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

Regular Meeting
Monday, April 22, 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 (VCMMCC) doing business as Gold Coast Health Plan (GCHP) on the agenda. Persons wishing to address VCMMCC should complete and submit a Speaker Card.

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

REPORTS

1. Chief Executive Officer (CEO) Update

   Staff: Dale Villani, Chief Executive Officer

   RECOMMENDATION: Accept and file the report.

PRESENTATIONS

2. Population Health – Diabetes

   Staff: Paula Bossoletti, Pauline Preciado and Dr. Lupe Gonzalez

   RECOMMENDATION: Accept and file the presentation.
FORMAL ACTION

3. AmericasHealth Plan (AHP) Plan-to-Plan Pilot

Staff: Dale Villani, CEO, Ruth Watson, COO, Nancy Wharfield, M.D., CMO, Brandy Armenta, Compliance Officer

RECOMMENDATION: Commission to provide direction to staff.

4. February 2019 Financials Report

Staff: Kashina Bishop, Chief Financial Officer


REPORTS

5. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Accept and file the report.

6. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Interim Chief Diversity Officer

RECOMMENDATION: Accept and file the report.

7. Chief Operating Officer (COO) Report

Staff: Ruth Watson, Chief Operating Officer

RECOMMENDATION: Accept and file the report.
CONSENT

8. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of March 25, 2019.

Staff: Maddie Gutierrez, CMC, Clerk of the Commission

RECOMMENDATION: Approve the minutes.

9. Approval of Peer Review/Credentialing Committee Member

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

RECOMMENDATION: Approve Menashe Ehrenburg, D.O., FACOOG, Associate Medical Director, Clinicas Del Camino Real, Inc. as an active member of the Credentials / Peer Review Committee.

10. Provider Advisory Committee (PAC) Membership

Staff: Ruth Watson, Chief Operating Officer

RECOMMENDATION: Appoint the Provider Advisory Committee as described in the Staff Report and expand the 10 member PAC by adding one additional member, making PAC an 11 member advisory committee.

11. PBM Contract Amendment

Staff: Anne Freese, PharmD, Director of Pharmacy

RECOMMENDATION: Approve the signing of the PBM amendment.

DISCUSSION

12. Commission Meeting Times and Location

Open Discussion between Staff and Commissioners.

CLOSED SESSION

13. REPORT INVOLVING TRADE SECRETS

Discussion will concern: Rates for PBM program
Estimated Date of Public Disclosure: Three (3) years from meeting date.
OPEN SESSION

COMMENTS FROM COMMISSIONERS

ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on May 20, 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 Health Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: April 22, 2019

SUBJECT: Chief Executive Officer Update

SUMMARY: CEO Update verbal.

Government Affairs:

Community Relations Update: GCHP in the Community

Gold Coast Health Plan has been actively participating in the community by attending various events as well as providing sponsorships to community based organizations. Recent activity includes, participation in Cesar Chavez Elementary Read Across America Day, the Ventura County Office of Education’s Agency 101 event, and the American Heart Association’s Go Red for Women Luncheon.

In the first quarter of 2019, GCHP awarded sponsorships to the following organizations:

- **Boys & Girls Club of Ventura:** The Leaders in Training Program is geared towards helping teens acquire leadership skills; teaching them the necessary skills to give back to their communities and helping them reach their higher educational goals.

- **For the Troops:** The Military Tribute Gala, this year, honored World War II and Korean War veterans. The event’s proceeds go towards sending care packages to deployed troops.

- **Make a Wish Tri-Counties, Inc.:** Proceeds from the Big Wish Gala go towards creating life-changing wishes for children with critical illnesses.

- **Boys & Girls Club of Camarillo:** The Bids for Kids Gala is the Boys & Girls Club Annual Signature Event that raises funds to ensure that all children have access to the Club despite their family’s economical position.

- **Boys & Girls Club of Santa Clara Valley:** Proceeds of the Third Annual Poker Tournament will go towards helping the organization achieve its vision to enable all young people to reach their full potential as productive, caring, responsible citizens.
GCHP values the services provided by our community organizations. We believe in supporting our community partners, and our economic support focuses on making our community stronger and a better place to live. GCHP serves half of all children between the ages of 0-5, many whose lives are enriched by our local Boys & Girls Clubs. We are privileged to provide sponsorship support to our various chapters of the Boys & Girls Club in Ventura County.

There are several events that GCHP will be participating in the coming months being held by community based organizations, such as: schools, social service agencies, and county departments. Additional information will be shared in future Commission meetings.

California Legislative Update
Assembly Budget Subcommittee/ Executive Order

Jennifer Kent, the Department of Health Care Services (DHCS) Director, provided an overview of the Governor’s Executive Order to carve out the pharmacy benefit from Medi-Cal managed care plans. The transition, which would be completed by January 2021, is intended to create additional negotiating advantage on behalf of the state’s 13.2 million Medi-Cal beneficiaries. According to the Administration, this transition would standardize the Medi-Cal drug benefit, reduce confusion among beneficiaries without sacrificing quality or outcomes, and result in hundreds of millions of dollars in additional savings beginning in the 2021-2022 fiscal year.

The Legislative Analyst Office (LAO) provided an overview of the report they drafted regarding the Executive Order. The LAO indicated that the carve out is likely to generate net savings, but the amount of those savings is highly uncertain. The LAO suggested that the legislature asks for a robust fiscal analysis and implementation plan from DHCS. The LAO further recommended that the Legislature could withhold any potential funding requests necessary for DHCS to implement the program absent these details.

Additionally, stakeholders expressed concern with the future ability of managed care plans to manage patient care given the potential loss of real-time prescription drug data. There is also concern over the potential loss of 340B revenue for 340B providers (primarily clinics and hospitals).

During the hearing, legislators seemed apprehensive to approve the Executive Order. While they would like to see some savings in drug costs, they are concerned about making a policy change without data and assurance that the proposal will provide the promised cost savings without disrupting timely prescription services to Medi-Cal recipients. For now, both the Senate and Assembly Budget Subcommittees are withholding any formal action until after the May Revise is released.

Assembly Health Committee Hearing

The Assembly Health Committee has begun hearing legislative bills and moving them out of Committee. The legislative bills below moved out of Committee and into the Assembly
Appropriations Committee. These bills were previously reported to the GCHP Commission and are being monitored by the Government Relations staff:

- **AB 4 (Arambula)** – This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages, if otherwise eligible for those benefits, but for their immigration status. The Governor's proposal would only extend Medi-Cal benefits to individuals between the ages of 19-26.

- **AB 316 (Ramos)** – This bill would require the Department of Health Care Services (DHCS) to provide an increased payment to Medi-Cal providers who render dental services to Medi-Cal beneficiaries.

- **AB 318 (Chu)** – This bill would mandate DHCS and managed care plans to require field testing of all translated materials provided to Medi-Cal beneficiaries.

- **AB 319 (Rubio)** – This bill would require DHCS to create reimbursement rates and rate billing codes for use by licensed narcotic treatment programs providing medication-assisted treatment using non-controlled medications approved by the Food and Drug Administration for patients with a substance use disorder.

- **AB 537 (Arambula)** – This bill would require DHCS to establish both a quality assessment and performance improvement program and a value-based financial incentive program to ensure that a Medi-Cal managed care plan achieves a Minimum Performance Level (MPL).

- **AB 577 (Eggman)** – Under existing law, an individual is eligible for Medi-Cal benefits for pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy. 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.

- **AB 678 (Flora)** – This measure would restore podiatric services as a covered Medi-Cal benefit as of January 1, 2020.

- **AB 848 (Gray)** – This bill would add continuous glucose monitors and related supplies required for use with those monitors to the schedule of benefits under the Medi-Cal program for the treatment of diabetes mellitus when medically necessary, subject to utilization controls.

- **AB 1088 (Wood)** – This bill would provide that an aged, blind, or disabled individual who would otherwise be eligible for Medi-Cal benefits would be eligible for Medi-Cal without a share of cost if their income and resources otherwise meet eligibility
requirements. The bill would authorize DHCS to implement this provision by provider bulletins or similar instructions until regulations are adopted.

- **AB 1494 (Aguiar-Curry)** – This bill would make telehealth services, telephonic services, and other specified services reimbursable under the Medi-Cal program when provided by a community clinic during or immediately following a State of Emergency.

- **AB 1642 (Wood) Medi-Cal: Alternative Access Requests** – Requires Medi-Cal managed care plans to schedule appointments with out-of-network providers if there is an alternative access that requires travel. The bill further mandates that a health plan file non-emergency transportation plans when submitting alternative access requests to the Department of Health Care Services. Also raises the penalty for plans that do not meet minimum performance levels.

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Enterprise Transformation Project (ETP) Update

Project re-planning efforts and planning continue with GCHP, Conduent, and HSP. The team completed requirements and internal GCHP process mapping work flows. Additionally, GCHP and Conduent are reviewing Call Center, Data Warehouse, and APR DRG solutions in order to confirm a final decision for implementation. While the team is still working to finalize the revised project schedule, the new projected go-live target is Q3 2020.

COMPLIANCE UPDATE:

DHCS Annual Medical Audit:

Audits and Investigation (A&I) will conduct the annual 2018-2019 onsite medical audit June 3, 2019 through June 14, 2019. GCHP staff and GCHP subcontractors are compiling the required pre-audit documentation and data due in A&I office by April 25, 2019. GCHP will keep the commission apprised of the audit.

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. 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 audited by DHCS 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 Type</th>
<th>Audit Status</th>
<th>Date Issued</th>
<th>Date Closed</th>
<th>CAP Monitoring</th>
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<tr>
<td>VTS</td>
<td>2016 Security Risk Assessment</td>
<td>Closed</td>
<td>9/20/2016</td>
<td>4/16/2019</td>
<td>N/A</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>2018 Annual Claims</td>
<td>Open</td>
<td>9/23/2018</td>
<td>Under CAP Pending Closure</td>
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<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>
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<tr>
<td>Beacon Health Options</td>
<td>2018 6 month Claims (focused) audit</td>
<td>*Open</td>
<td>11/21/2018</td>
<td>Under CAP &amp; Under Financial Sanctions</td>
<td>Ongoing monitoring imposed</td>
</tr>
<tr>
<td>Clinicas del Camino Real, Inc.</td>
<td>2018 PDR Claims (focused)</td>
<td>Closed</td>
<td>7/23/2018</td>
<td>April 2, 2019</td>
<td>N/A</td>
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<tr>
<td>Clinicas del Camino Real, Inc.</td>
<td>2018 Annual Claims Audit</td>
<td>Open</td>
<td>12/28/2018</td>
<td>Under CAP</td>
<td>Ongoing monitoring imposed</td>
</tr>
<tr>
<td>USC Keck</td>
<td>2019 Annual Credentialing</td>
<td>Open</td>
<td>March 4, 2019</td>
<td>Closure Letter Pending</td>
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<tr>
<td>Optum</td>
<td>2019 Annual Audit (C&amp;L, FWA, HIPAA, UM, Credentialing)</td>
<td>Open</td>
<td>March 4, 2019</td>
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<td></td>
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</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 audit of the PBM started at the end of December 2018. The audit was completed in February 2019 and a Corrective Action Plan was issued to Optum on March 4, 2019 in all areas audited. The areas audited included: cultural & linguistics, fraud waste and abuse, HIPAA, utilization management and credentialing. The received a partial response from Optum and material to address the findings have been reviewed. A few outstanding legal questions are pending however based on review of Optum’s CAP submission the CAP will remain open.

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

RECOMMENDATION:

Accept and file the report.
AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Nancy Wharfield, M.D., Chief Medical Officer and Kathy Neal, RN, DNP, Executive Director, Health Services
DATE: April 22, 2019
SUBJECT: Population Health: Diabetes

RECOMMENDATION: Accept and file the presentation.
Population Health: Diabetes

Pauline B. Preciado, RN, MPA
Lupe Gonzalez, PhD, MPH
Paula Bossoletti, RN, BSN
April 22, 2019
Agenda

- Overview of Diabetes
- Health Care Disparities and Cultural Factors
- Diabetes Programs
- Next Steps
National Overview

- 30.3 million US adults have diabetes
- In the last 20 years, the number of adults diagnosed with diabetes has more than tripled
- Diabetes is the No. 1 cause of kidney failure, lower-limb amputations, and adult blindness
Ventura County Overview

- Since 2005, adults who are obese has increased 20%

- There is a higher rate of Seniors diagnosed with Diabetes than the CA Average

- The age adjusted death rate related to diabetes is steadily increasing

(HealthyPeople2020, HealthMattersinVC.org)
Why Focus on Diabetes?

- In 2017, the total estimated cost of diagnosed diabetes was $327 billion
- About 1 in 4 health care dollars is spent on people diagnosed with diabetes
- Medical expenses for diabetics are about 2.3 times higher than for people without diabetes.
Population Health Framework

- Provider & Community Partnerships
- Understanding Equity

Equity

Population Management

P1: Physical and/or Mental Health

P2: Social and/or Spiritual Well-being

P3: Community Health and Well-being

P4: Communities of Solutions

Community Well-being Creation
Identification of Health Disparities

- Use of data to identify and stratify health disparities
- Culture plays a strong role in many diverse groups
- GCHP data shows 20,276 adults with pre-diabetes/diabetes
  - 53% are Hispanic and 47% are non-Hispanics.
Diabetic Population Distribution

- 42% are from the greater Oxnard Area
- 34% are from Ventura/Santa Clara Valley area
- 23% are from East County

Members with Pre-Diabetes and Diabetes by City
N=20,276
What are we doing?

