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

Regular Meeting
Monday, February 25, 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

ROLL CALL

PUBLIC COMMENT

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

Persons wishing to address VCMCC 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.

CONSENT ITEMS

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting
   
   Staff: Maddie Gutierrez, Clerk of the Commission

   RECOMMENDATION: Approve the minutes.

2. Provider Advisory Committee (PAC) Membership
   
   Staff: Ruth Watson, Chief Operating Officer

   RECOMMENDATION: Appoint the Provider Advisory Committee as described.
   Staff: Nancy Wharfield, M.D., Chief Medical Officer

   **RECOMMENDATION:** Extend the Pacific Interpreters’ contract for an additional twenty-four (24) month period at the end of the current term.

**REPORTS**

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

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

**PRESENTATION**

5. Population Health Framework
   Staff: Nancy Wharfield, M.D., Chief Medical Officer

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

6. MAC Appeals Audit Information
   Staff: Nancy Wharfield, M.D., Chief Medical Officer

   **RECOMMENDATION:** Accept and file the information as presented.

**FORMAL ACTION ITEMS**

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

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

**REPORTS**

8. Chief Medical Officer (CMO) Report
   Staff: Chief Medical Officer, Nancy Wharfield, M.D.

   **RECOMMENDATION:** Accept and file the report.
9. Chief Diversity Officer (CDO) Report
   Staff: Interim Chief Diversity Officer, Ted Bagley
   RECOMMENDATION: Accept and file the report.

10. Chief Operating Officer (COO) Report
    Staff: Chief Operating Officer, Ruth Watson
    RECOMMENDATION: Accept and file the report.

CLOSED SESSION

11. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
    Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Section 54956.9: One case.

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

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on March 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: Maddie Gutierrez, Clerk to the Commission
DATE: February 25, 2019
SUBJECT: Meeting Minutes of January 28, 2019 Regular Commission Meeting

RECOMMENDATION:
Approve the minutes.

ATTACHMENTS:
Copy of the January 28, 2019 Regular Commission Meeting minutes.
CALL TO ORDER

Commissioner Antonio Alatorre called the meeting to order at 2:01 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.

OATH OF OFFICE

The Oath of Office was administered to new Commissioners Dee Pupa, and Supervisor Bob Huber.

ROLL CALL

Present: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa (arrived at 2:05 p.m.), Johnson Gill (arrived at 2:16 p.m.), Debra Herwaldt, Bob Huber, Gagan Pawar M.D. (arrived at 2:08 p.m.) and Dee Pupa.

Absent: Commissioner Jennifer Swenson.
Commissioners Laura Espinosa, Johnson Gill and Gagan Pawar, M.D. were not present at time of roll call.

PUBLIC COMMENT

Dorothy, who requested not to provide her last name, gave public comment around her challenges and frustrations with her health care and navigating the health system. Dorothy provided examples of challenges with managing her medical records, specifically stating they should not be in a paper format, and that information on a CD is not acceptable as some facilities are unable to open them and cannot get to what they need to coordinate treatment. She asserted that protocols and laws should be followed to ensure patients get the care they need.
Commissioner Espinosa asked if someone from Member Services could assist in finding a resolution. Commissioner Espinosa stated that she has worked with Member Services when assisting the community and they are always very helpful.

Commissioner Alatorre stated he was changing the order of the agenda. The changes were as follows:

Agenda items 1 and 2 will stay as is.
Agenda items 3, 4, and 5 will move to Formal Action items 9, 10 and 11, respectively.
Agenda item 6 will move to Agenda Item 3.
Agenda item 7 will move to Agenda Item 4.
Agenda item 8 will move to Agenda Item 5.
Agenda item 9 will move to Agenda Item 6.
Agenda item 10 will move to Agenda Item 7.
Agenda item 11 will move to Agenda Item 8.
Agenda items 12 through 18 will stay as is.

REPORTS

1. **Chief Executive officer (CEO) Update**

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

- **Welcome New Commissioners:** CEO Villani welcomed new Commissioners Dee Pupa and Supervisor Bob Huber. CEO Villani also announced that Commissioner Herwaldt was retiring soon, but would continue on the Commission until further notice.

- **Strategic Planning Retreat:** CEO Villani highlighted the success of the recent strategic planning retreat with the Commission. The retreat provided the opportunity for staff and Commissioners to review and discuss the five-year strategic plan, and share member stories from GCHP’s grants program, exemplifying the Plan’s positive impact within the community. CEO Villani thanked Commissioner Alatorre for his email acknowledging GCHP’s great work accomplished with the grants program and testimonials. Based on dialogue at the retreat, staff will re-evaluate the frequency of the strategic planning meetings, as well as next steps in developing the metrics and goals tied to the plan. More discussion around these will occur at upcoming executive finance committee meetings.

- **Governor Newsom’s Health Care Agenda:** CEO Villani provided highlights from Governor Newsom’s proposed budget, sharing that one significant change would be the transition of pharmacy services from managed Medi-Cal to fee-for-service. Governor Newsom asserts that the state can address and manage rising drug costs through bulk purchasing capabilities at the state level. The change would take effect by January 2021. DHCS is already starting to work on policies and procedures and any changes this will entail.
The budget also includes a proposal to expand Medi-Cal coverage for eligible young adults aged 19-26 regardless of immigration status. There are approximately 21,000 members who would remain enrolled with the Plan. This coverage could start as soon as July.

The new Surgeon General is looking at how early childhood adversity has impacted the social determinants of health. GCHP will have contact with her in a variety of forums dealing with social determinants of health and programs that might be put in place.

- **Pharmacy Updates:** The pharmacy audit by the Joint Legislative Audit Committee (JLAC) is in progress. The auditors were onsite for a week and will return in February for further work. The final report should be available mid-summer with their findings.

The third-party MAC Appeal audit is wrapping and staff expects to present findings at the February Commission meeting.

- **Upcoming Legislative Meetings:** Marlen Torres and Dale Villani will travel to Washington D.C. February 12-13, to meet with Legislative staff. The 2019 LHPC Legislative & Agency Staff Briefing meeting in Sacramento is February 26th.

- **Conduent Changes and Enterprise Transformation Project (ETP):** CEO Villani advised the Commission of a change within Conduent that will affect the ETP project. Conduent, recently announced the acquisition of Health Solutions Plus (HSP), a claims technology software company. Rather than implement the Virtual Benefits Administrator (VBA) system, Conduent will now implement HSP as its claims system platform. CEO Villani noted there was no budget impact to the ETP project with the change to HSP. Staff is working with Conduent and HSP on project re-planning. Currently, the project is running below budget. CEO Villani introduced Debbie Rieger, who was brought on as a senior level resource with dedicated focus to deliver the project.

- **Compliance Update:** Compliance Officer, Brandy Armenta provided the following updates:
  - **2018 DHCS Annual Medical Audit:** DHCS conducted the audit in June. There were two findings, to which the Plan submitted responses. DHCS requested additional changes to policies and procedures, and is currently under review by DHCS.
  - **DHCS Contract Amendment:** CMS has not approved the DHCS contract amendment, however, DHCS has directed all Plans to comply with the requirements in the contract and Plans will be audited to those requirements.
  - **Delegation Oversight:** Delegation Oversight is a huge emphasis area at DHCS. The Plan's methodology are applied consistently to
all delegates, within the packet the table in the compliance update outlines subcontractors who have been issued a CAP and or if CAPs have been closed. When DHCS audits the Plan the auditors look closely at the Plan policies & procedures, audit tools/results, corrective action plans and any letter so non-compliance letters issued or sanctions imposed. The DHCS auditors have been pleased with the oversight structure and program in place and it is clear GCHP holds all delegates to the same standards, The PBM is currently being audited and results of the audit from a compliance oversight perspective will be shared next month provided it has been communicated to the PBM prior to the commission meeting.

- A new APL was released last year by DHCS, which requires that GCHP submit all corrective action plans of subcontractors to DHCS.
- The next DHCS medical audit is tentatively slated to be held in June 2019.

Commissioner Dial moved to accept and file the CEO report. Commissioner Herwaldt seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

CONSENT CALENDAR

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

RECOMMENDATION: Approve the minutes.

Commissioner Dial moved to approve the minutes as presented. Commissioner Atin seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Johnson Gill, and Debra Herwaldt.

NOES: None.

ABSENT: Commissioner Jennifer Swenson.
ABSTAIN: Commissioners Laura Espinosa, Bob Huber, Gagan Pawar, M.D., and Dee Pupa.

Commissioner Alatorre declared the motion carried.


RECOMMENDATION: Approve and authorize the CEO to execute DHCS Contract Amendment A28.

CEO Villani stated agenda items 6 and 7 could be reviewed together as they are DHCS contract amendments formally ratifying rates they are currently paying to the Plan. There is no financial impact to GCHP.

7. State of California Contract Amendment A29

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

Commissioner Espinosa moved to approve Contract Amendments A28 and A29. Commissioner Herwaldt seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

REPORTS

8. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

Dr. Wharfield provided updates on pharmacy trends, indicating that September, October and November were higher cost months and that pharmacy utilization increases predictably in months related to flu season.

9. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report.
CDO Ted Bagley welcomed the new Commissioners and provided the following updates:

- CDO Bagley presented at a recent Ventura County Board of Supervisors around the responsibilities of a CDO.
- CDO Bagley met with Supervisor John Zaragoza, at his request. The purpose was to discuss process, diversity council activities, and community relations.
- CDO Bagley reported there were no new cases at the Plan and clarified the differences between “cases” and “investigations”. He stated that investigations are done on a constant basis. He will present potential cases that could affect GCHP to the commission, but not investigations.
- Lunch and Learn series’ will continue. The series topics are open discussions that have a variety of themes that staff has shown interested in, such as leadership development, and Black History Month. The series are open to all who want to attend and there has been “full-house” attendance.
- CDO Bagley is working on a Diversity and Leadership Manual that he will present at a future meeting.

Commissioner Espinosa asked if there had been any specific questions from the Board of Supervisors. CDO Bagley stated that the questions were only around his responsibilities as CDO.

Commissioner Espinosa asked at what point (diversity) cases would be presented to the Commission, as she wanted clarification on her role as a Commissioner. CDO Bagley responded that cases would be presented prior to EEO or any other agency - once it is determined that after an investigation, it could go external party, then the case would be presented to the Commission.

Commissioner Espinosa’s final question was on the monthly confidential hotline report. She noted it had not been presented in a long period of time and that she would like to see that information either in a Commission report or via email. CDO Bagley stated he was not familiar with that report or the hotline. CEO Villani stated there are two hotlines put in place; the fraud, waste and abuse hotline and the diversity hotline. The diversity line activity report went directly to BBK attorney, Joe Ortiz. General Counsel Scott Campbell stated that nothing has been reported through the diversity hotline for a year. Commissioner Alatorre asked who answers the calls. Compliance Officer Armenta stated the calls are handled by an outside call center who does the initial intake and the activity report then goes to BBK. Commissioner Alatorre agreed with Commissioner Espinosa, and asked that the hotline report be included in the CDO report to the Commission. Staff will included that information in future reports.

10. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.

COO Watson advised the Commission that staff, along with Margaret Tatar, from HMA, had worked with the Community Advisory Committee (CAC) – a sub-committee
of the Commission - on their goals plan for the coming year. Members from the CAC will present to the Commission at an upcoming meeting in the near future.

Membership: Membership volume continues to decrease, with a loss of 6,700 members, a gain of 4,130 new members, and retroactivity of 2,617. Conduent opened a call center in Tempe, Arizona resulting in improved call center metrics. Member Services Manager, Luis Aguilar is also working with Conduent on the improvement of call quality.

Proposition 56 (the tobacco law) funds are used for pass-through payments to providers, which is in effect and going well. The Plan is setting up the new rates and codes for future payments.

Staff is planning to kickoff off the project to implement the new provider contracting credentialing and data management system (PCCM). Staff is also working on Medi-Cal certification requirements of the provider network, along with new requirements for our provider directory and monthly form submittals. We expect provider data quality improvements with the new PCCM, along with our ability to meet regulatory requirements more efficiently.

COO Watson reviewed the standard operations dashboard chart, showing that GCHP is hitting all metrics.

Commissioner Alatorre asked about non-medical transportation. COO Watson stated the RFP is in progress and staff would provide a recommendation at the next Commission meeting. Commissioner Alatorre asked if there will be only one vendor, or multiple vendors. COO Watson stated it will probably be one vendor, but there might be an opportunity for sub-vendors. Commissioner Alatorre asked about Uber or Lyft drivers. COO Watson stated that most of those drivers don’t want to register with Medi-Cal, and DHCS requires all Medi-Cal providers (including transportation) be certified.

Commissioner Espinosa asked about out of area members. COO Watson responded that some of those members are long-term care or possibly foster children.

Commissioner Alatorre moved to approve the reports. Commissioner Huber seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.
Presentations were moved to a later section of the Commission meeting.

**FORMAL ACTION**

3. Contract Approval – Consulting Services Agreement: DR Management Services

**RECOMMENDATION:** Authorize the CEO to execute a Consulting Services Agreement with DR Management services in support of the ETP project.

Discussion was held amongst CEO Villani and the Commission around the contract. CEO Villani stressed the importance and criticality of the ETP project to the organization, and that management of day-to-day operations is more than a fulltime job. There is need for a full-time dedicated senior executive resource to manage the ETP project. The project is not limited to just the implementation of claims processing and call center activities. It requires looking at the internal process and controls across multiple departments. These are activities related to the project. The Commissioners approved an overall spend of $5.5 million dollars. This contract will be within the scope of the overall spend. When CEO Villani spoke with other managed care plan CEOs who have gone through claims system conversions about this type of resource support, Debbie Rieger’s name came up. She is also known for the work she did here at GCHP when it was first starting. We went through our Procurement department to ensure we were consistent with all procurement rules and whether it aligned with market rates. This is a multi-year proposal and is subject to termination with a 90-day notice. The ask is to approve a contract with Debbie Rieger to do the work over multiple years with a full update each month on ETP project status.

Dr. Pawar asked if Ms. Reiger had already started working. CEO Villani stated there are two parts to a contract: he is allowed to approve up to $100,000 and he brought her in to start the work. The ask is for a longer-term engagement. Commissioner Alatorre asked if CEO Villani had signed a contract up to $95,000 and she started work in December. CEO Villani stated yes. Commissioner Alatorre asked how many bids were received. CEO Villani stated we did not go out for bid, we did a sole source justification. The validation on a sole source was the urgency to get someone on board. Also, the uniqueness of her knowledge, knowing this system and plan, as well as having worked in California with other Medi-Cal plans doing claims system conversions. Commissioner Alatorre state that in the approved budget of $5.5 million, most went to additional IT staff and Conduent. Commissioner Alatorre asked what is being taken back from Conduent to provide this contract to Ms. Reiger. CEO Villani stated that Fluid Edge was also included in the $5.5 million.

Commissioner Atin requested clarification on whether the contract is for a single individual or multiple resources. CEO Villani stated one person. Commissioner Atin stated voiced concerned about the overall spend and asked if attempts were made to hire a permanent resource.
Commissioner Alatorre stated his understanding was that COO Ruth Watson was going to take the lead on this project, and asked for clarification. CEO Villani stated the day-to-day work was beginning to falter and a number of projects were coming in that required dedicated focus. He stated the idea of bringing an outside consultant was his idea. The other critical element to this project is the internal design and process flow.

Commissioner Atin stated his concern around the contract amount for a fixed term employee and suggested the Plan should recruit, go to RFP, and then possibly go sole source. He asked if we offered employment and if she (Debbie) was locally based. CEO Villani stated she travels in from Colorado, but is here during the week. Commissioner Atin asked if her flights were being paid for. CEO Villani stated that in her travel costs are included.

Commissioner Espinosa asked the distinction between agenda item 14 and this item. CEO Villani stated that in item 14 the Commission is being asked to give a blanket approval for contract spend within the $5.5 million total project budget. Commissioner Espinosa asked if this adds to the CEO’s authority to contract over $100,000. CEO Villani stated that if the $800,000 contract was approved, then if there are other contracts over $100,000 he was asking for authority to approve those items for ETP project costs. Commissioner Espinosa expressed her opinion that there is a clearly competent COO who has been working on the project, and she does not see the analysis – usually there are markers for major projects; none are seen. Upon review of the markers, it would then be determined if an outside contract is needed. There was a plan and there was assurance this could be done in-house and now there is a contract being presented, and now it is different. CEO Villani stated that he sees the activity with various projects and he determined it would be in best to get additional help.

Commissioner Cho asked for clarification: At the time initial engagement with this consultant for under the $100,000 was it known that ultimately the ongoing work would cost more, for the sake of transparency, it would have been better if it would have come to the Board first. CEO Villani stated the decision was based on real-time need to work on the project now, and anticipated, due to the urgency of the expertise needed, that it would be approved for the greater amount.

Commissioner Atin stated that he would support asking Ms. Reiger if she would like to be a GCHP employee, and if not, go to RFP – see how many bids come through, then go sole source.

Commissioner Dial stated there was an original thought which said this whole project would be $5.5 million, you had the staffing and now you are saying that you have to spend $800,000 to make sure this works. It seems you think that out of the $5.5 million there is $800,000 worth of savings within the project or costs that you don’t think you will have to spend. The Commission needs to see that information. A shorter interim plan is more comfortable at this time. CEO Villani stated there is a
short period of time on the current contract where work with Ms. Reiger can continue. He will gather the information requested and bring it back at a future date. Commissioner Atin asked about putting it as an employment option, he supports additional funds for two to three months to give enough time for the process to be done. Executive Director of Human Resources, Jean Halsell stated that it will be difficult to find an employee for an 18-month to 2-year short-term period, and agreed to posting the position.

MOTION: Commissioner Atin moved to authorize an additional $100,000 funding for the DR Management Services contract, along with an accounting of the ETP project budget, and follow up with a recruitment and/or RFP. Commissioner Dial seconded. Dr. Cho requested an update on deliverables for the next meeting. CEO Villani stated he will have Debbie Rieger present line item budget detail. Commissioner Alatorre stated he would like to see the budget that was approved in 2018 and line items where there will be a cost shifting. CEO Villani stated he will have Debbie Rieger present line item budget detail.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Johnson Gill, Debra Henwaldt, Bob Huber, and Dee Pupa.

NOES: Commissioners Antonio Alatorre and Gagan Pawar, M.D.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.


RECOMMENDATION: Approve the contract for Solera.

CMO Nancy Wharfield, M.D., stated the new Diabetes Prevention Program (DPP) is an unfunded mandate from DHCS which is effective January 1, 2019. CDC has developed an evidence-based lifestyle intervention program which consists of attending classes, being educated with a goal of losing weight. DHCS has adopted this into the Medi-Cal program. Quick implementation of this program is beyond GCHP resources. Solera will assist in getting a network of providers for DPP. The providers are not clinicians, they are health educators, peer counselors; but must be CDC certified. This certification is a long process. Currently through Public Health there are individuals who are on their way to certification, but currently there is no network to date. Solera would assist in developing the network, many locations are already established where services can be provided. Even with low engagement in this program there is a return on investment; over a three year period there is a possible savings of $800,000. GCHP would like to contract with Solera now in order to set up the program.
Commissioner Cho stated Public Health got accreditation for DPP. She asked if GCHP has worked with Public Health to offer these services. She also stated the County is working with the Diabetes Clinics on the DPP accreditation, in order to have it within the next year. Kathy Neal, Executive Director of Health Services, stated the process for DDP under CDC is different from the Medicare program. For the Medi-Cal population, they are required to register, they must teach a certain amount of classes, and have an outcome before they can become certified. Therefore, they still need a supervising agency, which is what Solera would provide for the first year.

Commissioner Gill stated he was in full support of the program, but he asked to explore how far along Public Health was in the accreditation instead of going with Solera. It might be better to work with Public Health if they are possibly just months away from accreditation and they have the infrastructure in place. Dr. Wharfield stated that GCHP will be paying for DDP either way, since still one year away from being fully accredited. Solera is not a long-term solution.

Commissioner Alatorre asked what Solera will provide. Dr. Wharfield stated they will provide contracting, credentialing and building the network as well as reporting.

MOTION: Commissioner Espinosa motioned the approval of a one-year contract with Solera. Commissioner Pawar seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Laura Espinosa, Johnson Gill, Debra Herwaldt, Bob Huber, Gagan Pawar, M.D., and Dee Pupa.

NOES: Commissioner Lanyard Dial, M.D.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

5. Additional Funding for Inovalon Purchase Order

RECOMMENDATION: Approve additional funding in order to align with anticipated expenses.

CMO Nancy Wharfield, M.D., stated this item is a request to supplement funding for Inovalon which is the Plan’s HEDIS vendor. There is no fiscal impact as the additional are budgeted for the current fiscal year. The Commission must approve the additional funding since it is over the total amount that was originally approved. CMO Wharfield stated that the $405,000 is through the end of the fiscal year and it is to ensure the purchase order is funded appropriately. It matches what was anticipated for budget.

Commissioner Dial asked for clarification on the moving of monies from one budget to another. CMO Wharfield stated the purchase order was done with the first part of the contract, but was adapted to budget yearly. To pay the invoice money is moved
from the budgeted fund to the purchase order. CFO Kashina Bishop explained the purchase order process. There is no impact to the budget but Commission must give approval additional dollars approved. Commissioner Dial asked if the total amount was already approved. CMO Wharfield replied yes. Commissioner Herwaldt asked if this was extending the contract. COO Watson stated it is not a fixed price contract, it is based upon hours used. Commissioner Pawar asked how GCHP is currently doing (on HEDIS). CMO Wharfield stated we have early preliminary reports but it was too soon to tell. Commissioner Alatorre stated it would be good to have validated data.

MOTION: Commissioner Dial motioned the approval of additional funding. Commissioner Johnson seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

PRESENTATION


RECOMMENDATION: Accept and file the presentation.

