Regular Meeting  
Monday, July 23, 2018, 2:00 p.m.  
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010  

AGENDA  

CALL TO ORDER  

PLEDGE OF ALLEGIANCE  

ROLL CALL  

CONSENT CALENDAR  

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of June 25, 2018.  
   Staff: Maddie Gutierrez, Clerk of the Commission  
   RECOMMENDATION: Approve the minutes.  

2. Ancient Contract Extension  
   Staff: Melissa Scrymgeour, Chief Administrative Officer  
   RECOMMENDATION: Approve the contract extension.  

3. Temp Staffing Labor Extension – CIO Solutions  
   Staff: Melissa Scrymgeour, Chief Administrative Officer  
   RECOMMENDATION: Approve the contract extension.  

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

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

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

REPORTS

5. Chief Executive Officer (CEO) Report
   Staff: Dale Villani, Chief Executive Officer

   RECOMMENDATION: Accept and file the report.

FORMAL ACTION

6. Quality Improvement Report
   Staff: Nancy Wharfield, M.D., Chief Medical Officer

   RECOMMENDATION: Accept and file the 2018 Quality Improvement Report.

7. May Financials Report
   Staff: Kashina Bishop, Chief Financial Officer

   RECOMMENDATION: Accept and file the May Financials Report.

PRESENTATION

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

   RECOMMENDATION: Accept and file the presentation

REPORTS

9. Chief Administrative Officer (CAO) Report

   RECOMMENDATION: Accept and file the report
10. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report.

11. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.

12. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

CLOSED SESSION

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: Chief Executive Officer

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

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

OPEN SESSION

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on August 27, 2018, at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106. Community Room, Camarillo, CA 93010.

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

In compliance with the Americans with Disabilities Act, If you need assistance to participate in this meeting, please contact (805) 437-5512. Notification for accommodation must be made by the Monday prior to the meeting by 3 p.m. to enable the Clerk of the Board to make reasonable arrangements for accessibility to this meeting.
AGENDA ITEM NO. 1

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Maddie Gutierrez, Clerk to the Commission
DATE: July 23, 2018
SUBJECT: Meeting Minutes of June 25, 2018 Regular Commission Meeting

RECOMMENDATION:
Approve the minutes.

ATTACHMENTS:
Copy of the June 25, 2018 Regular Commission Meeting minutes.
CALL TO ORDER

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

PLEDGE OF ALLEGIANCE

Commissioner Swenson led the Pledge of Allegiance.

ROLL CALL

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

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

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

CONSENT

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

   RECOMMENDATION: Approve the minutes.

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

   RECOMMENDATION: To continue service with TBJ Consulting.

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

NOES: None.

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

Commissioner Swenson declared the motion carried.

REPORTS

3. Chief Executive Officer (CEO) Report

RECOMMENDATION: Accept and file the report.

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

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

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

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

FORMAL ACTION ITEMS

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

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

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

Higher medical expenditures are the primary drivers for the loss, but staff expects these medical costs will be recognized in future State capitation rates. GCHP will continue to monitor revenue as well as State policy changes that could impact revenue in the future. Staff continues to minimize expenses wherever possible. It was noted
that GCHP is investing in programs and applications needed to meet changing needs of the healthcare market. GCHP was able to decrease some medical expenses by contracting changes but it is difficult for GCHP to control some medical expenses. For example, long-term care is up 3.9% because the facility rates are set by the State and go up each year. However, membership is going through a slightly downward trend.

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

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

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

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

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

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

PUBLIC COMMENT

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

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

NOES: None.

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

Commissioner Swenson declared the motion carried.

PUBLIC COMMENT

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

4. April Financials Report

RECOMMENDATION: Accept and file the April financials report.

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

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


NOES: None.

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

Commissioner Swenson declared the motion carried.
6. Adoption of Procedure for Adding Items to the Commission Agenda.

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

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

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


NOES: None.

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

Commissioner Swenson declared the motion carried.

PRESENTATIONS

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

RECOMMENDATION: Accept and file the presentation.

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

Ashley Nettles, Program Manager for Project Safer spoke to the Commission. She stated the main goal is to reduce opioid overdoses or death. Over 200 kits have been distributed to Oxnard and Simi Valley Police departments as well as Ventura County Sheriffs’ department. This has in turn saved 344 lives (since February 2014 – May 2018). Gold Coast Health Plan has contributed by providing a grant which was used to purchase kits.

Commissioner Espinosa stated this was a great program. No names have to be given in order to obtain a kit. There are 2 versions – a regular kit or a nasal spray. Training is required to use the kits.
Commissioner Pawar asked how results are monitored. Anne Freese, Pharmacy Director stated additional reporting was received from OptumRx. Guidelines were reviewed as well as patient history.

8. OptumRx Update

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

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

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

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

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

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

PUBLIC COMMENT

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

9. Chief Medical Officer (CMO) Update

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

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

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

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

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

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

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

PUBLIC COMMENT

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

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

NOES: None.

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

Commissioner Swenson declared the motion carried.

10. **Chief Diversity Officer (CDO) Update**

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

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

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

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

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

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

11. **Chief Operating Officer (COO) Update**

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

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

Americas Health Plan (AHP) and GCHP have agreed to submit documents to the State for review of the plan to plan agreement. A response from the State can take up to 60 days.
Commissioner Pawar asked about the turn-around time for a specialist appointment. COO Watson advised that the regulatory requirement was 15 days. CMO Nancy Wharfield, M.D. stated E-Consult Services are coming in the future.

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

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


NOES: None.

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

Commissioner Swenson declared the motion carried.

CLOSED SESSION

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

12. CONFERENCE WITH LEGAL COUNSEL- ANTICIPATED LITIGATION

Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: One case.

13. PUBLIC EMPLOYEE PERFORMANCE EVALUATION

Title: Chief Executive Officer

14. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION

Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One case.

OPEN SESSION

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

Mr. Campbell stated there was no reportable action taken.
COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

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

Approved:

________________________________________

Maddie Gutierrez, Clerk of the Commission
AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Melissa Scrymgeour, Chief Administrative Officer

DATE: July 23, 2018

SUBJECT: Contract Extension Approval – Ancient, Inc.

SUMMARY:

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

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

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

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

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

FISCAL IMPACT:

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

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

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<th>Master Subscription Agreement</th>
<th>Amount</th>
<th>Period</th>
<th>Budgeted</th>
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<td>Original Contract</td>
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<td>Additional Bldg</td>
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<td>Total Spend Years 1-3</td>
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<td>Contract Renewal</td>
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<tr>
<td>Years 4 &amp; 5</td>
<td>$92,844.00</td>
<td>08/01/2018 - 07/31/2020</td>
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<tr>
<td>Total Projected Cumulative Spend (Yrs. 1-5)</td>
<td>$230,808.00</td>
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RECOMMENDATION:

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

If the Commission desires to review these contracts, they are available at GCHP’s Finance Department.
AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Melissa Scrymgeour, Chief Administrative Officer
DATE: July 23, 2018
SUBJECT: Contract Extension Approval (SOW #7) – CIO Solutions, LP

SUMMARY:

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

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

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

<table>
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<th>Period</th>
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<tr>
<td>FY 2017/2018</td>
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<tr>
<td>FY 2018/2019</td>
<td>$74,880</td>
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<tr>
<td>Total Budgeted Cumulative Spend (Yrs. 1-2)</td>
<td>$149,760</td>
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</table>

*Estimate for budget purposes only: May not spend total amount

FISCAL IMPACT:

There is no impact to the current fiscal year, as the costs are included in the approved FY18-19 budget. The total spend last fiscal year for these services was $74,880 (713 hrs.). Based on project estimates and current workload we do not anticipate the service hours to exceed last fiscal year.
RECOMMENDATION:
GCHP recommends the Commission approve the continuation of services with CIO Solutions, LP. for an additional one-year period from July 1, 2018 – June 30, 2019.

If the Commission desires to review these contracts, they are available at GCHP’s Finance Department.
AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: July 23, 2018


SUMMARY:

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

BACKGROUND/DISCUSSION:

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

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

FISCAL IMPACT:

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

RECOMMENDATION:

It is the Plan’s recommendation to authorize the CEO to execute a Master Agreement For Temporary Services with FluidEdge Consulting Inc. and to pre-authorize any individual transaction for these services over $100,000.
If the Commission desires to review these contracts, they are available at Gold Coast Health Plan’s Finance Department.
AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: July 23, 2018

SUBJECT: Chief Executive Officer Update

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

National Update

Centers for Medicare and Medicaid (CMS) Update

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

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

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

Legislative Update

Last month, the House of Representatives passed a sweeping piece of legislation called H.R. 6 (the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act) to address the nation’s opioid overuse epidemic. H.R. 6
incorporated dozens of previously-passed bills that would impact Medicaid, as well as Medicare and other programs, by building provider capacity, including in rural areas, providing protections for pregnant and postpartum women impacted by substance use disorders (SUD), providing a state option to expand coverage periods for justice-involved populations, expanding drug utilization review practices, and in many additional ways.

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

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

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

California Legislative Update

California’s Enacted FY 2018-19 Budget

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

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

- $500 million for payments to physicians and $210 million for payments to dentists;
- Increased rates for home health services, pediatric day health care, and pediatric free-standing subacute facilities;
- One-time funding of $6 million for qualifying Program of All-Inclusive Care for the Elderly (PACE) programs and $2 million for qualifying Community-Based Adult Services Programs;
• $220 million for educational loan repayments for physicians ($190 million) and dentists ($30 million) and establishes a loan repayment program.

Other elements of the budget include the authorization of a dental integration pilot program to be operated by the Health Plan of San Mateo.

The budget also includes $60 million in one-time funding to establish a California Health Care Cost Transparency Database to collect information on the costs of health care in order to create transparency on health care costs, and to inform policy makers, and reduce disparities and costs.

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

The Legislature did have some small victories, as they rejected the Governor’s proposal to eliminate the 340B Pharmaceutical Program. Negotiations continue between the clinics, public hospitals, health plans, and the Department of Health Care Services (DHCS) on language to require new reporting requirements intended to bring more transparency to the program.
COMPLIANCE UPDATE:

DHCS Annual Medical Audit:
Audits and Investigation conducted the annual 2017-2018 onsite medical audit June 4, 2018 through June 15, 2018. The auditors reviewed the following areas: Utilization Management, Care Management and Care Coordination, Access and Availability, Grievance and Appeals, HIPAA, Fraud, Waste and Abuse, Delegation Oversight, Quality Improvement and Administrative Capacity. Staff will provide ongoing updates to the commission once received by A&I.

DHCS Contract Amendments:
The draft DHCS contract amendment has included multiple revisions based on CMS review. The contract amendment is still pending approval by CMS and the Plan is pending the final amendment for signature. The amendment incorporates approximately 156 Mega Reg provisions. Approximately 63 items remain TBD for the State to define and 28 items are TBD and not currently within the contract amendment. Additional provisions and requirements will be forthcoming via additional contract amendments, all plan letters, policy letters etc. GCCHP has received additional requirements from the Mega Reg via All Plan Letters and has had multiple deliverables due to DHCS to ensure compliance.

Delegation Oversight:
Gold Coast Health Plan (GCHP) is contractually required to perform oversight of all functions delegated through subcontracting arrangements. Oversight includes but is not limited to:
- Monitoring/reviewing routine submissions from subcontractors
- Conducting onsite audits
- Issuing a Corrective Action Plan (CAP) when deficiencies are identified
Delegation Audit(s) Update:

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<th>Audit Status</th>
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*Audit Status Open: Audits are closed when the CAP is closed.

**Audit Close out Letter definition: Delegate(s) were not issued a CAP due to passing results on the annual onsite audit; therefore, the delegate receives a formal closure letter.

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*All entries are as of the date of this document.*
The following delegates received an annual onsite audit in Q2-Q3 2018:

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Compliance will continue to monitor all CAP in place and work with each delegate to ensure compliance is achieved and sustained. Ongoing updates will be provided to the commission.

**RECOMMENDATION:**
Accept and File
AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, Chief Medical Officer

DATE: July 23, 2018

SUBJECT: Gold Coast Health Plan Quality Improvement Report

Summary

Dr. Wharfield will present Gold Coast Health Plan's Quality Improvement Report.
GOLD COAST HEALTH PLAN
2018 QUALITY IMPROVEMENT PROGRAM

I. Background 3
II. Mission, Vision, and Values 3
III. Purpose and Scope 3
IV. Authority and Responsibility 5
V. QI Program Goals and Objectives 6
VI. QI Program Methodology 7
VII. Key Program Initiatives 8
VIII. Program Organization, Oversight and Evaluation 10
IX. Annual Work Plan 11
X. Program Resources Dedicated to Quality Improvement 12
XI. Quality Committees and Subcommittees 14
   i. Quality Improvement Committee 14
   ii. Medical Advisory Committee 16
   iii. Member Services Committee 17
   iv. Grievance and Appeals Committee 18
   v. Utilization Management Committee 18
   vi. Health Education/Cultural Linguistics Committee 19
   vii. Credentials/Peer Review Committee 20
viii. Pharmacy and Therapeutics Committee 21
XII. Delegation of Quality Improvement 21
XIII. Committee Organizational Chart 23
XIV. Quality Committee Meetings for Calendar Year 24
I. BACKGROUND

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

II. MISSION, VISION, VALUES

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

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

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

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

III. PURPOSE AND SCOPE

The purpose of the Gold Coast Health Plan (GCHP) Quality Improvement (QI) Program is to achieve high quality and optimal clinical outcomes in all departmental programs reflecting the State mission to preserve and improve the health of all Californians. The QI Program provides the framework for Gold Coast to:
- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable health care and services.
- Identify and implement strategies to improve the quality, appropriateness and accessibility of member healthcare
- Implement an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services
- Facilitate organization wide integration of quality management principles
To accomplish this, GCHP's QI Program aligns its efforts with the current version of the Department of Health Care Services (DHCS) Strategy for Quality Improvement in Health Care.

