Regular Meeting
Monday, May 20, 2019, 2:00 p.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010

AGENDA

CALL TO ORDER

PLEDGE OF ALLEGIANCE

OATH OF OFFICE

ROLL CALL

PUBLIC COMMENT

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

Persons wishing to address 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.

CONSENT

1. Approval of Ventura County Medi-Cal Managed Care Commission Meeting Regular Minutes of April 22, 2019.

   Staff: Maddie Gutierrez, CMC, Clerk of the Commission

   RECOMMENDATION: Approve the minutes.
REPORTS

2. Chief Executive Officer (CEO) Update
   Staff: Dale Villani, Chief Executive Officer
   
   RECOMMENDATION: Receive and file the report.

PRESENTATIONS

3. Community Advisory Committee (CAC) Presentation
   Staff: Ruth Watson, Chief Operating Officer
   Guest Speaker: Rita Duarte-Weaver, CAC Chair
   
   RECOMMENDATION: Receive and file the presentation.

FORMAL ACTION

4. Quality Improvement Committee 2019 First Quarter Report
   Staff: Nancy Wharfield, M.D., Chief Medical Officer
   
   RECOMMENDATION: Approve the 2019 QI Program Description and the 2019 QI Work Plan as presented. Receive and file the complete report as presented.

5. HEDIS Gap Closure Services – Vendor Agreement Required
   Staff: Nancy Wharfield, M.D., Chief Medical Officer
   
   RECOMMENDATION: Approve entering into an agreement with a qualified vendor.
6. Setting Regular Off-Site Meetings to Foster Greater Public Participation.

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Approve the 2019 revised calendar and 2020 calendar as presented.

7. Appointment of Executive Finance Committee Member

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Appointment of Commission member to the Executive Finance Committee.

8. Recommendation for Enterprise Transformation Project (ETP) Senior Executive Program Management Services

Staff: Dale Villani, Chief Executive Officer

RECOMMENDATION: Authorize the CEO to award and execute a contract with DR Management Services for ETP Senior Executive Program Management Services.

9. Secure Additional Medi-Cal Funds through an Intergovernmental Transfer (IGT)

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Authorize and direct the Chief Executive Officer to provide DHCS with a proposal to the State of California. Authorize and direct the Chief Executive Officer to execute the Health Plan Provider Agreement between Gold Coast Health Plan and the County of Ventura to secure additional FY2017-18 and FY 2018-19 IGT funding.
10. Signature Authority Policy Revisions

Staff: Kashina Bishop, Chief Financial Officer

RECOMMENDATION: Approve the revisions associated with this new Signature Authority Policy.

11. March 2019 Financials Report

Staff: Kashina Bishop, Chief Financial Officer


REPORTS

12. Chief Medical Officer (CMO) Report

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

RECOMMENDATION: Receive and file the report.

13. Chief Diversity Officer (CDO) Report

Staff: Ted Bagley, Interim Chief Diversity Officer

RECOMMENDATION: Receive and file the report.

14. Chief Operating Officer (COO) Report

Staff: Ruth Watson, Chief Operating Officer

RECOMMENDATION: Receive and file the report.

CLOSED SESSION

None.

COMMENTS FROM COMMISSIONERS
ADJOURNMENT

Unless otherwise determined by the Commission, the next regular meeting will be held on June 24, 2019 at Gold Coast Health Plan at 711 E. Daily Drive, Suite 106, Community Room, Camarillo, CA 93010.

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

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

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

RECOMMENDATION:
Approve the minutes.

ATTACHMENTS:
Copy of the April 22, 2019 Regular Commission Meeting minutes.
CALL TO ORDER

Commissioner Antonio Alatorre called the meeting to order at 2:03 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


Commissioner Laura Espinosa arrived at 2:05 p.m. and Commissioner Johnson Gill arrived at 2:07 p.m.

Absent: Commissioner Gagan Pawar, M.D., and Supervisor John Zaragoza.

PUBLIC COMMENT

1. Arnoldo Torres appeared on behalf of the Working Group on COHS Project regarding two (2) follow-up letters he submitted under the Public Records Act.

   Mr. Torres stated that he was working with his legal counsel to ensure that the materials provided by GCHP are accurate to the questions submitted under the PRA and to possibly review materials as necessary. Mr. Torres also stated he would submit a letter to the [VCMMCC] Chair requesting all relevant information that VCMMCC counsel has used to submit conflict of interest rulings. Mr. Torres expressed his concern that conflict of interest has been selectively applied and stated he would ask outside counsel to review what has been determined as a conflict of interest. Mr. Torres stated the [PRA] requests were made to provide transparency and that results would be published in the Ventura County Star newspaper.

2. Christina Velasco, Chief Financial Officer of, appeared on behalf of Clinicas del Camino Real (CDCR), regarding Agenda Item No. 7 as it relates to vision services.

   Ms. Velasco stated that after reading Agenda Item No. 7 she assumed that CDCR optometrists would not be added to the GCHP website roster. Ms. Velasco explained
that CDCR must contract with the VSP commercial plan directly to be on the [provider] list. She stated that in 2011, CDCR requested to contract with VSP, but was denied because VSP only contracts with independent practitioners, not FQHCs. Ms. Velasco stated that this should not be a barrier to be on the list. They [CDCR] are a Medi-Cal provider and should be on the Medi-Cal roster. She then stated that GCHP partners with "people who do not understand the Medi-Cal population" and asserted that VSP considers Medi-Cal providers inferior. Ms. Velasco requested that the eight (8) CDCR optometrists be added to the roster, as they provide service to Medi-Cal members. She also requested that GCHP not include VSP "premier commercial providers" on the list as it does no good for Medi-Cal patients.

Commissioner Alatorre asked GCHP staff to provide a report on the issues Ms. Velasco raised. CEO Villani stated that COO Watson would provide more detailed information on this issue in her COO report.

Dr. Henry Villanueva expressed his embarrassment and shame of GCHP staff's response to a member who appeared at the last meeting to speak about an issue with adult diapers, stating that instead of staff offering help, they defended best practices. Dr. Villanueva also stated he was upset at the time in responses to the member on the diaper issue, asserting there is a delay in response to members. He stated he "wants transparency and people to have a choice."

Mr. Roberto Juarez, CEO of Clinicas del Camino Real appeared on behalf of Clinicas del Camino Real. Mr. Juarez provided copies of a letter he had written to Mike Engelhard (former CEO of GCHP) to the commissioners. Mr. Juarez stated that at the time of GCHP go-live, they [GCHP] stole 25,000 patients who had already made a choice to be part of the CDCR system, and they were given to the County. He then stated that he had scheduled a meeting with CEO Villani but it was cancelled and that he [CEO Villani] refuses to meet. Mr. Juarez alleged that there were ongoing personal attacks upon himself, Dr. Pawar and Antonio Alatorre, along with other members of the Commission by GCHP staff. Mr. Juarez stated Ms. Armenta spent her time "reporting Mr. Alatorre to the FPPC and it will come out and around to her". He also referenced the OIG investigation, stating it is ongoing and that $40 million had been paid out to providers. "The Commissioners need to know about this investigation as they could be responsible for triple damages and there are quite a few parties involved." Mr. Juarez then stated the County of Ventura is also in trouble in terms of finances. He then said he was going to ask for a grand jury investigation of this group [the VCMMCC] for violations of the Brown Act and business practices. "There have been at least five times in this fiscal year that other items are discussed in Closed Session other than what is on the agenda. The CEO refuses to meet for discussion. The patients in this County do not have a choice and a monopoly is going on."

Mr. Juarez alleged that CEO Villani has investigated LULAC and other civil rights organizations. "Today he noted that there are security guards present because someone on his staff feels threatened," Mr. Juarez stated he felt threatened and intimidated. "Now, because too many Mexicans come to this meeting, there are security guards. I hope at the next meeting there aren't German shepherds and hoses outside waiting for us."
Commissioner Alatorre asked CEO Villani why security guards were present as it has never happened before. CEO Villani explained that there was a concern about the rising level of intensity and discourse at recent meetings, and therefore some staff felt it would be safer to have guards present if needed. He stated that at most public board or council meetings there is security. Commissioner Alatorre stated he would have liked a phone call or email informing him ahead of time. CEO Villani also spoke of concerns with safety around the dais area and that at the last meeting there were individuals walking behind Commissioners and staff. He explained that the guards were here to observe and if anything should happen, they are available. Commissioner Alatorre asked for an example of safety concerns. CEO Villani responded that some individual staff felt intimidated by some members of the public walking behind staff and Commission members. He added that the security guards were there for the safety of staff and the Commission. Executive Director of Human Resources, Jean Halsell stated she suffers from PTSD and felt anxious at the last meeting. Commissioner Espinosa expressed her surprise at the presence of security. She stated that accommodations could be made to address safety concerns, but that having security at the meeting sends the wrong message. Commissioner Atin interjected that it was not uncommon to have the presence of security when issues get intense.

Commissioner Alatorre stated he wanted to move the CEO Report under reports and have the presentation done now. CEO Villani responded that the order of the agenda was done purposefully to create sequencing for certain topics. General Counsel, Scott Campbell, then reviewed the bylaws, which state that the Chair shall adhere to the order of the agenda as posted. Modifications may be made on the advice of counsel, or if the changes do not violate the Brown Act. Commissioner Alatorre stated the minutes had been moved to the end of the meeting and asked for input from the Commission. Vice-Commissioner Swenson agreed the agenda should be followed as posted and suggested that for future meetings, Commissioner Alatorre (as Chair) and CEO Villani discuss any agenda changes prior to the meeting. Commissioner Espinosa stated she agreed with Commissioner Swenson.

RECOMMENDATION: Accept and file the report.

CEO Villani stated he would like to respond to public comment made by Mr. Roberto Juarez. CEO Villani state that he has had several past meetings with Mr. Juarez, which tended to be one-sided and one-directional. The meetings became difficult to follow without an agenda. CEO Villani stated that he has requested an agenda for the requested meeting on several occasions, but none was provided. Without an agenda, the meeting will not be scheduled. CEO Villani would like to know ahead of time what the topic of the meeting will be in order to have a productive discussion.

CEO Villani provided brief updates on the following topics:

- **Commission Meeting Locations/Times** – Staff added a discussion topic to today’s agenda about Commission meeting locations and times based on
public comment presented and discussion held at the April Commission meeting.

- **Medi-Cal Incontinence Supply/Briefs** – CEO Villani expressed that this is an important issue and that the focus of dialogue last month might have been misunderstood. He explained that staff took immediate action on the issue and that Chief Medical Officer, Nancy Wharfield, M.D., would provide more information in her CMO report later in the agenda. CEO Villani also stated there was an immediate response to the member who spoke at last month’s meeting to ensure her needs were being met.

- **State (JLAC) Auditor / PBM Audit Exit Conference** – The exit conference is scheduled for 6/13/2019, with the draft report and the final report to be published in August. Staff will present the information to the Commission.

- **PBM Carve Out (Governor Executive Order) Update** – There is a Governor’s order to move the PBM services from the plans to the State, which will provide a savings. The impact to managed care plans is currently being assessed.

- **GCHP Financial Performance** – The Plan’s fiscal year ends in June. Expenses are approximately $11.4 million above what was budgeted due to higher health care costs. CEO Villani explained that there would be freeze on any provider contract rate changes until the State provides the Plan’s new rates, which are key to the budgeting process. He stated that Chief Financial Officer, Kashina Bishop would provide more detail in the financial reports.

- **Americas Health Plan (AHP)** – CEO Villani stated that Supervisor Zaragoza was not available for this meeting and that his Chief of Staff, Lourdes Solórzano was here to present Supervisor Zaragoza’s thoughts when the agenda item is presented. He added that GCHP did everything asked in terms of the thirteen-point proposal presented at the last Commission meeting. However, AHP issued a counter proposal, received today. GCHP agrees with the original 13-point proposal approved by the Commission.

- **Enterprise Transformation Project (ETP) Update** – Project re-planning and analysis continues. The revised implementation timeframe is July 2020, pending completion of project re-planning efforts due to the change in system platform from VBA to HSP. CEO Villani advised the Commission that GCHP will also move forward with Knox Keene licensing.

Commissioner Atin moved to receive and file the CEO report. Commissioner Swenson seconded.

**AYES:** Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Johnson Gill, Dee Pupa and Jennifer Swenson.

**NOES:** None.

**ABSENT:** Commissioner Gagan Pawar, M.D. and Supervisor John Zaragoza.

Commissioner Alatorre declared the motion carried.
PRESENTATIONS

2. Population Health – Diabetes

RECOMMENDATION: Receive and file the presentation.

Pauline Preciado, RN, MPA, Director of Population Health, Paula Bossoletti, RN, BSN, Care Management Manager, and Dr. Lupe Gonzalez, PhD, MPH, Health Education Director presented on the topic of diabetes as a population health issue. Ms. Preciado provided an overview of diabetes at the national, state and local level, highlighting that in Ventura County, adult obesity has increased by 20% since 2005, seniors in Ventura County are diagnosed with diabetes at a higher rate than the state average, and that the age adjusted death rate related to diabetes is steadily increasing. She noted that costs to treat diagnosed diabetes are high - $327B in 2017. Ms. Preciado discussed the Population Health Framework model, which is designed to improve health outcomes for a targeted population. She then provided an overview of the health disparities related to diabetes: GCHP data shows ~20,000 adults diagnosed with pre-diabetes/diabetes (53% Hispanic and 47% non-Hispanic) with a population distribution across Oxnard, Ventura/Santa Clara Valley, and East County. Ms. Preciado also reviewed current and upcoming plans for the GCHP diabetes program. Dr. Gonzalez reviewed the cultural effects of diabetes and Ms. Bossoletti discussed the care management for this population.

CEO Villani asked about cultural and linguistic services within the diabetes prevention program. Ms. Bossoletti stated that all members are linked to information in their own language to ensure they receive all necessary information. CEO Villani also inquired about success measure for the program. Ms. Bossoletti replied that HEDIS measures, as well as a member satisfaction tool, are used to determine health outcomes and metrics used to measure success. They are also developing a chronic disease self-management program.

Commissioner Swenson commented that the County, along with other health care systems in Ventura County have done health needs assessments and are still gathering data. It appears GCHP is working to address the needs of the community. Commissioner Atin thanked the presenters for the information and reminding/focusing the Commission on why they are here. The staff is doing great work. Commissioner Alatorre asked how many GCHP members are participating in the program today. He also asked for examples of community collaboration. Ms. Bossoletti stated there are collaborative meetings with CCS and metrics used to measure, as well as response from providers that collaboration is working. All have the same goal in mind.

Commissioner Swenson moved to receive and file the presentation. Commissioner Espinosa seconded.

AYES: Commissioners Antonio Alatorre, Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Johnson Gill, Dee Pupa and Jennifer Swenson.
NOES: None.

ABSENT: Commissioner Gagan Pawar, M.D. and Supervisor John Zaragoza.

Commissioner Alatorre declared the motion carried.

Commissioner Alatorre recused himself from Agenda Item No. 3 due to a conflict of interest. Commissioner Swenson assumed Chair duties.

PUBLIC COMMENT

Arnoldo Torres asked to hear the presentation on AHP before making his comments.

FORMAL ACTION

3. AmericasHealth Plan (AHP) Plan to Plan Pilot

RECOMMENDATION: Commission to provide direction to staff.

Chief Operating Officer, Ruth Watson stated AHP was going to present their counter proposal at this time. A handout with the 13-point proposal and responses was provided to Commissioners.

Commissioner Espinosa asked if this is only a presentation as she was not clear if there would be negotiation. Commissioner Swenson stated there would be no negotiation today.

CEO Villani clarified that 13-point proposal is a framework, and an alternative proposal is being brought forward to the Commission.

Commissioner Swenson clarified that the Commission will accept the counter proposal presentation without voting on the counter proposal.

Mr. Arnoldo Torres (member of the public) stated that all 13 points were not acceptable to AHP and that CEO Villani’s statement was not accurate. “There is no agreement on all 13 points. This presentation is to provide an update of what AHP thinks the 13 points are.”

Commissioner Atin stated his understanding was that Supervisor Zaragoza put out a motion on the 13 points and the motion was voted on and passed, with an element of working out details. Commissioner Atin stated that if AHP has different ideas, the Commission would listen to the counter proposal and vote.

Sonia DeMarta, Chief Financial Officer of AHP stated that a productive meeting was held with discussion and agreement on 7 of 13 points. One of the major accomplishments was agreement on the boilerplate. Ms. DeMarta requested that the
boilerplate be submitted to the State for approval, while the particulars on the 13 points are worked out. Once the State approves, AHP would like to set a Go-Live 90 days after that. The counter proposal is due to concern on the low membership enrollment of 5,000. This is a minimum number for a risk-based contract. There are red flags with healthcare costs as length of stay in the hospital are longer and high utilization of pharmacy. The risk is significantly higher with 5,000 than with 8,000 or 10,000 members. As part of the boilerplate contract, AHP must maintain 300% tangible net equity (TNE) as a reserve for unexpected/unforeseen illnesses. The TNE is tied to the revenue received. The size of the population at start should not be that after a few months. AHP could be out of compliance with the TNE that needs to be maintained. AHP proposed to expand the population and the timeframe for the pilot program. The proposal is that the pilot program be for three (3) years, with the initial enrollment in the first year between 10,000 to 15,000 members, second year between 20,000 to 25,000 members and the third year 30,000+ members. These are the counters for items 1, 2, and 3 of the 13-point proposal. There is also a counter for item 12, which is the term length of the pilot program. AHP proposed a change from five years to three years. For Item 13, Ms. DeMarta proposed that if improvement is demonstrated with the program, then the pilot population should not be limited. Instead, there should be consideration of expanding the member population.

Commissioner Swenson asked for a summary of the counter proposals. Ms. DeMarta listed the following counters:

Item #1: Propose to move forward with the pilot program. Submit the boilerplate contract along with the proposal.

COO Watson commented that this will depend on today’s Commission’s decision on the counter proposal. Compliance Officer Brandy Armenta added that the membership proposal was received by GCHP today. Ms. DeMarta stated she did not specify a certain number of members. COO Watson stated the proposal listed 30%, which is approximately 11,000 members, which is different from what was discussed.

Item #2: Propose change to 3 years instead of 5 years for pilot program.

Item #3: Propose change in number of 5,000 members to 10,000 - 15,000 in the first year.

Item #4: Additional 10,000 members added at the two-year mark.

Item #12: Propose conclusion of the pilot program be changed from 5 years to 3 years.

Item #13: Propose to draw members beyond the CDCR pool.

Commissioner Atin stated he was glad to hear the discussions were cordial. The Commission voted in favor of Supervisor Zaragoza’s 13-point proposal and that he is not in favor of the counter proposal.
PUBLIC COMMENT

3. Arnoldo Torres appeared on behalf of Clinicas del Camino Real.

Mr. Torres requested more than three minutes for comment. Commissioner Swenson approved the extension of time. Mr. Torres expressed his opinion that AHP negotiations were being conducted in public which he did not believe was appropriate. He added that Commissioner Atin’s comment was out of order, stating the original [AHP] framework proposal was in 2013, for all lives. Mr. Torres stated, “This agenda is not about turf. The real challenge for the Commission is to remember to have the best interest of the patient and cost efficiency.” He suggested a third party be involved in to resolve issues in to set up a more balanced relationship and try to reach an agreement. He asked that the Commission never lose perspective and consider having a third party to be involved to resolve the 5 remaining points.

Commissioner Atin responded that public feedback was received, along with input from staff in regards to this item and the Commission made a decision. There is no back and forth. The idea of a mediator was presented at the last meeting, put aside and things went forward. Mr. Torres replied stated this is exactly why a third party should be involved. Commissioner Atin "sees red, others see green". Commissioner Swenson asked Mr. Torres to refrain from further comment as she was moving onto the next speaker.

Dr. Henry Villanueva also suggested the use of a facilitator. He stated that it came to his attention there were no Spanish versions of reports presented at the meeting and that “according to the federal regulations of Medi-Cal, anytime you produce a report, it should be put in the language of the population you are serving, especially when that population is attending the meeting, this goes against the Civil Rights Act of 1964.”

Dr. Villanueva stated in regards to the plan-to-plan, 5,000 members is not enough and 10,000 to 15,000 sounds fair, that there needed to be transparency and not a monopoly.

4. Soledad Barragan was not available to make public comment.

5. Lourdes Solórzano, Chief of Staff for Supervisor John Zaragoza, spoke on behalf of Supervisor Zaragoza.

Ms. Solórzano stated that Supervisor Zaragoza apologized for not being in attendance. She then read a prepared statement by Supervisor Zaragoza. In the statement, Supervisor Zaragoza reiterated there had been many delays on the implementation of the Plan-to-Plan partnership between GCHP and AHP. He also reminded everyone that the Commission had approved a 13-point directive and wanted staff to continue with the initial directive and continue to concentrate on the best health care possible. Commissioner Espinosa requested a copy of Supervisor
Zaragoza's statement. All Commissioners will be emailed a copy of Supervisor Zaragoza's statement.

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

Dr. Aldana stated that she wanted the Commission to focus on goals and oversight and on improving health disparities. She asked if the Plan be able to do that in a meaningful way. She also asked how it will impact/affect members she represents. She added that she has concerns on members self-selecting in and out from specialized medical groups.

COO Watson responded to self-selecting, clarifying that as the population churns, the number goes back up to 5,000 members. This is imbedded in the pilot program guidelines.

Commissioner Swenson stated she had reviewed the minutes and that the Commission approved the 13 points. She stated there had been progress in dialogue, and that she would like to see an outline of the pilot based on the vote from the last meeting.

COO Watson asked for clarification, commenting that the 13-point proposal was reviewed by both parties and there is a difference of opinion. CEO Villani added that the 13 points were approved by the Commission and there is no negotiation on those.

Commissioner Atin motioned to direct staff to proceed with the original 13-point proposal and reach an agreement, otherwise the pilot would not go forward. Commissioner Pupa seconded.

Commissioner Espinosa stated she has a difference in opinion. The proposal was a framework and that the parties were to continue negotiations, which meant that things change so it would not be as originally presented in the 13-point proposal. She suggested that staff should continue negotiations due to the counter proposal and that a mediator is important. Commissioner Swenson agreed with Commissioner Espinosa, however she stated there had been significant changes to the original proposal. Expanding quickly could cause harm to AHP and GCHP. Commissioner Cho commented that there had been a thorough discussion on the number of years for the pilot, as well as the number of members involved. Commissioner Pupa added that at the last meeting she asked General Counsel, Scott Campbell for clarification on Commissioner roles, he essentially repeated everything that was just discussed. Commissioner Pupa stated she thought the Commission was voting on the proposal "as is" with the membership that was documented in the 13 points.

Ms. DeMarta stated there might be a misunderstanding on the counter proposal submitted today, and she wanted to clarify. She asked if the boilerplate could be forwarded to the State. GCHP Compliance Officer, Brandy Armenta stated the proposal today stated 30% of the total membership, and the State was very specific with GCHP since this was a pilot. The membership proposal needs to be defined and included as member choice is a priority. COO Watson stated 30% is approximately 11,000 members. Ms. DeMarta stated AHP wants 30% of how they would select members. Commissioner Espinosa stated the
two organizations need to come to an agreement and amend to add a mediator. Commissioner Atin stated he is not in agreement to amend. Commissioner Cho stated if there is a mediator, then what is the role of the Commission. Commissioner Swenson stated a mediator might be able to close the gap. CEO Villani commented that there were strict guidelines for a pilot, as it is too risky to enter into a large number of pilot members without testing. The pilot and 13 points presented by Supervisor Zaragoza need to be followed per the direction of the Commission.