Government & Community Relations Director Marlen Torres presented to the Commission a PowerPoint presentation around her research work with the ACAP fellowship in Washington D.C., which focused on education and employment support services as a social determinant of health to help provide better care for our members. Commissioner Espinosa praised Ms. Torres on her presentation. Commissioner Espinosa asked if Ms. Torres was currently serving in WIA. Ms. Torres responded no. Commissioner Espinosa stated County partners and CEO should be looking at Ms. Torres, as she is a perfect fit.

12. September through November 2018 Financials Report

RECOMMENDATION: Accept and file the financials report.

CFO Kashina Bishop presented the financials for September through November 2018 and provided context around financial losses in a COHS model. GCHP has experienced losses for two years. In looking in comparison at another COHS historical gains and losses, GCHP is not out of the norm. She stated these are bridge years for GCHP until 2019/2020, at which time there will be an increase on
capitation rates from the State. Staff is working with DHCS on fiscal year 2019/2020 rates. These rates are based on 2017 medical expenses. The Plan submits medical expenses and all utilization data. DHCS takes this information and makes a credibility adjustment, which gives base medical expenditures that are trended forward. All plans have seen a definite increase in scrutiny from DHCS around medical expenditures.

Commissioner Alatorre asked when rates will be published. CFO Bishop responded in April. We are over budget in medical expenses. For the month, medical expenses are comprised of changes to prior service months as well as estimates for the current month.

IBNR claims were reviewed, along with membership trends, showing a steady decline. CFO Bishop stated other areas driving expense variances are a utilization issue with physician Specialty and behavioral health/mental health utilization.

The projected loss for the year is approximately $12 million.

Commissioner Pupa asked about if GCHP goes through an IBNR annual certification. CFO Bishop replied yes. Commissioner Pupa asked about the current re-insurance threshold. CFO Bishop stated it was at approximately $650,000. Commissioner Pupa stated it would be good for the Commission to see costs on per member per month basis.

Commissioner Gill asked about inpatient expenses and whether utilization was occurring inside or outside of the County. CMO Wharfield stated some of the biggest costs have to do with transplants; bone marrow and solid organ which occur outside of the County.

Commissioner Alatorre moved to accept and file the September through November 2018 unaudited financial report. Commissioner Pupa seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

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

RECOMMENDATION: Adopt Resolution 2019-001, authorizing the investment of funds.
CFO Bishop stated the resolution presented gives authorization for current staff to make transactions with the LAIF.

Commissioner Herwaldt moved to adopt Resolution 2019-001. Commissioner Dial seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.


**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).

Commissioner Alatorre moved to have the CEO present all contracts over $100,000. Commissioner Huber seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

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

**RECOMMENDATION:** GCHP staff recommends approval of PBM contract amendment.

Discussion was held amongst staff and the Commission around the PBM contract amendment. Commissioner Atin suggested that due to the complexities of the contract, it would be helpful to provide the full contract (a red-lined version), and a
letter explaining the bullet points. It would also be helpful to provide the information before the Commission meeting in order to study the information.

CLOSED SESSION

The Commission adjourned to Closed Session at 4:35 p.m. regarding the following item:

18. REPORT INVOLVING TRADE SECRETS

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

Commissioners Theresa Cho, M.D. and Bob Huber left the meeting.

OPEN SESSION

The regular meeting reconvened at 5:12 p.m.

Mr. Campbell stated there was no reportable action taken in Closed Session.

Commissioner Atin moved to approve Agenda Item No.15 PBM contract amendment with two Commissioners (Antonio Alatorre and Laura Espinosa) voting no on item number 6 (price adjustments) of the contract extension. Commissioner Dial seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

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

RECOMMENDATION: GCHP staff recommends approval of the PBM contract extension.

Discussion was held amongst staff and the Commission around the PBM contract extension. CMO Wharfield reviewed information around the recent pharmacy services carve-out in Governor Newsom’s proposed budget and the impacts to the PBM contract and any potential RFP timeline. The date to transition pharmacy services from managed care to Fee-for-Service is scheduled for January of 2021. If the Plan does not extend the PBM contract with Optum, the Plan would have to start now with an RFP. There is no guarantee a new PBM would perform any better
than the current PBM and would likely result in more disruption to pharmacists as
new bidders would come forward with more aggressive reimbursement pricing.
The ability to extend is already in the contract as is today. Additionally, any
implementation of a new PBM (if selected through RFP), would overlap with the
ETP project and result in additional costs and risk.

Commissioner Dial asked about the term of the extension. CMO Wharfield stated
it would depend on what happens in 2020 with the pharmacy benefits carve-out.
General Counsel suggested a motion to approve the contract extension for up to
one year, depending on the Governor’s executive order.

Commissioner Dial moved to approve Agenda Item No. 16 PBM contract extension up to
one year dependent on the Governor’s executive order. Commissioner Alatorre
seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard
Dial, M.D., Laura Espinosa, Johnson Gill, Debra Herwaldt, Bob Huber,
Gagan Pawar, M.D., and Dee Pupa.

NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

Commissioners Antonio Alatorre and Gagan Pawar, M.D. recused themselves at 5:21
p.m. prior to Agenda Item No. 17 AmericasHealth Plan (AHP). Commissioner Dial will
chair the meeting from this point forward.

PUBLIC COMMENT

Dr. Sandra Aldaña, representative of the State Council of Developmental Disabilities,
presented a copy of the opposition to the Public Charge Rule to the Commission. On
Agenda Item No. 17 AHP, Dr. Aldaña stated there is a lack of coordination for patients in
regards to PBM. In regards to AHP, Dr. Aldana stated the importance of how to build
coordination into the pilot, in order to achieve goals and expand into more than one
system with coordination with one another.

17. AmericasHealth Plan (AHP)

Sonia Demarta, AHP Chief Financial Officer presented a PowerPoint to the
Commission around the Plan-to-Plan pilot, highlighting past presentations, as well
as Commission minutes about this topic. She stated she was hopeful all concerns
would be addressed.

Ms. Demarta stated in June 2017 the Commission approved the Plan to Plan pilot
program by AHP. In 2011, a different Plan to Plan was approved. AHP has
responded to all questions, requests for additional information, as well as provided a list of performance metrics that were presented at the October 2018 Commission meeting. A six page detailed description of the program was provided. As well as a document demonstrating added customer protections provided by the Knox Keene license. The boilerplate agreement was received by AHP on January 15th and is currently being reviewed by AHP’s attorney. The DOFR has been negotiated but needs to be priced out.

Commissioner Atin stated that he disagreed with a “go ahead” on the pilot. He stated the Commission agreed to review the pilot project in concept, dependent upon the particulars of what was negotiated.

Commissioner Espinosa stated the interpretation might be different, as she recalled the discussion differently.

CEO Villani stated he would provide staff perspective: The way the motion was written and captured in the minutes was to begin negotiations, take all preliminary steps and present back to the Commission for review, discussion and approval. Subsequent minutes asked for the value – what is the value proposition. There have been several presentations, but they never really answered the question for the Commissioners. There was no quorum last time, therefore Commissioner Alatorre was going to have a special session, which was scheduled, and then Commissioner Alatorre had to cancel due to other circumstances. There has not been a chance to meet to hear the final value proposition. We are at a point now for the Commissioners to make a decision on what is the value add and what is the direction to move forward. Commissioner Atin asked if the value add would be reviewed today. CFO Demarta stated that is the plan.

Ms. Demarta began her review of value propositions. All value propositions for GCHP, value propositions for AHP and member value propositions were demonstrated in the PowerPoint presented. The most important purpose is the benefit to the member. CEO Villani asked if there were network specialists out of County. Ms. Demarta replied they did have 4,000 specialists, 19 hospitals, some in the San Fernando Valley. CEO Villani asked about contracted hospitals. Ms. Demarta stated that AHP is contracted with the County, CMH, and Simi Valley Adventist. Members can opt in or out at any time. AHP would like to keep families together and members will be able to retain their primary care provider, which is less interruption. AHP has agreed to a set of metrics with GCHP; these were presented at the last Commission meeting.

Commissioner Atin asked about the metrics; will it be better coordinated and faster access. What is the pilot goal? What is the percentage of improvement? How will you know if it is a success? Ms. Demarta stated success is if it is better. AHP will measure through member experience, provider experience, and customer service and dispute resolution. Improvement in targeted HEDIS measures will be measured. AHP will measure against previous years. Currently AHP does not
have knowledge of what the population will be. COO Watson stated GCHP has
data. It was decided between GCHP and AHP that the first year would be to
establish a baseline because it is a 5,000 member pilot. The information would be
presented to the Commission at the end of the first year, and the Commission
would review and determine whether to move forward. Compliance Officer Brandy
Armenta stated success is defined if the experience was improved above existing
results instead of measures declining. Key indicators were identified such as the
HEDIS metrics. Member choice is also a factor with will result in the overall
population of the pilot to possibly change or fluctuate. CMO Wharfield stated the
current baseline is Gold Coast performance. Commissioner Espinosa stated that
she recalled that AHP/Clinicas has raised HEDIS measures to date. CMO
Wharfield stated that Clinicas has raised rates on some measures but not on all
and this would be for AHP.

Ms. DeMarta stated 5,000 member is approximately 2.5% of the population.
Clinicas currently provides primary and specialty care for 38,000 members and it
is done successfully. Commissioner Atin asked why there could not be a target,
either random or sample population, which would define the success for the pilot.
Ms. DeMarta stated AHP does not currently have access to those patient records.
COO Watson stated GCHP does have the data, but part of the challenge of a
random 5,000 members is that case mix is different, therefore to be reasonable it
was agreed this was the year of the baseline. Ms. DeMarta stated it is difficult to
set a target not knowing what the population will be. Compliance Officer Brandy
Armenta stated that the population must be random as DHCS is requires member
choice, therefore members for the pilot cannot be selected based on specific
diagnosis or aid categories it must be a result of member choice and member
selection.

Commissioner Atin asked if a review of the network could be conducted now. Ms.
DMarta indicated they are ready for a complete readiness audit.

Ms. Armenta stated it is possible to tease out a component of the full readiness
however it would not replace a full readiness audit. The network adequacy
readiness audit would be a scaled down version to ensure resources are utilized
appropriately and the network adequacy component can be conducted if the
Commission directs. The Compliance team will not conduct a full readiness until
the boilerplate/ Pilot is approved and would this component of readiness will not
replace a full readiness audit for AHP.

Commissioner Gill asked if the Plan is to maintain the 5,000 members will there be
a second set or randomized members approached to see if they want to be part of
the pilot due to member number fluctuation. Commissioner Gill asked if the
member has been with the plan longer is it more beneficial to be on the pilot.
Compliance Officer Armenta responded the challenge is member choice - it truly
has to be random selection. Commissioner Atin asked how it is determined it will
be a better outcome in the beginning instead of at the end of the one year pilot.
Commissioner Gill asked about controlled variables. COO Watson stated that is
not what GCHP was approached to do – it would change the scope, but up to the
Commission to provide clear direction. Commissioner Atin stated there needs to be clear definition. What is the benchmark? Five thousand is a credible number to determine what is successful and what is not. Ms. Demarta stated that if GCHP is willing to establish based on what their current measurements are today, AHP is more than happy to accept.