This foundation for a quality strategy is anchored in three linked goals of the "Triple Aim":
- Improve health
- Enhance quality of health care services, including the patient experience
- Reduce DHCS per-capita health program costs

The QI Program consists of the following elements:
A. QI Program Description
B. Annual QI Program Evaluation
C. Annual QI Work Plan
D. Quality Improvement Activities
E. QI Committee Structure
F. Policies and Procedures

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

1. Quality and safety of clinical care services including, but not limited to:
   - Preventive services
   - Chronic disease management
   - Disease Management/Care Management/Population Health
   - Prenatal care
   - Family planning services
   - Behavioral health care services
   - Medication management
   - Coordination and Continuity of Care

2. Quality of nonclinical services including, but not limited to:
   - Accessibility
   - Availability
   - Member satisfaction
   - Grievance and appeal process
   - Cultural and Linguistic Services

3. Patient safety initiatives including, but not limited to:
   - Facility site reviews
   - Credentialing of practitioners/providers
   - Peer review
   - Sentinel event monitoring
   - PQI/PPC monitoring
• Health Education

4. A QI focus which represents

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

IV. AUTHORITY AND RESPONSIBILITY

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

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

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

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

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

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

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

VCMHCC Membership

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

V. QI PROGRAM GOALS AND OBJECTIVES

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

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

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

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

VI. QI PROGRAM METHODOLOGY

GCHP utilizes the Institute for Health Care Improvement (IHI) Model for Improvement. Staff is encouraged to achieve improvement continuously by using the "Rapid Cycle Small Test of Change Methodology."
GCHP uses the “Plan-Do-Study-Act Cycle” (PDSA) to implement and test the effectiveness of changes. This model focuses on identifying improvement opportunities and changes, and measuring improvements. The PDSA cycle guides the test of a change to determine if the change is an improvement.

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

The indicators may reflect the following parameters of quality:

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

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

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

VII. KEY PROGRAM INITIATIVES

Case Management/Disease Management/Population Health

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

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

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

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

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

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

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

Inclusion and Diversity

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

To ensure that members have access to covered services that are delivered in a manner that meets their needs, GCHP conducts the following activities:
- Review of member complaints and grievances
- Provision of language assistance services to assist providers to provide linguistically appropriate medical care to Limited English Proficient members
- Conducting a Group Needs Assessment every 5 years
- Provision of a Cultural Competency Training Program for both providers and GCHP staff
- Conducting surveys of members to determine if culture and language needs are met by providers
- Provision of a Seniors and Persons with Disabilities (SPD) Cultural Sensitivity Training for providers and staff
- Assessment of provider linguistic capabilities
- Assessment of GCHP staff language capabilities

VIII. PROGRAM ORGANIZATION, OVERSIGHT AND EVALUATION

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

The Chief Medical Officer has the overall responsibility for the clinical direction of GCHP’s QI Program. The Chief Medical Officer ensures that the QI Program is adequate to monitor the full
scope of clinical services rendered, and that identified problems are resolved and corrective actions are initiated when necessary and appropriate.

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

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

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

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

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

Specific roles and responsibilities include but are not limited to:

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

The QI Director oversees staff consisting of an adequate number of Registered Nurses with the requirement to fulfill QI responsibilities, and other staff that includes a QI Manager, QI Project Manager, Senior Quality Improvement HEDIS® Analyst, a QI Data Analyst, a Credentialing Coordinator and the QI Specialist.
QI PROGRAM EVALUATION
A written evaluation of the QI Program is completed annually. This includes a review and revision of the QI Program Description, evaluation of the prior year’s QI Work Plan, and the development of the current year’s QI Work Plan to ensure ongoing performance improvement.

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

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

IX. ANNUAL WORK PLAN

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

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

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

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

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

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

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

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

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

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

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

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

• Credentialing and Recredentialing activities; and
• Peer Review Activities

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

X. PROGRAM RESOURCES DEDICATED TO QUALITY IMPROVEMENT

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

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

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

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

Credentialing and peer review functions are supported by QI staff.

The quality improvement staff assists the Director in assessing data for improvement opportunities. They work with other departments to assist in planning and implementing activities that will improve care or service.
Responsibilities include but are not limited to the following:

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

OTHER QI RESOURCES

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

QI Program Resources - Program and Tools

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

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

QI Tools, Resources and Sources of Data

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

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

QI Program Resources - Data, Information and Analytics Support

GCHP’s QI Program monitors and evaluates performance and information from many different sources throughout the organization including but not limited to:

- Enrollment and demographic data, including race, ethnicity and language preference data, is collected to monitor health care quality and for identifying and reducing health disparities among our patient population
- Claims data (utilization by diagnosis/procedure, provider, treatment/medications, site of care, etc.)
• Case management/disease management/population health reports to assess support of
members with complex or chronic medical and behavioral health conditions, and to evaluate
coordination of care across the continuum
• Complaint and appeal data, including type of complaints, trends, and root cause analysis
• Ongoing tracking and trending of quality of care or serious reportable event data to identify
patient safety issues and assess provider qualifications
• Member and provider survey data to assess satisfaction with services and operations
• Credentialing process data to measure timeliness of application processing and quality of
network providers
• Network adequacy/accessibility measurement data to assess provider availability and
accessibility
• HEDIS® data to assess the effectiveness of clinical care and services

XI. QUALITY COMMITTEES AND SUBCOMMITTEES

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

1. Quality Improvement Committee (QIC)

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

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

An annual QI Report is submitted to the VCMMCC addressing:

A. Quality improvement activities such as:
   i. Utilization Reports
   ii. Review of the quality of services rendered
   iii. HEDIS results
   iv. Quality Improvement Projects - status and/or results
   v. Satisfaction Survey Results
   vi. Collaborative initiatives - status and/or results
B. Success in improving patient care and outcomes, and provider performance.

C. Opportunities for improvement.

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

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

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

**QIC Objectives:**

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

**QIC Responsibilities:**

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

**QIC Membership:**

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

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

Meeting Frequency:

The QIC meets at a minimum quarterly.

2. Medical Advisory Committee (MAC)

Purpose:

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

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

Scope:

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

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

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

Membership:

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

Meeting Frequency:

The committee meets at a minimum on a quarterly basis.
3. Member Services Committee (MSC)

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

**MSC Objectives:**

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

**MSC Membership:**

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

**Meeting Frequency:**

The MSC meets quarterly at a minimum.

4. Grievance and Appeals Committee (G&A)

**G&A Charter:**

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

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

G&A Committee Membership:

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

Meeting Frequency:

The committee meets quarterly.

5. Utilization Management Committee (UMC)

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

UMC Responsibilities:

Responsibilities include but are not limited to the following:

- Annual review and approval of the UM and CM/DM/Population Health Program documents
- Review and approval of program documents addressing the needs of special populations. This includes but may not be limited to Children with Special Health Care Needs (CSHCN) and Seniors and Persons with Disabilities (SPD)
- Suggest and collaborate with other departments to address areas of patient safety. This may include but is not limited to medication safety and child safety.
- Annual adoption of preventive health criteria and medical care guidelines with guidance on how to disseminate criteria and ensure proper education of appropriate staff
• Review of the timeliness, accuracy and consistency of the application of medical policy as it is applied to medical necessity reviews
• Review utilization and case management monitors to identify opportunities for improvement
• Review data from Member Satisfaction Surveys to identify areas for improvement
• Ensure policies are in place to review, approve and disseminate UV criteria and medical policies used in review when requested
• Review, at least annually, the Inter Rater Reliability (IRR) test results of UM staff involved in decision making (RN’s and MD’s) and take appropriate actions for staff that fall below acceptable performance
• Interface with other GCHP committees for trends, patterns, corrective actions and outcomes of reviews

Membership:

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

Meeting Frequency:

The UMC meets quarterly at a minimum.

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

Purpose:

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

Functions:

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

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

Meeting Frequency:

The committee meets at a minimum quarterly.

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

Purpose:

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

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

Credentialing Responsibilities:

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

Peer Review Responsibilities:

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

Membership:

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

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

Meeting Frequency:

The committee meets quarterly.
8. Pharmacy & Therapeutics (P&T) Committee

**Purpose:**

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

**Functions:**

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

**Membership:**

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

**Meeting Frequency:**

The committee meets quarterly.

XII. DELEGATION OF QUALITY IMPROVEMENT

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

GCHP conducts ongoing oversight, evaluation and monitoring of the delegate. At a minimum, an annual audit is conducted. Corrective action plans are implemented based upon areas of non-
compliance. Delegated entities are required to submit at least semi-annually reports to GCHP according to the reporting schedule specified in the delegation agreement. Audit results and outcomes of corrective action plans are reported to QIC.
XIII. GOLD COAST HEALTH PLAN COMMITTEE ORGANIZATIONAL CHART

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

Ventura County Medi-Cal Managed Care Commission
dba
Gold Coast Health Plan

- Executive Finance Committee
- Quality Improvement Committee
- Provider Advisory Committee
- Consumer Advisory Committee
  - Medical Advisory Committee
  - Credentials/Peer Review Committee
  - Pharmacy and Therapeutics Committee
  - Grievance and Appeals Committee
  - Member Services Committee
  - Utilization Management Committee
  - Health Education/Cultural and Linguistics Committee
XIV. QUALITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2018

<table>
<thead>
<tr>
<th>Dates:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Tuesday</td>
<td>March 27, 2018</td>
<td></td>
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<tr>
<td>Tuesday</td>
<td>June 19, 2018</td>
<td></td>
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<tr>
<td>Tuesday</td>
<td>September 25, 2018</td>
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<tr>
<td>Tuesday</td>
<td>December 11, 2018</td>
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<tr>
<td>Location: Bell Canyon Conference Room</td>
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</tbody>
</table>

Availability of QI Program to practitioners and members

The QI Program is available on GCHP’s website at [www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org). Printed copies are available upon request.

REFERENCES

- Gold Coast Health Plan Quality Improvement System Policy QI-002
- Gold Coast Health Plan Utilization Management Program Description
- Gold Coast Health Plan Care Management/Disease Management/Population Health Program Description
- Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 13-005
- HEDIS® National Committee for Quality Assurance
- CAHPS® National Committee for Quality Assurance
- NCQA Standards and Guidelines for the Accreditation of Health Plans
- DHCS Quality Strategy
- National Quality Strategy
- Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010
- Title 42, Code of Federal Regulations, Section 438.240(b) (1)

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

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

The 2018 Quality Improvement Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMCC) on XX, 2018.
## 2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

**Objective:** Improve Quality and Safety of Clinical Care Services

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Department/Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCQA MED 2</td>
<td>Diabetes Clinical Practice Guideline (CPG) review and adoption at least every two years Distribution of guidelines to practitioners</td>
<td>Review of relevant CPGs Distribute if necessary</td>
<td>Q4 2017</td>
<td>Review and approval by Medical Advisory Committee (MAC) Annually measure performance against at least two important aspects of each of the CPGs Distribute guidelines to appropriate practitioners</td>
<td>MAC</td>
</tr>
</tbody>
</table>

### EVALUATION OF 2017 WORK PLAN

**RESULTS:** Completed - approved at MAC 5/15/17 - no substantive changes made. Showed great improvement in all of the HEDIS Measures related to diabetes, with the exception of Nephropathy. Recommend creating an action plan for conducting a causal analysis of Nephropathy rate in 2018.

**BARRIER ANALYSIS** Goal Met, no barriers presently identified.

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Department/Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCQA MED 2</td>
<td>Asthma Clinical Practice Guideline (CPG) review and adoption at least every two years Distribution of guidelines to practitioners</td>
<td>Review of relevant CPGs Distribute if necessary</td>
<td>Q4 2017</td>
<td>Review and approval by Medical Advisory Committee (MAC) Annually measure performance against at least two important aspects of each of the CPGs Distribute guidelines to appropriate practitioners</td>
<td>MAC</td>
</tr>
</tbody>
</table>

### EVALUATION OF 2017 WORK PLAN

**RESULTS:** Completed - approved at MAC 7/27/17 - no substantive changes made. We have made improvements but are still below the MPL for Asthma Medication Ratio. The Public Health in Home Asthma Program through Ventura County Public Health targeted high emergency department utilizers with asthma-related conditions. Home visits identified triggers, increased use of asthma action plans, and provided education on correct use of controller and rescue medications. Recommendation to look at analysis of asthma medication rates and create an action plan if warranted.

**BARRIER ANALYSIS** Goal Met, no barriers presently identified.
<table>
<thead>
<tr>
<th>Goal</th>
<th>Responsible Department/ Committee</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
</tr>
</thead>
</table>
| **PREVENTIVE HEALTH GUIDELINE (PHG)** | MAC | Review and approval by Medical Advisory Committee (MAC)  
Annually measure performance against at least two important aspects of two PHGs  
Distribute guidelines to appropriate practitioners |
| **EVALUATION OF 2017 WORK PLAN** | | |
| **RESULTS** | | Completed - approved at MAC 7/27/17 - no substantive changes made  
Met the MFL on all of CIS sub-measures, with year-over-year improvement. Achieved the 50th percentile on all but three of Combo 3 measures.  
Recommendation: continue monitoring for improvement. CIS rates can be found in the HEDS Measures section of the evaluation. |
| **BARRIER ANALYSIS** | | Goal Met, no barriers presently identified |
| **EVALUATION OF 2017 WORK PLAN** | | |
| **RESULTS (Quantitative Analysis): Goal Not Met** | | |

**Metrics**

- **Target Completion Date**: Q4 2017
- **Metrics**: Preventive Health Guideline PHG review and adoption at least every two years, distribution of guidelines to practitioners
RESULTS (Qualitative Analysis):
The 2015 CAHPS reported the percentage of members who smoke who reported being counseled to quit in the prior 6 months as NA (due to low denominator). During 2016, IHA audits of SHA forms yielded 103 members who were positive for use of tobacco products. A total of 68% were provided cessation counseling, and 32% were offered a cessation medication. The two rates were established as a baseline.

Data for smoking cessation was obtained during monthly IHA SHA medical record reviews. A total of 2940 medical records were reviewed, with 236 (8%) members age 18 or above. A total of 222 (94%) members were screened, with 66 (30%) of members positive for tobacco use. Of those members who indicated that they smoked, 33% (75 members) had evidence in the record that they were provided cessation counseling. This rate fell below the established baseline of 58%.

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

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

NEXT STEPS:
- Recommend new strategy to engage members in smoking cessation by identification of smoking members.
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

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

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**EVALUATION OF 2017 WORK PLAN**

**RESULTS (Quantitative Analysis): Goal Not Met**

![Bar Chart]

**Members Age 18+ Who Smoke and Were Offered Cessation Medication**

- 94% members screened
- 30% members offered cessation medication for tobacco use
- 14% cessation medication offered
RESULTS (Qualitative Analysis):
The 2015 CAHPS reported the percentage of members who smoke who reported being counseled to quit in the prior 6 months as NA (due to low denominator). During 2016, IHA audits of SHA forms yielded 103 members who were positive for use of tobacco products. A total of 68% were provided cessation counseling, and 32% were offered a cessation medication. The two rates were established as a baseline.