- Nursing Coaching
- Complex Case Management
- Transition of Care Team
- Community Collaboration

- Health Education
- Health Navigator
- Chronic Disease Self Management
- Community Collaboration

- HEDIS
- Readmission Rates
- Member Satisfaction

Care Management

Health Education

Health Outcomes
2019: Diabetes Prevention Program

- DHCS unfunded mandate
- Behavioral Lifestyle Change Program developed by the CDC
- At Risk Population
- Classes where members live
Strategies under Development

- Chronic Disease Self-Management Program
- Increase Local DPP Provider Capacity
- Training Opportunities
- Member Engagement Tools
AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Dale Villani, CEO, Ruth Watson, COO, Nancy Wharfield, M.D., CMO, Brandy Armenta, Compliance Officer
DATE: April 22, 2019
SUBJECT: Americas Health Plan (AHP) Pilot

SUMMARY:

As instructed by the Commission in the March 25, 2019 Commission Meeting, GCHP Staff met with representatives of Americas Health Plan (AHP) to review Supervisor Zaragoza’s 13-point motion on the AHP Plan-to-Plan Pilot. Both teams were able to come to agreement on various points. GCHP staff is in agreement on all 13 points. AHP discussed several points they wanted to review at this Commission meeting.

Please see attached summary of the 13-Point discussion meeting.

RECOMMENDATION:

Commission to provide direction.
Supervisor Zaragoza’s 13 Point Proposal

1. I move that the Gold Coast Health Plan staff continue to work closely and expeditiously with Americas Health Plan (AHP) staff to finalize the terms of a pilot plan-to-plan contract for review and approval by this Commission and then for final review and approval by the appropriate State agencies;

**GCHP and AHP: Timeline in development agreed upon by both parties.**

2. In order for the pilot to be fairly and accurately assessed I propose that the period of the pilot program be extended to **five years**;

**GCHP: No additional comment.**

**AHP: Counter proposal to be presented.**

3. That the pilot begin with up to **5,000 members** who will have the option to self-select from Clinicas' existing GCHP assigned membership pool;

**GCHP: No additional comment.**

**AHP: Counter proposal to be presented.**

4. At the end of a **two-year period**, in the event pre-agreed upon performance measures are met or exceeded and at the discretion of the Commission the pilot will be continued with up to an additional 10,000 members who will have the option to self-select from Clinicas' existing GCHP assigned membership pool for a total up to a maximum of **15,000 members**;

**GCHP: No additional comment.**

**AHP: Counter proposal to be presented.**

5. Furthermore, prior to the beginning of the program clear, fair, and specific, achievable performance measures and milestones shall be set in writing so that this Commission can determine the success of the pilot program;

**GCHP and AHP: In addition to already agreed upon quality metrics, GCHP will work with AHP to add additional performance standards that may be required by DHCS. (As stipulated by contract, GCHP conducts audits required by DHCS).**

6. All marketing and/or informational communications and **enrollment** for this pilot program shall be conducted by Gold Coast Health Plan and AHP together;

**GCHP and AHP:**

- **MARKETING: No marketing is allowed.** (AHP is restricted from marketing by restricted Knox Keene licensing and GCHP is restricted from marketing by DHCS).

- **MEMBER AND PROVIDER COMMUNICATIONS:** As detailed in boilerplate/contract.
Supervisor Zaragoza’s 13 Point Proposal

-ENROLLMENT: As detailed in boilerplate/contract.

7. Throughout the pilot program AHP members will have the option to opt out of the pilot program, at which time other Clinicas assigned GCHP members will have the option to opt-in to the AHP pilot program;

GCHP and AHP: No additional comment.

8. On a bi-annual basis, AHP will provide performance and other data to GCHP detailing activity of the pilot program;

GCHP and AHP: AHP will provide data to GCHP as required by contract and DHCS regulation.

9. In the event AHP pilot program performance measures fall below determined minimums which will be agreed upon prior to the beginning of the program, the Gold Coast Health Plan Commission will have at its discretion the ability to recommend corrective measures for the pilot program;

GCHP and AHP: In addition to evaluation of quality performance measures, GCHP will perform standard audits as defined by contract and issue CAPs as appropriate and report these actions to the Commission.

10. In the event disputes arise as to the performance or operation of the pilot program GCHP will have the ability to initiate an audit of the program;

GCHP and AHP: GCHP will audit AHP per contract.

11. The scope of the audit will be set by GCHP staff and approved by the GCHP Commission; the cost of the audit will be equally split between GCHP and AHP;

GCHP and AHP: GCHP is required to audit AHP per contract. There is no requirement for AHP to be responsible for any portion of the cost of an audit.

12. At the end of the five-year pilot program, in the event the program has been deemed to be successful by the GCHP Commission, the plan will enter into discussions with AHP regarding the creation of a permanent option whereby Clinicas and other GCHP assigned members will have the option to receive services by AHP;

GCHP: No additional comment.

AHP: Counter proposal to be presented.

13. In no event will the total AHP membership exceed the current percentage of eligible GCHP members assigned to Clinicas.

GCHP: No additional comment.

AHP: Counter proposal to be presented.
AGENDA ITEM NO. 4

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: April 22, 2019

SUBJECT: February 2019 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached February 2019 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 February 2019 FYTD financial package, including statements of financial position, statement of revenues, expenses and changes in net assets, and statement of cash flows.

FISCAL IMPACT:

Financial Highlights

- There was a decrease in net assets of $4.5 million for the month of February.
- For the fiscal year ended February 28, 2019, the Plan’s performance is a decrease in net assets of $17.3 million, which is an unfavorable budget variance of $11.4 million.
- February FYTD net revenue was $483.2 million, $14.0 million higher than budget.
- Cost of health care was $472.4 million, $33.0 million higher than budget.
- The medical loss ratio was 97.8% of revenue, which is 4.2% higher than the budget.
- The administrative cost ratio was 6.7%, 0.4% lower than budget.
- February membership of 197,234 which is 5,655 below the budgeted average.
- Tangible Net Equity was $114.9 million which represents less than two months of operating expenses in reserve and 344% of the required amount by the State.

Revenue

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 $8.4 million is the associated expense for the additional Proposition 56 payments to providers.
Note: Proposition 56 increased the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including specified services in managed care effective July 1, 2017.

MCO Tax
MCO tax is a pre-determined liability in accordance with Senate Bill X2-2, passed in October 2016. The Plan’s MCO tax liability for FY 2019 is $94.5 million, accrued at a rate of approximately $7.9 million per month and paid on a quarterly basis.

Health Care Costs
February FYTD health care costs were $472.4 million, which was $33.0 million higher than budget. The medical loss ratio (MLR) was 97.8% versus 93.6% for budget. While we are noting some significant variances from budget, at a high level, medical expenses on a per member per month basis have stabilized.
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 $7.3 million (8.8%).**
  The inpatient costs for the month of February increased significantly from prior months due to a number of high dollar cases (over $100K) paid in February, with one claim over $600K that was paid for dates of service in March 2017. There have been a number high dollar cases – in the past several months, there has been 6 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 offset by reinsurance claims; the reinsurance line item is a positive budget variance of $4.4 million. Also, there was an increase in bed days per thousand in the latter part of FY 17-18, and a higher bed days per thousand in FY 18-19 as compared to the same time period last fiscal year. The increase is mostly seen in Administrative days and further research indicated it related to hard to place members with drug and/or alcohol dependencies, behavioral health issues, or homelessness. Administrative days are days where a member is stable to go to lower level of care, but placement is not available.

- **Physician Specialty exceeded budget by $4.5 million (12.4%).**
  The two highest specialties with significant increases to utilization are physical therapy and Dermatology. In a 6 month period, physical therapy increased by over $600,000. New authorization requirements were implemented on December 1, 2018 which may reduce costs. Dermatology increased almost $500,000 in a 6 month period and this is attributed to a single practitioner that is currently being monitored. We anticipate that these expenses will start to decrease.

- **Home & Community Based Services exceeded budget by $1.8 million (16%).**
  The increase is in part related to hospice services that have steadily increased as a result of the Palliative Care benefit mandated by DHCS effective January 2018.

- **Applied Behavior Analysis and Mental Health were $2.0 million (40.7%) and $1.7 million (38.8%) over budget, respectively.**
  There has been a steady increase in utilization which seems to be stabilizing.

- **Pharmacy exceeded budget by $3.9 million (4.6%).**
  The primary drug class driving the budget variance is dermatologicals. Recent actions by the Pharmacy and Therapeutics Committee to remove high cost dermatological generics and non-FDA approved drugs are proving effective in reducing the costs as noted in the graph.
- **Provider reserve in the amount of $1.6 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 February, administrative costs were $30.9 million and $5.4 million below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 6.7% versus 7.1% for budget.

**Cash and Short Term Investment Portfolio** – At February 28th, the Plan had $143.5 million in cash and short-term investments. The investment portfolio included Ventura County Investment Pool $41.4 million; LAIF CA State 5.1 million; the portfolio yielded a rate of 2.0%.

**Medi-Cal Receivable** – At February 28th, the Plan had $105.5 million in Medi-Cal Receivables due from the DHCS.

**RECOMMENDATION:**

Staff requests that the Commission accept and file the February 2019 financial package.

**ATTACHMENT:**

February 2019 Financial Package
FINANCIAL PACKAGE
For the month ended February 2019

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

**Assets**

<table>
<thead>
<tr>
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<th>02/28/19</th>
<th>01/31/19</th>
<th>12/31/19</th>
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<tbody>
<tr>
<td>Total Cash and Cash Equivalents</td>
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<td>$97,663,326</td>
<td>$107,381,809</td>
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<td>Total Short-Term Investments</td>
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<td>Provider Receivable</td>
<td>384,421</td>
<td>353,526</td>
<td>275,033</td>
</tr>
<tr>
<td>Other Receivables</td>
<td>6,781,626</td>
<td>6,779,244</td>
<td>7,381,543</td>
</tr>
<tr>
<td><strong>Total Accounts Receivable</strong></td>
<td>$113,059,694</td>
<td>$106,670,394</td>
<td>$104,407,314</td>
</tr>
<tr>
<td>Total Prepaid Accounts</td>
<td>1,726,030</td>
<td>2,029,019</td>
<td>1,374,001</td>
</tr>
<tr>
<td>Total Other Current Assets</td>
<td>170,560</td>
<td>170,560</td>
<td>135,560</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td><strong>258,427,130</strong></td>
<td><strong>251,322,119</strong></td>
<td><strong>259,403,862</strong></td>
</tr>
<tr>
<td>Total Fixed Assets</td>
<td>1,725,626</td>
<td>1,771,503</td>
<td>1,617,380</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$260,152,756</strong></td>
<td><strong>$253,093,622</strong></td>
<td><strong>$261,221,242</strong></td>
</tr>
</tbody>
</table>

**Liabilities & Net Assets**

<table>
<thead>
<tr>
<th></th>
<th>02/28/19</th>
<th>01/31/19</th>
<th>12/31/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incurred But Not Reported</td>
<td>$45,755,782</td>
<td>$43,912,816</td>
<td>$45,860,524</td>
</tr>
<tr>
<td>Claims Payable</td>
<td>35,941,444</td>
<td>35,112,812</td>
<td>25,321,265</td>
</tr>
<tr>
<td>Capitation Payable</td>
<td>28,661,916</td>
<td>28,661,953</td>
<td>28,597,879</td>
</tr>
<tr>
<td>Physician Payable</td>
<td>5,198,762</td>
<td>4,984,537</td>
<td>4,192,710</td>
</tr>
<tr>
<td>DHCS - Reserve for Capitation Recoup</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>217,748</td>
<td>1,198,868</td>
<td>248,753</td>
</tr>
<tr>
<td>Accrued ACS</td>
<td>3,224,668</td>
<td>1,631,555</td>
<td>1,620,572</td>
</tr>
<tr>
<td>Accrued Provider Reserve</td>
<td>1,536,819</td>
<td>1,333,658</td>
<td>1,230,621</td>
</tr>
<tr>
<td>Accrued Expenses</td>
<td>8,396,265</td>
<td>8,371,513</td>
<td>8,379,139</td>
</tr>
<tr>
<td>Accrued Premium Tax</td>
<td>13,687,065</td>
<td>5,811,650</td>
<td>21,562,481</td>
</tr>
<tr>
<td>Accrued Payroll Expense</td>
<td>1,528,455</td>
<td>1,535,436</td>
<td>1,236,066</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td><strong>144,169,945</strong></td>
<td><strong>132,604,496</strong></td>
<td><strong>138,356,030</strong></td>
</tr>
</tbody>
</table>

**Long-Term Liabilities:**

<table>
<thead>
<tr>
<th></th>
<th>02/28/19</th>
<th>01/31/19</th>
<th>12/31/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Long-term Liability-Deferred Rent</td>
<td>1,129,483</td>
<td>1,129,154</td>
<td>1,128,825</td>
</tr>
<tr>
<td><strong>Total Long-Term Liabilities</strong></td>
<td><strong>1,129,483</strong></td>
<td><strong>1,129,154</strong></td>
<td><strong>1,128,825</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>145,299,428</strong></td>
<td><strong>133,733,650</strong></td>
<td><strong>139,484,855</strong></td>
</tr>
</tbody>
</table>

**Net Assets:**

<table>
<thead>
<tr>
<th></th>
<th>02/28/19</th>
<th>01/31/19</th>
<th>12/31/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Increase / (Decrease in Unrestricted Net Assets)</strong></td>
<td>(17,262,043)</td>
<td>(12,755,399)</td>
<td>(10,376,984)</td>
</tr>
<tr>
<td><strong>Total Net Assets</strong></td>
<td><strong>114,853,328</strong></td>
<td><strong>119,359,972</strong></td>
<td><strong>121,736,387</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Net Assets</strong></td>
<td><strong>$260,152,756</strong></td>
<td><strong>$253,093,622</strong></td>
<td><strong>$261,221,242</strong></td>
</tr>
</tbody>
</table>
## Statement of Revenues, Expenses and Changes in Net Assets