Commissioner Atin stated he is also concerned as there are a few new commissioners, one is retiring, and one is not present. They do not have the history and this will require more review. CEO Villani stated he would like to provide additional information to the Commission, which may cause the Commission to think through the next steps. There are confirmed sources who have given information that AHP is in Sacramento looking for a bill sponsor to change the nature of (Medi-Cal managed care) in Ventura County. The legislation they are trying to introduce would make Ventura County a two-plan model. It would have an immediate impact on GCHP staff, Commissioners and the County. There has been a discussion with Ventura County CEO, Mike Powers, as he was caught off-guard, and does not support the move, but the move is being pushed forward by AHP. If this is intended to be a partnership, and this is intended to improve the care for the members, there are no gaps – our care is solid, our network is solid. The discussion was to do a pilot to see what the outcomes would be, but in the spirit of a partnership, a partner doesn’t try to destroy GCHP in the meantime. The two-plan model is terrible for Ventura County and one can only determine it is self-serving. It is difficult to recommend to move forward with this pilot with this issue. Ms. Demarta stated that she had not heard of such a bill in Sacramento, that this is a rumor. Commissioner Atin asked Ms. Demarta if a bill exists. Ms. Demarta stated she has never heard of it and was shocked and the first she has heard of it. Commissioner Atin stated this is important information for the Commission to know. Commissioner Atin asked CEO Villani if he had a copy of the proposed legislation. CEO Villani stated he has seen the proposed legislation.

Commissioner Atin commented that AHP is a for-profit organization, therefore what is being suggested is to move 5,000 members from a non-profit to a for-profit model without clear definition of what success will be, along with potential legislation in place to undermine what is intended from the pilot. If the legislation goes through, then why do the pilot, as the whole model would change. Commissioner Atin stated AHP has presented four times to the Commission and the information requested has still not been presented. Commissioner Espinosa stated that her history (with this topic) has now been a couple of years and AHP has been asked to return due to new commissioners, or new questions. The focus is on a small number of patients, and so much attention has been given to this particular pilot. The nature of the word pilot is that it is a sample for one year’s time to assess, evaluate, and determine whether to move forward. She is troubled that advantage is being taken, that there is not a full Commission, there are new Commissioners, and this continues with AHP. She feels there is “something more here then what meets the eye”. This should be a very simple plan negotiation. The Commission directed staff to negotiate and that is what they are doing. If we
are now stopping mid-stream and asking for a different negotiation, that is wrong and would subject us to liability. Staff has been directed numerous times over the course of a number of years. They are doing what they hear this month and then next month it is something different. It is complicated for the public to understand our actions and we need to focus on the direction given to staff. It appears they are working well together to come together for a final contract.

Commissioner Gill stated he had three points:
- If the Commission directed the two parties to work on expectations and they are in agreement, then clearly share with the Commission what those expectations are.
- Network readiness
- If there is existing legislation drafted for a two-plan model that is not right.

CEO Villani stated if the legislation moves forward the pilot will be irrelevant.

Commissioner Dial moved to accept and file the presentation. Commissioner Espinosa seconded.

AYES: Commissioners Shawn Atin, Lanyard Dial, M.D., Laura Espinosa, Johnson Gill, Debra Herwaldt, and Dee Pupa.

NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Dial declared the motion carried.

Commissioner Atin moved to have CEO Villani to validate if the proposed legislation exists on a two-plan model, bring measureable outcomes back to define success and complete a network adequacy audit Commissioner Pupa seconded.

Commissioner Espinosa asked for verification of proposed legislation and how will it impact the pilot. CEO Villani stated that if AHP is working on a two-plan model then this hinders working together. Commissioner Espinosa asked how this will impact the members. Parameters were defined. Presentations have caused more inquiry and it seems to be the intention to hinder the pilot. Commissioner Atin stated the Commission decided to agree on a pilot – what are the measures of going from non-profit to for-profit. Ms. Demarta stated there is no difference. They are held to the same standards, there is no incentive, no bearing on healthcare.

AYES: Commissioners Shawn Atin, Johnson Gill, Debra Herwaldt, and Dee Pupa.

NOES: Commissioner Laura Espinosa

ABSTAIN: Commissioner Lanyard Dial, M.D.
ABSENT: Commissioner Jennifer Swenson.

**ADJOURNMENT**

Commissioner Atin motioned to adjourn. Commissioner Dial seconded.

AYES: Commissioners Shawn Atin, Lanyard Dial, M.D., Laura Espinosa, Johnson Gill, Debra Herwaldt, and Dee Pupa.

NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Dial declared the motion carried.

The regular meeting ended at 6:27 p.m.

Approved:

______________________________
Maddie Gutierrez, CMC
Clerk to the Commission
AGENDA ITEM 2

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Ruth Watson, Chief Operations Officer
DATE: February 25, 2019
SUBJECT: Provider Advisory Committee (PAC) Membership

SUMMARY:

GCHP leadership has worked diligently over the past year to re-engineer the PAC focusing on the charter, organization, reporting and meeting content for this important Committee. As part of our efforts, the Provider Advisory Committee (PAC) has been re-established of which there are eleven seats up for appointment. The Commission determined that the Provider Advisory Committee would consist of eleven members with one dedicated seat representing the Ventura County Health Care Agency (VCHCA). Each of the appointed members, with the exception of the designated VCHCA seat position, would serve a two-year term, have no term limits and individuals could apply for re-appointment. The eleven voting members would represent various professional disciplines and/or constituencies, which include: Allied Health Services, Community Clinics, Hospital, Long Term Care, Non-Physician Medical Practitioners, Nurses, Transportation Provider, Physician and Traditional/Safety Net.

BACKGROUND / DISCUSSION:

Ventura County Board of Supervisors enabling ordinance (Ordinance No. 4409, April 2010) and the California Department of Health Care Services, Medi-Cal Managed Care Division contract, required the establishment of a Provider based committee.

This Committee meets at least quarterly and makes recommendations, reviews policies and programs, explores issues and discusses how the Plan may fulfill its mission. The Commission originally established the Committee to be comprised of ten (10) members with one permanent seat represented by the Ventura County Health Care Agency (VCHCA). We are requesting the Commission expand the Committee by adding an eleventh seat.

Each of the appointed members, with the exception of the one permanent seat, would serve a two-year term, and individuals could apply for re-appointment, as there are no term limits.

The eleven voting members represent a constituency served by the Plan. Committee members may include representation from the following:
- County Health Care Agency
- Children Welfare Services Agency
- Allied health services providers
- Community Clinics
- Hospitals
- Long Term Care
- Home Health/Hospice
- Nurse
- Physician
- Traditional/Safety Net
- Ventura County Health Care Agency
- Transportation Provider

GCHP has received applications from seven candidates. Below is a brief biography of each candidate.

**Seat – Community Hospital**

**Richard Montmeny**, COO and Site Administrator
Dignity Health, St. John's Pleasant Valley Hospital
Over 33 years in the healthcare industry including academic healthcare organizations, community hospitals and a healthcare system. Clinical background as a physical therapist.

**Seat – Home Health**

**Joan Buck-Plassmeyer**, RN, MSN, CEO
Los Robles Homecare Services, Inc.
CEO/owner of Los Robles Homecare since inception 2000. Educator in the nursing industry. Has worked with several community organizations. Is currently a Board of Review member with CHAP (Community Health Accreditation Program) in Washington, DC.

**Seat – Adult Day Care**

**Katy Krul**, Acting Executive Director
Oxnard Family Circle, ADHC
Has served as Director of Operations/CFO for Oxnard Family Circle and been with the center since 2003. Prior experience is in the field of accounting.

**Seat – Community Hospital**

**Will Garand**, Vice President, Planning and Managed Care
Community Memorial Health System
Over 24 years in the healthcare industry, working with health plans, hospitals and physician organizations.
Seat – Skilled Nursing Facility
Sim Mandelbaum, Owner/Operator
U.S. Skilled Serve, Inc.
Over 20 years as a nursing home administrator in the skilled nursing facility industry.

Seat – Durable Medical Equipment
David Fein, Reimbursement Manager
Shield HealthCare
Over 14 years of healthcare experience – eight years working directly with Medi-Cal and managed care plans on policy, reimbursement and regulatory issues. Currently the President of the California Association of Medical Product Suppliers (CAMPS), which is the state trade association for DME/HME.

Seat – Allied Health Services Provider
Pablo Velez, CEO/Program Director
Amigo Baby, Inc.
CEO/President/Founder of Amigo Baby, Inc. (2004 to present). Has a Medical Doctoral Degree from Columbia where he developed several county-based services. Upon moving to the United States, he began working with special needs children, lectured in several community organizations and created Amigo Baby, Inc. to serve the Ventura community.

RECOMMENDATION:

Staff requests that the Commission appoint the Provider Advisory Committee as described above.
AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission

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

DATE: February 25, 2019

SUBJECT: Contract Extension Approval – Pacific Interpreters Inc.

SUMMARY:

Pacific Interpreters Inc. provides telephone interpreting and video remote interpreting services to Gold Coast Health Plan’s (GCHP) members and providers in over 200 different languages 24 hours, 7 days per week. Pacific Interpreters has provided these services since February 2012 and has consistently delivered high quality results. The current agreement expires on February 28, 2019, and the Plan is recommending renewal of this agreement for an additional twenty-four (24) month period, commencing March 1, 2019.

FISCAL IMPACT:

The agreement is a non-requirements contract which allows the Plan to use services ad-hoc at the rates specified. The agreement can be terminated without cause at any time with a sixty (60) day notice.

There is no impact to the current fiscal year as these resources are approved in the FY18/19 budget. The total renewal amount for the 24-month extension is $150,000, summarized in Table 1.

<table>
<thead>
<tr>
<th>Pacific Interpreters SOW 1</th>
<th>Amount</th>
<th>Period</th>
<th>Budgeted (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$42,000</td>
<td>03/01/2016 – 02/28/2017</td>
<td>Y</td>
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<td>Year 2 (including add’l funds)</td>
<td>$85,400</td>
<td>03/01/2017 – 02/28/2018</td>
<td>Y</td>
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<tr>
<td>Year 3</td>
<td>$75,000</td>
<td>03/01/2018 – 02/28/2019</td>
<td>Y</td>
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<td>SOW 1 Contract Extension</td>
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<tr>
<td>Year 4</td>
<td>$75,000</td>
<td>03/01/2019 – 02/29/2020</td>
<td>Y</td>
</tr>
<tr>
<td>Year 5</td>
<td>$75,000</td>
<td>03/01/2020 – 02/29/2021</td>
<td>Y</td>
</tr>
<tr>
<td>Total Projected Cumulative Spend (Years 1-5)</td>
<td>$352,400</td>
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</table>
RECOMMENDATION:

It is the Plan's recommendation to extend the Pacific Interpreters' contract for an additional twenty-four (24) month period at the end of the current term.