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

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

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

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

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Health Assessment</td>
<td>DHCS Increase rates of Initial Health Assessment (IHA)</td>
<td>90%</td>
<td>Q4 2017</td>
<td>Measure during medical record reviews for IHA and provide performance feedback at time of completion of record review. Educate providers of requirements and components of IHA Audit and provide feedback. Article in POB regarding requirements of IHA, including outreach requirements.</td>
</tr>
</tbody>
</table>

RESULTS (Quantitative Analysis): Goal Not Met
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

IHA Medical Records that scored 90% and Above

<table>
<thead>
<tr>
<th></th>
<th>Q-1</th>
<th>Q-2</th>
<th>Q-3</th>
<th>Q-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>56.86%</td>
<td>52.08%</td>
<td>64.65%</td>
<td>52.05%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>VCMC</th>
<th>CMH - CFH</th>
<th>Clinicas</th>
<th>Identity Med. Grp.</th>
<th>Dignity Health</th>
<th>Independent Providers</th>
<th>2017 Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>91%</td>
<td>79%</td>
<td>100%</td>
<td>84%</td>
<td>76%</td>
<td>88%</td>
<td>86%</td>
</tr>
</tbody>
</table>

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

Primary reasons for not achieving 90% on medical record audits included:
- Incomplete, unsigned, or no Staying Healthy Assessment in the medical record
- Age-appropriate preventive health screenings were missing documentation in the medical record
- Missing TB Risk Assessment
- Missing immunization status in the medical record

BARRIER ANALYSIS:
- The IHA and SHA process is lengthy - SHA form takes significant time during clinic visits in busy practices.
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

INTERVENTIONS:

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

NEXT STEPS:

- Identify and share best practices with providers of strategies used by other offices that are successful in performing the IHA /SHA.
- Continue to monitor for staff turnover and offer training for new hires.
- Continue monitoring clinic site performance and provide outreach to clinics with failing or declining scores.
- Continue to educate providers and staff of the Gold Coast Health Plan IHA support resources available. Encourage requests for re-training or focused training to meet needs.
- Continue monitoring via MRR.
- Build an IHA Database to collect the results of IHA medical record reviews and perform automated tabulation of outcomes.
- Discuss IHA strategies with other COHS to gain insight on alternate processes or best practices.
- Consider adding performance monitoring of member outreach compliance by clinics to 2018 Workplan to recognize this key component of IHA efforts.
# 2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

**Objective:** Improve Quality and Safety of Clinical Care Services

## HEDIS® Measures

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

## Evaluation of 2017 Work Plan

### RESULTS (Quantitative Analysis): Goal Not Met.

<table>
<thead>
<tr>
<th>HEDIS Measure/Data Element</th>
<th>Domain of Care</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2016-17 Rate Difference</th>
<th>Current NCQA Percentile Ranking</th>
<th>10th</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Postpartum Care</td>
<td>Q, A, T</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum Care</td>
<td></td>
<td>59.12</td>
<td>65.45</td>
<td><strong>68.35</strong></td>
<td>↑ 2.90</td>
<td>50th</td>
<td>51.74</td>
<td>59.59</td>
<td>64.38</td>
<td>69.44</td>
<td>73.37</td>
</tr>
</tbody>
</table>

### RESULTS (Qualitative Analysis): Increase was only 2.9%
A greater percentage of members did not have postpartum exams across all age bands.

**Aid Category Comparison**
- Adult Expansion
- Disabled
- Family
- Family/Adult
- TUC

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

<table>
<thead>
<tr>
<th>Denominator (n=376)</th>
<th>English</th>
<th>Spanish</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%</td>
<td>24%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

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

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

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

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

Analyze distribution of demographic indicators to identify any disparity among aid codes and language, and create an action plan as applicable.
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Analysis of Member Outreach Activities: 2017 Postpartum Member Incentive Evaluation
Quantitative Analysis
Graph 1: Postpartum Member Incentive Mailings by Year (2015-2017)

Graph 2: Postpartum Member Incentive Participation by Year (2015-2017)
2017 Postpartum Member Incentive Evaluation
Qualitative Analysis
Successes

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

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

**Barriers**

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

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

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Department/Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childhood Immunizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHCS</td>
<td>Childhood Immunization Status Combo 3 – Percentage of two year old children who receive a specific group of vaccines (DTap, IV, MMR, Hib, HepB, VZV and PCV) on or before their 2nd birthday</td>
<td>Increase rates by 5% over previous measurement year</td>
<td>Q4 2017</td>
<td>Provide provider performance feedback by means of 2016 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Educate Providers on trending of rates via Provider Update</td>
<td>QI</td>
</tr>
</tbody>
</table>
### RESULTS (Quantitative Analysis) Goal Met. Rate increased 5.57% over previous year.

<table>
<thead>
<tr>
<th>HEDIS Measure/Data Element</th>
<th>Domain of Care</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2016-17 Rate Difference</th>
<th>Current NCQA Percentile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10th</td>
</tr>
<tr>
<td>Effectiveness of Care: Prevention and Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunization Status</td>
<td>Q, A, T</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combination #3</td>
<td></td>
<td>75.43</td>
<td>64.96</td>
<td>70.53</td>
<td>✓ 5.57</td>
<td>26th</td>
</tr>
</tbody>
</table>

Rate increased 5.57% over previous year.

**BARRIER ANALYSIS:** Goal met, no barrier analysis needed.

**INTERVENTIONS:** Please see notes regarding the Childhood Immunization PIP.

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

### Required By | Goals | Metrics | Target Completion Date | Action Steps & Monitoring/Improvement Activities | Responsible Department/Committee
---|---|---|---|---|---
**Adolescent Immunizations**
DHCS | Immunizations for Adolescents (Combo 2) – percentage of adolescents 13 years of age who received a meningococcal vaccine on or between the member’s 11<sup>th</sup> and 13<sup>th</sup> birthday and Tdap or Td on or between the member’s 10<sup>th</sup> and 13<sup>th</sup> birthdays and at least two HPV vaccines on or between the member’s 9<sup>th</sup> and 13<sup>th</sup> birthdays. | Increase rates by 5% over previous measurement year | Q4 2017 | Provide provider performance feedback by means of 2016 HEDIS report cards. Bi-monthly prospective HEDIS report cards and performance feedback reports | QI
RESULTS (Quantitative Analysis): Goal met. We increased the rate by 11.5% over the 2016 rate.

<table>
<thead>
<tr>
<th>HEDIS Measure/Data Element</th>
<th>Domain of Care</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2016-17 Rate Difference</th>
<th>Current NCQA Percentile Ranking</th>
<th>2017 NCQA Percentile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of Care: Prevention and Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations for Adolescents</td>
<td>Q, A, T</td>
<td>NR</td>
<td>22.08</td>
<td>33.58</td>
<td>↑ 11.50</td>
<td>90th</td>
<td>12.27</td>
</tr>
</tbody>
</table>

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

BARRIER ANALYSIS: Goal met, no barrier analysis needed.

INTERVENTIONS: NA

NEXT STEPS: Consider discontinuing this Work Plan item in 2018. Focus efforts on other high-priority measures.

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

EVALUATION OF 2017 WORK PLAN
# 2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

## RESULTS (Quantitative Analysis): Goal not met

<table>
<thead>
<tr>
<th>HEDIS Measure/Data Element</th>
<th>Domain of Care</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2016-17 Rate Difference</th>
<th>Current NCQA Percentile Ranking</th>
<th>2017 NCQA Percentile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access/Availability of Care</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Children and Adolescents' Access to Primary Care Practitioners</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-24 Months</td>
<td></td>
<td>94.65</td>
<td>93.86</td>
<td>95.05</td>
<td><strong>↑ 1.19</strong></td>
<td>25th</td>
<td>90.86</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25th</td>
<td>90.86</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>50th</td>
<td>95.07</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75th</td>
<td>97.09</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>90th</td>
<td>97.9</td>
</tr>
<tr>
<td>25 Months - 6 Years</td>
<td></td>
<td><strong>84.87</strong></td>
<td>85.52</td>
<td><strong>84.72</strong></td>
<td><strong>↓ 0.80</strong></td>
<td>10th</td>
<td>80.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10th</td>
<td>84.94</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>50th</td>
<td>87.87</td>
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<td></td>
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<td></td>
<td></td>
<td>75th</td>
<td>90.75</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90th</td>
<td>93.2</td>
</tr>
<tr>
<td>7-11 Years</td>
<td></td>
<td><strong>85.62</strong></td>
<td>84.54</td>
<td><strong>86.12</strong></td>
<td><strong>↑ 1.58</strong></td>
<td>10th</td>
<td>83.39</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10th</td>
<td>87.56</td>
</tr>
<tr>
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<td></td>
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<td></td>
<td></td>
<td>50th</td>
<td>90.77</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>75th</td>
<td>93.51</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90th</td>
<td>95.1</td>
</tr>
<tr>
<td>12-19 Years</td>
<td></td>
<td><strong>84.14</strong></td>
<td>82.32</td>
<td><strong>83.69</strong></td>
<td><strong>↑ 1.37</strong></td>
<td>10th</td>
<td>81.72</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10th</td>
<td>85.65</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>50th</td>
<td>89.52</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75th</td>
<td>92.45</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90th</td>
<td>94.7</td>
</tr>
</tbody>
</table>

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

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

### INTERVENTIONS:
- CAP P4P incentive for one clinic
- Provide provider performance feedback by means of 2015 HEDIS report cards
- Bi-monthly prospective HEDIS report cards and performance feedback reports
- Member incentive campaign for well child visits (7-11 years; 3-6 years)

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>7 – 11 Year Old Well-Child Member Incentive Activity</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Incentives Mailed</td>
<td>3060</td>
</tr>
<tr>
<td>Total Forms Returned</td>
<td>64</td>
</tr>
<tr>
<td>No Visit</td>
<td>6</td>
</tr>
<tr>
<td>Not Child</td>
<td></td>
</tr>
<tr>
<td>Not Member</td>
<td></td>
</tr>
<tr>
<td>Valid</td>
<td>58</td>
</tr>
<tr>
<td>Total Valid Forms Returned by Age</td>
<td></td>
</tr>
<tr>
<td>12-24 months</td>
<td></td>
</tr>
<tr>
<td>25 months - 6 years</td>
<td>8</td>
</tr>
<tr>
<td>7 - 11 years</td>
<td>49</td>
</tr>
<tr>
<td>12-19 years</td>
<td>1</td>
</tr>
<tr>
<td>Participation Rate</td>
<td>1.75%</td>
</tr>
</tbody>
</table>
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Qualitative Analysis:

- **Increased Member Engagement**
  A guaranteed gift card increased member engagement with participating in the well-child member incentive program compared to the previous well-child raffle member incentive program.

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

Barrier Analysis:

- Low member participation in incentive program

Next Steps:

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

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

   **Study Period:** 02/21/17 to 12/31/17
   **Prediction:** The revised member incentive, which guarantees a $15.00 gift card if a well-child exam is completed, will increase member engagement in participating in the well-child incentive program.
   **Goal:** By December 31, 2017 increase the administrative rate of well-child exams for 3 to 6 years old children, who have full-scope Medi-Cal benefits in Ventura County, by 5% over the previous measurement year from 66% (2016 MY) to 71% (2017 MY goal).

Quantitative Analysis:

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

<table>
<thead>
<tr>
<th>3 - 6 Year Old Well-Child Member Incentive Activity</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Incentives Mailed</td>
<td>14,322</td>
</tr>
<tr>
<td>Total Forms Returned</td>
<td>287</td>
</tr>
<tr>
<td>Total Valid Forms Returned</td>
<td>280</td>
</tr>
</tbody>
</table>
Qualitative Analysis:

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

**Barrier Analysis**

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

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

**Next Steps:**

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

---

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

had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling

**Provider Operations Bulletin article**
Meet with clinics to discuss rates

### EVALUATION OF 2017 WORK PLAN

#### RESULTS (Quantitative Analysis): Goal Met

<table>
<thead>
<tr>
<th>HEDIS Measure/Data Element</th>
<th>Domain of Care</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2016-17 Rate Difference</th>
<th>Current NCQA Percentile Ranking</th>
<th>2017 NCQA Percentile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of Care: Prevention and Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Activity for Children/Adolescents</td>
<td>Q</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling for Nutrition</td>
<td>55.99</td>
<td>54.50</td>
<td>79.56</td>
<td></td>
<td>↑ 25.06</td>
<td>75th</td>
<td>42.92</td>
</tr>
<tr>
<td>Counseling for Physical Activity</td>
<td>49.88</td>
<td>48.66</td>
<td>74.94</td>
<td></td>
<td>↑ 25.28</td>
<td>75th</td>
<td>35.90</td>
</tr>
</tbody>
</table>

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

**BARRIER ANALYSIS:** Goal met, no barrier analysis needed.

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

**NEXT STEPS:**
- Continue Well Child Member Incentive for 3-6 year old.
- Consider discontinuing this Work Plan item in 2018. Focus efforts on other high-priority measures.
# 2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

**Objective:** Improve Quality and Safety of Clinical Care Services

## Over/Under Utilization

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

## EVALUATION OF 2017 WORK PLAN

### RESULTS (Quantitative Analysis): Goal Not Met

<table>
<thead>
<tr>
<th>HEDIS Measure/Data Element</th>
<th>Domain of Care</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2016-17 Rate Difference</th>
<th>Current NCQA Percentile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness of Care: Respiratory Conditions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10th</td>
</tr>
<tr>
<td>Appropriate Testing for Children with Pharyngitis (GWP)</td>
<td>Q</td>
<td>51.46</td>
<td>59.46</td>
<td>60.46</td>
<td>↑ 1.00</td>
<td>59.70</td>
</tr>
</tbody>
</table>

### RESULTS (Qualitative Analysis):

**HEDIS 2018 Appropriate Testing for Children with Pharyngitis**

**Aid Category Comparison**
- Adult Expansion
- Disabled
- Family
- Family/Adult
- TUC
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

Spoken Language Comparison
- English
- Spanish

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

Gender Comparison
- Female
- Male
**2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation**

**Denominator**

- 46% Females are receiving more proper tests for pharyngitis than males
- 54% Males are receiving more proper tests for pharyngitis than females

**Compliant**

- 44% Females are receiving more proper tests for pharyngitis than males
- 56% Males are receiving more proper tests for pharyngitis than females

**Non-Compliant**

- 50% Females are receiving more proper tests for pharyngitis than males
- 50% Males are receiving more proper tests for pharyngitis than females

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

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

**NEXT STEPS:**
- This is a non-reported measure, consider replacing with higher priority measure.

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

**RESULTS (Quantitative Analysis): Goal not met**

<table>
<thead>
<tr>
<th>HEDIS Measure/Data Element</th>
<th>Domain of Care</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2016-17 Rate Difference</th>
<th>Current NCQA Percentile Ranking</th>
<th>2017 NCQA Percentile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Care: Overuse/Appropriateness</td>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</td>
<td>Q</td>
<td>94.82</td>
<td>94.80</td>
<td>95.40</td>
<td>↑0.60</td>
<td>75th</td>
</tr>
</tbody>
</table>

**RESULTS (Qualitative Analysis):**

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

<table>
<thead>
<tr>
<th>Aid Category Comparison</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Expansion</td>
<td>Disabled</td>
<td>Family</td>
<td>Family/Adult</td>
</tr>
</tbody>
</table>

**Denominator**

<table>
<thead>
<tr>
<th>Compliant</th>
<th>Non-Compliant</th>
</tr>
</thead>
</table>
| TLIC and Disabled has less non-compliance than compliance for this measure.
### Language Spoken Comparison

<table>
<thead>
<tr>
<th>English</th>
<th>Spanish</th>
<th>Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Compliant</th>
<th>Non Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Pie Chart" /> 47% 52% 1%</td>
<td><img src="image2" alt="Pie Chart" /> 47% 52% 1%</td>
<td><img src="image3" alt="Pie Chart" /> 48% 51% 1%</td>
</tr>
</tbody>
</table>

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

### Gender Comparison

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Compliant</th>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image4" alt="Pie Chart" /> 50% 50%</td>
<td><img src="image5" alt="Pie Chart" /> 47% 52% 1%</td>
<td><img src="image6" alt="Pie Chart" /> 50% 50%</td>
</tr>
</tbody>
</table>

*Females were slightly more compliant than males for this measure.*

### Barrier Analysis

- Aid Categories TLIC and Disabled performed better than the other Aid Categories, English speakers performed better than Spanish speakers and females better than males.
- Resources did not permit Academic Detailing.
INTERVENTIONS:
- This is a provider education issue and additional analysis will be done to determine how our clinics or clinic systems are performing. This information will be utilized to guide our educational efforts.