The motion was re-read as follows: Commissioner Atin motioned to direct staff to proceed with the original 13 points and reach an agreement; otherwise the pilot would not go forward. Commissioner Pupa seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Johnson Gill, Dee Pupa and Jennifer Swenson.

NOES: Commissioner Laura Espinosa.

ABSTAIN: Commissioner Lanyard Dial, M.D.

ABSENT: Commissioner Gagan Pawar, M.D. and Supervisor John Zaragoza.

Commissioner Swenson declared the motion carried.

The meeting was recessed at 4:19 p.m.

Commissioner Alatorre left the meeting at 4:26 p.m.

The regular meeting reconvened at 4:31 p.m.

Commissioner Espinosa asked General Counsel for clarification on any legal issues voting on a counter proposal with no discussion since the counter was just received today. Mr. Campbell stated the motion was made and voted on and that there were no legal issues. The item was agendized for the Commission to provide direction to staff.

4. February Financials Report


Chief Financial Officer Kashina Bishop reviewed medical expense trends and the February financial statements. There are currently over 198,000 members. There is a downward slope in membership but it is leveling. The PMPM medical expense graph was reviewed, which goes back to 2017 by quarter excluding capitation. Commissioner Pupa asked about increases in costs for in-patient and the reinsurance. Commissioner Dial asked if we pay for admin days. COO Watson replied that the plan does pay for admin days, adding that there is difficulty placing Medi-Cal members in SNF’s due to lower reimbursement rates.
CFO Bishop noted that physician specialty costs were higher due to increased utilization of physical therapy related to the transition of behavioral health treatment members to the plan. Commissioner Espinosa asked about the connection between physical therapy and behavior analysis. CMO Wharfield replied there had been a change in responsibilities with the expansion of ABA benefit to non-autism diagnosed members transitioned from the regional centers.

Commissioner Atin asked about a plan if the trend continued, CFO Bishop replied that staff is in the middle of the budgeting process. She is waiting for the state to provide the Plan rates for FY 19/20 and anticipating is a rate increase. CEO Villani added that the Plan cannot budget for further losses. CFO Bishop commented that there are some increases we cannot control and that there would not be a solid recommendation until DHCS provides the new Plan rates [to determine Plan revenue].

Commissioner Dial moved to accept and file the financials report. Commissioner Pupa seconded.

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

NOES:  None.

ABSENT:  Commissioners Antonio Alatorre, Gagan Pawar, M.D. and Supervisor John Zaragoza.

Commissioner Swenson declared the motion carried.

REPORTS

5. Chief Medical Officer Update

RECOMMENDATION:  Accept and file the update.

CMO Wharfield provided additional information on the Governor's Mandate around quality and access, adding that the full plan is not yet final. HEDIS measures will change. The Minimum Performance level (MPL) will move up from the 25th percentile to the 50th percentile. Plans will report on hybrid levels. DHCS will report on claims-based administrative measure from encounter data reports. Plans are currently giving feedback to DHCS. One suggestion is that supplemental data will need to be included in administrative measures. The State is raising the bar. Commissioner Cho commented that it will be impossible to meet the bar, it is too high. She asked how large the sanctions would be. Dr. Wharfield replied that DHCS is still working on the sanctions, but the projection is that they are for multi-year low performance. She added that this is a good opportunity to get preventative measures done.
Commissioner Espinosa stated she had been informed that some pharmacy chains are providing vaccinations without knowing health histories. CMO Wharfield stated health information exchange is important along with immunization registries. She added that the Plan does not currently contract with pharmacies for immunizations.

Dr. Wharfield provided an update on the incontinence issue. She explained that staff needs to work with members to get the best product possible for them. About one year ago, the Medi-Cal formulary changed due to new national standards which arose from studies documented that plastic-backed incontinence products lead to skin breakdown. Dr. Wharfield stated that GCHP Care Management team met with members from last meeting to assist them with product information. They identified the problem with one of the products, which was the waistband texture. Shield, one of the largest vendors for incontinence products, is working on improvement of products, and representatives are keeping in contact with the member to make sure the product is working. The Shield representative stated she spoke with both members and there had been a communication gap but once discussed, she was able to get the member what was needed. Commissioner Espinosa asked about the type of communication gap. The Shield representative replied that the member was mixing and matching her products and her orders were different each time. Information was not communicated to get the maximum number of liners needed and that Shield had not asked the member the proper questions.

6. **Chief Diversity Officer Update**

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

Chief Diversity Officer, Ted Bagley was not present at the meeting. There were not questions on his report.

7. **Chief Operating Officer Update**

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

Chief Operating Officer, Ruth Watson addressed the optometry issue mentioned by CDCR CFO Chris Velasco. She stated that she reached out to Vision Service Plan (VSP) and was told that Clinicas del Camino Real is a non-member provider. However, GCHP has made special arrangements with VSP to pay for vision services when rendered by CDCR Optometrists to GCHP members. She also reviewed GCHP’s network adequacy for Spanish-speaking members seeking vision services. COO Watson’s review of the GCHP vision services provider network indicated that there is sufficient access throughout Ventura County for covered vision services. COO Watson did note the website could be clearer when searching for vision service providers and that this would be addressed in a future website refresh to make it more user friendly.
Commissioner Swenson stated concern about barring CDCR. CEO Villani stated that even though CDCR is not in the network, claims for CDCR are paid. COO Watson stated “Secret Shopper” will continue to ensure members are getting the services needed.

Commissioner Espinosa stated patients don’t know there is a provider available and that GCHP still needs to do better.

Commissioner Dial moved to accept and file Agenda Items 5, 6, and 7. Commissioner Cho seconded.

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

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Gagan Pawar, M.D. and Supervisor John Zaragoza.

Commissioner Swenson declared the motion carried.

CONSENT

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

RECOMMENDATION: Approve the minutes.

CEO Villani commented on the length of the meeting minutes (25 pages long) adding that the level of detail is not typical of most Commissions. However, due to previous Commission discussions, the minutes had become almost dictation based. CEO Villani added that he would like to see the minutes move away from verbatim minutes to a summarized version which is standard practice. Chief Administrative Officer, Melissa Scrymgeour, stated that GCHP is looking into videotaping the meetings.

Commissioner Atin asked how long the recordings are kept and if recordings can be posted on the website. CAO Scrymgeour responded that minutes and audio recordings are kept permanently. Clerk to the Commission, Maddie Gutierrez, added that GCHP currently uses Granicus, which is a program/system used throughout the state in cities and special districts, such as GCHP. Granicus has the capability to videotape the meetings. Commissioner Atin stated as soon as we can begin to videotape, he would like to see the minutes go back to summary format.

Commissioner Dial moved to accept and file the March 25, 2019 Commission Regular meeting minutes as presented. Commissioner Cho seconded.
AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Johnson Gill, and Dee Pupa.

NOES: None.

ABSTAIN: Commissioner Jennifer Swenson.

ABSENT: Commissioners Antonio Alatorre, Gagan Pawar, M.D. and Supervisor John Zaragoza.

Commissioner Swenson declared the motion carried.

9. **Approval of Peer Review/Credentialing Committee Member**

**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.

Commissioner Dial moved to accept the recommendation as presented. Commissioner Atin seconded.

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

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Gagan Pawar, M.D. and Supervisor John Zaragoza.

Commissioner Swenson declared the motion carried.

10. **Provider Advisory Committee (PAC) Membership**

**RECOMMENDATION:** Appoint the Provider Advisory Committee as described and expand the 10 member PAC by adding an 11 member Advisory Committee.

COO Watson requested three (3) additional members to be added to the Committee. The recommendation is to have an eleven (11) member team, which includes one independent.

**PUBLIC COMMENT**

10. Dr. Sandra Aldana stated she was concerned how members of the advisory committees are appointed. She stated the majority are professionals, instead of members of the community and asked the Commission to consider recruitment from communities that are not currently represented. Dr. Aldana commented that the
Consumer Advisory Committee also has many professionals and it is not clear if these professionals are representing the community.

COO Watson provided clarification around PAC composition, explaining that is a professional committee and that seats were defined at time of Plan "Go-Live". The members are representatives of the physician community. The CAC is different and is made up of community members and professionals. COO Watson announced that the CAC would present at the next Commission meeting.

Commissioner Dial moved to accept the recommendation as presented. Commissioner Pupa seconded.

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

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Gagan Pawar, M.D. and Supervisor John Zaragoza.

Commissioner Swenson declared the motion carried.

11. PBM Contract Amendment

RECOMMENDATION: Approve the signing of the PBM amendment.

Dr. Anne Freese, Pharmacy Director, requested the PBM amendment be approved. Commissioner Espinosa asked if there was a dollar amount connected with the amendment. Dr. Freese stated that would be discussed in Closed Session. Commissioner Atin stated he needed more information/detail.

General Counsel, Scott Campbell, stated the meeting could go into Closed Session for discussion.

Commissioner Swenson stated they would finish this agenda item after discussion in Closed Session.

PUBLIC COMMENT

7. Mr. Arnoldo Torres appeared to speak on Agenda Item 12 – Commission Meeting Times and Locations.

Mr. Torres stated he wanted to hear CEO Villani’s comments first. CEO Villani replied that he had no comment, and that this discussion item was being presented at the request of a Commission member. He explained that the Chair Alatorre had forwarded (via email) a letter from a City of Ventura Councilmember, stating her position on Commission meetings. CEO Villani noted this was the individual opinion of the
Councilmember. Mr. Torres stated he had met with various city council members, including the City of Ventura Councilmember. Mr. Torres stated the meetings could continue on the 4th Monday of the month but should be at 6:00 p.m., on a rotating basis within the five County districts. He commented that it was difficult for the public to participate at 2:00 p.m., and it is important for the government to go where the communities are.

12. Mr. Rick Castaniero, LULAC District Director spoke on Agenda Item 12 – Commission Meeting Times and Locations.

Mr. Castaniero stated three moms had come to the meeting, but two had to leave due to responsibilities with their children, and had taken time off work. Public access is important to both healthcare and meeting attendance.

13. Ms. Laura Ramirez spoke on Agenda Item 12 – Commission Meeting Times and Locations.

Ms. Ramirez stated she was a resident of Oxnard, and had to take time off work to attend this meeting. She requested that the Commission consider changing the times and locations of the meeting in order for the community to attend and gain knowledge on healthcare options.

Commissioner Johnson Gill left the meeting at 5:20 p.m.

DISCUSSION

12. Commission Meeting Times and Locations

Discussion was held between staff and Commissioners around the Commission meeting calendar times and locations. Commissioner Atin stated the Board of Supervisors practice holding meetings two times per year at a different location. He believes a “happy medium” can be reached. Commissioner Espinosa stated she would also like to follow the Board of Supervisors meetings. She also suggested a different meeting time.

Commissioner Espinosa motioned to have one meeting per quarter at a different location with a different start time.

Commissioner Dial stated there should be outreach to the community to provide information on available services. He did not believe the Commission meetings are the right venue for this outreach. COO Watson stated there are member orientation meetings held three times per month, in the evening, in both English and Spanish, yet attendance is low. CEO Villani added that community relations is expanding their role in outreach. He commented that CAC is also a voice for members. CEO Villani stated he spoke with Supervisor Zaragoza, and the Supervisor suggested following the Board of Supervisor example. He added that the time of the
Commission meetings was originally 3:00 p.m. and was changed at the request of the Commission.

Commissioner Swenson stated there was a motion on the floor for quarterly meetings to be held at different locations with a different start time. Commissioner Cho asked if there would be a time limit on the meeting. Commissioner Swenson asked if one meeting could be held at a different location every six months with a start time of 3:00 p.m. Commissioner Espinosa objected at the start time, stating that 3:00 p.m. does not allow the public to attend.

General Counsel, Scott Campbell stated a resolution would be prepared with proposed dates and times.

Commissioner Cho stated 6:00 p.m. could be the start time for the two (2) meetings with a hard stop.

Commissioner Espinosa amended her motion to one (1) meeting in 2019, with a start time of 6:00 p.m., and two (2) meetings per year beginning in 2020 with a start time of 6:00 p.m., with the locations to rotate between the five districts.

General Counsel, Scott Campbell stated there had been a prior amendment and therefore now there is a sir-amendment to the amended motion. Commissioner Atin stated he did not agree with the sir-amendment.

The amended motion is as follows: One meeting in 2019 to be held at a different location with a start time of 6:00 p.m., with 2 meetings per year for 2020, each at a different location with a start time of 6:00 p.m.

Commissioner Swenson stated there was an amended motion on the floor, made by Commissioner Espinosa, with a second by Commissioner Cho.

AYES: Commissioners Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Johnson Gill, Dee Pupa and Jennifer Swenson.

NOES: Commissioner Shawn Atin.

ABSENT: Commissioners Antonio Alatorre, Gagan Pawar, M.D. and Supervisor John Zaragoza.

Commissioner Swenson declared the motion carried.
CLOSED SESSION

The Commission adjourned to Closed Session at 5:55 p.m. regarding the following item:

13. REPORT INVOLVING TRADE SECRETS

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

The regular meeting reconvened at 6:16 p.m.

There was no reportable action from Closed Session discussion.

CONSENT

11. PBM Contract Amendment

Commissioner Dial moved to accept the recommendation as presented. Commissioner Pupa seconded.

AYES: Commissioners Shawn Atin, Theresa Cho, M.D., Lanyard Dial, M.D., Laura Espinosa, Dee Pupa and Jennifer Swenson.

NOES: None.

ABSENT: Commissioners Antonio Alatorre, Johnson Gill, Gagan Pawar, M.D. and Supervisor John Zaragoza.

Commissioner Swenson declared the motion carried.

COMMENTS FROM COMMISSIONERS

Commissioner Pupa stated she appreciated all efforts made by GCHP staff. The past few meetings have been challenging. She wanted to convey to the Executive Team and all staff that she appreciates all the work that is done.

ADJOURNMENT

Commissioner Swenson adjourned the meeting at 6:19 p.m.
AGENDA ITEM NO. 2

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Dale Villani, Chief Executive Officer

DATE: May 20, 2019

SUBJECT: Chief Executive Officer Update

CEO Highlights:

Welcome Fred Ashworth, CFO, Los Robles Regional Medical Center

Translation of GCHP Commission Materials

At the April 22, 2019 Commission meeting, a member of the public expressed concern around whether GCHP followed the regulatory requirements for translation of commission materials into Spanish. A formal compliance hotline complaint of discrimination followed.

This is not a requirement under our contract with the California Department of Health Care Services (DHCS), nor is it a requirement under California law. However, we provide interpreter services at all commission meetings, and we would be happy to assist members of the public with the specific materials in question. To date, however, no one has requested translated materials.

DHCS contractually requires GCHP to provide materials defined as member informing material in threshold language(s). Examples of member information materials include notice of action letters, member rights and responsibility letters, and member forms. GCHP is not required to provide Commission meeting agendas and related documents in languages other than English.

AmericasHealth Plan (AHP) Update

GCHP has submitted the boilerplate contract template to DHCS so they can begin the review/approval process. This boilerplate can be used for the AHP pilot once approved by DHCS. DHCS will also require the AHP membership pilot proposal in order to move forward. AHP is revising their membership proposal and indicates they will be providing their revision soon. They understand it must conform to the commission approved pilot requirements. AHP also indicated they will be sending the boilerplate to DMHC for their approval.
GOVERNMENT AFFAIRS AND COMMUNITY RELATIONS UPDATE

GCHP in the Community

Gold Coast Health Plan (GCHP) was a sponsor of the Cinco de Mayo Festival at College Park held in Oxnard on May 4 and 5. In addition to sponsoring the event, GCHP held a booth at the festival. Over 300 community members stopped by the GCHP booth in which GCHP employees shared with them information regarding member benefits, non-emergency medical transportation, and the grievance and appeals process.

Additionally, staff attended MICOP’s annual Indigenous Knowledge Conference at Oxnard College, where mental health/wellness issues and the art of healing within the indigenous Mexican community and US indigenous communities was discussed.

In the second and third quarters of 2019, GCHP awarded sponsorships to the following organizations:

- **United Way of Ventura County**: Proceeds from the 3rd Annual Women United Luncheon go towards single mothers transferring to a four-year university.

- **Turning Point Foundation**: Proceeds from the 30th Anniversary Brunch go towards operating community-based mental health programs in Ventura County.

- **Ventura County Housing Trust Fund**: Proceeds for this event go towards supporting development of new and affordable housing in Ventura County.

On May 9, GCHP staff attended the Humanizing Homelessness Town Hall held in collaboration between California State University, Channel Islands (CSUCI), the City of Oxnard, and the City of Port Hueneme. Students from CSUCI presented their research findings on homelessness in both cities. There was also a local panel discussion on what is currently being done to address the issue. The panel was comprised of law enforcement, community based organizations, and the business community.

The Community Relations team participated in the Kindship Care Awareness event hosted by Kids & Families Together. The event is intended to share resources with kinship caregivers. This event was held at Poinsettia Elementary School in Ventura. Finally, the team also participated in Oxnard Union High School District’s Health & Wellness Fair, intended for students and their families. The health fair was hosted by Pacifica High School.

**Governor Newsom’s FY 2019-20 Budget May Revise**

On May 9, Governor Newsom released the “May Revise” of the 2019-2020 Budget. Like the January Budget, the May Revise focuses primarily on one-time spending rather than continuous budget obligations. The Budget predicts a slower economic growth, but not to the extent of a recession. Thus, the May Revise allocates an additional $15 billion to budget...
reserves and paying down the state’s unfunded liabilities, $1.4 billion higher than his January Budget proposal, bringing the total Rainy-Day Fund to $16.5 billion by the end of 2019-2020.

The May Revise proposes $162.3 billion ($41.4 billion General Fund (GF) and $120.9 billion other funds) in Health and Human Services program spending, which is a $1.1 billion increase compared to January.

**Overall Medi-Cal Budget**

- Total Budget: $102.2 billion ($23 billion General Fund) in 2019-20.

- Total projected enrollment: 13 million Californians, 3.8 million of whom are part of the Medi-Cal Expansion (MCE) population.
  - Assumes a caseload decrease of 2.4% from 2017-18 to 2018-19.
  - Assumes a caseload increase of 0.02% from 2018-19 to 2019-20.

**Prescription Drug Executive Order**

- The Governor’s revised budget provides an estimated savings of up to $393 million General Fund by 2022-23. The summary notes that due to timing of drug rebates and managed care rate-setting process, savings will not be immediate. It is important to note that this policy proposal has been greatly discussed in the legislative budget subcommittees. Senator Richard Pan, the Chair of the Senate Budget Subcommittee on Health, commented last week that he opposed this proposal because of the effect on the 340B program and the negative financial impact to clinics and hospitals serving some of the state’s poorest individuals. Thus, the Government Relations team will continue to closely monitor this proposal.

**MCO Tax**

The May Revision does not include renewal of the MCO tax. The summary notes that one third of the estimated $3.3 billion increase in Medi-Cal expenditures in 2019-20 is due to the expiring MCO tax. The Governor stated that the risk the federal government would reject the tax was too high to propose its renewal at this time. Additionally, the Administration indicated it did not want to close out the 2019-20 budget with a significant component reliant on approval by the Federal Administration.

**Medi-Cal Drug Rebate Fund**

The May Revision projects a $172 million reserve in the Medi-Cal Drug Rebate Fund. This fund, proposed in the Governor’s Budget, will provide a fiscal management tool that will help alleviate the General Fund volatility resulting from pharmacy rebates.
Coverage Expansion

The Governor’s Budget includes $98 million ($74.3 million General Fund) to expand full-scope Medi-Cal coverage to eligible young adults aged 19 through 25 regardless of immigration status. This is a decrease from the $280 million estimated in the January budget due to delaying the implementation date to be no sooner than January 1, 2020. The Budget estimates coverage will be provided to approximately 90,000 undocumented young adults in the first year. The May Revision also maintains the associated redirection of county realignment savings resulting from Medi-Cal expansion.

Proposition 56

The May Revision includes $263 million in additional Proposition 56 revenues and the following additional one-time investments totaling $226.3 million, which are set to sunset on December 31, 2021:

- **Loan repayment program**: $120 million for physicians and dentists who commit to serving the Medi-Cal population. This funding is in addition to the funding allocated the 2018 Budget Act, totaling $340 million for the program ($290 million for physicians and $50 million for dentists).

- **Value-based payment (VBP) program**: $70 million additional funds for the behavioral health integration component of the proposed VBP program. The Governor’s January budget included $180 million for the proposed VBP program with a focus on prenatal/post-partum care, chronic disease management, pediatric prevention, and behavioral health integration. With the additional funds, $250 million will be dedicated to this program over the next few years.

- **Trauma screenings**: $60 million over three years to train providers to conduct trauma screenings. The Governor’s Budget proposed $52.5 million for trauma and developmental screenings for enrollees in Medi-Cal.

- **Benefit restoration**: $11.3 million for optician and optical lab services for adult beneficiaries in Medi-Cal, effective no sooner than January 1, 2020.

- The Legislature will continue to deliberate the budget through May and June and must adopt a spending plan by June 15.
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 submitted the required pre-audit documentation to A&I. In addition to GCHP data and material submission, the request from A&I also included GCHP subcontractor’s data and material. GCHP is in daily receipt of additional document requests and verification studies pull(s), which are inclusive of GCHP and subcontractors information. GCHP will keep the commission apprised of the audit status.