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: Dale Villani, Chief Executive Officer
DATE: February 25, 2019
SUBJECT: Chief Executive Officer Update

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

GCHP Golden Gate Award

On February 6th the Human Resource department met with Cal OSHA, as the result of an invitation from GCHP to review and receive assistance for our safety and work comp programs. The representative reviewed work comp results, written Illness Injury and Prevention Program (IIPP) and performed a physical review of the worksite, which included impromptu interviews with employees. During the exit interview, the industrial engineer from Cal OSHA noted a few minor suggestions for the office, which facilities has addressed. The representative was so impressed with the documentation and results from GCHP's efforts she recommended GCHP for the “Golden Gate Award”. Her comment was that she rarely, if ever, recommends the award after the first visit, but she thought the program and team deserved the award. The Golden Gate Award has been given to 94 companies in the State of California in the last year, and we are proud to have our team recognized with this prestigious acknowledgment of their efforts.

LEGISLATIVE ADVOCACY IN WASHINGTON, DC

On February 12-13, GCHP’s Chief Executive Officer (CEO) and the Director of Government and Community Relations participated in the Association for Community Affiliated Plans (ACAP’s) Legislative Advocacy “Fly-In”. This event is held annually to allow ACAP member plans to meet with members of Congress and their staff to discuss federal legislation and policies that may affect the Medicaid/Medi-Cal program. GCHP staff met with Congress Representatives Julia Brownley and Salud Carbajal along with staff from Congresswoman Katie Hill’s office. The Plan’s staff discussed the positive impacts GCHP has made in Ventura County in the last year.

The ACAP “Fly-In” also provided the opportunity for health plans to learn about health policy initiatives/trends occurring at a national level. ACAP hosted a Health Policy Seminar that included speakers from the House Energy & Commerce Committee, the Ways and Means Committee, and the Senate Committee on Health, Education, Labor and Pensions. Topics discussed included initiatives being proposed by Congress on how to address the
opioid epidemic, conversations around the 340B Program, and addressing high cost specialty drugs.

**California Legislative Update**

**Senate Budget Committee Joint Informational Hearing**

On February 14, the Senate Budget Committee held an informational hearing on the Governor’s health proposals. These included full-scope Medi-Cal coverage for young adults who would qualify if not for their immigration status and the Governor’s prescription drug proposals. While no action was taken on the items heard, the proposals were discussed in detail with consumer advocates voicing strong support for both proposals. Concrete action on these items will occur in the coming months.

**Legislative Bills Update**

February 22, was the last day for legislators to introduce new legislative bills. Once a bill has been introduced, it goes to the Senate or Assembly Rules Committee, where it is assigned to a policy committee. A legislative bill cannot be heard in policy committee until 30 days after it was introduced and printed. Thus far, there have been several legislative bills introduced to add new services under the Medi-Cal program. While Governor Brown, in the past, had vetoed these types of legislative bills, Governor Newsom may have a different perspective on expanding the Medi-Cal program’s services and treatments.

The following legislative bills relevant to Medi-Cal have been introduced:

- **AB 166 (Gabriel)** Medi-Cal: Violence Prevention Counseling Services: This bill would allow Medi-Cal reimbursement for violence prevention counseling services.

- **AB 318 (Chu)** Medi-Cal Materials: Readability: This bill would require the department and managed care plans, commencing January 1, 2020, to require field testing of all translated materials released by the department or the managed care plans, respectively, to Medi-Cal beneficiaries, as specified. The bill would define “field testing” as a review of translations for accuracy, cultural appropriateness, and readability.

- **AB 537 (Arambula)** Medi-Cal Managed Care: The bill would require the Department of Health Care Services to establish both a quality assessment and performance improvement program and a value-based financial incentive program to ensure that a Med-Cal managed care plan achieves a Minimum Performance Level.
- **AB 577 (Eggman)** Medi-Cal: Maternal Mental Health: This bill would extend Medi-Cal postpartum care for up to one year beginning on the last day of the pregnancy for an eligible individual diagnosed with a maternal mental health condition.

- **SB 66 (Atkins)** Medi-Cal: Federally Qualified Health Center and Rural Health Clinic Services: This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined.

- **SB 207 (Hurtado)** Medi-Cal: Asthma Preventive Services: This bill would include asthma preventive services, as defined, as a covered benefit under the Medi-Cal program. The bill would require the department, in consultation with external stakeholders, to develop a coverage policy consistent with specified federal and clinically appropriate guidelines.

- **SB 165 (Atkins)** Medical Interpretation Services: Existing law requires the department to work with stakeholders to conduct a study to identify current requirements for medical interpretation services and make recommendations on strategies that may be employed regarding the provision of medical interpretation services for Medi-Cal beneficiaries who are limited English proficient. This bill would instead require the department to establish a pilot project concurrent with the study, as specified. The bill would extend the operation of these provisions to July 1, 2022.

A complete list and detailed analysis of the legislative bills tracked in 2019 is forthcoming.

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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 had 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
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>
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</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>
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<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>
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<tr>
<td>Kaiser</td>
<td>2017 Annual Claims</td>
<td>Closed</td>
<td>2/8/2018</td>
<td>Under CAP</td>
<td></td>
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<tr>
<td>Kaiser</td>
<td>2018 Annual Claims</td>
<td>Open</td>
<td>9/23/2018</td>
<td>Under CAP Pending Closure</td>
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</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>
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<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>
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<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>
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<td>2018 Annual Utilization Management</td>
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<td>N/A</td>
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<tr>
<td>VTS</td>
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<td>Open</td>
<td>6/7/2018</td>
<td>Under CAP Pending Closure</td>
<td></td>
</tr>
<tr>
<td>VTS</td>
<td>2018 6 month follow-up NEMT/NMT</td>
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<td>12/28/2018</td>
<td>Under CAP Pending Closure</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>---------</td>
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<td>--------</td>
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<td></td>
</tr>
<tr>
<td>Cedars Sinai</td>
<td>2018 Annual Credentialing</td>
<td>Closed</td>
<td>9/17/2018</td>
<td></td>
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</tr>
<tr>
<td>UCLA</td>
<td>2018 Annual Credentialing</td>
<td>Closed</td>
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<td>CMH</td>
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<tr>
<td>CDCR</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 the 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
AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Dr. Kathy Neal, RN, DNP, Executive Director, Health Services
DATE: February 25, 2019
SUBJECT: Population Health: Framework to the Future

PowerPoint Presentation attached
Population Health:
Framework to the Future

Dr. Kathy Neal, RN, DNP
Executive Director, Health Services
February 25, 2019
Agenda

- Population Health Framework
- Chronic Disease Overview
- Why Population Health?
- Next Steps
Population Health Framework

P1: Physical and/or Mental Health

P2: Social and/or Spiritual Well-being

P3: Community Health and Well-being

P4: Communities of Solutions

Equity

Source: Pathways to Population Health, 2018
Chronic Disease Overview


- Can lead to health inequities, especially for the poor and underserved populations.

- Up to 80% of cardiovascular disease, stroke, type 2 diabetes and over 30% of cancers could be prevented (CDPH 2019).
What is Chronic Disease?

• According to Centers for Disease Control (CDC) chronic conditions are defined as:
  ➢ Conditions that last 1 year or more and,
  ➢ Require ongoing medical attention and/or,
  ➢ Limits activities of daily living

• Common Chronic Diseases:
  ➢ Cancer
  ➢ Diabetes
  ➢ High Blood Pressure
  ➢ Heart Disease
Why Focus on Chronic Disease?

- 6 in 10 Americans live with at least one chronic disease (CDC 2019)

- Research suggest that Medicaid/Medi-Cal beneficiaries tend to have a higher rate of chronic disease than people not on Medicaid.

- Chronic diseases - key driver of healthcare costs:
  - Heart Disease: $205B
  - High Blood Pressure: $49B
  - Diabetes: $237B
How to Reduce Chronic Disease

- Eliminate unhealthy behaviors and promote healthy behaviors
- Ensuring programs meet the cultural and linguistic needs of members
- Collaboration with providers, members, and community to promote evidence-based health programs
Health Impact Pyramid

Factors that Affect Health

Counseling & Education
Clinical Interventions
Long-lasting Protective Interventions
Changing the Context to make individuals' default decisions healthy
Socioeconomic Factors

Examples
- Eat healthy, be physically active
- Rx for high blood pressure, high cholesterol, diabetes
- Immunizations, brief intervention, cessation treatment, colonoscopy
- Fluoridation, trans fat, smoke-free laws, tobacco tax
- Poverty, education, housing, inequality

Check the Tarrant County Public Health Web site to learn more.
http://health.tarrantcounty.com
Why Population Health?

- Aligns with GCHP vision
- Disease Continuum
- Builds on Evidence Based Standards
- Inclusive of SDOH
- Data Driven
- New Category in 2018 by the National Committee of Quality Assurance (NCQA)
Pathway to Population Health

- Partnering with Providers
- Focus on Clinical Innovation
- Better use of Data and Analytics
- Addressing the Social Determinants of Health

(Adapted from AHP, 2017)
Next Steps

• Solution: Evidence Based Practice

• Future Topics:
  ▶ Diabetes
  ▶ Asthma/COPD
  ▶ Hypertension
  ▶ End Stage Disease
Questions?
AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Anne Freese, PharmD, Director of Pharmacy
DATE: February 25, 2019
SUBJECT: MAC Appeals Audit

Verbal Presentation
AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Kashina Bishop, Chief Financial Officer
DATE: February 25, 2019
SUBJECT: December 2018 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached December 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 December 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 December 31, 2018, the Plan's performance is a decrease in net assets of $10.4 million, which is an unfavorable budget variance of $8.5 million.
- December FYTD net revenue was $360.3 million, $7.6 million higher than budget.
- Cost of health care was $350.2 million, $22.4 million higher than budget.
- The medical loss ratio was 97.2% of revenue, which is 4.3% higher than the budget.
- The administrative cost ratio was 6.3%, 0.8% lower than budget.
- December membership of 197,634 which is 6,077 below the budgeted average.
- Tangible Net Equity was $121.7 million which represents two months of operating expenses in reserve and 376% of the required amount by the State.

Revenue – December FYTD net revenue was $360.3 million or $7.6 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 $6.3 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.

Health Care Costs – December FYTD health care costs were $350.2 million, which was $22.4 million higher than budget. The medical loss ratio (MLR) was 97.2% versus 92.9% 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 $5.6 million (9.0%).**
  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 $4.2 million.

- **Physician Specialty exceeded budget by $4.0 million (15.0%).**
  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 $1.1 million (13.0%).**
  The increase is in part is 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 $1.5 million (40.0%) and $1.0 million (31.8%) 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 $3.8 million (6.0%).**
  The primary drug class driving the increase is dermatologicals. There has been a steady increase in utilization as displayed below:

  ![Dermatologicals Graph]

  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. The impact to the pmpm cost is reflected in the graph.

- **Provider reserve in the amount of $1.3 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.
Administrative Expenses – For the fiscal year to date through December, administrative costs were $22.8 million and $4.5 million below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 6.3% versus 7.1% for budget.