NEXT STEPS: Recommend evaluation of program and continue monitoring.

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

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis): Goal Met

<table>
<thead>
<tr>
<th>HEDIS Measure/Data Element</th>
<th>HEDIS Measure/Data Element</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2016-17 Rate Difference</th>
<th>Current NCQA Percentile Ranking</th>
<th>2017 NCQA Percentile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
<td>Q</td>
<td>25.58</td>
<td>29.27</td>
<td>32.75</td>
<td>↑ 3.48</td>
<td>50th</td>
<td>21.69</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10th</td>
<td>25th</td>
</tr>
</tbody>
</table>

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

BARRIER ANALYSIS: Goal met, no barrier analysis needed.

INTERVENTIONS: N/A

NEXT STEPS: Consider evaluation of program and continue monitoring.
### 2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

#### Ambulatory Care (AMB)

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHCS</td>
<td>Ambulatory Care: Summarizes Utilization of Ambulatory Care Outpatient Visits – per 1,000 Member Months</td>
<td>Meet Medi-Cal Managed Care Performance Dashboard Rate</td>
<td>Q4 2017</td>
<td>Adult and child member letters for appointment reminders/engage members to see their PCP Meet with clinics to discuss results of clinic rates</td>
</tr>
</tbody>
</table>

#### EVALUATION OF 2017 WORK PLAN

**RESULTS (Quantitative Analysis): Goal Partially Met**

<table>
<thead>
<tr>
<th>HEDIS Measure/Data Element</th>
<th>Domain of Care</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2016-17 Rate Differenc</th>
<th>Current NCQA Percentile Ranking</th>
<th>2017 NCQA Percentile Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>Visits/1000</td>
<td>246.05</td>
<td>252.22</td>
<td>271.06</td>
<td>18.84</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Outpatient Visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED Visits</td>
<td></td>
<td>41.05</td>
<td>38.79</td>
<td>41.21</td>
<td>2.42</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

**RESULTS (Qualitative Analysis):** Current DHCS Dashboard rate for Outpatient Visits at 90% is 473.7/1000 and our rate, while it is up nearly 15% falls far short of the goal. Conversely, while the ED Visits are also up from last year, and they are below the DCHS Dashboard rate of 52.3/1000.

**BARRIER ANALYSIS:**
- Further evaluate 2017 performance to identify improvement opportunities

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

**Objective: Improve Quality and Safety of Clinical Care Services**

#### Quality Improvement Projects

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Department/Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHCS</td>
<td>Child Immunization PIP: Increase the Rate of Combo 3 Immunizations Administered</td>
<td>By June 30, 2019, increase the rate of Combo 3</td>
<td>June 30, 2019</td>
<td>This is a two-year performance improvement project (PIP) health plan/clinic collaborative between GCHP’s Quality Improvement (QI) and Health Education/Cultural Linguistics (HE/CL)</td>
<td>QI</td>
</tr>
</tbody>
</table>
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

On/Before the 2nd Birthday for Children Enrolled at Mandalay Bay Women’s and Children’s Medical Group

Immunizations administered on/before the 2nd birthday for children enrolled at Mandalay Bay Women’s and Children’s Medical Group from 73.64% to 83.64%.

Departments and Ventura County Medical Center’s Mandalay Bay Women’s and Children’s Medical Group. This project requires the submission of five PIP modules to the Department of Health Care Services (DHCS) and to Health Services Advisory Group (HSAG), which is the Quality Improvement Organization contracted with DHCS to oversee the two-year PIP projects.

EVALUATION OF 2017 WORK PLAN

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

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

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

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

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

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

- Parent/guardian perception that child immunizations are not important.
- Parent/guardian is unaware of what vaccinations their child needs and/or have been administered.
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

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

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

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

EVALUATION OF 2017 WORK PLAN

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

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

<table>
<thead>
<tr>
<th></th>
<th>Administrative Data</th>
<th>Hybrid Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>English</td>
<td>English</td>
</tr>
<tr>
<td>Numerator</td>
<td>2451</td>
<td>130</td>
</tr>
<tr>
<td>Denominator</td>
<td>3225</td>
<td>242</td>
</tr>
<tr>
<td>Rate</td>
<td>0.753</td>
<td>0.537</td>
</tr>
<tr>
<td>P-Value</td>
<td>The Z-Score is -3.828. The p-value is 0.00012. The result is significant at p &lt; 0.05.</td>
<td>The Z-Score is -0.4704. The p-value is 0.63836. The result is not significant at p &lt; 0.05.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Administrative Data within Hispanic or Latino Diabetic Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>English</td>
</tr>
<tr>
<td>Numerator</td>
<td>829</td>
</tr>
<tr>
<td>Denominator</td>
<td>1086</td>
</tr>
<tr>
<td>Rate</td>
<td>0.7634</td>
</tr>
<tr>
<td>P-Value</td>
<td>The Z-Score is -2.1071. The p-value is 0.03486. The result is significant at p &lt; 0.05.</td>
</tr>
</tbody>
</table>

RESULTS (Qualitative Analysis)

Discussions with the clinic partner, Las Islas Family Medical Clinic, revealed that a significant process issue in the clinic setting that is contributing to the higher rate of uncontrolled HbA1C in this population is difficulty with getting the diabetic patient into the clinic to get the lab tests. Since the HEDIS specifications for the Comprehensive Diabetes Care measure places a member with no HbA1c test during into the HbA1c > 9.0 category, an intervention that increases the administration of HbA1c tests may reduce the HbA1c > 9.0 rate in non-English speaking Hispanics and Latinos because these members will have a lab reading that may be < 8.0 or they will receive the necessary treatment to reduce it.

BARRIER ANALYSIS

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

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

These drivers were included in the Key Driver Diagram section of Module 1 which was submitted to DHCS and HSAG on November 15, 2017.
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

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

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

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

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

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

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

**Post-Intervention Analysis:**
We exceeded our 10%-point goal for each clinic and 100% of the labs ordered were completed at both clinics during the three-month study period.
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

RESULTS (Qualitative Analysis)

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

BARRIER ANALYSIS

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

NEXT STEPS

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

<table>
<thead>
<tr>
<th>MPM Measures</th>
<th>2016 MY Rate</th>
<th>2017 MY Rate</th>
<th>2017 DHCS MPL</th>
<th>2016-2017 MY Rate Change</th>
<th>Goal Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE/Arbs</td>
<td>85.09</td>
<td>85.48</td>
<td>85.93</td>
<td>+ 0.39</td>
<td>Did Not Meet MPL</td>
</tr>
<tr>
<td>Diuretics</td>
<td>85.14</td>
<td>86.54</td>
<td>85.52</td>
<td>+ 1.40</td>
<td>Met MPL</td>
</tr>
<tr>
<td>Total</td>
<td>84.95</td>
<td>85.85</td>
<td>85.58</td>
<td>+ 0.90</td>
<td>Met MPL</td>
</tr>
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</table>
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

IP: Comprehensive Diabetes Care – Blood Pressure Control

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Department/Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHCS</td>
<td>IPI: Comprehensive Diabetes Care • Blood Pressure Control</td>
<td>Meet or exceed DHCS MPL</td>
<td>Q4 2017</td>
<td>Ensure aggressive management of medical records retrieval of HEDIS vendor, Member educational mailing with health education materials</td>
<td>QI</td>
</tr>
</tbody>
</table>

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

Between June 1, 2017 and November 30, 2017, the Quality Improvement applied the following quality improvement activities to increase the Comprehensive Diabetes Care blood pressure sub-measure:
1. Generate provider gap reports with CBP and CDC-BP measure indicators.
2. Member outreach to educate members on monitoring their blood pressure.
3. Retrospective analysis of gaps in the 2016 MY medical record retrieval, abstraction, and overread process.
4. Coordinate HEDIS vendor’s remote access to VCMC’s EMR.
5. Provider chase flag logic reconfiguration.
6. Provider education on CBP and CDC-BP measures.

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

**CDC-BP Rate Analysis**

<table>
<thead>
<tr>
<th>Blood Pressure Measures</th>
<th>2015 MY Rate</th>
<th>2017 MY Rate</th>
<th>2017 DHCS MPL</th>
<th>2016-2017 MY Rate Change</th>
<th>Goal Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC-BP</td>
<td>48.66</td>
<td>65.94</td>
<td>52.70</td>
<td>+17.28</td>
<td>Exceeded MPL</td>
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</table>

RESULTS (Qualitative Analysis)

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

BARRIER ANALYSIS

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

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

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

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

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)
This one-year improvement project transitioned to the two-year disparity PIP.

RESULTS (Qualitative Analysis)
This one-year improvement project transitioned to the two-year disparity PIP.

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

NEXT STEPS
This one-year improvement project transitioned to the two-year disparity PIP.
### 2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
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<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Department/Committee</th>
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</thead>
<tbody>
<tr>
<td>IP: Controlling Blood Pressure</td>
<td>IP: Controlling Blood Pressure</td>
<td>Meet or exceed DHCS MPL</td>
<td>Q4 2017</td>
<td>Ensure aggressive management of medical records retrieval of HEDIS vendor, Member educational mailing with health education materials</td>
<td></td>
</tr>
</tbody>
</table>

### EVALUATION OF 2017 WORK PLAN

#### RESULTS (Quantitative Analysis)

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

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

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

#### CBP Rate Analysis

<table>
<thead>
<tr>
<th>Blood Pressure Measure</th>
<th>2016 MY Rate</th>
<th>2017 MY Rate</th>
<th>2017 DHCS MPL</th>
<th>2016-2017 MY Rate Change</th>
<th>Goal Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBP</td>
<td>45.01</td>
<td>54.50</td>
<td>47.69</td>
<td>+ 9.49</td>
<td>Met MPL</td>
</tr>
</tbody>
</table>

#### RESULTS (Qualitative Analysis)

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

### BARRIER ANALYSIS

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

- The HEDIS vendor contracted with a 3rd party retrieval vendor (COX) that had a separate reporting software that was not integrated with the HEDIS vendor’s software which also affected the accuracy and timeliness of retrieval status reports.
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

NEXT STEPS
The QI Department will continue to practice the QI activities implemented in 2015-2017 to ensure the continuous oversight and monitoring of internal and external activities related to HEDIS data collection and reporting. Continue monitoring.

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Department/Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Use Improvement Strategy</td>
<td>GCHP Opioid Use Improvement Strategy</td>
<td>Develop strategy</td>
<td>Q4 2017</td>
<td>Formulary Edits Provider education</td>
<td>Pharmacy</td>
</tr>
</tbody>
</table>

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

Formulary Edits:
The following ‘soft edits’ were developed for implementation of 1/1/2018:
- Concurrent Use Prenatal Edit
- Concurrent Use Benzodiazapine Edit
- DEA Verification
- Cumulative Daily Acetaminophen Dose > 4000mg
- High Dose Opioid Edit

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

Practice Resources
1. Opioid Risk Tool (ORT)
2. PHQ-9 Health Assessment
3. CAGE-AID (Alcohol/Drug Screening Tool)
4. Sample Pain Contract
5. Urine Drug Testing Tool
## 2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

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

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

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

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

### NEXT STEPS
Next steps are as follows:
1. Consider changing the “soft edits” to “hard edits” that require the providers to submit a prior authorization with documentation of medical necessity.
2. Develop a webpage on the GCCHP website for the provider toolkit

### Objective: Improve Quality of Nonclinical Services

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Department/Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>Primary Care Access</td>
<td>Standards met for minimum of 90% of providers</td>
<td>Q4 2017</td>
<td>Monitor performance and complaints relating to appointments Report quarterly performance to QIC Develop and implement corrective action plans when timely access standards not met Conduct survey</td>
<td>Network Operations Grievances and Appeals</td>
</tr>
</tbody>
</table>

| NCQA NET 2 DHCS | Non-urgent primary care within 10 business days of request | Urgent care within 48 hours | | | |

Return to Agenda
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis): Survey was not conducted in Q4 2017

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

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

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

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

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

NEXT STEPS
A Provider Appointment Availability Survey is currently in progress, it began June 1, 2018. Network Operations anticipates receiving the results report package in Q3 2018. Consider action plan based on results.
### 2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

### EVALUATION OF 2017 WORK PLAN

**RESULTS (Quantitative Analysis):** Survey was not conducted in Q4 2017

**RESULTS (Qualitative Analysis)**

**Network Ops:** The Provider After Hours Survey was not repeated in Q4 2017 however, results taken from 2016/17 were shared with PCP’s and in-area Specialists by way of Joint Operation Meetings (JOM’s), Orientations and routine site visits to ensure understanding and improve future scores.  
954 PCP/Specialist Providers surveyed. Over all approximately 18% of the surveyed providers did not meet After-Hours standards.  
Person or type of recording equipment reached after hours;  
- Recording or Auto Attendant: 72.2% met the after-hours standards  
- Live Person: 70.7%  
  - The PCP portion yielded 74.7% met the after-hours standards  
    - 25.3% did not meet standards  
  - For Specialists 82.7%  
    - 17.3% did not meet standards

No grievances were received related to after-hours availability.