DHCS Contract Amendments:

The draft DHCS contract amendment has included multiple revisions based on CMS review. The contract amendment is still pending approval by CMS and the Plan is pending the final amendment for signature. 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 Year and Type</th>
<th>Audit Status</th>
<th>Date CAP Issued</th>
<th>Date CAP Closed</th>
<th>Ongoing Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduent</td>
<td>2017 Claims</td>
<td>Open</td>
<td>12/28/2017</td>
<td>Under CAP</td>
<td>Open item system configuration change will be modified in new system</td>
</tr>
<tr>
<td>Company</td>
<td>Product/Service Description</td>
<td>Status</td>
<td>Date</td>
<td>Under CAP</td>
<td>Notes</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>-----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Kaiser</td>
<td>2018 Annual Claims</td>
<td>Open</td>
<td>9/23/2018</td>
<td>Under CAP</td>
<td>N/A</td>
</tr>
<tr>
<td>Conduent</td>
<td>2018 Annual Claims</td>
<td>*Open</td>
<td>6/20/2018</td>
<td>Under CAP</td>
<td>Ongoing monitoring imposed</td>
</tr>
<tr>
<td>Beacon Health Options</td>
<td>2018 6 month Claims (focused) audit</td>
<td>*Open</td>
<td>11/21/2018</td>
<td>Under CAP &amp; Under Financial Sanctions</td>
<td>Ongoing monitoring imposed</td>
</tr>
<tr>
<td>Clinicas del Camino Real, Inc.</td>
<td>2018 Annual Claims Audit</td>
<td>*Open</td>
<td>12/28/2018</td>
<td>Under CAP</td>
<td>Ongoing monitoring imposed</td>
</tr>
<tr>
<td>USC Keck</td>
<td>2019 Annual Credentialing</td>
<td>Open</td>
<td>March 4, 2019</td>
<td>April 4, 2019</td>
<td></td>
</tr>
<tr>
<td>Optum</td>
<td>2019 Annual Audit (C&amp;L, FWA, HIPAA, UM, Credentialing)</td>
<td>Open</td>
<td>March 4, 2019</td>
<td>Under CAP</td>
<td></td>
</tr>
<tr>
<td>CDCR</td>
<td>Concurrent UM Quarterly Audit</td>
<td>Closed</td>
<td>May 9, 2019</td>
<td>N/A (CAP not issued )</td>
<td></td>
</tr>
<tr>
<td>Beacon</td>
<td>Concurrent UM Quarterly Audit</td>
<td>Closed</td>
<td>April 11, 2019</td>
<td>N/A (CAP not issued )</td>
<td></td>
</tr>
<tr>
<td>VTS</td>
<td>Call Center</td>
<td>Open</td>
<td>April 26, 2019</td>
<td>Under CAP</td>
<td></td>
</tr>
</tbody>
</table>

*Ongoing monitoring denotes delegate is not making progress on a CAP issued and/or audit results were unsatisfactory and GCHP is required to monitor the delegate closely as it is a risk to the Plan when delegates are unable to comply.
The Compliance Department will be responsible for delegation oversight of the PBM effective November 2018. The audit of the PBM started at the end of December 2018. The audit 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. GCHP is in receipt of the CAP responses from Optum. GCHP was able to close out a few items, however additional items remain open therefore the CAP remains open until all deficiencies are addressed. Staff will continue to keep the Commission apprised.

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

RECOMMENDATION:
Accept and File
AGENDA ITEM NO. 3

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Ruth Watson, Chief Operating Officer
DATE: May 20, 2019
SUBJECT: Community Advisory Committee (CAC) Presentation

RECOMMENDATION:
Receive and file the presentation.
Community Advisory Committee (CAC) Report to the Commission

Ruth Watson, COO
Rita Duarte-Weaver
CAC Committee Chairperson
Monday, May 20, 2019
Community Advisory Committee Members

Rita Duarte-Weaver  
CAC Committee Chair  
Health Care for Kids

Laurie Hall Jordan  
Director  
Rainbow Connection

Ruben Juarez  
Whole Person Care  
VC Health Care Plan

Paula Johnson  
Dir. Clinical Services  
The ARC of Ventura

Estelle Cervantes  
Beneficiary Member

Curtis Updike  
Deputy Director  
Human Services Agency

Norma Gomez  
Project Manager  
MICOP

Pablo Velez  
CEO  
Amigo Baby

Frisa Herrera  
Health Services Manager  
Casa Pacifica

Most of the CAC members also have a personal connection to GCHP through a family member.
CAC/GCHP Collaboration

- CAC members regularly attend GCHP meetings, including those held by GCHP Health Services.
- CAC members routinely reach out to GCHP Member Services for assistance in resolving member issues.
- CAC and GCHP Employee Activities Committee work collaboratively to meet the needs of the community, including events such as:
  - County Healthcare Agency Sock Drive
  - Amigo Baby Thanksgiving Meal Delivery
Evolution

- CAC/GCHP collaborated to
  - Redesign quarterly CAC meetings
  - CAC reviews member materials
- Address Member issues/concerns/requests:
  - Incontinence Supplies
  - Foster Care system changes
  - Navigation of the Healthcare System
    - Collaboratively developed Member Resource Guide
Initiatives

- CAC/GCHP ongoing partnership to find new ways to help members navigate Medi-Cal system
- Identifying barriers for members with the goal of empowering and educating members with regard to:
  - Accessing the healthcare system
  - Understanding benefits
  - Understanding their Grievance and Appeals rights and process
- Collaborating on the creation of a members “Rights and Responsibilities” resource document
Discussion

CAC represents the voice of the members in our community. In order to ensure that the Plan always keeps our members in the forefront, CAC requests that the VCMCC consider placing a member of the CAC on the commission to:

- Engage in discussion and decision making
- Foster open dialogue
- Participate in setting the strategic direction for the Plan
Rita Duarte-Weaver

Mrs. Duarte-Weaver is the CAC Committee Chair. She is the daughter and caretaker of a current GCHP member. Mrs. Duarte-Weaver is currently employed at the Ventura County Public Health Department where she has been for the last seventeen (17) years. As part of her employment she is the Community Services Coordinator for the Health Care for All program. Mrs. Duarte-Weaver conducts regular presentations on Medi-Cal, VC Self-Discount Program and Health Care for All. She has extensive knowledge of Medi-Cal and how to assist our population with their needs, not only because of her employment but as the daughter of a GCHP member.

Ruben Juarez

Mr. Juarez is the CAC Vice-Chairperson. Mr. Juarez is a Community Services Worker (III) with the Whole Person Care (WPC) program for the county. The program facilitates the coordination of health, behavioral health, and social services. They help all patients with their goals and improving overall health and well-being. This is accomplished through more efficient and effective use of resources. In his role with the WPC program, Mr. Juarez supports all Medi-Cal beneficiaries who have been identified as high utilizers of the systems and continue to have poor health. He connects members with public and private entities, providing comprehensive care and follow up, to help each and every member in the Homeless community.
Estelle Cervantes

Ms. Cervantes is the Beneficiary Member serving on the CAC; Ms. Cervantes’s son is also a GCHP member. Ms. Cervantes has been a volunteer for the United Way Volunteer Income Tax Assistance program; is currently serving as a Conejo Valley Unified Board District Advisory Committee Member; and is a Conejo Valley High School Council Member for the District Advisory Council. In 2016 she received Recognition from the “Latino American Who’s Who” for her achievements in advancing the culture of the Latino American Business Community. As a second time cancer survivor, her goal is to someday be an advocate, speaking out in support of women.

Norma Gomez

Ms. Gomez has worked as an interpreter, educator, and case manager with the Mixteco/Indigena Community Organization Project (MICOP) in Oxnard since 2000. As an educator to the Mixteco Community, she leads workshops and group activities to provide information on nutrition, health, and parenting. Ms. Gomez also provides case management and conducts follow-up home visits with the Mixteco Community. She assists Mixteco residents with completing applications for disability, unemployment, school, Medi-Cal, Cal-Fresh, passport applications, etc. Ms. Gomez facilitates “Aprendiendo con Mama y Papa” (learning with mother and father), educational workshops for Mixteco and Latino/migrant farm worker children.
Frisa Herrera

Ms. Herrera has been employed at Casa Pacifica since March 1999 as both the Clinic Manager and Medi-Cal Biller. Casa Pacifica serves abused, neglected, and severely emotionally disturbed children and adolescents from the tri-county regions of Southern California. Ms. Herrera has a unique understanding and familiarity with the needs of foster children and is deeply committed to serving this population. Her stated goal is to “be the voice for the foster community in Ventura County.”

Laurie Hall Jordan

Ms. Jordan has a son and granddaughter who are served by GCHP. Laurie Hall Jordan works for the Rainbow Connection Family Resource Center at Tri-Counties Regional Center. She has been with Rainbow Connection for almost thirty (30) years providing information, training and support for children and adults with developmental disabilities and their families. Ms. Jordan serves as a community representative on the Improving State Systems subcommittee for the state Interagency Coordinating Council on Early Intervention. She is currently the chair for the Community Advisory Committee for the Special Education Local Plan Area. She is on the Behavioral Health Advisory Board Youth & Family Committee.
**Paula Johnson**

Ms. Johnson is the Director of Clinical Services at The Arc of Ventura County. She has many years working with individuals and families of adults with intellectual and developmental disabilities. Her educational background includes a Master’s Degree in Education and a Bachelor’s Degree in Behavioral Psychology. Ms. Johnson is a Certified Instructor for the Crisis Prevention Institute and American Heart Association.

---

**Pablo Velez**

Mr. Velez is the CEO/President/Founder of Amigo Baby, Inc. (2004 to present). He has a Medical Doctoral Degree from Columbia where he developed several county-based services. Upon moving to the United States, he began working with special needs children, lectured in several community organizations and created Amigo Baby, Inc. to serve the Ventura Community. Mr. Velez brings over 20 years of medical and special needs experience to infants and children with developmental delays in Ventura County.
Curtis Updike

Mr. Updike currently serves as the Deputy Director of the Ventura County Human Services Agency where he oversees Medi-Cal and CalFresh (formerly known as Food Stamps) eligibility determination. Prior to his selection as Deputy Director in 2005, he served as manager of the County's East County Intake and Eligibility Center from 2002 to 2005. The East County IEC processes intake and continuing cases in Medi-Cal and CalFresh. Before joining HSA, he served as Chief of Staff for County Supervisor Kathy Long and Field Deputy for Supervisor Maggie Kildee. Mr. Updike holds an Associate's Degree in Business Administration, a Bachelor's Degree in Mass Communications, and a Master's Degree in Public Administration.
AGENDA ITEM NO. 4

TO: Gold Coast Health Plan Commission
FROM: Nancy Wharfield, Chief Medical Officer
DATE: May 20, 2019

SUBJECT: Q1 2019 Quality Improvement Committee Report

The Department of Health Care Services (DHCS) requires Gold Coast Health Plan (GCHP) to implement an effective quality improvement system and to ensure that the governing body routinely receives written progress reports from the Quality Improvement Committee (QIC).

The attached PPT report contains a summary of activities of the QIC and its subcommittees.

APPROVAL ITEMS

- 2019 QI Program Description
- 2019 QI Work Plan

RECOMMENDATION:

Approve the 2019 QI Program Description and the 2019 QI Work Plan as presented. Receive and file the complete report as presented.
Quality Improvement Committee Report

Kimberly Timmerman, MHA, CPHQ
Director, Quality Improvement
May 20, 2019
2019 QI Program Description

**Purpose:**
The QI Program clearly defines GCHP's quality improvement program structure and processes and assigns responsibilities to appropriate business owners across the organization.

**Summary of Key Changes:**
- Case Management/Disease Management/Population Health updated to "Population Health/Care Management" throughout document
- Committee names, descriptions, membership rosters and titles updated by business areas
- Reporting relationship of QI Director
2019 QI Work Plan

**Purpose:**
The QI Work Plan reflects ongoing progress on QI activities throughout the year, with a focus on quality/safety of clinical care, quality of service, and regulatory requirements.

**Summary of Key Changes:**
- **New Measures:**
  - Well Child Visits 3-6 (W34) – Evaluate effectiveness of member incentive program
  - Asthma Medication Ratio (AMR) – low performing measure – partner with Optum Rx and Health Education on interventions
  - Low Back Pain (LBP) – low performing measure – identify high utilizing providers and develop/implement intervention
  - Credentialing – dashboard measure previously not being monitored in QI Work Plan

- **Retired Measures (Goal Met or focus areas re-prioritized)**
  - Appropriate Testing for Children with Pharyngitis (CWP) – Not an EAS measure

- **2019 QI Work Plan to be reassessed upon DHCS finalization of quality measures**
2018 Annual Reporting of Member Incentive Projects
2018 Postpartum Exam Member Incentive Evaluation

**Member Incentive:** Women that had a postpartum exam within 21-56 days after a livebirth delivery receive a large pack of diapers (sizes 1, 2, or 3).

**2018 Goal:** Increase the 2018 MY administrative postpartum exam rates by 3% over the previous measurement year (2017 MY).

**Results:** Rate increased by **12.09%** points from 63.69% to 75.78%, which is greater than 90th percentile.

**Successes:**
- The postpartum exam administrative rate increase exceeded the 3% goal
- The member incentive participation rate increased 63% in 2018.
- Health Navigator program, launched in Q4 2018, increased member engagement.

**Barriers:**
Despite increased member incentive engagement in 2018, the overall participation remained low with only 258 forms returned out of the 1823 forms delivered to members.

**HEDIS® Administrative PPC-Post Rate Comparison 2017-2018 MY**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2017 MY Final Admin Rate</th>
<th>2018 MY Initial Admin Rate*</th>
<th>Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPC-Post</td>
<td>63.69%</td>
<td>75.78%</td>
<td>+12.09</td>
</tr>
</tbody>
</table>

*This rate is based on the initial 2018MY administrative rate. The final administrative rate will be available after the admin refresh in April 2019.

**2015-2018 Postpartum Member Incentives Awarded by Year**

<table>
<thead>
<tr>
<th>Study Period</th>
<th>Member Participation</th>
<th>Forms Mailed to Members</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/01/15 - 12/31/16</td>
<td>98</td>
<td>2142</td>
<td>4.6%</td>
</tr>
<tr>
<td>01/01/17 - 12/31/17</td>
<td>158</td>
<td>1897</td>
<td>8.3%</td>
</tr>
<tr>
<td>01/01/18 - 12/31/18</td>
<td>258</td>
<td>1823</td>
<td>14.15%</td>
</tr>
</tbody>
</table>

**Gold Coast Health Plan**
A Public Entity
2018 Well-Child Exam Member Incentive Evaluation

**Member Incentive:** Children 3 to 6 years of age receive the choice of a $15.00 gift card to Target or Walmart for completing a well-child exam in 2018.

**2018 Goal:** Increase well-child exams in children 3-6 years old (W34 measure) by 5% points over the previous measurement year (2017 MY).

**Results:** W34 admin rate increased by **6.50%** points from 63.27% to 69.77%.

**Successes:**
- The well-child exam (W34) administrative rate increase exceeded the 5% goal.
- The member incentive participation rate increased **304%** in 2018.

**Barriers:**
Despite increased member incentive engagement in 2018, the overall participation remained low with only 1,130 forms returned out of the 21,375 forms mailed to children.

**HEDIS® Administrative W34 Rate Comparison 2017-2018MY**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2017 MY Final Admin Rate</th>
<th>2018 MY Initial Admin Rate*</th>
<th>Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>W34</td>
<td>63.27%</td>
<td>69.77%</td>
<td>+6.50</td>
</tr>
</tbody>
</table>

*This rate is based on the initial 2018MY administrative rate. The final administrative rate will be available after the admin refresh in April 2019.

**2017-2018 Well-Child Member Incentives Awarded by Year**

<table>
<thead>
<tr>
<th>Study Period</th>
<th>Member Participation</th>
<th>Forms Mailed to Members</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/01/17 – 12/31/17</td>
<td>280</td>
<td>14,322</td>
<td>2%</td>
</tr>
<tr>
<td>01/01/18 – 12/31/18</td>
<td>1,130</td>
<td>21,375</td>
<td>5.3%</td>
</tr>
</tbody>
</table>
Member Outreach Campaign
Closing Gaps in Care
Eliza Member Outreach Campaign: Summary

Program
- GCHP contracted with Eliza to conduct outreach to members via Interactive Voice Response (IVR) in a year-end care gap closure initiative.

Measures in scope:
- Childhood Immunizations
- Well Child Visits (ages 3-6)
- Children & Adolescents’ Access to Primary Care Practitioners (12mo.–19 yrs)
- Breast Cancer Screening
- Cervical Cancer Screening
- Comprehensive Diabetes Care (HbA1c, Eye Exam, Microalbumin Test)
- Monitoring for Patients on Persistent Medications

Timeline
November 12, 2018 - December 14, 2018
Eliza Member Outreach Campaign: Final Performance Measures

- Over 36,000 unique calls attempted
- 2,118 individuals connected to live agent
  - 82% of connected individuals completed the live agent call
  - The remaining 18% who connected to the live agent may have disconnected the call early

<table>
<thead>
<tr>
<th>Gold Coast Performance</th>
<th>Standard Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>84% reachable</td>
<td>79-87% reachable</td>
</tr>
<tr>
<td>27.7% reach rate (8,596 members)</td>
<td>26% reach rate</td>
</tr>
<tr>
<td>24.6% of reached members connected to a live agent (2,118 members)</td>
<td>14% connect rate</td>
</tr>
<tr>
<td>19.3% of connected members scheduled at least 1 appointment (409 members)</td>
<td>12% appointment rate</td>
</tr>
</tbody>
</table>

Reachable: Eliza has valid contact info for member
Reach Rate: Connection achieved (spoke with live person, VM)
Eliza Member Outreach Campaign: Appointments Scheduled

Summary

- 409 (19%) members scheduled at least one appointment of 2,118 members connected
  - Pap Result: 73% of 376 members had an appointment scheduled as a result of the call
  - Eye Exam Result: 69% of 117 members had an appointment scheduled as a result of the call

Total appointments scheduled: 793

- Pap: 286
- Annual Wellness Visit: 211
- Eye Exam: 83
- Mammogram: 54
- Microalbumin: 52
- Lab: 50
- HbA1c: 31
- Immunization: 26
Next Steps

- Formally evaluate program effectiveness
  ✓ Review claims/encounter data for targeted members – Q2
  ✓ Assess HEDIS results – Q3

- Assess options for member engagement campaigns for 2019
  ✓ RFP for HEDIS Gap Closure Vendor (in process - fielded 4/18/19)
  ✓ Target outreach activity June – Dec 2019
HEDIS®
(Healthcare Effectiveness Data and Information Set)

Measurement tool used to evaluate the quality of care provided by practitioners/clinics
GCHP HEDIS Performance Status

• Currently in Measurement Year 2018/Reporting Year 2019 (MY 2018/RY 2019)

• GCHP performance for prior year (MY 2017/RY 2018)
  - DHCS Most Improved Award
    • Effort toward production of complete claims, encounter and supplemental data submission to maximize administrative positive hits
    • Pursuit of medical records began 6 weeks earlier than prior year
    • Remote medical record collection
      ✅ New agreements executed to allow remote EHR access for HEDIS vendor (Inovalon) and for GCHP QI staff
    • GCHP QI Staff conducted oversight of Inovalon throughout project stages:
      • Medical record retrieval/abstraction
      • Measure escalation/resolution
      • 100% over-read of abstracted records to validate review process/accuracy and correct identified errors
HEDIS – MY2018/RY2019

Key highlights:
- Timeframe for retrieval/abstraction: February 25 - May 3, 2019
- Partnering with Inovalon for record collection and abstraction (3rd season)
- External Accountability Set (EAS) measures remain the same as prior year
- EMR access procured for VCMC, CMH (new!) for GCHP QI Team. CDCR access via document appliance.
HEDIS – Status as of 5/14/19

Key Successes:

- Increased EMR access to optimize efficiency/accuracy
- HSAG HEDIS Compliance Audit (March 13, 2019)
  - Successful onsite review
  - Passed Convenience Sample – no findings
  - Passed Primary Source Validation for non-standard supplement data sources for BCS and MPM – no findings
- Achieved 99.96% chase completion rate

Next Steps:

- HSAG Medical Record Review Validation (May 10-31)
- Final audited results available by Q4
HEDIS – Looking Ahead – 2020

• Managed Care Accountability Set
  - MCPs and DHCS will report yearly on a set of quality measures
  - Measures will be from CMS Child and Adult Core Sets

• Benchmarks
  - MPL - perform at least as well as 50% of Medicaid plans in the US (currently at 25%)

• Reporting
  - MCPs will report on 13 hybrid measures
  - DHCS will report on 8 admin measures
Measures for RY 2020

- **Children’s Health**
  - *WCC BMI
  - *CIS 10
  - *W15
  - *W34
  - *IMA 2
  - *AWC

- **Behavioral Health**
  - FU ADHD Meds Int.
  - FU ADHD Meds Cont.
  - Antidepressant Med Mgmt Acute
  - Antidepressant Med Mgmt Cont.

- **Women’s Health**
  - *CCS
  - Chlamydia
  - BCS
  - *PPC-Pre
  - *PPC-Pst

- **Acute and Chronic Disease Mgmt**
  - *Adult BMI
  - *CBP
  - *CDC HT
  - *CDC H9
  - AMR
  - PCR

* - Denotes a measure reported by MCPs with hybrid methodology.
Additional Measures

• **Children’s Health**
  - Developmental Screening
  - CAP
  - Audiological Diagnosis
  - AMB-ED

• **Behavioral Health**
  - Depression Screening
  - DM Screening SMI
  - DM Care SMI H9
  - Opioids high dose
  - Opioids and benzos

• **Women’s Health**
  - Elective Delivery
  - Cesarean Section
  - Contraceptive Care All Women
  - Contraceptive Care Postpartum

• **Acute Chronic Disease Mgmt**
  - PQI Diabetes
  - PQI COPD
  - PQI CHF
  - PQI Asthma
  - HIV Viral Load Suppression
  - MPM

Admin measures DHCS may report on; no benchmarks currently
GOLD COAST HEALTH PLAN
20189 QUALITY IMPROVEMENT PROGRAM

I. Background 3
II. Mission, Vision, and Values 3
III. Purpose and Scope 3
IV. Authority and Responsibility 5
V. QI Program Goals and Objectives 6
VI. QI Program Methodology 6
VII. Key Program Initiatives 8
VIII. Program Organization, Oversight and Evaluation 9
IX. Annual Work Plan 11
X. Program Resources Dedicated to Quality Improvement 12
XI. Quality Committees and Subcommittees 14
   i. Quality Improvement Committee 14
   ii. Medical Advisory Committee 16
   iii. Member Services Committee 17
   iv. Grievance and Appeals Committee 17
   v. Utilization Management Committee 18
   vi. Health Education/Cultural Linguistics Committee 19
   vii. Credentials/Peer Review Committee 20
<table>
<thead>
<tr>
<th></th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>viii.</td>
<td>Pharmacy and Therapeutics Committee</td>
<td>21</td>
</tr>
<tr>
<td>XII.</td>
<td>Delegation of Quality Improvement</td>
<td>22</td>
</tr>
<tr>
<td>XIII.</td>
<td>Committee Organizational Chart</td>
<td>23</td>
</tr>
<tr>
<td>XIV.</td>
<td>Quality Committee Meetings for Calendar Year</td>
<td>24</td>
</tr>
</tbody>
</table>
I. BACKGROUND

Gold Coast Health Plan is an independent public entity created by County Ordinance and authorized through Federal Legislation. The Ventura County Board of Supervisors approved implementation of a County Organized Health System (COHS) model, transitioning from fee-for-service Medi-Cal to managed care, on June 2, 2006. A year later, the board established the Ventura County Medi-Cal Managed Care Commission as an independent oversight entity, to govern and operate a single plan — Gold Coast Health Plan — to serve Ventura County’s Medi-Cal population. The commission is comprised of locally-elected officials, providers, hospitals, clinics, the county healthcare agency and consumer advocates.

II. MISSION, VISION, VALUES

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

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

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

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

III. PURPOSE AND SCOPE

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

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

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

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

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

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

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

4. A QI focus which represents

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

IV. AUTHORITY AND RESPONSIBILITY

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

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

To address the scope of the Plan’s QI Program goals and objectives, the structure consists of the following committees:

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

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

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

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

VCMMC Membership

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

V. QI PROGRAM GOALS AND OBJECTIVES

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

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

The QI Program goals include:

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

The Program Objectives include the following:

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

VI. QI PROGRAM METHODOLOGY

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

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

The indicators may reflect the following parameters of quality:
- Structure, process, or outcome of care
- Administrative and care systems within healthcare services to include:
  - Acute and chronic condition management including disease, case care management, and population health activities
  - Utilization management
  - Credentialing
  - Member experience/satisfaction
  - Care and provider experience
    - Medical record review
  - Member grievances and appeals
  - Practitioner accessibility and availability
HEDIS® measures and CAHPS® results are integrated in the QI Program. HEDIS® measures and methodology may be adopted as performance indicators for clinical improvement. The CAHPS® survey is utilized as one of the tools for accessing member satisfaction.

