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

Executive/Finance Committee Meeting

Regular Meeting
Thursday, October 3, 2019 – 3:00 p.m.
Community Room at Gold Coast Health Plan
711 E. Daily Drive, Suite 106, Camarillo, CA 93010

AGENDA

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Ventura County Medi-Cal Managed Care Executive Finance Committee on the agenda. Persons wishing to address the Committee should complete and submit a Speaker Card.

Persons wishing to address the Executive Finance Committee are limited to three (3) minutes unless the Chair of the Committee extends time for good cause shown. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Committee.

CONSENT

1. **Approval of Executive Finance Committee Special Meeting Minutes of August 13, 2019.**

   Staff: Maddie Gutierrez, CMC, Clerk to the Commission

   RECOMMENDATION: Approve the minutes.

FORMAL ACTION ITEMS

2. August 2019 Financials

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Accept the August 2019 Financials and forward to the Ventura County Medi-Cal Managed Care Commission for approval.

DISCUSSION

3. Financial Performance Review and Action Plan

Staff: Dale Villani, Chief Executive Officer
Kashina Bishop, Chief Financial Officer

4. Conduent Contract Performance

Staff: Dale Villani, Chief Executive Officer

5. Strategic Planning

Staff: Melissa Scrymgeour, Chief Administrative

Officer

COMMENTS FROM COMMITTEE MEMBERS

ADJOURNMENT

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 Committee after distribution of the agenda packet are available for public review during normal business hours at the office of the Clerk of the Board.

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

AGENDA ITEM NO. 1

TO: Executive Finance Committee

FROM: Maddie Gutierrez, Clerk to the Commission

DATE: October 3, 2019

SUBJECT: Meeting Minutes of August 13, 2019 Special Executive Finance Committee Meeting

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the August 13, 2019 Special Executive Finance Committee meeting minutes.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
Executive/Finance Committee Meeting

August 13, 2019

CALL TO ORDER

Committee member Antonio Alatorre called the meeting to order at 3:06 p.m. in the Community Room located at Gold Coast Health Plan, 711 East Daily Drive, Camarillo, California.

ROLL CALL

Present: Committee members Antonio Alatorre, Fred Ashworth, Laura Espinosa, Dee Pupa, and Jennifer Swenson

PUBLIC COMMENT

None.

CONSENT

1. **Approval of Executive Finance Committee Regular Meeting Minutes of June 6, 2019.**

   RECOMMENDATION: Approve the minutes.

2. **Approval of Executive Finance Committee Special Meeting Minutes of July 9, 2019.**

   RECOMMENDATION: Approve the minutes.

Committee member Pupa motioned to approve the Executive Finance Committee Regular Meeting Minutes of June 6, 2019 and the Executive Finance Committee Special Meeting Minutes of July 9, 2019. Committee member Ashworth seconded. The vote was as follows:

AYES: Committee member Antonio Alatorre, Laura Espinosa, Dee Pupa and Jennifer Swenson

NOES: None.

Committee Chair Antonio Alatorre declared the motion carried.

FORMAL ACTION ITEMS

3. June 2019 Financials

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Accept the June 2019 Financials and forward to the Ventura County Medi-Cal Managed Care Commission for approval.

No action taken. Moved to Discussion.

DISCUSSION

3. June 2019 Financials

CFO Bishop reviewed the status of the June 2019 Financial Statements. She stated when we close June we what we report to be accurate. She is reviewing every reconciliation for all accounts. The financial statements will not be presented today, but they will be sent out once they are completed.

Currently, we have the June 2019 financial statements, and the audit of June FY 2019 has already started. We have the fiscal year 2016/2017 AE MLR template which has a potentially significant financial impact. We are working on the calendar year 2018 RDT. In the calendar 2017 RDT audit there are budget projections and cost savings that will be reviewed. When we close June, we will have solid processes and reconciliations and have a fresh start for July.

Medical expenses and IBNP calculations are complete. We have been averaging about $11M in pharmacy expenses per month, the last two months jumped up $1M. There will be more information at the Commission Meeting.

Commissioner Pupa asked if IBNP is certified on an annual basis. CFO Bishop replied it is, the IBNP is complete and gets certified for our financial audit. It is currently in process and should be complete in September.

