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

Regular Meeting  
Monday, January 28, 2019, 2:00 p.m.  
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

OATH OF OFFICE

ROLL CALL

PUBLIC COMMENT

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

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

REPORTS

1. Chief Executive Officer (CEO) Update

   Staff: Dale Villani, Chief Executive Officer

   RECOMMENDATION: Accept and file the report.
CONSENT CALENDAR

2. Approval of Ventura County Medi-cal Managed Care Commission Meeting Regular Minutes of October 29, 2018.
   
   Staff: Maddie Gutierrez, CMC, Clerk of the Commission
   
   RECOMMENDATION: Approve the minutes.

3. Contract Approval – Consulting Services Agreement: DR Management Services
   
   Staff: Dale Villani, Chief Executive Officer
   
   RECOMMENDATION: Authorize the CEO to execute a Consulting Services Agreement with DR Management services in support of the ETP Project.

   
   Staff: Nancy Wharfield, M.D., Chief Medical Officer
   
   RECOMMENDATION: Approve the contract for Solera.

5. Additional Funding for Inovalon Purchase Order
   
   Staff: Nancy Wharfield, M.D., Chief Medical Officer
   
   RECOMMENDATION: Approve additional funding in order to align with anticipated expenses.

   
   Staff: Dale Villani, Chief Executive Officer
   
   RECOMMENDATION: Approve and authorize the CEO to execute DHCS Contract Amendment A28.
7. **State of California Contract Amendment A29**

   Staff: Dale Villani, Chief Executive Officer

   **RECOMMENDATION:** Approve and authorize the CEO to execute DHCS Contract Amendment A29.

**REPORTS**

8. **Chief Medical Officer (CMO) Report**

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

   **RECOMMENDATION:** Accept and file the report.

9. **Chief Diversity Officer (CDO) Report**

   Staff: Ted Bagley, Interim Chief Diversity Officer

   **RECOMMENDATION:** Accept and file the report.

10. **Chief Operating Officer (COO) Report**

    Staff: Ruth Watson, Chief Operating Officer

    **RECOMMENDATION:** Accept and file the report.

**PRESENTATION**

11. **Association for Community Affiliated Plans (ACAP) – Policy & Research Fellowship: “Where Education, Employment, and Health Meet”**

    Staff: Marlen Torres, Government Relations Director

    **RECOMMENDATION:** Accept and file the presentation.
FORMAL ACTION ITEMS

12. September through November 2018 Financials Report

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Accept and file the financials report.

13. Adoption of Resolution 2019-001 Authorizing the Investment of Monies in the Local Agency Investment Fund (LAIF)

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Adopt resolution 2019-001, authorizing the investment of funds.


Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Authorize the CEO to act on behalf of the Plan to conduct all negotiations, execute and submit documents, including, without limitation, applications, agreements, amendments, and billing statements that may be necessary to complete the Enterprise Transformation Project (ETP).

15. Approval of Pharmacy Benefits Manager (PBM) Contract Amendment

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

RECOMMENDATION: GCHP Staff recommends extending the current PBM contract amendment.

16. Approval of Pharmacy Benefits Manager (PBM) Contract Extension

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

RECOMMENDATION: GCHP Staff recommends approval of PBM contract extension.
17. AmericasHealth Plan (AHP)

Guest Speakers: Sonia Demarta, CPA, Chief Financial Officer, AHP
               Anita Guevin, Compliance Officer, AHP

RECOMMENDATION: Accept and file the presentation. Commission to provide direction to staff.

CLOSED SESSION

18. REPORT INVOLVING TRADE SECRETS
    Discussion will concern: Rates for PBM program.
    Estimated date of public disclosure: Three years from the implementation of rates.

OPEN SESSION

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on February 25, 2019 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: Dale Villani, Chief Executive Officer

DATE: January 28, 2019

SUBJECT: Chief Executive Officer Update

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

New Commissioners

GCHP staff welcomes the addition of two new members to the commission. In January 2019, the VC County Board of Supervisors appointed Supervisor Bob Huber and Ms. Dee Pupa to replace the VCMMCC seats formerly held by Supervisor Kelly Long and Ms. Narci Egan, respectively.

Strategic Planning

The GCHP executive leadership team and commission held its fourth annual strategic planning meeting on Thursday, January 17, 2019. The meeting provided interactive discussion amongst staff, commissioners, and external industry representatives on a variety of topics and issues related to GCHP’s strategic direction, including, but not limited to:

- National and state healthcare policy and regulations,
- Medi-Cal membership trends,
- Financial reimbursement models and
- Current GCHP performance and,
- Anticipated or potential impacts to the Plan, our members, and community at large.

The afternoon also included highlights of GCHP’s positive community impact with the recent community health investments grants program.

Enterprise Transformation Project Update

In April 2018, the commission authorized GCHP staff to extend the ASO services agreement with Conduent, which included the transition to a new CORE claims system platform, Virtual Benefits Administrator (VBA). In January 2019, Conduent announced the acquisition of Health Solutions Plus (HSP), a fully developed CORE claims system platform recognized by Gartner and named “Best in KLAS” for Payer Claims and Administration Platforms in 2018.
KLAS is a leading healthcare IT research firm that provides the definitive ranking of vendors in the industry.

Conduent gave GCHP the option to remain on VBA or switch, at no additional cost to HSP. After staff conducted due diligence on the optional platform, the executive leadership team made the decision to switch to HSP. Conduent’s acquisition of HSP provides GCHP a single vendor solution that provides both the ASO operations and CORE system development and support. Additionally, GCHP can leverage the experience of two existing California Medi-Cal managed care plans also using the HSP system. HSP is a platform that staff is confident Conduent will continue to support since it is now a subsidiary versus a contracted entity. While there is no financial impact, Plan staff and Conduent project resources are currently in the process of project re-planning to determine impacts to the project schedule and target implementation dates. GCHP staff will apprise the commission of the new schedule once the team completes re-planning efforts.

California Update

Governor Newsom’s Executive Orders

On January 7, Gavin Newsom became California’s fortieth Governor. Unlike the former Governor, Newsom appears ready to place a great emphasis on healthcare policy. Hence, it was not surprising that just hours after his inauguration, Governor Newsom began working towards these policy goals by signing executive orders and previewing budget proposals that outline his plans for health policy in the coming years.

Governor Newsom’s executive order aims to create the nation’s largest single-purchaser system for drugs, whereby the Department of Health Care Services (DHCS) will negotiate the pricing and purchasing of prescription drugs on behalf of 13 million Medi-Cal beneficiaries. The executive order directs state agencies to make purchases from drug companies together, instead of each agency negotiating independently. Private purchasers, such as small business owners, will also be able to join the bargaining table, resulting in lower drug costs around the state. Under this new system, Medi-Cal managed care plans like GCHP will no longer have the responsibility of negotiating or contracting with a third party to negotiate prescription drug prices.

The Governor’s second executive order creates a California Surgeon General, who has been tasked with addressing the root causes of California’s greatest health challenges and inequities. On January 21, Governor Newsom appointed Dr. Burke Harris to this position. Dr. Harris has dedicated her professional career to understanding the link between adverse childhood experiences and toxic stress in children, and the effect both have on future health outcomes.

Governor Newsom also proposed extending Medi-Cal eligibility to young adults between 19-25 years of age who would otherwise meet the program’s eligibility requirements if not for their immigration status. In addition, the Legislature has introduced AB 4 (Arambla), under
this proposal, all individuals who would qualify for the Medi-Cal program, if not for their immigration status, would be eligible for full-scope Medi-Cal coverage. Whether this legislative bill makes it to the Governor’s desk and receives approval is yet to be seen. Governor Newsom’s proposal is estimated to annually cost the state approximately $250 million, while the more expansive proposal proposed in AB 4 would cost California approximately $3 billion.

The Legislature has until February 22 to introduce new legislative bills. Based on the proposal already put forth by the Governor, it is expected that there will be many bills introduced in the healthcare arena.

Proposed California Budget Fiscal Year 2019-20

On January 11, Governor Newsom released his proposed state budget for FY 2019-20. During a press conference, in which Governor Newsom discusses his proposed budget, he began with statements characterizing the Budget as “a reflection of our [California’s] values.” Later remarks emphasized fiscal prudence by acknowledging that while the Budget includes significant new proposals, it is also “disciplined” and is “building a strong foundation” for the continued health of the State’s finances. For the purpose of this write-up, only items pertaining to the Medi-Cal program will be analyzed.

Overall Medi-Cal Budget
- Total budget: $100.7 billion ($22.9 billion General Fund) in 2019-20.
- Total projected enrollment: 13.2 million Californians, 3.8 million of whom are part of the Medi-Cal Expansion (MCE) population.
- State share for MCE population: $19.9 billion ($2.2 billion General Fund); 8.5% state share of cost.
- Proposes the creation of a Medi-Cal Drug Rebate Fund: The Governor’s budget proposes a new special fund, the Medi-Cal Drug Rebate Fund, beginning July 1, 2019. This will fund healthcare services for Medi-Cal beneficiaries. The fund will enhance management of drug rebate accounting and transparency.

Prescription Drug Executive Order
The Budget proposes to transition all pharmacy services for Medi-Cal managed care to a fee-for-service benefit. A fee-for-service pharmacy program will increase drug rebate savings and help the state secure better prices by allowing California to negotiate with pharmaceutical manufacturers on behalf of a much larger population of Medi-Cal beneficiaries. The proposal is estimated to result in hundreds of millions of dollars in annual savings starting in fiscal year 2021-22. DHCS believes this directive will occur no sooner than January 2021.
The Department notes this will achieve the following goals:

1. Strengthen California’s negotiating power for supplemental rebates in Medi-Cal.

2. Improve pharmacy services while maintaining quality and outcomes by expanding the FFS pharmacy network to Medi-Cal managed care.

3. Standardization of the Medi-Cal pharmacy benefit which will reduce confusion for beneficiaries who move between counties or managed care plans.

Coverage Expansion
The Governor’s Budget includes $260 million ($196.5 million General Fund) to expand full-scope Medi-Cal coverage to eligible young adults aged 19 through 25 regardless of immigration status. Coverage will begin no sooner than July 1, 2019. According to the Legislative Analyst’s Office (LAO), approximately 138,000 individuals would gain coverage. In Ventura County, approximately 21,000 members would remain enrolled with GCHP if this proposal is approved and redetermination is met.

Proposition 56
The Budget sustains existing Proposition 56 supplemental payments and proposes three new programs funded by Proposition 56 revenues, totaling $3.2 billion ($1.05 billion proposition 56 funds) for these programs.

- Continuing Proposition 56 programs: supplemental payments and rate increases for physicians, dentists, family planning services, Intermediate Care Facilities for the Developmentally Disabled, HIV/AIDS waiver services, Home Health, pediatric day health services.

- New Proposition 56 programs:
  - Value-based payment (VBP) program: The Budget includes $180 million to establish a VBP program through Medi-Cal managed care plans that will provide incentive payments to providers meeting specified metrics in areas such as behavioral health integration, prenatal/post-partum care and chronic disease management. There will be additional detail in proposed Trailer Bill Language.
  - Developmental and trauma screenings: The Budget includes $52.5 million for screenings of both children and adult enrollees conducted by providers in both Medi-Cal managed care and FFS.
  - Family planning supplemental payment program: The Budget includes an additional $50 million for this program.

Whole-Person Care
The Budget proposes $100 million for Whole Person Care Pilot programs that provide housing services. The funding will focus on the homeless mentally ill population and will be available for expenditure through 2025.
Additional information will be provided as the respective budget subcommittees begin to meet to discuss the proposals stated above as well as other proposals put forth by stakeholders.

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. The final audit results were received by the Plan on September 28, 2018. Two deficiencies were identified in the corrective action plan (CAP). The first finding was specific to Conduent notifying GCHP within defined timeframes of any HIPAA breaches. The second finding is creating a policy for excluded providers. The policies created, included: claims payment procedures to stop payment for excluded/suspended providers, DHCS notification process of excluded/suspended providers and transition of members. The response was due to DHCS on November 2, 2018. GCHP has been in ongoing communication with DHCS and has answered clarifying questions. In addition, GCHP has made changes to the policies and procedures submitted as a part of the CAP process based on the review and feedback by DHCS. The CAP remains open and is still under review. Staff will keep the commission apprised of the corrective action plan status.