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

VII. KEY PROGRAM INITIATIVES

**Case Management/Disease Management/Population Health/Care Management**

GCHP's Case Management/Disease Management (CM) Programs are a collaborative process that assess, develop, plan, implement, coordinate, monitor, and evaluate the options and services needed to meet the member's health and human service needs and is characterized by advocacy, communication and resource management. Through telephonic interaction with the member, the member's significant other(s) and providers, the GCHP staff collects and analyzes data about the actual and potential care needs for the purpose of developing an individualized care plan.

The goal of the GCHP/Population Health/Care Management (CM) program is to simultaneously promote the member's wellness, autonomy, and appropriate use of services and financial resources. These programs strive to empower members to exercise their options and access the services appropriate to meet their individual health needs to promote quality outcomes. The GCHP/Population Health/Care Management (CM) Program adheres to the Triple Aim by striving to improve the health and health outcomes of GCHP members by empowering members to take control of their health.

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

Members may be identified for GCHP/Population Health/Care Management (CM) through:
- member or caregiver referral
- practitioner referral
- HIF/MET with an identified relative health risk, such as diabetes, pre-diabetes, or asthma
- internal GCHP departments such as Member Services/Health Education/Utilization Management/Transition of Care Team
- referral from hospital and GCHP discharge planners
- referrals from Community agencies
- information collected from Health Risk Assessment Tools
- review of hospital and outpatient utilization patterns
- review and profiling of encounter data/pharmacy utilization data/claims and billing data

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

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

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

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

Inclusion and Diversity

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

To ensure that members have access to covered services that are delivered in a manner that meets their needs, GCHP conducts the following activities:

- Review of member complaints and grievances
- Provision of language assistance services to assist providers to provide linguistically appropriate medical care to Limited English Proficient members
- Conducting a Group Needs Assessment every 5 years
- Provision of a Cultural Competency Training Program for both providers and GCHP staff
- Conducting surveys of members to determine if culture and language needs are met by providers
- Provision of a Seniors and Persons with Disabilities (SPD) Cultural Sensitivity Training for providers and staff
- Assessment of provider linguistic capabilities
- Assessment of GCHP staff language capabilities

VIII. PROGRAM ORGANIZATION, OVERSIGHT AND EVALUATION

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

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

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

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

**MEDICAL DIRECTOR**

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

**DIRECTOR OF QUALITY IMPROVEMENT**

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

The Director reports to the **Executive Director of Health Services**, who collaborate to ensure that the **CMO** and ensures that he/she is updated on any deficiencies and proposed improvement activities.

Specific roles and responsibilities of the QI Director include but are not limited to:

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

The QI Director oversees staff consisting of an adequate number of Registered Nurses with the requirement to fulfill QI responsibilities, and other staff that includes a QI Manager, QI Project Manager, Senior Quality Improvement HEDIS® Analyst, a QI Data Analyst, a Credentialing Coordinator and the QI Specialists.

QI PROGRAM EVALUATION
A written evaluation of the QI Program is completed annually. This includes a review and revision of the QI Program Description, evaluation of the prior year’s QI Work Plan, and the development of the current year’s QI Work Plan to ensure ongoing performance improvement.

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

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

IX. ANNUAL WORK PLAN

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

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

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

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

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

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

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

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

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

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

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

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

• Credentialing and Recredentialing activities; and
• Peer Review Activities

Communication and Feedback
Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings and announcements. Providers are educated regarding quality improvement initiatives via on-site quality visits, provider update memos, newsletter, Provider Operations Bulletin and the GCHP website. Specific HEDIS® performance feedback is communicated to providers via an annual HEDIS® report card and periodic progress reports of projected rates including listings of members who need specific clinical services (“gap reports”).

X. PROGRAM RESOURCES DEDICATED TO QUALITY IMPROVEMENT

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

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

Quality initiatives related to service including member satisfaction and those related to complaints and appeals are supported by Member Services and Grievance and Appeals staff.
Quality initiatives related to provider network and provider communication is supported by Provider Network Operations staff.

Credentialing and peer review functions are supported by QI staff.

The quality improvement staff assists the Director in assessing data for improvement opportunities. They work with other departments to assist in planning and implementing activities that will improve care or service.

Responsibilities of multidisciplinary staff include but are not limited to the following:

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

OTHER QI RESOURCES

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

QI Program Resources - Program and Tools

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

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

QI Tools, Resources and Sources of Data

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

- National initiatives and measurement sets such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Healthcare Effectiveness Data and Information Set (HEDIS®), Quality Compass
- Government issued laws, regulations and guidance including those from DHCS, CMS, the U.S. Preventive Services Taskforce (USPSTF), and National Institutes of Health (NIH)
- Healthcare Quality Improvement Organizations such as the National Committee for Quality Assurance (NCQA), the Institute for Healthcare Improvement (IHI), and the Agency for Healthcare Research and Quality (AHRQ)

QI Program Resources - Data, Information and Analytics Support
GCHP's QI Program monitors and evaluates performance and information from many different sources throughout the organization including but not limited to:

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

XI. QUALITY COMMITTEES AND SUBCOMMITTEES

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

1. Quality Improvement Committee (QIC)

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

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

An annual QI Report is submitted to the VCMCCC addressing:
A. Quality improvement activities such as:
   i. Utilization Reports
   ii. Review of the quality of services rendered
   iii. HEDIS® results
   iv. Quality Improvement Projects and initiatives - status and/or results
   v. Satisfaction Survey Results
   vi. Collaborative initiatives - status and/or results

B. Success in improving patient care and outcomes, and provider performance.

C. Opportunities for improvement.

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

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

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

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

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

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

QIC Reporting Structure:
The QIC reports to the VCM MCC. The Chair of the QIC ensures that quarterly reports are submitted to the VCM MCC.

Meeting Frequency:
The QIC meets at a minimum quarterly.

2. Medical Advisory Committee (MAC)

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

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

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

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

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

Membership:
Membership is comprised of physicians representing the contracted provider community for GCHP's programs. The Chief Medical Officer will serve as Chairman and will ensure that the membership has adequate specialty representation. Efforts are made to rotate membership every two years; however, in order to ensure continuity of committee activity, membership may be extended.

Meeting Frequency:
The committee meets at a minimum on a quarterly basis.

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

MSC Objectives:

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

MSC Membership:

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

Meeting Frequency:
The MSC meets quarterly at a minimum.

4. Grievance and Appeals Committee (G&A)
G&A Charter:

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

G&A Committee Objectives:

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

G&A Committee Membership:

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

Meeting Frequency:

The committee meets quarterly.

5. Utilization Management Committee (UMC)

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

UMC Responsibilities:

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

Membership:

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

Meeting Frequency:

The UMC meets quarterly at a minimum.

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

Purpose:

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

Functions:

• Ensure that members have access to appropriate health education materials.
• Ensure that Providers have access to health education services and materials.
• Ensure that Providers and Plan staff deliver culturally and linguistically (C&L) appropriate healthcare services to GCHP’s diverse membership.
• Ensure that Providers and staff receive trainings on cultural competency, language assistance, Seniors and Persons with Disabilities (SPD) and/or diversity trainings.
• Ensure that all members—regardless of race, color, region, national origin, gender, gender identity, disability or language capabilities have equal access to quality healthcare.
• Ensure that GCHP implements C&L requirements set by Department of Health Care Services (DHCS).
• Ensure the Group Needs Assessment (GNA) is completed to determine a baseline for serving education and cultural language needs.
• Collaborate and Work with GCHP’s Health Services, Quality Improvement and other departments to ensure areas and the C&L to prioritize health education, cultural and linguistic services needs are addressed.
• Ensure opportunities are available to educate members on the disease process, preventive care, plan processes and all other areas essential to good member health.
• Assist providers in educating Plan members and promote positive health outcomes.
• Ensure that all written information materials comply with the readability and suitability requirements set by the Department of Health Care Services. The member informed materials shall be at a sixth grade or lower. It should also be reading level consistent with the Plan’s membership needs, and are no greater than the sixth-grade reading level.
• Educate Plan staff on specific cultural barriers that might hinder the delivery of optimal health care.

Membership:
• Director of Health Education & Cultural Linguistic Services (Chair)
• Chief Medical Officer or designee
• Executive Senior Director of Health Services or designee
• Managers of CDM/Population Health/Care Management or designee
• Director of Communications or designee
• Manager of Member Services or designee
• Senior Director of Network Operations or designee
• Director of Quality Improvement or designee
• Cultural and Linguistic Specialist
• Health Navigator /Health Navigator Lead

Meeting Frequency:
The committee meets at a minimum quarterly.

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

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

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

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

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

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

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

Meeting Frequency:
The committee meets quarterly.

8. Pharmacy & Therapeutics (P&T) Committee

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

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

Membership:
• Chief Medical Officer (Chair)
• PBM representative
• Director of Pharmacy Services, or pharmacist designee
• Physicians and representatives of a variety of clinical specialties.

Meeting Frequency:
The committee meets quarterly.

XII. DELEGATION OF QUALITY IMPROVEMENT

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

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

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

- **Executive Finance Committee**
- **Quality Improvement Committee**
- **Provider Advisory Committee**
- **Consumer-Community Advisory Committee**
- **Medical Advisory Committee**
- **Credentials/Peer Review Committee**
- **Pharmacy and Therapeutics Committee**
- **Grievance and Appeals Committee**

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

**Member Services Committee**
- **Utilization Management Committee**
- **Health Education/Cultural and Linguistics Committee**
XIV. QUALITY COMMITTEE MEETINGS FOR CALENDAR YEAR 2019

Dates:
Tuesday March 27, 2018/March 26, 2019
Tuesday June 18, 2018/June 16, 2019
Tuesday September 24, 2018/September 22, 2019
Tuesday December 11, 2018/December 10, 2019
Location: Bell Canyon Conference Room

Availability of QI Program to practitioners and members

The QI Program is available on GCHP’s website at www.goldcoasthealthplan.org. Printed copies are available upon request.

REFERENCES

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

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

The 2019 Quality Improvement Program Description and Work Plan were approved by the Quality Improvement Committee on June 18, 2018/March 26, 2019.

The 2019 Quality Improvement Program Description and Work Plan were approved by Ventura County Medi-Cal Managed Care Commission (VCMMCC) on July 23, 2018.
<table>
<thead>
<tr>
<th>Practice Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals</strong></td>
</tr>
<tr>
<td>Review and adoption of evidence-based Diabetes Clinical Practice Guideline (CPG) at least every two years</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Review and adoption of evidence-based Asthma Clinical Practice Guidelines (CPG) at least every two years</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Review and adoption of Preventive Health Guideline (PHG) at least every two years</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**

- Return to Agenda
# Objective #1: Improve Quality and Safety of Clinical Care Services

**Required by:** DHCS  
**Objective Met:**  
**Target Completion Date:** Q4 2019

**Advance Prevention**

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase awareness of benefits of tobacco cessation in member population identified as smoking</td>
<td>Utilize DHCS methodology to identify smokers via monthly data pulls</td>
<td>QI</td>
<td>50% of identified smokers receive intervention</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Create and implement education campaign for members and providers</td>
<td>Health Education/Provider Operations</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Measure and report tobacco cessation medication dispensing and cessation counseling quarterly</td>
<td>DSS/QI</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Create system to monitor provider performance regarding offering interventions</td>
<td>QI/DSS</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase rates of Initial Health Assessment (IHA)/IHEBA completion by provider sites</td>
<td>Educate providers regarding requirements and components of IHA</td>
<td>QI</td>
<td>Increase rate of IHA completion by 5% compared to CY18</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Audit providers and provide feedback on opportunities for improvement</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Monitor and report provider compliance with outreach to new members. Follow up on deficient sites.</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Create and implement campaigns to increase provider awareness of requirements; member awareness of IHA offering</td>
<td>Health Education/PNO/QI/Member Services</td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
</tbody>
</table>
### Objective #1: Improve Quality and Safety of Clinical Care Services

**Objective Met:**

- **Target Completion Date:** Q4 2019

**Required by:** DHCS

#### HEDIS® Measures

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Postpartum Care – Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery</td>
<td>Evaluate effectiveness of the PP member incentive program and identify program changes/enhancements, as applicable</td>
<td>QI</td>
<td>Increase rates by 3% over previous measurement year</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Analyze demographic results for potential disparity; create action plan to address if present</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Provide provider/clinic performance feedback by means of MY2018 Annual HEDIS Report Cards</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Develop and implement member campaign regarding value of timely postpartum visit</td>
<td>Health Education</td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**


<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Well Child Visits - Percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year</td>
<td>Evaluate effectiveness of the W34 member incentive program and identify program changes/enhancements, as applicable</td>
<td>QI</td>
<td>Increase rate by 3% over previous measurement year</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
</tbody>
</table>

Evaluation/Analysis of Interventions:
<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Childhood Immunization Status Combo 3 - Percentage of two year old children who received required vaccines (DTaP, IPV, MMR, HiB, HepB, VZV and PCV) on or before their 2nd birthday</td>
<td>Improve Childhood Immunization Status Combo 3 - Percentage of two year old children who received required vaccines (DTaP, IPV, MMR, HiB, HepB, VZV and PCV) on or before their 2nd birthday</td>
<td>QI</td>
<td>Increase rates by 3% over previous measurement year</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Provide provider/clinic performance feedback by means of MY2018 annual HEDIS report cards</td>
<td>Provide provider/clinic performance feedback by means of MY2018 annual HEDIS report cards</td>
<td>QI</td>
<td>Increase rates by 3% over previous measurement year</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Provide bi-monthly prospective HEDIS progress reports and performance feedback reports</td>
<td>Provide bi-monthly prospective HEDIS progress reports and performance feedback reports</td>
<td>QI</td>
<td>Increase rates by 3% over previous measurement year</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Explore partnerships with VCPH/VCOE/community agencies to educate clinics on Cocasa reporting and cr best practices</td>
<td>Explore partnerships with VCPH/VCOE/community agencies to educate clinics on Cocasa reporting and cr best practices</td>
<td>QI/Health Education</td>
<td>Increase rates by 3% over previous measurement year</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Create and implement provider and member education campaigns</td>
<td>Create and implement provider and member education campaigns</td>
<td>Health Education / PNO</td>
<td>Increase rates by 3% over previous measurement year</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
</tbody>
</table>

Evaluation/Analysis of Interventions:
<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improve Cervical Cancer Screening - Percentage of women 21-64 years of age who were screened for cervical cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evaluate MY2018 performance to identify opportunities and develop interventions</td>
<td>QI</td>
<td>Increase rates by 4% over previous measurement year</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Provide bi-monthly prospective HEDIS progress reports and performance feedback reports</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Provide provider/clinic performance feedback by means of MY2018 annual HEDIS report cards</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Collaborate with partners (e.g. lab vendors, clinic systems) to evaluate and improve data capture</td>
<td>QI/PNO/IT</td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Create and implement provider and member awareness campaign</td>
<td>Health Education / PNO /QI</td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
# 2019 Gold Coast Health Plan
## Quality Improvement Work Plan

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

**Required by:** DHCS  
**Target Completion Date:** Q4 2019

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
| Improve Children and Adolescents' Access to Primary Care Practitioners – Percentage of members 12 months – 19 years of age who had a visit with a PCP, measured by four age stratifications:  
*12-24 months  
*24 months - 6 years  
*7-11 years  
*12-19 years | Evaluate MY2018 performance to identify opportunities and develop interventions, including analysis of potential disparities  
Evaluate outcomes of VCMC APM  
Evaluate data collection improvement opportunities  
Evaluate outcomes of W34 member incentive for the 3-6 year old membership  
Provide provider/clinic performance feedback by means of MY2018 Annual HEDIS Report Cards  
Provide bi-monthly prospective HEDIS progress reports and performance feedback reports  
Create and implement provider and member awareness campaign | QI  
QI/DSS  
QI  
QI  
QI  
QI | Increase rates by 3% in each age stratification over previous measurement year | 1/1/2019  
1/1/2019  
1/1/2019  
1/1/2019  
1/1/2019  
1/1/2019 | 12/31/2019  
12/31/2019  
12/31/2019  
12/31/2019  
12/31/2019  
12/31/2019

**Evaluation/Analysis of Interventions:**
### Objective #1: Improve Quality and Safety of Clinical Care Services

**Required by:** DHCS

**Target Completion Date:** Q4 2019

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma Medication Ratio - Percentage of members 5-64 years of age identified having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year</td>
<td>Evaluate MY2018 performance to identify opportunities and develop interventions</td>
<td>QI</td>
<td>Increase rates by 3% over previous measurement year</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Provide bi-monthly prospective HEDIS progress reports and performance feedback reports</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Provide provider/clinic performance feedback by means of MY2018 annual HEDIS report cards</td>
<td></td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Based on identified individuals diagnosed with asthma, develop program to conduct follow up education (i.e. home and office visits)</td>
<td>Health Education/QI</td>
<td></td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
# 2019 Gold Coast Health Plan
## Quality Improvement Work Plan

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

<table>
<thead>
<tr>
<th>Over/Under Utilization</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis Percentage of adults 18 – 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.</td>
<td>Evaluate MY2018 performance for opportunities and develop interventions (e.g. targeting high volume providers) Provide provider/clinic performance feedback by means of MY2018 Annual HEDIS Report Cards Provide bi-monthly prospective HEDIS progress reports and performance feedback reports Create and implement member and provider campaigns</td>
<td>QI</td>
<td>Improve 3% compared to prior year performance</td>
<td>1/1/2019</td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
# 2019 Gold Coast Health Plan
Quality Improvement Work Plan

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

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Use of Imaging Studies for Low Back Pain - Percentage of members with a primary diagnosis of low back pain who did not have an imaging study within 28 days of diagnosis</td>
<td>Evaluate MY2018 results to identify opportunities</td>
<td>QI</td>
<td>Improve 3% compared to prior year performance</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Provide provider/clinic performance feedback by means of MY2018 annual HEDIS report cards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Create and implement action plan to improve metric by looking at high utilizing providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Create and implement member and provider campaigns among members who frequent the ER for low back pain</td>
<td>Health Ed/PNO/QI/IT</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
## 2019 Gold Coast Health Plan
Quality Improvement Work Plan

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

**Objective Met:**

**Target Completion Date:** Q4 2019

**Required by:** DHCS

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
| Health Disparity PIP: Decrease the Rate of HbA1c > 9.0 in Non-English-Speaking Hispanic/Latino Members with Diabetes Who Are Enrolled at Las Islas Family Medical Group | Two-year performance improvement project (PIP) - health plan/clinic collaborative between GCHP QI and Ventura County Medical Center’s Las Islas Family Medical Group.  
- Submit Modules as directed by DHCS/HSAG for approval  
- Report updates/results to QIC | QI | By June 30, 2019, decrease the rate of HbA1c > 9.0 among adults, 18-75 years of age, non-English speaking Hispanic/Latinos member with diabetes who are enrolled at Las Islas Family Medical Group from 70.39% to 59.20%. | 1/1/2019 | 6/30/2019 |

**Evaluation/Analysis of Interventions:**
## Quality Improvement Work Plan

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

**Required by:** DHCS  
**Objective Met:**  
**Target Completion Date:** Q4 2019

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
| Child Immunization PIP: Increase the Rate of Combo 3 Immunizations Administered On/Before the 2nd Birthday for Children Enrolled at Mandalay Bay Women’s and Children’s Medical Group. | Two-year performance improvement project (PIP) - health plan/clinic collaborative between GCHP QI Department and Ventura County Medical Center’s Mandalay Bay Women’s and Children’s Medical Group.  
- Submit Modules as directed by DHCS/HSAG for approval  
- Report updates/results to QIC | QI | By June 30, 2019, increase the rate of Combo 3 immunizations administered on/before the 2nd birthday for children enrolled at Mandalay Bay Women’s and Children’s Medical Group from 73.64% to 83.64% | 1/1/2019 | 6/30/2019 |

### Evaluation/Analysis of Interventions:

- (Additional analysis can be added here.)
## 2019 Gold Coast Health Plan
### Quality Improvement Work Plan

<table>
<thead>
<tr>
<th>Objective #1: Improve Quality and Safety of Clinical Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective Met:</strong></td>
</tr>
<tr>
<td><strong>Target Completion Date:</strong> Q4 2019</td>
</tr>
<tr>
<td><strong>Required by:</strong> DHCS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP: Annual Monitoring for Patients on Persistent Medications</td>
<td>Perform barrier analysis to determine factors that contributed to the MPM performance in MY2017</td>
<td>QI</td>
<td>Meet or exceed DHCS MPL</td>
<td>8/1/2018</td>
<td>8/31/2019</td>
</tr>
<tr>
<td></td>
<td>Implement and test intervention to improve the MPM rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
## Objective #1: Improve Quality and Safety of Clinical Care Services

**Required by:** DHCS  
**Target Completion Date:** Q4 2019

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP: Asthma Medication Ratio</td>
<td>Perform barrier analysis to determine factors that contributed to the AMR performance in MY2017</td>
<td>QI</td>
<td>Meet or exceed DHCS MPL</td>
<td>8/1/2018</td>
<td>8/31/2019</td>
</tr>
<tr>
<td></td>
<td>Implement and test intervention to improve the AMR rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Evaluation/Analysis of Interventions:
### Objective #1: Improve Quality and Safety of Clinical Care Services

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP: Comprehensive Diabetes Care</td>
<td>Perform barrier analysis to determine factors that contributed to the CDC Nephropathy performance in MY2017</td>
<td>QI</td>
<td>Meet or exceed DHCS MPL</td>
<td>8/1/2018</td>
<td>8/31/2019</td>
</tr>
<tr>
<td>Improve rate of medical attention for nephropathy in diabetic members</td>
<td>Implement and test intervention to improve the CDC Nephropathy rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**

- [ ]
- [ ]
- [ ]
<table>
<thead>
<tr>
<th>Objective Met:</th>
<th>Start Date</th>
<th>End Date</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain Compliance with Facility Site Review (FSR) Requirements</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
<td>100% on time, QI, Complete and document initial, interim, and tri-annual FSR Site Reviews timely, Comply with FSR Site Reviews, Issue and monitor CAPs as needed to facilitate clinic compliance and improvement on identified deficiencies, Submit bi-annual reports to DHCS (7/31/2019 (Jan-June), 12/31/2019 (July-December)), Submit PARS report to DHCS (by 1/31/2019)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal:</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review FSR database regularly to maintain scheduled visits</td>
<td></td>
</tr>
<tr>
<td>Complete and document initial, interim, and tri-annual FSR Site Reviews timely</td>
<td></td>
</tr>
<tr>
<td>Issue and monitor CAPs as needed to facilitate clinic compliance and improvement on identified deficiencies</td>
<td></td>
</tr>
<tr>
<td>Submit bi-annual reports to DHCS (7/31/2019 (Jan-June), 12/31/2019 (July-December))</td>
<td></td>
</tr>
<tr>
<td>Submit PARS report to DHCS (by 1/31/2019)</td>
<td></td>
</tr>
<tr>
<td>Complete and document PARS for identified provider sites</td>
<td></td>
</tr>
</tbody>
</table>