Cash and Short Term Investment Portfolio – At December 31st, the Plan had $153.5 million in cash and short-term investments. The investment portfolio included Ventura County Investment Pool $41.2 million; LAIF CA State 4.9 million; the portfolio yielded a rate of 2.0%.

Medi-Cal Receivable – At December 31st, the Plan had $96.1 million in Medi-Cal Receivables due from the DHCS.

RECOMMENDATION:

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

ATTACHMENT:

December 2018 Financial Package
**FINANCIAL PACKAGE**
For the month ended December 2018

**TABLE OF CONTENTS**

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

**Executive Dashboard as of December 31, 2018**

<table>
<thead>
<tr>
<th></th>
<th>FYTD 18/19 Budget</th>
<th>FYTD 18/19 Actual</th>
<th>FY 17/18 Actual</th>
<th>FY 16/17 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Enrollment</strong></td>
<td>203,620</td>
<td>198,048</td>
<td>202,748</td>
<td>207,100</td>
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<tr>
<td><strong>Revenue</strong></td>
<td>$288.72</td>
<td>$301.68</td>
<td>$284.60</td>
<td>$273.72</td>
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<tr>
<td>Capitation</td>
<td>$24.34</td>
<td>$25.56</td>
<td>$13.90</td>
<td>$26.22</td>
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<tr>
<td>Inpatient</td>
<td>$51.22</td>
<td>$57.11</td>
<td>$58.08</td>
<td>$53.44</td>
</tr>
<tr>
<td>LTC / SNF</td>
<td>$52.09</td>
<td>$52.31</td>
<td>$51.30</td>
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<tr>
<td>Outpatient</td>
<td>$23.28</td>
<td>$24.75</td>
<td>$25.74</td>
<td>$23.17</td>
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<td>Emergency Room</td>
<td>$10.70</td>
<td>$10.89</td>
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<td>$9.07</td>
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<td>Physician Specialty</td>
<td>$21.88</td>
<td>$25.74</td>
<td>$23.82</td>
<td>$22.55</td>
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<td>Primary Care Physician</td>
<td>6.41</td>
<td>7.06</td>
<td>6.78</td>
<td>6.45</td>
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<tr>
<td>Home &amp; Community Based Services</td>
<td>7.11</td>
<td>8.22</td>
<td>6.88</td>
<td>7.33</td>
</tr>
<tr>
<td>Behavioral and Mental Health</td>
<td>5.65</td>
<td>7.88</td>
<td>6.37</td>
<td>4.67</td>
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<tr>
<td>Pharmacy</td>
<td>$51.19</td>
<td>$55.64</td>
<td>$48.76</td>
<td>$47.76</td>
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<tr>
<td>Other</td>
<td>$8.35</td>
<td>$12.28</td>
<td>$9.48</td>
<td>$6.67</td>
</tr>
<tr>
<td>Medical &amp; CM</td>
<td>$6.05</td>
<td>$5.87</td>
<td>$4.79</td>
<td>$4.92</td>
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<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>$27,349,727</td>
<td>$22,811,383</td>
<td>$132,115,371</td>
<td>$142,360,951</td>
</tr>
<tr>
<td><strong>% of Revenue</strong></td>
<td>92.9%</td>
<td>97.2%</td>
<td>95.1%</td>
<td>95.0%</td>
</tr>
<tr>
<td><strong>Required TNE</strong></td>
<td>$126,991,855</td>
<td>$121,736,387</td>
<td>$132,115,371</td>
<td>$142,360,951</td>
</tr>
<tr>
<td><strong>% of Required</strong></td>
<td>433%</td>
<td>376%</td>
<td>406%</td>
<td>487%</td>
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</table>

### Membership and Growth

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<thead>
<tr>
<th>Membership</th>
<th>FY 2015-15</th>
<th>FY 2016-17</th>
<th>FY 2017-18</th>
<th>FYTD Dec 18</th>
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<tr>
<td>Adult Expansion</td>
<td>120,000</td>
<td>125,000</td>
<td>130,000</td>
<td>130,000</td>
</tr>
<tr>
<td>LIC</td>
<td>100,000</td>
<td>105,000</td>
<td>110,000</td>
<td>110,000</td>
</tr>
<tr>
<td>Adult / Family</td>
<td>225,000</td>
<td>230,000</td>
<td>235,000</td>
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</table>

### Operating Gain and Tangible Net Equity

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<thead>
<tr>
<th>FY 2015-16</th>
<th>FY 2016-17</th>
<th>FY 2017-18</th>
<th>FYTD Dec 18</th>
</tr>
</thead>
<tbody>
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<td>Operating Gain/(Loss)</td>
<td>$53,112</td>
<td>$13,509</td>
<td>$(10,240)</td>
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<tr>
<td>TNE</td>
<td>$152,507</td>
<td>$142,361</td>
<td>$132,115</td>
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<tr>
<td>Required TNE</td>
<td>$25,240</td>
<td>$28,321</td>
<td>$32,374</td>
</tr>
<tr>
<td>= 100% of Required TNE</td>
<td>$126,231</td>
<td>$146,165</td>
<td>$161,868</td>
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## STATEMENT OF FINANCIAL POSITION