DHCS Contract Amendments:

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

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
- Imposing sanctions
- Issuing ongoing monitoring in addition to CAP
The table below provides an overview of GCHP delegation oversight activities:

<table>
<thead>
<tr>
<th>Delegate</th>
<th>Audit Year and Type</th>
<th>Audit Status</th>
<th>Date CAP Issued</th>
<th>Date CAP Closed</th>
<th>Ongoing Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>VTS</td>
<td>2016 Security Risk Assessment</td>
<td>Open</td>
<td>9/20/2016</td>
<td>Under CAP Pending Closure letter</td>
<td></td>
</tr>
<tr>
<td>Conduent</td>
<td>2017 Claims</td>
<td>Open</td>
<td>12/28/2017</td>
<td>Under CAP</td>
<td>Open item system configuration change will be modified in new system</td>
</tr>
<tr>
<td>Kaiser</td>
<td>2017 Annual Claims</td>
<td>Open</td>
<td>2/8/2018</td>
<td>Under CAP Pending closure one item remaining system conversion delay</td>
<td></td>
</tr>
<tr>
<td>Kaiser</td>
<td>2018 Annual Claims</td>
<td>Open</td>
<td>9/23/2018</td>
<td>Under CAP</td>
<td></td>
</tr>
<tr>
<td>Conduent</td>
<td>2018 Annual Claims</td>
<td>*Open</td>
<td>6/20/2018</td>
<td>Under CAP</td>
<td>Ongoing monitoring imposed</td>
</tr>
<tr>
<td>Beacon Health Options</td>
<td>2018 6 month Claims (focused) audit</td>
<td>*Open</td>
<td>11/21/2018</td>
<td>Under CAP &amp; Under Financial Sanctions</td>
<td></td>
</tr>
<tr>
<td>Beacon Health Options</td>
<td>2018 Clinical Audit: QI, C&amp;L, MRR, UM</td>
<td>Closed</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Clinicas del Camino Real, Inc.</td>
<td>2018 Annual Claims Audit</td>
<td>Open</td>
<td>12/28/2018</td>
<td>Under CAP</td>
<td>Ongoing monitoring imposed</td>
</tr>
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<tr>
<td>Clinicas del Camino Real, Inc</td>
<td>2018 Annual Utilization Management</td>
<td>Closed</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>VTS</td>
<td>2018 Annual NEMT/NMT</td>
<td>Open</td>
<td>6/7/2018</td>
<td>Under CAP</td>
<td></td>
</tr>
<tr>
<td>VTS</td>
<td>2018 6 month follow-up NEMT/NMT</td>
<td>Open</td>
<td>12/28/2018</td>
<td>In Review</td>
<td></td>
</tr>
<tr>
<td>VSP</td>
<td>2018 Claims Annual Claims Audit</td>
<td>Closed</td>
<td>11/2/2018</td>
<td>December 12, 2018</td>
<td></td>
</tr>
<tr>
<td>Cedars Sinai</td>
<td>2018 Annual Credentialing</td>
<td>Open</td>
<td>9/17/2018</td>
<td>Under CAP</td>
<td></td>
</tr>
<tr>
<td>UCLA</td>
<td>2018 Annual Credentialing</td>
<td>Closed</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Ongoing monitoring denotes delegate is not making progress on a CAP issued and/or audit results were unsatisfactory and GCHP is required to monitor the delegate closely as it is a risk to the Plan when delegates are unable to comply.*

The compliance department will be responsible for delegation oversight of the PBM effective November 2018. The audit of the PBM started at the end of December 2018. The audit is currently in progress by GCHP Compliance Director. Upon completion of the audit, the results will be reported to the commission in the same manner all other delegates are.

Compliance will continue to monitor all CAP(s) in place and work with each delegate to ensure compliance is achieved and sustained. It is a DHCS requirement for GCHP to hold all delegates accountable. The oversight activities conducted by GCHP is evaluated during the DHCS annual medical audit. DHCS auditors review GCHP’s audit policy and procedures, audit tools, audit methodology as well as audits conducted and corrective plans issued by GCHP during the audit period. DHCS continues to emphasize the high level of responsibility Plans have in oversight of delegates.

**RECOMMENDATION:**

Accept and file the report.
AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Maddie Gutierrez, Clerk to the Commission
DATE: January 28, 2019
SUBJECT: Meeting Minutes of October 29, 2018 Regular Commission Meeting

RECOMMENDATION:
Approve the minutes.

ATTACHMENTS:
Copy of the October 29, 2018 Regular Commission Meeting minutes.
CALL TO ORDER

Commissioner Antonio Alatorre called the meeting to order at 2:09 p.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

PLEDGE OF ALLEGIANCE

Commissioner Alatorre led the Pledge of Allegiance.

ROLL CALL


Absent: Commissioners Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

FORMAL ACTION

1. Public Comment Policy.

RECOMMENDATION: Discuss and Adopt a Policy regarding Public Comment and Participation at Public Meetings.

DISCUSSION: General Counsel Scott Campbell presented a draft for approval/adoption of a policy regarding Public Comment and participation in public meetings. This policy is based upon Commissioner Input, the recent Supreme Court case on the Brown Act, and best practices. This policy provides each speaker be given three (3) minutes to speak during public comment. It also provides that if the Chair/Commission feel this item needs a longer discussion, prior to the start of the comment the Chair/Commission can extend the public comment to five (5) minutes. If this is not done prior to the speaker starting their comment, it will be the role of the Clerk to inform the speaker their time is up. At that time, the Chair or Commission can extend the time by a set amount before the speaker begins to talk again. This will be on a speaker by speaker basis.

The public comment does not apply to presentations being made by persons who are listed on the agenda. If there is a proponent on a position, it is policy to work with that proponent or opponent to set a time limit. There is a new provision in the policy, under
State law, which allows a speaker double the time (6 minutes) if there is a need for an interpreter.

Commissioner Long requested clarification around public comments topics, specifically, whether individuals who have submitted a speaker card can speak on any item, even if not on the agenda, or if they can choose to speak when a particular item is presented. General Counsel stated that there is a limit of three (3) minutes for items not on the agenda. For items that are listed on the agenda, the speaker is given an opportunity to speak during the consideration of that item. The reason being that often, after a report, there is information given that may have the speaker adjust their comments they can speak during general public comment as well as after an item is presented. Commissioner Alatorre asked if it was best practice to have the Commission vote on whether or not a person is allowed to speak more than three (3) minutes. General Counsel advised it was best practice to have the Chair make the decision as they run the meeting, but the Commission can counter the decision.

In the event that more than one person from the public raises their hand to comment, Mr. Alatorre suggested the Clerk advice as to who was first.

General Counsel added that the Brown Act requires only a brief comment or response can be given by the Commission. The Commission is not required to respond, but can provide direction to staff or ask for questions. Anything that the Commission does during Public Comment time has to be brief under State law.

Commissioner Atin moved to approve the recommendation for Formal Action Item 1. Commissioner Egan seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Kelly Long, and Debra Herwaldt.

NOES: None.

ABSENT: Commissioners Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

CONSENT

2. Approval of Ventura County Medi-Cal Managed Care Commission meeting Regular Minutes of September 29, 2018.

RECOMMENDATION: Approve the minutes.
3. Approval of the 2019 Ventura County Medi-Cal Managed Care Commission and Executive Finance Committee Meeting Calendar.

RECOMMENDATION: Approve the 2019 Commission and Executive Finance Committee Meeting Calendar.


RECOMMENDATION: Approve the contract extension as presented.

6. DHCS Contract Amendment – A26 Rates and New Language

RECOMMENDATION: Approve and authorize the CEO to execute DHCS contract Amendment A26.

7. State of California Contract Amendment A05

RECOMMENDATION: Approve and authorize the CEO to execute DHCS contact amendment A05.

8. Resolution Adopting Name Change of Consumer Advisory Committee to Community Advisory Committee

RECOMMENDATION: Adopt Resolution 2018-002 name change of Consumer Advisory Committee to Community Advisory Committee.


RECOMMENDATION: Approve GCHP to enter into an agreement with a qualified vendor for this technology in the amount not to exceed $1,249,365.

Commissioner Alatorre asked General Counsel for more information on Agenda Item 4 – Amended Conflict of Interest Code. General Counsel stated that certain positions within GCHP might deal with contractors or financials and the purpose of the code is to set forth types of disclosures, in terms of what interests an employee might have. The Form 700 ensures that the employee is disclosing to the public what their financial interests are so when performing their position, there is not a conflict. It also serves as a reminder to list gifts, and anything that might be a conflict. Each position is analyzed and the appropriate disclosure category is determined.
Commissioner Dial had a question on two agenda items that exceeded typical contract amounts, wanting to ensure the Commission was comfortable approving these items as
past practice was to review them separately rather than in conjunction with other items. All Commissioners stated they reviewed and did not have questions.

Commissioner Long moved to approve the recommendations for Consent items 2 through 9. Commissioner Herwaldt seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Kelly Long, and Debra Herwaldt.

NOES: None.


Commissioner Alatorre declared the motion carried.

PUBLIC COMMENT

None.

REPORTS

10. Chief Executive Officer (CEO) Report

RECOMMENDATION: Accept and file the report.

CEO Villani provided updates on the following topics:

- **2018 DHCS Quality Award:** DHCS awarded GCHP the 2018 Overall Most Improved Award for Quality Care. The Plan ranked 50th last year and has moved up significantly to 31st position.

- **GCHP Data Breach:** CEO Villani advised that all affected by the breach, which occurred through a single phishing attack, were mailed notifications and the Plan met all regulatory breach reporting requirements. The Plan also offered additional identify protection through ID Theft for the impacted members and employees. Currently there are no financial impacts that GCHP is aware of. Additionally, staff is performing due diligence in training and will continue employee information security awareness education efforts.

Commissioner Alatorre asked if the State or HHS is coming in to audit the Plan. Compliance Officer Brandy Armenta stated that GCHP has been contacted by OCR (the Office of Civil Rights) and they will conduct an investigation of the breach. Commissioner Alatorre asked if there were policies and procedures for both security and privacy. Compliance Officer Armenta stated there are policies for privacy and on the IT security side new policies are being created and updates are being completed on policies and procedures. Commissioner Alatorre asked if there were policies prior to this incident. CAO Scrymgeour responded yes, some
were in finalized format and some were in draft. Currently draft reviews are being finalized for formal approval by the State. Commissioner Alatorre asked if the Commission has to approve the privacy and security policies and procedures. Compliance Officer Armenta stated both privacy and security policies are required to go to Department of Health Care Services for review and approval.

General Counsel, Scott Campbell added that GCHP has cyber-security insurance. Commissioner Long asked about employee training. CAO Scrymgeour stated information and security awareness training began last fiscal year, as well as phishing simulations. Currently more targeted trainings will be done for specific departments upon review of findings. Compliance Officer Armenta stated that HIPAA training has been in place since the start of the plan and it is a contractual requirement. Trainings are updated annually.

- **DHCS Adult Expansion (AE) Financial Reconciliation (January 2014 – June 2016):** The State reviewed payments made around Adult Expansion and the need to reach an 85% MLR to determine any monies owed back to the State. GCHP was ready to make payment, but DHCS was not ready to accept (or process) it. Our financials show we accrued on the monies owed. In setting initial rates for the AE population, DHCS established them based on seniors and persons with disabilities – the group with the highest rate of reimbursement – as DHCS had no utilization experience for this population and did not know what utilization would be. The State notified GCHP last week that pay back needs to be issued.

- **AmericasHealth Plan Pilot:** Both teams have taken direction from the Commission and have worked on materials to present - AHP will provide their proposal. GCHP asked specific direction from the Commission when this project started in June 2017 to approve specific items for the Plan-to-Plan contract. Minutes reflect that on June 26, 2017, Commissioner Dial motioned to direct staff to begin a negotiation for an at-risk contract with AHP. The contract would be a pilot in compliance with the Plan's policies, specifically identifying goals, outcomes, and financials, with a limited number of patients. Commissioner Atin seconded the motion. CEO Villani noted that he received a call from the Clinicas team advising that CEO Tom Smith was no longer with AHP and that the interim AHP CEO is Antonio Alatorre.