Gold Coast Health Plan
Quality Improvement Work Plan

2019 Gold Coast Health Plan
Objective #3: Improve Member Safety
Required by: DHCS; NCQA MEDI 3
A Public Entity
<table>
<thead>
<tr>
<th>Conduct Facility Site Monitoring to Ensure Safety Practices</th>
<th>Monitor FSR site visit results and deficiencies; track and trend</th>
<th>QI</th>
<th>100% on time</th>
<th>1/1/2019</th>
<th>12/31/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor member complaints/grievances and PQIs involving quality of care/safety concerns</td>
<td>Grievances &amp; Appeals QI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue corrective actions and track improvements as needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective Mkt</td>
<td>Target Completion Date: Q4 2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start Date</td>
<td>1/1/2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End Date</td>
<td>12/31/2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metrics</td>
<td>100% on time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Party</td>
<td>QI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credentialing/Recredentialing</td>
<td>Perform timely verification of all required credentialing elements to ensure current, accurate and complete files for credentialing decisions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities</td>
<td>Perform ongoing monitoring of sanctions and adverse events</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation/Analysis of Interventions</td>
<td>Perform timely recredentialing (within 36 months of last approval date)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 2019 Gold Coast Health Plan
Quality Improvement Work Plan

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

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>
| Achieve reduction in potential unsafe opioid prescriptions including the following:  
• Reduction in number of users above 90 mg/MEDD  
• Reduction in total number of opioids users  
• Reduction in number of users concurrently using with benzodiazepines and prenatal vitamins | 1. Formulary Edits  
• Implementation of soft edits  
• Potential for hard edit development  
2. Provider education  
• Development and release of GCHP opioid use webpage for provider resources | Pharmacy | Reduce 5% from prior year metrics | 1/1/2019 | 12/31/2019 |

**Evaluation/Analysis of Interventions:**
**Objective #2: Improve Quality of Nonclinical Services**

<table>
<thead>
<tr>
<th>Cultural and Linguistic Needs and Preferences</th>
<th>Objective Met:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required by: NCQA NET 1; DHCS</td>
<td>Target Completion Date: Q4 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner Availability - Cultural and Linguistics Needs &amp; Preferences</td>
<td>Evaluate the demographic needs of members and identify opportunities for improvement</td>
<td>Network Operations Health Education</td>
<td>Development and implementation of action plan to improve</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>• Ensure adequate resources to address cultural, ethnic and linguistic needs of our members</td>
<td>Create and implement an action plan to address areas for improvement, as needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
# 2019 Gold Coast Health Plan
Quality Improvement Work Plan

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

**Required by:** NCQA NET 2; DHCS

**Target Completion Date:** Q4 2019

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Access</strong>&lt;br&gt;Members are offered:&lt;br&gt;- Non-urgent primary care within 10 business days of request&lt;br&gt;- Urgent care within 24 hours</td>
<td>Conduct survey and evaluate results</td>
<td>Network Operations</td>
<td>Standards met for minimum of 90% of providers</td>
</tr>
<tr>
<td></td>
<td>Monitor performance and complaints relating to appointments</td>
<td>G&amp;A</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Care Access</strong>&lt;br&gt;Members are offered:&lt;br&gt;- Non-urgent specialty care appointment within 15 business days&lt;br&gt;- Non-urgent ancillary services within 15 business days</td>
<td>Develop and implement corrective action plans when timely access standards not met</td>
<td>Network Operations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Report quarterly performance to QIC</td>
<td>Network Operations</td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>After Hours Availability</td>
<td>Conduct survey and evaluate results</td>
<td>Network Operations</td>
<td>Standards met for minimum of 90% of providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Members are able to reach a provider after hours</td>
<td>Monitor performance and complaints relating to after-hours availability</td>
<td>Grievances &amp; Appeals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop and implement corrective action plans when timely access standards not met</td>
<td>Network Operations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Report quarterly performance to QIC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Evaluation/Analysis of Interventions:
## 2019 Gold Coast Health Plan
### Quality Improvement Work Plan

<table>
<thead>
<tr>
<th>Objective #2: Improve Quality of Nonclinical Services</th>
<th>Objective Met:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required by: NCQA NET 1; DHCS</td>
<td>Target Completion Date: Q4 2019</td>
</tr>
</tbody>
</table>

### Network Adequacy

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess and Improve Network Adequacy as demonstrated by availability of practitioners</td>
<td>Conduct bi-annual ratio analysis and annual Quest Analytics analysis for primary care and high-volume specialties</td>
<td>Network Operations</td>
<td>Ratios: 1 PCP 1:2000 Total Physicians 1: 1200</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify gaps and implement corrective action plan</td>
<td></td>
<td>Physician Supervision to Non-Physician Practitioner Ratio Nurse Practitioners 1:4 Physician Assistants 1:4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitor progress toward action plans to maintain or improve GeoAccess standards</td>
<td></td>
<td>Network maintained PCP located within 30 minutes or 10 miles</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Develop process for network certification (with ratios) for implementation by 3/31/19</td>
<td></td>
<td>Network maintained DHCS core specialists located within 60 minutes or 30 miles</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Report bi-annual ratio analysis and annual GeoAccess findings to QIC</td>
<td></td>
<td>Hospitals 30 minutes or 15 miles</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Evaluation/Analysis of Interventions:

---

111 of 182 pages

Return to Agenda
# 2019 Gold Coast Health Plan
## Quality Improvement Work Plan

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

**Objective Met:**

**Target Completion Date:** Q4 2019

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Satisfaction Survey</td>
<td>Analyze results and identify opportunities for improvement</td>
<td>Network Operations</td>
<td>Development and implementation of action plan to improve</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>Develop and implement interventions as needed to improve rates</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
2019 Gold Coast Health Plan
Quality Improvement Work Plan

**Objective #4: Assess and Improve Member Experience**

**Objective Met:**
Target Completion Date: Q4 2019

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess Member Access and Satisfaction</td>
<td>Identify opportunities for improvement based on data analysis</td>
<td>Network Operations</td>
<td>Development and implementation of action plan to improve</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Assess Member Complaints and Grievances</td>
<td>Conduct annual assessment of complaints and grievances</td>
<td>Grievances and Appeals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify opportunities for improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Create and implement action plan for improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
# 2019 Gold Coast Health Plan
## Quality Improvement Work Plan

<table>
<thead>
<tr>
<th>Objective #4: Assess and Improve Member Experience</th>
<th>Objective Met:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required by: NCQA QI 4; DHCS</td>
<td>Target Completion Date: Q4 2019</td>
</tr>
</tbody>
</table>

### Call Center Monitoring

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Center Monitoring</td>
<td><strong>Call Center Satisfaction</strong></td>
<td>Member Services</td>
<td>ASA: 30 seconds or less</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>• Monitor results/reports of after call survey performed by call center; follow up if issues identified</td>
<td></td>
<td>Abandonment Rate: 5% or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Member Services Telephone Access</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monitor Average Speed of Answer (ASA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monitor Abandonment Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Evaluation/Analysis of Interventions:
## Objective #5: Ensure organizational oversight of delegated activities

**Objective Met:**

**Target Completion Date:** Q4 2019

**Required by:** NCQA CR 8; QI 7; UM 12; RR 5; DHCS

<table>
<thead>
<tr>
<th>Delegation Oversight</th>
<th>Activities</th>
<th>Responsible Party</th>
<th>Metrics</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of Delegation Oversight</td>
<td>1. Complete audits</td>
<td>Compliance</td>
<td>100%</td>
<td>1/1/2019</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Delegated Activities</td>
<td>2. Issue CAPs as applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Follow-up on CAPs as applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Report to Compliance Committee, QIC, and C/PRC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation/Analysis of Interventions:**
AGENDA ITEM NO. 5

TO: Ventura County Medi-Cal Managed Care Commission

From: Nancy Wharfield, MD, Chief Medical Officer

Date: May 20, 2019

Subject HEDIS Gap Closure Services - Vendor Agreement Required

SUMMARY:

GCHP staff seek approval to enter into a contract with a Healthcare Effectiveness Data and Information Set (HEDIS) Gap Closure vendor to improve member health outcomes and HEDIS scores.

BACKGROUND/DISCUSSION:

GCHP staff engaged a HEDIS Year-End Gap Closure vendor during the 4th quarter of Measurement Year (MY) 2018. The vendor engaged members in English and Spanish IVR/Live Agent telephonic outreach and appointment scheduling resulting in nearly 800 appointments to accomplish required preventive care activities.

For the current measurement year, (MY 2019), the Plan will improve on this successful quality strategy by beginning outreach efforts earlier in the MY and including texting as a modality in addition to telephonic outreach. Targeted campaigns may include:

1) Childhood Immunizations (CIS)
2) Adolescent immunizations (IMA)
3) Well Child Visits (ages 3-6) (W34)
4) Children & Adolescents’ Access to Primary Care Practitioners (12 months–19 years) (CAP)
5) Women’s Health [Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), Chlamydia Screening]
6) Comprehensive Diabetes Care (HbA1c, Eye Exam, Micro albumin Test) (CDC)
7) Monitoring for Patients on Persistent Medications (MPM)
8) Asthma Medication Ratio (AMR)
9) Flu shot reminder

On April 18, 2019, the Plan issued Request For Proposal, (“RFP”) #GCHP03262019 to thirteen, (13) vendors requesting a proposal due date of May 9, 2019.
The Plan received seven, (7) responsive proposals and using predetermined weighted evaluation criteria, scored each proposal from the RFP’s qualitative and quantitative requirements. The results are as follows:

<table>
<thead>
<tr>
<th>Qualitative Scores:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor 1</td>
</tr>
<tr>
<td>39.93</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quantitative Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor 1</td>
</tr>
<tr>
<td>13.90</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall Scores (High to Low):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor</td>
</tr>
<tr>
<td>Vendor 1</td>
</tr>
<tr>
<td>Vendor 4</td>
</tr>
<tr>
<td>Vendor 7</td>
</tr>
<tr>
<td>Vendor 2</td>
</tr>
<tr>
<td>Vendor 3</td>
</tr>
<tr>
<td>Vendor 6</td>
</tr>
<tr>
<td>Vendor 5</td>
</tr>
</tbody>
</table>

FISCAL IMPACT:

The projected dollar amount for this two year engagement should not exceed $650,000.00. There is no impact to the current fiscal year. The annual amount is in the approved FY 18/19 budget plan.

RECOMMENDATION:

The Plan recommends the Commission provide its approval of the Plan to enter into a two year agreement with one of the three highest scored vendors for this service, with a not-to-exceed amount of, $650,000.
AGENDA ITEM NO. 6

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Scott Campbell, General Counsel
DATE: May 20, 2019

SUBJECT: Setting Regular Off-Site Meetings to Foster Greater Public Participation

SUMMARY:

At the Commission’s April 22, 2019 regular meeting, the Commission discussed holding regular off-site meetings to bolster public participation and a motion was passed to hold one meeting off-site over calendar year 2019, and two meetings off-site for calendar year 2020. Staff requests the Commission take formal action to approve the off-site location scouted and reserved for 2019, and offer recommendations and take formal action for the two meetings to be held off-site in 2020.

BACKGROUND/DISCUSSION:

At the Commission’s April 22, 2019 regular meeting, a motion was approved by the Commission to hold one of its regular 2019 Commission meetings, and two of its regular 2020 Commission meetings, off-site, in locations within Ventura County at 6:00 pm, to foster greater public participation and community involvement. As moving its regular Commission meetings requires the Commission to revise its existing calendars for calendar years 2019 and 2020, formal action is required. The Commission’s April 22, 2019 approved motion regarding off-site meetings contemplated an off-site regular Commission meeting every six months alternating within the jurisdictional bounds of the five Ventura County Supervisor Districts.

For the scheduled August 26, 2019 regular Commission meeting, staff has reserved the Ventura County Hall of Administration, Lower Plaza conference room, and is requesting formal approval by the Commission. Staff is also seeking the Commission’s suggestions, and possible formal action, for moving the following two scheduled regular Commission meetings in 2020:

- March 23, 2020; and

The Commission is being asked to hold these two meetings within the jurisdictional bounds of Oxnard and Santa Paula, respectively. Doing so would effectuate the Commission’s goal of holding off-site meetings within two additional Ventura County Supervisors’ Districts. For 2021, the Commission will again be asked to approve two off-site regular Commission meetings within the jurisdictional bounds of the two remaining Ventura Districts not covered by the off-
site meetings contemplated by this Staff Report. This process will occur in perpetuity moving forward, with an off-site meeting held every six months.

FISCAL IMPACT:

Gold Coast Health Plan will incur incidental costs associated with moving the regular meeting location. For example, the cost to move the Commission’s scheduled August 26, 2019 regular meeting to the Ventura County Hall of Administration, Lower Plaza conference room, will cost $600.00, and may include other required costs associated with the move.

RECOMMENDATION:

For the Commission to take formal action approving the Ventura County Hall of Administration for the Commission’s scheduled August 26, 2019 regular meeting (to be held at 6:00 pm), and offer suggestions and take formal action approving locations for the Commission’s regular March 23, 2020 and August 24, 2020 meetings (to be held at 6:00 pm), within the jurisdictions of Oxnard and Santa Paula.

ATTACHMENTS:

1. 2019 Commission & Committee Meetings Calendar
2. 2020 Commission & Committee Meetings Calendar
# 2019 (Revised)
Ventura County Medi-Cal Managed Care
Commission & Committee Meetings

<table>
<thead>
<tr>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
</tr>
</thead>
<tbody>
<tr>
<td>S M T W T F S</td>
<td>S M T W T F S</td>
<td>S M T W T F S</td>
<td>S M T W T F S</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>May</td>
<td>June</td>
<td>July</td>
<td>August</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>S M T W T F S</td>
<td>S M T W T F S</td>
<td>S M T W T F S</td>
<td>S M T W T F S</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>September</td>
<td>October</td>
<td>November</td>
<td>December</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>S M T W T F S</td>
<td>S M T W T F S</td>
<td>S M T W T F S</td>
<td>S M T W T F S</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>29</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This meeting will be held at Ventura County Admin. Building/Lower Plaza Assembly Room at 6PM.
<table>
<thead>
<tr>
<th>Month</th>
<th>Su</th>
<th>M</th>
<th>Tu</th>
<th>W</th>
<th>Th</th>
<th>F</th>
<th>Sa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>January</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>February</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>March</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>April</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>May</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>June</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>July</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>August</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>September</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>October</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>November</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>December</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*These meetings will be held at a different location and will begin at 6PM.*
AGENDA ITEM NO. 7

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Scott Campbell, General Counsel
DATE: May 20, 2019
SUBJECT: Appointment of Commissioner to Executive/Finance Committee

SUMMARY:

The Executive/Finance Committee (the "Committee") is an advisory committee to the Commission that consists of five Commission members: the Chairperson, Vice Chairperson, one private hospital/healthcare representative, one Ventura County Medical Health System representative and one Clinicas del Camino Real representative. If the Chairperson or Vice Chairperson on the Committee also represents one of these constituencies, that appointment can be made from the Commission at-large. The Committee assists the Chairperson and the Commission generally in accomplishing its work in the most efficient and timely way possible. While one appointment to the Executive/Finance Committee was made at the Commission’s March 25, 2019 regular meeting, to ensure full membership of the Committee one additional appointment must still be made to the Committee pursuant to the Gold Coast Health Plan bylaws.

BACKGROUND/DISCUSSION:

The Chairperson and Vice Chairperson were elected at the Commission’s March 26, 2018 meeting for a two-year term in accordance with the Commission’s bylaws. The bylaws also establish a five-person Executive/Finance Committee, which must consist of the Chairperson, Vice Chairperson, and three other members. Each of these three members must represent the following constituencies or organizations of the Commission: one private hospital/healthcare representative; one Ventura County Medical Health System representative; and one Clinicas del Camino Real representative. (See bylaws, Art. IV, section (b).)

In 2017, the bylaws were amended so that in the instance where the Chairperson or Vice Chairperson is also a representative of one of these constituencies, then the Commission shall appoint any Commissioner to fill the open position. So for instance, if the Chairperson on the Committee also serves as the Clinicas del Camino Real representative, the Commission will be able to appoint any member to fill the Committee position reserved for Clinicas.

In response to the resignation of two Executive/Finance Committee members, Narcisa Egan and Debra Herwaldt, the Commission filled one vacancy at the March 25, 2019 Commission meeting, but deferred on the final appointment to the Committee until the vacancy on the
Commission was filled. At this time, the Commission seeks to make its final appointment, so the Committee will once again have full membership. The current composition of the Committee, based on the election of the Chairperson and Vice Chairperson, allows the Commission to fill the remaining vacancy on the Committee with any Commission member not currently serving.

The Executive/Finance Committee is an advisory committee to the Commission. It cannot take any action on behalf of the Commission, but it does serve a number of functions. The Committee assists the CEO with planning and presentation of items to the full board, reviewing policies, monitoring the Plan's economic performance and developing the CEO review process and criteria on an annual basis. The Executive/Finance Committee is currently scheduled to meet at 3:00 p.m. on the following dates over the remainder of 2019:

- June 6, 2019
- October 3, 2019

RECOMMENDATION:

Make necessary appointment to the Executive/Finance Committee for full membership.

ATTACHMENTS:

1. Amended and Restated Bylaws for the Operation of the Ventura County Organized Health System
AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF
THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
(dba Gold Coast Health Plan)

Approved: October 24, 2011
Amended: April 25, 2016
# Table of Contents

<table>
<thead>
<tr>
<th>Article</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Name and Mission</td>
<td>3</td>
</tr>
<tr>
<td>II</td>
<td>Commissioners</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Selection and Terms of Commissioners</td>
<td>5</td>
</tr>
<tr>
<td>III</td>
<td>Officers</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Election</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Duties</td>
<td>6</td>
</tr>
<tr>
<td>IV</td>
<td>Standing Committees</td>
<td>6</td>
</tr>
<tr>
<td>V</td>
<td>Special Committees</td>
<td>9</td>
</tr>
<tr>
<td>VI</td>
<td>Meetings</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Conduct of Meetings</td>
<td>10</td>
</tr>
<tr>
<td>VII</td>
<td>Powers and Duties</td>
<td>12</td>
</tr>
<tr>
<td>VIII</td>
<td>STAFF</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Officer</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Clerk</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Assistant Clerk</td>
<td>14</td>
</tr>
<tr>
<td>IX</td>
<td>Rules of Order</td>
<td>14</td>
</tr>
<tr>
<td>X</td>
<td>Amendments</td>
<td>14</td>
</tr>
<tr>
<td>XI</td>
<td>Nondiscrimination Clause</td>
<td>14</td>
</tr>
<tr>
<td>XII</td>
<td>Conflict of Interest and Ethics</td>
<td>14</td>
</tr>
<tr>
<td>XIII</td>
<td>Dissolution</td>
<td>15</td>
</tr>
</tbody>
</table>
AMENDED AND RESTATED BYLAWS FOR THE OPERATION OF THE VENTURA COUNTY ORGANIZED HEALTH SYSTEM  
(dba Gold Coast Health Plan)

ARTICLE I

Name and Mission

The name of this Commission shall be the Ventura County Medi-Cal Managed Care Commission, hereafter referred to in these Bylaws as the VCMMCC. VCMMCC shall operate under the fictitious name, Gold Coast Health Plan.

The VCMMCC shall design and operate a program or programs, whose mission is to improve the health of its members through the provision of the best possible quality care and services. This will be accomplished by:

(a) Delivering medical care via a contracted provider network that will improve access to primary, specialty and ancillary services;

(b) Establishment of mechanisms to assure that medical care services meet appropriate quality of care standards;

(c) Incorporating a plan of service delivery and implementing reimbursement mechanisms which promote the long-term viability of a locally operated Medi-Cal managed care system and the existing participating provider networks inclusive of “Safety Net” providers herein defined as Medi-Cal disproportionate share hospitals, county clinics, federally qualified health centers, and licensed rural health clinics;

(d) Implementing a financial plan which includes the creation of a prudent reserve and which provides that if additional surplus funds accrue, they shall be used to expand access, improve benefits and augment provider reimbursement in Ventura County;

(e) Placing a high priority on prevention, education, early intervention services and case management for enrolled recipients;

(f) Ensuring that all obligations, statutory, contractual or otherwise, shall be the obligations of the VCMMCC and shall not be the obligations of the County of Ventura or the State of California; and

(g) Implementing programs and procedures to ensure a high level of member satisfaction.
ARTICLE II
Commissioners

The governing board of the VCMCC shall consist of eleven (11) voting members ("members" or "Commissioners") who shall be legal residents of Ventura County. Members shall possess the requisite skills and knowledge necessary to design and operate a publicly managed health care delivery system.

Members of the VCMCC shall be appointed by a majority vote of the Board of Supervisors and shall consist of the following:

(a) **Physician Representatives.** Three members shall be practicing physicians who serve a significant number of Medi-Cal beneficiaries in Ventura County. One shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Association, one shall be selected from a list with a minimum of three (3) nominees submitted by Clinicas Del Camino Real and one shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center Executive Committee.

(b) **Private Hospital/Healthcare System Representatives.** Two members shall be representatives of private hospitals and healthcare systems operating within Ventura County and shall be selected from a list with a minimum of three (3) nominees submitted by the Hospital Association of Southern California. Nominees shall be from different hospitals and healthcare systems. The two appointed members shall not be affiliated with the same hospital or healthcare system.

(c) **Ventura County Medical Center Health System Representative.** One member shall be a representative of the Ventura County Medical Center Health System and shall be selected from a list with a minimum of three (3) nominees submitted by the Ventura County Medical Center administration.

(d) **Public Representative.** One member shall be a member of the Board of Supervisors, nominated and selected by the Board of Supervisors.

(e) **Clinicas Del Camino Real Representative.** One member shall be the chief executive officer of Clinicas del Camino Real or designee nominated by the Clinicas del Camino Real chief executive officer and approved by the Ventura County Board of Supervisors.

(f) **County Official.** One member shall be the Ventura County Health Care Agency Director or designee nominated by the Health Care Agency Director and approved by the Board of Supervisors.

(g) **Consumer Representative.** One member shall be a Medi-Cal beneficiary and/or a representative of an advocacy organization that serves the Medi-Cal population and is
not otherwise represented on the Ventura County Medi-Cal Managed Care Commission. This member shall be appointed from applications submitted to the Ventura County Executive Office after a posting of public notice for the open position.

(h) **Ventura County Medical Center Health System Representative.** One member shall be the Ventura County Medical Center Family Medicine Residency Program Director or Faculty Designee and approved by the Board of Supervisors.

**Selection and Terms of Commissioners**

In order to stagger terms with the intent of maintaining experienced members, in the initial cycle of appointments, the following appointees shall serve two-year terms: one of the Ventura County Medical Center Health System Representatives, the Physician Representative nominated by the Ventura County Medical Association, the Public Representative, and one Private Hospital/Healthcare System Representative. All other initial appointments and all subsequent appointments to the VCMMCC shall be for four-year terms. No member may serve more than two consecutive four-year terms. Any vacancy will be filled by the Board of Supervisors for the remainder of the unexpired term and shall maintain the balance of representation on the VCMMCC. The term of each subsequent appointment shall be deemed to commence on March 15 of the year of the appointment.