We have made adjustments - Payables were too high, and we had to write some off as well as write some Receivables off, which hurt us. The biggest estimates that we have outstanding are monies we owe to the State. We have a risk corridor on the Prop 56 payments. If we pay out less than 95% of the revenue, we will owe to the State. We are still reconciling our capitation from the State. As soon as we are complete and a full review done, financial statements will be sent out.

CEO Villani stated he is confident as we go into the new fiscal year all of the adjustments will no longer carry forward. The turnaround times will be much quicker but this particular month (last of the fiscal year) has been a bit of a challenge in closing the books. We do expect that we will show a loss again for the remainder of the fiscal year and will close on a negative note. We hope the new year brings a positive trend.

Commissioner Pupa asked if our accounts were reviewed by our auditors. CFO Bishop stated she has asked the auditors about the documentation, there was an amount of $3.7M which was undetermined. We discussed and found that was under their Materiality, $3.7M is material to us but given the size of our organization what may not be material to an auditor is material to us. Some of the work they do is look at reconciliations. Follow-up calls are scheduled weekly as the audit progresses. The auditors did not include a review of all the reconciliations. They test a few to make sure that they were done and signed off. It is not known which they chose and if reconciliations made sense. They were checking to see if completed, reviewed and took a sample; but upon review, they may have been completed and reviewed, but all did not make sense.

Commissioner Alatorre asked if we need to hire a third party to review our accounts. CFO Bishop stated she doesn't have any concerns that they need to be looked at further because she understands what each of them should comprise.

Commissioner Ashworth asked about the receivable items and if consideration is being given to engaging a third party in collection efforts or are they government related receivables. CFO Bishop stated they are receivables from DHCS for Medi-Cal capitation.

Commissioner Alatorre asked about the FY15/16 Adult Expansion MLR, there might be a negative impact. CFO Bishop stated it would be a negative impact and what we owe for that period is approximately $7M and we had accrued about $3M ($4M more). We are checking our accounts because every dollar for revenue that is higher you must give back to the State. If we are not completely accurate in our revenue, or what we counted, then it can swing. We are going back and double checking all of our revenue accounts and are confident on the expense side. We are going back and checking all revenue which is based on enrollment. DHCS stated their enrollment counts were different than ours. We are checking the enrollment and how it was completed to ensure it is accurate because it can cause fluctuations. Even though the initial estimate was lower, we are hoping when it comes back it will be lower because of size; seemingly small differences in enrollment can cause these big dollars.

Commissioner Alatorre asked if we were looking at $167M like last year (FY14/15). CFO Bishop replied we are not. It was from January 1, 2014 through June 30, 2016. Those were higher in that time period because utilization was lower and the rates were higher. Commissioner Pupa stated they were claw backs. CEO Villani

stated we discussed that huge gap and funding was too high. With a $160M estimate and you are off a little bit, it turns into big dollars; then you go into FY16/17, even though much smaller, it is still significant dollars we will owe. You go forward to FY17/18 the costs are well over the 85% MLR. Commissioner Pupa stated that is what the other plans experienced as well.

Commissioner Swenson stated in the last Commission Meeting there were some key financial positions that were open on the Finance team. CFO Bishop stated that the Director of Finance position was filled. We have one open position, however, as CEO Villani will discuss, we currently have a hiring freeze.

CEO Villani stated we have brought back to Commission the P&L's by aid category. We have discussed the Adult Expansion is really driving the expense. There are other aid categories that are not showing the losses we are seeing with the Adult Expansion. We are seeing a higher incidence of high cost cases being sent to Los Angeles (tertiary care, cancer, transplants, etc.).

4. FY19-20 Strategies to Contain Administrative and Medical Expense Costs

CFO Villani stated some necessary job eliminations and some reorganization has been started. As we close out the fiscal year for June, it's probable that our total losses for the fiscal year will be $50M. We anticipate July will be better because we have a 12% increase, but there is no guarantee.

In reviewing our financials $19.9M went to paying Conduent to do claims, calls and all back office functions. What we have done in the past organizationally is try to replicate what they do because when we first went live with Xerox there were operational issues. There is additional staff, processes and controls that were put in place because of the failings of Conduent. The model we need to move to is one of oversight, holding them accountable and sanctioning them. As part of this, we had to look at organizational redesign; we had three job eliminations effective today. Three may not seem significant but they were in terms of the team and staff who had been working. We also had five positions that were vacant but deemed not critical that can be eliminated. The goal is to show a savings. We have an approved budget which had a $1.5M surplus and that budget was also assuming a $5M savings that would come from contract negotiations, better utilization and other controls. Getting to that $5M we felt it was critical to put in place specific strategies. Our biggest administrative expense (salaries) is on our employees. We have done some organizational redesign and put a hiring freeze in place. This is a hard freeze and we want to assess and get a sense of what the new fiscal year will bring and will we have an opportunity to back-fill key positions.

