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

May 22, 2017 Regular Meeting Minutes

CALL TO ORDER

Commissioner Darren Lee called the meeting to order at 2:04 p.m. in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Lee led the Pledge of Allegiance.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Laura Espinosa, Peter Foy (arrived at 2:12 p.m.), Michele Laba, M.D., Darren Lee, Gagan Pawar, M.D., Catherine Rodriguez, and Jennifer Swenson.

Absent: None.

PROCLAMATIONS AND COMMENDATIONS

Dale Villani, Chief Executive Officer, introduced new employee, Jean Halsell, Human Resources Executive Director.

PUBLIC COMMENT

None.

PRESENTATIONS

Community Outreach and Engagement Presentation

The Commission unanimously agreed to move the presentation after the formal action items.

CONSENT CALENDAR

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of April 24, 2017

RECOMMENDATION: Approve the minutes.

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

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

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Foy.

Commissioner Lee declared the motion carried.

FORMAL ACTION ITEMS

2. March 2017 Year to Date Financials

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

Patricia Mowlavi, Chief Financial Officer, reported for the nine-month period ending March 31, 2017, there was a gain in net assets of $6.6 million, which was $9 million higher than budget due to the timing of the Alternative Resources for Community Health (ARCH) program. The Medical Loss Ratio (MLR) continues to grow at 92%, which is .7% under target and does not include all the contract changes made throughout the year. On page 18, the liquid reserve target was added to the cash and operating expense requirements graph. Staff is currently working on the 2017-2018 budget and it will be presented at the Executive/Finance Committee on June 8 and to the Commission on June 26. On page 24, the line item, Proceeds from Investments of $30 million, represents maturities of commercial paper. Proceeds were reinvested in similar issues in the subsequent month.

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

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

NOES: None.

ABSTAIN: None.

ABSENT: Commissioner Foy.

Commissioner Lee declared the motion carried.

Commissioner Foy arrived at 2:12 p.m.

3. Approval of Benefit Enhancement – Continuous Glucose Monitoring (ARCH)

RECOMMENDATION: Approve continuous glucose monitoring as a benefit for Gold Coast Health Plan members.

Nancy Wharfield, M.D., Associate Chief Medical Officer, stated Gold Coast Health Plan (Plan) is requesting continuous glucose monitoring (CGM) be allowed as a benefit for the Plan's members. CGM consists of a subcutaneously inserted sensor that measures interstitial glucose and delivers glucose values to a recording device. It is estimated there are less than 300 members who would be eligible for this benefit with an additional projected cost of $6,000 per year and the program would be reevaluated after one year.

A discussion followed between the Commissioners and staff regarding prior authorization would be required by the Plan's Health Services Department and medical necessity would be determined using MCG's Clinical Guidelines.

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

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

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

4. Approval of Benefit Enhancement – Panniculectomy (ARCH)

RECOMMENDATION: Approve panniculectomy as a benefit for Gold Coast Health Plan members.

Dr. Wharfield explained panniculectomy is the surgical removal of excess abdominal skin and fat associated with bariatric surgery without the tightening of underlying muscles or abdominoplasty. The estimated annual cost for this benefit enhancement would be approximately $32,000.

A discussion followed between the Commissioners and staff regarding the procedure being an outpatient surgery therefore it would automatically require prior authorization from the Plan's Health Services Department and the anticipated cost savings would be seen in a relatively short period.

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

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

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

5. Quality Improvement Committee 2017 First Quarter Report

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

C. Albert Reeves, M.D., Chief Medical Officer, gave an update on the Quality Improvement Committee's first quarter and stated staff is continuing to look for new measurement benchmarks.

Dr. Reeves reported the Performance Improvement Project (PIP) No. 1 is a childhood immunization program in conjunction with Las Islas Clinic and is currently in stage four: testing the proposed interventions, which are to identify members not fully immunized and reach out to the families to schedule appointments for the immunizations. As of February 2017, immunization rates were at 79.31%; 96.24% of calls resulted in an appointment, and 96.95% of the appointments kept. PIP No. 2 involves increasing the utilization of standardized Child Developmental Screening Tools Project and is in the interventions testing module.

The mandated Healthcare Effectiveness Data and Information Set (HEDIS) Improvement Projects continue but will be concluding soon as the Plan has reached the required 25th percentile for Well-Child Exams in the 3rd, 4th, 5th, and 6th years of life and for the Cervical Cancer Screening.