### For Eight Months Ended February 28, 2019

<table>
<thead>
<tr>
<th></th>
<th>February 2019</th>
<th>February 2019 Year-To-Date</th>
<th>Variance</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>$ (Unf)</td>
<td>%</td>
</tr>
<tr>
<td><strong>Membership (includes retro members)</strong></td>
<td>197,234</td>
<td>1,587,479</td>
<td>(38,633)</td>
<td>-2.20%</td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td>69,060,519</td>
<td>546,234,343</td>
<td>15,291,983</td>
<td>2.88%</td>
</tr>
<tr>
<td>MCO Premium Tax</td>
<td>(7,875,415)</td>
<td>(61,678,206)</td>
<td>(1,325,016)</td>
<td>2.15%</td>
</tr>
<tr>
<td><strong>Total Net Premium</strong></td>
<td>62,185,104</td>
<td>483,231,021</td>
<td>13,966,966</td>
<td>2.98%</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>62,185,104</td>
<td>483,231,021</td>
<td>13,966,966</td>
<td>2.98%</td>
</tr>
<tr>
<td><strong>Medical Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>14,196,890</td>
<td>83,798,193</td>
<td>33,094,287</td>
<td>2.50%</td>
</tr>
<tr>
<td>LTC / SNF</td>
<td>5,373,066</td>
<td>20,602,856</td>
<td>45,475,427</td>
<td>3.20%</td>
</tr>
<tr>
<td>Laboratory and Radiology</td>
<td>337,799</td>
<td>1,240,778</td>
<td>40,900,778</td>
<td>2.00%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>2,073,630</td>
<td>7,750,792</td>
<td>17,953,968</td>
<td>1.87%</td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>5,085,147</td>
<td>40,628,533</td>
<td>17,096,062</td>
<td>5.63%</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>1,006,601</td>
<td>11,048,078</td>
<td>10,041,472</td>
<td>9.04%</td>
</tr>
<tr>
<td>Home &amp; Community Based Services</td>
<td>1,743,350</td>
<td>13,207,612</td>
<td>12,464,295</td>
<td>9.37%</td>
</tr>
<tr>
<td>Applied Behavior Analysis Services</td>
<td>832,024</td>
<td>9,124,944</td>
<td>8,292,920</td>
<td>9.00%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>752,748</td>
<td>5,393,696</td>
<td>4,640,940</td>
<td>17.11%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>9,169,955</td>
<td>68,821,944</td>
<td>70,962,994</td>
<td>10.36%</td>
</tr>
<tr>
<td>Provider Reserve</td>
<td>153,162</td>
<td>1,836,819</td>
<td>1,683,659</td>
<td>9.12%</td>
</tr>
<tr>
<td>Other Medical Professional</td>
<td>323,730</td>
<td>2,589,799</td>
<td>2,266,069</td>
<td>8.76%</td>
</tr>
<tr>
<td>Other Medical Care</td>
<td>5,122</td>
<td>23,416</td>
<td>22,294</td>
<td>94.04%</td>
</tr>
<tr>
<td>Other Fee For Service</td>
<td>782,283</td>
<td>5,674,312</td>
<td>4,892,029</td>
<td>17.63%</td>
</tr>
<tr>
<td>Transportation</td>
<td>203,894</td>
<td>1,150,050</td>
<td>946,156</td>
<td>82.22%</td>
</tr>
<tr>
<td><strong>Total Claims</strong></td>
<td>56,896,964</td>
<td>428,878,106</td>
<td>379,981,142</td>
<td>8.97%</td>
</tr>
<tr>
<td>Medical &amp; Care Management Expense</td>
<td>1,080,482</td>
<td>9,209,727</td>
<td>8,129,245</td>
<td>8.82%</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>245,738</td>
<td>(2,956,945)</td>
<td>4,407,684</td>
<td>219.31%</td>
</tr>
<tr>
<td>Claims Recoveries</td>
<td>(151,037)</td>
<td>(969,622)</td>
<td>818,585</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Cost of Health Care</strong></td>
<td>63,106,889</td>
<td>472,359,859</td>
<td>429,253,970</td>
<td>7.50%</td>
</tr>
<tr>
<td><strong>Contribution Margin</strong></td>
<td>(929,944)</td>
<td>(10,871,063)</td>
<td>(9,901,119)</td>
<td>(63.52)%</td>
</tr>
<tr>
<td><strong>General &amp; Administrative Expenses:</strong></td>
<td>1,910,510</td>
<td>16,770,270</td>
<td>14,860,620</td>
<td>88.68%</td>
</tr>
<tr>
<td>Salaries, Wages &amp; Employee Benefits</td>
<td>1,909,510</td>
<td>16,770,270</td>
<td>14,860,620</td>
<td>88.68%</td>
</tr>
<tr>
<td>Training, Conference &amp; Travel</td>
<td>27,971</td>
<td>176,377</td>
<td>158,406</td>
<td>89.50%</td>
</tr>
<tr>
<td>Outside Services</td>
<td>2,023,881</td>
<td>15,466,975</td>
<td>13,443,094</td>
<td>81.67%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>199,454</td>
<td>1,956,666</td>
<td>1,757,112</td>
<td>89.33%</td>
</tr>
<tr>
<td>Occupancy, Supplies, Insurance &amp; Others</td>
<td>605,883</td>
<td>4,750,278</td>
<td>4,144,393</td>
<td>87.27%</td>
</tr>
<tr>
<td>Care Management Credit</td>
<td>(1,080,482)</td>
<td>(9,209,727)</td>
<td>(8,129,245)</td>
<td>(89.21)%</td>
</tr>
<tr>
<td>G&amp;A Expenses</td>
<td>3,691,325</td>
<td>30,535,669</td>
<td>29,844,344</td>
<td>97.74%</td>
</tr>
<tr>
<td>Project Portfolio</td>
<td>94,478</td>
<td>952,184</td>
<td>857,706</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total G&amp;A Expenses</strong></td>
<td>3,772,801</td>
<td>30,948,053</td>
<td>27,175,252</td>
<td>88.18%</td>
</tr>
<tr>
<td><strong>Total Operating Gain / (Loss)</strong></td>
<td>(4,765,795)</td>
<td>(20,076,991)</td>
<td>(13,311,204)</td>
<td>(63.83)%</td>
</tr>
<tr>
<td>Non Operating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenues - Interest</td>
<td>259,151</td>
<td>2,814,947</td>
<td>(525,796)</td>
<td>18.60%</td>
</tr>
<tr>
<td>Total Non-Operating</td>
<td>259,151</td>
<td>2,814,947</td>
<td>(525,796)</td>
<td>18.60%</td>
</tr>
<tr>
<td><strong>Total Increase / (Decrease) in Unrestricted Net Assets</strong></td>
<td>(4,695,844)</td>
<td>(17,262,043)</td>
<td>(11,569,199)</td>
<td>(65.44)%</td>
</tr>
</tbody>
</table>
## INCOME STATEMENT BY CATEGORY OF AID
### FOR EIGHT MONTHS ENDED FEBRUARY 28, 2019

<table>
<thead>
<tr>
<th></th>
<th>AE</th>
<th>SPD</th>
<th>Classic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Membership (includes retro members)</strong></td>
<td>433,394</td>
<td>234,170</td>
<td>919,915</td>
<td>1,587,479</td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td>186,956,225</td>
<td>136,509,813</td>
<td>223,768,305</td>
<td>546,234,343</td>
</tr>
<tr>
<td>MCO Premium Tax</td>
<td>(17,283,313)</td>
<td>(9,213,499)</td>
<td>(36,506,510)</td>
<td>(63,003,322)</td>
</tr>
<tr>
<td><strong>Total Net Premium</strong></td>
<td>169,672,912</td>
<td>127,296,314</td>
<td>187,261,796</td>
<td>483,231,021</td>
</tr>
<tr>
<td><strong>Medical Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitalization (PCP, Specialty, Kaiser, NEMT &amp; Vision)</td>
<td>18,156,250</td>
<td>2,990,275</td>
<td>18,492,157</td>
<td>40,638,692</td>
</tr>
<tr>
<td><strong>FFS Claims Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>41,579,638</td>
<td>25,143,616</td>
<td>24,863,829</td>
<td>91,677,083</td>
</tr>
<tr>
<td>LTC / SNF</td>
<td>9,174,627</td>
<td>24,246,127</td>
<td>52,377,429</td>
<td>85,798,183</td>
</tr>
<tr>
<td>Outpatient</td>
<td>17,945,981</td>
<td>9,979,396</td>
<td>12,125,511</td>
<td>40,050,888</td>
</tr>
<tr>
<td>Laboratory and Radiology</td>
<td>1,215,024</td>
<td>315,283</td>
<td>1,067,347</td>
<td>2,597,654</td>
</tr>
<tr>
<td>Directed Payments - Provider</td>
<td>2,612,159</td>
<td>937,014</td>
<td>4,880,605</td>
<td>8,430,778</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>6,503,371</td>
<td>1,994,332</td>
<td>9,353,088</td>
<td>17,950,792</td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>18,110,971</td>
<td>8,735,869</td>
<td>13,781,693</td>
<td>40,628,533</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>3,412,502</td>
<td>1,917,458</td>
<td>5,218,117</td>
<td>11,548,078</td>
</tr>
<tr>
<td>Home &amp; Community Based Services</td>
<td>1,907,758</td>
<td>10,108,732</td>
<td>1,261,124</td>
<td>13,277,612</td>
</tr>
<tr>
<td>Applied Behavior Analysis Services</td>
<td>-</td>
<td>2,956,061</td>
<td>3,956,883</td>
<td>6,912,944</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>2,115,844</td>
<td>1,226,590</td>
<td>2,588,165</td>
<td>5,930,599</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>43,566,516</td>
<td>19,654,997</td>
<td>25,320,081</td>
<td>88,521,594</td>
</tr>
<tr>
<td>Adult Expansion Reserve</td>
<td>805,879</td>
<td>85,120</td>
<td>745,820</td>
<td>1,636,819</td>
</tr>
<tr>
<td>Provider Reserve</td>
<td>1,242,565</td>
<td>661,382</td>
<td>695,853</td>
<td>2,599,798</td>
</tr>
<tr>
<td>Other Medical Professional</td>
<td>(3,581)</td>
<td>(26,999)</td>
<td>23,418</td>
<td>23,418</td>
</tr>
<tr>
<td>Other Medical Care</td>
<td>1,268,560</td>
<td>3,829,844</td>
<td>1,848,808</td>
<td>6,747,321</td>
</tr>
<tr>
<td>Other Fee For Service</td>
<td>597,334</td>
<td>404,403</td>
<td>424,313</td>
<td>1,516,050</td>
</tr>
<tr>
<td>Transportation</td>
<td>3,875,845</td>
<td>2,706,314</td>
<td>(739,000)</td>
<td>5,843,150</td>
</tr>
<tr>
<td><strong>Total Claims</strong></td>
<td>152,059,697</td>
<td>112,022,732</td>
<td>161,276,677</td>
<td>425,358,106</td>
</tr>
<tr>
<td><strong>Medical &amp; Care Management Expense</strong></td>
<td>3,310,112</td>
<td>2,417,263</td>
<td>3,482,352</td>
<td>9,209,727</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>565,734</td>
<td>288,051</td>
<td>(3,251,729)</td>
<td>(2,396,945)</td>
</tr>
<tr>
<td>Claims Recoveries</td>
<td></td>
<td></td>
<td>(969,622)</td>
<td>(969,622)</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>3,875,845</td>
<td>2,706,314</td>
<td>(739,000)</td>
<td>5,843,150</td>
</tr>
<tr>
<td><strong>Total Cost of Health Care</strong></td>
<td>175,090,803</td>
<td>117,789,321</td>
<td>179,479,835</td>
<td>472,359,959</td>
</tr>
<tr>
<td><strong>Contribution Margin</strong></td>
<td>(6,417,891)</td>
<td>9,506,993</td>
<td>7,781,961</td>
<td>10,871,063</td>
</tr>
</tbody>
</table>
### STATEMENT OF CASH FLOWS

#### Cash Flows Provided By Operating Activities

<table>
<thead>
<tr>
<th>Description</th>
<th>February 2019</th>
<th>FYTD 18-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Income (Loss)</td>
<td>(4,503,644)</td>
<td>(17,262,043)</td>
</tr>
<tr>
<td>Adjustments to reconcile net income to net cash provided by operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation on fixed assets</td>
<td>45,877</td>
<td>361,359</td>
</tr>
<tr>
<td>Amortization of discounts and premium</td>
<td>-</td>
<td>(105,364)</td>
</tr>
</tbody>
</table>

#### Changes in Operating Assets and Liabilities

<table>
<thead>
<tr>
<th>Description</th>
<th>February 2019</th>
<th>FYTD 18-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts Receivable</td>
<td>(7,389,300)</td>
<td>(31,152,068)</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>302,989</td>
<td>(29,841)</td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>783,257</td>
<td>(159,324,433)</td>
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<tr>
<td>Claims Payable</td>
<td>1,064,140</td>
<td>13,056,116</td>
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<tr>
<td>MCO Tax liability</td>
<td>7,875,415</td>
<td>(6,585,192)</td>
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<tr>
<td>IBNR</td>
<td>1,842,966</td>
<td>(3,463,662)</td>
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</table>

#### Net Cash Provided by (Used in) Operating Activities

<table>
<thead>
<tr>
<th>Description</th>
<th>February 2019</th>
<th>FYTD 18-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Cash Provided by (Used in) Operating Activities</td>
<td>18,701</td>
<td>(204,505,328)</td>
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</tbody>
</table>

#### Cash Flow Provided By Investing Activities

<table>
<thead>
<tr>
<th>Description</th>
<th>February 2019</th>
<th>FYTD 18-19</th>
</tr>
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<tbody>
<tr>
<td>Proceeds from Restricted Cash &amp; Other Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from Investments</td>
<td>-</td>
<td>172,056,288</td>
</tr>
<tr>
<td>Proceeds for Sales of Property, Plant and Equipment</td>
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<td>0</td>
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<tr>
<td>Payments for Restricted Cash and Other Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of Investments plus Interest reinvested</td>
<td>(131,911)</td>
<td>(21,789,507)</td>
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<tr>
<td>Purchase of Property and Equipment</td>
<td></td>
<td>(113,868)</td>
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#### Net Cash (Used In) Provided by Investing Activities

<table>
<thead>
<tr>
<th>Description</th>
<th>February 2019</th>
<th>FYTD 18-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Cash (Used In) Provided by Investing Activities</td>
<td>(131,911)</td>
<td>150,152,913</td>
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</table>

#### Increase/(Decrease) in Cash and Cash Equivalents

<table>
<thead>
<tr>
<th>Description</th>
<th>February 2019</th>
<th>FYTD 18-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and Cash Equivalents, Beginning of Period</td>
<td>97,063,326</td>
<td>151,302,531</td>
</tr>
<tr>
<td>Cash and Cash Equivalents, End of Period</td>
<td>96,950,115</td>
<td>96,950,115</td>
</tr>
</tbody>
</table>
AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Nancy Wharfield, MD, Chief Medical Officer

DATE: April 22, 2019

SUBJECT: Chief Medical Officer Update

Quality Update

At the April 11, 2019 Chief Medical Officer meeting in Sacramento, the Department of Health Care Services (DHCS) shared details about their proposed response to Governor Newsom’s mandate to improve quality for Med-Cal members.