**BARRIER ANALYSIS**

N/A – Q4 2017

**NEXT STEPS**

Provider After Hours Survey currently in progress, began June 1, 2018. Network Operations anticipates the results report package in Q3 2018. Consider action plan based on results.
## 2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

### EVALUATION OF 2017 WORK PLAN

#### RESULTS (Quantitative Analysis)
- Ratio of Members to PCPs 1.796
  - With the inclusion of CHLA, COH and UCLA we far exceeded the standard which dropped the ratio.
- Ratio of Members to Total Physicians 1:43
- Network maintained 99.9% of members within 30 minutes or 10 miles to PCP
- Nurse Practitioners to PCP Physicians 1:2
- Physician Assistants to PCP Physicians 1:3
- All Mid-levels to Total Physicians 1:4

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

#### BARRIER ANALYSIS
None

#### NEXT STEPS
Continue to monitor and access standards in accordance with the new Network certification APL, which takes into account ratios based on actual FTE’s.
### Objective: Improve Quality of Nonclinical Services

#### Practitioner Availability: Cultural Needs & Preferences

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

### EVALUATION OF 2017 WORK PLAN

#### RESULTS (Qualitative Analysis)

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

#### BARRIERS ANALYSIS: None

#### NEXT STEPS: Continue to monitor
## RESULTS (Qualitative Analysis)

### Ethnicity Distribution

<table>
<thead>
<tr>
<th>MbrDataElement</th>
<th>ETHNICITY</th>
<th>M_ETHNICITY</th>
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<tbody>
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### Language Distribution

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</tbody>
</table>
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Practitioner Availability: Cultural Needs & Preferences

<table>
<thead>
<tr>
<th>Language</th>
<th>Member Language</th>
<th>Physician Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>73,931</td>
<td>1929</td>
</tr>
<tr>
<td>Farsi</td>
<td>390</td>
<td>117</td>
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<tr>
<td>Tagalog</td>
<td>669</td>
<td>62</td>
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<tr>
<td>Russian</td>
<td>121</td>
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<tr>
<td>Arabic</td>
<td>441</td>
<td>55</td>
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<tr>
<td>Vietnamese</td>
<td>667</td>
<td>17</td>
</tr>
<tr>
<td>Mandarin</td>
<td>295</td>
<td>74</td>
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<tr>
<td>Cantonese</td>
<td>96</td>
<td>24</td>
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<tr>
<td>Korean</td>
<td>191</td>
<td>42</td>
</tr>
<tr>
<td>Other</td>
<td>592</td>
<td>549</td>
</tr>
</tbody>
</table>

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

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)
New contracted provider groups by end year 2017 = 47
New Physicians/Professionals added into the network by end year 2017 = 1264

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

BARRIER ANALYSIS
None
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

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

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

**EVALUATION OF 2017 WORK PLAN**

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

**RESULTS (Qualitative Analysis): None**

**BARRIER ANALYSIS:** Discussed above in quantitative results

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

**Objective: Improve Patient Safety**

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
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<th>Target Completion Date</th>
<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Department/ Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Site Reviews</td>
<td>Complete initial and tri-annual facility site reviews Complete Interim Reviews</td>
<td>100%</td>
<td>Year End 2017</td>
<td>Monitor FSR database Submit bi-annual reports to DHCS</td>
<td>FSR Nurse QI</td>
</tr>
</tbody>
</table>
## EVALUATION OF 2017 WORK PLAN

### RESULTS (Quantitative Analysis): Goal Met

### RESULTS (Qualitative Analysis): All site reviews completed for 2017 and bi-annual reports submitted to DHCS.

### BARRIER ANALYSIS: Goal Met, no barriers presently identified.

<table>
<thead>
<tr>
<th>Required By</th>
<th>Goals</th>
<th>Metrics</th>
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<th>Action Steps &amp; Monitoring/Improvement Activities</th>
<th>Responsible Department/Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Accessibility Site Reviews</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHCS</td>
<td>Complete Physical Accessibility Site Reviews</td>
<td>100%</td>
<td>Year End 2017</td>
<td>Compile reports for high volume/ancillary specialists Submit report to State Complete PARs for new provider sites</td>
<td>FSR Nurse QI</td>
</tr>
</tbody>
</table>

### EVALUATION OF 2017 WORK PLAN

### RESULTS (Quantitative Analysis): Goal Met

### RESULTS (Qualitative Analysis): All PARs completed for 2017. Reports completed and submitted to DHCS.

### BARRIER ANALYSIS: Goal Met, no barriers presently identified.

<table>
<thead>
<tr>
<th>Required By</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Safe Clinical Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCQA MED 4 DHCS</td>
<td>Improve Safe Clinical Practice</td>
<td>Tracking</td>
<td>Ongoing</td>
<td>Monitor site visit results from practitioner credentialing Monitor member complaints involving clinical quality of care concerns (safety)</td>
<td>Credentialing/ Peer Review Grievances and Appeals</td>
</tr>
</tbody>
</table>

### EVALUATION OF 2017 WORK PLAN

### RESULTS (Quantitative Analysis): Goal Met

### RESULTS (Qualitative Analysis): No site visits were conducted in 2017 as no grievances were submitted to QI that would trigger a site visit.

### BARRIER ANALYSIS: Goal Met, no barriers presently identified.

### NEXT STEPS: Grievances will continue to monitor member complaints involving clinical quality of care concerns (safety). QI will ensure site visits are completed within 30 days as needed.
2017 Gold Coast Health Plan Quality Improvement Work Plan Evaluation

Objective: Member Experience: CAHPS, Complaints/Grievances TBD

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

EVALUATION OF 2017 WORK PLAN

RESULTS (Quantitative Analysis)

Call Center Average Speed of Answer (ASA) and Abandonment Rate:
Results of the call center show an increase of 35 seconds for the ASA in 2017 (51 seconds), in comparison to the 16 seconds ASA in 2016. The abandonment rate also shows an increase of 1.60% for 2017 (2.49%) in comparison to 0.89% abandonment rate in 2016.

Monitor Complaints and Grievances:
The grievance data for 2016 shows 156 grievances received and in 2017, there were 217 grievances received. In comparison, this equates to an increase of about 39%.
RESULTS (Qualitative Analysis)
Call Center After Call Survey, IVR satisfaction:
Results of the survey show an 8.4% improvement on the satisfaction of using the IVRS. In 2017, 5.5% of the callers expressed their dissatisfaction with the IVRS in comparison to 6% in 2016.

Monitor Complaints and Grievances:
The results from the previous year show that the increase is related increase in membership.

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

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

BARRIERS COMPLAINTS AND GRIEVANCES:
At this time, no barriers were identified.

COMPLAINTS AND GRIEVANCES NEXT STEPS:
Continue to track all complaints and grievances for possible trending to communicate to all departments to identify process improvement opportunities.

<table>
<thead>
<tr>
<th>Objective: Health Plan Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required By</td>
</tr>
<tr>
<td>---------------</td>
</tr>
</tbody>
</table>
| QIPO, Program Evaluation, Workplan | NCQA QI 1 | DHCS | 100% | June 2017 | 1. Review and revise annual QI Program Description, Work Plan and Evaluation  
2. Obtain approval of 2016 QI Program and Work Plan and Evaluation of 2015 QI Program  
3. Evaluate the adequacy of resources, committee structure, practitioner participation and leadership involvement in the QI Program in order to restructure or change the QI Program for subsequent year as necessary | Chief Medical Officer  
QI Director  
Quality Improvement Committee |
### Evaluation of 2017 Work Plan

**Results (Quantitative Analysis):** Goal met.

**Results (Qualitative Analysis):** The QI Program Description, Work Plan, and Work Plan Evaluation were approved at QIC on June 20, 2017 and at the Ventura County Medi-Cal Managed Care Commission meeting on August 21, 2017.

**Barrier Analysis:** No barriers presently identified.

**Next Steps:** Develop and implement 2018 QI Program Description and QI Work Plan based upon evaluation of 2017 activities. Consider removing these tasks from the QI Work Plan as these are regularly monitored and reported.

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

### Evaluation of 2017 Work Plan

**Results (Quantitative Analysis):** Goal Met

**Results (Qualitative Analysis):** Delegation oversight audits were completed.

**Barrier Analysis:** Goal met, no barriers presently identified.

**Next Steps:** Continue delegation oversight activities timely.
<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Clinical Practice Guideline (CPG) review and adoption at least every two years</td>
<td>Review and approval by Medical Advisory Committee (MAC) Distribute guidelines to appropriate practitioners</td>
<td>Health Services</td>
<td>MAC Approval Timely distribution</td>
<td>1/1/2018</td>
<td>12/31/2018</td>
</tr>
<tr>
<td>Asthma Clinical Practice Guidelines (CPG) review and adoption at least every two years</td>
<td>Review and approval by Medical Advisory Committee (MAC) Distribute guidelines to appropriate practitioners</td>
<td>Health Services</td>
<td>MAC Approval Timely distribution</td>
<td>1/1/2018</td>
<td>12/31/2018</td>
</tr>
<tr>
<td>Preventive Health Guideline (PHG) review and adoption at least every two years</td>
<td>Define, review and approval by Medical Advisory Committee (MAC) Distribute guidelines to appropriate practitioners Align PHG with Provider Handbook and applicable policies</td>
<td>Health Services</td>
<td>MAC Approval Timely distribution Updates completed</td>
<td>1/1/2018</td>
<td>12/31/2018</td>
</tr>
</tbody>
</table>

Evaluation/Analysis of intervention(s):
# 2018 Gold Coast Health Plan
## Quality Improvement Work Plan

<table>
<thead>
<tr>
<th>Objective #1: Improve Quality and Safety of Clinical Care Services</th>
<th>Objective Met:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required by:</strong> DHCS</td>
<td><strong>Target Completion Date:</strong> Q4 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advance Prevention</strong></td>
<td>Increase awareness of benefits of tobacco cessation in member population identified as smoking</td>
<td>Research mechanisms to identify smokers (e.g. upon enrollment and/or within existing member population) Create and implement campaign for members and providers Quarterly measurement of tobacco cessation medication dispensing Create system to monitor provider performance regarding offering interventions</td>
<td>Health Ed Health Ed/Provider Operations Pharmacy Health Ed/QI</td>
<td>50% of identified smokers receive intervention</td>
<td></td>
</tr>
</tbody>
</table>
## Objective #1: Improve Quality and Safety of Clinical Care Services

**Objective Met:**

Required by: DHCS

**Advance Prevention**

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

**Evaluation/Analysis of Intervention(s):**
### Objective #1: Improve Quality and Safety of Clinical Care Services

<table>
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<tr>
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<th>Metrics</th>
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<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum Care – Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery</td>
<td>Re-evaluate effectiveness of the PP intervention and member incentives program. Analyze demographic results for potential disparity; create action plan to address if present. Provide provider performance feedback by means of 2017 HEDIS report cards Develop and implement member campaign regarding value of timely postpartum visit</td>
<td>QI</td>
<td>Increase rates by 3% over previous measurement year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of intervention(s):**
**2018 Gold Coast Health Plan**  
**Quality Improvement Work Plan**

<table>
<thead>
<tr>
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<td>Target Completion Date: Q4 2018</td>
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</table>

<table>
<thead>
<tr>
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<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Immunization Status Combo 3</td>
<td>Provide provider performance feedback by means of 2017 HEDIS report cards</td>
<td>QI</td>
<td>Increase rates by 3% over previous measurement year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of two year old children who receive required vaccines (DTaP, IPV, MMR, Hib, HepB, ZVZ and PCV) on or before their 2nd birthday</td>
<td>Bi-monthly prospective HEDIS report cards and performance feedback reports</td>
<td>Health Ed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Create and implement provider and member education campaigns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of intervention(s):**
<table>
<thead>
<tr>
<th>Objective #: Improve Quality and Safety of Clinical Care Services</th>
<th>HEDIS® Measures</th>
<th>Goals</th>
<th>Activities</th>
<th>Start Date</th>
<th>End Date</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Evaluation/Analysis of intervention(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer Screening</td>
<td></td>
<td></td>
<td>Evaluate 2017 performance to identify opportunities</td>
<td>QI</td>
<td></td>
<td>Health Ed</td>
<td></td>
<td>Bi-monthly prospective HEDIS report cards and performance feedback reports</td>
</tr>
</tbody>
</table>
## Objective #1: Improve Quality and Safety of Clinical Care Services

**Objective Met:**

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

**Evaluation/Analysis of Intervention(s):**
### Objective #1: Improve Quality and Safety of Clinical Care Services

**Objective Met:**

**Required by:** DHCS

**Target Completion Date:** Q4 2018

<table>
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<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
| Comprehensive Diabetes Care  
  - Improve rate of medical attention for nephropathy in diabetic members (screening or monitoring or evidence of nephropathy) | Evaluate 2017 performance for opportunities  
  Provide provider performance feedback by means of 2017 HEDIS report cards  
  Bi-monthly prospective HEDIS report cards and performance feedback reports  
  Create and implement member and provider awareness campaigns | QI  
  Health Ed | Improve 3% over prior year results | | |

**Evaluation/Analysis of Intervention(s):**
### Objective #1: Improve Quality and Safety of Clinical Care Services

<table>
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<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate Treatment for Children with Upper Respiratory Infection - percentage of children 3 months – 18 years of age who were diagnosed with an upper respiratory infection (URI) and were not dispensed an antibiotic prescription.</td>
<td>Provide provider performance feedback by means of 2017 HEDIS report cards</td>
<td>QI</td>
<td>Improve 5% compared to prior year performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bi-monthly prospective HEDIS report cards and performance feedback reports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Create and implement member and provider campaigns</td>
<td>Health Education</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Intervention(s):**
# 2018 Gold Coast Health Plan
## Quality Improvement Work Plan

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<th>Objective Met:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required by: DHCS</td>
<td>Target Completion Date: Q4 2018</td>
</tr>
</tbody>
</table>

### Over/Under Utilization

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis - percentage of adults 18 – 64 years of age with a diagnosis of acute bronchitis <strong>who were not dispensed</strong> an antibiotic prescription.</td>
<td>Evaluate 2017 performance for opportunities. Provide provider performance feedback by means of 2017 HEDIS report cards Bi-monthly prospective HEDIS report cards and performance feedback reports Create and implement member and provider campaigns</td>
<td>QI</td>
<td>Improve 5% compared to prior year performance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Evaluation/Analysis of Intervention(s):
### Objective #1: Improve Quality and Safety of Clinical Care Services