It was noted page 40 was inadvertently included in the staff report.

Eight interim facility sites were reviewed and all passed. A physical accessibility review survey was completed in 2016 on 112 sites in which all the sites passed. A review of the Initial Health Assessment completions resulted with a 68% pass rate and 32% fail rate primarily due to the failure of the Staying Health Assessments being completed.

A pay for performance program to improve the HEDIS rate for children ages 25 months to 19 years old has begun at the three largest provider groups. It will compare the 2015 HEDIS rates with the 2017 HEDIS rates and will conclude July 15, 2018, with the finalization of the 2017 HEDIS rates.

The Quality Improvement Committee approved the updated versions of the following policies: 1) medical records requirements; 2) communicable disease reporting requirements; and 3) provider preventable conditions reporting requirements.

Beacon Health Strategies continues to experience issues and the 10% administrative payment withholding remains in place. An on-site audit for Conduent was performed on February 8 and 9, but as they did not comply with the pre-audit claims pull request, the audit could not be completed. Vision Service Plan was found to be out of compliance in several areas and a notice has been given with a follow-up audit to be performed. Credentialing audits were completed on Clinicas Del Camino Real, Community Memorial Hospital, and Ventura County Medical Center in January 2017 with all three passing the audit.

Three new drugs were reviewed resulting in the approval of one to be added to the formulary as it provided significant clinical advantages. Due to the Department of Health Care Services' (DHCS) requirements, certain IV solutions including ones used for intravenous nutrition were added to the formulary. Additionally, the DHCS required the removal of the prior authorization requirements on eight drugs, which the Committee agreed the Plan should appeal these requirement removals to the DHCS.

The Credentials/Peer Review reported 14 new providers were approved, 86 providers were recredentialed, four facilities were credentialed, and one facility was recredentialed. The Medical Board of California monitoring of the three providers on probation remains unchanged. There were no highly rated Practice Quality Improvements (PQI) reported. One case was reviewed involving a member injury at a contracted hospital resulting in the removal of a piece of defective equipment and there was one significant surgical complication, which was sent to two outside reviewers from different specialties resulting in different conclusions. Staff is currently waiting for a response from the surgeon.

The goal was met for providing sign language services for members. There were 38 outreach events where 2,888 participants were contacted.

Total grievances received were 495 compared to 298 grievances received in 2015. The top three administrative grievances were claims billing disputes (311), claim payments (75), and post service retro authorizations (24). The top three clinical grievances were quality of care (16), quality of services (2), and accessibility (2). Twenty-one clinical appeal cases were heard resulting in seven cases being upheld, six cases overturned, seven cases pending, and one case withdrawn. There were two State fair hearing cases resulting in one case being denied and one case was withdrawn. The Quality Workgroup reviewed all the cases in which one case was referred for Practice Quality Improvement (PQI). It was noted Dr. Wharfield reviews all of the clinical grievances and examines each of the cases for any serious omission in care. She stated the majority of the grievances are disagreements regarding the use of opiates.

Utilization measures for hospital admits, hospital days, emergency room visits, appeals, and denials remain at the same ranges and 99% of authorizations approved resulted in members being seen.

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

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

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

PRESENTATIONS

Community Outreach and Engagement Presentation

Lupe Gonzalez, Director of Health Education, Outreach, Cultural and Linguistic Services, recognized the community partners that have supported the Plan's efforts in increasing awareness of the services provided by Gold Coast Health Plan as well as available resources. The community partners were introduced to the Commission and received certificates of recognition, which included the following agencies: Ventura County Health Care Agency, Ventura Public Health: Child Health and Disability Prevention Program, Clinicas del Camino Real, Inc., FOOD Share, Inc., Community Action of Ventura County, MICOP, Oxnard Unified School District, Dignity Health Central Coast, and Tri-County GLAD. A copy of the presentation is on file.

REPORTS

6. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

Mr. Villani stated the CEO update includes a summary of compliance and the political environment, which staff is closely monitoring. Two community outreach events were highlighted: the May 5th Opioid Policy Summit which had over 200 attendees with two national presenters (Dr. R. Corey Waller and Dr. Kelly Pfeifer); and the Annual Community Resource Fair in Oxnard which served over 300 families with 40 agencies represented. Through the Community Health Investments grant-making program, the Plan received 23 request for applications, which are being reviewed by a committee made of internal staff from multiple departments. The grant award recommendations will be presented at the June Commission meeting. The estimated award amount is approximately $1.5 million.