- **Healthcare Policy Update:** CAO Melissa Scrymgeour reported on healthcare trends and review of systems. GCHP staff recently attended the annual CAHP Conference. Discussion was held on the national and state level trending of healthcare cost containment. At the national level, 18% of GDP is spent on healthcare with an increasing federal deficit, which is not sustainable. The focus is on controlling healthcare costs at both the national and state levels, which will bring more pressure for local health plans. Health reform will also be a big focus with the new governor, with the possibility of a publicly operated health plan, which would compete with private insurance. It was noted that DMHC is pushing for local health plans to become Knox-Keene certified.

In October, the Department of Homeland Security (DHS) modified the Public Charge Policy as it applies to immigration status. They are modifying the level of
public assistance an individual receives in determining whether to deem someone as a public charge. If deemed as a public charge, it can negatively impact immigration status. This can impact the health care of immigrants residing in the U.S. CEO Villani stated that in California, the children of undocumented immigrants will be at risk. GCHP can take a public position against this policy, as it impacts this community and the State. Commissioner Alatorre asked if CAHP was providing comment. CAO Scrymgeour stated that LHPC was taking a collective position.

- **DHCS Medical Audit Final Report**: Compliance Officer Brandy Armenta stated GCHP received two findings, both in non-clinical areas: 1) HIPAA – Finding related to a sub-contractor not adhering to the business agreement of notifying the Plan within 24 hours of identifying a breach. GCHP is currently working on a response to DHCS. 2) Fraud, Waste and Abuse - Processes are in place in multiple departments, however policies and procedures needed to be updated to clearly document the interconnectivity to multiple departments responsibility and hand offs associated with them. Responses are due November 2, 2018, then DHCS has a thirty- day turn around on accepting the Plan’s response or requesting more information. The Commission will be kept apprised.

Commissioner Dial moved to accept and file Agenda Item 10 - CEO Update. Commissioner Herwaldt seconded.

**AYES:** Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Kelly Long, and Debra Herwaldt.

**NOES:** None.

**ABSENT:** Commissioners Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

**FORMAL ACTION**

**11. Quality Improvement Committee Report – Third Quarter**

**RECOMMENDATION:** Approve and file the report as presented.

Chief Medical Officer Nancy Wharfield, M.D., presented highlights of the QIC third quarter report. There were minor revisions to the work plan for 2018, involving reassignment of responsibilities. Two additional low performing metrics were included and a high performing metric was removed. There have been minor changes to HEDIS specifications; the change in the immunization measure requirement may make it harder to capture and document performance. The other is a change in monitoring blood pressure, which makes is easier to capture information. There are a number of improvement projects in place for low performing measures – those are things that happen in clinics, where there will be small projects to test interventions,
work on lab data and communicating the HEDIS requirements out to providers. There is a year-end care gap closure in process with a vendor partner – ELIZA. ELIZA will reach out to over 40,000 members via phone. GCHP gives them the information where care gaps exist. They will assist in closing those gaps by scheduling an appointment with their home clinic to get the care gap closed.

Commissioner Alatorre asked about the immunization project and requested a report on the HEDIS results for improvement on immunization rates. CMO Wharfie stated those improvement projects are interventions to improve the capture of the HEDIS results. A measure was identified that needed improvement and there was grant money given out to improve systems in order to capture information and potential earnings for clinics were different, they were graded and rewarded on percent improvement. Clinicas earned about half of the money that was available. No money was given unless the goal was achieved.

Commissioner Dial moved to accept and file Agenda Item 11 – Third Quarter Quality Improvement Committee Report. Commissioner Atin seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Kelly Long, and Debra Herwaldt.

NOES: None.

ABSENT: Commissioners Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Commissioner Alatorre declared the motion carried.


Chief Financial Officer Kashina Bishop presented a PowerPoint which addressed membership trends, August fiscal year-to-date medical expenses, a financial statements summary, and June 30, 2018 adjustments. She noted that the final determination letter for the Expansion MLR Reconciliation was received. It related to prior years, therefore June 30 financial statements are being adjusted due to significant changes.

The membership trend was reviewed by CFO Bishop giving a brief explanation which included current membership in August along with expected retroactive increases.

A graph with a three-year comparison of per member per month (PMPM) medical expenses by major categories and the medical expense section of the August 2018 Statement of Revenues, Expenses and Changes in Net Assets was also reviewed. Ms. Bishop highlighted the more significant variances from budget – Inpatient, Physician Specialty, Applied Behavioral Analysis and Mental Health, and Pharmacy. Commissioner Dial asked about the difference between primary care physician
capitation and primary care physician payments. CFO Bishop stated those are only on fee-for-service primary care. A chart showing the difference between volume versus cost was recommended. The inpatient variance is related to an unusually high claim. The physician specialty variance seems to be driven by an increase to Diagnostic Radiology and Emergency Medicine. ABA and Mental Health increase is due to Beacon claims submitted to GCHP were 36% higher, which is related to prior months’ dates of service. Ms. Bishop noted while it is too early in the year to assess if the variance noted in those service categories will continue to trend above budget, the pharmacy expense is real-time data; within two months, GCHP is $1.7M over budget. If this continues and not offset somewhere else, it could potentially turn into a $20M loss. Commissioner Atin asked if this trend has anything to do with PBM/pharmaceuticals costs growing at a faster trend. Dr. Wharfied responded that there are new drugs on the market and they can be very costly. Commissioner Alatorre noted that the County is not moving forward with 340B Program, and could specialty drugs also have caused an effect on the budget.

For the month of August, the Plan experienced a loss of just under $1M, but this is still in line with budget expectations. Fiscal year-to-date revenue is above budget by $1.7M. Medical costs are running at $282 PMPM and were are over budget by approximately $4M. The medical loss ratio is running at 95%. Administrative costs are currently under budget, but there are large project costs that have not been included yet. Interest income is expected to drop significantly once funds are returned to the State. CFO Bishop stated there were some adjustments to the June 2018 financial statements. Due to the MLR adjustments there have been significant adjustments to revenue.

Commissioner Long moved to accept and file Agenda Item 12 – August Financials Report. Commissioner Alatorre seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Kelly Long, and Debra Herwaldt.

NOES: None.

ABSENT: Commissioners Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

13. Fiscal Year 2017-18 Audit Results

RECOMMENDATION: Approve and accept the FY2017-18 Financial Audit results.

Moss Adams representatives, Kimberly Sokoloff and Stelian Damu, reviewed the audit financial statements and audit results. Hard copies of the audit results were handed out to the Commission along with a draft report. Moss Adams stated the financial statements that were prepared are free of material errors. The auditors’ responsibility is to audit the financial statements. Management puts together all the
information and Moss Adams audits and ensure they are put together in accordance with accepted accounting principles. Moss Adams is required to report all significant findings during the audit. The audit was completed as planned.

Accounting policies were reviewed and evaluated and it is determined if they are properly implemented. Disclosures were reviewed and there were no unusual items noted. Control testing was done. There were two items that were found to have significant deficiencies: 1) Provider Rate upload - final executed contract rates were not uploaded to the system in a timely manner, correct amounts were reflected and there are no errors in the financial statements. This was highlighted to management and remediation efforts have been put in place. 2) Conduent (outsourcer responsible for claims processing) - Documentation issues and control weaknesses were noted. Management is working with Conduent, and no significant difficulties or errors were found. Inquiries were also made for potential fraud and there were not areas of fraud risk found.

Commissioner Atin inquired whether any other plans go through an internal control audit, and whether GCHP should go through an internal control audit. CFO Bishop stated that she had reviewed the work of the consultant engaged to provide internal work and had found no significant benefit to continue with the services. Additionally, staff presented this topic to the Executive Finance Committee, with agreement on the recommendation to move away from the internal audits and assess the future need if potential risks are identified through the financial statement audit. She noted that the biggest risk is claims, and currently Compliance does delegation oversight for Conduent. CFO Bishop noted that Moss Adams reviews all internal controls and a detailed report of all deficiencies that have been identified by Moss Adams and what GCHP is doing to remediate will be reported to the Executive Finance Committee.

Commissioner Herwalt moved to accept and file Agenda Item 13 – Fiscal Year 2017-18 Financial Audit results. Commissioner Long seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Kelly Long, and Debra Herwalt.

NOES: None.

ABSENT: Commissioners Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

14. Interim Chief Diversity Officer

RECOMMENDATION: Provide direction to staff and approve the contract extension.

General Counsel, Scott Campbell presented information on a one year extension with TBJ Consulting for the Interim CDO (Ted Bagley) contract. Both the original contact
and the proposed contract were available for the Commission’s review. The proposed contract is for an extension of an additional year, through the end of 2019.

Commission Atin stated he supports the extension and looks forward to Mr. Bagley’s continued efforts in working with GCHP staff.

Commissioner Atin moved to accept and file Agenda Item 14 – Chief Diversity Officer Contract Extension. Commissioner Long seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Kelly Long, and Debra Herwaldt.

NOES: None.

ABSENT: Commissioners Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

Mr. Bagley called for point of order: He stated that he appreciates the contract extension and believes things are going well. Mr. Bagley stated that the one year extension is contingent upon working successfully on both sides. If at any point CEO Villani does not believe it is going in the direction he expects, or the Commission does not feel that Mr. Bagley is going in the right direction, then something should be done. This position is about results - getting things done. It is not about relationships or attitudes; it is about ensuring GCHP is in a positive light.

15. AmericasHealth Plan (AHP) / Gold Coast Health Plan (GCHP) Joint Presentation

Commissioner Alatorre asked Dr. Dial to step in as Chair during this presentation and recused himself from the discussion at 3:42 p.m. due to conflict of interest and left the dais and sat in the audience.

Chief Operating Officer, Ruth Watson, stated she will be joined by Sonia DeMarta, AmericasHealth Plan Chief Financial Officer and Anita Guevin, AHP Compliance Officer.

COO Watson stated both teams met on two occasions to review the list of requests. A PowerPoint was presented with the list made by the Commission. Both AHP and GCHP have come to an agreement on the boilerplate and are ready to submit to the State. Compliance Officer Armenta stated there is one part of the boilerplate that AHP legal counsel had questions around therefore GCHP counsel followed up with staff and the updated version is being finalized. COO Watson stated the next outstanding item is the AHP State proposal, which refers to how membership is selected. This is also ready for submission to the State. The division of financial responsibility (DOFR), which is a comprehensive document, was sent to the Commission with a summary page listing what is and what is not covered under the
pilot. There is a high-level financial agreement on rates, but until the boilerplate gets approved by the State, it might need to be fine-tuned.

Performance metrics: GCHP worked with AHP on details and Commissioners have a formal document for their review. Commissioners also requested more information on the value proposition, and AHP representatives will do that review.

The next step would be Commission approval, but there is no quorum on this date. Once there is final approval, the pilot will go to DHCS, GCHP’s regulator, for approval and at the same time go to the Department of Managed Healthcare (DMHC) for approval, as they are the governing body for AHP. Once all State regulatory agency approvals are issued, our Compliance Officer will do a readiness assessment.

The Commission had also requested information on the ROI. If this is a pass-through capitation, there is no savings. GCHP would have to conduct vendor oversight, so GCHP would lose money. If there is a 2.5% withhold, in which GCHP would keep some money, there is a potential savings of $192,000 minus vendor oversight. If 5% is withheld on the premium, there would be $385,000 potential savings to GCHP minus administrative costs that would be incurred.

Commissioner Atin asked if the pilot set up is done the same way it would be done with a larger group. COO Watson stated it was scalable and there would be a more significant impact on the metrics if it was a larger population (more than 5,000). Commissioner Egan asked if the required TNE is the required TNE from AHP. COO Watson stated it was GCHP’s TNE. Therefore, it is a reduction of our TNE requirement from the State.

AHP’s CFO Sonia DeMarta reviewed a PDF handout with the Commission. The pilot is for 5,000 members which will be done by random choice. CFO DeMarta stated that those members who choose to be part of the pilot will have a smooth transition without any interruption of data flow. Clinicas will provide primary specialty care as well as health education, behavioral health, lab, imaging, tests and prescription fulfillment. AHP will provide all coordinated, institutional care, platform utilization management and monitor care quality. AHP would like to keep families together for the pilot program.

