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

Regular Meeting
Monday, June 26, 2017, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AMENDED AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

ROLL CALL

PUBLIC COMMENT

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

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

CONSENT CALENDAR (ROLL CALL VOTE REQUIRED)

1. **Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of May 22, 2017**

   Staff: Tracy Oehler, Clerk of the Board

   RECOMMENDATION: Approve the minutes.

2. **April 2017 Year to Date Financials**

   Staff: Patricia Mowlavi, Chief Financial Officer

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

3. Approval of Updated Credentialing for Organization Providers Policy

Staff: C. Albert Reeves, MD, Chief Medical Officer

RECOMMENDATION: Approve the updated Credentialing for Organizational Providers policy.

4. Approval of Contract Extension with TEKsystems, Inc. for IT Resources to Support Regulatory Initiatives

Staff: Melissa Scrymgeour, Chief Information and Strategy Officer

RECOMMENDATION: Approve contract extension with TEKsystems, Inc. for IT resources to support regulatory initiatives with a not to exceed amount of $163,625.

5. Approval of Contract Amendment with Milliman Solutions LLC for the MedInsight Software Milliman Advanced Risk Adjusters (MARA) Component

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

RECOMMENDATION: Approve contract amendment with Milliman Solutions LLC for the MedInsight Software MARA component for four years with a not to exceed amount of $127,016.

6. Approval of Reinsurance Policy with StarLine for High Cost Claims

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION

Approve and authorize binding reinsurance with StarLine for high cost claims with a not to exceed amount of $3,055,000.

FORMAL ACTION ITEMS

7. Award of the Community Health Investments' Social Determinants of Health I Grants Funding

Presenter: Karen Escalante-Dalton, KED Consultants

RECOMMENDATION: Approve $1,501,217 in grant funds to be awarded to sixteen (16) organizations through the Community Health Investment's Social Determinants of Health Request for Applications.

8. Approval of the Fiscal Year 2017/2018 Proposed Operating Budget

Staff: Patricia Mowlavi, Chief Financial Officer

RECOMMENDATION: Approve the proposed Fiscal Year 2017/2018 Operating Budget.

9. Request to Receive and Approve Resolution No. 2017-003 Approving Electronic Communications Policy in Accordance with *City of San Jose v. Superior Court* California Supreme Court Case

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Receive and Approve Resolution No. 2017-003.

REPORTS

10. Chief Executive Officer (CEO) Update

RECOMMENDATION: Accept and file the report.

11. Chief Operating Officer (COO) Update

RECOMMENDATION: Accept and file the report.

12. Chief Medical Officer (CMO) Update

RECOMMENDATION: Accept and file the report.

13. Pharmacy Benefits Manager (PBM) Update

RECOMMENDATION: Accept and file the report.

14. Chief Diversity Officer (CDO) Update

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

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

16. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: Three Cases

OPEN SESSION

FORMAL ACTION ITEMS

17. Approval of Contract with Conduent Health Administration, Inc. for Administrative Services

Staff: Ruth Watson, Chief Operating Officer

RECOMMENDATION: Approve contract with Conduent Health Administration, Inc. for two years with a fee for services based on a "per member/per month" fee schedule.

18. Approval of Plan-to-Plan Subcontracting Program as Proposed by America's Health Plan

Staff: Dale Villani, Chief Executive Offer

RECOMMENDATION: Approve Plan-to-Plan subcontracting program as proposed by America's Health Plan.

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on July 24, 2017, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

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

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5509. Notification for accommodation must be made by the Monday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.

AGENDA ITEM NO. 1

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 2017 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.

AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Patricia Mowlavi, Chief Financial Officer

DATE: June 26, 2017

SUBJECT: April 2017 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached April 2017 fiscal year-to-date (FYTD) financial statements (unaudited) of Gold Coast Health Plan ("Plan") for the Commission to accept and file. These financials were review by the Executive / Finance Committee on June 8, 2017, where the Executive/Finance Committee recommended that the Commission accept and file these financials.

BACKGROUND/DISCUSSION:

The staff has prepared the April 2017 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

Overall Performance – For the ten-month period ended April 30, 2017, the Plan's performance was a gain in net assets of $6.1 million, which was $8.7 million higher than budget. Cost of health care was lower than budget, driven by timing of the ARCH program. Administrative savings were realized through lower than projected administrative expenses – most notably those expenses related to projects and those whose variability are determined by membership levels.

Membership – April's membership of 205,106 was 8,716 members below budget. For FYTD membership is 2,077,072 or 38,758 below budget.

Revenue – April FYTD net revenue was $569.9 million or $1.9 million below budget due to the aforementioned below budget membership. On a PMPM basis, FYTD revenue was $4.15 above budget resulting from membership mix, with more than expected Adult Expansion membership.

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 FY2017 is $84.1 million, accrued at a rate of approximately $7.0 million per month. $70.1 million of MCO tax has been expensed FYTD. The third of four MCO tax payments of $21.0 million occurred in early April 2017.

Health Care Costs – Health care costs through April 30, 2017 were $525.6 million or $4.3 million below budget. The FYTD MLR was 92.2%, 0.5% lower than budget.

Adult Expansion Population 85% Medical Loss Ratio – The Balance Sheet contains a $131.3 million reserve for potential Medi-Cal capitation revenue to be paid back to DHCS under the terms of the MLR contract language.

	Expansion Population			Classic Population
	1/1/14-6/30/15 MLR Period 1	7/1/15-6/30/16 MLR Period 2	7/1/16-4/30/17 MLR Period 3	7/1/16-4/30/17
Total Revenue (net of MCO tax)	361,237,234	293,172,661	224,302,453	341,873,003
Total Estimated Medical Expense	206,719,452	238,300,734	195,802,465	329,786,742
	57.2%	81.3%	87.3%	96.5%
Total MLR Reserve	**118,168,494**	**13,101,452**	**-**	

Administrative Expenses – April FYTD administrative costs were $40.8 million or $4.6 million below budget. As a percentage of revenue, administrative costs (or ACR) were 7.2% versus 7.9% for budget.

Cash and Medi-Cal Receivable – At April 30, the Plan had $531.5 million in cash and short-term investments and $59.9 million in Medi-Cal Receivable for an aggregate amount of $591.4 million. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $280.2 million. The Plan anticipates AE repayment to commence sometime in July 2017.

Investment Portfolio – At April 30, 2017, the value of the investments (all short term) was $279.1 million. The portfolio included Cal Trust $50.9 million; Ventura County Investment Pool $85.7 million; LAIF CA State $63.5 million; Bonds and Commercial Paper $79.0 million.

RECOMMENDATION:

Staff requests that the Commission accept and file the April 2017 financial package.

CONCURRENCE:

June 8, 2017 Executive/Finance Committee

ATTACHMENT:

April 2017 Financial Package

Gold Coast Health Plan℠
A Public Entity

FINANCIAL PACKAGE
For the month ended April 30, 2017

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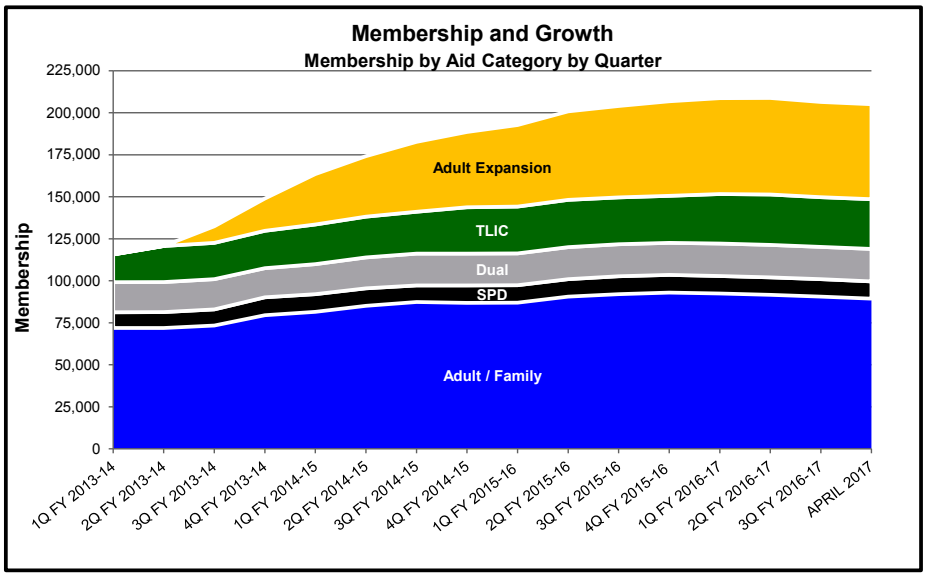
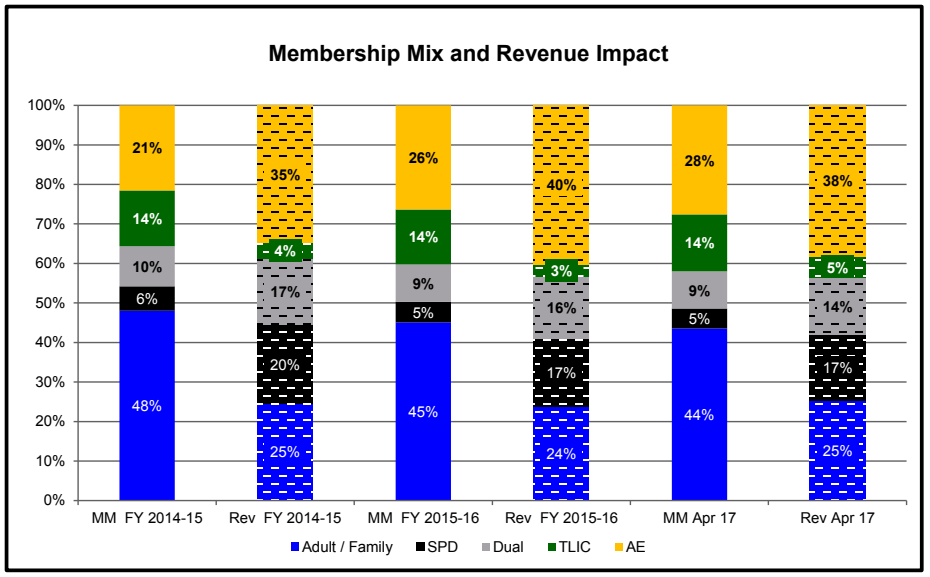
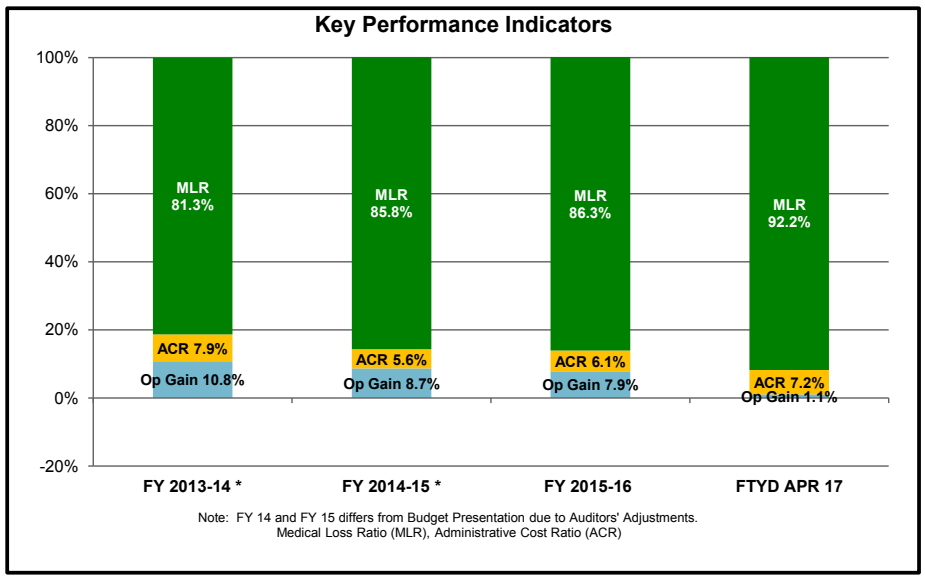
APPENDIX

Description	AUDITED FY 2014-15	AUDITED FY 2015-16	FY 2016-17 JUL - SEP 16	FY 2016-17 OCT - DEC 16	FY 2016-17 JAN - MAR 17	FY 2016-17 APR 17	FY 2016-17 FYTD APR 17	Budget Comparison Budget FYTD	Budget Comparison Variance Fav / (Unfav)
Member Months	**2,130,979**	**2,413,136**	**626,084**	**626,419**	**619,463**	**205,106**	**2,077,072**	**2,115,830**	(38,758)
Revenue	**595,607,370**	**675,629,602**	**148,815,746**	**190,063,083**	**175,648,323**	**55,364,984**	**569,892,136**	**571,752,587**	(1,860,451)
pmpm	*279.50*	*279.98*	*237.69*	*303.41*	*283.55*	*269.93*	*274.37*	*270.23*	4.15
Health Care Costs	**509,183,268**	**583,149,780**	**155,478,257**	**156,886,345**	**161,064,037**	**52,160,568**	**525,589,207**	**529,898,404**	4,309,197
pmpm	*238.94*	*241.66*	*248.33*	*250.45*	*260.01*	*254.31*	*253.04*	*250.44*	(2.60)
% of Revenue	85.5%	86.3%	104.5%	82.5%	91.7%	94.2%	92.2%	92.7%	0.45%
Admin Exp	**34,814,049**	**38,256,908**	**12,063,462**	**12,399,366**	**12,325,129**	**4,029,965**	**40,817,922**	**45,443,526**	4,625,604
pmpm	*16.34*	*15.85*	*19.27*	*19.79*	*19.90*	*19.65*	*19.65*	*21.48*	1.83
% of Revenue	5.8%	5.7%	8.1%	6.5%	7.0%	7.3%	7.2%	7.9%	0.79%
Non-Operating Revenue / (Expense)		**1,790,949**	**596,568**	**647,800**	**1,004,824**	**330,298**	**2,579,490**	**941,742**	1,637,747
pmpm		*0.74*	*0.95*	*1.03*	*1.62*	*1.61*	*1.24*	*0.45*	0.80
% of Revenue		0.3%	0.4%	0.3%	0.6%	0.6%	0.5%	0.2%	0.29%
Total Increase / (Decrease) in Unrestricted Net Assets	**51,610,053**	**56,013,863**	**(18,129,405)**	**21,425,172**	**3,263,981**	**(495,251)**	**6,064,497**	**(2,647,601)**	8,712,098
pmpm	*24.22*	*23.21*	*(28.96)*	*34.20*	*5.27*	*(2.41)*	*2.92*	*(1.25)*	4.17
% of Revenue	8.7%	8.3%	-12.2%	11.3%	1.9%	-0.9%	1.1%	-0.5%	1.53%
YTD									
100% TNE	22,556,530	25,246,284	26,097,131	27,075,526	27,709,401	28,612,411	28,612,411	29,271,853	(659,442)
% TNE Required	100%	100%	100%	100%	100%	100%	100%	100%	
Minimum Required TNE	22,556,530	25,246,284	26,097,131	27,075,526	27,709,401	28,612,411	28,612,411	29,271,853	(659,442)
GCHP TNE	**107,145,264**	**155,959,127**	**137,829,722**	**159,254,894**	**162,518,875**	**162,023,623**	**162,023,623**	**150,409,555**	**11,614,069**
TNE Excess / (Deficiency)	**84,588,734**	**130,712,843**	**111,732,591**	**132,179,367**	**134,809,474**	**133,411,212**	**133,411,212**	**121,137,702**	**12,273,510**
% of Required TNE level	**475%**	**618%**	**528%**	**588%**	**587%**	**566%**	**566%**	**514%**	

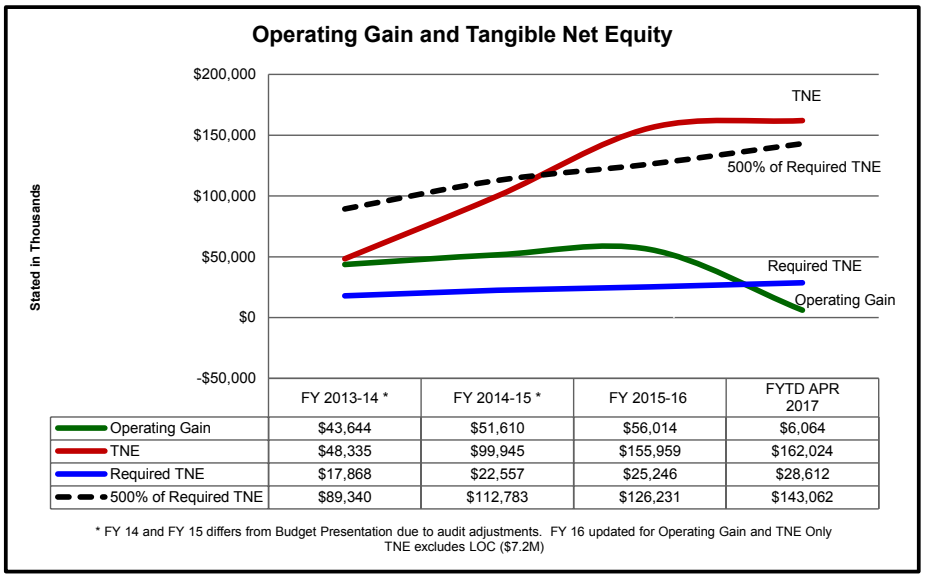
FINANCIAL PERFORMANCE DASHBOARD
FOR MONTH ENDING APRIL 30, 2017







Note: FY 14 and FY 15 differs from Budget Presentation due to Auditors' Adjustments.
Medical Loss Ratio (MLR), Administrative Cost Ratio (ACR)

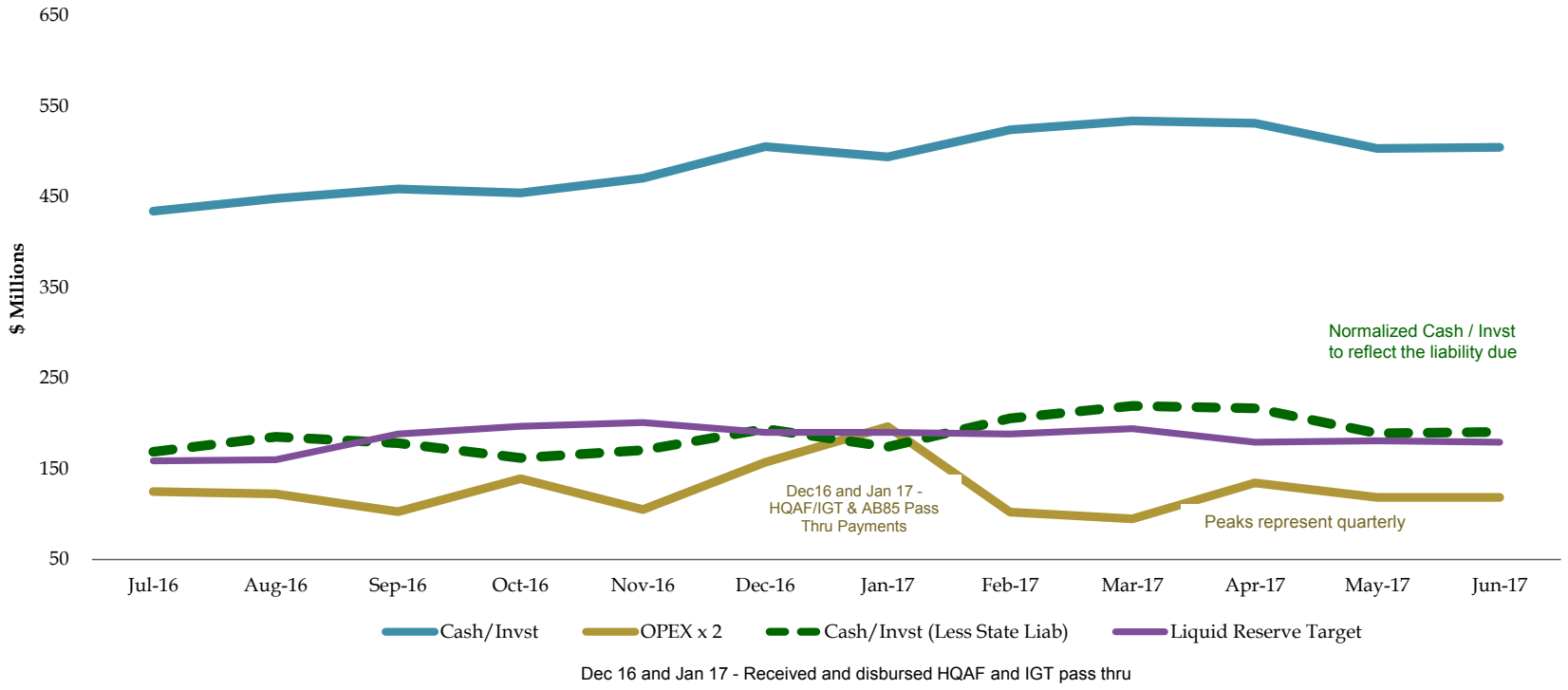


	FY 2013-14 *	FY 2014-15 *	FY 2015-16	FYTD APR 2017
Operating Gain	$43,644	$51,610	$56,014	$6,064
TNE	$48,335	$99,945	$155,959	$162,024
Required TNE	$17,868	$22,557	$25,246	$28,612
500% of Required TNE	$89,340	$112,783	$126,231	$143,062

* 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)

GOLD COAST HEALTH PLAN
FY 2016 - 17

Cash & Operating Expense Requirements



Dec 16 and Jan 17 - Received and disbursed HQAF and IGT pass thru

Gold Coast Health Plan℠
A Public Entity

For the month ended April 30, 2017

APPENDIX

- Statement of Financial Position
- YTD Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows
- Membership
- Paid Claims and IBNP Composition

STATEMENT OF FINANCIAL POSITION

	04/30/17	03/31/17	02/28/17
ASSETS			
Current Assets:			
Total Cash and Cash Equivalents	**$ 252,321,190**	**$ 275,089,340**	**$ 235,471,944**
Total Short-Term Investments	**279,137,218**	**258,959,818**	**288,884,145**
Medi-Cal Receivable	59,897,643	66,185,676	66,972,133
Interest Receivable	532,839	624,606	483,116
Provider Receivable	655,718	481,141	373,828
Total Accounts Receivable	**61,086,200**	**67,291,423**	**67,829,077**
Total Prepaid Accounts	1,423,907	1,681,886	1,749,644
Total Other Current Assets	133,545	133,545	133,545
Total Current Assets	**594,102,059**	**603,156,013**	**594,068,356**
Total Fixed Assets	**2,417,225**	**2,462,002**	**2,509,454**
Total Long-Term Investments	**0**	**0**	**0**
Total Assets	**$ 596,519,284**	**$ 605,618,015**	**$ 596,577,810**
LIABILITIES & NET ASSETS			
Current Liabilities:			
Incurred But Not Reported	$ 59,143,280	$ 55,118,983	$ 51,907,342
Claims Payable	16,146,292	13,955,262	13,432,317
Capitation Payable	57,092,423	57,064,473	56,990,011
Physician ACA 1202 Payable	591,696	591,696	591,696
AB 85 Payable	1,461,995	1,464,483	1,468,678
DHCS - Reserve for Capitation Recoup	131,269,946	0	0
Accounts Payable	2,882,782	2,434,125	2,174,458
Accrued ACS	1,669,857	1,668,962	1,652,846
Accrued Expenses	155,346,947	156,614,148	155,195,354
Accrued Premium Tax	6,507,001	20,519,903	13,513,936
Accrued Payroll Expense	1,361,309	1,374,754	1,181,933
Total Current Liabilities	**433,473,527**	**310,806,788**	**298,108,571**
Long-Term Liabilities:			
DHCS - Reserve for Capitation Recoup	0	131,269,946	135,269,946
Other Long-term Liability-Deferred Rent	1,022,133	1,022,406	998,881
Total Long-Term Liabilities	**1,022,133**	**132,292,352**	**136,268,827**
Total Liabilities	**434,495,661**	**443,099,140**	**434,377,398**
Net Assets:			
Beginning Net Assets	155,959,127	155,959,127	155,959,127
Total Increase / (Decrease in Unrestricted Net Assets)	6,064,497	6,559,748	6,241,285
Total Net Assets	**162,023,623**	**162,518,875**	**162,200,412**
Total Liabilities & Net Assets	**$ 596,519,284**	**$ 605,618,015**	**$ 596,577,810**

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
FOR TEN MONTHS ENDED APRIL 30, 2017

	APRIL 2017 Year-To-Date		Variance
	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	2,077,072	2,115,830	(38,758)
Revenue			
Premium	$ 636,318,857	$ 642,628,478	$ (6,309,621)
Reserve for Rate Reduction	3,350,000	(2,069,633)	5,419,633
MCO Premium Tax	(70,143,401)	(68,806,258)	(1,337,143)
Total Net Premium	**569,525,456**	**571,752,587**	**(2,227,131)**
Other Revenue:			
Miscellaneous Income	366,680	0	366,680
Total Other Revenue	366,680	**0**	366,680
Total Revenue	**569,892,136**	**571,752,587**	**(1,860,451)**
Medical Expenses:			
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	54,749,224	50,353,473	(4,395,750)
FFS Claims Expenses:			
Inpatient	109,404,736	105,953,961	(3,450,775)
LTC / SNF	96,620,371	96,077,304	(543,067)
Outpatient	44,506,739	41,101,712	(3,405,027)
Laboratory and Radiology	2,843,223	2,430,546	(412,676)
Emergency Room	18,233,316	18,041,770	(191,546)
Physician Specialty	45,012,952	47,884,549	2,871,597
Primary Care Physician	12,768,587	15,636,972	2,868,385
Home & Community Based Services	15,269,798	13,165,052	(2,104,746)
Applied Behavior Analysis Services	4,036,863	1,198,636	(2,838,227)
Mental Health Services	6,258,493	3,460,520	(2,797,973)
Pharmacy	95,865,482	98,013,249	2,147,767
Provider Reserve	266,667	10,126,426	9,859,759
Other Medical Professional	2,465,607	2,083,495	(382,112)
Other Medical Care	201,880	0	(201,880)
Other Fee For Service	6,824,140	6,336,688	(487,452)
Transportation	1,323,616	1,295,626	(27,990)
Total Claims	461,902,471	462,806,507	904,036
Medical & Care Management Expense	9,981,056	11,702,748	1,721,692
Reinsurance	1,035,227	5,035,675	4,000,448
Claims Recoveries	(2,078,771)	0	2,078,771
Sub-total	8,937,513	16,738,424	7,800,911
Total Cost of Health Care	**525,589,207**	**529,898,404**	**4,309,197**
Contribution Margin	**44,302,929**	**41,854,183**	**2,448,746**
General & Administrative Expenses:			
Salaries, Wages & Employee Benefits	18,658,393	20,019,057	1,360,665
Training, Conference & Travel	343,894	481,029	137,134
Outside Services	23,034,887	24,365,757	1,330,870
Professional Services	3,309,711	5,253,042	1,943,331
Occupancy, Supplies, Insurance & Others	5,452,094	7,027,390	1,575,296
Care Management Credit	(9,981,056)	(11,702,748)	(1,721,692)
Total G & A Expenses	**40,817,922**	**45,443,526**	**4,625,604**
Total Operating Gain / (Loss)	**$ 3,485,007**	**$ (3,589,343)**	**$ 7,074,350**
Non Operating			
Revenues - Interest	2,579,490	941,742	1,637,747
Total Non-Operating	2,579,490	941,742	1,637,747
Total Increase / (Decrease) in Unrestricted Net Assets	**$ 6,064,497**	**$ (2,647,601)**	**$ 8,712,098**
Net Assets, Beginning of Year	155,959,127		
Net Assets, End of Current Period	162,023,623		

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2016-17 Monthly Trend			Current Month		
	Jan 17	Feb 17	Mar 17	APRIL 2017 Actual	APRIL 2017 Budget	Variance Fav / (Unfav)
Membership (includes retro members)	206,664	206,970	205,829	205,106	213,822	(8,716)
Revenue:						
Premium	$ 63,165,021	$ 63,438,477	$ 62,813,120	$ 62,371,164	$ 64,881,381	$ (2,510,217)
Reserve for Rate Reduction	1,650,000	1,500,000	4,000,000	0	(205,273)	205,273
MCO Premium Tax	(7,005,835)	(7,006,118)	(7,006,094)	(7,006,180)	(6,950,347)	(55,833)
Total Net Premium	**57,809,187**	**57,932,359**	**59,807,026**	**55,364,984**	**57,725,760**	**(2,360,776)**
Other Revenue:						
Miscellaneous Income	99,751	0	0	0	0	0
Total Other Revenue	99,751	0	0	0	0	0
Total Revenue	**57,908,938**	**57,932,359**	**59,807,026**	**55,364,984**	**57,725,760**	**(2,360,776)**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	5,071,929	5,029,586	5,227,526	4,925,418	5,084,206	158,788
FFS Claims Expenses:						
Inpatient	10,137,221	9,355,847	12,784,974	11,425,679	10,710,450	(715,229)
LTC / SNF	5,498,137	11,439,236	9,891,367	8,511,453	9,650,061	1,138,608
Outpatient	6,695,529	4,477,337	4,028,914	4,851,932	4,154,883	(697,049)
Laboratory and Radiology	310,758	226,793	312,311	355,908	245,890	(110,018)
Emergency Room	2,082,908	2,113,200	2,177,348	1,909,550	1,822,778	(86,771)
Physician Specialty	5,003,052	3,959,094	4,747,630	4,820,252	4,846,048	25,797
Primary Care Physician	1,481,695	1,176,119	1,175,549	1,690,721	1,581,804	(108,917)
Home & Community Based Services	2,343,302	1,805,214	1,459,004	1,471,628	1,338,115	(133,513)
Applied Behavior Analysis Services	555,128	460,227	621,128	467,688	120,480	(347,208)
Mental Health Services	2,036,393	892,933	542,188	412,599	349,067	(63,532)
Pharmacy	9,506,656	9,204,612	10,301,143	9,184,491	9,889,800	705,309
Provider Reserve	100,000	0	166,667	0	1,021,064	1,021,064
Other Medical Professional	220,980	241,561	293,662	295,072	210,704	(84,368)
Other Medical Care	0	234	0	0	0	0
Other Fee For Service	752,515	630,149	601,990	785,269	639,356	(145,912)
Transportation	142,606	115,093	91,625	240,721	130,546	(110,175)
Total Claims	46,866,880	46,097,649	49,195,501	46,422,962	46,711,046	288,084
Medical & Care Management Expense	1,036,138	1,085,264	1,066,266	907,107	1,194,543	287,436
Reinsurance	172,390	231,721	256,032	254,509	508,896	254,388
Claims Recoveries	(7,459)	(1,439)	(263,948)	(349,428)	0	349,428
Sub-total	1,201,069	1,315,547	1,058,350	812,188	1,703,439	891,251
Total Cost of Health Care	**53,139,878**	**52,442,783**	**55,481,377**	**52,160,568**	**53,498,692**	**1,338,123**
Contribution Margin	**4,769,060**	**5,489,576**	**4,325,650**	**3,204,416**	**4,227,069**	**(1,022,652)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	1,995,362	1,749,737	1,982,336	1,667,223	2,079,959	412,736
Training, Conference & Travel	19,453	44,206	28,317	20,403	34,394	13,991
Outside Services	2,299,058	2,246,393	2,353,686	2,324,945	2,461,457	136,511
Professional Services	216,954	187,769	438,247	431,279	436,990	5,711
Occupancy, Supplies, Insurance & Others	594,220	743,167	613,892	493,222	680,972	187,751
Care Management Credit	(1,036,138)	(1,085,264)	(1,066,266)	(907,107)	(1,194,543)	(287,436)
Total G & A Expenses	**4,088,911**	**3,886,007**	**4,350,212**	**4,029,965**	**4,499,230**	**469,265**
Total Operating Gain / (Loss)	**680,149**	**1,603,570**	**(24,562)**	**(825,549)**	**(272,161)**	**(553,388)**
Non Operating:						
Revenues - Interest	334,894	326,906	343,025	330,298	62,157	268,140
Total Non-Operating	**334,894**	**326,906**	**343,025**	**330,298**	**62,157**	**268,140**
Total Increase / (Decrease) in Unrestricted Net Assets	**1,015,043**	**1,930,476**	**318,463**	**(495,251)**	**(210,004)**	**(285,247)**
Full Time Employees				**185**	**200**	**15**

