate Living Home.
- Finalizing Agreement with 2 Urgent Care centers one located in Simi Valley, the other in Oxnard.
- Finalizing Agreement with subacute and specialty care for pediatric and adult traumatic brain injury rehabilitation, and patients with medically complex injuries and neuromuscular or congenital anomalies.

B. Provider Network:
- Contract renewal finalized with VCMC.
- Finalizing contract amendment and rate schedule with Dignity Health.
- In negotiations with Simi Valley hospital on contract renewal.
- Finalized Amendment to UCLA Agreement reflecting charge master adjustments.

C. Regulatory Initiatives:
- Network Operations received notification from DHCS that we passed all Network certification requirements.
- Prop-56 (Cigarette Tax Initiative) - outlined for providers the terms of this proposition, eligibility components and payment parameters. Payments sent out to providers and Vendors.
- Finalizing UCLA Credentialing Delegation Agreement.
- Completed State Medical Audit Survey and awaiting survey findings.
-

Completed Provider timely access and after-hours access surveys and awaiting final result

Gold Coast Health Plan
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: July 23, 2018

SUBJECT: Chief Medical Officer Update

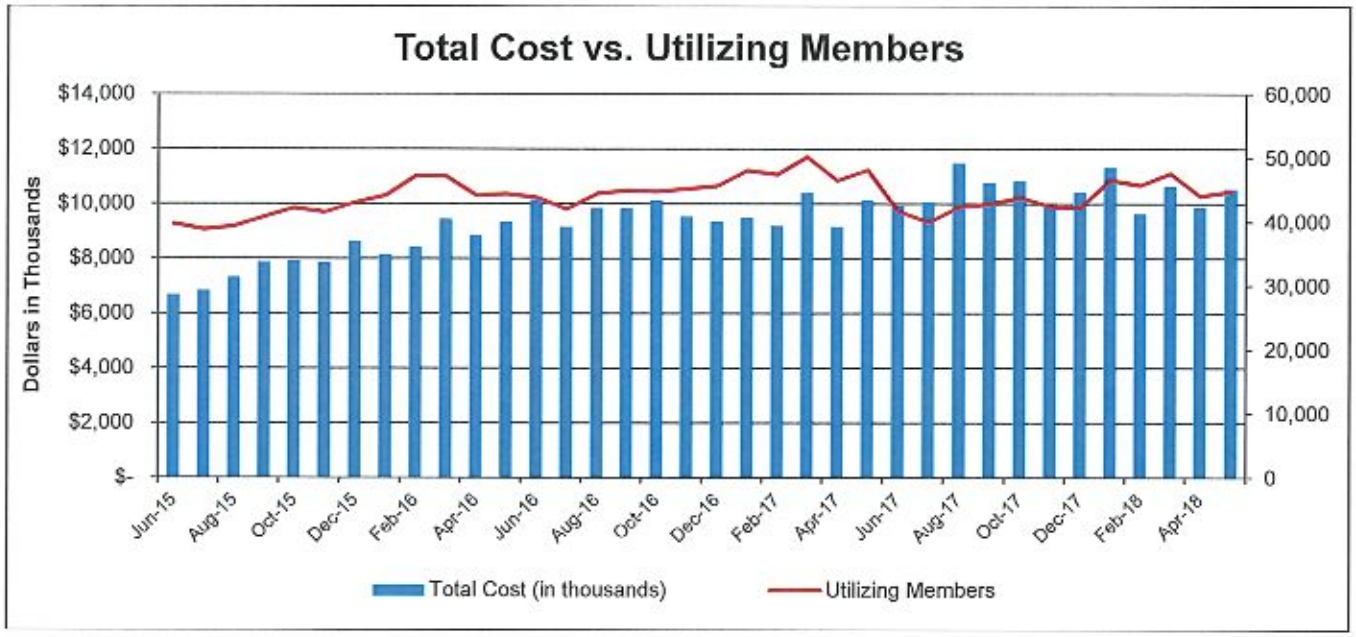
Pharmacy Benefit Performance and Trends

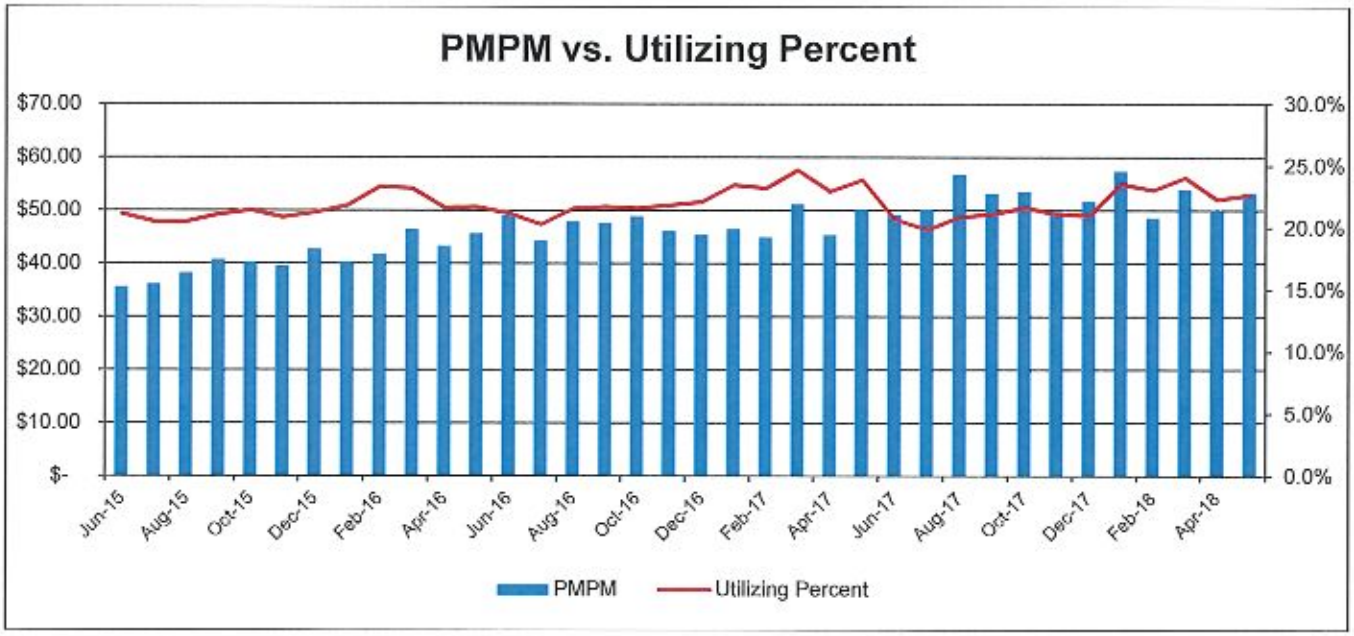
SUMMARY:

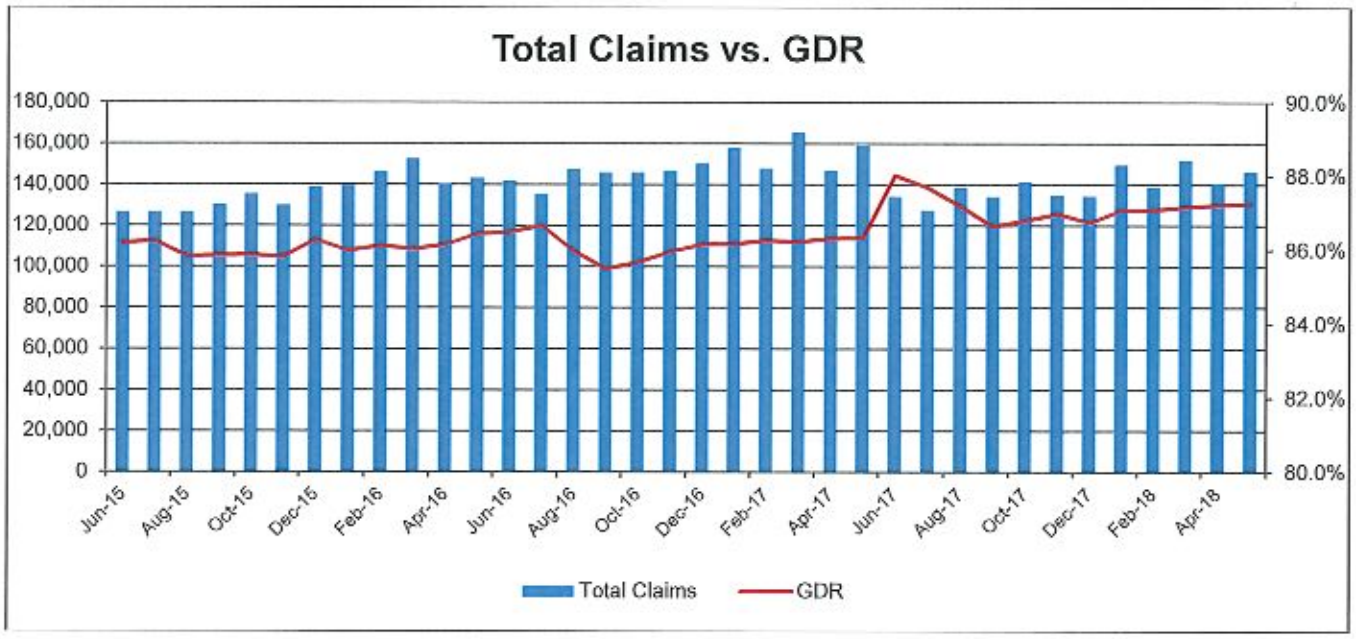
Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of May 2018. Although minor changes may occur to the data going forward due to the potential 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

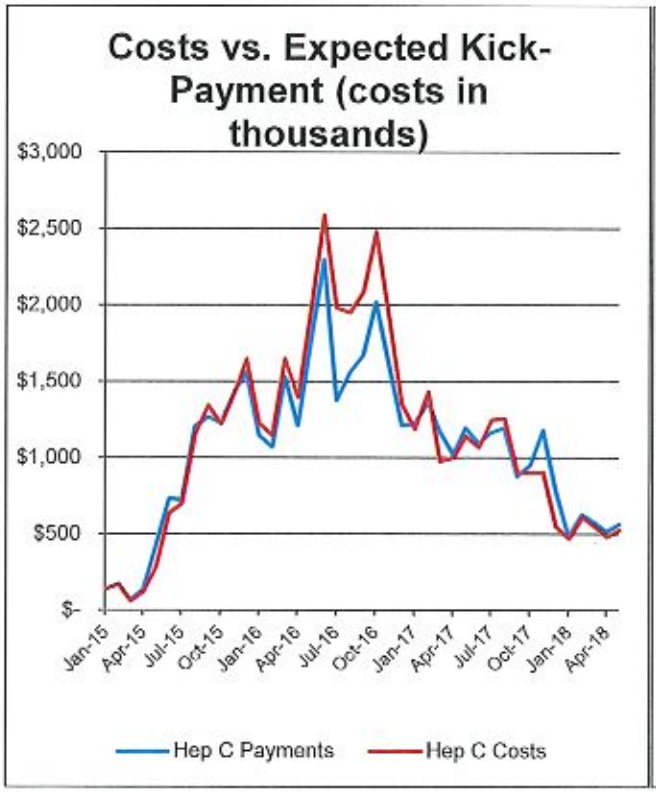
PHARMACY COST TRENDS:

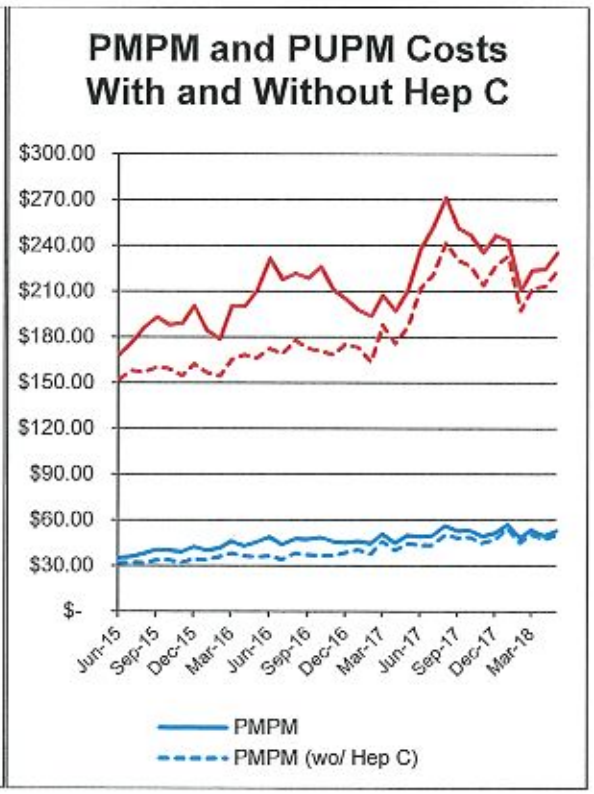




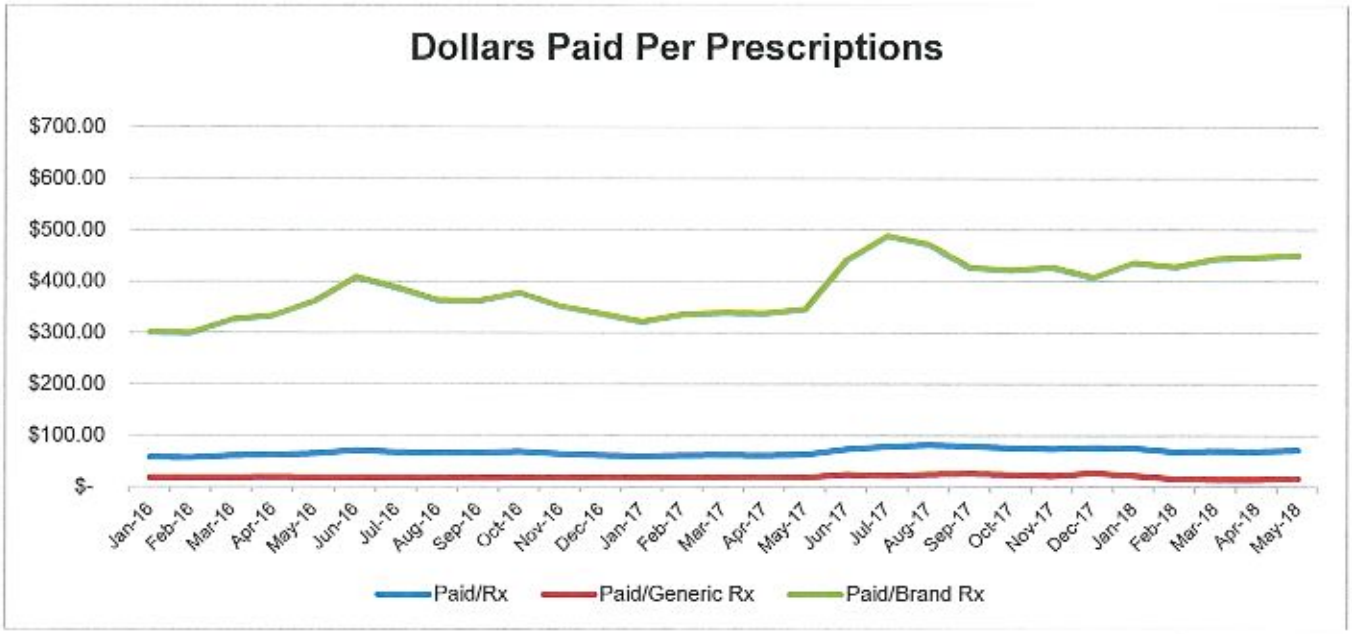


HEPATITIS C FOCUS:





PAID PER PERSCRIPTION:



PBM OVERSIGHT:

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

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

Number of Items	Items Open	Items Pending Closure	Items Closed
14	4	2	10

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

Number of Items	Items Open	Items Pending Closure	Items Closed
5	2	1	3