Anita Guevin, AHP Compliance Officer, provided an overview and clarified how the pilot will work. She noted that AHP will have a dual regulator because they have a limited Knox-Keene license. Once the pilot is in place, AHP will be responsible for the institutional, primary, and specialty risk.

CFO DeMarta began review of questions made by the Commission. AHP currently has several plan-to-plan arrangements and they track their performance. AHP believes they will give added value to GCHP. They have the infrastructure, the skills and ability to manage inpatient population. The pilot allows for the coordination of institutional care, which is crucial for a complete care model. The 5,000 members assigned to AHP will not lose their Clinicas PCP, therefore the transition will be smooth. The only time there will be a notable change is if the patient is hospitalized.
AHP offers a large network of specialists in both Los Angeles and Ventura County. Clinicas and AHP both use a common medical management system, which integrates both in-patient and institutional care, assisting in better communication and oversight of member health planning. The pilot proposal will add value by giving additional protection for the members as it will compliment what GCHP is currently doing for them; giving the member dual oversight. Cost savings will allow GCHP to shift the full financial risk for these members over to AHP for a fixed monthly capitation fee. AHP will provide the nursing staff to coordinate in-patient care, perform quality assurances and utilization management; all costs that GCHP will not have to incur. Additionally AHP will carry the insurance for these members and also carry the IBNR reserves for member care, which would also be a reduction in cost for GCHP. The four major categories of metrics were briefly reviewed – member experience, provider experience, quality of care and appropriate utilization of services. Currently there are no specified benchmarks for the outcomes because it is a small population and currently AHP does not know the population that they will be receiving. They are focusing for improved metrics over the current year.

Commissioner Herwaldt asked if the fixed monthly capitation fee had been negotiated. Ms. DeMarta stated the administrative DOFR has not been finalized and the capitation rates have not been broken into sub-groups or specific amounts. Commissioner Herwaldt stated that Commissioners have not been given that information for review as yet. COO Watson stated it will not be given, as it is a provider agreement and actual contract rates are confidential. Commissioner Herwaldt asked what oversight on inpatient side AHP will provide. Ms. DeMarta stated they will provide a coordinated integrated system. Clinicas oversees the primary care of the member. If that member goes into the hospital, GCHP takes over. GCHP and Clinicas are on two different health care technology systems and those systems do not speak to each other. Therefore the member is away from their PCP during that time. When the member comes out of the hospital, that member could have a different prescription plan or different lifestyle changes that they need to make, but that data is not transmitted to Clinicas.

Commissioner Herwaldt asked if there were costs associated with the integrated system. Ms. DeMarta stated the integrated system is on the AHP/Clinicas side, and it is already in use with some of the other plan-to-plan contracts. CMO Wharfield stated that GCHP uses their own medical management system where both inpatient and outpatient care is reviewed. What is missing is that GCHP and AHP/CDCR are not connected directly to the hospital’s EHR system and their medical records.

Commissioner Long raised a concerned around potential HIPAA violations for members. Ms. Guevin stated it was randomizing the numbers so there is no patient data put into the database. COO Watson stated it was members that have already been assigned to Clinicas. The members would have to opt in to be part of the pilot. Commissioner Long asked what happens after one year. COO Watson stated the Commission gets to see the result of the metrics and there is an option for additional years. This is a limited risk contract and there is an option for the member to opt out of the pilot.
Commissioner Long asked if there is any liability for GCHP. COO Watson stated the GCHP is responsible for the care of members. GCHP will report to the Commission after six months of the pilot. Compliance Officer Armenta stated that an audit will be done every six months due to it being a pilot program. COO Watson stated that once the State approves the boilerplate and the metrics, the baseline will be presented to the Commission. Commissioner Herwaldt asked how long it will take to get the 5,000 members for the pilot. Ms. DeMarta stated that she believes that the Clinicas members will be happy to continue their continuity of care.

Commissioner Dial stated that AHP will not be responsible for the pharmacy care but what about the cost if the member needs long term care, at whose cost? Ms. DeMarta stated that it would be at the cost of AHP. Commissioner Dial asked who will pay for specialty service. Ms. Guevin stated that would be handled via utilization management requirements. Commissioner Dial stated that there will probably be a lot of young moms in this pilot, what happens to the newborn if the pilot is over the 5,000 member mark. Will someone need to drop off in order not to exceed the 5,000 members? COO Watson stated there is some flexibility and the pilot can go slightly over 5,000.

The next steps: Due to lack of quorum, this item will need to be revisited for final approval. COO Watson noted that the State takes 60 days to get a response back to GCHP. Commissioner Dial stated that a special meeting will need to be scheduled. Commissioner Atin asked if the next meeting will include all rates, all metrics and all major provisions.

Commissioner Alatorre returned to chair the meeting.

16. Chief Medical Officer Update

Chief Medical Officer, Nancy Wharfield, M.D., highlighted the following from her report:

- **Quality:** Reviewed chart showing improvements in quality.

- **Pharmacy:** The California Pharmacy Association proposed some contract considerations. Everything that was suggested was agreed to by OptumRx and a contract amendment is being finalized to reflect the changes. Additionally, the Plan has engaged an independent firm to conduct a MAC audit. A report of the findings will be presented once the audit is complete. Dr. Wharfield also reviewed the pharmacy trend graphs. Commissioner Long asked about the prevention of diabetes. CMO Wharfield stated currently there is disease management in place and the State has mandated that there be a Diabetes Prevention Program and GCHP is looking into doing so.

Commissioner Dial moved to accept and file Agenda Item 16 – Chief Medical Officer Report. Commissioner Herwaldt seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Kelly Long, and Debra Herwaldt.
NOES: None.

ABSENT: Commissioners Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

17. Chief Diversity Officer Update

Interim Chief Diversity Officer, Ted Bagley, reviewed tactical activities. Mr. Bagley explained that these activities help to maintain internal and external relationships in the community. He reviewed his Plan Activities document, which was presented when the process was initially started. He reviewed items on the document, both internal procedures and policies, as well as developing community relationships. Commissioner Long stated she appreciated the performance evaluation and that he is hitting the metrics. Commissioner Dial asked if Mr. Bagley has provided feedback to the Board of Supervisors on what he has done while in the position of CDO. Commissioner Long stated she would like an update to the Board of Supervisors at an upcoming meeting. Mr. Bagley stated he would be happy to present.

18. Chief Operating Officer Update

Chief Operating Officer, Ruth Watson gave a brief update on the enterprise transformation Project (ETP). Phase I, which is Initiation, has been completed. The project is baselined and the team is continuing to work on sub-plans for different supporting initiatives. The requirements phase has begun and there are many requirements that have been developed between Conduent and VBA. The major requirement phase for employees starts in November and goes through February.

The Community Advisory Committee (CAC) is a sub-committee of the Commission and they would like to be more engaged with the Commission. CAC is currently working on items they would like to present to the Commission as it relates to members. Margaret Tatar did a facilitative session with CAC on how they can be most effective. In the first quarter of 2019 CAC will do their first presentation to the Commission.

Membership numbers were reviewed as well as call center performance. The call center is located in Lexington, Kentucky. An Amazon call center moved into the area, taking many call center employees. Due to the loss of employees, it affected call center performance. We are currently working with Conduent and they have established an overflow call center in Tempe, Arizona. Fourteen new employees have been hired, along with a supervisor. A third party will be reviewing call center processes to ensure they are following best practices. It is expected that the call center performance will be corrected by December of 2018.

Directed Payments with the State of California were highlighted. Directed payments are on the forefront Proposition 56, which is the physician supplemental payment program. There is an EPP program, which includes a public enhanced payment program, public hospital quality incentive pool, and private hospital directed payment. The only thing we
are paying on is a pass-through of Prop. 56. We have completed payments for fiscal year 2017/18, are starting on 2018/19.

Commissioner Dial asked about the distribution of membership by provider/member type: 40% of members are with VCMC, 19% are with Clinicas and 15% are with CMH. Medi-Medi’s are with no particular group? COO Watson stated the Medi-Medi’s are administrative members. We don’t see much of them until they become long-term care. Commissioner Dial noted that the absence of a CMH representative on the Commission, even they are a major provider. CEO Villani stated representatives are selected according to how Plan bylaws are written. The Hospital Association of Southern California nominates the two representatives for the Commission. The Board of Supervisors would need to address the bylaws to make changes. General Counsel Campbell stated the ordinance set by the County sets forth the categories and it has two set aside for hospitals, but that can always be changed. If the Commissioners have thoughts on what they believe would be the right composition of the Commission it could be presented to the Board of Supervisors.

Commissioner Alatorre moved to accept and file Agenda Items 17 and 18 – Chief Diversity Officer Report and Chief Operating Officer Report. Commissioner Dial seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Kelly Long, and Debra Herwaldt.

NOES: None.

ABSENT: Commissioners Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

CLOSED SESSION

The Commission adjourned to Closed Session at 5:34 p.m. regarding the following items in the following order:

19. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION

(Paragraph (1) of subdivision (d) of Section 54956.9)

Name of Case: Shannon Fleming v. Ventura County Medi-Cal Managed Health Care Commission et al, VCSC Case No. T181951

20. REPORT INVOLVING TRADE SECRETS

Discussion will concern: Rate for PBM program.

Estimated date of public disclosure: three years from the implementation of rates.

Commissioner Egan recused herself at 6:19 p.m.
21. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One case.

22. PUBLIC EMPLOYEE PERFORMANCE EVALUATION

Title: Chief Executive Officer

REPORTABLE ACTION

The Commission unanimously voted not to appeal the Department of Health Care Services letter.

COMMENTS FROM COMMISSIONERS

None.

ADJOURNMENT

Commissioner Alatorre motioned to adjourn the meeting. Commissioner Long seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Lanyard Dial, M.D., Narcisa Egan, Kelly Long, and Debra Herwaldt.

NOES: None.

ABSENT: Commissioners Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar, M.D., and Jennifer Swenson.

Commissioner Alatorre declared the motion carried.
The regular meeting ended at 6:47 p.m.

Approved:

________________________________________
Maddie Gutierrez, CMC
Clerk to the Commission
AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission (VCMMCC)

FROM: Dale Villani, Chief Executive Officer

DATE: January 28, 2019

SUBJECT: Contract Approval – Consulting Services Agreement: DR Management Services

SUMMARY:

The VCMMCC approved the funding associated with the ASO Core Replacement Project, now referred to as the Enterprise Transformation Project ("ETP") at the April 23, 2018 commission meeting. The approved funding of $5.5MM includes the associated costs of using specialized external vendors to supplement GCHP’s ETP related activities. Previously, GCHP managed this project using existing staff also responsible for managing the Plan’s day-to-day business. Given the critical importance of this initiative, senior leadership decided to engage the services of a dedicated and experienced senior executive resource to oversee all aspects of the project. GCHP has identified and is recommending approval to contract with DR Management Services (DRMS) in support of migrating its core administrative technology to a new platform.

BACKGROUND/DISCUSSION:

DRMS specializes in the implementation of healthcare core administrative platforms, with extensive background in managed care in a government setting and an in-depth understanding of DHCS compliance requirements within this capacity. DRMS has a successful performance track record that includes senior level oversight for a number of local health plans’ core administrative migration programs and other initiatives, including Alameda Alliance for Health and San Francisco Health Plan.

GCHP considered other contracting firms and determined that DRMS’s unique knowledge and expertise of the CA Medi-Cal managed care model and direct work with other local health plans in implementing their core technology platforms is critical to the successful implementation of this transformational, enterprise initiative.

The criteria used for vendor selection included cost, credentials and availability. GCHP compared market rates to resources who offer similar services and found DRMS’ rates to be comparable or better, therefore allowing GCHP to manage the ETP project within the approved budget.

This agreement is a non-requirements contract, allowing GCHP to receive services at a negotiated fixed rate of $225/hr., with an initial term from December 3, 2018 until June 5, 2020 (anticipated duration of the ETP project). GCHP has the option to renew or cancel with a sixty (60) day notice at the end of the initial term.
FISCAL IMPACT:

There is no impact to the approved funding for the ETP project. The amount included falls within the approved $5.5MM project funding.