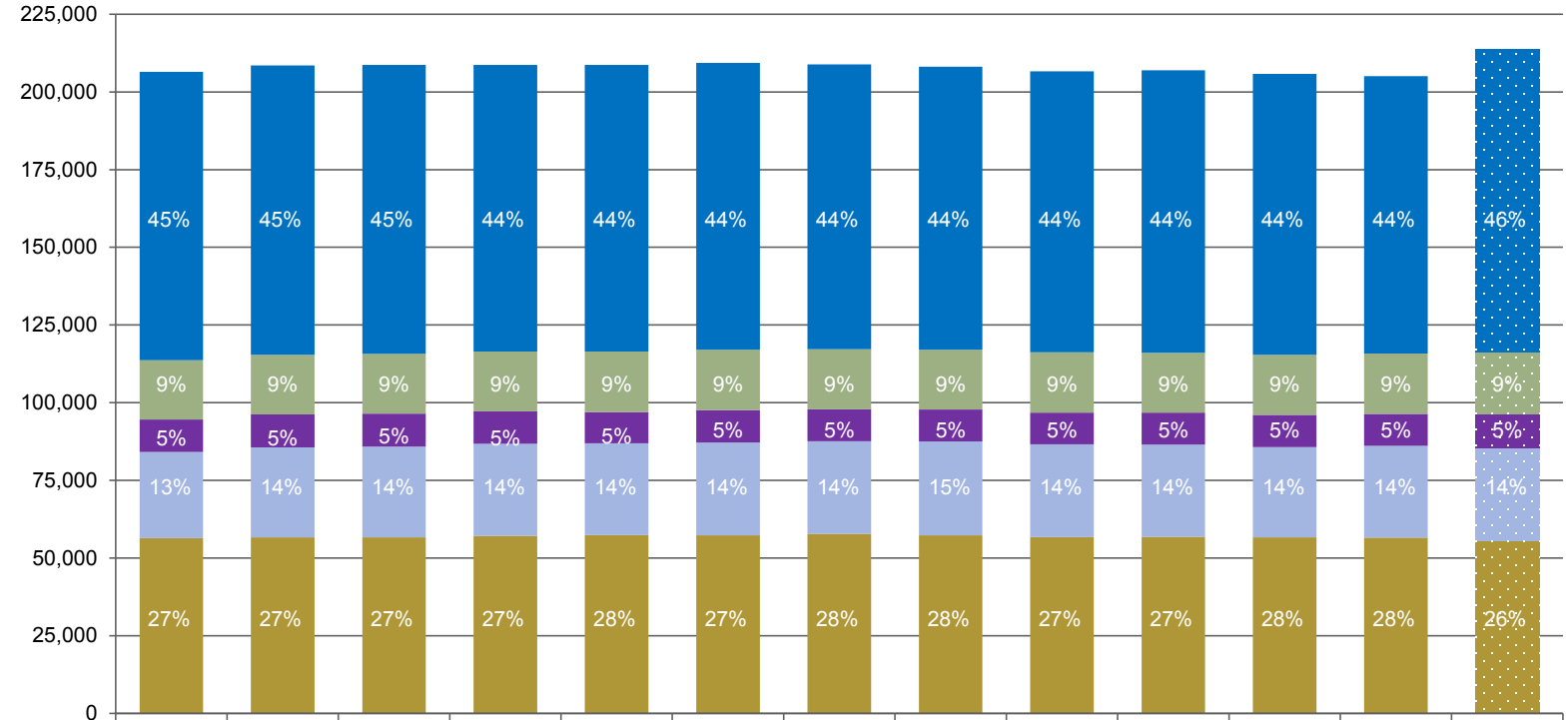
PMPM - STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

	FY 2016-17 Monthly Trend			APRIL 2017		Variance
	Jan 17	Feb 17	Mar 17	Actual	Budget	Fav / (Unfav)
Membership (includes retro members)	206,664	206,970	205,829	205,106	213,822	(8,716)
Revenue:						
Premium	305.64	306.51	305.17	304.09	303.44	0.66
Reserve for Rate Reduction	7.98	7.25	19.43	0.00	(0.96)	0.96
MCO Premium Tax	(33.90)	(33.85)	(34.04)	(34.16)	(32.51)	(1.65)
Total Net Premium	**279.73**	**279.91**	**290.57**	**269.93**	**269.97**	**(0.04)**
Other Revenue:						
Miscellaneous Income	0.48	0.00	0.00	0.00	0.00	0.00
Total Other Revenue	0.48	0.00	0.00	0.00	0.00	0.00
Total Revenue	**280.21**	**279.91**	**290.57**	**269.93**	**269.97**	**(0.04)**
Medical Expenses:						
Capitation (PCP, Specialty, Kaiser, NEMT & Vision)	24.54	24.30	25.40	24.01	23.78	(0.24)
FFS Claims Expenses:						
Inpatient	49.05	45.20	62.11	55.71	50.09	(5.62)
LTC / SNF	26.60	55.27	48.06	41.50	45.13	3.63
Outpatient	32.40	21.63	19.57	23.66	19.43	(4.22)
Laboratory and Radiology	1.50	1.10	1.52	1.74	1.15	(0.59)
Emergency Room	10.08	10.21	10.58	9.31	8.52	(0.79)
Physician Specialty	24.21	19.13	23.07	23.50	22.66	(0.84)
Primary Care Physician	7.17	5.68	5.71	8.24	7.40	(0.85)
Home & Community Based Services	11.34	8.72	7.09	7.17	6.26	(0.92)
Applied Behavior Analysis Services	2.69	2.22	3.02	2.28	0.56	(1.72)
Mental Health Services	9.85	4.31	2.63	2.01	1.63	(0.38)
Pharmacy	46.00	44.47	50.05	44.78	46.25	1.47
Provider Reserve	0.48	0.00	0.81	0.00	4.78	4.78
Other Medical Professional	1.07	1.17	1.43	1.44	0.99	(0.45)
Other Medical Care	0.00	0.00	0.00	0.00	0.00	0.00
Other Fee For Service	3.64	3.04	2.92	3.83	2.99	(0.84)
Transportation	0.69	0.56	0.45	1.17	0.61	(0.56)
Total Claims	226.78	222.73	239.01	226.34	218.46	(7.88)
Medical & Care Management Expense	5.01	5.24	5.18	4.42	5.59	1.16
Reinsurance	0.83	1.12	1.24	1.24	2.38	1.14
Claims Recoveries	(0.04)	(0.01)	(1.28)	(1.70)	0.00	1.70
Sub-total	5.81	6.36	5.14	3.96	7.97	4.01
Total Cost of Health Care	257.13	253.38	269.55	254.31	**250.20**	**(4.11)**
Contribution Margin	**23.08**	**26.52**	**21.02**	**15.62**	**19.77**	**(4.15)**
General & Administrative Expenses:						
Salaries, Wages & Employee Benefits	9.66	8.45	9.63	8.13	9.73	1.60
Training, Conference & Travel	0.09	0.21	0.14	0.10	0.16	0.06
Outside Services	11.12	10.85	11.44	11.34	11.51	0.18
Professional Services	1.05	0.91	2.13	2.10	2.04	(0.06)
Occupancy, Supplies, Insurance & Others	2.88	3.59	2.98	2.40	3.18	0.78
Care Management Credit	(5.01)	(5.24)	(5.18)	(4.42)	(5.59)	(1.16)
Total G & A Expenses	19.79	18.78	21.14	19.65	21.04	1.39
Total Operating Gain / (Loss)	3.29	7.75	(0.12)	(4.02)	(1.27)	(2.75)
Non Operating:						
Revenues - Interest	1.62	1.58	1.67	1.61	0.29	1.32
Total Non-Operating	1.62	1.58	1.67	1.61	0.29	1.32
Total Increase / (Decrease) in Unrestricted Net Assets	4.91	9.33	1.55	(2.41)	(0.98)	(1.43)

STATEMENT OF CASH FLOWS	FEB 17	MAR 17	APR 17	FYTD
Cash Flows Provided By Operating Activities				
Net Income (Loss)	1,930,476	318,463	(495,251)	6,064,497
Adjustments to reconciled net income to net cash provided by operating activities				-
Depreciation on fixed assets	47,677	47,452	44,777	515,413
Amortization of discounts and premium	(35,451)	(38,568)	(29,586)	(60,539)
Changes in Operating Assets and Liabilites				-
Accounts Receivable	24,043,067	537,654	6,205,223	68,920,073
Prepaid Expenses	(178,950)	67,758	257,979	181,219
Accounts Payable	(3,460,945)	(2,093,274)	(833,853)	77,066,433
Claims Payable	(648,733)	597,407	2,218,979	7,975,547
MCO Tax liablity	4,746,779	7,005,967	(14,012,903)	931,005
IBNR	3,530,722	3,211,641	4,024,297	2,831,888
Net Cash Provided by Operating Activities	29,974,642	9,654,501	(2,620,336)	164,425,535
Cash Flow Provided By Investing Activities				
Proceeds from Restricted Cash & Other Assets				-
Proceeds from Investments	-	30,000,000	20,000,000	95,000,000
Proceeds for Sales of Property, Plant and Equipment				-
Payments for Restricted Cash and Other Assets				-
Purchase of Investments	(117,156)	(37,105)	(40,147,814)	(150,808,914)
Purchase of Property and Equipment	21,879	-	-	(387,897)
Net Cash (Used In) Provided by Investing Activities	(95,277)	29,962,895	(20,147,814)	(56,196,812)
Cash Flow Provided By Financing Activities				
None				-
Net Cash Used In Financing Activities	-	-	-	-
Increase/(Decrease) in Cash and Cash Equivalents	29,879,365	39,617,397	(22,768,151)	108,228,723
Cash and Cash Equivalents, Beginning of Period	205,592,579	235,471,944	275,089,340	144,092,466
Cash and Cash Equivalents, End of Period	235,471,944	275,089,340	252,321,190	252,321,190

GOLD COAST HEALTH PLAN

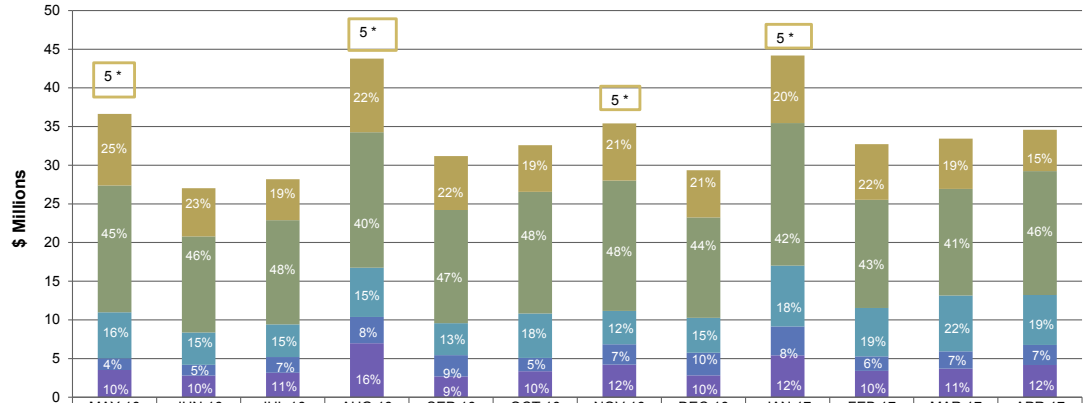
Membership - Rolling 12 Month



	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17	Budget - Apr 17
Total	206,495	208,533	208,714	208,680	208,690	209,381	208,890	208,148	206,664	206,970	205,829	205,106	213,822
FAMILY	92,798	93,158	93,007	92,221	92,213	92,364	91,653	91,071	90,477	90,911	90,456	89,311	97,598
DUALS	19,075	19,147	19,224	19,259	19,481	19,381	19,376	19,250	19,352	19,213	19,329	19,401	19,944
SPD	10,521	10,577	10,645	10,406	10,095	10,438	10,277	10,282	10,246	10,321	10,326	10,319	10,718
TLIC	27,676	28,952	29,209	29,672	29,511	29,858	29,788	30,238	29,858	29,682	29,038	29,495	30,043
AE	56,425	56,699	56,629	57,122	57,390	57,340	57,796	57,307	56,731	56,843	56,680	56,580	55,519

SPD = Seniors and Persons with Disabilities TLIC = Targeted Low Income Children AE = Adult Expansion

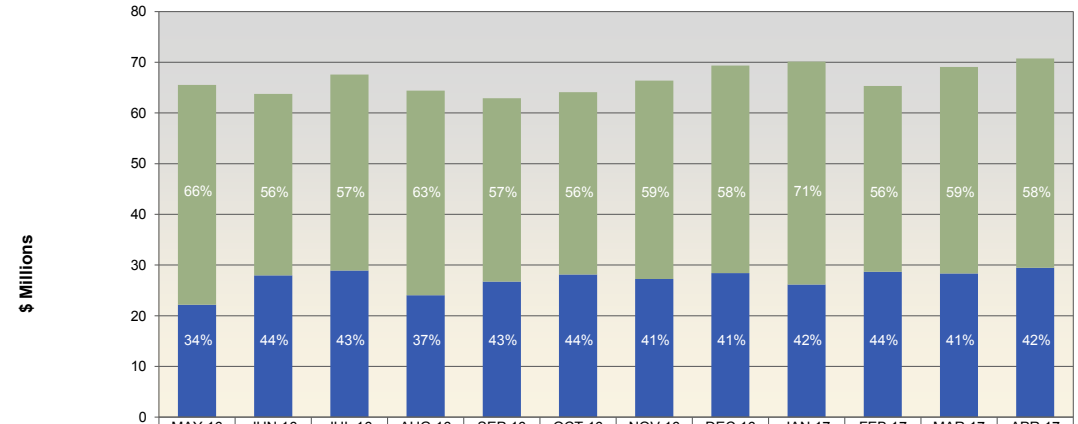
Paid Claims Composition (excluding Pharmacy and Capitation Payments)



	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17
Current	9.24	6.24	5.31	9.51	6.99	6.03	7.39	6.12	8.76	7.17	6.49	5.35
30	16.40	12.42	13.47	17.52	14.62	15.73	16.84	12.98	18.43	14.01	13.80	16.01
60	5.95	4.18	4.23	6.38	4.15	5.73	4.32	4.51	7.87	6.24	7.21	6.47
90	1.51	1.38	2.03	3.38	2.75	1.73	2.64	2.92	3.73	1.87	2.23	2.59
120+	3.52	2.81	3.17	6.99	2.68	3.36	4.21	2.82	5.42	3.42	3.70	4.16

Note: Paid Claims Composition - reflects adjusted medical claims payment lag schedule.
Months Indicated with 5* represent months for which there were 5 claim payments. For all other months, 4 claim payments were made.

IBNP Composition (excluding Pharmacy and Capitation)



	MAY 16	JUN 16	JUL 16	AUG 16	SEP 16	OCT 16	NOV 16	DEC 16	JAN 17	FEB 17	MAR 17	APR 17
Prior Month Unpaid	43.34	35.80	38.68	40.34	36.17	35.98	39.12	40.94	43.98	36.66	40.73	41.27
Current Month Unpaid	22.18	27.96	28.92	24.06	26.74	28.14	27.26	28.41	26.14	28.68	28.34	29.47
Total Unpaid	65.52	63.77	67.60	64.40	62.91	64.12	66.38	70.12	62.14	65.34	69.07	70.74
Current Month Unpaid	66%	56%	57%	63%	57%	56%	59%	58%	71%	56%	59%	58%
Prior Month Unpaid	34%	44%	43%	37%	43%	44%	41%	41%	42%	44%	41%	42%

Note: IBNP Composition - reflects updated medical cost reserve calculation plus total system claims payable.

AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

FROM: C. Albert Reeves, MD, Chief Medical Officer

DATE: June 26, 2017

SUBJECT: Credentialing for Organizational Providers Policy

SUMMARY:

As of July 1, 2017, Gold Coast Health Plan (Plan) will be required by the Department of Health Care Services to contract with at least one freestanding birth center (FSBC). The Plan has not previously contracted with any freestanding birth centers, and the Policy for Credentialing of Organizational Providers has not included this type of facility with the requirements for credentialing. This action will update the policy to include FSBC's.

BACKGROUND:

The Department of Health Care Services is mandating that managed care plans contract with at least one freestanding birth center in their area. This classification of facility has not previously been included in the Plan's Credentialing for Organizational Providers Policy. The Plan needs to include these facilities in the Policy so that the requirements for credentialing are defined.

RECOMMENDATION:

GCHP is requesting the Commission's approval of the updated Credentialing for Organizational Providers Policy.

ATTACHMENT:

QI-005 Credentialing for Organizational Providers

Title: Credentialing for Organizational Providers	Policy Number: **QI-005**
Department: Quality Improvement	Effective Date: 01/27/2011
CEO Approved:	Revised: ~~09/24/2015~~05/26/2017

Purpose:
This policy is to describe the process of initial credentialing and re-credentialing of contracted organizational providers.

Policy:
Gold Coast Health Plan conducts initial assessments and re-assessments of organizational providers to evaluate and confirm that the organizational provider has met all regulatory and quality requirements as set forth by Gold Coast Health Plan policies and procedures, DHCS, NCQA standards, and any other applicable regulatory entities. Organizational providers will be re-assessed within three (3) years of the last assessment date.

Gold Coast Health Plan will credential and re-credential:

- Hospitals
- Skilled Nursing Facilities
- Free-Standing Surgical Centers
- Home Health Agencies/Hospice Providers
- Acute Rehabilitation Facilities
- Freestanding Birthing Centers

Definitions:
N/A

Procedure:
Each organizational provider must meet minimum standards for participation with Gold Coast Health Plan. These guidelines are intended to comply with regulatory and accreditation standards established by DHCS or its designee, NCQA, Gold Coast Health Plan, and the laws of California. The Gold Coast Health Plan standards for participation include:

- A copy of the current valid State License
- A copy of the current Liability Insurance Coverage face sheet
- A copy of the documentation of accreditation status
- Verification of current Medi-Cal license number
- The provider is in good standing with State and Federal regulatory bodies and complies with all federal, state, local, city and county laws and regulations currently in effect or later enacted by these agencies as relates to services rendered to members.

Title: Credentialing for Organizational Providers	Policy Number: **QI-005**
Department: Quality Improvement	Effective Date: 01/27/2011
CEO Approved:	Revised: ~~9/24/2015~~05/26/2017

The credentialing staff will review the application. Verification of the required information stated above will be completed. Primary source verification is not required; however, the status must be verified other than by an attestation by the organizational provider. A copy of the license, accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider is acceptable. The credentialing staff may verify the information from other sources (e.g., verify accreditation by searching the list of accredited organizations on the accrediting body's website, verify licensure status with the state licensing agency).

The requirements for the types of organizational providers are as follows:

1. Hospitals
    - All Hospitals must be accredited by an acceptable accrediting organization.
    - Copy of current accreditation by an acceptable accrediting organization Acceptable accrediting organizations for hospitals are The Joint Commission (TJC) or Det Norske Veritas Healthcare (DNV)
    - A copy of the valid State License
    - A copy of the current Liability Insurance Coverage face sheet
    - Verification of current Medi-Cal License Number

2. Skilled Nursing Facilities/Long Term Care Facilities
    - Accreditation by an acceptable accrediting organization or a survey report or letter from CMS or the California State Department of Public Health that, within the last 3 years, the organization has been reviewed and passed inspection.
      (Acceptable accrediting organizations are - TJC, Commission on Accreditation of Rehabilitation Facilities (CARF) or Continuing Care Accreditation Commission (CCAC), Accreditation Association for Ambulatory Health Care (AAAHC)
    - Copy of valid State License
    - Copy of current Liability Insurance Coverage face sheet
    - Verification of current Medi-Cal License Number.

3. Free-Standing Surgical Center
    - All Free-Standing Surgical Centers must be accredited by an acceptable accrediting organization
    - Copy of a current TJC, American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), Accreditation Association for Ambulatory Health care (AAAHC), Institute for Medical Quality (IMQ)
    - Copy of valid State License
    - Copy of current Liability Insurance Coverage face sheet
    - Verification of current Medi-Cal License Number

4. Home Health agencies/Hospice Providers:
    - Accreditation by an acceptable accrediting organization or a survey report or letter from CMS or the California State Department of Public Health that, within the last 3 years, the organization has been reviewed and passed inspection
    - Copy of a current TJC, Community Health accreditation Program (CHAP), Accreditation Commission for Home Cared, Inc. (ACHC), or the Continuing Care Accreditation Commission (CCAC)
    - Copy of valid State License
    - Copy of current Liability Insurance Coverage face sheet
    - Verification of current Medi-Cal License Number

5. Free-Standing Acute Rehabilitation Facilities:
    - Accreditation by an acceptable accrediting organization or a survey report or letter from CMS or the California State Department of Public Health that, within the last 3 years, the organization has been reviewed and passed inspection.
    - Copy of accreditation by TJC, or CARF
    - Copy of valid State License
    - Copy of current Liability Insurance Coverage face sheet
    - Verification of current Medi-Cal License Number

6. Freestanding Birthing Centers:
    - Birthing Center must be accredited by one of the following agencies. Copy of certificate is required.
        i. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
        ii. Accreditation Association for Ambulatory health Care, Inc. (AAAHC)
        iii. Critical Access Certification for hospitals
        iv. Commission for the Accreditation of Birth Centers (CABC)
    - A copy of the Division of Health Services regulation license for each site (or letter attesting to all covered sites) if applicable
    - A general liability insurance face sheet for each site (or letter attesting to all covered sites). It must include current coverage dates, provider name, address and limits of coverage. Minimum coverage for all network is $1 million occurrence / 3 million aggregate.
    - A copy of the policy and procedure for coverage arrangements with a participating provider and hospital, in the event of an emergency is required.
    - City business license (if applicable)
    - Medi-Cal and Medicare certification

Non-Accredited Organizational Providers:

- Gold Coast Health Plan may substitute a CMS or State Review in Lieu of the required site visit. The CMS or state review may not be greater than three years old at the time of verification. Gold Coast Health Plan will obtain the survey report or letter from CMS or the state, from either the provider or the agency stating that the facility was reviewed and passed. Non-Accreditation substitution is not applicable to Hospitals, ~~or~~ Free-Standing Surgical Centers, and Freestanding Birthing Centers as they are required to be accredited by an acceptable accrediting organization.

Title: Credentialing for Organizational Providers	Policy Number: **QI-005**
Department: Quality Improvement	Effective Date: 01/27/2011
CEO Approved:	Revised: ~~9/24/2015~~05/26/2017

Attachments:
Organizational Provider Application

Title: Credentialing for Organizational Providers	Policy Number: **QI-005**
Department: Quality Improvement	Effective Date: 01/27/2011
CEO Approved:	Revised: ~~9/24/2015~~05/26/2017

Gold Coast Health Plan
A Public Entity

Gold Coast Health Plan
ORGANIZATIONAL PROVIDER APPLICATION
INSTRUCTIONS

- Application should be completed only for the facility types listed on Page 3.
- Applications should be typed or legibly printed in black or dark blue ink. If more space is needed, attach additional sheets and reference the question being answered. ALL fields are **required** to be completed unless otherwise directed.
- Modification to the wording or format of the application will invalidate the application.
- Separate applications are required for EACH practice location and for each provider type.
- See shaded areas of each section for further instructions.
- Information submitted on page 8 will be used to update our Provider Directories.
- If you have credentialing questions, please send an email message to Credentialing Coordinator Erica Rocha ERocha@goldchp.org or call 805-437-5582

Submit completed application along with **all** required documentation by one of these methods.

EMAIL: ERocha@goldchp.org
FAX: 805-437-5135

>> PLEASE NOTE <<

An application cannot be processed if fields are left blank; Please use "N/A" if not applicable. A "Pending" response is not acceptable - All licenses/certificates must be current and submitted along with the application in order to get processed. All fields must be complete and all information required provided. Completion of Credentialing application does not constitute approval or acceptance of participating status with Gold Coast Health Plan.

Initial Credentialing – Failure to legibly complete all sections of this Application and submit current copies of all required documentation will constitute an incomplete application that will be returned to the provider without processing.

Re-credentialing - Submission of re-credentialing information is a contractual obligation. Failure to complete all sections of this Application and submit current copies of all required documentation *in a timely manner* will be considered a request to terminate the facility's participation in our networks.

Title: Credentialing for Organizational Providers	Policy Number: **QI-005**
Department: Quality Improvement	Effective Date: 01/27/2011
CEO Approved:	Revised: ~~9/24/2015~~05/26/2017

FACILITY CREDENTIALING APPLICATION

☐ **INITIAL CREDENTIALING** ☐ **RE-CREDENTIALING**

IDENTIFICATION

CORPORATE IDENTIFICATION INFORMATION

Legal Business Name: (As reported to the IRS)	Federal Tax Identification Number (TIN):
Doing Business As (DBA) Name: (If applicable)	National Provider Identifier (NPI) for facility being credentialed: (Application **cannot** be processed without a valid 10-digit NPI)
Corporate Address: _____ _____	☐ Hospital or Health System Affiliation: List Hospital or Health System Affiliation below: _____ ☐ Not affiliated with any hospital/health system
Date of Incorporation: _____/_____/_____	Length of time in business with this Name and Tax ID: _____ Years _____ Months _____

Is facility owned in whole or in part or managed by a hospital or health care system/organization?
☐ Yes, owned in whole or in part by _____
☐ Yes, managed by _____
☐ Not affiliated with a hospital or health care system/organization

FACILITY INFORMATION
Address must be a street address, not a Post Office box.

Facility Name:			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
Facility Phone:	Fax:	Website:	
Credentialing Contact Name:		Contact Title:	
Phone:	Fax:	Email:	
Facility Administrator:		Email:	

MAILING/CORRESPONDENCE ADDRESS
Must be an address where provider can be contacted directly. PAYMENTS WILL BE MAILED TO THIS ADDRESS.

☐ Check here if all correspondence can be directed to the facility location above.
If not, complete the section below.

Name:			
Mailing Address Line 1:			
Mailing Address Line 2:			
City:	State:	Zip:	Phone:

FACILITY TYPE
Check ONE box only per Application.
If your facility type is not listed below, do not complete and submit this application.

MEDICAL

- ☐ Free-Standing Surgical Centers – Free standing only
- ☐ Acute Rehabilitation Facilities
- ☐ Home Health Care Agency that provides skilled nursing services (Not a PCA-only agency)
  Must complete Page 7 if not Medicare (CMS) certified – INITIAL credentialing only.
- ☐ Hospital - All types including Psychiatric
- ☐ Skilled Nursing Facility/Nursing Home

PLEASE NOTE: BEHAVIORAL HEALTH FACILITIES & PROVIDERS ARE TO CONTACT BEACON HEALTH STRATEGIES REGARDING CREDENTIALING PROCESS

HEALTH CARE LICENSURE

Attach a copy of each license for this facility. Use a separate sheet if necessary.
All licenses must be unrestricted/unconditional.
Do not submit practitioner licenses

License Number	State or City	Licensing Agency	Initial Issue Date	Renewal Date	Expiration Date
			___/___/___	___/___/___	___/___/___
			___/___/___	___/___/___	___/___/___

MEDICAID & MEDICARE STATUS

1. Is this facility participating in the Medicare program? ☐YES ☐NO ☐PENDING
   Medicare number: _____ Date of initial Certification: _____/_____/_____
2. ☐ Check here is facility is not eligible for Medicare certification.
3. HOSPITALS ONLY: Is hospital designated by CMS as a Sole Community Provider? ☐YES ☐NO
   If YES, attach copy of documentation from CMS specifying Sole Community Provider designation.
4. Is this facility participating in California Medicaid (Medi-cal) program? ☐YES ☐NO ☐PENDING
5. NPI number: _____ Date of initial Certification: _____/_____/_____
   If YES, attach copy of documentation from California Medicaid (Medi-cal) showing participation.

MEDICAL FACILITIES – COMPLETE THIS PAGE

• Free-Standing Surgical Center • HOME HEALTH CARE AGENCY • SKILLED NURSNG FACILITY/NURSING HOME
• Acute Rehabilitation Facilities • HOSPITAL – ALL TYPES

ACCREDITED FACILITIES

Complete this section and attach copy of current Accreditation certificate or letter. Certificate/letter should list this facility location as being included in the accreditation.

- ☐ **AAAASF** - American Association for Accreditation of Ambulatory Surgery Facilities
- ☐ **AAAHC** - Accreditation Association for Ambulatory Health Care
- ☐ **ACHC** - Accreditation Commission for Health Care
- ☐ **CARF** - Commission on Accreditation of Rehabilitation Facilities
- ☐ **CCAC** - Continuing Care Accreditation Commission
- ☐ **CHAP** - Community Health Accreditation Program
- ☐ **DNV (NIAHO) -** Det Norske Veritas (National Integrated Accreditation for Healthcare Organizations)
- ☐ **TJC** – The Joint Commission (Formerly known as JCAHO)

1. Date of last full survey: _____ / _____ / _____
2. Effective dates of accreditation: _____ / _____ / _____ through _____/_____/_____

NON ACCREDITED FACILITIES

Complete this section and attach copy of most recent onsite government agency survey along with your Corrective Action Plan (CAP), if deficiencies were cited, OR attach letter from government agency stating facility is in substantial compliance with most recent survey standards.

Has this facility had an onsite licensing/certification survey by the Department of Health or CMS within the past 36 months?

- ☐ YES – Date of most recent onsite survey: _____/_____/_____ ***See instructions above.***
- ☐ NO - Contact Gold Coast Health Plan.

STAFFING

Does this facility validate, for each licensed practitioner employed or contracted at the facility, the credentials necessary to perform health care services? ☐ YES ☐ NO

- If YES, indicate how the facility conducts the credentialing process for each practitioner:
  - ☐ Credentialing procedures are performed internally.
  - ☐ Credentialing procedures are outsourced/delegated to _____
  - ☐ Other, specify: _____
- If NO, explain: _____

Title: Credentialing for Organizational Providers	Policy Number: **QI-005**
Department: Quality Improvement	Effective Date: 01/27/2011
CEO Approved:	Revised: ~~9/24/2015~~05/26/2017

INSURANCE

Complete this section and attach a copy of the facility's insurance certificate(s) that includes:

- ***Insurer(s) Affording Coverage***
- ***Policy Number***
- ***Effective Date and Expiration Date***
- ***Amounts of Coverage***
- ***This facility listed as covered by the policy***
- ***Name and Phone Number of Agency issuing policy***

Facilities that are covered by Government Insurance - and a certificate was not issued - should attach a letter detailing coverage.

1. Is this facility covered by Commercial General liability insurance in the amount of $1 million per occurrence and $3 million aggregate? (Excess liability/Umbrella coverage can be counted toward the $3 million aggregate amount.)
   - ☐ ☐ Yes
   - ☐ ☐ No - ***Please obtain the above amount of required coverage before submitting application.***
   - ☐ ☐ Facility is covered by Government insurance.

2. Is facility covered by Professional liability insurance in the amount of $1 million per occurrence and $3 million aggregate? Must be a facility/organizational policy, not Individual-only, policy. (Excess liability/Umbrella coverage can be counted toward the $3 million aggregate amount.)
   - ☐ ☐ Yes
   - ☐ ☐ No - ***Please obtain the above amount of required coverage before submitting application.***
   - ☐ ☐ Facility is covered by Government insurance.