A member may resign effective on giving written notice to the Clerk of the VCMMCC, unless the notice specifies a later date for his/her resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chairperson and the Board of Supervisors. The Clerk of the VCMMC shall enter the notice in the proceedings of the Commission. The acceptance of a resignation shall not be necessary to make it effective.

A member may be removed from the VCMMCC by a 4/5 vote of the Board of Supervisors.

Nominations to the VCMMCC shall be submitted to the Ventura County Executive Office, which shall be responsible for screening nominees and presenting candidates to the Board of Supervisors.

**ARTICLE III**

**Officers**

(a) **Officers of the VCMMCC shall be a Chairperson and Vice-Chairperson.**

(b) **The Chairperson and the Vice-Chairperson shall be elected by majority vote of the members in attendance at the first meeting of the VCMMCC to serve for the remainder of the calendar year in which the first meeting occurs. Officers subsequently elected to these offices, pursuant to the procedures outlined under "Election" below, shall serve a term of two years or until their successor(s) has/have been duly elected.**
(c) No individual shall serve more than two consecutive terms in any of the elected officer positions.

Election

(a) The VCMCC shall elect officers by majority vote of the members present.

(b) The election of officers shall be held at the first regular meeting of the VCMCC after March 15 (or after the date upon which the Board of Supervisors appoints Commissioners for the present term if later than March 15) in every even-numbered year. The two-year terms of office shall be deemed to commence on March 15 of the year of the election, regardless of when the election actually occurs. The officers of the prior term shall continue to preside over any meetings and perform all other functions of their offices until new officers are elected.

(c) Notwithstanding the normal election process detailed in paragraphs (a) and (b) above, when circumstances warrant it, an election may be held at any time during the year. Circumstances that would warrant a special election include: one or more of the officers wishes to resign as an officer, or one or more of the officers is terminated.

Duties

(a) The Chairperson shall:

1. Preside at all meetings;

2. Execute all documents approved by the VCMCC;

3. Be responsible to see that all actions of the VCMCC are implemented; and

4. Maintain consultation with the Chief Executive Officer (CEO).

(b) The Vice-Chairperson shall:

1. Exercise all the responsibilities of the Chairperson in the absence of the Chairperson; and

2. In agreement with the Chairperson, perform all responsibilities mutually agreed upon.
ARTICLE IV

Standing Committees

(a) At a minimum, the VCMCCC shall establish two (2) committees/advisory boards, one member/consumer based and one provider based. VCMCCC staff will be responsible to gather a list of potential appointments and make recommendations to the VCMCCC for membership on these boards. Each of the boards shall submit a charter to the VCMCCC for approval. All meetings of standing committees shall be subject to the provisions of the Brown Act.

(b) Executive/Finance Committee.

i. **Purpose.** The role of the Executive/Finance Committee shall be to assist the CEO and VCMCCC accomplish its work in the most efficient and timely way. Meetings of this committee shall be at the request of the Chairperson or CEO to evaluate time sensitive matters. The Committee shall report on all of its activities to the governing board at the next regular meeting of the governing board.

ii. **Membership.** The Executive/Finance Committee shall be comprised of the following five (5) Commissioners:

1. Chairperson.

2. Vice-Chairperson.

3. Private hospital/healthcare system representative (to rotate between the two representatives following the representative’s resignation from the committee). If the Chairperson and/or Vice-Chairperson is a private hospital/healthcare system representative, then the Commission may appoint any one of its members to fill this position.

4. Ventura County Medical Center Health System representative. If the Chairperson and/or Vice-Chairperson is a Ventura County Medical Center Health System representative, then the Commission may appoint any one of its members to fill this position.

5. Clinicas Del Camino Real representative. If the Chairperson and/or Vice-Chairperson is a Clinicas Del Camino Real representative, then the Commission may appoint any one of its members to fill this position.

The CEO and Finance Director will serve as Ex-Officio members to Co-Chair the committee.
If the private hospital/healthcare system representative, the Ventura County Medical Center Health System representative and/or the Clinicas Del Camino Real representative are also the Chairperson and/or Vice-Chairperson of the governing board, then, the other Commissioner who is a representative of the same constituency or organization as the Commissioner serving as Chairperson or Vice-Chairperson shall be appointed to the Executive/Finance Committee to fill that reserved seat. For example, if the Ventura County Medical Center Health System representative and the Clinicas Del Camino Real representative are also the Chairperson and Vice-Chairperson, respectively, of the governing board, then, the other Ventura County Medical Center Health System representative and the physician representative nominated by Clinicas Del Camino Real shall be appointed to fill the respective designated seat on the Executive/Finance Committee.

Appointments to the Committee shall be made at either the regular meeting in which the Chairperson and Vice-Chairperson are elected or at the next regular meeting immediately thereafter. Appointments may also be made at any regular meeting where the appointment is necessitated by a resignation, termination, vacancy, special election of officers, or other event which results in the Committee lacking full membership.

iii. Duties of the Executive/Finance Committee.

1. Advise the governing board Chairperson on requested matters.

2. Assist the CEO in the planning or presentation of items for governing board consideration.

3. Assist the CEO or VCMCC staff in the initial review of draft policy statements requiring governing board approval.

4. Assist the CEO in the ongoing monitoring of economic performance by focusing on budgets for pre-operational and operational periods.

5. Review proposed State contracts and rates, once actuary has reviewed and made recommendations.

6. Review proposed contracts for services over the assigned dollar value/limit of the CEO.

7. Establish basic tenets for payment-provider class and levels as related to Medi-Cal rates:
   - PCP
   - Specialists
   - Hospitals / LTC
   - Ancillary Providers
8. Recommend auto-assignment policies for beneficiaries who do not select a Primary Care Provider.

9. Review and recommend provider incentive program structure.

10. Review investment strategy and make recommendations.

11. On an annual basis, develop the CEO review process and criteria.

12. Serve as Interview Committee for CEO/CMO/CFO.

13. Assist the governing board and/or the CEO in determining the appropriate committee, if any, to best deal with questions or issues that may arise from time-to-time.

14. Develop long-term and short-term business plans for review and approval by the governing board.

15. Undertake such other activities as may be delegated from time-to-time by the governing board.

iv. **Limitations on Authority.** The Executive/Finance Committee shall not have the power or authority in reference to any of the following matters:

1. Adopting, amending or repealing any bylaw.

2. Making final determinations of policy.

3. Approving changes to the budget or making major structural or contractual decisions (such as adding or eliminating programs).

4. Filling vacancies or removing any Commissioner.

5. Changing the membership of, or filling vacancies in, the Executive/Finance Committee.

6. Hiring or firing of senior executives, but may make recommendations to the governing board as to their appointment, dismissal or ongoing performance.

7. Taking any action on behalf of the governing board unless expressly authorized by the governing board.

**ARTICLE V**

**Special Committees**
Members may be asked to participate on a subcommittee, task force or special project as part of their responsibilities. The VCMMCC may establish a committee(s) or advisory board(s) for any purpose that will be beneficial in accomplishing the work of the VCMMCC.

ARTICLE VI
Meetings

(a) All meetings shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code relating to meetings of local agencies ("Brown Act").

(b) A regular meeting shall be held monthly. The VCMMCC shall by resolution establish the date, time and location for the monthly meeting. A regular meeting may, for cause, be rescheduled by the Chairperson with 72 hour advance notice.

(c) Closed session items shall be noticed in compliance with Government Code section 54954.5.

(d) Special meetings may be called, consistent with the Brown Act, by the Chairperson or by a quorum of the VCMMCC. Notice of such special meeting shall conform to the Brown Act.

(e) Any meeting at which at least a quorum cannot attend, or for which there is no agenda item requiring action may be cancelled by the Chairperson with 72 hour advance notice.

(f) A quorum shall be defined as one person more than half of the appointed members of the VCMMCC. For these purposes, "appointed members" excludes unfilled positions and those vacated by resignation or removal. Unless otherwise expressly stated in these bylaws, a majority vote of members present and constituting a quorum shall be required for any VCMMCC action.

(g) After three (3) absences of any member during a fiscal year, the reasons for the absences will be reviewed by the VCMMCC and it may notify the Board of Supervisors of the absences, if it deems this action appropriate. Three or more absences from regular meetings may be cause for the VCMMCC to recommend dismissal of that member to the Board of Supervisors.

Conduct of Meetings

(a) The Chairperson shall adhere to the order of items as posted on the agenda. Modifications to the order of the agenda may be made to the extent that (on the advice of the Executive Director).
of counsel) the rearrangement of the agenda items does not violate the spirit or intent of the Brown Act.

(b) All motions or amendments to motions require a second in order to be considered for action. Upon a motion and a second the item shall be open for discussion before the call for the vote.

(c) Voice votes will be made on all items as read. An abstention will not be recognized except for a legal conflict of interest. In furtherance of the foregoing, an abstention or refusal to vote (not arising from a legal conflict of interest) shall be deemed a vote with the majority of those Commissioners who do vote, except when there is a tie vote and the motion or action fails. For example, if there are 7 Commissioners present at a meeting (none of whom are subject to a legal conflict of interest), (i) a motion passes with 3 votes in favor and 4 Commissioners abstaining, (ii) a motion passes with 3 votes in favor, 2 votes against and 2 Commissioners abstaining; and (iii) a motion fails with 3 votes in favor, 3 votes against and 1 Commissioner abstaining.

(d) A call for a point of order shall have precedence over all other motions on the floor.

(e) Without objection, the Chairperson may continue or withdraw any item. In the event of an objection, a motion to continue or reset an item must be passed by a majority of the members present. A motion to continue or reset an item shall take precedence over all other motions except for a point of order.

(f) An amendment to a motion must be germane to the subject of the motion, but it may not intend an action contrary to the motion. There may be an amendment to the motion and an amendment to an amendment, but no further amendments. In the event the maker of the original motion accepts the amendment(s), the original motion shall be deemed modified. In the event the maker of the original motion does not accept the amendment(s), the amendment(s) shall be voted separately and in reverse order of proposal.

(g) Where these Bylaws do not afford an adequate procedure in the conduct of a meeting, the Chairperson may defer to the most current edition of Robert's Rules of Order or Rosenberg's Rules of Order, to resolve parliamentary questions.

(h) The Chairperson shall be permitted to make motions and vote on all matters to the same extent and subject to the same limitations as other Commissioners.

ARTICLE VII

Powers and Duties

The VCMMCC is responsible for all of the activities described in Article I of these Bylaws and in its enabling ordinance. In furtherance of such responsibility, the VCMMCC shall have the following powers and duties and shall:
(a) Advise the Chief Executive Officer (CEO) and request from the CEO information it deems necessary;

(b) Conduct meetings and keep the minutes of the VCMC;

(c) Provide for financial oversight through various actions and methodologies such as the preparation and submission of an annual statement of financial affairs and an estimate of the amount of funding required for expenditures, approval of an annual budget, receipt of monthly financial briefings and other appropriate action in support of its financial oversight role;

(d) Evaluate business performance and opportunity, and review and recommend strategic plans and business strategies;

(e) Establish, support and oversee the quality, service utilization, risk management and fraud and abuse programs;

(f) Encourage VCMC members to actively participate in VCMC committees as well as subcommittees;

(g) Comply with and implement all applicable federal, state and local laws, rules and regulations as they become effective;

(h) Provide for the resolution of or resolve conflict among its leaders and those under its leadership;

(i) Respect confidentiality, privacy and avoid any real or potential conflict of interest; and

(j) Receive and take appropriate action, if warranted, based upon reports presented by the CEO (or designated individual). Such reports shall be prepared and submitted to the VCMC at least annually.

ARTICLE VIII

STAFF

The VCMC shall employ personnel and contract for services as necessary to perform its functions. The permanent staff employed by the VCMC shall include, but not be limited to, a Chief Executive Officer (CEO), Clerk and Assistant Clerk.

Chief Executive Officer

The CEO shall have the responsibility for day to day operations, consistent with the authority conferred by the VCMC. The CEO is responsible for coordinating all activities of the County Organized Health System.
The CEO shall:

(a) Direct the planning, organization, and operation of all services and facilities;

(b) Direct studies of organizations, operations, functions and activities relating
to economy, efficiency and improvement of services;

(c) Direct activities which fulfill all duties mandated by federal or state law, regulatory or
accreditation authority, or VCMMCC board resolution, and shall bring any conflict
between these laws, regulations, resolutions or policy to the attention of the VCMMCC;

(c) Appoint and supervise an executive management staff, and such other individuals
as are necessary for operations. The CEO may delegate certain duties and
responsibilities to these and other individuals where such delegated duties are in
furtherance of the goals and objectives of the VCMMCC;

(d) Retain and appoint necessary personnel, consistent with all policies and procedures,
in furtherance of the VCMMCC's powers and duties; and

(f) Implement and enforce all policies and procedures, and assure compliance with all
applicable federal and state laws, rules and regulations.

Clerk

The Clerk shall:

(a) Perform the usual duties pertaining to secretaries;

(b) Cause to be kept, a full and true record of all VCMMCC meetings and of such
special meetings as may be scheduled;

(c) Cause to be issued notices of regular and special meetings;

(d) Maintain a record of attendance of members and promptly report to the VCMMCC
any member whose position has been vacated; and

(e) Attest to the Chair or Vice-Chair's signature on documents approved by the
VCMMCC.

Assistant Clerk

The Assistant Clerk shall perform the duties of the Clerk in the Clerk's absence.

ARTICLE IX

Rules of Order
The Chairperson shall be responsible for maintaining decorum during VCMMCC meetings. All motions, comments, and questions shall be made through the Chairperson. Any decision by the Chairperson shall be considered final unless an appeal of the decision is requested and passed by a majority of the VCMMCC members present.

ARTICLE X

Amendments

(a) These Bylaws may be amended by an affirmative vote of a majority of the voting members of the VCMMCC. A full statement of a proposed amendment shall be submitted to the VCMMCC at least two weeks prior to the meeting at which the proposed amendment is scheduled to be voted upon.

(b) The Bylaws shall be reviewed annually and amendments to the Bylaws may be proposed by any VCMMCC member.

(c) Bylaws may be suspended on an ad hoc basis upon the affirmative vote of a majority of the VCMMCC members present.

ARTICLE XI

Nondiscrimination Clause

The VCMMCC or any person subject to its authority shall not discriminate against or in favor of any person because of race, gender, religion, color, national origin, age, sexual orientation or disability with regard to job application procedures, hiring, advancement, discharge, compensation, training or other terms or condition of employment of any person employed by or doing business with the VCMMCC or any person subject to its direction pursuant to federal, state or local law.

ARTICLE XII

Conflict of Interest and Ethics

VCMMCC members are subject to conflict of interest laws, including Government Code section 1090 and the 1974 Political Reform Act (Government Code section 8100 et seq.), as modified by Welfare and Institutions Code section 14087.57, and must identify and disclose any conflicts and refrain from participating in any manner in such matters in accordance with the applicable statutes. Members of the VCMMCC agree to adhere to all relevant standards established by state or federal law regarding ethical behavior.

ARTICLE XIII

Dissolution
Pursuant to California Welfare & Institutions Code, section 14087.54:

(a) In the event the Commissioners determine that VCMMCC may no longer function for the purposes for which it was established, at the time that VCMMCC’s then existing obligations have been satisfied or VCMMCC’s assets have been exhausted, the Board of Supervisors may by ordinance terminate the VCMMCC.

(b) Prior to the termination of the VCMMCC, the Board of Supervisors shall notify the State Department of Health Care Services ("DHCS") of its intent to terminate VCMMCC. The DHCS shall conduct an audit of VCMMCC’s records within 30 days of the notification to determine the liabilities and assets of VCMMCC. The DHCS shall report its findings to the Board of Supervisors within 10 days of completion of the audit. The Board of Supervisors shall prepare a plan to liquidate or otherwise dispose of the assets of VCMMCC and to pay the liabilities of VCMMCC to the extent of VCMMCC’s assets, and present the plan to the DHCS within 30 days upon receipt of these findings.

(c) Upon termination of the VCMMCC by the Board of Supervisors, the County of Ventura shall manage any remaining assets of VCMMCC until superseded by a DHCS-approved plan. Any liabilities of VCMMCC shall not become obligations of the County of Ventura upon either the termination of the VCMMCC or the liquidation or disposition of VCMMCC’s remaining assets.

(d) Any assets of VCMMCC shall be disposed of pursuant to provisions contained in the contract entered into between the state and VCMMCC.
AGENDA ITEM NO. 8

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Dale Villani, Chief Executive Officer
DATE: May 20, 2019
SUBJECT: Recommendation for Enterprise Transformation Project (ETP) Senior Executive Program Management Services

SUMMARY:

The Plan requires a third party vendor to provide dedicated executive level program management services on the ASO Core Replacement Project, now referred to as the Enterprise Transformation Project ("ETP"). Previously, GCHP managed this project using existing staff who are also responsible for managing the Plan's day-to-day business. Given the critical importance of this initiative, the Plan requires a dedicated and experienced senior level executive resource to oversee all aspects of this project.

BACKGROUND/DISCUSSION:

The commission approved the funding associated with the Enterprise Transformation Project ("ETP") at the April 23, 2018 commission meeting. The approved funding of $5.5MM includes estimated costs for specialized external vendors to supplement GCHP’s ETP project related tasks and activities. In December 2018, the Plan contracted with DR Management Services (DRMS) for immediate executive level dedicated support of the ETP project. After discussion on the extension of the DRMS contract for the remainder of the project at the February 25, 2019 commission meeting, the commission directed staff to post and recruit for a full-time position as well as issue a Request For Proposal (RFP) for these services.

The Plan has completed both requests and a summary is below:

Recruitment:

A position description was completed for a Senior Executive Business Transformation position. The position was posted on the company website on February 11th, in addition to external websites, Monster, Indeed, and HealthFacts. Nine resumes were received with varying experience. Only one applicant (from North Carolina) had the requisite skills identified to fill the role. A phone screening interview was completed, and the candidate informed us she did not want a position as an employee; she wanted a consulting role.
RFP:

On February 26, 2019, staff issued the RFP to ten interested vendors. The Plan received eight responsive proposals. An internal evaluation team was identified, made up of the COO, Executive Director of Health Services, Executive Director of HR, and Director of IT. Using predetermined evaluation criteria and weights, the team scored each proposal on the RFP qualitative and quantitative requirements.

The scoring results from the evaluation team are as follows:

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluid Edge</td>
<td>58.86</td>
</tr>
<tr>
<td>Change Healthcare</td>
<td>58.41</td>
</tr>
<tr>
<td>DR Management</td>
<td>58.39</td>
</tr>
</tbody>
</table>

RECOMMENDATION:

Based on relative equivalence of the top three overall scores, the Evaluation Team recommends awarding this initiative and contracting to DR Management Services. This will allow the Plan to maintain continuity of the current work effort, eliminate switching/transition costs and the need for critical knowledge transfer. The CEO concurs. Therefore, staff recommends the Commission to authorize the CEO to award and execute a contract with DR Management Services for ETP senior executive program management services.

If the Commission desires to review this contract, it is available at Gold Coast Health Plan’s Finance Department.

FISCAL IMPACT: None. The commission approved budget for the ETP project was $5.5MM. Staff have identified areas in the approved budget to offset the cost of this contract. The total price of the contract award to DR Management is $646,750.
AGENDA ITEM 9

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Kashina Bishop, Chief Financial Officer

DATE: May 20, 2019

SUBJECT: Secure Additional Medi-Cal Funds through an Intergovernmental Transfer (IGT)

SUMMARY:

Authorize and direct the Chief Executive Officer’s submission of a proposal to the California Department of Health Care Services (DHCS) to begin the process to secure additional Medi-Cal Funds through an Intergovernmental Transfer (IGT) for FY 18-19. The proposal includes a voluntary letter of interest and additional documentation from the funding entity (i.e., Ventura County Medical Center (VCMC) or other appropriate County agency).

Authorize and direct the Chief Executive Officer to execute the Health Plan Provider Agreement between Gold Coast Health Plan and the County of Ventura to secure additional FY2017-18 and FY 2018-19 IGT funding.

BACKGROUND:

Intergovernmental Transfers (IGTs) are a mechanism for Medi-Cal managed care plans, counties and certain types of public hospitals to work with the State of California to bring federal Medicaid matching dollars to the local level.

To accomplish an IGT, a “funding entity” (County of Ventura in this case) provides funds to the State Department of Health Care Services (DHCS). A funding entity can be counties, cities and State University teaching hospitals, or any other political subdivision of the State, as long as they meet the requirements as defined by 42 C.F.R. Section 433, Subpart B for the funding of IGTs. The federal government then matches those funds according to a set formula. The State uses these combined funds to increase the rates it pays to the local Medi-Cal managed care plan consistent with the Plan’s actuarially determined payment rates. The funding entity recoups the original outlay of funds and the federal match to those funds.

DISCUSSION:

The proposed IGT is expected to be structured similar to prior years’ IGTs which require that the ultimate payments be tied to covered Medi-Cal services for enrolled beneficiaries. An initial transfer of funds from the funding entity to DHCS will be required. The DHCS would then use a portion of these funds to leverage a federal match at the Federal Medical Assistance
Percentages (FMAP) rate in effect during Fiscal Year 2018-19. A portion of the funds (20%) would be paid to DHCS as an assessment fee. Subsequently, Gold Coast Health Plan (GCHP or Plan) would receive an increased capitation via a rate amendment to the Primary Agreement between GCHP and DHCS. The Plan would return the funds received via the increased capitation rate to the County of Ventura, after withholding a 2% administrative fee.

**FISCAL IMPACT:**

The impact to the Plan's FY2017-18 revenue due to the IGT administrative fee is $686,625 and estimated to be approximately $705,000 for FY 2018-19.

**RECOMMENDATION:**

1. Authorize and direct the Chief Executive Officer to provide DHCS with a proposal (including information from the funding entity) to the State of California.

2. Authorize and direct the Chief Executive Officer to execute the Health Plan Provider Agreement between Gold Coast Health Plan and the County of Ventura to secure additional FY2017-18 and FY 2018-19 IGT funding.
AGENDA ITEM NO. 10

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Kashina Bishop, Chief Financial Officer
DATE: May 20, 2019
SUBJECT: Signature Authority Policy Revisions

BACKGROUND AND SUMMARY:

The Plan established a Signature Authority Policy in October, 2016. This newly created policy clarified the internal authorization amounts and specifically the authorization level of the Plans CEO. The current policy states that the CEO has internal signature authority of up to one hundred thousand dollars, ($100,000) which is calculated as an original transaction amount, plus any applicable change order, (the cumulative amount).

Since the inception of this policy, the Plan has presented several contract renewal recommendations exceeding $100,000 to the Commission for signature approval. In this year’s budget cycle, the Plan proactively identified contract expirations requiring individual Commission approval of their projected contract renewal cumulative expenditure amount.

The Plan also recently implemented an automated method of tracking expenditures associated with an approved project.