The total estimated value of this contract is $800,000. The amount is based on the estimated project work effort – 3,155 hours over 19 months at $225/hr. – including estimated travel and expenses. These project expenses will incur over multiple fiscal years.

RECOMMENDATION:

It is the Plan’s recommendation to authorize the CEO to execute the consulting services agreement with DR Management Services for a not-to exceed amount of $800,000 in support of the ETP project.

If the Commission desires to review this contract, it is available at Gold Coast Health Plan’s Finance Department.
AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: January 28, 2019

SUBJECT: Contract Approval – Solera for Diabetes Prevention Program Mandate

SUMMARY:

On November 20, 2018, DHCS released APL 18-018 mandating Plans offer a Center for Disease Control (CDC) recognized Diabetes Prevention Program (DPP) beginning January 1, 2019. Staff is requesting approval for a one-year agreement with Solera Health to provide an approved DPP for an amount not exceeding $99,300.

Diabetes is a leading contributor to death and disability in the United States. According to the CDC, one in four health care dollars are spent on people with diagnosed diabetes. In California alone, that is more than $27.6 billion a year. For GCHP membership, diabetes is the plan's top disease category for medications and is within the top five most expensive chronic conditions. Research indicates that 25% of prediabetic individuals will develop Type 2 diabetes within 5 years. In Ventura County, nearly 28% of Ventura County adults are obese and/or at risk of developing diabetes (CHIS, 2016).

Research shows that lifestyle modification is the cornerstone of diabetes prevention with evidence of a 40%-70% relative risk reduction. Therefore, in order to rein in the cost of diabetes and improve the quality of care for this population, DHCS has mandated a focus on prevention through an approved CDC evidence-based lifestyle change program.

Currently, Ventura County does not have an existing program that meets the CDC's National Diabetes Prevention Recognition Program (DPRP) requirements. Solera Health is an approved CDC DPP provider that has agreed to contract with and support local providers interested in becoming CDC recognized. In order to comply with the DHCS mandate, it is necessary to outsource the administration of a DPP to a qualified vendor for the first year.

FISCAL IMPACT:

This is an unfunded DHCS mandate with an implementation date of January 1, 2019. This was not included in the FY 18/19 budget. Even with low member engagement, it is estimated a DPP could avoid up to $1 million dollars in medical costs over 3 years.
RECOMMENDATION:

Staff recommends approval of $99,300 to fund the agreement with Solera Health to provide a DHCS-mandated, CDC-approved DPP for one year.
AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Nancy Wharfield, M.D., Chief Medical Officer
DATE: January 28, 2019
SUBJECT: Additional Funding for Inovalon Purchase Order

SUMMARY:
Staff is requesting to move $405,943.84 to an existing Inovalon purchase order. This amount is needed to ensure adequate funding of the PO for Inovalon through this HEDIS season and fiscal year. The contract ends June 30, 2019.

In April of 2016, Gold Coast Health Plan entered a 3-year contract with Inovalon, a HEDIS software vendor, to perform critical data collection, measurement calculations, medical record pursuit and abstraction, and reporting functions required by GCHP’s contract with DHCS.

Although there is no impact to the 2018-19 Commission approved budget for this effort, the original purchase order requires additional funds. Over the initial three years of this contract, unanticipated costs were incurred due to:

- Rate reconciliation and data mapping activity related to changing HEDIS vendors
- Increased data storage requirements
- Increased member count threshold requirements
- Increased medical record retrieval and chasing
- Evaluation of additional metrics required by Department of Health Care Services

FISCAL IMPACT:
There is no fiscal impact to GCHP 2018-19 budget.

RECOMMENDATION:
Staff recommends approval of $405,943.84 additional funding for the Inovalon purchase order to align with anticipated expenses through June 2019.
AGENDA ITEM 6

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Dale Villani, Chief Executive Officer
DATE: January 28, 2019
SUBJECT: State of California Contract Amendment A28

SUMMARY

The State of California Department of Health Care Services (DHCS) establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A28 reflects changes to Gold Coast Health Plan (GCHP or Plan) capitation rates for FY2015-16.

BACKGROUND / DISCUSSION

GCHP received a revised contract amendment from DHCS on December 24, 2018 which formally reiterates updates to the Plan’s FY2015-16 capitation rates for certain Medi-Cal aid codes as follows:

- The amendment contains the FY2015-16 rates for the Classic and Adult Expansion (AE) populations to include funding for the Hospital Quality Assurance fee (HQAF) pursuant to Senate Bill (SB) 239 for the period July 1, 2015 to June 30, 2016.
- The amendment contains the FY2015-16 rates for the Classic populations to include funding for the Intergovernmental Transfer (IGT) for the period July 1, 2015 to June 30, 2016.
- The amendment contains the FY2015-16 rates for the AE population to include funding for the Cost Balance Payment pursuant to Assembly Bill (AB) 85 to the Designated Public Hospital. The amount was determined by the state’s actuaries, with agreement by the California Association of Public Hospitals.

FISCAL IMPACT

Amendment A28 memorializes rates included in a rate package received by GCHP on September 13, 2017. The capitation rates for the FY2015-16 apply to the Classic and AE
populations. As the Plan had recorded any associated revenue based on the rates in the rate package, there is no impact to the Plan’s net assets at this time.

Amendment A28 increased capitation rates for the FY2015-16 SB239 funds, and enabled GCHP to receive approximately $65.6 million for distribution to various hospitals that serve Medi-Cal and uninsured patients. The allocation of distributions was determined by the California Hospital Association. As a pass-through item, there was no impact to the Plan’s net assets.

Amendment A28 included rate increases necessary to effect the payment of the FY2015-16 IGT. The IGT funding included in the rates was treated as a pass-through item and did not impact the Plan’s net assets.

Amendment A28 increased capitation rates for the AE population to enable the Plan to process the FY2015-16 AB85 “Cost Balance” payment to the Designated Public Hospital. The impact to the Plan’s net assets was an increase of $4.2 million.

RECOMMENDATION

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendment A28.
AGENDA ITEM 7

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Dale Villani, Chief Executive Officer
DATE: January 28, 2019
SUBJECT: State of California Contract Amendment A29

SUMMARY

The State of California Department of Health Care Services (DHCS) establishes monthly capitation payments by major Medi-Cal population groups and updates them periodically to reflect policy changes and other adjustments. Amendment A29 reflects changes to Gold Coast Health Plan (GCHP or Plan) capitation rates for FY2016-17.

BACKGROUND / DISCUSSION

GCHP received a revised contract amendment from DHCS on December 24, 2018 which formally reiterates updates to the Plan's FY2016-17 capitation rates for certain Medi-Cal aid codes as follows:

- The amendment contains the FY2016-17 rates for the Classic and Adult Expansion (AE) populations to include funding for the Hospital Quality Assurance fee (HQAF) pursuant to Senate Bill (SB) 239 for the period July 1, 2016 to December 31, 2016.
- The amendment contains the FY2016-17 rates for the Classic populations to include funding for the Intergovernmental Transfer (IGT) for the period July 1, 2016 to June 30, 2017.
- The amendment contains the FY2016-17 rates for the AE population to include funding for the Cost Balance Payment pursuant to Assembly Bill (AB) 85 to the Designated Public Hospital. The amount was determined by the state's actuaries, with agreement by the California Association of Public Hospitals.

FISCAL IMPACT

Amendment A29 memorializes rates included in a rate package received by GCHP on May 7, 2018. The capitation rates for the FY2016-17 apply to the Classic and AE populations. As the
Plan had recorded any associated revenue based on the rates in the rate package, there is no impact to the Plan's net assets at this time.

Amendment A29 increased capitation rates for the FY2016-17 SB239 funds, and enabled GCHP to receive approximately $27.1 million for distribution to various hospitals that serve Medi-Cal and uninsured patients. The allocation of distributions was determined by the California Hospital Association. As a pass-through item, there was no impact to the Plan’s net assets.

Amendment A29 included rate increases necessary to effect the payment of the FY2016-17 IGT. The IGT funding included in the rates was treated as a pass-through item and did not impact the Plan’s net assets.

Amendment A29 increased capitation rates for the AE population to enable the Plan to process the FY2016-17 AB85 “Cost Balance” payment to the Designated Public Hospital. The impact to the Plan’s net assets was an increase of $5.0 million.

RECOMMENDATION

Staff is recommending the Commission approve and authorize the CEO to execute DHCS contract amendment A29.
AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: January 28, 2019

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 December 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 user per month
GDR: Generic dispensing rate
COHS: County Organized Health System
KPI: Key Performance indicators
RxPMPM: Prescriptions per member per month
PHARMACY COST TRENDS:

Total Cost vs. Utilizing Members

PMPM vs. Utilizing Percent
Total Claims vs. GDR

*Claim totals prior to June 2017 are adjusted to reflect net claims.

HEPATITIS C FOCUS:

Costs vs. Expected Kick-Payment (costs in thousands)

PMPM and PUPM Costs With and Without Hep C
PAID PER PRESCRIPTION:

![Graph showing dollars paid per prescriptions]

PRESCRIPTIONS PER MEMBER PER MONTH:

![Graph showing prescriptions per member per month]

*Calculation reflects net claims.
PRIOR AUTHORIZATION STATISTICS:

Prior Authorization
Denials and Appeal Rates

PBM OVERSIGHT:

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. As of November 12, 2018, call CAP items have been closed.

Pharmacy Monitoring:

<table>
<thead>
<tr>
<th>Issue Type</th>
<th>Number of Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA Board of Pharmacy Disciplinary Actions – Pending</td>
<td>2</td>
</tr>
<tr>
<td>CA Board of Pharmacy Disciplinary Actions – License Revoked</td>
<td>0</td>
</tr>
<tr>
<td>CA Board of Pharmacy Disciplinary Actions – Probation</td>
<td>2</td>
</tr>
<tr>
<td>OptumRx Audits – Appeal Complete; Termination Scheduled</td>
<td>1*</td>
</tr>
<tr>
<td>OptumRx Audits – Ongoing</td>
<td>1</td>
</tr>
<tr>
<td>DEA Investigations</td>
<td>1*</td>
</tr>
</tbody>
</table>

*One pharmacy listed in multiple categories.

340B DRUG DISCOUNT PROGRAM

Clinicas del Camino Real (CDCR) and GCHP continue to have discussions regarding the proposed 340B compliance contract GCHP provided to CDCR in early 2018.
AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Chief Diversity Officer

DATE: January, 2018

SUBJECT: Chief Diversity Officer Update

Community Relations

- Presented the CDO responsibilities at the Board of Supervisors monthly meeting.
- Currently serving on two community Boards: CSUCI Foundation Board and the Gold Coast Veterans Foundation Board. Participated on (2) community panels related to diversity.
- Served as advisor to the Martin Luther King March and Birthday Celebration held at the Oxnard City Park and Performing Arts Center in Oxnard (January 21, 2019).
- At his request, met with Supervisor Zaragoza to further discuss my role as CDO and discuss subjects such as: 1) Appraisal Process 2) Succession Planning 3) Community Relations 4) Supervisor training 5) Diversity Council.

Gold Coast Health Plan

- Held Diversity Council meeting at GCHP with a focus best practices of other area councils.
- Conducted five (5) diversity related discussions during the month and referred 4 other to HR for solution.
- By-weekly update meeting with Dale Villani and staff.
- CDO/HR still waiting the results of old lingering cases that are unresolved.
- Diversity Council reviewing last 2 years of promotions for fairness and equity.
- No new cases since we last met.

Upcoming events

Lunch and Learn 2019

- Subjects to include: Traits of a Good Leader, Personal Branding, Career Development, Time Management and Mentoring.

Work in Progress

- Diversity and Leadership desktop manual for managers. In early stages of development. Must be vetted with Executive team.
AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: January 28, 2019

SUBJECT: Chief Operating Officer Update

SUMMARY:

Community Activities Committee (CAC) – GCHP is looking forward to the first CAC meeting of 2019. We will be working with the Committee on goals for this coming year and planning a presentation of those goals to the Commission in the coming months.

Membership - GCHP membership for January 2019 is 194,013. The plan continues to experience churn in the membership while incurring a small decrease over the previous month. GCHP lost 679 (net) member in the month of January which includes a loss of 6,720 members, 4,130 new members and 2,617 retroactive members.