Thirteen MegaRule deliverables were received and returned to the Centers for Medicare and Medicaid Services. The annual onsite Medical Audit will begin June 5 through June 16. On May 10, 2017, Mr. Villani spoke with Sarah Brooks, Jacey Cooper, and Javier Portela from the Department of Health Care Services (DHCS) regarding a pilot program versus a plan-to-plan contract and that the same rules and requirements apply to both programs. The DHCS reiterated that any previous contracts entered into are invalid contracts and recommended the use of a Request of Proposal instead of a sole source contract as it would provide protection from potential lawsuits to both the Plan and DHCS.

Scott Campbell, General Counsel, stated Commissioners Alatorre and Pawar would be recusing themselves at this time for the plan-to-plan contract discussion due to the potential of this matter resulting in a contract with a subsidiary of Clinicas del Camino Real and discussion under 1090 of the broad rules of engagement that Commissioners can be involved.

A discussion followed between the Commissioners and staff regarding three-party contracts being invalid if only two of the parties have signed it and clarification was made that in Ventura County any previous contracts that were drafted between the Plan and any other party are invalid as the contracts were never approved by the DHCS. Mr. Campbell stated in January the Commissioners had been provided the correspondence from DHCS stating the previous contract entered into by the Plan and American Health Plan is not valid as one of the conditions was the State had to approve the contract.

Dr. Enrique de la Garza, a representative from America's Health Plan, expressed concern regarding the plan-to-plan contract not being recognized as valid.

Mr. Villani stated the Plan cannot go against the direction given by the State. He suggested working with the prior documents as a foundation to create a new boilerplate and to bring it to the Commission for approval, as a plan-to-plan contract needs to bring value to the community. Mr. Villani proposed contracting with Margaret Tatar from Health Management Associates (HMA) to provide a feasibility study to create the new boilerplate and to navigate the RFP rules that may or may not be in place. HMA's proposal would be presented at the June meeting so staff may receive direction from the Commission.

Commissioner Atin inquired whether the authorities explicitly stated that the sole source would not be legal in this context. Mr. Villani stated they did not explicitly state this and read the information received: "Other local counties do RFPs. For your own legal protection, you should consider doing a RFP and you should abide by your County code." Commissioner Atin expressed doubt, as the State is not the Plan's Counsel and stated they do not know the history and background of this matter, and requested an analysis on whether the Plan can legally do a sole source.

Dr. Garza spoke in favor of the plan-to-plan contract and expressed concern about having to go through a feasibility process.

Commissioners Alatorre and Pawar returned to the meeting at 3:16 p.m.

A discussion followed between the Commissioners and staff regarding why the Commission cannot give direction to move forward on this matter, as it is not listed on the agenda. Mr. Campbell stated the discussion at the last meeting was the Plan would ask the State about the procedures going forward and whether a RFP was needed, which information was provided to the Commission today. Additionally, staff had indicated it would then provide an analysis and update at the June meeting.

Commissioner Atin requested for the June meeting an item be placed on the agenda as an Action Item in regards to the RFP option and if a sole source option can be done legally and a summary of all of the Commission's actions on plan-to-plan contracts.

7. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

Ruth Watson, COO, stated membership is at 201,514 and reflects a net loss of 905 members from April 2017 through May 2017 mostly due to the lack of re-determination from the prior year and members being terminated as they no longer meet the qualifications. Claims processing turnaround time and accuracy results exceeded standards. However, the volume of claims has increased negatively affecting the turnaround time. This is due to the start of the long-term care rates resulting in the processing of 4,000 new claims, which required significant manual processing as well as a loss of staff. Additional information was added to the Provider Network section of the agenda report to illustrate why the Plan signed with UCLA group as it relates to the California Children's Services population and the continuity of care. Grievances and Appeals increased slightly to .09 percent compared to other County Organized Health Systems' survey results of percentages between .04 and 1.1. The increase from .07 to .09 percent per thousand members was due to four grievances cases being added. The turnaround time for grievance acknowledgement was non-compliant at 67% due to misrouted correspondence and new procedures and training are being implemented.