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Ambulatory Care</td>
<td>Evaluate 2017 results to identify opportunities</td>
<td>QI/Claims/Provider Operations</td>
<td>Meet Medi-Cal Managed Care Performance Dashboard Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilization of Ambulatory Care Outpatient Visits per 1,000 Member Months</td>
<td>Create and implement action plan to improve metric</td>
<td></td>
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</tr>
</tbody>
</table>

**Objective Met:**

**Required by:** DHCS

**Target Completion Date:** Q4 2018

**Evaluation/Analysis of intervention(s):**
### Objective #1: Improve Quality and Safety of Clinical Care Services

**Required by:** DHCS

**Target Completion Date:** Q4 2018

#### Quality Improvement Projects

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

**Evaluation/Analysis of Intervention(s):**
# 2018 Gold Coast Health Plan
## Quality Improvement Work Plan

### Objective #1: Improve Quality and Safety of Clinical Care Services

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

### Evaluation/Analysis of Intervention(s):

- 
- 
- 
-
# 2018 Gold Coast Health Plan
## Quality Improvement Work Plan

**Objective #1: Improve Quality and Safety of Clinical Care Services**

<table>
<thead>
<tr>
<th>Required by: DHCS</th>
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<td>Target Completion Date: Q4 2018</td>
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### Quality Improvement Projects

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<tr>
<th>Goals</th>
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<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP: Annual Monitoring for Patients on Persistent Medication</td>
<td>Provider performance feedback by means of 2017 HEDIS report cards</td>
<td>QI</td>
<td>Meet or exceed DHCS MPL</td>
<td></td>
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<tr>
<td></td>
<td>Bi-monthly prospective HEDIS report cards and performance feedback reports</td>
<td></td>
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<tr>
<td></td>
<td>Educate providers via Provider Update</td>
<td></td>
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<tr>
<td></td>
<td>Conduct audit and provide feedback</td>
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</tbody>
</table>

**Evaluation/Analysis of intervention(s):**
## Objective #1: Improve Quality and Safety of Clinical Care Services

**Objective Met:**

**Required by:** DHCS

**Target Completion Date:** Q4 2018

### Quality Improvement Projects

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<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP: Comprehensive Diabetes Care</td>
<td>Ensure aggressive management of medical records retrieval of HEDIS vendor</td>
<td>QI</td>
<td>Meet or exceed DHCS MPL</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Member educational mailing with health education materials</td>
<td>Health Education</td>
<td></td>
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</table>

**Evaluation/Analysis of Intervention(s):**
**Objective #1: Improve Quality and Safety of Clinical Care Services**

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<th>Goals</th>
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<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
| IP: Controlling Blood Pressure | Ensure aggressive management of medical records retrieval of HEDIS vendor  
Member educational mailing with health education materials | QI Health Education | Meet or exceed DHCS MPL      | 1/1/2018   | 05/31/2018 |

**Evaluation/Analysis of Intervention(s):**
<table>
<thead>
<tr>
<th>Objective Met:</th>
<th><strong>Objective #1:</strong> Improve Quality and Safety of Clinical Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required by:</td>
<td>DHCS</td>
</tr>
<tr>
<td><strong>Quality Improvement Projects</strong></td>
<td><strong>Goal:</strong> AMR Medication Ratio</td>
</tr>
<tr>
<td><strong>Activities</strong></td>
<td><strong>Evaluation/Analysis of Intervention(s):</strong></td>
</tr>
<tr>
<td>Start Date</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>End Date</td>
<td>12/31/2018</td>
</tr>
<tr>
<td>Metrics</td>
<td>Meet or exceed DHCS Mpl.</td>
</tr>
<tr>
<td>Responsible Party</td>
<td>Perform barrier analysis to determine factors that contributed to the AMR rate decrease in 2017.</td>
</tr>
<tr>
<td></td>
<td>Implement and test intervention to improve the AMR rate.</td>
</tr>
</tbody>
</table>
### Objective #1: Improve Quality and Safety of Clinical Care Services

**Objective Met:**

**Required by:** DHCS  
**Target Completion Date:** Q4 2018

#### Quality Improvement Projects

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

**Evaluation/Analysis of intervention(s):**
Objective #2: Improve Quality of Nonclinical Services

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Access</strong></td>
<td>Conduct survey and evaluate results</td>
<td>Network Operations</td>
<td>Standards met for minimum of 90% of providers</td>
<td>06/01/18</td>
<td>08/31/18</td>
</tr>
<tr>
<td></td>
<td>Monitor performance and complaints relating to appointments</td>
<td>G&amp;A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop and implement corrective action plans when timely access standards not met</td>
<td>Network Operations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Report quarterly performance to QIC</td>
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</tbody>
</table>

| Specialty Care Access         |                                                                  |                   |                                      |            |          |
|                               | Members are offered:                                              |                   |                                      |            |          |
|                               | - Non-urgent primary care within 10 business days of request      |                   |                                      |            |          |
|                               | - Urgent care within 24 hours                                     |                   |                                      |            |          |
|                               | Members are offered:                                              |                   |                                      |            |          |
|                               | - Non-urgent specialty care appointment within 15 business days   |                   |                                      |            |          |
|                               | - Non-urgent ancillary services within 15 business days           |                   |                                      |            |          |

Evaluation/Analysis of Intervention(s):
## Objective #2: Improve Quality of Nonclinical Services

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>After Hours Availability</td>
<td>Conduct survey and evaluate results.</td>
<td>Network Operations</td>
<td>Standards met for 90% of providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitor performance and complaints relating to after-hours availability</td>
<td>Operations Grievances</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Develop and implement corrective action plans when timely access standards not met</td>
<td>and Appeals</td>
<td></td>
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<tr>
<td></td>
<td>Report quarterly performance to QIC</td>
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**Evaluation/Analysis of Intervention(s):**
## Objective #2: Improve Quality of Nonclinical Services

**Required by:** NCQA NET 1; DHCS

**Objective Met:**

**Target Completion Date:** Q4 2018

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

**Required by:** GCHP Internal Activity  
**Target Completion Date:** Q4 2018

<table>
<thead>
<tr>
<th>Goals</th>
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<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Satisfaction Survey</td>
<td>Analyze 2017 results and identify opportunities for improvement</td>
<td>Network Operations</td>
<td>Development and implementation of action plan to improve</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Develop and implement interventions as needed to improve rates</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Prepare for 1Q19 provider survey</td>
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</table>

**Evaluation/Analysis of intervention(s):**
## 2018 Gold Coast Health Plan
Quality Improvement Work Plan

### Objective #2: Improve Quality of Nonclinical Services

<table>
<thead>
<tr>
<th>Objective Met:</th>
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<tr>
<td>Target Completion Date: Q4 2018</td>
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</table>

| Required by: | NCOA NET 1; DHCS |

<table>
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<tr>
<th>Goals</th>
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<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
| **Practitioner Availability - Cultural and Linguistics Needs & Preferences**  
   - Adequate resources to address the cultural, ethnic and linguistic needs of our members  
   - Evaluate the demographic needs of members and identify opportunities for improvement  
   - Create and implement an action plan to address areas for improvement | | Network Operations  
Health Education | Development and implementation of action plan to improve | | |

**Evaluation/Analysis of Intervention(s):**
### Objective #3: Improve Member Safety

**Required by:** DHCS; NCQA MED 4

<table>
<thead>
<tr>
<th>Goals</th>
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<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with facility site reviews (FSR)</td>
<td>Review FSR database regularly to maintain scheduled visits Complete initial, Interim, and Tri-annual Facility Site Reviews timely Issue CAPs as needed to facilitate clinic compliance improvement Submit bi-annual reports to DHCS</td>
<td>QI</td>
<td>100% on time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete Physical Accessibility Review (PAR)</td>
<td>Compile reports for high volume/ancillary specialists Complete PARs for new provider sites Submit report to DHCS</td>
<td>QI</td>
<td>100% on time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor Clinic for safety practices</td>
<td>Monitor FSR site visit results from deficiencies, track and trend Monitor member complaints and PQIs involving clinical quality of care concerns (safety) Issue CAP(s) and track improvements as needed</td>
<td>QI</td>
<td>Grievances and Appeals</td>
<td>Evaluate tracking system, Improve if needed</td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Intervention(s):**
### Objective #4: Assess and Improve Member Experience

**Required by:** NCQA QI 4; DHCS  

**Target Completion Date:** Q4 2018

<table>
<thead>
<tr>
<th>Goals</th>
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<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
| Assess Member Access and Satisfaction  
Conduct annual assessment of complaints and grievances. | Review and evaluate 2017 Member Access and Satisfaction Survey  
Identify opportunities for improvement  
Create and implement action plan for improvement  
Continue to monitor complaints and grievances | Network Operations  
QI  
Grievances and Appeals | Development and implementation of action plan to improve | | |

**Evaluation/Analysis of Intervention(s):**
## Objective #4: Assess and Improve Member Experience

**Required by:** NCQA QI 4; DHCS  
**Target Completion Date:** Q4 2018

<table>
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<tr>
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<th>End Date</th>
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</thead>
<tbody>
<tr>
<td>Call Center Monitoring</td>
<td>Customer Service Interventions:</td>
<td></td>
<td>ASA: 30 seconds or less Abandonment Rate: 5% or less</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Monitor results/reports of after call survey performed by call center; follow up if issues identified</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Monitor Average Speed of Answer (ASA and Abandonment Rate)</td>
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**Evaluation/Analysis of Intervention(s):**
### Objective #5: Ensure organizational oversight of delegated activities

**Required by:** NCQA CR 8; QI 7; UM 13; RR 5; DHCS

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
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<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
| Completion of Delegation Oversight Delegated Activities  
  - Credentialing  
  - CI  
  - UM  
  - Members' Rights  
  - Claims | 1. Complete audits  
  2. Issue CAPs as applicable  
  3. Follow-up on CAPs as applicable  
  4. Report to Compliance Committee and QIC | Compliance | 100% | 1/1/2018 | 12/31/2018 |

**Evaluation/Analysis of Intervention(s):**
AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Kashina Bishop, Chief Financial Officer
DATE: July 23, 2018
SUBJECT: May 2018 Fiscal Year to Date Financials

SUMMARY:

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

BACKGROUND/DISCUSSION:

The staff has prepared the May 2018 FYTD financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Financial Highlights

- There was a net gain of $1.6 million for the month of May 2018. For the eleven month period ended May 31, 2018, the Plan’s performance is an increase in net assets of $1.5 million, which is $371 thousand below budget.
- May FYTD net revenue is $559.2 million, $32.9 million higher than budget.
- Cost of health care is $617.0 million, $37.1 million higher than budget.
- The medical loss ratio is 93.6%, which is 1.0 percent higher than the budget.
- The administrative cost ratio is 6.8%, 0.5 percent lower than budget.
- May membership of 201,822 was 1,124 members lower than budget and 559 lower than April’s membership of 202,381.
- Tangible Net Equity is $143.8 million, which represents just over two months of operating expenses in reserve and 458% of the required amount by the state.

Revenue – May FYTD net revenue was $559.2 million or $32.9 million higher than budget. Revenue for the month of May contained three significant unusual items. Approximately $9.0 million of revenue was recouped by the state through a multi-year retroactive reclassification of Adult Expansion (AE) members as Dual Seniors and Persons with Disabilities (SPD), which carry a lower rate. However, the reduction in AE revenue and other factors made it possible for the Plan to release approximately $20.5 million of the
revenue reserve associated with the 85% Medical Loss Ratio (MLR) requirement. May results also include a revenue reserve of approximately $3.8 million as a result of the state’s recent announcement that fiscal year 2016-17 would also be subject to the 85% MLR requirement. Membership mix in May contributed a $1.4 million revenue increase through higher than expected AE and SPD member-months.

MCO Tax – MCO tax is a pre-determined liability in accordance with Senate Bill X2-2, passed in October 2016. The Plan’s MCO tax liability for FY 2018 is $89.3 million, accrued at a rate of approximately $7.4 million per month. The fourth quarterly installment of MCO tax was paid on July 2. The MCO tax remains unfunded.

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

As displayed in the above graph, medical expenses are over budget in several service categories. The cause of the significant variances are as follows:
Inpatient exceeded budget by $8.1 million (6.8%). The variance is largely the result of contract rate increases. May's Inpatient costs also contain high-dollar claims roughly double the typical amount, adding approximately $3.0 million to the monthly variance.

Outpatient was over budget by $10.0 million or 21.2%. Unit cost increased by 24.5% over the comparable period last fiscal year, while utilization increased only 1.5%.

Lab and Radiology exceeded the budget by $2.0 million (78.2%). However, May's costs, at $297 thousand, were approximately 29% lower than the recent trend.

Emergency Room exceeded the budget by $5.0 million (21.8%) as a result of contract rate increases. Paid-per-utilization was 28.6% above the same period last year, while utilization increased 0.2%.

Physician Specialty exceeded budget by 5.7 million (12.3%). The high dollar-volume diagnoses are diseases of the circulatory system, musculoskeletal system, nervous system, complications of pregnancy and neoplasms. These five categories comprise nearly 50% of total specialty services.

Primary Care Physician exceed budget by $1.8 million (13.3%). The heaviest utilization and expenditures occurred in standard office visits, consultation and standard diagnostics.

Home and Community Based Services was lower than budget by $1.6 million (9.4%). The largest component, CBAS, experienced flat utilization, but this was accompanied by minor rate decreases as compared to the same 11 months of the prior year. Hospice has maintained steady utilization during the current fiscal year, but is about 20% below the level experienced in the prior year.

Pharmacy exceeded budget by $9.2 million (9.0%). Utilization is 8.1% more than the comparable prior period. May's cost per prescription was only 0.9% more than the average during the prior year.

Other Medical Professional was under budget by $1.2 million (26.7%). A large portion of this category is related to eye care, audiology and physical therapy. While utilization and unit cost are gently rising, the increases are lower than anticipated in the budget.

Other Fee-For-Service exceeded budget by $1.5 million (21.2%) due to a slow but steady increase in volume. The largest expenditures in this category are medical supplies, DME and hearing devices.

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

Administrative Expenses – For the eleven months ended May 31, administrative costs were $44.9 million or $598 thousand below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 6.8 percent versus 7.3 percent for budget.
Cash and Medi-Cal Receivable – At May 31, the Plan had $356.0 million in cash and short-term investments and $63.3 million in Medi-Cal Receivables. The AE overpayment due to DHCS (related to incorrect rate payments and to achieve 85% MLR) totals $126.3 million.