3. Has this facility's Commercial General or Professional liability insurance ever, for any reason, been denied, cancelled, non-renewed, or initially refused upon application?
   - ☐ ☐ Yes – *Explain fully below.*
   - ☐ ☐ No

_____
_____
_____
_____

ATTACHMENTS

Have you attached all required documents? If not, the processing of your application will be delayed.
Check all documents included with this application.

- ☐ ☐ Copy of all State and local licenses required to operate as a health care facility
  Do not attach practitioner licenses.
- ☐ ☐ Copy of facility's Commercial General liability insurance certificate
- ☐ ☐ Copy of facility's Professional liability insurance certificate covering all facility employees
- ☐ ☐ Copy of Accreditation certificate or letter
  ☐ Copy of California Medicaid (Medi-cal) facility participation.
- ☐ ☐ Copy of most recent onsite governmental licensing agency survey including facility's corrective action plan if deficiencies were cited, OR cover letter/email from licensing agency stating facility is in substantial compliance with licensing standards from most recent survey
- ☐ ☐ Copy of CMS letter certifying facility to provide partial hospitalization services
- ☐ ☐ Other (specify): _____
  _____

ATTESTATION

Answer every question YES or NO.
Provide a detailed explanation, including dates below for all for any question(s) answered YES.
Use a separate sheet if necessary.
Be sure to Sign and date Attestation.

☐ YES ☐ NO	1. Has this facility ever had or currently have pending any legal actions against it?
☐ YES ☐ NO	2. Has this facility ever been convicted of a crime, excluding misdemeanors?
☐ YES ☐ NO	3. Has any government agency ever investigated, suspended, revoked, or taken other action against this facility/organization's license to conduct business?
☐ YES ☐ NO	4. At any time has any license or certification been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions which may lead to such conclusions now underway?
☐ YES ☐ NO	5. At any time, has this facility/organization been assessed a penalty or fined by a government agency or is the facility currently under investigation by the Medicaid or Medicare programs or any other government agency?
☐ YES ☐ NO	6. At any time, has any third party payor ever revoked, reduced, denied, or suspended this facility's network participation due to inappropriate utilization management, quality of care issue, or for any other reason?
☐ YES ☐ NO	7. Has any managing employee or person with an ownership or controlling interest in this facility/organization been excluded from participation in any government health care program?
☐ YES ☐ NO	8. Has this facility, under any current former name or business identity, ever had its accreditation revoked or suspended?

Explanation for question(s) answered YES:

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate, and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a Health Plan participating provider or cause for summary dismissal from the Health Plan.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

_____ Printed Name of Authorized Representative

_____ Authorized Representative's Title

_____ Signature of Authorized Representative

_____/_____/_____ Date Signed

HHA MEDICARE CERTIFICATION EXCEPTION FORM

Only Non Medicare certified Home Care agencies should complete this form.
All questions must be answered. Completion of this form doesn't guarantee acceptance to plan.

Home Care Agency Name: _____

1. Indicate the number of hours and days per week the agency is available to serve clients.

   Hours per day: _____ Days per week: _____

2. List all states and years this agency has been in business.

   State: _____ Year(s): _____-_____

   State: _____ Year(s): _____-_____

   State: _____ Year(s): _____-_____

3. Indicate the number of clients you have served:

   This year: _____

   Last year: _____

   Two years ago: _____

4. Indicate the number of agency employees in each category.

   Registered Nurses (RN): _____
   Licensed Practical Nurses (LPN): _____
   Personal Care Assistants (PCA): _____
   Other _____: _____

5. Indicate percentage of your clients, in the past year through present, who primarily received **personal care assistant (PCA)** or **home health aide** services rather than skilled nursing services.

   _____%

6. Give reason(s) this home care agency has not pursued/been granted Medicare (CMS) certification.

Title: Credentialing for Organizational Providers	Policy Number: **QI-005**
Department: Quality Improvement	Effective Date: 01/27/2011
CEO Approved:	Revised: ~~9/24/2015~~05/26/2017

FACILITY CREDENTIALING APPLICATION

LANGUAGES

- ***Please check all languages spoken by facility staff fluently enough to treat patients/clients who speak only that language.***
- ***If none of these languages are spoken at your facility, check "None of These."***
- ***Indicate if Sign Language and/or an Interpreter Service is available at your facility.***

☐	AFRIKAANS	☐	HILIGAYNON	☐	OROMO
☐	AKAN	☐	HINDI	☐	PAKASTANI
☐	AMHARIC	☐	HINDU	☐	PERSIAN
☐	ARABIC	☐	HMONG	☐	POLISH
☐	ARABIC NORTH LEVAN	☐	HUNGARIAN	☐	PORTUGUESE
☐	ARMENIAN	☐	IBO OF NIGERIA	☐	PUNJABI
☐	ASSAMESE	☐	ICELANDIC	☐	ROMANIAN
☐	BENGA	☐	INDONESIAN	☐	RUSSIAN
☐	BENGALI	☐	IOLOCANO	☐	SERBIAN
☐	BOSNIAN	☐	ITALIAN	☐	SINDHI
☐	BULGARIAN	☐	KANNADA	☐	SINHALA
☐	BURMESE	☐	KAREN	☐	SLAVIC
☐	CAMBODIAN	☐	KASHMIRI	☐	SLOVENIAN
☐	CANTONESE	☐	KISII	☐	SOMALI
☐	CHILEAN	☐	KISWAHILI	☐	SPANISH
☐	CHINESE	☐	KONKANI	☐	SWAHILI
☐	CHINESE MANDARIN	☐	KOREAN	☐	SWEDISH
☐	CROATIAN	☐	KUNIAN	☐	TAGALOG
☐	CZECH	☐	KURDISH	☐	TAIWANESE
☐	DANISH	☐	LATIAN	☐	TAMIL
☐	DUTCH	☐	LAOTIAN	☐	TELUGU
☐	EGYPTIAN	☐	LATVIAN	☐	THAI
☐	ESAN	☐	LIINGALA	☐	TIGRIGNA
☐	ESTONIAN	☐	LITHUANIAN	☐	TSWANA
☐	FARSI	☐	LUGANDA	☐	TURKISH
☐	FILIPINO	☐	LUO	☐	TURKMEN
☐	FINNISH	☐	MALAY	☐	UKRANIAN
☐	FLEMISH	☐	MALAYALAM	☐	URDU
☐	FRENCH	☐	MANDARI	☐	VIETNAMESE
☐	GERMAN	☐	MANDINKA	☐	WELSH
☐	GREEK	☐	MARATHI	☐	WOLOF
☐	GUJARATI	☐	NEPALI	☐	YIDDISH
☐	HAITIAN CREOLE FRENCH	☐	NORWEGIAN	☐	YORUBA
☐	HEBREW	☐	OJIBWE	☐	**NONE OF THESE**

☐☐ **AMERICAN SIGN LANGUAGE** ☐ **INTERPRETER SERVICE UTILIZED BY FACILITY**

Facility Name: _____ **TIN:** _____

Title: Credentialing for Organizational Providers	Policy Number: **QI-005**
Department: Quality Improvement	Effective Date: 01/27/2011
CEO Approved:	Revised: ~~9/24/2015~~05/26/2017

References:
N/A

Revision History:

Review Date	Revised Date	Approved By
01/27/2011		Charles Cho, MD (CMO)
01/27/2011		Earl Greenia (CEO)
10/29/2014		PRC
01/05/2015		DHCS
01/05/2015		Ruth Watson, (COO, Interim CEO)
01/19/2016		DHCS (Default)
01/20/2016		Dale Villani

AGENDA ITEM NO. 4

TO: Gold Coast Health Plan Commission

FROM: Melissa Scrymgeour, Chief Information and Strategy Officer

DATE: June 26, 2017

SUBJECT: Contract Approval – TEKsystems, Inc.

SUMMARY:

TEKsystems, Inc. is a provider of IT staffing throughout the United States. Gold Coast Health Plan (GCHP) utilized TEKsystems in December 2016 to fill an urgent gap for an additional development resource to support a number of high priority regulatory initiatives, including the DHCS 274 provider file submission. Additionally, this development resource provides mission critical production support for the Plan's reporting and data environments.

GCHP has identified a need to extend the developer resource provided by TEKsystems through FY17/18, to support the following:

- High priority, regulatory driven program of work around provider data management, which includes SB137 – Provider Directories and new provider network requirements stemming from the CMS Medicaid Megarule and the Plan's revised DHCS contract.

- Project workload for approved GCHP 2017/2018 Portfolio Initiatives, estimated at >1,000 development hours.

FISCAL IMPACT:

Cost to extend the Senior SQL Developer resource for 1,925 hours over the next 52 weeks is $163,625 ($85/hr.). These costs are included in the FY17/18 budget.

RECOMMENDATION:

The Plan recommends extending the Senior SQL Developer resource, as provided by TEKsystems, through FY 17/18, not to exceed 1,925 hours.

If the Commission desires to review this contract, it is available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 5

TO: Gold Coast Health Plan Commission

FROM: Nancy Wharfield M.D., Associate Chief Medical Officer

DATE: June 26, 2017

SUBJECT: Contract Approval – Milliman Advanced Risk Adjusters (MARA)

SUMMARY:

The GCHP Commission approved renewal of a contract with Milliman Inc. in January 2017. Milliman Inc. is GCHP's incumbent vendor providing business critical analytics software, MedInsight (MI). GCHP staff uses the MI business intelligence platform to support business critical analytics functions, including financial analysis, such as IBNR and RDT calculations and processes, as well as demographic and clinical analysis which help drive business decisions around key programs that support improved health outcomes for our members.

Milliman Advanced Risk Adjusters (MARA) is a suite of risk adjustment tools for population analysis that supports budgeting, pricing and underwriting, payment, stratifying risks, and many other predictive modeling applications for the Plan.

FISCAL IMPACT:

The cost of adding the MARA risk stratification module to MedInsight is $127,016 over four years, including implementation and subscription renewals. (Excluding implementation, the annual subscription renewal cost averages out to approximately $31,000.)

RECOMMENDATION:

The Plan recommends approval of a contract to add MARA risk stratification analytics to our MedInsight business intelligence platform through 2020.

If the Commission desires to review this contract, it is available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Patricia Mowlavi, Chief Financial Officer

DATE: June 26, 2017

SUBJECT: Reinsurance Renewal

SUMMARY:

The annual reinsurance policy for high cost claims coverage is due for renewal. The current policy expires on June 30, 2017.

BACKGROUND/DISCUSSION:

Gold Coast Health Plan has elected to renew with StarLine due to a favorable rate structure and terms for an aggregating specific deductible (ASD) reinsurance policy. Beecher Carlson, the Plan's insurance broker, took the policy to market. After comparing with offerings of other carriers, Beecher Carlson recommended renewing the reinsurance policy with StarLine.

FISCAL IMPACT:

The StarLine ASD renewal quote received was $3,055,000, and is comparable to the current year's premium. The policy renewal includes a potential premium refund of up to $855,000, depending on experience.

RECOMMENDATION:

Staff is recommending the Commission approve and authorize binding reinsurance with StarLine.

AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Karen Escalante-Dalton, KED Consultants

DATE: June 26, 2017

SUBJECT: Community Health Investments' Social Determinants of Heath I Request for Applications

SUMMARY:

This memo provides an overview of the grants recommended for funding through Gold Coast Health Plan's (GCHP) Community Health Investments' Social Determinants of Health I Request for Applications (SDH I RFA), which was released last April. A total of $1,501,217 is recommended in grant funds to 16 organizations. (See Table I below for details).

The purpose of the SDH I RFA is to provide financial support for programs that address the social determinants affecting the health of GCHP members and other underserved Ventura County residents. Applicants to the SDH I RFA were asked to select one of three areas of focus including: Access to Health Care, Access to Food, or Built Environment.

An 18-member Grant Review Committee representative of diverse departments within GCHP, along with an expert consultant, reviewed the proposals received in response to the RFA. Each application was read and scored by 4-5 individuals. The consultant also conducted a review of the financial standing of each applicant organization. The Grant Review Committee then met in person to discuss at length the risks and benefits of supporting each application. After much deliberation, the Grant Review Committee recommended that 16 organizations be selected for funding. Funding recommendations were then presented to GCHP's Executive Leadership Team prior to moving for final approval by GCHP's Commission.

Table I below provides an overview of the 16 grants recommended for funding. The table includes the organization name, the selected focus area, a brief description of the project recommended for funding, and the grant amount recommended.

For the Focus Area, A = Access to Health Care, F = Access to Food, and BE = Built Environment.

Table I. SDH I Funding Recommendations				
	Name	**Focus**	**Project Description**	**Amount**
1	**Boys and Girls Club of Santa Clara Valley**	A	To address overweight and obesity among children and youth by teaching kids to prepare healthy meals with fresh produce, bringing agriculture into the classroom, allowing kids to take fresh produce home to practice what they learned, and taking field trips to the local agriculture museum to learn about food sources and about alternative ways to grow produce using science and engineering skills.	$27,840
2	**Brain Injury Center of Ventura County**	A	To build a safety net of care for brain injury survivors to safely remain in the community following hospitalization by providing home safety and fall risk evaluation, developing a service coordination plan, along with providing caregiver support services.	$100,000
3	**Camarillo Health Care District**	A	To provide linkages to critical social supports in the community to dual seniors and persons with disabilities being discharged from skilled nursing facilities along with support services for their caregivers.	$150,000
4	**CAREGIVERS: Volunteers Assisting the Elderly**	A	To match up to 480 homebound seniors with volunteers that will provide practical support and transportation services in order to remove access barriers to health-supportive services and promote an enhanced quality of life.	$35,000
5	**Casa Pacifica Centers for Children and Families**	A	To support the construction of two residential substance abuse treatment cottages for adolescents on Casa Pacifica's campus that will provide 30-day residential substance abuse treatment programs.	$50,000
6	**FOOD Share**	F	To provide healthy food distributions, nutrition education, and healthy recipe taste testing throughout Ventura County to improve the health and reduce hunger among food insecure clients, including GCHP members.	$150,000
7	**Habitat for Humanity**	BE	To support construction of six homes in Oxnard by September 2018 that will serve six low-income families, or approximately 18 people.	$75,000

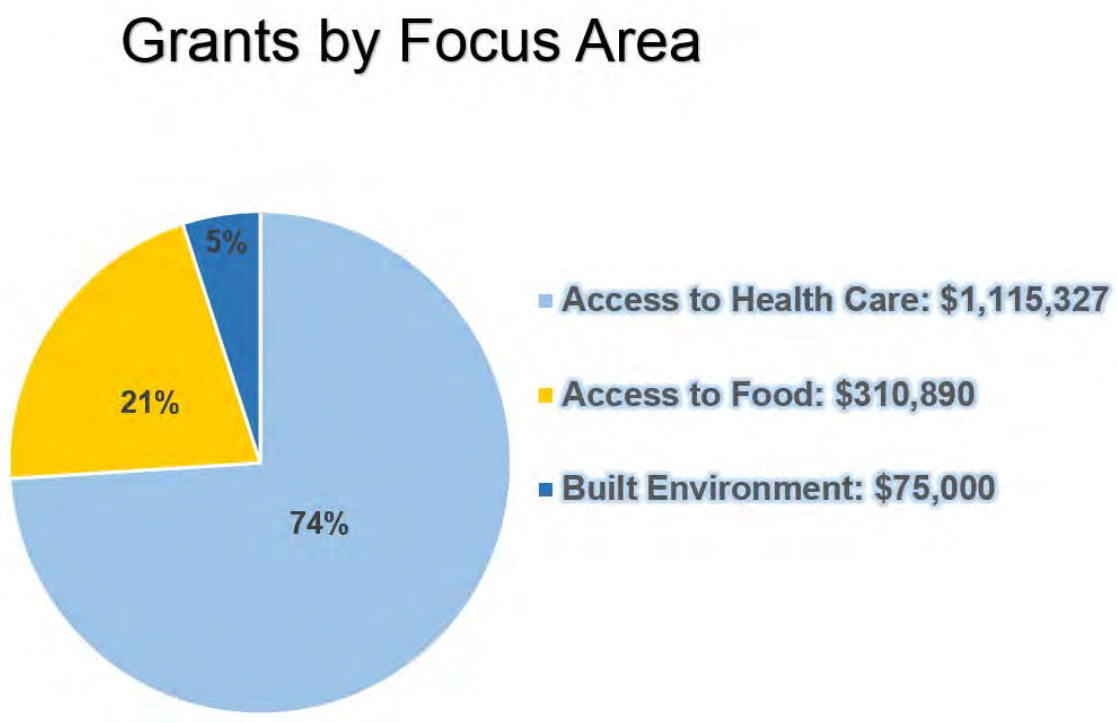
Table I. SDH I Funding Recommendations				
8	**Kids & Families Together**	A	To provide community-based support and linkages to health, mental health and other health-supportive services to kinship parents caring for at-risk children and youth.	$150,000
9	**Manna Conejo Valley Food Bank**	F	To distribute at least 280,000 pounds of food annually to low-income residents of the Conejo Valley.	$73,050
10	**Many Mansions**	F	To provide access to food to Many Mansions residents monthly along with healthy eating and healthy living workshops.	$10,000
11	**Mixteco/Indigena Community Organizing Project**	A	To hire a Mixtec Health Caseworker that will help indigenous immigrants advocate for themselves as patients; to launch a PSA campaign in indigenous languages to be broadcast on Radio Indigena encouraging immigrants to utilize care; and to meet monthly with GCHP representatives to convey barriers faced by indigenous immigrants when accessing health care services in Ventura County.	$150,000
12	**St. John's Healthcare Foundation**	A	To provide community-based support through community health workers to patients diagnosed with diabetes and pre-diabetes including patient care plans, linkages to community-based nutrition and physical activity programs, home visits, and elimination of language and cultural barriers to care.	$132,100
13	**United Way of Ventura County**	F	To acquire and implement Benefit Kitchen, a screening tool to be utilized by 2-1-1 call center specialists to determine eligibility and connect callers to the CalFresh program.	$50,000
14	**Ventura County Health Care Agency**	A	To provide home visits, nutrition and exercise education, health coaching, and referrals for health care and other community-based services to individuals at risk for or diagnosed with hypertension through community health workers.	$149,547
15	**Ventura County Public Health**	A	To provide a 6-week obesity prevention program for elementary school-age children in Port Hueneme and in Fillmore schools along with a public education campaign centered on obesity prevention through health promotion messaging.	$148,680

Table I. SDH I Funding Recommendations				
16	**Vision y Compromiso**	A	To support community health workers or *promotoras de salud* that will assist GCHP members and other low-income individuals navigate their health insurance and link them to health supportive services.	$50,000
TOTAL RECOMMENDED FOR APPROVAL				**$1,501,217**

As the Figure 1 below shows, 74% funding recommendations focus on improving Access to Health Care for high risk populations, including seniors, brain injury survivors, individuals diagnosed with or at high risk for diabetes or hypertension, children and families affected by obesity and overweight, youth with substance abuse disorders, kinship families, and other low-income hard-to-reach populations.

Twenty-one percent (21%) of funding recommendations focus on making food more readily available to vulnerable populations including seniors, low-income individuals and families, and low-income housing residents.

Only one grant, or 5% of funding recommended, addresses housing, under the built environment focus area.



FISCAL IMPACT:

The cost to award the grant funds for the one-year grant cycle is $1,501,217.

RECOMMENDATION:

Staff hereby recommends that the Commission approve $1,501,217 in grant funds to be awarded to sixteen (16) organizations through the Community Health Investment's Social Determinants of Health Request for Applications. Funds awarded will be used to address the social determinants that affect the health of Gold Coast Health Plan members and other disadvantaged Ventura County residents.

AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Patricia Mowlavi, Chief Financial Officer

DATE: June 26, 2017

SUBJECT: Fiscal Year 2017-2018 Proposed Operating Budget

SUMMARY/DISCUSSION:

Gold Coast Health Plan (GCHP or Plan) membership has leveled-off after a period of significant growth, which was fueled by the Affordable Care Act's Medi-Cal Adult Expansion (AE) program. Membership reached a high of 208,533 in June 2016 and declined by 1.7 percent in fiscal year 2016-17. During fiscal year 2017-18, membership is expected to stabilize and end the year with 202,696 members. To better reach and serve potential enrollees, collaborative efforts are commencing to review membership gaps and determine ways to outreach, attract and enroll Medi-Cal eligibles in Ventura County.

Total fiscal year 2017-18 revenue is projected to remain essentially flat at $683 million, growing by 0.16 percent or $1 million year over year. On a per member per month basis, revenue is increasing by 1.8 percent.

During the past fiscal year, significant investments were made to improve members' health through ongoing support of contracted hospitals, providers and the safety net. These investments and GCHP's commitment to collaboration are demonstrated by the increase in medical benefits, as a percent of revenue from 86 percent in fiscal year 2015-16 to 93 percent in fiscal year 2016-17, continuing into fiscal year 2017-18.

Administrative expenses are budgeted to remain flat at 7 percent of revenue. Essential projects including regulatory requirements and efficiency enhancing technology are included in the proposed budget. Staffing is budgeted to remain at current levels over the fiscal year.

FISCAL IMPACT:

The proposed budget reflects an operating gain of $2 million or 0.3 percent, on revenues of $683 million. Tangible net equity (TNE) is projected to be $157 million, which represents just over two months of operating expenses. GCHP trails the other County

Organized Health Systems in total TNE. With the uncertainty surrounding Medi-Cal and the Affordable Care Act, it is prudent to maintain adequate reserves and cash liquidity (working capital) to protect the financial viability of the Plan.

It is expected that the Department of Health Care Services will recoup the $280 million related to the AE rate overpayments and to achieve the AE MLR minimum 85% medical loss ratio requirement, during fiscal year 2017-18.

Alternative Resources for Community Health (ARCH) programs are not included in the budget proposal. The ARCH program is intended to increase collaboration with plan provider partners to drive outcome-based payment and foster new benefit design to drive innovation in how GCHP pays for health care and how health care will be delivered. Recommendations to fund ARCH programs will be brought to the Commission for review and approval, per policy.

RECOMMENDATION:

Staff is recommending the Commission approve the proposed Fiscal Year 2017-2018 Operating Budget.

ATTACHMENT:

Fiscal Year 2017-18 Operating and Capital Budget

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Integrity
Accountability
Collaboration
Trust
Respect

Fiscal Year 2017-18 Operating and Capital Budget

Commission Meeting
Patricia Mowlavi, CFO / Lyndon Turner, Director
June 26, 2017

Key Budget Assumptions

- Annual membership remains stable reaching 202,696 members, by June 2018.
- Total revenue remains essentially flat, increasing by 0.16%.
- Cost of Health Care Benefits for members continues to exceed the state rate assumption, at 92.6% of revenue.
- Administrative expenses are consistent with current year at 7.3% of revenue.
- TNE is projected to end the year at 547% of the state required minimum. GCHP has the lowest TNE of all COHS.

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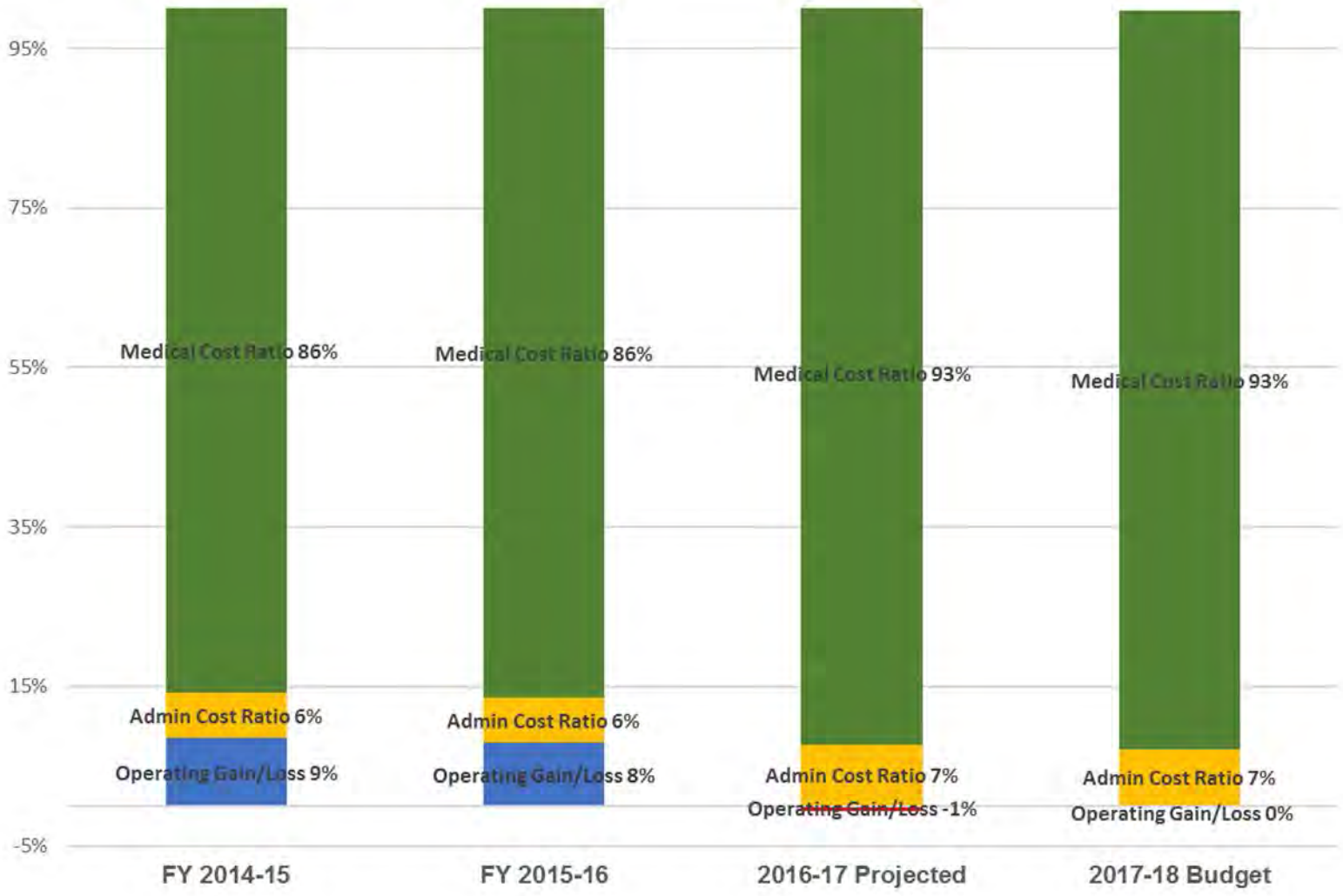
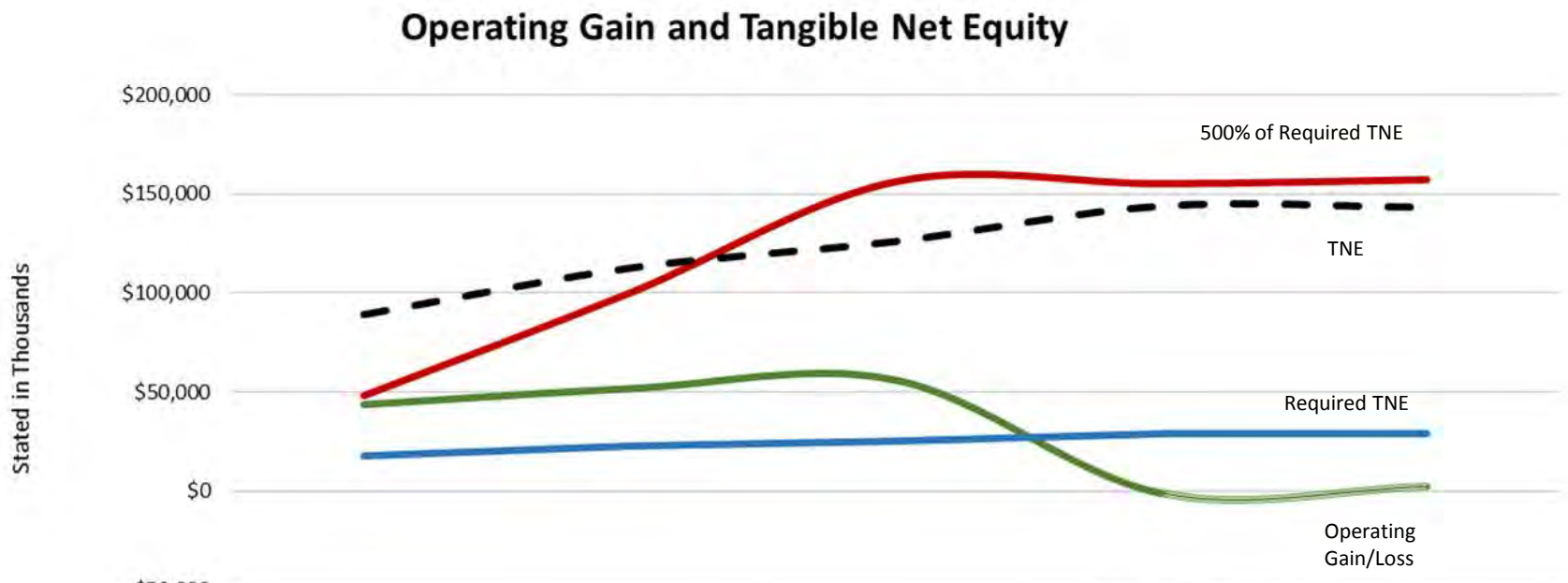
Key Performance Indicators



Key Indicators – Net Position



	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17 (Projected)	FY 2017-18 Budget
Operating Gain	43,644	51,610	56,014	(1,025)	2,044
TNE	48,335	99,945	155,959	154,934	156,978
Required TNE	17,868	22,557	25,246	28,815	28,700
500% of Required TNE	89,340	112,783	126,231	144,075	143,498
% of Required TNE	271%	443%	618%	538%	547%