Adult Expansion for January was slightly lower with a total of 767 members. The AB85 50% assignment is 383 members, bringing the VCMC total to 27,240 or 41.4% of the target enrollment of 65,765 members, established by the state.

Governor Newsom recently released his budget for 2019. The budget included expanding Medi-Cal benefits to children past 19 to 26 years of age. GCHP currently has approximately 24,000 members who could become eligible for this extended benefit, if they pursue eligibility with Ventura County Human Services Agency (HSA). GCHP would have the ability to retain these members so long as they continue to meet the eligibility requirements of this aid code and proceed with the HSA redetermination process.

Call Center – Beginning December 3, 2018, Conduent implemented an additional call center in Tempe, AZ to service GCHP providers and members. The implementation of this call center has provided immediate positive impact to service.

In the several weeks since the live date, the call center metrics have all been within the contractual Service Level Agreement (SLA) requirements. The impact has resulted in members and providers speaking with an agent within 30 seconds or less, reduced call abandonment rates and improved talk times, all leading to an improved customer experience.
GCHP and Conduent continue to review the call center program for additional improvements including areas such as increased Interactive Voice Response (IVR) functionality, leading to caller self-serve capabilities. The plan to escalate the implementation of the new call center system continues and we will bring additional updates on timing back to the Commission when we have dates identified.

**Proposition 56** – Proposition 56 (also referred to as the “smoking tax”) allows for additional reimbursement to providers who see members for specified qualifying services.

The Prop 56 project began in 2018 for Fiscal year 2017/2018. GCHP received state funds and distributed the funds to providers with qualifying visits. The state recently approved funding for fiscal 2018/2019 with increased rates and service codes.

GCHP provides funding based on encounter and claim data submission. We review data on a monthly basis to determine which providers met the criteria for additional payment. We produce a report and a check to all providers who have satisfied the requirements.

Fiscal 2018/2019 rate increases and code changes will be implemented over the next six (6) weeks providing additional funding to qualifying provider visits.

**Provider Contracting and Credentialing Management System (PCCM)** – GCHP staff conducted a comprehensive RFP process to replace the current, home grown, provider network data base (PNDB) system, with one that is scalable, provides enhanced reporting, automates transactions and meets increased regulatory requirements.

Vistara a wholly owned subsidiary of Symplr was chosen through the RFP process. The contract was signed in December and planned implementation is scheduled to begin in March 2019. The Vistara provider data management and credentialing system is a robust workflow solution that will automate and streamline all aspects of provider data and credentialing management for the Plan and will serve to enhance contracting, network management, quality improvement, ongoing monitoring & compliance.

**Network Certification Project** – The Department of Health Care Services (DHCS) conducts an Annual Network Certification of its managed care health plans (MCPs) to certify the network adequacy of their provider network. GCHP is required to submit all required reports to the DHCS no later than 105 days prior to beginning of the Contract Year (July 1). March 16, 2019 is the required submission date for 2019. The Plan is using Quest Analytics to assist in this project along with working closely with Claims and the IT/DSS departments.

**Better Doctor** – GCHP is working on a comprehensive provider data remediation project to ensure complete clean-up of provider data. In order to verify and obtain the demographic information as quickly and efficiently as possible. To accomplish this the Plan will use Better Doctor - a software/service product with Quest Analytics, a current vendor. Better Doctor is
a primary source verified data management platform utilized by a number of health plans providing:
  o Single Source solution for network adequacy and data quality
  o Improved data quality, network visibility/adequacy
  o Fully compliant with CMS, NCQA, Medicaid & SB137
  o The provider portal is provides auditable attestations
  o Provider Directory Accuracy

Better Doctor will reach out to our 6,000 plus individual providers via a multichannel outreach (provider portal, email, fax, telephone to validate provider information. The Plan’s demographic provider data will be reviewed and updated on a quarterly basis. The term of our agreement with Quest Better Doctor is 1 year at which time will re-assess the contract and benefit.

**Medi-Cal Enrollment (Regulatory Requirement)** - DHCS All Plan Letter (APL) 17-019, required all Medi-Cal Plans to ensure that contracted providers are Medi-Cal licensed by December 31, 2019, requiring the Plan to terminate non-Medi-Cal licensed providers from the GCHP network. Anticipating a delay in the state licensing process, DHCS allowed MCPs to enter into an interim letter of agreement (LOA) with providers who submit proof to the Plan of DHCS’ acknowledgement letter showing that the provider has applied for Medi-Cal licensing.

Project progress to date:
- April 2018, GCHP Providers were notified through Provider Updates and Quarterly Provider Bulletins, with three (3) follow-up communications by phone e-mail and fax
- 565 out of over 4,000 contracted providers were identified as non-Medi-Cal licensed
- 228 providers were terminated as they were either deceased, retired or had no utilization for the past 5 years
- 337 providers required Medi-Cal licensure
- November 2018, letters sent to 337 non-Medi-Cal licensed providers
- 147 confirmed their application submission to DHCS and were contracted via Interim LOA’s
- 190 providers were terminated from the Plan – determined no significant implications regarding provider access or continuity of care
- GCHP Health Services and Member Services staff have been engaged in the process, working with providers and members to ensure an efficient transition of care as needed
Non-Medical Transportation (NMT) / Non-emergency Medical Transportation (NEMT)
RFP - The Plan has solicited the marketplace, received and evaluated proposals and will be making a recommendation to the Commission by no later than the March 2019 Commission meeting.

1. Member PCP Assignments

<table>
<thead>
<tr>
<th></th>
<th>VCMC</th>
<th>CLINICAS</th>
<th>CMH</th>
<th>PCP-Other</th>
<th>DIGNITY</th>
<th>MEDI/MEDI</th>
<th>ADMIN MBRs</th>
<th>UNASSIGNED</th>
<th>KAISER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov-18</td>
<td>79,232</td>
<td>38,244</td>
<td>28,795</td>
<td>5,571</td>
<td>4,090</td>
<td>23,427</td>
<td>11,424</td>
<td>3,943</td>
<td>5,026</td>
</tr>
</tbody>
</table>

Unassigned members are Newly Eligible/Enrolled
Administrative Member(s)

- Share of Cost (SOC): A Member who has Medi-Cal with a Share of Cost requirement.
- Long-Term Care (LTC): A Member who is residing in a skilled or intermediate-care nursing facility and has been assigned an LTC Aid Code.
- Out of Area: A Member who resides outside GCHP's service area but whose Medi-Cal case remains in Ventura County.
- Other Health Coverage: A Member who has other health insurance that is primary to their Medi-Cal coverage; this includes Members with both Medi-Cal and commercial insurance. Medi-Cal is the payer of last resort; therefore GCHP Members with other coverage must access care through their primary insurance.
## Operations Scorecard - December 2018

<table>
<thead>
<tr>
<th>Category</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Call Center</strong></td>
<td></td>
</tr>
<tr>
<td>Total Calls</td>
<td>9,562</td>
</tr>
<tr>
<td>Average Talk Time</td>
<td>7 min. 34 sec.</td>
</tr>
<tr>
<td>Average Speed of Answer</td>
<td>8 seconds</td>
</tr>
<tr>
<td>Abandonment Rate</td>
<td>0.00% (Goal ≤ 5%)</td>
</tr>
<tr>
<td>Call Quality Audit Scores</td>
<td>96.02% (Goal ≥ 95%)</td>
</tr>
<tr>
<td>Call Satisfaction Survey</td>
<td>97.63% (Goal ≥ 95%)</td>
</tr>
</tbody>
</table>

| **Membership**    |                               |
| Membership        | 194,013                       |
| Member Orientation Attendance | 9                          |
| Walk-Ins          | 24                            |
| MS Inquiries      | 284                           |
| Quality Audit Scores | 98.90% (Goal ≥ 95%)         |
| LTC Conversion Rate | 41%                         |

| **Claims**        |                               |
| Claims Received   | 188,658                       |
| Claims Processed  | 172,557                       |
| Turn around time  | 89.76% (Goal ≥ 95% within 30 days) |
| Days Receipt on Hand | 7 days                     |
| Financial Accuracy| 99.00% (Goal ≤ 5 business days) |
| Procedural Accuracy| 99.89% (Goal ≥ 97%)          |
| Auto adjudication Rate | 72.14%                  |

| **Grievance and Appeals** |                               |
| Grievance Totals       | 170                           |
| Member Griev per 1000 Mem | 9%                      |
| Appeals Totals         | 38                            |
| Appeals Upheld Rate    | 71%                           |
| Appeals Overturned Rate| 3%                            |
| Acknowledgement TAT    | 86%                           |
| Resolutions TAT        | 100%                          |

| **Operations Support** |                               |
| Total Encounters Submitted | 370,571                  |
| Total Encounter Quality (% of Errors) | 1.4%                     |
| Professional Quality (% of Errors) | 3.1%                     |
| Institutional Quality (% of Errors) | 13%                      |
| Pharmacy Quality (% of Errors) | 0.1%                     |
| DHCS Encounter Data Report Card | 2018 2nd Quarter 83.3%*    |

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Turn Around Time- Missed by .25%, claim volume reflecting increase for previous 2 months, tracking for January as claim volume remains high.

Days Receipt on Hand- Missed by 2 days, claim volume reflecting increase for previous 2 months, tracking for January as claim volume remains high.

Acknowledgement TAT- Missed by 12%, continues to be a challenge, remediation plan development underway to meet goal.

DHCS Encounter Data Report Card- Missed by 15% due to reprocessing of large volume of pharmacy claims.
AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Marlen Torres, Director, Government and Community Relations
DATE: January 28, 2019
SUBJECT: Association for Community Affiliated Plans (ACAP) – Policy & Research Fellowship Presentation: “Where Education, Employment and Health Meet”.

RECOMMENDATION:
Accept and file the presentation.

ATTACHMENTS:
Copy of the PowerPoint presentation.
AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Kashina Bishop, Chief Financial Officer
DATE: January 28, 2019
SUBJECT: November 2018 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached November 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 November 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

- For the fiscal year ended November 30, 2018, the Plan’s performance is a decrease in net assets of $8.5 million, which is an unfavorable budget variance of $6.5 million.
- November FYTD net revenue was $296.7 million, $2.7 million higher than budget.
- Cost of health care was $288.3 million, $15.0 million higher than budget.
- The medical loss ratio was 97.2% of revenue, which is 4.2% higher than the budget.
- The administrative cost ratio was 6.4%, 1.4% lower than budget.
- November membership of 199,103 which is 2,671 below the budgeted average.
- Tangible Net Equity was $123.6 million which represents two months of operating expenses in reserve and 392% of the required amount by the State.

Revenue – November FYTD net revenue was $296.7 million or $2.7 million higher than budget.

Revenue is in line with budget expectations. Proposition 56 funding was not included in budget as it was projected to be neutral to the bottom line. The Direct Payments line item
under medical expenses in the amount of $2.4 million is the associated expense for the additional Proposition 56 payments to providers.

Note: Proposition 56 increased the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including specified services in managed care effective July 1, 2017.

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 2019 is $94.5 million, accrued at a rate of approximately $7.9 million per month. The second quarterly installment of MCO tax was paid on January 14th. The total tax for FY2017-18 has not yet been funded by the state, as well as the current year’s (FY2018-19) MCO tax.

Health Care Costs – November FYTD health care costs were $288.3 million, which was $15.0 million higher than budget. The medical loss ratio (MLR) was 97.2% versus 93.0% for budget.

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 $5.9 million (11.3%).**
  There has been an increase to the number of high dollar cases – in the past several months, there has been 5 claims paid for Adult Expansion members that were each approximately $600,000. In addition, there was one claim paid of $1.6 million. Two of these cases are treatment of leukemia. The expense is partially offset by reinsurance claims; the reinsurance line item is a positive budget variance of $2.6 million.

- **Physician Specialty exceeded budget by $2.5 million (11.1%).**
  There has been a 15% increase to utilization, primarily driven by diseases of urinary systems, non-traumatic joint disorders, spondylosis, and disc and back problems. GCHP staff is working to drill down into the data to determine root causes of these increases.