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

RECOMMENDATION:

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

CONCURRENCE:

N/A

ATTACHMENT:

May 2018 Financial Package
TABLE OF CONTENTS

- Executive Dashboard
- Statement of Financial Position
- Statement of Revenues, Expenses and Changes in Net Assets
- Statement of Cash Flows

FINANCIAL PACKAGE
For the month ended May 2018
## Statement of Financial Position

### Assets

<table>
<thead>
<tr>
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<th>05/31/18</th>
<th>04/30/18</th>
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<tbody>
<tr>
<td><strong>Current Assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cash and Cash Equivalents</td>
<td>$159,501,424</td>
<td>$171,002,203</td>
</tr>
<tr>
<td>Total Short-Term Investments</td>
<td>196,461,673</td>
<td>196,247,013</td>
</tr>
<tr>
<td>Medi-Cal Receivable</td>
<td>63,299,720</td>
<td>95,054,432</td>
</tr>
<tr>
<td>Interest Receivable</td>
<td>650,537</td>
<td>569,676</td>
</tr>
<tr>
<td>Provider Receivable</td>
<td>374,873</td>
<td>443,928</td>
</tr>
<tr>
<td>Other Receivables</td>
<td>3,808,831</td>
<td>3,809,366</td>
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<tr>
<td><strong>Total Accounts Receivable</strong></td>
<td><strong>68,133,161</strong></td>
<td><strong>99,887,422</strong></td>
</tr>
<tr>
<td>Total Prepaid Accounts</td>
<td>1,410,209</td>
<td>1,458,171</td>
</tr>
<tr>
<td>Total Other Current Assets</td>
<td>135,560</td>
<td>135,560</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td><strong>425,542,027</strong></td>
<td><strong>468,710,370</strong></td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>1,934,973</td>
<td>1,978,733</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$ 427,577,000</strong></td>
<td><strong>$ 470,689,103</strong></td>
</tr>
</tbody>
</table>

### Liabilities & Net Assets

<table>
<thead>
<tr>
<th></th>
<th>05/31/18</th>
<th>04/30/18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incurred But Not Reported</td>
<td>$47,553,203</td>
<td>$48,795,918</td>
</tr>
<tr>
<td>Claims Payable</td>
<td>23,473,293</td>
<td>19,669,066</td>
</tr>
<tr>
<td>Capitation Payable</td>
<td>57,554,269</td>
<td>57,516,379</td>
</tr>
<tr>
<td>Physician Payable</td>
<td>5,263,839</td>
<td>4,185,159</td>
</tr>
<tr>
<td>AB 85 Payable</td>
<td>0</td>
<td>20,570,412</td>
</tr>
<tr>
<td>DHCS - Reserve for Capitation Recoup</td>
<td>124,143,559</td>
<td>140,843,569</td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>1,969,200</td>
<td>4,617,876</td>
</tr>
<tr>
<td>Accrued ACS</td>
<td>1,708,703</td>
<td>1,701,053</td>
</tr>
<tr>
<td>Accrued Expenses</td>
<td>7,315,000</td>
<td>22,801,655</td>
</tr>
<tr>
<td>Accrued Premium Tax</td>
<td>12,825,917</td>
<td>5,381,576</td>
</tr>
<tr>
<td>Accrued Payroll Expense</td>
<td>926,901</td>
<td>1,393,012</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td><strong>282,740,882</strong></td>
<td><strong>327,465,664</strong></td>
</tr>
<tr>
<td><strong>Long-Term Liabilities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Long-term Liability-Deferred Rent</td>
<td>1,012,333</td>
<td>1,015,733</td>
</tr>
<tr>
<td><strong>Total Long-Term Liabilities</strong></td>
<td><strong>1,012,333</strong></td>
<td><strong>1,015,733</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>283,753,215</strong></td>
<td><strong>328,481,397</strong></td>
</tr>
<tr>
<td><strong>Net Assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beginning Net Assets</td>
<td>142,360,951</td>
<td>142,360,951</td>
</tr>
<tr>
<td>Total Increase / (Decrease in Unrestricted Net Assets)</td>
<td>1,462,834</td>
<td>(153,246)</td>
</tr>
<tr>
<td><strong>Total Net Assets</strong></td>
<td><strong>143,823,785</strong></td>
<td><strong>142,207,706</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Net Assets</strong></td>
<td><strong>$ 427,577,000</strong></td>
<td><strong>$ 470,689,103</strong></td>
</tr>
</tbody>
</table>
### Statement of Revenues, Expenses and Changes in Net Assets

For Eleven Months Ended May 31, 2018

<table>
<thead>
<tr>
<th></th>
<th>May 2018</th>
<th>May 2018 Year-To-Date</th>
<th>Variance</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Fav/Unfav</td>
<td>%</td>
</tr>
<tr>
<td>Membership (includes retro members)</td>
<td>221,522</td>
<td>2,232,999</td>
<td>2,244,393</td>
<td>(-1,404) (-0.02)%</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td>57,015,118</td>
<td>770,054,343</td>
<td>712,980,344</td>
<td>57,384,300 8.05%</td>
</tr>
<tr>
<td>Facility Expense AB6</td>
<td>0</td>
<td>34,885,333</td>
<td>0</td>
<td>34,885,333 0.00%</td>
</tr>
<tr>
<td>Reserve for Rate Reduction</td>
<td>16,701,000</td>
<td>7,126,827</td>
<td>0</td>
<td>7,126,827 0.00%</td>
</tr>
<tr>
<td>MOC Premium Tax</td>
<td>(7,445,341)</td>
<td>(13,075,145)</td>
<td>(66,325,300) 3,253,246 -5.77%</td>
<td></td>
</tr>
<tr>
<td>Total Net Premium</td>
<td>66,299,777</td>
<td>669,320,953</td>
<td>628,364,643</td>
<td>32,950,600 5.25%</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>66,299,777</td>
<td>669,220,353</td>
<td>626,364,643</td>
<td>32,850,600 5.25%</td>
</tr>
<tr>
<td>Medical Expenses:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capture (SCC, Specialty, Kaiser, NEMT &amp; Vision)</td>
<td>2,057,969</td>
<td>57,077,737</td>
<td>59,218,594</td>
<td>1,353,857 2.05%</td>
</tr>
<tr>
<td>FFS Claims Expenses:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>13,569,269</td>
<td>127,872,668</td>
<td>119,796,516</td>
<td>5,032,152 -0.57%</td>
</tr>
<tr>
<td>LTC / SNF</td>
<td>11,295,344</td>
<td>110,393,328</td>
<td>105,458,229</td>
<td>(4,935,100) -4.6%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>6,729,067</td>
<td>67,326,167</td>
<td>73,702,599</td>
<td>(6,376,422) -21.19%</td>
</tr>
<tr>
<td>Laboratory and Radiology</td>
<td>29,523,353</td>
<td>4,487,758</td>
<td>2,371,060</td>
<td>(1,116,698) -31.21%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>2,531,820</td>
<td>27,877,242</td>
<td>22,834,487</td>
<td>(5,042,755) -21.76%</td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>5,520,637</td>
<td>52,486,918</td>
<td>48,757,998</td>
<td>(3,728,923) -12.25%</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>1,498,749</td>
<td>15,037,488</td>
<td>13,270,247</td>
<td>(1,767,241) -13.32%</td>
</tr>
<tr>
<td>Home &amp; Community Based Services</td>
<td>1,404,779</td>
<td>15,190,960</td>
<td>15,757,519</td>
<td>5,666,597 39.4%</td>
</tr>
<tr>
<td>Applied Behavior Analysis Services</td>
<td>990,375</td>
<td>7,609,179</td>
<td>4,279,229</td>
<td>(3,330,950) -65.95%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>520,149</td>
<td>5,658,853</td>
<td>5,621,443</td>
<td>2,242,780 39.15%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>10,555,464</td>
<td>111,000,446</td>
<td>101,845,031</td>
<td>(9,154,415) -8.9%</td>
</tr>
<tr>
<td>Other Medical Professional</td>
<td>302,725</td>
<td>3,212,119</td>
<td>3,353,470</td>
<td>1,141,351 26.27%</td>
</tr>
<tr>
<td>Other Medical Care</td>
<td>3,519</td>
<td>29,576</td>
<td>29,579</td>
<td>0         0.00%</td>
</tr>
<tr>
<td>Other Fee For Service</td>
<td>7,652,503</td>
<td>6,820,779</td>
<td>7,211,024</td>
<td>(1,490,245) -21.23%</td>
</tr>
<tr>
<td>Transportation</td>
<td>149,657</td>
<td>2,047,025</td>
<td>1,336,264</td>
<td>(710,761) -35.18%</td>
</tr>
<tr>
<td>Total Claims</td>
<td>55,019,630</td>
<td>548,535,271</td>
<td>522,352,022</td>
<td>(46,934,259) -9.34%</td>
</tr>
<tr>
<td>Medical &amp; Care Management Expense</td>
<td>1,091,674</td>
<td>10,587,971</td>
<td>13,102,599</td>
<td>2,514,628 19.33%</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>77,143</td>
<td>1,719,627</td>
<td>4,915,221</td>
<td>3,195,594 65.01%</td>
</tr>
<tr>
<td>Claims Recoveries</td>
<td>(370,152)</td>
<td>(2,548,368)</td>
<td>0</td>
<td>2,548,368 1.00%</td>
</tr>
<tr>
<td>Sub-total</td>
<td>798,038</td>
<td>9,576,672</td>
<td>8,041,832</td>
<td>8,354,859 45.69%</td>
</tr>
<tr>
<td>Total Cost of Health Care</td>
<td>61,474,658</td>
<td>616,972,940</td>
<td>579,423,416</td>
<td>(37,149,464) -6.41%</td>
</tr>
<tr>
<td>Contribution Margin</td>
<td>6,193,427</td>
<td>42,247,473</td>
<td>46,441,348</td>
<td>(4,393,655) -9.37%</td>
</tr>
<tr>
<td>General &amp; Administrative Expenses:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>States, Wage &amp; Employee Benefits</td>
<td>2,053,052</td>
<td>21,033,705</td>
<td>21,056,649</td>
<td>559,943 2.61%</td>
</tr>
<tr>
<td>Training, Conference &amp; Travel</td>
<td>25,072</td>
<td>227,741</td>
<td>249,433</td>
<td>22,692 9.58%</td>
</tr>
<tr>
<td>Outside Services</td>
<td>2,206,871</td>
<td>24,150,484</td>
<td>26,728,337</td>
<td>2,573,853 10.04%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>301,352</td>
<td>3,459,649</td>
<td>3,717,676</td>
<td>(258,027) -7.93%</td>
</tr>
<tr>
<td>Occupancy, Supplies, Insurance &amp; Others</td>
<td>536,518</td>
<td>64,381,100</td>
<td>7,738,996</td>
<td>1,269,885 16.97%</td>
</tr>
<tr>
<td>ARO-Community Grants</td>
<td>0</td>
<td>323,254</td>
<td>323,254</td>
<td>0         0.00%</td>
</tr>
<tr>
<td>Care Management Credit</td>
<td>(1,091,874)</td>
<td>(10,387,871)</td>
<td>(13,399,599)</td>
<td>(3,011,728) -22.73%</td>
</tr>
<tr>
<td>Total G &amp; A Expenses</td>
<td>4,130,373</td>
<td>44,948,474</td>
<td>48,543,002</td>
<td>397,728 1.31%</td>
</tr>
<tr>
<td>Total Operating Gain / Loss</td>
<td>$1,061,154</td>
<td>$(2,697,701)</td>
<td>$2,598,456</td>
<td>$(3,695,737) -370.15%</td>
</tr>
<tr>
<td>Non Operating Revenues</td>
<td>552,928</td>
<td>4,150,134</td>
<td>635,653</td>
<td>3,324,891 526.13%</td>
</tr>
<tr>
<td>Total Non-Operating</td>
<td>552,928</td>
<td>4,150,134</td>
<td>635,653</td>
<td>3,324,891 526.13%</td>
</tr>
<tr>
<td>Total Increase (Decrease) in Unrestricted Net Assets</td>
<td>$1,616,080</td>
<td>$1,422,834</td>
<td>1,833,589</td>
<td>$(310,756) -20.22%</td>
</tr>
</tbody>
</table>

For FMFF - FYTD
<table>
<thead>
<tr>
<th>Statement of Cash Flows</th>
<th>FYTD 17-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows Provided By Operating Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Net Income (Loss)</td>
<td></td>
</tr>
<tr>
<td><strong>Adjustments to reconcile net income to net cash provided by operating activities</strong></td>
<td></td>
</tr>
<tr>
<td>Depreciation on fixed assets</td>
<td></td>
</tr>
<tr>
<td>Amortization of discounts and premium</td>
<td></td>
</tr>
<tr>
<td><strong>Changes in Operating Assets and Liabilities</strong></td>
<td></td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td></td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td></td>
</tr>
<tr>
<td>Accounts Payable</td>
<td></td>
</tr>
<tr>
<td>Claims Payable</td>
<td></td>
</tr>
<tr>
<td>MCO Tax liability</td>
<td></td>
</tr>
<tr>
<td>IBNR</td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash Provided by (Used in) Operating Activities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Flow Provided By Investing Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Proceeds from Restricted Cash &amp; Other Assets</td>
<td></td>
</tr>
<tr>
<td>Proceeds from Investments</td>
<td></td>
</tr>
<tr>
<td>Proceeds for Sales of Property, Plant and Equipment</td>
<td></td>
</tr>
<tr>
<td>Payments for Restricted Cash and Other Assets</td>
<td></td>
</tr>
<tr>
<td>Purchase of Investments plus Interest reinvested</td>
<td></td>
</tr>
<tr>
<td>Purchase of Property and Equipment</td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash (Used In) Provided by Investing Activities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Flow Provided By Financing Activities</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash Used In Financing Activities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Increase/(Decrease) in Cash and Cash Equivalents</strong></td>
<td></td>
</tr>
<tr>
<td>Cash and Cash Equivalents, Beginning of Period</td>
<td></td>
</tr>
<tr>
<td>Cash and Cash Equivalents, End of Period</td>
<td></td>
</tr>
</tbody>
</table>
AGENDA ITEM NO. 8

To: Ventura County Medi-Cal Managed Care Commission
From: Ruth Watson, Chief Operating Officer
Date: July 23, 2018
RE: Americas Health Plan (AHP) Update

SUMMARY:

Ruth Watson, Chief Operating Officer and Margaret Tatar, Managing Principal, Health Management Associates will give a verbal presentation to the Commission.
AGENDA ITEM NO. 9

To: Ventura County Medi-Cal Managed Care Commission
From: Melissa Scrymgeour, Chief Administrative Officer
Date: July 23, 2018
RE: Chief Administrative Officer (CAO) Report

SUMMARY:

Melissa Scrymgeour, Chief Administrative Officer will give a verbal presentation to the Commission.
AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Ted Bagley, Interim Chief Diversity Officer
DATE: July 23, 2018
SUBJECT: Interim Chief Diversity Officer Update

Actions:

Community Relations

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

Developed Competency Model for Diversity

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

Case Investigations

No new cases to-date. In discussions with several employees on performance issues.
AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Ruth Watson, Chief Operating Officer
DATE: July 23, 2018
SUBJECT: Chief Operating Officer (COO) Update

Executive Summary

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

Operations Dashboard

Membership

Membership continues to remain below 200,000 for July 2018. January’s enrollment was 197,609. July is 1854 members lower. Adult Expansion also remains flat between January (52,745 members) and July (52,383 members). Retroactivity for July shows a gain of 1,985 member for previous months.