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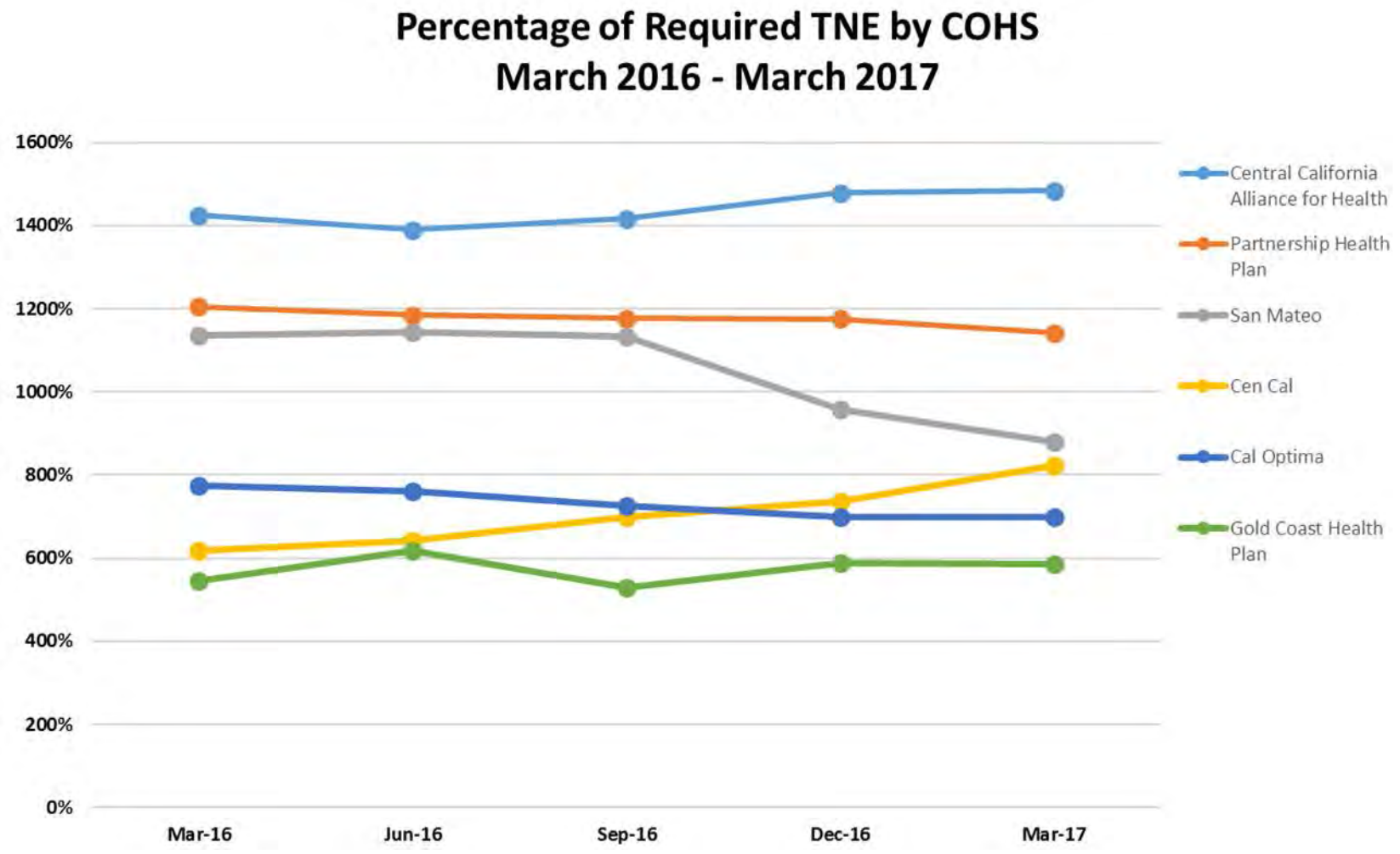
Tangible Net Equity



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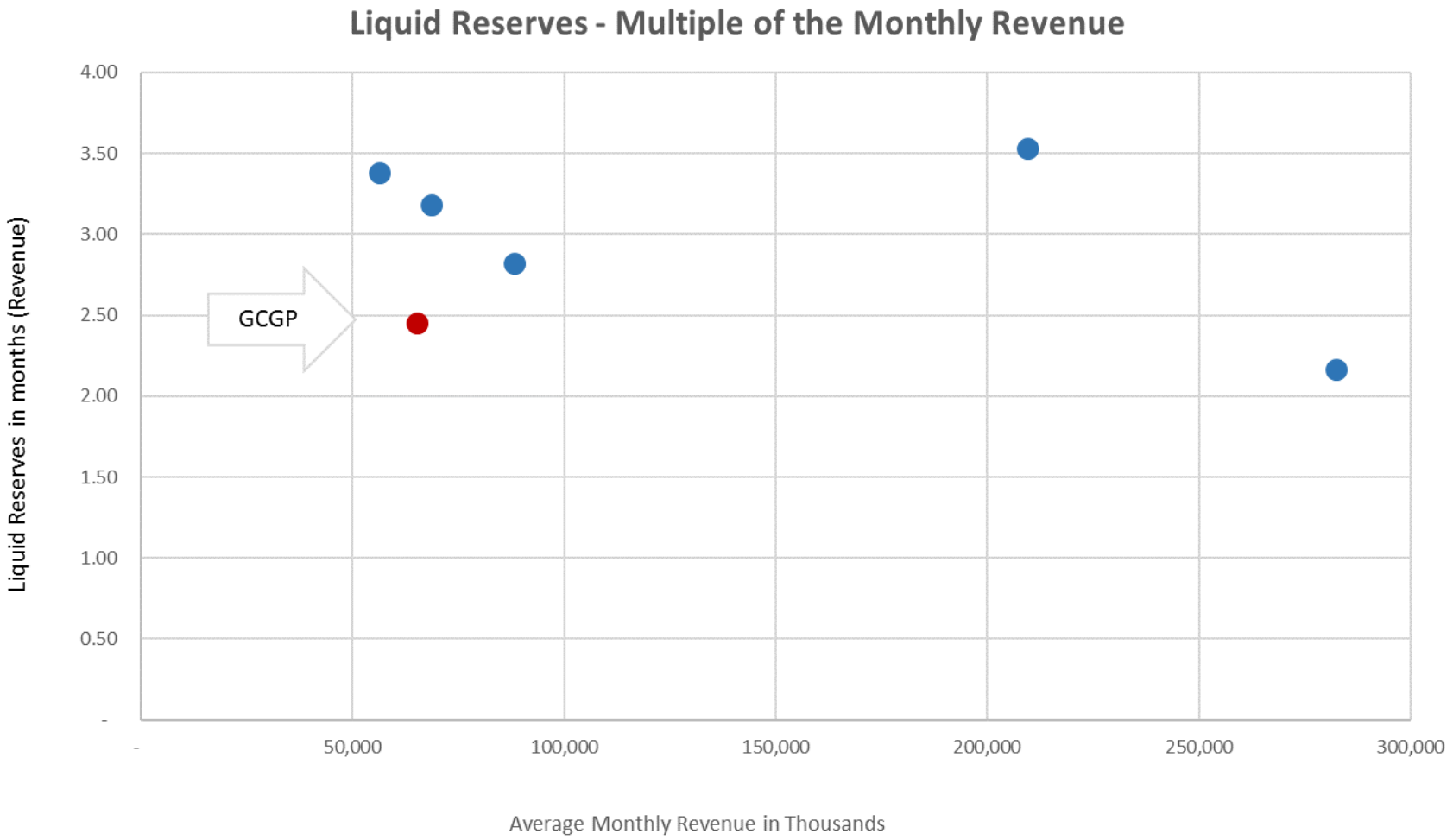
Cash (Liquid Reserves)



TNE and Working Capital Policy (FI 004) calls for maintaining cash and equivalents (working capital) of three months of medical and administrative expenses.

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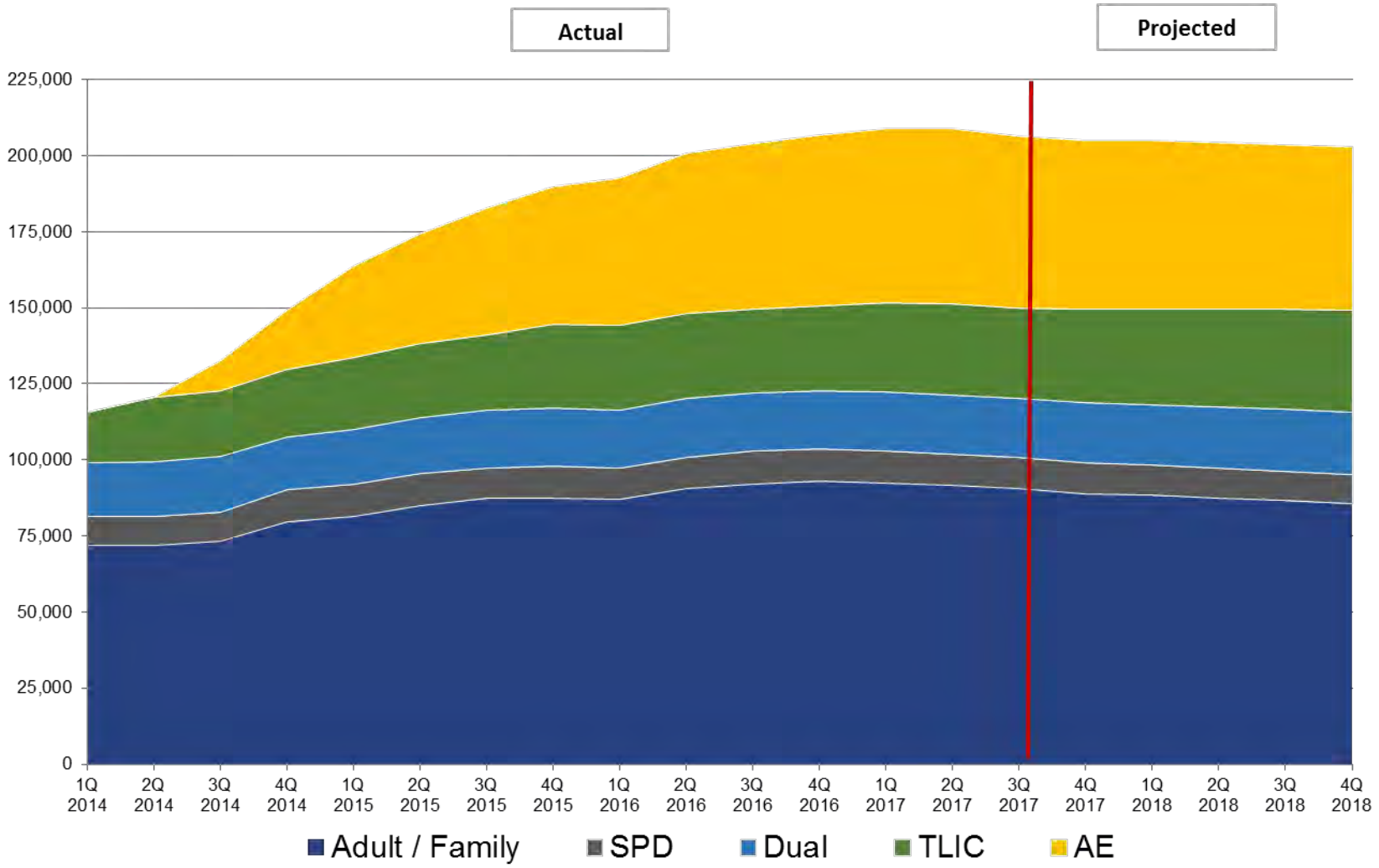
Members by Aid Category



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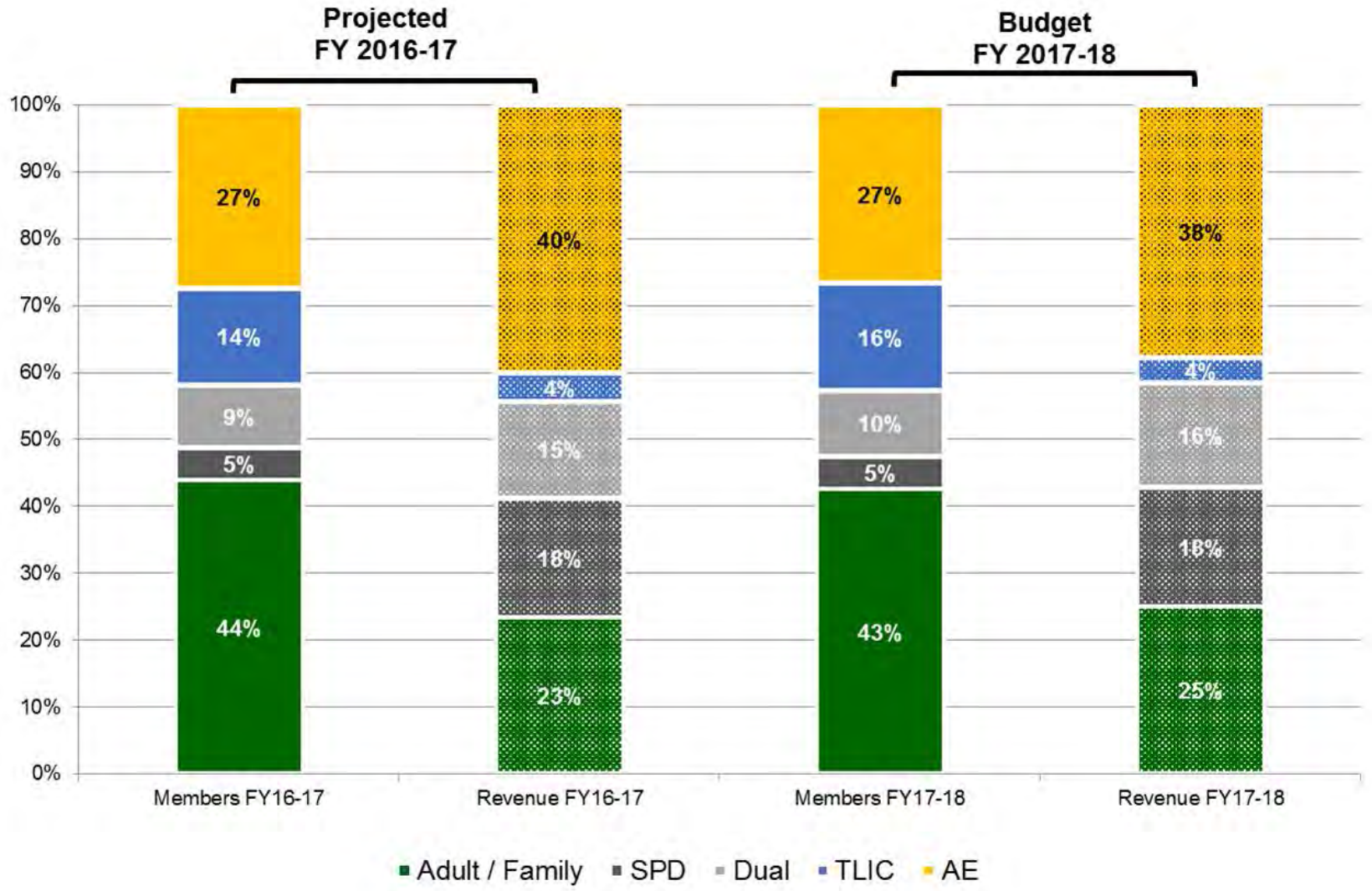
Membership Mix and Revenue Impact



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Income Statement Summary

	Actual FY 2015-16	Projected FY 2016-17 *	Budget FY 2017-18
	(Amounts are stated in thousands, except Enrollment)		
FYE Membership	208,533	205,024	202,696
Average Monthly Enrollment	*201,095*	*207,254*	*203,924*
Premium Revenue	$ 674,862	$ 681,676	$ 682,768
Capitation	101,993	64,560	64,540
Inpatient	217,913	253,775	245,722
Outpatient	67,554	77,157	79,248
Professional/Other	79,397	112,997	117,209
Pharmacy	100,617	114,996	110,991
Care Management	15,735	12,403	14,320
	481,217	571,327	567,490
Total Health Care Costs	583,210	635,887	632,030
Administrative Expense	38,231	49,618	49,605
Operating Gain (Loss)	**53,421**	**(3,830)**	**1,134**
Non-Operating Income (Expense)	2,593	2,804	910
Change in Net Position	**$ 56,014**	**$ (1,025)**	**$ 2,044**

** Reflects actual experience through 3/31/17 and estimates from 4/1/17 to 6/30/17*

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Income Statement Summary - PMPM

	Actual FY 2015-16	Projected FY 2016-17 *	Budget FY 2017-18	Increase (Decrease) Year-over-Year PMPM ($)	PMPM (%)
FYE Membership	208,533	205,024	202,696	(2,328)	-1.1%
Average Monthly Enrollment	201,095	207,254	203,924	(3,330)	-1.6%
Premium Revenue	$ **279.66**	$ **274.09**	$ **279.01**	$ **4.92**	**1.8%**
Capitation	42.27	25.96	26.37	0.42	1.6%
Inpatient	90.30	102.04	100.41	(1.62)	-1.6%
Outpatient	27.99	31.02	32.38	1.36	4.4%
Professional/Other	32.90	45.43	47.90	2.46	5.4%
Pharmacy	41.70	46.24	45.36	(0.88)	-1.9%
Care Management	6.52	4.99	5.85	0.86	17.3%
	199.42	229.72	231.90	2.18	1.0%
Total Health Care Costs	241.68	255.68	258.28	2.60	1.0%
Administrative Expense	15.84	19.95	20.27	0.32	1.6%
Operating Gain (Loss)	**22.14**	**(1.54)**	**0.46**	**2.00**	**130.1%**
Non-Operating Income (Expense)	1.07	1.13	0.37	(0.76)	-67.0%
Change in Net Position	$ **23.21**	$ **(0.41)**	$ **0.84**	$ **1.25**	**302.6%**

** Reflects actual experience through 3/31/17 and estimates from 4/1/17 to 6/30/17*

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Balance Sheet

	Actual 6/30/16	Projected 6/30/17	Budget 6/30/18
	(in thousands)		
Assets			
Cash and marketable securities	$ 367,360	$ 474,855	$ 132,609
Other current assets	131,745	132,608	134,796
	499,105	607,463	267,405
Capital assets (net of accum depr)	2,545	2,287	1,716
Total Assets	$ 501,650	$ 609,750	$ 269,121
Liabilities and Net Position			
Medical claims payable	$ 123,277	$ 141,959	$ 77,155
Other accrued liabilities	86,987	180,493	32,604
	210,264	322,452	109,759
Other long-term liabilities	135,427	132,364	1,382
Total Liabilities	345,691	454,816	111,141
Net Position	155,959	154,934	157,980
Total Liabilities and Net Position	$ 501,650	$ 609,750	$ 269,121

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Operational Metrics

	Actual FY 2015-16	Projected FY 2016-17 *	Budget FY 2017-18
Premium PMPM	$ 279.66	$ 274.09	$ 279.01
Medical Cost Ratio - PMPM	$ 241.68	$ 255.68	$ 258.28
Medical Cost Ratio (MCR)	86.3%	93.1%	92.6%
Administrative Expense - PMPM	$ 15.84	$ 19.95	$ 20.27
Administrative Cost Ratio (ACR)	5.7%	7.3%	7.3%
Required TNE (thousands)	$ 25,246	$ 28,815	$ 28,700
TNE	$ 155,959	$ 154,934	$ 156,978
% of Required	618%	538%	547%

** Reflects actual experience through 3/31/17 and estimates from 4/1/17 to 6/30/17*

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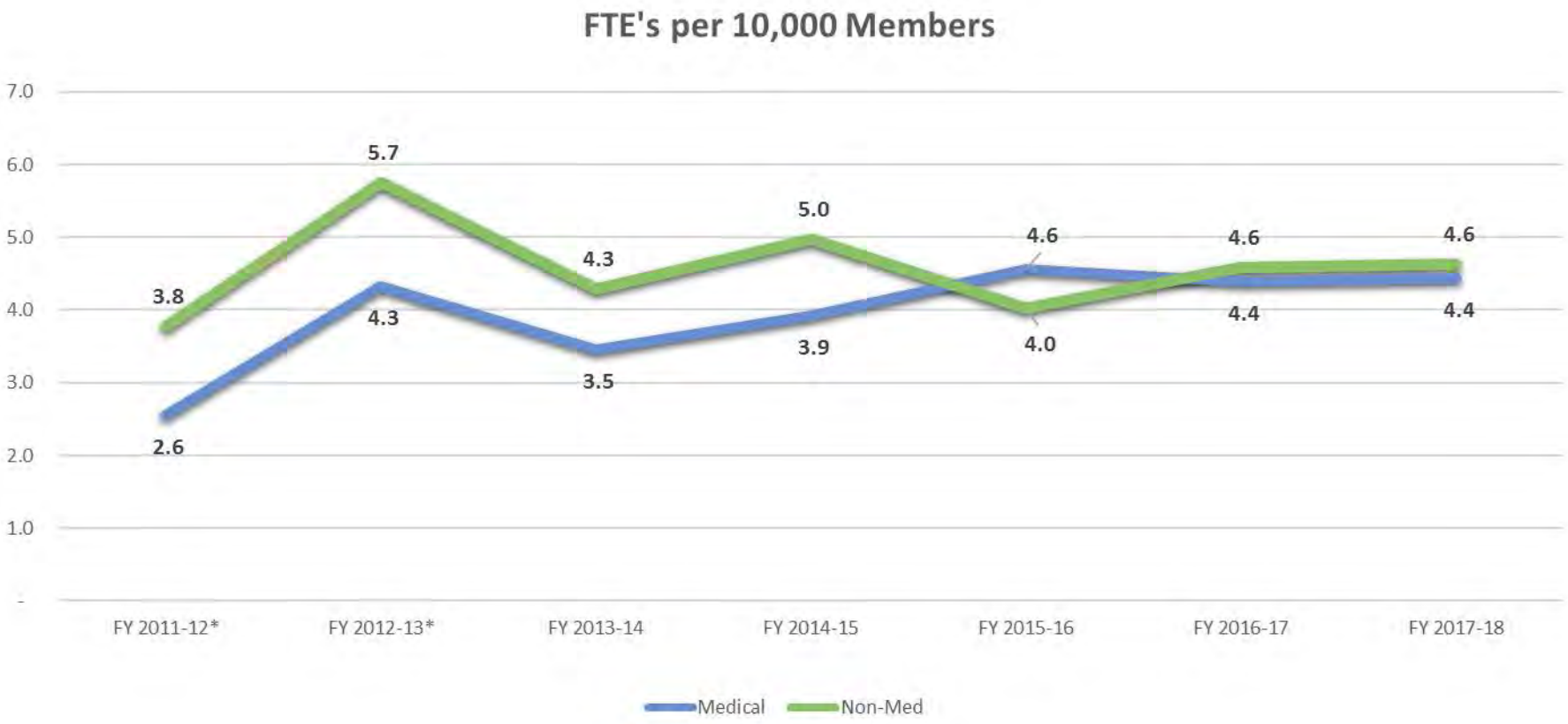
Staffing



*FY 2011-12 and FY 2012-13 - FTE includes Staffing from Agencies - 1 Medical and 1 Non-Med per 10,000 members
Assumptions: Merit increase 3% to average 185 FTEs

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Salary Ranges & Budget Assumptions

Level	25th Percentile	50th Percentile	60th Percentile	75th Percentile	90th Percentile
3	$41,284	$46,097	$47,249	$50,909	$60,534
4	$43,348	$48,486	$49,698	$53,624	$63,900
5	$45,517	$50,911	$52,184	$56,306	$67,095
6	$47,792	$53,456	$54,792	$59,121	$70,449
7	$50,182	$56,129	$57,532	$62,078	$73,973
8	$52,690	$58,935	$60,408	$65,180	$77,670
9	$55,325	$61,882	$63,429	$68,440	$81,554
10	$57,757	$62,671	$64,238	$67,403	$72,261
11	$60,996	$68,220	$69,926	$75,445	$89,893
12	$64,045	$71,636	$73,427	$79,228	$94,410
13	$67,248	$74,318	$76,176	$81,387	$95,526
14	$70,610	$78,033	$79,984	$85,456	$100,302
15	$74,141	$82,186	$84,240	$90,230	$106,320
16	$78,026	$84,606	$86,721	$90,921	$97,338
17	$81,740	$88,690	$90,908	$95,641	$108,961
18	$85,827	$93,124	$95,453	$100,422	$115,017
19	$90,119	$97,782	$100,226	$105,444	$120,768
20	$94,625	$102,671	$105,237	$110,716	$126,807
21	$104,324	$118,853	$121,825	$128,168	$146,795
22	$109,539	$118,853	$121,825	$128,168	$146,795
23	$110,200	$119,000	$121,975	$134,900	$149,300
24	$115,017	$124,796	$127,916	$134,575	$154,134
25	$120,768	$131,036	$134,312	$141,305	$154,134
26	$126,807	$137,588	$141,028	$148,370	$169,933
27	$133,147	$144,468	$148,080	$155,788	$178,430
28	$139,803	$151,691	$155,483	$163,578	$187,353
29	$146,693	$159,276	$163,258	$171,757	$196,720
30	$154,134	$167,239	$171,420	$180,344	$206,554
31	$161,840	$175,601	$179,991	$189,361	$216,882
32	$169,932	$184,381	$188,991	$198,829	$227,726
33	$178,429	$193,600	$198,440	$208,771	$239,112
34	$187,350	$203,280	$208,362	$219,209	$251,068
35	$196,718	$213,444	$218,780	$230,169	$263,621
36	$216,883	$235,323	$241,206	$253,763	$290,643
37	$227,726	$247,088	$253,265	$266,450	$305,175
38	$239,112	$259,443	$265,929	$279,773	$320,434
39	$251,068	$272,415	$279,225	$293,762	$336,455
40	$276,175	$299,657	$307,148	$323,138	$370,101

- Budget FY17/18 Salaries are consistent with 2016 Salary Ranges
- FTEs flat year over year
- Assumes 3% merit increase
- Market Salary Review underway

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Project Portfolio - Primary Business Drivers

- Investments in Provider Network Management technology driven by:
  - Regulatory requirements (MegaReg, DHCS Contract Amendment, Senate Bills)
  - Organic provider network growth,
  - Limited scalability of current in-house solution
- Investments in analytics and technology for population health/ whole person care (supports Triple Aim)
- Initiatives for improved staff safety and information security
- Keep the Lights On (KTLO) – “must do” infrastructure projects to run the day-to-day business
- Other regulatory mandates

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Appendix

Project Portfolio

Regulatory Mandates

- Medi-Cal Provider Data Improvement (MCPDIP), includes 274 and SB137
- FWA Cost Containment RFP & Implementation

Keep the Lights On (KTLO) – "Run the Business"

- ShoreTel "End of Life" Upgrade
- ASO RFP
- Sharepoint Department Site Migrations
- O365 Upgrade

Security/Information Security

- Internet Access Security Implementation
- Office 365 HIPAA Security Assessment
- Security Penetration Test
- iReceptionist

Technology Investments/BPI

- Provider Credentialing, Contracting, Data Management Suite
- Provider Portal
- Communications Strategy

Triple Aim

- ADT Real-Time ED Utilization (MLR)
- DM Registry (MLR)

Project Portfolio – Regulatory Mandates

- **Managed Care Provider Data Improvement Project (MCPDIP):** Transition to reporting Provider data in a 274-mandated formatted. Implement a standardized Provider Directory reporting process as mandated by DHCS (SB 137). Provider data clean up.

- **Fraud, Waste and Abuse Cost Containment:** Contract with vendor with the expertise to help GCHP cost-avoid expenses on a pre-payment basis and/or identify overpayment recovery opportunities.

Project Portfolio – 'Keep The Lights On'

- **ShoreTel End of Life Upgrade:** Retirement of current ShoreTel version forces to GCHP replace switch & remote user phones.
- **Administrative Services Organization (ASO) RFP(s):** Potential replacement of and/or separation of services currently provided by ASO.
- **SharePoint Department Site Migrations:** Migration of the remaining business departments onto the new SharePoint platform.
- **Office 365 Upgrade:** Upgrade Office 365. Supports business intelligence and reporting.

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Project Portfolio – Security

- **Internet Access Security Implementation:** Implement enhanced internet access security measures (hardware and software) to protect GCHP data.
- **Office 365 HIPAA Security Assessment:** Contract with outside vendor to evaluate Office 365 environment for HIPAA security.
- **Security Penetration Test:** Contract with 3rd party vendor to assess the integrity of GCHP network security and make recommendations.
- **iReceptionist:** Implement a system adding an additional layer of physical security. Allows GCHP to issue time specific badges with access audit tracking.

Project Portfolio – Technology Investments/ Business Process Improvements

- **Provider Credentialing, Contracting, Maintenance System:** RFP and implementation of a suite of products to manage and support the Provider data regulatory reporting (MCPDIP).

- **Provider Portal:** RFP and Implementation of a replacement Provider Portal to enhance Provider collaboration and information sharing.

- **Communications Strategy:** Enhance the functionality and improve the customer experience for internal and external GCHP consumers.

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Project Portfolio – Triple Aim

- **ADT Real-Time Emergency Department (ED) Utilization:** Provides GCHP clinical real time ED data for member for care coordination and interventions as appropriate. Supports Population Health Outcomes, Whole Person Care and other State mandated initiatives.

- **Disease Management (DM) Registry:** Implement a registry for managing GCHP member in the DM programs.

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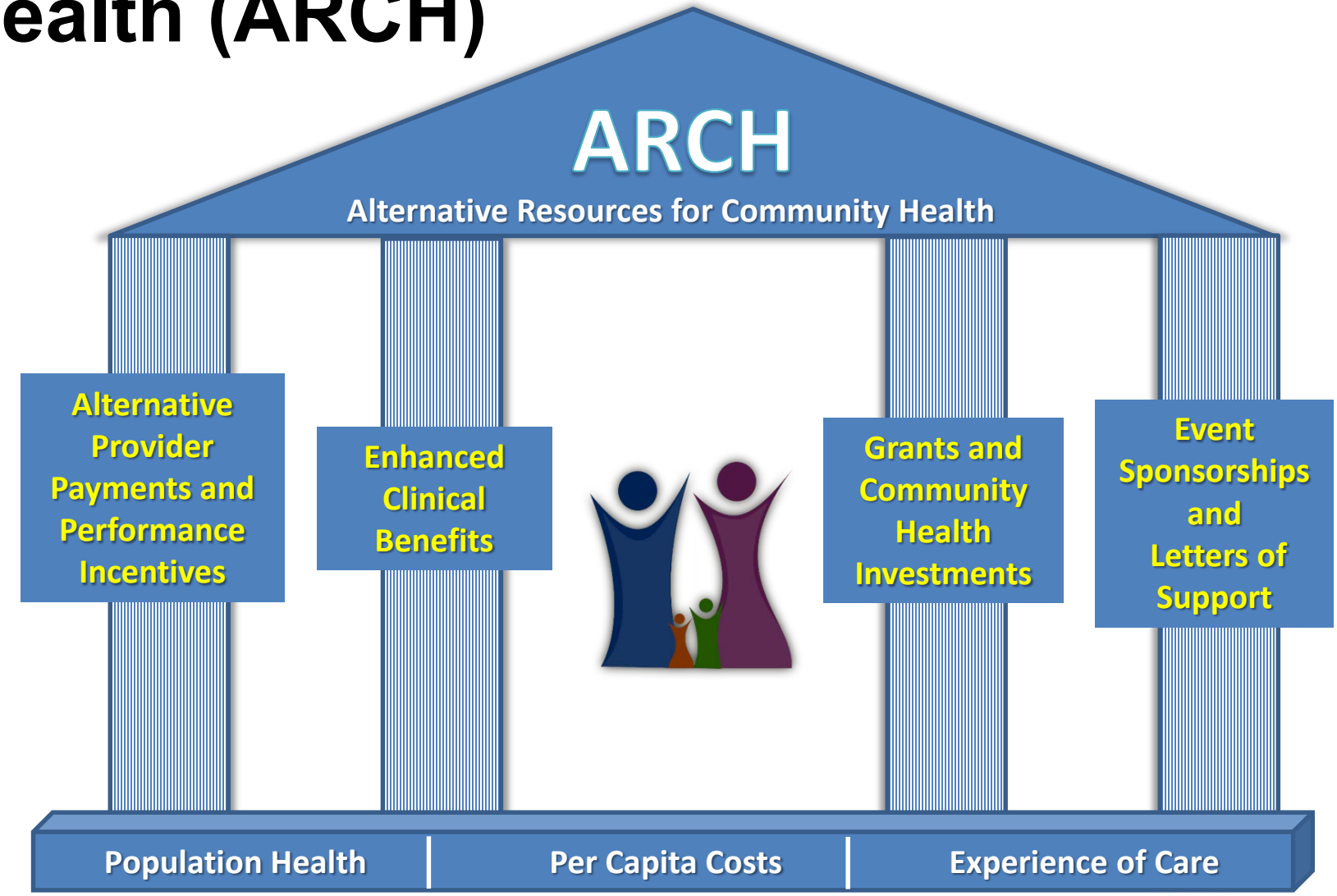
Alternative Resources for Community Health (ARCH)



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AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Scott Campbell, General Counsel

DATE: June 26, 2017

SUBJECT: Request to Approve Electronic Communications Policy In Accordance with *City of San Jose v. Superior Court* California Supreme Court Case

SUMMARY:

In accordance with a recent California Supreme Court decision and to ensure compliance with California's transparency and open government laws, General Counsel recommends adoption of the Electronic Communications Policy, attached as Exhibit "A."