A discussion followed between the Commissioners and staff regarding the benchmark for claims denial being around 15% for the industry though the State has not set one. Ms. Watson stated staff would prepare a report for the reasons why claims are denied based on the reason codes. Clarification was made on the definition of tertiary facilities as being facilities that provide specialized consultative health care, after a referral from primary and secondary care personnel, by specialists working in a center that has the personnel and facilities for specialized treatment. Ms. Watson stated Utilization Management could generate a report to show each hospital's utilization.

Commissioner Foy expressed concern about the legality of the conversation. Mr. Campbell stated the discussion was not in conflict as the discussion is on whether there are facilities located in Ventura County that can provide services for the benefit of the members and the reasons why would the members need to go out of area.

Ms. Watson stated the rollout for value-based program has begun. A new ruling came from the Administrative Law Review relative to the Health Plan of San Mateo's pay for performance program and how some of the Federally Qualified Health Centers (FQHC) were funded. It was noted it is very challenging to incentivize an entity when they are already being compensated for in either a contract or capitated service. Staff has analyzed the value-based programs based on this ruling to ensure there are clear starting points and goals. The first program to be implemented in June is the Transition of Care program with the Network Enhancement, After Hours Access, and Opioid Reduction programs scheduled for July 2017.

Commissioner Alatorre requested staff to provide information on the number of new Adult Expansion members who selected a Primary Care Physician from January 1 to date and to bring the All Plan Letter to the next Commission meeting as it contains the definition of "new".

8. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

Dr. Wharfield stated there is new information contained in the report on Seniors and Persons with Disabilities (SPD) Utilization, which reflects a different utilization pattern from the other categories. It was noted the benchmarks are good and one likely factor is the Plan's SPD population is young compared to the overall DHCS SPD population.

Anne Freese, PharmD, Director of Pharmacy, reviewed the pharmacy utilization information including a slight increase in costs in January and March 2017 due to the month of February having 28 days and the beginning of the allergy session. Hepatitis C continues to be a major driver of pharmacy costs though there has been a decrease since May 2016. Adjustments have been made to the formulary for the treatment of Hepatitis C in order to offset the reduction in the kick-payment amount received from DHCS. Pharmacy costs related to diabetic members continues to be more than double the costs related to non-diabetic members and the Per Member Per Month (PMPM) for diabetic members is more than five times that of non-diabetic members. Approximately 40% of all drug costs for diabetic members is in the age group of 50 to 59 and as these members mature into the 65+ age category, costs will shift to Medicare. It was noted the Pharmacy Benefits Manager (PBM) contract with OptumRx starts June 1, 2017.

The Commission unanimously agreed to hear Agenda Item No. 10 – Chief Information & Strategy Officer Update.

10. Chief Information & Strategy Officer (CISO) Update

RECOMMENDATION: Accept and file the report.

Melissa Scrymgeour, Chief Information & Strategy Officer, gave an update on the project activity highlights including the implementation of the PBM on June 1; the completed implementation of the new HEDIS vendor Inovalon; and DHCS has accepted the Plan's Phase IV test file for the DHCS 274 Provider File Submission on May 10. Pending final approval from DHCS, the Plan will move into production fulfilling the requirement. Additionally, project work is in progress on business process improvements that introduce new technology and software to make the organization more efficient, which consists of budgeting and forecasting tools and a significant upgrade to the MedHOK Medical Management System, which will enhance functionally and a new care management user interface is expected to provide significant efficiencies in workflow and care management processes.

A discussion followed between the Commissioners and staff regarding patient-centered technology using member texting and the success of the disease management program with the diabetes pilot program and how it is being used to support the asthma disease management program. Staff is researching what other campaigns or areas member texting might be utilized, as the initial usage produced positive results. Currently, there is not a member portal available as it is not a Medi-Cal requirement, though staff has discussed evaluating the implementation of one as well as the reevaluation of the provider portal in order to meet probable regulatory requirements.

9. Chief Diversity Officer (CDO) Update

RECOMMENDATION: Accept and file the report.