- The measure set will change from the Healthcare Effectiveness Data and Information Set (HEDIS) to the CMS Child and Adult Core sets.
- The minimum performance level (MPL) benchmark will change from 25th percentile to 50th percentile of US Medicaid plans. (DHCS will establish alternative benchmarks when Medicaid information is not available).
- The responsibility for reporting rates will be divided between Managed Care Plans (MCPs) and DHCS. DHCS will report on administrative measures (claims-based) and MCPs will report on hybrid measures (claims-based complemented by medical chart review).
- Quality oversight processes will be enhanced, progressive, and for repeated poor performance could result in financial sanctions, placement of a DHCS monitor with the Plan, and/or contract termination.
### CHANGES TO QUALITY MONITORING

<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Current</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Set</td>
<td>HEDIS</td>
<td>CMS Child and Adult Core Sets</td>
</tr>
<tr>
<td>MPL*</td>
<td>25th Percentile</td>
<td>50th Percentile</td>
</tr>
<tr>
<td>Reporting of Results</td>
<td>MCP – All Measures</td>
<td>MCP – 13 Hybrid Measures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DHCS – 8 Admin Measures</td>
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</table>

*Minimum Performance Level

### ENHANCED QUALITY OVERSIGHT PROPOSAL

<table>
<thead>
<tr>
<th>Tier</th>
<th>PDSA/PIP*</th>
<th>Quarterly Summary To DHCS</th>
<th>Technical Assistance Calls</th>
<th>In-Person DHCS Meeting</th>
<th>Progressive Sanctions</th>
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<tbody>
<tr>
<td>Tier 1</td>
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<td>✓</td>
<td>✓</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
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<td>✓</td>
<td>✓</td>
<td>1x/year</td>
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<tr>
<td>CAP*</td>
<td>✓</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Maximum # 8</td>
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<td>Tier 3</td>
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<td>Multi-Year Tier 3</td>
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<tr>
<td>CAP</td>
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<td></td>
<td>✓</td>
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<tr>
<td></td>
<td>Maximum # 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Plan Do Study Act/Performance Improvement Plan
*Corrective Action Plan

### Pharmacists as Providers

The DHCS Pharmacy Division has announced that pharmacists will be allowed to provide the following services to Medi-Cal members:

- Naloxone (opioid overdose reversal drug)
- Self-administered birth control
- Immunizations
- Nicotine replacement
- Travel medications

This is an important opportunity to increase our member’s access to services and improve quality outcomes. As more information is available, GCHP staff will work with interested
pharmacists to learn more about requirements around becoming a Medi-Cal provider, billing, and coding for these services.

**Changes to Medi-Cal Incontinence Supply Formulary**

Changes to the Medi-Cal Incontinence Supply Formulary have impacted the kind of incontinence briefs/diapers our members over 5 years of age receive under the Medi-Cal benefit administered by GCHP.

DHCS adopted new incontinence supply standards based on the National Quality Performance Standards for Disposable Adult Absorbent Products for Incontinence assembled by the National Association for Continence (NAFC). NAFC found that "A nonbreathable, plastic outer layer or pant negatively impacts skin health, contributes to trapped heat, and thus more perspiration, and increases the risk of skin breakdown. It also contributes to the growth in odor-causing bacteria, is noisy and uncomfortable, and generally service no useful benefit over high-quality disposable briefs/absorbents with breathable zones." Effective April 1, 2018 the Medi-Cal formulary was changed to exclude products not meeting these standards. Large distributors were allowed to dispense remaining supplies, which meant members who requested plastic lined briefs were not impacted until those supplies were depleted and could no longer be obtained.

Approximately 3,300 GCHP members receive diapers and there are over 300 products on the Medi-Cal formulary. Distributors, such as Shields and Byrum, routinely work directly with members to help them choose the best available product, and then ship them to the member’s home as needed. Distributors began transitioning members to alternate products beginning in the spring of 2018. Manufacturers of incontinence supplies then notified distributors that products with plastic backings would no longer be manufactured after August 2018. In July 2018, Shields, who supplies over 65% of all incontinence supplies to GCHP beneficiaries, sent written notification in English and Spanish to the 68 members that had not transitioned to a covered incontinence item. This notice advised members and families that manufacturers were no longer producing the plastic backed briefs/diapers due to the change in national standards.

As the health plan becomes aware of issues, members are referred to Care Management for assistance in obtaining high level replacements within the Medi-Cal Incontinence Supply Formulary. GCHP has received two (2) grievances since April 1, 2018 related to incontinence supplies. The health plan's CM staff has facilitated a satisfactory transition for both these members to an alternative product on the State's list of products. The CM staff subsequently acquired several boxes of product samples that are being used to facilitate discussions and transitions with families and caregivers of those members who need alternative products. Additionally, staff are actively interfacing with the large distributors of the incontinence products, Tri-Counties Regional Center, and Rainbow Coalition to better understand the problems our members are experiencing and to proactively advocate for the members. A
provider communication is being planned to inform PCP’s of changes and resources available to help with members they may become aware of needing assistance.

Another consideration to ensure the provision of high quality products would be an RFP for selection of a preferred provider/distributor of incontinence supplies. While this solution could limit choice for members who prefer to use a local DME supplier, such as local pharmacies, it would ensure a consistent quality of choice, communication, and selection for all members.

Public Health Update

As of April 11, 2019, 555 cases of measles have been confirmed in 20 states, including California. This is the second greatest number of reported cases since measles was eliminated in the in the US in 2000. The majority of people who got measles were unvaccinated. Measles outbreaks have been linked to travelers bringing measles back from other countries such as Israel, Ukraine, and the Philippines where large outbreaks are occurring. The Centers for Disease Control and Prevention (CDC) recommend keeping all vaccines up to date and to make sure you are vaccinated against measles before travelling internationally.

CDC is reporting that influenza activity continues to decrease but is relatively high for this time of year. Influenza A (H3N2) is the predominant circulating strain in California. A total of 486 deaths have been attributed to influenza since September 20, 2018 (86 were pediatric deaths). Several more weeks of flu activity are expected and the California Department of Public Health stresses that it’s not too late to get vaccinated.

Pharmacy Benefit Performance and Trends

SUMMARY:

Pharmacy utilization data is compiled from multiple sources including the pharmacy benefits manager (PBM) monthly reports, GCHP’s ASO operational membership counts, and invoice data. The data shown is through the end of February 2019. Although minor changes may occur to the data going forward due to the potential of claim adjustments from audits and/or member reimbursement requests, the data is generally considered complete due to point of sale processing of pharmacy data.

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

Total Cost vs. Utilizing Members

PMPM vs. Utilizing Percent
Total Claims vs. GDR

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

PAID PER PRESCRIPTION:

Dollars Paid Per Prescriptions

Paid/Rx  Paid/Generic Rx  Paid/Brand Rx
**PRESCRIPTIONS PER MEMBER PER MONTH:**

Prescriptions Per Member Per Month

*Calculation reflects net claims.

**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 – Ongoing</td>
<td>1</td>
</tr>
<tr>
<td>DEA Investigations</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).
ON GOING PHARMACY INITIATIVES

**Clinical Programs:**
Gold Coast Health Plan has selected the following clinical programs offered by OptumRx:

<table>
<thead>
<tr>
<th>Programs</th>
<th>Modules</th>
<th>Start Date</th>
<th>Outcomes</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Retrospective Drug Utilization Review (RDUR) | • Safe and Appropriate Utilization  
• Gaps in Care                                      | 10/1/2018  | Initial outcomes and provider feedback are being reviewed for potential process improvement  | Potential to impact some HEDIS rates       |
| Opioid Risk Management                | • Retrospective Drug Utilization Review (RDUR)  
• Intensive Case Management                | 10/1/2018  | Preliminary outcome data is being reviewed                                               |                                            |

**Provider Relations:**
Gold Coast Health Plan is reaching out to providers offices in the following mechanisms in order to facilitate a more efficient process for provider offices:
- Provider Survey on PBM Functions
- GCHP Pharmacy Staff Provider Office Visits
AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Chief Diversity Officer

DATE: April 22, 2019

SUBJECT: Chief Diversity Officer Update

Community Relations

- Presented Personal Branding and Diversity seminar to several groups at Moorpark College. Over 1500 students in attendance.
- Met with a community group in Ventura County organized by the NAACP to address student relationship issues in the Ventura County schools.
- Working with Irene Pinkard of The Pinkard Institute, to put together a directory of diverse resources in Oxnard, Camarillo, Westlake, Thousand Oaks and Simi Valley.
- Met with Joseph Ortiz of BBK to understand prior handling of the “Diversity Hotline” and to smoothly transition to me as primary contact by NAVEX, the administrator of the “Hotline” service. Had phone call with Sarah Wright who supports GCHP’s NAVEX concerning other diversity initiatives that are a part of our contract.

Gold Coast Health Plan

- Held Diversity Council meeting at GCHP with a focus on identifying major diversity events in the surrounding communities. A diversity quiz was developed to distribute to the employees for the purpose of identifying community events that should be recognized.
- Three (3) coaching sessions were conducted - not related to Diversity (mostly career development).
- **No diversity Investigations during the month.**
- **There were no “Hotline” calls during the month.**
- Sat in on orientation on the use of the NAVEX system for logging diversity calls.
- Met with Supervisor Zaragoza to give an update on current diversity direction and community concerns.
- Bi-weekly business update with Dale Villani, CEO, GCHP.
- Diversity training for Commissioners is scheduled for May 29, 2019 in the Community Room at GCHP.
AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Ruth Watson, Chief Operating Officer
DATE: April 22, 2019
SUBJECT: Chief Operating Officer Update

Optometry Public Comment Response:

In the March 25, 2019 Commission meeting a public comment was made by Chris Velasco, Chief Financial Officer (CFO) from Clinicas del Camino Real (CDCR). According to the audio recording of the meeting Ms. Velasco stated that “she received notification that Medi-Cal patients could not find Clinicas listed in the vision provider roster on the GCHP website. She stated that 60 providers within the 93030 zip code (within a 30-mile radius) were found. Of the 60 providers, 26 accepted Medi-Cal, 34 did not, and only 17 had staff that were Spanish speaking. Ms. Velasco requested that GCHP add Clinicas’ six sites to the optometry roster as soon as possible. She also requested that GCHP staff meet with VSP to get availability of the on-site process for Medi-Cal members. Ms. Velasco requested that Clinicas be treated like any other GCHP contracted optometry office. She also stated a clean-up of the optometry roster was needed to provide better service to the Medi-Cal population.”

GCHP staff has researched the issue raised by Ms. Velasco and determined the following:

- GCHP is required by DHCS to provide optometry services to its members with full-scope Medi-Cal benefits. Like most Medi-Cal Managed Care Plans, GCHP contracts with a third-party vision services program, Vision Services Plan (VSP) to provide optometric services to GCHP members.
  - VSP covers about 80 million people worldwide, is the largest vision insurance company in the United States and has the largest eye care doctor network in California.
- GCHP has a capitlated arrangement with VSP and does not contract directly with Optometrists.
- CDCR Optometrists do not have a contract with VSP and therefore are not listed in the VSP provider directory.
- Should CDCR decide to contract directly with VSP they would be listed in the VSP directory.
- GCHP has made special arrangements with VSP to pay for covered vision services provided to GCHP members by CDCR optometrists, despite the fact that they are not contracted with VSP.
- When a member accesses the GCHP paper directory and searches for an Optometrist they are directed to VSP. (Attachment 1)
- When a member accesses the GCHP on-line directory the VSP tab will automatically direct them to the VSP website where they can access available providers by zip code and language. (Attachment 2)
The GCHP website lists VSP and does not spell out Vision Services Plan. This is a known gap and one that will be addressed as part of the website re-design project.

Review of the VSP on-line directory indicates the following number of vision care providers located within 5 and 25 miles of zip code 93030 (Attachment 3)

- Spanish speaking:
  - Within 5 miles of 93030 - 10 providers
  - Within 25 miles of 93030 – 24 providers
- English speaking:
  - Within 5 miles of 93030 - 17 providers
  - Within 25 miles of 93030 – 30 providers

Executive Summary

Membership - GCHP membership for April 2019 is 196,769; an overall increase to the Plan of 605 members. Monthly membership continues to churn as the plan had a decrease of 6,317 members, an increase of 4,051 and a retroactive adjustment of 2,871 members coming back into the Plan.

Call Center – GCHP's call center continues to perform well against established metrics. Additionally, talk time continues to decrease as new call center agents become more seasoned in their roles. The addition of agents in the Tempe Call Center has achieved the goals of meeting the member expectations and metrics.

Operations Scorecard – The March COO report introduced a section highlighting a specific element of the metrics we measure on a monthly basis. We discussed Long Term Care Conversion Rate in March. This month, staff is highlighting Days Receipt On Hand (DROH).