BACKGROUND:

On March 2, 2017, the California Supreme Court published its decision in *City of San Jose v. Superior Court* (2017) 2 Cal.5th 608, holding that communications by public agency employees made using private electronic devices or personal email accounts may be disclosable under the Public Records Act if those communications concern the public's business.

In response to that decision, staff has prepared an Electronic Communications Policy to ensure agency officials and employees are able to continue utilizing existing and emerging electronic communication technologies to efficiently conduct Plan business. At the same time, the Electronic Communications Policy guarantees that all communications that relate to the public's business are properly retained by the Plan in line with California statutory law and the *City of San Jose v. Superior Court* decision.

Procedures contained within the Electronic Communications Policy include a requirement that all Plan officials and employees be assigned a Plan-specific electronic messaging account and prohibits officials and employees from using a separate personal account for the creation, transmission or storage of any electronic communications regarding Plan business. In other words, going forward all electric communications regarding Plan business will be on a Plan created email. In addition, the Policy describes specific protocols for an official or employee to search a personal account for electronic communications in response to a public records request, and the necessary steps to ensure adequate retention when an electronic message regarding Plan business is received on a personal account. The Electronic Communications Policy updates the Plan's AB 1234 ethics training to include discussion of the *City of San Jose v. Superior Court* case. The policy applies to Commissioners as well as Gold Coast staff.

FISCAL IMPACT:

It is estimated there will be a $3,000 annual cost to maintain the email accounts created for the Commissioners.

RECOMMENDATION:

Staff recommends that the Commission approve the Electronic Communications Policy attached as Exhibit “A.”

CONCURRENCE:

N/A

ATTACHMENTS

Exhibit No. 1 – Electronic Communications Policy
Exhibit No. 2 – Resolution No. 2017-003

SUBJECT: BUSINESS PRACTICES	POLICY: #4-__
POLICY: ELECTRONIC COMMUNICATIONS POLICY	EFFECTIVE: 06/26/2017

BACKGROUND AND PURPOSE:
The Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan hereby adopts the following policy regarding the conduct of Gold Coast Health Plan business via electronic communications by Agency Commissioners, officials and employees. Specifically, this policy is adopted in light of the holding in *City of San Jose v. Superior Court* (2017) 2 Cal.5th 608, which held that a city employee's communications related to the conduct of public business do not cease to be public records under the California Public Records Act, simply because they were sent or received using a personal account or personal device.

Existing and emerging electronic communications technologies have become an integral part of the ability of Agency officials and staff members to efficiently and effectively conduct Agency business. Such technology has the potential to enhance communications with the public and provide a higher level of service to the public and members of the Agency. However, with such technology in the work environment, the Agency must ensure it continues to meet its legal obligations with respect to transparency in the conduct of the people's business, including in the area of public records disclosure and retention requirements. To that end, the following protocol will be followed.

DEFINITIONS:
For purposes of this policy, the following definitions apply:

"Agency" means the Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan.

"Agency official" shall mean any appointed commissioner, official or employee of the Agency.

"Agency business" shall be construed broadly to mean information relating to the conduct of the public's business or communications concerning matters within the subject matter of the Agency's jurisdiction, including, but not limited to, pending or potential Agency projects, past or prospective Agency agenda items, or Agency budgets or expenditures involving Agency funds. Resolution of the question will involve an examination of several factors, including: (a) the content itself; (b) the context in, or purpose for which, it was written; (c) the audience to whom it was directed; (d) the purpose of the communication; and (e) whether the writing was prepared by an Agency official acting or purporting to act within the scope of his or her employment.

"Electronic communications" includes any and all electronic transmission, and every other means of recording upon any tangible thing in any form of communication or representation, including letters, words, pictures, sounds, or symbols, or combinations thereof, and any record thereby created, regardless of the manner in which the record has been stored. Without limiting the nature of the foregoing, "electronic communications" include e-mails, texts, voicemails, and also includes communications on or within commercial applications (apps) such as Facebook

Messenger, Twitter, WhatsApp, etc.

"Electronic messaging account" means any account that creates, sends, receives or stores electronic communications.

POLICY:

All Agency officials shall be assigned an Agency electronic messaging account.

Agency accounts shall be used to conduct Agency business. Agency officials shall not use personal accounts for the creation, transmission or storage of electronic communications regarding Agency business.

The Agency account, along with the attendant access to the Agency's account server, are solely for the Agency and Agency official's use to conduct Agency business and shall not be used for personal business or political activities. Incidental use of Agency electronic messaging accounts for personal use by Agency officials is permissible, though not encouraged.

If an Agency official receives an electronic message regarding Agency business on his/her non-Agency electronic messaging account, or circumstances require such person to conduct Agency business on a non-Agency account, the Agency official shall either: (a) copy ("cc") any communication from an Agency official's personal electronic messaging account to his/her Agency electronic messaging account; or (b) forward the associated electronic communication to his/her Agency account no later than 10 days after the original creation or transmission of the electronic communication.

Agency officials shall endeavor to ask persons sending electronic communications regarding Agency business to a personal account to instead utilize the Agency official's account, and likewise shall endeavor to ask a person sending an electronic communication regarding non-Agency business to use the Agency official's personal or non-Agency electronic messaging account.

Agency officials understand they have no expectation of privacy in the content of any electronic communication sent or received on an Agency account or communication utilizing Agency servers. Agency provided electronic devices, including devices for which the Agency pays a stipend or reimburses the Agency official, are subject to Agency review and disclosure of electronic communications regarding Agency business. Agency officials understand that electronic communications regarding Agency business that are created, sent, received or stored on an electronic messaging account, may be subject to the Public Records Act, even if created, sent, received, or stored on a personal account or personal device.

In the event a Public Records Act request is received by the Agency seeking electronic communications of Agency officials, the Agency Clerk's office shall promptly transmit the request to the applicable Agency official(s) whose electronic communications are sought. The Agency Clerk shall communicate the scope of the information requested to the applicable Agency official, and an estimate of the time within which the Agency Clerk intends to provide any responsive electronic communications to the requesting party.

It shall be the duty of each Agency official receiving such a request from the Agency Clerk to promptly conduct a good faith and diligent search of his/her personal electronic messaging accounts and devices for responsive electronic communications. The Agency official shall then promptly transmit any responsive electronic communications to the Agency Clerk. Such transmission shall be provided in sufficient time to enable the Agency Clerk to adequately review and provide the disclosable electronic communications to the requesting party.

In the event an Agency official does not possess, or cannot with reasonable diligence recover, responsive electronic communications from the Agency official's electronic messaging account, the Agency official shall so notify the Agency Clerk, by way of a written declaration, signed under penalty of perjury. In addition, an Agency official who withholds any electronic communication identified as potentially responsive must submit a declaration under penalty of perjury with facts sufficient to show the information is "personal business" and not "public business" under the Public Records Act. The form of the declaration is attached hereto as Attachment A.

It shall be the duty of the Agency Clerk, in consultation with the Agency's Legal Counsel, to determine whether a particular electronic communication, or any portion of that electronic communication, is exempt from disclosure. To that end, the responding Agency official shall provide the Agency Clerk with all responsive electronic communications, and, if in doubt, shall err on the side of caution and should "over produce". If an electronic communication involved both public business and a personal communication, the responding Agency official may redact the personal communication portion of the electronic communication prior to transmitting the electronic communication to the Agency Clerk. The responding Agency official shall provide facts sufficient to show that the information is "personal business" and not "public business" by declaration. In the event a question arises as to whether or not a particular communication, or any portion of it, is a public record or purely a personal communication, the Agency official should consult with the Agency Clerk or the Legal Counsel. The responding Agency official shall be required to sign a declaration, in a form acceptable to the Legal Counsel, attesting under penalty of perjury, that a good faith and diligent search was conducted and that any electronic communication, or portion thereof, not provided in response to the Public Records Act request is not Agency business.

Agency provided AB 1234 (ethics) training should include a discussion of the impacts of the City of San Jose case and this policy. Such training should include information on how to distinguish between public records and personal records. Agency officials who receive AB 1234 training from other providers should actively solicit training from the alternative provider on the impacts of the City of San Jose case.

Agency officials understand that electronic communications regarding Agency business are subject to the Agency's records retention policy, even if those electronic communications are or were created, sent, received or stored on an Agency official's personal electronic messaging account. It is a felony offense to destroy, alter or falsify a "public record". As such, unless the Agency official has cc'd/transmitted electronic communications in accordance with paragraph 5 above, that Agency official must retain all electronic communications regarding Agency business, in accordance with the Agency's adopted records retention policy, regardless of whether such

electronic communication is originally sent or received on a personal electronic messaging account.

Failure of an Agency official to abide by this policy, following its adoption, may result in one or more of the following:

- Disciplinary action, up to and including termination (for employees);
- Removal from office (for commissioners);
- Censure (for commissioners or elected officials);
- Revocation of electronic device privileges (including revocation of stipend or reimbursement);
- Judicial enforcement against the Agency official directly, by the requesting party; and

This policy does not waive any exemption to disclosure that may apply under the California Public Records Act.

EXHIBIT NO. 1

ATTACHMENT A

DECLARATION

[attached on following page]

The policies in this manual are intended for all employees of GCHP. The organization reserves the right to revise, change, or terminate policies or procedures at any time, with or without notice.

EXHIBIT NO. 1

In the matter of: California Public Records Act Request Pursuant to Gov. Code § 6250 *et seq*. Re: _____ _____ Insert shorthand name of record request, including request number, if applicable. Requester: _____ Print or type name of requester	Declaration of: _____ Print or type name of official **Regarding Search of Personal Electronic Messaging Account**

STATE OF CALIFORNIA
COUNTY OF VENTURA
VENTURA COUNTY MEDI-CAL MANAGED HEALTH CARE COMMISSION, DBA GOLD COAST HEALTH PLAN

I, _____ declare:
Print name

1. I received notice of a California Public Records Act ("CPRA") request regarding a search of my personal electronic messaging account(s).

2. I understand that the CPRA request seeks:

   _____
   Insert text of CPRA request.

3. I am the owner or authorized user of the following personal electronic messaging account and have the authority to certify the records:

   _____
   Insert description of personal electronic messaging account(s).

4. I have made a good faith, diligent, thorough, and complete search of the above-mentioned personal electronic messaging account(s) for all electronic communications potentially responsive to the above-mentioned CPRA request.

5. Any responsive electronic communications discovered, and referenced below, were prepared or used by me in the ordinary course of business at or near the time of the act, condition or event.

6. Any responsive electronic communications discovered, and referenced below, are true copies of all records described in the above-mentioned CPRA request.

_____

The policies in this manual are intended for all employees of GCHP. The organization reserves the right to revise, change, or terminate policies or procedures at any time, with or without notice.

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EXHIBIT NO. 1

Check the applicable box:

☐ I certify that I do not possess responsive electronic communications.

☐ I certify that I cannot reasonably recover responsive electronic communications.

_____
_____
_____
_____
_____

Explain efforts to retrieve responsive electronic communications and why you were unable to recover responsive electronic communications.

☐ I certify that I discovered potentially responsive electronic communications from my personal electronic messaging account, but I am withholding that information because the information is "personal" business. This is for the following reasons:

_____
_____
_____
_____
_____

Describe with sufficient facts why the contested information is personal business and not subject to the CPRA. Attach additional pages, if necessary.

☐ I certify that I discovered potentially responsive electronic communications from my personal electronic messaging account. I am providing all responsive information. However, some information is nonresponsive and I am withholding that information, because the information is

_____
_____
_____
_____
_____

Describe with sufficient facts why the contested information is personal business and not subject to the CPRA. Attach additional pages, if necessary.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that I have personal knowledge of the facts set forth above.

Executed this ___ day of _____ 20___ , in _____, California.

By:_____

Print Name:_____

EXHIBIT NO. 2

RESOLUTION NO. 2017-003

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, DOING BUSINESS AS THE GOLD COAST HEALTH PLAN, ADOPTING AN ELECTRONIC COMMUNICATIONS POLICY

WHEREAS, the California Supreme Court recently decided the *City of San Jose* case, holding that public employees' communications related to the conduct of public business do not cease to be public records under the California Public Records Act simply because they were sent or received using a personal account or personal device; and

WHEREAS, the Ventura County Medi-Cal Managed Care Commission, doing business as the Gold Coast Health Plan ("Plan"), desires to adopt the "*City of San Jose* Case Electronic Communications Policy" establishing procedures and protocols relating to electronic communications.

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

Section 1. Determination of Recitals. The Plan hereby finds and determines that all of the recitals set forth above are true and correct. The above recitals are hereby incorporated as substantive findings of this Resolution.

Section 2. The Plan hereby adopts the "*City of San Jose* Case Electronic Communications Policy," a copy of which is attached hereto as "Exhibit A" and incorporated herein by reference.

Section 3. Severability. The provisions of this Resolution are severable and if any provision of this Resolution is held invalid, that provision shall be severed from the Resolution and the remainder of this Resolution shall continue in full force and effect, and not be affected by such invalidity.

Section 4. Effective Date. This Resolution shall take effect upon its adoption.

Section 5. Certification. The Clerk of the Board shall certify to the adoption of this Resolution.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission at a regular meeting on the ____ day of _____, 2017, by the following vote:

AYE:
NAY:
ABSTAIN:

ABSENT:

_____
Chair

Attest:

_____
Clerk of the Board

AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: June 26, 2017

SUBJECT: Chief Executive Officer Update

GOOD LUCK TO DR. ALBERT REEVES

This is the last commission meeting for Dr. Reeves and we want to thank him for all he has done for Gold Coast Health Plan and for the health care of members and families in Ventura County. His leadership at GCHP will be greatly missed. We wish him and his wife Adrianne much happiness and good health in their retirement. Dr. Nancy Wharfield will be the acting Chief Medical Officer until a replacement is found. Witt Kieffer has identified three potential candidates for GCHP to consider and interviews will be taking place over the next few weeks.

LEGISLATIVE

Universal Health Care in California

The Healthy California Act, SB 562, would enact a universal, single payer health care system in California. SB 562 is sponsored by the California Nurses Association (CNA). Last month, the bill passed the state Senate by a vote of 23-14 with three Democrats (Hueso, Pan, Roth) not voting. One Democrat, Senator Steve Glazer, voted against the bill along with all Republicans. It is currently waiting to be heard in the Assembly Health Committee.

According to the Senate Appropriations Committee analysis, the cost to implement a universal health care program would be about $400 billion per year. The analysis indicated that major tax increases between $106 to $200 billion would be required to fund government-run healthcare for all Californians. The analysis was based on the assumption that California will continue to receive the same level of waivers from the federal government.

Despite its costs estimates, the bill does not contain a funding mechanism to address the hundreds of billions in new revenue (i.e. taxes) needed to fund the program. The bill also does not contain a transition plan from our current health care systems to single payer. Additionally, the Centers for Medicare and Medicaid Services (CMS) would have to agree to a waiver to allow the Medi-Cal program to merge into single payer system.

The Government Relations team at Gold Coast Health Plan (GCHP) will continue monitoring the legislative bill and provide updates as needed.

The American Health Care Act Update

The Senate continues its work on an Affordable Care Act "repeal/replace" bill. Senate Majority Leader, Mitch McConnell, has indicated he intends to have a bill on the Senate floor for a vote by the last week of June. Once agreement has been reached within the Republican Caucus on the specific provisions, legislative language will be shared with the Congressional Budget Office, as reconciliation requires a CBO estimate before a bill can be voted on. Senate leadership has indicated they do not intend to make the legislative language public. On June 20, Senate Democrats took the Senate floor to protest closed-door negotiations and asked for more time to consider the bill.

The Medicaid program is still being negotiated by moderate GOP Senators seeking to delay elimination of the expansion and modify key aspects of the per capita cap (e.g., base year). While the Senate's Medicaid provisions may be more moderate than the House's, they also will result in major reductions in federal spending and eligibility and eliminate the Medicaid entitlement. Assuming a bill passes the Senate, it will go back to the House for a final vote.

The Local Health Plans of California and many of the local plans will be in Washington, DC at the end of June for ACAP's fly-in, Board meeting and CEO Summit. The Government Relations team at GCHP has scheduled Hill visits with some members of California's Republican delegation in the House.

COMPLIANCE

Audits and Investigations (A&I) conducted the annual onsite medical audit during the weeks of June 5, 2017 through June 16, 2017. Gold Coast Health Plan (GCHP) is anticipating a draft report July/August 2017. Staff will keep the commission apprised as GCHP receives information.

On March 17, 2017, DHCS issued GCHP a CAP relative to the Provider Network 274 File, which is a new requirement for provider network data reporting. GCHP staff has been working diligently with DHCS during the entire process and has continuously kept DHCS abreast of the status of the test submissions. GCHP is complying with the CAP and submitting timelines and updates to DHCS on a biweekly basis.

GCHP continues to meet all regulatory contract submission requirements. GCHP submitted all required initial Final Rule deliverables on May 12, 2017 to DHCS. DHCS is currently reviewing the material submitted and has provided feedback to GCHP on most deliverables. For items that required follow up staff has incorporated the additional information and sent the deliverables back to DHCS for review and approval. All regulatory agency inquiries and requests are processed timely. Compliance staff is actively engaged in sustaining contract compliance.

GCHP CFO and Director of Financial analysis met with commissioners of the audit committee individually to discuss the 2017/2018 audit plan. The commission members were in support of the 2017/2018 audit plan and utilizing Estonien, a third party audit firm. The first phase of the audit plan will evaluate AB85 auto assignment compliance for the adult expansion population.

Per GCHP current DHCS contract, "*If an Adult Expansion Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, and resides in a public hospital system county, as defined in Welfare and Institutions Code Section 17612.2, Subdivision (u), Contractor shall assign the Adult Expansion Member to a Primary Care Provider as follows: 1) During a three (3) year period, ending on December 31, 2016, Contractor shall assign at least 75 percent of Adult Expansion Members who do not select a Primary Care Provider, to a Primary Care Provider within the county public hospital health system, until the county public hospital health system meets its enrollment target, as defined in Welfare and Institutions Code Section 14199.1(b) (3).*

2) Following the expiration of the three (3) year period as stated above, Contractor shall assign at least 50 percent of Adult Expansion Members who do not select a Primary Care Provider to a Primary Care Provider within the county public hospital health system until the county public hospital health system meets its applicable enrollment target.

As of January 1, 2017, the percentage requirement has decreased from 75% to 50% therefore an audit is being conducted by Estonien and the results will be shared with the commission upon completion.

An audit was conducted on Conduent and because of poor quality prep and lack of material to review; compliance failed Conduent on the audit and issued a CAP. Compliance staff conducted a second audit on Conduent the week of April 24, 2017 through April 27, 2017. A CAP was issued to Conduent on June 16, 2017.

An audit was conducted on GCHP MBHO for quality improvement, utilization management and member rights and responsibilities on February 20, 21 2017. A CAP was issued on April 3, 2017 and the CAP response was received on April 12, 2017. Upon review of the material, the CAP was successfully closed. GCHP MBHO was under a CAP for their call center falling below service level agreements. After a significant amount of monitoring by GCHP to achieve sustained compliance the CAP has been closed. GCHP MBHO remains under a CAP, for claims processing and financial sanctions are currently in place. GCHP Vision provider is also under a CAP. GCHP delegation oversight staff is working with each delegate on achieving compliance to address the deficiencies identified and ultimately close out the CAPs issued.

The compliance dashboard is attached for reference and includes information on but is not limited to staff trainings, fraud referrals, HIPAA breaches, delegate audits.

COMPLIANCE REPORT 2017

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
Hotline A confidential telephone and web-based process to collect info on compliance, ethics, and FWA	Referrals *one referral can be sent to multiple referral agencies*	5	1	7	14	9								36
Hotline Referral *FWA	Department of Health Care Services Program Integrity Unit / A&I	0	0	0	3	1								4
Hotline Referral *FWA	Department of Justice	0	0	0	0	0								0
Hotline Referral	Internal Department (i.e. Grievance & Appeals, Customer Services etc.)	5	1	7	11	8								32
Hotline Referral	External Agency (i.e. HSA)	0	0	0	0	0								0
Hotline Referral	Other * Legal, HR, DHCS (Division outside of PIU i.e. eligibility, note to reporter), etc.	0	0	0	0	0								0
Delegation Oversight The committee's function is to ensure that delegated activities of subcontracted entities are in compliance with standards set forth from GCHP contract with DHCS and all applicable regulations	Delegated Entities	8	8	8	8	8								8
	Reporting Requirements Reviewed **	71	83	68	81	75								378
	Audits conducted	5	1	0	1	0								7
Delegation Oversight	Letters of Non-Compliance	0	0	1	0	0								1
Delegation Oversight	Corrective Action Plan(s) Issued to Delegates	0	1	1	1	0								3
Audits External regulatory entities evaluate GCHP compliance with contractual obligations.	Total	0	0	0	0	0								0
	Medical Loss Ratio Evaluation performed by DMHC via interagency agreement with DHCS	0	0	0	0	0								0
	DHCS Facility Site Review & Medical Records Review *Audit was conducted in 2013*	0	0	0	0	0								0
	HEDIS Compliance Audit (HSAG)	0	0	0	0	0								0
	DHCS Member Rights and Program Integrity Monitoring Review *Review was conducted in 2012*	0	0	0	0	0								0
	DHCS Medical Audit	0	0	0	0	0								0
Fraud, Waste & Abuse The Fraud Waste and Abuse Prevention process is intended to prevent, detect, investigate, report and resolve suspected and /or actual FWA in GCHP daily operations and interactions, whether internal or external.	Total Investigations	5	1	0	14	8								28
	Investigations of Providers	0	0	0	1	0								1
	Investigations of Members	5	1	0	1	5								12
	Investigations of Other Entities	0	0	0	1	4								5
	Fulfillment of DHCS/DOJ or other agency Claims Detail report Requests	0	0	0	0	0								0

Back to Agenda

Category		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Calendar Year Total
HIPAA	Referrals	6	2	4	2	3								17
Appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of health information and ensure compliance with HIPAA regulatory requirements.	State Notification	6	2	4	2	3								17
	Federal Notification	0	3	0	0	0								3
	Member Notification	2	0	0	0	0								2
	HIPAA Internal Audits Conducted	0	0	1	0	0								1
Training	**Training Sessions**	12	2	0	3	1								48
Staff are informed of the GCHP's Code of conduct, Fraud Waste and Abuse Prevention Program, and HIPAA	Fraud, Waste & Abuse Prevention (Individual Training)	2	2	0	1	1								6
	Fraud, Waste & Abuse Prevention (Member Orientations)	6	6	6	6	6								30
	Code of Conduct	2	2	0	1	1								6
	HIPAA (Individual Training)	2	2	0	1	1								6
	HIPAA (Department Training)	0	0	0	0	0								0

** Reporting Requirements are defined by functions delegated and contract terms. Revised contracts, amendments or new requirements form DHCS may require additional requirements from subcontractors as a result the number is fluid

** Audits- Please note multiple audits have been conducted on the Plan, however many occurred in 2012 and 2013 and will be visible on the annual comparison dashboard

** This report is intended to provide a high level overview of certain components of the compliance department and does not include/reflect functions the department is responsible for on a daily basis.

^ The large aggregates for the month of November and December represent the yearly training of full time employees and new coming Commissioners.

AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: June 26, 2017

SUBJECT: Chief Operating Officer Update

OPERATIONS UPDATE

Membership Update – (Month/Year)

Gold Coast Health Plan (GCHP) membership is a product of Ventura County residents who are eligible for Medi-Cal and who choose to sign up for our plan. Membership is fluid, as people must re-determine each year, move in and out of the county or move to Medi-Cal fee for service.

As of June 1, 2017, Gold Coast Health Plan's (GCHP's) total membership is 201,455. The Plan experienced a net loss of 59 members over the previous month. We attribute the loss to the following potential impacts:

- Lack of redeterminations;
- Movement of members out of the county;
- Increases to income rendering member ineligible for plan participation.

AB 85 Auto Assignment- State Assembly Bill (AB 85) requires that the Plan assign 50% of those new Adult Expansion (AE) members who have not chosen a PCP within 30-days of enrollment to the County Public Hospital System, VCMC. In the month of June, GCHP assigned 646 members to VCMC, while the remaining 647 members were assigned to providers in compliance with the VCMMCC Auto Assignment policy. VCMC has 30,895 AE members assigned as of June 1, 2017. VCMC's target enrollment, as established by DHCS, is 65,765 and is currently at 46.98% of the target.

FY 16-17 Monthly Adult Expansion (AE) Membership Lookback (by aid code)

	L1	M1	7U	7W	7S	Total
Jun 17	484	55,462	83	31	91	56,151
May 17	505	55,331	92	35	113	56,076
Apr 17	520	55,333	94	44	163	56,154
Mar 17	560	55,539	100	48	210	56,457
Feb 17	590	55,667	113	55	243	56,668
Jan 17	646	55,551	141	50	203	56,591
Dec 16	695	55,820	521	123	240	57,399
Nov 16	770	55,567	1,057	216	314	57,924
Oct 16	919	55,103	1,227	254	374	57,877
Sep 16	1,015	54,740	1,370	280	336	57,741

Aug 16	1,162	54,237	1,470	307	361	57,537
Jul 16	1,261	53,767	1,593	346	397	57,364

Member PCP Assignments:

PCP Member assignments continue to reflect the normal trends expected. The 3 major Clinics (VCMC, Clinicas and CMH) represent 74.2% of the total GCHP enrollment or 152,251 members. The remaining 25.8% of GCHP enrollment or 53,978 are comprised of PCP other, Medi/Medi and Admin Members, unassigned and Kaiser.

Member Orientation Meetings

Sixty (60) total members (51 English, 9 Spanish) attended Member Orientation meetings between January and May 2017. Of the 60 members, 32 indicated they learned about the meeting because of the informational flyer included in each new member packet.
Other methods of notification included:

- Website
- TCRC
- HSA

Claims Update

Claims Inventory represents the number of claim received but not adjudicated. Claims Inventory for April is 164,613. This equates to a Days Receipt on Hand (DROH) of 4.613 days compared to a DROH maximum goal of 5 days and shows a decrease over the previous month of 22%. GCHP received approximately 8231 claims per day in April.

FY 2016-2017 Monthly Claims Receipts

Month	Total Monthly Claims Received	Average Daily Claims Receipts
April 2017	164,613	8,231
March 2017	208,407	9,061
February 2017	171,343	9,018
January 2017	168,660	8,433
December 2016	190,686	9,080
November 2016	170,209	8,510
October 2016	209,638	9,983
September 2016	159,446	7,593
August 2016	180,049	7,828
July 2016	166,955	8,347

Claims Processing Results – Conduent has several Service Level Agreements (SLAs) in place with GCHP to ensure that claims processed meet the minimum state and generally accepted service levels for claim processing. GCHP measures three (3) SLAs for claim processing:

- **Claims Turnaround Time (TAT) -** The number of days needed to process a claim from date of receipt to date of determination. The target is determination of 90% of original clean claims processed within 30 calendar days of receipt.
- **Financial Claims Processing Accuracy-** Percentage of correct payments against the total payments made in a month. The target is ≥ 98%
- **Procedural Claims Processing Accuracy-** The number of claims without any procedural errors (non-financial) against the total number of claims processed. The target is ≥ 97%.

Conduent did not meet the Claim Turnaround Time target in the month of April due to system issues, which limited processing time. This resulted in a penalty payment to Gold Coast Health Plan. As requested by GCHP, Conduent submitted a plan designed to reduce claims processing turnaround time. Preliminary May and June results indicate that the turnaround target is being met.

Conduent met the remaining claims targets.

Monthly SLA Performance

Month		
Service Level Agreement	**Expected Outcome**	**Actual Outcome**
Claim Turnaround Time	90%	88.6%
Financial Claims Processing Accuracy	98%	99.48%
Procedural Claim Processing Accuracy	97%	99.98%

Claim Denials – 14.45% of total volume, which is within industry norms.

Top Claim Denial Reasons:

- Service is included in Monthly Capitation per contract with provider
- Duplicate line item
- Primary Carrier EOB Required
- Charges incurred after term date
- Denied base on system edit
- Services are the financial responsibility of Clinicas

Encounter Data Quality Summary – GCHP collects monthly encounter data, which we submit to DHCS. These data are used in calculating the rates GCHP receives from the state to manage member care. GCHP measures three (3) aspects of encounter data on a monthly and quarterly basis:

- **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.

SLAs do not apply to encounter data.

In the 2nd quarter of YTD 2017, GCHP received 954,783 encounters. Encounter errors totaled 10,092, which equal and error rate of 1.0%. GCHP is current with all DHCS submissions.

Reasons for the errors include:

- Not Valid code
- Duplicate encounter
- No Medi-Cal eligibility
- Procedure date
- Admission date

Quarterly Encounter Data

Q2-2017 ENCOUNTER QUALITY			
MONTH	**SUBMITTED**	**ERRORS**	**% of ERRORS**
March	246,775	2,939	1.2%
April	409,696	4,413	1.1%
May	298,312	2,740	0.9%
TOTALS	**954,783**	**10,092**	**1.1%**

Call Center Results – Conduent is responsible for taking level one calls from members and providers. The volumes reported reflect only Conduent call data. Additional calls are taken by the GCHP member services team which includes calls routed from Conduent considered escalated or second level calls, calls from providers and members directly to the GCHP member services team and any calls to members or providers requesting a call be by the GCHP member services team. Conduent has three (3) call queues: provider, member (English), member (Spanish).

GCHP monitors and reports on two (2) specific areas that help identify the Conduent Call Center work effort:

- **Call Volume** – Call volume measures the number of calls taken in a month's time. April's call volume was 10,358. This is a decrease over the previous month.

- **Average Call Length** – Call length measures the amount of time a call center representative spends on a call with a member or provider. Call length is a function of the call type and may be shorter or longer depending on the type of call and type of caller. GCHP measures the average call length only as an indicator of how long the call center representatives are spending with our callers. April's average call length was 7 minutes and 23 seconds.

GCHP currently has three (3) SLAs that measure Conduent's call center efficacy on a monthly basis. Conduent met all targets in the month of April.

- **Average Speed to Answer (ASA) –** The number of seconds a caller waits in a queue until the call is answered by a call center representative.
  - Target - all calls answered within 30 seconds or less
- **Abandonment Rate –** Abandonment rate measures the percentage of calls disconnected by a caller prior to the call being answered by a Customer Service Representative.
  - Target - ≤ 5%.
- **Call Center Call Quality** – Conduent and GCHP staff work collaboratively to calibrate selected calls each week and use a standardized scoring tool to measure the percentage of calls answered accurately.
  - Target - 95% or higher.

Monthly SLA Performance

Month		
Service Level Agreement	Expected Outcome	Actual Outcome
Average Speed To Answer	≤30 seconds	17.9 sec
Abandonment Rate	≤5%	0.70%
Call Center Call Quality	≥95%	94.4%

Grievance and Appeals – Conduent is responsible for taking level one Provider Grievances, while GCHP handles all first level member appeals. Should the member or provider choose to continue to a second level action, those requests are sent to GCHP for resolution. In April, GCHP received 10 member grievances and 168 provider-claim payment grievances.

The 10 member grievances equate to 0.05 grievances per 1,000 members.

GCHP received eight Quality of Care member grievances, which consisted of the following issues:

- Delay of Care
- Poor provider / staff attitude

GCHP received three total clinical appeals in April; two appeals were upheld and one appeal was overturned. There were no State Fair Hearing cases in April.

Monthly Member Grievances

Type of Member Grievances	Number of Grievances
Accessibility	1
Denials/Refusals	1
Quality of Care	8
Total Member Grievances	**10**

Conduent Contract Negotiations:
Gold Coast Health Plan and Conduent Health Administration have agreed to terms for a new contract beginning July 1, 2017 and ending June 30, 2019. The terms of the contract delineate services in detail, which the previous contract lacked. The new contract outlines increased SLAs, greater liability limits and Conduent responsibility for cyber liability issues should they arise. Additional details can be found in the staff report included in this month's Commission Packet.