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<tr>
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<th>12/31/18</th>
<th>11/30/18</th>
<th>10/31/18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Assets:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total Cash and Cash Equivalents</td>
<td>$ 107,361,809</td>
<td>$ 99,324,854</td>
<td>$ 146,605,953</td>
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<td>Total Short-Term Investments</td>
<td>46,165,178</td>
<td>58,105,171</td>
<td>168,028,687</td>
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<td>Medi-Cal Receivable</td>
<td>96,140,746</td>
<td>87,337,794</td>
<td>82,623,900</td>
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<td>Interest Receivable</td>
<td>609,992</td>
<td>534,837</td>
<td>524,476</td>
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<td>Provider Receivable</td>
<td>275,033</td>
<td>252,202</td>
<td>281,306</td>
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<tr>
<td>Other Receivables</td>
<td>7,381,543</td>
<td>7,379,366</td>
<td>7,495,119</td>
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<td>Total Accounts Receivable</td>
<td>104,407,314</td>
<td>95,504,199</td>
<td>90,924,802</td>
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<td>Total Prepaid Accounts</td>
<td>1,374,001</td>
<td>1,853,218</td>
<td>1,763,467</td>
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<tr>
<td>Total Other Current Assets</td>
<td>135,560</td>
<td>135,560</td>
<td>135,560</td>
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<tr>
<td>Total Current Assets</td>
<td>259,403,862</td>
<td>252,922,801</td>
<td>407,458,489</td>
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<tr>
<td>Total Fixed Assets</td>
<td>1,817,380</td>
<td>1,798,765</td>
<td>1,843,707</td>
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<tr>
<td>Total Assets</td>
<td>$ 261,221,242</td>
<td>$ 254,721,566</td>
<td>$ 409,302,196</td>
</tr>
<tr>
<td><strong>LIABILITIES &amp; NET ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Liabilities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incur But Not Reported</td>
<td>$ 45,960,524</td>
<td>$ 42,543,027</td>
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<tr>
<td>Claims Payable</td>
<td>25,321,265</td>
<td>30,856,279</td>
<td>35,659,430</td>
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<td>Capitation Payable</td>
<td>28,597,879</td>
<td>28,536,379</td>
<td>28,588,150</td>
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<td>Physician Payable</td>
<td>4,192,710</td>
<td>607,372</td>
<td>457,584</td>
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<td>DHCS - Reserve for Capitation Recoup</td>
<td>0</td>
<td>0</td>
<td>160,526,043</td>
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<tr>
<td>Accounts Payable</td>
<td>248,753</td>
<td>1,844,104</td>
<td>2,023,262</td>
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<td>Accrued ACS</td>
<td>1,626,572</td>
<td>1,600,901</td>
<td>1,662,427</td>
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<tr>
<td>Accrued Provider Reserve</td>
<td>1,230,621</td>
<td>1,076,698</td>
<td>845,550</td>
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<tr>
<td>Accrued Expenses</td>
<td>8,376,139</td>
<td>8,160,163</td>
<td>7,972,601</td>
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<tr>
<td>Accrued Premium Tax</td>
<td>21,562,481</td>
<td>13,697,065</td>
<td>5,811,650</td>
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<tr>
<td>Accrued Payroll Expense</td>
<td>1,236,068</td>
<td>1,073,406</td>
<td>1,175,421</td>
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<tr>
<td>Total Current Liabilities</td>
<td>138,356,030</td>
<td>129,985,394</td>
<td>268,780,630</td>
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<tr>
<td>Long-Term Liabilities:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other Long-term Liability-Deferred Rent</td>
<td>1,128,825</td>
<td>1,128,496</td>
<td>1,128,166</td>
</tr>
<tr>
<td>Total Long-Term Liabilities</td>
<td>1,128,825</td>
<td>1,128,496</td>
<td>1,128,166</td>
</tr>
<tr>
<td>Total Liabilities</td>
<td>139,484,855</td>
<td>131,113,889</td>
<td>267,908,796</td>
</tr>
<tr>
<td>Net Assets:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Increase / (Decrease in Unrestricted Net Assets)</td>
<td>(10,378,084)</td>
<td>(8,507,694)</td>
<td>(10,721,971)</td>
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<tr>
<td>Total Net Assets</td>
<td>121,736,387</td>
<td>123,607,977</td>
<td>121,393,400</td>
</tr>
<tr>
<td>Total Liabilities &amp; Net Assets</td>
<td>$ 261,221,242</td>
<td>$ 254,721,566</td>
<td>$ 409,302,196</td>
</tr>
<tr>
<td>December 2018</td>
<td>December 2015 Year-To-Date</td>
<td>Variance</td>
<td>Variance</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>%</td>
</tr>
<tr>
<td>Membership (includes retro members)</td>
<td>198,706</td>
<td>1,104,288</td>
<td>1,261,718</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td>71,487,572</td>
<td>407,543,861</td>
<td>390,157,876</td>
</tr>
<tr>
<td>MCO Premium Tax</td>
<td>(7,875,415)</td>
<td>(47,292,492)</td>
<td>(46,425,521)</td>
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<tr>
<td>Total Net Premium</td>
<td>63,612,156</td>
<td>360,291,369</td>
<td>352,722,555</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>63,612,156</td>
<td>360,291,369</td>
<td>352,722,555</td>
</tr>
<tr>
<td>Medical Expenses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitation (PSP, Specialty, Kaiser, NSMT &amp; Vision)</td>
<td>5,100,820</td>
<td>30,525,977</td>
<td>29,741,330</td>
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<tr>
<td>FFS Claims Expenses:</td>
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<tr>
<td>Inpatient</td>
<td>5,930,044</td>
<td>68,207,905</td>
<td>62,577,803</td>
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<tr>
<td>LTC / SNF</td>
<td>11,502,372</td>
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<td>63,803,336</td>
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<tr>
<td>Outpatient</td>
<td>6,711,459</td>
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<td>26,412,901</td>
</tr>
<tr>
<td>Laboratory and Radiology</td>
<td>420,457</td>
<td>1,977,857</td>
<td>1,578,641</td>
</tr>
<tr>
<td>Directed Payments - Provider</td>
<td>3,905,573</td>
<td>6,341,677</td>
<td>-</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>2,807,241</td>
<td>13,003,766</td>
<td>13,786,831</td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>5,932,266</td>
<td>30,743,473</td>
<td>28,758,311</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>1,499,404</td>
<td>8,428,683</td>
<td>8,319,391</td>
</tr>
<tr>
<td>Home &amp; Community Based Services</td>
<td>1,689,389</td>
<td>9,813,153</td>
<td>8,642,143</td>
</tr>
<tr>
<td>Applied Behavior Analysis Services</td>
<td>655,271</td>
<td>5,171,774</td>
<td>5,652,652</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>1,304,164</td>
<td>4,236,969</td>
<td>3,216,789</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>10,454,713</td>
<td>66,359,050</td>
<td>62,544,843</td>
</tr>
<tr>
<td>Provider Reserve</td>
<td>1,932,368</td>
<td>1,300,022</td>
<td>1,520,053</td>
</tr>
<tr>
<td>Other Medical Professional</td>
<td>298,518</td>
<td>1,930,002</td>
<td>1,553,035</td>
</tr>
<tr>
<td>Other Medical Care</td>
<td>24,429</td>
<td>24,429</td>
<td>-</td>
</tr>
<tr>
<td>Other Fee For Service</td>
<td>949,479</td>
<td>5,228,433</td>
<td>4,513,002</td>
</tr>
<tr>
<td>Transportation</td>
<td>198,018</td>
<td>1,119,861</td>
<td>834,657</td>
</tr>
<tr>
<td>Total Claims</td>
<td>56,970,461</td>
<td>315,915,090</td>
<td>289,040,467</td>
</tr>
<tr>
<td>Medical &amp; Care Management Expense</td>
<td>1,157,766</td>
<td>7,015,411</td>
<td>7,387,285</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>(1,310,722)</td>
<td>(2,822,711)</td>
<td>1,511,298</td>
</tr>
<tr>
<td>Claims Recoveries</td>
<td>(155,857)</td>
<td>(585,605)</td>
<td>665,505</td>
</tr>
<tr>
<td>Total Sub-total</td>
<td>(259,314)</td>
<td>5,728,185</td>
<td>9,208,563</td>
</tr>
<tr>
<td>Total Cost of Health Care</td>
<td>61,817,267</td>
<td>350,167,268</td>
<td>327,716,380</td>
</tr>
<tr>
<td>Contribution Margin</td>
<td>1,794,889</td>
<td>10,124,101</td>
<td>25,016,175</td>
</tr>
<tr>
<td>General &amp; Administrative Expenses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, Wages &amp; Employee Benefits</td>
<td>2,049,242</td>
<td>12,377,022</td>
<td>12,224,651</td>
</tr>
<tr>
<td>Training, Conference &amp; Travel</td>
<td>27,850</td>
<td>125,281</td>
<td>329,742</td>
</tr>
<tr>
<td>Outside Services</td>
<td>2,599,142</td>
<td>12,336,720</td>
<td>13,360,012</td>
</tr>
<tr>
<td>Professional Services</td>
<td>171,558</td>
<td>1,330,074</td>
<td>1,347,285</td>
</tr>
<tr>
<td>Occupancy, Supplies, Insurance &amp; Others</td>
<td>585,503</td>
<td>3,419,485</td>
<td>4,412,561</td>
</tr>
<tr>
<td>Care Management Credit</td>
<td>(1,577,789)</td>
<td>(7,015,411)</td>
<td>(7,387,285)</td>
</tr>
<tr>
<td>G&amp;A Expenses</td>
<td>3,815,439</td>
<td>22,573,732</td>
<td>24,877,166</td>
</tr>
<tr>
<td>Project Portfolio</td>
<td>61,193</td>
<td>238,181</td>
<td>2,412,652</td>
</tr>
<tr>
<td>Total G&amp;A Expenses</td>
<td>3,877,632</td>
<td>22,811,353</td>
<td>27,349,777</td>
</tr>
<tr>
<td>Total Operating Gain / (Loss)</td>
<td>(2,082,743)</td>
<td>(12,687,252)</td>
<td>(2,313,652)</td>
</tr>
<tr>
<td>Non Operating Revenues - Interest</td>
<td>211,453</td>
<td>2,308,267</td>
<td>410,310</td>
</tr>
<tr>
<td>Total Non-Operating</td>
<td>211,453</td>
<td>2,308,267</td>
<td>410,310</td>
</tr>
<tr>
<td>Total Increase / (Decrease) in Unrestricted Net Assets</td>
<td>(1,871,289)</td>
<td>(10,379,984)</td>
<td>(1,963,242)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>December 2018 Year-To-Date</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>PMPM / FYTD</td>
<td></td>
</tr>
<tr>
<td>341.24</td>
<td>320.72</td>
</tr>
<tr>
<td>(36.57)</td>
<td>(38.00)</td>
</tr>
<tr>
<td>301.68</td>
<td>288.72</td>
</tr>
<tr>
<td>(36.57)</td>
<td>(38.00)</td>
</tr>
<tr>
<td>301.68</td>
<td>288.72</td>
</tr>
<tr>
<td>(36.57)</td>
<td>(38.00)</td>
</tr>
<tr>
<td>Description</td>
<td>December 2018</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Cash Flows Provided By Operating Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Net Income (Loss)</td>
<td>(1,871,290)</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>45,877</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>(8,933,116)</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>479,217</td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>(1,033,773)</td>
</tr>
<tr>
<td>Claims Payable</td>
<td>(1,888,175)</td>
</tr>
<tr>
<td>MCO Tax liability</td>
<td>7,875,415</td>
</tr>
<tr>
<td>IBNR</td>
<td>3,417,498</td>
</tr>
<tr>
<td><strong>Net Cash Provided by (Used in) Operating Activities</strong></td>
<td>(1,878,346)</td>
</tr>
<tr>
<td><strong>Cash Flow Provided By Investing Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Proceeds from Restricted Cash &amp; Other Assets</td>
<td>10,000,000</td>
</tr>
<tr>
<td>Proceeds from Investments</td>
<td></td>
</tr>
<tr>
<td>Proceeds for Sales of Property, Plant and Equipment</td>
<td></td>
</tr>
<tr>
<td>Payments forRestricted Cash and Other Assets</td>
<td></td>
</tr>
<tr>
<td>Purchase of Investments plus Interest reinvested</td>
<td>(7)</td>
</tr>
<tr>
<td>Purchase of Property and Equipment</td>
<td>(64,491)</td>
</tr>
<tr>
<td><strong>Net Cash (Used In) Provided by Investing Activities</strong></td>
<td>9,935,502</td>
</tr>
<tr>
<td><strong>Increase/(Decrease) in Cash and Cash Equivalents</strong></td>
<td>8,057,155</td>
</tr>
<tr>
<td>Cash and Cash Equivalents, Beginning of Period</td>
<td>99,324,654</td>
</tr>
<tr>
<td>Cash and Cash Equivalents, End of Period</td>
<td>107,381,809</td>
</tr>
</tbody>
</table>
AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: February 25, 2019

SUBJECT: Chief Medical Officer Update

HEALTH SERVICES UPDATE

UTILIZATION SUMMARY
Inpatient and ED utilization metrics for CY 2019 are similar to CY 2018.

Bed Days
Bed days/1000 members for Q3 are similar for the past 3 years:

<table>
<thead>
<tr>
<th>Year</th>
<th>Overall</th>
<th>SPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>221</td>
<td>961</td>
</tr>
<tr>
<td>2017</td>
<td>219</td>
<td>986</td>
</tr>
<tr>
<td>2016</td>
<td>213</td>
<td>968</td>
</tr>
</tbody>
</table>

While the rate of bed days for SPD members is high, it does not have a strong effect on the overall plan rate of bed days per 1,000 members because SPD is such a small portion of our membership (5%).

Bed days/1000 benchmark: While there is no Medi-Cal Managed Care Dashboard report of bed days/1000 members, review of available published data from other managed care plans averages 238/1000 members.

Average Length of Stay (ALOS)

ALOS is similar for the past 3 years. ALOS for 2016 and 2017 were 4.3 and 4.0. ALOS for 2018 Q1 – Q3 are 4.2.

Average length of stay benchmark: While there is no Medi-Cal Managed Care Dashboard report of ALOS, review of available published data from other managed care plans averages 5.
**Admits/1000**

*Admits/1000 members* are similar for the past 3 years. Admits/1000 member for the SPD aid code group have decreased by about 15% in the same period of time.

<table>
<thead>
<tr>
<th>Overall</th>
<th>SPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>54</td>
</tr>
<tr>
<td>2017</td>
<td>57</td>
</tr>
<tr>
<td>2016</td>
<td>53</td>
</tr>
</tbody>
</table>

**Admits/1000 SPD benchmark:** The DHCS average admits/1000 for SPD members is 514. This variation between GCHP and DCHS may be explained by the relative youth of GCHP SPD members versus DHCS SPD members. (52% of GCHP SPD members are under age 40 years versus 42% for the DHCS SPD population.)

**ED Utilization/1000**

*ED utilization/1000 members* typically peaks in Q1. The Q1 average for the past 3 years is 530. Q3 average for the past 3 years is 448. GCHPs HIFMET efforts are contributing to the decline in SPD ED utilization.

<table>
<thead>
<tr>
<th>Overall</th>
<th>SPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>461</td>
</tr>
<tr>
<td>2017</td>
<td>461</td>
</tr>
<tr>
<td>2016</td>
<td>438</td>
</tr>
</tbody>
</table>

**ED utilization benchmark:** The HEDIS mean for managed Medicaid plans for ED utilization/1000 members is 587. The September 2018 Medi-Cal Managed Care Performance Dashboard reported average SPD ED utilization to be 1243/1000 members.
Bed Days Per 1,000

- FY 2016-17: 203, 223, 189, 218, 206, 211, 228, 212, 210, 206, 207, 188
- FY 2017-18: 220, 213, 201, 205, 210, 183, 223, 216, 231, 235, 225, 249

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.

Average Length of Stay

- FY 2016-17: 4.3, 4.0, 3.9, 4.8, 4.5, 4.1, 4.4, 4.1, 3.9, 4.0, 3.8, 3.7
- FY 2017-18: 3.9, 3.8, 3.8, 3.7, 3.9, 3.8, 4.1, 4.1, 4.1, 4.3, 4.2, 4.6
- FY 2018-19: 4.2, 4.2, 4.0, 4.0

*Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.
Acute Inpatient Admissions/1000 Members

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts, Skilled Nursing Facilities (SNF), and Long Term Care (LTC) days are not included in this data.
*Data from MedInsight 02/11/2019

ER Utilization Per 1,000

*Per 1000 Calculation based on monthly membership published in MedInsight. Dual-eligible pts are not included in this data.
*ER Utilization calculated on visits without an IP admit
TOP ADMITTING DIAGNOSES

Pregnancy related diagnoses and sepsis continued to dominate top admitting diagnoses for CYTD 2018. For members admitted with a primary diagnosis of sepsis, secondary diagnoses were cancer, heart disease, liver or renal transplant, and diabetes.