DROH is a measure that calculates the number of days needed to process all of the claims currently received. The methodology is to divide the total number of claims distributed across the current number of claims staff processing claims at the peak processing rate. The goal is to complete all received claims within 5 working days. The current claims DROH is 7 working days and although that is higher than the Plan’s 5-day goal, we continue to consistently meet the regulatory requirement for processing 90% of all claims within 30 calendar days with a plan performance in March of 92.7%.

Several elements can impact the DROH measure. Some of these causes include: increase to claim volume, decrease in auto adjudication rate, staffing changes or decrease in production rates. While these are some of the reasons, there are many root causes that can impact DROH.

The Plan works monthly with Conduent to review and identify trends impacting DROH to determine what may be impacting changes in this metric. In April we have determined
that the impact to the DROH is a combination of the automated Medicare COB file and staff attrition on the claims team. The Conduent and GCHP claims teams have convened a group of subject matter experts to review how/if we can improve the electronic processing of this file to reduce the amount of manual intervention currently required.

**Regulatory** – GCHP staff have received numerous requests from DHCS over the past month requiring tight turnaround times. The following is a list of what Plan staff has received and completed:

- DHCS Annual Network Certification Report-completed 3/14
- DHCS submission of new GCHP Hospital Services Agreement template for audit of contractual requirements- completed 3/27
- DHCS ACA OE Health Plan Survey for CY 2017 RDT- completed 3/29
- DHCS SNF, LTC, CBAS Annual Network Certification Supplemental Report-completed 3/29
- DHCS Hospital Contract Audit Request- completed 4/2
- DHCS Delegated Entities Survey- completed 4/5. Additional follow-up received from DHCS and survey revised and re-submitted on 4/11
- DHCS Validation Request of provider contracts applicable for Direct payment- completed 4/15
- DHCS Pre-Annual Audit Survey Request- completed 4/16
- DHCS Pharmacy and Hospital provider Validation- completed 4/17
- DHCS Hospital Boiler Plate modifications- in process, due 4/28

**Provider Contracting and Credentialing Management System (PCCM)** – This major system initiative to replace both GCHP Network Operations and Credentialing’s legacy provider network data base, kicked off on April 8th. It is expected that the system implementation and integration will take 12 months from the date of the kick-off meeting.

**Better Doctors** – GCHP staff continues to verify the demographic information obtain from Better Doctors. The initial reports provided updated information for 1360 provider records. In order to ensure accurate information is loaded into the GCHP provider database. To date, GCHP staff have reviewed and/or updated 328 provider records. To date, GCHP staff have reviewed and completed all 1360 provider records on the 1st report and is in the process of working on the 2nd report which contains 1100 provider updates. GCHP staff have completed review of 642 of those providers.

**Provider Contracting Update** – GCHP staff are in the process of reviewing the more detailed demographic updates and are following up directly with providers to obtain this information. To date, GCHP staff have updated and/or requested information from 103 providers.

**Contracting:**
• Contracted with an acupuncturist with locations in Camarillo and Oxnard, a key network need.
• Transitioned four Interim Letters of Agreement with providers are part of the Medi-Cal enrollment certification into Amendments.
• Transitioned one Interim Letter of Agreement with delegated entity that added additional clinic site which included the transitioning of 27 providers to fully contracted status.
• Added four Amendments with rate and/or code adjustments:
  - 1 Hospital
  - 2 Home Health/Hospice
  - 1 Laboratory

I. Member PCP Assignments
Unassigned members are Newly Eligible/Enrolled Administrative Member(s)

Share of Cost (SOC): a Member who has Medi-Cal with a Share of Cost requirement.

Long-Term Care (LTC): A Member who is residing in a skilled or intermediate-care nursing facility and has been assigned an LTC Aid Code.

Out of Area: A Member who resides outside GCHP’s service area but whose Medi-Cal case remains in Ventura County.

Other Health Coverage: A Member who has other health insurance that is primary to their Medi-Cal coverage; this includes Members with both Medi-Cal and commercial insurance. Medi-Cal is the payer of last resort; therefore GCHP Members with other coverage must access care through their primary insurance.
Operations Scorecard - April 2019

Days Receipts on Hand: Missed by 2 days, claim volume remains high, root causes include attrition and impact of Medicare COB file integration.
Acknowledgement TAT: Missed by 1%, root cause identified as higher volume of appeals due to CMS mega rule, staff addressing need to increase G&A staff.
Resolution TAT: Missed by 3%, root cause is a combination of increased volume and a staff member leave of absence.
DHCS Encounter Data Report Card: Missed by 15%, this remains an impact of Pharmacy claim reprocessing.
Attachment 1
Ventura County
Vision Service Plan

Vision Service Plan

Phone/Telefon: 1-800-877-7195
Hours/Horas: M-F 5am-8pm S 6am-5pm

For assistance with translation and hearing impaired callers may call 1-800-428-4833

Website: www.vsp.com

Email: iMember@vsp.com

Members can fill out the VSP online email form to get a response within 12 - 15 business hours.
Attachment 2
Welcome Members

At Gold Coast Health Plan we have a Member-first focus that's geared to maintaining the health of you and your family. We take our role in the community seriously and make every effort to provide the highest quality care and choice for our Members.

Our Member Services Department and call center representatives are skilled at helping you learn about your coverage and how to get the services you need. We can answer your questions in English or Spanish. If your language is not spoken by one of our team members, we'll provide interpreter services in the language you need.

So give us a call at 888.301.1228, and remember: We're more than a managed healthcare system; we're your partner in maintaining good health.

Pending Applicants and Newly Enrolled Medi-Cal Members

Find out how to enroll and what to do next.
Attachment 3
Get the most out of your benefits, all at one convenient location:

- Available to all VSP Members
- Preventative eye health and wellness program participant
- Wide selection of featured frame brands
- Advanced eye exam technology
- Performance lenses for sharp vision

**PREMIER PROGRAM**

**REFINE YOUR SEARCH**

- Show Results Within: 25 miles
- Frame Brand: Choose a Brand
- Language: Spanish
- Doctor Network: Medicare
- Services: Doctor Profiles, New Patients Welcome, Eye Exam, Advanced Eye Exam, Extensive Hours, Express Service, Laser Vision Care, Vision Therapy, Children Ages 0-6, Preventive Eye Care, Special Offers & Savings, CareCredit Credit Card

**MEDICAID NETWORK SEARCH RESULTS**

**A Street Optometric Center**
- Contact: 362 S A St
  - Oxnard, CA 93030
  - (805) 402-8510
- Hours: Mon - Fri 9:00 - 5:00
- Distance: 0.75 miles
  - View Map
  - Handicap Accessible

**William J Shaffer OD**
- Contact: 340 S 5th St
  - Oxnard, CA 93030
  - (805) 493-8000
- Hours: Mon - Wed, Fri 9:00 - 5:00
  - Thu 9:00 - 4:00
  - Sat 9:00 - 12:00
- Distance: 0.93 miles
  - View Map
  - Handicap Accessible

**Phyllis Quintana OD**
- Contact: 607 W 7th St
  - Oxnard, CA 93030
  - (805) 487-0600
- Hours: Mon - Thu 9:00 - 5:00
  - Fri 9:00 - 4:00
- Distance: 1.26 miles
  - View Map
  - Handicap Accessible

**Family Optometric Group**
- Contact: 1645 W 5th St Ste 100
  - Oxnard, CA 93030
  - (805) 382-2020
- Hours: Mon, Wed 9:00 - 5:30
  - Tue, Thu 9:00 - 6:00
  - Fri 9:00 - 5:00
- Distance: 1.08 miles
  - View Map
  - Handicap Accessible
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<th>Premier Program</th>
<th>Channel Islands Optometric Center</th>
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<tr>
<td><strong>Contact</strong>:</td>
<td>591 W Channel Islands Blvd</td>
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<tr>
<td></td>
<td>Port Hueneme, CA 93041</td>
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AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Maddie Gutierrez, Clerk to the Commission
DATE: April 22, 2019
SUBJECT: Meeting Minutes of March 25, 2019 Regular Commission Meeting

RECOMMENDATION:
Approve the minutes.

ATTACHMENTS:
Copy of the March 25, 2019 Regular Commission Meeting minutes.
CALL TO ORDER

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

PLEDGE OF ALLEGIANCE

Commissioner Alatorre led the Pledge of Allegiance.

ROLL CALL


Absent:  Commissioner Jennifer Swenson.

OATH OF OFFICE

The Oath of Office was administered to new Commissioner Supervisor John Zaragoza.

PUBLIC COMMENT

1. Arnoldo S. Torres appeared on behalf of the Working Group for Better Health Care and Accountability for Ventura County and Clinicas del Camino Real.

   Mr. Torres requested additional time for his public comment. The Chair allowed the extra time. Mr. Torres first wanted to clarify comments made by CEO Dale Villani at the February 2019 Commission meeting about the topic of securing legislative support for the two-plan model. He stated, “There are authors for a spot bill, and will consider moving forward in legislature.”

   Mr. Torres then addressed errors written in a letter published by the VC Star about the two-plan model. One was around commission composition. Mr. Torres clarified that there are actually five county employees on the GCHP Commission, but he had originally counted Dr. Dial as a county employee also, as he was once affiliated with the County, and added that a second hospital representative was not included. The other mistake was in reference to the [GCHP] budget of $800 million dollars per year referenced in the letter. Mr. Torres stated that the budget fluctuates per enrollment at approximately $700 million.
Mr. Torres then provided the Commission with copies of an open letter he drafted, along with various articles. Mr. Torres stated the letter includes specifics on information requested from the Plan, and asked that a response to the letter be provided within ten days. He referenced the following requested items: the outreach plan CDO Ted Bagley compiled; the salaries of the Executive team including any bonus payments made since Dale Villani became the CEO; a list of all outside consultants under contract; the reasons for outsourcing along with RFP process information; and information on contractors allowed to bid on a contract when they have already been doing consulting prior to the bid process. Mr. Torres indicated some of these informational requests would be provided as an addendum to his letter.

Mr. Torres expressed concern around the timing of the Commission meetings (scheduled monthly at 2 pm), suggesting the meetings need to be more accessible to the public, allowing beneficiaries to participate and understand what is discussed.

Mr. Torres then questioned the Plan’s managed care performance, referencing the 2016 [DHCS] Managed Care Performance Dashboard. He stated that the Ventura County Health Plan was in 21st place, below the 60% performance level. Then, in 2017, performance was down to 50 out of 53 plans with a score of 43, and that last year the plan went up to 31 out of 50 and were at 59/60 when the weighted average was at 68%. Mr. Torres described this as a “whiplash”. He stated, “Per GCHP minutes, there is no explanation for this whiplash.”

Mr. Torres moved to the topic of the Executive Finance Committee. He inquired about the number of times the committee met last year, this year and wanted a record of what committee activities occurred during the meetings.

Mr. Torres stated, “There will continue to be cameras brought to the meetings to monitor what is said and ensure the minutes accurately reflect what has taken place.”

Dr. Dial responded to Mr. Torres’ earlier comments around the commission make-up, providing clarification around his employment with the County. Dr. Dial stated that he left employment with the county 12½ years ago, prior to when the [GCHP] Commission began. Dr. Dial further clarified that his seat on the Commission represents the Ventura County Medical Association. He stated that he has worked closely with the County as well as with Clinicas, was appointed by the Board of Supervisors, and is the longest active member on the Commission.

2. Dr. Sandra Aldana appeared on behalf of the State Council on Developmental Disabilities.

Dr. Aldana stated that March is Developmental Disabilities Awareness Month and that the community is happy to partner with providers to foster a better understanding of living with a disability.
3. Christina Velasco, Chief Financial Officer appeared on behalf of Clinicas del Camino Real to discuss vision services.

Ms. Velasco reported that she received notification that Medi-Cal patients could not find Clinicas listed in the vision provider roster on the GCHP website. She stated that 60 providers within the 93030 zip code (within a 30-mile radius) were found. Of the 60 providers, 26 accepted Medi-Cal, 34 did not, and only 17 had staff that were Spanish speaking. Ms. Velasco requested that GCHP add Clinicas’ six sites to the optometry roster as soon as possible. She also requested that GCHP staff meet with VSP to get availability of the on-site process for Medi-Cal members. Ms. Velasco requested that Clinicas be treated like any other GCHP contracted optometry office. She also stated a clean-up of the optometry roster was needed to provide better service to the Medi-Cal population.

Commissioner Atin asked if Ms. Velasco had recently contacted GCHP on her concerns. Ms. Velasco responded that she should not have to tell GCHP what their job is.

Supervisor Zaragoza requested a link be added to the GCHP website to include Clinicas. CEO Villani replied that staff would review the concerns noted and take appropriate actions to ensure Medi-Cal patients have access to the information. Supervisor Zaragoza asked if providers who accept Medi-Cal are listed as opposed to those who do not. COO Ruth Watson stated that if the provider is listed in the GCHP directory, they should take Medi-Cal.

Commissioner Alatorre inquired about the monthly monitoring process (under SB137) of all vendors to ensure providers who accept Medi-Cal are listed, along with language assistance. Compliance Officer, Brandy Armenta replied that the Plan submits monthly files to DHCS. The files are reviewed by DHCS as well as the GCHP provider relations team. Commissioner Alatorre asked why Clinicas was not listed, to which Ms. Armenta replied that Clinicas is contracted with VSP and would need to check with VSP as this is the first she has heard this.

4. Ana Barranco appeared on behalf of her daughter, Litzy Gaspar, on the topic of diapers.

Ms. Barranco expressed concern about the quality of the diapers, which she stated is poor. CMO Nancy Wharfield, M.D. stated there was a benefit change at the state level for diapers due to clinical reasons. Dr. Wharfield explained that the National Association for Continence made recommendations to the department to change the type of diaper based on studies that showed increased heat trapping, moisture and bacterial growth contributed to skin break down. Due to these issues, the products were removed from the list of benefits. A new type of diaper, with a more breathable material is now used, and more frequent changes may be required.