The revisions in the Signature Authority Policy represent an improved method of reviewing and approving these initiatives and their associated costs as an itemized and detailed attachment to the Plans budget. Upon Commission approval of the Plans budget, these specific initiatives will also be approved up to their amounts listed, verses on an individual transaction basis.

FISCAL IMPACT:

There is no impact to the current fiscal year or any associated future year. These multiyear contract renewals and enterprise level projects will be an approved budget item in each of the applicable fiscal year budget.

RECOMMENDATION:

The Plan recommends the Commission approve the revisions associated with this new Signature Authority Policy.
1.0 Background:

Good internal controls require proper authorization of disbursement transactions to ensure that funds are expended in conformity with management’s intentions.

Gold Coast Health Plan ("GCHP") grants specific levels of signature authority to certain employees to authorize and approve the commitment or expenditure of GCHP funds ("GCHP Commitments"). This policy is intended to ensure that any GCHP Commitment is properly authorized prior to being made.

2.0 Definitions:

"Signature" means written in the hand of the authorizing individual or an approved electronic signature format within GCHP’s documents. Signature stamps are not accepted.

3.0 Purpose:

The purpose of this policy is to establish consistent company-wide control over accounts payable disbursements, wire transfers, purchases and contractual commitments made on the behalf of GCHP that are generally non-claim related. It is essential that potential transactions have all required approvals prior to GCHP making a commitment with the associated vendor or other outside party.

This policy attempts to balance the need for corporate approval of transactions that could potentially have a material effect on GCHP as a whole against the need for departments to conduct their operations efficiently.

4.0 Scope:

This policy is made on behalf of GCHP, applies to new transactions that will ultimately result in the use of GCHP assets. These transactions include, but are not limited to, purchase requisitions, check requests, purchase orders, contracts, leases, and capital expenditures – regardless if such transactions were budgeted or unbudgeted. Exceptions include claims payments that are NOT processed and paid through GCHP accounts payable system; provider contracts and capitation contracts which are the responsibility of the associated Chief Officer to the extent they are routine and within budgetary expectations; -and-payments of pass-through items designated by DHCS as available for disbursement to providers through various government programs.-Invoice transactions that have been previously authorized by a contract summary and approval form and/or a requisition/PO do not require Signature approval.

All transactions are required to have the proper level of authorization prior to GCHP making a commitment with a vendor or other outside party. The proper level of authorization for transactions is defined as, "The signature of at least one employee with authorization for the related cost center and an authorization limit greater than or equal to the total amount of the transaction." Reference to paragraph 6.1 for authorized spending limits. The approver or his/her designee is responsible for ensuring that the transaction represents a proper use of GCHP funds.
<table>
<thead>
<tr>
<th>Title: Signature Authority Policy</th>
<th>Policy Number: FI-XXX005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department: Finance</td>
<td>Effective Date: 10/24/16</td>
</tr>
<tr>
<td>CEO Approved:</td>
<td>Revised: <strong>May 20, 2019</strong></td>
</tr>
</tbody>
</table>
5.0 Policy Statement:
GCHP's Finance Department is responsible for administering this policy. **It is the responsibility of the requesting employee or business unit to obtain all necessary approvals prior to submitting the purchase requisition, check the issuance of a request, purchase order, signing of a contract, leases, capital expenditures, entering a lease agreement, etc., to Procurement or Finance Department. No funds should be disbursed or purchase orders should be issued or contractual documents signed or funds disbursed, until the required approvals have been obtained. Any revisions to this policy must be approved by the Ventura County Medi-Cal Managed Care Commission.**

6.0 Authorization Limits:
The appropriate approval level is determined by the amount of the total transaction, regardless of whether the transaction is submitted using one purchase requisition/check request/purchase order/contract summary and approval form or multiple smaller transactions. The following approval rules apply to all change orders to amend an existing open-purchase order:

- Purchase orders may be increased up to the lesser of five percent (5%) of the total original purchase order amount or $500 without additional approvals. For example, if the total of the original purchase order total price is $45,000, the maximum amount that can be increased without additional approvals is $45,500.

- Changes required above the 5% or $500 threshold require approval for the total amount of the transaction, including the change order. In the above example, if the change order amount were $501, then the approval amount would be for $45,501.

In situations where the appropriate level of management is not available for approval, the next higher level of management within the operating unit will apply. For control purposes, e-mails should only be used in place of actual electronic signatures in Multiview for urgent purchase order changes, allowing GCHP to amend the same purchase order number. Where the original document bears the original signatures, faxed/scanned copies are acceptable on an exception basis for urgent payment requests. The original document should be forwarded to the Procurement or Accounts Payable, ("AVP") department and marked for "file only, previously faxed/scanned on mm/dd/yy".
6.1 General Authorization:

Employees are identified with authorization limits up to a specified amount based on their job title within GCHP (e.g., manager, director, chief, Ventura County Medi-Cal Managed Care Commission). General disbursement authorization limits are designated in Table 1 below.

<table>
<thead>
<tr>
<th>Job Level</th>
<th>Authorization Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventura County Medi-Cal Managed Care Commission*</td>
<td>Over $100,000</td>
</tr>
<tr>
<td>Chief Executive Officer</td>
<td>Up to $100,000</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>All transactions over $50,000 and under $100,000</td>
</tr>
<tr>
<td>Department Chief</td>
<td>All transactions over $25,000 and up to $50,000</td>
</tr>
<tr>
<td>Department Director</td>
<td>Up to $25,000</td>
</tr>
<tr>
<td>Department Manager</td>
<td>Up to $5,000</td>
</tr>
<tr>
<td>Procurement Cardholders</td>
<td>Up to $1,000</td>
</tr>
</tbody>
</table>

The applicable General Authorization, as set forth in the following table, is based on the GCHP job level. **General Authorization is granted only to Procurement, Cardholders or Manager and above job levels.**
*Note The Ventura County Medi-Cal Managed Care Commission may delegate approval to the Chief Executive Officer. All transactions associated with the projects and contract renewals listed in GCHP’s approved budget are hereby delegated to the Chief Executive Officer and do not require individual transactional approval from Ventura County Medi-Cal Managed Care Commission.*

7.0 Delegation of Authority:

Authority to approve check requests or requisitions/purchase orders under this Signature Authority Policy may be temporarily delegated to another employee during periods of planned absences. Delegation must be to a direct report at a Manager or above job level. Delegation of authority is requests are initiated in Multiview, (GCHP’s purchasing system) or by using the attached Delegation of Authority form. This form is also located in the Finance Department section on SharePoint.

Individuals below Director job level cannot temporarily delegate authority. Notwithstanding delegation, the responsibility for all actions remains with the originally authorized associate. At the time of signing any authorization to expend GCHP’s funds, the employee to whom authority has been delegated must indicate on whose behalf the associate is exercising authority; i.e., "Joe Smith for Jane Doe."
8.0 Contracts and Authorized Agents:
The Chief Executive Officer (CEO), is GCHP’s authorized agent to sign all non-claims related contracts. Properly authorized requisitions/purchase orders from originating departments, serve as the internal authorization for the CEO to make external funding commitments with vendors of administrative goods and services. The CEO may only temporarily delegate his/her authority to a Chief or the Procurement Officer during periods of planned absences.

9.0 Legal Review of Contracts:
Where practical, all contractual negotiations should be initiated from legally pre-approved standard agreements. Circumstances may arise where standard contract templates are not applicable. In these situations, a standard contract template may be modified or a different contract format may be used. In every situation, if there are changes to a legally pre-approved contract, the Legal Department must review and approved of such changes. If the contract is a statement of work/service order/schedule against a pre-approved master agreement and the terms and conditions contained in the statement of work/service order/schedule do not conflict with the master agreement terms and conditions the Legal Department does not need to review the statement of work/service order/schedule/statement of work.
Exhibit A

DELEGATION OF AUTHORITY LETTER

By means of this letter, I, [name and title], hereby temporarily delegate my signature authority as described in the Signature Authority Policy to [position title and name], on the following terms and conditions:

1. In accordance with the Signature Authority Policy, [name and title] may review and sign, on my behalf, check requests, requisitions/purchase orders in an amount and duration not to exceed [insert dollar limit] from [starting date] until [end date].

2. The authority delegated in this document cannot be sub-delegated.

I hereby acknowledge and agree that the responsibility for all actions remains with the delegating party.

[signature]  
________________________  Date:

[Name ]
Title [delegating official]

Acknowledged and agreed:

[signature]  
________________________  Date:

Name
Title [delegate]

Approved:

[signature]  
________________________  Date:

[Title] **

** The signed form must be sent to A/P.
AGENDA ITEM NO. 11

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Kashina Bishop, Chief Financial Officer
DATE: May 20, 2019
SUBJECT: March 2019 Fiscal Year to Date Financials

SUMMARY:

Staff is presenting the attached March 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 March 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 $13.6 million for the month of March.
- For the fiscal year ended March 31, 2019, the Plan's performance is a decrease in net assets of $30.9 million, which is an unfavorable budget variance of $21.7 million.
- March FYTD net revenue was $540.2 million, $12.8 million higher than budget.
- Cost of health care was $539.1 million, $42.5 million higher than budget.
- The medical loss ratio was 99.8% of revenue, which is 5.6% higher than the budget.
- The administrative cost ratio was 6.5%, 1.2% lower than budget.
- March membership of 197,064 which is 3,104 below the budgeted average.
- Tangible Net Equity was $101,214 million which represents less than two months of operating expenses in reserve and 303% of the required amount by the State.

Revenue

Base revenue is in line with budget expectations. The budget variance is being driven by Proposition 56 funding which 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 $9.7 million is the associated expense for the additional Proposition 56 payments to providers.

There was decrease in net revenue for the month of March of $2.7 million due to a new requirement from DHCS which put a minimum expenditure requirement of 95% on Proposition 56 funding. GCHP had to record a $2.7 million liability of the difference between 95% of the Proposition 56 revenue and amounts paid to providers for rendering the qualifying services.

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
March FYTD health care costs were $539.1 million, which was $42.5 million higher than budget. The medical loss ratio (MLR) was 99.8% versus 94.2% 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. One significant change impacting health care costs in the month of March is an updated Incurred But Not Paid (IBNP) model. GCHP engaged a consultant to develop a new IBNP model which plans use to estimate medical expenses for services that have occurred but the plan has not paid the claim. The updated model indicated that the estimated liability for medical expenses is approximately $5 million higher than the previous model.
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 $13.6 million (14.2%).**
The inpatient costs for the month of March increased significantly from prior months due to a number of high dollar cases (over $100K) paid in both February and March, with one claim over $600K that was paid for dates of service in March 2017. There have been a number high dollar cases – most related to cancer, transplants and heart surgery. The expense is offset by reinsurance claims; the reinsurance line item is a positive budget variance of $4.5 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 $5.1 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 $1.6 million (12.9%).**
  The increase is in part is related to hospice services that have steadily increased as a result of the Palliative Care benefit mandated by DHCS effective January 2018.

- **Applied Behavior Analysis and Mental Health were $2.4 million (43.7%) and $2.0 million (41.0%) over budget, respectively.**
  There has been a steady increase in utilization which seems to be stabilizing.

- **Pharmacy exceeded budget by $3.2 million (3.3%).**
  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.

- **Provider reserve in the amount of $1.8 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 March, administrative costs were $35.0 million and $5.6 million below budget. As a percentage of revenue, the administrative cost ratio (or ACR) was 6.5% versus 7.7% for budget.

**Cash and Short Term Investment Portfolio** – At March 31st, the Plan had $232.9 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 March 31st, the Plan had $85.0 million in Medi-Cal Receivables due from the DHCS.

**RECOMMENDATION:**

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

**ATTACHMENT:**

March 2019 Financial Package
AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Nancy Wharfield, MD, Chief Medical Officer
DATE: May 20, 2019
SUBJECT: Chief Medical Officer Update

Ventura County Community Health Needs Assessment (VC CHNA)

The VC CHNA collaborative was created to comply with Affordable Care Act/IRS tax-exempt requirements and Public Health Accreditation Board (PHAB) standards. Charitable hospitals must conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. The CHNA must take into account input from persons who represent the broad interests of the knowledge of or expertise in public health. The CHNA must also be made widely available to the public.

Under the direction of the Ventura County Public Health Department (VCPH), the mission of the VC CHNA is to build partnerships between VCPH, area hospitals, health providers, and health systems including Gold Coast Health Plan, to improve population health outcomes in Ventura County. The first collaborative assessment will be published in June 2019 and will result in a cooperative approach to addressing population health and benefit the communities we serve.

On April 29, 2019, the VC CHNA met to review feasibility study results, which included analysis of over 20,000 surveys and identified disparities in Ventura County. Gold Coast Health Plan (GCHP) staff are actively participating in these efforts which will result in a fully integrated Community Health Improvement/Implementation Plan (CHIP) that aligns with identified health priorities and focuses on achieving health equity. The collaborative has provided an effective platform for GCHP to advocate for member needs, identify shared goals, and support the work of our community partners.

Additionally, the Communities Lifting Communities (CLC) project, a subcommittee of the CHNA collaborative, was created to address the needs of our prediabetic population in Ventura County. GCHP continues to actively partner in this effort as we develop strategies to address food insecurity and identify social determinants of health affecting population.

Medi-Cal Managed Care Plans like GCHP are also required to conduct a needs assessment for their members. The GCHP Health Education and Cultural and Linguistic Group Needs Assessment (GNA) is directed by the Department of Health Care Services (DHCS) All Plan Letter (APL) 10-012 to explore the cultural, linguistic and health education needs of our membership. The GCHP GNA identifies health disparities, barriers to care, and gaps in
AGENDA ITEM NO. 13

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

Community Relations

- Attended meeting with Girl Scouts of America to assist with their diversity training as needed.
- Met with Gold Coast Veteran’s Board to advise on specifics around homeless veterans entering the Veteran’s Court system, and strategize on getting more help from elected officials related to housing and employment for the veteran population.
- Still Working with Dr. Irene Pinkard of The Pinkard Institute, in putting together a directory of diverse resources in Oxnard, Camarillo, Westlake, Thousand Oaks and Simi Valley. Project should be complete by mid-year.
- Had a call with NAVEX (Data compliance resource) to continually understand how their “Hot Line” reporting works and to ensure all diversity related reports are sent directly to me.

Gold Coast Health Plan

- Held Diversity meeting at GCHP, with a focus on identifying major diversity Lunch and Learn topics. A diversity quiz was distributed to employees for the purpose of identifying community events that should be recognized. Response data will be compiled and shared with the executive team.
- Five (5) coaching sessions not related to Diversity - mostly career development.
- **No Diversity investigations during the month.**
- **No “Hotline” calls during the month.**
- There was (1) one Diversity complaint that was discussed and follow-up was completed. There was no need for an investigation.
- Bi-weekly business update with Dale Villani, CEO, GCHP.
- Plan to start my quarterly review with Executive staff to update them on the Diversity strategic plan and to identify needs for improvement.
FINANCIAL PACKAGE
For the month ended March 2019

TABLE OF CONTENTS

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

## ASSETS

<table>
<thead>
<tr>
<th></th>
<th>03/31/19</th>
<th>02/28/19</th>
<th>01/31/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cash and Cash Equivalents</td>
<td>$186,238,369</td>
<td>$96,950,115</td>
<td>$97,063,326</td>
</tr>
<tr>
<td>Total Short-Term Investments</td>
<td>46,661,093</td>
<td>46,520,731</td>
<td>46,388,819</td>
</tr>
<tr>
<td>Medi-Cal Receivable</td>
<td>85,035,618</td>
<td>105,452,919</td>
<td>98,111,098</td>
</tr>
<tr>
<td>Interest Receivable</td>
<td>386,826</td>
<td>440,728</td>
<td>426,526</td>
</tr>
<tr>
<td>Provider Receivable</td>
<td>285,133</td>
<td>394,421</td>
<td>353,526</td>
</tr>
<tr>
<td>Other Receivables</td>
<td>6,780,916</td>
<td>5,781,626</td>
<td>6,778,244</td>
</tr>
<tr>
<td><strong>Total Accounts Receivable</strong></td>
<td><strong>52,496,494</strong></td>
<td><strong>113,059,894</strong></td>
<td><strong>106,570,394</strong></td>
</tr>
<tr>
<td>Total Prepaid Accounts</td>
<td>1,709,046</td>
<td>1,726,030</td>
<td>2,029,019</td>
</tr>
<tr>
<td>Total Other Current Assets</td>
<td>168,060</td>
<td>170,560</td>
<td>170,560</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td><strong>327,273,082</strong></td>
<td><strong>258,427,130</strong></td>
<td><strong>251,322,119</strong></td>
</tr>
<tr>
<td>Total Fixed Assets</td>
<td>1,658,081</td>
<td>1,725,626</td>
<td>1,771,503</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$328,971,122</strong></td>
<td><strong>$260,152,756</strong></td>
<td><strong>$253,093,622</strong></td>
</tr>
</tbody>
</table>

## LIABILITIES & NET ASSETS

<table>
<thead>
<tr>
<th></th>
<th>03/31/19</th>
<th>02/28/19</th>
<th>01/31/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inurred But Not Reported</td>
<td>$53,636,086</td>
<td>$45,755,782</td>
<td>$43,912,016</td>
</tr>
<tr>
<td>Claims Payable</td>
<td>39,518,458</td>
<td>35,641,444</td>
<td>35,112,912</td>
</tr>
<tr>
<td>Capitation Payable</td>
<td>28,800,886</td>
<td>28,681,916</td>
<td>28,661,653</td>
</tr>
<tr>
<td>Physician Payable</td>
<td>3,465,375</td>
<td>5,199,782</td>
<td>4,984,537</td>
</tr>
<tr>
<td>DHCS - Reserve for Capitation Recoup</td>
<td>2,721,112</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>719,178</td>
<td>217,748</td>
<td>1,198,968</td>
</tr>
<tr>
<td>Accrued ACS</td>
<td>3,335,302</td>
<td>3,224,688</td>
<td>1,631,555</td>
</tr>
<tr>
<td>Accrued Provider Reserve</td>
<td>1,689,926</td>
<td>1,538,819</td>
<td>1,383,658</td>
</tr>
<tr>
<td>Accrued Expenses</td>
<td>69,444,453</td>
<td>8,966,265</td>
<td>8,371,513</td>
</tr>
<tr>
<td>Accrued Premium Tax</td>
<td>21,562,461</td>
<td>13,687,005</td>
<td>5,811,650</td>
</tr>
<tr>
<td>Accrued Payroll Expense</td>
<td>1,704,091</td>
<td>1,525,455</td>
<td>1,535,436</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td><strong>226,627,257</strong></td>
<td><strong>144,169,945</strong></td>
<td><strong>132,604,496</strong></td>
</tr>
<tr>
<td><strong>Long-Term Liabilities:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Long-term Liability-Deferred Rent</td>
<td>1,129,812</td>
<td>1,294,83</td>
<td>1,129,154</td>
</tr>
<tr>
<td><strong>Total Long-Term Liabilities</strong></td>
<td><strong>1,129,812</strong></td>
<td><strong>1,294,83</strong></td>
<td><strong>1,129,154</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>227,757,069</strong></td>
<td><strong>145,399,828</strong></td>
<td><strong>133,733,650</strong></td>
</tr>
</tbody>
</table>

## Net Assets:

<table>
<thead>
<tr>
<th></th>
<th>03/31/19</th>
<th>02/28/19</th>
<th>01/31/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Increase / (Decrease in Unrestricted Net Assets)</td>
<td>(30,901,318)</td>
<td>(17,262,043)</td>
<td>(12,755,399)</td>
</tr>
<tr>
<td><strong>Total Net Assets</strong></td>
<td><strong>$101,214,053</strong></td>
<td><strong>$114,853,328</strong></td>
<td><strong>$119,359,972</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Net Assets</strong></td>
<td><strong>$328,971,122</strong></td>
<td><strong>$260,152,756</strong></td>
<td><strong>$253,093,622</strong></td>
</tr>
</tbody>
</table>
**STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS**
**FOR NINE MONTHS ENDED MARCH 31, 2019**