<table>
<thead>
<tr>
<th>Top 10 Diagnosis Including Pregnancy</th>
<th>Top 10 Diagnoses (Excluding Pregnancy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year 2019</td>
<td>Calendar Year 2019</td>
</tr>
<tr>
<td>0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00</td>
<td>0.00 0.50 1.00 1.50 2.00 2.50 3.00 3.50 4.00</td>
</tr>
<tr>
<td>Pregnancy/Childbirth</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Sepsis</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>Digestive System</td>
</tr>
<tr>
<td>Digestive System</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Genitourinary</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Respiratory System</td>
</tr>
<tr>
<td>Respiratory System</td>
<td>Infectious</td>
</tr>
<tr>
<td>Infectious</td>
<td>Mental and behavioral disorders</td>
</tr>
<tr>
<td>Alcohol Related Disorder</td>
<td>HIV</td>
</tr>
</tbody>
</table>

READMISSION RATE

The quarterly readmission rate for 2018 is 13.7%.

Readmission rate benchmark: The DHCS Managed Care weighted average for readmission is 18.8%.

CLINICAL GRIEVANCES AND APPEALS

For Q4 2018, there were 67 grievances. Most grievances were categorized by quality of care (69%) and accessibility (25%). The volume of grievances has increased since the institution of a new DHCS requirement that requires members to grieve to the Plan before filing a State Fair Hearing. Most grievances result in members being linked to GCHP RN Care Managers, Health Navigators, or Member Services representatives to assist with needs revealed at the time of the grievance.

The volume of appeals increased to 100 for Q4 2018. This increase is driven by the new DHCS requirement to file an appeal with the Plan before filing a State Fair Hearing and UM controls put in place to address areas of overutilization.

For Q4 2018, 48% of denials were upheld on appeal and 21% were overturned. The remainder were either withdrawn or are in progress.
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 last month was through the end of December 2018. In an effort to match the reporting to the financials, there will be no additional graphs this month. However, below are a few early trend indicators to keep in mind:

1. January typically sees an increase in costs due to the seasonal flu hitting California. Some years a second spike is seen in March.
2. Tamiflu generic was in shortage last year and we have some early indicators that there isn’t as big of a shortage this year, but there may be low inventory at some points resulting in approvals of the brand version at a higher cost.
3. Early indicators have shown that the formulary changes implemented for January are having positive effects by decreases in dermatology agents by $400K for January alone.

PBM OVERSIGHT:

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 – Appeal Pending</td>
<td>1</td>
</tr>
</tbody>
</table>

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. This is affected by a pending release of a DHCS All Plan Letter (APL) regarding 340B program oversight requirements for managed care plans (MCPs).

¹Utilization data in the Health Services quarterly update to the Commission is based on paid claims compiled by date of service and is lagged by 3 months to allow for partial run out of claims data. Claims data is complete at approximately 6 months. While incomplete, a 3 month lagged snapshot allows us to see an estimate of utilization without waiting for a more complete 6-month report. Administrative days are included in these calculations. Dual eligible members, Skilled Nursing Facility (SNF), and Long Term Care (LTC) data is not included in this presentation.
AGENDA ITEM NO. 9

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Ted Bagley, Chief Diversity Officer
DATE: February 20, 2019
SUBJECT: Chief Diversity Officer Update

Community Relations

- Participated in Supervisor’s recognition ceremony for Black Community groups during Black History Month.
- Presented Black History to Moorpark Unified School District Junior and Senior students (over 1500 students).
- Attended ceremony to honor Irene Pinkard, past Oxnard Mayor Pro Tem, who is the originator of Black College Tours for young worthy minority participants bound for college.
- Met with the diversity network at Amgen Pharmaceuticals to share best practices. Four (4) of GCHP diversity council members accompanied me to the session.
- Interview with the Ventura Star related to environment at GCHP. Article published on February 17, 2019.

Gold Coast Health Plan

- Held Diversity Council meeting at GCHP with a focus on best practices of other area councils.
- Conducted one (1) diversity related discussion during the month and referred two others to HR for solution.
- No diversity Investigations during the month.
- Bi-weekly update meeting with Dale Villani and Staff when available.
- Conducted Lunch and Learn session on Black History.
- One (1) new case since we last met. In investigation stage through HR and Legal.
- Discussed with Joseph Ortiz the Diversity Hot Line and process going forward in addressing concerns coming through that process. There has been no calls coming through that system in the last year.
**Action Item**

- Request from Commission to have a diversity training session. How? When? Where? Should I arrange the training or will it come through Mike Powers?
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

Executive Summary

Community Activities Committee (CAC) – GCHP met with the CAC on January 30, 2019. The CAC continues to work on CAC goals for FY 19-20. The committee’s focus is on improving the community experience for GCHP members. The CAC is planning on making a presentation to GCHP’s commission in Q4, FY 19-20.

Membership - GCHP membership for January 2019 is 194,028. The plan continues to experience churn in the membership while incurring a small increase over the previous month. GCHP gained 15 (net) members in the month of February which includes a loss of 5,610 members, 3,615 new members and 2,010 retroactive members.

Call Center – GCHP’s call center met all Plan service metrics for customer service in January and early indicators show that February metrics. Now that transactional metrics are stable, staff has begun redesign work with Conduent to focus call center staff on improving the customer experience.

Member/Provider Operations Liaison- Operations has repurposed an existing position to assist in the continual process improvement of service to members and providers. This position provides specialized assistance and analysis relevant to provider and operational issues. The staff member serves as a liaison between Gold Coast Health Plan, claims, providers, health services and other internal departments to effectively identify and resolve issues. The goal is to implement improvements for existing and new obstacles effecting the plan, providers and members.

Enterprise Transformation Project- Operations staff continues to work on developing and refining process flows and job aids to ensure that the most current and complete information is captured as we move into requirements with Conduent for the HSP system.

Network Certification Project – The Plan is working diligently on the annual network certification audit required by the Department of Health Care Services (DHCS). GCHP
staff has completed 85% of the project and we expect the project will be completed by the March 16, 2019 required submission date.

**Better Doctor** – The Plan continues to verify the demographic information obtained from GCHP’s software vendor; Better Doctor. Staff is following up with providers to insure accurate information is loaded into the GCHP provider database.

**Medi-Cal Enrollment (Regulatory Requirement)** – The regulatory requirement for all Plans to ensure contracted providers are Medi-Cal licensed is in its final stage. The Plan has contacted 100% of our provider network to ascertain their status with the state and has executed 48 interim letters of agreement (LOAs) with providers who have submitted applications ensuring their inclusion in GCHP’s network.

**DHCS Provider Timely Access Survey** – GCHP received preliminary results with a request for additional information by DHCS. Upon review of the Health Services Advisory Group (HSAG) data, questions were raised by the Plan regarding the methodology utilized. In particular, there appears to be problems with how the large Kaiser network was calculated. GCHP’s compliance officer will submit Plan feedback to the state to determine next steps.

**Contracting Initiatives:**

- Finalized contract renewal negotiations with Adventist Health encompassing a three (3) year agreement.
- Finalized contract renewal negotiations with Community Memorial Health System.
- In contract renewal negotiations with Clinicas del Camino Real (CDCR). Met with CDCR on 2/13/2019 to review proposed DOFR. Our next scheduled meeting with CDCR is 2/26/2019.
- SNF Contracts- network is amending all SNF agreements to reflect rates for bed hold days. This is needed to ensure GCHP members have a bed when they transition from the SNF level of care to inpatient and then back to SNF.
- Added CMH-Center for Family Health- Brent Street Clinic.
- Contracted with Advanced Bionics a Cochlear Implant Manufacturer and Supplier. We contracted with Advanced Bionics due to the number of LOA’s that have been requested. The new agreement will result in a savings to the plan.
- Adding an Infectious Disease provider, Dr. Miguel Saldovar located in Camarillo.
- Added the key anesthesiology group out practicing out of Los Robles Hospital (Conejo Los Robles Anesthesiology Medical Group)
Addendum:

I. Member PCP Assignments

![Bar chart showing PCP assignments]

<table>
<thead>
<tr>
<th>Type</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>
<tr>
<td>Jan-19</td>
<td>78,476</td>
<td>38,166</td>
<td>28,693</td>
<td>5,662</td>
<td>4,094</td>
<td>23,291</td>
<td>10,733</td>
<td>4,791</td>
<td>5,001</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
### Operations Scorecard - December 2018

| Call Center | | | | | | |
|-------------|-------------|-------------|-------------|-------------|-------------|
| Total Calls | Average Talk Time | Average Speed of Answer | Abandonment Rate | Call Quality Audit Scores | Call Satisfaction Survey |
| 9,562 | 7 min. 56 sec. | 8.4 seconds | 0.68% | Goal ≥ 95% | 96.02% | Goal ≥ 95% | 97.62% |

<table>
<thead>
<tr>
<th>Membership</th>
<th>Member Orientation Attendance</th>
<th>Walk-ins</th>
<th>MS Inquiries</th>
<th>Quality Audit Scores</th>
<th>LTC Conversion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>194,028</td>
<td>9</td>
<td>24</td>
<td>284</td>
<td>96.02%</td>
<td>Goal ≥ 95%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claims</th>
<th>Claims Processed</th>
<th>Days Receipt on Hand</th>
<th>Financial Accuracy</th>
<th>Procedural Accuracy</th>
<th>Auto Adjulication Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>188,658</td>
<td>172,557</td>
<td>6</td>
<td>99.00%</td>
<td>98.90%</td>
<td>72.14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claims and Appeals</th>
<th>Appeals Totals</th>
<th>Appeals Upheld Rate</th>
<th>Appeals Overturned Rate</th>
<th>Acknowledgement TAT</th>
<th>Resolutions TAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>170</td>
<td>38</td>
<td>71%</td>
<td>3%</td>
<td>86%</td>
<td>103%</td>
</tr>
</tbody>
</table>

| GJ & Claims | GJ & Claims | | | | | |
|-------------|-------------|-------------|-------------|-------------|-------------|
| Grievance Totals | Member Griev per 1000 Members | Appeals Totals | Appeals Upheld Rate | Appeals Overturned Rate | Acknowledgement TAT |
| 170 | 9% | 38 | 71% | 3% | 86% |

| Operations Support | | | | | |
|-------------------|-------------|-------------|-------------|-------------|
| Total Encounters Submitted | Total Encounter Quality (% of Errors) | Professional Quality (% of Errors) | Institutional Quality (% of Errors) | Pharmacy Quality (% of Errors) | DHCS Encounter Data Report Card |
| 309,651 | 1.0% | 2.1% | 1.4% | 0.1% | 2018 3rd Quarter 63.3% |

Turn Around Time- Missed by .20%, reflecting increased claims volume for previous 2 months, tracking for January as claim volume remains high, this is typical for the first 3 months of the year
Days Receipt on Hand- Missed by 1 days, reflecting increased claim volume for previous 2 months, tracking for January as claim volume remains high, this is typical for the first 3 months of the year
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