COO Watson asked if a formal grievance was filed, to which Ms. Barranco replied that she was in the process. COO Watson suggested that this is good information for the plan to present to the State and that the more information members could provide would help to bring further attention at the state level around the issue.
Commissioner Alatorre asked if there was a current appeal process. Dr. Wharfield stated it is not a medical benefit, so the appeal process would not apply, but what would be advocated for is high quality breathable products on the Medi-Cal formulary.

5. Joe S. Ramirez appeared on behalf of Santa Clara Valley LULAC Council on the topic of a two-plan model.

Mr. Ramirez stated that organizations need to work together to better serve the people of Ventura County. He is in support of a two-plan model as, "we live in a democracy and there should be the ability to have choice". Mr. Ramirez added that the mental health population has been underserved in the Santa Clara Valley area and that these patients should also be given the option of choice. He encouraged the Commission to consider a two-plan model.

6. Cynthia Salas appeared on behalf of the Working Group for Better Health Care and Accountability for Ventura County.

Ms. Salas stated that culturally competent providers are needed along with more communication in the community. Ms. Salas suggested there should be after-hours meetings to ensure transparency. She also stated that comments from the community have been devalued and that she would like a solution to be found for the community. She asked that GCHP staff be mindful of the words used when speaking with the local newspaper and talking about the community.

7. Roberto S. Juarez appeared on behalf of Clinicas del Camino Real to speak about the AHP Plan-to-Plan contract.

Mr. Juarez stated the [GCHP] Commission passed two motions for the Plan-to-Plan contract, and that seven years later, nothing has happened. Mr. Juarez stated that, "Templates and DOFRS have been discussed. Changes have been made and discussed again. Tens of thousands of dollars in legal fees have been spent and thousands of man hours as well. Now there is a proposal for 5,000 lives for one year." Mr. Juarez stated that he does not want it and instead wants the past motions to be honored. He indicated that he does not want to do away with Gold Coast, but wants to convert it to a two-plan model. Mr. Juarez asserted that the only contracts presented before the Commission are AHP and Clinicas. He stated that, "CEO Villani said to Clinicas staff that he has full authority to do the Plan-to-Plan and doesn’t need Commission approval, yet he defers to the Commission, in order to wash his hands and laugh."

Mr. Juarez alleged that his 990’s were pulled and were made public in the newspaper at the doing of GCHP staff. He stated his retirement plan has been earned, as has his staff’s. Mr. Juarez asserted that GCHP staff is "now investigating the largest minority agency in this county, and attempting to publicly humiliate Clinicas." He stated that they [GCHP] are auditing Clinicas and state that they [Clinicas] are failing, yet Clinicas has the highest HEDIS measures, and is number one out of eight in the County for NCQA designation, level three. Mr. Juarez further stated that GCHP requested additional information, although it was
not part of the audit, and [Clinicas] is now put on a corrective action plan. “There were 22,000 immunizations that went wrong with County, yet is there a corrective action plan for them? Probably not.”

Mr. Juarez said that GCHP is going out of their way investigating Clinicas and trying to find dirt as well as trying to get the names, phone numbers and occupations of LULAC and the Latino Town Hall members so they can contact them. He alleged that the CEO is investigating a civil rights organization and stated the Commission is responsible and needs to get things back on track. “CEO Villani and Gold Coast was established to manage Medi-Cal lives, provide care, contract as much as possible with local organizations and provide services to the Medi-Cal population.”

Mr. Juarez added that he had considered retiring, but when CEO Villani “met with a group from Northern California for insider trading on the PACE program, he decided he would stay on, in hopes that he would see the mess cleaned up.”

8. Dr. Henry Villanueva appeared on behalf of the two plan system and mental health.

Dr. Villanueva stated that one group is being isolated for trying to push the two-plan model and that is a form of bullying. In reality, the Commission needs to look at what is best for the community. Approximately 25% of the community are Medi-Cal recipients. One of the cornerstones as a democracy is transparency and choice. There is also a serious problem with mental health in Ventura County. Many have gone with no response for their mental health issues. Dr. Villanueva asserted that GCHP is not meeting the needs of the community.

9. Lorenzo Moraza provided public comment. He is a resident of Santa Paula.

Mr. Moraza stated that he and has worked with various community organizations and is concerned with the quality of services in Ventura County. He stated that a 2 pm meeting time is not practical and that there needs to be transparency and good communication.

10. Imelda Magana appeared on behalf of her daughter, Johana Magana, to discuss the topic of diapers. She was assisted by the interpreter.

Ms. Magana spoke about the change in the diapers, stating that the material is different and the quality is poor. She provided samples to show the Commission the difference in quality, also mentioning that sizes vary from month to month and are often not available in the size needed for her daughter. Supervisor Zaragoza stated there is a need for a petition to the State for better quality diapers. Dr. Wharfield added that the plastic wrapped diaper is more durable, but causes skin breakdown. Dr. Wharfield stated she would address this concern with local DME providers. Commissioner Alatorre asked for a report at the next Commission meeting on how many patients are affected and potential solutions to this issue. Commissioner Alatorre stated he would like an update on a monthly basis.

11. Laurie Jordan provided public comment about the poor quality of the diapers.
Ms. Jordan stated that the diapers do not work and that they leak. She added that it is embarrassing for the patient and a burden for the family, who are often the caregivers. Ms. Jordan stated that the diapers are changing quality of life; they need to be changed more often; bedding is constantly soiled. She stated, “This is a dignity issue.”

Commissioner Alatorre modified the order of the agenda, stating that Consent items would be reviewed first.

PUBLIC COMMENT cont’d.

12. Rick Castaniero appeared on behalf of LULAC regarding the two-plan model.

Mr. Castaniero stated there are challenges with maintaining just one plan and that there should be a choice for medical care for individuals. Mr. Castaniero then introduced two Medi-Cal beneficiaries who receive services and reside on the Southside of Oxnard. He stated that that they [the beneficiaries] are not satisfied with the treatment they receive. Mr. Castaniero said, “This should not be about politics. This should be for the betterment of the people that are served through Medi-Cal.” He asked the two organizations to learn to work together for the benefit of the people they serve, asserting that the COHS has not been able to provide the service needed in Ventura County.

CONSENT

2. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of February 25, 2019.

RECOMMENDATION: Approve the minutes.

Commissioner Espinosa stated some Commissioners arrived late for the February 25, 2019 meeting and that she wanted the minutes to reflect they were present for the meeting. Maddie Gutierrez, Clerk of the Board, clarified that the minutes show the commissioners were absent at the time of roll call, but also show the time the commissioners arrived to the meeting.

Commissioner Espinosa moved to approve the minutes with the changes noted. Commissioner Cho seconded.

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

NOES: None.

ABSTAIN: Commissioner Lanyard Dial, M.D., and Supervisor John Zaragoza.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.
3. **Contract Extension Approval – Database Services, Jason Kim dba dbpundIT**

**RECOMMENDATION:** Approve the continuation of part-time outsourced database services with Jason Kim dba dbpundIT through December 31, 2019 and allow the CEO to execute an agreement extension with additional funding of $125,000.

Commissioner Atin moved to approve the contract extension. Commissioner Dial seconded.

**AYES:** Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Johnson Gill, Gagan Pawar M.D., Dee Pupa and Supervisor John Zaragoza.

**NOES:** None.

**ABSENT:** Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

Commissioner Alatorre modified the order of the agenda, stating that presentations would be done next, followed by reports, and that formal action items would be last.

**PRESENTATIONS**

4. **Ventura County Medi-Cal Membership Trends**

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

Chief Operating Officer, Ruth Watson, introduced Mr. Barry Zimmerman, Ventura County Human Services Agency Representative.

Mr. Zimmerman presented to the Commission information about Medi-Cal membership trends in Ventura County. (PowerPoint presentation provided as a handout to the Commission.)

Mr. Zimmerman reviewed a map, which showed where beneficiaries are located in Ventura County, with the majority residing in the Oxnard Plain area. He explained that Oxnard represents 43% of the County Medi-Cal population, and that one in four County residents are on Medi-Cal or a benefit program. Mr. Zimmerman then discussed the County unemployment rate and how it affects benefit programs. A comparison chart for Medi-Cal participation between the State of California and Ventura County was shown. There is a 96% penetration rate for Medi-Cal enrollment in the County, indicating that the County is more stable in sustaining and maintaining individuals on the Medi-Cal program.
Mr. Zimmerman highlighted efforts to maintain individuals in Medi-Cal, including a texting program to keep in communication with members and help avoid a lapse in coverage. He added that there are eligibility centers in each of the communities throughout the County to assist with enrollment and outreach, also mentioning there are many outreach activities through trained individuals or an organization. Mr. Zimmerman stated that the goal of the Human Services Agency is to outreach to those entitled to services and assist them in becoming eligible for the programs that are administered. There is currently a slight decrease in Ventura County, but sustaining a greater eligibility rate as a whole.

Commissioner Pawar asked about enrollment numbers on the graph showing more than 217,000 but that she believes the number is less than 200,000. COO Watson explained that GCHP does not have all Medi-Cal beneficiaries; there are some who do not become GCHP members, such as fee-for-service. The 217,000 reflects all Medi-Cal beneficiaries in Ventura County, a subset of those beneficiaries are enrolled with GCHP. CEO Villani stated that Commissioners had expressed concern about the membership decreases and asked Mr. Zimmerman whether they could be avoided, or what actions GCHP could take in assisting members with eligibility. Mr. Zimmerman replied that HSA does an extensive amount of outreach, but they are not funded to do outreach. They are funded to provide eligibility services, but will work with GCHP on strategies. COO Watson added that because of State regulatory requirements, GCHP can only conduct eligibility outreach for active members.

Commissioner Dial asked about the graph showing statewide versus County Medi-Cal participants and whether the county has done a better job of keeping people on the program as opposed to the state. Mr. Zimmerman responded yes, but added that economic improvement might be another factor on the enrollment decreases.

Commissioner Espinosa thanked the agency for the efforts made during the Thomas Fire. She noted the expansion of hours at Blanchard Library, adding that for advocacy, meeting times are limited and do not meet the schedules of farm workers. She asked Mr. Zimmerman where hard data could be found to give direction to improve the numbers. Mr. Zimmerman stated there is outreach done in the communities and that they continue to explore methodology and hour extension. He replied that there is a fluctuation in enrollment, but there is effort made in outreach. Commissioner Espinosa asked whether there were any policy or process changes for eligibility. Mr. Zimmerman stated there has been no policy change. “People get notices of action on why they are no longer eligible. Those who call are referred to programs that they may qualify for.”

The Commission requested a break out of information between traditional and Adult Expansion member enrollment.

**Commissioner Alatorre changed the order of the agenda, stating to move forward with Formal Action – Agenda Item No. 8. – AmericasHealth Plan (AHP) Plan-to-Plan Pilot**
Commissioners Antonio Alatorre and Gagan Pawar, M.D., recused themselves at 3:45 p.m. Commissioner Alatorre directed Commissioner Espinosa to assume Chair duties.

FORMAL ACTION

8. AmericasHealth Plan (AHP) Plan-to-Plan Pilot

RECOMMENDATION: Commission to provide direction to staff.

CEO Villani stated there were specific deliverables requested by the Commission at the February 25, 2019 meeting:

1) Activity on Two Plan Model
2) AHP Network Adequacy
3) Pilot Performance Metrics

CEO Villani noted activity around the two-plan model, as confirmed by public comment, and VC Star articles.

AHP Network Adequacy

Compliance Officer Brandy Armenta informed the Commission that this was a limited readiness scope and that full readiness would be done prior to contracting, after the Commission decides to move forward and DHCS approves. Ms. Armenta said there was a productive meeting held with AHP staff and that they were aware of the results she would review with the Commission. She added that the teams were in agreement on any gaps noted, which AHP agreed would be cured during full readiness assessment.

Ms. Armenta provided an overview of the network adequacy review process. She stated that information was requested from AHP relative to their network. Ms. Armenta emphasized that the Commission must be aware and understand that when GCHP contracts with a delegate regardless of the service delegated they are a subcontractor. If the subcontractor contracts with another entity to provide the service, it is a sub-subcontractor. Ms. Armenta then provided an example to illustrate the importance of Plan responsibilities in subcontracting arrangements. LA Care contracted with an entity, who in turn contracted with SynerMed and as a direct result, LA Care ended up on a corrective action plan by DHCS. Plans must provide proper oversight and infrastructure in these arrangements.

Ms. Armenta reported AHP sub-contracts the majority of their network through Clinicas del Camino Real, which means the majority of their (AHP) providers come from Clinicas. Clinicas then contracts with VMC, CMH and some tertiary care facilities. They (AHP) do have some direct contracts, but not to the same volume as their contractor Clinicas. They (AHP) have a direct contract with one tertiary care center as the other tertiary care center is contracted via Clinicas. The concern is that if there are members who receive services in other tertiary care centers,
AHP would have to enter into a letter of agreement or try to contract with those facilities.

From a network capacity standpoint, Ms. Armenta stated it was difficult to glean the actual capacity because a provider is counted as 1 FTE if they are truly seeing a member fulltime. Ms. Armenta added that AHP included providers in their list who are in administration, so they should count as .5 FTE, because they are doing administrative services half of the time, and are providing services to members the other half. Another concern Ms. Armenta expressed is that AHP is not currently contracted with a major hospital system in Ventura County. She noted per AHP they are currently in negotiations however as of today the contract is expired and not legally binding. At the point of a full readiness assessment, staff will know if the contract has been executed. Ms. Armenta stated there are 14 providers directly contracted with AHP who are not Medi-Cal certified. Per DHCS, these providers cannot be included as a part of the AHP Medi-Cal network because all providers must be Medi-Cal certified.

Ms. Armenta noted that AHP does not have contracts or sub-contracts with the American Indian Health Centers, which is also a requirement of DHCS. Free-Standing Birthing Centers is another directive of DHCS, and as of today, AHP does not have these centers in their network.