Appendix A: 2016 through FY 2015-2016 Monthly Membership Lookback

Monthly Membership Lookback (by aid code)

	L1	M1	7U	7W	7S
Jun 16	1,349	53,864	1,703	386	424
May 16	1,407	52,898	1,820	433	478
Apr 16	1,596	51,769	1,910	462	549
Mar 16	1,800	50,648	2,015	510	620
Feb 16	1,873	50,185	2,110	549	579
Jan 16	1,953	49,653	2,205	608	736

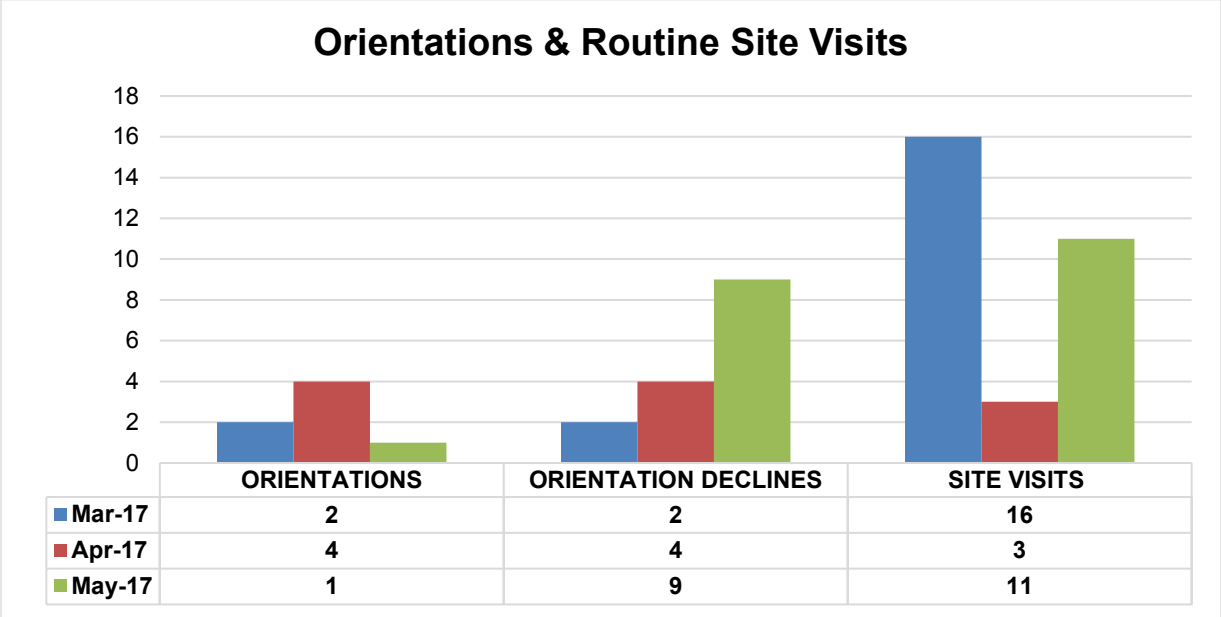
Appendix B: 2015 through FY 2015-2016 Monthly Claims Receipts

Monthly Claims Receipts

Month	Total Monthly Claims Received	Average Daily Claims Receipts
June 2016	177,246	8,057
May 2016	157,434	7,497
April 2016	162,287	7,728
March 2016	193,881	8,429
February 2016	176,656	8,833
January 2016	154,770	8,146
December 2015	170,897	7,768
November 2015	142,247	7,902
October 2015	156,109	7,095
September 2015	164,510	7,834
August 2015	152,840	7,278
July 2015	162,237	7,374

NETWORK UPDATE

Provider Site Visit Results:



	ORIENTATIONS	ORIENTATION DECLINES	SITE VISITS
Mar-17	2	2	16
Apr-17	4	4	3
May-17	1	9	11

- Orientations: 6 new provider orientations were conducted by GCHP Provider Relations Staff over the last 3 months. This figure is down approximately 25% due to pulling all network operations staff to focus primarily on the AB 274 project.

- 15 physicians declined orientation during this reporting period due to their joining an established contracted group with GCHP. Established groups such as delegated providers have participated in previous orientations; they are familiar with GCHP policies and procedures and have the staff and capability to perform the orientation function on their own.

- Site Visits: 30 provider site visits were completed by Network Operations - Provider Relations staff. The goal for the Provider Relations team is to complete 20 site visits per Provider Relations Specialists per month i.e. A total of 40 visits per month. These figures are down for this 3-month period due to two factors: loss of a Provider Relations Specialists who moved to Colorado and the other a result of the “all hands on deck” approach utilized to address the AB 274 project. Network Operations is in the process of interviewing candidates for this replacement position.

274 INITIATIVE (All Plan Letter 16-019)

- Significant progress has been made in meeting CAP requirements and deadlines. Project status is green.
- GCHP 274 work plan is 76% complete and pending 100% completion based on file testing over the weekend of 6/24-6/25.
- Received letter from the state acknowledging receipt of phase IV test file and confirmation that the file was accepted.
- Waiting on formal letter from DHCS to confirm GCHP is no longer under CAP, which should be within the next two weeks based on our notifying DHCS of 100% work plan completion.
- Job Aid Manuals (JAMs) are in development.
- Provider Network Database (PNDB) production freeze to take place Friday 23rd in preparation for Post implementation testing (smoke testing)
- Saturday 6/23 implementation of newly added 274 fields on the Enhanced UI.

VALUE BASED INITIATIVES

Child Access Initiative (Enhanced Access for Well Child Visits): received one quarterly update report from one of the three Clinics participating in this P4P program. Expect to receive the remaining reports the first week of July. By all accounts the Clinics have been actively engaged in efforts to improve well child visit access in the following age categories:

- 25 months to 6 years
- 7 years to 12 years
- 12 years to 19 years

Transition of Care Pilot: signed an agreement with Camarillo Health Care District (CHCD) with an effective date of 8/1/2017.

Purpose and Intent:

The Pilot is designed to enhance 30 to 90 day care transition interventions to Members discharged from the Hospital. Each Member will receive an inpatient visit from a Transitional Health Coach, one to three home visits and weekly check-in calls following each visit. Additionally, Pilot staff will collaborate with and offer support to the home health agencies and other community health partners involved in the care of the Member post discharge.

It is the goal of this this Pilot to keep the Targeted Population of Members out of the emergency room and help avoid hospital re-admissions when possible. This Pilot allows both Gold Coast and Provider to address the broader aspect of a Member's care, not only for medical conditions, but also for day-to-day improvement of functional abilities, cognitive status and social supports that will allow a Member to thrive at home and in the community.

A partnership with CHCD offers an advantage in achieving better care:

- Experienced track record of successful innovative accomplishments
- Integrates critical community-based support as a "warm handoff' to a trusted source, long after a member has returned home
- Creates a new circle of communication back to the health plan regarding patient red flags
- Links to evidence-based health promotion programs to support member's return to health in the community
- Incorporates the silent army of family caregivers into the care plan with critical support and education for their job at home
- Prepares and provides person-centered supports for recovery at home

The parties endeavor to achieve the following outcomes through the Pilot:

- Readmission cost savings
- Emergency department cost savings
- Improved HCAHPS (Hospital Consumer Assessment of Heathcare Providers and Systems), HEDIS and Star ratings relating to patient experience with post-hospital care due to enhanced patient support, satisfaction, and engagement
- Enhanced patient care long after the 30-day Hospital to Home intervention due to use of community services.

PROVIDER ADDS & TERMINATIONS- May 2017

Provider Adds: 25

- PCPs & Mid-levels: 4
- Specialists: 15
  - Cardiology:1
  - Emergency Medicine: 8
  - Hospitalists: 3
  - OB/GYN:1
  - Ophthalmology (Retina): 2
- Ancillary: 6
  - Ambulatory Surgery Center: 1
  - Pharmacy:1
  - Physical Therapy: 2
  - Radiology: 2

Provider Terms: 3

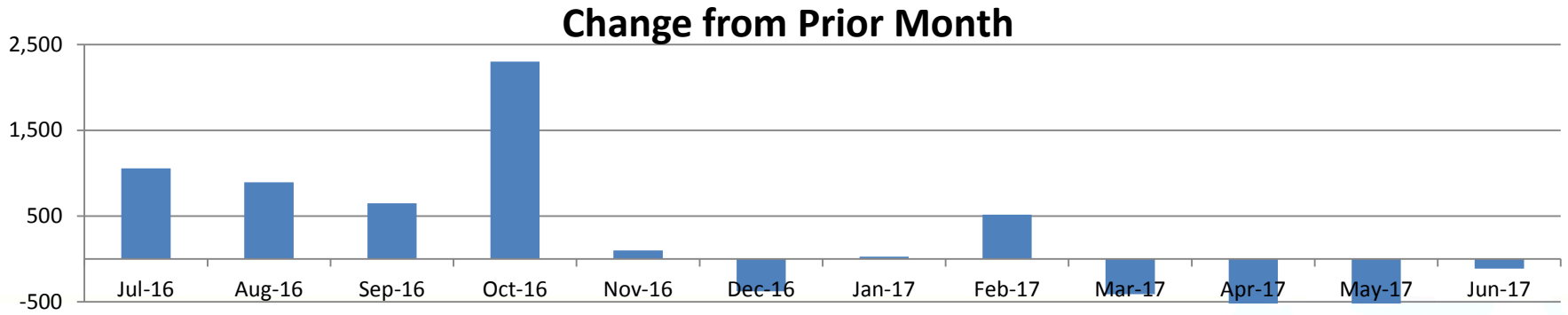
- Cardiologists: 1
- LTAC: 1 (ceased doing business)
- Neurologist: 1

GCHP Membership

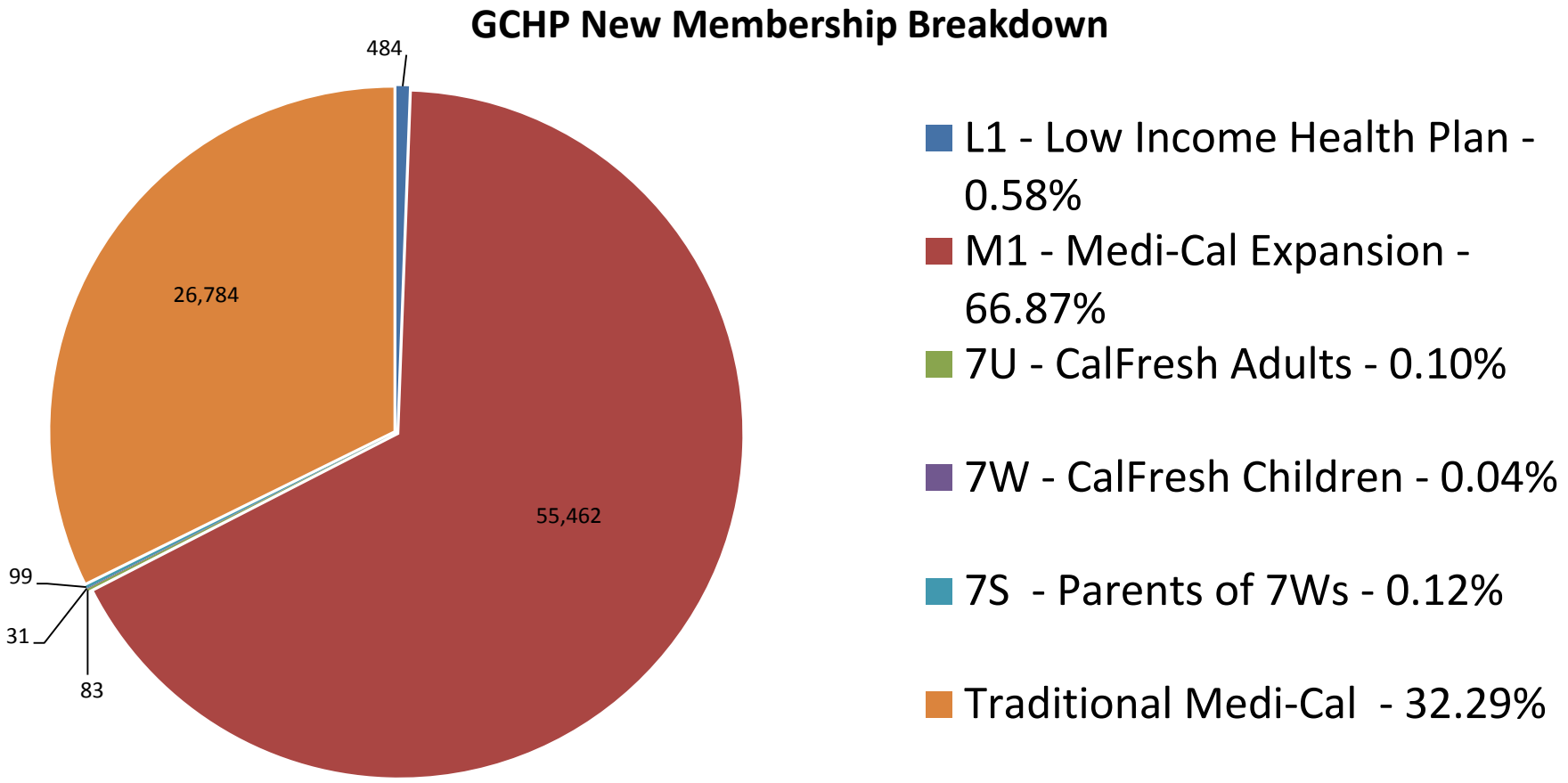
Total Membership as of June 1, 2017 – 201,455

*New Members Added Since January 2014 – 82,943

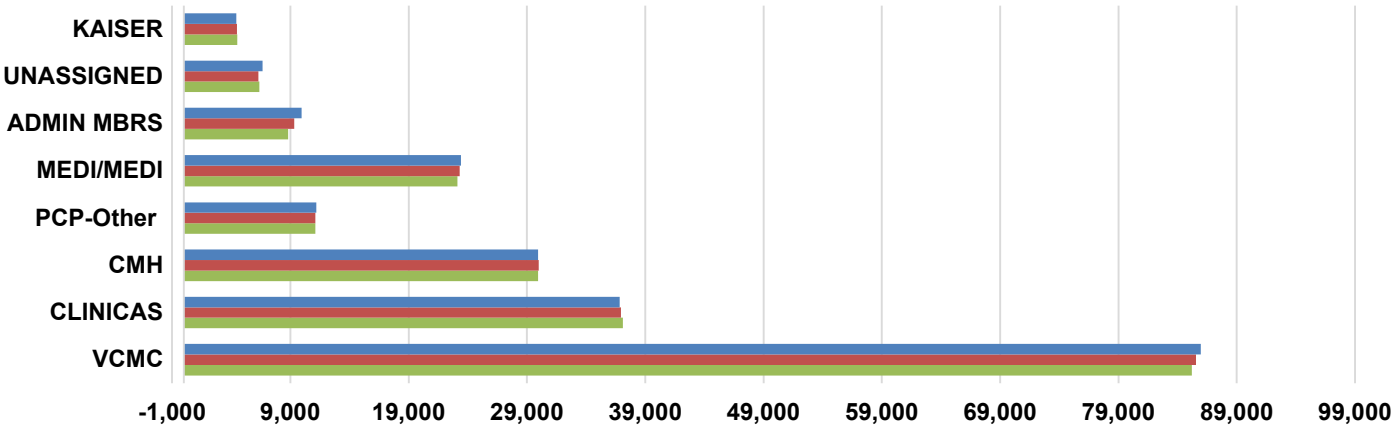
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Active Membership	207,019	206,644	206,672	207,188	206,780	206,252	204,529	204,417	203,243	202,338	201,514	201,455



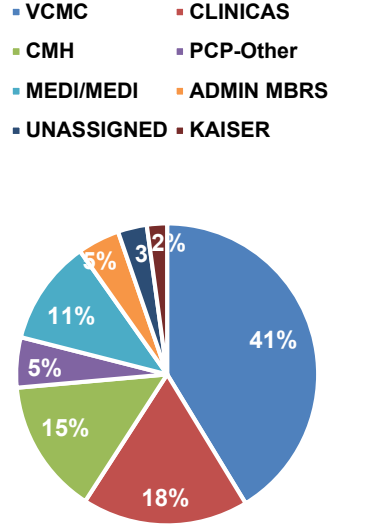
Membership Growth



Member PCP Assignments



	VCMC	CLINICAS	CMH	PCP-Other	MEDI/MEDI	ADMIN MBRS	UNASSIGNED	KAISER
Mar-17	85,959	36,832	29,942	11,196	23,425	9,938	6,639	4,422
Apr-17	85,556	36,947	29,984	11,117	23,327	9,333	6,304	4,499
May-17	85,197	37,115	29,939	11,109	23,133	8,826	6,385	4,525



- Unassigned members are Newly Eligible/Enrolled
- Administrative Member(s)
  - Share of Cost (SOC): a Member who has Medi-Cal with a Share of Cost requirement.
  - Long-Term Care (LTC): A Member who is residing in a skilled or intermediate-care nursing facility and has been assigned an LTC Aid Code.
  - Out of Area: A Member who resides outside GCHP's service area but whose Medi-Cal case remains in Ventura County.
  - Other Health Coverage: A Member who has other health insurance that is primary to their Medi-Cal coverage; this includes Members with both Medi-Cal and commercial insurance. Medi-Cal is the payer of last resort; therefore GCHP Members with other coverage must access care through their primary insurance.

Gold Coast Health Plan℠
A Public Entity

GCHP Membership Churn Summary

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Membership from Prior Month	204,619	206,920	207,019	206,644	206,672	207,188	206,780	206,252	204,529	204,417	203,244	202,404	202,204
Prior Month Members Inactive in Current Month	5,584	5,881	6,182	6,083	5,575	6,866	6,054	8,733	6,682	7,555	8,028	7,399	6,475
Sub-total	199,035	201,039	200,837	200,561	201,097	200,322	200,726	197,519	197,847	196,862	195,216	195,005	195,729
Percentage of Inactive Members from Prior Month	2.73%	2.84%	2.99%	2.94%	2.70%	3.31%	2.93%	4.23%	3.27%	3.70%	3.95%	3.66%	3.20%
Current Month New Members	6,316	4,378	3,916	4,256	4,193	4,533	3,809	5,165	4,118	4,088	4,587	4,371	4,237
Sub-total	205,351	205,417	204,753	204,817	205,290	204,855	204,535	202,684	201,965	200,950	199,803	199,376	199,966
Percentage of New Members Reflected in Current Membership	3.05%	2.11%	1.90%	2.06%	2.02%	2.19%	1.85%	2.53%	2.01%	2.01%	2.27%	2.16%	2.10%
Retroactive Member Additions	1,569	1,602	1,891	1,855	1,898	1,855	1,717	1,845	2,452	2,294	2,601	2,828	2,253
Active Current Month Membership	**206,920**	**207,019**	**206,644**	**206,672**	**207,188**	**206,780**	**206,252**	**204,529**	**204,417**	**203,244**	**202,404**	**202,204**	**202,219**
Percentage of Retroactive Members Reflected in Current Membership	0.76%	0.77%	0.92%	0.90%	0.92%	0.90%	0.83%	0.90%	1.20%	1.13%	1.29%	1.40%	1.11%

GCHP Auto Assignment by PCP/Clinic as of May 1, 2017

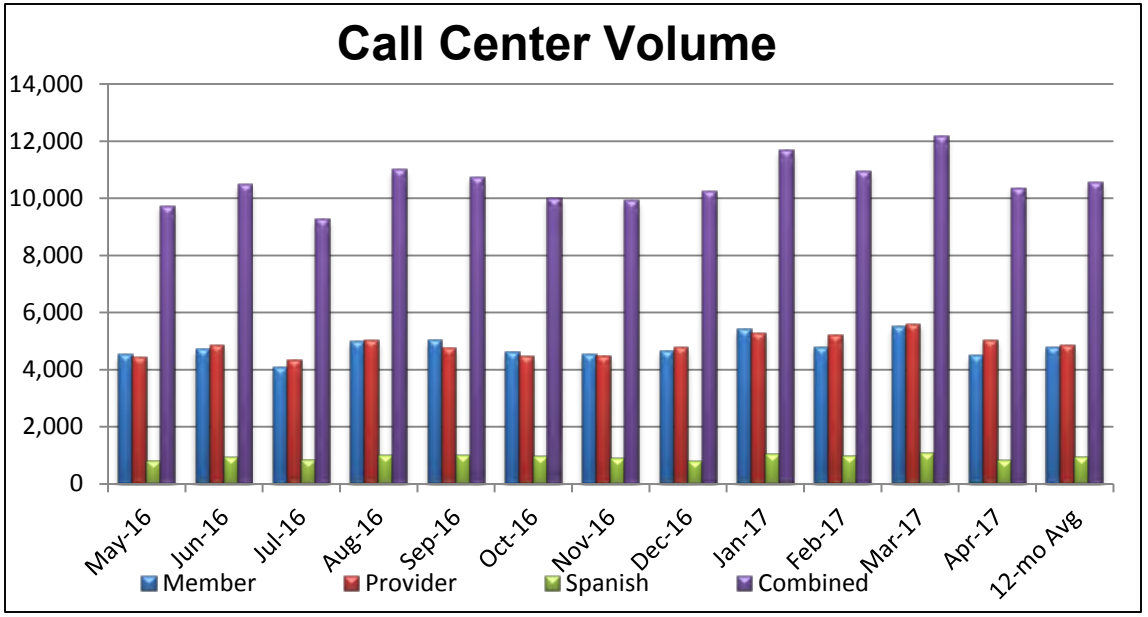
	Jun-17		May-17		Apr-17		Mar-17		Feb-17		Jan-17	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
AB85 Eligible	1293		**1290**		**1518**		**2141**		**1357**		**1,000**	
VCMC	646	49.96%	645	50.00%	759	50.00%	1070	49.98%	678	49.96%	499	49.90%
Balance	647	50.04%	645	50.00%	759	50.00%	1071	50.02%	679	50.04%	499	49.90%
Regular Eligible	**883**		**983**		**1,567**		**2,121**		**1,102**		**888**	
Regular + AB85 Balance	**1,530**		**1,628**		**2,326**		**3,192**		**1,781**		**1,387**	
Clinicas	347	22.68%	384	23.59%	552	23.73%	726	22.74%	396	22.23%	314	22.64%
CMH	203	13.27%	194	11.92%	299	12.85%	391	12.25%	225	12.63%	170	12.26%
Independent	45	2.94%	34	2.09%	57	2.45%	82	2.57%	33	1.85%	32	2.31%
VCMC	935	61.11%	1016	62.41%	1418	60.96%	1993	62.44%	1127	63.28%	871	62.80%
Total Assigned	**2,176**		**2,273**		**3,085**		**4,262**		**2,459**		**1,888**	
Clinicas	347	15.95%	384	16.89%	552	17.89%	726	17.03%	396	16.10%	314	16.63%
CMH	203	9.33%	194	8.53%	299	9.69%	391	9.17%	225	9.15%	170	9.00%
Independent	45	2.07%	34	1.50%	57	1.85%	82	1.92%	33	1.34%	32	1.69%
VCMC	1581	72.66%	1661	73.08%	2,177	70.57%	3,063	71.87%	1,805	73.40%	1,370	72.56%

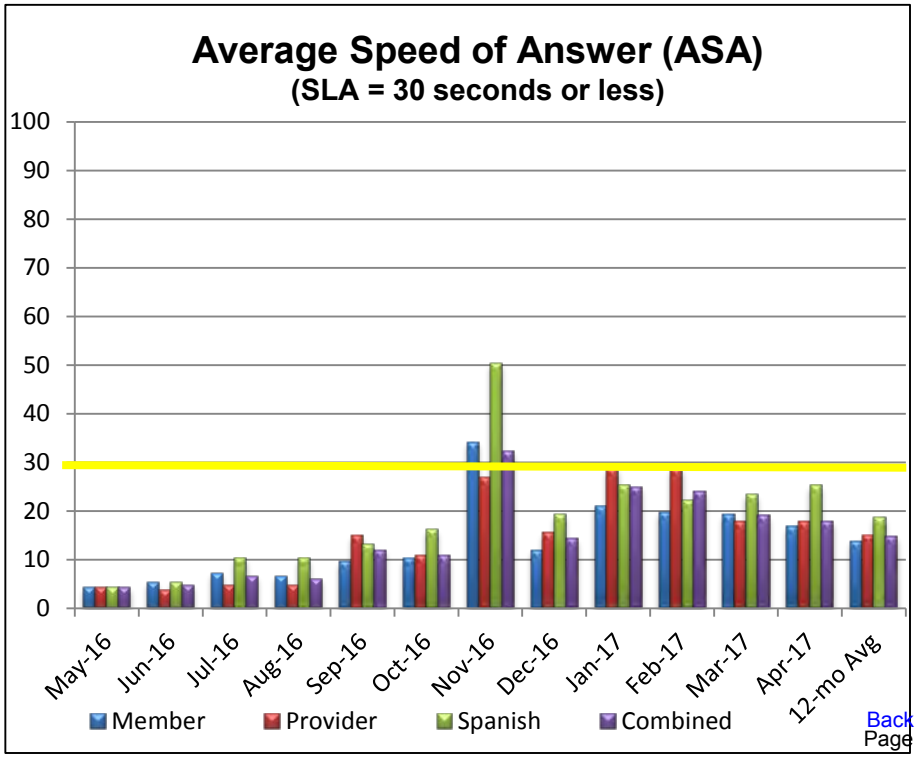
Auto Assignment Process

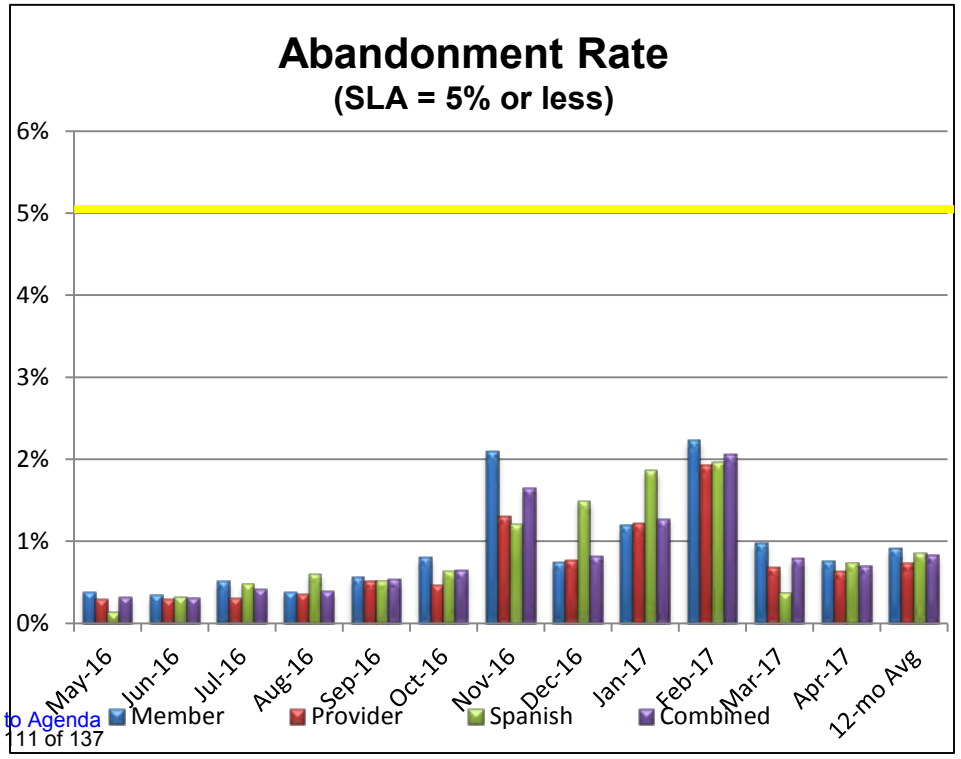
- 50% of eligible Adult Expansion (AE) members (M1 & 7U) are assigned to the County as required by AB 85
- The remaining 50% are combined with the regular eligible members and assigned using the standard auto assignment process, i.e., 3:1 for safety net providers and 1:1 for all others
- The County's overall auto assignment results will be higher than 50% since they receive 50% of the AE members plus a 3:1 ratio of all other unassigned members
- VCMC's target enrollment is 65,765
  - VCMC has 30,895 assigned Adult Expansion members as of June 1, 2017 and is currently at 46.98% of capacity

GCHP Call Center Metrics – April 2017

- Call volume remained above 10,000 during the month; GCHP received 10,358 calls during April
- Service Level Agreements (SLA) for ASA (17.9 seconds vs the contractual requirement of ≤ 30 seconds) and Abandonment Rate (0.70% vs the contractual requirement of ≤ 5%) ASA and Abandonment Rate were met for April