Based on the current economy and the time of year, we can expect enrollment to remain at this level.
### Operations Dashboard

#### Monthly Volumes - July 2018

<table>
<thead>
<tr>
<th>Description</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Membership:</strong></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>195,755</td>
</tr>
<tr>
<td>July Loss</td>
<td>-6,216</td>
</tr>
<tr>
<td>July Add</td>
<td>3,192</td>
</tr>
<tr>
<td>July Retroactivity</td>
<td>1,985</td>
</tr>
<tr>
<td>Gain/Loss (net)</td>
<td>-1,039</td>
</tr>
<tr>
<td><strong>AB-85: (new)</strong></td>
<td></td>
</tr>
<tr>
<td>VCMC</td>
<td>398</td>
</tr>
<tr>
<td>Remaining Providers</td>
<td>397</td>
</tr>
<tr>
<td>VCMC Target</td>
<td>65,765</td>
</tr>
<tr>
<td>VCMC % of Target</td>
<td>42.20%</td>
</tr>
</tbody>
</table>

**AB 85 Auto Assignment** - GCHP assigned 398 new members to VCMC, while the remaining 397 new members were assigned to providers in compliance with the VCMCC Auto Assignment policy (MS-005) for July. VCMC has 27,753 Adult Expansion (AE) members assigned as of July 1, 2018. VCMC’s target enrollment, as established by DHCS, is 65,765 and is currently at 42.20% of the target.

**Operations Dashboard**

**Encounter Data**

Encounter data fluctuates month over month depending on provider submissions and services. The error rates are consistent month over month by provider type. The most common error types submitted involve members not effective on date of service, coding errors and duplicate submissions.

GCHP encounter data continues to reflect 100% submission rates on the quarterly and annual DHCS scorecards indicating that the data submitted is clean and useable by the state.
Operations Dashboard
Monthly Volumes - June 2018
Total Encounters Submitted: 388,691

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>Errors</th>
<th>% of Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>2,815</td>
<td>2.0%</td>
</tr>
<tr>
<td>Institutional</td>
<td>568</td>
<td>0.6%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>613</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,026</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

- **Submitted** – the total number of encounter records submitted to GCHP each month.
- **Errors** – the total number of encounters submitted with invalid data such as formatting, errors, utilization of out of date coding or missing data.
- **Percent of Errors** – the number of errors divided by the total number of encounters submitted.

Claims

Annually, Conduent processes approximately 2,300,000 claims for GCHP. This does not include the volume of encounters received by GCHP. June claim submission is lower than May by 8,754, a significant drop in claims for June. We expect that claim counts will increase towards the end of the summer which is a typical claim cycle. The average daily receipt in June was 9,924 which is slightly higher than May.

Operations Dashboard
Monthly Claims Volumes - March to June 2018

<table>
<thead>
<tr>
<th>Month</th>
<th>June</th>
<th>May</th>
<th>April</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>208,412</td>
<td>215,166</td>
<td>217,183</td>
<td>215,953</td>
</tr>
<tr>
<td>Daily Average Receipt</td>
<td>9924</td>
<td>9,780</td>
<td>9,529</td>
<td>9,816</td>
</tr>
<tr>
<td>Days Receipt on Hand</td>
<td>6</td>
<td>4</td>
<td>3.79</td>
<td>3.12</td>
</tr>
</tbody>
</table>

Conduent is measured on claim performance by three industry-standard metrics (Service Level Agreements (SLAs)). Conduent continues to meet and exceed these metrics month over month. We also continue to review processes and performance through audit and quality goals and initiatives.
### Operations Dashboard

#### Key Performance Metrics - March - June 2018

<table>
<thead>
<tr>
<th></th>
<th>Benchmark</th>
<th>June</th>
<th>May</th>
<th>April</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turn Around Time</td>
<td>90.00%</td>
<td>91.92%</td>
<td>99.08%</td>
<td>97.70%</td>
<td>95.62%</td>
</tr>
<tr>
<td>Financial Accuracy</td>
<td>98.00%</td>
<td>99.16%</td>
<td>99.30%</td>
<td>99.00%</td>
<td>99.74%</td>
</tr>
<tr>
<td>Procedural Accuracy</td>
<td>97.00%</td>
<td>99.25%</td>
<td>99.91%</td>
<td>99.00%</td>
<td>99.99%</td>
</tr>
</tbody>
</table>

### Call Center

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

### Operations Dashboard

#### Call Volume - March-June 2018

<table>
<thead>
<tr>
<th></th>
<th>June</th>
<th>May</th>
<th>April</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Volume (# of calls)</td>
<td>11,916</td>
<td>12,183</td>
<td>12,455</td>
<td>12,719</td>
</tr>
</tbody>
</table>

### Operations Dashboard

#### Key Performance Metrics - March - June 2018

<table>
<thead>
<tr>
<th></th>
<th>Benchmark</th>
<th>June</th>
<th>May</th>
<th>April</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. Speed To Answer</td>
<td>30 Seconds</td>
<td>20.4</td>
<td>90.6</td>
<td>22</td>
<td>40.8*</td>
</tr>
<tr>
<td>Abandonment Rate</td>
<td>5.00%</td>
<td>1.02%</td>
<td>4.73%</td>
<td>1.05%</td>
<td>2.13%</td>
</tr>
<tr>
<td>Call Quality Scores</td>
<td>95.00%</td>
<td>97.24%</td>
<td>96.7%</td>
<td>97.56%</td>
<td>96.73%</td>
</tr>
</tbody>
</table>

*ASA spike due to attrition, new employees being hired and illness*

### Grievance and Appeals

Grievance and Appeals (G&A) is measured in a 2-month lookback due to the time allowed to process the request (45 days).
DHCS measures G&A performance against 2 metrics for each category (2 for Grievance, 2 for Appeals). The metrics are timeliness of acknowledgement and timeliness of resolution. The metrics are significantly rigid (100%) and GCHP continues to look at ways to improve the process to meet each metric at 100%.

<table>
<thead>
<tr>
<th>Operations Dashboard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Volumes: March - May 2018</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>G&amp;A Volume:</td>
</tr>
<tr>
<td>Clinical</td>
</tr>
<tr>
<td>Upheld</td>
</tr>
<tr>
<td>Overturned</td>
</tr>
<tr>
<td>Withdrawn</td>
</tr>
<tr>
<td>Provider</td>
</tr>
<tr>
<td>Member</td>
</tr>
<tr>
<td>Grievances/ 1,000</td>
</tr>
<tr>
<td>Quality of Care (reasons)</td>
</tr>
<tr>
<td>State Fair Hearings</td>
</tr>
<tr>
<td>Denied</td>
</tr>
<tr>
<td>Dismissed</td>
</tr>
<tr>
<td>Withdrawn</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operations Dashboard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Volumes by Issue Type: March - May 2018</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Grievance (Issue Type):</td>
</tr>
<tr>
<td>Accessibility</td>
</tr>
<tr>
<td>Benefits/Coverage</td>
</tr>
<tr>
<td>Billings</td>
</tr>
<tr>
<td>Denial/Refusals</td>
</tr>
<tr>
<td>Quality of Care</td>
</tr>
<tr>
<td>Quality of Service</td>
</tr>
<tr>
<td>Referral</td>
</tr>
</tbody>
</table>
1. Provider Orientations and Routine Site Visits

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

- 40 Physicians declined orientation during this reporting period due to their joining an established contracted group with GCHP. This was a significant increase from the previous reporting period with the increase exclusively associated with large Radiology Medical Groups, who have historically declined orientation as they are familiar with GCHP policies and procedures and have the staff and capability to perform the orientation function on their own.
- Site Visits: 102 provider site visits were completed by Network Operations- Provider Relations staff. This represents a 53% increase in provider site visits compared to the previous reporting period. The goal for the Provider Relations team is to complete 20 site visits per Provider Relations Specialists per month. A total of 40 visits per month. This figure was exceeded for the month of June 2018 as the Provider relations Team is now at full staffing levels and reprioritization of tasks.

2. PROVIDER ADDS AND TERMINATIONS JUNE 2018

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

<table>
<thead>
<tr>
<th>PROVIDER TYPE</th>
<th># PROVIDER ADDS June 2018</th>
<th>TOTAL PROVIDER ADDS June 2017-July 2018</th>
<th>TOTAL NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Acute Care</td>
<td>0</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>-LTAC</td>
<td>0</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>-Tertiary</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td>42</td>
<td>1,202</td>
<td>6,447</td>
</tr>
<tr>
<td>-PCP's &amp; Midlevels</td>
<td>2</td>
<td>62</td>
<td>443</td>
</tr>
<tr>
<td>-Specialists</td>
<td>40</td>
<td>1,090</td>
<td>5,663</td>
</tr>
<tr>
<td>-Hospitalists</td>
<td>0</td>
<td>50</td>
<td>341</td>
</tr>
<tr>
<td><strong>Ancillary</strong></td>
<td>2</td>
<td>11</td>
<td>388</td>
</tr>
<tr>
<td>-ASC</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>-CBAS</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>-DME</td>
<td>0</td>
<td>2</td>
<td>108</td>
</tr>
<tr>
<td>-Home Health</td>
<td>0</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>-Hospice</td>
<td>0</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>-Laboratory</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>-Optometry</td>
<td>0</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>-OT/PT/ST</td>
<td>0</td>
<td>6</td>
<td>83</td>
</tr>
<tr>
<td>-Radiology/Imaging</td>
<td>0</td>
<td>0</td>
<td>29</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>1</td>
<td>7</td>
<td>838</td>
</tr>
<tr>
<td><strong>SNF/LTC/CLF</strong></td>
<td>1</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td>4</td>
<td>89</td>
<td>377</td>
</tr>
</tbody>
</table>
3. **TERMINATIONS:**

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

<table>
<thead>
<tr>
<th>PROVIDER TYPE</th>
<th># PROVIDER TERMS June 2018</th>
<th>TOTAL PROVIDER TERMS July 2017-June 2018</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>0</td>
<td>0</td>
<td>---</td>
</tr>
<tr>
<td>- Acute Care</td>
<td>0</td>
<td>0</td>
<td>---</td>
</tr>
<tr>
<td>- LTAC</td>
<td>0</td>
<td>0</td>
<td>---</td>
</tr>
<tr>
<td>- Tertiary</td>
<td>0</td>
<td>0</td>
<td>---</td>
</tr>
<tr>
<td>Providers</td>
<td>23</td>
<td>190</td>
<td>---</td>
</tr>
<tr>
<td>- PCP’s &amp; Midlevels</td>
<td>5</td>
<td>52</td>
<td>No major impact</td>
</tr>
<tr>
<td>- Specialists</td>
<td>18</td>
<td>113</td>
<td>No major impact</td>
</tr>
<tr>
<td>- Hospitalists</td>
<td>0</td>
<td>25</td>
<td>No major impact</td>
</tr>
<tr>
<td>Ancillary</td>
<td>1</td>
<td>11</td>
<td>No major impact</td>
</tr>
<tr>
<td>- ASC</td>
<td>0</td>
<td>1</td>
<td>No major impact</td>
</tr>
<tr>
<td>- CBAS</td>
<td>0</td>
<td>0</td>
<td>---</td>
</tr>
<tr>
<td>- DME</td>
<td>0</td>
<td>3</td>
<td>No major impact</td>
</tr>
<tr>
<td>- Home Health</td>
<td>0</td>
<td>0</td>
<td>---</td>
</tr>
<tr>
<td>- Hospice</td>
<td>0</td>
<td>1</td>
<td>No major impact</td>
</tr>
<tr>
<td>- Laboratory</td>
<td>0</td>
<td>0</td>
<td>---</td>
</tr>
<tr>
<td>- Optometry</td>
<td>0</td>
<td>0</td>
<td>---</td>
</tr>
</tbody>
</table>
4. CONTRACTING INITIATIVES

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

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

C. Regulatory Initiatives:
   - Network Operations received notification from DHCS that we passed all Network certification requirements.
   - Prop-56 (Cigarette Tax Initiative) - outlined for providers the terms of this proposition, eligibility components and payment parameters. Payments sent out to providers and Vendors.
   - Finalizing UCLA Credentialing Delegation Agreement.
   - Completed State Medical Audit Survey and awaiting survey findings.
   - Completed Provider timely access and after-hours access surveys and awaiting final result.
AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Nancy Wharfield, MD, Chief Medical Officer
DATE: July 23, 2018
SUBJECT: Chief Medical Officer Update

Pharmacy Benefit Performance and Trends

SUMMARY:

Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP's ASO operational membership counts, and invoice data. The data shown is through the end of May 2018. Although minor changes may occur to the data going forward due to the potential of claim adjustments from audits and/or member reimbursement requests, the data is generally considered complete due to point of sale processing of pharmacy data.

Abbreviation Key:
PMPM: Per member per month
PUPM: Per utilization per month
GDR: Generic dispensing rate
PHARMACY COST TRENDS:

**Total Cost vs. Utilizing Members**

- Total Cost (in thousands)
- Utilizing Members

**PMPM vs. Utilizing Percent**

- PMPM
- Utilizing Percent

---

Gold Coast Health Plan
A Public Entity

www.goldcoasthealthplan.org
HEPATITIS C FOCUS:

- Costs vs. Expected Kick-Payment (costs in thousands)
- PMPM and PUPM Costs With and Without Hep C
PAID PER PRESCRIPTION:

Dollars Paid Per Prescriptions

PBM OVERSIGHT:

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

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

<table>
<thead>
<tr>
<th>Number of Items</th>
<th>Items Open</th>
<th>Items Pending Closure</th>
<th>Items Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>4</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Number of Items</th>
<th>Items Open</th>
<th>Items Pending Closure</th>
<th>Items Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>