- **Home & Community Based Services exceeded budget by $849,361 (11.7%).**
  The increase is in part related to hospice services that have steadily increased as a result of the Palliative Care benefit mandated by DHCS effective January 2018. There have also been significant increases to Qualified Physical Therapist in the Home, Home Skilled Nursing and Treprostinil injections.

- **Applied Behavior Analysis and Mental Health were $1.4 million (46.9%) and $855 thousand (31.9%) over budget, respectively.**
  There are several factors affecting the ABA and Mental Health expenses. There is an increase in utilization of services as displayed in the following graphs:
In addition, it appears that Beacon is holding claims and continues to have a backlog. Beacon is currently on a Corrective Action Plan for this issue. This creates volatility in estimating the current expense with claims lag.

- **Pharmacy exceeded budget by $3.9 million (7.6%).**
  The primary drug class driving the increase is dermatologicals. There has been a steady increase in utilization as displayed below:

There have been several recent actions by the Pharmacy and Therapeutics Committee to remove high cost dermatological generics and non-FDA approved drugs that should result in reduced pharmacy expense in 2019 by approximately $800,000 per month.
• **Provider reserve in the amount of $1.2 million was not budgeted.**
  This is accrued amounts based on the potential for a provider to earn back all or a portion of withheld capitation under an incentive program.

**Adult Expansion Population 85% Medical Loss Ratio** —In October, the Plan received from the DHCS the AE MLR Determination Letter which contained the final calculation of the amount due, which totaled $160.5 million. This amount was reimbursed back to the DHCS on November 5, 2018.

**Administrative Expenses** — For the fiscal year to date at November 30, administrative costs were $18.9 million or $15.2 million below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 6.4 percent versus 7.8 percent for budget.

**Cash and Short Term Investment Portfolio** — At November 30, 2018, the Plan had $155.4 million in cash and short-term investments; a decrease of $159.2 million from October. The decrease is related to the payment of amounts due to DHCS under the AE MLR Medical Loss Ratio determination. The investment portfolio included Ventura County Investment Pool $51.2 million; LAIF CA State 4.9 million; the portfolio yielded a rate of 1.99%.

**Medi-Cal Receivable** — At November 30, the Plan had $87.3 million in Medi-Cal Receivables due from the DHCS.

**RECOMMENDATION:**

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

**ATTACHMENT:**

November 2018 Financial Package
FINANCIAL PACKAGE
For the month ended November 2018

TABLE OF CONTENTS

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

<table>
<thead>
<tr>
<th></th>
<th>11/30/18</th>
<th>10/31/18</th>
<th>09/30/18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Assets:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Total Cash and Cash Equivalents</td>
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<td>$146,605,953</td>
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<tr>
<td>Total Short-Term Investments</td>
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<td>$188,028,887</td>
<td>$187,838,364</td>
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<tr>
<td>Medi-Cal Receivable</td>
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<td>$79,902,390</td>
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<tr>
<td>Interest Receivable</td>
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<tr>
<td>Provider Receivable</td>
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<tr>
<td>Other Receivables</td>
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<tr>
<td>Total Accounts Receivable</td>
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<tr>
<td>Total Prepaid Accounts</td>
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<td>$1,842,790</td>
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<tr>
<td>Total Other Current Assets</td>
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<td>$135,560</td>
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<td><strong>Total Current Assets</strong></td>
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<td>$1,843,707</td>
<td>$1,888,602</td>
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<tr>
<td><strong>Total Assets</strong></td>
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<td>$409,302,196</td>
<td>$433,465,710</td>
</tr>
</tbody>
</table>

|                      |             |             |             |
| **LIABILITIES & NET ASSETS** |             |             |             |
| **Current Liabilities:** |             |             |             |
| Incurred But Not Reported | $42,543,027 | $41,753,512 | $41,077,683 |
| Claims Payable          | $30,856,279 | $35,959,430 | $35,697,420 |
| Capitation Payable      | $28,536,379 | $28,588,150 | $28,447,193 |
| Physician Payable       | $607,372 | $457,584 | $235,269 |
| DHC3 - Reserve for Capitation Recoup | $0 | $100,020,043 | $160,520,040 |
| Accounts Payable        | $1,644,104 | $2,028,262 | $2,452,595 |
| Accrued ACS             | $1,600,901 | $1,662,427 | $1,671,937 |
| Accrued Provider Reserve | $1,076,698 | $845,550 | $565,346 |
| Accrued Expenses        | $8,160,163 | $7,972,601 | $7,860,189 |
| Accrued Premium Tax      | $13,687,685 | $5,811,850 | $21,562,481 |
| Accrued Payroll Expense  | $1,073,406 | $1,175,421 | $1,448,218 |
| **Total Current Liabilities** | $129,585,394 | $286,780,830 | $301,744,373 |

|                      |             |             |             |
| **Long-Term Liabilities:** |             |             |             |
| Other Long-term Liability-Deferred Rent | $1,128,496 | $1,128,166 | $1,127,837 |
| **Total Long-Term Liabilities** | $1,128,496 | $1,128,166 | $1,127,837 |
| **Total Liabilities**      | $131,113,889 | $287,908,796 | $302,872,210 |

|                      |             |             |             |
| **Net Assets:**       |             |             |             |
| **Total Increase / (Decrease in Unrestricted Net Assets)** | $(8,507,694) | $(10,721,971) | $(1,521,871) |
| **Total Net Assets**   | $123,607,677 | $121,393,400 | $130,593,499 |
| **Total Liabilities & Net Assets** | $254,721,566 | $409,302,196 | $433,465,710 |
### Statement of Revenues, Expenses and Changes in Net Assets

**For Five Months Ended November 30, 2018**

<table>
<thead>
<tr>
<th></th>
<th>November 2018</th>
<th>November 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><strong>Membership (includes retro members)</strong></td>
<td>159,103</td>
<td>996,618</td>
<td>1,018,007</td>
<td>(21,391)</td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td>67,038,253</td>
<td>336,059,289</td>
<td>332,646,894</td>
<td>3,415,395</td>
</tr>
<tr>
<td>MCO Premium Tax</td>
<td>(7,975,415)</td>
<td>(38,377,076)</td>
<td>(38,084,287)</td>
<td>(692,779)</td>
</tr>
<tr>
<td><strong>Total Net Premium</strong></td>
<td>59,062,837</td>
<td>296,769,213</td>
<td>293,956,597</td>
<td>2,722,616</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>59,062,837</td>
<td>296,769,213</td>
<td>293,956,597</td>
<td>2,722,616</td>
</tr>
<tr>
<td><strong>Medical Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitation (PCP, Specialty, Kaiser, NEMT &amp; Vision)</td>
<td>5,042,827</td>
<td>25,425,367</td>
<td>24,777,763</td>
<td>(648,604)</td>
</tr>
<tr>
<td>FFS Claims Expenses:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>10,598,436</td>
<td>58,277,861</td>
<td>52,376,695</td>
<td>(5,901,282)</td>
</tr>
<tr>
<td>LTC / SNF</td>
<td>8,434,913</td>
<td>50,069,497</td>
<td>52,741,604</td>
<td>1,772,106</td>
</tr>
<tr>
<td>Outpatient</td>
<td>4,944,073</td>
<td>23,845,476</td>
<td>23,636,930</td>
<td>(5,040)</td>
</tr>
<tr>
<td>Laboratory and Radiology</td>
<td>246,529</td>
<td>1,557,420</td>
<td>1,435,857</td>
<td>(121,016)</td>
</tr>
<tr>
<td>Directed Payments - Provider</td>
<td>463,337</td>
<td>3,435,304</td>
<td>(2,435,304)</td>
<td>0.00%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>1,493,358</td>
<td>10,033,555</td>
<td>10,090,696</td>
<td>867,140</td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>4,731,492</td>
<td>24,611,207</td>
<td>22,386,208</td>
<td>(2,472,999)</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>1,231,437</td>
<td>6,029,280</td>
<td>6,161,296</td>
<td>(318,990)</td>
</tr>
<tr>
<td>Home &amp; Community Based Services</td>
<td>1,531,339</td>
<td>8,123,765</td>
<td>7,274,404</td>
<td>(849,361)</td>
</tr>
<tr>
<td>Applied Behavior Analysis Services</td>
<td>1,073,109</td>
<td>6,418,503</td>
<td>3,075,847</td>
<td>(1,442,656)</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>3,951,391</td>
<td>32,971,852</td>
<td>22,297,015</td>
<td>(154,634)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>11,390,471</td>
<td>56,873,337</td>
<td>51,952,095</td>
<td>(4,920,903)</td>
</tr>
<tr>
<td>Provider Reserve</td>
<td>231,146</td>
<td>1,178,698</td>
<td>-1,176,698</td>
<td>-0.00%</td>
</tr>
<tr>
<td>Other Medical Professional</td>
<td>284,747</td>
<td>1,631,440</td>
<td>1,340,607</td>
<td>(287,777)</td>
</tr>
<tr>
<td>Other Medical Care</td>
<td>5,720</td>
<td>24,559</td>
<td>-23,132</td>
<td>-0.00%</td>
</tr>
<tr>
<td>Other Fee For Service</td>
<td>817,105</td>
<td>2,478,894</td>
<td>3,773,717</td>
<td>(505,233)</td>
</tr>
<tr>
<td>Transportation</td>
<td>171,042</td>
<td>721,843</td>
<td>726,504</td>
<td>(4,663)</td>
</tr>
<tr>
<td><strong>Total Claims</strong></td>
<td>45,199,576</td>
<td>258,838,635</td>
<td>241,906,154</td>
<td>(17,696,481)</td>
</tr>
<tr>
<td>Medical &amp; Care Management Expense</td>
<td>1,247,297</td>
<td>5,867,845</td>
<td>6,195,189</td>
<td>337,344</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>(1,018,004)</td>
<td>(3,340,266)</td>
<td>(3,222,062)</td>
<td>204,203</td>
</tr>
<tr>
<td>Claims Recoveries</td>
<td>(189,992)</td>
<td>(2,569,468)</td>
<td>(2,479,468)</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>58,276</td>
<td>3,869,008</td>
<td>7,451,827</td>
<td>3,501,818</td>
</tr>
<tr>
<td><strong>Total Cost of Health Care</strong></td>
<td>53,300,679</td>
<td>288,360,001</td>
<td>273,333,734</td>
<td>(15,016,267)</td>
</tr>
<tr>
<td>Contribution</td>
<td>5,862,158</td>
<td>8,329,212</td>
<td>20,022,833</td>
<td>(12,293,615)</td>
</tr>
<tr>
<td><strong>General &amp; Administrative Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, Wages &amp; Employee Benefits</td>
<td>1,995,211</td>
<td>10,327,270</td>
<td>10,264,045</td>
<td>(73,225)</td>
</tr>
<tr>
<td>Training, Conference &amp; Travel</td>
<td>16,840</td>
<td>97,931</td>
<td>87,309</td>
<td>66.02%</td>
</tr>
<tr>
<td>Outside Services</td>
<td>2,085,017</td>
<td>10,197,578</td>
<td>11,159,747</td>
<td>599,168</td>
</tr>
<tr>
<td>Professional Services</td>
<td>323,493</td>
<td>1,159,515</td>
<td>1,054,141</td>
<td>425,626</td>
</tr>
<tr>
<td>Occupancy, Supplies, Insurance &amp; Others</td>
<td>642,944</td>
<td>2,832,363</td>
<td>3,273,161</td>
<td>450,807</td>
</tr>
<tr>
<td>Care Management Credit</td>
<td>(1,247,257)</td>
<td>(3,687,545)</td>
<td>(3,159,199)</td>
<td>(528,346)</td>
</tr>
<tr>
<td><strong>G&amp;A Expenses</strong></td>
<td>3,794,246</td>
<td>18,759,132</td>
<td>20,011,494</td>
<td>2,054,701</td>
</tr>
<tr>
<td>Project Portfolio</td>
<td>47,577</td>
<td>175,988</td>
<td>215,061</td>
<td>19,073</td>
</tr>
<tr>
<td><strong>Total G&amp;A Expenses</strong></td>
<td>3,841,825</td>
<td>18,933,721</td>
<td>22,073,144</td>
<td>4,099,424</td>
</tr>
<tr>
<td><strong>Total Operating Gain (Loss)</strong></td>
<td>2,020,333</td>
<td>(10,604,509)</td>
<td>(8,354,271)</td>
<td>(8,254,227)</td>
</tr>
<tr>
<td>Non Operating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenues - Interest</td>
<td>193,943</td>
<td>2,098,815</td>
<td>391,942</td>
<td>1,704,872</td>
</tr>
<tr>
<td>Total Non-Operating</td>
<td>193,943</td>
<td>2,098,815</td>
<td>391,942</td>
<td>1,704,872</td>
</tr>
<tr>
<td><strong>Total Increase / (Decrease) in Unrestricted Net Assets</strong></td>
<td>2,214,277</td>
<td>(8,507,854)</td>
<td>(1,957,339)</td>
<td>(6,549,515)</td>
</tr>
</tbody>
</table>
# Statement of Cash Flows