Performance based incentive programs (bonus) that went to the executive team will not be paid this year. An adjustment in the original budget was made but it is a benefit restatement and this is about a $500K over statement an additional savings against budget that we think we can make as we go to the $5M.

Commissioner Pupa asked what the level of positions eliminated were. CEO Villani stated a Director, Financial Analyst II, and a Delegation Oversight Nurse were eliminated. CEO Villani stated the vacant positions that were eliminated were Operations Liaison, Claims Analyst II, Member Services, Quality Analyst and Outreach Representative (three exempt and two non-exempt). There is significant savings that comes with the Administrative expenses.

Senior Director, Network Management, Steve Peiser explained how his department is working to contain costs related to some of our contractual relationships with providers. Every provider arrangement is being looked at separately. We want to ensure that we do not do anything to disrupt our provider network. From a high level strategic standpoint we are going to take the necessary actions to achieve rate reductions across the board for all providers. We have estimated that it is somewhere around $3.5M that can be a potential save with the strategies that have been initiated. In addition, expectations need to be set both at the leadership level and from the Executive Finance Committee to the Commission; we are not going to see immediate savings. It will take anywhere from 3-6 months from the time in which we readdress or readjust the contracts.

Commissioner Pupa asked if it was an annual number, and if we don't get amendments completed by September or October, will it will be less than $3.5M. Mr. Peiser stated it was on an annual basis and would be less. We are shifting to alternative payment methodologies which includes capitation or looking at AP DRG payments, another thing we have not been able to do because we have system issues relative to our claims, it can't handle DRG type of payments. For out of network it can, but on a larger scale it would take a lot of effort. We are looking at case rates, bundled payment methodologies and also looking at incorporation of quality improvement initiatives across the board. We are looking at evaluating preferred networks. That would be looking at laboratory arrangements, which is capitated. We understand the implications that may have on existing providers, especially hospitals that are doing outpatient laboratories, so that is another piece we need to assess in our evaluation. DME is another area we can have an impact especially around capitated arrangements and we are looking at doing an RFP or RFI to basically gain some element of understanding in terms of what they can do and how we might capitate. When looking at capitated arrangements it will not happen right away as there is a lot of actuarial analysis that needs to be done. We would need to call Milliman and they would have to analyze how this would be put together. From an operational perspective we have seen increases in provider disputes related issues as well as increases in interest payments. These actions are going to need to be accomplished with our Plan partners through contract negotiation and contract amendments. Capitation savings will require actuarial analysis. We want to avoid the unintended consequences of establishing mechanisms that rates go so low, providers say we're done and walk away from the network.

CEO Villani stated there are important contracting strategies that Network Operations is doing. We are limited and bound by our current claim system and everything is per diem (not DRG, capitation or industry). This puts us at risk with the models we have to put in place. There are different mechanisms whether first dollar, second dollar, stop/loss thresholds put in place. The risk with some of those contracting methodologies is you may get a per diem rate up to the first dollar stop/loss then it reverts to a percent of billed charges. Some of those contracts are in place. They are not industry in terms of what we should be paying for Medi-Cal lives. One of the things we are beginning down the path with is AHP, being the best example is plan-to-plan arrangements, where you have flat full risk capitated contract, from a financial standpoint it is predictable and the risk is on the delegates. The delegation of services that goes to those sub-delegates means your overhead costs go down.

Commissioner Pupa said if TNE is calculated the way it is for a Knox Keene license plan, it improves your TNE because it is a lower percentage when capitated 4% versus 8% of medical costs. CEO Villani stated we are one year away with go live for the new claims system and the opportunity to put different payment strategies in place. We are pushing forward with capitated models. Commissioner Pupa asked if the new claims system will be able to process APT DRG. CEO Villani replied yes. What we pay in the market is still close to what other Medi-Cal plans pay for services. In terms of the budget, we did some additional (nominal) savings; we reviewed what we pay for printing, travel, advertising/promotion.