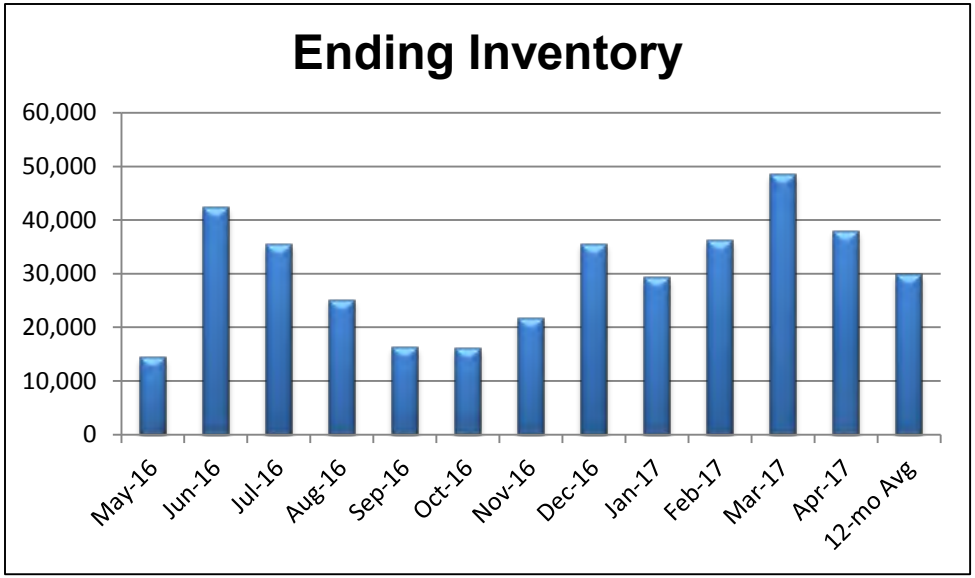


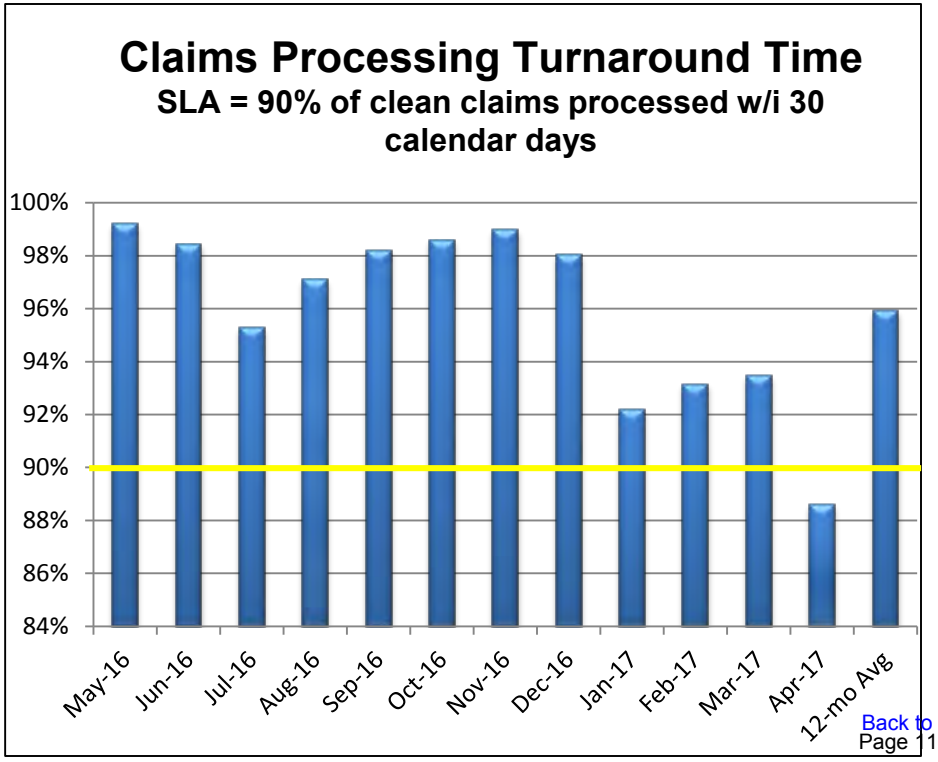


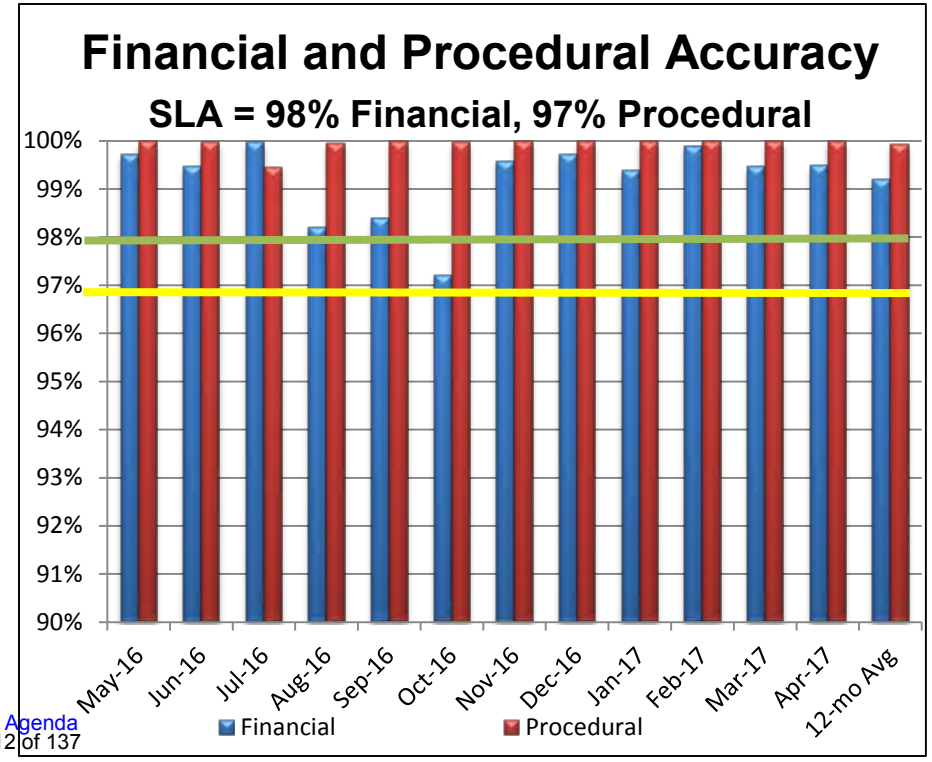


GCHP Claims Metrics – April 2017

- The 30 Day Turnaround Time (TAT) was non-compliant with the expected service level. Only 88.6% of clean claims were processed timely with the minimum requirement at 90%.
- Ending Inventory was 37,968 which equates to a Days Receipt on Hand (DROH) of 4.6 days vs a target DROH ≤ 5 days
- Service Level Agreements (SLAs) for Financial Accuracy (99.48%) and Procedural Accuracy (99.98%) were both met in April







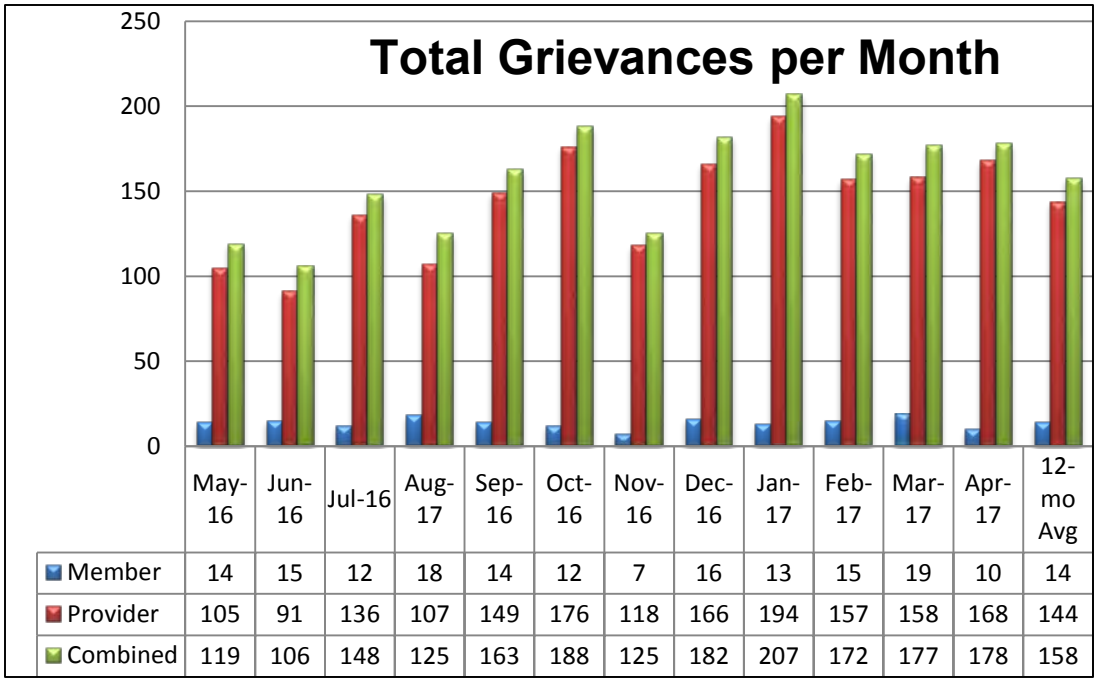
Gold Coast Health Plan
Weekly Claims Processing Dashobard
January 4, 2017 - April 26,2017

	01/04/17	01/11/17	01/18/17	01/25/17	02/01/17	02/08/17	02/15/17	02/22/17	03/01/17	03/08/17	03/15/17	03/22/17	03/29/17	04/05/17	04/12/17	04/19/17	04/26/17
Corrective Action Plan Tracking																	
CAP Reference																	
3c - Percentage of Claims Denied (1)	20.21%	13.81%	14.81%	13.96%	15.37%	14.68%	14.65%	18.00%	16.28%	12.32%	13.15%	11.95%	11.98%	13.02%	13.39%	15.79%	15.61%
3e - Number of Claim Adjustments (2)	2,199	1,386	932	815	2	854	816	949	1	961	835	1,533	1,173	998	4,974	1,072	1,206
3f - Number of Claims Processing FTEs (3)	68	67	66	65	63	62	62	62	62	62	62	61	61	61	61	61	51
3g - Auto Adjudication Rate (4)	55.87%	50.43%	49.93%	53.18%	48.16%	54.63%	54.89%	56.46%	61.10%	50.10%	58.53%	61.89%	58.14%	57.25%	52.39%	42.20%	37.42%
3g - Auto Adjudication Rate including Autobot (4)	70.00%	64.67%	62.30%	62.94%	59.52%	66.01%	66.21%	67.81%	67.45%	70.21%	70.95%	72.36%	70.55%	71.31%	65.97%	56.66%	59.76%
4a - Number of Items in ACS Refund Check Queue (5)	203	228	275	271	279	290	265	239	234	232	187	176	150	96	98	151	121
4a - Number of Items in ACS Refund Check Queue > 20 Days TAT (	155	180	197	223	240	203	196	206	184	169	133	124	84	55	54	63	75
4a - Number of Items in Non-Indexed Refund Check Queue (5)	20	42	27	80	83	42	32	41	53	34	71	40	35	74	76	10	44
Claim Receipts																	
Total Claim Receipts	36,882	39,905	40,424	41,641	39,461	46,006	43,772	37,910	43,655	45,270	43,767	44,238	43,942	47,124	43,230	41,041	31,322
Average Claims Receipts (6)	8,684	8,268	8,096	7,849	7,943	8,072	8,377	8,544	8,357	8,567	8,530	8,530	8,847	8,861	8,954	8,927	8,767
Mailroom Inventory on Hand																	
Items in EDGE to be worked (8)	11	11	11	11	11	11	11	11	11	9	9	9	9	9	9	9	9
Claims with Front-end Errors (9)	1,757	1,799	1,722	1,887	1,178	1,170	1,302	1,395	1,487	1,594	1,974	2,343	2,180	1,871	1,176	1,180	522
IKA Inventory on Hand																	
Pended Inventory	33,472	34,330	32,790	31,009	28,058	28,306	28,161	31,410	34,769	31,909	35,768	39,386	41,734	45,018	42,245	43,333	34,516
Working Inventory (10)	**35,240**	**36,140**	**34,523**	**32,907**	**29,247**	**29,487**	**29,474**	**32,816**	**36,267**	**33,512**	**37,751**	**41,738**	**43,923**	**46,898**	**43,430**	**44,522**	**35,047**
Claims Ready to Pay (11)	2,843	3,865	4,310	4,002	3,843	3,731	4,608	3,444	4,372	4,360	4,787	4,775	4,843	3,986	4,778	4,292	3,025
Current Inventory	**38,083**	**40,005**	**38,833**	**36,909**	**33,090**	**33,218**	**34,082**	**36,260**	**40,639**	**37,872**	**42,538**	**46,513**	**48,766**	**50,884**	**48,208**	**48,814**	**38,072**
DROH Working Inventory (10, 12)	4.1	4.4	4.3	4.2	3.7	3.7	3.5	3.8	4.3	3.9	4.4	4.9	5.0	5.3	4.9	5.0	4.0
DROH Current Inventory (12)	4.4	4.8	4.8	4.7	4.2	4.1	4.1	4.2	4.9	4.4	5.0	5.5	5.5	5.7	5.4	5.5	4.3
Clean Claims Aging (7)																	
31 to 60 Days	5,374	4,964	4,824	4,768	3,809	3,493	3,184	2,963	2,989	3,120	3,221	3,389	2,794	2,070	3,037	2,423	2,747
61 to 90 Days	1035	935	713	53	9	7	13	17	22	33	41	57	19	21	26	27	1
90+ Days	136	9	5	2	3	1	4	4	3	3	9	13	6	0	7	9	4
Total Clean Claims Aged > 30 Days	**6545**	**5908**	**5542**	**4823**	**3821**	**3501**	**3201**	**2984**	**3014**	**3156**	**3271**	**3459**	**2819**	**2091**	**3070**	**2459**	**2752**
Contested Claims Aging (7)																	
0 to 30 Days	179	199	268	352	600	396	753	381	315	206	252	208	152	227	226	336	346
31 to 60 Days	249	56	29	38	62	39	94	35	52	51	100	65	50	106	170	53	37
61 to 90 Days	8	13	34	3	1	1	1	0	1	0	0	1	0	0	0	0	1
90+ Days	36	0	0	0	0	0	1	1	1	1	1	1	1	1	1	1	2
Aging of Total Contested Claims	**472**	**268**	**331**	**393**	**663**	**436**	**849**	**417**	**369**	**258**	**353**	**275**	**203**	**334**	**397**	**390**	**386**
Productivity																	
EDI Claims Rejected	0	0	4784	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Deleted Claims (13)	2,685	631	845	959	1,392	794	889	900	991	917	1,198	885	968	888	1,440	641	1,091
Denied Claims	6,919	5,226	6,132	5,854	6,469	6,690	5,991	6,308	6,129	5,443	5,233	4,892	4,722	5,782	5,807	6,140	6,499
Allowed Claims	27,314	32,618	35,261	36,079	35,613	38,870	34,892	28,728	31,520	38,733	34,555	36,035	34,704	38,613	37,571	32,754	35,137
Actual Weekly Production (14)	34,233	37,844	41,393	41,933	42,082	45,560	40,883	35,036	37,649	44,176	39,788	40,927	39,426	44,395	43,378	38,894	41,636
Total Weekly Production (15)	**36,918**	**38,475**	**47,022**	**42,892**	**43,474**	**46,354**	**41,772**	**35,936**	**38,640**	**45,093**	**40,986**	**41,812**	**40,394**	**45,284**	**44,818**	**39,535**	**42,727**
Average Daily Production (16)	6,655	7,794	7,660	7,716	7,955	8,404	8,741	8,740	8,349	8,162	8,104	8,042	8,393	8,438	8,405	8,615	8,477
DWOH Working Inventory (10, 17)	5.3	4.6	4.5	4.3	3.7	3.5	3.4	3.8	4.3	4.1	4.7	5.2	5.2	5.6	5.2	5.2	4.1
DWOH Current Inventory (17)	5.7	5.1	5.1	4.8	4.2	4.0	3.9	4.1	4.9	4.6	5.2	5.8	5.8	6.0	5.7	5.7	4.5

Gold Coast Health Plan
Weekly Claims Processing Dashobard
January 4, 2017 - April 26,2017

Notes:
(1) Percentage of Claims Denied is calculated as the number of Denied claims divided by Actual Weekly Production (total denied and allowed claims for the week).
(2) Number of Claims Payment Adjustments processed in the ika claims system as reported by Xerox on the claims Financial Transaction Summary Report.
(3) Number of Xerox claims processing FTEs as reported in the Roster Report provided by Xerox.
(4) Auto Adjudication Rate calculated from "Inventory Tracking to Date" using week to date productivity totals as of Wednesday of each week.
Auto Adjudication Rate including Autobot includes claims processed with Autobot, which allows for systematic processing of claims.
(5) Number of Items in Refund Queue reflects the number reported by Xerox in the "Queue Aging Report" as of Wednesday of each week.
(6) Average Claims Receipts is calculated as the number of receipts in the past four weeks divided by 20 days.
(7) Reflects the aging reported by Xerox on the "Claims Aging Report" as of Wednesday of each week.
(8) Count of items still in EDGE process that have not been loaded into KWIK or ika.
(9) Includes claims that need additional research to determine whether or not they can be loaded into ika.
(10) Working inventory includes mailroom inventory on hand and pending claims inventory. It does not include claims that have been adjudicated and have a status of ready to pay.
(11) Claims Ready to Pay have been adjudicated and are ready for payment stream.
(12) Days Receipt on Hand (DROH) is calculated as the Working/Current Inventory divided by the Average Claim Receipts.
(13) Deleted claims have been replaced by a new claim. Deleted claims are still in ika; however, the status has been changed to deleted so the new claim can be worked.
(14) Actual Weekly Production is the total number of Denied and Allowed claims.
(15) Total Weekly Production includes Deleted, Denied and Allowed claims.
(16) Average Daily Production is calculated as the total production in the past four weeks divided by 20 days.
(17) Days Work on Hand (DWOH) is calculated as the Working/Current Inventory divided by the Average Daily Production.

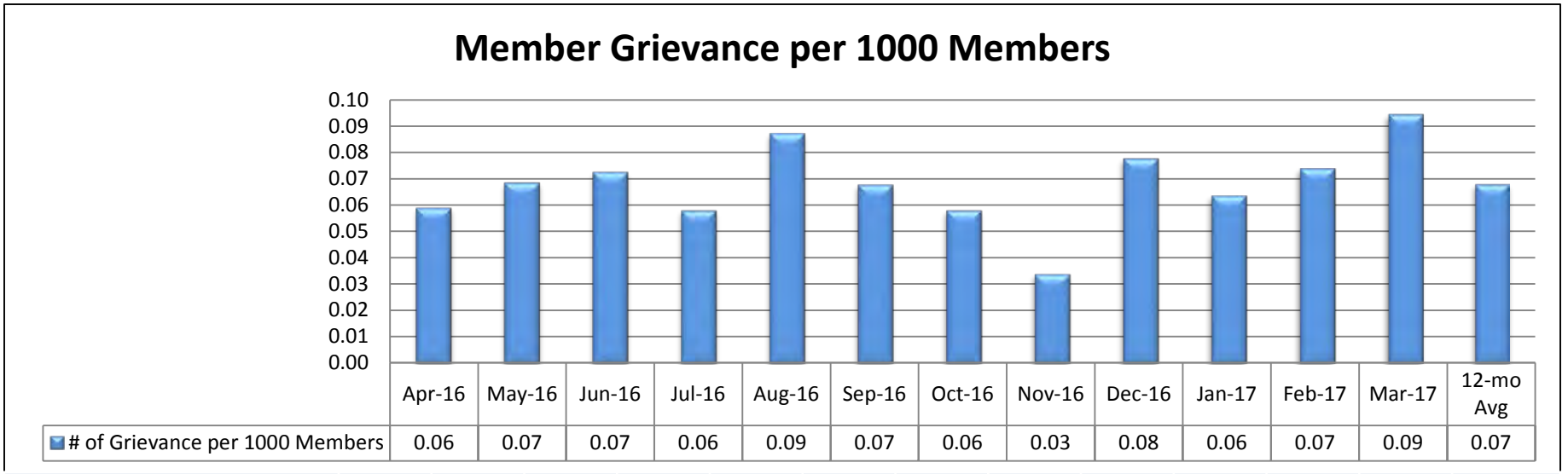
Sources: Claims Financial Transaction Summary Report, GCHP Inventory Tracking to Date, Claims Aging Report, Queue Aging Report, Xerox Roster Report



	May-16	Jun-16	Jul-16	Aug-17	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	12-mo Avg
Member	14	15	12	18	14	12	7	16	13	15	19	10	14
Provider	105	91	136	107	149	176	118	166	194	157	158	168	144
Combined	119	106	148	125	163	188	125	182	207	172	177	178	158

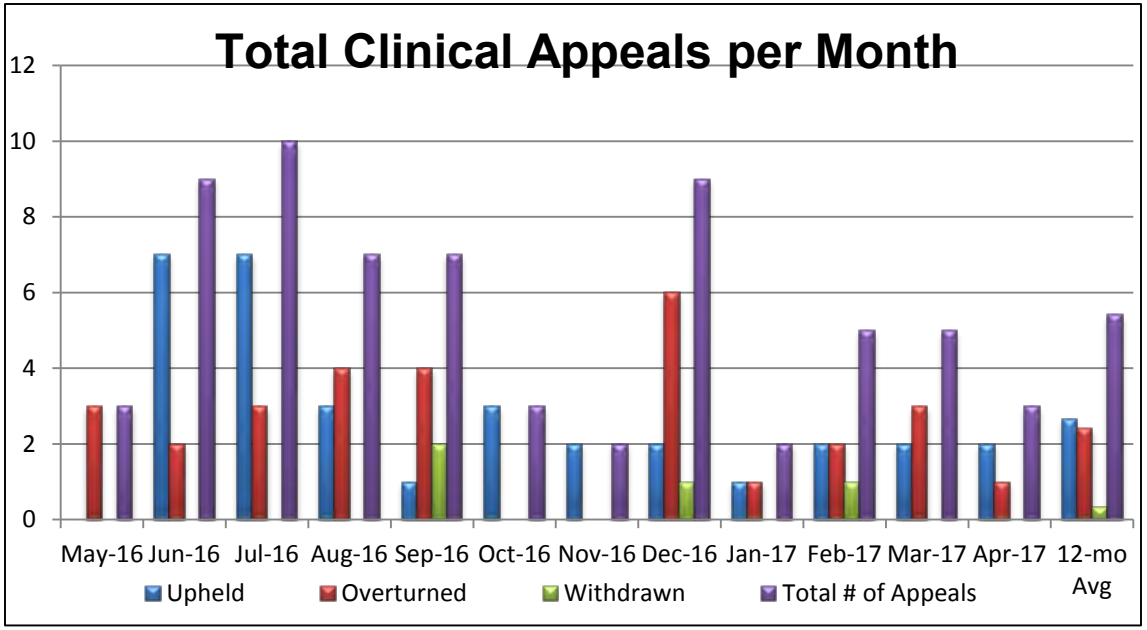
GCHP Grievance & Appeals Metrics – Apr. 2017

- GCHP received 10 member grievances (0.05 grievances per 1,000 members) and 168 provider grievances during April 2017
- GCHP's 12-month average for total grievances is 158
  - 14 member grievances per month
  - 144 provider grievances per month



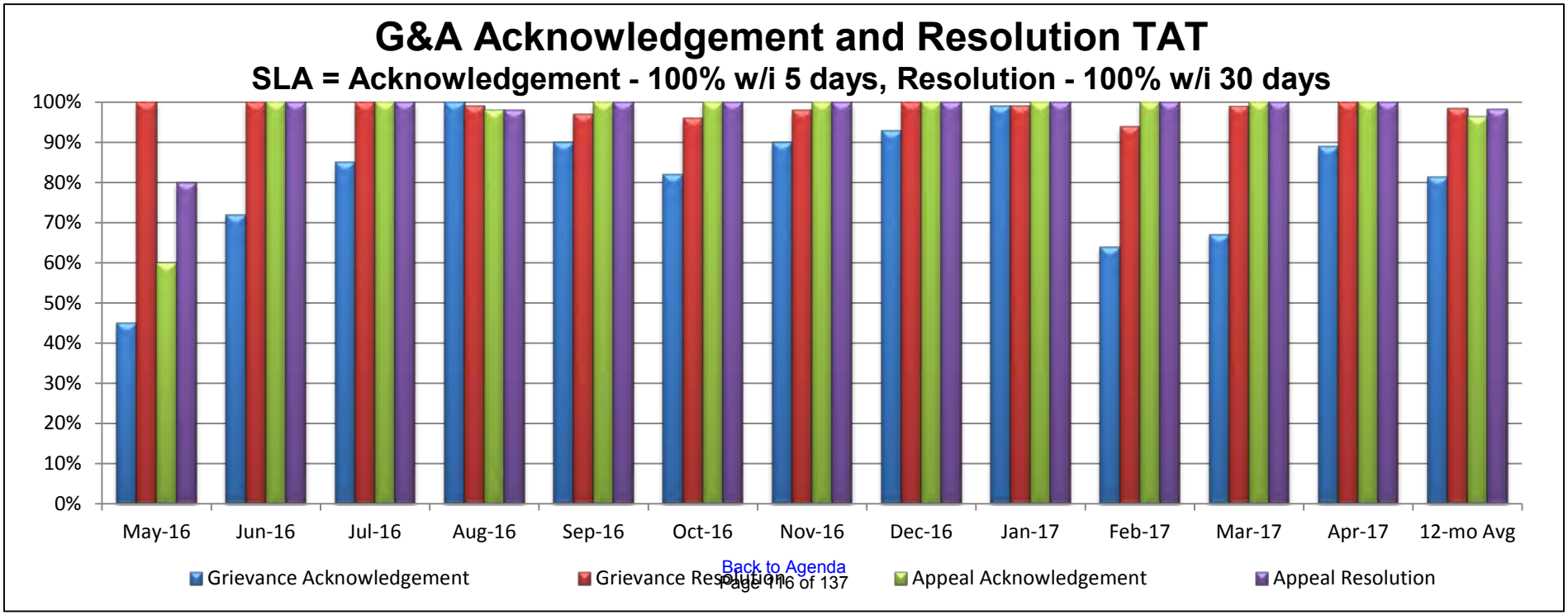
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	12-mo Avg
# of Grievance per 1000 Members	0.06	0.07	0.07	0.06	0.09	0.07	0.06	0.03	0.08	0.06	0.07	0.09	0.07

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	12-mo Avg
Membership Count	203,969	204,619	206,920	207,019	206,644	206,672	207,188	206,780	206,252	204,529	203,243	201,514	205,446
Total Member Grievances Filed	12	14	15	12	18	14	12	7	16	13	15	19	14
# of Grievance per 1000 Members	0.06	0.07	0.07	0.06	0.09	0.07	0.06	0.03	0.08	0.06	0.07	0.09	0.07



GCHP Grievance & Appeals Metrics – April 2017

- GCHP had 3 clinical appeals in April; 2 Upheld and 1 Overturned
- TAT for grievance acknowledgement was non-compliant at 89% due to misrouted correspondence
- TAT for grievance resolution was compliant at 100%
- TAT for appeal acknowledgement and resolution were compliant at 100%.
- No State Fair Hearings were reported in April 2017



AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission

FROM: C. Albert Reeves, MD, Chief Medical Officer

DATE: June 26, 2017

SUBJECT: Chief Medical Officer Update

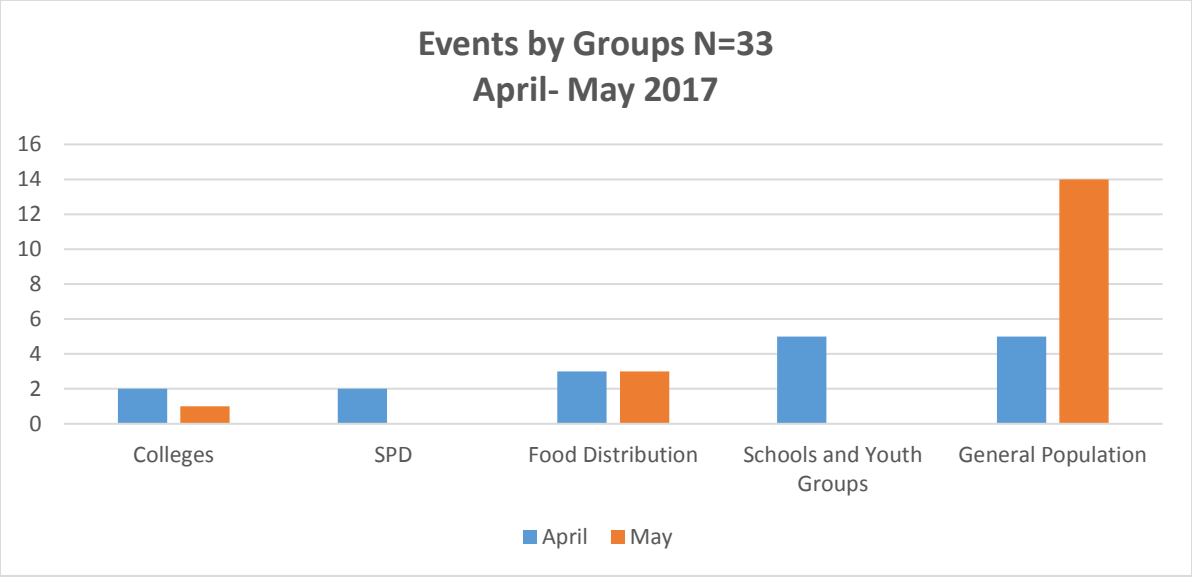
HEALTH EDUCATION UPDATE

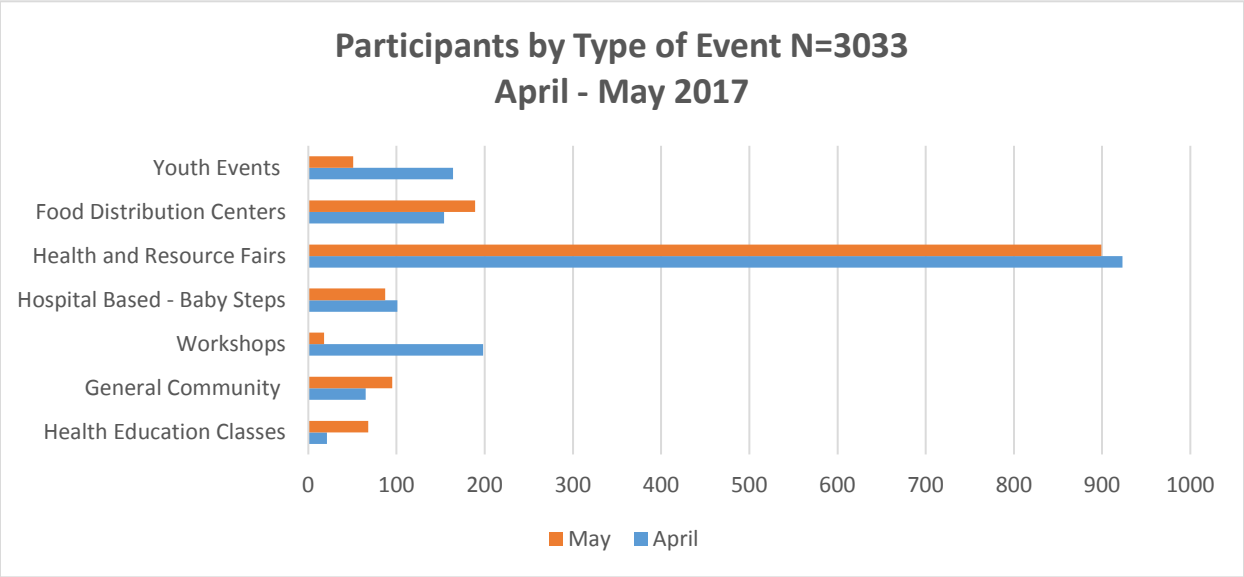
Summary

Gold Coast Health Plan (GCHP) continues to participate in community education and outreach activities throughout the county. The health education and outreach team maintains a positive presence in the community by working with various county public health departments, community based organizations, schools, senior centers, faith-based centers and social service agencies.

Outreach Activities

Below are combination charts that highlight the total number of events and participants for the months of April and May. On average, the health education team participated in roughly 17 different outreach events monthly and reached approximately 1500 individuals per month.





Outreach Events. Below is a list of activities during the months of April and May:

April 2017	List of Activities
4/7/2017	Sharing the Harvest hosted by Santa Clara Valley Neighborhood for Learning, Santa Paula
4/11/2017	27TH Annual Multicultural Day at Moorpark Community College
4/11/2017	Baby Steps Program hosted by Ventura County Medical Center, Ventura
4/12/2017	Diversity in Culture Festival, presented by Ventura College
4/15/2017	2K Mud Dash Run, hosted by Boys & Girls Club of Greater Conejo Valley
4/182017	Baby Steps Program hosted by Santa Paula Hospital, Santa Paula
4/19/2017	Simi Valley Wellness Expo 2017, Simi Valley Senior Center
4/19/2017	Westpark Community Center Monthly Food Distribution Program & Health Services, Ventura
4/20/2017	3rd Annual Health & Awareness Fair, hosted by LULAC, Oxnard Elks Lodge
4/22/2017	Veterans Information Seminar, Oxnard Family Circle ADHC
4/27/2017	Community Market Produce Giveaway hosted by Moorpark Neighborhood for Family Learning, Moorpark
4/27/2017	Community Market Produce Giveaway hosted by Simi Valley Neighborhood for Family Learning, Simi Valley
4/27/2017	Richard Bard Elementary School Open House & Community Resource Fair, Port Hueneme
4/28/2017	Carnival/Community Health and Wellness Fair, Rose Avenue Elementary School, Oxnard
4/29/2017	Fall Prevention Coalition Event: Maintaining Your Equilibrium! Santa Paula Senior Center
4/29/2017	Family Health and Wellness Fair, hosted by Oxnard Union Union High School District
4/29/2017	MICOP Dia de los Ninos Celebration, Haydock Intermediate School, Oxnard

May 2017	List of Activities
5/4/2017	Oxnard College Mental Health Fair
5/4/2017	College and Career Fair Boys & Girls Clubs of Greater Oxnard and Port Hueneme
5/5/2017	Opioid Policy Summit, Ventura
5/5/2017	Sharing the Harvest hosted by Santa Clara Valley Neighborhood for Learning (NfL)
5/5/2017	Interface Annual Enrollment and Wellness Day, Camarillo
5/6/2017	NAMI Walks, Ventura
5/9/2017	Baby Steps Program hosted by Ventura County Medical Center, Ventura
5/13/2017	Gold Coast Health Plan 6th Annual Community Resource Fair, Oxnard Plaza Park
5/16/2017	Baby Steps Program hosted by Santa Paula Hospital, Santa Paula
5/17/2017	Monthly Food Distribution Program & Health Services, Ventura
5/19/2017	Limoneira Company Annual Employee Health and Wellness Fair, Santa Paula
5/25/2017	Community Market Produce Giveaway hosted by Simi Valley Neighborhood for Family Learning, Moorpark
5/25/2017	Community Market Produce Giveaway hosted by Simi Valley Neighborhood for Family Learning, Simi Valley
5/25/2017	Family Care and Volunteer Resource Fair, Ventura
5/30/2017	Women's Week Cervical Cancer Awareness and Prevention, Mexican Consulate
5/31/2017	Women's Week Cervical Cancer Awareness and Prevention, Mexican Consulate

Provider Education Training. GCHP Health Education Department, in collaboration with the Ventura County Public Health Department, hosted the 5A's Training – Basic Tobacco Intervention Skills Certification Program for providers and GCHP staff. The training is designed for clinicians and professionals who interact with members who are smokers. The training provides tools to engage members to quit smoking or to think about quitting.