Douglas Freeman, Chief Diversity Officer, presented a high-level overview of the Diversity and Inclusion Blueprint Framework including the three components: why this strategy, what is the strategy, and how the strategy will be implemented. The "why" component is fulfilled through inclusive leadership as it will build an environment where employees can reach their optimum performance level. The "what" consists of the three pillars: compliance, workforce/workplace, and members/community with the initial emphasis being on the compliance pillar. Examples of the "how" component include programs and policies like a code conduct policy, a diversity and inclusion mission statement, and diversity councils.

Commissioner Atin stated the framework is solid and priority should be placed first on ensuring compliance, then focusing on the workforce/workplace and an extensive dialog needs to occur with the Commission prior to the community component.

Commissioner Dial moved to approve the recommendations for Agenda Items 6 through 10. Commissioner Laba seconded.

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

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

Mr. Campbell announced Closed Session Agenda Item No. 11 - An update on the Script Care lawsuit and Agenda Item No. 12 - Public Employee Evaluation for the Chief Diversity Officer.

CLOSED SESSION

The Commission adjourned to Closed Session at 4:17 p.m.

11. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Name of Case: Script Care v. Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan, Case No. 56-2017-00492349 CV-WM-VTA

12. PUBLIC EMPLOYEE EVALUATION
Title: Chief Diversity Officer

OPEN SESSION

The Regular Meeting reconvened at 5:27 p.m.

Mr. Campbell stated there was no reportable action taken.

FORMAL ACTION ITEMS

13. Consider Proposed Expansion of Human Resources/Cultural Diversity Subcommittee and Direction to Subcommittee and Chief Diversity Officer

RECOMMENDATION: Consider the appointment of additional Subcommittee members and provide guidance to the Subcommittee and Chief Diversity Officer.

Commissioner Espinosa moved to have the Chief Diversity Officer report to the Ventura County Medi-Cal Managed Care Commission and to eliminate the Human Resources/Cultural Diversity Subcommittee. Commissioner Alatorre seconded.

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

NOES: None.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried.

14. Chief Diversity Officer Travel and Expenses and Signature Authority

RECOMMENDATION: Approve Chief Diversity Officer Travel and Expense policy and approve guidelines on Signature Authority.

Commissioner Espinosa moved to have the Chief Diversity Officer report to the Chief Financial Officer for signature authority. Commissioner Alatorre seconded.

Commissioner Lee moved to amend the motion to include that the Chief Diversity Officer be subject to Gold Coast Health Plan's policies and procedures similar to all other Gold Coast Health Plan employees and as it relates to travel and expense signing authority; and that the director level will apply and any approvals over $25,000 typically signed by the Chief Executive Officer would be signed by the Chief Financial Officer.

Commissioner Atin stated the discussion at hand is regarding the Chief Diversity Officer to come to the Commission to discuss the initiatives and timelines with expense details, and once the Commission approves the initiatives, then the $25,000 limit will apply.

A discussion followed between the Commissioners and staff regarding whether or not the Chief Diversity Officer would need to come back to the Commission at the next meeting for approval on the Chief Diversity Officer's proposed initiatives with the expenditure amounts, as there was concern, as there were no detailed parameters provided.

Commissioner Swenson moved to amend the motion that 1) the Chief Diversity Officer's travel and expenditures be subject to the general travel and expense limits applicable to all Gold Coast Health Plan employees, with the caveat that travel and expenses budgeted by the Chief Diversity Officer be approved by the Chief Financial Officer; and 2) as to signature authority, the Chief Diversity Officer be provided an authorization limit of up to $25,000, consistent with that authorization limit provided to a Department Director, and expenses over $25,000 must be approved by the Commission, which may delegate approval authority to the Chief Financial Officer.

Commissioner Espinosa accepted the amended motion. Commissioner Swenson seconded.

AYES: Commissioners Alatorre, Dial, Espinosa, Lee, Pawar, and Swenson.

NOES: Commissioners Atin, Egan, Foy, Laba, and Rodriguez.

ABSTAIN: None.

ABSENT: None.

Commissioner Lee declared the motion carried by a 6-5-0 vote.

Commissioner Lee advised Mr. Freeman the vote emphasized the concerns of the Commission in general and wanted to ensure he is fiscally responsible, to exercise great stewardship and caution in spending public funds, and reemphasized the expectation he comes to the next Commission meeting with a detailed plan to satisfy the concerns of the entire Commission.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

The meeting was adjourned at 5:41 p.m.

APPROVED:

Tracy J. Oehler, Clerk of the Board