We are currently spending $162 on translation services, at one point we thought we might have to translate all of the Commission packets but we don't need to do that. We have disabled members that may not be getting the SSI payments. There are firms that work on a contingency basis, we pay nothing up front, and they take a percentage of whatever they can increase your rates on. We do have an overpayment recovery service through Conduent. Primary insurance for whatever reason is not paying and we are paying - even in Pharmacy. We will take to the full Commission as an agenda item but wanted to ensure we discussed with Executive Finance.

Commissioner Ashworth stated there have been comments made about members having to go out of market for service and the costs associated. This is leakage and the systems of care has to be able to handle and manage their own leakage. Some have higher leakage rates than others and we have gone back to those systems of care to look at the referral patterns of their internal doctors. We do have statistics and the percentage of those members who are going out of the area, it is small for tertiary care and is staying steady. CMO Wharfield gives authorization prior to going out.

CMO Wharfield added any care that is either out of area or out of network would require prior authorization. A lot of out of area network care which gets authorized is for transplants and cancer care not available in the county. When we look at

out of network care that may happen, often that will be something we aren't aware of until after the fact. CMO Wharfield stated in order to pay the claim we must have authorization. We have never put a barrier that you need a referral authorization to go to these services just to see the physician. CMO Wharfield stated this is what our nurses do; If we are saying no to a referral requested, we are researching to see what the options are in the area and in network.

Commissioner Ashworth asked if GCHP has ever sat down with in- patient services in order to have that level of materiality. CEO Villani we're not the biggest payer in the market when it goes to Los Angeles, so our opportunity to negotiate rates is limited but we have moved from Letters of Agreement to actual contractual documents.

Commissioner Ashworth stated he would like to see providers and facilities sit down and discuss where there is leakage and what is driving it. CEO Villani replied using the County system as an example, we can't get the physicians to keep their own internal referrals to our internal specialists. The model we're thinking of for the future, if we go to a full risk capitated model with any system of care, and they send someone out of network (still at the same capitated rate) they are now accountable for that cost and that puts the risk back on the system of care.

Commissioner Pupa asked if the Plan had an entity that reprices the out of network claims or is that done in-house by negotiation. The plan has an entity that you pay a PMPM per month we are only contracted in the County of Ventura, so when we have folks outside the system, we've engaged with an entity that will reprice our claims. Senior Director, Network Management, Steve Peiser, stated that has not been necessary. For example, before UCLA came on board, we were paying a percentage of bill charges, that changed to a per diem contract which was a significant savings to the plan. We had a liver transplant case at UCLA and we did not have a transplant agreement at the time, our reinsurance carrier had an entity who did the entire repricing in the rental network.

Commissioner Pupa stated it helps the healthcare plan with out of area emergent admits in other states. Mr. Peiser stated those would be paid on an admit basis at DRG based reimbursement rates unless the facility calls and wants to establish a Letter of Agreement directly with the Plan.

Commissioner Pupa stated we have engaged claim auditors in the past and it comes down to some of the findings are level of care issues, and contract interpretation issues. Commissioner Alatorre asked how many LOAst. Mr. Peiser stated 45-50 per week. Part of the problem was the requirement is yet to be Medi-Cal certified so that has delayed some contracting efforts which delays getting people off LOAs. We have told them we either end our contract with you or have to refer someplace else because we cannot use a non-Medi-Cal provider. Many of them who wanted LOAs are now contracted, resulting in a savings.

CEO Villani stated the other contracting strategy is Centers of Excellence. Commissioner Espinosa asked what determines a Center of Excellence. Commissioner Ashworth stated the Plan does their own designation Center of Excellence based on whatever criteria they have established. You get all sorts of certifications in different areas and specialties. To be deemed a Center of Excellence by a plan you have met all of the criteria of that plan.