6th Annual Community Resource Fair

On Saturday, May 13, 2017, GCHP held its annual Community Resource Fair at Plaza Park in downtown Oxnard. A total of 46 community agencies participated and six departments at GCHP, for a total of 52 information booths. Approximately 320 children and families attended the event.

Below is a list of agencies who participated in the resource fair:

Participating Agencies	
Beacon Health Options	Rainbow Connection
Ventura County National Alliance on Mental Illness (NAMI)	National Association Against Child Cruelty-The Children's Wall of Tears
The Wellness Center/Turning Point Foundation	Planned Parenthood
Diversity Collective Ventura County	Costco Wholesale
Community Action of Ventura	Ventura County Credit Union
FOOD Share	Health Insurance & Counseling Program (HICAP) and (VCAAA)
Tri-County GLAD	Among Friends Adult Day Health Care Center
New York Life	Livingston Memorial Visiting Nurse Association
Ventura County Rugby Club- Orca Youth Rugby	Ventura County Adult Health Care Center
El Centrito Family Learning Centers	Shield Healthcare
Boys & Girls Club of Greater Oxnard and Port Hueneme	Oxnard Family Circle
Child Development Resources (CDR)	Employment Development Dept. (EDD)
Ventura Transit System, Inc. (VTS)	Coalition for Family Harmony
Gold Coast Transit	Every Woman Counts
Ventanilla de Salud/Consulate of Mexico in Oxnard	American Cancer Society
Mixteco/Indigena Community Org Project (MICOP)	Clinicas del Camino Real, Inc.
Center for Employment Training (CET)	Magnolia Family Medical Clinic
Oxnard School District	VCPH - Chronic Disease Prevention
Vision Service Plan (VSP)	VC Public Health – Children's Health Programs
INTERFACE Children and Family Services	VC Behavioral Health Alcohol & Drug Prevention Services
Kids and Family Together	VC Behavioral Health & Mental Health
Women, Infants & Children Program (WIC)	VC Health Care Agency – CATCH Program
United Parents	Dignity Health

Participants were able to receive free blood pressure and glucose screenings through the Dignity Health mobile unit. Dignity Health was able to screen a total of 50 adults and 4 minors. The majority of individuals screened were Spanish speaking. A total of 43 BMI screenings were conducted and 14 individuals had an abnormal BMI of over 30. A total of 53 individuals had their blood pressure taken and of those 30% (16) had abnormal levels. A total of 53 individuals had a blood glucose test and 4 people had abnormal results. Staff made 29 referrals for individuals to follow-up with their physician and 54 received health education information related to their condition.

Overall, participants were able to participate in the free health screenings, and gather information about various social and behavioral health services available in the community. Other family activities included face painting, Zumba demonstration, and musical entertainment and a dance group was provided by INLAKECH Cultural Arts Center.


beacon
HEALTH FAIR NOTEBOOK

Sponsorships Requests

A total of $7,500 was allocated to six organizations under the GCHP Sponsorship Program during the month of April and May. The fiscal year-to-date (YTD) total is $50,000. Below is a summary of the programs and funding approved.

Agency/Organization	Approved Award Amount	Event/Org Summary
Casa Pacifica	$1,500	24th Annual Wine, Food & Brew Festival to be held on Sunday, June 4, 2017. Casa Pacifica Angels help abused, neglected or at-risk children and their families in our community.
City Oxnard	$1,000	22nd Annual Multicultural Festival to be held on Saturday, October 7, 2017. Family event promoting Oxnard's diverse community and health wellness.
For The Troops	$1,500	7th Annual Heroes Golf Tournament fundraiser. Golf tournament to be held on Monday, July 24, 2017. This fundraiser supports volunteer commitment to sending "We Care" packages to our deployed U.S. Military service members.
Santa to the Sea	$1,500	10th Annual Santa to the Sea Health and Fitness Expo to be held on December 9-10, 2017. This annual fundraiser supports the holiday toy drive, scholarship program, and many others.
Sports Academy Foundation	$1,000	The Sports Academy Foundation "Full Circle" Scholarship program for Casa Pacifica youth fills in the gaps in human development for at-risk youth in our local community.
Boys & Girls Club of Greater Ventura	$1,000	Day for Kids event to be held on September 23, 2017. The Boys & Girls Club of Greater Ventura provides quality programs to help our local youth become health, responsible, confident and productive members of our community.

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's operational membership counts, and invoice data. The data shown is through the end of April 2017. 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.

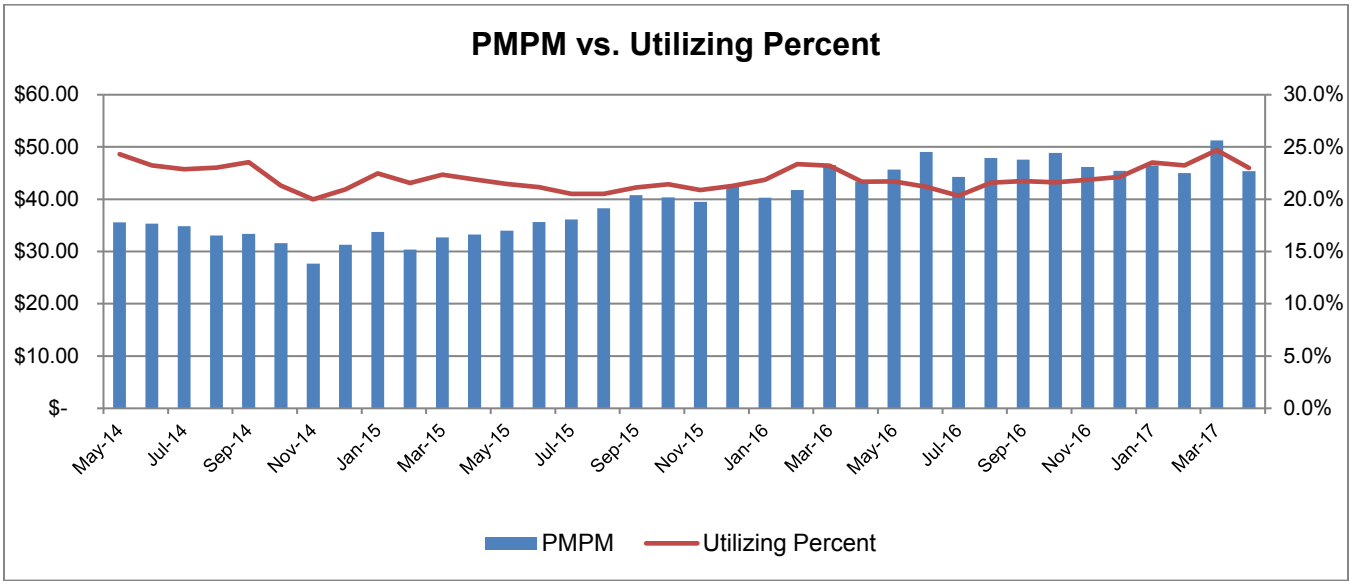
GCHP has seen a slight membership drop in 2017, while utilization has generally remained flat. Slight cost declines occurred in November and December 2016, however costs increased again in January and March 2017.

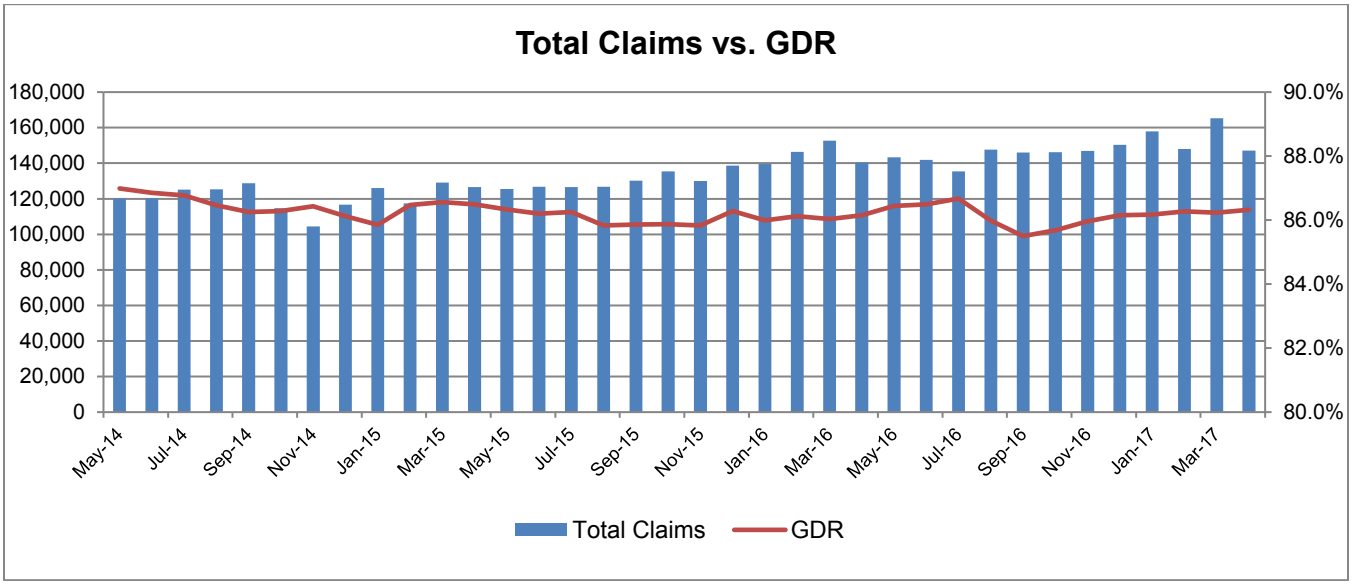
Hepatitis C continues to be a major driver of pharmacy costs though cost has decreased since the peak in May 2016. Formulary changes and the implementation of preferred products to align with DHCS kick payment utilization and cost assumptions has resulted in the Plan estimating to recoup all costs related to Hepatitis C in January and March 2017. This trend is expected to continue through June. However, the kick payment rate will likely be adjusted for FY17-18 and will impact this trend.

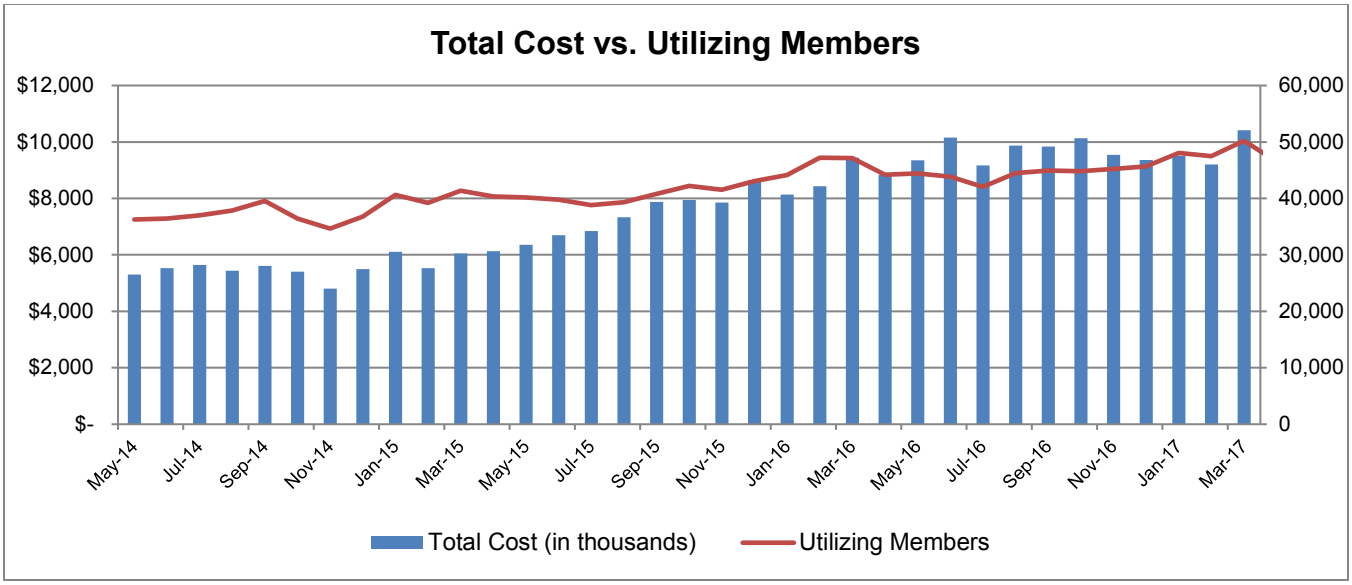
For a focused look at GCHP's utilization as it compares to other County Organized Health Systems, there is a graph comparing the utilization on a prescription per member per month basis. While all the plans are very close in utilization with numbers ranging from 0.58 to 0.74, GCHP is trending on the higher end of this utilization close to 0.7.

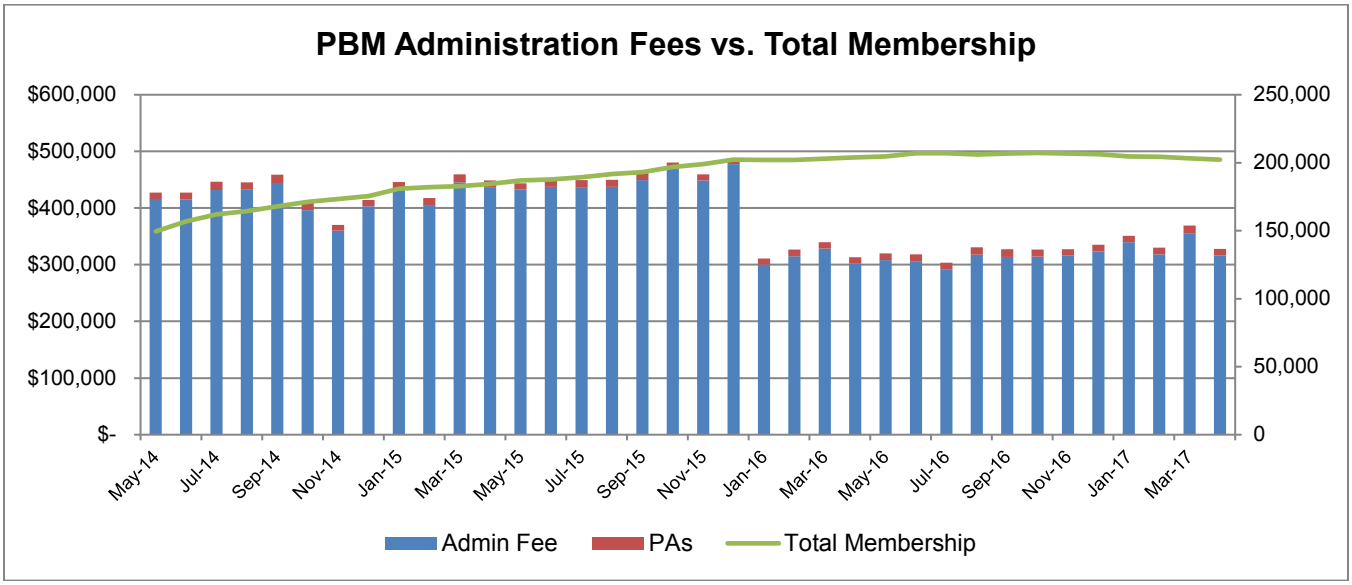
Abbreviation Key:
PMPM: Per member per month
PUPM: Per utilizer per month
GDR: Generic dispensing rate
PA: Prior authorization

PHARMACY COST TRENDS:

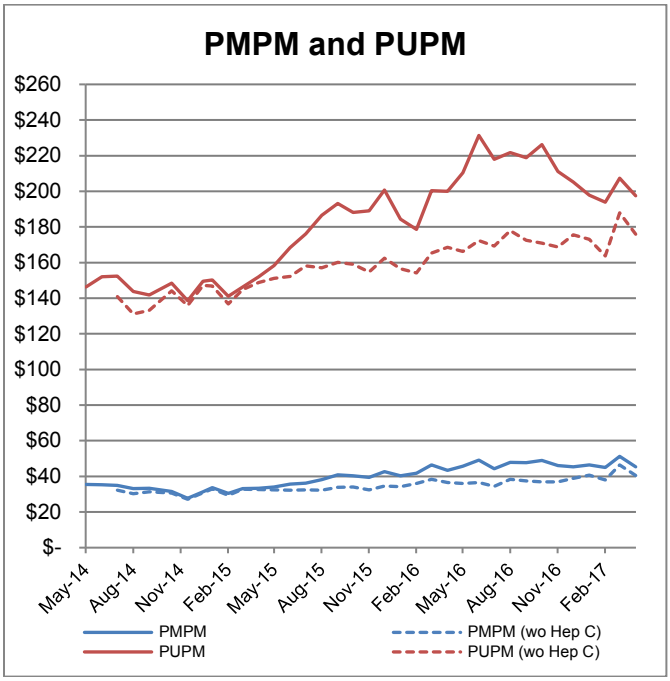


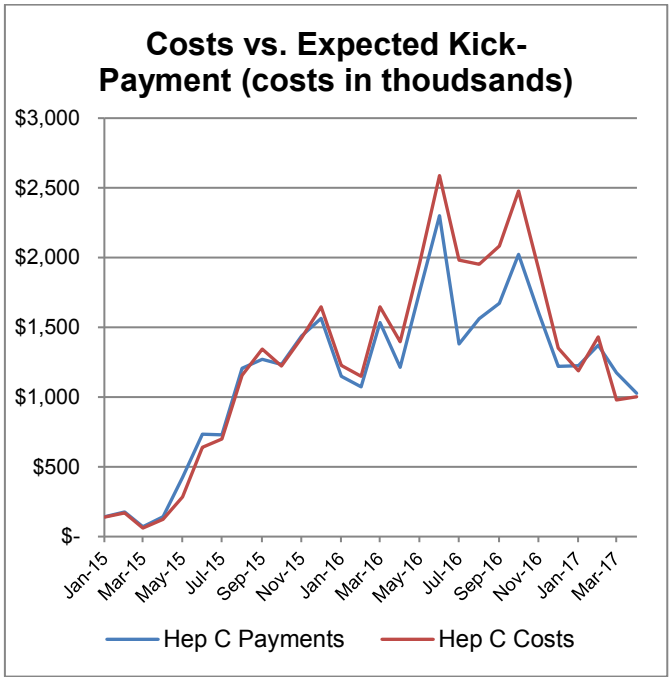



Total Cost vs. Utilizing Members
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
60,000
50,000
40,000
30,000
20,000
10,000
0
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
Total Cost (in thousands)
Utilizing Members

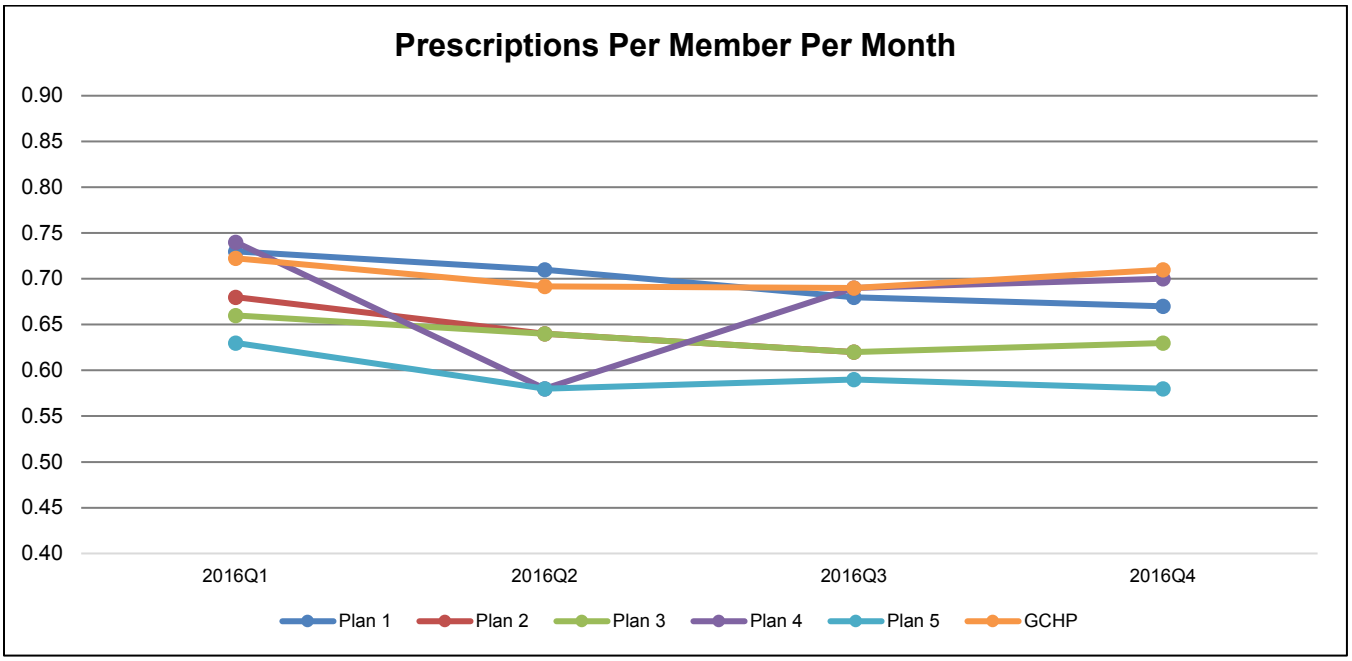

PBM Administration Fees vs. Total Membership
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
250,000
200,000
150,000
100,000
50,000
0
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
Admin Fee
PAs
Total Membership

HEPATITIS C FOCUS:





COHS Comparisons:



AGENDA ITEM NO. 13

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Anne Freese, PharmD, Director of Pharmacy

DATE: June 26, 2017

SUBJECT: Implementation of New Pharmacy Benefit Manager (PBM): OptumRx

SUMMARY:

Gold Coast Health Plan (GCHP or the Plan) contracts with a Pharmacy Benefits Manager (PBM) in order to provide pharmacy benefit services to its members. The commission entered into a new contract with OptumRx (ORx) to be the PBM effective June 1, 2017.

BACKGROUND:

For the past six months, GCHP has worked diligently with ORx on plan specifications to build out GHCP's pharmacy benefit within ORx's systems. This has been a very detailed and long process to ensure that the benefit is built to the same specifications that was coded with Script Care, LTD., the prior PBM.

DISCUSSION

ORx's claim system went live for GCHP on June 1. At that time, GCHP and ORx conducted daily check-in calls to verify reports of identify issues and ensure that the benefit and systems were working properly. Through June 15, the first billing cycle, OptumRx has paid over 70,000 prescriptions claims for GCHP members.

During the daily calls, there were several issues identified by GCHP staff and ORx's account management team during the first several days of the implementation. These items have been corrected:

- Some pharmacies had not updated their systems to ensure that they were able to properly bill ORx for GCHP claims.
- The set-up to ensure proper billing of Medicare Part D excluded drugs was incorrectly coded.
- Several quantity limits were coded to enforce ratios that were rounded incorrectly or were enforced for products that could not be split (i.e. spacers for use with inhalers).

There are several outstanding issues and verbal updates will be provided on the following items:

- Transition/grandfathering benefit

- Kaiser pharmacies
- 340B eligible drugs claims
- Pharmacy reimbursement

Finally, GCHP is working very closely with the implementation team and account management teams for ORx to resolve any outstanding issues. The pharmacy department performs continuous oversight of the PBM and contract performance. Reporting of performance and contract adherence is provided to the following committees in accordance with established reporting protocols:

- Quality Improvement Committee
- Compliance Committee
- Pharmacy and Therapeutics Committee
- Utilization Management Committee

AGENDA ITEM NO. 14

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Douglas Freeman, Chief Diversity Officer

DATE: June 26, 2017

SUBJECT: Chief Diversity Officer Update

Gold Coast Health Plan℠
A Public Entity

Integrity
Accountability
Collaboration
Trust
Respect

Gold Coast Health Plan: D&I Compliance Deliverable- Code of Conduct Policy Development

Presented to VCMMCC
June 26, 2017

Compliance Strategy Pillar Deliverable: Code of Conduct Development

Compliance (Mandatory Activities)

- Code of Conduct Policy
- Diversity and Inclusion Mission Statement
- Diversity Hotline Employee Rollout
- Completion of 2017 Investigations
- Lawsuit/Grievances Support
- Diversity Councils
- Diversity Metrics as Major Component of All Employee Evaluations
- Diversity Dashboard: Compliance/ Workforce & Workplace/ Members & Community

Figure 1: Gold Coast Code of Conduct Policy (Page 1 of 6 DRAFT)

Gold Coast Health Plan Code of Conduct:
Policy Prohibiting Discrimination and Harassment

1. Gold Coast Health Plan's Commitment

The Gold Coast Health Plan ("GCHP") is committed to providing a workplace free of discrimination and harassment for all employees and employment applicants. GCHP has a zero tolerance policy for discrimination and harassment, which means that we will not tolerate workplace discrimination or harassment of our employees by any coworker, company officer, manager, supervisor, contractor, vendor, customer, client, or any other person.

2. What Constitutes Discrimination or Harassment

Discrimination means treating someone differently, in a way that negatively affects the terms or conditions of employment, based on gender, race, color, national origin, religion, age, disability, genetic information, or any other category protected by federal, state, or local law.

Harassment is workplace conduct that creates an intimidating, offensive, or hostile working environment and is based on someone's gender, race, color, national origin, religion, age, disability, genetic information, or any other category protected by federal, state, or local law. Sexual harassment includes all of these prohibited acts, as well as the conditioning of work benefits upon an employee's consent or submission to sexual conduct.

3. Prohibited Conduct

All discriminatory or harassing acts, behavior, and conduct are prohibited, including, but not limited to, comments, jokes, gestures, unwelcome physical contact, drawings, cartoons, videos, emails, name-calling, slurs, or use of derogatory terms. Prohibited sexual harassment includes all of these actions as well as other unwelcome sex-based conduct, such as unwanted sexual advances, requests for sexual favors, or sexually suggestive gestures, jokes, and propositions. Such conduct is prohibited whether it occurs in person; via email, text or instant messaging; or on social networking sites. These lists are intended as illustrations only. Conduct not listed may be considered discriminatory or harassing if it otherwise meets the definition above.

Gold Coast Health Plan

Policy Prohibiting Discrimination and Harassment Page 1 of 3

Gold Coast Health Plan
A Public Entity

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

AGENDA ITEM NO. 17

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: June 26, 2017

SUBJECT: Contract Approval – Conduent Health Administration, Inc.

SUMMARY:

Conduent Health Administration, Inc. (Conduent) (formerly ACS Health Administration) is the incumbent provider of administrative services to Gold Coast Health Plan's (GCHP's) members. GCHP engaged Conduent to provide administrative services including eligibility processing, customer service, claims adjudication, fulfillment services, payment services, etc., in 2010. The current contract expires June 30, 2017, and both parties have reached agreement on a new contract. Below is a partial list of key enhancements:

- General Liability Insurance was increased from $5M to $10M;
- Additional termination language regarding state termination for convenience or non-renewal, termination for force majeure event and runout services;
- Inclusion of cyber liability;
- Travel and expense limitations;
- Division of service into separate service components with the ability to terminate one or all individually;
- Number of and risk for Service Level Agreements have increased in number, with 10% of the monthly fee at risk and stringency;
- Reporting provided increased to include areas not previously reported.

The contract term negotiated is for two years with up to four 6-month unilateral extensions. The contract also allows GCHP to end services based on our needs or choice to move a particular service to another vendor, with the exception of the core services, which includes claim processing, and customer service. Termination of the core services would terminate the contract in totality.

Additionally, GCHP and Conduent agreed to include settlement of potential litigation between the two parties, which will be discussed in closed session. GCHP determined and assigned a dollar value to this litigation. A tolling agreement has maintained Gold Coast's right to pursue its causes of action against Conduent pending resolution of the dispute.

FISCAL IMPACT:

The fees for all services provided to GCHP is based on a "per member/per month" (PMPM) fee structure, dependent on GCHP's monthly membership. The PMPM includes all services provided by Conduent. Should GCHP decide to move any or all of the services, the PMPM fee would decrease proportionally for that service. With current membership levels, the monthly payment to Conduent would approximate $1,6M.

The negotiated PMPM fee also includes compensation for the settlement of the potential litigation. The settlement includes reductions in both actual fees as well as elimination of the cost of living adjustment increase (COLA) for year one of the contract. The annualized savings are estimated at $830,000 for year one and $850,000 for year two. Projecting total Plan savings of $1.6M for the life of the contract. This is dependent on membership remaining at or near current levels.

RECOMMENDATION:

It is the Plan's recommendation to initiate a two-year agreement with Conduent for all services currently included in the contract.

If the Commission desires to review this contract, it is available at Gold Coast Health Plan's Finance Department.

AGENDA ITEM NO. 18

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: June 26, 2017

SUBJECT: Approval of Plan-to-Plan Subcontracting Program as Proposed by AmericasHealth Plan

SUMMARY:

Gold Coast Health Plan (GCHP) proposes to subcontract with a licensed California health plan under a full-risk contract arrangement. This plan-to-plan contract must demonstrate value to GCHP members and the community. Previous commission discussions involved a pilot program with AmericasHealth Plan (AHP) with a first year membership cap of 5,000 members.

BACKGROUND/DISCUSSION:

All Department of Health Care Services (DHCS) requirements must be fulfilled, and approval obtained, in order to proceed with this contract. DHCS indicates they will not approve a new boilerplate contract until final CMS approval of all DHCS submitted managed care mega rule changes and DHCS issues the new GCHP contract amendment.

Significant effort is required of GCHP to proceed in contract preparation and analysis. GCHP intends to engage the services of an outside consultant to assist in these efforts.

FISCAL IMPACT:

The fiscal impact is unknown at this time until financial analysis is completed as a part of the negotiation process.

The contract with an industry consultant is TBD based on the scope of work.

RECOMMENDATION:

GCHP recommends giving priority to a health plan willing to take full risk for all member related health care costs. This minimizes complexity and confusion for obtaining care and treatment for carved-in versus carved-out services.

GCHP recommends the Commission provide direction and approve the following items related to the plan-to-plan contract:

- Identify the specific goals and outcomes expected from the contract including the number of members and/or geographic area for the contract;
- Approve GCHP to move forward with developing all required documents and procedures for a plan-to-plan contract including a new contract boilerplate, division of financial responsibilities, underwriting and utilization analysis, readiness review, and rate negotiations;
- Provide direction regarding proceeding with solicitation of potential subcontract vendors. A separate attorney client privileged memo from the General Counsel discusses the potential for sole sourcing this contract.
- Approve contracting with an industry consultant to begin all document preparation and analysis related to the contracting work. GCHP recommends using Health Management Associates (HMA).