In terms of policies and procedures, Ms. Armenta reported GCHP received two out of ten policies and procedures requested as a part of the limited scope audit. AHP did not provide policies and procedures on cultural competency for members, for providers, traditional safety nets, or American Indian Health Centers etc. AHP indicated they were aware and would work on creating those policies prior to full readiness. AHP delegates the majority, not all, credentialing activities to Clinicas for their providers; there was contradiction in language of the policies and procedures provided of who did what.

Commissioner Atin asked for clarification on full readiness. Ms. Armenta stated when full readiness occurs, the expectation is that these deficiencies would be corrected. AHP agreed via phone call that if they go to full readiness, they would provide the required documentation.

Commissioner Pupa asked if DHCS would review and validate the full readiness. Ms. Armenta replied that DHCS would review her team’s readiness findings when it is submitted. CEO Villani added that provider agreements (contracts) are delegated to the plan to execute, but that plan-to-plan contracts require State approval. The AHP pilot requires DHCS approval as well as DMHC (Department of Managed Health Care) because AHP (as a commercial plan) is regulated by DMHC. If the Commission recommends to move forward with next steps, the boiler plate template must be approved. CEO Villani emphasized that the State requires a number of steps and approvals in the process including boilerplate approval and full readiness review. He mentioned that currently there are potential gaps in the AHP network that would prevent passing a full readiness review. Ms. Armenta added that the boilerplate was provided to AHP and that their legal counsel requested an in-person meeting, which is scheduled for the second week in April.
Pilot Performance Metrics

CMO Wharfield informed the Commission that metrics were provided to the AHP team and that they agreed to the metrics and specific goals, with minor modifications. Dr. Wharfield indicated that the focus is to increase HEDIS percentiles, moving from the prior years' CDCR percentile performance into the next percentile area as defined by HEDIS. The goal going forward is to be at 50% or above for all measures, noting that there is a difference between a rate and a percentile. Dr. Wharfield added that all California health plans should improve their percentile rankings for access for children, but the performance rates for GCHP providers are in the 80-90%. Essentially, members are getting care but it is not hitting the 50% percentile ranking.

Commissioner Dial spoke about the concept of choice for Medi-Cal patients in the county. He explained that members covered by GCHP have primary doctors and they can switch monthly if they do not like their doctor. Dr. Dial asked whether members who chose AHP (from the pilot) would still have a wide choice of doctors and specialty care if the county goes to a two-plan model. CEO Villani replied that the GCHP network is broad and there are currently no gaps in the network. Ms. Armenta stated that from an out of county and specialist care standpoint, choices are limited at primary care on what AHP has available. Members cannot be locked in, as all members have a choice in their provider. Commissioner Dial expressed his concern that members need to understand that they can make a change to their provider.

Commissioner Cho asked who would be responsible for collecting data for the metrics. Dr. Wharfield replied that data collection would be done together by GCHP and AHP.

Commissioner Espinosa expressed her hesitation with the process of micro-managing by the Commission. She stated that the Commission had provided parameters directing staff to negotiate this plan. The public has raised questions of how did it get this far, and people recognize that it should have never happened this way. Commissioner Espinosa stated that there are professionals who have served on various boards and commissions and this process never occurs elsewhere. "A Commission directs staff to handle the process and the Commission is to set policy not micro-manage." She added that she hopes this can be worked out.

PUBLIC COMMENT

13. Arnoldo Torres appeared on behalf of Clinicas del Camino Real. He deferred his time to Ms. Sonia DeMarta, CFO for AmericasHealth Plan.

Ms. DeMarta requested extended time. Commissioner Espinosa granted the extra time. Ms. DeMarta stated there appeared to be confusion on why the Commission is being asked to consider the two-plan model versus the single COHS model. AHP has addressed that it is not about the size of the provider network; it is the coordination of care. AHP is trying to address the gap for treatment plan. AHP is
requesting the two-plan model because they want one continuous treatment of care plan for Clinicas members. Clinicas has a large provider network that includes specialists in and outside of the County. Ms. DeMarta emphasized that it is not about whether a member has a choice to go from one doctor to another, but whether the member choice is on care coordination.

Ms. DeMarta also wanted to discuss the results of the audit (network assessment) and the pilot performance metrics. She agreed with Dr. Wharfield, that they had met and discussed the metrics, confirming that Dr. Wharfield informed them of mandated changes made by the Governor. Ms. DeMarta added that the AHP medical team reviewed the changes to the metrics and all are in agreement.

Ms. DeMarta stated that due to questions at the February commission meeting regarding AHP specialists in and outside of the County and AHP contracted hospitals, Brandy performed an evaluation of the AHP network. Ms. DeMarta informed the Commission that on February 1st at end of day, AHP received a letter which included the network adequacy but also expanded to policies and procedures, and copies of contracts in place. AHP had 6 ½ days to gather the information. Ms. DeMarta stated that typically, it would not be a 6 ½ day process and added that the vast majority of requested documents were uploaded and submitted by midnight, February 11th. She mentioned that usually in this process, the audit is performed and the health plan holds an exit conference, where there is an opportunity to discuss initial findings. Ms. DeMarta stated this did not occur.

Ms. DeMarta informed the Commission that she asked GCCHP to meet prior to the March Commission meeting, yet a month later, had not received the audit results. Therefore, AHP had to defend itself publicly without seeing the results. Ms. DeMarta explained that Ms. Armenta did allow AHP to meet with her and ask questions regarding the results, stating that they need to work together as business partners and business partners would not do this. She explained that many of the missing policies were ready within a few days after submitting the audit materials, but AHP was not allowed to submit anything else. With the exception of one provider contract, Ms. DeMarta said that all other documentation was in place within a week after the deadline. She stated that the fact that the information did not need to be presented until today caused her to wonder why AHP was not given an opportunity to provide the additional information.

Ms. DeMarta then addressed the topic of delegation oversight, indicating it was mentioned in the audit and that AHP is aware of the importance as they delegate to Clinicas. Ms. DeMarta stated that perhaps GCCHP has higher standards, and AHP is willing to comply with them.

Ms. DeMarta state that credentialing policies that were not consistent between Clinicas and AHP were currently being reviewed. She explained that AHP is currently a primary Medicare provider, and therefore did not have contracts with the American Indian Health Centers or Free Standing Birthing Centers (these are DHCS Medi-Cal requirements). Ms. DeMarta stated that AHP immediately worked on these items and completion was within one week. She stated that CEO Villani
had indicated that GCHP had provided AHP with a readiness checklist, given to the previous AHP CEO. Ms. DeMart had requested a copy of the checklist.

Ms. DeMart stated that because the audit findings were pushed back one month (with the Commission), a good business partner would try to work together to resolve the issues in order to have a complete product. To date, AHP had not seen the audit report.

Ms. Armenta stated that she wanted to respond to Ms. DeMart’s comments around deliverable submissions, emphasizing that she did not receive all of the delegation oversight items on the due date. They were received five days later, which tightened her teams review timeline. Additionally, GCHP’s attorney communicated confidentially with the AHP attorney regarding this issue. Commissioner Espinosa asked about the five day due date. Ms. Armenta explained that they (her team) needed five days to review the materials and prepare a report for the February Commission meeting. Ms. Armenta also stated all material was not provided as indicated and a significant portion was withheld until legal was brought in to assist.

Ms. Armenta provided a few additional points for the Commission. She stated that Ms. DeMart said they submitted all of their Medicare providers. However, GCHP has a signed attestation by AHP consultant stating they provided only their Medi-cal providers. Accurate information is essential to complete the evaluation. However, the attestation was taken in good faith.

Point two: The template that GCHP provided to AHP for the network was not utilized. Instead, AHP used a roster. In terms of credentialing, all credentialing is delegated to CDCR per agreement between AHP and CDCR however in their (AHP) policies it states otherwise. AHP does some credentialing and CDCR retains some credentialing. There was an inconsistency and lack of clarity with conflicting documentation submitted.

Commissioner Espinosa stated that she would allow Ms. DeMart to respond, but again, the Commission is sitting in on negotiations and that is not the role of this Commission. The parties should be together discussing these items.

Ms. DeMart stated these are the types of items that when there is a partnership relationship, the findings would be discussed, resolved and resubmitted. In a normal setting, these issues would have been discovered and resolved.

Ms. Armenta responded that there were various communications between her and the AHP Compliance Officer and the information missing and omitted was not provided. There were also communications between both legal teams.

14. Irma Lopez requested a speaker card. Her statement were read by Mr. Rick Castaniero.

Mrs. Lopez stated she is an advocate for those in need of health services for decades. Mayor Lopez has been a doctor in the community for many years. Mrs.
Lopez is familiar with the value of Medi-Cal services provided by Gold Coast Health Plan. However, she believes a monopoly does not align with our American values. A two-plan model will provide competition and raise the level of service provided to the needy. She requests for more accountability, cultural proficiency and better service.

15. Mr. Arnoldo Torres provided a folder to the Commission with various articles, one titled as, "It's Time to Pay Medi-Cal Plans Differently".

Mr. Torres stated the article identifies healthcare across the board leaves a great deal to be desired. He asserted that concerns have been raised on the quality of care based on data that both Ms. Armenta and Dr. Wharfield use. Mr. Torres also noted that DHCS found disparities by race and ethnicity with black and Native Americans faring worse than other Medi-Cal beneficiaries. He stated the concern in this county is that Latinos are faring worse and if there is an opportunity to improve things that should be done. He added that mental health is also a concern in Ventura County.

Commissioner Atin stated this public comment is on AmericasHealth Plan and the two-plan model comments were heard earlier in the meeting.

Commissioner Espinosa asked Mr. Torres to wrap up his comments.

Mr. Torres stated that many believe in the two-plan model and the pilot program: because it takes a holistic approach and takes care of patient needs in a comprehensive manner. He said that clearly there is animosity between GCHP staff and AHP and that many items should have been discussed at a staff level. "Mr. Juarez has stated that if the pilot is for 5,000 members he no longer wants to participate." Mr. Torres said the AHP pilot would require a subcommittee or an individual to interject in discussion with staff. He stated that there had been an agreement in 2013 for 22,000-25,000 lives and that nothing had changed in terms of the focus. He asserted that the challenge for the Commission is how to proceed with a plan-to-plan when all requirements are met, but [Mr. Juarez] does not agree to a 5,000 member cap.

Mr. Bill Foley declined to make his public comment.

Commissioner Pupa asked General Counsel, Scott Campbell what is the responsibility of the Commission regarding this item. Mr. Campbell stated the Commission was asked to provide direction whether to go forward in presenting a contract to the State. The Commission asked for two items to be presented at this meeting: the provider network readiness review and an agreement on the performance metrics for a 5,000 member plan that had been proposed by AHP. That information has been presented. The options for the Commission are to: decide whether to go forward or not, and if to go forward with an AHP contract, set some parameters, or create a sub-committee to work with staff. Regardless of the Commission decision, the agreement has to go to the State for approval as it is a plan-to-plan agreement and it cannot be finalized until approval is received. The State of California has ultimate authority due to current regulations.
Commissioner Pupa stated her understanding that nothing had yet gone to DHCS or DMHC and that DHCS has the ultimate authority to approve a plan-to-plan contract.

Mr. Juarez stated the template had gone to the State five or six times and that it is the original template that was developed. He requested the Commission to honor what that had originally agreed, which was not 5,000 members but the 22,000 members.

Supervisor Zaragoza then presented a thirteen-point motion on the AHP Plan-to-Plan item. He first thanked all for being present, along with the Commissioners and members of the public. He mentioned that there have been numerous delays on the implementation and that in 2011/12, the GCHP Commission sent the plan to the State and the State did not approve.

Supervisor Zaragoza also stated that he is not joining the Commission to appease Mr. Juarez. He joined and is on the Commission for the best care for his constituency. He added that the misunderstandings between Mr. Juarez and Mr. Villani are unfortunate and disappointing, and that they need to work as a team. Supervisor Zaragoza stated there are approximately 193,000 people in the County, and 41% are in the 5th District. He said he has served the public for almost 60 years and his constituency will be the judgement of his legacy for the services he has provided to the community.

Supervisor Zaragoza said the proponents of AmericasHealth Plan shared that they can provide better health care than Gold Coast Health Plan. The 13-point proposal he is sharing will be an opportunity for AHP to prove or disprove their claim, and they will also take the financial risk and responsibilities for that plan.

Supervisor Zaragoza's motion is as follows:

1. That the Gold Coast Health Plan staff continue to work closely and expeditiously with AmericasHealth Plan (AHP) staff to finalize the terms of a pilot plan-to-plan contract for review and approval by this Commission and then for final review and approval by the appropriate State agencies;

2. In order for the pilot to be fairly and accurately assessed I propose that the period of the pilot program be extended to five years;

3. And that the pilot begin with up to 5,000 members who will have the option to self-select from Clinicas’ existing GCHP assigned membership pool;

4. At the end of a two-year period, in the even pre-agreed upon performance measures are met or exceeded and at the discretion of the Commission the pilot will be continued with up to an additional 10,000 members who will have the option to self-select from Clinicas existing GCHP assigned membership pool for a total up to a maximum of 15,000 members;
5. Furthermore, prior to the beginning of the program clear, fair, and specific, achievable performance measures and milestones shall be set in writing so that this Commission can determine the success of the pilot program;

6. All marketing and/or informational communications and enrollment for this pilot program shall be conducted by Gold Coast Health Plan and AHP together;

7. Throughout the pilot program AHP members will have the option to opt out of the pilot program, at which time other Clinicas assigned GCHP members will have the option to opt-in to the AHP pilot program;

8. **On a biannual basis**, AHP will provide performance and other data to GCHP detailing activity of the pilot program;

9. In the event AHP pilot program performance measures fall below determined minimums which will be agreed upon **prior to the beginning of the program**, the Gold Coast Health Plan Commission will have at its discretion the ability to recommend corrective measures for the pilot program;

10. In the event disputes arise as to the performance or operation of the pilot program GCHP will have the ability to initiate an audit of the program;

11. The scope of the audit will be set by GCHP staff and approved by the GCHP Commission; the cost of the audit will be equally split between GCHP and AHP;

12. At the end of the five-year pilot program, in the event the program has been deemed to be successful by the GCHP Commission, the plan will enter into discussions with AHP regarding the creation of a permanent option whereby Clinicas and other GCHP assigned members will have the option to receive services by AHP;

13. In no event will the total AHP membership exceed the current percentage of eligible GCHP members assigned to Clinicas.