5. Overview of Medi-Cal Transportation Benefit

CMO Wharfield reviewed a summary on the transportation benefit. We had an opportunity to share information with California Healthcare Foundation. DHCS expects us to do an oversight when there is a new benefit. The plan has always provided emergency transportation through an ambulance or air transport (if needed) and non-emergency medical transportation if in a wheel chair or gurney. A couple of years ago they expanded to non-medical transportation; NEMT and NMT. It is confusing as they are similar but different. NMT is transportation in a regular vehicle, car, bus, taxi. The other difference between the two benefits is NEMT requires a prescription, our vendor for this is Ventura County Transit Systems (VTS). We used our collaborations with community based organizations to get information out and developed a business card that was dispersed in the community, doctor's offices and community organizations that help people understand the benefit. There has been a lot of infrastructure built inside the plan to administer properly. Providing about 17,000 rides/month to about 1,400 people. A lot are dialysis rides, so there are multiple rides in a week for one member. This benefit has doubled and it looks like there is no end in sight and we continue to have NMT utilized much more (1-1/2 times) than NEMT. Mostly adults are taking advantage of this benefit and our grievance rate is low. Commissioner Espinosa asked if NMT requires a prescription. CMO Wharfield replied it does not. NEMT is for wheelchairs and gurney vans. Commissioner Espinosa questioned if NEMT includes transportation for lab work and x-rays. CMO Wharfield stated it's beyond just a doctor's visit, you can go to the pharmacy or get lab work done.

Commissioner Alatorre asked if we were providing 17,000 rides for 1,400 members per month – not 1,400 total out of 200,000. CMO Wharfield stated 1.400 unique members are using the service per month. Commissioner Alatorre asked if we were capitating VTS. CMO Wharfield replied yes.

Commissioner Espinosa asked if members call Gold Coast to schedule. CMO Wharfield replied there are rules and we facilitate that for them if they need extra help but they should work directly with the VTS scheduling center. The capitated rate we have is good which means people are using the service.

Commissioner Ashworth asked if we are doing 17,000 rides/month on 1,400 unique members, dialysis is probably three times per week. CMO Wharfield replied three to four times per week. Commissioner Ashworth asked how many of the 1,400 members are dialysis patients. CMO Wharfield replied about half are

dialysis patients. Commissioner Ashworth stated if we had 1,400 members on dialysis and they are getting transportation three to four per week, half of them (700 or two-thirds) of runs are dialysis. CMO Wharfield stated an individual who has dialysis or other chronic medical conditions are not just getting dialysis, they are getting care with cardiology, nephrology, etc. It's not just the dialysis rides.

Commissioner Pupa commented this is three rides per week, 12 rides per month. CMO Wharfield stated many members are SPDs, very sick. Commissioner Ashworth added 12,000 out of 17,000 runs for a small sub-set of the total membership served. CMO Wharfield replied that is also the picture of a small number of people is driving a large number of utilization.

Commissioner Jennifer Swenson left the meeting at 4:12 pm.

6. FY19-20 Annual Strategic Planning Retreat

CAO Scrymgeour reviewed the Strategic Planning Retreat scheduled for December. We are positioning ourselves for the future and getting in a better financial position. As an eight year old plan, we are still very young and we are still maturing and that also goes for our Strategic Planning process as a whole. We started our Strategic Planning Process in the 2015 timeframe. At our next Executive Finance Committee meeting in October, we could break up each of those strategic objectives and do a deep dive, three at a time, during these meetings and get everybody's inputs and thoughts on how to leverage this committee for December.

Commissioner Alatorre stated at the last retreat in January, it was mentioned that this was a very high level strategic plan with no smart goals or objectives – how are we going to get there. At that meeting several commissioners wanted to be involved, we can ask to volunteer, and set a date to discuss each of the measures. CAO Scrymgeour asked if they want to take this back to the full Commission and ask for volunteers for a sub-committee. Commissioner Alatorre replied yes. Commissioner Espinosa stated that we should include members of the public and GCHP employees. CEO Villani suggested using the CAC members who represent the public.

CAO Scrymgeour stated the senior leaders get together quarterly. We also look at department goals and identify a set of shared enterprise goals, those goals are aligned with each of the objectives and linked to our strategy and we evaluate throughout the year. Commissioner Alatorre asked who developed the objectives. CAO Scrymgeour stated we originally worked with HMA in 2015. Strategies have evolved based on internal piece. We worked with a communications firm to package. Commissioner Alatorre stated Clinicas had two nurses, providers, front desk staff, it was a big committee but the process worked well.

CEO Villani added the next Commission meeting starts at 6 pm at the Ventura County Government Center. Notices have been distributed throughout the community. CAO Scrymgeour has created a flyer and it has been promoted on the radio. Community Relations has been working with community groups to get the word out to the clinics, hospitals and local businesses.

Meeting adjourned at 4:25 pm.