|                                  | March 2019 Actual  | March 2019 Year-To-Date Budget | Variance  | Variance %
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Membership (includes retro members)</strong></td>
<td>197,064</td>
<td>1,784,543</td>
<td>1,235,460</td>
<td>(-2.13%)</td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td>67,533,392</td>
<td>513,767,736</td>
<td>569,609,736</td>
<td>17,088,000</td>
</tr>
<tr>
<td>Reserve for Cap Requirements</td>
<td>(2,721,112)</td>
<td>(2,721,112)</td>
<td>(2,721,112)</td>
<td>0.00%</td>
</tr>
<tr>
<td>MCO Premium Tax</td>
<td>(7,875,415)</td>
<td>(78,875,415)</td>
<td>(78,875,415)</td>
<td>2.29%</td>
</tr>
<tr>
<td><strong>Total Net Premium</strong></td>
<td>56,936,855</td>
<td>540,167,887</td>
<td>527,408,580</td>
<td>12,759,306</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>66,936,855</td>
<td>540,167,887</td>
<td>527,408,580</td>
<td>12,759,306</td>
</tr>
<tr>
<td><strong>Medical Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitation (IPC, Specialty, Kaiser, NEMT &amp; Vision)</td>
<td>5,149,121</td>
<td>45,797,814</td>
<td>44,383,183</td>
<td>(-1.66%)</td>
</tr>
<tr>
<td>FFS Claims Expenses:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>18,835,695</td>
<td>108,512,778</td>
<td>94,495,422</td>
<td>(13,005,356)</td>
</tr>
<tr>
<td>LTC / SNF</td>
<td>12,369,835</td>
<td>98,194,122</td>
<td>94,495,422</td>
<td>(3,796,543)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>4,125,810</td>
<td>44,176,678</td>
<td>42,323,119</td>
<td>-2.19%</td>
</tr>
<tr>
<td>Laboratory and Radiology</td>
<td>580,027</td>
<td>5,161,081</td>
<td>2,671,187</td>
<td>(-61.56%)</td>
</tr>
<tr>
<td>Directed Payments - Provider</td>
<td>1,290,940</td>
<td>9,721,718</td>
<td>(9,721,718)</td>
<td>0.00%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>2,725,190</td>
<td>20,675,652</td>
<td>20,199,972</td>
<td>(-2.40%)</td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>5,457,128</td>
<td>46,085,661</td>
<td>40,212,885</td>
<td>(-12.35%)</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>1,235,870</td>
<td>12,785,408</td>
<td>12,587,538</td>
<td>-1.20%</td>
</tr>
<tr>
<td>Home &amp; Community Based Services</td>
<td>1,247,448</td>
<td>14,455,601</td>
<td>12,807,746</td>
<td>12.80%</td>
</tr>
<tr>
<td>Applied Behavior Analysis Services</td>
<td>1,021,894</td>
<td>7,934,628</td>
<td>5,821,111</td>
<td>-43.69%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>842,047</td>
<td>6,073,476</td>
<td>4,300,484</td>
<td>-10.09%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>11,332,938</td>
<td>99,574,692</td>
<td>89,271,681</td>
<td>-12.65%</td>
</tr>
<tr>
<td>Provider Reserve</td>
<td>153,106</td>
<td>1,703,826</td>
<td>1,550,720</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other Medical Professional</td>
<td>432,828</td>
<td>3,032,618</td>
<td>2,599,792</td>
<td>-14.20%</td>
</tr>
<tr>
<td>Other Medical Care</td>
<td>2,080</td>
<td>25,488</td>
<td>23,498</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other Fee For Service</td>
<td>2,615,180</td>
<td>6,812,577</td>
<td>6,692,674</td>
<td>0.17%</td>
</tr>
<tr>
<td>Transportation</td>
<td>351,210</td>
<td>1,007,260</td>
<td>655,020</td>
<td>-42.51%</td>
</tr>
<tr>
<td><strong>Total Claims</strong></td>
<td>55,079,777</td>
<td>438,757,084</td>
<td>385,677,311</td>
<td>-10.71%</td>
</tr>
<tr>
<td><strong>Medical &amp; Care Management Expense</strong></td>
<td>1,471,714</td>
<td>10,681,441</td>
<td>11,191,607</td>
<td>4.73%</td>
</tr>
<tr>
<td><strong>Reinsurance</strong></td>
<td>2,446,838</td>
<td>23,109,408</td>
<td>(20,662,570)</td>
<td>189.87%</td>
</tr>
<tr>
<td><strong>Claims Recoveries</strong></td>
<td>(17,430)</td>
<td>(987,050)</td>
<td>867,025</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>1,698,892</td>
<td>5,742,520</td>
<td>5,054,708</td>
<td>44.12%</td>
</tr>
<tr>
<td><strong>Total Cost of Health Care</strong></td>
<td>62,779,299</td>
<td>539,879,349</td>
<td>524,090,251</td>
<td>-8.55%</td>
</tr>
<tr>
<td><strong>Contribution Margin</strong></td>
<td>(9,795,925)</td>
<td>(10,068,373)</td>
<td>(25,909,545)</td>
<td>36.49%</td>
</tr>
<tr>
<td><strong>General &amp; Administrative Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, Wages &amp; Employee Benefits</td>
<td>2,034,261</td>
<td>18,481,541</td>
<td>18,551,400</td>
<td>73,399</td>
</tr>
<tr>
<td>Training, Conference &amp; Travel</td>
<td>2,049,340</td>
<td>19,295,922</td>
<td>20,304,262</td>
<td>62.47%</td>
</tr>
<tr>
<td>Outside Services</td>
<td>3,278,283</td>
<td>30,418,735</td>
<td>27,840,453</td>
<td>91.72%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>441,188</td>
<td>2,137,804</td>
<td>1,696,641</td>
<td>20.59%</td>
</tr>
<tr>
<td>Depreciation, Supplies, Insurance &amp; Others</td>
<td>679,543</td>
<td>5,929,222</td>
<td>5,550,665</td>
<td>20.34%</td>
</tr>
<tr>
<td>Care Management 441,188</td>
<td>(1,471,714)</td>
<td>(10,681,441)</td>
<td>(8,209,727)</td>
<td>171.21%</td>
</tr>
<tr>
<td><strong>GSA Expenses</strong></td>
<td>3,085,037</td>
<td>34,863,035</td>
<td>32,778,000</td>
<td>7.46%</td>
</tr>
<tr>
<td><strong>Project Portfolio</strong></td>
<td>228,684</td>
<td>818,098</td>
<td>598,403</td>
<td>1.72%</td>
</tr>
<tr>
<td><strong>Total G&amp;A Expenses</strong></td>
<td>4,111,320</td>
<td>35,095,974</td>
<td>30,984,647</td>
<td>1.38%</td>
</tr>
<tr>
<td><strong>Total Operating Gain / (Loss)</strong></td>
<td>(13,902,844)</td>
<td>(33,979,838)</td>
<td>(24,082,771)</td>
<td>243.33%</td>
</tr>
<tr>
<td><strong>Non Operating</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenues - Interest</td>
<td>283,871</td>
<td>3,078,818</td>
<td>703,211</td>
<td>237,507</td>
</tr>
<tr>
<td><strong>Total Non-Operating</strong></td>
<td>283,871</td>
<td>3,078,818</td>
<td>703,211</td>
<td>237,507</td>
</tr>
<tr>
<td><strong>Total Increase / (Decrease) in Unrestricted Net Assets</strong></td>
<td>(13,629,275)</td>
<td>(30,901,518)</td>
<td>(6,191,824)</td>
<td>(21,707,465)</td>
</tr>
</tbody>
</table>
## INCOME STATEMENT BY CATEGORY OF AID
**FOR NINE MONTHS ENDED MARCH 31, 2019**

<table>
<thead>
<tr>
<th></th>
<th>MARCH 2019 Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AE</td>
</tr>
<tr>
<td><strong>Membership (includes retro members)</strong></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td>208,866,186</td>
</tr>
<tr>
<td>Reserve for Cap Requirements</td>
<td>(837,352)</td>
</tr>
<tr>
<td>MCCO Premium Tax</td>
<td>(19,444,727)</td>
</tr>
<tr>
<td><strong>Total Net Premium</strong></td>
<td>188,585,106</td>
</tr>
<tr>
<td>Medical Expenses:</td>
<td></td>
</tr>
<tr>
<td>Capitation (PCP, Specialty, Kaiser, NEMT &amp; Vision)</td>
<td>21,607,556</td>
</tr>
<tr>
<td>FFS Claims Expenses:</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>50,564,112</td>
</tr>
<tr>
<td>LTC / SNF</td>
<td>10,548,434</td>
</tr>
<tr>
<td>Outpatient</td>
<td>19,836,368</td>
</tr>
<tr>
<td>Laboratory and Radiology</td>
<td>1,503,915</td>
</tr>
<tr>
<td>Directed Payments - Provider</td>
<td>2,992,505</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>7,629,914</td>
</tr>
<tr>
<td>Physician Specialty</td>
<td>20,424,727</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>3,652,818</td>
</tr>
<tr>
<td>Home &amp; Community Based Services</td>
<td>1,717,616</td>
</tr>
<tr>
<td>Applied Behavior Analysis Services</td>
<td>-</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>2,372,166</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>49,084,453</td>
</tr>
<tr>
<td>Adult Expansion Reserve</td>
<td>886,414</td>
</tr>
<tr>
<td>Other Medical Professional</td>
<td>1,494,293</td>
</tr>
<tr>
<td>Other Medical Care</td>
<td>-</td>
</tr>
<tr>
<td>Other Fee For Service</td>
<td>1,346,850</td>
</tr>
<tr>
<td>Transportation</td>
<td>765,124</td>
</tr>
<tr>
<td><strong>Total Claims</strong></td>
<td>174,618,809</td>
</tr>
<tr>
<td>Medical &amp; Care Management Expense</td>
<td>3,843,082</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>636,564</td>
</tr>
<tr>
<td>Claims Recoveries</td>
<td>-</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>4,479,645</td>
</tr>
<tr>
<td><strong>Total Cost of Health Care</strong></td>
<td>200,966,111</td>
</tr>
<tr>
<td><strong>Contribution Margin</strong></td>
<td>(12,321,005)</td>
</tr>
<tr>
<td>Category</td>
<td>March 2019</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Cash Flows Provided By Operating Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Net income (Loss)</td>
<td>(13,639,275)</td>
</tr>
<tr>
<td><strong>Adjustments to reconciled net income to net cash provided by operating activities</strong></td>
<td></td>
</tr>
<tr>
<td>Depreciation on fixed assets</td>
<td>46,097</td>
</tr>
<tr>
<td>Amortization of discounts and premium</td>
<td>-</td>
</tr>
<tr>
<td><strong>Changes in Operating Assets and Liabilities</strong></td>
<td></td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>20,563,200</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>19,484</td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>64,712,726</td>
</tr>
<tr>
<td>Claims Payable</td>
<td>1,991,577</td>
</tr>
<tr>
<td>MCO Tax liability</td>
<td>7,875,415</td>
</tr>
<tr>
<td>IBNR</td>
<td>7,880,304</td>
</tr>
<tr>
<td><strong>Net Cash Provided by (Used in) Operating Activities</strong></td>
<td>89,449,530</td>
</tr>
<tr>
<td><strong>Cash Flow Provided By Investing Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Proceeds from Restricted Cash &amp; Other Assets</td>
<td></td>
</tr>
<tr>
<td>Proceeds from Investments</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds for Sales of Property, Plant and Equipment</td>
<td></td>
</tr>
<tr>
<td>Payments for Restricted Cash and Other Assets</td>
<td></td>
</tr>
<tr>
<td>Purchase of Investments plus Interest reinvested</td>
<td>(140,362)</td>
</tr>
<tr>
<td>Purchase of Property and Equipment</td>
<td>(20,914)</td>
</tr>
<tr>
<td><strong>Net Cash (Used In) Provided by Investing Activities</strong></td>
<td>(161,276)</td>
</tr>
<tr>
<td><strong>Increase/(Decrease) in Cash and Cash Equivalents</strong></td>
<td>89,288,253</td>
</tr>
<tr>
<td>Cash and Cash Equivalents, Beginning of Period</td>
<td>96,950,115</td>
</tr>
<tr>
<td>Cash and Cash Equivalents, End of Period</td>
<td>186,238,369</td>
</tr>
</tbody>
</table>
AGENDA ITEM NO. 12

TO: Ventura County Medi-Cal Managed Care Commission
FROM: Nancy Wharfield, MD, Chief Medical Officer
DATE: May 20, 2019
SUBJECT: Chief Medical Officer Update

Ventura County Community Health Needs Assessment (VC CHNA)

The VC CHNA collaborative was created to comply with Affordable Care Act/IRS tax-exempt requirements and Public Health Accreditation Board (PHAB) standards. Charitable hospitals must conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. The CHNA must take into account input from persons who represent the broad interests of the knowledge of or expertise in public health. The CHNA must also be made widely available to the public.

Under the direction of the Ventura County Public Health Department (VCPH), the mission of the VC CHNA is to build partnerships between VCPH, area hospitals, health providers, and health systems including Gold Coast Health Plan, to improve population health outcomes in Ventura County. The first collaborative assessment will be published in June 2019 and will result in a cooperative approach to addressing population health and benefit the communities we serve.

On April 29, 2019, the VC CHNA met to review feasibility study results, which included analysis of over 20,000 surveys and identified disparities in Ventura County. Gold Coast Health Plan (GCHP) staff are actively participating in these efforts which will result in a fully integrated Community Health Improvement/Implementation Plan (CHIP) that aligns with identified health priorities and focuses on achieving health equity. The collaborative has provided an effective platform for GCHP to advocate for member needs, identify shared goals, and support the work of our community partners.

Additionally, the Communities Lifting Communities (CLC) project, a subcommittee of the CHNA collaborative, was created to address the needs of our prediabetic population in Ventura County. GCHP continues to actively partner in this effort as we develop strategies to address food insecurity and identify social determinants of health affecting population.

Medi-Cal Managed Care Plans like GCHP are also required to conduct a needs assessment for their members. The GCHP Health Education and Cultural and Linguistic Group Needs Assessment (GNA) is directed by the Department of Health Care Services (DHCS) All Plan Letter (APL) 10-012 to explore the cultural, linguistic and health education needs of our membership. The GCHP GNA identifies health disparities, barriers to care, and gaps in
services which lead to a better understanding of our members' health risks and needs and helps to create health education, cultural and linguistic and quality improvement programs to support improved health outcomes. The GCHP GNA is scheduled to be published 2021.

Social Finance Cost of Homelessness Study

Sharing information across service sectors is an important activity which supports models of coordinated care across medical and community services, orienting care around the needs of an individual. For the past three years, GCHP has collaborated with the Whole Person Care (WPC) Pilot in Ventura County by providing cost and utilization data for the population they serve. The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.

Currently, the County of Ventura, with supplemental funding from the cities of Oxnard and Ventura and other sources, is engaging the services of Social Finance in the development of a local study about the cost of homelessness. Gathering information about medical, emergency response, behavioral health and law enforcement expenditures for homeless persons in our County is anticipated to not only inform future policies to target limited resources for those with the greatest need, but provide critical information to pursue pay for success financing for permanent supportive housing for this population.

Social Finance is a nonprofit organization which partners with governments, nonprofits, foundations, impact investors, and financial institutions to create innovative financing solutions to improve social outcomes. In April 2019, GCHP collaborated with Social Finance and the County of Ventura to provide valuable information about the medical costs of homelessness. Homelessness contributes to increased utilization and costs of inpatient days and emergency department use. This information will help to inform strategies to improve the housing inventory and reduce service gaps in our county and lead to improved health outcomes in our homeless population.
Measles Update

The number of measles cases in the United States continues to rise and as of May 10, 2019, there were over 800 reported cases. While no cases have been reported in Ventura County, there have been measles outbreaks in Los Angeles and Orange counties. GCHP utilized our member publication, Winning Health, to encourage members who need it to get a measles vaccine and to seek care immediately if they have measles symptoms.

California State University Channel Islands (CSUCI) Nursing Students at GCHP

Five California State University, Channel Islands (CSUCI) nursing students completed the Spring semester Nursing Leadership Lab at GCHP on May 10, 2019. Each student was assigned to one of our most seasoned and experienced RN leaders who worked with the students to introduce them to Medi-Cal Managed Care and the role of nursing in promoting evidence based care and community collaboration over the 14 week semester that started in January. The students presented the results of an evidence based clinical project to the nursing leadership team the first week of May. Projects ranged from applications of the scope of practice to improving productivity of clinical assistants to improving member outcomes. All five BSN students, who hailed from CSUCI’s Goleta campus, will graduate from CSUCI on May 18, and take their licensing exam to become entry level RNs this summer. The students have secured employment in hospitals, and expressed appreciation for their experiences at GCHP. Their projects are listed below:

- RN Scope of Practice in Care Management
- Improving Childhood Immunizations
- Care Plan: Hypertension
- Increasing Productivity of Clinical Operations Assistants
- Utilization of Evidence Based Guidelines by Concurrent Stay Review RNs
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 March 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 utilizor 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:
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).
ONGOING 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 provider offices in the following mechanisms in order to facilitate more efficient PBM communications for provider offices:
- Provider Survey on PBM Functions
- GCHP Pharmacy Staff Provider Office Visits
AGENDA ITEM NO. 13

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ted Bagley, Chief Diversity Officer

DATE: May 20, 2019

SUBJECT: Chief Diversity Officer Update

Community Relations

- Attended meeting with Girl Scouts of America to assist with their diversity training as needed.
- Met with Gold Coast Veteran’s Board to advise on specifics around homeless veterans entering the Veteran’s Court system and to strategize on getting more help from the elected officials related to housing and employment for the veteran population.
- Still working with Dr. Irene Pinkard of The Pinkard Institute, in putting together a directory of diverse resources in Oxnard, Camarillo, Westlake, Thousand Oaks and Simi Valley. Project should be complete by mid-year.
- Had a call with NAVEX (Data compliance resource) to continually understand how their “Hot Line” reporting works and ensure that all diversity related reports are sent to me directly.

Gold Coast Health Plan

- Held Diversity meeting at GCHP with a focus on identifying major diversity lunch and learn topics. A diversity quiz was distributed to employees for the purpose of identifying community events that should be recognized. Response data will be compiled and shared with the Executive team.
- Five (5) coaching sessions not related to Diversity - mostly career development.
- No Diversity investigations during the month.
- There were no “Hotline” calls during the month.
- There was (1) Diversity complaint that was discussed and follow-up was completed. There was no need for an investigation.
- Bi-weekly business update with Dale Villani, CEO, GCHP.
- Plan to start my quarterly review with Executive staff to update them on the Diversity strategic plan and to identify any needs for improvement.
Commissioner diversity training scheduled for May 29th, 2019 in the Community Room at GCHP. There are concerns about the planned attendance. A letter will be sent to the commission to see if there is a need to reschedule. As of this report, there are three (3) commissioners who have conflicts and two (2) others who have not responded.
AGENDA ITEM NO. 14

TO: Ventura County Medi-Cal Managed Care Commission

FROM: Ruth Watson, Chief Operating Officer

DATE: May 20, 2019

SUBJECT: Chief Operating Officer Update

Executive Summary

GCHP membership for May 2019 is 194,206, a slight increase in membership of 329 members. Since March GCHP membership has shown a small increase of 934 members. As always, Medi-Cal membership churn continues - 5,243 members were terminated, while 3,484 members were added (2,088 retroactively).

Proposition 56 (Prop 56) – Proposition 56 (also referred to as the “smoking tax”) allows for additional reimbursement to providers who see members for specified qualifying services. DHCS provides Prop 56 funding for monthly disbursement by the Plan to providers who meet the criteria for payment.

Below are the Year to Date totals of payments to qualifying providers from the Plan.

<table>
<thead>
<tr>
<th>Total GCHP Prop 56 Payments as of 05/15/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 17-18</td>
</tr>
<tr>
<td>FY 18-19</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

The Governor’s 2019-2020 budget proposes to make three changes to Prop 56 funding:
- Use all Prop 56 funding on provider payment increases
- Intent to make Prop 56 provider funding permanent
- New provider payment increases aimed at improving care in such areas as identification of children with developmental delays and chronic disease management (through a new value based payment program to be developed)

Additional information will be reported by Staff, including updates to payments made to providers by the Plan on a quarterly basis following submission of data to the State and based on budget updates from the Governor.
Regulatory:

- **Annual Network Certification (ANC)** – The State responded to the Plan with preliminary findings of the ANC submission. Of the 54 items the State reviewed that allows for a pass/fail, 2 were not applicable to the Plan, 2 were still in review by the State (submission of a contract signature page) and 1 required a narrative regarding the availability of a licensed Midwife. All required submissions have been sent timely to the State and we are awaiting final disposition.

- **274 State File Submission** – The State continues to adjust requirements on what is reported on the 274 monthly network file. Staff continues to enhance the quality of each monthly 274 file submission to the State as DHCS requirements morph and change. The following enhancements have been implemented:
  - Member assignment counts to PCPs, and
  - Identification of mid-level supervising physicians.

Changes to be reflected in the next 274 monthly file submission.

- **Annual Medical Audit** – Staff is in preparing for the upcoming DHCS annual Medical Audit to be conducted the week of June 3rd.

**Provider Advisory Committee (PAC):**

The first of 4 four scheduled PAC meetings occurred on May 8, 2019. Nine out of eleven PAC members were in attendance representing all facets of the Plan’s provider network. GCHP is in the process of filling one of the two remaining Committee member seats. We are looking to fill the final seat with a behavioral health provider and are pursuing recommendations to fulfill this last seat on the PAC.

**Contracting:**

- Provider Contracting and Credentialing Management System (PCCM-Symplir) – This major system initiative to replace Network Operations and Credentialing’s legacy provider network data base, was kicked off on April 8th. The project is in the system requirement phase. The first iteration of the new system (eVIPS) is scheduled for Plan review within the next 30 days. It is expected that the system implementation and integration will take 12 months from the date of the kick-off meeting. This process includes a comprehensive provider data base remediation project of all GCHP providers and their contracts, the status of which is as follows:
  - 476 provider contract folders have been reviewed and updated
  - 587 contracts have been audited and updated
• Better Doctors – This initiative is tied to the above system implementation to ensure clean provider data goes into the new system by verifying the demographic information obtained from Better Doctors. The following reviews were performed:
  - 317 providers were completed and updated in Provider Network Database (PNDB)
  - 1644 provider records were audited to ensure the providers were loaded accurately in PNDB and IKA (GCHP Claims system).

• GCHP has instituted a 90-day moratorium on new provider contracts and contract rate renewals pending receipt and review of DHCS Plan rates and the impact to the upcoming budget.

• Medi-Cal Licensing Project:
  - Todd Matthews, MD (Podiatrist) Foot and Ankle - Transitioned from Interim
  - Letter of Agreement was added to the Foot and Ankle Concepts, Inc. as fully contracted provider.
  - CMH- Midtown Medical Brent Street location- Transitioned from Interim Letter of Agreement and was added to CMH as a fully contracted location.
  - West Coast Vascular – Amended agreement to cover provider entity while waiting on completion of DHCS review for Medi-Cal licensing.
  - Genetics Center- Updated rate sheet to include newly updated Prenatal Screening CPT Code.
Plan Operations Metrics

Call Center Metrics FY2018-2019

Average calls received monthly
- Total calls received = 11,586
- % member calls = 48%
- % provider calls = 52%
- % Spanish calls = 7%
Call Center Metrics FY2018-2019

Abandonment Rate Goal ≤ 5%

- Staff attrition due to competition with new call center in area resulted in abandonment rates not being met 8/2018 – 11/2018
- Conduent was issued a corrective action plan and penalties were assessed
- Corrective actions included – hiring additional staff and adding a new site in Phoenix
- Abandonment rates have been met consistently since 12/2018
Call Center Metrics FY2018-2019

- Staff attrition due to competition with new call center in area resulted in abandonment rates not being met 8/2018 – 11/2018
- Conduent was issued a corrective action plan and penalties were assessed.
- Corrective actions included – hiring additional staff and adding a new site in Phoenix
- ASA metrics have been met consistently since 12/2018
Encounter Data Submission FY 2018-2019

DHCS Submissions & Encounter Quality

- This graph represents the quality of encounter data as received by GCHP from its provider partners
- Percentages listed indicate encounter data returned to providers for correction and re-submission
- Encounter quality metrics continue to be an area of strength for GCHP
Encounter Data Submission FY 2018-2019

- Q2, Q3 and Q4 scores were negatively impacted by the reprocessing and resubmittal of pharmacy claims by Optum Rx
- Q1 2019 results are back at 100%
Grievance and Appeals FY2018-2019

Total Grievances

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>34</td>
<td>27</td>
<td>18</td>
<td>24</td>
<td>34</td>
<td>21</td>
<td>29</td>
<td>17</td>
<td>32</td>
<td>20</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td>Provider</td>
<td>108</td>
<td>147</td>
<td>117</td>
<td>151</td>
<td>170</td>
<td>227</td>
<td>203</td>
<td>153</td>
<td>132</td>
<td>219</td>
<td>169</td>
<td>260</td>
</tr>
<tr>
<td>Combined</td>
<td>142</td>
<td>174</td>
<td>135</td>
<td>175</td>
<td>204</td>
<td>248</td>
<td>232</td>
<td>170</td>
<td>164</td>
<td>239</td>
<td>196</td>
<td>284</td>
</tr>
</tbody>
</table>

- GCHP Grievance volume remains relatively static month over month
Grievance and Appeals FY2018-2019

<table>
<thead>
<tr>
<th>Month</th>
<th>Upheld</th>
<th>Overturned</th>
<th>Withdrawn</th>
<th>Total # of Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-18</td>
<td>10</td>
<td>1</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>May-18</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Jun-18</td>
<td>4</td>
<td>1</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>Jul-18</td>
<td>2</td>
<td>11</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Aug-18</td>
<td>2</td>
<td>6</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Sep-18</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Oct-18</td>
<td>1</td>
<td>14</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Nov-18</td>
<td>2</td>
<td>9</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Dec-18</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Jan-19</td>
<td>0</td>
<td>13</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Feb-19</td>
<td>0</td>
<td>18</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>Mar-19</td>
<td>1</td>
<td>15</td>
<td>1</td>
<td>27</td>
</tr>
</tbody>
</table>

- The appeals spike in November and December of 2018 are directly related to one provider submitting increased volume. GCHP is working to resolve this provider issue through traditional methods.