**November 2018**

<table>
<thead>
<tr>
<th>Cash Flows Provided By Operating Activities</th>
<th>FYTD 17-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Income (Loss)</td>
<td>$2,214,277</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>44,942</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>(4,579,397)</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>(89,731)</td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>(160,454,701)</td>
</tr>
<tr>
<td>Claims Payable</td>
<td>(5,005,135)</td>
</tr>
<tr>
<td>MCO Tax liability</td>
<td>7,875,415</td>
</tr>
<tr>
<td>IBNR</td>
<td>789,515</td>
</tr>
<tr>
<td><strong>Net Cash Provided by (Used in) Operating Activities</strong></td>
<td>(159,204,816)</td>
</tr>
</tbody>
</table>

| Cash Flow Provided By Investing Activities | |
|--------------------------------------------||
| Proceeds from Restricted Cash & Other Assets| | |
| Proceeds from Investments                  | 112,056,288 | 162,056,288 |
| Proceeds for Sales of Property, Plant and Equipment | - | - |
| Payments for Restricted Cash and Other Assets | - | - |
| Purchase of Investments plus Interest reinvested | (132,772) | (21,373,947) |
| Purchase of Property and Equipment         | | (49,377) |
| **Net Cash (Used In) Provided by Investing Activities** | 111,923,516 | 140,632,964 |

<table>
<thead>
<tr>
<th>Increase/(Decrease) in Cash and Cash Equivalents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and Cash Equivalents, Beginning of Period</td>
<td>146,605,953</td>
</tr>
<tr>
<td>Cash and Cash Equivalents, End of Period</td>
<td>99,324,654</td>
</tr>
</tbody>
</table>

**Return to Agenda**
AGENDA ITEM 13

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Kashina Bishop, Chief Financial Officer
DATE: January 28, 2019

SUBJECT: Adoption of Resolution 2019-001 Authorizing the Investment of Monies in the Local Agency Investment Fund

SUMMARY

Gold Coast Health Plan (GCHP or Plan) currently has unallocated excess funds invested in various interest bearing accounts as allowed per the organization’s investment policy. The Local Agency Investment Fund (LAIF) is one such investment. Due to staff turnover, an update of authorized signers is needed. LAIF requires a formal resolution to effect these changes.

BACKGROUND / DISCUSSION

LAIF is a voluntary State program created by statute, which creates an investment option for local governments and special districts. The program operates a large portfolio and is managed by the State Treasurer’s Office investment staff. Investments with LAIF are specifically authorized by the Plan’s Investment Policy, in an amount up to the allowable limit established by LAIF, which is $65 million.

Authorized personnel initiate LAIF deposits or withdrawals using only pre-designated GCHP bank accounts as transferring institutions, and may execute and deliver all documents necessary for the management of the account. Staff turnover in key positions has affected the list of authorized signers on GCHP’s LAIF investment account. The Plan is updating the list to reflect these changes. LAIF requires that any changes to the list of designated authorized personnel must be accompanied by a formal board resolution.

FISCAL IMPACT

None. The Resolution simply authorizes the proper GCHP personnel to initiate transactions with the fund and execute documents.
RECOMMENDATION

Staff recommends the Commission adopt Resolution 2019-001 authorizing the investment of funds.

ATTACHEMENTS

Resolution 2019-001 Authorizing the Investment of Monies in the Local Agency Investment Fund
RESOLUTION NO. 2019-001

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, DBA GOLD COAST HEALTH PLAN AUTHORIZING THE INVESTMENT OF MONIES IN THE LOCAL AGENCY INVESTMENT FUND

Resolution of: Ventura County Medi-Cal Managed Care Commission, doing business as Gold Coast

Agency Address: Gold Coast Health Plan
711 East Daily Drive, Suite 106
Camarillo, CA 93010-6082

Agency Phone: (805) 437-5500

WHEREAS, The Local Agency Investment Fund is established in the State Treasury under Government Code section 16429.1 et. seq for the deposit of money of a local agency for purposes of investment by the State Treasurer; and

WHEREAS, the Commissioners of the Ventura County Medi-Cal Managed Care Commission, doing business as Gold Coast Health Plan, hereby find that the deposit and withdrawal of money in the Local Agency Investment Fund in accordance with Government Code section 16429.1 et. seq for the purpose of investment as provided therein is in the best interests of the Ventura County Medi-Cal Managed Care Commission, doing business as Gold Coast Health Plan;

NOW THEREFORE, BE IT RESOLVED, that the Commissioners of the Ventura County Medi-Cal Managed Care Commission, doing business as Gold Coast Health Plan hereby authorizes the deposit and withdrawal of Ventura County Medi-Cal Managed Care Commission, doing business as Gold Coast Health Plan, monies in the Local Agency Investment Fund in the State Treasury in accordance with Government Code section 16429.1 et. seq. for the purpose of investment as provided therein.

BE IT FURTHER RESOLVED as follows:

Section 1. The following Ventura County Medi-Cal Managed Care Commission, doing business as Gold Coast Health Plan, officers holding the title(s) specified herein below or their successors in office are each hereby authorized to order the deposit or withdrawal of monies in the Local Agency Investment Fund and may execute and deliver any and all documents necessary or advisable in order to effectuate the purposes of this resolution and the transactions contemplated hereby:
Section 2. This resolution shall remain in full force and effect until rescinded by the Commissioners of the Ventura County Medi-Cal Managed Care Commission, doing business as Gold Coast Health Plan by resolution and a copy of the resolution rescinding this resolution is filed with the State Treasurer’s Office.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission dba the Gold Coast Health Plan at a regular meeting on The 28th day of January, 2019, by the following vote:

AYE:
NAY:
ABSTAIN:
ABSENT:

I, Magdalen Gutierrez, Clerk of the Board of the Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan hereby certify that Resolution No. 2019-001 was adopted at the January 28, 2019 Commission Meeting and that is a true and correct copy of said document on file in my office.

Date this __________ day of January, 2019.

__________________________________________
Clerk of the Board
Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
AGENDA ITEM NO. 14

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: January 28, 2019

SUBJECT: Authorization for CEO to execute contracts and agreements for the Enterprise Transition Project (ETP)

SUMMARY:

At the April 23, 2018 Commission meeting, the VCMH approved project funding of $5.5MM for associated Plan costs estimated to support the Enterprise Transformation Project (ETP), formerly called the ASO Core Replacement Project. The funding included Plan estimates for temporary staffing/consulting services, data conversion, integration costs, and infrastructure investments to support the successful transition to a new core administrative system.

BACKGROUND/DISCUSSION:

The ETP project requires staff to procure various services and products to support the transition to a new core administrative system. Staff anticipates that some of these contracts will exceed the current CEO contract authorization limit of $100,000 (for the total life of the contract). The need to execute these contracts on a timely basis is critical to the ability of the ETP project team in delivering the project on-budget and within schedule.

Because the Commission previously approved the ETP budget funding of $5.5MM, staff recommends the Commission authorize the CEO to execute any and all contractual agreements to deliver the project (including individual transactions greater than $100k), so long as it falls within the total approved budget funding.

FISCAL IMPACT:

There is no fiscal impact as the $5.5MM project funding has been previously approved by the commission. The total estimated spend will incur over multiple fiscal periods, with estimated FY18-19 costs already included in the approved FY18-19 budget. To ensure transparency, staff will update the Commission of any new contracts entered into along with project budget updates in the monthly ETP project status report to the Commission.

RECOMMENDATION:

Staff recommends the Commission authorize the Chief Executive Officer to act on behalf of the Plan to conduct all negotiations, execute and submit all documents, including, without limitation, applications, agreements, amendments, and billing statements that may be necessary to
complete the Enterprise Transformation Project (ETP) for a total not-to-exceed amount of $5.5M, for life of this project, or until June 5, 2020.

If the Commission desires to review these contracts, they are available at Gold Coast Health Plan’s Finance Department.
AGENDA ITEM NO. 15

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Nancy Wharfield, MD, Chief Medical Officer
DATE: January 28, 2019
SUBJECT: PBM Contract Amendment

SUMMARY:

Gold Coast Health Plan contracts with a Pharmacy Benefits Manager (PBM) in order to provide pharmacy benefit services to its members. In November 2016, GCHP signed a contract with OptumRx, Inc. This contract amendment adds additional language and protections to GCHP as it relates to pharmacy benefit services.

DISCUSSION:

This amendment clarifies or adds the following provisions and protections to GCHP:

1. Transparency/Pass-Through: remove exception of mail order and specialty pharmacy to the transparent, pass-through pricing model
2. Pricing Changes:
   a. Allowed under the following conditions:
      i. Industry-wide change in AWP benchmarking methodology
      ii. Change in OptumRx's scope of services, including the exclusion of a service line (i.e. retail, mail order, or specialty)
      iii. GCHP's membership is reduced by greater than 50%
   b. OptumRx must do the following:
      i. Provide 60 days notice
      ii. Provide equitable financial terms
      iii. GCHP may terminate contract if financial terms are not acceptable
3. Rebates: remove exception to pass-through model of rebates obtained by a third party vendor
4. Certification against remuneration
5. Performance Guarantees:
   a. Addition of penalties for specified errors
   b. Clarifying changes to measurement tool for performance guarantee
FISCAL IMPACT:

No additional cost anticipated in current fiscal year.

RECOMMENDATION:

Staff recommends the Commission authorize the signing of an amendment reflecting the items discussed in this report.
AGENDA ITEM NO. 16

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Nancy Wharfield, M.D., Chief Medical Officer
DATE: January 28, 2019
SUBJECT: Approval of Pharmacy Benefits Manager (PBM) Contract Extension

SUMMARY:
The following listed items were considered in making the recommendation:

- **Governor’s Executive Order**
  Earlier this month, Governor Newsom signed an Executive Order to carve out prescription drugs from managed Medi-Cal by January 2021.

- **Impact to Pharmacies**
  Competitive bidding during an RFP for a new PBM would likely result in decreased reimbursement to pharmacies.

- **Impact to Providers and Members**
  Implementation of a new PBM would likely result in disruption to providers and members.

- **Impact to Enterprise Transformation Project (ETP)**
  The ETP, which includes a transition to a new core claims processing system, requires integration with the Plan’s PBM. The project duration is estimated at approximately 18 months. Implementing a new PBM during this timeframe would require the Plan to develop duplicative interfaces: one with the sun-setting core system (IKA), and one with the replacement system (HSP). The redundant effort would add additional costs along with undue complexity and risk to the project.

- **Financial Impact to GCHP**
  The cost of implementing a new PBM is estimated to be approximately $200K. Additionally, the Plan would lose pricing guarantees available in the last half of 2020.

- **Improved performance of current PBM**
  OptumRx has successfully closed all CAP items.
- **Unknown advantage with new PBM**

  It is unclear what advantage substitution of another PBM would confer on the Plan and member, pharmacy and provider stakeholders.

**RECOMMENDATION:**

Staff recommends extending the current Pharmacy benefits manager (PBM) contract without pursuing a Request for Proposal (RFP) at this time.
AGENDA ITEM NO. 17

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Sonia Demarta, CPA, Chief Financial Officer, AHP
Anita Guevin, Compliance Officer, AHP
DATE: January 28, 2019
SUBJECT: AmericasHealth Plan (AHP)

RECOMMENDATION:
Accept and file the presentation. Commission to provide direction to staff.

ATTACHMENTS:
Copies of AHP PowerPoint presentation will be available at the Commission meeting.