Commissioner Atin seconded the motion as presented.

**Discussion**

CMO Nancy Wharfleld, M.D. commented she appreciated the encouragement to work together in order to find a resolution. She mentioned that performance metrics should align with the new Governor’s mandate.

Supervisor Zaragoza then stated he had received an orientation at GCHP and admired the work being done. He has also worked with Mr. Juarez for many years and commends all the good work he has done in the community.

Mr. Campbell stated that the motion is clear and states that the two organizations work together on the 13 points and return at the next meeting if there is a general agreement, then the next step would be to go to the State.
Commissioner Espinosa expressed her concern that there are some involved who might say this is what the motion presented and that there is no leeway. She suggested having two members of the Commission work with the two parties.

Supervisor Zaragoza stated that he hopes AHP and GCHP will work together to bring a recommendation to the Commission at the next meeting. He asked Mr. Campbell to clarify the motion.

Mr. Campbell stated, "A motion has been made that sets forth parameters and goals for the two parties to come to an agreement on the points made in the motion and present an agreement to the Commission at the next meeting for consideration and action."

Commissioner Espinosa interjected that Mr. Campbell was leading the Commission and asked him to refrain. Commissioner Zaragoza stated he asked Mr. Campbell for the protocol and that Mr. Campbell responded.

Commissioner Atin stated the motion was specific in framework and general in outcome, and that he would vote for Supervisor Zaragoza's motion as is, without modification.

Commissioner Espinosa stated she was going to allow Mr. Arnoldo Torres to weigh in on the motion.

Mr. Torres suggested the word "parameters" be changed to "guidelines". He said there needs to be a reasonable amount of people to participate and the number is too small at 5,000.

Commissioner Espinosa asked Commissioner Atin if it was acceptable to change the wording. Commissioner Atin responded that he was comfortable with the original wording.

Commissioner Cho asked if the two parties cannot agree, would the issue come back to the Commission to break the tie or make a final decision? What happens if these are only guidelines? Commissioner Cho stated the wording should stay as is.

Commissioner Espinosa stated she is not comfortable and wants the parties to work it out and return to the next meeting with a final recommendation. CEO Villani stated the parameters are reasonable and realistic and that 5,000 members for two years provides enough time to move the bar. He added that if a two-plan model is introduced, the five-year pilot would need to be re-evaluated because it would not make sense to continue. Ms. DeMarta commented that the risk is not as great as CEO Villani implies.

Commissioner Zaragoza motioned that GCHP and AHP work together on the 13 points listed and that the parties return to the next meeting for Commission action on the agreement of the 13 points. Commissioner Atin seconded the motion.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Johnson Gill, Dee Pupa and Supervisor John Zaragoza.

NOES: None.
ABSENT: Commissioner Jennifer Swenson, Antonio Alatorre and Gagan Pawar, M.D.

Commissioner Espinosa declared the motion carried.

The meeting was adjourned at 5:08 p.m. for a short break.

The regular meeting reconvened at 5:26 p.m.

OPEN SESSION Cont’d.

Commissioners Antonio Alatorre and Gagan Pawar, M.D. returned to the meeting.

FORMAL ACTION Cont’d.

6. Appointment of Executive Finance Committee Members

RECOMMENDATION: Appointment of two Commission members to the Executive Finance Committee.

General Counsel Scott Campbell stated there are two vacancies on the Executive Finance Committee. This committee is currently occupied by Commissioners Alatorre, Swenson and Espinosa. One of the requirements is that one of the vacancies must be filled by a member of the Ventura County Medical Health system. Commissioner Dee Pupa has previously served on this committee and has volunteered. The other position can be an “at large” position. There is currently one vacancy on the Commission, which will be filled soon. The Commission can make one appointment at this meeting and wait until the Commission vacancy is filled to make the second appointment.

Commissioner Dial moved to appoint Commissioner Pupa to the Executive Finance Committee. Commissioner Pawar seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

Commissioner Alatorre stated there had not been a meeting in a while and he recommended that if there is not a quorum on the scheduled date, a make-up meeting should be scheduled.
REPORTS

9. Chief Medical Officer (CMO) Report

RECOMMENDATION: Accept and file the report.

10. Chief Diversity Officer (CDO) Report

RECOMMENDATION: Accept and file the report.

11. Chief Operating Officer (COO) Report

RECOMMENDATION: Accept and file the report.


RECOMMENDATION: Accept and filed the January 2019 Financials report

In the interest of time, Commissioner Alatorre asked the Commission if they had any questions or discussion/comments on any of the reports.

Commissioner Espinosa asked if there was a date for the Commission Diversity and Inclusion training. CDO Bagley stated the date was Thursday, May 2nd and a morning session would be held from 8:00 a.m. to 12 noon.

Commissioner Atin moved to accept and file the CMO, CDC, COO and January Financials reports. Supervisor Zaragoza seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

Commissioner Cho left the meeting at 5:42 p.m.

1. Chief Executive Officer (CEO) Report

RECOMMENDATION: Accept and file the report.

CEO Villani gave a brief overview. Governor Newsom wrote letters to all CEO’s in California concerning early childhood development. He has hired a new Surgeon General and they want to put greater emphasis and focus on this issue. There was a comprehensive audit done on children’s preventative care services and a broad generalization was made. They reviewed who was eligible under the age of 21
and has had preventative services in each of the fiscal years. It was determined that California is lagging nationwide, and was ranked 40th. There is going to be an implementation of moving from minimum performance levels of 25th to 50th %. Plans will be reviewed and if not meeting the level, they will get sanctioned. GCHP will respond to the Governor stating we are in full support of the initiative to do more enhanced care and services. We can do pay for performance, which was done with Clinicas, there was a good reimbursement for moving the bar and immunizations. More will be done.

PRESENTATION

5. Governor’s Mandate for Immediate Improvement: New Managed Care Plan Quality Metrics, Baselines, and Sanctions

RECOMMENDATION: Accept and file the presentation.

Chief Medical Officer, Nancy Wharfield, M.D., reviewed the PowerPoint presented. This is an opportunity for Medi-Cal to provide quality care for members. She reviewed background information and consequences. There is a prediction of what measures will be.

DHCS has communicated four areas of focus. The areas are: behavioral health integration, prenatal/post-partum care, chronic disease management (diabetes and hypertension are the current focus) and improving outcomes for children. Good news is proposition 56 funds will be available for provider incentives for three (3) years to improve outcome in these areas of focus. This money will be targeted for providers. Needs assessment will be highlighted and transformed and will be identified. There will be more transparency.

Commissioner Espinosa asked who are considered children, was it persons up to age 18. The HEDIS measures are specific on age bands. Dr. Wharfield answered that each HEDIS measure has specifications which define the age of the members being measured under it.

Sanctions will be applied, but there not much insight into what the details are.

The new quality standard to perform at the 50th percentile will apply to the current measurement year. Predicted measures were reviewed and more feedback from DHCS is expected soon.

Supervisor Zaragoza asked if the plan works with the school districts on vaccinations. CMO Wharfield stated members have to have their children vaccinated to enter school. Often, they have to play catch up in order to enter school and this can be difficult. Commissioner Alatorre stated timeliness is important.

Commissioner Alatorre moved to accept both presentations; Agenda Item 4 and Agenda Item 5. Commissioner Dial seconded.

NOES: None.

ABSENT: Commissioner Jennifer Swenson.

Commissioner Alatorre declared the motion carried.

COMMENTS FROM COMMISSIONERS

Commissioner Alatorre asked if the Executive Finance Committee would be working on the goals and objectives for the Strategic Plan and that it is important to get back on track with the meetings.

Commissioner Pawar stated she is bothered by the disconnect on the diaper issue. CMO Wharfield advised that the diaper issue is a national problem, and that there needs to be a high quality breathable diaper available for our Medi-Cal members. Commissioner Atin asked that a brief presentation with data be made so members of the public might understand why staff are not able to resolve this issue.

Commissioner Dial stated that he attended a State of California meeting on Palliative Care. He noted that Director of Population Health, Pauline Preciado, was also in attendance.

Supervisor Zaragoza thanked the Commission for the invitation to serve. He hopes misunderstandings stop as it does not serve the community well. He participated in the Cesar Chavez Walk in the Colonia and he was asked by members of the public what is happening between the two agencies. He hopes that in the future there will be an understanding between the two agencies.

Commissioner Espinosa stated she met with the Santa Paula Youth Advisory Committee on March 7th and was a guest speaker. The emphasis was on behavioral health. She mentioned there is a bill - AB512 - that deals with specialty and mental health services and preparing a cultural competency assessment plan. This will be a bill to watch as it will impact the work at GCHP.

ADJOURNMENT

Commissioner Alatorre motioned to adjourn. Supervisor Zaragoza seconded.


NOES: None.

ABSENT: Commissioner Jennifer Swenson.
Commissioner Alatorre declared the motion carried.

The regular meeting ended at 6:17 p.m.

Approved:

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Maddie Gutierrez, CMC
Clerk to the Commission
AGENDA ITEM NO. 9

TO:       Ventura County Medi-Cal Managed Care Commission
FROM:     Nancy Wharfield, Chief Medical Officer
DATE:     April 22, 2019
SUBJECT:  Approval of Credentials / Peer Review Committee Member

Summary

As directed in the Gold Coast Health Plan Provider Credentialing Policy, the Ventura County Medi-Cal Managed Care Commission is required to approve changes to the Credentials / Peer Review Committee membership. Menashe Ehrenburg, DO, FACOOG, Associate Medical Director, Clinicas Del Camino Real, Inc., was suggested to replace Guillermo Rios-Rios, MD, as an active member of the Credentials / Peer Review Committee.

Recommendation:

Approve Menashe Ehrenburg, DO, FACOOG, Associate Medical Director, Clinicas Del Camino Real, Inc. as an active member of the Credentials / Peer Review Committee.
AGENDA ITEM 10

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Ruth Watson, Chief Operations Officer
DATE: April 22, 2019
SUBJECT: Provider Advisory Committee (PAC) Membership

SUMMARY:

The Plan has been actively recruiting for applicants to fill the ten (10) member Provider Advisory Committee (PAC). 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 PAC by adding one (1) additional physician seat, making PAC an eleven member Committee.

The Commission has previously approved the candidacy of seven (7) members to Gold Coast Health Plan’s (GCHP’s) PAC. In addition to the previous applications submitted, staff presents the following three (3) applicants for approval by the Commission. With the number of sitting Committee members at ten (10), there should be no issue in establishing a quorum, while staff continue to recruit for the remaining physician seat.

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 for GCHP.

This Committee meets at least quarterly and makes recommendations to Staff and the Commission, 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). Staff requests that the Commission expand the Committee by adding an additional physician representative for an eleventh seat.

As established by the Commission, 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 staff submits the following three (3) candidates for Commission approval. A brief biography of each candidate is included below.

**Seat – Physician/Safety Net Provider – Permanent Seat**

**Bryan Wong, CMO**
Ventura County Medical Center
Practicing Family Physician since 2003 in the County of Ventura. Previously held the position of Medical Director of the Academic Family Medicine Center, a primary care clinic in Ventura. Also associated with the Ventura County Health Care Agency (VCHCA).

**Seat – Nurse/FQHC**

**Linda Baker, RN, MBA, CCM, Director, Medical Management**
Clinicas del Camino Real
Director of Medical Management with a history of working in the hospital & health care industry. Skilled in Healthcare Consulting, Certified Case Manager, Medicaid, Medicare, Case Management, Population Health, Utilization Management and Employee Health Benefits. Managed care professional with a Master of Business Administration (MBA) focused in Business Administration and General Management.

**Seat – Transportation Provider**

**Masood Babaedian, CEO**
Ventura Transit System
As the CEO of Ventura Transit System (VTS) he oversees the multiple transportation operations currently offered by VTS. These operations include community area transit programs, Guaranteed Ride Home programs, and elderly and developmentally disabled transportation programs throughout Southern California. Mr. Babaedian is ultimately responsible for all decisions relating to the recruitment, screening, hiring, training, management and discipline of all operations personnel.
RECOMMENDATION:

Staff requests that the Commission appoint the Provider Advisory Committee as described above and expand the 10 member PAC by adding one additional member making PAC an 11 member advisory committee.
AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Anne Freese, PharmD, Director of Pharmacy
DATE: April 22, 2019
SUBJECT: PBM Contract Amendment

SUMMARY:
Staff seeks approval to sign a contract amendment with Gold Coast Health Plan’s (GCHP) Pharmacy Benefits Manager (PBM) OptumRx.

DISCUSSION:
At the January 28, 2019 commission meeting, staff was authorized to sign a contract amendment with OptumRx which added additional language and protections to GCHP as it relates to pharmacy benefit services.

After contract negotiations, pricing guarantees anticipated to be implemented in contract year 2 have been moved to contract year 3 and beyond and the Pharmacy Management Allowance has been increased. The Pharmacy Management Allowance is a refundable credit that GCHP can use to purchase additional clinical programs or any additional services that OptumRx offers.

These pricing changes may be discussed in Closed Session.

FISCAL IMPACT:
There is no impact to the current fiscal year.

RECOMMENDATION:
Staff recommends that Commission approve the signing of the PBM amendment.
AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission
DATE: April 22, 2019
SUBJECT: Commission Meeting Times and Location

Open Discussion between GCHP Staff and Commissioners